1 IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
2 CHARLOTTE DIVISION
NO. 3:22-cv-191
3
______________________________
4 KANAUTICA ZAYRE-BROWN, )
)
5 Plaintiff, )
)
6 vs. )
)
7 NORTH CAROLINA DEPARTMENT OF )
PUBLIC SAFETY, et al., )
8 )
Defendants. )
9 ______________________________)

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12 VIDEOTAPED DEPOSITION OF

13 KANAUTICA ZAYRE-BROWN

14 (Taken on behalf of Defendants)

15 Polkton, North Carolina

16 January 18, 2023

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REPORTED BY: Kristy L. Clark, RPR, NV CCR #708,
20 CA CSR #13529, NC Notary #201807900150

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**CONTAINS GENERAL CONFIDENTIAL INFORMATION**

1 **Q. How long did you live in Wilson?**
2 A. I would say maybe 15 years.
3 **Q. Okay. And after you moved away from Wilson**
4 **after about 15 years, where did you move to?**
5 A. I went to different foster homes, therapeutic
6 group homes all over the state.
7 **Q. Okay. And how old were you when you lived in**
8 **your last foster home or therapeutic group home?**
9 A. Eighteen.
10 **Q. Eighteen. And where did you reside after**
11 **exiting your last group home or therapeutic?**
12 A. Raleigh.
13 **Q. Raleigh? So now, the time that you were**
14 **living in Wilson, who were you -- who were you living**
15 **with?**
16 A. My grandparents, which became my adoptive
17 parents.
18 **Q. Okay. And what are your grandparents' names?**
19 A. Francis Chestnut and John Lee Chestnut.
20 **Q. And was Francis Chestnut your grandmother?**
21 A. Yes.
22 **Q. And do you recall when they adopted you?**
23 A. I was in middle school when it happened. I
24 don't remember the year.
25 **Q. Did anyone other than either of your**

1 **grandparents live with you when you were residing in**
2 **Wilson?**
3 A. Yes.
4 **Q. Who was that?**
5 A. My aunt Patricia Chestnut, my cousin Lavon
6 Chestnut, my cousin Jeffrey Chestnut, and my cousin
7 Craig Chestnut.
8 **Q. Did your mother or father ever live with you**
9 **--**
10 A. No.
11 **Q. -- when -- sorry.**
12 A. Oh.
13 **Q. No?**
14 A. No.
15 **Q. And do you have any brothers or sisters?**
16 A. I have a sister.
17 **Q. What's her name?**
18 A. Alicia Chestnut.
19 **Q. And does she live in North Carolina?**
20 A. Yes.
21 **Q. Where does she live in?**
22 A. Wilson, North Carolina.
23 **Q. And what kind of work does she do?**
24 A. I don't know.
25 **Q. When is the last time you communicated with**

1 **her?**
2 A. 2017.
3 **Q. Do you recall what kind of work she did then?**
4 A. Yes.
5 **Q. What was that?**
6 A. She worked at a cell phone store.
7 **Q. What about your grandparents? What kind of**
8 **work do your grandparents do?**
9 A. My grandfather is deceased now, and my
10 grandmother is retired.
11 **Q. Before your grandfather passed away, what**
12 **kind of work did he do?**
13 A. He was a trucker.
14 **Q. And your grandmother before she retired -- is**
15 **she still alive?**
16 A. Uh-huh.
17 **Q. Before she retired, what kind of work did she**
18 **do?**
19 A. Educator.
20 **Q. Was she a teacher?**
21 A. Yes.
22 **Q. Where did she teach?**
23 A. In Wilson County Schools.
24 **Q. Do you know what level she taught?**
25 A. No, I don't remember.

1 Q. And aside from being a educator, did she have
2 any other careers?
3 A. I remember when I was younger, she used to do
4 a cleaning business at nighttime, but I don't know if
5 she owned it or not.
6 Q. Now, are you close with any of your family
7 members?
8 A. All of them.
9 Q. All of them? And are there any family
10 members that you're close with that you haven't already
11 mentioned?
12 A. I'm close with all of my family members.
13 Q. So you've got your Aunt Patricia, your
14 cousin -- a couple of cousins, your sister,
15 grandparents. Anyone else that --
16 A. I have other cousins, other aunts, other
17 uncles, great aunts, great uncles, yeah.
18 Q. And have you ever worked with any of your
19 family members?
20 A. Never.
21 Q. Have you ever worked for any of your family
22 members?
23 A. No.
24 Q. And are you currently married?
25 A. Yes.

1 **Q. What's your husband's name?**
2 A. Dionne Garret Brown.
3 **Q. And how do you spell Dionne?**
4 A. D-i-o-n-n-e.
5 **Q. And what was the middle name? Sorry.**
6 A. Garret, G-a-r-r-e-t.
7 **Q. And what kind of work does your husband do?**
8 A. A logistic engineer.
9 **Q. Who does he work for?**
10 A. He works for U.S.T., I think it is.
11 **Q. Was he previously in the United States**
12 **military?**
13 A. No.
14 **Q. He was never in the United States military?**
15 A. No.
16 **Q. He never worked for the U.S. Army?**
17 A. He worked for them, yes, but he was never
18 active duty. He was a contractor.
19 **Q. He was a contractor?**
20 A. Yes.
21 **Q. So did he hold a rank?**
22 A. I don't know.
23 **Q. When did you meet your husband?**
24 A. 2011.
25 **Q. And did you-all reside -- did you reside with**

1 one another before you were incarcerated?
2 A. Yes, sir.
3 Q. When did you start living with Mr. Brown?
4 A. 2013.
5 Q. And where did you guys live together?
6 A. Corpus Christi, Texas; San Antonio, Texas;
7 Brier Creek, North Carolina; and Atlanta, Georgia, and
8 that's it.
9 Q. So I want to kind of work backward now.
10 Where were you residing at the time that you were
11 incarcerated -- became incarcerated in October of 2017?
12 A. Orange Park, Florida.
13 Q. Orange Park, Florida? And was Mr. Brown
14 living with you there?
15 A. No, sir.
16 Q. How long were you in Orange Park or in
17 Florida?
18 A. Maybe seven months.
19 Q. Before that, were you also somewhere else in
20 Florida?
21 A. I was in Charlotte, North Carolina.
22 Q. Okay. And how long were you in Charlotte?
23 A. I don't remember.
24 Q. Before Charlotte, where were you living?
25 A. I was in Atlanta, Georgia.

1 Q. And then before Atlanta?
2 A. Texas.
3 Q. Texas? How long were you in Atlanta?
4 A. I want to say a year.
5 Q. And then in Texas, I understand you were in
6 Corpus and in San Antonio. How long were you in Texas
7 total?
8 A. From 2013 till 2000 -- beginning of '16
9 maybe.
10 Q. Okay. And then where were you living before
11 Texas?
12 A. Brier Creek.
13 Q. How long were you living in Raleigh -- or in
14 Brier Creek?
15 A. From 2011 to '13.
16 Q. All right. So before '11, before 2011, where
17 did you live?
18 A. I stayed in Wilson from 2010 to 2011.
19 Q. Okay. And then before Wilson, in 2010, where
20 were you living?
21 A. I was in DPS custody.
22 Q. Okay. How long were you incarcerated for
23 that -- in that -- for that incarceration?
24 A. Five years.
25 Q. So that's about 2005?

1 A. Yeah.
**2 Q. So in 2005, before you were incarcerated**
**3 then, where were you living?**
4 A. Wilson, North Carolina.
**5 Q. And how long had you been living in Wilson at**
**6 that time?**
7 A. I don't remember.
**8 Q. Do you remember, were you living anywhere**
**9 else before Wilson?**
10 A. No.
**11 Q. Okay. So from the time that you exited the**
**12 foster system and the therapeutic group home system,**
**13 you came back to live in Wilson?**
14 A. I was in DPS custody in juvenile.
**15 Q. Okay.**
16 A. They had me at the youth offender program.
17 And then after I was released from there, I went to
18 Wilson.
**19 Q. Okay. So after the juvenile detention**
**20 program, you went to Wilson, and you stayed in Wilson**
**21 till '05, and then DPS custody?**
22 A. Yes.
**23 Q. And then from '05 to '10, DPS custody?**
24 A. Yes.
**25 Q. And then from '10 is where we start the --**

1 A. Yes.
2 **Q. -- the movements that we just talked about.**
3 **Can you tell me what -- what kind of work did**
4 **you do before this most recent incarceration?**
5 A. Is worked for Humana TRICARE.
6 **Q. What was your job?**
7 A. I was a master social worker. I was -- I
8 worked in the field. Field care social worker.
9 **Q. When you say "master social worker," what do**
10 **you mean by that?**
11 A. I was a master level social worker. I worked
12 as a field care case manager.
13 **Q. Okay. So were you providing therapy?**
14 A. No, no therapy. I wasn't licensed. I would
15 just do case management and assessments for Humana.
16 **Q. How long did you work for Humana?**
17 A. 2013 till -- no, not 2013 -- 2014, till about
18 the beginning of 2016.
19 **Q. All right. And before working for Humana,**
20 **what kind of work were you doing?**
21 A. I worked for Nueces Behavioral Health Center
22 in Corpus Christi, Texas.
23 **Q. What did you do for the behavioral health**
24 **center?**
25 A. I was a respite case manager.

1 **Q. And can you spell that?**
2 A. R-e-s-p-i-t-e, respite.
3 **Q. And what kind of -- what kind of work is**
4 **that?**
5 A. Emergency care for people that's going in
6 emergency crisis.
7 **Q. So is that like EMT work?**
8 A. No, it's case management.
9 **Q. Okay. Emergency behavioral health crisis?**
10 A. Yeah. People that's suicidal, had homicidal
11 ideations, suicidal ideation.
12 **Q. And so that was '14. How long did you do**
13 **that?**
14 A. I went from '13 to '14.
15 **Q. All right. And then, what was your job**
16 **before that?**
17 A. I worked at Holly Hill Hospital in Raleigh.
18 **Q. And what did you do at Holly Hill?**
19 A. I was a CPI instructor, and I worked with the
20 youth as a youth case manager.
21 **Q. And what -- can you tell me what "CPI" means?**
22 A. It's cognitive preventative intervention.
23 And it's a training where if someone gets out of
24 control, upset, you use your training knowledge to
25 respond to it.

1 Q. How long did you do that work?
2 A. 2011 until 2013 -- no, 2011 to 2012.
3 Q. And Holly Hill, was that -- is that a state
4 hospital?
5 A. It's a private. It's a psych hospital
6 through UnitedHealthcare.
7 Q. And where was that? That was located in
8 Raleigh you said?
9 A. (Witness nods head.)
10 Q. And what about -- what did you do before
11 Holly Hill?
12 A. I worked at Club Nova, psychosocial
13 rehabilitation in Carrboro.
14 (Clarification by the reporter.)
15 THE WITNESS: Carrboro, North Carolina.
16 BY MR. RODRIGUEZ:
17 Q. And when you were working at Holly Hill and
18 at Club Nova, were you -- is this when you were living
19 in Brier Creek?
20 A. Yes, sir.
21 Q. All right. And what -- how long did you work
22 at Club Nova?
23 A. Maybe a year or so. It was like a few months
24 after I got out of DPS custody.
25 Q. All right. So then before you went into DPS

1 custody -- before you went into DPS custody the first
2 time, which would have been in 2005 about, what kind of
3 work were you doing then?
4 A. I don't remember. I think maybe like fast
5 food or something.
6 Q. Did you hold any other jobs beyond what you
7 have talked about already?
8 A. I have worked at Otto (phonetic) Shoes
9 before, but I didn't stay there long. Just maybe two
10 months maybe.
11 Q. And did you engage in any other activities to
12 earn money beyond what we've talked about?
13 A. I had owned a company called KZP Consults and
14 Home Care.
15 Q. You owned it. You say it was called KZB --
16 A. KZP.
17 Q. KZP.
18 A. Uh-huh, Consults and Home Care.
19 Q. Consulting [sic] Home Care. What kind of
20 business was that?
21 A. It was providing consults for home care and
22 nursing.
23 Q. And when did you do that?
24 A. I did it while I was in Texas.
25 Q. And tell me a little bit more about that.

1 **What kind of consultations would your business provide?**
2 A. It never really got -- it got off the ground,
3 but really didn't get off the ground because I never
4 got the articles of incorporation in Texas.
5 **Q. Okay. So did you ever have any clients**
6 **through that business?**
7 A. I did. I had personal clients. Like clients
8 that wasn't through any kind of insurance.
9 **Q. Okay. Private pay stuff?**
10 A. Yes.
11 **Q. How long did you do that?**
12 A. Maybe a year.
13 **Q. All right. Any other activities to earn --**
14 **earn income? Side hustles, Uber driving, anything like**
15 **that?**
16 A. No.
17 **Q. Did you ever work as an exotic dancer?**
18 A. No.
19 **Q. No?**
20 A. (Witness shakes head.)
21 **Q. In any of the employment that you described,**
22 **did you have to register or get licensed?**
23 A. No. In Texas, I did have to get a TIN number
24 in Texas, but I don't know. There was like no
25 occupational license or nothing.

1 Q. Okay. Right. So that was just to get paid;
2 right?
3 A. Yeah.
4 Q. A TIN?
5 A. Yeah.
6 Q. Okay. Do you -- do you have any plans for
7 future employment upon your release?
8 A. Yes.
9 Q. What's that?
10 A. To attend law school.
11 Q. And that might be a good seg- -- well,
12 actually, have you received any offers of employment
13 post release?
14 A. Not to me, but through individuals in the
15 community that have spoke of people that have worked in
16 law offices, yes.
17 Q. Okay. Tell -- can you tell me a little bit
18 more about that?
19 A. Yes. The House of Kanautica organization has
20 worked closely with a lot of nonprofit social justice
21 places, and would like for me to come work with them as
22 a paralegal until I finish law school.
23 Q. To work with the House of Kanautica?
24 A. No, work with the nonprofit social justice
25 organizations.

1 **Q. Any -- anyone in particular?**

2 A. Yes, the Southern Justice -- Southern

3 Coalition for Social Justice in Durham.

4 (Clarification by the reporter.)

5 BY MR. RODRIGUEZ:

6 **Q. Is that the only one?**

7 A. That's the only one.

8 **Q. Now, you mentioned the -- the law school.**

9 **What -- describe your highest level of education.**

10 A. Master's.

11 **Q. You have a master's degree?**

12 A. Yes.

13 **Q. And what did you -- what did you study?**

14 A. Social work.

15 **Q. And when did you receive that degree?**

16 A. 2008.

17 **Q. And what institution did you graduate?**

18 A. Liberty University.

19 **Q. Liberty University?**

20 A. (Witness nods head.)

21 **Q. Okay. So then I assume -- do you have a high**

22 **school diploma?**

23 A. No, I got a GED.

24 **Q. GED. When did you get your GED?**

25 A. In 2000.

**1 Q. And what about college or post-secondary**
**2 courses after your GED?**
3 A. GED was at Mayland Community College. My
4 undergrad was at Louisiana Baptist University.
**5 Q. And when did you -- did you receive an**
**6 undergraduate degree?**
7 A. Yes.
**8 Q. When did you receive that?**
9 A. 2004.
**10 Q. And what was your undergraduate degree in?**
11 A. Psychology.
**12 Q. All right. So we've got a GED through**
**13 Mayland Community College. We've got a -- was it a**
**14 bachelor of arts or a bachelor's of science?**
15 A. A bachelor of arts.
**16 Q. You got a BA from Louisiana Baptist in 2004.**
**17 And then we have a master's of social work from Liberty**
**18 University in 2008. Do you have any other degrees from**
**19 other higher educational institutions?**
20 A. I have diplomas for paralegal studies through
21 Blackstone Career Institute. I got a specialized
22 certificate for civil litigation and business and
23 corporate law through Blackstone Career Institute.
**24 Q. And when did you receive those certificates**
**25 and diplomas?**

1 A. 2020, 2021, and 2022.
**2 Q. So aside from Liberty University, Mayland**
**3 Community College, Louisiana Baptist, and -- and**
**4 Blackstone, have you taken any other courses from any**
**5 other institutions?**
6 A. The rest are just self-enrichment vocational
7 classes.
**8 Q. And what about online or correspondence**
**9 courses?**
10 A. Those were my grad -- my undergrad and my
11 graduate degree come from.
**12 Q. Okay. So your 2004 from the Louisiana**
**13 Baptist and your '08 from Liberty were online?**
14 A. Yes. And the corr- -- and Blackstone was
15 correspondence as well.
**16 Q. Okay. So no other educational history to**
**17 report?**
18 A. No.
**19 Q. All right. Now, before you entered DPS**
**20 custody in October of 2017, were you under the care of**
**21 any -- any healthcare providers?**
22 A. Yes.
**23 Q. Can you tell me which ones?**
24 A. UNC psychiatry and UNC endocrinologist,
25 Dr. Hope Sherie at Concierge Cosmetics in Charlotte,

1 North Carolina.

**2 Q. Okay. Did you have a primary care provider**

**3 before you entered in October of 2017?**

4 A. Not primary care.

**5 Q. No. So you didn't have a regular doctor,**

**6 physicals and stuff?**

7 A. I did all that through endocrinology.

**8 Q. Okay. And how long were you going to UNC**

**9 endocrinology?**

10 A. Since 2010.

**11 Q. Okay.**

12 A. No, 2012 with endocrinology. Psych from

13 2012.

**14 Q. So 2012 up until your incarceration in**

**15 2017 --**

16 A. Right.

**17 Q. -- you were treated through UNC**

**18 endocrinology?**

19 A. Right.

**20 Q. And then 2010 to 2017, UNC psychiatry you**

**21 said?**

22 A. UNC psychiatry after 20 -- I don't remember

23 when it ended, but it was in 2017.

**24 Q. Okay. It was before?**

25 A. Yeah.

1 **Q. Before then? Okay. And then you mentioned**
2 **the Dr. Hope Sherie out of Charlotte. What kind of**
3 **physician is she?**
4 A. She's a cosmetic surgeon for gender-affirming
5 care.
6 **Q. Did you have any other mental -- did you have**
7 **mental health providers beyond any care you received**
8 **from UNC psychiatry prior to entering custody?**
9 A. No.
10 **Q. So you weren't seeing a therapist?**
11 A. That's what was going -- that was through the
12 psychiatry services. They did -- the psychologist was
13 through them.
14 **Q. Okay. And so outside of UNC psychiatry, were**
15 **you seeing any -- any therapists?**
16 A. No.
17 **Q. And what locations would you receive**
18 **treatment from UNC endocrinology?**
19 A. High Tower -- UNC High Tower. It was between
20 Durham and Chapel Hill.
21 **Q. And was both the endocrinology and psychiatry**
22 **at the same location?**
23 A. They was not far apart.
24 **Q. Okay. But both at the High Tower?**
25 A. No. UNC was at High Tower. UNC psychiatry

1 was at a different location, but it was close to High
2 Tower. I don't remember the actual name of it, like
3 the location.
**4 Q. And for both of these specialty care, the**
**5 endocrinology and the psychiatry, did you go to one**
**6 location consistently?**
7 A. (Witness nods head.)
**8 Q. So the endocrinology, was it only at High**
**9 Tower?**
10 A. Yeah, that's the only -- endocrinology I went
11 to, and it changed once I came to prison and got
12 switched over to Meadow Lark or something like that.
**13 Q. And how did you end up seeing -- being --**
**14 being under the care of the UNC endocrinology program?**
15 A. Through UNC psychiatry program.
**16 Q. Okay. And how did you end up under the care**
**17 of UNC psychiatry program?**
18 A. Through my insurance.
**19 Q. Through your health insurance?**
20 A. Yes.
**21 Q. And what health insurance did you have at**
**22 that time?**
23 A. I want to say it was Blue Cross Blue Shield.
**24 Q. Was that an employer-provided plan?**
25 A. Yes.

**1 Q. And who was your employer at the time?**
2 A. Holly Hill.
**3 Q. And do you know how it was that you came to**
**4 be referred to UNC psychiatry?**
5 A. I looked in my in-network referrals.
**6 Q. So you sought out the care; you weren't**
**7 referred the care?**
8 A. Like for psychiatry?
**9 Q. Uh-huh.**
10 A. No, I looked at it to see what services was
11 available in my network, and I called and scheduled an
12 appointment.
**13 Q. With the UNC psychiatry?**
14 A. Yes.
**15 Q. And why did you do that?**
16 A. Because I felt like I was suffering from --
17 at the moment, I didn't understand what it was called,
18 gender dysphoria, but I felt like that it was something
19 going on that I needed some clarification on.
**20 Q. And this was 2010?**
21 A. Yes.
**22 Q. And so at that time, were you already under**
**23 the care of -- or had you already received any surgical**
**24 services from Hope Sherie?**
25 A. No.

1 Q. And so UNC psychiatry then led you to UNC
2 endocrinology?
3 A. Yes.
4 Q. What kind of services did you receive from
5 UNC psychiatry?
6 A. Just psychotherapy. And -- and after
7 psychotherapy, she offered a community support letter
8 to start hormones.
9 Q. And who is "she"?
10 A. Dr. Jones.
11 Q. Dr. Jones?
12 A. Yes.
13 Q. And is this a medical doctor or physician or
14 is this --
15 A. Psychologist.
16 Q. Psychologist? So it's a PhD doctor?
17 A. Yes.
18 Q. And do you recall Dr. Jones' first name?
19 A. Katrina I want to say.
20 Q. Did you ever -- Katrina Jones or we'll just
21 say Dr. Jones. Any other mental health providers at
22 UNC psychiatry?
23 A. No, sir.
24 Q. So what about a provider by the name -- last
25 name Hans?

1 A. Dr. Hahn.

2 **Q. Hans?**

3 A. That was in prison.

4 **Q. Hans was in prison?**

5 A. H-a-h-n-s, Dr. Patricia Hahns?

6 **Q. No, that's Patricia -- Dr. Hahn, H-a --**

7 **H-a-h-n. This is at UNC psychiatry. Do you recall any**

8 **other providers at UNC psychiatry?**

9 A. Not that I can remember.

10 **Q. So you had some -- you had some talk therapy**

11 **sessions. How regularly did you attend those sessions?**

12 A. If I recall, at first, it was often. And

13 then after that, it was like monthly until when I felt

14 that I was -- needed some talking. I needed to talk to

15 someone.

16 **Q. And so first often, maybe weekly or more**

17 **often than that?**

18 A. I don't remember.

19 **Q. Okay. And so then you said that UNC**

20 **psychiatry referred you to UNC endocrinology. Was that**

21 **to begin hormone treatment you mentioned?**

22 A. Yes.

23 **Q. And so when -- when did you start hormone**

24 **therapy?**

25 A. 2012.

1 **Q. And who prescribed this treatment to you?**
2 **What is the physician's name?**
3 A. The first one, if I remember, was Sherman Yin
4 was my first endocrinologist.
5 **Q. Yean?**
6 A. Yin.
7 **Q. Yin?**
8 A. Yeah, yeah.
9 **Q. And do you recall any others?**
10 A. There was a second one, but I don't remember
11 her name.
12 **Q. Now, before you started the endocrinology**
13 **treatment or the hormone replacement therapy, who did**
14 **you talk with -- outside of your medical care**
15 **providers, who did you talk with about your interest in**
16 **that?**
17 A. My husband was my only person that I talked
18 to about it.
19 **Q. Did you speak about this with any of your**
20 **family members?**
21 A. I don't remember.
22 **Q. And why did you seek out this -- this**
23 **treatment?**
24 A. I sought out hormone therapy to decrease my
25 testosterone in my body and to get a more female look.

**1 Q. So would you say that you had -- those were**
**2 two of your objectives in seeking out that treatment?**
3 A. It was the beginning.
**4 Q. What was that?**
5 A. It was the beginning, the start of my
6 objectives.
**7 Q. Okay. Well, what other objectives did you**
**8 have in undergoing hormone therapy?**
9 A. I wanted to have breast augmentation, and I
10 wanted to create breast tissue so I wouldn't have to go
11 through chest -- I mean chest expanders to expand my
12 chest to wear them.
**13 Q. And did you discuss these objectives with**
**14 anybody?**
15 A. Yes. My physician.
**16 Q. And what -- what -- excuse me. What was the**
**17 nature of your discussions with your physicians about**
**18 your objectives?**
19 A. My discussion was that I wanted to match the
20 gender for which I knew I was and my body wasn't.
**21 Q. What were you told about the prospects of the**
**22 hormone replacement therapy actually achieving those**
**23 objectives?**
24 A. They let me know that it was stages and
25 steps, but it would ultimately get me where I needed to

1 be.
2 (Interruption in proceedings.)
3 BY MR. RODRIGUEZ:
**4 Q. What sort of -- what sort of relief were you**
**5 hoping to gain from beginning the hormone therapy?**
6 A. The beginning relief was to have a decrease
7 in an arousal, morning arousals, afternoon arousals, to
8 create breast tissue, to slow my hair growth, softening
9 of the skin, and ultimately, to decrease my
10 testosterone levels.
**11 Q. And did you discuss these hopes with your --**
**12 with anybody?**
13 A. My physician and my psychiatrist.
**14 Q. Beyond the physician and the psychiatrist,**
**15 have you -- did you discuss this with anybody else?**
16 A. I had a few conversations about my
17 augmentation hopes and how my hormones and stuff was
18 going with my aunts and my husband.
**19 Q. Okay. So you -- you did talk about the**
**20 hormone treatment and your objectives with your family**
**21 members?**
22 A. Once I started taking them.
**23 Q. And what were you told about the prospects of**
**24 attaining the relief that you just described through**
**25 taking hormones?**

1 A. Can you rephrase it?

**2 Q. Sure. Were you given any information about**
**3 how likely it would be that the relief that you**
**4 discussed, the decrease in arousals, creating breast**
**5 tissue, decreasing hair growth, lowering testosterone,**
**6 were you given any information about how likely it was**
**7 that the hormone therapy would achieve those or provide**
**8 that relief to you?**

9 A. Yes. I was told that it will get me there,
10 but it was -- it would ultimately decrease -- sorry.
11 It would decrease it. It would decrease the
12 testosterone by taking the hormones. They did tell me
13 that I would have to get laser because the hair
14 wouldn't stop growing; so I have to get laser.
15 They told me that my -- it would create
16 breast tissue, but it would be a very long process to
17 get -- to achieve the look that I was looking for. And
18 the softening of the skin will happen over time. And
19 then I remember them giving me like a flow sheet of
20 showing me like the periods, how long that the periods
21 would actually take.

**22 Q. And what was the look that you were looking**
**23 for?**

24 A. A very feminine look.

**25 Q. Now, before you began your hormone**

1 **replacement therapy, what kind of limitations did you**
2 **feel you had that you were hoping the therapy could**
3 **address?**
4 A. Therapy help me address me understanding
5 gender dysphoria and help me understand that I was
6 trans.
7 **Q. The hormone replacement therapy?**
8 A. The hormone replacement therapy assisted me
9 to begin my transition.
10 **Q. So were there any limitations that you felt**
11 **that you had, things that you either couldn't do or**
12 **didn't like to do that you were hoping would be**
13 **addressed by the hormone therapy?**
14 A. Definitely. Outings, hobbies, family
15 functions, being around other people with my spouse.
16 Definitely socially, a lot of sociable issues.
17 **Q. And did you discuss these limitations and**
18 **your hopes that the hormone replacement therapy would**
19 **address these limitations with anybody?**
20 A. I addressed them, but I also let them know
21 that I probably won't get the desire that I'm looking
22 for.
23 **Q. Who -- who is -- who's this that you let**
24 **know?**
25 A. I talked to my husband about it. I remember

1 talking to my Aunt Betty about it. We had a very
2 emotional setting with her about it one day. And then
3 I talked to the psychiatrist and the endocrinologist
4 about it.

**5 Q. And what did they tell you about the**
**6 prospects of the hormone therapy helping you achieve**
**7 these easing of the limitations?**

8 A. That I would need to seek a cosmetic surgeon
9 to have a breast augmentation. I need to see a nurse
10 practitioner at a laser center to get lasered to
11 address the beginning of my issues.

**12 Q. So tell me a little bit about how the hormone**
**13 replacement therapy, how that treatment, how it either**
**14 achieved or didn't achieve the objectives and the**
**15 relief that you had sought.**

16 A. Hormone therapy did not achieve the
17 objectives.

**18 Q. Why not?**

19 A. Hormone therapy is only designed to get you
20 but so far. And my transition wasn't solely based off
21 of just receiving hormone therapy.

**22 Q. When you first started the hormones, were you**
**23 -- do you feel you were reasonably informed of the --**
**24 the prospects of the relief that you would get from the**
**25 hormones?**

1 A. I think when I was informed about hormones, I
2 was informed that taking hormones long-term can be more
3 of a health issue to me than it would be for me to
4 obtain the desires that I was looking for.
**5 Q. And what were those desires?**
6 A. To have breasts, to have a feminine
7 appearance to be so I can socially transition to get me
8 the fat that I needed in the feminine areas.
**9 Q. So you mentioned earlier when I asked about**
**10 limitations, you mentioned social out -- social**
**11 outings, hobbies, family get-togethers perhaps. Were**
**12 you unable to do those things before you began hormone**
**13 therapy?**
14 A. I was very shy. I was very
15 not-so-out-in-the-open with them about it.
**16 Q. And how did that change, if at all, after you**
**17 started hormone therapy?**
18 A. Mentally, hormone therapy helped me feel I
19 was beginning my transitioning and helped me feel like
20 I was becoming the woman that I wanted to be.
**21 Q. Okay. What surgeries have you had?**
22 A. I had breast augmentation. I have had facial
23 feminization surgery. I had had a Brazilian butt lift.
24 I had a bilateral orchiectomy. I had earlobe
25 replacement surgery. I had double bunionectomy. I

1 think -- that's it.

**2 Q. When -- which one of those surgeries, aside**

**3 from the bunions, was the first surgery you had?**

4 A. My first surgery was my breast augmentation.

**5 Q. And when was that?**

6 A. 2012.

**7 Q. 2012?**

8 A. Yes.

**9 Q. And who performed that surgery?**

10 A. Dr. Jacob Freiman at Coral Gable Cosmetics in

11 Coral Gables, Florida.

**12 Q. Okay. So at this time, were you under the**

**13 care of UNC endocrinology?**

14 A. Yes.

**15 Q. And UNC psychiatry?**

16 A. Yes.

**17 Q. But you were residing in Florida?**

18 A. No, I stayed in Raleigh.

**19 Q. Okay. How did you come to find Dr. Freiman?**

20 A. Looking up that there's a

21 transgender-affirming surgery network that you can look

22 in to get all your providers.

**23 Q. Were there any providers in North Carolina**

**24 that provided that care -- that surgery?**

25 A. I don't recall.

1 **Q. And did you pay for this surgery out of**
2 **pocket?**
3 A. Yes, I did.
4 **Q. Now, this -- this breast augmentation, who**
5 **did you talk about your interest in pursuing the**
6 **surgery with?**
7 A. Dr. Sherman Yin. I talked with -- and I
8 talked with the psychologist at UNC.
9 **Q. And what was your -- what was your hope in**
10 **seeking out this procedure?**
11 A. To have the feminine look that I needed.
12 **Q. Would you -- are there any other objectives**
13 **that you had in seeking out this procedure?**
14 A. No, I didn't have no other objectives.
15 **Q. And what about the feminine appearance that**
16 **you were seeking, why was that something that you**
17 **sought?**
18 A. Because a woman is feminine.
19 **Q. Was there any -- were there any issues in how**
20 **you felt others perceived you?**
21 A. Very much so.
22 **Q. Can you tell me a little bit about that?**
23 A. I felt that people looked at me as being a
24 faggot, a punk, a sissy, queer, I -- instead of being a
25 woman. I felt that people looked at me to say you

1 don't have the boobs that you -- women supposed to
2 have. You don't have the bottom that a woman have.
3 Socially, I just was not accepted.
**4 Q. At this time, you were married; right?**
5 A. No.
**6 Q. You weren't married yet?**
7 A. No.
**8 Q. Had you met Mr. Brown?**
9 A. Yes.
**10 Q. Okay. Were you -- were you dating him at the**
**11 time?**
12 A. Yes.
**13 Q. Okay. Were there aspects of your**
**14 relationship with Mr. Brown that you were hoping would**
**15 improve?**
16 A. No. Dionne accepts me for me regardless.
**17 Q. What about with your family?**
18 A. They accept me regardless.
**19 Q. Okay. What kind of relief were you seeking**
**20 by pursuing the breast augmentation? And this I mean**
**21 more along the lines of emotionally. Were you -- what**
**22 were you hoping would -- would happen to you after the**
**23 breast augmentation?**
24 A. It validated me becoming the woman that I
25 desired.

1 **Q. Okay. Where was -- who -- who performed that**
2 **surgery or that procedure?**
3 A. I don't remember the individual's name, but
4 it was done in San Antonio, Texas. And I don't
5 remember the name. I don't remember the name of the
6 person or the center. It was in San Antonio.
7 **Q. Was it like a freestanding clinic or was it**
8 **associated with a hospital system?**
9 A. Oh, yeah, it was free standing.
10 **Q. Freestanding?**
11 A. Yeah.
12 **Q. Were you living in Texas at that time?**
13 A. Yes.
14 **Q. Now, who did you speak with about your**
15 **interest in pursuing the body contouring?**
16 A. I went through that same network, the
17 transgender community network.
18 **Q. But this time you didn't have to travel out**
19 **of state?**
20 A. No.
21 **Q. Now, what was your aim in -- in having this**
22 **procedure done? What were you -- why did you seek it**
23 **out?**
24 A. To align my body to be as feminine as
25 possible.

1 **Q. And did the desired femininity that you were**
2 **seeking out include, what, a rounder butt? Is that**
3 **what you were --**
4 A. Yes, I wanted a big butt. I wanted wide
5 thighs.
6 **Q. Okay. So wider thighs, a bigger butt, were**
7 **those your objectives --**
8 A. Uh-huh.
9 **Q. -- in seeking out the procedure? What was it**
10 **about not having those things that you were hoping to**
11 **change?**
12 A. I felt boyish.
13 **Q. What is that?**
14 A. I felt very boyish.
15 **Q. And so what was the relief that you were**
16 **looking for in seeking out the body contouring**
17 **procedure? To alleviate the feeling of feeling like a**
18 **boy?**
19 A. Yeah, to try to alleviate the dysphoria.
20 **Q. Alleviate the dysphoria?**
21 A. Uh-huh.
22 **Q. What -- what was -- what would you say was**
23 **causing your dysphoria at that time?**
24 A. Me -- my body not aligning with my -- with me
25 being a female, my body wasn't aligning to it.

**1 Q. Specifically with regard to the size of**
**2 your --**
3 A. Yeah.
**4 Q. -- waist and your --**
5 A. Yes.
**6 Q. -- and your butt?**
7 A. Right.
**8 Q. Or hips, I guess?**
9 A. Yes.
**10 Q. Now, before -- before the body contouring**
**11 surgery -- I don't know if it's a surgery or**
**12 procedure -- but before the body contouring procedure,**
**13 were there -- were there physical limitations that you**
**14 were hoping to ease or address? You mentioned the**
**15 playing sports and swimming and dancing.**
**16 Can you describe some of the things that you**
**17 were hoping you could do after body contouring that you**
**18 were refraining from before body contouring?**
19 A. I will -- to be, like, very honest, if I
20 could have had afford to do everything at one time, I
21 would had completed my whole alignment of my body at
22 one time to alleviate anything that I was feeling. But
23 being that I was not financially able to, I had to do
24 everything in steps to align my body with -- to -- to
25 transition to the female that I wanted to.

1 So the same objectives that I had when I was
2 getting my breast augmentation were kind of the same
3 objectives that I had when I got body contouring and
4 other surgeries. And the same restrictions that I had
5 were the same restrictions when I got one surgery
6 compared to the next surgery.
**7 Q. So there was nothing specific about the body**
**8 contouring -- that you were hoping the body contouring**
**9 would address by way of like a limitation?**
10 A. It would help address my dysphoria.
**11 Q. Aside from -- aside from addressing your**
**12 dysphoria, were there any physical limitations that you**
**13 were hoping would be eased by the body contouring?**
14 A. Yes. The -- the appearance of being
15 feminine. The feminine out to be more feminized, and
16 that's why I did the body contouring.
**17 Q. And did you discuss the -- the prospects of**
**18 the body contouring making you feel more feminine with**
**19 anybody?**
20 A. Uh-huh.
**21 Q. Who did you talk about that with?**
22 A. The one who did my procedure, my husband,
23 family. And at that time, I was a member of a church
24 in Corpus Christi, and I went over it with the people
25 there; so, yeah.

**1 Q. And what were you told about the prospects**
**2 that the body contouring would help your -- help you**
**3 feel more feminine?**
4 A. I was told it would give me the look -- when
5 I put clothes on, it would give me more of a feminine
6 look. It will make me feel more self-confident.
**7 Q. What was the recovery like for this**
**8 procedure?**
9 A. I had to lay on my stomach for two days, or
10 if I got up -- I just could not sit on my butt area or
11 thigh area for two days.
**12 Q. And did the body contouring, did it achieve**
**13 the objectives of helping you feel more feminine?**
14 A. It was a start.
**15 Q. Did it improve your -- your contentment?**
16 A. It helped.
**17 Q. How much?**
18 A. Just a little.
**19 Q. Were you disappointed by the amount or was**
**20 that expected?**
21 A. I think I got what I expected.
**22 Q. So now, on a 100-point scale, we were, like,**
**23 at a 7 or 8 before body contouring, where would you say**
**24 we are now after body contouring?**
25 A. Maybe a 8 if we were at a 7.

1 **Q. All right. So then after the body**
2 **contouring, what was the next surgery you had?**
3 A. I had -- oh, I had done a earlobe -- I had
4 changed the shape of my earlobe.
5 **Q. When was that?**
6 A. In 2000 -- 2007 -- I want to say that was in
7 2017 as well.
8 **Q. 2017 as well?**
9 A. Uh-huh.
10 **Q. Wait. So was the body contouring not in '14?**
11 A. I had bilateral orchiectomy and face done in
12 2017.
13 **Q. Okay. Okay. Okay. So the -- so the**
14 **earlobes or the face was done at the same time as the**
15 **orchiectomy?**
16 A. No, separately.
17 **Q. Okay. Which one was first?**
18 A. The earlobe.
19 **Q. Okay. So we had -- we had '12 for the breast**
20 **augmentation, '14 for the body contouring, '17 -- first**
21 **'17 earlobes.**
22 A. Uh-huh.
23 **Q. And you said the facial feminization, was**
24 **that just the ear lobes? What else did they --**
25 A. No, the facial feminization was done when I

1 got my orchiectomy all at the same time while I was
2 under anesthesia. It was totally different.
**3 Q. Okay. I'm confused now, so -- all right.**
**4 After the body contouring, what was the very -- the**
**5 next surgery that you had?**
6 A. My earlobe.
**7 Q. And was that the only surgery --**
8 A. Yes.
**9 Q. -- they did?**
**10 Okay. So just earlobes?**
11 A. Uh-huh.
**12 Q. And what did they do to your earlobes?**
13 A. They just -- because it was kind of
14 elongated, so I just got them -- they just made them
15 more shorter.
**16 Q. Why did you -- who -- who performed that**
**17 surgery?**
18 A. I got it done in Clay County, Florida, in
19 Orange Park, Florida, at the local hospital. It was a
20 hospital there, but they offered cosmetic surgery as
21 well, like, at one of the centers. And I don't
22 remember the doctor either.
**23 Q. And why did you seek out the earlobe shaping**
**24 surgery?**
25 A. To make -- in alignment with my face,

1 feminine face.

**2 Q. And so an objective was to have your --**

**3 your -- your ear lobes look more like what you wanted**

**4 them to look like?**

5 A. Yes. And -- yes. Because I knew I was

6 getting ready to have my cheeks -- my chin and my cheek

7 and forehead area done.

**8 Q. And so were you hoping that the shaping of**

**9 your earlobes would improve your dysphoria?**

10 A. Very much so.

**11 Q. Did it?**

12 A. Yes.

**13 Q. How many points?**

14 A. Maybe a half a point.

**15 Q. A half a point?**

16 A. Yeah.

**17 Q. Okay. Was there -- what was the recovery**

**18 period like for the earlobes?**

19 A. Very -- that, I didn't even really feel it.

20 I think I kept the bandage on for two weeks. Went back

21 and took the bandage off, and I was better.

**22 Q. So would you say that the -- the earlobe**

**23 surgery satisfied the objective of changing the shape**

**24 of your earlobes?**

25 A. It did.

1 **Q. Did it satisfy the objective of relieving**
2 **your dysphoria?**
3 A. No.
4 **Q. So on that 100-point scale, we're still 8 1/2**
5 **maybe?**
6 A. No. Yeah, about 8 1/2.
7 **Q. After the earlobe surgery?**
8 A. Yeah.
9 **Q. And this was in Clay County, Florida. Where**
10 **were you living at the time?**
11 A. Orange Park, which is in Clay County,
12 Florida.
13 **Q. Okay. Did you -- I'm assuming -- did you**
14 **seek -- how did you find this particular --**
15 A. Same network.
16 **Q. Same network?**
17 A. Uh-huh.
18 **Q. All right. Now, the next surgery looks like**
19 **it was two surgeries?**
20 A. Yeah.
21 **Q. The facial feminization surgery and the**
22 **orchiectomy?**
23 A. Yes.
24 **Q. And when was that?**
25 A. October -- I mean, July of 2017.

**1 Q. So July 2017. So a few months before you**
**2 enter custody -- DPS custody?**
3 A. Uh-huh.
**4 Q. And you had both surgeries at the same time?**
5 A. Yes.
**6 Q. And tell me first about the facial**
**7 feminization surgery. What did they do?**
8 A. So she put in permanent fillers into my chin
9 area, my cheek area, and my forehead area to decrease
10 the structure -- the square structure of the face to
11 have more of a feminine look.
**12 Q. And "she," was this Dr. Sherie?**
13 A. Yes.
**14 Q. Okay. And did you talk with anybody aside**
**15 from Dr. Sherie about your interest in pursuing the**
**16 facial feminization surgery?**
17 A. No.
**18 Q. No? What about with your husband or your**
**19 family members?**
20 A. Not at that time, no.
**21 Q. Okay. So they didn't know that you were**
**22 going to have --**
23 A. No.
**24 Q. -- facial feminization surgery?**
25 A. Huh-uh.

1 **Q. Okay. And what was the objective of having**
2 **the facial feminization surgery?**
3 A. To have a more of a feminine look.
4 **Q. And the purpose for that was?**
5 A. To help allieve [sic] my dysphoria.
6 **Q. And did you discuss the prospects of the**
7 **facial feminization surgery improving your dysphoria**
8 **with anybody?**
9 A. With the doctor.
10 **Q. With Dr. Sherie?**
11 A. Uh-huh.
12 **Q. Did you discuss this with any mental health**
13 **care providers?**
14 A. No.
15 **Q. Were there any physical limitations that you**
16 **were hoping, activities that you were hoping to engage**
17 **in before the surgery -- after the surgery that you**
18 **couldn't before the surgery?**
19 A. Same as before. I was working towards
20 alleviating my dysphoria. I was working towards being
21 more socially transitioned. I was working closer to
22 getting -- to having more of a feminine look so I can
23 be presented to the person -- presented as a person
24 that I am. I can be around people -- like, when I want
25 to play hobbies and sports -- I mean doing my sports

1 and doing my hobbies. I was working. It was a work in
2 progress.
**3 Q. What were some of your hobbies? You**
**4 mentioned hobbies a couple of times.**
5 A. Volleyball, baseball, and swimming.
**6 Q. Any other non-sport hobbies?**
7 A. I like to dance.
**8 Q. And did you discuss the prospects of how well**
**9 the next step of the process would improve your**
**10 dysphoria with anyone other than Dr. Sherie?**
11 A. No.
**12 Q. Okay. Now, what was the recovery like for**
**13 your facial portion of the surgery?**
14 A. It was just swelling for a few weeks and then
15 it went away.
**16 Q. Did the recovery process, was it kind of like**
**17 what they told you it would be like or was it worse?**
18 A. Identical.
**19 Q. Okay. Now, let's talk about the orchiectomy**
**20 portion of the surgery. This was the same time; right?**
**21 July 2017?**
22 A. Uh-huh.
**23 Q. Dr. Sherie performed this surgery?**
24 A. Yes.
**25 Q. It was performed in Charlotte?**

1 A. Yes.

**2 Q. Where were you living at this time?**

3 A. I was staying in Jacksonville, Florida.

**4 Q. In Jacksonville, Florida?**

5 A. Which is Orange Park. It's all the same

6 thing.

**7 Q. What county is Jacksonville in again?**

8 A. Clay County. Jacksonville? Jacksonville is

9 Duval County. Orange Park is Clay County, but it's a

10 suburb of Jacksonville.

**11 Q. Okay. Gotcha.**

**12 Why did you pursue the orchiectomy?**

13 A. I pursued the orchiectomy to have full gender

14 reassignment surgery to have a vaginoplasty. But the

15 first step for me was to remove the testicles due to my

16 financial ability at that moment.

**17 Q. Okay. So just before the orchiectomy**

**18 surgery, where would you rate your -- on the 100-point**

**19 scale, where would you rate your level of contentment**

**20 with your -- your body matching your gender identity?**

21 A. Where I was at that moment, I would say 8.5.

**22 Q. Okay. Now, after the orchiectomy, where**

**23 would you rate that?**

24 A. My orchiectomy I would say decreased my scale

25 number due to me having to come to prison, and I -- I

1 was -- I entered into a world that knew nothing about
2 anything that happened to me, and everything kind of
3 just went totally haywire from there, so it decreased
4 my points.

**5 Q. Okay. Just before you were incarcerated, so**
**6 perhaps before -- did you plead guilty or were you**
**7 tried?**

8 A. I pled guilty.

**9 Q. Pled guilty?**

10 A. Uh-huh.

**11 Q. Just before you pled and were sentenced, you**
**12 had completed the orchiectomy; right?**

13 A. Uh-huh.

**14 Q. Where would you rate your level of**
**15 contentment at that point in time before you became**
**16 incarcerated?**

17 A. I would put it at a 12.

**18 Q. Okay. So we're at 12 out of 100 post**
**19 orchiectomy but before incarceration?**

20 A. Uh-huh.

**21 Q. Did you discuss with anyone prior to the**
**22 orchiectomy your -- your desire or hopes that the**
**23 orchiectomy would alleviate your dysphoria?**

24 A. Dr. Hope Sherie.

**25 Q. Beyond Dr. Hope Sherie, did you speak with**

**1 anybody about this?**

2 A. Her assistant.

**3 Q. And at this time, were you under the care of**

**4 any mental health care providers?**

5 A. I was just seeing them as -- as needed.

**6 Q. Who is "them"?**

7 A. At UNC psychiatry.

**8 Q. While you were in Florida?**

9 A. Yes.

**10 Q. Okay. Is this telemedicine?**

11 A. No. I went there. I came to North Carolina

12 sometimes weekly if not twice a week.

**13 Q. Okay. So you were -- you were still actively**

**14 going to the UNC psychiatric practice at the time that**

**15 you had the orchiectomy?**

16 A. And most of my appointments was set around my

17 court dates. Like, if I had to be in North Carolina

18 for court dates, if I needed to see someone.

**19 Q. All right. What did Dr. Sherie tell you**

**20 about the likelihood of the orchiectomy improving your**

**21 dysphoria?**

22 A. The first conversation Dr. Hope Sherie had

23 with me before she did my orchiectomy was that the way

24 she was doing my orchiectomy, she only agreed to do it

25 if I was to continue -- she -- she did it in a manner

1 for which I would get a vaginoplasty next. If not, my
2 orchiectomy would have been done a totally different
3 way.
**4 Q. Right. So you -- did you have any particular**
**5 tissue left during the surgery?**
6 A. She purposefully left the tissue for the
7 vaginoplasty.
**8 Q. And that's because that -- that's your**
**9 intention is to -- that was your intention at the time,**
**10 and still is, to pursue the vaginoplasty?**
11 A. Yes.
**12 Q. And, again, did -- did she discuss with you**
**13 any -- did she provide you any information about how**
**14 likely this course of surgery would help your gender**
**15 dysphoria?**
16 A. She let me know that it probably would not
17 allieve my gender dysphoria because I was still dealing
18 with my primary sex -- primary sex characteristics at
19 the time. It was just basically taking the
20 testosterone out of my body so I wouldn't have to take
21 as much estrogen and spironolactone and progesterone.
22 Like, it was just helping me work myself off the
23 hormones.
**24 Q. So the removal of the testicles allowed you**
**25 to take less or different hormones?**

1 A. Uh-huh.
**2 Q. Were there any physical limitations that you**
**3 were hoping to address by seeking out the orchiectomy?**
4 A. I was seeking to go to surgery in August to
5 go to my next step; so, yes, I was hope -- still
6 seeking to have surgery soon right after. So at that
7 moment, nothing was -- helped alleviate anything
8 because I was just focusing on my next steps.
**9 Q. So you were -- at the time that you had the**
**10 orchiectomy in July, you were -- you were focused on**
**11 having an additional surgery --**
12 A. Yes.
**13 Q. -- the next month in August?**
14 A. Yes.
**15 Q. And who was going to perform that surgery?**
16 A. Dr. Hope Sherie was willing to perform a
17 basic liposuction on me for my chin area and my body
18 area to -- in preparation of kind of getting me more
19 feminine to go into my vaginoplasty.
**20 Q. Okay. So the -- so the anticipated surgery**
**21 in August would have been liposuction of your chin and**
**22 your -- you motioned to your mid-section, your abs?**
23 A. My mid-section, yes.
**24 Q. And doing that was in -- in preparation of**
**25 the vaginoplasty?**

1 A. Yes.
2 **Q. Why would -- why was it necessary to -- to**
3 **have the liposuction before the vaginoplasty?**
4 A. Because you have to have -- be at a certain
5 BMI, you have to be in good health, and my whole thing
6 was just to remove fat from my body so I can be in the
7 right BMI.
8 **Q. So that was the -- the desire to -- to have**
9 **liposuction at that time was --**
10 A. Yes.
11 **Q. -- to lower your BMI so you could proceed**
12 **with the vaginoplasty?**
13 A. Well, I was already in the area, because I
14 was 226. The most you can be is 250. I was 226. I
15 just wanted to be less than the 226.
16 **Q. And why was that?**
17 A. Because it give you more of a feminine look
18 and not more of a masculine look if you're bigger
19 compared if you're smaller.
20 **Q. And so -- it's important -- is it important**
21 **to you that -- that your appearance feel feminine to**
22 **you with respect to your weight?**
23 A. Very much so.
24 **Q. And so did the orchiectomy achieve its**
25 **outcomes, aside from obviously removing the testicles**

1 **which was the physical outcome, but what about the --**
2 **the outcome of alleviating your dysphoria? Did the**
3 **orchiectomy provide any benefit in that regard?**
4 A. Orchiectomy benefited removing the
5 testosterone from my body so I wouldn't have to be on
6 such medications. It helped with the body hair, and it
7 definitely had a lot of cons to it.
8 **Q. The orchiectomy did?**
9 A. Yes.
10 **Q. What were those?**
11 A. Not having -- going to my next surgery and
12 not being on the hormones caused me a lot of unwanted,
13 like, invasive arouse. It made me gain a lot of
14 weight, and it had made me feel like I was into, like,
15 a hot flash moment. And then also I had a lot of
16 stress situation about not being medically treated once
17 I came into DPS custody because somebody never
18 performed the physical. I never had any postoperative
19 care, so I worried about scarring, dehiscing.
20 **Q. What was that? Dehiscing?**
21 A. Yeah.
22 **Q. What's that?**
23 A. When your surgery site comes open.
24 **Q. Okay. How many postoperative visits did you**
25 **have before you came to prison?**

1 A. I had two -- two or three.
**2 Q. And how were you healing at those**
**3 appointments?**
4 A. At one time she had to put extra staples in.
5 At one moment she put a staple in and put a honey
6 patch, and then after that, everything else was
7 healing.
**8 Q. Okay. And when you came to prison, how was**
**9 your -- how was the surgical site at that time?**
10 A. It was still healing. I was still packed
11 with gauze. I was feeling -- it still had -- was the
12 staples in? No, the staples was out. Dr. Hope Sherie
13 took the staples out. I was still healing. I had
14 gauze, and I was patched. I was still, like,
15 postoperative. Needed postoperative care.
**16 Q. Okay. All right. So now we're at a 12,**
**17 right, out of 100?**
18 A. No, we done went down because I came to
19 prison.
**20 Q. Before prison.**
21 A. Yeah.
**22 Q. So we're talking -- we're talking the day**
**23 before you walked through the doors or the day perhaps**
**24 before you were sentenced.**
25 A. Yes.

1 Q. Where would you rate your level of
2 contentment?
3 A. When?
4 Q. Right before you were sentenced to DPS.
5 A. The 12.
6 Q. Okay. Now, you had -- you've talked about
7 some desires for further surgery. What additional
8 surgery are you envisioning?
9 A. A vulvoplasty.
10 Q. Vulvoplasty? And what is that compared to
11 the vaginoplasty?
12 A. You do not have the vagina canal.
13 Q. Okay. Earlier, you mentioned vaginoplasty --
14 A. Uh-huh.
15 Q. -- as your target.
16 A. Uh-huh.
17 Q. Where does the vulvoplasty fit into that?
18 A. After consultation with the UNC transgender
19 health center, I concluded that.
20 Q. Why -- why did you choose the vulvoplasty
21 versus the vaginoplasty?
22 A. After details was given to me from DPS Terry
23 Catlit, Katherine Croft, about DPS desire of not
24 wanting to pay for the six months of laser surgery that
25 it needed to have vulvoplasty -- I mean, to have a

1 vaginoplasty, 'cause you can't have hair growth in the
2 testicle area -- the skin that was left on the testicle
3 area. You had to go through electrolysis for six
4 months.
5 DPS said they was not willing to pay for the
6 electrolysis, and that DPS also stated that -- that me
7 having dilating cones in prison was considered
8 intrusive, provocative. So it would be kind of -- my
9 odds of getting approval would be better for
10 vulvoplasty than it would for vaginoplasty. And it
11 would help alleviate my dysphoria faster instead of
12 waiting for the process of seeing people would approve
13 it or not approve it.
14 So after consultation with the nurse and the
15 doctor at UNC, I decided a vulvoplasty.
**16 Q. And which nurse are you referring to?**
17 A. Katherine Croft.
**18 Q. Which doctor are you referring?**
19 A. Bradley Figler.
**20 Q. Okay. So you -- you came to the conclusion**
**21 to request a vulvoplasty rather than the vaginoplasty**
**22 after your consultation with Dr. Figler and with**
**23 Katherine Croft?**
24 A. I did it on two different incidence. I did
25 one in May, I made a decision of vulvoplasty, and I did

1 it again in June -- July again with Dr. Figler.
**2 Q. Okay. So was the May after your meeting or**
**3 during your meeting with Katherine Croft?**
4 A. It was during the meeting with Katherine
5 Croft, Dr. Hahn, and myself.
**6 Q. Was Dr. Hahn in that meeting?**
7 A. Yes, sir.
**8 Q. So was it the three of you in the meeting?**
9 A. Yes, sir.
**10 Q. And the primary or the reason that you opted**
**11 for the vulvoplasty -- to request a vulvoplasty rather**
**12 than the vaginoplasty was because you understood that**
**13 DPS wouldn't pay for the laser hair removal, which was**
**14 required prior to the vaginoplasty, but not for the**
**15 vulvoplasty, and there was some issue regarding**
**16 dilating cones --**
17 A. Yes.
**18 Q. -- that you felt --**
19 MS. MAFFETORE: Objection to form. Primary
20 and compound.
21 MR. RODRIGUEZ: Okay. Let me do this. All
22 right?
23 BY MR. RODRIGUEZ:
**24 Q. So in May when you met with Katherine Croft,**
**25 and Dr. Hahn, Patricia Hahn who's a PhD psychologist**

1 **with DPS; correct?**
2 A. Uh-huh.
3 **Q. You decided after that meeting to opt for the**
4 **vulvoplasty?**
5 A. Yes. After consult with her, yes, and an
6 explanation of the two. She explained one; she
7 explained the other. She went into detail. She said
8 this is normal for every trans person to come in there,
9 they get those options to them, doing one that's less
10 invasive compared to one that's invasive.
11 And she explained to me about the invasive
12 part and what DPS had already communicated with her.
13 Ms. Terry Catlit, compared to what she thought would be
14 best. And based off their professional judgment, and
15 them dealing with trans before, after she explained it
16 to me, the healing, the postoperative care, taking
17 account of DPS's concern with postoperative issues,
18 providing security for me to go to the hospitals back
19 and forth, I agreed with the consultation, and felt
20 that it was best as a lot of other trans people in the
21 world has done -- chose vulvoplasty over vaginoplasty.
22 **Q. Okay. And so those are the reasons that you**
23 **opted for the vulvoplasty -- to request the vulvoplasty**
24 **instead of the vaginoplasty?**
25 A. Along with it would alleviate my dysphoria

1 then and now compared to me not having it at all.
**2 Q. What about the laser hair removal part? You**
**3 mentioned that the first time, but the second time you**
**4 left that one out.**
5 A. The laser hair removal was required for me to
6 get a vulvoplasty, and they said that DPS had denied --
7 (Clarification by the reporter.)
8 THE WITNESS: The laser hair removal was
9 which -- well, it's really laser hair
10 removal/electrolysis was something that was mandatory
11 to get a vulvoplasty, and DPS had already denied it,
12 along with hair -- facial hair removal. So if I
13 couldn't have that, I couldn't have the vulvoplasty.
14 It wouldn't have -- I wouldn't have got the
15 vulvoplasty.
16 BY MR. RODRIGUEZ:
**17 Q. Okay.**
18 A. I mean, the -- sorry, the vaginoplasty.
**19 Q. And so your understanding, then, was that as**
**20 of May 2021, I guess that would have been --**
21 A. Yes.
**22 Q. -- when you had that meeting, is that when**
**23 that was?**
24 A. Uh-huh.
**25 Q. That you had requested and DPS had denied**

1 **electrolysis for your pelvic region in preparation of**
2 **the vaginoplasty?**
3 A. Yes. They said they was -- what was told to
4 me that DPS would not approve it, yes, basically. They
5 would have considered that cosmetic.
6 **Q. Who told you this?**
7 A. This was coming -- Terry Catlit. This was
8 told to me by Katherine Croft, which according to a
9 grievance that was read in that they had consultation
10 with each other prior to me even seeing them.
11 **Q. So --**
12 A. She had to me -- Terry Catlit had to meet
13 with Katherine Croft who set her up on a DX80 and DPS's
14 records and what the whole entire ordeal would take
15 with vulvoplasty, vaginoplasty. So, basically, when I
16 got there, she explained to me the difference and what
17 she had already received from DPS compared to what was
18 going on then, like what my options would be.
19 **Q. And have you seen any medical records**
20 **regarding that visit with Katherine Croft?**
21 A. I saw a -- I seen a grievance from that --
22 from the statement of Terry Catlit that stated that she
23 had to consult with them prior to me going to see
24 Dr. Figler. And I'm -- I don't remember 100 percent if
25 I saw the record, but I do remember seeing some records

1 from UNC.

**2 Q. And you mentioned -- correct me if this is**
**3 incorrect -- but you mentioned, I believe, that**
**4 Katherine Croft recommended the vulvoplasty to you over**
**5 the vaginoplasty?**

6 A. No. She told me the difference, and she told
7 me what would happen with the vulvoplasty, and she told
8 me what DPS stance was with the vaginoplasty. So after
9 both -- and after that recommendation of both, I chose
10 the vulvoplasty. And then when I got to Dr. Figler, he
11 went over it with me, and his -- and the physician, he
12 recommended the vulvoplasty.

**13 Q. So he -- Dr. Figler recommended the**
**14 vulvoplasty?**

15 A. Uh-huh.

**16 Q. Over the vaginoplasty?**

17 A. Yes.

**18 Q. Did you discuss with either of -- if you had**
**19 a vulvoplasty, would you pursue a vaginoplasty later?**

20 A. Yes. I did have that conversation. They
21 gave me -- they told me what would happen if I chose a
22 vulvoplasty, and if I want to have a vaginoplasty years
23 down the road, that what the options and how it would
24 happen. They told me exactly how it would happen.

**25 Q. And what did they say?**

1 A. That it would have to be robotic surgery.
**2 Q. Did they say that that was typical?**
3 A. They said it has been done before, but most
4 people are satisfied, and it alleviates their dysphoria
5 with the vulvoplasty because the primary sex
6 characteristics isn't there anymore.
**7 Q. So you -- so who -- who told you that?**
8 A. This is happened -- Katherine Croft and
9 Dr. Figler.
**10 Q. So Katherine Croft and Dr. Figler told you**
**11 that most transgender females are satisfied with just**
**12 the vulvoplasty and not the vaginoplasty?**
13 A. Right.
**14 Q. Had you heard that from anyone else?**
15 A. I did my own research and studies afterwards.
**16 Q. And what did that research reveal?**
17 A. It was very true.
**18 Q. So is it more common, then, for transgender**
**19 females to pursue vulvoplasty and not vaginoplasty?**
20 A. There's really depends on your transition,
21 different transitions. I mean, there's -- of 100
22 transgenders, there's going to be 100 different
23 transitioning ways. So I think it's just all about
24 what they -- their personal desire.
25 But their records did say, like, the research

1 that me and my husband and even Dr. Hahn have done, we
2 did, said that most people are satisfied with whatever
3 surgery they choose.
**4 Q. Satisfied with whatever surgery they choose?**
5 A. Yeah. Like, if they choose either
6 vulvoplasty or vaginoplasty, that the -- the odds were
7 that they were totally satisfied and that it alleviated
8 their dysphoria.
**9 Q. Okay. Now, what about the conversation in**
**10 particular about being able to pursue the vaginoplasty**
**11 after a vulvoplasty? You mentioned that it was -- you**
**12 were told it would have to be done --**
13 A. Robotic.
**14 Q. -- robotically. Were you provided any**
**15 information about whether pursuing a vaginoplasty after**
**16 the vulvoplasty was more risky of a procedure?**
17 A. Vulvoplasty is a riskier procedure than a
18 vulvoplasty. Vaginoplasty is a riskier procedure than
19 a vulvoplasty.
**20 Q. Right. But I guess let me ask the question**
**21 differently then. Were you given any information about**
**22 whether pursuing a vaginoplasty after a vulvoplasty has**
**23 been performed is riskier than just performing a**
**24 vaginoplasty?**
25 A. No.

**1 Q. You weren't given any information?**
2 A. No, because I was told during when Katherine
3 Croft that actually robotic surgery that people
4 normally choose if they choose five or ten years down
5 the road is basically going -- is kind of like more
6 like arthroscopic way.
7 Instead of more having to create tissue,
8 create the vulva, create the clitoris area, because all
9 that stuff is just created. So, basically, all they're
10 doing is they're creating a vagina lining, like
11 parallel to the rectum lining. So, basically, it's to
12 have more tissue from your inner body to create the
13 lining of it.
14 So it's just not -- it's a little bit more
15 invasive having a vulvoplasty than -- I mean, to just
16 have -- already having your vulva is kind of basically
17 getting the hardest part out of the way.
**18 Q. Okay. And did you discuss -- well, at the**
**19 time in May, I guess, and then was it July when you met**
**20 with Dr. Figler?**
21 A. Uh-huh.
**22 Q. In May and in July -- or let me just ask it**
**23 this way. In May with Katherine Croft, when you**
**24 resolved in your mind that you were going to go for the**
**25 vulvoplasty, were you anticipating at a later date**

**1 pursuing a vaginoplasty as well?**
2 A. I had no more desires. I had already made my
3 decision that I wanted vulvoplasty.
**4 Q. Okay. Did you -- so at that time, in May of**
**5 2021, you resolved you wanted a vulvoplasty and were**
**6 not going to pursue, at a later date, the vaginoplasty?**
7 A. Right. Prior to our going in the door, I
8 wanted a vaginoplasty. After my consult and she
9 explained all the details, I agreed and I left there,
10 and that's what I decided was a vulvoplasty.
**11 Q. All right. So --**
12 A. And still to this day, I desire a
13 vulvoplasty.
**14 Q. Okay. Same set of questions for Dr. Figler's**
**15 meeting, then. When you went in there and resolved**
**16 that you wanted a vulvoplasty as opposed to the**
**17 vaginoplasty, at that time, were you thinking that that**
**18 would be it, the vulvoplasty and no other surgeries?**
19 A. Me and Dr. Figler didn't talk about me
20 wanting a vaginoplasty at all. We just totally focused
21 on the vaginoplasty [sic]. And he asked me my
22 demographics, my life surgeries, if I was circumcised,
23 uncircumcised, like basic medical questions, and he
24 just basically said I met the WPATH guidelines, and he
25 recommended vulvoplasty after I had lost weight.

1 **Q. Can you tell me a little bit more about that?**
2 A. I didn't get a postoperative exam until last
3 month after being in prison for five years.
4 **Q. You didn't get a postoperative exam for --**
5 A. I didn't -- no. Nobody ever examined me.
6 **Q. Examined which part of you?**
7 A. My orchiectomy site.
8 **Q. Okay. So you --**
9 A. And I did my dressings myself when I was at
10 Harnett Correctional.
11 **Q. So no one examined -- physically examined**
12 **your orchiectomy -- the site of your orchiectomy until**
13 **last month?**
14 A. Yes. And that was by Nurse Practitioner
15 Brittany Baker.
16 **Q. And what about the -- when you entered**
17 **custody in October 2017, were you on hormones?**
18 A. Yes, I was.
19 **Q. And did you have any issues related to your**
20 **hormone treatment upon entering DPS custody?**
21 A. Yes, they stopped it.
22 **Q. Okay. And what was your understanding about**
23 **that?**
24 A. That it had to be approved.
25 **Q. Okay. Can you talk a little bit about the**

**1 process for that?**
2 A. Said that it had to go through a facility
3 TARC. Then it has to be approved through the DTARC
4 and, ultimately, eight months after my incarceration
5 started in June of 2018.
**6 Q. Okay. So there was an eight-month period**
**7 from when you were incarcerated until you started**
**8 receiving your hormones?**
9 A. Yes, sir.
**10 Q. And during that period of time, how did you**
**11 feel?**
12 A. I felt really bad. I was having real bad hot
13 flashes. I was having arousals. I was having feeling
14 of feeling like I was having, like, some joint type of
15 issues like in my back. And I was just really moody.
16 I can tell that I was off hormones.
**17 Q. Okay. And so did you believe that -- that**
**18 all those things you just listed were related to the**
**19 lack of hormones?**
20 A. Yes.
**21 Q. Did you discuss those issues with any -- any**
**22 medical providers?**
23 A. Yes.
**24 Q. Which ones?**
25 A. Dr. Joseph Yunessy and Nurse Brian Crawley.

**1 Q. And after about eight months when you resumed**
**2 the hormone therapy, did those issues resolve?**
3 A. No, not immediately.
**4 Q. Did they eventually resolve?**
5 A. No, they didn't.
**6 Q. So you still experience those problems?**
7 A. I have an issue with DPS not following up
8 with my scheduled maintenances and not doing labs when
9 they supposed to. So when the endocrinologist may say
10 I suppose to take something for three months, DPS end
11 up having it on me for six months. Where like one time
12 it was a whole year. So the management of my hormones
13 are not adequate.
**14 Q. Okay. And so what sort of, first, physical**
**15 impacts do you feel are associated with what you**
**16 contend are the inadequate management of your hormones?**
17 A. No. 1 is the -- the emotional effect of it,
18 where it causes you to be very emotional. Second
19 aspect would be where it comes from like the hot
20 flashes feeling like I'm in menopause.
21 The second part of it's knowing that my body
22 have no hormones whatsoever by the removal of my
23 testosterone. My body needs some type of hormone. And
24 knowing that my body has nothing in it, it mentally
25 mess with me knowing that my body lacks no kind of

1 hormones in it.

**2 Q. So after you started the hormones in -- in**

**3 eight months after becoming incarcerated, so that's**

**4 June 2018?**

5 A. Uh-huh.

**6 Q. After June 2018, have you gone periods of**

**7 time without any hormones?**

8 A. Yes.

**9 Q. How -- how many times has that happened?**

10 A. Over three. I don't remember the number, but

11 it's over three.

**12 Q. More than five?**

13 A. I would say between three and five.

**14 Q. Okay. And for how long of a period of time**

**15 in each of those instances would you go without**

**16 hormones?**

17 A. Without hormones? I have been without it for

18 a two-week period.

**19 Q. Is that the longest?**

20 A. I think that was the longest.

**21 Q. Okay. So aside from those three to five**

**22 instances when you didn't have hormones for at most two**

**23 weeks, have you had hormones in your system?**

24 A. I have had hormones in my system, yes.

**25 Q. Okay. And so, is your contention, then, that**

1 **the management of those hormones has not been**
2 **appropriate?**
3 A. Yes.
4 **Q. And that's based off of what?**
5 A. Based off of what the endocrinologist
6 recommend, and during his follow-up and consult with me
7 to tell me how they should be managing and how much I
8 suppose to get and when I suppose to get them.
9 **Q. And which -- which medication in particular**
10 **has been mismanaged?**
11 A. The estradiol.
12 **Q. Estradiol?**
13 A. Uh-huh.
14 **Q. And how do you ingest that medication?**
15 A. Intramuscle injection.
16 **Q. So it's a -- it's a -- it's a needle**
17 **injection?**
18 A. Yes.
19 **Q. Have you had a patch?**
20 A. I have had a patch.
21 **Q. So what's been the -- what's your**
22 **understanding of the issue regarding the dosage of the**
23 **estradiol?**
24 A. One of the issues was that the doctor wanted
25 me to have 0.5, and the medical was giving me -- was

1 giving me 1. Instead of 0.5, they was giving me .5
2 more.
**3 Q. And when did that happen?**
4 A. That happened this year. It happened for a
5 period of about six months this year.
**6 Q. That you got too much estradiol?**
7 A. Yeah. And it was notated into the Hero
8 (phonetic). And I didn't even know it. I didn't know
9 that I was getting that much. And then Dr. Caraccio
10 (phonetic) noticed it at my follow-up in August that I
11 was getting 1 -- 1.0 instead of the 0.5.
**12 Q. Okay. And that was this past August you**
**13 said?**
14 A. Yes.
**15 Q. And -- okay. So setting aside that incident,**
**16 what other incidents have you had with dosing and**
**17 hormones?**
18 A. Not getting labs when I'm supposed to to show
19 my lab levels. It got so high one time where the Lab
20 Corp people called here to the prison, and it was kind
21 of listed that I was -- my hormones was being still
22 read and they're a male gender and not a female gender.
23 And it also showed that my hormone level was not in the
24 range where he wanted it to be within 200. It was
25 lower than the target range that he was trying to get

1 to.

**2 Q. And was that an issue with dosing?**

3 A. I think that was an issue with not following

4 up so he can up the dose to get it to where it needed

5 to be.

**6 Q. Okay. So aside from the issue with getting**

**7 the 1.0 instead of the .5, do you know of any instances**

**8 where you were provided what you believe to be the**

**9 incorrect dose of medication?**

10 A. No.

**11 Q. You alluded earlier to a period of separation**

**12 perhaps with your husband?**

13 A. Uh-huh.

**14 Q. Did I -- is that accurate?**

15 A. Yes, it's accurate.

**16 Q. Okay. Are you presently separated from your**

**17 husband?**

18 A. No.

**19 Q. Have you been in the past separated from your**

**20 husband?**

21 A. I was only staying in a totally different

22 house. So that was the only type of separation that we

23 had. I was staying in one -- in one state, and he was

24 staying in another state.

**25 Q. And when was that?**

1 A. And that was prior to my incarceration.
2 About six months prior to my incarceration.
3 **Q. Okay. So that would have been early --**
4 A. 2000 --
5 **Q. -- 2017?**
6 A. Yes.
7 **Q. And where were you living at that time?**
8 A. Orange Park, Florida.
9 **Q. And where was Mr. Brown living?**
10 A. In North Carolina.
11 **Q. And why were you all separated?**
12 A. I was waiting to go to court, and I was
13 staying there, and that's where my bond was posted at.
14 I mean, not my bond was posted -- my bails bond, they
15 had my address there; so I stayed there.
16 **Q. And so that -- that wasn't a consequence of**
17 **your relationship with Mr. Brown; that was a logistical**
18 **issue?**
19 A. Yeah, it was logistic.
20 **Q. And I notice you have various tattoos.**
21 A. Uh-huh.
22 **Q. Tell me about some of those tattoos. When**
23 **you received them, and what they -- what they mean to**
24 **you.**
25 A. My tattoos is my form of expressing myself.

1 It's a form of art. And I have been getting them since
2 early 2000s.
**3 Q. Have you received any tattoos since you have**
**4 been incarcerated?**
5 A. No, I have not.
**6 Q. Do any of the tattoos have any special**
**7 significance to you?**
8 A. Every last one of them have special
9 significance.
**10 Q. Any you care to share?**
11 A. No.
**12 Q. Have any of the tattoos that you have, do any**
**13 of them relate to your struggle with gender dysphoria?**
14 A. A lot of them.
**15 Q. Can you elaborate?**
16 A. It expresses what I go through. Like, it
17 shows expression of the pain. It shows the expressions
18 of how gender dysphoria is hard for me. It's just an
19 expression of it.
**20 Q. Okay. I want to circle back briefly before**
**21 we continue our chronological conversation to your --**
**22 your consultation with Dr. Ettner. How many times have**
**23 you met Dr. Ettner?**
24 A. Once in person and once over the phone.
**25 Q. Okay. When was the first time you spoke with**

1 **Dr. Ettner? Was it over the phone or in person?**
2 A. In person.
3 **Q. And when was that?**
4 A. That was -- I want to say maybe -- I don't
5 remember.
6 **Q. Was it 2022?**
7 A. Yes, beginning of this year.
8 **Q. And do you recall how long that in-person**
9 **meeting was?**
10 A. I want to say it was three hours.
11 **Q. And what about the phone call with**
12 **Dr. Ettner? That was after the in-person meeting?**
13 A. Yes.
14 **Q. How long was that phone call?**
15 A. An hour.
16 **Q. An hour?**
17 A. (Witness nods head.)
18 **Q. So aside from those two instances, have you**
19 **communicated with Dr. Ettner at all?**
20 A. No.
21 **Q. And what did you discuss with Dr. Ettner?**
22 A. My gender dysphoria, my current feeling, my
23 current mental state, what I have been through in my
24 past, my past histories, my demographics, my family, my
25 relationships, my education, my entire life story.

**1 Q. Did you discuss your desire for a vulvoplasty**
**2 with Dr. Ettner?**
3 A. Yes, I did.
**4 Q. And did you discuss your hopes that the**
**5 vulvoplasty would alleviate your gender dysphoria?**
6 A. Yes, I did.
**7 Q. And what did she tell you -- what did**
**8 Dr. Ettner tell you about the prospects of the**
**9 vulvoplasty alleviating your dysphoria?**
10 A. Based off her experience and the guidance
11 from many associations, that it will alleviate my
12 gender dysphoria.
**13 Q. Did she tell you -- talk about with you**
**14 whether you would experience any distress related to**
**15 misgendering or transphobia post vulvoplasty?**
16 A. No, I have always -- only time I have all --
17 publicly identified as transgender is when I had to
18 when DPS publicly identified me as transgender in
19 prison. Besides that, I don't prefer to be publicly
20 identified as transgender. I'd just like to be
21 publicly identified as a woman.
**22 Q. Did you have any discussions with Dr. Ettner**
**23 about the possibility that even post vulvoplasty you**
**24 might still experience some afflictive emotions related**
**25 to your transgender status?**

1 A. Based off of what I have been told by
2 Dr. Ettner is that emotions is something that's going
3 to come from my hormones, not from my surgery.
**4 Q. Okay. So did Dr. Ettner offer any insight as**
**5 to how surgery then would alleviate your dysphoria if**
**6 your emotions are tied to your hormones?**
7 A. Surgery allieves dysphoria based off --
8 'cause it eliminates the primary sex characteristics,
9 and it gives me secondary characteristics to align with
10 my genders -- I mean, to align with who I am as a
11 female and to help alleviate my gender dysphoria.
**12 Q. Okay. The vulvoplasty would not remove**
**13 any -- it would -- the vulvoplasty would remove the --**
**14 the tissue of the penis; correct?**
15 A. Vulvoplasty removes the -- yeah, the inner of
16 the, but the remainder is used.
**17 Q. Okay. And do you understand -- do you know**
**18 whether vulvoplasty has any impact physiologically on**
**19 someone's hormones?**
20 A. It definitely would not.
**21 Q. You mentioned earlier that you had done**
**22 some -- some research, I think specifically related to**
**23 patient satisfaction perhaps regarding vulvoplasty or**
**24 vaginoplasty. Tell me a little bit more about that**
**25 research you conducted.**

1 A. The research is done with myself and Dr. Hahn
2 and myself and Mrs. Dula.
**3 Q. Mrs. --**
4 (Clarification by the reporter.)
5 THE WITNESS: Dula, D-u-l-a.
6 BY MR. RODRIGUEZ:
**7 Q. And who's Ms. Dula?**
8 A. Jennifer Dula was a licensed clinical social
9 worker assigned to my therapy here at Anson.
**10 Q. Assigned through your therapist?**
11 A. She was assigned as my therapist.
**12 Q. How many therapy sessions did you have with**
**13 Jennifer Dula?**
14 A. Every 14 days, numerous.
**15 Q. How -- how long of a period of time do you**
**16 think?**
17 A. Over maybe close to a year.
**18 Q. So biweekly for about a year?**
19 A. Yes.
**20 Q. And at that time was she your only mental**
**21 healthcare provider?**
22 A. At the beginning, no, her and Dr. Hahn.
**23 Q. Okay. Was this around the time Dr. Hahn**
**24 retired?**
25 A. Yes. This was all the way up until June of

1 2021.

**2 Q. And so when you say you conducted this**

**3 research with Dr. Hahn and Ms. Dula, where -- where did**

**4 you -- how did you guys do this research?**

5 A. They did it online.

**6 Q. Okay. Were you with them when they**

**7 researched it?**

8 A. Yes. I was in the therapy session with them.

**9 Q. You were what?**

10 A. In the therapy session with them.

**11 Q. Okay. So the three of you all conducted**

**12 research during your therapy sessions?**

13 A. It wasn't all three of us. It was -- I was

14 with Dr. Hahn sometimes, and I was with Ms. Dula on

15 other times.

**16 Q. Okay. So you never had any joint sessions**

**17 with the two of them?**

18 A. No.

**19 Q. Okay.**

20 A. Well, Ms. Dula sat in one time to get her --

21 trying, I guess, to get like a rapport of what was

22 going on with me after reading my medical records, but

23 it was very brief, like maybe ten minutes, and then she

24 left out of the therapy session, and Dr. Hahn

25 continued.

1 **Q. Okay. And what is, then -- well, do you know**
2 **what websites or research tools were used to conduct**
3 **this research?**
4 A. No. I did not see the computer.
5 **Q. Did you read any of the actual research**
6 **yourself?**
7 A. Yes. I read some of the papers that they
8 printed off.
9 **Q. Did you discuss the research with Dula or**
10 **Dr. Hahn?**
11 A. Yes.
12 **Q. What was some of the research that you**
13 **remember reading?**
14 A. Actually showed a diagram of step-by-step
15 process of how it happens.
16 **Q. How the surgery happen -- how the vulvoplasty**
17 **happens?**
18 A. Yes. It actually told me how the
19 satisfaction of trans women that have been through
20 gender-affirming surgery, how they feel post at
21 certain, like, six months, one year, three years, five
22 years. Told me about how some of them may feel when it
23 come to down to being on hormones, if they want to
24 continue hormones, not continue hormones.
25 **Q. Post surgery?**

1 A. Yes, post surgery. And then just all around
2 basically their review of it.
**3 Q. So I think you said earlier that the**
**4 vulvoplasty would not impact hormone levels; correct?**
5 A. No. 'Cause I don't have testosterone in my
6 body. My testicles has already been removed, so
7 vulvoplasty wouldn't affect that because it's already
8 been affected.
**9 Q. So what's your understanding, then, of**
**10 whether you would want to continue on hormones post**
**11 vulvoplasty?**
12 A. I want to -- to continue at a decreased level
13 of hormones, which I'm trying to do currently, but I
14 can't get to the doctor.
**15 Q. And you can -- you can decrease your hormone**
**16 levels without a vulvoplasty?**
17 A. You don't have to be on hormones ever again
18 if you don't want to if -- after you have
19 testosterone -- after you have your testicles removed
20 and have a orchiectomy. That's a choice.
**21 Q. Okay.**
22 A. Some people do; some people don't.
**23 Q. Right. So, then, is your decision to -- to**
**24 either stay on hormones or change your hormones level,**
**25 is that contingent at all on the vulvoplasty?**

1 A. No. Hormones and vulvoplasty are two
2 different things. My hormone I want to stay on them
3 for still the -- the breast tissue, the softening of
4 the skin, you know, to have the effects that it does.
5 My vulvoplasty is to relieve me of my
6 gender -- alleviate my gender dysphoria for me to feel
7 better because I won't have that primary sex
8 characteristic no more.
**9 Q. And that's the penis that you're referring**
**10 to?**
11 A. Yes. I prefer to call it a phallus.
**12 Q. A what?**
13 A. A phallus.
**14 Q. A phallus. Okay.**
**15 The research that you reviewed and discussed**
**16 with Dula and Dr. Hahn, what's your understanding of**
**17 what that medical research says about the potential for**
**18 a vulvoplasty to alleviate the mental distress that may**
**19 be associated with gender dysphoria?**
20 A. After -- when we did research based off of
21 numerous associations like the Psychiatric Association,
22 Sociology Association -- I mean, not sociology --
23 Psychologist Association, the WPATH, the American
24 Medical Associations, that according to them, it
25 alleviates gender dysphoria for trans females.

1 **Q. Had you been aware of that research in**
2 **general before you did the research with Hahn and Dula?**
3 A. Yes. I did it myself as well before I came
4 to prison.
5 **Q. Oh, you did?**
6 A. Uh-huh.
7 **Q. Tell me about how did you that research**
8 **before you came to prison.**
9 A. I talked about it in my therapy sessions at
10 UNC. I did it over the phone, like, look it up on
11 Google and different transgender sites. Look at videos
12 of numerous of trans females on YouTube that documented
13 their recoveries and their transition post. Different
14 ways.
15 **Q. So you discussed your hopes that the**
16 **vulvoplasty would alleviate your gender dysphoria with**
17 **folks at UNC psychiatry?**
18 A. I had spoke to them about it, yes.
19 **Q. Okay.**
20 A. And I don't think I actually would say
21 "vulvoplasty." It was gender-affirming surgery that I
22 would say anything. I don't think I said
23 "vulvoplasty." It's like gender-affirming surgery.
24 **Q. And what's your understanding of what that**
25 **means, gender-affirming surgeries?**

1 A. It affirms your gender.
2 Q. Right. Does that -- well, okay. What
3 procedures are included in that category?
4 A. It all depends on the person's transition.
5 Q. Okay. Would -- would all the surgeries you
6 -- that we already discussed qualify as
7 gender-affirming surgeries?
8 A. Rephrase.
9 Q. Okay. I'll just do one at time. The breast
10 augmentation, is that gender-affirming surgery?
11 A. That's -- yes.
12 Q. Okay. What about the earlobe surgery?
13 A. Yes.
14 Q. The facial feminization surgery?
15 A. Yes.
16 Q. The -- the Brazilian butt lift? I can't
17 remember the name.
18 A. Yes.
19 Q. Okay. What about some of the surgeries
20 you -- procedures you haven't had done, the liposuction
21 of the abdomen?
22 A. Yes.
23 Q. That would be gender-affirming surgery?
24 A. Yes.
25 Q. Are there other surgical interventions that

1 you are aware of that you would consider
2 gender-affirming surgery?
3 A. I think it all depends on the person that's
4 transition, what they consider is gender-affirming
5 surgery to them.
6 Q. And so when you were conducting this
7 research, then, before you came into prison, so
8 pre-October 2017, when you were looking into research
9 about how effective surgery would be for improving
10 gender dysphoria, that research was not specifically
11 focused on vulvoplasty?
12 A. I don't remember.
13 Q. Okay. It was more broadly focused on
14 gender-affirming surgeries categorically?
15 A. Yes.
16 Q. To include the various types of surgeries we
17 discussed?
18 A. Yes.
19 Q. So you don't have -- do you have any specific
20 recollection of reviewing on your own before you came
21 into prison any medical literature regarding the
22 effectiveness of vulvoplasty or vaginoplasty in
23 alleviating gender dysphoria?
24 A. Vaginoplasty.
25 Q. Vaginoplasty?

1 A. Yes.
2 **Q. You do recall --**
3 A. Uh-huh.
4 **Q. -- reviewing studies that discussed the**
5 **effectiveness of vaginoplasty in alleviating symptoms**
6 **of gender dysphoria?**
7 A. Yes.
8 **Q. Do you remember what those studies said?**
9 A. That it allieves gender dysphoria.
10 **Q. Completely alleviates or improves?**
11 A. I don't believe -- I don't even believe I
12 would be completely alleviated, so I don't say -- I
13 would not say that it said it would be completely
14 alleviated, because I wouldn't be completely
15 alleviated.
16 **Q. That's the 95 versus the 100; right?**
17 A. Yes.
18 **Q. So then -- okay. And that was literature you**
19 **reviewed before coming to prison?**
20 A. Yes.
21 **Q. And what about the literature that you**
22 **reviewed with Dr. Hahn and Jennifer Dula? Do you**
23 **remember discussing or seeing any literature that**
24 **specifically dealt with the effectiveness of**
25 **vulvoplasty or vaginoplasty in alleviating gender**

1 **dysphoria?**
2 A. Vulvoplasty because that was totally what we
3 was researching.
4 **Q. Okay. So pre-incarceration you recall seeing**
5 **studies that discussed the effectiveness of**
6 **vaginoplasty in alleviating gender dysphoria.**
7 **Post-incarceration, Dr. Hahn and Jennifer Dula and you**
8 **recall seeing studies that discussed the effectiveness**
9 **of vulvoplasty in alleviating gender dysphoria. Is**
10 **that your testimony?**
11 A. Yes.
12 **Q. All right. Beyond -- would you -- would you**
13 **seek out a vaginoplasty after you had a vulvoplasty?**
14 A. I don't have that desire.
15 **Q. Okay. So vaginoplasty is off the table?**
16 A. Yes.
17 **Q. Beyond vaginoplasty, are there any other**
18 **surgical procedures that you would anticipate**
19 **undergoing, irrespective of your being incarcerated?**
20 **If you were out in the free world, what other surgical**
21 **procedures would you pursue?**
22 A. If I was home, I will definitely start with
23 veneers. I will get liposuction. I will possibly
24 consider having a rib removed. And I will contour my
25 waistline.

**1 Q. Okay. Veneers, is that for teeth?**
2 A. Yes.
**3 Q. And why would you pursue veneers?**
4 A. 'Cause it would give me more of a feminine
5 smile when I smile.
**6 Q. And how would that -- how would you**
**7 anticipate that would improve your -- what affect do**
**8 you think that would have on your well-being?**
9 A. It helps a lot because it will make me feel
10 more satisfying. It will satisfy my look that I'm
11 achieving -- trying to achieve.
**12 Q. And is -- is the look that you're trying to**
**13 achieve, is that the -- does that impact your**
**14 dysphoria?**
15 A. I feel that veneers wouldn't impact my
16 dysphoria. It's not something that will help alleviate
17 it or increase it. So, no, that is just a -- an answer
18 to your question like what things I would pursue if I
19 was out of prison.
**20 Q. Right. But the -- the look, trying to**
**21 achieve a particular look, is -- is not looking a**
**22 certain way, does that affect your dysphoria?**
23 A. The look that I have currently has alleviated
24 my dysphoria with look wise.
**25 Q. Okay.**

1 A. I don't seek no other surgery to enhance my
2 look --
**3 Q. Okay.**
4 A. -- for dysphoria.
**5 Q. For dysphoria?**
6 A. Yes.
**7 Q. Okay. So, then, what -- does that include**
**8 the vulvoplasty?**
9 A. That -- that has to do with my facial look.
10 My vulvoplasty definitely has to be done because it
11 will alleviate my gender dysphoria by removing my
12 primary sex characteristics.
**13 Q. Okay. Okay. So what -- what drives your**
**14 dysphoria? What do you think fuels your feelings of**
**15 dissatisfaction?**
16 A. Not -- my sex not being aligned with the
17 woman that I am. That I'm still dealing with the sex
18 at birth.
**19 Q. And so what things have helped you align that**
**20 look?**
21 A. My medical transitions.
**22 Q. And so changing the way that you look,**
**23 whether it be through the breast augmentation or the**
**24 vulvoplasty, that has helped your dysphoria because**
**25 it's moved you closer to the way you want to look?**

1 A. Yes.
2 **Q. Okay. And the same thing with the Brazilian**
3 **butt lift, the narrower hips and -- and whatnot, those**
4 **improvements in your -- in your look, from your**
5 **perspective, have improved your dysphoria?**
6 A. Yes.
7 **Q. But veneers, that's not a -- would that be a**
8 **gender-affirming procedure?**
9 A. No.
10 **Q. And why would that not be?**
11 A. It's just for me to have a different smile,
12 for me to feel more -- like, more happier with myself.
13 Make me feel more feminine with myself. Like, it makes
14 me -- if I smile, I just know I have pretty teeth.
15 **Q. And -- and having a more feminine smile, that**
16 **would -- would that be helpful for your dysphoria?**
17 A. I am satisfied with my look as being a female
18 that I am as far as my dysphoria.
19 **Q. Your facial look?**
20 A. Yes.
21 **Q. So we said veneers. You mentioned**
22 **liposuction as an additional surgical procedure?**
23 A. Yes.
24 **Q. Where would you have liposuction performed?**
25 A. I would perform it on my stomach, my back,

1 and my bra line -- I mean, my bra roll area in the
2 back.
**3 Q. And what would be the purpose of that**
**4 procedure?**
5 A. To narrow my mid-section.
**6 Q. And to what end? Why -- why do you want to**
**7 narrow your mid-section?**
8 A. So I can have more of an hourglass look.
**9 Q. And is -- is that in an effort to ease your**
**10 dysphoria?**
11 A. Very much so.
**12 Q. Okay. So the lack of an hourglass look in**
**13 your mind contributes to your dysphoria?**
14 A. It's my -- part of my transition, yes.
**15 Q. In the same way that the -- the desire for a**
**16 larger butt was part of your transition and improving**
**17 your look to match more what you envision?**
18 A. Yes.
**19 Q. And so, then, the liposuction would be**
**20 gender-affirming care?**
21 A. To me, yes.
**22 Q. And you mentioned a rib -- removal of a rib?**
23 A. Uh-huh.
**24 Q. What -- I've never heard of that, so can you**
**25 tell me a little bit about --**

1 A. That's very common for trans females to have
2 a rib removed to have a smaller waistline.
**3 Q. Okay. So there's an aesthetic result for**
**4 that too?**
5 A. Yes.
**6 Q. Okay. And why would you -- you would do it**
**7 for a smaller waistline?**
8 A. Yes.
**9 Q. And why is a smaller waistline important to**
**10 you?**
11 A. Also a more enhanced, feminine look.
**12 Q. And a more enhanced, feminine look --**
**13 feminine look is a goal of yours because if you -- if**
**14 you look more like how you want to look as a woman, it**
**15 eases your dysphoria?**
16 A. Yes.
**17 Q. And were there any other -- the -- the**
**18 liposuction, the ribs, and the veneers, were those the**
**19 only additional surgical procedures you would**
**20 undertake?**
21 A. That's it.
**22 Q. Okay. What about nonsurgical treatments or**
**23 procedures? In the free world, if you had your choice**
**24 to pursue, what would -- what would those be?**
25 A. A decrease in hormones.

1 Q. Do you not have the ability to take less
2 hormones?
3 A. Evidently, I don't here in prison because
4 it's not happening.
5 Q. Okay. So a desire to decrease the amount of
6 hormones you're taking?
7 A. Yes.
8 Q. How many hormones do you take? Just one or
9 two?
10 A. I take them -- hormones every 14 days, 0.5 ML
11 every 14 days, which equate to about 20 ML a month.
12 Q. Is it one -- one -- one medication, though?
13 A. Yes, just one.
14 Q. Just estradiol?
15 A. Uh-huh.
16 Q. And so you want to take less of that, or you
17 want to stop taking it?
18 A. No, I would prefer to take less.
19 Q. Take less. Okay. And have you told your
20 providers in DPS that you want to take less estradiol?
21 A. I total of five times since August.
22 Q. Okay. And their response to you was what?
23 A. I have not got to the endocrinologist when I
24 suppose to have gotten to him in November, and it's
25 January, and I still haven't made it there yet.

**1 Q. Okay. So nobody has told you that you can't**
**2 take less?**
3 A. It was denied to go to the endocrinologist.
4 You are disapproved it.
**5 Q. Right. To go -- to go visit with the**
**6 endocrinologists?**
7 A. Yes.
**8 Q. But no one has denied your request to take**
**9 less hormones, have they?**
10 A. They did deny. That was my whole reason of
11 going to the endocrinologist to get less hormones, and
12 they denied it.
**13 Q. Okay. So they said that they're not sending**
**14 you on a trip to go see Dr. --**
15 A. Amos was the person who said it.
16 MS. MAFFETORE: Let him finish his question.
17 THE WITNESS: Okay.
18 BY MR. RODRIGUEZ:
**19 Q. All right. So less hormones. You want to**
**20 take less hormones. What other nonsurgical procedures**
**21 would you want to pursue?**
22 A. None.
**23 Q. What about laser hair removal?**
24 A. Yes.
**25 Q. Okay.**

1 A. But that's a surgical procedure.

**2 Q. Is it? Okay.**

3 A. It was denied in here.

**4 Q. Okay. So that is a surgical -- you would**

**5 consider that to be a --**

6 A. Yes.

**7 Q. Okay. So tell me about laser hair removal.**

8 A. I started it in Corpus Christi, Texas. And

9 when I came to prison, part of my hair on this side and

10 this side started to come back.

**11 Q. And how did -- how does the presence of hair**

**12 on your face affect you?**

13 A. Because a female don't have hair on their

14 face.

**15 Q. Okay. All right. So you -- so you'd done**

**16 laser hair removal in the past. And the purpose of**

**17 that, I presume, was to remove the hair; right?**

18 A. Yes.

**19 Q. And why -- and you wanted to remove the hair**

**20 because, as you said, females don't have hair on their**

**21 face. And so was that an effort to make your**

**22 appearance align more closely with what you envision a**

**23 female to look like?**

24 A. Yes.

**25 Q. And is that an effort -- does that alleviate**

1 your dysphoria?
2 A. Yes.
3 Q. Okay. So you would -- you would continue, or
4 you would pursue additional laser hair removal?
5 A. Yes.
6 Q. And -- and just of the facial area?
7 A. Yes.
8 Q. And have you discussed with anybody the
9 effectiveness of laser hair removal alleviating
10 symptoms of gender dysphoria? Not removing the hair.
11 Let's assume that it's 100 percent effective at
12 removing the hair, but have you discussed with anyone
13 of the likelihood that your gender dysphoria symptoms
14 would be substantially lessened if you had laser hair
15 removal?
16 A. Yes.
17 Q. Who did you discuss that with?
18 A. The facility TARC here at Anson, Ms. Dula,
19 Dr. Bowman, Ms. Foster, and Dr. Housen (phonetic).
20 Q. And what is your understanding of whether
21 laser hair removal would lessen your symptoms of gender
22 dysphoria?
23 A. You don't have to shave every day to be
24 reminded that you were assigned a male at birth. It's
25 gone; you don't have to worry about it.

1 Q. Are you aware of any medical literature
2 addressing the effectiveness of laser hair removal in
3 alleviating the emotional symptoms of gender dysphoria?
4 A. Yes.
5 Q. What does that literature say?
6 A. That it helps alleviate gender dysphoria in
7 trans women. It was given to me by UNC
8 endocrinologist.
9 Q. Okay. So beyond the laser hair removal,
10 which is a -- you would put that in the surgical
11 bucket; right? So beyond the laser hair removal and
12 then the -- the rib and the veneers and the
13 liposuction, any other surgical -- what you would
14 consider to be surgical interventions that you would
15 pursue?
16 A. No.
17 Q. So if you had all -- okay. And then any
18 other nonsurgical interventions?
19 A. No.
20 Q. So if you had all of these interventions that
21 we've discussed, the vulvoplasty, the ribs, the
22 veneer -- or the rib, the veneers, the liposuction, the
23 laser hair removal, what would your -- what would you
24 anticipate your level of contentment to be on a scale
25 of 1 to 100?

1 knowing the name?

**2 Q. Knowing the name.**

3 A. Knowing the name. Once I understood what I

4 was going through, and it was gender dysphoria, 2010.

**5 Q. 2010?**

6 A. Uh-huh.

**7 Q. Okay. And what were you -- what were you**

**8 going through? What was -- describe to me in 2010 when**

**9 you were feeling things that you didn't really have the**

**10 ability to put a name to, what were those things you**

**11 were feeling?**

12 A. I was feeling a difference between my

13 assigned sex at birth to how I was feeling, and the

14 things that I was doing to make me align to my feminine

15 look like makeup and hair and dressing as a female.

16 I was often confused about the difference

17 between being gay and drag queen and transvestites,

18 transsexuals. I was -- I just didn't have the clarity

19 to understand what I was going through.

**20 Q. And so you gained that clarity in 2010?**

21 A. Yes.

**22 Q. And how did that come about?**

23 A. Therapy.

**24 Q. Okay. And that was therapy that you pursued**

**25 through UNC for purposes of transitioning?**

1 A. Yes.
**2 Q. Before you started therapy in 2010, then,**
**3 were you -- describe the kind of distress that you felt**
**4 by feeling this misalignment.**
5 A. I feel like I just told you that, but ...
**6 Q. Okay. I'll ask some different questions,**
**7 then.**
8 A. Yes.
**9 Q. So we walked through your employment**
**10 history --**
11 A. Yes.
**12 Q. -- right? And your educational history.**
13 A. Uh-huh.
**14 Q. On a Tuesday when it was time to get up and**
**15 go to work, how did you feel in relation to having to**
**16 go about your daily activities and responsibilities?**
**17 How did the -- what you later learned to be gender**
**18 dysphoria, how did that impact your life?**
19 A. It impact it because I had to put pads on to
20 make my -- have a butt, hips. I had to put silicone --
21 fake silicone boobs on to fill my bra. I had to make
22 sure that my makeup looked a certain way to have a
23 presentation of a female. That's very stressful.
**24 Q. Okay. Did you have trouble sleeping?**
25 A. No.

**1 Q. When you say it's "stressful," was it -- was**
**2 it stressful in the sense that you felt like you had to**
**3 do all of these things like you mentioned, the pads and**
**4 the bras and the makeup and hair, in order to appear**
**5 more feminine? Was that the stress that you were**
**6 feeling?**
7 A. It's the stress of me not understanding what
8 gender dysphoria was, and just gender dysphoria gives
9 you stress and anxiety of having to live your life as
10 the person you was born compared to the person you're
11 trying to align yourself to be. It causes like stress
12 and anxiety.
**13 Q. When you were employed, when you would show**
**14 up to work, did you -- did you show up to work with the**
**15 hair and the makeup the way you wanted it to look to**
**16 present the way you wanted to present?**
17 A. To a certain degree, because I was still --
18 at the beginning, still having the name of Kevin
19 Chestnut. So to a certain degree, I -- I would appear
20 feminine, but I appeared myself as more feminine queer
21 than I did as a transgender woman.
**22 Q. Okay. And did you feel like you were limited**
**23 in your ability to present how you wanted to present?**
24 A. I was -- yes. I felt very limited, yes.
**25 Q. By what?**


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1 A. I felt limited what I could do and how I can
2 do it, because I didn't know how to deal or how to
3 attack gender dysphoria because I didn't know what it
4 was yet.
**5 Q. Okay. So were you -- were you doing the hair**
**6 and the makeup and the pads and all that stuff before**
**7 you put a name to gender dysphoria?**
8 A. Yes.
**9 Q. And when you were able to express yourself or**
**10 present the way that you wanted to present without a**
**11 limitation, how did you feel? Did you feel sad about**
**12 that?**
13 A. Sad about putting the pads and stuff on?
**14 Q. Right.**
15 A. It made me feel better in the moment. It
16 made me feel in the moment, like, good for the moment,
17 but still knowing that, you know, I'm not who I think
18 I -- mentally know I am. I know I'm not who I am. Or
19 if I have to take my clothes off or have to wear
20 certain things, you know, it does trigger, like, the
21 distress and everything, more anxiety.
**22 Q. So when -- describe how you -- how you felt**
**23 when you felt anxious, when it would trigger the kind**
**24 of anxiety you just mentioned.**
25 A. Sweat.

1 Q. You would sweat?
2 A. Yes.
3 Q. Did you have trouble sleeping?
4 A. No.
5 Q. Did you have panic attacks?
6 A. I am known to have a few panic attacks, yes.
7 Q. Did you have any periods of depression?
8 A. If I did, I didn't know how to identify it.
9 Q. Were there any periods of time where you
10 couldn't go to work, couldn't get out of bed because
11 you were so upset over having this sort of incongruence
12 between the way you wanted to be and how you felt you
13 were?
14 A. No.
15 Q. Did you ever take any -- before being
16 incarcerated, any medication for anxiety or depression?
17 A. No.
18 Q. Did you ever feel sad about feeling the way
19 you felt?
20 A. No.
21 Q. So, then, on a -- on a scale of 0 to -- 0 to
22 10 or 0 to 100, whichever you would prefer, then, say
23 in the 12 months before your incarceration, how would
24 you rate your general level of stress, not specific to
25 gender dysphoria, just in general?

1 A. I would rate it pretty high because I had a
2 pending court case.
**3 Q. Okay. Let's back up, then, to a period of**
**4 time where you didn't have any criminal issues. How**
**5 would you rate your general level of distress?**
6 A. I didn't have any.
**7 Q. Okay. So was life pretty good, then --**
8 A. Yes.
**9 Q. -- before you had your criminal issues?**
10 A. Yes.
**11 Q. And what -- how was it -- what were you --**
**12 what's your offense for that you're currently**
**13 incarcerated on?**
14 A. Insurance fraud. Obtaining property by false
15 pretenses.
**16 Q. Okay. How was the insurance fraud**
**17 perpetrated? Were you the policyholder?**
18 A. Yes, I was.
**19 Q. Okay. What insurance company was that?**
20 A. Travelers and Nationwide.
**21 Q. What kind of insurance was it?**
22 A. It was an auto insurance.
**23 Q. Okay. Did you have to pay restitution?**
24 A. $20,000.
**25 Q. Did you pay it?**

1 A. Not all of it. It's not paid.

**2 Q. How much -- what were the total proceeds from**

**3 the fraud?**

4 A. $20,022 and, like, 20-cent or something like

5 that.

**6 Q. What did you use the money for?**

7 A. Different things.

**8 Q. Did you use the money to pay for any of the**

**9 surgeries?**

10 A. I did not.

**11 Q. You did not?**

12 A. No.

**13 Q. Did you ever tell anybody you did?**

14 A. No. I have not told, no.

**15 Q. Sorry. I got sidetracked.**

**16 Okay. So before your incarceration, before**

**17 your pending criminal charges, low level of stress.**

18 A. Yes.

**19 Q. What about anxiety? Again, not associated**

**20 with your criminal matter.**

21 A. No. No.

**22 Q. What about just feeling sad or depressed?**

23 A. During the period of 2011 when my mother

24 died, and the period of 2012 when my grandfather died.

**25 Q. You felt sad in the loss of those close**

1 family members?
2 A. Yes.
3 Q. Any other issues -- again, setting aside the
4 pending criminal matters, before that cropped up, any
5 other issues in your life that caused you sadness,
6 anxiety, or depression, or just stress in general?
7 A. No.
8 Q. Would you say that -- how would you say your
9 dysphoria at that point in time -- so this would have
10 been after you figured out what, you know, had a name
11 for it, how would you say that that -- your dysphoria
12 was impacting your well-being at that time?
13 A. My dysphoria was impacted because I
14 haven't -- I wasn't working on any kind of plan to
15 alleviate it; so it was impacting it.
16 Q. Okay. So your first surgery, I think, was
17 2012; right?
18 A. Uh-huh.
19 Q. And so on a scale of 1 to 100, or 1 to 10,
20 whichever you would prefer, how would you rate your
21 level of dysphoria before -- you know, before the
22 criminal stuff started cropping up?
23 A. Prior to any surgeries?
24 Q. No. This is right before you get wrapped up
25 in the criminal stuff and come into custody.

1 A. Oh, so in 2017?
2 **Q. Uh-huh. After you've had surgery.**
3 A. My orchiectomy. So it was about a 12. I
4 would say about a 12. And then when I went down, it
5 went down to the 10.
6 **Q. Okay. And that was your level of**
7 **contentment --**
8 A. Yeah.
9 **Q. -- right? So that was how good you were**
10 **feeling?**
11 A. Uh-huh.
12 **Q. And so then how bad were you feeling at that**
13 **same time?**
14 A. I would have to filter the two, because I
15 felt the bad for my gender dysphoria, then I felt the
16 bad because I was coming to prison.
17 **Q. Right. Right. Which is why I'm trying to**
18 **parse out the -- you know, as much as you can unrelated**
19 **to the criminal matters.**
20 **We -- you said that you didn't have any**
21 **anxiety, any distress, or depression, you know, in the**
22 **period of time before your criminal stuff pops up.**
23 A. Right.
24 **Q. So during that period of time, say, perhaps**
25 **2012 to -- when did the criminal stuff start to crop**

**1 up?**

2 A. It happened in 2012. October 2012.

**3 Q. Oh, okay. So you had the -- those charges**

**4 that you were incarcerated in 2017 were from 2012?**

5 A. It took five years for me to get to court.

**6 Q. Okay. All right. Well, then, it's pretty**

**7 hard to parse that out, then, isn't it?**

8 A. Yes.

**9 Q. So then tell me in general, then, about your**

**10 level of stress -- we can go year by year if you'd**

**11 like -- your level of stress, anxiety, and depression**

**12 in that period of time.**

13 A. I don't remember.

**14 Q. Okay. Now, outside of prison, before you**

**15 came to prison, did you ever have any instances of**

**16 feeling like you had loads of energy?**

17 A. Oh, yeah.

**18 Q. Yeah?**

19 A. Uh-huh.

**20 Q. Tell me about that.**

21 A. I'm always a happy person. I always have

22 loads of energy. Like, I'm -- I'm never -- I'm not a

23 sad person. I'm not a -- I'm a very happy spirit

24 person.

**25 Q. Did you have any experiences with transphobia**

1 **before coming to prison?**
2 A. No.
3 **Q. No?**
4 A. Definitely not.
5 **Q. When you would, I don't know, go out to the**
6 **grocery store, you never encountered what you felt like**
7 **was people being transphobic or anything like that?**
8 A. Like people being transphobic towards me, or
9 me being transphobic towards people?
10 **Q. No, no, no, no. People being transphobic**
11 **towards you?**
12 A. I mean, yeah. That's just everyday life.
13 **Q. Right.**
14 A. I mean, but if it was, I didn't know anything
15 about it. Nobody has never approached me about it.
16 Like, nobody has ever say, hey, this, this, and that.
17 I lived a very -- my life prior to prison was -- I
18 lived as being almost like a staff transgender woman.
19 Like, I didn't -- I didn't use the label as
20 transgender. I used woman with everything that I did.
21 **Q. Okay. And so you -- did you encounter -- you**
22 **didn't encounter much misgendering then?**
23 A. No.
24 **Q. Okay.**
25 A. I don't think that's a -- if it -- I didn't

1 -- if it happens in the world to people, I mean, it's
2 probably, as people will call it, clockable people. I
3 just don't feel I live my life as a clockable trans
4 person.
**5 Q. So, then, in your daily sort of life before**
**6 prison, you don't recall having many episodes where,**
**7 you know, you came home from a social interaction and**
**8 feeling kind of down on yourself because of that**
**9 interaction, feeling like maybe that person was**
**10 transphobic or misgendered you or anything like that?**
11 A. No.
**12 Q. Before you came to prison in October of 2017,**
**13 had you ever tried to harm yourself?**
14 A. I had multiple incidents of not, like,
15 suicidal, but like trying to harm myself from when I
16 was younger [redacted]
17 [redacted], where I had thoughts of just
18 being harm -- like harming myself. But I only have one
19 incidence where I wanted to commit suicide.
**20 Q. So -- so when you were younger, you -- you**
**21 said you tried to harm yourself?**
22 A. Yes.
**23 Q. Can you tell me a little bit about that? Was**
**24 it cutting?**
25 A. No. I ran in front of a car.

1 Q. You ran in front of a car?
2 A. Yes.
3 Q. How old were you?
4 A. Maybe 13, 14.
5 Q. Was that the -- the suicide attempt you were
6 talking about?
7 A. Yes.
8 Q. Any other history of self-harm?
9 A. No.
10 Q. What about ideation, thinking about harming
11 yourself before -- before prison?
12 A. Oh, no.
13 Q. Are you aware of any family history of
14 suicide attempts?
15 A. My mother.
16 Q. She tried to kill herself?
17 A. Once she found out she had breast cancer, she
18 tried to jump off a bridge.
19 Q. Did she actually jump?
20 A. I think they prevented her from jumping.
21 Q. Okay. So since coming to prison in October
22 of 2017, have you had any difficulty sleeping?
23 A. Not sleeping.
24 Q. Now, describe to me -- I'm going to have to
25 break this up so it's maybe easier for me. Describe

**1 what types of things cause you distress in prison. Not**
**2 specific to your gender. You can include your gender**
**3 dysphoria, but give me some examples of things that**
**4 cause you distress in prison.**
5 A. Misgendering -- misgendering me, using
6 incorrect pronouns, people just not getting trans
7 people and the care that it needs. And not being able
8 to be as sociably accepted as, like, the next female is
9 more socially effected. Like, that's a big deal.
**10 Q. Okay. All -- all of those things sound like**
**11 they're related to your gender dysphoria.**
12 A. Those are my only issues in prison.
**13 Q. Okay. You don't have any other -- nothing**
**14 else about being in prison causes you distress?**
15 A. No. I do what I'm supposed to do. I go to
16 school, take classes. I work. I just -- no. It's
17 just everything has something surrounding around my
18 dysphoria or me identifying as trans.
**19 Q. Other aspects of the incarcerated environment**
**20 don't cause you distress?**
21 A. I mean, it's stressful to be in prison, but
22 no.
**23 Q. What about anxiety? What sort of things**
**24 cause you anxiety in prison?**
25 A. Things that can cause me anxiety in prison is

1 to just when people just don't get it. Like, that's,
2 like, the biggest thing is just people not
3 understanding.
**4 Q. And "people," are you referring to -- who are**
**5 you referring to when you say "people"?**
6 A. Staff, doctors, lawyers, inmates, everybody.
**7 Q. And that causes you anxiety --**
8 A. Yes.
**9 Q. -- when they don't get it?**
**10 Now, on a scale of 0 to 100 or 0 to 10, how**
**11 would you rate the level of distress that you feel**
**12 around those various issues that you discussed?**
13 A. I would say two years ago it was higher,
14 maybe 20. Now I will say 5.
**15 Q. Out of 100?**
16 A. Yes.
**17 Q. So two years ago meaning before you came to**
**18 Anson?**
19 A. No. I've been in Anson almost four years.
**20 Q. Oh, yeah. My mistake. So what happened two**
**21 years ago?**
22 A. Two years ago -- like, for the first two
23 years in Anson, things was just -- I think people was
24 trying to acclimate with me. I was trying to acclimate
25 with them. They was trying to understand, trying to

1 get it, trying not to get it. I don't know. It was
2 just a -- a very crazy world two years ago.
3 From '19 till the end of '20, it was just a
4 very -- from August 2019 to December 2020, it was a
5 very weird time here. But after that, it's just --
6 it's been -- I guess people understand, you know, I'm
7 here now.
**8 Q. Right. So like a little -- some adjusting --**
9 A. A lot of adjustment had to happen, yes.
**10 Q. And after that adjustment and those growing**
**11 pains, you feel like your level of distress has**
**12 improved significantly?**
13 A. Anxiety has.
**14 Q. Anxiety. Excuse me. Anxiety.**
15 A. Yes.
**16 Q. Okay. So that was the anxiety that you rated**
**17 at 20 a couple years back and then now down to 5?**
18 A. Yes.
**19 Q. What about your level of distress?**
20 A. I feel like my distress level stays the same
21 because my distress is just totally focused on my
22 dysphoria.
**23 Q. Okay. And where would you rate that?**
24 A. Off the charts, but, like, really high, like
25 75, 80 probably or higher.

**1 Q. And would you say that that's been consistent**
**2 your entire incarceration?**
3 A. It -- I would say at the beginning, it was
4 75, 80. When I thought I had some kind of
5 understanding mid-2021, it kind of went down a little
6 bit. And now with this current situation with my
7 dysphoria litigation, everything is back to the roof
8 again.
**9 Q. And -- and what is it in particular that you**
**10 think, if you can pinpoint, is causing this**
**11 dysphoria -- causing the distress to be that high?**
12 A. DPS not getting it. They don't -- they're
13 just -- they're just not willing to understand.
**14 Q. Does it have -- how much of that is tied up**
**15 with the decision on the vulvoplasty?**
16 A. One -- 96 percent of it.
**17 Q. Ninety-six percent. So, in your mind, if**
**18 the -- your belief is that the -- the vulvoplasty**
**19 would -- what would your level of distress be after**
**20 that in prison?**
21 A. Minus the trying to get adequate mental
22 health care, probably back -- probably just normal with
23 everyday distress with life, maybe 5.
**24 Q. What happens in prison if you receive a**
**25 vulvoplasty, and you are still -- your distress level's**

1 **still at a 50?**
2 MS. MAFFETORE: Object to the form. Calls
3 for speculation.
4 BY MR. RODRIGUEZ:
5 **Q. You can answer.**
6 A. I don't know what -- I can't predict the
7 future.
8 **Q. When -- what about your -- I know you**
9 **described yourself as a happy person, but do you**
10 **sometimes get sad?**
11 A. I get sad, but not often. Like, maybe -- it
12 all depends on what's going on. Like being in prison
13 makes you, like, sad because you can't be around your
14 family, but being sad when it comes around to the
15 things that I have going on with my life, I get sad.
16 But I get more emotionally, like, torn --
17 like, it's -- it's more emotionally than just, oh, I
18 just feel sad today. It's just more like -- it's --
19 it's a lot of anguish in my mind like how I feel. It
20 makes me feel like I just -- I don't know. I can't
21 even explain it. I don't know how to put words to it.
22 **Q. And how -- how about the distress? If the**
23 **distress is -- is running high, how does that affect**
24 **you day-to-day?**
25 A. I don't allow it to affect my day-to-day.

1 Those I just try to use tactics that make me feel
2 better.
**3 Q. Like what?**
4 A. Meditation, journaling, calling people on the
5 phone.
**6 Q. Do those things help?**
7 A. Somewhat, yes.
**8 Q. Okay. So after coming to prison, you -- you**
**9 mentioned before when you were on the outside that you**
**10 didn't encounter much transphobia; right? Tell me**
**11 about your encountering transphobia inside of prison,**
**12 specifically in the men's prisons first before you came**
**13 to Anson.**
14 A. Men prison was bad because they -- they
15 target you. They make you feel like you're like prey
16 and food or, like, it makes you feel vulnerable.
**17 Q. The other inmates?**
18 A. Yeah. They are -- they are not a great crowd
19 to be around, yeah.
**20 Q. What about the staff?**
21 A. The staff is just as worse. They -- because
22 they are -- are -- and part of it I get because they do
23 work in a men's prison, so in their mind is that
24 everybody here is a guy. But the misgendering and the
25 incorrect pronouns and not giving the undergarments and

1 not understanding that you need hormones and not
2 understanding that you need this and that is -- it
3 wasn't a great two years.
**4 Q. Yeah. And -- and how did those episodes,**
**5 those types of scenarios, the misgendering, the pronoun**
**6 usage, how did those affect you day-to-day?**
7 A. I had a very rough time at the men's prison.
**8 Q. Did you feel that those types of encounters**
**9 in the men's prison increased your level of distress?**
10 A. It very much. It increased it a lot.
**11 Q. So if you were running at a 70, what would**
**12 you say -- what kind of a bump would you say you had on**
**13 the level of distress from being in a men's prison if**
**14 you were misgendered in the cafeteria or something?**
15 A. I cried almost daily at the men's prison; so
16 I was hurt a lot.
**17 Q. Were you ever physically or sexually**
**18 assaulted by any -- any inmates at the men's prisons?**
19 A. No, I wasn't.
**20 Q. What about any staff members?**
21 A. I wasn't assaulted by a staff member, but a
22 staff member had to resign because they felt like that
23 he was doing too much for me or something.
**24 Q. Okay. Undue influence or something? One of**
**25 those phrases.**


GENERAL CONFIDENTIAL INFORMATION

1 A. I guess. They gave me work paper and all
2 this other stuff.
**3 Q. No physical?**
4 A. No.
**5 Q. Did you feel that you were ever subject to**
**6 any retaliation by staff at the men's prisons?**
7 A. Very much so.
**8 Q. Describe some of that for me.**
9 A. I felt like I was retaliated against with the
10 undergarments, and it led to me getting infractions,
11 but they did it within policy. And I feel like all of
12 my -- I feel like all of my retaliation was done within
13 policy. Like it was done blatantly, but it was done --
14 but they found reason within policy to punish me for
15 it.
16 And when I attempted to try to wear female
17 garments, I was retaliating about it -- I mean, got --
18 and got punished for it. Every time I would ask for
19 things at medical, I would get kicked out of medical.
20 And I feel like they retaliated against it.
21 I feel like when I got the media involved,
22 things got worse as well. And I feel like when ACLU
23 got involved at the men's prison, things kind of got
24 worse again. I was placed in protective custody. Then
25 out of protective custody, I got sent out to a

1 different men's prison.

**2 Q. Now, how about the move to -- to Anson, to**

**3 the women's prison, has -- did you encounter any**

**4 transphobia?**

5 A. At the beginning, yes.

**6 Q. At the beginning?**

7 A. Yes.

**8 Q. What kind of scenarios?**

9 A. The misgendering, the incorrect pronouns, and

10 Miss Warden Richardson basically, I guess, put her foot

11 down, and it kind of died off a little bit. And they

12 went through some kind of cross-gender training or

13 whatever, and things started to get better.

**14 Q. Okay. What about from the female offenders?**

15 A. Oh, yeah, they was really on it. They had

16 articles and everything from printed off the internet

17 and all kinds of stuff about me.

**18 Q. In a good or a bad way?**

19 A. In a bad way.

**20 Q. In a bad way?**

21 A. Yep.

**22 Q. And that was more toward the beginning of**

**23 your --**

24 A. Yes.

**25 Q. Did you ever feel -- was there ever a period**

1 **of time where you felt like you -- perhaps being in a**
2 **women's facility was -- was more triggering?**
3 A. Yes, I did.
4 **Q. Describe some of that.**
5 A. I felt like it was more triggering because if
6 the women -- women are more hands on, women are more
7 emotional creatures, women are more family-oriented
8 than men are. They are more, you know, who in the
9 shower, let's take a shower. Like, they take showers.
10 You know, it's just things are a little bit more hands
11 on, more family orientated [sic] compared to the men's
12 prison.
13 It's kind of like you stay in your lane,
14 that's your only lane, nobody else get in your lane.
15 And I couldn't -- and I still to this day, I can't
16 really align with the -- some of the things that they
17 do because I do have that fear that they will see my
18 bottom half of my body.
19 **Q. Do some of your peers here know you still**
20 **have a phallus?**
21 A. They do because of articles, newspaper
22 articles.
23 **Q. Okay. Since -- since coming to prison in**
24 **2017, tell me a little bit about your -- your suicidal**
25 **ideation or self-harm attempts.**


GENERAL CONFIDENTIAL INFORMATION

1 A. The first one was in March of 2019. I took
2 an overdose of medication. Then after those times, on
3 numerous occasions, I told Dr. Hahn that I was going to
4 mutilate my phallus. Phallus, phallus, however you --
5 you say it different ways.
6 And then in I want to say it was either March
7 or April, but the beginning of 2011, I tied a band
8 around my phallus area. Dr. Hahn had to get it
9 removed.
10 In December of 2020, after I got into a
11 situation in here in Anson, I told Dr. Hahn that I just
12 feel -- I'd rather feel like I wasn't alive, and that I
13 was going to pull the skin off myself. And those are
14 the ones I remember.
**15 Q. What kind of pills did you try to overdose**
**16 with?**
17 A. Chloraphine [sic].
**18 Q. What's -- what's that prescribed for?**
19 A. It's allergy medications.
**20 Q. Was it your prescription?**
21 A. No, they sell them in the commissary.
**22 Q. They sell them at the commissary?**
23 A. Yes.
**24 Q. Since your incarceration, have you had any --**
**25 particularly at the beginning of your incarceration,**


GENERAL CONFIDENTIAL INFORMATION

1 **did you have any distress or anxiety or sadness related**
2 **to pending criminal charges?**
3 A. Yes, I did.
4 **Q. Did you have any distress or sadness,**
5 **anxiety, or negative emotions related to perhaps not**
6 **wanting extra attention from staff?**
7 A. Like, can you rephrase that one?
8 **Q. Yeah. Was there ever a time where you felt**
9 **like perhaps there was too much attention being paid to**
10 **you, that you just wanted to kind of blend in like**
11 **everybody else?**
12 A. Oh, I feel like that to this day.
13 **Q. And does that ever cause you any anxiety or**
14 **distress that you can't just be another person in the**
15 **prison?**
16 A. Yes.
17 **Q. How does that make you feel?**
18 A. Everybody knows your business. I can't be a
19 woman anymore. I have to be a trans female for the
20 rest of my life now. Like, I just can't go home to be
21 a female. I'm just always labeled as that trans female
22 or that trans gender female that DPS did this or
23 Kanautica Brown did this, or, like, there's -- I have
24 no more privacy anymore for the rest of my life.
25 There's no more privacy. My life is a book now to

1 Then, the second day the therapist came and
2 saw me, and Dr. Mann had made the decision that I was
3 not suicidal, and they transferred me on a Code Red
4 during COVID back to Anson.
**5 Q. So I want to -- I want to drill down a little**
**6 bit on the -- the report to Dr. Hahn about wanting to**
**7 rip the skin off of your phallus.**
**8 Were you upset when you made that comment to**
**9 Dr. Hahn about the altercation you had with the**
**10 offender and what she said to you?**
11 A. I was upset at myself for allowing someone to
12 get to me like that. And my thing was that this
13 phallus is causing me all kinds of distress. It's
14 messing with me emotionally. I just rip it off, I take
15 it off, it'll get me to the doctor so it would have to
16 be gone. That was my whole intention.
**17 Q. But -- but for the interaction with the**
**18 offender, do you believe you would have made that kind**
**19 of a comment to Dr. Hahn?**
20 A. I had been making those comments to Dr. Hahn
21 for a long time.
**22 Q. Before --**
23 A. Yes.
**24 Q. Before this?**
25 A. Yes.

1 **Q. You mentioned earlier that Dr. Hahn had to**
2 **get the band removed. This was an episode where you**
3 **put a rubber band around your phallus?**
4 A. Yes.
5 **Q. How many times did you do that?**
6 A. I have done it numerous but -- times, but the
7 time where staff actually knew and had to assist me to
8 get it off was once. Times I told them I was going to
9 do it and actually done it, and I took it off myself at
10 a later time, I would say three or four.
11 **Q. So you've -- so you've put a band around your**
12 **phallus three or four times where nobody else knew**
13 **about it?**
14 A. Right.
15 **Q. And only once where someone else knew about**
16 **it?**
17 A. Right.
18 **Q. And you -- did you need assistance to remove**
19 **the band?**
20 A. She just made sure it was there. She went to
21 the restroom with me to make sure that I took it off.
22 But I took it off myself.
23 **Q. She went with you to the restroom?**
24 A. Yeah, she was outside the door.
25 **Q. Okay. She wasn't inside the restroom with**

1 **you?**

2 A. No, no. It was a staff member, a nurse -- a

3 staff meaning officer, a nurse, and her.

4 **Q. What did you do with the rubber band?**

5 A. They took it, and I think they threw it away.

6 They put it in a red bag and threw it away.

7 **Q. And the -- the three to four incidences where**

8 **no one knew, when were those incidents in relation to**

9 **the one with Dr. Hahn?**

10 A. Either prior or after. Like instance

11 where -- like, in one instance, like, maybe a nurse

12 have told me or nurse practitioner have told me that I

13 wasn't going to get the care, DTARC had denied me, and

14 I act out my emotions. And I went to my room and just

15 felt like it was just better if I just take it off

16 myself since nobody else didn't want to do it.

17 **Q. When would have been the most recent time**

18 **that this happened?**

19 A. The last time was with Dr. Hahn.

20 **Q. The last time was with Dr. Hahn?**

21 A. Yeah.

22 **Q. So the most recent one was the one with**

23 **Dr. Hahn, and that was before the NCCIW inpatient?**

24 A. Yes.

25 **Q. Okay. So pre-December 2020?**


GENERAL CONFIDENTIAL INFORMATION

1 A. Yes.

**2 Q. So since December 2020, have you attempted**

**3 to -- have you put a rubber band on your phallus?**

4 A. No.

**5 Q. Have you made any other attempts at**

**6 self-harm?**

7 A. No.

**8 Q. All right. I think this is a good stopping**

**9 point for another short break, and then -- then we'll**

**10 be pretty close, I think.**

11 THE VIDEOGRAPHER: The time on the monitor is

12 2:30 p.m. We are off the record.

13 (Whereupon a short recess was taken.)

14 THE VIDEOGRAPHER: The time on the monitor is

15 2:43 p.m. We are back on the record.

16 MS. MAFFETORE: Before you resume your

17 questioning, I believe on break we realized that

18 Kanautica needed to clarify the timeline regarding the

19 incident that you were just discussing before the

20 break.

21 MR. RODRIGUEZ: All right.

22 MS. MAFFETORE: So did you want to clarify?

23 THE WITNESS: Yeah. The last time I spoke

24 with Dr. Hahn was April of 2021. That was about the

25 phallus area when they took the band off.

1 BY MR. RODRIGUEZ:
2 Q. Okay. So April 2021 was --
3 A. Yeah.
4 Q. -- the band that -- that Hahn knew about?
5 A. Yeah.
6 Q. And so the three to four incidents where she
7 didn't know or nobody knew about it, that was
8 beforehand?
9 A. Yeah, that was prior to then.
10 Q. Okay.
11 A. Yep.
12 Q. So since April 2021, any other episodes?
13 A. No.
14 Q. No other attempts to -- to harm yourself?
15 A. No.
16 Q. Thank you for clarifying that.
17 Okay. Let's see. I understand you have been
18 in communication with various -- and you mentioned some
19 of this earlier, like various advocacy groups?
20 A. Uh-huh.
21 Q. Can you tell me some about that? Aside from,
22 obviously, the ACLU, who else have you been in
23 communication with?
24 A. BYP100, Southerners Underground, The House of
25 Kanautica, Gender Benders, Trans Mission, Equality ENC.


GENERAL CONFIDENTIAL INFORMATION

1 I'm probably missing a slew of people. I talked to the
2 Southern Justice -- Southern Coalition for Social
3 Justice in Durham, the governor's office. That's all I
4 can remember right now.
**5 Q. And you said BYP?**
6 A. Yeah.
**7 Q. Do you know what that stands for?**
8 A. It's Black Young People.
**9 Q. And have you -- are you in regular**
**10 communication with any of these groups?**
11 A. Yes.
**12 Q. All of them or anyone in particular?**
13 A. All of them.
**14 Q. All of them? And what's the basis of your**
**15 communications with them?**
16 A. They just advocate and organize on behalf of
17 myself and trans people that's incarcerated, or any
18 LGBTQ-Plus people that's incarcerated.
**19 Q. And what -- what kind of sort of input do you**
**20 provide to them?**
21 A. I just update them things that's going on
22 with me. They just make sure that I'm updated with
23 things that's going on on the outside as far as trans
24 care, new laws. Things that's going on with trans
25 youth. They also advocate on my behalf if things are

1 not so right at the prison or not going right within
2 DPS.
**3 Q. Do you engage in advocacy efforts for people**
**4 other than yourself?**
5 A. No.
**6 Q. Do you feel any -- any pressure related to**
**7 your involvement with these organizations?**
8 A. Like, can you rephrase it?
**9 Q. Does it cause you any kind of stress or**
**10 pressure dealing with communicating with these**
**11 organizations?**
12 A. No.
**13 Q. Do you have any general suggestions as to how**
**14 perhaps life of transgender incarcerated people can be**
**15 improved?**
16 A. Yes, I have a lot of suggestions for that. I
17 would suggest that there be a better gender training
18 with understanding LGBTQ individuals. Understanding
19 trans people -- incarcerated trans people, emphasis on
20 incarcerated. The understanding of people pronouns and
21 their gender identification. Therapy surrounding trans
22 care or gender-affirming care or any type of care
23 around LGBTQ rights and organization advocacy, classes.
24 I would say that's about it.
**25 Q. What's been your motivation? Why have you**

**1 reached out to the media at various times during your**
**2 incarceration?**
3 A. It started out with DPS kept telling me
4 things that wasn't true.
**5 Q. And has the media attention, has that been a**
**6 source of stress for you?**
7 A. I'm not going to say it's a source of stress.
8 Here -- maybe like in the last year or so, having to
9 put myself back in the media has made things a little
10 bit kind of -- maybe a little stressful.
**11 Q. Have you felt compelled to do that?**
12 A. I felt that was my only way to advocate for
13 myself.
**14 Q. What about your -- your current release date?**
**15 What's your understanding of where that stands?**
16 A. November 2nd, 2024.
**17 Q. And what's your custody level?**
18 A. Medium.
**19 Q. Have you had a custody review recently?**
20 A. I did have one in December, but it was denied
21 because I had those three infractions from the men's
22 prison. I have been told that I should have another
23 custody review on February the 3rd.
**24 Q. Have you had any clarity about the**
**25 infractions? Are they going to be adjusted at all?**

1 A. No. They said that they're there, and they
2 have to stay there until the end of 2000 -- of this
3 year, 2023. That the male infractions at the male
4 prison classifies different from the ones that the --
5 that the females' facility classifies.
6 Like my infraction I got here is already gone
7 from my record, but I'm still holding the ones at the
8 male prison because they stay on their record for five
9 years, but female stay on for a year.
**10 Q. So when you're -- when you're released, what**
**11 are your plans?**
12 A. I plan to find employment as a paralegal.
13 Try my best to, like, really lobby for myself to get
14 into law school. Be back with my husband so we can try
15 to make up some lost times. Be with my family. And --
16 and it's just kind of, like, sad to say, but if, you
17 know, DPS doesn't give me my surgery, definitely have
18 my surgery.
**19 Q. That was going to be my next question. If**
**20 you were denied the surgery, you would pursue it after**
**21 you were released?**
22 A. Yes.
**23 Q. Where does your husband live now?**
24 A. He stays in Raleigh, North Carolina.
**25 Q. He lives in Raleigh?**

1 A. Yes.

**2 Q. And I forgot to ask this when we were talking**

**3 about background stuff too. But when the two of you**

**4 were sharing a home together in the various places you**

**5 lived, did anyone else live with you two?**

6 A. Yes. We was -- we was also foster parents as

7 well when we was in Texas; so we had three different

8 kids as well. And at one time I had my godson, LaDavia

9 (phonetic), staying there when we was in Texas.

**10 Q. Okay. So that's in addition to the foster**

**11 kids?**

12 A. Uh-huh.

**13 Q. And how long did the foster children stay**

**14 with you two?**

15 A. They stayed with me -- I think the longest

16 one was, like, maybe eight months or so, but they had

17 to stop because the social worker said that my

18 background prevented me from continuing to be a foster

19 care -- foster parent, unless Dionne wanted to do it by

20 hisself, but we was married. So I couldn't do it,

21 continue.

**22 Q. So were you -- who was approved first to be**

**23 the foster?**

24 A. I was in North Carolina at first in Wayne

25 County, and I had one. And then the foster parent --


GENERAL CONFIDENTIAL INFORMATION

1 the foster care provider at Wayne County Social
2 Services -- well, it was kind of like a guardianship
3 that was transferred to me, and then social service got
4 involved because they wanted to know where the kid was
5 staying at. They had to check my house out and all the
6 stuff like that.
7 And then she found out that I was going
8 through a name change, and she wanted to know about my
9 name change situation. They did a background check and
10 said that I had a felony, so I couldn't care for the
11 child no more. So --
**12 Q. That was in North Carolina?**
13 A. That was in North Carolina. Then when I
14 moved to Texas, my husband became a foster parent, and
15 I was there. And it took, like, a while for the
16 background, but they let it go because I passed the
17 preliminary. But when the -- because it was like more
18 than five years or something like that. But when it
19 came back, she said I couldn't do it.
**20 Q. So in North Carolina, Dionne was approved?**
21 A. No, I was approved.
**22 Q. I'm sorry. In Texas, excuse me. You're**
**23 right. In Texas, your husband was approved first, and**
**24 you were -- you were initially okayed.**
25 A. Yes.

# North Carolina Department of Public Safety
# Clinical Encounter

| | | | | | |
|---|---|---|---|---|---|
| Offender Name: ███, ███ | | | | Off #: | 0618705 |
| Date of Birth: ███ | Sex: | M | Race: BLACK | Facility: | HARN |
| Encounter Date: 01/07/2019 09:03 | Provider: | Umesi, Joseph J MD | | Unit: | GDM- |

Provider Evaluation encounter performed at Clinic.

**SUBJECTIVE:**

**COMPLAINT 1** **Provider:** Umesi, Joseph J MD

**Chief Complaint:** Other Problem

**Subjective:** Patient is a 37 year transgender female who started gender reassignment surgery prior to incarceration. Prior surgeries include bilateral orchiectomy, breast augmentation, facial feminization, Brazilian butt lift, forehead and chin fillers. Per Dr. Hope Sherrie, Cosmetic Concierge, the reassignment surgery was performed according to the guidelines of World Professional Association for Transgender Health Standards of Care. The next stage for patient prior to incarceration was full genital gender-affirming surgery. Patient is therefore requesting this surgery.

Patient is also working towards being transferred to a female camp. He is requesting female undergarment. According to patient, policy TX 1 through 13 subject evaluation and management for transgender offenders (section care of treatment for patients), requires accommodation including having female under garments if desired by patient.

Patient is requesting renewal of his medications. Patient's TARC (Transgender Accommodation Review Committee) meeting is scheduled for January 11, 2019.

**Pain Location:**

**Pain Scale:**

**Pain Qualities:**

**History of Trauma:**

**Onset:**

**Duration:**

**Exacerbating Factors:**

**Relieving Factors:**

**Comments:**

**OBJECTIVE:**

**Temperature:**

| Date | Time | Fahrenheit | Celsius | Location | Provider |
|---|---|---|---|---|---|
| 01/07/2019 | 08:59 HARN | 98.4 | 36.9 | Oral | Sansone, Kaneisia E RN |

**Pulse:**

| Date | Time | Rate Per Minute | Location | Rhythm | Provider |
|---|---|---|---|---|---|
| 01/07/2019 | 08:59 HARN | 75 | Via Machine | | Sansone, Kaneisia E RN |

**Respirations:**

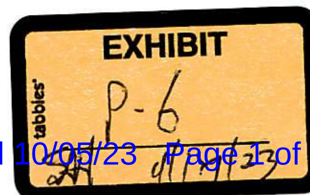
| Date | Time | Rate Per Minute | Provider |
|---|---|---|---|
| 01/07/2019 | 08:59 HARN | 18 | Sansone, Kaneisia E RN |

**Blood Pressure:**

| Date | Time | Value | Location | Position | Cuff Size | Provider |
|---|---|---|---|---|---|---|
| 01/07/2019 | 08:59 HARN | 110/77 | Left Arm | Sitting | Adult-large | Sansone, Kaneisia E RN |

**SpO2:**

| Date | Time | Value(%) | Air | Provider |
|---|---|---|---|---|






Case 3:22-cv-00191-MOC-DCK Document 61-4 Filed 10/05/23 Page 1 of 6

Offender Name: [redacted], [redacted]
Date of Birth: [redacted]
Encounter Date: 01/07/2019 09:03

Sex: M Race: BLACK
Provider: Umesi, Joseph J MD

Off #: 0618705
Facility: HARN
Unit: GDM-

| Date | Time | Value(%) | Air | Provider |
|---|---|---|---|---|
| 01/07/2019 | 08:59 HARN | 99 | Room Air | Sansone, Kaneisia E RN |

**Height:**

| Date | Time | Inches | Cm | Provider |
|---|---|---|---|---|
| 01/07/2019 | 08:59 HARN | 70.0 | 177.8 | Sansone, Kaneisia E RN |

**Weight:**

| Date | Time | Lbs | Kg | Waist Circum. | Provider |
|---|---|---|---|---|---|
| 01/07/2019 | 08:59 HARN | 255.0 | 115.7 | | Sansone, Kaneisia E RN |

**Exam:**

**General**

**Affect**

Yes: Pleasant, Cooperative

**Appearance**

Yes: Apparent Distress

**Head**

**General**

Yes: Symmetry of Motor Function, Atraumatic/Normocephalic

**Eyes**

**General**

Yes: PERRLA, Extraocular Movements Intact

**Periorbital/Orbital/Lids**

Yes: Normal Appearing

**Conjunctiva and Sclera**

Yes: Normal Appearing

**Neck**

**General**

Yes: Supple, Symmetric, Trachea Midline

**Thyroid**

No: Diffuse Enlargement, Multinodular, Nodule, Tenderness

**Musculoskeletal**

Yes: Full ROM

No: Tenderness, Muscle Spasms, Trauma

**Pulmonary**

**Auscultation**

Yes: Clear to Auscultation

**Cardiovascular**

**Auscultation**

Yes: Regular Rate and Rhythm (RRR), Normal S1 and S2

No: M/R/G

**Genitourinary**

Previously evaluated and with presence of signs of reported surgeries.

**Musculoskeletal**

**Wrist/Hand/Fingers**

Yes: Normal Exam, Full Range of Motion

**Ankle/Foot/Toes**

Yes: Normal Exam, Full Range of Motion

**Breast**

Offender Name: [redacted], [redacted] | Off #: 0618705
Date of Birth: [redacted] | Sex: M | Race: BLACK | Facility: HARN
Encounter Date: 01/07/2019 09:03 | Provider: Umesi, Joseph J MD | Unit: GDM-

**Exam:**

Female appearing breast. Did not perform brace exam.

**Neurologic**

**Sensory And Motor Reflexes**

Yes: Normal Exam

**Cranial Nerves (CN)**

Yes: CN 2-12 Intact Grossly

**Motor System-General**

Yes: Normal Exam

**Mental Health**

Patient is alert, oriented, cooperative, appropriate. Patient has no signs of higher cognitive deficits and appears confident and decisive as to what she wants to do.

**ASSESSMENT:**

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

**PLAN:**

**Renew Medication Orders:**

| Rx# | Medication | Order Date | Prescriber Order |
|---|---|---|---|
| A3554227 | ESTRADIOL 2 MG TAB | 01/07/2019 09:03 | Take one (1) tablet by mouth daily *UR approved until 1-20-19 x 180 day(s) |
| | **Indication:** Gender Dysphoria in Adolescents and Adults | | |
| A3517861 | CYANOCOBALAMIN 250 MCG TAB | 01/07/2019 09:03 | Take one (1) tablet by mouth daily x 365 day(s) |
| | **Indication:** Other fatigue | | |
| A3517863 | VITAMIN D3 1000 U TAB | 01/07/2019 09:03 | Take one (1) tablet by mouth daily x 365 day(s) |
| | **Indication:** Other fatigue | | |

**New Laboratory Requests:**

| Details | Frequency | Due Date | Priority |
|---|---|---|---|
| Lab Tests-E-Estradiol<br>Lab Tests-L-Luteinizlng Hormone (LH)<br>Lab Tests-T-Testosterone, Total | One Time | 01/08/2019 00:00 | Routine |

**New Consultation Requests:**

| Consultation/Procedure | Due Date | Priority | Translator | Language |
|---|---|---|---|---|

| Offender Name: [redacted], [redacted] | | Off #: 0618705 |
|---|---|---|
| Date of Birth: [redacted] | Sex: M Race: BLACK | Facility: HARN |
| Encounter Date: 01/07/2019 09:03 | Provider: Umesi, Joseph J MD | Unit: GDM- |

UR Request — Routine (review within 30 days) — No

**Reason for Request:**

Full genital gender-affirming surgery. Patient started surgeries prior to incarceration. Prior surgeries include bilateral orchiectomy, breast augmentation, facial feminization, Brazilian butt lift, forehead and chin fillers. Per Dr. Hope Sherrie, Cosmetic Concierge, the reassignment surgery was performed according to the guidelines of World Professional Association for Transgender Health Standards of Care. The next stage for patient prior to incarceration was full genital gender-affirming surgery. Patient has TARC hearing 1/11/2019 and patient's endocrinology appointment has been scheduled. Patient has been followed by endocrinologist and mental health physician.

**Provisional Diagnosis:**

Transgender.

UR Request — Rush (review within 7 days) — No

**Reason for Request:**

Estradiol 2 mg daily x 6 months. Patient is transgender under care by endocrinologist who has approved continuing Estradiol which patient was on before incarceration.

**Provisional Diagnosis:**

Transgender.

UR Request — Rush (review within 7 days) — No

**Reason for Request:**

Five female undergarments every six months (size 8). Patient requesting this for accommodation following policy treatment 1 through 13, section care and treatment for patient, subject evaluation and management for transgender offenders.

**Provisional Diagnosis:**

Transgender.

**Disposition:**

Follow-up at Sick Call as Needed

**Patient Education Topics:**

| Date Initiated | Format | Handout/Topic | Provider | Outcome |
|---|---|---|---|---|
| 01/07/2019 | Counseling | Plan of Care | Umesi, Joseph | Verbalizes Understanding |

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

Completed by Umesi, Joseph J MD on 01/07/2019 09:47

# North Carolina Department of Public Safety
# Clinical Encounter - Administrative Note

| | | | | | |
|---|---|---|---|---|---|
| Offender Name: | [redacted], [redacted] | | | Off #: | 0618705 |
| Date of Birth: | [redacted] | Sex: M | Race: BLACK | Facility: | HARN |
| Note Date: | 01/07/2019 07:09 | Provider: | Burwell, Gwendolyn H | Unit: | GDM- |

Record Review encounter performed at Non Patient Contact.

**Administrative Notes:**

**ADMINISTRATIVE NOTE 1** **Provider:** Burwell, Gwendolyn H LPN

Scheduled for podiatry surgery at CP on 1/9/2019

**New Non-Medication Orders:**

| Order | Frequency | Duration | Details | Ordered By |
|---|---|---|---|---|
| Nursing Instructions | One Time | | On01/08/2019 the night before the procedure, instruct patient to drink plenty of fluids, then - NPO at 11:30, Review MAR, Review pre-operative medication guide for non-cardiac surgery May take meds with sip of water the day of surgery. (01/09/2019). | Umesi, Joseph J MD |

**Discontinue Reason:**

**Order Date:** 01/07/2019

**End Date:**

**Diet Orders:**

| Start Date | | Expiration Date |
|---|---|---|
| 01/07/2019 | Other - NPO after midnight on 01/08/2019 until after procedure on (01/09/2019). | 01/09/2019 |

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

**Telephone/Verbal Order:** No

**Standing Order:** Yes

Completed by Burwell, Gwendolyn H LPN on 01/07/2019 07:12

Requested to be cosigned by Umesi, Joseph J MD.

Cosign documentation will be displayed on the following page.

# North Carolina Department of Public Safety
## Cosign/Review

| Offender Name: | [redacted], [redacted] | | | Off #: | 0618705 |
|---|---|---|---|---|---|
| Date of Birth: | [redacted] | Sex: | M | Race: | BLACK |
| Encounter Date: | 01/07/2019 07:09 | Provider: | Burwell, Gwendolyn H | Facility: | HARN |

**Cosigned with New Encounter Note by Umesi, Joseph J MD on 01/07/2019 20:22.**

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION

Civil Action No. 3:22-cv-0191

KANAUTICA ZAYRE-BROWN, )
)
Plaintiff, )
)
v. )
)
THE NORTH CAROLINA )
DEPARTMENT OF PUBLIC )
SAFETY, et al., )
)
Defendants. )
)

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30(b)(6) DEPOSITION OF ARTHUR CAMPBELL, M.D.
THE NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY

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(Taken by plaintiff.)

Raleigh, North Carolina

April 18, 2023, 9:30 a.m.

Reported By:
SUSAN GALLAGHER, CA CSR, CVR-CM

1 if they were in the community, what community are you
2 looking to to determine what constitutes community
3 consistent healthcare?
4 A So in the broad context, it's outside the
5 prison.
6 Q So would that be nationwide?
7 A Well, not specifically because, again, states
8 have -- for instance, you know, Medicaid is a state-run
9 program. So states have variations in what their
10 individual state provides and covers. Within the
11 context of medical care though, the care should be the
12 same. You know, if it is truly standard of care, it's
13 going to be fairly consistent across the country.
14 Q Okay. So if I'm understanding your testimony
15 correctly, in certain circumstances the community
16 against which you're judging would be the state, but
17 generally speaking it is nationwide?
18 A Correct.
19 Q Okay. Where does the definition or the
20 explanation you just described, "community consistent
21 healthcare," come from?
22 A I don't know what the origins of that is.
23 Q How did you come to be familiar with that?
24 A Again, by reading these policies and
25 understanding what the department's policy is and how

1 we are supposed to take care of these offenders.
2 That's where I became aware of what that standard is.
3 Q Does DPS provide training to its health
4 services staff members regarding the meaning of
5 community consistent care?
6 A I don't know if there's any specific training
7 for that. You obviously review policies and
8 procedures, and you have orientation when you arrive at
9 the organization, and that's part of that, but I don't
10 know if there's a specific training dedicated to this
11 particular aspect of that.
12 Q Okay. From your understanding or from DPS's
13 understanding, is medically necessary care the same as
14 community consistent care?
15 A Generally, yes.
16 Q You said "generally, yes." Are there
17 circumstances when that is not the case?
18 A Well, I think the difference would be in the
19 community, individuals can pay for care that may be
20 elective. Whereas, in the prison, we are responsible
21 for providing that care.
22 Q I'm not sure I understand -- I'm not sure I
23 understand that answer. So that's a situation where
24 medically necessary care and community consistent care
25 would not be similar is where elective procedures are

1 involved?
2 A Well, not just elective, but individuals in the
3 community may not have, for instance, insurance. So
4 it's different here. We cover these individuals for
5 the care that's provided in the prison.
6 Q Okay. How does DPS define "medical necessity"?
7 A That's a big answer. So in its simplest terms,
8 when you look at medical necessity, it's probably best
9 defined as a procedure that is reasonable and
10 appropriate for a particular individual, really, to
11 either protect their life, to prevent significant
12 disability or illness, or to prevent significant pain
13 and suffering. That is a very broad definition of
14 medical necessity, and quite honestly, it's been
15 through a lot of subjectivity, and so within prisons we
16 need to be a little more deliberate in how we define
17 that.
18 So what we need to be sure in prisons is that
19 every officer that has a similar clinical circumstances
20 that has a case submitted for review or a clinical
21 condition, it's evaluated in the exact same way as
22 objectively as possible as any other offender in the
23 prison, and that's for any medical condition that they
24 may see.
25 In my interpretation of medical necessity, in

1 order to get after that and to be able to come up with
2 a more clear understanding of what that means, you have
3 look at what factors would you see with medical
4 necessity that could be attributed to that, and there's
5 really three broad ones, I think, that fall under that
6 category.
7 First is a risk-benefit analysis. Second is
8 standard of care, and third is evidence based medicine,
9 and I can certainly talk in more detail about each of
10 those.
11 So as we look at a particular case or
12 circumstance, those are the broad criteria we need to
13 use to evaluate that. With risk-benefit analysis, it's
14 important to note that this is by far the most critical
15 piece of that evaluation. What that means is that you
16 have to look at that particular patient and those
17 particular circumstances and their clinical condition,
18 and you need to determine whether the proposed
19 treatment, what would be the impact if you were to not
20 perform that procedure as opposed to performing the
21 procedure for the offender. So you balance the risk of
22 performing the procedure versus the potential risk of
23 not performing that procedure, and what is the outcome
24 of that, and that involves, again, a very
25 individualized review of that particular patient and

1 those particular circumstances, and I think one of the
2 things about that balance is that you cannot perform
3 analysis without doing that individualized review of
4 that case, and that's to your other question you asked
5 about, that individualized review. So we do that.
6 So, for instance, if a procedure is proposed
7 and you know the potential treatment for that, you look
8 at that particular patient, those circumstances, and
9 determine whether that procedure is appropriate and
10 it's going to do those things I mentioned. Is it going
11 to protect their life? Is it going to prevent
12 significant illness or disability, and is it going to
13 prevent significant pain and suffering? And that's how
14 you do that risk-benefit analysis.
15 Q So I just have one follow-up regarding
16 preventing significant pain and suffering. Is your
17 understanding that emotional pain and suffering is also
18 relevant to whether or not something is medically
19 necessary?
20 A Yes, ma'am.
21 Q Psychological pain and suffering?
22 A Yes, ma'am.
23 Q And I believe a moment ago when you started
24 explaining this to me, you said, "at least in my view,"
25 and I just want to be clear we're in the 30(b)(6)

1 portion of your deposition so I'm asking for DPS's
2 position. Is your understanding that everything you
3 just explained to me is DPS's position?
4 A No. So I think that DPS does not have a medical
5 necessity definition, per se, or DAC.
6 Q So where did the definition of medical
7 necessity as you just explained to me come from?
8 A Well, I'm thought you were asking my opinion of
9 that. I probably should have not answered that, but
10 that's --
11 MR. RODRIGUEZ: It was asked in the context of the
12 30(b)(6), and your response was in the context of your
13 understanding of that as the representative, and then I
14 think you clarified that it is not written in a policy,
15 a departmental policy.
16 THE WITNESS: Correct.
17 BY MS. MAFFETORE:
18 Q And that's your understanding. So is that the
19 definition that you use acting as medical director for
20 DPS, what you just explained to me?
21 A The medical necessity for DPS would be what I
22 described initially, the generally accepted medical
23 definition of medical necessity. So that first thing I
24 told you where it's basically those things that prevent
25 death, significant illness, and disability. That is

1 the accepted standard, really, everywhere for what
2 medical necessity is.
3 Q So you mentioned certain factors that are taken
4 into account regarding medical necessity. Does DPS
5 ever take into consideration the cost of a procedure
6 when it's considering medical necessity?
7 A No.
8 Q How about security?
9 A Security is always considered in every context
10 in our setting.
11 Q So it's considered a medical necessity
12 determination?
13 A It's not a medical necessity determination, no,
14 but security's always a determination.
15 Q Okay. How about logistics?
16 A Again, not for medical necessity, if that's
17 what you're asking.
18 Q What about the ability to provide postoperative
19 care?
20 A Again, not for medical necessity.
21 Q Is your interpretation as medical director on
22 behalf of DPS of medical necessity the same for all DPS
23 decisions about the provision of, for example, mental
24 health care?
25 MR. RODRIGUEZ: Object to speculation.



Case 3:22-cv-00191-MOC-DCK Document 61-5 Filed 10/05/23 Page 8 of 137

1 You can answer.
2 THE WITNESS: It's universal when it relates to
3 health care, regardless of the type of healthcare.
4 BY MS. MAFFETORE:
5 Q So also all medical care, all sorts of care?
6 MR. RODRIGUEZ: Same objection. Speculation.
7 You can answer.
8 THE WITNESS: Yes.
9 BY MS. MAFFETORE:
10 Q And in evaluating the request from someone in
11 DPS custody for healthcare services, is there any kind
12 of care where DPS would consider an individual's legal
13 history in making a medical necessity determination?
14 A No, ma'am.
15 Q Is there any situation where DPS would consider
16 an individual's criminal record in making a medical
17 necessity determination?
18 A No, ma'am.
19 Q Is there any instance where DPS would consider
20 an individual's disciplinary history or history of
21 interactions in a medical necessity determination?
22 A No, ma'am.
23 Q If you to turn to page 2 of Exhibit 3, if
24 you'll look at Section 2G5, it states there that "one
25 of the goals of health and wellness is to engage in

1 sound healthcare practices that meet an acceptable
2 standard of care"; correct?
3 A Correct.
4 Q So I think that you started to get into this
5 when you were talking about medical necessity, but if
6 you could get into it now, what constitutes an
7 acceptable standard of care according to DPS?
8 A So, again, within DPS we rely on the same
9 things I mentioned, which are clinical practice
10 guidelines, and that is across the board what we rely
11 on for standard of care.
12 Q What are the sources of those clinical practice
13 guidelines?
14 A They will vary. It can be from the individual
15 professional medical associations and societies. We
16 often develop our own clinical practice guidelines
17 specific for our individual setting. Each one of those
18 references the pertinent medical society clinical
19 practice guidelines, and we'll adapt those as needed
20 for the prison environment.
21 Q Are there any circumstances where DPS would not
22 look to individual medical associations and societies
23 for clinical guidelines?
24 MR. RODRIGUEZ WITNESS: Object to speculation.
25 You can answer.

1 THE WITNESS: No, ma'am.
2 BY MS. MAFFETORE:
3 Q Okay. So on the same page of this exhibit,
4 Section 2H, it states that "the provision of treatment
5 regarding clinical decisions that involve health and
6 wellness providers are the sole responsibility of the
7 managing health and wellness practitioner and are not
8 reversed by non-clinicians."
9 Did I read that correctly?
10 A Yes, ma'am.
11 Q What does DPS mean by this?
12 A So it means that medical decisions are made by
13 medical authorities within the prison.
14 Q Okay. How does DPS define "clinician"?
15 A It is a licensed independent provider. So it's
16 a provider who is credentialed to practice within our
17 healthcare system.
18 Q So you said is a licensed health provider.
19 What degrees of licensure does that encompass?
20 A So it can be family nurse practitioners,
21 physician assistants, and physicians.
22 Q Anyone else?
23 A No.
24 Q Would a mental health care provider be
25 considered a clinician?

1 A Yes.
2 Q And at what levels of medical health -- or
3 mental health licensure would be considered a
4 clinician?
5 A Licensed clinical social workers,
6 psychologists, obviously psychiatrists are physicians,
7 but they all fall in that same spectrum.
8 Q Does DP's definition of clinician have anything
9 to do with the degree of patient contact a medical
10 provider or mental health care provider has?
11 A No. They're licensed or credentialed based on
12 their qualifications.
13 Q Okay. So if somebody holds a licensure within
14 DPS but is in a position where they do not see patients
15 at all, that person is still considered a clinician
16 based on DPS's definition of clinician?
17 A Yes, ma'am.
18 Q Who, if anyone within Health and Wellness
19 Services, would not be considered a clinician by DPS?
20 A So the registered nurses, the LPNs, the
21 certified nursing assistant, the certified medical
22 assistants. There are lots of administrative staff,
23 both budgetary and accounting. The section is very
24 large and includes not only clinical folks, but
25 clinical support folks as well. There's respiratory

1 In other words, it's not a discrete incident right then
2 that requires some immediate intervention at that point
3 to stop that severe illness.
4 So, again, we look a lot at trends in medicine.
5 Whereas, again, a very acute psychotic episode that
6 requires immediate intervention is different than an
7 individual that may have some suicidal ideation. You
8 evaluate that overtime.
9 Q What about self-injurious behavior?
10 A I would say the same thing applies. Now, if
11 they've injured themselves severely enough to where
12 that needs an immediate intervention, so say they've
13 cut themselves so severely that you have to intervene
14 right then to treat that injury, then yes. But, again,
15 I'd go back to what I said before is that for most --
16 and I would say it's not only for behavioral health
17 conditions, but medical conditions as well. We rely on
18 trends in medicine. We rely on what's been tried
19 before, what's been successful, what hasn't, and what
20 would be the next step in the course of treatment.
21 Q Under 2B again, what is meant by "intensity of
22 service"?
23 A So that would be the frequency of having to
24 have the appointment. So, for instance, a highly
25 intensive service would be individuals that are getting

1 chemotherapy or radiation therapy, individuals that are
2 getting physical therapy or occupational therapy.
3 Those are more high-intensity services that require
4 more frequent appointments and interventions.
5 Q I realize that I skipped when we were talking
6 about the first sentence. What nationally recognized
7 authorities does utilization management staff look to
8 for its evidenced-based clinical guidelines?
9 A So, again, we've talked some about that. So
10 it's relying on the individuals who have the expertise
11 in that area. So depending on what condition you're
12 looking at, you will consider their recommendations.
13 Again, what I would say is that you have to do that in
14 the context of prison. So we consider all of those
15 things and evaluate all of those things, but we have to
16 consider in the context of the prison setting.
17 Q So does that mean that utilization management
18 does not utilize community consistent care?
19 A Absolutely not. So we have to treat the
20 conditions, the same conditions the community treats.
21 Precisely how they're treated and how they're addressed
22 in prisons is going to vary to some degree. So, again,
23 all of those professional organizations provide -- and,
24 again, they call them guidelines for a reason, and we
25 evaluate those guidelines accordingly.

1 Q So how does all of this inform medical
2 necessity?
3 MR. RODRIGUEZ: Object to the form.
4 You can answer.
5 BY MS. MAFFETORE:
6 Q And I can clarify. How does severity of
7 illness and intensity of service inform the decisions
8 regarding medical necessity?
9 A So, again, I talked a little bit about that.
10 So a severe illness, again, tips that risk-benefit
11 scale in the direction of being medical necessary to
12 prevent the things that I talked about, you know,
13 death, severe disability, severe illness, so all of
14 those things, and that's tips the scale dramatically in
15 that direction.
16 Intensity of services is the same thing. So
17 use the chemotherapy as an example. That is a highly
18 intense service, but the risk of not performing that
19 procedure is very significant to the individual patient
20 were you not to proceed with that treatment. So that,
21 again, tips the scale toward medical necessity.
22 Q So in terms of the evidence-based clinical
23 guidelines, which organizations or sources does UM look
24 to in developing those evidence-based clinical
25 guidelines or reviewing those evidence-based clinical

1 guidelines?
2 A Really, any of them out there. It's going to
3 depend on the condition you're treating. So if you're
4 looking at an individual with diabetes, you'll
5 obviously look to the Endocrine Society for what their
6 recommendations are. If you're treating someone with
7 heart disease, you'll look at the American Heart
8 Association. So it's going to depend on the specific
9 condition you're evaluating.
10 And, again, you look at those guidelines. You
11 consider them. You consider them in the context of
12 your clinical experience and in the context of prisons,
13 and there you derive your conclusions, how you're going
14 to proceed.
15 Q But as when we were discussing the Health and
16 Wellness Services organizations policy, you would say
17 that the folks on the utilization management board
18 still look to those professional associations and
19 organizations that we discussed previously that you
20 stated were reliable?
21 MR. RODRIGUEZ: Object to the form.
22 You can answer.
23 THE WITNESS: They are the same ones I just
24 mentioned. There is no distinction. So, yes, we do
25 look to them. We do consider them, but they're not the

1 only consideration.
2 Q What about the American Medical Association?
3 A Sure.
4 Q The American Psychiatric Association?
5 A Yes.
6 Q And they do that even though their review is
7 done in the context of prisons, as you said previously?
8 A Yes. All those agencies provide some
9 guidelines to us, you know, some input into our
10 consideration.
11 Q Given that you represented that UM does not
12 provide community consistent care, are there other
13 sources aside from those professional medical
14 associations that we discussed that the UM would look
15 to for guidance?
16 MR. RODRIGUEZ: I'm going to object to the form.
17 You can answer.
18 THE WITNESS: You said the UM doesn't provide
19 community consistent care?
20 BY MS. MAFFETORE:
21 Q Maybe we misunderstood each other. So earlier
22 you told me that what utilization management does, they
23 have to do within the context of prisons because in the
24 prison setting, things are different than they would be
25 in the community, and I have followed up to ask you the

1 determination of UM then, do they still provide
2 community consistent care, and I understood you to say
3 absolutely not; is that not correct?
4 MR. RODRIGUEZ: I'm going to object to
5 mischaracterization of the previous testimony.
6 You can answer.
7 (Simultaneous speakers.)
8 THE REPORTER: One at a time, please.
9 THE WITNESS: That is not at all what I said.
10 BY MS. MAFFETORE:
11 Q Okay. If you could clarify.
12 A Yeah. So I'm trying to remember the question,
13 but the point is that we do provide community
14 consistent care. The difference being that there can
15 be differences in the prison, but it doesn't mean it's
16 not consistent with community standards because
17 community standards is a broad term that, quite
18 honestly, there are variations, kind of like we talked
19 about before. So there's variations within
20 communities, across states, across the country, based
21 on the insurance carrier. So there are always
22 variations, and there's no difference here in prison.
23 In other words, we're still treating the same
24 condition, but there can be some variations in how we
25 do that, and a lot of the organizations acknowledge

1 that. In their recommendations, they will make that
2 clarification that there can be variations. They're
3 not dictates. I'll put it that way.
4 Q Sure. I just want to make sure I'm
5 understanding. DPS's position is that utilization
6 management conducts their reviews and makes approvals
7 consistent with community care, community standards of
8 care?
9 A Correct, but, again, what I'll tell you is that
10 there can be some variations.
11 Q Okay.
12 A It doesn't mean they're inconsistent with that.
13 It just means that there are variations with that.
14 Q Can you provide an example?
15 A So if an individual needs -- say the therapist
16 recommends a particular type of physical therapy and
17 there's another alternative that would still meet that
18 therapeutic goal, then we can provide that therapy
19 alternatively as opposed to what the other one might
20 be. So, again, we're were still meeting the intent.
21 We're still treating the condition. It's just
22 different than what may have been initially
23 recommended.
24 Q When looking for alternatives, does DPS -- how
25 does DPS ensure that the alternative is a sufficient

1 replacement for what has been recommended?
2 MR. RODRIGUEZ: Objection to speculation.
3 You can answer it.
4 THE WITNESS: Again, I would say it goes back to
5 what I said. It's evidence-based medicine. So just
6 because something is not necessarily specifically
7 spelled out in clinical practice guidelines does not
8 mean there's a efficacious alternative to that. That's
9 been proven through evidence-based medicine to be
10 effective.
11 BY MS. MAFFETORE:
12 Q Looking again at Exhibit 4 under C, it states,
13 "With the specific information collected regarding an
14 offender's clinical condition, staff referenced the
15 following criteria as guides in making coverage
16 determinations as applicable," and I'll stop there.
17 What is meant by "coverage determinations"?
18 A I'm reading to the next line to understand what
19 the context was for that.
20 So, again, my interpretation of what that is
21 is, again, getting back to the approval of the
22 procedure, I think it's a different terminology for
23 saying it's going to be covered, but it's inherent when
24 we do approve it that it is going to be covered, if
25 that makes sense. So when we approve it, it's going to

1 be covered.
2 Q So by coverage determination, DPS means here
3 whether the whatever is requested will be approved?
4 A Correct.
5 Q Okay. And that is what is meant by coverage
6 determination?
7 A Correct.
8 Q So if something is determined to be covered,
9 does DPS consider it medically necessary?
10 A Yes. That's inherent in the decision. So when
11 you approve a decision procedure, you've endorsed it as
12 being medically necessary.
13 Q Okay. So should I then understand C to mean
14 that the sources that are cited should be referenced as
15 applicable in making medical necessity determinations?
16 MR. RODRIGUEZ: I'm going to object to
17 mischaracterization of what the document says.
18 You can answer.
19 THE WITNESS: When you said the organizations
20 mentioned, what do you mean specifically?
21 BY MS. MAFFETORE:
22 Q Or rather the sources mentioned. The coverage
23 determinations and local coverage determinations for NC
24 or guideline policy listed in health and wellness
25 utilization review guidelines, is that a source that

1 should be consulted in making a medical necessity
2 determination?
3 A It is a source, but there's multiple sources
4 for how you determine that. It's not the sole source.
5 Q Is this policy suggesting that this source
6 should be a criteria on -- that guides a medical
7 necessity determination?
8 MR. RODRIGUEZ: Objection. Mischaracterization of
9 the document.
10 You can answer.
11 THE WITNESS: Again, these are a factor in the
12 determination.
13 BY MS. MAFFETORE:
14 Q Okay. And so what is UpToDate?
15 A So UpToDate is an online clinical consultative
16 service. So it's a website that contains medical
17 information. They call it UpToDate because it is
18 updated very regularly, and all of our clinicians have
19 access to UpToDate. We provide them a subscription to
20 UpToDate. So they can research any condition they want
21 to look up, and they can look in there and find out
22 what the latest practices are, recommendations for that
23 condition.
24 Q So is UpToDate one of the sources should be
25 consulted by UM in making determinations as to medical

1 necessity?
2 A Yes, ma'am.
3 Q The next is, the Center of Medicare and
4 Medicaid Services, national coverage determinations and
5 local coverage determinations. Is that a source that
6 the UM should consider when making determinations as to
7 medical necessity?
8 A Yes, ma'am. It's another one of the sources.
9 Q Okay. And then the United States Preventive
10 Services Task Force, is that another source that UM
11 should consult on making determinations of medical
12 necessity?
13 A Yes, ma'am.
14 Q Which, if any of these sources, are used to
15 guide coverage determinations for the treatment of
16 gender dysphoria?
17 A All of them can be, and, again, this is not an
18 all-inclusive list, kind of like we've already talked
19 about. These are just some of the major ones, but
20 certainly transgender health can -- certainly UpToDate
21 covers that. Certainly Medicare and Medicaid has some
22 national coverage determinations on some of that.
23 So, again -- as does the US Preventative Task
24 Force. So, again, these are references that contribute
25 to that consideration when it comes to transgender

1 services.
2 Q And when you say "transgender services," what
3 do you mean by that?
4 A Transgender health.
5 Q Okay. And so are you using that term as
6 synonymous with the treatment of gender dysphoria,
7 which is the way the question was phrased?
8 A No. They're not necessarily synonymous.
9 Q Okay. So what I asked was which of these
10 criteria would be used to guide coverage determination
11 specifically for the treatment of gender dysphoria.
12 Does your answer change if we are speaking specifically
13 about the treatment of gender dysphoria?
14 A No.
15 Q Going back to that first factor on page 1 under
16 C, it mentions "health and wellness utilization review
17 guidelines." What are health and wellness utilization
18 review guidelines?
19 A Point me to where you're reading now.
20 Q Under 2-C-1?
21 A Okay.
22 Q After closed bracket, "guideline policy listed
23 in health and wellness utilization review guidelines."
24 A So, again, that's the guidance we give to our
25 utilization review nurses, for instance. So the way

1 the utilization review process works is the provider
2 submits a request. The medical records tech enters
3 that request, and it initially goes to the utilization
4 review nurses.
5 There are some things that they have the
6 authority to approve at their level. They can't defer
7 anything at their level, but there are some things that
8 they can automatically approve at their level. So
9 that's what those guidelines talk about. What are
10 those things that have the authority to automatically
11 approve, and what are those things that they need to
12 send utilization review for approval?
13 Q Okay. And are those written guidelines?
14 A They are.
15 Q Is there anything that would be provided for
16 the treatment of gender dysphoria that a utilization
17 review nurse has the authority to approve?
18 A No, and the reason for that is that in the case
19 of gender dysphoria, the utilization review process,
20 again, mirrors the utilization review process for
21 everything else, but the utilization authority for
22 gender dysphoria is the DTARC.
23 Q So did you just say the utilization review
24 authority for the treatment of gender dysphoria is the
25 DTARC?

1 Services organization policy, apply to considerations
2 for gender affirming surgical care?
3 A Yes, ma'am. It applies to all healthcare.
4 Q Does the UM policy that we just discussed apply
5 to considerations for gender affirming surgical care?
6 A Yes, ma'am. Same answer, it applies to all
7 medical conditions.
8 Q And the care and treatment of patient
9 disabilities policy we just discussed, does that apply
10 to considerations for gender affirming care?
11 A Yes, ma'am. Same answer.
12 Q What does DPS consider to be community
13 consistent care when delivering health services related
14 to gender affirming surgery?
15 A Again, there is no difference from what we
16 consider for any other condition. So we review and
17 consider all appropriate entities and agencies and
18 authorities that have provided evidence-based practices
19 for the treatment of those conditions. We consider
20 them and make decisions accordingly in the context of
21 our setting, just like we do for any other medical
22 condition. There is no distinction.
23 Q What community does DPS look to as a point of
24 reference when it's considering community consistent
25 care for gender affirming surgery?

1 A So there are a lot of them. There's the
2 endocrinological society. Certainly we look at the
3 WPATH guidelines as well and consider those. Again, we
4 don't exclude any of those entities that could be --
5 you know, provide some valuable input into forming our
6 decisions.
7 Q That's helpful, but not quite the question that
8 I was getting after. So when we were talking about
9 community consistent care previously, we were talking
10 about, like, the geographic scope, and you said that
11 some determinations might be state-based, but generally
12 speaking, it was national. So what I'm asking here is
13 what community, in terms of geographic scope, does DPS
14 look to as a point of reference when considering
15 community consistent care for gender affirming surgery?
16 MR. RODRIGUEZ: Object to form.
17 You can answer.
18 THE WITNESS: So, again, I would say that's
19 all-encompassing. So the societies that I just
20 mentioned don't specifically dictate anything based on
21 a specific community. So all of those things are
22 considered. We are in the state of North Carolina. So
23 certainly what the accepted care within the state of
24 North Carolina is another consideration. None of those
25 are in and of themselves the sole determinant of our

1 decisions.
2 BY MS. MAFFETORE:
3 Q So would you say that DPS looks at state-based,
4 nationwide, and in some circumstances even global
5 guidance with respect to the treatment of gender
6 dysphoria?
7 A Yes, ma'am. Not as much globally, obviously,
8 but certainly it's a consideration.
9 Q So you did mention WPATH as one of the sources
10 that you reference; correct?
11 A Correct.
12 Q Do you understand that to stand for World
13 Professional Association of Transgender Health?
14 A Of course I do. They based out of the United
15 States.
16 Q Do they have participants from other countries?
17 A Yes, they do, just like other endocrine
18 societies and other medical societies do as well.
19 Q And so you also mentioned the Endocrine
20 Society. Can you recall any other organizations or
21 sources that DPS looks to for the treatment of gender
22 dysphoria or the provision of gender affirming surgery?
23 A Sure. The American Psychiatric Society, the
24 American Academy of Pediatrics, especially dealing with
25 adolescents. So there's a lot of them.

1 Q Any others that you can recall?
2 A I'm sure there are others. I'd have to think
3 on it, but not at the moment.
4 Q Okay. Has DPS identified an acceptable
5 standard of care for the provision of gender affirming
6 surgical care to treat gender dysphoria?
7 MR. RODRIGUEZ: I'm going to object to the form.
8 You can answer.
9 THE WITNESS: Say that one more time.
10 BY MS. MAFFETORE:
11 Q Has DPS identified an acceptable standard of
12 care for the provision of gender affirming surgical
13 care to treat gender dysphoria?
14 MR. RODRIGUEZ: Same objection.
15 You can answer.
16 THE WITNESS: No, but we haven't identified an
17 acceptable standard of care for any conditions in the
18 prison. Again, we based on the community standard, so.
19 BY MS. MAFFETORE:
20 Q Has DPS identified standards of care that are
21 particularly useful for the provision of gender
22 affirming surgical care to treat gender dysphoria in
23 the prison context?
24 MR. RODRIGUEZ: Object. Ambiguity.
25 You can answer.

1 THE WITNESS: Again, I go back to my initial
2 comments that we rely on the medical literature,
3 evidence-based medicine, and the appropriate societies.
4 BY MS. MAFFETORE:
5 Q So you would say DPS relies on a multitude of
6 sources, but there is not one particular source you
7 look to as standard of care for gender affirming
8 surgery?
9 A That's correct.
10 Q And so I understood you before to say that
11 clinical decisions support resources, even though it
12 was capitalized as a term of art in the policy in which
13 we discussed it, it's just another term to apply to
14 these various sources that we have been discussing; is
15 that correct?
16 MR. RODRIGUEZ: Which policy is that one? The
17 clinical --
18 MS. MAFFETORE: The health and wellness
19 organization, I believe.
20 MR. RODRIGUEZ: Which page is that on, again? It's
21 on page 5. Okay.
22 BY MS. MAFFETORE:
23 Q So even though it is capitalized in the policy
24 as if it is a term of art, I understood you to testify
25 earlier that clinical decisions --

1 THE REPORTER: I'm sorry. I'm really going to have
2 to ask you to slow down.
3 "I understood you to testify."
4 Q -- that even though in the policy it is
5 capitalized as if it is a term of art, clinical
6 decision support resources is another term that simply
7 refers to the various sources from the medical field
8 that we have been discussing, for example, guidance
9 from the Endocrine Society, WPATH, or the American
10 Medical Association?
11 MR. RODRIGUEZ: Object to form.
12 You can answer.
13 THE WITNESS: Yes. Again, I don't know of an
14 entity, per se, or an agency within the department that
15 has that name.
16 BY MS. MAFFETORE:
17 Q Okay. You don't know of any written materials
18 that are known as clinical decision support resources
19 that are generated by the department?
20 A No, ma'am, not that I'm aware of.
21 Q Okay. Are there any other diagnostic criteria
22 that are used by DPS to evaluate the appropriateness of
23 gender affirming surgery for the treatment of gender
24 dysphoria?
25 MR. RODRIGUEZ: Object to the form.

1 You can answer.
2 THE WITNESS: Diagnostic -- what did you say?
3 BY MS. MAFFETORE:
4 Q Diagnostic criteria?
5 A So, again, the diagnostic criteria for gender
6 dysphoria are pretty well established.
7 Q And what are those?
8 A So in the DSM-5 the diagnostic criteria are
9 really -- there's three broad categories. So there's a
10 marked incongruence between the individual's
11 experience, gender, and their primary and secondary sex
12 characteristics. There is a strong desire, really, in
13 about four quadrants. Number one is to be able to have
14 the primary and secondary sex characteristics that they
15 have eliminated. They want the primary and secondary
16 sex characteristics of the opposite gender. They want
17 to be of the other gender, and they want to be treated
18 as the other gender.
19 The final criterion is that there is a firm
20 belief that they have the feelings and expressions of
21 the other gender, and then most importantly is that
22 those things that I just talked about have to be
23 reflected in clinically significant disability or
24 impairment in important areas of their life, such as
25 social or occupational areas.

1 Q And what is the source of those criteria?
2 A That's the DSM-V.
3 Q And just to be clear, those are the diagnostic
4 criteria for gender dysphoria?
5 A Correct.
6 Q Are there any criteria that DPS uses to
7 determine if gender affirming surgery is appropriate
8 for the treatment of gender dysphoria?
9 A There are no specific criteria.
10 Q You previously testified that DPS does look to
11 the WPATH criteria?
12 A Correct. It's one of the considerations.
13 Q Does DPS ever look to coverage of insurance
14 carriers outside of the department?
15 A Again, that's always considered, even outside
16 of transgender care. That's one of the ways you can
17 evaluate standard of care is if it's truly a standard
18 of care, then the expectation would be that that
19 procedure, diagnostic procedure or treatment is going
20 to be covered by the overwhelming majority of insurance
21 companies because that's how insurance carriers make
22 determinations.
23 Q So, for example, if Blue Cross Blue Shield of
24 North Carolina covered the procedure at issue and had
25 criteria, that would be relevant to the determination

1 for DPS?
2 A Again, it would be a factor. We're not covered
3 by Blue Cross Shield in prison.
4 Q But you're testifying that if major insurance
5 carriers do provide coverage and have criteria, that's
6 relevant to DPS; correct?
7 A It is relevant, but it's not -- we don't rely
8 on any single entity like that.
9 Q So I believe you testified that if the
10 overwhelming majority of insurance carriers provided
11 that, that would be extremely relevant to DPS's
12 determination; correct?
13 MR. RODRIGUEZ: Objection. Mischaracterization of
14 the witness's testimony.
15 THE WITNESS: Again, it helps inform our decision.
16 BY MS. MAFFETORE:
17 Q Okay. Are there any other sources that DPS
18 would look to that we haven't already discussed to
19 determine whether or not gender affirming surgery would
20 be appropriate for the treatment of gender dysphoria?
21 A Again, none come to mind that we haven't
22 already discussed in one context or another.
23 Q And I just want to make sure I understood your
24 previous testimony. You testified previously that
25 coverage determinations for utilization management is,

1 in essence, the same as an approval; correct?
2 A Correct.
3 Q And that if a procedure is approved by
4 utilization management, then utilization management
5 considers that procedure to be medically necessary?
6 A Correct.
7 Q What criteria does DPS utilize to determine
8 whether or not gender affirming surgery is medically
9 necessary?
10 A So there aren't established criteria for gender
11 affirming surgery within prisons. It's evaluated, as
12 with all other accommodations or treatment for gender
13 dysphoria, through the DTARC. So it's a
14 multi-disciplinary evaluation, consideration, and
15 decision.
16 Q Okay. So you stated that it is determined by
17 the DTARC. Does utilization management still play a
18 role in determining the medical necessity of gender
19 affirming surgery?
20 A Not directly. So in other words, if you
21 remember what I said is that the DTARC serves as the UR
22 approval authority in the context of gender dysphoria.
23 Q I believe that you stated previously that the
24 UM procedures still apply to the treatment of gender
25 dysphoria; is that correct?

1 A Say that again.
2 Q The UM policies and procedures still apply to
3 the treatment of gender dysphoria?
4 A Correct. So it's all nested in the same
5 policy. So for instance, when a referral is made --
6 and we're talking about gender affirming surgery so
7 we'll stick with that. If there was a recommendation
8 to come to the primary care provider from a specialist
9 for gender affirming surgery, that primary care
10 provider would enter that order.
11 It would go to the UR. The UR nurses would
12 then defer that to the DTARC. In other words, instead
13 of referring to the UR review approval authority, it
14 comes to the DTARC.
15 Q Okay. So we're skipping ahead a little so
16 we're going to have to go back to discuss DTARC just a
17 second. But if DTARC makes a recommendation for
18 medication or treatment of gender dysphoria, does that
19 recommendation subsequently go to utilization
20 management?
21 A It does. So the decision from the DTARC goes
22 back to the primary care provider. Again, the primary
23 care provider has to be the one involved in the care of
24 that offender. So if they had made a decision for
25 hormone replacement therapy out of the DTARC, the

1 primary care provider would be notified of that, would
2 enter the order. It would be approved, and it would be
3 administered to the patient.
4 Q Okay. So the process then is request, DTARC --
5 so the primary care provider makes the request. It
6 goes to DTARC, and then DTARC approves it. It goes
7 back to the primary care provider that it's been
8 approved, and then the primary care provider makes the
9 request to utilization management, who then approves it
10 and then sends that approval back to the physician to
11 administer care?
12 A Not to the physician directly. In this case it
13 would go to the pharmacy. They'd activate the
14 prescription and send it to the facility. There would
15 be nursing orders, and the nurse would administer the
16 medication.
17 Q Okay. And in the case of a procedure, it would
18 go back to not the treating physician?
19 A It always goes back to the treating physician.
20 That is that offender's physician or provider.
21 Q Sorry. I will clarify. So if it is not, for
22 example, hormone therapy, it is a procedure that is
23 being requested, it would go -- the primary care
24 physician would recommend the procedure. It would go
25 to the DTARC. The DTARC would, in this hypothetical,

1 approve the procedure.
2 That procedure approval would go back to the
3 physician. The physician would have to then re-request
4 the procedure to utilization management, and then if
5 utilization management approves that request, where
6 does it go?
7 MR. RODRIGUEZ: I'm going to object to the form.
8 You can answer.
9 THE WITNESS: I think I'm a little confused on the
10 question, but it's the same process that we've covered
11 with any other surgery. So it's the identical process
12 where there's not gender affirming surgery. It's the
13 exact same process that happens. It's just that
14 instead of the UR review approval authority, it's the
15 DTARC that acts as that approval.
16 BY MS. MAFFETORE:
17 Q But UM still has to approve? I thought that's
18 what you just testified.
19 A Correct, but it's an automatic approval at that
20 point.
21 Q It's an automatic --
22 A Correct.
23 Q So the UM no longer has discretion at that
24 point?
25 A That's correct.

1 Q Okay. So if DTARC approves a medication or a
2 procedure, it goes to UM as a formality?
3 A Again, it never leaves. All of this is UM. It
4 never leaves the utilization management. DTARC is part
5 of utilization management in this context. So it never
6 goes -- it never bounces back and forth between the
7 two. It's just that as that is routed through the
8 process, some of them are routed to the UR review
9 approval authority. In this case they're routed to the
10 DTARC, and there's specific reasons. We can talk about
11 why it goes to the DTARC. But then that is the
12 approval stage of that, and from there the orders are
13 executed.
14 Q Okay. Understood. But if somebody is approved
15 by the DTARC for hormone replacement therapy, they
16 cannot be administered a prescription without approval
17 from a utilization management reviewer; correct?
18 A That's not correct.
19 Q Okay. So no UR request needs to be made in
20 order for that patient to then get their hormone
21 therapy after DTARC approval?
22 A Correct. It's just the orders are entered in
23 the computer for the medication. The primary care
24 provider has to enter those orders.
25 Q Okay. But they do not have to enter a UR

1 request?
2 A Correct. Technically it's UR because it goes
3 to the pharmacy the same route that it would normally
4 go, and the pharmacy just automatically approves that
5 because they see that the DTARC has endorsed it.
6 Q Okay.
7 MS. MAFFETORE: Can we go off the record?
8 (Recess.)
9 BY MS. MAFFETORE:
10 Q So, Dr. Campbell, before we broke, I was
11 seeking clarity from you about how DTARC and
12 utilization management interact, and you clarified for
13 me that DTARC serves essentially as utilization
14 management, that when requests go in, they are
15 technically UR requests because that is their form; is
16 that correct?
17 A So that's correct. Now, I will caveat to say
18 that there are times when there's not a UR associated
19 with a referral to the DTARC, and I should've mentioned
20 this before. So if the FTARC meets, for instance, and
21 say an offender has requested hormone replacement
22 therapy, so there's no UR that exists right now.
23 There's never been a UR submitted, but the FTARC refers
24 that to the DTARC.
25 The DTARC will then review it, and if they

1 approve it, then it goes back to the provider, in this
2 case to enter an endocrinology consult. There's only
3 that one consultant that's entered. The only time it
4 would be confusing is if there were in order for
5 something that was caught beforehand and that the
6 DTARC -- that was then diverted to the DTARC, and then
7 DTARC approves it, then it's got to go back.
8 And I guess the best way to explain it would be
9 when it goes to the regular UR approval authority, it's
10 in the system. There's literally a button they click
11 that says "approved," and it automatically translates
12 in the system. The way we've just described it, the
13 DTARC, they don't have a button they push to approve
14 it. So what has to happen is it has to go back to that
15 primary care provider to enter that, and then it's
16 approved.
17 So I hope that makes more sense, but more often
18 than not, there's not initial UR for that. The case is
19 referred by the offender, usually. It's a
20 self-generated request by the offender for hormone
21 replacement therapy. The FTARC reviews. Obviously
22 they can't approve that. They refer it to the DTARC.
23 If the DTARC says yes, it goes to the primary
24 care provider. The primary care provider enters that
25 consult, and it's really an automatic approval at that

1 point because the DTARC has approved it already. I
2 hope that clarifies it a little.
3 Q It does. And so if there was ever a
4 circumstance where a UR request got submitted directly
5 to utilization management for, for example,
6 gender-affirming surgery but the DTARC had not yet
7 considered that, what would utilization management do
8 with that request?
9 A So there's a couple options at that point.
10 What is most likely to happen in that case is
11 utilization management would defer that consult back to
12 the primary care provider and tell that primary care
13 provider that that needs to be referred through the
14 FTARC up to the DTARC, if that makes sense. So in
15 other words, and I'm trying not to jump ahead to the
16 DTARC stuff, but the FTARC input is critical to the
17 DTARC's ability to be able to review a case. So we've
18 got to have that input from the facility level for the
19 DTARC to be able to make an informed decision. So in
20 the scenario you just described, a referral would be
21 deferred back to the provider. The provider would then
22 refer that offender to the FTARC for review.
23 Q Or if it's already past the FTARC stage, to the
24 DTARC?
25 A Correct.

1 Q And based on your testimony, do I understand
2 correctly that if DTARC has approved a medication or
3 procedure, UM no longer has the ability to defer that
4 as not medically necessary?
5 A That's correct.
6 Q Okay. And so if UM did that, that would be
7 inappropriate under the policies that you just
8 articulated?
9 A Yes, ma'am.
10 Q So just speaking a little bit more about how
11 the general policies apply, specifically to the
12 treatment of gender dysphoria, is it DPS's position
13 that requests for gender-affirming surgery be
14 considered on a case-by-case basis?
15 A Yes, ma'am.
16 Q And when considering the treatment of gender
17 dysphoria, are clinical decisions the sole
18 responsibility of managing health and wellness
19 practitioners?
20 A Say that one more time.
21 MR. RODRIGUEZ: Object to the form.
22 BY MS. MAFFETORE:
23 Q Sure. So we were speaking earlier about the
24 health and wellness policy, and we were speaking about
25 a portion of that policy that stated "clinical

1 decisions are the sole responsibility of managing
2 health and wellness practitioners." Do you recall our
3 discussion about that?
4 A I do.
5 Q Okay. When considering the treatment of gender
6 dysphoria, are clinical decisions the sole
7 responsibility of managing health and wellness
8 practitioners?
9 A Again, ultimately yes, but I will say this:
10 With gender dysphoria, because of the nature of that
11 condition, it is a multidisciplinary approach, and
12 that's why we have a DTARC and why not an individual
13 approval authority. So you've got to have input from
14 multiple avenues, and when you say "treatment for
15 gender dysphoria," there can be many things that are
16 technically not clinical, especially in the prison
17 setting, for instance.
18 So it can be simple accommodations, whether
19 it's undergarments, whether it's cosmetics. Those type
20 of things are technically not a clinical medical
21 decision, but they do require input from other
22 entities, particularly at the custody level. There are
23 certain products or devices that are a security risk in
24 those contexts I just described. So I think you have
25 to exclude the things that are more purely medical,

1 meaning HRT and gender-affirming surgery from that
2 whole category of gender dysphoria treatment, for lack
3 of a better term.
4 Q Okay. So with respect to HRT and
5 gender-affirming surgery, which you just categorized as
6 clinical and medical, is the treatment of gender
7 dysphoria -- are those clinical decisions with respect
8 to hormone replacement therapy and gender-affirming
9 surgery the sole responsibility of managing health and
10 wellness practitioners?
11 MR. RODRIGUEZ: Object to the form.
12 You can answer.
13 THE WITNESS: So, again, it's the responsibility of
14 the agency appointed committee, which is the DTARC
15 collectively, to make that decision. The medical input
16 is in these two circumstance, obviously, critical for
17 that, but it's still a collective decision that's made
18 by the committee.
19 BY MS. MAFFETORE:
20 Q So with regard to the clinical medical
21 treatment of gender dysphoria, clinical decisions are
22 not the sole responsibility of managing health and
23 wellness practitioners?
24 MR. RODRIGUEZ: Object to the form.
25 You can answer.

1 THE WITNESS: Ultimately it is. In other words
2 that --
3 BY MS. MAFFETORE:
4 Q The sole responsibility?
5 A Yes. I would say ultimately it ends up
6 being -- because the medical authority, and when I say
7 that, I mean both the behavioral health and the medical
8 authority on the committee, are going to carry a very
9 disproportionate amount of weight on that committee for
10 those particular things, and there has not been a
11 circumstance where I'm aware of where behavioral health
12 and medical made a recommendation that was not carried
13 forward by the committee.
14 Where it becomes a little more problematic is
15 things like facility transfers and things like that.
16 Those involve custody and other things. So, again,
17 ultimately yes, but there's still other input that has
18 to be considered.
19 Q I'm sorry to bounce back to this, but I just
20 had one more clarification regarding DTARC and
21 utilization management and how those work together. So
22 am I understanding correctly that a request for
23 gender-affirming surgery or hormone therapy would not
24 proceed through the utilization management appeals
25 process as we discussed it?

1 A I'm sorry?
2 Q We discussed the utilization management appeals
3 process --
4 A Correct.
5 Q -- where the UR request is deferred, that there
6 is an appeals process for that for which you are
7 ultimate decision maker?
8 A Correct.
9 Q A request for gender-affirming surgery or for
10 hormone therapy, even though it's technically submitted
11 as a UR request, if for some reason that were deferred,
12 would that go through the UR appeals process?
13 A So I presume you mean it was deferred by the
14 DTARC because that's who's the authority for this,
15 correct. In other words, it would never be in the
16 process where there is a UR review approval authority
17 looking at that. It would be the DTARC.
18 Q So if for some reason that took place, would
19 that proceed through the UR -- would that proceed
20 through that appeal process?
21 MR. RODRIGUEZ: What's the "that"?
22 MS. MAFFETORE: That a UR decision-maker deferred a
23 request related to gender-affirming surgery or hormone
24 therapy.
25 THE WITNESS: So the UR decision-maker is the DTARC

1 in these cases. So it would never be seen by one of
2 our usual UR review approval authorities. So the DTARC
3 would make that decision, which happens in cases, and
4 the process for that is that that individual -- and we
5 do you see offenders with gender dysphoria who reappear
6 before the committee again with the same request.
7 So it's not a one-time shot at the DTARC. Clinical
8 scenarios change. Clinical circumstances change. The
9 individual's specific condition changes. So they do
10 come back to the DTARC and are reviewed again. It's
11 not the technical appeal process that you discussed
12 through the UM policy though.
13 Q Okay. So if, for example, a glitch in the
14 system, I presume, is the only way this would happen
15 based on your testimony, a UR physician reviewer has
16 screened and denied a request for gender-affirming
17 surgery as not medically necessary, would that be
18 appealable for the UR process, or would that get
19 diverted in some way?
20 MR. RODRIGUEZ: Object as to ambiguity and related
21 to the timing.
22 You can answer.
23 THE WITNESS: So it will need to be deferred back
24 to what I talked about, back to the FTARC and
25 subsequent to the DTARC. If the DTARC had approved

1 that, then there's absolutely -- I don't want to call
2 it necessarily an appeal, but say there were a glitch
3 and this consult got submitted a UR approval authority,
4 maybe they're new, maybe they weren't trained well,
5 maybe they deferred that, but when we find out that the
6 DTARC had already approved that, then we would correct
7 that. We wouldn't need an approval.
8 And again I'm trying to think through a
9 hypothetical here, but, again, the processes remain the
10 same, and we are usually very deliberate that we don't
11 have things crossed through multiple approval
12 authorities because this is what could happen if that
13 were to be the case.
14 BY MS. MAFFETORE:
15 Q Understood. I'm now handing the court reporter
16 will be marked as Exhibit 6.
17 (Exhibit 6 marked for identification.)
18 BY MS. MAFFETORE:
19 Q Exhibit 6 is a policy entitled Evaluation and
20 Management of Transgender Offenders.
21 Have you seen this policy before?
22 A Yes, ma'am.
23 Q Are you familiar with this policy?
24 A I am.
25 Q Have you played any role in the drafting of

1 this policy?
2 A Yes, ma'am. The entire committee was involved
3 in developing this policy.
4 Q And we were speaking a bit before about who has
5 the responsibility of managing health and wellness
6 related to the treatment of gender dysphoria. This
7 policy requires that certain treatment decisions must
8 be approved by committees that we've been referring to
9 as FTARC and DTARC; correct?
10 A Correct.
11 Q And FTARC stands for Facility Transgender
12 Accomodation Review Committee?
13 A Correct.
14 Q And DTARC stands for Division Transgender
15 Accomodation Review Committee?
16 A That's correct.
17 Q Does the FTARC have the ability to approve or
18 disapprove clinical decisions?
19 MR. RODRIGUEZ: I'm going to object to the scope of
20 the topics.
21 You can answer.
22 THE WITNESS: I guess, can you define what you mean
23 as clinical decisions? What would be -- in what
24 context?
25 BY MS. MAFFETORE:

1 Q So I believe you characterized as clinical or
2 medical treatment of gender dysphoria hormone
3 replacement therapy. Are there any situations in which
4 the FTARC has the ability to approve or disapprove
5 hormone replacement therapy?
6 A They don't really approve or disapprove. They
7 defer those to the DTARC. In other words, if it's not
8 within their authority to approve at their level, then
9 they're deferred to the DTARC.
10 Q Is there any situation in which the FTARC would
11 have the authority to approve hormone replacement
12 therapy?
13 MR. RODRIGUEZ: I'm going to object to beyond the
14 scope of the topics. This was addressed by Dr. Peiper
15 in Topic 4 or 5 in relation to FTARC and DTARC.
16 THE WITNESS: Repeat the question one more time.
17 BY MS. MAFFETORE:
18 Q Sure. Are there any situations in which FTARC
19 has the ability to approve hormone replacement therapy?
20 MR. RODRIGUEZ: Same objection.
21 THE WITNESS: No. Again, all those have to come
22 from the DTARC.
23 Q Could you turn with me to page 6 of this
24 policy, also DAC 3426. I'm looking at No. 3. It says,
25 "Routine accommodation review. Routine accommodation

1 decisions will be made at the facility level by the
2 facility TARC and documented on the DC-411-F."
3 Skipping down. "Routine accommodations are, A,
4 continuation of hormone therapy. If immediately prior
5 to incarceration hormone therapy was prescribed in the
6 community by a licensed provider as part of a
7 professionally accepted protocol for gender
8 affirmation, then unless clinically contraindicated,
9 the hormone therapy will" --
10 THE REPORTER: Ma'am, I need you to slow down a
11 little bit.
12 Q Sure.
13 "Then unless clinically contraindicated,
14 hormone therapy will be continued. Consultation with
15 endocrinology may be requested by the facility medical
16 provider, and if appropriate, hormone therapy may be
17 continued while awaiting evaluation by endocrinology.
18 Interruption in hormone therapy should be avoided
19 unless otherwise clinically indicated."
20 Under this policy, is continuation a form of
21 hormone therapy something that the FTARC has the
22 ability to approve?
23 MR. RODRIGUEZ: Objection to beyond the scope of
24 Topics 1, 3, 6, 7, or 15. This was, again, discussed
25 at length in Dr. Peiper's deposition.

1 THE WITNESS: So the way I would answer that is if
2 you read that paragraph that you just read, it's really
3 done by the medical provider. In other words what we
4 do in those cases are, if we can receive medical
5 records from that offender that they had been legally
6 prescribed hormone replacement therapy, then that
7 provider can make an individual decision to continue
8 that temporarily and continue the offender on that
9 treatment. So it's not necessarily something the FTARC
10 has to approve.
11 MS. MAFFETORE: I'd just like to stay for the
12 record that this falls under Topic 6, "medical
13 necessity criteria, utilization review criteria" --
14 THE REPORTER: Ma'am, ma'am.
15 MS. MAFFETORE: Topic 6, "medical necessity
16 criteria, utilization review criteria, and any related
17 policies or gender-affirming surgical care for the
18 treatment of gender dysphoria utilized currently and at
19 any other time since October 1, 2017, by NCDPS, DTARC,
20 or any and all FTARCs."
21 MR. RODRIGUEZ: And I appreciate that, and for the
22 record, I'd like to emphasize that the beginning of
23 that phrase "and any related policies for
24 gender-affirming surgical care," which does not include
25 hormone replacement therapy, which is what you were

1 just asking about.

2 MS. MAFFETORE: Sure.

3 BY MS. MAFFETORE:

4 Q So moving on to page 7 of the policy, at C it

5 states -- so well, beginning at the last sentence

6 before we go into the letter subparts.

7 So "the Division TARC will review nonroutine

8 accommodations to include, but not limited to, NC

9 State's gender-affirming surgical requests."

10 Did I read that correctly?

11 A You did.

12 Q Okay. So DPS's official policy allows for

13 gender-affirming surgery in theory; correct?

14 A Correct.

15 Q And just for the record, while this policy is

16 called "evaluation and management of transgender

17 offenders," we have begun refer to it in shorthand as

18 EMTO policy in this lawsuit. I know nobody in DPS

19 calls it that, but if I refer to the policy as EMTO

20 policy, this is the policy I'm talking about, just for

21 clarity.

22 A Okay.

23 Q So if there is a clinical decision that

24 gender-affirming surgery should be provided, the

25 clinician recommending that surgery is not enough for

1 somebody to receive surgery; correct?
2 MR. RODRIGUEZ: Objection to the form and assuming
3 facts that aren't present for the witness.
4 THE WITNESS: Say that one more time.
5 BY MS. MAFFETORE:
6 Q So this is a hypothetical scenario. Under DPS
7 policy, if a clinician believes that for their patient
8 that they treat directly, gender-affirming surgery is
9 medically necessary and wants to recommend that
10 treatment, that, under DPS policy, is insufficient for
11 the individual to get that treatment; correct?
12 MR. RODRIGUEZ: I'm going to object to form and
13 speculation.
14 You can answer.
15 THE WITNESS: So I'd say the same thing applies.
16 I'd broaden it beyond just gender-affirming surgery.
17 That's all surgeries. So any time a specialist sees an
18 offender and makes a surgery request, it's not
19 automatically approved in any context. It always comes
20 back to the primary care provider, utilization review
21 management. In this case it'd come back to the primary
22 care provider and the DTARC for that.
23 So, again, they're very analogous. They're
24 parallel systems. So it's not just exclusionary
25 towards the gender-affirming surgery. It's all

1 surgeries.
2 BY MS. MAFFETORE:
3 Q Understood. So if somebody were to request a
4 surgery that is not for the treatment of gender
5 dysphoria, that would go to a utilization review;
6 correct?
7 MR. RODRIGUEZ: Objection. Ambiguity as to
8 somebody.
9 You can answer.
10 THE WITNESS: Correct. All surgical requests are
11 routed that same way, regardless of whether it's
12 related to gender dysphoria or not.
13 BY MS. MAFFETORE:
14 Q They would not go to a multidisciplinary
15 committee; correct?
16 A Who wouldn't?
17 Q A surgical request for the treatment of
18 something other than the treatment of gender dysphoria?
19 A No. There are specific reasons for that, and
20 the reasons for that are pretty complex. So for
21 instance, gender dysphoria is incredibly unique. It is
22 the only condition that crosses disciplines.
23 So it's a psychiatric condition that carries
24 with it potential surgical treatments as an option.
25 There is no other psychiatric condition in the DSM-V

1 where surgery is an available option.
2 So the reason it has to be multidisciplinary is
3 because in other cases of surgeries, the primary care
4 provider is going to have the training and expertise to
5 evaluate that particular offender for those particular
6 conditions and make a recommendation. That primary
7 care provider does not possess the training or
8 expertise to deal with a condition such as gender
9 dysphoria. Again, that crosses disciplines. So by
10 definition has to be multidisciplinary evaluation for
11 this particular condition.
12 Q So is it DPS's position that gender dysphoria
13 is a psychiatric condition?
14 A It absolutely is. It's in the DSM-V.
15 Q And is it DPS's position that the individuals
16 on the DTARC have the training and expertise to make
17 decisions about gender-affirming surgery?
18 MR. RODRIGUEZ: Objection to form.
19 You can answer.
20 THE WITNESS: Yes, ma'am.
21 BY MS. MAFFETORE:
22 Q Okay. I was speaking with you about the
23 process, and we can talk about justifications in a
24 moment, but speaking about the process, if somebody
25 requests gender-affirming surgery, it has to go to a

1 multidisciplinary committee; correct?
2 A For gender dysphoria?
3 Q Gender-affirming surgery for the treatment of
4 gender dysphoria --
5 A Yes.
6 Q -- has to go to a multidisciplinary committee?
7 A Yes.
8 Q For other conditions, it would simply go to a
9 UR reviewer; correct?
10 A It would go to a UR reviewer through the
11 primary care provider, but again, because that primary
12 care provider and the UR review approval authority has
13 the expertise to --
14 Q We don't need to talk about justifications
15 right now.
16 MR. RODRIGUEZ: Let the witness finish his answer,
17 please.
18 MS. MAFFETORE: He's not answering my question.
19 MR. RODRIGUEZ: He was answering it and qualifying
20 it, which is his right. So once he finishes, you can
21 follow up.
22 BY MS. MAFFETORE:
23 Q I'm happy to talk about justifications in just
24 a moment, but right now I would just like to speak
25 about the process. So just about process. After a

1 surgery is approved by a utilization reviewer, does it
2 have to be approved by anyone else?
3 MR. RODRIGUEZ: Objection. Ambiguity. Vague.
4 THE WITNESS: Say that one more time.
5 BY MS. MAFFETORE:
6 Q If a surgery for the treatment of a condition
7 other than gender dysphoria is approved by a
8 utilization reviewer, does it have to be approved by
9 anyone else at DPS?
10 A No. And in the case of gender dysphoria or
11 gender-affirming surgery, that UR reviewer is the
12 DTARC. So, again, same process, it's just different
13 entities.
14 Q Right. And so after the DTARC approves a
15 request for gender-affirming surgery, is there another
16 step?
17 A Just the mechanical entry of that referral into
18 the system.
19 Q So I would like to direct you to the third
20 paragraph on page 7 of Exhibit 6, which reads, "All
21 accommodation requests for surgical intervention or
22 gender identity consistent facility transfer shall be
23 reviewed by the Division TARC with recommendations
24 referred to the assistant commissioner of prisons and
25 director of Health and Wellness Services for review and

1 determination."
2 Did I read that correctly?
3 A You did.
4 Q Are there any -- so the policy then requires
5 that after DTARC approves, there is another step for
6 approval process; correct?
7 A Correct.
8 Q Okay. Are there any other surgical requests
9 that have to be approved by the director of Health and
10 Wellness Services and the assistant commissioner of
11 prisons before they will be provided?
12 A Not that I'm aware of, but there are other
13 surgeries that, for instance, will come to my level.
14 Well, not just surgeries, but other interventions will
15 come to my level where I'm essentially acting as this
16 entity, as the director of health and wellness and now
17 the deputy secretary.
18 Q And that is through the UR appeal process?
19 A No. That's through the UR. So, for instance,
20 if we get a request for a prosthetic that's $300,000,
21 then that's going to come to me for review. So there
22 are instances where there is another level of review
23 for procedures that -- the gender-affirming surgery is
24 not the only case where that occurs.
25 Q Okay. But there are no other surgeries for

1 which the assistant commissioner of prisons makes a
2 determination for an approval determination as to
3 surgery; correct?
4 MR. RODRIGUEZ: Object. Mischaracterization of the
5 document.
6 You can answer.
7 THE WITNESS: Again, it's analogous to the other
8 example I gave. That review is required.
9 BY MS. MAFFETORE:
10 Q That review is required by the assistant
11 commissioner of prisons?
12 A Correct.
13 Q For other conditions?
14 A No. For this condition.
15 Q So my question was, there are no other
16 conditions for which surgical approval is required by
17 the assistant commissioner of prisons; correct?
18 MR. RODRIGUEZ: Objection. Incomplete reference to
19 the document.
20 You can answer.
21 BY MS. MAFFETORE:
22 Q Are there other conditions where the director
23 of Health and Wellness Services has final review and
24 approval process of a surgical request?
25 A Not that I'm aware of.

1 MR. RODRIGUEZ: Object to the form.
2 You can answer.
3 THE WITNESS: So, again, I think it's as an
4 extension of the DTARC, it's analogous to the DTARC.
5 Although, within the DTARC, those decisions are really
6 going to fall on myself and behavioral health. The
7 same thing applies at their level in that she is going
8 to defer to Dr. Junker as a clinical representative at
9 that level, and conversely Dr. Junker will refer to the
10 assistant commissioner or deputy secretary for those
11 specific custody-related things.
12 Because, again, it's important to remember there's
13 a lot of things reviewed at the DTARC that are not just
14 medical considerations, and so you've got to have a way
15 to properly synchronize and filter and validate those
16 things.
17 BY MS. MAFFETORE:
18 Q Okay. Moving on from that, I'm going to hand
19 the court reporter what will be marked as Exhibit No.
20 7.
21 (Exhibit 7 marked for identification.)
22 BY MS. MAFFETORE:
23 Q Have you seen this document before?
24 A No, ma'am, not that I recall.
25 Q So I will represent to you that this is a

1 document was produced to us in discovery. As you can
2 tell by the Bates number at the bottom, DAC 4009, as
3 responsive to an interrogatory request seeking
4 information about individuals who have received
5 gender-affirming surgery. Does that sound familiar to
6 you? -- excuse me -- who have requested
7 gender-affirming surgery. Does that sound familiar to
8 you?
9 A It does sound familiar. I just don't remember
10 if I've seen this document before or not.
11 Q Okay. Well, you can take your time in
12 reviewing it if you need to.
13 A That's okay.
14 Q So this represents requests from 15 different
15 individuals for gender-affirming surgery. Are you
16 aware of any other requests for gender-affirming
17 surgery from people who are incarcerated with DPS?
18 A I don't see -- I don't understand why I don't
19 see names on here so it's going to be difficult for me
20 to say whether this is an all-inclusive list or not.
21 Q So based on objections from your counsel
22 regarding personally identifiable health information, I
23 believe that individuals have been removed and they
24 have been assigned a requester number instead --
25 A Okay.

1 Q So my understanding of this document is that
2 Requester 1, the entire first row is applicable,
3 whereas Requester 2, those three rows are applicable to
4 Requester 2, and there are 15 requesters in total
5 represented on this document. Are you aware of more
6 than 15 people who have requested gender-affirming
7 surgery from the DPS?
8 A Again, I've never counted the number so I can't
9 tell you for sure.
10 Q Does 15 sound about right to you?
11 MR. RODRIGUEZ: Objection. Speculation.
12 You can answer.
13 BY MS. MAFFETORE:
14 Q Based on your involvement with the DTARC, does
15 15 sound right to you?
16 A Again, it's hard to gauge. You know, we review
17 15 to 20 cases at every DTARC. Some of them are cases
18 that are being re-presented. So I really can't tell
19 you whether that is an all-inclusive list or not just
20 by reviewing it.
21 Q Did you prepare today to discuss Topic No. 7,
22 the North Carolina Department of Public Safety's
23 considerations of requests for gender-affirming
24 surgical care by incarcerated transgender prisoners
25 since October 1, 2017?

1 A Yes, ma'am.
2 Q Okay. So did you become familiar with the
3 general tenor of the requests made in your preparation
4 for this deposition topic?
5 MR. RODRIGUEZ: Objection to form.
6 You can answer.
7 THE WITNESS: I mean, yes, I'm aware that I'm
8 supposed to answer questions related to
9 gender-affirming surgery.
10 BY MS. MAFFETORE:
11 Q Okay. To requests for gender-affirming surgery
12 by incarcerated transgender prisoners since October 1,
13 2017?
14 A Correct.
15 Q Okay. Does this list represent those requests?
16 A They represent gender-affirming surgery
17 requests, yes.
18 Q Okay.
19 MS. MAFFETORE: Can we go off the record for just a
20 second?
21 (Pause in proceedings.)
22 BY MS. MAFFETORE:
23 Q So the medical necessity standards that you
24 laid out previously, whether it's reasonable and
25 appropriate to protect life, to prevent a significant

1 disability or illness, or to prevent pain and
2 suffering -- significant pain and suffering, is that
3 the medical necessity criteria that was utilized to
4 review each of the requests for gender-affirming
5 surgery that have come before the DTARC?
6 A Yes, ma'am.
7 Q Were the community standards that we discussed
8 previously utilized for each of these when review of
9 each of these requests before the DTARC?
10 MR. RODRIGUEZ: Objection. Vague.
11 You can answer.
12 THE WITNESS: Yes, ma'am. So as I said before,
13 there's an individualized review of every single one of
14 these cases that are presented at the DTARC.
15 BY MS. MAFFETORE:
16 Q Okay. And for each and every one of these
17 cases, were those sources that you referred to earlier,
18 WPATH, Endocrine Society, and all other relevant
19 sources, would those have been considered when
20 reviewing these requests before the DTARC?
21 A Yes, ma'am.
22 Q Would DTARC have reviewed relevant insurance
23 coverages?
24 A No. That's not really part of the DTARC
25 review. So there's not a separate discussion about

1 insurance coverages because in our context that's not
2 what we're looking at.
3 Q So we discussed earlier that in making a
4 medical-necessity determination, whether or not a
5 majority of insurance providers cover the treatment
6 would be a relevant consideration to the medical
7 necessity of a treatment; correct?
8 MR. RODRIGUEZ: Objection. Slight
9 mischaracterization of the witness's testimony.
10 THE WITNESS: Yeah. So, again, it's an associated
11 portion of that evaluation. So it goes along with the
12 standard of care determination, but there's a lot of
13 other things that go into that. So it's just a factor,
14 but certainly not -- you asked if this was a topic of
15 discussion at the DTARC, and generally it's not a
16 specific topic of discussion at the DTARC.
17 BY MS. MAFFETORE:
18 Q Has the DTARC ever approved a gender-affirming
19 surgery as medically necessary for anyone in DPS's
20 custody?
21 A Not that I'm aware of.
22 Q So I just want to be clear, speaking as DPS,
23 has DPS ever approved a gender-affirming surgery as
24 medically necessary?
25 A Not that I'm aware of.

1 Q Has any prisoner in DPS's custody ever received
2 gender-affirming surgery?
3 MR. RODRIGUEZ: Asked and answered.
4 But you can't -- well.
5 THE WITNESS: While incarcerated?
6 BY MS. MAFFETORE:
7 Q While incarcerated.
8 MR. RODRIGUEZ: Asked and answered.
9 You can answer.
10 THE WITNESS: Not that I'm aware of.
11 BY MS. MAFFETORE:
12 Q What are the reasons why these requests have
13 never been granted?
14 MR. RODRIGUEZ: Objection. Vague. Speculation.
15 You can answer.
16 THE WITNESS: Again, I'll go back to what I
17 discussed, that for each of these cases there is an
18 individualized review. There's specific cases and
19 clinical circumstances in the context of that
20 definition for medical necessity that we discussed, and
21 that consideration, that risk-benefit analysis, that
22 standard of care and that medicine review is part of
23 every single one of those analyses.
24 BY MS. MAFFETORE:
25 Q So can you provide a summary list of reasons

1 why individuals seeking gender-affirming surgery from
2 the DTARC have been denied that surgery?
3 MR. RODRIGUEZ: Objection. Form. Vague.
4 You can answer.
5 THE WITNESS: A summarized list?
6 BY MS. MAFFETORE:
7 Q To the best of your ability.
8 A So, again, I think I'll go back to what I said
9 before, that there's that risk-benefit analysis. You
10 have to look at that individual offender and determine
11 if their particular clinical circumstances are such
12 that it warranted that step in the gender dysphoria
13 treatment algorithm, and in each of these cases, they
14 did not did not rise to that level.
15 Q What are some examples of clinical
16 circumstances that would have cut against the
17 individuals being considered for gender-affirming
18 surgery by DTARC?
19 MR. RODRIGUEZ: Objection. Form. Speculation.
20 You can answer.
21 THE WITNESS: That would cut against them being
22 considered?
23 BY MS. MAFFETORE:
24 Q That would cut against a finding of medical
25 necessity.

1 A I guess I'm not clear. So you're saying what
2 circumstances would make it medically necessary; is
3 that what you're asking?
4 Q No. So the DTARC has considered at least 18
5 individuals' requests for gender-affirming surgery --
6 A I think it was 15.
7 Q At least 15 individuals' requests for
8 gender-affirming surgery. I'm trying to get this top
9 level so that we're not discussing any
10 individual-specific circumstances, as I understand that
11 that's an objection that your counsel has raised. So
12 I'm trying to understand from you, what are -- you just
13 said that certain circumstances are considered and
14 weighed into a risk-benefit analysis, and then DTARC
15 concludes that the surgery is not medically necessary.
16 What are the -- what are some of the
17 circumstances that go into that risk-benefit analysis
18 that have led the DTARC to conclude that these
19 individuals do not require gender-affirming surgery and
20 that it is not medically necessary or appropriate?
21 MR. RODRIGUEZ: Objection to form. Legal opinion.
22 You can answer.
23 THE WITNESS: Okay. So probably the best way to
24 answer that would be that as you do that analysis, and
25 I guess I should step back a little bit and talk about

1 one of the principles that we look at in medicine. So
2 in medicine there are stepwise treatments for any
3 condition, step outside of gender dysphoria. In
4 medicine when you do that risk-benefit analysis, you
5 always opt for the least risky, least invasive
6 procedure that meets your therapeutic objective.
7 So applying that to gender dysphoria, the
8 therapeutic objective is to address their dysphoria.
9 So at each of these points in time when they appear
10 before the DTARC, we evaluate their current status of
11 their gender dysphoria. That's the purpose of the
12 DTARC.
13 So we get behavioral health assessments. We get
14 mental health assessments. We get medical assessments,
15 and we make an overall determination of is that
16 individual stable. Are there indications that their
17 gender dysphoria has not been adequately treated by the
18 current or previous treatments? And if they are stable
19 and doing well and there's no indication to step up
20 that therapy, then oftentimes we will not step up that
21 therapy.
22 So it's analogous to an orthopedic condition. If
23 you come in to see your provider for knee pain, he's
24 not going to immediately jump to surgery short of a
25 catastrophic joint destruction. You're probably going

1 to get a nonsteroidal anti-inflammatory. You're going
2 to get some rest, ice, heat, compression, elevation.
3 You're going to get physical therapy. You may get an
4 injection at the next stage, and eventually you may
5 progress to surgery.
6 So, again, we should be consistent when we look at
7 gender dysphoria, just like we are with every other
8 medical condition we take care of. So at this point in
9 time when these individuals appeared before the DTARC,
10 their condition was satisfactorily controlled, again,
11 met therapeutic objectives, and this next step was not
12 indicated.
13 BY MS. MAFFETORE:
14 Q So I believe you just testified one of the
15 things that you look to is whether or not the
16 individual is stable, and if the individual is stable
17 that would lead you to conclude that further
18 intervention is not necessary; is that correct?
19 A May not be necessary, correct.
20 Q Okay. So if you could just look with me at
21 Requester No. 7. The first entry related to Requester
22 No. 7 in the DTARC recommendations column says,
23 "Request not supported. Psychiatric instability."
24 So is it the case that instability would also
25 in the DTARC's view and DPS's view counsel against

1 providing gender-affirming surgery for the treatment of
2 gender dysphoria?
3 MR. RODRIGUEZ: Before you answer, I just want to
4 make sure that your answer is not reflective of a
5 particular case, but rather in the high-level sense of
6 the question.
7 THE WITNESS: Yeah. So, again, without knowing
8 exactly which case this is, what I can tell you is that
9 very frequently, and this is true of not just with
10 gender dysphoria, but patients often have concomitant
11 illnesses, concomitant psychiatric illnesses. So very
12 often what we see is an individual may be
13 psychiatrically unstable for another condition, not for
14 the gender dysphoria. And, again -- and that's -- even
15 WPATH recommends that those conditions, those comorbid
16 psychiatric conditions need to be sufficiently
17 controlled and stable before you proceed with any
18 treatments related to gender dysphoria. So that is
19 certainly one way that that psychiatric instability
20 does not necessarily mean that they're unstable from a
21 gender dysphoria perspective by any means.
22 BY MS. MAFFETORE:
23 Q Okay. So if somebody is psychiatrically
24 unstable, they can be denied gender-affirming surgery,
25 but if somebody is a psychiatrically stable, that could

1 also be a reason to deny gender-affirming surgery for
2 the treatment of gender dysphoria?
3 MR. RODRIGUEZ: Objection. Slight
4 mischaracterization of the witness's testimony.
5 You can answer.
6 THE WITNESS: So, again, if they are
7 psychiatrically stable for the gender dysphoria, that
8 would indicate you don't need to proceed with
9 treatment. If they're psychiatrically unstable from
10 other conditions, you do not want to embark on
11 treatment of their gender dysphoria until we stabilize
12 those other conditions. So, again, many of these
13 individuals have concomitant psychiatric illnesses that
14 need to be addressed concurrently with their gender
15 dysphoria.
16 Q Can gender dysphoria lead to concomitant
17 psychiatric illness?
18 A I don't know that the research is completely
19 clear on that. I think that there's probably research
20 on both sides of that as to that association.
21 Q For several of these entries, all that is noted
22 is, "request not supported, not medically necessary."
23 Do you see that?
24 A Yes, ma'am.
25 Q But there is no other indication in the DTARC

1 recommendation column as to justification for that
2 conclusion; correct?
3 MR. RODRIGUEZ: Objection to form.
4 You can answer.
5 THE WITNESS: In this column on this document,
6 that's correct.
7 BY MS. MAFFETORE:
8 Q On the very last one in this document, No. 15,
9 in the last column it says, "Request not supported.
10 Does not meet diagnostic criteria."
11 Which diagnostic criteria would those have
12 been?
13 A Again, it would be a presumption on my part
14 without knowing this particular case, but there have
15 been cases that are presented to the DTARC that do not
16 have a gender-dysphoria diagnosis at all, and so those
17 cases that present -- you know, in medicine we treat
18 conditions. An individual needs to have a diagnosed
19 condition for us to embark on treatment. That's
20 universally true of any medical condition that we
21 treat. So, again, I'm presuming that's what's meant
22 here because I do remember seeing cases like that are
23 presented to the committee that either don't have the
24 diagnosis or actually have medical documentation that
25 counters the fact that they even have gender dysphoria,

1 so.

2 Q Has DPS ever approved a request for a procedure

3 that could be considered a gender-affirming surgery but

4 for treatment of something other than gender dysphoria?

5 MR. RODRIGUEZ: Objection to form. Speculation.

6 You can answer.

7 THE WITNESS: So if I understand the question,

8 there are many, many surgeries that are performed for

9 completely medical indications that just also happen to

10 be treatments for gender dysphoria. So there's a long

11 list. A hysterectomy would be one, for instance.

12 BY MS. MAFFETORE:

13 Q Does DPS provide a hysterectomy for the

14 treatment of conditions other than gender dysphoria?

15 A Yes, ma'am, when it's medically necessary.

16 Q What about mastectomy?

17 A When it's medically necessary.

18 Q What about gonadectomy?

19 A When it's medically necessary.

20 Q Okay. How does the medical necessity

21 determination with respect to those other situations

22 that you just detailed where, for example, hysterectomy

23 might be necessary, how would the medical necessity

24 determination differ there for treatment of gender

25 dysphoria?

1 MR. RODRIGUEZ: Objection. Vague. Form.
2 You can answer.
3 THE WITNESS: So there are clear indications for
4 hysterectomy, and we consider those. So it could be
5 that they're having dysfunctional uterine bleeding. It
6 could be that they have uterine cancer. It could be
7 that they have leiomyoma. So there's a long list of
8 medical indications for a hysterectomy, and those
9 would, of course, be endorsed and carried out.
10 BY MS. MAFFETORE:
11 Q So you're saying that that is different from
12 gender dysphoria?
13 MR. RODRIGUEZ: Objection. Mischaracterization the
14 witness's testimony.
15 You can answer.
16 THE WITNESS: No, it's not different. It's just
17 that those are all clear medical necessity indications
18 for that procedure, the hysterectomy that you just
19 mentioned.
20 BY MS. MAFFETORE:
21 Q Okay. So my question was how does the medical
22 necessity determination differ in those circumstances
23 to consideration for treatment of gender dysphoria?
24 A It doesn't differ at all. So we do the same
25 risk-benefit analysis for that particular patient for

1 that particular condition in their clinical
2 circumstances and make the determination that is
3 medically necessary for that patient at that time.
4 Q So moving from the general to the specific,
5 what was the process for considering Mrs. Zayre-Brown's
6 request for surgery at the February 17, 2022, DTARC
7 meeting?
8 A What was the process?
9 Q Yes.
10 A I'm assuming you're asking at the DTARC?
11 Q The February 17, 2022, DTARC meeting.
12 A Okay. So it's the same process that we use for
13 every DTARC for every offender that's presented to the
14 committee. So what happens is is that the case is
15 initially presented. Dr. Peiper, as the chair of the
16 committee, will present the case. They'll talk about,
17 we are now evaluating offender X, incarcerated on this
18 date, release date on this date, review of all of the
19 previous FTARCs and DTARCs and those decisions that
20 have been made up to that point, and then what is in
21 front of the committee today for that individual, and
22 then we proceed with the rest of the evaluations from
23 each of the entities that sit on the DTARC.
24 So Dr. Peiper would generally give a mental
25 health history or behavioral history. Dr. Sheitman

1 will give a mental health history. The PREA
2 representative will talk about any concerns from that
3 perspective. The custody or security will then provide
4 their input into the case, any concerns. Programs will
5 be involved and provide their input, and then medical
6 also provides their input to the committee.
7 So we follow that same process every single
8 time for every offender, and then there's discussion
9 that follows after that to talk about what we want to
10 do for that particular request for that particular
11 offender.
12 Q So aside from your contribution on that day,
13 did you serve any other role?
14 A Again, I am the medical authority on the DTARC.
15 I also serve as a co-chair on the DTARC, but that's
16 always my role.
17 Q So you served as co-chair on February 17, 2022?
18 A I did.
19 Q Okay. What comes along with the co-chair role?
20 A So, again, it's coordinating with Dr. Peiper to
21 have the cases reviewed, presented to the committee,
22 and then to provide my medical input.
23 Q Okay. What were the DTARC members expected to
24 do to prepare in advance for this meeting?
25 A So we get the list of offenders that are going

1 to be presented, and the list includes, you know, what
2 their previous FTARC -- the last FTARC date was, the
3 previous FTARCs, and the issues that are in front of
4 the committee for that particular offender for this
5 upcoming committee meeting, and then each of us do our
6 individual review of that case based on our individual
7 perspective. So I'll review the medical history
8 related to that, and each of them do their research up
9 front so that they are prepared to present that to the
10 committee.
11 Q So did each of the DTARC members review Mrs.
12 Zayre-Brown's medical records in advance of that
13 meeting?
14 A No. Many of them don't have access to the
15 medical records. They're obviously protected. So
16 custody officers don't have access to medical records.
17 The programs folks generally don't have access to
18 medical records. So it's the individuals that have a
19 need to review those medical records will have access
20 to those.
21 Q Who are the individuals who have the need to
22 review those records?
23 A On the committee it's myself, Dr. Peiper, and
24 that Dr. Sheitman.
25 Q So only you, Dr. Peiper, and Dr. Sheitman would

1 have reviewed Mrs. Zayre-Brown's medical records in
2 advance of this meeting?
3 A Correct. I will make one caveat that the PREA
4 representative is also able to review at least some of
5 the medical record.
6 Q Would that have been Ms. Charlotte Williams?
7 A Yes.
8 Q Do you know if Ms. Charlotte Williams reviewed
9 the medical records in advance of this DTARC meeting?
10 A I'm not sure.
11 Q Is there an expectation that those who have
12 access to the medical records will review them to be
13 prepared the DTARC meeting?
14 A There's an expectation that they review their
15 perspective lanes for the DTARC. So in her case it's
16 to review the pertinent aspects of her presentation at
17 the committee.
18 Q And when we are speaking about medical records,
19 do you interpret that term to be inclusive of mental
20 health records?
21 A Yes, ma'am.
22 Q Okay. For the members of DTARC that have
23 access to medical records, did the review of those
24 medical records include records related to Mrs.
25 Zayre-Brown's history of suicidal thoughts?

1 MR. RODRIGUEZ: Objection to form.
2 You can answer.
3 THE WITNESS: Yes. It's an all-inclusive. There's
4 not a time period or any parameters. It's the entire
5 medical record that's pertinent.
6 BY MS. MAFFETORE:
7 Q So then it also would have included her
8 previous history of self-injury behavior?
9 MR. RODRIGUEZ: Objection to the characterization.
10 The evidence is not before the witness.
11 You can answer.
12 THE WITNESS: Yes, ma'am, all medical records are
13 included.
14 BY MS. MAFFETORE:
15 Q So you mentioned that the DTARC reaches
16 consensus determination at the end of the meeting; is
17 that correct?
18 A That's correct.
19 Q Prior to reaching that determination, is there
20 a discussion among the members of DTARC?
21 A Yes, ma'am.
22 Q Okay. In the discussion regarding Mrs.
23 Zayre-Brown on February 17, 2022, were there any
24 disagreements?
25 A I really can't recall specific conversations

1 about specific individuals on that day. I know on that
2 day we reviewed, if I'm not mistaken, 12 cases before
3 the committee. Ms. Brown has been presented at the
4 committee on several occasions. So again, I can't tell
5 you specifically what was said by whom at this
6 particular meeting.
7 Q And so I'm not asking you to quote anyone
8 specifically or tell me anything anyone specifically
9 said. Do you recall there being any disagreements at
10 the meeting about Mrs. Zayre-Brown's request for
11 gender-affirming surgery?
12 A Not that I recall.
13 Q Okay. And you mentioned that she's been
14 considered multiple times for gender-affirming surgery.
15 Do you recall if at any of the DTARC meetings you
16 attended there have ever been disagreements regarding
17 whether or not Mrs. Zayre-Brown should receive
18 gender-affirming surgery?
19 MR. RODRIGUEZ: Objection. Slight
20 mischaracterization of the witness's previous
21 testimony.
22 You can answer.
23 THE WITNESS: Yeah. So I didn't necessarily say
24 she had been presented multiple times for
25 gender-affirming surgery. She's been presented before

1 the committee multiple times, but not just for
2 gender-affirming surgery, so for other associated
3 accommodations. But again, I just -- I don't recall
4 any significant disagreements among the committee.
5 BY MS. MAFFETORE:
6 Q Okay. Did anybody present at that DTARC
7 meeting in the consideration of Mrs. Zayre-Brown's
8 request for gender-affirming surgery express the view
9 that her request should be approved?
10 A Not that I recall.
11 Q And you already stated you don't recall any
12 comments specifically made by other members, but I just
13 want to ask if you recall whether certain subjects were
14 discussed. Do you recall if there was any discussion
15 about the cost of the surgery?
16 A There was no discussion of that.
17 Q Do you recall whether there was any discussion
18 about security concerns?
19 A No, there was no discussion.
20 Q At the February 17th DTARC meeting, did the
21 DTARC discuss logistical concerns?
22 A Not that I recall.
23 Q Did the DTARC at the February 17th meeting
24 discuss postoperative care concerns?
25 A Not that I recall.



Case 3:22-cv-00191-MOC-DCK Document 61-5 Filed 10/05/23 Page 84 of 137

1 Q And just to clarify, all of these are as it
2 relates to Mrs. Zayre-Brown's request, not the other 11
3 people considered that day. Did the DTARC discuss any
4 reactions of staff to Kanautica potentially having
5 surgery?
6 MR. RODRIGUEZ: Objection. Speculation.
7 You can answer.
8 THE WITNESS: I don't recall any discussions like
9 that.
10 BY MS. MAFFETORE:
11 Q Was there any discussion at the February 17th
12 meeting about the possible reactions of other prisoners
13 if Kanautica were to receive surgery?
14 MR. RODRIGUEZ: Objection. Speculation. Vague.
15 You can answer.
16 THE WITNESS: Again, I don't recall that
17 discussions really wouldn't be pertinent, so.
18 BY MS. MAFFETORE:
19 Q At the February 17, 2022, meeting of the DTARC,
20 were there discussions about the benefits to Kanautica
21 from obtaining surgery?
22 A I'm not sure what those would be, but I don't
23 recall that.
24 Q I'm sorry. You don't --
25 A I don't know what you mean by "benefits," but I

1 don't recall a discussion.
2 Q Whether Mrs. Zayre-Brown would benefit in any
3 way from the receipt of gender-affirming surgery.
4 MR. RODRIGUEZ: Objection. Vague.
5 You can answer.
6 THE WITNESS: I don't recall that specific
7 discussion, no.
8 BY MS. MAFFETORE:
9 Q Were there any discussions by the DTARC on
10 February 17, 2022, regarding the risks to Kanautica
11 from not obtaining surgery?
12 A So, again, when you talk about the risk-benefit
13 analysis, I routinely -- and I can't say that I did it
14 in this specific case, but we routinely talk about both
15 the risk and benefit from both sides, from proceeding
16 and from not proceeding with the surgery. So that's
17 routinely a consideration in all of these cases.
18 Q Did anybody voice a concern that without the
19 surgery, Kanautica's gender dysphoria could worsen at
20 the DTARC meeting on February 17, 2022?
21 A Again, I know we've talked about that in the
22 general context, but I can't remember if we talked
23 about it in her specific case.
24 Q What do you mean by the "general context"?
25 A Again, going back to the risk-benefit analysis,

1 there's always that potential, that not treating a
2 condition can result in a worsening of that condition.
3 Q And was that discussed by the DTARC with
4 respect specifically to Mrs. Zayre-Brown?
5 A Not that I recall specifically.
6 Q Has that ever been discussed by the DTARC with
7 respect to specifically to Mrs. Zayre-Brown?
8 A Again, I can't recall a specific conversation,
9 but it's routinely addressed with each one of these
10 cases. It's hard for me to pinpoint from that
11 particular -- for this particular offender.
12 Q How did DTARC arrive at the consensus of the
13 February 17th meeting?
14 A So, again, as I discussed, everybody presented
15 their portion of the case and their individual
16 recommendations, and then there's a discussion. I'll
17 tell you, it's probably the most collegial committee
18 I've ever participated in. Everybody openly talks
19 about what their impressions are, what their
20 recommendations are, and there's discussion back and
21 forth, and then there's a consensus that's reached. So
22 it's a very frank and robust discussion.
23 Q But you can't, sitting here today, recall any
24 of the opinions or recommendations that were discussed
25 on February 17, 2022, with respect to Mrs. Zayre-Brown?

1 MR. RODRIGUEZ: Objection. Mischaracterization of
2 the witness's testimony.
3 You can answer.
4 THE WITNESS: Again, to tell you specifically that
5 that was discussed about her on that day as opposed to
6 about her on another day, I cannot tell you with
7 certainty that occurred on that day.
8 BY MS. MAFFETORE:
9 Q Did anybody from the DTARC express concern
10 about denying her surgery on any other day?
11 A Not that I recall.
12 Q So you discussed with me, sort of, the
13 discussion process, but I'm speaking specifically about
14 the decision making, like getting down to the final
15 decision to write on paper "gender-affirming surgery is
16 not medically necessary, request denied." How did the
17 DTARC arrive at that decision? By -- through what
18 method?
19 A It's the method I've already described, that
20 each prospective member of that committee discusses
21 their particular points in the committee, and then
22 there's a discussion. Because this was
23 gender-affirming surgery, as we discussed before, very
24 often it's going to be the medical individuals on that
25 committee, it's their recommendation that's going to

1 carry the most weight.
2 Q So is it your impression that the nonmedical
3 members of DTARC defer to the decision-making of the
4 medical members of the DTARC?
5 MR. RODRIGUEZ: Objection. Mischaracterization of
6 the witness's testimony.
7 You can answer.
8 THE WITNESS: Again, I don't know that they
9 necessarily differ, but they are going to weigh their
10 opinions very heavily. We, as physicians, are
11 considered the authority on that committee related to
12 this. So they're going to weigh that very heavily,
13 just like if there's a custody-related concern, I'm
14 going to weigh very heavily what security says. The
15 same thing applies.
16 BY MS. MAFFETORE:
17 Q So when I'm asking you about the method of
18 arriving at the decision, you keep mentioning to me the
19 discussion process, and I understand that. I'm really
20 just trying to understand how you ascertained that
21 everybody is in agreement at the end of the day when
22 you go to write that down. Do you go around the table
23 and say, do you agree? Do you agree? Do you agree?
24 Do you do a show of hands? Is there a vote? How did
25 you determine that everybody was an agreement at the

1 end of the day? How do you confirm that?
2 MR. RODRIGUEZ: Objection. Form.
3 You can answer.
4 THE WITNESS: So after that discussion, then Dr.
5 Peiper as the chair will basically present what he
6 believes to be the outcome of that discussion, and
7 he'll say something to the effect of, well, it appears
8 at this point that the committee does not feel this is
9 medically necessary, and he'll ask if there are any
10 objections or any disagreement, and if there are none
11 then we accept that.
12 Q What did Dr. Peiper say with respect to Mrs.
13 Zayre-Brown to the committee?
14 A Again, on that day to tell you specifically for
15 her exactly what he said would be difficult. It's
16 intentionally a very deliberative and very specific
17 process that follows the same procedure every single
18 time.
19 Q So did Peiper agree that it was not medically
20 necessary on February 17, 2022?
21 MR. RODRIGUEZ: Objection. Speculation.
22 You can answer.
23 THE WITNESS: He did. Like I say, I don't remember
24 any disagreement from the committee.
25 BY MS. MAFFETORE:

1 MR. RODRIGUEZ: Objection to form.
2 You can answer.
3 THE WITNESS: I mean, there are references to
4 standards of care in this document, yes.
5 BY MS. MAFFETORE:
6 Q What is DPS's position as to the normal
7 recovery period after vulvoplasty surgery?
8 A So assuming there's no complications,
9 vulvoplasty is much less invasive then vaginoplasty.
10 So it's generally going to be two to four weeks to
11 recover from that.
12 Q And vulvoplasty is the procedure that Mrs.
13 Zayre-Brown was requesting that was being addressed in
14 this case summary; correct?
15 A Yes, at this point it was vulvoplasty. There
16 was some uncertainty on her part initially. When she
17 saw UNC, she originally requested vaginoplasty, ended
18 up changing to vulvoplasty, and subsequently changed
19 back to vaginoplasty. So there's been some, you know,
20 uncertainty on her part as to which procedure she
21 wanted to undergo.
22 Q So the recovery period that was at issue here
23 was the two to four weeks for vulvoplasty. How did
24 that factor into DTARC's decision regarding Mrs.
25 Zayre-Brown?

1 A I don't remember that being a specific
2 consideration.
3 Q So looking at the statement beginning on page 2
4 through the end of the document is a medical analysis.
5 Who contributed to the medical analysis?
6 A I did.
7 Q Did anybody else contribute to the medical
8 analysis?
9 A Not that I recall.
10 Q What aspects of Kanautica's individual medical
11 history did DTARC consider in the medical analysis?
12 A So all aspects of her history. So, again,
13 when -- as you read through this medical analysis,
14 there are references to her stability, to her
15 particular situation, the fact that she's continued to
16 have follow-up, so.
17 Q Other than the final paragraph on page 5, can
18 you point me to an area in the medical analysis that
19 discusses Mrs. Zayre-Brown's specific medical
20 situation?
21 MR. RODRIGUEZ: Object to the form.
22 You can answer.
23 THE WITNESS: Again, I think all of these certainly
24 apply to Ms. Brown.
25 BY MS. MAFFETORE:

1 Q Do these paragraphs discuss her specific
2 medical situation, is my question, her specific medical
3 circumstances.
4 A I don't see her specific name referenced
5 anywhere on these.
6 Q Okay. Are you familiar with Katherine Croft at
7 UNC Health?
8 A Yes, ma'am.
9 Q Are you aware that Katherine Croft asserted
10 with respect to Mrs. Zayre-Brown, "She likely does meet
11 the requirements for medical necessity under gender
12 dysphoria"?
13 MR. RODRIGUEZ: Objection. Speculation. Assuming
14 facts that aren't before the witness.
15 You can answer.
16 THE WITNESS: She asserted that, you said, or
17 inserted that?
18 BY MS. MAFFETORE:
19 Q Yes. Asserted.
20 A I don't remember if I saw that or not.
21 Q Okay. I'd like to hand the witness document
22 DAC 4469, will which will be marked by the court
23 reporter as Exhibit 11.
24 (Exhibit 11 marked for identification.)
25 BY MS. MAFFETORE:

1 Q Do you recognize this document?
2 A I don't remember it specifically.
3 Q Is this an email on which you are a recipient?
4 A Correct.
5 Q Okay. And it is from Lewis Peiper; correct?
6 A That's correct.
7 Q Okay. And among the other individuals included
8 on this email, this is a forward of an email from
9 Katherine Croft; is that correct?
10 A That's correct.
11 Q Okay. And the third email entry down into the
12 chain dated July 29, 2021, at timestamp 12:44 p.m. is
13 that an email from Katherine Croft at UNC Health --
14 Trans Health?
15 A It is.
16 Q Okay. And that email states, "I got a message
17 yesterday from our mutual patient letting me know that
18 her procedure was denied. Is there any further
19 information I can provide or assistance I can give that
20 this patient, in our estimation, likely does meet
21 requirements for medical necessity under gender
22 dysphoria pending a look at her records, of course.
23 Let me now I can assist you."
24 Did I read that correctly?
25 A You did read that correctly.

1 Q Okay. How did Katherine Croft's assertion that
2 Mrs. Zayre-Brown likely does meet requirements for
3 medical necessity under gender dysphoria factor into
4 DTARC's analysis?
5 A The first thing I'd point out is the word
6 "likely," and the second concern I'd point out is that
7 it's apparent from this that she has not even looked at
8 her medical records. So, again, I have to consider
9 that in the entire context. It's the person that says
10 that they likely need it without having reviewed their
11 records and without knowing their medical history
12 carries very little weight, quite frankly, in these
13 considerations.
14 Q Okay. Are you familiar with the endocrinology
15 provider Dr. Caraccio?
16 A I'm familiar with the name, yes.
17 Q Are you aware of whether Dr. Caraccio has
18 recommended gender-affirming surgery as medically
19 necessary for Mrs. Zayre-Brown?
20 A I would have to look at his notes to say for
21 sure, but what I can say is that I think that at some
22 point he did make a referral or did recommend a
23 referral for surgery, but I don't remember using the
24 terminology that it's medically necessary.
25 Q Okay. I'm now handing the court reporter DAC

1 444 which we'll have marked as Exhibit 12.
2 (Exhibit 12 marked for identification.)
3 BY MS. MAFFETORE:
4 Q And I'll represent to you this is a clinical
5 encounter note from provider Donald Caraccio. Does
6 that appear correct to you?
7 A Yes, ma'am.
8 Q If you'll turn with me to the second page of
9 this document, it will be DAC 445. If you look at the
10 last paragraph under the assessment section, it reads,
11 "Regarding her desire for vulvoplasty, this is
12 medically necessary part of treatment for this patient.
13 She has been treated with hormones since 2012 and
14 orchiectomy in 2017 with persistent symptoms of gender
15 dysphoria. Will communicate my plans with Dr. Figler."
16 Did I read that correctly?
17 A You did read that correctly.
18 Q Okay. How would the recommendation by Dr.
19 Caraccio that gender-affirming surgery was medically
20 necessary for Mrs. Zayre-Brown factor into the DTARC's
21 consideration of Mrs. Zayre-Brown's request for
22 surgery?
23 A Again, it is considered. What I would say is
24 the simple statement that "persistent symptoms of
25 gender dysphoria" is an inadequate explanation. There

1 is no clarification on there to degree, severity,
2 progression, how this has trended, what specific
3 concerns they are as to why current treatment is not
4 sufficient. So, again, it's a consideration along with
5 several other considerations.
6 Q Did anybody ask Dr. Caraccio to elaborate
7 further on his assertion that she had persistent
8 symptoms of gender dysphoria and a medical necessity
9 determination?
10 A I'm not aware.
11 Q Are you familiar with master's of clinical
12 social worker Jennifer Dula?
13 A I am.
14 Q Are you aware of whether Ms. Dula ever
15 indicated that gender-affirming surgery was medically
16 necessary for Mrs. Zayre-Brown?
17 A I don't recall if she did.
18 Q I'd like to hand you what will be marked as
19 Exhibit 13, which is DAC 686.
20 (Exhibit 13 marked for identification.)
21 BY MS. MAFFETORE:
22 Q Is this a document a transgender recommendation
23 summary by provider Jennifer Dula dated October 20,
24 2021?
25 A Yes, ma'am.

1 Q This document has categories including review
2 of mental health history, accommodation request, review
3 of transfer gender history, adjustment to
4 incarceration; correct?
5 A Correct.
6 Q Okay. And are you aware of Ms. Dula's role in
7 treating Mrs. Zayre-Brown?
8 A I am. So she's a master's in social work.
9 Q So I'd like to direct you to the review of
10 transgender history section.
11 A Okay.
12 Q It's the second paragraph. We'll go to the
13 last two sentences of the first paragraph.
14 "She has been consistently on hormone therapy
15 since 2012. Ms. Brown has also undergone several other
16 gender affirming surgeries as part of her transition
17 such as orchiectomy, breast augmentation, and facial
18 feminization. Despite these interventions, Ms. Brown
19 continues to report clinically significant anxiety,
20 depression, and distress associated with her gender
21 dysphoria that has been documented consistently
22 throughout her mental health treatment.
23 "My clinical evaluation and the existing mental
24 health documentation for Ms. Brown meets the criteria
25 for diagnosis of gender dysphoria."

1 Did I read that correctly?
2 A You did.
3 Q Continuing to the third paragraph, "Based on
4 the review of records and the current assessment, it
5 appears the next appropriate step for Ms. Brown is to
6 undergo trans-feminine bottom surgery. The surgery
7 will help her make significant progress in the
8 treatment of her gender dysphoria. Ms. Brown is
9 psychologically stable to undergo the surgery and will
10 be able to access postop care at an appropriate DPS
11 facility.
12 "She has no issues with illicit drug use or
13 abuse. Review of all medical consultations with UNC
14 Trans Health show that the risks, benefits, and
15 alternatives of surgery have been reviewed with Ms.
16 Brown, and she showed excellent understanding during
17 those consultations and this evaluation. She
18 demonstrated the ability to make an informed decision
19 about undertaking surgery. In summary, Ms. Brown has
20 met the WPATH criteria and is an appropriate candidate
21 for surgery?"
22 Did I read that correctly?
23 A You did.
24 Q How did the recommendation by Ms. Dula factor
25 into the DTARC's analysis?

1 A So, again, it was also a consideration. Not
2 taking anything away from Ms. Dula, but she is a
3 master's in social work, coupled with this are
4 assessments from psychiatry, psychology, multiple
5 incidents of those evaluations by those higher-level
6 providers. So, again, it's considered. It's important
7 in context. Again, it's the trend that we want to see
8 what these offenders. So, again, it's a consideration.
9 Q Are you aware of the outcome of the surgical
10 consult with Dr. Figler with regard to Mrs.
11 Zayre-Brown's request for gender-affirming surgery?
12 MR. RODRIGUEZ: Objection. Vague.
13 You can answer.
14 THE WITNESS: I'm aware that she saw Dr. Figler,
15 yes.
16 BY MS. MAFFETORE:
17 Q What did Dr. Figler conclude?
18 A If I'm not mistaken, he simply concluded that
19 she met the minimum WPATH criteria for surgery, but if
20 I recall correctly, he also did not provide any
21 justification for that, no explanation of why he felt
22 that was indicated. To my knowledge, he can't even
23 review the records to be able to tell whether she was
24 psychiatrically stable or not. So, again, I think from
25 what I understand, it was simply saying that she met

1 minimum WPATH criteria for surgery.
2 Q Did anybody follow up with Dr. Figler to seek
3 additional justification from him regarding his
4 assertion that she met the WPATH criteria for surgery?
5 A I'm not aware.
6 Q How did the surgical consult with Dr. Figler
7 factor into the DTARC's analysis?
8 A Again, it was also a factor.
9 Q So these four providers who have seen Mrs.
10 Zayre-Brown in person and evaluated her all confirmed
11 that she was a candidate for surgery. What led DTARC
12 to conclude that Mrs. Zayre-Brown was not an
13 appropriate candidate for surgery?
14 MR. RODRIGUEZ: Objection. Mischaracterization of
15 the previous testimony.
16 THE WITNESS: So I guess I'll start by saying that
17 before you were referencing, I assume, Ms. Katherine
18 Croft, who is one of those who is not a provider, who
19 simply runs the trans health medicine program,
20 transgender health program. I'm not sure who the
21 other -- you've got Dr. Caraccio, the endocrinologist,
22 Ms. Dula, and who was the last one?
23 BY MS. MAFFETORE:
24 Q Dr. Figler.
25 A Dr. Figler. So, again, all of those are

1 considered. Again, the same thing I referenced before
2 is that their opinions are important. They are
3 considered, but we look at the entire picture in the
4 context of prisons and in this case how Ms. Brown had
5 responded to the accommodations that had already been
6 provided and whether or not her condition had
7 progressed significantly enough to give us an
8 indication that current treatments were not sufficient.
9 Q So you mentioned that there were higher-level
10 individuals than Ms. Dula who had rendered some kind of
11 clinical evaluation of Mrs. Zayre-Brown. Who were
12 those higher-level individuals that rendered those
13 decisions?
14 A So I know she was seen by multiple
15 psychiatrists and psychologists over her time in
16 prison.
17 Q Did any of them conclude that gender-affirming
18 surgery was not medically necessary to treat her gender
19 dysphoria?
20 A That was not a clinical question they were
21 asked. So they were providing care for her.
22 Q Were any of the higher-level individuals who
23 treated Mrs. Zayre-Brown asked by the DTARC whether or
24 not Mrs. Zayre-Brown required gender-affirming surgery
25 for the treatment of her gender dysphoria?



Case 3:22-cv-00191-MOC-DCK Document 61-5 Filed 10/05/23 Page 102 of 137

1 A I don't know if they were specifically asked
2 that question, no.
3 Q Were they consulted regarding the decision to
4 deny Mrs. Zayre-Brown gender-affirming surgery?
5 MR. RODRIGUEZ: Objection to form.
6 You can answer.
7 THE WITNESS: There's not that type of consultative
8 process that occurs. So their clinical documentation
9 is what we review. We review everyone's clinical
10 documentation related to, in this case, Mrs.
11 Zayre-Brown as she presented to the committee, and we
12 make a collective decision on her stability and whether
13 or not her condition had progressed to the point that
14 we felt that the next step in treating was indicated.
15 BY MS. MAFFETORE:
16 Q So DTARC did not consider other mental health
17 professionals that had treated Mrs. Zayre-Brown's
18 professional opinions as to whether gender-affirming
19 surgery was medically necessary?
20 MR. RODRIGUEZ: Objection. Mischaracterization of
21 the witness's testimony.
22 THE WITNESS: No. I already stated we considered
23 it.
24 BY MS. MAFFETORE:
25 Q Did any of the higher-level professionals

1 within DPS disagree with Ms. Dula's assertion that
2 gender-affirming surgery was medically necessary for
3 Mrs. Zayre-Brown?
4 MR. RODRIGUEZ: Objection to form.
5 You can answer.
6 THE WITNESS: Again, it's not their role to
7 disagree with another provider. So they make an
8 independent assessment of the patient at that clinical
9 encounter and provide that feedback.
10 BY MS. MAFFETORE:
11 Q Did any of those providers disagree with Ms.
12 Dula's assessment that Mrs. Zayre-Brown was suffering
13 from clinically significant anxiety, depression, or
14 distress associated with her gender dysphoria?
15 A Again, I don't know if they were asked about
16 that specific question. For instance, I know that
17 around the same time there were ongoing discussions
18 with Mrs. Zayre-Brown, for instance, about whether to
19 restart psychotropic medications in the course of her
20 treatment. So there were ongoing discussions with her
21 clinical status with the psychiatrist, with the
22 psychologist that was treating her, but I don't know
23 that there was a consultation between these
24 individuals.
25 Q Did DTARC have any information to contradict

1 Ms. Dula's assertion that Ms. Zayre-Brown was suffering
2 from clinically significant anxiety, depression, and
3 distress associated with her gender dysphoria?
4 MR. RODRIGUEZ: Objection. Speculation. Form.
5 You can answer.
6 THE WITNESS: So, yes. So if you read through --
7 what you've done here is you've identified one
8 particular clinical note, which was four months prior
9 to the DTARC that we're mentioning. So all of these
10 are actually four months prior to that DTARC that we
11 met in February. So maybe it's convenience, but what
12 is not included in here is her clinical condition
13 between this point in time and the time in which she
14 appeared before the committee. Those clinical notes
15 are significant because, again, it gives us the trend
16 of how she has done over that period of time. These
17 notes, really within a matter of a day or two of each
18 other, signify a point in time, and that's what they
19 signify.
20 BY MS. MAFFETORE:
21 Q Are you aware of whether anybody on DTARC
22 requested that these notes be submitted?
23 A Submitted to who?
24 Q Well, looking at the Dula medical record, DAC
25 686, which is Exhibit 11 -- No. 12 -- no. 13. It's

1 entitled "transgender accommodation summary."
2 A Right.
3 Q When does a mental health provider fill out a
4 transgender accommodation summary?
5 A In advance of an FTARC.
6 Q And why would they do that?
7 A Because it's required by policy, first of all.
8 They have to complete this transgender accommodation
9 summary in preparation for the FTARC. So that's what
10 was done in this case.
11 Q So this would have gone before an FTARC, after
12 which point a DTARC would have convened; correct?
13 A Correct.
14 Q And the information gathered by the FTARC would
15 have then been passed along to the DTARC. Are you
16 aware of whether there was any other DTARC meeting
17 between October 20, 2021, and February 17, 2022, when
18 Mrs. Zayre-Brown's case was considered by the DTARC?
19 A I'd have to look at the calendar to see if we
20 had a DTARC. I would guess probably not over the
21 holidays.
22 Q So at what point would there have been another
23 opportunity for somebody to weigh in in the form of a
24 transgender accommodation summary regarding Mrs.
25 Zayre-Brown's mental health status?

1 MR. RODRIGUEZ: Objection to form.
2 You can answer.
3 THE WITNESS: So the transgender accommodation
4 summary, if this was the time that she appeared before
5 the FTARC and then the DTARC, this is presented and was
6 presented to the DTARC after the FTARC. My point is
7 that the DTARC also considers the clinical notes from
8 this point in time till the committee met.
9 BY MS. MAFFETORE:
10 Q Did Jennifer Dula at some point subsequent to
11 October 20, 2021, conclude that Kanautica was no longer
12 experiencing clinically significant distress or anxiety
13 or depression related to her gender dysphoria?
14 A I would have to review the records to say
15 whether she made any additional recommendations.
16 Q Can you point with specificity to any other
17 provider who made findings to say that Kanautica was no
18 longer experiencing clinically significant distress?
19 MR. RODRIGUEZ: Objection to form. Speculation.
20 You can answer.
21 (Simultaneous speakers.)
22 THE REPORTER: One at a time, please.
23 THE WITNESS: I'd have to review the records.
24 BY MS. MAFFETORE:
25 Q Okay. Is there anything that you can point to

1 with specificity that shows that the candidate was no
2 longer experiencing clinically significant anxiety,
3 depression, or distress related to her gender dysphoria
4 after October 20, 2021?
5 A So there was a lot occurring during this time
6 frame in advance of her getting to that DTARC in
7 February, and again, you asked previously about whether
8 we had reviewed some of the other incidents from a year
9 or so prior to this event, and we had.
10 So, again, what we looked at is the trend and
11 how she had responded, and I do remember specifically
12 that at the DTARC it was made very clear based off the
13 assessments from Dr. Peiper and Dr. Sheitman that she
14 was remarkably resilient. She had responded very well.
15 She had adapted very well to changes, and it
16 was in August that she had just -- I think it was
17 August she had moved -- if I recall correctly, she had
18 responded very well, and they presented to the
19 committee that she was stable and in her current
20 status, and that's the recommendation that came from
21 both Dr. Peiper and Dr. Sheitman at the DTARC.
22 Q Did Dr. Peiper have a clinical encounter for
23 evaluation with Mrs. Zayre-Brown leading up to the
24 DTARC to evaluate her circumstances?
25 A I'm not aware.

1 Q Did Dr. Sheitman?
2 A I'm also not aware.
3 Q Did Dr. Peiper conclude that she no longer had
4 clinically significant distress related to her gender
5 dysphoria?
6 MR. RODRIGUEZ: Objection to form.
7 You can answer.
8 THE WITNESS: Not using those exact words, but
9 certainly Dr. Peiper did conclude that she was stable
10 and that there was no indication of worsening illness.
11 So that's essentially what that means.
12 BY MS. MAFFETORE:
13 Q Can somebody be stable but in critical
14 condition?
15 MR. RODRIGUEZ: Objection. Form.
16 You can answer.
17 THE WITNESS: Stable and critical condition?
18 BY MS. MAFFETORE:
19 Q Can somebody maintain the same level, a stable
20 level of bad?
21 MR. RODRIGUEZ: Objection to form.
22 BY MS. MAFFETORE:
23 Q Does stable imply good?
24 A No, it does not.
25 Q Okay. That was my question. Can somebody be

1 stable but still be depressed?
2 A Yes.
3 Q Can somebody be at a stable level of distress?
4 A Yes.
5 Q By Dr. Peiper saying that Mrs. Zayre-Brown was
6 stable, that does not necessarily indicate that she was
7 no longer experiencing a clinical level of distress
8 related to her gender dysphoria; correct?
9 MR. RODRIGUEZ: Mischaracterizing as to what Dr.
10 Peiper said.
11 THE WITNESS: So I think I understand your
12 question. I think that the -- in this case there was
13 more than just the stable. You keep honing in on the
14 stable, but you left out the well adapted, you know,
15 all of those things that are clarifiers of that
16 stability, that made that stability more than just --
17 I understand your point. Stable, you can have no
18 vital signs. They're still stable; right? But that's
19 not the point. The point is that there were clarifiers
20 that he added to that.
21 BY MS. MAFFETORE:
22 Q Is there any other medical condition where an
23 individual's resiliency or adaptability would make it
24 unnecessary for them to receive care in order to
25 address their underlying condition?

1 MR. RODRIGUEZ: Objection. Speculation.
2 You can answer.
3 THE WITNESS: I think that's a mischaracterization
4 of what I said. So individuals can have medical
5 conditions that are, we'll use the term "stable," but
6 that doesn't mean that you need to intervene.
7 So what I would say is that what you want to see, I
8 referenced it before, is that you want to see that that
9 individual -- resiliency is commonplace in prisons or
10 commonplace in medicine, you know. It doesn't just
11 refer to gender dysphoria, and it's particularly
12 important when it comes to behavioral health conditions
13 that they're resilient because that's where the biggest
14 impact of that is. So I think you mischaracterized
15 what I said.
16 Q I didn't characterize what you said. I asked
17 you a question. If somebody requires a medical
18 intervention, how does the fact that they are a
19 resilient person factor into their need for medical
20 care?
21 MR. RODRIGUEZ: Objection. Assumption of facts.
22 You can answer.
23 THE WITNESS: Again, it's a hypothetical. I'm not
24 sure I understand the question.
25 BY MS. MAFFETORE:

1 Q Sure. We can move on.
2 Does DPS know if Mrs. Zayre-Brown was
3 experiencing clinically significant distress related to
4 her gender dysphoria on November 17, 2022?
5 A I'd have to review the records to see if
6 there's any documentation.
7 MR. RODRIGUEZ: Do you guys want to take a break,
8 or are you not in a good spot for that?
9 MS. MAFFETORE: We can take a break.
10 (Recess.)
11 BY MS. MAFFETORE:
12 Q Dr. Campbell, we are back on the record, and I
13 remind you you're still under oath. At the time of the
14 DTARC's February 17th consideration, Mrs. Zayre-Brown
15 was requesting a vulvoplasty; correct?
16 A Correct.
17 Q And has she continued to do request vulvoplasty
18 since that time?
19 A If I'm not mistaken, there's been some
20 discussion of a vaginoplasty of late, but I'd have to
21 read the records to confirm.
22 Q Okay. On what basis is your understanding of
23 that?
24 A I'd have to review the records to confirm, but
25 I know there's been some discussion on which procedure

1 she wanted to undergo.
2 Q And your understanding -- is it your
3 understanding that was before the DTARC meeting or
4 afterward?
5 A I know it was definitely before that she
6 changed. So with her consultation with Dr. Figler, I
7 think, if I recall correctly, once Dr. Figler explained
8 the procedure and the potential complications and
9 postop recovery, at the conclusion of his note, if I
10 recall correctly, he said that she had opted to go
11 forward with vulvoplasty as opposed to vaginoplasty.
12 Q Are you aware that it's changed since then?
13 A I'm not aware.
14 Q Okay. And I asked you a very specific question
15 before that was maybe a little too specific so I'd like
16 to ask you a slightly more general version of that
17 question.
18 Was DPS aware of whether Mrs. Zayre-Brown was
19 suffering from clinically significant distress
20 associated with her gender dysphoria around the time of
21 the February 17, 2022, DTARC meeting?
22 A Were we aware of whether she was or not?
23 Q Yes.
24 A That is the underlying question always when
25 you're evaluating gender dysphoria cases before the

1 DTARC because that is the requirement, that it's
2 necessary for the diagnosis and also to measure
3 clinical stability. You know, what I'll say is that --
4 I know I keep going back to this, but if you were to go
5 back exactly a year before this DTARC that -- where we
6 were considering her for this case you're asking me
7 about, that's the point where -- you referenced those
8 earlier -- where she had done some things that were
9 genital-mutilation type activities or efforts, and so
10 at that point we could consider that that was -- at
11 that point was a peak of her gender dysphoria, the
12 severity of her gender dysphoria --
13 Q So what I'm asking is, what are you aware of
14 about her condition of clinically significant distress
15 around the time of the DTARC meeting in February of
16 2022? What was DPS aware of regarding her clinically
17 significant -- her clinically significant distress at
18 that time?
19 A So we were aware of what was presented to the
20 DTARC from both Dr. Peiper and Dr. Sheitman regarding
21 her current condition and how well she's adapted -- her
22 clinical status, her stability, and how well she's
23 adapted to the facility.
24 Q Okay. Around the time of February 17, 2022's,
25 DTARC meeting, was Mrs. Zayre-Brown experiencing

1 clinically significant distress as a result of her
2 gender dysphoria?
3 MR. RODRIGUEZ: Objection. Vague.
4 You can answer.
5 THE WITNESS: It was not relayed to us at the DTARC
6 that it was severe enough to warrant proceeding with
7 surgery.
8 BY MS. MAFFETORE:
9 Q Regardless of severity, was she experiencing
10 clinically significant distress around the time of the
11 DTARC meeting as a result of her gender dysphoria?
12 MR. RODRIGUEZ: Objection to form.
13 You can answer.
14 THE WITNESS: I don't recall any specific note
15 saying that she was.
16 BY MS. MAFFETORE:
17 Q Do you recall any specific note saying that she
18 was not?
19 A Again, what I discussed is the assessment from
20 our chief of psychiatry and chief of behavioral health.
21 Q And I believe you testified previously that
22 neither of them stated that she was not suffering from
23 clinically significant distress as a result of her
24 gender dysphoria; is that correct?
25 A I don't know that's what I said, but what I do

1 know is what they presented to the committee was the
2 same thing I've mentioned before, is that there were no
3 indication of worsening of her condition.
4 Q We can move on. So regarding the case summary,
5 which was Exhibit 8, a comprehensive literature review
6 is mentioned. Who engaged in that comprehensive
7 literature review?
8 A So if you're referencing a medical analysis,
9 that would be my literature review.
10 Q Okay. And what sources were considered?
11 A All sources. So as I started looking -- as I
12 started evaluating medical necessity in the context of
13 gender dysphoria, I initially started with the
14 references, which are listed in WPATH. So at the
15 time -- I think this was a still on the seventh
16 version. I subsequently did the same thing with the
17 eighth version.
18 So I initially started the literature review
19 looking at those sources. I didn't review every single
20 source. There's quite an extensive list in there, but
21 as I read through the standards of care and there was a
22 particular recommendation that was of concern, I would
23 then review the literature associated with that.
24 From there what I did is, you can often when
25 you review other studies, you can then branch out to --

1 imagination.
2 BY MS. MAFFETORE:
3 Q Fair enough. We can move on.
4 So I want to hand you a document that is Bates
5 5129, and this will be marked as Exhibit 14.
6 (Exhibit 14 marked for identification.)
7 BY MS. MAFFETORE:
8 Q What is this document?
9 A It appears to be a version of a case summary
10 for Mrs. Zayre-Brown from the DTARC from 17
11 February 2022.
12 Q Would this have been a draft of what ultimately
13 became the final case summary?
14 A Potentially. I can't say with certainty
15 though.
16 Q Okay. So looking at the last paragraph on the
17 second page of Exhibit 14, the third sentence in that
18 final paragraph says, "From a psychological
19 perspective, the offender is quite stable currently
20 without any indication that current medical,
21 psychological, and supportive treatments have failed to
22 sufficiently address the underlying gender dysphoria."
23 Did I read that correctly?
24 A You did.
25 Q That sentence is not reflected in the final

1 paragraph of the final case summary, is it?
2 A It's not.
3 Q Why was that sentence omitted from the final
4 case summary?
5 A Again, I can't recall why specific changes are
6 made from one document to the next or one draft to the
7 next. I can't really answer that.
8 Q Did DPS have sufficient documentation to
9 substantiate the claim that "current medical,
10 psychological, and supportive treatments" -- that
11 "there was no indication that current medical,
12 psychological, and supportive treatments have failed to
13 sufficiently address of the underlying gender
14 dysphoria"?
15 MR. RODRIGUEZ: Object to the form and vagueness.
16 You can answer.
17 THE WITNESS: Certainly I think if you read the
18 final version with the statement that, you know --
19 especially from behavioral health that she was stable
20 at that time and doing well is another way of stating
21 this in a more succinct manner.
22 BY MS. MAFFETORE:
23 Q Is the statement that Mrs. Zayre-Brown was
24 stable the same as the statement that her treatments
25 have sufficiently addressed the underlying gender

1 dysphoria?
2 MR. RODRIGUEZ: Objection. Mischaracterization of
3 the document.
4 THE WITNESS: Say that one more time.
5 BY MS. MAFFETORE:
6 Q Is the statement that she is stable the same as
7 a statement that her treatments had sufficiently
8 addressed the underlying gender dysphoria that she was
9 experiencing?
10 MR. RODRIGUEZ: Objection. Form.
11 You can answer.
12 THE WITNESS: So, again, they certainly are close
13 to equivalent statements. In other words, if you have
14 not sufficiently addressed the underlying problem, they
15 would not be considered stable because what you would
16 see is that there would be deterioration.
17 BY MS. MAFFETORE:
18 Q Again, can somebody maintain a stable baseline
19 level of unwell?
20 MR. RODRIGUEZ: Objection to form.
21 You can answer.
22 THE WITNESS: As I stated before, yes, but again,
23 when you look at the trend over time with Ms. Brown,
24 there had been a very -- initially some deterioration a
25 year ago and significant improvement over that period

1 of time, that year, leading up to the DTARC.
2 Q Was there any indication that the gender
3 dysphoria she was experiencing had improved at all her
4 sense of incongruence?
5 MR. RODRIGUEZ: Objection to form.
6 You can answer.
7 THE WITNESS: So, again, there's more to gender
8 dysphoria than just the sense of incongruence. So
9 that's just one factor involved in the diagnosis.
10 There's all those other factors and then, again, is
11 clinically significant distress, or the impact on
12 occupational, social, and other factors. I can tell
13 you that during this time, Ms. Brown continued to
14 participate in programs. She continued to pursue a lot
15 of her academic and career goals. This was actually
16 the point where we saw that she was starting to
17 actually recognize what she wanted to do when she left
18 prison.
19 So there was a lot of forward sight into what her
20 plans were after leaving prison. All of those things
21 together led us to the conclusion that she was doing
22 well.
23 BY MS. MAFFETORE:
24 Q So I'm going to hand you a document that was
25 produced to us in discovery, which is Bates DAC 3404,

1 which I believe is Exhibit 15.
2 (Exhibit 15 marked for identification.)
3 BY MS. MAFFETORE:
4 Q Do you recognize this document?
5 A Yes, ma'am.
6 Q What is this a document?
7 A This is the draft position statement that I put
8 together regarding gender-affirming surgery.
9 Q Is this the final draft?
10 A There never was a final draft because, again,
11 this document remained in draft. There was never a
12 final draft completed for this document.
13 Q Is this the most final draft that was
14 completed?
15 A To my knowledge, yes.
16 Q And you stated that you put it together. Did
17 you draft this document?
18 A I did.
19 Q Did anybody assist you in drafting this
20 document?
21 A No.
22 Q When did you draft this document?
23 A I think it's going to be important to go back a
24 little bit in time as we talk about this document. So
25 I think we should talk about the origins of how this

1 arose. So we talked earlier about the number of
2 utilization review requests that we get through DPS,
3 and so in my capacity as the chief medical officer,
4 what I needed to ensure was that there was a consistent
5 way of evaluating every utilization review request that
6 came through the system.
7 So essential to every one of those hundred
8 thousand requests is this medical necessity question.
9 Again, it is historically largely subjective. What I
10 needed to ensure was that there was a uniform decision
11 made for every offender for every circumstance that
12 every recommendation was reviewed the same way. So I
13 started looking at the essential question of medical
14 necessity, and I came to the -- we've talked briefly --
15 I can certainly talk more about those. We came to
16 those three criteria that are contained in here --
17 Q Sorry. Dr. Campbell, I don't want to cut you
18 off, and I appreciate the information that you're
19 sharing with me, but the question I asked you was when
20 was this drafted.
21 MR. RODRIGUEZ: Right, and he's telling you --
22 THE WITNESS: I'm telling you --
23 MS. MAFFETORE: Temporally.
24 MR. RODRIGUEZ: Right. Out of respect I'm
25 requesting that you allow the witness to give the

1 complete answer, and then you can follow up.
2 MS. MAFFETORE: This is a nonresponsive answer.
3 MR. RODRIGUEZ: Well, it's not a complete answer
4 yet. So I think when the answer is completed --
5 MS. MAFFETORE: And is he testifying in his
6 capacity as DPS as he's giving me this answer?
7 MR. RODRIGUEZ: You asked him if he wrote it. He
8 said yes. Then you asked him when he wrote. He's
9 telling you when he wrote it.
10 (Simultaneous speakers.)
11 MS. MAFFETORE: I asked him when he wrote it, and
12 he's telling me why he wrote it, but we can carry on.
13 MR. RODRIGUEZ: So as to give you context to the
14 timing of --
15 MS. MAFFETORE: I don't want to argue with you
16 anymore because that's also my time.
17 BY MS. MAFFETORE:
18 Q So please carry on.
19 A Okay. So I will abbreviate my answer. So as I
20 did that, I then took those factors and that
21 consideration and considered in the context of
22 gender-affirming surgery. That would have occurred
23 probably around the time of January, maybe, of 2021,
24 again, rough timeline as to when I started looking at
25 it from this perspective.

1 Q Okay. So you believe that you began drafting
2 this around January of 2021?
3 A Correct.
4 Q And that was before the DTARC considered Mrs.
5 Zayre-Brown's request for surgery; correct?
6 A Her requests for surgery's been considered
7 previously, so.
8 Q Before her February 17, 2022, DTARC meeting
9 that we were just discussing?
10 A That's correct.
11 Q Okay. And did anyone direct you to draft this
12 document?
13 A No, and that's a part of what I was trying to
14 answer is that this was something that I did
15 independently as the chief medical officer to assist
16 with utilization review across the board to simply
17 apply those standards, those tenets that I came up
18 with, in this context to assist in this case a
19 utilization review authority, which is the DTARC. The
20 same thing was going to be applied to the utilization
21 review process across the board within DPS.
22 Q Did anybody else within DPS provide comment on
23 this summary -- this position statement?
24 A At some point it was presented to the DTARC for
25 their review, yes.

1 Q Did you receive comments on it?
2 A Yes. So this was a discussion that occurred
3 with the DTARC.
4 Q Did you receive comments on it?
5 A I did.
6 Q What comments did you receive?
7 A Again, from the DTARC members, they provided
8 their input to me. I don't remember specific input. I
9 think that, again, most people felt that this was
10 within my purview as the chief medical officer and as
11 the medical authority on the DTARC. So they reviewed
12 it, and we had a discussion about it, but I don't
13 remember any specific comments.
14 Q Okay. I'm not asking for specific comments.
15 What general feedback did you receive with regard to
16 this position statement?
17 MR. RODRIGUEZ: Asked and answered.
18 You can answer.
19 THE WITNESS: Same thing I stated before, that they
20 reviewed it. They deferred to me as the medical
21 authority on the DTARC.
22 BY MS. MAFFETORE:
23 Q Did anybody outside of the DTARC provide you
24 any input regarding this position statement?
25 MR. RODRIGUEZ: Asked and answered.

1 You can answer.
2 THE WITNESS: Not that I recall.
3 BY MS. MAFFETORE:
4 Q What about Dr. Peiper?
5 MR. RODRIGUEZ: Asked and answered.
6 You can answer.
7 THE WITNESS: Dr. Peiper is on the DTARC.
8 BY MS. MAFFETORE:
9 Q Did Dr. Peiper provide you any feedback, either
10 within the confines of the DTARC meeting or externally
11 to the DTARC process, regarding this position
12 statement?
13 A He may have. I don't recall specifically.
14 Q Did anybody express disagreement with the
15 position statement?
16 A I don't remember any specific disagreement. I
17 think, again, there was discussion, and I had to
18 explain to them the same thing that I'll tell you, that
19 this was not meant to be a blanket ban on surgery.
20 This was simply to provide some guidelines so that the
21 committee could review gender-affirming surgery
22 objectively as we looked at these cases.
23 So I think that there was some concerns raised
24 that we wanted to make sure that was not how this was
25 presented, and I pointed out to them that that was

1 never meant to be the case. This was never meant to be
2 a DPS policy. This was simply guidance being provided
3 to the DTARC in their capacity as the utilization
4 review authority.
5 Q So you just stated that this was not meant to
6 be a blanket ban on surgery, but it was supposed to
7 allow for consideration of these requests in an
8 objective way; am I understanding you correctly?
9 A Correct.
10 Q So page 2 of this document, the second
11 paragraph states, "After extensive and objective review
12 and analysis of hundreds of studies and other
13 publications, it has been determined that
14 gender-reassignment surgery, GRS, as a treatment for
15 gender dysphoria is not medically necessary."
16 Did I read that correctly?
17 A You did.
18 Q Okay. So I understand that you just said that
19 this was not intended to be a blanket ban but was
20 supposed to be considered for an objective
21 determination of surgical requests. If the position
22 that was expressed that that should be relied on
23 objectively, as you've indicated, is that
24 gender-reassignment surgery is not medically necessary
25 in any circumstance, what could -- what outcome would

1 result other than denial of gender-affirming surgery
2 following consultation of this position statement?
3 MR. RODRIGUEZ: Object to form.
4 You can answer.
5 THE WITNESS: So I did not say "under any
6 circumstances," and that's specifically intentional
7 that there are many procedures which are considered not
8 medically necessary, surgery procedures in particular.
9 However, there are always exceptions to that, and we
10 don't always list all those exceptions. So for
11 instance, a lipoma on an individual's skin is not
12 medically necessary for incision unless -- and there
13 can be various factors. It can be over a joint. It
14 can be impacting other organs. It can be impairing
15 function. So in that case that tips that over into
16 being medically necessary.
17 In the prison circumcision is not medically
18 necessary. However, there are circumstances where
19 circumcision will be conducted. So if an individual
20 has phimosis, paraphimosis, all of those symptoms, then
21 that procedure, which is generally not medically
22 necessary, becomes medically necessary.
23 Inguinal hernias are generally not medically
24 necessary for surgery. However, if they're
25 incarcerated, they become medically necessary.

1 So, again, I could go on and on and on and list
2 examples, but I specifically did not say "under any
3 circumstances," and that was never the intent of this
4 document.
5 BY MS. MAFFETORE:
6 Q So then what is meant by "gender-reassignment
7 surgery as a treatment for gender dysphoria is not
8 medically necessary"?
9 A It goes back to what I just stated, that
10 generally those things are not -- surgery is not
11 required for particular procedures, just like surgery's
12 generally not required in this context unless the
13 individual, through that risk-benefit analysis, through
14 that individualized review, demonstrates significant
15 disease that's not being adequately addressed with
16 current treatment therapies. So the same thing is
17 analogous to those other conditions that I just told
18 you about.
19 Q So you mentioned that there was concern
20 expressed that this was considered or going to be
21 perceived as a blanket ban on gender affirming surgery.
22 Who expressed that concern?
23 A I don't recall exactly. I know that -- Dr.
24 Peiper may have mentioned that, but I can't be certain,
25 but I know that that was brought up as how this could

1 be interpreted, and that's partly why we never
2 proceeded with making this an official document is that
3 we did not want that perception because that is clearly
4 not what the department does.
5 Q Okay. I want to hand you -- or hand the court
6 reporter to be marked as Exhibit 16 a document produced
7 in discovery, DAC 5130.
8 (Exhibit 16 marked for identification.)
9 BY MS. MAFFETORE:
10 Q Do you recognize this document?
11 A I do.
12 Q Okay. What is this document?
13 A So this was -- and I can't remember if this was
14 before or after I initially presented this document to
15 the DTARC, but this was me asking for the committee,
16 after we had discussed this, to concur with this
17 statement that I'm making here. Because my
18 intention -- and you asked this through some of your
19 questions. I understand that the perception was that
20 we've created hurdles, particularly for gender
21 affirming surgery, in the care of transgender offenders
22 with gender dysphoria in the prisons.
23 So what I was proposing here is that we change
24 this gender-affirming surgery review process to be
25 analogous to what we do for all other surgeries in

1 prisons. So in other words, gender-affirming surgery
2 is generally not medically necessary. However, the
3 clinician that's taking care of this offender believes
4 that that their clinical disease has reached a point
5 where they think it is now medically necessary, they
6 can then submit this request directly to the DTARC and
7 bypass the FTARC.
8 So this would have -- if this were voted on and
9 approved, this would have necessitated a policy change,
10 but again, this was to try to make the consideration
11 for gender-affirming surgery analogous to what we do
12 for all other surgeries within the prison.
13 Q Okay. So what is the date on this document?
14 A 22 March 2022.
15 Q Okay. And is it correct that this email was
16 sent to members of the DTARC?
17 A Correct.
18 Q And who at DPS made the decision that this
19 policy or position could be approved via email?
20 MR. RODRIGUEZ: Objection to form.
21 You can answer.
22 THE WITNESS: Okay. It's not a policy.
23 BY MS. MAFFETORE:
24 Q Position.
25 A It was never meant to be a department policy.

1 This was simply medical guidance like I provide for all
2 sorts of things within the medical arena. So it was
3 meant to be medical guidance, not a DPS or DAC policy.
4 Q Understood. So who made the decision that this
5 position statement could be approved via email?
6 MR. RODRIGUEZ: Objection. Mischaracterization of
7 the contents of the Exhibit 16.
8 You can answer.
9 BY MS. MAFFETORE:
10 Q So in the email you note, "In order to not
11 occupy valuable time during our meeting this week, I
12 would like to ask for review of the attached, please."
13 Did I read that correctly?
14 A You did.
15 Q And then at the bottom you say, "I have
16 included voting buttons in this email. If after review
17 you concur, I ask that you please vote accordingly"; is
18 that correct?
19 A That's correct.
20 Q And then later it says, "If/when we as a
21 committee approve, I will forward to both leadership
22 and legal for review and final endorsement."
23 Did I read that correctly?
24 A You did.
25 Q So is this email seeking a vote on whether or

1 not to approve sending this position statement on to
2 leadership and legal for review and final endorsement?
3 A No. So you skipped a line here that's
4 important. "If there's questions or additional
5 information, call me so we can discuss that," and the
6 only people that would need to have seen this, if we
7 decide to go this route because it would result in that
8 policy change that I referenced, would have been Dr.
9 Junker as, at that time, the director of health and
10 wellness because that's his policy.
11 Q Okay. So why were you seeking to have people
12 vote on this -- in this email?
13 A Because at this time the DTARC is responsible
14 for how we process these cases, where I was asking the
15 DTARC is if they had any objections to us converting
16 this to a process that was similar to what we do with
17 all other surgeries in prison.
18 Q Okay. Understood. So the email further
19 states, "This document, if approved by the committee,
20 would serve as our agency's position statement
21 regarding GRS. In short, it lays out the case
22 by objectively comparing GRS to what are accepted to be
23 medically necessary procedures that GRS, as we have
24 discussed, does not satisfy these standards."
25 Did I read that correctly?

1 A You did.
2 Q So you're laying out the position here that
3 gender-reassignment surgery, as you call it here, does
4 not meet standards to give rise to medical necessity;
5 correct?
6 MR. RODRIGUEZ: Objection. Mischaracterization of
7 the witness's prior testimony and the document itself.
8 You can answer.
9 THE WITNESS: So I'll restate exactly what I said
10 before, that there are many procedures that are
11 generally medically not necessary, but there can be
12 situations where those become medically necessary. So
13 that was the exact intent here as well.
14 BY MS. MAFFETORE:
15 Q Okay. In the next sentence you state, "If
16 approved, the position statement would be forwarded to
17 our FTARCs, and no further consideration would be given
18 to GRS within our system."
19 Did I read that correctly?
20 A That's correct.
21 Q What is meant by "no further consideration
22 would be given to GRS within our system"?
23 A Within the FTARC system. It would go directly
24 to the DTARC. So that would -- it would divert that
25 process around the FTARC to the DTARC.

1 Q So when you say "no further consideration would
2 be given to GRS within our system," you are only
3 referring to the FTARCs?
4 A Correct.
5 Q You further stated, "We do anticipate
6 challenges in court to the recent decisions we have
7 made as a committee."
8 To what are you referring?
9 A So there have been several press reports around
10 this time from various offenders about concerns related
11 to this. We knew it was inevitable at some point.
12 We're aware of what's going on in the community at
13 large and the nation at large. So we knew that this
14 was going to be met with some legal scrutiny.
15 Q In what way did you think that this document
16 was going to provide rationale to be utilized in court
17 to make your case?
18 MR. RODRIGUEZ: Objection to form.
19 You can answer.
20 THE WITNESS: So again, I think had we gone this
21 route, it would have probably avoided a whole line of
22 questioning that you had earlier for me as to why the
23 FTARC reviews procedures that they can't approve, they
24 have to automatically go through that hurdle to get to
25 the DTARC. So this was me, in anticipation of knowing

1 that to be the case, to try to prevent that and try to
2 make this more analogous of what we do for anything
3 else within prison.
4 BY MS. MAFFETORE:
5 Q Is starting from a position that an entire mode
6 of treatment for a condition is not medically necessary
7 consistent with DTARC's policy to consider each
8 individual's medical needs on a case-by-case basis?
9 MR. RODRIGUEZ: Objection to form.
10 You can answer.
11 THE WITNESS: Yes, it is. Because again, there are
12 always going to be exceptions to these as some of the
13 examples already cited.
14 BY MS. MAFFETORE:
15 Q Does that not alter it to some degree when it
16 the default is no?
17 MR. RODRIGUEZ: Objection to form.
18 You can answer.
19 THE WITNESS: It's not. Again, it's consistent
20 with other medical practice.
21 BY MS. MAFFETORE:
22 Q Was the DTARC aware of the rationale included
23 in the medical necessity position statement draft at
24 the time it was considering Mrs. Zayre-Brown's request
25 for gender-affirming surgery in February of 2022?

1 A Say that one more time.
2 Q Was the DTARC aware of the rationale included
3 in this draft position statement at the time that it
4 was considering Mrs. Zayre-Brown's request for
5 gender-affirming surgery during February of 2022?
6 MR. RODRIGUEZ: Objection. Vague as to rationale.
7 You can answer.
8 THE WITNESS: Certainly we had discussed aspects of
9 this in the DTARC as part of my medical recommendation.
10 So, yes.
11 BY MS. MAFFETORE:
12 Q Did any aspects of the position statement
13 inform the case summary that you provided for Mrs.
14 Zayre-Brown?
15 A It did.
16 Q Was there any further discussion within DPS
17 about this position statement after you sent this email
18 but before a vote was taken?
19 A I don't recall. I don't even recall whether
20 the voting ever occurred. I'm not sure if that voting
21 ever even occurred.
22 Q Is there a way that you can determine whether
23 the voting ever occurred?
24 A I don't know. I tried looking at my emails to
25 see if there were anything, and I certainly can't find

PRISONS
Health and Wellness Services
Policies and Procedures

| Title | Utilization Management | | | |
|---|---|---|---|---|
| Section | AD III-7 | Issue Date November 2, 2020 | Supersedes Date December 2010 | Next Review Date November 2021 |

**References**

**Performance-Based Standards and Expected Practices for Adult Correctional Institutions, 5th Edition 5-ACI-6A-04, 5-ACI-6A-05; 5-ACI-6A-43(M)**

## I. PURPOSE

The Division of Prisons (DOP) Health and Wellness Utilization Management (UM) is designed to evaluate the appropriateness and medical necessity of services provided to offenders. The program seeks to assure that services are provided efficiently, cost effectively and meet recognized standards of care. The program controls the cost of services provided through the establishment of a network of contracted providers. The UM program coordinates review of services to meet constitutional and applicable community standards of care.

## II. POLICY

(a) All Providers and Vendors are to follow these Utilization Management (UM) guidelines when requesting or providing offenders with specialty care or ancillary services.

(b) DOP Utilization Management staff use evidence-based clinical guidelines from nationally recognized authorities to guide utilization management decisions involving precertification, prospective review, concurrent inpatient review, discharge planning and retrospective review. Guidelines for prospective/concurrent approval of medical services are based on Severity of Illness and Intensity of Service.

(c) With the specific information collected regarding an offender's clinical condition, DOP staff reference the following criteria as guides in making coverage determinations as applicable:

(1) Coverage Determinations and Local Coverage Determinations for NC [LMRPs/LCDs for CIGNA Government Services], or guideline/policy listed in Health and Wellness Utilization Review Guidelines.

(2) UpToDate – a clinical decision support program.

(3) Center of Medicare and Medicaid Services (CMS) National Coverage Determinations and Local Coverage Determinations.

(4) United States Preventive Services Task Forces (USPSTF).

**III. Precertification and Preauthorization**

(a) A Utilization Review Request (UR) must be submitted by the facility providers for any service that requires precertification or prior authorization.

(b) Precertification and preauthorization is the process of confirming eligibility and obtaining authorization number prior:

(1) Scheduled inpatient admissions and,

(2) Selected ambulatory procedures and specialty consult services listed below:

(A) All Specialty Clinic visits.

(B) All radiological procedures except routine X-rays.

(C) All diagnostic/therapeutic procedures not being done by a DOP primary care provider.

(D) Orthotic supplies not available at Central Supply.

(E) Non formulary medications.

(F) Hemodialysis

(3) Any service (except emergencies) provided without obtaining an appropriate authorization number may be subject to non-payment by the NCDPS Medical Claims Section.

(c) **UM approval is not required for:**

(1) Routine Labs done by contracted lab vendor.

(2) Routine office procedures done at the facility by the facility provider.

(3) Orthotics available through Central Pharmacy formulary.

(d) **Purchase Care Process:**

(1) Certain items require an authorization number, but do not need to go through a formal Utilization Management process. These include:

(A) X-rays done at the facility by contracted vendor.

(B) Routine screening mammograms.

(C) ID clinic consults for HIV.

(D) Ambulance service.

(E) Optometry consults for yearly refraction.

(2) Purchase Care requests will be entered at the facility by the medical record staff or staff member identified by facility Nurse Supervisor/designee and will be automatically approved.

## IV. ROLES AND RESPONSIBILITIES

(a) **Utilization Management**

(1) The UM Medical Director (Deputy Medical Director) is responsible for:

(A) Case-specific review of “pended” UR requests.

(B) Case-specific discussion with institution staff, regarding appropriateness and/or coordination of medical services.

(C) Clinical oversight of ambulatory referrals.

(D) In-patient concurrent review and assist in discharge planning.

(E) Physician-to-physician interaction as needed.

(F) Review and analysis of utilization patterns to identify trends and opportunities for improvement.

(2) UM Physician Reviewers are responsible for:

(A) Case-specific Review of "pended" UR Requests.

(B) Case-specific discussion with facility staff, regarding appropriateness and/or coordination of medical services.

(C) Avoiding any undue criticism of current/previous treatments or making condescending remarks, etc.

(D) Providing comments/alternate suggestions for deferrals.

(3) UM Nurse is responsible for:

(A) Timely reviews and assessments of the appropriateness of UR requests, using UM review criteria.

(B) On-going education of UM procedures to facility staff designated for UR work.

(C) Concurrent review and assessment of appropriateness for community hospitalized patients.

**PRISONS**
**Health and Wellness Services**
**Policies and Procedures**

| **Title** | **Utilization Management** | | | |
|---|---|---|---|---|
| **Section** | AD III-7 | **Issue Date** November 2, 2020 | **Supersedes Date** December 2010 | **Next Review Date** November 2021 |

(D) Coordination of hospital discharge planning activities including infirmary/population bed placement according to clinical needs based on patient acuity.

(E) Generating reports as requested by the UM Director.

(b) **Facility Responsibilities**

(1) Primary Care Provider is responsible for:

(A) Coordinating all medically necessary services for offenders at the assigned institution.

(B) Requesting Specialty (sub-specialty) consultations, diagnostic and therapeutic procedures as medically appropriate.

(C) Providing appropriate information on all requests being submitted to UM for review.

(D) Providing general supervision to Nurse Practitioners and Physician Assistants.

(i) Such supervision may be provided on site or by telephone, in accordance to North Carolina Medical Board (NCMB) policies.

(ii) Supervision should include joint review of specialty consultant recommendations and any involved diagnostic procedure requests.

(2) The facility physician has ultimate responsibility for oversight of all care/treatment plans proposed/provided by Nurse Practitioners or Physician Assistants.

(3) May initiate an appeal for deferred UM determination for medical services if he/she still deems necessary.

(4) Primary Care Providers should be aware that not every specialist recommendation is necessarily appropriate. Circumstances such as specific diagnosis, patient condition, or expected duration of confinement in the correctional environment may influence the decision to proceed.

(5) After consultants offer opinions and treatment recommendations, Primary Care providers are responsible for reviewing consultant findings/ recommendations and making decisions regarding implementation of the treatment recommendations.

(6) If a Primary Care Provider feels that consultant recommendations should not be implemented, there should be documentation in the record on the rationale for the decision, including appropriate patient education.

(7) Nurse Practitioner and Physician Assistant responsibilities:

(A) Physician Assistants and Nurse Practitioners (PA/NP) function collaboratively with physicians to provide primary care services and are capable of clinical assessments and treatment under the supervision of a sponsoring physician.

(B) All medical assessments, treatment plans, and particularly consultation requests, should be reviewed or discussed with the physician. Physicians are ultimately responsible for oversight of all treatment plans proposed/provided by PA/NP.

(C) Providing appropriate information on all requests being submitted to UM for review.

(8) Facility Nursing and Staff responsible for UR's:

(A) Enter into HERO and OPUS all UR information as entered into HERO by the facility Providers.

(B) Communicate with UM Staff to ensure appropriate ICD-9 and CPT codes

are being utilized.

(C) Daily review status of all the facility UR's.

(D) Print deferrals and pended UR's for Provider review.

(E) Promptly respond to pended requests. Pended UR's with no response for over 60 days may be deferred or withdrawn by UM staff.

(F) Coordinate appointment scheduling once UR is approved.

(c) **DOP Health and Wellness Responsibilities**

(1) DOP Health and Wellness management includes Director of Health and Wellness, Medical Director, Director of Behavioral Health, Chief of Psychiatry, Dental Director, Director of Nursing, Director of Administration, Pharmacy Director and Director of Quality Assurance.

(2) Directors act in a supervisory role, serve as a resource to facility staff, and are available for consultations and direction in difficult cases. They are responsible for the orderly functioning of the system as a whole and shall be the ultimate arbiter of health and wellness matters related to their discipline, as appropriate.

## V. PROCEDURE

(a) **Type of Request**:

(1) Providers must use one of these types of request for all UR's based on the urgency of the needed service.

(A) **A – Emergent Service is life/limb threatening and is automatically approved by UR.** A retrospective review may be done by UR.

(B) **B – Urgent** Reviewed by UR Section within 2 working days.

(C) **C – Rush** Reviewed by UR Section within 7 working days.

(D) **D – Routine** - Reviewed by UR Section within 30 working days.

(b) **Appeals:**

(1) If a Health and Wellness provider disagrees with a UR deferral, the provider may submit an appeal to the Utilization Management Section. An appeal may be in the form of:

(A) **Immediate Appeal**

(i) When an initial determination to defer authorization of a health care service is made prior to or during an ongoing period of service and the attending physician believes that the determination warrants immediate appeal, the attending physician may appeal over the telephone to the Health and Wellness Deputy Medical Director.

(ii) All efforts will be made to obtain any information available to resolve the expedited appeal.

(iii) Immediate appeals which do not resolve a difference of opinion may bereferred to a physician advisor for another opinion or through the standard written appeal process.

(B) **Standard Appeal**

(i) The right to appeal a deferral through the Utilization Management Program is available to all providers.

(ii) All appeals will be completed within thirty days of receipt.

(iii) The facility must provide additional information justifying the

**PRISONS**
**Health and Wellness Services**
**Policies and Procedures**

| **Title** | **Utilization Management** | | | |
|---|---|---|---|---|
| **Section** | AD III-7 | **Issue Date** November 2, 2020 | **Supersedes Date** December 2010 | **Next Review Date** November 2021 |

appeal in the comment section.

(iv) A UM physician reviewer must not deny the same appeal twice and should "pend" the request for review by the Deputy Medical Director if appealed again.

(v) Comments/alternate suggestions for deferrals must be entered by the UM physician reviewer.

(vi) Any further appeals for deferrals by the Deputy Medical Director should be directed to the Medical Director.

(vii) The Medical Director will have the final authority.

(c) **"Second Opinion"**

(1) In general, offenders may not request a "second opinion" from either a different primary care institutional provider or a consultant.

(2) In these difficult medical situations, the institutional primary care provider should discuss the matter with the Deputy Medical Director.

______________________________ 11/2/20
Todd E. Ishee Date
Commissioner of Prisons

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION

Civil Action No. 3:22-cv-0191

| | |
|---|---|
| KANAUTICA ZAYRE-BROWN, | ) |
| | ) |
| Plaintiff, | ) |
| | ) |
| v. | ) |
| | ) |
| THE NORTH CAROLINA | ) |
| DEPARTMENT OF PUBLIC | ) |
| SAFETY, et al., | ) |
| | ) |
| Defendants. | ) |
| | ) |

DEPOSITION OF GARY JUNKER, PH.D.

(Taken by plaintiff.)

Raleigh, North Carolina

May 4, 2023, 9:06 a.m.

Reported By:
SUSAN GALLAGHER, CA CSR, CVR-CM

1 of health and wellness, is your involvement in policy
2 more of a final reviewer role rather than a drafter
3 role?
4 A That's correct.
5 Q Okay. And in your role as director of health
6 and wellness, did you ever treat patients directly?
7 A I did not.
8 Q Did you ever have any clinical encounters with
9 patients directly?
10 A No, I did not.
11 Q Broadly speaking, what was your involvement
12 with treating gender dysphoria as director of health
13 and wellness?
14 A I was not treating.
15 Q Okay. And so you also didn't treat any
16 patients directly seeking gender-affirming surgery in
17 that role?
18 A I did not.
19 Q And aside from the 2021 UNC trans health
20 training, which you've already mentioned, did you
21 receive any other trainings regarding the treatment of
22 gender dysphoria while serving as director of Health
23 and Wellness Services?
24 A I don't recall specifically. We do take
25 various types of sensitivity training within our

1 learning management system, LMS, but I don't recall
2 specifically related to gender-affirming surgery.
3 Q Did the 2021 training with UNC trans health in
4 addition to discussing gender dysphoria cover
5 gender-affirming surgery?
6 A It did.
7 Q While director of Health and Wellness Services,
8 have you given any trainings regarding the treatment of
9 gender dysphoria?
10 A I have not.
11 Q And so none regarding the provision of
12 gender-affirming surgery?
13 A I have not.
14 Q So the last thing before we set aside Exhibit 1
15 is beginning on page 3890 of Exhibit 1, there's a list
16 of publications and presentations that you have
17 conducted. Is this a complete list of publications and
18 presentations you've conducted?
19 A I have at least one additional publication.
20 Q And what is that?
21 A That was regarding -- let's see here. Perhaps
22 it's here. No, it's here. I think this is complete.
23 Q Okay. So is it correct that you have never
24 published on the issue of the treatment of gender
25 dysphoria with the provision of gender-affirming

1 surgery?
2 A I never have.
3 Q Okay. And you haven't given any presentations
4 regarding the treatment of gender dysphoria or the
5 provision of gender-affirming surgery?
6 A I have not.
7 Q Thank you. You can set that aside now.
8 A Okay.
9 Q I'm now going to hand to the court reporter
10 what's going to be marked as Exhibit 2, which is the
11 Evaluation and Management of Transgender Offenders
12 policy, or EMTO policy, as I mentioned we've been
13 calling it in this lawsuit.
14 (Exhibit 2 marked for identification.)
15 BY MS. MAFFETORE:
16 Q So do you recognize this policy?
17 A I do.
18 Q And what is it?
19 A It's the policy Evaluation and Management of
20 Transgender Offenders.
21 Q So you mentioned that you were involved in the
22 development of this policy. Could you elaborate on
23 your role in the development of this policy?
24 A Yes. So I was the point person in this policy
25 development along with several other individuals.

1 Q What do you mean when you say you were the
2 "point person"?
3 A I coordinated input from others, helped to
4 research policies from other jurisdictions, and put
5 together a draft for review.
6 Q And you mentioned research policies from other
7 jurisdictions, which jurisdictions did you research if
8 you recall?
9 A I don't recall specifically, several state
10 policies. I believe Massachusetts was one, Illinois
11 perhaps was a second, and the Federal Bureau of Prisons
12 policy. Also I recall that we did receive and looked
13 at other states. I don't recall all of them.
14 Q And when you say you did research, did you do
15 any other research beyond policies from other
16 jurisdictions?
17 A We had the world professional health
18 organization, WPATH Association, policy statement that
19 we reviewed as well, WPATH guidelines, and I don't
20 recall anything additional.
21 I know there was some conversations with others
22 as well from other jurisdictions around their policies
23 that occurred. I'm, again, a member of the American
24 Correctional Association, and so conversations during
25 conferences and such took place.

1 Q Did your research involve any medical journals
2 or articles or anything of that nature?
3 A Not that I recall.
4 Q You mentioned that you were coordinating input
5 from others. Who else was involved in the creation of
6 this policy?
7 A So our behavioral health team was involved,
8 Dr. John Peiper, Patricia Hahn was involved in the
9 process, our then-medical director, which I believe was
10 Dr. Wilson would have been involved, and I don't recall
11 the exact time frame I actually worked with Dr. Paula
12 Smith, who was our chief medical officer prior to Dr.
13 Wilson. Dr. Smith and I had a less formal process of
14 reviewing cases. It may have been toward the end of
15 her time with the State, and she may have had input as
16 well.
17 Our legal department reviewed the document.
18 And there were others, psychologists that undoubtedly
19 provided input. Dr. Ken Yearick was the assistant
20 director of behavioral health at Western Region, and
21 then Dr. John Monguilot was the South-Central Region
22 assistant director of behavioral health. I'm pretty
23 certain that they also had input.
24 Q Was anybody from whom you sought input hostile
25 to the policy?

1 MR. RODRIGUEZ: Objection. Speculation.
2 You can answer.
3 BY MS. MAFFETORE:
4 Q Did they express hostility to you regarding the
5 policy?
6 A No.
7 Q I'd like to hand to the court reporter what's
8 going to be marked as Exhibit 3.
9 (Exhibit 3 marked for identification.)
10 BY MS. MAFFETORE:
11 Q So I'll represent to you Exhibit 3, which is
12 marked DAC 005672, is a document that was produced to
13 us in discovery. Do you recognize this document?
14 A I recognize it as an e-mail. I don't recall
15 the document.
16 Q Okay. At the very top, is this an e-mail from
17 you to somebody named Betty Gardner?
18 A Yes.
19 Q Who is Betty Gardner?
20 A Betty Gardner was a nurse consultant with the
21 Department of Public Safety at that time.
22 Q Okay. And in your e-mail to Betty Gardner, you
23 state, "Please take a look at the comments below from
24 RDs and incorporate into the policy draft."
25 Did I read that correctly?

1 to the conclusion with a decision by the DTARC if there
2 were questions that we would have as reviewers
3 regarding any stage of that process, if something
4 hadn't been completed the way policy was intended,
5 hadn't been reviewed properly or in enough depth. We
6 certainly could question or ask how the DTARC came to
7 that conclusion or why certain steps were not taken.
8 Q Is there anything else that you would consider
9 cause?
10 A There could be. I can't -- I mean, there are
11 many complications and complexities to most of these
12 cases.
13 Q Has the situation you just described where
14 there were some steps that were missed or something
15 that wasn't delved into adequately or in-depth enough
16 and the DTARC needed to be revisited, has that ever
17 taken place since you -- or had that ever taken place
18 while you were the director of Health and Wellness
19 Services?
20 MR. RODRIGUEZ: And before you answer, I just want
21 to remind the witness that we're not divulging any
22 personally identifiable health information relative to
23 folks other than Kanautica. So with that in mind, you
24 can answer the question.
25 THE WITNESS: Sure.

1 There have been occasions where there has been some
2 feedback to the DTARC concerning additional measures
3 that would be recommended. I recall a circumstance
4 where the psychological testing was not completed for
5 an individual who had requested certain accommodations
6 at the start of the procedure.
7 There have been occasions where we have recommended
8 that the individual be provided behavioral health
9 services or additional support counseling or therapy.
10 So there have been occasions where we've had some
11 conversation back with the DTARC members to take into
12 consideration, some additional steps, if you will.
13 BY MS. MAFFETORE:
14 Q Is it your understanding that under this
15 policy, DTARC serves as the utilization management
16 process for purposes of considering and determining the
17 medical necessity for treatment of requests for gender
18 dysphoria?
19 A Could you repeat that, please?
20 Q Absolutely. Is it your understanding that
21 under this policy, DTARC serves as a utilization
22 management for purposes of considering and determining
23 the medical necessity of requests for treatment of
24 gender dysphoria?
25 A Yes.

1 Q Are there any other conditions or treatments
2 which you review or which you reviewed as director of
3 Health and Wellness Services on medical necessity
4 decisions that are made by utilization management?
5 MR. RODRIGUEZ: Objection to form.
6 BY MS. MAFFETORE:
7 Q So I can ask it a different way. Are there
8 other conditions or treatments that the director of
9 Health and Wellness Services reviews after disposition
10 on those from the utilization management?
11 MR. RODRIGUEZ: Objection. Vague.
12 You can answer.
13 THE WITNESS: No.
14 BY MS. MAFFETORE:
15 Q Why is that additional level of review, then,
16 required for treatment of gender dysphoria?
17 A So, again, the intention of the final review
18 was to be a quality assurance step to ensure that all
19 of the proper procedures had taken place through the
20 FTARC process to the DTARC, and, again, that reviewing
21 those more extreme types of interventions, like a
22 surgical procedure, or moving from one gender-assigned
23 facility to another, the operational considerations and
24 the impact of those decisions was felt to be a step to
25 make sure, again, that both the staff had followed

1 proper procedures and that the identified patient or
2 individual requesting accommodation had received the
3 proper level of review and care throughout the process.
4 Q So if somebody needs surgery, for example,
5 cancer treatment, the request for that surgical
6 procedure has to go through a multistep approval
7 process; correct?
8 A That's correct.
9 Q And it involves multiple staff members at
10 multiple levels of the organization; is that correct?
11 A Yes.
12 Q Would you consider a surgical intervention that
13 would be -- with cancer to be an extreme accommodation?
14 MR. RODRIGUEZ: Objection. Vague.
15 You can answer.
16 THE WITNESS: Yeah. I mean, it's surgery, so yes.
17 BY MS. MAFFETORE:
18 Q So once the utilization management process is
19 completed and has concluded that a surgical
20 intervention for the treatment of cancer is medically
21 necessary, is there any additional level of review by
22 the director of Health and Wellness Services or the
23 assistant commissioner of prisons?
24 A No.
25 Q Why not?

1 A That is -- as you referenced, is managed
2 through utilization review, and would be reviewed by
3 the medical director of the department and our
4 utilization review department to approve that surgery.
5 Q And so I take it that your understanding is
6 that process is adequate to provide oversight to ensure
7 that staff has followed procedures regarding that
8 surgical procedure and given sufficient consideration
9 to the patient that is requesting that treatment?
10 A Yes.
11 Q Why is that not the case for gender-affirming
12 surgery?
13 A I don't know. I don't think it was taken into
14 consideration, you know, within this policy. Having
15 both a behavioral health and a medical component, it's
16 a bit different. It is new to, you know, the system to
17 adequately address the needs and accommodations of
18 offenders. It was intended to be a safety valve,
19 again, for quality assurance, not to in any way deviate
20 from other procedures or operational pathways that
21 medical decisions are made.
22 Q So you said it was intended to be a safety
23 valve for quality assurance. Have you -- has it acted
24 in that fashion or have you seen it pan out differently
25 than how it was intended?

1 A Right. Not necessarily different than how it
2 was intended, but there, again, have not been a lot of
3 cases that have come to that level. But the examples I
4 gave previously as far as some feedback that has
5 occurred to the DTARC regarding certain aspects of the
6 case have occurred, but not to a great extent.
7 So, you know, I don't know that it has --
8 again, we're reviewing the case and making sure that,
9 you know, all of the proper procedures were taken, and
10 so in that regard, it has functioned as it was
11 intended, but not in regard to changing a decision or
12 challenging a decision necessarily.
13 Q Has the structure in your view presented any
14 roadblocks to access to care?
15 MR. RODRIGUEZ: Objection. Vague.
16 You can answer.
17 THE WITNESS: No.
18 BY MS. MAFFETORE:
19 Q What preceded the EMTO policy that we're
20 looking at currently?
21 A So I came to the department in September
22 of 2015. At that time the chief medical officer was
23 Dr. Paula Smith, and at that time she was managing the
24 review of transgender cases that were housed within the
25 system. And I was brought into that process at some

1 point, 2017 -- 2016, 2017. She and I would review
2 cases. She was the point person from a medical
3 standpoint.
4 And from my recollection, before we put this
5 policy into place, there were not accommodations
6 provided frequently, and, you know, we can talk more if
7 we need to about routine accommodations that we were
8 able to accomplish through this policy that facilities
9 would follow. So there wasn't a standardized approach
10 to how cases were managed necessarily. It was
11 primarily medically driven.
12 Q So if you look at the first page of Exhibit 2,
13 so it notes that the issue on this particular policy
14 was March 31, 2021, but supersedes a policy that went
15 into place August 22, 2019.
16 A Yes.
17 Q To the best of your recollection, was there
18 another policy that the August 22, 2019, policy
19 superseded?
20 A I believe there was. I don't recall, but I
21 believe there was. If so, it was drastically
22 different.
23 Q Do you recall whether that policy was called
24 something along the lines of TX-I-13?
25 A I don't recall.

1 Q Okay. Do you recall whether it was in the
2 health services manual previously?
3 A I believe it probably was.
4 Q Okay. Do you know why this policy moved out of
5 the health services manual?
6 MR. RODRIGUEZ: Object to speculation.
7 You can answer.
8 THE WITNESS: The policy -- one of the things that
9 we wanted to accomplish with this policy was that it
10 was everyone's responsibility to enforce it, to follow
11 it, that it wasn't strictly a healthcare policy, that
12 there are many operational aspects to the policy that
13 the correctional custody side of the house needed to
14 follow as well, and so the move of this policy into the
15 correctional operations manual was that attempt to make
16 it available for, broadly, staff to recognize that the
17 policy existed.
18 BY MS. MAFFETORE:
19 Q But to be clear, some of what this policy
20 encompasses are, nonetheless, health services; correct?
21 A That's correct.
22 Q Okay.
23 MS. MAFFETORE: We've been going for about an hour.
24 Now would be a good time for me to take a break, if
25 that would work for you all.

1 MR. RODRIGUEZ: Yeah.
2 (Recess.)
3 BY MS. MAFFETORE:
4 Q Welcome back, Dr. Junker. Just a reminder that
5 you are still under oath.
6 I am now going to hand the court reporter what
7 will be marked as Exhibit 4.
8 (Exhibit 4 marked for identification.)
9 BY MS. MAFFETORE:
10 Q Okay. And so Exhibit 4 is a document
11 Bates-stamped DAC 005446. Do you recognize this
12 document?
13 A Yes.
14 Q And what is it?
15 A It is behavioral health services Evaluation and
16 Management of Transgender Offenders. It looks like a
17 slide presentation, PowerPoint.
18 Q Okay. And is that your name in the bottom
19 right-hand corner of the first page?
20 A That is correct.
21 Q So would this have been a presentation that you
22 gave?
23 A Yes.
24 Q And given its date of May of 2018, would this
25 presentation have been related to the -- an earlier

1 iteration of the policy than the one that we were
2 discussing?
3 A Yes.
4 Q Okay. And why did you conduct this training?
5 A This looks like the training that I referenced
6 earlier that Dr. Anita Wilson and I provided to Anson
7 Correctional, and I believe it was also provided to our
8 women's prison in Raleigh, NCCIW.
9 Q Okay. So who at those facilities would have
10 received this training?
11 A The group at Anson was a mixture of
12 disciplines, so it would've been warden -- associate
13 warden, some of the operational correctional services
14 staff, in addition to healthcare staff. It was a
15 mixture of staff.
16 Q Would the individuals responsible for sitting
17 on the Facility Transgender Accommodations Review
18 Committee have participated in this training?
19 A I don't know for sure.
20 Q Okay.
21 A I wouldn't -- wouldn't have thought so.
22 Q Okay. But you're not sure?
23 A I don't know who all was there.
24 Q And would any facilities other than Anson and
25 NCCIW have received this -- this particular training?

1 A They could have. I don't recall that I -- that
2 I provided the training elsewhere. Although,
3 certainly, it is a possibility. I may have provided
4 the training to other leadership staff. Again, around
5 what was then a very new policy. So it was basically
6 focused on this is the policy. This is what we do.
7 Q Sure. Why were Anson and NCCIW selected to
8 receive this presentation?
9 A So -- and my dates may be off. This says
10 May 2018. So this -- this slideshow may have been
11 related to those two facilities, and it could have
12 been, also, earlier than that where this slideshow,
13 again, was created after the evaluation and management
14 of transgender offender policy was first created. So
15 we were educating people more broadly about the policy.
16 So I can fast-forward a little bit and answer
17 the question --
18 (Reporter clarification.)
19 THE WITNESS: I said I could fast-forward a bit and
20 answer the question of my recollection about Anson and
21 NCCIW if you want me to.
22 BY MS. MAFFETORE:
23 Q Let's -- so let's do it this way. If this
24 policy -- if this presentation was created for the
25 purposes of educating folks on a brand-new policy, who

1 actually attended that meeting. I'm not certain, but
2 it appears to be an update to the commissioner and
3 executive staff regarding current information about
4 transgender care.
5 Q So sitting here today, you don't recall if you
6 attended a meeting with the individuals on this e-mail
7 sometime in the third week of September of 2021?
8 A '21? Yeah, I don't recall whether I was there
9 or not. It doesn't stand out to me.
10 Q What is your understanding of why Dr. Campbell
11 sent you this e-mail?
12 A Dr. Campbell reports to me, so he would send --
13 he would include me in an e-mail to let me know that --
14 whatever it is he's proposing or intending.
15 Q And so sitting here today, you can't recall if
16 you attended the meetings. I think it's pretty safe to
17 say that you don't recall what was discussed at that
18 meeting; correct?
19 A Yeah, I don't. You know, it's interesting that
20 Charles Mautz was included, preparation for our meeting
21 next week, basic information.
22 Q Do you have any understanding of why
23 Dr. Campbell would have needed to provide these
24 individuals a transgender primer?
25 A I just don't recall. I really don't, so no.

1 Q So looking at his commentary on some of what
2 was attached to this e-mail, he notes, "WPATH, World
3 Professional Association for Transgender Health
4 criteria for procedures related to gender transition."
5 He goes on to state, "Important point to recognize that
6 the threshold and minimum," quote/unquote,
7 "requirements," quote/unquote, "to qualify for these
8 procedures are extremely lax."
9 Did I read that correctly?
10 A You did.
11 Q What is your understanding of Dr. Campbell's
12 views on WPATH?
13 A Well, I've read a document regarding his
14 scrutiny of individuals who are members of WPATH and
15 their dual role in other organizations, like the
16 Endocrine Society, and just some question about the
17 objectivity and conclusions of WPATH and whether or not
18 they represent a consensus across the broader medical
19 field.
20 Q Have you ever -- so we're going to come back
21 and talk about that later, but have you ever spoken
22 with Dr. Campbell in any other context about his views
23 on WPATH?
24 A No. I have just read some of his conclusions.
25 Q Do you agree with those views?



Case 3:22-cv-00191-MOC-DCK Document 61-7 Filed 10/05/23 Page 20 of 24

1 A I wouldn't have any -- enough knowledge to be
2 able to relate, make that determination.
3 Q Why not?
4 A Because if I'm reading, I didn't research it
5 myself, or look in any greater depth as to, you know,
6 any of those comments.
7 Q Okay. So separate and apart from those
8 comments, which you just expressed that you haven't
9 done independent research regarding, what are your
10 views on WPATH?
11 A WPATH, we've always used it as kind of a guide
12 for, you know, what is -- trends and guidelines for
13 transgender care. So I see it as a useful resource.
14 People have different opinions and different
15 backgrounds. I certainly would -- I'm open to
16 entertaining what information is out there, and I have
17 no -- you know, no real opinion one way or the other
18 about the WPATH or any other organization that provides
19 information. Certainly we have, you know, historically
20 used it to look at some of the criteria that is
21 expected for an individual who is seeking transgender
22 care.
23 Q Do you consider WPATH a reliable resource?
24 A Yeah.
25 Q Are you now or have you ever been a WPATH

1 member?
2 A I haven't -- I'm not and I have not.
3 Q Are you aware of any other standards of care
4 for treating gender dysphoria published by any other
5 organization or individuals?
6 A No.
7 Q So later on in this e-mail under "transgender
8 definitions and procedures" at the second bullet point,
9 Dr. Campbell states that this second document he's
10 provided describes cost estimates, "which vary widely
11 from facility to facility" and notes that "it is a
12 critical consideration that female to male, FTM,
13 gender-confirming surgeries are incredibly extensive,
14 often multistage procedures, and very costly, exceeding
15 $100,000 in most cases."
16 What is your understanding of why Dr. Campbell
17 identified cost as a critical consideration?
18 A I don't know. You would need to ask him. But
19 certainly taking into at least knowing the physical
20 need from a budgetary standpoint would be probably
21 important, although we have a lot of medical care that
22 we provide that certainly this doesn't astound me or,
23 you know, raise any flag that there's no way that we'd
24 be able or willing to cover medical cost for an
25 individual receiving gender-affirming surgery.

1 Q Understood. He then goes on to say "If we
2 approve male to female, MTF, surgical procedures while
3 less extensive and less costly, $40,000 generally, we
4 must also be prepared to allow FTM surgeries."
5 Did I read that correctly?
6 A Yes.
7 Q In your understanding, were others at DPS -- or
8 did others at DPS ever express concern that if an MTF
9 surgical procedure was approved, more costly FTM
10 surgical procedures would also have to be approved?
11 A No.
12 Q Did you understand Dr. Campbell to be
13 expressing that concern here in his e-mail?
14 A It seems to me that this document is
15 educational in nature, just to make everyone aware of
16 these factors.
17 Q Sure. So the presidential effect of
18 potentially providing a male to female surgery was then
19 never provided as a justification for denying surgery
20 to anyone?
21 MR. RODRIGUEZ: Objection. Vague and form.
22 You can answer.
23 THE WITNESS: No.
24 BY MS. MAFFETORE:
25 Q Okay. So I would now like to hand the court

1 reporter what is going to be marked as Exhibit 20.
2 (Exhibit 20 marked for identification.)
3 BY MS. MAFFETORE:
4 Q And Exhibit 20 is a document Bates-stamped
5 DAC 004110. Do you recognize this e-mail?
6 A I don't recall it, but...
7 Q Is this an e-mail that was sent to you from
8 Gary Junker and -- or sorry -- sent to you from Lewis
9 Peiper?
10 A Yes.
11 Q Okay. Is Brandeshawn Harris also in this
12 e-mail?
13 A That is correct.
14 Q And copied on this e-mail is Jodi Harrison and
15 Sarah Cobb?
16 A That's correct.
17 Q And is this e-mail a forward of an e-mail from
18 Dionne Brown?
19 A That is correct.
20 Q And as we establish previously, Dionne Brown is
21 Ms. Zayre-Brown's husband; correct?
22 A Correct.
23 Q Okay. What is your -- so in the first e-mail,
24 Dr. Peiper notes "Dr. Junker and EC Harris, just wanted
25 to share this e-mail with you as an FYI"; correct?

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION

Civil Action No. 3:22-cv-0191

| | |
|---|---|
| KANAUTICA ZAYRE-BROWN, | ) |
| | ) |
| Plaintiff, | ) |
| | ) |
| v. | ) |
| | ) |
| THE NORTH CAROLINA | ) |
| DEPARTMENT OF PUBLIC | ) |
| SAFETY, et al., | ) |
| | ) |
| Defendants. | ) |
| | ) |

______________________________________________________

# DEPOSITION OF LEWIS PEIPER, M.D.

______________________________________________________

(Taken by plaintiff.)

Raleigh, North Carolina

May 1, 2023, 11:04 a.m.

Reported By:
SUSAN GALLAGHER, CA CSR, CVR-CM

**CONTAINS GENERAL CONFIDENTIAL INFORMATION**

1 A I would say not necessarily. She's had
2 multiple incarcerations with us, maybe six, maybe five,
3 and during that, there is a piece of always asking
4 about, you know, "What is your suicidal history? Have
5 you ever attempted it? Do you have thoughts?"
6 She consistently says no in past
7 incarcerations, current incarceration. Continues to
8 not show any evidence of that risk either.
9 Q So you're not aware of any self-harm efforts
10 that Ms. Zayre-Brown engaged in while she was in the
11 current incarceration?
12 A She's shared ideation. She's talked about it
13 with her therapist. I haven't seen any evidence of
14 self-harm, but she has discussed it.
15 Q Okay. And you're not aware of any actual
16 attempts to harm herself?
17 A Huh-uh, I'm not aware of her having, you know,
18 suicide attempts. I'm not aware of her presenting
19 those elements of risk for harm, basically none of
20 those mental health red flags.
21 Q And what about any attempts to harm her
22 genitals?
23 A She's talked about it.
24 Q But you're not aware of any actual efforts?
25 A I'm not directly of her actually harming her

1 genitals, but she has talked about it. She even told
2 her therapist that she was using a rubber band on her
3 penis, but no, I'm not aware of her actually engaging
4 in any self-harm.
5 Q And using a rubber band to do what?
6 A Put the rubber band on her penis. That's what
7 she told her therapist in a therapy session, and the
8 therapist said, "Take it off," and so she went to the
9 bathroom, came back, and said that she had taken it
10 off. I wouldn't imagine that there was a physical exam
11 at that point in time. It's not generally something
12 that they would do in a therapy session. So I don't
13 know if the therapist saw it either.
14 Q Was it your understanding that she put the
15 rubber band around her penis in order to injure her
16 penis?
17 A No. I understand that she was telling the
18 therapist that.
19 Q Okay. Do you have any reason to believe that
20 that was not true?
21 A I don't have any evidence about her engaging in
22 harm to her body, but as I did say, she has talked
23 about it. She did talk to her therapist about it, and
24 there is that one instance of her talking to her
25 therapist about it.

1 of these, and looking at them, do you have any
2 recollection as to which you provided feedback on?
3 A Yes. I would have given her feedback on what
4 you described as "the letter."
5 Q Okay. Exhibit 5?
6 A Exhibit 5.
7 Q And can you tell me what you recollect the
8 feedback was?
9 A I was trying to translate the information from
10 a colleague at UNC Trans Health, Katherine Croft, and
11 what the UNC Trans Health program would need for --
12 they called them "letters," but based off of that
13 Standards of Care 7 framework that one of the letters
14 would come from Jennifer Dula, who was the primary
15 therapist.
16 Q Okay. So you were trying to make sure that
17 whatever was prepared met the requirements for UNC
18 Trans Health Program; is that correct?
19 A Yes, sir.
20 Q Looking at Exhibit 5, if you'll look at that
21 second -- end of the second paragraph continued on to
22 the third, it says, quote, She has been living
23 consistently on -- sorry -- she has been consistently
24 on hormone therapy since -- and then there's five
25 asterisks -- Ms. Zayre-Brown has also undergone several

1 other gender-affirming the surgeries as part of her
2 transition. Despite these interventions, she continues
3 to report clinically significant anxiety, depression
4 and is depressed associated with her gender dysphoria
5 that has been documented consistently throughout her
6 mental health treatment.
7 Did you provide any feedback to Ms. Dula about
8 that?
9 A I don't know specifically if I gave her
10 feedback on that sentence or two or three sentences.
11 Q Okay. Do you have any reason to believe that
12 any of the statements in those sentences that I read to
13 you were not accurate?
14 A So she has been on hormone therapy. I might
15 have a clinical discussion about clinically
16 significant, but otherwise no. I mean, she's got a
17 well-documented history, and this is all based off of
18 those -- I believe there were like four or five set
19 criteria that UNC Trans Health wanted the letters to
20 address. This is all ensuring that whatever the
21 determination was from the DTARC that UNC Trans Health
22 would have what they need so they could do the surgery.
23 Q I see. So if the DTARC approved Ms.
24 Zayre-Brown receiving vulvoplasty, the point of Ms.
25 Dula drafting something was that then UNC Trans Health

1 would have everything it needed to be able to proceed
2 with the surgery?
3 A Yes, sir. We wanted to make sure that at the
4 point of that decision being reached, that everything
5 was to go forward. So part of that is to do the
6 surgery.
7 Q Okay. And in the final paragraph on the first
8 page, it says, quote, Based on the review of her
9 records and my own assessment, I believe the next
10 appropriate step for Ms. Zayre-Brown is to undergo
11 vulvoplasty. It is my clinical opinion that this will
12 help her make significant progress in further treatment
13 of her gender dysphoria. My professional
14 recommendation is to refer Ms. Zayre-Brown for this
15 surgery.
16 Do you recall providing any feedback to Ms.
17 Dula about that?
18 A I don't recall specifically that. I do recall
19 signaling to Dula in conversation about the
20 significance of this letter and how this letter had to
21 meet these set criteria, and some of those criteria
22 were about the consistent well-documented history of
23 the gender dysphoria. I signaled to her that it's got
24 to capture that she's meeting these criteria.
25 Q Right.

1 A And largely based off of the Standards of Care
2 7, but Standards of Care 7 as UNC Trans Health was
3 using them in their system.
4 Q By Standards of Care 7, you mean the WPATH
5 Standards of Care 7?
6 A Yes.
7 Q Okay. So looking again at that last paragraph
8 I read, the first three sentences of it, do you have
9 any reason to believe that any of the statements in
10 those three sentences is inaccurate?
11 A Sorry. Can you point me to the section you're
12 referencing again?
13 Q Sure. It's the last paragraph on Exhibit 5,
14 the first three sentences. I'm asking if you have
15 any -- my question is, is there anything in it that you
16 believe to be inaccurate?
17 MR. RODRIGUEZ: I'm going to object to the form of
18 the question in that this represents her clinical
19 opinion.
20 You can answer.
21 THE WITNESS: That's actually what I was going to
22 say, that I think Dula was expressing her opinion on
23 it.
24 BY MR. DAVIDSON:
25 Q Okay.

1 A And Jennifer Dula was asked to produce a letter
2 that would meet that criteria set by the UNC Trans
3 Health Program based off Standards of Care 7 from the
4 WPATH so that in the event the determination was made
5 based off the medical necessity of that surgery for
6 that person, that it would be clear on UNC's side to
7 move forward.
8 Q Well, do you believe that Ms. Dula stated
9 anything in these three sentences that she did not
10 believe?
11 A I don't know that I can necessarily speculate
12 about what Dula did or didn't believe, but I do know
13 that -- the context she was writing this because I
14 asked her to prepare it.
15 Q I understand that. My question is, do you have
16 any reason to believe that Ms. Dula was not accurately
17 stating her belief?
18 MR. RODRIGUEZ: Object to the form.
19 You can answer.
20 THE WITNESS: I don't know her state of mind, what
21 Dula was actually believing or not believing, but I do
22 know that she was asked to prepare -- this was an
23 example draft. I don't know if this was one draft, a
24 second draft, third draft, or which draft, but I know
25 that this was an early part of the process. What she

1 put into the medical record was her final piece. So
2 the HERO note, the one you identified as transgender
3 accommodation summary was what she actually entered
4 into the medical record.
5 BY MR. DAVIDSON:
6 Q All right. Well, I guess I'm trying to
7 understand, do you have any reason to believe that Ms.
8 Dula would state that it is her professional
9 recommendation to refer Ms. Zayre-Brown for the surgery
10 if that was not her professional recommendation?
11 MR. RODRIGUEZ: Asked and answered.
12 You can answer.
13 THE WITNESS: This you can see just with asterisk
14 areas, this is an evident template that was set up
15 prior to even completing the contact evaluation for
16 that. So I would suggest that this is viewed as a
17 template of what a letter includes.
18 You can see that that is different from what she
19 put in the medical record. So I would imagine that
20 through her process of identifying what she was going
21 to write, that she determined what she would write and
22 wrote that in the HERO note that was submitted.
23 BY MR. DAVIDSON:
24 Q Okay. We'll look to that in a minute, but I
25 just wanted to get one or two things clear.

1 A Sure.
2 Q Back in the third paragraph, "B," referring to
3 Ms. Zayre-Brown, "continues to report clinically
4 significant anxiety, depression, and distress related
5 to gender dysphoria," and my question to you is, did
6 you believe on February 17, 2022, that Ms. Zayre-Brown
7 had clinically significant anxiety, depression, or
8 distress associated with her gender dysphoria?
9 A I believe that she still met diagnostic
10 criteria for gender dysphoria. The diagnostic criteria
11 for gender dysphoria with the DSM -- DSM-V at that
12 point, not much has changed between the V and the V-TR
13 as it relates -- but that is one of the factors for
14 meeting the minimum criteria for gender dysphoria. So
15 to the extent that you're asking, did she still meet
16 diagnostic criteria for gender dysphoria during the
17 DTARC review, yes, she continued to meet diagnostic
18 criteria for the gender dysphoria diagnosis.
19 Q I appreciate that. Thank you. But my question
20 is, at the time of this February 17, 2022, meeting, did
21 you believe that Ms. Zayre-Brown had clinically
22 significant anxiety?
23 A I don't know how much I would go with anxiety.
24 I'm not sure how much I would say that there was
25 clinically significant this or -- she did continue to

1 meet the criteria for the distress that's associated.
2 So if you're asking anxiety as a term, distress as a
3 term, yes, I would say that she continued to be
4 distressed about it.
5 Q And what would lead you to question whether she
6 continued to experience significant anxiety?
7 A It's a very specific symptom.
8 Q Okay. And do you have any --
9 (Simultaneous speakers.)
10 THE WITNESS: Yeah. You're asking me, do I agree
11 that she had this specific symptom. You're asking me,
12 do I know what Dula means when Dula writes in this
13 draft version --
14 BY MR. DAVIDSON:
15 Q No. I'm not asking --
16 (Simultaneous speakers.)
17 BY MR. DAVIDSON:
18 Q What I'm asking you is simply whether you
19 believe that on February 17, 2022, that Ms. Zayre-Brown
20 was experiencing significant anxiety associated with
21 gender dysphoria?
22 MR. RODRIGUEZ: Asked and answered.
23 You can answer.
24 THE WITNESS: So her diagnostic criteria has not
25 been disputed, recognize that she meets diagnostic

1 criteria for gender dysphoria. The significant
2 distress that relates to that incongruence is one
3 characteristic, one criteria of gender dysphoria. So
4 yes, yes.
5 BY MR. DAVIDSON:
6 Q And did you believe on February 17, 2022, that
7 Ms. Zayre-Brown was experiencing depression related to
8 her gender dysphoria?
9 A Again, you're getting very specific on, kind
10 of, a symptom term. So I don't know that I would say
11 yes to that.
12 Q And what causes you to question that?
13 A You're using very specific symptom terms.
14 Q Well, is depression an unusual symptom term in
15 psychology?
16 MR. RODRIGUEZ: He said "specific." Objection,
17 anyway. Never mind.
18 You can answer.
19 THE WITNESS: Depression is a term used in
20 psychology, yes, sir.
21 BY MR. DAVIDSON:
22 Q Okay. And I'm trying to understand whether on
23 February 17, 2022, you believed that Ms. Zayre-Brown
24 was experiencing depression related to her gender
25 dysphoria?

1 MR. RODRIGUEZ: Asked and answered.
2 You can answer.
3 THE WITNESS: So if you're asking me, does she have
4 depression. Are you asking me if she is depressed?
5 Are you asking me if she has depressive symptoms?
6 Again you're talking about some specific symptoms here,
7 some of which have, kind of, general language
8 involvement. Some of them also are diagnoses in and of
9 themselves. No, she is not diagnosed with depression.
10 Q Did she have depressive symptoms?
11 A She has expressed some depressive symptoms.
12 She has experienced some, based off of the medical
13 record, and I do think she is distressed about her
14 gender dysphoria.
15 Q Okay. Turning to Exhibit 6, so you're belief
16 is that this is the final evaluation -- I'm sorry --
17 this is the final document that was prepared to meet
18 UNC Trans Health's requirements to show that DTARC
19 approved Ms. Zayre-Brown for surgery?
20 A Yes, sir. This was the document intended to
21 serve that purpose. This is the document Ms. Dula put
22 into HERO for that.
23 Q Okay. Now, if you'll look at the third
24 paragraph under "review of transgender history," it
25 starts, "Based on the review." It says, quote, Based

1 on review of her records and the current assessment, it
2 appears the next appropriate step for Ms. Zayre-Brown
3 is to undergo trans-feminine bottom surgery. The
4 surgery will help her make significant progress in
5 further treatment of her gender dysphoria.
6 Do you have any reason to believe that any of
7 those statements were not accurate?
8 MR. RODRIGUEZ: Objection to form. Expresses an
9 opinion.
10 You can answer.
11 THE WITNESS: So this is part of the determination
12 for her candidacy for the surgery.
13 BY MR. DAVIDSON:
14 Q Yes.
15 A And the information shared from UNC Trans
16 Health about what they required to even consider
17 somebody to be a candidate for the surgery, this is
18 outlining that she is a candidate. Ms. Dula used the
19 word "appropriate."
20 Q And did you have any belief about whether or
21 not it was the next appropriate step for Ms.
22 Zayre-Brown at this point to undergo trans-feminine
23 bottom surgery?
24 A She was definitely a candidate for the surgery.
25 She met all the criteria. She even met the piece about

1 the weight. I think they said -- they might have said
2 weight or BMI, but some of those pieces. There were
3 some other aspects for what they needed before she
4 could actually undergo the surgery. But no, she met
5 their criteria for being a candidate for surgery.
6 Q Well, she could meet the criteria for being a
7 candidate, but did you agree that such surgery was the
8 next appropriate step for Ms. Zayre-Brown?
9 A Ms. Dula, like I said, used the word
10 "appropriate," and so yeah, you could say that she is
11 appropriate for the surgery. Kanautica had identified
12 that this was the next step. She did not identify that
13 this was the end of the process for her in her gender
14 journey.
15 But no. She had identified this was her
16 desired next step. Dula had the criteria, explained to
17 her about what we need to make sure that this is
18 meeting the surgical requirements that they have before
19 the person can move forward, and so she identified that
20 this is the next step that she's requesting, and it's
21 appropriate. She's meeting those criteria. She's a
22 candidate.
23 Q And did you agree that the surgery will help
24 make significant progress in further treatment of her
25 gender dysphoria?

1 A Yeah. This is -- was Kanautica's goal. She
2 did want to have bottom surgery, and that would make
3 progress in that aspect. I mean, she is looking for
4 this to treat her gender dysphoria, and the bottom
5 surgery, she had been wanting the vaginoplasty, had
6 requested at this point the vulvoplasty. So it would
7 take her -- that next would be a step forward in that.
8 I don't think it was where she wanted to go
9 ultimately, that she may have still wanted additional
10 surgeries after that. At least that's what she had
11 expressed to folks.
12 Q I just want to get a clear answer. So I'm
13 asking about your belief, your belief, not Dula, not
14 UNC, was it your belief on February 17, 2022, that a
15 vulvoplasty would help Ms. Zayre-Brown make significant
16 progress in further treatment of her gender dysphoria?
17 MR. RODRIGUEZ: I'm going to object to vague.
18 You can answer it.
19 THE WITNESS: You're asking me on February -- so
20 sorry. I'm shifting frame of reference here from
21 Dula's note --
22 BY MR. DAVIDSON:
23 Q In February of last year, was it your belief
24 that surgery would help Ms. Zayre-Brown make
25 significant progress in further treatment of her gender

1 dysphoria?
2 MR. RODRIGUEZ: Same objection. Vague.
3 You can answer.
4 THE WITNESS: I'm a little confused. You're
5 referencing Ms. Dula's note from October of 2021 and
6 asking me about February of 2022.
7 BY MR. DAVIDSON:
8 Q You can ignore what's in the note --
9 A Okay.
10 Q -- Just trying to get what you believed on
11 February 17, 2022. Did you believe that vulvoplasty
12 would help Ms. Zayre-Brown make significant progress in
13 further treatment of her gender dysphoria?
14 MR. RODRIGUEZ: Same objection. Vague.
15 You can answer.
16 THE WITNESS: So Kanautica wanted the surgery.
17 Vulvoplasty was the one she was requesting. She had
18 wanted vaginoplasty. You had helped clarify early on
19 the difference between vaginoplasty and vulvoplasty
20 with the vaginal canal being a key piece of it. I
21 would say that this would be from, kind of, a surgical
22 step, probably what you might consider a significant
23 step towards that.
24 I believe there might be some other considerations
25 going from a post vulvoplasty to now a vaginoplasty.

1 There might be some -- maybe some medical or surgical
2 hurdles or considerations or -- you know, it might be a
3 little bit more difficult maybe than going straight for
4 a vaginoplasty. So with that regard, it might actually
5 sent her back maybe a little bit from a surgical
6 perspective.
7 I'm not a surgeon. This is, again, just my
8 understanding. So it might be viewed as a significant
9 step forward, progress. It might be viewed as some
10 progress with maybe a hurdle being created for the
11 future, with the understanding that she had made it
12 known that she wanted more surgeries to come or maybe
13 one more surgery to come.
14 BY MR. DAVIDSON:
15 Q Okay. Looking at the last paragraph on this
16 first page, the third sentence says, "However, now that
17 the issue of housing has been addressed and is
18 affirming, it seems to have made her more aware and
19 dysphoric about the one part of her body that does not
20 affirm her gender identity."
21 Do you have any understanding of what part of
22 her body is being referred her to there?
23 A I could certainly assume what Dula is talking
24 about. I would assume she's talking about the part of
25 the body related to the surgical request, which would

1 be the genital surgery.
2 Q Well, is it the part of her body -- what I'm
3 trying to understand is that is referring, for example,
4 to the fact that she still has a phallus.
5 A I would assume that's what she's talking to.
6 Kanautica has completed surgeries on other parts of her
7 body. I know that she has an idea of the type of look
8 that she wants to have. She has described certain
9 things that go along with the process of transition for
10 herself. I can assume that that's what she's -- but I
11 don't know specifically that that's what Dula was
12 writing.
13 Q I'd like to mark as Exhibit 7 a document. At
14 the bottom it says DAC 004524.
15 (Exhibit 7 marked for identification.)
16 BY MR. DAVIDSON:
17 Q Looking at what's been marked as Exhibit 7,
18 this appears to be another draft of something that's
19 still in the form of a letter from Ms. Dula; is that
20 correct?
21 A I would say the same thing, yes, sir.
22 Q Okay. If you look at the second page, the last
23 paragraph there under "clinical recommendation," that
24 paragraph doesn't appear to have made its way into
25 Exhibit 6, at least -- well, I guess what I want to

1 know is, did you have any conversations with Ms. Dula
2 about whether or not to include any of the portions of
3 that paragraph in Exhibit 7 in the transgender
4 accommodations letter?
5 MR. RODRIGUEZ: I'm going to object to the form.
6 You can answer.
7 THE WITNESS: It's kind of similar to the first
8 one, the September 9, 2021, letter. I don't recall the
9 specific ones, but I know that Dula was creating
10 multiple drafts trying to get to the structure to line
11 up with what was being requested, and I did share with
12 her what the criteria were for the letters, and so yes,
13 I have talked to Dula. I don't recall if I talked to
14 her about this specific set of sentences.
15 BY MR. DAVIDSON:
16 Q Well, the specific sentence I'm most interested
17 in is, "My professional recommendation is to refer Ms.
18 Zayre-Brown for the surgery." That doesn't appear in
19 Exhibit 6. Did you ever talk to Ms. Dula or otherwise
20 communicate with her that that sentence would not
21 appear in the transgender accommodations letter?
22 MR. RODRIGUEZ: Did you say "could not" or "did
23 not"?
24 BY MR. DAVIDSON:
25 Q Did you ever have any conversations that it

1 should not --
2 MR. RODRIGUEZ: Should not.
3 THE WITNESS: Which sentence again?
4 BY MR. DAVIDSON:
5 Q "My professional recommendation is to refer Ms.
6 Zayre-Brown for this surgery."
7 (Reporter clarification.)
8 THE WITNESS: I don't know. It certainly is not
9 what's being asked for in the letter. That would come
10 from the DTARC process.
11 BY MR. DAVIDSON:
12 Q I'd like to move on and mark as Exhibit 8 a
13 five-page document. It starts DAC 3399.
14 (Exhibit 8 marked for identification.)
15 BY MR. DAVIDSON:
16 Q On the bottom of the first page, it says, "Case
17 summary, DTARC."
18 (Reporter clarification.)
19 BY MR. DAVIDSON:
20 Q At the bottom of the first page of what's been
21 marked as Exhibit 8, it says "Case summary, DTARC
22 2/17/2022."
23 Can you tell me what a case summary is?
24 A Yes, sir. This would be a summary of the
25 DTARC's review of this case. This is Kanautica's case

1 from that February 2022 DTARC.
2 Q And is this something that you compiled?
3 A Yes.
4 Q And did you prepare this before, during, or
5 after the February 17, 2022, meeting or some
6 combination of those?
7 A So some of the information comes in advance.
8 Some is the discussion. We had started talking about
9 this earlier on, and you said we could hold it for a
10 later point so I guess this is that later point. But
11 yes, so some of it's the discussion from the DTARC.
12 Some of it's the information that comes prior to the
13 DTARC.
14 Q Okay. And was this reviewed by anyone other
15 than yourself prior to it being completed?
16 A Prior to it being submitted up to the
17 leadership?
18 Q Yes.
19 A It's my responsibility to take the information
20 from the DTARC in that capacity and put it together
21 into the document that moves forward. So no, that was
22 my responsibility to move it forward, made available to
23 the DTARC members as the summary from the DTARC. Like
24 I mentioned to you, before you asked where do things
25 go, and I said there was a file. This goes into that

1 person's file for that date, and then the leadership is
2 given access to that information for that review.
3 Q And by the leadership in this case, was that
4 Dr. Gunter and Brandeshawn Harris?
5 A Yes, sir. They would be in that next level --
6 or would've been in that next level.
7 Q So this was something that was made available
8 to them along with DTARC's recommendation?
9 A Yes. This is the summary report from the DTARC
10 based off of our review of Kanautica's case.
11 Q Okay. I'd like you to look at the top of the
12 second page. It says, "The patient's mood and anxiety
13 symptoms appear well-controlled by psychiatric
14 interventions."
15 Was that you're view at the time of the
16 February 17, 2022, DTARC meeting?
17 A At that point in time?
18 Q Yes.
19 A Yes. At that point in time, she was seeing
20 psychiatry and was showing good control over
21 psychiatric symptoms.
22 Q And what led you to conclude that Ms.
23 Zayre-Brown's mood and anxiety symptoms were
24 well-controlled?
25 A We get input on psychiatric stability from the

1 chief psychiatrist for the department. So that would
2 have been an aspect of information that would relate
3 specifically to psychiatric. Of course, there are the
4 psychiatry notes that are in the medical record. There
5 are the behavioral health clinical notes, so what the
6 therapist is writing as well. But that totality of
7 information would have been what came in for this
8 conclusion.
9 Q Between the time of Ms. Dula's completion of
10 the Exhibit 6, which is dated October 20, '21, and the
11 DTARC meeting on February 17, 2022, did you have any
12 conversations with Ms. Dula about Ms. Zayre-Brown's
13 mental health?
14 A You're saying in between?
15 Q Yes.
16 A I don't recall specifically, but yes, I was in
17 communication with Dula.
18 Q Well, I'm just trying to check whether after
19 Ms. Dula prepared Exhibit 6 leading up to the
20 February 17th DTARC meeting, did you talk to her about
21 how Ms. Zayre-Brown was doing?
22 A I don't recall a specific conversation that I
23 would point to, but yes, I was in communication with
24 Ms. Dula.
25 Q The continuation of that sentence on page 2 of

1 Exhibit 8 is, quote, However, recent progress notes
2 from supportive counseling and therapy sessions
3 indicate that patient has been heavily focused on the
4 status of the final decision regarding her requested
5 desire for surgery and experiencing related
6 anxiety/frustrated mood.
7 Was that your view at the time of the February
8 17, 2022, DTARC meeting?
9 A Yeah. Kanautica has experienced situational
10 distress at a few different places, For instance, the
11 rubber band incident you were referencing previously.
12 She was really anxiously awaiting in-person consult
13 with Dr. Figler as part of that review process. There
14 was an aspect where she had been informed that she was
15 going to move from a male-oriented prison to a
16 female-oriented prison. As that date approached, she
17 was having, kind of, distress. You might call it even
18 some elements of crisis. So when she was waiting for
19 the outcome, yeah, she was processing that during
20 therapy sessions and supportive counseling sessions.
21 Q And at the time of the February 17, 2022, DTARC
22 meeting, did you believe that Kanautica would benefit
23 from having gender-affirming surgery or further
24 gender-affirming surgery?
25 A "Benefit" is certainly a word that would have a

1 variety of meetings to a variety of people.
2 Q Do you think it would help reduce her
3 dysphoria?
4 A So Kanautica was wanting the surgery. She was
5 wanting the vaginoplasty, was requesting vulvoplasty.
6 It was her intent to have what you might call "bottom
7 surgery," to have the genital surgery. She continued
8 to want it, and I would say that, yeah, she would have
9 likely felt benefit from having it. I'm kind of
10 assuming her state of mind, but, you know.
11 Q Well, have you ever met Ms. Zayre-Brown?
12 A I have not met her in person, no.
13 Q Okay. So your information is based upon what's
14 in her medical records and conversations with mental
15 health staff; is that accurate?
16 A Yeah, to a large extent I'd say that's
17 accurate.
18 Q Okay. Well, did you have any information about
19 Ms. Zayre-Brown's mental health aside from what's in
20 her medical and mental health records and conversations
21 you had with others at DPS?
22 A You might include the OPUS record in there as
23 part of her full record, but if you were to rephrase
24 that, you know, based off of her records, based off of
25 conversations with staff at DPS, based off of staff

1 involved in it, then I would say, yes, that's correct.
2 Q Okay. And did you have a belief of whether
3 receiving a vulvoplasty would reduce Ms. Zayre-Brown's
4 anxiety?
5 A Are you talking about the sentence you
6 referenced about her anxiety about the pending
7 decision?
8 Q No, no. Just in general when we talked
9 previously about her experiencing symptoms of anxiety
10 related to gender dysphoria, and I'm trying to
11 understand what you believe. I'm going to try a yes or
12 no question.
13 Do you believe that receiving vulvoplasty
14 likely would reduce her experience of anxiety?
15 A Yeah, and I recall us having those discussions
16 during that particular set of questions. I don't know
17 that we got to a point of saying one symptom or the
18 other, but as it relates to kind of a general
19 consideration, she's wanting it. She's wanting it for
20 part of her transition. I mean, I could certainly see
21 her finding, you know, this a positive relief from
22 having it. So, yeah, I could say yes.
23 Q Okay. I'd like to mark as Exhibit 9 DAC 4550.
24 (Exhibit 9 marked for identification.)
25 THE WITNESS: And if I could, I am getting close to

1 empty on my water so I'll just ask for --
2 (Simultaneous speakers.)
3 THE WITNESS: -- where it's convenient.
4 BY MR. DAVIDSON:
5 Q Okay. Okay. This appears to be a different
6 draft of what we've marked as Exhibit 8. Does it look
7 that way to you?
8 A Yeah. I don't see the footnote on this.
9 Q Well, the question I have is, if you look on
10 the first page, there's a bolded sentence, "Patient
11 also remains quite stable without any destructive,
12 homicidal, or suicidal ideation and describes normal
13 sleep, appetite, and energy level," and that sentence
14 is not in Exhibit 8. My question for you is, do you
15 know why that sentence is not in Exhibit 8?
16 A So it is consistent. She to this day remains
17 quite stable, no destructive, homicidal, or suicidal
18 ideation. Sleep, appetite, energy level are
19 appropriate, but no, I can't say for certain.
20 It still applies.
21 Q Okay. Do you have any knowledge about who
22 wrote that bolded sentence?
23 A No.
24 Q Okay. When you were describing Ms. Zayre-Brown
25 as being stable, I'm trying to understand what the term

1 "stable" means.
2 A So the stability, talking about the psychiatric
3 stability. So showing evidence of -- in shorthand,
4 absence of mental health red flags. But an unstable
5 person would be demonstrating, you know, you might see
6 decompensation across different life domains.
7 Sometimes you might see the person, like, not able to
8 handle their activities of daily living, you know, like
9 showering or hygiene. These are some of the areas that
10 are looked at. It's got kind of the psychiatric field
11 to it with, you know --
12 (Simultaneous speakers.)
13 MR. RODRIGUEZ: Can you let him finish his thought?
14 THE WITNESS: Because when they're reviewing the
15 psychiatric symptoms of a person, they'll ask, you
16 know, about general areas of, you know, "how's your
17 appetite? Eating more? Less often? Do you find
18 yourself being hungry more or not hungry at all?"
19 They will review for energy level. Sometimes they
20 might ask questions about, you know, "Are you getting
21 out of the bed? Are you finding yourself not having
22 energy for activities you used to otherwise enjoy?"
23 And they'll also ask about sleep. Sleep is a
24 common one, actually, to talk about because you could
25 imagine sleeping in a prison environment where you

1 might be in a dorm setting in some environments.
2 But, yeah, so with that, stability would relate to
3 all of those aspects for the psychiatric stability of
4 the person.
5 BY MR. DAVIDSON:
6 Q Well, let me ask you a specific yes or no
7 question. Can a patient have a high level of gender
8 dysphoria consistently and be considered stable?
9 A I'm not sure what your consideration for
10 high --
11 Q If a patient is experiencing gender dysphoria
12 consistently, would they be considered stable? Yes or
13 no?
14 A So Kanautica is quite stable and continues to
15 meet diagnostic criteria for gender dysphoria. That is
16 clear, and so I would say, yes, both can exist at the
17 same time. She is quite stable. She does meet
18 criteria for gender dysphoria.
19 Q So she consistently experiences gender
20 dysphoria; is that correct? Yes or no?
21 A We have never disputed her gender dysphoria
22 diagnosis. I don't recall there being a point where
23 that was removed from the system either. So yes, I
24 would say consistent.
25 Q Okay.

1 A And that was one of the areas of the WPATH
2 requirements that UNC Trans Health wanted to make sure
3 was that well consistent documented gender dysphoria
4 was present. So we made sure that that was included in
5 the letter, but the letter that would be written as a
6 note.
7 Q I'd like to turn back -- sorry. I'd like to
8 mark as the next exhibit, Exhibit 10, DAC 688 through
9 690.
10 (Exhibit 10 marked for identification.)
11 THE WITNESS: And did you want us to include a
12 brief break after distribution of this?
13 MR. DAVIDSON: I'm sorry. You wanted to get some
14 water. How much time do you think you need?
15 MR. RODRIGUEZ: Let's take 15 so we can grab a
16 quick Power Bar, if that's okay.
17 MR. DAVIDSON: That's fine.
18 (Recess.)
19 BY MR. DAVIDSON:
20 Q I'd like to mark as the next exhibit, which is
21 No. 10, DAC 688 through 690. Dr. Peiper, is this a
22 document that you believe you have ever seen before?
23 A Yes, yes, I would have seen this. I'm trying
24 to place it in context of time, but yes.
25 Q Okay. Well, it's dated October 4, 2021, in the

1 upper left-hand corner, and I am trying to
2 understand -- could you look for a minute at Exhibit 8
3 and also in Exhibit 6? If you could have Exhibit 6 and
4 Exhibit 8 in front of you, that would help. Exhibit 8,
5 which is the case summary, the last bulleted items on
6 of the first page -- do you have 8?
7 A 8, yes.
8 Q The last of the bulleted items on the first
9 page says "10/4/2021, new updated transgender
10 accommodation summary completed" as part of the
11 referral letter requirement, and what I'm trying to
12 understand is -- so there is an Exhibit 10 as of that
13 date 10/4/2021, but it's entitled "Mental Health
14 Assessment Update."
15 Exhibit 6, which is entitled "Transgender
16 Accommodation Summary," is dated October 20, 2021. So
17 I'm trying to understand on Exhibit 8, that bulleted
18 item referring to a new updated transgender
19 accommodation summary of 10/4/2021, is that referring
20 to Exhibit 6 or Exhibit 10 or something else?
21 A So you're correct with the dates, that the
22 bulleted item on Exhibit 8 says 10/4/2021 and then
23 describes the transgender accommodation summary, which
24 in Exhibit 6 is dated 10/20/2021. So you are correct
25 that the date that's bulleted on Exhibit 8 is a

1 different date.
2 Q Well, I'm trying to understand, do you think
3 there was an additional transgender accommodation
4 summary dated 10/4/21 that is in addition to Exhibit 6?
5 A No, sir. What Dula wrote is intended to be
6 that transgender accommodation summary that was
7 completed as part of the referral letter requirement
8 summarizing the history. Everything that's written
9 there does reflect what Dula wrote. So yes, I would
10 say those are referencing the same document, but you're
11 right that the bullet point has a different date on it.
12 Q Okay. So your belief at the moment is that
13 that should have said 10/20/21?
14 A I would have to believe that, yes, that this is
15 a typo on the 4 instead of the 20.
16 Q Okay. I spent a lot of time looking for a
17 10/4/2021 transgender accommodation. So that clears
18 that up, and I appreciate that.
19 A Okay. Thank you.
20 Q Looking at Exhibit 10. Now, you if you look on
21 the first page, it's near the end of the blocked
22 paragraph, it starts of "Offender Brown," the second
23 one. No. I guess it's the third one.
24 It says "documentation of a medical provider
25 indicating that surgery is not medically necessary has

1 also led her to believe that she has been denied
2 surgery altogether, which has notably increased
3 distress," and my question to you is, yes or no, on
4 October -- sorry --
5 My question is, do you have any reason to
6 believe that Ms. Zayre-Brown was not experiencing
7 notably increased distress on October 4, 2021, as a
8 result of believing that she had been denied surgery
9 altogether?
10 MR. RODRIGUEZ: Object to the form.
11 You can answer.
12 THE WITNESS: So when I first started looking at
13 this document you gave, Exhibit 10, I said I'm trying
14 to put this in the context of time. You pointed out
15 the date for me at that point.
16 This feels connected to me, and I'm sorry that
17 that's a less specific term. It feels connected to me
18 to a point where Kanautica reached out to Katherine
19 Croft at UNC Trans Health. She had medical contact,
20 and based off of that, there was some belief about the
21 surgeries not having been approved, and so when it was
22 not already approved, there might've been the use of
23 the word "elective." It might have even been during a
24 nutritional consult. Please don't hold me to those
25 specific details, but it feels in the context of that.

1 necessarily have any reason to believe that she was not
2 having some distress at that point.
3 Q And further down in that paragraph it states,
4 "She reports and sometimes she thinks she may need to
5 do self-mutilating," and that's in quotes, "behavior to
6 get help."
7 Did you ever think that Ms. Zayre-Brown might
8 engage in self-mutilating behavior to get help?
9 A You were asking about this earlier, and in that
10 line of questioning, we were talking about how she has
11 expressed it. She's talked about it, an example being,
12 you know, talking in therapy about the rubber band.
13 She was talking about that.
14 She was at that point frustrated that she
15 wasn't getting her Dr. Figler consult in the time
16 frame. She shared that information with, I believe, it
17 was Dr. Hahn, her therapist at the time, highlighting
18 that, "You know what? If I don't get this Dr. Figler
19 appointment, you know, maybe I have to do something
20 just to make it happen."
21 Here's a conversation where she was telling --
22 this looks like a psychiatrist telling that "thinks she
23 may need to do self-mutilating behavior to get help.
24 She is upset that her surgery was denied," and it was
25 not at that point.

1 Q Okay. But my question is, did you ever think
2 that she might follow through with that?
3 A That she might? That's a big open term for a
4 psychologist, and it's hard to think like a
5 psychologist and to answer like one too, I guess, but
6 so "might" is --
7 So assessing Kanautica in her suicide-risk
8 profile, no. Her suicide risk is incredibly low.
9 She's not seen as an elevated risk for that, no.
10 Q Well, okay. I'm not asking about suicide right
11 now. I'm asking you about engaging in self-mutilating
12 behavior. Did you ever think that Ms. Zayre-Brown was
13 at risk of engaging in self-mutilating behavior?
14 A Well, sir, if you're pointing to this note, you
15 can also look to the self-injury alert section. The
16 psychiatrist at the time that was meeting with
17 Kanautica also identified that there is "no apparent
18 current significant risk of self injury noted for
19 inmate." So I would assert that that also, in the
20 Exhibit 11 that you're using in this question, that's
21 relevant information from the perspective of the person
22 writing the note that you were discussing.
23 Q Okay. Please listen to my question. My
24 question is, regardless of what's on this line, did you
25 ever think that there was a risk that Ms. Zayre-Brown

1 might engage in self-mutilating behavior in order to
2 get help?
3 A Sir, I do believe that I've answered the
4 question about my evaluation of her self-injury risk or
5 suicide risk. No, she is not at an elevated risk for
6 self injury, for suicide. She has talked about it.
7 She's talked about it with therapists here. She's
8 talked about it with a psychiatrist.
9 She has talked about it as it relates to
10 situations, timing, phrased it in such a way as, "Do I
11 need to do something to myself to get an immediate
12 answer, to get this immediate appointment?"
13 It can be frustrating when you're not
14 controlling your own appointments. You've got to go
15 through an agency, go through a prison system to get
16 it. I myself have had frustrations with when I wanted
17 to see the doctor and there wasn't an appointment
18 within my available time frame, and I had to wait. So
19 it's perfectly reasonable. I wouldn't say that that's
20 anything necessarily against Kanautica.
21 Q So at the time of the February 17, 2022, DTARC
22 meeting, you had no concerns that Ms. Zayre-Brown was
23 at risk of self-mutilation; is that correct?
24 A I would likely tell you a similar answer to
25 what I was just sharing, but no.

1 Q No, you had no concerns?
2 A No, I did not evaluate Kanautica to be at that
3 level of risk.
4 Q Okay. I'd like to mark as Exhibit 12 DAC 677
5 through 678.
6 (Exhibit 12 marked for identification.)
7 BY MR. DAVIDSON:
8 Q So this is -- it says at the top consultation
9 and it's dated October 4, 2021, and if you look under
10 comments in the fourth sentence, it says, "Ms.
11 Zayre-Brown remarked she wanted to be sent to," quote,
12 Raleigh acute, closed quote, as she needed, quote,
13 respite, closed quote.
14 What is Raleigh Acute?
15 A I would assume that's referencing the prison in
16 Raleigh, the NCCIW, the North Carolina Correctional
17 Institute for Women. I would assume her use of Raleigh
18 Acute would likely relate to the inpatient mental
19 health unit there.
20 Q Okay. I'd like to mark as Exhibit 13 DAC 673
21 through 675.
22 (Exhibit 13 marked for identification.)
23 BY MR. DAVIDSON:
24 Q Under -- it's the next to the last paragraph,
25 the second sentence says, "Offender Brown requested

1 there is not quite as much discussion or development.
2 When you're a teenager identity development, I mean,
3 it's going to be fluid, and, you know, allowing for the
4 fluidity. So I don't recall a percentage, but yes, I
5 am aware and do recall that all of that's discussed.
6 Folks with lived experiences have described it as well.
7 Q And is it your understanding that most of the
8 studies that were done -- have been done regarding
9 de-transitioning were studies with respect to
10 individuals who sought to de-transition as minors as
11 opposed to adults?
12 A Are you asking, did I say that the literature
13 was --
14 Q No. Was it your understanding that most of the
15 studies about de-transitioning were looking at
16 individuals who had expressed gender dysphoria, a
17 gender identity disorder, and that subsequently felt
18 that they were comfortable with their gender
19 assignment?
20 A You know, I don't recall the degree to how much
21 weighted this way or the other. I recall examples, of
22 course, of adults who had undergone surgery, you know,
23 18 and above that would get surgery. I know there was
24 some discussion, of course, about the adolescents
25 piece, but most of that was more focused on adults.

1 Q Okay. If you'll look at page 9, there's a
2 reference to something called the "Society for
3 Evidence-Based Gender Medicine." It's a little --
4 about halfway down. It starts, for example -- have you
5 ever heard of that organization, the Society for
6 Evidence-Based Gender Medicine?
7 A Yes, yes. I have heard of it within the
8 context of this position statement.
9 Q And what do you know about them? the Society
10 for Evidence-Based Gender Medicine?
11 A I do recall reviewing them at the time. I
12 don't recall completely what their mission statement is
13 or any of that.
14 Q Do you know whether they're a more reputable
15 organization than WPATH or not?
16 A More reputable? I don't necessarily know that
17 I can speak about their reputation.
18 Q Well, turn to the top of page 10. It says,
19 "WPATH remains under increasing scrutiny and continues
20 to be mired in controversy for the very reasons cited
21 above, calling into question its objectivity."
22 Do you think that WPATH lacks objectivity?
23 A So in discussion about the comments about
24 WPATH, some information I've shared in those
25 conversations is -- in many ways if you think about

1 trans health and, you know, services, it's going from
2 relatively nonexistent and growing into the field that
3 it is, and in order to grow that, there is --
4 naturally, folks that are advocating for it are going
5 to be involved in the growth of it, and so to the
6 degree that folks are involved that also happen to
7 advocate for it --
8 Like, for instance, even in the DSM-V in the
9 diagnostic criteria development, going back from the
10 IV-TR to the V, and then also continuing from the V to
11 the TR, there's been discussion about how can we reduce
12 the medical pathologization -- I don't know how to
13 spell that -- how can we reduce pathologizing it while
14 also ensuring that we're able to get folks access, that
15 we're not limiting the access to care.
16 So there's, kind of, that balancing piece. So
17 I'm aware of that within the DSM, the development of
18 the diagnostic criteria. I'm aware of some of that
19 debate, even from going from the Standards of Care 7 to
20 the 8 and really trying to balance that, and there's
21 some folks when the 8 came out that were dissatisfied
22 that it didn't go quite far enough, or it still be
23 related to do -- sorry to use a colloquial term -- but
24 a little bit too "pro-birther" in some areas as well,
25 and that that might be offensive or problematic, and so

1 to the degree that it's trying to build this consensus
2 for where things are as it evolves while also ensuring
3 that you balance that -- making that recognition that
4 this is a personal experience for folks and trying to
5 not pathologize their identity, while also giving just
6 enough to where there is still that level of insurance
7 consideration or to make sure that folks are having
8 access.
9 So yes, to that degree I am very much aware of,
10 maybe, the evolving discussion within the community.
11 Q Well, do you think that the WPATH standards of
12 care are unreliable?
13 A So WPATH does a good job of, in my opinion,
14 marking that there are flexible guidelines to be
15 applied in the different settings, and with that, it
16 provides that opportunity for it to be brought in. So
17 for instance, earlier we were talking about UNC Trans
18 Health and how they were using the Standard 7 at that
19 point, but using those in how they approached their
20 review of their surgery cases. So it was still a UNC
21 Trans Health version of it, but with that, you know,
22 inspired from those standards.
23 So to that degree they do -- they provide --
24 you know, it's a tough balancing act. So they
25 certainly do provide that level of flexibility, and to

1 the credit of the authors, that does create broader
2 applicability and flexibility.
3 Q Does DPS rely on WPATH standards of care in
4 providing care to prisoners with gender dysphoria?
5 A So we have used those, you know, flexibility of
6 applying it, you know, I mean, the lived experience.
7 So there's that aspect that's frequently described.
8 What does "lived experience" look like in prison, and,
9 you know, moving the transition process forward. So
10 it's informed by that, certainly. So yes.
11 Q And do you consider WPATH to be an activist-led
12 organization?
13 A So my earlier description, I see it as kind of
14 a reasonable aspect that folks that are, kind of,
15 really leading the push for either, "We need to ensure
16 that there is the medical access to care. We need to
17 ensure that we're reducing the stigma associated with a
18 diagnosis, while also recognizing that while we need a
19 diagnosis if, you know, insurance companies are going
20 to consider it for payment."
21 So with that, yes. I tend to be a person, as
22 you can tell, that cares about the semantics, maybe, of
23 the woods and to a degree. So I wouldn't necessarily
24 say it that way, but yeah, there are folks that are,
25 you know, advocating for certain rights that are part

1 of it, and, you know, folks that advocate lead the
2 charge.
3 Q And you referred previously to, like, well -- I
4 don't want to put words in your mouth -- so the general
5 idea that, you know, there are people working there and
6 to the extent there's more medical care being provided,
7 then they'll have more business --
8 A Oh, no. No, sir.
9 Q I'm sorry. I totally misrepresented what you
10 were suggesting.
11 A Sorry about that. I'm stuck on the strategic,
12 you ask then that I answer. I apologize. No, sir. As
13 soon as I heard you inferring, summarizing, stating
14 that I was saying this was for people's business
15 motivation that more service creates more business, as
16 soon as I started hearing you say something that
17 sounded like that, it was just, kind of, immediate
18 negative reaction. I apologize. But no, sir that is
19 not what I meant.
20 Q Well, do you think that WPATH has conflicts of
21 interest based on its funding or the funding of its
22 members?
23 A So that was an area that I believe Dr. Campbell
24 had some information in the statement about. It's not
25 an element, necessarily, that arises to my level of

1 concern or consideration, so.
2 Q Okay. In Dr. Campbell's deposition, he stated
3 that at the time of the February 17, 2022, DTARC
4 meeting, you were the chair of the meeting, is that
5 correct, that you were the chair then?
6 A Chair?
7 Q Were you the chair of the DTARC meeting on
8 February 17, 2022?
9 A Yes. I do serve the role as chair. There is
10 some discussion about cochairing with Dr. Campbell, but
11 yes, I have taken the chair role for the DTARC.
12 Q And he also said that as chair, you generally
13 present a case; is that accurate?
14 A Uh-huh.
15 Q And what does that mean?
16 A Yeah. So with the information that's being
17 pulled together -- so in the chair role, kind of almost
18 like you might have in, you know, ordering the, kind
19 of, the proceedings of a meeting. So all right. The
20 next case is OPUS number et cetera. This is so and so.
21 She, he, they are seeking X, Y, Z accommodation. FTARC
22 review date. There have been prior DTARC reviews.
23 You know, this is information from a PREA
24 report, and then like Charlie Williams would say some
25 information about the PREA report, but some of the

1 information is already provided in a written format.
2 Q Okay. And Dr. Campbell also said that
3 generally during the DTARC meetings, you give out
4 mental or behavioral health history with regard to the
5 presenter whose request was being considered. Is that
6 something you did with regard to Ms. Zayre-Brown?
7 A Yeah. So one piece of information that I am
8 providing is aspect from the behavioral health record.
9 So yes, sir.
10 Q And do you recall anything you said during the
11 DTARC meeting about Ms. Zayre-Brown's mental health or
12 behavioral history that you haven't already testified
13 about?
14 A I lost the last words there.
15 Q Anything you said that you haven't already
16 testified about her mental health or behavioral
17 history?
18 A No, sir. I don't believe I recall anything
19 that I would have said that I've not already discussed
20 with you.
21 Q Did you discuss with them at all the results of
22 Dr. Figler's consultation with Ms. Zayre-Brown?
23 A Dr. Figler's consultation?
24 Q With Ms. Zayre-Brown?
25 A Yeah. And what were you asking about Dr.

1 Figler's consultation?
2 Q Was it discussed with the DTARC at the February
3 17, 2022, meeting the results of Dr. Figler's
4 consultation?
5 A The results of Dr. Figler's consultation were
6 discussed with the DTARC. Some of that has happened
7 over time, and there have been a multiple DTARC
8 meetings related. But yes, it was discussed.
9 Q And do you have any reason to question the
10 qualifications of Dr. Figler to opine about surgery for
11 gender dysphoria?
12 A Dr. Figler was the person giving that consult,
13 giving that information to the agency, and I would
14 certainly believe he's qualified to do that.
15 Q Do you have any reason to doubt the
16 qualifications of Jennifer Dula to have an opinion
17 about the treatment of gender dysphoria?
18 A Jennifer Dula?
19 Q Yes.
20 A She's a licensed clinical social worker. She
21 was on contract with us. My assessment of her and the
22 work she did was it was good. She did great work.
23 Certainly have her back on contract, if that's an
24 indication. She did good work.
25 Q And do you have any reason to question the

1 qualifications of Dr. Caraccio, who's the
2 endocrinologist who saw Ms. Zayre-Brown at UNC?
3 A I would not have any reason to question the
4 endocrinology training qualifications of the
5 endocrinologist.
6 Q So I understand in preparing for the February
7 17, 2022, meeting, you reviewed the records that
8 related to Dr. -- Zayre-Brown. My question is, did you
9 have any conversations with any of her mental health
10 providers to prepare for the February 17, 2022, DTARC
11 meeting?
12 A I've had conversations with her mental health
13 providers. I had conversations with Jennifer Dula
14 about her case. I've had conversations with Dr. Hahn
15 about her case. I've had conversations with Dr. Bowman
16 about her case. I'm blanking on her name, but most
17 recently the treating clinician when she came off the
18 caseload. She's no longer requiring mental health
19 services or psychiatric care, and I'm blanking on that
20 person's name. But yes. The folks that were providing
21 care for her, I have had conversations with them about
22 her case.
23 Q And when you say "she's no longer requiring"
24 that, is it because she no longer wants them or that
25 someone has determined that she no longer needs them?

1 A It was jointly determined. So she identified
2 not needing it anymore, and she came off the psych
3 medicines a while back, and continued -- you know, we
4 want to continue meeting with the person. So a general
5 process for us, you know. You come off the psych meds,
6 we'll keep working with you.
7 And she identified that, you know what? She's
8 at a point where she's focused on, you know, earning
9 her custody level, which she has. So at the point of
10 that assault, she had moved up to a closed custody.
11 She's moved all the way up to minimum custody now.
12 So she's actually done a great job with that
13 wanting to work on a certain types of educational
14 pursuits, really focused in on what you might consider,
15 you know, making the most of what the prison education
16 and programs have to offer.
17 Q So you said right now she's been moved to
18 minimum security, but Anson is not a minimum security
19 facility, is it?
20 A It does house minimum, medium, and in-house
21 close. So yes.
22 Q So is Ms. Zayre-Brown currently in minimum
23 security status at Anson?
24 A She has earned minimum custody level. I
25 understand that she hit minimum just recently. Maybe

1 you could count the weeks. I don't recall exactly when
2 she did that, but she is, I understand, is at Anson or
3 has recently been at Anson. I don't know if today
4 she's there or not, but I believe she's on the backlog
5 list to transfer to a minimum-only facility, maybe out
6 in the western part of the state.
7 We've got three female prisons. So it's either
8 NCCIW, Anson, or what's called Western Correctional
9 Center for Women, WCCW. It used to be known as
10 Swannanoa.
11 Q I do understand that Anson has a minimum
12 custody unit with male offenders, but does it have a
13 minimum custody unit for female offenders?
14 A For minimum custody, the intention is to have
15 the person at the minimum-specific unit, so Western. I
16 believe she's backlogged for -- backlog is the process
17 on the prison operation side where a person is
18 scheduled to move and go to another prison, and then as
19 they are able to -- there's been space issues to be
20 considered within custody operations and movement and
21 transportation going from Anson to the facility over in
22 Black Mountain. So it's over in the mountains of North
23 Carolina.
24 Q Well, are individuals looked at in order based
25 on when they were put on the list to be moved, or do

1 people move out of order?
2 A I don't deal with the transportation or the bus
3 schedules or population management in that regard.
4 Q In your conversations with Jennifer Dula, did
5 she ever express that she thought Ms. Zayre-Brown would
6 do better if she received the gender-affirming surgery
7 she was seeking?
8 MR. RODRIGUEZ: Objection. Vague.
9 You can answer.
10 THE WITNESS: I was about to comment on "do
11 better." She certainly wanted it. It's part of her,
12 I'd use the term "gender journey" previously. It's
13 part of her, like, transition process. She has given
14 it thought.
15 She has identified that this is the next step for
16 her as a person, for her body, yes.
17 BY MR. DAVIDSON:
18 Q I understand what she said. I'm just trying to
19 understand whether Jennifer Dula ever expressed her
20 view that it would be beneficial for Ms. Zayre-Brown's
21 mental health to receive it?
22 A Beneficial? Yeah. I could concede to that.
23 Yeah, that there was a belief that there's a benefit to
24 it.
25 Q Okay. And how about Dr. Hahn? Did she ever

1 express that to you?
2 A She hasn't worked with Kanautica in a good long
3 while, but -- so I don't know for certain. It sounds
4 like something Dr. Hahn might say. She's a very --
5 she's like a clinician at heart. She's a very
6 empathetic individual in patient care, really kind of
7 has that quality of a therapist that you want, like
8 they aligned with you know matter what they align with
9 you. So definitely a very caring therapist, so a
10 really strong clinician in that regard.
11 Q Did UNC Trans Health, did they want to have --
12 well, let me do it this way. As I understand it,
13 Jennifer Dula prepared this transgender accommodation
14 summary that we looked at before. Was that going to be
15 sufficient for UNC Trans Health, or did they require
16 two letters or reports like that?
17 A Yeah. Just like the Standard 7, they were
18 asking for two referral letters, and the one that we
19 were providing was from the current therapist, and
20 Jennifer Dula shared the criteria with her for what
21 should be included in that letter.
22 Q Well, to the best of your understanding, was
23 there ever a second one prepared by anyone at DPS?
24 A I believe the letter from the therapist is the
25 one we were providing, and I believe there was an

1 outside one that UNC Trans Health was having someone
2 do.
3 Q But no one else from DPS, to the best of your
4 recollection?
5 A Correct. So Dula was the only person I asked
6 to create that letter.
7 Q Did you ever ask Dr. Hahn to prepare a referral
8 letter?
9 A Dr. Hahn was not working -- she may not have
10 even been -- so Dr. Hahn retired.
11 Q Right.
12 A And there is a mandatory break before you can
13 come back on contract. She hasn't -- she hasn't worked
14 with Kanautica since she retired.
15 Q Okay. Do you know who did this second letter
16 who was not at DPS?
17 A No, I can't give you a specific name. I do
18 recall it occurring, but I'm sorry. I'm blanking on
19 that.
20 Q Do you think it was somebody at UNC or no?
21 A Yes, yes. It was not within our department.
22 Q Okay. And just trying to understand, do you
23 think it was somebody at UNC or someone not at DPS and
24 not at UNC?
25 A I would think it was somebody at UNC. Now, I

1 don't know if it might've been somebody that UNC Trans
2 Health program would claim as "this is our person" or
3 "this is a person that works with us." Maybe they're
4 part of the UNC Health System at large, not part of the
5 Trans Health Program, but yes, I do recall there being
6 the intention to get another letter from somebody, that
7 UNC trans health was going to get another letter not
8 from us.
9 Q I'd like to mark as Exhibit 23 DAC 4825.
10 (Exhibit 23 marked for identification.)
11 BY MR. DAVIDSON:
12 Q If you'll look at the second page here, there's
13 an email on July 6, 2021, from you to Dr. Hahn. "As I
14 saw your note in HERO and it looked like you all had a
15 good closing session, do you think you'll be able to
16 write a summary note that covers was referenced below
17 this week? My thought is to have it included in HERO
18 as a transgender accomodation summary note. I can then
19 direct the UNC side to review the specific note in
20 HERO, and won't have to send it separately."
21 Does that refresh your recollection that
22 perhaps you asked Dr. Hahn to prepare a referral letter
23 for transgender accomodation summary --
24 A It doesn't refresh my recollection, but you've
25 got it here. So yeah. I do not dispute that.

1 Q Okay. To the first page from Dr. Hahn,
2 July 7th, it says "see the attached referral letter,"
3 I'd like to mark as Exhibit 24, DAC 4826.
4 (Exhibit 24 marked for identification.)
5 BY MR. DAVIDSON:
6 Q So if you look at the numbers at the bottom,
7 this is what follows in the document production from
8 DPS, and my question is, do you have any belief one way
9 or the other as to whether this was what was attached
10 to the email that's Exhibit 23?
11 A I really have no idea.
12 Q Okay.
13 A I'm looking at the emails, and it looks like I
14 outlined to Dr. Hahn -- it really does look spot on
15 Standards of Care 7 in that first email, and then Hahn
16 said that, yeah, it looks like it wouldn't be a problem
17 to capture all of that, that she's meeting those
18 criteria. I think you'll be able to write a summary
19 note that covers what is referenced below, then direct
20 the UNC side to review it. And then she said over on
21 the backlog, if she does transfer, see attached
22 referral letter?
23 Q Yes --
24 (Simultaneous speakers.)
25 BY MR. DAVIDSON:

1 Q It doesn't look like a letter.
2 A No, it does not. Honestly, I would imagine if
3 we have these notes from -- this almost looks like
4 snippets from notes.
5 Q Yes.
6 A Because you even have the scale "on a scale
7 from 0 to 10," what do you say? No, I don't -- I don't
8 know. It certainly does not look like anything I would
9 consider a referral letter.
10 Q And do you recall ever getting a draft referral
11 letter from Dr. Hahn?
12 A I didn't even recall this conversation with Dr.
13 Hahn. I'm sorry. No. I'm sorry. I mean, I discussed
14 the case a lot with Trish. I don't recall us having
15 the conversation, "Hey, you're leaving. Right before
16 you leave, can you write this letter?"
17 That's around the time that we were --
18 Katherine Croft and I were really nailing down what UNC
19 Trans Health would need so that everything is clear to
20 go based off of the final decision. But no. I'm
21 sorry. I don't know.
22 Q That's okay. Looking at the bottom of the
23 snippet that's there on Exhibit 24 for December 11,
24 2020, it says, "She has had increasing problems coping
25 with institution issues, and on November 23 got into an

1 altercation with another offender."
2 I believe you previously discussed that.
3 A Yes.
4 Q "Who implied Ms." -- and then it's blacked
5 blocked, "still had a penis." Is that your
6 recollection that that was part of what occurred during
7 that altercation?
8 A Yes, sir. There were -- the verbal low blows
9 that the two women were passing around, Kanautica was
10 trying to hit her with the I've got a projected release
11 date, and you've got life. What's next to your name?
12 Knew that she was in there for murder and was telling
13 her, "Why don't you try killing somebody else? Why
14 don't you do that?"
15 And the other girl his Kanautica with that
16 comment about, "Why don't you make me? How are you
17 going to make me? Are you going to use your penis to
18 make me?"
19 And they had the piece of Kanautica inviting
20 her to finish the discussion privately in a single-cell
21 setting, and Kanautica finished the conversation with
22 her.
23 Q Okay. And then it continues on, "One of her
24 greatest fears is that someone will find out she still
25 has part of a penis, and so it is an extremely

1 emotionally arousing issue for her. Since that time
2 Ms." -- and again it's blacked out -- "symptoms of
3 depression have significantly increased, and she had
4 thoughts of ripping the skin of" -- I think it should
5 be "off," whatever it is is -- "ripping the skin of her
6 penis and thinks she may be better off dead."
7 Do you have any information that any of that,
8 of what's written there is untrue?
9 A So I shared some of this information with you
10 previously about the different instances of a mental
11 health crisis. This was the one that immediately
12 followed that fight. I'll call it a fight. I think
13 she got an assault charge on it, but, you know, it's a
14 fight. There were two people.
15 So right after that, Kanautica received -- it's
16 a customary nursing screening before you go to
17 restrictive housing. You get into a fight, you have an
18 assault, you do receive restrictive housing placement.
19 Going in, she had the nurse screening. They screened,
20 you know, just tell us about what's happening. Tell us
21 about your physical. You know, do you have any
22 injuries? But they also asked about suicidal ideation.
23 She denied at that point, told the nurse doing the
24 intake for restrictive housing that day or right
25 thereafter that, no.

1 Then afterwards when a person's in restrictive
2 housing, we have a behavioral health clinician that
3 does rounds to check on everybody shortly thereafter
4 getting in restrictive housing. She told that
5 clinician, no, actually everything was fine and that
6 she was looking forward to seeing her primary clinician
7 that Friday, I think it was. So it was, you know, a
8 few days later.
9 That was Dr. Hahn. Dr. Hahn had a scheduled
10 appointment with her, and she was going to travel down
11 to Anson to see her based off of that schedule. Saw
12 her, and in that context kind of got into discussion
13 with Kanautica, and Kanautica told basically, I want
14 out of here.
15 I mean, we've seen in some of the other
16 documents how she was saying, "I don't want to be at
17 Anson anymore. I want out of here."
18 There was a certain point that she was even
19 saying, you know, "Send me to a male prison." But I
20 think that was, like some of the other comments, made
21 out of frustration and not what she actually intended
22 to say when she said, "Send me to a male prison."
23 Nobody acted on that whatsoever.
24 But for this one, Dr. Hahn in the discussion sent
25 her over to the NCCIW. As soon as she got there, she

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION

KANAUTICA ZAYRE-BROWN, )
Plaintiff )
)
vs. )
)
THE NORTH CAROLINA DEPARTMENT )
OF PUBLIC SAFETY, et al. )
Defendants )

DEPOSITION

OF

DR. LEWIS J. PEIPER

APRIL 17, 2023 - 9:09 A.M.

NORTH CAROLINA DEPARTMENT OF JUSTICE
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1 Q. Okay. And right now in this policy -- well, no.
2 Currently at DPS is there any review of policies around gender
3 affirming surgery underway?
4 A. This policy would be under review on an annual basis
5 as well, yes.
6 Q. Okay. So as of now the gender affirming surgery or
7 the portion that applies to gender affirming surgery is
8 current?
9 A. So the current policy is still active, if that's what
10 you are asking. Yes, the current policy -- and again, I can't
11 say that this was the one -- the last one off the Website or
12 not.
13 Q. Okay.
14 A. Thanks for working through those answers and
15 questions.
16 Q. No. No. It's important. I don't want you to be
17 nervous.
18 A. No. It's just when certain things are said in a
19 certain way and I'm like now what is the actual question. So
20 thank you for clarifying the actual questions.
21 Q. And so you mention that this is interdisciplinary and
22 so you make some contributions. Who else has responsibility
23 for making contributions to the EMTO policy?
24 A. So there are aspects related to custody, to
25 operations, some elements with programs, of course there's

1 medical, mental health, behavioral health. The policy review
2 process involves the general counsel's office as well for
3 general policy reviews. There's of course the folks that sign
4 them as well at the end.
5 Q. Okay. And who has responsibility for signing the
6 policy?
7 A. This one was commissioner of prisons. And it was the
8 same on the interim, commissioner of prisons.
9 Q. And looking back at what we have marked as plaintiff's
10 Exhibit-4, which is the interim policy, just for a second. And
11 on that second page.
12 A. Second page of the interim.
13 Q. And do you see the highlighted portion?
14 A. Yes. It's in blue.
15 Q. After gender-identity-consistent facility transfers,
16 subsequent transfers will be managed according to division
17 guidelines. Can you explain that to me?
18 A. So if you -- let's say if you start a mental-focused
19 facility, gender-identity-consistent facility transfer, you're
20 in a female-focused facility, transfers from one facility to
21 the next after that would be the typical transfer process.
22 Q. And that's another policy, not within this policy?
23 A. Correct. That would not have to be governed by -- so
24 if you're talking about the FTARC and the DTARC process, that
25 would not be governed by the FTARC DTARC process. It would be

1 the standard procedures.
2 Q. Okay. Why were these policies developed?
3 A. About --
4 Q. Well, why were these EMTO policies developed? Sorry,
5 let me rephrase that.
6 A. To give policy and procedure for the care and custody
7 of folks. Sorry, I don't -- I'm struggling with the question.
8 Q. I'm just wondering was there anything that caused them
9 to be developed at DPS, the EMTO policies?
10 MR. RODRIGUEZ: I'm going to object as
11 speculation. You can answer.
12 THE WITNESS: I'm trying to understand the
13 question to answer it.
14 MS. BROWN: Okay. Yeah.
15 THE WITNESS: If you're asking is there a
16 specific thing like -- I'm not aware of there being a specific
17 thing that sparked.
18 BY MS. BROWN:
19 Q. Okay. And how was the first policy developed? I
20 don't know if we have handed -- so the August 22, 2019 EMTO
21 policy.
22 A. That one -- again, I'm not -- I'm not certain on the
23 exact date, but in that 2019 calendar time frame was placement
24 of the policy within the prison manual, if you will.
25 Q. And how did that policy -- how was it developed? How



Case 3:22-cv-00191-MOC-DCK Document 61-9 Filed 10/05/23 Page 4 of 153

1 did it come to be?
2 A. It was -- I can't remember what it was called in the
3 healthcare manual. It had a tx. If you don't hold me to it,
4 it might have been TXI13, like Roman number one.
5 Q. What was TXI13?
6 A. That was the policy when it was in the health service
7 manual.
8 Q. Okay. And when was the DTARC created?
9 A. That was for the -- so the actual DTARC was part of
10 the -- what I would call the 2017/2018 policy. And so it was
11 implemented with that policy. I think that policy had a 2018
12 date associated with it.
13 Q. Okay. And to be --
14 A. If you have it, I can point to it.
15 Q. Yeah. That's the TX13 policy you were talking about?
16 A. That would have still been in a TX, yeah.
17 Q. Does that same policy create FTARCs?
18 A. Yes. You could think of that as kind of the TARC
19 process was implemented through those policies.
20 Q. And are you a member of DTARC?
21 A. Yes, I am currently a member of the DTARC.
22 Q. How long have you been a member?
23 A. Goodness. 2020 right around the date of becoming
24 interim. So if you give me some flexibility on that, if I can
25 say on or about.

1 Q. Okay.
2 A. The date of me becoming interim.
3 Q. Okay. And you became a member of DTARC because you're
4 the interim director of behavioral health?
5 A. Yes.
6 Q. Okay.
7 A. Yeah. When I moved into that position I was moving
8 into the DTARC capacity.
9 Q. Okay. And so let's look at the current version --
10 let's look -- yeah, the current version, the March 31, 2021
11 EMTO policy. Based on this policy, Dr. Peiper, who all is a
12 member of DTARC?
13 A. You're talking about on definition K?
14 Q. Yes.
15 A. So it says at a minimum, there is the medical
16 director, chief psychiatry, behavioral health director,
17 director of rehabilitative services, and the PREA director.
18 Q. So at a minimum. Does that mean there could be more?
19 A. Yes. That would -- yeah.
20 Q. And how are they selected?
21 A. These individuals in their position, in their capacity
22 they have got the authority and the understanding of those
23 specific areas that bring that kind of holistic
24 interdisciplinary perspective.
25 Q. Okay. And what would create a need to add more than

1 the minimum that's required?
2 MR. RODRIGUEZ: Object as speculation. You can
3 answer.
4 THE WITNESS: So there's additional value the
5 perspective of nursing has and so the director of nursing is
6 included in the DTARC.
7 BY MS. BROWN:
8 Q. Who all is on the DTARC now?
9 A. We have got the representation from operations,
10 programs, which that's another term we use for rehabilitative
11 services. Psychiatry, medical, nursing, behavioral health,
12 PREA.
13 Q. Did you say someone from operations?
14 A. I did say operations.
15 Q. Not everyone currently on DTARC has a medical degree
16 or a background?
17 A. That is correct, not everybody on DTARC has a medical
18 degree.
19 Q. Okay.
20 A. I also do not have a medical degree.
21 Q. Or mental health degree?
22 A. Yes. Yes. And nursing you could -- yeah.
23 Q. So let's say so some kind of healthcare degree. Not
24 everyone has some kind of healthcare degree?
25 A. Correct, not everyone is health service.



Case 3:22-cv-00191-MOC-DCK Document 61-9 Filed 10/05/23 Page 7 of 153

1 Q. Okay.
2 A. Maybe that's an easier catchall term.
3 Q. Yeah. We got there, I think. And so under the
4 current EMTO policy gender-affirming surgery is a non-routine
5 accommodation that has to be determined by DTARC, correct?
6 A. The process with gender-related surgeries comes up
7 through the DTARC. There is an additional level review as
8 well.
9 Q. And describe that level of review.
10 A. So the DTARC review and then decisions from the DTARC
11 go up for additional level review of the health service chain
12 and the -- kind of the prison chain.
13 Q. And so can you describe that chain specifically,
14 meaning who exactly?
15 A. Yeah. Right now it is Dr. Junker and Mr. Buchholtz.
16 Basically he's in the position of commission of prison,
17 director of prisons. They have got new terms now with us being
18 the DAC. Might be deputy secretary.
19 Q. Who was in his position before?
20 A. That was Brandy Harris. It would have been Junker and
21 Harris.
22 Q. So let me ask another question. So do FTARCs review
23 none routine accommodation requests from transgender people in
24 custody?
25 A. Yeah. So all of the accommodations that move through

1 the TARC process begin with the facility-level review.
2 Q. And so describe what happens when someone in custody
3 seeks gender-affirming surgery for the treatment of gender
4 dysphoria at their facility.
5 A. So someone would make some type of a request. They
6 would make it known. They would -- there's a consent process
7 before the TARC process. That's one thing that you probably
8 see in the current version here. And there is also
9 PREA-related aspects that are required, mandates. And so for
10 the TARC process there are different evaluations, and then
11 there's a piece of the actual TARC meeting, if you will, where
12 the committee comes together and shares review. That would be
13 at the facility level.
14 Q. Looking back at those definitions of FTARC, that
15 includes -- a multi-disciplinary committee that includes
16 representatives from psychiatry, behavioral health, primary
17 care provider, nursing -- or nursing -- sorry. Administration,
18 and it has in parentheses associate warden for custody and
19 operation/programs, unit manager, and the facility PREA
20 compliance manager. And so --
21 A. I'm sorry, I was saying uh-huh. Yes. Yes, that is
22 how it reads.
23 Q. Okay. And so you said make it -- you know, how that
24 would arise is that someone would make it known at their
25 facility. Could they make it known to health services?

1 A. Yes.
2 Q. Could they make it known to medical health services?
3 A. To -- are you -- like a medical doctor? Like an M.D.?
4 Q. No. I mean just through medical services. Or maybe
5 I'm assuming something. Are medical services and mental health
6 services distinct? Okay. Moving along. So they make it known
7 and it goes to FTARC. And so again, what we're talking about
8 is a request for gender-affirming surgery. So does the FTARC
9 review that request for gender-affirming surgery?
10 A. So there's an expectation that they're -- like I was
11 describing before, certain evaluations that are taking place at
12 the facility level. And so they'll complete those evaluations.
13 If there's any additional things that might relate, like I
14 mentioned PREA mandates, there's the aspects of ensuring that
15 the person is getting what the requirements are based off of
16 PREA. And so making sure that their declaration of identity is
17 known as relates to those PREA components. The information is
18 sent up, basically referred, if you will, to the DTARC for
19 review.
20 Q. Okay. And you said some evaluations are done at the
21 FTARC level?
22 A. Yes. The clinicians of the facility, physicians at
23 the facility.
24 Q. Which evaluations specifically though?
25 A. I believe the policy will speak to kind of the medical

1 and the mental health evaluations. I don't know if you would
2 call the PREA piece as an evaluation.
3 Q. What's the medical evaluation at the FTARC level for
4 someone requesting gender-affirming surgery?
5 A. If there are certain pieces of their medical
6 presentation, medical needs that needs to be captured, they'll
7 provide as summary information.
8 Q. Can you provide me just an example?
9 A. I don't know that I can right now.
10 Q. So would a medical evaluation be -- could it be
11 considered physical?
12 A. They might document it as a history and physical.
13 They might document it as a medical note, a clinical encounter
14 note. But it would be related to whatever they would be doing
15 in the course of their evaluation and the notes relay -- we
16 call it Hero, electronic medical record. There's a statement
17 in the policy about -- really trying to be respectful of kind
18 of the physical body during that medical component.
19 Q. Okay.
20 A. I don't know if that's what you were asking about.
21 Because sometimes when people say physicals they're mentioning
22 that.
23 Q. What about the mental health evaluation?
24 A. Mental health evaluation, yes.
25 Q. Okay. And describe that evaluation for me.

1 A. Mental health evaluations certainly do differ from
2 person to person based off of what's presented, what's coming
3 through. But there would be an element of, you know, certainly
4 a clinical interview. We do want there to be some sort a broad
5 spectrum personality assessment inventory used. There's
6 history taking, file reviews. Ideally if there's any
7 description of prior records, that those are getting confirmed,
8 release of records signed. There could be aspects of, you
9 know, kind of collateral input if something is being mentioned
10 as to something that relates to housing unit, prison
11 experience. In our line of work prison adjustment is always
12 something that is being considered. So it's kind of a routine
13 process as well.
14 Q. Part of the mental health evaluation is there a gender
15 dysphoria assessment?
16 A. They would be assessing for that and any other mental
17 health issues, concerns or diagnosis.
18 Q. Okay. Can you describe the gender dysphoria
19 assessment in this context for me? And again, just so we're
20 clear, we're talking about someone at the FTARC level who is
21 seeking gender-affirming surgery and is undergoing a mental
22 health evaluation and part of that is a gender dysphoria
23 evaluation.
24 A. So they would be evaluating through that history
25 taking, the clinical interview, those aspects of really kind of

1 like that marked incongruence that folks experience and
2 present. They would be evaluating for the clinical
3 significance and distress and dysphoria. You're saying only
4 specific to gender dysphoria?
5 Q. Correct.
6 A. Any other comorbidities or additional mental health
7 needs would also be evaluated.
8 Q. I want to make sure I heard your testimony correctly
9 about the gender dysphoria evaluation. You said history taking
10 and so that -- well, I won't suggest. What does history taking
11 mean in this context?
12 A. Goodness. In a -- I'm sorry about the oh goodness
13 because in the prison context there's so many different areas of
14 history taking, because we also have criminal history that
15 comes into it, as well as kind of the prison adjustment
16 history. But with gender dysphoria, you know, aspects of lived
17 experience of course would be considered. A lot of folks will
18 share even back to kind of early childhood time periods.
19 Really kind of talking about their sense of self, their
20 identity development, if they have already started an aspect of
21 the transition process in some way. Sometimes it's private.
22 Really kind of getting an understanding -- sorry if it sounds
23 interesting, but their gender journey. Kind of a common way
24 that it's referred to.
25 Q. Well, I have been on my own gender journey so I can

1 relate. And when you say transition process in this context of
2 the history taking, what does that mean?
3 A. Elements of -- you know, if it is lived experience,
4 elements of living out. Of course in the clinical interview
5 understanding that person's experience of living it out. That
6 -- yeah. Apologize if I'm getting hard to understand. I'm out
7 of water.
8 MR. RODRIGUEZ: I was about to say, we have
9 been going about an hour and 15, 20 or so. Maybe take 10, 15?
10 What do you think?
11 MS. BROWN: Yes. Let me mark the time just for
12 myself because I'm anxious. My nature. 10:33. So you said
13 how long? Sorry, and we're off the record.
14 - - -
15 (A break was taken, 10:35 a.m. - 10:53 a.m.)
16 - - -
17 BY MS. BROWN:
18 Q. Dr. Peiper, what do you have in front of you or what
19 do you have in your hand?
20 A. I have got a cell phone that is keyed in on our
21 policies, the Department's policies.
22 Q. Okay.
23 A. And I have got the current posted version of the
24 F.4300 policy. The evaluation and management of transgender
25 offenders. Issue date March 31, 2021. Supersedes August 22,

1 2019, consistent with the one that was provided. Of course
2 we've changed from DPS to DAC.
3 Q. Okay. Thank you. So back to where we left off, which
4 I'm actually -- okay. So right before break we were talking
5 about the FTARC process and what happens when an individual in
6 the facility is seeking gender-affirming surgery for the
7 treatment of gender dysphoria. And we were going through the
8 process that happens and part of that was a medical evaluation
9 and part of that was a health evaluation, and we were walking
10 through some of the gender dysphoria evaluation. And we were
11 talking about history taking and mentioned some examples of
12 that, lived experience, early childhood stuff. I can't
13 remember verbatim, so I'll stop there.
14 A. Sure.
15 Q. And transition process and gender journey. Actually I
16 do remember this. Back to that specifically. So during this
17 process is the FTARC evaluation or at least mental health
18 evaluation establishing a gender dysphoria diagnosis?
19 A. That would be an aspect of what they would be
20 evaluating for, yes.
21 Q. Okay. And a gender dysphoria diagnosis under DPS
22 policy would be required for gender affirming surgery?
23 A. Yes.
24 MR. RODRIGUEZ: Can I ask a clarifying
25 question, Taylor? And this is totally semantics, but probably



Case 3:22-cv-00191-MOC-DCK Document 61-9 Filed 10/05/23 Page 15 of 153

1 for the record. When you say under DPS -- gender dysphoria
2 diagnosis under DPS policy, you mean the DPS policy requires a
3 diagnosis of gender dysphoria, or do you mean a diagnosis as
4 provided for in the policy?
5 MS. BROWN: I don't think -- I don't think I
6 understand that, so let me ask a question and maybe this will
7 clarify.
8 BY MS. BROWN:
9 Q. So when FTARC is evaluating someone for -- well, no,
10 actually let me think about this.
11 MR. RODRIGUEZ: I wasn't trying to throw a
12 monkey wrench.
13 MS. BROWN: Actually just restate your
14 question. Maybe that will help me.
15 MR. RODRIGUEZ: Were you asking if DPS requires
16 -- prior to any gender affirming surgery that DPS requires a
17 diagnosis of gender dysphoria and that that requirement is
18 built into the policy? Or were you asking that the diagnosis
19 of gender dysphoria as provided for the policy?
20 MS. BROWN: No. I think the former. Okay.
21 Yeah, so the former.
22 BY MS. BROWN:
23 Q. Did you understand that?
24 A. Yes. We use the current version of the DSM.
25 MR. RODRIGUEZ: That's what I was making sure

1 we were --
2 THE WITNESS: Yeah. Sorry. Thank you. That
3 is actually what I believe. So thanks for clarifying.
4 BY MS. BROWN:
5 Q. Okay. Yeah. Thanks. And the DSM is the -- the
6 current version is which version?
7 A. The TR, the 5-TR. Sorry, DSM-5-TR.
8 Q. And so definitely not trying to quiz you -- actually
9 I'm not going to quiz you. This is not going to be a quiz.
10 Okay. And so the medical evaluation and the mental health
11 evaluation are completed. The person has made it known that
12 they are seeking gender-affirming surgery. And so what happens
13 at the FTARC? So now the FTARC members have both of those
14 evaluations and I believe you mentioned some kind of PREA
15 report. Okay. Anything else that the FTARC needs before they
16 start the review process?
17 A. Each person that's coming in if there's information
18 there they need to bring forward, they're bringing that
19 forward.
20 Q. What kind of information?
21 A. So if you work -- so like you saw in the FTARC the
22 unit manager. If there's things happening in the unit context,
23 the unit manager might bring that forward. I just -- you had
24 mentioned the evaluations and the PREA report.
25 Q. Yeah. Okay. And so --

1 A. Sorry for the big hand gesture.
2 Q. Oh, no. I use my hands a lot too. And so how does
3 the PREA report factor into the FTARC's consideration of
4 someone requesting gender-affirming surgery?
5 A. So with the PREA report there's the record of the
6 person identifying.
7 Q. Okay.
8 A. And so ensuring that the PREA-mandated services are
9 occurring per identification.
10 Q. Okay. What about information a unit manager would
11 bring into this consideration for gender-affirming surgery at
12 the FTARC level?
13 A. How things are going on the unit. Just general input
14 that might relate to what's happening in the unit context,
15 information that might relate.
16 Q. Okay. And is there any category of information that a
17 unit manager could bring that would contraindicate
18 gender-affirming surgery for someone?
19 A. Surgery?
20 Q. Yeah.
21 A. It would be much less relevant. I would be hard
22 pressed to find an exact example of unit-based information that
23 would even get close to contraindicating those type of
24 considerations.
25 Q. Okay. And so, you know, just because, you know, we

1 both want to be very careful. When you say much less relevant,
2 to me that doesn't mean zero, but you just can't think of
3 anything that you --
4 A. That's fair to say. Yes.
5 Q. Okay. Any other information gathered before the FTARC
6 review process begins outside of what we just talked about?
7 A. I believe that covers it.
8 Q. Okay. And so what happens when FTARC convenes to
9 consider this request?
10 A. Frequently the person will come and be able to speak
11 to the FTARC, present information, share information, be part
12 of the conversation. They can, you know, refuse to come, but
13 typically folks come. So there would be discussion, review,
14 clarification of, you know, what's being asked. For instance,
15 somebody might write a particular statement on -- if they wrote
16 it in, like make it be known. If they made it known in
17 writing, maybe they are just making sure they clarify what's
18 written.
19 Q. Can you tell me -- so that interview is optional, it's
20 not required?
21 A. Correct. We do not force the person to come to the
22 committee.
23 MR. RODRIGUEZ: And I would object to the
24 characterization of an interview. I don't believe Dr. Peiper
25 phrased it as interview.

1 BY MS. BROWN:
2 Q. And so what happens after FTARC reviews?
3 A. There is a form that goes along with moving the review
4 to the DTARC for those things that the DTARC would review.
5 Q. And what are they putting on this form?
6 A. There's the -- it's the 411F information about the
7 request and identifying information of the person. And then
8 that 411F goes -- it actually goes into the medical record, but
9 it moves the case forward to the DTARC.
10 Q. Okay. Are the members of FTARC making a
11 recommendation?
12 A. You know, they are not actually really making a
13 recommendation. I was looking at the 411F and -- actually we
14 have -- there's a behavioral health documentation committee
15 that does the annual review sort of forms. And that particular
16 form is one that does have the wording of recommendation down
17 at the bottom, the 411F. And really what that's capturing is
18 their -- kind of more of a comments section. So no, honestly I
19 do think that that's maybe a -- some wording that needs to be
20 clarified and they could make the form clearer.
21 MR. RODRIGUEZ: Taylor, can I just ask for my
22 clarification? These questions are all referring to
23 specifically FTARC reviews of request for gender-affirming
24 surgery?
25 MS. BROWN: For the treatment of gender

1 dysphoria, yes.
2 MR. RODRIGUEZ: So not FTARCs generally.
3 Specific FTARCs convened for gender-affirming surgical
4 requests?
5 MS. BROWN: Yes. Yes. It's a hypothetical.
6 So yeah, I guess.
7 MR. RODRIGUEZ: Earlier in your line of
8 questioning you were prefacing it by saying for
9 gender-affirming surgical requests. So I just wanted to make
10 sure if that premise carried out throughout all of the
11 questions, to the extent that that may have impacted the
12 witness's answer.
13 MS. BROWN: Yes. We're in the same
14 hypothetical world of this individual seeking gender-affirming
15 surgery for the treatment of gender dysphoria.
16 BY MS. BROWN:
17 Q. So you were testifying about this recommendation part
18 on the form. First, do the FTARC individuals have to put
19 anything in that form or in that section of the form, the
20 recommendation part?
21 A. We would still review. So I guess no.
22 Q. Can the FTARC not recommend gender-affirming surgery?
23 A. Can they not recommend? They can't make that
24 decision. It's at the DTARC and up level.
25 Q. Okay. Let me ask it this way. FTARC is -- from your

1 testimony would it be fair to say FTARC is simply acquiring
2 information related to the request for gender-affirming surgery
3 for the treatment of gender dysphoria?
4 A. I wouldn't necessarily characterize it with those
5 words maybe. But that's -- yeah, it's similar to what I'm
6 presenting --
7 Q. Okay.
8 A. -- for surgeries.
9 Q. For surgeries?
10 A. Yeah.
11 Q. And FTARC is not making a medical necessity
12 determination?
13 A. No. FTARC would not be making a final determination
14 on a surgery or a medical necessary final determination on a
15 surgery.
16 Q. Okay. Does FTARC make a non-final recommendation?
17 A. Does FTARC make a non-final recommendation? I would
18 answer that no.
19 Q. Does FTARC give its views about whether
20 gender-affirming surgery would be appropriate for the person
21 requesting it?
22 MR. RODRIGUEZ: Objection. Medical conclusion.
23 You can answer it.
24 THE WITNESS: If you're asking does it, I would
25 say no.

1 BY MS. BROWN:
2 Q. I think previously you testified there are I believe
3 -- and maybe I'll just clarify, but there are medical doctors
4 on FTARC?
5 A. There are interdisciplinary folks represented, yes.
6 Q. Okay. And so FTARC has reviewed and so -- and again,
7 I think maybe I'm just not understanding what you're saying and
8 that is probably my fault, believe me. It's been a long week.
9 What are the different determinations that FTARC can make after
10 its review?
11 A. So FTARC has the routine accommodations, as defined in
12 the policy.
13 Q. Oh, no. I mean, we're still in the hypothetical. I'm
14 talking about for gender-affirming surgery.
15 A. For surgery?
16 Q. Yeah.
17 A. Okay. You said determination?
18 Q. Yeah. What are the options? After they have done
19 their review, you know, what are the options in terms of
20 determinations?
21 A. They're not determining surgery.
22 Q. They're not determining surgery?
23 A. Correct.
24 Q. Okay. And so at that point what happens?
25 A. The DTARC review.

1 Q. The DTARC review. Okay. Does every request for
2 surgery that goes to FTARC go on to DTARC?
3 A. Every request for surgery? Yes, every request is
4 reviewed by DTARC.
5 Q. Okay.
6 A. Yes.
7 Q. Okay. That's helpful. And to be clear, we're talking
8 about surgery here. And so during the review both medical and
9 nonmedical members of FTARC are weighing in?
10 A. I don't know about the wording of that question
11 because there are different ways you might --
12 Q. Let's see. I guess I'm kind of -- yeah. I guess I'm
13 kind of confused about if -- so let's start here. So
14 gender-affirming surgery -- well, maybe I should ask. Does DPS
15 consider gender-affirming surgery a treatment option for gender
16 dysphoria?
17 A. Yeah. Yeah, surgery is an available treatment. It's
18 reviewed when requested and determinations are made.
19 Q. Okay. But that determination is not made at the FTARC
20 level?
21 A. Surgery, correct.
22 Q. Okay. So why does FTARC review it?
23 MR. RODRIGUEZ: Asked and answered. But you
24 can answer.
25 THE WITNESS: All of the requests start at

1 facility level. There are evaluations, information is
2 gathered, interdisciplinary process, and then the ones that are
3 surgery specific would be determined.
4 BY MS. BROWN:
5 Q. We are talking about surgery specific.
6 A. Surgery specific would be determined.
7 Q. Would it be fair to say that -- and again, I'm going
8 to recap some of your testimony. If it's inaccurate let me
9 know.
10 A. Sure.
11 Q. FTARC is collecting a lot of information, this
12 multidisciplinary team. And so we have talked about some of
13 that. The mental health evaluation, the medical evaluation,
14 PREA, unit managed -- potentially information from a unit
15 manager?
16 A. Sure.
17 Q. And then at that point because it's surgery it goes
18 straight to DTARC?
19 A. Yeah. The final determination for surgery rests at
20 the DTARC level and so they would be making that determination.
21 Q. What about the initial determination then?
22 A. I don't know that I would characterize it with the
23 words you just used.
24 Q. How would you characterize it?
25 A. The FTARC review?

1 Q. Yeah.
2 A. For surgery?
3 Q. Yes.
4 A. I would talk about the facility evaluations that take
5 place, talk about the committee process that the FTARC proceeds
6 with their input from those that are involved, including the
7 person, if the person were to come. And then the DTARC reviews
8 the case.
9 Q. For a final determination?
10 A. Yeah.
11 Q. Okay.
12 A. Yeah.
13 Q. And so I guess I'm still unclear about what
14 determination, if any, the FTARC is making.
15 A. The FTARC is not able to make determinations on
16 surgery. We rest that with the DTARC level and up.
17 Q. Okay.
18 MR. RODRIGUEZ: Taylor, could I just clarify
19 too. When you say final determination per the policy, you have
20 already asked questions about this, the DTARC's determination
21 is not the final determination.
22 MS. BROWN: I'm aware. Yeah. I was just
23 repeating on what he was saying. But yeah, I'm aware that it
24 goes to the next level. It was Ms. Harris. I cannot say the
25 first person and the other person. I'm aware. And we'll get

1 into that too. It's logistically confusing.
2 BY MS. BROWN:
3 Q. Okay. You said for gender-affirming surgery requests
4 FTARC doesn't make recommendations. But for other non-routine
5 requests for trans accommodations does FTARC make
6 recommendations?
7 A. The discussion before when asking does it. No, it
8 does not. The facility transfers sharing information that
9 relates. There would of course be more custody or security
10 operational type input there. There's operational input
11 otherwise. The hormones, similar evaluations would be
12 happening in those and that information would be shared forward
13 or up.
14 Q. But I still didn't really hear an answer. But do they
15 make a recommendation about those routine -- sorry. Nonroutine
16 accommodation requests?
17 A. They pull together information. You have got the
18 different evaluations, different disciplinary input as well,
19 and then that information is moved up to the DTARC. For those
20 nonroutine it's all reviewed at the DTARC level, and then that
21 information becomes part of what the determination is and of
22 course what the final determination as we were saying before.
23 Q. I'm really not trying to stop you. I'm trying to word
24 the question I want to ask.
25 A. Thank you. I do feel like I'm answering the same

1 question.

2 Q. I get that. So this is going to be my last --

3 actually I'll try to make this my last try, you guys. So when

4 it gets to -- so here it is. Again, now we're in the same

5 surgery hypothetical. So we're talking about FTARC having

6 reviewed a nonroutine accommodation request because that's

7 surgery.

8 A. Okay. Surgery.

9 Q. Okay. So when it gets to DTARC, all DTARC has is the

10 information that FTARC has collected and that information is

11 the -- or can be, may be not exhaustive, the mental health

12 evaluation, the medical evaluation, any potential unit

13 information and the PREA?

14 A. I would have to disagree.

15 Q. On what part?

16 A. You said all they would have.

17 Q. What else would they have outside of that?

18 A. Any other information from the medical record or the

19 prison record that would be relevant, input from the DTARC

20 members as well.

21 Q. Sorry, input -- we're at the DTARC.

22 A. DTARC members as well. Sorry, input from the DTARC

23 members as well.

24 Q. Okay. Any input from the FTARC members?

25 A. The information that's shared up from the FTARC would

1 bring input. So, yeah.
2 Q. Okay.
3 MR. RODRIGUEZ: Can we go off the record for a
4 second?
5 - - -
6 (Discussion held off the record.)
7 - - -
8 BY MS. BROWN:
9 Q. There's no way that FTARC could deny -- again, back in
10 this hypothetical, there's no way that FTARC could deny a
11 request for a gender-affirming surgery?
12 A. That is correct. Yes.
13 Q. Okay. And that means that there's no way they could
14 approve it?
15 A. Yeah. I would say yes, that's correct.
16 Q. Okay. And is that true of all nonroutine
17 accommodation requests?
18 A. Correct. FTARC does not make the determination on the
19 nonroutine and so that would include not approving and also not
20 denying. If that --
21 Q. Okay. So I think we're going to move on hopefully.
22 And so now we're at DTARC, yay, where you are. No more FTARCs.
23 Okay. Again, back in the hypothetical world. DTARC is now
24 evaluating a request for gender-affirming surgery for the
25 treatment of gender dysphoria. Explain that process to me.

1 Explain that review process to me.
2 A. The DTARC review?
3 Q. Yes.
4 A. There's a list of individuals that are being reviewed
5 based off of the request that was made from those individuals.
6 The different members of the committee are aware of who's being
7 reviewed. They do their own discipline-specific kind of
8 reviews. Provide that information in advance of the DTARC.
9 And then the DTARC meets as a committee, reviews the cases.
10 Q. Okay. And so how do they their non-final
11 determination about whether or not gender-affirming surgery for
12 the treatment of gender dysphoria is appropriate?
13 MR. RODRIGUEZ: Object to medical conclusion,
14 but you can answer.
15 THE WITNESS: So they review the information in
16 the records, review the information shared from the FTARC, pull
17 the input from the committee members, and then based of what it
18 is that's being requested.
19 BY MS. BROWN:
20 Q. And again, we're specific to surgery?
21 A. Specific to surgery. Request for surgery would have
22 those pieces I just described and then there would be other
23 aspects that might relate to surgery. If you're at the final
24 point there would be of course kind of what you might call a
25 medical analysis.

1 Q. What's the final place?
2 A. So if an individual is not even a candidate for
3 surgery, like you wouldn't necessarily be at that final point
4 of determining whether the person would be -- whether it be
5 necessary for the surgery to occur.
6 Q. How do you know if an individual is a candidate?
7 A. We do use consults. And so some of the feedback from
8 the consults will say what needs to happen, what's necessary
9 for the surgery for the person to be a candidate for the
10 surgery.
11 Q. Okay. And so there's a lot there, so I'm going to
12 walk back. So you said during the review process and again --
13 let me just do this. Until I say otherwise, we are talking
14 about gender-affirming surgery. We are talking about that same
15 request that we were at at the FTARC level.
16 A. Sure.
17 Q. It is now here. And so at the DTARC level you said
18 that each member of DTARC gives input, correct?
19 A. Yeah. Yeah. That's fair to say.
20 Q. Okay. And so as director of behavioral health what
21 kind of input do you give regarding gender-affirming surgery
22 for the treatment of gender dysphoria?
23 A. There are aspects from the behavioral health file,
24 case file. I'll of course review the evaluations that have
25 been completed. You asked about progress notes before. So

1 progress notes. The mental health progress notes. And give a
2 -- kind of capture the history. There could be multiple
3 evaluations maybe that have occurred for this person over time.
4 Some of our folks do have lengthy sentences. I'm also making
5 sure that the consent process has occurred.
6 Q. So first, what's the consent process?
7 A. There is a TARC consent form. Of course we love
8 adding letters to things so it's the 411C for consent.
9 Q. And describe that form to me.
10 A. It's a form that shares information with the person
11 who is requesting accommodations. Let's them know about the
12 process, the TARC process. Really it's about informing them so
13 that they are consenting to the process.
14 Q. Okay. And consenting to the process of being reviewed
15 for surgery by DTARC, just to be clear?
16 A. Yeah.
17 Q. So it's behavioral health or director of behavioral
18 health. So you give input from a behavioral health
19 perspective. Why are you giving that kind of input in this
20 context?
21 A. It's a role and that's my background and my expertise.
22 Q. So this input is headed towards a determination?
23 MR. RODRIGUEZ: I'm going to object to the form
24 of the question. You can answer.
25 BY MS. BROWN:

1 Q. Your input is part of the determination that
2 ultimately will be reached by DTARC at some point?
3 A. Yes. My information is part of what DTARC's
4 reviewing.
5 Q. So you said multiple evaluations. Can you explain
6 that to me? Sometimes you'll review multiple evaluations and
7 give input on that?
8 A. Yeah. Folks that have been in our prison system for a
9 while sometimes encounter mental health in different ways and
10 there are different evaluations that occur.
11 Q. For surgery?
12 A. This would be evaluations in the general context.
13 Q. Okay. But in terms of for surgery, you know, the
14 gender -- you're obviously reviewing gender dysphoria. Maybe
15 not. Are you reviewing a gender dysphoria evaluation?
16 A. When folks request surgery at a facility level there
17 are evaluations that occur. Those evaluations would be looking
18 to -- you know, does the person meet the criteria for gender
19 dysphoria. Also be looking for those other mental
20 health-related concerns. Am I mumbling again?
21 MS. COOPER: You're just a little quiet.
22 THE WITNESS: I've have said this a number of
23 times, I'm sorry.
24 BY MS. BROWN:
25 Q. So we'll move on -- well, we may not. What input --

1 again, same universe. What input does the medical director
2 give in this review process for gender-affirming surgery for
3 the treatment of gender dysphoria?
4 A. They would be medical-based information.
5 Q. Like? Can you give me an example?
6 A. Medical care, medical needs.
7 Q. In the surgery context?
8 A. From the -- so you're asking what type of input does a
9 medical director bring to the DTARC. They would bring --
10 Q. For gender-affirming surgery. When you're reviewing
11 someone for gender-affirming surgery.
12 A. Yes. Yeah. They would bring medical input, I mean,
13 for even nonsurgery case.
14 Q. Is it about the surgery being requested?
15 A. It would be about whatever is being requested, yes.
16 Q. Okay. So chief of psychiatry, what kind of input are
17 they bringing?
18 A. Psychiatric-based considerations. The chief
19 psychiatrist has, you know, insight on psychiatric disorders.
20 Also, it's another mental health perspective, if you will.
21 Q. And I think I know what you mean, but I'll ask if you
22 could explain that more in terms of the difference between
23 obviously you as a psychologist and this person as a
24 psychiatrist.
25 A. So the psychiatrist is also part of the DTARC.

1 Shiteman. So Shiteman is reviewing the case. Shiteman is
2 providing input on psychiatric considerations. Might be some
3 elements of psychiatric instability that the person is
4 demonstrating. So it's another element of mental health input,
5 if you will.
6 Q. And what about the director of rehabilitative
7 services?
8 A. So internally sometimes we say programs.
9 Q. Programs.
10 A. And that would relate to the individual's, you know,
11 interactions in any of the program settings. Programs include
12 jobs and different -- sometimes if they're engaged in an
13 education program, for instance.
14 Q. Okay. And then the PREA director. I think I have an
15 idea, but -- I'm assuming it's similar to -- is this the same
16 -- this isn't the same PREA director from the FTARC, correct?
17 A. Correct. This would be at the -- kind of the division
18 level.
19 Q. What kind of information are they bringing in in
20 relationship to evaluating a request for gender-affirming
21 surgery?
22 A. Information related to what they review within the
23 PREA context. Some aspects about, like I said, how the person
24 identified for PREA purposes. They also -- if there are any
25 PREA claims, reports from the person.

1 Q. Okay. Is my understanding correct that after FTARC
2 has reviewed there are -- well, no actually. So after FTARC
3 has reviewed, what are the options? Sorry, DTARC. After DTARC
4 has reviewed a request for gender-affirming surgery for the
5 treatment of gender dysphoria, what happens next?
6 A. What happens after a review?
7 Q. Yeah.
8 A. Some aspect of a decision based off of the
9 information.
10 Q. Some aspect of a decision based on the information.
11 What aspects?
12 A. You might have a case where there are other questions
13 that haven't been answered that -- additional information.
14 There might be a consult that's still pending that information
15 hasn't been received. There might be other information.
16 Q. Okay. And so when we're talking about a consult, so
17 this is an external consult?
18 A. Yes. Yeah. That would be outside consults.
19 Q. Okay.
20 A. External consults.
21 Q. Okay. And for gender-affirming surgery what are the
22 typical -- or maybe not even typical. What are the external
23 consults that DTARC utilizes?
24 A. We worked with the UNC Trans Health Program and as the
25 program themselves they of course also have their own elements

1 of bureaucracy, and so there are certain expectations they
2 have.
3 Q. Yeah. I'll warn you, I'm a Tar Heel, so tread
4 carefully. And so do you only participate with or do you only
5 use the UNC Trans Health Program for consults regarding
6 gender-affirming surgery?
7 A. That's all I'm aware of us using.
8 Q. Okay. And so what is the consult -- what exactly is
9 the consultation that UNC is performing for DTARC?
10 A. Depends. So they've -- during COVID they were
11 altering their program, enhancing, changing some things. But
12 as I understand it now there's an element of kind of that
13 initial contact, consultative in nature, information sharing.
14 Really trying to make sure the person understands. Again, I
15 don't represent UNC Trans Health, so this is just my
16 understanding.
17 Q. Okay. Does DTARC send UNC -- or request or send UNC
18 Trans Health any specific information? I know they're
19 consulting, but is there anything specific that DTARC needs to
20 know or wants to know for its review?
21 MR. RODRIGUEZ: Before you answer that, I want
22 to make sure that we're not going to get into any protected
23 health information.
24 MS. BROWN: Oh, no, not at all.
25 MR. RODRIGUEZ: Other than Ms. Brown. To the

1 extent that you answer the question, make sure you keep that in
2 mind because we have a protective order in place and keeping
3 clear of that. So to the extent you're talking about specific
4 information that's being requested by UNC from the department
5 that doesn't have to do with Kanautica, that would be quite
6 close to PHI and other folks.
7 BY MS. BROWN:
8 Q. Let me backtrack a little bit. So during this
9 hypothetical that we have been discussing we have been talking
10 about -- I have been using this hypothetical to try to get an
11 understanding of your process that DPS uses. So we have been
12 saying gender-affirming surgery. What does DTARC consider
13 gender-affirming surgery?
14 A. So surgery covers a very broad area. We will review
15 the request from the person.
16 Q. What are some examples?
17 A. Of what people request?
18 MR. RODRIGUEZ: Here's where I want to make
19 sure -- that's where I want to make sure that we're not
20 discussing specific requests of individual cases that are not
21 Kanautica's.
22 MS. BROWN: Okay.
23 BY MS. BROWN:
24 Q. Let's do this. Let's go back. Give me one second and
25 try this. Actually no, I don't even have to do that. Is

1 vaginoplasty gender-affirming surgery?
2 A. There are a variety of different surgeries and that is
3 one of the surgeries.
4 Q. Is vaginoplasty a surgery that DTARC would consider
5 for the treatment of gender dysphoria?
6 MR. RODRIGUEZ: I'm going to object to medical
7 and legal conclusions. You can answer.
8 THE WITNESS: If a person requests that we
9 would review it, yes.
10 BY MS. BROWN:
11 Q. And so I understand, I mean they're requesting it.
12 Your job is to review it. And so what I understand when you
13 say review at this point is the various inputs that -- and
14 correct me if I'm wrong, the various inputs that these people
15 that we talked about before are giving?
16 MR. RODRIGUEZ: Object to the form of the
17 question.
18 MS. BROWN: Okay.
19 BY MS. BROWN:
20 Q. Would DTARC approve it? Would DTARC approve
21 vaginoplasty -- a request for vaginoplasty -- gender-affirming
22 vaginoplasty for the treatment of gender dysphoria?
23 MR. RODRIGUEZ: I would object to legal
24 opinion, medical opinion, compound. Just not clear. Yeah.
25 BY MS. BROWN:

1 Q. How does DTARC review a request for a vaginoplasty?
2 A. All the information is reviewed. There's input from
3 the different committee members. In these there would be
4 surgery based. There would be consults, surgical consults that
5 would share information. All of that would be taken together.
6 The medical analysis with all of those pieces of information
7 considered.
8 Q. And who does the medical analysis for DTARC?
9 A. So there's medical input from the chief medical
10 officer, Dr. Campbell.
11 Q. So medical input. I mean the medical analysis. Is
12 that the same thing?
13 A. It would be his responsibility to bring that forward.
14 Q. To bring the medical analysis forward?
15 A. Yeah.
16 Q. Okay.
17 A. Yeah. Now, there may be consults involved, like I
18 said. But yes.
19 Q. Consults involved. In this context we're talking
20 about surgery and I specified now vaginoplasty.
21 A. Okay.
22 Q. Okay. And so is a request for vaginoplasty always
23 referred out by DTARC for a consult?
24 MR. RODRIGUEZ: Object to speculation. You can
25 answer.

1 THE WITNESS: You're asking always and it's
2 making me try to think of every scenario where it has or would
3 occur. Yeah, I would say that for any surgery request there
4 would be some aspect of a consult for that, yeah.
5 BY MS. BROWN:
6 Q. An external consult?
7 A. Yeah, there would be -- yeah. I mean, I would believe
8 so.
9 Q. Okay. And so if there's an external consult about the
10 vaginoplasty, what information is Dr. Campbell bringing in
11 about the vaginoplasty?
12 MR. RODRIGUEZ: I'm going to object to
13 speculation, but you can answer.
14 THE WITNESS: So it's the medical director,
15 there would be of course medical input. There would be kind of
16 the totality of the medical review that would come in through
17 his expertise to the DTARC. Sorry, I'm not able to speak for
18 Dr. Campbell directly or his mind but --
19 BY MS. BROWN:
20 Q. Of course. I think he'll be here tomorrow. And I
21 really don't mean this -- it sounds weird, but I'm meaning it
22 in terms of like, you know, obviously the folks at UNC
23 specialty is gender-affirming surgery. And so what specialty
24 necessarily is Dr. Campbell bringing?
25 MR. RODRIGUEZ: I'm going to object to the form

1 of the question. You can answer.
2 THE WITNESS: He's got a medical background, of
3 course. One thing that of course is unique about the DTARC
4 process versus what maybe the trans health program does -- and
5 this is something Katherine and I -- sorry, Katherine Croft,
6 Ms. Croft and I had to really try to nail down is just how
7 their structure works and kind of how our process works, and
8 how our process could match what they're expecting. They have
9 certain expectations about when letters come, first letter,
10 second letter, and how they time up their system, their
11 process. Again, just kind of -- I said they is have a
12 bureaucracy just like we have a bureaucracy. And so we had to
13 work to line those up. I was like real specific with her on
14 ensuring that what we do and how we were documenting, and what
15 we would routinely do in the documentation matches with what
16 they would expect as well.
17 BY MS. BROWN:
18 Q. And what do they expect?
19 MR. RODRIGUEZ: Object to speculation. I also
20 am not clear which topic we're on. You know, we were hyper
21 focused on gender-affirming surgery as reviewed by the DTARC
22 and topics four and five -- four is the relationship between
23 DTARC and FTARC. Five is the membership and how the policies
24 function as they're described in the EMTO policy. The EMTO
25 policy does not refer gender-affirming surgery specifically,

1 which is a defined term. Does not reference gender-affirming
2 surgery as a defined term as you guys have in your depo notice.
3 I'm not clear which topic we're on. These are questions,
4 again, for an individual deposition makes perfect sense, but
5 we're here on the 30(b)(6). We're quite clear about that and I
6 want to be cognizant of our clock, your clock really.
7 MS. BROWN: Can we go off the record for a
8 second?
9 - - -
10 (Discussion held off the record.)
11 - - -
12 BY MS. BROWN:
13 Q. First, I'm just going to -- if you want to, Dr.
14 Peiper, you can look with me, but I'm going to look at -- and I
15 guess this is for a point of clarity. So when I'm talking
16 about -- yeah. So when I'm talking about what we've been
17 talking about, which is this context of gender-affirming
18 surgery -- sorry, page seven of 10 of the current version of
19 this EMTO policy.
20 A. Okay. Where did you want me to look?
21 Q. So you see the third paragraph?
22 A. Is it --
23 Q. All accommodation requests for surgical intervention
24 or gender-identity consistent facility transfer shall be
25 reviewed by the division TARC with recommendations referred to

1 the assistant commissioner of prisons and director of Health &
2 Wellness Services for review and determination.
3 Okay. And so I guess what I'm saying on
4 gender-affirming surgery, I'm meaning surgical intervention as
5 well. Does that make sense to you? Or actually -- yeah. So
6 what kind of surgical interventions does DTARC review? Start
7 there, I guess.
8 A. I don't know if I have a different answer for you on
9 that. They review the surgical requests from the person.
10 Q. Okay. And what are the surgical requests for?
11 A. Sorry, could you be a little more specific on that?
12 Q. So actually, I'll strike that.
13 A. Okay.
14 Q. So again, I think -- somehow we got away from, I
15 think, sort of the original point that I was trying to get to.
16 So DTARC has done all of this that we have talked about. They
17 have gathered the information. They have had the input from
18 the various people that you have discussed. There may have
19 been a consult. There may have not been a consult. Again,
20 we're talking about surgery. And actually now we're talking
21 about vaginoplasty here. Under what circumstances would DTARC
22 approve a vaginoplasty?
23 MR. RODRIGUEZ: I'm going to object to
24 speculation, medical/legal conclusions. You can answer.
25 THE WITNESS: So you're talking about at the

1 final review area kind of DTARC is -- the FTARC process has
2 occurred. DTARC's reviewing. All the information is
3 available. You know, I mentioned previously there might be
4 other pieces, there might be questions, there might be things
5 still pending. Then there would be a medical analysis. There
6 would be a review of kind of the surgery, the risk benefit
7 analysis of that one for that individual.
8 BY MS. BROWN:
9 Q. Okay. And then what are the determination options?
10 That too, but I thought that was going to help. But again,
11 under what circumstances would DTARC approve vaginoplasty?
12 MR. RODRIGUEZ: Same objection. Speculation,
13 medical opinion, legal opinion. You can answer to the extent
14 you haven't already.
15 THE WITNESS: I don't know if I was answering
16 what you were just whispering or just --
17 MS. BROWN: It was the same question.
18 THE WITNESS: Thanks. Could you have repeat it
19 for me?
20 BY MS. BROWN:
21 Q. Under what circumstances would DTARC approve a request
22 for a vaginoplasty for the treatment gender dysphoria?
23 MR. RODRIGUEZ: Same objection. Speculation,
24 medical opinion, legal opinion. You can answer.
25 THE WITNESS: Would be based off of that

1 evaluation of the case and the severity of the need, the
2 analysis of the intervention, the individual base,
3 consideration for the person and then from that a
4 determination.
5 BY MS. BROWN:
6 Q. And so you said the -- I do appreciate the point that
7 -- you know, you are a psychologist. So you're not Dr.
8 Campbell. So Dr. Campbell would do the medical analysis that
9 we're talking about. And I don't mean that disparagingly. I
10 hope that's not coming across. So perhaps maybe that's why
11 it's confusing.
12 A. I got a Ph.D. on purpose.
13 Q. Yeah. Of course. I mean, yeah. So for the
14 vaginoplasty though -- so in its determination in this medical
15 -- you know, this medical analysis. But from your perspective
16 and, you know, in terms of treatment of gender dysphoria when
17 would a vaginoplasty be appropriate from a behavioral health
18 perspective?
19 MR. RODRIGUEZ: I'm going to object on a couple
20 of grounds. One, your perspective as in the individual versus
21 the department designee, which is what he's sitting as. I'm
22 going to object as to speculation, medical opinion, legal
23 opinion. You can answer as a designee of the department.
24 THE WITNESS: Can you ask me --
25 BY MS. BROWN:

1 Q. It was kind of sloppy. I'll admit that. So as
2 director of behavioral health under DPS behavioral health
3 policy or considerations, when would a vaginoplasty be
4 appropriate?
5 MR. RODRIGUEZ: I'm going to object. Same
6 basis. He's not answering questions as a -- even in his
7 professional capacity as a director of behavioral health. He's
8 a designee of the 30 -- 30(b)(6) designee of the Department.
9 And so he's here to answer questions on behalf of the
10 department as the department. His individual understanding or
11 beliefs about things is not relevant. I also want to object to
12 medical opinion, legal opinion, and speculation.
13 You can answer as a designee, unless you want
14 to rephrase the question.
15 MS. BROWN: You can go ahead and answer, if you
16 like.
17 MR. RODRIGUEZ: As a designee.
18 MS. BROWN: As a designee.
19 THE WITNESS: The question was as the director
20 of behavioral health?
21 MS. BROWN: Yes.
22 BY MS. BROWN:
23 Q. When would a vaginoplasty be indicated?
24 A. I'm sorry, I'm getting confused by the roles that I'm
25 here to speak for. As the designee of the department, when

1 A. Yeah. The assistant commissioner of prisons, that
2 position would have kind of the authority, responsibility over
3 those more kind of prison-focused, operation-focused aspects of
4 the department.
5 Q. And they can say no? They can -- you have approved it
6 but they can say no?
7 MR. RODRIGUEZ: I'm going to object to the form
8 as to they. Vague. You can answer.
9 THE WITNESS: The additional level review?
10 BY MS. BROWN:
11 Q. Yes. So we're talking about the assistant
12 commissioner of prisons and the director of health & wellness.
13 A. You're saying is it a possibility? It could be a
14 possibility.
15 Q. Under what circumstances?
16 MR. RODRIGUEZ: Objection, speculation. You
17 can answer.
18 THE WITNESS: Yeah. We haven't been there. So
19 it's hard to give you specific -- it would be very difficult
20 for there to be a reason, but I have to hold on that there is
21 the possibility. It's hard for me to imagine.
22 BY MS. BROWN:
23 Q. And just for clarity, the assistant commissioner of
24 prisons is not a healthcare professional?
25 A. That person? No.

1 Q. The current one.
2 A. No. That person, that position, no, is not a
3 healthcare position.
4 Q. And was Ms. Harris a healthcare professional?
5 A. She was not a healthcare professional and she was not
6 in a healthcare position.
7 Q. Okay. And earlier you just said we haven't been there
8 yet. What did that mean?
9 A. You were asking me to kind of speculate on some
10 specific examples or try to imagine. I couldn't imagine
11 something, so I was trying to think of something that I could
12 say, you know.
13 Q. And has DTARC approved a request for vaginoplasty?
14 A. Has DTARC approved a vaginoplasty?
15 Q. Yeah.
16 A. No.
17 Q. And what are the person's options after that?
18 MR. RODRIGUEZ: After -- vague.
19 BY MS. BROWN:
20 Q. Sorry. After -- so I'm assuming if you haven't
21 approved it that means that you have -- what happens if you
22 don't approve it?
23 MR. RODRIGUEZ: Objection, vague. You can
24 answer it.
25 THE WITNESS: If the -- so after the DTARC

1 makes its review, completes that, and there's that additional
2 level review? Is that what you're asking about?
3 BY MS. BROWN:
4 Q. No. So I'll be very granular again.
5 A. Sorry.
6 Q. So we're at DTARC. They are reviewing a request for
7 vaginoplasty for the treatment of gender dysphoria and it is
8 not approved.
9 A. Okay.
10 Q. What happens after that or what can happen after that?
11 A. So after that, if you're talking about there's the
12 final determination, that information is -- after the final
13 determination, if that's the scenario that's being described,
14 that information would be shared back with the individual, the
15 person who's making the request.
16 Q. When you say information, do you just mean that it was
17 not approved?
18 A. That outcome, yeah.
19 Q. And is there any rationale provided to that
20 individual?
21 A. Yeah. Yeah. There's information that's documented.
22 So the case summary is added into the medical record, the
23 411(d), the form itself is added into it. And the typical
24 course is there's someone from behavioral health that would
25 meet with the person, talk about it, share the information with

1 them.

2 Q. And we have talked about approving. So in this

3 instance when DTARC has not approved a request for vaginoplasty

4 for the treatment of gender dysphoria, that decision was made

5 by all members of DTARC?

6 MR. RODRIGUEZ: Asked and answered. You can

7 answer.

8 THE WITNESS: Yeah. So the DTARC pulls

9 together the input from the committee. Different members,

10 different sources, as we have described. That information is

11 reviewed. If there is any questions, disagreement I think

12 might have been how you phrased it, there's discussion with the

13 DTARC. And so when the decision moves from the DTARC that is

14 the formal -- maybe we'll say formal recommendation, formal

15 determination from the DTARC.

16 BY MS. BROWN:

17 Q. And so how is the determination accomplished in the

18 sense of is it vote based?

19 A. The committee functions with discussion about it.

20 Each individual has an area that they're presenting. But no, I

21 wouldn't describe it necessarily as a vote.

22 Q. What does the director of programs discuss about

23 vaginoplasty when you're having this discussion to make a

24 decision?

25 A. The person when they're preparing their input for the

1 DTARC and it happens that individual has requested that
2 surgery, they would still prepare the information from the
3 program's perspective. They would share information about --
4 so inside the programs you have got the different things about
5 programs they're involved with, it might be jobs, education
6 programs would be sharing that information.
7 Q. Does DTARC have programatic reasons to deny
8 vaginoplasty?
9 MR. RODRIGUEZ: Objection, speculation, medical
10 opinion, legal opinion. You can answer.
11 THE WITNESS: I don't know if I can like
12 imagine necessarily input that -- like what you did in school,
13 that that in and of itself would really be anything that would
14 deny a surgery that you should have. It would be important
15 information, she's doing great in school, love it. She's doing
16 horrible in school. What's going on in school. But yeah, I'm
17 having a hard time giving you an example.
18 BY MS. BROWN:
19 Q. And in terms of again -- I'm going to start over. So
20 we're back at DTARC. There is a vaginoplasty being considered
21 for the treatment of gender dysphoria. A consultation to UNC
22 has been ordered. That consultation has occurred with the
23 surgeon at UNC and that surgeon provides their recommendation.
24 A. Okay.
25 Q. Who does that recommendation go to at DTARC?

1 A. So outside consults, medical records come into the
2 medical record. They're scanned in is generally how they would
3 come in. That information would be brought forward from
4 someone with the medical expertise. It likely in this case
5 would be Campbell. Could be nursing -- nursing might,
6 depending on who's bringing information in. But yeah, that
7 information would be brought into the DTARC review process by
8 that person.
9 Q. Okay. But it's available for everyone on DTARC to
10 review?
11 A. Yeah. Information that is put forward by each of
12 those individuals is shared. That's part of what makes up that
13 case summary. And so that information is available. And then
14 of course there's discussion.
15 Q. And does the discussion follow any kind of particular
16 format in this context for vaginoplasty?
17 A. The discussion might have different information for a
18 surgery. But no, there's not a prescribed format for -- no.
19 Q. Okay. So say that DTARC is considering a request for
20 vaginoplasty for the treatment of gender dysphoria. Does the
21 approval have to be unanimous?
22 A. There's not a requirement that there's a unanimous
23 vote that I support, I support, I support. If there is some
24 question then there would be discussion about that. And again,
25 that's all about kind of weighing all of that information.

1 Evaluating that -- the holistic perspective based off of
2 information that's being brought in by the different members.
3 Q. And if one member still says no after discussion?
4 MR. RODRIGUEZ: Objection, speculation. You
5 can answer.
6 THE WITNESS: There's the information that's
7 being brought in. So I'm really, again, kind of struggling
8 with imagining the scenario.
9 BY MS. BROWN:
10 Q. I'm not necessarily asking for a scenario. I guess
11 I'm asking --
12 A. So like you asked about the school -- well, I gave
13 school as an example of programs. Sorry. It would be
14 difficult to imagine a reason that the school was an issue for
15 that. So I would -- I'm struggling with maybe the concept of
16 the question.
17 Q. I'm just trying to understand how the determination is
18 reached if there is disagreement and discussion and discussion
19 has not resolved the disagreement.
20 MR. RODRIGUEZ: Objection, speculation. You
21 can answer.
22 THE WITNESS: The expectation is that within
23 the committee structure that the information is brought in.
24 Information is reviewed. That there's discussion about what's
25 being presented. Each individual is bringing their expertise

1 into the DTARC. From that there's expectation that from each
2 individual's kind of background, position, expertise that
3 they're contributing certain information into the DTARC
4 process.
5 BY MS. BROWN:
6 Q. Okay. And in that same context who decides if there's
7 disagreement?
8 MR. RODRIGUEZ: Objection, speculation. You
9 can answer.
10 THE WITNESS: Who decides --
11 MS. BROWN: Yes.
12 THE WITNESS: -- if there's disagreement? I
13 would imagine that that would present itself.
14 BY MS. BROWN:
15 Q. Well, taking it back a level, I guess. So DTARC is
16 considering, again vaginoplasty for the treatment of gender
17 dysphoria and a determination cannot be reached.
18 MR. RODRIGUEZ: Objection, speculation. You
19 can answer.
20 THE WITNESS: That might occur if there's
21 information that's missing, there's something that's still
22 pending. And that would -- we call that deferred.
23 BY MS. BROWN:
24 Q. What does a deferral mean?
25 A. There's information still pending.

1 Q. Outstanding. Okay. And so if there's disagreement --
2 back to -- this is the same question. If there's disagreement
3 who makes the final decision on approval or disapproval of
4 vaginoplasty for the treatment of gender dysphoria to be
5 considered by DTARC?
6 MR. RODRIGUEZ: Objection, speculation. You
7 can answer.
8 THE WITNESS: I'm trying to think if there's a
9 different way to answer it. I don't know if I have a different
10 way to answer it. I really don't know that I have a different
11 way to answer it.
12 BY MS. BROWN:
13 Q. If you all don't come to an agreement, who makes the
14 decision?
15 MR. RODRIGUEZ: Same objection. Speculation,
16 asked and answered. You can answer.
17 THE WITNESS: There's additional level review
18 that's built into this process. The committee process has the
19 expectation that we're coming in, bringing information from our
20 expertise, from our backgrounds. There is a discussion when
21 there's disagreement is the word that we're discussing. That
22 would be shared. There would be a review. That would be an
23 aspect of what's being reviewed. And then the outcome of the
24 DTARC review would be the opinion of the DTARC.
25 BY MS. BROWN:

1 Q. So let's reset just because I want to -- I appreciate
2 you being patient with me. Do you need a water break? I'm
3 going to take a water break just a second.
4 A. I used all mine up.
5 Q. Okay. Let's reset our universe. We're back in DTARC
6 and DTARC is considering a request for vaginoplasty for the
7 treatment of gender dysphoria. Does any one member of DTARC
8 have final say on whether vaginoplasty will be approved or not
9 approved?
10 A. No. No, there would not be -- it's not one person's
11 decision.
12 Q. And do all members of DTARC have to be present in
13 order to make a determination on whether or not vaginoplasty
14 for the treatment of gender dysphoria is going to be approved
15 or not approved?
16 A. We do expect that the areas that are being
17 contributed, the information that is being brought forward,
18 that that information is available and there is representation.
19 Q. And that's what you expect, but I'm asking -- I expect
20 a lot and I'm constantly let down. So that's not exact. So
21 that's not exactly what I'm asking. So I want to go back to
22 sort of the original question, which again is do all members of
23 DTARC have to be present in order for DTARC to approve or not
24 approve a request for vaginoplasty for the treatment of gender
25 dysphoria?

1 A. You had asked about the definition of DTARC and what
2 minimum means. Yes, that needs to be present for there to be a
3 DTARC review.
4 Q. Not just review, but an approval or a disapproval?
5 A. You can't approve or disapprove outside of the review.
6 You have got to have the DTARC in order to come up with the
7 DTARC's recommendation based off of their review.
8 Q. Okay. And say that the director of behavioral health
9 is being deposed during a DTARC meeting and they are
10 considering a request for a vaginoplasty --
11 A. We would not have a DTARC if the core members of the
12 DTARC could not be there. So there's not a DTARC today.
13 Q. Okay. And so outside of -- well, actually let me
14 check before I ask this. In general -- I mean, you may or may
15 not know this just given your position, but are you aware of
16 any other medical procedures that have to be approved by the
17 assistant commissioner or that have to be reviewed by the
18 assistant commissioner and the director of health & wellness?
19 A. I'm aware that there are other review processes for
20 medical procedures.
21 Q. Are you aware of --
22 A. But I'm not aware -- but I'm not aware of any that
23 have those two specific individuals as part of the review
24 process.
25 MR. RODRIGUEZ: Taylor, just to confirm, was

1 that question in his capacity as a designee or individual of
2 behavioral health?
3 MS. BROWN: As a designee.
4 MR. RODRIGUEZ: Okay.
5 BY MS. BROWN:
6 Q. And so --
7 A. I'm not aware of all medical procedures and how they
8 -- I know they have got reviews.
9 Q. Yeah. For sure.
10 A. And I know that there's a UR process. I'm not
11 intimately -- it's not in my personal professional wheelhouse.
12 So, sorry.
13 Q. Can you describe the UR process at all?
14 MR. RODRIGUEZ: Yeah, I think --
15 THE WITNESS: It's outside of what I'm doing on
16 the job. Sorry.
17 MS. BROWN: Yeah. No worries. Okay. Yeah.
18 So I think that's -- I'm sure you'll be happy to hear, that's
19 all I have on that for now. Well, maybe not. At least at this
20 point in time. So before we get into the next section -- can
21 we go off the record?
22 - - -
23 (Lunch break - 12:24 p.m. - 1:23 p.m.)
24 - - -
25 BY MS. BROWN:

1 Q. And again, I'll just reiterate that this is still the
2 30(b)(6) component of this. Dr. Peiper, Ms. Zayre-Brown has
3 been requesting gender-affirming surgery since at least 2019,
4 right?
5 A. You said 2019?
6 Q. Since 2019?
7 A. Yes. That's correct.
8 MR. RODRIGUEZ: Did you say '18 or '19?
9 MS. BROWN: '19.
10 BY MS. BROWN:
11 Q. How many requests are you aware of that she's made
12 since then? Or how many requests are you aware that she's made
13 to DTARC since then?
14 A. I don't have an exact number on that.
15 Q. Do you have an estimate?
16 A. Probably ballpark it. More than three. More than
17 five maybe. But again, I'm sorry, I don't have an exact count.
18 Q. DTARC through DPS has determined that gender-affirming
19 surgery is not medically necessary for her, correct?
20 A. Could you repeat that?
21 Q. Sorry. DTARC has determined -- since then, despite
22 those requests, DTARC has determined that gender-affirming
23 surgery is not medically necessary for her, correct?
24 MR. RODRIGUEZ: I'm going to object to the
25 form. You can answer.

1 THE WITNESS: That DTARC review did come up
2 with that determination. That was the -- I can't remember
3 exactly which DTARC date that was, but yes, that was
4 determined.
5 BY MS. BROWN:
6 Q. DTARC has determined that gender-affirming surgery for
7 Ms. Zayre-Brown was not medically necessary on more than one
8 occasion, right?
9 MR. RODRIGUEZ: Objection to form. You can
10 answer.
11 THE WITNESS: I wouldn't say that that's been
12 in more than one occasion. There were multiple requests.
13 There were some reviews. There were -- yeah, there were some
14 early decisions, yeah. Yeah.
15 BY MS. BROWN:
16 Q. Okay. And so when do you recall the first denial --
17 or when do you recall denial of gender-affirming surgery for
18 Ms. Zayre-Brown?
19 MR. RODRIGUEZ: I'm going to object to the
20 form. You can answer.
21 THE WITNESS: So me as an individual, I wasn't
22 there for it. So I'm trying to sort of scan my memories of the
23 documentation. If you have it, I can look and comment on it
24 but -- maybe it was -- maybe it was in '19. Some version of
25 that. I'm sorry, I can speak to a specific document, if you

1 have got one.
2 BY MS. BROWN:
3 Q. So can you walk us through the process of again how
4 that decision was made in terms of why gender-affirming general
5 surgery has not been medically necessary -- or why DTARC has
6 determined that gender-affirming general surgery has not been
7 necessary for Ms. Zayre-Brown?
8 MR. RODRIGUEZ: I'm going to object. Assuming
9 facts that the witness has not testified to for purposes of the
10 question.
11 BY MS. BROWN:
12 Q. You can still answer the question though.
13 A. Okay. You are asking me about the instance that I
14 couldn't quite recall exactly when it was?
15 Q. Yeah.
16 A. Y'all were discussing about there being the
17 possibility of that note being available to review, but it's
18 for later. So I'm -- right now I don't know all the details
19 about that to speak to it. But I'm sure if there is something
20 later that refreshes that topic for me I can maybe respond more
21 thoroughly.
22 Q. And so, let me ask you this. As a member of DTARC,
23 you're aware that Ms. Zayre-Brown has had prior
24 gender-affirming surgeries, correct?
25 A. Yes, she has had different surgeries prior to coming

1 into prison.
2 Q. What surgery?
3 MR. RODRIGUEZ: I just want to -- you prefaced
4 the question as a member of DTARC. I want to make sure that
5 we're -- he's a designee of the department. So he's speaking
6 as the department for all intents and purposes.
7 MS. BROWN: Okay. That's fine.
8 BY MS. BROWN:
9 Q. I'll repeat the question. So you're aware that -- DPS
10 is aware that Ms. Zayre-Brown had gender-affirming surgeries
11 prior to her incarceration?
12 A. Yes, there were other surgeries that she had. She had
13 orchiectomy, I believe; some level of breast augmentation,
14 implants. Not sure what the formal term is, but kind of like a
15 Brazilian lift, some shaping of the hips and posterior. I
16 believe I recall some facial work as well. But yes, there were
17 other surgeries and those were in the record.
18 Q. And how did DPS learn of those surgeries?
19 A. So some of it was communicated and records sought.
20 Some of it documentation. But yeah, generally her telling them
21 about it and seeking the records for it.
22 Q. Okay. Dr. Peiper, I'm going to show you -- or I'm
23 going to hand you what I'm marking plaintiff's Exhibit-5.
24 - - -
25 (Document marked as P-5 for identification.)

1 - - -
2 BY MS. BROWN:
3 Q. Do you recognize this document, Dr. Peiper?
4 A. Yes. This is one of the 411(d) forms from earlier on,
5 2019.
6 Q. It has August 21, 2019?
7 A. Yes.
8 Q. To be clear, under the offender name, that is our
9 client, correct?
10 A. That does not say Kanautica, you are correct.
11 Q. Were you on DTARC at this time?
12 A. No, I was not.
13 Q. And it says she's requesting vaginoplasty?
14 A. Correct.
15 Q. Let's go to DTARC's decision here. Under
16 accommodations not approved and rationale it says request for
17 vaginoplasty. Deferred as offender has successfully completed
18 gender reassignment surgically. Vaginoplasty is an elective
19 procedure which is not medically necessary for reassignment.
20 Current staffing and resources does not allow for the proper
21 postoperative care of this procedure.
22 Do you know who wrote this?
23 A. No, I don't know who actually typed that one.
24 Q. And so reading this rationale, what was DPS's basis
25 for again not considering it medically necessary for Ms.

1 Zayre-Brown at the time?
2 MR. RODRIGUEZ: I'm going to object --
3 MS. BROWN: Sorry. I'll rephrase.
4 BY MS. BROWN:
5 Q. Reading the rationale, what was -- or yeah. Yeah.
6 Why was it not medically necessary for her at this time
7 according to DPS?
8 A. Reading this rationale, it would have been they were
9 determining there was not a medical necessity at that time.
10 There was some indication about review of staffing and
11 resources that would be required for the postoperative care of
12 that procedure. And there's the reference in there about
13 having a prior surgery.
14 Q. Okay. So it says accommodations not approved. That
15 doesn't mean denied in this context?
16 A. Oh, the word deferred.
17 Q. Deferred. Okay. So earlier you testified that
18 deferred meant that there was outstanding information that may
19 be required for DTARC to make a decision?
20 A. I was not aware I was defining the term deferred in
21 all cases, but at that point I was trying to give a different
22 word to help it be more understood what I was saying. It felt
23 like there were more questions coming so I tried to change what
24 I was saying so I could answer the question.
25 Q. Again, what was the basis for not determining medical

1 necessity at this time?
2 MR. RODRIGUEZ: Object as speculation. Medical
3 opinion, legal opinion.
4 BY MS. BROWN:
5 Q. What was DPS's?
6 MR. RODRIGUEZ: Same objection because that
7 wasn't the basis of the objection. Speculation, legal opinion,
8 medical conclusion.
9 BY MS. BROWN:
10 Q. What was the basis for determining that the surgery
11 was not medically necessary for Ms. Zayre-Brown?
12 MR. RODRIGUEZ: Same objection. Speculation,
13 medical opinion, legal conclusion. And it's not exactly
14 characterized that way in the document. You can answer though
15 to the extent you --
16 THE WITNESS: I was seeing if there was --
17 BY MS. BROWN:
18 Q. Let me ask you this. Again, so you're testifying on
19 behalf of DPS and part of that is, you know, under the topics
20 again it is going to be not just at the time that you were on
21 in, but, you know, understanding how DTARC applied its
22 protocols at other stages of time too.
23 A. Is there an aspect of the notes that go with this that
24 might help the questioning?
25 Q. I guess what I'm trying to get at is that I still

1 don't understand from this right here what was the basis for
2 not -- what was the basis for determining that this was not
3 medically necessary?
4 MR. RODRIGUEZ: Mischaracterization of what the
5 document says and speculation. You can answer.
6 THE WITNESS: There are always additional notes
7 that go along with the 411(d) and the form in and of itself may
8 not give all the information. If there's additional notes that
9 you have that relate to it, it might help.
10 BY MS. BROWN:
11 Q. Well, under DPS protocol -- let's start here. So
12 you're a DPS 30(b)(6) witness. And so again, under this
13 action, what you're reading here, what was the basis of the
14 denial here for vaginoplasty for Ms. Zayre-Brown?
15 MR. RODRIGUEZ: Objection. Mischaracterization
16 of what the document says. You can answer.
17 THE WITNESS: If there is additional
18 information, I could certainly use that in answering. This one
19 here talks about the rationale and the deferral. It does talk
20 about prior surgeries or surgery, if you will. Talks about
21 that there is, you know, the procedure, vaginoplasty that was
22 requested. It was not necessary. It does also talk about
23 staffing and the resources that would be needed for that
24 postoperative care for that specific one that's being requested
25 the vaginoplasty.

1 BY MS. BROWN:
2 Q. According to DPS -- well, first I guess let's make
3 sure that we're starting with the same terminology. So Ms.
4 Zayre-Brown is a trans woman, correct?
5 A. I do believe that's how she identifies, yes.
6 Q. What does DPS understand a trans woman to mean, to be?
7 A. So individuals identifying to their gender identity.
8 Q. As opposed to...
9 A. So the trans identity would be related to their gender
10 identity.
11 Q. So from DPS's perspective, what is a complete gender
12 reassignment surgery for a transgender woman like Ms.
13 Zayre-Brown?
14 A. I would say that it would be a surgery that was
15 completed. Seems here that they were referencing a surgery or
16 some surgeries that had been completed. And this rationale,
17 again, if there is something additional from notes that go
18 along with this form, I can review those.
19 Q. Are you saying you're not prepared to answer the
20 question of what DPS's position is about why vaginoplasty was
21 not medically necessary for her?
22 MR. RODRIGUEZ: I'm going to object to the form
23 of the question. The witness is here prepared to discuss the
24 documents that relate to the topics that are referenced.
25 You're asking him to divine intentions of somebody who he's

1 - - -
2 (A break was taken, 1:44 p.m. - 1:52 p.m.)
3 - - -
4 MS. BROWN: I'm going to hand you what I'm
5 marking as Exhibit-6.
6 - - -
7 (Document marked as P-6 for identification.)
8 - - -
9 BY MS. BROWN:
10 Q. Dr. Peiper, do you recognize this document?
11 A. Yes. This is one of the medical notes, clinical
12 encounter note Dr. Umesi wrote.
13 Q. And Dr. Umesi is a medical doctor, correct?
14 A. Yes, M.D.
15 Q. What does Dr. Umesi say according to this document
16 that Ms. Zayre-brown is here for?
17 MR. RODRIGUEZ: I'm going to object to vague.
18 BY MS. BROWN:
19 Q. Well, under chief complaint.
20 A. It looks like chief complaint: Other problem.
21 Q. And so I'm going to read this to you. Okay. And the
22 date on this is January 7, 2019. Patient is a 37-year
23 transgender female who started gender reassignment surgery
24 prior to incarceration. Prior surgeries include bilateral
25 orchiectomy, breast augmentation, facial feminization,

1 Brazilian butt lift, forehead and chin fillers. Per Dr. Hope
2 Sherrie, cosmetic concierge, the reassignment surgery was
3 performed according to the guidelines of World Professional
4 Association for transgender health standards of care. The next
5 stage for patient prior to incarceration was full genital
6 gender-affirming surgery. Patient is therefore requesting this
7 surgery. Patient is also working -- so we can stop there.
8 MR. RODRIGUEZ: Is there a question?
9 MS. BROWN: Oh, no, sorry. If you'll just give
10 me one moment.
11 BY MS. BROWN:
12 Q. Okay. If you can turn to page four.
13 A. (Witness complies.)
14 Q. You see on the top here where it says UR request?
15 A. Yes.
16 Q. And so under DPS policy, what is a UR request?
17 A. What is a UR request?
18 Q. Yeah.
19 A. A UR request is the request that goes into the UR
20 review process.
21 Q. Okay. What does UR stand for?
22 A. Utilization review.
23 Q. Okay. And what kind of analysis is that?
24 MR. RODRIGUEZ: I'm going to object to the
25 scope of the topic. There's a specific 30(b)(6) topic about



Case 3:22-cv-00191-MOC-DCK Document 61-9 Filed 10/05/23 Page 70 of 153

1 URs. Dr. Peiper's does not include that.
2 MS. BROWN: But this is about a
3 gender-affirming procedure that ended up with DTARC, which he
4 is able to talk about?
5 MR. RODRIGUEZ: Right. But you're asking him
6 about the UR process.
7 MS. BROWN: Okay.
8 MR. RODRIGUEZ: She's asking the question of
9 the witness, and so I, for the clarity of the record, would
10 like for discussions specifically about the UR process and
11 policies to be dedicated to that designee. But you certainly
12 can examine him about the contents of this document as it
13 relates to particularly topic 12, which I assume we're getting
14 at, which is the request for Kanautica for all requests to the
15 DTARC.
16 BY MS. BROWN:
17 Q. And so I'll ask one last question about this. It says
18 patient has TARC hearing 1/11/2019 and patient's endocrinology
19 appointment has been scheduled.
20 Do you know if at that TARC hearing DPS considered Ms.
21 Zayre-Brown's request for full genital gender-affirming
22 surgery?
23 A. Is this the one that you gave me a moment ago? No,
24 you gave me the August one. Do you have one for --
25 Q. No. I'm just asking if you know or not.

1 A. I don't have that information.
2 Q. Okay.
3 A. Sorry. And --
4 Q. Sorry. Were you going to say something?
5 A. No.
6 Q. I think earlier you testified that incarcerated
7 people, in part of making it known they can go to medical
8 staff. According to this document was Dr. Umesi requesting
9 gender-affirming surgery for Ms. Zayre-Brown?
10 MR. RODRIGUEZ: Object to speculation. But you
11 can answer to the extent you're able.
12 THE WITNESS: You're asking if Dr. Umesi made a
13 request to the TARC?
14 BY MS. BROWN:
15 Q. No. Just in general. As a provider was he requesting
16 full gender -- or as he phrased it, full genital
17 gender-affirming surgery for Ms. Zayre-Brown?
18 MR. RODRIGUEZ: Can you direct the witness to
19 which page you're --
20 BY MS. BROWN:
21 Q. Sorry. We're on page four.
22 A. Right here where it talks about the reason for the
23 request?
24 Q. Yeah.
25 A. That request relates to the heading above it. See how

1 it's indent had below.
2 Q. The UR request?
3 A. Yeah.
4 Q. Yeah. Dr. Zayre-Brown submit a UR request?
5 A. The UR request -- and again, I'm not necessarily
6 prepared to explain the UR process. But the UR request is what
7 you call it when you submit something through the utilization
8 review system. And so you have UR request here and then
9 beneath it that's what's going along with this. And then you
10 have over here, this is what's going along with that one here.
11 This is -- and similarly down here with disposition, which was
12 follow-up at as needed.
13 Q. Do you know if this UR request ever reached DTARC?
14 MR. RODRIGUEZ: Objection to form. You can
15 answer.
16 THE WITNESS: The UR request I'm not
17 necessarily aware of what happened in the UR process.
18 MS. BROWN: Okay. And I'm going to hand you
19 what I'm going to mark as plaintiff's Exhibit-7.
20 - - -
21 (Document marked as P-7 for identification.)
22 - - -
23 BY MS. BROWN:
24 Q. Do you recognize this document, Dr. Peiper?
25 A. Yes.

1 Q. What is this document?
2 A. This is from the TARC meeting itself. The date here
3 is 5/21/2020.
4 Q. And you were not on the DTARC at this time, correct?
5 A. I was. I was thinking this is probably my first one
6 because that was right around...
7 Q. Okay. And so if you -- let's see here. If you go to
8 page -- one of the last ones here. Yes. Okay. So page 11.
9 A. Oh, they have got numbers. That's easy. I did not
10 realize that. All right.
11 MR. RODRIGUEZ: Page 12 actually.
12 MS. BROWN: Yeah. Sorry.
13 MR. RODRIGUEZ: I was telling Peiper because
14 he's on the -- flip the next page.
15 THE WITNESS: All right.
16 BY MS. BROWN:
17 Q. So I want to read a couple passages from this, from
18 the section in the medical/mental health overview, or MH which
19 stands for mental health overview.
20 A. Yes.
21 Q. It says this is a follow-up case. This case was
22 reviewed in February 2020 and DTARC recommended a referral to
23 UNC for a consultation requesting in writing what this type of
24 surgery would entail. DTARC also wanted to know if the
25 offender is a good candidate, the number of required

1 appointments, the number of required procedures and cost.
2 And so, do you recall getting that information?
3 A. Are you asking?
4 Q. Or did DTARC get that information?
5 A. Yes. There was information that was -- that came back
6 through the medical chain to the DTARC.
7 Q. It says the information states the cost would be 20 to
8 $40,000.
9 A. Yes, that is how it's written.
10 Q. That 20 to $40,000 that was reported back to DTARC,
11 what was that for?
12 MR. RODRIGUEZ: Objection to the form. It says
13 it right here.
14 BY MS. BROWN:
15 Q. Vaginoplasty?
16 A. Yes. It sounded like you were stating what it said.
17 I'm sorry.
18 Q. Yeah.
19 A. Sorry about that.
20 Q. Further down it says it could be argued that this
21 surgery could be considered medically necessary if there has
22 been documented history that without this type of surgery,
23 there would be severe psychiatric or psychological injuries to
24 the person, for not being able to totally live the life they
25 gender identified with. Psychologically, if a person is in the

1 midst of transitioning, this would be considered the final
2 stage of this process to complete the transition to female. In
3 the community setting, oftentimes this surgery is considered
4 cosmetic and is not covered by insurance. We do not have the
5 authority at this time to approve the surgery. We can
6 recommend follow-up appointments with UNC so surgery can
7 possible be recommended and then send the case to a higher
8 level to make the final decision. The committee will research
9 if UNC has a GYN surgical specialist in network that can
10 perform this type of surgery. At the end it says DTARC
11 recommends an in-person consultation with an ob-gyn surgical
12 specialist with experience in gender affirmation surgery.
13 DTARC is referring this case to the director of health and
14 wellness and the assistant commissioner for final
15 determination.
16 So I guess who did DPS contact to get this 20,000 to
17 $40,000 estimate?
18 MR. RODRIGUEZ: Objection, speculation. You
19 can answer, if you know.
20 THE WITNESS: I'm not sure of the exact
21 individual that was contacted. I am aware that it was through
22 the medical chain.
23 MS. BROWN: I'm sorry, if you could just give
24 us -- actually, let's do -- 15 minutes okay? Or 10 minutes.
25 - - -

1 (A break was taken, 2:07 p.m. - 2:34 p.m.)

2 - - -

3 MS. BROWN: I am going to hand you what I'm

4 marking as plaintiff's Exhibit-8. I'm also going to hand you

5 what I'm marking plaintiff's Exhibit-9.

6 - - -

7 (Documents marked as P-8 and P-9 for

8 identification.)

9 - - -

10 BY MS. BROWN:

11 Q. So we are looking at what's bates stamped DAC00453.

12 MR. RODRIGUEZ: 4523?

13 MS. BROWN: Yeah, 4523. Sorry.

14 BY MS. BROWN:

15 Q. Okay. Dr. Peiper, do you recognize this document?

16 A. Yeah, it looks like an email between me and Dula, me

17 and Jennifer Dula.

18 Q. Who is Jennifer Dula?

19 A. She was a clinician, behavioral health clinician.

20 Q. You said was, so she has left?

21 A. Correct. She was on contract.

22 Q. What's the date of this email?

23 A. This shows 10/5/2021.

24 Q. What does it say on attachments?

25 A. K_Brown_rough_draft_10.5.21 docx.

1 Q. Jennifer Dula says Dr. Peiper, here is what I came up
2 with for the letter. Let me know what you think. Thanks again
3 for the opportunity to help. And so Dr. Peiper, what was this
4 letter for?
5 A. This was for UNC ultimately.
6 Q. Okay.
7 A. Sorry, UNC Trans Health Program.
8 Q. Why did you UNC Trans Health Program need a letter
9 from Jennifer Dula?
10 A. This is one of their required pieces, letters,
11 different letters, first letter, second letter they needed at
12 different times. This was to satisfy one of those letters that
13 they needed.
14 Q. What were you trying to satisfy or what was the letter
15 supposed to be satisfying?
16 MR. RODRIGUEZ: I'm going to object as to
17 speculation. You can answer.
18 BY MS. BROWN:
19 Q. You didn't answer.
20 A. Sorry about that.
21 Q. And so again, what was the letter in support of that
22 UNC was requesting?
23 MR. RODRIGUEZ: Object to the form of the
24 question. You can answer.
25 THE WITNESS: It wouldn't say it was a letter

1 in support of, but this was the letter -- I believe it was
2 their second letter that they wanted.
3 BY MS. BROWN:
4 Q. Again, you can turn the page. Did you read this
5 letter?
6 A. Yes.
7 Q. Okay. And now, looking at the other exhibit that I
8 marked as plaintiff Exhibit-8. Do you recognize this document?
9 A. I'm sorry, did you say this other one?
10 Q. Yes, this first one that I handed you.
11 A. Looks like an email between me and -- is that Marvella
12 -- me and -- no, Jennifer Dula. Okay. Marvella is on there,
13 but yes, Jennifer Dula.
14 Q. And who is Marvella Bowman?
15 A. Supervisor.
16 Q. Supervisor for who?
17 A. Anson Correctional.
18 Q. Supervisor in terms of what? What field?
19 A. She's a psychologist.
20 Q. A psychologist. Okay. And was she Ms. Zayre-Brown's
21 treating psychologist?
22 A. Dr. Bowman?
23 Q. Yes.
24 A. Yes, she has been.
25 Q. What's the date on this letter?

1 A. This email is dated Thursday, September 9, 2021. And
2 the letter -- these other pages here seem to have that same
3 date.
4 Q. And the letter is the next. And have you read this
5 letter before? Have you seen this letter before?
6 A. Yes. Yes, I have.
7 Q. Why are there two versions of this letter?
8 MR. RODRIGUEZ: I'm going to object as
9 speculation. You can answer.
10 THE WITNESS: This was Jennifer Dula's effort
11 in crafting information that would meet -- remember earlier we
12 were talking about the two bureaucracies, how we do things and
13 how they do things? That would allow that second letter.
14 There were certain expectations for what that second letter
15 included.
16 BY MS. BROWN:
17 Q. When you say bureaucracy, I guess I'm still confused
18 by that word. Can you explain that?
19 A. Ways that two systems work.
20 Q. Okay. And so you're saying that DPS's bureaucracy was
21 different from UNC bureaucracy? That's what you testified to
22 earlier?
23 A. I guess I would say that we're two different systems,
24 yeah.
25 Q. Why was DPS using UNC's bureaucracy, I guess, if

1 that's how you want to term it?

2 MR. RODRIGUEZ: Object to the form. You can

3 answer the question.

4 THE WITNESS: Okay. Sorry, mouth is getting

5 dry. Was there a new question?

6 MS. BROWN: No. No. I thought you were

7 drinking. Sorry.

8 THE WITNESS: I was. Why were we trying to get

9 a second letter to UNC based off of what they were asking us?

10 BY MS. BROWN:

11 Q. Well, no. I'm asking why did Dula write two different

12 letters.

13 A. Oh, this is her drafting.

14 Q. And did she draft this all by herself?

15 MR. RODRIGUEZ: Objection, speculation. You

16 can answer, if you know.

17 THE WITNESS: I believe she did. It was hers.

18 She was the treating clinician and it was hers that she was

19 writing.

20 BY MS. BROWN:

21 Q. Okay. Why did she send this letter to you?

22 A. I was the one communicated with Katherine Croft and

23 based off of that input was asking someone that was involved

24 with her to be able to provide that information.

25 Q. What did Katherine Croft tell you?

1 A. What they need in their second letter.
2 Q. And what did they need?
3 A. I don't have that memorized. She had several things
4 that she listed. It would seem that what Dula created touches
5 on the areas that were needed.
6 Q. Okay.
7 A. And it looks likes she -- in this one you'll see she
8 kind of left room. So she was creating her structure and then
9 was ensuring that she was able to build from that structure.
10 Basically for the structure to already exist --
11 Q. Okay.
12 A. -- so that it would meet that expectation.
13 Q. And did you ever provide feedback to either of these
14 letters?
15 A. Yeah, of course.
16 Q. What kind of feedback did you provide?
17 MR. RODRIGUEZ: I'm going to object to the --
18 I'm not sure which topic we're on on the 30(b)(6). Are we
19 talking about the DTARC's determination?
20 MS. BROWN: Yes.
21 MR. RODRIGUEZ: Okay. So if we could tighten
22 the question to say what the designee is here to testify about
23 topic 12 rather than --
24 MS. BROWN: Okay.
25 THE WITNESS: I'm sorry, I was answering as

1 Jon. I'm so sorry.
2 MS. BROWN: Okay.
3 THE WITNESS: I did not follow --
4 BY MS. BROWN:
5 Q. So DPS sent Kanautica to UNC Trans Health Program for
6 a consultation for gender-affirming surgery, correct?
7 A. Yes.
8 Q. Okay.
9 A. Yes, we sent her there for the consultation. We got
10 -- there were other consultations with them that were for her,
11 but that she was not directly there for as you saw in some of
12 the earlier notes that you put to me.
13 Q. And so how did UNC let DPS know that they needed these
14 letters?
15 A. So UNC has their expectations for what happens and
16 when it happens, letter one, letter two, et cetera. This, as I
17 described, was shared in communication with Katherine Croft.
18 Q. Okay. And so aside from two letters, what other
19 expectations did UNC Trans Health communicate to DPS in terms
20 of this consulting for this surgery?
21 A. There was some stuff about weight. They had a weight
22 goal for Kanautica. They communicated that weight goal to her
23 directly and to us as well. And then we tried to work with her
24 on that weight goal.
25 Q. What else did UNC Trans Health Program -- what was the

1 result of the consultation with UNC Trans Health Program?
2 A. Which one of them were you talking about?
3 Q. This was the consultation that DPS arranged with Dr.
4 Figler at UNC Trans Health.
5 A. So you're talking about the in person evaluation,
6 consultation that occurred?
7 Q. Yes.
8 A. I don't know that I can quote Dr. Figler's
9 documentation completely.
10 Q. That's not really what I'm asking. So you sent over
11 Kanautica to be -- to consult with Dr. Figler about
12 gender-affirming surgery, correct?
13 A. She had an in-person consultation with Dr. Figler.
14 And there were other ones that occurred that were not in
15 person, and some that occurred that were just in a general kind
16 of consultation where it was not -- the patient was not
17 involved.
18 Q. It's my understanding that DPS arranged for a
19 telehealth call with Katherine Croft and Ms. Zayre-Brown at
20 least twice, correct?
21 A. There have been multiple scheduled contacts with
22 Katherine Croft and some Kanautica was there for, and others
23 were Katherine Croft in more kind of a liaison role, if you
24 will.
25 Q. But here we're talking about specifically the

1 recommendation that DPS made to send Kanautica Zayre-Brown to
2 Dr. Figler to consult for gender-affirming surgery. You do
3 recall that?
4 A. Talking about this one that she had -- the May 2020
5 one?
6 Q. I'm talking about the in-person consultation, not the
7 telephone call. Not the telephone call.
8 A. Yeah, the DTARC from May 2020?
9 Q. Yes.
10 A. DTARC recommends an in-person consultation with an
11 ob-gyn surgical specialist with experience in gender
12 affirmation surgery. DTARC is referring this case to director
13 of health and wellness commissioner. Yeah, so the DTARC
14 recommended an in-person consultation with a surgical
15 specialist.
16 Q. And did that take place?
17 A. Yes. Yeah. The in-person consult did happen. Yes.
18 Q. Who was that with?
19 A. Yes, Dr. Figler.
20 Q. And so what was the result of that consultation with
21 Dr. Figler?
22 A. I'm not sure the specific thing you're asking about,
23 what was the result. There's a report that's written. It's in
24 the record. If there's a certain thing in there you want me to
25 speak to, I can. But I know that information is communicated

1 back. There was some information about the weight piece that
2 we did work directly with Kanautica on. So some of that was
3 also -- there was some requests about some additional labs or
4 something like that maybe. I don't know if there's a specific
5 piece that you're questioning about.
6 Q. No. I'm just asking you generally. And again, you
7 did -- earlier you testified again that you prepared for this,
8 right?
9 MR. RODRIGUEZ: I'm going to object to the
10 form. You're asking a vague question that he's already said
11 that he's not sure what you're getting at when you said the
12 results. He indicated that there's a report that Dr. Figler
13 already completed that he does not remember the contents
14 offhand.
15 MS. BROWN: Okay.
16 BY MS. BROWN:
17 Q. You did just testify that you recalled a weight
18 component from Dr. Figler, the results of Dr. Figler's
19 consultation. What was that about?
20 A. I don't recall the exact weight, but there was an
21 ideal weight and then there was another weight goal. I don't
22 know what the term was. But basically that was in order to be
23 a candidate.
24 Q. In order to --
25 A. Sorry, to be a candidate for surgery. They had a

1 weight goal based off of her and their evaluation of her. They
2 had a weight goal for her that if she were to be a candidate
3 there was this weight goal. Basically she had to lose weight.
4 Q. Okay. Did she lose that weight?
5 A. Yes.
6 Q. And so you recall the weight component and you recall
7 Dr. Figler's office, the UNC Trans Health Program requesting
8 DPS provide two letter?
9 A. Recall through communication with Katherine Croft
10 about the letter. I believe it was formally satisfying the
11 second letter requirement they have.
12 Q. Okay. And so looking at this letter it says --
13 A. Talking about the draft from September or the draft
14 from October?
15 Q. I'm looking at September 9, 2021.
16 A. The older draft?
17 Q. Yes.
18 A. Okay.
19 Q. So this is on DPS letterhead, correct?
20 A. It looks like it. Looks like prior, but yes.
21 Q. And do you see where it says Ms. Brown has more than
22 met the WPATH criteria for surgery?
23 A. Sorry, I wasn't looking.
24 Q. We're still talking about the earlier draft,
25 September.

1 A. Which spot?
2 Q. So this is the third paragraph.
3 A. Yeah, Ms. Zayre-Brown has more than met the WPATH
4 criteria for surgery -- it says at the end of the third
5 paragraph Ms. Brown has more than met the WPATH criteria for
6 surgery.
7 Q. And then can you read the three sentences of the last
8 paragraph as well?
9 A. The three sentences that are at the end?
10 Q. Last paragraph, first three sentences.
11 A. First three sentences. Based on the review of her
12 records and my own assessment, I believe the next appropriate
13 step for Ms. Brown is to undergo vulvoplasty. It is my
14 clinical opinion this will help her make significant progress
15 in further treatment of her gender dysphoria. Is that three?
16 Q. Yeah, that's fine.
17 MR. RODRIGUEZ: Is there a question?
18 MS. BROWN: No. He just finished reading it
19 and was just about to ask him a question, if you can give me a
20 moment. Thanks.
21 BY MS. BROWN:
22 Q. Did you ever send this letter to the rest of the
23 members of DTARC?
24 A. Talking about the unfinished draft? No.
25 Q. I mean this letter.

1 A. This unfinished draft letter? No, I did not -- this
2 was not -- no.
3 Q. Did you ever send any version of this letter to any
4 other of the members of DTARC?
5 A. Yes. This should also be in the Hero, in the medical
6 records. And it should be summarized in the case summary that
7 goes along with it. That was the expectation of the UNC Trans
8 Health letter, was to speak to those specific WPATH criteria
9 that were the standard seven criteria.
10 Q. Okay. You can set these to the side. And I'm going
11 to now hand you what I am going to mark as plaintiff's
12 Exhibit-10.
13 - - -
14 (Document marked as P-10 for identification.)
15 - - -
16 BY MS. BROWN:
17 Q. Dr. Peiper, do you recognize this document?
18 A. Yes.
19 Q. And what is it?
20 A. It's a DC-411(d) from the February 2022 DTARC for
21 Kanautica.
22 MR. RODRIGUEZ: So are we talking about both
23 pages? I have two pages.
24 MS. BROWN: Yeah. You only have one?
25 MR. RODRIGUEZ: Oh, no. So this is part of the

1 same record?
2 MS. BROWN: Yes. I mean, that's how it came to
3 us and how you produced it in discovery.
4 MR. RODRIGUEZ: That doesn't mean that that's
5 how it's kept in a medical record context. But anyway, go
6 ahead. Make sure you look at both pages is what I'm saying.
7 BY MS. BROWN:
8 Q. Are these part of the same record, Dr. Peiper?
9 A. This is -- when you type something up in Hero, notes
10 in Hero can be sent to an individual as a notification process.
11 So the second page shows the notification to Ms. Dula. So
12 she's the clinician. She was Kanautica's therapist. So that
13 she would have that information to be able to -- notification
14 to share back with Kanautica.
15 Q. Okay. And it says DTARC does not recommend
16 gender-affirmation surgery. This surgery is not medically
17 necessary.
18 Dr. Peiper, why was the surgery not medically
19 necessary according to DTARC? Or why according to DPS was the
20 surgery not medically necessary?
21 MR. RODRIGUEZ: But I'm also going to -- are we
22 topically on 12? Is this a disposition question of DTARC?
23 MS. BROWN: Yes.
24 MR. RODRIGUEZ: The reason why I'm asking is
25 there's a specific topic about this particular document. So I

1 just want to make sure that we're not crossing purposes.
2 There's another topic that's specifically on this document.
3 MS. BROWN: That's fine. I'm asking about this
4 one. Okay.
5 BY MS. BROWN:
6 Q. Did you hear my question?
7 A. I did, but then I forgot what you asked.
8 Q. So I'll reask it.
9 MS. BROWN: I'm going to ask that you keep the
10 objections limited in terms of speaking objections in this or
11 what have you. Okay?
12 MR. RODRIGUEZ: Okay.
13 BY MS. BROWN:
14 Q. Okay. Again, so I'm going to ask. It says DTARC does
15 not recommend gender-affirmation surgery. This surgery is not
16 medically necessary.
17 Dr. Peiper, why did DPS determine that
18 gender-affirmation surgery or a vulvoplasty was not medically
19 necessary for Ms. Zayre-Brown?
20 MR. RODRIGUEZ: I'm going to object to legal
21 opinion, medical conclusion. You can answer.
22 THE WITNESS: This was the DTARC review
23 process. You saw a lot of those DTARCs where information was
24 being forwarded. Additionally, reviewed information that was
25 being moved forward. At the completion of this there was a

1 medical analysis, that kind of review of the medical necessity.
2 So for this individual who had been identified as a candidate,
3 surgery, there was the medical review, there was a risk, need
4 sort of assessment of it. Through that the ultimate decision
5 was made that it was not medically necessary for this person at
6 this time.
7 BY MS. BROWN:
8 Q. Who made the ultimate decision that you're referring
9 to?
10 A. DTARC.
11 Q. But that wasn't the final decision, right?
12 A. So that was the decision you're asking me about and
13 yes, that was the decision that they made.
14 Q. Okay. But again, you didn't answer the question. But
15 why specifically was it not medically necessary?
16 A. The individual case review, they looked at the aspects
17 of the medical analysis, of the surgery, the requested piece,
18 her as an individual, severity of presentation. All of those
19 aspects were reviewed in making this medical necessity
20 determination.
21 Q. And what part of the medical analysis determined that
22 it was not medically necessary for her?
23 A. Complete analysis.
24 Q. Okay. And what did that analysis --
25 MR. RODRIGUEZ: I'm going to object to the

1 topics. If you would like for me to expand, I'm happy to. And
2 this one I need to expand because the witness is not prepared
3 to talk about medical necessity because that is a specific
4 topic. Again, it's not this witness's. His topic is the DTARC
5 and the disposition of that. He's already testified as to how
6 they reached that decision. And so continuing to ask him about
7 medical necessity determinations is beyond the scope of the
8 designee's topics.
9 MS. BROWN: You still need to answer.
10 THE WITNESS: I'm sorry, I felt that I had.
11 BY MS. BROWN:
12 Q. No. You are listed on here, Dr. Lewis Peiper as a
13 member of DTARC. You have previously testified that DTARC
14 reaches its decisions together about --
15 A. Correct.
16 Q. -- recommendations?
17 A. Yes.
18 Q. Here the recommendation was DTARC does not recommend
19 gender-affirming surgery. This surgery is not medically
20 necessary.
21 A. Right.
22 Q. I'm asking you to explain to me why exactly it was not
23 medically necessary.
24 MR. RODRIGUEZ: I'm going to repeat my
25 objection as to beyond the scope of this designee's topics and

1 asked and answered.
2 MS. BROWN: You still need to answer. I said
3 that in the beginning in the instructions. He can object but
4 unless he instructs you not to answer you still need to answer.
5 THE WITNESS: No, there was conversation and so
6 I was waiting to see --
7 BY MS. BROWN:
8 Q. You can ignore that.
9 A. It's hard to.
10 Q. Just focus on me.
11 A. It's right in front of me. Yes. So the DTARC process
12 involved pulling together the information, information comes
13 from the different sources of the committee. Each individual
14 has their own kind of expertise, role, information they bring.
15 It's prepared, shared. During the DTARC there's a review, have
16 a discussion of information being shared. And this was the
17 determination of the DTARC, the decision that it was not
18 medically necessary.
19 Q. And so what was your part in that consideration, that
20 it was not medically necessary?
21 MR. RODRIGUEZ: Object to beyond the scope of
22 the designee. Asking for his individual part in that
23 determination of medical necessity, which is also outside the
24 scope of the topics. You can answer to the extent you're able.
25 THE WITNESS: So the Department has a chair for

1 the DTARC and with that kind of the chair is expected to
2 facilitate the process.
3 BY MS. BROWN:
4 Q. Okay. So he facilitated the process and you have
5 testified that again, everyone has input. So I'm asking what
6 input did you bring into this DPS determination that this was
7 not medically necessary as the director of behavioral health
8 and a memory of the DTARC?
9 MR. RODRIGUEZ: Same objection. Asked and
10 answered. Beyond the scope of the topics of this designee.
11 Medical, legal opinion and individual questions as to his
12 individual role as a member of the DTARC, which is beyond the
13 scope of the 30(b)(6). You can answer to the extent you're
14 able.
15 THE WITNESS: Okay. So on behalf of the
16 department the director of behavioral health brings forward
17 information that are within the scope of the behavioral health
18 services.
19 BY MS. BROWN:
20 Q. Sorry. Can you speak up? I didn't hear that last
21 part.
22 A. Behavioral health services.
23 Q. And so what happened after DPS reached this
24 determination?
25 A. After the determination this information was entered

1 into Hero, was shared with the therapist, Ms. Dula.
2 Q. And so tell me -- again, tell me about the DTARC
3 meeting around this decision making --
4 A. This --
5 Q. -- 2/17/2022.
6 A. -- DTARC meeting? Multiple DTARC meetings had lead up
7 to this. As you can see there's some -- for instance, the one
8 you showed earlier, there's reference to a follow-up. That's
9 kind of the continuation piece of ensuring that the review is
10 happening, information. So it's kind of a multiple-step piece
11 where ensuring all of the information is brought forward to the
12 DTARC. In this one there was discussion about that, the
13 completion of all that information and the review. And then
14 the -- kind of the discussion about the determination from the
15 DTARC and the not being medically necessary.
16 Q. And what was DPS's reaction to Dr. Figler's report?
17 Was that part of the information brought to this 2/17/22
18 discussion?
19 MR. RODRIGUEZ: I'm going to object to vague.
20 You can answer.
21 THE WITNESS: I'm not sure about the reaction.
22 But you asked about was information included? Yes, information
23 was included.
24 BY MS. BROWN:
25 Q. Did DPS agree with Dr. Figler's conclusion?

1 A. Dr. Figler shared information. That information was
2 used in the determination of medical necessity.
3 Q. He shared it. I'm saying did DPS agree with Dr.
4 Figler's conclusion?
5 MR. RODRIGUEZ: I'm going to object to the form
6 and the vagueness of the question. I'm not sure which
7 conclusion you're talking about. It's assuming certain
8 information that's not before the deponent.
9 THE WITNESS: Dr. Figler's information was
10 included in the DTARC review.
11 BY MS. BROWN:
12 Q. Yes. And I'm saying did DPS agree with Dr. Figler's
13 conclusion that was included in the information?
14 MR. RODRIGUEZ: Same objection. Vague as to
15 what conclusion we're talking about.
16 MS. BROWN: Okay.
17 THE WITNESS: I can't see the question.
18 MS. BROWN: No, I'm saying go ahead. The
19 question I asked you.
20 BY MS. BROWN:
21 Q. Did DPS agree with the conclusion?
22 MR. RODRIGUEZ: Same objection. It's vague as
23 to what you're talking about when you say conclusion.
24 BY MS. BROWN:
25 Q. Did Dr. Figler conclude that gender-affirming

1 surgery/vulvoplasty was medically necessary for Ms.
2 Zayre-Brown?
3 A. I don't know if Dr. Figler took that on in his report.
4 Q. What was the consult for then with Dr. Figler?
5 A. About the surgery.
6 Q. What about the surgery?
7 A. Dr. Figler being someone who performs these surgeries
8 shared information about what the surgery involves, was there
9 also to do the kind of in-person consultation, physically
10 present. That information was shared. There is of course the
11 piece about what it would require to be a medical candidate, to
12 be a candidate for the surgery. Those specs were communicated
13 back.
14 Q. And --
15 A. DTARC was making the medical necessity determination.
16 Q. Okay. And I have asked you what that was based on and
17 you still haven't answered that question.
18 MR. RODRIGUEZ: I'm going to object to the
19 characterization of the witness's testimony and asked and
20 answered and the form of the question.
21 BY MS. BROWN:
22 Q. Did Dr. Figler conclude she was a candidate for
23 surgery?
24 A. Yes. Yeah. Yeah. I think that was in the case
25 summary that you have.

1 Q. I'm sorry, which case are you referring to go?
2 A. The case summary that goes --
3 Q. Okay. We'll get to that. Did Dr. Campbell agree with
4 Dr. Figler's assessment that Ms. Zayre-Brown was a candidate
5 for surgery?
6 MR. RODRIGUEZ: I'm going to object to beyond
7 topics and speculation. Dr. Campbell's agreement or mental
8 state is not one of the topics that Dr. Peiper is prepared to
9 testify to.
10 THE WITNESS: I certainly can't speak for Dr.
11 Campbell. But I believe in the case summary the review of her
12 candidacy for surgery is documented. Do you need me to look at
13 any of --
14 BY MS. BROWN:
15 Q. I'm asking about the -- so you said that you discussed
16 these matters. That's how DTARC --
17 A. Yeah. And the summary is included. Sorry, I don't
18 know if there's a specific piece of that.
19 Q. Did Dr. Campbell agree that gender-affirming surgery,
20 vulvoplasty should be denied?
21 MR. RODRIGUEZ: Again, objection to beyond the
22 scope of the topics, speculation.
23 BY MS. BROWN:
24 Q. Did DPS agree that the surgery should be denied?
25 A. DTARC made the determination it's medically necessary.

1 Did not support the surgery. And DAC through additional level
2 review concurred.
3 Q. Did Ms. Croft agree that the surgery should be denied?
4 MR. RODRIGUEZ: Wait. So just for clarity.
5 Are you saying agreed with what?
6 MS. BROWN: With DTARC's --
7 MR. RODRIGUEZ: DTARC's conclusions.
8 MS. BROWN: Correct. Yeah.
9 THE WITNESS: So Sarah Cobb on the DTARC? Yes,
10 Sarah Cobb is on the DTARC. Sarah Cobb was there for the
11 discussion. This is the opinion of the DTARC.
12 BY MS. BROWN:
13 Q. And so did Sarah Cobb, director of rehabilitative
14 services, agree that the surgery was not medically necessary?
15 MR. RODRIGUEZ: I'm going to object to
16 speculation to the extent you're asking for the witness to
17 testify as to a particular person's mental state. You can
18 answer the question, to the extent you know.
19 BY MS. BROWN:
20 Q. Again, we're talking about Sarah Cobb, the same person
21 that you worked with on the DTARC with. Did Sarah Cobb express
22 agreement that surgery should be denied?
23 A. It's a strange phrasing of that question. Sarah Cobb
24 was there for the discussion. Sarah Cobb is part of the DTARC.
25 DTARC did review the information and make this determination.

1 So yes, this is the decision of the DTARC. These were the
2 members of the DTARC that were present and this is the
3 decision.
4 Q. Did all members of the DTARC agree that surgery should
5 be denied?
6 MR. RODRIGUEZ: Objection, speculation to the
7 extent the question calls for a statement as to the mental
8 state of other folks. You can testify, to the extent you know.
9 THE WITNESS: There's no disagreement among the
10 DTARC about it. There is discussion. We came to the complete
11 conclusion on behalf of the DTARC. We documented that
12 conclusion. We shared that conclusion up for the review. Once
13 that happened we shared that conclusion with Kanautica through
14 her therapist.
15 BY MS. BROWN:
16 Q. And so again, as you said, nonmedical staff are on
17 DTARC and you all agreed, as you testified, that the surgery
18 was not medically necessary for Ms. Zayre-Brown?
19 MR. RODRIGUEZ: I'm going to object to form.
20 You can answer.
21 THE WITNESS: The DTARC made the determination
22 that it was not medically necessary. Sorry. You asked me if
23 one person can make the determination and I answered no. And
24 again, one person cannot make that determination. But the
25 DTARC did review it and the determination was made that it was

1 not medically necessary.
2 BY MS. BROWN:
3 Q. Did any memory of DTARC express disagreement with the
4 conclusion that surgery should be denied?
5 A. No, I wouldn't say so.
6 Q. Did any member of DTARC express agreement with the --
7 or that it should be granted?
8 A. It should not happen?
9 Q. Sorry. I'm sorry, no. Did anyone disagree with that?
10 MR. RODRIGUEZ: Disagree with what?
11 THE WITNESS: I'm confused as to what you're
12 asking.
13 BY MS. BROWN:
14 Q. Let's just look at the case summary. Perhaps that
15 will clarify. I'm going to hand you what I'm going to mark as
16 Plaintiff's 11.
17 - - -
18 (Document marked as P-11 for identification.)
19 - - -
20 BY MS. BROWN:
21 Q. So this is a case summary you were referencing?
22 A. Yeah. This looks like the case summary that was
23 included with the DTARC for that additional level review.
24 You'll notice a similar version from the medical record.
25 Q. Okay.

1 A. And so inside the medical record the 411(d) coincides
2 with the summary that's inside the medical record. So they're
3 kind of a package.
4 Q. Again, so do you recognize this document?
5 A. I do.
6 Q. Okay. What is this document?
7 A. This is a case summary from the DTARC.
8 Q. Who wrote this document?
9 A. I was the one responsible for compiling the
10 information together. So I did the physical typing and
11 preparation, formatting of these pages.
12 Q. You said compiling, typing and formatting. So you
13 wrote every word here?
14 A. I wouldn't characterize it that way.
15 Q. Let me ask you again. Which parts of this did you
16 write in totality?
17 A. Goodness gracious. I don't know that I can pars it
18 out to that level. I don't know that it's possible to pars it
19 out to that level.
20 Q. Okay. Did you write the surgery request and case
21 summary?
22 A. Did I write the surgery request and case --
23 Q. Did you type? Let me say that. Did you type the
24 surgery request and case summary? It's on page one of five.
25 First page.

1 A. Very likely that that was completely typed by me.
2 Q. Okay. And what about the section DTARC review
3 2/17/2022? Did you type this section?
4 A. Some of those words may have been summary words of
5 words that have been typed.
6 Q. Some of those words may be summary words of words that
7 have been typed. By you?
8 A. It's like you're asking me about authorship and
9 original authorship. So authorship you would be looking at who
10 contributed that original wording, if you may. And then me in
11 my role as chair was to pull together the input, the totality
12 of the DTARC record, the information that was presented. I
13 testified previously about each individual in their role and
14 that they're expected to bring this information forward. That
15 information comes together and is summarized in the case and
16 it's why we call it a summary.
17 Q. Okay. I'm asking who typed this document though and
18 this specific provision.
19 MR. RODRIGUEZ: I'm going to object as asked
20 and answered. Dr. Peiper has already testified he created this
21 document from various sources of information and cannot tell
22 you with specificity which particular word he typed versus
23 copied and pasted from another source. But you can answer the
24 question, to the extent you know.
25 THE WITNESS: I prepared this document for the

1 if they happen to share wording or share references, is it
2 possible that they share that? If they do share it, then yes,
3 the answer would be they do share it. If they don't share it
4 then I would say that no, they don't share it.
5 BY MS. BROWN:
6 Q. Okay. You can set that aside.
7 A. Thanks.
8 Q. While she's pulling that together, let me ask you
9 another question.
10 A. Sure.
11 Q. So in terms of that email that -- if you want to
12 reference it, you can pull it back, the one with the draft
13 position statement attached to it.
14 A. The March 2022?
15 Q. Correct. Okay. And so is it DPS policy to use this
16 kind of voting mechanism for decisions within DTARC?
17 A. Is there a policy about using a voting mechanism in
18 DTARC? No.
19 Q. Okay. And have you ever used this kind of voting
20 mechanism before in decision making as a member of DTARC?
21 A. For DTARC? No, there wouldn't be anything that was
22 what I would qualify as a specific vote.
23 Q. All right.
24 MS. BROWN: I'm going to hand you what I am
25 going to mark as, I believe, plaintiff's exhibit -- we're at

1 14?

2 - - -

3 (Document marked as P-14 for identification.)

4 - - -

5 BY MS. BROWN:

6 Q. So do you recognize this document?

7 A. Yes. This would be the Hero note.

8 Q. Okay. Sorry, do you have the first page? Okay.

9 A. This appears to be the one from previous.

10 Q. Okay. So this first page. This is the, again,

11 February 17, 2022 DTARC decision. That says DTARC does not

12 recommend gender affirmation surgery. The surgery is not

13 medically necessary.

14 A. Uh-huh. Sorry, yes. I did uh-huh. Sorry about that.

15 Q. And then on the next page which you were just looking

16 at, do you recognize this document?

17 A. Yes.

18 Q. And tell me what this is.

19 A. This is the Hero note that goes along with that 411(d)

20 from the DTARC.

21 Q. And when did you author this Hero note?

22 A. This would have been directly entered into the medical

23 record on April 26, 2022 at 12:12.

24 Q. So it's entered into the medical record on April 26,

25 2022 at 12. When did you write this?

1 A. Goodness. This got sticky earlier. So this is --
2 like I was saying when you presented this one earlier, there is
3 -- this is the case summary that was prepared as part of moving
4 the DTARC process forward. And then this is the summarized
5 version of this entered into the medical record. And it occurs
6 after the final process comes back.
7 Q. Okay.
8 A. So when this went forward there was no final section
9 there at the bottom of that.
10 Q. And when did you write this? When did you write this
11 summary as you're characterizing it?
12 A. This was entered into the medical record on April 26,
13 12:12. It was written prior to that.
14 Q. Okay. And when was it written?
15 A. Prior to that.
16 Q. What date was it written?
17 A. This comes from the February 17, 2022 DTARC, along
18 with this form, the top portion of this form. It was moved
19 forward up the process. Then when it came back this
20 information that is the case summary was added into the Hero
21 medical record.
22 Q. Okay. And so why did you write this summary?
23 A. The 411(d) -- oh, I'm sorry, I'm giving my personal
24 answers. I'm so sorry. But the 411(d) -- so the department
25 has the process for the 411(d) to be the form. And then this

1 case summary information goes with it. You can see how the
2 form gives basic information. This completes the record. The
3 two of these go together into the medical record.
4 Q. Yes.
5 A. This case summary and this are together as well in the
6 DTARC process. So it's a summarized version of the DTARC case
7 summary.
8 Q. Can you tell me the specific date that you wrote this
9 North Carolina Department of Public Safety Division Transgender
10 Accommodation report that was entered 4/26/2022?
11 MR. RODRIGUEZ: Asked and answered. You can
12 answer.
13 THE WITNESS: So you're asking me as me. It
14 would be prior to 4/26/2022 at 12:12. It would have been
15 prior. So this document was written and of course we talked
16 about what does it mean to a write a document, where does the
17 information originally get typed and then summarized together.
18 This summarized information was put in here. And you can look
19 at certain aspects and see how maybe this is bullet pointed.
20 The medical record doesn't really give you the space in the
21 comment field of this particular note. You can see that this
22 note is structured, it has this one field comment. Previously
23 we talked about on that medical clinical encounter note you
24 were asking about UR request and what does this one mean. And
25 it goes under the heading. Each heading in the medical record

1 has a certain amount of space that's allowed to it. So the
2 summarized version of this information was moved into a more, I
3 guess you could say, a pro version, whereas this has like some
4 bullet point.
5 BY MS. BROWN:
6 Q. Okay. What date did you write this though? This is
7 what I'm asking about. What specific date? You entered it on
8 4/26/2022. What date did you write it?
9 MR. RODRIGUEZ: Asked and answered. You can
10 answer.
11 THE WITNESS: Prior to 4/26/2022 at 12:12.
12 BY MS. BROWN:
13 Q. Did you write it in April 2022?
14 A. You asked me if I knew of an exact date. I do not
15 know of an exact date. Me as a person, I do not know of an
16 exact date.
17 Q. Did you write this in April 2022?
18 MR. RODRIGUEZ: Asked and answered. He just
19 told you he doesn't know the exact date.
20 BY MS. BROWN:
21 Q. Did you write it in April 2022?
22 A. I don't know.
23 Q. Did you write it in March 2022?
24 MR. RODRIGUEZ: Same objection. You can
25 answer.

1 THE WITNESS: I don't know the exact date of
2 when it was written. I can tell you about the process --
3 MS. BROWN: No.
4 THE WITNESS: -- and how it comes -- the
5 information, how it comes into the DTARC. I can tell you about
6 the process of how it's summarized. I can tell you about the
7 process and even the justification about why they even put this
8 information in the medical record. I can -- but I don't have
9 the exact date.
10 BY MS. BROWN:
11 Q. Can you tell me about the justification for putting
12 this in the medical record? That would be helpful to know.
13 A. The 411(d), as you can tell, the form does not share a
14 whole lot of information. It's an important form. This
15 provides a broader understanding of what went into the 411(d)
16 response.
17 Q. Are these kind of summaries submitted with every
18 411(d) that the DTARC issues?
19 A. Not every one that has ever been, but yes, they are.
20 Q. How many for Ms. Zayre-Brown have you written?
21 A. I don't recall.
22 Q. Well, one.
23 A. It's one or greater.
24 Q. Two?
25 A. Am I -- I don't know.



Case 3:22-cv-00191-MOC-DCK Document 61-9 Filed 10/05/23 Page 110 of 153

1 Q. Okay.
2 A. Do you have another one?
3 Q. Sorry?
4 A. Do you have another one that you wanted me to speak
5 to? If there is one more then it would be at least two.
6 Q. Who asked you to draft this?
7 MR. RODRIGUEZ: Object as beyond the scope of
8 the topics. He can answer.
9 THE WITNESS: This is a process of the DTARC to
10 include a 411(d) along with the summarizing note that goes into
11 the medical record.
12 BY MS. BROWN:
13 Q. How does DPS select who is going to write these for
14 DTARC?
15 A. The DTARC has the chair of the DTARC put this in. I
16 am -- in the medical record you have got author rights for
17 certain types of notes. Me and my credentials I have got
18 authoring rights for what they consider the mental health side.
19 Just basically the way the profiles are set up with the medical
20 record. You have to give specific access to certain authoring
21 areas. I do have the authoring access for this particular side
22 and the chair pulls together the information on behalf of the
23 committee. And so for both of those reasons it makes sense for
24 the director of behavioral health in that capacity within the
25 DTARC to do it. Has the access and has the expectation to kind

1 of pull together the information.
2 Q. When did you become aware that you and DPS and among
3 others were being sued by Kanautica Zayre-Brown?
4 A. I don't remember the date.
5 MR. RODRIGUEZ: I'm going to object to beyond
6 the scope of the topics if you're asking him as an individual.
7 MS. BROWN: No, DPS and DTARC.
8 MR. RODRIGUEZ: Still beyond the scope of the
9 topics, but you can answer.
10 THE WITNESS: I don't recall when members of
11 the DTARC were aware that the department was being sued on
12 behalf of Kanautica.
13 BY MS. BROWN:
14 Q. How was DTARC told that they were being sued on behalf
15 of Kanautica?
16 MR. RODRIGUEZ: I'm going to object to the
17 extent it calls for attorney/client information. You can
18 answer to the extent it does not reveal any communication with
19 anybody from the office of general counsel for DPS or our
20 office.
21 THE WITNESS: I don't know that I can answer
22 that.
23 BY MS. BROWN:
24 Q. Why don't you know?
25 MR. RODRIGUEZ: Objection to form. You can

1 answer.

2 THE WITNESS: Indicated that -- so it's

3 communicated -- there were certain considerations about who was

4 communicating it and I don't know that I can answer it.

5 BY MS. BROWN:

6 Q. Did you write this 4/26 comment before or after

7 learning that Ms. Zayre-Brown was going to sue DPS?

8 MR. RODRIGUEZ: I'm going to object to the

9 question and we're going to go off the record.

10 - - -

11 (Discussion held off the record.)

12 - - -

13 BY MS. BROWN:

14 Q. Did you write this 4/26 comment before or after

15 learning that Ms. Zayre-Brown was going to sue DPS?

16 MR. RODRIGUEZ: I'm going to object to beyond

17 the scope of the topics of the 30(b)(6) deposition. Also, the

18 timing of the question is completely unclear. It's also

19 speculative as to who knew what when as to when Ms. Brown was

20 going to file a lawsuit is beyond anybody's personal knowledge,

21 except for hers, and I'm going to instruct the witness not to

22 answer.

23 BY MS. BROWN:

24 Q. And on the second page of this, it says requested to

25 be reviewed by Dula, Jennifer L MSW Clinical Social Worker. Do

1 you know if Jennifer Dula reviewed this?
2 A. I don't see any note that you have given me that shows
3 that it was marked as reviewed. But if you're asking if she
4 reviewed in the sense of becoming aware, she would have. But I
5 don't know. Sorry. Trying to answer.
6 Q. Did anyone give input on the content of this comment?
7 I'm sorry, we're talking about the same document. This is the
8 comment that you entered on 4/26/2022.
9 A. Yes.
10 Q. Who?
11 A. Yes. DTARC provides input on the cases being
12 reviewed. That input is included in the summary. With that
13 summary it's shared forward. The kind of review at that
14 additional level gets documented as well. And then those
15 pieces of information do become part of the full summary. I
16 would answer your question yes.
17 Q. How many drafts were there of this comment?
18 A. I don't know. I don't know. This is -- maybe you
19 could call this a draft because this did create the information
20 that did float in here. Again, it's kind of like when did you
21 write, who's the author. And again, I'm saying things as me in
22 my personal knowledge here.
23 Q. Did anyone at DPS review this comment?
24 MR. RODRIGUEZ: Objection to the form. Beyond
25 the scope of the topics, I guess. You can answer.

1 THE WITNESS: This information?
2 BY MS. BROWN:
3 Q. No, this right here. 4/26/2022.
4 A. Would have been asked to review, yes. Yes.
5 Q. And who asked to review it?
6 A. If I can answer as an individual, I guess.
7 MR. RODRIGUEZ: No. You should answer as the
8 designee for the 30(b)(6). This topic is 16, the April 26,
9 2022 comment is topic 16.
10 THE WITNESS: Okay. The Department's process
11 includes communicating the results back to the facility. There
12 is a medical personnel, generally the nurse supervisor, nurse
13 manager, and someone within the behavioral health chain of
14 command. You see here that Jennifer Dula had this notification
15 sent to her through the medical record.
16 BY MS. BROWN:
17 Q. Okay. And did anyone approve this comment before you
18 submitted it from DPS?
19 MR. RODRIGUEZ: Objection to form. You can
20 answer.
21 THE WITNESS: This is the summarized
22 information of the DTARC and this was the completed note from
23 the DTARC.
24 BY MS. BROWN:
25 Q. So looking at the 4/26/2022 comment that you have

1 you said that was part of the consideration -- sorry. Yeah, I
2 have lost the question.
3 We'll try it one more time. What do you say by saying
4 the possibility of -- what did you mean by saying the
5 possibility of denying surgery could worsen her gender
6 dysphoria was part of the consideration of medical necessity?
7 MR. RODRIGUEZ: I'm going to object. I don't
8 believe that's part of the witness's testimony.
9 THE WITNESS: I never said that.
10 MS. BROWN: Okay. Let's take five or 10.
11 - - -
12 (A break was taken, 4:35 p.m. - 5:05 p.m.)
13 - - -
14 BY MS. BROWN:
15 Q. We are going to look back at the 2/17/22 DTARC denial
16 of gender-affirming surgery vulvoplasty for Ms. Zayre-Brown.
17 Do you have that document in front of you?
18 A. The 411(d).
19 Q. Yes, the 411(d).
20 A. Yes.
21 Q. So let's see here. So you intrigued me about the
22 coulds. So I have some questions --
23 A. Sure.
24 Q. -- about this decision-making process. Dr. Peiper,
25 during the discussion that took place in consideration of

1 gender-affirming surgery/vulvoplasty for Ms. Zayre-Brown on
2 February 17, 2022, what did Dr. Campbell say during the meeting
3 about any potential negative impacts on Kanautica's gender
4 dysphoria if surgery was not done?
5 A. What did Dr. Campbell say during the February 17, 2022
6 DTARC about any possible --
7 Q. Any potential negative impacts.
8 A. Potential negative impacts. I was there. I don't
9 recall specific statements made, discussions during that.
10 We're a little over a year past that. There is -- I do recall
11 there being discussions about severity of her symptoms, about
12 the -- kind of that piece of the review for the medical
13 analysis, the medical necessity piece. I don't know that I can
14 quote Dr. Campbell specifically from that day.
15 Q. Okay. And during this same discussion, what did Dr.
16 Campbell say during the February 17, 2022 DTARC meeting about
17 the severity of her symptoms and considering the potential
18 negative impact on her gender dysphoria if surgery was denied?
19 MR. RODRIGUEZ: Object to the form of the
20 question and asked and answered. You can answer.
21 THE WITNESS: I don't know that I can recall
22 exactly what Dr. Campbell said that day a little over a year
23 ago.
24 BY MS. BROWN:
25 Q. Again, going back to that same day. What did Dr.

1 Shiteman say during the meeting about any potential negative
2 impact on Kanautica's gender dysphoria if surgery was denied?
3 A. Similarly I don't know if I can recall specific words
4 from Dr. Shiteman from that day.
5 Q. Do you recall anything aside from specific quotes?
6 A. So with that process, folks are sharing those pieces
7 of information. So Shiteman would have been sharing some
8 information related to the psychiatric care, role. Dr.
9 Campbell would have been sharing some information about kind of
10 the medical needs. We were discussing the medical analysis,
11 kind of the medical necessity of it at the time. So the DTARC
12 discussion did evolve around that topic. Sorry, that was
13 evolve around or I guess revolve around.
14 Q. Again, I'm just going to run through this. What did
15 Ms. Catlett say during the meeting about any potential negative
16 impact on Ms. Zayre-Brown's gender dysphoria surgery was
17 denied?
18 A. I don't know if I can recall specific comments made by
19 DTARC members during the February 17, 2022 DTARC.
20 Q. But your testimony earlier, just to be clear, was that
21 potential negative impacts on her gender dysphoria was a
22 consideration in discussing the surgery being denied?
23 MR. RODRIGUEZ: Objection to form. You can
24 answer.
25 THE WITNESS: I recall you sharing that you

1 thought that was something I'm saying and I still don't believe
2 that that was how I was saying whatever it was that you were
3 responding to.
4 BY MS. BROWN:
5 Q. What did Ms. Williams say during the meeting about any
6 potential negative impacts on Ms. Zayre-Brown's gender
7 dysphoria if surgery was denied?
8 A. I similarly don't know that I have a recollection of
9 any direct quote or any direct statements from the individuals
10 there that day. Sorry, I don't recall specifics.
11 Q. Okay. And what did you say about the risk of
12 suicidality for Ms. Zayre-Brown if surgery was denied?
13 A. I don't know what I would have said specifically.
14 Q. What about what did you generally say about
15 suicidality or what did you generally say about the risk of
16 suicidality for Ms. Zayre-Brown if surgery was denied?
17 A. Kanautica is actually a really, I guess you could say,
18 remarkably well-adjusted. Suicidality wasn't a concern.
19 Q. Was it a concern for you?
20 A. For Kanautica?
21 Q. I mean in your consideration of what it would mean in
22 denying the request.
23 A. Yes. Yes. In my consideration Kanautica was -- I
24 would not have said she was at significant risk.
25 Q. Was there any consideration about her prior expression

1 of suicidal thoughts when you all were discussing the potential
2 impact on her gender dysphoria?
3 A. Yeah --
4 MR. RODRIGUEZ: I'm going to object to
5 assumption of -- assuming facts that are not present before the
6 witness inside the question. You can answer.
7 THE WITNESS: I would say reviewing
8 self-injury, we talked about self-injury because it's, you
9 know, broad, encompasses suicidal and nonsuicidal, and that is
10 a standard piece of the DTARC process to review for all the
11 cases that are coming forward. So yeah, it is reviewed and it
12 would have been reviewed at different points along the way.
13 Yes.
14 BY MS. BROWN:
15 Q. Okay. And that's what I'm interested in that review
16 specifically. So what did Dr. Campbell say in terms of, again,
17 potential impact on suicidal thoughts if the surgery was denied
18 for Ms. Zayre-Brown?
19 A. You're asking specific statements? Again, I don't
20 recall specific statements from that particular DTARC.
21 Q. Okay. And so what was generally said about the risk
22 -- well, no. Actually strike that. Generally, not
23 specifically, what was said about prior expressions of suicidal
24 thoughts in considering the impact on Ms. Zayre-Brown's gender
25 dysphoria and denying the surgery?

1 MR. RODRIGUEZ: Objection. I'm going to object
2 to assumption of facts not before the witness inside the
3 question. You can answer.
4 THE WITNESS: The DTARC review of her case the
5 general consensus was that she was not presenting a suicide
6 risk.
7 BY MS. BROWN:
8 Q. Did anyone during these discussions discuss cost in
9 terms of whether or not the surgery was medically necessary for
10 Ms. Zayre-Brown?
11 A. I think you had some notes from before. I can't
12 recall what that date was where that initial input, but I don't
13 recall that being a discussion point anymore after that.
14 Q. When you all were again discussing whether or not this
15 was going to be medically necessary, generally how did cost
16 factor in?
17 MR. RODRIGUEZ: Objection.
18 Mischaracterization. He just testified that cost wasn't a
19 factor.
20 BY MS. BROWN:
21 Q. Generally did anyone talk about any specific
22 post-surgical complications in considering whether or not this
23 was medically necessary for Ms. Zayre-Brown during this DTARC
24 discussion?
25 A. So were postoperative needs discussed? Yes. As you

1 added that into the medical necessity piece. It's important to
2 be able to provide the postoperative care for the person.
3 Q. What did Josh Panter say generally about the ability
4 to provide postoperative care in considering the surgery for
5 Ms. Zayre-Brown during this discussion?
6 A. What did Josh Panter say? I don't recall specifically
7 what Panter said.
8 Q. Did anyone discuss, again, any specific risks of this
9 specific surgery, vulvoplasty, during this discussion?
10 MR. RODRIGUEZ: Objection, vague. You can
11 answer.
12 THE WITNESS: Were risks considered? Yeah,
13 risks and part of the medical analysis for the medical
14 necessity piece. Risk is a component of that.
15 BY MS. BROWN:
16 Q. What were some of the risks discussed?
17 A. I don't recall the specific details of any exact
18 discussion.
19 Q. Okay. And again, I'm not asking specifically. I'm
20 talking generally in your discussions before the determination
21 was made.
22 A. Generally?
23 Q. Generally. What were any risks that anyone from DTARC
24 spoke about in considering this request?
25 MR. RODRIGUEZ: Objection, vague. You can

1 answer.

2 THE WITNESS: So prior to that determination,

3 going back, let's see, Kanautica was getting kind of consults,

4 information about kind of the aspects of the vaginoplasty.

5 What that would require pre-op. What it would require post-op.

6 She was also getting some input on some of those, if you would

7 call them risks to what happens when you actually undergo

8 surgery. So yeah, all that information that -- over that

9 period of time when those consults were happening. That

10 information came into the DTARC process as part of the review

11 from the DTARC was considered.

12 BY MS. BROWN:

13 Q. Did anyone discuss the concept of detransitioning

14 during consideration of this surgery for Ms. Zayre-Brown?

15 A. Was there any discussion of detransitioning?

16 Q. The risk of detransitioning?

17 A. The risk of detransitioning or detransitioning as a --

18 Q. After surgery?

19 A. We described gender journey previously and with that

20 there's -- some folks are kind of fluid in that. And so yeah,

21 it has been discussed within DTARC. It has been -- yes.

22 Q. And was that discussed the consideration for Ms.

23 Zayre-Brown?

24 A. I believe so.

25 Q. Okay. And what was generally said about the risk of

1 detransition --
2 A. It does occur. And if it does occur it's surgically
3 difficult to add that functioning back. I do believe that was
4 part of her consult with UNC as well. Kind of explaining that
5 a -- what is the term, phalloplasty, when you create that,
6 that's less effective. So if you do detransition and the
7 surgical response to that would be -- I believe that was part
8 of her consult.
9 Q. And did the risk of detransition contribute to DTARC's
10 decision not to provide surgery?
11 A. All of the information was part of the analysis.
12 Q. And so that is a yes?
13 A. That is a piece of information that was an aspect of
14 discussion. So yeah, it would have been part of the discussion
15 for the medical analysis.
16 Q. And at the meeting was there discussion of Dr.
17 Campbell's review of the medical literature?
18 A. Yes.
19 Q. And this was medical literature about gender-affirming
20 surgery?
21 A. Yeah. The information that you asked me if I
22 reviewed --
23 Q. Yeah.
24 A. -- those studies.
25 Q. And what was asked about those studies during the

1 discussions?
2 A. There was discussion about the information being
3 shared. He presented information, shared his opinions. There
4 were questions that were asked. I don't recall any specific
5 question necessarily.
6 Q. And all of those discussions -- so when you say he
7 shared. This was done verbally?
8 A. During the DTARC.
9 Q. Discussion?
10 A. Yeah.
11 Q. Okay. Again, during consideration of gender-affirming
12 surgery for Ms. Zayre-Brown, did DTARC discuss WPATH at all?
13 A. Did WPATH come up at all? Yes.
14 Q. Yes. What was discussed about WPATH during this
15 meeting?
16 A. So the WPATH expectations for what those conditions
17 are for being a candidate for that surgery, UNC Trans Health
18 Program utilized those. They might have had their own sort of
19 approach to it. But yeah, it was important that we have our
20 process kind of line up in a way that would also line up with
21 theirs.
22 Q. Did anyone discuss WPATH not being a reliable
23 authority?
24 MR. RODRIGUEZ: Objection to the form. You can
25 answer.

1 THE WITNESS: Did anybody talk about WPATH not
2 being a reliable authority?
3 MS. BROWN: Yes.
4 THE WITNESS: I wouldn't characterize any
5 discussion that way.
6 BY MS. BROWN:
7 Q. Did Campbell mention at all WPATH being an unreliable
8 authority?
9 MR. RODRIGUEZ: Objection. Asked and answered.
10 You can answer.
11 THE WITNESS: I don't know that I would say
12 anybody characterized it in that way.
13 BY MS. BROWN:
14 Q. Did Dr. Campbell ever raise the idea that WPATH was
15 less credible because they are advocates?
16 MR. RODRIGUEZ: Objection to form. You can
17 answer.
18 THE WITNESS: Yeah. WPATH and the guidelines
19 were discussed as how they're described as being flexible
20 guidelines to be applied to the different settings and how that
21 applies to our setting. Yes, that was all discussed.
22 BY MS. BROWN:
23 Q. Did anyone discuss specifically any WPATH guidelines
24 that did not apply in the prison setting during consideration?
25 MR. RODRIGUEZ: Objection to form. You can

1 answer.
2 THE WITNESS: The WPATH guidelines from
3 standard seven that sort of line up some of those presurgical
4 candidacy requirements, those were discussed based off of UNC
5 Trans Health Program utilizing those with their process and so
6 yes.
7 BY MS. BROWN:
8 Q. And did Campbell mention during that meeting that
9 WPATH is not reliable because its members have conflicts of
10 interest?
11 A. Did he mention that during the meeting? I don't
12 recall.
13 Q. Okay. Did DTARC use the WPATH criteria in any way in
14 consideration of the surgery for Ms. Brown during this
15 discussion?
16 A. Based off my answer previously and your question that
17 in any way, I would say yes.
18 Q. And in what way did you do that? In what way did
19 DTARC do that?
20 A. So the UNC Trans Health Program uses that as part of
21 determining whether you're a candidate for the surgery. We
22 utilize that process in putting her forward as a candidate.
23 Q. Did anyone, during this DTARC meeting, discuss
24 alternative criteria to WPATH?
25 A. Alternative criteria to WPATH?

1 Q. Yeah.
2 A. I would not say that there was alternative criteria to
3 WPATH.
4 Q. Okay. During the meeting did Campbell talk about a
5 study by Lisa Litman about detransition?
6 A. A study by Lisa Litman?
7 Q. Yes.
8 A. I don't recall that specifically.
9 Q. Okay. Let me ask again. During the meeting did
10 Campbell talk about a study by Lisa Litman about the
11 detransition?
12 A. I don't recall that specifically.
13 Q. Did anyone discuss Lisa Litman at all during this
14 meeting?
15 A. I don't recall that specifically.
16 Q. Okay. Did Dr. Campbell say anything at the meeting
17 about the prevalence of detransition?
18 MR. RODRIGUEZ: Asked and answered. You can
19 answer.
20 THE WITNESS: Detransitioning has been
21 discussed, yes.
22 BY MS. BROWN:
23 Q. What about prevalence though?
24 A. Prevalence? You mean like a percentage?
25 Q. Yeah.

1 A. I don't recall exactly.
2 Q. Did anyone at DTARC know if it was a high percentage
3 of folks who detransition or a low percentage of folks who
4 detransition?
5 A. I don't know what you would characterize as high
6 versus low.
7 Q. Did anyone at DTARC discuss the idea of regret
8 postsurgery?
9 A. Was it discussed? Regret. That would -- of course
10 that would come in with detransitioning. It's not necessarily
11 the same thing. I don't recall if that was a specific thing or
12 not.
13 Q. At the meeting did Dr. Campbell discuss the
14 conclusions he reached from the medical literature of you?
15 MR. RODRIGUEZ: Asked and answered. You can
16 answer.
17 THE WITNESS: Yes.
18 BY MS. BROWN:
19 Q. And what were those conclusions?
20 A. About the medical literature review?
21 Q. Yes.
22 A. It was mixed. To be straight to the point. Mixed.
23 Q. Sorry, when you say mixed, mixed in terms of what?
24 A. Mixed research on the efficacy. Mixed research on use
25 of it, outcomes of it. It was generally literature that it was

1 mixed.
2 Q. And, you know, I think your previous testimony was
3 that DTARC had discussed -- sorry. I think your previous
4 testimony was that DTARC had considered requests for
5 gender-affirming surgery for Ms. ZAYRE-BROWN in the past, at
6 least once before, correct?
7 A. Considered it? Yes. Considered surgeries? Yes.
8 Q. And at any point in time between then and this
9 consideration, did anyone do any kind of medical literature
10 review similar to the one that Dr. Campbell performed for this
11 purpose?
12 MR. RODRIGUEZ: Objection. Vague. You can
13 answer.
14 THE WITNESS: I don't recall if any particular
15 individual did a medical review like what Dr. Campbell did.
16 BY MS. BROWN:
17 Q. Did Dr. Campbell say based on the medical literature
18 review in his view gender-affirming surgery is never medically
19 necessary for the treatment of gender dysphoria?
20 MR. RODRIGUEZ: Objection. Beyond the scope of
21 the topics that this witness has been designated to testify to.
22 But you can answer as the designee.
23 THE WITNESS: Did he say that in the DTARC
24 meeting? Is that what you just said?
25 BY MS. BROWN:

1 Q. Did Dr. Campbell say based on his medical literature
2 review gender-affirming surgery is never medically necessary
3 for the treatment of gender dysphoria?
4 MR. RODRIGUEZ: Same objection as to beyond the
5 scope of the topics. You can answer.
6 THE WITNESS: Did he say that? I don't know.
7 I don't recall if that would be what he said.
8 BY MS. BROWN:
9 Q. You don't recall if that is what he said?
10 A. Yes.
11 Q. Did he say anything similar to that?
12 MR. RODRIGUEZ: Objection. Vague. You can
13 answer.
14 THE WITNESS: Dr. Campbell presented review of
15 the literature, talked about it being mixed. Yeah, he did talk
16 about the surgeries.
17 BY MS. BROWN:
18 Q. Was there any one particular factor discussed amongst
19 the DTARC members that contradicted providing the treatment for
20 Ms. Zayre-Brown?
21 MR. RODRIGUEZ: Objection to the form. You can
22 answer.
23 THE WITNESS: No.
24 BY MS. BROWN:
25 Q. And so I guess as, you know, thinking about the EMTO

1 policy and -- let me ask this. Has Dr. Campbell's medical
2 literature review affected the current EMTO policy in terms of
3 surgical intervention?
4 A. No.
5 Q. Okay. So under the EMTO policy, DTARC is still
6 considering requests for gender-affirming genital surgery?
7 A. Yes.
8 Q. Again, at the same meeting, did Dr. Campbell express
9 that gender-affirming surgery is not effective in treating
10 gender dysphoria?
11 A. Effective. It would certainly seem like that's a
12 specific term that might have some specificity to it that I
13 don't know that I would speak to that. He certainly shared
14 literature review about the studies. Certainly shared
15 literature review about the -- kind of the mixed status of the
16 reviews on efficacy.
17 Q. And did Dr. Campbell discuss any limitations to the
18 availability of research on the efficacy of gender-affirming
19 surgery for the treatment of gender dysphoria?
20 A. Limitations on the research?
21 Q. The availability of research, yes.
22 A. I don't recall if that was a specific thing or not.
23 Q. What is your understanding of Dr. Campbell's position
24 as medical director on whether gender-affirming surgery is ever
25 medically necessary?

1 MR. RODRIGUEZ: Objecting. Speculation, beyond
2 the scope of the 30(b)(6) topics, and actually instructing the
3 witness not to answer that question.
4 BY MS. BROWN:
5 Q. Well, what is DPS's understanding of Dr. Campbell's
6 position as medical director on whether gender-affirming
7 surgery is ever medically necessary?
8 MR. RODRIGUEZ: Same objection. Beyond the
9 scope of the topics and speculation of Dr. Campbell's
10 particular understanding of anything in particular. And I
11 instruct the witness not to answer that one.
12 BY MS. BROWN:
13 Q. Is DTARC currently considering any other requests for
14 gender-affirming surgery for Ms. Zayre-Brown at this time?
15 A. I don't believe we have any requests from Kanautica at
16 this time.
17 Q. Okay. And under EMTO policy is there anything
18 stopping Ms. Zayre-Brown from requesting gender-affirming
19 surgery again?
20 A. There is nothing within the policy that stops an
21 individual from putting forward additional requests, no.
22 Q. And about how long was the discussion that you all had
23 in considering Ms. Brown's request at the February 17, 2022
24 DTARC meeting?
25 A. I don't recall exact amount of time.

1 Q. Okay. How long are DTARC meetings typically scheduled
2 for?
3 A. We try to schedule the committee piece for generally a
4 two to three hour time slot.
5 Q. Do you recall the number of candidates you reviewed on
6 that day other than Ms. Zayre-Brown?
7 A. I know it was very reduced from a typical DTARC. I
8 don't recall the exact number. No more than four I would say.
9 THE WITNESS: Am I allowed to say how many
10 people?
11 MR. RODRIGUEZ: Yeah, how many, that's fair.
12 That's fine.
13 THE WITNESS: I didn't think that was
14 protected.
15 BY MS. BROWN:
16 Q. Again, February 17, 2022 meeting last more than an
17 hour? Did this discussion on February 17, 2022 about Ms.
18 Zayre-Brown last more than an hour?
19 A. I don't recall the exact amount of time spent.
20 Q. And did anyone at the DTARC meeting mention Ms.
21 Zayre-Brown's suicidal thoughts and self-harm?
22 MR. RODRIGUEZ: Objection. Asked and answered.
23 You can answer.
24 THE WITNESS: There's always the review of the
25 self-injury history, suicidal and nonsuicidal. And so any

1 aspect from the record that would have related would have been
2 reviewed. The consensus from the DTARC was that she was not
3 presenting that risk.
4 BY MS. BROWN:
5 Q. Which in this case, self-injury or suicidal ideation,
6 thoughts?
7 A. Yes. No, she was not being considered as a suicidal
8 risk.
9 Q. But who mentioned it in the discussion?
10 A. I don't recall specifically. Like I referenced, that
11 is a piece that's generally introduced through the mental
12 health input, and so there would have been a possibility that
13 it came through Shiteman or me.
14 Q. We talked a lot about different considerations DTARC
15 may or may not use in assessing someone. And especially, but
16 specifically in this case for Ms. Zayre-Brown, was her release
17 date a factor in her -- or was it discussed in considering
18 whether or not the surgery was medically necessary for her?
19 A. Folks in our system, their release date is a standard
20 piece of information that's always identified. So you might
21 see, say, PRD, projected release date. Was it a factor? Is
22 that what you're asking?
23 Q. Or was it discussed?
24 A. No, it was not a factor at all in medical necessity.
25 Q. No, sir. I'm asking was it discussed?

1 A. The projected release date of folks in the prison is
2 always an aspect. You'll see it in notes, routine, everything
3 that's happening within the system inside of a prison. And so
4 yes, there would be recognition of her current projected
5 release date at that time being 11/2/2024. As well as some of
6 the prison transfers that were documented. Those were also
7 pieces of information.
8 Q. And was it a factor considered in assessing whether to
9 approve her surgery?
10 MR. RODRIGUEZ: Objection. Asked and answered.
11 THE WITNESS: I think I answered that, but no.
12 BY MS. BROWN:
13 Q. Did anyone discuss the idea that it would be better
14 for Ms. Zayre-Brown to have surgery in the community versus in
15 an incarceral setting?
16 A. I don't recall discussing that.
17 Q. Did anyone at DPS discuss that?
18 A. I don't recall if anybody else has ever had that
19 conversation with Kanautica about whether she would prefer to
20 do it in the community or not. She may have presented an
21 opinion about that, but I don't know for sure.
22 Q. She may have presented an opinion about that?
23 A. Yeah, she may have talked about that.
24 Q. To who?
25 A. I just indicates I don't have any direct knowledge of

1 that happening.
2 Q. Okay. So it's just a possibility?
3 A. Yes.
4 Q. Okay.
5 A. Sorry to speak hypothetically.
6 Q. Yeah, sorry. Well, did anyone discuss alternative
7 gender-affirming surgeries to a vulvoplasty during this
8 discussion?
9 A. So Kanautica did have those discussions. And from
10 those discussions based off the records she preferred the
11 vulvoplasty.
12 Q. What was DPS's understanding of why she preferred the
13 vulvoplasty?
14 MR. RODRIGUEZ: Objection, speculation of what
15 Kanautica may have -- reasons that Kanautica may have preferred
16 it. You can answer.
17 THE WITNESS: I don't know.
18 BY MS. BROWN:
19 Q. You testified she did have those discussions?
20 A. I do know that in her discussions in some of those
21 early encounters with UNC Trans Health was about informing her
22 about what are the requirements, what's involved. You had
23 asked earlier about risks to surgery. Those would have been
24 discussed. And in that she had identified somewhere in those
25 consults that vulvoplasty was her preference.

1 Q. Okay. Did her desire for a vulvoplasty -- yeah. Let
2 me say that again. Did Ms. Zayre-Brown's, you know, decision
3 to go for a vulvoplasty factor into surgery being approved or
4 not?
5 MR. RODRIGUEZ: Objection to form. You can
6 answer to the extent that you are able.
7 THE WITNESS: I don't necessarily understand
8 what the question is, but if you're saying -- I don't
9 understand. I'm sorry.
10 BY MS. BROWN:
11 Q. Okay. So you previously testified that she had those
12 discussions at some of the encounters with the UNC Trans Health
13 program and she preferred a vulvoplasty?
14 A. Yes, she did have a preference for the vulvoplasty.
15 Q. And do you recall in previous requests she requested
16 vaginoplasty as well?
17 A. Yes.
18 Q. Okay. And so in this consideration was the fact that
19 she had chose vulvoplasty a factor in why surgery was denied?
20 MR. RODRIGUEZ: Objection to form. You can
21 answer.
22 THE WITNESS: No.
23 BY MS. BROWN:
24 Q. Okay. So during this February 17, 2022 meeting, were
25 there any moments where the conversation could be considered

1 heated?
2 MR. RODRIGUEZ: Objection to form. You can
3 answer.
4 THE WITNESS: There's nothing I would
5 characterize as heated.
6 BY MS. BROWN:
7 Q. Did any member of DTARC come into the meeting
8 indicating that they were approving surgery?
9 MR. RODRIGUEZ: Objection. Asked and answered.
10 You can answer.
11 THE WITNESS: Right up through the whole
12 process there was that openness across the DTARC to be prepared
13 for the amount of determination one way or the other.
14 BY MS. BROWN:
15 Q. Was anyone open longer than someone else as you all
16 discussed?
17 A. Was anybody open longer than someone else? I don't
18 know.
19 Q. Okay. But did anyone come in expressing that they
20 were -- did anyone come in expressing that they favored
21 approving the surgery for Ms. Zayre-Brown?
22 MR. RODRIGUEZ: Objection. Asked and answered.
23 THE WITNESS: The discussion was about the
24 evaluation, that analysis of the medical necessity of it. And
25 so through that it was a deliberative process of discussing

1 information that's being shared.
2 BY MS. BROWN:
3 Q. And did anyone say they thought surgery should be
4 approved?
5 MR. RODRIGUEZ: Objection. Asked and answered.
6 You can answer.
7 THE WITNESS: It would be similar to this same
8 response I just gave.
9 BY MS. BROWN:
10 Q. Okay. All right. I'm switching gears a little bit,
11 Dr. Peiper.
12 A. Yes.
13 Q. What is your understanding of what happened during the
14 March 2, 2019 emergency hospitalization of Ms. Zayre-Brown?
15 MR. RODRIGUEZ: Object to the use of the phrase
16 hospitalization. Topic indicates hospital emergency room
17 visit. You can answer.
18 THE WITNESS: March 2019 she was at Harnett at
19 the time and there was an incident where maybe you would
20 describe it bizarre behavior being presented. She was making
21 some statements that called the staff's attention and they
22 asked for medical and there were additional responses.
23 BY MS. BROWN:
24 Q. And what is DPS's position on what the bizarre
25 statements were?

1 A. There were some quotes, if I can be allowed to maybe
2 paraphrase my recollection of the quotes. I feel like I'm
3 dying. I don't want to die. There's some quotes about I'm
4 high. Call the ACLU. There are some quotes about I love my
5 man. God -- please God, forgive me. There were some comments
6 that were sexual in nature. I won't repeat those here, but
7 they are available if needed. There is I love my grandma. She
8 did say that she smoked something out of a pipe. I believe
9 that might be -- that's probably the gist of what I remember.
10 Q. And what's DPS's position of who all she said this to?
11 MR. RODRIGUEZ: Objection to form as far as
12 DPS's position. But you can answer.
13 THE WITNESS: This occurred -- I believe it
14 started in the housing area. So anybody that was there would
15 have been hearing her say these things. I believe there was
16 also -- maybe she was in an area off the housing unit when some
17 other statements were being made.
18 BY MS. BROWN:
19 Q. And you said staff heard them first?
20 A. I don't know who heard it first. I would imagine if
21 I'm a person sleeping right next to her in the bunk, these are
22 dorms, maybe the closest person to her heard it. But yes,
23 staff called for medical.
24 Q. Okay. And this was at Warren?
25 A. I believe this was at Harnett.

1 Q. Harnett. And is it DPS's position that that housing
2 situation played any factor in her distress?
3 MR. RODRIGUEZ: Objection to form. And I'm
4 going to object to the scope. The events, circumstances,
5 communications and documents concerning the hospital room visit
6 does not connote the Department taking a position as to what
7 may have prompted her making particular statements.
8 MS. BROWN: Okay.
9 BY MS. BROWN:
10 Q. You can still answer.
11 A. She ended up standing in her own vomit and spreading
12 the vomit on some of the staff that were there helping her.
13 They were encouraging her to come out of the vomit.
14 Q. Did DPS consider Kanautica to be in emotional
15 distress?
16 A. I believe the medical response was one that was beyond
17 emotional distress. They were -- that of course was some
18 aspect of it, but they immediately kind of went into -- we see
19 individuals do this when they smoke K2 in the prison, synthetic
20 marijuana. Some of that stuff is just really, really nasty and
21 toxic. And if you happen to kind of be familiar with smoking
22 maybe marijuana in the community and in a prison context you're
23 not familiar with whatever that is that is in the contraband
24 trade there, it can really have a significant impact on you.
25 And so they were taking these additional medical concerns and

1 considerations and getting her immediate medical care that
2 would go beyond what you would do for emotional distress only.
3 Q. Just to make sure I understand, earlier you testified
4 that you believe there were statements to the effect of
5 Kanautica saying she was high?
6 A. She was quoted saying I'm high, call the ACLU. She
7 talked about being the voice for all transgender people. Just
8 prior to that she was, maybe it was a day or two before that
9 stressing about the News and Observer newspaper article that
10 had come out or was coming out. She was concerned about being
11 interviewed or possibly being interviewed by WRAL. And then I
12 think later that day, I believe it was February 28th, it was
13 right before this one, I think she had a meeting with the ACLU
14 as well.
15 Q. And what is DPS's position on what caused this
16 incident?
17 MR. RODRIGUEZ: Again, objection as beyond the
18 scope of the topic. The events, circumstances, communications,
19 documents concerning the episode. The Department wasn't asked
20 to and did not produce a witness ready to testify as to what
21 may have caused the incident.
22 MS. BROWN: You can still answer.
23 MR. RODRIGUEZ: You can still answer.
24 THE WITNESS: I said that there is no position
25 from DAC what caused them.

1 BY MS. BROWN:
2 Q. Has there been any evidence that drug use caused these
3 incidents?
4 MR. RODRIGUEZ: Same objection. But you can
5 answer.
6 THE WITNESS: She said it did. She said I'm
7 high. She said I smoked something out of a pipe. And so that
8 would be her admission to it. So you could call that evidence,
9 I guess.
10 BY MS. BROWN:
11 Q. Does DPS have any documentation of this other than
12 what she said?
13 A. Talking about like --
14 Q. In terms of drug use?
15 A. Like the drugs that she had smoked, if she did smoke
16 them?
17 Q. Yes.
18 A. I don't believe there's any evidence of that.
19 Q. And along those same lines, does DPS have any
20 documentation of any drug test taken around the time of this
21 incident?
22 A. One reason K2 is so popular is that it's known not to
23 be picked up on drug test.
24 Q. Was she tested though?
25 A. That I don't know about the specifics. She was sent

1 out to an outside hospital there in Harnett. So it would have
2 been local. They did their evaluation, their medical workup
3 with her. I don't recall offhand if they completed a drug test
4 there at the hospital.
5 Q. And so the event that we were just talking about was
6 on March 2, 2019. What is DPS's position about Ms.
7 Zayre-Brown's August 6, 2019 emergency room hospitalization?
8 MR. RODRIGUEZ: Object to the use of the phrase
9 hospitalization. You can answer.
10 THE WITNESS: The August 2019 would have been
11 when she was over at Warren. And around that time -- so DAC
12 doesn't have an actual position on it, but around that time
13 Kanautica was talking a lot about when the transfer was going
14 to occur. She had been notified. It was several months before
15 that. And so as that date approached there was more discussion
16 about it. So I know from her statements that was something
17 that was on her mind. At the time she had a somewhat similar
18 presentation to what came at Harnett. Not quite to that
19 extent. But called for help. Called for medical attention.
20 Got medical attention. They got her out and got her some care
21 for it.
22 BY MS. BROWN:
23 Q. Okay. What kind of care did they provide her?
24 A. I think they told her it was -- they used a medical
25 term for it. Syncope maybe. They said she fainted.

1 Q. Okay.
2 A. And so they treated her for fainting.
3 Q. Okay. And quickly looking back or thinking back to --
4 obviously these happened in 2019. But during the February 17,
5 2022 consideration of Ms. Zayre-Brown's gender-affirming
6 surgical request, were either of these hospitalization events
7 discussed?
8 MR. RODRIGUEZ: Objection to the use of the
9 phrase hospitalization. You can answer.
10 THE WITNESS: These events are part of the
11 history of the review for Kanautica and these events are not
12 indications of any suicidal episodes or suicidal intent. They
13 would not have been considered as suicidal in nature. But yes,
14 they are considered as part of her record and all of those
15 pieces of information moving forward into the DTARC.
16 BY MS. BROWN:
17 Q. Let's go back to the March 2, 2019 emergency room
18 hospitalization event. How long was she in care?
19 A. How long was she outside? I don't recall those
20 specific -- was not a long period.
21 Q. Did DPS provide her with any substance abuse treatment
22 upon her return at any time subsequent to that?
23 A. Provide her with substance abuse treatment? I
24 wouldn't say that there was any necessarily specific thing I
25 would ascribe as substance abuse treatment programming. As

1 events happen with an individual -- because she was under the
2 care of a therapist at that point, those aspects are brought
3 into the discussion, treatment planning, it's kind of an
4 interim process involving -- between the therapist and the
5 person.
6 MS. BROWN: We're going to step out just for a
7 couple seconds. We're going to go off the record.
8 - - -
9 (A break was taken, 5:59 p.m. - 6:08 p.m.)
10 - - -
11 BY MS. BROWN:
12 Q. Dr. Peiper, what is DPS's position about what happened
13 on December 11, 2020 when Ms. Zayre-Brown was put in inpatient
14 mental health unit at NCCIW?
15 A. You're talking about the -- just the part where she
16 was transferred over to NCCIW or are you talking about the
17 events that surrounded that?
18 Q. Both.
19 A. So prior to that, maybe it was three days before -- it
20 was a few days before that, was the -- I think it was
21 classified as an assault. But she and the other person there
22 at Anson, basically they got into a verbal back and forth.
23 Probably best way I would describe it as they started trading
24 low blows. Not physical, but like verbal. And so Kanautica --
25 the other woman was there for killing her dad, so she had a

1 life sentence. And Kanautica was telling her that -- look at
2 my release date and look at the date next to yours and
3 something about mine has a date or maybe she said yours has
4 life. But basically it was trying to get at her about that. I
5 don't know exactly what they were arguing back and forth about,
6 getting into the verbal argument with each other about. But
7 there were other individuals kind of in it almost like they
8 were kind of posse'ing up with it. It's not an unusual scene
9 in a prison environment. Folks have their groups. Then the
10 other individual, the we'll say lifer, traded a low blow, as
11 I'll call it, to Kanautica and made some reference to her
12 anatomy. And so this came in some sort of an exchange where
13 they were -- basically it escalated. So they started here,
14 went here, went here, went here and then there was that point
15 where Kanautica basically -- kind of like the
16 let's-take-it-outside moment. And you can't take it outside.
17 So she took it up -- I think she took it up to her room.
18 They're single cell rooms. And there was some sort of a quick
19 altercation that occurred and the other woman required some
20 outside medical care. Of course it was an altercation and so
21 there was a disciplinary infraction that comes with that. She
22 moved into the restrictive housing area. She was screened on
23 the way in. There's a typical process where there's a nursing
24 screening that's done as somebody is moving into restrictive
25 housing. And they ask certain things about are you suicidal,

1 any health complaints. She was still upset definitely. She
2 denied being suicidal. Then while in restrictive housing, I
3 think it was the next day, we have -- anybody that's come into
4 restrictive housing there's also kind of a mental health check
5 on them. So one of our clinicians rounded in restrictive
6 housing. Met with Kanautica. She denied suicidal concerns at
7 that point. She was concerned with the other woman kind of
8 getting in trouble for it. And so she was sharing some
9 information. The other woman did -- they actually reviewed the
10 video footage and were able to see some of that jawing
11 beforehand that lead up to the assault. It was classified as
12 an assault. And so the other woman did get her disciplinary
13 infraction for that after they were able to review the video
14 footage. Then Dr. Hahn was still kind of being the primary
15 therapist with her and had a scheduled appointment. It was
16 probably that Friday of that week. She had referenced it in
17 conversation with the clinician that was doing that restrictive
18 housing check with her, the mental health check. Met with Dr.
19 Hahn and she was upset about the -- we'll call it an
20 altercation. Upset about the altercation. Discussed that.
21 Really had kind of a -- call it a sour opinion on Anson at that
22 point. And was expressing some suicidal thoughts and some
23 concerns with Dr. Hahn when they were talking. I guess that
24 was three, four days later, something like that. And so at
25 that point Dr. Hahn made a determination, let's get over to the

1 NCCIW inpatient and got her over there for that. And pleased
2 at that point. Said she was fine. And that's the extent of
3 those four days or whatever it might have been.
4 Q. And you say suicidal thoughts -- it was around being
5 housed at Anson in terms of like the conditions?
6 A. So she was saying that she had started getting
7 frustrated with -- she just had this fight. She was frustrated
8 with the fight and she's still thinking about what this other
9 person did. So that's -- it would be on anybody's mind. Not
10 saying that was a problem for her whatsoever, but she was
11 having what you would expect, reactions to this. It feels
12 unfair to her at that point. She got in trouble. We make a
13 point of not telling individuals whether the other person got
14 in trouble and what happened to them. But she had been
15 concerned about the other person getting in trouble. But so --
16 yeah, she was in, I guess, maybe soured.
17 Q. And I'll just ask similar to the other incidents, this
18 was also information that was part of the information DPS had
19 in its consideration of surgery for Ms. Zayre-Brown on February
20 17, 2022?
21 A. Yes. Sorry for answering you before you --
22 Q. I think we got it. And a couple questions on that
23 meeting that just came to my mind. During those discussions
24 about the surgery for Ms. Zayre-Brown, did anyone discuss the
25 fact that she has a disability in considering whether or not to

1 deny the surgery?
2 MR. RODRIGUEZ: Objection to form. You can
3 answer.
4 THE WITNESS: During the February 17, 2022
5 DTARC did anybody talk about disability?
6 BY MS. BROWN:
7 Q. Her having a disability.
8 A. Her having a disability. So I wouldn't say that using
9 those terms. But disability is, you know, impairment, impact
10 on the person, looking at them, what's going on for her. So
11 maybe, but I would say no.
12 Q. Maybe, but no. You said maybe not in those terms.
13 What other terms?
14 A. As it was described. When you're talking about
15 disability, you're talking about impact on life areas for
16 folks. And so in that regard, you know, looking at the
17 totality of her case you would be looking at different impacts,
18 if there's any areas of significant issues that are going on
19 for her.
20 Q. And did anyone at DTARC discuss any specific life
21 areas that could be impacted by Ms. Zayre-Brown being denied
22 the surgery during that discussion?
23 A. Did we discuss life areas that would be impacted?
24 Struggling with the question. My best answer is going to be
25 no.

1 Q. Let me rephrase it. Did anyone discuss any negative
2 affects being denied the surgery -- being denied surgery could
3 have on any -- sorry, what was the terminology, life areas in
4 DTARC discussions?
5 MR. RODRIGUEZ: Objection to form. You can
6 answer.
7 THE WITNESS: Life areas is such a big area of
8 life. I don't know. I'm trying to find a way to bridge
9 between, but just based off what you're saying I'll say no.
10 BY MS. BROWN:
11 Q. Did anyone take notes during this meeting?
12 MR. RODRIGUEZ: Which meeting?
13 BY MS. BROWN:
14 Q. Sorry. During the February 17, '22 consideration of
15 Ms. Zayre-Brown's surgery request.
16 A. The case summary creates the notes, minutes of
17 meeting.
18 Q. Okay. So you took those notes?
19 A. I compiled the case summary.
20 Q. And so does that mean multiple people were taking
21 notes and then they sent them to you?
22 A. Folks submit information. I don't know if that was
23 clear previously. So the DTARC process involves people that
24 are putting forward information as part of their roles with the
25 DTARC and then that information is reviewed and discussed. And

1 then the summary of that complete review is put into a case
2 summary that moves forward with that.
3 Q. So my understanding of that is that that's -- that is
4 -- that comes into the meeting, right? That information in
5 that is what their bringing in to inform the decision?
6 A. The input that they're bringing in does come into the
7 meeting. Discussion within the meeting and kind of some of the
8 -- I don't know if you want to use findings, but the outcome of
9 the review happens within the meeting.
10 Q. Does anyone take notes of that during the meeting?
11 A. We meet by Webinar, Zoom. I don't know if anybody was
12 jotting anything down.
13 MS. BROWN: So that is the conclusion of the
14 30(b)(6) portion of the deposition of Dr. Peiper. Can we go
15 off the record, please?
16 - - -
17 (Witness excused.)
18 - - -
19 (Deposition concluded 6:21 p.m.)
20 - - -
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# Division Transgender Accommodation Review Committee (TARC) Meeting

## May 21, 2020 2:00 pm

### Attendees:

Dr. Lewis Peiper, Interim Behavioral Health Director; Dr. David Snell, Medical Director; Dr. Brian Sheitman, Psychiatry Director; Dr. Abhay Agarwal, Deputy Medical Director; Dr. Rosemary Jackson, UR Physician; Dr. Neva Bartholomew, Regional Medical Director; Valerie Langley, Interim Director of Nursing; Terri Catlett, Director Health Services Administration; Charlotte Williams, PREA Director; Operations; Sarah Cobb, Director of Rehabilitative Services; Josh Panter, Designee for Operations

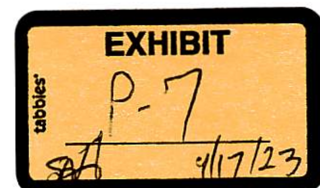
**Old Business**

- New confidentiality forms have been signed and received by Dr. Peiper for all DTARC committee members.
- The minutes have been distributed and reviewed by the DTARC committee for the month of February.
- The DTARC committee has unanimously agreed to have all DTARC committee information moved to the Randall Building I: Drive. This change will allow all information to be stored in one central location. All committee members, Dr. Junker and Assistant Commissioner Harris will have access to the DTARC folder.

**Updates/Recap:**

- A specialized consent form primarily used by the HERO healthcare staff at the facility level will be utilized. The DC-411C form will be processed when an individual is starting the TARC process, prior to the FTARC review. The DC-411C form is a confidentiality and consent form that outlines the TARC process. This is a new form gives DTARC the permission to access medical records and discuss their cases. This form will be added to the policy.

- PREA Director, Charlotte Williams discussed the need for consistency in making sure the Mental and Medical Health transgender lists, matches the Agency screening list. We want to make sure all individuals requesting accommodations are addressed.
  - ✓ When an offender is processed through our diagnostic center, they have to complete a screening process upon intake and upon transfers to any facility in the state. At that time individuals can change their sexual orientation and the information will be updated in OPUS.
  - ✓ It is the offender's right to identify or disclose through the screening process and they can't be penalized under PREA for not wanting to answers those questions.



- ✓ In Dashboard, under PREA reports, a report can be generated to identify the number of individuals identifying as transgender in the state. We currently have a total of 59 transgender offenders who have identified themselves in the screening process.
- ✓ In efforts to create more consistency and better communication, Dr. Peiper and Charlotte Williams will work together on cross-referencing the Mental and Medical data with the agency screening data.

**New Business:**

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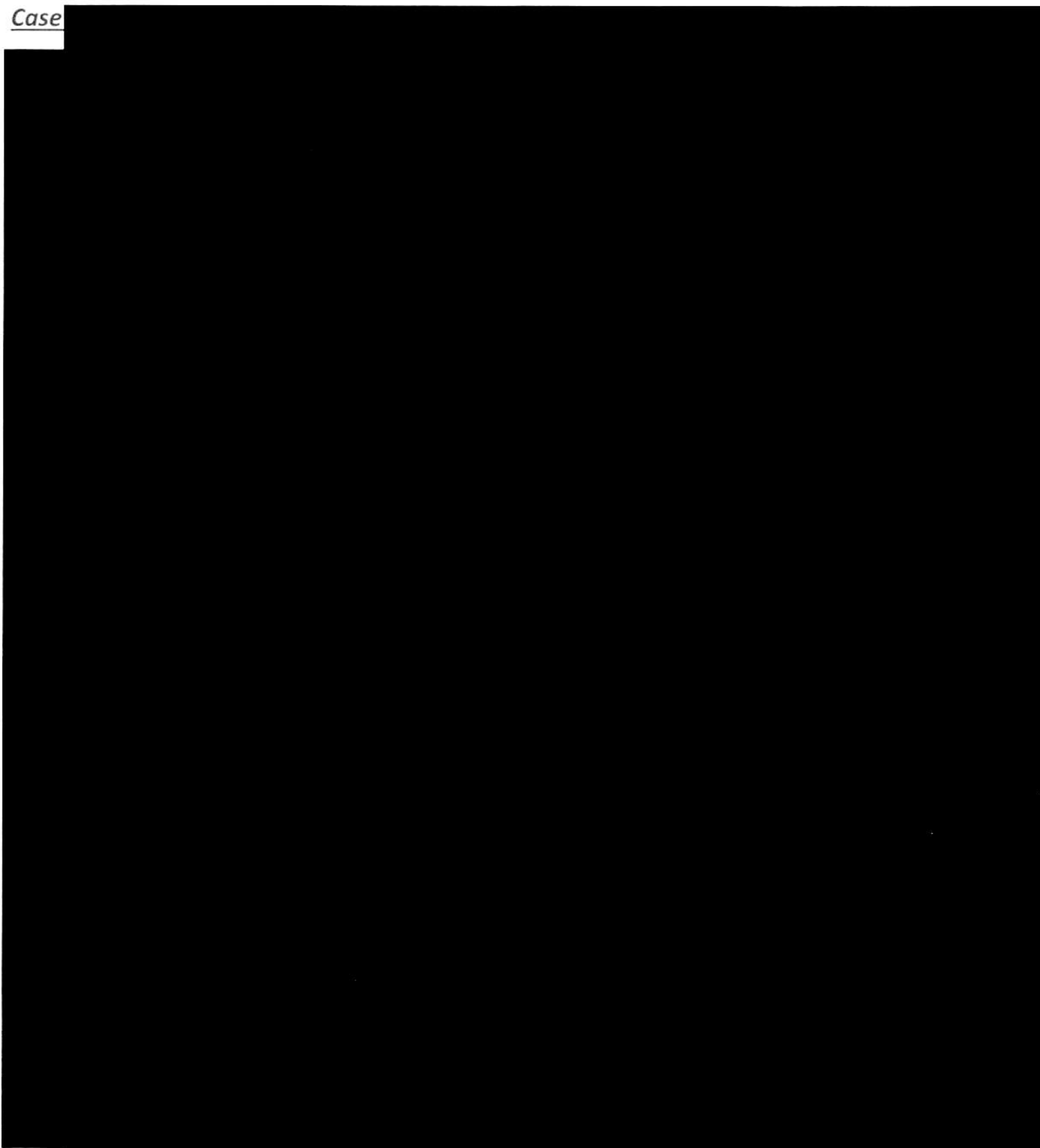

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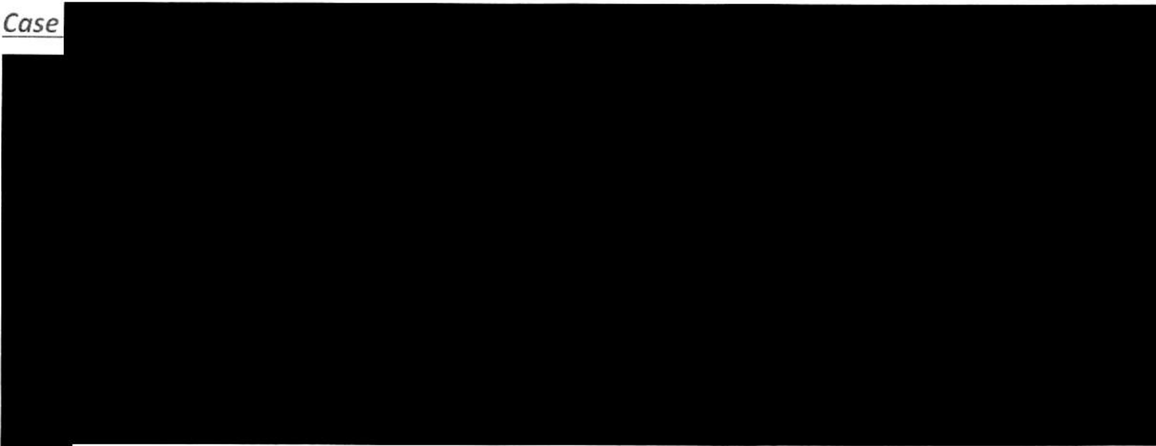

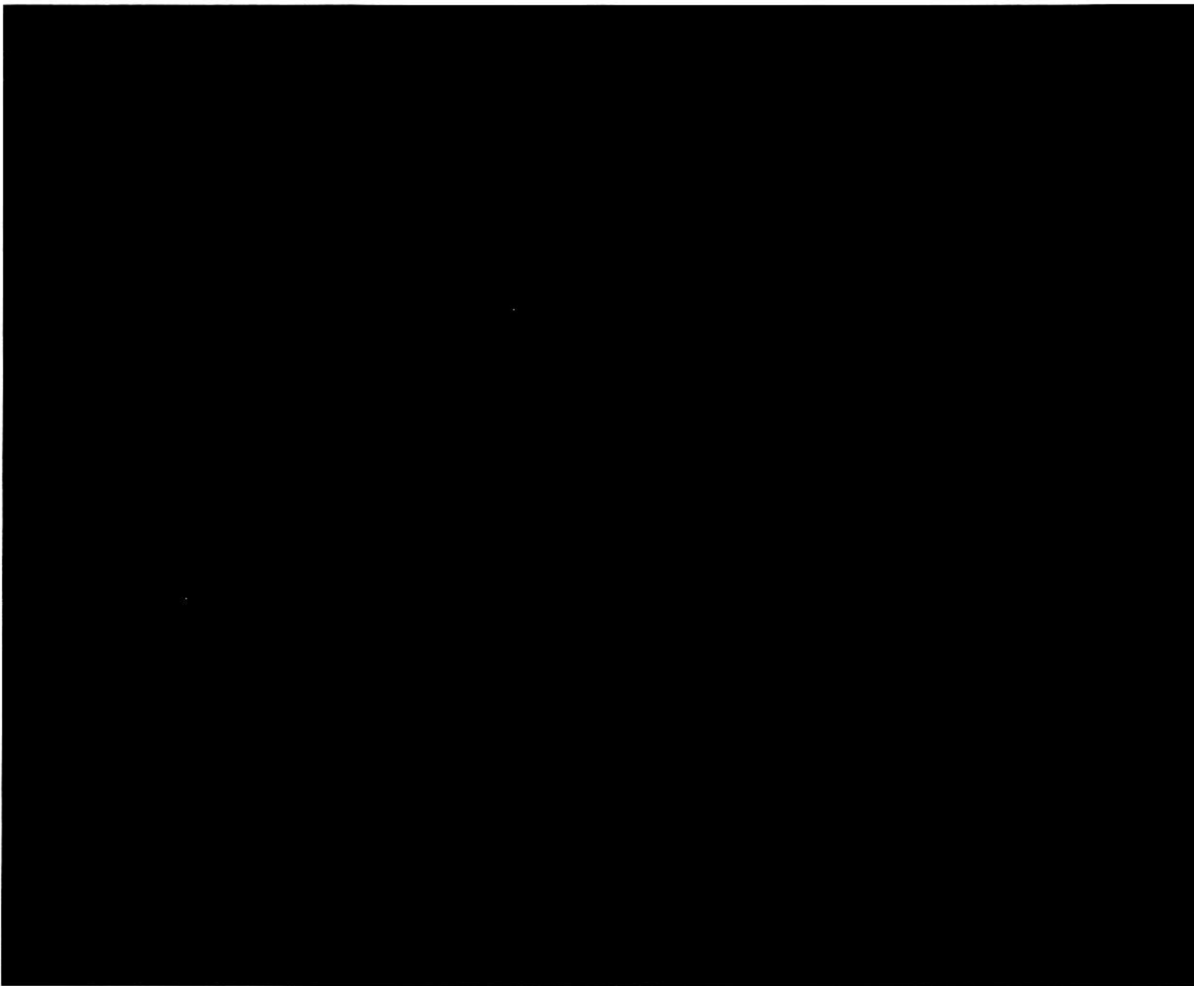

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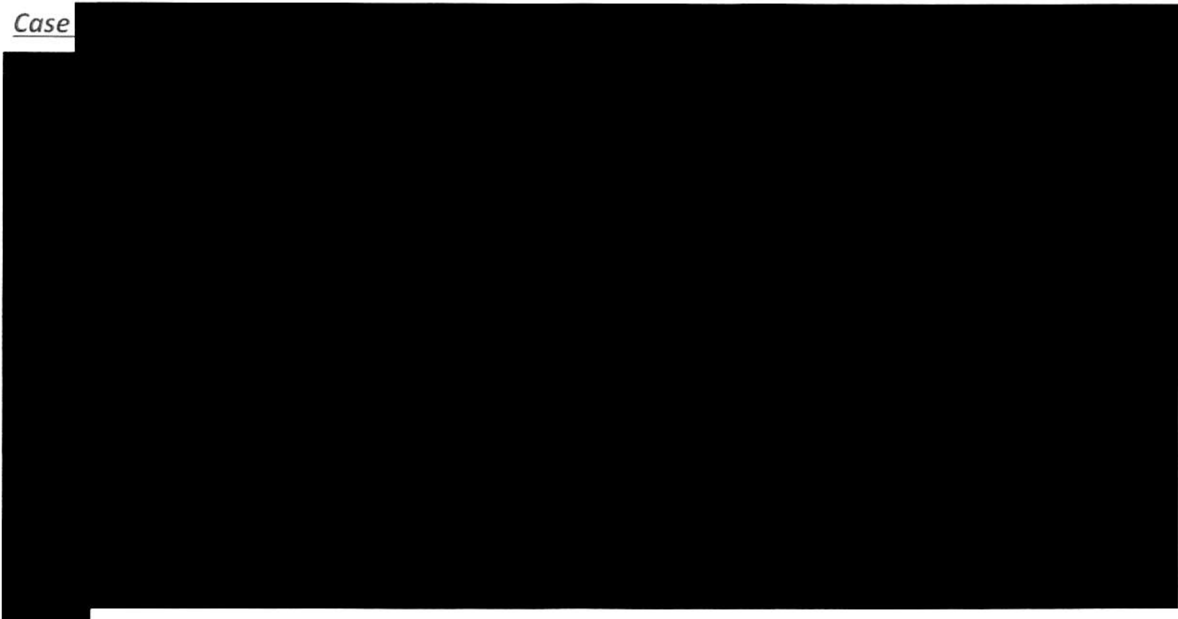

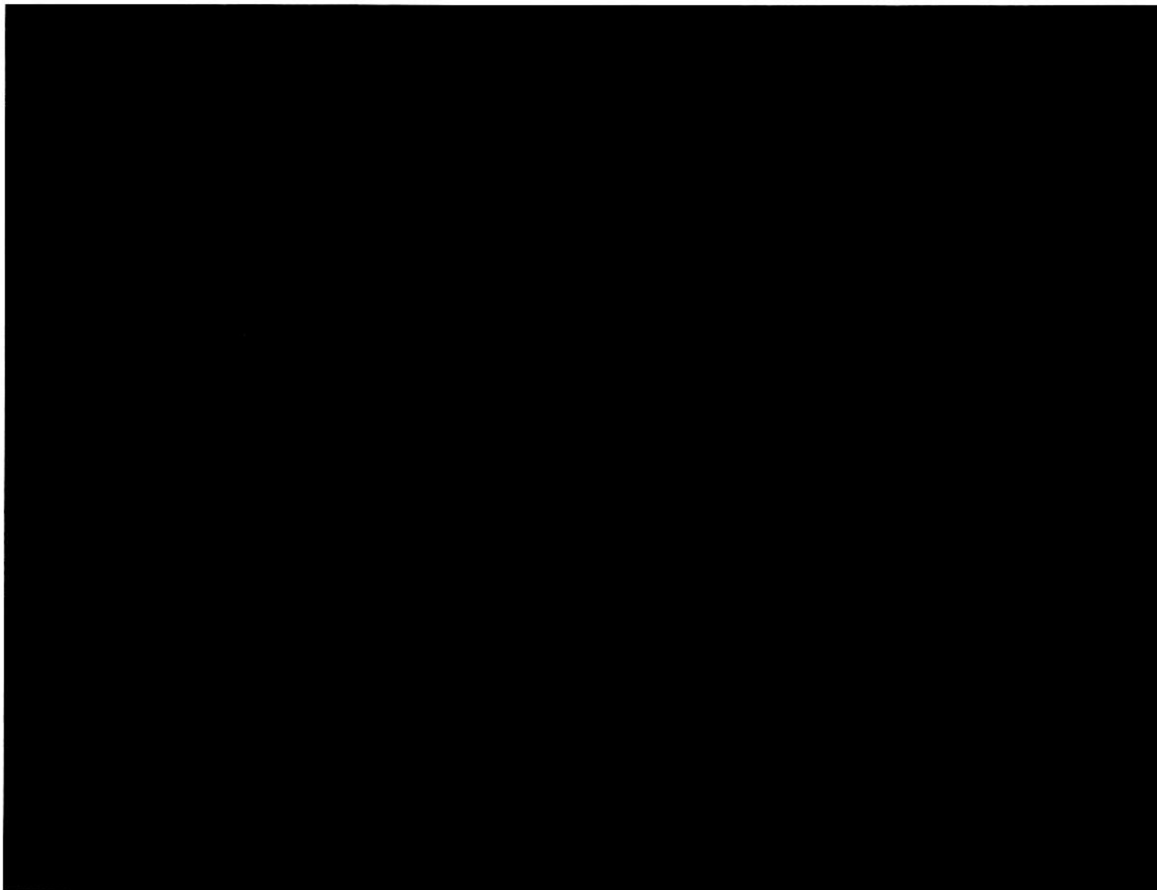

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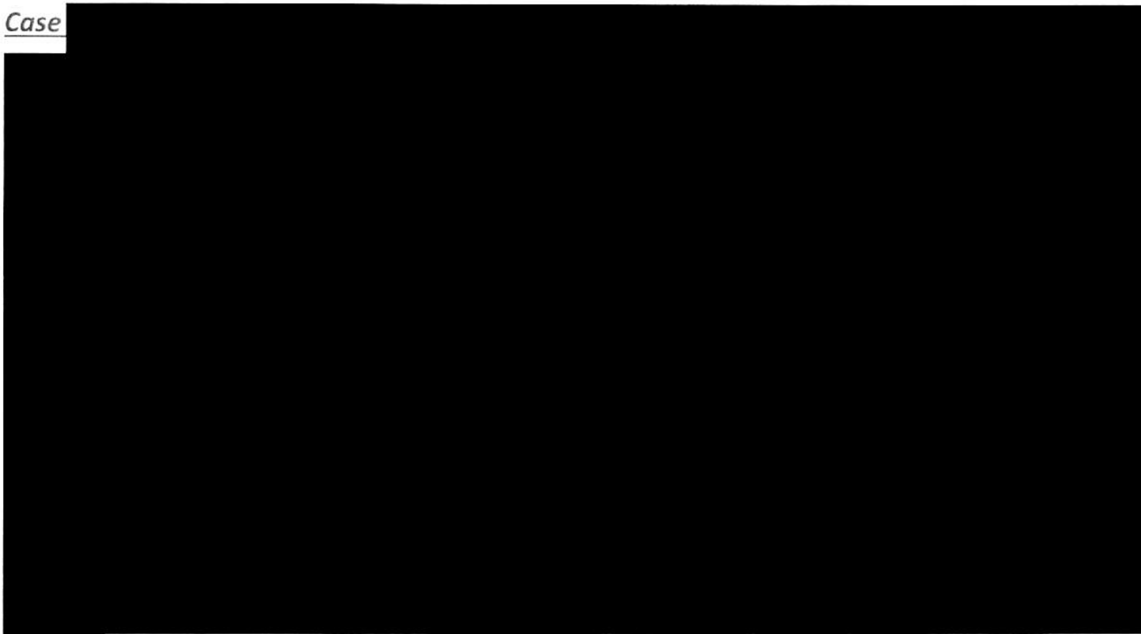

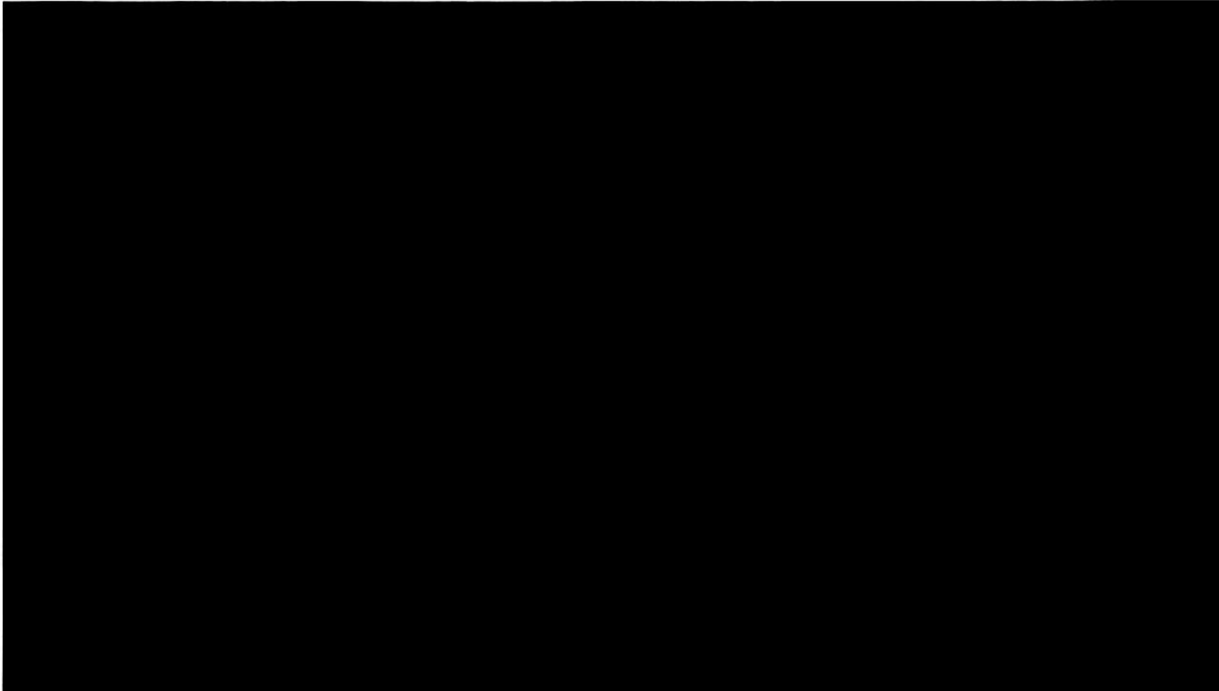

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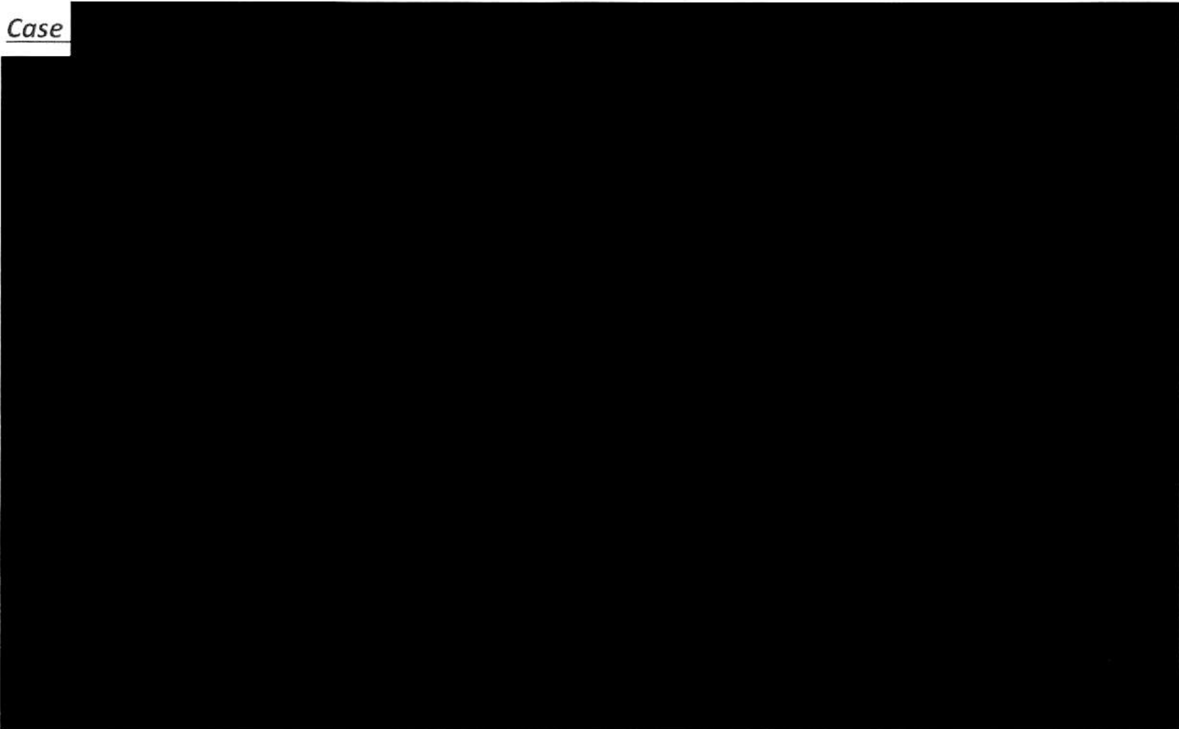

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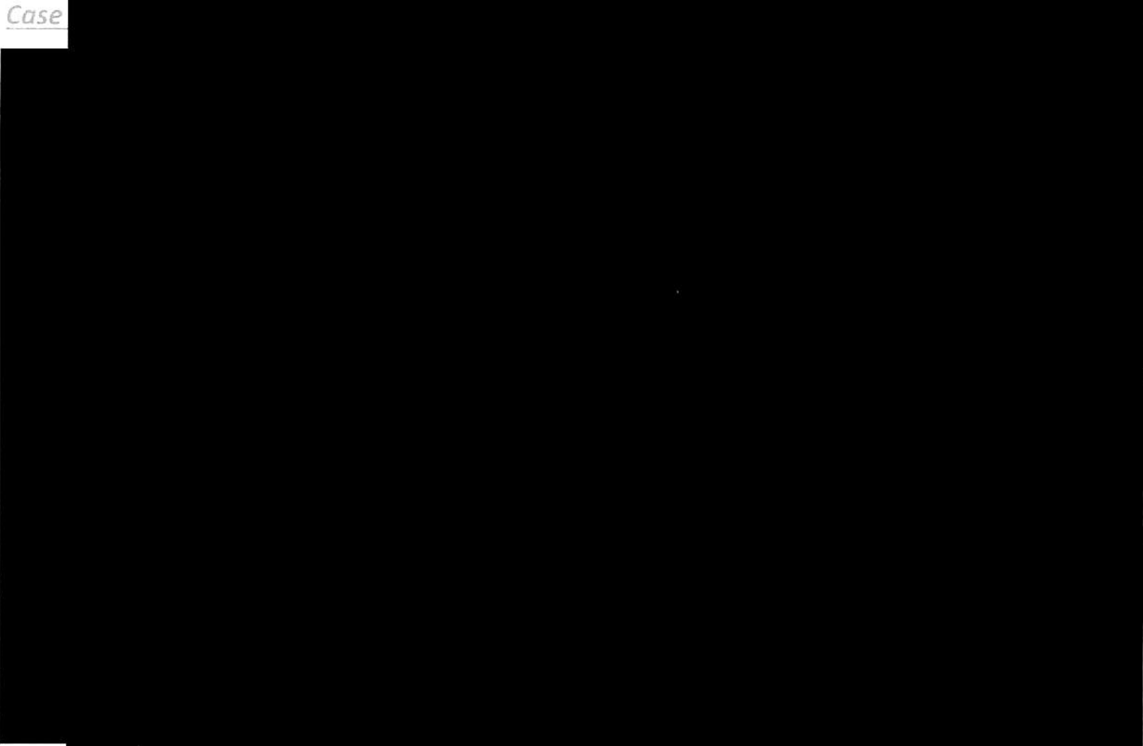

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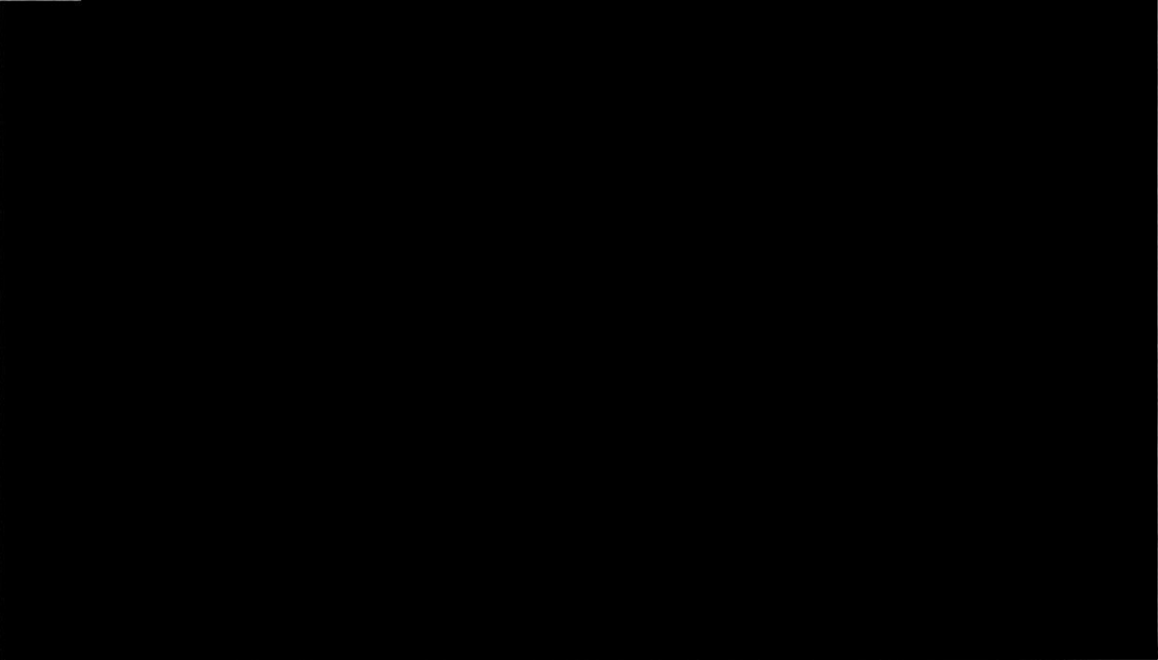

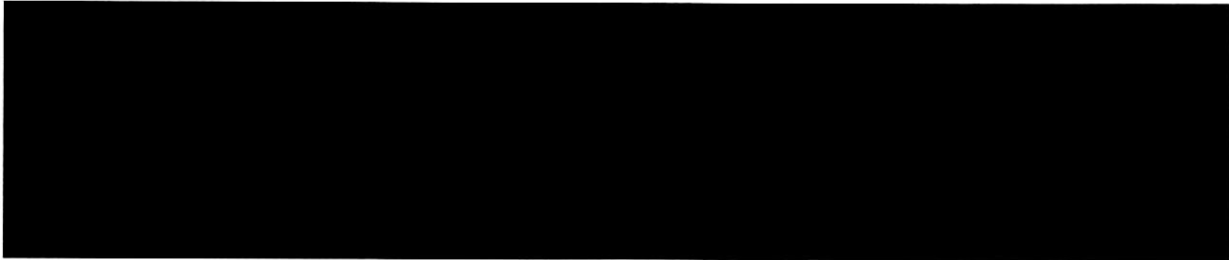

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*Case 0618705*

**Offender Background-** Case 0618705 was admitted into prison on 10/10/2017. The offender has a projected release date of 11/02/2024.

**Medical/MH overview:** This is a follow-up case. This case was reviewed in February 2020 and DTARC recommended a referral to UNC for a consultation requesting in writing what this type of surgery would entail. DTARC also wanted to know if the offender is a good candidate, the number of required appointments, the number of required procedures and cost. The offender has had a number of surgeries at UNC. The information received states the cost would be between $20,000 to $40,000. This is a 4 to 6 hour surgery and can require a significant recovery period. Follow-up surgery may be required that involves establishing a labia. The entire surgical process can take 1 year to complete with potential for complications. The initial surgery does require a hospital stay of 3 to 4 days and is a significant expense. Previously, it was documented the surgery is not medically necessary. It can be argued that this surgery could be considered medically necessary if there has been documented history that without this type of surgery, there would be severe psychiatric or psychological injuries to the person, for not being able to totally live the life they gender identify with. Psychologically, if a person is in the midst of transitioning, this would be considered the final stage of the process to complete the transition to female. In the community setting, oftentimes this surgery is considered cosmetic and is not covered by insurance. We do not have the authority at this time to approve the surgery. We can recommend follow-up appointments with UNC so surgery can possible be recommended and then send the case to a higher level to make the final decision. The committee will research if UNC has an GYN surgical specialist in network that can perform this type of surgery.

**FTARC meeting results:** This is a follow-up.

a) PREA Case History: 2 Non-PREA/Non-PREA 1st time SSH
b) Movement Concerns: Currently housed at a female facility; no major issues to note
c) Disciplinary: Yes
    i. Significant: 4/2020- wearing white uniform on yard; 3/2019 Substance Possession
d) CTS entries: 32
    i. Significant: 10/2019 Gender reassignment surgery/conditions of confinement
e) Current Screening reflects: Transgender
f) High Risk Status: None

***Accommodations reviewed:*** Gender Affirmation Surgery

***Decision:*** DTARC recommends an in-person consultation with an OBGYN surgical specialist with experience in gender affirmation surgery. DTARC is referring this case to the Director of Health and Wellness and the Assistant Commissioner for final determination.

**The next DTARC meeting**

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION

Civil Action No. 3:22-cv-0191

KANAUTICA ZAYRE-BROWN, )
)
Plaintiff, )
)
v. )
)
THE NORTH CAROLINA )
DEPARTMENT OF PUBLIC )
SAFETY, et al., )
)
Defendants. )
)

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DEPOSITION OF ARTHUR CAMPBELL, M.D.

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(Taken by plaintiff.)

Raleigh, North Carolina

April 18, 2023, 4:36 p.m.

Reported By:
SUSAN GALLAGHER, CA CSR, CVR-CM

1 requirement for severity to proceed with surgery. So
2 again, they have essentially tried to remove that as a
3 requirement. So the severity doesn't have any
4 influence at all on whether or not the individual
5 requires surgery in accordance with the WPATH.
6 Q So right now I'm just trying to discuss with
7 you why you concluded that gender-affirming surgery is
8 not considered medically necessary, and I feel that we
9 discussed that there are other conditions whereby only
10 25 to 35 percent of the people that suffer that
11 condition might need surgery, but that doesn't mean
12 that surgery for that 25 to 35 percent of people is not
13 medically necessary to treat that condition; correct?
14 MR. RODRIGUEZ: Objection. Mischaracterization of
15 the context in which that phrase or that sentence is
16 embedded in the position statement.
17 THE WITNESS: So I think my intent of this -- let
18 me think of a way I can describe it. So pick a
19 condition where surgery is clearly indicated. So let
20 me think of a condition. So complete disruption of the
21 ACL or PCL where surgery is a clear indication for
22 that. A far higher number of individuals undergo
23 surgery for that condition, for that diagnosis than
24 those who would not because it is medically necessary.
25 BY MS. MAFFETORE:

1 Q What about a chronic condition such as, for
2 example, ulcerative colitis?
3 A So I can't tell you a percentage of people with
4 ulcerative colitis that ultimately undergo surgery, but
5 I'm sure at some point that more than 25 percent of
6 those will ultimately undergo some sort of surgery
7 during the course of their disease.
8 Q What makes you say that you're sure about that?
9 A I have been taking care of many, many patients
10 with ulcerative colitis, and a very high percentage of
11 them end up having surgery at some point.
12 Q Can you state definitively that it's more than
13 35 percent?
14 A From my experience with my patients that I've
15 seen, yes.
16 Q You also discuss insurance coverage in your
17 position statement; correct?
18 A Correct.
19 Q Could another reason that the percentage of
20 people having gender-affirming surgery relate to a
21 historical lack of insurance coverage for those
22 procedures?
23 MR. RODRIGUEZ: Objection. Speculation.
24 You can answer.
25 THE WITNESS: Again, that wasn't the point of me

1 putting this in the position paper. The point was to
2 say that health insurance carriers, in particular, the
3 main driver of them providing coverage is medical
4 necessity. So they look at that same underlying
5 question, and if a procedure is medically necessary,
6 that insurance company is going to provide coverage for
7 that.
8 So when you reference it relating to
9 gender-affirming care or gender-affirming surgery, that
10 is clearly not the case. The majority of insurance
11 carriers, and that's at the federal level with both
12 Medicaid and Medicare, they recently changed some of
13 their criteria, but what's interesting is that their
14 2016 position paper after reviewing hundreds of studies
15 said there is no conclusive medical evidence to show
16 benefit to their patients with surgery.
17 And in 2021, I believe it was, they modified that
18 to some degree saying that there can be select patients
19 who need surgery, but they actually are in opposition
20 to the WPATH with Medicare saying that there are very
21 regimented criteria to get to the point where they need
22 surgery. Both TRICARE and the Veterans Administration
23 at the federal level, to my knowledge, are not
24 providing any gender-affirming surgery at this point.
25 At the state level, there's more than half the

1 states that still at this point either have an outright
2 ban against providing gender-affirming surgery coverage
3 or have no statement at all on that policy. So again,
4 in the broad context, if this were truly a
5 medically-necessary procedure, those very large health
6 maintenance organizations and government organizations
7 would be providing care because it is universally
8 agreed upon that this is medically necessary.
9 BY MS. MAFFETORE:
10 Q So is it your view that whether a treatment is
11 medically necessary is determined by whether insurers
12 agree that it is medically necessary?
13 MR. RODRIGUEZ: Objection. Mischaracterization of
14 the witness's testimony.
15 You can answer.
16 THE WITNESS: No. I described earlier, and I can
17 certainly describe it again, what medically necessary
18 means, and the insurance was only one factor included
19 in how you -- that was one of the associated factors
20 you could consider, but again, there was much more to
21 that explanation in addition to just the insurance
22 coverage. So that's not an exclusionary criteria, no.
23 BY MS. MAFFETORE:
24 Q Are there other plainly medically-necessary
25 treatments or medical equipment that insurance carriers

1 have historically refused to cover that are,
2 nonetheless, accepted as medically necessary?
3 MR. RODRIGUEZ: Objection to form. Speculation.
4 You can answer.
5 THE WITNESS: Historically, I'm sure there are
6 conditions that weren't previously covered that now are
7 covered.
8 BY MS. MAFFETORE:
9 Q When insulin pumps were not covered by
10 insurance companies, is it your position that they were
11 or were not still medically necessary for people
12 suffering from diabetes?
13 A So again, I think that when the insulin pump
14 came into emergence, there was a lot of questions about
15 the efficacy of that device, how effective it was going
16 to be. Over time it proved to be more and more
17 effective, and thereby insurance companies began to
18 cover that because they saw it as a medically-necessary
19 treatment. When it was first introduced there were
20 many questions, and I think that the same thing applies
21 here. There are many questions related to this. As
22 I've said before there is a lot more research needs to
23 be done before we can reach the point to conclusively
24 say that it is medically necessary.
25 Q Do you know whether Blue Cross Blue Shield of

1 North Carolina currently covers gender-affirming
2 surgery under its insurance plan?
3 A I believe they do.
4 Q How about Cigna?
5 A I believe they do as well.
6 Q What about United Healthcare?
7 A I'm not sure about United Healthcare.
8 Q Is there any major private medical insurance
9 provider of which you are aware that does not cover
10 gender-affirming surgery?
11 A I have not reviewed all the private insurance
12 companies.
13 Q Does DPS deny that such coverage is provided by
14 numerous insurance companies and health plans at the
15 present?
16 MR. RODRIGUEZ: Objection. Speculation as to what
17 DPS does or does not --
18 BY MS. MAFFETORE:
19 Q Do you deny?
20 A Do I deny what?
21 Q That such coverage is provided by numerous
22 insurance companies and health plans at present.
23 A No, and I never said I did. When I said half
24 the states don't cover it, half the states do, so.
25 Q Do you know whether the North Carolina state

1 employees health plan currently covers the cost of
2 gender-affirming surgery?
3 A If I'm not mistaken, there is a recent court
4 case that required them to now be providing that
5 coverage.
6 Q So I think that you discussed a moment ago the
7 CMS proposed decision memo?
8 A Correct.
9 Q And you cite that proposed decision memo in
10 your policy statement as support that gender-affirming
11 surgery is not medically necessary; correct?
12 A Again, it's not a policy statement.
13 Q Position statement. I apologize.
14 A Yeah. So again, at the time this was written,
15 that was before CMS had modified that, and that's what
16 I just talked about. So at the time this document was
17 written, that was indeed the case, but that has since
18 changed.
19 Q What is your understanding of CMS's position
20 currently?
21 A So CMS's position now is that there are
22 patients for whom they believe there is benefit to
23 gender-affirming surgery, and they set some pretty
24 strict criteria in how you meet that qualification.
25 Q But CMS does concede at this point that in

1 certain circumstances gender-affirming surgery is
2 medically necessary?
3 MR. RODRIGUEZ: Objection to form.
4 You can answer.
5 THE WITNESS: Yes, which is in line with my
6 position statement.
7 BY MS. MAFFETORE:
8 Q Do you know, does the CMS require
9 individualized determination on a case-by-case basis?
10 A Yes, I think that there was some language in
11 there that they require that.
12 Q So on page 7 of your policy statement --
13 position statement. See this is an error in my notes.
14 That's going to recur.
15 In your position statement on page 7, you
16 assert that 64 percent of state Medicaid programs don't
17 provide gender-affirming surgery. To your knowledge,
18 is this assertion of insurance coverage still accurate?
19 A No. I believe that's changed. I do believe
20 some other states -- like I said, I think I said a
21 minute ago that it's roughly 25 states at this point
22 that either don't or -- either have a blanket
23 prohibition against it or don't have a statement at
24 all. So again, because this was just a position
25 statement, this was meant to be a living document, and

1 had this been implemented across our utilization review
2 process, those are the kind of things that would be
3 continually updated, but again, this was written before
4 that.
5 Q So your understanding of the present state of
6 things, is it roughly 50-50?
7 A Roughly, yes.
8 Q If roughly 50 percent of all Medicaid programs
9 now cover gender-affirming surgery, does that change
10 your assessment of the medical necessity of
11 gender-affirming surgery in the general sense as
12 discussed in the position statement?
13 A It does show a trend toward more states
14 providing it.
15 Q So how does that affect your position as
16 expressed in your position statement?
17 A Again, it's a piece of data in the larger
18 picture. Again, I wouldn't -- I would never base it on
19 one single entity as to whether or not they provide
20 coverage. So I told you a few of them -- several of
21 those at the federal and state level already that do
22 not, and so it's more of a global picture.
23 You know, over time it would not be surprising
24 to me if there is evidence at some point to show this
25 more conclusively that this is indeed medically

1 necessary, but we're not there at this point. The data
2 is still very uncertain, and there's a lot of
3 questions, and we owe it to our patients to be sure.
4 Q Okay. So on page 9 of your policy statement,
5 you note that "treatment recommendations should be
6 developed through evidence-based medicine/practice and
7 are modified based on findings from continuous future
8 studies."
9 A Correct.
10 Q You go on to assert that "WPATH simply does not
11 utilize these criteria in developing their standards of
12 care"; is that correct?
13 A Yes. So they have moderated that to some
14 degree, and the Standards of Care 8 that came out,
15 there was a bit more -- and they acknowledged this as
16 well in their introduction in their Standards of Care
17 8. However, what I will say is that they also still
18 conclude that much of their recommendations are down to
19 the Delphi consensus process, which is basically a
20 consensus of a panel of experts, which is still rated
21 as the lowest level of medical evidence. So a huge
22 proportion of what is included in those standards are
23 still exactly that, consensus.
24 Q How do you know what WPATH's process is?
25 A It's written in the Standards of Care 8.

1 Q Are you familiar with any other standards of
2 care that have the same Delphi ranking as WPATH?
3 A Again, it's hard to find organizations that
4 publish true standards of care. We talked about that
5 earlier. Most professional organizations publish
6 clinical practice guidelines. So I'm hard-pressed to
7 find another organization that issues what they call
8 "standards of care."
9 Q You also cite, too, the Society for
10 Evidence-Based Gender Medicine and their criticisms of
11 WPATH; correct?
12 A Correct.
13 Q Do you believe that the Society for
14 Evidence-Based Gender Medicine is more reliable than
15 WPATH?
16 A I think it's a fairly new organization. They
17 have just recently formed and started gathering
18 evidence. I think it's yet another piece of evidence.
19 As I stated before, I don't place everything on one
20 particular organization, but I think it's important we
21 look at all these organizations.
22 I think that their mission statement, it sounds
23 promising, that they're going to be looking at this
24 from a purely evidence-based perspective, which is what
25 we need in medicine. So I'm optimistic, but at this

1 DTARC, and so there were very lengthy discussions that
2 occurred around what that input needed to look like and
3 how much of my position statement needs to be reflected
4 in those individual responses. So during the DTARC we
5 had lots and lots of discussions about the individual
6 case and the applicability of the position statement to
7 that particular case, and what Dr. Peiper and I talked
8 about was making sure that I capture that in my summary
9 that's going to be included from the DTARC.
10 Q Okay. So the text, or at least some part of
11 the text, of the position statement document
12 incorporated into case summaries for individual cases,
13 even though the position statement was not adopted?
14 MR. RODRIGUEZ: Object to form.
15 You can answer.
16 THE WITNESS: Yes. Portions of it were because
17 it's certainly applicable when we're looking at
18 gender-affirming surgery surgery and during the DTARC.
19 Q Okay. You can set that document aside. Thank
20 you.
21 I'm now handing the court reporter what will be
22 marked as Exhibit 7.
23 (Exhibit 7 marked for identification.)
24 BY MS. MAFFETORE:
25 Q Which is DAC 4463. Do you recognize this

1 document?
2 A Yes, ma'am.
3 Q And what is it?
4 A I think this was a previous version or draft
5 version before I got to the final position paper. I'm
6 not exactly sure if that was before or after, but I
7 think it was kind of a working format of that.
8 Q Okay. And if you'll go with me to page 4 of
9 Exhibit 7, at the very top of page 4 -- just let me
10 know when you get there.
11 A Okay.
12 Q At the very top of page 4, you have a header
13 that says "serious medical need", and it reads "Gender
14 dysphoria when thoroughly evaluated and comprehensively
15 diagnosed can indicate a serious medical need. While
16 complex, individuals with this diagnosis may eventually
17 be considered for gender-affirming surgery surgery."
18 Did you include this language in the draft?
19 A Did not include this specific language, no, but
20 certainly the intent is there. So what I did talk
21 about in the position statement was the medical
22 necessity requirement, the individualized review, and
23 the fact that although the bar to meet it is high, it
24 certainly can be met.
25 As a blanket -- it's not a blanket ban. I'd

1 say generally it is not medically necessary, but there
2 are going to be cases where it is going to be medically
3 necessary. So the intent of this is still there, maybe
4 not this exact language, but this is absolutely
5 consistent with my opinion on this.
6 Q Did you discuss this language with anybody?
7 A Not that I recall.
8 Q Why was this specific language removed from the
9 final draft -- or the most final draft that ever
10 existed?
11 A Again, I wish I could tell you which came
12 first. I'm not even sure that this did not come after
13 the other position statement.
14 Q And I'm happy to provide some context, if that
15 would be helpful.
16 A But I certainly don't remember why it was
17 included or not included.
18 Q So I'm handing the court reporter what we can
19 mark as Exhibit 8.
20 (Exhibit 8 marked for identification.)
21 BY MS. MAFFETORE:
22 Q Do you recognize this document?
23 A I do.
24 Q And what is it?
25 A It's an email from myself to Dr. Junker.

1 Q Okay. And I will represent to you this
2 document, DAC 4462, is the Bates number that
3 immediately precedes the Bates number of the document
4 that we were just discussing as Exhibit 7, which I
5 understand to mean that Exhibit 7 is an attachment to
6 this email. Does that provide you some clarification
7 on the timeline of this draft as it relates to the
8 final draft of the position statement?
9 A I can't remember the date of the position
10 statement. Oh, 23 March.
11 Again, these were -- it appears that these were
12 both being at least drafted concurrently. If what you
13 told me is correct and this is the version that was
14 sent with this email, then it was before this final
15 version, but again, I'd been working on this document
16 for some time, as I discussed earlier. So they were
17 both kind of in existence at around at the same time.
18 Q Understood. So at some point between
19 February 22nd and March 23rd, you decided to remove the
20 passage that we were just discussing from the position
21 statement; correct?
22 A Not necessarily. So as I look at this, I think
23 that there's a little bit different content and context
24 to this document you just provided me than what's in
25 this. So the intent was a little bit different. And

1 again, because this was a working document that was a
2 draft that was -- that I was developing independently,
3 there were a couple of different versions of this that
4 maybe took a little bit different approach to it. So
5 again, if you notice the table of contents on this, it
6 is different than what's on here. So it's not just
7 that that paragraph was removed. The content is
8 different, but the intent and the overall purpose of
9 both of these are the same, and again, we never got to
10 what would have been a final version of this.
11 Q Understood. So we can set that aside for now
12 or probably forever.
13 I'm going to hand that the court reporter what
14 will be marked as Exhibit 9.
15 (Exhibit 9 marked for identification.)
16 BY MS. MAFFETORE:
17 Q This is Bates 6532. Do you recognize this
18 document?
19 A I do.
20 Q And what is it?
21 A It's an email from myself to Dr. Peiper.
22 Q And what is the date on this document?
23 A 17 February 2022.
24 Q Is that the same day as of the DTARC meeting
25 that was held for Mrs. Zayre-Brown?

1 A Yes.
2 Q What is the attachment to this document?
3 A Again, appears to be the position statement.
4 Q Is this one entitled "Medical Director Position
5 Statement"?
6 A Yes.
7 Q You state, "I will provide summary for our
8 DTARC inclusion."
9 What do you mean by that?
10 A So again, similar to how I responded to the
11 last question about the fact that we were trying to
12 figure out how we incorporate portions, applicable
13 portions of the position statement into our DTARC
14 analysis, and how we include that will ultimately be
15 the summaries coming out of the DTARC.
16 Q And what did you mean here when you say that
17 this represents your "overall Gestalt on these cases"?
18 A So I think I mentioned earlier that what we
19 were doing at this point was trying to begin uploading
20 our individual input to the DTARC in advance of the
21 meeting so that we had a document to present to the
22 members of the DTARC that had our summaries on it, and
23 this was around at the same time that we were doing
24 that. So it was something that Dr. Peiper and I had
25 talked about independently to see if it would make the

1 committee more consistent and more efficient in
2 evaluating these cases.
3 Q So did you believe that this policy should
4 apply to all cases requesting gender-affirming surgery
5 surgery?
6 A Again, it's not a policy.
7 Q Position.
8 A But certainly aspects of this must be
9 considered when you're making that medically-necessary
10 determination for gender-affirming surgery surgery.
11 Q I'm going to hand to the court reporter what is
12 going to be marked as Exhibit 10.
13 (Exhibit 10 marked for identification.)
14 BY MS. MAFFETORE:
15 Q Do you recognize this document?
16 A I do.
17 Q And what is it?
18 A Yet another iteration or synopsis of what would
19 ultimately be my position statement.
20 Q Okay. And if you did note the Bates No. DAC
21 6533. That is the Bates number that is immediately
22 subsequent to the email that we were just reviewing.
23 Do you believe this to be the attachment to that email?
24 A Sounds like it is, yes.
25 Q Okay. And this document is entitled "Medical

1 Director Position Statement"; correct?
2 A Correct.
3 Q And all of the other drafts of position
4 statements we discussed have been entitled DTARC
5 position statement; correct?
6 A Correct.
7 Q Is this document the precursor to what became
8 or was considered as the DTARC position statement?
9 A Again, I think that all of these were different
10 versions. Again, as I described, this was a live,
11 working document draft that we were working on. So
12 it's very likely that we -- these were all different
13 versions that existed at the same time. So I don't
14 know that there was an evolution, per se.
15 Q Sure. How did it become the case that the
16 position statement you were writing started as a
17 statement of the medical director's position that
18 ultimately ended up being considered a position
19 statement for DTARC?
20 A So as I discussed before, this was in my role
21 as the chief medical officer, my attempt to try to
22 standardize the evaluation of medical necessity for
23 gender-affirming surgery surgery, and initially I
24 started it in my capacity as the medical director, and
25 then the intent was to expand that further into being

1 an overall policy -- I did the same thing you did --
2 overall position statement for the DTARC. So that in
3 other words, it was to provide the entire committee an
4 understanding of my medical take on this particular
5 procedure.
6 Q So it was your idea to try to introduce this as
7 a position statement of the DTARC as a whole?
8 A Yes.
9 Q Does the position statement reflect your view
10 as medical director regarding gender-affirming surgery
11 surgery?
12 A I would say it reflects my concerns and my
13 considerations in looking at this procedure.
14 Q Okay. Does the position statement represent
15 your frame of mind when you were considering whether
16 vulvoplasty was medically necessary for Mrs.
17 Zayre-Brown?
18 A I don't think it represents my frame of mind
19 for a particular case, no.
20 Q Does the position statement represent your
21 views on the medical necessity of vulvoplasty while you
22 were considering the request for vulvoplasty for Mrs.
23 Zayre-Brown?
24 A Again, I think I'd answer the same way. This
25 was, first of all, not specific for vulvoplasty, not

1 specific for a particular offender. This was a very
2 large-scale attempt to try to standardize our
3 evaluations of gender-affirming surgery surgery in the
4 context of medical necessity so that we had an
5 objective way of determining if and when offenders
6 would meet that bar, and therefore, surgery would be
7 indicated for them.
8 Q Did you utilize this document, which you
9 created as a standardized way to make these
10 assessments, while you were trying to make the
11 assessment with regard to Mrs. Zayre-Brown's request
12 for vulvoplasty?
13 MR. RODRIGUEZ: Objection as to vague as to which
14 document.
15 MS. MAFFETORE: The medical position statement that
16 we are currently discussing.
17 THE WITNESS: Which exhibit?
18 MS. MAFFETORE: Exhibit 10.
19 MR. RODRIGUEZ: Okay.
20 THE WITNESS: So I would say that this is -- you
21 know, this is certainly not inconsistent with any
22 version of this. So there is no version of this that
23 conflicts with the others. They just include different
24 aspects and different considerations and, again,
25 represent an evolution of the document over time and

1 different versions that were being prepared.
2 BY MS. MAFFETORE:
3 Q Okay. So my question is, the considerations
4 that are discussed in this medical director position
5 statement, did you also consider these considerations
6 as you were reviewing Mrs. Zayre-Brown's request for
7 vulvoplasty?
8 A So these were considered in any cases --
9 Q So I'm asking you specifically about Mrs.
10 Zayre-Brown's --
11 A Yes.
12 Q Okay. Thank you.
13 Did anything from your review of specifically
14 Mrs. Zayre-Brown's case lead you to believe that she
15 would experience increased suicidality if she received
16 vulvoplasty?
17 A No.
18 Q If not, why did that factor into your medical
19 analysis?
20 MR. RODRIGUEZ: Object to assumption of facts.
21 You can answer.
22 THE WITNESS: So as I discussed before, when you do
23 that risk-benefit analysis, you do that with every
24 case, and again, there's the -- I'll call it the
25 positive and negative way of looking at it, the

1 converse way of looking at that analysis. So what is
2 the risk of not providing a procedure for a particular
3 offender in a particular situation? And if you do
4 provide the procedure, what are those risks that you
5 may see with that? So again, I think that consistent
6 analysis occurs in every case, including Mrs.
7 Zayre-Brown's.
8 BY MS. MAFFETORE:
9 Q Did you have any concerns of persistent or
10 increased psychiatric morbidity or mortality with
11 respect to Mrs. Zayre-Brown if she received
12 vulvoplasty?
13 A So the consideration, as I have discussed and
14 as the committee discussed, is that based on her
15 current clinical condition and looking at her clinical
16 condition and clinical mental health, particularly
17 clinical encounters certainly over the past year, and
18 the summaries provided by both Dr. Peiper and Dr.
19 Sheitman was that she was not in a state where we felt
20 that her condition was deteriorating or that she was in
21 such a state that surgery would now be medically
22 indicated.
23 Q So I was asking, did you believe -- did you
24 have concerns about persistent or increased psychiatric
25 morbidity or mortality if she did receive a

1 vulvoplasty?
2 A I don't remember those specific concerns for
3 her, no.
4 Q Okay. To your knowledge, has Mrs. Zayre-Brown
5 ever expressed regret for any of her prior
6 gender-affirming surgery surgeries?
7 A Not to my knowledge, no.
8 Q Do you have any reason to believe that if Mrs.
9 Zayre-Brown had a vulvoplasty, she would subsequently
10 regret that?
11 A Difficult to say, again, for the same reason we
12 talked about before is that we really don't know what
13 leads to individuals having regret or -- you know,
14 related to those procedures. So more research is
15 needed for us to be able to make that determination
16 objectively.
17 Q So does that mean that you don't have any
18 specific reason to believe that Mrs. Zayre-Brown
19 specifically would subsequently regret a vulvoplasty
20 had she received one?
21 A No, I don't have any specific regret -- or that
22 she had regret. I also don't have any specific
23 evidence that it would be a tremendous benefit to her
24 either because that's the state of the medical
25 literature at this point.

1 Q Did anything from Mrs. Zayre-Brown's medical
2 history lead you to believe that she is likely to
3 de-transition?
4 A Nothing specifically, no.
5 Q So why did that factor into your medical
6 analysis specifically as it related to Mrs.
7 Zayre-Brown?
8 MR. RODRIGUEZ: Objection. Mischaracterization of
9 the witness's testimony and the documents presented.
10 MS. MAFFETORE: I asked specifically about the
11 medical analysis about Mrs. Zayre-Brown. So I'm not
12 asking about this specific document. I asked him about
13 his medical analysis as it pertains to Mrs.
14 Zayre-Brown.
15 MR. RODRIGUEZ: So medical analysis in the general
16 sense, not the documents.
17 MS. MAFFETORE: Not this document.
18 MR. RODRIGUEZ: Or any document.
19 MS. MAFFETORE: It's in the case summary, but we're
20 not --
21 MR. RODRIGUEZ: Right. That's why I'm trying to
22 make sure --
23 (Simultaneous speakers.)
24 MR. RODRIGUEZ: So same objection.
25 You can answer.

1 THE WITNESS: Repeat the question one more time.
2 BY MS. MAFFETORE:
3 Q Why did the discussion of de-transition factor
4 into your medical analysis of Mrs. Zayre-Brown?
5 THE WITNESS: Same objection as to
6 mischaracterization of the medical analysis that
7 appears in various exhibits to this deposition.
8 You can answer.
9 THE WITNESS: So same answer as I just said a few
10 minutes ago in that there's really inconclusive data at
11 this point as to exactly why some patients desist or
12 de-transition. So it's more the uncertainty as any
13 specific concerns because the evidence is still
14 lacking.
15 BY MS. MAFFETORE:
16 Q Are there any circumstances under which you
17 would have concluded that vulvoplasty is medically
18 necessary for Mrs. Zayre-Brown?
19 A Sure. Conceivably, there could be.
20 Q What are those circumstances?
21 A So again, going back to the condition you're
22 treating, which is gender dysphoria, so I guess just
23 very quickly, I know we're short on time, but dysphoria
24 has unfortunately become almost exclusively associated
25 with gender dysphoria, but dysphoria is actually in the

1 DSM-V is on the spectrum of obsessive-compulsive
2 disorders.
3 So it's a general feeling of unease,
4 restlessness, frustration. It's associated with
5 probably at least two-dozen other psychiatric
6 conditions. It's not exclusive to gender dysphoria.
7 So the dysphoria is what we are treating.
8 So indications of that dysphoria can be
9 indications that you obtain from the subjective or
10 objective portion of the evaluation of the patient. So
11 it could be the fact that they're having trouble
12 sleeping at either extreme, either insomnia or
13 hypersomnia. It can be that they have anhedonia or
14 lack of interest in activities they were previously
15 interested in.
16 They can spend an exorbitant amount of time
17 perseverating about a problem, blaming themselves for
18 things. They can have either increased or decreased
19 energy level. Their concentration can be affected to
20 where they're not able to focus on activities, not able
21 to participate in activities they normally focus on.
22 We look at appetite. We look at psychomotor
23 agitation. Are they anxious and agitated? Are they
24 striking out? And then you look at other things such
25 as are there SIB indications? Are there suicidal

1 ideation?
2 So again, that collective sphere that composes
3 gender dysphoria, or dysphoria more broadly, are the
4 things we would look at to determine if an individual
5 is not doing well or needs accelerated treatment for
6 that condition.
7 Q And so the various things that you just
8 discussed are circumstances that would have potentially
9 led you to conclude that gender-affirming surgery
10 surgery is medically necessary for Mrs. Zayre-Brown?
11 A Again, this is a theoretical. You look at the
12 global picture. I'll go back to what I said before is
13 that we look at the clinical course of that particular
14 patient. In other words, how are they doing overall?
15 What's been the trend with them, and what are the other
16 indicators? None of them, in and of themselves, would
17 mandate that surgery should be indicated, but globally
18 they can mandate that because what it does is it tips
19 that risk-benefit scale.
20 Q Do you believe that gender dysphoria is a
21 legitimate medical diagnosis?
22 A I do.
23 Q Do you believe that gender dysphoria is a
24 disability?
25 A Not in and of itself, but again, like every

1 other condition, if the manifestations of that -- and
2 again, it needs to have significant social or
3 occupational impact, adverse impact on that particular
4 individual, and that previous treatments or current
5 treatments have been insufficient to treat that
6 condition. So in other words, you're always trying to
7 improve that patient's condition to the point where
8 they are not disabled, but certainly they can reach a
9 point theoretically where they can be disabled.
10 Q Do you believe that DPS should use health and
11 wellness services resources to treat the other aspects
12 of gender dysphoria?
13 A Yes, ma'am.
14 Q Are there aspects of gender-dysphoria treatment
15 that you think DPS should not have to provide?
16 A No.
17 MS. MAFFETORE: We can go off the record.
18 (Pause in proceedings.)
19 BY MS. MAFFETORE:
20 Q Are you aware if Dr. Sheitman ever personally
21 treated Kanautica?
22 A I'm not aware.
23 Q How about Dr. Peiper?
24 A I couldn't say with certainty.
25 Q Have you ever personally treated Kanautica?

1 A I have not.
2 Q Have you ever met Kanautica?
3 A No.
4 MS. MAFFETORE: I don't have any further questions.
5 (Pause in proceedings.)
6 MR. RODRIGUEZ: We do not have any questions.
7 (Deposition concluded at 6:52. Signature
8 reserved.)
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STATE OF NORTH CAROLINA

COUNTY OF ORANGE

CERTIFICATE OF REPORTER

I, SUSAN L. GALLAGHER, CA CSR, CVR-CM, Notary Public do hereby certify that ARTHUR CAMPBELL, M.D. was duly sworn by me prior to the taking of the foregoing deposition, that said deposition was taken and transcribed under my supervision and direction; that the parties were present as stated; and that I am not of counsel for or in the employment of any of the parties to this action, nor am I financially or otherwise interested in the outcome of this action.

I do further certify that the foregoing 88 pages constitute a true and accurate transcript of the testimony, and that the witness is being given 30 days in which to affix his notarized signature to the testimony.

This the 6th day of May, 2023.

________________________________

SUSAN L. GALLAGHER, CA CSR, CVR-CM

Notary Public #20230500301

WITNESS CERTIFICATION

I, ARTHUR CAMPBELL, M.D., hereby certify:

That I have read and examined the contents of the foregoing testimony as given by me on April 18, 2023, and that to the best of my knowledge and belief the foregoing pages are a complete and accurate record of the testimony given by me, except as noted on the attached Addendum A hereto.

I have __ have not __ made changes/corrections.

____________________________________

ARTHUR CAMPBELL, M.D.

I,______________________, Notary Public for the County of _________________, State of ____________________, hereby certify that the herein above-named appeared before me this the _______ day of ______________, _____; and that I personally witnessed the execution of this document for the intents and purposes as herein above described.

____________________________________

Notary Public

(SEAL)

My Notary Seal Expires:

_______________________________

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION

Civil Action No. 3:22-cv-0191

KANAUTICA ZAYRE-BROWN, )
)
Plaintiff, )
)
v. )
)
THE NORTH CAROLINA )
DEPARTMENT OF PUBLIC )
SAFETY, et al., )
)
Defendants. )
)

---

DEPOSITION OF BRIAN SHEITMAN, M.D.

---

(Taken by plaintiff.)

Raleigh, North Carolina

May 17, 2023, 10:59 a.m.

Reported By:
SUSAN GALLAGHER, CA CSR, CVR-CM

**CONTAINS GENERAL CONFIDENTIAL INFORMATION**

1 community standards?
2 A Yes.
3 Q And in doing that, how are community standards
4 determined?
5 A Well, I look at how we would compare to if
6 people were at the State psychiatric hospitals or at
7 maybe UNC inpatient psychiatric hospital or where I had
8 worked at UNC Healthcare at WakeBrook.
9 Q Okay. So -- so it's basically a state standard
10 as opposed to a national standard?
11 A Yes, for the most part, because I think there's
12 such variability across the nation when you look at
13 standards that I thought it would be more reasonable
14 for it to be what would be in close proximity in North
15 Carolina.
16 Q And what, according to your understanding, are
17 the accepted community standards for treatment of
18 gender dysphoria?
19 A Yeah, That's -- that's -- I'm not sure I can
20 give you an easy answer for that. I think there's a
21 range of services that are provided. It depends who
22 you talk to and who you believe. I'm not sure there's
23 one generally accepted community standard.
24 Q Okay. On the sixth page of this exhibit, which
25 has the page number 361 in the lower right-hand corner,

1 in the fourth line of the left-hand column, the article
2 states that, quote, The suicide rate in correctional
3 facilities is high.
4 What's your -- is that something you still
5 believe?
6 A Yes.
7 Q And what's your best estimate of the rate of
8 suicide in correctional facilities?
9 A Completed suicide or suicide attempt? I assume
10 completed suicide?
11 Q Let's -- let's -- let's talk first about
12 suicide attempt.
13 A I don't know the exact number. Again, I'm not
14 trying to be, like, evasive. I know it's -- you get
15 into issues of definition -- like, is it self injury,
16 is it suicide, and then you sort of -- you get all
17 these different kinds of numbers. I think it's fair,
18 and I feel strongly saying, compared to the general
19 population, the suicide attempts and completed suicides
20 tend to be higher in prison.
21 Q And do you have, like, just a general estimate
22 of how much higher? Is it twice as high? Is it --
23 A You know, I actually don't know. I think it's
24 significantly higher, but I don't know the exact
25 number. I should, but I don't.

1 Q And that's true both for suicide attempts and
2 completed suicides?
3 A I would -- suicide attempts are a lot harder to
4 get at, but I think the answer is yes.
5 Q And do you have any information about how the
6 suicide rate in correctional facilities in North
7 Carolina compares to that in other states?
8 A I think it's -- it's not much. I think it's --
9 it compares favorably, I believe. Last year, there was
10 a higher suicide rate in North Carolina. This year so
11 far, it looks like it's gone back down again compared
12 to historical years. But I believe that we're on
13 the -- well, I shouldn't say -- I think, and I could be
14 wrong, but we're on the lower end, I believe.
15 It's also not as accessible data as -- as one
16 would think, but I think there's a whole Bureau of
17 Justice statistics data that I looked at. I don't
18 remember off the top of my head. I apologize.
19 Q That's fine. And when you say last year was a
20 higher rate in North Carolina, did you mean in the
21 state generally or in the state prison system?
22 A I was referring to the state prison system.
23 Q Thank you. That paragraph, which is continued
24 on from the previous pages discussion of incarcerated
25 people sometimes feigning psychiatric symptoms, says

1 that, quote --
2 MS. BRENNAN: Jon -- Jon, can you give me a second?
3 Where -- where are you at again? Still on 361?
4 MR. DAVIDSON: On page 6 -- I'm sorry. It's the
5 sixth page. It says "361" in the lower right-hand
6 corner.
7 BY MR. DAVIDSON:
8 Q It's the same paragraph that we were talking
9 about the suicide rate. The previous page -- bottom of
10 the previous page says, "The aforementioned motivations
11 for feigning psychiatric symptoms are largely
12 nonexistent in general."
13 The next page says, "Incarcerated people who
14 engage in such tactics often have personality disorders
15 and other risk factors for suicide, and thus cannot be
16 easily dismissed as low risk for suicide."
17 Is that something you still believe?
18 A Yeah, I can't find it, but I -- I remember it.
19 I do believe it, yes.
20 MS. BRENNAN: And I would just note for the record
21 that that entire statement was not read.
22 BY MR. DAVIDSON:
23 Q Okay. That sentence says, "further complicate
24 the matter is that the suicide rate in correctional
25 facilities is high. And incarcerated people who engage

1 in such tactics often have personality disorders and
2 other risk factors for suicide, and thus cannot easily
3 be dismissed as low risk for suicide."
4 MS. BRENNAN: The -- the issue I took was that you
5 also started with "the aforementioned motivations,"
6 that sentence, and you did not read that entire
7 sentence.
8 MR. DAVIDSON: Okay. That's fine.
9 BY MR. DAVIDSON:
10 Q Is experiencing gender dysphoria a risk factor
11 for suicide?
12 A I -- I know there's a lot of literature that
13 makes an association between the two. I'm not sure
14 it's an established risk factor, but I -- I have seen
15 that in the literature.
16 Q Okay. And -- and do you have any belief about
17 how the level of completed suicide among transgender
18 people compares to the level of completed suicide among
19 people who are not transgender?
20 A Yeah, I think the issue that I struggle with is
21 the psychiatric comorbidity. So I haven't seen where
22 you sort out the psychiatric comorbidities and you're
23 just left with the gender dysphoria. So -- so that's
24 why I'm not sure.
25 Q And is that also true with respect to suicide

1 attempts?
2 A I would -- the same issues I think would be in
3 play. I don't know the actual numbers.
4 Q Are you familiar with the term "DTARC"?
5 A Yes.
6 Q And is that the Division Accommodation Review
7 Committee?
8 A Yeah, I think you left out of the T part of it,
9 but yes, I think.
10 Q Oh, sorry. Division Transgender Accommodation
11 Review Committee. When did you first become a member
12 of DTARC?
13 A You know, I don't remember the exact date, but
14 it was -- I could relate it to this case. It was a
15 little bit before Ms. Brown was transferred to the
16 female facility, whatever that date was.
17 Q And by "transferred to the female facility," do
18 you mean Anson Correctional Institute?
19 A I believe so.
20 Q And are you still a member of DTARC?
21 A I am.
22 Q Okay. What's your understanding of the purpose
23 of DTARC?
24 A I think it's to -- it's like the equate of,
25 like, a utilization review where we -- to make sure

1 that we're giving these people the best care, that
2 we're getting the most input, that everybody's giving
3 their opinions. So, you know, it's done in a way that
4 things are less likely to slip through the cracks.
5 Q And does DTARC make final decisions about
6 accommodation requests that come to it, or does it --
7 does it make recommendations to someone else?
8 A I think it makes recommendations to the
9 leadership, and the -- I think the leadership folks are
10 the ones who actually sign off, I believe.
11 Q And do you know, is that the process of -- of a
12 committee making recommendations that are signed off by
13 the leadership, is that the same process that is
14 followed for other populations or conditions?
15 A I don't -- I'm not aware of that level of
16 scrutiny.
17 Q Do you know why greater scrutiny would be given
18 to the treatment of transgender prisoners?
19 MS. BRENNAN: Objection. Mischaracterizes.
20 You may answer.
21 THE WITNESS: I don't know.
22 BY MR. DAVIDSON:
23 Q Are -- are -- for the treatment of other
24 conditions other than gender -- gender dysphoria, are
25 those normally sent to utilization management?

1 A Could you ask the question again? Sorry.
2 Q For the treatment of -- of other conditions
3 than gender dysphoria for prisoners who need care, are
4 those normally handled by utilization management?
5 A Yeah, I think everybody who's sent to an
6 emergency department, everybody who's sent to an
7 outside hospital, goes through the utilization review
8 process, and I think that's pretty much standard.
9 Q And if the -- if the -- say treat -- there are
10 treating physicians at the prison; correct?
11 A Correct.
12 Q And if those treating physicians believe
13 that -- that certain care is needed for their patient,
14 do they have to go through utilization management if
15 it's not going to be provided outside of the
16 hospital -- outside of the prison?
17 A I think if something is not a routine medicine
18 and it's not on the -- like, for medication on the
19 formulary, then it would go through a utilization
20 review -- somebody would be reviewing it also. For the
21 not -- for the basic -- for the everyday things, I
22 think they would not.
23 Q Okay. And what's been your specific role on
24 DTARC?
25 A I review -- I kind of have my own process. I

1 look through the cases. The case summary is given to
2 me. I review the charts. I look through, you know,
3 kind of behavioral stability as of -- focusing on the
4 non-gender dysphoria conditions.
5 If I look at, if there's a problem, like, what
6 was the reason that the problem happened. You know, I
7 try to start out as best you can, gender dysphoria,
8 non-gender dysphoria. I tend to look at things like
9 are they taking their medications as prescribed?
10 What's the general tone as I read through the progress
11 notes. I read the psychiatric progress notes. I read
12 through the non -- the mental health people's progress
13 notes.
14 I might -- I usually do look at the OPUS, which
15 is the other medical record. I see if substance abuse
16 is a problem, have there been infractions, just to get
17 a general -- try as best I can to get a general feel of
18 how this person is doing, are they working, and
19 generally how are things going. You know, as much
20 objective and subjective data as I can put together,
21 and then I just give my report.
22 Q Okay. And when you give that report, do you --
23 were you referring to give it to other members of
24 DTARC?
25 A Yes. Well, sometimes -- it's evolved, to be

1 honest. So it used to be I would give the report -- I
2 think the meetings were taking a long time, so I think
3 Dr. Peiper has asked to send it ahead so it gets on
4 a -- so now it's distributed, but it's still shown to
5 the -- I guess the other members of the group at the
6 same time, but I send it ahead now.
7 Q I see. When you send it ahead, does it become
8 a part of something called the "case summary"?
9 A Yes, I think.
10 Q Okay. I'd like to mark as Exhibit 3 a two-page
11 e-mail dated June 6th, 2022, numbered at the bottom
12 right-hand corner DAC 006294-000001.
13 (Exhibit 3 marked for identification.)
14 THE COURT REPORTER: Thank you.
15 BY MR. DAVIDSON:
16 Q Do you believe you've seen this document
17 before?
18 A Just let me take a -- I think so, but let me
19 take a quick look just to be sure. My name is on it,
20 so -- yes.
21 Q In the first paragraph, it asks -- those
22 e-mails were sent to you, to send -- please send your
23 case summaries by 6/21. And then in the third bullet,
24 it lists your name, and then it lists a number of
25 things under the term "psychiatric stability."

1 In your role at DTARC, do you usually try to
2 provide the DTARC meeting with information about the
3 prisoners' psychiatric stability?
4 A As best I can, yes.
5 Q And about their mental health diagnosis?
6 A Yes. Diagnoses often, multiple.
7 Q Thank you. About any incidents of self injury?
8 A Yes.
9 Q About any mental health inpatient experience?
10 A Yes.
11 Q And about treatment participation?
12 A Yes.
13 Q And is there anything else that you usually try
14 to share with DTARC in its consideration of the
15 provision of medical care for transgender prisoners?
16 A I mean, if I -- if it's available, just, you
17 know, if they're working, if they're taking their
18 medications regularly, if they've had visitors, if
19 those are the kinds -- like, generally, if I can
20 capture a summary how they're socially functioning and
21 that kind of stuff.
22 Q Great. Thanks. Has -- has that changed at all
23 in your tenure at DTARC? I understand, previously, you
24 didn't necessarily put it in writing in advance of the
25 meeting, but what you're trying to convey to the DTARC?

1 A I think there's an effort to be more structured
2 about it.
3 Q And do you recall when that started? Is that
4 with this e-mail or was it before this e-mail?
5 A I think like everything, it's a CQI thing.
6 You're always trying to evolve and do a little bit
7 better, to be truthful. I don't remember the exact
8 date, but --
9 Q Do you recall whether you were sending things
10 in writing before the meeting or that were incorporated
11 into some writing before the meeting in February of
12 2022?
13 A I don't recall. I -- I don't.
14 Q There may be some documents that will refresh
15 your recollection about that, so we'll -- we'll wait
16 for that.
17 I'd like to mark as Exhibit 4 a document, the
18 lower right-hand corner DAC 004297-000001.
19 (Exhibit 4 marked for identification.)
20 THE COURT REPORTER: Thank you.
21 MR. DAVIDSON: Sure.
22 BY MR. DAVIDSON:
23 Q This is a one-page document dated February 21,
24 2019. At least that's what it says on the right-hand
25 side after provision, park, date. Have you seen this

1 document before?
2 A I've seen like documents. I don't specifically
3 remember this. You know, it's hard to be sure I saw
4 this one.
5 Q Under the names of TARC members present, it
6 lists your name; correct?
7 A Correct.
8 Q And I will represent to you that the OPUS
9 number, 0618705, has been previously identified by
10 other witnesses as the OPUS number for Ms. Zayre-Brown.
11 This document lists among the transgender accommodation
12 requests under review as No. 2, a gender reassignment.
13 So my question is, is it correct that you are
14 aware that Ms. Zayre-Brown was seeking gender-affirming
15 surgery since at least February of 2019?
16 A I'm not 100 percent sure, but I -- well, let's
17 say I'm not 100 percent sure. I just don't remember.
18 Q Okay. Do you remember when you first became
19 aware that Ms. Zayre-Brown was seeking such surgery?
20 A I remember when I found out that she had an
21 orchiectomy, that -- that sort of made me ask about
22 that. So that -- around that time, but I don't
23 remember exactly when, to tell the truth.
24 Q Okay. And under "other," it says, "The
25 decision on gender reassignment has been deferred until

1 the next quarterly Division TARC meeting to allow time
2 for requested medical records to be received and
3 reviewed." Do you have any understanding of what
4 medical records needed to be reviewed?
5 A I don't remember if -- I don't know.
6 Q I'd like to mark as Exhibit 5 an exhibit -- a
7 one-page exhibit that says on the bottom right-hand
8 corner DAC 1913.
9 (Exhibit 5 marked for identification.)
10 THE COURT REPORTER: Thank you.
11 BY MR. DAVIDSON:
12 Q This -- this document in the right-hand top
13 under Division TARC date says August 21, 20 -- 2019,
14 which is six months after the last exhibit we looked
15 at, and if you look at the names and titles of TARC
16 members present, it does not list you. Do you recall
17 whether you were at this DTARC meeting?
18 A I don't recall. Sometimes I take vacation
19 around that time so it's possible I was on vacation.
20 Q Under "accommodations not approved and
21 rationale," the document states, quote, Request for
22 vaginoplasty, dash, deferred as offender has
23 successfully completed gender reassignment surgically.
24 Is it your understanding that Ms. Zayre-Brown
25 has completed gender reassignment surgically?

1 A I don't think that's my understanding.
2 Q Okay. Could you tell me what you do understand
3 about the level of completion of gender reassignment
4 surgically that Ms. Zayre-Brown has?
5 A My -- my understanding is she had the
6 orchiectomy, and I think that was it, but -- I could be
7 wrong, but that was my understanding.
8 Q If a transgender woman still has a penis, would
9 you consider her to have completed her gender
10 reassignment surgically?
11 A Again, you know, it's case by case. I'm not
12 sure I should be weighing in on that. If the person
13 thinks they have, then I would be okay with it. If the
14 person doesn't think they have, I'd probably be okay
15 with that, too.
16 Q Okay. This -- in the same part of this
17 document that we've been looking at, the next sentence
18 says, "Vaginoplasty is an elective procedure, which is
19 not medically necessary for reassignment."
20 Do you believe that vaginoplasty is an elective
21 procedure which is not medically necessary for someone
22 who is a transgender woman who still has a penis?
23 A Could you ask the question again? I'm sorry.
24 Q Yes. I'm asking whether you believe that
25 vaginoplasty is an elective procedure which is not

1 medically necessary for reassignment for a transgender
2 woman who still has a penis?
3 A I think what I'm hearing is there's two issues.
4 One is medical necessity, and then one is reassignment.
5 So I'm not sure I can answer because I think it crosses
6 both.
7 Q Okay. Do you believe it's medically -- do you
8 believe that vaginoplasty is an elective procedure for
9 a transgender woman with a penis?
10 A I think, again, it will probably be a case by
11 case. You'd have to see the larger case and sort of --
12 whether it's medically necessary, I think, would go
13 case by case.
14 Q So a vaginoplasty might not be an elective
15 procedure, it might be medically necessary for some
16 transgender individuals?
17 A I think that's probably the case.
18 Q And it might be medically necessary for
19 reassignment in some prisoners, but not others?
20 A Yes.
21 Q The next sentence says -- oh, I'm sorry.
22 Have you ever heard anyone who served on DTARC
23 along with you express the view that gender-affirming
24 surgery is an elective procedure?
25 A Yes. It was discussed.

1 Q And do you recall what was said about that?
2 MS. BRENNAN: Can we specify the time frame?
3 MR. DAVIDSON: Sure.
4 BY MR. DAVIDSON:
5 Q When was it discussed?
6 A I remember that was -- when I first started,
7 that was part of the discussion.
8 Q And what do you recall was said about it?
9 A I think there were some people who felt that it
10 was an elective procedure.
11 Could you repeat the question again? I just
12 want to make sure I get it right. I'm sorry.
13 Q My question was, what was said about
14 vaginoplasty being an elective procedure?
15 A I think there was a discussion that I recall
16 about whether this is more cosmetic surgery or it's --
17 this falls into the medical necessity, and I think
18 there was a discussion. Different people had some
19 different opinions, and I think -- I'm not sure we --
20 there was -- there was a range of opinions, to be
21 honest.
22 Q Okay. And did you have a view about whether
23 gender-affirming surgery was cosmetic surgery?
24 A I think I was more in the case by case.
25 Q And do you recall who expressed the view that

1 gender-affirming surgery is cosmetic surgery?
2 A You know, it ranges because I think if you set
3 the question up different ways, you get different
4 responses. So I think there's a feeling that a lot of
5 people have, quite frankly, if there isn't severe
6 symptoms, then maybe it is more cosmetic, but if there
7 are severe -- if the dysphoria is very severe, then it
8 would not be. So I think that it was tricky to get
9 it -- for me to answer that easily.
10 Q Do you recall whether Dr. Campbell expressed
11 any views about whether or not gender-affirming surgery
12 was cosmetic surgery?
13 A I think he felt strongly that it should not be
14 a routine procedure, which I think a lot of people
15 agreed with.
16 Q And -- I'm sorry. Let me just get the time
17 frame for when -- when you're saying he expressed that
18 feeling.
19 A It was later on when he became part of the
20 DTARC committee.
21 Q Okay. This exhibit states, "Current staffing
22 and resources do not allow for the proper postoperative
23 care of this procedure."
24 What type of postoperative care for
25 vaginoplasty did DPS not have staffing and resources to

1 provide?
2 A I'm not an expert in this area, but my
3 understanding from asking others is that the postop
4 care is relatively extensive, and I think a lot of
5 folks expressed the opinion, given the resource
6 limitations of the prison, should -- is this something
7 that we should be doing.
8 But I think that was -- and I don't remember
9 kind of -- like, it kind of melded together, but I
10 think there was eventually a clear understanding that
11 that wasn't really our call about resource utilization,
12 and that that's a separate issue.
13 Q And do you have a view on whether DPS is still
14 unable to provide postoperative care for vaginoplasty
15 due to staffing and resources?
16 A I think there's always problems with staffing,
17 but I think that what we were told is if -- the
18 staffing would be found if it was needed.
19 Q Are you aware of the differences between a
20 vaginoplasty and a vulvoplasty?
21 A I'm not an expert in that area.
22 Q Okay. As far as you understand it are -- is
23 the postoperative care for a vulvoplasty less -- easier
24 to provide than the postoperative care for a
25 vaginoplasty?

1 A That's what I was told. I haven't looked at it
2 myself, but that's my understanding from secondhand
3 information from others.
4 Q I'd like to mark as Exhibit --
5 THE COURT REPORTER: 6.
6 MR. DAVIDSON: 6. Thank you.
7 BY MR. DAVIDSON:
8 Q It's a seven-page document. It says at the top
9 "Division Transgender Accommodation Review Committee,"
10 paren, "TARC meeting," August 21, 2019, 2:00 p.m.
11 (Exhibit 6 marked for identification.)
12 THE COURT REPORTER: Thank you.
13 BY MR. DAVIDSON:
14 Q So this is the same date as the -- as the last
15 exhibit, which was Exhibit 5. If you'll turn to
16 page 6, it's the only part that's not redacted on that
17 page other than the word "case." It says,
18 "Case 061-8705," and that's the same OPUS number for
19 Ms. Zayre-Brown that was on the previous document.
20 And it says, "The offender is located at Anson
21 CI, a UR was submitted for endocrinology update." And
22 UR is a utilization review; is that correct?
23 A Yes.
24 Q "During the consult, there were questions about
25 assignment surgery and other issues the endocrinologist

1 seem to endorse." Do you have any information about
2 what it is that the endocrinologist seemed to endorse?
3 A I'm not sure.
4 Q Then it says, "Per medical records, the gender
5 reassignment is complete." Did you believe at any
6 point that Ms. Zayre-Brown's medical records show that
7 her gender reassignment was complete?
8 A I don't think she thought it was complete.
9 I'll say that. You know, I -- mine was more of an
10 evolution of understanding her thinking.
11 Q So you didn't have a view at any point on
12 whether or not her gender reassignment was complete?
13 A Well, until I actually read the -- like, I
14 heard stuff, then I was on the committee, then I read
15 the records. Once I read the records, my thinking was
16 from her point of view, it was not complete.
17 Q Okay. I understand that was your understanding
18 of her point of view. Did you have a point of view?
19 A Again, I look at these as -- as I would follow
20 the lead of the person. So if they tell me that
21 they're feeling better now, that they had this partial
22 surgery and they feel good, then I would accept it.
23 Q It then states, "Additional surgery would be
24 for outward appearance and is not necessary for
25 reassignment." Do you believe that a vaginoplasty

1 performed on a transgender woman is only for outward
2 appearance?
3 A I think it would be inconsistent with
4 Ms. Brown's thinking. I'm not sure what outward
5 appearance -- I'm not sure what that really means,
6 but -- but I think she would not see it that way, and I
7 would defer to what she thinks.
8 Q And would that also be true for a vulvoplasty?
9 A I think the same would hold, yes.
10 Q I'd like to mark as Exhibit 7 --
11 THE COURT REPORTER: Yes.
12 BY MR. DAVIDSON:
13 Q -- a document, the lower right-hand corner
14 says 5205. I'm not going to read all the numbers.
15 (Exhibit 7 marked for identification.)
16 THE COURT REPORTER: Thank you.
17 BY MR. DAVIDSON:
18 Q This is a 12-page document. The top of the
19 first page, the second line, it says May 21, 2020,
20 2:00 p.m. This appears to be notes from the DTARC
21 meeting on that date. Do you believe you have ever
22 seen this document or an un-redacted version?
23 A I most likely have, yes.
24 Q If you could please turn -- oh -- to the next
25 to the last page. It, again, lists Case No. 061-8705.

1 It is what's previously been identified as
2 Ms. Zayre-Brown's OPUS number.
3 So now turn to the last page. If you'll look
4 at the underlined portion, it states, "This is a
5 follow-up case. This case was reviewed in February of
6 2020, and DTARC recommended a referral to UNC for a
7 consultation request in writing what this type of
8 surgery would entail."
9 What -- why did DTARC have to refer this to UNC
10 for such a consultation as opposed to providing it
11 itself?
12 A I think UNC would be the people who would be
13 doing the surgery if it occurred so I think it was
14 logical to send it there for the consultation.
15 Q Then the next sentence says, "DTARC also wanted
16 to know if the offender is a good candidate."
17 That's -- it's your understanding that that means a
18 good candidate for surgery?
19 A I mean, that's what I would think. I don't
20 know for sure.
21 Q And then it says, reading the whole sentence,
22 "DTARC also wanted to know if the offender is a good
23 candidate, the number of required appointments, the
24 number of required procedures, and cost."
25 Why did DTARC want to know the cost?

1 A I don't -- I don't know.
2 Q And looking -- looking at that paragraph, can
3 you tell whether it's referring to a vaginoplasty or a
4 vulvoplasty?
5 A I cannot tell.
6 Q Okay. It says, "Follow-up surgery may be
7 required that involves establishing a labia." But
8 isn't that part of what's done during a vulvoplasty?
9 A I'm not an expert in that. I'm not -- I don't
10 feel comfortable really answering.
11 Q Okay. It also says the entire surgical process
12 can take one year to complete. Is that your
13 understanding with respect to vulvoplasties?
14 A I -- I understood that vulvoplasty is less
15 complicated than the vaginoplasties, but as far as the
16 times, I'm not really -- I don't feel comfortable
17 answering.
18 Q And then a little less than halfway down, it
19 says, quote, It can be argued that this surgery could
20 be considered medically necessary if there's been
21 documented history that without this type of surgery,
22 there would be severe psychiatric or psychological
23 injuries to the person for not being able to totally
24 live -- it says "they life," I think it should be "the
25 life" -- "they life they gender identify with."

1 Did you believe that on February 17th, 2022?
2 A Sorry. Could you ask that again?
3 Q Well, let me just ask -- maybe this is
4 simpler -- do you believe that today?
5 A I think I would struggle with the "totally,"
6 with what that means. I'm not sure what that means.
7 Q So if we -- if we took out the word "totally,"
8 would you agree with that sentence?
9 A I think severe psychiatric or psychological --
10 if there were, not there could be. If there were, I
11 could generally agree with it.
12 Q Okay. And then it states, "Psychologically, if
13 a person is in the midst of transitioning, this would
14 be considered a final stage of the process to complete
15 the transition to female." Is that something that you
16 believe?
17 A See, that's something I do struggle with
18 because if -- you know, I look at it like other
19 psychiatric illnesses. You have to go to the -- if
20 you're -- you're depressed -- I'm just giving an
21 example -- and you get some -- a few talk therapy
22 sessions and you're much better, do you have to go on
23 to shock therapy? So in the same way, I would do it
24 case by case and see how the person is doing.
25 Q And then a little further down, it says, "We do

1 not have the authority at this time to approve the
2 surgery." Why would that be?
3 A I'm not sure.
4 Q Do you have any understanding about whether
5 DTARC at the moment has the authority to approve
6 this -- it's referring to -- to some form of
7 gender-affirming surgery?
8 A My understanding is the DTARC committee makes
9 recommendations, if that's kind of what this is
10 referring to. It makes recommendations to the next
11 level of authority. So I don't think the DTARC, if
12 that's what it is, can say, yes, have the surgery,
13 without it being approved, is my --
14 Q But DTARC does -- is it correct that DTARC does
15 have the authority to recommend approval of the
16 surgery?
17 A That's my understanding.
18 Q And it would also have authority to recommend
19 that the surgery not be provided; is that correct?
20 A That's my understanding, yes.
21 Q This Exhibit 7 and the previous Exhibit 6 list
22 DTARC meetings that started at 2:00 p.m. for both of
23 those meetings. Was that generally the time that DTARC
24 meetings began?
25 A I don't remember. I think so. I'm not sure on

1 that.
2 Q Okay. And in general, how long did DTARC
3 meetings last?
4 A Very long is my recollection. At a minimum --
5 Q How many hours?
6 MS. BRENNAN: He didn't quite finish his answer,
7 Jon.
8 MR. DAVIDSON: I'm sorry. I didn't hear.
9 THE WITNESS: I would say at a minimum of two and a
10 half to three hours is my recollection.
11 BY MR. DAVIDSON:
12 Q Have you ever met Kanautica Zayre-Brown?
13 A No.
14 Q Have you ever spoken with her?
15 A No.
16 Q To the best of your knowledge, have you ever
17 spoken with a family member of hers?
18 A No.
19 Q I'd like to mark as Exhibit 8 a document in the
20 lower right-hand corner, it says DAC 3382. It's a
21 three-page document.
22 (Exhibit 8 marked for identification.)
23 THE COURT REPORTER: Thank you.
24 MR. DAVIDSON: Let me also mark another exhibit,
25 Exhibit 9. It says in the lower right-hand

1 corner 3381.
2 (Exhibit 9 marked for identification.)
3 THE COURT REPORTER: One moment, please.
4 MR. DAVIDSON: Thank you.
5 THE COURT REPORTER: Thank you.
6 BY MR. DAVIDSON:
7 Q On Exhibit 9, which at the top says "North
8 Carolina Department of Public Safety, the Division
9 Transgender Accommodation Review Committee," paren,
10 "TARC," closed paren, "report." It lists under
11 offender name Kanautica Zayre-Brown, and then the same
12 OPUS number we've been looking at before, so that would
13 seem to confirm that that is her OPUS number.
14 Do you have any reason to doubt that?
15 A No, no.
16 Q And lists the Division TARC date of
17 February 17th, 2022. And then under the names and
18 titles of the TARC members present, it lists your name.
19 Do you have any reason to believe that you were not
20 present at that DTARC meeting?
21 A No.
22 Q Okay. Turning back to Exhibit 8, it states at
23 the top "DTARC meeting notes PREA report," same date,
24 February 17th, 2022. Have you ever seen this document
25 or an un-redacted version of it before?

1 A I don't -- it's hard to look at this and know
2 for sure. I mean, I don't know.
3 Q Okay. And do you recall whether a
4 February 17th, 2022, DTARC meeting was longer than
5 normal, shorter, about the same?
6 A I don't remember.
7 Q The first numbered paragraph on Exhibit 8, the
8 only one that's not redacted on this form, again uses
9 Ms. Zayre-Brown's OPUS number. Does that mean that
10 Ms. Zayre-Brown's accommodation request was the first
11 one discussed at this meeting?
12 A I honestly don't know. I don't remember. I
13 don't know how to tell.
14 Q Did -- did you generally go in some order?
15 A I mean, I didn't really pay attention to the
16 order. I just -- so I don't know.
17 Q Okay. That's fine. There are -- in addition
18 to Ms. Zayre-Brown, there appear to be 12 other case
19 numbers on this document. Does that mean 12 additional
20 prisoners' accommodation requests were discussed at
21 this meeting in addition to Ms. Zayre-Brown?
22 A Most likely, in some form or another, they were
23 discussed.
24 Q And what's your best recollection of how long
25 the discussion of Ms. Zayre-Brown's accommodation

1 request lasted during this meeting?
2 A I honestly don't remember the specifics.
3 Q Did you take notes at this meeting?
4 A I don't remember. I don't think so.
5 Q Did you generally take notes, then, at DTARC
6 meetings?
7 A I usually don't because it's just another piece
8 of paper, and other people send out the notes, and then
9 I'm not sure what my notes are half the time so I
10 usually don't take notes if I could avoid it.
11 Q Did you talk with anyone in preparation for
12 this February 17th, 2022, DTARC meeting?
13 A I don't remember.
14 Q You talked before about, in general, reviewing
15 psychiatric notes, mental health notes, medical
16 records?
17 A Right.
18 Q And do you recall, is that something you would
19 have done in preparation for this DTARC meeting?
20 A Yeah, I would expect I would have done that.
21 Q I'd like to mark as Exhibit 9 in this
22 deposition -- oh, no. I already marked.
23 Looking at Exhibit 9, it states a little more
24 than halfway down, "DTARC does not recommend gender
25 affirmation surgery."

1 What's your understanding of why DTARC
2 recommended against granting Ms. Zayre-Brown's request
3 for gender-affirming surgery?
4 A I believe just thinking was this a procedure --
5 I mean, it's hard to scrunch it all together, if that's
6 a word, but, you know, I'm looking through the
7 literature and you go through it, and is this --
8 methodologies now, how to have rank treatments, and
9 this is generally considered not a high category
10 evidence medically necessary procedure in most cases.
11 So I think -- I can't speak for everybody, but
12 I think that she wasn't doing that poorly. There
13 wasn't evidence of severe psychiatric psychological
14 distress on any consistent basis, and, therefore, the
15 thinking was -- and I'm probably giving mostly my
16 thinking because I don't remember everybody else's
17 thinking -- was that it didn't meet criteria for use of
18 a non-evidence-based treatment in a prison setting for
19 a condition that didn't seem that severe looking
20 through the records. As best I can tell, that was kind
21 of my thinking.
22 Q And so it is -- is it your view that a genital
23 surgery on a transgender individual with gender
24 dysphoria is not evidence-based treatment?
25 A The surgeries -- focusing on the surgeries and

1 recommendations. Again, they have to get approval or
2 disapproval. But the DTARC committee, I think, would
3 be the ones making that recommendation.
4 Q And do you have any reason to doubt
5 Dr. Bowman's statement that Ms. Zayre-Brown's belief at
6 that time that she had been denied surgery altogether
7 notably increased her distress?
8 MS. BRENNAN: Objection. Calls for speculation.
9 You can answer.
10 THE WITNESS: I don't have any reason to doubt
11 Dr. Bowman.
12 BY MR. DAVIDSON:
13 Q Looking at the next page under "chief
14 complaint," it states, quote, Offender Brown has most
15 recently expressed significant distress and frustration
16 due to inability to move forward with requested surgery
17 within preferred, slash, anticipated time frame.
18 Do you have any reason to believe that that was
19 not true?
20 MS. BRENNAN: Same objection.
21 You may answer.
22 THE WITNESS: I -- I believe if Dr. Bowman wrote
23 it, then it's factual.
24 BY MR. DAVIDSON:
25 Q Likewise, further down under "assessment," it

1 states, quote, Offender Brown is a transgender female
2 of at least average intelligence most recently
3 presenting with anxiety and sadness regarding her
4 inability to fully transition as desired.
5 Do you have any reason to believe that
6 Ms. Zayre-Brown was not presenting with anxiety and
7 sadness regarding her inability to fully transition as
8 desired?
9 MS. BRENNAN: Same objection.
10 You may answer.
11 THE WITNESS: I don't have any reason to doubt it.
12 BY MR. DAVIDSON:
13 Q I'd like to mark as the next exhibit --
14 MS. BRENNAN: Jon, we're coming up on about an hour
15 and half. Before we --
16 MR. DAVIDSON: You want to take a break? Sure.
17 That's fine. This is a good time.
18 MS. BRENNAN: -- good time to take a break?
19 We can go off the record.
20 (Recess.)
21 BY MR. DAVIDSON:
22 Q Hi, Dr. Sheitman. I hope you had a good lunch.
23 A I did.
24 Q And just to remind you, you're back -- you're
25 still under oath.

1 A Okay.
2 Q Before our lunch break, we were looking at a
3 document prepared by Dr. Bowman, and I just wanted to
4 ask you, is Dr. Bowman somebody you supervise?
5 A No, she isn't.
6 Q Okay. And also before the break -- I don't
7 want to put words in your mouth, but I believe you said
8 something -- I just want to confirm that this is right
9 or not. I believe you said something like -- that
10 there was literature that you reviewed that concluded
11 that gender-affirming surgery was not adequately
12 evidenced-based. Did I get that correctly?
13 A It doesn't reach a high level of evidence.
14 Q Okay. And do you recall any specifics about
15 any -- you know, what that literature was?
16 A I think the criticism was that there aren't
17 long-term, randomly assigned surgeries that have, you
18 know, validated the effectiveness of the surgery.
19 Q And do you know what literature you reviewed
20 that said that?
21 A There was a -- there was a bunch. There's a
22 recent review -- I always get them mixed up if it's,
23 like, an AHRQ or NIH, but it was a summation of the
24 literature that sort of tried to put the standards
25 of -- you know, it meets this criteria or this criteria

1 or, you know, the highest level of criteria, and it
2 wasn't literature that supported that that I saw.
3 Q Okay. Thank you. I'd like to mark as the next
4 Exhibit --
5 THE COURT REPORTER: 11?
6 MR. DAVIDSON: 11. Yes.
7 (Exhibit 11 marked for identification.)
8 BY MR. DAVIDSON:
9 Q It's a two-page document. The first page,
10 bottom right, it has numbers 4127.
11 THE COURT REPORTER: Thank you.
12 MR. DAVIDSON: Sure.
13 BY MR. DAVIDSON:
14 Q Dr. Sheitman, do you believe you've seen this
15 document before?
16 A My name's on it, so -- let me -- give me a
17 second to read it.
18 Q Sure.
19 A I honestly don't remember it, but since I sent
20 this document -- I asked Dr. Peiper to take a look at
21 it, I probably saw it.
22 Q Okay. It appears that you were responding to
23 an e-mail from Terri Catlett that appears to be
24 forwarding an e-mail from -- or at least part of an
25 e-mail from Dionne Brown. Do know who Dionne Brown is?

1 A I do not.
2 Q Okay. That e-mail from Dionne Brown -- at
3 least the part that's attached -- in the -- in the
4 second full sentence, it says -- and I believe there's
5 some typos in this -- "Kanautica has voiced to me that
6 she is emotionally withdrawn and manically depressed.
7 She has also informed out family that she desire to
8 self-mutilated her primary sex characteristics."
9 Seeing that now, do you -- do you recall having
10 seen an e-mail that included that before?
11 A Honestly, I don't.
12 Q Okay.
13 A But I believe it since I'm on it.
14 Q And if you had heard from someone that a
15 prisoner at DPS was emotionally withdrawn and manically
16 depressed and had expressed a desire to mutilate
17 herself, is that something that would give you concern?
18 A Yes.
19 Q And do you believe that's why you suggested to
20 Dr. Peiper to have a psychologist meet with
21 Ms. Zayre-Brown?
22 A Yes.
23 Q Okay. Thank you. I'd like to mark as
24 Exhibit 12 a two-page document. At the bottom, it says
25 DAC 686 on the first page.

1 (Exhibit 12 marked for identification.)
2 THE COURT REPORTER: Thank you.
3 BY MR. DAVIDSON:
4 Q This says on the second line at the top
5 "transgender accommodation summary." What's a
6 transgender accommodation summary?
7 A I would assume -- and I honestly don't know for
8 sure, I mean, the exact definition, but it's a
9 summation of the care and issues surrounding a person.
10 Q And is this something you recall reviewing
11 before the February 17th, 2021, DTARC meeting?
12 A If it was in the medical record, then I'm sure
13 I probably took a look at it.
14 Q Okay. This document lists the provider as
15 Jennifer L. Dula, MSW Clinical. Do you know Ms. Dula?
16 A I don't think I've ever met her.
17 Q Okay. Do you have any reason to doubt her
18 credibility?
19 A I do not.
20 Q Okay. If you could please look at the end of
21 the first paragraph through the second paragraph,
22 there's a review of transgender history. It says,
23 "Ms. Brown has also" -- let me -- I'm sorry. Let me
24 back up.
25 "She has changed pronouns, legally changed her

1 name, engages in tucking" --
2 A I'm sorry. I don't mean to interrupt. Could
3 you just tell me again where you're reading from?
4 Sorry.
5 Q Sure. Under "review of transgender history"
6 about halfway down.
7 A Okay. Okay. I got it.
8 Q I'm kind of starting at this third sentence.
9 "She has changed pronouns, legally changed her name,
10 engages in tucking, and is currently housed in a female
11 facility." What is tucking?
12 A I'm not sure.
13 Q Okay. It's not a term you've heard before?
14 A No.
15 Q "She has successfully" -- I'm sorry -- "she has
16 been successfully living in a gender role congruent
17 with her affirmed gender since at least 2014. She has
18 been consistently on hormone therapy since 2012.
19 Ms. Brown has also undergone several other
20 gender-affirming surgeries as part of her transition,
21 such as orchiectomy, breast augmentation, and facial
22 feminization."
23 Do you have any reason to doubt any of those
24 statements?
25 A No.

1 Q And it says, "Despite these interventions,
2 Ms. Brown continues to report clinically significant
3 anxiety, depression, and distress associated with
4 gender dysphoria that has been documented consistently
5 throughout her mental health treatment."
6 Do you have any reason to believe that that is
7 untrue?
8 A I think the issue of consistently -- I think
9 through her record, it's not as consistent. I mean,
10 there's -- there's typically some mention of it, but
11 oftentimes it doesn't -- reading -- just reading
12 through, it doesn't seem -- the intensity of the
13 distress is a pervasive thing in some notes.
14 Q Okay. Looking at the next paragraph, it says,
15 "Based on the review of her records and the current
16 assessment, it appears the next appropriate step for
17 Ms. Brown is to undergo transfeminine bottom surgery.
18 This surgery will help her make significant progress in
19 further treatment of her gender dysphoria."
20 Do you have any reason to believe that -- that,
21 that I just read, was not accurate?
22 A I think it's accurate as to -- to Ms. Dula's
23 opinion.
24 Q Okay. And does that not reflect your opinion?
25 A I'm less sure, you know, based on if it would

1 change things.
2 Q Okay. And looking at the last paragraph under
3 "adjustment to incarceration," it states, "However, now
4 that the issue of housing has been addressed and is
5 affirming, it seems to have made her more aware and
6 dysphoric about the one part of her body that does not
7 affirm her gender identity."
8 Do you have any understanding of what part of
9 her body was being referred to?
10 A I don't know for sure. I mean, I would suspect
11 it's her penis, but I -- I don't know for sure.
12 Q And as part of a vulvoplasty, would that
13 involve the removal of a transgender woman's penis?
14 A I'm not 100 percent sure.
15 Q Okay. And if you look at the -- sorry.
16 MR. DAVIDSON: I'm sorry. Let -- let me go off the
17 record for a minute.
18 (Pause in proceedings.)
19 BY MR. DAVIDSON:
20 Q If you look under -- near the top of the
21 document under "review of mental health history," in
22 the third paragraph that starts "since incarceration,"
23 it says, "Since incarceration, Ms. Brown has engaged in
24 mental health services to access transgender
25 accommodations and to address and manage her feelings

1 of gender dysphoria and the subsequent anxiety and
2 depression associated with it."
3 Is it your understanding that anxiety is
4 something that may be associated with gender dysphoria?
5 A I think it can be.
6 Q And how about depression?
7 A Also, I think it can be.
8 Q Do you have any reason to believe that
9 Ms. Brown was -- Ms. Brown, I'm sorry -- had not
10 experienced anxiety and depression associated with her
11 feelings of gender dysphoria?
12 A Again, if she reported it, certainly at times I
13 would believe it, yes.
14 Q Okay. And do you have any reason to believe
15 she was not still experiencing anxiety and depression
16 associated with her feelings of gender dysphoria four
17 months after this when the February 17th, '22, DTARC
18 meeting was held?
19 A Yeah, I see it, though, it's not just a
20 categorical anxiety, yes; anxiety, no; depression, yes;
21 depression, no. It's sort of the magnitude. So I
22 think the magnitude of the stress and the anxiety
23 probably fluctuates.
24 Q Okay. And then further down in that
25 paragraph -- that same paragraph, it says, "There has

1 been some crisis intervention required, including four
2 SIRAs and one inpatient placement since 2017." What is
3 an SIRA?
4 A Self-injury risk assessment.
5 Q Okay. And when are those done?
6 A Usually when there's some emergent concern
7 about someone's -- whether they might be wanting or
8 not -- to hurt themselves.
9 Q And do you have any reason to doubt that
10 Ms. Zayre-Brown has had four SR -- SIRAs?
11 A I have no doubt that she -- I don't know, but I
12 don't doubt that she had them completed, sure.
13 Q And were you aware that she had had an
14 inpatient placement?
15 A I was. I am.
16 Q And what was your understanding of why she had
17 an inpatient placement?
18 A As best as I can remember without the admission
19 summary in front of me, there was some issue that was
20 going on at Anson, and, you know, there was -- the
21 story sort of evolved from pre to during the
22 hospitalization. So in retrospect, I'm not 100 percent
23 sure why the hospitalization occurred because I think
24 there was different information pre and then during the
25 hospitalization, and then -- then the records I read

1 during the hospitalization.

2 Q It then says, "The acute events have been

3 connected to Ms. Zayre-Brown's stress over her gender

4 identity and the process of addressing her transitional

5 needs within a multilevel medical system." Do you have

6 any reason to doubt that statement?

7 A Just give me one second. Let me just --

8 Q Sure.

9 A I think the notes did have a lot of words about

10 it was related. There was also some issues about her

11 wanting -- as best I can remember, and I could be

12 wrong -- about her wanting to get out of Anson. There

13 was some issues going on there, too. So I'm not -- it

14 may be a bigger story than just the gender dysphoria.

15 Q Thank you.

16 MR. DAVIDSON: Michele, I'm going to jump ahead

17 again.

18 I'd like to mark as Exhibit 12 -- no, 13 -- a

19 document, says at the bottom DAC 444 through 446.

20 (Exhibit 13 marked for identification.)

21 THE COURT REPORTER: Thank you.

22 BY MR. DAVIDSON:

23 Q This is a three-page document. The top, it

24 says "North Carolina Department of Public Safety

25 Clinical Encounter." And under "provider," it says

1 "Donald Caraccio." Do you know Dr. Caraccio?
2 A I do not.
3 Q Okay. Is he someone who works at -- is
4 employed by DPS, or do you know?
5 A I don't know.
6 Q Okay. This document is dated October 21, 2021.
7 Is this one -- do you recall seeing this document
8 before?
9 A I don't.
10 Q Okay. Is this the sort of document that if it
11 were in Ms. Zayre-Brown's medical files, you would have
12 reviewed prior to the 20 -- the February 17th, 2022,
13 DTARC meeting?
14 A To be honest -- it says "clinical encounter,"
15 so it might've been in the medical portion of the
16 record, so I may not have seen it. Like, sometimes
17 I'll -- I'll look, but I may not have seen this one.
18 Q Uh-huh. So on -- and do you believe you ever
19 communicated with Dr. Caraccio?
20 A I have not.
21 Q Okay. If you please look at the bottom of the
22 second page of the exhibit --
23 MS. BRENNAN: Jon, given that he's said he's not
24 sure he's ever seen it, can you give him a moment to
25 review the record?

1 MR. DAVIDSON: Oh, sure.
2 BY MR. DAVIDSON:
3 Q The only thing I'm going to ask you about is
4 the bottom on the second page, but feel free to look at
5 the whole thing.
6 I lied. I'm going to ask you some stuff on the
7 first page, too.
8 A Okay. I read it. Thank you.
9 Q Okay. On the first page under "Complaint 1,"
10 it says under "subjective," "This is 41 y/o transgender
11 woman seen for continued hormonal treatment. She is
12 s/b orchiotomy and has been on estrogen since 2012.
13 She is seeking vulvoplasty as part of her treatment of
14 gender dysphoria," paren, "DSM-5 diagnosis."
15 So were you aware that Ms. Zayre-Brown had been
16 on hormonal treatment for a number of years?
17 A Yes, I have.
18 Q Okay. Now, turning to the bottom of the second
19 page. It says under "assessment," "Gender dysphoria in
20 adolescents and adults, 302.85 current chronic." Do
21 you know what the 302.85 refers to?
22 MS. BRENNAN: It -- John, just for completeness, it
23 says "current, chronic, marked improvement."
24 MR. DAVIDSON: Okay.
25 BY MR. DAVIDSON:

1 Q Again, does the number 302.85 refer to
2 something that you're -- you're -- does that number
3 mean something to you?
4 A The .85 are usually qualifiers about the
5 diagnosis. I don't know that -- I would have to look
6 at the DSM.
7 Q And then looking at the bottom of the page, it
8 says, "Regarding for desire for vulvoplasty, this is a
9 medically necessary part of treatment for this patient.
10 She has been treated with hormones since 2012, an
11 orchiectomy in 2017, with persistent symptoms of gender
12 dysphoria."
13 Were you aware that Dr. Caraccio had written
14 this prior to the February 17th, 2022, DTARC meeting?
15 A Yeah, I don't know who Dr. Caraccio is.
16 Q Okay. Do you recall whether or not
17 Dr. Caraccio's conclusion that a vulvoplasty was a
18 medically necessary part of treatment for
19 Ms. Zayre-Brown was discussed at the February 17th,
20 2022, DTARC meeting?
21 A I don't remember.
22 Q Okay. The next I'd like to mark as Exhibit --
23 THE COURT REPORTER: 14.
24 MR. DAVIDSON: Sorry. Losing count here.
25 BY MR. DAVIDSON:

1 Q Sorry. It's an exhibit, on the first page,
2 lower right-hand corner, it says DAC 826.
3 (Exhibit 14 marked for identification.)
4 THE COURT REPORTER: Thank you.
5 MR. DAVIDSON: Thanks.
6 BY MR. DAVIDSON:
7 Q This is a -- hard to tell -- multipage
8 document. The top, it says "UNC Health." There's a
9 fax date of July 20th, 2021, but under progress notes,
10 it says filed 7/18/2021. And then it -- it lists as
11 author Bradley David Figler, MD. Is this a document
12 you recall seeing before?
13 A I believe so, yes.
14 Q And do you know who Dr. Figler is?
15 A I think he's the UNC endocrinologist.
16 Q Okay. So it says right under UNC 7/12/2021,
17 "office visit UNC urology"?
18 A Oh.
19 Q Does that perhaps change your view about
20 whether he's an endocrinologist?
21 A That would change my view, yes.
22 Q Okay. And it -- if you turn to the second page
23 under "plan," it says, "Proceed with vulvoplasty per
24 WPATH criteria, pending." And then under that, "Weight
25 loss goal 215, BMI 30; max 250, BMI 35. Will order

1 case request and notify surgery scheduler when approved
2 by THP." Do you have any knowledge of what THP means?
3 A I'm not sure.
4 Q Okay. And based on -- on this, does that lead
5 you to believe that Dr. Figler was a surgeon or is a
6 surgeon?
7 A I am moving in that direction, yes.
8 Q Okay. And were you aware that DTARC had
9 referred Ms. Zayre-Brown to a doctor at UNC Health for
10 a consultation regarding possible surgery?
11 A Yes.
12 Q And do you have any reason to doubt that
13 Dr. Figler was that surgeon?
14 A I do not.
15 Q Okay. Were you aware on February 17th, 2022,
16 that Dr. Figler believed that the plan for
17 Ms. Zayre-Brown should be to, quote, proceed with
18 vulvoplasty?
19 A What date did you say again?
20 Q Were you aware at the -- at February 17th,
21 2022? This document is dated -- well, in July of 2021.
22 A So at July -- could you ask the question again?
23 Q Were you aware in February of 2022 --
24 February 17th specifically -- that Dr. Figler had
25 stated that the plan for Ms. Zayre-Brown was to proceed

1 with vulvoplasty?
2 A I was aware going forward that there was a
3 plan, that Dr. Figler or whoever the surgeon at UNC
4 said it was okay. I don't remember -- I couldn't say
5 the date specifically, but going forward after this
6 date, I was aware of that.
7 Q And why did DTARC disagree with the
8 determination of the surgeon at UNC Health to whom she
9 had been sent for a consult that the plan should be to
10 proceed with vulvoplasty?
11 MS. BRENNAN: Objection to form.
12 You can answer.
13 THE WITNESS: I think the same strategy that when
14 you send to any consultant, you're looking for the
15 consultant's opinion, and then you review the opinion
16 to see if you agree with the opinion or not. But it's
17 not -- it's like you send in to the cardiologist, and
18 they may say they recommend surgery. You may -- there
19 are mitigating factors, and you don't think surgery is
20 indicated. So it's sort of the same process.
21 BY MR. DAVIDSON:
22 Q And why did DTARC disagree with this opinion?
23 MS. BRENNAN: Same objection.
24 You can answer.
25 THE WITNESS: I think the same issue was that we

1 didn't think her distress was great enough to warrant
2 this type of surgery.
3 BY MR. DAVIDSON:
4 Q I'd next like to mark as Exhibit -- it says in
5 the lower right-hand corner DAC 204522.
6 (Exhibit 15 marked for identification.)
7 THE WITNESS: Thank you.
8 THE COURT REPORTER: Thank you.
9 BY MR. DAVIDSON:
10 Q I'm sorry. Before I -- before I finish with
11 this document, I believe you testified that the DTARC
12 did not believe that Ms. Zayre-Brown was experiencing
13 enough distress for gender-affirming surgery to be
14 warranted, and I'm trying to understand how much
15 distress would be enough.
16 MS. BRENNAN: Objection to form.
17 You may answer.
18 THE WITNESS: Yeah, again, we didn't think the
19 surgery meets the criteria for medical necessity. So
20 going on a case-by-case basis, the truth is there may
21 be cases where the gender dysphoria is so severe that
22 we would say, even though it's not really an
23 evidence-based treatment, it may be worth going
24 forward. Quantifying it and drawing a line is really
25 hard to do. I mean, I don't know if I could do that in

1 a way that would be valid.
2 BY MR. DAVIDSON:
3 Q So how -- how would you normally try to measure
4 how much distress a patient was experiencing?
5 A Well, first, I would sort out -- assuming that
6 it's not psychiatric comorbidities, situational
7 depression because you're in prison, is it severe and
8 persistent? There's not a -- a sort of -- sometimes a
9 person seems happy, other times the person is
10 extraordinarily depressed, then they seem happy again.
11 Then something good happens and they're happy, and then
12 something bad happens and they're very depressed. So I
13 try to get the persistence of the severity of the
14 dysphoria.
15 Q Okay. So this D -- DAC 4522, I believe -- is
16 that Exhibit 16?
17 THE REPORTER: The one we just marked is 15.
18 (Discussion off the record.)
19 BY MR. DAVIDSON:
20 Q Looking at Exhibit 15. So this is at least set
21 up as a letter from Jennifer Dula, if you look at the
22 second page, but at the deposition of Dr. Peiper, he
23 stated that this was a draft prepared by Ms. Dula. I
24 believe you said you'd never met to Ms. Dula, but is it
25 your understanding that she was a social worker who

1 worked at DPS?
2 A Yes.
3 MS. BRENNAN: Objection to the characterizations.
4 You can answer.
5 THE WITNESS: Yes.
6 BY MR. DAVIDSON:
7 Q Okay. Have you ever seen this document before,
8 Exhibit 15?
9 A I don't think I have.
10 Q Okay. If you look at Exhibit 15, and also if
11 you could look again at Exhibit 12 which is the
12 transgender accommodation summary authored by Jennifer
13 Dula, and if you -- if you look at what we were looking
14 at, Exhibit 12, under "review of transgender history"
15 where it says, "She has been consistently on hormone
16 therapy since 2012. Ms. Brown has also undergone
17 several" --
18 MS. BRENNAN: Jon, I'm sorry. I don't see where
19 you're at. Can you tell us where you are specifically?
20 MR. DAVIDSON: Sure. I'm -- I'm sorry. Let me
21 start that again.
22 BY MR. DAVIDSON:
23 Q Looking at Exhibit 15 in the second paragraph,
24 it says, "She has socially transitioned by changing
25 pronouns, legally changing her name, tucking, and being

1 Q And is that someone you supervise?
2 A I -- indirectly.
3 Q Okay. By "indirectly," do you mean you
4 supervise somebody who supervises them, or what do you
5 mean?
6 A She works as -- in the women's -- NCCIW Prison.
7 So she reports up the line of the prison. We don't
8 have a chief of psychiatry at the prison. So the chief
9 of psychiatry at the prison would technically report to
10 me. So she, I think, reports to the people directly at
11 the women's prison, and then indirectly to me. I mean,
12 if that makes any sense.
13 Q Sure. And were you aware at the time of the
14 February 17th, 2022, DTARC meeting that Ms. Zayre-Brown
15 had at one point been on Zoloft?
16 A I'm sure I was, yes.
17 Q And what is Zoloft used to treat?
18 A Depression and anxiety are the two most common
19 things.
20 Q And why would a Zoloft dose be increased?
21 A I'm just reading it, so if you could just give
22 me a second.
23 Q Sure.
24 A Well, it's probably an attempt to reduce her
25 stress. I mean, she said the Zoloft is helping her.

1 She denies depression. She feels she's not getting out
2 of her therapy. She sleeps good. She --
3 (Reporter clarification.)
4 THE WITNESS: She feels Zoloft is helping her. She
5 denies depression. And then she goes on to say she
6 feels she is not getting adequate therapy. She sleeps
7 good. She has lost weight, which I think she was
8 intending to do. So I think it was an attempt to
9 reduce her stress.
10 BY MR. DAVIDSON:
11 Q And do you have any reason to believe that
12 Ms. Zayre-Brown was not feeling stressed and
13 overwhelmed on October 17th, 2021?
14 A I have no reason not to believe it.
15 Q Okay. And near the end of that paragraph, it
16 says, "She reports sometimes she thinks she may need to
17 do," quote, "self mutilating," closed quote, "behavior
18 to get help."
19 Do you have any reason to believe that
20 Ms. Zayre-Brown was not, in late October of 2021,
21 thinking about engaging in self-mutilating behavior?
22 MS. BRENNAN: Objection to characterization.
23 You can answer.
24 THE WITNESS: I mean, it's written here her
25 motivations seem mixed, but I have no reason to doubt

1 it if she said it.
2 BY MR. DAVIDSON:
3 Q And then if you go up under "self-injury
4 alerts," it states, "PT reports one suicide attempt in
5 2019 by OD to get away from men's prison." That was in
6 quotes, "to get away from men prison."
7 Do you have any understanding of what "OD"
8 refers to?
9 A Overdose.
10 Q And do you have any reason to doubt that
11 Ms. Zayre-Brown attempted to commit suicide in 2019 by
12 overdose?
13 MS. BRENNAN: Objection. Foundation; calls for
14 speculation.
15 You can answer.
16 THE WITNESS: I'm not sure. I'm not sure if, like,
17 a suicide attempt was a suicide attempt to die or was a
18 suicide attempt to call attention. I'm not judging it
19 either way. I'm just saying I'm not sure what the
20 motivation was.
21 BY MR. DAVIDSON:
22 Q Okay. At the time of the 20 -- of the
23 February 17th, 2022, DTARC meeting, did you have any
24 understanding of whether or not Ms. Zayre-Brown had
25 attempted suicide at some point?

1 A I would have read through the chart, and I
2 would look at -- look at that, yes. I don't
3 remember --
4 Q Okay.
5 A -- right now, but I would have, yes.
6 Q And then under that sentence, it says, "She was
7 admitted to inpatient NCCIW in December of 2020 due to
8 self-harm." Do you have any reason to believe that
9 that is not true?
10 MS. BRENNAN: Jon, we didn't catch the end of that,
11 and also we're not seeing your face again. We're
12 generally hearing you very well.
13 MR. DAVIDSON: I'm backing up.
14 MS. BRENNAN: Okay.
15 MR. DAVIDSON: Backing up.
16 MS. BRENNAN: We're generally hearing you okay, but
17 it's still helpful if we can see -- see your face.
18 MR. DAVIDSON: Sure.
19 BY MR. DAVIDSON:
20 Q All right. So in the -- the last sentence
21 under "self-injury alerts," it says, "She was admitted
22 to inpatient NCCIW in December of 2020 due to
23 self-harming thoughts"?
24 A I have no doubt -- I have no question that she
25 probably reported self-harming thoughts.

1 Q Were you aware at the time of the
2 February 17th, 2022, DTARC meeting that Ms. Zayre-Brown
3 had been admitted to -- as an inpatient at NCCIW?
4 A Yes.
5 Q Were you aware on February 17th, 2022, of
6 whether or not Ms. Zayre-Brown had engaged in any
7 self-harm?
8 A That was in the record. There was some in the
9 record, I believe, yes.
10 Q Okay. And as best as you recall, was that
11 self-harm through any particular part of her body?
12 A I think there was one episode where there
13 was -- she reported there was a rubber band that she
14 put around her penis, I think.
15 Q Okay. I'd next like to mark as Exhibit 17,
16 DAC 681.
17 (Exhibit 17 marked for identification.)
18 BY MR. DAVIDSON:
19 Q So this is dated February 2nd, 2021. So five
20 days after Exhibit 16. Do you believe that this is a
21 document you've seen before?
22 A I think so.
23 Q In the second paragraph under "comment," it
24 says, "Offender Brown attended today's FTARC and
25 expressed her frustration and anger regarding

1 denial/delay of requested vulvoplasty." And then in
2 the last sentence, it says, "Notably Offender Brown
3 stated that she is willing to pay for surgery herself.
4 And additionally stated that if she did not receive an
5 update before Christmas, she would require surgery due
6 to taking matters into her own hands."
7 Do you have any understanding of what that
8 means?
9 A I would only be guessing, so I'd say no.
10 Q Okay. I'd like to mark as Exhibit 18 a
11 one-page document, it's DAC 680.
12 (Exhibit 18 marked for identification.)
13 THE COURT REPORTER: Thank you.
14 BY MR. DAVIDSON:
15 Q It's also dated November 2nd, 2021, but it says
16 1500 -- I normally refer to it as 3:00 -- so a little
17 later in the day, but then Exhibit 17, which said
18 1420 -- otherwise known as 2:20 p.m. And my question
19 is with respect to Exhibit 18, have you ever seen this
20 document before?
21 A I probably have.
22 Q Okay. And under "comment," this is -- this is
23 also listed as provider Marvella Bowman just like the
24 prior one. Under comments, it says, "Offender Brown
25 made a statement of self-harm during today's FTARC,

1 indicating that if she did not receive an update about
2 progress on the decision regarding DTARC determination
3 re requested surgery, she would mutilate her phallus,
4 referred to in earlier documentation as taking matters
5 into her own hands."
6 So do you recall on seeing this whether you --
7 it raised any concerns on your part that
8 Ms. Zayre-Brown might engage in self-harm such as
9 mutilating her phallus?
10 A Yes. So it was mitigated by the next couple of
11 statements, so --
12 Q Okay. What -- what mitigated it?
13 A "No risk assessment indicated." So this is
14 like -- sometimes they do, they'll --
15 (Reporter clarification.)
16 THE WITNESS: A SIRA, S-I-R-A. Sorry.
17 So I know Dr. Bowman, and I think she's competent
18 and -- and a good person. So the fact that she didn't
19 think there was any risk assessment indicated at the
20 time and that she would be following the person made me
21 less concerned.
22 BY MR. DAVIDSON:
23 Q Next I'd like to mark as Exhibit 19 a two-page
24 document. It says in the lower right DAC 666. I'm
25 sorry. It's a three-page document.

1 (Exhibit 19 marked for identification.)
2 THE COURT REPORTER: Thank you.
3 BY MR. DAVIDSON:
4 Q This is dated December 6th, 2021, and also the
5 provider, again, is listed as Marvella Bowman. Have
6 you seen this document?
7 A I certainly -- I probably have because I would
8 review the record.
9 Q Okay. If you look at the bottom of the first
10 page, it says "progress towards goals." And then
11 continuing on to the next page, it says, "Reduced
12 feelings of dysphoria measured" -- paren, "measured by
13 rating dysphoric feelings on a scale from 0 to 10, 0
14 equals dysphoria, 10 equals extreme dysphoria, by
15 getting 5 or below at least three weeks -- three days a
16 week."
17 So I'm trying to understand. Is it your
18 understanding that what Dr. Bowman was saying that --
19 was that it was bold to try to reduce Ms. Zayre-Brown's
20 feelings of dysphoria to 5 or below at least three days
21 a week?
22 A I think so, yes.
23 Q And then it says, "Today Offender Brown
24 reported a level of 11," quote, "it's high."
25 Do you have any reason to believe that that

1 portion of this document is inaccurate?
2 A I think if Dr. Bowman wrote what -- and she
3 probably said it, so I -- I don't have an issue with
4 it, no.
5 Q Were you ever informed by any of
6 Ms. Zayre-Brown's healthcare providers that
7 Ms. Zayre-Brown was not reporting high feelings of
8 dysphoria in December of 2021?
9 A You know, the time frame is -- is difficult.
10 I -- you know, I wouldn't -- I don't really -- I
11 couldn't comment on that. I just -- I do know that
12 there is -- I won't say "inconsistencies," but
13 there's -- she describes herself as content. She is
14 doing her school work more regularly. She remains
15 focused on weight loss, but not hyper focused on where
16 I want to be.
17 So she has -- you know, so -- you know,
18 certainly if I see 11 over 10, it always -- it would
19 get me concerned, and it certainly would catch my
20 attention. It's something I'd want to look and see, is
21 the objective data as much as -- I want to have
22 consistent with that.
23 So this is, you know, her self-report. She --
24 just -- I'm randomly pulling out things. She described
25 hopeless -- not hopelessness -- hopefulness.

1 So -- and I -- again, I -- I don't think
2 Dr. Bowman came away with this -- it didn't sound like
3 there was an urgency to Dr. Bowman's change of plan to
4 follow up. So, you know, it's something I definitely
5 would note. It definitely would raise some concerns in
6 follow-up, but it -- as a clinician, but reading
7 through the actual narrative, it's this bit of
8 incongruence about the details with the subjective
9 rating.
10 Q Well, in your experience, is it possible for
11 someone to have high levels of gender dysphoria, and
12 yet engage in programs and -- yeah. Let's leave it at
13 that.
14 A I think it would be possible.
15 Q And do you recall whether this document was
16 referenced or not during the February 17th, 2022, DTARC
17 meeting?
18 A I do not recall.
19 Q And did you believe at the time of the
20 February 17th, 2022, DTARC meeting that Ms. Zayre-Brown
21 was no longer experiencing high dysphoria?
22 A No, I don't think there's ever been really a
23 question if she meets the criteria for gender
24 dysphoria. I think we're all in sort of agreement that
25 she does meet that -- you know, she does meet the

1 diagnosis of gender dysphoria.
2 Q Mark as Exhibit --
3 MS. DELGADO: Jon, can we pause for a second?
4 MR. DAVIDSON: Yes, of course. Is Jaci here?
5 MS. DELGADO: Yes.
6 MR. DAVIDSON: Okay. Let's take a break.
7 (Pause in proceedings.)
8 BY MR. DAVIDSON:
9 Q I want to mark as the next exhibit, it would be
10 Exhibit 20, a three-page document, at the lower
11 right-hand corner, it says DAC 659.
12 (Exhibit 20 marked for identification.)
13 THE COURT REPORTER: Thank you.
14 BY MR. DAVIDSON:
15 Q This is dated December 20th, 2021, and it's
16 also -- it says the provider Marvella Bowman, PhD,
17 again. Is this a document you've seen before?
18 A I would have reviewed it probably. If it was
19 in the records, then I would review it.
20 Q And looking at the top of the second page --
21 MS. BRENNAN: If he could have just a moment to
22 review.
23 MR. DAVIDSON: Sure.
24 THE WITNESS: Okay. I'm okay if you're ready.
25 BY MR. DAVIDSON:

1 Q Okay. So under "schedule" on the second page,
2 it says "Routine F/U" -- is that a common abbreviation
3 for follow-up?
4 A Where was that --
5 Q It's about halfway -- a little more than
6 halfway down the schedule, "Routine F/U"?
7 MS. BRENNAN: The schedule is right here.
8 THE WITNESS: Oh, okay.
9 Routine follow-up every two weeks.
10 BY MR. DAVIDSON:
11 Q Yeah, is F/U follow-up?
12 A Yes. Sorry.
13 Q And then it says, "Transferred to JD." Can you
14 tell me what that stands for other than my initials?
15 A I -- I don't know.
16 Q Okay. And at the top of this page, it says,
17 "Reduced feelings of dysphoria, measured by rating,
18 dysphoric feelings on a scale from 0 to 10, 0 equals no
19 dysphoria to ten equals extreme dysphoria, by being 5
20 or below at least three days a week. Today Offender
21 Brown reported a level of 10."
22 Do you have any reason to believe that
23 Ms. Zayre-Brown did not warrant a level of 10 of her
24 dysphoric feelings on December 20th, 2021?
25 A No. I -- I believe that she reported a level

1 of 10.
2 Q Okay. I'd like to mark as Exhibit 21 a
3 one-page document. It says at the bottom right
4 DAC 368.
5 (Reporter clarification.)
6 (Exhibit 21 marked for identification.)
7 THE COURT REPORTER: Thank you.
8 BY MR. DAVIDSON:
9 Q Under "progress toward goals," the last
10 sentence says, "Offender asked to be seen every two
11 weeks as she describes her current level of dysphoria
12 as off the charts." Is that something you would have
13 seen before the February 17th, 2022, DTARC meeting?
14 A Yes.
15 Q And did you have any reason to believe then
16 that Ms. Zayre-Brown was not reporting a level of
17 dysphoria as off the charts?
18 A I would -- if it's written by Ms. Dula, I
19 assume that that's what she said.
20 Q And then the follow-up next appointment, it
21 says, "Clinician agreed to increase contact due to
22 offender's continue" -- that's a typo -- "high level of
23 dysphoria."
24 Do you have any reason to doubt that
25 Ms. Dula -- who's listed as the provider here -- at

1 that time felt the need to do increase the visits due
2 to the high level of dysphoria that Ms. Zayre-Brown was
3 reporting?
4 A No. I think she switched therapists, which
5 creates some angst in and of itself. So the
6 dysphoria -- I'm not sure if it's the dysphoria of
7 switching therapists or dysphoria associated with the
8 gender dysphoria or both, but I -- I don't doubt it was
9 concern.
10 Q And was this document discussed at the
11 February 17th, 2022, DTARC meeting?
12 A I don't remember.
13 Q Was a recent decision to increase her mental
14 health visits discussed?
15 A I also do not remember.
16 Q Okay. I would like to mark as Exhibit 22 a
17 one-page document. It says in the lower right DAC 6 --
18 I'm sorry -- 366.
19 (Exhibit 22 marked for identification.)
20 THE COURT REPORTER: Thank you.
21 MR. DAVIDSON: Sure.
22 BY MR. DAVIDSON:
23 Q Dr. Sheitman, do you believe you have ever seen
24 this document?
25 A I suspect I have, yes.

1 Q It is dated February 7th, 2022. So that's just
2 ten days before the February 17th DTARC meeting; right?
3 A Yes.
4 Q It's also -- provider, again, was Jennifer
5 Dula. Under "progress toward goals," the first
6 sentence says "Offender is reporting increased
7 dysphoria and associated anxiety." Do you have any
8 reason to believe that that is not a true statement?
9 A I do not.
10 Q And was that discussed at the February 17th,
11 2022, DTARC meeting?
12 A I keep saying "I don't remember," but I
13 sincerely don't remember.
14 Q Okay. And do you have any reason to doubt that
15 Ms. Zayre-Brown on February 7th, 2022, was not
16 reporting increased dysphoria and associated anxiety?
17 A I do not.
18 Q At the time of the February 17th, 2022, DTARC
19 meeting, did, in your view, Ms. Zayre-Brown have
20 clinically -- clinically significant distress,
21 depression, or anxiety associated with her gender
22 dysphoria?
23 A I definitely think she had some distress. The
24 magnitude isn't clear to me. I mean, if you look at
25 this appointment, the follow-up is in 45 days. If you

1 look at self-injury alert, there are no elevated risk
2 factors. So this is sort of a mixed picture here. So
3 I'm not -- I'm not sure. I definitely think there was
4 some distress. The magnitude, though, is not clear to
5 me.
6 Q So you're saying that the follow-up on -- from
7 Exhibit 22 is 45 days?
8 A Yeah, follow-up in 45 days or sooner.
9 Q If you look at her schedule, it says two-week
10 follow-up.
11 A Oh.
12 Q Do you have any understanding as to why those
13 say different things?
14 A I don't. Well, in any case, it's not more.
15 Even in the least case, it's two weeks. But I -- well,
16 I don't want to guess.
17 Q Well -- so in a number of the -- of these
18 records that we've been looking at, her mental health
19 providers noted that she was reporting increased
20 dysphoria in the weeks leading up to the February 17th,
21 2022, DTARC meeting. Did you believe at the time of
22 that DTARC meeting that she was no longer experiencing
23 increased dysphoria?
24 A I'm sure she was increasing -- experiencing
25 dysphoria. Again, I'm honestly not sure of the

1 magnitude of the dysphoria. I suspect -- it would only
2 be natural that if she's waiting to hear about the
3 decision -- the recommendation to have surgery or not
4 have surgery, that she would become increasingly
5 anxious thinking about it. So I would suspect that was
6 on her mind.
7 And, again, offender does not report any
8 concern. There's no sleep, appetite, energy level,
9 insight, and judgment are adequate. She denied any
10 current destructive, homicidal, or suicidal ideation.
11 So there's -- there's mixed sort of -- it's hard for me
12 to be clear that it's -- how severe it is.
13 Q Okay. Were you at any time concerned that
14 Ms. Zayre-Brown might engage in self-harm if DPS
15 rejected her request to obtain gender-affirming
16 surgery?
17 A Yes.
18 Q Okay. And what -- what was your concern?
19 A I mean, it's an inexact science. So we do the
20 best we can, make the best judgments on the -- on the
21 recommendations which we think is the best treatment
22 and the safest. And I don't know if it's right or
23 wrong, but there could be a variety of outcomes.
24 Q And aside from engaging in self-harm, were you
25 at -- at any time concerned about the effect of the

1 denial of Ms. Zayre-Brown's receipt of gender-affirming
2 surgery on her gender dysphoria?
3 A Yes. But, again --
4 Q Can you please describe your concern?
5 MS. BRENNAN: He was still finishing his answer.
6 MR. DAVIDSON: I'm sorry.
7 THE WITNESS: It's a yes. You know, again, looking
8 at the -- what's the likelihood of benefits, what's the
9 likelihood of risks, recommend -- recommending a
10 procedure that's not, you know, considered
11 evidence-based in a prison setting that could have
12 negative outcomes.
13 So yeah, I always worry, but whenever I'm involved
14 I always worry about the outcome. I have nothing
15 against her or against the procedure. I'm just trying
16 to make the best decision in my opinion.
17 BY MR. DAVIDSON:
18 Q Well, did you believe there was a high
19 likelihood of harm to Ms. Zayre-Brown if she had
20 gender-affirming surgery?
21 A I think the -- the risks outweigh the potential
22 benefits based on what we know at this point in time.
23 The history of medicine is that there's a lot of
24 unintended consequences. The first thing you learn is
25 to do no harm. So I was just really trying to follow

1 that.
2 Q And what was your belief about the risks of --
3 to Ms. Zayre-Brown of having gender-affirming surgery
4 at the time of the February 17th, 2022, DTARC meeting?
5 A Well, surgery itself is complicated. There's
6 postop complications. You know, what goes on in the
7 prison, you know, are people making a truly informed
8 decision in the prison setting? It just -- again, to
9 recommend a non-evidenced-based treatment makes me
10 concerned. That's all.
11 Q Well, what -- I mean, I understand surgery
12 itself always presents some risks. Are there any
13 particular risks that you're aware of of a vulvoplasty?
14 A Well, like any surgery, I mean, it's -- there's
15 complexities of the surgery. It's not that complex,
16 but there's infection risks. Is she going to come back
17 two years later and say that -- you know, why did I
18 have this surgery? Was I really making a free choice
19 in the prison? Those are the things that cross my
20 mind.
21 Q Did you have any reason to believe that
22 Ms. Zayre-Brown would experience regret at having
23 gender-affirming genital surgery when she already had
24 an orchiectomy?
25 A I have no object -- there's nothing I could


Case 3:22-cv-00191-MOC-DCK Document 61-12 Filed 10/05/23 Page 72 of 115

1 point to with absolute certainty, but it's certainly
2 something that crosses my mind.
3 Q Well, I understand you can't be absolutely
4 certain about it. How likely do you think that
5 Ms. Zayre-Brown would experience regret if she received
6 a vulvoplasty?
7 A I don't know. I just -- I don't know.
8 Q Have you ever had an experience where a patient
9 was saying that they were doing better than they
10 actually were in order to avoid being denied surgery
11 based on the presence of other psychological problems
12 and comorbidities?
13 MS. BRENNAN: And I'll just say you can answer that
14 at a high level, but don't reveal any personal
15 information about any other patients.
16 THE WITNESS: Could you ask me that question again?
17 BY MR. DAVIDSON:
18 Q Yeah. Were you ever aware of a patient
19 expressing that they were doing better than they
20 actually were in order to avoid being denied surgery
21 because other people may believe that the patient had
22 other psychological problems or comorbidities?
23 A To avoid surgery?
24 Q No. To avoid being denied surgery.
25 MS. BRENNAN: I'm going to object to the form of

1 that question.
2 MR. DAVIDSON: Let me try it a different way.
3 BY MR. DAVIDSON:
4 Q Were you ever aware of a patient who said they
5 were doing better than they actually were?
6 A Oh, yes.
7 Q Okay. Is it your understanding that in order
8 for gender-affirming surgery to be recommended,
9 patients should not be experiencing other significant
10 psychological problems or comorbidities aside from
11 gender dysphoria?
12 A Yes.
13 Q Okay. So in your assessment, is it possible
14 that Ms. Zayre-Brown was playing down other
15 psychological problems she was having?
16 MS. BRENNAN: Objection. Calls for speculation.
17 You can answer.
18 THE WITNESS: I think it's possible.
19 BY MR. DAVIDSON:
20 Q And do you know whether anyone involved in
21 recommending against or disapproving Ms. Zayre-Brown's
22 request for gender-affirming surgery ever considered
23 that as a possibility?
24 A I can speak for myself, but it's hard for me to
25 speak for other people.

1 Q Okay. And for yourself --
2 A Sure.
3 Q -- did you consider that?
4 A Sure.
5 Q And did any -- and did you say anything about
6 that at the meeting?
7 A I don't recollect that I did.
8 Q And do you recollect anyone else at the meeting
9 saying anything about that?
10 A That she was down -- she was downplaying the
11 symptoms that she was having? I -- I don't --
12 Q Yes.
13 A I don't think so. I don't remember at least.
14 Q Did you at any point think that Ms. Zayre-Brown
15 would benefit from receiving gender-affirming surgery?
16 A It went through my mind that it's possible.
17 Q And what -- what sort of benefits went through
18 your mind?
19 A Well, maybe that she would -- she would no
20 longer report -- I thought it would just move her off
21 the topic, you know, because it seemed like that was a
22 theme that you read about. So if she had the surgery,
23 that wouldn't be an issue anymore. Now, it might come
24 with other things, but I thought it's possible.
25 Q Did you believe it could help her gender --

1 reduce the levels of her gender dysphoria?
2 A You know, it's possible.
3 Q Did you believe it would reduce the level of
4 her anxiety?
5 A It's possible.
6 Q Did you believe it could have any effect on her
7 prior self-harm efforts being engaged in again?
8 A It's possible.
9 Q And, finally, did you believe any -- it might
10 have any effect on her prior suicidal thoughts?
11 A It's possible.
12 Q And has -- to any of those, are you able to
13 quantify how likely it was?
14 MS. BRENNAN: Objection to form.
15 THE WITNESS: Yeah, I would just be guessing.
16 BY MR. DAVIDSON:
17 Q Okay. To the best of your knowledge, did
18 Ms. Zayre-Brown have any psychometric tests
19 administered to her in the year prior to the
20 February 17th, 2022, DTARC meeting to determine her
21 mental or emotional well-being?
22 A I'm not sure. I don't recollect.
23 Q Do you recall any psychological inventories
24 being done in that period on her?
25 A I don't recollect.

1 Q Okay.
2 MS. BRENNAN: Jon, I don't know when you're getting
3 to a good point, but --
4 MR. DAVIDSON: Let's do it now because --
5 MS. BRENNAN: Okay.
6 MR. DAVIDSON: Let's take a break.
7 (Recess.)
8 BY MR. DAVIDSON:
9 Q Dr. Sheitman, in connection with DPS's
10 consideration of Ms. Zayre-Brown's request for
11 gender-affirming surgery, was the cost of such surgery
12 ever referred to, in any conversation you were a part
13 of or heard, as a reason for not providing the surgery?
14 A There was a discussion about the cost, but it
15 was never taken to the point where that would be an
16 issue. So, you know, people thought it would be a lot
17 of money -- I think I mentioned before, there's not
18 that much money in the prison. Everything is tight.
19 So there was discussion, but we were instructed that
20 that was not an issue and that we'd just take it off
21 the table.
22 Q So that was not a reason at all for denial?
23 A Not to my knowledge, no.
24 Q Okay. Did you have any -- what was your
25 understanding of what the cost for a vulvoplasty is?

1 A I've seen numbers all over the place. I don't
2 really have a great understanding. It just didn't
3 interest me because it wasn't going to be in the
4 discussion, so I didn't really bother to look.
5 Q Okay. In connection with DPS's consideration
6 of Ms. Zayre-Brown's request for gender-affirming
7 surgery, was her release date referred to in any
8 conversation that you were a part of or heard as a
9 reason for not providing gender-affirming surgery?
10 A That also was discussed, but it wasn't really a
11 consideration. I think that, you know, if somebody's
12 getting out in three weeks, you're not going to do it
13 or -- you know, there's no absolute date. But I think
14 it was far enough out that it was never really part of
15 the discussion. It was discussed, but it was never in
16 any consideration of yes, no.
17 Q And as a -- in connection with DPS's
18 consideration, again, of Ms. Zayre-Brown's request for
19 gender-affirming surgery, were security concerns
20 referred to in any conversation you were a part of or
21 overheard as a reason for denying Ms. Zayre-Brown's
22 request for surgery?
23 A I don't recall any.
24 Q And in connection with DPS's consideration of
25 Ms. Zayre-Brown's request for a vulvoplasty, were

1 concerns about providing her postoperative care for
2 that procedure referred to in any conversation you were
3 a part of or heard as a reason for not providing the
4 surgery?
5 A That also was discussed, but it was the same
6 kind of issue as -- we just have to do what we have to
7 do.
8 Q Did you ever hear or otherwise learn of any
9 concern expressed by anyone at DPS that if DPS provided
10 gender-affirming surgery for one transgender prisoner,
11 it would have to be provided to others?
12 A I think that was more loose conversations. I'm
13 not sure of any structured way. I think I did hear
14 that kind of stuff, but I -- I don't think it was
15 any -- I don't think it was part of the DTARC
16 committee. It was just more like people talked. But I
17 don't -- it never reached the substantive stage.
18 Q Did you ever hear that from anyone who was on
19 the DTARC?
20 A I don't remember who I heard that from, to be
21 honest. But I remember -- I do remember hearing some
22 discussion about those kind of things.
23 Q Okay. So you don't recall -- you said you
24 didn't recall who it was? I just want to check, do you
25 have any recollection of Dr. Junker having ever said

1 that?
2 A I don't.
3 Q And -- and I believe her title was Assistant
4 Commissioner Harris?
5 A No.
6 Q Did you ever think that?
7 A You know, obviously, I remembered it, so, you
8 know, it's not something I completely didn't think
9 about, but it didn't have anything in the
10 decision-making process.
11 Q Do you know whether DPS has ever provided
12 gender-affirming surgery to any transgender patient?
13 A I'm not aware of any.
14 Q Did you ever hear or otherwise learn of any
15 concern expressed by anyone at DPS that there might be
16 a negative political reaction to DPS providing a
17 prisoner gender-affirming surgery?
18 A Yes.
19 Q And who did you hear that from?
20 A That also was, like, the side conversations
21 that people talk about. I don't remember exactly who,
22 but yeah, I think people thought that, politically, it
23 wouldn't be a great idea.
24 Q And did they express what their concerns were
25 about the political reaction?

1 A This is just -- I don't know how exact this is,
2 but my recollection is that North Carolina is a little
3 bit more of a conservative state, and people wouldn't
4 like going ahead with these kind of surgeries. But
5 I -- it was just kind of the talk, and it could be
6 blended into conversations that I've had other places.
7 I'm not sure. I don't remember that kind of thing ever
8 in the DTARC, though.
9 Q And did you ever hear a concern expressed by
10 anyone on the DTARC that higher-up officials within DPS
11 might be displeased if DTARC recommended that a
12 prisoner be provided gender-affirming surgery?
13 MS. BRENNAN: Objection to form.
14 You can answer.
15 THE WITNESS: I don't remember -- again, I remember
16 this is the kind of thing that's discussed, not ever as
17 part of the DTARC to my recollection, but I think, you
18 know, people -- actually, I have even forgot -- which
19 was the last thing you mentioned? I was -- my mind
20 went somewhere else.
21 BY MR. DAVIDSON:
22 Q About -- about -- it was about whether
23 higher-up officials with DPS might be displeased?
24 A I think there was discussions, like -- again,
25 side discussions, never about the DTARC. But, clearly,

1 people thought that it wouldn't be popular, I think in
2 general discussions, to be honest.
3 Q So in Dr. Campbell's deposition in this case,
4 he said that in DTARC meetings chaired by Dr. Peiper,
5 he would usually begin by presenting a case. Do you
6 recall that happening on February 17th, 2022?
7 MS. BRENNAN: Objection. Vague.
8 You can answer.
9 THE WITNESS: Yeah, I mean, I think that's kind of
10 the usual process. You know, the February 17th is --
11 you know, I'm getting old. The days sort of blur
12 together. I don't really remember specifically that
13 one, to be honest. You know, anything -- yeah.
14 There's so many of these things. I just don't remember
15 the actual date.
16 But it would be part of the process that we go
17 through, that Dr. Peiper usually takes the lead,
18 discusses the case, goes through them. So that would
19 have occurred.
20 BY MR. DAVIDSON:
21 Q Do you recall, in 2022, how frequently did
22 DTARC meet?
23 A I think it's quarterly, maybe a little more
24 frequently.
25 Q Okay. When Dr. Peiper presented a case,

1 what -- what would that usually entail?
2 A He would give us some, maybe, background
3 information, where we are with this case, is this the
4 first time we've seen this case, is this -- we've
5 reviewed, discussed this case, you know, get us up to
6 date again. It's probably -- you know, and then what
7 would -- any new specific issues. And then we would
8 go -- each person would give their input about the
9 case. That's typically how it goes.
10 Q Okay. And did -- did you go in a particular
11 order providing input?
12 A I think it's evolved that way. I'm not sure
13 originally it was that way. I mean, again, it's sort
14 of an evolution of a process that we would try to
15 tighten it up, get more structured. At first, it may
16 not have been as structured.
17 I think, like, Peiper -- Peiper, Dr. Campbell,
18 myself, Josh Panter who is the custody person, the PREA
19 representative always speaks, and there might be some
20 other folks, too, that I'm not recalling.
21 But I know that that group always sort of gives
22 their input. There might be -- again, there might be
23 somebody else I'm blanking on, but that -- that's the
24 group that usually always will give their input.
25 Q So I understand that the February 17th DTARC

1 meeting was 15 months ago, but as best as you can
2 recall, what -- what did Dr. Peiper say at the
3 February 17th, 2022, meeting?
4 A I apologize, but I would remember the process.
5 I just don't -- I would be just making stuff up if I
6 would go through the content.
7 Q Don't want you to do that.
8 Do you have any recollection of anything you
9 said?
10 A No. At this moment -- again, you know, I know
11 what I must have said in some form, but the specifics,
12 I just don't remember.
13 Q All right. I don't want you to speculate. But
14 I -- when you say you know what you must have said, you
15 know what you must have said based on what?
16 A Based on the review of the record. I would
17 have reviewed the record. I would look for certain
18 things, and I would, you know, give my opinion based on
19 what I saw in the record, and I would give, you know,
20 what she said plus I would also give, you know, what I
21 think about the comments. You know, stuff like that.
22 Q Okay. And -- and do you recall what your
23 assessment was?
24 A No. Without -- you know, without looking at
25 that, I would -- again, I would just be making it up.

1 Q Okay. Do you recall anything that Dr. Campbell
2 said?
3 A Not specifically.
4 Q At -- at DTARC meetings, would Dr. Campbell
5 typically present his perspective from a medical
6 context?
7 A Yes.
8 Q Now -- now, you're -- you were also an MD;
9 correct?
10 A Correct.
11 Q But you are more trying to provide a
12 psychiatric context; is that correct?
13 A Correct. Yes.
14 Q Do you recall whether Dr. Campbell stated at
15 the meeting whether he believed gender-affirming
16 surgery was medically necessary for Ms. Zayre-Brown?
17 A I mean, I would -- I don't -- I can't see it,
18 like, played out in a movie right in front of me, but I
19 would be fairly certain that Dr. Campbell did not think
20 it was medically necessary.
21 Q Okay. And as far as you recall, do you -- do
22 you have any recollection of what he may have said
23 about why he believed it was not medically necessary?
24 A I think he also felt that the weight of the
25 evidence didn't support it. The weight of the evidence

1 for its benefits versus its risk versus her current
2 condition.
3 Q Got it. I'd like to mark as Exhibit 23 a
4 five-page document. It says in the lower right-hand
5 corner DAC 3399.
6 (Exhibit 23 marked for identification.)
7 THE COURT REPORTER: Thank you.
8 MR. DAVIDSON: Sure.
9 BY MR. DAVIDSON:
10 Q This says at the bottom "Case Summary DTARC
11 2/17/22, Offender No. 061-8705," which we've previously
12 seen on other documents referencing Ms. Zayre-Brown.
13 Have you seen this document before?
14 A Yes.
15 Q And -- and what is a case summary?
16 (Reporter clarification.)
17 THE WITNESS: It's something that's -- basically,
18 you take the case and you summarize the case, the
19 issues, the background, where we are on plans,
20 treatments tried, things like that.
21 BY MR. DAVIDSON:
22 Q I believe you previously testified today that,
23 at some point, you started providing written input in
24 advance of the DTARC meeting?
25 A Correct.

1 Q And my question is, looking at this document,
2 do you know whether you provided written input into
3 this document before this DTARC meeting?
4 A I don't think it went back that far.
5 Q Okay.
6 A So I -- I don't think so.
7 Q Do you know whether or not this case summary
8 was prepared before or after the February 17th, 2022,
9 DTARC meeting?
10 A I don't know.
11 Q Okay. Do you have any recollection of whether
12 you reviewed this before the February 17th, 2022, DTARC
13 meeting?
14 A Let me -- could I just -- let me read it --
15 Q Sure.
16 A -- for a little bit, and then it might help jog
17 my memory.
18 Q Yeah. It's a long document, so why don't we go
19 off the record?
20 (Pause in proceedings.)
21 THE WITNESS: Okay.
22 BY MR. DAVIDSON:
23 Q So my question was do you believe you reviewed
24 this before the February 17th, 2022, DTARC meeting?
25 A Again, if it was in the record, I reviewed it

1 when it got in the record. I don't remember exactly,
2 but I have reviewed it a couple of times actually. I
3 just didn't remember. That's the best I can do.
4 Q Okay. Near the top of page 2, it says, "The
5 patient's mood and anxiety symptoms appear
6 well-controlled by psychiatric interventions."
7 The -- so my question is, is that something you
8 felt at the time of the February 17th, 2022, DTARC
9 meeting?
10 A I think "well-controlled" might be stronger
11 than I might have characterized. Reasonably controlled
12 would probably be more what I thought.
13 Q Okay. And -- and what psychiatric
14 interventions did you think made her mood and anxiety
15 symptoms reasonably well-controlled?
16 A I think she, truthfully, didn't have that many
17 psychiatric interventions. I think she was on just a
18 little bit of medication. Wasn't -- she saw a
19 psychiatrist probably every few months. So it
20 really -- she didn't have that much psychiatric
21 interventions, which I saw was actually a fairly good
22 sign.
23 I mean, she was -- again, I don't want to get
24 into a whole date issue because I always get mixed up,
25 but I think she was -- compared to lots of the patients

1 that I see, she didn't really stand out to me as
2 excessively dysphoric, depressed, anxious.
3 Again, mostly -- most of the people in prison
4 have symptoms of depression and anxiety. The rates of
5 depression in the population are much higher than
6 people think, and anxiety -- 25 percent -- 18 percent
7 of the people in the general population have some kind
8 of mental health disorder. It's much, much higher in
9 prison. Serious mental illness, it's like four times
10 as high in the prison population. Substance abuse is
11 like eight times higher.
12 So my point is that compared to a general
13 person, I saw her symptoms did not seem -- I'm not
14 dismissing them. We take them seriously. But her
15 symptoms didn't jump out at me as very severe at this
16 point in time.
17 Q So I believe we saw before that
18 Ms. Zayre-Brown, at least at some point, was taking
19 Zoloft?
20 A Correct.
21 Q That would have been one of the psychiatric
22 interventions?
23 A Right. And I think she came off. I'm not sure
24 when she even came off, but she didn't feel she needed
25 it.

1 Q And were you aware that, at some point,
2 Ms. Zayre-Brown was taking atomoxetine?
3 A Atomoxetine. It's Strattera. I think she had
4 ADHD symptoms or reported that she did.
5 Q And would atomoxetine have any effect on gender
6 dysphoria experienced by a transgender patient?
7 A I don't think so. I think it would just help
8 in general if you're having trouble focusing in
9 anything you're doing, that if you can control that
10 some, you'd probably feel better.
11 Q And this -- this view that patient's mood and
12 anxiety symptoms appear reasonably well-controlled --
13 or reasonably controlled by psychiatric interventions,
14 was that based on anything anyone told you?
15 A I don't think I actually wrote this, but I
16 think I probably reported that, in my opinion, her
17 symptoms did not seem that severe at this time.
18 Q Okay. And was that based on -- on information
19 from any particular provider?
20 A I did -- read through the notes and tried to
21 look -- see objective things that she said and what
22 was -- how she was doing in general.
23 Q Okay. And do you recall any particular notes
24 that led you to that impression?
25 A No. I'm sorry. I don't.

1 Q That's okay. Then the rest of that sentence
2 says, "However, recent progress notes from supportive
3 counseling and therapy sessions indicate that the
4 patient has been heavily focused on the status of that
5 final decision regarding her requested/desired surgery
6 and experiencing related anxiety/frustrated mood."
7 Did you believe at the time of the
8 February 17th, 2022, DTARC meeting that
9 Ms. Zayre-Brown's anxiety and frustration were due only
10 to her focus on the status of the final decision
11 regarding her surgery?
12 A I mean, I can't say "only." I would just say
13 that that would be a component of it.
14 Q And do you believe that anxiety and frustration
15 were the only emotions Ms. Zayre-Brown --
16 Ms. Zayre-Brown was experiencing at that time?
17 MS. BRENNAN: Objection to form.
18 You can answer.
19 THE WITNESS: Yeah, again, I would just take what's
20 in the record.
21 BY MR. DAVIDSON:
22 Q By "the record," you mean the medical record?
23 A Correct.
24 Q Okay. Then continuing on to page 2 through the
25 end of that document -- well, through the top of

1 page 5 -- no, I guess through the end of the document.
2 Under where it says "medical analysis," do you have any
3 knowledge about who provided the information in this
4 medical analysis in this document?
5 A It looks like something similar that
6 Dr. Campbell had written previously.
7 Q Okay. Were you aware of any clinical provider
8 for Ms. Zayre-Brown that had ever recommended against
9 providing her surgery?
10 A I am not aware of any.
11 Q And we looked before at several things from
12 Dr. Caraccio saying it was medically necessary and
13 Dr. Figler saying that was the plan and Ms. Dula
14 expressing her opinions. Did you believe they were all
15 wrong?
16 MS. BRENNAN: Objection to form and
17 characterizations.
18 You can answer.
19 THE WITNESS: I think in the real world when you go
20 to a specialist, I think they see their role is to
21 see -- you know, they don't see the larger picture. So
22 I think from -- they believe what they wrote. Ms. Dula
23 I think -- I'll say everybody believed what they wrote.
24 I have no reason to doubt it. I'll leave it at that.
25 BY MR. DAVIDSON:

1 Q But the people on DTARC -- DTARC did not agree
2 with what they wrote, is that correct, about whether or
3 not this was something Ms. Zayre-Brown needed?
4 MS. BRENNAN: Objection to form; characterization.
5 You can answer.
6 THE WITNESS: At least -- at least we thought it
7 wasn't -- wouldn't meet criteria for medical necessity.
8 BY MR. DAVIDSON:
9 Q So in this medical analysis -- in the second
10 line, it refers to medical analysis, including a
11 comprehensive literature review. Who did that
12 comprehensive literature review?
13 A I believe Dr. Campbell put together a
14 literature review.
15 Q And then in the next sentence, it says, "Based
16 on this review, it is the determination of the medical
17 authority that gender reassignment surgery for MGRS as
18 requested by this offender is not medically necessary."
19 Who is the medical authority?
20 A Again, I didn't write this. So I am guessing
21 it's Dr. Campbell.
22 Q Okay. Then on -- on this page and again on
23 page 4 of this document, there's a number of underlined
24 passages that seem to be references to various
25 studies --

1 A Yes.
2 Q -- from published documents. And my question
3 is if you could look through them and tell me if there
4 are any of those that you yourself have reviewed?
5 A I had not reviewed any of these particular
6 studies. As I said before, I went through the
7 literature, and there was some already, like, reviews
8 available in the literature, and it was easier for me
9 to just review that than to focus on these because I
10 was -- I was hoping to find, like, the best studies.
11 And in fair -- in honesty, it would just take
12 me too much time to review the whole literature and
13 make sure that I got the right studies. So I was
14 looking at the experts, and I would just take theirs.
15 So that's what I did.
16 Q Okay.
17 A But I -- I have not read these studies --
18 particular studies from cover to cover. I may be --
19 you know, I may have looked at the abstract, but not
20 the whole thing.
21 Q It is your belief that Dr. Campbell did look at
22 these studies?
23 A If he said he did, I'm sure he did.
24 Q Okay. And did you rely on his characterization
25 of these studies?

1 A I definitely looked at it, and I was impressed
2 by the -- the thoroughness of it. I tend to be a
3 skeptic by nature, so I also, like, took a look myself
4 too, so --
5 Q Okay. So did you yourself contribute in any
6 way to this medical analysis?
7 A What's written here, I do not believe that I
8 did.
9 Q Okay. And is there anything that you see in
10 this medical analysis -- and, again, we can go off the
11 record so you can read it again if you'd like -- that
12 you don't agree with?
13 A I don't know enough -- I may be concerned about
14 what he was saying about the WPATH committee, so it's
15 concerning because, you know, I've been in a little bit
16 of the research world and I sort of know what goes on a
17 little. So it is very concerning when I read that. It
18 had nothing to do with him.
19 And then when I went to the literature and
20 reviewed it, there's literature in both directions.
21 It's not all one-sided literature. So there's some
22 other literature. But for the most part, I don't
23 really disagree with anything that he put in here.
24 Q Well, in -- on page 3 in the fifth paragraph
25 near the end of that, it says, "This precisely the case

1 here where there is significant concern for objectivity
2 and conflict of interest among WPATH."
3 A What side --
4 Q Did you have significant concern for
5 objectivity and conflict of interest by WPATH?
6 A Sorry -- where are you? Sorry.
7 Q I'm sorry. Page 3.
8 A Okay.
9 Q It's five paragraphs down. It starts, "When as
10 clinicians."
11 A Okay.
12 Q So my question is, did you have significant
13 concern for the objectivity and conflict of interest
14 among WPATH?
15 A I had no reason to have concerns, but I went to
16 the literature anyway just to -- to satisfy myself.
17 But I had no reason to be concerned. I wouldn't be
18 shocked if some of these things were true, but I
19 personally had no reason to be concerned.
20 Q And how about US Endocrine Society, do you have
21 any reason for significant concern for their
22 objectivity and conflict of interest?
23 A I don't.
24 Q There's a reference in this document to
25 "de-transitioning." Do you know what that concept is?

1 I'm sorry. It's on page 4, the second full
2 paragraph. "There's a growing body of research into
3 what seems to be an increasing number of transgender
4 individuals who, at some point," quote,
5 "de-transition."
6 Is that something you had heard about
7 previously?
8 A I have heard about it, but -- but I don't have
9 a strong -- I mean, I -- the literature on that wasn't
10 overwhelming either, so...
11 Q Do you have -- you know, what's your best sense
12 of what percentage of trans -- transgender individuals
13 at some point de-transition?
14 A It depends -- I could be wrong on this, but I
15 think I looked at this, and it varies from very little
16 to substantial. So it depends where you read, but some
17 studies will say it's very little and some studies, I
18 think, say more. But I -- I don't think the quality of
19 the studies was great, and I shouldn't probably even be
20 saying it because I don't remember enough about it.
21 But that's what I remember.
22 Q Do you -- do you recall there being any
23 discussion at the DTARC meeting of the risk to
24 Ms. Zayre-Brown of de-transitioning after undergoing
25 gender-affirming surgery?

1 A If there was, it wasn't a substantive
2 discussion. It could have been just a few words, but I
3 don't remember. I do remember -- I don't recall any
4 substantive discussion.
5 Q And do you have any view about whether
6 de-transitioning is more or less likely for someone
7 who's been on hormones for more than a decade and has
8 had a orchiectomy before than for someone who's not?
9 A I would be guessing. I don't -- I don't know
10 the literature on that.
11 Q Okay. Looking at the bottom of page 3, the
12 paragraph that says, "Perhaps one of the most important
13 considerations in developing treatment plans for our
14 patients is the long-term prognosis following a
15 treatment."
16 Did you have any view on February 17th, 2022,
17 about the long-term prognosis for Ms. Zayre-Brown if
18 she were provided gender-affirming surgery?
19 A I think the medical literature would still say
20 it's somewhat inconclusive. And I do believe what
21 is -- as I said before, first do no harm, is a strong
22 consideration.
23 Q And the last sentence there says -- so the do
24 know harm is part of what's known as the -- is that
25 part of the Hippocratic Oath?

1 A I think so.
2 Q And then the last sentence of that paragraph
3 says, "The evidence regarding GRS does not provide
4 sufficient confidence that the procedure should be
5 undertaken without concern for having violated that
6 oath." Is that something that you believe?
7 A I believe you look case by case, and in certain
8 cases, you would probably be more likely to go forward;
9 other cases, you would not. In this case, as I saw it,
10 I did not think the severity of the dysphoria warranted
11 the risk of a non-evidenced-based surgery.
12 Q So do you believe that doctors that perform
13 gender-affirming surgery should be concerned about
14 whether they are violating the Hippocratic Oath by
15 doing so?
16 MS. BRENNAN: Objection to form.
17 You can answer.
18 THE WITNESS: I would assume they think they're
19 doing the right thing, but there are different ways
20 to -- to see it. I'm not -- I don't judge anybody if
21 they think that they're doing the right thing, and it's
22 just I wouldn't agree with it, but there's other
23 opinions.
24 BY MR. DAVIDSON:
25 Q Okay. Well, of the gender-affirming surgeries

1 A I would just be guessing the deputy
2 commissioner director of health and wellness.
3 Q Okay. And --
4 A I don't know if that's true.
5 Q -- was the director -- I'm sorry.
6 A I don't know if that's true. I'm just saying.
7 Q Okay. Was the director of health and wellness
8 in -- in this period around December -- February 17th,
9 2022, was that Dr. Junker?
10 A I think so, yes. I think.
11 Q And was the deputy commissioner Brandeshawn
12 Harris?
13 A Yes. I'm pretty sure of that.
14 Q Okay. I would like to mark as Exhibit 26 a
15 two-page document; right-hand corner says DAC 3417.
16 (Discussion off the record.)
17 MR. DAVIDSON: What we're marking as Exhibit 25
18 is -- in the right-hand corner, it says DAC 3416,
19 DAC 3417, and DAC 3418, on the respective pages.
20 THE COURT REPORTER: Thank you.
21 BY MR. DAVIDSON:
22 Q So do you believe you've ever seen what's on
23 3417 and 3418?
24 A I think so, yes.
25 Q And in the fifth paragraph that starts -- well,

1 "Review of patient's related mental health and
2 behavioral health record and the baseline criteria as
3 identified by UNC Trans Health Program could make her a
4 candidate for surgery." So is that something you
5 believed on February 17th, 2022?
6 A Could make her, yes.
7 Q Okay. And on 3418, it says, "Based on this
8 review, it was the determination of the medical
9 authority that gender reassignment surgery as requested
10 by this offender is not medically necessary." And
11 what's your understanding of who the medical authority
12 was?
13 A Well, I think Dr. Campbell brought the medical
14 input into the DTARC committee, and then the DTARC
15 committee sort of heard the recommendations and
16 approved. It's sort of recommendations, but I -- and I
17 also contributed, and I generally agree with what he
18 said.
19 Q Uh-huh. Do you recall anything that Terri
20 Catlett said at the meeting -- the February 17th, 2022,
21 DTARC meeting?
22 A No. I mean, I don't, not specifically.
23 Q That's fine. Do you recall anything that Sarah
24 Cobb said?
25 A No. It would be hard to -- you know, to

1 remember those things. Unless there was an outlier
2 thing, and I don't think there was anything. So --
3 Q Okay. How about Josh -- Josh Panter?
4 A No. I mean, Josh usually goes through how the
5 person is doing custody-wise, so I know he would speak
6 up, but I don't remember anything specific that he
7 said.
8 Q And was there anything custody-wise that was a
9 reason for not providing Ms. Zayre-Brown
10 gender-affirming surgery?
11 A I don't think so.
12 Q Do you recall anything that Valerie Langley
13 said at the meeting?
14 A Nothing specific, no.
15 Q And as for them -- Terri Catlett, Sarah Cobb,
16 Josh Panter, Valerie Langley -- do you recall any of
17 them saying that they believed that gender-affirming
18 surgery was or was not medically necessary for
19 Ms. Zayre-Brown?
20 A I think it was a consensus decision. I don't
21 remember anything specific that people said.
22 Q So you don't recall -- do you recall anyone
23 disagreeing with that decision at the meeting?
24 A No. I don't -- I don't think anyone did.
25 Q Okay. I'd like to next mark as Exhibit 26 a

1 one-page exhibit, DAC 005130.
2 (Exhibit 26 marked for identification.)
3 THE COURT REPORTER: Thank you.
4 BY MR. DAVIDSON:
5 Q So this is a one-page document. It says, "From
6 Arthur Campbell to Peiper Lewis," and it also lists
7 your name and some other members of the DTARC. It
8 doesn't list Ms. Catlett. Do you know why?
9 A I do not.
10 Q And, similarly, it doesn't list Ms. Langley.
11 Do you know why?
12 A I do not.
13 Q Okay. Do you recall seeing this document
14 before?
15 A Give me one more second. I don't remember this
16 whole -- I know there was -- I think it was an e-mail.
17 The voting buttons, I don't remember that stuff. But
18 I -- I vaguely do remember this, yes.
19 Q Okay. And it says, "Attachment, DTARC medical
20 necessity position statement gender reassignment
21 surgery." And so I'd like to mark as Exhibit 27 a
22 12-page document. The first page at the bottom right
23 says DAC 3404.
24 (Exhibit 27 marked for identification.)
25 THE COURT REPORTER: Thank you.

1 BY MR. DAVIDSON:
2 Q Okay. So Exhibit 27 is entitled "Division
3 Transgender Accommodation Review Committee, DTARC,
4 position statement gender reassignment surgery."
5 So seeing that and seeing what it says in the
6 attachment to -- as the attachment to Exhibit 26, do
7 you have any belief on whether or not this is what was
8 the attachment to the e-mail that's Exhibit 26?
9 A I remember the attachment wasn't as cleaned up
10 as this, I think. This might be another version, but I
11 could be wrong. I mean, it's probably substantively
12 the same thing.
13 Q Okay. So looking then at Exhibit 26 --
14 Exhibit 26 -- sorry. You said you didn't recall the
15 bit here about voting buttons. Do you recall whether
16 or not DTARC ever voted on the position statement that
17 was attached to this e-mail?
18 A Yes, I think --
19 Q And --
20 A -- it was supported.
21 Q It was supported. Okay.
22 Did that take place at a DTARC meeting?
23 A I believe it did.
24 Q Okay. And do you have any recollection as to
25 when that DTARC meeting was?



Case 3:22-cv-00191-MOC-DCK Document 61-12 Filed 10/05/23 Page 104 of 115

1 A No. I apologize. I don't.
2 Q It's okay. And do you recall, was it supported
3 unanimously by everyone --
4 A And -- it may not be a DTARC meeting, but I'm
5 sure there was some kind of -- it was, like, a
6 conference with the players. It may not have been a
7 meeting. I don't remember. But it was discussed, and
8 I remember discussing it.
9 Q Okay. And the people who were on the "to" line
10 here, do you think they were all part of that meeting?
11 A I would suspect, yes.
12 Q And -- and Dr. Campbell also was part of that
13 meeting?
14 A Yes, definitely.
15 Q And was -- was -- you said it was supported.
16 Was that support unanimous among the people at the
17 meeting?
18 A Yes.
19 Q Okay. And then in the fourth paragraph, it
20 says, "If approved, the position statement would be
21 forwarded to our FTARCs and no further consideration
22 would be given to GRS within our system." Is -- you
23 know, when this was supported by you, did you agree
24 with that sentence?
25 A I think I'm -- what I meant was that a

1 routine -- we would look -- still look case by case,
2 but we wouldn't go through a laborious discussion. If
3 we didn't think this person really was going to meet
4 criteria, we wouldn't get a referral to UNC. Like,
5 what would be the point if we're not going to sincerely
6 go through it?
7 If there was a case that we were, then we would
8 proceed. But we wouldn't proceed routinely for cases
9 where there was -- the person is doing pretty well and
10 we're not really thinking about saying that there's
11 medical necessity for surgery. So that -- that was my
12 take on this. So I kind of approved it, but maybe I
13 wasn't exactly as clear about what I was approving.
14 But I think that was kind of the understanding.
15 Q So I'm trying to understand. You are -- you
16 think the understanding was no further consideration
17 would be given to GRS within our system if this
18 position statement was approved meant except when --
19 (Simultaneous speakers.)
20 BY MR. DAVIDSON:
21 Q -- except when it would?
22 A Well, except when the severity of the gender
23 dysphoria raised -- you know, changed the equation
24 about whether gender transition surgery should be
25 approved in some -- some special cases.

1 So I think if the person was what we would --
2 and "doing well" is not a very sophisticated term.
3 But, again, if the person is doing well, why send this
4 person for a consult for a surgery that we're not going
5 to -- where we say none of us are going to approve.
6 But if the person was really struggling and we
7 thought there was -- you know, we've exhausted our
8 treatments, the person is really struggling, then we
9 would proceed. So I -- although I approved it, it
10 might've been an error on my part that I didn't think
11 it through or articulate what I was thinking well
12 enough.
13 Q Well, who would decide whether or not the
14 person was doing well enough or not as to whether or
15 not it should receive further consideration? Is that
16 something FTARC would decide?
17 A Well, the FTARC -- if it gets to the DTARC, I
18 guess there's some question about it. So the DTARC
19 would review the case and make that decision.
20 Q So would there be no difference if this was
21 adopted in terms of whether or not DTARC would consider
22 requests for gender-affirming surgery?
23 A Yeah, I think there would always be in the
24 differential is that something we should consider. But
25 if we -- if we say, "Hey, this person is, you know,

1 doing really well, they're minimizing their symptoms,
2 should we really be going on for, like, a consult with
3 the urologist at UNC?" Like, what would be the point?
4 Q Then the next sentence is "We do anticipate
5 challenges in court to the recent decisions we have
6 made as a committee." Did you have any understanding
7 as to what recent decisions were being referred to
8 there?
9 A I would assume it's the -- the statement right
10 above it. I don't know for sure. I didn't write it,
11 but I would assume that's it.
12 Q Okay. Well -- so this is dated March 22nd,
13 2022, which is, you know, a little after a month over
14 the DTARC meeting at which Ms. Zayre-Brown was
15 denied -- it was recommended that she not be provided
16 surgery. So you think this is referring to the
17 adoption of the -- of the position statement and not
18 decisions of the DTARC about individual cases?
19 MS. BRENNAN: Objection to form; characterization.
20 You can answer.
21 THE WITNESS: Yeah, as best as I can tell -- and,
22 again, I could be wrong -- if approved, the position
23 statement --
24 (Reporter clarification.)
25 THE WITNESS: I'm just reading the actual sentence.

1 Just read it out loud. I apologize for being so fast.
2 THE COURT REPORTER: That's okay.
3 THE WITNESS: "If approved, the position
4 statement" -- I'm reading now -- "would be forwarded to
5 our FTARCs, and no further consideration would be given
6 to GRS within our system."
7 So I'm thinking the next sentence is probably
8 referring to that, but I don't know. That's just --
9 I'm guessing.
10 BY MR. DAVIDSON:
11 Q Okay. And then it says in the sentence below
12 that, "We do anticipate challenges in court to the
13 recent decisions we have made as a committee. This
14 document simply provides more specific rationale, which
15 can be utilized in court to make our case."
16 Did you talk with Dr. Campbell about potential
17 future cases -- court cases --
18 A This -- sorry.
19 Q -- related to this?
20 A This has come up. I personally don't care
21 about the court thing, so it's just not something that
22 I'm interested in. So it doesn't -- like, people talk
23 about it a lot. I personally am not that interested in
24 the whole court proceeding around it, so I didn't talk
25 much about it.

1 Q Okay. So looking now at Exhibit 27. The -- so
2 is this something you believe you reviewed at some
3 point?
4 A Yes. It may have been in a little different
5 form, but I think the substance is the same.
6 Q And do you -- at the meeting at which consensus
7 was reached to -- regarding a DTARC position statement
8 on gender reassignment surgery, do you recall anything
9 being said about the position statement itself?
10 MS. BRENNAN: Objection. Mischaracterizes the
11 testimony.
12 You can answer.
13 THE WITNESS: I don't remember any specifics of
14 this. I'm sure it came up.
15 BY MR. DAVIDSON:
16 Q Okay. If you -- please turn to the last page
17 of Exhibit 27, page 12. There's a number of citations
18 there. Do you believe you've read any of those
19 citations?
20 A I doubt I read them cover to cover, but it's
21 possible one or two. But most of them, I probably have
22 not read.
23 Q Okay. Are there any that jump out, one or two,
24 that you think it's possible?
25 A I suspect I have not read cover to cover most

1 of these because I try to focus on the more current and
2 big reviews rather than the smaller articles.
3 Q The eight numbered document there -- and this
4 is by an organization, SEGM. Have you ever heard of
5 them?
6 A No.
7 Q And under the -- what's marked as page --
8 what's indicated as page 2 of this Exhibit 27 where it
9 says "summary position statement," the second paragraph
10 says, "After extensive and objective review and
11 analysis of hundreds of studies and other publications,
12 it has been determined that gender reassignment surgery
13 as a treatment for gender dysphoria is not medically
14 necessary."
15 So this document, Exhibit 27, is not about a
16 particular patient; is that correct?
17 A I don't believe so. It's a -- it's more of a
18 general topic.
19 Q And is it your understanding that this --
20 Exhibit 27 -- was something written by Dr. Campbell?
21 A It -- it looks like a lot of stuff that he's
22 written, and I believe -- and his name is on it, so I
23 would assume that he did write it.
24 Q You're right. His name's there on the first
25 page.

1 Do you agree with Dr. Campbell's conclusions
2 stated here on page 2 that GRS treatment -- GRS as a
3 treatment for gender dysphoria is not medically
4 necessary?
5 A I would say, overall, I think the literature
6 would support that.
7 Q When you reviewed this document, do you recall
8 there being anything in it that you disagreed with?
9 A I think there's two sides to the story. So I
10 think there's another -- you probably could quote, you
11 know, 15 other articles saying that it's helpful. And
12 so I don't know if it's a -- if I disagree, but I think
13 the story is a bigger one, I think, so --
14 Q Uh-huh. And does this article cite any of the
15 studies that say that gender reassignment surgery or
16 gender-affirming surgery can be helpful?
17 A I don't think it did.
18 Q Do you know why not?
19 A I can't speak for Dr. Campbell. I think he was
20 probably just trying to make an argument, so that's --
21 that's why. But I think, though, the reality of this
22 is it kind of got shelved, so it was just -- never went
23 anywhere, so that was it.
24 Q So even though the people who considered
25 whether or not this -- this should be approved at the

1 meeting that you were at where there was consensus, it
2 was never adopted. Is that your understanding?
3 A Correct.
4 Q And do you have any information as to why it
5 was never adopted?
6 A I think it was reviewed by people senior to us
7 who didn't think it was a good policy. No one really
8 ever discussed exactly why, and it was fine with me.
9 Q And do you have any information as -- as who
10 reviewed it after DTARC?
11 A I've heard indirectly, you know, the
12 commissioner, but I don't know if that's true or not.
13 Q Okay. And was that Brandeshawn Harris?
14 A I suspect she was in there, but also Todd
15 Ishee.
16 Q Okay. Right. She was the assistant
17 commissioner. Sorry.
18 A It's okay.
19 Q The -- if you please look at page 3, it -- the
20 paragraph that says, "Some prominent characteristics of
21 medically necessary procedures include," and there are
22 three bullets there. Is there anything that's in those
23 bullets that you would disagree with as characteristics
24 of medical -- something being medically necessary?
25 A I think it's tricky with a majority of health

1 insurance carriers if -- if I was looking at it. I
2 don't know what their procedure is, so I wouldn't
3 necessarily -- I mean, it's -- probably signals
4 something, but it's not something I would think would
5 be absolutely necessary.
6 Q And do you have any belief whether on
7 February 17th, 2022, the majority of health insurance
8 carriers did provide coverage for gender-affirming
9 surgery?
10 A I think it's mixed. Some do and some don't.
11 It changes, and I'm not sure which ones, to be honest
12 with you.
13 Q Do you have any view about whether at present
14 the majority of health insurance carriers provide
15 coverage for gender-affirming surgery or not?
16 A I'm not sure.
17 Q Okay. Do you know whether the North Carolina
18 Health Insurance Program for North Carolina employees
19 covers gender-affirming surgery?
20 A I honestly don't because it's not part of my
21 world, so I don't know if it does or not.
22 Q Okay. If you could look at page -- pages 4
23 to 5, there's -- on page -- I'm sorry. In the second
24 paragraph, it says, "In fact, there are studies which
25 cause great concern that a not insignificant portion of

1 individuals" --
2 A Sorry. Where are you?
3 Q Page 4. It's the second paragraph under the
4 bullet.
5 A From the definition above?
6 Q It starts "In the case of GRS."
7 A Okay. Sorry.
8 Q And the second sentence says, "In fact, there
9 are studies which cause great concern that a not
10 insignificant portion of individuals who undergo the
11 procedures not only fail to improve, but in many cases
12 experience worse symptoms with quite concerning
13 consequences."
14 Do you have any belief as to what portion of
15 individuals who undergo gender-affirming surgeries
16 experience worse symptoms after the surgery?
17 A I think there are probably studies that show
18 both. So some studies I think show good outcomes.
19 Some of these studies I'm sure do show bad outcomes. I
20 think it's somewhat of an open question.
21 Q The next paragraph refers to a study in Sweden.
22 Are you familiar with that study?
23 A I have not read it.
24 Q Okay. And in the paragraph that starts
25 "Another important consideration" --