EXHIBIT 7

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.

Case 3:22-cv-00191-MOC-DCK Document 62-7 Filed 10/05/23 Page 1 of 9

(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.

Case 3:22-cv-00191-MOC-DCK Document 62-7 Filed 10/05/23 Page 2 of 9

(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.

(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

Case 3:22-cv-00191-MOC-DCK Document 62-7 Filed 10/05/23 Page 6 of 9

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

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

Case 3:22-cv-00191-MOC-DCK Document 62-7 Filed 10/05/23 Page 9 of 9

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 TERRI CATLETT

(Taken by plaintiff.)

Raleigh, North Carolina

May 18, 2023, 8:59 a.m.

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

CONTAINS GENERAL CONFIDENTIAL INFORMATION

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19
20 DEPOSITION OF TERRI CATLETT a witness called before
21 SUSAN GALLAGHER, CA CSR, CVR-CM, a Notary Public in and
22 for the State of North Carolina, at 114 West Edenton
23 Street, Raleigh, North Carolina, on Thursday the 18th
24 of May, 2023, commencing at 8:59 a.m.
25 Please note: All quoted material is as-read.

Case 3:22-cv-00191-MOC-DCK Document 62-8 Filed 10/05/23 Page 2 of 32

1 affirm them in their transition from male to female
2 female to male.
3 Q Okay. I'm going to introduce that I would like
4 the court reporter to mark as Exhibit 1.
5 (Exhibit 1 marked for identification.)
6 BY MS. DELGADO:
7 Q Ms. Catlett, if you can take a moment to look
8 over Exhibit 1 and let me know when you're ready.
9 A I'm ready.
10 Q Okay. Do you recognize this?
11 A Yes.
12 Q What is it?
13 A It's my CV or the CV of mine at one time.
14 Q Is this accurate?
15 A Yes, it's accurate.
16 Q Are there any updates since you submitted this?
17 A Yes.
18 Q What are those updates?
19 A I no longer work for the department.
20 Q And where do you work now?
21 A I work for the American Correctional
22 Association.
23 Q And what's your role there?
24 A I'm the director of the Office of Correctional
25 Health.

Case 3:22-cv-00191-MOC-DCK Document 62-8 Filed 10/05/23 Page 3 of 32

1 Q Can you please walk me through your education?
2 A Certainly.
3 Q What, if any, degrees did you receive?
4 A I have a BS degree.
5 Q From where?
6 A Hahnemann University -- what was then Hahnemann
7 University, is now consolidated with another university
8 in Philadelphia.
9 Q Did you receive any other degrees?
10 A No.
11 Q While receiving your education, did you gain
12 any experience in the treatment of gender dysphoria?
13 A No. Honestly, not at the time. I graduated in
14 1986. It wasn't something that was part of the, you
15 know, education at that point.
16 Q Did you gain any experience in learning about
17 gender-affirming care?
18 A No.
19 Q What about gender affirming-surgery?
20 A No.
21 Q Can you please walk me through your work
22 experience?
23 A Certainly. Right after I graduated, I worked
24 in a family practice for a few years, typically seeing
25 the family, whether it's the mother, the father, the

Case 3:22-cv-00191-MOC-DCK Document 62-8 Filed 10/05/23 Page 4 of 32

1 children, basic primary care. Then I was employed by
2 the Federal Bureau of Prisons in various capacities. I
3 was hired as a physician assistant, but after two years
4 I went into the administrative role and have remained
5 as an administrator from that point forward.
6 I gave up my clinical privileges and have
7 worked as an administrator since 1992 in various
8 capacities. Left the Bureau of Prisons and came to
9 North Carolina in 2011 to help activate the Central
10 Prison healthcare complex and the new female inpatient
11 facility at Women's, and remained in that role.
12 Leadership changes, and so my role changed in 2016.
13 Remained as the director of healthcare administration
14 until I left earlier this year.
15 Q And prior to working for North Carolina DPS,
16 those prior positions, did you hold any position that
17 allowed you to be involved in the authorization of
18 medical treatment?
19 A So my role was to -- once a decision was made
20 for care, then my role was to ensure that services were
21 in place, for example, that contracts were in place
22 with local community hospitals and contracts were in
23 place with providers to perform the care that was
24 recommended by a provider. So if somebody needed a
25 knee replacement, then I would make sure that the

1 facility had a contract in place with a local
2 orthopedist and that we had a contract in place with a
3 local hospital to perform the surgery.
4 So my role was strictly to make it happen after
5 the decision was made clinically. So, again, making
6 sure all those things were in place.
7 Q And that responsibility was during which of
8 these appointments?
9 A All of them.
10 Q All of them?
11 A Yes.
12 Q Okay. And was that the same responsibility for
13 mental health treatment?
14 A For mental health treatment, yes. So if we
15 needed a consult with a psychiatrist, yes, I would have
16 to make sure that there was a contract in place for us
17 to reach out to a consultant and -- whatever consultant
18 it might be. Orthopedist, psychiatrist, you know,
19 surgeon, gastroenterologist, so yes, psychiatry was
20 part of it as well?
21 Q And in those positions. Did any of them give
22 you experience with the treatment of gender dysphoria?
23 A Not while I was in -- no, not until my first --
24 no.
25 Q And did any of them give you experience with

Case 3:22-cv-00191-MOC-DCK Document 62-8 Filed 10/05/23 Page 6 of 32

1 working with patients that need gender-affirming care?
2 A I first was exposed to an individual who needed
3 or had -- was in the transition probably in early,
4 maybe 2002, 2004, but it was a patient that we received
5 at the federal Bureau of Prisons in Butner who had gone
6 through gender-affirming surgery. So that was my first
7 time we received a patient who had gone through the
8 surgery. So there wasn't anything we needed to do at
9 that point other than just manage them in the facility.
10 Q So just to be clear, were you a part of any
11 authorization of care for that person?
12 A No.
13 Q Now, moving forward to your time at North
14 Carolina DPS, can you tell me what roles you held while
15 working for them?
16 A So when I first came to the department, I was
17 the Deputy Director, again, provided oversight
18 primarily to bring on the two new facilities that had
19 been built, the male and female facility. That was my
20 role, and to bring those facilities online, to bring
21 the staffing online, to reach out to local community
22 providers for partnerships for treatment and care,
23 working in the community to find, not only hospital
24 organizations that wanted to accept our patients, but
25 providers who were willing to see patients in their

Case 3:22-cv-00191-MOC-DCK Document 62-8 Filed 10/05/23 Page 7 of 32

1 office. So that was my primary role.
2 Again, leadership changed, and by 2016 we were
3 pretty much sound in the development of those contracts
4 with UNC and whatnot, and we had a lot of providers who
5 were willing to, then, at that point see our patients.
6 So then my role kind of switched to the director of
7 healthcare administration where then I became the
8 liaison between the department and all healthcare
9 organizations in the state, not only UNC, but Blue
10 Ridge Healthcare and Vidant across the state. It was,
11 you know -- because we had so many facilities across
12 the state, inmates needed to be able to go out to
13 various small community hospitals for urgent care. So
14 my role was to ensure that contracts were in place for
15 services and then make sure that if adjustments needed
16 to be made, then I would get those adjusted.
17 Q Did you have any additional duties or
18 responsibilities on top of that?
19 A I was responsible for bringing online the
20 telehealth network for the department. I also
21 supervised, like, medical records. I also -- most
22 recently before I left, we had a retirement of one of
23 the branch chiefs who -- and so I kind of took over
24 temporarily on an interim basis of a few staff, but
25 that was my primary role, healthcare administration,

Case 3:22-cv-00191-MOC-DCK Document 62-8 Filed 10/05/23 Page 8 of 32

1 contracts, and again, telehealth and medical records
2 and some administrative staff on the floor.
3 Q While in this position, did you serve on any
4 committees?
5 A Yes.
6 Q Which?
7 A So I served on -- we certainly had leadership
8 committees. You know, we also had committees to
9 implement the inmate medical record. I chaired that
10 committee, So that the initiative. Chaired committees
11 looking at purchasing of different types of equipment
12 to make the operation more efficient, such as at
13 Central Prison the committee to purchase big-ticket
14 items, such as automatic dispensing cabinets for the
15 inpatient units.
16 I served on committees for new initiatives such
17 as the implementation of a new unit for chronic care
18 patients, so a variety of different committees.
19 Q Did any of those committees focus on
20 transgender accommodations?
21 A Yes. I served on the DTARC committee.
22 Q What does DTARC stand for?
23 A Division Transgender Referral Committee, maybe.
24 Division -- DTARC. Division Transgender Referral
25 Committee. I'm not...

1 Q The Accommodation Committee?
2 A Accommodation Committee, DTARC.
3 Q Does the Division Transgender Accomodation
4 review Committee sound correct?
5 A Review Committee. Sorry. It's been a while.
6 Q No problem. What was the purpose of that
7 committee?
8 A That committee was to look at referrals that
9 had come up from the field of patients who requested
10 certain accommodations.
11 Q And who served on that committee?
12 A Various individuals served on that committee.
13 So we had the director of psychiatry, the director of
14 behavioral health. We had the director of operations.
15 We had the pre-op coordinator. We had the medical
16 director. We had someone from security. I'm not sure
17 what the title was, but say, maybe, the chief of
18 security. So there was operational people and clinical
19 people on that committee.
20 Q So it was a multidisciplinary committee?
21 A It was.
22 Q And what was your role in this committee?
23 A My role was clearly as the administrator once a
24 clinical decision was made for me to ensure that the
25 appointments were scheduled for outside care. That's

Case 3:22-cv-00191-MOC-DCK Document 62-8 Filed 10/05/23 Page 10 of 32

1 the only role that I served, as someone to ensure that
2 any kind of recommendations for appointments could be
3 made with UNC, again, because I was the liaison at UNC.
4 Q Okay. So there were nonmedical members of this
5 committee?
6 A Yes.
7 Q And medical?
8 A Yes.
9 Q And which one would you consider yourself to
10 have been?
11 A I was nonclinical. My role was the
12 administrator only.
13 Q And how long did you serve on this committee?
14 A A few years.
15 Q And if there were to be a medical accommodation
16 that was discussed, did you weigh in?
17 A No.
18 Q And in this committee were there any chairs or
19 cochairs?
20 A Initially when the committee was established,
21 there was just a chair, and that person was the
22 director of either behavioral health. It then evolved
23 into cochairs, where there was a medical director and
24 the director of behavioral health cochairing the
25 committee.

Case 3:22-cv-00191-MOC-DCK Document 62-8 Filed 10/05/23 Page 11 of 32

1 THE WITNESS: No.
2 BY MS. DELGADO:
3 Q From your experience have you ever seen or
4 heard of a reason as to why it would have to be
5 canceled that did not include security?
6 A No.
7 Q When it comes to decisions on clinical
8 appointments, you've made clear that you defer to
9 clinicians for that decision; is that correct?
10 A That's correct.
11 Q What clinicians are you talking about?
12 A So it may be the medical director. It may be
13 the director of behavioral health. It might be the
14 director of psychiatry. They're the clinical treatment
15 team.
16 Q Out of those three, is there one person that
17 you usually will go to first or defer to first?
18 A It depends on the symptom or the problem or the
19 reason for the referral. If it's a medical reason for
20 the referral, then I would work with Dr. Campbell. If
21 there was a behavioral health, which is extremely rare,
22 then it would be psychiatry. Maybe there is a certain
23 kind of test that needs to be done on this individual
24 that we can't do internally, and I would work with Dr.
25 Peiper or Dr. Sheitman for that.

1 Q For Mrs. Kanautica Zayre-Brown, what clinician
2 did you defer to?
3 A My discussions on Ms. Brown were typically with
4 Dr. Peiper because he was the one that, you know, had
5 been the director of mental health -- or behavioral
6 health and was pretty much my contact throughout the
7 whole process.
8 Q And speaking of process, I know you said you've
9 been on the DTARC for several years. Can you give an
10 approximate date or year of when you served on the
11 DTARC?
12 A No. Four years, five years maybe. Probably
13 five years.
14 Q Would looking at your CV help you remember?
15 A No.
16 Q Okay. But you believe it's about five years?
17 A Four to five years, correct.
18 Q Okay. Do you recall the first time you were
19 asked to pursue coordination of care for Mrs. Kanautica
20 Zayre-Brown to have a surgical consult?
21 A No, I don't recall the exact date or time.
22 Q Do you recall the approximate year?
23 A No.
24 Q Do you know if that surgical consult took
25 place?

Case 3:22-cv-00191-MOC-DCK Document 62-8 Filed 10/05/23 Page 13 of 32

1 BY MS. DELGADO:
2 Q Did you ever receive this response at all?
3 A No, I wasn't copied on it.
4 Q Okay. After receiving this email, did you
5 notify mental health?
6 A These -- they are mental health.
7 Q So you just forwarded to mental health, and
8 that was it?
9 A Right, yes.
10 Q Okay. All right. We're done with this one.
11 Oh, last question. Did you respond to Dionne at any
12 point?
13 A Did I respond to Dionne? Typically I did not
14 respond to any external emails. I would refer them to
15 the appropriate discipline, and they would respond.
16 For some reason my email was, you know, front and
17 center on some of the pages from my previous role as
18 deputy director so I would get hundreds of emails from
19 family members, and I would just refer them to whatever
20 discipline that it related to. I didn't respond.
21 Q Okay. All right. I'm introducing another
22 document to be marked as Exhibit 10.
23 (Exhibit 10 marked for identification.)
24 BY MS. DELGADO:
25 Q Ms. Catlett, if you could let me know when

Case 3:22-cv-00191-MOC-DCK Document 62-8 Filed 10/05/23 Page 14 of 32

1 you're ready.
2 A Okay.
3 Q Do you recognize this?
4 A I do.
5 Q What is it?
6 A Just an email about the situation with the
7 primary mental health provider, and I didn't realize
8 that this was -- Dionne Brown, whether it's a male or
9 female, was Ms. Brown's husband, but it was a
10 conversation apparently or a discussion.
11 Q What did you do after reading this email?
12 A I contacted Dr. Junker.
13 Q Why?
14 A I was concerned about Dr. Hahn's -- the
15 information that was going back between the patient and
16 Dr. Hahn and Ms. Brown, it was information -- first of
17 all, it was incorrect information. I have no idea who
18 this Anson mental health behavior specialist that told
19 Kanautica that I was in contact with a UNC provider.
20 I don't know how that information would have
21 been relayed to a behavioral health specialist at
22 Anson. They would not know what I do or don't do.
23 That was my concern.
24 Q In your response, which is on page 1, the
25 second sentence reads, "My concern is that the offender

Case 3:22-cv-00191-MOC-DCK Document 62-8 Filed 10/05/23 Page 15 of 32

1 and her family have my name and other confidential
2 information that should have never been shared with the
3 offender."
4 Did I read that correctly?
5 A You did.
6 MR. RODRIGUEZ: And just for the record, you said
7 "response." This is not a response to the sender of
8 that previous email.
9 MS. DELGADO: That is correct. My apologies.
10 BY MS. DELGADO:
11 Q When you forward the email, in your email you
12 stated that -- you wrote that sentence. Did I read
13 that correctly?
14 A You did.
15 Q Okay. What confidential information were you
16 referring to?
17 A Confidential information in the fact that what
18 I do, when I do it, who I call, who I don't call.
19 That's really not information a family member should
20 have.
21 Q What is your concern with them having that
22 information?
23 A Again, it's a breach of confidentiality. In
24 the secured environment, we do not release of this kind
25 of information to family members. It's a breach of

Case 3:22-cv-00191-MOC-DCK Document 62-8 Filed 10/05/23 Page 16 of 32

1 confidentiality. At any time if a family member knows
2 when a visit is going to occur, then that's the
3 ultimate a breach of security, and the appointment is
4 canceled.
5 So anytime any family member has any
6 inclination of when an appointment is scheduled or
7 being scheduled, we stop because that's a breach of
8 security. People get hurt. The public could get hurt.
9 It's a breach of security so we have to stop.
10 That's my concern, and that was my concern, and
11 that's still my concern.
12 Q So after having this concern, did you, in turn,
13 have to cancel any appointments regarding Kanautica
14 Zayre-Brown?
15 A I did not cancel any of Kanautica's
16 appointments.
17 Q Did you report this concern security?
18 A I reported my concern to Dr. Junker.
19 Q Okay. The next sentence states, "We should
20 never be sharing this much detail with the population."
21 What detail are you speaking of?
22 A The work that staff do is not to be -- it's not
23 any concern of the inmate population. We do our job to
24 assist them, but they don't need to know the details of
25 what we do and how we do it.

Case 3:22-cv-00191-MOC-DCK Document 62-8 Filed 10/05/23 Page 17 of 32

1 Q Does that relate to the second to last sentence
2 that says, "This is definitely a training opportunity"?
3 A Yeah. It is a training opportunity.
4 Q In line 5 of the original message from
5 Dionne -- actually the sentence starts at the end of
6 line 4. It starts with the word "as."
7 A Okay.
8 Q Okay. "As a direct result of the continued
9 denial of care, our family, including myself, has had
10 to be in receipt of the voicing desires to commit
11 suicide and engage in self-mutilation."
12 Did this raise concern for you?
13 A Anytime anyone addresses concerns of any
14 suicide gestures, then, of course, you get concern, but
15 I refer it to the mental health staff to treat it and
16 to manage it, to address it.
17 Q Why did you not include that concern when you
18 forwarded the email?
19 A Dr. Hahn was treating her, and so she was
20 onsite. I wasn't -- neither Dr. Peiper or Dr. Junker
21 -- Dr. Hahn was treating her onsite so she would have
22 addressed it.
23 Q Did you forwarded this to Dr. Hahn so she could
24 also know this concern?
25 A Dr. Hahn was a recipient of the same letter.

Case 3:22-cv-00191-MOC-DCK Document 62-8 Filed 10/05/23 Page 18 of 32

1 Q Okay. Can you point me to where that is?
2 A "Greetings, Dr. P. Hahn and Ms. Catlett."
3 Q Did you notice that you're the only one that it
4 went to?
5 A No, I didn't.
6 Q Looking at the dates of the original email and
7 the date that you forwarded it, about how many days
8 passed?
9 A It appears seven days.
10 Q Why did it take you seven days to address this
11 email -- or not address it, but forward this email?
12 A I may have been out of the office on training.
13 Actually, as a matter of fact, I'm not in the office
14 all the time, so. I travel internationally for ACA. I
15 could have been conducting an international audit. I
16 don't know, but it wasn't something that --
17 So again, the urgency was -- with any kind of
18 suicidal things would have been handled by Dr. Hahn. I
19 don't answer every one of my emails every day.
20 Q Okay. What's your average response time or
21 forwarding time?
22 MR. RODRIGUEZ: Objection. Vague.
23 You can answer.
24 THE WITNESS: I have -- I've never determined that.
25 I don't think there's a magic number. I try to answer

Case 3:22-cv-00191-MOC-DCK Document 62-8 Filed 10/05/23 Page 19 of 32

1 scheduled, and I didn't have access to the telehealth
2 schedule at the time. I told her I would get back with
3 her.
4 Q Did you get back with her?
5 A I got back with the facility to let them know
6 so they could schedule it. Dr. Hahn isn't at the
7 facility every day. So when I had access to the
8 scheduler, I made sure that Kanautica had the first
9 available appointment, even though I had to move other
10 people around, and then I notified the facility.
11 Q Okay. All right. Moving on to the next
12 document that I would like to be marked as Exhibit 11.
13 (Exhibit 11 marked for identification.)
14 BY MS. DELGADO:
15 Q Ms. Catlett, if you'll let me know when you're
16 ready.
17 A I'm ready.
18 Q Okay. Do you recognize this?
19 A Yeah, I'm familiar with the discussion.
20 Q What was this discussion about?
21 A Ms. Brown's distrust or concerned that she had
22 to speak to somebody right away at UNC, and they were
23 just trying to find out when the appointment has been
24 made, and as you can see by the email chain, I don't
25 make the appointments. I call. I call. I call, and I

1 wait for UNC to respond, and at the end, the facility
2 said no.
3 But this was, again, in the midst of lockdown
4 COVID, and they weren't seeing patients, not only in
5 the community, but certainly not our offender
6 population. So many specialities said, "Don't send any
7 of your inmates to us at all." I had to be diligent in
8 calling, calling, calling to get appointments. I
9 didn't always get them every time I called.
10 So this was just kind of like "Hey, Ms. Catlett
11 is going to follow up," which I did. "She'll let us
12 know as soon as the appointment," et cetera. So that's
13 kind of what it is. You can see that I called. I
14 haven't received confirmation. I called again. I
15 didn't get confirmation, and Kanautica was being -- was
16 impatient with all that.
17 Q You said that "Kanautica was impatient with all
18 that." How did you determine that?
19 A Well, it appears that she -- based on what the
20 psychologist wrote, that she was experiencing dysphoria
21 because of the length of time that had passed.
22 Q Which psychologist said that?
23 A Shannon Lutz (phonetic) lots. She was a
24 psychological services coordinator.
25 Q So you said that she said that Ms. Kanautica

Case 3:22-cv-00191-MOC-DCK Document 62-8 Filed 10/05/23 Page 21 of 32

1 Zayre-Brown was experiencing dysphoria because of the
2 length of time?
3 A Yes.
4 Q And you understood that to mean she was
5 impatient?
6 A No. Just inmates want an appointment the next
7 day. If they don't get it, they get very impatient.
8 It appears that she was experiencing dysphoria.
9 Q Drawing your attention to page 2 under Shannon
10 Lutz's response, if you count six lines up from the
11 bottom, there is a sentence that starts with "from an
12 emotional health."
13 A Uh-huh.
14 Q Okay. I'm going to read that.
15 "From an emotional health standpoint, it does
16 appear that Ms. Brown continues to experience acute
17 dysphoria secondary to the length of time that has
18 passed, which has yet to resolve medically necessary
19 treatment."
20 Was that the sentence you were referring to
21 when you mentioned length of time?
22 A No. I was referring to, she provided this --
23 the first two or three sentences. That's what I was
24 referring to. "She expressed strong distrust in the
25 accuracy of information in referencing upcoming

1 medically necessary appointments."
2 Q Okay. From the sentence I read, do you think
3 it was possible that Ms. Brown was actually
4 experiencing distress instead of being impatient?
5 MR. RODRIGUEZ: Objection. Speculation.
6 You can answer.
7 THE WITNESS: I don't know. I'm not the
8 psychologist, and I wasn't onsite. I don't know. I
9 didn't see her or have any personal knowledge of her
10 distress.
11 BY MS. DELGADO:
12 Q Okay. The psychologist writes in the next
13 sentence, "Being able to trust the accuracy of
14 information/dates given to her would certainly go a
15 long way in reducing this distress distrust."
16 Does this indicate to you that Kanautica was
17 under distress based on what the psychologist said?
18 MR. RODRIGUEZ: Objection. Speculation.
19 You can answer.
20 THE WITNESS: Again, I wasn't there onsite. I ever
21 treated the patient. I just go by what information
22 that's provided, and second of all, we're not going to
23 give them the dates and time of their appointment ever,
24 again, for security reasons. So the only people that
25 know the date and time of the appointments are the

Case 3:22-cv-00191-MOC-DCK Document 62-8 Filed 10/05/23 Page 23 of 32

1 folks in medical records that make the appointment and
2 the officers who have to transport.
3 It's a breach of security for the patient to know
4 the date and time of their appointment, and even if I
5 did know, I wouldn't tell her.
6 BY MS. DELGADO:
7 Q Do you have any reason to doubt the accuracy of
8 what the psychologist is stating?
9 A I'm not privy to the psychologist or what they
10 think or what they diagnosed.
11 Q Shannon Lutz indicates there was distress, that
12 Kanautica was experiencing distress. Do you have any
13 reason to doubt that?
14 MR. RODRIGUEZ: Asked and answered --
15 MS. DELGADO:
16 BY MS. DELGADO:
17 Q Her assessment of that?
18 MR. RODRIGUEZ: Asked and answered.
19 You can answer.
20 THE WITNESS: If the clinician wrote that, then I
21 would trust the clinician.
22 BY MS. DELGADO:
23 Q Did you assume that Ms. Kanautica Zayre-Brown
24 was impatient?
25 MR. RODRIGUEZ: Objection to form.

Case 3:22-cv-00191-MOC-DCK Document 62-8 Filed 10/05/23 Page 24 of 32

1 You can answer.
2 THE WITNESS: Kanautica -- did I assume that she
3 was?
4 BY MS. DELGADO:
5 Q Being impatient, and I ask because you said you
6 hadn't interacted with her --
7 A No, I have not.
8 Q -- to make any assessments.
9 A I haven't.
10 Q Okay. What is your -- when you stated that she
11 was impatient, what is that based on?
12 MR. RODRIGUEZ: Asked and answered.
13 You can answer.
14 THE WITNESS: Offenders who don't get what they
15 want immediately can be inpatient, and she was very
16 demanding and didn't get what she wanted right away,
17 and so I would classify that as being impatient,
18 someone who is impatient.
19 BY MS. DELGADO:
20 Q How was she demanding?
21 A Her and her family, the phone calls, the
22 hundreds of phone calls that I have on my voicemail
23 demanding that I do X, Y, and Z for Kanautica Brown,
24 her community who demanded that we take action when
25 they weren't involved in the process or the

Case 3:22-cv-00191-MOC-DCK Document 62-8 Filed 10/05/23 Page 25 of 32

1 decision-making or had any idea what the clinical
2 treatment plan was for the provider -- I'm sorry -- for
3 the patient.
4 So we had a lot of times, not only Kanautica
5 but others, who are impatient when they don't get
6 exactly what they want when they think they should get
7 it. They have to understand the environment that
8 they're in, and we cannot make decisions and make
9 things happen because we are dependent upon the
10 consultants and the community providers.
11 I could call and ask for an appointment today,
12 and I won't get it. I can make an inpatient call every
13 day. I'm inpatient. When I call UNC every day to get
14 an appointment, I'm inpatient.
15 I finally got my appointment. I relayed that
16 to the facility. So it's a level of frustration with
17 the system. Maybe that's a better term than
18 "impatient," frustration with the system.
19 Q You mentioned multiple calls and emails from
20 community members; is that correct?
21 A From advocates.
22 Q Do you believe that those individual people are
23 acting under the order of Kanautica Zayre-Brown?
24 A I don't -- there would be no way of me knowing
25 that.

Case 3:22-cv-00191-MOC-DCK Document 62-8 Filed 10/05/23 Page 26 of 32

1 Q Why did you attribute that to the reasoning as
2 to why she was -- that you deemed impatient?
3 MR. RODRIGUEZ: Objection. Mischaracterization of
4 the testimony.
5 You can answer.
6 THE WITNESS: There wasn't a correlation. I just
7 said I received many phone calls from external
8 advocates on multiple occasions on behalf of Ms. Brown.
9 Again, the frustration of the process.
10 BY MS. DELGADO:
11 Q Shannon Lutz in that -- the first sentence I
12 read to you, the "from an emotional health standpoint,"
13 that one, at the end of that sentence she mentions "to
14 resolve medically necessary treatment." Is it your
15 understanding that the clinicians deemed it medically
16 necessary at that point?
17 MR. RODRIGUEZ: Objection. Vague. Speculation.
18 You can answer.
19 THE WITNESS: It may be what Shannon thinks is
20 medically necessary, but I don't think anyone had
21 determined it was medically necessary. There hadn't
22 been a decision from the DTARC. Certainly I can't -- I
23 don't understand or I would have no reason to
24 understand why she would have put that statement.
25 BY MS. DELGADO:

Case 3:22-cv-00191-MOC-DCK Document 62-8 Filed 10/05/23 Page 27 of 32

1 verbally somebody would be opposed, and they would
2 voice their opinion.
3 Q So can a nonmedical person at this meeting
4 object?
5 A To?
6 Q To a surgical request?
7 A The nonclinical people would trust the judgment
8 of the clinical providers and their recommendation.
9 It's definitely out of our lane to agree or disagree.
10 We trust the clinical judgment of the psychiatrist, of
11 the behavioral therapist, of the medical provider, and
12 trust that, you know, their clinical decision is sound
13 and has been vetted, and so none of us will challenge.
14 That's a clinical decision that's made, again, because
15 we have to trust their professional expertise.
16 Q For Mrs. Kanautica Zayre-Brown's request for
17 gender-affirming surgery, what objections were stated
18 during this meeting -- these meetings?
19 A During these meetings?
20 Q During any DTARC meetings that you attended?
21 MR. RODRIGUEZ: Objection. Vague and form.
22 You can answer.
23 THE WITNESS: Yeah. I can't recall specifically
24 who objected to, you know, what and at what date and
25 what time. I know, as I stated, we relied heavily on

Case 3:22-cv-00191-MOC-DCK Document 62-8 Filed 10/05/23 Page 28 of 32

1 the clinical decision of the subject-matter expert,
2 just like the clinical people rely heavily on the
3 advice from the custodial team. So whoever is
4 presenting, you know, we rely on their subject-matter
5 expertise.
6 BY MS. DELGADO:
7 Q For the clinical professionals that are part of
8 DTARC, what objections did they raise regarding Mrs.
9 Kanautica Zayre-Brown's request?
10 MR. RODRIGUEZ: Objection.
11 You can answer. Go ahead.
12 THE WITNESS: I don't recall if there were any
13 objections.
14 BY MS. DELGADO:
15 Q Is that because everyone was in agreement to
16 deny surgery?
17 MR. RODRIGUEZ: Objection to form.
18 You can answer.
19 THE WITNESS: No. I don't think anybody made the
20 decision. Nobody had any kind of preconceived yes or
21 no. It was based on the clinical summary, I think, that
22 was provided. If I'm not mistaken, Dr. Campbell did
23 extensive research on the pros and cons of the surgery
24 and the implication that it would have, and so everyone
25 just kind of yielded to his decision because of his

Case 3:22-cv-00191-MOC-DCK Document 62-8 Filed 10/05/23 Page 29 of 32

1 role as medical director and because there weren't any
2 red flags that were raised from the behavioral health
3 team that there was any kind of crisis intervention
4 that would be required with Ms. Brown if it was denied.
5 Certainly all that would weigh heavily on the decision.
6 So his research and then also the fact that mental
7 health didn't raise their concerns at all, and we had
8 to -- as a nonclinical person, I just -- my role was to
9 rely on their expertise.
10 BY MS. DELGADO:
11 Q I want to circle back really quickly from the
12 beginning of the deposition when we were talking about
13 your CV. You mentioned that one of your former places
14 of employment that you interacted with someone who was
15 transgender; is that correct?
16 A We had a case, yes, when I was employed at the
17 federal correctional complex in Butner.
18 Q What happened there?
19 A What happened there?
20 Q Like, what was the concern?
21 MR. RODRIGUEZ: Just before you answer that
22 question, make sure we don't divulge any confidential
23 patient information related. So if you could keep your
24 comments into the general tone.
25 THE WITNESS: It was a male offender who was in the

STATE OF NORTH CAROLINA

COUNTY OF ORANGE

CERTIFICATE OF REPORTER

I, SUSAN L. GALLAGHER, CA CSR, CVR-CM, Notary Public do hereby certify that TERRI CATLETT 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 101 pages constitute a true and accurate transcript of the testimony, and that the witness is being given 30 days in which to affix her notarized signature to the testimony.

This the 13th day of June, 2023.

____

SUSAN L. GALLAGHER, CA CSR, CVR-CM

Notary Public #20230500301

Case 3:22-cv-00191-MOC-DCK Document 62-8 Filed 10/05/23 Page 31 of 32

WITNESS CERTIFICATION

I, TERRI CATLETT, hereby certify:

That I have read and examined the contents of the foregoing testimony as given by me on May 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.

____

TERRI CATLETT

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:

____

Case 3:22-cv-00191-MOC-DCK Document 62-8 Filed 10/05/23 Page 32 of 32

EXHIBIT 9

THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION
NO. 3:22-cv-191

KANAUTICA ZAYRE-BROWN, Plaintiff, v. NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY, et al., Defendant.	))))))))))	**DEFENDANTS' OBJECTIONS AND ANSWERS TO PLAINTIFF'S FIRST SET OF INTERROGATORIES**

PLAINTIFF'S FIRST SET INTERROGATORIES

1. Identify with specificity all NCDPS Policies related to the psychological or medical treatment of Gender Dysphoria provided to or available to prisoners with Gender Dysphoria in NCDPS custody, including but not limited to, necessary provider qualifications and role, Gender Dysphoria diagnosis guidelines, available treatments, excluded treatments, medical necessity criteria, and identified providers competent in the rendering of available treatments.

ANSWER: Objection. Defendants object to this interrogatory as overly broad and unduly burdensome. This is particularly true when balancing the extraordinary efforts that would be required to compile and organize such information against the likely benefit of the information sought by this interrogatory. Thus, this interrogatory exceeds the scope of discovery as prescribed in Rule 26(b)(1).

Without waiving the above-stated objection, Defendants have identified the following documents, some of which may be publicly available[1], but which will also be provided:

[1] https://www.ncdps.gov/our-organization/adult-correction/prisons/policy-procedure-manual; https://www.ncdps.gov/our-organization/adult-correction/prisons/policy-procedure-manual/health-care-policy-manual

- **Parts of Chapter F, Section 4300, of the Department's Adult Correction Policy and Procedure Manual, ("the EMTO Policy") contains information related to behavioral health and medical treatment of transgender individuals, some of whom may have a diagnosis of Gender Dysphoria.**
- **Parts of Chapter F, Section 3400, of the Department's Adult Correction Policy and Procedure Manual, may contain information that could relate to behavioral health and medical treatment of transgender individuals, some of whom may have a diagnosis of Gender Dysphoria.**
- **Section AD I-7 of the Health Care Policy Manual contains information regarding available behavior health services available to all persons, some of whom may have a diagnosis of Gender Dysphoria.**
- **Other parts of the Department's Health Care Policy Manual also relate to behavioral health and medical treatment of all persons in the Department's custody, which would include persons diagnosed with Gender Dysphoria.**
- **Some facilities have Standard Operating Procedures modeled on the ETMO Policy and would thus contain information related to behavioral health and medical treatment of transgender individuals, some of whom may have a diagnosis of Gender Dysphoria.**

Defendants will supplement this answer to provide such Standard Operating Procedures maintained at facilities where Plaintiff is currently or has previously been housed.

2. From the list of procedures provided above in the definition of Gender Affirming Surgical Care, please identify which procedures NCDPS considers are or could be medically necessary for the treatment of Gender Dysphoria and which procedures NCDPS does not consider medically necessary under any circumstances for the treatment of Gender Dysphoria. If NCDPS does not consider a procedure from the list of procedures medically necessary for the treatment of Gender Dysphoria because NCPDS considers that procedure elective and/or cosmetic, please state as such.

ANSWER: Objection. Defendants object to this interrogatory as vague and ambiguous and to the extent it calls for a legal conclusion. The phrase "medically necessary" as used herein is undefined and thus subject to varying interpretations.

Without waiving the above-stated objection, Defendants state that whether a particular medical treatment is considered "medically necessary" by a healthcare provider in a particular case is dependent upon the particular factors associated with the patient, the diagnoses, the interventions contemplated and other patient and situation-specific factors. Accordingly, the Department does not maintain that any given medical treatment is or is not or could or could not be medically necessary in the abstract. Instead, the healthcare providers employed by the Department utilize their own independent medical judgment and medical knowledge in making treatment decisions, including whether certain medical treatments are "medically necessary" based upon their education, training, and experience, in conjunction with other factors which said healthcare providers deem relevant, including but not limited to a review of available recommendations and medical literature.

3. Identify all individuals with knowledge related to any NCDPS Policy related to any treatment provided for Gender Dysphoria and each individual's role in the creation, development, and implementation of the NCDPS Policy.

ANSWER: Objection. Defendants object to this interrogatory as unduly burdensome. This is particularly true when balancing the extraordinary efforts that would be required to compile and organize such information against the likely benefit of the information sought by this interrogatory. Thus, this interrogatory exceeds the scope of discovery as prescribed in Rule 26(b)(1). Defendants also object to this interrogatory to the extent that it calls for information produced in anticipation of litigation, communications subject to attorney-client privilege, and/or material protected from discovery as work product.

Without waiving the above-stated objections, the ETMO was written by Defendant Junker who received input from Defendant Pieper and Patricia Hahn, Ph.D. Defendant Junker also received input from Paula Smith, M.D., the former medical director of prisons. Defendant Junker also likely received input from other Department personnel, the names of whom he cannot recall, on the draft policy. Additionally, legal staff from the Department's General Counsel office also provided some input on the ETMO policy. The Standard Operating Procedures referenced in Defendants answer to Interrogatory No. 1 are modeled on the ETMO Policy and thus reflect the input of those persons who were involved in the creation of the ETMO. Additionally, these Standard Operating Procedures were enacted by the facility heads, each of whom would thus have knowledge of the Standard Operating Procedures. Moreover, all staff at these facilities, as well as other Department personnel, should have knowledge of these Standard Operating Procedures.

4. Taking necessary steps to redact information that would identify an individual, identify all NCDPS prisoners who have requested and/or been evaluated for Gender Affirming Surgical Care, including when the request was made, the facility they were housed in when the request was made, their diagnoses, the requested surgery, the evaluators, the final determination, when that final determination was made, and the rationale and/or explanation supporting that final determination.

ANSWER: Objection. Defendants object to this interrogatory to the extent that it calls for information produced in anticipation of litigation, communications subject to attorney-client privilege, and/or material protected from discovery as work product. Additionally, Defendants object to this interrogatory to the extent that it seeks personally identifiable information and/or protected health information of individuals who are not parties to this litigation. Moreover, Defendants object to this interrogatory to the extent that seeks information concerning requests for various accommodations which are not at issue in this litigation.

Defendants further object to this interrogatory as it is unduly burdensome. Answering this interrogatory would require medical and other staff to collect, review, and organize a multitude of information from across the Department, including dozens of facilities, and various divisions. Doing so is unduly burdensome. Thus, this interrogatory exceeds the scope of discovery as prescribed in Rule 26(b)(1).

Without waiving the above-state objections, Defendants are presently working on compiling the following information for each request for Gender Affirming Surgical Care reviewed by the DTARC since October 2017:

- **The date such request was made**

- **The facility in which the requester was housed at the time the request was made**
- **The specific surgery requested**
- **The recommendation of the DTARC**
- **Statement of the basis for that recommendation.**

Defendants will supplement their answer to this interrogatory as soon as compilation of this information can be completed.

5. State whether Defendants have ever denied or deferred a request by Mrs. Zayre-Brown for Gender Affirming Surgical Care because of safety, security, administrative burden, and/or cost concerns, and explain with specificity the rationale of all such denials.

ANSWER: Defendants have not denied or deferred any such requests by Plaintiff based on the rationale listed in this interrogatory.

6. Explain with specificity all the reasons underlying and/or supporting Defendants' determination that Gender Affirming Surgical Care is not medically necessary for Mrs. Zayre-Brown for the treatment of her Gender Dysphoria, as set out in the February 17, 2022 DTARC Committee Report and subsequent addendum by Defendant Dr. Lewis J. Peiper dated April 26, 2022.

ANSWER: The bases for DTARC's determination to not approve Plaintiff's requested surgery are articulated in the documents identified in Interrogatory number 6. Additionally, this determination was based on the collective education, training, experience, and professional judgments of multiple Department personnel, including Defendants Campbell, Pieper, Sheitman, and others. The determination of the DTARC reflects the consensus of its members which was reached after all members were able to present information relevant to Plaintiff's requested surgery—including, but not limited to, the

recommendations promulgated by the World Professional Association for Transgender Health (WPATH) and other organizations, information regarding the medical literature concerning various aspects of gender affirming surgical care, information regarding Plaintiff's medical history, behavioral health history, and other personal history.

7. For each Defendant except NCDPS, explain with specificity how that individual participated in the process of evaluating Mrs. Zayre-Brown's request for Gender Affirming Surgical Care for the treatment of her Gender Dysphoria that was denied on April 26, 2022.

ANSWER: <u>Objection.</u> Defendants object to this interrogatory as overly broad and ambiguous. This is particularly true when balancing the extraordinary efforts that would be required to compile and organize such information against the likely benefit of the information sought by this interrogatory. Thus, this interrogatory exceeds the scope of discovery as prescribed in Rule 26(b)(1).

Without waiving the above-stated objection, Defendants Buffaloe, Ishee, Agarwal, and Amos, did not participate in the process of evaluating Plaintiff's request for surgery.

The members of the DTARC, Defendants Campbell, Pieper, Sheitman, Catlett, Langley, Panter, Cobb, and Williams met on or about February 17, 2022, to review and make recommendations regarding a number of requests by various individuals. One such request was Plaintiff's request for a vulvoplasty. During this meeting, as with the other DTARC meetings, each member of the DTARC was given an opportunity to speak to the particular request at hand from their disciplinary perspective. The DTARC then discussed the request and reached a consensus determination as to Plaintiff's requested surgery.

Defendant Panter generally provides any relevant information to the DTARC regarding any security or operational implications that could flow from approving or

denying a given request.

Defendant Cobb generally provides any relevant information to the DTARC from a programming perspective. More specifically, Defendant Cobb provides information regarding the person's projected release date, involvement in a job or other program assignments, and custody and housing related information (e.g. restrictive housing, protective custody).

Defendant Catlett generally provides any relevant logistical information to the DTARC, particularly as it relates to arranging and coordinating specialty care. She also implements any requests from the DTARC for medical consultations.

Defendant Langley generally provides any relevant information to the DTARC regarding the ability of nursing staff to support the contemplated request.

Defendant Campbell is a co-chair of the DTARC and as such he often helps facilitate the meetings. Defendant Campbell generally offers information to the DTARC concerning the individual's medical history with a focus on prior and current history treatment. With regard to Plaintiff's request, Defendant Campbell reviewed Plaintiff's lab results, her medication history, her mental health records, Dr. Figler's assessment, and other medical records prior to the DTARC meeting where Plaintiff's request was discussed. Defendant Campbell also reviewed the WPATH recommendations and conducted a review of medical literature concerning gender affirming surgical care and offered his assessment of whether he believed the requested surgery to be medically necessary.

Defendant Pieper co-chairs the DTARC with Defendant Campbell. Defendant Pieper typically prepares the agenda for the meetings and operates as the main facilitator during the meetings. Additionally, Defendant Pieper generally provides information to the DTARC

regarding a person's social history of transition, and that person's evaluation and diagnosis of gender dysphoria. Also, Defendant Pieper informs the DTARC as to the completeness of psychological information on file (e.g. consents signed, IQ tests, other cognitive evaluations). Moreover, Defendant Pieper communicates issues to the DTARC regarding the consistency and persistence of a person's dysphoria, including the use of objective measures to assess dysphoria. Additionally, Defendant Pieper would inform the DTARC of any elements of mental illness, and if present, whether the illness is well controlled. Also, Defendant Pieper would inform the DTARC of any self-injury history or concerns. Defendant Peiper provided this sort of information, where applicable, to the DTARC as it determined whether to approve Plaintiff's requested surgery.

Defendant Sheitman generally presents information to the DTARC regarding the person's behavioral stability over the previous 6 months or so. More specifically, Defendant Sheitman presents information to the DTARC regarding psychiatric medication compliance, substance abuse, hospitalizations, attempts to self-injure, and more.

Defendant Williams generally informs the DTARC with respect to any issues that intersect with PREA. More specifically, Defendant Williams reviews the person's history as it relates to PREA, which could include complaints by or against that person, disciplinary matters tied to PREA related concerns, housing issues, and more.

After all input was received and discussed during the DTARC meeting, the DTARC reached a consensus to recommend denial of the requested surgery. Subsequently, the DTARC's recommendation to not approve the surgery request was forwarded to Defendants Junker and Harris, who reviewed the DTARC's recommendation and agreed with the same.

8. Please explain with specificity all bases for DTARC's disagreement with the medical necessity determinations supporting Mrs. Zayre-Brown's request for Gender Affirming Surgical Care made by any provider employed by or engaged by NCDPS, including but not limited to Dr. Brad Figler, Licensed Clinical Social Worker Jennifer Dula, and Dr. Donald Carracio.

ANSWER: <u>Objection.</u> Defendants object to this interrogatory as vague and ambiguous and to the extent it calls for a legal conclusion. The phrase "medical necessity" as used herein is undefined and thus subject to varying interpretations. Defendants also object the characterizations of this interrogatory, which assume facts not in evidence.

Without waiving these objections, see the answer to Interrogatory No. 6 for the bases for DTARC's medical necessity determination.

This the 1st day of December 2022.

AS TO OBJECTIONS:

JOSHUA H. STEIN
ATTORNEY GENERAL

/s/ Orlando L. Rodriguez
Orlando L. Rodriguez
Special Deputy Attorney General
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Attorneys for Defendants

CERTIFICATE OF SERVICE

I hereby certify that on the date indicated below, as agreed upon by the parties, I served **DEFENDANTS' ANSWERS TO PLAINTIFF'S INTERROGATORIES** upon counsel for Plaintiff as follows:

Jaclyn A. Maffetore
Daniel K. Siegel
Michele Delgado
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tbrown@aclu.org

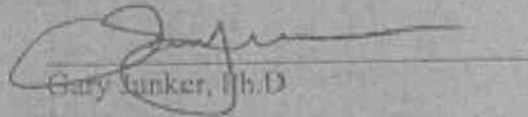
This the 1st day of December 2022.

/s/ Orlando L. Rodriguez
Orlando L. Rodriguez

VERIFICATION

Pursuant to 28 U.S.C. § 1746(2), I, Gary Junker, Ph.D, verify under penalty of perjury that the answers to Plaintiff's First Set of Interrogatories Numbers 1, 3, and 4, in the matter of *Kanautica Zayre-Brown v. North Carolina Department of Public Safety, et al.*, File No. 3:22-cv-191, currently pending in the District Court for the Western District of North Carolina, are true and correct, in substance and in fact, to the best of my knowledge and belief.

This the 29 day of November 2022.



Gary Junker, Ph.D

VERIFICATION

Pursuant to 28 U.S.C. § 1746(2), I, Arthur Campbell III, M.D., verify under penalty of perjury that the answers to Plaintiff's First Set of Interrogatories Numbers 2, 5, 6, 7, and 8, in the matter of *Kanautica Zayre-Brown v. North Carolina Department of Public Safety, et al.*, File No. 3:22-cv-191, currently pending in the District Court for the Western District of North Carolina, are true and correct, in substance and in fact, to the best of my knowledge and belief.

This the 29 day of NOVEMBER 2022.

[signature], M.D.
Arthur L Campbell, III, M.D.

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 A I have a bachelor's degree from Wright State
2 University in Dayton, Ohio, in sociology and social
3 work. I have a master's degree from University of New
4 Mexico in Albuquerque, New Mexico, in counseling
5 psychology, and I have a doctorate degree from Georgia
6 State University in Atlanta, Georgia, in counseling
7 psychology.
8 Q While receiving your education, did you have
9 any experience in the treatment of gender dysphoria?
10 A No.
11 Q What about experience treating any patients
12 that were seeking gender-affirming care?
13 A No.
14 Q And so then I would -- I think it will follow,
15 you did not receive any experience treating patients
16 seeking specifically gender-affirming surgery?
17 A I have not.
18 Q What are your professional qualifications?
19 A So beyond my education, I'm also a licensed
20 psychologist in the State of North Carolina and have
21 34 years of experience in working in correctional
22 healthcare across a number of different correctional
23 organizations. I could go into more detail if you'd
24 like.
25 Q Any other -- so you mentioned that you have

1 your licensure. Any other certifications or
2 specialties?
3 A No.
4 Q So I see that you worked in prisons quite a bit
5 prior to arriving to DPS. So the first role on your
6 resume you noted that you're the director of clinical
7 training at the United States Federal Penitentiary in
8 Atlanta, Georgia. Did that role involve any experience
9 in the treatment of gender dysphoria?
10 A Not that I recall.
11 Q And so no experience treating patients seeking
12 gender-affirming care in that role?
13 A No.
14 Q What about your associate professorship at the
15 Georgia school of professional psychology, did you have
16 any clinical aspect related to that professorship that
17 would have allowed you to have experience treating
18 patients with gender dysphoria?
19 A No.
20 Q And no patients seeking gender-affirming care I
21 assume as well?
22 A Correct.
23 Q So from 1998 to 2002, I see that you were a
24 lead psychology examiner at the Federal Bureau of
25 Prisons central office program review division. In

Case 3:22-cv-00191-MOC-DCK Document 62-10 Filed 10/05/23 Page 3 of 56

1 that role did you have any experience in the treatment
2 of gender dysphoria?
3 A No.
4 Q And none with patients seeking gender-affirming
5 care?
6 A No.
7 Q From 2002 to 2008, as chief of psychology and
8 social work at the Federal Medical Center at Butner,
9 North Carolina, did you have any experience in the
10 treatment of gender dysphoria?
11 A Not directly, no.
12 Q What do you mean by "not directly"?
13 A We did have individuals housed at the medical
14 center complex who were transgender individuals at
15 several of the prison facilities at the Butner complex,
16 but I wasn't -- I was the head of the department. I
17 didn't directly provide care or treatment to them or
18 for them.
19 Q Okay. Did you supervise care or treatment to
20 them in any sort of direct supervisory way?
21 A Not that I recall.
22 Q So from 2008 through 2013, I see that you were
23 complex chief psychologist at the Federal Bureau of
24 Prisons correctional complex at Butner, North Carolina.
25 In that role did you have any experience treating

Case 3:22-cv-00191-MOC-DCK Document 62-10 Filed 10/05/23 Page 4 of 56

1 gender dysphoria?
2 A No.
3 Q And no experience treating patients seeking
4 gender-affirming care?
5 A That's Correct.
6 Q From 2013 to 2015, you were a behavioral health
7 director at Horizon Health in Nashville, Tennessee; is
8 that correct?
9 A That's correct.
10 Q In the role did you have any experience in the
11 treatment of gender dysphoria?
12 A Not directly. I did assist the Tennessee State
13 Department of Corrections in creating transgender
14 policy.
15 Q And, again, when you say "not directly," did
16 you have any supervisory role in treating patients with
17 gender dysphoria or supervising individuals treating
18 patients with gender dysphoria?
19 A No, I did not.
20 Q And no experience there treating patients
21 seeking gender-affirming care?
22 A Did not.
23 Q Okay. So in any of those roles, did you have
24 any training in the treatment of gender dysphoria?
25 A I have participated in training over the course

Case 3:22-cv-00191-MOC-DCK Document 62-10 Filed 10/05/23 Page 5 of 56

1 of my career, and I don't remember all of that
2 training. I do know that over the last four or
3 five years, I have had training -- we did a training
4 session with Katherine Croft in the UNC trans health
5 program, provided training to our staff. I
6 participated and attended that training, and have also
7 through various continuing education modules over the
8 course of my more recent career have attended training,
9 some at the American Correctional Association
10 conferences that I attend twice a year.
11 Q I'm going to ask a bit more about your training
12 since you've been an employee of North Carolina DPS a
13 little bit later, but just to be clear, prior to
14 joining DPS, you had not engaged in any training for
15 the treatment of gender dysphoria?
16 A Not that I recall.
17 Q Okay. So I want to talk a little bit more
18 about your time with DPS. I see that you were the
19 director of behavioral health from 2015 to 2020; is
20 that correct?
21 A That's correct.
22 Q And what were your responsibilities in that
23 role?
24 A My responsibilities, again, was oversight of
25 behavioral health services statewide and both -- some

Case 3:22-cv-00191-MOC-DCK Document 62-10 Filed 10/05/23 Page 6 of 56

1 clinical oversight, but largely operational oversight
2 of delivery of behavioral healthcare throughout the
3 system. That also included psychologists. It also
4 included the social work department that reported to
5 me, and it included what we call the alcohol chemical
6 dependency program, which is substance use treatment
7 within prisons also reported to me.
8 Q Did you engage in policy development when you
9 were the director of behavioral health?
10 A I did.
11 Q Okay. Were there policies that you were
12 directly responsible for the development of?
13 A Yes.
14 Q And which were those?
15 A I was directly involved in the creation of our
16 management of the transgender offender policy, and I
17 believe most of the other policies were under annual
18 revision that I would be involved with. We worked with
19 disability rights and ACLU prison legal services for a
20 couple of years engaging on various policy updates
21 regarding management of offenders who are receiving
22 mental health treatment.
23 Q And so you mentioned the evaluation and
24 management of transgender offenders policy. I will
25 definitely come back to that later. I want to flag for

1 you now that -- we have been referring to that in the
2 papers in this lawsuit as the EMTO policy as a
3 shorthand. So if I mention EMTO policy, that's what
4 I'm referring to, but I'll try to be clear about what
5 policy I'm referring to.
6 A Thank you.
7 Q In your role as director of behavioral health,
8 to what extent do you treat patients directly?
9 A I did not treat patients directly.
10 Q Did you ever see patients in a clinical
11 encounter-type setting?
12 A Throughout my career?
13 Q No. While -- sorry. Just to clarify, while
14 director of behavioral health with DPS.
15 A No, I did not.
16 Q Okay. And aside from the policy development
17 which we will talk about more, what was your
18 involvement with treating gender dysphoria while you
19 were the director of behavioral health at NCDPS?
20 A My role through policy development was in a
21 consultative function or manner that's typically
22 operational issues, not as much clinical issues. Our
23 system is set up where we have system directors of
24 behavioral health in each of our four regions, and
25 there would be direct supervision at the facility level

Case 3:22-cv-00191-MOC-DCK Document 62-10 Filed 10/05/23 Page 8 of 56

1 with a psychology program manager. So there were
2 several levels of clinical supervision from doctoral
3 level psychologists that would usually provide that
4 direct clinical oversight.
5 Q And so you did not directly treat any patients
6 with gender dysphoria while serving as director of
7 behavioral health?
8 A I did not.
9 Q Did you evaluate any patients for
10 gender-affirming surgery?
11 A Not directly, no.
12 Q And while you were the director of behavioral
13 health, which trainings did you receive related to
14 gender dysphoria?
15 A I mentioned the training from UNC trans health.
16 I attended that training. I do recall -- and I don't
17 remember the specific date. I think it was probably in
18 the 2019 time frame that the agency brought in an
19 outside presenter. I don't recall their name. But
20 training was provided to all of our wardens at a
21 statewide meeting. That was, I believe, a half-day
22 training that we provided.
23 Q And just to clarify. So you mentioned the UNC
24 trans health training. Is that the training you're
25 saying took place, you think, in 2019?

1 A No. That was training that was provided to our
2 wardens in 2019 and myself and our executive staff.
3 That was an in-person training. The training with UNC
4 trans health was probably in 2021, perhaps, and that
5 was a virtual training that was provided.
6 Q Okay. So the UNC trans health training would
7 have taken place after you had already become the
8 director of health and wellness if it took place in
9 2021; is that correct?
10 A Yes.
11 Q So aside from the half-day training to the
12 wardens in 2019 that you just discussed, is there any
13 other training that you received while director of
14 behavioral health in the treatment of gender dysphoria?
15 A There is other training, but I don't recall
16 that all at this time.
17 Q Okay. While you were director of behavioral
18 health, did you give any trainings regarding the
19 treatment of gender dysphoria?
20 A Yes. So, again, I believe it would have been
21 in 2019, we provided training at Anson Correctional
22 Institution for their staff, myself, and I believe
23 Dr. Anita Wilson was part of a broader training. We
24 had a module that we spoke with the leadership and
25 various staff at Anson Correctional about policy, about

1 the management for transgender offenders. We just
2 walked through, provided training about that, how that
3 policy was set up and to be delivered.
4 Q So I recognize you said you can't remember in
5 detail each training that you took while director of
6 behavioral health. Do you recall if any of the
7 trainings that you received dealt specifically with the
8 provision of gender-affirming surgery?
9 A I don't believe that they did.
10 Q Okay. How about any of the trainings that you
11 delivered, did they discuss the provision of
12 gender-affirming surgery?
13 A No, they did not.
14 Q And so I had asked you previously whether you
15 evaluated any patients for gender-affirming surgery in
16 your role as the director of behavioral health, and I
17 believe that you said no. I'll ask you more about this
18 later, but while you were director of behavioral
19 health, were you a member of DTARC?
20 A Yes, I was.
21 Q Okay. Now I'd like to discuss some of the same
22 things but during your time as the director of health
23 and wellness, which I understand was from April 2022 to
24 actually the January of this year, not to present
25 because you have taken on a different role; correct?

Case 3:22-cv-00191-MOC-DCK Document 62-10 Filed 10/05/23 Page 11 of 56

1 this -- in this litigation.
2 A Okay.
3 Q And so those blanks there would be her
4 deadname.
5 If you'll take a look with me now at Exhibit 7,
6 which is the other one that you have right next to you,
7 do you recognize this document?
8 A I don't recall it, but I recognize it as a
9 gender dysphoria treatment plan.
10 Q Okay. So Exhibit 7 has a Bates stamp
11 DAC 004270, which is the Bates number that immediately
12 follows the Bates number of Exhibit 6, DAC 004719, and
13 I'll represent to you that our understanding of that
14 sequential numbering means that this is an attachment
15 to the e-mail that we were just looking at. Do you
16 have any reason to believe that this was not the
17 attachment to this e-mail that you received?
18 A No reason.
19 Q Okay. So does it follow from Exhibit 6, then,
20 the e-mail, that you were made aware of
21 Ms. Zayre-Brown's case on -- for the first time, at
22 least to the extent that the information was provided
23 in this treatment plan, on -- in November of 2017?
24 A That's correct.
25 Q Okay. Now, if you'll look with me at Exhibit 6

Case 3:22-cv-00191-MOC-DCK Document 62-10 Filed 10/05/23 Page 12 of 56

1 with the treatment of gender dysphoria?
2 A I don't know.
3 Q Ms. Terri Catlett, director of health services
4 administration, are you aware of whether she had any
5 experience or training in the treatment of gender
6 dysphoria?
7 A Only -- and I would say with each of these
8 individuals -- the policy portion of it, but as far as
9 treatment, no.
10 Q Okay. What about -- so Sarah Cobb is listed
11 here as deputy director. Deputy director of what?
12 A Programs.
13 Q Okay. Are you aware of whether Sarah Cobb has
14 any experience in the treatment or any training in the
15 treatment of gender dysphoria?
16 A I'm not aware.
17 Q Is Sarah Cobb a medical professional?
18 A No, she is not.
19 Q Okay. What about Ms. Charlotte Williams, PREA
20 director, are you aware whether she had any training or
21 experience in the treatment of gender dysphoria?
22 A I don't know.
23 Q Okay. Is she a medical professional?
24 A No, she is not.
25 Q So if you'll turn with me to page 6 then. So

1 rendered --
2 Q Okay.
3 A -- or a comment made on a -- on a DTARC
4 committee form, the 411D.
5 Q And so as the chair and a member of the DTARC
6 meeting, you would have been involved in the
7 decision-making process that took place at that
8 meeting; correct?
9 A Right.
10 Q Okay. So did you agree with the conclusion
11 that gender reassignment was complete?
12 MR. RODRIGUEZ: Asked and answered.
13 You can answer.
14 THE WITNESS: I would not think that I would have
15 agreed with that.
16 BY MS. MAFFETORE:
17 Q Okay.
18 A But I'm wondering, at the time, what
19 information was being drawn upon, you know, to come to
20 that conclusion.
21 Q Okay. Do you know why others considered gender
22 assignment -- gender reassignment to be complete?
23 MR. RODRIGUEZ: Speculation.
24 You can answer.
25 THE WITNESS: Where are you reading now?

1 BY MS. MAFFETORE:
2 Q "The gender reassignment is complete." Do you
3 know why others made that determination?
4 MR. RODRIGUEZ: Objection. Speculation.
5 You can answer.
6 THE WITNESS: I don't -- I don't recall.
7 BY MS. MAFFETORE:
8 Q Based on -- you don't recall any communications
9 at that meeting that conveyed that to you?
10 A Why it would've been considered complete?
11 Unless there were records that indicated from somewhere
12 that either the patient or another professional made a
13 statement to that effect. I don't recall that.
14 Q Do you -- are you familiar with the surgeries
15 that Ms. Zayre-Brown has had to date?
16 (Reporter clarification.)
17 THE WITNESS: Somewhat.
18 BY MS. MAFFETORE:
19 Q Are you aware that Ms. Zayre-Brown still has an
20 intact penis?
21 A Yes.
22 Q Okay. With that understanding, is it your
23 belief that gender reassignment is complete for
24 Ms. Zayre-Brown?
25 A No.

1 Q Okay. Did you agree --
2 A If I can just -- unless, in a circumstance, the
3 patient said that this is all that I am wanting in
4 regard to gender reassignment surgery, and so, for me,
5 I'm -- you know, I'm finished and complete.
6 Q Understood. In the context of what we're
7 discussing now that Ms. Zayre-Brown was requesting a
8 vaginoplasty, is it your understanding that
9 Ms. Zayre-Brown's gender reassignment was complete?
10 A From the -- from what information was provided,
11 no, unless there is some other document or reference
12 that was indicating the contrary.
13 Q Understood. So, as we noted, this also states
14 that additional surgery would be for outward
15 appearance. Do you agree that additional surgery would
16 be for outward appearance only for Ms. Zayre-Brown?
17 A I'm not sure what -- what that is indicating.
18 I mean, it's for outward appearance only. It is not
19 what I would think at this time.
20 Q What would you think at this time?
21 A Well, if surgery were completed, an individual
22 would have internal experience as well of their gender
23 reassignment. So not only for outward appearance, but
24 also for their personal sense of having transitioned.
25 Q Is it your understanding that having additional

1 that vaginoplasty is an elective procedure which is not
2 medically necessary for reassignment, how could that
3 position be reconsidered at a later date?
4 A It was an ongoing discussion that was taking
5 place. I think that, you know, these circumstances
6 were new to our system. And so, you know, this is --
7 this language, again, is medically based.
8 There could be a reversal if it were then
9 determined that reassignment surgery was medically
10 necessary. So a person can -- you know, a patient
11 requesting accommodations can always come back to the
12 committee and say look at this again, and that is
13 actually what happened in this case.
14 Q So -- sorry. Did I cut you off?
15 What do you understand the term "elective
16 procedure" to mean?
17 A A procedure that a person requests that is --
18 to use this language -- may not be medically necessary.
19 Q So was there a medical necessity determination
20 made at this DTARC meeting?
21 A Please, again.
22 Q Was there a medical necessity determination
23 made at this DTARC meeting?
24 A From the language here -- and can I look back
25 at the minutes again for the language being used?

1 Q Uh-huh.
2 A It -- from the language, it certainly reads
3 that the procedure is not medically necessary for
4 reassignment.
5 Q Does it read that the procedure is not
6 medically necessary for reassignment because, based on
7 the position of the person rendering this decision,
8 reassignment had already been completed surgically for
9 Ms. Zayre-Brown?
10 A Yes.
11 Q Okay. And you expressed previously that you
12 are not of the belief that gender reassignment has been
13 completed for Ms. Zayre-Brown?
14 A So, again, I would need -- I don't recall
15 exactly the context within which this statement was
16 made and what information it was based upon. So I
17 don't recall that, but, again, I do know that the
18 deferred language was purposeful to leave open the
19 conversation about providing this type of surgery in
20 the future.
21 Q Sure. So looking back at Exhibit 11 on page 6
22 where we were, it also states, "We currently do not
23 have the staff or training"; correct?
24 A Correct.
25 Q Was the decision not to approve surgery made on

1 that basis?
2 A Not to my recollection. Again, I do recall
3 that there was a conversation about the -- the level of
4 aftercare that would be required, and the consideration
5 as to whether the patient would remain in the hospital
6 for the aftercare surgery as, perhaps, an option.
7 Q Was there any discussion of ensuring better
8 staffing at the DPS level in order to approve the
9 surgery at that meeting?
10 A Not that I recall.
11 Q All right. How about discussion of
12 facilitating training of staff in order to approve the
13 surgery?
14 A I don't recall that either.
15 Q Okay. So if you had a disagreement with the
16 assertion that gender reassignment had already been
17 completed for Ms. Zayre-Brown and was, therefore, not
18 medically necessary, would you have had the opportunity
19 to voice that belief at the DTARC meeting?
20 A I don't, again, recall the context of the
21 conversation, but I certainly would think that that was
22 discussed during that DTARC meeting, and however that
23 conclusion was reached would have been based on some
24 information or evidence, but I don't recall.
25 Q Would you have had to ultimately agree with the

1 final determination as it's expressed on the form in
2 order for that determination to have been reached
3 following the DTARC meeting?
4 A At that time, again, it's -- the context, I
5 don't recall exactly how that conversation took place,
6 but there may have been some discussion about that
7 during the DTARC meeting, and the decision being
8 deferred is certainly qualifying. The -- you know,
9 what appears to be conclusive or an opinion from
10 someone, you know, was still left open. So that, most
11 likely at that time, to me, indicated that we were
12 going to continue this discussion.
13 Q Okay. So from your perspective, sitting here
14 looking back on it, you can see the use of the deferral
15 language being a compromise on --
16 (Simultaneous speakers.)
17 (Reporter clarification.)
18 BY MS. MAFFETORE:
19 Q -- related to a disagreement that you might
20 have had with, perhaps, the medical director as to the
21 necessity for surgery?
22 A Or the compromise as a committee in total --
23 Q Okay.
24 A -- that we're leaving open the possibility to
25 revisit the topic.

1 Q Do you recall whether there were other people
2 at this particular meeting who disagreed with the
3 contention that gender reassignment had already been
4 completed and was, therefore, not medically necessary?
5 MR. RODRIGUEZ: Speculation.
6 You can answer.
7 THE WITNESS: Sure.
8 I don't recall that, and, again, I don't recall the
9 information that was provided that may have tempered or
10 framed this in a way that was understandable at that
11 time. So I'm not sure that I was openly disagreeing
12 just based on what information was available at that
13 particular time.
14 BY MS. MAFFETORE:
15 Q Okay.
16 (Discussion held off the record.)
17 MR. RODRIGUEZ: You're reading my mind.
18 DR. JUNKER: You want to take a break?
19 MR. RODRIGUEZ: Do you want to keep on going, or --
20 we're about an hour and then 15 or so since we started
21 back.
22 MS. MAFFETORE: The next chunk is a chunky chunk so
23 if you want to take a break now, that would probably be
24 better than taking a break -- like, if we waited until
25 the after the next chunk, it would probably be awhile.

Case 3:22-cv-00191-MOC-DCK Document 62-10 Filed 10/05/23 Page 21 of 56

1 (Discussion held off the record.)
2 (Recess.)
3 BY MS. MAFFETORE:
4 Q Hi, Dr. Junker, just a reminder that we're
5 still under oath. I hope you enjoyed your lunch break.
6 A Can I revisit just quickly a topic before we
7 jump into the next?
8 Q You have a clarification or correction?
9 A Well, a clarification or an additional comment.
10 Q I mean, if you have something that you believe
11 that was incorrect that you testified before that needs
12 correcting --
13 A It's a clarification, I think. Is that
14 permitted?
15 Q Sure.
16 A Just in reference to the DTARC 411D, the DTARC
17 committee meeting that occurred on August 21, 2019, and
18 the language in the section under accommodations not
19 approved and rationale, I didn't, and I don't think
20 that anyone on the committee, felt that reassignment
21 surgery had been completed already.
22 Q Okay.
23 A That language -- I'm struggling with how the
24 language reads, and that the reference to deferred
25 indicates to me that it was left open, and, in fact, if

1 we -- as we probably will look at what happened after
2 that, it continued, the effort to seek consultation at
3 UNC hospital.
4 But myself, certainly the language is
5 misleading and, perhaps, inadvertent, but I wasn't
6 under the impression then or now that gender-affirming
7 surgery was complete. So I just wanted to clarify that
8 if I hadn't before.
9 Q Sure. So who would have filled out the form,
10 the DC 411D form?
11 A Right. So in my memory, this language most
12 likely came from the medical director.
13 Q Okay. So I wanted to start with what will be
14 marked by the court reporter as Exhibit 13, which is a
15 document, the first page of which is marked DAC 3999.
16 (Exhibit 13 marked for identification.)
17 BY MS. MAFFETORE:
18 Q Do you recognize this document?
19 A Do I recognize what it is? Yes.
20 Q Okay. What is it?
21 A This looks to be the Division Transgender
22 Accommodation Review Committee meeting minutes from
23 February 20, 2020.
24 Q Okay. And is it correct that you were in
25 attendance at this meeting?

1 A Yes.
2 Q And what role would you have been attending
3 this meeting?
4 A Again, it would have been in a role of
5 cochairing the meeting.
6 Q And we've got a few different people at this
7 meeting then the -- the 2019 meeting that we discussed;
8 correct?
9 A Yes.
10 Q And so I'd just like to ask you regarding
11 Dr. David Snell, the medical director, are you aware of
12 whether Dr. Snell had any experience or training in the
13 treatment of gender dysphoria?
14 A I'm not aware.
15 Q How about Dr. Brian Sheitman, psychiatry
16 director, are you aware of whether he had any
17 experience or training in the treatment of gender
18 dysphoria?
19 A I don't know.
20 Q What about Loris Sutton, director of
21 operations, are you aware of whether Loris Sutton had
22 any training in the treatment -- treatment or
23 experience in the treatment of gender dysphoria?
24 A No. I don't know. She is not a medical
25 professional.

Case 3:22-cv-00191-MOC-DCK Document 62-10 Filed 10/05/23 Page 24 of 56

1 Q Okay. Thank you. So on page 4003 of this
2 document, there is an entry listed which says
3 Case 061-8705. Do you see that?
4 A Yes.
5 Q Do you understand that to be Ms. Zayre-Brown
6 based on the number that we have discussed previously?
7 Case 061-8075 up at the top. The one that's not
8 redacted.
9 A Yes.
10 Q And where it states "accommodations reviewed,"
11 it states "vaginoplasty"; correct?
12 A Yes.
13 Q Okay. Why was the DTARC reconsidering this
14 request following the August 2019 deferral that we
15 discussed previously?
16 A It was requested again, it appears, on 2/7/2020
17 from the FTARC. So it would have been one of several
18 accommodation requests that would have been reviewed at
19 the FTARC level. So it would have been sent back to
20 the DTARC.
21 Q Okay. Is your understanding that this was
22 being considered as an appeal from the previous
23 decision?
24 A It would have been a re-request from the
25 previous decision, yes.

Case 3:22-cv-00191-MOC-DCK Document 62-10 Filed 10/05/23 Page 25 of 56

1 Q Okay. And under medical/MH overview, does MH
2 there stand for mental health?
3 A That's correct.
4 Q The last sentence of that paragraph states,
5 "The request for vaginoplasty was previously denied as
6 not medically necessary." Did I read that correctly?
7 A That's correct.
8 Q Okay. And then it says "The offender is
9 appealing this decision." Did I read that correctly?
10 A Okay. Very good.
11 Q So is it your understanding that whoever
12 completed these notes is under the impression that the
13 request for vaginoplasty had been previously denied as
14 not medically necessary?
15 A Yes.
16 Q And this is an appeal from that deposition;
17 correct?
18 A Yes.
19 Q In the decision section of these meeting
20 minutes, it states "The requested surgery is very
21 extensive and requires a lot of follow-up. DTARC
22 recommends a referral to UNC for a consultation. We're
23 requesting in writing what this type of surgery would
24 entail. We also need to know if the offender is a good
25 candidate, the number of required appointments, the

1 number of required procedures, and costs. DTARC will
2 do further research."
3 Did I read that correctly?
4 A You did.
5 Q At this time had DTARC determined whether
6 surgery was medically necessary for Ms. Zayre-Brown?
7 A There had been the previous DTARC that was
8 deferred and referenced that it wasn't medically
9 necessary. These notes indicate that it previously was
10 denied as not medically necessary and that it would be
11 appealed.
12 So as I mentioned earlier, an individual is
13 always free to request an accommodation again. So that
14 was where we were at this point was reviewing the case
15 again.
16 I think that it always -- personally I think
17 that it always had remained open. And we did have a
18 different medical director at this time. So Dr. Wilson
19 apparently had left -- it must've been toward the end
20 of 2019, somewhere in that time frame, but simply by
21 the fact that the offender, Ms. Brown, requested again
22 that it be reviewed, we were going to do that, and at
23 this point push for that consult to take place.
24 Q So to clarify my question, at the February 20,
25 2020, DTARC meeting, was there a determination

1 regarding whether or not surgery was medically
2 necessary for Ms. Zayre-Brown?
3 A I don't recall that being the case in this
4 meeting that we're talking about because we referred it
5 to UNC to get further information.
6 Q If it was not determined at that time whether
7 or not surgery was medically necessary for
8 Ms. Zayre-Brown, why was so much time invested into
9 determining the details that were going to be requested
10 from UNC?
11 A That's correct.
12 Q Why was so much time invested into determining
13 those details if there had been no decision regarding
14 the medical necessity of the surgery?
15 A To find out what would be required if it were
16 approved.
17 Q Okay. Does the required follow-up factor into
18 the medical necessity determination regarding
19 gender-affirming surgery?
20 A No.
21 Q Do the details of what the surgery would entail
22 factor into the medical necessity determination
23 regarding the surgery?
24 A No.
25 Q Would the number of required appointments

1 factor into the medical necessity determination
2 regarding the surgery?
3 A No.
4 Q Would the cost of the procedure factor into the
5 medical necessity determination?
6 A No.
7 Q In situations where a procedure is considered
8 medically necessary, do those factors that we just
9 discussed usually render -- do they usually factor into
10 whether or not the surgery is provided?
11 A No.
12 Q In your view what would it mean for
13 Ms. Zayre-Brown to be considered a good candidate for
14 gender-affirming surgery?
15 A Well, there are several factors, which I think
16 are summarized throughout the process of evaluation of
17 Ms. Brown. She previously had lived experience in the
18 community prior to incarceration living as a female.
19 Ms. Brown had undergone -- are we talking specific to
20 her or are we talking in general?
21 Q So the question was in your view what would it
22 mean for Ms. Zayre-Brown to be considered a good
23 candidate for gender-affirming surgery?
24 A Yes. So had invested a lot of time and
25 resources for other types of surgical procedures to be

Case 3:22-cv-00191-MOC-DCK Document 62-10 Filed 10/05/23 Page 29 of 56

1 completed before incarceration, was voicing a desire to
2 have surgical procedure completed. She was mentally --
3 from a mental health perspective was stable, and she
4 had a -- has a diagnosis of gender dysphoria.
5 Q So from your view the fact that Ms. Zayre-Brown
6 was stable from a mental health standpoint was a factor
7 in favor of her being a good candidate for surgery?
8 A I think that is -- yes. I think that is a
9 factor that is considered.
10 Q Thank you. Do you know who on DTARC was in
11 charge of doing the further research?
12 A I don't, but typically that would probably be
13 nursing or the medical staff who would look into that
14 or someone that they designated to look into that.
15 Q Okay. Do you know whether that research was
16 done?
17 A I don't recall. I think that it was. I mean,
18 I can recall some discussion and, in fact, it was even
19 referenced in the earlier DTARC meeting about the
20 follow-up care that would be required and the types of
21 nursing services that would be required to care for a
22 patient post surgery. I know that there was certainly
23 a difference between certain types of surgical
24 procedures as far as the extent of follow-up that would
25 be required.

Case 3:22-cv-00191-MOC-DCK Document 62-10 Filed 10/05/23 Page 30 of 56

1 You can answer.
2 THE WITNESS: We were not rendering a decision on
3 gender-affirming surgery. We were reviewing the
4 results of the DTARC.
5 BY MS. MAFFETORE:
6 Q So is it your position that you're in that
7 context not making the final determination?
8 A We're reviewing the results of the DTARC,
9 whatever that may be. So in some instances, it may be
10 gender-affirming surgery. And others, it may not. In
11 those cases we would either, you know, have no
12 questions or cause to go back to the DTARC and would
13 concur with their conclusion or their thinking. So
14 it's confirming, not approving.
15 Q Okay. So just to make sure that I understand
16 what you're saying, is it your view that the role of
17 the assistant commissioner of prisons and the Health
18 and Wellness director is to simply review the DTARC's
19 decision and process for procedural defects? And if
20 those are lacking, to essentially defer to the decision
21 of the DTARC?
22 MR. RODRIGUEZ: Objection to form.
23 You can answer.
24 THE WITNESS: Unless there were some reason to
25 question or get clarification, yes, we would defer to

Case 3:22-cv-00191-MOC-DCK Document 62-10 Filed 10/05/23 Page 31 of 56

1 the decision of the DTARC.
2 BY MS. MAFFETORE:
3 Q Okay. And just so that -- the original
4 question that I asked, though, was in addition to the
5 summary that you discussed that's pulled together, is
6 there any other information that you receive when
7 you're doing this -- conducting this review?
8 A No, there is not. But through time and, again,
9 as this case came forward when I was in the role of
10 director of Health and Wellness, we had -- Dr. Peiper
11 had put together more detailed summaries. You can see
12 that in the meeting minutes when I was the chair versus
13 some of what Dr. Peiper produced as he took over that
14 role.
15 And I think, again, it's an evolution. We
16 recognized that we needed more of that information
17 available for review. So there was more information
18 available to me when I was reviewing as the director of
19 Health and Wellness. So I would rely on that.
20 But there were times and certainly I could pull
21 other documents if I felt the need to in cases. Again,
22 we would typically be -- the DTARC would be reviewing
23 15 to 20 cases a quarter, and, you know, we may have
24 three to five cases referred up to, you know, that
25 review process.

1 A Well, relevance is relative.
2 Q So up to the point at which this case was
3 initiated, which would've been mid April of 2022?
4 A There were several times other people sat in
5 with me.
6 Q Okay. So the assistant commissioner of
7 prisons, generally speaking, that is not a medical
8 professional; right?
9 A That's correct.
10 Q Or a mental health care provider of any sort?
11 A That is correct.
12 Q Okay. Does that person typically defer to your
13 judgment regarding decisions on medical treatment?
14 A That person would typically defer to the DTARC
15 and the judgment of those medical professionals, their
16 summary, and our review.
17 Q Have you ever had a disagreement with the
18 assistant commissioner of prisons regarding the
19 ultimate decision to be rendered on one of these
20 referrals that you've been reviewing?
21 A I don't recall that we've had a disagreement.
22 Q How many requests for gender-affirming surgery
23 have you reviewed following a referral from the DTARC?
24 A I would only be able to make an estimate?
25 Q What's your best estimate?

Case 3:22-cv-00191-MOC-DCK Document 62-10 Filed 10/05/23 Page 33 of 56

1 offending behavior factor into the determination of
2 whether or not they should have gender-affirming
3 surgery?
4 A Those are considerations that the DTARC would
5 take into account, so that is part of -- possibly part
6 of what would be looked at for an individual. I don't
7 know specifically, but certainly we've had a number of
8 cases that have been referred up to the review
9 committee, cases that came through the DTARC where
10 there was a history of violence and sexual predator
11 behavior.
12 Q Okay. In what way would a person's history of
13 violence factor into whether or not they should have
14 gender-affirming surgery?
15 A It would be one of a number of factors. It may
16 not be the only factor.
17 Q Understood. I guess I'm asking how is it
18 relevant to the determination?
19 A Well, each case is different. So, you know,
20 reading in the chart and individuals who sometimes have
21 made statements in their clinical chart about their
22 intention to continue in their aggressive behavior
23 towards others if they were to transition, and concern
24 about safety of both themselves and safety for others.
25 Q Are there other medically necessary procedures

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

Case 3:22-cv-00191-MOC-DCK Document 62-10 Filed 10/05/23 Page 35 of 56

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 "Regarding her desire for vulvoplasty, this is a
2 medically necessary part of treatment for this patient.
3 She has been treated with hormones since 2012, an
4 orchiectomy in 2017. With persistent symptoms of
5 gender dysphoria, will communicate my plans with
6 Dr. Figler." Did I read that correctly?
7 A You did.
8 Q Okay. Were you made aware of the assessment by
9 Dr. Caraccio that vulvoplasty is a medically necessary
10 part of Ms. Zayre-Brown's treatment for gender
11 dysphoria in the course of your consideration of
12 Ms. Zayre-Brown's request for gender-affirming surgery
13 following the DTARC's February 2022 determination?
14 A Right. So I don't remember specifically that
15 language. I knew that Ms. Zayre-Brown was receiving
16 various consultations out in the community. And this
17 is a contract provider for the department. It could be
18 with UNC medicine. We contract out to their clinics.
19 But I'd say that the determination of a
20 contract provider -- the recommendations would be
21 considered by our medical staff and ultimately we would
22 make the decision, so that a contract physician doesn't
23 ultimately make the decision about what's medically
24 necessary for patients.
25 Q Sure. But did anybody make you aware in the

Case 3:22-cv-00191-MOC-DCK Document 62-10 Filed 10/05/23 Page 37 of 56

1 course of your consideration that this contract
2 provider who was Ms. Zayre-Brown's treating
3 endocrinologist determined that gender-affirming
4 surgery was medically necessary to treat her gender
5 dysphoria?
6 A I don't remember that specifically.
7 Q And so you're not aware of whether or not it
8 factored into your consideration of Ms. Zayre-Brown's
9 request for gender-affirming surgery in 2022?
10 A Right. The conclusion and summary that was
11 provided by the DTARC took into consideration, I'm
12 sure, all of these factors. I'm certain and trust that
13 Dr. Campbell and Dr. Sheitman and Dr. Peiper reviewed
14 the health record, reviewed all of these notes, and
15 then came to their conclusions based on all of the
16 evidence.
17 Q But did anything in the information that you
18 were provided indicate that was the case, that this
19 recommendation was taken into account in that
20 evaluation?
21 A Not directly.
22 Q Okay. I'd now like to hand you what will be
23 marked as Exhibit 31, which is a document that is
24 Bates-stamped DAC 826.
25 (Exhibit 31 marked for identification.)

Case 3:22-cv-00191-MOC-DCK Document 62-10 Filed 10/05/23 Page 38 of 56

1 BY MS. MAFFETORE:
2 Q Have you seen this document before?
3 A I don't believe that I -- I don't recall that
4 I've read this document myself, but I was briefed on
5 part of it.
6 Q Okay. What do you understand this document to
7 be?
8 A This is a consult note from UNC Health that is
9 provided for the same OPUS number, Kanautica
10 Zayre-Brown, dated 7/12/2021. This was an office visit
11 at UNC urology in Hillsboro, North Carolina. Provider
12 was Bradley Figler, MD.
13 Q And do you know Bradley Figler is?
14 A I know that he's a consultant with us with UNC
15 Heath.
16 Q Do you know whether he works for UNC's
17 Transgender Healthcare Center?
18 A I believe he does.
19 Q Do you know whether he's the director of that
20 center?
21 A That could be the case.
22 Q Okay. So on the second page of this document,
23 just above this little cut with these four little
24 lines, it notes "After extensive discussion of risks,
25 benefits, and alternatives, decision was made to move

Case 3:22-cv-00191-MOC-DCK Document 62-10 Filed 10/05/23 Page 39 of 56

1 forward with" -- and I believe this is a typo based on
2 what follows -- "vaginoplasty"; correct?
3 A That's correct.
4 Q And then under "plan," it states "Proceed with
5 vulvoplasty per WPATH criteria pending. Weight loss
6 goal, goal 215, max 250. Will order case request and
7 notify surgery scheduler when approved by THP"; is that
8 correct? Is that correct?
9 A Yes, it is.
10 Q Okay. So based on your understanding of what's
11 conveyed in this document and the portion that we just
12 read, following a discussion of risks, benefits, and
13 alternatives, Dr. Figler was comfortable proceeding
14 with performing a vulvoplasty for Ms. Zayre-Brown
15 pending some weight loss; correct?
16 A That's correct.
17 Q Okay. And you said that you did not review
18 this directly, but the information was conveyed to you;
19 is that correct?
20 A That's correct.
21 Q Okay. Do you have any reason to doubt the
22 qualifications of Dr. Figler to make a determination
23 that Ms. Zayre-Brown was a candidate for surgery?
24 A No.
25 Q Why did you decide not to follow his

1 recommendation?
2 MR. RODRIGUEZ: Objection. Mischaracterization of
3 the document.
4 You can answer.
5 THE WITNESS: Again, as an outside contract
6 provider, as with many different recommendations
7 concerning a variety of illnesses, recommendations are
8 communicated internally to the medical staff within the
9 Department of Adult Correction, taken into
10 consideration, and then decisions are based on our
11 model of care and the decision ultimately, whether our
12 staff determined if a particular procedure is indicated
13 or not.
14 So I trust and have confidence in our staff
15 reviewing these documents and coming to a decision
16 based on that information and based on their own
17 understanding of the case.
18 BY MS. MAFFETORE:
19 Q So Dr. Figler and Dr. Caraccio, although they
20 were contract providers, were clinicians of
21 Ms. Zayre-Brown's; correct?
22 A Uh-huh.
23 Q They met with her?
24 A Yes.
25 Q They had clinical encounters with her; correct?

1 A Yes.
2 Q Okay. But the members of the DTARC, as we
3 discussed, did not have clinical encounters with
4 Ms. Zayre-Brown; correct?
5 A That's correct.
6 Q And Ms. Dula, who worked with North Carolina
7 DPS, was also a clinician of Ms. Zayre-Brown's;
8 correct?
9 A That's correct.
10 Q And she worked with Ms. Zayre-Brown directly;
11 correct?
12 A That's correct.
13 Q And so all three of these providers recommended
14 that Ms. Zayre-Brown receive gender-affirming surgery
15 for the treatment of her gender dysphoria; correct?
16 MR. RODRIGUEZ: Objection to the form and
17 speculation and mischaracterization of the content of
18 those various documents.
19 You can answer.
20 THE WITNESS: That's correct.
21 BY MS. MAFFETORE:
22 Q Okay. But it's your position that the DTARC --
23 strike that.
24 You stood by the DTARC's decision to disregard
25 those recommendations; correct?

Case 3:22-cv-00191-MOC-DCK Document 62-10 Filed 10/05/23 Page 42 of 56

1 MR. RODRIGUEZ: Objection to the form.
2 You can answer.
3 THE WITNESS: I don't think they disregarded them.
4 They took them into consideration and came to their
5 conclusion.
6 BY MS. MAFFETORE:
7 Q Did you receive any explanation from the DTARC
8 regarding how they took those recommendations into
9 consideration?
10 A Not specifically.
11 Q Did you receive any justification from the
12 DTARC regarding why they reached a contradictory
13 conclusion to those recommendations?
14 MR. RODRIGUEZ: Objection. Mischaracterization of
15 some of the documents.
16 You can answer.
17 THE WITNESS: Just in their analysis of current
18 mental status of the patient and the risks and
19 benefits, as we've discussed, and efficacy of the
20 treatment. But whether they took into consideration,
21 again, I'm making an assumption, but, you know, they
22 looked at all the documents and all the evidence as a
23 division level committee.
24 BY MS. MAFFETORE:
25 Q Understood. Just for clarification purposes,

Case 3:22-cv-00191-MOC-DCK Document 62-10 Filed 10/05/23 Page 43 of 56

1 I'm going to hand you what is going to be marked as
2 Exhibit 32.
3 (Exhibit 32 marked for identification.)
4 BY MS. MAFFETORE:
5 Q You now have what has been marked as
6 Exhibit 32, which has the -- the first page of which
7 has the Bates number DAC 399 -- 3399. Do you recognize
8 this document?
9 A Yes.
10 Q What is this document?
11 A This is the summary that was provided to me
12 regarding Ms. Kanautica Zayre-Brown for the DTARC
13 committee meeting dated -- was it February of 2022?
14 Q Yes.
15 So this whole time that we've been discussing a
16 summary that was provided to you, this is the document
17 to which you were referring?
18 A That's right.
19 Q So by the time this made it to you, it was
20 already in this completed form, and you did not
21 contribute anything to this document; is that correct?
22 A That's correct.
23 Q And so you stated previously that essentially
24 the medical records and things that you considered,
25 aside from the ones from Dula that you reviewed

Case 3:22-cv-00191-MOC-DCK Document 62-10 Filed 10/05/23 Page 44 of 56

1 directly, you considered as conveyed through this
2 summary; is that correct?
3 A This is the summary that was provided to me,
4 yes.
5 Q Okay. Anywhere in this document does it
6 mention Ms. Zayre-Brown's ongoing desires to mutilate
7 her genitals?
8 MR. RODRIGUEZ: Objection. Mischaracterization of
9 the previous documents.
10 You can answer.
11 THE WITNESS: No.
12 BY MS. MAFFETORE:
13 Q And nowhere in this document does it mention
14 the recommendation by Dr. Caraccio that Ms. Zayre-Brown
15 should have gender-affirming surgery for treatment of
16 her gender dysphoria; correct?
17 A No.
18 Q Does this document mention anywhere that Ms.
19 Zayre-Brown had to be placed in inpatient at NCCIW due
20 to suicidal ideation and desire to self mutilate?
21 A No. It just provides information about there
22 being no current evidence of any significant mental
23 health issues.
24 Q And with regard to the medical analysis here
25 that begins on page 2 of Exhibit 32, can you point me

1 Q Do you consider increased anxiety to mean
2 suffering?
3 MR. RODRIGUEZ: To be what now?
4 MS. MAFFETORE: Suffering.
5 MR. RODRIGUEZ: I'm going to object to vague and
6 ambiguous.
7 You can answer.
8 THE WITNESS: Everyone experiences anxiety. So
9 we're all suffering, I guess. So anxiety is a symptom.
10 It can be treated. But it's not easy living in prison.
11 It's not easy being a trans-female in prison. So
12 certainly I would expect that she would be experiencing
13 some anxiety.
14 BY MS. MAFFETORE:
15 Q Would you consider an ongoing desire to
16 self-harm to be suffering?
17 A It's very relative to the individual.
18 Q Did you have any concerns about the cost of
19 surgery when you were considering Ms. Zayre-Brown's
20 request for gender-affirming surgery?
21 A No, none.
22 Q Did you have any security concerns about
23 providing the surgery?
24 A No.
25 Q Did you have any concerns about providing

Case 3:22-cv-00191-MOC-DCK Document 62-10 Filed 10/05/23 Page 46 of 56

1 postoperative care?
2 A We would need to work that out and, you know,
3 determine what care was necessary. It sounded, from
4 what I was briefed on, that the vulvoplasty was not
5 quite as intense and probably more manageable
6 internally for her. So we provide a lot of various
7 types of care after individuals go out for surgical
8 procedures. So I was confident we would be able to
9 accommodate that.
10 Q Did that factor into your decision at all
11 regarding Ms. Zayre-Brown?
12 A No, I did not.
13 Q Did you have any concerns about the precedent
14 that it would set to provide Kanautica surgery?
15 A No, I did not.
16 Q Did you have any concerns about the potential
17 political ramifications that DPS would face if they
18 provided Kanautica with surgery?
19 A No.
20 Q Regarding Ms. Harris, you talked earlier
21 generally about how she is involved with the process.
22 How would she have been involved with the process as it
23 related to decision-making for Kanautica specifically?
24 A It would've been looking at any operational
25 concerns from the custody side of the house, so

Case 3:22-cv-00191-MOC-DCK Document 62-10 Filed 10/05/23 Page 47 of 56

1 certainly listen to the full review, review the
2 material, but she certainly has more of an operational
3 focus.
4   Q Did she express any disagreement with you in
5 regard to the decision related to Ms. Zayre-Brown?
6   A No.
7   Q And you mentioned that the meeting that you had
8 was roughly 60 to 90 minutes. Did you render the
9 decision at that meeting?
10   A Yes.
11   Q On what date did you render that decision?
12   A The date that we met, which I think was 3/28/22
13 perhaps.
14   Q So did you believe that gender-affirming
15 surgery was not medically necessary for Ms.
16 Zayre-Brown?
17   A I concurred with the conclusion that the DTARC
18 reached, that it was at that time not medically
19 necessary.
20   Q What was your understanding of the basis for
21 that conclusion?
22   A Again, the risks and benefits of treatment.
23 Although seeming general, they were written in the
24 context of her case, the risks and benefits, and that
25 other options were available as far as treatment

Case 3:22-cv-00191-MOC-DCK   Document 62-10   Filed 10/05/23   Page 48 of 56

1 considerations, that she was stable from a mental
2 health standpoint at that time, so.
3 Q What risks did you understand surgery to pose
4 to Ms. Zayre-Brown that were considered by the DTARC?
5 A Well, it doesn't go into specifics, but again,
6 surgery is a very extreme, intrusive procedure. So
7 there are always risks in any type of surgical
8 procedure, and the consideration as to whether surgical
9 intervention was -- would have an efficacious outcome
10 or impact on the dysphoria that she was experiencing.
11 Dysphoria, again, it's not specific to gender.
12 Dysphoria can be depression about being incarcerated,
13 about your circumstances in life, about a lot of things
14 that you don't have control over. So whether that
15 would truly impact her dysphoria or not is an unknown.
16 Q What in the materials that you received or
17 considered made you doubt that surgery would resolve
18 Ms. Zayre-Brown's dysphoria?
19 A Would not resolve her dysphoria?
20 Q Made you doubt that it would resolve her
21 dysphoria.
22 A Some of the conclusions that were provided in
23 the summary document that was provided to me.
24 Q Do you have an example?
25 A Well, I mean, you know, some of the data that

1 the committee references that came from Dr. Campbell's
2 analysis. So, you know, again, just the information
3 provided that 65 to 75 percent of individuals who are
4 transgender don't undergo gender-affirmation surgery
5 and are able to function quite well, are able to
6 function as a trans-person without full surgery. So --
7 and certainly comments about the definition of medical
8 necessity and reference to insurance companies not
9 considering that to be the case and not approving
10 surgeries was referenced there. So a number of factors
11 that -- from review of what the committee concluded.
12 Again, a group of healthcare professionals and their
13 opinion that at this particular time that the surgical
14 intervention was not medically necessary. We concurred
15 with that.
16 Q So you mentioned that one of the things that
17 you looked to was that 65 to 75 percent of transgender
18 individuals don't pursue surgery and are able to
19 nonetheless function in society, but is it your
20 understanding that Ms. Zayre-Brown has been seeking or
21 requesting gender-affirming surgery while in DPS
22 custody since November of 2017?
23 A Yes.
24 Q Is it your understanding that Ms. Zayre-Brown
25 was pursuing gender-affirming surgery prior to

Case 3:22-cv-00191-MOC-DCK Document 62-10 Filed 10/05/23 Page 50 of 56

1 incarceration?
2 A Prior to?
3 Q Her incarceration.
4 A She was requesting and undergoing certain types
5 of surgical procedures, yes.
6 Q How did the fact that Ms. Zayre-Brown had been
7 actively pursuing gender-affirming surgery while in DPS
8 custody for three and half years factor into your
9 consideration of whether or not gender-affirming
10 surgery was medically necessary to treat specifically
11 Ms. Zayre-Brown's gender dysphoria?
12 A Her pursuing it?
13 Q Yes.
14 A I would expect that she would -- under the
15 circumstances of her pursuing it was not directly
16 influential. A lot of people request certain types of
17 medical interventions, and, you know, that's their own
18 personal belief of what they need and certainly press
19 for that and advocate for that, but was looking more at
20 the context that the committee considered in their
21 conclusion.
22 Q Understood. So you also mentioned a discussion
23 of insurance companies. You testified previously that
24 you did not independently vet any of the assertions
25 related to insurance companies or any of the sources

Case 3:22-cv-00191-MOC-DCK Document 62-10 Filed 10/05/23 Page 51 of 56

1 cited.
2 A That's right.
3 Q Okay. So you talked about -- in determining or
4 in concurring with the medical-necessity determination,
5 you talked about risks and benefits. Are there any
6 other risks that you considered that would apply
7 specifically to Ms. Zayre-Brown that lead you to concur
8 with the DTARC's determination that surgery was not
9 medically necessary for her to treat her gender
10 dysphoria?
11 A I relied upon the summary document of the
12 DTARC.
13 Q You also mentioned the fact that other
14 procedures or other treatments were available that led
15 you to concur with the DTARC's assessment that surgery
16 was not medically necessary. What other treatments or
17 procedures are available to treat Ms. Zayre-Brown's
18 gender dysphoria that she has not already explored?
19 A Well, there is indication that what has been
20 provided has had some benefit. I believe it may have
21 been Dr. Figler's document that said that there was
22 marked improvement regarding her response to hormone
23 treatment. I'm not exactly sure, you know -- and
24 again, in the context of what that marked improvement
25 was referencing.

Case 3:22-cv-00191-MOC-DCK Document 62-10 Filed 10/05/23 Page 52 of 56

1 But the supportive counseling that's provided,
2 the hormone treatment that's provided, her living in a
3 female facility to be able to interact with other
4 females. I mean, there's a supportive environment
5 there within the female milieu. So a number of
6 protective factors that, you know, are currently being
7 addressed for her that I think are certainly a
8 positive.
9 Q Understood. But even following receiving that
10 care, is it your understanding that Ms. Zayre-Brown is
11 still experiencing clinically significant distress
12 associated with gender dysphoria?
13 MR. RODRIGUEZ: Objection. Speculation.
14 You can answer.
15 THE WITNESS: I don't know. I think a thorough
16 psychological assessment and some objective instruments
17 to determine levels of certain types of symptoms, you
18 know, would probably help to determine that. I don't
19 recall, -- you know, again, her 2017, that was related
20 prior to putting a lot of things in place that we now
21 have in place for individuals, but I think, you know,
22 medication and her current circumstances -- and the
23 summary from the DTARC is that she was psychologically
24 stable and, you know, her mental status was -- it
25 seemed to level off.

1 So I don't know, but it had no impact on her saying
2 she's an 11 out of 10. That's really -- that's really
3 difficult to say.
4 BY MS. MAFFETORE:
5 Q Do you dispute that Ms. Zayre-Brown is still
6 suffering from gender dysphoria?
7 MR. RODRIGUEZ: Objection. Speculation.
8 You can answer.
9 THE WITNESS: I have no way to really fully and
10 adequately determine that.
11 BY MS. MAFFETORE:
12 Q At the time of your consideration, did you
13 dispute that Ms. Zayre-Brown was still suffering from
14 gender dysphoria at that time, when she was being
15 considered for gender-affirming surgery?
16 A She was still -- from what -- again, that's
17 difficult to say in total, but it did you know say
18 that, you know, her mental status was stable, and in
19 another note it said that she was content, and so I
20 would imagine, yes, she still is likely suffering from
21 some level of gender dysphoria. Does it rise to the
22 level of significant persistent distress? I, you know,
23 would need to have someone conduct some further
24 evaluation of her to know exactly.
25 Q Sure. So you noted several times that one

Case 3:22-cv-00191-MOC-DCK Document 62-10 Filed 10/05/23 Page 54 of 56

1 reason that you supported the conclusion that surgery
2 is not medically necessary to treat Ms. Zayre-Brown's
3 gender dysphoria is because she is stable. Didn't you
4 testify earlier in this deposition that whether
5 somebody -- somebody's mental health condition is
6 stable is a criteria that would make them a good
7 candidate for gender-affirming surgery?
8 A That's the difference between appropriate and
9 medically necessary.
10 Q So why would it make Ms. Zayre-Brown -- why
11 would it make surgery not medically necessary for Ms.
12 Zayre-Brown if she is mentally stable if being mentally
13 stable is a prerequisite to being a candidate for
14 gender-affirming surgery?
15 A That's the dilemma that we face.
16 Q Okay?
17 A If you pathologize a condition then it becomes
18 a difficult to make it a prerequisite, and it's
19 difficult to not be able to disqualify yourself or make
20 yourself appropriate for treatment if you're well, you
21 know, I mean, if your dysphoria resolves and treatment
22 is successful. That's the exact dilemma that I think
23 we face here.
24 Q Isn't it the case that we reviewed her record
25 previously where Ms. Zayre-Brown indicates she was

Case 3:22-cv-00191-MOC-DCK Document 62-10 Filed 10/05/23 Page 55 of 56

1 again, not to confuse appropriate with medically
2 necessary.
3 Q Under what circumstances would you have
4 approved Ms. Zayre-Brown for surgery?
5 A If the DTARC had concluded that surgery was
6 medically necessary.
7 Q Are there any other circumstances under which
8 you would've approved Ms. Zayre-Brown for surgery?
9 A If it was considered medically necessary.
10 Q How would you have independently determined
11 that it was medically necessary absent the DTARC's
12 indicating as such?
13 A I would rely upon of them. They're the
14 experts. That's how the process works.
15 Q So there are no other circumstances aside from
16 if the DTARC had indicated that surgery was medically
17 necessary for Ms. Zayre-Brown?
18 A That is our protocol.
19 Q Have you ever met Ms. Zayre-Brown?
20 A I have not. I feel like I have, but I have
21 not.
22 Q Have you ever spoken to her on the phone?
23 A I have not.
24 Q Do you believe Ms. Zayre-Brown still has gender
25 dysphoria?

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 ARTHUR CAMPBELL, M.D.

(Taken by plaintiff.)

Raleigh, North Carolina

April 18, 2023, 4:36 p.m.

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

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19
20 DEPOSITION OF ARTHUR CAMPBELL, M.D., a witness
21 called before SUSAN GALLAGHER, CA CSR, CVR-CM, a Notary
22 Public in and for the State of North Carolina, at 114
23 West Edenton Street, Raleigh, North Carolina, on
24 Tuesday the 18th of April, 2023, commencing at 4:36
25 p.m.

Case 3:22-cv-00191-MOC-DCK Document 62-11 Filed 10/05/23 Page 2 of 77

1 dysphoria or what was previously known as gender
2 identity disorder?
3 A Yes, ma'am. So you're exactly right. When I
4 started medical school in 1993 -- actually, in '93 it
5 was still transgenderism. In '94 it was a transition
6 to gender identity disorder. So I was in medical
7 school during that transition, and really that gender
8 identity disorder persisted through the remainder of
9 both my operational time as a flight surgeon and also
10 during my residency in family medicine.
11 There were courses in medical school that
12 specifically addressed, again, that. It was in that
13 transition phase so they called them different things,
14 but there was certainly human sexuality, the human
15 context in medicine. So there were those type of
16 course is this topic was introduced and discussed.
17 Q During your time at the school, did you have
18 any clinical experience in the treatment of gender
19 identity disorder?
20 A Yes, ma'am. So as a family medicine resident,
21 we are taught how to care for the transgender patient,
22 and as I recall, I had at least two patients during my
23 residency. One was a spouse, and one was a dependent
24 child who were transgender.
25 Q And did you provide treatment related to their,

Case 3:22-cv-00191-MOC-DCK Document 62-11 Filed 10/05/23 Page 3 of 77

1 at the time, gender identity disorder?
2 A I did.
3 Q What kind of treatment did you provide?
4 A At that time there really wasn't a lot of
5 hormonal treatment. I don't recall doing any hormonal
6 treatment at that point for either one of these two
7 individuals. It was largely supportive, getting them
8 behavioral therapy, counseling, those type of things.
9 Q And so while you were providing them care, you
10 did not provide them any treatment specifically that we
11 would now consider gender-affirming care?
12 A Not that I recall.
13 Q And during your time -- during your residency,
14 did you have any experience in treating patients
15 seeking specifically gender-affirming surgery?
16 A I don't recall seeing any of those.
17 Q Did you use any specific standards of care
18 while you were treating your patients who were
19 diagnosed with what was at the time gender identity
20 disorder?
21 A I don't remember there being standards of care
22 at that time. Yeah. There were certainly clinical
23 practice guidelines that existed back then, but.
24 Q So following your education, what professional
25 qualifications did you obtain?

Case 3:22-cv-00191-MOC-DCK Document 62-11 Filed 10/05/23 Page 4 of 77

1 A So again, I'm board certified in family
2 medicine, and also I'm a military flight surgeon.
3 Q Anything else?
4 A Those are my certifications.
5 Q What about licensure?
6 A Sure. I've been licensed in North Carolina
7 since 1998, I believe. I maintain that license
8 consistently.
9 Q Prior to your time with DPS, is it correct that
10 you were in the Army?
11 A Yes, ma'am.
12 Q Okay. Did you have any work history following
13 your education outside of the United States Army other
14 than DPS?
15 A Any work or education?
16 Q Work.
17 A Yes. So I did -- there were a couple of times
18 back in the early 2000s that I moonlighted at some
19 clinics. There was one in the Fayetteville area.
20 There was another one in the Lumbar Bridge area, and I
21 believe another one in Lumberton.
22 Q And while you were in the United States Army,
23 did you have any experience in the treatment of gender
24 identity disorder or gender dysphoria?
25 A Not any experience in treatments. I know

Case 3:22-cv-00191-MOC-DCK Document 62-11 Filed 10/05/23 Page 5 of 77

1 patients that were impaneled to me. I will say that in
2 my last role as the group commander for the special
3 warfare medical group, I was -- as the commander, I
4 was -- and as the medical advisor to the two-star
5 general of the special warfare center of the school, I
6 was serving in that capacity at the time that soldiers
7 were able to begin transitioning in the military, and
8 so it was my responsibility to educate all senior
9 leadership, all medical providers that took care of any
10 of our soldiers and their dependent families, and
11 incidentally, to oversee that program being safely
12 instituted in my unit, we actually had the first
13 special forces medic who was actively transitioning who
14 was under my command, and it was my responsibility to
15 make sure that we followed all procedures and policies
16 and that we provided the appropriate care for that
17 individual.
18 Q Okay. So you were in charge of instituting --
19 strike that.
20 So you were in a leadership role at a time
21 where the Army began to allow individuals to transition
22 while in the Armed Forces?
23 A Correct.
24 Q Okay. And did you conduct any trainings
25 related to the provision of care for people diagnosed

Case 3:22-cv-00191-MOC-DCK Document 62-11 Filed 10/05/23 Page 6 of 77

1 with gender dysphoria?
2 A I did.
3 Q And can you describe those trainings?
4 A Yes. So it was -- and it depended on the
5 audience. So regarding the care specifically, there
6 were medics that were assigned to my command, and there
7 were providers that were assigned to my command that
8 would be providing care. So we had to provide them --
9 the education largely focused on the DOD policies
10 related to transgender soldiers and not as much in the
11 direct patient care.
12 Q Did you refer to any standards of care in those
13 trainings for the treatment of gender dysphoria?
14 A I do recall that we mentioned WPATH in some of
15 those trainings. I can't recall if we referenced -- I
16 can't remember exactly what we referenced in that
17 training.
18 Q Okay. So you said that during your time in the
19 Army, though, you had no patients impaneled to you
20 specifically for the treatment of gender dysphoria?
21 A That's correct.
22 Q Okay. So then you also didn't have any
23 experience in treating patients seeking
24 gender-affirming care during that time?
25 A That's correct.

1 Q And none seeking gender-affirming surgery
2 during that time; correct?
3 A Correct.
4 Q How about your clinical experience? Did you
5 have any patients that you were treating for gender
6 dysphoria at any of your clinics where you were
7 moonlighting?
8 A Not that I recall.
9 Q Since coming to DPS, have you had any patients
10 that were impaneled to you that you were treating for
11 gender dysphoria?
12 A Not impaneled to me, no.
13 Q Okay. Have you had any training in the
14 treatment of gender dysphoria?
15 A Yeah. So I mentioned some of the initial
16 residency in family medicine training. We also
17 attended training through the UNC Trans Health program
18 in conjunction with our duties with the DTARC. I also
19 recently completed a continuing medical education
20 course at the American Academy of Family Physicians and
21 quite extensive, you know, independent research.
22 Q And what was the continuing medical education
23 course you mentioned?
24 A It was through the American Academy of Family
25 Physicians. I believe it was entitled "Care of the

Case 3:22-cv-00191-MOC-DCK Document 62-11 Filed 10/05/23 Page 8 of 77

1 Transgender and Gender Diverse Patient" or something to
2 that effect. I believe that was the title.
3 Q And when did you complete the UNC Trans Health
4 training that you mentioned?
5 A I do not recall the exact date. We did it as a
6 committee. It was probably a year, year and a half
7 ago.
8 Q Would it have been before or after DTARC's
9 consideration of Kanautica Zayre-Brown's request for
10 gender-affirming surgery in February of 2020?
11 A I'm not sure specifically.
12 Q And what about the CME course? When did you
13 complete that?
14 A That was certainly within the past year. I
15 don't know the exact date.
16 Q Any training, aside from when you were
17 obtaining your medical degree as you mentioned, any
18 training prior to the UNC Trans Health training
19 regarding the treatment of gender dysphoria?
20 A Other than what I mentioned related to
21 transgender soldiers that we all had to undergo. So we
22 were training the trainers. So we had to undergo
23 training, and we had to then conduct the training.
24 Q So I asked you if you had previously been
25 deposed when we were discussing if -- in your 30(b)(6)

1 deposition, I asked if you had previously been deposed,
2 and I believe you said you had been deposed about four
3 times. Have you ever been sued before?
4 A No, ma'am.
5 Q Okay. When did you first become involved in
6 DTARC?
7 A When I assumed my role as chief medical
8 officer.
9 Q Okay. So you became involved right away, or
10 was there lag time between you coming on board and
11 becoming involved in DTARC?
12 A If I'm not mistaken, there was a transition
13 period of time where Dr. Agarwal, who was the deputy
14 medical director, had stepped in. I think talked about
15 that before where there was a period of time where Dr.
16 Snell had departed and I was coming into the position,
17 and during that time Dr. Agarwal would have served on
18 the committee.
19 Q So that would have been around October of 2020,
20 perhaps slightly later, that you became involved in the
21 DTARC; correct?
22 A Yes, ma'am.
23 Q And when you became involved in DTARC, were you
24 involved as cochair right away?
25 A Yes.

1 Q Did you have any reservations about taking on
2 that role?
3 A I did not.
4 Q And I think that you've essentially just
5 answered this, but I just want to confirm. Did you
6 receive any training in conjunction with you becoming
7 involved in the DTARC regarding your upcoming roles and
8 duties on DTARC?
9 A I don't recall any specific training. I think
10 the first thing that was involved was being introduced
11 to the policies and procedures and then sitting down
12 with Dr. Peiper discussing the processes involved in
13 the DTARC. So training, but not formal course
14 structure training.
15 Q Okay. So when you said that you became
16 familiar with the policies, was one of those policies
17 that you became familiar with the EMTO policy?
18 A Yes, ma'am.
19 Q The Evaluation and Management of Transgender
20 Offender policy. But you said it was not formal
21 training; correct? It was more of an orientation; is
22 that a fair characterization?
23 A It is.
24 Q And how many orientation meetings would you say
25 you had related to the DTARC prior to your onboarding?

1 A I seem to recall at least twice that we met.
2 I'm not positive.
3 Q Okay. Did you agree with the EMTO policy?
4 A It wasn't up to me to agree with it. It's a
5 department policy.
6 Q Well, regardless of whether or not it was up
7 to, did you agree with the policy?
8 A Again, it's a policy. I'm going to follow it.
9 My opinion of a policy isn't necessarily important.
10 Q What is your opinion of the policy?
11 A I support the policy.
12 Q Are there any aspects of the policy that you
13 don't agree with?
14 A No, I can't -- I don't think -- there's nothing
15 I disagree with. We talked during my prior deposition
16 that I think we could do some things to improve the
17 process, but that's not a disagreement. That's
18 something that's an ongoing process. We always try to
19 improve policies and procedures.
20 Q Have you ever tried to get DTARC to rescind the
21 policy?
22 A No, ma'am.
23 Q Okay. Have you ever tried to get DPS to amend
24 the policy?
25 A No. Again, we all did provide -- were able to

1 provide input, like I discussed, in the editing of the
2 policy shortly after I came on board so I was able to
3 provide input to that, and my recommendations on any
4 changes, I don't remember there was anything
5 significant in that policy, and I never technically
6 tried to amend it, but, again, referencing a discussion
7 we had in my 30(b)(6) that I had at least begun initial
8 discussions of processing requests for gender-affirming
9 surgery a little differently, more consistent with how
10 we do other surgeries in the system, so.
11 Q Okay. Have you ever had any disagreements with
12 other people on DTARC?
13 A I don't recall any disagreements.
14 Q Never?
15 A I mean, not that come to mind immediately.
16 Q I'd like to refer back to an exhibit that was
17 previously marked in your 30(b)(6) deposition, so that
18 would be the Campbell 30(b)(6) deposition Exhibit
19 Number 15.
20 (Previously marked Exhibit 15 referenced.)
21 BY MS. MAFFETORE:
22 Q So you testified in your 30(b)(6) deposition
23 that you were the drafter of this position statement.
24 How did you go about drafting this?
25 A So as I began discussing in the 30(b)(6)

Case 3:22-cv-00191-MOC-DCK Document 62-11 Filed 10/05/23 Page 13 of 77

1 initial documents.
2 Q Okay. So I understand how you ended up, maybe,
3 reviewing the studies that you decided to include. Why
4 did you decide to include only the studies that you
5 included?
6 A So as I began working, as I began reading
7 studies in the WPATH, what I found, that there were
8 often shortfalls in many of the studies that were
9 cited, or as I read the actual study that was
10 referenced, I read the reference in the WPATH. So they
11 would include an excerpt from a study. When I reviewed
12 the study in its entirety, there were portions of that
13 that were not included in the WPATH standards of care.
14 So I would be looking into that as a topic of
15 consideration.
16 So what I started to find is that there were a
17 large number of studies out there, but there were many
18 that were either on one end of the spectrum or the
19 other, and what I was trying to do was try to hold it
20 down to studies that were in that middle ground to try
21 to see that they were more objective studies, that they
22 were not simply consensus studies, that they were
23 properly designed studies, and so as I did that, I
24 started noticing that there were some pretty important
25 discrepancies.

1 So a lot of the points I made in here -- I
2 don't want to call them counterpoints to WPATH, but
3 they were often things that WPATH did not include in
4 their standards of care but that were a consideration
5 and that we need to make sure we consider all of those
6 factors when we look at this. We have to be completely
7 objective in our analysis.
8 We can't approach this with a foregone
9 conclusion to try to find studies that support our
10 contention, and so the WPATH references stand on their
11 own, and these were just some select articles that I
12 think provided some additional context to those things
13 that were found in the WPATH.
14 Q Do you have a rough estimation of how many
15 sources you consulted while you were researching this
16 position statement?
17 A No, I really don't, and what I would say is
18 that this is not all I was researching either. So, you
19 know, I do this for multiple conditions. It's a very
20 continuous thing for me. So, you know, when a provider
21 calls me with a particular case and I don't have an
22 immediate answer or there is some question about it, I
23 will do research on that.
24 Again, it's harder for me to quantify because
25 this is just one of many any things that I research on

1 Q Would you say it was less than half?
2 MR. RODRIGUEZ: I'm going to object to the
3 mischaracterization of the -- and assumption of facts
4 that aren't present before the witness.
5 But you can answer.
6 THE WITNESS: Yeah. I didn't really look at it
7 that way so I never considered whether a study was
8 consistent with that or not. I didn't have a preformed
9 opinion as I did this -- the literature reviews.
10 BY MS. MAFFETORE:
11 Q So you can't say if it was more than half
12 either?
13 A Hard for me to say.
14 Q You wouldn't be able to tell me if it was
15 80 percent?
16 A No.
17 Q Okay. Was the research that you did in
18 conjunction with the position statement the same
19 literature review that was conducted in conjunction
20 with Mrs. Zayre-Brown's case summary?
21 A Some of that overlapped, for sure.
22 Q How much of it would you say overlapped?
23 A The pertinent aspects of her particular case I
24 think -- I get it started to put a percentage on that,
25 but certainly two thirds of it probably overlap.

1 transitioning over most periods?
2 MR. RODRIGUEZ: Right, but before that you had him
3 read that sentence that started, in fact, there are
4 studies which cause great concern"; right?
5 MS. MAFFETORE: So that is the second paragraph?
6 MR. RODRIGUEZ: Yeah.
7 MS. MAFFETORE: In fact, there are studies which
8 cause great concern that not an insignificant portion
9 of individuals who undergo procedures not only failed
10 to improve, but in many cases experienced worse
11 symptoms with quite concerning consequences."
12 MR. RODRIGUEZ: Then you jump to --
13 MS. MAFFETORE: And then I jump down two paragraphs
14 and said that to support this contention he cited the
15 study --
16 MR. RODRIGUEZ: Which contention?
17 MS. MAFFATORE: That there are studies which cause
18 great concern that not an insignificant portion of
19 individuals who undergo procedures not only failed to
20 improve, but in many cases experienced worse symptoms
21 with quite concerning consequences.
22 MR. RODRIGUEZ: Right. So I'm going to object to
23 mischaracterization of the document based on that
24 clarification.
25 You can answer to the extent you're able.

1 BY MS. MAFFETORE:
2 Q So Exhibit 1, is this the study that you are
3 citing?
4 A Yes, ma'am.
5 Q Okay. Isn't it true that this article asserts
6 that barriers to surgery and transition-related
7 healthcare actually increase instances of suicidality?
8 A That is one of the statements they make.
9 Q Okay. And we can note at page 71 of this
10 article, the first full paragraph, the sentence
11 beginning with, "However" --
12 Actually, I'd like to skip down to the sentence
13 beginning with, "By contrast, evidence is mounting that
14 barriers to transition-related healthcare contribute to
15 suicidality among those who desire such measures and
16 though it sometimes increase during transition, it
17 typically decreases once desired transitional goals are
18 completed. Indeed, a recent qualitative inquiry into
19 suicide protective factors among trans adults
20 identified several important protective factors among
21 this population, one of which was socially and/or
22 medically transitioning for those who seek it."
23 Did I read that correctly?
24 A You did.
25 Q Okay. And isn't it also true that this article

1 actually recommends the provision of transition related
2 healthcare in reducing barriers to that care in order
3 to decrease suicidality?
4 A That is one of the contentions they make.
5 Q Okay. And again, at page 71 under
6 "implications" they note, "For example, as noted above
7 there is growing evidence for the role of both
8 transgender discrimination and transitional services
9 and suicidality among the population with the former
10 implicated in heightened suicidality in the provision
11 of the latter in its reduction. Physical healthcare
12 providers may therefore find it advisable to reduce
13 barriers to transition while mental health care
14 providers should be prepared to support transgender
15 clients seeking out preparing for and obtaining these
16 services.
17 Did I read that correctly?
18 A You did.
19 Q And isn't it true that this article advocates
20 for policies that support transgender healthcare?
21 MR. RODRIGUEZ: Objection. Mischaracterization of
22 the totality of this document.
23 But you can answer.
24 THE WITNESS: And I don't contend otherwise
25 anywhere in my position statement.

Case 3:22-cv-00191-MOC-DCK Document 62-11 Filed 10/05/23 Page 19 of 77

1 BY MS. MAFFETORE:
2 Q Okay. And so your position is that this
3 article is supportive of the notion that
4 gender-affirming surgery leads to higher instances of
5 suicidality?
6 MR. RODRIGUEZ: Objection. Mischaracterization of
7 the document the position paper what it stands.
8 For you can answer.
9 THE WITNESS: So again the single paragraph that
10 you referenced from my position statement is indeed
11 found on page 71 of this literature. So there is a
12 concern that -- they admitted in here that there are
13 additional research and additional studies are
14 required, and you are going to see that in a lot of
15 these studies. So they clearly make that point. I can
16 certainly read it to you if you want me to. I know
17 you're able to read it, but that is true because they
18 said, it seems counterintuitive, on the other hand,
19 that suicide attempts are lower before transition than
20 over most other periods.
21 So that is a true statement, and what that does is
22 what I referenced before is that that requires some
23 additional consideration they admit. So in this study
24 that there are additional studies and additional
25 evaluations are needed they work on a presumption that

1 is no definitive evidence that surgery does the things
2 that some people report that it does for these
3 patients.
4 Q Okay. So just to be clear, sitting here today
5 you do not have a firm rate -- understanding of a firm
6 rate of de-transition among adults?
7 MR. RODRIGUEZ: Objection. Mischaracterization of
8 the witnesses testimony.
9 You can answer.
10 THE WITNESS: No, and that's because no one does.
11 It depends on the source you read. You're going to get
12 widely varying numbers. So for me to come up with a
13 number would be -- would not be accurate on my account
14 because it's not available right now.
15 BY MS. MAFFETORE:
16 Q All right. What is your understanding of how
17 common regret is in adults who undergo surgical
18 transition procedures?
19 A The same thing applies. Often these
20 individuals self select out of future studies. So we
21 don't really know how many of them may do that. So
22 it's hard to pin a number down, and that's part of my
23 overarching philosophy in this paper is that there's so
24 much that we don't know, and WPATH rightly points that
25 out. If you read in the standard of care for WPATH,

1 they will say, for instance, that top surgery may
2 provide some benefit, but they'll say immediately after
3 that, there is no definitive study that confirms an
4 absolute benefit to that, and they also acknowledged in
5 their defense that additional studies are required.
6 And so when we in medicine encounter that
7 phenomenon where even people that are providing
8 clinical practice guidelines and standards of care and
9 acknowledge that there is not definitive evidence, and
10 you read studies that show there is also not definitive
11 evidence, and you can find 100 studies that say there
12 are and 100 studies that say there aren't, we need to
13 be cautious, and that's my point of this position paper
14 is that we need to be cautious.
15 Q With respect de-transition, do you deny that
16 most of the research conducted on de-transition was
17 done on minors before current standards diagnosis of
18 gender dysphoria adolescents were created?
19 MR. RODRIGUEZ: Objection to form.
20 You can answer.
21 THE WITNESS: Yes. Because those studies began
22 before transition services began occurring on a large
23 scale for adolescents. So that would naturally be the
24 case.
25 BY MS. MAFFETORE:

1 Q So with respect to a rate of transition, at the
2 bottom of page four you note that a study published in
3 the Archives of Sexual Behavior in October 2021 found a
4 24 percent rate of de-transition.
5 Did I read that correctly?
6 A You did.
7 Q Okay. I'm handing the court reporter what will
8 be marked as Exhibit 2 to your individual defendant's
9 deposition.
10 (Exhibit 2 marked for identification.)
11 BY MS. MAFFETORE:
12 Q Is this the same article that you cited for
13 that proposition?
14 A Yes, ma'am, I believe it is.
15 Q In your position statement, what did you mean
16 when you said a "24 percent rate of de-transition"?
17 A I'd have to look back over the study to see
18 where that was referenced.
19 Q I'm happy to move on.
20 A Okay. And I could probably --
21 MR. RODRIGUEZ: You asked him where he --
22 MS. MAFFETORE: No. I actually asked him what he
23 meant by a "24 percent rate of de-transition." I
24 didn't ask him to find in the article where it said
25 that.

1 MR. RODRIGUEZ: That's a very disingenuous line of
2 questioning, but you can proceed.
3 BY MS. MAFFETORE:
4 Q So isn't it the case that the studies discussed
5 in this article was a survey of 100 people who all
6 self-described as de-transitioners?
7 A That's correct.
8 Q And isn't it the case that this study did not
9 intend or attempt to evaluate the trans population as a
10 whole?
11 MR. RODRIGUEZ: Objection. Speculation as to what
12 the authors of the study intended.
13 You can answer.
14 THE WITNESS: Again, I don't believe that's what
15 their intent was.
16 BY MS. MAFFETORE:
17 Q Okay. So I would like to just direct you to
18 page 3355 of this study. It's like the third page, and
19 the numbers are on the top right-hand corner.
20 A 3355?
21 Q Yes.
22 A Okay.
23 Q So this little paragraph above where it says
24 "method," second to last sentence states, "This study
25 does not describe the population of individuals who

1 undergo medical or surgical transition without issue,
2 nor is it designed to assess the prevalence of
3 de-transition as an outcome of transition. Instead the
4 goal was to identify de-transition reasons and
5 narratives in order to inform clinical care and future
6 research."
7 Did I read that correctly?
8 A You did.
9 Q And so this article does not purport to
10 represent the prevalence of de-transition as an outcome
11 among the general population; is that correct?
12 A No, it does not. I don't believe I said that.
13 Q Would you consider the representation of a
14 24 percent rate of de-transition a representation
15 regarding the prevalence of de-transition?
16 A Again, I'd have to read the study, and I
17 acknowledge we don't have time to do that here to
18 understand where that number came from, but my intent
19 of including this study is -- I do agree completely
20 that this can inform us as to why individuals
21 de-transition, and that's important for us as we go to
22 select patients, particularly for surgery, because it's
23 important for us to make sure that we are selecting the
24 most appropriate patients for those surgical
25 interventions.

1 identified people who currently identify as cisgender."
2 Did I read that correctly?
3 A You did.
4 Q Does this article note any rate of
5 de-transition?
6 A It doesn't, and again, I don't report that
7 either in my study -- in my paper.
8 Q Does this article urge that any prevalence
9 estimates should be interpreted with caution?
10 A Yes, which is the same statement I made, that
11 we just frankly don't know what the rate is.
12 Q Understood. So just to be clear, you're not
13 aware of any data on the prevalence of transition that
14 supported your position statement?
15 MR. RODRIGUEZ: Objection. Mischaracterization of
16 the position statement and his testimony.
17 THE WITNESS: Yeah. I wouldn't say that's the case
18 at all. I don't understand.
19 BY MS. MAFFETORE:
20 Q Can you point me to specific data in support of
21 your position statement that speaks to the prevalence
22 of de-transition?
23 A Again, the point of -- as I said just a few
24 minutes ago, the point of me including this was not to
25 try to point to a specific prevalence rate, but to

1 point to of those who de-transition, the reasons they
2 de-transition in order to help better inform us as we
3 select and begin people taking that step into
4 transition.
5 So in other words, this should help inform us
6 in selecting the proper patients to undergo, in this
7 case, gender-affirming surgery. Because if we
8 understand why the people that de-transition do so, we
9 can make those accommodations upfront to try to make
10 sure that those reasons are eliminated in future cases.
11 Again, it was never my point to try to point to a
12 prevalence because as I stated, no one has a firm rate
13 at this point. The studies are literally all over the
14 map on prevalence.
15 Q So if you're unaware of the prevalence of
16 de-transition, how does the fact that de-transition
17 occurs in some amount of cases impact your view on
18 whether or not gender-affirming surgery was medically
19 necessary?
20 MR. RODRIGUEZ: Mischaracterization of the
21 witness's testimony.
22 You can answer.
23 THE WITNESS: Again, it is a real phenomenon, and
24 increasing evidence is showing that it is increasing.
25 The WPATH attributes that increase to a simple

1 proportional increase in the number of individuals that
2 are undergoing gender-affirming surgery. However, as
3 all of these entities, including WPATH, acknowledge,
4 there are additional studies that are needed because we
5 do need to know what that rate is, and we simply don't
6 at this point.
7 So it advises caution as we evaluate these patients
8 and determine medical necessity. So it is clearly at
9 the root of a medical necessity determination because
10 we need to understand, of the people that move forward
11 with the surgery, why, how many, and under what
12 circumstances do they de-transition. Because it's our
13 job to make sure we select the proper patients for
14 surgery, as we would for any surgery out there.
15 There's copious evidence on most other surgical
16 procedures. We know, for instance, who is going to do
17 well with a hip replacement, who is not going to do
18 well with a hip replacement. We need the same level of
19 fidelity when it comes to gender-affirming surgery as
20 we do for that hip surgery replacement so that we are
21 selecting the proper patients.
22 If there are preoperative, intraoperative,
23 postoperative things that we can do to affect that
24 rate, we need to take those steps in doing so. And
25 again, this is simply a caution, and it's a phenomenon

Case 3:22-cv-00191-MOC-DCK Document 62-11 Filed 10/05/23 Page 28 of 77

1 that's not yet known, but it's critical we understand
2 it.
3 BY MS. MAFFETORE:
4 Q Okay. And if there were myriad studies
5 concluding that the rate of de-transition of the
6 population was in the low single digits, would you
7 still think it was critical to your assessment of
8 whether or not gender-affirming surgery is medically
9 necessary for the treatment of gender dysphoria?
10 MR. RODRIGUEZ: Objection. Speculation. Legal
11 conclusion.
12 You can answer.
13 THE WITNESS: So again, you've spent a lot of time
14 on de-transition, which really didn't represent a
15 significant portion of this position paper, but that
16 would be one aspect that would be important. So the
17 answer to your question is yes, if there ever is
18 definitive evidence of what that rate is, things we can
19 do to counter that to ensure we select the proper
20 patients and we take the proper steps before, during,
21 and after surgery so that they have the best recovery
22 and the most successful treatment of their gender
23 dysphoria, then it would not be a factor in the medical
24 necessity determination, but we're not there yet.
25 BY MS. MAFFETORE:

Case 3:22-cv-00191-MOC-DCK Document 62-11 Filed 10/05/23 Page 29 of 77

1 Q I'd like to focus on other aspects of your
2 position statement. If we can turn to page 6 of your
3 position statement. So you note on page 6 at the top,
4 "If a procedure, surgery in this case, were the
5 standard of care, there would be a single or at most a
6 discrete subset of procedures which have been
7 determined by the medical community to be the most
8 appropriate to treat the condition."
9 Did I read that correctly?
10 A You did.
11 Q Are you aware of any other conditions for which
12 there are a variety of medical options for treatment
13 depending on the severity of the condition?
14 A You would have to define "variety." There are
15 a limited number of procedures. There are probably
16 approaching 60 to 100 procedures related to
17 gender-affirming surgery. There is no other condition
18 that I'm aware of, medical condition, where there are
19 60 to 100 different -- completely different procedures
20 to treat that condition.
21 Q What about cancer?
22 A So again, you'd have to be more specific. So
23 cancer broadly, you could probably come up with that
24 many, but if you look at a specific type of cancer,
25 which would be a better analogy to this because this is

1 a specific condition -- so say that you're going to
2 look at hepatocellular cancer. There are a limited
3 number of treatments to treat hepatocellular cancer,
4 but it is really not an appropriate thing to look at
5 the entire human body and every conceivable cancer and
6 every conceivable surgery they can use to treat that.
7 So you need to compare apples to apples when
8 you look at these things. So this is a discrete
9 condition. For example, I gave hepatocellular
10 carcinoma. Renal cell carcinoma are discrete
11 conditions for which there is only a very small subset
12 of surgical procedures to treat those.
13 Q Is it your position that gender dysphoria
14 manifests in exactly the same way in every individual
15 that has gender dysphoria?
16 A No, it is not.
17 Q Are there a multitude of -- are there multiple
18 treatment options for the specific type of cancer that
19 you just referenced?
20 A Yes, there are multiple treatment options. So
21 there can be chemotherapy. There can be radiation.
22 There can be surgery. There are always multiple
23 treatment options, but again, not to this scale.
24 Q Are there multiple surgical options?
25 A I would say there are several surgical options

1 for a particular type of cancer.
2 Q Also on page 6 you note, "The overwhelming
3 expectation would be that excluding patients who
4 decline surgery against medical advice, that virtually
5 every patient with this condition and without
6 contraindications would indeed be provided the
7 procedure."
8 Did I read that correctly?
9 A You did.
10 Q On page 7 you note, "Only 25 to 35 percent of
11 individuals with gender dysphoria ever undergo any
12 GRS."
13 Did I read that correctly?
14 A You did.
15 Q Are there other conditions for which the need
16 for surgery is not always necessary depending on the
17 severity of the condition?
18 A So, yes. I mean, there are certainly
19 conditions you treat without surgery, yes.
20 Q Are there conditions that you attempt to treat
21 without surgery that might ultimately require surgery
22 in a limited number of cases?
23 A Yes.
24 Q Can you give an example?
25 A So you could treat -- so I'll go back to the

Case 3:22-cv-00191-MOC-DCK Document 62-11 Filed 10/05/23 Page 32 of 77

1 cancer analogy. So you could initially treat a
2 condition, say, with radiation therapy in hopes that
3 you can debulk the tumor enough to where it doesn't
4 have to have the surgical incision. It may not be
5 effective. That condition may later require surgery to
6 remove that cancer.
7 Q Do you know the rate at which surgery is
8 require to treat cancer?
9 A It's true in a broad term. It is -- I don't
10 think -- we'd have to talk about a specific type of
11 cancer, and I'd have to, again, review the research
12 related to that specific type of cancer. There's no
13 way to quantify how often surgeries are necessary with
14 cancer.
15 Q Are you aware of any other conditions for which
16 the need for surgery only presents in about 25 to
17 35 percent of people with that condition?
18 A I think -- probably any condition is probably
19 going to be a percentage of people that are treated
20 effectively without surgery.
21 Q So I'm trying to understand what you mean by
22 "the overwhelming expectation would be that excluding
23 patients who decline surgery against medical advice,
24 virtually every patient with this condition would
25 indeed be provided the procedure."

1 A So we're talking specifically about
2 gender-affirming surgery in this case and whether it is
3 medically necessary or not for that condition to have
4 surgery. So I guess I'm kind of confused on the
5 question, but when you're looking at just that
6 condition and whether or not surgery is indicated,
7 there is an extraordinarily small number of people as
8 opposed to other conditions where surgery is medically
9 necessary, so medically necessary surgery for other
10 conditions and medically necessary surgery for
11 gender-affirming care.
12 Q But in the situations that we were discussing,
13 isn't it the case that surgery only becomes medically
14 necessary if the condition reaches a certain degree of
15 severity?
16 MR. RODRIGUEZ: Objection. Vague.
17 Mischaracterization of previous testimony, and
18 incomplete representation of what the cite -- the
19 reference that you're making to the position statement.
20 THE WITNESS: Repeat the question.
21 BY MS. MAFFETORE:
22 Q We were just discussing about other conditions
23 that do not always require surgery, where other
24 interventions are sought first. Isn't it the case in
25 those situations that surgery is only necessary in that

1 smaller number of cases when a condition reaches a
2 certain degree of severity?
3 A That's true, and it's been -- that has been our
4 position the entire time, that there can be a severe
5 enough case of gender dysphoria where surgery is
6 indicated.
7 Q Is it then possible that only 25 to 35 percent
8 of individuals present with gender dysphoria severe
9 enough to render gender-affirming surgery medically
10 necessary?
11 MR. RODRIGUEZ: I'm going to object to the -- it's
12 mischaracterization of the basis for that statement and
13 its reference in the position statement.
14 You can answer.
15 THE WITNESS: One more time.
16 BY MS. MAFFETORE:
17 Q Sure. Isn't it then possible that roughly only
18 25 to 35 percent of individuals with gender dysphoria
19 undergo gender-affirming surgery because only roughly
20 that many have gender dysphoria that rises to the level
21 of severity that makes gender-reassignment surgery
22 necessary?
23 A I mean, that is certainly possible, yes. I
24 would say that if you -- my concern with that is --
25 again, referencing the WPATH, is there is no

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:

Case 3:22-cv-00191-MOC-DCK Document 62-11 Filed 10/05/23 Page 36 of 77

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

Case 3:22-cv-00191-MOC-DCK Document 62-11 Filed 10/05/23 Page 39 of 77

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

Case 3:22-cv-00191-MOC-DCK Document 62-11 Filed 10/05/23 Page 42 of 77

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.

Case 3:22-cv-00191-MOC-DCK Document 62-11 Filed 10/05/23 Page 45 of 77

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 point I think they're a relatively new organization
2 that have just recently begun publishing data.
3 Q Do you believe that the Society for
4 Evidence-Based Gender Medicine uses an evidence-based
5 process?
6 A From the evidence I've reviewed from them so
7 far, yes.
8 Q What is your basis for that?
9 A So I'd have to look at the studies that were
10 referenced, but that is their mission statement
11 specifically, and in the studies that I looked at, it
12 appeared to be the case. Again, fairly new, not a lot
13 of research done by them yet, but they're certainly
14 starting to publish more.
15 Q Are you aware of any criticisms regarding the
16 reliability of the Society for Evidence-Based Gender
17 Medicine?
18 A I have not heard any of that.
19 Q Have you done any independent research or
20 investigation into the reliability of the Society for
21 Evidence-Based Gender Medicine?
22 A No.
23 Q Why not?
24 A Again, as I stated, especially when I started
25 writing this position paper, they were a relatively new

1 organization with not a lot of literature behind them
2 yet to be able to make that analysis.
3 Q Okay. So on page 10 of the position statement,
4 you note that WPATH is an activist-led rather than
5 evidence-led organization. What is your basis for that
6 assertion?
7 A So there's several ways. In many of the
8 articles I read, they specifically cite that. There
9 are very senior folks that not only helped found that
10 organization, but were members of that organization who
11 subsequently left, and there are certainly reports from
12 colleagues about the fact that the opportunity -- that
13 have been to these committee meetings, that the
14 opportunities for individuals to express even a hint of
15 contrary opinion or recommendations are not, you know,
16 well received. So it's not a professional organization
17 in the sense that they're willing to hear all sides.
18 Q So you spoke of individuals who left WPATH
19 making those assertions. Is one of those individuals
20 who left WPATH now involved with the Society for
21 Evidence-Based Gender Medicine?
22 A I believe so.
23 Q Are you aware that the Society for
24 Evidence-Based Gender Medicine has been described by
25 researchers at the Yale School of Medicine as a small

Case 3:22-cv-00191-MOC-DCK Document 62-11 Filed 10/05/23 Page 48 of 77

1 group of anti-trans activists?
2 A I'm not aware of that.
3 Q Do you contest that?
4 A I have no reason to contest it at this point.
5 Q Also on page 10 of your position statement, you
6 state that "conflicts of interest among the
7 organization" referring to WPATH, "are also of
8 significant concern"; correct?
9 A Correct.
10 Q And I'm now handing the court reporter what I
11 believe is going to be marked as Exhibit 5.
12 (Exhibit 5 marked for identification.)
13 BY MS. MAFFETORE:
14 Q The court reporter has just handed you
15 Exhibit 5, which is an article entitled "Bias, Not
16 Evidence, Dominates WPATH Transgender Standards of
17 Care." Is this is the article that you relied upon in
18 support of your statement that conflicts of interest
19 among the organization WPATH are also of significant
20 concern?
21 A This was one of the articles, yes.
22 Q Do you consider this article to be a reliable
23 source of critique of WPATH?
24 A I would say yes.
25 Q Is this a peer-reviewed publication?

Case 3:22-cv-00191-MOC-DCK Document 62-11 Filed 10/05/23 Page 49 of 77

1 A Not to my knowledge, no.
2 Q Isn't it the case that this article was written
3 pseudonymously?
4 A I'm not certain.
5 Q So it unfortunately looks like the way that
6 this was printed has cut off a disclaimer at the top,
7 but are you aware of whether or not @lisamacrichards
8 (phonetic) is a pseudonym?
9 A I'm not aware. I don't know.
10 Q Were you able to vet the credentials of the
11 author of this article in any way?
12 A What I did when I looked at this is I did look
13 at many of the references that were cited. So there
14 were several other references that are cited in here.
15 So just pick one. On page 4, you know, Institute of
16 Medicine, now called the National Academy of Medicine
17 wrote "clinical practice guidelines we can trust." So
18 again, what I did when I looked at this article was I
19 looked deeper into these other references that were
20 included in here to help me ascertain the veracity of
21 this article.
22 Q So were you able to independently verify the
23 claims in the article?
24 A Some of them, yes.
25 Q Do you consider this pseudonymous author more

1 reliable than the American Medical Association?
2 A No.
3 Q How about the Endocrine Society?
4 A No.
5 Q How about at the American Psychological
6 Association?
7 A No.
8 Q How about the American Psychiatric Association?
9 A No.
10 Q The World Health Organization?
11 A No.
12 Q The American Academy of Family Physicians?
13 A No.
14 Q The American Public Health Association?
15 A No.
16 Q The National Association of Social Workers?
17 A No.
18 Q The American College of Obstetrics and
19 Gynecology?
20 A No.
21 Q The American Society of Plastic Surgeons?
22 A No.
23 Q Are you aware of whether the American Medical
24 Association has endorsed the WPATH's standards of care
25 for the treatment of gender dysphoria?

1 A I believe they have.
2 Q How about the Endocrine Society?
3 A Yes.
4 Q The American Psychological Association?
5 A Yes.
6 Q The American Psychiatric Association?
7 A Yes.
8 Q The World Health Organization?
9 A I'm not sure about that.
10 Q Okay. American Academy of Family Physicians?
11 A Yes.
12 Q The American Public Health Association?
13 A I'm not sure.
14 Q The National Association of Social Workers?
15 A I'm not sure.
16 Q The American College of Obstetrics and
17 Gynecology?
18 A Yes.
19 Q The American Society of Plastic Surgeons?
20 A Not sure.
21 Q Did you cite to the same article on page 10 to
22 support your assertion that WPATH -- sorry -- page 10
23 of your position statement to assert that "WPATH and
24 the Endocrine Society did not use the systematic review
25 process in developing their guidelines for the

Case 3:22-cv-00191-MOC-DCK Document 62-11 Filed 10/05/23 Page 52 of 77

1 treatment of gender dysphoria"?
2 A Where is that on here?
3 Q Page 10.
4 A Oh, yes.
5 Q Do you contest that the Endocrine Society
6 guidelines were cosponsored by, among others, the
7 American Association of Endocrinologists, the American
8 Society of Andrology, the European Society for
9 Endocrinology, and the Pediatric Endocrine Society?
10 A I have no reason to contest that.
11 Q Do you find the pseudonymous author of this
12 article more reliable than those societies or
13 associations?
14 A No.
15 Q On page 11 of your position statement, you note
16 that you reviewed hundreds of studies and other
17 publications, but you only cited ten here. Why?
18 A So I explained that briefly earlier, that I was
19 really trying -- for the sake of this position paper,
20 it was really more of a caution to try to say that the
21 evidence is not completed here. These were just some
22 of the evidence that supported the fact, that there is
23 not definitive evidence out there, and that it does
24 require additional study, additional evaluation until
25 we can reach that conclusion.

Case 3:22-cv-00191-MOC-DCK Document 62-11 Filed 10/05/23 Page 53 of 77

1 (Exhibit 6 marked for identification.)
2 (Discussion held off the record.)
3 (Recess.)
4 BY MS. MAFFETORE:
5 Q We're back on the record. So, Dr. Campbell,
6 just before the break, the court reporter handed you
7 Exhibit 6, which is DAC 5125. Do you recognize this
8 document?
9 A Yes, ma'am.
10 Q And what is it?
11 A It's an email from myself to Dr. Peiper.
12 Q Okay. And what is the attachment to this
13 email?
14 A It appears to be the position statement that
15 we've been discussing.
16 Q Okay. And this email to Dr. Peiper you note,
17 "Let me know when you need to" -- "let me know when you
18 need to me to add input form DTARC. I'm going to
19 tailor my responses to each individual case when I do."
20 Did I read that correctly?
21 A Yes, with my typo.
22 Q What did you mean by that?
23 A So this is around the same time that we were
24 working on trying to provide a more comprehensive
25 assessment of every single case in writing through the

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 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

Case 3:22-cv-00191-MOC-DCK Document 62-11 Filed 10/05/23 Page 59 of 77

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

Case 3:22-cv-00191-MOC-DCK Document 62-11 Filed 10/05/23 Page 62 of 77

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

Case 3:22-cv-00191-MOC-DCK Document 62-11 Filed 10/05/23 Page 69 of 77

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

Case 3:22-cv-00191-MOC-DCK Document 62-11 Filed 10/05/23 Page 70 of 77

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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Case 3:22-cv-00191-MOC-DCK Document 62-11 Filed 10/05/23 Page 72 of 77

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

Case 3:22-cv-00191-MOC-DCK Document 62-11 Filed 10/05/23 Page 73 of 77

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:

____

Case 3:22-cv-00191-MOC-DCK Document 62-11 Filed 10/05/23 Page 74 of 77

1 deposition, I asked if you had previously been deposed,
2 and I believe you said you had been deposed about four
3 times. Have you ever been sued before?
4 A No, ma'am.
5 Q Okay. When did you first become involved in
6 DTARC?
7 A When I assumed my role as chief medical
8 officer.
9 Q Okay. So you became involved right away, or
10 was there lag time between you coming on board and
11 becoming involved in DTARC?
12 A If I'm not mistaken, there was a transition
13 period of time where Dr. Agarwal, who was the deputy
14 medical director, had stepped in. I think talked about
15 that before where there was a period of time where Dr.
16 Snell had departed and I was coming into the position,
17 and during that time Dr. Agarwal would have served on
18 the committee.
19 Q So that would have been around October of 2020,
20 perhaps slightly later, that you became involved in the
21 DTARC; correct?
22 A Yes, ma'am.
23 Q And when you became involved in DTARC, were you
24 involved as cochair right away?
25 A Yes.

1 deposition is that I initially drafted this as an
2 overarching policy related to medical necessity on a
3 broad scale to provide some guidance and direction for
4 utilization review approval authorities, the three
5 tenets of which are listed on here, and what I
6 applied -- what I did is what I would expect all of the
7 utilization review authorities to do for any case
8 that's presented before them as part of the UR is to
9 consider the request in the context of those tenets,
10 and I did the same with this document.
11 I took those tenets, that, you know,
12 risk-benefit analysis, the standard of care, and the
13 evidence-based medicine and considered gender-affirming
14 surgery in that context and that evaluation for whether
15 it met the medical necessity requirements.
16 Q How did you arrive at the studies that you
17 decided to include in this position statement?
18 A So again, referencing back to my previous
19 deposition, I initially started with reviewing any of
20 the references cited in the WPATH, and as I found other
21 references in there to other documents, I would then
22 begin reviewing those documents or those journals or
23 studies, and those would point me to further studies.
24 So it was -- I guess, the best way to describe it is
25 kind of a branching out of my research from those

Case 3:22-cv-00191-MOC-DCK Document 62-11 Filed 10/05/23 Page 76 of 77

1 the things that you describe could alleviate those, but
2 there's no evidence that that would do that. So what
3 they're saying is that there is this occurrence, which
4 is in my position paper, and they are proposing that
5 some of the things that they talk about in here could
6 help to counter that, and I don't refute any of that in
7 my position paper.
8 BY MS. MAFFETORE:
9 Q Okay. Your policy statement then goes on to
10 discuss de-transition, which you have described here in
11 the paragraph on that same page as the act of stopping
12 or reversing gender transition, often going back to
13 living as their sex assigned at birth; correct?
14 MR. RODRIGUEZ: Objection to the characterization
15 of the position statement as a policy statement.
16 You can answer.
17 THE WITNESS: So again, it's not a policy, but that
18 is indeed what that paragraph says.
19 BY MS. MAFFETORE:
20 Q Okay. And you noted that the transition is
21 critically important in considering treatment options
22 for patients, particularly when treatment involves
23 either a reversible or incredibly difficult/poor
24 outcomes such as a surgery; correct?
25 A Correct.

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
114 WEST EDENTON STREET
RALEIGH, NORTH CAROLINA

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Also Present:

Jon Davidson (via Zoom)
Michele Delgado (via Zoom)
Margaret Hay (via Zoom)
Lauren Robbins (via Zoom)
Dan Siegel (via Zoom)
Lucas Helton - Intern

Case 3:22-cv-00191-MOC-DCK Document 62-12 Filed 10/05/23 Page 2 of 37

1 DR. LEWIS J. PEIPER, having been first duly
2 sworn, was examined and testified as follows:
3 BY MS. BROWN:
4 Q. Good morning, Dr. Peiper. Again, I'm Taylor Brown.
5 I'm with the American Civil Liberties Union and I'm an attorney
6 representing Kanautica Zayre-Brown in this matter. I use
7 she/her pronouns and you may address me as Ms. Brown. Are you
8 okay with Dr. Peiper?
9 A. Peiper is good. Dr. Peiper is good. Jon is good. I
10 go by all those names.
11 Q. Okay. Before we begin, please state and spell your
12 full name for the record.
13 A. Lewis Jonathan Peiper. L-e-w-i-s. And Jonathan is
14 J-o-n-a-t-h-a-n. And then Peiper is P-E-I-P-E-R.
15 Q. Okay. And before we begin the deposition today, do
16 you have any obligations that's going to cause you to leave for
17 any extended period of time today?
18 A. I have cancelled plans tonight and made sure that I
19 was free.
20 Q. Okay. Which may be better. And for the record, I'm
21 deposing Dr. Peiper in his capacity as a 30(b)(6) witness,
22 designated to testify on certain topics on behalf of defendant,
23 the North Carolina Department of Public safety, who I'll refer
24 to as DPS which may -- and which may previously have been known
25 by another name.

Case 3:22-cv-00191-MOC-DCK Document 62-12 Filed 10/05/23 Page 3 of 37

1 it.
2 Q. Okay. And has that license ever been suspended?
3 A. No.
4 Q. And when was that license obtained?
5 A. I don't know the exact, but 2012.
6 Q. 2012. Okay. Do you any areas of specialization?
7 A. You mean specialization as in like boarded
8 specialties?
9 Q. That -- well, that first.
10 A. Okay. No, I do not.
11 Q. And within counseling psychology?
12 A. I am not boarded in counseling psychology.
13 Q. So there's no subconcentrations? I guess that's what
14 I'm asking. Like counseling -- like psychology for children or
15 --
16 A. Oh, yeah. No. So counseling psychology is one of the
17 boarded specialties, but I am not boarded in counseling
18 psychology.
19 Q. Okay. Did you receive any education or training
20 related to gender dysphoria or gender identity disorder, which
21 is what it used to be known as, during your education programs?
22 A. Yeah. Yes.
23 Q. Okay.
24 A. Yes.
25 Q. Which ones? Which programs?

Case 3:22-cv-00191-MOC-DCK Document 62-12 Filed 10/05/23 Page 4 of 37

1 A. Talking about which trainings have I attended?
2 Q. Yes. So I asked if you received any training
3 specifically related to gender dysphoria or what it used to be
4 known as, gender identity disorder under your education?
5 A. Yes. Yes.
6 Q. Okay. And so, which part of your education?
7 A. So they include aspects of gender diverse
8 presentations and expenses and multicultural courses, and
9 postdoctoral like continuing education, other trainings,
10 conferences, symposiums.
11 Q. What do you mean when you say gender expressive?
12 MR. RODRIGUEZ: I don't think he testified
13 gender expressive. I think he said gender diverse
14 presentation.
15 BY MS. BROWN:
16 Q. What do you mean by gender diverse presentation?
17 A. My understanding is gender diverse is a term that's
18 used to kind of capture the variety of expressions of gender.
19 Q. Okay. But what about gender dysphoria specifically as
20 a psychological term?
21 A. Did you say gender dysphoria?
22 Q. Gender dysphoria.
23 A. Gender dysphoria as the diagnosis is part of these
24 trainings.
25 Q. Okay.

Case 3:22-cv-00191-MOC-DCK Document 62-12 Filed 10/05/23 Page 5 of 37

1 A. Most of those trainings have kind of a definition
2 piece where they kind of clarify definitions and also
3 diagnostic presentations.
4 Q. Prior to working for DPS did you have any professional
5 experience treating any patients with gender dysphoria?
6 A. Some. I would probably call that limited.
7 Q. Okay. And so when you say some, how much would that
8 be?
9 A. For folks that are gender diverse, so back before
10 2012, not much. Some.
11 Q. Some. Okay. Can you describe what you were -- you
12 know, what you were treating?
13 A. So in the broad context of identity development,
14 before here I was working in the juvenile justice system up in
15 Virginia. And so folks in the juvenile justice population,
16 adult prison population as well, identity development and kind
17 of creating that core sense of self is a huge piece. As we
18 know there are a variety of areas of identity, and the
19 development of your identity can come at different times in
20 different ways for different people. And so as it related to
21 the whole person and as it related to what was happening for
22 them, it was addressed in the clinical setting.
23 Q. Okay. And what kind of treatment protocols did you
24 use?
25 A. In work with people in clinical settings?

Case 3:22-cv-00191-MOC-DCK Document 62-12 Filed 10/05/23 Page 6 of 37

1 Q. Yes.
2 A. What kind of treatment?
3 Q. For gender diverse experience or gender dysphoria.
4 A. So for folks that I have worked with in their broad
5 identity development, there are some aspects that psychodynamic
6 can be useful for. Some folks, their interactions that are
7 maybe a little bit more along the line of like CBT-type
8 considerations. Some folks, you know, supportive counseling as
9 they're going through an experience. Some other folks maybe
10 you might actually work on different types of, you know, coping
11 skills based off of what's happening.
12 Q. Okay. I want to be clear. So this was during -- you
13 know, this was pre-2012 before you were licensed? This is the
14 time period we're talking about?
15 A. I thought that's what you asked me about.
16 Q. Okay.
17 A. So prior to being licensed in North Carolina, I was
18 licensed in Virginia. I was a licensed psychologist and a
19 certified sex offender treatment provider.
20 Q. What year did you get that license in Virginia?
21 A. Oh, goodness. I'm thinking that was -- maybe that was
22 2010. I'm sorry, I did not memorize that for you.
23 Q. No worries. Okay. When you say CBT, what does that
24 stand for?
25 A. Cognitive behavioral therapy.

Case 3:22-cv-00191-MOC-DCK Document 62-12 Filed 10/05/23 Page 7 of 37

1 Q. And copying as well as a treatment protocol and --
2 yes?
3 A. Yeah. I mean, coping skills.
4 Q. And supportive counseling?
5 A. Yeah.
6 Q. And for the treatment -- and that was for the
7 treatment of gender dysphoria?
8 A. So that was -- you asked me to explain what I
9 experienced prior to 2012. And so yes, those would be things
10 that I would use when working with somebody in that capacity.
11 Q. Okay. When you say in that capacity -- I want to be
12 clear --
13 A. You were saying specifically gender dysphorias --
14 Q. Yes.
15 A. -- in this last question. But in what was being
16 answered as to prior to 2012 it was not specific to gender
17 dysphoria.
18 Q. Okay.
19 A. So I wanted to make sure that I was still answering
20 the question I started off answering. That I wasn't answering
21 a different question.
22 Q. Yeah. Okay. So maybe I'll -- maybe I'll redo this
23 because I think I'm a little confused too. Prior to 2012, was
24 it your testimony that you have treated individuals with gender
25 dysphoria?

1 A. I don't know if a read back is appropriate, but I was
2 answering that folks with gender diverse presentations --
3 explained that I had been working the juvenile justice system
4 up in Virginia, talked about my licensure up in Virginia. I
5 talked about being a certified sex offender treatment provider,
6 which is the term they use in Virginia. Talked about identity
7 presentation. I'm thinking I talked about the various aspects
8 of identity. I don't think I talked about intersectionalities
9 of those identities, but when you're working with somebody in
10 that capacity these were some of the things which you were
11 writing down were some of the things that you can use in a
12 treatment setting.
13 Q. Maybe it's semantics because this was pre-2012.
14 Pre-2012 have you treated anyone -- did you treat anyone with a
15 gender identity disorder diagnosis?
16 A. So you're talking about DSM-IV diagnosis time frame
17 then?
18 Q. However you understand it.
19 A. Gender identity disorder, no, I would not say that
20 that was the specific diagnosis that was of care.
21 Q. Okay. And what was the diagnosis?
22 A. Do you have a specific person you want me to talk
23 about.
24 Q. No. I'm just talking about your general experience as
25 --

Case 3:22-cv-00191-MOC-DCK Document 62-12 Filed 10/05/23 Page 9 of 37

1 A. People that were -- anybody that was in need of care
2 that was at the facility where I was working at. This was
3 juvenile justice up in Virginia. And so some of them were in
4 the sexual offense treatment program and so -- some of them the
5 general population, some had diagnosed needs, some had just
6 general needs.
7 Q. Were any diagnosed with gender dysphoria?
8 A. No. No. Or the gender identity disorder, which would
9 have been at the time.
10 Q. No to that as well?
11 A. No to that as well.
12 Q. Okay. Thanks. And after you left -- or, you know,
13 after you left Virginia and came to North Carolina, what was
14 your first position?
15 A. At that point the prison was called Polk, it's now
16 Granville Correctional, and I was the psychological program
17 manager.
18 Q. And what's your current position or title?
19 A. Director of behavioral health.
20 Q. And when did you become the director of behavioral
21 health?
22 A. Fortunately right as COVID started, so it's a definite
23 period in time where I can remember the date. So that was
24 right at April of 2020 became interim.
25 Q. You became interim in April 2020?

1 A. Correct.
2 Q. And when did you become director?
3 A. It was about a year later.
4 Q. And --
5 A. Do you need the exact date?
6 Q. No. That's fine.
7 A. Okay.
8 Q. So what are your current responsibilities?
9 A. Actually it was right at --
10 Q. It's okay.
11 A. Okay.
12 Q. What are your current responsibilities in your role as
13 director of behavioral health?
14 A. Yeah. Responsible for oversight of the behavioral
15 health services. Two primary sections, we have got our
16 substance abuse treatment section and what we call clinical
17 behavioral health services.
18 Q. Okay. And what kind of services do you offer in
19 clinical behavioral health services?
20 A. Full spectrum of care across different levels of need.
21 We have got -- the highest level you have got inpatient acute
22 mental health. We have got residential mental health for kind
23 of that more chronic need. We have got outpatient level of
24 care. And then for folks who maybe need like a brief
25 intervention, we have that available as well. There is

Case 3:22-cv-00191-MOC-DCK Document 62-12 Filed 10/05/23 Page 11 of 37

1 individual, group-based services. There are unit-based
2 treatment programs. Day treatment as well. So you're not --
3 you know, you're going to a location for more day-long
4 treatment services. Assessments, you know, general referral
5 access to care type. Folks that are in crises situations.
6 Provide for screening, response, self-injury risk assessments.
7 Q. And you said unit-based services. What kind of units
8 are there?
9 A. So different facilities structures of prisons have
10 housing areas. And some of those are dedicated to a treatment
11 mission. So some are more general population where it's --
12 like this is where you live, where you sleep. Others are, you
13 know, specific to that treatment context.
14 Q. Okay.
15 A. That's what I mean by unit based.
16 Q. Are any of them demographic based?
17 A. No, it's all treatment need.
18 Q. Okay. Does DPS have for example a sort of LGBTQ unit?
19 A. Oh, a separate unit for folks that are LGBTQ?
20 Q. Yes.
21 A. No.
22 Q. In your current role do you offer or do you provide
23 any direct clinical services?
24 A. In this capacity, no.
25 Q. In this role do you supervise any staff treating

Case 3:22-cv-00191-MOC-DCK Document 62-12 Filed 10/05/23 Page 12 of 37

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 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:

Case 3:22-cv-00191-MOC-DCK Document 62-12 Filed 10/05/23 Page 15 of 37

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.

Case 3:22-cv-00191-MOC-DCK Document 62-12 Filed 10/05/23 Page 20 of 37

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.

Case 3:22-cv-00191-MOC-DCK Document 62-12 Filed 10/05/23 Page 23 of 37

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

Case 3:22-cv-00191-MOC-DCK Document 62-12 Filed 10/05/23 Page 24 of 37

1 already testified he's not sure who wrote the document. He's
2 referenced several times that there's additional documents.
3 He's happy to look at those. You've asked the same question
4 several times now. You're not getting the answer you like so
5 you keep on trying, but he's answered the question.
6 BY MS. BROWN:
7 Q. So you're aware of those documents and so you read
8 those documents, correct?
9 A. There are notes that go along with each DTARC. This
10 would be from that DTARC in looks like August of 2019.
11 Q. DPS does not know the basis for their determination
12 that surgery was not medically necessary for her in 2019?
13 MR. RODRIGUEZ: Objection to the form of the
14 question.
15 MS. BROWN: You can still answer.
16 THE WITNESS: I'm sorry, what?
17 BY MS. BROWN:
18 Q. DPS does not know the basis for their determination
19 that surgery was not medically necessary for her in 2019?
20 MR. RODRIGUEZ: Objection to the form. You can
21 answer.
22 THE WITNESS: Okay. It's a confusing wording.
23 Trying to answer what you're asking. Sounds like you're asking
24 me as I'm testifying, being deposed on behalf of the
25 Department, do I have this additional specific piece of detail

1 that you might have in some other documents. No, I'm not aware
2 of that specific information that you're asking about. You
3 have put this in front of me, so I do have this information
4 shared with me at this time.
5 BY MS. BROWN:
6 Q. Okay. Thank you. Sorry, I really didn't mean to
7 interrupt you. Does DPS consider vaginoplasty an elective
8 procedure that is not medically necessary for
9 gender-reassignment surgery for the treatment of gender
10 dysphoria?
11 MR. RODRIGUEZ: Object to beyond the scope of
12 the topics in the 30(b)(6). Legal opinion, medical opinion
13 speculation. You can answer.
14 THE WITNESS: The way you asked that, my only
15 answer would be no.
16 BY MS. BROWN:
17 Q. So just to be clear, vaginoplasty --
18 A. No, we do not in and of itself consider that always in
19 every case elective.
20 Q. When you're talking about in every case, we're talking
21 about for people with gender dysphoria?
22 A. Yes. You're asking me about people with gender
23 dysphoria, yes.
24 Q. Okay. And is current staffing and resources a medical
25 reason to deny -- does DPS consider its lack of staffing or its

1 lack of resources a reason to deny someone a
2 medically-necessary procedure?
3 MR. RODRIGUEZ: Object to the form. You can
4 answer.
5 THE WITNESS: The ability to have the resources
6 to provide for postoperative care is a consideration in the
7 planning process, yes.
8 BY MS. BROWN:
9 Q. Okay. But that wasn't the question though. It's very
10 important, yes, I would agree. But for DPS is not having staff
11 and not having the resources for someone who needs a
12 vaginoplasty a reason to deny that care?
13 MR. RODRIGUEZ: Objection to the form. You can
14 answer.
15 THE WITNESS: If the decision is made that the
16 treatment is medically necessary, staffing and resources are
17 considerations. But that does not invalidate the decision that
18 it was medically necessary. Is that what you're asking?
19 BY MS. BROWN:
20 Q. And so based on that testimony, what I'm -- I want to
21 make sure I'm understanding. So you're saying that it could
22 have been medically necessary even though they didn't have the
23 resources and the staffing?
24 MR. RODRIGUEZ: Mischaracterization of the
25 witness's testimony. You can answer.

1 THE WITNESS: I would actually agree with that
2 one. Yeah, that's not how I was saying it. But the decision
3 is made that it's medically necessary. The staffing and
4 resources to carry out the postoperative care would be an
5 important consideration. It would not in and of itself
6 invalidate that decision that it was medically necessary.
7 BY MS. BROWN:
8 Q. Did DPS ever deny medically-necessary surgery because
9 of resources for postoperative care?
10 MR. RODRIGUEZ: I'm going to object to
11 medical/legal opinion. You can answer.
12 THE WITNESS: I'm not aware of the full scope
13 of all medical decisions. I'm sorry.
14 BY MS. BROWN:
15 Q. But again, does DPS ever deny other
16 medically-necessary surgery because of resources?
17 MR. RODRIGUEZ: I'm going to object to beyond
18 the scope of the 30(b)(6) topics and medical/legal opinions.
19 BY MS. BROWN:
20 Q. And so you do not know?
21 MR. RODRIGUEZ: I'm going to object to the form
22 of the question.
23 MS. BROWN: Can we go off the record for a
24 second?
25 MR. RODRIGUEZ: Sure.

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?

Case 3:22-cv-00191-MOC-DCK Document 62-12 Filed 10/05/23 Page 30 of 37

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.

Case 3:22-cv-00191-MOC-DCK Document 62-12 Filed 10/05/23 Page 31 of 37

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,

Case 3:22-cv-00191-MOC-DCK Document 62-12 Filed 10/05/23 Page 33 of 37

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 CERTIFICATE OF REPORTER

2 STATE OF NORTH CAROLINA)

3 COUNTY OF ALAMANCE)

4 I, Susan A. Hurrey, RPR, the officer before

5 whom the foregoing deposition was taken, do hereby certify that

6 the witness whose testimony appears in the foregoing deposition

7 was duly sworn by me; that the testimony of said witness was

8 taken by me to the best of my ability and thereafter reduced to

9 typewriting under my direction; that the witness reserves the

10 right to read and sign the transcript of the deposition prior

11 to filing; that I am neither counsel for, related to, nor

12 employed by any of the parties to the action in which this

13 deposition was taken; and further, that I am not a relative or

14 employee of any attorney or counsel employed by the parties

15 thereto, nor financially or otherwise interested in the outcome

16 of the action.

17 This the 1st day of May, 2023.

18

19 ________________________

SUSAN A. HURREY, RPR

20 Notary Public #201826800211

21

22

23

24

25

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

1 provided at Central Prison Inpatient Unit that's
2 provided at the North Carolina Correctional Institute
3 for Women Inpatient Unit. I supervise the outpatient
4 psychiatry that's provided at about 30 different camps
5 by about 40 different providers. I also do a lot of
6 direct clinical care myself.
7 Q And are -- are you supervised in that position
8 by someone?
9 A Dr. Gary Junker is my supervisor.
10 Q Great. In connection with the education that's
11 listed specifically on the first page of your CV, did
12 you receive any training in the depart -- in the
13 treatment of gender dysphoria?
14 A I don't recall that I did.
15 Q And do you have any experience in the treatment
16 of gender dysphoria?
17 A I see a number of patients. Some of them
18 report gender dysphoria.
19 Q And in general without disclosing any personal
20 identifying information of those patients, how do you
21 provide treatment to address those patients' gender
22 dysphoria? What do you do?
23 A Well, most of the time, me personally, I'm in
24 the inpatient unit or outpatients where the primary
25 problem is the psychiatric comorbidities to the gender

Case 3:22-cv-00191-MOC-DCK Document 62-13 Filed 10/05/23 Page 2 of 24

1 dysphoria. So my main function is trying to get those
2 comorbidities improved, let's say. I'm not sure that's
3 the right term, but...
4 Q That's fine. Oh, you know, one thing I didn't
5 ask is since the educational experiences you listed on
6 the first page of your CV, have you had any other
7 training in the treatment of gender dysphoria?
8 A The -- there was a formal training that the
9 State had where an expert from UNC Chapel Hill came in.
10 I've tried to read up on -- on the literature on this.
11 There was a -- I think on correctional healthcare,
12 fairly recently there was five or six papers about
13 gender dysphoria.
14 I didn't think it was that well-written or that
15 helpful, but I did read it, and I've tried to read up
16 on the evidence base for surgeries in the last few
17 months especially. But I read it before, too, but I
18 went over it again.
19 Q In connection with the -- a treatment that you
20 provide for gender dysphoria, do you use the WPATH
21 standards of care?
22 A I'm aware of them. I would have to review them
23 again to be specific.
24 Q Okay. And do you have any experience in
25 treating patients who are seeking gender-affirming

Case 3:22-cv-00191-MOC-DCK Document 62-13 Filed 10/05/23 Page 3 of 24

1 surgery?
2 A Yes. In terms of, again, when I see my -- see
3 patients on a daily basis, some of them will say that
4 they would like to have gender-affirming surgery.
5 Q And -- and do you try to make a determination
6 in that treatment of whether or not gender-affirming
7 surgery would be helpful to them?
8 A In truth, again, when I treat them personally,
9 it's usually because of other issues that are going on.
10 Usually, in a more severe sense, if they're inpatient
11 and my number one goal -- I tend not to focus that much
12 on the gender-affirming surgery unless it's directly
13 related to the illness itself, and I spend most of my
14 time trying to work on the psychiatric comorbidities.
15 Q Got it. If you would turn to what's marked top
16 right pages 2 to 3 of your CV, it lists your employment
17 history. And I'm just curious. I think what you've
18 been describing to me about your experience in
19 treatment has been in chief -- as chief of psychiatry;
20 is that correct?
21 A Correct. I've always made it a point to also
22 directly see patients, but for many, many years, I've
23 been a psychiatric administrator, too.
24 Q Yes. So I was just curious, in any of these
25 other professional experiences listed on pages 2 to 3,

Case 3:22-cv-00191-MOC-DCK Document 62-13 Filed 10/05/23 Page 4 of 24

1 did you provide treatment of gender dysphoria?
2 A Again, most of my time is either emergency
3 rooms like seeing the more difficult patients, you
4 know, so I -- I don't truthfully focus on people who
5 are more stable and where the one problem remaining
6 is -- is the gender dysphoria.
7 Q Okay. Have you ever been disciplined by a
8 licensing agency?
9 A No.
10 Q And how about at a job?
11 A No.
12 Q On page 4 of your CV, you list numerous
13 committees that you've been a participant of, and at
14 any of those positions, did the committee work on
15 issues relating to transgender patients?
16 A I think when I was at the State psychiatric
17 hospital, it was just beginning to be an issue, and
18 that was a long time ago. I truly don't remember -- I
19 remember it was more of an oddity at that time, where
20 now it's sort of more, in some ways, mainstream that
21 this comes up, but I remember that was a little unusual
22 back in the late '90s and 2000.
23 Q Was -- was that at a job or committee?
24 A It was at a committee, like, the executive
25 committee, Dorothea Dix Hospital, Dorothea Dix Hospital

Case 3:22-cv-00191-MOC-DCK Document 62-13 Filed 10/05/23 Page 5 of 24

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

Case 3:22-cv-00191-MOC-DCK Document 62-13 Filed 10/05/23 Page 7 of 24

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

Case 3:22-cv-00191-MOC-DCK Document 62-13 Filed 10/05/23 Page 8 of 24

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."

Case 3:22-cv-00191-MOC-DCK Document 62-13 Filed 10/05/23 Page 9 of 24

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?

Case 3:22-cv-00191-MOC-DCK Document 62-13 Filed 10/05/23 Page 10 of 24

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

Case 3:22-cv-00191-MOC-DCK Document 62-13 Filed 10/05/23 Page 11 of 24

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

Case 3:22-cv-00191-MOC-DCK Document 62-13 Filed 10/05/23 Page 12 of 24

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

Case 3:22-cv-00191-MOC-DCK Document 62-13 Filed 10/05/23 Page 13 of 24

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

Case 3:22-cv-00191-MOC-DCK Document 62-13 Filed 10/05/23 Page 14 of 24

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.

Case 3:22-cv-00191-MOC-DCK Document 62-13 Filed 10/05/23 Page 16 of 24

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 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 --

Case 3:22-cv-00191-MOC-DCK Document 62-13 Filed 10/05/23 Page 19 of 24

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 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 bolded sentence in Exhibit 24?
2 A I don't. I -- whoever authored this, it
3 wasn't -- I didn't write this, so I don't know.
4 Q Okay. Do you have any understanding for why
5 that sentence does not appear in the case summary?
6 A No.
7 Q And if you turn to the last page of that
8 exhibit, there's, again, a part that's bolded. Did
9 you -- did you write that bolded part?
10 A No.
11 Q Do you know who did?
12 A No.
13 Q And do you have any understanding about why
14 that's in this -- in Exhibit 24 but not in Exhibit 23?
15 A No, I don't.
16 Q It says in the second sentence of that -- no --
17 yeah, the third sentence of that bolded paragraph on
18 the last page of Exhibit 24, "Fortunately, in this
19 case, these interventions have been both successful and
20 sufficient in addressing the underlying gender
21 dysphoria as evidenced by the lack of depressive or
22 destructive behaviors, and the offender's well-adapted
23 approach to the current environment."
24 Is that something you believed on
25 February 22nd, 2017?

1 A I'm just reading it. Please give me one
2 second. Yeah, I mean, I think it might be a little too
3 strong in terms of "have been both successful and
4 sufficient in addressing the underlying gender" -- I
5 think she seemed to be doing better, but I think
6 there's still some issues there. So it seems a little
7 strong, to be honest.
8 Q Okay. If -- if you were going to try to make
9 it more accurate, what words would you use?
10 A Have helped to manage the person's gender
11 dysphoria as -- by the lack of severe depressive or --
12 and no destructive behaviors, and the offender's -- I'm
13 not sure the well-adapted approach. Like, I'm not sure
14 what I would substitute for that.
15 Q Okay. Well, I was trying to focus on the
16 "successful and sufficient," which is what you pointed
17 to before.
18 A Okay.
19 Q What -- what terms you might use?
20 A Helpful.
21 (Reporter clarification.)
22 BY MR. DAVIDSON:
23 Q Okay. All right. I'd next like to mark as
24 Exhibit 25 a document, so it's a one-page document, in
25 the lower right-hand corner DAC 3416.

Case 3:22-cv-00191-MOC-DCK Document 62-13 Filed 10/05/23 Page 23 of 24

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

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 BRANDESHAWN HARRIS

(Taken by plaintiff.)

Raleigh, North Carolina

May 16, 2023, 10:03 a.m.

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

1 Q Okay. So this case has some specific
2 terminology that I'd like to get your understanding of.
3 Could you please tell me your understanding of the term
4 "transgender"?
5 A I understand it as an individual who wishes to
6 -- I'm trying to think of the correct terminology.
7 It's a person who is transferring from one gender to
8 another or accepts some parts of different types of
9 gender.
10 Q Okay. Is that your complete understanding of
11 the term "transgender"?
12 A Yes.
13 Q Are you familiar with the term "gender
14 dysphoria"?
15 A Yes.
16 Q What is your understanding of what that term
17 means?
18 A The way I understand it is it's when a person
19 identifies as a different gender than what they were
20 born as.
21 Q Do you know if a person has gender dysphoria,
22 what they might experience as a result of their gender
23 dysphoria?
24 A No.
25 Q Do you understand gender dysphoria to be a

Case 3:22-cv-00191-MOC-DCK Document 62-14 Filed 10/05/23 Page 2 of 16

1 medical condition?
2 A No.
3 Q So to be clear, you do not understand gender
4 dysphoria is a medical condition requiring medical
5 treatment?
6 A I don't -- I'm not sure what you're asking. I
7 always understood it as being part of a mental health
8 diagnosis.
9 Q Okay. And so as part of the mental health
10 diagnosis, is it something that can require mental
11 health treatment?
12 A Yes.
13 Q Okay. Do you know what happens if it is not
14 treated?
15 A No, not -- no. I'm not diverse enough to know
16 that much. That's something I usually rely on our
17 advanced level practitioners over in the mental health
18 side or medical side to provide information on that.
19 Q And just to be clear, what do you mean by
20 "diverse enough"?
21 A What I mean is I'm not a medical provider or a
22 mental health provider.
23 Q Okay. All right. So I'm going to hand you a
24 document and ask the court reporter to mark this as
25 Exhibit 1.

Case 3:22-cv-00191-MOC-DCK Document 62-14 Filed 10/05/23 Page 3 of 16

1 (Exhibit 1 marked for identification.)
2 BY MR. SIEGEL:
3 Q Sec. Harris, you'll see that this is a copy of
4 your resume as provided to us in discovery. Would you
5 please take a look at this and let me know, is it up to
6 date? Is there anything missing here?
7 A It is up-to-date as it was provided. I
8 recently was promoted to chief deputy secretary.
9 Q Okay. Does everything else appear to be
10 accurate?
11 A Yes.
12 Q Okay. Could you just walk me through your
13 educational background, please?
14 A Yes. I earned an associate's degree at the
15 University of Akron in criminal justice, a bachelor's
16 degree in criminal justice administration from Tifton
17 University, and earned a master's degree in management
18 at Indiana Wesleyan University.
19 Q And when you were pursuing your degrees, did
20 you take any courses or receive any training in medical
21 care?
22 A No.
23 Q Any courses or medical training in mental
24 health care?
25 A No.

Case 3:22-cv-00191-MOC-DCK Document 62-14 Filed 10/05/23 Page 4 of 16

1 Q And I see next is listed your leadership
2 training. Is that a broad level? Could you walk me
3 through what that means and what that involved?
4 A I attended Executive Excellence in 2020. I
5 graduated in 2020. It's a training program for
6 executives from the National Institute of Corrections
7 Strategic Development for executive women Phase I and
8 Phase II. That is a program that's dedicated to
9 training women to become leaders in the corrections
10 field.
11 Being Gender Responsive Operation Management of
12 Women's Prisons, that's a training that was done by
13 National Institute of Corrections that is specifically
14 for being responsive to the gender needs for females
15 that's incarcerated. Executive Leadership for New
16 Wardens is a training that NIC does that sends -- that
17 I attended that provides you an overview of your
18 responsibility as a warden.
19 Managing Restrictive Housing Populations is a
20 leadership training for -- to teach you how to ensure
21 that you have the right people in restrictive housing,
22 and Security Audits is a training that is dedicated to
23 ensuring that you have the ability to recognize when
24 you have security deficiencies inside of your
25 facilities.

Case 3:22-cv-00191-MOC-DCK Document 62-14 Filed 10/05/23 Page 5 of 16

1 Q Okay. In those trainings or any other
2 trainings you've experienced in your career, did they
3 involve healthcare of any kind?
4 A No.
5 Q Okay. You said a moment ago that you had been
6 promoted recently. Could you repeat for me just what
7 your title is now?
8 A Chief deputy secretary of operations.
9 Q And you might've already said this, but when
10 were you promoted?
11 A November 2022.
12 Q Okay. What are your duties in your current
13 position?
14 A Currently I am over the community supervision,
15 the prison institutions, corrections enterprises, and
16 emergency preparedness.
17 Q Do you provide healthcare to anyone?
18 A No.
19 Q Do you supervise anyone who provides
20 healthcare?
21 A No.
22 Q Do you make any kinds of decisions related to
23 the provision of healthcare to the incarcerated
24 population?
25 A What do you mean "provisions of healthcare"?

Case 3:22-cv-00191-MOC-DCK Document 62-14 Filed 10/05/23 Page 6 of 16

1 Q Whether someone receives or doesn't receive
2 healthcare.
3 A No.
4 Q What was your position before you were
5 promoted?
6 A I was the assistant commissioner of prisons,
7 and then I was acting commissioner of prisons for some
8 time.
9 Q And can you tell me what your responsibilities
10 were in those jobs?
11 A Basically overseeing the entire operations of
12 the prison system.
13 Q And did that involve medical care or mental
14 health care?
15 A Yes.
16 Q Okay. And so what does that mean?
17 A Just providing oversight, and really I would
18 say more of creating a collaborative service that we
19 provide that we are working together to achieve one
20 goal.
21 Q And when you say "we," who are you referring
22 to?
23 A All systems, like facility maintenance,
24 medical, mental health, HR, emergency preparedness, the
25 prison system as a whole, working across -- we have to

1 work together to be able to take care of the offender
2 population.
3 Q Could you tell me how the collaboration that
4 you were describing worked with respect to medical care
5 and mental health care?
6 A All components play a major role. So as far
7 as, you know, if there is a medical need, we have to
8 meet the operation need. So it maybe a medical need
9 that we have to -- maintenance put in electronic -- we
10 may have to do different things, and it's just making
11 sure that we are working together to meet the needs of
12 the offender population altogether.
13 Q Were you directly supervising anyone who was
14 providing medical care or mental health care?
15 A Yes.
16 Q What does the supervision look like?
17 A It's mainly oversight and consultation. We --
18 I'm not part of the medical decision piece, but I'm a
19 part of the overall operations piece that has to occur.
20 So with prisons lives, you know, healthcare and also,
21 too, the custody piece.
22 Q So in this position, were you ever making
23 decisions about whether a specific form of medical care
24 or mental health care would be provided or not
25 provided?

Case 3:22-cv-00191-MOC-DCK Document 62-14 Filed 10/05/23 Page 8 of 16

1 A No.
2 Q Were you ever providing -- did you ever provide
3 an opinion as to whether, you know, a specific medical
4 care or mental health care would be provided?
5 A No.
6 Q Okay. I see you've had a long career before
7 you came to DPS. Could you just walk me through what
8 the rest of your professional career has looked like?
9 A I started -- I guess, I have to see how far you
10 want to go back. I started as a records clerk at the
11 sheriff's department in high school doing an internship
12 and then was hired full time. I later went on to
13 become a correction officer with the State of Ohio.
14 During that time, I worked through the ranks becoming
15 -- holding positions of correction officer, lieutenant,
16 investigator, wardens' assistant, deputy warden of
17 special services, and deputy warden of operations, and
18 then moved on to warden at two different facilities,
19 and then became assistant commissioner here in North
20 Carolina.
21 Q And throughout these positions, were you ever
22 involved in making decisions about whether incarcerated
23 population would receive healthcare?
24 A No.
25 Q Were you ever involved in providing an opinion

Case 3:22-cv-00191-MOC-DCK Document 62-14 Filed 10/05/23 Page 9 of 16

1 as to whether someone in the incarcerated population
2 should receive healthcare?
3 A No.
4 Q Is there anything else in your resume that you
5 think is important to understand about just your career
6 as a whole, your professional experience?
7 A No.
8 Q Okay. You can set that aside. I'm going to
9 hand the court reporter another document. I'd like it
10 to be labeled Exhibit 2, please.
11 (Exhibit 2 marked for identification.)
12 BY MR. SIEGEL:
13 Q Will you please take a look at this document
14 and tell me if you recognize it?
15 A Yes, I'm familiar with it.
16 Q What is this document?
17 A An email.
18 Q And what is the email about?
19 A It's about two male offenders being
20 strip-searched by a female employee.
21 Q So why were you receiving this email?
22 A I'm not sure.
23 Q Is Pasquotank a men's prison?
24 A Yes.
25 Q And so the two offenders in question, were they

1 A Because they are at a -- one, is they're at a
2 male facility, and two, was that it doesn't appear that
3 it had been through the DTARC.
4 Q Do you know Kanautica Zayre-Brown?
5 A No.
6 Q Have you ever met her or spoken to her?
7 A No.
8 Q Do you understand her to be a man?
9 A No.
10 Q Do you understand her to be a woman?
11 A I understand that's what she prefers to be,
12 yes.
13 Q Okay. But what is your understanding of her?
14 A I have no -- I have no opinion of that. I
15 don't know. I've never conducted a search on her. I
16 don't know.
17 Q What would conducting a search tell you?
18 A I don't know. I'm saying -- I guess my point
19 is, what I'm trying to explain is, I'm not a medical
20 provider. I don't have any reason to have that -- I
21 don't have any reason to be that far in the weeds with
22 what her gender is. If she prefers to be a female,
23 then that's what she is.
24 Q You can set this aside.
25 I'm going to hand you another document and ask

Case 3:22-cv-00191-MOC-DCK Document 62-14 Filed 10/05/23 Page 11 of 16

1 A I can't recall exact -- I can't recall exact
2 reasons.
3 Q Well, without providing exact reasons, I'm
4 speaking kind of roughly, why would you send something
5 to the DTARC?
6 A Either the accommodations initial request, it
7 wasn't reviewed thoroughly, they didn't -- they may
8 have not received input from a section that's required,
9 something to that effect, or maybe their required form
10 didn't appear that we had everybody's perspective on
11 it. Those are the type of things that we will send it
12 back for, just making sure that we had everything, We
13 had the big picture of the accommodation and at the
14 recommendation that was provided, but right now I just
15 can't think of any exact examples.
16 Q Is there any level of review after the director
17 of health and wellness and the assistant commissioner
18 consider a DTARC recommendation?
19 A No.
20 Q So for all practical purposes, were you and Dr.
21 Junker the final decision makers?
22 A Yes.
23 Q Can you take me through your process for
24 rendering decisions based on the DTARC's recommendation
25 regarding gender-affirming surgery?

Case 3:22-cv-00191-MOC-DCK Document 62-14 Filed 10/05/23 Page 12 of 16

1 ever hear Dr. Junker express disagreement with a DTARC
2 recommendation?
3 A No.
4 Q Did you ever read anything Dr. Junker had
5 written expressing disagreement with a DTARC
6 recommendation?
7 A No.
8 Q Okay. Did you ever deny gender-affirming
9 surgery for reasons concerning prison safety?
10 A No.
11 Q What about the cost of a requested procedure?
12 A No.
13 Q Did you ever deny a request for
14 gender-affirming surgery for reasons concerning prison
15 administration?
16 A No.
17 Q Did you ever deny a request for
18 gender-affirming surgery for reasons not having to do
19 with medical necessity?
20 A No.
21 Q All right. I'm going to hand you and the court
22 reporter another document. This will be Document No.
23 5.
24 (Exhibit 5 marked for identification.)
25 BY MR. SIEGEL:

1 there was a different opinion. So if I understand what
2 you're asking of me is to take the different providers
3 and then make my own diagnoses, which I'm not qualified
4 to do.
5 Q Just to be clear, when you were discussing the
6 DTARC's recommendation with Dr. Junker, did you discuss
7 Dr. Figler at all?
8 A No. We discussed UNC.
9 Q What did you discuss about UNC?
10 A We discussed the entire -- what I would say, we
11 looked at the recommendation for -- that a consultation
12 had been done by UNC and then what the outcome was that
13 DTARC recommended after they received the consultation.
14 So our discussion was based off if the consultation was
15 actually completed like it was supposed to be done.
16 Q So you talked about whether the consultation
17 happened. Did you talk about what the outcome of the
18 consultation was?
19 A No. Just that the DTARC committee members were
20 able to get the results of the consultation.
21 Q Okay. Did you understand the DTARC
22 recommendation to be based on any concern for prison
23 safety?
24 A No.
25 Q Did you understand it to be based on any

1 concern regarding the cost of the procedures at issue?
2 A No.
3 Q Did you understand it to have anything to do
4 with prison administration?
5 A No.
6 Q Did Dr. Junker conclude that gender-affirming
7 surgery was I'm not medically necessary for Ms.
8 Zayre-Brown?
9 A Based off the recommendation? Yes.
10 Q Do you know if Dr. Junker reviewed anything
11 besides the recommendation?
12 A No.
13 Q I'm sorry. Is that you don't know or he did
14 not?
15 A I don't know.
16 Q Okay. Did you ask Dr. Junker any questions
17 when you were discussing the DTARC recommendation?
18 A I asked if he received the UNC evaluation
19 because I knew that was what we looked at the meeting
20 before, and that was one of the requirements.
21 Q Did you ask him anything else?
22 A Not that I can remember.
23 Q Did he ask you anything?
24 A No.
25 Q Did you make your decision here after a single

1 conversation, or were there multiple conversations?
2 A It was a single conversation. We had a
3 meeting. I think the meeting lasted some time. We
4 discussed it. We had a meeting about it, just me and
5 Dr. Junker.
6 Q And about how long did that last?
7 A I'm not sure. We typically took maybe -- it
8 depends on -- I can't say because we normally review
9 more than just one So I can't say specifically how long
10 we spent on this particular one. I know it was some
11 time.
12 Q And you concluded that gender-affirming surgery
13 was not medically necessary to treat Ms. Zayre-Brown's
14 gender dysphoria; is that right?
15 MS. BRENNAN: Objection to form.
16 THE WITNESS: Based off of the recommendation from
17 the DTARC committee.
18 BY MR. SIEGEL:
19 Q When you rendered that decision, did you
20 believe that -- well, strike that. Do you believe that
21 Ms. Zayre-Brown still has gender dysphoria?
22 MS. BRENNAN: Objection. Foundation. Vague.
23 THE WITNESS: I don't know.
24 BY MR. SIEGEL:
25 Q At the time you rendered your decision, did you

EXHIBIT 15

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 PATRICIA HAHN, PhD

(Taken by plaintiff.)

Raleigh, North Carolina

April 11, 2023, 10:57 a.m.

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

Contains Confidential Information

1
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2 For the plaintiff:
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12
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15 (919) 716-6516
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17
18
19 DEPOSITION OF PATRICIA HAHN, PhD, a witness
20 called before SUSAN GALLAGHER, CA CSR, CVR, CM, a
21 Notary Public in and for the State of North Carolina,
22 at 114 West Edenton Street, Raleigh, North Carolina, on
23 Tuesday the 11th of April, 2023, commencing at 10:57
24 a.m.
25

Case 3:22-cv-00191-MOC-DCK Document 62-15 Filed 10/05/23 Page 2 of 49

1 Raleigh, North Carolina
2 PATRICIA HAHN, PhD,
3 Having been first duly sworn, was examined and
4 testified as follows:
5 EXAMINATION
6 BY MS. NOWLIN-SOHL:
7 Q Good morning, Ms. Hahn. How are you today?
8 A I'm fine. How are you?
9 Q I'm doing well. Thank you.
10 Would you mind stating your full name for the
11 record, please?
12 A My name is Patricia Marie Hahn.
13 Q Okay. And would you mind spelling that?
14 A H-A-H-N.
15 Q Okay. And have you been deposed before,
16 Ms. Hahn?
17 A Yes.
18 Q Okay. So it sounds like you're probably
19 familiar with some of the ground rules, but I will
20 still go over them. So, you know, the court reporter
21 is taking down everything we say, which means that when
22 I ask a question, you'll need to verbally answer just
23 for the clarity of the record.
24 Your attorney may object to my questions at
25 some point. For the purposes of a clean record, it's

1 A Yes.
2 Q And when did you first meet Mrs. Brown?
3 A I do not know any dates without my notes.
4 Q Okay.
5 A So I might as well just not give you any dates.
6 Q All right.
7 MS. NOWLIN-SOHL: Jaci, if you could pull up Bates
8 No. 2490, and I think this is Exhibit 5.
9 (Exhibit 5 marked for identification.)
10 BY MS. NOWLIN-SOHL:
11 Q Ms. Hahn, do you recognize this document?
12 A Yes.
13 Q What is this document?
14 A It is a mental health progress note.
15 Q And what is a mental health progress note?
16 A It is our standard note for, usually, routine
17 therapy sessions.
18 Q And where do you sort of write and save this
19 note?
20 A Into our electronic medical records.
21 Q Okay. And what is the date of this note?
22 A 9/13/2018.
23 Q And did you prepare this note?
24 A Yes.
25 Q Okay. And I will put you to the section titled

Case 3:22-cv-00191-MOC-DCK Document 62-15 Filed 10/05/23 Page 4 of 49

1 Progress Towards Goals. It says that "This is the
2 undersigned's first session with Ms." -- and it's
3 redacted but it is Mrs. Brown. Do you see that?
4 A Yes.
5 Q Okay. Was this the first time you met
6 Mrs. Brown?
7 A Yes.
8 Q Okay. And how did you come to be the provider
9 that Mrs. Brown met with?
10 A I am not sure. At that time I think I was
11 trying to help Harnett with their clinical work, and so
12 I just had a number of patients at Harnett, and as I
13 said, I believe that most of the time people try to
14 give me the transgender patients, But I don't -- she
15 could have just been a regular patient on the transfer
16 list and I just took her. I don't know.
17 Q Okay. And Harnett is a men's facility;
18 correct?
19 A Correct.
20 Q Did you diagnose Mrs. Brown with gender
21 dysphoria?
22 A Not at that particular time. She had been in
23 the facility -- I think she -- she either processed or
24 already had a mental health assessment, and so I did
25 not do her mental health assessment at that particular

Case 3:22-cv-00191-MOC-DCK Document 62-15 Filed 10/05/23 Page 5 of 49

1 time.
2 Q Do you know if she had already been diagnosed
3 with gender dysphoria?
4 A I do not know, unless it's in my notes, and I
5 don't even remember when they changed it. No, it was
6 after 2018 -- I mean, before 2018 that they changed it
7 from gender identity disorder to gender dysphoria.
8 So no, I don't know what her diagnosis was at
9 that particular time.
10 Q Okay. Do you know if Mrs. Brown was diagnosed
11 with gender dysphoria at one point?
12 A I believe so, but without my notes, I don't
13 really know. But yes, I think -- I mean, as far as I
14 remember, I may have diagnosed her with gender
15 dysphoria myself.
16 Q Okay. Would you agree that Mrs. Brown has
17 gender dysphoria?
18 A Yes.
19 Q During this first appointment with Mrs. Brown,
20 did she express an interest in receiving hormone
21 therapy for gender dysphoria? And I'll direct you
22 toward the section "progress towards goals" which might
23 be helpful.
24 The second sentence says "She reported her main
25 focus was on hormones and sexual reassignment surgery."

1 Do you see that?
2 A Yes, I do see that, and I'm assuming that means
3 that she was not on hormones at the time and wanted to
4 be on hormones.
5 Q Do you know if she had been on hormones
6 previously?
7 A Not if it's not in the note, I do not know.
8 Q Okay.
9 A Or I do not remember, I should say. I mean,
10 yes, I think she had been on hormones, but I guess I
11 don't remember -- I don't remember if they were illegal
12 or legal. I believe in her case they were legal
13 hormones.
14 Q Okay. And so she expressed an interest in
15 hormones at this meeting with you?
16 A Yes.
17 Q Okay. And she expressed an interest in
18 gender-affirming surgery as well?
19 A Yes.
20 Q Do you know what that conversation involved?
21 A Not in detail. I mean, I -- and plus, I don't
22 know what happened at this particular incident or what
23 we discussed over the years.
24 Q Okay. Did Mrs. Brown express a desire for
25 surgery at later times as well?

Case 3:22-cv-00191-MOC-DCK Document 62-15 Filed 10/05/23 Page 7 of 49

1 A Yes.
2 Q Okay. And was her desire for gender-affirming
3 surgery consistent during the time that you met with
4 her over the years?
5 A Yes.
6 Q How frequently did you meet with Mrs. Brown?
7 A Well, hopefully by policy, but because I was
8 not necessarily assigned to every facility I saw her
9 at, we are supposed to see somebody approximately every
10 45 days. With people that I saw on a regular basis,
11 they knew I was assistant director of mental health,
12 and they knew I might be late depending on what I had
13 to do, and they were fine with that. Sometimes I would
14 put that in the note. Sometimes they just, you know,
15 knew it.
16 Q Was Mrs. Brown somebody that you saw on a
17 regular basis?
18 A Yes.
19 Q And for how long did you see Mrs. Brown?
20 A I thought I -- I know I saw her regularly at
21 Harnett. I can't remember if it was Warren whether I
22 saw her periodically when I could, and she had a
23 regular therapist also, and then at Anson, I saw her --
24 usually I tried to see her once a month.
25 Q And was that up until you retired?

Case 3:22-cv-00191-MOC-DCK Document 62-15 Filed 10/05/23 Page 8 of 49

1 A Yes.
2 Q Okay.
3 A More or less.
4 Q And so you saw her at Harnett regularly, at
5 least -- at Warren at least occasionally, and then at
6 Anson regularly?
7 A Yes. Anson, I know I saw her regularly. In
8 part because I supervised the psychological program
9 manager there, and I had to see him once a month. So I
10 would see her -- I would see her and do my supervision.
11 Q Okay. Were these visits in person or via
12 telehealth?
13 A They were in person.
14 Q And I think you mentioned she met with another
15 therapist at Warren; is that accurate?
16 A I think -- yes, I believe -- I'm not sure.
17 I've had to see my notes. I can't remember if I was
18 her primary therapist or somebody else was the primary
19 therapist.
20 Q Okay. Beyond her primary therapist, do you
21 know if there were occasions where she would meet with
22 other therapists as well?
23 A Yes. There were occasions she met with other
24 therapists, at least at Anson. Because I was not
25 on-site if something came up, like a referral, she

Case 3:22-cv-00191-MOC-DCK Document 62-15 Filed 10/05/23 Page 9 of 49

1 might be seen by somebody else, or if -- not speaking
2 of her specifically, but if somebody's put on SIB
3 precautions, they have to be seen by somebody, and if I
4 was scheduled to come there, it had to be the facility
5 therapist who see people.
6 Q And you used an acronym. Was that SIP?
7 A SIB. Sorry. Self-injurious behavior.
8 Q Okay. Are you still treating Mrs. Brown?
9 A No.
10 Q Okay. Have you treated her at any point since
11 you returned as a contractor?
12 A No. I have had no contact with her.
13 Q Okay. Do you know who is treating Mrs. Brown?
14 A Currently, no.
15 Q Do you know if it somebody that you supervised?
16 A I don't know who's treating her.
17 Q Okay. Do you know if she is still receiving
18 any mental health treatment?
19 MR. RODRIGUEZ: Objection to foundation.
20 You can answer.
21 THE WITNESS: No. I have not -- the only time I've
22 looked her up at all was just to see if she was still
23 in the system, if she was still at Anson, and whether
24 she had a therapist, and I do not remember who that
25 therapist was. It would have been in probably August

1 Q Okay. And so what was your view on her request
2 for gender-affirming surgery?
3 A My view was that she requested gender-affirming
4 surgery. I don't -- it's her personal request. So
5 I -- if somebody requests something, I don't question
6 it. I put it on the -- I mean, I might talk to them
7 about it. I might question it with them, but if they
8 want it on the DTARC as a request, I put it on -- I
9 mean, the FTARC, I put it on their FTARC.
10 Q Okay. But there's still the question of
11 whether it's recommended or not recommended. Did you
12 think FTARC should recommend or not recommend her
13 gender-affirming surgery?
14 A I thought it had no relevance because they
15 really are not in the position to do either.
16 Now, I certainly didn't -- I know I did not not
17 recommend it because -- because if I had done this
18 sheet, it might have looked a little bit differently,
19 but it was not my FTARC meeting.
20 Q Okay. And as her mental health therapist, what
21 was your position on her request for gender-affirming
22 surgery?
23 MR. RODRIGUEZ: Objection. Asked and answered.
24 You can answer.
25 THE WITNESS: What was my position? I mean, in

1 what aspect?
2 BY MS. NOWLIN-SOHL:
3 Q You're her mental health provider. You meet
4 with her regularly. What was your opinion on her
5 request for gender-affirming surgery?
6 A I thought it was a legitimate request given
7 where she was in the process.
8 Q And what do you mean by "where she was in the
9 process"?
10 A She had -- it was one of the last steps for her
11 to take for her gender-affirming surgery.
12 Q Did you think it was a step she needed?
13 MR. RODRIGUEZ: Objection to medical and legal
14 conclusions.
15 You can answer.
16 THE WITNESS: I don't really -- I mean, I guess I
17 would say yes.
18 BY MS. NOWLIN-SOHL:
19 Q Of the members of the TARC that were present at
20 the meeting, were you the only one to have treated
21 Mrs. Brown?
22 A Probably not, no. Thomas Laub or -- who else
23 was there at that time? -- or Deloatch. It's possible
24 that Thomas Laub or Deloatch had seen her for various
25 reasons. I don't know.

Case 3:22-cv-00191-MOC-DCK Document 62-15 Filed 10/05/23 Page 12 of 49

1 Q Okay. Were you part of any future FTARC
2 meetings regarding accommodation requests by
3 Mrs. Brown?
4 A I'm not sure. I'd have to see my HERO records.
5 Q I missed that last thing you said. I'm sorry.
6 A I'd have to see my HERO records.
7 Q Okay. So you just don't recall?
8 A I don't recall.
9 Q Okay.
10 A I would assume so. I don't recall, though.
11 Q Okay. Okay. I'm going to mark as Exhibit 13
12 Bates No. 4065.
13 (Exhibit 13 marked for identification.)
14 BY MS. NOWLIN-SOHL:
15 Q What is this document?
16 A It's e-mails.
17 Q And who are the participants of this e-mail
18 chain?
19 A Me, Dr. Junker, Dr. Wilson.
20 Q And who is Dr. Wilson?
21 A I am not sure. I suspect -- we had a lot of
22 changes in the medical chain. If I'm remembering
23 correctly, she had something to do with the -- oh,
24 yeah. Because I wasn't -- I could be wrong. I thought
25 I might have referenced that, but no. Dr. Junker sent

1 it to her. So you'd have to ask him.
2 Q Okay. So you don't know who Anita Wilson is,
3 that works for DPS?
4 A I think she was -- I think she was high up in
5 the medical chain, but I do not know her exact
6 position.
7 Q Okay. And so going to the bottom, your e-mail
8 is July 17th?
9 A Uh-huh.
10 Q So that's approximately six months after that
11 FTARC report from January 11th; correct?
12 A Yes.
13 Q Okay. And you wrote, "We realize the UR is
14 still pending." Do you know which UR you're referring
15 to?
16 A No. Maybe it was Dr. Umesi's. As I said, he
17 could have put in a UR.
18 (Reporter clarification.)
19 THE WITNESS: It could have been Dr. Umesi's. For
20 all I know, he put in the UR.
21 BY MS. NOWLIN-SOHL:
22 Q Okay. Do you know what the UR was requesting?
23 A No.
24 Q Okay. And this e-mail refers to an
25 endocrinologist. Does that suggest that it might

Case 3:22-cv-00191-MOC-DCK Document 62-15 Filed 10/05/23 Page 14 of 49

1 relate to hormones?
2 A No. I think it referred to the
3 gender-affirming surgery.
4 Q Okay. For Dr. Pough -- do you know how to
5 pronounce that last name?
6 A It's Pough.
7 Q Pough? Does Dr. Pough work for DPS?
8 A No.
9 Q No. Who does that Dr. Pough work for?
10 A I want to say UNC. She was an outside doctor.
11 Q Okay. Do you know how Mrs. Brown came to have
12 an appointment with Dr. Pough?
13 MR. RODRIGUEZ: Objection. Foundation.
14 You can answer.
15 THE WITNESS: If I'm remembering correctly, I
16 believe she saw Dr. Pough because she was put on
17 hormones I think. I am not sure, but that makes the
18 most sense.
19 BY MS. NOWLIN-SOHL:
20 Q Okay. And you wrote, "She indicated Dr. Pough,
21 the endocrinologist, that Dr. Figler, an experienced
22 urologist who specializes in gender-affirming surgery,
23 to do her vaginoplasty"?
24 A Yes.
25 Q Do you know if Mrs. Brown had met with

Case 3:22-cv-00191-MOC-DCK Document 62-15 Filed 10/05/23 Page 15 of 49

1 Dr. Figler at this time?
2 A She had not.
3 Q Had not. Okay.
4 Did she have an appointment with Dr. Figler?
5 A She did not.
6 Q Okay. You refer to Dr. Figler as an
7 experienced urologist. How did you know that?
8 A I did not know that. I was quoting her.
9 Q Okay.
10 A Or Dr. Pough through her -- through Mrs. Brown.
11 Q Okay. And then you wrote that "Dr. Pough
12 received an e-mail from someone stating that Mrs. Brown
13 was not interested in pursuing transgender care,
14 including surgery." Do you see that?
15 MR. RODRIGUEZ: I'm going to object to the
16 characterization of the content of the e-mail.
17 You can answer.
18 THE WITNESS: I didn't hear the -- was there a
19 question? I'm sorry.
20 BY MS. NOWLIN-SOHL:
21 Q I said that you wrote that "Mrs. Brown
22 indicated Dr. Pough received an e-mail from someone
23 stating Mrs. Brown was not interested in pursuing
24 transgender care, including surgery." Do you see that?
25 A Yes.

Case 3:22-cv-00191-MOC-DCK Document 62-15 Filed 10/05/23 Page 16 of 49

1 Q Okay. And then you wrote, "This is, of course,
2 incorrect, but she does not know who at Warren sent
3 this." How did you know that it was incorrect that
4 Mrs. Brown was not interested in pursuing surgery?
5 A Because she told me. She had never mentioned
6 that she did not want surgery. Never. Or -- so I
7 don't know where that came from.
8 Q So in your time working with Mrs. Brown, she
9 was consistent in her desire for surgery?
10 A Yes.
11 Q Okay. Was Mrs. Brown's lack of surgery
12 causing -- increasing her gender dysphoria at this
13 time?
14 MR. RODRIGUEZ: I'm going to object to medical
15 opinion.
16 You can answer to the extent.
17 THE WITNESS: I don't know at this particular time
18 whether it was or not.
19 BY MS. NOWLIN-SOHL:
20 Q Okay. You say "at this particular time." Were
21 there times that it was -- the lack of surgery was
22 increasing her gender dysphoria?
23 A Yes.
24 Q Can you tell me more about that?
25 A There were various hurdles that she -- there

1 are various interventions or treatments that she tried
2 to get. So, I mean, I think she started with hormones,
3 then her focus shifted to getting sent to a female
4 facility, and then she put more focus on the
5 gender-affirming surgery.
6 Both -- I mean, she had already -- always
7 mentioned it, but there was a specific focus at a
8 different time. And when she was transferred to Anson,
9 she was concerned about the fact that she still had a
10 partial penis left, and that made her focus be more on
11 the gender-affirming surgery.
12 Q So I guess what -- I'm trying to get a sense of
13 when those increases in gender dysphoria from the lack
14 of surgery happened. So you mentioned her time at
15 Anson; is that correct?
16 A Yes.
17 Q Okay. Were there other times as well?
18 A Without my notes, I could not say.
19 Q Okay. And so this e-mail that you sent to
20 Dr. Junker, what was your goal in sending this e-mail?
21 A I think my main goal was Ms. Brown wanted me to
22 say that there was a surgeon that would -- who has
23 gender-affirming surgery who will do her vaginoplasty.
24 Q Okay. And then on the last e-mail you
25 mentioned that you're going to "do a little more

1 exploring in HERO today if I can."
2 (Reporter clarification.)
3 BY MS. NOWLIN-SOHL:
4 Q What did you mean by "exploring in HERO"?
5 A Where is that?
6 Q At the very top of Exhibit 13.
7 A Oh, oh. I don't -- I don't know.
8 Q Okay.
9 A I assume I was trying to find out who might
10 have said that, but it was not necessarily a medical
11 provider.
12 Q Okay. And do you recall Ms. Wilson being the
13 former medical director at DPS?
14 A Vaguely. We had, like, medical directors boom,
15 boom, boom, boom, boom. So that was what I thought she
16 was.
17 Q Okay. Let me get my bearings a little bit in
18 my notes.
19 Okay. I'm going to mark as Exhibit 14 Bates
20 No. 1913.
21 (Exhibit 14 marked for identification.)
22 BY MS. NOWLIN-SOHL:
23 Q Ms. Hahn, what is this document?
24 A The Division Transgender Accommodation Review
25 Committee report.

1 Q Have you seen this DTARC report before?
2 A Most likely, yes.
3 Q And you say "most likely." Why is that?
4 A I -- I cannot, you know, swear 100 percent, but
5 I most likely saw this. I mean...
6 Q Did you regularly receive DTARC reports?
7 A No, because I was not at the facility, and
8 sometimes they just are sent -- the psychologist at the
9 facility puts it in HERO, and it just sort of pops up.
10 More than likely, I saw this one.
11 Q Okay. So this would have been put in HERO in
12 Mrs. Brown's file?
13 A Yes.
14 Q Okay. And since you were -- you treated
15 Mrs. Brown, there's a good chance you would have seen
16 it in her file?
17 A Yes, yes.
18 Q Okay. That's helpful. Thank you.
19 And so this DTARC report is dated August 21st,
20 2019; correct?
21 A Yes.
22 Q Okay. And it says it relates to the FTARC on
23 7/11/2019.
24 A Uh-huh.
25 Q So now I'm wondering if that might be a typo

1 because we have the FTARC report from January 11th,
2 2019.
3 A Maybe. I don't know.
4 Q Okay. Well, it's fine.
5 Were you a part of this DTARC meeting?
6 A No.
7 Q No. Okay. And what was the DTARC's decision
8 about her request for vaginoplasty?
9 MR. RODRIGUEZ: Objection. Lack of foundation.
10 You can answer.
11 THE WITNESS: According to them, "Deferred, as
12 offender has successfully completed gender reassignment
13 surgically. Vaginoplasty is an elective procedure,
14 which is not medically necessary for reassignment.
15 Current staffing and resources does not allow for the
16 proper postoperative care of this procedure."
17 BY MS. NOWLIN-SOHL:
18 Q Do you agree that Mrs. Brown had successfully
19 completed gender reassignment surgery?
20 MR. RODRIGUEZ: Object to medical opinion.
21 But you can answer.
22 THE WITNESS: I personally would say no.
23 BY MS. NOWLIN-SOHL:
24 Q Do you agree that vaginoplasty is an elective
25 procedure that is not medically necessary?

Case 3:22-cv-00191-MOC-DCK Document 62-15 Filed 10/05/23 Page 21 of 49

1 MR. RODRIGUEZ: Objection. Medical opinion.
2 You can answer.
3 THE WITNESS: Once again, I don't know what is the
4 definition of "medically necessary." Does she need it
5 to live? No.
6 BY MS. NOWLIN-SOHL:
7 Q Okay.
8 A Mental health-wise, she might need it to live.
9 Q And as a mental health provider, you know, do
10 you agree that vaginoplasty is an elective procedure
11 which is not medically necessary?
12 MR. RODRIGUEZ: Objection. Medical opinion.
13 You can answer.
14 THE WITNESS: I already answered that. I don't
15 know what medically necessary means.
16 BY MS. NOWLIN-SOHL:
17 Q Okay. You said she might need it to live.
18 What did you mean by that?
19 MR. RODRIGUEZ: Objection. Mischaracterization of
20 the witness's testimony.
21 THE WITNESS: There are certain procedures --
22 medical procedures that aren't -- if they are not done,
23 the person will physically die because of the medical
24 procedure not being done.
25 BY MS. NOWLIN-SOHL:

Case 3:22-cv-00191-MOC-DCK Document 62-15 Filed 10/05/23 Page 22 of 49

1 Q Okay. And you said in reference to Mrs. Brown.
2 What did you mean by in reference to her?
3 MR. RODRIGUEZ: Mischaracterization of testimony.
4 But you can answer.
5 THE WITNESS: I'm not speaking exactly towards
6 Ms. Brown with this. But some people if they don't --
7 there's a high level of suicide in the transgender
8 population. I -- you just never know what will tip
9 somebody over to committing suicide.
10 BY MS. NOWLIN-SOHL:
11 Q Okay.
12 A So, I mean, in that respect, you could say it's
13 medically -- or it's -- for mental health reasons, it's
14 necessary.
15 Q Okay. Did Mrs. Brown ever express suicidal
16 thoughts to you?
17 A I would like to refer to my notes if -- to
18 answer that.
19 Q You don't recall off the top of your head if at
20 any point she expressed suicidal thoughts to you?
21 A Well, yes. There was one episode. I do
22 remember one particular episode.
23 Q Okay. So I'm going to mark as Exhibit 15 --
24 MR. RODRIGUEZ: Before we go to this next exhibit,
25 do you want to take a quick break?

1 MS. NOWLIN-SOHL: Let me do this document, and then
2 we can.
3 MR. RODRIGUEZ: All right.
4 (Exhibit 15 marked for identification.)
5 BY MS. NOWLIN-SOHL:
6 Q And that is Bates 5044.
7 Ms. Hahn, have you seen this document before?
8 A No.
9 Q Okay. And what does this document appear to
10 be?
11 A It says it is the Division Transgender
12 Accommodation Review Committee meeting notes, I assume.
13 Q And the date for these notes, it's the same
14 date for the DTARC report we were just looking at for
15 Mrs. Brown, yes?
16 A Yes.
17 Q Okay. And so if you'll go down to page 6, I
18 think, so the second to last page, the only one that's
19 not fully blacked out.
20 A Uh-huh.
21 Q So this addresses Mrs. Brown's case, and on the
22 third line down, it says -- her medical records -- "The
23 gender reassignment is complete. Additional surgery
24 would be for outward appearance and is not necessary
25 for reassignment."

Case 3:22-cv-00191-MOC-DCK Document 62-15 Filed 10/05/23 Page 24 of 49

1 Do you agree that surgery would be for outward
2 appearance only?
3 MR. RODRIGUEZ: Objection. Medical opinion.
4 You can answer.
5 THE WITNESS: I don't -- I don't really know. I --
6 there's a lot of nuance to that question.
7 BY MS. NOWLIN-SOHL:
8 Q What are -- what are some of the nuances?
9 A It is not -- the surgery is not necessarily
10 needed for -- well, I don't know. I don't know what
11 they mean by that.
12 Q Okay. How do you think surgery would impact
13 Mrs. Brown's mental health?
14 A I don't know. I can only make an assumption
15 based on what I know about her.
16 Q Okay. As her mental health provider who
17 treated her for a couple of years and had discussions
18 with her about surgery, do you think having surgery
19 would have a positive impact on Mrs. Brown?
20 MR. RODRIGUEZ: I'm going to object to medical
21 opinion.
22 But you can answer.
23 THE WITNESS: It is my belief it would.
24 BY MS. NOWLIN-SOHL:
25 Q Okay. Would it -- do you think it would help

1 alleviate her gender dysphoria?
2 MR. RODRIGUEZ: Objection to medical opinion.
3 You can answer.
4 THE WITNESS: Yes. I believe it would affect her
5 in a positive way, her gender dysphoria.
6 MS. NOWLIN-SOHL: Okay. I think that's a good
7 point to take a break.
8 (Recess.)
9 BY MS. NOWLIN-SOHL:
10 Q All right. Welcome back. And you know you're
11 still under oath and still on the record.
12 So earlier we talked a little bit about
13 Mrs. Brown's gender dysphoria and how that kind of
14 fluctuated a little bit at various times. Do you
15 remember that conversation?
16 A Yes.
17 Q Okay. What I'd like to do is to go through
18 some of your notes with you. Some of it's happened
19 quite some time ago, and you see a lot of patients.
20 So let's mark as Exhibit 16 Bates No. 1796.
21 (Exhibit 16 marked for identification.)
22 BY MS. NOWLIN-SOHL:
23 Q And what is this document, Ms. Hahn?
24 A It is a mental health progress note.
25 Q Okay. And did you prepare this document?

Case 3:22-cv-00191-MOC-DCK Document 62-15 Filed 10/05/23 Page 26 of 49

1 A Yes.
2 Q Okay. And is this the typical format that your
3 mental health progress notes take?
4 A Yes. They have to take that format.
5 Q Okay. So we're going to be looking at several
6 of these. This one is dated November 15, 2019, yes?
7 A Yes.
8 Q Okay. In her progress towards goals, it
9 mentions Ms. Dula as Mrs. Brown's on-site clinician.
10 What is an on-site clinician?
11 A I was not physically present at Anson during
12 any time except for once a month when I saw Ms. Brown.
13 So in case Ms. Brown had an emergency, she would see
14 Ms. Dula. Or if she put in a referral -- it didn't
15 even have to be a big emergency -- she would see
16 Ms. Dula.
17 Q Okay. Did she have a regular schedule for
18 seeing Ms. Dula, or just as needed?
19 A As needed.
20 Q Okay. And who is Ms. Dula?
21 A She was a mental health clinician there.
22 Q Okay. And "there" is Anson?
23 A Anson, yes.
24 Q Okay. So in the second paragraph of progress
25 toward goals, the last two sentences. So it says,

1 "Ms. Brown is also wanting to get the rest of her
2 gender-affirming surgery completed and may pursue this
3 through the ACLU. She wants to continue to pursue all
4 that she needs because," quote, "I never want to be in
5 a situation where I want to take my life again," end
6 quote.
7 When you wrote "pursue all that she needs,"
8 were you referring to the gender-affirming surgery?
9 A Not necessarily.
10 Q Okay. What were you referring to?
11 A That was -- when I write my notes, even though
12 I don't quote -- put everything in quotes, oftentimes
13 I'm using the person's language. So what they actually
14 said but I don't necessarily quote it all, or I end up
15 quoting everything.
16 I assume, in this particular case, she's
17 talking about her gender-affirming surgery, but it
18 might be other things. She's just saying that if she
19 needs something associated with being transgender,
20 she's going to try to pursue that.
21 Q Okay. So it includes her gender-affirming
22 surgery, but might include other things as well?
23 A Yes.
24 Q Okay. And then when she said "I never want to
25 be in a situation where I want to take my life again,"

Case 3:22-cv-00191-MOC-DCK Document 62-15 Filed 10/05/23 Page 28 of 49

1 what did you understand her to mean?
2 A That she would have suicidal ideation.
3 Q If she didn't get surgery?
4 A That or whatever she was talking about pursuing
5 her needs.
6 Q Would not being able to access surgery
7 exacerbate Mrs. Brown's gender dysphoria?
8 MR. RODRIGUEZ: Objection. Medical opinion.
9 You can answer.
10 THE WITNESS: Yes.
11 BY MS. NOWLIN-SOHL:
12 Q To the point of suicidal ideation?
13 MR. RODRIGUEZ: Objection. Medical opinion.
14 You can answer.
15 THE WITNESS: I can't answer that specifically
16 without looking at my notes because I do not remember
17 the exact issue when I saw her most -- having an
18 episode of suicidal ideation. I can -- if -- once we
19 get to that note, I'll be able to answer that.
20 BY MS. NOWLIN-SOHL:
21 Q Okay. All right. Well, let's mark as
22 Exhibit 17 Bates 1214.
23 (Exhibit 17 marked for identification.)
24 BY MS. NOWLIN-SOHL:
25 Q Do you recognize this document?

1 A It is my document, yes.
2 Q Okay. And what's the date of this encounter
3 with Mrs. Brown?
4 A 1/31/20.
5 Q Okay. And can you read the first sentence
6 under "progress towards goals"?
7 A "Ms. Blank described having brief self-injuring
8 thoughts on January 9th and 19th involving," quote,
9 "finding a way to not have my pee pee penis," unquote,
10 "usually by thinking about creating an infection
11 somehow."
12 Q So was Mrs. Brown having self-injuring thoughts
13 at this time?
14 A At the time of my note?
15 Q Well, not necessarily on a specific day, but
16 just this time generally --
17 A Yes --
18 Q -- in the month of January 2019 or --
19 A -- on January 9th and 19th.
20 Q Okay. Sorry. I think I might've spoken over
21 you and I missed your answer.
22 A Yes, she did on January 9th and 19th.
23 Q Okay. And were those self-injuring thoughts
24 related to her gender dysphoria?
25 A It was related to the fact that she still had

1 part of her penis.
2 Q Okay.
3 A And as I said -- and her penis was a trigger
4 for -- is a trigger for her dysphoria.
5 Q Okay. And is that something that is likely to
6 continue as long as she has a penis?
7 MR. RODRIGUEZ: Objection. Medical opinion.
8 You can answer.
9 THE WITNESS: I believe she will have dysphoria
10 until she has gone through her full transition.
11 BY MS. NOWLIN-SOHL:
12 Q And by "full transition," you mean surgically
13 removes her penis?
14 A Yes.
15 Q Okay. Near the end of this document under
16 plan/diagnostic changes, it says that "Mrs. Brown
17 reported an increase in dysphoria." Do you know what
18 caused that?
19 A The fact that she still had a penis -- part of
20 a penis. I'm sorry.
21 Q Okay. And then it says, "Cognitive therapy
22 will be used to address her thoughts about her penis
23 and body image." Do you see that?
24 A Yes.
25 Q Okay. How did that go?

1 A I don't know. I'd have to see my next notes.
2 Sometimes I don't -- the way I do cognitive therapy is
3 during the course of the session, I address cognitive
4 distortions or negative thinking. I don't, like,
5 say -- well, sometimes I do. But it's rare that I say,
6 this is -- "we're going to do cognitive therapy right
7 now."
8 But I do try to address people's cognitions
9 that might not be congruent with reality. A lot of
10 it -- some of it had to do with her body image, I
11 think, here.
12 Q Okay. Can cognitive therapy -- do you think
13 cognitive therapy alone can address Mrs. Brown's gender
14 dysphoria related to her penis?
15 MR. RODRIGUEZ: Objection. Medical opinion.
16 You can answer.
17 THE WITNESS: No.
18 BY MS. NOWLIN-SOHL:
19 Q Right. So let's go and mark as Exhibit 18
20 Bates No. 1182.
21 (Exhibit 18 marked for identification.)
22 BY MS. NOWLIN-SOHL:
23 Q Do you recognize this document?
24 A Yes.
25 Q Okay. And what's the date on this document?

1 A 12/11/20.
2 Q Okay. This is approximately a year after the
3 last document we were looking at; correct?
4 A Yes.
5 Q Was this a normally scheduled meeting with
6 Mrs. Brown?
7 A Yes.
8 Q Okay. And so this one says "self-injury risk
9 assessment" at the top, whereas the other two said
10 "mental health progress notes." What are the
11 differences between those two entries -- types of
12 entries?
13 A The mental health progress note is for the
14 routine follow-up sessions, and if during the routine
15 follow-up session or at any other time they have
16 suicidal ideation and have thoughts of self-harm, then
17 they need a self-injury risk assessment.
18 Q Okay. And do you know why a self-injury risk
19 assessment was conducted at this time?
20 A Because she "experienced a worsening of gender
21 dysphoria due to recent events, and currently expressed
22 self-injurious and suicidal ideation."
23 Q Do you know what the recent events are that
24 referred to?
25 A She had an increase in symptoms of gender

1 dysphoria since August, and we had been working on
2 that. There were a lot of institutional issues having
3 to do with just being in a women's prison.
4 Oh, and the -- one of the things that was a
5 main issue is that somebody found out or implied that
6 she still had a penis, and that was always one of the
7 things that upset her a lot, that people would think
8 she still had a penis.
9 Q Okay. And was Mrs. Brown having thoughts of
10 self-injury?
11 A Yes. She had thoughts of ripping the skin off
12 her penis so that they would have to do something with
13 it.
14 Q And when you say "do something with it," what
15 do you mean?
16 A I'm sorry. I don't even remember what I said.
17 Oh, so that -- she had sometimes talked about
18 self-mutilation. That if she damages her penis, maybe
19 they'll have to remove it because of the damage she
20 did.
21 Q Okay. And so one year after the last note we
22 were looking at, Mrs. Brown was still having thoughts
23 of self-harm related to her penis?
24 A Yes.
25 Q Okay. Was Ms. Brown having suicidal ideation

1 at this time?
2 A I said yes. I don't see -- well, it was in
3 part because of the whole idea of "being given a
4 medication that would put me to sleep and keep me to
5 sleep -- keep me asleep." That is sort of suicidal
6 ideation, but it wasn't what made me do the self-injury
7 risk assessment.
8 The self-injury risk assessment -- because I've
9 had people who say "I want to die. I want to be dead.
10 But I'm not going to kill myself." But, you know, if
11 somebody else kills me, yeah. Great. That was more
12 what she was saying. If circumstances make me dead,
13 I'm basically okay with that, but I don't want to die,
14 but it's good.
15 But -- so the self-injury risk assessment
16 was -- she was -- I did the self-injury risk assessment
17 primarily because of the saying that she was going to
18 harm her penis.
19 Q Okay. And the ideation that you wrote down,
20 this current suicidal ideation about going to sleep and
21 not wanting to die but feeling that it's best, did you
22 understand that to be related to her gender dysphoria?
23 MR. RODRIGUEZ: Objection. Speculation.
24 You can answer.
25 THE WITNESS: Yes.

1 as well? So not just at that time, but in your overall
2 experience, how common?
3 A I cannot speak to that with NCCIW. Not like I
4 could with Central Prison. I mean, it just is
5 completely -- it depends. It's not real common.
6 Q Okay. Helpful.
7 All right. Let's mark as Exhibit 20 Bates
8 No. 730.
9 (Exhibit 20 marked for identification.)
10 MS. NOWLIN-SOHL: And, Jaci, it has me skipping one
11 document.
12 BY MS. NOWLIN-SOHL:
13 Q Ms. Hahn, do you recognize this document?
14 A Yes.
15 Q And what is it?
16 A A mental health progress note.
17 Q Did you prepare this note?
18 A Yes.
19 Q And what's the date?
20 A 3/26/21.
21 Q Okay. Under "progress towards goals," you
22 mentioned that Ms. Brown reported her Zoloft was
23 recently increased. What is Zoloft?
24 A Zoloft is an antidepressant.
25 Q Okay. And why was she prescribed Zoloft?

Case 3:22-cv-00191-MOC-DCK Document 62-15 Filed 10/05/23 Page 36 of 49

1 A For depression.
2 Q Do you know what impact it had?
3 MR. RODRIGUEZ: Objection. Medical opinion.
4 You can answer.
5 THE WITNESS: I think she felt it was not -- well,
6 she didn't want to take medication in the first place,
7 which was why she was off medication, and then I think
8 when she went to NCCIW, she started taking medication,
9 and I think sometimes when people take antidepressants,
10 they feel sort of foggy and not -- not like they
11 usually feel, not themselves, and I think that's part
12 of the reason she did not like the Zoloft in general.
13 BY MS. NOWLIN-SOHL:
14 Q Okay.
15 A Or she was implying it didn't help.
16 Q Do you know if she discontinued taking it at
17 some point?
18 A I don't remember whether she did or she didn't.
19 Q Okay. And under "plan diagnostic changes," you
20 indicate that her depression appears to have improved
21 since December since taking Zoloft; correct?
22 A Let's see. Yes, I did say her depression had
23 improved.
24 Q Okay. And the Zoloft treats the depression,
25 but not gender dysphoria as we discussed earlier;

Case 3:22-cv-00191-MOC-DCK Document 62-15 Filed 10/05/23 Page 37 of 49

1 correct?
2 A I wouldn't quite put it that way, no. I mean,
3 it -- depression is made up of symptoms. So if it
4 treats some of the symptoms, even if it doesn't get at
5 a root cause, it still is treating depression -- or
6 gender dysphoria. Or it could, but it might not.
7 Q Okay. In your opinion from speaking with
8 Mrs. Brown at this appointment, did she still have
9 gender dysphoria?
10 A Yes.
11 Q Okay. All right. I'm going to show you
12 Exhibit 21, which is Bates 728, which is approximately
13 one month after this appointment.
14 (Exhibit 21 marked for identification.)
15 BY MS. NOWLIN-SOHL:
16 Q Ms. Hahn, do you recognize this document?
17 A Yes.
18 Q And is this your mental health progress notes
19 from a meeting with Mrs. Brown on April 28th, 2021?
20 A Yes.
21 Q Okay. And did Mrs. Brown come to this
22 appointment with a band tied around her penis?
23 A She said she did, yes.
24 Q Did you have any reason to disbelieve her at
25 that time?

1 A No, I did not.
2 Q Okay. Do you know how long she had it on?
3 A She said a week and a half.
4 Q What was your understanding of why she was --
5 had that band on her penis?
6 MR. RODRIGUEZ: Objection. Speculation as to the
7 mental motivations of the plaintiff.
8 You can answer.
9 MS. NOWLIN-SOHL: I'll rephrase.
10 BY MS. NOWLIN-SOHL:
11 Q From your conversation with Mrs. Brown at that
12 appointment, what was your understanding of why she had
13 a band on her penis?
14 A I think it was in part -- going back to the
15 reason for self-mutilating -- that if she has a band
16 and damages her penis, things might move a little
17 faster.
18 Q Can having a band on her penis damage her
19 penis?
20 A Yes.
21 Q And was that a form of self-injury?
22 A Yes.
23 Q And was that related to her gender dysphoria?
24 MR. RODRIGUEZ: Objection. Speculation.
25 You can answer.

1 THE WITNESS: Yes.
2 BY MS. NOWLIN-SOHL:
3 Q And in your conversations with Mrs. Brown at
4 this appointment, was it your understanding that the
5 lack of surgery was exacerbating Mrs. Brown's gender
6 dysphoria?
7 MR. RODRIGUEZ: Objection. Medical and legal
8 opinion and speculation.
9 You can answer.
10 THE WITNESS: Yes.
11 BY MS. NOWLIN-SOHL:
12 Q So looking under that section that says
13 "progress toward goals," the second paragraph, if you
14 could just take a look at that. When you wrote that
15 she stated, "I can't live with this anymore," what did
16 you understand her to be referring to?
17 MR. RODRIGUEZ: Objection. Speculation.
18 You can answer.
19 THE WITNESS: She was tired of having her penis,
20 and that's why she put a band around her penis.
21 BY MS. NOWLIN-SOHL:
22 Q And you said the situation was acute now, not
23 chronic. What did you understand that to mean in your
24 conversation with her?
25 A That she was -- had symptoms or feelings or did

1 behaviors right then because she still had her penis.
2 Q Okay. Who did you tell that Ms. Brown had tied
3 a band around her penis?
4 A Ms. Catlett.
5 Q Anyone else?
6 A I don't think so. I can't remember.
7 Q Okay. Under "plan/diagnostic changes," you
8 wrote that "Mrs. Brown has increased dysphoric mood,
9 but her mood improved when she was provided information
10 that she should have her appointment with the program
11 manager of the UNC Transgender Health Program within
12 the next week or the week after."
13 Why do you think that information improved her
14 mood?
15 MR. RODRIGUEZ: Objection. Speculation.
16 You can answer.
17 THE WITNESS: Because things were actually moving
18 finally. That was the next step is she had to talk to
19 that program manager.
20 BY MS. NOWLIN-SOHL:
21 Q So did taking steps toward surgery help
22 alleviate her gender dysphoria?
23 MR. RODRIGUEZ: Objection. Speculation.
24 You can answer.
25 THE WITNESS: Yes. It helped decrease her gender

1 dysphoria -- or the symptoms of depression associated
2 with the gender dysphoria.
3 BY MS. NOWLIN-SOHL:
4 Q Okay. So I'm going to mark as Exhibit 21 Bates
5 No. 4166.
6 THE COURT REPORTER: We're on 22 now.
7 MS. NOWLIN-SOHL: Okay. Thank you. Oh, yeah. I
8 see it now.
9 (Reporter clarification.)
10 MS. NOWLIN-SOHL: 4166.
11 (Exhibit 22 marked for identification.)
12 MS. NOWLIN-SOHL: And then there's a companion
13 document that we'll mark as 23, which is 4246.
14 (Exhibit 23 marked for identification.)
15 BY MS. NOWLIN-SOHL:
16 Q Okay. So the one marked as 22 is an e-mail
17 chain, and the very first e-mail in the chain at the
18 bottom is from Dionne Brown, and, unfortunately, it
19 looks like part of the e-mail was cut off, and so I've
20 also included is Exhibit 23, what I believe to be the
21 full e-mail. So that was the version that was sent to
22 Terri Catlett.
23 A Okay.
24 MR. RODRIGUEZ: I'm going to just object for the
25 record as to an assumption of that as a factual --

1 A Not necessarily about the order of things. I
2 don't know when Dr. Peiper did -- okay. Yes. Okay.
3 So -- well, yes. Because I think Mr. Brown sent
4 separate e-mails to me and Ms. Catlett, and then to
5 Dr. Peiper, and from what I see in the e-mail in
6 Exhibit 22, it looks like I may have asked somebody to
7 see Ms. Brown, and Dr. Peiper also asked somebody, and
8 so Ms. Lutz saw him -- her. Sorry.
9 Q Okay. I'm going to mark as Exhibit 25
10 Bates 0724.
11 (Exhibit 25 marked for identification.)
12 BY MS. NOWLIN-SOHL:
13 Q You can hang on to some of those documents,
14 Ms. Hahn. I'll come back to some of them.
15 And are these notes from Ms. Lutz on May 17th
16 from her meeting with Mrs. Brown?
17 A Yes.
18 Q Okay. And at the very bottom on the second
19 page, it says, "Requested to be reviewed by Hahn,
20 Patricia." That is you; correct?
21 A Yes.
22 Q Okay. Do you know if you reviewed these notes?
23 A I did, because they just stick in your queue
24 forever if you don't.
25 Q And do you know why she asked that you review

1 them?
2 A Because I was her primary therapist probably.
3 Q Okay. And when you reviewed these notes, do
4 you comment or change the notes at all?
5 A You can't comment. It only gives you the
6 option of saying you reviewed it, or that you review it
7 and write another progress note. But I did not see her
8 in person, so a progress note would not have been
9 appropriate.
10 Q Okay. Thank you.
11 So going back to Exhibit 24, on the second
12 page, it's a paragraph e-mail from Ms. Lutz, and a
13 little past the midway point, there is a sentence that
14 starts "From an emotional heath standpoint." Do you
15 see that?
16 A Yes.
17 Q Do you agree with Ms. Lutz's comment that "From
18 an emotional health standpoint, it does appear that
19 Ms. Brown continues to experience acute dysphoria
20 secondary to the length of time that has passed, which
21 has yet to resolve medically necessary treatment"?
22 MR. RODRIGUEZ: I'm going to object to medical and
23 legal opinions and foundation.
24 You can answer.
25 THE WITNESS: Yes. But it also does say here that

1 they -- this is what I said. It was UNC. They were
2 not -- they were temporarily pausing the intake of new
3 patients. So our -- there was nothing we could do
4 to -- I mean, we listen to what we -- they told us.
5 BY MS. NOWLIN-SOHL:
6 Q Right. And I'm not trying to place blame in
7 that question. I'm just curious if you agree with the
8 statement that "Ms. Brown was continuing to experience
9 acute dysphoria secondary to the length of time that
10 has passed, which has yet to resolve medically
11 necessary treatments"?
12 A Yes.
13 MR. RODRIGUEZ: Same objection to the last time you
14 asked that question.
15 BY MS. NOWLIN-SOHL:
16 Q And by "medically necessary treatment," did you
17 understand Ms. Lutz to be referring to the
18 gender-affirmation surgery Ms. Brown was seeking?
19 MR. RODRIGUEZ: Objection to legal and medical
20 opinion.
21 You can answer.
22 And lack of foundation.
23 THE WITNESS: I believe, yes, that was the main
24 topic under discussion then.
25 BY MS. NOWLIN-SOHL:

1 Q Okay. And is that the World Professional
2 Association for Transgender Health?
3 A Yes, because somebody mentioned that recently.
4 I don't -- I don't memorize acronyms. I never know
5 what they mean.
6 Q Okay. And in this e-mail from Dr. Peiper, is
7 he providing you with the WPATH standards for surgery?
8 A Yes.
9 Q Okay. And do you know why -- or why was a
10 referral letter consistent with the WPATH criteria
11 needed?
12 MR. RODRIGUEZ: Objection. Lack of foundation.
13 You can answer.
14 THE WITNESS: I believe UNC requests it.
15 BY MS. NOWLIN-SOHL:
16 Q Okay. And these numbers 1 through 6 here,
17 those are the WPATH criteria for the surgery?
18 A Yes.
19 Q Are the WPATH criteria widely accepted among
20 those who treat individuals with gender dysphoria?
21 MR. RODRIGUEZ: Objection. Legal conclusion and
22 medical opinion.
23 You can answer.
24 THE WITNESS: Yes.
25 BY MS. NOWLIN-SOHL:

1 Q Have you ever received any training regarding
2 the WPATH standards of care?
3 A No.
4 Q Okay. Do you know if other medical or mental
5 health staff at DPS have been provided training on the
6 WPATH standards of care?
7 MR. RODRIGUEZ: Objection. Speculation.
8 You can answer.
9 THE WITNESS: I don't know what has happened since
10 July 31st, 2021, when I retired. But prior to that, I
11 don't believe so.
12 Now, I have -- you know, as you probably know, the
13 WPATH standards -- they deal with lots of different
14 things. I have read relevant parts of the WPATH
15 standards.
16 BY MS. NOWLIN-SOHL:
17 Q Okay. And you responded that Mrs. Brown met
18 these criteria; correct?
19 MR. RODRIGUEZ: Objection. Mischaracterization of
20 the document.
21 You can answer.
22 THE WITNESS: Yes.
23 BY MS. NOWLIN-SOHL:
24 Q And why did you think that Mrs. Brown met the
25 criteria for the first bullet, "persistent,

Case 3:22-cv-00191-MOC-DCK Document 62-15 Filed 10/05/23 Page 47 of 49

1 well-documented gender dysphoria"?
2 A Because she met the DSM-V criteria for gender
3 dysphoria. See, even -- even that Wellpath -- W --
4 Wellpath used to be a insurance company, so I keep
5 saying Wellpath.
6 Even the WPATH -- it surprises me a little that
7 they are saying you need that for certain -- I mean, I
8 don't -- I didn't think that that was their overall
9 take on that. But it didn't matter because she met
10 that criteria.
11 Q Okay. Did you believe Mrs. Brown had a medical
12 need for surgery?
13 MR. RODRIGUEZ: Objection. Medical opinion.
14 You can answer.
15 THE WITNESS: I believe she had a mental health
16 need for surgery.
17 BY MS. NOWLIN-SOHL:
18 Q Did anyone else at DPS share that with you?
19 MR. RODRIGUEZ: Objection. Speculation.
20 You can answer.
21 THE WITNESS: Yeah, I don't know.
22 BY MS. NOWLIN-SOHL:
23 Q Okay. Did you provide a referral letter for
24 Mrs. Brown?
25 A I don't think I was the one who wrote the

Case 3:22-cv-00191-MOC-DCK Document 62-15 Filed 10/05/23 Page 48 of 49

1 STATE OF NORTH CAROLINA
2 COUNTY OF ORANGE
3
4 CERTIFICATE OF REPORTER
5
6 I, SUSAN L. GALLAGHER, CA CSR, CVR-CM, Notary
7 Public do hereby certify that PATRICIA HAHN, PhD, was
8 duly sworn by me prior to the taking of the foregoing
9 deposition, that said deposition was taken and
10 transcribed under my supervision and direction; that
11 the parties were present as stated; and that I am not
12 of counsel for or in the employment of any of the
13 parties to this action, nor am I financially or
14 otherwise interested in the outcome of this action.
15 I do further certify that the foregoing
16 228 pages constitute a true and accurate transcript of
17 the testimony, and that the witness is being given 30
18 days in which to affix her notarized signature to the
19 testimony.
20 This the 25th day of April, 2023.
21
22 _______________________________
23 SUSAN L. GALLAGHER, CA CSR, CVR-CM
Notary Public #20230500301
24
25

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

KANAUTICA ZAYRE-BROWN, *Plaintiff*, v. THE NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY, *et al.*, *Defendants*.	No. 3:22-cv-00191

DECLARATION OF KATHERINE CROFT, B.S.N, R.N.

1. I am the Program Manager of the Transgender Health Program at UNC Health, which is North Carolina's largest academic health system. This declaration is based on my personal knowledge, and I could and would testify to the following if called as a witness.

2. I received a Bachelor of Science in Registered Nursing from the University of North Carolina at Chapel Hill in 2017. I also became licensed as a Registered Nurse by the North Carolina Board of Nursing in 2017. From May 2016 through May 2017, I was a VALOR (VA Learning Opportunities Residency) Nurse Extern at the U.S. Department of Veterans Affairs at the Durham VA Medical Center.

3. I worked as a Registered Nurse at UNC Health Care from June of 2017 to July of 2019, when I became the Program Manager of what was then known as the UNC Transgender Health Program in the University of North Carolina School of Medicine's Department of Urology.

4. I became the Program Manager of the UNC Transgender Health Program (the "Transgender Health Program") at its inception in 2019. I was selected for the position because of my previous experience in operations management, in healthcare, and with the transgender community. I assisted Dr. Bradley Figler, who conceived of the Transgender Health Program, in designing and launching the program, hiring the program's staff, and managing the program. The program was designed to assist patients seeking gender affirming care through UNC in obtaining information and education about gender affirming care, obtaining pre-authorization for surgical procedures, and connecting with medical, mental health, and surgical providers at UNC.

5. The Transgender Health Program offers the full range of gender affirming surgical care, including vaginoplasty and vulvoplasty surgeries. The Transgender Health Program has served approximately 1,500 patients and, since it became part of UNC Health in July 2021, has performed approximately 60 vaginoplasties and 20 vulvoplasties for transgender women.

6. When gender affirming surgery is being considered for a patient, I or one of the other nurses I supervise in the Transgender Health Program meet with the patient to provide them information and education about such surgery, evaluate if they should be seen by a surgeon at UNC, and, if so, arrange for such a consultation.

7. Not all individuals who consult with us end up having surgery. Some have obstacles that prevent them from having surgery. The Transgender Health Program follows the WPATH Standards of Care and typically requires two letters from the patient's providers indicating that they meet the WPATH criteria for gender affirming surgery. Some patients have trouble getting their two letters. Some patients seeking vaginoplasty have difficulty obtaining genital hair removal required for that procedure. We also require that patients provide informed consent, have cardiac clearance, refrain from using nicotine, and patients

have a body-mass index goal of 35 or lower to provide safer recovery. We also require that all other health concerns be well-managed, including any mental health conditions.

8. My experience is that I am able to assist nearly all patients to obtain financial coverage for their gender affirming surgery. Fewer than 5% of all patients have been denied coverage and many of those denials are overturned on appeal.

8. On November 16, 2020, Terri Catlett, the Director of Healthcare Administration for what was then known as the North Carolina Department of Public Safety ("DPS"), reached out by email to my former colleague Julie Farmer to arrange for a surgical evaluation with Dr. Figler for Mrs. Kanautica Zayre-Brown, who was in the custody of DPS. I responded by email that day to Ms. Catlett that the Transgender Health Program's patient coordinator had been in contact with Mrs. Zayre-Brown's case worker for scheduling and was waiting for calls back to set up a clinic appointment for her. Ms. Catlett replied by email that day that she would have someone reach out to schedule the appointment and she asked if a telehealth visit would be more appropriate for the initial encounter. I responded on December 3, 2020, that the Transgender Health Clinic could do a telehealth visit. Ms. Catlett responded that day that Dr. Figler would need to get set up and credentialed and suggested January 28, 2021, for the appointment. I responded that same day that the Transgender Health Clinic eventually would have to see Mrs. Zayre-Brown in-person at the clinic for examination.

9. I emailed Ms. Catlett on January 8, 2021, that Dr. Figler had asked to see Mrs. Zayre-Brown in person rather than virtually and that I was having my patient coordinator reach out to one of DPS's case managers to try and pick some dates in the end of January time frame. Ms. Catlett responded that day that she was waiting for leadership to approve the consultation and, once approved, she would reach out to me again.

10. I did not hear anything further from Ms. Catlett or anyone else at DPS for over a month. On February 22, 2021, I emailed Ms. Catlett to check in and see if there was anything needed to assist with the process. Ms. Catlett responded on February 25, 2021, asking for information regarding post-operative conditions DPS would need to meet when one of the individuals in their custody has surgery and information to provide to a patient when they are trying to make an informed decision. She inquired if I had any training materials or whether someone at the Transgender Health Program would be able to have a discussion with her team. I responded on February 26, 2021, providing her UNC Transgender Health Program educational materials for gender affirming vaginoplasty and offered to speak with a member of her team if they had any questions after reviewing the materials. I noted that vaginoplasty requires genital hair removal prior to surgery and requires the patient be able to extensively complete vaginal dilation after surgery. Ms. Catlett responded that day that she and her team would review the materials and she would see if there were any questions.

11. The next time I heard from Ms. Catlett was a month later, on March 25, 2021, when she emailed me asking if I was available for a discussion regarding the UNC Transgender Health Program with her and Dr. Jonathan Lewis Peiper, the DPS Director of Behavioral Health. I responded that same day that I would be happy to do so and inquired when and how we should talk. A conference call between the three of us was scheduled for March 26, 2021.

12. The March 26, 2021 conference call clarified logistical considerations between the UNC Transgender Health Program and the DPS Divisional Transgender Accommodation Review Committee ("DTARC") process. It was decided that an individualized, in-depth, informational consultation would take place between Mrs. Zayre-Brown and me by telehealth, which would be followed by an in-person consultation with Dr. Figler. The

resulting information from both would then be reviewed for further consideration by DTARC. I also went through the credentialing process to be able to access DPS systems to document my visit with Mrs. Zayre-Brown.

13. A telehealth conference thereafter was set up between me and Mrs. Zayre-Brown for May 25, 2021, more than six months after DPS had reached out about Mrs. Zayre-Brown being evaluated by the Transgender Health Program.

14. Attached hereto as Exhibit A is a true and correct copy of my clinical encounter notes regarding my May 25, 2021 telehealth conference with Mrs. Zayre-Brown. The purpose of this clinical encounter with Mrs. Zayre-Brown was to evaluate her medical history and provide her education about gender affirming surgery in order to appropriately assess next steps. Mrs. Zayre-Brown and I discussed her surgical goals. I educated Mrs. Zayre-Brown about two options for gender affirming genital surgery—in her case, vaginoplasty and vulvoplasty. Mrs. Zayre-Brown eventually decided on gender affirming vulvoplasty and endorsed that all of her questions had been answered. Based on Mrs. Zayre-Brown's medical history, no primary concerns were identified that would interfere with surgery except for Mrs. Zayre-Brown's weight. She indicated that she intended to lose weight in order to obtain the surgery.

15. On May 25, 2021, I emailed Ms. Catlett to inform her that the appointment went well and noted that the next step was an in-person consultation with Dr. Figler. In that email, I asked Ms. Catlett how we should proceed. On June 1, 2021, I received a voicemail and an email from Dr. Peiper stating that he wanted to discuss what the next steps would look like and explained that he was interested in whether the Transgender Health Program has a format used for providing review information after a completed surgical consult and if this might be in the form of a "letter" for him to review. We spoke by phone on June 2, 2021,

during which I explained what was required and we determined what equivalent documentation from DPS providers would meet requirements.

16. On June 9, 2021, Ms. Catlett emailed me about scheduling an in-person consultation with Dr. Figler. An appointment for Mrs. Zayre-Brown with Dr. Figler was eventually scheduled for and occurred on July 12, 2021, seven-and-a-half months after DPS' initial contact regarding Mrs. Zayre-Brown.

17. On July 21, 2021, I provided DPS information regarding the WPATH Standards of Care for gender affirming care.

18. On July 29, 2021, I emailed Ms. Catlett and Dr. Peiper that I had received a message from Mrs. Zayre-Brown that her procedure was denied as not medically necessary. I asked if there was any further information I could provide or assistance I could give Mrs. Zayre-Brown. It was my belief at this time as a nurse with training and experience in the treatment of gender dysphoria that gender affirming surgery was medically necessary to treat Mrs. Zayre-Brown's gender dysphoria. I explained that "In our estimation she does meet requirements for medical necessity under gender dysphoria, pending a look at her records of course." Later that day, I received a phone call from Dr. Peiper explaining that there had been no denial or final determination and that DPS would get word to Mrs. Zayre-Brown to clear up her misunderstanding.

19. On September 7, 2021, I had a phone call with Dr. Peiper in which he asked whether Mrs. Zayre-Brown would need a pre-op visit prior to surgery. I emailed Dr. Peiper on September 8, 2021, that Mrs. Zayre-Brown would need such a visit two weeks prior to surgery and would also require some updated lab tests.

20. Dr. Peiper thereafter asked me to provide a training to high-level administrators and some medical providers at DPS regarding gender affirming care, geared toward considerations for patients seeking care while in DPS custody, the WPATH Standards

of Care, and options for treatment, which I provided in person on October 21, 2021. Dr. Peiper thanked me for doing this in an email later that day referencing the "great information" in the presentation. He also emailed me regarding a conference presentation I had mentioned I would be giving in November and asked if that was the USPATH Symposium. I responded that I was as part of a group delivering a presentation on the main day of the symposium. Dr. Peiper replied that he was sure he would catch my group presentation and repeated that he thought I did a great job with my presentation that day.

21. On October 22, 2021, I emailed Dr. Peiper a safe environment pre-op nursing checklist describing the environment and social support that should be available after gender affirming genital surgery. In that email, I mentioned that I had learned that Mrs. Zayre-Brown had told a provider that her surgery had been denied, but noted that, as far as Dr. Peiper and I had discussed, everything was still on track for Mrs. Zayre-Brown to receive surgery. I asked him to have someone interface with Mrs. Zayre-Brown about this.

22. Dr. Peiper emailed me back on October 22, 2021 thanking me for the checklist and for letting him know what I had learned. He told me he had talked with Mrs. Zayre-Brown's assigned psychologist about Mrs. Zayre-Brown's misinformation. He also mentioned that he had received an evaluation letter regarding Mrs. Zayre-Brown from a licensed clinical social worker who had experience with the transgender community.

23. Dr. Peiper subsequently asked me to provide a secondary training for mental health provider students at DPS, which I delivered on December 21, 2021.

24. The next I heard from anyone at DPS regarding Mrs. Zayre-Brown having gender affirming surgery was on February 17, 2022, when Dr. Peiper emailed me asking if the checklist I had sent him on October 22, 2021, would apply to any genital surgery. In that email he said he was curious as this related to vaginoplasty versus vulvoplasty and that he thought that the need for dilation seemed like it may be the main part that might be different.

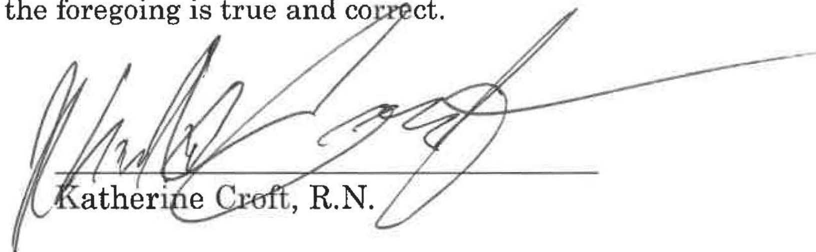
I responded by email that day that the checklist I had provided related to post op needs for all the Transgender Health Program's surgeries. I explained that different surgeries had different post-op needs and confirmed that dilation is not needed for vulvoplasty.

25. I reached out to Dr. Peiper in March of 2022 because I had not heard from DPS regarding Mrs. Zayre-Brown receiving surgery and was told by Dr. Peiper that DPS was still in the decision-making process. The Transgender Health Program was prepared to schedule and provide vulvoplasty for Mrs. Zayre-Brown once DPS approved her receiving such surgery. Mrs. Zayre-Brown met all of the WPATH criteria that the Transgender Health Program requires in order to conclude that surgery is medically necessary.

26. The Transgender Health Program was never informed by anyone at DPS whether or not Mrs. Zayre-Brown would receive gender affirming surgery.

Pursuant to 28 U.S.C. § 1746, I declare the foregoing is true and correct.

Dated: 10/2/2023



Katherine Croft, R.N.

Croft Declaration Exhibit A

North Carolina Department of Public Safety
Clinical Encounter

Offender Name: [redacted], [redacted] Off #: 0618705
Date of Birth: [redacted]1981 Sex: F Race: BLACK/AFRI Facility: OFF
Encounter Date: 05/25/2021 13:52 Provider: Croft, Katherine RN Unit: OFF

Nursing Note encounter performed at Telehealth.

SUBJECTIVE:

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

Chief Complaint: Pre-operative Eval

Subjective: Evaluation and education for gender-affirming vaginoplasty

Pain Location:

Pain Scale:

Pain Qualities:

History of Trauma:

Onset:

Duration:

Exacerbating Factors:

Relieving Factors:

Comments:

OBJECTIVE:

Exam:

ASSESSMENT:

Other

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

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

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

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

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

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

Patient endorsed that all of her questions were answered.

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

PLAN:

Disposition:

Consultation Written

Patient Education Topics:

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

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

Telephone/Verbal Order: No

Standing Order: No

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

Case 3:22-cv-00191-MOC-DCK Document 62-16 Filed 10/05/23 Page 11 of 11