short-term health effects occurred as a result of the spill and the response, and that there is the potential for additional effects to become evident in the future.

For instance, Dr. Cox mischaracterizes my discussion of NIOSH's HHE 6, claiming that I "attempt[ed] to link … symptoms [reported in HHE 6] to exposures to oil or dispersants." (Cox Round 2, p. 5.) As mentioned above, I made no causal conclusions in my report. In citing to HHE 6, I simply noted that *NIOSH* found, in at least one instance, a greater prevalence of reported symptoms in groups that had been exposed to oil and dispersants than in groups that had not been so exposed. (NIOSH HHE 6, 2010, p. 6A-2.) Furthermore, Dr. Cox suggests other possible explanations of the respiratory symptoms reported in HHE 6, such as road and gravel dust exposure or crowded work and living conditions for Coast Guard DWH response workers. (Cox Round 2, p. 6.) While these are not oil exposures, these workers were working and living in such conditions *because* they were responding to the oil spill. Such exposures would therefore be a result of the DWH oil spill and would not have occurred if not for the need to respond to the spill.

Dr. Cox is not correct in his assertion that I did not review exposure data from the DWH spill. (Cox Round 2, pp. 2, 3.) As my report did not include a risk assessment, I did not cite to exposure data, however, I reviewed numerous sources of exposure data, as referenced in my list of considered materials. (*See, e.g.*, Ex. 12023, Ex. 12252, Ex. 12258, BP-HZN-2179MDL09231990, US_PP_RC002795.)