STORYCLOUD

Transcript of Proceedings:

Grievance of First Officer Michael Danford, ATL 18-14

AIR LINE PILOTS ASSOCIATION, INT'L
and
DELTA AIR LINES CO.

Volume Two

October 29, 2020

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VIRTUAL ARBITRATION

GRIEVANCE OF FIRST OFFICER MICHAEL DANFORD

CASE NO. 18-14

BETWEEN

AIR LINE PILOTS ASSOCIATION, INT'L

AND

DELTA AIR LINES CO.

VOLUME TWO

OCTOBER 29, 2020

REPORTED BY:

DAMIEN STONEBERGER

STORYCLOUD

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Also Present:

Michael Danford, Grievant
Emily Zavis, Remote Technician

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OCTOBER 29, 2020

MR. KASSIN: And good morning, Captain Storbeck. This is Tom Kassin. I see you now. You are appearing before the Delta Airlines Pilot System Board of Adjustment and the neutral arbitrator is Burdette, and he will administer the oath to you at this time.

THE ARBITRATOR: Would you raise your right hand, please, Captain? Do you swear or affirm that the testimony you're about to give in this case will be the whole truth and nothing but the truth?

THE WITNESS: I do.

THE ARBITRATOR: Thank you very much. And would you please affirm to us that there's nobody else in the room with you and that you don't have any documents that are not a part of this case in front of you?

THE WITNESS: I have no people in the room with me and no documents.

THE ARBITRATOR: Thank you. Thank you very much.

CHRIS STORBEK,

having been first duly sworn, testifies as follows:

DIRECT EXAMINATION

BY MR. KASSIN:

Q. Okay. For the record, please state your

name.

A. Chris Storbeck.

Q. And Captain Storbeck, what's your current relationship and position with Delta?

A. I'm a retired pilot.

Q. Okay. And prior to your retirement, how many years had you worked with Delta?

A. 31.

Q. Okay. And just briefly for the boards' background, can you tell them what type of aircraft you flew when you were with Delta?

A. I was an engineer on a 727. I was a first officer on the DC-9 and also 757/767 domestic. And I was a captain and line check airman on an MD-8080 and 8090. And then I flew the 757/767 again as a captain both domestically and internationally.

Q. Okay. And prior to Delta Airlines, could you give us a brief summary of your aviation background?

A. I was in the Air Force for a little over 10 years before coming to Delta, primarily serving as a flight instructor and flight examiner in the T-37 and then I flew operationally as a flight commander and flight instructor in the F-4E and the F-4G.

Q. Okay.

A. I was a -- I was also a distinguished

graduate of every training program I entered and I was an instructor in every airplane I flew.

Q. Thank you. While employed by Delta as a pilot, did you hold any positions with the Air Line Pilots Association?

A. I held positions both on the DPAC committee and then also at the national level as a national HIMS chairman.

Q. Okay. And I'm going to ask you to explain what the DPAC committee is and then I want to ask you how you got involved in it?

A. Okay. The DPAC committee is essentially a -- a union committee that's designed to support pilots who may suffer from chemical dependency, either alcoholism or some other form of chemical dependency. And -- and so we -- we try to provide information to the individual pilot about professional health resources, about the DPAC substance abuse program, about the national HIMS program. And then we also -- the committee also serves to fulfill functions -- monitoring functions like peer monitor.

Q. Okay. And why did you volunteer to work with the DPAC Committee?

A. I'm sorry. Could you say again?

Q. Sure. Why did you volunteer to work with

DPAC?

A. I actually had some questions about my own alcohol consumption early on in my career at Delta and I contacted the committee and then after receiving a professional referral, I went and spoke to a professional specialist about my drinking. So I -- I elected to voluntarily enter treatment in 1990. And then as I progressed in my recovery, I felt it was important to make sure that, that program not only supported other pilots that were in a position similar to me, but also that -- that program was available for pilots in the future.

Q. Okay. And based on your -- how many years were you involved working with the DPAC committee and what positions have you, if any, did you hold?

A. I started actually my committee work in 1991 after I was a year into my monitoring period from my initial treatment in 1990, and initially I served as a peer monitor and actually wrote a number of articles for local union publications related to the program and to the disease. And then eventually in 1995, I was selected to be the chairman of the Atlanta DPAC committee, the domicile committee. And then in 1999 I was asked to take over as the chairman of the -- the committee for the -- the airline as a whole and served

in that capacity from 1999 through 2012.

Q. Okay. And then in 2012, did you continue work with HIMS?

A. I was actually began to work on the national level while I was still chairman of the DPAC committee. In the early 2000s, I was asked to do presentations at the -- at the national basic training seminar that was held in Denver. And 2005, I was asked to join the HIMS advisory board. Board that -- that advises the national. And then later on in, I guess it was 20 -- hope I get my dates right here, I think in 2011, I was selected to be the national HIMS chairman. So I held both the national chair position and the Delta chairman coincidentally for a year. 2012, I resigned the Delta position and concentrated on the national. 2013 I was disabled from flying due to heart disease, but I continued to do the national work till 2014 when I -- when I resigned the position.

Q. Okay. Going back to some questions on the Delta DPAC committee and your role there. Based on your experience, what would you say is the overall objective of the DPAC committee?

A. Well, the committee hopes to, you know, provide an environment where pilots can have access to help if they have concerns about substance abuse or

addiction. And we want to try to support to make sure that program is available for pilots in the future. Which also of course involves managing the risk of keeping those pilots employed for the company.

Q. Okay. And what do you hope is the goal for each pilot that participates in DPAC?

A. Well, for a person who becomes -- who receives a diagnosis, we hope that they basically learn to accept the diagnosis, that they have a chronic illness and that the best way for them to treat that illness or to manage that illness is to establish long-term sobriety by embracing their recovery.

Q. Okay. We're going to go into more detail in terms of your duties and responsibilities and what you did with the Delta DPAC committee, but what was the relationship of the ALPA representatives on the DPAC committee with any representatives from Delta Air Line company?

A. I think generally there was a -- when I -- when I took over the committee, there was already a -- a supportive atmosphere amongst the management that was particularly noteworthy and the company specialist, I believe at that point in time he was called the alcoholism consultant, which was Captain Fred Beardsley who was a retired Delta pilot and -- and previously

served as DPAC committee chairman himself.

Q. When you were the chairman of the ALPA DPAC Committee at Delta Airlines, what was your role? I mean, in other words, what were your duties and responsibilities?

A. And this is of the Delta as -- the MEC's chairman, the Delta chairman of the -- of the DPAC Committee; is that correct?

Q. Yes, and then I'm going to go to the national position in a little bit.

A. Okay. For Delta basically, I was given the responsibility of selecting the local counsel DPAC Committee chairman and training them into what their responsibilities and duties were. I was also responsible for selecting and training the -- the approximately 40 members of the -- the committee that were spread throughout the system. I provided training for managers both individually and through specific OPS manager training programs. I provided information to the Delta Pilot Group through articles and -- and I created a continuation training multimedia program about substance abuse for use at a continuation training. I also did briefings for every new hire class that came through Delta Airlines. So I had contact with all the new pilots. I coordinated with

chairman of other airlines. We actually assisted the development on the establishment of the HIMS Program at ASA when I was a Delta DPAC chairman and we also coordinated with other programs about -- about the nature of our program and of theirs trying to make sure that we were making our program as effective and supportive as possible and then overall, I was -- I think my -- my task was to -- to basically try to perpetuate and in fact improve the support that the program got from the Delta Management Group and also foster an attitude of responsibility and -- and accountability in the Pilot Group for the program to make sure that the program was serving the interest of all parties.

Q. Okay. We talked about your relationship in dealing with some of the Delta Management folks that were part of the DPAC Program. What was your practice in terms of keeping your MEC leadership at Delta advised of what all you were doing on DPAC?

A. Well, I regularly briefed the MEC at the MEC meetings, I also met with the -- the executive administrator on a -- on a regular basis. We -- one of the duties I -- I didn't mention was, I was deeply involved in -- in any changes that might become about in the program myself, the substance abuse program, as

to how we handled cases historically or what changes were going to be anticipated into the future. So I was in regular contact with -- with my ALPA representatives, and company representatives as well.

Q. Were you the ALPA MEC DPAC chairman at Delta at the time of the merger with Northwest Airlines?

A. I was.

Q. And did you have any role in terms of integrating those two programs?

A. Yeah. I was -- I was primarily responsible for the integration of those two programs.

Q. Okay. Among other responsibilities and accomplishments when you were the Delta MEC Chairman of the DPAC Committee, were you involved at all in the preparation of what we referred to as the flight operations substance abuse policy?

A. Yeah, I authored that document.

Q. Okay. I'm going to ask you some questions about that a little bit later, but I just wanted to get that out in terms of the overview of the scope of the type of work that you did?

A. Yeah, I actually flew a little bit too, which is, you know -- something.

Q. I'm going to come back to the things that you did at Delta. I want to also at this point you

mentioned your role as the national HIMS committee chairman and if you could describe for us what that position was and what all you did in that position at the national level?

A. So the national HIMS community chairman rises out of the fact that the HIMS Program was originally sort of initiated by the Airline Pilots Association, and the Airline Pilots Association has the contract for the training of that program, and so the national HIMS Committee chairman is responsible for administering the training program under FAA contract. So besides having some -- some administrative responsibilities related to the -- the funding of the program and the administration of that funding, I -- I also was responsible for working with the -- the HIMS Program Manager, which in the time of my tenure was Dr. Dawne Hudson in Colorado, and with Dr. Barry -- Mike Barry at the FAA related to what kind of training was to be accomplished and how it was to be accomplished and -- and the -- the scene on the national level when I arrived was less than optimal in my viewpoint.

The years that I had spent working on a local DPAC Committee at Delta and coordinating with the other chairman, I -- I realized that the program had become very much siloed and independent at various airlines.

So there were -- every airline was pretty much operating their own program, and some of those policies they had were effective and some of the policies that they followed were very ineffective and -- and there was a wide variation in terms of the quality of support that was being offered to the pilots in the referring program and to the success rates at the various airlines and so the doctors had essentially risen to sort of take over leadership of the program from the pilots, and -- and as a consequence the -- the treatment and the medical aspects of the program expanded considerably along with the costs of the program.

Unfortunately, that change did not result in higher success rates, and so I felt that returning sort of to the original model with a pilot led program was actually in the best interest, not only of the pilots of the various airlines, but that if we broke down some of these barriers between the airlines and focused on trying to harmonize our programs with what we had learned over the years about the treatment process that overall the program would be more successful. So I led those -- those changes.

Q. Okay. While you were in the national position, did you have any involvement in the evolution

of the testing that was used for monitoring individual pilots that were in HIMS Programs at their individual carriers?

A. I did, it's probably best to explain that in -- in the context of sort of what testing was going on in the industry at the time. When I began working on the DPAC Committee in 1991, testing overall in industry was pretty much limited to on-duty testing, and -- and so that applied to both pilots in a monitoring program and just regular employees. If the company felt that there was a need to do a test because there was some observable behavior of intoxication or smelling of alcohol that put someone's fitness for duty in doubt, they could remove the -- the person from duty and go have them tested it. In the -- in 1990, actually, the month before I entered treatment in March of 1990, there was a Northwest Airlines incident. Northwest Airlines at the time was the only carrier that actually didn't have an active HIMS program, and that incident, which is often referred to as the Fargo incident, was with -- had pilots that were charged with operating an aircraft under the influence of alcohol.

That led a fire so to speak, underneath Congress. They passed the 1991 Omnibus Testing Act, which resulted in the 1992 implementation of the DOT Testing

Program. DOT testing changed things and then it put testing facilities and trained collectors at the airport property itself, which prior that time had not occurred and so there at that point in time, testing was available for on-duty personnel essentially, whereas previously they had to be removed from the airport and taken to a hospital or whatever to collect the sample and that -- that was essentially the state of testing in the industry.

There's -- there was some -- parallel with those changes, there were some changes within the program in that when the 1990 Fargo incident lit a fire under -- under Congress, it also lit a bit of a fire underneath the FAA and Dr. Bart Pakull who was the chief psychiatrist at the time in the early '90s, began to speak to the AMEs, the -- the -- the special AMEs that sponsor a pilot for their Special Issuance Medical, and -- and prevail upon them that it was important that they have testing programs. And prior to that, basically monitored pilot testing was -- was exclusive purview of those individuals across the country. And some AMEs had good programs, most did not, most didn't test at all. Many of those that tested were testing in a very predictable manner, like the same day every month or something along that line because it was

easier to administer. So even though there was some improvement in testing on the AME level, it really wasn't very sophisticated at that point in time. Testing for most part -- I'm sorry, do you have a question?

Testing for the most part was limited to alcohol testing, that's kind of the drug of choice. Alcohol testing in -- in those days was done through blood alcohol samples or breathalyzers. By the mid 2000s, alcohol metabolite testing started to become more popularized, that's the -- what you commonly think of as the EtG test, ethyl glucuronide, and then ethyl sulfate came along a little later, about 2008. And then PEth testing basically arrived on the scene in about 2010.

Q. Okay.

A. Long answer, sorry.

Q. No. It's important background. We're going to talk more about testing, but one of the accomplishments that you mentioned when you were the -- at Delta and you were the HIMS or the DPAC Chairman for ALPA at Delta Airlines, you mentioned that you were involved in and actually were the author of the Flight Operations Substance Abuse Policy.

A. Yeah. I think previous to this you actually

asked me whether or not it had an effect on the national level as a National HIMS chairman and to -- to kind of sum up that, the answer to that question, I would say that, you know, I recognize the value of -- of random testing and -- and effective testing of our pilots in the monitoring system so that was something that I promoted at -- at the national level which was adopted at Delta and then was actually -- has been adopted in -- it's in widespread use at this point on -- on the national level.

Q. Okay. On the Delta Substance Abuse Policy that you authored, do you recall what year that was?

A. 2010, September.

Q. And can you tell us how it came about that you were asked to develop and author that substance abuse policy?

A. Prior to that point in time, our program at Delta was very reliant upon the memory of -- of Captain Beardsley and he had been there, we both, the union and the company held him in high regard. But essentially, it was -- it was a corporate memory that was held by one person and -- and consequently much of our policy was determined by past practice. Captain Dickson, when he was the -- I believe his title at that point in time was vice president of flight operations, recognized

that, you know, there was -- there were some issues with not having written policy and written guidance for both he and his other managers to follow. And so he decided that Delta should write down a -- a comprehensive substance abuse policy as it relates to how they treated the pilots. And Fred and I were the two subject matter experts in that area. I think Captain Dickson decided that as the union representative, it would be more palatable to the -- to the Air Line Pilots Association if I authored -- was the lead author on that document. But I coordinated closely with Captain Beardsley and -- and other Delta managers in the process.

Q. Okay. I'd like you to look at what's been identified as Company Exhibit 16. And do you have a copy of that document? It's the 2010 Substance Abuse Policy.

A. Okay.

(Company Exhibit 16 marked for identification)

Q. Okay. And if everybody has it, Emily, if you could just put on page 1 of that document right there? Yeah. Captain Storbeck, is this the policy that you authored?

A. It is.

MR. KASSIN: Okay. And I next want to turn your

attention to Company Exhibit 4, which is the 2014 Delta substance abuse policy. And Emily, I just need you to show page 1 of Company Exhibit 4.

(Company Exhibit 4 marked for identification)

Q. And Captain Storbeck, this is the -- the date on this policy is September 9th, 2014. At my request, did you earlier compare Company 16 with Company Exhibit 4?

A. I did.

Q. And can you tell us how Company Exhibit 4, the policy in effect at the time of Mr. Danford's termination, how it compared to the substance abuse policy that you drafted in 2010?

A. It's extraordinarily close. There was a couple of minor changes, I think there was an addition in a paragraph about documented -- documentation and tracking that was added, but much of the contract was word for word.

Q. Okay. And the substance abuse policy that you drafted, Company Exhibit 16, did it have model forms for what we refer to as Contract A and Contract B?

A. It did.

Q. Are those similar to the current policy, which is Company Exhibit 4, also having copies of those

attached as Contract A and Contract B?

A. Yes. They're -- they're again, virtually identical.

Q. Okay. Primarily I'm referring to Company Exhibit 4, but this goes back to, if you will, core philosophy that you included in the document that you authored, Company Exhibit 16. How does that substance abuse policy describe the relationship of ALPA and Delta with respect to implementation of it and any modifications of it?

A. Well, there's specific language in the policy that talks about that -- that that policy is a co-operative policy and the -- one of the important overriding factors in terms of creating the policy is I -- I think that there's common interest between the company and the union, and the individual pilot about how pilots with this illness are treated and handled. And -- and -- and because of these overlapping interests, it's important to make the policy changes mutually agreed to and co-operative in nature because any change in one area almost invariably has an impact on the other.

Q. Okay. And how does that translate in terms of both managing the risk of the pilot maintaining sobriety, as well as Delta managing the risk of

ensuring that impaired pilots do not fly in their cockpits?

A. Right. So the -- prior to the HIMS Program, it was common for airlines to terminate pilots. And so the HIMS Program basically created a framework for both the companies and the FAA regulators and the -- and the union to bring -- to allow pilots -- their careers. Obviously that's in the best interest of the union, but it's also in the interest of the individual pilot.

THE REPORTER: Can you please repeat your previous sentence? You broke up for a moment.

A. I'm not sure what I said. Let me just start over. The -- the union, the -- the HIMS program originally created an avenue for pilots with this diagnosis to keep their jobs. That's -- that's in the interest of the union. It's also in the interest of the individual pilot. Their -- the company -- the company has a lot of investment in an individual pilot as well and the training and -- and et cetera. So if they can -- if they can manage the risk associated with a person with this diagnosis operating aircraft subsequent to the diagnosis, then it makes sense financially for them too, to keep the pilot employed versus trying to replace them or training someone new.

But the risk to the airline is substantial in that

there's never been an incident of a -- of a impaired pilot who was in the program operating an aircraft and having some kind of accident. But it's not hard to imagine that the consequences -- financial consequences to the airline in that circumstance would be substantial. And so as a consequence to -- it's important for the program itself, both the pilot participants and for the -- the union and for everyone to manage their recovery in such a way that that risk is minimized and that the program is available for pilots that receive that diagnosis in the future.

Q. Do you know either from your experience as the head of the Delta DPAC Committee or in your national roles, whether the substance abuse policy that you authored, whether that served as models for other major carriers in the industry?

A. Yeah. Actually, when we completed the policy at Delta made its suggestion. We identified the policy, we made it available on a national level. It was adopted almost word for word by FedEx and it was also became sort of a template for other airlines and the development of their own programs and their own contracts.

Q. I'm going to ask you some specific questions now that have to do with -- still generic before we get

into Mr. Danford, but just generic questions about how the DPAC program works at Delta and how people may be identified and come into the program. So generally what is considered a volunteer under the DPAC program? For example, you said you were a volunteer.

A. Yeah. It's fairly broad. I mean, anyone who initiates their own -- their own, I guess introduction into the treatment program is considered to be a volunteer. So that could come about either because a person -- I mean, they might be having trouble with their wives. They might be -- they might think they just considering themselves as their drinking getting out of control, or they might have a DUI or some other circumstance which would cause them to step forward and say, you know, I think I need some help. So it -- it's under most circumstances, people that enter the program are considered to be volunteers.

Q. And do those individuals at some point go on what's called the Contract A?

A. They do.

Q. Okay. What treatment facility does Delta use? And I'm referring in these questions to your experience during the time that you would be in a position to know this information.

A. Yeah. So Delta, we -- we began to -- to

recognize that treatment quality varied depending on the location and it was in the interest of everyone concerned to have a high-quality treatment experience. And so, we also found it was important to get the managers -- management team involved with the pilots early in the process. And -- and also it was helpful that the pilot concerned had peer members who were -- who had gone through the program themselves that they could talk to and -- and discuss things with. So all of those high-quality treatment and these other supportive elements were readily available in Atlanta and the company made the decision along with the union to have all of our initial treatment centralized at Talbot Recovery Campus in Atlanta.

Q. Okay. Is the risk of a relapse, part of the disease of alcohol abuse or alcohol dependent?

MR. SEHAM: I'm going to -- I'm going to object. We're going into medical issues. I think this is a line pilot. He might have experiential background, but I don't think it qualifies him as an expert with respect to rehabilitation and relapse. I don't think there's been adequate foundation laid for this witness to testify as an expert in this field.

MR. KASSIN: And we're not asking him as a alcoholism expert, a medical doctor. We are asking him

based on his own personal experience, as well as the experience he had in multiple leadership roles on behalf of the Air Line Pilots Association. And so it would be antidotal testimony versus expert testimony.

THE ARBITRATOR: Okay. I'll overrule the objection. He can testify as to his knowledge and experience of people who may have relapsed.

A. Sir, can you repeat the question, please?

Q. Sure. Is the risk of relapse part of the disease of alcoholism?

A. Yes. In the training programs that we have, we're given at the basic seminars by the addiction specialists and from my own experience, it was -- was quite clear that relapse is one of the hallmarks of chemical dependency almost.

MR. SEHAM: I'm going to renew my objection, the arbitrator asked the witness and Counsel to confine the testimony to his own experience and his experience with other pilots and instead we're getting a translation of what he got at a seminar from addictionologist. So the witness is now standing in as a surrogate for expert testimony. So I object.

THE ARBITRATOR: Okay. I'll sustain that. Mr. Kassin, would you please ask questions relative to his experience with people who have relapsed?

Q. Yes. So Captain Storbeck, have you actually had experience with individual pilots that have experienced relapse?

A. I have personal experience as a pilot who relapsed and I've observed a number of pilots in the DPAC program and -- and at both our airlines and other airlines that have relapsed.

Q. Okay. And how did DPAC and the Delta Substance Abuse Policy address individual pilots that have relapsed, based on your experience?

A. Relapses consistently handled with once identified, the pilot is offered retreatment at a -- a different treatment facility.

Q. Okay. If a relapse occurs with a pilot on a Contract A who already has a special issuance, what is the process?

A. Once the relapse is identified the -- the special AME, the pilots medical doctor is notified and the company is notified to allow the pilot to be removed from flight status. And then we notify the treatment center to expect the admission of the pilot for retreatment.

Q. Okay. And both from your experience as the ALPA MEC DPAC chairman at Delta Airlines as well as your national ALPA HIMS experience, why is retreatment

required for a pilot after relapse?

MR. SEHAM: Objection. That, again, this is asking for expert addictionology testimony. If there's going to be some reference to a Contract A provision or an FOPP provision that specifies a requirement for retreatment, then we should be pointed to that reference in that document. But again, the effort here by Delta counsel to elicit expert testimony from a non-expert. If it's a policy that's in black and white somewhere let's see that policy.

MR. KASSIN: It doesn't need to be in black and white, but I'll rephrase the question and maybe that will resolve the concern.

THE ARBITRATOR: Thank you.

Q. Sure. Captain Storbeck, you mentioned that at Delta, under it's substance abuse policy, if a pilot has a relapse, he's offered retreatment. Why is he offered retreatment?

MR. SEHAM: Objection. No foundation laid. There's a reference to policy, and I have a best evidence objection. If it is in the policy and we've had two versions of it presented, then let the testimony show us where in the policy it exists.

MR. KASSIN: It doesn't need to be in the policy if it's a practice and --

MR. SEHAM: Then it's not a policy. Then ask a question about practice. But it's not policy because apparently it is not in the document. So I object to the form of the question. I object based on best evidence.

THE ARBITRATOR: Okay. Mr. Kassin, can you rephrase the question?

BY MR. KASSIN:

Q. Yes, sir. Captain Storbeck, what has been the practice at Delta based on your experience in terms of offering retreatment to a pilot at Delta who has a relapse?

A. The practice consistently through the time that I was in those positions, was that a pilot who relapsed was offered the opportunity to enter into retreatment.

Q. And why from a pilot's perspective and the chairman of the DPAC committee as well as the national positions, do you believe that that was important?

A. I think from my own experience as a relapsed pilot and from watching the -- the consequences of pilots who had experienced relapse in terms of their own health, and that it was important to reestablish sobriety and -- and promote a continued commitment to -- to that -- to that sobriety. And that was best

accomplished by sending a pilot to retreatment.

Q. And do you know which treatment facility Delta pilots would be referred to for retreatment if they had a relapse?

A. At the time that I was DPAC chairman and national HIMS chairman, it was the Metro Atlanta Recovery Residence in Atlanta.

Q. You mentioned what I'll describe as an arc of testing from when you first got involved with HIMS issues, and from DOT testing to AME individually determined testing and the expansion testing program. What changes, if any, were you responsible for bringing about in the testing program that used -- we'll keep it right now at the Delta DPAC program, but later I'll ask you about national HIMS programs.

A. On the Delta property, we recognized from some of our experience with some of our AMEs that their testing programs were pretty unsophisticated. And we also recognized that there were a lot of relapses both at Delta and Northwest and that had -- that we're going undetected. My own relapse experience, all of the -- the relapses I experienced were undetected. We had multiple cases where pilots relapse was identified through a DUI or some other incident that -- that would signify that they were no longer maintaining abstinence

as required by their special issuance medical and the Delta contract. And so from my own experience, I also recognized that the opportunity to drink without being caught was a factor in my own decision making about whether or not I would reuse alcohol. And so I thought that a random robust testing program would -- would remove some of that opportunity in the minds of the recovering pilot. So --

Q. And were you -- go ahead. Continue, please.

A. So following the -- the publication of the -- the 2010 substances abuse policy, we moved to change the wording in the contracts to give the company the authority to test the pilots both on an off duty.

Q. Okay. Do you know how it came about at Delta that it started to use PEth testing?

A. I do.

Q. Please tell us.

A. So when we were -- when we were trying to develop the company testing program, it was important to develop a program that was as, again, I said, robust and random. One of the issues that you deal with when you start trying to use various forms of metabolite testing like EtG and EtS is that, you know, a positive, for example, on one test may or may not indicate drinking depending on the sensitivity of the test. And

so it's important to have a sort of a layered approach that -- that removes some uncertainty about any positive test result that you might receive, and that was the function of the PEth test.

MR. SEHAM: Mr. Arbitrator, I'm going to object to any further testimony about EtS, EtG and PEth testing and the rationales for using those methodologies. We just had a director of a laboratory who we were told was not an expert witness and was not giving expert testimony, and now we're going to have a pilot who appears to be embarking on providing expert testimony. No foundation, no qualification. Any testimony concerning policy issues related to the different forms of biomarker testing is not properly elicited from this witness given that it was not proffered from the prior witness.

MR. KASSIN: Mr. Burdette?

THE ARBITRATOR: Yes.

MR. KASSIN: I hope it's been clear multiple times, Captain Storbeck is not here as a toxicologist. He's here as a pilot who drafted and authored what is the substance abuse policy effectively in effect today at Delta Airlines. He's the pilot that established the longstanding relationship of mutual cooperation between Delta and ALPA. And he's also the individual that's

responsible for introducing PEth testing into the monitoring program for DPAC. And I think he could talk about why he introduced it. The toxicologist can discuss the merits and other scientific issues related to it, but with Delta Airlines's PEth testing, and Captain Storbeck is the individual that introduced it to Delta Airlines.

MR. SEHAM: But if I may respond, testifying as to why they introduced PEth testing is necessarily going to lead to testimony in terms of what this witness's impressions are in terms of its reliability.

THE ARBITRATOR: I think you're a little premature, okay? Because I think he can certainly say since he was a party to introducing it at Delta, I think he can certainly say why he and the company came to that conclusion to use that as a means of testing. But I agree with you that if he's going to talk about the reliability of PEth testing, then that's not a proper subject for him. Does that solve the issue?

MR. SEHAM: Yes. Well, that provides some assurance. Although, I don't understand -- frankly, I still would lodge an objection in terms of the relevance as to why. Really, we understand that there's a monitoring program. The question is the forensic reliability of the testing methodologies

chosen.

THE ARBITRATOR: That's not for him to talk about necessarily, but he can address, I think why Delta decided to do that since he was involved in the introduction of it at Delta.

MR. SEHAM: Yeah. Well, I object to the relevance of that testimony. We have a written policy, we have litigation packages. So those are the documents that define the why and the backing in terms of documentation of chain of custody. But why this witness is necessary when the best evidence is in the policy itself --

THE ARBITRATOR: But I don't --

MR. SEHAM: Evidence objection and irrelevance objection.

THE ARBITRATOR: All right. But I'm going to overrule your objection. Mr. Kassin proceed but with caution, please.

BY MR. KASSIN:

Q. Sure. I'm just going to back up because with all the objections I lost track where Captain Storbeck's testimony was. So Captain Storbeck, can you tell us, you know, how it came about that you recommended to introduce PEth testing at Delta Airlines?

A. I -- I think that if I -- I think the question you asked me was what was the rationale behind it. And --

Q. Okay. Thank you.

A. -- and -- and -- and our understanding of an appropriately structured system was that you -- you -- it's -- it's inappropriate and not in the best interest of anyone involved to have a system that's relied upon one particular type of test. And so the tests that we used at the time that we -- that we developed, that we decided were appropriate, that we felt were -- would give us both an early detection of possible relapses and also be able to confirm whether or not those relapses actually occurred, was a combination of using the EtG test and the PEth test.

Q. And can you give us an example of, you know, situations in which you would see the PEth test being used when you recommended it to Delta and to ALPA?

A. At -- at Delta Airlines?

Q. Yes.

A. So the -- the program that we set up was designed to do an initial screen with an EtG test and then a confirmatory test was the PEth test.

Q. Okay. On a national level, did you have -- did you recommend the introduction of PEth testing at

other carriers?

A. I suggested that it might be useful as an additional testing tool, as an additional monitoring tool because of the -- what we had been -- had been described to us as the -- through various professional publications of the look bac- period, if you will. And -- and so one of the early adopters of PEth was American Airlines.

Q. Okay. Did you continue to work with your counterparts at the union and American Airlines and even American Management, I'm not sure who all you worked with, and learned what their experience was when they introduced PEth testing at American?

A. Yeah, I primarily worked with Ed Finley, who was the HIMS chairman at -- at the time that I was the national HIMS chairman.

MR. SEHAM: I'm going to object to the hearsay here. This is another airline, and all -- any information we're going to hear now is from an individual I cannot cross-examine.

THE ARBITRATOR: I don't think that that's the case. I think he's talking, from his first hand experience, in recommending the test, so I don't know.

MR. SEHAM: I may have misunderstood, but I thought the question was, what did you learn from your

counterparts in Delta Airlines.

THE ARBITRATOR: Okay. That would be hearsay, but --

BY MR. KASSIN:

Q. I'll rephrase it the way the arbitrator stated it. What was your experience in working with American for the introduction of PEth? And American, I'm referring to your specific counterpart on the HIMS program?

THE WITNESS: I just want to be clear about my answer so I -- can I say what Ed told me, or do you want me -- I'm sorry.

THE ARBITRATOR: No, we'd prefer you not do that. That's hearsay.

A. Okay. So -- so my experience was that I made this suggestion and American -- and American implemented PEth testing as part of their their program; is that correct? I mean, is that acceptable?

Q. I think you're allowed to say that. What is your understanding at the national level as you exchanged information on the implementation of PEth program -- I mean, PEth testing, as to what American learned when they introduced it?

MR. SEHAM: Object. Hearsay. It's speculative.

THE ARBITRATOR: I think that he had some direct

knowledge of this. Okay. So I'm going to allow it, but again, Mr. Kassin, proceed carefully, please.

MR. KASSIN: Okay.

A. American made a presentation at the National HIMS conference. I have a copy of that presentation, and that showed the results of their production of PEth and the short answer to this is that they determined they had a relatively high number -- some high-risks that were in the program that they had not recognized as having relapsed, as a result of using the test.

Q. Captain Storbeck, there's another exhibit that I would like you to look at right now. It's Company Exhibit 17, and I believe it's just a one-pager. Emily, if you'd just put that up.

(Company Exhibit 17 marked for identification)

A. I think that was added after -- after I received my document. I know which one you're referring to. Yes, go ahead.

Q. Okay. Let me describe it to you. It's a memorandum from the Federal Aviation Administration from Dr. Giovanetti, Director of Medical Specialties Division, and it's dated August 17th, 2020. Do you have a copy of that?

A. I have the copy that's on the screen. I have an electronic copy and another point on my computer.

MR. SEHAM: Counsel for the grievant, and I believe counsel for ALPA don't have this document.

MR. KASSIN: You should. It should be in your notebooks. I'm sorry.

MR. SEHAM: No, no. There are Exhibits 1 through 16, but we were never sent this document. So I would like -- I would like to have a pause here while we get emailed this document, so we can review it.

THE ARBITRATOR: Okay.

MR. KASSIN: Sorry. They were supposed to be included in the books. I apologize.

MR. SEHAM: Yeah. If you look at the table of contents, it goes 1 through 16, I'm pretty sure.

MR. KASSIN: Check it. It's the -- if you just check your tab, they were sitting at the left.

MR. SEHAM: The table of contents is 1 through 16. I have Exhibits 1 through 16. We never received this document.

MR. KASSIN: Okay. I'm so sorry. Mr. Burdette, if we might have a 10-minute break to --

THE ARBITRATOR: Let's do that.

MR. KASSIN: Okay.

THE ARBITRATOR: Okay. Let's do that. Damien, we'll go off the record until 9:36.

THE REPORTER: All right. We are now off the

record. The time is 10:26 a.m.

(OFF THE RECORD)

THE REPORTER: Back on the record at 10:38 a.m.

THE ARBITRATOR: Thank you.

MR. KASSIN: Arbitrator Burdette, I just want to check with you and counsel, both Ms. Samuda and Mr. Seham, did you get Company Exhibit 17 okay?

MR. SEHAM: Yes, I do.

THE ARBITRATOR: Yeah, I have it.

BY MR. KASSIN:

Q. Okay. Captain Storbeck, can you tell us what is Company Exhibit 17?

A. I'm sorry. What was the question?

Q. Yeah. The question to you is, what is your understanding of Company Exhibit 17?

A. I just -- I was sent this a couple of days ago by Dr. Quay Snyder, who is the current HIMS program manager, and it is, as I understand it, federal aviation medical specialties division policy about --

MR. SEHAM: Objection. Sorry, I'm going to interpose an objection here. We're having testimony concerning something he got a couple of days ago and about what his understanding of it is.

MR. KASSIN: I think he can testify to that.

MR. SEHAM: I'm willing to not object to the

admission of this document. I'm willing to exceed that it is most likely what it purports to be, but what I object to is now a witness testifying about what his understanding is of a government document that he had no participation in the issuance of.

MR. KASSIN: Okay. Well, we'll take those stipulations, and then let me ask him the next question, which is Captain Storbeck, what's the significance of the policy that are set out in this FAA document?

MR. SEHAM: I'm going to object to that too. He's not a member of the -- he's not a representative of the FAA. The significance means the meaning of, and that meaning is best derived from reading the document. The document speaks for itself.

THE ARBITRATOR: Okay. Mr. Kassin, can we move on?

BY MR. KASSIN:

Q. Well, let me keep -- there's an important point to be made. Captain Storbeck, do the policies that are set out in this document, Company Exhibit 17, reflect a change in the FAA's direction to its AMEs as to how they conduct their HIMS program evaluations?

A. Compared to the time that I was HIMS chairman, it does.

Q. And what are those changes?

A. There is an extension -- well, there's a number of changes. One is the group monitoring period was shortened to one year. There was an extension of the monitoring period, which has evolved multiple times in the time that I was HIMS chairman, but as -- under this document, it -- the -- the FAA specifies what type of testing or the frequency of testing that they want their AMEs to perform.

Q. Okay. And is there any reference in this document to the FAA referencing PEth testing?

A. There is.

Q. Can you point it out to us, please?

A. I believe it's the end of page 2. Again, as -- let me see if I can get -- I can't -- can you page through the document?

Q. I think she just did.

A. Advanced phase, years 5 through 7, it says, random PEth testing plus drug schemes, if indicated, four times in 12 months.

Q. By the FAA articulating the use of random PEth testing, is that a change?

A. It is.

Q. And what is the change?

A. The FAA previously left the -- the types of test up to the discretion of the AME, and apparently,

the current director of the Medical Specialties Division has decided that they want to dictate the type of testing being used.

Q. Okay. I do want to go back to some of the questions that we didn't quite get to based on your experiences as Delta DPAC chairman, as well as your role in the national HIMS committee on behalf of the Airline Pilots Association. Specific to Delta Airlines, and your involvement with your counterparts at Delta, when a pilot on a Contract A had a relapse, are you aware of any situation in which Delta did not offer re-treatment?

A. I am not.

Q. Okay. And you may have heard the back-and-forth on the objections and the responses to the objections of what's written in the policy versus what a practice may be. Was the practice that Delta Airlines for pilots that were on a Contract A, to your knowledge the entire time that you were involved until your retirement, was the practice to offer pilots on a Contract A that had a relapse, the opportunity to go to re-treatment?

A. It was.

Q. Okay. As the author of the substance abuse policy from 2010, why did you not put that in there?

A. My experience at that point in time was that there was no circumstance under which a part 121 pilot was re-certified by the FAA following a relapse without re-treatment.

Q. Okay. And did you feel it was necessary to put that into the substance abuse policy that you drafted?

A. No. It -- it -- from my -- my experience, it was -- it was a practice that was -- that had no exceptions, and as comprehensive as I tried to make the policy, I -- I just didn't think it was -- there are other circumstances, for example -- I think the best way to answer this is, there's another circumstance, for example, when a pilot is terminated, the company's policy is also offer that terminated pilot who has no chance of rehire an opportunity for -- for treatment. Again, that policy per se is not -- is not written in the document either, but the circumstances are different, so --

Q. Is that what Delta and ALPA refer to as the save the man policy?

A. Correct.

Q. And, Emily, if you could, you could take the exhibit down, we're done with our questions on Exhibit 17. Thank you. You've made a reference earlier to

Captain Dickson, you know, working with you and asking you to draft the substance abuse policy. Are you referring to Captain Steve Dickson who's today the administrator of the Federal Aviation Administration?

A. I am.

Q. Okay. How has the introduction of PEth testing as part of the -- what Delta DPAC does influenced you or affected you in terms of assist you with maintaining your sobriety?

A. I'm sorry, my -- you -- PEth testing for my own personal sobriety. I mean, my -- my sobriety was well established by the time PEth testing was introduced. I'm not sure I understand your question.

Q. Okay. If they -- do you in your role as DPAC chairman and even at a national level, would you meet individually with pilots and confer with them? And I'm not asking for names because of the confidentiality of the program, but would you have personal experience in -- in engaging with other pilots and just talking through sobriety issues with them?

A. I would.

Q. Based on your interaction with those pilots, did the introduction of PEth testing at Delta have any impact, positive or negative, on assisting them maintaining their sobriety?

A. Well, it was -- I -- I believe it did. Based on my conversations.

Q. And what conclusions did you reach in terms of the impact that it would have on them?

A. That I -- I basically had to depend on my own experience in terms of in -- in -- in terms of trying to understand my alcoholic, if you will. I mean, I am an alcoholic, recovering alcoholic, and so I've sort of used my own -- mine as an example. And, so I know that my own relapse experience in part was formed by, a belief that it was -- it was quote, unquote, safe for me to drink and not be discovered through the testing program that was in place at the time. And I knew that the PEth testing, as I understood it, would -- would create serious doubt as to when it would be safe to drink.

Q. Did you at some point after learning about PEth testing, did you have to make a recommendation to the Delta ALPA MEC to include it in the testing protocol for DPAC?

A. Yes.

Q. And what did you say to them in terms of your recommendation or in other words, what was your recommendation to them in terms of whether this would be a positive addition to the testing protocol for

DPAC?

MR. SEHAM: I'm going to object because I think this is a sort of a Trojan Horse way of getting expert testimony in from a non expert. I mean, the rationale for including a PEth to the extent it goes to the test reliability -- is expert testimony and it appears to me the question is designed to elicit that testimony.

Q. The question's designed to ask him what he recommended to the Delta -- to the Delta ALPA MEC. We have, you know, we had testimony for Dr. Jones. I don't know who your experts are going to be other than Dr. Tordella, but -- I mean, he certainly can tell the arbitrator and board members why he recommended it to the MEC and what his recommendation was and why he thought it was important to recommend it.

THE ARBITRATOR: Yeah, I'm going to overrule the objection, Mr. Seham, and allow him to answer the question about why he recommended it.

A. In general terms, I believe that robust testing program, which in -- in the case of Delta Airlines and the program we constructed included both EtG and PEth testing was -- and off-duty testing as well as on-duty testing was an important component in terms of supporting the pilot's sobriety. And so what that meant was that it was in the interest of the

individual pilot's health, long-term health. It was interested -- it was important in terms of helping the company identify a relapse pilot who would represent an -- an inappropriate risk to the company, and it would also help in gender support overall for the program if there was this, by having a -- a robust effective program, the likelihood would be that both that the program would continue to the future and be available for other pilots.

MR. KASSIN: Mr. Chairman, I'm going to request a 10-minute break. I believe I may not have any more questions for Captain Storbeck --

THE ARBITRATOR: Okay.

MR. KASSIN: -- we were scrambling to get Company Exhibit 17 before, if we could reconvene at 11:00, and then I'll be very close, if not ready at that moment to turn it over the witness for questions for Mr. Seham.

THE ARBITRATOR: Okay. We'll take a 10-minute break, Damien, until 11:00 Eastern Time.

THE REPORTER: Off the record at 10:51 a.m.

(OFF THE RECORD)

THE REPORTER: On the record at 11:00 a.m.

THE ARBITRATOR: Thank you very much. Mr. Kassin?

BY MR. KASSIN:

Q. Captain Storbeck, this DPAC testing that's

done for pilots, the 14 tests a year that are done randomly. Are those in addition to the DOT required test that all pilots are subject to?

A. Yes.

MR. KASSIN: Okay. And Mr. Chairman, with that, the company is complete with its direct examination of Captain Storbeck.

THE ARBITRATOR: Okay. Mr. Seham?

MR. SEHAM: Yes --

THE ARBITRATOR: Cross-examination?

CROSS EXAMINATION

BY MR. SEHAM:

Q. Yeah. Just a few questions designed to clarify what you testified to on direct. Now, you said that into the Delta program, there was introduced PEth testing in order to confirm EtG results. Did I understand that correctly?

A. That -- that was the way that we designed the protocols for the program we put in place, correct.

Q. Okay. And that was -- did I understand correctly that your testimony was that the intent underlying that two test program was in part to protect the pilot?

A. Of course.

Q. Okay. And the idea underlying that

protection was to have two positive tests, one confirming the other?

A. Correct.

Q. And that if one of those -- and that in order to confirm the existence of relapse, you would require a positive for EtG and a positive for PEth?

A. Correct.

MR. SEHAM: No further questions.

THE ARBITRATOR: Any redirect, Mr. Kassin?

REDIRECT EXAMINATION

BY MR. KASSIN:

Q. Yes, sir. Captain Storbeck, under the DPAC program in Contract A, a pilot is subject to a PEth test directly without having to first do a urine test for EtG or EtS, correct?

MR. SEHAM: Object. Objection. Leading. Again, testimony from counsel.

THE ARBITRATOR: Can you rephrase the question, Mr. Kassin?

Q. Sure. Under the pilot contract are they --

MR. SEHAM: I'd just like to say -- I would like to state the testimony -- the testimony's already been given. So it's hard to -- it's hard to withdraw or rephrase to undo the damage of a leading question. I wanted to state that.

THE ARBITRATOR: I don't -- I don't think he answered it, did he?

MR. KASSIN: No, sir.

MR. SEHAM: He didn't answer it, but he knows the answer now. He knows the answer.

THE ARBITRATOR: Oh --

BY MR. KASSIN:

Q. I would assume as the author of Contract A, he would know the answer already. Captain Storbeck, under Contract A, is a pilot subject to a PEth test by itself?

A. At the time that I -- that we initially created the program, the program protocol was to do an EtG test using the PEth as the confirmatory test.

Q. Okay.

A. That was the protocol when the program was initially implemented.

Q. And as it evolved, do you understand that PEth testing is done independent of not requiring a urine test?

MR. SEHAM: Objection. The same leading -- the same testimony.

THE ARBITRATOR: Okay. I'll sustain the objection.

Q. In connection with the way that the PEth testing was used that you were just discussing where it

was used to confirm a positive EtG, why was that?

A. The -- our understanding of the EtG test was that it was a sensitive test and that depending on the cutoff that was used and Delta chose to use a relatively low cutoff level, it would be possible to get a positive EtG test from sources of ethanol that -- that was not due to consumption. And as a consequence, the PEth test was used to try to clarify whether or not the result on the EtG test was due to consumption of alcohol or incidental exposure to alcohol.

Q. And how did it do that?

A. I -- I'm not sure I can explain that without try -- without getting into my understanding of -- of -- of this -- of the duration of a PEth test. And as opposing counsel pointed out I'm not an expert on toxicology.

Q. But I think you could explain -- because you introduced it, I think you can explain your understanding. And if he has an expert that disagrees with your understanding, there'll be opportunity for him to present that type of evidence.

MR. SEHAM: I'm going to object on the relevance of the understanding and again --

THE ARBITRATOR: I'll sustain the objection.

MR. SEHAM: -- relevance of the understanding.

Q. Captain Storbeck, were you part -- did you agree with the relatively low cutoff level that was being used by Delta DPAC when it was doing the EtG testing?

A. Under the circumstances we created onto the testing program, I did.

Q. And what was the principle behind establishing the lower cutoff for use at Delta in DPAC?

A. I was aware of testing being used at various both by -- I was -- I was aware of A&E testing programs. I was aware of testing programs of other Airlines. And -- and I felt that when we designed the Delta program, we wanted to ensure that we didn't miss relapses. And so I thought it was important that we have a sensitive threshold for the initial test.

Q. Why did you think it was important to not miss relapses?

A. Correct.

Q. But why was your -- what was your analysis or thought process on why you thought that was important?

A. Well, relapse -- I thought I testified earlier, but perhaps I didn't. Relapse represents a threat to the health of the pilot. If a person is diagnosed with the illness, then it's acknowledged that reuse of mood altering chemicals, whether it be the

drug of choice or some other drug, can result in reactivation of the disease state and under that state, the pilot's health is put in jeopardy, along with the rest of the airline is substantially. And -- and particularly a relapse is undiscovered that results in a public incident could undermine public support for the program.

Q. Go ahead.

A. I'm sorry. I was going to say an overriding concern is always the safety of the traveling public.

MR. KASSIN: Captain Storbeck, thank you. That's all I had on redirect questions.

RECROSS EXAMINATION

BY MR. SEHAM:

Q. I have -- I have -- I have few questions on re-cross based on what was elicited during redirect. You -- you refer to the cutoff level that's used at the delta program as being a relatively low cutoff level, correct?

A. Correct.

Q. Okay. I'm going to -- do you know what that cutoff level is?

A. I know what it was at the time. It was a 100 nanograms per milliliter.

Q. Okay. And are you familiar with -- so you

must be familiar -- if you consider that relatively low, you must be familiar with the application of a higher cutoff level, correct?

A. Right.

Q. Okay. And what commonly applied higher cutoff level is utilized?

A. Well, there's multiple levels. It depends on -- other airline programs that I'm aware of typically used 150, 200. I believe DOT testing was for like truck drivers and stuff like that was like 400, but I'm, you know, it just depends on -- on how much -- how much reliance you place on that test in terms of what it's supposed to indicate.

Q. Okay. You broke up a little, but I think I heard you say that other airline programs were you using 100, 150, or 200?

A. Depending upon the airline.

MR. SEHAM: Okay. All right. Thank you. No further questions.

THE ARBITRATOR: Anything else, Mr. Kassin?

MR. KASSIN: Arbitrator Burdette, no. Thank you very much, Captain Storbeck.

THE ARBITRATOR: Captain Storbeck, you may be excused. Thank you very much.

THE WITNESS: Thank you, sir. My pleasure.

THE ARBITRATOR: Emily, can you take him out of the out of the hearing room, please?

MR. KASSIN: You could leave.

THE ARBITRATOR: Okay. What's next, Mr. Kassin?

MR. KASSIN: If we can go off the record, I think we should try to get Dr. Jones back on his cross-examination for Mr. Seham.

THE ARBITRATOR: Okay.

MR. SEHAM: All right. Yes. But before we proceed with that, he had done promised us an article that he was going to send us last night and we never received that.

MR. KASSIN: think we may -- I think he may have -- we may have -- let us send that out to you. We're looking for it right now. So hold on.

THE REPORTER: Off the record at 11:10 a.m. Thank you.

(OFF THE RECORD)

MR. SEHAM: All right. Someone with --

THE ARBITRATOR: Mr. Seham's cross-examination of you, Dr. Jones. You're still under oath from yesterday.

THE REPORTER: On the record at 11:22 a.m.

THE ARBITRATOR: Thank you. Mr. Seham, proceed.

///

JOSEPH TIMOTHY JONES, PH.D.,
having been previously sworn, testifies as follows:

CROSS EXAMINATION

BY MR. SEHAM:

Q. Okay. Good morning, Dr. Jones. Would you agree that the scientific literature suggests that it requires multiple servings of ethanol on a single occasion to produce a positive test result?

A. On average, yes.

Q. Just so we can define a term relating to the next question. Would you agree that in the context of testing, the term matrix refers to the substance that you're testing such as saliva, blood, urine, et cetera; is that correct?

A. Correct

Q. Okay. Would you agree that each matrix has its own advantages, disadvantages and limits of interpretation?

A. Yes.

Q. And one, for example, in the context of umbilical cord issue testing, one could have a blood positive in an EtG negative from this sample; isn't that correct?

A. Correct.

Q. Okay. And there really is no answer as to

why these results would differ. Would you agree?

A. There's an answer, but we probably in some instances can't get to the causation. There is an answer somewhere.

Q. Okay. And in your FAQ in talking about -- I'll refer back to it if necessary. But in your FAQ there's this reference that the literature suggests that it requires multiple servings of ethanol on a single occasion to produce a positive PEth result. And I'm wondering why the FAQ would use the verb suggest.

A. The -- the literature that you read, you know, there's more than one paper. When you review the literature in its entirety, and frankly, at this point, it's difficult for anyone to say that they've read all the literature on PEth. Five years ago, I probably read 99 percent of the literature. But now it's -- it's exploded. There's so many papers that talk about the use of PEth just -- just, you don't have enough time in the day. So when you say that the literature suggests, you're -- what you're saying is that the literature that we've made -- been made available to, the literature that were aware of, in its entirely suggests that. And the reason we don't say that -- that it definitively concludes that is that there may be papers out there that have an alternative

explanation for some -- for some of these observations and so you really have to qualify your -- or you should qualify your -- sometimes we're good with that and sometimes we're probably sloppy with that qualification of language, depending on the context.

Q. Very good. Would it be your position that a positive PEth result reflects that an individual has consumed sometime in the past two to four weeks?

A. It would be consistent or that is a reasonable explanation, yes.

Q. So does when that time frame, two to four weeks, does that indicate that it takes some time for the PEth to be generated?

A. No. The -- the-- the phrase I believe is or should be up to approximately two to four weeks. So that could be two hours ago. It could be three weeks, six days, and eighteen hours a go. From a reservoir type specimen, you're not going to be able to discern which one it was. We just no, it was during that really broad period of time.

Q. In terms of setting up the the calibration programs and quality controls in your laboratory work were whole blood samples used?

A. Yes.

Q. Okay. And were anticoagulants used in that

whole blood?

A. Yes.

Q. What kind of anticoagulants?

A. Fluoride oxalate with the grey top tubes.

Q. Were the same anticoagulants introduced into the DBS samples?

A. For the preparation of the calibrators and controls, yes.

Q. Okay. But not into the DBS samples actually tested, correct?

A. Not at the patient samples, no.

MR. SEHAM: Have you talked -- well, I'm sorry. Let me let me skip that. Is Emily with us still? If we could bring up Union Exhibit 28?

(Union Exhibit 28 marked for identification)

Q. Just for the sake of the record, since this is a visual document, it's showing a chain of custody document for USDTL in a plastic bag. Is it an acceptable manner to ship a DBS sample to USDTL in a Ziplock storage bag?

A. It's not recommended, no. Who -- who was the collector -- who was the collector on the sample? I'm familiar with the American Maritime Safety. Who was the collector on this?

Q. I'm not here to answer the questions, Dr.

Jones. If we could move to Union Exhibit 29.

A. Okay.

(Union Exhibit 29 marked for identification)

REMOTE TECH: Mr. Seham, please repeat which exhibit you're looking for.

Q. Yes, Union Exhibit 29. And what we're showing here is an envelope, hopefully you can perceive that it's a bubble wrap lined envelope. Is a bubble wrap lined envelope such as the one depicted here is shipping a DBS specimen to USDTL in an envelope of this nature, is that compliant with USDTL protocol?

A. It is not recommended. It's not a best practice. And -- but we do accept the sample if it was to come like that because we don't know the conditions of the collection. And so the collector -- the collector certifies with their signature that they've collected the specimen properly. And so we rely on that certification when they make the attestation. So we have samples that come to us for all kinds of reasons, for all different circumstances. And so we -- we recommend how to ship the samples, but at the end of the day, the client is responsible for sending their specimens in the way that we ask them to.

Q. Okay.

A. And we make accommodations accordingly.

Q. Isn't it more than best practices actually in the USDTL collection protocol that you must not set the sample in a plastic lined envelope; isn't that correct?

A. Yes.

Q. But your testimony is even if it's received in this condition, that specimen would be tested anyway, correct?

A. Yes.

Q. Okay.

MR. KASSIN: Mr. Burdette, before we go further, I know we have a practice of if you don't object, it's admitted. We're reserving our right to object to Union Exhibits 28 and 29 till there's more evidence about their foundation and we'll wait for an appropriate time on that.

THE ARBITRATOR: Okay.

MR. SEHAM: Okay. I mean, I would like to address that now. They are at this point simply depictions of conditions of a sample and whether those are acceptable under USDTL protocol or not.

MR. KASSIN: I would like some foundation on those in the sense of were they actually sent to USDTL, or are these just hypotheticals -- are these just hypotheticals that are being presented for purposes of hypothetical answers?

MR. SEHAM: Well, I could send you the envelope showing the bubble wrap, and I can show you a -- send you a sandwich bag relating to Union Exhibit 28. This is the purpose of the way to do this. We've sent pictures of samples packaged in some ways, ask the questions we've asked as to whether they comply with USDTL protocols or not.

MR. KASSIN: Okay. And so the point is, I'm just trying to clarify. Were these actually sent to USDTL, or are these just examples of showing Dr. Jones and saying, does this meet your criteria?

MR. SEHAM: Actually these samples, and I don't -- here I'm being asked to testify, and if I'm being asked to testify, I will. These samples were sent to USDTL, but that's not -- that's not relevant to the purpose of why I put these documents into place at this time because the testimony has already been elicited from this witness that they would test the specimen received under these conditions.

MR. KASSIN: Okay. So that was the purpose of -- that was the purpose of your examples?

MR. SEHAM: Correct.

THE ARBITRATOR: Okay. Very good. Let's move on.

BY MR. SEHAM:

Q. Thank you. Now, I want to address the issue

of cutoffs a little more. The reason you said a cutoff concentration of 20 nanograms per milliliter is in part to distinguish beverage alcohol consumption from abstinence or incidental exposure; is that correct?

A. That was -- that was one of the selection criteria, yes.

THE ARBITRATOR: Mr. Seham, excuse me, I just want to say, are you done with this exhibit, this union exhibit? Can we take it down now?

MR. SEHAM: Yeah.

THE ARBITRATOR: Okay.

MR. SEHAM: Yes.

THE ARBITRATOR: Emily, would you please take down union exhibit? Thank you. Okay. That way I can -- that way I can see everybody better.

BY MR. SEHAM:

Q. Thank you, that's appropriate. And you have knowledge of a laboratory that uses a cutoff of eight nanograms per milliliter, but that would be limited to research testing, correct?

A. Research and special request.

Q. Okay. And then the Swedish Laboratory is currently using a cutoff of 35 nanograms per milliliter, correct?

A. I'm not aware of what their cutoff is.

Q. Would you agree with me that none of these cutoffs are supported by a strong evidence base?

A. I would disagree with that statement.

Q. Okay. Now, what does sensitivity, that term mean in the context of DBS PEth testing?

A. Sensitivity refers to how many true positives that you pick up versus false negatives. I think there's a -- there's a -- there's a back and forth between sensitivity and specificity. But just in layman's terms, it's like it describes how many you pick up as you drop the cutoff, and then you started picking up samples that you don't want. That's when it switches from like a sensitivity discussion to a specificity discussion.

So if a -- if a cutoff is too high and you're missing everybody, then your sensitivity is too high and you need to improve it. If the sensitivity is too low and you start picking up people that just use Windex in their kitchen, then your sensitivity is too high and you need to raise your cutoff accordingly. So that's -- that's the thought process behind sensitivity.

Q. And what is the specificity? You referenced it in your answer to the question on sensitivity, but specificity would indicate what?

A. There -- there's -- there's two perspectives on specificity and actually sensitivity as well. But for this context is -- it's -- it's more important. You have the analytical specificity, and you have the clinical specificity. So for the analytical specificity, you want to make sure that when you identify a compound, that it is actually that compound. And if you continue dropping your cutoff increasing -- increasing -- increasing your sensitivity, at some point you run into a place where yeah, you're picking up a lot of positives, but maybe some of them aren't really that compound. And so there's a trade-off between the sensitivity and specificity, but that's analytical in the laboratory. Then there's another layer of specificity about picking up the answers to the question that you're asking of the test, so in other words. If you are asking a question of did alcohol play a part -- did someone say stop?

MR. SEHAM: No, no.

THE ARBITRATOR: Go ahead.

MR. SEHAM: I just turned off my video, you can go ahead.

A. If -- if someone has the research question of -- or the routine question of the individuals showing up in a burn center, is long term alcohol misuse part

of why they're showing up in the burn center? Okay. So -- so this isn't about did you have a couple of drinks last week, or did you have a binge last week and whatnot. And this is about are you a hardcore drinker if you will, and that, you know, most accidents happen at home, et cetera, et cetera. And so when you do a receiver operating characteristic curve, ROC curve, it will point to a value of like -- for a paper that I'm familiar with, a cut off of like 215, all right? And so what that's demonstrating is that someone consistently, but not conclusive evidence of, someone drinking a six pack of beer or a bottle of wine a day, that type of person is going to have a much higher odds ratio or risk -- relative risk factor of showing up in the burn center in Des Moines, Iowa, okay? So that's the question that you're asking there, and that cutoff you choose there is going to increase your sensitivity specificity.

So if you lowered that cutoff, increased your sensitivity down to 20 for that question, all of a sudden you're going to pick up all these other positives. So for all us that had a glass of wine, with dinner, maybe we had a binge watching football last weekend, all of a sudden we're showing up positive, but we're not burning ourselves up in our

house and showing up at the burn center at the University of Iowa Burn Center. And so it -- it -- it's relative to the question that you're asking. So when we're looking at our question with our demographics here, what cutoff do we choose? And so 20 was arbitrarily chosen, just like most of the other cutoffs that we used outside of the clinical situation.

And then the question comes in to, are we picking up the individuals that we want to pick up, and are we not picking up the individuals that we don't want to pick up? And 20 has kind of been -- over time it has proved to be a decent cut off. May it change in the future, it may as more data comes out, or as situations come up, or if someone comes up with a mechanism, or a situation, or a scenario that'll explain blood level PEths. Obviously, the cutoff will be adjusted just like it happened with the EtG urine. And so -- so these are things that you're always evaluating, but you got to have a mechanism to look at to -- to make that evaluation and not just because someone says so.

Q. Thank you for that comprehensive answer. Now, my takeaway is that these different cutoffs represent deferring sensitivity and specificity considerations. Is that a fair statement?

A. That is correct. Can you -- hold a second.

Can you repeat that question, please?

Q. That these different cutoffs represent deferring sensitivity and specificity considerations.

A. Yes. And on different -- in different questions.

Q. Very good. I understand that in context from your extended answer previously given. Now, can you define the term PEth precursor homologues?

A. PEth precursor homologues, I'm not familiar with that term.

Q. Okay. Very good. And the term -- I'm going to butcher the pronunciations. So I'm going to do my best and then spell it out for the record. The term phospholipase D concentrations. I think it's referred to as PLD concentration.

A. Yes.

Q. And it's spelled P-H-O-S-P-H-O-L-I-P-A-S-E followed by a capital D. And I'll refer to you -- actually, would it be appropriate, Dr. Jones, to refer to that as a PLD concentration?

A. Yes. Yeah. You'll see it spelled that way in papers. Well, abbreviated

Q. Can you define the term PLD con?

A. Yeah. From the slides that I showed yesterday, the formation of Phosphatidyl ethanol is

catalyzed by the enzyme phospholipase D. And so that's the PLD that we're talking about here. And so one of the areas of research at this time is that, are there individuals with varying amounts of PLD in their blood? And if they do, does it affect the formation rate? So if you're looking at this as a clinical question of answering is the individual taking their alcohol as their doctor has prescribed or they're abusing the alcohol, this would be an extremely important question to answer along with hematocrit and maybe some of these other items that you will see in therapeutic drug monitoring circles. And not so important in the detection of abstinence because regardless of the concentration of PLD in the blood, there should be no PEth in the blood of someone in the monitoring program. Because they're not supposed to drink socially or casually, they're not supposed to use ethanol containing products. These programs give them a long list of things to avoid dietary and cosmetic.

So well, it's important and it's a very interesting question. And the following to that is something called, in this abbreviation, is the PLC. And so PLC, phospholipase C is an enzyme that breaks down phosphatidyl ethanol. Typically, it does not show up in human blood for most people. But some of the

research that's being talked about is that maybe some people do express this PLC -- for the formation of PLC that exists in their blood because it is in other tissues. And for -- for whatever reason, it's not in the blood of most people. And that may explain some of the wide variance that we see in the half-life in humans of the phosphatidyl ethanol.

So we talked about yesterday that the average half-life is four-and-a-half days and that's been reported for 20 years if you will. But what is also reported is the fact that in humans that half-life does have a wide range, and the wide range of elimination rate may have something to do with PLD concentrations that you're talking about. It may also have something to do with the phosphotid -- phospholipase C concentrations and -- and that work is ongoing.

Q. How about the concept of eliminations?

A. Say that again, please.

Q. Are you familiar with elimination rates?

A. Yes.

Q. Okay.

A. That's what I mean by the half-life.

Q. Okay. And with respect to -- now you say you're not familiar with the term PEth precursor homologues, correct?

A. I -- I -- I think that now in this context, I believe you're referring to the phospho -- phosphatidylcholine and the concentration of the phospholipase D. But I'm -- I'm assuming that's the context in which to use that term.

A. All right. Well, assuming -- making that assumption, with respect to the three concepts you've just addressed, would you agree, and the context being the PEth precursor homologues, the PLD concentrations, and elimination rates, there are inter-individual differences?

A. Absolutely. Absolutely.

Q. And that does -- and does SDTL -- USDTL doesn't make any adjustments in its quantitative report based on these inter-individual differences, correct?

A. No. No.

Q. But isn't it true that it is unknown whether individual differences in these three areas could produce PEth concentrations above the cutoff threshold as a result of incidental alcohol exposure?

A. I'm not aware of any description of that. I am aware of consumption of alcohol giving you higher levels than what you would expect or you being positive longer than you would expect. But I have not seen any data in peer review journals or, you know, under a peer

review situation showing the incidental or non-intentional ingestion of alcohol. I have not seen that. And -- and maybe I've missed it in the literature. Maybe it's there and I just missed it though.

Q. Well, you're answering and I don't tribute any cynicism on your part. But you're answering is --

A. Could you rephrase the question, please?

Q. I'll repeat the question. Isn't it true that it is unknown whether individual differences in the three areas we've discussed could produce PEth concentrations above the cutoff threshold as a result of incidental alcohol exposure?

A. I am -- I -- I don't think I'm aware of that. The way that you phrased that question, I don't think I'm aware of that.

Q. Very good. And would you agree that there is no evidence-based consensus on abstinence cutoffs for PEth and EtS?

A. It depends on your definition of consensus. Is there somebody that has come down from above and, you know, carved on stone that thou shall use a 20 cutoff like -- like SAMHSA does with their urine cutoffs? No. It -- that -- that's not there and it's not there for most other testing in forensic toxicology

either. But just for the 9 to 5 in urine there's recommendations, and suggestions, and over time as more and more people use these things over time, they become market expectations, they become entrenched in the literature. And -- and then over time, is there -- is there a consensus? Yes, overtime and -- and -- and when there's more of a subjective phasing in rather than, you know, at the stroke of midnight after Reagan signed the Federal Drug Free Workplace Act, boom the five panel came into being, it was concrete. These were the cutoffs, this is how you do it. But that's a very, very, very fractional portion of all the forensic toxicology.

Q. Okay. Based on your -- based on your CV, we obtained an article. And I'm sorry. Give me a second here because it's -- I did send a document we recently obtained and I want to make sure I have the right number for it. Give me 60 seconds there. Yes.

And Emily, I'm going to ask you to bring up Union Exhibit 82. This is a new rebuttal exhibit. As I said that it was prompted by a CV reference. We've emailed a hard copy to the arbitrator, and Mr. Kassin, and to Ms. Samuda. And if we could get --

THE ARBITRATOR: Can the board members get it as well, please.

MR. SEHAM: Well, of course. I'd have to search for your -- well, it's going to be up on the screen. I'm only going to ask a couple of questions and then I'll -- I'm not sure if I have the email address for the other board members. Oh, I do. I do. I'll send it to -- I'll send it to the other board members as well. Emily?

(Union Exhibit 82 marked for identification)

Q. Dr. Jones, we have on the screen a research article titled "The roles of phosphatidylethanol, ethyl glucuronide, ethyl sulfate in identifying alcohol consumption among participants in professionals health programs". And you appear to be one of the authors of this article, correct?

A. Correct.

Q. Okay. And this was a fairly recently submitted article, correct?

A. Yes.

Q. I noticed it's copyrighted 2020 at the bottom of the first page. So to the best of your knowledge, have you learned anything since the publication of this article that would cause you to disavow any of the contents of the article?

A. I don't recall anything. I got -- I got a feeling you're going to pointt something out to me.

Q. No, no. I don't -- I guess the article speaks for itself, so in order to expedite the proceeding. But the article refers to biomarker testing study conducted by colleagues. Would that be Gregory Skipper?

A. Yes.

Q. Okay. Would you recognize Dr. Skipper as having some expertise in the area of PEth testing?

A. Yes.

MR. SEHAM: I have no further questions.

THE ARBITRATOR: Okay. Mr. Kassin, any redirect? Mr. Kassin?

MR. KASSIN: I do.

THE ARBITRATOR: Okay.

REDIRECT EXAMINATION

BY MR. KASSIN:

Q. And I'm going to see if we can start with Union Exhibit 82. Emily, put that back up, please. And I'm looking for -- I'm looking for the last sentence in the abstract which is the -- which is blocked out, which is black, kind of the blacker -- the darker, the gray area. Okay. Dr. Jones, if you can see what's on the screen for you that last -- okay. I got it. Part of the abstract, what you have in there -- okay. Just focusing on the last sentence. "In this

study, blood PEth was the most sensitive biomarker for evidencing alcohol use." Do you agree with that statement?

A. I would agree with that statement and that has been one of the reasons that PEth is becoming more and more popular over time. You know, if -- if self-report and breath alcohol and urine alcohol and EtG and urine were -- were 100% adequate for the question these guys are trying to answer, nobody would have bothered with the time and expense to develop PEth. But there were -- there were significant limitations to using those specimens. And the -- the authors on this paper at the University of Florida, specifically the Florida Recovery System, which is a major residential and outpatient treatment center that does a lot of work for the Florida physician in that program, they put a lot of intakes of physicians. It's not just in Florida, but around the country. They'll fly in from other states, they'll do the intake evaluation. And so as I mentioned yesterday, at any given time, alcohol use disorder is four times, if not more, of a bigger public health concern than the drug use. But typically that's what they -- they -- they come in for. It's very common for people to be sent for a -- a drug use issue, if you will. And you've got

this underlying alcohol problem and if you don't get it, all of it, you'll -- you'll not help the individuals recover.

And so these types of tests are very important for these individuals to do their recovery work. And so when -- PEths, they were some of the earlier doctors to PEth. And -- and frankly, these guys have pressured me to lower our standard cutoff to eight. And we've been really hesitant out of an abundance of caution to do that. And so just for research, do we typically offer an eight cut off for PEth. But when you compare this with all of their clinical data that they have, with these individuals on the intake and on their recovery progress and -- and -- and collecting multiple specimens including self-reports over time, this is the conclusion that they drew.

Now clearly, I'm not there doing the evaluations and the intakes. That's -- that's a whole different aisle in the grocery store from where I -- I run. I -- I kind of have to stay in my lane on this. And so my -- my contribution to this paper was that I assisted with the analytical portion, making sure that -- that the specimens were received at USDTL and that we analyze them and put the data together in an Excel spreadsheet form, so they didn't have to do that and --

and then write the analytical portions for the paper. So that was my role here, but clearly they're the clinical people. But this was their conclusion.

MR. KASSIN: Emily, I'm going to ask you to go to page 6 of 7 of the PDF that you were sent and I'm looking for where it says conclusions. I'm having a little trouble with my document loading, but I believe it's on page 6 of 7.

THE ARBITRATOR: And this is a different document, Mr. Kassin?

MR. KASSIN: Same document, Union Exhibit --

THE ARBITRATOR: Oh, same document. Okay.

MR. KASSIN: -- 82, sir.

THE ARBITRATOR: Okay. Thank you.

MR. SEHAM: I'm sorry. Did you say page 7?

MR. KASSIN: No, I said page 6 of 7. And Emily, if you could blow up just a little bit that paragraph that says conclusions, and bring it -- there we go.

BY MR. KASSIN:

Q. So Dr. Jones, can you see that on your screen?

A. Yes, I can.

Q. Okay. And that last sentence, "The combination of the relatively slowly eliminated PEth, and the relatively eliminated EtG and EtS improves the

ability to detect past 60-day plus alcohol consumption and may suggest possible chronologies of recent drinking." You agree with that statement?

A. You know, that's kind of outside of my wheelhouse. But that's what these guys are kind of telling me with the work that they do. So I -- I don't have a direct knowledge on that kind of a takeaway. You would need to rope in Dr. Teitelbaum and Dr. Reisfield on that. The feedback that I get from the field from individuals like Dr. Reisfield and Dr. Teitelbaum, Dr. Lewis and others is -- is that they find real value with the PEth. It helps them get to the bottom of a lot of situations. And it -- it gives them another valuable tool for their tool belt to do what is a very difficult job and -- and it's one that -- that I don't envy that they do. And it's recognized as a very valuable tool.

Q. Okay. Emily, if you can go to page 2 of 7 of the PDF company -- or Union Exhibit 82, please. Okay. Dr. Jones, if you could see the paragraph that starts the word most PHP, you see that --

MR. SEHAM: I'm going to -- I'm going to object at this time. The document either speaks for itself or doesn't, either accepts authorship or not. We submitted this document into the record. We did not go

through this process of taking out a sentence here and a sentence there because we believed there was -- at this stage in the proceeding where we may not finish in three days, it would be appropriate just to put it into the record and confirm his authorship thereof. I would object to going through this sentence by sentence and cherry-picking out sentences to be read into the record because this document is in the record now.

MR. KASSIN: This is actually my last -- this is actually my last question and --

MR. SEHAM: I withdraw the object -- I'll withdraw the objection. Go ahead for the sake of expediency. Go ahead.

Q. Okay. Dr. Jones, can you see the sentence that starts, "Most PHPs use EtG as the analyte of choice for detecting alcohol consumption." Do you --

A. Yes.

Q. Do you agree with that statement?

A. I -- I think so. I think that at this time EtG in -- in urine is -- is -- is -- is more prevalent in PEth. It certainly is in my laboratory, but I can't speak for all laboratories. But EtG had like a seven-year headstart on PEth. So it takes time for -- for these new innovations to become adopted. So I -- I kind of thinking it -- I think I would agree with that

statement, yeah.

Q. Emily, I would ask you to turn to what was originally introduced as Union Exhibit 1 and I think we just need the cover page for Union 1. This was one of the initial questions that you had Dr. Jones, and you started to tell Mr. Seham that you had found it on your own. Can you give us the background of how you found that and why?

A. Yeah. When I received the -- when I received the subpoena from -- from Mr. Seham, it kept referring to Capiau table 1 and Capiau table 2. And -- and so I'm sitting here thinking," What -- what's a Capiau table?" Is that some legal Latin term thing?" And so I'm looking it up in the Latin dictionary and it's not coming up, and I'm just trying to figure out what is a Capiau table. And when you look it up, it's Portuguese, and it means table in Portuguese. And so I'm like, well, what is he talking about? A table -- table -- table -- table 1 and a table -- table 2. As they were going through the -- the -- if you look at the subpoena there, you know, items from Capiau table 1 and this -- this -- this -- this in Capiau table 2. So I was really confused because a lot of the questions on the subpoena were just like out there and just had nothing to do with anything that we had talked about or

considered that was important or relevant in the validation of the test.

And while I was looking up the word Capiau, Sara Capiau's name came up and I was like, and I saw she was PharmD and I went, again, and I looked up her name and boom, this paper shows up. So it's -- it's almost incredible that this is -- is put in today after I kind of came through it, through that kind of -- just trying to figure out what a table -- table was in the subpoena. It's kind of funny.

But then what I noticed was that almost in order down the list of the subpoena are the validation considerations recommended in this recent paper. And so then now I had a understanding of the context, and it's like oh, okay, so now this is why we're talking about hematocrit, this is why we were talking about volcano effect. This is why we're talking about this and that and the other thing.

And so after reviewing this paper and -- and -- and -- and -- and, you know, at first kind of insecure, I was like oh my God, if we missed all this stuff and, or we negligent in some way. And -- and so -- so you look at the date and of course, the -- the date is much more recent than -- than what we -- I had offered. This is a -- this is a document though that is written for a

very, very different reason than for what we're doing and for different compounds than what we're doing. And so this is kind of interesting in that, this is for therapeutic drug monitoring -- therapeutic drug monitoring. And this is for compounds that are in solution in the blood.

And so -- so for things like anti-rejection drugs, those concentrations like following a kidney transplant, we'll say, those concentrations in the blood need to be in very, very tight parameters or it's not enough or too much and it's lethal, and so they have to be monitored in a very, very tight window. And one of the ways to help make that testing more efficient would be to move it from the whole blood to the dried blood spot. And so that's just one example of many -- one of the -- if you track some of the journals, one of the things that you see repeated over and over again over the last, I don't know, five or seven years, all of these new assays migrate into DBS. So this is -- because now the instruments are sensitive enough to do a punch out in a dried blood spot. And -- and -- and so it's an option now that we didn't have you know, 20 years ago.

So the difference here is -- is that this is talking about a clinical therapeutic drug monitoring

test. So going back to an example I used probably a couple of times today and yesterday, was that these are for tests where you're monitoring if the patient is taking his alcohol as prescribed by his physician, and is his alcohol level sufficient to do the job that the drugs are supposed to do. So this is a very, very different question than abstinence or not. Verification of the abstinence or not. And so if it's negative, the test that we offer in the test, the question that we validated the test and answer was, if it's negative, it's consistent with abstinence, but it's clearly not conclusive evidence of abstinence. But if it's positive, now we need some reasonable explanation as to why it's positive, and the numbers are relevant for a second reason.

And so I mentioned before that these therapeutic drug monitoring are typically for compounds that send solution in the blood. So they're in solution in the liquid. So things like hematocrit, how concentrated is the solid matter in a blood sample? Is it 40 percent? Is it 60 percent? That's going to kind of affect how much liquid hits the paper, all right, and how it spreads. And so you get concerns about volcano effect and hematocrit effect, and those kinds of things. In a abstinence test that's kind of irrelevant. A 60 and a

600 for a question that we answered here, it's the same result, it's positive, and we need a reasonable explanation.

I had a binge watching NFL last weekend, now we got a reasonable explanation. I've been using Purell, not a reasonable explanation. You're not supposed to use Purell. I was pumping gas at the gas station, not a reasonable explanation. Because I say so, that's not a reasonable explanation. And so I have not been personally involved in anyone giving me a reasonable explanation that can be reproduced and supported in the literature so far, and -- and I'm still waiting for that. But the compound that we're looking for why the hematocrit appears to not be of issue, is that we're not looking for something dissolved in the liquid like we would of blood cocaine. We're looking for something that's actually incorporated into the solid matter, the red blood cells -- the blood cells. And so this is kind of a different thing. And so even though blood is considered a dynamic matrix, kind of like a blood alcohol, breath alcohol, that kind of a thing, what's going on in the blood is what's going on in person. These reservoir matrices things accumulate over time, and you have different formation rates, you have different elimination rates. So it really comes down

to a yes, no answer at the end of the day, even though there's a number associated with it.

And so this paper here, which is very interesting and -- and I read it with a lot of interest, so there's probably some experiments that I'm going to do to just to see what influence that it may have. It may help answer some questions, it may not. But this paper is written for a very different field of toxicology than what we're talking about. There's another paper that came out in 2016 that was talking about hematocrit, that was talking about dried blood spots, and what they demonstrated in their literature was that the effect of the hematocrit, e -- effect of -- of location of the punch across this spot had a negligible effect. And that's probably -- and that's the most reasonable explanation to me is that, because we're not talking about what's dissolved in the liquid, we're talking about what's actually incorporated in the solid material. And I wish I could remember the name of that author, I -- I saw it just the other day, but I remember it was 2016, and it came from some of the researchers over in Switzerland and Germany, I remember that. It may even be part of the union exhibits here. They got a bunch of papers.

Q. Dr. Jones, you were asked two specific

questions with respect to Union Exhibit 1. And I'm going to ask Emily to turn to Page 416. It's about the eighth page in, and the number 416 at the bottom, and highlighting the sentence under the bold words, analytical validation.

(Union Exhibit Number 1 marked for identification.)

Q. There you go. And if you could blow up analytical validation. Dr. Jones, you were asked whether you agreed with that statement under Analytical Validation and you said you did not. Can you explain why you did not?

A. Yeah. The bioanalytical validation guidelines that have been followed for decades were written in general for all specimen types. And so, you know, there's not a specific analytical guide for doing hair. There's not a specific analytical guide for doing fingernail. And so for urine, there is because you do have a national program that is a large program, but it's extremely limited in scope, although it is large. And so the -- if you look at the FDA guidelines for biological method validation, it is not specific for dried blood spots. It is not specific for urine either. It's not specific for blood. It covers all of them. And so if I was doing breath testing, I would still use those guidelines as -- as a mechanism. Now

what these authors are -- are saying is that for the purpose that they are trying to use these for, one of the analytical validation guidelines -- by the way, this is -- if I'm not mistaken, this is a European paper, and they're operating under the EU. There's an EU document for method validation, which we -- we pull some from there as well. They have a really neat thing called identification points that we sometimes use. In the EU, in the FDA, in the Federal Register for CLIA, even in SWGFTOX; Scientific Working Group for Forensic Toxicology, I'm not aware of, and -- and I've read through them and I don't recall where they have specific stuff that has to be done for specific specimen types. But this is the power of this paper and I agree with this paper for what they're trying to do because for the things that they're wanting to use this for, the effects that's listed in one of these tables following here could make a big difference if you're doing clinical monitoring of someone, say like they're, you know, they're immunosuppressant drugs that they're using following a transplant.

MR. KASSIN: Okay. And Emily, if you can go to the next page, which on the document is page 417 of Union Exhibit 1. And we're looking at the chart at the very top that says Validation Parameters.

THE WITNESS: Yes.

Q. And Dr. Jones, you were asked if you agreed with that and you said you did not. Can you explain that?

A. Yeah, he asked -- he -- he -- asked me was it true that we did none of these validation and -- and I've disagreed with that because we certainly did a recovery, to matrix in the process, extraction efficiency. That's part -- part of -- of any validation that you would do. What we did not do were these other three: the volume effect, the hematocrit effect, the volcano effect. Mainly because these -- these parameters and variables are irrelevant for the question that we're asking.

Q. Okay. And Emily, we're finished with Union Exhibit 1, so you can please take it down if you would. So with respect to the questions you were asked on validation data, did your validation data include all of the recommendations included in the guideline documents for forensic toxicology laboratories?

A. Yes.

Q. Are you familiar with SWGFTOX? It's spelled W-S-G-F-T-O-X [sic]?

A. Yes. The Scientific Working Group for Forensic Toxicology.

Q. Okay. And did your validation data include all their recommendations?

A. Yes.

Q. Are your validation records and data available for review if an expert wanted to come on site to review it?

A. Yes.

Q. Okay. For example, the arbitrator want to come to Chicago and review your validation data, he could do so?

A. Yes.

Q. And do you recall -- did Mr. Seham ask to review this data?

A. He asked for copies of it, yes.

Q. Okay. Was he permitted to come on your property and review your standard operating procedure in the process of the laboratory?

A. Yes.

Q. Okay. And did that happen?

A. No.

Q. Okay. I think you may have covered it in your additional cross-examination, but you were asked some questions about half-life and mentioned the average of 4.5. But what is the range of half-life of PEth?

A. In the published literature -- I kind of brushed up on that before this testimony. In the published literature, you'll see anywhere from 3 to 14 days as a range of elimination half-life. And -- and I have seen in presentations at scientific conferences and posters where it ranges from 1 to 14 days. And -- and so just to -- to keep an open mind about it, I used the widest range that -- that I've seen presented in the -- in the community.

Q. Is it possible to know any one individual's half-life?

A. Not without some experimentation. And another question that would follow onto that would be: Does the half-life change over time? And -- and so we -- I don't know the answer to that question neither.

Q. Okay. Do you know from the scientific literature whether it's been established that alcoholics, people alcohol dependent, heavy drinkers, have a shorter half-life of PEth because of their ingestion -- the quantity of alcohol they've been ingested?

A. I -- I have seen that, but I'm -- I'm not really up-to-date on that. But I have seen that.

Q. I was asking you questions about your validation data and your standard operating procedures.

Is it common for laboratories to not allow their standard operating procedures out of their offices?

A. For private laboratories, that's a standard practice. If you're dealing with like a state crime lab or Highway Patrol or State Police lab, they're public entity and their -- their documents are not proprietary documents. But a privately owned laboratory, that's -- a standard practice has not let those proprietary documents leave the premises.

Q. Okay.

A. There's -- there's truly an absence for shenanigans.

MR. KASSIN: Mr. Arbitrator, I'd like to ask permission to mute and just check -- I think we're done with the redirect.

THE ARBITRATOR: Okay. Go ahead.

MR. KASSIN: Arbitrator Burdette, I'm back, but I've looked for Mr. Seham though.

THE ARBITRATOR: He's there, but he's not on the video.

MR. SEHAM: I'm sorry. I'm here. Let me figure out I'm trying to -- I have documents and --

THE ARBITRATOR: Okay.

MR. KASSIN: And Arbitrator Burdette, we're done with our redirect questions for Dr. Jones at this time.

THE ARBITRATOR: Okay. Mr. Seham, any re-cross?
MR. SEHAM: Yes. Just a few questions.
THE ARBITRATOR: Okay.

RECROSS EXAMINATION

BY MR. SEHAM:

Q. Dr. Jones, SWIGTOX, that would be S-W-I-G-T-O-X, correct?

A. S -- S -- S-W -- Scientific Working, Yeah. Yes.

MR. KASSIN: I believe it's --

THE WITNESS: They changed their name a couple of years ago. They don't go by that anymore. But, yeah, they have.

Q. In fact, that's an industry working group, correct?

A. Yes. And it was organized by the Department of Justice.

Q. Okay. And it was -- and it was dissolved in 2014, correct?

A. It was -- it was evolved into ODACS, which was a much bigger project, I believe.

Q. And isn't the current standard American Academy of Forensic Sciences, AAFS, standard practices for method validation in forensic toxicology?

A. For AAFS type work, I would assume so. I'm

-- I'm not involved with that group. I'm involved with the Society of Forensic Toxicologist. And -- and so not the AAFS. AAFS is a much bigger outfit. They deal with like ballistics and fingerprints and that kind of a thing. And toxicology is a very small sliver for what they operate in so -- but we operate in the Society of Forensic Toxicologist surface.

MR. SEHAM: Emily, if you could put up UX 83, Union Exhibit 83. It's not 83. I don't think so. I'm looking for 82. I'm looking --

MR. KASSIN: The new one. Okay. 82.

Q. Yeah. All right. If you could go up to page -- the first page. With respect to the -- your co-authors here, Gary Reisfield, Scott Teitelbaum, Shannon O. Opie, Deborah Morrison, Ben Lewis, would you consider them qualified professionals in their fields?

A. In their fields, yes.

Q. Okay. And would you consider them to have professional integrity?

A. Yes.

Q. Did they publish this document with your name on it without giving you a final draft for review?

A. No. I had an opportunity to review the document, yes.

Q. And you had an opportunity to suggest any

revisions and make any changes you desired, correct?

A. I did.

MR. SEHAM: No further questions.

THE ARBITRATOR: Mr. Kassin?

MR. KASSIN: No further questions here either.

THE ARBITRATOR: Okay. Thank you very much. Dr. Jones, you may be excused. Thank you very much.

THE WITNESS: Thank you. Have a good day.

THE ARBITRATOR: You too.

MR. KASSIN: Mr. Arbitrator, can we go off the record and talk about what's next?

THE ARBITRATOR: Sure. Yeah. Go ahead. We'll go --

(OFF THE RECORD)

THE ARBITRATOR: Do you swear or affirm that the testimony you're about to give in this case will be the truth, the whole truth, and nothing but the truth?

THE WITNESS: I do.

THE ARBITRATOR: Thank you very much. And additionally, I have to ask you if there's anybody else in the room with you?

THE WITNESS: There is not.

THE ARBITRATOR: Okay. And you don't have any reference material other than the exhibits that are in evidence for this case, right?

THE WITNESS: No. In fact, I -- because of the power outage, I don't have any exhibits up in front at the moment.

THE ARBITRATOR: Okay. Very good. Thank you. Mr --

THE ARBITRATOR: I have enough power on my laptop if need be to call it up there, that might be easier, but -- or you can show it.

THE ARBITRATOR: Okay. Mr. Kassin, proceed.

MR. KASSIN: Sure. Let me let me ask you a clarification, Doctor. Dr. Sample, we're going to ask you to refer to five or six, maybe seven pages in the request documentation package. Are you able -- are you able to refer to those?

THE WITNESS: Yeah. So give me just a second while I power up my -- it's actually powered up. I will --

MR. KASSIN: Yeah.

THE WITNESS: -- and wake it up from being asleep and call up the documents. So bear with me for just a second.

MR. KASSIN: And we have a host on board on this from StoryCloud and they're helping with this. So if you were to say, please go to handwritten page X, the host will put that up on --

THE WITNESS: Okay.

MR. KASSIN: Okay. I'm ready. With that, I'm ready to proceed.

THE WITNESS: I'm not quite ready.

MR. KASSIN: Okay.

THE WITNESS: I have the documentation package up. And I believe the CV is the only other document that we will be referring to; is that correct?

MR. KASSIN: That's correct.

THE WITNESS: Let me get that up as well.

MR. SEHAM: I don't know -- just to help expedite things, I want to disclose that I would be referring to Union Exhibits 78 and 79. I don't know if it would help, Dr. Sample. Those got emailed to him or --

THE WITNESS: Yeah. No, I -- I -- I don't -- I don't have that so --

MR. SEHAM: Okay.

THE WITNESS: I just shut down Outlook again. So if you heard the -- all those reminders popped up for the meetings that had been attending via my iPad so -- okay. I have the two documents ready so I'm ready whenever you are.

BARRY SAMPLE, PH.D., D-FTCB,

having been first duly sworn, testifies as follows:

DIRECT EXAMINATION

BY MR. KASSIN:

Q. Sure. Dr. Sample, I'm going to ask you some introductory questions. If you will, please state your name for the record.

A. Sure. It's RH Barry Sample.

Q. Okay. Dr. Sample, who are you employed by?

A. Quest Diagnostics.

Q. Tell us what your position is with Quest.

A. I'm the Senior Director of Science and Technology for the Employer Solutions business at Quest Diagnostics.

Q. How long have you held that position?

A. I've been with Quest Diagnostics for -- since 1991. So over 29 years now. Was the doctor of science and technology in 2000, 2001 and I've been the senior director of science and technology for the last several years.

Q. All right. How would you describe --

A. Essen -- essentially the same roles and responsibilities, just a change in title.

Q. Okay. And briefly tell us what your responsibilities are in that position.

A. I'm primarily responsible for leading research and development efforts, looking at new science and technology for our business. Responsible for managing something we call the drug test index,

which is an annual report on workforce -- the results of workforce drug testing. I'm also the laboratory director under the College American Pathologist Forensic Drug Testing Accreditation Program for our Kansas facility and hold several state licenses there. And I'm also the CLIA laboratory director for our Philadelphia laboratory, or West Norriton Laboratory, where the testing in this case was performed.

Q. Okay. Briefly tell us what your educational background was.

A. So I have a PhD in Pharmacology from Indiana University, which I earned in the end of 1977. Sorry. Sorry. That was -- that was the undergraduate degree, the bachelor's in chemistry. But the doctorate in pharmacology was 1985.

(Company Exhibit Number 14 marked for identification)

Q. Sure. And I'd like to refer to Company Exhibit 14, which is your curriculum vitae. And ask you, is this just an accurate reflection of your laboratory experience, your licenses, your academic experience, your awards, and all the items covered?

A. Yes, it is.

Q. Okay. I'd like to just go right into the Quest documentation package, which is Company Exhibit 9. And what I'd like you to do is to explain to the

arbitrator and board members, the key pages and in doing so, covering who's sample it was, the date that sample was taken, the chain of custody, the initial test results on the EtG and the confirmatory tests that were done after the initial results.

A. Sure. So I'll start with a description of the receiving protocols before actually jumping into any specific pages in the documentation package. So the specimens are received under chain of custody. There's the chain of custody form and the specimen container, which in a sealed specimen transportation bag. And then those are transported either by a Quest courier or FedEx or, you know, some of the traditional couriers who are laboratory. Upon receipt of the specimen at our laboratory, the specimens are initially sorted, still in their specimen transportation bag based on the type of testing as a regulated drug test, as a non regulated drug test, as a different specimen type.

After that pre-sort process, the specimens are delivered and handled by the specimen processors in the accessioning area where each one of those specimen transportation bags is opened one at a time. The custody and control form or CCF, and the urine specimen bottle are removed from the bag. The two are compared

to ensure that the identification on the specimen bottle matches that on the accompanying custody and control form and to look for any evidence of tampering, is the seal is intact, for instance. Are those -- are there other evidence of tampering with that sealed specimen container. If there is evidence of tampering, then those specimens would be set aside and ultimately that specimen rejected as being suitable for -- for test for any irregularities. If no irregula -- irregularities are identified, then we can continue on with the testing process. So I will direct you to the handwritten page number 6. So if you look at the handwritten numbers at the lower right-hand corner. So page number 6 is the custody and control form. So let me know when you're ready.

THE ARBITRATOR: I believe that Candice is putting it up on the screen right now. And Candice it's on the lower right of the page.

A. So if she's looking at it as a PDF, It's page 7 in her PDF number in there. There you go. That's it. So this is a copy of the custody and control form that was received with the specimen when it arrived in the laboratory. The left-hand corner of the form, you see a bar code and human readable numbers underneath it. The first eight digit number corresponds to the

client account number. The following seven digits are the specimen ID number. And that's the information that is compared to the bottle during the accessioning process. You'll see over on the right-hand side a label that has been affixed to the form, that's what we referred to as an accession label.

So after logging the specimen into our laboratory computer system, a accession number is generated. And during all testing of the specimen, we refer to the specimen not by its specimen ID number that you see on that left-hand side, but by the laboratory accession number. And the laboratory accession number for this specimen is 675976T, as in Tom. The -- the -- the exact information that is ultimately recorded sometimes varies from customer to customer but in this case, you see there's an ID number. So it's identified presumably as a different ID number, is not enough digits for a Social Security member as being 404185.

And the specimen that was -- that arrived at the laboratory was identified as being provided by donor, Mike Danford. So last name Danford, first name Mike. A little bit further down, it indicates the test that was requested. So you see that the SAP 10-50/2K-3+EtG1 is indicated. So the specimen was submitted for screening for drugs of abuse, 10 panel

drugs of abuse, as well as testing for EtG or ethyl glucuronide. The collection location is identified on the form as well as the collector telephone number and fax number.

Step 2 is completed by the collector indicating that temperatures and range at the time of collection, a split sample collection. Skipping down to step 4, you see the signature of the collector and the date and time of collection and the mode of transport which is indicated by the collector.

Immediately below that, there's a section that says received the lab. So you can see that Kelly Toner is the individual working in the West North laboratory who received the specimen. So she would have been the one doing that initial accessioning process, opening the bag, so she signed her name, printed her name, the date that she received it is indicated, and that we are releasing the specimen to an internal specimen chain of custody document. So this would have the external specimen chain of custody once that the CCF is received at the laboratory.

And I'll also draw your attention to the section just on the immediate right to that where it says specimen -- primary specimen bottle seal intact and the yes boxes checked. So that is affirmative notation by

the collector that there was no evidence of tampering with the specimen when it arrived in the laboratory. And then the lower section is, is step 5 would've been completed by the donor at the time of collection.

Okay. So the next step after accessioning the specimen would then be to transfer the specimen. That would be a group of specimens that were received at the same time for aliquoting, that's the -- aliquoting is the phrase or term of art that's used for describing moving a portion of the original specimen for testing. So when testing occurs in the laboratory, when you don't have that addition -- the raw sample, the complete sample with a specimen bottle, go into the testing section of the laboratory. Whenever testing occurs, a portion of that original specimen is removed for testing purposes. So that aliquoting process also occurs following chain of custody protocols. In this case, both immunoassay screening tests were performed as well as on a separate portion of that original specimen a test for EtG -- screening test for EtG.

So to do those two tests, our option would have been to aliquots that were prepared. The results of the immunoassay screening for the drugs of abuse were all negative. Also part of that process we performed test for specimen validity such as creatinine and pH,

and all of those were found to be acceptable. We skip down now to the results of the EtG screening test on -- I got a page here for you. Okay. So the first set of screening results for the EtG can be found on page 63.

MR. SEHAM: Are you referring to the hand letter 63?

THE WITNESS: Yeah. Always a hand numbered, sorry. So on the PDF it would be 64 if you look. Yeah, right there. Would it be easier if I referred to the handwritten number or the number on the PDF there? Which you would you prefer?

MR. KASSIN: I think -- I think the handwritten number is something we could all relate to.

THE WITNESS: Okay. So you see the sample name is 675976T, which corresponds to that laboratory accession number that was assigned during the process. While there is a positive result at or above, the test of 100 nanograms per ML, the result was 126 nanograms per ML. The specimen met identification criteria. You can see list the expected ion ratio and the calculated ion ratio. And there's a little checkbox indicating that that ratio confirms the ID. And if you look at the retention time, you see that the calculated retention time is 0.79 minutes and expected retention time is 0.81 minutes. All of which are within acceptable

limits. The internal standard also met criteria. However, in the opinion of the analyst dropped down just a little bit to where you see those peaks in the chromatograms. In the opinion of the analyst and the people doing the data review, they felt that the chromatography there was not totally within -- there wasn't quite symmetrical, wasn't quite as clean as it.

As a result of that, they scheduled this specimen for reanalysis on a times two dilution. It's not unusual sometimes maybe to have some other substances in the specimen that might be closely alluding. They come off of the chromatography column at roughly the same time and oftentimes, forming a -- on dilution will resolve that issue. Number ID criteria in the judgment of the people reviewing it, they thought the chromatography was less than ideal, so they rescheduled it. The rescheduled analysis results can be found at the bottom of handwritten page 76. So again, sample name 6759716T.

MR. SEHAM: I'm having -- mine goes up to 74 and then starts getting re-paginated at 10.

MR. KASSIN: Mr. Seham, we're referring to the hand -- there's some hand written number on the bottom right-hand page.

MR. SEHAM: Yes. I know mine goes up to 74 and

then begins at 10 again. I guess -- I guess it's been duplicated twice. Okay. I -- it looks like I've got two packages in one. So 76. Number 76 now?

MR. KASSIN: Correct.

MR. SEHAM: Okay.

THE WITNESS: So we are all on the same page?

MR. SEHAM: Yes.

BY MR. KASSIN:

A. Okay. So sample name 675976T, retention time are acceptable. 0.76 -- sorry, 0.78, expected retention time measure 9.78. ion ratios are acceptable. The concentration on this analysis was a 116 nanograms per mL. Also still above the cutoff that's applied for the initial test. Specimen would consider to be presumptively positive for ethyl glucuronide. While we're using what are considered to be definitive methods, screening for EtG because were doing chromatography, mass spectrometry, mass spectrometry. Even though you using that definitive technology, we still always perform confirmatory analysis on another portion of that original urine specimen in order to reconfirm or confirm those results that we had on the initial testing.

Another thing that in the case of EtG that is done with our confirmatory analysis is that we include

testing for EtS or ethyl sulfate. Go to that page. Bottom of page 107. Right-hand corner. Okay. So this is our confirmatory analysis for EtG and EtS on a different portion of the original specimen identified by laboratory accession number 675976T. The slight difference in the the format that you see here is that we have results for both EtG as well as EtS. So the EtG met identification criteria both in terms of retention time and the ion ratios. It was considered to be identified and it was identified at a concentration of a 117 nanograms per ML, which is again at or above the cutoff applied for the specific test that was requested. In the case of EtS or the ethyl sulfate, while you see a calculated concentration of 41.4 nanograms per ML and the expected retention time matches the actual retention time measured. The ion ratios did not meet criteria. EtS was considered to be negative in this analysis for EtG and EtS. Subsequently the specimen would've been reported positive only for EtG.

Q. Okay. Go ahead, Dr. Sample.

A. Just going to direct you to the laboratory report or a copy of the laboratory report, handwritten page number 111. So this laboratory report, you see the -- the client number, the upper left-hand corner,

which is corresponding client number that was on the accompanying CCF. The requisition number or specimen ID number 8372382, the same that was on that CCF donor name of Mike Danford and laboratory accession number of 675976T. If you scroll down you can see that the results of the specimen validity testing, and nothing is abnormal there, and the results of the immunoassay testing for the drugs of abuse, and all of those results are negative, and the Ethyl Glucuronide was reported as positive at the cutoff of 100 nanograms per ML for the screening and 100 nanograms per ML for the confirmation, the Ethyl Sulfate was reported as negative and the concentration of the EtG and we'll -- reporting always rely on the confirmatory level for reporting concentration is 117 nanograms per ML.

Q. Okay. And based on the laboratory analysis, there's no doubt that Mr. Danford's urine sample of May 1, 2018 was positive for EtG?

A. What I would say there, there is no doubt that the specimen identified as being provided by Mr. Danford was reported positive EtG concentration of 117 nanograms per ML. And both the laboratory, as well as my subsequent review of the documentation package indicates that it was all done in compliance with the applicable policies and procedures.

Q. Dr. Sample, as you testified the EtS was reported negative, but you're not required to have a positive EtS in order for the EtG to be positive, are you?

A. Not at this concentration of EtG that was found. That is correct.

Q. Is it relatively common in your experience that EtG is present at low concentrations and EtS is negative?

A. That's -- that's quite common. That's not unusual at all which is why for concentrations of EtG less than 500 nanograms per ML, we do not require the presence of EtS. So above 500 nanograms -- at or above 500 nanograms per ML of EtG, we would expect EtS to always be present, but at concentrations below 500, we don't have that expectation.

Q. And I noticed also on this page 111, which is the report you're just referring to. There's a reference to creatinine. Does Quest normalize EtG to creatinine and if not, why not?

A. No. So no, we -- we do not normalize an -- and this was quite frankly, true for all of our drug testing, our reporting is based on the absolute concentration that is measured. Cutoffs are based on the concentration, not a normalization to creatinine or

any other substance that may be present in the urine. And while others, for instance, Medical Review Officers or other people that are reviewing and interpreting the results may use such a ratio, that's not part of the administrative criteria commonly used by laboratories such as ours for reporting results.

Q. So is it -- do you know of any laboratories in the United States that normalize ETT -- EtG results for creatinine?

A. For -- for reporting purposes? I'm not aware of any, in the US.

Q. One second, sir.

A. Sure. I can't hear, Tom.

MR. KASSIN: I'm back. I'm sorry. I just wanted to check. Dr. Sample, that's all the questions we have for you on direct examination. Mr. Burdette, we're done with our direct, sir.

THE ARBITRATOR: Thank you. Mr. Seham, cross examination?

MR. SEHAM: Yes. Good afternoon, Dr. Sample.

THE WITNESS: Good afternoon. How are you today?

MR. SEHAM: Just fine, and yourself?

THE WITNESS: Well, if I had power, I'd be better, but I'm -- I'm good. I appreciate everyone's flexibility. I'm with the tablet testimony here.

CROSS EXAMINATION

BY MR. SEHAM:

Q. So we're all doing that form this these days. You -- just referring to your some of your recent testimony. You referred to, if I recall correctly, you testified that it was the applied cut off that was requested. Did I understand that correctly?

A. Yes.

Q. And who requested that you apply -- and when you were referring to the cutoff, you're saying you're referring to 100 nanograms per milliliter?

A. That is correct.

Q. Okay. And then who requested that you apply that cut off?

A. Our customer specifies the cutoffs that they wish to use. We -- for the drugs of abuse for EtG, we may offer a variety of both screening or initial testing cutoffs as well as confirmatory cutoff. So, you know, if you look back at the custody and control form that was on, what, page 6, if memory serves me. So while the cutoff isn't necessarily indicated, that panel number 22898 profile, which includes both the substance abuse testing panel as well as an EtG tests, correspond to specific cutoffs to -- to utilize.

MR. SEHAM: But I want to make sure that the system

is functioning. I now only see myself and nobody else is on the screen.

THE WITNESS: Yeah. I see a circle over your face, so it sounds like there's a -- it looks like there's a bandwidth problem somewhere.

THE ARBITRATOR: Mr. Seham, are you still not seeing everybody else?

MR. SEHAM: No.

THE ARBITRATOR: Okay.

BY MR. SEHAM:

Q. So you requested the applica -- cutoff?

A. Yes. It's a -- it's our customer. It's our customer that selects the cutoff to be applied.

Q. Would you -- to my -- Attorney Kassin, as -- as scientifically --

THE REPORTER: Mr. Seham, you're breaking up. We couldn't hear the last part of the statement.

MR. SEHAM: The pictures are going in and out. So I'm concerned about -- is that just happening to me?

THE ARBITRATOR: Yes, Yeah. You're -- you're fading in and out on our screen. We've got everybody else solidly.

MR. SEHAM: Well, I don't know -- I just have audio. If you can hear me now, I'm willing to proceed without actually -- oh, I've now -- I got Dr. Sample

back. Let me rephrase the question.

THE WITNESS: Okay.

MR. SEHAM: Yes. Go ahead.

THE REPORTER: I was just going to suggest if you're continuing to have these issues, you may want to just turn off your video so that we can hear you clearly as you're continuing to have the bandwidth problems.

MR. SEHAM: I've turned off my video.

THE WITNESS: Okay.

THE REPORTER: Usually that will help.

MR. SEHAM: Okay. And if Arbitrator Burdette has no objection to that, then I'll proceed that way.

THE ARBITRATOR: No, we're fine for that right now.

BY MR. SEHAM:

Q. Let me rephrase the question because since it was disrupted anyway. Did you consider anything to be clinically or forensically inappropriate with a medical review officer applying normalization based on creatinine to interpret the results produced by Quest Diagnostics?

A. I mean, ultimately that's a program decision. It's a decision that's made by the people that are receiving and interpreting the results.

Q. What other cutoffs do you use for your

customers?

A. We have a 100 cut off, a 250 cut off, and a 500.

Q. Now, you talked about in your direct testimony about the laboratory's SOP, that stands for standard operating procedures manual; is that correct?

A. Correct.

Q. And is the laboratory obligated to comply with its standard operating procedure?

A. I mean, the -- the SOP describes the laboratory's policies and procedures. So the -- the -- the staff are expected to comply and adhere to those policies and procedures and one of the roles of certifying scientist is to -- as reviewing the data, to ensure that they check the custody, if its in compliant with policies and procedures.

Q. And the name of the person who -- not the Christian name or the surname, but the name of the job position of the individual who first receives the test, what is that job classification?

A. That variously known as a specimen officer or a specimen accessioner. If you want the exact job title in our PeopleSoft system, I'd have to look at that. I -- I don't recall, but it's -- it's a -- a specimen accessioner or specimen processor.

Q. And part of their obligation is to confirm that the specimen was shipped in the packaging and required -- and sealed as required, correct?

A. Well, they're -- they're verifying that the specimen that's in the specimen transportation bag does not show any evidence of tampering, and that the identification on those two agree. They're not the ones that are on FedEx package.

Q. Okay. If the bag were torn open, are they required to report that if it was torn open before it arrived?

A. Which -- which bag? The FedEx package or the specimen --

Q. No, the plastic sealed bag within.

A. Okay. So the -- the specimen --

Q. Correct.

A. That is not -- that -- that is not considered to be a flaw so long as the specimen is still securely fill -- sealed. There's no -- no -- no requirement that that outer specimen transportation bag not have a rip or a tear.

Q. Okay. And if the seal is completely torn, is that test process?

A. The seal on what? The specimen --

Q. On the specimen bottle -- on the specimen

bottle.

A. Oh, on the specimen bottle. That -- that is a fatal flaw.

Q. Okay. And if the seal is not initialed?

A. That is not a flaw, nor is it noted.

Q. And that's all laid out in the SOP in terms of the directive to the accessioner?

A. Well, the -- the affirmative directions are outlined in the SOP. It doesn't tell them what they don't have to look at, for instance, initials. It doesn't say you don't need to look for initials. It tells them more specifically, affirmatively what they need to be evaluated.

Q. So request does review the CCF prior to proceeding with the testing --

A. Yes.

Q. -- with the Chain of Custody Form? And what job classification conducts that review?

A. So initially that would be done by the specimen accessioner, and then also on the back-end by certifying scientist.

Q. You're familiar with the standards of 49 CFR Part 40 in terms of the specimen collection, correct?

A. Yes.

Q. And in terms of review of the Chain of

Custody Forms that come in for an EtS or EtG urine based test, is Quest through his SOP applying the same standards as 49 CFR Part 40 in terms of reviewing the Chain of Custody Form for errors?

A. Well, first of all, the federal CCF is different than the non federal CCF, so there will be differences in -- in terms of that review process. So actually the different SOP for review of non federal forms versus for -- would -- would -- you know, if you have a specific question in terms of what they look at, I'd be happy to respond to that but --

Q. Well, for example, where the ID numbers on the specimen bottle and the CCF do not match.

A. Fatal.

Q. Okay. And it would be under Part 40, and it would be under your process for EtG, correct?

A. Yes, that would be -- that would be an ID mismatch. That's again, part of the review process that I think I described at the beginning, verified that the seals are intact and the ID matches.

Q. Okay. And where there is a specimen bottle seal that's broken or shows evidence of tampering, that would also be a fatal flaw, correct?

A. Yes.

Q. And if there's an omission of a collector's

name and signature, that would be a fatal flaw, correct?

A. So collector name and signature, yes, we would -- we would view that as a fatal flaw.

Q. The donor is the first link in the chain of custody that has to be maintained, correct?

A. I don't understand your question.

Q. Well, certainly under Part 40, the donor is entitled to have visual control of his specimen at all times prior to it being sealed in the specimen bottle, correct?

A. Certainly.

Q. Okay. And would you apply that same standard to EtG collection processes?

A. I apply that standard to our non regulated collection as well as regulated collection, but again, we weren't -- the collection sites plus diagnostics wasn't involved in the collection process. So I -- I can't really answer questions as to what happened prior to the -- to the specimen arriving at the laboratory.

Q. But if that came to your attention in an undisputed manner, that would be considered a fatal flaw?

A. It'd be considered an -- again, fatal flaw is -- is a laboratory testing term. Laboratory wouldn't

-- wouldn't have any knowledge. So if -- I mean, if you look at Part 40 in the definition of fatal flaw, that's not a fatal flaw.

Q. I'm sorry. Thank you. Is there a sufficiency of urine requirement in terms of the sample?

A. Yes.

Q. Okay. So in Part 40 would be 45 milliliters, correct?

A. Well, Part 40 is 45 milliliters for the collection, 30 for A, 15 for the B.

Q. Correct. So what's your requirement?

A. Well --

Q. EtG urine test requirement?

A. As a -- as a -- as a laboratory, we will accept lower volumes than the 30 and 15 respectively in -- in A and B because there -- there are some different requirements.

Q. What does your SOP require? Does your SOP require a minimum amount of urine in order to proceed with the EtG testing?

A. Generally, for non regulated testing, we'd be looking to have at least 10 milliliters of urine so that we have a sufficient volume in order to perform screening and confirmation.

Q. Well, does your SOP address what actually is taken? Let me finish the question. And I don't mean to be rude, for the sake of the transcript, it's better that we have the full question. But if a specimen bottle arrives with five milliliters of urine, does your SOP specify how you proceed?

A. So I -- I would have to review the SOP that was in effect at that -- on that specific date. But yes, there is -- there is a minimum volume below which the specimen would be rejected or classified as QNS for both regulated and non regulated testing.

Q. Okay. Thanks. Do you observe in terms of EtG testing and the review of the chain of custody, the same dichotomy that's observed in Part 40 as between correctable and fatal flaws?

A. For instance, that is a very general question, I'm having trouble following that.

Q. Well, for example, if there's an omission of a signature, but the name is printed, of the specimen collector.

A. Gen -- generally, yes, that would be -- but in this case, we had both a collector printed and signature on the CCS.

Q. Is there a --

A. No memorandum of correction was required from

the collection.

Q. Is there a time limit placed on the correction of a correctable -- if there were a situation where you had the printed name of the collector, but not the signature. Is there a -- is there a time limit within the SOP to obtain that memorandum of correction?

A. Yeah. So generally we try and recover that within one week, but, you know, sometimes it takes longer than that. The collector, may be out, there may not be somebody who can sign in their -- so generally, it's consistent with -- with people who may be more accustomed to on -- on the federal level, but even for federal tests, you can go beyond that. It's not exactly a hard-and-fast rule.

Q. I'm not sure I got an answer. The question I posed before, given the background I gave you about the visual control, I just want to address the concept of chain of custody, which in the context of forensic testing, would you agree with me that the first link in the chain of custody in terms of what transpires at the collection site, is the donor?

A. Well, both the collector and the donor.

Q. Okay.

A. They -- they're both critical components of

the chain of custody. But, you know, the -- there -- there is a donor certification statement in step five.

Q. All right.

A. Now, for federal CCS, we don't see that obviously, but on non federal CCS, we would see it, and, you know, that donor certification statement indicates that they -- they provided the specimen, to have adulterated in any manner. Each specimen bottle used was sealed with tamper tape in my presence. Some of the information number provided in the form and the label affixed with the specimen bottle is correct.

Q. Okay. And then the next link after the donor and collector, what's the next link in the chain of custody?

A. The -- after the collector and the donor, well, that would be what we received at the laboratory.

Q. Okay. Now, the laboratory maintains its own internal chain of custody for the specimen, correct?

A. That is correct.

Q. All right.

A. Both the specimen and aliquots.

Q. Okay. An aliquot is just a pipette portion of the specimen that's extracted from the bottle?

A. Yeah, it -- it may be pipetted off, maybe t--it's a portion of the original specimen that is

removed that specimen container and placed into a test tube or another specimen container for actual testing within the laboratory.

Q. Sorry about that. Is it acceptable practice for a technician to omit documentation of handling of a specimen and just go from memory?

A. No, it is not.

Q. Okay. Or jotting down the handling of a specimen or an aliquot in a personal diary as opposed to official laboratory documentation?

A. No --

Q. How many times --

A. Let me finish first.

Q. Go ahead, I'm sorry.

A. And -- and that's part of the certifying review process to ensure that there aren't errors or omissions. And just since there can be correctable flaws. So it's possible to get a memorandum of -- of correction, within the laboratory just as it is, you know, laboratory sending to collection sites to recover missing information.

Q. And how many -- how many tests does Quest do per day? I mean, at the location where you were processing the EtG.

A. I -- I -- I -- I don't know -- I don't know

that off of the top of my head nor do I know what it was at this date in -- in 2018. You know, across our network of laboratories, we're doing, you know, 10 to 11 million tests annually.

Q. And how many specimen bottles does the average technician handle per day?

A. I have no idea.

Q. Okay. I mean, would it be tens, or hundreds, or thousands? You don't know?

A. I would not -- I would not venture a guess.

Q. Okay. And you didn't actually perform any of the testing or handling in this case, correct?

A. Me personally, no, I did not.

Q. Now, what happens if there is an omission and you said there is an omission and the internal chain of custody memorandum can be prepared to address that issue?

A. Yes.

Q. And is there any given the multiple tests are being handled per day, is there any time limit on capturing the correction in a memorandum?

A. Well, it will not -- the results will not be reported prior to correcting the errors or omissions.

Q. Is that in the SOP? That standard that you just articulated?

A. I -- I would have to see exactly what the SOP verbiage is pertaining to that. But yes, that's our -- that's our -- that's our policy.

Q. Now, the initial test for the EtG in this case was 126 nanograms per milliliter; is that correct?

A. The first initial -- the -- the results of the first aliquot for the initial screening test by -- that is correct.

Q. And then the final result, I guess I'm not clear. The final result was 100 and the reported value with 117?

A. That is -- that's correct. And if you remember, I -- I indicated there were actually two screening tests -- two screening analyses that were performed on two separate aliquots of the urine because the individuals reviewing the data from that first initial LC-MS/MS test for EtG were not fully satisfied with the chromatography on that second EtS transition.

Q. Okay. So for both of these tests, that resulted in the 126 and 117 quantitative results respectively, the same urine sample was used, correct?

A. The same original urine specimen, but three different aliquot. So again, 126 on that first screen, 116 I believe on the second screen and 117 was the final result from the confirmatory analysis. So three

LC-MS/MS analyses on three different portions of that original specimen with values ranging between 116 and 126.

Q. Okay. And the same chemical testing methodology was used for all three of these tests; is that correct?

A. What do you mean by chemical testing methodology?

Q. Well, I thought --

A. It was all performed by -- it was all performed by liquid chromatography mass spectrometry mass spectrometry, or LC- MS/MS.

Q. Okay. So that came across very fast to me and just as a benefit, maybe half for myself, half for the court reporter. Is that sometimes -- is that sometimes written out as LC hyphen MS slash MS.

A. Yes. So LC-MS/MS. Could be hyphen MS, hyphen M second time or -- or slash MS slash MS the second time. It could maybe recorded variably, but yes, there will be a separator between all three of those two letter acronyms.

Q. Okay. And however you slice it in terms of laying out the letters, that was the same method of -- if my methodology is the wrong word, please correct me, but is the same -- my question is, was it the same

methodology for those three tasks, for this three aliquots?

A. It's the same -- same analytical -- analytical instrumentation was used for all three.

Q. Okay. Now there was -- somewhere in the area of an eight to nine percent decrease in the quantitative result from the first test to the second and third is -- would you agree with me that that's roughly the right percentage?

A. Well, I would -- I would actually focus more on the 116 to 117, which would be slightly less than a one percent increase. But if you are going from 126 to 117, I'd have to get out my calculator, but I'll -- I'll take you at your word for what percent decrease that is.

Q. All right. Well, if -- if -- if we were speaking in terms of a 126 to 116 differentiation, is that a tolerable discrepancy as between the two tests?

A. I wouldn't -- I wouldn't even classify it as a discrepancy. It is definitely a tolerable difference.

Q. Is there any time at which it becomes intolerable in terms of percentage differentiation?

A. So EtG is a little bit different than -- than other tests, you know, primarily because we're

screening and confirming using what many considered to be dependent of technology by LC-MS/MS. And because of some of the well-documented characteristics of -- of EtG, I think at post-collection, we do have criteria that the screening test and the confirmatory test must agree or be consistent. Because we don't want to see values that are decreasing significantly between the screening testing, confirmatory test, which would be indicative of bacterial contamination, causing degradation in the EtG. Similarly, we don't expect to see marked differences, you know, increases between the screening test and the confirmatory test, indicating that it might be one of those unusual urines where there could be post-collection symphysis of EtG. In which case, if we believed that there may be degradation, bacterially -- would soon be bacterially derived degradation of EtG or post-collection increases in the EtG concentration, we would report that specimen to be not be reported negative, but not be reported positive even though we've identified EtG, it would be reported as invalid.

Q. Very good. And in the case of an invalid test, what would you recommend to the -- would you recommend to the client that another test be conducted?

A. Ordinarily, we recommend a recollection, yes.

But ultimately, the decision on subsequent action is up to the -- to the customer --

Q. Okay.

A. -- and/or medical review officer.

Q. And in the Part 40 context, the employer would conduct a recollection, correct?

A. It -- it depends on the type of test.

Q. Okay. But -- but in any case, the -- the -- the employer would not be permitted to treat that as a positive result, correct?

A. An invalid is never treated as a -- as a positive result that I'm aware of.

Q. Okay. Thank you. When is the first time that you discussed these test results with anyone at Delta Airlines?

A. I'd have to look back at my calendar, but it was several weeks ago.

MR. KASSIN: Mr. Arbitrator, at this point, we interject the attorney work product privilege.

MR. SEHAM: I'm not going to pursue that. I just wanted the time frame, so --

THE ARBITRATOR: I understand. We're good. That objection is sustained, Mr. Kassin. Go ahead.

Q. And prior to this discussion you had several weeks ago, do you know if anyone else at your

laboratory had discussions with Delta about the test result?

A. Not that I'm aware of -- not that I'm aware of.

Q. Would you agree that it is something in the order of seven years that EtG has been used as a long-term biomarker?

A. Oh, I would say it's been longer than that.

Q. If we could --

A. Probably -- probably 15 plus years. Maybe -- maybe not so much in workforce monitoring, but certainly in -- in professional monitoring as a condition of continued -- for people that are in a substance abuse program.

MR. SEHAM: If Emily -- or I'm sorry, it's Candice now?

THE ARBITRATOR: Yes, Candice now.

MR. SEHAM: Candice, if could you put Union Exhibit 78 up, please?

(Union Exhibit 78 marked for identification)

Q. Dr. Sample -- if you could actually scroll down a little bit, that's fine. I'm just trying to see there. It seems like the top of this is cut off because the top of the document -- yeah, there we go. All right. So do you recognize this, Dr. Sample, as a

publication of Quest Diagnostics that would be carried on its website?

A. Well, it's -- it's certainly identified as such, but what I would add is this relates to our clinical testing, not our forensic testing.

Q. Okay.

A. Well, it's -- it's related to the testing done by an entirely different line of business for different purposes.

Q. Okay. If we could amplify it, Candice, so it's more readable. If you look at the second sentence that reads, "While EtG has been used as a long-term biomarker in urine testing for more than seven years." I'll pause there. You disagree with that statement?

A. Well, I -- I -- I -- first of all, I don't know when this document was prepared, so I -- seven years from when?

Q. Uh-huh. All right, so --

A. That may -- that may be totally accurate when this document was prepared.

Q. Right. And so you don't know one way or the other whether this is a document today currently carried on Quest's website?

A. No, I don't. But again, I would direct you, there's probably a date somewhere on the bottom of the

document that tells you when it was --

MR. SEHAM: Let's see if there is. And Candice, if you can scroll down.

MR. KASSIN: Mr. Arbitrator, I just don't understand the relevance of this. I mean, I think we've established a good background on the history of EtG testing. You know, more than seven years is consistent with the witness' answer. I'm not seeing us gain any ground on this.

MR. SEHAM: I'm not seeing in --

THE WITNESS: Go up, got to look at the -- their date.

THE ARBITRATOR: I don't think --

MR. SEHAM: It shows the copy --

THE WITNESS: It's the copyright date, so I don't -- I don't know that that's going to be particularly useful, so --

MR. SEHAM: If necessary, we'll have a -- we'll have a witness testify that this is currently on the website. But if we can scroll back up to the top.

THE WITNESS: No, it may be current. What's relevant if you're talking about the dates is when was the document prepared? They don't update it every year.

MR. SEHAM: Okay.

THE WITNESS: On the basis that while another year has passed, it's still true. It's more than seven years.

MR. SEHAM: Got it.

THE ARBITRATOR: Okay. And --

MR. SEHAM: Okay. So let me I'll move forward from that.

THE ARBITRATOR: Please.

BY MR. SEHAM:

Q. Would you agree that in in vitro formation of EtG may occur when ethanol-producing bacteria are present in the urine?

A. Well, it's more than just ethanol-producing bacteria, yes. It's -- it's what some of us in the industry refer to as the perfect storm. You need ethanol or you need -- you need glucose, you need yeast, you need the bacteria going to perform glucuronidation, take glucuronide off certain compounds and then attach it to the ethanol. But it -- it takes a whole host of circumstances to have post-collection symphysis of EtG. And as I referred to just a little bit ago, that's why we have this criteria looking at either increasing or decreasing EtG levels between the screen and confirmatory test. And if we detect anything that would make it appear that there's

contamination, either causing degradation or increases in the EtG level, we would report the specimen as invalid, at least for our -- for testing.

Q. Very good. Thank you. If you could scroll down, Candice, I think I want to pick up the last paragraph. Now, the last paragraph reads, "As with EtG, the presence of EtS in a urine specimen does not establish the source of the ethanol containing product and the possibility of "incidental exposure", and post-collection specimen changes needs to be considered when interpreting results." Do you agree with that statement?

A. Yes. I -- I might have had something to -- I might have been around when that phraseology was first developed.

Q. Okay. But you still agree with that today?

A. Absolutely.

Q. And who should be interpreting the results?

A. Well, this document is prepared for really healthcare providers. But on our forensic side of the business, we have generated similar communications regarding EtG and EtS. So, you know, that would be the recipient of the results. And we all -- you know, we recommend that a medical review officer be used, not just for federal testing or it's required or in certain

states where it's required, but for all tests, particularly in interpreting positive results. But that's the ultimately a customer or an employer decision. We're not required by applicable regulation or law.

Q. Okay. Thank you. And if you go down to where there's a subtitle reference range, it says ethyl glucuronide EtG, less than 500 nanograms per milliliter, ethyl sulfate EtS, less than 100 nanograms per milliliter. Is that referring back to that concept that you said where EtG is above 500, EtS must be --

A. No.

Q. -- present or is that something different?

A. Totally some -- these are just -- these are just cutoffs that are used with this panel that is on the clinical testing side of the business. This document is totally, really unrelated to any service offerings that we performed in the employer solution business in support of workplace or workforce testing.

(Union Exhibit 79 marked for identification)

Q. Okay. We could up Union Exhibit 79. Would you agree that this document is in the format of publications on Quest Diagnostics website?

A. It appears to be, but again, this is a clinical drug monitoring side of the business document.

It's not one related to our workforce drug testing service office.

Q. Would you agree that the incidental exposure to products such as mouthwash or hand sanitizer have been shown to produce positive alcohol metabolites detected by EtG and EtS?

A. Well documented.

Q. Okay. And in the clinical context, would you agree -- well, let's actually, if we can move back to 78. The last sentence reads, "Quest Diagnostic recommends clinical correlation and/or healthcare provider review when interpreting EtG and EtS results." You agree with that statement?

A. Again, this is a clinical tests since hence the clinical correlation and/or healthcare provider review.

Q. Okay. And what do you mean by -- when you use the term clinical, what are you referring to?

A. Testing of patients for diagnosis or treatment by healthcare providers.

MR. SEHAM: Okay. Let me see. If I could have five-minutes to consult with my technical adviser.

THE ARBITRATOR: Sure. We'll go off the record until 2:05. And anybody wants to use this as a bio break this would be a good time to do it.

MR. SEHAM: If we could combine that, Arbitrator Burdette, and make it ten minutes. If you don't, then objection.

MR. KASSIN: I don't have any objection to that. So, Damien, we'll come back on the record at 3:10 p.m. Eastern Time.

THE REPORTER: Off the record at 3:00 p.m.

(OFF THE RECORD)

THE ARBITRATOR: Raise your right hand. And do you swear or affirm that the testimony you are -- there he is, we got him. Do you swear or affirm that the testimony you're about to give in this case will be the truth, the whole truth, and nothing but the truth?

THE WITNESS: Yes.

THE ARBITRATOR: Thank you very much. And would you please just advise us? Do you have anybody else in the room with you?

THE WITNESS: There is no one with me.

THE ARBITRATOR: Okay. And do you have any documents that are not a party of this case that you would potentially be able to refer to?

THE WITNESS: No.

THE ARBITRATOR: Thank you very much. Mr. Seham, you may proceed.

///

MATTHEW STEPANIAN,

having been first duly sworn, testifies as follows:

DIRECT EXAMINATION

BY MR. SEHAM:

Q. Thank you. First of all, I want to thank you for taking time out of your day and we apologize for all the technical glitches and thank you for bearing witness. Could you please once again, state your name for the record.

A. My name is Matt Stepanian.

Q. And what town do you live in?

A. I currently reside in Chandler, Texas, a suburb of Tyler, Texas.

Q. And did there come a time when you were required by court order to submit to testing to confirm your abstinence from alcohol?

A. Yes.

Q. And I do not want to invade your privacy unduly, but can you briefly describe what the circumstances were, that led to this testing?

A. Yes, I can do that. The court said that testing would be a factor in determining child custody issues that I had between my children's mother and I. I had previously been restricted from driving my children myself and petitioned the court to have this restricted

-- restriction lifted after my divorce.

Q. Okay.

A. First step in reinstating my driving privilege was submitting to an EtG and a PEth test, which was -- after receiving negatives on both, I was to be cleared to drive. I was also required to use a breathalyzer once the driving privileges reinstated, although I used it all throughout the period when false positive tests inhibited me from driving my children.

Q. And during the -- focusing on the period of 2017 to '18, how many tests for abstinence did you have?

A. There was 18 tests.

Q. Okay. And I'm going to go slowly with this question because it involves some terminology, but I'm going to ask you what testing methodologies and the matrix used, and when I say matrix, I mean, was it urine, hair, fingernails, blood, etc. Could you just tell us what the methodologies were?

A. Sure. There was urine based EtS, there was hair based EtG, fingernail based EtG and blood based, phosphatidylethanol PEth testing.

Q. Okay. We're going to bring up, if we would Emily, Union Exhibit 59. I don't know if you have the exhibits with you?

A. I do.
Q. You do?
A. Yes.
Q. You can either look on the screen. We have some people who don't have the exhibits. So we're going to also take a moment for them to be posted on the screen. So it's 50 -- Union 59 we're looking for.
A. I see it on screen.
(Union Exhibit 59 marked for identification)
Q. Right. And can you explain to us what this document is?
A. My attorney who is helping me to rectify my driving privileges with my children, had assembled this spreadsheet. It lists all the collection dates and times for each test, the place that it came from, the testing method and the results.
Q. Okay. And starting from the time period of September 1, 2017 to August 1, 2018, did you imbibe any alcoholic beverages?
A. No, I did not.
Q. And does this chart accurately reflect the tests administered to you using urine based, hair based, or nail based EtG methods as listed?
A. Yes.
Q. Did these three types of tests ever yield a

positive test result for alcohol?

A. No, they did not.

Q. Did there come a time when you began to question the accuracy of blood based PEth testing?

A. Yes, I did.

Q. When was it?

A. Back in October 27th of 2017, I had an EtG test and a PEth test on the same day and the EtG came back negative as it should have, and the PEth test came back positive. Then on February 22nd of the following year 2018, I had a positive for PEth collected by forensic DNA and testing here in the Dallas area. But when that same sample was retested, the result was negative.

Q. And which laboratory, if you recall, tested the PEth for the PEth test?

A. That was USDTL.

Q. Okay. And now I'm going to ask you to refer to Union Exhibit 7. And Emily, if you could post up Union Exhibit 7. Yeah. Okay. Thank you. Now, we may have to squint a little, but I think it's legible. I'm showing you two tests reports from USDTL referring to a blood specimen collected on February 22nd. One showing a positive quantitation of 321 nanograms per milliliter, and the other quantitative result of four

when tested again four days later. Did you receive these two documents from USDTL?

A. Yes, I did.

Q. And were these testing results based on the same blood spots you provided at forensic DNIA and drug testing on February 22nd, 2018?

A. Yes, it was the same sample.

Q. Can you explain what happened with respect to testing in the beginning of April 2018?

A. I was still required to submit to PEth testing, but I thought I would begin to create my own verification process by going to two or more different facilities for the testing whenever I was called in by the court.

Q. Okay. Can you describe to that -- could you describe what happened on April 6th and April 7th of 2018?

A. Yes. On April 6th, I went to the collection facility called Forensic DNA and Testing in the Dallas area and arrived at a -- my sample was collected at approximately 4:25 and then the next morning, at the earliest opportunity to go and -- to another location, I went to Any Lab Test Now also in the Dallas area and had the same collection methodology at 10:45 a.m.

Q. And were they both dried blood tests?

A. Yes.
Q. And were the results as indicated on the chart?
A. Yes.
Q. Okay.
A. The earlier one was positive at Forensic DNA and Testing and the later one was negative.
MR. SEHAM: Okay. Now, if you could turn to -- Emily, if we could post up Union Exhibit 8.
THE WITNESS: Pardon me.
(Union Exhibit 8 marked for identification)
Q. Are these the PEth tests collections that you had on April 6th and April 7th?
A. Yes.
Q. I see there the SSN donor ID number is different here between one and the other. Can you account for that? One is 5167, the other begins 10135.
A. I see. The one on the left is my social -- the last four digits of my Social Security number and the one on the right, is my Texas driver's license number, but they are both correct.
Q. Okay. Now, can you describe what happened on May 3?
A. Yes. On May 3rd, I went to Forensic DNA and a sample was collected at approximately 4:00 p.m. and

on that same day, at approximately 4:45, I went to Any Lab Test Now, for the same collection.

Q. The results were as indicated on the chart that you submitted?

A. Yes. Yes, they were.

MR. SEHAM: And could you turn -- Emily, if you could post Union Exhibit 9.

(Union Exhibit 9 marked for identification)

Q. Can you identify these two documents for Union Exhibit 9?

A. Yes. They are the results of that May 3rd collection.

Q. Can you describe what happened on July 6th 2018?

A. Yes. I went to Forensic DNA on July 6th at approximately 2:20, had a blood spot sample taken and on that same day, I went to National Drug Services and had the same collection 21 minutes later, approximately 2:41 p.m.

Q. And were the results as indicated on the chart, in Exhibit 59?

A. Yes. The Forensic DNA earlier one was positive and the National Drug screening later one was negative.

MR. SEHAM: And can you identify -- if you could

move, Emily, to Union Exhibit 10.

(Union Exhibit 10 marked for identification)

Q. Are these the tests reports for the two collections that you described?

A. Yes, they are from the aforementioned July -- I'm sorry. It's July 6th testing.

Q. Okay. Did the court restrict your custody or visitation rights in any way based on the results of the PEth positive tests that we've just reviewed?

A. Yes. There was a substantial period of time in which I was unable to see my children because of these false positives.

Q. Okay. Was that ever re-visited or addressed in any way by the judge?

A. Yes. Beginning in -- on October 27th of 2017, from there until January 26th of 2018, I was not allowed to see my children as a result of this false positive from Forensic DNA. After the January 26th, 2018 hearing, after that PEth negative until a false positive some weeks later, I had regular custodial periods with my children. Then from a period of February 22nd of 2018, where there was another false positive until a March 16th hearing, I was not allowed to see my children and from March 16th hearing until April 6th hearing of 2018, false positives at Forensic

DNA, I did have regular custodial periods with my children, but after the April 6th, 2018 false positive until nearly five months later, July 7th hearing, I was not allowed to see my children, but after the -- I'm sorry, September 7th, 2018 until -- until that -- after that hearing in which a toxicologist testified on my behalf, and during which time the judge declared I have lost faith in this PEth test. My custodial rights were reinstate -- reinstated with exclusion of Forensic DNA as a collection agency and have had no false positive since.

MR. SEHAM: I have no further questions but the attorney for Delta Airlines, Mr. Kassin, may have questions.

THE WITNESS: Understood.

CROSS EXAMINATION

BY MR. KASSIN:

MR. KASSIN: Arbitrator Burdette?

THE ARBITRATOR: Yes, sir.

MR. KASSIN: Oh, sorry. One second. There's way too much to click. Okay. So we are going to need to reserve the right of cross-examination of this particular witness except for two questions so that we can get the appropriate chains of custody and background information. I'd like to know what court he

was in that involved this particular dispute so that we can get the transcript from the court order so he can get the name of the courts, please.

THE ARBITRATOR: Mr. Stepanian, can you hear him?

THE WITNESS: I can, yes.

THE ARBITRATOR: Okay. He wants to know what court you got the court order from.

THE WITNESS: I can look that up, but I don't know that in the top of my head. But very quickly here, I can provide that for you.

MR. SEHAM: I'm going to intercede just for one second.

THE ARBITRATOR: Okay.

MR. SEHAM: From my discourse with this witness, the order to which he just referred may have been an oral order in terms of the reinstatement of custody, but I don't know. I know it's certainly the comment that the judge had lost faith in the PEth test result as an oral comment.

THE ARBITRATOR: Okay. Well, I think still Mr. Kassin has the right to try and develop a cross-examination if he can, so would you please tell us the name of the court?

MR. BRIAN: Mr. Burdette, it's Brian. Is the witness consulting notes right now that we do not have

access to?

THE ARBITRATOR: He's looking up the name of the court.

MR. BRIAN: Okay.

THE ARBITRATOR: I think.

MR. BRIAN: It just appeared that he was reading from notes when he was making his statement.

THE ARBITRATOR: Okay. Mr. Stepanian, were you reading from notes when you were making your statement earlier?

THE WITNESS: Yes, I was.

THE ARBITRATOR: Okay. We may want to have those notes provided to the arbitrator, please. If you can make arrangements to have those notes sent to us, we'd appreciate it.

MR. SEHAM: I will work with the witness to --

THE ARBITRATOR: Okay.

MR. SEHAM: -- make that happen.

THE ARBITRATOR: Yeah.

MR. SEHAM: You know, after reflection, I don't see the relevance of the court proceedings. What's relevant here are these test results.

MR. KASSIN: Well, did you open -- I mean, you raised the issue and he said that there was an order from the court and we're going to get a copy of those

court proceedings and if there's a trial transcript, we're going to get a copy of that transcript, and also we need to know the name of the toxicologist that testified at that particular proceeding.

MR. SEHAM: This is frankly, a heartless chilling of a witness to produce these laboratory documents.

THE ARBITRATOR: I don't agree, Mr. Seham. You have introduced him and I think this goes to -- I think Mr. Kassin has a right to test the credibility of the testimony, and that these are documents that are necessary in order to do that so --

MR. KASSIN: Mr. Seham, if you know the name of the toxicologist?

MR. KASSIN: I do not know. I do not know, but we can get --

THE ARBITRATOR: Okay so Mr. --

MR. SEHAM: You want the name of the court. You want the name of the court, you want the name of the toxicologist.

MR. KASSIN: Right. And we need to know the date of the proceeding too. And with that information, we'll reserve the right of cross-examination, and Mr. Burdette, if it would speed things up if Mr. Seham would represent to us that he'll provide us the information on the court proceeding, the dates of the

hearing, the civil action number, and the toxicologist, we'll be reserving our right to cross-examination and we'll let you and the board members know when we're prepared to proceed.

THE ARBITRATOR: Okay. Mr. Seham, can you take care of that?

MR. SEHAM: Yeah. To the best of my ability, yes, I will.

THE ARBITRATOR: Okay. Well, I think the -- the witness can certainly provide it, perhaps with some research, but -- okay. With that, are we going to excuse Mr. Stepanian?

MR. SEHAM: I believe so. If there's no further -- if they're reserving cross-examination, we have no further questions.

THE ARBITRATOR: Okay. Mr. Kassin, we're going to release Mr. Stepanian?

MR. KASSIN: Yes, sir.

THE ARBITRATOR: Okay.

MR. KASSIN: We'll be back in touch with you when the board will be recalling him.

THE ARBITRATOR: Yes. Okay. Thank you, Mr. Stepanian, and you may be excused. Thank you very much for your testimony.

THE WITNESS: Thank you, gentlemen.

THE ARBITRATOR: And please work with your counsel to provide that additional documentation.

MR. SEHAM: Yes. Well, he's gone, but yes. We'll --

THE ARBITRATOR: Okay. All right.

MR. SEHAM: And he's not my client, he's a witness, but --

THE ARBITRATOR: I understand. I understand.

MR. SEHAM: -- to that end. We actually have Dr. Tordella who I originally told to be available at 4:00 and now I told him given the delay with Mr. Stepanian, to be available at 4:30, and he set --

THE ARBITRATOR: Okay.

MR. SEHAM: -- himself available at 4:30. He should also be a very brief witness.

THE ARBITRATOR: Okay.

MR. SEHAM: And then I got word from Michael Perez that he's recently landed, and my aspiration would be to have Dr. Tordella testify and I think that might be 10 or 15 minutes, at least on direct, and then see if we can arrange for Mr. Perez right after that.

THE ARBITRATOR: Okay. That's fine.

MR. SEHAM: Yeah. We can take a --

THE ARBITRATOR: 15-minute break?

MR. SEHAM: Yeah. And Emily -- yeah. I think the

contact should have -- let me contact Tordella and we'll -- yeah. We'll take a 15-minute break.

THE ARBITRATOR: Okay.

THE REPORTER: Okay. Off the record at 4:14 p.m.

(OFF THE RECORD)

THE ARBITRATOR: Okay. Mr. Tordella, my name is Mark Burdette. I am the Neutral chair of the System Board of Adjustment and for Delta and ALPA in which you're about to testify. We are swearing witnesses so would you please raise your right hand. Do you swear or affirm that the testimony you're about to give in this case will be the truth, the whole truth, and nothing but the truth?

THE WITNESS: I do.

THE ARBITRATOR: Thank you. And would you tell us if there's anybody else in the room with you?

THE WITNESS: There is not.

THE ARBITRATOR: Okay. And do you have any documents that are not part of the exhibits to this case?

THE WITNESS: No, I do not.

THE ARBITRATOR: Thank you very much. Mr. Seham, you may proceed.

MS. SAMUDA: Before you proceed, I'm sorry to interrupt. My board member -- one of my board members

is in the restroom, so can we give them a couple of minutes?

THE ARBITRATOR: Okay. Sure.

MS. SAMUDA: Thank you.

THE ARBITRATOR: Thank you. I see that we're missing a couple board members.

MR. MORRIS: I'm back.

THE ARBITRATOR: Okay. We're still missing Mr. Meyer.

MR. MEYER: I'm here, Mr. Burdette.

THE ARBITRATOR: Okay. Thank you very much. All right. Now, you may proceed, Mr. Seham.

JOSEPH TORDELLA, DO,

having been first duly sworn, testifies as follows:

DIRECT EXAMINATION

BY MR. SEHAM:

Q. Thank you. Doctor, could you please state your full name for the record.

A. Joseph R. Tordella.

Q. And could you please give us your medical background both flight and medical -- your work background, both flight and medical.

A. Okay. I graduated from Philadelphia College of Osteopathic Medicine in 1976. I was also trained and graduated US Air Force pilot training and

separately, years later I went back and graduated as a flight surgeon with the US Air Force.

Q. And are you an aviation medical examiner or AME?

A. Yes. I'm a senior AME and I'm HIMS trained, and I'm a independent medical sponsor for many of the pilots.

Q. And how long have you been an AME?

A. Approximately 43 years.

Q. And you said you were a HIMS doctor. How long have you been -- since your graduation from medical school, how long have you been in the HIMS program as a monitoring doctor?

A. Almost the same amount of time. It followed a few months after being appointed as an AME.

Q. And have you also worked with the NTSB with respect to the substance abuse issues?

A. Yes, I'm an accepted witness for the NTSB on -- on aviation medicine, all the above.

Q. Have you acted --

A. Excuse me.

Q. Have you acted in the role of HIMS doctor, and for the record, HIMS is an acronym, H-I-M-S. Have you acted in the role of HIMS doctor for a pilot by the name of Matt Dacier, D-A-C-I-E-R, and correct my

pronunciation if I --

A. Yes, I have met Dacier.

Q. Okay. And you've a HIMS doctor for many pilots over the years?

A. Probably about a thousand of them. I would -- could guesstimate that I've done more than anybody else in the country or very close to it.

Q. And did you have Mr. Dacier's authorization to discuss his case before the system board?

A. Yes, I do.

Q. Please tell us what brought Mr. Dacier into the HIMS program.

A. He had received a DUI and he came to me to participate in the HIMS program in order to get his medical certificate back so he can get back into flying professional -- professionally.

Q. For how many years have you monitored him?

A. Approximately five years.

Q. And did you consider Mr. Dacier to have a substance addiction problem?

A. No.

MR. SEHAM: Let's bring up Union Exhibit 37.

(Union Exhibit 37 marked for identification)

Q. If we can scroll slowly down so the witness can see the document, we can stop there. Can you

identify this document as a USDTL report that you received concerning Mr. Dacier?

A. Yeah. Yes, I can.

Q. And did you see there that he received a result of 24 nanograms per milliliter. Is that consistent with your recollection?

A. Yes, that's correct.

Q. Okay. Now, this collection is reported -- if you see after the word collected, it's collected May 18th, but the email reporting the result -- if we can go scroll back to the top.

A. I can see it right here. Report date 5/26.

Q. Okay. But if we can go back to the very top of the document and because there was an email covering this result, Emily, if we could go to the very top. So there's the emails May 28th with a subject line results. Is May 28th the date that you received these results?

A. Yes, would be correct.

Q. Okay. If we can bring up Union Exhibit 18. Okay, is the -- is this an email between you and Dr. Joseph Jones, the director of USDTL on May 28th, 2020?

A. Yes. It says from Joe Jones to Joe Tordella. Correct.

Q. Okay. And why -- why did you communicate

with Joseph Jones concerning Matt Dacier?

A. When I received that positive test, I didn't -- I -- I was shocked. I didn't feel that Matt Dacier would have the potential to relapse at this point in his treatment, and after five years of monitoring, and I had questions.

Q. Okay. And -- and how many -- how many -- he had a history of negative tests in the past?

A. Yes, I counted approximately 41 tests. They were all zero and there was one that was a three -- three nanograms. But Joe Jones told me that is considered clinically insignificant. So he really had 41 zeros, you know.

Q. Okay. Now, Emily, if you could scroll down, I think, towards the very end of the email. Okay. So stop right there. If you -- if you see here there's an email from Joseph Jones and his request. "Can you query by collector name? It would be interesting to see if the collector Lynn Collins has an unusual proportion of PEth positives." Did you ask Mr. Jones to run that query?

A. No, I did not.

Q. Do you know Dr. Jones?

A. Yes, I do.

Q. You worked for them on cases together?

A. Yes. Many times over many years.

Q. Did you also discuss Mr. Dus -- in addition to this email exchange, did you also discuss Mr. Dacier's test result with Dr. Jones by telephone?

A. Yes, I did.

Q. And did Dr. Jones advise you of the -- no, you made arrangements for a subsequent -- hold on. I'm going to skip something here. Give me one second. I think I did skip something. We can move to Union Exhibit 38. Is there an issue, Emily, with Union Exhibit 38?

REMOTE TECH: One moment.

(Union Exhibit 38 marked for identification)

Q. Okay. So we have on the screen here USDTL PEth report based on a collection of May 28th, 2020. Were you involved in the initiation of this test?

A. Yes.

Q. Okay. And why did you have Matt submit to a test on or collection of hair on May 28th, 2020.

A. When they get a test as quickly as possible to see if he would verify the results that were given earlier of a positive test or a negative test.

Q. We can scroll down, Emily. Then the result of this test was negative?

A. This test was negative, yes.

Q. Now, going back -- going back to the conversation that you had with -- hold on a second, going back to the conversation that you had with Dr. Jones on May 28, did you discuss the -- the quantitative result of the May 28th test?

A. Yes, I discussed all the tests with Dr. Joe Jones. I couldn't understand why I could have negative tests so closely after the positive one and they didn't show anything.

Q. Did Dr. Jones tell you what the -- the quantitation was on the May 28th collection?

A. That was zero, I believe.

Q. Did your -- did your knowledge or your communication with Dr. Jones concerning the PEth result of 24 nanograms per milliliter based on the May 18th collection and a zero for a May 28th collection prompt any further conversation with him concerning half-life?

A. Yes. I -- I felt the half-life is as I have learned from my discussions over the years, the half-life of a PEth test is 4-10 days. And that means if you take a test approximately a week later, I would expect somewhere half the amount. So 24 hour I think would be a 12 or something should show. The fact that it shows zero to me was very surprising. Why I asked for an explanation.

Q. Well, did Dr. Jones provide you with an explanation?

A. They did, but not one that I was satisfied with. I can't -- satisfied with the explanation.

Q. Did you discuss with Dr. Jones whether the test result for the blood spots collected May 18th definitively established alcohol consumption?

A. Yes, he said I'm just a lab guy. He said I don't come up with the diagnosis. That's your job. But he didn't mention that he thought that one data point should not be definitive for a diagnosis. And I also talked to another doctor at University of Texas, San Antonio --

MR. KASSIN: I can understand the -- objection. If we're getting in -- I can understand because Dr. Jones has been a witness and him -- him referring to his discussions with him because they're related to the USDTL testing. But if the intent is to bring in a another doctor toxicologist from University of Texas as a witness, let's bring them in, let's not have hearsay testimony as to medical -- as to Dr. Tordella was headed.

MR. SEHAM: Well, we would characterize the testimony that we're about to hear as an admission against interest, a University of Texas has a

relationship with USDTL. They're used as a confirmatory laboratory and that we're not -- we think that this is admissible as an admission against interest in terms of the fallibility of this testing process.

MR. KASSIN: I'm sorry. If you bring in that -- bring in that doctor and have them come here and testify in person to the arbitrator and board members and subject that doctor to cross-examination, it's just totally unacceptable to use hearsay to make that point.

MR. SEHAM: Well, that's your opinion. We both stated our position. We consider this relevant and an admission against interest, and we await Arbitrator Burdette's ruling on this.

THE REPORTER: It's not an admission against interest. It's medical testimony.

MR. SEHAM: We both stated our position. I would like a ruling from --

THE ARBITRATOR: Hold on a second. Would you repeat the question that you're asking please, so I can rule on that.

MR. SEHAM: The question to him is whether he spoke to a Dr. Javors from the Texas University testing facility and what was the nature of the conversation concerning the reliability of this testing process.

THE ARBITRATOR: All right. Well, I'm going to allow it now for whatever purpose it might be at the end of the day, but you can go ahead and testify to that, Dr. Tordella.

THE WITNESS: Okay.

THE ARBITRATOR: We're on the record. This is hearsay testimony, however, go ahead.

BY MR. SEHAM:

A. Yeah. When I talked to him, I gave him my same concerns. We talked at length and he -- one day at the point should not define the answer for a diagnosis. And he thinks or he stated as Dr. Jones did that the PEth test is infallible. However, there's no such thing as infallible when you're looking at the big picture, the complete data points. And he had no explanation why one might put the point up, that how can it go from 24 to zero in a week? I said everybody tells me that everyone metabolizes different, but to me it raised quite a bit of doubt and he said, you have a good point.

THE ARBITRATOR: Okay. I understand.

Q. That discussion you're just referring to, was with Dr. Jones?

A. I was both with Dr. Jones and with Dr. Javors, they were separate discussions. It was not a

conference.

MR. SEHAM: If you can, now bring up Union Exhibit 4, please? Okay. And then another.

(Union Exhibit 4 marked for identification)

Q. So we saw at the top that this is a lab report from LabCorp and there's a statement in here reads," PEth levels in excess of 20 nanograms per milliliter are considered evidence of moderate to heavy ethanol consumption. However, alternate explanation should be explored following any positive finding. Please note that while path is considered relatively insensitive to incidental ethanol exposures, the possibility remains that an individual elevated PEth level may result from incidental or unintentional ethanol exposure." My question is, what is your opinion as a HIMS doctor, with your over 40 years of experience with respect to this disclaimer?

A. I think that caveat is spot on. I think it's very accurate.

Q. What was your ultimate conclusion as to whether the PEth test for Mr. Dacier based on the May 18th sample was accurate?

A. I don't think it's necessarily -- certainly reflects possible use without question by the individual.

MR. SEHAM: No further questions for me at this time. I will pass the witness to Mr. Kassin.

THE ARBITRATOR: Okay, Mr. Kassin.

MR. KASSIN: Yes, Sir. Good afternoon, Dr. Tordella. Thank you for joining us at this late time of the day.

THE WITNESS: Good afternoon.

CROSS EXAMINATION

BY MR. KASSIN:

Q. Are you -- are you a qualified toxicologist?

A. No, I am not.

Q. And how many -- as a HIMS AME, how many Delta pilots have you been medical sponsors for?

A. Delta pilots? As a medical sponsor, I can't remember. I don't think I have for Delta.

Q. That's correct so --

A. But I have been doing this for 43 years. So there could have been a Delta pilot in there, but I can't recall any.

Q. Mike Doyle. who does he fly for?

A. He flies for Republic.

Q. Original carrier?

A. Correct.

Q. Are you familiar with their HIMS program at Republic?

A. Yes, I am.
Q. Okay. I should have asked you first, are you familiar with the Delta HIMS program?
A. Somewhat, yes.
Q. Okay. Are you familiar with FAA's requirements for re-treatment after a relapse for a pilot who's flying for a Part 121 carrier?
A. Yes, I am.
Q. The FAA does require re-treatment for a Part 121 pilot who's had a relapse, correct?
A. If -- yes. My opinion is if it's definitely proved as a relapse.
Q. I did have a question about a couple of the documents that you were asked about. Let's deal with that hair test. And I believe that is Union Exhibit 38. And this is simple, we can call it up -- Emily, if you could put what the cutoff was on at 20 pg/mg. Doctor, what is 20 PG, What does the unit measurement for that?
A. Well, this was a hair test as opposed to PEth test. PEth is the nanograms and -- I'm sorry?
Q. The hair test is in a picograms?
A. Correct.
Q. That's per milligram?
A. Yes.

Q. Okay. Did you tell the laboratory to use 20 as the cutoff?

A. I don't tell the laboratory to do anything. That's their position.

Q. Are you familiar with the normal cutoff for a hair test for EtG would be 2?

A. I'm not familiar with that. I looked at many of them, but I don't -- as you say I'm not a toxicologist, so I had no need to look at it that closely.

Q. Are you familiar with the standards that are used by the Society of Hair Testing for EtG hair test?

A. No, I'm not.

Q. Okay. I mean, so you don't know that they considered 7 picograms per milligram to be the indicated repeated alcohol exposure?

A. No, I did not know.

MR. SEHAM: I object to the form. It appears that counsel is testifying.

MR. KASSIN: Thank you.

MR. SEHAM: I object to the form that unless you have had a witness who established that, then it's inappropriate for an attorney to state a fact and cross-examine a witness based on his stated fact.

MR. KASSIN: I asked him if he was aware of it, he

said he wasn't aware of it. I think asked and answered.

A. Generally as a doctor, I'm aware of many things. Yeah, I am aware that there are things like this. But not specifically to answer your question.

Q. Okay. You commented on what you understood to be the half- life of Peth. Can you tell us what your understanding is again? I'm sorry, I missed that.

A. Half-life of PEth, my understanding is four to ten days and this has been told to me by Dr. Jones, by Dr. Javors, others.

Q. Are you aware of scientific studies that establish that the half-life of PEth can range from one to 13?

A. I had been told that, yes.

Q. Okay. And are you aware that individuals with alcohol dependent can have a very short half-life as low as one day?

A. Anything is possible. That's why I don't say tests are infallible.

Q. Well, let's talk about that. You talked to Dr. Javors at the University of Texas, San Antonio laboratory?

A. Yes, I did.

Q. And Steve told you specifically that PEth was

infallible, correct?

A. Correct.

Q. And are you aware of any scientific studies that have shown there to be false positives in PEth?

A. No. I know there had been studies but, I'm not aware of it, but Dr. Javors did admit to me that even though it's infallible, he said I have a point that when there's questions like this is anything 100 % infallible and nobody gave me that answer.

Q. Does it -- I'm sorry. Are you finished?

A. Yes. Correct.

Q. Isn't it true that you told Dr. Jones that one of the pilots that you had that had tested positive for alcohol, that you couldn't believe that individual was positive and later when they went to retrieve it, they admitted they had been drinking?

A. Yes, I've had that happen.

Q. Could we call up Union Exhibit 4, please? You were asked about a statement in there about the PEth levels in excess of 20 nanograms per milliliter. And the possibility remains that an individual elevated PEth level may result from incidental or unintentional ethanol exposure. What is the source of that statement?

A. The source of the statement, it's on this lab

report. This caveat that's on here.

Q. Is there like a scientific study that supports this statement?

A. You'd have to ask whoever put the statement on the -- printed out that statement from the company.

Q. And so you were just relying on what you were reading on that particular statement?

A. Absolutely.

Q. Matt Dacier, the pilot that you talked about that came into the program with a DUI. Do you know what his blood alcohol content was for that DUI?

A. If I -- if I recall correctly, and again, you know, I've done thousand pilots roughly. His was a refusal to blow.

Q. Okay.

A. Refusal to test.

Q. So there might be a real problem there.

A. What do you mean by that?

Q. So somebody is refusing the test. So he was convicted of a DUI?

A. Yes, he was convicted.

Q. And you don't think somebody convicted of a DUI may have a substance abuse problem?

A. I didn't say he didn't have a substance abuse problem. Where did you -- where did you get that?

Q. That's why I made -- I'm glad you're clarifying that. Did you consider him to have a substance abuse problem?

A. I wasn't asked that. I was asked if he had a substance dependence problem. There's a difference.

Q. Okay. So may I ask you, does he have a substance abuse problem in your opinion?

A. He did because it resulted in him getting involved and everything that's happened. So you'd have to say yes.

Q. Okay. One minute, sir, I need to look at one of the exhibits you referred to. You may have already answered the question. I think you may have already covered this, I'm referring to Union Exhibit 35. I believe. I'm sorry, 37.

And Emily, if you could put on the sample information timing. If I could ask if you could put on the top of the page, the whole page. These are just very brief points of clarification.

REMOTE TECH: Union Exhibit 37?

Q. Yes, it is 37. Some of my tabs are smudged. I'm sorry. First question is, who is Lynn Collins?

A. As far as I know, she's a person who works for a lab near Matt Dacier's home where we get test -- testing done.

Q. Does she -- like a collector? Does she do the blood spot or the whole blood?

A. Correct. She'd been doing it for many years when I questioned her.

Q. Okay. And you've already pointed out that on this particular sample that was collected on May 18th, 2020, it came back positive at 24 nanograms per milliliter, correct?

A. That's correct.

Q. Okay. The only questions that you're raising is the later hair test that was given on May 28th, 2020 or collected on May 28, 2020 using the 20 picogram per milligram cutoff, correct?

A. That is correct. But remember we also performed other PEth tests on him and urine. I tested Mr. Dacier every way I could, trying to find any evidence that there could be alcohol involved.

MR. KASSIN: Okay. Mr. Burdette, I may not have any additional questions, but I'm going to need five minutes just to look at my notes real quick. So --

THE ARBITRATOR: Okay.

MR. KASSIN: -- let's have a five-minute break.

THE ARBITRATOR: Take five minutes break.

MR. SEHAM: All right. Before we break, Mr. Arbitrator, I would like as soon as we're finished with

this witness to move onto Michael Perez.

THE ARBITRATOR: That's fine.

MR. SEHAM: So I'll use these five minutes to try to contact him and get him.

THE ARBITRATOR: Okay.

(OFF THE RECORD)

THE REPORTER: We are back on the record at 4:00 p.m.

THE ARBITRATOR: Thank you, Damien. Any redirect, Mr. Seham?

MR. SEHAM: No, Mr. Arbitrator. We are done. No.

THE ARBITRATOR: Thank you very much. Dr. Tordella, you may be excused. Thank you very much for your time and participation.

THE WITNESS: Thank you.

THE ARBITRATOR: Emily, will you take him out of the meeting, please? Thank you.

MR. SEHAM: We're now ready to proceed with Michael Perez.

THE ARBITRATOR: Okay. You know, if Michael Perez is in the waiting room, would you please bring him in?

THE REPORTER: He's in now. He just needs to connect. His --

THE ARBITRATOR: Okay. Very good. I see him, yeah.

THE REPORTER: There he is.
THE WITNESS: Good evening.
MR. SEHAM: Good evening.
THE ARBITRATOR: Good evening. Mr. Perez, would you please raise your right hand, we're swearing witnesses in this case.
THE WITNESS: Yes, sir.
THE ARBITRATOR: Do you swear or affirm that the testimony you're about to give in this case will be the truth, the whole truth, and nothing but the truth?
THE WITNESS: I do.
THE ARBITRATOR: Thank you very much. Is there anybody else in the room with you?
THE WITNESS: There's not.
THE ARBITRATOR: Do you have any documents that are not a part of the exhibits to this case?
THE WITNESS: No, I do not.
THE REPORTER: Thank you very much. Mr. Seham, you may proceed in statement.

MICHAEL PEREZ,

having been first duly sworn, testifies as follows:

DIRECT EXAMINATION

BY MR. SEHAM:

Q. Okay. Please state your name again, for the record.

A. Michael Douglas Perez.
Q. And where are you currently employed?
A. Delta Airlines.
Q. What capacity?
A. I'm an airline pilot for them.
Q. How long have you been a pilot for Delta?
A. I was hired September 25, 1997.
Q. Okay. Are you a heavy drinker?
A. I am not.
Q. Okay. When's the last time you had a drink of alcohol?
A. Last time I had a drink was August 2015, the day of -- of my incident, so.
Q. Okay. And we'll come to that. Have you ever had an alcohol dependency issue?
A. I have not.
Q. Okay. But you made reference to a driving incident related to alcohol?
A. I did.
Q. Okay. Can you briefly describe how the incident came about?
A. Yeah. It was in middle -- I believe it was August the 22nd, 2015. My wife and I attended an outdoor concert and met up with some friends. And I had several drinks, too much to drink. And we were

leaving the concert, I was driving, we were in a parking lot in a line of cars waiting to leave, and I hit the bumper of -- of the car ahead of me, scratching the bumper of the -- the vehicle. He was not happy about it. Wanted a police report, police came, administered a field sobriety test, and subsequently I was arrested for a DUI on that day.

Q. And did that incident have any impact on your employment with Delta?

A. It -- it did. Mostly the, you know, I had to go through the -- the HIMS program, and I was -- I had to sign a -- a contract with what, I think, they refer to it as Contract A, for Delta Airlines.

Q. And did that require you to enter a rehabilitation program?

A. It did. I went to a facility called Talbots in Atlanta, Georgia.

Q. Who was your AME at the time?

A. They -- they assigned me, Dr. Charles Harper Senior.

Q. Did he express any opinion as to whether a rehabilitation program was appropriate for you?

A. Yeah, he did, yeah. Throughout the -- the initial process and then even afterwards, he -- he said that, you know, he didn't believe that I was an

alcoholic, that I didn't have an alcohol dependency problem. He thinks I just made a mistake. And subsequently, then he petitioned to have a reduced sentence, if you will, a one-year program instead of the usual three to five- year program. And he submitted that to the FAA, but the -- the FAA denied it.

Q. Ultimately, why did you agree to go to Talbots?

A. Well, when I was going through the evaluation at Talbots, which is part of the HIMS program, apparently, you'd -- you'd go through the initial assessments. I was met by two chief pilots, the outgoing HIMS director, who unfortunately I can't remember his name, and an incoming HIMS director, Harry Miller, who was really -- had -- had -- I had all the contact with throughout this program. And they pulled me off to the side in a room, just the three of us. And the outgoing chief pilot looked at me, and he said, we don't think you belong here, but this is going be the fastest way you get back in the air. This is going to be the easiest way you get back in the air. And we don't -- I don't want you to be angry about it. You -- we should -- you should learn something during the process. And perhaps everybody could learn from the

process, but -- and that's what I wanted to do. I wanted to get back in the air and fly. So that's -- that's why I went -- went ahead and went through the program.

Q. How would you describe your treatment at Talbot?

A. I -- I -- I think it's -- it's similar to trying to push a s -- a round peg through a square hole. You know, they were -- regardless of what you say, they're going to put you in the program. I -- I -- I would tell them -- I said, listen, I -- I just I -- I maintain three jobs, you know, I was not only with Delta, but I was a sheriff's deputy, I was teaching motorcycle classes, and -- and I very seldom drank, and -- and they said, well, you know, denial, you know, all alcoholics deny it. And -- and I said, well, but I -- I haven't drank since I had the accident. I don't have urges. I don't have triggers, you know, I -- I just -- if you told me to quit drinking, I just quit drinking. And they said, well, that just makes you a dry drunk. And -- and I said, well then, you know, I -- I do all these jobs -- these three jobs that require me to be at my peak level. And I've -- I've been very successful. It's never affected my -- my occupations. And they said, well, that just makes you a high-functioning

alcoholic. So I was -- it was -- you just couldn't win, I -- in my opinion. And what was, you know, so the solution to this disease, that they said I had, was, you know, never drink again, and you're going to go through a 12-step religious program. I mean, that's -- that was their answer.

Q. Did you receive any warnings from Talbot concerning alcohol ingestion or exposure at the time you completed the program?

A. Yes. Yeah. They -- they -- throughout the program, especially at the end, they -- they submitted, and I -- I don't have it with me, but they -- they submitted a -- a sheet of -- of hundreds of household products that people could find at home, a typical home, consumer products that could cause you to test positive for -- during a urine test. And -- and they -- it was everything from -- I -- I -- I remember I took it home, and we went through food products that you would, normally, have in the refrigerator. I do remember there was a -- a detergent that we happened to use, that we had to get rid of. And especially they -- they always emphasized to -- to completely avoid any type of hand soaps or hand sanitizers that were alcohol-based, which, apparently, they've just corrected, and sent out a memo saying that, it's okay

after the COVID kicked up. Yeah, there's a lot of -- a lot of products, they said that you needed to avoid.

Q. Did you return to flying immediately when you completed the Talbot program?

A. No. The FAA has to issue a special issuance FAA medical. And I came out of Talbot in -- in late December, right before Christmas. And I wasn't released on my special issuance until I think, June of -- of, you know, about six months.

Q. During this interval, when you were on the ground, what projects, if any, did you involve yourself with?

A. Well, I -- I, you know, I had a lot of time off. My -- my wife is a yoga instructor, Pilates instructor, personal trainer. She has a business called Faith In You Fitness, and she decided to open a business in town. So we took a building. We rented a building that had been formerly a -- everything from a gas station, to a meatery, to a, I think, it was last a pizza place. And we decided to do -- do the work ourselves and -- and make a -- a private studio for her -- for her -- her and her clients.

Q. Okay. And did that work involve any products or compounds that might contain alcohol?

A. It contained a lot of products. It -- it can

-- we -- we did have a lot of solvents, a lot of degreasers, paint thinners, paints, a lot of industrial cleaners, that we had to use. The place was -- required a lot of work and -- and yeah, there were a lot of chemicals that I dealt with.

Q. Okay. And during this period prior to resuming flight, were you required to abstain from the consumption of alcohol?

A. Yes. In fact, I'm -- I'm required to abstain throughout my entire career at Delta Airlines.

Q. And were you subject to any testing to confirm this abstinence?

A. Yes. Random drug testing from home. They would call me and tell me to go to a lab and take a urine test for -- for alcohol.

MR. SEHAM: Okay. Emily, could you bring up Union Exhibit 34. Okay.

(Union Exhibit 34 marked for identification)

Q. Okay. Can you identify maybe just -- yes. Okay. Can you can you identify, Captain Perez, this email dated February 23rd, 2016?

A. Yes. That was actually an email from Choice Labs from Michele Gable indicating that I had tested positive on a urine test.

Q. Could we scroll down to the second page? We

might have to blow that up a little bit. Then if you could scroll down, can you -- can you see there at the very, very bottom what your -- your EtG quantitative result was?

A. Yes. It indicates 138 Nanograms per milliliter.

Q. What was the cutoff being applied for a positive test?

A. 100 Nanograms per milliliter.

Q. Now, were you terminated or sent back to rehabilitation based on this test result?

A. I was not, no.

Q. Did you ever have -- do you know who chief pilot Harry Miller who he was or did you ever deal with him?

A. Yeah. He was a lot of times just my direct contact. He is the one that called me initially when this happened, before I ever got the results back from Michele Gable. He just called me and said that I had a positive EtG.

Q. Did he make any reference to the positive -- the possible cause from that?

A. Yeah, well, he did, you know, I was very alarmed, but he told me, he said it -- what he -- and I didn't have him expound on, but he says it just appears

that it was an incidental exposure to something so that's what I assumed it was.

Q. All right. Did you have further contact with with Ms. Gable concerning this issue?

A. Yeah. I contacted Michele Gable and she said that I had to at this point submit to a PEth test.

Q. How did you get the PEth collection kit?

A. She FedExed it to me the next day.

Q. Where was the collection performed?

A. To my knowledge the lab -- I live in Indiana and I've used several labs. Most of them, you know, the -- well, they've all been approved by Michele, but the one I believe it was was a Medical Laboratories in Noblesville, Indiana, which is where I have to drive to take these urine tests.

Q. Did they extract whole blood from your veins or was it a question of placing drops on a card?

A. It was the drops on the card.

Q. Can -- can you describe the collection process?

A. Yeah. They have you wash your hands. They pull out the kit, put it on a napkin and they take a needle and prick your finger and then they have the blood droplets deposited on a card. I don't remember how many droplets, but droplets on a card.

MR. SEHAM: Emily, if we could now move to Union Exhibit 33.

THE REPORTER: We lost Mr. Burdette, Mr. Seham. Mr. Burdette, are you there? Arbitrator Burdette? Okay. Off the record at 5:26 p.m.

(OFF THE RECORD)

THE ARBITRATOR: Sorry, gang. I got jumped out.

MR. SEHAM: Okay.

BY MR. SEHAM:

Q. We would move forward to his proceeding with a PEth test that was on using the DBS process. The next question was going to be, did you later have a further contact with chief pilot Captain Harry Miller concerning the results of that PEth test?

A. I did. I received a call. I don't remember the timeline, but he called me and he told me that the PEth results came back as a non negative.

Q. All right. If we could move, Emily, please, to Union Exhibit 33 and move to page 5, which is Bates stamp USDTL001110. Okay. Now, this is a test report from Michael Perez indicating a positive for a PEth blood spot with a collection date of March 16th, 2016. Does that correspond to your collection or your provision of the blood spots?

MR. KASSIN: I'm sorry, Mr. Seham and Arbitrator

Burdette. I'm confused. We've just been talking about a February 11, 2016 test, Union Exhibit 34. Then he said he was required to go take a PEth. When was -- are we talking about the PEth test at this point that he was required to take?

MR. SEHAM: Correct.

MR. KASSIN: What was the date of that?

MR. SEHAM: Collection was March 16th.

MR. KASSIN: Okay. Well, that's inaccurate. The actual collection was on February 23rd. I've got the sequence of his testing right here. He was given -- he had a split EPG, negative EtS on February 11, 2016. That's just what we looked at it as Union Exhibit 34. He was then sent on February 23rd for the PEth when the result came back and it came back negative.

THE ARBITRATOR: What Union Exhibit is that now?

MR. KASSIN: That's what I'm trying to figure out. I mean, we -- we -- we skipped a bunch, so I've think if we'd go to Union Exhibit 33. If we look for -- do we have that? Do we have that in there?

THE ARBITRATOR: Yeah. I've got it.

MR. KASSIN: Okay. I'm looking for the test that was collected on February 23rd, and it looks to be -- I'm looking for a Bates stamp or something on it, but it's several documents into this exhibit,.

THE ARBITRATOR: It was not Union 33, because that has to do with an October test.

MR. KASSIN: Well, there's a bunch of exhibits in there. That's what I'm confused with.

THE ARBITRATOR: Okay. All right, I'll look.

MR. KASSIN: That's why I'm having a problem, okay. The Union Exhibit 33, what I'm looking at the very first page is a February as a random blood taken on 10/3/2017. On the -- then there's something copied on the back of that on our page which looks to be a chain of custody for October 3rd, 2017. Then we skip to a May 4, 2016 EtG that came back negative. Then on the back of that is a chain of custody dated May 4th, 2016. Okay.

THE ARBITRATOR: It's down on page -- it's a Page 8 of, 23 is February 23rd, test. If that's what you're talking about.

MR. KASSIN: Thank you, sir, that's what I'm trying to find.

THE ARBITRATOR: Okay. It's on the PDF, it's Page 8 of 23. Is that what you were referring to, Mr. Seham?

MR. SEHAM: No.

THE ARBITRATOR: No? What are you referring to?

MR. SEHAM: I was referring to page 5.

THE ARBITRATOR: Page 5.

MR. SEHAM: It's a document, it's by USDTL indicating a positive -- a collection on March 16, 2016.

THE ARBITRATOR: Got it.

MR. SEHAM: Okay. And it was received on 17th the next day and then it shows at the bottom that it was positive for PEth at a quantification of 10 nanograms per milliliter.

THE ARBITRATOR: All right.

MR. KASSIN: That's not part of his testing protocol. I'm sorry. He was tested -- I mean, he started -- I mean, he just testified he was tested on 2/11. He had a split. He was positive on the EtG at 138, he was negative on the EPS. He testified that the PEth he was given was the one on Page 8. It's the one in February 23. Why are we talking about the March one? It's irrelevant to the follow-up. So he came out of -- the February 11 was exactly the protocol that we talked about earlier with Captain Storbeck.

MR. SEHAM: This plaintiff's argument and I'm trying to present evidence without trying to skip to the briefing period.

MR. KASSIN: But it's not appropriate for you to try to use another document to prove something that is

not related to that February test.

MR. SEHAM: I would ask not to be -- I would ask not to be shouted down. I would ask not to be interrupted. I would ask not to be subject to allegations, really pedestrian vulgar representations about my not doing things right. There's -- so much for Delta cordiality.

THE ARBITRATOR: Okay. Okay. Okay.

MR. SEHAM: I have a document providing USDTL and I'm asking questions about the document and what this man was subject to as a result of testing positive as referenced by USDTL. That -- now we're briefing issues. I would like to proceed with the questions.

THE ARBITRATOR: Proceed. Go ahead.

BY MR. SEHAM:

Q. So did you, to the best of your recollection, provide a specimen -- blood spot specimen on or about March 16, 2016?

A. Yes, sir.

Q. Okay. And you were subsequently told by Captain Miller to, I'm just recalling your testimony that you had had a non negative test, right?

A. That's correct. That's the exact term they used. That was a non negative.

Q. And how did you respond to this news?

A. Well, I -- I wasn't sure what -- first of all, what a non negative meant. I mean, they use such vague terms, but I -- excuse my French, but I did -- I said, what in the hell does a non negative mean? He said, well, it just means that you're going to have to go get tested further, but I didn't realize that, you know, regardless of being 100% compliant with this program and never consuming alcohol, how easily it was for me to get exposed to something that's going to test positive and -- and jeopardize my career.

Q. Did you communicate your concerns to Captain Miller?

A. Oh, I did. I told him I -- I plain out told him I'm willing to take a polygraph test and, I think Harry was more just the -- the guy giving the information, you know, he -- he handed me off to, at that point, to my AME Charles Harper.

Q. How did Captain Miller -- I may have spaced there for a minute. Captain Miller responded by referring you back to Dr. Harper?

A. Yes.

Q. Okay. And how did things proceed with Dr. Harper?

A. Well, I -- I talked to Dr. Harper and -- and told him -- I said, listen, the only thing I can -- I

can think of -- now my wife's on the phone calling every restaurant that we've eaten at. Trying to figure out if any of the cook has put alcohol in and it was just -- it was a goat rope trying to figure out what -- where this -- this test came positive from and -- and the -- I told Dr. Harper in the past I've been a firefighter. I knew that he was going to probably want the material safety data sheets indicating the chemicals in the -- in the breakdown of chemicals in the product and I just started firing off as many material safety data sheets as I could via text message to him.

Saying this is what I've -- I'm-- I'm dealing with. This is what I think may have caused all this. Whether or not it actually said the word alcohol or whether it triggered a positive -- a false positive, I don't know. But I sent off dozens of these material safety data sheets on these chemicals that -- that I could find, most of which, you know, I had to go online to find.

Q. Was there any additional testing arranged for you as a result of this PEth test?

A. Yeah. So Dr. Harper said that -- that he wanted to do a long-term test. He wanted to do a hair sample test to indicate long exposure or something on alcohol. Unfortunately, I keep my hair short. So he

said what we're going to do is we will submit a nail test.

Q. And who performed the process of -- you're talking about fingernails?

A. Yes -- yes.

Q. And who performed the process of obtaining the nail clippings?

A. I absolutely cannot tell you for sure. I -- I do know that Michele Gable indicated that there were certain labs that had -- that was equipped to do it, and so I just went to the lab that she told me to and I -- I -- I can't tell you which lab that was.

MR. SEHAM: And if we can go to Union Exhibit, I can't recall which exhibit we're on.

THE ARBITRATOR: We're on 33.

Q. Okay. So 33. So we can move two pages back to Page 3. Okay. And just for the record, it's a USDTL drug test report on page Bates stamp USDTL 001108. And did you provide, as indicated here, a nail sample on or about May 4th, 2016?

A. Yes.

Q. And the result here indicates a negative. Does that conform to what you were advised in terms of the test result?

A. Correct, yes.

Q. Okay. How did Chief Pilot Miller react to your negative nail test?

A. He called me up and he said, you're good to go. And that's -- and that's -- and what that meant is continue with the program. I wasn't flying yet, so just continue with the program, you know, waiting for my special issuance. So he just said you're good to go.

Q. All right. Were you required to return to Talbot or some other rehabilitation or treatment program based on the PEth test?

A. No.

Q. And did they tell you why not? It had something to do with the negative nail test?

A. Yeah. Yeah. That -- that satisfied them. And you know, I was -- I was thankful that it -- that it, you know, proved my point. I mean, I -- like I said, I -- I don't know much about these tests, but I -- I do know that I've been 100 percent compliant, that -- that I felt, you know, that finally something came through, that pretty much, you know, agreed with my story line which is I did not drink any alcohol, so I was very --

Q. Okay. I'm sorry.

A. -- relieved.

Q. Did the process that you underwent cause you any concern going forward?

A. Oh, yeah. Absolutely. I -- at that point, I knew that -- that, you know, that there can be anything that -- that can, you know, cause these false positives and -- and -- and put my -- my career in jeopardy.

Q. Did you do anything further about the matter? I mean, in terms of the inconsistency of the PEth and EtG nail test at that time?

A. No. You know, I -- I didn't do a lot of -- I would -- I assumed that Delta Airlines and the people that ran the HIMS program knew what they were doing. I -- I didn't -- I -- I -- I would make -- made the assumption, right, wrong, or indifferent that this was just par for course that -- you know -- people test positive because they washed their hands with the wrong stuff or they put the -- they didn't check what was in their food. And so I was just letting them do their job and I was going along with the program.

Q. Did there come a day when you got a call from Michael Danford?

A. Yes.

Q. And you discussed with him -- what was your reaction to Michael Danford's account that he told you?

A. There was a lot of reactions. One, I was

very surprised that I even got a call from anybody. I was told from the very beginning by Harry Miller, if you don't want anybody to know about this program -- that you were in this program, that's up to you and I didn't tell anybody. And suddenly I'm getting calls from these pilots saying, hey, we heard that there were some tests discrepancies, and -- and Mike told me that -- that he had a similar situation. And I said, well, you know, it seems to be what happens and -- and the -- the unfortunate thing is, is it seemed to be that he was being treated a lot differently than I was. And, you know, although I had been released by the FAA and I didn't feel much obligation to do anything, I -- I felt for him because it was -- it's exhausting to go through this process wondering if you were going to have a career tomorrow morning. And I just felt that somehow that I was getting a different treatment than he was. And -- and I don't know why because I didn't -- I've never asked for special consideration.

Although, I will even today deny that I've ever been an alcoholic or never had a alcohol dependency problem, you know, suddenly I -- I'm being treated what appears to be, you know, I have this preferential treatment that I didn't ask for and Mike unfortunately he's on a different paths and I -- and I think that's

-- and that's what I thought, and I thought, well, yeah, I'll -- I'll tell him my story and that's what I've told every pilot that has ever contacted me. I -- I'm not here to defend anybody. I'm here to tell my story and that's -- that's it.

Q. Okay. Did USDTL ever provide you with the test results prior to this case coming up?

A. No.

Q. Did Michele Gable provide you with a PEth test resolve or nail clipping test results?

A. She did not. And -- and when -- and I again, thinking that these guys knew what they were doing, if they said, hey, you need to go get retested, I just went and got retested. When suddenly -- when Mike starts bringing this up, I, you know, I -- I have a curiosity about well, what are these tests, what were the actual numbers? Because I've never seen the actual numbers until this started happening. And so I -- I asked Michele, I said, can you send me all the records of -- of all the testing I've ever done through Choice Labs.

Q. Okay. And did she provide that to you?

A. She provided the last three years which did not include the -- the tests that we're talking about here today.

Q. And did you provide your medical authorization to my law firm to obtain the results directly from USDTL?

A. I did.

MR. SEHAM: Yes. And if we could bring up the Union Exhibit 60.

THE WITNESS: Okay.

(Union Exhibit 60 marked for identification)

Q. And if you can scroll I think down to the second page. Okay. And is this an authorization executed by you, the second page of Union Exhibit 60?

A. It is.

MR. SEHAM: All right. I have no further questions. But I imagine Delta's Counsel, Mr. Kassin will have questions.

THE WITNESS: That's fine.

CROSS EXAMINATION

BY MR. KASSIN:

Q. Mr. Perez, are you Captain or first officer, do I refer as Captain Perez or Mr. Perez?

A. You can just call me Mr. Perez. I'm a captain, but Mr. Perez is fine.

Q. And what -- and so what do you flying these days?

A. I fly 737.

Q. You can take that subpoena down. We don't need that. Okay. So I want to try to put things in the chronological order and that's the purpose of these questions. It's just try to get a sequence in here because we did jump around a little bit. So your DUI as best you recall was August 22, 2015, correct?

A. Correct.

Q. What was your blood alcohol on that DUI?

A. It was, I think .14.

Q. Okay. So then you go into the treatment at TRC. There's a meeting that you had with Captain Harry Miller, who was coming in and then who is the outgoing Chief pilot?

A. I cannot tell you his name. I'm sorry.

Q. Okay.

A. I'm sorry. Was there a question?

Q. No, I'm thumbing through notes. I really don't have that many questions for you.

A. I'm sorry.

Q. Currently, who is your HIMS AME?

A. I -- I no longer have a HIMS AME. I -- when Dr. Charles Harper Senior passed away, his son, Charles Harper Junior, took over and I've been out of the HIMS program, although I'm -- I'm still subject for a two-year period that ends, I think in June of next year

of -- of random drug testing at a much lesser frequency. I -- I've been released by the FAA and I'm no longer under the HIMS program.

Q. Okay. And, so you go into the TRC November 16th, 2015, does that sound right?

A. Yeah, it was I -- I -- I remember it was, I think the chief pilots offered me the opportunity to wait until after Thanksgiving and I said, no, let's just get this thing over with. So it was right before Thanksgiving. I -- I can't tell you the exact date. I -- and I know I came out right before Christmas.

Q. Okay. These questions are intended to -- what's your understanding of the DPAC program was that was affecting you and then I'm going to get into some of the specifics of the testing that you heard the exchange about. While you were in TRC, did they give you a test as part of their process and part of the rehabilitation program as you recall?

A. As -- as part of the evaluation process?

Q. Well, did they give you a urine test or PEth tests or --

A. Yes. Yes.

Q. And all those were negative?

A. Yes. I believe so. I -- you know, I just -- like I said, I'm just in the program, but --

Q. Okay. And you graduated from TRC and sign your Contract A on December 18, 2015?

A. That sounds about right, on the day. I think I signed that contract at the beginning. I might be wrong, but I -- I thought --

Q. You might have. Okay. I think we have a copy of your Contract A. And what we're seeing on that is that it was signed on December 18, 2015.

A. Yeah, that's probably correct.

Q. So the first test that Delta shows you receiving while you were in DPAC is the one that's on Exhibit 34, and it's the -- let me be sure I can find it again. I had it a second ago. It's the one that showed the -- it's on page 2 of Exhibit 34. Emily, if you could pull that up for us so we can see it. Thank you. And that's the one where we've had a lot of testimony about the EtG EtS test, but this is the one that you were positive on the EtG and you were negative on the EtS. And then you were asked to do a PEth test after that. And if you could look at page 5 of -- let me see. We got to get the right document.

MR. SEHAM: Exhibit 33?

Q. I believe that was 33. It's the one with all the -- all the tests in it. Yep. I got it. So it's 33. And if you can look at Page 5. And Emily, if you

could -- I'm sorry, Page 8. Page 8 is the one that I want to go to. And Captain Perez, what I'm trying to do is establish that after you had that positive EtG, negative EtS that you were given a PEth and the PEth test was collected on February 23rd, 2016, and that you came back negative on that. And that's what the document is that Emily has put up for us on a -- can you see that?

A. I -- I see it. If that's what you're asking.

Q. Okay. And during the course of your time with the folks at DPAC, did you have, like, pilot sponsors or in addition to company sponsors, was there somebody from ALPA that you might have worked with?

A. No. I had -- I mean, I had -- I had a pilot peer monitor.

Q. And I'm not asking names or anything like that. I just want to know if you had somebody. Did you understand that the positive cutoff for the PEth test was 20 nanograms?

A. I knew nothing about the PEth test.

Q. Okay. Again, that's what I'm trying to do is establish the level of what your information and your knowledge was as you were going through this program. So if I told you that to be positive on a PEth test, you had to be 20 nanograms or greater, you're saying

you had never heard that before?

A. Never.

Q. Okay. Did Mr. Danford tell you that? That you had to be 20 or more before you --

A. He -- he did not.

Q. Okay. I'm asking you this for a reason because I don't want to ask a question if it's inappropriate. Is Mr. Seham your attorney?

A. He is not.

Q. Okay. Then did Mr. Seham tell you that the positive -- the cutoff for a positive PEth test is 20 nanograms or higher?

A. I think we exchanged some emails when -- when he got those tests because that's the first I've ever seen the test was when he received them. And -- and let me make something perfectly clear to everybody that I never -- some of it's ignorance. I assumed Choice Labs was the lab I was dealing with. I -- I -- I didn't pay much attention to this UTL lab and I never requested information from them. And so that was the beginning. And -- and when I started getting this information, you know, he was giving me the exhibits. I'm trying to make sense. I -- and I don't know if he actually gave me the cutoff.

And -- and even today, I couldn't tell you the --

what the cutoff is, but that's the first I've seen the test, so I don't know if that's an answer or not, but I -- I honestly don't know anything about the PEth test other than what I was told by either Michele or from Harry Miller saying you got to go get retested so, you know, something's not right.

Q. Okay. So the test that you did the sample on February 11, 2016 would have been the one that Michele Gable from Choice Labs asked you to go in and give a urine sample?

A. The urine test, is that what we're talking about?

Q. Yeah. The February 11th urine test.

A. The one that tested positive yeah, the -- she's -- yeah. All these -- all these have been directed by Michele. You know, it -- she'd say you've been randomly selected and I go, I just take a form and I drive to Noblesville, Indiana to a lab and I take a urine test.

Q. Now, would Dr. Harper Senior also do some -- direct you to do some testing before your special issuance was issued?

A. The only thing he directed, to my knowledge and I don't know what -- if they had any other subsequent conversations with the rest of the team, was

-- was the nail test. I don't know whether he was a -- a direct contact to Michele or if Michele had contacted him. I don't -- I don't know the relationship there, but I do know that -- that when -- excuse me. When the PEth test came back as a non-negative, whatever that meant, it was Dr. Harper says, you know what? We want to do a hair test, I said okay, good luck on that and he said, well, we'll do a nail test which required me to grow me -- I don't have long nails, so that required my -- me to grow my nails out for an extended period of time before I get -- got those clipped and tested.

Q. Okay. And I'm going to ask you questions about Page 5 of Union Exhibit 33. And Emily, if you could put that page up again, please. Okay. This is the test that -- do -- did Dr. Harper ask you to do this test?

A. The -- is that the PEth test?

Q. Yeah. The March 16th sample --

A. To my knowledge, he didn't let -- he did not tell me directly, no. I mean, he did not -- I did not have a conversation with that. That was directed by Michele Gable.

Q. Okay. And --

A. And I don't know where she got her -- her directive from so --

Q. Did you understand that this was not a DPAC required test?

A. No. I'm just following what the guys that run the program told me to do.

Q. Okay. Well, so your best recollection is that Michele Gable told you to take this test?

A. I was told that -- yeah. To the best of my knowledge, like I said, I don't know who directed who in this program, but I do know that she's the one that I -- that she sent me the email. I think that was in a -- an earlier thing. And she said, you know, you've tested positive. I think in the exhibit it said something like you've -- this is what we discussed, that you tested positive, and I'm going to forward a PEth test to you. And I made contact with her. She wanted to know my address and that it was going to be FedExed immediately.

Q. Okay. So you mentioned you got your special issuance in June of 2016. Does June 22nd, 2016 sound about right for getting your FAA specialty issuance back?

A. That sounds about right. I -- I don't know the exact date, but it was in June.

Q. Okay. So all the things that we've been talking to up until this point in time were things that

occurred prior to the FAA issuing your specialty issuance?

A. That's correct.

Q. And Dr. Harper would have to support it -- Harper Senior would have had to support your special issuance or the FAA would not have done it, correct?

A. I would assume, I -- I don't know. I don't know how -- I don't know how the -- how this works.

Q. Okay. And is it fair to say that once you'd been issued your special issuance back in June of 2016, that any of your -- all of your later tests that you did part of the DPAC program all came back negative?

A. I think that's fair to say, yes.

Q. Okay. And then going forward, after your first specialty issuance, Dr. Harper would help you with the renewals of your special issuance and you're flying today like you discussed earlier?

A. I'm sorry. Oh, that he --

Q. I'm just saying that you've had no issues, you've had no positive tests since the special issuance and renewals of your specialty issuance have taken place on a regular basis?

A. Well, I'm no longer under a special issuance so --

Q. Okay. But before that, did you have renewals

of that special issuance from June of 2016?

A. I mean, I was under a special issuance until a specific date. I don't know whether someone has to constantly -- I don't know how that works, I don't.

Q. Okay.

A. I was given the special issuance for a certain amount of time and then I was given my regular medical and at that point, I -- I could see whatever AME I wanted to see.

Q. Okay. How did Mr. Danford know that you had been in the DPAC program?

A. I have absolutely no idea because I've never mentioned it to anybody.

Q. Okay. Did you ask him how he found out that you were in the program?

A. No.

Q. Okay. Did you ask Mr. Seham how they found out that you were in the DPAC program?

A. I did not.

Q. Okay. And do you understand that Delta Airlines Management takes the confidentiality of the DPAC program incredibly seriously and --

A. Someone -- someone didn't. Someone didn't.

Q. Do you have any indication that it was somebody at Delta Management that talked to Mr. Seham

about --

A. I have no indication who it was, but I'll tell you I've never ever told anybody I was in the HIMS program, ever.

Q. Well, and I want to assure you that the Delta Management respects the confidentiality of the program and takes the breach of what took place in your case very seriously.

MR. SEHAM: Objection. Objection. This is probably the 10th time that we're having counsel for Delta testify. He's not Delta Management, he's not under oath, and it is not appropriate to inject into this record his testimony. I would move a reason --

MR. KASSIN: It's a breach of confidentiality of the DPAC program.

MR. SEHAM: Please not talk over me.

MR. KASSIN: Period.

MR. SEHAM: Please not talk over me. I was not -- I'm making an objection. And you're disrupting the court reporting process, you're not respecting the arbitrator's authority, and you're disrespecting me. The only way this is going to work as a proceeding is that I am allowed to make an objection and finish that objection. You respond to the arbitrator and the arbitrator makes a ruling. So I'm finished with my

objection. If you want to respond now that I'm completed, then make your response and then let's have a ruling from the arbitrator and try to respect the cordiality that you say that Delta respects.

MR. KASSIN: Mr. Burdette, I need about five minutes, but I don't believe I have any more questions for this witness. But I'll be back in five minutes, sir.

THE REPORTER: You're muted, Arbitrator Burdette.

THE ARBITRATOR: Sorry. Sorry. Thank you. We will go off for five minutes.

MR. KASSIN: Thank you.

THE REPORTER: We're off the record at 6:02 p.m.

(OFF THE RECORD)

THE ARBITRATOR: Okay.

MR. KASSIN: Okay. I'm good now.

THE ARBITRATOR: No, you're good. You're good now. Sorry. I keep looking at the thing on your computer and it shows you're muted and it takes a minute to realize that you've got the speaker phone there, so --

MR. KASSIN: We have no further questions for Captain Perez.

THE ARBITRATOR: Okay. Mr. Seham, any redirect?

MR. SEHAM: No. No.

THE ARBITRATOR: Okay. Then Captain Perez, you may

be excused as you wanted to. So thank you very much for your time and participation. We appreciate it.

THE WITNESS: In case I -- I miss the people that were not in the room, I do apologize for having to mess the schedule up because of my reroute, but thank you for accommodating me. Thank you very much, gentlemen.

THE ARBITRATOR: No problem. Thank you.

THE WITNESS: All right.

THE ARBITRATOR: Take care. Emily, you can remove Mr. Perez. Thank you. Okay. What's next?

MR. KASSIN: Mr. Burdette, we have our last witness for our case in chief, which is Captain Jim Graham, who is available to us tomorrow at a window starting at 9:30 a.m. So I would suggest --

THE ARBITRATOR: Okay.

MR. KASSIN: -- we reconvene tomorrow at 9:30 a.m. Eastern, 8:30 Central.

THE ARBITRATOR: Okay.

MR. KASSIN: Again, our case in chief with Captain Graham.

MR. SEHAM: Well --

THE ARBITRATOR: Okay. Seham?

MR. SEHAM: -- I had something to say to that because we had advised the panel that we had Dr. Gregory Skipper, we had made arrangements with him to

testify tomorrow at 10:00 a.m. The problem with that is he's a doctor and consultant with a very busy schedule. And that time that we set with him at some expense to us and inconvenience to him.

THE ARBITRATOR: Okay. Mr. Kassin, is your chief pilot going to be available later in the day or no?

MR. KASSIN: Not afternoon.

THE ARBITRATOR: Not afternoon?

MR. KASSIN: We'll go back and talk to him. But what we were given, his window ending right about noon.

THE ARBITRATOR: Okay. Well, I think --

MR. KASSIN: Let me know. If we need to do Dr. Skipper we'll --

THE ARBITRATOR: Yeah. I think so.

MR. KASSIN: -- we get all the other witnesses in. So if we need to get Dr. Skipper --

MR. SEHAM: Do you want -- do you want -- I mean, if you would all just hold three minutes, I'll see if I -- I'm fairly certain he told me that was -- he has all these patients coming in and he has his window as well. But I could call him right now and see if he --

THE ARBITRATOR: Okay. All right. Why don't you call him to see if he can do the afternoon instead of the morning tomorrow?

MR. SEHAM: I'll try that.

THE ARBITRATOR: Okay.
MR. SEHAM: I'm back.
THE ARBITRATOR: Okay.
MR. SEHAM: The witness for Captain Graham was what time?
THE ARBITRATOR: He said 9:00
MR. KASSIN: 9:30 in the morning.
MR. SEHAM: 9:30. All right. So I mean, I should hope -- I mean, do you have a sense of how long you have on direct for him?
MR. KASSIN: Well, Captain Graham's direct is usually about an hour.
MR. SEHAM: Okay.
MR. KASSIN: It may not be that long in this particular case because the issue is pretty narrow.
MR. SEHAM: Okay.
MR. KASSIN: That's generally what it's been running.
MR. SEHAM: Okay. So when I spoke to Dr. Gregory Skipper, he said he could push back to 12:00 Eastern Time.
THE ARBITRATOR: Okay.
MR. SEHAM: But his witching hour would be about 3:00 or about 3:00 or 3:30. I think that's enough.
THE ARBITRATOR: Okay. Yeah.

MR. KASSIN: I would say that would work.

THE ARBITRATOR: Yeah. Let's try and do that. I think we should be able to manage that okay. All right. So we'll deal with the company's last witness at 9:30 in the morning, Eastern, and then we'll plan on Dr. Skipper at noon time on -- tomorrow as well.

MR. SEHAM: Okay.

THE ARBITRATOR: Eastern. Okay. Anybody have anything else before we close for the day?

MR. KASSIN: No, sir.

THE ARBITRATOR: All right. Thank you. Have a good evening and we'll see you at 9:30 in the morning Eastern Time.

(Whereupon the proceeding concluded.)

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REPORTER CERTIFICATE

I, DAMIEN STONEBERGER, hereby certify that the foregoing proceedings were recorded by audio by me, a disinterested person, and that the proceedings were thereafter transcribed to typewriting, by computer;

That I am neither attorney for nor a relative or employee of any of the parties to the action; further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto, nor financially interested in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand this October 29, 2020.

DAMIEN STONEBERGER
STORYCLOUD

SCOPIST CERTIFICATE

I, the undersigned, do hereby affirm:

That the foregoing electronically-recorded proceedings were scoped by me to the best of my ability.

I further affirm I am neither certified or financially interested in the action nor a relative or employee of any attorney or party to this action.

IN WITNESS WHEREOF, I have this date subscribed my name.

Dated: November 16, 2020

Stephanie Morano

STEPHANIE MORANO

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