

# COMMUNITY BOARD REPORT



**To:** The Chairperson and Members of the Te Awamutu and Kihikihi Community Board

**From:** Board Member Titchener

**Subject:** **Notice of Motion**

**Meeting Date:** 23 October 2024

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## 1 EXECUTIVE SUMMARY – WHAKARĀPOPOTOTANGA MATUA

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A Notice of Motion has been received from Board Member Titchener

## 2 APPENDIX - ĀPITITANGA

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No:	Appendix Title
1	Notice of Motion

## **APPENDIX 1**

### **Notice of Motion from Board Member Titchener**

**Notice of Motion – Fluoridation US Court Ruling and Recent Research published.**

**Background**

The Director General of Health has directed Waipa District Council to fluoridate Cambridge's public water supply per Direction Letter Waipa 27 July 2022. In 2018, the Supreme Court ruled that fluoridation of the water was compulsory medical treatment, meaning that if an area is fluoridated, the fluoridated water is unavoidable to be consumed by residents.

Two recently published pieces of major research, National Toxicology Program (NTP) review (21 August 2024) and the Cochrane Collaboration review (4 October 2024), and a recent US Federal Court ruling (24 September 2024) have dramatically changed the landscape on the fluoridation issue. There is now clear scientific evidence that shows that fluoridation needs to cease immediately in New Zealand, and we certainly should not be starting fluoridation in Cambridge. If Cambridge is fluoridated then it will be the intention of the Director General of Health to continue the expansion of fluoridation into other the other townships namely, Te Awamutu, Pirongia, Ohaupo and Kihikihi. This is the reason why the Te Awamutu and Kihikihi Community Board is raising this notice of motion. Attached is a letter of response from the Ministry of Health which does not address the concerns of the US Federal Court ruling.

Legally, Waipa District Council could apply for an interim order. This is based on point 11 of the NHNZ Ruling (see attached). *"Any decision on enforcement action would need to be informed by the Solicitor-General's guidelines. In the event that enforcement action was threatened, then the most appropriate course would be for any council affected to seek interim orders".*

**National Toxicology Program**

The National Toxicology Program has been finalised. The NTP concluded that "with moderate confidence, that higher estimated fluoride exposures (e.g., as in approximations of exposure such as drinking water fluoride concentrations that exceed the World Health Organization Guidelines for Drinking-water Quality of 1.5 mg/L of fluoride) are consistently associated with lower IQ in children."

NTP Review abstract is included as an appendix and the full report can be found at this link:

<https://ntp.niehs.nih.gov/publications/monographs/mgraph08>

Ten consecutive NIH-funded studies between 2017 and 2024 show fluoride significantly impacts brain development in young children. 9 of the 10 peer reviewed studies make up the just-released NTP report on fluoride neurotoxicity. All were conducted at 0.7ppm equivalent. 6 were conducted in water fluoridated Canada and 4 were conducted in Mexico where they have salt Fluoridation.

- #1. Bashash et al. (2017) – Fluoride & IQ
- #2. Thomas et al. (2018) – Fluoride & IQ
- #3. Bashash et al. (2018) – Fluoride & ADHD
- #4. Green et al. (2019) – Fluoride & IQ
- #5. Till et al. (2020) – Fluoride & IQ
- #6. Cantoral et al. (2021) – Fluoride & IQ

- #7. Adkins et al. (2022) – Fluoride & Behavior
- #8. Goodman et al. (2022) – Fluoride & IQ
- #9. Hall et al. (2023) – Fluoride & IQ
- #10. Malin et al. (2024) – Fluoride & Behavior (published after NTP cutoff date for inclusion)

## **Research**

### **Cochrane Review**

The Cochrane Collaboration Review 2024 has been finalised and published. The Cochrane Collaboration is considered the gold standard in systematic reviews and the Cochrane Review 2015 was used as evidence by the Director General of Health to support the Waipa District Council directive to fluoridate. This updated review should force a reassessment of the directive to fluoridate Cambridge.

The Cochrane Review 2024 concluded that Water fluoridation might result in 1/4 less filling per person. “There is insufficient evidence to determine the effect of cessation of CWF on caries and whether water fluoridation results in a change in disparities in caries according to socioeconomic status. We found no eligible studies that report caries outcomes in adults.”

Their key conclusion was that “The implementation or cessation of CWF requires careful consideration of this current evidence, in the broader context of a population’s oral health, diet and consumption of tap water, movement or migration, and the availability and uptake of other caries-prevention strategies.”

Water fluoridation might result in 1/4 less filling per person or 3-4% more people without any tooth decay – or it might have no benefit at all!

Cochrane 2024 abstract only: Conclusions - Contemporary studies indicate initiation of CWF may lead to a slightly greater reduction in dmft and may lead to a slightly greater increase in proportion of caries-free children. There is insufficient evidence to determine the effect of CWF cessation on caries and whether water fluoridation results in a change in disparities in caries according to socio-economic status.

The Cochrane review abstract is included as an appendix and the full report can be found at this link:  
<https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD010856.pub3/full>

## **US Federal Court Ruling**

US Federal Court Ruling made by Judge Chen attachment.

	<b>UNITED STATES OF AMERICA</b>
<b>Background</b>	Food and Water Watch v the US EPA

UNSAFE	<p>p. 2: <b>the Court finds that fluoridation of water at 0.7 milligrams per liter ("mg/L") – the level presently considered “optimal” in the United States – poses an unreasonable risk of reduced IQ in children.</b></p> <p>"In all, there is substantial and scientifically credible evidence establishing that fluoride poses a risk to human health; it is associated with a reduction in the IQ of children and is hazardous at dosages that are far too close to fluoride levels in the drinking water of the United States...Reduced IQ poses serious harm. Studies have linked IQ decrements of even one or two points to, e.g., reduced educational attainment, employment status, productivity, and earned wages."</p> <p>p. 3: There is little dispute in this suit as to whether fluoride poses a hazard to human health. Indeed, <b>EPA’s own expert agrees that fluoride is hazardous at some level of exposure. And ample evidence establishes that a mother’s exposure to fluoride during pregnancy is associated with IQ decrements in her offspring.</b></p>
EXPOSURE	<p>p. 5: The pooled benchmark dose analysis concluded that a 1-point drop in IQ of a child is to be expected for each 0.28 mg/L of fluoride in a pregnant mother’s urine. This is highly concerning, because <b>maternal urinary fluoride levels for pregnant mothers in the United States range from 0.8 mg/L at the median and 1.89 mg/L depending upon the degree of exposure.</b> Not only is there an insufficient margin between the hazard level and these exposure levels, for many, <b>the exposure levels exceed the hazard level of 0.28 mg/L.</b></p> <p>p. 5: Even if the toxicologically determined hazard level of 0.28 mg/L were deemed insufficiently substantiated, <b>evidence in the record still establishes with little doubt that fluoridated drinking water presents a risk of injury to health.</b></p> <p><b>p. 6: “The EPA’s default margin of error requires a factor of 10 between the hazard level and exposure level due to variability in human sensitivities...Here, an even greater margin (100x) is owed because the methodology (which yields the 4 mg/L hazard level) uses the lowest observed adverse effect level (“LOAEL”); this methodology adds an additional level of uncertainty (and hence the application of a 100x rather than 10x margin). But even if only the default 10x margin is required, the safe level of fluoride exposure would be 0.4 mg/L (4 mg/L (hazard level) divided by 10). The “optimal” water fluoridation level in the United States of 0.7 mg/L is nearly double that safe level of 0.4 mg/L for pregnant women and their offspring.”</b></p>
RISK	<p><b>p. 77: The scientific literature in the record provides a high level of certainty that a hazard is present;</b> fluoride is associated with reduced IQ. There are uncertainties presented by the underlying data regarding the appropriate point of departure and exposure level to utilize in this risk evaluation. But those uncertainties do not undermine the finding of an unreasonable risk; <b>in every scenario utilizing any of the various possible points of departures, exposure levels and metrics, a risk is present in view of the applicable uncertainty factors that apply.</b></p>
CERTAINTY	<p><b>p. 78: There is significant certainty in the data set regarding the association between fluoride and reduced IQ. Namely, there is a robust body of evidence finding a statistically significant adverse association between fluoride and IQ.</b> A large majority of the 72</p>

	<p>epidemiological studies assessed by the NTP Monograph observed this relationship including all but one of the 19 high-quality studies, see ¶¶ 34-36, and literature published after the NTP Monograph cutoff date observed the same relationship, see ¶ 37 – and countervailing evidence, for various reasons described previously, are of little impact on this repeated, and consistently observed association between fluoride and reduced IQ, see ¶ 39. Moreover, complete consistency amongst studies is not expected. See Dkt. No. 414, Feb. 9, 20240, Trial Tr. at 1172:23-1173:6 (Savitz). Notably, notwithstanding inherent difficulties in observing this association at lower exposure levels, studies assessing such levels still observed a statistically significant relationship between fluoride and reduced IQ. See ¶¶ 42-44. Again, to put the breadth of evidence supporting this finding in perspective, the EPA has identified a LOAEL based upon far less in other contexts. For instance, in the EPA's risk evaluation of Methylene, conducted pursuant to Amended TSCA, the EPA used a LOAEL for developmental neurotoxicity, derived from the analysis of one study conducted upon mouse pups (Fredriksson et al., 1992). See Methylene Risk Evaluation at 262. Compare this with 6 (water fluoride) and 9 (urinary fluoride), high-quality, epidemiological studies of human populations underling the 4 mg/L LOAEL underlying the POD here. Dkt. No. 431-2, Trial Ex. 68 at 39, 41 (eTable 4). <b>The scientific literature in the record provides a high level of certainty that a hazard is present; fluoride is associated with reduced IQ. The qualitative evidence is superior.</b></p>
<b>VULNERABLE POPULATION</b>	<p>p. 76: <b>The size of the affected population is vast.</b> Approximately 200 million Americans have fluoride intentionally added to their drinking water at a concentration of 0.7 mg/L. See Dkt. No. 421 at 206-07 (undisputed). Other Americans are indirectly exposed to fluoridated water through consumption of commercial beverages and food manufactured with fluoridated water.</p>
<b>SUSCEPTIBLE POPULATION</b>	<p>p. 76: Approximately two million pregnant women, and over 300,000 exclusively formula-fed babies are exposed to fluoridated water. <b>The number of pregnant women and formula-fed babies alone who are exposed to water fluoridation each year exceeds entire populations exposed to conditions of use for which EPA has found unreasonable risk;</b> the EPA has found risks unreasonable where the population impacted was less than 500 <b>has found unreasonable risk;</b> the EPA has found risks unreasonable where the population impacted was less than 500 people.</p>
<b>RULING</b>	<p>p. 79: Plaintiffs have proven, by a preponderance of the evidence, that water fluoridation at the level of 0.7 mg/L – the prescribed optimal level of fluoridation in the United States – presents an “unreasonable risk of injury to health or the environment, without consideration of costs or other non-risk factors, including an unreasonable risk to a potentially exposed or susceptible subpopulation under the conditions of use.”</p> <p>The Court thus orders the Administrator to initiate rulemaking pursuant to Subsection 6(a) of TSCA. See id. §§ 2605(a), 2620(a)</p>
<b>DIRECTION</b>	<p>The ruling did not specify exactly what measures must be adopted by the EPA, but under the Toxic Substances Control Act (TSCA), once the court rules that a chemical poses an unreasonable risk, the EPA is obligated by law to restrict or eliminate the risk.</p>

	Judge Chen described a range of options for regulating fluoridation, including banning it, but he warned, "One thing the EPA cannot do, however, in the face of this Court's finding, is to ignore that risk."
<b>IMPORTANCE OF THE NTP</b>	The US Federal Court leaned heavily on the finalisation of the NTP review hence why the ruling came soon after the publishing of the NTP report. The NTP concluded: "with moderate confidence, that higher estimated fluoride exposures (e.g., as in approximations of exposure such as drinking water fluoride concentrations that exceed the World Health Organization Guidelines for Drinking-water Quality of 1.5 mg/L of fluoride) are consistently associated with lower IQ in children."].

### New Zealand implications

The same hazard exposure identified by the US Federal Court also applies to New Zealand. New Zealand has a higher level of fluoridation 0.85ppm (0.7 -1ppm) than the US single target of 0.7ppm.

Maternal urinary fluoride levels for pregnant mothers in the United States range from 0.8 mg/L at the median and 1.89 mg/L. The maternal urinary fluoride levels found in the pregnant women of Palmerston North by Brough et al, 2015 found a median concentration of 0.82 (0.62, 1.03) mg/L urine F. Bashash et al. (2017) found that the mean urinary fluoride in mothers was 0.90 mg/L (Mexico). <https://nutr2015.p.events4you.currinda.com/days/2015-12-02/abstract/307>

### Notice of Motion

That the Te Awamutu and Kihikihi Community Board request that the Waipa District Council seek an Interim Order, or some other appropriate legal remedy, so that fluoridation would be put on hold until the end of the New Zealand Court Case.

That the Te Awamutu and Kihikihi Community Board request that Waipa District Council liaise and work together with one or more of the 13 other directed Councils to push back against the Director General of Health's directives to add fluoride chemicals to the public water supply.

That the Te Awamutu and Kihikihi Community Board request that the Waipa District Council acknowledge to the Waipa community that the US Federal Court has ruled that adding fluoride to the water supply at 0.7 to 1ppm is an unreasonable risk relating to neurotoxicity.

KANE TITCHENER



Name and Signature of Mover

UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF CALIFORNIA

FOOD & WATER WATCH, INC., et al.,  
Plaintiffs,  
v.  
UNITED STATES ENVIRONMENTAL  
PROTECTION AGENCY, et al.,  
Defendants

Case No. 17-cv-02162-EMC

## **FINDINGS OF FACT AND CONCLUSIONS OF LAW**

## I. INTRODUCTION

In 2016, Congress amended the Toxic Substances Control Act (“TSCA”), empowering United States citizens to petition the Environmental Protection Agency (“EPA”) to consider whether a chemical presents an unreasonable risk of injury to health. *See* Pub. L. No. 114-182, 114th Congress (Frank R. Lautenberg Chemical Safety for the 21st Century Act) (the “Act”). The Act addresses the modern day reality that “human beings and the environment are being exposed each year to a large number of chemical substances and mixtures,” 15 U.S.C. § 2601(a)(1), and that, “among the many chemical substances and mixtures which are constantly being developed and produced, there are some whose manufacture, processing, distribution in commerce, use, or disposal may present an unreasonable risk of injury to health or the environment,” *id.* § 2601(a)(2).

To this end, under TSCA, as amended by the Act (“Amended TSCA”), a citizen is entitled to judicial review of the EPA’s denial of the citizen’s petition, wherein a court considers whether the chemical poses an unreasonable risk *de novo*, *i.e.*, without deference to the EPA’s decision. *See id.* § 2620(b)(4)(B). Amended TSCA sets up a system of judicial review that is remarkably different from the usual scope of judicial review of administrative actions under the Administrative Procedure Act, which confers substantial deference to administrative agencies. *See id.* Under Amended TSCA, the Court owes no deference to the EPA in assessing the risk posed by chemical substances. *See id.* If the Court finds anew that the chemical at issue presents

1 an unreasonable risk, it then orders the EPA to engage in rulemaking regarding the chemical. *See*  
2 *id.* The EPA is afforded in the first instance the authority to respond; regulatory actions can range  
3 from requiring a mere warning label to banning the chemical. *See id.* § 2605(a)(1)-(7). The EPA,  
4 in short, has options. *See id.*

5 The issue before this Court is whether the Plaintiffs have established by a preponderance  
6 of the evidence that the fluoridation of drinking water at levels typical in the United States poses  
7 an unreasonable risk of injury to health of the public within the meaning of Amended TSCA. For  
8 the reasons set forth below, the Court so finds. Specifically, the Court finds that fluoridation of  
9 water at 0.7 milligrams per liter (“mg/L”) – the level presently considered “optimal” in the United  
10 States – poses an unreasonable risk of reduced IQ in children. It should be noted that this finding  
11 does not conclude with certainty that fluoridated water is injurious to public health; rather, as  
12 required by the Amended TSCA, the Court finds there is an unreasonable *risk* of such injury, a  
13 risk sufficient to require the EPA to engage with a regulatory response. This order does not dictate  
14 precisely what that response must be. Amended TSCA leaves that decision in the first instance to  
15 the EPA. One thing the EPA cannot do, however, in the face of this Court’s finding, is to ignore  
16 that risk.

17 A. Context

18 Water fluoridation has a long history in the United States and has been a source of political  
19 discord, at times. *See, e.g.*, Dkt. No. 429-3, Trial Ex. 13 at 15.<sup>1</sup> In 1975 the EPA recommended  
20 adding fluoride to water, with an optimal level up to 1.2 mg/L for its dental health benefits. *Id.* at  
21 16. Between 1981 and 1984, fluoride’s association with adverse effects including osteosclerosis,  
22 enamel fluorosis, and psychological and behavioral problems was contested. *Id.* at 17-18. Still, as  
23 of 1986, up to 1.2 mg/L water fluoridation was considered optimal, and the maximum level was 4  
24 mg/L. *Id.* at 14-18. After evidence increasingly established fluoride’s connection to adverse

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26 <sup>1</sup> Controversy over fluoridation of drinking water has even found its way into Hollywood. *See* DR.  
27 STRANGELOVE (Columbia Pictures 1964) (General Ripper characterizing fluoridation as a threat to  
28 our “precious bodily fluids” and “the most monstrously conceived and dangerous communist plot  
we’ve ever had to face”).

1 effects, including severe enamel fluorosis, risk of bone fracture, and potential skeletal fluorosis,  
2 recommended levels were lowered in 2006. *Id.* at 10. Community water fluoridation has since  
3 continued at levels believed to be safe for its dental health benefits. At present, fluoride is added  
4 to tap water in the United States, with an optimal level of 0.7 mg/L.

5 However, scientific evidence has increasingly identified a link between fluoride exposure  
6 and adverse cognitive effects in children (reduced IQ). Accordingly, Plaintiffs exercised their  
7 power under Amended TSCA and petitioned the EPA to consider whether fluoride in drinking  
8 water presents an unreasonable risk of injury to human health. Notwithstanding the growing and  
9 robust body of evidence indicating an association between fluoride intake and cognitive  
10 impairment in children, the EPA denied Plaintiffs' petition. Plaintiffs filed suit in this Court,  
11 arguing that the EPA was wrong and that community water fluoridation at 0.7 mg/L (the  
12 "condition of use") poses an unreasonable risk of injury to human health.

13 **B. Summary**

14 To succeed in a suit brought under the Amended TSCA, Plaintiffs must prove, by a  
15 preponderance of the evidence, that a risk of injury to human health is present and that such risk is  
16 unreasonable. For a risk to be present, Plaintiffs must show that some segment of the United  
17 States population is exposed to the chemical at issue at levels that either exceed, or are too close to  
18 the dosage at which the chemical presents a hazard.<sup>2</sup> The reasonableness of the risk is informed  
19 by several factors, including *inter alia*, the size and susceptibility of impacted populations,  
20 severity of the harm at issue, and the frequency and duration of exposure.

21 There is little dispute in this suit as to whether fluoride poses a hazard to human health.  
22 Indeed, EPA's *own expert* agrees that fluoride is hazardous at some level of exposure. And ample  
23 evidence establishes that a mother's exposure to fluoride during pregnancy is associated with IQ  
24 decrements in her offspring. The United States National Toxicology Program ("NTP") – the  
25 federal agency regarded as experts in toxicity – undertook a systematic review of all available  
26 literature near the time of publication considering whether fluoride poses cognitive harm,

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<sup>2</sup> The level at which the chemical presents a hazard is known as the "hazard level." The level at  
which human populations are exposed to the chemical is known as the "exposure level."

1 reviewing 72 human epidemiological studies considering this question. The NTP concluded that  
2 fluoride is indeed associated with reduced IQ in children, at least at exposure levels at or above 1.5  
3 mg/L (*i.e.*, “higher” exposure levels). And notwithstanding inherent difficulties in observing  
4 effects at lower exposure levels, explained in further detail below, scientists have observed a  
5 statistically significant association between fluoride and adverse effects in children even at such  
6 “lower” exposure levels (less than 1.5 mg/L).

7 Notwithstanding recognition by EPA’s expert that fluoride is hazardous, the EPA points to  
8 technicalities at various steps of the risk evaluation to conclude that fluoride does not present an  
9 unreasonable risk. Primarily, the EPA argues the hazard level and the precise relationship between  
10 dosage and response at lower exposure levels are not entirely clear. These arguments are not  
11 persuasive.

12 Importantly, the chemical at issue need not be found hazardous at the exposure level to  
13 establish that a risk is present under Amended TSCA. Instead, the EPA requires a *margin* exist  
14 between the hazard level and exposure level to ensure safety; if there is an insufficient margin then  
15 the chemical poses a risk. The trial evidence in this case establishes that even if there is some  
16 uncertainty as to the precise level at which fluoride becomes hazardous (hazard level), under even  
17 the most conservative estimates of this level, there is not enough of a margin between the accepted  
18 hazard level and the actual human exposure levels to find that fluoride is safe. Simply put, the risk  
19 to health at exposure levels in United States drinking water is sufficiently high to trigger  
20 regulatory response by the EPA under Amended TSCA.

21 To this end, as mentioned previously, the NTP compiled and analyzed all relevant studies it  
22 could find and concluded that, at least at dosages of 1.5 mg/L or higher, fluoride is associated with  
23 reduced IQ in children. Subsequently, toxicology experts endeavored to put a finer point on the  
24 impact of fluoride on children’s IQ at “lower” exposure levels, *i.e.*, those below 1.5 mg/L, and  
25 conducted a pooled benchmark dose analysis to define the precise hazard level of fluoride. For  
26 reasons described below, this pooled benchmark dose analysis benefited from increased statistical  
27 power relative to the NTP’s assessment due to its methodology (*i.e.*, the benchmark dose analysis  
28 used individualized, continuous data, while the NTP assessment did not, due to quantity and variety

1 of studies the NTP reviewed in that assessment). The pooled benchmark dose analysis concluded  
2 that a 1-point drop in IQ of a child is to be expected for each 0.28 mg/L of fluoride in a  
3 pregnant mother's urine. This is highly concerning, because maternal urinary fluoride levels for  
4 pregnant mothers in the United States range from 0.8 mg/L at the median and 1.89 mg/L  
5 depending upon the degree of exposure. Not only is there an insufficient *margin* between the  
6 hazard level and these exposure levels, for many, the exposure levels *exceed* the hazard level of  
7 0.28 mg/L.

8 The EPA challenges, for a variety of reasons, whether this 0.28 mg/L hazard level  
9 (measured in maternal urinary fluoride) is appropriate for this risk evaluation. The EPA argues,  
10 among other things, that the hazard and exposure levels should not be expressed in maternal  
11 urinary fluoride because that metric reflects total fluoride exposure – not just exposure resulting  
12 from drinking fluoridated water from one's community. Fluoride may also be ingested through,  
13 e.g., tea, fish, toothpaste, and commercial food and beverage made with fluoridated water.  
14 Nonetheless, the risk analysis should consider the *additive* effect of the chemical under the  
15 subjected condition of use (here, fluoridated community drinking water), especially where, as here,  
16 the fluoridated drinking water is a significant (and likely primary) contributor to aggregate  
17 exposure to fluoride. Indeed, the Amended TSCA, expressly contemplates that the *aggregate*  
18 exposure to a chemical will be considered when conducting a risk assessment. *See* 15 U.S.C. §  
19 2605(b)(4)(F). In this sense, maternal urinary fluoride is not just an acceptable metric, it is highly  
20 useful in assessing the real-world end result of exposure from drinking fluoridated water along  
21 with other sources.

22 Even if urinary fluoride were not the appropriate metric in assessing health risk, or even if  
23 the toxicologically determined hazard level of 0.28 mg/L were deemed insufficiently  
24 substantiated, evidence in the record still establishes with little doubt that fluoridated drinking  
25 water presents a risk of injury to health. Using a highly conservative estimate of the hazard level  
26 of 4 mg/L measured in drinking water fluoride (well above the 1.5 mg/L identified as hazardous to  
27 children by the NTP) based on the consistent and repeated observation of adverse effects  
28 summarized in the NTP's assessment, a risk is present. There is little dispute that there is a

1 statistically significant association between IQ decrements in children and fluoride concentration  
2 levels at 4 mg/L.

3 The EPA's default margin of error requires a factor of 10 between the hazard level and  
4 exposure level due to variability in human sensitivities. Put differently, only an exposure that is  
5 below 1/10th of the hazard level would be deemed safe under Amended TSCA, given the margin  
6 of error required. Here, an even greater margin (100x) is owed because the methodology (which  
7 yields the 4 mg/L hazard level) uses the lowest observed adverse effect level ("LOAEL"); this  
8 methodology adds an additional level of uncertainty (and hence the application of a 100x rather  
9 than 10x margin). But even if only the default 10x margin is required, the safe level of fluoride  
10 exposure would be 0.4 mg/L (4 mg/L (hazard level) divided by 10). The "optimal" water  
11 fluoridation level in the United States of 0.7 mg/L is nearly double that safe level of 0.4 mg/L for  
12 pregnant women and their offspring.

13 In all, there is substantial and scientifically credible evidence establishing that fluoride  
14 poses a risk to human health; it is associated with a reduction in the IQ of children and is  
15 hazardous at dosages that are far too close to fluoride levels in the drinking water of the United  
16 States. And this risk is unreasonable under Amended TSCA. Reduced IQ poses serious harm.  
17 Studies have linked IQ decrements of even one or two points to *e.g.*, reduced educational  
18 attainment, employment status, productivity, and earned wages. Indeed, the EPA recognizes that  
19 reduction of IQ poses a serious community health issue. Moreover, highly susceptible populations  
20 are impacted, including over two million pregnant women and babies, a number far exceeding  
21 population size the EPA has looked to in determining whether regulatory action was warranted in  
22 other risk evaluations (*i.e.*, 500 people or less).

23 Thus, the Court finds Plaintiffs have met their burden in establishing, by a preponderance  
24 of the evidence, that community water fluoridation at 0.7 mg/L presents an unreasonable risk of  
25 injury to health under Amended TSCA and that the EPA is thus obliged to take regulatory action  
26 in response. The Court does not in this order prescribe what that response should be.

United States District Court  
Northern District of California

**II. BACKGROUND****A. Factual and Procedural Background**

1. Section 6(a) of the Toxic Substances Control Act (“TCSA”) requires Defendant United States EPA<sup>3</sup> to regulate the use of certain chemical substances that it determines pose an unreasonable risk to health or the environment. 15 U.S.C. § 2605(a).

2. The TSCA was initially passed in 1976, codified at 15. U.S.C. § 2601 *et seq.* Congress enacted the original TSCA, motivated by findings that “human beings and the environment are being exposed each year to a large number of chemical substances and mixtures,” 15 U.S.C. § 2601(a)(1), and that, “among the many chemical substances and mixtures which are constantly being developed and produced, there are some whose manufacture, processing, distribution in commerce, use, or disposal may present an unreasonable risk of injury to health or the environment,” *id.* § 2601(a)(2).

3. On June 22, 2016, the Frank R. Lautenberg Chemical Safety for the 21st Century Act was signed into law. *See* Pub. L. No. 114-182, 114th Congress. The Act amended the TSCA. *See id.*

4. Amended TSCA requires the EPA to regulate the use of certain chemical substances that pose an unreasonable risk of harm to health or the environment. 15 U.S.C. § 2605(a). If a chemical substance poses a risk of unreasonable harm, the EPA must promulgate a rule imposing one or more of a wide range of possible requirements. *See id.* § 2605(a)(2). Specifically, the rule adopted by the EPA must impose one or more of the following: a prohibition, restriction, or limitation of the amount of such substance that may be manufactured, processed, or distributed in commerce, *id.* § 2605(a)(1); a prohibition, restriction, or limitation upon such manufacture, processing, or use in connection with “a particular use” or “a particular use in a concentration in excess of a level specified by the Administrator,” *id.* § 2605(a)(2); labeling requirements for such substance, *id.* § 2605(a)(3); record-keeping requirements for manufacturers or processors of the substance, *id.* § 2605(a)(4); commercial-use regulations, *id.* § 2605(a)(5); disposal requirements,

<sup>3</sup> Scott Pruitt, Administrator of the EPA is also named as a Defendant in his official capacity. Dkt. No. 372 (Supplemental Complaint (“FAC”)) ¶ 1.

1        *id.* § 2605(a)(6); and/or notice requirements, *id.* § 2605(a)(7). The EPA may limit the application  
 2        of such requirements to “specified geographic areas.” *Id.* § 2605(a).

3        5. After the Act’s amendment to TSCA, there are three pathways to obtain a Section 6(a) rule  
 4        regulating a chemical: (1) an EPA’s *sua sponte* designation of a chemical as “high priority,”  
 5        resulting in a finding that it presents an unreasonable risk,<sup>4</sup> 15 U.S.C. § 2605(c)(1); (2) an EPA  
 6        risk evaluation of a chemical at the request of a manufacturer, *see id.* § 2605(b)(4)(C)(ii), which  
 7        results in a finding of unreasonable risk; or (3) a successful Section 21 “citizen petition,” *see id.* §§  
 8        2620(a), (b)(3).

9        6. A Section 21 citizen’s petition to the EPA to initiate Section 6(a) rulemaking is to be  
 10       granted if the petitioner demonstrates a chemical substance poses an unreasonable risk of harm.  
 11       *Id.* § 2620(a). Amended TSCA provides judicial review of a denial of such a petition to the EPA.  
 12       *Id.* § 2620(b)(4). In contrast to the typical standard of judicial review under the Administrative  
 13       Procedure Act, in considering a Section 21 citizen’s petition, the Court considers the issue *de*  
 14       *novo*; no deference is owed under to the EPA’s denial of the petition. *See id.* § 2620(b)(4)(B).

15       7. Plaintiffs in the instant suit are non-profit advocacy organizations and associations and  
 16       individuals suing on behalf of themselves and their children. FAC ¶ 1.<sup>5</sup>

17       \_\_\_\_\_  
 18       <sup>4</sup> To elaborate, Section 6(b) requires the EPA to perform its own evaluations of the risks posed by  
 19       certain chemical substances. 15 U.S.C. § 2605(b)(4)(A). To this end, the EPA is required by  
 20       Amended TSCA to designate chemical substances as “high-priority” or “low-priority” based on a  
 21       risk screening process. *See id.* § 2605(b)(1). “High-priority” chemicals are those that “may  
 22       present an unreasonable risk to health or the environment because of potential hazard and a  
 23       potential route of exposure under the conditions of use.” *Id.* § 2605(b)(1)(B)(i). A “low-priority”  
 24       substance, in contrast, is one that the Administrator “concludes, based on information sufficient to  
 25       establish . . . does not meet the standard” to be designated a high-priority substance. *Id.* §  
 26       2605(b)(1)(B)(ii). Once the EPA has designated a chemical substance “high-priority,” it must  
 27       initiate a Section 6(b) “risk evaluation.” *Id.* §§ 2605(b)(3)(A), (4)(C)(i). A risk evaluation is not  
 28       required for a “low-priority” substance. *Id.* § 2605(b)(1)(A). The EPA must pursue these risk  
 29       evaluations at a minimum pace established by statute: within 6 months, risk evaluations must be  
 30       underway on at least 10 substances drawn from the 2014 TSCA Work Plan for Chemical  
 31       Assessments, *id.* § 2605(b)(2)(A); within three and a half years, risk evaluations must be  
 32       underway on “at least 20 high-priority substances,” *id.* § 2605(b)(2)(B); a new high-priority  
 33       substance must be designated anytime a risk evaluation has been completed (other than those  
 34       commenced at the request of a manufacturer), *id.* § 2605(b)(3)(C); and, generally, the EPA must  
 35       continue designating substances and conducting evaluations “at a pace consistent” with its ability  
 36       to meet the 3-year deadline to complete each risk evaluation, *id.* § 2605(b)(2)(C).

37       <sup>5</sup> Specifically, Plaintiffs are Food & Water Watch, Fluoride Action Network, and Moms Against  
 38       Fluoridation (“Organizational Plaintiffs”), and Audrey Adams individually and on behalf of Kyle

1       8. On November 22, 2016, a group of organizations and individuals including Plaintiffs  
2 petitioned the EPA under Section 21 of Amended TSCA to regulate the fluoridation of drinking  
3 water supplies under Section 6(a). Dkt. No. 117-1, Ex. 1. Plaintiffs asserted that the ingestion of  
4 fluoride poses an unreasonable risk of neurotoxic harm to humans including IQ loss and other  
5 neurotoxic effects, particularly for infants, young children, and other subpopulations standing at  
6 elevated risk. *Id.*

7       9. On February 17, 2017, the EPA denied Plaintiffs' petition. Dkt. No. 28-1; 82 Fed. Reg.  
8 11,878 (Feb. 27, 2017).

9       10. After the EPA denied Plaintiffs' petition, Plaintiffs filed this suit seeking judicial review of  
10 the EPA's denial pursuant to 15 U.S.C. § 2620. Dkt. No. 1 (Complaint ("Compl.")) ¶¶ 106-07.

11       11. Beginning on June 8, 2020, after the parties engaged in fact and expert discovery, the  
12 Court held a seven-day bench trial, which included expert testimony regarding the state of the  
13 scientific research on fluoride neurotoxicity ("Trial Phase 1"). *See* Dkt. Nos. 219, 238.

14       12. On August 10, 2020, the Court stayed the case due to concerns about Plaintiffs' standing  
15 and developments in scientific literature regarding fluoride. *See* Dkt. No. 262. The Court  
16 explained that the stay would allow EPA to consider new scientific studies published after EPA's  
17 denial of Plaintiffs' administrative petition and allow the Court to consider the imminent  
18 publication of the NTP systematic review "Monograph on the Systematic Review of Fluoride  
19 Exposure and Neurodevelopmental and Cognitive Health Effects." *Id.* at 3-5.

20       13. Thereafter, Plaintiffs filed a supplemental administrative petition for reconsideration to the  
21 EPA. Dkt. No. 270.

22       14. EPA again denied the petition. Dkt. No. 278.

23       15. On October 28, 2022, the Court granted Plaintiffs' motion to lift the stay and take the case  
24 out of abeyance, finding that Plaintiffs had standing and that there was new evidence that scientific  
25 developments had changed, including the fact that the aforementioned NTP's systematic review

27       28       Adams, Kristen Lavelle individually and on behalf of Neal Lavell, and Brenda Staudenmaier  
individually and on behalf of Ko Staudenmaier and Hayden Staudenmaier ("Individual Plaintiffs")  
(collectively "Plaintiffs" or "FWW"). FAC ¶ 1.

1 had since undergone three additional rounds of peer review resulting in a near-final version of the  
2 document. *See* Dkt. No. 319 at 2-5.

3 16. Beginning on January 31, 2024, the Court held a second, ten-day bench trial (“Trial Phase  
4 2”) which included expert testimony regarding the updated state of the scientific research on  
5 fluoride neurotoxicity. *See* Dkt. Nos. 407-413, 422-424.

6 B. Relief Requested

7 17. Plaintiffs contend that the addition of fluoridation chemicals to drinking water at levels  
8 recommended in the United States (0.7 mg/L) presents an unreasonable risk of neurological harm  
9 when assessed under the risk evaluation framework that EPA uses under the Amended TSCA.

10 Dkt. No. 378 (Joint Pretrial Conference Statement (“PTC Statement”)) at 1-2.

11 18. Plaintiffs seek a declaration that fluoridation of water at 0.7 mg/L presents an unreasonable  
12 risk of injury to health and injunctive relief requiring the EPA to initiate the rulemaking  
13 proceeding requested by Plaintiffs in their Petition to the EPA. PTC Statement at 2. Specifically,  
14 Plaintiffs seek an order requiring the EPA to “initiate a proceeding for the issuance of a rule,” but  
15 the order would not “prescribe the content of a rule or the outcome of such a proceeding.” *Id.* In  
16 short, rulemaking would be left in the first instance to the EPA.

17 19. Plaintiffs also seek recovery of their costs of suit and reasonable fees for attorneys and  
18 expert witnesses, as permitted by 15 U.S.C. § 2620(b)(4)(C), and such further relief that the Court  
19 may deem just and proper. PTC Statement at 2.

20 C. Statutory Standard and Burden

21 20. Plaintiffs bear the burden of proving, by a preponderance of the evidence, that the  
22 chemical substance at issue presents an “unreasonable risk of injury to health or the environment,  
23 without consideration of costs or other nonrisk factors, including an unreasonable risk to a  
24 potentially exposed or susceptible subpopulation under the conditions of use.” 15 U.S.C. §  
25 2620(b)(4)(B)(ii). The Court considers the issue *de novo*; no deference is owed under TSCA to  
26 the EPA’s denial of the petition. *Id.* § 2620(b)(4)(B).

27 21. If the Court determines that petitioner has met its burden, demonstrating unreasonable risk  
28 by a preponderance of the evidence, the Court “shall order the Administrator to initiate the action

1 requested by the petitioner.” *Id.* Specifically, EPA would be directed to engage in rulemaking  
2 pursuant to Subsection 6(a) of TSCA wherein the EPA would consider applying one or more  
3 methods to neutralize the risk, ranging from requiring a notice be provided to the public of risks  
4 (*i.e.*, utilizing a warning label or disseminating a public advisory), *see id.* § 2605(a)(7), to  
5 prohibiting manufacturing or distributing the chemical at issue, *see id.* § 2605(a)(1).

6 **D. Standing**

7 22. The Court previously held, in lifting its stay on proceedings and allowing the case to  
8 proceed to phase two of trial, that Plaintiffs had standing. Dkt. No. 319 at 2-3. The Court  
9 reaffirms this finding. At a minimum, Organizational Plaintiff FWW has standing in a  
10 representative capacity. An association has standing to sue on behalf of its members when: “(1)  
11 its members would otherwise have standing to sue in their own right; (2) the interests it seeks to  
12 protect are germane to the organization’s purpose; and (3) neither the claim asserted nor the relief  
13 requested requires the participation of individual members in the lawsuit.” *Am. Unites for Kids v.*  
14 *Rousseau*, 985 F.3d 1075, 1096 (9th Cir. 2021) (citing *Hunt v. Wash. State Apple Advert. Comm’n*,  
15 432 U.S. 333, 343 (1977)). Each prong is satisfied:

16 a. In its previous order, the Court found that Jessica Trader, a member of FWW, has  
17 standing. Dkt. No. 319 at 2-3. Article III standing requires: (1) an injury-in-fact that is concrete  
18 and particularized and actual or imminent, (2) a causal connection between the injury and the  
19 conduct complained of, and (3) probable redressability. *Id.* (citing *Lujan v. Defs. of Wildlife*, 504  
20 U.S. 555, 560–61 (1992)). Ms. Trader became pregnant in November 2020 and gave birth in  
21 August 2021 (during the pendency of this lawsuit) and testifies that she plans to have several more  
22 children; she has taken steps to effectuate this goal including discontinuing her use of birth control  
23 medication. Dkt. No. 430-18, Trial Ex. 66 (Declaration of Jessica Trader) ¶¶ 5-8 & Ex. A. Ms.  
24 Trader has incurred costs and taken measures to avoid fluoridated water during her first pregnancy  
25 and continues to do so to protect her future children. *Id.* ¶¶ 9-16. As the Court previously  
26 explained, neurodevelopmental harm from fluoride exposure to Ms. Trader’s child and future  
27 children is concrete and imminent; there is a credible causal connection between that  
28 neurodevelopmental harm and EPA’s regulation of fluoride exposure or lack thereof; and the harm

1 would likely be redressed if EPA were to pass a rule prohibiting the addition of fluoridation  
2 chemicals to public drinking water supplies. Dkt. No. 319 at 2-3. Moreover, the EPA has  
3 conceded that standing would be satisfied by “someone who is an expectant parent who – who  
4 could be consuming fluoridated water, and, and – that could have potential effects on the baby  
5 she’s carrying in utero. It could be a potential – a parent, someone with very young children.” *Id.*  
6 (quoting Dkt. No. 133 at 14:9-17). Ms. Trader is such an individual. Thus, the first prong is  
7 satisfied; a member has standing.

8 b. As for the second prong, there is no dispute that FWW’s mission is to ensure  
9 “clean, safe water for drinking” which it views as a “fundamental right that should be afforded to  
10 all people,” and to “advocate for more government responsibility in protecting our drinking water  
11 resources.” Dkt. No. 430-8, Trial Ex. 52 (Second Amended Declaration of Scott Edwards, Co-  
12 Director of FWW) ¶¶ 4, 6. Thus, the interests at stake in this suit – regulation of water  
13 fluoridation to protect public health – are germane to the organization’s purpose. *See, e.g., Am.*  
14 *Unites for Kids*, 985 F.3d at 1097 (explaining that where there is a close connection between the  
15 organization’s mission and the interests of others it seeks to represent, organizational standing is  
16 appropriate); *G.G. by & through A.G. v. Meneses*, 638 F. Supp. 3d 1231, 1241 (W.D. Wash. 2022)  
17 (finding nonprofit disability rights organization had associational standing to bring claims on  
18 behalf of disabled members as rights of people with developmental disabilities was an interest the  
19 organization sought to protect).

20 c. The third prong is a “judicially fashioned and prudentially imposed” question, as  
21 opposed to a constitutional requirement of standing. *Or. Advocacy Ctr. v. Mink*, 332 F.3d 1101,  
22 1109 (9th Cir. 2003). This suit is appropriately brought by a representative plaintiff; analysis  
23 under Amended TSCA focuses on scientific evidence substantiating the alleged risk to public  
24 health rather than focusing upon anecdotal evidence from plaintiffs. *See* ¶ 26-95; *accord*  
25 *Laborers Int’l Union Loc. 261 v. City & Cnty. of San Francisco*, 2022 WL 2528602, at \*6 (N.D.  
26 Cal. July 6, 2022) (explaining that unlike claims seeking damages which require individualized  
27 proof, claims seeking injunctive relief are well-suited for adjudication by organizational plaintiff)  
28 (citing *Comm. for Immigrant Rts. of Sonoma Cnty. v. Cnty. of Sonoma*, 644 F. Supp. 2d 1177,

1 1194 (N.D. Cal. 2009)). The harm redressable herein is precisely the kind of harm that Amended  
2 TSCA is designed to address. For these reasons, the Court reaffirms its finding that requirements  
3 of standing have been satisfied.

4 **III. FINDINGS OF FACT**

5 23. To discern whether a chemical substance presents an unreasonable risk of injury to health  
6 or the environment, without consideration of costs or other non-risk factors, including an  
7 unreasonable risk to a potentially exposed or susceptible subpopulation, under the conditions of  
8 use, under TSCA section 6, the EPA engages in a TSCA risk evaluation process. 15 U.S.C. §  
9 2605(b)(4); 82 Fed. Reg. 33,726 (July 20, 2017); Dkt. No. 434-18, Trial Ex. 544.

10 24. The TSCA risk evaluation is comprised of a risk assessment and risk determination. *See*  
11 Dkt. No. 400, Feb. 5, 2024, Trial Tr. at 653:22-655:11 (Barone). The National Research Council  
12 (NRC, 1983) has defined risk assessment as including the following components: (1) hazard  
13 assessment (including hazard identification and quantitative dose response analysis); (2) exposure  
14 assessment; and (3) risk characterization. A risk evaluation under the Amended TSCA includes  
15 the three aforementioned steps of a risk assessment, as well as a fourth and final step: (4) a risk  
16 determination. *See id.* The “risk assessment” is the scientific technical evaluation, encompassing  
17 the first three parts of this process, resulting in an unbiased, transparent, and reproducible  
18 description of the risk. *See id.* The “risk determination” is the final step of the risk evaluation  
19 process, where EPA summarizes its findings and determines whether a chemical does or does not  
20 present unreasonable risk. *See id.*

21 25. The following is a summary of the risk evaluation steps. *See id.*; *accord* 15 U.S.C. §  
22 2605(b)(4)(F)(i)-(v).

23 a. At step 1 (hazard assessment) the EPA determines if a chemical is considered  
24 hazardous and if so, the EPA endeavors to determine the point at which the chemical becomes  
25 hazardous (“point of departure” or “hazard level”). *See* Dkt. No. 400, Feb. 5, 2024, Trial Tr. at  
26 653:22-655:11 (Barone); *accord* 15 U.S.C. § 2605(b)(4)(F)(i)-(iii), (v).

27 b. At step 2 (exposure assessment) the EPA determines the level at which populations  
28 are exposed to the chemical. *See* Dkt. No. 400, Feb. 5, 2024, Trial Tr. at 653:22-655:11 (Barone);

1 *accord* 15 U.S.C. § 2605(b)(4)(F)(i)-(iii), (v).

2 c. At step 3 (risk characterization), the EPA compares the point of departure with the  
3 exposure level to determine if a risk is present. *See* Dkt. No. 400, Feb. 5, 2024, Trial Tr. at 575:8-  
4 583:13 (Barone). Because of uncertainty in data, the EPA establishes a margin between the point  
5 of departure and the community's exposure level. There must be a sufficient margin to find  
6 absence of risk. *See id.* The appropriate margin varies based upon how much uncertainty there is  
7 in the chosen point of departure. *See id.* The appropriate or required margin is referred to as the  
8 benchmark margin of exposure ("benchmark MOE"). *See id.* The actual margin is the actual  
9 margin of exposure ("actual MOE"). If there is an insufficient margin, *i.e.*, the actual MOE is less  
10 than the benchmark MOE, a risk has been identified. *See id.*

11 d. At step 4 (risk determination) if a risk is identified, the EPA will then determine if  
12 that risk is unreasonable, considering various factors such as the type of harm at issue and number  
13 of people exposed. *See* Dkt. No. 400, Feb. 5, 2024, Trial Tr. at 653:22-655:11 (Barone); *accord*  
14 15 U.S.C. § 2605(b)(4)(F)(iii)-(v). Each step of the risk assessment is discussed in turn below.<sup>6</sup>

15 A. Step 1: Hazard Assessment

16 26. The Hazard Assessment step is comprised of three subparts: (a) hazard identification; (b)  
17 weight-of-the-scientific evidence; and (c) dose-response assessment. *See* Dkt. No. 400, Feb. 5,  
18 2024, Trial Tr. at 654:19-655:11 (Barone). Each are addressed in turn below.

19 1. Step 1A: Hazard identification

20 a. Framework

21 27. The first component of the hazard assessment is hazard identification. Dkt. No. 417, Feb.  
22 2, 2024, Trial Tr. at 489:11-17 (Barone), 656:8-661:16 (Barone). At the hazard identification step  
23 of the risk evaluation framework, the reviewer determines if an adverse effect is associated with a  
24 chemical exposure. *See* Dkt. No. 417, Feb. 2, 2024, Trial Tr. at 489:11-17 (Barone), 656:8-661:16  
25 (Barone).

26 \_\_\_\_\_  
27 6 The evaluation of fluoridation chemicals under TSCA follows the same standards for  
28 demonstrating hazard and risk that EPA uses for its evaluations of other industrial chemicals under  
TSCA; there is no justification for holding fluoridation chemicals to a higher burden. *See* Dkt.  
No. 401, Feb. 6, 2024, Trial Tr. at 742:25-743:8 (Barone).

1        28. Proof of causation is not required to establish a hazard of neurotoxicity, only association  
 2        between the chemical exposure and the adverse effect is required for a hazard to be identified. *See*  
 3        *id.* at 490:1-5.

4        29. At this stage of the process EPA reviews, searches, screens, and evaluates all studies  
 5        related to different hazards to determine whether the data are sufficient or insufficient for  
 6        identified adverse effects. *Id.* at 492:24-494:9.

7                b.        *Key finding*

8        30. The hazard identification step of the hazard assessment here is satisfied; exposure to the  
 9        chemical fluoride is associated with the adverse effect of reduced IQ in children, and particularly  
 10        in boys.

11                c.        *Underlying findings*

12        31. The NTP is headquartered within the National Institute of Environmental Health Sciences  
 13        (“NIEHS”). Dkt. No. 440, Feb. 13, 2024, Trial Tr. at 1425:23-1426:8 (Barone). By May of 2022,  
 14        the NTP completed its systematic review of fluoride, titled *NTP Monograph on the State of the*  
 15        *Science Concerning Fluoride Exposure and Neurodevelopmental and Cognitive Health Effects: A*  
 16        *Systematic Review* (hereafter “NTP Monograph”). Dkt. No. 431-1, Trial Ex. 67. *See also* Dkt.  
 17        No. 440, Feb. 13, 2024, Trial Tr. at 1427:5-8 (Barone); Dkt. No. 400, Feb. 4, 2024, Trial Tr. at  
 18        535:15-21 (Berridge). In August 2024, the NTP Monograph was formally published. *See* Dkt No.  
 19        442 (letter from parties recognizing publishing of document). The parties agree that there are no  
 20        material differences between the published Monograph and the pre-publication version that was  
 21        the subject of testimony and argument at trial (*i.e.*, Trial Exhibit 67). *Id.*<sup>7</sup>

22  
 23        <sup>7</sup> The parties originally filed a letter agreeing that the published version of the NTP Monograph  
 24        was the same in all material respects as the Monograph this Court reviewed at trial. Dkt. No. 442.  
 25        Subsequently, Plaintiffs filed a letter suggesting that certain aspects of the published NTP  
 26        Monograph were modified in a way that lends *additional* support for their case. *See* Dkt. No. 443.  
 27        In particular, Plaintiffs assert:

28        Page 101 of the now-published version of the NTP Monograph summarizes the findings of  
 29        the “in-press” meta-analysis as follows:

28        The group-level meta-analysis of 59 studies (n = 20,932 children)  
 29        used SMD as the effect measure and reported statistically significant

1       32. According to the EPA, a systematic review is “a scientific investigation that focuses on a  
2 specific question and uses explicit, pre-specified methods to identify, select, assess, and  
3 summarize the findings of similar but separate studies.” Dkt. No. 255 (EPA Proposed Findings of  
4 Fact, Trial Phase 1) at 15 (citing 82 Fed. Reg. at 33,734). Moreover, “[t]he goal of systemic  
5 review methods is to ensure that the review is complete, unbiased, reproducible, and transparent.”  
6 *Id.* The EPA explains that a systematic review is pertinent and is ideal in conducting a risk  
7 assessment under TSCA. *See id.* at 14-19 (arguing that during the first phase of trial, before the  
8 NTP Monograph was finalized, that Plaintiffs failed to meet their burden because they did not  
9 conduct a systematic review).

10      33. The NTP Monograph is a systematic review as the EPA has defined that term. The NTP  
11 Monograph is a scientific investigation, focusing on a specific question using explicit, pre-

12  
13      United States District Court  
14      Northern District of California

15      inverse associations between fluoride exposure measures and  
16      children’s IQ. There was also a significant dose response  
17      relationship between group-level fluoride exposure and IQ. **In**  
18      **stratified dose-response meta-analyses of the low risk-of-bias**  
19      **studies, the direction of association remained consistent when**  
20      **group-level exposure was restricted to <4mg/L, <2 mg/L, and**  
21      **<1.5 mg/L fluoride in drinking water and <4 mg/L, <2 mg/L,**  
22      **and <1.5 mg/L fluoride in urine.** The regression slopes meta-  
23      analysis of 13 studies (n = 4,475 children) with individual-level  
24      measures of fluoride found a **significant decrease in IQ of 1.63**  
25      **points (95% CI: -2.33, -0.93; p-value <0.001) per 1-mg/L**  
26      **increase in urinary fluoride.** In subgroup analyses of both group-  
27      level and individual level data, the direction of the association  
28      remained inverse when stratified by study quality (high versus low  
risk of bias), sex, age group, outcome assessment, study location,  
exposure timing, and exposure metric.

29      Dkt. No. 443 (citing *NTP Monograph on the State of the Science Concerning*  
30      *Fluoride Exposure and Neurodevelopment and Cognition: A Systematic Review*,  
31      National Toxicology Program (August 2024),  
32      [https://ntp.niehs.nih.gov/sites/default/files/2024-08/fluoride\\_final\\_508.pdf](https://ntp.niehs.nih.gov/sites/default/files/2024-08/fluoride_final_508.pdf)  
33      (emphases added)).

34      The EPA disputes whether the post-trial version of the NTP Monograph is properly considered by  
35      this Court. *See* Dkt. No. 444. Because the Court finds in Plaintiffs favor based upon the version  
36      of the NTP Monograph that the Court reviewed at trial, and because neither party suggests the  
37      aspects of the NTP Monograph that the Court reviewed therein have changed in a way that  
38      undermines Plaintiffs’ case, the Court need not resolve this dispute. Instead, the Court bases its  
39      finding upon the version of the NTP Monograph reviewed at trial (Trial Exhibit 67), though noting  
40      that it has since been published formally, and that if it were considered, it would find the published  
41      Monograph even more supportive of the decision reached herein.

1 specified methods. Namely, the objective of the NTP Monograph was “[t]o conduct a systematic  
2 review of the human, experimental animal, and mechanistic literature to evaluate the extent and  
3 quality of the evidence linking fluoride exposure to neurodevelopmental and cognitive effects in  
4 humans.” NTP Monograph at xii (Abstract). Regarding the methods: “[a] systematic review  
5 protocol was used following the standardized OHAT [referring to the Office of Health Assessment  
6 and Translation] systematic review approach for conducting literature-based health assessments.  
7 This monograph presents the current state of evidence associating fluoride exposure with  
8 neurocognitive or neurodevelopmental health effects and incorporated predefined assessments of  
9 study quality and confidence levels. Benefits of fluoride with respect to oral health are not  
10 addressed in this monograph.” *Id.* Ultimately, the NTP Monograph analyzed all available studies  
11 assessing impacts of fluoride, including seventy-two human studies that assessed the association  
12 between fluoride exposure and IQ in children and integrated the findings in the studies to draw  
13 conclusions about the impact of fluoride to neurodevelopmental and cognitive effects in humans.  
14 *Id.* at xii-xiii. Moreover, the NTP Monograph’s protocol underwent multiple rounds of peer  
15 review. *Id.* at G-1. And the Monograph’s substance underwent multiple rounds of peer review,  
16 including assessment of technical accuracy, and the sufficiency of evidence supporting the NTP  
17 Monograph’s conclusion. *Id.* at x. The peer review panel includes professors from Brown  
18 University School of Public Health, Columbia University Medical Center, Johns Hopkins  
19 Bloomberg School of Public Health, and other epidemiological experts. *See id.* The EPA does  
20 not dispute that the NTP Monograph is likely to have captured all relevant studies that were in  
21 existence as of the Monograph’s literature cutoff date analyzing human data regarding  
22 neurodevelopmental impacts of fluoride. Dkt. No. 421 at 12-13. Even before the NTP  
23 Monograph was formally published, the EPA agreed that the NTP Monograph “followed the rules  
24 that have been developed by NTP for conducting systematic reviews” and utilized a “rigorous  
25 approach to assembling the evidence,” “clearly defined rules for identifying and evaluating  
26 studies,” and “a well-defined protocol for drawing inferences” from the studies. *Id.*<sup>8</sup> Indeed,

27  
28 <sup>8</sup> Plaintiffs submitted evidence indicating that the delay in publication was highly irregular, and  
perhaps politically motivated. *See* Dkt. No. 385 at 12-13. The Court excluded evidence regarding

1 EPA's expert, Dr. Barone agreed that the NTP Monograph is a "high quality review." Dkt. No.  
2 440, Feb. 13, 2024, Trial Tr. at 1427:2-4 (Barone). Accordingly, the Court finds that the NTP  
3 Monograph is probative and afforded significant weight in the risk evaluation analysis.

4 34. The NTP Monograph concludes that the majority of the 72 epidemiological studies on  
5 fluoride and IQ that had been published by April 2021 found an association between fluoride and  
6 reduced IQ in children, including 18 of the 19 studies the NTP Monograph deemed "high quality"  
7 and "low-risk-of-bias" as well as 46 of the 53 lower-quality studies. NTP Monograph at xii (NTP  
8 Monograph Abstract describing 46 of the 53 low-quality studies found an association between  
9 higher fluoride exposure and lower IQ in children and 18 of 19 high-quality studies reported an  
10 association between higher fluoride exposure and lower IQ in children including 3 prospective  
11 cohort studies and 15 cross-sectional studies); *accord* Dkt. No. 428-1, Trial Ex. 69 at 65 (NTP  
12 Board of Scientific Counselors Working Group Report agreeing that low-risk-of-bias studies were  
13 "consistent," meaning generating results in the same direction, in finding a negative association  
14 between fluoride exposure and children's IQ); Dkt. No. 396, Feb. 1, 2024, Trial Tr. at 313:25-  
15 314:5 (Grandjean) (summarizing and agreeing with NTP Monograph's finding that higher  
16 fluoride exposure (at or above 1.5 mg/L) was found to be associated with lower IQ scores in  
17 children in the majority of both low- and high-quality studies the NTP Monograph reviewed); Dkt.  
18 No. 414, Feb. 9, 2024, Trial Tr. at 1197:2-15 (Savitz) (expressing confidence in NTP's literature  
19 search strategy and its ability to identify all relevant studies on fluoride exposure published prior  
20 to the closing date of April 21, 2021, and confirming that the "vast majority of studies" that NTP  
21 reviewed identified an association between fluoride and reduced IQ), 1114:24-1115:1 (describing  
22 NASEM critique of adequate definition of the term "consistent" in NTP Monograph, but not  
23 disagreeing with characterization of NTP Monograph finding association between IQ and  
24 fluoride). The NTP Monograph explained its key finding regarding the impact of fluoride on  
25 children's IQ as follows:

26  
27 27 partisanship relating to publishing of the Monograph, in large part because the EPA did not argue  
28 the Monograph be afforded less weight for its draft status. *Id.* at 17. Eventually, the NTP  
Monograph was published, in August 2024. *See* Dkt. No. 442.

1                   *In summary, the high-quality studies (i.e., studies with low*  
 2                   *potential for bias) consistently demonstrate lower IQ scores with*  
 3                   *higher fluoride exposure [e.g., represented by populations whose*  
 4                   *total fluoride exposure approximates or exceeds the WHO*  
 5                   *Guidelines for Drinking-water Quality of 1.5 mg/L of fluoride*  
 6                   *(WHO 2017)].* The consistency in association is observed among  
 7                   studies of varying study designs, exposure measures, and study  
 8                   populations. Although some studies that conducted multiple  
 9                   analyses observed within-study variations in results (e.g.,  
 10                  differences between subsets of IQ tests), these variations were  
 11                  unique to individual studies and did not detract from the overall  
 12                  consistency in the findings that higher fluoride is associated with  
 13                  lower IQ scores.

14                  Trial Ex. 67 at 47 (emphasis added).

15                  35. To come to this conclusion: the NTP Monograph identified 19 studies as being high-  
 16                  quality (i.e., low risk-of-bias); all but one identified an association between fluoride and reduced  
 17                  IQ in children: Bashash et al. 2017; Choi et al. 2015; Cui et al. 2018; Ding et al. 2011; Green et al.  
 18                  2019; Rocha-Amador et al. 2007; Saxena et al. 2012; Seraj et al. 2012; Sudhir et al. 2009; Till et  
 19                  al. 2020; Trivedi et al. 2012; Wang et al. 2012; Wang et al. 2020b; Xiang et al. 2003a; Xiang et al.  
 20                  2011; Yu et al. 2018; Zhang et al. 2015b. NTP Monograph at 40, 29-39 (Table 6). To summarize  
 21                  these high-quality studies:

22                  a. Bashash (2017): This study evaluated 211 mother-child pairs that were participants  
 23                  in The Early Life Exposures in Mexico to Environmental Toxicants Project (“ELEMENT  
 24                  Cohort”)<sup>9</sup> and concluded that higher prenatal fluoride exposure was associated with statistically

19                  20                  9 Bashash (2017) (like Green (2019) and Till (2020), discussed in subparagraphs (b) and (c)), is a  
 21                  longitudinal cohort study, evaluating fluoride in the urine of pregnant mothers. In such a cohort  
 22                  study design:

23                  24                  [A] healthy group of people is assembled and followed forward in  
 25                  time and observed for the development of dysfunction. Such studies  
 26                  are invaluable for determining the time course for development of  
 27                  dysfunction (e.g., follow-up studies performed in various cities on  
 28                  the effects of lead on child development). This approach allows the  
 29                  direct estimate of risks attributed to a particular exposure, since  
 30                  toxic incidence rates in the cohort can be determined. Prospective  
 31                  study designs also allow the study of chronic effects of exposure.  
 32                  One major strength of the cohort design is that it allows the  
 33                  calculation of rates to determine the excess risk associated with an  
 34                  exposure. Also, biases are reduced by obtaining information before  
 35                  the disease develops. This approach, however, can be very time-  
 36                  consuming and costly. In cohort studies information bias can be  
 37                  introduced when individuals provide distorted information about  
 38                  their health because they know their exposure status and may have  
 39                  been told of the expected health effects of the exposure under study.

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1 significant lower scores on tests of cognitive function in offspring at ages 4 and 6-12 years; an  
2 increase in maternal urine fluoride of 0.5 mg/L predicted a 3.15 lower General Cognitive Index  
3 ("GCI") score and 2.50 lower IQ score of the offspring. Dkt. No. 432-2, Trial Ex. 106 at 1.  
4 ELEMENT collected urinary samples from women during pregnancy and from their children  
5 when the children were 6-12 years old (299 mother-child pairs) recruited from hospitals caring for  
6 low to moderate income populations in Mexico City. *Id.* at 1-2. The mean urinary fluoride in  
7 mothers and children was 0.90 mg/L (mothers) and 0.82 mg/L (children). *Id.* Child intelligence  
8 was measured via GCI for children at age 4 and IQ and from the Wechsler Abbreviate Scale of  
9 Intelligence ("WASI") at ages 6-12. *Id.* Fluoride exposure derived from fluoridated salt and  
10 naturally occurring fluoride in drinking water in Mexico City, ranging from 0.15 to 1.38 mg/L. *Id.*  
11 at 2. A second morning void ("spot") urine sample was targeted for collection during each  
12 trimester of pregnancy from mothers and the offspring children at time of measurements of  
13 intelligence. *Id.* A total of 1,484 prenatal samples was measured; after controlling for, *e.g.*,  
14 quality, duplicates, covariates, and outliers, 877 urine samples adjusted for creatinine were  
15 retained, stemming from 512 unique mothers. *Id.* at 3. A total of 287 mother-child pairs had  
16 complete data on exposure and outcome for children at 4 years and 211 for children at 6-12 years.  
17 Dkt. No. 434-27, Trial Ex. 656 (Savitz Summary of Methods in Key Studies of Fluoride Exposure  
18 and Neurodevelopment).

19 b. Green (2019): Green et al. (2019) studied mother-child pairs in Canada that were  
20

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21 More credence should be given to those studies in which both  
22 observer and subject bias are carefully controlled (*e.g.*, double-blind  
23 studies). A special type of cohort study is the retrospective cohort  
24 study, in which the investigator goes back in time to select the study  
25 groups and traces them over time, often to the present. The studies  
26 usually involve specially exposed groups and have provided much  
assistance in estimating risks due to occupational exposures.  
Occupational retrospective cohort studies rely on company records  
of past and current employees that include information on the dates  
of employment, age at employment, date of departure, and whether  
diseased (or dead in the case of mortality studies). Workers can then  
be classified by duration and degree of exposure.

27 Dkt. No. 429-7, Trial Ex. 17 at 17-18. Moreover, "[p]ositive or negative results  
28 from a properly controlled prospective study *should weigh heavily* in the risk  
assessment process." *Id.* (emphasis added).

1 participants in the Maternal-Infant Research on Environmental Chemicals program (“MIREC  
2 Cohort”) and found a statistically significant, negative association between fluoride exposure and  
3 IQ in boys, but not girls. Dkt. No. 432-5, Trial Ex. 109 at 940, 944. The study concluded that 1  
4 mg/L increase in maternal urinary fluoride was associated with a 4.49-point lower IQ score in  
5 boys and 1 mg higher daily intake of fluoride among pregnant women was associated with a 3.66  
6 lower IQ score in boys and girls. *Id.* MIREC collected urinary spot samples and estimates of  
7 daily fluoride intake from water consumption for pregnant women recruited from cities across  
8 Canada (Vancouver, Montreal, Kingston, Toronto, Hamilton, Halifax). *Id.* at 941-942. Urinary  
9 samples from the women were collected across each trimester of pregnancy; the mean maternal  
10 urinary fluoride of mothers was 0.42 mg/L in fluoridated communities and 0.27 mg/L in non-  
11 fluoridated communities. *Id.* at 944. The mean estimated intake of water fluoride concentration  
12 was 0.39 mg/day; 0.43 mg for women in communities with fluoridated drinking water and 0.26 for  
13 those living in communities without fluoridated drinking water. *Id.* Children were between ages 3  
14 and 4 years at testing. *Id.* at 940. Data on exposure and outcome was complete for 512 mother-  
15 child pairs measuring exposure through maternal urinary fluoride and 400 mother-child pairs  
16 estimating water fluoride intake. *Id.*

17 c. Till (2020): Till (2020) studied samples taken from 398 mother-child pairs that  
18 participated in the MIREC Cohort project (the cohort studied in Green (2019)), to evaluate IQ of  
19 children that were breastfed compared to formula-fed as infants in areas that had fluoridated and  
20 non-fluoridated water. Dkt. No. 432-19, Trial Ex. 123 at 1. This study found that an increase in  
21 fluoride intake from infant formula corresponded to an 8.8 decrement in performance IQ which  
22 was statistically significant, including after controlling for fetal fluoride exposure. *Id.*<sup>10</sup>

23 d. Cross-sectional studies<sup>11</sup> of children in China found significant inverse association

24  
25 <sup>10</sup> Till (2020) and Green (2019) exemplify how the same samples from one cohort may be  
26 analyzed in multiple studies to either confirm results from a previous study or to extract different  
information from the same samples from a given cohort.

27 <sup>11</sup> Cross-sectional studies are afforded less weight than cohort studies. As the EPA guidelines  
28 explain:

In cross-sectional studies or surveys, both the disease and suspected  
risk factors are ascertained at the same time, and the findings are

1 between fluoride and children's IQ score: Xiang (2003a) (finding significant inverse correlation  
2 between IQ and urinary fluoride; significant association of fluoride on IQ score based on drinking  
3 water levels); Ding (2011) (significant association between urinary fluoride and decrease in IQ  
4 score); Xiang (2011) (significant association between serum (blood-derived sample) fluoride and  
5 reduced IQ score in children); Wang (2012) (significant correlation between total fluoride intake  
6 and reduced IQ); Zhang (2015b) (significant correlation between reduced IQ score and children's  
7 serum fluoride, and urinary fluoride), Cui (2018) (significant association between IQ score and  
8 urinary fluoride); Yu (2018) (significant difference in mean IQ scores in high water fluoride areas  
9 compared to normal water fluoride areas); and Wang (2020b) (significant negative association  
10 between IQ and water and urinary fluoride and IQ in boys and girls). NTP Monograph at 29-33  
11 (Table 6). One study, Cui (2020) identified a directionally negative, though not statistically  
12 significant decrease in mean IQ score with increasing fluoride levels. *Id.* at 32.

13 e. Rocha-Amador (2007), a cross-sectional study of children in Mexico found  
14 significant associations between fluoride and IQ scores. *Id.* at 33.

15 f. Cross-sectional studies of children in India found significant association between  
16 fluoride and intellectual impairment: Sudhir (2009) (found a significant increase in proportion of  
17 children with intellectual impairment with increasing drinking water fluoride levels); Saxena  
18 (2012) (significant correlations between reduced IQ and water fluoride and urinary fluoride  
19 levels); Trivedi (2012) (found significantly lower mean IQ scores in high fluoride villages  
20 compares to low-fluoride villages for boys and girls combined and separately). *Id.* at 38.

21 g. Siraj (2012), a cross-sectional study of children in Iran found a significant negative  
22 association between water fluoride and IQ score. *Id.* at 39.

23 \_\_\_\_\_  
24 useful in generating hypotheses. A group of people are interviewed,  
25 examined, and tested at a single point in time to ascertain a  
26 relationship between a disease and a neurotoxic exposure. This  
27 study design does not allow the investigator to determine whether  
the disease or the exposure came first, rendering it less useful in  
estimating risk. These studies are intermediate in cost and time  
required to complete compared with case reports and more complex  
analytical studies, but should be augmented with additional data.

28 Dkt. No. 429-7, Trial Ex. 17 at 16.

h. Soto-barreras (2019), a cross-sectional study of children in Mexico 9-10 years of age did *not* find a significant association between fluoride and IQ levels. *Id.* at 34.

36. In addition to the studies that the NTP Monograph deemed “high-quality,” and thus most relevant to understanding impact of fluoride, the NTP Monograph explains that 46 of the 53 studies deemed low-quality by the NTP Monograph also found an association between fluoride exposure and reduced IQ in children. NTP Monograph at xii.

37. Several studies published after the NTP Monograph literature cut-off date (April 2021), see NTP Monograph at 5-12, 12 n.8, B-2, C-2-C-44, also found negative association between fluoride and IQ, and acutely, for boys – bolstering the NTP Monograph’s finding of a negative association between IQ in children and fluoride exposure:

a. Goodman (2022a): studied samples from the ELEMENT cohort and concluded that an increase in maternal urinary fluoride predicated an average 2.12-point decrease in GCI scores of 4-year-olds and a 2.63 decrease in performance IQ of 6- to 10-year-olds. Dkt. No. 432-11, Trial Ex. 115 at 1-2. The study also found a marginal association with maternal urinary fluoride and verbal IQ across time. *Id.* at 2. The study concluded that visual-spatial and perceptual reasoning ability may be more impacted by prenatal fluoride exposure as compared to verbal abilities. *Id.*

b. Cantoral (2021): studied 103 mother-child pairs from the Programming Research in Obesity, Growth, Environment and Social Stressors (“PROGRESS Cohort”) program. Dkt. No. 432-6, Trial Ex. 110 at 2. The PROGRESS Cohort collected data regarding dietary fluoride intake from mothers (via food and beverage) during pregnancy and neurodevelopmental testing from their offspring for 948 mother-child pairs from Mexico City. *Id.* at 2. Dietary fluoride intake was measured via food frequency questionnaires from mothers in trimesters two and three of pregnancy and children’s cognitive, motor, and language outcomes were measured at 12 and 24 months. *Id.* at 1. Cantoral (2021) studied data from 103 mother-child pairs from the PROGRESS Cohort to understand if dietary fluoride intake during pregnancy is associated with toddlers’ neurodevelopment. *Id.* The study found a statistically significant association between maternal fluoride intake and cognitive outcome in 24-month-old boys (0.5 mg/day increase in overall dietary fluoride intake associated with 3.5-point lower cognitive outcome). *Id.* There was no

1 statistical association for girls or boys at 12 months of age. *Id.* Averaging across the entire age  
2 group, a 0.5 mg/day increase was associated with a 3.46-point lower cognitive outcome in boys,  
3 which was statistically significant. *Id.* The study concludes: “[t]hese findings suggest that the  
4 development of nonverbal abilities in males may be more vulnerable to prenatal fluoride exposure  
5 than language or motor abilities, even at levels within the recommended intake range.” *Id.*

6 c. Godebo (2023): this study assessed the association between chronic exposure to  
7 naturally occurring fluoride and drinking water and cognitive function in school-aged children,  
8 measured by two distinct assessments: a drawing test with familiar objects and the Cambridge  
9 Neuropsychological Test Automated Battery, Paired Associate Learning (“CANTAB PAL”)<sup>12</sup> test.  
10 Dkt. No. 432-14, Trial Ex. 118 at 15-16. The population studied was recruited from eight  
11 communities exposed to chronic fluoride ranging from 0.41 to 15.5 mg/L fluoride in water  
12 sources. *Id.* at 15. The study reported adverse associations of fluoride exposure in drinking water  
13 with children’s drawing and CANTAB task performance, with the most significant negative  
14 impacts observed for more challenging drawing tasks (*i.e.*, drawing a donkey rather than a house  
15 or a person). *Id.* at 16. The study concluded that this may be indicative of a greater challenge  
16 “accessing working memory for this task.” *Id.*

17 d. Adkins (2022): this study evaluated data collected from the Cincinnati Childhood  
18 Allergy and Air Pollution Study (“CCAAPS”). Dkt. No. 432-8, Trial Ex. 112 at 1. CCAAPS  
19 collected urine samples from children at 12 years of age and collected Behavior Assessment  
20 System for Children-2 which evaluates internalizing symptoms such as anxiety depression and  
21 somatization. *Id.* at 2. The study found that higher children’s urinary fluoride concentrations were  
22 significantly associated with increased somatization, but not depression or anxiety. *Id.* The study  
23 found that male participants exhibited higher internalizing and somatization behaviors relative to  
24 female participants. *Id.* at 6. The study concluded that “[d]espite males and females having  
25 comparable urinary fluoride concentrations, males may be at greater risk for adverse effects of

26 \_\_\_\_\_  
27 <sup>12</sup> The tests present patterns and shapes on a screen and ask children to touch and recount the  
28 patterns to assess spatial memory and learning. Dkt. No. 432-14, Trial Ex. 118 at 10-11. Spatial  
memory and learning are linked to the medial temporal lobe *e.g.*, hippocampus, which the study  
reports is the brain region thought to be most affected by fluoride toxicity. *Id.* at 5.

1 fluoride exposure as the association between fluoride concentrations and internalizing symptoms  
2 was more robust among males.” *Id.* at 9.

3 e. Risk Sciences International (“RSI”), under contract with Health Canada, also  
4 conducted an extensive systematic review of the fluoride neurotoxicity literature: Taher (2024).  
5 Dkt. No. 433-4, Trial Ex. 129; Dkt. No. 433-6, Trial Ex. 131 (Taher (2024) Supplementary  
6 Materials). Taher (2024) came to a similar conclusion as the NTP Monograph, finding a  
7 “moderate to strong magnitude (strength) of association between fluoride and neurocognitive  
8 effects with consistent evidence across studies for the impact on childhood IQ.” Dkt. No. 433-4,  
9 Trial Ex. 129 at 21; Dkt. No. 433-6, Trial Ex. 131 at 1516 (“The overall evidence identified to date  
10 strongly suggests that fluoride can affect cognitive outcomes in children (specifically, reduction in  
11 IQ scores), at levels close to those currently seen in North American drinking water.”).<sup>13</sup>

12 38. Other post-NTP Monograph studies did not find fluoride was associated with adverse  
13 cognitive outcomes in children:

14 a. Ibarluzea (2021): the study evaluated data from 316 to 248 mother-child pairs from  
15 the Infancia y Medio Ambiente cohort project (“INMA Cohort”). Dkt. No. 432-10, Trial Ex. 114  
16 at 1. The INMA Cohort draws on data from mothers and children in Gipuzkoa, Spain (Basque  
17 Country) living in fluoridated and non-fluoridated water communities that supplied water with the  
18 mean fluoride level of 0.81 mg/L. *Id.* at 1, 3. The INMA study collected maternal urinary  
19 fluoride levels in the first and third trimesters of pregnancy, and children’s cognitive domains and

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20  
21 <sup>13</sup> Unlike the NTP Monograph, Taher (2024) considered evidence relating to multiple endpoints  
22 (*i.e.*, a particular adverse effect, *see* Dkt. No. 434-15, Trial Ex. 535 at 43) aside from reduced IQ to  
23 decide which endpoints need be accounted for by regulators; endpoints considered included  
24 kidney dysfunction, sex hormone disruptions, and dental fluorosis, *see* Dkt. No. 433-4, Trial Ex.  
25 129 at 21-23. Taher (2024) concluded that dental fluorosis and reduced IQ are critical endpoints;  
26 evidence supported the association between fluoride and those two adverse effects. *See id.* at 27.  
27 Taher (2024) did find that dental fluorosis should be the primary endpoint used by regulators  
28 because data regarding the association between dental fluorosis and fluoride was more certain than  
evidence regarding the association between IQ reduction and fluoride. *Id.* However, Taher (2024)  
explained that *both* dental fluorosis, and separately, IQ reduction in children should be considered  
by regulatory bodies, including the United States EPA, when assessing regulation of fluoride. *Id.*  
To this end, the review recommended that fluoride at 1.56 mg/L be deemed hazardous, explaining  
that this level should be utilized by regulators in its calculations to protect the public against *both*  
dental fluorosis *and* IQ reduction. *See id.* Thus, the findings of Taher (2024) are consistent with  
the NTP Monograph’s finding that fluoride is associated with reduced IQ, particularly at exposure  
levels above 1.5 mg/L.

1 intelligence indexes, evaluated used the Bayley Scales (age 1) and McCarthy Scales (age 4). *Id.* at  
2 1. The study concluded that per unit of maternal fluoride across the pregnancy was associated  
3 with a sizeable *increase* in IQ scores (15-point increase) and an increase in verbal, performance,  
4 numeric, and memory domains in boys. *Id.* For girls, there was no significant association  
5 between maternal fluoride and cognitive score. *Id.*

6 b. Dewey (2023): This study compared data collected from maternal-child pairs in  
7 Calgary, Canada pre- and post-May 19, 2011, when the city stopped fluoridating its drinking water  
8 (with a recommended level of 0.7 mg/L) to discern if fluoridated drinking water was associated  
9 with children's intelligence and executive function at 3-5 years of age. Dkt. No. 432-13, Trial Ex.  
10 117 at 1. The study compared data from maternal-child pairs that were either fully exposed to  
11 fluoridated drinking water throughout pregnancy, exposed for part of the pregnancy, and those not  
12 exposed to fluoridated drinking water. *Id.* The study found no adverse associations between  
13 maternal exposure to fluoridated drinking water for intelligence. *Id.* at 7. The study observed that  
14 maternal exposure to fluoridated drinking water was associated with poorer executive function in  
15 preschool aged children and, particularly, girls. *Id.*

16 c. Do (2022): This study collected additional data from participants in Australia's  
17 National Child Oral Health Study 2012-14, which gathered data from children aged 5-10 years,  
18 and collected additional data from them again 7-8 years later but before the children turned 18  
19 years of age. Dkt. No. 432-9, Trial Ex. 113 at 1. The study estimated lifetime exposure to  
20 fluoridated water based upon residential history and postcode-level fluoride levels in public tap  
21 water and measured children's emotional and behavioral development and executive functioning  
22 using questionnaires. *Id.* The study concluded that exposure to fluoridated water during the first 5  
23 years of life (post-birth) was not associated with altered measures of child emotional and  
24 behavioral development and executive functioning by 18 years of age. *Id.*

25 39. For several reasons, the studies that did not find a negative association between fluoride  
26 and IQ, or that observed the association in some groups (boys) but not others (girls) do not  
27 undermine the significant evidence finding such an association, reflected in the NTP Monograph  
28 and studies published after the Monograph. The Court affords less weight to these studies finding

1 lack of an association due to various characteristics of those studies:

2 a. The reliability of Ibarluzea (2021) is questionable in several respects:

3 i. This study found that per one unit increase in the mg/L maternal urinary  
4 fluoride, there was an association with a 15-point increase in the IQ of boys associated with  
5 maternal urinary fluoride. Dkt. No. 432-10, Trial Ex. 114 at 1. Dr. Savitz, EPA's expert, agrees  
6 that this finding is an outlier and unexpected, insofar as no other study has reported a *positive*  
7 association between fluoride exposure upon IQ, and does not meaningfully support that fluoride is  
8 beneficial. *See* Dkt. No. 414, Feb. 9, 2024, Trial Tr. at 1067:2-1069:11 (Savitz) ("Again, based on  
9 what I know, I would doubt that that is an accurate reflection of the causal impact of fluoride on  
10 IQ."). Experts also testified that they were not aware of *any* other chemical known to increase the  
11 IQ of humans by 15 points. Dkt. No. 417, Feb. 2, 2024, Trial Tr. at 372:14-16 (Grandjean); Dkt.  
12 No. 395, Jan. 31, 2024, Trial Tr. at 111:4-6 (Hu). This association appears scientifically  
13 implausible and raises questions about the overall reliability of this study.

14 ii. Further, the 15-point increase in IQ disappeared to reflect a null finding  
15 when the maternal urinary fluoride was not adjusted for creatinine. Dkt. No. 395, Jan. 31, 2024,  
16 Trial Tr. at 109:5-11 (Hu). Adjusting maternal urinary fluoride for creatinine is standard practice,  
17 and results from creatinine-adjusted urinary fluoride are considered the informative and reliable  
18 results of a study. Dkt. No. 395, Jan. 31, 2024, Trial Tr. at 108:7-10 (Hu); Dkt. No. 414, Feb. 9,  
19 2024, Trial Tr. at 1089:5-17 (Savitz), 1090:24-1091:2 (Savitz). However, adjusting for creatinine  
20 is expected to sharpen results, because the adjustment countervails for urinary dilution which  
21 might introduce noise into a study; the adjustment is *not*, however, expected to have any  
22 significant impact on the direction of results of the study. Dkt. No. 395, Jan. 31, 2024, Trial Tr. at  
23 108:11-22 (Hu); Dkt. No. 417, Feb. 2, 2024, Trial Tr. at 372:25-373:22 (Grandjean), 376:15-  
24 378:24 (Grandjean). The results in the Ibarluzea (2021) study, which transitioned from a  
25 significant positive association to a null finding when urinary fluoride was adjusted for creatinine,  
26 was considered surprising and not a plausible result. Dkt. No. 395, Jan. 31, 2024, Trial Tr. at  
27 109:13-110:7 (Hu); Dkt. No. 417, Feb. 2, 2024, Trial Tr. at 372:25-373:22 (Grandjean), 376:15-  
28 378:24 (Grandjean). Plaintiffs' experts credibly testified that this discrepancy suggests there was

1 an error when matching fluoride and creatinine data. Dkt. No. 417, Feb. 2, 2024, Trial Tr. at  
2 372:25-373:22 (Grandjean). EPA’s experts at trial could not explain or account for this aspect of  
3 the study. Dkt. No. 414, Feb. 9, 2024, Trial Tr. at 1091:3-1093:8 (Savitz).

iv. Taher (2024) likewise concluded that Ibarluzea (2021) does not overcome evidence linking fluoride to reduced IQ in children. Namely, Taher (2024) concluded that “[t]he available evidence demonstrated a moderate to strong magnitude (strength) of association between fluoride and neurocognitive effects with consistent evidence across studies for the impact on childhood IQ at fluoride exposures relevant to current North American drinking water levels.” Dkt. No. 433-4, Trial Ex. 129 at 21. This is because, “[f]ocusing on high quality cohort studies, most of the evidence suggests a reduction in childhood IQ scores associated with fluoride levels.

1 though results from one 2023 study in Spain (Ibarluzea et al. 2022) documented an improvement  
2 in specific cognitive domain scores in boys.” *Id.*

3 b. Dewey (2023) is not strong evidence regarding the association between fluoride  
4 and reduced IQ because of the design of this study. The study attempted to take advantage of  
5 what was thought to be a naturally occurring cohort with an exposure contrast (*i.e.*, one cohort  
6 exposed to fluoride and one not exposed to fluoride) to see if there was a meaningful difference in  
7 cognitive outcomes amongst the two groups. Dkt. No. 397, Jan. 31, 2024, Trial Tr. at 368:22-  
8 369:7 (Grandjean). Specifically, the study looked at individuals from a Canadian community that,  
9 for a long time, fluoridated its water and stopped fluoridating the water; the study compared the  
10 cognition of children in fluoridated and non-fluoridated groups to discern the impact of fluoride.  
11 Dkt. No. 397, Jan. 31, 2024, Trial Tr. at 368:22-369:7 (Grandjean). However, the study did not  
12 collect data on the urinary fluoride levels of the mother or assess how long pregnant mothers lived  
13 in the area prior to their pregnancy. Dkt. No. 397, Jan. 31, 2024, Trial Tr. at 368:22-369:18  
14 (Grandjean). This is relevant because women who live in a fluoridated area throughout their lives  
15 will have fluoride which accumulates in her bones from consumption of fluoridated water, along  
16 with other sources; for several years after cessation of fluoride exposure she is likely to release  
17 accumulated fluoride from her bones into blood due to skeletal breakdown. Dkt. No. 397, Jan. 31,  
18 2024, Trial Tr. at 370:6-371:12 (Grandjean); Dkt. No. 402, Feb. 8, 2024, Trial Tr. at 932:16-20  
19 (Thiessen). This skeletal breakdown is particularly present during pregnancy, as the maternal  
20 skeleton dissolves itself to provide calcium to the growing fetal skeleton. Dkt. No. 395, Jan. 31,  
21 2024, Trial Tr. at 121:10-20 (Hu). Accordingly, the group that was considered non-fluoridated in  
22 the study, thus creating an exposure contrast between the two groups allowing for a potential  
23 association to be observed, may have in fact exposed the child to fluoride during pregnancy if she  
24 lived in a fluoridated area prior to the study (a phenomenon that is not reported or considered by  
25 the study). This could lessen the exposure contrast and calls the results of the study into question.  
26 See Dkt. No. 397, Jan. 31, 2024, Trial Tr. at 368:22-369:18 (Grandjean). EPA’s expert witnesses  
27 did not account for this concern regarding the study design. Thus, the Dewey study is accorded  
28 diminished weight.

1 c. Do (2022) assessed primarily behavioral outcomes rather than impact on IQ in  
2 children and, as Dr. Savitz testified, “doesn’t stand out as definitive or more persuasive,” relative  
3 to other studies directly on point to association of fluoride on the IQ of children. Dkt. No. 414,  
4 Feb. 9, 2024 Trial Tr. at 1106:22-1107:10 (Savitz). Plaintiffs’ experts also expressed concerns  
5 with the study. The study utilized the “SDQ” test to measure impact of fluoride on children in  
6 Australia, which is a test that, for certain cultural or linguistic reasons, has been determined to be  
7 unreliable for Australians by another study conducted by the co-author of Do (2022). Dkt. No.  
8 397, Jan. 31, 2024, Trial Tr. at 364:8-14, 365:15-366:4 (Grandjean). EPA’s expert witness did not  
9 rebut evidence that there were significant problems with the validity of the SDQ test in Australia.  
10 Dkt. No. 415, Feb. 12, 2024, Trial Tr. at 1240:1-6 (Savitz). Further, the value of this study is  
11 weakened because it did not analyze individualized data, but instead measured exposure based on  
12 residence of the child and community-wide data on fluoride in that area. *See* Dkt. No. 396, Feb. 1,  
13 2024, Trial Tr. at 240:17-19 (Lanphear) (explaining that individualized data is generally a strength  
14 of a study); Dkt. No. 417, Feb. 2, 2024, Trial Tr. at 366:5-367:4, 367:15-368:4 (Grandjean). Lack  
15 of individualized data can lead to exposure imprecision, creating “noise” in the data, which may  
16 bias results toward the null, *i.e.*, noise makes it less likely to show an association between the  
17 chemical and a result. Dkt. No. 395, Jan. 31, 2024, Trial Tr. at 106:18-107:16 (Hu); Dkt. No. 396,  
18 Feb. 1, 2024, Trial Tr. at 281:14-17 (Lanphear), 281:24-282:3 (Lanphear), 317:16-24 (Grandjean);  
19 Dkt. No. 414, Feb. 9, 2024, Trial Tr. at 1176:4-17 (Savitz) (agreeing with a statement made in his  
20 textbook that in general exposure misclassification tends to produce results with a bias towards the  
21 null). Thus, this study is not particularly probative evidence as to association between fluoride  
22 and IQ of children.

23 40. EPA experts agreed, in line with the NTP Monograph’s conclusion, that fluoride is  
24 associated with adverse IQ in children at “higher” levels of exposure. Namely, Dr. Barone  
25 testified that he agreed that there is “something going on” at higher-dose levels, though unclear  
26 about where the threshold is. Dkt. No. 415, Feb. 12, 2024, Trial Tr. at 1372:9-1373:9 (Barone).  
27 Dr. Barone agreed that, at 4 mg/L of fluoride exposure and above, there is more data to support a  
28 finding of an adverse effect associated with fluoride. *Id.* at 1373:1-9 (Barone). Dr. Barone further

1 testified: “I agree with the NTP’s conclusions that at some level above 1.5 mg/L that there is  
2 moderate evidence to support an association between fluoride and developmental IQ decrements.”  
3 Dkt. No. 416, Feb. 12, 2024, Trial Tr. at 1428:4-11 (Barone).<sup>14</sup> The primary concern presented by  
4 EPA’s experts relates to lack of clarity as to whether *lower* exposure levels of fluoride (below 1.5  
5 mg/L) results in an adverse outcome and the precise relationship between dose and response. *See*  
6 Dkt. No. 415, Feb. 12, 2024, Trial Tr. at 1357:9-1360:10 (Barone). For example, Dr. Savitz  
7 (EPA’s expert witness) did not opine that the NTP Monograph’s main conclusion that fluoride is  
8 presumed to be a cognitive neurodevelopmental hazard to humans was incorrect, though  
9 expressing concerns as to a previous draft of the Monograph regarding whether its conclusion was  
10 well explained and qualified. Dkt. No. 414, Feb. 9, 2024, Trial Tr. at 1113:16-1115:23 (Savitz)  
11 (“Whether [a committee reviewing a draft of the NTP Monograph] agreed with [the NTP  
12 Monograph’s conclusion] was not the issue. It was – the story that gets to the punchline at the end  
13 we did not find persuasive.”). Indeed, Dr. Savitz explained that he does not have a basis to  
14 challenge the NTP’s conclusion that, with moderate confidence, there is an association or appears  
15 to be an association between neurological decrements in fluoride concentrations above 1.5 mg/L.  
16 *Id.* at 1140:10-19 (Savitz) (“I don’t have any reason to challenge [this conclusion], but I haven’t  
17 corroborated it by going through the dozens of studies one-by-one to make my own assessment.”).  
18 Dr. Savitz likewise made clear he did not undertake a complete review of the NTP Monograph,  
19 but testified his primary concern was the Monograph’s “inferences regarding lower levels of  
20 fluoride exposure.” *Id.* at 1129:11-1131:3 (Savitz).

21 41. The robust body of scientific literature systematically assessed by the NTP Monograph  
22 (described above, ¶ 35) and literature published after the NTP Monograph cutoff date (described  
23 above, ¶ 37), even considering some countervailing scientific literature (described above, ¶¶ 38-  
24 39) establishes by a preponderance of the evidence that fluoride is associated with reduced IQ in

25  
26 <sup>14</sup> Dr. Barone testified that the NTP Monograph was helpful but not complete and thus insufficient  
27 to satisfy the hazard identification prong of TSCA hazard assessment. Dkt. No. 440, Feb. 13,  
28 2024, Trial Tr. at 1428:22-1429:3 (Barone). That testimony is not credible because it directly  
contradicts Dr. Barone’s prior testimony during his deposition that the literature the NTP reviewed  
through April 2021 was sufficient to satisfy the human evidence standard for identifying a hazard  
under the EPA’s TSCA guidelines. *Id.* at 11-21.

1 children – at least at “higher” concentration levels, *i.e.*, above 1.5 mg/L (measured in either water  
2 fluoride levels or urinary fluoride levels). At the hazard identification step, the EPA does not  
3 require showing that an adverse effect is present at the level akin to the exposure in the community  
4 (*i.e.*, 0.7 mg/L) or require the establishment of a dose-response relationship of the chemical at  
5 “lower” levels. Dkt. No. 417, Feb. 2, 2024, Trial Tr. at 493:16-495:12 (Barone). The evidence  
6 regarding the “higher” exposure levels is sufficient to satisfy the hazard identification step of the  
7 analysis.

8 42. Regardless, scientific literature in the record also indicates there is an association between  
9 fluoride and reduced IQ in children even at “lower” levels of exposure (*i.e.*, below 1.5 mg/L).

10 43. Two of the three high-quality studies that evaluated the effects of “lower” levels of fluoride  
11 exposure (below 1.5 mg/L) did observe an association between fluoride and reduced IQ in  
12 children or boys. Namely: (1) Bashash (2017), studied mother-child pairs from the ELEMENT  
13 Cohort (Mexican population) and observed a statistically significant decrement of 3.15 GCI score  
14 and 2.5 IQ score of offspring per an increase of 0.5 mg/L of maternal urinary fluoride where the  
15 mean maternal urinary fluoride in mothers was **0.9 mg/L**, Dkt. No. 432-2, Trial Ex. 106 at 1; and  
16 (2) Green (2019) studied mother-child pairs in the MIREC Cohort (Canadian population) and  
17 found a statistically significant decrement of 3.66 IQ score in boys only (3.66 IQ score decrement  
18 per a 1 mg/L per day increase in maternal urinary fluoride) where the mean maternal urinary  
19 fluoride of mothers was **0.42 mg/L**, Dkt. No. 432-5, Trial Ex. 109 at 1-3, 5.

20 44. Another program collected samples from 837 mother-child pairs from the Odense  
21 municipality in Denmark: the Odense Child Cohort (“OCC Cohort”). Dkt. No. 432-15, Trial Ex.  
22 119 at 1. The OCC Cohort measured maternal urinary fluoride during pregnancy and the IQ of  
23 school-aged offspring of those mothers. *Id.* The maternal urinary fluoride concentrations  
24 averaged at **0.58 mg/L** per day. *Id.* at 2. The study, when accounting for covariables did not  
25 observe a statistically significant association between maternal urinary fluoride and child Full-  
26 Scale IQ score, with no clear interaction between sex and fluoride exposure. *Id.*

27 45. The result of the OCC Cohort does not negate the findings regarding the MIREC and  
28 ELEMENT cohorts. It is inherently more difficult to observe an adverse effect of a chemical at

1 lower exposure levels because of reduced exposure contrast<sup>15</sup> at those levels. Dkt. No. 395, Jan.  
2 31, 2024, Trial Tr. at 113:2-25 (Hu), 114:8-14 (Hu); Dkt. No 396, Feb. 1, 2024, Trial Tr. at 213:5-  
3 25 (Lanphear); Dkt. No. 400, Feb. 5, 2024, Trial Tr. at 525:9-526:13 (Berridge). EPA's expert,  
4 Dr. Savitz, agreed. Dkt. No. 402, Feb. 8, 2024, Trial Tr. at 1009:7-23 (Savitz) ("[Y]ou could think  
5 of the worst cases, if we all had the exact same value, everybody in the population had the same  
6 exposure, you could not do an informative study of the association of exposure with a disease.  
7 And if it's very narrow, of course, you're only able to study – if you're only able to study, let's  
8 say, the contrast of, you know, .4 and .5 milligrams per liter fluoride, you're going to have a tough  
9 time, even if there were an effect, it's going to be difficult to find because you have a very limited  
10 contrast. As you spread that out more, of course, you are – you have a larger contrast and you're  
11 able to address a more informative range of exposure."). It is particularly difficult to observe  
12 effects of fluoride at lower exposure levels because of challenges in finding a control group with  
13 zero or very little fluoride exposure. Dkt. No 396, Feb. 1, 2024, Trial Tr. at 212:7-213:25  
14 (Lanphear). This is because fluoride exposure is prevalent. Some common sources aside from  
15 fluoridated water include naturally occurring fluoride in food and beverage, fluoride in food and  
16 beverage made with fluoridated water, and other products, like toothpaste. *Id.* at 212:10-19  
17 (Lanphear). Thus, it is difficult to find a control group without any fluoride exposure; the "noise"  
18 created by background fluoride exposure tends to obscure the contrast between those who  
19 consume fluoridated water and those who do not. *Id.* at 212:19-23 (Lanphear) ("And so if we  
20 wanted to ask a question . . . is there a difference in children who are unexposed to fluoride? Well,  
21 we really can't find children who are unexposed to fluoride versus kids who have levels in a  
22 nonfluoridated community or a fluoridated community."). It is thus more challenging to observe  
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24 <sup>15</sup> Exposure contrast refers to the difference between exposure of a chemical in one group (a  
25 control group) and another group (the group exposed to the chemical). Dkt. No. 395, Jan. 31,  
26 2024, Trial Tr. at 113:6-22 (Hu). For example, an observer would compare a group with less or  
27 no fluoride exposure to a group with more exposure to determine if there is a meaningful  
28 difference in the group with more exposure. *See* Dkt. No 396, Feb. 1, 2024, Trial Tr. at 212:10-23  
(Lanphear). When trying to observe effects of a chemical at lower levels, there is less "exposure  
contrast" between the control group and exposed group. *See id.* at 212:10-213:25. Dr. Hu  
provided an illustration: "It's sort of like looking at, you know, a picture and trying to determine  
whether this shade is different from that shade. If you increase the contrast, it's easier to see."  
Dkt. No. 395, Jan. 31, 2024, Trial Tr. at 114:12-14 (Hu).

1 effects at lower concentration levels of fluoridated water. *Id.* at 212:24-213:25 (Lanphear).  
2 Accordingly, the Court finds convincing and credible the expert testimony that studies analyzing  
3 the OCC Cohort are not inconsistent with studies analyzing the ELEMENT and MIREC Cohorts;  
4 the lower exposure levels account for some difficulty in repeating observed effects. Dkt. No. 395,  
5 Jan. 31, 2024, Trial Tr. at 116:24-117:4 (Hu).<sup>16</sup> In short, the association between intake of water  
6 at lower fluoridated levels and IQ is likely harder to detect. Inconsistent results between studies  
7 are not unexpected. The two high-quality studies which detected such an association at lower  
8 concentration levels of fluoride remain significant and are not undermined by the OCC Cohort  
9 study.

10 46. In conclusion, Plaintiffs have established by a preponderance of the evidence that exposure  
11 to fluoride is associated with the adverse effect of reduced IQ in children, and particularly, young  
12 boys. Hence, the hazard identification step of the analysis is satisfied.

13 2. Step 1B: Weight of the scientific evidence

14 a. Framework

15 47. Once a hazard has been identified, the EPA assesses the weight of the scientific evidence,  
16 wherein the risk assessor considers the weight of that evidence, determining which adverse effects  
17 (endpoints) are to be assessed, and which studies are appropriate for use in quantifying the  
18 relationship between the dose of the chemical and adverse effect(s) (response) at issue (the “dose-  
19 response” assessment). Dkt. No. 400, Feb. 4, 2024, Trial Tr. at 661:18-666:14 (Barone). To this  
20 end, not all studies are appropriately utilized in the dose-response assessment. *See* Dkt. No. 417,  
21 Feb. 2, 2024, Trial Tr. at 494:17-495:12 (Barone). Rather, the EPA identifies the studies from the  
22 hazard identification step that are generally of high or medium quality, and thus are deemed  
23 permissible to use in the dose-response assessment. *Id.* at 494:17-495:12; Dkt. No. 421 at 5  
24 (undisputed fact).

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27 <sup>16</sup> Expert witnesses also testified credibly that there are some possible explanations for the  
28 differing study results; for example, it is possible that Denmark has higher iodine consumption,  
accounting for the discrepancy, as iodine deficiency is theorized to be an aggravating factor for  
impacts of fluoride on neurodevelopment. *See* Dkt. No. 396, Feb. 1, 2024, Trial Tr. at 248:10-  
250:3 (Lanphear).

1       48. The parties disagree as to precisely how the weight-of-the-scientific evidence analysis  
2 intersects with the subsequent step of the analysis: the dose-response assessment wherein a point  
3 of departure<sup>17</sup> is identified (Step 1C, discussed in Section III.A.3.). *See* Dkt. No. 421 at 22-23.  
4 Plaintiffs assert that the weight-of-the-scientific evidence analysis is a distinct, qualitative  
5 characterization of the evidence regarding a “chemical’s potential to produce neurotoxicity,”  
6 separate from the quantitative dose-response assessment wherein a point of departure is calculated  
7 (Step 1C, discussed in Section III.A.3.). *Id.* The EPA asserts that there is not a clear distinction  
8 between the qualitative and quantitative dose-response assessment. *See id.* Dr. Barone, EPA’s  
9 expert does recognize that risk evaluation includes a “quantitative track wherein the agency is  
10 doing a quantitative measurement, deriving a point of departure, and a qualitative track where [the  
11 assessor is] assessing whether that evidence is appropriate for that purpose.” *See* Dkt. No. 400,  
12 Feb. 4, 2024, Trial Tr. at 666:9-14 (Barone). Moreover, Dr. Barone stated that: “in this weight of  
13 the scientific evidence evaluation . . . [we ask] how much data do we actually have for that  
14 particular endpoint or that particular outcome, and are there a series of outcomes that are related to  
15 neurotoxicity that we should consider as an example or reproductive toxicity. So we may have  
16 multiple endpoints to consider and multiple studies within that, that can be *carried forward* to  
17 dose response.” *Id.* at 662:2-19 (emphasis added). This testimony intimates that the weight-of-  
18 scientific-evidence analysis occurs prior to, and separately from, the quantitative dose-response  
19 assessment wherein a point of departure is calculated. *See id.* However, to avoid any doubt, the  
20 Court assesses the weight-of-the-scientific evidence both as a standalone, qualitative issue,  
21 characterizing the weight of the evidence assessing the association between the chemical and  
22 endpoint (in this section of the analysis (Section III.A.2., as Step 1B)) and also assesses the  
23 weight-of-the-scientific-evidence, as part of the quantitative dose-response assessment wherein a  
24 point of departure is identified (Section III.A.3, as Step 1C, discussed below).

25                   b.       Key finding

26       49. The weight of the scientific evidence regarding fluoride’s association with reduced IQ is

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<sup>17</sup> As explained in depth in Section III.A.3., the point of departure represents the level at which the  
chemical at issue becomes hazardous.

1 sufficient to proceed to the dose-response assessment; the evidence in the record is appropriate for  
2 use in calculating a point of departure.

c. Underlying findings

4       50. The term “weight of the scientific evidence” is supported by EPA’s systematic analysis of  
5 the related information to support the Agency’s findings. *Id.* at 651:22–652:5; *accord* 40 CFR  
6 702.33. The assessor uses the “best available science,” in the analysis, which means that TSCA  
7 risk evaluations need to be unbiased and objective, and the methodologies employed must be  
8 transparent and reproducible and generally peer reviewed. Dkt. No. 400, Feb. 5, 2024, Trial Tr. at  
9 652:6-16 (Barone); *accord* 40 C.F.R. 702.33.

51. In the weight-of-the-scientific-evidence analysis, generally, high- or medium-quality studies are adequate to move to the dose-response determination. Dkt. No. 417, Feb. 2, 2024, Trial Tr. at 494:17-495:12 (Barone); Dkt. No. 421 at 5 (undisputed fact). Still, the EPA sometimes carries over low-quality studies into the dose-response analysis as well. Dkt. No. 417, Feb. 2, 2024, Trial Tr. at 494:21-495:1 (Barone). In this weight-of-the-scientific-evidence analysis, some or all factors referred to as the “Bradford Hill” factors may be considered. Dkt. No. 400, Feb. 5, 2024, Trial Tr. at 626:8-24 (Barone). The nine Bradford Hill factors are: (1) strength of the association, (2) consistency of the association; (3) specificity of the association; (4) temporality of the association; (5) biological gradient (*i.e.*, dose response) of the association; (6) plausibility of the association; (7) coherence of the association, (8) experimental support for the association, and (9) analogies for the association. *See* Dkt. No. 198-3, Grandjean Trial Decl. ¶¶ 111-125. However, there is no mandate that each of the Bradford Hill factors be considered in the weight-of-the-evidence assessment in a non-cancer TSCA risk evaluation such as this one. *See* Dkt. No. 437-1, Trial Ex. 96 (hereinafter “PCE Risk Evaluation”) at 326 (considering only consistency of association factor); Dkt. No. 437-7, Trial Ex. 102 (hereinafter “Methylene Risk Evaluation”) at 285-95 (considering some, but not all, of the Bradford Hill factors).

26 52. As discussed previously, not every epidemiological study on fluoride has found  
27 associations with reduced IQ in children. See ¶¶ 35, 38. However, the evidence at issue is overall  
28 **consistent** as to the finding that fluoride is associated with reduced IQ in children, and there is a

1 vast amount of **experimental support** for the association:

2 a. The NTP Monograph studied a robust amount of literature regarding fluoride's  
3 impact on children's IQ: 72 epidemiological studies – 19 of which were deemed "high quality"  
4 and "low-risk-of-bias," and 53 lower-quality studies – a large majority of which identified an  
5 association between fluoride and reduced IQ. NTP Monograph at xii (describing that 46 of the 53  
6 low-quality studies found an association between higher fluoride exposure and lower IQ in  
7 children and 18 of 19 high-quality studies reported an association between higher fluoride  
8 exposure and lower IQ in children including 3 prospective cohort studies and 15 cross-sectional  
9 studies). Indeed, when narrowing evidence to view only 19 studies that are high quality and low  
10 risk-of-bias, all but one identified an association between fluoride and reduced IQ: Bashash et al.  
11 2017; Choi et al. 2015; Cui et al. 2018; Ding et al. 2011; Green et al. 2019; Rocha-Amador et al.  
12 2007; Saxena et al. 2012; Seraj et al. 2012; Sudhir et al. 2009; Till et al. 2020; Trivedi et al. 2012;  
13 Wang et al. 2012; Wang et al. 2020b; Xiang et al. 2003a; Xiang et al. 2011; Yu et al. 2018; Zhang  
14 et al. 2015b). NTP Monograph at 29-40 (Table 6).

15 b. The findings of the NTP Monograph are properly afforded substantial weight. The  
16 NTP is headquartered within NIEHS, which is "is one of the premier environmental health  
17 sciences research institutions in the world." Dkt. No. 440, Feb. 13, 2024, Trial Tr. at 1425:23-  
18 1426:2 (Barone). The EPA does not dispute this fact. Dkt. No. 421 at 10. Even before the NTP  
19 Monograph was formally published, the EPA agreed the NTP Monograph is a high-quality review,  
20 followed rules that have been developed by NTP for conducting systematic review, had a  
21 "rigorous approach to assembling the evidence," "clearly defined rules for identifying and  
22 evaluating studies," and "a well-defined protocol for drawing inferences" from the studies. Dkt.  
23 No. 440, Feb. 13, 2024, Trial Tr. at 1427:9-21 (Barone), 1427:2-8 (Barone).

24 c. Though there were some critical peer review comments on earlier drafts of the NTP  
25 Monograph, the core conclusion of the NTP Monograph regarding the high-quality studies was  
26 not called into question by reviewers. *See, e.g.*, Dkt. No. 438-1, Trial Ex. 69 at 65 (NTP Board of  
27 Scientific Counselors Working Group Report agreeing that low-risk-of-bias studies were  
28 "consistent," meaning generating results in the same direction, in finding a negative association

1 between fluoride exposure and children's IQ); Dkt. No. 414, Feb. 9, 2024, Trial Tr. at 1114:24-  
2 1115:1 (Savitz) (describing NASEM critique of adequate definition of the term "consistent" in  
3 NTP Monograph, but not disagreeing with characterization of NTP Monograph finding  
4 association between IQ and fluoride). Indeed, EPA's experts at trial expressed confidence in the  
5 NTP Monograph's methodologies. Dkt. No. 414, Feb. 9, 2024, Trial Tr. at 1197:2-15 (Savitz)  
6 (expressing confidence in NTP's literature search strategy and its ability to identify all relevant  
7 studies on fluoride exposure published prior to the closing date of April 21, 2021, and agreeing  
8 that the "vast majority of studies" that NTP reviewed identified an association between fluoride  
9 and reduced IQ). *See also* Dkt. No. 414, Feb. 9, 2024, Trial Tr. at 1140:10-19 (Savitz) ("I don't  
10 have any reason to challenge [this conclusion], but I haven't corroborated it by going through the  
11 dozens of studies one-by-one to make my own assessment."). Further, Dr. Savitz, the expert  
12 called by the EPA herein, acknowledged he is not an expert in conducting risk assessment, and  
13 particularly not under Amended TSCA. Dkt. No. 415, Feb. 9, 2024, Trial Tr. at 1264:2-6 (Savitz).  
14 Formal publication of the NTP Monograph affirms its quality. *See also* ¶ 33.

15 d. As explained previously, studies published after the NTP Monograph's literature  
16 cut-off date likewise observed a negative association between fluoride and children's cognition:  
17 Goodman (2022(a)), Cantoral (2021), Godebo (2023), and Adkins (2022)). *See* ¶ 37.

18 e. Further, notwithstanding difficulties in observing effects of a chemical at lower  
19 levels, *see* ¶ 45, adverse outcomes have even been observed at those levels with statistical  
20 significance: Green (2019) and Bashash (2017), ¶¶ 42-43.

21 f. As explained previously, some studies have not observed an association between  
22 fluoride and reduced IQ: Soto-barreras (2019), ¶ 35(h); Ibarluzea (2021), ¶ 38(a); Dewey 2023, ¶  
23 38(b); Do (2022), ¶ 38(c); and the OCC Cohort, ¶ 44. However, complete consistency amongst  
24 studies is not expected. Dkt. No. 414, Feb. 9, 2024, Trial Tr. at 1172:23-1173:6 (Savitz). To this  
25 end, various co-factors or susceptibilities can influence the impact or manifestation of  
26 neurotoxicants, and as such, it is to be expected that there will be some variability in results across  
27 studies of different populations. *See id.* What may appear to be a discrepant result may, in fact,  
28 reflect unmeasured differences in cofactors that influence the course of a chemical's

1 neurotoxicity. *See* Dkt. No. 395, Jan. 31, 2024, Trial Tr. at 102:22-104:24 (Hu); Dkt. No. 417, Feb. 1,  
2 2024, Trial Tr. at 242:21-243:9 (Lanphear), 328:14-23 (Grandjean). And, as also explained  
3 previously, particular characteristics of these studies finding null outcomes render them less  
4 probative here. *See* ¶ 39. Namely, Ibarluzea (2021) found an unrealistic 15-point IQ benefit,  
5 included unexplained and implausible results regarding creatinine adjustments, and failed to  
6 control for seafood, ¶ 39(a); Dewey (2023) did not account for previous residence of mothers or  
7 continued excretion of fluoride from skeletal breakdown during pregnancy in the control group, ¶  
8 39(b); Do (2022) utilized an unreliable IQ test and did not analyze individualized data, ¶ 39(c);  
9 and the OCC Cohort measured lower exposure levels which makes it more difficult to observe  
10 adverse effects, ¶ 45.

11 53. Though not definitive, there is additional evidence that supports the **plausibility** of the  
12 association by assessing potential *mechanisms* for fluoride to impact IQ. Specifically, studies  
13 have endeavored to consider explanations for the observed association between fluoride and IQ  
14 and hypothesize that thyroid disruption may be the mechanism by which fluoride impacts  
15 cognitive function:

16 a. Goodman (2022b) studied samples from the MIREC Cohort to assess the three-way  
17 interplay between prenatal fluoride exposure, maternal iodine status, and child IQ. Dkt. No. 432-  
18 12, Trial Ex. 116 at 1, 8. The study found that the negative association between fluoride exposure  
19 and IQ observed in Green (2019) was exacerbated by low maternal iodine in pregnancy among  
20 boys. *Id.* The study hypothesized that change in thyroid function may be a mechanism by which  
21 fluoride impacts cognition; iodine impacts thyroid function. *Id.* at 1-2.

22 b. Hall (2023): studied samples from the MIREC Cohort and concluded that fluoride  
23 in drinking water was associated with increased risk of hypothyroidism in pregnant women, and  
24 that thyroid disruption may contribute to developmental neurotoxicity of fluoride. Dkt. No. 432-  
25 16, Trial Ex. 120 at 1-2.

26 54. A lack of a dose-response relationship in the data may suggest that the effect is not related  
27 to the putative neurotoxic effect or that the study was not appropriately controlled. Dkt. No. 429-  
28 7, Trial Ex. 17 (Guidelines for Neurotoxicity Risk Assessment, Fed. Reg. 63(93):26926-26954

1 (hereinafter “EPA Guidelines”))<sup>18</sup> at 50. As discussed in the next section regarding the dose-  
2 response assessment, there is some lack of clarity as to the precise dose-response relationship at  
3 lower exposure levels of fluoride. However, evidence indicates that there is no **threshold** by  
4 which fluoride and adverse IQ cease to be associated. *See ¶¶ 42-43.*

5 55. In conclusion, this evidence is sufficient to proceed to the dose-response assessment of the  
6 analysis. *Cf.* Methylene Risk Evaluation at 262 (conducting dose-response analysis for Methylene  
7 under Amended TSCA based upon one animal study).

8       3.     Step 1C: Dose-response assessment

9           a.     Framework

10 56. The point at which the chemical ceases to be safe is known as the “point of departure” (*i.e.*,  
11 “POD”) or “hazard level.” *See* Dkt. No. 429-20, Trial Ex. 38 at 1; Dkt. No. 417, Feb. 2, 2024,  
12 Trial Tr. at 495:9-14 (Barone); Dkt. No. 421 at 5. To this end, the dose-response assessment  
13 describes the relationship between dosage of the chemical and a response, and endeavors to  
14 identify the dosage at which a chemical is safe, and conversely, becomes hazardous; this is the  
15 point of departure. *See* EPA Guidelines at 57. *See also* Dkt. No. 429-20, Trial Ex. 38 at 1  
16 (describing that the objective of the dose-response assessment is to “document the relationship  
17 between dose and toxic effect”).

18 57. There are different points of departure that can be used in a risk assessment. EPA  
19 Guidelines at 57-58. The first approach is the NOAEL/LOAEL approach. *See* Dkt. No. 429-19,  
20 Trial Ex. 38 at 3-4. A No-Observed-Adverse-Effect Level (“NOAEL”) is the “highest exposure  
21 level at which no statistically or biologically significant increases are seen in the frequency or  
22 severity of adverse effect between the exposed population and its appropriate control population.”  
23 *Id.* at 4. In cases in which a NOAEL cannot be identified, the term lowest-observed-adverse-effect  
24 level (“LOAEL”) is used, which is the lowest dose tested at which an adverse effect is detected.

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<sup>18</sup> These Guidelines were published in April 1998 and are the currently applied guidelines for EPA  
27 Neurotoxicity Risk Assessment according to the EPA’s website. *See Guidelines for Neurotoxicity*  
28 *Risk Assessment*, UNITED STATES ENVIRONMENTAL PROTECTION AGENCY (last visited September  
12, 2024), <https://www.epa.gov/risk/guidelines-neurotoxicity-risk-assessment>.

1       1       Id. at 4. Alternatively, when possible, the benchmark dose (“BMD”) approach can be used to  
2       2       arrive at a point of departure. *Id.*

3       3       58. The BMD approach is preferred over the NOAEL/LOAEL approach, and use of a NOAEL  
4       4       is preferred over the LOAEL. *Id.* *See also* Dkt. No. 417, Feb. 2, 2024, Trial Tr. at 495:23-496:25  
5       5       (Barone); EPA Guidelines at 2-3, 57-58; Dkt. No. 421 at 5 (undisputed fact). The  
6       6       NOAEL/LOAEL approach derives the point of departure from a dosage and corresponding  
7       7       response in subjects that was actually observed. *See* EPA Guidelines at 57-59. *See also* Dkt. No.  
8       8       400, Feb. 5, 2024, Trial Tr. at 672:1-11 (Barone) (“So generally a NOAEL or LOAEL, as we  
9       9       described earlier, comes directly from what is the observed concentration for an effect or no effect.  
10      10      So it’s directly coming from the study of where that threshold for non-cancer – generally gets a  
11      11      threshold – where does that concentration occur. And that’s describing, generally speaking, a  
12      12      single dose. It’s within the dose continuum of how many doses were employed in the study, what  
13      13      concentration did they measure an effect.”). *See also* EPA Guidelines at 57-59. The  
14      14      NOAEL/LOAEL is thus limited to only dosages observed in the study. *See* EPA Guidelines at 57-  
15      15      59. Other limitations of the NOAEL/LOAEL approach include that this approach is highly  
16      16      dependent upon sample size of a study (e.g., where a sample size is limited, it might present a  
17      17      higher point of departure than the true point of departure), and it does not account for the shape of  
18      18      the dose-response curve from the experiment at issue. *Id.* Because of these limitations, the BMD  
19      19      approach is preferred if the data set is appropriate for such modeling. *See* Dkt. No. 429-20, Trial  
20      20      Ex. 38 at 4; Dkt. No. 400, Feb. 5, 2024, Trial Tr. at 479:14-580:9 (Barone).

21      21      59. In utilizing the BMD approach, a benchmark dose, *i.e.*, BMD or benchmark concentration  
22      22      (“BMC”) is identified. *See* Dkt. No. 429-20, Trial Ex. 38 at 4. The BMD/BMC is the dose of a  
23      23      substance that produces a “predetermined change in the response rate of an adverse effect.” *Id.*  
24      24      The benchmark dose level (“BMDL”) or benchmark concentration level (“BMCL”) is the lower  
25      25      end of the statistical confidence limit on the dose that produces the selected response. *Id.* In other  
26      26      words, there is a statistical confidence interval on either side of the BMD/BMC; the  
27      27      BMDL/BMCL is the point at the lower side of that confidence interval. *See id.* Like the  
28      28      NOAEL/LOAEL, the BMCL/BMDL can be used as the point of departure. *Id.*

60. 0.28 mg/L, or alternatively, 0.768 and/or 1.536 mg/L measured in maternal urinary  
fluoride is associated with a 1-point decrease in IQ of girls and boys and is a legitimate point of  
departure (BMCL) to use in this risk evaluation.

5       61. Alternatively, 4 mg/L measured in either urinary fluoride or water fluoride, is a legitimate,  
6       conservative point of departure (LOAEL) to use in the risk evaluation.

7       62. Regarding the weight of the scientific evidence, the quality and weight of the evidence in  
8 the record substantiates points of departure derived from either BMD modeling of the data or from  
9 a LOAEL/NOAEL approach.

## 10 c. *Underlying findings*

11 (a) POD: 0.28 mg/L BMCL (Grandjean (2023)) or in the alternative,  
12 0.768 mg/L and/or 1.536 mg/L BMCL (Grandjean (2022))

13 63. Dr. Philippe Grandjean (“Grandjean”) was the lead author of two pooled BMCL analyses,  
14 one published in 2022 and another in 2023. Dkt. No. 432-20, Trial Ex. 124. (hereinafter  
15 “Grandjean (2022)”; Dkt. No. 432-15, Trial Ex. 119 (hereinafter “Grandjean (2023)”).

16 64. Dr. Grandjean and his co-authors are well-regarded for their benchmark dose analyses. To  
17 this end, EPA cited a pooled benchmark dose analysis authored by Grandjean as an example of  
18 how to perform such an analysis in its Benchmark Dose Technical Guidance Manual, and EPA  
19 has relied upon the authors' benchmark dose analysis work in its assessment of other chemicals.  
20 Dkt. No. 417, Feb. 2, 2024, Trial Tr. at 287:16-288:18 (Grandjean), 479:25-5 (Grandjean); Dkt.  
21 No. 401, Feb. 6, 2024, Trial Tr. at 748:19-750:6 (Barone)

22 65. Grandjean (2022) analyzed data from two cohorts, the ELEMENT Cohort and the MIREC  
23 Cohort to conduct its BMCL analysis. Grandjean (2022) at 1-2. Grandjean (2023) analyzed three  
24 cohorts: ELEMENT, MIREC, and the OCC cohorts. Grandjean (2023) at 1

25       66. The pooled BMCL analyses of the birth cohorts sought to determine the level of fluoride in  
26 maternal urine (“MUF”) that is associated with a 1-point drop in the IQ of the mothers’  
27 offspring. Dkt. No. 417, Feb. 1, 2024, Trial Tr. at 339:13-23 (Grandjean). As described by RSI,  
28 “[t]he choice of a BMR of 1 IQ point (corresponding to a 1% reduction from a mean IQ of 100)

1 has been adopted as an appropriate benchmark on this endpoint by several regulatory bodies,  
2 including the US EPA and EFSA.” Dkt. No. 433-4, Trial Ex. 129 at 27. Pooled analyses are also  
3 particularly useful because a pooled analysis benefits from heightened statistical power and  
4 precision that comes from large samples sizes. Dkt. No. 395, Jan. 31, 2024, Trial Tr. at 111:9-  
5 112:16 (Hu).

6 67. Grandjean (2023) concluded that “[t]he joint analysis of all three cohorts showed a  
7 statistically significant association between urine-fluoride and IQ, with a BMC of 0.45 mg/L  
8 (BMCL, 0.28 mg/L).” Grandjean (2023) at 1-2. Specifically, Grandjean (2023) found that the  
9 BMCL associated with a 1-point decrease in IQ scores of boys and girls was 0.28 mg/L maternal  
10 urinary fluoride; this BMCL was adjusted for creatinine and derived from use of a linear dose-  
11 response model. Grandjean (2023) at 1-2, 9. This BMCL is a legitimate point of departure to use  
12 in the risk evaluation for fluoride.

13 68. When determining whether the point of departure can be derived using the BMD or BMC  
14 approach, as opposed to identifying a LOAEL or NOAEL, it is necessary to consider whether the  
15 data set is appropriate for use in the BMD/BMC modeling. *See* Dkt. No. 400, Feb. 5, 2024, Trial  
16 Tr. at 658:9-659:10 (Barone) (explaining that in identifying studies and key endpoints to “carry  
17 forward to the dose-response analysis,” the assessor considers whether “are [the studies] amenable  
18 to BMDS, benchmark dose modeling? Are they amenable to a LOAEL/NOAEL approach?  
19 Should we use some other type of approach?”). To this end, the EPA’s technical guidance  
20 provides that the following should be considered as to whether the data set is appropriate for BMD  
21 modeling: (1) whether there is a statistically or biologically significant dose-related trend in the  
22 selected endpoint; (2) whether a response is not only seen at a high dose; and (3) where there are  
23 adequate model fits. *See* Benchmark Dose Technical Guidance, U.S. ENVIRONMENTAL  
24 PROTECTION AGENCY (June 2012) available at [https://www.epa.gov/sites/default/files/2015-01/documents/benchmark\\_dose\\_guidance.pdf](https://www.epa.gov/sites/default/files/2015-01/documents/benchmark_dose_guidance.pdf) (hereinafter “EPA’s Benchmark Dose Technical  
25 Guidance”) at 12-18.<sup>19</sup>

26  
27  
28 <sup>19</sup> This document was not submitted as an exhibit, but the EPA’s witnesses rely on the document  
for their testimony. *See, e.g.*, Dkt. No. 401, Feb. 6, 2024, Trial Tr. at 745:9-25 (Barone) (“Q:

1       69. For the reasons discussed below, the data that Dr. Grandjean analyzed is appropriate for  
2 use in BMD modeling, and for similar reasons, his point of departure is supported by the weight of  
3 the scientific evidence. *See ¶ 51* (discussing weight-of-scientific-evidence factors). It is  
4 demonstrated by a preponderance of the evidence.

5       70. As explained previously, there is a well-supported and documented, statistically significant  
6 dose-related trend in the selected endpoint (reduced IQ). *See ¶¶ 52-53* (discussing the robust body  
7 of evidence establishing the relationship between fluoride and reduced IQ, including studies  
8 observing this relationship at “lower” exposure levels).

9       71. Dr. Grandjean rests his BMCL analysis upon studies observing the ELEMENT, MIREC,  
10 and OCC cohorts. Grandjean (2023) at 1-2. These high-quality studies are appropriate for use in  
11 BMD modeling, particularly because they include data regarding dose-response at “lower”  
12 exposure levels, *i.e.*, 0.9 mg/L (mean maternal urinary fluoride in ELEMENT cohort), 0.42 mg/L  
13 (mean maternal urinary fluoride in MIREC cohort), and 0.58 mg/L (average maternal urinary  
14 fluoride in the OCC cohort). *See ¶¶ 42-44*. Thus, rather than observing only a response at high  
15 dosages, the data set utilized by Dr. Grandjean observes dose-response at low exposure levels.  
16 The data set are thus appropriate for BMD modeling. To this end, RSI found that the MIREC and  
17 ELEMENT cohorts represent a “high quality of evidence partly based on Canadian population,  
18 conducted within a context relevant to Canadian drinking water fluoride exposure levels.<sup>[20]</sup> Both  
19 studies included prospective data collection, with prenatal exposure assessment (maternal urine  
20 collection over successive trimesters) and follow-up during the early life of the infants and  
21 children.” Dkt. No. 433-4, Trial Ex. 129 at 23. And the ELEMENT and MIREC cohort studies  
22

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23       Now, moving beyond semantics, I wanted to ask you about your testimony about benchmark dose,  
24 okay? You made comments in your testimony about Dr. Grand[j]ean's BMCL analysis, correct?  
25 A. Yes, I did. Q. You based your comments on EPA's BMD guidance technical  
26 manual, correct? A. Yes, I did.”). The Court thus considers this technical guidance document.

27       <sup>20</sup> The United States and Canada take a similar approach to water fluoridation; this finding is  
28 applicable to United States drinking water fluoride exposure levels. *See* Tr. Ex. 129, Dkt. No.  
433-4 at 16 (describing optimal water fluoride levels in Canada of 0.7 mg/L). *See also* Dkt. No.  
396, Feb. 1, 2024 Trial Tr. at 245:1-22 (Lanphear) (describing optimal 0.7 mg/L water fluoride  
standard in Canada).

1 are strong for their extensive control for covariates and individualized measurements of fluoride  
2 exposure during the prenatal period. Dkt. No. 395, Jan. 31, 2024, Trial Tr. at 95:2-96:5 (Hu).

3       72. The model fits of the data utilized by Grandjean's BMCL are also adequately supported.  
4 On this point, the EPA takes issue with the fact that Dr. Grandjean's BMCL of 0.28 mg/L was  
5 derived by applying a linear model of the dose-response curve.<sup>21</sup> Grandjean (2023) at 1-2, 9. To  
6 discern the best model fit for a set of data, a model is used to find a fit to the data, and based upon  
7 that fit, an "AIC" score is generated; the lower the AIC score, the better the model fit. Dkt. No.  
8 417, Feb. 2, 2024, Trial Tr. at 421:20-21 (Grandjean). To EPA's point, Grandjean (2023) did not  
9 include a published table illustrating the AIC scores for all model fits, but did so only for the linear  
10 model and piece-wise model, though not the squared model. *See* Grandjean (2023) at 9 (Table  
11 S3). The government thus argued at trial that Dr. Grandjean improperly assumed, without testing  
12 the assumption, that the linear model was appropriate for the data set evaluated. However, the use  
13 of the linear model in Grandjean (2023) to generate the BMCL is sufficiently justified:

14                   i.       Dr. Grandjean testified, and the Court finds this testimony credible,  
15 that he did not assume that the linear model was the best fit, but rather that he and his co-authors  
16 compared various models and determined that the linear model was the preferred model for the  
17 data. Dkt. No. 396, Feb. 1, 2024, Trial Tr. at 333:6-19 (Grandjean). Dr. Grandjean did state that  
18 "[i]n my communications with the EPA, I was told that the default curve function was the linear  
19 one." *Id.* at 333:8-9. However, Dr. Grandjean clarified that this default was only a starting point  
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22 <sup>21</sup> When a curve is linear, generally the dose and effect increase or decrease in a somewhat  
23 uniform fashion, *i.e.*, when the dose increases, the effect increases; when the dose decreases, the  
24 effect decreases. *See* EPA's Benchmark Dose Technical Guidance at 25-26, 77-78 (describing  
25 linear, quadratic, and other models), 71 (defining "Linear Dose-Response Model" as "[a]  
26 mathematical relationship in which a change in response is proportional to a fixed amount of  
27 change in dose, e.g., Response = a + b × Dose. This is in distinction from a more general linear  
28 mathematical model, which is a linear combination of parameters"). The shape of the dose-  
response curve is relevant, particularly because it is used to extrapolate to lower levels of exposure  
not observed in the study, and thus to calculate the BMCL. *See id.* at 5 ("The dose response  
assessment under the guidelines is a two-step process: (1) response data are modeled in the range  
of empirical observation — modeling in the observed range is done with biologically based or  
curve-fitting models; and then (2) extrapolation below the range of observation is accomplished by  
modeling, if there are sufficient data, or by a default procedure (linear, nonlinear, or both.")."). The  
model will thus determine the BMCL identified. *See id.* at 5, 25-26, 77-78.

1 and that “what we’ve done in our work is to compare that to some variations and the statistical  
 2 methods so that you can actually compare the fit if, let’s say, curvilinear or a broken line fits  
 3 better. And in our case the linear was actually – was the best fit.” *Id.* at 333:10-14. And further,  
 4 Dr. Grandjean testified that he also used “nonlinear methods to assess whether the dose-response  
 5 relationship is linear,” *id.* at 333:15-19. *See also id.* at 339:24-340:7 (“We started out with EPA’s  
 6 default recommendation, namely that linear association. But we then also looked at a curvilinear,  
 7 for example, log 2 transformation of exposure. We also looked at broken lines of – and overall the  
 8 linear association was not inferior to anything. It was sometimes clearly superior.”); Dkt. No. 417,  
 9 Feb. 2, 2024, Trial Tr. at 440:23-419:1 (Grandjean) (“[W]e certainly did look at other models.”).  
 10 Dr. Grandjean and his co-authors did not simply assume that the linear model was the best fit for  
 11 the data. It was chosen through an analytical process.

12 ii. Moreover, Grandjean (2022) includes a table that reports the AIC  
 13 scores for squared models as they fit to data from the MIREC and ELEMENT cohorts and reveals  
 14 comparable fit scores and supports Dr. Grandjean’s testimony as to the validity of the linear model  
 15 fit:

Table 2.

16 Benchmark Concentration Results (mg/L Urinary Fluoride, Creatinine-Adjusted) for a BMR of 1 IQ Point Obtained from the MIREC Study and the Two  
 17 Cognitive Assessments from the ELEMENT Study as Well as the Joint Results. Two Concentration-Response Models are used, A Linear and One with the  
 18 Squared Exposure Variable. For both Models, Sex-Specific and joint benchmark Results are Provided. The fit of the Regression models was Compared by  
 the AIC (Where Lower Values Indicate a Better Fit)

Study	MIREC (n = 407)		ELEMENT IQ (n = 211)		ELEMENT GCI (n = 287)		MIREC and ELEMENT IQ (n = 618)		MIREC and ELEMENT GCI (n = 694)				
	Model	Sex	BMC	BMCL	BMC	BMCL	BMC	BMCL	AIC	BMC	BMCL	AIC	
Linear	Both	0.497	0.228	0.200	0.122	0.159	0.099	0.326	0.201	4770.1	0.312	0.192	5491.3
Linear	Boys	0.201	0.125	0.275	0.130	0.148	0.084	0.222	0.144	4766.7	0.184	0.125	5488.4
Linear	Girls	∞	0.609	0.160	0.091	0.169	0.087	1.098	0.275	4766.7	2.972	0.315	5488.4
Squared	Both	1.545	0.896	0.614	0.496	0.611	0.467	1.008	0.768	4768.8	1.133	0.807	5493.9
Squared	Boys	0.840	0.622	0.684	0.496	0.581	0.435	0.787	0.619	4769.4	0.761	0.601	5493.7
Squared	Girls	∞	1.262	0.576	0.449	0.642	0.434	1.637	0.866	4769.4	∞	1.040	5493.7

19 Abbreviations: AIC, Akaike Information Criterion; BMC, benchmark concentration; BMCL, benchmark concentration level; BMR, benchmark response; GCI, Global Cognitive Index; IQ, Intelligence Quotient.

20 Grandjean (2022) at 17 (Table 2) (red annotation added). The AIC scores for the linear and  
 21 squared models were comparable, with the best fit for boys and girls individually, measuring IQ,  
 22 using a linear model (AIC 4766.7 linear compared to 4769.4 squared), and squared combined  
 23 (AIC 4768.8 squared compared to 4770.1 linear). *See id.* For GCI (the General Cognitive Index  
 24

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1 score), the linear model was a better fit than the squared model for all categories. *See id.* Even if  
2 not definitive, the comparable AIC fits for linear and squared models reflected in Grandjean  
3 (2022) support that the linear model is a justifiable model to apply to the MIREC and ELEMENT  
4 cohort data.

Exposure Analysis	Parameters	Fluoride Exposure			
		All data	<4 mg/L	<2 mg/L	<1.5 mg/L
Urinary Fluoride – All Studies					
No. Studies/No. Observations		18/32	13/26	7/11	5/8
Number of Children		8,502	6,885	4,654	3,992
Linear Model <sup>b</sup>	Beta (95% CI)	-0.16 (-0.24, -0.08)	-0.17 (-0.30, -0.05)	-0.06 (-0.14, 0.01)	-0.09 (-0.16, -0.01)
	p-value	p < 0.001	p = 0.005	p = 0.094	p = 0.026
	AIC	AIC = 73.8	AIC = 68.0	AIC = 1.2	AIC = 2.8
Quadratic Model <sup>c</sup>	Beta (95% CI); p-value	-0.10 (-0.31, 0.11); p = 0.360	0.07 (-0.23, 0.38); p = 0.645	-0.22 (-0.65, 0.20); p = 0.303	0.65 (-1.46, 2.76); p = 0.548
	Beta (95% CI); p-value	-0.01 (-0.05, 0.02); p = 0.496	-0.07 (-0.16, 0.01); p = 0.071	0.08 (-0.13, 0.30); p = 0.456	-0.66 (-2.11, 0.80); p = 0.379
	AIC	AIC = 84.3	AIC = 75.8	AIC = 9.2	AIC = 8.3
	p-value*	p* = 0.14	p* = 0.08	p* = 0.42	p* = 0.10
Restricted Cubic Splines Model <sup>d</sup>	Beta (95% CI); p-value	-0.12 (-0.28, 0.04); p = 0.150	-0.03 (-0.22, 0.16); p = 0.741	-0.14 (-0.32, 0.04); p = 0.130	-0.52 (-1.65, 0.62); p = 0.371
	Beta (95% CI); p-value	-0.10 (-0.43, 0.23); p = 0.545	-0.24 (-0.47, -0.002); p = 0.048	0.13 (-0.17, 0.43); p = 0.395	0.63 (-1.32, 2.59); p = 0.524
	AIC	AIC = 79.6	AIC = 73.3	AIC = 8.5	AIC = 6.7
	p-value*	p* = 0.13	p* = 0.07	p* = 0.37	p* = 0.07

19 *Id.* Using urinary fluoride as the exposure metric, the linear model reflected the lowest AIC score  
20 unilaterally. *See id.* And although the linear model did not generate a statistically significant  
21 inverse association at all exposure levels, the linear model generated a statistically significant  
22 inverse association at <1.5 mg/L (in line with Grandjean (2023)'s finding relating to lower-  
23 exposure levels as noted above), and the findings remained directionally negative at all levels  
24 which also supports Grandjean (2023)'s use of the linear model. *See* Dkt. No. 395, Jan. 31, 2024,  
25 Trial Tr. at 115:16-25 (Hu) ("In fact, epidemiology is moving away from a simple reliance on just  
26 P values and saying 'this is significant, this is not significant.' It's really important to also look at  
27 the so-called directionality of the relationships."). Additionally, as explained in more detail  
28 below, some of the loss of association observed in the NTP Meta-analysis may be explained by the

1 use of the means effect method in the Meta-analysis, which results in loss of statistical power and  
2 sensitivity in the data. *See ¶ 74(b).* Ultimately, the authors of the NTP Meta-analysis concluded  
3 that “[b]ased on the AIC and likelihood ratio tests, the best model fit was achieved when quadratic  
4 or restricted cubic spline exposure levels were added to the linear models for drinking water  
5 (eFigure 17); ***the linear model was the best fit for urinary fluoride*** (eFigure 18).” NTP Meta-  
6 analysis at 10 (emphasis added). This further bolsters the legitimacy of Grandjean (2023)’s use of  
7 a linear model to generate the BMCL, expressed in maternal urinary fluoride.

8 73. Assuming, in the alternative, that the squared model is a more appropriate fit for this data  
9 set, as EPA suggested at trial, a BMCL of 0.768 mg/L and/or 1.536 mg/L is appropriately used to  
10 conduct the risk assessment. Though Grandjean (2023) did not identify a BMCL using the squared  
11 model, Dr. Grandjean’s 2022 BMCL analysis did identify a BMCL of 0.768 mg/L utilizing a  
12 squared model. Grandjean (2022) at 17 (Table 2); Dkt. No. 417, Feb. 2, 2024, Trial Tr. at  
13 423:12-21 (Grandjean). It is true that this BMCL is derived from the ELEMENT and MIREC  
14 cohort data only and excludes data from the OCC Cohort. This is relevant because inclusion of  
15 the OCC Cohort data is likely to increase the BMCL; when the OCC cohort data was added to the  
16 BMCL analysis in Grandjean (2023), the BMCL increased by 0.08 mg/L, or forty percent<sup>22</sup> (from  
17 0.20 mg/L (MIREC and ELEMENT alone) to 0.28 mg/L (MIREC, ELEMENT and OCC cohort  
18 data)). *See* Grandjean (2023) at 3 (“The joint BMC was found to be 0.45 mg/l (BMCL, 0.28 mg/l),  
19 *i.e.* slightly higher than previously found (BMC, 0.33 mg/l; BMCL, 0.20 mg/L) for the two North  
20 American cohorts alone.”). But a preponderance of the evidence indicates the inclusion of the  
21 OCC Cohort data would not make a material difference. To be highly conservative, the BMCL of  
22 0.768 mg/L can be *doubled*, to account for any discrepancy caused by the omission of the OCC  
23 data: 1.536 mg/L (0.768 mg/L times two). This could be used conservatively as an alternative  
24 point of departure implied from the data if the squared model is used. As discussed below, even  
25 using this higher point of departure, the ultimate finding of an unreasonable risk would not change.

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28 <sup>22</sup> ((.08 / .20) \* 100).

1       74. One additional concern with Dr. Grandjean's BMCL calculation is that it, at first glance,  
2 appears to be in tension with the NTP Monograph's conclusion that “[m]ore studies are needed to  
3 fully understand the potential for lower fluoride exposure [i.e., below 1.5 mg/L] to affect  
4 children's IQ.” NTP Monograph at xiii.<sup>23</sup> However, this ultimately does not undermine the  
5 validity of the BMCL identified in Grandjean (2023) for the following reasons:

6           a. Though the authors of the NTP Monograph recognized some lack of clarity in the  
7 precise relationship between fluoride and reduced IQ at lower exposure levels, NTP Monograph at  
8 xiii, given the strength of the association between fluoride and reduced IQ, the authors of the NTP  
9 Monograph refused to limit the applicability of its findings in the systematic review to higher  
10 exposure levels and made clear that its confidence assessment also considered fluoride exposures  
11 “that are similar to, or lower than, those associated with optimally fluoridated water supplies in the  
12 United States,” *i.e.*, 0.7 mg/L. Dkt. No. 438-1, Trial Ex. 69 at 24-25 (comments and responses  
13 from NTP Monograph authors and evaluators of the NTP Monograph).

14           b. The NTP also conducted a Meta-analysis, integrating all of the studies assessed in  
15 the NTP Monograph to analyze the dose-response relationship between fluoride and reduced IQ.  
16 The findings of the NTP Meta-analysis first appear to be in tension with Dr. Grandjean's findings  
17 but are, in fact, consistent with those findings because of the methodologies used. Namely, the  
18 NTP Meta-analysis concluded that “the consistency of the data supports an inverse association  
19 between fluoride exposure and children's IQ.” NTP Meta-analysis at 3. However, the Meta-  
20 analysis reported somewhat mixed results regarding the dose-response relationship, particularly at

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<sup>23</sup> Regarding “lower” fluoride exposure levels – both Grandjean (2023) and the NTP Monograph analyzed data from the ELEMENT and MIREC cohorts though Grandjean (2023) also analyzed data from the OCC Cohort, another lower-exposure level study.

1 lower levels of fluoride exposure:

Exposure Analysis	Parameters	Fluoride Exposure			
		All data	<4 mg/L	<2 mg/L	
Linear model	Beta (95% CI) p-value AIC	-0.15 (-0.23, -0.07) p < 0.001 AIC = 74.5	-0.16 (-0.28, -0.04) p = 0.011 AIC = 68.6	-0.05 (-0.14, 0.04) p = 0.259 AIC = 1.3	-0.08 (-0.16, -0.01) p = 0.036 AIC = 3.0
<b>Urinary Fluoride – Low Risk-of-bias Studies</b>					
No. Studies/No. Observations		9/15	9/15	5/8	
Number of Children		5,713	5,713	4,141	
Linear model	Beta (95% CI) p-value AIC	-0.10 (-0.21, 0.01) p = 0.082 AIC = 5.9	-0.10 (-0.21, -0.01) p = 0.082 AIC = 5.9	-0.05 (-0.17, 0.08) p = 0.472 AIC = 2.8	-0.08 (-0.16, -0.01) p = 0.028 AIC = 2.5

7 *Id.* at 41 (eTable 4) (red annotation added). In reviewing all studies and measuring exposure of  
8 fluoride per urinary fluoride the NTP Meta-analysis found a statistically significant inverse  
9 association between children's urinary fluoride exposure and IQ at <4 mg/L urinary fluoride. *Id.*  
10 When restricted to <2 mg/L and <1.5 mg/L urinary fluoride, there was still an inverse association.  
11 *Id.* This finding is consistent with Grandjean (2023). However, when analyses were restricted to  
12 low risk-of-bias publications, the associations at <2 mg/L and <1.5 mg/L became smaller in  
13 magnitude and were only statistically significant at <1.5 mg/L, but not at <2 mg/L. *Id.* That  
14 finding of an adverse association at <1.5 mg/L is consistent with the conclusion in Dr. Grandjean's  
15 pooled benchmark dose analysis (though appearing somewhat anomalous compared to the finding  
16 at <2 mg/L). Dr. Grandjean's pooled benchmark analysis uses a method with more statistical  
17 precision than the NTP Meta-analysis, and thus could account for the more specific findings as to  
18 the relationship between fluoride and IQ at lower exposure levels. Specifically, the NTP Meta-  
19 analysis used a "means effect analysis," which is useful for its ability to compare different types of  
20 studies with varied methodologies and metrics (72 total and 19 low-risk-of-bias studies) – but it  
21 loses sophistication and precision in the underlying data of each study when it converts the  
22 findings into standard, comparable metrics. Dkt. No. 417, Feb. 2, 2024, Trial Tr. at 469:3-471:6  
23 (Grandjean). Specifically, so that different studies using different exposures or result metrics  
24 could be compared, the data was grouped into buckets (e.g., high exposure, low exposure) and  
25 analyzed. *Id.* at 471:6-15. Accordingly, each of the underlying studies lose some of its statistical  
26 power when data is simplified to allow for cross-study, like-to-like comparison. *See id.* at 471:6-  
27 473:24. On the other hand, the pooled benchmark analysis maintains individualized, continuous  
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1 data and does not simplify that data for meta-analysis comparison; the benchmark analysis  
2 maintains increased sophistication and statistical sensitivity. *Id.* at 473:18-24. Thus, the findings  
3 of the NTP Meta-analysis are not inconsistent with Dr. Grandjean's pooled benchmark analysis.

4 75. Ultimately, TSCA does not require complete certainty as to the threshold level at which a  
5 chemical produces the hazard; indeed, such certainty is very difficult to obtain from epidemiologic  
6 studies of human populations. Dkt. No. 440, Feb. 13, 2024, Trial Tr. at 1440:18-23 (Barone); Dkt.  
7 No. 414, Feb. 9, 2024, Trial Tr. at 1173:7-13 (Savitz). Either BMCL of 0.28 mg/L (linear model  
8 per the MIREC, ELEMENT, and OCC cohort data) or 0.768 mg/L (squared model per the MIREC  
9 and ELEMENT cohort data) identified by Dr. Grandjean and his co-authors are legitimate points  
10 of departure to utilize in a risk analysis. So is the implied BMCL of 1.536 mg/L (were the OCC  
11 study taken into account). The Court finds, though not with absolute certainty, Dr. Grandjean's  
12 BMCLs are supported by a preponderance of the evidence.<sup>24</sup>

13 (b) POD: 4 mg/L urinary or water fluoride (LOAEL)

14 76. As described previously, use of the BMD approach is preferred in identifying a point of  
15 departure because of limitations of a NOAEL or LOAEL, but where data is not amenable to  
16 benchmark dose modeling, a NOAEL or LOAEL may be utilized instead. *See ¶¶ 57-59.* The  
17 Court thus examines this alternative approach to establishing a point of departure.

18 77. Again, notwithstanding the limitations of the NOAEL/LOAEL approach, this approach is  
19 properly used, and has been used by the EPA, with the application of uncertainty factors, to  
20 determine the point of departure where datasets are, for various reasons, not amenable to BMD  
21 modeling. *See* Dkt. No. 429-20, Trial Ex. 38 at 4. For example, the EPA conducted a risk  
22 evaluation of Perchloroethylene ("PCE"), pursuant to Amended TSCA, and utilized  
23 NOAEL/LOAELs as PODs because it was unable to use BMD modeling. *See* PCE Risk  
24 Evaluation at 351 ("For this risk evaluation, non-cancer PODs were all based on NOAELs and  
25 LOAELs because the data for the selected endpoints was unable to be BMD modeled. This results

26 \_\_\_\_\_  
27 <sup>24</sup> The government also takes issue with the use of maternal urinary fluoride ("MUF") as the  
28 metric of the exposure or hazard level utilized in the risk assessment analysis. The validity of  
maternal urinary fluoride as a metric is taken up subsequently in Section III.B (Exposure  
Assessment).

1 in reduced precision in POD estimates because the POD is dependent on the dose selection of the  
2 study as opposed to the response rate/level for the effect of interest.”); Dkt. No. 401, Feb. 6, 2024,  
3 Trial Tr. at 772:3-11 (Thiessen).

4 78. To the extent that the BMD approach is not appropriate based upon the present data set, in  
5 the alternative, 4.0 mg/L (using exposure measurement of water fluoride intake) is a legitimate and  
6 highly conservative LOAEL to utilize as a point of departure to conduct a risk assessment of  
7 fluoride per the findings of the NTP Meta-analysis. Utilizing 4.0 mg/L as the LOAEL is  
8 especially conservative in view of the NTP Monograph’s conclusion with moderate confidence  
9 that exposure to fluoride concentration in drinking water at or above 1.5 mg/L is associated with  
10 lower IQ in children. One could reasonably take 1.5 mg/L as a LOAEL. Nonetheless, the Court  
11 uses the more conservative 4.0 mg/L based on a close analysis of the NTP Meta-analysis which  
12 establishes with consistency an association with reduced IQ at that level. Specifically, the NTP  
13 Meta-analysis observed a statistically significant inverse association between fluoride and reduced  
14 IQ at 4 mg/L measured in water fluoride, based on low-risk-of-bias/high quality studies (*i.e.*, 6  
15 epidemiological studies deemed high quality), which is reflected in the below table from the Meta-

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1 analysis summarizing the NTP's dose-response analysis:<sup>25</sup>

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3 **eTable 4. Dose-Response Meta-analysis Using Mean Effects—Model Selection<sup>a</sup>**

Exposure Analysis		Parameters	Fluoride Exposure			
			All data	<4 mg/L	<2 mg/L	
<b>Water Fluoride – All Studies</b>						
No. Studies	No. Observations		29 (39)	21 (27)	7 (9)	
Number of Children			11,656	8,723	2,971	
Linear Model <sup>b</sup>	Beta (95% CI) p-value AIC		-0.15 (-0.20, -0.11) p < 0.001 AIC = 53.8	-0.22 (-0.27, -0.17) p < 0.001 AIC = 16.1	-0.15 (-0.41, 0.12) p = 0.274 AIC = 11.8	
Quadratic Model <sup>c</sup>	Beta (95% CI); p-value Beta (95% CI); p-value AIC p-value*		-0.27 (-0.34, -0.21); p < 0.001 0.02 (0.01, 0.03); p < 0.001 AIC = 48.8 p* < 0.001	-0.12 (-0.35, 0.11); p = 0.318 -0.04 (-0.10, 0.03); p = 0.280 AIC = 21.2 p* = 0.012	0.79 (-0.01, 1.58); p = 0.052 -0.56 (-0.97, -0.16); p = 0.006 AIC = 12.5 p* = 0.007	
Restricted Cubic Splines Model <sup>d</sup>	Beta (95% CI); p-value Beta (95% CI); p-value AIC p-value*		-0.29 (-0.39, -0.20); p < 0.001 0.48 (0.18, 0.78); p = 0.002 AIC = 42.3 p* < 0.001	-0.14 (-0.34, 0.06); p = 0.162 -0.23 (-0.66, 0.20); p = 0.295 AIC = 16.9 p* = 0.009	1.15 (0.07, 2.22) p = 0.037 -1.20 (-2.03, -0.36) p = 0.005 AIC = 10.5 p* = 0.010	
<b>Water Fluoride – Low Risk-of-bias Studies</b>						
No. Studies	No. Observations		6/11	6/9	3/4	
Number of Children			4,355	4,251	921	
Linear model	Beta (95% CI) p-value AIC		-0.19 (-0.34, -0.05) p = 0.009 AIC = 10.3	-0.22 (-0.36, -0.07) p = 0.003 AIC = 3.9	-0.34 (-0.72, 0.03) p = 0.070 AIC = 4.5	

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14 Dkt. No. 431-2, Trial Ex. 68 at 39 (eTable4) (red annotation added). That value was derived from  
 15 a linear model which, for this group of studies, had the lowest AIC score. *See id.* (identifying AIC  
 16 of 16.1 (linear for all studies), 21.1 (quadratic for all studies), 16.9 (restricted cubic splines for all  
 17 studies)).

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<sup>25</sup> Note that where values in the parenthesis, which represent the confidence interval, are below zero, the finding is statistically significant. *See* Dkt. No. 417, Feb. 2, 2024, Trial Tr. at 394:2-14 (Grandjean).

1           79. Further, the NTP Meta-analysis observed an association between fluoride and  
 2 reduced IQ at <4 mg/L measured in urinary fluoride, based on low-risk-of-bias/high-quality  
 3 studies (9 epidemiological studies deemed high quality):

Exposure Analysis	Parameters	Fluoride Exposure			
		All data	<4 mg/L	<2 mg/L	
<b>Urinary Fluoride – All Studies</b>					
No. Studies/No. Observations		18/32	13/26	7/11	
Number of Children		8,502	6,885	4,654	
Linear Model <sup>b</sup>	Beta (95% CI) p-value AIC	−0.16 (−0.24, −0.08) p < 0.001 AIC = 73.8	−0.17 (−0.30, −0.05) p = 0.005 AIC = 68.0	−0.06 (−0.14, 0.01) p = 0.094 AIC = 1.2	−0.09 (−0.16, −0.01) p = 0.026 AIC = 2.8
Quadratic Model <sup>c</sup>	Beta (95% CI); p-value Beta (95% CI); p-value AIC p-value*	−0.10 (−0.31, 0.11); p = 0.360 −0.01 (−0.05, 0.02); p = 0.496 AIC = 84.3 p* = 0.14	0.07 (−0.23, 0.38); p = 0.645 −0.07 (−0.16, 0.01); p = 0.071 AIC = 75.8 p* = 0.08	−0.22 (−0.65, 0.20); p = 0.303 0.08 (−0.13, 0.30); p = 0.456 AIC = 9.2 p* = 0.42	0.65 (−1.46, 2.76); p = 0.548 −0.66 (−2.11, 0.80); p = 0.379 AIC = 8.3 p* = 0.10
Restricted Cubic Splines Model <sup>d</sup>	Beta (95% CI); p-value Beta (95% CI); p-value AIC p-value*	−0.12 (−0.28, 0.04); p = 0.150 −0.10 (−0.43, 0.23); p = 0.545 AIC = 79.6 p* = 0.13	−0.03 (−0.22, 0.16); p = 0.741 −0.24 (−0.47, −0.002); p = 0.048 AIC = 73.3 p* = 0.07	−0.14 (−0.32, 0.04); p = 0.130 0.13 (−0.17, 0.43); p = 0.395 AIC = 8.5 p* = 0.37	−0.52 (−1.65, 0.62); p = 0.371 0.63 (−1.32, 2.59); p = 0.524 AIC = 6.7 p* = 0.07
<b>Urinary Fluoride – Sensitivity analysis including Ibarluzea et al. (2021)<sup>87</sup> Bayley MDI scores</b>					
No. Studies/No. Observations		19/33	14/27	8/12	
Number of Children		8,815	7,445	4,967	
Linear model	Beta (95% CI) p-value AIC	−0.15 (−0.23, −0.07) p < 0.001 AIC = 75.0	−0.15 (−0.28, −0.03) p = 0.015 AIC = 69.0	−0.04 (−0.14, 0.05) p = 0.371 AIC = 1.7	
<b>Urinary Fluoride – Sensitivity analysis including Ibarluzea et al. (2021)<sup>87</sup> McCarthy GCI scores</b>					
No. Studies/No. Observations		19/33	14/27	8/12	
Number of Children		8,749	7,445	4,901	
<b>Fluoride Exposure</b>					
Exposure Analysis	Parameters	Fluoride Exposure			
		All data	<4 mg/L	<2 mg/L	
Linear model	Beta (95% CI) p-value AIC	−0.15 (−0.23, −0.07) p < 0.001 AIC = 74.5	−0.16 (−0.28, −0.04) p = 0.011 AIC = 68.6	−0.05 (−0.14, 0.04) p = 0.259 AIC = 1.3	−0.08 (−0.16, −0.01) p = 0.036 AIC = 3.0
<b>Urinary Fluoride – Low Risk-of-bias Studies</b>					
No. Studies/No. Observations		9/15	9/15	5/8	
Number of Children		5,713	5,713	4,141	
Linear model	Beta (95% CI) p-value AIC	−0.10 (−0.21, 0.01) p = 0.082 AIC = 5.9	−0.10 (−0.21, −0.01) p = 0.082 AIC = 5.9	−0.05 (−0.17, 0.08) p = 0.472 AIC = 2.8	−0.08 (−0.16, −0.01) p = 0.028 AIC = 2.5

21           Dkt. No. 431-2, Trial Ex. 68 at 39 (eTable 4) (red annotation added). That value was also derived  
 22 from a linear model which, for this group of studies, likewise had the lowest AIC score. *See id.*  
 23 (identifying 68 (linear for all studies), 75.8 (quadratic for all studies), 73.3 (restricted cubic splines  
 24 for all studies)).

25           80. Even if there may be some uncertainty about the dose-response relationship below that  
 26 exposure level (4 mg/L), significant data supports that there is an adverse effect *at or above the*  
 27 *specified level*. *See* Dkt. No. 415, Feb. 12, 2024, Trial Tr. at 1373:1-9 (Barone) (testimony from  
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1 Dr. Barone agreeing that at 4 mg/L of fluoride exposure and above there is relatively more data to  
2 support a finding of an adverse effect associated with fluoride.), 1428:4-11 (Barone) (“I agree with  
3 the NTP’s conclusions that at some level above 1.5 that there is moderate evidence to support an  
4 association between fluoride and developmental IQ decrements.”). Again, TSCA does not require  
5 absolute certainty as to the threshold level at which a chemical produces the hazard, and indeed as  
6 noted above such certainty is very difficult to obtain from epidemiologic studies of human  
7 populations. Dkt. No. 440, Feb. 13, 2024, Trial Tr. at 1440:18-23 (Barone); Dkt. No. 414, Feb. 9,  
8 2024, Trial Tr. at 1173:7-13 (Savitz). In view of the record evidence, 4 mg/L as the lowest-  
9 observed-effect-level would be a conservative point of departure to utilize in the analysis; it is  
10 certainly well-supported by scientific evidence as described in the conclusion of the NTP  
11 Monograph: “the high-quality studies (*i.e.*, studies with low potential for bias) consistently  
12 demonstrate lower IQ scores with higher fluoride exposure [*e.g.*, represented by populations  
13 whose total fluoride exposure approximates or exceeds the WHO Guidelines for Drinking-water  
14 Quality of 1.5 mg/L of fluoride (WHO 2017)].” NTP Monograph at 47.

15 81. The EPA has identified a LOAEL based upon far less evidence than that in the record  
16 before this Court. In the EPA’s risk evaluation of Methylene, conducted pursuant to Amended  
17 TSCA, it used a LOAEL for developmental neurotoxicity, derived from the analysis of ***one study***  
18 ***conducted upon mouse pups*** (Fredriksson et al., 1992). *See* Methylene Risk Evaluation at 262.  
19 Here, there are between six and nine<sup>26</sup> high-quality, epidemiological studies of human populations  
20 underlying the point of departure. Dkt. No. 431-2, Trial Ex. 68 at 39, 41 (eTable 4).

21 82. To restate, in conclusion, either the LOAEL of 4.0 mg/L, measured either in urinary  
22 fluoride or water fluoride, or the BMCL of 0.28 mg/L, 0.768 mg/L, or even 1.536 mg/L measured  
23 in maternal urinary fluoride, is a well-supported point of departure to utilize in the risk evaluation.  
24 Each of these measures of the point of departure is supported by a preponderance of high-quality  
25 evidence.

26 Six studies measuring fluoride exposure by way of water fluoride and nine studies measuring  
27 urinary fluoride. Dkt. No. 431-2, Trial Ex. 68 at 39, 41 (eTable 4).

1 B. Step 2: Exposure Assessment2 a. Framework

3 83. At this step, the EPA conducts an exposure assessment to identify the exposure level under  
4 the conditions of use for the chemical at issue. Dkt. No. 400, Feb. 5, 2024, Trial Tr. at 567:18-  
5 568:2 (Barone); 15 U.S.C. § 2605(b)(4)(F)(iv) (“In conducting a risk evaluation under this  
6 subsection, the Administrator shall . . . take into account, where relevant, the likely duration,  
7 intensity, frequency, and number of exposures under the conditions of use of the chemical  
8 substance.”). Namely, the EPA identifies sources of exposure to the chemical (e.g., food or  
9 water), estimates what the intake level of exposure is, and endeavors to understand and  
10 characterize the population that is exposed. Dkt. No. 401, Feb. 6, 2024, Trial Tr. at 694:4-695:11  
11 (Barone).

12 84. To understand the level of exposure, the EPA estimates a range of exposure levels for a  
13 condition of use from the central tendency exposure (e.g., 50th percentile) to high-end exposure  
14 (e.g., 95th percentile). Dkt. No. 400, Feb. 5, 2024, Trial Tr. at 649:1-650:10 (Barone), 697:15-  
15 698:6 (Barone); *see also* EPA Guidelines at 64 (describing consideration of upper percentile  
16 exposure and highest-exposed individuals in risk assessment).

17 85. As discussed in depth in the next section (Section III.C), the exposure level is important  
18 because it is used to calculate whether the chemical presents a risk to humans. Specifically, in the  
19 next step of the analysis (risk characterization), the exposure level is compared to the point of  
20 departure to determine if a risk is present. *See* Dkt. No. 401, Feb. 6, 2024, Trial Tr. (Barone) at  
21 705:7-706:21. At that step, the EPA determines the appropriate margin that needs to exist from  
22 the point of departure (*i.e.*, point at which the chemical becomes hazardous). *See id.* This is the  
23 benchmark Margin of Exposure (“MOE”). *See id.* The benchmark MOE is calculated by  
24 multiplying the point of departure by Uncertainty Factors (“UFs”) to account for assumptions or  
25 uncertainty in the data. *See id.* The benchmark MOE is then compared to the actual MOE, *i.e.*,  
26 the existing margin between the exposure level and the point of departure, to determine if that  
27 margin is sufficient. *See id.*

2       86. For reasons discussed below, **maternal urinary fluoride** is an appropriate metric to use in  
3       conducting the risk evaluation of fluoride under the condition of use, *i.e.*, community water  
4       fluoridation at 0.7 mg/L.

5       87. Pregnant mothers in fluoridated communities in the United States have a median exposure  
6       level to fluoride of **0.8 mg/L**, measured in **maternal urinary fluoride**; at the 95th percentile,<sup>27</sup>  
7       pregnant mothers have an exposure level to fluoride of **1.89 mg/L**, measured in **maternal urinary**  
8       **fluoride**. Approximately half of these maternal urinary fluoride levels is attributed to community  
9       water fluoridation.

10        88. Alternatively, the exposure levels of **0.7 mg/L**, or **0.56 mg/L** measured in **water fluoride**,  
11        is an appropriate exposure level to use in this risk evaluation.

## 12 || c. Underlying findings

13        89. Two studies are highly probative in assessing exposure levels in this risk evaluation: Till  
14        (2018), and Malin (2023). To summarize these studies:

15 a. Till (2018) studied samples collected from the MIREC Cohort (1,566 pregnant  
16 women in Canada) to assess the relationship between maternal urinary fluoride in pregnant women  
17 and water fluoride concentrations and concluded that “[c]ommunity water fluoridation is a major  
18 source of fluoride exposure” for the pregnant women studied. Dkt. No. 432-4, Trial Ex. 108 at 1.  
19 Specifically, the study observed that the mean urinary fluoride values were almost two times  
20 higher for pregnant women living in fluoridated regions compared to non-fluoridated regions, and  
21 “significantly lower” for women living in non-fluoridated regions. *Id.* at 6. The median  
22 concentration of fluoride in drinking water in Canada was 0.56 mg/L in fluoridated areas. *Id.* at 8  
23 (Table 2). Given that the United States fluoridates its water levels at an optimal 0.7 mg/L (higher  
24 than the median in Till (2018)), the urinary fluoride levels in this sample are lower, if anything,  
25 relative to the condition of use at issue (fluoridation at 0.7 mg/L). The findings of Till (2018),

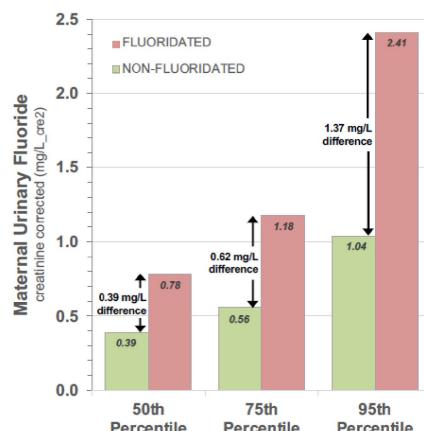
<sup>27</sup> The 95th percentile reflects individuals that have exposure levels greater than 95 percent of the population. *See Dkt. No. 108 at 6.* The median, on the other hand, reflects individuals at the mid-point of exposure. *See id.*

1 comparing the maternal urinary fluoride levels of pregnant women in fluoridated compared to  
 2 non-fluoridated reasons are exemplified in the below tables, summarizing the key results of this  
 3 study:

4 **Table S4** Fluoride concentrations in the urine of pregnant women from the MIREC cohort living in fluoridated versus  
 5 non-fluoridated communities.

	Trimester	N	Arith Mean	Arith SD	Geo Mean	Geo SD	Min	5%	25%	50%	75%	95%	Max
<b>NON-FLUORIDATED</b>													
MUF_Unadjusted	1	541	0.24	0.29	0.15	2.65	0.01	0.03	0.08	0.15	0.30	0.69	3.56
	2	509	0.32	0.33	0.23	2.22	0.03	0.06	0.13	0.22	0.38	0.90	3.54
	3	476	0.47	0.39	0.36	2.05	0.04	0.11	0.22	0.36	0.60	1.23	3.77
MUF <sub>SG</sub>	1	541	0.31	0.39	0.20	2.56	0.01	0.04	0.12	0.20	0.35	0.84	4.67
	2	507	0.39	0.32	0.31	1.89	0.04	0.12	0.21	0.29	0.46	0.96	2.44
	3	475	0.48	0.32	0.40	1.78	0.08	0.17	0.28	0.38	0.56	1.09	2.71
MUF <sub>CRE_1</sub>	1	533	0.50	0.50	0.35	2.40	0.01	0.08	0.22	0.37	0.60	1.41	4.5
	2	502	0.58	0.44	0.48	1.85	0.06	0.19	0.31	0.46	0.69	1.47	3.31
	3 <sup>a</sup>	386	0.67	0.47	0.56	1.75	0.12	0.24	0.40	0.54	0.79	1.45	4.61
MUF <sub>CRE_2</sub>	1	534	0.41	0.45	0.29	2.42	0.01	0.06	0.18	0.30	0.49	1.15	4.81
	2	502	0.43	0.32	0.35	1.85	0.04	0.14	0.23	0.34	0.51	1.08	2.43
	3 <sup>a</sup>	386	0.48	0.33	0.40	1.75	0.08	0.17	0.29	0.39	0.56	1.04	3.29
<b>FLUORIDATED</b>													
MUF_Unadjusted	1	762	0.57	0.49	0.40	2.57	0.02	0.06	0.23	0.43	0.79	1.48	3.98
	2	728	0.71	0.53	0.56	2.03	0.04	0.17	0.35	0.56	0.89	1.68	3.77
	3	712	0.82	0.60	0.63	2.04	0.11	0.19	0.39	0.64	1.06	1.99	4.36
MUF <sub>SG</sub>	1	762	0.52	0.46	0.37	2.44	0.01	0.07	0.25	0.4	0.64	1.30	3.84
	2	728	0.71	0.47	0.59	1.84	0.03	0.23	0.40	0.58	0.87	1.63	3.78
	3	711	0.88	0.55	0.74	1.81	0.06	0.27	0.51	0.77	1.08	1.89	3.97
MUF <sub>CRE_1</sub>	1	757	0.83	0.68	0.60	2.44	0.01	0.12	0.39	0.65	1.09	2.19	4.89
	2	723	1.13	0.77	0.93	1.91	0.05	0.32	0.61	0.91	1.42	2.63	4.89
	3 <sup>a</sup>	546	1.30	0.82	1.10	1.86	0.12	0.41	0.72	1.08	1.63	3.10	4.63
MUF <sub>CRE_2</sub>	1	759	0.68	0.58	0.49	2.46	0.01	0.09	0.31	0.53	0.88	1.80	4.61
	2	727	0.85	0.60	0.69	1.92	0.04	0.24	0.45	0.67	1.05	2.00	4.66
	3 <sup>a</sup>	553	0.97	0.68	0.80	1.90	0.09	0.29	0.52	0.78	1.18	2.41	4.78

16 *Id.* at 25 (Table S4) (red annotations added). This data is reflected in the below bar graph,  
 17 illustrating that Till (2018) found that fluoride levels were approximately two times higher in  
 18 fluoridated vs. non-fluoridated areas.<sup>28</sup>



28 Though not in evidence, the Court includes this demonstrative bar graph (presented to the Court

1 b. Malin (2023) studied the maternal urinary fluoride levels of pregnant women in  
2 Los Angeles, California (*i.e.*, samples collected from the Maternal and Developmental Risks from  
3 Environmental and Social Stressors cohort (“MADRES Cohort”)) to discern if those levels of  
4 American women were comparable to levels observed amongst pregnant women in Mexico and  
5 fluoridated communities in Canada. Dkt. No. 432-18, Trial Ex. 122 at 9. Malin (2023) concluded  
6 that the maternal urinary levels observed in Los Angeles were comparable to those found in  
7 pregnant women in Mexico and Canada. *Id.* at 1, 9. These findings corroborate the conclusions of  
8 Till (2018), and further support that water intake is an important contributor to maternal urinary  
9 fluoride levels.

10 Plaintiffs have shown, by a preponderance of the evidence, that a pregnant mother in the  
11 United States, under the condition of use (community water fluoridation of 0.7 mg/L, which is  
12 higher than the median water fluoridation levels in the Till (2018) data set of 0.56 mg/L found in  
13 Canada) produces a maternal urinary fluoride concentration level of at least **0.8 mg/L** for median  
14 water consumption or **1.89 mg/L** for 95th percentile water consumption.

15 a. As explained above, Till (2018) studied urinary fluoride levels in fluoridated areas  
16 of Canada, and identified a median (specific gravity adjusted) urinary fluoride level of 0.77  
17 mg/L and a 95th percentile urinary fluoride level of 1.89 mg/L. Dkt. No. 432-4, Trial Ex. 108 at  
18 25-26 (Table S4); Dkt. No. 395, Jan. 31, 2024, Trial Tr. at 118:5-20 (Hu). Malin (2023) studied  
19 pregnant mothers living in Los Angeles, California, a fluoridated city, and similarly observed that  
20 those mothers had a median (specific gravity-adjusted) urinary fluoride level of 0.8 mg/L,  
21 and a 95th percentile level of 1.89 mg/L, in the third trimester. Dkt. No. 432-18, Trial Ex. 122  
22 at 5 (Table 2); Dkt. No. 395, Jan. 31, 2024, Trial Tr. at 124:1-16 (Hu). Dr. Hu testified credibly  
23 that the Malin (2023) cohort is representative of mothers in the United States as a whole, though if  
24 anything, this cohort would present *lower* fluoride exposure levels relative to other populations  
25 because data indicates Hispanic communities have a greater distrust of tap water relative to other  
26 communities, in part due to immigration from Mexico where tap water is distrusted. Dkt. No. 395.

as Plaintiff's Demonstrative No. 4 at trial) to illustrate fully the trial testimony

1 Jan. 31, 2024, Trial Tr. at 118:11-119:9 (Hu). Canada and the United States each take a similar  
2 approach to water fluoridation; both countries identify 0.7 mg/L as the optimal fluoridation level.  
3 See NTP Monograph at 1; Dkt. No. 396, Feb. 1, 2024, Trial Tr. at 245:1-22 (Lanphear). It follows  
4 that pregnant woman in the United States, exposed to fluoride under the condition of use at issue  
5 (community water fluoridation at a typical or optimal level of 0.7 mg/L) have an exposure level of  
6 **0.8 mg/L measured in maternal urinary fluoride** (median water intake) and **1.89 mg/L**  
7 **measured in maternal urinary fluoride** (95th percentile water intake), urinary fluoride levels  
8 that reflect the real world results of drinking water fluoride levels at the condition of use at issue in  
9 this case.

10 b. To be sure, maternal urinary fluoride reflects not only fluoride that a pregnant  
11 woman is exposed to from drinking fluoridated water from her community (the condition of use at  
12 issue), but also fluoride from other sources such as food and beverage and household items such as  
13 toothpaste; it reflects aggregate exposure to fluoride. See Dkt. No. 395, Jan 31, 2024, Trial Tr. at  
14 105:10-25 (Hu); Dkt. No. 416, Feb. 12, 2024, Trial Tr. at 1404:19-21 (Barone); Dkt. No. 198-1  
15 (Hu Trial Decl.). The EPA argues that because maternal urinary fluoride reflects *aggregate*  
16 fluoride exposure, rather than exposure attributed solely from community water fluoridation,  
17 maternal urinary fluoride is an inappropriate metric to use in assessing the risk of community  
18 water fluoridation. However, exposure level of fluoride expressed in the metric of maternal  
19 urinary fluoride is properly used in this risk assessment because:

20 i. Maternal urinary fluoride, though not a perfect metric in all respects,  
21 is a valuable metric in assessing risk associated with water fluoridation since it is a comprehensive  
22 metric, reflecting the true aggregate exposure to the chemical at issue. As Dr. Hu explained:  
23 “[T]he primary benefit [of using urinary fluoride as the metric of fluoride exposure] is that you’re  
24 integrating fluoride exposure from whatever exposure source there is. So if it’s dietary, if it’s in  
25 the water, it’s in the food, it’s in the food that was cooked with the fluoridated water; if you  
26 happen to swallow toothpaste or if you’re using other sources of fluoride, it will integrate all of it  
27 and express it in terms of what is the level of fluoride that’s circulating in your blood and then gets  
28 filtered out into the kidneys. And that ultimately is the component of fluoride in the body that’s

available to cross the blood-brain barrier to the brain and also to go to other target organs in the body.” Dkt. No. 395, Jan. 31, 2024, Trial Tr. at 105:13-25 (Hu). Put differently, this metric reflects that water fluoridation does not occur in a vacuum; in the real world, fluoridating water means exposing women to fluoride *in addition to* the exposure a woman has to fluoride via other sources. Because dosage matters, it makes good sense to consider other sources of exposure to fluoride in deciding if adding to that exposure level presents a risk. *See* Dkt No. 400, Feb. 5, 2024, Trial Tr. at 676:12-21 (Barone) (recognizing that exposure and point of departure can be expressed in urine content in a risk assessment); Dkt. No. 402, Feb. 8, 2024, Trial Tr. at 1015:9-1020:13 (Savitz) (discussing pros and cons of using urinary fluoride as a measurement of water fluoridation and recognizing that urinary fluoride has a “number of positive features,” including integrating exposure from different sources, that it is a measurement reflecting not just what is in that body on a given day but for a longer period of time, and explaining that he has used urinary fluoride as a metric in assessing another chemical, PFAS); Dkt. No. 401, Feb. 6, 2024, Trial Tr. at 790:8-12 (Thiessen) (“there’s no scientific reason why [the exposure level and hazard level] have to be milligrams per kilogram per day. They could also be milligrams per liter in the drinking water, they could also be milligrams per liter *in the urine*”) (emphasis added).

1 specific, but TSCA specifically permits EPA to consider aggregate exposures to the chemical,  
2 correct? A. *TSCA specifically allows for consideration of aggregate exposures.* It doesn't require  
3 us to quantify based upon aggregate exposures") (emphasis added). Indeed, rather than preventing  
4 a risk evaluator from considering aggregate exposure to a chemical in evaluating risk, Amended  
5 TSCA expressly identifies that a risk evaluator should describe whether *aggregate exposure* was  
6 considered and explain why, or why not. *See 15 U.S.C. § 2605(b)(4)(F).* Specifically, the statute  
7 provides: “[i]n conducting a risk evaluation under this subsection, the Administrator shall . . .  
8 describe *whether aggregate or sentinel exposures to a chemical substance under the conditions of*  
9 *use were considered*, and the basis for that consideration.” 15 U.S.C. § 2605(b)(4)(F) (emphasis  
10 added).

1 drinking water]. So you can still make that hazard-to-exposure comparison.”).<sup>29</sup>

2 91. To the extent that risk assessment requires determining the exposure level attributed solely  
3 to the condition of use (community water fluoridation), Plaintiffs have shown, by a preponderance  
4 of the evidence, that at least half of the maternal urinary fluoride levels observed, **0.4 mg/L**  
5 (median) (*i.e.*, 0.8 mg/L divided by two) maternal urinary fluoride and **0.945 mg/L** (95th  
6 percentile) (*i.e.*, 1.89 mg/L divided by two) maternal urinary fluoride can be attributed to the  
7 condition of use (community water fluoridation):

8 a. As explained above, ¶ 89(a), Till (2018) observed that the maternal urinary fluoride  
9 levels were approximately **two-times higher** for pregnant women living in fluoridated regions  
10 compared to non-fluoridated regions. Dkt. No. 432-4, Trial Ex. 108 at 6, 25-26 (Table S4). Dr.  
11 Thiessen credibly testified that it is reasonable to conclude from Till (2018) that the 2x increase in  
12 maternal urinary fluoride levels in fluoridated areas can be attributed to community water  
13 fluoridation in those areas. *See* Dkt. 401, Feb. 6, 2024, Trial Tr. at 784:1-16 (Thiessen) (“The  
14 primary difference and the only main group difference that we’re aware of is that one group is  
15 fluoridated and one is not. So a difference in the urinary fluoride would be attributable to the  
16 fluoride in the drinking water.”); Dkt. No. 402, Feb. 8, 2024, Trial Tr. at 934:18-22 (Thiessen).  
17 And the EPA’s expert witness agreed that the increase in maternal urinary fluoride levels can  
18 largely be attributed to intake of fluoridated water. Dkt. No. 416, Feb. 13, 2024, Trial Tr. at  
19 1408:10-1409:11 (Barone) (explaining that the “parsimonious” explanation as to the 2x increase  
20 of maternal urinary fluoride levels observed in Till (2018) is that it is “due to intake, total intake,  
21

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22 <sup>29</sup> In Thippeswamy (2021), the researchers compared fluoride concentrations in urine, serum, and  
23 cord blood of women consuming water with designated “low” and “optimum” concentrations of  
24 fluoride to understand the relationship of these metrics. Dkt. No. 432-7, Trial Ex. 111 at 1.  
25 Thippeswamy (2021) did not observe a one-to-one correlation between urinary fluoride and water  
26 fluoride concentration, but concluded that “the low/optimum fluoride concentration in drinking  
27 water compared to urine . . . correlated significantly.” *Id.* The strong relationship between the  
28 fluoride concentration in water and urinary fluoride is further corroborated by Green (2019).  
Green (2019) studied samples collected from the MIREC Cohort (Canadian women and offspring)  
and identified a moderate correlation between maternal urinary fluoride intake and water fluoride  
concentration. Dkt. No. 432-5, Trial Ex. 109 at 1, 5 (“The MUF, was moderately correlated with  
fluoride intake ( $r = 0.49$ ;  $P < .001$ ) and water fluoride concentration ( $r = 0.37$ ;  $P < .001$ ).”).  
Though not a one-to-one comparison, the correlation observed in these studies further corroborates  
Dr. Thiessen’s testimony as to the relationship between water fluoride and urinary fluoride.

1 and that's probably both food and water . . . [a]nd water is a significant portion . . . of that").  
2 Moreover, water fluoridation also contributes to fluoride exposure indirectly because commercial  
3 food and beverages are made using fluoridated water; this is known in the scientific community as  
4 the "halo effect" of water fluoridation. *See, e.g.*, Dkt. No. 401, Feb. 6, 2024, Trial Tr. at  
5 799:7:800:13 (Thiessen) (describing the "halo effect" of water fluoridation wherein individuals  
6 ingest water that has been fluoridated by way of beverages such as colas, juices, beer and wine,  
7 that were made using water from a fluoridated community); Dkt. No. 396, Feb. 1, 2024, Trial Tr.  
8 at 212:7-23 (Lanphear) (describing the "halo effect" of communities that fluoridate water, causing  
9 exposure of fluoride in surrounding areas by way of food and beverage). *See also* Dkt. No. 432-4,  
10 Trial Ex. 108 at 6-7 (describing the "diffusion or halo effect" . . . "which refers to the extension of  
11 fluoridation to residents of nonfluoridated communities as a result of foods and beverages that are  
12 commercially processed in fluoridated areas and consumed in nonfluoridated communities")  
13 (citing Griffin et al. 2001; Ripa 1993). Accordingly, it is appropriate to infer conservatively that  
14 approximately **half** of the maternal urinary fluoride observed in a pregnant woman's urine is  
15 attributed to community water fluoridation.<sup>30</sup> Here, that is **0.4 mg/L** (0.8 mg/L divided by two)  
16 (median) maternal urinary fluoride and **0.945 mg/L** (1.89 mg/L divided by two) (95th percentile)  
17 maternal urinary fluoride.

18 b. One concern regarding extrapolating water intake from maternal urinary fluoride is  
19 that fluoride intake is not necessarily equivalent with fluoride excretion; the absorption and  
20 excretion process adds complexity. For example, a pregnant woman will experience the  
21 breakdown of her own skeleton during pregnancy to form the fetal skeleton, releasing fluoride  
22 absorbed in her bones, resulting in an increase in excretion of urine not tied to additional fluoride  
23 consumption. *See* Dkt. No. 395, Jan. 1, 2024, Trial Tr. at 121:10-20 (Hu). To this end the EPA  
24 argues that because of the complexities regarding absorption and excretion of fluoride, use of a  
25 physiologically based pharmacokinetic ("PBPK") modeling<sup>31</sup> is necessary to convert maternal

26  
27 <sup>30</sup> As noted below in Paragraph 91(b)(i), the EPA allows for assumptions, including, *e.g.*,  
absorption rates, when specific data is not available.

28 <sup>31</sup> PBPK model is "a computer model that estimates concentrations of a substance in other parts of

1 urinary fluoride levels to estimate the fluoride intake level. Because Plaintiffs have not done  
2 PBPK modeling, EPA argues, it is inappropriate to estimate exposure attributed to the condition of  
3 use from maternal urinary fluoride. *See* Dkt. No. 402, Feb. 8, 2024, Trial Tr. at 943:1-7  
4 (Thiessen) (recognizing that PBPK models have not been identified to predict maternal urinary  
5 fluoride concentrations based on drinking water exposures.). The Court rejects the EPA's  
6 argument for the following reasons.

7 i. While PBPK modeling may be useful and perhaps ideal, it is not  
8 essential to conduct a risk evaluation. The Amended TSCA does not expressly mandate use of a  
9 PBPK model, but instead affords ample discretion in the methodologies and modeling the risk  
10 assessor may employ in assessing risk. *See* 15 U.S.C. § 2625(h) (describing factors to be  
11 considered determining the methodologies or models to employ when assessing risk and omitting  
12 any reference to a PBPK model).<sup>32</sup> And the EPA Guidelines expressly recognize that  
13 pharmacokinetic data may not always be available and instructs a risk assessor to be aware of

14  
15 the body based on physiological parameters like absorption" and is used to convert from excretion  
16 level to intake level. *See* Dkt. No. 402, Feb. 8, 2024, Trial Tr. at 943:1-7 (Thiessen).

17 <sup>32</sup> This section provides in full:

18 In carrying out sections 2603, 2604, and 2605 of this title, to the  
19 extent that the Administrator makes a decision based on science, the  
20 Administrator shall use scientific information, technical procedures,  
21 measures, methods, protocols, methodologies, or models, employed  
22 in a manner consistent with the best available science, and shall  
23 consider as applicable – (1) the extent to which the scientific  
24 information, technical procedures, measures, methods, protocols,  
25 methodologies, or models employed to generate the information are  
26 reasonable for and consistent with the intended use of the  
27 information; (2) the extent to which the information is relevant for  
28 the Administrator's use in making a decision about a chemical  
substance or mixture; (3) the degree of clarity and completeness  
with which the data, assumptions, methods, quality assurance, and  
analyses employed to generate the information are documented; (4)  
the extent to which the variability and uncertainty in the  
information, or in the procedures, measures, methods, protocols,  
methodologies, or models, are evaluated and characterized; and (5)  
the extent of independent verification or peer review of the  
information or of the procedures, measures, methods, protocols,  
methodologies, or models.

15 U.S.C. § 2625(h).

uncertainties posed by lack of such data. Specifically, the EPA Guidelines provide: “If data to be used in a risk characterization are from a route of exposure other than the expected human exposure, then pharmacokinetic data should be used, if available, to make extrapolations across routes of exposure. If such data are not available, the Agency makes certain assumptions concerning the amount of absorption likely or the applicability of the data from one route to another (U.S. EPA, 1992).” EPA Guidelines at 62. This is an implicit recognition that a risk evaluation can proceed without pharmacokinetic modeling when such data is not available. *See also* EPA Guidelines at 47 (“Pharmacokinetic data *may* be helpful in defining the dose-response curve, developing a more accurate basis for comparing species sensitivity (including that of humans), determining dosimetry at sites, and comparing pharmacokinetic profiles for various dosing regimens or routes of administration. The correlation of pharmacokinetic parameters and neurotoxicity data *may* be useful in determining the contribution of specific pharmacokinetic processes to the effects observed.”) (emphasis added). Dr. Barone likewise testified that the EPA has conducted risk evaluations under Amended TSCA without PBPK modeling as such models are not always available, explaining: “[w]e used PBPK models in five of the first [ten] risk evaluations. And to varying degrees . . . In some cases we actually had the ability to . . . incorporate studies that included oral exposures, inhalation exposures and dermal exposures . . . so we could look at a wider range of exposures and to do that aggregation of exposures across routes. That’s not always available to us, we don’t always have those kinds of models available to us.” Dkt. No. 400, Feb. 5, 2024, Trial Tr. at 675:9-676:7 (Barone). *See also* Dkt. No. 401, Feb. 6, 2024, Trial Tr. at 576:12-17 (Barone), 578:8-10 (Barone) (“Q. And in EPA’s 10 risk evaluations under TSCA, EPA has only departed from using the default uncertainty factor of 10 for intraspecies variability when it had an acceptable physiologically-based pharmacokinetic model for the chemical, correct? A. In the first ten that is a true statement.”). Put simply, this lack of PBPK modeling is not fatal to Plaintiffs’ proof.

1 Tr. at 678:6-21 (Barone) (describing that in assessing risk under a condition of use one endeavors  
2 to subtract the background exposure from the water intake component to understand the risk at  
3 issue, ideally through modeling, but ultimately “to the best of your ability”). And uncertainties  
4 posed by lack of modeling may be accounted for in subsequent steps of the analysis (*i.e.*, assessing  
5 overall confidence in data in the risk characterization, *see ¶¶ 112-13* and when determining the  
6 appropriate uncertainty factor to employ when assessing the margin of exposure, *see ¶ 101(b)*).  
7 Under the present circumstances, there is sufficient data to support the exposure levels identified  
8 notwithstanding lack of PBPK modeling.<sup>33</sup>

25       <sup>33</sup> Though EPA does not bear the burden of proof in this context the Court does note that EPA has  
26       not explained why, if PBPK modeling is necessary to understand risk associated with water  
27       fluoridation and appropriate models are available, the EPA has not itself conducted this PBPK  
28       modeling. This is not legally relevant given the statutory framework, and does not bear on the  
Court's findings. However, to the extent that the EPA determines that PBPK modeling is  
necessary to engage in rulemaking, it may conduct this assessment to put a finer point on risk  
posed by the condition of use before taking regulatory action; there is nothing preventing EPA  
from doing so.

1 Till (2018) and Malin (2023).

2 92. The present recommended water fluoride concentration in the United States is 0.7 mg/L  
3 fluoride. NTP Monograph at 1. It follows that pregnant women living in a fluoridated community  
4 in the United States are typically exposed to fluoride levels of **0.7 mg/L** fluoride, measured in  
5 water fluoridation. Even more conservatively, the Till (2018) median water fluoride level of **0.56**  
6 **mg/L** measured in water fluoride is also an appropriate, conservative exposure level to utilize in  
7 the risk evaluation. This is because the United States and Canada (where data for Till (2018) was  
8 collected) take a similar approach to water fluoridation. *See* Dkt. No. 433-4, Trial Ex. 129 at 16  
9 (describing optimal water fluoride levels in Canada of 0.7 mg/L); Dkt. No. 396, Feb. 1, 2024 Trial  
10 Tr. at 245:1-22 (Lanphear) (describing optimal 0.7 mg/L water fluoride standard in Canada).  
11 Moreover, urinary fluoride levels in mothers from Los Angeles observed in Malin (2023) and Till  
12 (2018) are highly similar. *See* Dkt. No. 432-18, Trial Ex. 122 at 1, 9.

13 93. The EPA often expresses exposure and hazard level in mg/kg/day, but this is not  
14 necessary. What is vital, however, is that the exposure level and hazard level is in the same unit.  
15 Dkt. No. 400, Feb. 5, 2024, Trial Tr. (Barone) at 672:22-673:4 (testifying that what matters is that  
16 the “[e]xposure concentration in the denominator has to be in the same units as the hazard point of  
17 departure or hazard level in the numerator[;] [t]hey have to match up”). Dr. Thiessen likewise  
18 testified that “there’s no scientific reason why [the hazard and exposure levels] have to be  
19 milligrams per kilogram per day. They could also be milligrams per liter in the drinking water,  
20 they could also be milligrams per liter in the urine. What matters is comparison of a hazard level  
21 and exposure level that are in the same units.” Dkt. No. 401, Feb. 6, 2024, Trial Tr. at 790:18-  
22 791:16 (Thiessen). Thus, the exposure and hazard level need not be expressed in mg/kg/day, but  
23 the units for each must match when conducting subsequent steps of the analysis.

24 94. For the reasons stated above, and in view of the record evidence, Plaintiffs have shown by  
25 a preponderance of the evidence that:

26 a. Pregnant mothers in fluoridated communities in the United States are typically  
27 exposed to fluoridation of drinking water at a concentration level of **0.7 mg/L**, or conservatively,  
28 **0.56 mg/L**. They have a median exposure level to fluoride of **0.8 mg/L** (measured in maternal

1 urinary fluoride), and at the 95th percentile have an exposure level to fluoride of **1.89 mg/L**  
2 (measured in maternal urinary fluoride).

3 b. To the extent that the exposure level used in this risk assessment must reflect  
4 exposure attributed solely to the condition of use of the chemical, approximately half of the  
5 maternal urinary fluoride levels discussed in Paragraph 87 are attributed to water fluoridation.

6 C. Step 3: Risk Characterization

7 a. Framework

8 95. At this step, the EPA calculates the risk presented by the chemical at issue by comparing  
9 the point of departure (*i.e.*, hazard level) with the human exposure level. *See* Dkt. No. 401, Feb. 6,  
10 2024, Trial Tr. at 705:7-706:21 (Barone). To ensure a risk is not present, the EPA utilizes a  
11 Margin of Exposure (MOE) equation that compares a safe margin from the point of departure  
12 (benchmark MOE) with the actual margin between the exposure level and point of departure  
13 (MOE). *See id.* at 707:13-708:19.

14 96. The actual MOE is calculated by discerning the ratio of the point of departure and the  
15 human exposure level, *i.e.*, the point of departure divided by the exposure level. Dkt. No. 429-7,  
16 Trial Ex. 17 at 65. The benchmark MOE (*i.e.*, the safe or requisite margin) is the product of the  
17 applicable uncertainty factors (UFs) (*i.e.*, UF x UF). *See id.* at 2-3; Dkt. No. 400, Feb. 5, 2024,  
18 Trial Tr. at 575:17-576:24 (Barone), 580:10-13 (Barone) (“Q. Now, the benchmark MOE is the  
19 product of all uncertainty factors that are found to be applicable to a given – to a given hazard,  
20 correct? A. To a given hazard, that’s correct.”), 580:24-581:19 (Barone) (“We don’t add them.  
21 We multiply – if the uncertainty factor is the default of 10 for human variability, then we use that  
22 and multiply is by any other uncertainty factors.”). For example, if there is an uncertainty factor  
23 of 10 for intraspecies variability, and an uncertainty factor of 10 for using a LOAEL as the point  
24 of departure, the benchmark MOE is 100 (10 times 10). *Id.* at 581:12-582:11. As another  
25 example, if the first uncertainty factor is 10, and the second uncertainty factor is 3, the benchmark  
26 MOE is 30 (10 times 3). *Id.*

27 97. If the actual MOE is lesser (*i.e.*, there is a smaller margin) than the benchmark MOE, then  
28 there is a risk present; if the actual MOE is greater (*i.e.*, there is a bigger margin) than the

1 benchmark MOE then a risk is presumed not to be present. *See* Dkt. No. 400, Feb. 5, 2024, Trial  
2 Tr. at 583:8-13 (Barone) (explaining that if the benchmark MOE exceeds the MOE between the  
3 hazard and exposure level a risk is present); Dkt. No. 401, Feb. 6, 2024, Trial Tr. at 707:20-708:9  
4 (Barone) (explaining the converse).

5 b. Key findings

6 98. A risk is present when using the BMCL of 0.28 mg/L (maternal urinary fluoride) as the  
7 point of departure, and whether calculating risk using either the median or high-end exposure  
8 levels; the exposure levels exceed the point of departure.

9 99. A risk is present when using the BMCL of 0.768 mg/L or even 1.536 mg/L (maternal  
10 urinary fluoride) as the point of departure, whether calculating risk using either the median or  
11 high-end exposure levels; the exposure levels exceed the point of departure.

12 100. Alternatively, a risk is present when utilizing the conservative 4 mg/L (water  
13 fluoride) as the point of departure; the actual MOE is less than the benchmark MOE.

14 c. Underlying findings

15 (a) BMCL: 0.28 mg/L and in the alternative, 0.768 mg/L and/or 1.536  
16 mg/L (maternal urinary fluoride)

17 101. The appropriate benchmark MOE to use in calculating risk for the BMCLs  
18 identified by Dr. Grandjean is 10, which includes at least one UF of 10 to account for intraspecies  
19 variability:

20 a. A UF of 10 is utilized as a default practice in calculating risk to account for  
21 intraspecies variability, *i.e.*, the variability within the human species in reacting to chemicals.<sup>34</sup>  
22 *See* Dkt. No. 401, Feb. 6, 2024, Trial Tr. at 712:12-713:22 (Barone).

23 b. Absent use of physiologically based pharmacokinetic (PBPK) modeling to account  
24 for those variabilities, which could allow for the reduction of the UF from 10 down to 3, the EPA  
25 applies the UF of 10 in calculating the benchmark MOE. *See id.* at 712:24-713:22; Dkt. No. 401,

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27 <sup>34</sup> Intraspecies variability can be compared with interspecies variability, which accounts for  
28 variability between different species (*i.e.*, animals and humans) when extrapolating from  
animal studies. Dkt. No. 401, Feb. 6, 2024, Trial Tr. at 713:6-10 (Barone).

1 Feb. 6, 2024, Trial Tr. at 576:12-17 (Barone), 578:8-10 (Barone) (“Q. So the default uncertainty  
2 factor that EPA uses to account for intraspecies variability and uncertainty is 10, correct? A. That  
3 is the default. Q. And in EPA’s 10 risk evaluations under TSCA, EPA has only departed from  
4 using the default uncertainty factor of 10 for intraspecies variability when it had an acceptable  
5 physiologically-based pharmacokinetic model for the chemical, correct? A. In the first ten that is  
6 a true statement.”).

7 c. A PBPK model has not been performed to assess fluoride intake in pregnant  
8 women. Dkt. No. 402, Feb. 8, 2024, Trial Tr. at 943:1-16 (Thiessen); Dkt. No. 440, Feb. 13,  
9 2024, Trial Tr. at 1396:17-1397:2 (Barone), 1397:20-23 (Barone) (“Q. And so in the nearly four  
10 years since the first trial in this case, plaintiffs still have not performed a PBPK model to extract a  
11 urinary fluoride value to an intake value, right? A. No, they haven’t.”).

12 d. Because there is no PBPK model utilized here, which would decrease uncertainty  
13 and allow from a downward departure of the default UF of 10, the default UF of 10 is  
14 appropriately used as the benchmark MOE in the present risk evaluation.

15 102. The median exposure level for pregnant women measured in urinary fluoride is 0.8  
16 mg/L, and the 95th percentile is 1.89 mg/L. *See ¶ 87.*

17 103. The actual MOE for the BMCL of 0.28 mg/L at the median exposure level is 0.35  
18 (0.28 mg/L divided by 0.8 mg/L) and 0.148 at the 95th percentile exposure level (0.28 mg/L  
19 divided by 1.89 mg/L). The actual MOEs, 0.35 and 0.148, do not exceed the benchmark MOE of  
20 10; thus, the MOE is below the benchmark MOE and a risk is present. *See* Dkt. No. 401, Feb. 6,  
21 2024, Trial Tr. at 707:20-708:9 (Barone) (explaining that a risk is not present where the actual  
22 MOE is *higher* than the benchmark MOE). Another way of looking at exposure/risk is taking the  
23 BMCL and adjusting it downward for risk factors. To account for a ten-fold risk factor of human  
24 variability, actual exposure should not exceed 1/10th of the BMCL of 0.28 mg/L – *i.e.*, 0.028  
25 mg/L. However, the trial evidence establishes actual exposure of levels of 0.8 and 1.89 mg/L –  
26 this far exceeds that safety limit of 0.028 mg/L. *See also* Dkt. No. 198-4 at 75-77 (Thiessen Decl.)  
27 (providing MOE calculations).

28 104. The actual MOE for the BMCL of 0.768 mg/L at the median exposure level is 0.96

1 (0.768 mg/L divided by 0.8 mg/L) and 0.406 at the 95th percentile exposure level (0.768 mg/L  
2 divided by 1.89 mg/L). The actual MOEs, 0.96 and 0.406, do not exceed the benchmark MOE of  
3 10; thus, the MOE is below the benchmark MOE and a risk is present. *See* Dkt. No. 401, Feb. 6,  
4 2024, Trial Tr. at 707:20-708:9 (Barone). *See also* Dkt. No. 198-4 at 75-77 (Thiessen Decl.)  
5 (providing MOE calculations). Put differently, 1/10th of this BMCL is 0.0768 mg/L (0.768 mg/L  
6 divided by 10). Both the median and upper exposure levels of fluoride found in mothers' urine  
7 exceed this amount.

8 105. Even using the higher 1.536 mg/L BMCL to account for omission of the OCC  
9 Cohort data, *see ¶ 73* (discussing exclusion of OCC Cohort data in deriving 0.768 mg/L BMCL  
10 using squared model in Grandjean (2022)), a risk is present. Using this figure, the actual MOE at  
11 the median exposure level is 1.92 (1.536 mg/L divided by 0.8 mg/L) and 0.813 at the 95th  
12 percentile exposure level (1.536 mg/L divided by 1.89 mg/L). 1.92 and 0.813 do not exceed 10;  
13 thus, the actual MOE is below the benchmark MOE and a risk is present. *See* Dkt. No. 401, Feb. 6,  
14 2024, Trial Tr. at 707:20-708:9 (Barone). *See also* Dkt. No. 198-4 at 75-77 (Thiessen Decl.)  
15 (providing MOE calculations). Put differently, 1/10th of this BMCL is 0.1536 mg/L (1.536 mg/L  
16 divided by 10). Both the median and upper exposure levels in mothers' urine exceed this amount.

17 106. Even if the Court were to consider only half of the exposure level, directly  
18 attributable to water fluoridation, as opposed to other sources of fluoride (0.4 mg/L (0.8 mg/L  
19 divided by 2) (median) maternal urinary fluoride and 0.945 mg/L (1.89 mg/L divided by 2) (95th  
20 percentile) maternal urinary fluoride, a risk is still present. Both of these figures exceed the safe  
21 level using a BMCL of 0.28 mg/L (0.028 mg/L). *See ¶ 103.* And these figures also exceed the  
22 safe level considering the margin of error if the BMCL of 0.768 mg/L or 1.536 mg/L; the safe  
23 levels are 0.0768 mg/L and 0.1536 mg/L (1/10th of each BMCL), respectively. *See ¶¶ 104-05.*

24 (b) LOAL: 4 mg/L (water fluoride)

25 107. Alternatively, to the extent that the BMCLs identified previously are not  
26 appropriate points of departure, or maternal urinary fluoride is not an appropriate metric, a risk is  
27 present using a LOAL of 4 mg/L measured in water fluoride.

28 108. The appropriate UF applied in the benchmark MOE analysis using the LOAEL of 4

1 mg/L is 100 (10 x 10):

2 a. The UF of 10 is appropriately applied to account for intraspecies variability.

3 See ¶ 101.

4 b. A second UF of 10 is also appropriately applied when using a LOAEL as the point  
 5 of departure. Dkt. No. 440, Feb. 13, 2024, Trial Tr. at 1425:13-17 (Barone) (“Q. Right. If we  
 6 were using a human study and only had a LOAEL, like was the case with PCE, you would, at that  
 7 point, consider an additional uncertainty factor beyond the intraspecies variability uncertainty  
 8 factor? A. Generally, yes. Yes, we would.”).

9 c. Again, the benchmark MOE is calculated by multiplying the applicable UFs. Dkt.  
 10 No. 400, Feb. 5, 2024, Trial Tr. at 575:17-576:24 (Barone), 580:10-13 (Barone) (explaining that  
 11 the benchmark MOE is the product of applicable UFs), 580:24-581:19 (stating that “[w]e don’t  
 12 add them[;] [w]e multiply”).

13 109. Pregnant women in “optimally” fluoridated communities in the United States have  
 14 an exposure level of at least 0.7 mg/L (water fluoride). *See* ¶ 86. Or conservatively, 0.56 mg/L  
 15 derived from Till (2018), in the alternative. *See* ¶ 89(a).

16 110. The actual MOE for the LOAEL of 4 mg/L (water fluoride) is 5.71 (4 mg/L divided  
 17 by 0.7 mg/L) or 7.14 (4 mg/L divided by 0.56 mg/L).

18 111. 5.71 and/or 7.14 do not exceed 100; the actual MOE is below the benchmark MOE  
 19 and thus a risk is present. Dkt. No. 400, Feb. 5, 2024, Trial Tr. at 583:8-13 (Barone) (explaining  
 20 that if the benchmark MOE exceeds the MOE between the hazard and exposure level a risk is  
 21 present). *See also* Dkt. No. 198-4 at 75-77 (Thiessen Decl.) (providing MOE calculations).

22 Again, another way of looking at this is to take the LOAEL of 4 mg/L, and divide that by the two  
 23 risk factors. To this end, 4 mg/L divided by 100 equals 0.04 mg/L, reflecting the tolerable  
 24 concentration of exposure given the risk factors. Exposure to 0.7 mg/L in United States drinking  
 25 water, or conservatively 0.56 mg/L (Till (2018)),<sup>35</sup> far exceeds that limit.

26 \_\_\_\_\_  
 27 28 <sup>35</sup> The condition of use at issue in this suit is fluoridation of water at 0.7 mg/L. However, it is useful to consider the risk posed with the lesser exposure level of 0.56 mg/L given the findings of Till (2018). There, subjects in Canada – which has the same optimal level of water fluoridation as the United States – had a median community water fluoride level of 0.56 mg/L. It follows that

1       D.     Step 4: Risk Determination2           a.     Framework

3       112.     Once the risk has been identified, in the last step of the risk evaluation process the  
4     assessor determines if that risk is an *unreasonable* one. Dkt. No. 401, Feb. 6, 2024, Trial Tr. at  
5     735:11-19 (Barone).

6       113.     In making the determination of whether the risk is unreasonable, the assessor  
7     considers several factors including: (1) severity of the hazard; (2) exposure-related considerations  
8     (e.g., duration, magnitude, or frequency of the exposure, and size of the affected population); (3)  
9     other characteristics of the population that is exposed, including the susceptibility of  
10    subpopulations; (4) confidence in the information used to inform the hazard and exposure values;  
11    and relatedly, the (5) overall strength of the evidence and uncertainties and assumptions included  
12    throughout the risk assessment. *See* Dkt. No. 401, Feb. 6, 2024, Trial Tr. at 735:11-736:19  
13    (Barone); Dkt No. 437-1, Trial Ex. 96, at 500 (PCE Risk Evaluation); Dkt. No. 437-3, Trial Ex.  
14    98 at 271 (1,4-Dioxane Risk Evaluation).

15           b.     Key finding

16       114.     Based on the aforementioned factors, and in view of the record evidence, the risk at  
17     issue – reduced IQ in children posed by water fluoridation at 0.7 mg/L – is an unreasonable risk.

18           c.     Underlying findings

19       115.     Given the seriousness of reduced IQ, and the ample support in the record that the  
20     United States population is at risk of experiencing IQ decrements of over four IQ points, the  
21     **severity** of the hazard at issue (reduced IQ in children, *see* Section III.A.1.), weighs in favor of  
22     finding the risk at issue unreasonable:

23           a.     The EPA has recognized that cognitive deficits including reduced IQ are critical  
24     chronic health effects, as exemplified by its in its risk evaluation of PCE under the Amended  
25     TSCA which identified cognitive deficits as the hazard warranting regulatory action. Dkt. No.

27       some communities in the United States may have similar median water fluoridation levels. Thus,  
28     it is worth considering if a risk is present at this lower level of exposure, to understand the risk of  
   setting an optimal fluoridation level of 0.7 mg/L as is the standard in the United States.

1 400, Feb. 5, 2024, Trial Tr. at 597:9-13 (Barone). Moreover, according to the EPA's Clean Air  
 2 Science Advisory Commission, in the context of its analysis of lead: “[a] population loss of 1-2 IQ  
 3 points is highly significant from a public health perspective.” Dkt. No. 430-1, Trial Ex. 42 at  
 4 67000. To this end, a 1-to-2 point loss in IQ was the hazard that supported the identification of  
 5 lead as a substance posing an unreasonable risk. *Id. See also* Dkt. No. 433-4, Trial Ex. 129 at 27  
 6 (recognizing that one study found that a reduction of one IQ point “has been shown to be  
 7 associated with reduced educational attainment, employment status, productivity, and earned  
 8 wages, reflecting substantial public health concerns”).

9       b. In risk assessments, the EPA evaluates not only the hazard presented at median  
 10 exposures levels, but considered the hazard posed to the 95th percentile (*i.e.*, high exposure  
 11 populations). Dkt. No. 430-1, Trial Ex. 42 at 67000. And the EPA considers impact upon  
 12 smaller, susceptible subpopulations in assessing the risk at issue. *See* Dkt. No. 400, Feb. 5, 2024,  
 13 Trial Tr. at 587:7-18 (Barone) (testifying that the EPA considered impact on small, susceptible  
 14 subgroup of population in regulating lead).

15       c. As Dr. Grandjean explained, women in the 95th percentile exposure level to  
 16 fluoride exceed the BMCL for a 1-point loss in IQ by over a factor of four. *See* Dkt. No. 397, Feb.  
 17 2, 2024, Trial Tr. at 358:2-18 (Grandjean). Indeed, when considering high-end exposure levels,  
 18 relative to Dr. Grandjean's BMCL identifying the dosage at which a 1-point IQ decrement is  
 19 expected, fluoride presents a risk of a decrease in IQ ranging from 2.86 to 6.75 IQ points.<sup>36</sup>

20       116.       **Exposure-related considerations** (*e.g.*, duration, magnitude, or frequency of the  
 21 exposure, and size of the affected population) weighs heavily toward finding the risk at issue  
 22 unreasonable; the exposure is continuous, and nearly all Americans are affected.

23

---

24       <sup>36</sup> According to Dr. Grandjean's analysis, an increase of 0.28 mg/L of fluoride exposure (measured  
 25 in maternal urinary fluoride) is associated with a 1-point IQ loss in the mother's offspring (boys  
 26 and girls). *See* Dkt. No. 432-15, Trial Ex. 119 (Grandjean (2023)) at 1-2, 9. Pregnant mothers in  
 27 fluoridated communities in the United States have a median and 95th percentile exposure level to  
 28 fluoride of 0.8 mg/L and 1.89 mg/L, respectively (measured in maternal urinary fluoride). *See* ¶¶  
 86-88; Trial Ex. 122, Dkt. No. 432-18 at, Trial Ex. 122 at 9. Thus, fluoride presents a hazard of  
 reduced IQ ranging from approximately 2.86 points at the median intake level, ((0.8 mg/L (median  
 exposure level) divided by 0.28 mg/L (dosage at which 1 IQ point decrease is observed)), *i.e.*,  
 2.857) to 6.75 points at the 95th percentile ((1.89 mg/L (95th percentile exposure level) divided by  
 0.28 mg/L (dosage at which 1 IQ point decrease is observed)), *i.e.*, 6.75).

1       117.       The size of the affected population is vast. Approximately 200 million Americans  
2 have fluoride intentionally added to their drinking water at a concentration of 0.7 mg/L. *See* Dkt.  
3 No. 421 at 206-07 (undisputed). Other Americans are indirectly exposed to fluoridated water  
4 through consumption of commercial beverages and food manufactured with fluoridated water (*i.e.*,  
5 the “halo effect”). *See, e.g.*, Dkt. No. 401, Feb. 6, 2024, Trial Tr. at 799:7-800:13 (Thiessen)  
6 (describing the “halo effect” of water fluoridation); Dkt. No. 396, Feb. 1, 2024, Trial Tr. at 212:7-  
7 23 (Lanphear) (similar). *See also* Dkt. No. 432-4, Trial Ex. 108 at 6-7 (describing the “diffusion  
8 or halo effect” . . . “which refers to the extension of fluoridation to residents of nonfluoridated  
9 communities as a result of foods and beverages that are commercially processed in fluoridated  
10 areas and consumed in nonfluoridated communities”) (citing Griffin et al. 2001; Ripa 1993).  
11       Approximately two million pregnant women, and over 300,000 exclusively formula-fed babies are  
12 exposed to fluoridated water. Dkt. No. 421 at 209-210. *See also* Dkt. No. 401, Feb. 6, 2024, Trial  
13 Tr. at 815:6-816:23 (Thiessen). The number of pregnant women and formula-fed babies alone  
14 who are exposed to water fluoridation each year exceeds entire populations exposed to conditions  
15 of use for which EPA has found unreasonable risk; the EPA has found risks unreasonable where  
16 the population impacted was less than 500 people. *See* Dkt. No. 400, Feb. 5, 2024, Trial Tr. at  
17 588:11-15 (Barone) (testifying that under TSCA the EPA had made unreasonable risk  
18 determinations for conditions of use that involve less than 500 people, and that “many are less  
19 than 500 people”). *See also* Dkt. No. 421 at 209-210 (EPA agreeing that “the exposed population  
20 for the condition of use of community water fluoridation exceeds the exposed populations of the  
21 first ten risk evaluations under Amended TSCA”).

22           a. Individuals are exposed to fluoride through water intake every day; the parties do  
23 not dispute that frequency of exposure for most people is several times daily (*i.e.*, through  
24 drinking tap water). Dkt. No. 421 at 207 (undisputed).

25           b. And the duration of exposure to fluoridated water is continuous with its effects  
26 long-lasting. *See* Dkt. No. 401, Feb. 6, 2024, Trial Tr. at 813:18-20 (Thiessen) (describing that  
27 exposure to community water fluoridation is intended to be lifelong). To this end, fluoride  
28 remains in the body through years; for several years after cessation of fluoride exposure a woman

1 is likely to release fluoride into blood due to skeletal breakdown. Dkt. No. 397, Jan. 31, 2024,  
2 Trial Tr. at 370:6-371:12 (Grandjean); Dkt. No. 402, Feb. 8, 2024, Trial Tr. at 932:16-20  
3 (Thiessen).

4 118. The **susceptibility** of exposed populations weighs heavily toward finding the risk at  
5 issue unreasonable. It is undisputed that large numbers of susceptible individuals are being  
6 exposed each year to fluoride through fluoridation, namely, approximately two million **pregnant**  
7 **women**, and over 300,000 exclusively formula-fed **babies**. Dkt. No. 421 at 209-210. *See also*  
8 Dkt. No. 401, Feb. 6, 2024, Trial Tr. at 815:6-816:23 (Thiessen).

9 119. The scientific literature in the record provides a high level of certainty that a hazard  
10 is present; fluoride is associated with reduced IQ. There are uncertainties presented by the  
11 underlying data regarding the appropriate point of departure and exposure level to utilize in this  
12 risk evaluation. But those uncertainties do not undermine the finding of an unreasonable risk; in  
13 every scenario utilizing any of the various possible points of departures, exposure levels and  
14 metrics, a risk is present in view of the applicable uncertainty factors that apply:

15 a. Regarding the point of departure, as discussed above, there is some uncertainty  
16 regarding the appropriate point of departure to utilize. Specifically, there is lack of certainty  
17 regarding the model fit to be utilized in the BMD modeling analysis, which determines the BMCL  
18 to utilize as a point of departure. *See ¶ 72* (discussing use of linear vs. squared model to derive  
19 BMCL). However, under either scenario (whether using a linear or squared model), there is an  
20 insufficient safety margin between the exposure level and hazard level; a risk is present. *See ¶¶*  
21 102-106. Even assuming BMD modeling cannot be used for the data set and using a highly  
22 conservative LOAEL of 4 mg/L, a risk remains present by a substantial margin. *See ¶¶* 107-111.  
23 Accordingly, the uncertainty regarding the point of departure (hazard level) is ultimately not  
24 consequential to the conclusion herein. The EPA has deemed a risk unreasonable even where it  
25 lacked high confidence in the hazard data. *See* Dkt. No. 421 at 211 (undisputed).

26 b. Regarding the exposure level, there is uncertainty presented by the fact that a  
27 PBPK model was not utilized to determine the precise amount of fluoride reflected in pregnant  
28 women's maternal urinary fluoride levels that derives from fluoridated water. *See ¶ 91(b).*

1 Uncertainty due to lack of modeling is offset by the fact that it is appropriate to view risk  
2 presented by water fluoridation in context of its additive effects on aggregate exposure, which is  
3 best reflected by real world maternal urinary fluoride levels. *See ¶¶ 89-90.* And this is  
4 particularly true where, as here, water fluoridation is known to be a significant contributor to  
5 maternal urinary fluoride levels, and indeed functions roughly as a 2x multiplier to those levels.  
6 *See id.* Further, here, there is real-world observational data showing what the maternal urinary  
7 fluoride levels of women that live in communities with fluoridation levels comparable to that of  
8 the United States; this data makes the PBPK model less critical to the analysis. *See ¶¶ 89-91.* The  
9 uncertainty from the lack of PBPK model weighs against finding the risk unreasonable, but not  
10 strongly so due to these mitigating circumstances. Moreover, when utilizing the conservative  
11 LOAEL as a point of departure, that metric is derived from water fluoride intake, and does not  
12 present the same uncertainty posed by using maternal urinary fluoride levels as the metric of  
13 hazard and exposure. Finally, the EPA has deemed a risk unreasonable even where it lacked high  
14 confidence in the exposure data. *See* Dkt. No. 421 at 211 (undisputed).

15 c. There is significant *certainty* in the data set regarding the association between  
16 fluoride and reduced IQ. Namely, there is a robust body of evidence finding a statistically  
17 significant adverse association between fluoride and IQ. A large majority of the 72  
18 epidemiological studies assessed by the NTP Monograph observed this relationship including all  
19 but one of the 19 high-quality studies, *see ¶¶ 34-36*, and literature published after the NTP  
20 Monograph cutoff date observed the same relationship, *see ¶ 37* – and countervailing evidence, for  
21 various reasons described previously, are of little impact on this repeated, and consistently  
22 observed association between fluoride and reduced IQ, *see ¶ 39.* Moreover, complete consistency  
23 amongst studies is not expected. *See* Dkt. No. 414, Feb. 9, 20240, Trial Tr. at 1172:23-1173:6  
24 (Savitz). Notably, notwithstanding inherent difficulties in observing this association at lower  
25 exposure levels, studies assessing such levels still observed a statistically significant relationship  
26 between fluoride and reduced IQ. *See ¶¶ 42-44.* Again, to put the breadth of evidence supporting  
27 this finding in perspective, the EPA has identified a LOAEL based upon far less in other contexts.  
28 For instance, in the EPA's risk evaluation of Methylene, conducted pursuant to Amended TSCA,

1 the EPA used a LOAEL for developmental neurotoxicity, derived from the analysis of ***one study conducted upon mouse pups*** (Fredriksson et al., 1992). *See* Methylene Risk Evaluation at 262.  
2 Compare this with 6 (water fluoride) and 9 (urinary fluoride), high-quality, epidemiological  
3 studies of human populations underling the 4 mg/L LOAEL underlying the POD here. Dkt. No.  
4 431-2, Trial Ex. 68 at 39, 41 (eTable 4). The scientific literature in the record provides a high  
5 level of certainty that a hazard is present; fluoride is associated with reduced IQ. The qualitative  
6 evidence is superior.

7  
8 120. In sum, the first three factors weigh toward finding the risk unreasonable. Namely,  
9 the severity of the hazard weighs toward finding the risk unreasonable. The exposure-related  
10 considerations and exposure of susceptible populations weighs *strongly* toward finding the risk  
11 unreasonable; millions of susceptible individuals are exposed to fluoride and the exposure is  
12 frequent and long-lasting. The two final factors, confidence in hazard data and overall strength of  
13 the evidence and uncertainties, are largely neutral. Because the first three factors weigh strongly  
14 toward finding the risk unreasonable and the last two are largely neutral, the totality of the factors  
15 establish that the risk is unreasonable under the Amended TSCA. The Court thus finds that the  
16 Plaintiffs have established by a preponderance of the evidence that the risk at issue is  
17 **unreasonable.**

#### 18 IV. CONCLUSIONS OF LAW

19 121. Plaintiffs have proven, by a preponderance of the evidence, that water fluoridation  
20 at the level of 0.7 mg/L – the prescribed optimal level of fluoridation in the United States –  
21 presents an “unreasonable risk of injury to health or the environment, without consideration of  
22 costs or other non-risk factors, including an unreasonable risk to a potentially exposed or  
23 susceptible subpopulation under the conditions of use.” 15 U.S.C. § 2620(b)(4)(B)(ii).

24 122. The Court thus orders the Administrator to initiate rulemaking pursuant to  
25 Subsection 6(a) of TSCA. *See id.* §§ 2605(a), 2620(a).

26 123. The Court defers ruling as to whether Plaintiffs are entitled to recovery of their  
27 costs of suit and attorneys and expert witness fees. Parties are ordered to submit a proposed  
28 supplemental briefing schedule regarding costs and fees within two weeks of the date of this order.

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1 Defendant shall respond two weeks thereafter. The Court will take the matter under submission  
2 unless it orders a hearing.

3

4 The Clerk of Court is directed to enter judgment in Plaintiffs' favor.

5

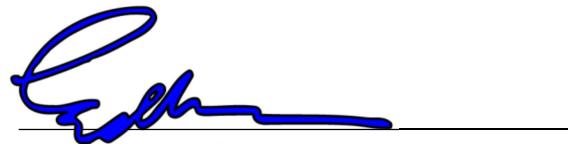
6 **IT IS SO ORDERED.**

7

8 Dated: September 24, 2024

9

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EDWARD M. CHEN  
United States District Judge

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United States District Court  
Northern District of California



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## Water fluoridation for the prevention of dental caries (Review)

Iheozor-Ejiofor Z, Walsh T, Lewis SR, Riley P, Boyers D, Clarkson JE, Worthington HV, Glenny AM, O'Malley L

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[Intervention Review]

## Water fluoridation for the prevention of dental caries

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## ABSTRACT

### Background

Dental caries is a major public health problem in most industrialised countries, affecting 60% to 90% of school children. Community water fluoridation (CWF) is currently practised in about 25 countries; health authorities consider it to be a key strategy for preventing dental caries. CWF is of interest to health professionals, policymakers and the public. This is an update of a Cochrane review first published in 2015, focusing on contemporary evidence about the effects of CWF on dental caries.

### Objectives

To evaluate the effects of initiation or cessation of CWF programmes for the prevention of dental caries.

To evaluate the association of water fluoridation (artificial or natural) with dental fluorosis.

### Search methods

We searched CENTRAL, MEDLINE, Embase and four other databases up to 16 August 2023. We also searched two clinical trials registers and conducted backward citation searches.

### Selection criteria

We included populations of all ages.

For our first objective (effects of initiation or cessation of CWF programmes on dental caries), we included prospective controlled studies comparing populations receiving fluoridated water with those receiving non-fluoridated or naturally low-fluoridated water. To evaluate change in caries status, studies measured caries both within three years of a change in fluoridation status and at the end of study follow-up.

For our second objective (association of water fluoridation with dental fluorosis), we included any study design, with concurrent control, comparing populations exposed to different water fluoride concentrations. In this update, we did not search for or include new evidence for this objective.

### Data collection and analysis

We used standard methodological procedures expected by Cochrane.

For our first objective, we included the following outcomes as change from baseline: decayed, missing or filled teeth ('dmft' for primary and 'DMFT' for permanent teeth); decayed, missing or filled tooth surfaces ('dmfs' for primary and 'DMFS' for permanent teeth); proportion of

### Water fluoridation for the prevention of dental caries (Review)

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caries-free participants for both primary and permanent dentition; adverse events. We stratified the results of the meta-analyses according to whether data were collected before or after the widespread use of fluoride toothpaste in 1975.

For our second objective, we included dental fluorosis (of aesthetic concern, or any level of fluorosis), and any other adverse events reported by the included studies.

### Main results

We included 157 studies. All used non-randomised designs. Given the inherent risks of bias in these designs, particularly related to management of confounding factors and blinding of outcome assessors, we downgraded the certainty of all evidence for these risks. We downgraded some evidence for imprecision, inconsistency or both. Evidence from older studies may not be applicable to contemporary societies, and we downgraded older evidence for indirectness.

#### Water fluoridation initiation (21 studies)

Based on contemporary evidence (after 1975), the initiation of CWF may lead to a slightly greater change in dmft over time (mean difference (MD) 0.24, 95% confidence interval (CI) -0.03 to 0.52; P = 0.09; 2 studies, 2908 children; low-certainty evidence). This equates to a difference in dmft of approximately one-quarter of a tooth in favour of CWF; this effect estimate includes the possibility of benefit and no benefit. Contemporary evidence (after 1975) was also available for change in DMFT (4 studies, 2856 children) and change in DMFS (1 study, 343 children); we were very uncertain of these findings.

CWF may lead to a slightly greater change over time in the proportion of caries-free children with primary dentition (MD -0.04, 95% CI -0.09 to 0.01; P = 0.12; 2 studies, 2908 children), and permanent dentition (MD -0.03, 95% CI -0.07 to 0.01; P = 0.14; 2 studies, 2348 children). These low-certainty findings (a 4 percentage point difference and 3 percentage point difference for primary and permanent dentition, respectively) favoured CWF. These effect estimates include the possibility of benefit and no benefit. No contemporary data were available for adverse effects.

Because of very low-certainty evidence, we were unsure of the size of effects of CWF when using older evidence (from 1975 or earlier) on all outcomes: change in dmft (5 studies, 5709 children), change in DMFT (3 studies, 5623 children), change in proportion of caries-free children with primary dentition (5 studies, 6278 children) or permanent dentition (4 studies, 6219 children), or adverse effects (2 studies, 7800 children).

Only one study, conducted after 1975, reported disparities according to socioeconomic status, with no evidence that deprivation influenced the relationship between water exposure and caries status.

#### Water fluoridation cessation (1 study)

Because of very low-certainty evidence, we could not determine if the cessation of CWF affected DMFS (1 study conducted after 1975; 2994 children). Data were not available for other review outcomes for this comparison.

#### Association of water fluoridation with dental fluorosis (135 studies)

The previous version of this review found low-certainty evidence that fluoridated water may be associated with dental fluorosis. With a fluoride level of 0.7 parts per million (ppm), approximately 12% of participants had fluorosis of aesthetic concern (95% CI 8% to 17%; 40 studies, 59,630 participants), and approximately 40% had fluorosis of any level (95% CI 35% to 44%; 90 studies, 180,530 participants). Because of very low-certainty evidence, we were unsure of other adverse effects (including skeletal fluorosis, bone fractures and skeletal maturity; 5 studies, incomplete participant numbers).

### Authors' conclusions

Contemporary studies indicate that initiation of CWF may lead to a slightly greater reduction in dmft and may lead to a slightly greater increase in the proportion of caries-free children, but with smaller effect sizes than pre-1975 studies. There is insufficient evidence to determine the effect of cessation of CWF on caries and whether water fluoridation results in a change in disparities in caries according to socioeconomic status. We found no eligible studies that report caries outcomes in adults.

The implementation or cessation of CWF requires careful consideration of this current evidence, in the broader context of a population's oral health, diet and consumption of tap water, movement or migration, and the availability and uptake of other caries-prevention strategies. Acceptability, cost-effectiveness and feasibility of the implementation and monitoring of a CWF programme should also be taken into account.

### PLAIN LANGUAGE SUMMARY

#### Does adding fluoride to water supplies prevent tooth decay?

#### Key messages

#### Water fluoridation for the prevention of dental caries (Review)

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- Adding fluoride to water supplies may lead to slightly less tooth decay in children's baby teeth.
- It may also lead to slightly more children being free of tooth decay.
- The benefits of fluoride in water supplies may be smaller than they were before the widespread addition of fluoride to toothpaste.

### Tooth decay and the use of fluoride

Tooth decay is a worldwide problem affecting most adults and children. Untreated decay may cause pain and lead to teeth having to be removed.

Fluoride is a mineral which occurs naturally in water at different concentrations. It prevents tooth decay. Since 1975, fluoride has been an ingredient in most toothpastes. It is available in some mouth-rinses, and dentists use treatments that contain fluoride. It is possible to add fluoride to the local water supply. In this case, everyone in a community will have access to fluoride.

If young children swallow too much fluoride while their permanent teeth are forming, marks may develop on those teeth – this is called dental fluorosis. This can be very mild, with barely noticeable white lines or streaks. Rarely, some fluorosis is more noticeable, and people can dislike how their teeth look.

### What did we want to find out?

We wanted to find out if water with added fluoride in the local water supply is better than water without added fluoride at:

- reducing the number of teeth, or tooth surfaces, with signs of decay;
- increasing the number of people who have no tooth decay.

We also wanted to find out about unwanted effects.

### What did we do?

We searched for studies comparing communities that had fluoride added to their water supplies with communities that had no additional fluoride in their water.

The last time we published this Cochrane review, we also searched for studies that reported dental fluorosis and the concentration of fluoride in the water. Because the association of fluoridated water with dental fluorosis is widely accepted, we did not update the evidence on this occasion.

### What did we find?

We found 21 studies that assessed the effects of adding fluoride to a water supply. We also found one study that assessed the effects of stopping artificially-added fluoride in a water supply. Studies only measured tooth decay in children.

In the last version of the review – not updated on this occasion – we found 135 studies that assessed the association of fluoridated water with dental fluorosis.

### Main results

Studies conducted after 1975 showed that adding fluoride to water may lead to slightly less tooth decay in children's baby teeth. We could not be sure whether adding fluoride to water reduced tooth decay in children's permanent teeth or decay on the surfaces of permanent teeth.

Adding fluoride to water may slightly increase the number of children who have no tooth decay in either their baby teeth or permanent teeth. However, these results also included the possibility of little or no difference in tooth decay.

Studies conducted in 1975 or earlier showed a clear and important effect on prevention of tooth decay in children. However, due to the increased availability of fluoride in toothpaste since 1975, it is unlikely that we will see this effect in all populations today.

We were unsure whether there were any effects on tooth decay when fluoride is removed from a water supply.

We were unsure if fluoride reduces differences in tooth decay between richer and poorer people.

In the last version of the review, we found that adding fluoride to water supplies increases the number of people with dental fluorosis. If water contains 0.7 mg/L of fluoride, about 12% of people may have dental fluorosis that causes them to be bothered about how their teeth look, and about 40% of people may have dental fluorosis of any level. We were unsure whether fluoride in water leads to other unwanted effects.



### What are the limitations of the evidence?

Our confidence in the evidence is limited because this review included studies in which communities were deliberately selected to have changes to fluoride levels in the water supply. Although a common study approach for this topic, it can mean that there are differences between communities that might affect the results. In addition, the findings in some studies were different from others, and some results included the possibility of benefit and no benefit.

Older studies were conducted before the widespread use of fluoride toothpaste and other improvements in tooth decay prevention. This meant we could not tell if these results were applicable to current times. However, they may still be relevant to countries in which tooth decay is very high and people don't have easy access to fluoride toothpaste and other prevention strategies.

### How current is this evidence?

For the effects of water fluoridation on tooth decay, this review updates our previous review and the evidence is current to August 2023.

For the association of fluoridated water with dental fluorosis, the review evidence is current to February 2015.

Abstract for MGRAPH-08

**NTP Monograph on the State of the Science Concerning Fluoride Exposure and Neurodevelopment and Cognition: A Systematic Review**

**Report Date:** August 2024

**Background**

Fluoride is a common exposure in our environment that comes from a variety of sources and is widely promoted for its dental and overall oral health benefits. Contributions to an individual's total exposure come primarily from fluoride in drinking water, food, beverages and dental products. A 2006 evaluation by the National Research Council (NRC) found support for an association between consumption of high levels of naturally occurring fluoride in drinking water and adverse neurological effects in humans and recommended further investigation. The evidence reviewed at that time was from dental and skeletal fluorosis-endemic regions of China. Since the NRC evaluation, the number and location of studies examining cognitive and neurobehavioral effects of fluoride in humans have grown considerably, including several recent North American prospective cohort studies evaluating prenatal fluoride exposure.

In 2016, the National Toxicology Program (NTP) published a systematic review of the evidence from experimental animal studies on the effects of fluoride on learning and memory. That systematic review found a low-to-moderate level of evidence that deficits in learning and memory occur in non-human mammals exposed to fluoride.

**Objective**

To conduct a systematic review of the human, experimental animal, and mechanistic literature to evaluate the extent and quality of the evidence linking fluoride exposure to neurodevelopmental and cognitive effects in humans.

**Method**

A systematic review protocol was developed and utilized following the standardized OHAT systematic review approach for conducting literature-based health assessments. This monograph presents the current state of evidence associating fluoride exposure with cognitive or neurodevelopmental health effects and incorporated predefined assessments of study quality and confidence levels. Benefits of fluoride with respect to oral health are not addressed in this monograph.

**Results**

The bodies of experimental animal studies and human mechanistic evidence do not provide clarity on the association between fluoride exposure and cognitive or neurodevelopmental human health effects. Human mechanistic studies were too heterogeneous and limited in number to make any determination on biological plausibility.

This systematic review identified studies that assessed the association between estimated fluoride exposure and cognitive or neurodevelopmental effects in both adults and children, which were evaluated separately. The most common exposure assessment measures were drinking water concentrations and estimates of total fluoride exposure, as reflected in biomarkers such as urinary fluoride. In adults, only two high-quality cross-sectional studies

examining cognitive effects were available. The literature in children was more extensive and was separated into studies assessing intelligence quotient (IQ) and studies assessing other cognitive or neurodevelopmental outcomes. Eight of nine high-quality studies examining other cognitive or neurodevelopmental outcomes reported associations with estimated fluoride exposure. Seventy-two studies assessed the association between fluoride exposure and IQ in children. Nineteen of those studies were considered to be high quality; of these, 18 reported an inverse association between estimated fluoride exposure and IQ in children. The 18 studies, which include 3 prospective cohort studies and 15 cross-sectional studies, were conducted in 5 different countries. Forty-six of the 53 low-quality studies in children also found evidence of an inverse association between estimated fluoride exposure and IQ in children.

### **Discussion**

Existing animal studies provide little insight into the question of whether fluoride exposure affects IQ. In addition, studies that evaluated fluoride exposure and mechanistic data in humans were too heterogeneous and limited in number to make any determination on biological plausibility. The body of evidence from studies in adults is also limited and provides low confidence that fluoride exposure is associated with adverse effects on adult cognition. There is, however, a large body of evidence on associations between fluoride exposure and IQ in children. There is also some evidence that fluoride exposure is associated with other neurodevelopmental and cognitive effects in children; although, because of the heterogeneity of the outcomes, there is low confidence in the literature for these other effects. This review finds, with moderate confidence, that higher estimated fluoride exposures (e.g., as in approximations of exposure such as drinking water fluoride concentrations that exceed the World Health Organization Guidelines for Drinking-water Quality of 1.5 mg/L of fluoride) are consistently associated with lower IQ in children. More studies are needed to fully understand the potential for lower fluoride exposure to affect children's IQ.

National Toxicology Program (NTP). 2024. NTP monograph on the state of the science concerning fluoride exposure and neurodevelopment and cognition: a systematic review. Research Triangle Park, NC: National Toxicology Program. NTP Monograph 08. <https://doi.org/10.22427/NTP-MGRAPH-8>

7 October 2024

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Tēnā koe 

Thank you for your email of 27 September 2024 to the Director-General of Health, Dr Diana Sarfati, regarding a United States court judgment relating to community water fluoridation. The Director-General has asked that I respond to you directly.

The Director-General is aware of the recent decision of the US District Court for the Northern District of California.

As was required by the New Zealand High Court, the Director-General is undertaking a Bill of Rights analysis of the 2022 directions to fluoridate to ensure that section 11 of the New Zealand Bill of Rights Act 1990 is considered. The directions to fluoridate remain in place in accordance with High Court rulings.

As was outlined in my previous response to you, the World Health Organization and other international and national health and scientific experts endorse water fluoridation as a safe and effective public health measure for preventing dental decay. A 2014 report conducted by Royal Society Te Apārangi, jointly with the Office of the Prime Minister's Chief Science Advisor, concluded that there are no adverse health effects of any significance from fluoridation at the level used in New Zealand. In June 2021, the Office of the Prime Minister's Chief Science Advisor released an evidence update confirming this conclusion. These reviews are publicly available at: [www.pmcra.ac.nz/topics/fluoridation-an-update-on-evidence/](http://www.pmcra.ac.nz/topics/fluoridation-an-update-on-evidence/)

Nāku noa, nā



Jane Chambers  
Group Manager Public Health Policy and Regulation  
Public Health Agency | Te Pou Hauora Tūmatanui

**IN THE HIGH COURT OF NEW ZEALAND  
WELLINGTON REGISTRY**

**I TE KŌTI MATUA O AOTEAROA  
TE WHANGANUI-A-TARA ROHE**

**CIV-2023-485-330  
[2024] NZHC 1717**

UNDER the Judicial Review Procedure Act 2016 and  
Part 30 of the High Court Rules

IN THE MATTER of an application for judicial review of  
directions made by the Director-General of  
Health under section 116E(1) of the Health  
Act 1956

BETWEEN NEW HEALTH NEW ZEALAND  
INCORPORATED  
Applicant

AND DIRECTOR-GENERAL OF HEALTH  
First Respondent

ATTORNEY-GENERAL  
Second Respondent

Hearing: Teleconference on 26 June 2024 at 10 am

Counsel: L M Hansen and C F J Reid for Applicant  
J N E Varuhas and R E R Gavey for First and Second  
Respondents

Judgment: 26 June 2024

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**JUDGMENT OF RADICH J**

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[1] In my judgment on relief in this proceeding of 16 February 2024, I made an order under s 17(3) of the Judicial Review Procedure Act 2016 directing the Director-General to reconsider and determine the decision described in [1] of my first decision in the proceeding.<sup>1</sup>

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<sup>1</sup> *New Health New Zealand Inc v Director-General of Health* [2024] NZHC 196 at [31].

[2] In [33] of that decision, I observed that, in accordance with s 17(6) of the Judicial Review Procedure Act, the decision to be reconsidered continues to have effect. In that paragraph I went on to say:

It is not in my view an appropriate case for an interim order to be made and, for the reasons given, I do not see additional relief under s 16 of the Judicial Review Procedure Act as being warranted.

[3] Despite those findings, on 4 June 2024, the applicant sought, in a memorandum, interim orders under s 15(3) of the Judicial Review Procedure Act to prevent the first respondent taking any further action in relation to the directions to the 14 local authorities to fluoridate that are in question. Interim orders were sought, also, declaring that the first respondent not to instigate or continue any proceedings in connection with any matter to which the application relates pending completion of the reconsideration I had directed.

[4] Following the respondents' response to that memorandum, the applicant adjusted its position and filed, instead, an 'interlocutory application for recall of judgment and further interim orders' on 18 June 2024. That application seeks orders:

- (a) That my judgment on relief of 16 February 2024 be recalled.
- (b) That paragraph [33] of that decision be amended to reserve leave to the applicant to apply for further directions and/or interim orders.
- (c) That consequential on (b), the reconsideration process on the part of the first respondent be timetabled.
- (d) By way of declaration, that the first respondent ought not to institute any proceedings in connection with any council that does not comply with any direction unless and until the first respondent has undertaken a reconsideration and determined that a direction is a reasonable limit on the right to refuse medical treatment.

[5] At this morning's teleconference on the applicant's application, timetabling directions were made for a hearing of the application on 9 August 2024.<sup>2</sup>

[6] In the meantime, the applicant seeks an interim declaration in the nature of that described in [4(d)] above pending further consideration of the issue at the 9 August hearing. That application is opposed by the respondents. In support of the application for what is essentially an interim declaration under s 15(3) of the Judicial Review Procedure Act, Ms Hansen said that it would be wrong in principle for the Director-General to take action against a council until the reconsideration process had been carried out. She said that, if the Director-General was not constrained, a risk of predetermination in the reconsideration process would arise.

[7] In circumstances in which a failure to comply with a direction of the Director-General to fluoridate is a statutory offence, giving rise to a fine of up to \$200,000, it is said that the position should effectively be held at least until the 9 August hearing.<sup>3</sup>

[8] Mr Varuhas, for the respondents, opposed the application on the basis that it is at odds with my previous decisions, that the first respondent is actively complying with the orders that have been made, that the first respondent's directions remain valid in the meantime<sup>4</sup> and that there is no indication that the Director-General would take enforcement action in relation to the directions.

[9] At the conclusion of this morning's teleconference, I said that I would not be making the interim declarations sought.

[10] The starting point is that, in [33] of my 16 February 2024 decision, having considered the position, I concluded that it was not appropriate in this case for an interim order to be made. The applicant seeks, through the recall application, to have that conclusion altered. That application is yet to be considered but at this stage I do not see a basis to make such a material change to the decision on relief.

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<sup>2</sup> Those directions are the subject of a separate minute.

<sup>3</sup> Reference was made, by way of example, to the Waitaki District Council which, it is said, has a 28 June deadline to comply with the Director-General's directions.

<sup>4</sup> Reference having been made by both parties to the decision of La Hood J in *Fluoride Action Network (NZ) Inc v Hastings District Council* [2024] NZHC 1313

[11] Moreover, as has been said for the respondents, there has been no indication that the Director-General would take enforcement action and the Director-General has not taken any such action. Mr Varuhas put it on the basis that at this stage the Director-General is taking an educative approach. Any decision on enforcement action would need to be informed by the Solicitor-General's guidelines. In the event that enforcement action was threatened, then the most appropriate course would be for any council affected to seek interim orders.

[12] Accordingly, I do not at this stage see a sufficient position on the part of the applicants that needs to be preserved. In addition, I do not see the applicant's case on the interim declaration sought to be sufficiently strong and, moreover, I do not see the balance of convenience or the overall justice of the current position to favour the applicant.

[13] Whether there is a basis for the 16 February 2024 decision to be recalled so that a form of interim order or declaration could be made will be the subject of the hearing on 9 August 2024.

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Radich J

Solicitors:  
Maxwell Law, Wellington for Plaintiff  
Crown Law, Wellington for First and Second Defendants