████ ██████ (Kanautica Zayre-Brown, 0618705), referred to as offender and/or patient below

EXHIBIT P-11 SAN 4/17/23

- admitted to prison 10/10/2017
- current projected release date 11/2/2024
- Anson CI (transferred from Warren on 8/15/02019)
- Medium Custody (promoted from Close on 1/4/2022)

Surgery Request and Case Summary:

- 2/20/2020, DTARC recommended receiving a consult from a specialist experienced in performing vaginoplasty surgeries to obtain information to further evaluate treatment options and required course going forward.
- 8/4/2020, patient participated in telehealth appointment with Kristia Vasilof from UNC Transhealth Program as part of initial review for consult referral
- 8/27/2020, DTARC reviewed and recommended UR approval for in-person consult with UNC Transhealth Program
- 2/25/2021, DTARC reviewed information regarding need to meet with UNC Transhealth Program Manager prior to scheduling in-person appointment.
- 5/25/2021, Katherine Croft (Transhealth Program Manager) completed a telehealth consult with Offender Brown as part of the planned surgical consult with the UNC Transhealth program. The consult noted "no primary concerns were identified that would interfere with surgery except for weight, which the patient indicated she was intending to lose for surgery."
- 7/12/2021, patient was transported for an in-person consultation with Dr. Figler with the UNC Transhealth Program on 7/12/2021. The consultation documentation was received on 7/20/2021 at Anson and entered into the offender's document manager. The consultation indicated the patient's desire for vulvoplasty (not vaginoplasty) and need for weight loss from the recorded weight of 288 at the time down to a maximum of 250 with an identified weight goal of 210.
- 7/29/2021, Dr. Peiper informed by UNC Telehealth Program that they will need two referral letters related to WPATH criteria
- 10/4/2021, new updated Transgender Accommodation Summary completed as part of the referral letter requirement summarizing history of transition, patient's continued commitment to surgery, current and recent psychological stability, absence of uncontrolled comorbid mental health conditions, and that the patient met appropriate criteria for surgery.

DTARC Review 2/17/2022:

Patient has maintained the minimum weight goal identified by UNC Transhealth program. Weight has been below 240 since 11/15/2021 and at the time of the DTARC was most recently (2/11) at 236. Patient is now eligible for review related to DTARC recommendation on requested vulvoplasty surgery.

Mental health and behavioral health case reviews indicated no current evidence of any significant comorbid mental health issues. Review of patient's related mental health and behavioral health record indicates the criteria identified by UNC Transhealth Program for appropriateness for surgery have been met. The patient has a well-documented, persistent transgender identity with a commitment for "bottom surgery." The patient has been educated on the surgical interventions by the UNC Transhealth Program and identified a preference for a vulvoplasty if performed. The patient has lived as a female in the community prior to this incarceration and has been housed in a female prison since 8/2019. The

patient has completed other gender-affirming surgeries (orchiectomy, breast implants) and has been on hormone replacement therapy since 2012. The patient's mood and anxiety symptoms appear well-controlled by psychiatric interventions, however, recent progress notes from supportive counseling and therapy sessions indicate the patient has been heavily focused on the status of the final decision regarding her requested/desired surgery and experiencing related anxiety/frustrated mood.

MEDICAL ANALYSIS:

Medical analysis for this case included a comprehensive review of the offender's medical and behavioral health history, as well as a comprehensive literature review. When treatments are considered for any patient, the most important imperative for physicians is to base recommendations on evidence-based medicine and consideration of that information in the context of the individual patient.

Based on this review, it is the determination of medical authority that gender reassignment surgery (GRS) as requested by this offender is not medically necessary. The rationale for this determination is several fold, particularly when the requested treatment for this offender (vulvoplasty), is compared to what are considered "medically necessary" surgeries for other medical conditions.

First, medically necessary treatments, and this is particularly true of surgical procedures, consist of a single, or at most a very discrete subset of surgeries. This is entirely not the case in the context of GRS, where there are a wide range of treatments, most notably absent surgery, but also including surgeries, which are presented as "options" in treatment, and are largely determined by the patient's desires. This would not be the case were the procedure truly "necessary", defined as treatment required in order to protect life, to prevent significant disability, or to alleviate pain. In these cases, barring any individual contraindications to surgery, almost all individuals suffering with these symptoms would indeed consent to surgery. This is clearly not the case with GRS, as, according to NIH data (2019), only 25-35% of transgender individuals ever undergo any form of GCS. (Demographic and temporal trends in transgender identities and gender confirming surgery (nih.gov)). This would not be true of any other "medically necessary" procedure in this country.

Almost universally, medically necessary procedures are by definition covered by insurance carriers. This too is not the case with GRS. In fact, 64% (32 States) of U.S. States' Medicaid programs do not offer coverage for GRS. (Issue brief: Health insurance coverage for gender-affirming care of transgender patients (ama-assn.org)). In fact, in N.C. the State Employees Health Plan, as with the majority of other US State health plans similarly do not cover the cost of GCS. This absolutely would not be the case were the procedure indeed "medically necessary".

Medically necessary treatments must be based on standards of practice, must be evidence-based, peer-reviewed and without bias or conflict of interest among the researchers or agency providing the recommendations, and there is almost always consensus among the medical community as to not only the necessity of the treatment/ procedure, but further, the preferred treatment. These factors establish standard of care, and physicians are derelict in their duties when they stray from these critical considerations. Unfortunately, in the case of GRS in the treatment of gender dysphoria, none of these factors are true. Most notably, the entity most often referred to for guidance regarding treatment of gender dysphoria, namely WPATH (World Professional Association for Transgender Health), simply does not meet these criteria.

WPATH remains under increasing scrutiny and continues to be mired in controversy for the very reasons cited above, calling into question its objectivity and the very real concern that it is not the typical professional organization that develops reliable clinical practice guidelines. WPATH is considered by many to instead be a hybrid professional and activist organization, where activists have become voting members, and even move on to lead the organization. In fact, it is argued by many that WPATH is "activist-led" rather than "evidence-led", and therefore are not a reliable agency in medical decision making for our patients.

Conflicts of interest among the organization are also of significant concern. The overwhelming majority of WPATH Committee members either receive income based on recommendations in the guidelines, work at clinics or universities who receive funds from advocacy groups, foundations, or pharmaceutical companies who heavily favor a certain treatment paradigm, or have received grants and published papers or research in transgender care.

The majority of the members of the WPATH Committee are from the U.S., and six of them have affiliations with the same university–the University of Minnesota Program in Sexuality, which is primarily funded by a transgender advocacy organization (Tawani Foundation).

As if the factors above were not concerning enough, the situation becomes more concerning when we consider another source we as practitioners use to develop treatment plans for our patients, namely specialty societies. In the case of WPATH, three of the same committee members for the WPATH Guidelines also served on the Endocrine Society guideline committee, which raises intellectual conflict of interest concerns, as recommendations based on faulty conclusions in the WPATH guidelines could potentially have been duplicated in the Endocrine Society guidelines.

When, as clinicians we encounter concerns related to objectivity or conflict of interest, for instance, a study recommending a particular pharmacologic treatment or prosthetic device wherein the study was funded by the pharmaceutical company or prosthetic manufacturer, we are then obligated to expand our research and consider other studies. To do otherwise as medical professionals would be negligent; we simply cannot rely solely on a single organization with these concerns at the forefront in making decisions for our patients. This is precisely the case here, where there is significant concern for objectivity and conflict of interest among WPATH, as well as the US Endocrine Society.

When further research is conducted, as we have done in this case, it becomes even more apparent why there is indeed not consensus among the medical community in the treatment of gender dysphoria, and particularly GCS.

Perhaps one of the most important considerations in developing treatment plans for our patients is the long term prognosis following the treatment. Most critically, the imperative "*Primum non nocere*", ("First do no harm") must be at the forefront of consideration. This imperative is the underpinning of the oath all physicians take. In order to ensure the most appropriate, effective, and safest care to patients, clinicians must exercise due diligence in evaluating all available information in formulating recommendations to patients. The evidence regarding GRS does not provide sufficient confidence that the procedures should be undertaken without concern for having violated that oath.

Case in point is the 2016 CMS (Centers for Medicaid and Medicare) Decision Memo which summarizes the following: "Based on a thorough review of the clinical evidence available at this time, there is not

enough evidence to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria". Further in the report, "When considering even the 'best studies', the conclusion was that there is no evidence of 'clinically significant changes' after sex reassignment surgery." (NCA - Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N) - Proposed Decision Memo (cms.gov))

No studies conclusively demonstrate that GCS improves quality of life or sufficiently addresses gender dysphoria. In fact, in the largest and most thorough long term study looking at quality of life after GCS [Sweden; 324 individuals over a 30 year period (1973-2003)] (Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden (plos.org)), found evidence to the contrary. Specifically, 1-15 years after surgical reassignment, the suicide rate of those who had undergone sex reassignment surgery rose to 20 times that of comparable peers; there was notable increased mortality and psychiatric hospitalization (which was 2.8 times greater than in controls). As/ more interesting was the finding that death due to neoplasm and cardiovascular disease was increased 2-2.5 times in the surgical group, and this increased mortality was not realized for some 10 years after surgery.

There is a growing body of research into what seems to be an increasing number of transgender individuals who at some point "de-transition", or go back to living as their sex assigned at birth (or at least discontinue some or all aspects of gender affirmation).

The phenomenon of de-transition is critically important in considering treatment options for patients, particularly when treatment involves either irreversible or incredibly difficult/ poor outcomes, such as surgeries. This consideration is of even greater concern when the veracity of the patient is in question or there are other factors such as secondary gain to be considered.

A study recently (June 2021) published by the National Institutes for Health (National Center for Biotechnology Information-NCBI) found that among individuals who had undergone transition, more than 13% had undergone de-transition. Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis (nih.gov)

Further analysis of this data demonstrated that of those who de-transitioned, 38% did so because transitioning had failed to resolve their psychological issues, so they concluded that "gender dysphoria wasn't the cause"; another 23% did so because they came to understand that they had in fact been struggling with sexual orientation issues rather than gender dysphoria. Why Some Transpersons Decide to Detransition | Psychology Today

A large sample, peer-reviewed study conducted in 2021 found that 70% of those who detransitioned did so after they realized their gender dysphoria was "related to other issues" and 50% did so because transition had failed to alleviate their dysphoria. Interestingly, 43% endorsed a "change in political views" as a reason for detransition. Importantly, 43% of those who detransitioned had previously undergone GCS. Full article: Detransition-Related Needs and Support: A Cross-Sectional Online Survey (tandfonline.com)

Another more recent study (Oct 2021) found that 70% were dissatisfied with their decision to transition. 61% of those who detransitioned had returned to their identifying with their birth sex, 14% identified as nonbinary, and 8% identified as transgender. The study goes on to emphasize the need for "alternative,

non-invasive approaches for gender dysphoria management in young people".
Growing Focus on Detransition | SEGM

Having taken all these factors into consideration, it remains my medical determination that the surgical procedure requested by this offender is not medically necessary. Further, there is increasing evidence that GRS does not represent the definitive treatment for gender dysphoria, nor does the literature provide the confidence in long-term success required in order to undertake invasive procedures. There simply is not consensus among the medical community that GRS represents THE only acceptable nor THE most recommended treatment for gender dysphoria. In no other context would surgery be considered for a patient if at least one of these factors were not considered to be consensus among the medical community.

Division Transgender Accommodations Review Committee (DTARC) Position Statement

Gender Reassignment Surgery

NCDPS-Prisons

23 March 2022

Dr Arthur L Campbell, III, M.D.

Chief Medical Officer, NC Prisons

EXHIBIT 15
Deponent Campbell
Date 4/18/23 Rptr. SP
WWW.DEPOBOOKPRODUCTS.COM

SUMMARY POSITION STATEMENT:

As with all treatments, including procedures and surgeries provided to offenders, the first consideration is whether the treatment is medically necessary. This consideration is precisely the same as that utilized by every managed care system and health insurance agency in the Country.

After extensive and objective review and analysis of hundreds of studies and other publications, it has been determined that gender reassignment surgery (GRS), as a treatment for gender dysphoria, is not medically necessary.

When GRS is considered with and compared to other procedures and surgeries which are broadly considered medically necessary, GRS procedures fail to satisfy the criteria and characteristics evidenced by those broadly accepted procedures. Specifically, there are concerns that the risk, as defined by failure of the procedure to correct the underlying problem or the need for subsequent reversal of the procedure outweigh any potential benefit of the procedure. GRS simply does not represent an objective "standard of care" and there are grave concerns with significant conflict of interest and the lack of evidence-based, peer-reviewed criteria utilized in developing criteria.

ANALYSIS/ DISCUSSION

There continue to be variable, and at times discrepant definitions of "medical necessity" between medical professionals, insurance providers, legislators, legal authorities, and activists. Across the country, the Courts continue to be somewhat inconsistent in their interpretations of what constitutes "medical necessity". These discrepancies become even more complex in the context of medical care for the prison population.

Broadly speaking, at the most basic level, a medically necessary procedure is one which is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. More specifically, there are fairly standard characteristics which most in the medical community would agree either constitute or are associated with a "medically necessary" treatment or procedure, and in the context of gender reassignment surgery (GRS), these characteristics can be applied to reach a determination.

Some prominent characteristics of "medically necessary" procedures include:

- The risk to the patient of not performing the surgery exceed the potential risks of the surgery itself (includes intraoperative, postoperative and long term risks).
- The procedure has been determined to constitute "standard of care", which leads to the following:
  - Overwhelming majority of individuals with the condition undergo the procedure
  - Majority of health insurance carriers provide coverage for the procedure, particularly when the procedure is not costlier than an alternative service or sequence of treatments that are at least as likely to produce equivalent therapeutic results.
- Treatment recommendations are developed through evidence-based medicine/ practice and are modified based on findings from continuous future studies.

When gender reassignment surgery is considered utilizing the general principles outlined above, it becomes apparent that the procedure(s) are indeed not "medically necessary". What follows is a summary analysis and explanation.

- **For medically necessary procedures, the risk to the patient of not performing the surgery exceeds the potential risks of the surgery itself.**

From the definition above, it follows that for a "medically necessary" procedure, the consensus among the medical community would be that not undertaking the procedure (surgery) will of course fail to alleviate the symptoms associated with the condition, but most importantly, could also result in one/ more of the following: (1) Death, (2) Severe disability, or (3) Significant worsening of the condition. A procedure which is unlikely to improve symptoms, carries with it increased risk of worsening symptoms, or those that disproportionately jeopardize a patent's well-being would not be considered "medically necessary". In fact, they would instead likely not be recommended at all.

In the case of GRS, it is far from consensus among the medical community that individuals with gender dysphoria who do not undergo the procedure(s) are at increased risk of any of the sequelae outlined above. In fact, there are studies which cause great concern that a not insignificant portion of individuals who undergo the procedure(s) not only fail to improve, but in many cases, experience worse symptoms with quite concerning consequences.

One example: The largest and longest term study looking at quality of life after GCS, conducted in Sweden with 324 individuals over 30 years (1973-2003), actually demonstrated a 20-fold increase in suicides and 2.8 times greater rate of psychiatric hospitalization. Individuals also had a 2-2.5 times greater rate of neoplasm and cardiovascular disease. Importantly, many of these quite concerning outcomes did not occur until 10 years or more after surgery. [1]

Studies demonstrating findings such as those above are not isolated. Another study in 2017, incidentally sponsored by a group that was clearly pro-transition, found that "suicide attempts were lower before transition than over most other periods". For example, the study found that suicidal ideation was 50.6% after transition compared with a 36.1% rate before transition. [2]

Another important consideration in any surgical treatment is outcomes, including analysis of the need for further surgeries, etc. There is a growing body of research into what seems to be an increasing number of transgender individuals who at some point "de-transition", the act of stopping or reversing gender transition, often going back to living as their sex assigned at birth.

This phenomenon of de-transition is critically important in considering treatment options for patients, particularly when treatment involves either irreversible or incredibly difficult/ poor outcomes, such as surgeries.

A study published in the Archives of Sexual behavior in October 2021 found a 24% rate of de-transition. This study uncovered some interesting, and frankly concerning statistics. For example, 60% of those who de-transitioned did so at least partly because they had become more comfortable with their natal(birth) sex. A quite significant mount (49%) did so as a result of concerns about the potential medical complications from transitioning. Perhaps most

significantly, 55% expressed concerns that they had "not received adequate evaluations from a doctor or mental health professional before starting transition". [3]

Further analysis of this data and other studies demonstrated that of those who de-transitioned, 38% did so because transitioning had failed to resolve their psychological issues, so they concluded that "gender dysphoria wasn't the cause"; another 23% did so because they came to understand that they had in fact been struggling with sexual orientation issues rather than gender dysphoria. [4]

A large sample, peer-reviewed study conducted in 2021 found that 70% of those who de-transitioned did so after they realized their gender dysphoria was "related to other issues" and 50% did so because transition had failed to alleviate their dysphoria. Interestingly, 43% endorsed a "change in political views" as a reason for de-transition. Importantly, 43% of those who de-transitioned had previously undergone GCS. [5]

Another more recent study (Oct 2021) found that among individuals who de-transitioned, 70% did so due to being dissatisfied with their decision to transition. 61% of those who de-transitioned had returned to their identifying with their birth sex, 14% identified as non-binary, and 8% identified as transgender. The study goes on to emphasize the need for "alternative, non-invasive approaches for gender dysphoria management in young people". [6]

Findings such as these raise serious concerns and tip the "risk-benefit" analysis away from the support for surgery among objective medical observers, thereby refuting its "medical necessity".

- **"Medically necessary" procedures are by definition considered to constitute "standard of care".**

  If a procedure (surgery in this case) were the "standard of care", there would be a single, or at most a discrete subset of procedures which have been determined by the medical community to be most appropriate to treat the condition.
  - ***There are specific criteria which indicate not only the "qualification" for surgery, but also the specific procedure or approach would be best***
  - ***There are specific criteria which determine relative or absolute contraindications to surgery***
  - ***Based on these standards, the overwhelming expectation would be that (excluding patients who decline surgery against medical advice), that virtually every patient with this condition (and without contraindications) would indeed be provided the procedure.***
  - ***Majority of health insurance carriers provide coverage for the procedure, particularly when the procedure is not costlier than an alternative service or sequence of treatments that are at least as likely to produce equivalent therapeutic results.***

When evaluating and researching these factors in the context of GRS, it becomes readily apparent that GRS indeed does not satisfy the requirements necessary for it to be considered "standard of care".

The justification used by those who advocate for surgeries is that they are "necessary" in order to alleviate the "dysphoria" associated with the condition. However, unlike other "medically necessary" surgeries, where there is single or at most a very discrete set of established procedures, in the case of GRS, there is a wide spectrum of continually expanding surgical options designed to treat gender dysphoria.
While not all inclusive, these potential surgical options include (not all inclusive) mastectomy, mammoplasty, orchiectomy, penectomy, metoidioplasty, scrotoplasty, vulvoplasty, vaginoplasty, phalloplasty, voice feminization surgery (anterior glottal web formation; cricothyroid approximation; laser reduction glottoplasty), chondrolaryngoplasty, facial feminization/ masculinization surgery, hip augmentation/ enhancement, gluteal augmentation/ reduction, body contouring and fat transfer, and others.

What this list makes very evident is that there is clearly no established specific (or even series of surgeries) which is the "standard" in the treatment of gender dysphoria. Instead, clinicians and advocates involved in the care of patients with gender dysphoria believe that the extent, type and number of surgeries an individual "needs" ("upper" and/ or "lower") are quite literally determined by what makes the patient feel "complete" (or what they "choose"). Unlike pre-operative evaluations for other surgeries (such as a CT scan, MRI, biopsy, etc), in the case of gender dysphoria, there are no objective studies of any kind that can be performed to either determine indications for surgery or to develop specific surgical recommendations; these

determinations are purely subjective on the part of the individual. These facts alone make it clear that none of these surgeries can in any way be considered "necessary".

Over time, for most every surgical procedure, criteria and pre-operative evaluations are continually refined in order to ensure the procedures are offered only to those patients who are most likely to benefit from the procedure. Data is collected continuously and that data helps to not only identify the best candidates for a particular surgery, but also to determine those who are not likely to benefit, and most importantly, those who have risk factors which would contraindicate the surgery.

In the case of GRS, the opposite is true. Treatment advocacy groups continue to significantly relax criteria to the point where it is simply a matter of the individual "asking" for the procedure(s). In fact, their approach to individuals with gender dysphoria has just recently been updated to an "informed consent model"/ "affirmation only" model, which "seeks to better acknowledge and support patient's right of, and their capability for, personal autonomy in choosing care options without the requirement of external evaluations or therapy by mental health professionals" [7]

Another important consideration is the fact that for traditional "medically necessary" surgeries, the overwhelming majority of patients with the condition (unless there are specific contraindications or the patient declines), will indeed end up undergoing the procedure. This too is not the case at all with GRS. In fact, only 25-35% of individuals with gender dysphoria ever undergo any GRS. [8]. This further substantiates the case that GRS for the treatment of gender dysphoria is indeed not "medically necessary", as the vast majority of individuals never undergo these procedures. That is not the case at any truly "medically necessary" surgeries.

Another factor with "medically necessary" procedures (again, which equates to being the "standard of care") is that due to these procedures being established as the "standard of care", the majority of health insurance carriers provide coverage for the procedure, particularly when the procedure is not costlier than an alternative service or sequence of treatments that are at least as likely to produce equivalent therapeutic results. This too is not true when evaluating the current state of health insurance coverage for GCS.

At the federal level, CMS (Centers for Medicare and Medicaid), after an exhaustive review of hundreds of studies in 2016, concluded that the procedures would not be mandated as part of Medicare plans due to the conclusion that there is a "lack of evidence that the procedures benefits patients". More specifically, the Decision Memo stated the following: "Based on a thorough review of the clinical evidence available at this time, there is not enough evidence to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria", and went on to conclude that there is no evidence of "clinically significant changes" after GRS. [9]

Similarly, at the State level, while there are expected variations, 64% (32) of States' Medicaid Programs also do not provide GRS coverage. [10] Further, most State Employees' Health Plans (including North Carolina) do not provide coverage for GRS.

When specifically considering GRS in prisons, it is important to note that there have been no Federal inmates who have received GRS and only two states to date have provided for the procedure, both of which were very discrete circumstances in court settlements. Were GRS indeed "medically necessary", not providing the procedure would bolster court cases regarding the 8th Amendment to the US Constitution. However, this has not been the case. Recent court rulings on this have been inconsistent to say the least. In fact, cases in both the First and Fifth Circuit Courts of Appeal have concluded that the State prison systems did not violate inmate's rights (did not inflict "cruel and unusual punishment") by declining provision of GRS for inmates.

More specifically, in the Fifth Circuit Court of Appeals case (March 2019; Gibson v Collier), in its findings, the Court confirmed that *"it is indisputable that the necessity and efficacy of sex reassignment surgery is a matter of significant disagreement within the medical community. As the First Circuit has noted—and counsel here does not dispute—respected medical experts fiercely question whether sex reassignment surgery, rather than counseling and hormone therapy, is the best treatment for gender dysphoria."*
Further, the Court provided the following explanation:
"Under established precedent, it can be cruel and unusual punishment to deny essential medical care to an inmate. But that does not mean prisons must provide whatever care an inmate wants. Rather, the Eighth Amendment "proscribes only medical care so unconscionable as to fall below society's minimum standards of decency." Interestingly, the Court went on to point out that something (in this case, GRS) cannot be "unusual" if doing so is not the "usual" treatment, which is clearly the case in the context of GRS in either prisons or across the country as a whole. [11]

None of these would be the case were GRS indeed the "standard of care" and the procedures were "medically necessary", which further bolsters the case that these procedures are indeed not medically necessary.

- <u>**Treatment recommendations are developed through evidence-based medicine/ practice and are modified based on findings from continuous future studies.**</u>

  Surgical procedures are determined using evidence-based, peer-reviewed medical studies which are free of bias or conflict of interest, leading to near consensus among the medical community as to not only the necessity of the treatment/ procedure, but further, the preferred treatment.
  - ***Critically important is that these studies continually evaluate (and modify based on the data obtained) the pre-operative, intra-operative, post-operative, and long term approaches and prognosis associated with the procedure.***

This factor associated with evaluating medical necessity for any procedure is critical in order to ensure the best care for our patients, and in the case of GRS, is perhaps one of the most concerning factors. Unfortunately, in the case of GRS in the treatment of gender dysphoria, this level of scrutiny is simply not present. Most notably, the entity most often referred to for guidance regarding treatment of gender dysphoria, namely WPATH (World Professional Association for Transgender Health), simply does not utilize these criteria in developing their "standards of care". This realization has led to individuals/groups, who are supportive of treatments for gender dysphoria but who lack confidence in WPATH, establishing other organizations in order to ensure the level of scrutiny needed in undertaking these procedures.

For example, the Society for Evidence-Based Gender Medicine (SEGM) has recently been established by a physician in Oregon who has grown increasingly concerned with the lack of objectivity displayed by WPATH, stating that the organization "remains captured by activists". "We need a serious organization to take a sober look at the evidence and that is why we have established the Society for Evidence-Based Gender Medicine [SEGM]," she noted. "This is what we do — we are looking at all of the evidence. "She specifically recommends the WPATH SOC not be "the new gold standard going forward, primarily because it is not evidence-based". Instead, she points out that "WPATH utilizes the 'Delphi consensus process' to determine their recommendations, but this process is designed for use with a panel of experts when evidence is lacking". Instead of a panel of experts, she and an increasing number of other physicians across the country view WPATH as a "panel of activists" instead of a panel of experts. [12]

Medically necessary treatments must be based on standards of practice, must be evidence-based, peer-reviewed and without bias or conflict of interest among the researchers or agency providing the recommendations, and there is almost always consensus among the medical community as to not only the necessity of the treatment/ procedure, but further, the preferred treatment. These factors establish standard of care, and physicians are derelict in their duties when they stray from these critical considerations.

Unfortunately, the literature often relied upon is fraught with study design problems, including convenience sampling, lack of controls, cross-sectional design, small sample sizes, short study lengths, and enormously high drop-out rates among participants. Very few studies on transition escape these issues. For example, a 2018 systematic review of quality-of-life studies of transitioned adults rated only two out of twenty-nine studies as high-quality. [13]

WPATH remains under increasing scrutiny and continues to be mired in controversy for the very reasons cited above, calling into question its objectivity and the very real concern that it is not the typical professional organization that develops reliable clinical practice guidelines. WPATH is considered by many to instead be a hybrid professional and activist organization, where activists have become voting members, and even move on to lead the organization. In fact, it is argued by many that WPATH is "activist-led" rather than "evidence-led", and therefore are not a reliable agency in medical decision making for our patients.

Conflicts of interest among the organization are also of significant concern. The overwhelming majority of WPATH Committee members either receive income based on recommendations in the guidelines, work at clinics or universities who receive funds from advocacy groups, foundations, or pharmaceutical companies who heavily favor a certain treatment paradigm, or have received grants and published papers or research in transgender care. [14]

The majority of the members of the WPATH Committee are from the U.S., and six of them have affiliations with the same university–the University of Minnesota Program in Sexuality, which is primarily funded by a transgender advocacy organization (Tawani Foundation). In fact, the current chairman of WPATH has his very position at the University of Minnesota funded by Jennifer Pritzer, a trans person and head of Tawani. In fact, there are press releases of Eli Coleman in 2017 thanking Jennifer Pritzer profusely for a generous donation, which adds up to 6.5 million dollars that Tawani has given to the university. Tawani also funded WPATH SOC development. Another advocacy group, Gender Identity Research and Education Society (GIRES) funded the translation of the SOC into various languages. [14]

As if the factors above were not concerning enough, the situation becomes more concerning when we consider another source we as practitioners use to develop treatment plans for our patients, namely specialty societies. In the case of WPATH, three of the same committee members for the WPATH Guidelines also served on the Endocrine Society guideline committee, which raises intellectual conflict of interest concerns, as recommendations based on faulty conclusions in the WPATH guidelines could potentially have been duplicated in the Endocrine Society guidelines.

This concern is supported by the fact that ECRI (Emergency Care Research Institute), the DHHS-appointed Agency for Healthcare Research and Quality (AHRQ) for the National Guideline Clearinghouse (NGC), has failed to provide Trust Ratings for either WPATH or the Endocrine Society guidelines for the treatment of gender dysphoria. The reason for this lack of inclusion was because "only a few of the recommendations were supported by the systematic review; the majority were not", and that the agencies "did not use a systematic review process" in developing their guidelines. [14]

When, as clinicians we encounter concerns related to objectivity or conflict of interest, for instance, a study recommending a particular pharmacologic treatment or prosthetic device wherein the study was funded by the pharmaceutical company or prosthetic manufacturer, we are then obligated to expand our research and consider other studies. To do otherwise as medical professionals would be negligent; we simply cannot rely solely on a single organization with these concerns at the forefront in making decisions for our patients. This is precisely the

case here, where there is significant concern for objectivity and conflict of interest among WPATH, as well as the US Endocrine Society.

When further research is conducted, as we have done in this case, it becomes even more apparent why there is indeed not consensus among the medical community in the treatment of gender dysphoria, and particularly GCS.

In summary, based on the extensive and objective review of hundreds of studies and other publications, it is quite clear that gender reassignment surgery as a course of treatment for gender dysphoria is indeed not a medical necessity. When GRS is considered with and compared to other procedures and surgeries which are broadly considered medically necessary, the procedures fail to satisfy the criteria and characteristics evidenced by those procedures. Specifically, there are concerns that the risk, as defined by failure of the procedure to correct the underlying problem or the need for subsequent reversal of the procedure outweigh the potential benefit of the procedure. GRS simply does not represent an objective "standard of care" and there are grave concerns with significant conflict of interest and the lack of evidence-based, peer-reviewed criteria utilized in developing criteria.

Accordingly, to support these procedures given all these concerns would be in conflict with the most critical imperative in medicine, *"Primum non nocere"* (First, do no harm"). This imperative is the underpinning of the oath all physicians take. In order to ensure the most appropriate, effective, and safest care to patients, clinicians must exercise due diligence in evaluating all available information in formulating recommendations to patients. The evidence regarding GCS does not provide sufficient confidence that the procedures should be undertaken without concern for having violated that oath.

CITATIONS

[1] Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden (plos.org)

[2] Varied Reports of Adult Transgender Suicidality: Synthesizing and Describing the Peer-Reviewed and Gray Literature | Transgender Health (liebertpub.com)

[3] Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners | SpringerLink

[4] Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis - PMC (nih.gov)

[5] Why Some Transpersons Decide to Detransition | Psychology Today

[6] Full article: Detransition-Related Needs and Support: A Cross-Sectional Online Survey (tandfonline.com)

[7] Demographic and temporal trends in transgender identities and gender confirming surgery (nih.gov)

[8] Growing Focus on Detransition | SEGM

[9] Informed Consent in the Medical Care of Transgender and Gender-Nonconforming Patients | Journal of Ethics | American Medical Association (ama-assn.org)

[10] NCA - Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N) - Proposed Decision Memo (cms.gov)

[11] Issue brief: Health insurance coverage for gender-affirming care of transgender patients (ama-assn.org)

[12] Gibson v. Collier, No. 16-51148 (5th Cir. 2019) :: Justia

[13] WPATH Draft on Gender Dysphoria 'Skewed and Misses Urgent Issues' (medscape.com)

[14] Quality of life of treatment-seeking transgender adults: A systematic review and meta-analysis | SpringerLink

[15] Bias, not evidence dominates WPATH transgender standard of care - CANADIAN GENDER REPORT

North Carolina Department of Public Safety
Clinical Encounter

Offender Name: [redacted], [redacted] — Off #: 0618705
Date of Birth: [redacted] — Sex: M — Race: BLACK — Facility: CRAV
Encounter Date: 10/11/2017 11:29 — Provider: Lenn, Robert M RN — Unit: HATAU

Nursing Note encounter performed at Clinic.

SUBJECTIVE:

COMPLAINT 1 **Provider:** Lenn, Robert M RN

Chief Complaint: Skin Problem

Subjective: Patient new processor, arrived on camp last night. Reports being transgender. Has had breast surgery and orchiectomy. Is wearing sports bra and jock strap. Reports draining surgical site to scrotum. States that he is on hormone therapy. Denies other issues. States that he feels safe. Denies pain to surgical site.

Pain Location:

Pain Scale:

Pain Qualities:

History of Trauma:

Onset:

Duration:

Exacerbating Factors:

Relieving Factors:

Comments:

ROS:

Breasts

General

Yes: Implants

OBJECTIVE:

Exam:

Skin

Wound

Yes: Wounds present

Noted to have open wound, non draining to scrotum, appears to be healing well. Did not palpate for testicles. Loose skin, penis present.

Genitourinary

Scrotum

No: Normal

Testicles

Yes: Deferred

ASSESSMENT:

Wound Care

Will refer to Dr. Engleman for further follow up and H&P. Patient given telfa bandages for self care. Patient stated that he felt he could change dressing by self without problems.

PLAN:

New Non-Medication Orders:

Order	Frequency	Duration	Details	Ordered By

Offender Name: [redacted], [redacted]
Date of Birth: [redacted]
Encounter Date: 10/11/2017 11:29

Sex: M Race: BLACK
Provider: Lenn, Robert M RN

Off #: 0618705
Facility: CRAV
Unit: HATAU

New Non-Medication Orders:

Order	Frequency	Duration	Details	Ordered By
Athletic Supporter	One Time		Needs two, size XL	Lenn, Robert M RN
	Discontinue Reason:			
	Order Date:	10/11/2017		
	End Date:			
Bra: Support	One Time		#5, size 38DD	Lenn, Robert M RN
	Discontinue Reason:			
	Order Date:	10/11/2017		
	End Date:			

Disposition:

Refer to Provider

Patient Education Topics:

Date Initiated	Format	Handout/Topic	Provider	Outcome
10/11/2017	Counseling	Access to Care	Lenn, Robert	Verbalizes Understanding

Co-Pay Required: No **Cosign Required:** No
Telephone/Verbal Order: No
Standing Order: No

Completed by Lenn, Robert M RN on 10/11/2017 11:48

SENSITIVE BUT UNCLASSIFIED

North Carolina Department of Public Safety
Mental Health Assessment

Offender Name:	[redacted]			Off #:	0618705
Date of Birth:	[redacted]	Sex:	M	Facility:	CRAV
Date:	10/13/2017 09:30	Provider:	Garvey, Susan C M.A. Staff		

Treatment Setting

Outpatient Program at CRAVEN CI.

Referral

Nursing

Violence Alerts

There are no elevated risk factors presently noted for inmate CHESTNUT.

Escape Alerts

There are no elevated risk factors presently noted for inmate CHESTNUT.

Self-Injury Alerts

There are no elevated risk factors presently noted for inmate CHESTNUT.

Current Problems

Inmate Chestnut is a 36 year old, African American male who reports he identifies as transgender, male to female. He reports he has undergone breast augmentation, hormone replacement therapy, and an orchiectomy (removal of testicles). He reports he had the orchiectomy on August 25, 2017. He reports prior to beginning the surgeries for transformation, he participated in counseling at UNC Chapel Hill School of Psychiatry.

Inmate Chestnut reports he was around the age of 17 when he "came out" as gay. He states "I lived a gay lifestyle until I was 29." He reports it has been within the last 5 years he has begun his transition to becoming a female. When asked about how he saw himself as a child, he replies "I acted boyish but presented as feminine. I was confused. I fought a lot." He then states "I always had an inclination to change."

Inmate Chestnut reports he legally changed his name to Kanautica Zayre in 2011, through Wake County. He states he would like to be referred to by his legal name while incarcerated instead of the name he provided at the time of his arrest. He reports in December 2012, he began seeing a psychologist through UNC Healthcare, so he could be approved to begin his transition to becoming a woman. He reports after eight months in counseling, he was approved to begin having surgeries and to receive hormones. He states he began hormones prior to surgeries which include estrogen, progestin, and spermalactin (blocks testosterone and is described is required pre-castration). Prior to his orchiectomy, he reports he was seen again by his psychologist at UNC Healthcare, for approval and/or clearance to undergo this surgery. He states he was given two letters by his psychologist stating he was ready to have these surgeries completed. He reports his psychologist's name was Neffateria Hans.

Inmate Chestnut reports he began having surgery in May 2017 with a Brazilian Butt Lift. He reports in October 2013, he had breast implant surgery. He reports his third surgery involved a facial fat transfer in which fat was transferred to his forehead jaw, chin, and cheeks. He reports this process also concealed his Adam's Apple. He notes this surgery, as well as a surgery to feminize his ear lobes, were completed in July 2017. He reports just prior to being incarcerated, he had an orchiectomy, in which his testicles were removed. He notes his last surgery is to have a vagioplasty. He reports he has spent approximately $57,000 on surgeries.

Inmate Chestnut reports he feels more like a woman with each surgery, which he notes is comforting to him. When asked how he would describe himself to others, he replies "A breath of fresh air. I always try to smile."

History

Inmate Chestnut reports his mother was 13 years old when she gave birth to him so he was primarily raised by his maternal grandparents. [redacted] He states after this occurred, he often ran away from home to [redacted]. He reports after he first ran away, he was placed in the Kennedy Home for two years. He states shortly after he returned home, he ran away again, and then was sent to Samarkand for a few months and then was transferred to Eckerd Youth Camp. He reports he returned home after he completed the youth camp. He states shortly after he returned home, he stole his teacher's car. He reports he did not receive any charges but was sent to Dobbs Training

Offender Name:	[redacted]			Off #:	0618705
Date of Birth:	[redacted]	Sex:	M	Facility:	CRAV
Date:	10/13/2017 09:30	Provider:	Garvey, Susan C M.A. Staff		

School for four months. He reports after he returned to his grandparents after being released from Dobbs, he was sent to live with his mother in Raleigh. He reports his mother then "disappeared" and he returned to his grandparents. He reports at this point, his grandparent were told if they did not legally adopt him, he would be placed in a foster home. He states despite being adopted, he was sent back to the Kennedy Home. He reports he was sent back to his grandparents after being sexually harassed while at the Kennedy Home.

Inmate Chestnut states his mother is gay and describes her as a "stud." He reports she recently passed away from breast cancer. He reports his mother was hospitalized once after an unsuccessful suicide attempt.

Inmate Chestnut reports he has been with his spouse, Dionne Brown, since August 2011. He reports he and his spouse were married shortly after the court ruling on same sex marriages, on October 24, 2014. He notes since he began having surgeries to change his body, he and his spouse have "grown apart." He reports his spouse believes he is changing too fast. Inmate Chestnut reports the rapidness of his changes have boosted his self-esteem.

Inmate Chestnut reports he completed the 11th grade and then did not return to school to graduate. He denies being held back any grades. He reports he was in honor's classes and part of the school's Honor's Society. He reports a history of suspension for fighting. He denies any history of expulsion. He indicates continuing his education in 2004 through Mayland Community College in Spruce Pines, NC. He reports from 2005 through 2009, he took courses through University of North Carolina and earned an Associate's Degree in Sociology. He reports he began working on his Bachelor's of Social Work while incarcerated at Avery-Mitchell CI. He reports he completed his Bachelor's of Social Work after his release, through an online program with Michigan State University in 2013.

Inmate Chestnut reports from 2009 through 2013, he worked began as a direct care employee and moved to a Qualified Professional for Supreme Love Inc, group homes owned by a family member. He reports from 2013 through 2016, he worked as a Program Supervisor for Holly Hill Hospital. He reports he was an instructor for NCI and CPI. He reports he also worked part time for the Autism Society during this period. He reports from 2016 through September 2017, he worked "nightlife and dancing" at "exotic" strip clubs.

Inmate Chestnut denies any significant medical conditions at this time. Please refer to medical encounters regarding recent medical diagnoses. He denies any significant history of head injury. He reports a family history of hypertension and cancer.

Inmate Chestnut denies any mental health treatment history outside of what is required for a transgender individual to have treatments or surgeries. He denies any history of inpatient mental health treatment. He denies any history of taking psychotropic medications. He denies any history of engaging in self-injurious or suicidal behavior.

Inmate Chestnut reports a history of alcohol and marijuana use. He states his last use was approximately four years ago. He denies any history of substance abuse treatment.

Inmate Chestnut is currently serving a 7 year, 5 month to 9 year, 11 month sentence for charges of Habitual Felon, Obtaining Property by False Pretense, and Insurance Fraud. Per OPUS, he has 125 days of jail credit towards his sentence. Per OPUS, his projected release date is currently unaudited.

Interview/MSE

Inmate Chestnut was informed of the limits of confidentiality as they pertain to the state prison system. He is appropriately dressed in prison attire and demonstrates proper personal hygiene. Alert and oriented in all spheres. Inmate denies current or recent suicidal or homicidal ideation or intent. He denies any current or recent self-injurious behaviors or destructive ideations. Inmate Chestnut did not present with any paranoid or delusional ideation. His speech was normal in rate and volume. No flight of ideas, loose associations, or pressure was noted. Mood and affect are unremarkable.

Assessment

According to the DSM-V, inmate Chestnut meets the criteria for a diagnosis of Gender Dysphoria in Adolescents and Adults (302.85) based on the following markers...

Offender Name:	[redacted]			Off #:	0618705
Date of Birth:	[redacted]	Sex:	M	Facility:	CRAV
Date:	10/13/2017 09:30	Provider:	Garvey, Susan C M.A. Staff		

Inmate Chestnut has expressed an interest in openly living as a female since the age of 29. He notes the incongruence between his expressed gender and primary and/or secondary sex characteristics are of significant distress to him, especially given he has one more surgery to complete his full transition to becoming a female. He reports he has undergone several treatments and surgeries already to have his male primary and secondary characteristics changed to meet his expressed gender.

Diagnosis

302.85 Gender Dysphoria in Adolescents and Adults

Plan

Per Health Services policy (TX I-13), a multidisciplinary treatment team will be formed and will interview inmate Chestnut and review all available records. This will occur at his receiving facility. Once this psychologist is aware of the unit he will transfer, they will be informed of the need to bring together a treatment team. The treatment team will develop an individualized treatment plan. The mental health assessment and psychiatric assessment will be made available to the treatment team to the extent necessary for treatment decisions and recommendations.

Diagnosis:

Gender Dysphoria in Adolescents and Adults, 302.85 - Current, Chronic, Initial

Schedule:

Activity	Date Scheduled	Scheduled Provider
Mental Health Progress Note F/U	11/10/2017 00:00	Garvey, Susan C Staff Psychologist

Co-Pay Required: No **Cosign Required:** No
Telephone/Verbal Order: No
Standing Order: No

Completed by Garvey, Susan C M.A. Staff Psychologist on 11/01/2017 10:37
Requested to be reviewed by Peiper, Lewis J Ph.D Asst. Dir. of Beh. Health.
Review documentation will be displayed on the following page.

North Carolina Department of Public Safety
Mental Health Progress Note

Offender Name:	[redacted], [redacted]			Off #:	0618705
Date of Birth:	[redacted]	Sex:	M	Facility:	HARN
Date:	11/14/2017 09:00	Provider:	Graham, Phillip E. Predoc.		

Treatment Setting

Outpatient Program at HARNETT CI.

Reason for Services

Routine Follow-Up Session. Inmate is being seen for his initial appointment with this writer, after being transferred to the facility on the mental health caseload on 11/02/2017. Writer reviewed the medical chart, including the Mental Health Assessment completed by Ms. Gravey, Psychiatric Evaluation completed by Dr. Hamra, and Outside MH records by Ms. Robinson; as well as other pertinent information.

Violence Alerts

There are no elevated risk factors presently noted for inmate [redacted].

Escape Alerts

There are no elevated risk factors presently noted for inmate [redacted].

Self-Injury Alerts

There are no elevated risk factors presently noted for inmate [redacted].

MSE/Behavioral Observations

Inmate presented on time for his scheduled appointment, dressed in typical prison attire. He presented with adequate grooming/hygiene and made appropriate eye contact. He was attentive and cooperative throughout the session. His energy level seemed within normal limits, and no psychomotor abnormalities were noted. His speech was normal for rate, rhythm, volume, and amount. His thought processes were coherent, well-organized, and goal-directed with no evidence of delusional content. He denied current thoughts of self-harm or plans to harm others or escape. He described his mood as "frustrated," and his affect was congruent. He described his sleep as "poor," his energy as "alright," and his appetite as "good." He rated his overall well-being at a "7" on a scale of 1 = worst imaginable to 10 = best imaginable.

Inmate reported that he was "frustrated" with "staff" after being at this facility for or short term and having multiple staff encounters perceived as negative. He reported that he is working hard to remain compliant and fears he may not be given the opportunity to remain at an open facility for long, due to his presentation as a transsexual female. Inmate reported that he is married and petitioning to be transferred to an all women facility ASAP.

Mr. [redacted] reported a long history of sexual confusion and gender dysphoria dating back to childhood. His history is outlined in the MHA written by Ms. Garvey. Furthermore, inmate expressed that he is experiencing hot flashes throughout the day and the night. He reported that this is primarily due to the lack of hormones as a result of the orchiectomy he had on August 25, 2017. Inmate requested to initiate hormones treatment and was informed that he scheduled to complete the gender dysphoria review process, including a review by a facility panel and central administrative committee. The later make a determination about his request for hormone treatment.

Inmate reported that he is generally adjusting well, other than the minor encounters he has had with staff and stated that he is looking forward to the opportunity to meet with the review panel. Inmate received supportive therapy, encouraged to journal to process emotions and practice mindfulness and meditation practices.

Progress Towards Goal(s)

-No recent missed appointments, per HERO.
-Moderate subjective rating of his overall well-being.
-No recent infractions or positive drug tests, per OPUS. Writer provided positive feedback.

Plan/Diagnostic Changes

A new outpatient treatment plan was developed today with input from the client, to include his stated goal of "learn to be open, communicate." There are no diagnostic changes at this time.

Follow-up/Next Appointment

Inmate will continue to be seen at least every 45 days by mental health (or at least every 30 days if in restrictive housing). The self-referral process was reviewed with Mr. [redacted], and he indicated an understanding of how to

Offender Name:	[redacted], [redacted]			Off #:	0618705
Date of Birth:	[redacted]	Sex:	M	Facility:	HARN
Date:	11/14/2017 09:00	Provider:	Graham, Phillip E. Predoc.		

self-refer, should he require services earlier.

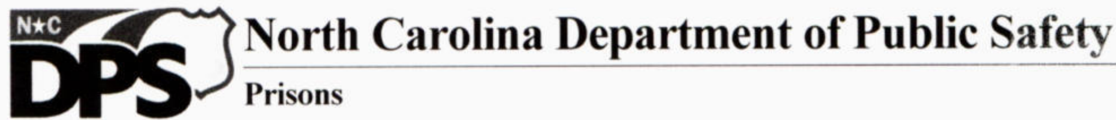
Schedule:

Activity	Date Scheduled	Scheduled Provider
Mental Health Progress Note	11/27/2017 00:00	Graham, Phillip E. Predoc. Psychology Intern

Follow up with inmate prior to review panel. Address concerns, follow up with inmate in regards to emotional stability.

Co-Pay Required: No **Cosign Required:** No
Telephone/Verbal Order: No
Standing Order: No

Completed by Graham, Phillip E. Predoc. Psychology Intern on 11/20/2017 09:08
Requested to be reviewed by Brumbaugh, Marcia L. Ph.D Psych. Program Manager.
Review documentation will be displayed on the following page.



Roy Cooper, Governor
Erik A. Hooks, Secretary

W. David Guice, Commissioner
George T. Solomon, Director

GENDER DYSPHORIA TREATMENT PLAN

Inmate: [redacted]
OPUS #: 0618705
DOB: [redacted] (age 36)
Facility: Harnett Correctional Institute, 3805

Review Panel Date: 11/27/2017
Review Panel Members:
Joseph Umesi, MD, primary care provider who completed physical examination
Phillip Graham, Predoctoral Intern, inmate's assigned clinician under the supervision of:
Marcia L. Brumbaugh, PhD, Psychological Program Manager
Tammy Black, RN, Nursing Supervisor
Melanie Shelton, Assistant Superintendent of Programs

The panel interviewed inmate [redacted] on the above date and reviewed relevant records, including the 10/18/2017 Psychiatric Evaluation by Dr. Hamra; the 10/12/2017 History and Physical records by Dr. Engleman; and the 10/13/2017 Mental Health Assessment by Ms. Garvey (all are attached).

Diagnosis: 302.85 (F64.1) Gender Dysphoria in Adolescents and Adults

Accommodations Requested: Inmate [redacted] requested the following accommodations during his panel interview:
-Privacy during showers, with a request to shower during count time if possible. He also requested that not as many staff be present during his showers. (He was informed that these requests are consistent with the facility SOP, which will be followed henceforth.)
-That he receive mail under his alias name Kanuatica Zayre. (He reports that he legally changed his name in 2011; community records scanned into HERO confirmed this alias.)
-He requested that records that contain his aforementioned alias be included with his recognized name ([redacted] [redacted]) in the NCDPS system.
-Inmate requested documents to have his name legally changed, noted and included in the NCPDS system with a badge to reflect his name change. (He was informed of how to complete the process.)
-He inquired about why his UR request for hormones treatment was cancelled. (Inmate was informed that policy only allows for continuation of hormone treatment that was active immediately prior to incarceration, which records verify is not the case for this inmate, and so he does not meet criteria for pursing UR approval during processing. He was further informed that the purpose of the current meeting is to seek approval for endocrinologist consultation.)

MAILING ADDRESS:
Post Office Box 1569
Lillington, N.C. 27546
COURIER: 14-70-02
www.ncdps.gov

OFFICE LOCATION:
Harnett Correctional Institution, #3805
1210 E. McNeill Street
Lillington, N.C. 27546
Telephone: (910) 893-2751
Fax: (910) 893-6432

- Bras (Please note that he currently has 5 bras but reported that he has "gained weight" and requires bras to accommodate the changes in his body. He was informed that he would need to have his measurements updated and placed on the list for the next clothing shipment.)
-Inmate requested the grooming and hygiene policy for women. (Inmate was informed that panel members are not aware of such gender specific polices but will check.)
-Inmate inquired about how to move forward with completing his gender reassignment surgery. He inquired if it would be possible. (Dr. Umesi informed the inmate that he will need to follow up and let him know at a later date.)

Psychiatric Referral: Not indicated, as inmate [redacted] was already seen in Psychiatry Clinic, most recently by Dr. Badri Hamra for a Psychiatric Evaluation. Neither psychiatric medication nor psychiatry appointments were indicated.

Other Appropriate Referrals: The panel recommends referring inmate [redacted] to Endocrinology for consideration of cross-sex hormone treatment. Inmate stated his goal is to have a "more feminine appearance," and he inquired if the "State" will follow up with his request to continue with gender reassignment surgery.

Education Resources to Make Available: None. Inmate reports being familiar with the process due to having done "extensive research."

Management Recommendations: The panel recommends housing inmate [redacted] in a single cell environment. This recommendation was made in consideration for the well-being of the inmate's safety due to his vulnerable status as a trans-female housed in a male facility.

Submitted by:

[signature] 7/28/2017
Phillip Graham, B.A. Date
Predoctoral Intern, Harnett Correctional Institute

[signature], PhD 11/28/17
Marcia L. Brumbaugh, PhD Date
Psychological Program Manager, Harnett Correctional Institute

cc: Central Office Transgender Review Committee, Facility Review Panel and Administrators
Ms. Tammy Black, Nurse Manager, Harnett Correctional Institute
Ms. Terri Catlett, Health Services Deputy Director
Mr. Jamie Cobb, Assistant Superintendent of Custody, Harnett Correctional Institute
Dr. Patricia Hahn, Assistant Director of Behavioral Health, Triangle Region
Dr. Bryan Harrelson, Acting Chief of Psychiatry
Dr. Gary Junker, Director of Behavioral Health
Ms. Melanie Shelton, Assistant Superintendent of Programs, Harnett Correctional Institute
Dr. Paula Smith, Director of Health Services
Ms. Cynthia Thornton, Correctional Administrator I, Harnett Correctional Institute
Dr. Joseph Umesi, Physician

KB10

NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY
MEDICAL TREATMENT REFUSAL

HEALTH SERVICES

4-25-2022
Date

I, [redacted] 0618705 , refuse treatment recommended by the Department of Public Safety, Health Services staff for the following condition(s):

DESCRIBE CONDITION IN LAYMAN'S TERMINOLOGY:
Refuse prescribed medications.

The following treatment(s) was/were recommended:
Recommended to take ATOMOXETINE 80 MG CAP, SERTRALINE 100 MG TAB, and TOPIRAMATE 25 MG TAB

Department of Public Safety, Health Services staff members have carefully explained to me that the following possible consequences and/or complications may result because of my refusal to accept treatment:
Refusing may cause delay of care and continued pain and anxiety

I understand the possible consequences and/or complications, listed above, and still refuse recommended treatment. I hereby assume all responsibility for my physical and/or mental condition, and release the Department of Public Safety and its employees from any and all liability for respecting and following my expressed wishes and directions.

DOLLENTE, ALVIN A RN 4-25-2022
Counseled by Date

[signature] 25 April 22
Patient's Signature Date

[signature] 4-25-22
Signature of Witness Date

Anson CI

North Carolina Department of Public Safety
Mental Health Progress Note

Offender Name:	█████, ████			Off #:	0618705
Date of Birth:	█████	Sex:	M	Facility:	HARN
Date:	12/07/2018 09:05	Provider:	Hahn, Patricia M Ph.D Asst. Dir.		

Treatment Setting

Outpatient Program at HARNETT CI.

Reason for Services

Routine Follow-Up Session

Violence Alerts

Ms. █████ denied any current thoughts of wanting to harm others.

Escape Alerts

None currently noted.

Self-Injury Alerts

Ms. █████ denied any current thoughts of wanting to harm herself.

MSE/Behavioral Observations

Ms. █████ presented as a polite 37 year old Black-American male to female transgnder inmate who appeared approximately her stated age. She was pleasant and cooperative during the therapy session. She displayed good eye contact and had no significant psychomotor agitation or retardation. Her speech was of normal rate, rhythm and volume. She was oriented to person, place, and time. Her attention and immediate memory appeared within normal limits. Her affect was frustrated, and she described her mood as "agitated." She denied current suicidal or homicidal ideation. She did not currently show active symptoms of psychosis or a thought disorder. Her judgment and insight were good. She has been attempting to handle her frustration over her transgender concerns in an appropriate way.

Progress Towards Goal(s)

Ms. █████ reported "I'm tired of being in this place." She expressed concern about the way she is being treated as a transgender individual. She presented a protocol that transgender individuals should be able to follow that consisted of hormone therapy, "real life experience," and surgery.

Ms. █████'s fTARC requests were discussed. Her requests for accommodations are as follows:
1. Ms. █████ would like to be assigned to NCCIW, Neuse, or another appropriate female facility. If this is not possible, she would like to be able to transfer to a different camp. (She wants to go to Warren for the dog program.)
2. She would like to complete her gender surgery, with the first step submitting a UR for the surgery.
3. She would like to have female underwear.

Also, she would like her legal name placed in the computer but indicated Ms. Bostic has taken care of that.

The undersigned is having a meeting for Harnett transgender individuals on 12/14/18. Ms. █████ does not want to attend the meeting but said she would try to come.

Plan/Diagnostic Changes

Ms. █████ will have her fTARC meeting on January 11, 2019.

Follow-up/Next Appointment

Ms. █████ will be seen for her individual therapy appointment in approximately 45 days. She knows she can submit a referral if she needs to be seen before that time.

NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY
Division Transgender Accommodation Review Committee (TARC) Report

Offender Name: [redacted]　　OPUS Number: 0618705

Facility TARC Date: 7/11/2019　　Division TARC Date: August 21, 2019

Names and Titles of TARC Members Present: Anita Wilson, Medical Director; Charlotte Williams, PREA Director; Gary Junker, Director of Behavioral Health; Anita Myers, Director of Nursing; Sarah Cobb, Deputy Director Rosemary Jackson, UR physician; Terri Catlett, Director of Administration

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Transgender Accommodation Requests Under Review:

Request vaginoplasty

Approved Accommodations:

Accommodations Not Approved and Rationale:

Request for vaginoplasty - Deferred as offender has successfully completed gender reassignment surgically. Vaginoplasty is an elective procedure which is not medically necessary for reassignment. Current staffing and resources does not allow for the proper post operative care of this procedure

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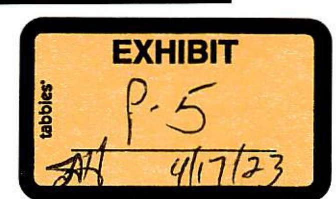
Other:

Scan into HERO as "TARC/Division Report."
Attach to HERO Scanned Document Type "Division Transgender Accommodation Committee Report."



DC – 411D (07/18)　　This form is not to be amended, revised, or altered without approval of the Medical Records Committee.

North Carolina Department of Public Safety
Clinical Encounter - Administrative Note

Offender Name:	[redacted], [redacted]			Off #:	0618705
Date of Birth:	[redacted]	Sex:	F Race: BLACK	Facility:	ANSO
Note Date:	07/22/2020 14:23	Provider:	Norris, Jennifer L. NP	Unit:	JPODA

Record Review encounter performed at Non Patient Contact.

Administrative Notes:

ADMINISTRATIVE NOTE **1** Provider: Norris, Jennifer L. NP

Per nursing supervisor, patient will need UR approval for a telephone interview with Kristia Vasiloff, the transgender patient coordinator at UNC to discuss expectations and plan for surgical reassignment surgery if approved. This telephone interview is required prior to an office visit with Dr. Figler and this phone interview is scheduled for 8/4/2020.

New Consultation Requests:

Consultation/Procedure	Due Date	Priority	Translator	Language
UR Request		Rush (review within 7 days)	No	

Reason for Request:

Per nursing supervisor, patient will need UR approval for a telephone interview with Kristia Vasiloff, the transgender patient coordinator at UNC to discuss expectations and plan for surgical reassignment surgery if approved. This telephone interview is required prior to an office visit with Dr. Figler and this phone interview is scheduled for 8/4/2020.

Co-Pay Required: No **Cosign Required:** No

Telephone/Verbal Order: No

Standing Order: No

Completed by Norris, Jennifer L. NP on 07/22/2020 14:26

UNCH
500 Eastowne Drive
Chapel Hill NC 27514-2244

Chestnut, Kevin
MRN: 000015493026, DOB: 9/23/1981, Sex: F
Visit date: 8/4/2020

08/04/2020 - Documentation in UNC TRANSGENDER HEALTH HILLSBOROUGH

Encounter Notes

Progress Notes

Kristia R Vasiloff at 8/4/2020 12:49 PM

Author: Kristia R Vasiloff | Service: — | Author Type: —
Filed: 08/05/20 0956 | Encounter Date: 8/4/2020 | Status: Signed
Editor: Kristia R Vasiloff

Kanautica Chestnut is a transgender female / male-to-female , assigned female at birth who uses she/her/hers pronouns, contacted UNC Trans Health Program for general questions about surgery. Kanautica is currently incarcerated.

Intake done by Kristia R Vasiloff on 08/04/20

The following information was reported by the patient:

Demographic information: See chart
Medication Information: See chart

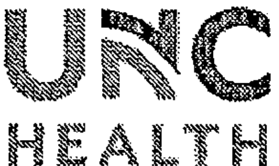
Transition
Social transition: 1999
Medical transition: 2010 - continuously, no breaks, before incarceration.
Currently taking estrogen pacth 1mg bi-weekly
On hormone therapy: yes

Providers
HRT Prescriber: Dr.Kate Pou, soon to be Dr. Donald Caracio
PCP: yes
-Name: See Above
Mental Health Provider: yes
-Name: Correctional Facility Caseworker

Interest in Care
Hair removal: yes
Top Surgery: no
Bottom Surgery: yes
-Type:vaginoplasty
GYN Surgery: no

Allergies
N/A

WPATH Standards
WPATH standards of care for gender confirmation surgery not explained to patient
Patient endorses understanding of WPATH standards, but clinician concerned with demonstrated level of understanding; follow up required.
Patient has the following WPATH items: N/A
Patient needs the following WPATH items prior to surgery: N/A



UNCH
500 Eastowne Drive
Chapel Hill NC 27514-2244

Chestnut, Kevin
MRN: 000015493026, DOB: 9/23/1981, Sex: F
Visit date: 8/4/2020

08/04/2020 - Documentation in UNC TRANSGENDER HEALTH HILLSBOROUGH (continued)

Encounter Notes (continued)

No medical conditions to report.

Possible need for referrals: Urology

Referral intake sent to Katherine Croft, BSN, RN - Program Manager for continued care.

Electronically signed by Kristia R Vasiloff at 08/05/20 0956

End of Document

North Carolina Department of Public Safety
Consultation

Offender Name:	[redacted], [redacted]			Off #:	0618705
Date of Birth:	[redacted]	Sex:	F	Facility:	ANSO
Date:	03/26/2021 09:00	Provider:	Peiper, Lewis J Ph.D Dir. of		

Treatment Setting

Outpatient Program at Anson CI.

Comments

Telephone consultation completed between myself (Dir. of Beh. Health), Terri Catlett (Dir. of Health Administration), and Katherine Croft (Program Manager, UNC Transgender Health Program). Katherine Croft, BSN, RN is the Program Manager and primary Nurse Navigator for the UNC Transgender Health Program. She serves as the primary point of contact for initial surgical consults for genital surgery procedures, including metoidioplasty, phalloplasty, and vaginoplasty.

The consultation clarified logistical considerations between the UNC Transgender Health Program and the Prison TARC process. We are now able to schedule an individualized, in-depth, informational consultation between UNC and Offender Brown (prison record name = [redacted] [redacted]). The individualized consultation with Katherine Croft will occur by telehealth; the schedule and telehealth connection are being coordinated by Ms. Catlett.

The DTARC has already approved any in-person consultation with a surgical specialist that may occur moving forward. The resulting information from all consultations will be reviewed for further consideration by the DTARC.

Co-Pay Required: No **Cosign Required:** No

Telephone/Verbal Order: No

Standing Order: No

Completed by Peiper, Lewis J Ph.D Dir. of Beh. Health on 03/26/2021 09:55

Requested to be reviewed by Messer, Charles E M.A. Psych. Program Manager.

Review documentation will be displayed on the following page.

North Carolina Department of Public Safety
Clinical Encounter

Offender Name: [redacted], [redacted] | Off #: 0618705
Date of Birth: [redacted] | Sex: F | Race: BLACK/AFRI | Facility: OFF
Encounter Date: 05/25/2021 13:52 | Provider: Croft, Katherine RN | Unit: OFF

Nursing Note encounter performed at Telehealth.

SUBJECTIVE:

COMPLAINT **1** Provider: Croft, Katherine RN

Chief Complaint: Pre-operative Eval

Subjective: Evaluation and education for gender-affirming vaginoplasty

Pain Location:

Pain Scale:

Pain Qualities:

History of Trauma:

Onset:

Duration:

Exacerbating Factors:

Relieving Factors:

Comments:

OBJECTIVE:

Exam:

ASSESSMENT:

Other

Kanautica [redacted] is a transgender female / male-to-female ,39 y.o. , who uses she/her/hers pronouns, and is here for consult for vaginoplasty.

Surgical Goals: Kanautica [redacted] and I discussed their goals for surgery
Kanautica [redacted] has the following goals post-operatively:
Do not feel comfortable/complete - dysphoria
Maybe penetrative sex - unsure
Interested in Vulvaplasty

Pre-Op:
Concerns present: BMI currently >35, patient working to lose weight.
does not have a history or family history of VTE risk

Surgical Discussion: Kantautica is a well-appearing transgender woman of 39 years consulting for consideration of vaginoplasty surgery with Dr. Bradley Figler. Per DPS consideration, patient is first meeting with clinical nurse navigator to discuss medical hx and considerations for surgery to appropriately assess next steps.

The two available gender-affirming procedures, vaginoplasty and vulvoplasty, were explained in-depth including operative time, pre-and post surgical considerations, and specific concerns from the patient. After discussing the difference between the procedures, the patient expressed a desire for vulvoplasty based on considerations of concern for time to complete hair removal and concern for post-op care, including dilation, necessary for vaginoplasty, while incarcerated. Patient asked if vaginal canal can be added after vulvoplasty, and was counseled that, while more difficult without a scrotal graft, operative techniques such as robotic vaginoplasty were available for revision to create a vaginal canal at a later time. Based on these consideration the patient elected that she wished to move forward with vulvoplasty if possible.

Offender Name: [redacted], [redacted] Off #: 0618705
Date of Birth: [redacted] Sex: F Race: BLACK/AFRI Facility: OFF
Encounter Date: 05/25/2021 13:52 Provider: Croft, Katherine RN Unit: OFF

Based on the patient's medical hx, no primary concerns were identified that would interfere with surgery except for weight, which the patient indicated she was intending to lose for surgery.

Patient endorsed that all of her questions were answered.

Plan: in-clinic consultation with Dr. Figler for Vulvoplasty.

PLAN:

Disposition:

Consultation Written

Patient Education Topics:

Date Initiated	Format	Handout/Topic	Provider	Outcome
05/25/2021	Counseling	Pre-op Instructions	Croft, Katherine	Verbalizes Understanding

Co-Pay Required: No **Cosign Required:** No

Telephone/Verbal Order: No

Standing Order: No

Completed by Croft, Katherine RN on 05/25/2021 15:02

UNCH
500 Eastowne Drive
Chapel Hill NC 27514-2244

█████, ███
MRN: 000015493026, DOB: 9/23/1981, Sex: F
Visit date: 7/12/2021

Lindsey [illegible], RN

07/12/2021 - Office Visit in UNCH UROLOGY HILLSBOROUGH

Abstract Notes

Progress Notes

Bradley David Figler, MD at 7/12/2021 1100

Author: Bradley David Figler, MD Service: — Author Type: Physician
Filed: 07/18/21 0652 Encounter Date: 7/12/2021 Status: Signed
Editor: Bradley David Figler, MD (Physician)

ASSESSMENT:
Transgender adult, interested in vaginoplasty

DISCUSSION:

We had an extensive discussion re: vaginoplasty.

We discussed indications for the procedures. She is aware that we follow the World Professional Association for Transgender Health (WPATH) standards of care (SOC), and has access to the latest standards of care. Criteria for genital surgery, according to WPATH SOC:

- Pesistent, well documented gender dysphoria
- Capacity to make fully informed decisions and to consent to treatment
- Age of majority in a given country
- If significant medical or mental health concerns are present, they must be well controlled
- 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unwilling or unable to take hormones)
- 12 continuous months of living in a gender role that is congruent with their gender identity
- Two referrals, at least one from a qualified mental health professional

We discussed rationale for referrals. The purpose of these assessment letters is to assess emotional stability and confirm these three primary categories:

- Presence of persistent gender dysphoria
- If any mental health issues are present, they are reasonably well controlled
- Someone has lived in their identified gender for at least one year.

We discussed penile inversion vaginoplasty in detail, including our technique, pre-operative and post-operative management. We discussed peri-operative hormone management, and I requested that she consult with her hormone provider re: peri-operative dosing.

We discussed risks of the procedure. General risks of the procedure include heart attack, stroke, pneumonia, blood clots, pulmonary embolus, and others. Estrogen has been associated with venous thromboembolism through multiple mechanisms, though there is considerable variability in practice patterns related to perioperative estrogen and there are currently no guidelines. Risks specific to the procedure include bleeding, tissue necrosis, wound dehiscence, poor cosmesis, pelvic pain, poor graft take, granulation tissue, neovaginal/labial hair, urge incontinence, stress incontinence, urethral stricture, post-void dribbling, urinary tract infections, weak, splayed and non-directable urine stream, adhesions, inability to orgasm or change in orgasm, pain/scarring, prolapse, vaginal stenosis/shortening, injury to surrounding tissue (including bowel, rectum, bladder, urethra) and possible development of fistula.

Because of the risk of neovaginal hair, we discussed the need for hair removed pre-operatively and we provided a template.

We discussed risks related to high lithotomy position, including lower extremity paresthesias or pain (the vast majority of which would resolve in 24 hours), compartment syndrome (requiring emergency surgery to decompress), and

EXHIBIT 14
Deponent Sheitman
Date 5/17/23 Rptr. SS
WWW.DEPOBOOKPRODUCTS.COM

UNCH
500 Eastowne Drive
Chapel Hill NC 27514-2244

[redacted], [redacted]
MRN: 000015493026, DOB: [redacted], Sex: F
Visit date: 7/12/2021

07/12/2021 - Office Visit in UNCH UROLOGY HILLSBOROUGH (continued)

Abstract Notes (continued)

rhabdomyolysis. These complications are more likely with longer times in the lithotomy position, and this surgery will require a prolonged lithotomy time.

We discussed importance of bolster and limited activity for graft take, and the importance of post-operative dilation and pelvic floor physical therapy.

We also discussed alternative approaches to vaginoplasty, including robotic peritoneal flap and bowel interposition.

A copy of "What You Need Before Vaginoplasty" from the UNC Transgender Health Program was provided.

After extensive discussion of risks, benefits and alternatives, decision was made to move forward with vaginoplasty.

PLAN:

- Proceed with **vulvoplasty** per WPATH criteria pending
  - Weight loss. Goal 215 (BMI 30), max 250 (BMI 35)
- Will order case request & notify surgery scheduler when approved by THP

HISTORY OF PRESENT ILLNESS:

A 39 y.o.-year-old transgender adult seen today in consultation at the request of Umesi, Joseph for bottom surgery.

Assigned male at birth
Pronouns: she/her
Living full time in current gender role since: 2012
On gender affirming hormones since: 2012
Hair removal: Face/chest only

Are you sexually active? No
Preferred gender of sexual partner(s)? Male
Do you use your penis for penetrative sex? No
Are you seeking a vaginal canal (vaginoplasty) or limited depth vulvoplasty? Vulvoplasty

Goals of surgery, ranked:
1. Dysphoria

PMH: [redacted]
PSH: Orchiectomy (hope sherry), brazilian butt lift, top surgery
Meds: Currently on transdermal estrogen 0.1mg biweekly for hormone therapy
Family Hx: No familial hx of bleeding or clotting disorders. No personal or family hx of DVT, PE.

Any tobacco use previous or current: No
IDU previous or current: No
Genital injury, surgery, UTIs, dysuria, hematuria, stricture, scrotal pain, elevated PSA, history of prostate biopsy, prostatitis, pelvic radiation: No
Circumcised: no
Children/interest in future fertility: No

UNCH
500 Eastowne Drive
Chapel Hill NC 27514-2244

[redacted]
MRN: 000015493026, DOB: [redacted] Sex: F
Visit date: 7/12/2021

07/12/2021 - Office Visit in UNCH UROLOGY HILLSBOROUGH (continued)

Abstract Notes (continued)

PMHX: [redacted]
No hx of clotting disorders in family

Height: 5'10 3/4"
Weight: (approx) 275lbs

I review history elements and review of systems on new patient intake form.

PAST MEDICAL HISTORY:

Past Medical History:

Diagnosis	Date
• Goiter	
• Male-to-female transgender person	
• Testosterone deficiency	
• Thyroid nodule *Left lobe complex nod*	07/27/2018

PAST SURGICAL HISTORY:

Past Surgical History:

Procedure	Laterality	Date
• BUNIONECTOMY		2018
• ORCHIECTOMY	Bilateral	
• TRANSUMBILICAL AUGMENTATION MAMMAPLASTY		10/2012

MEDICATIONS:

Current Outpatient Medications

Medication	Sig	Dispense	Refill
• bictegrav-emtricit-tenofov ala (BIKTARVY) 50-200-25 mg tablet	Take 1 tablet by mouth daily.		
• estradioL (VIVELLE) 0.1 mg/24 hr	Place 1 patch on the skin Two (2) times a week.		
• sertraline (ZOLOFT) 100 MG tablet	Take 150 mg by mouth daily.		
• biotin 5 mg tablet	Take one tablet daily as directed by Dr. Pou Medically necessary for transition	90 tablet	1
• cholecalciferol, vitamin D3, (VITAMIN D3) 1,000 unit capsule	Take 1,000 Units by mouth daily.		
• cyanocobalamin (VITAMIN B-12) 100 MCG tablet	Take 250 mcg by mouth daily.		
• MINERAL OIL-	Apply 120 g topically		

UNCH
500 Eastowne Drive
Chapel Hill NC 27514-2244

[redacted]
MRN: 000015493026, DOB: 9/23/1981, Sex: F
Visit date: 7/12/2021

07/12/2021 - Office Visit in UNCH UROLOGY HILLSBOROUGH (continued)

Abstract Notes (continued)

PETROLAT,WHT-WATER TOP every thirty (30) days.

No current facility-administered medications for this visit.

ALLERGIES:
No Known Allergies

FAMILY HISTORY:
Family History

Problem	Relation	Age of Onset
• Cancer	Mother	

SOCIAL HISTORY:
Social History

Socioeconomic History	
• Marital status:	Single
Spouse name:	Not on file
• Number of children:	Not on file
• Years of education:	Not on file
• Highest education level:	Not on file
Occupational History	
• Not on file	
Tobacco Use	
• Smoking status:	Never Smoker
• Smokeless tobacco:	Never Used
Substance and Sexual Activity	
• Alcohol use:	No
• Drug use:	Not on file
• Sexual activity:	Not on file
Other Topics	**Concern**
• Not on file	
Social History Narrative	
• Not on file	

Social Determinants of Health

Financial Resource Strain:
• Difficulty of Paying Living Expenses:
Food Insecurity:
• Worried About Running Out of Food in the Last Year:
• Ran Out of Food in the Last Year:
Transportation Needs:
• Lack of Transportation (Medical):
• Lack of Transportation (Non-Medical):
Physical Activity:

UNCH
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[redacted]
MRN: 000015493026, DOB: [redacted] Sex: F
Visit date: 7/12/2021

07/12/2021 - Office Visit in UNCH UROLOGY HILLSBOROUGH (continued)

Abstract Notes (continued)

- Days of Exercise per Week:
- Minutes of Exercise per Session:

Stress:

- Feeling of Stress :

Social Connections:

- Frequency of Communication with Friends and Family:
- Frequency of Social Gatherings with Friends and Family:
- Attends Religious Services:
- Active Member of Clubs or Organizations:
- Attends Club or Organization Meetings:
- Marital Status:

REVIEW OF SYSTEMS:
10-system review of systems negative other than what is mentioned above.
The patient was asked to review all abnormal responses not pertinent to today's visit with their primary care physician.

PHYSICAL EXAM:
GENERAL: Pleasant adult in no acute distress.
VITAL SIGNS: Blood pressure 125/85, pulse 62, temperature 36.4 °C (97.6 °F), temperature source Temporal, resp. rate 18, height 180.3 cm (5' 11"), weight(!) 130.6 kg (288 lb), SpO2 100 %.
Estimated body mass index is 40.17 kg/m² as calculated from the following:
Height as of this encounter: 180.3 cm (5' 11").
Weight as of this encounter: 130.6 kg (288 lb).
HEENT: Normocephalic, atraumatic, extraocular muscles intact
NECK: Supple, no lymphadenopathy
CARDIOVASCULAR: No peripheral edema
PULMONARY: Normal work of breathing, no use of accessory muscles
ABDOMEN: Soft, non-tender, non-distended. No organomegaly or hernias.
BACK: No costovertebral angle tenderness, no spiny bone tenderness.
EXTREMITIES: No clubbing, cyanosis or edema.
NEUROLOGIC: Cranial nerves II-XII grossly intact
PSYCHOLOGIC: Normal affect, normal mood
SKIN: Warm and dry. No lesions.
GU: nl non-circ phallus
Penis size: Adequate
Scrotal size: Adequate

LAB RESULTS:
Results for orders placed or performed in visit on 03/06/20

TSH

Result	Value	Ref Range
TSH	0.907	0.600 - 3.300 uIU/mL

Estradiol (Estrogen) Level

Result	Value	Ref Range
Estradiol	277.4	pg/mL

Luteinizing hormone

Result	Value	Ref Range

UNCH
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Chapel Hill NC 27514-2244

[redacted], [redacted]
MRN: 000015493026, DOB: [redacted], Sex: F
Visit date: 7/12/2021

07/12/2021 - Office Visit in UNCH UROLOGY HILLSBOROUGH (continued)

Abstract Notes (continued)

LH	6.8	mIU/mL

Vitamin B12 Level

Result	Value	Ref Range
Vitamin B-12	653	193 - 900 pg/ml

Vitamin D 25 Hydroxy (25OH D2 + D3)

Result	Value	Ref Range
Vitamin D Total (25OH)	26.5	20.0 - 80.0 ng/mL

Ordered at this visit: No orders of the defined types were placed in this encounter.

No results found for: PSASCRN, PSADIAG

Lab Results

Component	Value	Date
WBC	6.8	10/17/2012
HGB	14.7	10/17/2012
HCT	44.8	10/17/2012
PLT	308	10/17/2012

Lab Results

Component	Value	Date
NA	138	12/02/2019
K	4.1	12/02/2019
CL	102	12/02/2019
CO2	27.0	12/02/2019
BUN	20	12/02/2019
CREATININE	1.12	12/02/2019
GLU	89	12/02/2019
CALCIUM	9.4	12/02/2019

Lab Results

Component	Value	Date
BILITOT	0.6	12/02/2019
BILIDIR	0.20	12/02/2019
PROT	7.6	12/02/2019
ALBUMIN	4.3	12/02/2019
ALT	17	12/02/2019
AST	28	12/02/2019
ALKPHOS	66	12/02/2019

No results found for: LABPROT, INR, APTT

UNC HEALTH

UNCH
500 Eastowne Drive
Chapel Hill NC 27514-2244

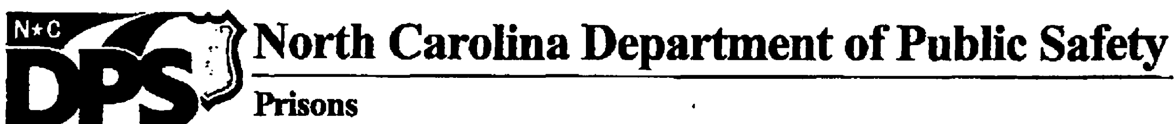
[redacted]
MRN: 000015493026, DOB: [redacted] Sex: F
Visit date: 7/12/2021

07/12/2021 - Office Visit in UNCH UROLOGY HILLSBOROUGH (continued)

Abstract Notes (continued)

Electronically signed by Bradley David Figler, MD at 07/18/21 0652

End of Document



Roy Cooper, Governor
Erik A. Hooks, Secretary

Kenneth E. Lassiter, Director
Reuben F. Young, Interim Chief Deputy Secretary

Fax Transmittal Cover Sheet

NC DPS Adult Corrections
Anson Correctional Institution-4575
PO Box 280
552 Prison Camp Rd.
Polkton, NC 28135
Telephone 704-695-1013 Fax 704-694-1729
Miranda Richardson, Correctional Administrator I

Medical Department

Main Medical 704-272-4861
Hasty, Kandi RN, Nurse Supervisor I 704-272-4855
Totou, Amba RN, Nurse Supervisor I 704-272-4859
West, Dena RN, Nurse Supervisor II 704-272-4858

FROM: Case, Krystle A.S.I 704-272-4662
Medical Fax: 704-694-1729

Date: 07/13/21

To: UNC HEALTHCARE

From: Anson Correctional- K.Case ASI

Attention: MEDICAL RECORS

Fax Number: 984-974-0472

URGENT REQUEST

Re: Requesting Urology visit notes for our mutual patient: [redacted] **(Kanautica Zayre-Brown) DOB:[redacted], DOS: 7/12/21.** Please fax to 1-704-694-1729.

Thank you, K.Case ASI.

Number of pages: 1 (including cover sheet)

MAILING ADDRESS:
4260 Mail Service Center
Raleigh, NC 27699-4260
www.ncdps.gov

OFFICE LOCATION:
831 W. Morgan St.
Raleigh, NC 27699-4260
Telephone: (919) 838-4000
Fax: (919) 838-4749

North Carolina Department of Public Safety
Cosign/Review

Offender Name:	[redacted], [redacted]			Off #:	0618705
Date of Birth:	[redacted]	Sex:	F	Race:	BLACK/AFRIC
Scanned Date:	07/22/2021 10:10			Facility:	ANSO

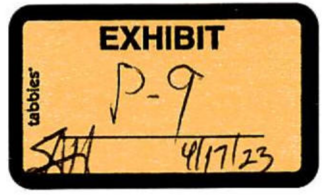
Reviewed by Norris, Jennifer L. NP on 07/22/2021 13:34.

From: "Dula, Jennifer L" <jennifer.dula@ncdps.gov>
To: "Peiper, Lewis" <lewis.peiper@ncdps.gov>
Cc: "Bowman, Marvella" <Marvella.Bowman@ncdps.gov>
Subject: K. Brown letter
Date: Tue, 5 Oct 2021 19:57:59 +0000
Importance: Normal
Attachments: K._Brown_rough_draft_10.5.21.docx

Dr. Peiper,
Here is my what I came up with for the letter. Let me know what you think. Thanks again for the opportunity to help.

Jennifer Dula, MSW, LCSW
(She, her, hers)
Corrections Psychological Services
NC Department of Public Safety
Division of Adult Correction and Juvenile Justice
Anson Correctional Institution #4575
Post Office Box 280
Polkton, NC 28135
Direct: (704) 272-4860
Fax: (704) 694-1729
Email: jennifer.dula@ncdps.gov
Website: http://www.ncdps.gov/

Email correspondence to and from this address may be subject to the North Carolina Public Records Law and may be disclosed to third parties by an authorized state official.



October 4. 2021

RE: Kanautica Brown (OPUS# 0618705)

To Whom It May Concern,

Ms. Brown is a transgender female receiving mental health services with Corrections Psychological Services through the North Carolina Department of Public Safety Division of Prisons. She is currently housed at Anson Correctional Institution for Women. She has actively engaged with Corrections Psychological Services since October 2017.

Review of Mental Health History:

Prior to incarceration, offender endorses engaging in mental health services as part of the requirements for trans-affirming medical care such as cross-hormonal therapy and various gender-affirming surgical interventions. Specifically, Ms. Brown reports engaging in eight months of psychotherapy in 2012 prior to initiating gender-affirming medical procedures and care. She denies engaging in any other mental health services outside of addressing her gender dysphoria.

Since incarceration, Ms. Brown has engaged in mental health services to access transgender accommodations and to address and manage her feelings of gender dysphoria and the subsequent anxiety and depression associated with it. Review of the records shows mostly routine treatment but there has also been intermittent crisis intervention required. Most of the acute events have been connected to Ms. Brown's distress over her gender identity and the process of addressing it within the correctional system.

Accommodations Requests:

She expresses a persistent desire for vulvoplasty. Her goals of surgery are *in her own words when interviewed*

Review of Transgender History:

Ms. Brown identifies as a transgender female and uses female pronouns (she, her hers). Ms. Brown endorses feelings of gender incongruence since the age of *in her own words*. She began the process to socially transition in 2011. She has changed pronouns, legally changed her name, engages in tucking and is currently housed in a female facility. She has been successfully living in a gender role congruent with her affirmed gender since at least 2014. She has been consistently on hormone therapy since 2012. Ms. Brown has also undergone several other gender affirming surgeries as part of her transition such as an orchiectomy, breast augmentation and facial feminization.

Despite these interventions, Ms. Brown continues to report clinically significant anxiety, depression and distress associated with her gender dysphoria that has been documented consistently throughout her mental health treatment. My clinical evaluation and the existing mental health documentation for Ms. Brown meets the criteria for a diagnosis of Gender Dysphoria.

Adjustment to Incarceration:

Ms. Brown has struggled at times with being incarcerated as a transgender female. Her adjustment has improved since being transferred to a female facility. For the most part, the other inmates and staff have been inclusive and supportive. However, now that the issue of housing has been addressed and is affirming, it seems to have made her more aware and dysphoric about the one of her body that does not affirm her gender identity. Ms. Brown demonstrates a desire to use her coping strategies but is expressing increased frustration with the process.

Clinical Recommendation:

Based on the review of her records and my own assessment, I believe the next appropriate step for Ms. Brown is to undergo vulvoplasty. It is my clinical opinion this will help her make significant progress in further treatment of her gender dysphoria. Ms. Brown is psychologically stable to undergo this surgery and will be able to access post op care at an appropriate DPS facility. She has no issues with illicit drug use or abuse. Ms. Brown has more than met the WPATH criteria for surgery. I have reviewed all the risks, benefits and alternatives of this surgery and believe Ms. Brown has an excellent understanding of them. She has demonstrated the ability to make an informed decision about undertaking surgery. My professional recommendation is to refer Ms. Brown for this surgery.

Sincerely,

Jennifer Dula, MSW, LCSW

General Confidential Information

North Carolina Department of Public Safety

Division of Prisons

Roy Cooper, Governor
Casandra Skinner Hoekstra, Interim Secretary

Timothy D. Moose, Chief Deputy Secretary
Todd E. Ishee, Commissioner of Prisons
Brandeshawn Harris, Assistant Commissioner

Sept 9, 2021

RE: Kanautica Brown AKA: [redacted] (OPUS# 0618705)

To Whom It May Concern,

Ms. Brown is a transgender female receiving mental health services with Corrections Psychological Services through the North Carolina Department of Public Safety Division of Prisons. She is currently housed at Anson Correctional Institution for Women. She has actively engaged with Corrections Psychological Services since October 2017.

Ms. Brown identifies as a transgender female and uses female pronouns (she, her hers). Ms. Brown endorses feelings of gender incongruence since the age of ******. She has socially transitioned by changing pronouns, legally changing her name, tucking and being housed in a female facility. She has been successfully living in a gender role congruent with her affirmed gender since at least 2014. She has been consistently on hormone therapy since *****. Ms. Brown has also undergone several other gender affirming surgeries as part of her transition.

Despite these interventions, she continues to report clinically significant anxiety, depression and distress associated with her gender dysphoria that has been documented consistently throughout her mental health treatment. My clinical evaluation and the existing mental health documentation for Ms. Brown meets the criteria for a diagnosis of Gender Dysphoria. She has expressed a persistent desire for vulvoplasty. Her goals of surgery are *****. Surgery will address her gender dysphoria in these ways: ****. Ms. Brown is psychologically stable to undergo this surgery and will be able to access post op care at an appropriate DPS facility. She has no issues with illicit drug use or abuse. Ms. Brown has more than met the WPATH criteria for surgery. I have reviewed all the risks, benefits and alternatives of this surgery and believe Ms. Brown has an excellent understanding of them. She has demonstrated the ability to make an informed decision about undertaking surgery.

Based on the review of her records and my own assessment, I believe the next appropriate step for Ms. Brown is to undergo vulvoplasty. It is my clinical opinion this will help her make significant progress in further treatment of her gender dysphoria. My professional recommendation is to refer Ms. Brown for this surgery. If you have any questions or concerns, please do not hesitate to contact me at the information listed below.

MAILING ADDRESS:
P.O. Box 280
Polkton, NC 28135
www.ncdps.gov

OFFICE LOCATION:
552 Prison Camp Road
Polkton, NC 28135
Telephone: (704)-695-1013
Fax: (704)-694-1721

An Equal Opportunity Employer

Sincerely,

Jennifer Dula, MSW, LCSW
Correction Psychological Services
NC Department of Public Safety
Division of Adult Correction and Juvenile Justice
Anson Correctional Institution #4575
Post Office Box 280
Polkton, NC 28135
Direct: (704) 272-4860
Fax: (704) 694-1729
Email: jennifer.dula@ncdps.gov

SENSITIVE BUT UNCLASSIFIED

North Carolina Department of Public Safety
Transgender Accommodation Summary

Offender Name:	[redacted]			Off #:	0618705
Date of Birth:	[redacted]	Sex:	F	Facility:	ANSO
Date:	10/20/2021 09:00	Provider:	Dula, Jennifer L MSW Clinical		

Review of Mental Health History

Ms. Brown is a transgender female receiving mental health services while currently housed at Anson Correctional Institution for Women. She has actively engaged with mental health services since October 2017.

Prior to incarceration, Ms. Brown endorses engaging in mental health services as part of the requirements for trans-affirming medical care such as cross-hormonal therapy and various gender-affirming surgical interventions. Specifically, Ms. Brown reports engaging in eight months of psychotherapy in 2012 prior to initiating gender-affirming medical procedures and care. She denies engaging in any other mental health services outside of addressing her gender dysphoria.

Since incarceration, Ms. Brown has engaged in mental health services to access transgender accommodations and to address and manage her feelings of gender dysphoria and the subsequent anxiety and depression associated with it. Review of the records shows mostly routine psychotherapy and treatment in support of her transitional care. There has been some crisis intervention required including four SIRA's and one in-patient placement since 2017. The acute events have been connected to Ms. Brown's distress over her gender identity and the process of addressing her transitional needs within a multi-level medical system.

Accommodation Requests

Ms. Brown expresses a persistent desire for trans-feminine bottom surgery. After consulting with outside medical providers at UNC Trans Health, Ms. Brown determined vulvoplasty was the next step in her transitional care. Her goals of surgery are to alleviate her gender dysphoria. She wants to feel comfortable in her own body and feel that it matches who she is on the inside. She feels others will see her as the woman she knows herself to be which will reduce her anxiety and depressive symptoms.

Review of Transgender History

Ms. Brown identifies as a transgender female and uses female pronouns (she, her hers). Ms. Brown endorses feelings of gender incongruence since the age of around the age 7 or 8 years old. She began the process to socially transition in 2011. She has changed pronouns, legally changed her name, engages in tucking and is currently housed in a female facility. She has been successfully living in a gender role congruent with her affirmed gender since at least 2014. She has been consistently on hormone therapy since 2012. Ms. Brown has also undergone several other gender affirming surgeries as part of her transition such as an orchiectomy, breast augmentation and facial feminization.

Despite these interventions, Ms. Brown continues to report clinically significant anxiety, depression and distress associated with her gender dysphoria that has been documented consistently throughout her mental health treatment. My clinical evaluation and the existing mental health documentation for Ms. Brown meets the criteria for a diagnosis of Gender Dysphoria.

Based on the review of her records and the current assessment, it appears the next appropriate step for Ms. Brown is to undergo trans-feminine bottom surgery. The surgery will help her make significant progress in further treatment of her gender dysphoria. Ms. Brown is psychologically stable to undergo this surgery and will be able to access post op care at an appropriate DPS facility. She has no issues with illicit drug use or abuse. Review of the all medical consultations with UNC Trans Health show that the risks, benefits and alternatives of this surgery have been reviewed with Ms. Brown, and she showed an excellent understanding during those consultations and this evaluation. She has demonstrated the ability to make an informed decision about undertaking surgery. In summary, Ms. Brown has met the WPATH criteria and is an appropriate candidate for surgery.

Adjustment to Incarceration

Ms. Brown has struggled at times with being incarcerated as a transgender female. Her adjustment has improved since being transferred to a female facility. For the most part, the other inmates and staff have been inclusive and supportive. However, now that the issue of housing has been addressed and is affirming, it seems to have made her more aware and dysphoric about the one part of her body that does not affirm her gender identity. Ms. Brown demonstrates a desire to use her coping strategies but is expressing increased frustration with the process.

EXHIBIT 6
Deponent Peiper
Date 5/1/23 Rptr. SS
WWW.DEPOBOOKPRODUCTS.COM

Offender Name:	[redacted]			Off #:	0618705
Date of Birth:	[redacted]	Sex:	F	Facility:	ANSO
Date:	10/20/2021 09:00	Provider:	Dula, Jennifer L MSW Clinical		

Co-Pay Required: No **Cosign Required:** No

Telephone/Verbal Order: No

Standing Order: No

Completed by Dula, Jennifer L MSW Clinical Social Worker on 10/26/2021 11:55

North Carolina Department of Public Safety
Clinical Encounter

Offender Name: [redacted], [redacted] | Off #: 0618705
Date of Birth: [redacted] | Sex: F | Race: BLACK/AFRI | Facility: ANSO
Encounter Date: 10/21/2021 08:24 | Provider: Caraccio, Donald MD | Unit: LPODE

Endocrinology encounter performed at Telehealth.

SUBJECTIVE:

COMPLAINT 1 Provider: Caraccio, Donald MD

Chief Complaint: Other Problem

Subjective: This is 40yo transgender woman seen for continued hormonal treatment. She is s/p orchiectomy and has been on estrogen since 2012. She is seeking vulvoplasty as part of her treatment of Gender dysphoria (DSM V diagnosis).

Tolerating estradiol 20mg Q 14 days. She is now at 245lbs (from ~275lbs). She saw Dr. Figler and was cleared from him for surgery (vulvoplasty) is she could get weight to under 250lbs. She was then denied by prison. She is working with ACLU on this.

Hair growth is less. Having less frequent erections, which has had a very big impact on her mental health status. No leg swelling. No chest pain/SOB. Her mood is excellent.

Her first estradiol measurement was 309 on day 13 after injection. Her next level was 1082 on day 8.

Pain Location:

Pain Scale:

Pain Qualities:

History of Trauma:

Onset:

Duration:

Exacerbating Factors:

Relieving Factors:

Comments:

OBJECTIVE:

Temperature:

Date	Time	Fahrenheit	Celsius	Location	Provider
10/16/2021	14:23 ANSO	98.3	36.8	Oral	Crump, Alison F LPN

Pulse:

Date	Time	Rate Per Minute	Location	Rhythm	Provider
10/16/2021	14:23 ANSO	76	Via Machine		Crump, Alison F LPN

Respirations:

Date	Time	Rate Per Minute	Provider
10/16/2021	14:23 ANSO	18	Crump, Alison F LPN

Blood Pressure:

Date	Time	Value	Location	Position	Cuff Size	Provider
10/16/2021	14:23 ANSO	114/77	Left Arm	Sitting	Adult-large	Crump, Alison F LPN

SpO2:

Date	Time	Value(%)	Air	Provider
10/16/2021	14:23 ANSO	100	Room Air	Crump, Alison F LPN

Height:

EXHIBIT 12
Deponent 30(b)(6)
Date 4/17/23 Rptr. SG
WWW.DEPOBOOKPRODUCTS.COM

Offender Name: [redacted], [redacted]
Date of Birth: [redacted]
Encounter Date: 10/21/2021 08:24

Sex: F Race: BLACK/AFRI
Provider: Caraccio, Donald MD

Off #: 0618705
Facility: ANSO
Unit: LPODE

Date	Time	Inches	Cm	Provider
10/16/2021	14:23 ANSO	71.0	180.3	Crump, Alison F LPN

Weight:

Date	Time	Lbs	Kg	Waist Circum.	Provider
10/16/2021	14:23 ANSO	240.8	109.2		Crump, Alison F LPN

Exam:

General

Appearance

Yes: Appears Well

No: Apparent Distress

Nutrition

Yes: Normal, Excellent food intake

Pulmonary

Observation/Inspection

Yes: Normal

Cardiovascular

Observation

No: Painful Distress

Abdomen

Inspection

Yes: Normal

Significant reduction in central obesity

Mental Health

Mood

Yes: Normal

Thought Process

Yes: Normal

ASSESSMENT:

Gender Dysphoria in Adolescents and Adults, 302.85 - Current, Chronic, Marked Improvement - *Patient responding well to IM estradiol. Her levels are above goal (mid cycle 200-350pg/ml).*

Plan: reduce to 10mg estradiol IM every 14 days.

Check estradiol level on day 7 after injection in December. Also check fasting lipid panel and hepatic function panel.

We discussed perioperative hormone reduction. There is no established guidelines in this area. Given her age and obesity, she has some risks for VTE. Given that she is on a hormone replacement with longer duration of action, I would recommend holding any estradiol injections two weeks prior to surgery and restarting and standard dose one week after surgery.

Did review recent literature on this "Effect of cross-sex hormone therapy on VTE risk in M-F gender affirming surgery" Annals of Plastic Surgery 1/2021.

Regarding for desire for vulvaplasty, this is medically necessary part of treatment for this patient. She has been treated with hormones since 2012 and orchiectomy in 2017, with persistent symptoms of gender dysphoria. Will communicate my plans with Dr. Figler.

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Date of Birth: [redacted]	Sex: F Race: BLACK/AFRI	Facility: ANSO
Encounter Date: 10/21/2021 08:24	Provider: Caraccio, Donald MD	Unit: LPODE

PLAN:

Schedule:

Activity	Date Scheduled	Scheduled Provider
Provider Clinic	10/21/2021 00:00	Physician

follow up 2 months (around 12/21) with caraccio telehealth endo for transgender

Disposition:

General Population

Patient Education Topics:

Date Initiated	Format	Handout/Topic	Provider	Outcome
10/21/2021	Counseling	Access to Care	Caraccio, Donald	Verbalizes Understanding

Co-Pay Required: No **Cosign Required:** No

Telephone/Verbal Order: No

Standing Order: No

Completed by Caraccio, Donald MD on 10/21/2021 09:35

Requested to be reviewed by Norris, Jennifer L. NP.

Review documentation will be displayed on the following page.

NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY
Division Transgender Accommodation Review Committee (TARC) Report

Offender Name: [redacted] (Kanautica Zayre-Brown) OPUS Number: 0618705

Facility TARC Date: review by DTARC Division TARC Date: 2/17/2022

Names and Titles of TARC Members Present: Dr. Lewis Peiper, Behavioral Health Director; Dr. Arthur Campbell, Chief Medical Officer; Dr. Brian Sheitman, Chief of Psychiatry; Terri Catlett, Dir. Health Services Admin; Charlotte Williams, PREA Director; Sarah Cobb, Dir. Rehabilitative Srvcs; Josh Panter, Director of Operations

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Transgender Accommodation Request(s) Under Review: Gender Affirmation Surgery/ Vulvaplasty

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Approved Accommodation(s):

Accommodation(s) Not Approved and Rationale:

Accommodation(s) Referred for Final Determination: DTARC does not recommend Gender Affirmation surgery. This surgery is not medically necessary.

Other:

EXHIBIT
tabbies
P. 14
SAH 4/17/23

Final Determination of Referred Accommodation(s)

The Deputy Commissioner and Director of Health and Wellness reviewed documents related to this accommodation request. After review and discussion we concur with the DTARC recommendation. The requested accommodation is not supported.

Scan Type: "TARC/Division Report."
Attach: "Division Transgender Accommodation Committee Report."

This form is not to be amended, revised, or altered without approval of the Behavioral Health Documentation Committee.
DC – 411D (05/20)

SENSITIVE BUT UNCLASSIFIED

North Carolina Department of Public Safety
Division Transgender Accommodation Committee Report

Offender Name:	[redacted], [redacted]		Off #:	0618705	
Date of Birth:	[redacted]	Sex:	F	Facility: ANSO	
Date:	04/26/2022 12:00	Provider:	Peiper, Lewis J Ph.D Dir. of		

Comment

The following note is a summary of related input and considerations from the 2/17/2022 Division Transgender Acommadation Review Committee and concludes with a medical analysis from the Division of Prisons Medical Authority related to [redacted] (Kanautica Zayre-Brown, 0618705), referred to as Offender Brown and/or patient below with she/her pronouns used where applicable.

Offender Brown was admitted to prison 10/10/2017 with a current projected release date of 11/2/2024. She is currently housed at Anson CI where she was transferred from Warren CI on 8/15/02019. Offender Brown is currently assigned to Medium Custody after being promoted from Close Custody on 1/4/2022.

In response to Offender Brown's request for vaginoplasty or vulvoplasty surgery, the DTARC recommended receiving a consult from a surgical specialist experienced in performing vaginoplasty surgeries to obtain information to further evaluate treatment options and proposed course going forward. Offender Brown participated in a telehealth appointment with Kristia Vasilof from the UNC Transhealth Program as part of the initial review for consult and Katherine Croft (UNC Transhealth Program Manager) completed a telehealth consult with Offender Brown as part of the planned surgical consult with the UNC Transhealth program. An in-person consultation with Dr. Figler from the UNC Transhealth Program on 7/12/2021 indicated the patient's desire for vulvoplasty (versus vaginoplasty) and the need for weight loss from the recorded weight of 288 at the time down to a maximum of 250 with an identified weight goal of 210.

DTARC Review 2/17/2022:
Offender Brown has maintained the minimum weight goal identified by the UNC Transhealth program. Weight has been below 240 since 11/15/2021 and at the time of the DTARC was most recently (2/11) at 236. Patient is now eligible for review related to DTARC recommendation on requested vulvoplasty surgery.

Review of patient's related mental health and behavioral health record, and the baseline criteria identified by UNC Transhealth Program could make her a candidate for surgery. The patient has a well-documented, persistent transgender identity with a desire for "bottom surgery." The patient has been educated on the surgical interventions by the UNC Transhealth Program and identified a preference for a vulvoplasty if performed. The patient had completed other gender-affirming surgeries (orchiectomy, breast implants) prior to incarceration and has been on hormone replacement therapy since 2012. Mental health and behavioral health case reviews indicated no current evidence of any significant comorbid mental health issues. Patient continues to demonstrate emotional and psychological stability with evidence of adequate coping skills. The patient's mood and anxiety symptoms appear well-controlled by psychiatric interventions, however, recent progress notes from supportive counseling and therapy sessions indicate the patient has been heavily focused on the status of the final decision regarding her requested/desired surgery and experiencing related anxiety/frustrated mood.

Offender Brown has been housed in a female prison since 8/2019 and her adjustment to being housed in a female prison has been generally acceptable apart from a period of time in the fall / winter of 2020 related to reports of this offender having engaged in assaultive and extortive behavior against female offenders. Although she has largely adapted well to her current facility assignment, continued vigilance is necessary in order to ensure the offender's continued stability and to protect other offenders.

MEDICAL ANALYSIS:
This offender has received and continues to receive extensive treatment while incarcerated. As with all treatments in medicine, ongoing re-evaluations are conducted and regimens adjusted based on the clinical course, with further interventions based on findings from those reevaluations.

Medical analysis for this case included a comprehensive review of the offender's medical and behavioral health history, as well as a comprehensive literature review. When treatments are considered for any patient, the most important imperative for physicians is to base recommendations on evidence-based medicine and consideration of that information in the context of the individual patient. Although the offender has clearly communicated a desire for further

Offender Name:	██████, ████			Off #:	0618705
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Date:	04/26/2022 12:00	Provider:	Peiper, Lewis J Ph.D Dir. of		

gender-affirming surgery, there is insufficient medical evidence to indicate such a complex and irreversible surgical intervention is medically necessary for her at this time.

Based on this review, it is the determination of the medical authority that gender reassignment surgery (GRS) as requested by this offender is not medically necessary.

Co-Pay Required: No **Cosign Required:** No

Telephone/Verbal Order: No

Standing Order: No

Completed by Peiper, Lewis J Ph.D Dir. of Beh. Health on 04/26/2022 12:12

Requested to be reviewed by Dula, Jennifer L MSW Clinical Social Worker.

Review documentation will be displayed on the following page.