

CHAP Study A comments received from Cecile E. Willert (Jacques Whitford), dated April 26, 2005

Comment Number	Comment	Ventana Response
1	<p>Page 14, "Background" The four CoCs in the CBRA are noted here; however, the Ministry of the Environment also found elevated levels of other chemicals in the area that have not been attributed to Inco. Omitting mention of these introduces potential for bias since there is potential for health impacts from these chemicals, also, that may confound the interpretation of the study results. It would be useful to list these and indicate that they have not been attributed to the operation of the Inco refinery. These would include the following metals that exceed the MOEs human health based criteria (MOE 2002): antimony, beryllium, cadmium and lead.</p>	<p>Discussion of potential environmental pollutants other than the four CoCs was not in the scope of this project.</p>
2	<p>Page 14, "Research objectives" "contamination" appears to mean "CoC" or contaminants attributed to Inco, as opposed to all contaminants present in Port Colborne.</p>	<p>Research objective 3 has been revised (see Errata sheet).</p>
3	<p>Page 18, Odds ratios table The table is not referenced in the text. A reference indicating whether these numbers are based on self diagnosis or self reported as physician diagnosed would aid in the interpretation.</p>	<p>Reference to table is included in the November 30, 2004 version of the CHAP A report. All conditions listed in the table were self reported as physician diagnosed except as follows: Self-reported: nasal allergies/hay fever, >5 hypothyroid symptoms and 8 chronic fatigue syndrome symptoms Self-reported, followed by question of whether condition was confirmed by doctor: asthma, eczema, and contact dermatitis</p>
4	<p>The first 2 conditions given for defining a CoC are worded differently from those actually followed in identifying CoCs and the wording is sufficiently different to significantly alter the meaning. Please replace these bullets with the following: were historically used or generated by the Inco Refinery or its processes, and are present at a community level at concentrations greater than MOE generic effects-based guidelines (MOEE 1997), and whose presence in soil show a scientific linkage to the historical operations of the Inco Refinery.</p>	<p>Conditions have been revised (see Errata sheet).</p>
5	<p>Page 20, first sentence after bullets Please limit the statement to CoC concentrations above background and clarify that Inco is the major but not only source of the CoCs as</p>	<p>By definition (see page 26 of 222), a CoC is present above background levels. Statement regarding CoC source has been revised (see Errata sheet).</p>

CHAP Study A comments received from Cecile E. Willert (Jacques Whitford), dated April 26, 2005

Comment Number	Comment	Ventana Response
	Algoma was also a source. Algoma is not mentioned until page 23, making earlier comments imply that Inco is the only source.	
6	Page 20, last full paragraph Please reword 1st sentence. The CBRA does address the potential for CoCs to affect human health. What it doesn't do is provide a measure of whether health outcomes have occurred that may be associated with CoCs in the community.	Sentence has been re-worded (see Errata sheet).
7	Page 22, Section 1.3 It may also be useful to provide a brief summary on health conditions associated with antimony, beryllium, cadmium and lead (see comment 1).	Discussion of potential environmental pollutants other than the four CoCs was not in the scope of this project.
8	Page 22-23, sentence starting on page 22, ending on page 23. See comment #5 above.	Reference to other industrial sources of pollution (e.g., Algoma) immediately follows cited paragraph (pages 28 to 29 of 222).
9	Page 23, section 1.3.1, last paragraph This information is not correct and the MOE report cited indicates information very different from this. I suggest deleting paragraph.	The first sentence of the last paragraph of Section 1.3.1 has been amended (see Errata sheet).
10	Page 27, section 2.1.1 It may be helpful to list the exclusion of institutionalized persons including nursing home residents in the limitations of the study.	Exclusion of institutionalized persons from the sampling frame is detailed in Sections 2.1.1 and 2.1.2, and corresponds with practices used in national health surveys. In Port Colborne, these persons account for approximately 112 of 7803 households (1.4%) originally on the sampling frame.
11	Page 28, section 2.1.2 It would be helpful to present a discussion and map of the GSAs prior to referring to specific ones such as is done in this section.	Comment noted. No further action taken. Map of GSAs is presented in Appendix C2.
12	Page 39, section 2.6.1 It would be useful to list these constraints in the study limitations.	These constraints are discussed in Section 9.2 of the study report.
13	Page 88, Sample weighting It's unclear whether the weighting was applied to the entire study population, or to each of the GSAs, or both. Application to each of the GSAs may introduce additional bias that warrants acknowledgement. Another survey in the area (Jacques Whitford 2005) using a survey methodology in which somewhat less bias is expected than the self administered survey, indicated clear	Because comparisons to the 1996 Canadian census identified that participants were underrepresented in the younger age groups and were over-represented in the older age group, a sample weight was applied to each participant that represented the contribution of his or her response to the overall Port Colborne population. (see page 97 of 222).

CHAP Study A comments received from Cecile E. Willert (Jacques Whitford), dated April 26, 2005

Comment Number	Comment	Ventana Response
	differences in age demographics between study quadrants in Port Colborne.	Jacques Whitford (2005) was not an available reference at the time the Study A report was written.
14	Appendix A1 It should be noted that the maps presented as showing CoC contours are draft maps and the "Approved by" area of these maps is left blank, indicating that these maps have not been approved. The author is referred to approved, final maps found in more recent reports (see Jacques Whitford 2004; 2005). A pdf copy of these maps can be provided on request.	Final approved maps were not available at the time the report was prepared.
15	Appendix B2 Health affects shown for arsenic are more correctly applicable to inorganic arsenic. Please clarify this in the table and anywhere else in the report that refers to health impacts of arsenic, if not already specific to the inorganic form.	The table outlining the health effects of the CoCs identifies directly or indirectly (i.e., arsenic trioxide) that the arsenic in question is the inorganic form (for cardiovascular disorders, cancer, and gastrointestinal/hepatic disorders). The arsenic in question for the other listed disorders is also the inorganic form.
16	Appendix C1 [<i>sic</i>] We trust that this map was clear in the survey and will be clear in the final report, as the regions cannot be distinguished on the print out in the draft report.	The GSA map presented in Appendix C2 is best viewed in colour (either on screen or in print). The map was printed in colour and supplied with each questionnaire package. Furthermore, street names that form the boundaries of the GSAs are noted on the map.
17	Page D3, 2nd paragraph The final weights could not be found in Appendix B, as indicated. See also comment #13.	All sample weighting information summarized in the Appendix section is included in Appendix D. Reference to Appendix B has been deleted (see Errata sheet).

CHAP Study A comments received from Ellen Smith, with no date stated		
Comment Number	Comment	Ventana Response
1	Foremost, could Ventana explain a statement made in a piece of correspondence that was in the CHAP survey packages? The letter has no date, but explains that questionnaires will be sent out soon and provides a basic description of what the study's purpose is and is signed by Linda Kasprzak, CHAP Project Director. The paragraph of my concern states, "A final study [sic] will be made available to the local officials, health providers and all interested citizens. It may be that this final report or publications from this project will be used to resolve health or legal issues in your community or other communities." What is being referred to as "local officials [sic] and health providers"? Is this report or other parts of the CHAP study going to be used to resolve present and/or future legal issues? If so, I don't think the community, specifically those who responded to the questionnaires, were aware of the fact that their "health conditions" or "health status" would be used in a courtroom. That being said, I feel that INCO should publicly state their intended use of this report.	Ventana was commissioned to conduct a general health survey among the residents of Port Colborne, which included producing a study report. In its final form, the CHAP A report will be a public document, available to any person (as stated in the information sheet referenced by Ms. Smith). Ventana cannot comment on how the report will be used by any party.
2	Page 15 of 212: Last paragraph starting, "A closer look inside the Port Colborne community"...states that residents in GSA 3 "were more likely to report characteristics potentially associated with poor health (e.g. cigarette smoking and passive smoke exposure, alcohol use, lower income and obesity). And subsequently "perceived their health as "poor" and scored lower on the self-reported HRQ of Life measures". If one looks at each of these characteristics within the report findings individually for the GSA 3 area, the above statements differ considerably. For example:	In response to the comments by Ellen Smith, a brief explanation of the statistical analyses is given below. More specific responses are found beside each specific comment. Results are given as proportions (%) or Odds Ratios (OR) which account for differences in the sample sizes of each region (i.e., calculated based on the number of respondents reporting a specific outcome divided by the total number of respondents). The 95% Confidence Intervals (95% CI) of the ORs are also calculated in such a way that the size of the sample is taken into account. We can always say that we are "95% confident" that the interval includes the unknown value, and the width of the confidence interval gives us some idea about how uncertain we are about the unknown value. For example, when a region has a smaller sample size (as for GSA3), the 95% CI is wider. For GSAs 1,2, and 5 combined, where the sample size is larger, the

CHAP Study A comments received from Ellen Smith, with no date stated

Comment Number	Comment	Ventana Response
		<p>95% CI are narrower.</p> <p>When you are comparing the 95% CIs of ORs, and they do not overlap (that is the highest value for one interval is still lower than the lowest value for the other interval), then the difference between the two parameters are considered to be statistically significant (with a 5% probability that the difference occurred due to chance alone). Differences are reported in the report (and again below) where non-overlapping 95% CIs were observed. In these cases, even though the intervals were wider for GSA3 due to the smaller sample size and more variability, the differences were still statistically significant.</p>
<p>2a</p>	<p>Cigarette smoking/passive smoke exposure: Exhibit 23 demonstrates the prevalence of smoking variables for adult participants and doesn't show (in %'s) a huge difference between GSA's especially considering 3 other areas are grouped together and then compared to GSA 3. That would be 3 times the number of participants compared to one group and therefore an unfair and unbalanced comparison. Exhibit 24 reports passive smoke exposure and again, GSA 3 is compared to a combined group of 3 other areas therefore making an unbalanced comparison.</p>	<p>The rates of ever smoking, and passive smoke exposure, were significantly different between GSAs.</p>
<p>2b</p>	<p>Alcohol use: Exhibit 25 reports the prevalence of alcohol variables and shows that in GSA 3, only the specific category of "once per month or more" is slightly higher than the other combined GSA's. Statements like, "Once per month to four to six times per week" is quite a big spread. All it would take to increase that % is for a survey participant to report that they went to 1 (one) social function like a wedding in the last year and they would be categorized as having a higher alcohol consumption. Again, GSA 3 is being compared to a grouping of 3 other areas, which makes the outcome unbalanced.</p>	<p>The proportion of respondents who drank more than 5 drinks on any occasion 'once per month or more' was significantly different between GSAs. Drinking more than 5 drinks at a sitting is shown to be associated with negative health outcomes (as opposed to consuming 1-2 drinks per day which may be associated with better health outcomes). If one survey participant in GSA3 changed their response from one category to the other, the percentage would change by about 0.1 – 0.2%; the difference observed is about 7% (6.8%).</p>
<p>2c</p>	<p>Lower income: Exhibit 20 reports the prevalence of income level, highest level of education and employment status for</p>	<p>The number of respondents in GSA3 that reported grade school as highest level of education attained was about 2 times higher,</p>

CHAP Study A comments received from Ellen Smith, with no date stated		
Comment Number	Comment	Ventana Response
	adult participants. As with the other categories, there isn't a really big difference in %'s of the GSA 3 compared to the remaining GSA's. Again it must be noted that GSA 3 is being compared to a group of 3 other areas combined therefore making the comparison unbalanced.	and those that reported university was 2.4 times lower than in the combined GSAs. Respondents in GSA3 were less likely to report income levels of more than \$80,000 per year.
2d	Obesity: Exhibit 26 reports the body mass index for adult participants in the survey. How is BMI determined and where do the standards (used in the chart) come from? Is this explained in the report and more importantly explained in the survey so that participants understand how BMI is determined? Again, GSA 3 is being compared to a combined group of 3 other areas therefore producing an unbalanced comparison.	BMI was not self-reported by participants, it was calculated from the height and weight reported by the participants (the BMI calculation is given on p. 66, Methods for Chapter 4), therefore, it was not necessary for respondents to understand the calculation (it was not a question in the survey).
3	<p>In conclusion, each of these above mentioned exhibits (and others in the report) compare the small number of participants from GSA 3 to a combined number of participants from 3 other areas within Port Colborne. According to Exhibit 5 which reports the 1996 Canadian Census versus the number of responding households by GSA, there is a drastic difference between GSA's in response rates.</p> <p>GSA 1 responding households: 1,015 GSA 2 responding households: 1,090 GSA 3 responding households: 366 GSA 4 responding households: 472 GSA 5 responding households: 446</p> <p>In this report, most responses are separated as: GSA 3 (366) GSA 4 (472) and GSA 1,2 & 5 combined (2551)</p>	<p>The response rates were not drastically different; response rates (which are calculated as proportions (%) to account for differences in the total number of eligible households in each region) are similar between the GSAs. All of the response rates were between 40% and 50%; GSA3 was 45.9% (see p. 52 and 53, and Exhibit 5).</p> <p>The GSAs were derived according to estimations of soil contamination levels with specific boundaries defined according to census enumeration areas. Because the estimated exposure levels were similar between GSAs 1, 2, and 5, these areas were combined because separating them would not provide any additional information (i.e. this is the control group). The statistical methods for accounting for the differences in sample size were described above.</p>

CHAP Study A comments received from Ellen Smith, with no date stated		
Comment Number	Comment	Ventana Response
	As well, the numbers (% of results) in each of these exhibits are not drastically higher than the other GSA's compared to GSA 3, so how or why is it that Ventana can comfortably emphasize and make statements regarding the "characteristics of poor health" in GSA 3 participants?	GSA3 had differences in lifestyle characteristics associated with poorer health outcomes, including those described above. These characteristics are some of the many factors that may affect the health status of the residents. It is therefore necessary to report these characteristics to provide a balanced interpretation of the results and avoid false conclusions.

CHAP Study A (report version date September 24, 2004) comments received from Evert Nieboer (Regional Niagara Public Health Department), dated April 29, 2005

Comment Number	Comment	Ventana Response
1	It is our assessment that the current draft needs to be carefully and thoroughly reviewed and that a second draft is warranted. At a minimum, an addendum to the report is recommended. Most of the comments below constitute reasons for this.	Comment noted. No further action taken.
2	It is crucial that an effective communication strategy be employed during upcoming public discussions of the document. Issues such as "unfavourable" socio-demographic characteristics and awareness bias have the potential of placing severe strains on the Port Colborne community and incurring long-term divisions.	Comment noted. No further action taken.
3	The findings and limitations of the study need to be viewed in the context of the upcoming integration exercise of Studies A and C.	Comment noted. No further action taken.
4	Page 15, main paragraph and elsewhere. Is it possible to assess more quantitatively the impact of exploring lifetime prevalences rather than point prevalences as done in the published studies used in the comparisons (i.e., Canadian Community Health Survey, CCHS; and the National Longitudinal Survey of Children and Youth, NLSCY in Chapter 6)? If not, the Port Colborne findings may nevertheless have inherent, self-standing research validity, even though they may be difficult to compare to other completed surveys. Consistency with the results of Study C and intra-community comparisons come to mind.	The decision to explore lifetime prevalence was agreed upon prior to the start of the study and during review by the Technical Subcommittee. Additional analyses to assess the quantitative impact of this decision are outside the scope of the project.
5	Page 17, 185, 193, Recommendations. It seems appropriate to mention the CHAP decision tree and the integration report task that is to follow the completion of CHAP Studies A and C.	Mention of the integration study was specifically omitted as only references to final, approved documents could be included.
6	Page 18, the odds ratios printed in bold type are not identified as statistically significant and no adjustments are declared; neither is this table mentioned in the text. Also see Item 16 below.	This is a summary table included for readability in the executive summary. The in-text reference to the table is included in the November 30, 2004 version of the CHAP A report. Bolding has been footnoted (see Errata sheet).
7	Section 1.3.3. Reference 11 seems rather generic, while quite a few epidemiological studies have been published on Sudbury and Port Colborne nickel miners and/or refinery workers, mostly by McMaster researchers [with D.C.F. Muir as the senior author and	Reference 11 was the reference used while writing the final report for Study A. The reference cited in the comment was not used, and therefore cannot be included in report.

CHAP Study A (report version date September 24, 2004) comments received from Evert Nieboer (Regional Niagara Public Health Department), dated April 29, 2005

Comment Number	Comment	Ventana Response
	summarized/critically reviewed by Doll (Scand. J. Work Environ. Health 1990; 16:1-82)].	
8	<p>References 6 and 15 are incompletely cited.</p> <p>Leece B, Rifat S. Assessment of Potential Health Risks of Reported Soil Levels of Nickel, Copper and Cobalt in Port Colborne and Vicinity (May 1997). Toronto: Queen's Printer, 1998 (ISBN 0-7778-7884-4). [Revised January 2000 by R Williams and ML Decou, Regional Niagara Public Health Department.]</p> <p>Decou ML, Williams R, Ellis E. Lead Screening Report, Eastside Community, Port Colborne (April-June, 2001). St. Catharines, Regional Niagara Public Health Department, August, 2001.</p>	References corrected (see Errata sheet)
9	Section 2.1.5, p. 31. How closely does the GSA3 area correspond to the Eastside Community? And what about GSA4? More detailed descriptive information is warranted.	The map that defines the GSAs is supplied in Appendix C2, and is best viewed in colour (either on screen or in print). The map was printed in colour and supplied with each questionnaire package. Furthermore, street names that form the boundaries of the GSAs are noted on the map.
10	Page 34, Section 2.2.2. More information about the pilot testing of the questionnaire seems appropriate.	A sample of thirty individuals was sampled from a Community Centre in the Toronto area (n=15) and from a Long-Term Care facility for seniors (n=15) to test the questionnaire for overall impression, ease of use, comprehension, and time for completion (see Errata sheet).
11	Section 2.3, p. 35, might a bias exist in relation to the time the questionnaire was completed (February versus July for example)?	The questionnaires were constructed to reduce bias in relation to the time the questionnaire was completed. The only questions that referred to a specific time (e.g., past four weeks) were those of the SF-36, which could not be altered for comparative purposes. All other questions either did not have a temporal element or were asking for information over the past year.
12	Section 2.5, p.36, 2nd paragraph. How many people were contacted in the followup after the questionnaires had been submitted? What type of information was sought? Did this practice introduce a bias?	Only those participants who indicated a willingness for further contact were contacted to resolve any missing data from their questionnaires. This was not expected to introduce a bias.

CHAP Study A (report version date September 24, 2004) comments received from Evert Nieboer (Regional Niagara Public Health Department), dated April 29, 2005

Comment Number	Comment	Ventana Response
13	Section 2.6.1, p. 39, 2nd last par. This statement here seems to contradict the earlier discussion of lifetime versus point prevalences.	<p>The statement in question is as follows (page 45 of 222): "One important constraint is that this survey provides only a snapshot of the general health of the community of Port Colborne during the period when the SRHQ was completed. This study is unable to evaluate any changes in health status that have occurred over time and, as such, is unable to fully determine whether the currently observed level of health is a new or old phenomenon."</p> <p>The statement does not refer to lifetime versus point prevalence data. Rather, it identifies a study design constraint in that the survey could only capture the current health status of the current residents of Port Colborne (the "snapshot") instead of comprehensive health data of all residents, past and present, for an extended period of time.</p>
14	Chapters 4 to 7. Some more technical details on the statistical methods employed would be helpful, including: distribution normalization, stratification methods, and the SAS cluster option.	Additional statistical information can be found in Section 2.7. The statistical method summaries located at the beginning of each of Chapters 4 through 7 were intended to give general details to help the reader in the interpretations of the results.
15	Section 4.4.3. Underground mining is reported as a current occupation. This does not make sense.	Question 63 of the adult questionnaire asks "Do you now or have you ever worked for 2 years or longer in one of the following industries/occupations?" One of the options is underground mining. Whether underground mining is a current occupation is not considered.
16	For the non-expert reader, it would be helpful if the tables reporting results clearly state whether the reported data are based on self-reported outcomes or self supported physician-diagnosed outcomes. A prime example is the table on page 18 (see item 6 above) which reports data in both categories.	<p>All conditions listed in the table were self reported as physician diagnosed except as follows:</p> <p>Self-reported: nasal allergies/hay fever, >5 hypothyroid symptoms and 8 chronic fatigue syndrome symptoms</p> <p>Self-reported, followed by question of whether condition was confirmed by doctor: asthma, eczema, and contact dermatitis</p>
17	In the summaries on p. 115 and 141, odd ratio values are presented without the confidence interval.	Confidence intervals were not included when presented odd ratio values in the summaries of results as a means to simplify the summaries. Confidence intervals are included in all other tables

CHAP Study A (report version date September 24, 2004) comments received from Evert Nieboer (Regional Niagara Public Health Department), dated April 29, 2005

Comment Number	Comment	Ventana Response
		and in-text references.
18	A discussion of statistical power (sample size) seems essential in assessing the evidence presented in Chapter 7 when comparing the outcomes for the various GSAs.	This is stated as a limitation (Section 7.3 – Discussion, p.185) and, as described previously, the sample size characteristics are reflected in the width of the confidence intervals. Specific power calculations were not performed, as a separate calculation would be needed for each outcome/condition, and this is out of the scope of the project.
19	A more quantitative discussion of the magnitude of the odds ratios reported in Chapters 6 and 7 seems in order, especially in terms of the limitations of the study. This is needed to interpret the findings and to put them into context. Again, the difference between life-time and point prevalences comes in.	For those measures where validated criteria exist for determining clinical significance, statements of clinical significance have been made (i.e., SF-36, Quality of Life). For other conditions/outcomes, statements of clinical significance were not made because they would be based on investigator judgment, rather than validated criteria.
20	The limitations of the exposure index employed (i.e., average soil CoCs concentrations) need to be discussed. Is it really sensitive enough to even use it for exposure characterization, especially since the number of sample sites is quite different between the GSAs? In epidemiology, ecological measures of exposure such as those employed in the present study characterize geographical areas and are not the same as individual exposure indices.	The criteria for estimating exposure levels were agreed upon prior to the start of the study and during review with the Technical Subcommittee. The limitations of this are noted on page 31, Section 1.4.
21	What was the rationale for placing the "Self-Reported Health According to Perceived Level of Concern" and "Port Colborne Community Concerns" sections in the Appendices?	These were placed in the appendices to sharpen the focus of the report on the more quantifiable, less subjective elements of the study.
22	The massive amount of data presented is overwhelming and a more user-friendly format to help the reader navigate the document and absorb the data might be explored. Lists of exhibits and appendices are cases in point.	A list of exhibits has been included (report version date November 30, 2004).
23	Exhibit 116, p. 186 provides a tabulation of the number of individuals for each health outcome (self-reported physician-diagnosed) with statistically significant odds ratios who indicated in the SRHQ their willingness to participate in a followup study. This compilation may be helpful in the Study C and Study A integration deliberations.	Comment noted. No further action taken.

CHAP Study A (report version date September 24, 2004) comments received from Evert Nieboer (Regional Niagara Public Health Department), dated April 29, 2005

Comment Number	Comment	Ventana Response
24	A perusal of the comments released by the Expert Advisory Committee (EAC) concurrently with the Study A Report yields the following observations.	Comment noted. No further action taken.
24a	The EAC expands on the limitations of Study A recognized and summarized by the researchers (see Limitations section above) and as reflected in the independent comments 4,6,19 and 20 in the previous section.	Comment noted. No further action taken.
24b	The possibility of having misnumbered the SF-36 questions requires input from the researchers to resolve. The same action is required for the asthma definition and the sinusitis issue.	All missing SF-36 data was analyzed according to the procedures described in references 69 and 70 (page 208 of 222) to handle missing response data. Definitions of both asthma and sinusitis were left to the survey participant to resolve.
24c	If the responses to the "life-time (i.e. ever)" versus "Currently have (i.e., point prevalence)" questions are deemed to disqualify the comparison with the Ontario population, certainly the option remains to use the results not only in intra-community comparisons (as pointed out by the EAC), but also in conjunction with the conclusions of Study C in the upcoming integration step?	Mention of the integration study was specifically omitted as only references to final, approved documents could be included.
24d	About the emphysema versus the "emphysema or chronic obstructive pulmonary disease (COPD)" issue identified by the EAC. COPD comprises emphysema and chronic bronchitis, which often occur together. Since both these outcomes were explored in separate questions in the SRHQ, is there not some similarity, or complementary aspect, with the 'emphysema or COPD' question in the CCHS questionnaire? COPD and allied conditions are also explored in Study C.	Comment noted. No further action taken.
24e	One wonders if the acceptance of the absence of a dose-response is valid as done by the EAC. The soil CoC levels characterize and delineate geographical zones; and differences in mean soil CoC concentrations should not be accepted a priori as signifying actual differences in human exposure. Only for lead are relationships between lead in soil and in blood well established, and then only on a	Comment noted. No further action taken.

CHAP Study A (report version date September 24, 2004) comments received from Evert Nieboer (Regional Niagara Public Health Department), dated April 29, 2005

Comment Number	Comment	Ventana Response
	group basis.	