it was in the works?

A. No, ma'am.

Q. Did you have any -- how soon after this announcement was made did you become aware of it?

A. I can't give you a definitive time line, but very shortly after this announcement was made because it came to the secretaries in the military departments and we were all briefed.

Q. Did you have any understanding of the personnel factors that had led to this announcement being made?

A. No, ma'am.

Q. Did you ever discuss that with anybody?

A. Discuss what?

Q. Discuss the factors that had led Secretary Carter to make this announcement?

A. No, ma'am.

(Deposition Exhibit 4 was marked for identification.)

BY MS. LAPORTE:

Q. Do you have Exhibit 4 in front of you?

A. Yes, ma'am.

Q. Okay. And at the bottom right-hand corner, that should have what are called Bates markings with a USDOE number. In this case -17988 through -17991.

Is that what you have?

A. Yes, ma'am.

Q. Okay. So there's a cover E-mail on this involving people who were not you, and I just put it on there for the date, which is September 4 of 2015. Do you see that?

A. Yes, ma'am.

Q. So let me ask you to turn to the list that is on the second and subsequent pages of this document.

A. Uh-huh.

Q. Can you identify the people on this list?

A. I am familiar with some of them, yes, ma'am.

Q. Okay. Is this a list of the people who were either on the working group directly or plus ones?

A. Without knowing the specific working group, ma'am, I mean a lot of these people sit on a lot of different working groups.

Q. Okay. So is this the working group that you worked with in the wake of the 2015 announcement by Secretary Carter that the issue of open service in the military would be discussed?

A. I'd have to speculate that a lot of these people that are listed are people that would have been on that working group, yes, ma'am.

Q. Okay. Can you list any people that you see

on here who weren't involved in that working group?

A. There were people in that working group that I did not know their names. So I mean they may have been a part of that working group. I just didn't know their names.

Q. Okay. Who did you interact with, in your specific work to support the working group, who appears on this list?

A. The first individual is John Fedrigo. It says, DoD." He's my boss. So that I specifically worked with would be also Janet Bristol.

Q. And who is Janet Bristol?

A. She's my Navy counterpart.

Q. Okay. Who else?

A. Mark Ediger.

Q. And who is that?

A. He's the Air Force SG. He's a surgeon general. He's a three star. Hershel Eisenberger.

Q. And who is that?

A. He was the assistant to Mr. Camarillo. He was Mr. Camarillo's -- the staff MR appointee at the time. Lee Gearhart, he is my OSD counterpart. So he works for OSD P&R.

Q. "OSD P&R" being?

A. Personnel and readiness.

Q. And OSD is the office of the secretary of defense?

A. Yes, ma'am.

Q. Who else?

A. That I worked directly with would be Dorothy Hogg. She is the deputy surgeon general for the Air Force.

Q. What about Karen Guice, who's listed a few entries above that? Did you work with her?

A. I did not work directly with her. Karen Guice was the acting -- for health affairs, acting principal deputy for health affairs or deputy assistant secretary for health affairs. I can't remember if she was the acting or if she was the appointed.

The interactions I would have with her would be one of us sitting in this room and your name is Karen Guice. So that would be the familiarity. I did not work directly with her.

Q. Okay. Who else did you work directly with?

A. Brian Kelly. He was the A1 personnel.

Q. For the Air Force?

A. Yes, ma'am.

Q. And who else?

A. Mary Krueger, third one down on the top page.

She was my Army counterpart.

Q. Who else?

A. I did not work directly with Tony Kurta, but he was somebody that was in the working group there, kind of the equivalent of a Karen Guice interaction. So they are senior leaders. I would not have direct interaction with them. My boss would. So -- but we all work together on various issues.

Q. Okay. Who else?

A. William McWaters. He is the Marine Corps counterpart.

Q. Who else?

A. Dave Miller. David Miller.

Q. And what is his position?

A. He works for the Air Force SG office.

Q. And he's the one who wrote the -- or who was involved in the E-mail that you mentioned in your testimony earlier? Just "yes" or "no" for that, please.

A. Yes.

Q. Who else?

A. Daniel Sitterly.

Q. Okay. What was his position?

A. He's Mr. Fedrigo's boss. Martie Soper. That's it.

Q. Okay. And the reason that you've identified those people in particular, were you on any kind of subcommittees or addressing any particular issues with them?

A. Yes, ma'am.

Q. And was that -- well, am I correct in characterizing it as a "subcommittee"?

A. Yes, ma'am. That's a good characterization.

Q. Okay. And was there one subcommittee or multiple subcommittees on which you worked with these people?

A. There were various subcommittees.

Q. Okay. And what were they?

A. One of them was the transgender service review working group.

Q. And what was the point of that one?

A. That was the working group that was convened to help write the policy allowing transgender service members to serve.

Q. And what were the other subcommittees or working groups?

A. The other subcommittee was the accession medical standards working group.

Q. And the purpose of that one was what?

A. That was to look at the healthcare for

transgender service members. So the transgender service review working group was the personnel side, was the policy side, and then you have the accession medical standard working group. And as I mentioned earlier, the healthcare and personnel functions are intertwined. So that's why both of those groups were really important in the development of policy.

Q. Was the first one looking mainly at transgender people who were already in the military, while the accessions was looking at accessions, or was -- am I not understanding that correctly?

A. So the first -- they met simultaneously. So they were working groups that were going at the same time because we had to -- you know, in order to develop one policy, we need answers from another policy so we could make a complete policy because there were two requirements that came out of Secretary Carter's announcement in -- July 15, that we look at the currently serving service members who self identify as transgender, and what we were going to do in how to assess transgender individuals.

So in looking at that, we had to look at policy as what can we do right now to allow transgender members to serve, to look at any impact to readiness, healthcare, operational restraints, as well

as at the same time looking at the healthcare and any limitations in accordance with the currently established standards.

Q. In the answer that you just gave me, were you describing the two different ones, or was that all about the first one?

A. They both go to the first one. So I'm not sure what you mean by "the first one."

Q. Okay. So you identified, I think, earlier a transgender service review working group.

A. Correct.

Q. And then a second one which was accessions medical standards working group.

A. Correct.

Q. What I'm trying to understand is what's different about those two things.

A. One looks at the medical healthcare, and the other one looks at the policy on how do we revise policy to allow the open service of transgender individuals. And then in looking at that -- so you have individuals that are serving that may have a medical condition that has restrictions, but in order to identify those restrictions, we have to look at the medical capabilities. What are our standards right now.

And because transgender healthcare was so new to DoD, it was very difficult to try and really understand what -- where we were. We had many references to transgender healthcare in the civilian world. However, we had no basis of information on transgender members serving in the U.S. military.

So in trying to look at the healthcare needs and look at the understanding of transgender healthcare and some of the details that it involves, how could we best make a policy that allows a qualified candidate to serve in accordance with standards. And that's what we wanted to do.

Q. So these two subcommittees, as it were, were essentially working on finding out what the healthcare needs were and how that could work within the service, and then also, the earlier one, I think, was the one responsible for writing a policy that would take those kinds of inputs into account; is that correct?

A. Correct. Yes, ma'am. So the personnel policy, if you will, is the DoDI -- DoD instruction 1300.28, and that was the military service by transgender individuals. So that was developed in looking at educating the force. A transgender individual comes in. What are the requirements for that individual to be able to authorize the healthcare

that's needed. It melds a lot of medical in a policy document, but it also provides guidance for the transgender service member, what their responsibilities are as a service member to their commander, because all service members have a responsibility to disclose healthcare that they receive that may have an impact on the operational readiness capability.

So it outlined what the transgender individuals need to do in order to receive any healthcare that they need to -- I'm going to say to treat a dysphoric condition if they want to transition. And self-identifying as transgender as a label. And we get that. So if I identify as transgender and, you know, I want to be Mr. Martie Soper but I'm fine coming to work every day as a female, there's no problem. There's absolutely no problem because I'm not doing anything, you know.

But if I identify as Mr. Martie Soper and I want to transition because I feel strong enough that I really need to serve as a male, then I would seek care and have a provider identify a level of dysphoria because there is a level of distress within me that may impact my ability to do my job.

And we looked at a lot of the -- 2000 --

actually, back then it was 2009 Endocrine Society guidelines, as well as WPATH and some of the research because we didn't have any research. So we did a lot of work in trying to find out what the healthcare requirements are in the civilian world.

So we took some of that information and outlined what we could do for a service member, a service member who self-identifies as transgender and wants to transition. So we provided a guidance for them because we had no guidance. Then we provided a section for guidance for the medical providers on what their roles and responsibilities in order to provide the transgender care -- I should say transition care for the service member, all the while maintaining the dignity and respect for the service member, HIPAA requirements and things like that.

And then the commander, as with any service member that has a healthcare condition, has a responsibility to assess their operational impact on mission readiness. So the commander is -- there's rules and responsibilities for the commander to look at any healthcare that's being provided to a member as they would with any other member in their unit that has a healthcare condition that may impact the operational readiness of the unit.

It also outlines --

Q. You're talking about the policy now?

A. Yes, ma'am. Yes, ma'am.

Q. Okay. We'll come to the policy in a moment. One question I do have for you is -- and that I had trouble understanding the answer to by looking at the policy is if somebody is experiencing gender dysphoria, who are they supposed to go to to try to initiate a treatment process for that?

A. We're in the process of refining that policy, but right now it's referred to as a military medical provider to get that diagnosis, and in some of the interim guidance that has been put out, in Dr. Guice, she is the director of the DHA -- had informed the services or her Defense Health Agency that we would follow the 2009 Endocrine Society guidelines.

And if you look at those guidelines, it clearly states that a mental health provider would be the one to make a diagnosis of dysphoria and that mental health provider had to be -- there's criteria for that prior to be able to make that diagnosis. So they would have to have the expert care and providing transgender care for dysphoria.

Q. So, typically, in order to get into the treatment pathway, the service member has to go to a

mental health provider who can diagnose them with dysphoria; is that right?

A. Yes, ma'am.

Q. Typically that's going to require a number of mental health visits?

A. As established by the 2009, 2017 Endocrine Society guidelines, yes, ma'am. Because the mental health provider has to ensure that there is not a different diagnosis. So -- other than dysphoria. So it requires multiple visits.

Q. Right. So in other words, the mental health provider needs the multiple visits to be able to distinguish dysphoria from some other condition?

A. Yes, ma'am.

Q. Back to the working group for a moment. I think you testified earlier that you didn't have previous expertise in gender -- in healthcare for transgender people; is that right?

A. When this first came out, that's right.

Q. Okay. Did anyone from the working group, to your knowledge, consult any of the other military services that already had transgender people in open service?

A. When this was established, this was all brand new. So up until that point, as far as I'm aware, we

did not have transgender individuals serving in the military. So prior to this -- the release of Secretary Carter's message, I was unaware that we had transgender members serving.

Q. I'm sorry. I was unclear in that. Let me try it again. Did anyone in the working group consult with other military services from other countries where there were people in open service?

A. I don't know personally of any other members in our working group that consulted with other military services. We were provided documents from transgender service for different countries.

Q. Who provided those documents?

A. That would be the Health Affairs office.

Q. Okay. Who from the Health Affairs provided that information?

A. The lead from our working group was Colonel Lee Gearhart at the time. So he was the one that provided the documents from OSD and presented them to the working group.

Q. What did you do, in connection with your work on the working group, to get educated about the medical needs of transgender service members?

A. I did a great deal of reading.

Q. And what were your main sources that you

consulted?

A. I pulled down and printed off the WPATH standards of care. I pulled down information from the POM Center. I pulled down various research articles. I pulled down information from the VA. I watched media clips. I accepted information that was given to me by various people on transgender healthcare, media reports.

Q. Were there any members of the working group who did have prior experience in health issues of transgender people?

A. I don't know, ma'am.

Q. Okay. So if there were any, you don't know about them?

A. Yes, ma'am. That's correct.

Q. Now, did the working group or you, yourself, even do any looking into how the service was currently -- how the different branches of the service in the United States, now again, were handling issues of people who needed chronic hormone therapy of one kind or another?

A. No, ma'am.

Q. Okay. So there are some other conditions for which people might need chronic hormone treatments that do exist in the military population even before

open service; right?

A. Yes, ma'am.

Q. Okay. And so were the policies and procedures established to administer those hormones anything that people looked into when it came to providing hormone treatment for people with dysphoria or people transitioning?

A. Again, transgender healthcare is fairly new to the military. The hormone treatment for somebody, say -- there's a standard for accessions and there's a standard for retention.

So if we look at a service member who's in the service and has a health condition, whatever it is, the service accepts -- there's an acceptable level of risk, as we call it, that says your health condition can be treated with minimal risk. If your health condition exceeds that risk, then we'll take steps to, you know, either medically board you or, you know, find out if you're determined fit for duty.

So individuals who have, say, men with low "T." We will provide testosterone to bring them up to their acceptable levels of testosterone that are normal within their body. So there is risk associated with that by taking hormone therapy, as there are with women who are menopausal that take, you know, estrogen

and things. So stroke. There's all sorts of risk that are known risks that are associated with the hormone replacement therapy.

For transgender healthcare, what we really have to look at too, because we don't have a lot of history, is stopping ones -- so if I'm -- I want to become Mr. Martie Soper. So I want to transition, and I want to start testosterone. I would have to take an estrogen blocker to block my normal production of estrogen, but then also now start to introduce into my system levels of testosterone that are not normal, if you will, as a female in my body.

So there is a difference. When you talk about chronic hormone therapy, you're bringing somebody up to a normal physiological level that is commensurate with their birth sex, if you will, and then there's looking at hormone therapy that we are actually stopping the normal hormones for me as a female. So you're blocking my estrogen, and now you're introducing levels of testosterone.

So there is a little bit of a healthcare disparity in trying to figure out the risks associated with that healthcare. So it's not the same is what I'm trying to say.

Q. Did the military healthcare establishment

have any experience treating early stage breast cancer with estrogen suppressing drugs?

A. They may have, ma'am. Not to my knowledge. That's not within my purview.

Q. That wasn't an analog that came up while all of the issues of endocrine therapy were being considered?

A. Not with me, no, ma'am.

Q. Did the working group, or at least your parts of it, the parts of it that you knew about, consider the provision of surgical care that was similar between what would be required for a cisgendered person and what would be required for a transgender person, such as mastectomy, for example?

A. Yes, ma'am.

Q. Okay. And what steps did you take to try to understand the ability of the military health service to provide that kind of surgical care? And I'm talking now about the ones that do have analogs between what the cisgendered service members might need and what a transgender service person might need.

A. Uh-huh. So the military treatment facilities have surgeons capable of doing certain surgical procedures. As with any service member who would either like an elective procedure to be done or has a

required procedure that could be done, if the military treatment facility can't provide that surgical treatment, they will provide the treatment.

So I want to make sure that people understand that -- say, if I wanted to go in for a tummy tuck and my MTF had the surgeon that was capable of doing it. It would be an elective procedure, and there would be some cost share for me for an elective procedure. And I say that in that, you know, the military treatment facilities do do surgical procedures for a variety of reasons. So when you talk about a transgender -- so me, Mr. Martie Soper, I'm going to need a mastectomy as part of my transition to a male. Can the military treatment facilities do that? Yes, they can do that.

Whereas if you have an cyst that you -- and CA125 is high, so you have a preponderance to breast cancer and you choose to have a mastectomy, that can be done at military treatment facilities.

Q. So regardless of the reason that the surgery is done, the services do -- the military treatment facilities do have experience in certain of the surgeries that might be necessary for transgender healthcare?

A. Yes, ma'am. Part of the -- one of the things that we are working on is the coding for the surgical

procedures. So there's different ICD-9 codes, and until transgender -- or the treatment of dysphorias authorized, you know, surgeons would put in the appropriate code they felt necessary to allow the surgical procedure to be done.

Q. Okay. And ICD-9 is what?

A. Oh, the international something or other. I don't know. I'm sorry.

Q. So that's not a military acronym. That refers to coding --

A. Yes, ma'am.

Q. -- of healthcare procedures.

A. International code of diagnostics, I want to say.

Q. And those are standard throughout -- I mean those are referred to in civilian healthcare as well as military healthcare, to your knowledge; is that right?

A. Yes, ma'am.

Q. The military health facilities have had to address people who needed genital reconstruction after damage from combat operations; right?

A. Yes, ma'am.

Q. Okay. And did the working group consult with people to determine the extent to which that knowledge

and understanding might be applied to some of the other surgical procedures that would be necessary for transition healthcare?

A. The accession medical standards working group, I'm trying to remember if we had discussions about genital reconstructive surgery for trauma patients for multi-trauma patients, blast injuries, and things like that. There were discussions, yes, ma'am.

Q. Okay. Was the military health experience with that something that could be drawn upon to try to develop a reservoir of expertise for surgeries that would be needed for transition care?

A. In looking at blast injuries and the genital reconstructive surgeries are varied because of the type of damage that's done to the blast injury, and those surgical procedures are done for service members who are -- to save, you know, their life at the time of the injury and very often render the members not -- unable to serve.

Looking at the transgender healthcare, the reconstruction of the anatomy is not something that, I believe, the surgeons expressed that they were totally familiar with those specific procedures because it is -- there is a difference between traumatic blast

injury and trying to develop something out of nothing versus taking something and totally reconstructing it.

Q. Okay. Let me shift gears for a moment and ask you some questions about deployability.

What is "deployment"?

A. Deployment is a term that's used when you go to an alternate duty location, and oftentimes, it's associated with some type of either humanitarian mission or conflict, if you will.

Q. When you are deployed, are you in some kind of operational area?

A. You could be.

Q. Okay. Is it true that when you are on active duty, you're essentially either in a training phase or in the deployment phase?

A. I'm not sure what you mean by that.

Q. I'm trying to understand the relationship between deployment and the rest of what somebody might do during their active service.

A. So if I'm back at my base and I'm a flight nurse again and I'm at my air vac squadron, I would be performing my duties as a nurse to make sure the staff is ready to train to do the day-to-day operations. I would be flying my missions to maintain currency, and maybe even seeing patients at an MTF -- a medical

treatment facility. I'm sorry.

So I would be doing day-to-day operations, and within those day-to-day operations I would be, you know, maintaining some type of readiness skills, which could be equivalent to training.

When I deploy, I perform those same duties in an alternate location. So service members can actually deploy to backfill another unit within the continental United States. So just because you've deployed doesn't mean you always deploy outside of the United States to a conflict area. So that's why I want to -- you know, "deployment" is a vague term. It just means you are not at your home station. You are someplace else performing the duties of.

Q. So are there some deployed positions that -- so I think you've just testified that there's some deployed positions that are in the United States but just not in your regular location?

A. Yes, ma'am.

Q. And are there some deployed positions that essentially amount to desk jobs?

A. I don't know, ma'am.

Q. Okay. Well, if someone is deployed to administer a military hospital, for example, is that a desk job or is that something more physically

strenuous than that?

A. Well, I think anytime you leave your home station it's not only just physically strenuous but it's psychologically strenuous because you're away from your home, you're away from your home environment. For somebody to have a desk job, I don't know of anybody in the Air Force that just has a desk job.

You know, you're required to do your duties that are commensurate with what we call your AFC, your Air Force specialty code. So even administrative personnel have -- they do their admin work at a desk, but they're also required to do multiple, other duties.

Q. Okay. So what I'm really trying to understand -- and again, I hope you'll excuse the naivete of those of us who are not experienced in military affairs. I think that we often, in popular culture, have an image of deployment as people sitting, you know, in a tent in the desert, and what I'm trying to understand is are there different conditions, widely varying conditions under which people may be deployed?

A. Yes, ma'am.

Q. And some of those are more strenuous than

others?

A. They could be, yes, ma'am.

Q. And some of those might be more emotionally difficult than others?

A. For the individual perhaps.

Q. And some might be more physically difficult?

A. Perhaps.

Q. So not all deployments are the same, I guess.

A. That's a true statement, ma'am.

Q. Yes. Okay. And is it fair to say that someone who is nondeployable to one particular position might be deployable to a different one?

A. If you're nondeployable, you would have to have a good reason to go to an alternate location.

Q. What I'm trying to understand is whether there is an absolute standard for nondeployability or whether you're deployable might vary by what you're being deployed to do.

A. Right. So when you deploy to different locations, the locations themselves have what they call "standards" that have to be met, like eligibility standards. So each location may have a different standard based on the medical support that they have at that location, the -- it might have an impact on the SOFA agreement, the Status of Forces Agreements,

to different locations.

So each deployed location will establish what their standards are, what they can accept and what they can't accept. We do have airmen that are assigned what they call an ALC, an assignment limitation code. So -- which means that they have a healthcare condition that will allow them to deploy to certain locations that have that medical capability for them.

So when you deploy it's going to matter where you deploy to, and that deployed location may have requirements that prohibit you from deploying to that location.

Q. So when somebody has one of those ALCs, the assignment limitation codes, do you consider them deployable or nondeployable?

A. To certain locations. They can deploy to certain locations. And that is even under revision right now by ODS, the office of the secretary of defense.

Q. What's under revision?

A. The standards at which we will allow people to deploy.

Q. And are you involved in consideration of that policy?

A. No, ma'am.

Q. Now, are there also sometimes accommodations that can be given to permit someone to deploy? So, for example, certain treatments that might be given on a somewhat unusual basis in a deployed location? Does that ever happen?

A. I don't really understand the question.

Q. Are accommodations ever made for the needs of a service member so that they can be deployed but with perhaps some healthcare that is unusual for the deployed location?

A. We deploy all airmen to the same standard. So I don't know of any special accommodations that would need to be made.

Q. Do you know if accommodations are ever made in order to permit someone to deploy?

A. Outside of an assignment limitation code, that would be the only standard that I know of that would allow somebody to deploy. Again, we use a single standard that applies to all -- I'll speak for the Air Force -- to all airmen.

Q. Okay. What are the typical reasons in the general Air Force population for a period of nondeployability?

A. I'm sorry. Could you repeat that.

Q. What are the typical reasons in the general population of airmen for a period of nondeployability?

Okay. So that looks like that didn't make any sense. So let me try it another way.

A. Sorry. I'm not understanding what you're talking for a "period of nondeployability." I'm not sure.

Q. Let's say that an airman has a bereavement in the family, like a death in the family, and they may need to take some time away. Would that render that airman nondeployable for that period?

A. I wouldn't say they were nondeployable. They're unavailable. They're on leave. They're on leave status.

Q. What about somebody who breaks a bone. Would that person be nondeployable for a while?

A. That person would be nondeployable, yes, ma'am.

Q. Okay. And so sometimes also, I assume, that there are people who are nondeployable for a while because they received some kind of cancer diagnosis where it can be treated?

A. Yes, ma'am.

Q. Okay. And so that's what I'm really trying to ask you about. What are the reasons that you're

aware of that people have periods of nondeployability?

A. Well, there are administrative reasons, such as incarceration, any personnel reasons that somebody would be nondeployable. There are obviously the medical reasons that somebody would be nondeployable, and that would be more in my area of familiarity. So anybody that has a healthcare condition could be considered nondeployable depending on the condition and the care that's required to treat that condition until they're found fit for duty or found deployable.

Q. What percentage of active duty airmen are nondeployable at any given time?

A. I do not know, ma'am.

Q. I looked at the RAND report that said that in 2015 about 14 percent of the Army's active component was nondeployable for health or other reasons. Is that a statistic that would come as a surprise to you?

A. To be honest, I've never even considered that. I don't know.

Q. Okay. Well, was deployability or nondeployability something that you considered in your work on the working group?

A. Yes, ma'am.

Q. Okay. And did anybody, to your knowledge, look into what the typical number or percentage of

undeployable people or nondeployable people were at any given time in the Air Force?

A. Our focus was mostly on the transgender healthcare and what types of healthcare is needed and then what would be the impact on the deployability. The services have, if you will, a rolling percentage of nondeployable members. It could be for pregnancy. It could be for injuries. It could be for health -- so people will -- there will always be a constant level of nondeployable members for a variety of healthcare reasons, and a lot of them are short term.

Members that are nondeployable for greater than 12 months are usually referred to the integrated disability evaluation system to determine whether -- fitness for duty. So the services will have a percentage of nondeployable members.

Q. Okay. It sounds like you just don't know what that percentage was?

A. Correct.

Q. I also read in the RAND report that about three-quarters of the nondeployable people in the Army were nondeployable for health-related reasons. Does that sound about right in terms of how it works in the Air Force?

A. Well, I don't know how it works in the

Air Force. I mean nondeployable for health reasons is a -- you know, is probably a large percentage of the reasons people are not deployable.

Q. Okay. What does the Air Force do to minimize the impact of these sort of ongoing level of -- strike that.

What does the Air Force do to minimize the impact on readiness of the fact that there is always going to be some rolling percentage of people who were nondeployable?

A. There are certain career fields that we're allowed to overman, if you will. So that we have a population of personnel that are maybe double slotted against positions if we can recruit to those positions. We look at predictability for deployments. We have what they call -- there's a rotation schedule. So units know ahead of time when they're going to deploy, unless it's for a last-minute humanitarian-type mission or some kind of, you know, terrorist event that, you know, we just will deploy everybody, or those that we can deploy.

So there's a fair amount of preplanning for deployments for the Air Force, and as people become nondeployable, commanders have the option to move other unit members into those deployable positions.

So we don't deploy as a whole wing anymore.

There are certain line numbers, if you will, that people are expected to fill for certain long-standing deployments.

Q. And there's a redundancy that's built into those positions so if somebody becomes nondeployable in a position, there will be somebody else, hopefully, with that skill?

A. That's the hope. If the wing itself doesn't have that position, they may put it out to a deployment center to say, "Hey, we have a shortfall at Base 'X'. Does anybody out there have somebody with this Air Force specialty code that can fill this position." So they'll open it up.

Q. So is it fair to say that one purpose of trying to keep that level of redundancy is to be sure that periods of nondeployability don't have an impact on readiness?

A. The shortfalls are not something that's encouraged because everybody has a rotation requirement, and they want to make sure all unit members are healthy and deployable at all times because what happens is if you have a member that's down, somebody else has to fill that position. So within the units, it's looked first within the units

to fill that rotation.

So the goal and hope is not to have the same unit members constantly deploying because there's people that have nondeployable conditions.

Q. Right. So just let me restate that question. All I'm trying to get at is that the purpose of having people who are redundantly trained to be able to do the same kind of thing is to be able to be sure that when there is this inevitable level of nondeployability in the force, it doesn't have an impact on readiness; is that right?

A. I'm not sure. I'm not clear what you mean by "redundantly trained."

Q. Well, if you've got multiple people who can do the same job, then part of the reason why you would try to have multiple people who were able to do the same job is to minimize any impact on readiness when somebody becomes nondeployable; is that right?

A. Well, those people with the same type of training are at locations doing their jobs. So if you take a person from one base to fill a shortfall here, now you've just made that base short in their readiness requirements.

So each wing has to report a readiness statistic based on their assigned personnel. So you

want to stay as best at 100 percent as you can, and if you can't, then you report why you're short. So if you take a member from another unit to fill your shortfall, now that unit is short.

So if there's not a -- just because there's many people -- let's say security forces personnel, just because the Air Force has a lot of security forces personnel, it doesn't indicate that it's a manpower pool to fill shortfalls.

Q. Okay. But in each wing there are going to be multiple people who are able to perform a particular function; right?

A. There is a manpower assignment. So you may have a squadron of 10 people. By regulation, you are only allowed a certain percentage of overages. So if you have five people, you may or may not have one extra person in that squadron. It's a manpower formula that they have so not every person in that five-person billet has somebody else behind them.

So while I say we can overman in some career fields, some career fields we can't. There's a potential that we could have extra manning in some areas, but not all areas are like that.

Q. And when you do have people in those positions where you do not have extra people who can

also perform the position, are those sometimes the more highly skilled positions?

A. I wouldn't necessarily say they're highly skilled. I think all positions in the Air Force are highly skilled. So it's -- you know, sometimes there's the ability to overman a position with somebody that's not qualified too. So that extra person may not be qualified to do the duties. They may be a different level or they're working their way up to the qualified billet.

So we have to be careful when making assumptions that because we have extra people, they're ready to go.

Q. So I guess conversely, then, if you don't have extra people, it's important not to lose people who are qualified?

A. Absolutely.

Q. So let's go back to your work on the working group.

At what point did you -- did the work on the working group begin to arrive at a product? I think you mentioned that you were working on trying to develop a DoDI; is that right?

A. Yes, ma'am.

Q. And a DoDI is a department of defense --