



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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ARBITRATOR:

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APPEARANCES, CON'T

Also Present for the Union:

Emilio Marcos, Contract Administration
Committee Chairman
Kevin Morris, Union Board Member
Steve Mayer, Union Board Member

Also Present:

Michael Danford, Grievant
Emily Zavis, Remote Technician

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TRANSCRIPT OF PROCEEDINGS, VOLUME TWO
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

1 name.

2 A. Chris Storbeck.

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

5 A. I'm a retired pilot.

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

8 A. 31.

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

12 A. I was an engineer on a 727. I was a first
13 officer on the DC-9 and also 757/767 domestic. And I
14 was a captain and line check airman on an MD-8080 and
15 8090. And then I flew the 757/767 again as a captain
16 both domestically and internationally.

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

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

24 Q. Okay.

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

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

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

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

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

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

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

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

25 Q. Sure. Why did you volunteer to work with

1 DPAC?

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

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

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

1 in that capacity from 1999 through 2012.

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

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

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

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

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

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

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

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

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

1 served as DPAC committee chairman himself.

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

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

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

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

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

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

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

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

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

7 A. I was.

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

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

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

17 A. Yeah, I authored that document.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 Q. Okay.

17 A. Long answer, sorry.

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

25 A. Yeah. I think previous to this you actually

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

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

13 A. 2010, September.

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

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

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

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

18 A. Okay.

19 (Company Exhibit 16 marked for identification)

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

24 A. It is.

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

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

4 (Company Exhibit 4 marked for identification)

5 Q. And Captain Storbeck, this is the -- the date
6 on this policy is September 9th, 2014. At my request,
7 did you earlier compare Company 16 with Company Exhibit
8 4?

9 A. I did.

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

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

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

23 A. It did.

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

1 attached as Contract A and Contract B?

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

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

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

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

1 ensuring that impaired pilots do not fly in their
2 cockpits?

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

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

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

25 But the risk to the airline is substantial in that

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

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

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

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

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

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

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

20 A. They do.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 required for a pilot after relapse?

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

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

14 THE ARBITRATOR: Thank you.

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

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

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

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

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

8 BY MR. KASSIN:

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

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

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

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

1 accomplished by sending a pilot to retreatment.

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

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

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

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

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

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

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

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

16 A. I do.

17 Q. Please tell us.

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

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

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

17 MR. KASSIN: Mr. Burdette?

18 THE ARBITRATOR: Yes.

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

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

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

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

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

1 chosen.

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

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

13 THE ARBITRATOR: But I don't --

14 MR. SEHAM: Evidence objection and irrelevance
15 objection.

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

19 BY MR. KASSIN:

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

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

4 Q. Okay. Thank you.

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

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

19 A. At -- at Delta Airlines?

20 Q. Yes.

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

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

1 other carriers?

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

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

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

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

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

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

1 counterparts in Delta Airlines.

2 THE ARBITRATOR: Okay. That would be hearsay, but
3 --

4 BY MR. KASSIN:

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

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

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

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

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

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

25 THE ARBITRATOR: I think that he had some direct

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

3 MR. KASSIN: Okay.

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

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

15 (Company Exhibit 17 marked for identification)

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

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

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

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

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

5 MR. SEHAM: No, no. There are Exhibits 1 through
6 16, but we were never sent this document. So I would
7 like -- I would like to have a pause here while we get
8 emailed this document, so we can review it.

9 THE ARBITRATOR: Okay.

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

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

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

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

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

21 THE ARBITRATOR: Let's do that.

22 MR. KASSIN: Okay.

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

25 THE REPORTER: All right. We are now off the

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

2 (OFF THE RECORD)

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

4 THE ARBITRATOR: Thank you.

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

8 MR. SEHAM: Yes, I do.

9 THE ARBITRATOR: Yeah, I have it.

10 BY MR. KASSIN:

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

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

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

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

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

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

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

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

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

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

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

17 BY MR. KASSIN:

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

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

25 Q. And what are those changes?

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

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

11 A. There is.

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

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

16 Q. I think she just did.

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

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

22 A. It is.

23 Q. And what is the change?

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

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

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

13 A. I am not.

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

23 A. It was.

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

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

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

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

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

22 A. Correct.

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

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

5 A. I am.

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

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

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

21 A. I would.

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

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

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

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

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

21 A. Yes.

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

1 DPAC?

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

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

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

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

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

10 MR. KASSIN: Mr. Chairman, I'm going to request a
11 10-minute break. I believe I may not have any more
12 questions for Captain Storbeck --

13 THE ARBITRATOR: Okay.

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

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

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

21 (OFF THE RECORD)

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

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

24 BY MR. KASSIN:

25 Q. Captain Storbeck, this DPAC testing that's

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

4 A. Yes.

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

8 THE ARBITRATOR: Okay. Mr. Seham?

9 MR. SEHAM: Yes --

10 THE ARBITRATOR: Cross-examination?

11 CROSS EXAMINATION

12 BY MR. SEHAM:

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

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

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

24 A. Of course.

25 Q. Okay. And the idea underlying that

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

3 A. Correct.

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

7 A. Correct.

8 MR. SEHAM: No further questions.

9 THE ARBITRATOR: Any redirect, Mr. Kassin?

10 REDIRECT EXAMINATION

11 BY MR. KASSIN:

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

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

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

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

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

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

3 MR. KASSIN: No, sir.

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

6 THE ARBITRATOR: Oh --

7 BY MR. KASSIN:

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

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

15 Q. Okay.

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

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

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

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

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

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

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

11 Q. And how did it do that?

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

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

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

24 THE ARBITRATOR: I'll sustain the objection.

25 MR. SEHAM: -- relevance of the understanding.

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

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

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

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

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

18 A. Correct.

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

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

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

8 Q. Go ahead.

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

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

13 RE CROSS EXAMINATION

14 BY MR. SEHAM:

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

20 A. Correct.

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

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

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

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

4 A. Right.

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

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

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

17 A. Depending upon the airline.

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

20 THE ARBITRATOR: Anything else, Mr. Kassin?

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

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

25 THE WITNESS: Thank you, sir. My pleasure.

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

3 MR. KASSIN: You could leave.

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

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

8 THE ARBITRATOR: Okay.

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

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

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

18 (OFF THE RECORD)

19 MR. SEHAM: All right. Someone with --

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

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

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

25 ///

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

3 CROSS EXAMINATION

4 BY MR. SEHAM:

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

9 A. On average, yes.

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

15 A. Correct

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

19 A. Yes.

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

24 A. Correct.

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

1 why these results would differ. Would you agree?

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

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

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

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

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

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

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

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

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

24 A. Yes.

25 Q. Okay. And were anticoagulants used in that

1 whole blood?

2 A. Yes.

3 Q. What kind of anticoagulants?

4 A. Fluoride oxalate with the grey top tubes.

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

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

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

11 A. Not at the patient samples, no.

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

15 (Union Exhibit 28 marked for identification)

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

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

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

1 Jones. If we could move to Union Exhibit 29.

2 A. Okay.

3 (Union Exhibit 29 marked for identification)

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

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

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

24 Q. Okay.

25 A. And we make accommodations accordingly.

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

4 A. Yes.

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

8 A. Yes.

9 Q. Okay.

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

16 THE ARBITRATOR: Okay.

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

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

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

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

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

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

22 MR. SEHAM: Correct.

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

24 BY MR. SEHAM:

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

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

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

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

10 MR. SEHAM: Yeah.

11 THE ARBITRATOR: Okay.

12 MR. SEHAM: Yes.

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

16 BY MR. SEHAM:

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

21 A. Research and special request.

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

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

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

3 A. I would disagree with that statement.

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

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

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

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

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

19 MR. SEHAM: No, no.

20 THE ARBITRATOR: Go ahead.

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

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

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

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

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

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

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

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

1 Can you repeat that question, please?

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

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

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

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

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

16 A. Yes.

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

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

23 Q. Can you define the term PLD con?

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

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

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

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

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

17 Q. How about the concept of eliminations?

18 A. Say that again, please.

19 Q. Are you familiar with elimination rates?

20 A. Yes.

21 Q. Okay.

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

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

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

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

12 A. Absolutely. Absolutely.

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

16 A. No. No.

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

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

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

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

8 A. Could you rephrase the question, please?

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

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

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

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

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

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

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

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

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

8 (Union Exhibit 82 marked for identification)

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

15 A. Correct.

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

18 A. Yes.

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

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

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

6 A. Yes.

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

9 A. Yes.

10 MR. SEHAM: I have no further questions.

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

13 MR. KASSIN: I do.

14 THE ARBITRATOR: Okay.

15 REDIRECT EXAMINATION

16 BY MR. KASSIN:

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

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

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

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

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

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

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

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

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

11 MR. KASSIN: Same document, Union Exhibit --

12 THE ARBITRATOR: Oh, same document. Okay.

13 MR. KASSIN: -- 82, sir.

14 THE ARBITRATOR: Okay. Thank you.

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

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

19 BY MR. KASSIN:

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

22 A. Yes, I can.

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

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

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

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

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

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

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

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

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

17 A. Yes.

18 Q. Do you agree with that statement?

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

1 statement, yeah.

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

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

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

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

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

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

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

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

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

1 test. So going back to an example I used probably a
2 couple of times today and yesterday, was that these are
3 for tests where you're monitoring if the patient is
4 taking his alcohol as prescribed by his physician, and
5 is his alcohol level sufficient to do the job that the
6 drugs are supposed to do. So this is a very, very
7 different question than abstinence or not.

8 Verification of the abstinence or not. And so if it's
9 negative, the test that we offer in the test, the
10 question that we validated the test and answer was, if
11 it's negative, it's consistent with abstinence, but
12 it's clearly not conclusive evidence of abstinence.

13 But if it's positive, now we need some reasonable
14 explanation as to why it's positive, and the numbers
15 are relevant for a second reason.

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

1 600 for a question that we answered here, it's the same
2 result, it's positive, and we need a reasonable
3 explanation.

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

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

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

25 Q. Dr. Jones, you were asked two specific

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

6 (Union Exhibit Number 1 marked for identification.)

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

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

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

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

1 THE WITNESS: Yes.

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

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

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

21 A. Yes.

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

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

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

3 A. Yes.

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

7 A. Yes.

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

11 A. Yes.

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

14 A. He asked for copies of it, yes.

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

18 A. Yes.

19 Q. Okay. And did that happen?

20 A. No.

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

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

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

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

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

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

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

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

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

10 Q. Okay.

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

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

16 THE ARBITRATOR: Okay. Go ahead.

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

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

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

23 THE ARBITRATOR: Okay.

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

1 THE ARBITRATOR: Okay. Mr. Seham, any re-cross?

2 MR. SEHAM: Yes. Just a few questions.

3 THE ARBITRATOR: Okay.

4 RE-CROSS EXAMINATION

5 BY MR. SEHAM:

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

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

10 MR. KASSIN: I believe it's --

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

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

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

18 Q. Okay. And it was -- and it was dissolved in
19 2014, correct?

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

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

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

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

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

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

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

17 A. In their fields, yes.

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

20 A. Yes.

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

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

25 Q. And you had an opportunity to suggest any

1 revisions and make any changes you desired, correct?

2 A. I did.

3 MR. SEHAM: No further questions.

4 THE ARBITRATOR: Mr. Kassin?

5 MR. KASSIN: No further questions here either.

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

8 THE WITNESS: Thank you. Have a good day.

9 THE ARBITRATOR: You too.

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

12 THE ARBITRATOR: Sure. Yeah. Go ahead. We'll go
13 --

14 (OFF THE RECORD)

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

18 THE WITNESS: I do.

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

22 THE WITNESS: There is not.

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

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

4 THE ARBITRATOR: Okay. Very good. Thank you. Mr
5 --

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

9 THE ARBITRATOR: Okay. Mr. Kassin, proceed.

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

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

17 MR. KASSIN: Yeah.

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

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

25 THE WITNESS: Okay.

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

3 THE WITNESS: I'm not quite ready.

4 MR. KASSIN: Okay.

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

8 MR. KASSIN: That's correct.

9 THE WITNESS: Let me get that up as well.

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

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

16 MR. SEHAM: Okay.

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

22 BARRY SAMPLE, PH.D., D-FTCB,
23 having been first duly sworn, testifies as follows:

24 DIRECT EXAMINATION

25 BY MR. KASSIN:

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

4 A. Sure. It's RH Barry Sample.

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

6 A. Quest Diagnostics.

7 Q. Tell us what your position is with Quest.

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

11 Q. How long have you held that position?

12 A. I've been with Quest Diagnostics for -- since
13 1991. So over 29 years now. Was the doctor of science
14 and technology in 2000, 2001 and I've been the senior
15 director of science and technology for the last several
16 years.

17 Q. All right. How would you describe --

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

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

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

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

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

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

16 (Company Exhibit Number 14 marked for identification)

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

22 A. Yes, it is.

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

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

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

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

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

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

19 A. So if she's looking at it as a PDF, It's page
20 7 in her PDF number in there. There you go. That's
21 it. So this is a copy of the custody and control form
22 that was received with the specimen when it arrived in
23 the laboratory. The left-hand corner of the form, you
24 see a bar code and human readable numbers underneath
25 it. The first eight digit number corresponds to the

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

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

19 And the specimen that was -- that arrived at the
20 laboratory was identified as being provided by donor,
21 Mike Danford. So last name Danford, first name Mike.
22 A little bit further down, it indicates the test that
23 was requested. So you see that the SAP 10-
24 50/2K-3+EtG1 is indicated. So the specimen was
25 submitted for screening for drugs of abuse, 10 panel

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

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

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

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

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

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

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

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

5 MR. SEHAM: Are you referring to the hand letter
6 63?

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

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

14 THE WITNESS: Okay. So you see the sample name is
15 675976T, which corresponds to that laboratory accession
16 number that was assigned during the process. While
17 there is a positive result at or above, the test of 100
18 nanograms per ML, the result was 126 nanograms per ML.
19 The specimen met identification criteria. You can see
20 list the expected ion ratio and the calculated ion
21 ratio. And there's a little checkbox indicating that
22 that ratio confirms the ID. And if you look at the
23 retention time, you see that the calculated retention
24 time is 0.79 minutes and expected retention time is
25 0.81 minutes. All of which are within acceptable

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

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

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

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

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

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

4 MR. KASSIN: Correct.

5 MR. SEHAM: Okay.

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

7 MR. SEHAM: Yes.

8 BY MR. KASSIN:

9 A. Okay. So sample name 675976T, retention time
10 are acceptable. 0.76 -- sorry, 0.78, expected
11 retention time measure 9.78. ion ratios are
12 acceptable. The concentration on this analysis was a
13 116 nanograms per mL. Also still above the cutoff
14 that's applied for the initial test. Specimen would
15 consider to be presumptively positive for ethyl
16 glucuronide. While we're using what are considered to
17 be definitive methods, screening for EtG because were
18 doing chromatography, mass spectrometry, mass
19 spectrometry. Even though you using that definitive
20 technology, we still always perform confirmatory
21 analysis on another portion of that original urine
22 specimen in order to reconfirm or confirm those results
23 that we had on the initial testing.

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

1 testing for EtS or ethyl sulfate. Go to that page.
2 Bottom of page 107. Right-hand corner. Okay. So this
3 is our confirmatory analysis for EtG and EtS on a
4 different portion of the original specimen identified
5 by laboratory accession number 675976T. The slight
6 difference in the the format that you see here is that
7 we have results for both EtG as well as EtS. So the
8 EtG met identification criteria both in terms of
9 retention time and the ion ratios. It was considered
10 to be identified and it was identified at a
11 concentration of a 117 nanograms per ML, which is again
12 at or above the cutoff applied for the specific test
13 that was requested. In the case of EtS or the ethyl
14 sulfate, while you see a calculated concentration of
15 41.4 nanograms per ML and the expected retention time
16 matches the actual retention time measured. The ion
17 ratios did not meet criteria. EtS was considered to be
18 negative in this analysis for EtG and EtS.
19 Subsequently the specimen would've been reported
20 positive only for EtG.

21 Q. Okay. Go ahead, Dr. Sample.

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

1 which is corresponding client number that was on the
2 accompanying CCF. The requisition number or specimen
3 ID number 8372382, the same that was on that CCF donor
4 name of Mike Danford and laboratory accession number of
5 675976T. If you scroll down you can see that the
6 results of the specimen validity testing, and nothing
7 is abnormal there, and the results of the immunoassay
8 testing for the drugs of abuse, and all of those
9 results are negative, and the Ethyl Glucuronide was
10 reported as positive at the cutoff of 100 nanograms per
11 ML for the screening and 100 nanograms per ML for the
12 confirmation, the Ethyl Sulfate was reported as
13 negative and the concentration of the EtG and we'll --
14 reporting always rely on the confirmatory level for
15 reporting concentration is 117 nanograms per ML.

16 Q. Okay. And based on the laboratory analysis,
17 there's no doubt that Mr. Danford's urine sample of May
18 1, 2018 was positive for EtG?

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

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

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

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

10 A. That's -- that's quite common. That's not
11 unusual at all which is why for concentrations of EtG
12 less than 500 nanograms per ML, we do not require the
13 presence of EtS. So above 500 nanograms -- at or above
14 500 nanograms per ML of EtG, we would expect EtS to
15 always be present, but at concentrations below 500, we
16 don't have that expectation.

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

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

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

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

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

12 Q. One second, sir.

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

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

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

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

21 THE WITNESS: Good afternoon. How are you today?

22 MR. SEHAM: Just fine, and yourself?

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

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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

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

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

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

8 MR. SEHAM: No.

9 THE ARBITRATOR: Okay.

10 BY MR. SEHAM:

11 Q. So you requested the applica -- cutoff?

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

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

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

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

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

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

1 back. Let me rephrase the question.

2 THE WITNESS: Okay.

3 MR. SEHAM: Yes. Go ahead.

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

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

10 THE WITNESS: Okay.

11 THE REPORTER: Usually that will help.

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

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

15 BY MR. SEHAM:

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

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

25 Q. What other cutoffs do you use for your

1 customers?

2 A. We have a 100 cut off, a 250 cut off, and a
3 500.

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

7 A. Correct.

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

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

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

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

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

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

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

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

14 Q. No, the plastic sealed bag within.

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

16 Q. Correct.

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

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

24 A. The seal on what? The specimen --

25 Q. On the specimen bottle -- on the specimen

1 bottle.

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

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

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

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

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

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

16 A. Yes.

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

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

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

24 A. Yes.

25 Q. And in terms of review of the Chain of

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

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

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

14 A. Fatal.

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

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

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

24 A. Yes.

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

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

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

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

7 A. I don't understand your question.

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

12 A. Certainly.

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

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

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

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

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

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

7 A. Yes.

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

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

12 Q. Correct. So what's your requirement?

13 A. Well --

14 Q. EtG urine test requirement?

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

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

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

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

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

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

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

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

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

24 Q. Is there a --

25 A. No memorandum of correction was required from

1 the collection.

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

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

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

23 A. Well, both the collector and the donor.

24 Q. Okay.

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

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

3 Q. All right.

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

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

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

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

19 A. That is correct.

20 Q. All right.

21 A. Both the specimen and aliquots.

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

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

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

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

7 A. No, it is not.

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

11 A. No --

12 Q. How many times --

13 A. Let me finish first.

14 Q. Go ahead, I'm sorry.

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

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

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

1 that off of the top of my head nor do I know what it
2 was at this date in -- in 2018. You know, across our
3 network of laboratories, we're doing, you know, 10 to
4 11 million tests annually.

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

7 A. I have no idea.

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

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

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

13 A. Me personally, no, I did not.

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

18 A. Yes.

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

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

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

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

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

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

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

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

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

22 A. The same original urine specimen, but three
23 different aliquot. So again, 126 on that first screen,
24 116 I believe on the second screen and 117 was the
25 final result from the confirmatory analysis. So three

1 LC-MS/MS analyses on three different portions of that
2 original specimen with values ranging between 116 and
3 126.

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

7 A. What do you mean by chemical testing
8 methodology?

9 Q. Well, I thought --

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

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

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

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

1 methodology for those three tasks, for this three
2 aliquots?

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

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

10 A. Well, I would -- I would actually focus more
11 on the 116 to 117, which would be slightly less than a
12 one percent increase. But if you are going from 126 to
13 117, I'd have to get out my calculator, but I'll --
14 I'll take you at your word for what percent decrease
15 that is.

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

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

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

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

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

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

25 A. Ordinarily, we recommend a recollection, yes.

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

3 Q. Okay.

4 A. -- and/or medical review officer.

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

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

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

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

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

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

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

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

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

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

1 laboratory had discussions with Delta about the test
2 result?

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

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

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

9 Q. If we could --

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

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

17 THE ARBITRATOR: Yes, Candice now.

18 MR. SEHAM: Candice, if could you put Union Exhibit
19 78 up, please?

20 (Union Exhibit 78 marked for identification)

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

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

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

6 Q. Okay.

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

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

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

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

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

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

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

1 document that tells you when it was --

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

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

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

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

13 THE ARBITRATOR: I don't think --

14 MR. SEHAM: It shows the copy --

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

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

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

25 MR. SEHAM: Okay.

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

4 MR. SEHAM: Got it.

5 THE ARBITRATOR: Okay. And --

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

8 THE ARBITRATOR: Please.

9 BY MR. SEHAM:

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

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

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

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

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

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

17 A. Absolutely.

18 Q. And who should be interpreting the results?

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

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

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

12 A. No.

13 Q. -- present or is that something different?

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

20 (Union Exhibit 79 marked for identification)

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

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

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

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

7 A. Well documented.

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

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

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

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

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

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

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

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

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

8 (OFF THE RECORD)

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

14 THE WITNESS: Yes.

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

18 THE WITNESS: There is no one with me.

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

22 THE WITNESS: No.

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

25 ///

1 MATTHEW STEPANIAN,
2 having been first duly sworn, testifies as follows:

3 DIRECT EXAMINATION

4 BY MR. SEHAM:

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

10 A. My name is Matt Stepanian.

11 Q. And what town do you live in?

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

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

17 A. Yes.

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

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

1 -- restriction lifted after my divorce.

2 Q. Okay.

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

10 Q. And during the -- focusing on the period of
11 2017 to '18, how many tests for abstinence did you
12 have?

13 A. There was 18 tests.

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

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

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

1 A. I do.

2 Q. You do?

3 A. Yes.

4 Q. You can either look on the screen. We have
5 some people who don't have the exhibits. So we're
6 going to also take a moment for them to be posted on
7 the screen. So it's 50 -- Union 59 we're looking for.

8 A. I see it on screen.

9 (Union Exhibit 59 marked for identification)

10 Q. Right. And can you explain to us what this
11 document is?

12 A. My attorney who is helping me to rectify my
13 driving privileges with my children, had assembled this
14 spreadsheet. It lists all the collection dates and
15 times for each test, the place that it came from, the
16 testing method and the results.

17 Q. Okay. And starting from the time period of
18 September 1, 2017 to August 1, 2018, did you imbibe any
19 alcoholic beverages?

20 A. No, I did not.

21 Q. And does this chart accurately reflect the
22 tests administered to you using urine based, hair
23 based, or nail based EtG methods as listed?

24 A. Yes.

25 Q. Did these three types of tests ever yield a

1 positive test result for alcohol?

2 A. No, they did not.

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

5 A. Yes, I did.

6 Q. When was it?

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

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

17 A. That was USDTL.

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

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

3 A. Yes, I did.

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

7 A. Yes, it was the same sample.

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

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

15 Q. Okay. Can you describe to that -- could you
16 describe what happened on April 6th and April 7th of
17 2018?

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

25 Q. And were they both dried blood tests?

1 A. Yes.

2 Q. And were the results as indicated on the
3 chart?

4 A. Yes.

5 Q. Okay.

6 A. The earlier one was positive at Forensic DNA
7 and Testing and the later one was negative.

8 MR. SEHAM: Okay. Now, if you could turn to --
9 Emily, if we could post up Union Exhibit 8.

10 THE WITNESS: Pardon me.

11 (Union Exhibit 8 marked for identification)

12 Q. Are these the PEth tests collections that you
13 had on April 6th and April 7th?

14 A. Yes.

15 Q. I see there the SSN donor ID number is
16 different here between one and the other. Can you
17 account for that? One is 5167, the other begins 10135.

18 A. I see. The one on the left is my social --
19 the last four digits of my Social Security number and
20 the one on the right, is my Texas driver's license
21 number, but they are both correct.

22 Q. Okay. Now, can you describe what happened on
23 May 3?

24 A. Yes. On May 3rd, I went to Forensic DNA and
25 a sample was collected at approximately 4:00 p.m. and

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

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

5 A. Yes. Yes, they were.

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

8 (Union Exhibit 9 marked for identification)

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

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

13 Q. Can you describe what happened on July 6th
14 2018?

15 A. Yes. I went to Forensic DNA on July 6th at
16 approximately 2:20, had a blood spot sample taken and
17 on that same day, I went to National Drug Services and
18 had the same collection 21 minutes later, approximately
19 2:41 p.m.

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

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

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

1 move, Emily, to Union Exhibit 10.

2 (Union Exhibit 10 marked for identification)

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

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

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

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

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

15 A. Yes. Beginning in -- on October 27th of
16 2017, from there until January 26th of 2018, I was not
17 allowed to see my children as a result of this false
18 positive from Forensic DNA. After the January 26th,
19 2018 hearing, after that PEth negative until a false
20 positive some weeks later, I had regular custodial
21 periods with my children. Then from a period of
22 February 22nd of 2018, where there was another false
23 positive until a March 16th hearing, I was not allowed
24 to see my children and from March 16th hearing until
25 April 6th hearing of 2018, false positives at Forensic

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

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

15 THE WITNESS: Understood.

16 CROSS EXAMINATION

17 BY MR. KASSIN:

18 MR. KASSIN: Arbitrator Burdette?

19 THE ARBITRATOR: Yes, sir.

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

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

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

5 THE WITNESS: I can, yes.

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

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

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

13 THE ARBITRATOR: Okay.

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

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

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

1 access to?

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

4 MR. BRIAN: Okay.

5 THE ARBITRATOR: I think.

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

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

11 THE WITNESS: Yes, I was.

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

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

17 THE ARBITRATOR: Okay.

18 MR. SEHAM: -- make that happen.

19 THE ARBITRATOR: Yeah.

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

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

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

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

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

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

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

16 THE ARBITRATOR: Okay so Mr. --

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

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

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

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

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

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

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

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

18 MR. KASSIN: Yes, sir.

19 THE ARBITRATOR: Okay.

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

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

25 THE WITNESS: Thank you, gentlemen.

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

3 MR. SEHAM: Yes. Well, he's gone, but yes. We'll
4 --

5 THE ARBITRATOR: Okay. All right.

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

8 THE ARBITRATOR: I understand. I understand.

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

13 THE ARBITRATOR: Okay.

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

16 THE ARBITRATOR: Okay.

17 MR. SEHAM: And then I got word from Michael Perez
18 that he's recently landed, and my aspiration would be
19 to have Dr. Tordella testify and I think that might be
20 10 or 15 minutes, at least on direct, and then see if
21 we can arrange for Mr. Perez right after that.

22 THE ARBITRATOR: Okay. That's fine.

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

24 THE ARBITRATOR: 15-minute break?

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

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

3 THE ARBITRATOR: Okay.

4 THE REPORTER: Okay. Off the record at 4:14 p.m.

5 (OFF THE RECORD)

6 THE ARBITRATOR: Okay. Mr. Tordella, my name
7 is Mark Burdette. I am the Neutral chair of the System
8 Board of Adjustment and for Delta and ALPA in which
9 you're about to testify. We are swearing witnesses
10 so would you please raise your right hand. Do you
11 swear or affirm that the testimony you're about to
12 give in this case will be the truth, the whole truth,
13 and nothing but the truth?

14 THE WITNESS: I do.

15 THE ARBITRATOR: Thank you. And would you tell us
16 if there's anybody else in the room with you?

17 THE WITNESS: There is not.

18 THE ARBITRATOR: Okay. And do you have any
19 documents that are not part of the exhibits to this
20 case?

21 THE WITNESS: No, I do not.

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

24 MS. SAMUDA: Before you proceed, I'm sorry to
25 interrupt. My board member -- one of my board members

1 is in the restroom, so can we give them a couple of
2 minutes?

3 THE ARBITRATOR: Okay. Sure.

4 MS. SAMUDA: Thank you.

5 THE ARBITRATOR: Thank you. I see that we're
6 missing a couple board members.

7 MR. MORRIS: I'm back.

8 THE ARBITRATOR: Okay. We're still missing Mr.
9 Meyer.

10 MR. MEYER: I'm here, Mr. Burdette.

11 THE ARBITRATOR: Okay. Thank you very much. All
12 right. Now, you may proceed, Mr. Seham.

13 JOSEPH TORDELLA, DO,
14 having been first duly sworn, testifies as follows:

15 DIRECT EXAMINATION

16 BY MR. SEHAM:

17 Q. Thank you. Doctor, could you please state
18 your full name for the record.

19 A. Joseph R. Tordella.

20 Q. And could you please give us your medical
21 background both flight and medical -- your work
22 background, both flight and medical.

23 A. Okay. I graduated from Philadelphia College
24 of Osteopathic Medicine in 1976. I was also trained
25 and graduated US Air Force pilot training and

1 separately, years later I went back and graduated as a
2 flight surgeon with the US Air Force.

3 Q. And are you an aviation medical examiner or
4 AME?

5 A. Yes. I'm a senior AME and I'm HIMS trained,
6 and I'm a independent medical sponsor for many of the
7 pilots.

8 Q. And how long have you been an AME?

9 A. Approximately 43 years.

10 Q. And you said you were a HIMS doctor. How
11 long have you been -- since your graduation from
12 medical school, how long have you been in the HIMS
13 program as a monitoring doctor?

14 A. Almost the same amount of time. It followed
15 a few months after being appointed as an AME.

16 Q. And have you also worked with the NTSB with
17 respect to the substance abuse issues?

18 A. Yes, I'm an accepted witness for the NTSB on
19 -- on aviation medicine, all the above.

20 Q. Have you acted --

21 A. Excuse me.

22 Q. Have you acted in the role of HIMS doctor,
23 and for the record, HIMS is an acronym, H-I-M-S. Have
24 you acted in the role of HIMS doctor for a pilot by the
25 name of Matt Dacier, D-A-C-I-E-R, and correct my

1 pronunciation if I --

2 A. Yes, I have met Dacier.

3 Q. Okay. And you've a HIMS doctor for many
4 pilots over the years?

5 A. Probably about a thousand of them. I would
6 -- could guesstimate that I've done more than anybody
7 else in the country or very close to it.

8 Q. And did you have Mr. Dacier's authorization
9 to discuss his case before the system board?

10 A. Yes, I do.

11 Q. Please tell us what brought Mr. Dacier into
12 the HIMS program.

13 A. He had received a DUI and he came to me to
14 participate in the HIMS program in order to get his
15 medical certificate back so he can get back into flying
16 professional -- professionally.

17 Q. For how many years have you monitored him?

18 A. Approximately five years.

19 Q. And did you consider Mr. Dacier to have a
20 substance addiction problem?

21 A. No.

22 MR. SEHAM: Let's bring up Union Exhibit 37.

23 (Union Exhibit 37 marked for identification)

24 Q. If we can scroll slowly down so the witness
25 can see the document, we can stop there. Can you

1 identify this document as a USDTL report that you
2 received concerning Mr. Dacier?

3 A. Yeah. Yes, I can.

4 Q. And did you see there that he received a
5 result of 24 nanograms per milliliter. Is that
6 consistent with your recollection?

7 A. Yes, that's correct.

8 Q. Okay. Now, this collection is reported -- if
9 you see after the word collected, it's collected May
10 18th, but the email reporting the result -- if we can
11 go scroll back to the top.

12 A. I can see it right here. Report date 5/26.

13 Q. Okay. But if we can go back to the very top
14 of the document and because there was an email covering
15 this result, Emily, if we could go to the very top. So
16 there's the emails May 28th with a subject line
17 results. Is May 28th the date that you received these
18 results?

19 A. Yes, would be correct.

20 Q. Okay. If we can bring up Union Exhibit 18.
21 Okay, is the -- is this an email between you and Dr.
22 Joseph Jones, the director of USDTL on May 28th, 2020?

23 A. Yes. It says from Joe Jones to Joe Tordella.
24 Correct.

25 Q. Okay. And why -- why did you communicate

1 with Joseph Jones concerning Matt Dacier?

2 A. When I received that positive test, I didn't
3 -- I -- I was shocked. I didn't feel that Matt Dacier
4 would have the potential to relapse at this point in
5 his treatment, and after five years of monitoring, and
6 I had questions.

7 Q. Okay. And -- and how many -- how many -- he
8 had a history of negative tests in the past?

9 A. Yes, I counted approximately 41 tests. They
10 were all zero and there was one that was a three --
11 three nanograms. But Joe Jones told me that is
12 considered clinically insignificant. So he really had
13 41 zeros, you know.

14 Q. Okay. Now, Emily, if you could scroll down,
15 I think, towards the very end of the email. Okay. So
16 stop right there. If you -- if you see here there's an
17 email from Joseph Jones and his request. "Can you
18 query by collector name? It would be interesting to
19 see if the collector Lynn Collins has an unusual
20 proportion of PEth positives." Did you ask Mr. Jones to
21 run that query?

22 A. No, I did not.

23 Q. Do you know Dr. Jones?

24 A. Yes, I do.

25 Q. You worked for them on cases together?

1 A. Yes. Many times over many years.

2 Q. Did you also discuss Mr. Dus -- in addition
3 to this email exchange, did you also discuss Mr.
4 Dacier's test result with Dr. Jones by telephone?

5 A. Yes, I did.

6 Q. And did Dr. Jones advise you of the -- no,
7 you made arrangements for a subsequent -- hold on. I'm
8 going to skip something here. Give me one second. I
9 think I did skip something. We can move to Union
10 Exhibit 38. Is there an issue, Emily, with Union
11 Exhibit 38?

12 REMOTE TECH: One moment.

13 (Union Exhibit 38 marked for identification)

14 Q. Okay. So we have on the screen here USDTL
15 PEth report based on a collection of May 28th, 2020.
16 Were you involved in the initiation of this test?

17 A. Yes.

18 Q. Okay. And why did you have Matt submit to a
19 test on or collection of hair on May 28th, 2020.

20 A. When they get a test as quickly as possible
21 to see if he would verify the results that were given
22 earlier of a positive test or a negative test.

23 Q. We can scroll down, Emily. Then the result
24 of this test was negative?

25 A. This test was negative, yes.

1 Q. Now, going back -- going back to the
2 conversation that you had with -- hold on a second,
3 going back to the conversation that you had with Dr.
4 Jones on May 28, did you discuss the -- the
5 quantitative result of the May 28th test?

6 A. Yes, I discussed all the tests with Dr. Joe
7 Jones. I couldn't understand why I could have negative
8 tests so closely after the positive one and they didn't
9 show anything.

10 Q. Did Dr. Jones tell you what the -- the
11 quantitation was on the May 28th collection?

12 A. That was zero, I believe.

13 Q. Did your -- did your knowledge or your
14 communication with Dr. Jones concerning the PEth result
15 of 24 nanograms per milliliter based on the May 18th
16 collection and a zero for a May 28th collection prompt
17 any further conversation with him concerning half-life?

18 A. Yes. I -- I felt the half-life is as I have
19 learned from my discussions over the years, the
20 half-life of a PEth test is 4-10 days. And that means
21 if you take a test approximately a week later, I would
22 expect somewhere half the amount. So 24 hour I think
23 would be a 12 or something should show. The fact that
24 it shows zero to me was very surprising. Why I asked
25 for an explanation.

1 Q. Well, did Dr. Jones provide you with an
2 explanation?

3 A. They did, but not one that I was satisfied
4 with. I can't -- satisfied with the explanation.

5 Q. Did you discuss with Dr. Jones whether the
6 test result for the blood spots collected May 18th
7 definitively established alcohol consumption?

8 A. Yes, he said I'm just a lab guy. He said I
9 don't come up with the diagnosis. That's your job.
10 But he didn't mention that he thought that one data
11 point should not be definitive for a diagnosis. And I
12 also talked to another doctor at University of Texas,
13 San Antonio --

14 MR. KASSIN: I can understand the -- objection. If
15 we're getting in -- I can understand because Dr. Jones
16 has been a witness and him -- him referring to his
17 discussions with him because they're related to the
18 USDTL testing. But if the intent is to bring in a
19 another doctor toxicologist from University of Texas as
20 a witness, let's bring them in, let's not have hearsay
21 testimony as to medical -- as to Dr. Tordella was
22 headed.

23 MR. SEHAM: Well, we would characterize the
24 testimony that we're about to hear as an admission
25 against interest, a University of Texas has a

1 relationship with USDTL. They're used as a
2 confirmatory laboratory and that we're not -- we think
3 that this is admissible as an admission against
4 interest in terms of the fallibility of this testing
5 process.

6 MR. KASSIN: I'm sorry. If you bring in that --
7 bring in that doctor and have them come here and
8 testify in person to the arbitrator and board members
9 and subject that doctor to cross-examination, it's just
10 totally unacceptable to use hearsay to make that point.

11 MR. SEHAM: Well, that's your opinion. We both
12 stated our position. We consider this relevant and an
13 admission against interest, and we await Arbitrator
14 Burdette's ruling on this.

15 THE REPORTER: It's not an admission against
16 interest. It's medical testimony.

17 MR. SEHAM: We both stated our position. I would
18 like a ruling from --

19 THE ARBITRATOR: Hold on a second. Would you
20 repeat the question that you're asking please, so I can
21 rule on that.

22 MR. SEHAM: The question to him is whether he spoke
23 to a Dr. Javors from the Texas University testing
24 facility and what was the nature of the conversation
25 concerning the reliability of this testing process.

1 THE ARBITRATOR: All right. Well, I'm going to
2 allow it now for whatever purpose it might be at the
3 end of the day, but you can go ahead and testify to
4 that, Dr. Tordella.

5 THE WITNESS: Okay.

6 THE ARBITRATOR: We're on the record. This is
7 hearsay testimony, however, go ahead.

8 BY MR. SEHAM:

9 A. Yeah. When I talked to him, I gave him my
10 same concerns. We talked at length and he -- one day
11 at the point should not define the answer for a
12 diagnosis. And he thinks or he stated as Dr. Jones did
13 that the PEth test is infallible. However, there's no
14 such thing as infallible when you're looking at the big
15 picture, the complete data points. And he had no
16 explanation why one might put the point up, that how
17 can it go from 24 to zero in a week? I said everybody
18 tells me that everyone metabolizes different, but to me
19 it raised quite a bit of doubt and he said, you have a
20 good point.

21 THE ARBITRATOR: Okay. I understand.

22 Q. That discussion you're just referring to, was
23 with Dr. Jones?

24 A. I was both with Dr. Jones and with Dr.
25 Javors, they were separate discussions. It was not a

1 conference.

2 MR. SEHAM: If you can, now bring up Union Exhibit
3 4, please? Okay. And then another.

4 (Union Exhibit 4 marked for identification)

5 Q. So we saw at the top that this is a lab
6 report from LabCorp and there's a statement in here
7 reads, " PEth levels in excess of 20 nanograms per
8 milliliter are considered evidence of moderate to heavy
9 ethanol consumption. However, alternate explanation
10 should be explored following any positive finding.
11 Please note that while path is considered relatively
12 insensitive to incidental ethanol exposures, the
13 possibility remains that an individual elevated PEth
14 level may result from incidental or unintentional
15 ethanol exposure." My question is, what is your opinion
16 as a HIMS doctor, with your over 40 years of experience
17 with respect to this disclaimer?

18 A. I think that caveat is spot on. I think it's
19 very accurate.

20 Q. What was your ultimate conclusion as to
21 whether the PEth test for Mr. Dacier based on the May
22 18th sample was accurate?

23 A. I don't think it's necessarily -- certainly
24 reflects possible use without question by the
25 individual.

1 MR. SEHAM: No further questions for me at this
2 time. I will pass the witness to Mr. Kassin.

3 THE ARBITRATOR: Okay, Mr. Kassin.

4 MR. KASSIN: Yes, Sir. Good afternoon, Dr.
5 Tordella. Thank you for joining us at this late time
6 of the day.

7 THE WITNESS: Good afternoon.

8 CROSS EXAMINATION

9 BY MR. KASSIN:

10 Q. Are you -- are you a qualified toxicologist?

11 A. No, I am not.

12 Q. And how many -- as a HIMS AME, how many Delta
13 pilots have you been medical sponsors for?

14 A. Delta pilots? As a medical sponsor, I can't
15 remember. I don't think I have for Delta.

16 Q. That's correct so --

17 A. But I have been doing this for 43 years. So
18 there could have been a Delta pilot in there, but I
19 can't recall any.

20 Q. Mike Doyle. who does he fly for?

21 A. He flies for Republic.

22 Q. Original carrier?

23 A. Correct.

24 Q. Are you familiar with their HIMS program at
25 Republic?

1 A. Yes, I am.

2 Q. Okay. I should have asked you first, are you
3 familiar with the Delta HIMS program?

4 A. Somewhat, yes.

5 Q. Okay. Are you familiar with FAA's
6 requirements for re-treatment after a relapse for a
7 pilot who's flying for a Part 121 carrier?

8 A. Yes, I am.

9 Q. The FAA does require re-treatment for a Part
10 121 pilot who's had a relapse, correct?

11 A. If -- yes. My opinion is if it's definitely
12 proved as a relapse.

13 Q. I did have a question about a couple of the
14 documents that you were asked about. Let's deal with
15 that hair test. And I believe that is Union Exhibit
16 38. And this is simple, we can call it up -- Emily, if
17 you could put what the cutoff was on at 20 pg/mg.
18 Doctor, what is 20 PG, What does the unit measurement
19 for that?

20 A. Well, this was a hair test as opposed to PEth
21 test. PEth is the nanograms and -- I'm sorry?

22 Q. The hair test is in a picograms?

23 A. Correct.

24 Q. That's per milligram?

25 A. Yes.

1 Q. Okay. Did you tell the laboratory to use 20
2 as the cutoff?

3 A. I don't tell the laboratory to do anything.
4 That's their position.

5 Q. Are you familiar with the normal cutoff for a
6 hair test for EtG would be 2?

7 A. I'm not familiar with that. I looked at many
8 of them, but I don't -- as you say I'm not a
9 toxicologist, so I had no need to look at it that
10 closely.

11 Q. Are you familiar with the standards that are
12 used by the Society of Hair Testing for EtG hair test?

13 A. No, I'm not.

14 Q. Okay. I mean, so you don't know that they
15 considered 7 picograms per milligram to be the
16 indicated repeated alcohol exposure?

17 A. No, I did not know.

18 MR. SEHAM: I object to the form. It appears that
19 counsel is testifying.

20 MR. KASSIN: Thank you.

21 MR. SEHAM: I object to the form that unless you
22 have had a witness who established that, then it's
23 inappropriate for an attorney to state a fact and
24 cross-examine a witness based on his stated fact.

25 MR. KASSIN: I asked him if he was aware of it, he

1 said he wasn't aware of it. I think asked and
2 answered.

3 A. Generally as a doctor, I'm aware of many
4 things. Yeah, I am aware that there are things like
5 this. But not specifically to answer your question.

6 Q. Okay. You commented on what you understood
7 to be the half- life of Peth. Can you tell us what
8 your understanding is again? I'm sorry, I missed that.

9 A. Half-life of PEth, my understanding is four
10 to ten days and this has been told to me by Dr. Jones,
11 by Dr. Javors, others.

12 Q. Are you aware of scientific studies that
13 establish that the half-life of PEth can range from one
14 to 13?

15 A. I had been told that, yes.

16 Q. Okay. And are you aware that individuals
17 with alcohol dependent can have a very short half-life
18 as low as one day?

19 A. Anything is possible. That's why I don't say
20 tests are infallible.

21 Q. Well, let's talk about that. You talked to
22 Dr. Javors at the University of Texas, San Antonio
23 laboratory?

24 A. Yes, I did.

25 Q. And Steve told you specifically that PEth was

1 infallible, correct?

2 A. Correct.

3 Q. And are you aware of any scientific studies
4 that have shown there to be false positives in PEth?

5 A. No. I know there had been studies but, I'm
6 not aware of it, but Dr. Javors did admit to me that
7 even though it's infallible, he said I have a point
8 that when there's questions like this is anything 100 %
9 infallible and nobody gave me that answer.

10 Q. Does it -- I'm sorry. Are you finished?

11 A. Yes. Correct.

12 Q. Isn't it true that you told Dr. Jones that
13 one of the pilots that you had that had tested positive
14 for alcohol, that you couldn't believe that individual
15 was positive and later when they went to retrieve it,
16 they admitted they had been drinking?

17 A. Yes, I've had that happen.

18 Q. Could we call up Union Exhibit 4, please?
19 You were asked about a statement in there about the
20 PEth levels in excess of 20 nanograms per milliliter.
21 And the possibility remains that an individual elevated
22 PEth level may result from incidental or unintentional
23 ethanol exposure. What is the source of that
24 statement?

25 A. The source of the statement, it's on this lab

1 report. This caveat that's on here.

2 Q. Is there like a scientific study that
3 supports this statement?

4 A. You'd have to ask whoever put the statement
5 on the -- printed out that statement from the company.

6 Q. And so you were just relying on what you were
7 reading on that particular statement?

8 A. Absolutely.

9 Q. Matt Dacier, the pilot that you talked about
10 that came into the program with a DUI. Do you know
11 what his blood alcohol content was for that DUI?

12 A. If I -- if I recall correctly, and again, you
13 know, I've done thousand pilots roughly. His was a
14 refusal to blow.

15 Q. Okay.

16 A. Refusal to test.

17 Q. So there might be a real problem there.

18 A. What do you mean by that?

19 Q. So somebody is refusing the test. So he was
20 convicted of a DUI?

21 A. Yes, he was convicted.

22 Q. And you don't think somebody convicted of a
23 DUI may have a substance abuse problem?

24 A. I didn't say he didn't have a substance abuse
25 problem. Where did you -- where did you get that?

1 Q. That's why I made -- I'm glad you're
2 clarifying that. Did you consider him to have a
3 substance abuse problem?

4 A. I wasn't asked that. I was asked if he had a
5 substance dependence problem. There's a difference.

6 Q. Okay. So may I ask you, does he have a
7 substance abuse problem in your opinion?

8 A. He did because it resulted in him getting
9 involved and everything that's happened. So you'd have
10 to say yes.

11 Q. Okay. One minute, sir, I need to look at one
12 of the exhibits you referred to. You may have already
13 answered the question. I think you may have already
14 covered this, I'm referring to Union Exhibit 35. I
15 believe. I'm sorry, 37.

16 And Emily, if you could put on the sample
17 information timing. If I could ask if you could put on
18 the top of the page, the whole page. These are just
19 very brief points of clarification.

20 REMOTE TECH: Union Exhibit 37?

21 Q. Yes, it is 37. Some of my tabs are smudged.
22 I'm sorry. First question is, who is Lynn Collins?

23 A. As far as I know, she's a person who works
24 for a lab near Matt Dacier's home where we get test --
25 testing done.

1 Q. Does she -- like a collector? Does she do
2 the blood spot or the whole blood?

3 A. Correct. She'd been doing it for many years
4 when I questioned her.

5 Q. Okay. And you've already pointed out that on
6 this particular sample that was collected on May 18th,
7 2020, it came back positive at 24 nanograms per
8 milliliter, correct?

9 A. That's correct.

10 Q. Okay. The only questions that you're raising
11 is the later hair test that was given on May 28th, 2020
12 or collected on May 28, 2020 using the 20 picogram per
13 milligram cutoff, correct?

14 A. That is correct. But remember we also
15 performed other PEth tests on him and urine. I tested
16 Mr. Dacier every way I could, trying to find any
17 evidence that there could be alcohol involved.

18 MR. KASSIN: Okay. Mr. Burdette, I may not have
19 any additional questions, but I'm going to need five
20 minutes just to look at my notes real quick. So --

21 THE ARBITRATOR: Okay.

22 MR. KASSIN: -- let's have a five-minute break.

23 THE ARBITRATOR: Take five minutes break.

24 MR. SEHAM: All right. Before we break, Mr.
25 Arbitrator, I would like as soon as we're finished with

1 this witness to move onto Michael Perez.

2 THE ARBITRATOR: That's fine.

3 MR. SEHAM: So I'll use these five minutes to try
4 to contact him and get him.

5 THE ARBITRATOR: Okay.

6 (OFF THE RECORD)

7 THE REPORTER: We are back on the record at 4:00
8 p.m.

9 THE ARBITRATOR: Thank you, Damien. Any redirect,
10 Mr. Seham?

11 MR. SEHAM: No, Mr. Arbitrator. We are done. No.

12 THE ARBITRATOR: Thank you very much. Dr.
13 Tordella, you may be excused. Thank you very much for
14 your time and participation.

15 THE WITNESS: Thank you.

16 THE ARBITRATOR: Emily, will you take him out of
17 the meeting, please? Thank you.

18 MR. SEHAM: We're now ready to proceed with Michael
19 Perez.

20 THE ARBITRATOR: Okay. You know, if Michael Perez
21 is in the waiting room, would you please bring him in?

22 THE REPORTER: He's in now. He just needs to
23 connect. His --

24 THE ARBITRATOR: Okay. Very good. I see him,
25 yeah.

1 THE REPORTER: There he is.

2 THE WITNESS: Good evening.

3 MR. SEHAM: Good evening.

4 THE ARBITRATOR: Good evening. Mr. Perez, would
5 you please raise your right hand, we're swearing
6 witnesses in this case.

7 THE WITNESS: Yes, sir.

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

11 THE WITNESS: I do.

12 THE ARBITRATOR: Thank you very much. Is there
13 anybody else in the room with you?

14 THE WITNESS: There's not.

15 THE ARBITRATOR: Do you have any documents that are
16 not a part of the exhibits to this case?

17 THE WITNESS: No, I do not.

18 THE REPORTER: Thank you very much. Mr. Seham, you
19 may proceed in statement.

20 MICHAEL PEREZ,
21 having been first duly sworn, testifies as follows:

22 DIRECT EXAMINATION

23 BY MR. SEHAM:

24 Q. Okay. Please state your name again, for the
25 record.

1 A. Michael Douglas Perez.

2 Q. And where are you currently employed?

3 A. Delta Airlines.

4 Q. What capacity?

5 A. I'm an airline pilot for them.

6 Q. How long have you been a pilot for Delta?

7 A. I was hired September 25, 1997.

8 Q. Okay. Are you a heavy drinker?

9 A. I am not.

10 Q. Okay. When's the last time you had a drink
11 of alcohol?

12 A. Last time I had a drink was August 2015, the
13 day of -- of my incident, so.

14 Q. Okay. And we'll come to that. Have you ever
15 had an alcohol dependency issue?

16 A. I have not.

17 Q. Okay. But you made reference to a driving
18 incident related to alcohol?

19 A. I did.

20 Q. Okay. Can you briefly describe how the
21 incident came about?

22 A. Yeah. It was in middle -- I believe it was
23 August the 22nd, 2015. My wife and I attended an
24 outdoor concert and met up with some friends. And I
25 had several drinks, too much to drink. And we were

1 leaving the concert, I was driving, we were in a
2 parking lot in a line of cars waiting to leave, and I
3 hit the bumper of -- of the car ahead of me, scratching
4 the bumper of the -- the vehicle. He was not happy
5 about it. Wanted a police report, police came,
6 administered a field sobriety test, and subsequently I
7 was arrested for a DUI on that day.

8 Q. And did that incident have any impact on your
9 employment with Delta?

10 A. It -- it did. Mostly the, you know, I had to
11 go through the -- the HIMS program, and I was -- I had
12 to sign a -- a contract with what, I think, they refer
13 to it as Contract A, for Delta Airlines.

14 Q. And did that require you to enter a
15 rehabilitation program?

16 A. It did. I went to a facility called Talbots
17 in Atlanta, Georgia.

18 Q. Who was your AME at the time?

19 A. They -- they assigned me, Dr. Charles Harper
20 Senior.

21 Q. Did he express any opinion as to whether a
22 rehabilitation program was appropriate for you?

23 A. Yeah, he did, yeah. Throughout the -- the
24 initial process and then even afterwards, he -- he said
25 that, you know, he didn't believe that I was an

1 alcoholic, that I didn't have an alcohol dependency
2 problem. He thinks I just made a mistake. And
3 subsequently, then he petitioned to have a reduced
4 sentence, if you will, a one-year program instead of
5 the usual three to five- year program. And he
6 submitted that to the FAA, but the -- the FAA denied
7 it.

8 Q. Ultimately, why did you agree to go to
9 Talbots?

10 A. Well, when I was going through the evaluation
11 at Talbots, which is part of the HIMS program,
12 apparently, you'd -- you'd go through the initial
13 assessments. I was met by two chief pilots, the
14 outgoing HIMS director, who unfortunately I can't
15 remember his name, and an incoming HIMS director, Harry
16 Miller, who was really -- had -- had -- I had all the
17 contact with throughout this program. And they pulled
18 me off to the side in a room, just the three of us.
19 And the outgoing chief pilot looked at me, and he said,
20 we don't think you belong here, but this is going be
21 the fastest way you get back in the air. This is going
22 to be the easiest way you get back in the air. And we
23 don't -- I don't want you to be angry about it. You --
24 we should -- you should learn something during the
25 process. And perhaps everybody could learn from the

1 process, but -- and that's what I wanted to do. I
2 wanted to get back in the air and fly. So that's --
3 that's why I went -- went ahead and went through the
4 program.

5 Q. How would you describe your treatment at
6 Talbot?

7 A. I -- I -- I think it's -- it's similar to
8 trying to push a s -- a round peg through a square
9 hole. You know, they were -- regardless of what you
10 say, they're going to put you in the program. I -- I
11 -- I would tell them -- I said, listen, I -- I just I
12 -- I maintain three jobs, you know, I was not only with
13 Delta, but I was a sheriff's deputy, I was teaching
14 motorcycle classes, and -- and I very seldom drank, and
15 -- and they said, well, you know, denial, you know, all
16 alcoholics deny it. And -- and I said, well, but I --
17 I haven't drank since I had the accident. I don't have
18 urges. I don't have triggers, you know, I -- I just --
19 if you told me to quit drinking, I just quit drinking.
20 And they said, well, that just makes you a dry drunk.
21 And -- and I said, well then, you know, I -- I do all
22 these jobs -- these three jobs that require me to be at
23 my peak level. And I've -- I've been very successful.
24 It's never affected my -- my occupations. And they
25 said, well, that just makes you a high-functioning

1 alcoholic. So I was -- it was -- you just couldn't
2 win, I -- in my opinion. And what was, you know, so
3 the solution to this disease, that they said I had,
4 was, you know, never drink again, and you're going to
5 go through a 12-step religious program. I mean, that's
6 -- that was their answer.

7 Q. Did you receive any warnings from Talbot
8 concerning alcohol ingestion or exposure at the time
9 you completed the program?

10 A. Yes. Yeah. They -- they -- throughout the
11 program, especially at the end, they -- they submitted,
12 and I -- I don't have it with me, but they -- they
13 submitted a -- a sheet of -- of hundreds of household
14 products that people could find at home, a typical
15 home, consumer products that could cause you to test
16 positive for -- during a urine test. And -- and they
17 -- it was everything from -- I -- I -- I remember I
18 took it home, and we went through food products that
19 you would, normally, have in the refrigerator. I do
20 remember there was a -- a detergent that we happened to
21 use, that we had to get rid of. And especially they --
22 they always emphasized to -- to completely avoid any
23 type of hand soaps or hand sanitizers that were
24 alcohol-based, which, apparently, they've just
25 corrected, and sent out a memo saying that, it's okay

1 after the COVID kicked up. Yeah, there's a lot of -- a
2 lot of products, they said that you needed to avoid.

3 Q. Did you return to flying immediately when you
4 completed the Talbot program?

5 A. No. The FAA has to issue a special issuance
6 FAA medical. And I came out of Talbot in -- in late
7 December, right before Christmas. And I wasn't
8 released on my special issuance until I think, June of
9 -- of, you know, about six months.

10 Q. During this interval, when you were on the
11 ground, what projects, if any, did you involve yourself
12 with?

13 A. Well, I -- I, you know, I had a lot of time
14 off. My -- my wife is a yoga instructor, Pilates
15 instructor, personal trainer. She has a business
16 called Faith In You Fitness, and she decided to open a
17 business in town. So we took a building. We rented a
18 building that had been formerly a -- everything from a
19 gas station, to a meatery, to a, I think, it was last a
20 pizza place. And we decided to do -- do the work
21 ourselves and -- and make a -- a private studio for her
22 -- for her -- her and her clients.

23 Q. Okay. And did that work involve any products
24 or compounds that might contain alcohol?

25 A. It contained a lot of products. It -- it can

1 -- we -- we did have a lot of solvents, a lot of
2 degreasers, paint thinners, paints, a lot of industrial
3 cleaners, that we had to use. The place was --
4 required a lot of work and -- and yeah, there were a
5 lot of chemicals that I dealt with.

6 Q. Okay. And during this period prior to
7 resuming flight, were you required to abstain from the
8 consumption of alcohol?

9 A. Yes. In fact, I'm -- I'm required to abstain
10 throughout my entire career at Delta Airlines.

11 Q. And were you subject to any testing to
12 confirm this abstinence?

13 A. Yes. Random drug testing from home. They
14 would call me and tell me to go to a lab and take a
15 urine test for -- for alcohol.

16 MR. SEHAM: Okay. Emily, could you bring up Union
17 Exhibit 34. Okay.

18 (Union Exhibit 34 marked for identification)

19 Q. Okay. Can you identify maybe just -- yes.
20 Okay. Can you can you identify, Captain Perez, this
21 email dated February 23rd, 2016?

22 A. Yes. That was actually an email from Choice
23 Labs from Michele Gable indicating that I had tested
24 positive on a urine test.

25 Q. Could we scroll down to the second page? We

1 might have to blow that up a little bit. Then if you
2 could scroll down, can you -- can you see there at the
3 very, very bottom what your -- your EtG quantitative
4 result was?

5 A. Yes. It indicates 138 Nanograms per
6 milliliter.

7 Q. What was the cutoff being applied for a
8 positive test?

9 A. 100 Nanograms per milliliter.

10 Q. Now, were you terminated or sent back to
11 rehabilitation based on this test result?

12 A. I was not, no.

13 Q. Did you ever have -- do you know who chief
14 pilot Harry Miller who he was or did you ever deal with
15 him?

16 A. Yeah. He was a lot of times just my direct
17 contact. He is the one that called me initially when
18 this happened, before I ever got the results back from
19 Michele Gable. He just called me and said that I had a
20 positive EtG.

21 Q. Did he make any reference to the positive --
22 the possible cause from that?

23 A. Yeah, well, he did, you know, I was very
24 alarmed, but he told me, he said it -- what he -- and I
25 didn't have him expound on, but he says it just appears

1 that it was an incidental exposure to something so
2 that's what I assumed it was.

3 Q. All right. Did you have further contact with
4 with Ms. Gable concerning this issue?

5 A. Yeah. I contacted Michele Gable and she said
6 that I had to at this point submit to a PEth test.

7 Q. How did you get the PEth collection kit?

8 A. She FedExed it to me the next day.

9 Q. Where was the collection performed?

10 A. To my knowledge the lab -- I live in Indiana
11 and I've used several labs. Most of them, you know,
12 the -- well, they've all been approved by Michele, but
13 the one I believe it was was a Medical Laboratories in
14 Noblesville, Indiana, which is where I have to drive to
15 take these urine tests.

16 Q. Did they extract whole blood from your veins
17 or was it a question of placing drops on a card?

18 A. It was the drops on the card.

19 Q. Can -- can you describe the collection
20 process?

21 A. Yeah. They have you wash your hands. They
22 pull out the kit, put it on a napkin and they take a
23 needle and prick your finger and then they have the
24 blood droplets deposited on a card. I don't remember
25 how many droplets, but droplets on a card.

1 MR. SEHAM: Emily, if we could now move to Union
2 Exhibit 33.

3 THE REPORTER: We lost Mr. Burdette, Mr. Seham.
4 Mr. Burdette, are you there? Arbitrator Burdette?
5 Okay. Off the record at 5:26 p.m.

6 (OFF THE RECORD)

7 THE ARBITRATOR: Sorry, gang. I got jumped out.

8 MR. SEHAM: Okay.

9 BY MR. SEHAM:

10 Q. We would move forward to his proceeding with
11 a PEth test that was on using the DBS process. The
12 next question was going to be, did you later have a
13 further contact with chief pilot Captain Harry Miller
14 concerning the results of that PEth test?

15 A. I did. I received a call. I don't remember
16 the timeline, but he called me and he told me that the
17 PEth results came back as a non negative.

18 Q. All right. If we could move, Emily, please,
19 to Union Exhibit 33 and move to page 5, which is Bates
20 stamp USDTL001110. Okay. Now, this is a test report
21 from Michael Perez indicating a positive for a PEth
22 blood spot with a collection date of March 16th, 2016.
23 Does that correspond to your collection or your
24 provision of the blood spots?

25 MR. KASSIN: I'm sorry, Mr. Seham and Arbitrator

1 Burdette. I'm confused. We've just been talking about
2 a February 11, 2016 test, Union Exhibit 34. Then he
3 said he was required to go take a PEth. When was --
4 are we talking about the PEth test at this point that
5 he was required to take?

6 MR. SEHAM: Correct.

7 MR. KASSIN: What was the date of that?

8 MR. SEHAM: Collection was March 16th.

9 MR. KASSIN: Okay. Well, that's inaccurate. The
10 actual collection was on February 23rd. I've got the
11 sequence of his testing right here. He was given -- he
12 had a split EPG, negative EtS on February 11, 2016.
13 That's just what we looked at it as Union Exhibit 34.
14 He was then sent on February 23rd for the PEth when the
15 result came back and it came back negative.

16 THE ARBITRATOR: What Union Exhibit is that now?

17 MR. KASSIN: That's what I'm trying to figure out.
18 I mean, we -- we -- we skipped a bunch, so I've think
19 if we'd go to Union Exhibit 33. If we look for -- do
20 we have that? Do we have that in there?

21 THE ARBITRATOR: Yeah. I've got it.

22 MR. KASSIN: Okay. I'm looking for the test that
23 was collected on February 23rd, and it looks to be --
24 I'm looking for a Bates stamp or something on it, but
25 it's several documents into this exhibit,.

1 THE ARBITRATOR: It was not Union 33, because that
2 has to do with an October test.

3 MR. KASSIN: Well, there's a bunch of exhibits in
4 there. That's what I'm confused with.

5 THE ARBITRATOR: Okay. All right, I'll look.

6 MR. KASSIN: That's why I'm having a problem, okay.
7 The Union Exhibit 33, what I'm looking at the very
8 first page is a February as a random blood taken on
9 10/3/2017. On the -- then there's something copied on
10 the back of that on our page which looks to be a chain
11 of custody for October 3rd, 2017. Then we skip to a
12 May 4, 2016 EtG that came back negative. Then on the
13 back of that is a chain of custody dated May 4th, 2016.
14 Okay.

15 THE ARBITRATOR: It's down on page -- it's a Page 8
16 of, 23 is February 23rd, test. If that's what you're
17 talking about.

18 MR. KASSIN: Thank you, sir, that's what I'm trying
19 to find.

20 THE ARBITRATOR: Okay. It's on the PDF, it's Page
21 8 of 23. Is that what you were referring to, Mr.
22 Seham?

23 MR. SEHAM: No.

24 THE ARBITRATOR: No? What are you referring to?

25 MR. SEHAM: I was referring to page 5.

1 THE ARBITRATOR: Page 5.

2 MR. SEHAM: It's a document, it's by USDTL
3 indicating a positive -- a collection on March 16,
4 2016.

5 THE ARBITRATOR: Got it.

6 MR. SEHAM: Okay. And it was received on 17th the
7 next day and then it shows at the bottom that it was
8 positive for PEth at a quantification of 10 nanograms
9 per milliliter.

10 THE ARBITRATOR: All right.

11 MR. KASSIN: That's not part of his testing
12 protocol. I'm sorry. He was tested -- I mean, he
13 started -- I mean, he just testified he was tested on
14 2/11. He had a split. He was positive on the EtG at
15 138, he was negative on the EPS. He testified that the
16 PEth he was given was the one on Page 8. It's the one
17 in February 23. Why are we talking about the March
18 one? It's irrelevant to the follow-up. So he came out
19 of -- the February 11 was exactly the protocol that we
20 talked about earlier with Captain Storbeck.

21 MR. SEHAM: This plaintiff's argument and I'm
22 trying to present evidence without trying to skip to
23 the briefing period.

24 MR. KASSIN: But it's not appropriate for you to
25 try to use another document to prove something that is

1 not related to that February test.

2 MR. SEHAM: I would ask not to be -- I would ask
3 not to be shouted down. I would ask not to be
4 interrupted. I would ask not to be subject to
5 allegations, really pedestrian vulgar representations
6 about my not doing things right. There's -- so much
7 for Delta cordiality.

8 THE ARBITRATOR: Okay. Okay. Okay.

9 MR. SEHAM: I have a document providing USDTL and
10 I'm asking questions about the document and what this
11 man was subject to as a result of testing positive as
12 referenced by USDTL. That -- now we're briefing
13 issues. I would like to proceed with the questions.

14 THE ARBITRATOR: Proceed. Go ahead.

15 BY MR. SEHAM:

16 Q. So did you, to the best of your recollection,
17 provide a specimen -- blood spot specimen on or about
18 March 16, 2016?

19 A. Yes, sir.

20 Q. Okay. And you were subsequently told by
21 Captain Miller to, I'm just recalling your testimony
22 that you had had a non negative test, right?

23 A. That's correct. That's the exact term they
24 used. That was a non negative.

25 Q. And how did you respond to this news?

1 A. Well, I -- I wasn't sure what -- first of
2 all, what a non negative meant. I mean, they use such
3 vague terms, but I -- excuse my French, but I did -- I
4 said, what in the hell does a non negative mean? He
5 said, well, it just means that you're going to have to
6 go get tested further, but I didn't realize that, you
7 know, regardless of being 100% compliant with this
8 program and never consuming alcohol, how easily it was
9 for me to get exposed to something that's going to test
10 positive and -- and jeopardize my career.

11 Q. Did you communicate your concerns to Captain
12 Miller?

13 A. Oh, I did. I told him I -- I plain out told
14 him I'm willing to take a polygraph test and, I think
15 Harry was more just the -- the guy giving the
16 information, you know, he -- he handed me off to, at
17 that point, to my AME Charles Harper.

18 Q. How did Captain Miller -- I may have spaced
19 there for a minute. Captain Miller responded by
20 referring you back to Dr. Harper?

21 A. Yes.

22 Q. Okay. And how did things proceed with Dr.
23 Harper?

24 A. Well, I -- I talked to Dr. Harper and -- and
25 told him -- I said, listen, the only thing I can -- I

1 can think of -- now my wife's on the phone calling
2 every restaurant that we've eaten at. Trying to figure
3 out if any of the cook has put alcohol in and it was
4 just -- it was a goat rope trying to figure out what --
5 where this -- this test came positive from and -- and
6 the -- I told Dr. Harper in the past I've been a
7 firefighter. I knew that he was going to probably want
8 the material safety data sheets indicating the
9 chemicals in the -- in the breakdown of chemicals in
10 the product and I just started firing off as many
11 material safety data sheets as I could via text message
12 to him.

13 Saying this is what I've -- I'm-- I'm dealing with.
14 This is what I think may have caused all this. Whether
15 or not it actually said the word alcohol or whether it
16 triggered a positive -- a false positive, I don't know.
17 But I sent off dozens of these material safety data
18 sheets on these chemicals that -- that I could find,
19 most of which, you know, I had to go online to find.

20 Q. Was there any additional testing arranged for
21 you as a result of this PEth test?

22 A. Yeah. So Dr. Harper said that -- that he
23 wanted to do a long-term test. He wanted to do a hair
24 sample test to indicate long exposure or something on
25 alcohol. Unfortunately, I keep my hair short. So he

1 said what we're going to do is we will submit a nail
2 test.

3 Q. And who performed the process of -- you're
4 talking about fingernails?

5 A. Yes -- yes.

6 Q. And who performed the process of obtaining
7 the nail clippings?

8 A. I absolutely cannot tell you for sure. I --
9 I do know that Michele Gable indicated that there were
10 certain labs that had -- that was equipped to do it,
11 and so I just went to the lab that she told me to and I
12 -- I -- I can't tell you which lab that was.

13 MR. SEHAM: And if we can go to Union Exhibit, I
14 can't recall which exhibit we're on.

15 THE ARBITRATOR: We're on 33.

16 Q. Okay. So 33. So we can move two pages back
17 to Page 3. Okay. And just for the record, it's a
18 USDTL drug test report on page Bates stamp USDTL
19 001108. And did you provide, as indicated here, a nail
20 sample on or about May 4th, 2016?

21 A. Yes.

22 Q. And the result here indicates a negative.
23 Does that conform to what you were advised in terms of
24 the test result?

25 A. Correct, yes.

1 Q. Okay. How did Chief Pilot Miller react to
2 your negative nail test?

3 A. He called me up and he said, you're good to
4 go. And that's -- and that's -- and what that meant is
5 continue with the program. I wasn't flying yet, so
6 just continue with the program, you know, waiting for
7 my special issuance. So he just said you're good to
8 go.

9 Q. All right. Were you required to return to
10 Talbot or some other rehabilitation or treatment
11 program based on the PEth test?

12 A. No.

13 Q. And did they tell you why not? It had
14 something to do with the negative nail test?

15 A. Yeah. Yeah. That -- that satisfied them.
16 And you know, I was -- I was thankful that it -- that
17 it, you know, proved my point. I mean, I -- like I
18 said, I -- I don't know much about these tests, but I
19 -- I do know that I've been 100 percent compliant, that
20 -- that I felt, you know, that finally something came
21 through, that pretty much, you know, agreed with my
22 story line which is I did not drink any alcohol, so I
23 was very --

24 Q. Okay. I'm sorry.

25 A. -- relieved.

1 Q. Did the process that you underwent cause you
2 any concern going forward?

3 A. Oh, yeah. Absolutely. I -- at that point, I
4 knew that -- that, you know, that there can be anything
5 that -- that can, you know, cause these false positives
6 and -- and -- and put my -- my career in jeopardy.

7 Q. Did you do anything further about the matter?
8 I mean, in terms of the inconsistency of the PEth and
9 EtG nail test at that time?

10 A. No. You know, I -- I didn't do a lot of -- I
11 would -- I assumed that Delta Airlines and the people
12 that ran the HIMS program knew what they were doing. I
13 -- I didn't -- I -- I -- I would make -- made the
14 assumption, right, wrong, or indifferent that this was
15 just par for course that -- you know -- people test
16 positive because they washed their hands with the wrong
17 stuff or they put the -- they didn't check what was in
18 their food. And so I was just letting them do their
19 job and I was going along with the program.

20 Q. Did there come a day when you got a call from
21 Michael Danford?

22 A. Yes.

23 Q. And you discussed with him -- what was your
24 reaction to Michael Danford's account that he told you?

25 A. There was a lot of reactions. One, I was

1 very surprised that I even got a call from anybody. I
2 was told from the very beginning by Harry Miller, if
3 you don't want anybody to know about this program --
4 that you were in this program, that's up to you and I
5 didn't tell anybody. And suddenly I'm getting calls
6 from these pilots saying, hey, we heard that there were
7 some tests discrepancies, and -- and Mike told me that
8 -- that he had a similar situation. And I said, well,
9 you know, it seems to be what happens and -- and the --
10 the unfortunate thing is, is it seemed to be that he
11 was being treated a lot differently than I was. And,
12 you know, although I had been released by the FAA and I
13 didn't feel much obligation to do anything, I -- I felt
14 for him because it was -- it's exhausting to go through
15 this process wondering if you were going to have a
16 career tomorrow morning. And I just felt that somehow
17 that I was getting a different treatment than he was.
18 And -- and I don't know why because I didn't -- I've
19 never asked for special consideration.

20 Although, I will even today deny that I've ever
21 been an alcoholic or never had a alcohol dependency
22 problem, you know, suddenly I -- I'm being treated what
23 appears to be, you know, I have this preferential
24 treatment that I didn't ask for and Mike unfortunately
25 he's on a different paths and I -- and I think that's

1 -- and that's what I thought, and I thought, well,
2 yeah, I'll -- I'll tell him my story and that's what
3 I've told every pilot that has ever contacted me. I --
4 I'm not here to defend anybody. I'm here to tell my
5 story and that's -- that's it.

6 Q. Okay. Did USDTL ever provide you with the
7 test results prior to this case coming up?

8 A. No.

9 Q. Did Michele Gable provide you with a PEth
10 test resolve or nail clipping test results?

11 A. She did not. And -- and when -- and I again,
12 thinking that these guys knew what they were doing, if
13 they said, hey, you need to go get retested, I just
14 went and got retested. When suddenly -- when Mike
15 starts bringing this up, I, you know, I -- I have a
16 curiosity about well, what are these tests, what were
17 the actual numbers? Because I've never seen the actual
18 numbers until this started happening. And so I -- I
19 asked Michele, I said, can you send me all the records
20 of -- of all the testing I've ever done through Choice
21 Labs.

22 Q. Okay. And did she provide that to you?

23 A. She provided the last three years which did
24 not include the -- the tests that we're talking about
25 here today.

1 Q. And did you provide your medical
2 authorization to my law firm to obtain the results
3 directly from USDTL?

4 A. I did.

5 MR. SEHAM: Yes. And if we could bring up the
6 Union Exhibit 60.

7 THE WITNESS: Okay.

8 (Union Exhibit 60 marked for identification)

9 Q. And if you can scroll I think down to the
10 second page. Okay. And is this an authorization
11 executed by you, the second page of Union Exhibit 60?

12 A. It is.

13 MR. SEHAM: All right. I have no further
14 questions. But I imagine Delta's Counsel, Mr. Kassin
15 will have questions.

16 THE WITNESS: That's fine.

17 CROSS EXAMINATION

18 BY MR. KASSIN:

19 Q. Mr. Perez, are you Captain or first officer,
20 do I refer as Captain Perez or Mr. Perez?

21 A. You can just call me Mr. Perez. I'm a
22 captain, but Mr. Perez is fine.

23 Q. And what -- and so what do you flying these
24 days?

25 A. I fly 737.

1 Q. You can take that subpoena down. We don't
2 need that. Okay. So I want to try to put things in
3 the chronological order and that's the purpose of these
4 questions. It's just try to get a sequence in here
5 because we did jump around a little bit. So your DUI
6 as best you recall was August 22, 2015, correct?

7 A. Correct.

8 Q. What was your blood alcohol on that DUI?

9 A. It was, I think .14.

10 Q. Okay. So then you go into the treatment at
11 TRC. There's a meeting that you had with Captain Harry
12 Miller, who was coming in and then who is the outgoing
13 Chief pilot?

14 A. I cannot tell you his name. I'm sorry.

15 Q. Okay.

16 A. I'm sorry. Was there a question?

17 Q. No, I'm thumbing through notes. I really
18 don't have that many questions for you.

19 A. I'm sorry.

20 Q. Currently, who is your HIMS AME?

21 A. I -- I no longer have a HIMS AME. I -- when
22 Dr. Charles Harper Senior passed away, his son, Charles
23 Harper Junior, took over and I've been out of the HIMS
24 program, although I'm -- I'm still subject for a
25 two-year period that ends, I think in June of next year

1 of -- of random drug testing at a much lesser
2 frequency. I -- I've been released by the FAA and I'm
3 no longer under the HIMS program.

4 Q. Okay. And, so you go into the TRC November
5 16th, 2015, does that sound right?

6 A. Yeah, it was I -- I -- I remember it was, I
7 think the chief pilots offered me the opportunity to
8 wait until after Thanksgiving and I said, no, let's
9 just get this thing over with. So it was right before
10 Thanksgiving. I -- I can't tell you the exact date. I
11 -- and I know I came out right before Christmas.

12 Q. Okay. These questions are intended to --
13 what's your understanding of the DPAC program was that
14 was affecting you and then I'm going to get into some
15 of the specifics of the testing that you heard the
16 exchange about. While you were in TRC, did they give
17 you a test as part of their process and part of the
18 rehabilitation program as you recall?

19 A. As -- as part of the evaluation process?

20 Q. Well, did they give you a urine test or PEth
21 tests or --

22 A. Yes. Yes.

23 Q. And all those were negative?

24 A. Yes. I believe so. I -- you know, I just --
25 like I said, I'm just in the program, but --

1 Q. Okay. And you graduated from TRC and sign
2 your Contract A on December 18, 2015?

3 A. That sounds about right, on the day. I think
4 I signed that contract at the beginning. I might be
5 wrong, but I -- I thought --

6 Q. You might have. Okay. I think we have a
7 copy of your Contract A. And what we're seeing on that
8 is that it was signed on December 18, 2015.

9 A. Yeah, that's probably correct.

10 Q. So the first test that Delta shows you
11 receiving while you were in DPAC is the one that's on
12 Exhibit 34, and it's the -- let me be sure I can find
13 it again. I had it a second ago. It's the one that
14 showed the -- it's on page 2 of Exhibit 34. Emily, if
15 you could pull that up for us so we can see it. Thank
16 you. And that's the one where we've had a lot of
17 testimony about the EtG EtS test, but this is the one
18 that you were positive on the EtG and you were negative
19 on the EtS. And then you were asked to do a PEth test
20 after that. And if you could look at page 5 of -- let
21 me see. We got to get the right document.

22 MR. SEHAM: Exhibit 33?

23 Q. I believe that was 33. It's the one with all
24 the -- all the tests in it. Yep. I got it. So it's
25 33. And if you can look at Page 5. And Emily, if you

1 could -- I'm sorry, Page 8. Page 8 is the one that I
2 want to go to. And Captain Perez, what I'm trying to
3 do is establish that after you had that positive EtG,
4 negative EtS that you were given a PEth and the PEth
5 test was collected on February 23rd, 2016, and that you
6 came back negative on that. And that's what the
7 document is that Emily has put up for us on a -- can
8 you see that?

9 A. I -- I see it. If that's what you're asking.

10 Q. Okay. And during the course of your time
11 with the folks at DPAC, did you have, like, pilot
12 sponsors or in addition to company sponsors, was there
13 somebody from ALPA that you might have worked with?

14 A. No. I had -- I mean, I had -- I had a pilot
15 peer monitor.

16 Q. And I'm not asking names or anything like
17 that. I just want to know if you had somebody. Did
18 you understand that the positive cutoff for the PEth
19 test was 20 nanograms?

20 A. I knew nothing about the PEth test.

21 Q. Okay. Again, that's what I'm trying to do is
22 establish the level of what your information and your
23 knowledge was as you were going through this program.
24 So if I told you that to be positive on a PEth test,
25 you had to be 20 nanograms or greater, you're saying

1 you had never heard that before?

2 A. Never.

3 Q. Okay. Did Mr. Danford tell you that? That
4 you had to be 20 or more before you --

5 A. He -- he did not.

6 Q. Okay. I'm asking you this for a reason
7 because I don't want to ask a question if it's
8 inappropriate. Is Mr. Seham your attorney?

9 A. He is not.

10 Q. Okay. Then did Mr. Seham tell you that the
11 positive -- the cutoff for a positive PEth test is 20
12 nanograms or higher?

13 A. I think we exchanged some emails when -- when
14 he got those tests because that's the first I've ever
15 seen the test was when he received them. And -- and
16 let me make something perfectly clear to everybody that
17 I never -- some of it's ignorance. I assumed Choice
18 Labs was the lab I was dealing with. I -- I -- I
19 didn't pay much attention to this UTL lab and I never
20 requested information from them. And so that was the
21 beginning. And -- and when I started getting this
22 information, you know, he was giving me the exhibits.
23 I'm trying to make sense. I -- and I don't know if he
24 actually gave me the cutoff.

25 And -- and even today, I couldn't tell you the --

1 what the cutoff is, but that's the first I've seen the
2 test, so I don't know if that's an answer or not, but I
3 -- I honestly don't know anything about the PEth test
4 other than what I was told by either Michele or from
5 Harry Miller saying you got to go get retested so, you
6 know, something's not right.

7 Q. Okay. So the test that you did the sample on
8 February 11, 2016 would have been the one that Michele
9 Gable from Choice Labs asked you to go in and give a
10 urine sample?

11 A. The urine test, is that what we're talking
12 about?

13 Q. Yeah. The February 11th urine test.

14 A. The one that tested positive yeah, the --
15 she's -- yeah. All these -- all these have been
16 directed by Michele. You know, it -- she'd say you've
17 been randomly selected and I go, I just take a form and
18 I drive to Noblesville, Indiana to a lab and I take a
19 urine test.

20 Q. Now, would Dr. Harper Senior also do some --
21 direct you to do some testing before your special
22 issuance was issued?

23 A. The only thing he directed, to my knowledge
24 and I don't know what -- if they had any other
25 subsequent conversations with the rest of the team, was

1 -- was the nail test. I don't know whether he was a --
2 a direct contact to Michele or if Michele had contacted
3 him. I don't -- I don't know the relationship there,
4 but I do know that -- that when -- excuse me. When the
5 PEth test came back as a non-negative, whatever that
6 meant, it was Dr. Harper says, you know what? We want
7 to do a hair test, I said okay, good luck on that and
8 he said, well, we'll do a nail test which required me
9 to grow me -- I don't have long nails, so that required
10 my -- me to grow my nails out for an extended period of
11 time before I get -- got those clipped and tested.

12 Q. Okay. And I'm going to ask you questions
13 about Page 5 of Union Exhibit 33. And Emily, if you
14 could put that page up again, please. Okay. This is
15 the test that -- do -- did Dr. Harper ask you to do
16 this test?

17 A. The -- is that the PEth test?

18 Q. Yeah. The March 16th sample --

19 A. To my knowledge, he didn't let -- he did not
20 tell me directly, no. I mean, he did not -- I did not
21 have a conversation with that. That was directed by
22 Michele Gable.

23 Q. Okay. And --

24 A. And I don't know where she got her -- her
25 directive from so --

1 Q. Did you understand that this was not a DPAC
2 required test?

3 A. No. I'm just following what the guys that run
4 the program told me to do.

5 Q. Okay. Well, so your best recollection is
6 that Michele Gable told you to take this test?

7 A. I was told that -- yeah. To the best of my
8 knowledge, like I said, I don't know who directed who
9 in this program, but I do know that she's the one that
10 I -- that she sent me the email. I think that was in a
11 -- an earlier thing. And she said, you know, you've
12 tested positive. I think in the exhibit it said
13 something like you've -- this is what we discussed,
14 that you tested positive, and I'm going to forward a
15 PEth test to you. And I made contact with her. She
16 wanted to know my address and that it was going to be
17 FedExed immediately.

18 Q. Okay. So you mentioned you got your special
19 issuance in June of 2016. Does June 22nd, 2016 sound
20 about right for getting your FAA specialty issuance
21 back?

22 A. That sounds about right. I -- I don't know
23 the exact date, but it was in June.

24 Q. Okay. So all the things that we've been
25 talking to up until this point in time were things that

1 occurred prior to the FAA issuing your specialty
2 issuance?

3 A. That's correct.

4 Q. And Dr. Harper would have to support it --
5 Harper Senior would have had to support your special
6 issuance or the FAA would not have done it, correct?

7 A. I would assume, I -- I don't know. I don't
8 know how -- I don't know how the -- how this works.

9 Q. Okay. And is it fair to say that once you'd
10 been issued your special issuance back in June of 2016,
11 that any of your -- all of your later tests that you
12 did part of the DPAC program all came back negative?

13 A. I think that's fair to say, yes.

14 Q. Okay. And then going forward, after your
15 first specialty issuance, Dr. Harper would help you
16 with the renewals of your special issuance and you're
17 flying today like you discussed earlier?

18 A. I'm sorry. Oh, that he --

19 Q. I'm just saying that you've had no issues,
20 you've had no positive tests since the special issuance
21 and renewals of your specialty issuance have taken
22 place on a regular basis?

23 A. Well, I'm no longer under a special issuance
24 so --

25 Q. Okay. But before that, did you have renewals

1 of that special issuance from June of 2016?

2 A. I mean, I was under a special issuance until
3 a specific date. I don't know whether someone has to
4 constantly -- I don't know how that works, I don't.

5 Q. Okay.

6 A. I was given the special issuance for a
7 certain amount of time and then I was given my regular
8 medical and at that point, I -- I could see whatever
9 AME I wanted to see.

10 Q. Okay. How did Mr. Danford know that you had
11 been in the DPAC program?

12 A. I have absolutely no idea because I've never
13 mentioned it to anybody.

14 Q. Okay. Did you ask him how he found out that
15 you were in the program?

16 A. No.

17 Q. Okay. Did you ask Mr. Seham how they found
18 out that you were in the DPAC program?

19 A. I did not.

20 Q. Okay. And do you understand that Delta
21 Airlines Management takes the confidentiality of the
22 DPAC program incredibly seriously and --

23 A. Someone -- someone didn't. Someone didn't.

24 Q. Do you have any indication that it was
25 somebody at Delta Management that talked to Mr. Seham

1 about --

2 A. I have no indication who it was, but I'll
3 tell you I've never ever told anybody I was in the HIMS
4 program, ever.

5 Q. Well, and I want to assure you that the Delta
6 Management respects the confidentiality of the program
7 and takes the breach of what took place in your case
8 very seriously.

9 MR. SEHAM: Objection. Objection. This is
10 probably the 10th time that we're having counsel for
11 Delta testify. He's not Delta Management, he's not
12 under oath, and it is not appropriate to inject into
13 this record his testimony. I would move a reason --

14 MR. KASSIN: It's a breach of confidentiality of
15 the DPAC program.

16 MR. SEHAM: Please not talk over me.

17 MR. KASSIN: Period.

18 MR. SEHAM: Please not talk over me. I was not --
19 I'm making an objection. And you're disrupting the
20 court reporting process, you're not respecting the
21 arbitrator's authority, and you're disrespecting me.
22 The only way this is going to work as a proceeding is
23 that I am allowed to make an objection and finish that
24 objection. You respond to the arbitrator and the
25 arbitrator makes a ruling. So I'm finished with my

1 objection. If you want to respond now that I'm
2 completed, then make your response and then let's have
3 a ruling from the arbitrator and try to respect the
4 cordiality that you say that Delta respects.

5 MR. KASSIN: Mr. Burdette, I need about five
6 minutes, but I don't believe I have any more questions
7 for this witness. But I'll be back in five minutes,
8 sir.

9 THE REPORTER: You're muted, Arbitrator Burdette.

10 THE ARBITRATOR: Sorry. Sorry. Thank you. We
11 will go off for five minutes.

12 MR. KASSIN: Thank you.

13 THE REPORTER: We're off the record at 6:02 p.m.

14 (OFF THE RECORD)

15 THE ARBITRATOR: Okay.

16 MR. KASSIN: Okay. I'm good now.

17 THE ARBITRATOR: No, you're good. You're good now.
18 Sorry. I keep looking at the thing on your computer
19 and it shows you're muted and it takes a minute to
20 realize that you've got the speaker phone there, so --

21 MR. KASSIN: We have no further questions for
22 Captain Perez.

23 THE ARBITRATOR: Okay. Mr. Seham, any redirect?

24 MR. SEHAM: No. No.

25 THE ARBITRATOR: Okay. Then Captain Perez, you may

1 be excused as you wanted to. So thank you very much
2 for your time and participation. We appreciate it.

3 THE WITNESS: In case I -- I miss the people that
4 were not in the room, I do apologize for having to mess
5 the schedule up because of my reroute, but thank you
6 for accommodating me. Thank you very much, gentlemen.

7 THE ARBITRATOR: No problem. Thank you.

8 THE WITNESS: All right.

9 THE ARBITRATOR: Take care. Emily, you can remove
10 Mr. Perez. Thank you. Okay. What's next?

11 MR. KASSIN: Mr. Burdette, we have our last witness
12 for our case in chief, which is Captain Jim Graham, who
13 is available to us tomorrow at a window starting at
14 9:30 a.m. So I would suggest --

15 THE ARBITRATOR: Okay.

16 MR. KASSIN: -- we reconvene tomorrow at 9:30 a.m.
17 Eastern, 8:30 Central.

18 THE ARBITRATOR: Okay.

19 MR. KASSIN: Again, our case in chief with Captain
20 Graham.

21 MR. SEHAM: Well --

22 THE ARBITRATOR: Okay. Seham?

23 MR. SEHAM: -- I had something to say to that
24 because we had advised the panel that we had Dr.
25 Gregory Skipper, we had made arrangements with him to

1 testify tomorrow at 10:00 a.m. The problem with that
2 is he's a doctor and consultant with a very busy
3 schedule. And that time that we set with him at some
4 expense to us and inconvenience to him.

5 THE ARBITRATOR: Okay. Mr. Kassin, is your chief
6 pilot going to be available later in the day or no?

7 MR. KASSIN: Not afternoon.

8 THE ARBITRATOR: Not afternoon?

9 MR. KASSIN: We'll go back and talk to him. But
10 what we were given, his window ending right about noon.

11 THE ARBITRATOR: Okay. Well, I think --

12 MR. KASSIN: Let me know. If we need to do Dr.
13 Skipper we'll --

14 THE ARBITRATOR: Yeah. I think so.

15 MR. KASSIN: -- we get all the other witnesses in.
16 So if we need to get Dr. Skipper --

17 MR. SEHAM: Do you want -- do you want -- I mean,
18 if you would all just hold three minutes, I'll see if I
19 -- I'm fairly certain he told me that was -- he has all
20 these patients coming in and he has his window as well.
21 But I could call him right now and see if he --

22 THE ARBITRATOR: Okay. All right. Why don't you
23 call him to see if he can do the afternoon instead of
24 the morning tomorrow?

25 MR. SEHAM: I'll try that.

1 THE ARBITRATOR: Okay.

2 MR. SEHAM: I'm back.

3 THE ARBITRATOR: Okay.

4 MR. SEHAM: The witness for Captain Graham was what
5 time?

6 THE ARBITRATOR: He said 9:00

7 MR. KASSIN: 9:30 in the morning.

8 MR. SEHAM: 9:30. All right. So I mean, I should
9 hope -- I mean, do you have a sense of how long you
10 have on direct for him?

11 MR. KASSIN: Well, Captain Graham's direct is
12 usually about an hour.

13 MR. SEHAM: Okay.

14 MR. KASSIN: It may not be that long in this
15 particular case because the issue is pretty narrow.

16 MR. SEHAM: Okay.

17 MR. KASSIN: That's generally what it's been
18 running.

19 MR. SEHAM: Okay. So when I spoke to Dr. Gregory
20 Skipper, he said he could push back to 12:00 Eastern
21 Time.

22 THE ARBITRATOR: Okay.

23 MR. SEHAM: But his witching hour would be about
24 3:00 or about 3:00 or 3:30. I think that's enough.

25 THE ARBITRATOR: Okay. Yeah.

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1 MR. KASSIN: I would say that would work.

2 THE ARBITRATOR: Yeah. Let's try and do that. I
3 think we should be able to manage that okay. All
4 right. So we'll deal with the company's last witness
5 at 9:30 in the morning, Eastern, and then we'll plan on
6 Dr. Skipper at noon time on -- tomorrow as well.

7 MR. SEHAM: Okay.

8 THE ARBITRATOR: Eastern. Okay. Anybody have
9 anything else before we close for the day?

10 MR. KASSIN: No, sir.

11 THE ARBITRATOR: All right. Thank you. Have a
12 good evening and we'll see you at 9:30 in the morning
13 Eastern Time.

14 (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

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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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