

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF NEW YORK

MICHELE BAKER; CHARLES CARR; ANGELA CORBETT; PAMELA FORREST; MICHAEL HICKEY, individually and as parent and natural guardian of O.H., infant; KATHLEEN MAINLINGENER; KRISTIN MILLER, as parent and natural guardian of K.M., infant; JENNIFER PLOUFFE; SILVIA POTTER, individually and as parent and natural guardian of C.P, infant; and DANIEL SCHUTTIG, individually and on behalf of all others similarly situated,

Plaintiffs,

CIV. No. 1:16-CV-917 (LEK/DJS)

v.

SAINT-GOBAIN PERFORMANCE PLASTICS CORP., HONEYWELL INTERNATIONAL INC. f/k/a ALLIED-SIGNAL INC. and/or ALLIEDSIGNAL LAMINATE SYSTEMS, INC., E.I. DUPONT DE NEMOURS AND COMPANY and 3M CO.,

Defendants.

DECLARATION OF EDGAR C. GENTLE, III

I, Edgar C. Gentle, III, declare and state as follows:

1. I prepared the Expert Report attached as Exhibit A to this Declaration.
2. Each of the opinions in the Expert Report is stated to a reasonable degree of medical and scientific certainty and was arrived at using reliable and generally accepted scientific methods.
3. If called as a witness, I will testify competently to the matters stated in this Expert Report.
4. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: March 30, 2020


EDGAR C. GENTLE, III

EXHIBIT A

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF NEW YORK

MICHELE BAKER, *et al.*,)
 Individually, and on behalf of a Class of)
 persons similarly situated,)
)
 Plaintiffs,)
)
 v.)
)
 SAINT-GOBAIN PERFORMANCE)
 PLASTICS CORP., HONEYWELL)
 INTERNATIONAL INC. f/k/a ALLIED-)
 SIGNAL INC. and/or ALLIEDSIGNAL)
 LAMINATE SYSTEMS, INC., E.I. DUPONT)
 DE NEMOURS AND COMPANY and)
 3M CO.)
)
 Defendants.)

Case No. 1:16-CV-917 (LEK/DJS)

EXPERT REPORT OF EDGAR C. GENTLE, III, ESQ.

1. I have been asked by counsel for Plaintiffs, to provide this report as a **Medical Monitoring administration expert** in support of Plaintiffs’ Motion for Class Certification. I bill \$400 per hour for my services in this matter.

2. My education and experience are summarized as follows. I have 5 college degrees, 3 in law. I have been a licensed attorney, practicing in the State of Alabama, since September 25, 1981. As part of my practice, I have had the opportunity to serve as the Special Master or Claims Administrator of the Settlements around the country depicted in my resume attached as Exhibit A. In that capacity, I have had the opportunity to administer settlements involving either medical testing or medical clinics in Tolbert et al. v Monsanto Company, et al., in the United States District Court for the Northern District of Alabama, Southern Division, Civil Actions No. 2:01-cv-1407-UWC and 2:02-cv-0836-UWC (the “Tolbert Case”)(clinic); Lenora

Perrine, et al. v. E.I. DuPont De Nemours & Company, et al., in the Circuit Court of Harrison County, West Virginia, Civil Action No. 04-C-296-2, before the Honorable Thomas A. Bedell, having been appointed in 2009 (the “Perrine Case”)(testing); and, In Re: Mingo County Coal Slurry Litigation, in the Circuit Court of Ohio County, West Virginia, Civil Action No. 10-C-5000, before the Honorable James P. Mazzone, having been appointed in 2013 (the “Mingo Case”)(testing). I have also taken over the duties of administering the Perrine Medical Monitoring Program testing in-house, rather than utilizing a third-party administrator. I have served as an Expert Witness in the Medical Monitoring Class Action case of James D. Sullivan et al. v. Saint-Gobain Performance Plastics Corporation, in the United States District Court for the District of Vermont, Civil Action No. 5:16-cv-000125-GWC, before the Honorable Geoffrey W. Crawford, having testified as a deponent evidenced by the transcript in Exhibit B.

During the past 4 years I have provided the following additional expert testimony:

A. Allen et al. v. A.E. New et al., in the Circuit Court of Escambia County, Florida:

- (i). Settlement Administrator affidavit testimony on Settlement Grid Design in Jail Explosion Settlement for Public Objectors’ Hearing, on January 7, 2019.
- (ii). Settlement Administrator live testimony on how Settlement claims were scored at February 11 and 12, 2019 Public Fairness Hearing.

B. Abernathy et al. v. Occidental Chemical Corporation et al., in the Circuit Court of Colbert County, Alabama:

- (i). Settlement Administrator affidavit and live testimony on the fairness of a confidential Aggregate Chemical Contamination Settlement for minor claimants with the Occidental Defendants on May 6, 2019.

- (ii). Settlement Administrator affidavit testimony on the fairness of a confidential Aggregate Chemical Contamination Settlement between Plaintiffs and the Shaw Defendants on February 12, 2020.

I have been involved in the creation and administration of a variety of mass tort settlements with expenditures exceeding \$2 Billion.

3. I am the Claims Administrator for the Tolbert Case, having been appointed at Thanksgiving 2003, with the medical component lasting from 2003 until 2016. As Claims Administrator, I was responsible for overseeing all Claimant blood testing for the Tolbert Case and making all the resulting Claimant Benefit Payments from the Tolbert Fund, and administering a medical clinic that provided primary medical and dental care and prescriptions to the Claimants for an 11 year span from 2005 to 2016. CTIA acted as the Third-Party Administrator of the medical clinic.

4. I am also the Claims Administrator for the Perrine Case, which includes a 30 year biennial (every two years) Medical Monitoring Program that began in November 2011 and concludes in November 2041. As the Claims Administrator and Third-Party Administrator, I am responsible for supervising the Medical Monitoring Program.

5. In the Perrine Case, we initially engaged CTIA to act as the Third-Party Administrator of the Medical Monitoring Program, but my office, with the agreement of the Parties, took over the role after 4 rounds of testing because in that instance it was more cost effective.

6. In serving as Administrator of the above three medical programs, two being for medical monitoring, and one being for a claimant medical clinic, we usually provide the following services:

A. Participants are recruited and registered for the program. We confirm or deny patient medical program eligibility. Participant addresses are updated, and the participants are encouraged to participate and are updated about the program with newsletters and periodic on the ground meetings. Participants may be encouraged to help design the program by suggesting program medical providers they know and are comfortable with. We often convene a small Claimants Committee to facilitate participant program input. We understand that the Medical Monitoring Class in this case is defined as any individual with a blood level of perfluorooctanoic acid (“PFOA” or “C8”) above background (1.86 ug/L). We understand that there have been two rounds of testing in this

Redacted Pursuant to Protective Order (ECF Nos. 131 & 132)

B. We budget and financially administer the program, providing counsel for the Parties Financial Reports and preparing budgets, comparisons of actual expenditures with the budgets, accountings and tax returns for the program. We review and pay program expenses with sound accounting internal controls. We often use a Qualified Settlement Fund (a “QSF”) in program administration as a means by which Settlement funds are held and disbursed as approved by the Court.

C. We organize and conduct periodic program oversight meetings with a Finance Committee (comprised of Party representatives and ourselves) and the Claimants Committee, and, where appropriate, also serve as Third-Party Administrator, as we do for the Mingo and Perrine cases.

D. We facilitate the compilation of medical monitoring and epidemiological

study data for use in medical monitoring planning and possible research, while safeguarding participant confidentiality.

E. We often provide an on-the-ground presence for Medical Monitoring Programs by utilizing a local office to interface with participants and medical staff. By having a local office, we are often able to increase program participation, answer any questions and assist participants in a more timely fashion and be more accessible to the participants.

F. We charge for our services at hourly rates agreed to by the finance committee and within a budget. We have found that our administrative expenses run an average of 10% of program outlay once the program testing begins.

7. Based on our administrative experience in other cases, the following are additional parameters that should be addressed in implementing a Medical Monitoring Program:

A. **Participant Time is Valuable.** To recognize that the participant is taking the time to participate, participant monetary incentives for each stage of the program are recommended, including program recruitment and registration, and program participation. In the Mingo and Tolbert Cases, participants received a personal injury payment before Medical Monitoring began, which acted as an incentive for the participants to register for the Medical Monitoring Program. In the Perrine case, Medical Monitoring Class Members were originally paid an initial registration cash payment of \$200 for their verified registration. The Perrine Court, as shown in Exhibit C, increased this registration cash payment to \$400.

B. **Provisioning Model.** We should determine whether to use a retail or wholesale model in Medical Monitoring Program provisioning. Counterintuitively, a

retail model is usually more economical than a wholesale model in medical provisioning. A wholesale model involves paying for a physical clinic while a retail model involves only paying for units of medical testing services actually used by the participants. To facilitate claimant convenience and save money for the program, we will likely suggest that the program use a retail HMO¹ model. In this model, a third-party administrator like our Firm, negotiates with participating medical providers a per unit of medical monitoring services price by CPT code², and more than one medical practitioner can participate, if necessary, thereby facilitating participant convenience. This retail approach encourages claimant participation, runs the program more economically and facilitates claimant convenience by providing a choice of medical providers and monitoring times, if necessary. It facilitates use of doctors the participants already know and trust, with the doctors recommended by the participants being identified in the participant registration process through the use of a simple questionnaire. It costs the program nothing extra, because only units of service are paid for. In the Tolbert Case, we initially used one clinic with a wholesale model (paying participating doctors and overhead) which put economic stress on the Settlement. Switching to a retail model allowed us to balance the Tolbert Case budget. The retail model is used in the Perrine Case, and participants are given the option of using a number of doctors, many of whom were already their primary care

¹A Health Maintenance Organization (“HMO”) is a type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally will not cover out-of-network care except in an emergency. An HMO may require a participant to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

²The Current Procedural Terminology (“CPT”) code set is a medical code set maintained by the American Medical Association through the CPT Editorial Panel. The CPT code set describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes.

physicians. Utilizing the CPT code rates, participating physicians are paid uniformly.

C. **One Step or Two Step Medical Monitoring.** The two steps, of a blood draw, then looking at the results and asking the claimant to come back for a second visit and wellness exam has been implemented and worked well in a number of medical monitoring programs. Based on our experience, we believe a one step approach should also be considered. We have found that a one step approach of a blood draw and a consultation in the same participant visit can be more efficient, complete and may be preferred by the participants. If a one step approach is followed, the participant is later sent a confidential letter with the test results.

D. **Participant Data Can Only Be Used for Research by Consent.** To facilitate possible use of the resulting medical monitoring data for scientific research, we suggest that participants be given the option of consenting to such use of their data in a de-identified manner. An example of a participant Consent Form and the Order approving the form is attached as Exhibit D. We have found the consent rate usually to exceed 90%. We suggest that medical testing laboratories be asked to send the test results to the participating medical providers as well as the Third-Party Administrator to be collected in a Central Repository in a deidentified manner.

E. **If You Can't Load Data, You Can't Use It.** A HIPAA compliant central database should be created and maintained to load all participant Medical Monitoring Program data. Uniformity is the key to using the data for the participants' medical benefit in the future and for possible valuable future research data. For example, you need a uniform monitoring patient medical exam interview form so the data can be loaded into a database, for retrieval by the participant's doctor as well as for future research where

appropriate. We strive to keep this data uniform, so information may be retrieved for a participant should there be a medical necessity for providing it.

F. **Collect Data Efficiently.** We expect participants will be asked to complete an initial diagnostic surgery as well as an updated diagnostic survey annually. Coupling an epidemiological survey on the front end with medical monitoring itself instead of sending them to the participants later, hoping they will fill them out, will result in the data actually being collected.

G. **Use Local Medical Service Providers.** We assume that medical monitoring services are available in the class area with a limited number of medical providers, clinics, and hospitals. Southwestern Vermont Medical Center is nearby in Bennington, Vermont, as well as Twin Rivers Medical, PC, in Hoosick Falls, New York appear to be ideas. Using either of these facilities would provide more economical options rather than contracting for a mobile clinic as we did in the Mingo Case, and would probably help us to engage a national medical testing company such as LabCorp or Lab One for laboratory services.³

H. **Communicate with Participants.** To maximize participant use of the program, participants should receive letters reminding them to schedule their consultations or clinical tests and to remind them to reschedule if they have missed their consultations or tests. Follow-up telephone calls may prove helpful as well. Participants should also have access to a Medical Monitoring Program Website, which provides Class members with program related information and the ability to submit required information electronically.

³In the event a qualified Claimant, previously a resident of the contaminated area, has relocated, medical monitoring services may be obtained near their current place of residence using the same applicable CPT codes discussed herein.

The website, at a minimum, would provide general information about the Medical Monitoring Program, important information about legal and other program-related documentation, contact information for the program, answers to Frequently Asked Questions, a description of participant eligibility and registration documentation, and an online portal where participants can log-in and view their medical information and data.

9. For Settlements that I administer, my office has protocols and guidelines in place that are strictly adhered to with respect to medical testing, in order to adequately and properly administer Settlements, as well as to maintain confidentiality.

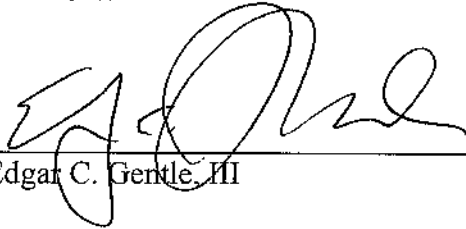
10. In my experience, our staff and the participating medical providers have thoroughly followed the protocols developed for each of the Settlements in which I have been involved. An audit of the Clinics is often performed at my direction, so that I can confirm that the Settlement protocols are being followed.

11. With our other Medical Monitoring Programs, we revise the programs over time to take into account increased scientific knowledge about the etiology of the toxin involved and improving medical testing methods, resulting in the possible need to revise the medical monitoring protocols. We would likely recommend revising this Medical Monitoring Program every five (5) years.

12. Finally, from an administrative and cost perspective, it is preferable to administer a medical monitoring program on a class wide basis for economies of scale, uniformity of testing results and optimum availability of testing facilities. Testing on a class wide basis allows for better negotiation of testing fees, due to the volume of potential testing claimants. In addition, there is a more robust interest from potential clinics/testing facilities, due to the anticipated increased testing volume. Establishing protocols for class wide testing also ensures that the

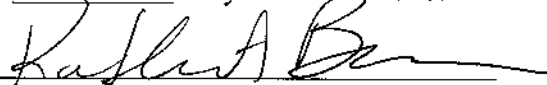
testing itself will be more uniform, therefore providing more reliable results for the Claimants individually, and for possible scientific research.

FURTHER THE AFFIANT SAYETH NOT.



Edgar C. Gentle, III

Sworn to and Subscribed
this 25th Day of March 2020.



Notary Public
[Notary Seal]



EXHIBIT A:

Resume

March 12, 2020

CURRICULUM VITA

Name of Attorney: Edgar C. Gentle, III, Esq.
Name of Firm: Gentle, Turner, Sexton & Harbison, LLC
Profession: Attorney
Date of Birth: February 17, 1953
Years with Firm: 28
Nationality: U.S.A.
Memberships in Professional Societies: Admitted to Alabama State Bar (1981) and various Federal District Court and Appellate Court Bars

A. Key Qualifications

Ed Gentle was born in Birmingham, Alabama, February 17, 1953. He graduated summa cum laude in 1975 from Auburn University where he was a Danforth Scholar and earned a Bachelor of Science degree. In 1977 he received a Master of Science (summa cum laude) from the University of Miami as a Maytag Fellow where he became familiar with the law of the sea and international resource planning issues involving competing nations.

He was a Rhodes Scholar (Auburn's second and Miami's first) at Oxford University—where he earned a B.A. degree with honors in Jurisprudence in 1979 and a M.A. degree in 1980. He then attended the University of Alabama School of Law as a Hugo Black Scholar. He earned his J.D. and was admitted to the Alabama State Bar in 1981.

Mr. Gentle has comprehensive experience in serving as Special Master and Claims Administrator in Mass Tort Litigation, and providing grid design, claims administration and financial and business advice to Courts, Settling Parties, and Mass Tort Settlements. Approximately 90% of his professional time is devoted to this practice. He has helped create and administer over \$2 Billion in Settlements during the past 25 years. He has also provided affidavit, deposition and hearing testimony on the fairness of Mass Tort Settlements.

From 1992 to 2014, Mr. Gentle served as Special Master and Escrow Agent for the MDL 926 Global Breast Implant Settlement, paying \$1.2 Billion in claims for 300,000 claimants. From 2001 until 2003, he was Interim Financial Advisor for the Settlement Facility - Dow Corning Trust

(the Dow Corning Breast Implant Settlement) overseeing the investment of over \$1 Billion and providing tax and accounting support for the Settlement, during part of Dow Corning's Chapter 11 Bankruptcy.

Commencing in December 2003, Mr. Gentle was appointed as the Settlement Administrator in the \$300 Million Anniston, Alabama Tolbert PCB Settlement with Monsanto and Solutia in connection with the administration of a Global Settlement before the Federal District Court for the Northern District of Alabama applicable to 18,000 claimants with respect to PCB contamination of property and PCB personal injury claims. In administering the \$300 Million settlement, Mr. Gentle designed the claimant payment program for property damage and personal injury, collected criteria for payments to each of the 18,000 claimants, ranked the claimants for payment amounts, satisfied private and government liens, and remitted payments to each of the claimants. The Settlement also provided primary medical and dental care and prescriptions to claimants, with this portion of the settlement being completed in 2016.

One of Mr. Gentle's specialties is serving as Settlement Administrator for Community Tort Settlements, such as a C-8 groundwater contamination case in Camden, New Jersey (with water filtration and damages 2004-2008), Warehouse Fire Settlements in Conyers, Georgia (2012) and Louisville, Kentucky (personal injury and property claims), Zinc Smelter Settlements in Spelter, West Virginia (medical monitoring and property remediation 2011-2017) and Blackwell, Oklahoma (property remediation 2013-2019), a coal slurry groundwater contamination Settlement in Mingo County, West Virginia (medical monitoring 2013), and two train wrecks in Kentucky (2010 and 2017), one in Alabama and one in West Virginia (personal injury and property claims 2017-2019).

In November, 2009, Mr. Gentle was appointed Claims Administrator in the Jefferson County, Alabama, Occupation Tax Refund Class Settlement before the Honorable David Rains, in the Circuit Court of Jefferson County. On May 14, 2010, the Supreme Court of Alabama upheld the \$37 Million Judgment. The Parties entered into a Class Settlement, which was approved by the Court, and tax refunds were issued to over 300,000 claimants. The case was completed in 2014.

In June 2010, Mr. Gentle was appointed Special Master and Settlement Administrator in the Total Body Multi-district Litigation, MDL 1985. The claimed toxigen was a selenium overdose in a health maintenance drink, with claimed damages being hair loss and damage to bodily organs. Working closely with the Court, Mr. Gentle facilitated the aggregate settlement of all cases, in August 2010. Mr. Gentle and his staff determined the value of each of the settled cases, which was consented to by all Plaintiffs, and Mr. Gentle administered the Settlement, satisfied private and government liens, and paid all claimants, which was completed in 2013.

In the Fall of 2011, Mr. Gentle was appointed Claim Administrator for the 1,000 family Perrine v. DuPont Zinc Smelter Class Action Settlement in Spelter, West Virginia, involving a \$40 million remediation program for soil and houses with respect to cadmium, arsenic, zinc and lead, and a 30 year medical monitoring program. The remediation program was completed in 2017, and the medical monitoring program will be completed in 2041.

In 2012, Mr. Gentle was appointed Claims Administrator of the Swiger v. AmeriGas, West Virginia statewide Class Settlement, involving monetary awards and remediation for approximately 12,000 claimants and with respect to propane gas lines.

Mr. Gentle is Special Master in the national MDL Blue Cross Antitrust Litigation, MDL 2406, with putative provider and subscriber classes, before the Honorable R. David Proctor, having been appointed in 2012. The case has 3 groups of litigants: the Policy Subscribers, the Medical Providers and the 37 Blue Cross companies. There are over 100 million potential plaintiffs. Among his duties are mediating a Settlement of the subscribers/Blue Cross litigation, and auditing subscriber and provider common benefit attorney time and expenses.

From 2012 to 2014, Mr. Gentle, as Special Master, facilitated the creation and administration of a 93 claimant settlement with an undisclosed manufacturer and hospital concerning CT-Scan radiation exposure, with claimed damages being hair loss and cognitive deficiencies.

In 2013 and 2014, Mr. Gentle administered four separate Pfizer Chantix Aggregate Settlements, designing the payment matrix, handling claimant appeals, resolving liens, and paying claimants.

In 2014, Mr. Gentle was appointed Claims Administrator for the Mingo County, West Virginia medical monitoring program, lasting 30 years and involving 750 claimants exposed to coal slurry well contamination. The program will be completed in 2044.

In 2013, Mr. Gentle was appointed Claims Administrator for the Coffey v. Phelps Dodge Oklahoma Circuit Court Class Settlement in Blackwell, Oklahoma with respect to a zinc smelter and involving a \$34 million remediation project for 1,000 households with respect to cadmium, arsenic, zinc and lead. The program was completed in 2019.

In 2014, Mr. Gentle was appointed Plaintiff Lien Administrator for the Hydroxycut Mass Settlement.

In November 2014, Mr. Gentle was appointed Special Master in the Stryker Hip MDL, MDL 2441, handling settlement appeals and opt-out mediations.

In 2015, 2016, and 2017, Mr. Gentle was hired by Smith & Nephew and Plaintiffs' Counsel to facilitate three Memphis, Tennessee aggregate settlements involving artificial hips and to resolve related plaintiff liens.

In May 2016, Mr. Gentle was appointed Claims Administrator by the Escambia County, Florida, Circuit Court in Allen v. A.E. New, the Pensacola jail fire and explosion case, to facilitate the class settlement of the 667 claimant case. The Settlement was approved in 2018.

In October 2016, Mr. Gentle was appointed Special Master by the Fulton County, Georgia Circuit Court in Smart v. Brenntag, to carry out the administration of a chemical spill class settlement.

In February 2017, Mr. Gentle was appointed Settlement Administrator of an industrial plant contamination settlement in Bowling Green, Kentucky involving personal injury and property damages plaintiffs and Federal Mogul, with the Aggregate Settlement being approved by the Court in August 2018.

In September 2017, Mr. Gentle was appointed Claims Administrator for a GE factory fire class settlement in Louisville, Kentucky.

In October 2017, Mr. Gentle was appointed Special Master by the West Virginia Federal District Court for the Southern District of West Virginia to administer the Mt. Carbon 400 claimant aggregate train derailment settlement with Sperry (personal injury and property damage). Subsequently, in March 2018, Mr. Gentle was appointed Special Master to administer the portion of the Settlement applicable to CSX.

In October 2017, Mr. Gentle was appointed Escrow Agent for the Common Benefit Fund in the Storz Morcellator Litigation in the Superior Court of California, of Los Angeles County.

In December 2017, Mr. Gentle was appointed Special Master by the Circuit Court of Duval County, Florida to administer a plastic surgery medical malpractice aggregate settlement with 260 female claimants.

In February 2018, Mr. Gentle was appointed Cy Pres Special Master for the Winston Jefferson County ad valorem tax class settlement case.

In June 2018 Mr. Gentle began to assist lead counsel in the Abilify MDL 2734, to design a claimant payment grid and to facilitate a potential settlement of the case, and in February 2019 he was appointed Extraordinary Damages Award Special Master for the resulting aggregate settlement. The opt-out rate was less than 1%.

In September 2018, Mr. Gentle was appointed Special Master of a personal injury aggregate settlement involving a train derailment in Maryville, Tennessee with CSX and Union Tank as defendants.

In December 2018, Mr. Gentle was appointed Claims Administrator for the U.S. Pipe North Birmingham lead contamination Aggregate Settlement.

In May 2019, Mr. Gentle was appointed Settlement Special Master for a mercury contamination aggregate settlement in Florence, Alabama involving 97 plaintiffs.

Mr. Gentle is a medical monitoring expert in two pending PFOA cases, one in New Jersey and one in upstate New York, being engaged in 2018 and 2019. He administered a PFOA settlement with DuPont in Camden, New Jersey in 2011.

In August 2019, Mr. Gentle was appointed by the Court to administer the aggregate settlement of a bus accident lawsuit in the Calhoun County, Alabama Circuit Court and involving 2 deaths and

44 personal injury claimants.

In November 2019 to January 2020, Mr. Gentle has been appointed Special Master to create grids and to administer three separate aggregate settlements for Bard IVC Filter claimants for three Plaintiffs' law firms.

B. Education

| <u>Class Rank</u> | <u>School</u> |
|-------------------|---|
| 4 | J.D., University of Alabama School of Law 1981 (Hugo Black Scholarship) |
| Middle | M.A., Jurisprudence, Oxford University 1980 (Rhodes Scholarship) |
| Middle | B.A., Honours Jurisprudence, Oxford University 1979 (Rhodes Scholarship) |
| 1 | M.S., <u>Summa Cum Laude</u> , University of Miami 1977 (Maytag Fellowship [washing machines]) |
| 1 | B.S., <u>Summa Cum Laude</u> , Auburn University 1975 (Danforth Scholarship [Purina]) |

C. Employment Record

| | |
|-------------------------------|---|
| June 1992 - Present | Gentle, Turner, Sexton & Harbison, LLC Managing Partner Birmingham, Alabama |
| September 1991 - June 1992 | Miller, Hamilton, Snider & Odom Partner Manager of Birmingham, Alabama Office |
| January 1987 - September 1991 | Schoel, Ogle, Benton, Gentle & Centeno Partner Birmingham, Alabama |
| December 1985 - January 1987 | Law Offices of James L. North Associate Birmingham, Alabama |
| June 1983 - December 1985 | AT&T Senior Staff Attorney Atlanta, Georgia |

May 1981 - June 1983

North, Haskell, Slaughter, Young & Lewis
Associate
Birmingham, Alabama

D. Contact Information

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E. References

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EXHIBIT B:

Transcript of Ed Gentle
Deposition in Sullivan v. Saint-Gobain

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UNITED STATES DISTRICT COURT
DISTRICT OF VERMONT
CIVIL ACTION NO.: 5:16-cv-00125

JAMES D. SULLIVAN, et al., individually,
and on behalf of a Class of persons
similarly situated,
Plaintiffs,

v.
SAINT-GOBAIN PERFORMANCE PLASTICS
CORPORATION,
Defendant.

VIDEOTAPED DEPOSITION TESTIMONY OF:
EDGAR GENTLE, III, ESQ.
February 16, 2018

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A P P E A R A N C E S

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1 ALSO PRESENT:

2

3 Scott Pierce, videographer

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1 I, Lane C. Butler, a Court
2 Reporter and Notary Public, State of
3 Alabama at Large, acting as Notary,
4 certify that on this date, pursuant to
5 the Federal Rules of Civil Procedure,
6 there came before me at the law offices
7 of Bradley Arant Boult Cummings, 1819
8 Fifth Avenue North, Birmingham, Alabama,
9 commencing at approximately 9:03 a.m., on
10 the 16th day of February, 2018, EDGAR
11 GENTLE, III, witness in the above cause,
12 for oral examination, whereupon the
13 following proceedings were had:

14
15 THE VIDEOGRAPHER: This begins
16 Disc No. 1 in the deposition of Edgar
17 Gentle in the matter of James D.
18 Sullivan, et al., v. Saint-Gobain
19 Performance Plastics Corporation, et al.,
20 Case 5:16-cv-00125. We're on the record
21 at 9:03 a.m. on Friday, February 16th,
22 2018. This deposition is taking place in
23 Birmingham, Alabama. My name is Scott
24 Pierce, representing Freedom Court
25 Reporting.

1 Would counsel identify
2 yourselves and state whom you represent.

3 MR. WILSON: Lincoln Wilson,
4 Quinn, Emanuel, Urquhart & Sullivan, for
5 defendant Saint-Gobain Performance
6 Plastics Corp.

7 MR. WILLIAMS: Nathan Williams
8 also present.

9 MR. WHITLOCK: Jamie Whitlock
10 with Davis & Whitlock on behalf of the
11 plaintiffs.

12 THE VIDEOGRAPHER: Would the
13 court reporter please swear in the
14 witness.

15
16 EDGAR GENTLE, III,
17 having been duly sworn,
18 was examined and testified as follows:

19
20 EXAMINATION BY MR. WILSON:

21 Q. Good morning, Mr. Gentle.

22 A. Good morning.

23 Q. We've been introduced off the
24 record. My name is Lincoln Wilson.

25 Would you please state your name for the

1 record?

2 A. Edgar Cuthbert Gentle, III.

3 Q. And I understand off the record,
4 Mr. Gentle, that you've been deposed
5 before?

6 A. I have, sir.

7 Q. About how many times?

8 A. About a half a dozen.

9 Q. So let's just go over the ground
10 rules for the deposition, though you are
11 familiar with them, I'm sure. We'll need
12 verbal answers for you for the sake of
13 the court reporter. And please wait
14 until the end of my question before you
15 give your answer. I know it's very
16 natural to anticipate where I'm going.
17 You're a lawyer as well, I'm sure you
18 know where I'm going half the time, but
19 we want to make a clear record for the
20 court reporter. Do you understand?

21 A. I do, sir.

22 Q. And if you have any questions or
23 any question I ask is unclear, please
24 feel free to ask for clarification. I'm
25 happy to try to answer -- ask the

1 question in a different way.

2 A. Okay. Thank you.

3 Q. And if you would like a break at
4 any time, you're free to do so just as
5 long as a question is not pending.

6 A. Fair.

7 Q. And you understand that you're
8 under oath today?

9 A. I do, sir.

10 Q. I'm handing you now what's been
11 premarked as Exhibit 1 to your
12 deposition.

13 (Exhibit 1 was marked for identification
14 and is attached.)

15 A. Yes, sir.

16 Q. Is this the expert report that
17 you furnished in this litigation?

18 A. Yes, sir, it appears to be.

19 Q. And also hand you what's been
20 premarked for identification as Exhibit

21 2. Can you tell me what this is?

22 (Exhibit 2 was marked for identification
23 and is attached.)

24 A. It's an additional exhibit we
25 prepared yesterday, and I think my lawyer

1 provided it to y'all.

2 Q. So this was prepared yesterday?

3 A. That's my understanding.

4 Q. And did your original report
5 identify an Exhibit D?

6 A. I can't remember.

7 Q. And is it your understanding
8 that this was served on counsel for
9 Saint-Gobain yesterday, day before
10 deposition?

11 A. That's my understanding.

12 Q. Do Exhibits 1 and 2 constitute
13 your complete report in this matter?

14 A. That's my understanding.

15 Q. Do you plan to offer any other
16 opinions about this case that don't
17 appear in Exhibits 1 and 2?

18 A. I'm not aware of any.

19 Q. Did you draft the report
20 yourself?

21 A. Yes, sir. I got some help, of
22 course, compiling some of the
23 information, for example, the exhibits.
24 But I did draft it.

25 Q. Who did you get help from?

1 A. One of my younger attorneys
2 named Chris Smith.

3 Q. Is there anything in your report
4 that you need to change or correct?

5 A. I think I have one typo where I
6 meant to say "retail" and I think it says
7 "referral." Let's see, I think it's in
8 the paragraph, sir, that talks about the
9 retail model. Let me just try to find
10 that real quick.

11 (Witness reviews document.)

12 A. I think that's it. Looking on
13 page 4, paragraph B, let me count --
14 actually, it might be easier in paragraph
15 B to count from the bottom of the
16 paragraph. It looks like the fourth line
17 from the bottom says, "Switching to a
18 referral model." I meant to say,
19 "Switching to a retail model." I think
20 that's probably the product of spell
21 check.

22 Q. Thank you. I don't anticipate
23 we'll try to impeach your credibility on
24 the basis of that typo.

25 A. Thank you.

1 Q. And your background, you've been
2 practicing law since 1981. Is that
3 correct?

4 A. That's correct.

5 Q. And you're licensed to practice
6 law in Alabama?

7 A. Yes, sir.

8 Q. Are you licensed in any other
9 jurisdictions?

10 A. No, sir. I'm pro hac vice at
11 times in other states, but not, you know,
12 not formally and generally for that
13 state.

14 Q. And can you describe to me
15 what's the general breakdown of your
16 practice at this time?

17 A. Ninety percent of what I do is
18 as a neutral, creating and administering
19 settlements, acting as a special master
20 in mass litigation for the Court, grading
21 appeals and en masse settlements, that
22 sort of thing. But basically working in
23 mass cases to facilitate their moving
24 forward, eventually to settle and then
25 eventually to pay out or administer,

1 depending on the type of remedy.

2 Q. And are those cases around the
3 country?

4 A. They pretty much are, yes, sir.

5 Q. So I'd like to go briefly over
6 your work experience. After you
7 graduated from the University of Alabama,
8 you began working as an associate at the
9 law firm of North, Haskell, Slaughter,
10 Young & Lewis? Is that correct?

11 A. That's my understanding.

12 Q. And then as a senior staff
13 attorney at AT&T?

14 A. Let me just pull that resumé.
15 That always helps. Yes, sir, that's my
16 recollection.

17 Q. And then as an associate at the
18 law offices of James North?

19 A. Yes, sir.

20 Q. Then as a partner at the law
21 firm of Schoel, Ogle, Benton, Gentle &
22 Centeno?

23 A. Yes, sir.

24 Q. Then as a partner at the law
25 firm of Miller, Hamilton, Snider & Odom?

1 A. Yes, sir.

2 Q. And you managed the Birmingham
3 office at that firm. Is that correct?

4 A. I did, sir.

5 Q. And since 1992, you've been the
6 managing partner at Gentle, Turner,
7 Sexton & Harbison. Is that correct?

8 A. Yes, sir, it is.

9 Q. So in the period from about 1981
10 to 1982, you had six employers. Is that
11 correct?

12 A. Yes, sir.

13 Q. What led you to change jobs so
14 frequently during that time?

15 A. Well, just a lot of it was as my
16 practice was evolving to a specialty.
17 For example, looking at the place I've
18 been for a few years now, it looks like
19 I've been there, what, 26 years, give or
20 take, I was -- I was beginning to
21 specialize and work as a neutral. So for
22 example, when I was with Miller Hamilton,
23 they do a lot of defense type of work,
24 and I found that if you're going to be a
25 neutral, you at times encounter conflicts

1 with your partners. Likewise, I've lost
2 some lawyers that wanted to be either a
3 plaintiff or a defendant lawyer because,
4 as a neutral, I'm pretty adept,
5 unfortunately, at conflicting people out.

6 Going -- just going down the
7 pile here, I left Schoel, Ogle, Benton
8 because I had a good opportunity for
9 Miller Hamilton to open a Birmingham
10 office. They were in Mobile at the time.
11 I left Jim North because I got an
12 opportunity to be a partner. I think
13 everybody can appreciate that. I left
14 AT&T because they were going to move me
15 to New York. I'm not against New York,
16 but I'm a Southerner. So those are
17 basically the explanations. I left
18 North, Haskell to go to AT&T because I
19 had a wife, three kids, and a mortgage,
20 and AT&T had a divestiture, I got a 50
21 percent raise. And those are some of the
22 reasons.

23 But obviously, I'm very loyal to
24 my firm now and don't intend on -- on
25 leaving it.

1 Q. Imminently reasonable, other
2 than the decision about New York, but I
3 understand.

4 A. Well.

5 Q. So the nature of your firm's
6 practice now, what is it that allows you
7 to not be conflicted now?

8 A. Well, because the majority of
9 what the firm does is what I do. And so
10 that way, as neutrals, we stay neutral.
11 We do have a handful of other cases, but
12 like I said, 90 percent of what I do and
13 probably maybe 80 percent of what the
14 firm does is in a neutral capacity.

15 Q. And just to understand, we were
16 looking at your firm's website --

17 A. Yes.

18 Q. -- in advance of this
19 deposition, and it seems like there's a
20 lot of practice areas on there, you know,
21 landlord/tenant, bankruptcy.

22 A. There are.

23 Q. And you're telling me that's not
24 much of what the firm does at this point?

25 A. It's really not.

1 Q. And does that tend to be for
2 local clients when -- when you do that?

3 A. When we do the other part?

4 Q. Or what -- when you do the --
5 what do you mean by "the other part"?

6 A. Well, are you talking about the
7 neutral part? Are you talking about the
8 dog or the tail?

9 Q. The tail.

10 A. Okay. The tail, I would say, is
11 more local, the dog is more national.

12 Q. Okay. And you drafted a
13 complete revised State constitution for
14 Alabama. Is that correct?

15 A. I did a while back.

16 Q. And that was on behalf of the
17 State senate?

18 A. Yes, sir. Roger Bedford and the
19 State senate.

20 Q. And what was the outcome of that
21 effort?

22 A. It was not approved.

23 Q. You were also involved in a
24 challenge to the validity of the Alabama
25 State constitution. Is that correct?

1 A. Yes, sir. In a lawsuit.

2 Q. You represented plaintiffs who
3 claimed that the 1901 -- the constitution
4 was ratified by voter fraud. Is that
5 correct?

6 A. The -- the complaint -- and
7 again, I don't have it in front of me,
8 and it's been some years. The
9 bottom-line fact, the allegation of the
10 complaint is the -- the votes were not
11 correctly compiled and so it was not
12 passed.

13 Q. And the Alabama Supreme Court
14 held that your clients didn't have
15 standing to challenge the State
16 constitution. Is that correct?

17 A. That's my recollection.

18 Q. After that decision by the
19 Alabama Supreme Court, is it correct that
20 you questioned whether, quote, Alabama
21 recognizes the rule of law?

22 A. I may have done that to a
23 newspaper reporter, if that's what you're
24 citing. I don't have it in front of me.

25 Q. Do you still question that?

1 A. I don't.

2 Q. What's caused you to change your
3 mind about that?

4 A. I think, by and large -- I
5 think, by and large, the judicial system
6 gets the right. We're all human,
7 however.

8 Q. What experience or expertise do
9 you believe allows you to offer the
10 opinions that you have in this
11 litigation?

12 A. Mostly, Lincoln, my experience
13 in other cases. They're not -- as you
14 know, every case is unique. But some of
15 the issues are similar. And so that's
16 the basic reason.

17 Q. And you've served as a claims
18 administrator in multiple claims
19 programs. Is that correct?

20 A. I have, sir.

21 Q. Can you describe for the jury
22 what a claims administrator is?

23 A. A claims administrator
24 administers claims. That's, I guess, the
25 short definition. Of course, it will

1 depend on what the type of claim is.
2 Some claims are cash, some are more
3 in-kind type of a relief, such as I think
4 is being talked about in this case. But
5 the claims administrator normally works
6 at the request of the Court to administer
7 the settlement.

8 Q. And what types of settlements do
9 you work in as a claims administrator?

10 A. Let's see. I have settlements
11 that are just the payment of money. I
12 have settlements that are remediation of
13 soil or houses. I had the Rowe v. DuPont
14 settlement, which was the PFO case in New
15 Jersey, in which we installed filters and
16 paid cash to homes. And I've had
17 settlements where I grade the claims
18 administrator's homework as the appeals
19 master, like the Stryker hip settlement
20 where I'm one of the special masters. So
21 those are some examples. It just -- it
22 just depends on what the Court wants me
23 to do, and I guess there's no, you know,
24 hard and fast rule of thumb, but those
25 are some examples of what I'm working on,

1 to answer your question.

2 Q. And when you describe your work
3 for settlements that just involve the
4 payment of money damages, is that
5 essentially you're working as an escrow
6 agent?

7 A. Well, maybe not. Because I
8 would define an escrow agent as someone
9 who holds money and invests it and
10 disbursements pursuant to instructions.
11 Usually, a claims administrator also
12 decides how much each person gets, so
13 it's a little bit more than that.

14 MR. WILSON: If it's all right,
15 can we go off the record for just a
16 moment? I need to take a very short
17 break.

18 THE VIDEOGRAPHER: Going off the
19 record, 9:16 a.m.

20 (Break taken.)

21 THE VIDEOGRAPHER: Going back on
22 the record, 9:19 a.m.

23 Q. (By Mr. Wilson) So, Dr. Gentle
24 -- or, excuse me, Mr. Gentle, in your
25 role as a claims administrator, do you

1 advocate any position?

2 A. I don't understand the question
3 about advocate a position.

4 Q. Are you acting as an attorney in
5 your role as a settlement administrator?

6 A. Sometimes you do. For example,
7 I would say that mediation skills are
8 those often of an attorney. And so in
9 that sense, I do. I also -- sometimes a
10 payment grid will have some legal
11 factors; for example, what the statute of
12 limitations may be and that sort of
13 thing. So to some extent, I have some
14 attorney skills involved, but there are
15 some other skills, of course.

16 Q. But you're not representing one
17 of the parties in those situations, are
18 you?

19 A. If I'm -- if I'm a claims
20 administrator, I'm representing the
21 settlement.

22 Q. And so in that role, it's your
23 task to implement the parties' wishes as
24 memorialized in the settlement agreement.
25 Is that correct?

1 A. It's my task to administer the
2 settlement agreement.

3 Q. So it's not your job to
4 determine what the settlement should be?

5 A. I don't understand the question.

6 Q. It's not your job to determine
7 what relief the parties are entitled to?

8 MR. WHITLOCK: Object to the
9 form.

10 A. Well, it is to some -- to some
11 extent. Because, for example, if I have
12 a settlement grid and I have a given
13 claimant, I've got to determine what that
14 claimant gets under the grid, and that's
15 that claimant's relief.

16 Q. But in that situation, you are
17 effectuating what the parties have
18 already decided, not deciding itself --
19 yourself?

20 A. I'm effectuating what the
21 settlement agreement says. Sometimes the
22 parties disagree on what it says.

23 Q. And when the parties disagree,
24 who decides?

25 A. Ultimately the Court at times,

1 but sometimes me. It depends on the
2 terms of the settlement. For example,
3 some settlements contemplate an appeals
4 master grading my homework. Some
5 settlements contemplate my making a final
6 decision. So it just varies.

7 Q. How are you typically recruited
8 to serve as a claims administrator?

9 A. Unwillingly. No, I'm just
10 kidding.

11 Usually at the request of the
12 Court. Because the Court ultimately
13 hires me.

14 Q. And is my understanding correct
15 that plaintiffs wish to retain you as the
16 administrator in this litigation?

17 MR. WHITLOCK: Object to the
18 form.

19 A. I don't think that decision has
20 been made, but if asked, I may
21 unwillingly agree.

22 Q. And since the court reporter
23 does not note laughter in the transcript,
24 when you say that you may unwillingly
25 agree, is that sarcastic?

1 A. Well, it's really a function of
2 time too. I just have to see what all I
3 have involved. So it's not completely
4 sarcastic, no.

5 Q. But you would, if asked and if
6 you were available, agree to serve as the
7 claims administrator in this settlement?

8 A. I would. But I would probably,
9 in fairness to everyone, try to meet with
10 the Court and see what the Court wants to
11 do and also try to vet it with both sides
12 of the "v." Because usually,
13 administering a case has to be
14 collaborative.

15 Q. And I'd like to just clarify my
16 question. I inadvertently said
17 "settlement." There's obviously been no
18 settlement in this case.

19 A. Understood. Understood.

20 MR. WHITLOCK: We don't have a
21 settlement?

22 Q. When you do serve as claims
23 administrator, how are you compensated?

24 A. I'm usually compensated by the
25 settlement, but not always. Sometimes

1 the defendant pays me. For example, in
2 the Monsanto PCB settlement, the
3 defendant pays me directly.

4 Q. Can you describe those two
5 different models, what you mean by that?

6 A. By that I mean that some
7 settlements have a bucket of money that
8 pays both claims and claims expenses.
9 Some settlements have a situation where
10 there may be a bucket for claims, but the
11 defendant pays the administration in
12 addition to that.

13 Q. And are you paid based on hours
14 expended or some other measure?

15 A. It varies. Usually what I do is
16 come up with a budget that the two sides
17 of the case agree to and try to -- try to
18 stay within the budget. I keep my time,
19 but at times I'll write the time off to
20 come within budget.

21 Q. So sometimes you'll bill hourly,
22 and sometimes you have a flat fee?

23 A. And sometimes I hybrid, like I
24 just described.

25 Q. Okay. But it's correct to say

1 that sometimes you'll bill hourly and
2 sometimes you'll bill flat fee?

3 A. I think it's more of a hybrid
4 because I almost always keep track of the
5 time. I just wouldn't charge a flat fee.

6 Q. And is it fair to say that the
7 amount that you're paid will be dependent
8 on the size of the settlement and the
9 number of claimants?

10 MR. WHITLOCK: Object to the
11 form.

12 A. That's part of it. Part of it,
13 too, is the intensity of -- of the
14 settlement. For example, some
15 settlements, like the Inamed breast
16 implant settlement I administered many
17 years ago just paid per capita for 37,000
18 people. That's an easy one. Whereas the
19 Baxter, Bristol, and 3M breast implant
20 case had a very detailed grid. And so it
21 took more labor to get each dollar out
22 the door with that second one than the
23 first.

24 Q. When you have served as an
25 escrow agent, can you describe the nature

1 of your role in that kind of case?

2 A. Yes, sir. I'll just give an
3 example. The breast implant case, I
4 served as the escrow agent in that case.
5 And my job was to receive the money for
6 the settlement, to administer it in terms
7 of investing it and disbursing it, to
8 come up with budgets, to make sure it had
9 good internal accounting controls, to
10 have annual audits with an outside
11 accountant, and to prepare the tax
12 returns.

13 Q. And how are you compensated when
14 you serve as an escrow agent?

15 A. In that situation, I was
16 compensated by the hour.

17 Q. In the aggregate, how much have
18 you been compensated as a claims
19 administrator in the last ten years?

20 A. I don't know the answer to that.

21 Q. Could you ballpark it?

22 A. Ten years?

23 Q. Yeah.

24 A. I would say between twenty and
25 thirty million dollars. And that's a

1 ballpark, like you said.

2 Q. You've also served as a retained
3 expert in litigation before.

4 A. I have, sir.

5 Q. Is that, correct?

6 A. Yes, sir.

7 Q. How many times have you been
8 retained to provide expert opinion?

9 A. I was retained one time by this
10 law firm in a helicopter case, an escrow
11 situation, escrow money in a helicopter
12 case. I was retained by a gentleman
13 named Bill Skepnek, S-K-E-P-N-E-K, in
14 Kansas on how to apply ABA Rule 1.8(g).
15 I think those are the two that I can
16 recall.

17 Q. I'm sorry. When you said "by
18 this law firm," are you referring to
19 Bradley Arant?

20 A. Yes, sir. That's right. Where
21 we're sitting.

22 Q. And when you say "helicopter
23 case," is that -- can you describe that a
24 little more in detail?

25 A. As I remember -- and it's been

1 some years, like twenty. But as I
2 remember, there was some buying and
3 selling of helicopter parts, and one
4 person in the transactions was thought --
5 was said to be the escrow agent. And the
6 Bradley Arant client thought that the
7 escrow agent had misspent the money
8 without their knowledge. And my -- my
9 job was to testify about what duties an
10 escrow agent may have to the parties for
11 whom he or she holds the money.

12 Q. And you described a separate
13 representation that was about Rule
14 1.8(g)?

15 A. Yes, sir.

16 Q. And that's the aggregate
17 settlement rule. Is that correct?

18 A. It is indeed.

19 Q. Okay. And what was the liti- --
20 that litigation about?

21 A. It was about the -- the case in
22 Kansas City, Missouri, that involved a
23 druggist who -- who cut in half the
24 cancer doses, and the plaintiff lawyers
25 argued that it shortened the lives of

1 three hundred people. There is a lawyer
2 by the name of Grant Davis who got a
3 settlement in the case, and the argument
4 of the plaintiffs against him was he
5 didn't correctly apply 1.8(g), and I was
6 the expert for the plaintiffs, or one of
7 the experts.

8 Q. Arguing that the settlement
9 administrator had not correctly applied
10 1.8(g)?

11 A. No, sir. Because at that time
12 when they were doing the case, there
13 wasn't -- there was not an administrator.
14 Arguing that the plaintiff lawyers did
15 not.

16 Q. Oh, I'm sorry. So you were
17 representing the plaintiffs against their
18 lawyers?

19 A. Yes, sir. Well, I was -- I was
20 retained as an expert for the lawyer that
21 was representing the plaintiffs. I was
22 an expert, not a lawyer in the case.

23 Q. Adverse to the plaintiffs'
24 former lawyers, or I'm -- I'm -- just so
25 I understand.

1 A. That's correct. That's correct.

2 Q. Okay. And those are the only
3 two prior times you've been retained as
4 an expert witness. Is that correct?

5 A. That is correct. But just to
6 make sure that this other topic is
7 covered, at times, when a case begins to
8 settle, I'm asked to take the stand, and
9 I guess what you might say give a job
10 interview under oath. So I've done that
11 a few times as the claims administrator,
12 fairness hearing and that sort of thing.

13 Q. And do you think of that more of
14 a fact witness capacity or an expert
15 witness capacity?

16 A. That's hard to say, because at
17 the time I'm being hired or possibly
18 hired as the claims administrator. I
19 guess that would, you know, show some
20 expertise. But usually what happens
21 there, sir, is I'm asked about what the
22 settlement involves and how I would carry
23 it out.

24 Q. And that would only be after a
25 settlement has been reached by the

1 parties. Is that correct?

2 A. Not necessarily. Sometimes it's
3 in the context of the settlement fairness
4 hearing before the judge decides.

5 Q. So the parties have reached a
6 settlement, but the Court has not
7 approved it. Is that what you're
8 referring to?

9 A. Yes, sir.

10 Q. How many times have you been
11 deposed?

12 A. I'm thinking about a half a
13 dozen.

14 Q. Were you deposed in the
15 helicopter case and in the druggist case?

16 A. Yes, sir. In the helicopter
17 case one time, and in the druggist case
18 I'm thinking three times for three
19 different plaintiffs.

20 Q. So that's four depositions
21 total.

22 A. Uh-huh.

23 Q. What were the other two times
24 you've been deposed?

25 A. I've been deposed in a divorce,

1 when I was divorcing my wife. And I, you
2 know, there may be another one that I
3 can't remember. So it's about a half a
4 dozen.

5 Q. Have you ever been retained by a
6 defendant as a claims administrator?

7 MR. WHITLOCK: Object to the
8 form.

9 A. How do you -- how do you define
10 "retained" in that question? Just so I
11 understand it.

12 Q. Well, I guess the first question
13 would be, has a defendant ever reached
14 out to you in the first instance as your
15 first contact with administration of a
16 settlement that you ultimately did --

17 A. Yes.

18 Q. -- administer?

19 Which cases were those?

20 A. The ones that I can remember are
21 the Rowe case that I mentioned. Another
22 one is the Blackwell Zinc smelter
23 settlement in Oklahoma.

24 Q. So DuPont retained you in the
25 Rowe case?

1 A. Well, they contacted me first.
2 I think that was the question.

3 Q. Yes. And who was the defendant
4 in Blackwell Zinc?

5 A. It was Freeport McMoRan, an
6 affiliate of Phelps Dodge.

7 Q. Have you ever had expert
8 testimony excluded as unreliable by a
9 Court?

10 A. No, sir.

11 Q. Have you ever testified at trial
12 as an expert witness?

13 A. One time before a jury the -- in
14 this Chelzer case we were talking about
15 out in Kansas City.

16 Q. What was the outcome of that
17 case?

18 A. I think there was a -- I think
19 that the plaintiff lawyer was not pleased
20 with it. I don't know exactly the
21 details, but I remember he was not
22 pleased with the result.

23 Q. And when you say -- since there
24 were several plaintiffs' lawyers in that
25 situation, the plaintiffs' lawyer that

1 you were aligned with was not pleased?

2 A. The lawyer for the plaintiff,
3 that's correct.

4 Q. Have you ever testified before a
5 legislative body or regulatory agency?

6 A. I've spoken, but I don't think
7 under oath.

8 Q. Have you ever made any media
9 appearances?

10 A. At times, I've been interviewed
11 by the media.

12 Q. Television or TV or?

13 A. I think I've been interviewed on
14 TV before.

15 Q. And, I'm sorry, "Television or
16 TV" was a silly question.

17 A. That's okay. I understood it.

18 Q. Television or print? Have you
19 been interviewed in print media?

20 A. By newspapers when they existed,
21 yes, sir.

22 Q. Okay. Is it fair to say that
23 your opinions in this case are limited to
24 addressing how to implement and
25 administer the proposed medical

1 monitoring program in this litigation?

2 MR. WHITLOCK: Object to the
3 form.

4 (Witness reviews document.)

5 A. That's basically my
6 understanding.

7 Q. Am I correct that you don't
8 purport to provide a legal opinion in
9 this case? And by that I mean an opinion
10 as to what the law requires with respect
11 to medical monitoring?

12 A. That's my understanding.

13 Q. Could you describe the area of
14 expertise as to which you're providing
15 opinions in this litigation?

16 A. Yes, sir. It's to help -- help
17 organize and carry out a medical
18 monitoring program.

19 Q. Would you say that you're
20 serving as an expert in claims
21 administration?

22 A. To the extent "claims
23 administration" includes what I just
24 described, yes.

25 Q. And do you believe you're

1 serving as an expert on litigation
2 settlement?

3 A. I don't understand the question.

4 Q. So, would you say that you don't
5 understand that your opinions in this
6 case relate to the issue of settling
7 litigation?

8 MR. WHITLOCK: Object to the
9 form.

10 A. Well, it -- it -- it could be a
11 settlement, or it could be an order for
12 medical monitoring. It depends, I would
13 think, on what the ultimate resolution of
14 the case is.

15 Q. Have you ever -- withdraw the
16 question.

17 Are you serving as an expert on
18 tort law in this case?

19 A. It's my understanding that I'm
20 not serving as an expert on any legal
21 opinion.

22 Q. And you're not a medical doctor.
23 Is that correct?

24 A. No, sir, I'm not.

25 Q. And you don't have a degree in

1 medicine. Is that correct?

2 A. No, sir, I do not.

3 Q. You've not been trained in
4 medicine?

5 A. No, sir, I have not.

6 Q. You don't have a degree in
7 epidemiology?

8 A. No, sir.

9 Q. You don't have a degree in
10 chemistry or biochemistry?

11 A. I have a degree in biology, but
12 not biochemistry.

13 Q. But you're not offering any
14 opinions on biology in this litigation,
15 are you?

16 A. I am not.

17 Q. How does one become an expert in
18 administering a medical monitoring
19 program?

20 A. I would say by administering
21 them.

22 Q. Are there any courses you can
23 take on the subject?

24 A. I don't believe there are, that
25 I'm aware of.

1 Q. Is it possible to apprentice
2 under someone else who has done it?

3 A. Yes, I think so. For example,
4 some of my younger lawyers, I would
5 think, are -- they have a lot of
6 expertise in working with me in the
7 cases.

8 Q. Did you apprentice under anyone?

9 A. Unfortunately, no.

10 Q. Are there legal courses on this
11 subject?

12 A. There may be. I mean, I haven't
13 looked at all the legal curricula, but
14 I'm not aware of any, sir.

15 Q. Is there any board or
16 organization that accredits experts in
17 this field?

18 A. Not that I'm aware of.

19 Q. Have you published any articles
20 on the subject?

21 A. I have drafted an article that's
22 not published on the subject, but it's
23 not published at this time, in a
24 document, you know, legal periodical type
25 of document.

1 Q. Is there any accepted method
2 that people in this area of expertise
3 follow?

4 A. I think the accepted method
5 would be based upon experience and the
6 expertise of the professionals that are
7 involved in the case. For example, just
8 to kind of go through what the program
9 would look like, you would have some
10 experts who decide what type of testing
11 to give and how often and the methods for
12 the testing. You'd have experts that
13 figure out how best to organize the
14 provisioning of it. By that I mean
15 trying to reduce it to a common language
16 of medical care, such as CPT codes. The
17 experts would also help decide whether
18 you have one location or many, what
19 doctors to use. There would be some
20 other expert input and also some judicial
21 input and input hopefully from the two
22 parties on other aspects of the case; for
23 example, how to recruit the claimants,
24 whether to pay them incentives, whether
25 to have a claimants committee, whether to

1 use a qualified settlement fund, and that
2 sort of thing.

3 So those are the rules of the
4 road that would be generated for a given
5 case. And so to that extent, there are
6 standards.

7 Q. But your opinion doesn't provide
8 any opinion on what kind of testing
9 should be provided to these claimants.
10 Is that correct?

11 A. That is correct, sir.

12 Q. And your opinion doesn't provide
13 any opinion on medical codes to be used
14 for this, does it?

15 A. Not specific codes, that's
16 correct.

17 Q. And your opinion doesn't state
18 what kind of doctors should be visited by
19 the plaintiffs. Is that correct?

20 A. Not completely correct. Because
21 my opinion, I believe, talks about trying
22 to tailor the doctors to ones the
23 claimants will go see.

24 Q. And what's the expertise that
25 you have that allows you to offer that

1 kind of opinion?

2 A. My experience, for example,
3 comparing the Mingo and the Perrine
4 cases, if we could, for a moment, we got
5 the information to answer that question
6 you just posed by vetting the people that
7 really know them; that is, the claimant
8 population. And ironically, the answer
9 was different for the two cases. In the
10 Mingo case, it's a remote area in West
11 Virginia, the people don't trust
12 outsiders, and they don't trust insiders,
13 for that matter. They did not want us to
14 use local doctors. That was a surprise.
15 So we had to have a portable clinic
16 from -- from Pennsylvania for them to
17 trust.

18 In the Perrine case, they wanted
19 the opposite, they wanted their local
20 doctors. And so the only way to answer
21 that question as to what kind of doctor
22 is to vet the claimant population.

23 Q. You also described the input
24 from the parties is important.

25 A. Absolutely.

1 Q. Now, is that because the
2 situations where you handle this are
3 typically settlement situations?

4 A. No, sir. I think it's just good
5 practice. You know, I think you should
6 do that, for example, throughout
7 litigation to the extent people can
8 agree. I just think if you can reduce
9 the number of -- of topics that are
10 disputed, I think it's more efficient for
11 everybody.

12 Q. Have you ever handled a medical
13 monitoring program that was not the
14 result of a settlement?

15 A. I've handled one that's the
16 result of both a judgment and a
17 settlement, and that is the Perrine one.
18 First there was a \$300 million, roughly,
19 judgment in I think the fall of 2008.
20 Then we mediated the case, the judge and
21 I mediated it. We were the mediators.
22 And we agreed on a -- on a medical
23 monitoring program, the parameters of
24 which were, that is, the testing, were
25 pursuant to the -- the jury verdict and

1 the judge's ultimate decision. So to
2 that extent, it was a hybrid.

3 Q. But you've never administered a
4 program that was the result of the judge
5 having issued an order as to the terms of
6 the program?

7 A. Well, the one I've just
8 described, that was true as to the
9 medical tests.

10 Q. But the details of the program
11 were not specified by the judge, they
12 were mediated by the parties. Is that
13 correct?

14 A. Well, some were pursuant to the
15 judgment, and some we modified. It was a
16 hybrid.

17 Q. So, is there a method for -- a
18 recognized method for determining how to
19 administer a medical monitoring program?

20 A. I think the recognized method
21 would be what the Court thinks is the
22 appropriate way to do it in the given
23 case.

24 Q. So the method is determined by
25 agreement of the parties and approval by

1 the Court. Is that correct?

2 MR. WHITLOCK: Object to the
3 form.

4 A. Or by decision of the Court and
5 maybe subsequent fine-tuning by the
6 parties, like the one I just described.

7 Q. Are you aware of any legal
8 standards that compel what kind of method
9 needs to be applied?

10 A. How do you define "legal
11 standards" in your question?

12 Q. Is there a way of determining ex
13 ante based on some recognized methodology
14 what kind of methods should be applied to
15 administer a medical monitoring program?

16 A. What do you mean by "ex ante"?

17 Q. Before any agreement by the
18 parties to settle.

19 A. Sometimes there is. For
20 example, in the Perrine case there was a
21 judgment.

22 Q. And what were the terms of that
23 judgment?

24 A. Well, first of all, it approved
25 the Dr. Werntz medical monitoring

1 regiment, that is, the testing you
2 mentioned, sir. And that ultimately was
3 part of the administration of the medical
4 monitoring program. As I remember, it
5 also decided the chronological pieces of
6 it; that is, thirty years, once every two
7 years. Some of the parts, though, were
8 not decided until later. But that --
9 that may -- that may fit your ex ante
10 definition, as I understand it, anyway.

11 Q. And so when you implemented the
12 Perrine settlement, it was your job to
13 figure out how to administer and
14 effectuate that settlement in order from
15 the Court. Is that correct?

16 A. That's not completely correct.
17 The way I perceived my job in that case
18 was to convene a finance committee made
19 up of lawyers from both sides of the
20 case, to review with them the orders, and
21 to see if we could come up with a
22 consensus on what they mean and how to
23 carry them out.

24 Q. Are there any standards that
25 determine or measure whether a medical

1 monitoring program is effective?

2 A. I --

3 MR. WHITLOCK: Object to the
4 form.

5 Go ahead.

6 A. I think there are some
7 commonsense standards. You know, for
8 example, are you aware of some people in
9 the case in the medical monitoring
10 program who have had diseases detected
11 early enough to be cured? That would be
12 a good parameter.

13 Q. Is there any external body that
14 dictates those standards for measuring
15 the efficacy of a medical monitoring
16 program?

17 A. That particular one I've
18 described?

19 Q. Yes.

20 A. For the particular one I've
21 described, I'm not aware of any.

22 Q. Are there any standards that
23 determine whether a medical monitoring
24 program is cost-effective?

25 A. Yes.

1 Q. What standards are those?

2 A. I think the standards that are
3 applied, like I talked about in my expert
4 report, by a third-party administrator
5 who does a few things to make it, sir,
6 cost-effective. The first thing the
7 third-party administrator does is to try
8 to boil down the medical monitoring
9 program to the alphabet of medical care,
10 and that is the CPT codes. The second
11 thing that he or she or it does to make
12 it cost-effective, which I think is the
13 question, is to bargain with the
14 potential medical providers of the
15 program to get a good, low price, which
16 makes it cost-effective. Another
17 provision that makes it cost-effective is
18 to carefully review all the invoices
19 provided to the third-party administrator
20 to make sure of two things. One, that
21 the -- the tests and other things given
22 do not exceed the ambit of the program
23 and do not bleed over into medical care,
24 which is often a problem. And so, to be
25 cost-effective, you don't want to pay for

1 those because it's not part of the
2 program; right? And another piece is
3 just to make sure it's true and correct.

4 Also, the third-party
5 administrator at times will spot-audit
6 the medical providers to make sure we
7 don't have anything going on that
8 constitutes, you know, padding the bill
9 and that sort of thing. Another
10 cost-effective step that I recommend and
11 carry out is, with the qualified
12 settlement fund itself that usually holds
13 the money, is to conduct outside annual
14 audits by an accountant to make sure,
15 again, there's no waste, defalcation, or
16 fraud, which would fall within the
17 definition of cost-ineffectiveness, I
18 would think.

19 Q. Now, I think what you've
20 described here are practical techniques
21 that you believe make a medical
22 monitoring program cost-effective. Are
23 those techniques recognized by any
24 peer-reviewed literature as measures of
25 cost-effectiveness?

1 A. I think they're recognized by
2 accountants as a whole in some of their
3 standards, and we have some accountants
4 on staff. I think they're also
5 recognized by the medical industry on how
6 a TPA, a third-party administrator
7 program is carried out. So yes.

8 Q. Are any of those sources cited
9 in your expert report?

10 A. They're not, but they're
11 certainly -- I had those in mind when I
12 was filling it out.

13 Q. Are you aware that your expert
14 report was required to state the bases of
15 all your opinions when you formed them?

16 MR. WHITLOCK: Object to the
17 form.

18 A. I think it -- it does. It talks
19 about in here how I do audits.

20 Q. But these articles that you're
21 referring to are not included or cited in
22 your expert report, are they?

23 A. What articles?

24 Q. Any articles by accountants or
25 medical professionals on measures of

1 cost-effectiveness?

2 A. Well, I mention third-party
3 administrators.

4 Q. But --

5 A. Here on page 4. And I also
6 mentioned doing audits toward the end of
7 the -- of the report.

8 Q. But any articles that set forth
9 these standards for recognizing whether a
10 medical monitoring program is
11 cost-effective are not cited in your
12 report, are they?

13 A. I think because it's just
14 standard currency of what an audit is and
15 what a third-party administrator does.

16 Q. But the specific standards that
17 would apply to a medical monitoring
18 program are neither cited or applied in
19 your expert report, are they?

20 A. The reason is that they're the
21 general standards applied in those two
22 fields I just described.

23 Q. And when you say "The reason is
24 that," are you agreeing that those
25 standards are not cited in your report?

1 A. I'm agreeing that they're
2 implied in the report.

3 Q. For you to agree that they're
4 implied in the report would require me to
5 state that they're implied in the report,
6 which I can't say that I do. Those
7 standards are not cited in your report,
8 are they?

9 A. Not specifically.

10 Q. Did you conduct any kind of a
11 literature review before writing your
12 report in this case?

13 A. No, sir. Except to the extent I
14 read documents and -- involved in the
15 case, which I believe I listed on page 1
16 and 2. No, just page 1.

17 Q. Did you evaluate the components
18 of any claims programs that had
19 previously been administered that you
20 were not involved with?

21 A. I did look at this article I
22 drafted in the Fernald case, and I think
23 that's summarized there.

24 Q. Just to be clear, did you look
25 at any other medical monitoring programs

1 in other litigations that you had not
2 been involved with to determine how to
3 administer this program here?

4 A. Just the one I described.

5 Q. So you were not involved in that
6 case?

7 A. I was not.

8 Q. Okay. So, I understand that
9 your methodology is based primarily on
10 your prior experience as a claims
11 administrator. Is that correct?

12 A. My methodology is based on that
13 in part, and also on the expertise that I
14 rely on that I described earlier.

15 Q. And that expertise, though, is
16 the result of your experience. Is that
17 correct?

18 A. No, sir, it is not, not
19 completely. Again, it deals with medical
20 doctors, third-party administrators,
21 outside accountants, and the parties to
22 the case and the Court.

23 Q. I just remembered something I
24 wanted to come back to, something we were
25 talking about a minute ago. You were

1 talking about one of the things that
2 makes a medical monitoring program
3 cost-effective is that you make sure that
4 the provision of the diagnostic tests
5 doesn't bleed over into medical care.

6 A. Yes, sir.

7 Q. Could you describe that a little
8 bit more?

9 A. Well, again, medical monitoring
10 is that, it's not medical care. And so
11 that's what's being paid for.

12 Q. And so it's important to keep
13 the program limited to that?

14 A. If that's how the program is
15 described, yes, sir.

16 Q. And is it your understanding
17 that the program proposed in this
18 litigation only provides monitoring, it
19 does not provide medical care?

20 A. That's my understanding as I sit
21 here.

22 Q. In paragraph 2 of your expert
23 report, you state that you, "have had the
24 opportunity to administer medical testing
25 as well as medical clinics." Is that

1 correct?

2 A. It does, sir.

3 Q. Can you just describe to me what
4 that role entails?

5 A. Which role?

6 Q. Administering medical testing as
7 well as medical clinics.

8 A. Well, medical testing can
9 involve many different things. Let's
10 just take Tolbert for a minute. We did a
11 blood test for the 18,000 claimants.
12 That's a medical test. We also
13 administered a clinic for them which had
14 three components: primary medical care,
15 dental care, and pharmaceutical benefits.
16 So that's what that involved in that
17 case.

18 In the Perrine case, that's a
19 medical monitoring case, so that's
20 medical testing. And the Mingo County
21 case is a medical monitoring case, and
22 that's medical testing.

23 Q. So you have experience in
24 programs that are both medical monitoring
25 and medical care programs. Is that fair

1 to say?

2 A. That is fair to say.

3 Q. And your opinion in this case is
4 limited to medical monitoring. Is that
5 correct?

6 A. That's my understanding.

7 Q. And not to beat a dead horse,
8 but that's distinct from medical care?

9 A. I think we've beaten that horse.

10 Q. Okay. So let's talk a little
11 bit more about the Tolbert case.

12 A. Yes, sir.

13 Q. That involved allegations of
14 personal injury and property damage from
15 PCB exposure. Is that correct?

16 A. That's correct, sir.

17 Q. And the defendant in that case
18 was who?

19 A. Monsanto and Pharmacia.

20 Q. Was the Tolbert claims program
21 the result of settlement or a
22 Court-mandated relief?

23 A. It was a settlement, sir.

24 Q. And as you described, the
25 Tolbert medical program provided medical

1 care, unlike the medical monitoring
2 program in this case. Is that correct?

3 A. It provided both testing and
4 medical care. Like I said earlier, it
5 had an 18,000-claimant blood test.

6 Q. And there were about --

7 A. And in connection with the blood
8 test -- I'm sorry to interrupt you, sir.

9 Q. Yeah.

10 A. In connection with the blood
11 test, there was a nurse interview. You
12 know, so there was sort of a, you know,
13 sort of like a wellness exam. So it's
14 not too different. It's not as
15 sophisticated, but it's not too different
16 from some medical monitoring programs.

17 Q. And there were approximately
18 18,000 claimants in the Tolbert
19 settlement. Does that sound about right?

20 A. It does, sir.

21 Q. And they all claimed to have
22 experienced personal injuries. Is that
23 correct?

24 A. That was the claim.

25 Q. Do you recall about how many

1 claimants used the services of the
2 medical clinic?

3 A. I'm thinking about 5,000.

4 Q. If I told you that there was a
5 2015 status letter that said, of the
6 18,000 claimants, approximately 7,000
7 have registered to receive services from
8 the clinic program and approximately
9 2,300 received services during a quarter,
10 does that sound about right to you?

11 A. It may have been at the time,
12 but the program continued to grow till
13 the end. So the -- the number of people
14 participating kept growing.

15 Q. And you believe it was about
16 7,000 -- or, excuse me, about 5,000 at
17 the end?

18 A. Yeah, something like that. But,
19 you know, certainly, I could accept that,
20 subject to check. I'd like to look at
21 it. It's not in front of me.

22 Q. So, of the 18,000 claimants,
23 about 5,000 ultimately received services
24 from the program. Is that your
25 testimony?

1 MR. WHITLOCK: Object to the
2 form.

3 A. From the medical clinic. They
4 all got a payment for personal injury,
5 and some got payments for property, to
6 the extent they owned it.

7 Q. And we'll also talk about the
8 Perrine case.

9 A. Sure.

10 Q. You were the claims
11 administrator there as well; correct?

12 A. I still am. Yeah.

13 Q. What are your responsibilities
14 as claims administrator in that case?

15 A. I had two major
16 responsibilities. One was to carry out a
17 soil and house remediation of the class
18 area. And then the other one was to
19 administer a medical monitoring program,
20 and that's still ongoing.

21 Q. Do you have any experience in
22 addition to Perrine in administering the
23 remediation? Environmental remediation,
24 that is?

25 A. Yes, sir. The Blackwell Zinc

1 smelter settlement in Blackwell,
2 Oklahoma, is -- is a soil and house
3 remediation, too. Another zinc smelter.

4 Q. Can you describe in a little
5 more detail what you do in that role?

6 A. In the Blackwell case?

7 Q. In your general role in both
8 Perrine and Blackwell as administering
9 environmental remediation.

10 A. Okay. Let me start with the
11 Perrine one, if you don't mind, because
12 they're different. So, on the Perrine
13 one, we pretty much did soup to nuts.
14 We -- we supervised the actual
15 remediation. So what we did is we
16 started by issuing a request for
17 proposals. We got eighteen proposals.
18 We interviewed everybody, we boiled it
19 down to some finalists and selected a
20 remediation company. We then supervised
21 that company on a daily basis. We hired
22 two or three people at any one time that
23 had some expertise in that field to be
24 the construction supervisors, and we
25 would interface with the remediation

1 company and the claimants to make sure
2 the remediation went smoothly.

3 We also paid the claimants some
4 remediation-related cash as the thing
5 went along. We then -- at the end, we
6 prepared some summaries of the
7 remediation, you know, both -- both
8 written and in a graphic way, to show
9 what the town looked like before and
10 after the remediation. And at the end,
11 we had a surplus of about \$4 million, and
12 we paid that out as a dividend to the
13 claimants. So that's a nutshell of that
14 one.

15 On the Blackwell one, if I could
16 turn to that one for a minute. In that
17 one, unlike in the Perrine one, the
18 defendant itself runs the remediation and
19 not us. What we do, though, is we
20 interface with the claimants and we help
21 expedite the remediation. We had an
22 office there for some years, and we
23 helped the claimants buy into the case.
24 When we were hired in the case, the
25 opt-out rate was pretty high, about 20

1 percent. And in Perrine it's derisory,
2 almost everybody stayed in. So the first
3 thing we did in that case was to win the
4 town back. And if I could just finish,
5 sir, sorry. The next thing we did is we
6 interfaced with Freeport, the defendant,
7 in carrying out the remediation. We got
8 access agreements. We tried to settle
9 disputes between the claimant and the
10 remediation company. And so now we
11 anticipate having a surplus, so the last
12 thing we're going to do as that case
13 winds down also is decide what to do with
14 the surplus.

15 Thank you.

16 Q. So just to clarify your role
17 there, when you say you were trying to
18 encourage claimants to buy into the case,
19 was that a class action settlement?

20 A. It was, sir.

21 Q. And you were trying to encourage
22 claimants that they should opt in to the
23 class relief rather than opting out?

24 A. That they should change their
25 opt-out decision, to be more precise.

1 Q. And in that case, you were
2 retained by the parties to effectuate
3 that settlement. Is that correct?

4 A. In that case, Lewis Sutherland
5 of Vinson & Elkins, the defendant, asked
6 me to do that case.

7 Q. I understand he asked you. But
8 just to clarify, ultimately, you were
9 retained in support of the settlement
10 rather than as representing the
11 defendant. Is that correct?

12 A. That's correct.

13 Q. So going back to the Perrine
14 settlement.

15 A. Yes, sir.

16 Q. The Perrine settlement was
17 unlike Tolbert because it provided
18 medical monitoring only rather than
19 medical care. Is that correct?

20 A. As far as the medical aspect of
21 the two cases, that's correct.

22 Q. And so in the Perrine program,
23 the participants have the opportunity to
24 receive diagnostic testing and a physical
25 exam every other year. Is that correct?

1 A. That's -- that's basically a
2 summary.

3 Q. And it covers referral
4 consultations with medical specialists.
5 Is that correct?

6 A. It does, yes.

7 Q. And that's not the case with the
8 medical monitoring program that's been
9 proposed in this case. Is that correct?

10 A. I don't know those details as I
11 sit here.

12 Q. So the Perrine plaintiffs
13 estimated that approximately 8,500
14 individuals were eligible for the medical
15 monitoring program. Is that correct?

16 A. I don't know if I understand the
17 question. Maybe you could tell me when
18 that estimate was made.

19 Q. If I told you that there was a
20 2011 article that reported that one of
21 the plaintiffs' attorneys, Clarksburg's
22 Perry Jones, said it was estimated that
23 around 8,500 people could be eligible,
24 does that sound about right to you?

25 A. That's certainly Perry's

1 opinion. It sounds about right.

2 Q. But fewer than 6,000 eligible
3 individuals actually registered for the
4 program. Is that correct?

5 A. It's my recollection that about
6 6,000 signed up, of whom 4,000 decided to
7 take medical monitoring and 2,000 decided
8 just to get cash, give or take.

9 Q. And there have been three rounds
10 of testing since the Perrine settlement
11 program began. Is that correct?

12 A. Well, we're on the fourth one
13 now, sir. It began earlier this year.

14 Q. Do you recall what the
15 participation rate was in the first round
16 of testing in Perrine?

17 A. It's -- it's approximately
18 2,000, as I remember.

19 Q. So the 4,000 individuals who
20 agreed to participate in testing, only
21 2,000 completed the testing.

22 A. Approximately.

23 Q. Is that correct?

24 A. Yes, sir.

25 Q. So, if there were about 8,500

1 plaintiffs to begin with, or, excuse me,
2 8,500 eligible participants in the
3 program, then the participation rate is
4 less than 25 percent in that settlement.
5 Is that correct?

6 A. If all that is correct, then
7 that would be -- that would be correct
8 math.

9 Q. And you're not offering an
10 expert opinion on math, are you?

11 A. Not today.

12 Q. Okay. And the second round of
13 testing in Perrine had even lower
14 participation. Is that correct?

15 A. It had, yes, sir.

16 Q. About a thousand individuals?

17 A. Give or take. That's my
18 recollection.

19 Q. So that was about 12 or 13
20 percent. Is that fair to say?

21 A. Of what? 4,000?

22 Q. Of 8,500.

23 A. Again, I don't know -- the Perry
24 Jones number, I'm not -- I don't know if
25 that number's correct or not.

1 Q. And what was the participation
2 rate in the third and fourth rates of
3 testing?

4 A. The participation rate, as I
5 remember, in the third round was about
6 500, and the fourth we don't know yet.

7 Q. Have you ever seen a medical
8 monitoring program that for every round
9 of testing it's the same participation
10 rate?

11 A. I haven't, but I've seen the
12 Tolbert case go up.

13 Q. But you've never seen a program
14 that has that high of a rate -- or excuse
15 me. Withdraw the question.

16 You've never seen a program
17 maintain the same rate over time. Is
18 that correct?

19 A. Not the same rate, I wouldn't
20 think, completely. I mean, it would
21 vary, wouldn't it?

22 Q. What's the longest medical
23 monitoring program that you've been
24 involved with?

25 A. I would say that Tolbert fits

1 the definition of medical monitoring.
2 Even though they get medical care also,
3 they do get monitoring. And that one
4 lasted eleven years. But the longest
5 ones that -- you know, I've got to live
6 that long; right? The longest ones are
7 in Mingo County and the Perrine case,
8 they're both thirty. But again, I
9 haven't lived through it yet.

10 Q. So, are there any programs
11 you've been involved with, medical
12 monitoring programs --

13 A. Okay.

14 Q. -- that you're now at the tail
15 end of the program or that the program
16 has completed?

17 A. I would say again the Tolbert
18 fits what I think is medical monitoring
19 because it has testing, and that one is
20 completed.

21 Q. And that was eleven years, you
22 said?

23 A. Yes, sir.

24 Q. And what was the participation
25 rate at the end?

1 A. I think, again, it was about
2 5,000 people.

3 Q. And -- but a program that was
4 pure medical monitoring, have you been
5 involved in any that you've seen through
6 to completion?

7 A. Not yet. I'm too -- too young.

8 Q. And any -- what's the furthest
9 advanced ongoing medical monitoring
10 program that you're involved with?

11 A. Mingo and Perrine are about the
12 same, they're both into their fourth
13 cycle, give or take. And they're --
14 they're biennial, I think is the fancy
15 name for them, every two years.

16 Q. Let's talk about Mingo.

17 A. Yes, sir.

18 Q. What are your responsibilities
19 as claims administrator in that case?

20 A. There's a trust that's set up
21 that has the funding for the case. As I
22 remember, the total allocated is five
23 million. We've got two million down, and
24 there's three million available to
25 replenish. That's being held by a

1 trustee, so unlike in the Perrine case,
2 I'm not actually holding the money. I
3 think my -- my title is monitoring
4 administrator or something to that
5 effect. And my job is to conduct the
6 tests. And what I do there is I use this
7 company out of Pennsylvania I mentioned.
8 I think they used to be called Apple, but
9 now they're something else. I use a
10 mobile clinic, just because of the
11 remoteness of the area and the distrust
12 of the people of the -- of local
13 physicians. But basically, I carry out
14 the program.

15 Q. And the Mingo County program
16 doesn't include treatment for any health
17 conditions. Is that correct?

18 A. It doesn't.

19 Q. And it included about 722
20 individuals who were eligible for the
21 program. Is that correct?

22 A. I think so. I think some have
23 died now, but I think initially 700, give
24 or take.

25 Q. And you expected and budgeted

1 for 85 percent participation in the first
2 year and as little as 20 percent
3 participation by the third year. Is that
4 correct?

5 A. I think we did create a budget,
6 and it did have some projections. I
7 can't remember completely what it said,
8 but that sounds familiar.

9 Q. And in fact, fewer than 200
10 individuals participated. Is that
11 correct?

12 A. In what time frame?

13 Q. If the medical monitoring
14 brochure stated that less than 200 of all
15 eligible claimants took advantage of
16 these free screenings, does that sound
17 about right?

18 MR. WHITLOCK: Object.

19 A. What was the date of it? If you
20 show it to me, I might be able to help
21 you. I'm just trying to answer it
22 accurately. Sorry.

23 Q. Okay. So mark this as Exhibit 3
24 for identification.

25 (Exhibit 3 was marked for identification

1 and is attached.)

2 A. Okay. Thank you.

3 Q. So taking a look, can you tell
4 me what this is, Mr. Gentle?

5 A. Yes, sir. It's -- it's a type
6 of newsletter that we send periodically
7 in the case to update the -- the medical
8 monitoring claimants on the case.

9 Q. And do you see on the first
10 page, on the right-hand side where it
11 says, "Why are screenings important?"

12 A. I do, sir.

13 Q. And then it says: "Almost four
14 years ago, we offered the first health
15 screenings of the Medical Monitoring
16 Plan. Less than 200 of all eligible
17 claimants took advantage of the
18 screenings - a start, but well short of
19 our goal of 100% participation."

20 A. I do. And that helps me with
21 the time frame. So it looks like, sir,
22 this -- this was looking back at the
23 first two rounds of testing. That is
24 what I was trying to figure out. So it
25 looks like within the first two rounds of

1 testing, there were two hundred or less
2 that participated.

3 Q. And about what time would this
4 have been published, then?

5 A. Well, let's -- let's think it
6 through. So we're on the fourth round,
7 this is 2018. '16, '14. I would say
8 about 2014, give or take.

9 Q. Okay. So, and what date was
10 that settlement agreed to?

11 A. I think about 2009, give or
12 take. I don't have it in front of me.

13 Q. So five years into the
14 settlement, there was about two hundred
15 people, or less than two hundred people
16 who had participated as of that time?

17 A. Or more precisely, after two
18 rounds of testing.

19 Q. Has participation gone up or
20 down since that time?

21 A. It's -- it's gone down to some
22 extent, but it's flattened out also.

23 Q. Now, according to your resumé,
24 you've worked on a number of claims
25 programs, and I just wanted to clarify a

1 couple of them.

2 A. Yes, sir.

3 Q. When you say you worked on a
4 Camden, New Jersey, contamination case,
5 that, was the Rowe-DuPont settlement?
6 Isn't that correct?

7 A. It was. It was, sir.

8 Q. And the Spelter, West Virginia,
9 zinc smelter settlement, that's the
10 Perrine settlement?

11 A. It is, sir.

12 Q. In paragraph 1 of your report,
13 you indicate that you provided this
14 report "respecting the proposed Medical
15 Monitoring Program, recommended in the
16 expert report of Alan Ducatman, M.D." Is
17 that correct?

18 (Witness reviews document.)

19 A. Yes, sir.

20 Q. And later in that paragraph you
21 state that you have reviewed the "Reports
22 of Alan Ducatman, M.D." Is that correct?

23 A. Yes, sir.

24 MR. WHITLOCK: Can we go off the
25 record for one second? Ducatman?

1 THE VIDEOGRAPHER: Going off the
2 record, 10:15 a.m.

3 (Discussion held off the record.)

4 (Break taken.)

5 THE VIDEOGRAPHER: This begins
6 Disk No. 2. Going back on the record,
7 10:28 a.m.

8 Q. (By Mr. Wilson) So, before our
9 break, Mr. Gentle, we were speaking about
10 how you have reviewed the "Reports of
11 Alan Ducatman, M.D." Is that correct?

12 A. Yes, sir.

13 Q. Does that refer to both his
14 September 1st, 2017, report on class
15 certification and his December 15th,
16 2017, report on the merits?

17 A. I know it applies to the one on
18 the merits. I'm not sure about the other
19 one.

20 Q. You also state that you reviewed
21 Dr. Ducatman's declaration. Is that
22 correct?

23 A. Yes, sir.

24 Q. Is there anything in Dr.
25 Ducatman's report with which you

1 disagree?

2 A. As I sit here, I can't recall of
3 anything.

4 Q. Any components of the medical
5 monitoring program that he proposes that
6 you would alter?

7 A. Again, I can't -- I can't recall
8 all the different details. But as I sit
9 here, I'm not aware of anything that I
10 would alter.

11 Q. Anything you would omit?

12 A. Omit? As far as tests or what?

13 Q. As far as anything in the
14 program that he includes that you would
15 omit.

16 A. Not that I can recall.

17 Q. And anything that he omits that
18 you would include?

19 A. Well, there may be. Because,
20 again, the scope of what he has is more
21 of a medical approach. He does not talk,
22 for example, about whether to have a
23 qualified settlement fund, whether -- he
24 may or may not -- talk about whether to
25 have a claimants committee, whether to

1 have some of this organizational
2 structure, both financially and
3 management-wise, that we discussed. So
4 to that extent, it could be omitted, but
5 it may, you know, rightfully be included.

6 Q. So I just want to understand
7 some of the language of your report.

8 A. Okay.

9 Q. There's several instances in
10 your report where you say "we" did this
11 or "we" provide that. For example, in
12 paragraph 3D [sic] you state that, "We
13 often provide on-the-ground presence for
14 medical monitoring programs.

15 Who's the "we" that you're
16 referring to in your report?

17 (Witness reviews document.)

18 A. In -- in paragraph E, which is
19 where I think you're reading, it talks
20 about having a local office, so that
21 would be employees of my firm, usually,
22 in that particular context.

23 Q. Are you -- are you aware of any
24 other "we's" in your report that you
25 would be referring to?

1 A. Yes, sir. I think, for example,
2 on D, "compilation of medical monitoring
3 and epidemiological study data for use,"
4 that may involve an epidemiologist, like
5 we have now in the Mingo case. It may
6 involve CTIA in the Perrine case that
7 compiles the medical monitoring study
8 data, to the extent the claimant agrees
9 to have it deidentified and used. So I
10 think the "we" would just depend on the
11 context.

12 Q. And would it be fair to say that
13 in all the contexts in which you use
14 "we," you're referring to you and the
15 individuals and companies that you
16 collaborate with in administrating
17 medical monitoring programs?

18 A. I think that's a fair summary.

19 Q. So when you say "we," you're not
20 referring to "we, as a profession of
21 medical monitoring administrators, do
22 this"?

23 A. Oh, I see the question. Okay.
24 I did not consult with other medical
25 monitoring administrators in deciding how

1 to use the "we."

2 Q. So you're not describing a
3 professional standard, you're describing
4 the practice of your firm and its
5 associates and partners and affiliates?

6 A. I'm describing the experience
7 I've had with a given "we" group in a
8 given context. For example, on the "we"
9 compile the medical monitoring data, that
10 would be the experience and standards
11 used by CTIA or the epidemiologist. So
12 to some extent, it's beyond your
13 suggested answer.

14 Q. Now, in paragraph 3 of your
15 report.

16 A. Three? Okay.

17 Q. Turn to that.

18 A. All right.

19 Q. You state that you usually
20 provide the following services for the
21 three medical monitoring programs
22 identified in the prior paragraph.
23 That's Tolbert, Perrine, and Mingo
24 County.

25 A. Yes, sir.

1 Q. Why did you qualify that
2 sentence by stating "usually"?

3 A. Well, for example, in the -- in
4 the Tolbert one, the -- the claimants
5 were recruited by the lawyers because
6 they're part of the case already as
7 actual plaintiffs, so it was an aggregate
8 case and not a class case. So that's why
9 even though there's a rule of thumb, it
10 didn't apply there.

11 Q. And who makes the decision about
12 what services are included?

13 A. I think we've gone over that.
14 It -- it -- of course, the ultimate
15 decision-maker is the Court. You look at
16 the documents that created the case, be
17 it a judgment, a settlement, or a hybrid
18 like we discussed. You collaborate with
19 the parties, and you meet with your
20 professionals that help carry it out, and
21 as a group they create the standards.

22 Q. And the services that you
23 identify in paragraph 3 that are usually
24 included, did you identify them because
25 you believe they should be implemented in

1 this litigation?

2 (Witness reviews document.)

3 A. Yes.

4 Q. In paragraph 3A of your report
5 you state that "Participants are
6 recruited and registered for the
7 program." How do you recruit
8 participants?

9 A. I think what you do is you first
10 identify the area of concern. And I
11 think that's already been done here, to
12 the extent I understand it, by Vermont
13 itself. You also have to see what the
14 criteria are. For example, I believe
15 there's a proposed class definition. You
16 might have to get the class certified
17 first. I'm not aware of that being done
18 yet. And then once that's done, then you
19 sort of know what your potential group
20 is, and you -- you tailor the
21 registration to the group.

22 For example, in the Tolbert
23 case, we had people in 44 states. So
24 recruiting them is a lot more difficult
25 than if they just lived in one

1 neighborhood. If I understand it in this
2 case, by and large, it's Bennington,
3 isn't it? You might just have one
4 neighborhood, and that could be done on
5 the ground, it could be done with town
6 meetings. So I think you would just
7 tailor it, you know, to the given
8 situation.

9 Q. Was the Tolbert settlement a
10 class action settlement?

11 A. No.

12 Q. So it was only the parties who
13 had been specifically named who were
14 settling their claims there?

15 A. No. It was somewhere in
16 between. It was individuals that had
17 signed up with a law firm.

18 Q. Okay.

19 A. Not necessarily had filed a
20 suit.

21 Q. And so the claimants were spread
22 throughout a number of states?

23 A. Yes, sir.

24 Q. But they were all identified?

25 A. Fortunately, yes.

1 Q. Have you ever had a situation
2 where you've had to identify multiple
3 claimants from out of state?

4 A. Yes, sir.

5 Q. What situation was that?

6 A. The Perrine case.

7 Q. And how did you go about that?

8 A. We did it iteratively. If I
9 could just explain my answer. We first
10 had town meetings on the ground in
11 Spelter itself, you know, ground zero,
12 where the -- where the smelter was.
13 Claimants that came and qualified, there
14 was a residency requirement, filled out a
15 claim form, and one of the questions on
16 the claim form was do you know people
17 that have left, you know, left the area.
18 Then we try to track those down, and then
19 we'd ask them iteratively, do you know
20 anybody else, iteratively. And so that's
21 what I meant by iterative.

22 Q. Do you know what the class
23 definition was in that case, Perrine?

24 A. As I remember, we had three
25 zones, 1, 2, and 3. One is at ground

1 zero, a little bit out; 2, further out;
2 3, further out. For Zone 1, you had to
3 have lived there at least one year; Zone
4 2, three; Zone 5 [sic], three years, to
5 qualify for medical monitoring. That's
6 for the medical-monitored class, as I
7 remember it, with some -- with some
8 fine-tuning, I'm sure.

9 Q. So you also state that you
10 confirm or denied patient medical
11 monitoring eligibility as administrator?

12 A. Yes, sir.

13 Q. Are your recruitment measures
14 restricted to a particular population or
15 class of potential participants who have
16 potential eligibility?

17 A. Ask that again? I'm sorry.

18 Q. Okay. When you're trying to
19 recruit people to the program.

20 A. Okay.

21 Q. Do you limit your inquiries to
22 people who are potential participants who
23 seem like they may be eligible for the
24 program?

25 A. I don't think we do, for this

1 reason. You know, you convene a town
2 meeting, and all kinds of people come.
3 You try to describe the criteria that
4 you've just mentioned. But people come,
5 especially if you feed them lunch or give
6 them a drink or have a Christmas party,
7 which I've done, a soft drink. But, you
8 know, that way, you know, you want to get
9 a high participation, but you have to
10 cull through those that, you know,
11 qualify versus those that don't. So
12 unfortunately, you try to use a sharp
13 criterion, but it doesn't completely
14 work. I hope that answers the question.

15 Q. And you state in that paragraph,
16 "participants are encouraged to
17 participate." How are they encouraged to
18 participate?

19 A. There's two ways, I think. One
20 is cash and one is kind. By "kind," I
21 mean that you encourage them to
22 participate to answer two questions that
23 I think claimants often have in these
24 situations: One, do I have any diseases;
25 two, what happened here? And if you have

1 a medical monitoring case and you compile
2 the data and you get research done, that
3 may help answer the second question. And
4 the other one, cash, you know, people's
5 time is valuable, and you might want to
6 give them some incentive to either sign
7 up or participate or both.

8 Q. Now, in paragraph 3B of your
9 report --

10 A. Okay.

11 Q. -- you state -- and you've
12 mentioned this already in the course of
13 your testimony today.

14 A. Yes, sir.

15 Q. You state, "We often use a
16 Qualified Settlement Fund," or QSF.

17 A. Yes, sir.

18 Q. Can you describe for the jury
19 what a qualified settlement is?

20 A. Yes, sir. It's established by
21 Internal Revenue Code 468B. It's
22 approved by a Court and used to receive
23 and disburse funds in carrying out a
24 settlement.

25 Q. And perhaps it is implicit in

1 the name, but I'm no stranger to obvious
2 questions, would a qualified settlement
3 fund ever be used in a medical monitoring
4 program that's not the product of a
5 settlement?

6 A. Could be. Depends on the Court.
7 If you -- if you look at the definition
8 of 468B, it has to be approved by a
9 Court. And certainly, I'm not going to
10 say how long the chancellor's foot may
11 be.

12 Q. So you're saying that a
13 qualified settlement fund might be
14 compelled even in the case where there's
15 not a settlement?

16 A. I think that's possible. It
17 depends on the Court.

18 Q. Do you have any expertise as a
19 tax lawyer regarding that provision of
20 the Internal Revenue Code that would give
21 you the ability to state that opinion?

22 A. I have not been asked to give
23 that opinion in this case.

24 Q. In paragraph 3D of your report?

25 A. Yes.

1 Q. You state that you "facilitate
2 the compilation of medical monitoring and
3 epidemiological study data." Is that
4 correct?

5 A. It does say that.

6 Q. Have each of the medical
7 monitoring programs that you have
8 administered included an epidemiological
9 study component?

10 A. Only one has.

11 Q. Which one was that?

12 A. Mingo.

13 Q. And what's the function of that
14 component in a medical monitoring
15 program?

16 A. It's to answer that third
17 question I posed to you, and that is:
18 What happened here? You know, whether
19 for the population as a whole there are
20 health trends.

21 Q. You also suggest in that
22 paragraph that the service has two
23 functions, to use in monitoring planning
24 and for possible use in research.

25 A. Yes, sir.

1 Q. So the possible use in research
2 goes to the "What happened here?" Is
3 that correct?

4 A. That's my understanding.

5 Q. And how would -- how would it be
6 used in planning the monitoring?

7 A. Well, for example, in the
8 Perrine case, as I'm sure you studied it
9 now, we have a medical panel that reviews
10 the tests that are conducted every five
11 years. And so, if you know the incidence
12 of certain diseases, based upon your
13 prior testing, that will help you tailor
14 future testing. And that panel every
15 five years updates the program's testing
16 protocols.

17 Q. Now, your report says "possible
18 use in research." Does that mean that
19 the data might not necessarily be used in
20 research?

21 A. It does.

22 Q. And does the inclusion of a
23 research initiative have to be decided
24 before the commencement of the medical
25 monitoring program?

1 A. It does not have to be, no.

2 Q. What criteria determine whether
3 or not the data will ultimately be used
4 for research?

5 A. I guess the first criterion is
6 to have a researcher who's interested.

7 Q. So there is not any necessary
8 way of being able to tell whether the
9 data will ultimately be used?

10 A. As we sit here, there's not.

11 Q. In paragraph 3E of your report,
12 you state that you "often provide
13 on-the-ground presence for medical
14 monitoring programs by utilizing a local
15 office to interface with participants and
16 medical staff." Is that correct?

17 A. It is correct.

18 Q. Who would staff such a local
19 office?

20 A. Usually, one or two employees.
21 And they -- the best -- the best
22 employees for that situation are local
23 employees that know the population.
24 That's so critical. Because it has to be
25 claimant class member-friendly.

1 Q. And would that be approved, the
2 establishment of a local office,
3 typically at the time that the medical
4 protocol is approved?

5 A. Typically, it's -- it's approved
6 in a couple of ways. First of all, in
7 this collaborative approach that we
8 described on how you -- how you decide
9 what the guidelines are. And secondly,
10 it's approved when the parties sign off
11 on the budget because it would be in the
12 budget. So those are the two things that
13 come to mind on the approval process for
14 that.

15 Q. Is it your opinion that a local
16 office would be appropriate for the
17 medical monitoring program being proposed
18 in this litigation?

19 A. Based upon what I know now, I
20 think it is something that we should
21 explore, and I would recommend it at this
22 time. You know, one big issue here is
23 recruitment. You've asked me a lot about
24 that this morning. And I think because
25 the population seems to be somewhat

1 concentrated and therefore local, it
2 seems to me that a local office may be
3 efficient in saving money and also in
4 interfacing directly with the claimant
5 population.

6 Q. In paragraph 3F of your report.

7 A. Yes, sir.

8 Q. You state that administrative
9 expenses run, on average, 10 percent of
10 program outlay. Is that correct?

11 A. It does say that.

12 Q. And is that a representative
13 figure for all the claim or settlement
14 programs you've been involved in?

15 A. I think what we're talking about
16 here is medical monitoring.

17 Q. Okay. So that includes Perrine,
18 Tolbert, and Mingo County?

19 A. It does, sir.

20 Q. And Tolbert, of course, is not a
21 pure medical monitoring program, but
22 includes that -- some of that relief. Is
23 that correct?

24 A. It does, sir.

25 Q. Okay. And to what extent are

1 administrative expenses typically tied to
2 program outlay?

3 A. Well, what happens is you
4 usually have a budget for a given year
5 and there is a line item. And we -- we
6 want to make sure it's -- it's fair and
7 reasonable in light of what all's going
8 to happen and how much money is going to
9 be spent. So we take that very
10 seriously, to come in with a budget
11 proposal in which our line item is fair
12 and reasonable in light of what all is
13 going to happen and what's going to be
14 spent.

15 Q. And your administrative
16 expenses, does that include your
17 compensation?

18 A. It does, sir.

19 Q. Now, in paragraph 4 of your
20 report, you state that you, quote,
21 recommend that the following medical
22 monitoring design programs be followed in
23 the Bennington Medical Monitoring
24 Program. Is that correct?

25 A. Parameters, yes, sir, I see it.

1 Q. Is it fair to say that you
2 believe these are necessary components of
3 a medical monitoring program?

4 MR. WHITLOCK: Object to the
5 form.

6 A. I don't know if "necessary" is
7 the right adjective. I would say they're
8 strongly recommended.

9 Q. In paragraph 4B of your report
10 you "suggest that the program use a
11 retail HMO model." Correct?

12 A. Yes, sir.

13 Q. What are the key features of a
14 retail HMO model?

15 A. The key feature is that unlike
16 in most business practices, retail is
17 often cheaper than wholesale in the
18 medical field, as counterintuitive as
19 that may be. And by "retail" I mean that
20 the medical monitoring program would pay
21 per unit of service as opposed to paying
22 for a medical facility, its overhead, and
23 its doctors. That's the basic
24 distinction.

25 Q. And can you just describe a

1 little bit more why you believe that that
2 model is more efficient?

3 A. Yes, sir. It's based upon --
4 that's why they call it the "practice" of
5 law -- my experience. Sometimes we do
6 things not perfectly; right? And so what
7 we did in the Tolbert case, we started
8 out with a wholesale model; and that is,
9 we engaged two clinics, we paid part of
10 their overhead, paid part of their
11 salaries and that sort of thing. And we
12 found that we could not do it
13 successfully within our budget. And so
14 we cast about for alternatives, and we
15 came up with this retail model, and it's
16 substantially less expensive. It's also
17 easier for the defendant to monitor
18 because you see where every penny went,
19 as opposed to just paying for somebody's
20 salary. And so it -- it's more effective
21 in terms of cost/benefit and also
22 transparency.

23 Q. So when you were describing the
24 Tolbert case --

25 A. Yes, sir.

1 Q. -- where you're unable to do the
2 wholesale model within the budget --

3 A. Yes, sir.

4 Q. -- who ended up eating the
5 excess cost in that situation?

6 A. Well, what happened is we just
7 -- we stretched the money after we
8 changed to the retail model to make it
9 come in on budget for the twelve years.
10 In fact, it was only meant to last ten.
11 So we stretched it a couple of years
12 because the retail model is so efficient.

13 Q. And so in that situation, if
14 there's a budget proposed --

15 A. Yes, sir.

16 Q. -- and the program is going over
17 the budget, did the defendant have to pay
18 more?

19 A. No.

20 Q. So, did your firm end up
21 absorbing the cost of that excess?

22 A. No. It was in a qualified
23 settlement fund, and we just carefully
24 managed the money and came in on budget
25 for the long term.

1 Q. Was the wholesale model less
2 efficient because of low participation?

3 A. No. It was less efficient
4 because, when I paid a doctor his or her
5 salary, I was not getting as much benefit
6 for that payment as I did when I paid per
7 unit of service. So I was paying the
8 doctor while they were eating lunch.

9 Q. Would the wholesale model have
10 been more efficient had there been higher
11 participation?

12 MR. WHITLOCK: Object to the
13 form.

14 A. I don't think so. I just think
15 the model is wrong. The payment model is
16 wrong.

17 Q. Have you checked whether higher
18 participation would have made the
19 wholesale model more efficient?

20 A. In a way, I have. What we did
21 is we let out for bids proposals to
22 administer the case in a way that would
23 help it cash-flow. And this was the
24 ultimate result based upon looking at the
25 bidders and their presentations. And

1 they were professionals, such as CTIA, in
2 administering medical programs. So I
3 think that's the peer review, so to
4 speak, that we engaged in. And when we
5 -- we let it out for proposal, we didn't
6 abandon the wholesale model, we just
7 asked for ideas.

8 Q. Would you say that the retail
9 HMO model that you're proposing here is
10 consistent with the program proposed by
11 Dr. Ducatman?

12 A. I -- I --

13 MR. WHITLOCK: Object to the
14 form. Sorry.

15 THE WITNESS: Sorry.

16 A. I haven't looked at that
17 question in detail. No, sir, I don't
18 know.

19 Q. We will mark this for
20 identification as Gentle Exhibit 4. Mr.
21 Gentle, can you tell me what this is?
22 (Exhibit 4 was marked for identification
23 and is attached.)

24 A. It's the merits report of Alan
25 Ducatman.

1 Q. And is this the report that you
2 reviewed in connection with formulating
3 your opinions in this case?

4 A. That's my understanding.

5 Q. Would you turn to page 13?

6 A. Yes, sir.

7 Q. At the bottom of page 13, last
8 paragraph?

9 A. Okay.

10 Q. Second sentence reads: "In
11 order to effectively communicate with and
12 properly advise participating Class
13 members, the program physician and nurse
14 will need to take training related to
15 PFOA, PFOA exposure in humans, and the
16 diseases and health risks associated with
17 PFOA exposure. The program physician
18 will supervise all aspects of office
19 practice and his/her general
20 responsibilities which will include," and
21 then it lists several things after that.

22 Did I read that correctly?

23 A. You did, sir.

24 Q. Do you agree that the program
25 physician and nurse will need to take

1 training related to PFOA, PFOA exposure
2 in humans, and the diseases and health
3 risks fasciated with PFOA exposure?

4 MR. WHITLOCK: Object to the
5 form.

6 A. That's not within my expertise
7 to answer.

8 Q. Does your opinion incorporate
9 that training into your retail HMO model?

10 A. It will if that -- if that's
11 something that we have to pay for. But
12 as I sit here, we have not gotten into
13 those details.

14 Q. Does that reduce the efficiency
15 of the retail HMO model?

16 A. I don't think so. Because the
17 model deals with actual medical care
18 provisioning. So for example, you'd look
19 over here on these -- on page 14 and
20 you'd reduce that to CPT codes and pay.

21 Q. But you didn't attempt any
22 analysis of whether this training would
23 affect the efficiency of that model in
24 the course of developing your opinion,
25 did you?

1 A. I don't see how it would. I
2 think you're just paying for units of
3 service.

4 Q. There's no opinions in your
5 report about whether this training would
6 affect the efficiency of the retail HMO
7 model, are there?

8 A. I don't think it would. You're
9 just paying for units of service.

10 Q. But there's no analysis of this
11 issue in your report, is there?

12 MR. WHITLOCK: Object to the
13 form.

14 A. I don't think it impacts it
15 because you're paying for units of
16 service.

17 Q. I understand that you don't
18 think that today. But there's nothing
19 about that opinion that you're stating
20 now in your report. Is that correct?

21 A. What opinion?

22 Q. Your opinion that this training
23 would not affect the efficiency of the
24 program.

25 A. I think it's inherently true

1 because we're just paying for CPT codes.

2 Q. But this view that you're
3 stating as inherent is not stated in your
4 report. Is that correct?

5 A. It is, because the retail model
6 says pay for CPT codes.

7 Q. How do CPT codes reflect
8 training?

9 A. CPT codes are for units of
10 service, which imply that the person
11 providing the service is able to do so
12 and therefore has the adequate training.

13 Q. But there's nothing that
14 specifically states anything about
15 training in your report, is there?

16 A. I think we've asked and
17 answered.

18 Q. I don't think it has been
19 answered. There's nothing in your report
20 about training the physicians about PFOA,
21 is there?

22 A. There's nothing in my report
23 that addresses whether to train
24 physicians for PFA -- PFOA.

25 MR. WILSON: I'd like to mark

1 Exhibit 5 for identification.

2 Q. Mr. Gentle, if you would take a
3 look at Exhibit 5.

4 (Exhibit 5 was marked for identification
5 and is attached.)

6 A. Yes, sir.

7 Q. Would you tell me what this is?

8 A. It's something I've written.

9 Q. And a little more specifically?

10 A. It's titled "The Medical
11 Monitoring Tort Remedy."

12 Q. And was this essay ever
13 published anywhere other than on your
14 blog?

15 A. I think it's on my blog and on
16 my website, and at times I've given it to
17 people. I guess providing to other
18 people is sometimes thought to be
19 publication.

20 Q. Did you submit it for
21 publication in any periodical?

22 A. I have.

23 Q. Did any periodical accept it for
24 publication?

25 A. No, not yet.

1 Q. If you turn to page 7.

2 A. Okay.

3 Q. Of your essay.

4 A. Yes, sir.

5 Q. The third full paragraph, second
6 sentence states, "In my experience, a
7 medical monitoring settlement is
8 fortunate if half of the claimants
9 participate, with a third sometimes being
10 the case."

11 Did I read that correctly?

12 A. You did, sir.

13 Q. What's the highest level of
14 participation you've ever seen in a
15 medical monitoring program?

16 A. Well, like we talked about in
17 Tolbert, it kept growing.

18 Q. And what was the peak
19 participation?

20 A. I think about 5,000.

21 Q. Out of 18,000 total claimants?

22 A. No. Because a lot of them were
23 not local. And it's just in Anniston.

24 Q. But there were 18,000 total
25 claimants in that case. Is that correct?

1 A. There were, yeah.

2 Q. So the highest participation
3 that you've seen was Tolbert. Is that
4 correct?

5 A. Again, as I define it, it kept
6 going up. So as far as the local
7 population, it kept going up.

8 Q. So the trajectory was upward?

9 A. It was.

10 Q. But the limit was 25 percent.
11 Is that correct?

12 A. No. Because, again, we've
13 talked about how for a lot of the 18,000
14 people, participating was not practical.

15 Q. Have you ever seen 92 percent
16 participation in a medical monitoring
17 program?

18 A. I have not.

19 Q. Now, in Tolbert, the 5,000
20 number, that was the total number of
21 people who ever used the clinic at any
22 time. Is that correct?

23 A. That's my understanding.

24 Q. So it wasn't reflecting
25 necessarily how frequently those 5,000

1 individuals used the clinic. Is that
2 correct?

3 A. That is correct.

4 Q. Were there cash incentives
5 involved in Tolbert?

6 A. There were. In terms of the --
7 of signing up for the case, you got a
8 \$500 advance payment. Also, you got a
9 payment for personal injury which was
10 driven 70 percent by the PCB score.
11 Also, to the extent that you can think
12 about the medical benefits as having to
13 be paid for by cash, there were
14 prescription drugs, primary medical care,
15 and dental care that you would get when
16 you would come to the clinic.

17 Q. Now, you've had experience with
18 three different medical monitoring
19 programs. Is that correct?

20 A. That is correct, sir.

21 Q. Do you think an economist with
22 no experience in medical monitoring
23 programs would be able to quantify the
24 expected participation of a proposed
25 program?

1 A. I don't know.

2 Q. Is it fair to say that medical
3 monitoring programs are not always
4 popular among eligible participants?

5 MR. WHITLOCK: Object to the
6 form.

7 A. They're not popular among all of
8 them, that's for sure.

9 Q. Would you say that claimants
10 tend to lose interest over time?

11 A. I think without -- without a lot
12 of interfacing with them in terms of a
13 periodic newsletter, trying to have town
14 meetings, and also without some cash
15 incentives, they do tend to lose interest
16 over time.

17 Q. And have you seen them lose
18 interest over time even with cash
19 incentives?

20 A. I have.

21 Q. Monetary incentives were used in
22 the Mingo County case; right?

23 A. They are.

24 Q. There's a \$20 Wal-Mart gift card
25 to get tested, another \$20 gift card to

1 come for the testing results. Is that
2 correct?

3 A. That's basically my
4 recollection. I don't have it in front
5 of me, but that's my basic recollection.

6 Q. And the Perrine program offered
7 \$200 to participants who registered. Is
8 that correct?

9 A. It offered eventually \$400.

10 Q. Yeah. So it was increased to
11 \$400 for registration?

12 A. It was, sir.

13 Q. And you requested that increase
14 because of the low participation. Is
15 that correct?

16 A. I increased -- I asked for the
17 increase because the participation wasn't
18 as high as it could be. And actuarially
19 speaking, you never overpay because you
20 can't get your money back.

21 So the \$200 assumed that every
22 single person would participate, and you
23 wait to see how it turns out before you
24 raise the money.

25 Q. But monetary incentives aren't

1 necessarily effective at boosting
2 participation, are they?

3 A. I think they have some
4 effectiveness, but they're not completely
5 effective.

6 Q. So you've never seen a program
7 with 92 percent participation, have you?

8 A. Not on my watch.

9 Q. Are you aware of any other
10 program that had 92 percent
11 participation?

12 A. Well, I think in this article we
13 talk about the Fernald case. I don't
14 know if it's that high. Let me just
15 look. Eighty-eight percent?
16 Eighty-eight percent.

17 Q. Can you tell me a little bit
18 about that program?

19 A. It's just what I've read. I did
20 not participate in the program. It's
21 described in my -- in my essay here on
22 pages 6 and 7.

23 Q. What was the alleged exposure in
24 the Fernald case?

25 A. Radiation and uranium dust, the

1 article says.

2 Q. Based on your experience in
3 Perrine with a \$400 registration
4 incentive, do you believe that a \$100
5 payment in this litigation is sufficient
6 to guarantee 92 percent participation?

7 MR. WHITLOCK: Object to the
8 form.

9 A. I think -- before I answer the
10 question, you know, I'm going to answer
11 your question, but I'm going to give you
12 an explanation first. I think the \$400
13 and the \$100 are apples and oranges. I
14 think the \$400 was just to sign up and
15 the \$100 is to actually participate,
16 isn't it? Maybe you could direct me to
17 where Dr. Ducatman talks about that. I
18 just don't want to get it wrong.

19 Q. I'm going to mark Exhibit 6 for
20 identification.

21 (Exhibit 6 was marked for identification
22 and is attached.)

23 A. Thanks. Okay.

24 Q. Can you tell me what this is?

25 A. Looks like an economic report by

1 Dr. Shepard.

2 Q. Did you review this in
3 connection with providing your opinion in
4 this case?

5 A. I think I reviewed it after I
6 gave my opinion, to be more precise.

7 Q. So turn to page 7 --

8 A. Okay.

9 Q. -- in this report. And the last
10 paragraph on the page --

11 A. Okay.

12 Q. -- states, "I have recommended
13 that class members should be paid an
14 incentive of \$50 for completion of the
15 diagnostic survey and for the initial
16 in-person consultation (with or without
17 the provision of a blood specimen) at the
18 outset of the program for a total payment
19 of \$100 to encourage registration and
20 initial participation."

21 Did I read that correctly?

22 A. You did.

23 Q. Does that change your view at
24 all about whether it's apples and oranges
25 with respect to Perrine?

1 A. Well, it sort of reinforces what
2 I was saying, and that is, it looks like,
3 instead of just filling out a claim form,
4 they had to actually go through a
5 diagnostic survey. With or without -- it
6 could be a blood specimen too; right? I
7 mean, that's what he's saying. So to
8 some extent, it's different than just
9 filling out a claim form, that's a
10 distinction I wanted to draw.

11 Q. So if more is required of the
12 claimants to receive \$100 than in Perrine
13 to receive \$400, do you expect that we'll
14 see lower or higher participation in this
15 case?

16 A. I think the way I'd answer your
17 question is that the \$400 was just to
18 sign up as a claimant and not participate
19 yet. For example, in looking at the
20 Perrine documents, you've seen that at
21 that decision tree stage, two-thirds of
22 the people said they want to potentially
23 do this stage, on page 7 of Dr.
24 Shepherd's report. One-third said they
25 just wanted the \$400. So what I'm

1 suggesting, Lincoln, is that when they
2 got the \$400, they weren't at this stage
3 yet. That was the point I was trying to
4 make. It looks like when you get the
5 \$100 that Dr. Shepherd is recommending,
6 you have to do a diagnostic survey and
7 you might get your blood drawn.

8 Q. Are you aware of any data that
9 would support the inference that the
10 initial \$50 incentive here is sufficient
11 to guarantee 92 percent participation in
12 this program?

13 MR. WHITLOCK: Object to the
14 form.

15 A. I wouldn't use the word
16 "guarantee." I would say it would incent
17 people to participate. In what percent,
18 I don't know.

19 Q. And so, though you have
20 experience in three medical monitoring
21 programs, you're not aware of any basis
22 that would allow you to opine that 92
23 percent participation is what we'll see
24 here?

25 A. I think you've already asked me

1 that question, but the answer's the same.

2 Q. Did Dr. Shepard receive any data
3 from you?

4 A. I don't --

5 Q. To --

6 A. Go ahead. Sorry.

7 Q. To develop his opinion regarding
8 participation rates in this case?

9 A. He may have reviewed some things
10 that I prepared, but I certainly didn't
11 give it to him directly.

12 Q. And you're not aware of any data
13 that you have in your possession that
14 would allow someone to determine that 92
15 percent participation is what we'll see
16 in this litigation. Is that correct?

17 A. Again, I think you just answered
18 me -- asked me the question a different
19 way the third time, and the answer is the
20 same.

21 Q. And what is that answer?

22 A. I'm not aware of 92 percent.

23 Q. Whose benefit do monetary
24 incentives for participation serve?

25 A. Whose benefit do they serve? I

1 think they serve a couple of benefits.
2 One thing they serve is the benefit of
3 the community, because it -- again, if
4 we're going to answer the question what
5 happened here, you need to have a good
6 sample. The other benefit is the
7 individuals. Because, for example, if
8 you read the book, The Emperor of All
9 Maladies, the key to curing a disease is
10 early detection. And so if it incents
11 the people to participate, you're more
12 likely to find a disease before it's too
13 late.

14 Q. So it serves the claimant's
15 benefit. Is that correct?

16 A. I think it does, for that reason
17 I just gave.

18 Q. And does that mean that the
19 program designers believe that they have
20 a better understanding of what's good for
21 the claimants than the claimants
22 themselves do?

23 MR. WHITLOCK: Object to the
24 form.

25 A. I don't know what the program

1 designers are thinking, so I can't answer
2 the question.

3 Q. But the individual participants,
4 if they would not participate in the
5 program without the incentive, does that
6 mean that they have made the
7 determination that in -- their best
8 interest is not served by participating
9 in the program?

10 MR. WHITLOCK: Object to the
11 form.

12 A. Might have to ask Dr. Pavlov. I
13 don't know.

14 Q. Now, you state in your essay
15 that there's ethical problems in paying
16 people to take medical tests. Is that
17 correct?

18 A. I think there is. And that's
19 why these -- these expenditures we're
20 talking about are more in the area of
21 what it would cost, for example, for
22 transportation or a missed meal or
23 something of that nature. And so I think
24 the amount has to be fair and reasonable.
25 But for example, if you pay an exorbitant

1 amount, then I think that's where it may
2 be a problem.

3 Q. And can you describe the ethical
4 problems in a little more detail that
5 paying monetary incentives can raise?

6 A. It's just, you know, I think
7 it's more of a commonsense moral problem,
8 and that is, that, you know, someone
9 should decide whether they want to be
10 tested or not and not -- not forced to do
11 so. If there's some exorbitant amount of
12 money, they may make the decision, you
13 know, because of the exorbitant amount of
14 the money. I think that's the basic
15 problem.

16 Q. Now, if you'll take a look at
17 page 18 of your essay.

18 A. Okay.

19 Q. Tell me when you're there.

20 A. I am, sir.

21 Q. Under 4(b) you state that, "One
22 ethical incentive for medical monitoring
23 is to combine it with medical care, such
24 as in the Tolbert Anniston, Alabama
25 Settlement, where free primary care and

1 prescription drugs are provided."

2 A. Yes, sir.

3 Q. Did I read that correctly?

4 A. You did.

5 Q. Am I a great reader?

6 A. Today you are.

7 Q. Okay.

8 A. I can't say in general.

9 Q. And --

10 MR. WHITLOCK: Actually, I need
11 to comment on that. No. Because a
12 couple of the past things that you've
13 read have not been quoted correctly, but
14 that's okay.

15 THE WITNESS: Luckily, he
16 didn't have to answer questions.

17 MR. WHITLOCK: Exactly.

18 MR. WILSON: That's for your
19 deposition, Jamie.

20 MR. WHITLOCK: Is that this
21 afternoon?

22 A. Sorry. Go ahead.

23 Q. (By Mr. Wilson) Do you identify
24 any other ethical incentives for medical
25 monitoring in this essay than this one?

1 A. Again, looking at 4(a) and (b),
2 they're -- what I'm suggesting in 4(a) is
3 when you have too big a number. I think
4 if you pay a reasonable number to
5 compensate for out of pockets and that
6 sort of thing, I think that's all right.
7 And (b), I think that way, in (b) we're
8 actually steering the resources to actual
9 medical care. And so I think 4(a) and
10 (b) are both candidates for an ethical
11 payment, but 4(a) has some strictures
12 like we talked about.

13 Q. And just to reiterate, the
14 medical monitoring program that's been
15 proposed here does not provide any
16 medical care. Is that correct?

17 A. That's my understanding. I
18 think that's been asked.

19 Q. In paragraph 4C of your report,
20 turning back to that.

21 A. Okay. Just give me a minute.

22 4C. Okay, I'm with you.

23 Q. So in paragraph 4C --

24 A. Yeah.

25 Q. -- you recommend against a

1 two-step approach in which a
2 participant's blood is drawn in one visit
3 and a follow-up visit is required to
4 discuss the results and conduct the
5 wellness exam. Is that correct?

6 A. What I'm saying is that you want
7 to try to do that in one visit; that is,
8 you have your blood drawn and have the
9 wellness exam then. Really for two
10 reasons. From -- from your client's
11 perspective, it's probably less
12 expensive. From the claimant's
13 perspective, they're more likely to do
14 it. So I think it's a win-win.

15 Q. And you state that the
16 participants often don't come back. Is
17 that correct?

18 A. I believe I say that somewhere
19 in there, yes, sir.

20 Q. Why do participants fail to
21 return?

22 A. I guess that's up to each
23 participant, on what they think is more
24 important.

25 Q. In your experience, do you know

1 why?

2 A. Well, I think I've heard people
3 say that the average individual spends
4 more time planning their vacation each
5 year than looking after their health. So
6 that's one example.

7 Q. So, is that a situation where
8 you feel that you're trying to determine
9 what's in the interest of the health of
10 the class members despite their
11 determination to the contrary?

12 A. I don't think so. I think that
13 we're trying to provide a good medical
14 monitoring program in an efficient way
15 and to make good use of the -- of the
16 claimants' time.

17 Q. Now, Dr. Ducatman proposed a
18 follow-up consultant to discuss any
19 abnormal results of the testing. Is that
20 approach inconsistent with your
21 recommendation for a one-step approach?

22 A. It -- it's different. You know,
23 frankly, that's typically how medical
24 monitoring is done. And a lot of these
25 recommendations are based upon how I did

1 it and thought about it and thought it
2 could be better. I have not had a
3 discussion with Dr. Ducatman on how to do
4 it best, but certainly, since he's going
5 to decide the -- the medical regimen, I
6 would defer to him. But I would -- I
7 would like to sit down with him and
8 discuss it. We just haven't had that
9 opportunity.

10 Q. Now, in paragraph 4D of your
11 report, you recommend that participants
12 be given the option of consenting to use
13 of the resulting medical monitoring data
14 for scientific research.

15 A. I do.

16 Q. And you state that, "With
17 encouragement, we found the consent rate
18 usually to exceed 90%." Is that correct?

19 A. That's what it says, yes, sir.

20 Q. Can you tell me what you mean by
21 "encouragement"?

22 A. What we try to do is talk about
23 that other goal of medical monitoring
24 with each claimant, and that is, what
25 happened here. "The only way to answer

1 what happened here is with a medical
2 study, and the only way to make it
3 reliable is to have a good sample. But
4 it's up to you." That's what I would
5 tell them.

6 Q. And so the encouragement is just
7 verbal encouragement, it doesn't include
8 any monetary incentive.

9 A. Oh, no.

10 Q. Is that correct?

11 A. No, that's completely voluntary,
12 and there's no monetary incentive for
13 signing up or not signing up.

14 Q. So in paragraph 4F of your
15 report.

16 A. Okay.

17 Q. You recommend that an
18 epidemiological survey be coupled with
19 medical monitoring on the front end. Is
20 that correct?

21 A. It is. The survey, yes, sir.

22 Q. And can you tell me what you
23 mean by "on the front end"?

24 A. That -- that means when you
25 first meet with the claimant to begin the

1 medical monitoring process with him or
2 her.

3 Q. And can you describe what you
4 mean by an "epidemiological survey"?

5 A. Yeah. It's a health survey
6 prepared with the input of a
7 professional. I think, for example,
8 there's a C8 survey mentioned in some of
9 these reports. But -- you know, a health
10 survey, and the only -- the only point of
11 F is just to couple it with, you know,
12 the initial medical treatment, that's
13 all.

14 Q. And that's different from a
15 survey that would be designed to diagnose
16 any medical conditions that the
17 participant may have. Is that correct?

18 A. It would be different, yes, sir.

19 Q. Now, if you turn to Dr.
20 Ducatman's report.

21 A. Okay.

22 Q. Take a look at page 16.

23 A. Okay. Yes, sir.

24 Q. And the bottom paragraph, second
25 sentence states that: "Each participant

1 will also fill out a revised diagnostic
2 survey on an annual basis concomitant
3 with yearly clinical testing. The survey
4 can be filled out on-line, by the
5 participant, parent, or guardian."

6 Did I read that correctly?

7 A. You did, sir.

8 Q. And the second sentence states
9 that the survey, "will be created and
10 modified by the expert panel to ensure
11 that Survey questions are diagnostic in
12 nature and targeted to elicit responses
13 indicative of symptoms and risk factors
14 for the specified monitored diseases."

15 A. I see that.

16 Q. Did I read that correctly?

17 A. You did.

18 MR. WILSON: And, Jamie, did I
19 get it right that time?

20 MR. WHITLOCK: I believe you
21 did, yes, sir.

22 Q. Is Dr. Ducatman's proposal for a
23 survey that is strictly diagnostic in
24 nature inconsistent with your proposal
25 for an epidemiological survey that is not

1 diagnostic in nature?

2 MR. WHITLOCK: Object to the
3 form.

4 A. I don't think so. Again, we
5 have not sat down and talked about this.
6 I think, obviously, when a claimant comes
7 in, you want to, you know, ask the
8 claimant about their individual
9 situation. An epidemiologist may have
10 some other questions that he might want
11 to add just while you have the claimant
12 and the claimant is available. But
13 that's something we haven't talked about.
14 That -- these are a couple of examples of
15 what we would do when we sit down and map
16 out exactly how to carry out a plan.

17 Q. Would it be correct to say that
18 epidemiological surveys are not typically
19 components of medical monitoring
20 programs?

21 A. Of the ones I've done, it's --
22 it's a third. That's what I can speak
23 to.

24 Q. So, meaning that you've seen one
25 program that's done this before?

1 A. One out of three.

2 Q. Would you agree that the focus
3 of a medical monitoring program should be
4 on the patient's health?

5 A. I think it ought to have a dual
6 focus, like we talked about at the
7 beginning of the deposition. Certainly,
8 the patient's health is very important
9 because of the Emperor of all Maladies
10 principle of trying to detect disease
11 early to cure it. But secondly, again,
12 the claimant population probably wants
13 the question answered, what happened
14 here? And that's the other aspect of
15 medical monitoring.

16 Q. Would it be fair to say that the
17 diagnostic focus of a medical monitoring
18 program is not typically compatible with
19 the goals of epidemiological research?

20 A. I disagree with that.

21 Q. Would it be fair to say that the
22 diagnostic focus of medical monitoring
23 programs is usually not sufficient to
24 provide what's necessary for
25 epidemiological research?

1 A. I don't think I'm qualified to
2 answer that question.

3 Q. Did you state in your essay at
4 page 19 that, "Often, the data collected
5 in monitoring human health is inadequate
6 for epidemiological studies, because the
7 experts that designed the medical
8 monitoring program only focused on health
9 and not scientific study"?

10 A. That was true of Perrine, and it
11 was true of Mingo, but I don't know if
12 it's always true.

13 Q. Now, most medical monitoring
14 programs are designed to test for health
15 conditions with demonstrated
16 relationships to a given exposure. Is
17 that correct?

18 A. The ones I've seen do that.

19 Q. But in your essay, on page 19.

20 A. Okay.

21 Q. You stated that one purpose of
22 medical monitoring is to determine if
23 there's a linkage between the toxic
24 substance or the dangerous product and
25 disease.

1 A. Uh-huh. Yes, sir.

2 Q. How is that consistent with the
3 idea that medical monitoring is only
4 appropriate where there's already an
5 established link?

6 A. Well, because to some extent the
7 link is not fully established but it's
8 theoretical. You know, for example, I'm
9 not part of this case, but in the C8 case
10 there was a medical panel in a DuPont
11 case that it did a study to verify the
12 potential, I guess for example, of
13 testicular cancer of C8 and found it.
14 And so that's an example.

15 In the PCB situation, that was
16 hotly debated, still is, what do PCBs do.
17 So what you try to do is try to have a
18 program that -- that correlates with the
19 scientific understanding or expectation
20 at the time, but to some extent, the
21 etiology is not completely known.

22 Q. Now, where the link is
23 unfounded, that would only ever be
24 effectuated in the case of settlement.
25 Is that correct?

1 A. No, I don't think so. And first
2 of all, let me -- let me -- let me --
3 let's examine your question for a minute.
4 The "unfounded" part. I'm -- I'm looking
5 at "unfounded" as it may be something
6 that is strongly suspected but not
7 completely proven. And in that case, it
8 could be it would be part of something
9 that would be looked at in terms of, you
10 know, potential disease. For example,
11 lung cancer related to cadmium, arsenic,
12 zinc, and lead is not completely proven,
13 but is suspected. And therefore, in
14 Perrine there were CT scans in the -- in
15 the health study of Dr. Werntz -- not
16 health study, excuse me, the protocols of
17 Dr. Werntz that were approved by the
18 judgment, so.

19 Q. I would like to mark Exhibit
20 7 --

21 A. Okay.

22 Q. -- for identification.

23 (Exhibit 7 was marked for identification
24 and is attached.)

25 THE WITNESS: Thank you.

1 Q. Can you tell me what this is?

2 A. Let me just look at it for a
3 minute.

4 (Witness reviews document.)

5 A. This is an order dated January
6 4, 2011, in the Perrine case approving
7 settlement.

8 Q. And so to be clear, this was a
9 settlement in this case, not a court
10 order. Is that correct?

11 A. Again, it was a mediated
12 settlement that followed a court order.

13 Q. If you turn to page 5.

14 A. And I'm looking to substantiate
15 my answer. Page 5, paragraph 5. Go
16 ahead.

17 Q. Okay. So let's talk about that.

18 A. Sure.

19 Q. Tell me, in paragraph 5, what
20 you're looking at.

21 A. Okay. "The verdicts were
22 ultimately rendered as awards of
23 \$55,537,522.25 for property damage and
24 associated costs, an estimated order of
25 approximately \$130,000,000 for a future

1 medical monitoring program to test for
2 forty years, and a punitive damages award
3 of \$196,200,000."

4 Q. Now, do you see in paragraph
5 7 --

6 A. Okay.

7 Q. -- it says that, "On November
8 16, 2007, this Court entered an Amended
9 Final Judgment Order finalizing the
10 jury's verdict in the amounts described
11 above against Defendant DuPont"?

12 A. I do.

13 Q. Did I read that correctly?

14 A. You did.

15 Q. And then it says, "Thereafter,
16 both the Plaintiffs and Defendants
17 appealed numerous aspects of this Court's
18 pre-trial, trial, and post-trial rulings
19 to the West Virginia Supreme Court of
20 Appeals."

21 A. Yes, sir.

22 Q. I read that correctly?

23 A. Uh-huh.

24 Q. And on paragraph 9 on the next
25 page, it says, "On March 26, 2010, after

1 a lengthy appellate process, the West
2 Virginia Supreme Court of Appeals
3 remanded this litigation to the Court
4 with directions to conduct a trial on
5 DuPont's statute of limitations defense."

6 A. Yeah, I remember that well. I
7 was to be the -- I was to conduct those
8 trials, so I remember I was not going to
9 have a life if that were to stand up.

10 Q. And then if we look at paragraph
11 10, the second sentence states that, "The
12 Supreme Court determined that this Court
13 erred in granting judgment as a matter of
14 law in favor of plaintiffs on the
15 affirmative defense of the statute of
16 limitations, and directed this Court to
17 hold a second trial to determine if the
18 defense was merit worthy."

19 Is that correct?

20 A. That is correct, and that's what
21 I was talking about, how it would be
22 claimant by claimant on statute of
23 limitations.

24 Q. And so the judgment was
25 overturned that you were referring to.

1 Is that correct?

2 A. I think the judgment was
3 modified. It says modified. Condition
4 -- conditionally affirmed.

5 Q. Conditionally affirmed.

6 A. Uh-huh. Based upon the statute
7 of limitations for each claimant.

8 Q. So there would have to be a
9 retrial of all the plaintiffs. Is that
10 correct?

11 A. There would have to be a trial
12 only, sir, on the statute of limitations.

13 Q. So the judgment was not
14 finalized on those plaintiffs. Is that
15 correct?

16 A. It was finalized for everything
17 but the statute of limitations.

18 Q. Let me read paragraph 11 of this
19 final approval order. It says: "The
20 effect of the Supreme Court's directive
21 created an all or nothing proposition for
22 the Parties. If the Plaintiffs prevailed
23 on the statute of limitations issue, they
24 would receive the relief obtained in the
25 2007 trial, as modified by the Supreme

1 Court opinion. If DuPont prevailed, this
2 Court could set aside the 2007 verdicts
3 and render judgment in favor of DuPont,
4 and the Plaintiffs would receive
5 nothing."

6 Did I read that correctly?

7 A. You did.

8 Q. So, is it correct that the
9 ultimate settlement in the Perrine case
10 that was approved by this order was not
11 simply effectuating the judgment that had
12 been entered by the Court?

13 A. Again, I disagree with your --
14 to your question, and for this reason.
15 If you look at 11, what paragraph 11 does
16 is it gives the two possible goal posts
17 for each side of the case. If the
18 plaintiffs won all 8,500 or however many
19 there were statute of limitation trials
20 the poor little special master had to --
21 had to try, they would have that goal
22 post. If DuPont won them all, they had
23 the other goal post. It would probably
24 be somewhere on the 50.

25 Q. But the validity of that

1 judgment was in doubt because of the
2 Supreme Court's ruling that the Court
3 erred as a matter of law. Is that
4 correct?

5 A. No, sir. Because it will be --
6 it would be somewhere on the football
7 field.

8 Q. Now, in the Perrine case, you
9 asked the Court to permit you to
10 implement a health study, didn't you?

11 A. I did, sir.

12 Q. And the Court rejected that
13 request?

14 A. It did recently, yes. I think
15 the way it rejected it, it said it has to
16 be done with private funding, as I
17 remember. I haven't looked at that
18 recently.

19 Q. I'd like to mark for
20 identification Exhibit 8.
21 (Exhibit 8 was marked for identification
22 and is attached.)

23 THE WITNESS: Thank you.

24 Q. Can you tell me what this is?

25 A. It's another order in the

1 Perrine case. This one's -- looks like
2 it's a November 2017 order.

3 Q. Turn to page 2.

4 A. Okay.

5 Q. Take a look at the last line of
6 page 2, continuing on to page 3.

7 A. Uh-huh.

8 Q. It says, "the Court, at this
9 time, does not believe that it is a
10 proper exercise of its discretion to
11 order a Health Study at DuPont's
12 expense."

13 Is that correct?

14 A. It is. And also on page 4 it
15 says, "The Court believes the design
16 implementation of such study, given the
17 facts available to the Court at this
18 time, to take place, should be borne by
19 the academic or private sector."

20 Q. And on page 4, it also says in
21 the first full paragraph of page 4, "In
22 West Virginia, medical monitoring must be
23 supported by reliable medical research
24 and not a platform to explore whether a
25 medically reliable link exists."

1 Did I read that correctly?

2 A. You did.

3 Q. And the next paragraph says,
4 "Expanding testing and having the MMP
5 fund research in the hopes of
6 establishing whether a link exists is not
7 supported by law and was not contemplated
8 by the agreement of the parties."

9 Did I read that correctly?

10 A. You did.

11 Q. Do you disagree with the Court's
12 decision?

13 A. I agree.

14 Q. Do you still believe an
15 epidemiological study would be an
16 appropriate component of a medical
17 monitoring program in this litigation?

18 A. I do.

19 Q. And why is that?

20 A. To answer the question, "What
21 happened here?"

22 MR. WILSON: How are we doing on
23 the tape?

24 THE VIDEOGRAPHER: About fifteen
25 minutes left.

1 MR. WILSON: Okay.

2 Q. I'd like to mark Exhibit 9 for
3 identification. Can you tell me what
4 this is, Mr. Gentle?

5 (Exhibit 9 was marked for identification
6 and is attached.)

7 A. Just give me a second.

8 (Witness reviews document.)

9 A. It looks like an affidavit I
10 prepared in connection with a shingles
11 case. And not -- not a medical shingles,
12 but roof shingles. Certainly brings back
13 a memory.

14 Q. And on page 4 of this affidavit
15 --

16 A. And I'm not putting on my
17 glasses to be rude. I roll my eyeballs
18 on the paper at times, so I apologize.
19 Go ahead. I'm sorry. Page 4. Okay.

20 Q. Page 4.

21 A. All right.

22 Q. Second to last paragraph?

23 A. Okay.

24 Q. You state: I "have found the
25 claimants arrive at remedies that improve

1 on ones designed by lawyers. For
2 example, in the Tolbert Case, the
3 claimants came up with a means of paying
4 families of deceased claimants who
5 therefore could not be tested for PCBs
6 that was accepted by the deceased
7 claimant families."

8 A. Yes, sir, I see that.

9 Q. And I read that correctly?

10 A. You did.

11 Q. Okay. Do you believe that all
12 claims programs should be based on a
13 collaborative model?

14 A. I think they should not all be
15 based on a collaborative model, but I
16 think they should be fine-tuned by one.
17 And let me give you an example.

18 In the Tolbert case, the core
19 complaint was PCB contamination of the
20 blood. And so that's an objective,
21 measurable factor that was not a product
22 of claimant collaboration. And when you
23 think about it, that's the most palpable
24 indication of what Monsanto may or may
25 not have done to each claimant. And so

1 when we designed the matrix in that case
2 -- by "matrix," I mean the payment
3 program -- 70 percent of the money to
4 adults was based upon that. At the same
5 time, we had town meetings and
6 questionnaires and a lot of calls with
7 the claimants. Every claimant thought
8 they should receive something for having
9 lived there. Now, there's a lot of
10 science on both sides of the ball on what
11 PCBs may do or not if you live there.
12 But we decided that residency, because of
13 the collaborative interest of the
14 population, and being paid for living
15 there was a fair piece of it, we gave 15
16 percent of the money based upon how long
17 you lived there.

18 And another piece was what --
19 what disease is caused by PCBs, if any.
20 So we had a medical panel who thought
21 certain diseases may be caused, it was
22 debatable, and we had a -- we had a
23 registered nurse interview that would
24 measure that. That was somewhat
25 controversial. But again, because a lot

1 of the claimants felt that their maladies
2 were caused by PCBs, we thought that
3 should be a component too as 15 percent.
4 And so that's an example of a matrix -- I
5 think that adds to a hundred; right? I
6 think that's an example of a matrix that
7 was both objective and collaborative.

8 Q. Okay. I've gotten to the end of
9 the stuff I had prepared. If we could
10 just take a five- or ten-minute break.

11 A. Sure.

12 Q. We'll see if we have any more
13 questions.

14 A. Thank you very much.

15 MR. WHITLOCK: Sure.

16 THE VIDEOGRAPHER: Going off the
17 record, 11:36 a.m.

18 (Break taken.)

19 THE VIDEOGRAPHER: This begins
20 Disc No. 3. Going back on the record
21 11:47 a.m.

22 Q. (By Mr. Wilson) All right, Mr.
23 Gentle. Thank you for your time today.
24 I just have a few more questions --

25 A. Okay.

1 Q. -- before we wrap up.

2 A. All right.

3 Q. You talked before about the
4 Fernald, Ohio, medical monitoring
5 program.

6 A. Yes.

7 Q. That you were not involved with
8 but you have some familiarity with. Is
9 that correct?

10 A. That I've read about, yes, sir.

11 Q. Can you tell me what was
12 different about that program from this
13 program?

14 A. Let me look at my summary of it
15 just for a minute to refresh my
16 recollection. Okay.

17 (Witness reviews document.)

18 A. Okay, I've read the summaries.
19 Is the question how was it different from
20 this case?

21 Q. Yes.

22 A. Okay. All right. Well, the --
23 the claimed toxogen is different.

24 Q. What was the claimed toxogen in
25 the Fernald settlement?

1 A. I think it was dust from
2 radiation, wasn't it? Yeah, uranium
3 dust. Exposed to radiation and uranium
4 dust from a plant that converted uranium
5 ore to metal, is what it says here.

6 Q. And the health risks from
7 uranium dust are fairly well settled. Is
8 that correct?

9 A. You know, I'm not an expert on
10 that. I'll take your word for it.

11 Q. Any other differences that
12 you're aware of between that program and
13 this one?

14 (Witness reviews document.)

15 A. That's the -- that's the major
16 difference, I think, is the toxogen, that
17 I see, but there may be some others.
18 Again, I just -- I just know what I've
19 read about that one.

20 Q. And the Fernald, Ohio,
21 settlement was not discussed in your
22 report. Is that correct?

23 A. It was not discussed in my
24 report in this case, that's correct.

25 Q. You mentioned earlier that

1 participation incentives are used as a
2 measure of compensation for the
3 witnesses' time. Is that correct? I'm
4 sorry. Not the witnesses' time, the
5 claimants' time.

6 A. I think that's one way to look
7 at it. It's to compensate them for
8 either their time or maybe their expense;
9 for example, gasoline.

10 Q. Was the \$200 participation
11 incentive in Perrine, was there any
12 effort to determine that that was a
13 reasonable measure of the witnesses' time
14 and gasoline?

15 A. Of the claimants' time and
16 gasoline?

17 Q. Claimants' time and gasoline.

18 A. Well, no. But the reason is
19 that, again, like we talked about when we
20 looked at one of the other experts, the
21 \$400 was really not in connection with
22 being tested but just signing a claim
23 form. So I think what I was trying to
24 talk about is incentives to continue to
25 participate in testing. So again, I

1 think it's somewhat of an apple and an
2 orange.

3 But to answer your question, no.
4 What happened is there was some money
5 allocated by agreement that would be paid
6 to all the claimants, and we decided to
7 do that in connection with their signing
8 up.

9 Q. And I think you've answered my
10 question, but just so we have a clear
11 record.

12 A. Sure.

13 Q. The increase from \$200 to \$400
14 in the Perrine settlement was not based
15 on some determination about the time and
16 inconvenience of the claimants for
17 purposes of the settlement. Is that
18 correct?

19 A. That's correct. But just the
20 available money.

21 Q. Are you aware of any 30-year
22 medical monitoring programs that have
23 seen the same rate of participation over
24 time?

25 A. You mean like one program

1 compared to another?

2 Q. Year after year, all thirty
3 years, same --

4 A. Oh, I see. Within the same
5 program, the same participation rate year
6 by year?

7 Q. Yes.

8 A. I'm not aware of that.

9 Q. So you're not aware of any
10 participation rates of 92 percent for
11 thirty years of a medical monitoring
12 program?

13 A. I'm not aware of any.

14 Q. And you're familiar with not
15 just the medical monitoring programs that
16 you have implemented, but a variety of
17 other medical monitoring programs around
18 the country. Is that correct?

19 A. A handful is probably more like
20 it, but yes.

21 Q. Would you say you're generally
22 familiar with the administration of
23 medical monitoring programs in America?

24 A. I would say, to the extent it's
25 in the literature, I'm familiar. But

1 again, there are some on the ground that
2 I don't know anything about.

3 Q. Do you know of any basis for
4 someone to claim that a medical
5 monitoring program would see 92 percent
6 participation for thirty years?

7 A. Well, I mean, one -- one idea
8 would be if it's like the Fernald case
9 that had, what, 88 percent, maybe that's
10 part of the rationale, is that perhaps
11 that the populations would be similar in
12 some ways as far as participation.

13 Q. And as you've described the
14 contaminant in the Fernald case was
15 uranium dust. Is that correct?

16 A. That's what I've read, yes, sir.

17 Q. And that's not the same as PFOA?

18 A. No, it's not.

19 Q. Take a very short break and
20 we'll be back on.

21 A. Okay.

22 THE VIDEOGRAPHER: Going off the
23 record, 11:54 a.m.

24 (Break taken.)

25 THE VIDEOGRAPHER: Going back on

1 the record, 11:56 a.m.

2 Q. (By Mr. Wilson) So, Mr. Gentle,
3 did you review the C8 litigation and
4 medical monitoring program in connection
5 with formulating your opinions in this
6 case?

7 A. I reviewed it when it came out
8 about a year ago, but not in connection
9 with formulating my opinions.

10 Q. And what was -- what's your
11 understanding of the use of the
12 epidemiological study in that case?

13 A. I don't know if it -- the word
14 "epidemiological" was used, but I know
15 there was a panel that tried to find
16 linkage between C8 and certain diseases.

17 Q. Was it your understanding that
18 the epidemiological questionnaire was
19 part of the medical monitoring program or
20 served a separate purpose?

21 A. I -- I don't know the answer to
22 that.

23 Q. If I represented to you that the
24 medical monitoring program was used to
25 determine which conditions would be

1 subject to the medical monitoring
2 program -- I'm sorry. Let me rephrase
3 the question.

4 If I told you that the
5 epidemiological study was used to
6 determine which conditions would be
7 subject to medical monitoring, does that
8 sound correct to you?

9 A. I don't know. I'm sorry.

10 Q. I have no further questions at
11 this time.

12 A. Thanks.

13 MR. WHITLOCK: I have no
14 questions for the witness. Thank you.

15 THE COURT REPORTER: And,
16 Lincoln, would you like a copy of the
17 transcript?

18 MR. WILSON: I would.

19 THE COURT REPORTER: Thank you.

20 And, Jamie, would you like a
21 copy of the transcript?

22 MR. WHITLOCK: Lane, I would
23 like a copy of the transcript --

24 THE COURT REPORTER: Thank you.

25 MR. WHITLOCK: -- please, ma'am.

1 THE VIDEOGRAPHER: Going off the
2 record, 11:57 a.m. This concludes the
3 deposition.

4

5 END OF DEPOSITION

6 (11:57 a.m.)

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ACKNOWLEDGMENT OF DEPONENT

I, EDGAR GENTLE, III, ESQ., do hereby certify that I have read the foregoing transcript of my testimony taken on 2/16/18, and further certify that it is a true and accurate record of my testimony (with the exception of the corrections listed below):

| Page | Line | Correction |
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EDGAR GENTLE, III, ESQ.

SUBSCRIBED AND SWORN TO BEFORE ME
THIS _____ DAY OF _____, 20____.

(NOTARY PUBLIC) MY COMMISSION EXPIRES:

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C E R T I F I C A T E

STATE OF ALABAMA)
COUNTY OF JEFFERSON)

I hereby certify that the above and foregoing proceeding was taken down by me by stenographic means, and that the content herein was produced in transcript form by computer aid under my supervision, and that the foregoing represents, to the best of my ability, a true and correct transcript of the proceedings occurring on said date at said time.

I further certify that I am neither of counsel nor of kin to the parties to the action; nor am I in anywise interested in the result of said case.



LANE C. BUTLER, RPR, CRR, CCR
CCR# 418 -- Expires 9/30/18
Commissioner, State of Alabama
My Commission Expires: 2/11/21

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[thanks - try]

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and
(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY. THE ABOVE RULES ARE CURRENT AS OF SEPTEMBER 1, 2016. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

Veritext Legal Solutions is committed to maintaining the confidentiality of client and witness information, in accordance with the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), as amended with respect to protected health information and the Gramm-Leach-Bliley Act, as amended, with respect to Personally Identifiable Information (PII). Physical transcripts and exhibits are managed under strict facility and personnel access controls. Electronic files of documents are stored in encrypted form and are transmitted in an encrypted fashion to authenticated parties who are permitted to access the material. Our data is hosted in a Tier 4 SSAE 16 certified facility.

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EXHIBIT C:

Order in the Perrine Case with
respect to claimant medical monitoring
registration payments

IN THE CIRCUIT COURT OF HARRISON COUNTY, WEST VIRGINIA

LENORA PERRINE, et al.,

Plaintiffs,

v.

Case No. 04-C-296-2
Judge Thomas A. Bedell

E. I. DUPONT DE NEMOURS &
COMPANY, et al.,

Defendants.

**FINAL ORDER INCREASING MEDICAL MONITORING VERIFIED REGISTRANT
CASH PAYMENT FROM \$200 TO \$400**

Presently before the Court is the Claims Administrator's request to increase the Medical Monitoring Verified Registrant cash payment from \$200 to \$400, based upon the registration rate experienced in the first two months of the six month Medical Monitoring Program registration period.

After a careful review of the Claims Administrator's submission, and in consideration of the applicable law, the Court **ORDERS** that the proposal is hereby **APPROVED** and shall be carried out during the administration of the Settlement. Medical Monitoring Verified Registrants who have previously received a \$200 cash payment shall receive the additional \$200 cash payment as soon as possible, and future cash Medical Monitoring Verified Registrant payments shall equal \$400, pending further Orders of this Court.

IT IS SO ORDERED.

No. 5434 P. 1

Apr. 28. 2011 2:53PM THOMAS A. BEDELL, Chief Judge


The Clerk of this Court shall provide certified copies of this Order to the following:

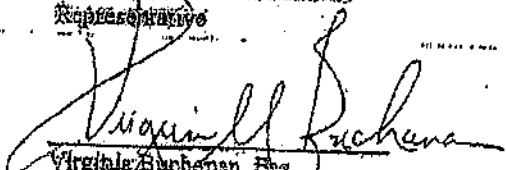
Stephanie Thacker, Esq.
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Charleston, WV 25333-3394
DuPont's Finance Committee Representative

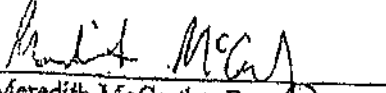
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P.O. Box 32308
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This Order Agreed to by:



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Plaintiff's Finance Committee Representative

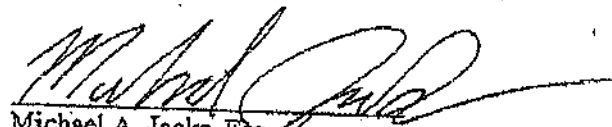


Meredith McCarthy, Esq.
Guardian Ad Litem for Children
901 W. Main Street
Bridgeport, WV 26330

Order Prepared By:

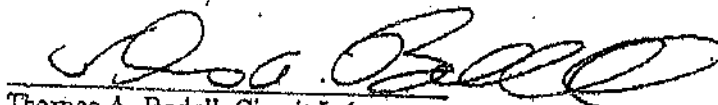


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ENTER: 4/28/2011



Thomas A. Bedell, Circuit Judge

EXHIBIT D

Consent to Use of Participant Data for Research

IN THE CIRCUIT COURT OF HARRISON COUNTY, WEST VIRGINIA

LENORA PERRINE, et al., individuals
residing in West Virginia, on behalf of
themselves and all others similarly situated,

Plaintiffs,

v.

E. I. DUPONT DE NEMOURS &
COMPANY, et al.,

Defendants.

Case No. 04-C-296-2
Thomas A. Bedell, Circuit Judge

**ORDER RESOLVING PENDING MEDICAL MONITORING PROGRAM ISSUES
IN PREPARATION FOR NOVEMBER 1, 2011 IMPLEMENTATION DATE**

Presently before the Court are the unresolved issues described below and related to the November 1, 2011 implementation of the Medical Monitoring Program.

In order to allow the Parties to be heard on these issues and all other issues related to the implementation of the Medical Monitoring Program, this matter came on to be heard on October 17, 2011, at 10:00 o'clock a.m., and said hearing was held before the Honorable Thomas A. Bedell, Judge of the Circuit Court of Harrison County, West Virginia, in the Division 2 Courtroom located on the 4th Floor of the Harrison County Courthouse, 301 West Main Street, Clarksburg, West Virginia.

At the Hearing, the Claims Administrator submitted his Report respecting the recommended resolution of the issues, while presenting the alternative positions of the Parties. Also appearing was Dr. Jubal Watts, an expert sponsored by the Claims Administrator, to address the CT Scan issue. The Claims Administrator and Dr. Watts subjected themselves to cross-examination by the Parties, with the Claims Administrator, as a neutral for the Court, then

resting. Class Counsel, the Guardian ad Litem for Children and DuPont then presented their positions for the Court's consideration.

After a careful review of the Claims Administrator's submission and the submissions of the Parties, and having weighed the evidence and the presentations made at the October 17, 2011 hearing, and in consideration of the applicable law, the Court ORDERS the following:

1. The Parties have stipulated that the Medical Monitoring Program is a primary plan for medical testing benefits, with DuPont being responsible for all costs thereof. The Court accepts this stipulation of the Parties.
2. To facilitate the collection of Medical Monitoring Plan data for possible future scientific and medical research, the Court hereby approves the use by the Medical Monitoring Plan of the final Optional Data Collection Consent Form submitted by the Claims Administrator in Attachment II to his October 10, 2011 Report, with Claimants being allowed to complete and sign the Form, at their option, during their initial Medical Monitoring Provider visit.
3. The Court has carefully considered the positions of the Guardian ad Litem and DuPont on how to handle "No" box minor Medical Monitoring Claimants, whose parent or guardian checked the "No" box and therefore did not choose Medical Monitoring, when these minor "No" box Claimants become adults. The Court further considered their positions on when an "Inactive" Medical Monitoring Claimant (a Claimant who signed up for Medical Monitoring but then fails to use it) may become "Active" again.

The Guardian ad Litem suggests that the Medical Monitoring Plan is a right which cannot be waived through a lack of use by a Claimant, while DuPont argues that the Medical Monitoring Plan is a right that can be waived by a Claimant through lack of use.

DuPont also objects to the use of resources to continue to notify such inactive Claimants of the Program and invite them back in. DuPont, however, does not object to current minors whose parents have marked the "no" box on their behalf being notified once they turn 18 and given the option themselves of participating in the Program. But, DuPont contends that this should be a one-time notification.

Although this is a difficult issue, the Court makes the following determination:

The Medical Monitoring Plan is a right of a Claimant that cannot be waived, with such a waiver not being reflected anywhere in the Settlement Memorandum of Understanding ("MOU") or any related Orders. The Court therefore decides that the Claims Administrator's suggested procedures to notice these Claimants, with the procedures being contained in Attachment III to the Claims Administrator's October 10, 2011 Report, are well taken and are hereby approved.

4. In connection with CT Scans, the Court has carefully reviewed the proposed CT Rule and CT Scan Verification Form provided by the Claims Administrator in his October 10, 2011 Report, as modified on October 19, 2011, based on the October 17, 2011 hearing. The Court understands that DuPont supports the Claims Administrator's suggested approach to CT Scanning and these related forms, but the Guardian ad Litem for Children and Class Counsel suggest that there first be baseline CT scanning made available to all CT Scan eligible Claimants during their first round of Medical Monitoring, and for younger Claimants as they reach age 35, with the CT Rule and the CT Scan Verification Form suggested by the Claims Administrator then being implemented thereafter.

After careful consideration of the submission of the Claims Administrator and the positions of DuPont, the Guardian ad Litem for Children and Class Counsel in this matter, the Court hereby makes the following determination:

The approach suggested by the Claims Administrator best carries out the terms of the MOU which provide that:

"The program shall provide those examinations and tests set forth in the Court's Order of February 25, 2008 with the exception that no routine CT Scans shall be performed as part of the Medical Monitoring Program. The Defendant does agree to provide CT Scans that are diagnostically medically necessary as determined by a competent physician as relevant to possible exposure to the heavy metal contamination at issue in this litigation." [Emphasis added].

That is, CT Scans cannot be baseline or routine even at the commencement of Medical Monitoring. However, as suggested by all Parties, the Claims Administrator's CT Rule and CT Scan Verification Form vouchsafes the diagnosis of a CT Scan by the attending physician for a decision. Exposure to heavy metals and not a specific diagnosis are all that is required to diagnose a CT Scan.

5. The Claims Administrator has submitted his proposed Budget for Medical Monitoring implementation from November 1, 2011 through August 31, 2012, which is divided into (i) a separate Medical Monitoring Implementation Budget without Incremental CT Scan Costs totaling \$1,977,207.41 and (ii) an incremental CT Scan Costs Budget, in an effort to ensure the timely commencement of Medical Monitoring on November 1, 2011 even if the CT Scan issue is further litigated.

The two major objections by DuPont to the finalization of the Budget at this time are that the number of Medical Monitoring Participating Claimants is unknown and the Medical Monitoring Medical Provider prices are not finalized.

However, as suggested by the Claims Administrator in his Report and in his Budget and supporting documentation in Attachment VII thereto, a materially accurate projection of the number of Medical Monitoring Participating Claimants was provided on October 3, 2011, and totals 4,000. In addition, Medical Monitoring Provider contracts are in the process of being

finalized, with a letter containing the prices, that was previously vetted with the Parties, having been submitted to the Providers on October 6, 2011, and with Medical Provider contracts; after vetting with the Parties, having been submitted to the Providers for review and possible signature.

The Court also understands that the Medical Monitoring prices that were ably negotiated by CTIA, the Third Party Administrator, are substantially below that originally budgeted on August 19, 2011. The Court therefore finds that these two variables have been reasonably established so that setting a Budget now, funding it by October 31, 2011, and commencing the Medical Monitoring Program on November 1, 2011 are appropriate.

Respecting the second component of the Medical Monitoring Budget, the amount of funding necessary to fund CT scans, the Claims Administrator reports that the amount of funding required depends on (i) whether the CT Rule and CT Scan Verification Form suggested by the Claims Administrator are implemented at the beginning of the Medical Monitoring Plan; or (ii) the baseline CT Scan approach suggested by Class Counsel and the Guardian ad Litem is implemented at the beginning of the Medical Monitoring Plan and as younger Claimants reach age 35; (iii) with the Incremental CT Scan Budget under the Claims Administrator's Proposal being \$839,302.10 and with the incremental CT Scan Budget under Class Counsel's and the Guardian ad Litem's proposal being \$1,192,414.99.

After carefully considering this matter, the Court makes the following decision:

The Claims Administrator's approach to CT Scans is the correct one, so that the Incremental CT Scan Budget is \$839,302.10.

THEREFORE, THE FIRST ALTERNATIVE MEDICAL MONITORING BUDGET IS APPROVED AND THE NEW CONTRIBUTION OF DUPONT TO THE MEDICAL MONITORING FUND DUE TO BE PAID OCTOBER 31, 2011 (FOR NON-CT SCAN AND FOR CT SCAN MEDICAL MONITORING) IS \$2,789,984.94.

6. In his August 24, 2011 and September 1, 2011 Reports to the Court, the Claims Administrator suggested that the Court consider whether DuPont should pay an additional \$26,524.57 for expenses incurred by CTIA, the Third Party Administrator for the Medical Monitoring Plan, during September and October 2011, as being post-implementation expenses, or whether these expenses should be paid from old money already contributed by DuPont at Settlement, as pre-implementation expenses. In his October 10, 2011, Report, the Claims Administrator now suggests that these expenses are not materially great and the appropriate payment is debatable. He also reports that approximately half of this amount, or \$15,440, is attributed to monthly charges of CTIA under its contract with the Settlement, which are not directly related to actual testing. The other costs are for communications materials, production and distribution of ID cards, and the scheduling of appointments and reminder letters and design consulting services. Although some of these costs are reasonably related to actual testing, there is a reasonable basis to find that none of them deal with testing itself until the testing actually begins.

Therefore, the Court accepts the Claims Administrator's proposal that these Bridge Funding expenses will be paid from the initial \$4,000,000.00 previously paid by DuPont to start up the Medical Monitoring Program.

7. In his October 14, 2011 Supplement to his October 10, 2011 Report, the Claims Administrator describes a Medicare reporting compliance proposal without admitting that Medicare is applicable to the Medical Monitoring Program. One of the Class Counsel has challenged the need for such reporting, while the Claims Administrator suggests that it is prudent.

After considering this matter carefully, the Court decides the following:

The Claims Administrator is hereby authorized to carry out the Medicare reporting proposal.

IT IS SO ORDERED.

Finally, it is **ORDERED** that the Clerk of this Court shall provide certified copies of this Order to the following:

David B. Thomas
James S. Arnold
Stephanie Thacker
Guthrie & Thomas, PLLC
P.O. Box 3394
Charleston, WV 25333-3394

Meredith McCarthy
901 W. Main St.
Bridgeport, WV 26330
Guardian ad litem

Virginia Buchanan
Levin, Papantonio, Thomas, Mitchell,
Eshner & Proctor, P.A.
316 South Baylen St., Suite 600
Pensacola, FL 32591

J. Farrest Taylor
Cochran, Cherry, Givens, Smith
Lano & Taylor, P.C.
163 West Main Street
Dothan, AL 36301

Edgar C. Gentle, III
Michael A. Jacks
Gentle, Turner & Sexton
P. O. Box 257
Spelter, WV 26438
Special Master

ENTER: October 31, 2011


Thomas A. Bedell, Circuit Judge

**THE PERRINE MEDICAL MONITORING PROGRAM
A PRODUCT OF THE PERRINE DUPONT SETTLEMENT
OPTIONAL CLAIMANT AUTHORIZATION OF LIMITED ANONYMOUS DISCLOSURE
OF PROTECTED HEALTH INFORMATION FOR POSSIBLE
SCIENTIFIC AND HEALTH RESEARCH**

I authorize the disclosure of my protected health information,¹ or the protected health information for _____ (minor child/incompetent adult), as described below. This authorization is voluntary and made because I want this information to be released for possible scientific and health research as described below. I understand that the Claims Administrator will take reasonable measures to protect the information, but it is possible that the information which is being released may be sent to an individual or entity (described below) which may not be subject to federal or state privacy laws and may be later disclosed again by that individual or entity and no longer be protected. I understand that I do not have to sign this form, and that signing this form is not a condition to enrollment in The Perrine Medical Monitoring Program, a product of the Perrine DuPont Settlement.

1. I authorize the following person(s) and/or organization(s) (specified below) to disclose my protected health information:

ED GENILE
CLAIMS ADMINISTRATOR
THE PERRINE MEDICAL MONITORING PROGRAM, A PRODUCT OF THE
PERRINE DUPONT SETTLEMENT
P.O. Box 257
Speltet, WV 26438
(800) 345-0837
www.perrinedupont.com

2. I authorize the following person(s) and/or organization(s) to receive my protected health information, as disclosed by the person(s) and/or organization(s) above:

¹Protected health information means health information, that identifies a person, and which relates to that person's (1) past, present, or future physical or mental health or condition; 2) the provision of health care to that person; or 3) the past, present, or future payment for the provision of health care to that person, 45 C.F.R. § 164.501. Here, the protected health information will be the results of medical tests, physical examinations, and the collection of medical histories in the Perrine Medical Monitoring Program.

**THE PERRINE MEDICAL MONITORING PROGRAM, A PRODUCT OF THE PERRINE DUPONT
SETTLEMENT, AUTHORIZATION OF LIMITED ANONYMOUS DISCLOSURE OF PROTECTED HEALTH
INFORMATION FOR POSSIBLE SCIENTIFIC AND HEALTH RESEARCH**
PAGE 1 OF 4

The Perrine Medical Monitoring Program, c/o the Claims Administrator
The Circuit Court of Harrison County, West Virginia
Judge Thomas A. Hedell
Any and All Special Masters Appointed By the Circuit Court of Harrison County, West Virginia, Who Work On or With the Perrine DuPont Settlement

3. I authorize the following person(s) and/or organization(s) to receive my depersonalized protected health information, with unique identifiers instead of individual information as disclosed by the person(s) and/or organization(s) above, if so ordered by the Court (with any and all information that would permit the identification of the subject of the test and the use of unique identifiers in place of such identifying information. My name, address, and social security number shall not be disclosed under any circumstances to the person(s) or organization(s) identified in paragraph 3).

Mercedith McCarthy - Current Guardian Ad Litem for the Minor Plaintiffs in the Perrine DuPont Settlement

Any Other Guardian Ad Litem for Minor Plaintiffs in the Perrine DuPont Settlement
Plaintiffs' Counsel and Plaintiffs' Liaison Counsel in connection with the Perrine DuPont Settlement

Research Departments of Accredited (as determined by the Court) Universities and Colleges
Research Department of Accredited (as determined by the Court) Research Hospitals and Medical Institutions

E. I. DuPont DeNemours and Company
The United States of America and any department or agency or service thereof
The State of West Virginia and any department or agency or service thereof

The United States Environmental Protection Agency
The United States Food and Drug Administration
The United States Occupational Safety and Health Administration

The World Health Organization
Environmental Protection Agency
Agency for Toxic Substances and Disease Registry

Centers for Disease Control
United States Department of Health and Human Services
National Health and Nutrition Examination Survey
National Institutes of Health

4. I direct that all protected health information that may be in the possession of the CLAIMS ADMINISTRATOR, THE PERRINE MEDICAL MONITORING PROGRAM (the "Claims Administrator") may be disclosed, released, revealed, and otherwise given to all person(s) and/or organization(s) identified in number 2 above. In addition, I specifically direct that the following information may be disclosed, released, revealed, and otherwise given to those person(s) and/or organization(s) identified in number 3 above:

Depersonalized, with unique identifiers instead of individual information, samples, reports, results, diagnoses, findings, and other depersonalized information obtained from the Perrine Medical Monitoring Program.

5. The additional specific reason and purpose for the disclosure as described above is as follows:

To allow the individuals, institutions and organizations named in sections 2 and 3 above to facilitate and to engage in scientific research, studies, investigations, environmental evaluations and comparisons, statistical analysis, and the development of programs to further understanding regarding the health effects of the potential, possible or alleged prolonged exposure to arsenic, cadmium, zinc and lead in Spelter, West Virginia, and like areas, and other scientific and health studies and purposes.

6. I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and or organization(s) named above have taken action in reliance on this authorization. This authorization may be revoked through a letter stating my name, address, telephone number, date of birth, and social security number, along with the following statement or similar statement: "I wish to revoke the AUTHORIZATION OF DISCLOSURE OF PROTECTED HEALTH INFORMATION which I signed and gave to your office." I must then sign the letter and date it, and have my signature witnessed. Then mail the letter to the following address:

ED GENTLE
CLAIMS ADMINISTRATOR
THE PERRINE MEDICAL MONITORING PROGRAM, A PRODUCT OF THE
PERRINE DUPONT SETTLEMENT
P.O. Box 257
Spelter, WY 26438
(800) 345-0837
www.perrinedupont.com

After the Claims Administrator receives my signed and witnessed letter, in the proper format, his office will notify me by phone or letter and confirm that my consent has been revoked.

7. I understand that I may inspect or copy my protected health information to be used and/or disclosed, as long as said information is in the possession of the Claims Administrator. I also understand that I have no right to inspect or copy the following: 1) psychotherapy notes; 2) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and 3) protected health information in the possession of the Claims Administrator to which federal law prohibits my access.

8. I understand that I may refuse to sign this authorization.

9. I understand that the Claims Administrator is creating information for the purpose, in whole or in part, of scientific or health research. I understand that the extent to which the information will be used to carry out the Medical Monitoring Program, includes: using my Protected Health Information (as authorized in section 4 above), to further scientific or health research into the human health effects of prolonged potential, alleged or possible contamination of arsenic, cadmium, zinc, and lead in Spelter, West Virginia. In addition, this Protected Health Information may be used to investigate other sites and compare contamination in those sites as

well, and treat other individuals exposed to similar contamination. I understand that this Protected Health Information could be used for scientific research, studies, investigations, environmental evaluations and comparisons, statistical analysis, and the development of programs to further understanding regarding the health effects of the potential, alleged or possible contamination in Spelter, West Virginia, and like areas, and other scientific studies and purposes. I also understand that it could be used by other entities to aid in preventing other types of contamination, or treating other types of contamination or sickness. It might also be used solely for statistical purposes or any other purpose deemed useful by the individuals, institutions, or organizations named in section 3.

10. I understand that no protected health information will be used or disclosed unless I agree to such disclosure herein.

11. I understand that the statements made in this document are binding.

I understand and acknowledge that the Ferrine Medical Monitoring Program does not include any provision for the funding of any of the potential scientific research, studies, investigations or other programs outlined in this disclosure and that this authorization does not create any expectation by me or by the medical monitoring class or any obligation on the part of Plaintiffs Counsel, DuPont or the Claims Administrator to provide any money to support such programs.

I have had the opportunity to read or have had this document read to me, and have considered the contents of this authorization. I confirm that the contents are consistent with my direction. I have been given a copy of this authorization.

Signed _____ Date _____

Print Name: _____

Address: _____

Telephone: _____

D.O.B.: _____

Social Security Number: _____

Check here if Social Security number is for a minor child

Relationship or Authority of Personal Representative (if applicable)
(If you have signed this form as a personal representative of the individual whose personal health information is being released, state your relationship to the individual, or your authority for signing for the individual here.)

EXHIBIT D:

Claimant Use of Data Consent Form
and Approval Order

IN THE CIRCUIT COURT OF HARRISON COUNTY, WEST VIRGINIA

LENORA PERRINE, et al., individuals
residing in West Virginia, on behalf of
themselves and all others similarly situated,

Plaintiffs,

v.

Case No. 04-C-296-2
Thomas A. Bedell, Circuit Judge

E. I. DUPONT DE NEMOURS &
COMPANY, et al.,

Defendants.

**ORDER RESOLVING PENDING MEDICAL MONITORING PROGRAM ISSUES
IN PREPARATION FOR NOVEMBER 1, 2011 IMPLEMENTATION DATE**

Presently before the Court are the unresolved issues described below and related to the November 1, 2011 implementation of the Medical Monitoring Program.

In order to allow the Parties to be heard on these issues and all other issues related to the implementation of the Medical Monitoring Program, this matter came on to be heard on October 17, 2011, at 10:00 o'clock a.m., and said hearing was held before the Honorable Thomas A. Bedell, Judge of the Circuit Court of Harrison County, West Virginia, in the Division 2 Courtroom located on the 4th Floor of the Harrison County Courthouse, 301 West Main Street, Clarksburg, West Virginia.

At the Hearing, the Claims Administrator submitted his Report respecting the recommended resolution of the issues, while presenting the alternative positions of the Parties. Also appearing was Dr. Jubal Watts, an expert sponsored by the Claims Administrator, to address the CT Scan issue. The Claims Administrator and Dr. Watts subjected themselves to cross-examination by the Parties, with the Claims Administrator, as a neutral for the Court, then

resting. Class Counsel, the Guardian ad Litem for Children and DuPont then presented their positions for the Court's consideration.

After a careful review of the Claims Administrator's submission and the submissions of the Parties, and having weighed the evidence and the presentations made at the October 17, 2011 hearing, and in consideration of the applicable law, the Court ORDERS the following:

1. The Parties have stipulated that the Medical Monitoring Program is a primary plan for medical testing benefits, with DuPont being responsible for all costs thereof. The Court accepts this stipulation of the Parties.
2. To facilitate the collection of Medical Monitoring Plan data for possible future scientific and medical research, the Court hereby approves the use by the Medical Monitoring Plan of the final Optional Data Collection Consent Form submitted by the Claims Administrator in Attachment II to his October 10, 2011 Report, with Claimants being allowed to complete and sign the Form, at their option, during their initial Medical Monitoring Provider visit.
3. The Court has carefully considered the positions of the Guardian ad Litem and DuPont on how to handle "No" box minor Medical Monitoring Claimants, whose parent or guardian checked the "No" box and therefore did not choose Medical Monitoring, when these minor "No" box Claimants become adults. The Court further considered their positions on when an "Inactive" Medical Monitoring Claimant (a Claimant who signed up for Medical Monitoring but then fails to use it) may become "Active" again.

The Guardian ad Litem suggests that the Medical Monitoring Plan is a right which cannot be waived through a lack of use by a Claimant, while DuPont argues that the Medical Monitoring Plan is a right that can be waived by a Claimant through lack of use.

DuPont also objects to the use of resources to continue to notify such inactive Claimants of the Program and invite them back in. DuPont, however, does not object to current minors whose parents have marked the "no" box on their behalf being notified once they turn 18 and given the option themselves of participating in the Program. But, DuPont contends that this should be a one-time notification.

Although this is a difficult issue, the Court makes the following determination:

The Medical Monitoring Plan is a right of a Claimant that cannot be waived, with such a waiver not being reflected anywhere in the Settlement Memorandum of Understanding ("MOU") or any related Orders. The Court therefore decides that the Claims Administrator's suggested procedures to notice these Claimants, with the procedures being contained in Attachment III to the Claims Administrator's October 10, 2011 Report, are well taken and are hereby approved.

4. In connection with CT Scans, the Court has carefully reviewed the proposed CT Rule and CT Scan Verification Form provided by the Claims Administrator in his October 10, 2011 Report, as modified on October 19, 2011, based on the October 17, 2011 hearing. The Court understands that DuPont supports the Claims Administrator's suggested approach to CT Scanning and these related forms, but the Guardian ad Litem for Children and Class Counsel suggest that there first be baseline CT scanning made available to all CT Scan eligible Claimants during their first round of Medical Monitoring, and for younger Claimants as they reach age 35, with the CT Rule and the CT Scan Verification Form suggested by the Claims Administrator then being implemented thereafter.

After careful consideration of the submission of the Claims Administrator and the positions of DuPont, the Guardian ad Litem for Children and Class Counsel in this matter, the Court hereby makes the following determination:

The approach suggested by the Claims Administrator best carries out the terms of the MOU which provide that:

"The program shall provide those examinations and tests set forth in the Court's Order of February 25, 2008 with the exception that no routine CT Scans shall be performed as part of the Medical Monitoring Program. The Defendant does agree to provide CT Scans that are diagnostically medically necessary as determined by a competent physician as relevant to possible exposure to the heavy metal contamination at issue in this litigation." [Emphasis added].

That is, CT Scans cannot be baseline or routine even at the commencement of Medical Monitoring. However, as suggested by all Parties, the Claims Administrator's CT Rule and CT Scan Verification Form vouchsafes the diagnosis of a CT Scan by the attending physician for a decision. Exposure to heavy metals and not a specific diagnosis are all that is required to diagnose a CT Scan.

5. The Claims Administrator has submitted his proposed Budget for Medical Monitoring implementation from November 1, 2011 through August 31, 2012, which is divided into (i) a separate Medical Monitoring Implementation Budget without incremental CT Scan Costs totaling \$1,977,207.41 and (ii) an incremental CT Scan Costs Budget, in an effort to ensure the timely commencement of Medical Monitoring on November 1, 2011 even if the CT Scan issue is further litigated.

The two major objections by DuPont to the finalization of the Budget at this time are that the number of Medical Monitoring Participating Claimants is unknown and the Medical Monitoring Medical Provider prices are not finalized.

However, as suggested by the Claims Administrator in his Report and in his Budget and supporting documentation in Attachment VII thereto, a materially accurate projection of the number of Medical Monitoring Participating Claimants was provided on October 3, 2011, and totals 4,000. In addition, Medical Monitoring Provider contracts are in the process of being

finalized, with a letter containing the prices, that was previously vetted with the Parties, having been submitted to the Providers on October 6, 2011, and with Medical Provider contracts, after vetting with the Parties, having been submitted to the Providers for review and possible signature.

The Court also understands that the Medical Monitoring prices that were ably negotiated by CTIA, the Third Party Administrator, are substantially below that originally budgeted on August 19, 2011. The Court therefore finds that these two variables have been reasonably established so that setting a Budget now, funding it by October 31, 2011, and commencing the Medical Monitoring Program on November 1, 2011 are appropriate.

Respecting the second component of the Medical Monitoring Budget, the amount of funding necessary to fund CT scans, the Claims Administrator reports that the amount of funding required depends on (i) whether the CT Rule and CT Scan Verification Form suggested by the Claims Administrator are implemented at the beginning of the Medical Monitoring Plan; or (ii) the baseline CT Scan approach suggested by Class Counsel and the Guardian ad Litem is implemented at the beginning of the Medical Monitoring Plan and as younger Claimants reach age 35; (iii) with the Incremental CT Scan Budget under the Claims Administrator's Proposal being \$839,302.10 and with the incremental CT Scan Budget under Class Counsel's and the Guardian ad Litem's proposal being \$1,192,414.93.

After carefully considering this matter, the Court makes the following decision:

The Claims Administrator's approach to CT Scans is the correct one, so that the Incremental CT Scan Budget is \$839,302.10.

THEREFORE, THE FIRST ALTERNATIVE MEDICAL MONITORING BUDGET IS APPROVED AND THE NEW CONTRIBUTION OF DUPONT TO THE MEDICAL MONITORING FUND DUE TO BE PAID OCTOBER 31, 2011 (FOR NON-CT SCAN AND FOR CT SCAN MEDICAL MONITORING) IS \$2,789,984.94.

6. In his August 24, 2011 and September 1, 2011 Reports to the Court, the Claims Administrator suggested that the Court consider whether DuPont should pay an additional \$26,524.57 for expenses incurred by CTIA, the Third Party Administrator for the Medical Monitoring Plan, during September and October 2011, as being post-implementation expenses, or whether these expenses should be paid from old money already contributed by DuPont at Settlement, as pre-implementation expenses. In his October 10, 2011, Report, the Claims Administrator now suggests that these expenses are not materially great and the appropriate payment is debatable. He also reports that approximately half of this amount, or \$15,440, is attributed to monthly charges of CTIA under its contract with the Settlement, which are not directly related to actual testing. The other costs are for communications materials, production and distribution of ID cards, and the scheduling of appointments and reminder letters and design consulting services. Although some of these costs are reasonably related to actual testing, there is a reasonable basis to find that none of them deal with testing itself until the testing actually begins.

Therefore, the Court accepts the Claims Administrator's proposal that these Bridge Funding expenses will be paid from the initial \$4,000,000.00 previously paid by DuPont to start up the Medical Monitoring Program.

7. In his October 14, 2011 Supplement to his October 10, 2011 Report, the Claims Administrator describes a Medicare reporting compliance proposal without admitting that Medicare is applicable to the Medical Monitoring Program. One of the Class Counsel has challenged the need for such reporting, while the Claims Administrator suggests that it is prudent.

After considering this matter carefully, the Court decides the following:

The Claims Administrator is hereby authorized to carry out the Medicare reporting proposal.

IT IS SO ORDERED.

Finally, it is **ORDERED** that the Clerk of this Court shall provide certified copies of this

Order to the following:

David B. Thomas
James S. Arnold
Stephanie Thacker
Guthrie & Thomas, PLLC
P.O. Box 3394
Charleston, WV 25333-3394

Meredith McCarthy
901 W. Main St.,
Bridgeport, WV 26330
Guardian ad litem

Virginia Buchanan
Levin, Papantonio, Thomas, Mitchell,
Eshner & Proctor, P.A.
316 South Baylen St., Suite 600
Pensacola, FL 32591

J. Farrest Taylor
Cochran, Cherry, Givens, Smith
Lane & Taylor, P.C.
163 West Main Street
Dothan, AL 36301

Edgar C. Gentle, III
Michael A. Jacks
Gentle, Turner & Sexton
P. O. Box 257
Spelter, WV 26438
Special Master

ENTER: October 21, 2011


Thomas A. Bedell, Circuit Judge

THE PERRINE MEDICAL MONITORING PROGRAM
A PRODUCT OF THE PERRINE DUPONT SETTLEMENT
OPTIONAL CLAIMANT AUTHORIZATION OF LIMITED ANONYMOUS DISCLOSURE
OF PROTECTED HEALTH INFORMATION FOR POSSIBLE
SCIENTIFIC AND HEALTH RESEARCH

I authorize the disclosure of my protected health information,¹ or the protected health information for _____ (minor child/incompetent adult), as described below. This authorization is voluntary and made because I want this information to be released for possible scientific and health research as described below. I understand that the Claims Administrator will take reasonable measures to protect the information, but it is possible that the information which is being released may be sent to an individual or entity (described below) which may not be subject to federal or state privacy laws and may be later disclosed again by that individual or entity and no longer be protected. I understand that I do not have to sign this form, and that signing this form is not a condition to enrollment in The Perrine Medical Monitoring Program, a product of the Perrine DuPont Settlement.

1. I authorize the following person(s) and/or organization(s) (specified below) to disclose my protected health information:

ED GENTLE
CLAIMS ADMINISTRATOR
THE PERRINE MEDICAL MONITORING PROGRAM, A PRODUCT OF THE
PERRINE DUPONT SETTLEMENT
P.O. Box 257
Spelter, WV 26438
(800) 343-0837
www.perrinedupont.com

2. I authorize the following person(s) and/or organization(s) to receive my protected health information, as disclosed by the person(s) and/or organization(s) above:

¹Protected health information means health information, that identifies a person, and which relates to that person's 1) past, present, or future physical or mental health or condition; 2) the provision of health care to that person; or 3) the past, present, or future payment for the provision of health care to that person. 45 C.F.R. § 164.501. Here, the protected health information will be the results of medical tests, physical examinations, and the collection of medical histories in the Perrine Medical Monitoring Program.

The Perrine Medical Monitoring Program, c/o the Claims Administrator
The Circuit Court of Harrison County, West Virginia
Judge Thomas A. Bedell
Any and All Special Masters Appointed By the Circuit Court of Harrison County, West
Virginia, Who Work On or With the Perrine DuPont Settlement

3. I authorize the following person(s) and/or organization(s) to receive my depersonalized protected health information, with unique identifiers instead of individual information as disclosed by the person(s) and/or organization(s) above, if so ordered by the Court (with any and all information that would permit the identification of the subject of the test and the use of unique identifiers in place of such identifying information. My name, address, and social security number shall not be disclosed under any circumstances to the person(s) or organization(s) identified in paragraph 3).

Meredith McCarthy – Current Guardian Ad Litem for the Minor Plaintiffs in the Perrine DuPont Settlement

Any Other Guardian Ad Litem for Minor Plaintiffs in the Perrine DuPont Settlement
Plaintiffs' Counsel and Plaintiffs' Liaison Counsel in connection with the Perrine DuPont Settlement

Research Departments of Accredited (as determined by the Court) Universities and Colleges
Research Department of Accredited (as determined by the Court) Research Hospitals and Medical Institutions

E. I. DuPont DeNemours and Company

The United States of America and any department or agency or service thereof

The State of West Virginia and any department or agency or service thereof

The United States Environmental Protection Agency

The United States Food and Drug Administration

The United States Occupational Safety and Health Administration

The World Health Organization

Environmental Protection Agency

Agency for Toxic Substances and Disease Registry

Centers for Disease Control

United States Department of Health and Human Services

National Health and Nutrition Examination Survey

National Institutes of Health

4. I direct that all protected health information that may be in the possession of the CLAIMS ADMINISTRATOR, THE PERRINE MEDICAL MONITORING PROGRAM (the "Claims Administrator") may be disclosed, released, revealed, and otherwise given to all person(s) and/or organization(s) identified in number 2 above. In addition, I specifically direct that the following information may be disclosed, released, revealed, and otherwise given to those person(s) and/or organization(s) identified in number 3 above:

Depersonalized, with unique identifiers instead of individual information, samples, reports, results, diagnoses, findings, and other depersonalized information obtained from the Perrine Medical Monitoring Program.

5. The additional specific reason and purpose for the disclosure as described above is as follows:

To allow the individuals, institutions and organizations named in sections 2 and 3 above to facilitate and to engage in scientific research, studies, investigations, environmental evaluations and comparisons, statistical analysis, and the development of programs to further understanding regarding the health effects of the potential, possible or alleged prolonged exposure to arsenic, cadmium, zinc and lead in Spelter, West Virginia, and like areas, and other scientific and health studies and purposes.

6. I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization. This authorization may be revoked through a letter stating my name, address, telephone number, date of birth, and social security number, along with the following statement or similar statement: "I wish to revoke the AUTHORIZATION OF DISCLOSURE OF PROTECTED HEALTH INFORMATION which I signed and gave to your office." I must then sign the letter and date it, and have my signature witnessed. Then mail the letter to the following address:

ED GENTLE
CLAIMS ADMINISTRATOR
THE PERRINE MEDICAL MONITORING PROGRAM, A PRODUCT OF THE
PERRINE DUPONT SETTLEMENT
P.O. Box 257
Spelter, WV 26438
(800) 345-0837
www.perrinedupont.com

After the Claims Administrator receives my signed and witnessed letter, in the proper format, his office will notify me by phone or letter and confirm that my consent has been revoked.

7. I understand that I may inspect or copy my protected health information to be used and/or disclosed, as long as said information is in the possession of the Claims Administrator. I also understand that I have no right to inspect or copy the following: 1) psychotherapy notes; 2) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and 3) protected health information in the possession of the Claims Administrator to which federal law prohibits my access.
8. I understand that I may refuse to sign this authorization.
9. I understand that the Claims Administrator is creating information for the purpose, in whole or in part, of scientific or health research. I understand that the extent to which the information will be used to carry out the Medical Monitoring Program, includes: using my Protected Health Information (as authorized in section 4 above), to further scientific or health research into the human health effects of prolonged potential, alleged or possible contamination of arsenic, cadmium, zinc, and lead in Spelter, West Virginia. In addition, this Protected Health Information may be used to investigate other sites and compare contamination in those sites as

well, and treat other individuals exposed to similar contamination. I understand that this Protected Health Information could be used for scientific research, studies, investigations, environmental evaluations and comparisons, statistical analysis, and the development of programs to further understanding regarding the health effects of the potential, alleged or possible contamination in Spelter, West Virginia, and like areas, and other scientific studies and purposes. I also understand that it could be used by other entities to aid in preventing other types of contamination, or treating other types of contamination or sickness. It might also be used solely for statistical purposes or any other purpose deemed useful by the individuals, institutions, or organizations named in section 3.

10. I understand that no protected health information will be used or disclosed unless I agree to such disclosure herein.

11. I understand that the statements made in this document are binding.

I understand and acknowledge that the Perrine Medical Monitoring Program does not include any provision for the funding of any of the potential scientific research, studies, investigations or other programs outlined in this disclosure and that this authorization does not create any expectation by me or by the medical monitoring class or any obligation on the part of the Plaintiffs Counsel, DuPont or the Claims Administrator to provide any money to support such programs.

I have had the opportunity to read or have had this document read to me, and have considered the contents of this authorization. I confirm that the contents are consistent with my direction. I have been given a copy of this authorization.

Signed _____ Date _____

Print Name: _____

Address: _____

Telephone: _____

D.O.B.: _____

Social Security Number: _____

Check here if Social Security number is for a minor child

Relationship or Authority of Personal Representative (if applicable).
(If you have signed this form as a personal representative of the individual whose personal health information is being released, state your relationship to the individual, or your authority for signing for the individual here.)