RECORD NO. 19-1952

In The
United States Court of Appeals
For The Fourth Circuit

GAVIN GRIMM,

Plaintiff – Appellee,

v.

GLOUCESTER COUNTY SCHOOL BOARD,

Defendant – Appellant.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF VIRGINIA AT NEWPORT NEWS

JOINT APPENDIX
VOLUME I OF IV
(Pages 1 – 360)

David P. Corrigan
Jeremy D. Capps
M. Scott Fisher, Jr.
George A. Somerville
HARMAN CLAYTOR CORRIGAN & WELLMAN
Post Office Box 70280
Richmond, Virginia 23255
(804) 747-5200

Counsel for Appellant

Joshua A. Block
Leslie Cooper
AMERICAN CIVIL LIBERTIES UNION
125 Broad Street, 18th Floor
New York, New York 10004
(212) 549-2593

Counsel for Appellee

Eden Brooke Heilman
Jennifer Marie Safstrom
Nicole Gloria Tortoriello
AMERICAN CIVIL LIBERTIES UNION FOUNDATION OF VIRGINIA
701 East Franklin Street, Suite 1412
Richmond, Virginia 23219
(804) 532-2152

Counsel for Appellee

THE LEX GROUP ♦ 1108 East Main Street ♦ Suite 1400 ♦ Richmond, VA 23219
(804) 644-4419 ♦ (800) 856-4419 ♦ Fax: (804) 644-3660 ♦ www.thelexgroup.com

TABLE OF CONTENTS
VOLUME I OF IV

Appendix Page

Docket Entries **1**

Order of
The Honorable Arenda L Wright Allen
Re: Granting Consent Motion for Dismissal of Requests for Relief and Plaintiff's Motion to Vacate Order for Supplemental Briefing and Dismissing Request for Relief of Plaintiff's A mended Compliant
filed December 12, 2017 .... **29**

Order of
The Honorable Arenda L Wright Allen
Re: Denying Amended Motion to Dismiss
filed May 22, 2018 .... **35**

Order of
The Honorable Arenda L Wright Allen
Re: Granting Plaintiff's Motion for Leave to File Second Amended Complaint
filed February 15, 2019 .... **66**

Second Amended Complaint
filed February 15, 2019 .... **70**

Answer to Second Amended Complaint
filed March 1, 2019 .... **89**

Declaration of Gavin Grimm,
With Exhibits,
filed March 26, 2019 108

Exhibits:

A. Treatment Documentation Letter
dated May 26, 2014 123

B. Letter from
R. Smalls to
Virginia Department of Motor Vehicles
dated June 5, 2015 124

C. Order of
The Circuit Court of Gloucester County
dated September 9, 2016 125

D. Redacted Birth Certificate 127

E. Redacted Transcript of Gavin Grimm's Grades
various dates 128

Declaration of Deirdre Grimm
filed March 26, 2019 129

Declaration of Shayna Medley Warsoff,
With Exhibits,
filed March 26, 2019 136

Exhibits:

1. Defendant's Answer to Plaintiff's First Interrogatories
dated December 13, 2018 145

2. Defendant's Supplemental Answer to
Plaintiff's Interrogatory No. 1
dated January 11, 2019 159

3. Expert Report and Declaration of Dr. Melinda Penn, M.D.,
dated January 8, 2019 172

Exhibits, continued:

4. **Eastern Virginia Medical School Curriculum Vitae of Melinda Penn, MD**
   various dates 183

5. **Standards of Care for the Health of Transsexual Transgender, and Gender Nonconforming People**
   undated 188

6. **Endocrine Society Guidelines**
   undated 306

7. **Expert Report of Dr. Quentin Van Meter**
   dated February 26, 2019 341

TABLE OF CONTENTS
VOLUME II OF IV

Appendix Page

Declaration of Shayna Medley Warsoff,
With Exhibits,
filed March 26, 2019:

Exhibits, continued:

8. **Rebuttal Expert Report and Declaration of Dr. Melinda Penn, MD dated March 4, 2019 .... 361**

9. **Excerpts of Transcript of Deposition of Nathan Collins taken September 21, 2018 .... 363**

    Examination 364

10. **Excerpts of Transcript of Deposition of Walter Clemons, PhD taken September 21, 2018 .... 408**

    Examination 409

11. **Excerpts of Transcript of Deposition of Tiffany Durr taken October 10, 2018 .... 426**

    Examination 427

12. **Excerpts of Transcript of Deposition of Matthew R. Lord taken October 10, 2018 .... 436**

    Examination 437

13. **Transcript of Deposition of Troy Andersen taken March 12, 2019 .... 443**

    Examination 447

Exhibits, continued:

14. Transcript of Deposition of Dr. Quentin Van Meter taken March 18, 2019 541

Examination by Mr. Block.. 547

TABLE OF CONTENTS
VOLUME III OF IV

Appendix Page

Declaration of Shayna Medley Warsoff,
With Exhibits,
filed March 26, 2019:

Exhibits, continued:

15. Mr. Collins's Memorandum to Deirdre Grimm
dated October 14, 2014 758

16. Dr. Clemons's Email to the School Board
dated October 22, 2014 759

17. Mr. Collins's Memorandum to Dr. Clemons
dated October 23, 2014 760

18. Emails from Carla Hook to a Constituent
dated October 24-27, 2014 762

19. Email from Carla Hook to a Constituent
dated October 31, 2014 765

20. Email from Carla Hook to the School Board
dated November 4, 2014 766

21. Email and Attachment from Carla Hook to the School Board
dated November 9, 2014 767

22. School Board's Press Release
dated December 3, 2014 769

23. Recorded Minutes of Gloucester County School Board Meeting
held December 9, 2014 772

24. Mr. Collins's Correspondence
to Deirdre and David Grimm
dated December 10, 2014 779

Exhibits, continued:

25. Email from Amy Bergh to Mr. Collins
dated November 19, 2014 780

26. Transcript of Deposition of Gavin Grimm
taken October 19, 2018 781

Examination by Mr. Corrigan 786
Examination by Mr. Block 948
Examination by Mr. Corrigan 952

27. Presentation Given at the
2014 Virginia School Board Association Conference 958

28. Map of Gloucester High School
dated 2009-2010 969

29. Gloucester High School Map, Locations of School Restrooms
dated 2009-2010 970

30. List of Restrooms at Gloucester High School
undated 971

31. Letter from Joshua Block to David Corrigan
dated December 23, 2016 972

35. Gloucester County School Board press release
dated February 13, 2019 973

36. Gloucester County School Board press release
dated February 21, 2019 974

37. Recorded Minutes of Gloucester County School Board Meeting
dated November 11, 2014 975

Declaration of Janet M. Rainey
filed March 26, 2019 982

Exhibits to Brief in Support of Defendant's Motion for Summary Judgment filed March 26, 2019:

<u>Exhibits</u>:

E. Declaration of Troy Andersen, With Supporting Documents, dated March 25, 2019 983

<u>Attachments</u>:

1. Gavin Grimm's Enrollment Records with The Gloucester County School System various dates 985

2. Gavin Grimm's freshman Report Card for the School Year 2013-2014 991

3. Gavin Grimm was Offered the Opportunity to Have a Hearing with the School Board on Iris Request to Change his School Records on January 18, 2017 992

I. Defendant's Supplemental Answer to Plaintiff's Interrogatory No. 1 dated January 11, 2019 994

Declaration of James H. Loving, With Attached Photographs, filed March 26, 2019 1007

Exhibits to Plaintiff's Memorandum of Law in Opposition to Defendant's Motion for Summary Judgment filed April 9, 2019:

1. **Declaration of Shayna Medley Warsoff dated April 9, 2019 ......1021**

A. **Transcript of Deposition of Melinda Penn, MD taken March 14, 2019 ......1023**

Examination by Mr. Capps 1028

C. **Diagnostic and Statistical Manual of Mental Disorders, With Attachment, Fifth Edition, DSM-5 ......1115**

Attachment:

Email from Amy Bergh to Nate Collins dated November 19, 2014 1118

Transcript of Motions Hearing before The Honorable Arenda L Wright Allen on July 23, 2019 1119

Order of The Honorable Arenda L Wright Allen Re: Granting Plaintiff's Motion for Summary Judgment, Denying the Board's Motion for Summary Judgment filed August 9, 2019 1165

Judgment in a Civil Case filed August 9, 2019 1193

Defendant's Notice of Appeal filed August 30, 2019 1194

TABLE OF CONTENTS
VOLUME IV OF IV – EXHIBIT

Appendix Page

Exhibits to Brief in Support of Defendant's Motion for Summary Judgment filed March 26, 2019:

Exhibits

F. Gavin Grimm's Enrollment Records with The Gloucester County School System various dates 1196

N. Redacted Birth Certificate 1218

O. Redacted Birth Certificate 1219

APPEAL,CLOSED

U.S. District Court
Eastern District of Virginia - (Newport News)
CIVIL DOCKET FOR CASE #: 4:15-cv-00054-AWA-RJK

Grimm v. Gloucester County School Board
Assigned to: District Judge Arenda L. Wright Allen
Referred to: Magistrate Judge Robert J. Krask
Case in other court: 4CCA Case Manager Jennifer Rice, 15-02056
4CCA - Case Manager Jennifer Rice, 16-01733
4CCA Case Manager Cathi Bennett, 19-01952
Cause: 20:1681 Civil Rights Education Amendments Act 1972

Date Filed: 06/11/2015
Date Terminated: 08/09/2019
Jury Demand: Defendant
Nature of Suit: 448 Civil Rights: Education
Jurisdiction: Federal Question

Plaintiff

Gavin Grimm represented by **Nicole Gloria Tortoriello**
American Civil Liberties Union of Virginia
701 E Franklin Street
Suite 1412
Richmond, VA 23219
(804) 726-6013
Fax: (804) 649-2733
Email: ntortoriello@acluva.org
LEAD ATTORNEY
ATTORNEY TO BE NOTICED

Claire Guthrie Gastanaga
ACLU of Virginia
701 E. Franklin Street
Suite 1412
Richmond, VA 23219
(804) 644-8022
Email: claire@acluva.org
TERMINATED: 09/19/2018

Eden Brooke Heilman
ACLU of Virginia
701 E. Franklin Street
Suite 1412
Richmond, VA 23219
(804) 523-2152
Fax: (804) 649-2733

Email: eheilman@acluva.org
ATTORNEY TO BE NOTICED

Gail Marie Deady
Center for Reproductive Rights
199 Water Street
22nd Floor
New York, NY 10038
(917) 637-3726
Fax: (917) 637-3666
Email: gdeady@reprorights.org
TERMINATED: 04/28/2018

Jennifer Marie Safstrom
ACLU of Virginia
701 E. Franklin Street
Suite 1412
Richmond, VA 23219
(804) 523-2159
Fax: (804) 649-2733
Email: jsafstrom@acluva.org
ATTORNEY TO BE NOTICED

Joshua Abraham Block
American Civil Liberties Union
125 Broad St
18th Floor
New York, NY 10004
NA
(212) 549-2627
Fax: (212) 549-2650
Email: jblock@aclu.org
PRO HAC VICE
ATTORNEY TO BE NOTICED

Leslie Jill Cooper
American Civil Liberties Union (NY-NA)
125 Broad St
18th Floor
New York, NY 10004
NA
(212) 549-2627
Fax: (212) 549-2650
Email: lcooper@aclu.org
PRO HAC VICE
ATTORNEY TO BE NOTICED

Rebecca Kim Glenberg

ACLU of Virginia
701 E. Franklin Street
Suite 1412
Richmond, VA 23219
(804) 644-8080
Fax: (804) 649-2733
Email: rglenberg@aclu-il.org
TERMINATED: 05/16/2017

Shayna Medley-Warsoff
American Civil Liberties Union (NY-NA)
125 Broad St
18th Floor
New York, NY 10004
NA
(212) 549-2500
Fax: (212) 549-2650
Email: smedley@aclu.org
TERMINATED: 08/22/2019
PRO HAC VICE

Defendant

Gloucester County School Board represented by **David P. Corrigan**
Harman Claytor Corrigan & Wellman
PO Box 70280
Richmond, VA 23255
(804) 747-5200
Email: dcorrigan@hccw.com
LEAD ATTORNEY
ATTORNEY TO BE NOTICED

Douglas Edward Pittman
Reed Smith LLP (Richmond)
901 East Byrd Street
Suite 1900
Richmond, VA 23219-4068
(804) 344-3400
Fax: (804) 334-3410
Email: dpittman@reedsmith.com
TERMINATED: 02/14/2019

Jeremy David Capps
Harman Claytor Corrigan & Wellman
PO Box 70280
Richmond, VA 23255
(804) 747-5200
Email: jcapps@hccw.com
ATTORNEY TO BE NOTICED

Maurice Scott Fisher , Jr
Harman Claytor Corrigan & Wellman
PO Box 70280
Richmond, VA 23255
804-747-5200
Email: sfisher@hccw.com
TERMINATED: 03/09/2018

Interested Party

The United States represented by **Clare Patricia Wuerker**
U.S. Attorney's Office (Norfolk)
101 W. Main Street
Suite 8000
Norfolk, VA 23510
(757) 441-6361
Fax: (757) 441-6689
Email: clare.wuerker@usdoj.gov
LEAD ATTORNEY
ATTORNEY TO BE NOTICED

Victoria Lill
United States Department of Justice
Educational Opportunities Section PHB
950 Pennsylvania Ave, N. W.
Washington, DC 20530
NA
(202) 514-4092
Fax: (202) 514-8337
Email: victoria.lill@usdoj.gov
PRO HAC VICE
ATTORNEY TO BE NOTICED

Amicus

Fairfax County School Board, Alexandria City School Board, Arlington School Board, Falls Church City School Board represented by **Stuart Alan Raphael**
Hunton Andrews Kurth LLP
2200 Pennsyvania Ave NW
Washington, DC 20037
202-419-2021
Fax: 202-828-3728
Email: sraphael@huntonak.com
LEAD ATTORNEY
ATTORNEY TO BE NOTICED

Trevor Stephen Cox
Hunton Andrews Kurth LLP
(Richmond)
951 East Byrd Street
Riverfront Plaza - East Tower

Richmond, VA 23219
(804) 788-8200
Fax: (804) 788-8218
Email: tcox@huntonak.com
ATTORNEY TO BE NOTICED

Date Filed	#	Docket Text
06/11/2015	2	Sealed Complaint per 1 Order entered on 6.16.15. (Attachments: # 1 Exhibit A) # 2 Civil Cover Sheet, # 3 Letter, # 4 Receipt) (epri). (Entered: 06/16/2015)
06/11/2015	3	Sealed Declaration of G.G. Document re 2 Sealed Complaint. (Attachments: # 1 Exhibit A)(epri) (Entered: 06/16/2015)
06/11/2015	4	Sealed Expert Declaration of Randi Ettner, Ph.D. re 2 Sealed Complaint. (Attachments: # 1 Exhibit A, # 2 Exhibit B)(epri) (Entered: 06/16/2015)
06/11/2015	5	SEALED PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION, by G. G. (epri) (Entered: 06/16/2015)
06/11/2015	6	SEALED PLAINTIFF'S MOTION FOR LEAVE TO FILE BRIEF IN EXCESS OF THIRTY PAGES by G. G. (epri) (Entered: 06/16/2015)
06/11/2015	7	Sealed Memorandum in Support of Plaintiff's Motion for Leave to File a Brief in Excess of Thirty Pages re 5 SEALED PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION, by G. G 6 SEALED PLAINTIFF'S MOTION FOR LEAVE TO FILE BRIEF IN EXCESS OF THIRTY PAGES by G. G. (Attachments: # 1 Proposed Memorandum of law in support of Plaintiff's Motion for Preliminary Injunction)(epri) (Entered: 06/16/2015)
06/11/2015	8	COMPLAINT (Redacted) against Gloucester County School Board (Filing fee $ 400, receipt number 24683027454.), filed by G. G. (Attachments: # 1 Civil Cover Sheet (Redacted), # 2 Letter (Redacted), # 3 Receipt)(epri) (Entered: 06/16/2015)
06/11/2015	9	Declaration of G. G. re 8 Complaint (epri) (Entered: 06/16/2015)
06/11/2015	10	Expert Declaration of Randi Ettner, Ph.D Preliminary Statement re 8 Complaint (epri) (Entered: 06/16/2015)
06/11/2015	11	PLAINTIFF'S MOTION for Preliminary Injunction by G. G. (epri) (Entered: 06/16/2015)
06/11/2015	12	PLAINTIFF'S MOTION for Leave to File Brief in excess of thirty pages by G. G. (epri) (Entered: 06/16/2015)
06/11/2015	13	Memorandum in Support of Plaintiff's Motion for Leave to File a Brief in Excess of Thirty Pages re 11 PLAINTIFF'S MOTION for Preliminary Injunction 12 PLAINTIFF'S MOTION for Leave to File Brief in excess of thirty pages filed by G. G. (Attachments: # 1 Proposed Memorandum of law in support of Plaintiff's Motion for Preliminary Injunction)(epri) (Entered: 06/16/2015)
06/16/2015	1	

		Sealed ORDER Signed by District Judge Robert G. Doumar on 6/15/2015. (epri) (Entered: 06/16/2015)
06/16/2015	14	One Summons, with service copy, Issued as to Gloucester County School Board. (Attachments: # 1 Civil Motions Procedures)(epri) (Entered: 06/16/2015)
06/17/2015	15	Motion to appear Pro Hac Vice by Joshua Abraham Block and Certification of Local Counsel Rebecca Kim Glenberg Filing fee $ 75, receipt number 0422-4501488. by G. G.. (Glenberg, Rebecca) (Entered: 06/17/2015)
06/17/2015	16	Motion to appear Pro Hac Vice by Leslie Jill Cooper and Certification of Local Counsel Rebecca Kim Glenberg Filing fee $ 75, receipt number 0422-4501506. by G. G.. (Glenberg, Rebecca) (Entered: 06/17/2015)
06/17/2015	17	ORDER granting 12 Motion for Leave to File a brief in excess of thirty pages in support of the plaintiff's motion for a preliminary injunction.. Signed by Magistrate Judge Tommy E. Miller on 6/17/2015. (Miller, Tommy) (Entered: 06/17/2015)
06/18/2015	18	Memorandum in Support re 11 MOTION for Preliminary Injunction filed by G. G.. (Deady, Gail) (Entered: 06/18/2015)
06/18/2015	19	Request for Hearing by G. G. re 11 MOTION for Preliminary Injunction (Deady, Gail) (Entered: 06/18/2015)
06/23/2015	20	ORDER granting 15 Motion for Pro hac vice for Joshua Abraham Block as to G. G.. Signed by District Judge Robert G. Doumar on 6/23/15. (tlev,) (Entered: 06/24/2015)
06/23/2015	21	ORDER granting 16 Motion for Pro hac vice for Leslie Jill Cooper as to G. G.. Signed by District Judge Robert G. Doumar on 6/23/15. (tlev,) (Entered: 06/24/2015)
06/29/2015	22	AFFIDAVIT of Service by G. G. (bgra,). (Entered: 06/29/2015)
06/29/2015	23	NOTICE of Appearance by David P. Corrigan on behalf of Gloucester County School Board (Corrigan, David) (Entered: 06/29/2015)
06/29/2015	24	NOTICE of Appearance by Jeremy David Capps on behalf of Gloucester County School Board (Capps, Jeremy) (Entered: 06/29/2015)
06/29/2015	25	NOTICE of Appearance by Maurice Scott Fisher, Jr on behalf of Gloucester County School Board (Fisher, Maurice) (Entered: 06/29/2015)
06/29/2015	26	MOTION for Extension of Time to File Response/Reply *to Motion for Preliminary Injunction* by Gloucester County School Board. (Fisher, Maurice) (Entered: 06/29/2015)
06/29/2015	27	RESPONSE to Motion re 26 MOTION for Extension of Time to File Response/Reply *to Motion for Preliminary Injunction* filed by G. G.. (Glenberg, Rebecca) (Entered: 06/29/2015)
06/29/2015	28	Statement of Interest of The United States by The United States. (Attachments: # 1 Exhibit A, # 2 Exhibit B)(bgra) (Entered: 06/29/2015)

CM/ECF - vaed Page 7 of 28

06/30/2015		Motion Hearing as to 11 MOTION for Preliminary Injunction set for 7/20/2015 at 02:30 PM in Norfolk Mag Courtroom 1 before District Judge Robert G. Doumar. (lbax,) (Entered: 06/30/2015)
06/30/2015		MOTIONS REFERRED to Magistrate Judge: Tommy E. Miller. 26 MOTION for Extension of Time to File Response/Reply *to Motion for Preliminary Injunction* (bgra) (Entered: 06/30/2015)
06/30/2015	29	ORDER granting 26 Motion for Extension of Time to File Response/Reply re 11 MOTION for Preliminary Injunction. Response due July 7, 2015.Signed by Magistrate Judge Tommy E. Miller on 6/30/2015. (bgra) (Entered: 06/30/2015)
07/07/2015	30	Opposition to 11 MOTION for Preliminary Injunction filed by Gloucester County School Board. (Attachments: # 1 Exhibit Exhibit A -, # 2 Exhibit Exhibit B, # 3 Exhibit Exhibit C)(Corrigan, David) (Entered: 07/07/2015)
07/07/2015	31	MOTION to Dismiss for Failure to State a Claim by Gloucester County School Board. (Corrigan, David) (Entered: 07/07/2015)
07/07/2015	32	Brief in Support to 31 MOTION to Dismiss for Failure to State a Claim filed by Gloucester County School Board. (Attachments: # 1 Exhibit Exhibit 1) (Corrigan, David) (Entered: 07/07/2015)
07/07/2015	33	CERTIFICATE of Service re 30 Opposition by David P. Corrigan on behalf of Gloucester County School Board (Corrigan, David) (Entered: 07/07/2015)
07/07/2015	34	CERTIFICATE of Service re 31 MOTION to Dismiss for Failure to State a Claim by David P. Corrigan on behalf of Gloucester County School Board (Corrigan, David) (Entered: 07/07/2015)
07/07/2015	35	CERTIFICATE of Service re 32 Brief in Support by David P. Corrigan on behalf of Gloucester County School Board (Corrigan, David) (Entered: 07/07/2015)
07/08/2015	36	MOTION for Hearing re 31 MOTION to Dismiss for Failure to State a Claim by Gloucester County School Board. (Corrigan, David) Mo (Entered: 07/08/2015)
07/08/2015	37	Brief in Support to 36 MOTION for Hearing (Corrigan, David) Modified docket text on 7/8/2015 (ccol); Modified docket text to correct linkage to motion on 7/10/2015 (bgra). (Entered: 07/08/2015)
07/08/2015	38	RESPONSE in Opposition re 36 MOTION for Hearing re 31 MOTION to Dismiss for Failure to State a Claim filed by G. G.. (Glenberg, Rebecca) (Entered: 07/08/2015)
07/10/2015	39	Motion to appear Pro Hac Vice by Victoria Lill and Certification of Local Counsel Clare P. Wuerker by The United States. (Attachments: # 1 Exhibit Pro Hac Vice Application)(Wuerker, Clare) (Entered: 07/10/2015)
07/10/2015	40	Reply to Motion re 36 MOTION for Hearing re 31 MOTION to Dismiss for Failure to State a Claim filed by Gloucester County School Board. (Corrigan, David) (Entered: 07/10/2015)
07/13/2015	41	

		REPLY to Response to Motion re 11 MOTION for Preliminary Injunction filed by G. G.. (Attachments: # 1 Exhibit A)(Deady, Gail) (Entered: 07/13/2015)
07/13/2015		Notice of Correction: The filing user has been notified to file a separate Certificate of Service. re 41 Reply to Response to Motion (bgra) (Entered: 07/16/2015)
07/16/2015	42	ORDER granting 39 Motion for Pro hac vice for Victoria Lill as to The United States. Signed by District Judge Robert G. Doumar on 7/15/15. (tlev,) (Entered: 07/16/2015)
07/16/2015	43	CERTIFICATE of Service re 41 Reply, Reply to Response to Motion by Gail Marie Deady on behalf of G. G. (Deady, Gail) (Entered: 07/16/2015)
07/16/2015	44	RESPONSE in Opposition re 31 MOTION to Dismiss for Failure to State a Claim filed by G. G.. (Attachments: # 1 Exhibit A - Tudor Opinion, # 2 Exhibit B - Tudor Intervenor Complaint)(Glenberg, Rebecca) (Entered: 07/16/2015)
07/17/2015	45	ORDER: This Court will hear the fully briefed Motion to Dismiss before it will consider any other motions. The hearing set on July 20, 2015, is hereby VACATED, and no motions will be heard at that time. Instead, all motions then pending and responded to will be heard on July 27, 2015 at11:00 a.m. in this Court. Copies distributed to all counsel of record. re 36 Motion for Hearing. Signed by District Judge Robert G. Doumar on 7/16/2015. (bgra) (Entered: 07/17/2015)
07/17/2015		Reset Hearing as to 31 MOTION to Dismiss for Failure to State a Claim , and Motions :. Motion Hearing reset for 7/27/2015 at 11:00 AM in Norfolk Grand Jury Courtroom before District Judge Robert G. Doumar. (ptom,) (Entered: 07/17/2015)
07/17/2015		Reset Hearing as to 31 MOTION to Dismiss for Failure to State a Claim , and Motions. Motion Hearing set for 7/27/2015 at 11:00 AM in Norfolk Mag Courtroom 1 before District Judge Robert G. Doumar. (Courtroom change from Grand Jury Room to Mag Courtroom 1) (ptom,) (Entered: 07/17/2015)
07/22/2015	46	Reply to Motion re 31 MOTION to Dismiss for Failure to State a Claim , REPLY to Response to Motion , Reply filed by Gloucester County School Board. (Corrigan, David) (Entered: 07/22/2015)
07/27/2015	47	Motion Hearing before District Judge Robert G. Doumar held on 7/27/2015 re 11 MOTION for Preliminary Injunction filed by G.G., 31 MOTION to Dismiss for Failure to State a Claim filed by Gloucester County School Board. Appearances: Rebecca K. Glenberg, Gail Deady, Leslie J. Cooper and Joshua A. Block appeared for the Plaintiff. David P. Corrigan and Jeremy D. Capps appeared for the Defendant. Clare P. Wuerker and Victoria Lill appeared on behalf of the Interested Party, The United States. Arguments of counsel. Comments of Court. The Court DISMISSED the Title IX claim but takes the remainder of the motions under advisement. The Court will issue a written opinion as to its findings. The Defendants will have 21 days from the filing of the Court's opinion to file an answer. The case will be referred for scheduling at that time. Court adjourned. (Court Reporter Heidi Jeffreys, OCR.)(lbax,) (Entered: 07/28/2015)

07/30/2015	49	Transcript Redaction Request re 48 Transcript,,, by attorney Rebecca Kim Glenberg. (Glenberg, Rebecca) (Entered: 07/30/2015)
07/31/2015	50	Redacted Version of 48 Transcript (afar) (Entered: 07/31/2015)
07/31/2015	51	ORDER: The Court ORDERS that G.G.'s identifying information, as shownon page fifteen (15) of the transcript of the June 27. 2015 hearing, lines fourteen (14). fifteen (15), sixteen (16). and eighteen (18), shall be under seal. The Court further ORDERS that this identifying information shall not be released by the Clerk or any party or individual without a specific order of the Court. Copy of Order provided to all counsel of record. Signed by District Judge Robert G. Doumar on 7/31/2015. (bgra) (Entered: 07/31/2015)
09/03/2015		Case Reassigned to Magistrate Judge Douglas E. Miller. Magistrate Judge Tommy E. Miller no longer assigned to the case. (afar) (Entered: 09/03/2015)
09/04/2015	53	ORDER - DENIES 11 Plaintiff's Motion for Preliminary Injunction. Signed by District Judge Robert G. Doumar on 9/4/15. (afar) (Entered: 09/04/2015)
09/08/2015	54	NOTICE OF APPEAL as to 53 Order on Motion for Preliminary Injunction by G. G.. Filing fee $ 505, receipt number 0422-4626161. (Glenberg, Rebecca) (Entered: 09/08/2015)
09/09/2015	55	Transmission of Notice of Appeal to US Court of Appeals re 54 Notice of Appeal (All case opening forms, plus the transcript guidelines, may be obtained from the Fourth Circuit's website at www.ca4.uscourts.gov) (Attachments: # 1 Notice of Appeal)(bgra) (Entered: 09/09/2015)
09/10/2015	56	USCA Case Number 15-2056 4CCA Case Manager Jennifer Rice for 54 Notice of Appeal filed by G. G. (15-2056) (bgra) (Entered: 09/10/2015)
09/17/2015	57	MEMORANDUM OPINION - the Court GRANTED the Motion to Dismiss as to Count II, Plaintiff's claim under Title IX, and DENIED the Plaintiff's Motion for Preliminary Injunction. Signed by District Judge Robert G. Doumar on 9/17/15. (afar) (Entered: 09/17/2015)
09/22/2015	58	Consent MOTION for Leave to File *Corrected Copies of Redacted Documents* by G. G.. (Attachments: # 1 Corrected Decl. of G.G., # 2 Corrected Decl. of Dr. Ettner)(Deady, Gail) (Entered: 09/22/2015)
09/23/2015		MOTIONS REFERRED to Magistrate Judge: Douglas E. Miller. 58 Consent MOTION for Leave to File *Corrected Copies of Redacted Documents* (bgra) (Entered: 09/24/2015)
10/01/2015	59	ORDER granting 58 Motion for Leave to File Corrected Copies of Redacted Exhibits. The corrected copies attached to the Motion (ECF Nos. 58-1 and 58-2) may be filed as substitutes for the redacted Declarations of G.G. and Dr. Randi Ettner originally filed in support of the Motion for Preliminary Injunction (ECF Nos. 9 and 10). Signed by Magistrate Judge Douglas E. Miller on October 1, 2015. (Miller, Douglas) (Entered: 10/01/2015)
10/05/2015	60	Declaration re 9 Declaration - *Corrected* by G. G.. (Deady, Gail) (Entered: 10/05/2015)
10/05/2015	61	

		Declaration re 10 Declaration - *Corrected* by G. G.. (Attachments: # 1 Exhibit A, # 2 Exhibit B)(Deady, Gail) (Entered: 10/05/2015)
04/19/2016	62	Published Opinion of USCA (Copy): Reversed in part, Vacated in part, and Remanded. re 54 Notice of Appeal attached copy of judgment will not take effect until issuance of the mandate. (15-2056) (bgra) (Entered: 04/19/2016)
04/19/2016	63	USCA JUDGMENT as to 54 Notice of Appeal filed by G. G.: In accordance with the decision of this court, the judgment of the district court is reversed in part and vacated in part. This case is remanded to the district court for further proceedings consistent with the court's decision.This judgment shall take effect upon issuance of this court's mandate in accordance with Fed. R. App. P. 41. (15-2056) (bgra) (Entered: 04/19/2016)
05/03/2016	64	STAY OF MANDATE: Under Fed. R. App. P. 41(d)(1), the timely filing of a petition for rehearing or rehearing en banc or the timely filing of a motion to stay the mandate stays the mandate until the court has ruled on the petition for rehearing or rehearing en banc or motion to stay. In accordance with Rule 41 (d)(1), the mandate is stayed pending further order of this court. as to 54 Notice of Appeal filed by G.G. (cchr) (Entered: 05/03/2016)
05/31/2016	65	PUBLISHED ORDER of USCA : denying Motion for rehearing en banc 54 Notice of Appeal filed by G. G. (15-2056) (bgra) (Entered: 06/01/2016)
06/07/2016	66	STAY OF MANDATE re 54 Notice of Appeal : Under Fed. R. App. P. 41(d)(1), the timely filing of a petition for rehearing or rehearing en banc or the timely filing of a motion to stay the mandate stays the mandate until the court has ruled on the petition for rehearing or rehearing en banc or motion to stay. In accordance with Rule 41(d)(1), the mandate is stayed pending further order of this court. (15-2056) (bgra) (Entered: 06/08/2016)
06/09/2016	67	ORDER of USCA as to 54 Notice of Appeal filed by G. G. Upon consideration of the motion to stay mandate pending filing of petition for writ of certiorari, the court denies the motion. Judge Floyd and Senior Judge Davis voted to deny the motion. Judge Niemeyer voted to grant the motion. (15-2056) (bgra) (Entered: 06/09/2016)
06/17/2016	68	USCA Mandate re 54 Notice of Appeal. The judgment of this court, entered 4/19/2016, takes effect today. This constitutes the formal mandate of this court issued pursuant to Rule 41(a) of the Federal Rules of Appellate Procedure. (15-2056) (bgra) (Entered: 06/17/2016)
06/23/2016		Rule 16(b) Scheduling Conference set for 6/29/2016 at 10:00 AM in Norfolk Grand Jury Courtroom before District Judge Robert G. Doumar. (lbax,) (Entered: 06/23/2016)
06/23/2016	69	ORDER: Based on the evidence submitted through declarations previously proffered for the purpose of the hearing on the Preliminary Injunction, this Court, pursuant to Title IX, hereby ORDERS that Gloucester County School Board permit the plaintiff, G.G., to use the boys' restroom at Gloucester High School until further order of this Court. Copy of Order delivered to all counsel of record. Signed by District Judge Robert G. Doumar on 6/23/2016. (bgra) (Entered: 06/23/2016)

06/27/2016	70	NOTICE OF APPEAL as to 69 Order, by Gloucester County School Board. Filing fee $ 505, receipt number 0422-5050850. (Corrigan, David) (Entered: 06/27/2016)
06/28/2016		Transmission of Notice of Appeal to US Court of Appeals re 70 Notice of Appeal (All case opening forms, plus the transcript guidelines, may be obtained from the Fourth Circuit's website at www.ca4.uscourts.gov) (bgra) (Entered: 06/28/2016)
06/28/2016	71	MOTION to Stay re 69 Order, *Pending Appeal* by Gloucester County School Board. (Corrigan, David) (Entered: 06/28/2016)
06/28/2016	72	Memorandum in Support re 71 MOTION to Stay re 69 Order, *Pending Appeal* filed by Gloucester County School Board. (Corrigan, David) (Entered: 06/28/2016)
06/29/2016		Scheduling Conference - Rule 16b held on 6/29/2016 before District Judge Robert G. Doumar: Rebecca Glenberg and Joshua block present on behalf of the plaintiff; David Corrigan and Jeremy Capps present on behalf of the defendant; Comments of Court and Counsel; Court directed counsel to file a response to motion by 7/1/16. Trial date selected; Discovery schedule reviewed. Order to follow. Court adjourned. (Court Reporter Heidi Jeffreys.) (lhow,) (Entered: 06/30/2016)
06/30/2016	73	Rule 16(b) Scheduling Order - Pursuant to the Rule 16(b) Conference it is ordered that the Final Pretrial Conference set for 1/19/2017 at 10:00 AM in Norfolk. Bench Trial set for 1/31/2017 at 10:00 AM in Newport News. Signed by District Judge Robert G. Doumar & filed on 6/30/16. (ptom,) (Entered: 06/30/2016)
06/30/2016	74	USCA Case Number 16-1733 4CCA - Case Manager Jennifer Rice for 70 Notice of Appeal filed by Gloucester County School Board. [16-1733] (cchr) (Entered: 06/30/2016)
07/01/2016	75	RESPONSE to Motion re 71 MOTION to Stay re 69 Order, *Pending Appeal* filed by G. G.. (Glenberg, Rebecca) (Entered: 07/01/2016)
07/06/2016	76	ORDER denying 71 Motion to Stay. This Court is bound by the Judgment of the Court of Appeals. The Court of Appeals' actions in denying a rehearing en banc and a stay of its mandate indicate that it desires that its Judgment take effect immediately. The Court of Appeals itself is bound by its own prior precedents. Although Defendant has filed an appeal of the Preliminary Injunction, the Court of Appeals' prior opinion in this case will control in that appeal. This Court believes that based on the law as laid out in that opinion and the evidence submitted by declarations in this case, thePreliminary Injunction was warranted. There are no grounds for a stay. Accordingly, the Court DENIES the Motion for Stay Pending Appeal. ECF No. 71. Signed by District Judge Robert G. Doumar on 7/6/2016. (bgra) (Entered: 07/06/2016)
07/06/2016	77	ANSWER to 8 Complaint by Gloucester County School Board.(Corrigan, David) (Entered: 07/06/2016)
07/07/2016		

		Jury Trial set for 1/31/2017 at 10:00 AM in Newport News Courtroom 1 before District Judge Robert G. Doumar. (lbax,) (Entered: 07/07/2016)
07/12/2016	78	ORDER of USCA as to 70 : Upon consideration of submissions relative to the motion of appellant for stay pending appeal, the court denies the motion.Entered at the direction of Judge Floyd. Senior Judge Davis wrote an opinion concurring in the denial of a stay pending the filing of, and action on, a petition for certiorari. Judge Niemeyer wrote an opinion dissenting from the denial of a stay pending appeal. Notice of Appeal filed by Gloucester County School Board (16-1733) (bgra) (Entered: 07/14/2016)
08/03/2016	79	SUPREME COURT REMARK: The application to recall and stay the mandate of the United States Court of Appeals for the Fourth Circuit in case No. 152056, presented to THE CHIEF JUSTICE and by him referred to the Court, is granted and the preliminary injunction entered by the United States District Court for the Eastern District of Virginia on June 23, 2016, is hereby stayed pending the timely filing and disposition of a petition for a writ of certiorari. Should the petition for a writ of certiorari be denied, this stay shall terminate automatically. In the event the petition for a writ of certiorari is granted, the stay shall terminate upon the issuance of the judgment of this Court. (15-2056) (bgra) (Entered: 08/04/2016)
08/18/2016	80	MOTION to Stay by Gloucester County School Board. (Corrigan, David) (Entered: 08/18/2016)
08/18/2016	81	Brief in Support to 80 MOTION to Stay filed by Gloucester County School Board. (Corrigan, David) (Entered: 08/18/2016)
08/19/2016	82	ORDER of USCA as to 70 Notice of Appeal filed by Gloucester County School Board : Upon consideration of the joint motion to hold appeal in abeyance pending disposition of certiorari petition, the court grants the motion. (16-1733) (bgra) (Entered: 08/19/2016)
08/23/2016	83	Joint MOTION for Protective Order by G. G.. (Deady, Gail) (Entered: 08/23/2016)
08/23/2016	84	Memorandum in Support re 83 Joint MOTION for Protective Order filed by G. G.. (Attachments: # 1 Proposed Order Protective Order)(Deady, Gail) (Entered: 08/23/2016)
08/23/2016		MOTIONS REFERRED to Magistrate Judge: Douglas E. Miller. 83 Joint MOTION for Protective Order (bgra) (Entered: 08/23/2016)
08/24/2016	85	AGREED CONFIDENTIALITY PROTECTIVE ORDER: granting 83 Joint MOTION for Protective Order by G. G. Signed by Magistrate Judge Douglas E. Miller on 8/24/2016. (bgra) (Entered: 08/24/2016)
08/31/2016	86	ORDER granting 80 Motion to Stay. The Court hereby GRANTS the Motion to Stay and STAYS this matter pending the disposition of the School Board's petition for a writ of certiorari with the United States Supreme Court. ECF No. 80. Copy of Order provided to all Counsel of Record. Signed by District Judge Robert G. Doumar on 8/31/2016. (bgra) (Entered: 08/31/2016)
09/02/2016	87	

		SUPREME COURT REMARK: The petition for a writ of certiorari in the above entitled case was filed on August 29, 2016 and placed on the docket September 1, 2016 as No. 16-273. re 54 Notice of Appeal. [15-2056] (ldab,) (Entered: 09/02/2016)
10/31/2016	88	Supreme Court Remark re 54 Notice of Appeal : The petition for a writ of certiorari is granted limited to Questions 2 and 3 presented by the petition. (bgra) (Entered: 11/02/2016)
02/07/2017	89	Appeal Remark re 70 Notice of Appeal : RECORD requested by Supreme Court from court of appeals and district court/agency. Supreme Court Docket No.: 16-273 (15-2056)(bgra) (Entered: 02/08/2017)
02/07/2017	90	Appeal Remark re 70 Notice of Appeal : RECORD (4CCA) transmitted to Supreme Court. Supreme Court Docket No.: 16-273 (15-2056) (bgra) (Entered: 02/08/2017)
03/06/2017	91	SUPREME COURT REMARK--order remanding case received. 03/06/2017, REMANDED vacated. re 70 Notice of Appeal, 54 Notice of Appeal : [15-2056, 16-1733] (bgra) (Entered: 03/07/2017)
04/07/2017	92	SUPREME COURT REMARK--judgment remanding case received. REMANDED vacated, 04/07/2017. 70 Notice of Appeal, 54 Notice of Appeal. (15-2056) (16-1733) (bgra) (Entered: 04/11/2017)
04/07/2017	93	PUBLISHED OPINION of USCA (Copy): Upon consideration of the unopposed motion to vacate preliminary injunction, the court vacates the preliminary injunction entered by the district court on June 23, 2016. Senior Judge Davis wrote a concurring opinion in which Judge Floyd joined. Entered at the direction of Judge Floyd with the concurrence of Judge Niemeyer and Senior Judge Davis. re 70 Notice of Appeal attached copy of judgment will not take effect until issuance of the mandate. (16-1733) (bgra) (Entered: 04/11/2017)
04/07/2017	94	USCA JUDGMENT as to 70 Notice of Appeal: In accordance with the decision of this court, the district court preliminary injunction entered June 23, 2016 is vacated. This judgment shall take effect upon issuance of this court's mandate in accordance with Fed. R. App. P. 41. (16-1733) (bgra) (Entered: 04/11/2017)
04/13/2017	95	MOTION to Continue *Stay, Unopposed* by Gloucester County School Board. (Corrigan, David) (Entered: 04/13/2017)
04/13/2017	96	Brief in Support to 95 MOTION to Continue *Stay, Unopposed* filed by Gloucester County School Board. (Corrigan, David) (Entered: 04/13/2017)
04/13/2017	97	ORDER granting 95 Motion to Continue. The Court hereby GRANTS the Motion to Continue Stay and STAYS this matter pending the Fourth Circuit's ruling on the preliminary injunction and the dismissal of the Title IX claim. ECF No. 95.Copy of Order provided all counsel of record.Signed by District Judge Robert G. Doumar on 4/13/2017. (bgra) (Entered: 04/13/2017)
04/18/2017	98	AMENDED ORDER of USCA as to 70 Notice of Appeal filed by Gloucester County School Board. The Court amends its order filed April 7, 2017, as

		follows: On page 4, line 12, Shehab is corrected to read Shihab. [16-1733] (bgra) (Entered: 04/19/2017)
04/18/2017	99	AMENDED PUBLISHED ORDER of USCA (Copy) re 70 Notice of Appeal attached copy of judgment will not take effect until issuance of the mandate. Upon consideration of the unopposed motion to vacate preliminary injunction, the court vacates the preliminary injunction entered by the district court on June 23, 2016. Senior Judge Davis wrote a concurring opinion in which Judge Floyd joined. Entered at the direction of Judge Floyd with the concurrence of Judge Niemeyer and Senior Judge Davis. [16-1733] (bgra) (Entered: 04/19/2017)
05/01/2017	100	USCA Mandate: The judgment of this court, entered 4/7/2017, takes effect today. This constitutes the formal mandate of this court issued pursuant to Rule 41(a) of the Federal Rules of Appellate Procedure. re 70 Notice of Appeal. (16-1733) (bgra) (Entered: 05/01/2017)
05/03/2017	101	MOTION to Withdraw as Attorney by G. G.. (Attachments: # 1 Proposed Order)(Glenberg, Rebecca) (Entered: 05/03/2017)
05/03/2017	102	ORDER of USCA as to 54 Notice of Appeal filed by G. G. The court grants the motion to withdraw from further representation on appeal. (15-2056) (bgra) (Entered: 05/04/2017)
05/04/2017	103	MOTION to Amend/Correct 8 Complaint by G. G.. (Attachments: # 1 Memorandum of Law In Support of Plaintiff's Unopposed Motion to Amend Case Caption)(Deady, Gail) (Entered: 05/04/2017)
05/04/2017		Notice of Correction: The filing user is requested to refile the Memorandum in Support as a separate pleading, linking same back to Motion to Amend/Correct. re 103 MOTION to Amend/Correct 8 Complaint (bgra) (Entered: 05/04/2017)
05/04/2017	104	Memorandum in Support re 103 MOTION to Amend/Correct 8 Complaint *Caption* filed by G. G.. (Deady, Gail) (Entered: 05/04/2017)
05/16/2017	105	ORDER granting 101 Motion to Withdraw as Attorney. Upon consideration of Rebecca K. Glenberg's motion to withdraw as attorney in this case, it is hereby ORDERED that the motion to withdraw is GRANTED. Signed by District Judge Robert G. Doumar on 5/16/2017. (bgra) (Entered: 05/16/2017)
05/16/2017	106	ORDER granting 103 Motion to Amend/Correct. The Court finds that Plaintiff has reached the legal age of majority in Virginia. Accordingly, the Court hereby GRANTS Plaintiffs Motion. ECF No. 103. The Court ORDERS the Clerk of the Court to amend the docket by substituting "Gavin Grimm" as Plaintiff for "G.G., by his next friend and mother, Deirdre Grimm" in the case caption, and further ORDERS that all future filings in this matter employ this case styling. Signed by District Judge Robert G. Doumar on 5/16/2017. (bgra) (Entered: 05/16/2017)
06/06/2017		Case Reassigned to District Judge Arenda L. Wright Allen. District Judge Robert G. Doumar no longer assigned to the case. (afar) (Entered: 06/06/2017)
08/02/2017	107	

		Published Opinion and Order DIRECTING LIMITED REMAND [4CCA retains jurisdiction] re 54 Notice of Appeal attached copy of judgment will not take effect until issuance of the mandate. 15-2056 (ldab,) (Entered: 08/02/2017)
08/04/2017	108	ORDER re 107 Published Opinion and Order DIRECTING LIMITED REMAND [4CCA retains jurisdiction]. On August 25, 2017, each party shall submit a Response to the Position Statements. SEE ORDER FOR DETAILS. Signed by District Judge Arenda L. Wright Allen and filed on 8/4/17. Copies distributed to all parties 8/4/17.(ldab,) (Entered: 08/04/2017)
08/11/2017	109	Consent MOTION to Amend/Correct 8 Complaint by Gavin Grimm. (Attachments: # 1 Exhibit A)(Deady, Gail) (Entered: 08/11/2017)
08/17/2017	110	ORDER of USCA as to 54 Notice of Appeal filed by Gavin Grimm. The court grants the motion to withdraw from further representation on appeal. (15-2056) (epri) (Entered: 08/18/2017)
08/18/2017	111	STATUS REPORT *Joint Position Statement* by Gavin Grimm. (Deady, Gail) (Entered: 08/18/2017)
08/22/2017	112	ORDER granting 109 , the Consent Motion to Amend/Correct the Complaint, as follows: the Clerk is DIRECTED to lodge the Plaintiff's Amended Complaint; the Defendant shall file a responsive pleading or motion on or before September 15, 2017. If Defendant files a motion to dismiss, the parties' respective memoranda in support and opposition shall not exceed forty-five pages, exclusive of affidavits and supporting documentation. All briefs shall otherwise comply with the requirements of this Court's Local Rules. Signed by District Judge Arenda L. Wright Allen on 8/22/2017. (Allen, Arenda) (Entered: 08/22/2017)
08/22/2017	113	AMENDED COMPLAINT FILED AS DIRECTED against Gloucester County School Board, filed by Gavin Grimm.(ecav,) (Entered: 08/22/2017)
08/30/2017	114	ORDER of USCA as to 54 Notice of Appeal filed by Gavin Grimm Upon consideration of the motion to dismiss this appeal pursuant to Rule 42(b) of the Federal Rules of Appellate Procedure, and there appearing no opposition, the court grants the motion. Entered at the direction of Judge Niemeyer with the concurrence of Judge Duncan and Judge Floyd. 15-2056(ldab,) (Entered: 08/30/2017)
08/30/2017	115	USCA Rule 42(b) Mandate re 54 Notice of Appeal. This court's order dismissing this appeal pursuant to Local Rule 42(b) takes effect today. This constitutes the formal mandate of this court issued pursuant to Rule 41(a) of the Federal Rules of Appellate Procedure. 15-2056 (ldab,) (Entered: 08/30/2017)
08/30/2017	116	MOTION for Extension *of Time to File Motion to Dismiss the Amended Complaint* by Gloucester County School Board. (Attachments: # 1 Proposed Order Agreed)(Corrigan, David) (Entered: 08/30/2017)
08/31/2017	117	ORDER granting 116 Defendant's agreed Motion for Extension of Time to File a Motion to Dismiss the Amended Complaint as follows: Defendant's Motion

		shall be filed on or before September 22, 2017. Signed by District Judge Arenda L. Wright Allen on 08/31/2017. (Allen, Arenda) (Entered: 08/31/2017)
09/22/2017	118	MOTION to Dismiss for Failure to State a Claim by Gloucester County School Board. (Corrigan, David) (Entered: 09/22/2017)
09/22/2017	119	Brief in Support to 118 MOTION to Dismiss for Failure to State a Claim filed by Gloucester County School Board. (Corrigan, David) (Entered: 09/22/2017)
09/29/2017	120	Memorandum in Opposition re 118 MOTION to Dismiss for Failure to State a Claim filed by Gavin Grimm. (Deady, Gail) (Entered: 09/29/2017)
10/02/2017	121	ORDER deferring ruling on 118 , the Motion to Dismiss for Failure to State a Claim; under the circumstances presented by counsel jointly in a communication to the Court, the Court shall permit Defendant to file its Reply brief on or before Wednesday, October 11, 2017. The motion will be taken under advisement as of that date. If a hearing is deemed warranted by the Court, the Court will notify counsel for purposes of scheduling the hearing after October 11, 2017. Signed by District Judge Arenda L. Wright Allen on 10/2/2017. (Allen, Arenda) (Entered: 10/02/2017)
10/11/2017	122	RESPONSE in Support re 118 MOTION to Dismiss for Failure to State a Claim filed by Gloucester County School Board. (Attachments: # 1 Exhibit A) (Corrigan, David) (Entered: 10/11/2017)
10/26/2017	123	ORDER - The parties are ORDERED to file supplemental briefing on mootness pursuant to the directives herein. A ruling on Defendant's Motion to Dismiss for Failure to State a Claim 118 is DEFERRED pending resolution of the mootness issue. Before undertaking any jurisdictional discovery, the party seeking to undertake discovery is ORDERED to file a motion for jurisdictional discovery no later than 14 calendar days after the date of the entry of this Order. Defendant shall file its Supplemental Memorandum no later than 60 calendar days after the date of the entry of this Order. Plaintiff shall file its Response no later than 21 calendar days after service of the Defendant's Memorandum. Defendant may file a Reply no later than 7 calendar days after the service of the Response. Briefs shall not exceed 35 pages, excluding exhibits. Signed by District Judge Arenda L. Wright Allen on 10/26/17. (bpet,) (Entered: 10/26/2017)
11/01/2017	124	NOTICE by Gavin Grimm *Supplemental Authority in Opposition to Defendant's Motion to Dismiss* (Attachments: # 1 Exhibit A)(Deady, Gail) (Entered: 11/01/2017)
11/02/2017	125	NOTICE by Gavin Grimm *Consent to Dismissal of Requests for Relief (C) and (D)* (Deady, Gail) (Entered: 11/02/2017)
11/02/2017	126	MOTION to Vacate 123 Order,,, by Gavin Grimm. (Deady, Gail) (Entered: 11/02/2017)
11/02/2017	127	ORDER of USCA as to 54 Notice of Appeal filed by Gavin Grimm. The court grants the motion to withdraw from further representation on appeal. (15-2056) (bpet,) (Entered: 11/03/2017)
11/16/2017	128	

		Opposition to 126 MOTION to Vacate 123 Order,,, filed by Gloucester County School Board. (Corrigan, David) (Entered: 11/16/2017)
11/17/2017	129	REPLY to Response to Motion re 126 MOTION to Vacate 123 Order,,, filed by Gavin Grimm. (Deady, Gail) (Entered: 11/17/2017)
11/20/2017	130	NOTICE by Gavin Grimm re 126 MOTION to Vacate 123 Order,,, *Oral Argument* (Deady, Gail) (Entered: 11/20/2017)
11/28/2017	131	NOTICE by Gavin Grimm re 118 MOTION to Dismiss for Failure to State a Claim *Supplemental Authority* (Attachments: # 1 Exhibit A)(Deady, Gail) (Entered: 11/28/2017)
12/12/2017	132	ORDER GRANTING 126 Motion to Vacate, DISMISSING Requests for Relief (C) and (D). Defendant shall file an amended Motion to Dismiss within 45 days of this Order. Plaintiff shall file a Response to same within 21 days, and Defendant may file a Reply 7 days thereafter. Signed by District Judge Arenda L. Wright Allen on 12/12/17. (bpet,) (Entered: 12/13/2017)
01/05/2018	133	NOTICE of Appearance by David P. Corrigan on behalf of Gloucester County School Board (Corrigan, David) (Entered: 01/05/2018)
01/05/2018	134	NOTICE of Appearance by Douglas Edward Pittman on behalf of Gloucester County School Board (Pittman, Douglas) (Entered: 01/05/2018)
01/05/2018	135	Amended MOTION to Dismiss for Failure to State a Claim *Amended Complaint* by Gloucester County School Board. (Pittman, Douglas) (Entered: 01/05/2018)
01/05/2018	136	Brief in Support to 135 Amended MOTION to Dismiss for Failure to State a Claim *Amended Complaint* filed by Gloucester County School Board. (Pittman, Douglas) (Entered: 01/05/2018)
01/09/2018	137	MOTION to Withdraw , MOTION to Withdraw as Attorney by Gloucester County School Board. (Attachments: # 1 Exhibit A)(Fisher, Maurice) (Entered: 01/09/2018)
01/09/2018	138	Brief in Support *of Motion to Withdraw as Attorney* filed by Gloucester County School Board. (Fisher, Maurice) (Entered: 01/09/2018)
01/10/2018	139	Memorandum in Opposition re 135 Amended MOTION to Dismiss for Failure to State a Claim *Amended Complaint* filed by Gavin Grimm. (Deady, Gail) (Entered: 01/10/2018)
01/16/2018	140	REPLY to Response to Motion re 135 Amended MOTION to Dismiss for Failure to State a Claim *Amended Complaint* filed by Gloucester County School Board. (Attachments: # 1 Exhibit A)(Corrigan, David) (Entered: 01/16/2018)
03/02/2018	141	ORDER of USCA as to 54 Notice of Appeal filed by Gavin Grimm. The court grants the motion to withdraw from further representation on appeal. [15-2056] (bpet) (Entered: 03/05/2018)
03/06/2018	142	NOTICE of Supplemental Authority by Gavin Grimm re 135 Amended MOTION to Dismiss for Failure to State a Claim *Amended Complaint*

		(Attachments: # 1 Exhibit A) (Deady, Gail) Dkt text modified on 3/6/2018 (bpet). (Entered: 03/06/2018)
03/09/2018	143	ORDER granting 137 , the Motion to Withdraw as Attorney filed by M. Scott Fisher, as follows: Mr. Fisher, counsel of record for Defendant Gloucester County School Board, is granted permission to withdraw from this matter as counsel. Defendant will continue to be represented in this matter by Harman Claytor Corrigan & Wellman and David Corrigan, Jeremy Capps, and Douglas Pittman of that firm, who are also counsel of record. Signed by District Judge Arenda L. Wright Allen on 3/9/2018. (Allen, Arenda) (Entered: 03/09/2018)
03/13/2018	144	NOTICE of Supplemental Authority by Gavin Grimm re 135 Amended MOTION to Dismiss for Failure to State a Claim *Amended Complaint* (Attachments: # 1 Exhibit A)(Deady, Gail) Dkt text modified on 3/13/2018 (bpet). (Entered: 03/13/2018)
04/23/2018	145	NOTICE of Appearance by Claire Guthrie Gastanaga on behalf of Gavin Grimm (Gastanaga, Claire) (Entered: 04/23/2018)
04/23/2018	146	MOTION to Withdraw as Attorney by Gavin Grimm. (Attachments: # 1 Proposed Order)(Deady, Gail) (Entered: 04/23/2018)
04/28/2018	147	ORDER granting 146 , the Motion to Withdraw as Attorney filed by Gail Deady, as follows: Ms. Deady, counsel of record for Plaintiff Gavin Grimm, is granted permission to withdraw from this matter as counsel. Plaintiff will continue to be represented in this matter by Claire Gastanaga of the American Civil Liberties Union Foundation of Virginia, Inc., and Joshua Block and Leslie Cooper of the American Civil Liberties Union Foundation, who are all counsel of record. Signed by District Judge Arenda L. Wright Allen on 4/28/2018. (Allen, Arenda) (Entered: 04/28/2018)
05/22/2018	148	ORDER denying 135 Amended Motion to Dismiss for Failure to State a Claim, DISMISSING as moot 118 Motion to Dismiss for Failure to State a Claim. Counsel for the parties are DIRECTED to contact the Magistrate Courtroom Deputy within 30 days to schedule a settlement conference. Signed by District Judge Arenda L. Wright Allen on 5/22/18. (bpet) (Entered: 05/22/2018)
06/01/2018	149	Consent MOTION for Leave to Appeal *to the United States Fourth Circuit Court of Appeals* by Gloucester County School Board. (Corrigan, David) (Entered: 06/01/2018)
06/01/2018	150	Brief in Support to 149 Consent MOTION for Leave to Appeal *to the United States Fourth Circuit Court of Appeals* filed by Gloucester County School Board. (Corrigan, David) (Entered: 06/01/2018)
06/04/2018	151	Joint MOTION to Stay *All Proceedings in this Case Pending Appeal and for an Extension of Time for the School Board to File an Answer to Grimm's Amended Complaint* by Gloucester County School Board. (Corrigan, David) (Entered: 06/04/2018)
06/04/2018	152	Brief in Support to 151 Joint MOTION to Stay *All Proceedings in this Case Pending Appeal and for an Extension of Time for the School Board to File an*

		Answer to Grimm's Amended Complaint filed by Gloucester County School Board. (Corrigan, David) (Entered: 06/04/2018)
06/05/2018	153	ORDER: Defendant's 149 Consent Motion to Certify an Interlocutory Appeal to the 4th Circuit Court of Appeals is GRANTED. The Court's 5/22/18 148 Order is AMENDED as described in the instant Order. The parties' 151 Joint Motion to Stay All Proceedings in this Case Pending Appeal and for an Extension of Time for the School Board to File an Answer to Plaintiff's Amended Complaint is GRANTED. It is ORDERED that all proceedings in this case are stayed pending a ruling by the Fourth Circuit, and Defendant's deadline to file an Answer to Plaintiff's Amended Complaint is extended to 10 days after the entry of such ruling. Signed by District Judge Arenda L. Wright Allen on 6/5/18. (bpet) (Entered: 06/05/2018)
07/20/2018	154	ANSWER to Complaint by Gloucester County School Board.(Corrigan, David) (Entered: 07/20/2018)
07/23/2018		Refer for 16(b). (bpet) (Entered: 07/23/2018)
07/31/2018		Set Hearings Settlement Conference set for 10/4/2018 at 09:30 AM in Norfolk Judges Chamber before Magistrate Judge Douglas E. Miller. (cdod,) (Entered: 07/31/2018)
07/31/2018	155	RULE 26(f) PRETRIAL ORDER: Rule 16(b) Scheduling Conference set for 9/17/2018 at 10:00 AM in Norfolk Courtroom 3. Signed by Magistrate Judge Robert J. Krask and filed on 7/31/18. (lhow) (Entered: 07/31/2018)
08/02/2018	156	Settlement Conference Order entered. Settlement conference scheduled for October 4, 2018 at 9:30 a.m. at the United States District Court in Norfolk. The parties must submit a brief memorandum of five pages or less directly to the chambers of the undersigned via facsimile by noon on October 1, 2018. See order for further details. Signed by Magistrate Judge Douglas E. Miller on 08/02/18. (jjon) (Entered: 08/02/2018)
09/11/2018	157	NOTICE of Appearance by Nicole Gloria Tortoriello on behalf of Gavin Grimm (Tortoriello, Nicole) (Entered: 09/11/2018)
09/11/2018	158	Motion to appear Pro Hac Vice by Eden Heilman and Certification of Local Counsel Nicole Gloria Tortoriello Filing fee $ 75, receipt number 0422-6266806. by Gavin Grimm. (Tortoriello, Nicole) (Main Document 158 replaced w/ ink-signed copy on 9/19/18) (bpet,). (Entered: 09/11/2018)
09/11/2018	159	Motion to appear Pro Hac Vice by Shayna Medley-Warsoff and Certification of Local Counsel Nicole Gloria Tortoriello Filing fee $ 75, receipt number 0422-6266816. by Gavin Grimm. (Tortoriello, Nicole) (Entered: 09/11/2018)
09/12/2018	160	MOTION to Withdraw as Attorney by Gavin Grimm. (Gastanaga, Claire) Motion terminated on 9/18/18 (bpet,). (Entered: 09/12/2018)
09/17/2018		Scheduling Conference - Rule 16b held on 9/17/2018. Eden Heilman appeared on behalf of the plaintiff. (pro hac application pending) (lhow) (Entered: 09/17/2018)
09/18/2018	161	

		MOTION to Withdraw as Attorney by Gavin Grimm. (Attachments: # 1 Proposed Order)(Gastanaga, Claire) (Entered: 09/18/2018)
09/19/2018	162	ORDER granting 161 , the Motion to Withdraw as Attorney as follows: Ms. Gastanaga, counsel of record for Gavin Grimm, is granted permission to withdraw from this matter as counsel. The Plaintiff has consented, and remains fully represented. Signed by District Judge Arenda L. Wright Allen on 9/19/2018. (Allen, Arenda) (Entered: 09/19/2018)
09/19/2018		Notice of Correction re 158 Motion to appear Pro Hac Vice by Eden Heilman: the filing user has been advised to resubmit 158 via email with the proper signatures, and the Clerk's Office will substitute it for the existing document. (bpet,) (Entered: 09/19/2018)
09/19/2018	163	ORDER granting 159 , the Motion to appear Pro Hac Vice by Shayna Medley-Warsoff as certified by local counsel Nicole Gloria Tortoriello for Gavin Grimm. Signed by District Judge Arenda L. Wright Allen on 9/19/2018. (Allen, Arenda) (Entered: 09/19/2018)
09/19/2018	164	ORDER granting 158 , the Motion to appear Pro Hac Vice by Eden Heilman as certified by local counsel Nicole Gloria Tortoriello for Gavin Grimm. Signed by District Judge Arenda L. Wright Allen on 9/19/2018. (Allen, Arenda) (Entered: 09/19/2018)
09/26/2018	165	Order Rule 16(b) Scheduling Order - Pursuant to the Rule 16(b) Conference it is ordered that Final Pretrial Conference set for 7/12/2019 at 11:00 AM at the courthouse in Norfolk. Jury Trial set for 7/23/2019 at 10:00 AM at the courthouse in Newport News. Signed by District Judge Arenda L. Wright Allen on 9/25/18 and filed on 9/26/18. (lhow) (Entered: 09/26/2018)
10/04/2018	166	SECOND SETTLEMENT CONFERENCE ORDER. Settlement conference scheduled for 10/18/18 at 10:00 a.m. in the **Richmond Courthouse**; any supplemental memoranda due by noon on 10/16/18; all other terms of the original 156 Settlement Conference Order remain in full force and effect; see Order for details. Signed by Magistrate Judge Douglas E. Miller on 10/4/18. (bpet,) (Entered: 10/04/2018)
10/18/2018		Settlement Conference held on 10/18/2018 before Magistrate Judge Douglas E. Miller. (lwoo) (Entered: 10/19/2018)
10/19/2018	167	ORDER Reassigning Case. Case reassigned to Magistrate Judge Robert J. Krask; Magistrate Judge Douglas E. Miller no longer assigned to case. Signed by Magistrate Judge Douglas E. Miller on 10/19/18. (bpet,) (Entered: 10/19/2018)
10/29/2018	168	Consent MOTION to Strike *Jury Demand and Set Case for Bench Trial* by Gavin Grimm. (Attachments: # 1 Proposed Order)(Tortoriello, Nicole) (Entered: 10/29/2018)
10/29/2018		MOTION REFERRED to Magistrate Judge Robert J. Krask: 168 Consent MOTION to Strike *Jury Demand and Set Case for Bench Trial*. (bpet,) (Entered: 10/29/2018)
10/29/2018	169	

		ORDER granting 168 Motion to Strike Jury Demand and Set Case for Bench Trial. Signed by Magistrate Judge Robert J. Krask on 10/29/18. (bpet,) (Entered: 10/29/2018)
10/29/2018		Bench Trial set for 7/23/2019 at 10:00 AM in Newport News Courtroom 1 before District Judge Arenda L. Wright Allen. (lhow) (Entered: 10/29/2018)
12/07/2018	170	MOTION for Leave to File *Second Amended Complaint* by Gavin Grimm. (Attachments: # 1 Exhibit A, # 2 Proposed Order)(Tortoriello, Nicole) (Entered: 12/07/2018)
12/21/2018	171	Memorandum in Opposition re 170 MOTION for Leave to File *Second Amended Complaint* filed by Gloucester County School Board. (Attachments: # 1 Exhibit A, # 2 Exhibit B)(Corrigan, David) (Entered: 12/21/2018)
12/27/2018	172	REPLY to Response to Motion re 170 MOTION for Leave to File *Second Amended Complaint* filed by Gavin Grimm. (Tortoriello, Nicole) (Entered: 12/27/2018)
02/13/2019	173	MOTION to Withdraw *as Counsel for Defendant* by Gloucester County School Board. (Attachments: # 1 Exhibit Proposed Order)(Pittman, Douglas) (Entered: 02/13/2019)
02/13/2019	174	Brief in Support to 173 MOTION to Withdraw *as Counsel for Defendant* filed by Gloucester County School Board. (Pittman, Douglas) (Entered: 02/13/2019)
02/14/2019	175	ORDER granting 173 , the Motion to Withdraw as Counsel for Defendant filed by Gloucester County School Board. Douglas E. Pittman is hereby granted leave to withdraw as counsel of record. Signed by District Judge Arenda L. Wright Allen on 2/14/2019. (Allen, Arenda) (Entered: 02/14/2019)
02/15/2019	176	ORDER granting 170 Motion for Leave to File *Second Amended Complaint*. The Clerk is DIRECTED to file the Second Amended Complaint. Signed by District Judge Arenda L. Wright Allen on 2/14/19. (bpet,) (Entered: 02/15/2019)
02/15/2019	177	SECOND AMENDED COMPLAINT against Gloucester County School Board, filed by Gavin Grimm. (bpet,) (Entered: 02/15/2019)
02/19/2019	178	MOTION for Extension *of Time to Serve Expert Disclosures* by Gloucester County School Board. (Capps, Jeremy) (Entered: 02/19/2019)
02/20/2019		MOTION REFERRED to Magistrate Judge Robert J. Krask: 178 MOTION for Extension *of Time to Serve Expert Disclosures*. (bpet,) (Entered: 02/20/2019)
02/21/2019	179	ORDER granting 178 Motion for Extension of Time to File expert disclosure by Gloucester County School Board. The defendant's expert disclosure responding to, contradicting, or rebutting plaintiff's expert disclosure shall be made on or before February 26, 2019. Signed by Magistrate Judge Robert J. Krask on 02/21/2019. (Krask, Robert) (Entered: 02/21/2019)
03/01/2019	180	ANSWER to Complaint *(Second Amended)* by Gloucester County School Board.(Corrigan, David) (Entered: 03/01/2019)
03/07/2019	181	

		NOTICE of Appearance by Jennifer Marie Safstrom on behalf of Gavin Grimm (Safstrom, Jennifer) (Entered: 03/07/2019)
03/19/2019	182	Consent MOTION for Leave to File Excess Pages by Gavin Grimm. (Attachments: # 1 Proposed Order)(Heilman, Eden) (Entered: 03/19/2019)
03/19/2019	183	ORDER granting 182 , Plaintiff's consent motion for leave to file summary judgment briefs in excess of the thirty-page limit on briefs imposed by Local Civil Rule 7(F)(3) as follows: for good cause shown, briefs filed in support of summary judgment, in opposition of summary judgment, and in reply shall be subject to a sixty-page limit. Signed by District Judge Arenda L. Wright Allen on 3/192019. (Allen, Arenda) (Entered: 03/19/2019)
03/26/2019	184	MOTION for Summary Judgment by Gavin Grimm. (Attachments: # 1 Proposed Order)(Heilman, Eden) (Entered: 03/26/2019)
03/26/2019	185	Memorandum in Support re 184 MOTION for Summary Judgment filed by Gavin Grimm. (Heilman, Eden) (Entered: 03/26/2019)
03/26/2019	186	EXHIBIT *1 Declaration of Gavin Grimm* re 185 Memorandum in Support by Gavin Grimm. (Attachments: # 1 Exhibit A - Treatment Documentation Letter (Redacted), # 2 Exhibit B - DMV, # 3 Exhibit C - Court Order (Redacted), # 4 Exhibit D - Birth Certificate (Redacted), # 5 Exhibit E - Transcript (Redacted)) (Heilman, Eden) Modified on 3/27/19 (bpet,) (Entered: 03/26/2019)
03/26/2019	187	EXHIBIT *2 Declaration of Deirdre Grimm* re 185 Memorandum in Support by Gavin Grimm.. (Heilman, Eden) Modified on 3/27/19 (bpet,) (Entered: 03/26/2019)
03/26/2019	188	MOTION Leave to File Brief in Support of Plaintiff *Unopposed Motion of Amicus Curiae Fairfax County School Board and Other Virginia School Boards for Leave to File Brief in Support of Plaintiff* by Fairfax County School Board, Alexandria City School Board, Arlington School Board, Falls Church City School Board. (Attachments: # 1 Proposed Amicus Brief, # 2 Proposed Order)(Cox, Trevor) (Entered: 03/26/2019)
03/26/2019	189	NOTICE of Appearance by Trevor Stephen Cox on behalf of Fairfax County School Board, Alexandria City School Board, Arlington School Board, Falls Church City School Board (Cox, Trevor) (Entered: 03/26/2019)
03/26/2019	190	NOTICE of Appearance by Stuart Alan Raphael on behalf of Fairfax County School Board, Alexandria City School Board, Arlington School Board, Falls Church City School Board (Raphael, Stuart) (Entered: 03/26/2019)
03/26/2019	191	MOTION for Summary Judgment by Gloucester County School Board. (Corrigan, David) (Entered: 03/26/2019)
03/26/2019	192	EXHIBIT *3 Declaration of Shayna Medley-Warsoff* re 185 Memorandum in Support by Gavin Grimm. (Attachments: # 1 Exhibit 1 - Def.'s Response to First Set of Interrogatories, # 2 Exhibit 2 - Def.'s Supplemental Response to First Set of Interrogatories, # 3 Exhibit 3 - Penn Expert Rep. & Decl., # 4 Exhibit 4 - Penn CV, # 5 Exhibit 5 - WPATH Standards of Care, # 6 Exhibit 6 - Endocrine Society Guidelines, # 7 Exhibit 7 - Van Meter Expert Rep., # 8 Exhibit 8 - Penn Rebuttal Rep., # 9 Exhibit 9 - Collins Dep., # 10 Exhibit 10 -

		Clemons Dep., # 11 Exhibit 11 - Durr Dep., # 12 Exhibit 12 - Lord Dep., # 13 Exhibit 13 - Anderson Dep., # 14 Exhibit 14 - Van Meter Dep., # 15 Exhibit 15 - Collins memo dated 10/14/2014 (GCSB 894), # 16 Exhibit 16 - Clemons email dated 10/22/14 (WAVYTVFOIA 007), # 17 Exhibit 17 - Collins memo dated 10/23/14 (GCSB 4122), # 18 Exhibit 18 - Hook email dated 10/24/14 (GCSB-0854), # 19 Exhibit 19 - Hook email dated 10/31/14 (GCSB 0844), # 20 Exhibit 20 - Hook email to Board dated 11/4/14 (GCSB 0513), # 21 Exhibit 21 - Hook email to the Board dated 11/9/14 with attachment (GCSB 0507-08), # 22 Exhibit 22 - Press Release dated 12/3/14, # 23 Exhibit 23 - Recorded Minutes of the Gloucester County School Board, December 9, 2014, # 24 Exhibit 24 - Collins memo to Deirdre and David Grimm dated 12/10/2014 (GCSB 0893), # 25 Exhibit 25 - Email to Nate Collins dated 11/19/2014 (GCSB 3932), # 26 Exhibit 26 - Gavin transcript GCSB, # 27 Exhibit 27 - VSBA Presentation, # 28 Exhibit 28 - Map of Gloucester High School 17 (GCSB 1276), # 29 Exhibit 29 - Annotated Map of GHS, # 30 Exhibit 30 - List of Restrooms at GHS (GCSB 03944), # 31 Exhibit 31 - Ltr. from J. Block to D. Corrigan dated 12/23/16, # 32 Exhibit 32 - Ltr. from D. Corrigan to J. Block dated 1/18/17, # 33 Exhibit 33 - Ltr. from J. Block to D. McNerney dated 1/18/17, # 34 Exhibit 34 - Ltr. from K. Duncan to D. McNerney dated 1/19/17, # 35 Exhibit 35 - Press Release dated 02/13/2019, # 36 Exhibit 36 - Press Release dated 02/21/2019, # 37 Exhibit 37 - Recorded Minutes of the Gloucester County School Board, November 11, 2014, # 38 Exhibit 38 - AAP Amicus, # 39 Exhibit 39 - School Administrator Amicus, # 40 Exhibit 40 - Nat'l PTA Amicus, # 41 Exhibit 41 - APA & NASP Resolution, # 42 Exhibit 42 - Gender Spectrum Frequently Asked Questions (2016), # 43 Exhibit 43 - NASSP Statement)(Heilman, Eden) Modified on 3/27/19 (bpet,) (Entered: 03/26/2019)
03/26/2019	193	EXHIBIT *4 Declaration of Diana Bruce* re 185 Memorandum in Support by Gavin Grimm. (Heilman, Eden) Modified on 3/27/19 (bpet,) (Entered: 03/26/2019)
03/26/2019	194	EXHIBIT *5 Declaration of Thomas Aberli* re 185 Memorandum in Support by Gavin Grimm. (Heilman, Eden) Modified on 3/27/19 (bpet,) (Entered: 03/26/2019)
03/26/2019	195	EXHIBIT *6 Declaration of Janet M. Rainey* re 185 Memorandum in Support by Gavin Grimm. (Heilman, Eden) Modified on 3/27/19 (bpet,) (Entered: 03/26/2019)
03/26/2019	196	Brief in Support to 191 MOTION for Summary Judgment filed by Gloucester County School Board. (Attachments: # 1 Exhibit 1, # 2 Exhibit A, # 3 Exhibit B, # 4 Exhibit C, # 5 Exhibit D, # 6 Exhibit E, # 7 Exhibit F, # 8 Exhibit G, # 9 Exhibit H, # 10 Exhibit I, # 11 Exhibit J, # 12 Exhibit K, # 13 Exhibit L, # 14 Exhibit M, # 15 Exhibit N, # 16 Exhibit O)(Corrigan, David) (Entered: 03/26/2019)
03/26/2019	197	EXHIBIT *7 Declaration of James H. Loving* re 185 Memorandum in Support by Gavin Grimm. (Attachments: # 1 Exhibit A - 1st multi user 1, # 2 Exhibit B - 1st multi user 2, # 3 Exhibit C - 1st multi user 3, # 4 Exhibit D - 2nd multi user 1, # 5 Exhibit E - 2nd multi user 2, # 6 Exhibit F - 2nd multi user 3, # 7

		Exhibit G - 2nd multi user 4, # 8 Exhibit H - single user 1, # 9 Exhibit I - single user 2, # 10 Exhibit J - single user 3, # 11 Exhibit K - single user 4, # 12 Exhibit L - single user 5)(Heilman, Eden) Modified on 3/27/19 (bpet,) (Entered: 03/26/2019)
03/27/2019		Notice of Correction re 186 , 187 , 192 , 193 , 194 , 195 , 197 Exhibits: The exhibits are not linked back to the document to which they refer. Additionally, to the extent possible, exhibits should filed as attachments to the document they support. In the event that exhibits are too numerous to be contained in one docket entry, they should be filed as attachments to a Notice of Submission bearing the signature of the filing user, as outlined in the ECF Policies and Procedures Manual. The filing user has been advised to note same for future reference. No further action is required at this time. (bpet,) (Entered: 03/27/2019)
03/27/2019	198	ORDER granting 188 , the Unopposed Motion of Amici Curiae for Leave to File Brief in Support of Plaintiff, filed by Fairfax County School Board and other Virginia school boards. The Clerk is directed to please file the proposed amicus brief, ECF No. 188-1. Signed by District Judge Arenda L. Wright Allen on 3/27/2019. (Allen, Arenda) (Entered: 03/27/2019)
03/27/2019	199	Amicus Brief by Fairfax County School Board, Alexandria City School Board, Arlington School Board, Falls Church City School Board. (bpet,) (Entered: 03/27/2019)
04/09/2019	200	RESPONSE in Opposition re 184 MOTION for Summary Judgment filed by Gloucester County School Board. (Attachments: # 1 Exhibit 1 - Index of Exhibits, # 2 Exhibit A, # 3 Exhibit B, # 4 Exhibit C, # 5 Exhibit D, # 6 Exhibit E, # 7 Exhibit F, # 8 Exhibit G, # 9 Exhibit H, # 10 Exhibit I, # 11 Exhibit J, # 12 Exhibit K, # 13 Exhibit L, # 14 Exhibit M, # 15 Exhibit N, # 16 Exhibit O, # 17 Exhibit P)(Corrigan, David) (Entered: 04/09/2019)
04/09/2019	201	RESPONSE in Opposition re 191 MOTION for Summary Judgment filed by Gavin Grimm. (Attachments: # 1 Exhibit 1, # 2 Exhibit A, # 3 Exhibit B, # 4 Exhibit C, # 5 Exhibit D, # 6 Exhibit E)(Heilman, Eden) (Entered: 04/09/2019)
04/15/2019	202	REPLY to Response to Motion re 191 MOTION for Summary Judgment filed by Gloucester County School Board. (Attachments: # 1 List of Exhibits, # 2 Exhibit A, # 3 Exhibit B, # 4 Exhibit C, # 5 Exhibit D, # 6 Exhibit E, # 7 Exhibit F, # 8 Exhibit G, # 9 Exhibit H, # 10 Exhibit I, # 11 Exhibit J) (Corrigan, David) (Entered: 04/15/2019)
04/16/2019	203	REPLY to Response to Motion re 184 MOTION for Summary Judgment filed by Gavin Grimm. (Attachments: # 1 Exhibit 1, # 2 Exhibit A, # 3 Exhibit B, # 4 Exhibit C, # 5 Exhibit D, # 6 Exhibit E)(Heilman, Eden) (Entered: 04/16/2019)
04/16/2019	204	MOTION to Seal by Gavin Grimm. (Attachments: # 1 Proposed Order) (Heilman, Eden) (Entered: 04/16/2019)
04/16/2019	205	Notice of Filing Sealing Motion LCvR5(C) by Gavin Grimm re 204 MOTION to Seal (Heilman, Eden) (Entered: 04/16/2019)

04/16/2019	206	Sealed Attachment/Exhibit(s) B re 204 MOTION to Seal . (Heilman, Eden) (Entered: 04/16/2019)
04/16/2019	207	Sealed Attachment/Exhibit(s) C re 204 MOTION to Seal . (Heilman, Eden) (Entered: 04/16/2019)
04/16/2019	208	Sealed Attachment/Exhibit(s) D re 204 MOTION to Seal . (Attachments: # 1 Supplement Continuation of Sealed Filing, # 2 Supplement Continuation of Sealed Filing)(Heilman, Eden) (Entered: 04/16/2019)
04/16/2019	209	Sealed Attachment/Exhibit(s) E re 204 MOTION to Seal . (Heilman, Eden) (Entered: 04/16/2019)
04/16/2019	210	Memorandum in Support re 204 MOTION to Seal filed by Gavin Grimm. (Heilman, Eden) (Entered: 04/16/2019)
04/19/2019	211	RESPONSE to Motion re 204 MOTION to Seal filed by Gloucester County School Board. (Capps, Jeremy) (Entered: 04/19/2019)
04/22/2019	212	ORDER granting 204 Motion to Seal. Signed by Magistrate Judge Robert J. Krask on 4/22/19. (bpet,) (Entered: 04/22/2019)
04/30/2019	213	MOTION to Exclude *and Strike Exhibits Filed with Gavin Grimm's Motion for Summary Judgment and Reply in Support of Motion for Summary Judgment* by Gloucester County School Board. (Corrigan, David) (Entered: 04/30/2019)
04/30/2019	214	Brief in Support to 213 MOTION to Exclude *and Strike Exhibits Filed with Gavin Grimm's Motion for Summary Judgment and Reply in Support of Motion for Summary Judgment* filed by Gloucester County School Board. (Attachments: # 1 List of Exhibits, # 2 Exhibit A, # 3 Exhibit B)(Corrigan, David) (Entered: 04/30/2019)
05/01/2019	215	Request for Hearing by Gloucester County School Board re 191 MOTION for Summary Judgment , 213 MOTION to Exclude *and Strike Exhibits Filed with Gavin Grimm's Motion for Summary Judgment and Reply in Support of Motion for Summary Judgment*, 184 MOTION for Summary Judgment (Corrigan, David) (Entered: 05/01/2019)
05/06/2019	216	Memorandum in Opposition re 213 MOTION to Exclude *and Strike Exhibits Filed with Gavin Grimm's Motion for Summary Judgment and Reply in Support of Motion for Summary Judgment* filed by Gavin Grimm. (Safstrom, Jennifer) (Entered: 05/06/2019)
05/13/2019	217	RESPONSE in Support re 213 MOTION to Exclude *and Strike Exhibits Filed with Gavin Grimm's Motion for Summary Judgment and Reply in Support of Motion for Summary Judgment* filed by Gloucester County School Board. (Corrigan, David) (Entered: 05/13/2019)
05/21/2019	218	ORDER deferring ruling on 184 the Motion for Summary Judgment filed by Plaintiff, and the other pending motions; oral argument will be heard on these motions at 9 AM on Tuesday, July 23, 2019 in Norfolk. The trial date of July 23, 2019, the Pretrial Conference previously set for July 12, 2019, and all trial document filing deadlines are stricken, and will be rescheduled if necessary

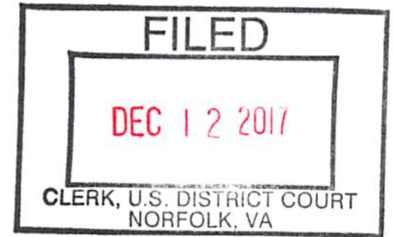
		after the pending motions are resolved. Signed by District Judge Arenda L. Wright Allen on 5/21/2019. (Allen, Arenda) (Entered: 05/21/2019)
05/21/2019	219	ORDER deferring ruling on 191 the Motion for Summary Judgment filed by the Defendant, as well as the other pending motions; oral argument will be heard on these motions at 9 AM on Tuesday, July 23, 2019 in Norfolk. The trial date of July 23, 2019, the Pretrial Conference previously set for July 12, 2019, and all trial document filing deadlines are stricken, and will be rescheduled if necessary after the pending motions are resolved. Signed by District Judge Arenda L. Wright Allen on 5/21/2019. (Allen, Arenda) (Entered: 05/21/2019)
05/21/2019	220	ORDER deferring ruling on 213 the Motion to Strike Exhibits filed by Defendant, as well as the other pending motions; oral argument will be heard on these motions at 9 AM on Tuesday, July 23, 2019 in Norfolk. The trial date of July 23, 2019, the Pretrial Conference previously set for July 12, 2019, and all trial document filing deadlines are stricken, and will be rescheduled if necessary after the pending motions are resolved. Signed by District Judge Arenda L. Wright Allen on 5/21/2019. (Allen, Arenda) (Entered: 05/21/2019)
05/24/2019	221	MOTION to Stay by Gloucester County School Board. (Corrigan, David) (Entered: 05/24/2019)
05/24/2019	222	Brief in Support to 221 MOTION to Stay filed by Gloucester County School Board. (Corrigan, David) (Entered: 05/24/2019)
05/31/2019	223	Memorandum in Opposition re 221 MOTION to Stay filed by Gavin Grimm. (Heilman, Eden) (Entered: 05/31/2019)
06/06/2019	224	REPLY Brief in Support re 221 MOTION to Stay filed by Gloucester County School Board. (Corrigan, David) Modified docket text on 6/6/2019 (jrin). (Entered: 06/06/2019)
06/18/2019	225	NOTICE of Supplemental Authority by Gavin Grimm re 201 Response in Opposition to Motion, 223 Memorandum in Opposition, 184 MOTION for Summary Judgment. (Attachments: # 1 Exhibit A)(Heilman, Eden) Modified text on 6/18/19 (bpet,) (Entered: 06/18/2019)
06/21/2019	226	ORDER denying 221 Motion to Stay. Signed by District Judge Arenda L. Wright Allen on 6/21/19. (bpet,) (Entered: 06/21/2019)
07/23/2019	228	Motions Hearing held before District Judge Arenda L. Wright Allen on 7/23/2019 re 184 MOTION for Summary Judgment 191 MOTION for Summary Judgment 213 MOTION to Exclude. Joshua Block, Nicole Tortoriello, Eden Heilman, Jennifer Safstrom and Shayna Medley-Warsoff present on behalf of the plaintiff. David Corrigan and Jeremy Capps present on behalf of the defendant. Arguments of counsel heard. Court to take the matter under advisement. (Court Reporter Jody Stewart.)(lhow) (Entered: 07/23/2019)
08/09/2019	229	ORDER. The Board's 213 Motion to Strike Exhibits is GRANTED IN PART andDENIED IN PART. Gavin Grimm's 184 Motion for Summary Judgment isGRANTED. The Board's 191 Motion for Summary Judgment is DENIED.

		Signed by District Judge Arenda L. Wright Allen on 8/9/19. (bpet,) (Entered: 08/09/2019)
08/09/2019	230	CLERK'S JUDGMENT. Signed by Clerk on 8/9/19. (bpet,) (Entered: 08/09/2019)
08/16/2019	231	Joint MOTION to Defer Filing of Bill of Costs and Petition for Fees by Gavin Grimm. (Heilman, Eden) (Entered: 08/16/2019)
08/19/2019	232	ORDER granting 231 , the Joint Motion to Defer Filing of Bill of Costs and Petition for Fees filed by Gavin Grimm, as follows: Plaintiff shall file his bill of costs and petition for fees within twenty-one days after the United States Court of Appeals for the Fourth Circuit issues its mandate on appeal. Signed by District Judge Arenda L. Wright Allen on 8/19/2019. (Allen, Arenda) (Entered: 08/19/2019)
08/21/2019	233	MOTION to Withdraw as Attorney *Shayna Medley-Warsoff* by Gavin Grimm. (Attachments: # 1 Proposed Order)(Heilman, Eden) (Entered: 08/21/2019)
08/22/2019	234	ORDER granting 233 , the Motion to Withdraw as Attorney filed by Shayna Medley-Warsoff for Gavin Grimm. Ms. Medley-Warsoff is terminated as counsel of record in this matter. Signed by District Judge Arenda L. Wright Allen on 8/22/2019. (Allen, Arenda) (Entered: 08/22/2019)
08/30/2019	235	NOTICE OF APPEAL by Gloucester County School Board. Filing fee $ 505, receipt number 0422-6814437. (Corrigan, David) (Entered: 08/30/2019)
08/30/2019	236	Transmission of Notice of Appeal to US Court of Appeals re 235 Notice of Appeal (All case opening forms, plus the transcript guidelines, may be obtained from the Fourth Circuit's website at www.ca4.uscourts.gov). (Attachments: # 1 Notice of Appeal) (bpet,) (Entered: 08/30/2019)
09/03/2019	237	USCA Case Number 19-1952, 4CCA Case Manager Cathi Bennett for 235 Notice of Appeal filed by Gloucester County School Board. [19-1952] (bpet,) (Entered: 09/03/2019)
09/27/2019	238	TRANSCRIPT of proceedings held on 7-23-2019, before Judge Arenda W. Allen, Court Reporter/Transcriber Jody Stewart, Telephone number 757-222-7071. **NOTICE RE REDACTION OF TRANSCRIPTS:The parties have thirty(30) calendar days to file with the Court a Notice of Intent to Request Redaction of this transcript. If no such Notice is filed, the transcript will be made remotely electronically available to the public without redaction after 90 calendar days. The policy is located on our website at www.vaed.uscourts.gov. Transcript may be viewed at the court public terminal or purchased through the court reporter/transcriber before the deadline for Release of Transcript Restriction. After that date it may be obtained through PACER Redaction Request due 10/28/2019. Redacted Transcript Deadline set for 11/27/2019. Release of Transcript Restriction set for 12/26/2019.(stewart, jody) (Entered: 09/27/2019)**

PACER Service Center

Transaction Receipt

10/16/2019 10:34:54			
PACER Login:	HarmanClay1:2559815:0	**Client Code:**	0203.0276
Description:	Docket Report	**Search Criteria:**	4:15-cv-00054-AWA-RJK
Billable Pages:	20	**Cost:**	2.00



UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM,

Plaintiff,

v.

GLOUCESTER COUNTY SCHOOL BOARD,

Defendant.

Civil No. 4:15-cv-54

ORDER

Currently before this Court are Plaintiff Gavin Grimm's Motion to Vacate Order for Supplemental Briefing and Plaintiff's Notice of Consent to Dismissal of Requests for Relief (C) and (D). ECF Nos. 125, 126. For the reasons stated herein, the Court dismisses Requests for Relief (C) and (D) in the Amended Complaint (ECF No. 113 at 17), and vacates its October 26, 2017 Order directing Supplemental Briefing (ECF No. 123).

I. BACKGROUND

The Court has recounted the procedural history of this case. *See* ECF No. 123 at 1–2.[1] On August 22, 2017, Plaintiff filed an Amended Complaint, alleging claims under Title IX of the

[1] Plaintiff Gavin Grimm, a transgender male teenager, commenced this action against the Gloucester County School Board in July 2015, alleging that the School Board's policy of assigning students to restrooms based on their biological sex violated Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681(a) and the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution. In September 2015, another judge of this Court issued a Memorandum Opinion and Order that (1) dismissed Grimm's claim under Title IX for failure to state a claim, and (2) denied his Motion for a Preliminary Injunction based on alleged violations of Title IX and the Equal Protection Clause. *G.G. ex rel. Grimm v. Gloucester Cty. Sch. Bd.*, 132 F. Supp. 3d 736, 753 (E.D. Va. 2015).

An interlocutory appeal of those decisions followed, which led to an appellate review process by the United States Court of Appeals for the Fourth Circuit and the United States Supreme Court that lasted nearly two years. *Grimm v. Gloucester Cty. Sch. Bd.*, No. 15-2056, slip op. at 5–6 (4th Cir. Aug. 2, 2017). During this time, the district court case was re-assigned to the undersigned. In August 2017, the

Education Amendments of 1972, 20 U.S.C. § 1681(a), and under the Equal Protection Clause of the Fourteenth Amendment. ECF No. 113. The Amended Complaint sought: (1) a retrospective declaratory judgment and nominal damages, and (2) a prospective declaratory judgment and permanent injunctive relief. *Id.* at 17. Subsequently, Defendant filed a Motion to Dismiss pursuant to Federal Rule of Civil Procedure 12(b)(6). ECF No. 118.

After the parties briefed the Motion to Dismiss, this Court issued an Order advising the parties that Plaintiff's graduation from high school raised threshold jurisdictional issues related to mootness. The Court further advised the parties that to the extent that the Motion to Dismiss questioned whether the case still presented a justiciable controversy, the Court would construe the Motion to Dismiss as brought pursuant to Rule 12(b)(1). The Court then ordered supplemental briefing regarding mootness. ECF No. 123. In response to the Court's Order, Plaintiff filed the Motions currently before the Court.

II. ANALYSIS

A. Plaintiff's Notice of Consent to Dismissal of Requests for Relief (C) and (D)

With respect to Plaintiff's Notice of Consent to Dismissal of Requests for Relief (C) and (D), Plaintiff has advised the Court that "[c]ontinuing to pursue claims for prospective

---

Fourth Circuit was again presented with the parties' original appeal of the September 2015 Memorandum Opinion and Order. *Id.* at 6.

During the pendency of the appeal, a potential mootness issue arose when Plaintiff graduated from high school. On August 2, 2017, the Fourth Circuit issued an Order remanding the case to this Court for a finding on the question of mootness and to develop a factual record on this issue. *Id.* at 6–8. This Court ordered the parties to submit a Joint Position Statement proposing procedures for developing this factual record and conducting proceedings on remand. ECF No. 108.

In their Joint Position Statement, the parties advised that they had filed a stipulation to voluntarily dismiss Plaintiff's interlocutory appeal regarding the Preliminary Injunction. ECF No. 111. Because of this, they believed that "there will be no need for additional fact-finding to determine whether the motion for preliminary injunction has become moot." *Id.* Instead, parties proposed that this Court grant Plaintiff's Motion to Amend the Complaint and set a schedule allowing Defendant to file a motion to dismiss. ECF Nos. 109, 111. This Court considered the Joint Position Statement, the record, and the history of the litigation, and granted the Consent Motion, allowing the parties to proceed with briefing in accordance with their proposed schedule. ECF No. 112.

declaratory and injunctive relief would require the parties and the court to expend time and resources resolving factual questions that would delay and distract from the central legal question of whether Defendant violated [Plaintiff's] rights under Title IX and the Fourteenth Amendment while he was a student at Gloucester High School." ECF No. 125 at 2. Accordingly, the parties consent to dismissal of Requests for Relief (C) and (D), and ask that the Court dismiss such Requests pursuant to Federal Rule of Civil Procedure 12(b)(1). *Id.* at 3. Based on parties' consent, the Court DISMISSES Requests for Relief (C) and (D), which seek a permanent injunction and a prospective declaratory judgment (ECF No. 113 at 17).

B. Plaintiff's Motion to Vacate Order for Supplemental Briefing

The dismissals of the requests for prospective declaratory relief leave Requests for Relief (A) and (B), which seek retrospective relief. Plaintiff has advised that these remaining requests should not be subject to mootness challenges, but may be subject to dismissal pursuant to Federal Rule of Civil Procedure 12(b)(6). ECF No. 126 at 2.

Plaintiff argues that his graduation did not moot his request for nominal damages. "Even if a plaintiff's injunctive relief claim has been mooted, the action is not moot if the plaintiff may be 'entitled to at least nominal damages.'" *Rendelman v. Rouse*, 569 F.3d 182, 187 (4th Cir. 2009) (quoting *Covenant Media of S.C., LLC v. City of N. Charleston*, 493 F.3d 421, 429 n.4 (4th Cir. 2007)).

Plaintiff also argues that his request for a retrospective declaratory judgment is not moot because this request is intertwined with the damages claim. A "plaintiff's request for declaratory relief is not moot [when] his 'damages claim is contingent upon a finding by the court that the [complained of activity] is unconstitutional.'" *Marks v. City Council of City of Chesapeake, Va.*,

723 F. Supp. 1155, 1160 (E.D. Va. 1988) (second brackets in original), *aff'd* 883 F.2d 308 (4th Cir. 1989).

Defendant responds by acknowledging that "a claim is not moot when there is a claim for compensatory damages *and* nominal damages pending such that the plaintiff could at a minimum recover nominal damages." ECF No. 128 at 3 (emphasis added). However, Defendant argues, because Plaintiff only seeks nominal damages in relation to his request for retroactive declaratory relief, but does not seek compensatory damages, Plaintiff's case should be declared moot. *Id.*

"When students challenge the constitutionality of school policies, their claims for declaratory and injunctive relief generally become moot when they graduate." *Mellen v. Bunting*, 327 F.3d 355, 364 (4th Cir. 2003) (internal citations omitted). After a student has graduated, "a case or controversy no longer exists between [the parties] with respect to the validity of the rules at issue." *Bd. of Sch. Comm'rs v. Jacobs*, 420 U.S. 128, 129 (1975) (per curiam).

However, claims for damages may continue to present a live controversy. *Id.* at 365. That is, "even if a plaintiff's injunctive relief claim has been mooted, the action is not moot if the plaintiff may be 'entitled to at least nominal damages.'" *Rendelman*, 569 F.3d at 187. To be awarded nominal damages, a plaintiff need only show that a constitutional deprivation occurred, not proof of actual injury. *Chapin Furniture Outlet Inc. v. Town of Chapin*, 252 Fed. App'x 566, 572 (4th Cir. 2007).

The decision in *Mellen* is particularly instructive on this point. In *Mellen*, cadets at the Virginia Military Institute filed a complaint alleging that the Institute's supper prayer violated federal and state constitutions and the Virginia Act for Religious Freedom. The cadets sought

declaratory and injunctive relief, as well as nominal damages. 327 F.3d at 363. The district court entered summary judgment in favor of the cadets, awarding declaratory relief and enjoining the defendant from sponsoring the supper prayer. However, as to the request for monetary damages, the district court concluded that the defendant was entitled to qualified immunity. The parties then filed cross-appeals. *Id.*

On appeal, the Fourth Circuit considered whether the case had become moot because the plaintiffs no longer attended the Institute. *Id.* The Fourth Circuit concluded that although the former cadets' claims for declaratory and injunctive relief were moot, "their damage claim"—that is, their claim for *nominal* damages—"continue[d] to present a live controversy." *Id.* at 365 (citing *Doe v. Madison Sch. Dist. No. 321*, 177 F.3d 789, 798 (9th Cir. 1999)).

Furthermore, "to the extent that . . . resolution [of a claim for declaratory relief] determines liability for damages to redress injuries alleged and proven," a plaintiff's claim for declaratory relief is not necessarily moot. *See Marks*, 723 F. Supp. at 1159 (citing *City of Cleburne, Tex. v. Cleburne Living Center*, 473 U.S. 432 n.7 (1985); *Lane v. Reid*, 559 F. Supp. 1047, 1048–51 (S.D.N.Y. 1983)). Accordingly, the Court finds that because Plaintiff's claim for damages rests upon a determination of the constitutionality of the complained-of action, his claim for retrospective declaratory relief is not moot. *See Powell v. McCormack*, 395 U.S. 486 (1969). That is, "this Court must decide the constitutional issue in order to make possible a decision on [plaintiff's] damages claim." *Marks*, 723 F. Supp. at 1160 (citing *Shifrin v. Wilson*, 412 F. Supp. 1282, 1292 (D.D.C. 1976)).

This Court concludes that Plaintiff's graduation did not moot either his request for nominal damages for the School Board's alleged past violations of his rights under Title IX and the Equal Protection Clause or his request for a declaratory judgment regarding these alleged

violations. This Court has jurisdiction over this case to the extent that Plaintiff seeks a retrospective declaratory judgment and nominal damages for past alleged violations of Title IX and the Equal Protection Clause. Defendant's Motion to Dismiss pursuant to Rule 12(b)(6) will be taken under advisement after additional briefing.

III. CONCLUSION

For the reasons stated herein, the Consent Motion for Dismissal of Requests for Relief (C) and (D) (ECF No. 125) and Plaintiff's Motion to Vacate Order for Supplemental Briefing (ECF No. 126) are GRANTED. Accordingly, Requests for Relief (C) and (D) of Plaintiff's Amended Complaint (ECF No. 113) are DISMISSED. The October 26, 2017 Order (ECF No. 123) directing the parties to file supplemental briefing on the question of mootness is VACATED.

The parties are DIRECTED to file amended briefing regarding Defendant's Motion to Dismiss (ECF No. 118) as follows: Defendant shall file an amended Motion to Dismiss regarding the remaining Requests for Relief no later than forty-five days after the date of entry of this Order. Plaintiff shall file a Response no later than twenty-one days after service of Defendant's amended Motion. Defendant may file a Reply no later than seven days after service of the Response.

IT IS SO ORDERED.

/s/
Arenda L. Wright Allen
United States District Judge

December 12th, 2017
Norfolk, Virginia

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM,

Plaintiff,

v.

GLOUCESTER COUNTY SCHOOL BOARD,

Defendant.

Civil No. 4:15cv54

ORDER

Pending before the Court is an Amended Motion to Dismiss pursuant to Federal Rule of Civil Procedure 12(b)(6) (ECF No. 135) filed by Defendant Gloucester County School Board ("Defendant" or "the Board"). For reasons set forth herein, the Motion is DENIED.

I. FACTUAL AND PROCEDURAL BACKGROUND

When ruling on a motion to dismiss for failure to state a claim, courts accept a complaint's well-pled factual allegations as true, and draw any reasonable inferences in favor of the plaintiff. *See Wag More Dogs, LLC v. Cozart*, 680 F.3d 359, 365 (4th Cir. 2012). Accordingly, the Court reviews the facts as alleged by Plaintiff Gavin Grimm ("Plaintiff" or "Mr. Grimm"). *See* Am. Compl., ECF No. 113.

Mr. Grimm is an eighteen-year-old man who attended Gloucester High School, a public school in Gloucester County, Virginia, from September 2013 through his graduation in June 2017. *Id.* ¶¶ 1, 79. When Mr. Grimm was born, hospital staff identified him as female. *Id.* ¶ 17. However, Mr. Grimm has known from a young age that he has a male gender identity—that is, he has a "deeply felt, inherent sense of being a boy, a man, or male," rather than a sense of being

"a girl, a woman, or a female." *Id.* ¶ 18. Because his gender identity differs from the sex assigned to him at birth, he is transgender. *Id.* ¶¶ 17–19.

Like many of his transgender peers, after the onset of puberty, Mr. Grimm began suffering from "debilitating levels of distress" as the result of gender dysphoria, "a condition in which transgender individuals experience persistent and clinically significant distress caused by the incongruence between their gender identity and the sex assigned to them at birth." *Id.* ¶ 19. There is a medical and scientific consensus that treatment for gender dysphoria includes allowing transgender individuals to live in accordance with their gender identity, including "use of names and pronouns consistent with their identity, grooming and dressing in a manner typically associated with that gender, and using restrooms and other sex-separated facilities that match their gender identity."[1] *Id.* ¶¶ 20–21. Furthermore, when medically appropriate, treatment also includes hormone therapy and surgery so that transgender individuals "may develop physical sex characteristics typical of their gender identity."[2] *Id.* ¶¶ 20, 25. In addition, under widely accepted standards of care, "boys who are transgender may undergo medically necessary chest-reconstruction surgery after they turn [sixteen years old]." *Id.* ¶ 27.

In 2014, by the end of his freshman year of high school, Mr. Grimm experienced such distress from his untreated gender dysphoria that he was unable to attend class. *Id.* ¶ 36. At this

---

[1] The consensus within medical and mental health communities is that excluding transgender individuals from using restrooms consistent with their gender identity "is harmful to their health and wellbeing. When excluded from the common restrooms, transgender [individuals] often avoid using the restroom entirely, either because the separate restrooms are too stigmatizing or too difficult to access." *Id.* ¶ 28. As a result, they suffer from physical consequences, and their risk of depression and self-harm is increased. *Id*; *see also id.* ¶ 29.

[2] "Hormone therapy affects bone and muscle structure, alters the appearance of a person's genitals, and produces secondary sex characteristics such as facial and body hair in boys and breasts in girls." *Id.* ¶ 25; *see also* Tim C. van de Grift et al., *Effects of Medical Interventions on Gender Dysphoria and Body Image: A Follow-Up Study*, 79:7 PSYCHOSOMATIC MED. 815 (2017) ("Overall, the levels of gender dysphoria . . . were significantly lower at follow-up [after medical intervention such as hormone therapy and genital or chest surgery] compared with clinical entry.").

time, he informed his parents of his male gender identity. *Id.* He began treatment with a psychologist experienced in counseling transgender youth and, as part of the medically-necessary treatment for his gender dysphoria, commenced the process of transitioning to live in accordance with his male identity. *Id.* ¶¶ 1, 36–37. By the time he began his sophomore year, Mr. Grimm had legally changed his first name to Gavin and had begun using male pronouns. He wore clothing and a hairstyle in a manner consistent with other males, and used men's restrooms in public venues without incident. *Id.* ¶¶ 2, 38. He also obtained a treatment documentation letter from his medical providers confirming that he was receiving treatment for gender dysphoria and was to be treated as a male in all respects—including restroom use. *Id.* ¶ 2.

In August 2014, prior to the beginning of his sophomore year, Mr. Grimm and his mother met with the Gloucester High School Principal and the Guidance Counselor, explaining that Mr. Grimm is a transgender boy and would be attending school as a boy. Mr. Grimm and his mother also provided the Principal and Counselor with the treatment documentation letter. *Id.* ¶ 39. At the time of the meeting, the Board lacked a policy addressing the restrooms that transgender students would use. *Id.* ¶ 41. Mr. Grimm initially requested the use of the restroom in the nurse's office. However, that restroom was located remotely, and using it left Mr. Grimm feeling stigmatized and isolated. That restroom was also far from many of his classrooms, causing Mr. Grimm to be late for class when he used it. After a few weeks, Mr. Grimm sought permission to use the boys' restrooms. With the Principal's support, he began using the boys' restrooms on October 20, 2014, and did so without incident for approximately seven weeks.[3] *Id.* ¶¶ 42–47.

[3] He also requested permission to complete his physical education requirements through a homebound program, bypassing any need to use the locker rooms at the school. *Id.* ¶ 45.

The Principal and Superintendent informed the Board that they had authorized Mr. Grimm to use the boys' restrooms, but otherwise kept the matter confidential. *Id.* ¶ 47. However, several adults in the community learned of a transgender student's use of the boys' restrooms. They contacted the Board, demanding that the transgender student be barred from the boys' restrooms. *Id.* The Board considered the matter in a private meeting and took no action for several weeks. However, one Board member proposed a policy regarding the use of restrooms by transgender students and submitted the policy for public debate at a Board meeting scheduled for November 11, 2014. In pertinent part, the policy proposed that "[i]t shall be the practice of the [Gloucester County Public Schools ("GCPS")] to provide male and female restroom and locker room facilities in its schools, and the use of said facilities shall be limited to the corresponding biological genders, and students with gender identity issues shall be provided an alternative appropriate private facility."[4] *Id.* ¶ 51.

At the meeting, Mr. Grimm decided to address the issue publicly, describing how he sought to use the restrooms "in peace" and had experienced "no problems from students" when using the boys' restrooms, "only from adults." *Id.* ¶ 55. The School Board deferred a vote on the proposed policy until its December 9, 2014 meeting. *Id.* ¶ 56. Before the next meeting, the

[4] The entirety of the policy stated:

> Whereas the GCPS recognizes that some students question their gender identities, and
>
> Whereas the GCPS encourages such students to seek support, advice, and guidance from parents, professionals and other trusted adults, and
>
> Whereas the GCPS seeks to provide a safe learning environment for all students and to protect the privacy of all students, therefore
>
> It shall be the practice of the GCPS to provide male and female restroom and locker room facilities in its schools, and the use of said facilities shall be limited to the corresponding biological genders, and students with gender identity issues shall be provided an alternative appropriate private facility.

Id. ¶ 51.

Board announced plans to add or expand partitions between urinals in the male restrooms, add privacy strips to the doors of stalls in all restrooms, and to designate single-stall, unisex restrooms "to give all students the option for even greater privacy." *Id.* ¶ 57.

Despite the announced plans, speakers at the December 9, 2014 meeting continued to demand that Mr. Grimm be excluded from using the boys' restrooms immediately. *Id.* ¶ 59. The Board then passed the policy at the meeting by a six-to-one vote. The following day, Mr. Grimm was informed by the principal that he could no longer use the boys' restrooms. *Id.* ¶¶ 61–62. The Board then installed three single-user restrooms, none of which was located near Mr. Grimm's classes. Although any student was allowed to use them, no student besides Mr. Grimm did. *Id.* ¶¶ 65–66.

Because using the single-user restrooms underscored his exclusion and left him physically isolated, Mr. Grimm refrained from using any restroom at school. He developed a painful urinary tract infection and had difficulty concentrating in class because of his physical discomfort. *Id.* ¶¶ 67–70. When he attended school football games, no restroom was available for Mr. Grimm's use. As a result, Mr. Grimm was forced to have his mother pick him up from games early. *Id.* ¶ 71.

Throughout his sophomore, junior, and senior years of high school, Mr. Grimm continued the process of transitioning to live in accordance with his male identity. In December 2014, the middle of his sophomore year, he had begun hormone therapy, which altered his bone and muscle structure, deepened his voice, and caused him to grow facial hair. *Id.* ¶¶ 72–73. In June 2015, prior to the beginning of his junior year, the Virginia Department of Motor Vehicles issued Mr. Grimm a state identification card designating his gender as male. *Id.* ¶ 74. A year later, prior to the beginning of his senior year, Mr. Grimm underwent chest-reconstruction

surgery, in accordance with the medical standards of care for treating gender dysphoria. *Id.* ¶ 75; *see id.* ¶ 27. Later that year, in September 2016, the Gloucester County Circuit Court issued an order changing his sex under Virginia state law and directing the Virginia Department of Health to issue Mr. Grimm a birth certificate listing his sex as male; this certificate was issued in October 2016. *Id.* ¶¶ 76–77. Throughout the process of these changes—up through Mr. Grimm's graduation in June 2017—the School Board maintained that Mr. Grimm's "biological gender" was female and prohibited administrators from permitting Mr. Grimm to use the boys' restrooms. *Id.* ¶¶ 78–79.

Mr. Grimm commenced this action against the Gloucester County School Board in July 2015, alleging that the Board's policy of assigning students to restrooms based on their biological sex violated Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681(a), as well as the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution. In September 2015, another judge of this Court issued a Memorandum Opinion and Order (1) dismissing Mr. Grimm's claim under Title IX for failure to state a claim and (2) denying his Motion for a Preliminary Injunction based on the alleged Title IX and Equal Protection Clause violations. *G.G. ex rel. Grimm v. Gloucester Cty. Sch. Bd.*, 132 F. Supp. 3d 736, 753 (E.D. Va. 2015), *rev'd in part and vacated in part*, 822 F.3d 709 (4th Cir. 2016). An interlocutory appeal of those decisions followed, leading to appellate review by the United States Court of Appeals for the Fourth Circuit and by the United States Supreme Court. *See infra* III.A; *see also* ECF No. at 132 at 1–2. During this time, the district court suit was re-assigned to the undersigned. The case was remanded to this Court for consideration of the Title IX claim. The Equal Protection Claim also remains pending before this Court.

Following the filing of Mr. Grimm's Amended Complaint (ECF No. 113), the School Board filed the instant Motion to Dismiss (ECF No. 135). With respect to the Title IX claim (Count II, ECF No. 113 ¶¶ 90–92), the School Board argues that its policy of separating restrooms by physiological sex is valid under Title IX because (1) Title IX only allows for claims on the basis of sex, rather than gender identity, and (2) gender identity and sex, as addressed in Title IX, are not equivalent. *See* ECF No. 136 at 6, 12–26. With respect to the Equal Protection claim (Count I, ECF No. 113 ¶¶ 81–89), the School Board argues that its policy does not violate the Equal Protection Clause because transgender individuals are not members of a suspect class entitled to heightened scrutiny, and the Policy should be viewed as presumptively constitutional under both rational basis review and intermediate scrutiny. *Id.* at 28–36.

II. LEGAL STANDARD

A motion to dismiss under Rule 12(b)(6) tests the sufficiency of a complaint. "To survive a Rule 12(b)(6) motion to dismiss, a complaint must 'state a claim to relief that is plausible on its face.'" *United States ex rel. Nathan v. Takeda Pharm. N. Am., Inc.*, 707 F.3d 451, 455 (4th Cir. 2013) (quoting *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009)). "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Iqbal*, 556 U.S. at 678. "The plausibility standard is not akin to a 'probability requirement,' but it asks for more than a sheer possibility that a defendant has acted unlawfully." *Id.* (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 556 (2007)). "Facts that are 'merely consistent with' liability do not establish a plausible claim to relief." *Takeda Pharm.*, 707 F.3d at 455 (quoting *Iqbal*, 556 U.S. at 678). Rather, the "'[f]actual allegations must be enough to raise a right to relief above the speculative level,' thereby 'nudg[ing] [the plaintiff's] claims across the line from conceivable to

plausible.'" *Vitol, S.A. v. Primerose Shipping Co.*, 708 F.3d 527, 543 (4th Cir. 2013) (quoting *Twombly,* 550 U.S. at 555) (first and second alteration in original).

At this stage, "(1) the complaint is construed in the light most favorable to the plaintiff, (2) its allegations are taken as true, and (3) all reasonable inferences that can be drawn from the pleading are drawn in favor of the pleader." 5B CHARLES A. WRIGHT ET AL., FEDERAL PRACTICE & PROCEDURE § 1357 & n.11 (3d ed.) (collecting cases); *accord Wag More Dogs*, 680 F.3d at 365.

However, courts "will not accept 'legal conclusions couched as facts or unwarranted inferences, unreasonable conclusions, or arguments.'" *Takeda Pharm.*, 707 F.3d at 455 (quoting *Wag More Dogs*, 680 F.3d at 365). Additionally, a threadbare recitation of the "elements of a cause of action, and bare assertions devoid of further factual enhancement fail to constitute well-pled facts for Rule 12(b)(6) purposes." *Nemet Chevrolet, Ltd. v. Consumeraffairs.com, Inc.*, 591 F.3d 250, 255 (4th Cir. 2009); *Iqbal*, 556 U.S. at 678 (noting that "the tenet that a court must accept a complaint's allegations as true is inapplicable to threadbare recitals of a cause of action's elements, supported by mere conclusory statements").

III. ANALYSIS

A. Reconsideration of the Interlocutory Order

As a preliminary matter, this Court must consider whether it is bound by the previous dismissal of the Title IX claim. *See* ECF No. 57. Following Mr. Grimm's interlocutory appeal of the dismissal, the Fourth Circuit reversed the dismissal. The reversal was based on the Fourth Circuit's conclusion that deference should be given to a guidance letter issued by the Department of Education's Office of Civil Rights that construed a Title IX regulation as generally requiring schools to treat transgender students consistent with their gender identity when electing to separate students on the basis of sex. *G.G. ex rel. Grimm v. Gloucester County Sch. Bd.* (*Grimm*

I), 822 F.3d 709, 718–22 (4th Cir. 2016) (citing *Auer v. Robbins*, 519 U.S. 452 (1997)), *vacated and remanded*, 137 S. Ct. 1239 (2017). The United States Supreme Court granted a stay of the Fourth Circuit's mandate and granted the Board's writ of certiorari. After the guidance letter was rescinded as the result of a change in administration, the Supreme Court vacated the Fourth Circuit's decision and remanded for reconsideration of the Title IX claim. ECF No. 91. The Fourth Circuit dismissed the appeal, and Mr. Grimm filed an Amended Complaint with this Court. ECF Nos. 113, 114.

The Board argues that this Court remains bound by the previous dismissal of the Title IX claim. In support of this position, the Board contends that because Mr. Grimm's "current Title IX claim is virtually identical to the claim that [the previous judge] already dismissed, [Mr. Grimm] is essentially asking the Court to reconsider" the original decision. ECF No. 136 at 7. The Board contends that this Court need not reevaluate the previous dismissal of the Title IX claim because the prior decision analyzed the Title IX claim thoroughly without applying *Auer* deference to the letter and instead based its conclusion that Mr. Grimm had failed to state a Title IX claim on "valid precedent." *Id.* at 6–7.

Such reconsiderations are governed by Federal Rule of Civil Procedure 54(b), which provides that:

> any order or other decision, however designated, that adjudicates fewer than all the claims or rights and liabilities of fewer than all the parties does not end the action as to any of the claims or parties and may be revised at any time before the entry of a judgment adjudicating all the claims and all the parties' rights and liabilities.

Both parties acknowledge that district courts retain the discretion to revise an interlocutory order at any time before the entry of a judgment adjudicating all the claims. *Carlson v. Boston Scientific Corp.*, 856 F.3d 320, 325 (4th Cir. 2017) (citing Fed. R. Civ. P. 54(b)).

Although courts have concluded that a successor judge should hesitate to overrule the earlier determination, *id.* (internal citation omitted), "whether rulings by one district judge become binding as 'law of the case' upon subsequent district judges is not a matter of rigid legal rule, but more a matter of proper judicial administration which can vary with the circumstances." *Hill v. BASF Wyandotte Corp.*, 696 F.2d 287, 290 n.3 (4th Cir. 1982); *see also Stoffels ex rel. SBC Tel. Concession Plan v. SBC Commc'ns, Inc.*, 677 F.3d 720, 727 n.3 (5th Cir. 2012) ("When a successor judge is reviewing another judge's interlocutory order, the law of the case doctrine requires only that the successor judge respect principles of comity when considering issues that have already been decided."); *Am. Canoe Ass'n v. Murphy Farms, Inc.*, 326 F.3d 505, 515 (4th Cir. 2003) (noting that reconsideration of interlocutory orders "is committed to the discretion of the district court," and that related doctrines such as law of the case "have evolved as a means of guiding that discretion" but "cannot limit the power of a court to reconsider an earlier ruling"). This Court's primary responsibility—the responsibility of all federal courts—"is to reach the correct judgment under law." *Am. Canoe Ass'n*, 326 F.3d at 515.

The Fourth Circuit has "cabined revision pursuant to Rule 54(b) by treating interlocutory rulings as law of the case." *Carlson*, 856 F.3d at 325 (internal citations omitted). Accordingly, a "court may review an interlocutory order under the same circumstances in which it may depart from the law of the case: (1) a subsequent trial producing substantially different evidence; (2) a change in applicable law; or (3) clear error causing manifest injustice." *Id.* (internal quotations and citations omitted). The Board argues that none of these requirements has been met, and that this Court should not depart from the previous adjudication of the Title IX claim. ECF No. 136 at 8.

This Court disagrees. First, there has been a significant change in the applicable law since the Motion to Dismiss the Title IX claim was initially considered in 2015. *See Carlson*, 856 F.3d at 325; *see also Bridger Coal Co. v. Dir., Office of Workers' Comp. Programs, U.S. Dep't of Labor*, 669 F.3d 1183, 1192 (10th Cir. 2012) (noting that the emergence of a circuit split can justify reconsideration). The Sixth and Seventh Circuits have since held that excluding boys and girls who are transgender from the restrooms that align with their gender identity may subject them to discrimination on the basis of sex under Title IX, the Equal Protection Clause, or both. *See Whitaker v. Kenosha Unified School Dist. No. 1 Board of Education*, 858 F.3d 1034, 1049–51 (7th Cir. 2017); *Dodds v. United States Dep't of Educ.*, 845 F.3d 217, 221 (6th Cir. 2016).

A number of district courts have also reached the same conclusion. *See A.H. by Handling v. Minersville Area Sch. Dist.*, No. 3:17cv391, 2017 WL 5632662, at *1, *3–*7 (M.D. Pa. Nov. 22, 2017) (denying school district's motion to dismiss a transgender student's Title IX and Equal Protection Claims based on school district's bathroom policy "dictating that children must use the bathroom corresponding to the sex listed on the student's birth certificate"); *Evancho v. Pine-Richland Sch. Dist.*, 237 F. Supp. 3d 267, 288, 295 (W.D. Pa. 2017); *Bd. of Educ. of the Highland Local Sch. Dist. v. U.S. Dep't of Educ.*, 208 F. Supp. 3d 850, 865, 869, 871 (S.D. Ohio 2016).

Recently, the District of Maryland denied a strikingly similar Motion to Dismiss a transgender student's Title IX and Equal Protection claims stemming from his school's policy of barring him from using the boys' locker room. *M.A.B. v. Bd. of Educ. of Talbot Cty.*, 286 F. Supp. 3d 704, 711 (D. Md. 2018). Although these precedents are not binding upon this Court, the thorough analyses of analogous questions provided by the rulings proves persuasive.

Moreover, to the extent that the Fourth Circuit's consideration of the Title IX claim provides meaningful guidance for this Court's analysis of the Title IX regulation, the earlier dismissal of the Title IX claim lacked such guidance. *See infra* p. 15 and note 6.

Second, a number of factual developments warrant reconsideration of the original decision to dismiss the Title IX claim. When Mr. Grimm filed his initial complaint in 2015, he alleged that the Board's policy violated his rights under Title IX on the day the policy was first issued, which occurred in the middle of his sophomore year. The Amended Complaint alleges that the Board violated his rights under Title IX when the policy was issued, and also throughout the remainder of his time as a student at Gloucester High School. Am. Compl., ECF No. 113 ¶ A. Since the previous dismissal of the Title IX claim, Mr. Grimm has received chest reconstruction surgery, obtained an order from Gloucester County Circuit Court legally changing his sex under Virginia law, and has received a new birth certificate from the Virginia Department of Health listing his sex as male. *Id.* ¶¶ 75–77. The previous decision was rendered without any opportunity to consider whether the Board's policy violated Title IX throughout the remainder of Mr. Grimm's time at Gloucester High School, and in light of these factual developments.

For these reasons, the Court concludes that revisiting the question of whether Mr. Grimm has stated a plausible Title IX claim is warranted. The Court now examines the claim's merits. *See* ECF No. 113 ¶¶ 90–92.

B. Title IX Claim

Title IX provides that no person "shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any educational program or activity receiving Federal financial assistance . . . ." 20 U.S.C. § 1681(a); *see also* 34 C.F.R. § 106.31. A covered institution may not, on the basis of sex, (1)

provide different aid, benefits, or services; (2) deny aid, benefits, or service, or (3) subject any person to separate or different rules, sanctions, or treatment. 34 C.F.R. § 106.31(b)(2)–(4).

However, "[n]ot all distinctions on the basis of sex are impermissible under Title IX." *Grimm I*, 822 F.3d at 718. The statute's regulations permit an institution to provide separate bathroom, shower, and locker facilities by sex, so long as the facilities are comparable. 34 C.F.R. § 106.33; *see also Whitaker*, 858 F.3d at 1047–48.

1. A Plaintiff's Claim of Discrimination on the Basis of Transgender Status Constitutes a Claim of Sex Discrimination Under Title IX

The parties dispute whether a transgender student's allegation of discrimination based on his or her transgender status can constitute a claim of sex discrimination under Title IX. Neither Title IX nor its regulations defines the term "sex." The Fourth Circuit has noted that because 34 C.F.R. § 106.33 permits separate toilets, locker rooms, and shower facilities on the basis of sex, "[b]y implication, the regulation also permits schools to exclude males from the female facilities and vice-versa." *Grimm I*, 822 F.3d at 720.

The Board notes that § 106.33 permits schools to establish separate facilities on the basis of sex. The Board also contends that the term "sex" "at a minimum *includes* the physiological distinction between men and women." ECF No. 136 at 13. Therefore, the Board argues, this Court must interpret Title IX as applying only to discrimination on the basis of physiological sex, rather than gender identity. *See id.* at 12–26.

Before evaluating whether discrimination on the basis of a plaintiff's transgender status constitutes sex discrimination under Title IX, the Court must address the difficulties inherent in the Board's view of "sex" under Title IX. That construction may be an appealingly simple way of interpreting the term "sex." However, the Board argues that the Policy "distinguishes boys and girls based on physical sex characteristics alone," ECF No. 136 at 21, but fails to

acknowledge that there are individuals who possess both male and female physical sex characteristics. As Mr. Grimm contends, attempting to draw lines based on physiological and anatomical characteristics proves unmanageable: how would the Board's policy apply to individuals who have had genital surgery, individuals whose genitals were injured in an accident, or those with intersex traits who have genital characteristics that are neither typically male nor female? *See Grimm I*, 822 F.3d at 720–21;[5] *Evancho*, 237 F. Supp. 3d at 279 ("[T]he Board has adopted a student bathroom policy that turns exclusively on the then-existing presence of a determinate external sex organ, no matter what other biological or gender markers may exist . . . ."). In Mr. Grimm's situation, how would the Board have continued to implement the Policy after Mr. Grimm's medical procedures? Mr. Grimm had attained some secondary male physical sex characteristics after hormone therapy and chest reconstruction surgery. Accordingly, acts of discrimination on the basis of physiological sex certainly could have occurred.

The Policy in question assigned restrooms based on "biological gender," not physiological characteristics. This term has not been accepted by the medical community, because "sex"—the "attributes that characterize biological maleness or femaleness" (such as sex-determining genes, sex chromosomes, internal and external genitalia, and secondary sex characteristics)—is distinct from "gender," or the "internal, deeply held sense" of being a man or a woman. *See* Wylie C. Hembree et al., *Endocrine Treatment of Gender-dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102(11) J. CLIN.

---

[5] *Grimm I* specifically noted:

> It is not clear to us how the regulation would apply in a number of situations—even under the Board's own "biological gender" formulation. For example, which restroom would a transgender individual who had undergone sex reassignment surgery use? What about an intersex individual? What about an individual born with X-X-Y sex chromosomes? What about an individual who lost external genitalia in an accident?

822 F.3d at 720–21.

ENDOCRINOLOGY & METABOLISM 3869, 3875 (2017) (noting that the terms "biological male or female" should be avoided because not all individuals have physical attributes that align perfectly with biological maleness or femaleness, such as individuals with XY chromosomes who may have female-appearing genitalia). Given the Policy's disregard for these distinctions, its use of the term "biological gender" functioned as a proxy for physiological characteristics that a student may or may not have had. The term allowed the Board to isolate, distinguish, and subject to differential treatment any student who deviated from what the Board viewed a male or female student *should* be, and from the physiological characteristics the Board believed that a male or female student *should* have.

The Court next turns to consideration of § 106.33. As the Fourth Circuit noted, the "inquiry is not ended" by § 106.33's reference to males and females. *Grimm I*, 822 F.3d at 720.[6] "Although the regulation may refer unambiguously to males and females, it is silent as to how a school should determine whether a transgender individual is a male or female for the purpose of access to sex-segregated restrooms." *Id.* The Fourth Circuit initially determined that § 106.33 was ambiguous "as applied to transgender students," and granted *Auer* deference to the guidance letter interpreting § 106.33 to generally require access to sex-segregated facilities on the basis of gender identity. *Id.* at 721–23. Following remand from the Supreme Court as the result of the withdrawal of the letter, the Fourth Circuit vacated its decision. Accordingly, *Grimm I* fails to

[6] The District of Maryland recognized that although the Supreme Court vacated the Fourth Circuit's judgment in *Grimm I* in light of the withdrawal of the guidance letter, the remainder of that decision remains binding law because (1) it has not overruled by a subsequent en banc opinion of the Fourth Circuit and (2) there has been no superseding contrary decision from the Supreme Court. *See United States v. Giddens*, 858 F.3d 870, 886 n.12 (4th Cir. 2017) (citing *United States v. Collins*, 415 F.3d 304, 311 (4th Cir. 2005)). "Thus, the Court will rely on [the Fourth Circuit's previous *Grimm I* judgment] to the extent it offers guidance for deciding the Motions present." *M.A.B.*, 286 F. Supp. 3d at 712 n.5.

inform this Court how § 106.33 is to be interpreted with respect to transgender students. The Fourth Circuit has not addressed this issue or Title IX's application to transgender students since.

The Board asks this Court to resolve this issue by cabining the definition of sex to the "then-universal understanding of 'sex' as a binary term encompassing the physiological distinctions between men and women," as understood during the passage of Title IX and the promulgation of § 106.33. *See* ECF No. 136 at 16. However, as noted above, this fails to address the question of how § 106.33 is to be interpreted regarding transgender students or other individuals with physiological characteristics associated with both sexes.

The Court has some guidance in resolving § 106.33's ambiguity. Courts may "look to case law interpreting Title VII of the Civil Rights Act of 1964," *as amended*, 42 U.S.C. §§ 2000e *et seq.* (2018)—which prohibits employment discrimination on the basis of, among other qualities, sex—"for guidance in evaluating a claim brought under Title IX." *Id.* at 718 (citing *Jennings v. Univ. of N.C.*, 482 F.3d 686, 695 (4th Cir. 2007)); *see also M.A.B.*, 286 F. Supp. 3d at 713 ("[T]he Court turns to Title VII precedent for guidance [in interpreting a Title IX claim].").

Neither the Fourth Circuit nor the Supreme Court has addressed how Title VII applies to transgender individuals. *See M.A.B.*, 286 F. Supp. 3d at 713. However, the Supreme Court has constructed a framework for addressing sex discrimination claims brought by individuals who fail to conform to social expectations for their gender group. In *Price Waterhouse v. Hopkins*, 490 U.S. 228, 235 (1989), the Supreme Court considered whether the plaintiff, a woman who was denied partnership in an accounting firm, had an actionable Title VII claim against the firm because the firm had allegedly denied her a promotion because she failed to conform to certain gender stereotypes related to women. *Id.* at 235, 250–53 (summarizing how firm partners

described the plaintiff as "macho" and a "tough-talking somewhat masculine hard-nosed manager"). Firm partners advised the plaintiff that her partnership chances would improve if she were to "walk more femininely, talk more femininely, dress more femininely, wear make-up, have her hair styled, and wear jewelry." *Id.* at 235. Six Justices of the *Price Waterhouse* Court agreed that Title VII barred discrimination not only based on the plaintiff's gender, but based on "sex stereotyping" because the plaintiff had failed to act in accordance with gender stereotypes associated with women. *Id.* at 250–51; *id.* at 258–61 (White, J., concurring); *id.* at 272–73 (O'Connor, J., concurring). In noting that "we are beyond the day when an employer could evaluate employees by assuming or insisting that they match[] the stereotype associated with their group," the *Price Waterhouse* Court recognized that Title VII's prohibition on sex discrimination necessarily includes a prohibition on gender stereotyping. *Id.* at 251.

Price Waterhouse, by its own terms, took an expansive view as to the forms of sex discrimination that Title VII was meant to reach, expressly leaving open the possibility of other forms of gender stereotyping. "By focusing on [gender stereotypes associated with appearance and behavior], however, we do not suggest a limitation on the possible ways of proving that stereotyping played a motivating role in an employment decision . . . ." *Id.* at 251–52.

The Supreme Court's expansion recognizes that the prohibition on sex discrimination pursuant to Title VII also includes same-sex harassment claims. *Oncale v. Sundowner Offshore Services, Inc.*, 523 U.S. 75, 79 (1998) (noting that same-sex "sexual harassment in the workplace was assuredly not the principal evil Congress was concerned with when it enacted Title VII," but that "statutory prohibitions often go beyond the principal evil to cover reasonably comparable

evils, and it is ultimately the provisions of our laws rather than the principal concerns of our legislators by which we are governed").[7]

The First, Second, Third, Seventh, and Ninth Circuits have all recognized that based on the logic of *Price Waterhouse*, a gender stereotyping allegation generally is actionable sex discrimination under Title VII. *Hively v. Ivy Tech Cmty. Coll.*, 854 F.3d 339, 351–52 (7th Cir. 2017 (en banc) (holding that a lesbian plaintiff could state a Title VII claim under a sex stereotyping theory); *Christiansen v. Omnicom Grp., Inc.*, 852 F.3d 195, 200–01 (2d Cir. 2017) (per curiam) (holding that a plaintiff had stated a plausible Title VII claim based on a gender stereotyping theory); *Prowel v. Wise Bus. Forms., Inc.*, 579 F.3d 285, 290 (3d Cir. 2009); *Nichols v. Azteca Rest. Enters., Inc.*, 256 F.3d 864, 874–75 (9th Cir. 2001); *Higgins v. New Balance Athletic Shoe, Inc.*, 194 F.3d 252, 261 n.4 (1st Cir. 1999).

Although the Fourth Circuit has yet to apply *Price Waterhouse* expressly to Title VII claims brought by transgender individuals,[8] this Court joins the District of Maryland in concluding that "discrimination on the basis of transgender status constitutes gender stereotyping because 'by definition, transgender persons do not conform to gender stereotypes.'" *M.A.B.*, 286 F. Supp. 3d at 714 (quoting *Finkle v. Howard Cty.*, 12 F. Supp. 3d 780, 787–88 (D. Md. 2014)). The Court also concludes that, pursuant to the logic of *Price Waterhouse*, transgender

---

[7] For these reasons, the Court rejects the Board's argument that Title IX should be cabined to its expressed purpose: ending discrimination against women in university admissions and appointments. *See* ECF No. 136 at 9, 24–25. The Court also finds unpersuasive the Board's argument that other students' privacy concerns—mentioned in the legislative history of Title IX regulations, *id.* at 10–12—should prevail in this context. *See infra* pp. 27–30 (rejecting such privacy concerns as a rationale for the Board's Policy).

Relatedly, the Board also objects to this interpretation of Title IX because of hypothetical privacy concerns (rather than those found in legislative history). ECF No. 136 at 22–24. For the reasons discussed below, the Court finds these concerns—although worthy of consideration—are conjectural and abstract and fail to provide a basis for interpreting Title IX in the manner sought by the Board.

[8] The Fourth Circuit also has not applied *Price Waterhouse* expressly to gender stereotyping claims brought under Title VII. *M.A.B.*, 286 F. Supp. 3d at 714.

discrimination is per se actionable sex discrimination under Title VII. *Id; see also G.G. ex rel. Grimm* (*Grimm II*), 654 Fed. App'x 606, 606–07 (4th Cir. 2016) (Davis, J., concurring) (internal citations omitted) (noting that "the Supreme Court has expressly recognized that claims based on an individual's failure to conform to societal expectations based on that person's gender constitute discrimination 'because of sex' under Title VII," and noting that the First, Sixth, Ninth, and Eleventh Circuits have held that based on the logic of *Price Waterhouse*, discrimination against transgender individuals based on their transgender status is discrimination because of sex under federal civil rights statutes and the Equal Protection Clause).

This conclusion comports with decisions from the First, Sixth, Ninth, and Eleventh Circuits, all of which recognize that based on the gender-stereotyping theory from *Price Waterhouse*, claims of discrimination on the basis of transgender status are per se sex discrimination under Title VII or other federal civil rights laws. *See EEOC v. R.G. & G.R. Harris Funeral Homes, Inc.*, 884 F.3d 560, 574–75 (6th Cir. 2018) (confirming that claims of discrimination on the basis of transgender status is per se sex discrimination under Title VII);[9] *Glenn v. Brumby*, 663 F.3d 1312, 1316–19 (11th Cir. 2011) (recognizing that a "person is defined as transgender precisely because of the perception that his or her behavior transgresses gender stereotypes," and holding that terminating an employee because she is transgender violates the prohibition on sex-based discrimination under the Title VII and the Equal Protection Clause following the reasoning of *Price Waterhouse*);[10] *Smith v. City of Salem, Ohio*, 378 F.3d 566, 573–75 (6th Cir. 2004) (recognizing that discrimination against a transgender individual

---

[9] The Sixth Circuit also reasoned (1) that "it is analytically impossible to fire an employee based on that employee's status as a transgender person without being motivated, at least in part, by the employee's sex," 884 F. 3d at 575, and (2) that "discrimination against transgender persons necessarily implicates Title VII's proscriptions against sex stereotyping," *id.* at 576–77.

[10] *Glenn* also held that "discrimination against a transgender individual because of her gender-nonconformity is sex discrimination, whether it's described as being on the basis of sex or gender." 663 F.3d at 1317.

because of his or her gender non-conformity amounts to gender stereotyping prohibited by Title VII and the Equal Protection Clause, and holding that a transgender employee had stated a claim under Title VII); *Rosa v. Park W. Bank & Trust Co.*, 214 F.3d 213, 215–16 (1st Cir. 2000) (holding that a transgender individual could state a claim for sex discrimination under the Equal Credit Opportunity Act based on *Price Waterhouse*); *Schwenk v. Hartford*, 204 F.3d 1187, 1201–03 (9th Cir. 2000) (holding that a transgender individual could state a claim under the Gender Motivated Violence Act under the reasoning of *Price Waterhouse*).

Numerous district courts have also concluded that a transgender individual can state a claim under Title VII for sex discrimination on the basis of a sex or gender-stereotyping theory. *See Roberts v. Clark Cty. Sch. Dist.*, 215 F. Supp. 3d 1001, 1014 (D. Nev. 2016), *reconsideration denied*, No. 2:15-cv-00388-JAD-PAL, 2016 WL 6986346 (D. Nev. Nov. 28, 2016); *Fabian v. Hosp. of Cent. Conn.*, 172 F. Supp. 3d 509, 527 (D. Conn. 2016); *Lopez v. River Oaks Imaging & Diagnostic Grp., Inc.*, 542 F. Supp. 2d 653, 660 (S.D. Tex. 2008); *Schroer v. Billington*, 577 F. Supp. 2d 293, 305 (D.D.C. 2008).

Accordingly, allegations of gender stereotyping are cognizable Title VII sex discrimination claims and, by extension, cognizable Title IX sex discrimination claims.[11] This Court joins the District of Maryland and several other appellate courts in concluding that "claims of discrimination on the basis of transgender status are per se actionable under a gender stereotyping theory" under Title IX, *M.A.B.*, 286 F. Supp. 3d at 715. Mr. Grimm has properly

[11] The Board's argument that Title IX must explicitly refer to discrimination against transgender students to fulfill the notice requirements under *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981), ECF No. 136 at 25–27, is unavailing. Title IX funding recipients "have been on notice that they could be subjected to private suits for intentional sex discrimination under Title IX since 1979," when the Supreme Court decided *Cannon v. University of Chicago*, 441 U.S. 677, 691 (1979), and "have been put on notice by the fact that . . . cases since *Cannon* . . . have consistently interpreted Title IX's private cause of action broadly to encompass diverse forms of intentional sex discrimination." *Jackson v. Birmingham Bd. of Educ.*, 544 U.S. 167, 182 (2005); *see also West Virginia Dep't of Health & Human Resources v. Sebelius*, 649 F.3d 217, 223 (4th Cir. 2011).

brought a Title IX claim of discrimination "on the basis of sex"—that is, based on his transgender status.

2. Mr. Grimm Has Sufficiently Pled a Title IX Claim

Having concluded that Mr. Grimm may bring a Title IX claim based on his transgender status, this Court next turns to the question of whether he has pled his claim of discrimination on the basis of sex sufficiently. To state a claim under Title IX, a plaintiff must allege: (1) that he or she was excluded from participation in an education program because of his or her sex; (2) that the educational institution was receiving federal financial assistance at the time of his or exclusion; and (3) that the improper discrimination caused the plaintiff harm. *Grimm I*, 822 F.3d at 718 (citing *Preston v. Virginia ex rel. New River Cmty. Coll.*, 31 F.3d 203, 206 (4th Cir. 1994)); *but cf. M.A.B.*, 286 F. Supp. 3d at 716–17 (finding plaintiff had stated a Title IX claim under a gender stereotyping theory because he had alleged that he was denied access to the boys' locker room on the basis of sex—that is, his transgender status); *Evancho*, 237 F. Supp. at 295 (describing the three requirements for stating a Title IX claim as (1) discrimination in an educational program that (2) receives federal assistance in which (3) such discrimination was on the basis of sex).

Before considering whether Mr. Grimm has stated a plausible Title IX claim, the Court recognizes the similarities between this case and *Whitaker*, in which a transgender male teenager was also subjected to a school policy in which he could use only the girls' restrooms or gender-neutral restrooms that were far from his classrooms. 858 F.3d at 1040, 1041–42. This limitation was imposed despite the undisputed facts that the plaintiff had begun socially transitioning to life as a male during his freshman year, including changing his legal name and pronouns, and had been diagnosed with gender dysphoria by a therapist. As a result of the school policy, the plaintiff suffered from depression and anxiety; avoided water intake to avoid needing to use the

restroom, thereby exacerbating medical issues; and contemplated suicide. He also attempted to use the boys' restrooms in violation of the administration's decision. In response, administrators removed him from class on several occasions and instructed security guards to monitor his restroom use. *Id.* at 1040–41. Eventually, the school permitted him to use the boys' restrooms after a surgical transition. *Id.* at 1041. In reviewing the facts as alleged by the plaintiff, the Seventh Circuit concluded that the plaintiff had established a likelihood of success on the merits of his Title IX, and affirmed the district court's granting of a preliminary injunction on behalf of the plaintiff. *Id.* at 1050.

The Court now considers the first prong in determining if the Title IX claim is pled sufficiently: whether Mr. Grimm has sufficiently alleged that he was improperly discriminated against on the basis of his sex—that is, his transgender status. The Seventh Circuit concluded that a policy that requires transgender students to use bathrooms not in conformity with their gender identity subjects "a transgender student . . . to different rules, sanctions, and treatment than non-transgender students," and amounts to discrimination on the basis of transgender status in violation of Title IX. *Whitaker*, 858 F.3d at 1049–50. This conclusion is sound. Furthermore, the provision of a gender-neutral alternative is insufficient to relieve a school board of liability, "as it is the policy itself which violates [Title IX]." *See id.* at 1050. Offering restroom alternatives that impose hardships like unreasonable distances to a student's classroom and increased stigma on a student is inadequate. *See id.*

In *M.A.B.*, the District of Maryland recognized that because the plaintiff had alleged that the school board had denied him access to the boys' locker rooms because of his transgender status, the policy subjected him to sex discrimination under a gender stereotyping theory. *M.A.B.* concluded that the plaintiff had sufficiently alleged discrimination under Title IX. 286 F. Supp.

3d at 716. Given the persuasive reasoning in *Whitaker* and *M.A.B.*, the Court concludes that Mr. Grimm has sufficiently pled that the Policy subjected him to sex discrimination under a gender stereotyping theory.

Having concluded that Mr. Grimm has properly alleged discrimination on the basis of sex, and finding the second pleading requirement is met because GCPS and Gloucester High School "are education programs receiving Federal financial assistance," ECF No. 113 ¶ 91, the Court now turns to determining whether Mr. Grimm has sufficiently alleged that the discrimination harmed him. The location of the bathrooms, coupled with the stigmatization and physical and mental anguish inflicted upon Mr. Grimm, caused harm. "A policy that requires an individual to use a bathroom that does not conform with his or her gender identity punishes that individual for his or her gender non-conformance, which in turn violates Title IX." *Whitaker*, 858 F.3d at 1049; *see also id.* at 1041 (noting that, among other harms, the plaintiff suffered from depression and anxiety because of the bathroom policy, and restricted his water intake to avoid restroom use, exacerbating his medical problems); *M.A.B.*, 286 F. Supp. 3d at 716–17 (applying *Whitaker* to conclude that the plaintiff had sufficiently pled a Title IX claim based on the school's policy of excluding him from use of the boys' locker room because of his transgender status). After full consideration of the facts presented and the compelling scope of relevant legal analyses, the Court concludes that Mr. Grimm has sufficiently pled a Title IX claim of sex discrimination under a gender stereotyping theory.

C. Equal Protection Claim

Mr. Grimm also brings a claim under the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution (ECF No. 113 ¶¶ 81–89), which provides that "[n]o State shall . . . deny to any person within its jurisdiction the equal protection of the laws." U.S. Const. amend. XIV § 1. As *Whitaker* recognized, the Equal Protection Clause "is

essentially a directive that all persons similarly situated should be treated alike." 858 F.3d at 1050 (quoting *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 439 (1985)). Under "rational basis review," state action will generally be presumed to be lawful and upheld if the classification drawn by the statute is rationally related to a legitimate state interest. *City of Cleburne*, 473 U.S. at 440. However, a state must not distinguish between classes of people in an "arbitrary or irrational" manner or out of a "bare . . . desire to harm a politically unpopular group." *Id.* at 446–47 (internal citation omitted).

Under "rational basis review," if a state classification of a group of people is rationally related to a legitimate state interest, courts will uphold the classifications. *Id.* at 440. However, when a state classifies a "suspect" or "quasi-suspect" group of people, courts will apply "heightened scrutiny." *Id.* at 440–41.

Sex-based classifications are subject to heightened scrutiny. The state bears the burden of demonstrating that its proffered justification for the use of a sex-based classification is "exceedingly persuasive." *United States v. Virginia*, 518 U.S. 515, 533 (1996). That is, the state is required to demonstrate that the classification "serves important governmental objectives and that the discriminatory means employed are substantially related to the achievement of those objectives." *Id.* at 524 (internal citation omitted). Hypothesized or *post hoc* justifications created in response to litigation are insufficient to meet this burden, as are justifications based on overbroad generalizations about sex. *Id.* at 533. Furthermore, "[i[f a state actor cannot defend a sex-based classification by relying upon overbroad generalizations, it follows that sex-based stereotypes are also insufficient sustain a classification." *Kenosha*, 858 F.3d at 1051 (internal citation omitted).

1. The Board's Policy Warrants Intermediate Scrutiny

The parties dispute which level of scrutiny is warranted. The Board contends that rational basis review should apply because transgender individuals do not constitute a quasi-suspect class under the Equal Protection Clause. ECF No. 136 at 28. Mr. Grimm contends that classification based upon transgender status amounts to classification based on sex, and so warrants heightened scrutiny. ECF No. 139 at 37–38.

The Fourth Circuit has not considered the question of whether transgender classifications are sex-based. *See M.A.B.*, 286 F. Supp. 3d at 718. The Seventh and Eleventh Circuits have considered the issue and have concluded that heightened scrutiny applies. *See Whitaker*, 858 F.3d at 1051; *Glenn*, 663 F.3d at 1321. This Court agrees and concludes that intermediate scrutiny is warranted for at least two reasons.

First, transgender individuals constitute at least a quasi-suspect class, and the Policy classified Mr. Grimm on the basis of his transgender status. *See M.A.B.*, 286 F. Supp. 3d at 718–20. Four factors are used to determine whether a group of people who have been classified by a state amount to a suspect or quasi-suspect class: (1) whether the class has historically been subject to discrimination, *Bowen v. Gilliard*, 483 U.S. 587, 602 (1987); (2) whether the class has a defining characteristic that bears a relation to ability to perform or contribute to society, *Cleburne*, 473 U.S. at 440–41; (3) whether the class exhibits obvious, immutable, or distinguishing characteristics that define the class as a discrete group, *Bowen*, 483 U.S. at 602; and (4) whether the class is a minority or politically powerless. *Id.* This Court joins the District of Maryland in concluding that transgender individuals meet all four factors and constitute at least a quasi-suspect class.

As to the first factor, there is no doubt that transgender individuals historically have been subjected to discrimination on the basis of their gender identity, including high rates of violence

and discrimination in education, employment, housing, and healthcare access. *See Whitaker*, 858 F.3d at 1051; *M.A.B.*, 286 F. Supp. 3d at 720; *see also Evancho*, 237 F. Supp. 3d at 288; *Highland*, 208 F. Supp. 3d at 874; *Adkins v. City of New York*, 143 F. Supp. 3d 134, 139 (S.D.N.Y. 2015).

The second factor is also met because transgender status has no bearing on a transgender individual's ability to contribute to society. *See M.A.B.*, 286 F. Supp. 3d at 720.

As to the third factor, "transgender status is immutable." *Id.* at 720–21. Furthermore, transgender individuals have distinguishing characteristics—the disparity between the gender they were assigned at birth and the gender they identify with—that define them as a discrete group. *Id.* at 721.

As to the fourth factor, there can be no doubt that transgender individuals are a minority and are politically powerless, comprising just a fraction of the population and frequently subjected to discriminatory federal policies and state laws. *Id.* at 721. This Court joins the District of Maryland, as well as a host of other district courts, in concluding that because transgender individuals are part of a quasi-suspect class, classifications based on transgender status are per se entitled to heightened scrutiny. *Id.* at 720–22; *see also Doe 1 v. Trump*, 275 F. Supp. 3d 167, 208–09 (D.D.C. 2017); *Evancho*, 237 F. Supp. 3d at 288; *Highland*, 208 F. Supp. 3d at 874; *Adkins*, 143 F. Supp. 3d at 139–40; *Norsworthy v. Beard*, 87 F. Supp. 3d 1104, 1119 (N.D. Cal. 2015).

Second, intermediate scrutiny is also warranted because, as Mr. Grimm has pled the matter, the Board Policy at issue relies on sex stereotypes. Accordingly, Mr. Grimm's claims amount to an allegation of a sex-based classification and, therefore, an allegation of sex-based

discrimination in violation of the Equal Protection Clause. *See M.A.B.*, 286 F. Supp. 3d at 718–19.

In *Whitaker*, the Seventh Circuit declined to conclude whether "transgender status is per se entitled to heightened scrutiny," but recognized that "it is enough to say that, just as in *Price Waterhouse*," that the record demonstrated that the plaintiff had been subject to sex stereotyping and therefore had experienced sex discrimination. *Whitaker*, 858 F.3d at 1051. The court reasoned that because "the School District decides which bathroom a student may use based upon the sex listed on the student's birth certificate," the policy could not be stated without referencing sex. *Id.* Accordingly, *Whitaker* concluded, "[t]his policy is inherently based upon a sex-classification," and "heightened review applies." *Id.*; *see also Glenn*, 663 F.3d at 1319–20 (recognizing that the consistent purpose of applying intermediate scrutiny to sex-based classifications has been to eliminate discrimination on the basis of gender stereotypes, and concluding that discrimination against a transgender individual because of his or her gender non-conformity constitutes sex discrimination under the Equal Protection Clause).

This Court joins other courts that have concluded that because the Policy relies on sex-based stereotypes, it is a sex-based classification. *See M.A.B.*, 286 F. Supp. 3d at 718–19. The Policy classified Mr. Grimm differently on the basis of his transgender status and, accordingly, subjected him to sex stereotyping. The Equal Protection Clause protects Mr. Grimm from impermissible sex stereotypes—just as Title IX does, for the reasons articulated previously—and the Court need only find that the Board's Policy demonstrated sex stereotyping under the Equal Protection Clause. *Cf. Price Waterhouse*, 490 U.S. 250–52. Mr. Grimm was subjected to sex discrimination because he was viewed as failing to conform to the sex stereotype propagated by

the Policy. Because the Policy relies on sex-based stereotypes, the Court finds that review of the Policy is subject to intermediate scrutiny.

2. As Pled by Mr. Grimm, the Policy was Not Substantially Related to Achieving an Important Governmental Objective

The Court next turns to whether the Policy survives review under heightened scrutiny. To survive, the Board must demonstrate that the classification serves an important governmental objective, and that the discriminatory means employed are substantially related to the achievement of those objectives. *Virginia*, 518 U.S. at 533 (internal citation omitted).

The Board argues that the Policy is substantially related to an important governmental objective: protecting the privacy rights of its students. *See* ECF No. 136 at 35–37. The Board expands this argument by contending that concerns over student privacy extend to protecting students like Mr. Grimm who, for whatever reason, may be uncomfortable using a restroom corresponding with their physiological sex. The Board argues that by permitting such students to use a single-user restroom, the Board is also protecting the privacy of students like Mr. Grimm. *Id.* at 36.

The Board's argument rings hollow. In *Whitaker*, the Seventh Circuit concluded that although the school's privacy justification may be a legitimate and important interest, the policy was not genuine because it is "based upon sheer conjecture and abstraction." *Whitaker*, 858 F.3d at 1052; *see also Grimm I*, 822 F.3d at 723.

Such conjecture is obvious. First, the plaintiff in *Whitaker*—like Mr. Grimm—used the boys' bathrooms for *weeks* without incident before *other adults in the community—not students*—complained of this use. Second, as the Seventh Circuit observed, a "transgender student's presence in a restroom provides no more of a risk to other students' privacy rights than the presence of an overly curious student of the same biological sex who decides to sneak

glances at his or her classmates performing their bodily functions." *Whitaker*, 858 F.3d at 1052. Third, if school districts were genuinely concerned with protecting the privacy of students who have different-looking anatomies, "then it would seem that separate bathrooms also would be appropriate for pre-pubescent and post-pubescent children who do not look alike anatomically," which the school district had not provided. *Id.* at 1052–53. This Court declines to further evaluate the legitimacy of the purported privacy concerns. The record here is less developed than it was in *Whitaker*. However, the Court underscores that, as pled by Mr. Grimm, Mr. Grimm used the boys' bathrooms for weeks without incident.

The Court concludes that, as pled by Mr. Grimm, the policy at issue was not substantially related to protecting other students' privacy rights. *See M.A.B.*, 286 F. Supp. 3d at 724–26.[12] There were many other ways to protect privacy interests in a non-discriminatory and more effective manner than barring Mr. Grimm from using the boys' restrooms. For example, the Board had taken steps "to give all students the option for even greater privacy" by installing partitions between urinals and privacy strips for stall doors. ECF No. 113 ¶ 57. Additionally, students who wanted greater privacy for any reason could have used one of the new single-stall restrooms made available upon implementation of the policy. *See Grimm I*, 822 F.3d at 728–29 (Davis, J., concurring). Furthermore, as the *M.A.B.* court recognized, it is significant when a

[12] The Court emphasizes that *M.A.B.* rejected the defendants' argument that single-use restrooms and stalls in the boys' locker room would be insufficient to assuage privacy concerns, because "if M.A.B. changing clothes in the designated restrooms makes him feel humiliated and embarrassed . . . then students who use those restrooms for greater privacy will feel the same way." 286 F. Supp. 3d at 724.

M.A.B. rejected that argument for four reasons: (1) the policy interfered with M.A.B.'s health and well-being because it prevented him from social transitioning, as required for treating his gender dysphoria; (2) M.A.B. was *required* to use the designated restrooms, unlike the students who had the *option* to do so if they desired greater privacy; (3) the policy singled out M.A.B. "and marks him as different for being transgender," again in contrast to students for whom using a single-stall restroom carried no stigma; and (4) "even if some boys feel humiliated, embarrassed, or alienated for deciding to change clothes in a single-use restroom or stall, changing there still serves [the defendants'] privacy concerns because those boys still enjoy greater privacy." *Id.* at 724–25. The Court agrees with *M.A.B.*'s reasoning.

school board fails to provide "any explanation for why completely barring [the transgender student] from the boys' [segregated facility] protects the privacy of other boys," "while the availability of single-use restrooms or locker stalls does not." *M.A.B.*, 286 F. Supp. 3d at 725. As in *Whitaker* and *M.A.B.*, preventing Mr. Grimm from using the boys' restrooms did nothing to protect the privacy rights of other students, but certainly singled out and stigmatized Mr. Grimm. *Id.*

Similarly, the Board's argument that the policy should not be construed as violating the Equal Protection Clause because the policy treated all boys and girls the same is unavailing. ECF No. 136 at 26–37. The Policy singled out Mr. Grimm for differing treatment because it "treat[ed] transgender students . . . who fail to conform to the sex-based stereotypes associated with their assigned sex at birth[] differently," whereas a boy making the personal choice to change clothes in or use a single-stall restroom would not have been singled out by the school policy. *Whitaker*, 858 F.3d at 1051; *see also Grimm I*, 822 F.3d at 729 (Davis, J., concurring) ("For other students, using the single-stall restrooms carries no stigma whatsoever, whereas for G.G., using those same restrooms is tantamount to humiliation and a continuing mark of difference among his fellow students.").

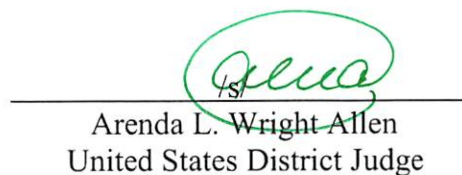
For these reasons, the Court concludes that Mr. Grimm has sufficiently pled that the Policy was not substantially related to protecting other students' privacy rights, because there were many other ways to protect privacy interests in a non-discriminatory and more effective manner than barring Mr. Grimm from using the boys' restrooms. The Board's argument that the policy did not discriminate against any one class of students is resoundingly unpersuasive. Accordingly, the Court declines to dismiss his Equal Protection Claim.

IV. CONCLUSION

For the reasons set forth herein, the Amended Motion to Dismiss (ECF No. 135) is DENIED. The Motion to Dismiss (ECF No. 118) is DISMISSED as moot.

Counsel for the parties are DIRECTED to contact the Courtroom Deputy for the United States Magistrate Judges at (757) 222-7222 within thirty days of entry of this Order to schedule a settlement conference.

IT IS SO ORDERED.



/s/
Arenda L. Wright Allen
United States District Judge

May 22nd, 2018
Norfolk, Virginia

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM,

Plaintiff,

v.

GLOUCESTER COUNTY
SCHOOL BOARD,

Defendant.

Civil No. 4:15cv54

ORDER

This matter comes before the Court on Plaintiff Gavin Grimm's ("Mr. Grimm") Motion for Leave to File Second Amended Complaint, ECF No. 170. For the reasons stated herein, Mr. Grimm's Motion is **GRANTED**.

Mr. Grimm filed his original Complaint on June 11, 2015 against Defendant Gloucester County School Board ("the Board"). ECF No. 8. Mr. Grimm filed a First Amended Complaint on August 22, 2017 after graduating from Gloucester High School. ECF No. 113. The original Complaint and the First Amended Complaint asserted that the Board violated Mr. Grimm's rights under Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681(a), and the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution, when it assigned him a restroom based on his biological sex rather than on his gender identity.

The Board filed a motion to dismiss the First Amended Complaint, which this Court denied on May 22, 2018. ECF No. 148. The Board filed an Answer to the First Amended Complaint on July 20, 2018. ECF No. 154.

Mr. Grimm now requests leave to file a Second Amended Complaint, attached as Exhibit A to his Motion. The proposed Second Amended Complaint contains new allegations against the Board.[1] Specifically, Mr. Grimm alleges that the Board continues to discriminate against him "by refusing to update his official school transcript to match the male sex on his birth certificate, despite [Mr. Grimm's] repeated requests." ECF No. 170-1, ¶ 12. Mr. Grimm alleges that he is stigmatized and humiliated whenever he is required to provide a high school transcript to a college or potential employer that declares his sex to be different than his gender identity. *Id.*

Federal Rule of Civil Procedure 15(a) provides that leave to amend "shall be freely given when justice so requires." F.R.C.P. 15(a). "[L]eave to amend a pleading should be denied only when the amendment would be prejudicial to the opposing party, there has been bad faith on the part of the moving party, or the amendment would have been futile." *Laber v. Harvey*, 438 F.3d 404, 426 (4th Cir. 2006) (en banc).

The Board opposes Mr. Grimm's request to file the Second Amended Complaint. The Board does not assert any prejudice or bad faith. Instead, the Board argues that the Second Amended Complaint would be futile because Mr. Grimm's new allegations do not constitute a violation of Mr. Grimm's rights under Title IX or the Equal Protection Clause.

The Board first argues that statutes and regulations passed by the Virginia General Assembly govern the amendment of vital records and that "matters of state law are not properly considered under Title IX or the Equal Protection Clause." ECF No. 171 at 3 (citing Va. Code Ann. § 32.1-269; 12 VAC 5-550-320; 12 VAC 5-550-460). The Board's argument is unpersuasive. The cited regulations do not support the Board's position. For example, 12 VAC

[1] The proposed Second Amended Complaint also contains several minor changes and removes requests for injunctive relief that the Court previously dismissed as moot.

5-550-320 states that a certificate of birth is to be amended upon presentation of acceptable evidence, such as a court order that the name or sex on the certificate be changed. Mr. Grimm obtained a court order from the Virginia Circuit Court and used that court order to obtain a birth certificate indicating his gender as male. He presented that birth certificate to the Board in support of his request to change his transcript. According to the regulations, Mr. Grimm presented acceptable evidence for his request. ECF No. 171-1. If the Board decided to treat Mr. Grimm differently than similarly situated students, that could be evidence of a violation of federal law, a fact that is not altered by the Board's citations to Virginia law.

Second, the Board argues that the Family Educational Rights and Privacy Act ("FERPA"), 20 U.S.C. § 1232g; 34 C.F.R. Part 99, provides the appropriate framework for relief. FERPA provides parents or students the opportunity to request an amendment to educational records. 34 C.F.R. § 99.20(a). If a request is denied, FERPA grants parents and students the right to be notified of the reasons and the right to a hearing to contest the decision. 34 C.F.R. § 99.20(b)–(c). Finally, FERPA grants parents and students the right to "place a statement in the record commenting on the contested information in the record or stating why he or she disagrees with the decision of the agency or institution, or both." 34 C.F.R. § 99.21(b)(1)(ii)(2).

There is no indication that FERPA was intended to be the sole remedy for students contesting information in their vital records. To the contrary, FERPA explicitly provides that "[n]othing in this chapter shall be construed to affect the applicability of . . . title IX of the Education Amendments of 1972 . . . or other statutes prohibiting discrimination." 20 U.S.C. § 1221(d). This language makes clear that FERPA does not preclude a suit pursuant to Title IX.

Nor does FERPA displace equal protection claims under 42 U.S.C. § 1983. In *Fitzgerald v. Barnstable Sch. Comm.*, the United States Supreme Court held that Title IX did not preclude

students from bringing equal protection claims under section 1983 because Title IX does not include "an express private means of redress" and "the protections guaranteed by the two sources of law diverge." 555 U.S. 246, 256 (2009). This line of reasoning applies with even greater force to FERPA, which does not create any private cause of action, expressly or impliedly. *Gonzaga University v. Doe*, 536 U.S. 273, 287 (2002). Moreover, the protection guaranteed by FERPA is that vital records are to be accurate, and the law provides procedural protections to accomplish that end. The protection guaranteed by the Equal Protection Clause, however, is that individuals are to be free from discrimination. In other words, "the protections guaranteed by the two sources of law diverge."

For these reasons, the proposed Second Amended Complaint would not be futile, and the Board has not asserted any other reason to deny Mr. Grimm's Motion for Leave. That Motion, ECF No. 170, is **GRANTED**. The Clerk is **DIRECTED** to file the Second Amended Complaint, ECF No. 170-1.

The Clerk is **REQUESTED** to forward a copy of this Order to all counsel of record.

IT IS SO ORDERED.

/s/
Arenda L. Wright Allen
United States District Judge

February 14th, 2019
Norfolk, Virginia

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM, Plaintiff, v. GLOUCESTER COUNTY SCHOOL BOARD, Defendant.	)	Civil Case No. 4:15-cv-54

SECOND AMENDED COMPLAINT

1. Gavin Grimm ("Gavin") is a 19-year-old young man who is transgender. When Gavin was 15, he came out to his family as a boy and, with the help of his medical providers, transitioned to living in accordance with his male identity as part of medically necessary treatment for gender dysphoria.

2. By the time Gavin began his sophomore year at Gloucester High School, he had legally changed his name to Gavin and begun using male pronouns. Gavin wore his clothing and hairstyles in a manner typical of other boys and used the men's restrooms in public venues, including restaurants, libraries, and shopping centers, without encountering any problems. Gavin's medical providers also gave him a "treatment documentation letter," which confirmed that Gavin was receiving treatment for gender dysphoria and stated that he should be treated as a boy in all respects, including when using the restroom.

3. With the support of the school principal and superintendent, Gavin used the boys' restrooms at Gloucester High School for approximately seven weeks without incident.

4. But in response to complaints from some adults in the community, the Gloucester County School Board (the "Board") overruled its own administrators and enacted a new policy prohibiting boys and girls "with gender identity issues" from using the same restrooms as other boys and girls. The new policy directed students who are transgender to an "alternative appropriate private facility."

5. The Board continued to exclude Gavin from using the same restrooms as other boys, even after he began receiving hormone therapy, obtained a Virginia state I.D. card listing his sex as male, underwent chest reconstruction surgery, obtained a court order legally changing his sex to male under Virginia law, and received a new Virginia birth certificate reflecting that his sex is male.

6. Throughout the rest of high school, Gavin was forced to use separate restrooms that no other student was required to use. That degrading and stigmatizing policy singled Gavin out as unfit to use the same restrooms that are available to every other student.

7. The Board's policy conflicts with the views of every major medical and mental health organization and school counselors', teachers', and administrators' organizations across the country.

8. In every part of the country, including Virginia, boys and girls who are transgender are already using sex-separated restroom and locker room facilities at school, participating in interscholastic athletic teams in both high school and college, and joining girl-scout and boy-scout troops.

9. Ignoring these realities, the Gloucester County School Board has adhered to its categorical ban, which prohibits the Board's own school administrators from ever allowing any

student who is transgender to use the common facilities that are available to every other boy and girl.

10. Gavin is recognized by his family, his medical providers, the Virginia Department of Health, and the world at large as a boy. Allowing him to use the same restrooms as other boys is the only way to provide him access to sex-separated restrooms without discrimination.

11. By segregating Gavin from his peers, excluding him from using the same restrooms that every other boy is allowed to use, and relegating him to separate restroom facilities, the Board discriminated against Gavin, in violation of the Equal Protection Clause of the Fourteenth Amendment and Title IX of the Education Amendments of 1972.

12. The Board also continues to discriminate against Gavin by refusing to update his official school transcript to match the male sex on his birth certificate, despite Gavin's repeated requests. As a result, every time Gavin is required to provide a high school transcript to a college or potential employer, he must provide a transcript that—unlike all his other identification documents—declares that his sex is "female." The Board thus continues to stigmatize and humiliate Gavin by treating Gavin differently from every other graduating student with a male birth certificate, in violation of Title IX and the Fourteenth Amendment.

13. Gavin seeks redress from this Court.

JURISDICTION AND VENUE

14. This action arises under Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681, *et seq.*, the Constitution of the United States, and 42 U.S.C. § 1983. This Court has jurisdiction pursuant to Article III of the United States Constitution and 28 U.S.C. § 1331. Declaratory relief is authorized by 28 U.S.C. §§ 2201 and 2202.

15. Venue lies with this Court pursuant to 28 U.S.C. §§ 1391(b)(1)-(2), because the defendant resides in this District and a substantial part of the events or omissions giving rise to the claim occurred in this District.

PARTIES

16. Plaintiff Gavin Grimm ("Gavin") is nineteen years old. From September 2013 to June 2017, he attended Gloucester High School, a public high school in Gloucester County, Virginia.

17. The Gloucester County School Board (the "School Board" or "Board") is an elected body responsible for the operation of the Gloucester County Public Schools ("GCPS"), including the promulgation of policies. At all times relevant, the School Board has acted and continues to act under color of state law.

FACTUAL ALLEGATIONS

Transgender youth and gender dysphoria

18. Gavin was born in Gloucester County and has lived in Gloucester County his entire life. Gavin is a typical teenager who is articulate and intelligent, reads broadly, loves his dog and cats, and enjoys hanging out with his friends.

19. When Gavin was born, the hospital staff identified him as female, but from a young age, Gavin knew that he was a boy. Although the sex assigned to Gavin at birth was female, Gavin has a male gender identity.

20. Everyone has a gender identity. It is an established medical concept, referring to a person's deeply felt, inherent sense of one's gender. Most people have a gender identity that matches the sex they are identified as at birth. But people who are transgender have a gender identity that differs from the sex they are assigned at birth.

21. Like many students who are transgender, Gavin succeeded at school until the onset of puberty, when he began to suffer debilitating levels of distress from gender dysphoria, a condition in which individuals who are transgender experience persistent and clinically significant distress caused by the incongruence between their gender identity and the sex assigned to them at birth. Although gender dysphoria is a serious medical condition recognized by the American Psychiatric Association's Diagnostic & Statistical Manual of Mental Disorders (5th ed. 2013), being transgender is not a mental disorder and "implies no impairment in judgment, stability, reliability, or general social or vocational capabilities." Am. Psychiatric Ass'n, *Position Statement on Discrimination Against Transgender & Gender Variant Individuals* (2012).

22. There is a medical and scientific consensus that the treatment for gender dysphoria is for boys who are transgender to live as boys and for girls who are transgender to live as girls. When medically appropriate, treatment also includes hormone therapy and surgery. This medical consensus is embraced by the American Medical Association, the American Academy of Pediatrics, the American Psychiatric Association, the American Psychological Association, the National Endocrine Society, and every other major medical and mental health organization in the United States.

23. The ability of individuals who are transgender to live consistently with their identity is critical to their health and well-being. That includes using names and pronouns consistent with their identity, grooming and dressing in a manner typically associated with that gender, and using restrooms and other sex-separated facilities that match their gender identity. Preventing students who are transgender from living in a manner that is consistent with their gender identity puts them at increased risk of debilitating depression and suicide. By contrast,

when gender dysphoria is properly treated, individuals who are transgender experience profound relief and can go on to lead healthy, happy, and successful lives.

24. Boys and girls who are transgender are people who consistently, persistently, and insistently do not identify with the sex assigned to them at birth, and who can experience the debilitating distress of gender dysphoria when they are not able to live as the boys and girls that they are. The gender identity of these adolescents is stable and fixed.

25. Boys and girls who are transgender are attending schools across the country. While students who are transgender have long been part of school communities, it is only in the last couple decades that there has been more widespread access to the medical and psychological support that they need. Beginning in the early 2000s, as a result of advances in medical and psychological treatment, students who are transgender finally began to receive the treatment necessary to alleviate the devastating pain of gender dysphoria and live their lives in accordance with who they really are.

26. Many students who are transgender attend school without classmates and peers knowing they are transgender. For example, many students have already transitioned before beginning school and many others transfer to a new school after transitioning.

27. With hormone therapy, students who are transgender develop physical sex characteristics typical of their gender identity—not the sex they were identified as at birth. Hormone therapy affects bone and muscle structure, alters the appearance of a person's genitals, and produces secondary sex characteristics such as facial and body hair in boys and breasts in girls.

28. In addition, children who are transgender who receive puberty blockers never go through puberty as their birth-designated sex. They will be exposed to the same levels of

testosterone or estrogen as other boys and girls during puberty, and those hormones will affect every major body system.

29. Under widely accepted standards of care developed by the World Professional Association of Transgender Health ("WPATH"), genital surgery is not recommended for minors, but boys who are transgender may undergo medically necessary chest-reconstruction surgery after they turn 16.

30. According to every major medical and mental health organization, including the American Medical Association, the American Academy of Pediatrics, the American Psychiatric Association, and the American Psychological Association, excluding boys and girls who are transgender from using the same restrooms as other boys and girls is harmful to their health and wellbeing. When excluded from the common restrooms, students who are transgender often avoid using the restroom entirely, either because the separate restrooms are too stigmatizing or too difficult to access. They suffer infections and other negative health consequences as a result of avoiding restroom use. The exclusion also increases their risk of depression and self-harm.

31. Educators and school administrators across the country also recognize that excluding boys and girls who are transgender from using the common restrooms interferes with their ability to learn and thrive at school. It impairs their ability to develop a healthy sense of self, peer relationships, and the cognitive skills necessary to succeed in adult life. In light of these harms, the National Association of School Psychologists, National Association of Secondary School Principals, National Association of Elementary School Principals, and the American School Counselor Association have all called upon schools to allow boys and girls who are transgender to use the same restrooms as other boys and girls.

32. According to the American Academy of Pediatrics and other major medical and mental health organizations, there is no evidence that allowing boys and girls who are transgender to use the same restrooms as other boys and girls causes any harm to the physical or mental health of students who are not transgender.

33. Schools can provide accommodations for all students—whether transgender or not—to enhance their own privacy without discriminating against students who are transgender by excluding them from common spaces.

34. In schools across the country, including Virginia, boys and girls who are transgender already use the same restrooms and locker rooms as other boys and girls.

35. In high school athletic associations across the country, including Virginia, boys and girls who are transgender already play on the same sports teams as other boys and girls.

36. Institutions ranging from the Girl Scouts and Boy Scouts to the Seven Sisters colleges to the National Collegiate Athletic Association already recognize boys who are transgender as boys and recognize girls who are transgender as girls.

37. Treating boys who are transgender as boys, and treating girls who are transgender as girls, is the only way they can equally participate in school, work, or society at large.

Gavin's experience at Gloucester High School

38. In 2014, near the end of his first year of high school, the distress caused by Gavin's untreated gender dysphoria became so great that he was unable to attend class. At that point, Gavin came out to his parents as a boy and, at his request, began seeing a psychologist with experience counseling youth who are transgender.

39. With the help of his medical providers, Gavin transitioned to living in accordance with his male identity as part of medically necessary treatment for gender dysphoria.

40. Gavin legally changed his name to Gavin and began using male pronouns. Gavin wore his clothing and hairstyles in a manner typical of other boys and began using the men's restrooms in public venues, including restaurants, libraries, and shopping centers, without encountering any problems. His medical providers also referred Gavin to an endocrinologist to begin hormone therapy.

41. Gavin and his mother met with the school guidance counselor in August 2014, before the beginning of his sophomore year, to explain that Gavin is a boy who is transgender and would be attending school as a boy.

42. Gavin and his mother gave the guidance counselor a "treatment documentation letter" from his psychologist, which confirmed that Gavin was receiving treatment for gender dysphoria and stated that he should be treated as a boy in all respects, including when using the restroom.

43. At the time Gavin and his mother met with the guidance counselor, the School Board did not have policies addressing which restrooms students who are transgender should use.

44. Gavin initially agreed to use the restroom in the nurse's office, but he soon felt stigmatized and isolated using a different restroom from everyone else. The restroom in the nurse's office was also located far away from many of his school classes, and Gavin was often unable to use the restroom without being late for class.

45. After a few weeks of using the restroom in the nurse's office, Gavin sought permission to use the boys' restrooms.

46. On October 20, 2014, with the school principal's support, Gavin began using the boys' restrooms, and did so for seven weeks without incident.

47. Gavin also requested permission to complete his physical-education requirements through a home-bound program. As a result, he never needed to use the locker rooms at school.

48. The principal of Gloucester High School and the superintendent of Gloucester County Public Schools informed the Board that they had authorized Gavin to use the same restrooms as other boys, but otherwise kept the matter confidential.

49. Although the principal and superintendent treated the matter as confidential, some adults in the community learned that a boy who is transgender was using the boys' restrooms at Gloucester High School. They contacted the Board to demand that the transgender student (who was not publicly identified as Gavin until later) be barred from the boys' restrooms.

50. On information and belief, at least some of the complaints came from a Gloucester High School employee who runs the school Bible club and is a pastor at a local church. That employee told the Washington Post that he spoke out against Gavin's use of the boys' restroom because "God puts us on this Earth as who we are."

51. The Board considered the matter at a private meeting and took no action for several weeks.

52. Unsatisfied with the results of the private meeting, one member of the Board alerted the broader community by proposing the following policy for public debate at the Board's meeting on November 11, 2014:

> Whereas the GCPS recognizes that some students question their gender identities, and
>
> Whereas the GCPS encourages such students to seek support, advice, and guidance from parents, professionals and other trusted adults, and
>
> Whereas the GCPS seeks to provide a safe learning environment for all students and to protect the privacy of all students, therefore
>
> It shall be the practice of the GCPS to provide male and female restroom and locker room facilities in its schools, and the use of said facilities shall be limited to the corresponding

biological genders, and students with gender identity issues shall be provided an alternative appropriate private facility.

53. The policy categorically prohibits administrators from allowing any boy who is transgender to use any boys' restroom (or allowing any girl who is transgender to use any girls' restroom) in any school within the Gloucester County School District, regardless of the student's individual circumstances.

54. The policy does not define "biological gender," and the term has no common or accepted meaning. There are many biological components of sex, including chromosomal, anatomical, hormonal, and reproductive elements, some of which could be ambiguous or in conflict within an individual, either because that individual has intersex traits or because that individual has undergone medical care for gender dysphoria.

55. After learning about the meeting through social media, Gavin and his parents decided to speak against the proposed policy. In order to speak against the policy, Gavin was forced to reveal himself to the entire community and the local media as the boy whose restroom use was at issue.

56. Gavin told the Board:

> I use the public restroom, the men's public restroom, in every public space in Gloucester County and others. I have never once had any sort of confrontation of any kind.
> …
> All I want to do is be a normal child and use the restroom in peace, and I have had no problems from students to do that—only from adults.
> …
> I did not ask to be this way, and it's one of the most difficult things anyone can face.
> …
> I am just a human. I am just a boy.

A recording of his remarks can be viewed online at https://goo.gl/CYh4gd

57. By a vote of 4-3, the School Board voted to defer a vote on the policy until its meeting on December 9, 2014.

58. Before its next meeting, the Board issued a press release announcing plans for "adding or expanding partitions between urinals in male restrooms, and adding privacy strips to the doors of stalls in all restrooms." In addition, the press release announced "plans to designate single stall, unisex restrooms … to give all students the option for even greater privacy."

59. Speakers at the December 9, 2014 Board meeting nonetheless demanded that Gavin be excluded from the boys' restrooms immediately, and many threatened to vote Board members out of office if they refused to pass the new policy.

60. With Gavin in attendance, several speakers pointedly referred to him as a "young lady." One speaker called Gavin a "freak" and compared him to a person who thinks he is a "dog" and wants to urinate on fire hydrants. "Put him in a separate bathroom if that's what it's going to take," said another.

61. The Board meeting made Gavin feel that he had been turned into a public spectacle in front of the entire community.

62. The Board passed the policy on December 9, 2014, by a 6-1 vote.

63. The following day, the principal told Gavin he could no longer use the same restrooms as other boys.

64. The Board's new policy did not affect the restroom usage of any other student at Gloucester High School. Every other student was allowed to continue using the same restrooms they had been using before the new policy was adopted. The only person who had to use a different restroom was Gavin.

65. The Board subsequently installed three single-user restrooms. One of the restrooms had previously been designated as a restroom for teachers and staff. The other two restrooms were converted from old utility closets.

66. None of the single-user restrooms was located near Gavin's classes.

67. Although any student was allowed to use the single-user restrooms, no one else did so. Everyone knew they were created for Gavin as part of the policy prohibiting him from using the same restrooms as other boys.

68. Being relegated to the separate restrooms was demeaning and shameful for Gavin. It signaled to Gavin and the entire school community that he is different, and it sent a public message to all his peers that he is not fit to be treated like everyone else.

69. Gavin did everything he could to avoid using the restroom at school. As a result, he developed painful urinary tract infections and was often distracted and uncomfortable in class.

70. When Gavin absolutely had to use the restroom, he used the nurse's restroom, but he still felt ashamed doing so. Every time he had to walk to the other side of school to use the nurse's restroom, Gavin felt like he was taking a "walk of shame." It was a constant reminder to Gavin—and to anyone who saw him—that Gavin is transgender and had been barred from using the same restrooms as other boys.

71. Being excluded from the common boys' restroom and forced to use separate restroom facilities also physically isolated Gavin from the rest of his peers by requiring him to travel to a separate part of the school if he had to use the restroom between classes.

72. When Gavin attended school football games, there was no restroom for him to use at all. The Gloucester High School building was locked after school, and there are no single-user

restroom facilities in the stadium. When he had to use the restroom, Gavin's only option was to call his mother to pick him up and take him home early.

Enforcement of the policy

73. The Board continued to exclude Gavin from the same restrooms as other boys throughout the remainder of his sophomore, junior, and senior years of high school.

74. In December 2014, Gavin began hormone therapy, which has altered his bone and muscle structure, deepened his voice, and caused him to grow facial hair.

75. In June 2015, the Virginia Department of Motor Vehicles issued Gavin a state I.D. card identifying him as male.

76. In June 2016, Gavin underwent chest-reconstruction surgery, in accordance with the medical standards of care for treating gender dysphoria.

77. On September 9, 2016, the Gloucester County Circuit Court issued an order changing Gavin's sex under Virginia state law and directing the Virginia Department of Health to issue Gavin a birth certificate listing his sex as male.

78. On October 27, 2016, the Virginia Department of Health issued Gavin a birth listing his sex as male.

79. Despite all of this, the Board disregarded Gavin's medical treatment, his Virginia I.D. card, his new Virginia birth certificate, and the court order changing his sex under Virginia state law. The Board maintained that Gavin's "biological gender" remains female and continued to prohibit its administrators from allowing Gavin to use the boys' restrooms.

Refusal to update gender designation on Gavin's official transcript

80. During his senior year, Gavin received an updated Virginia birth certificate reflecting that his sex is male and provided that birth certificate to school administrators. But

despite Gavin's repeated requests, the Board refused to update his official school transcript to match the male sex on his birth certificate. In doing so, the Board once again singled out Gavin for different treatment from every other student at Gloucester High School with a male birth certificate.

81. Every time Gavin is required to provide a high school transcript to a college or employer, he must provide a transcript that—unlike all his other identification documents—declares that his sex is "female."

82. Gavin graduated high school on June 10, 2017. But by refusing to update Gavin's official school transcript, the Board continues to stigmatize and humiliate Gavin to this day.

CLAIMS FOR RELIEF

COUNT I
Fourteenth Amendment to the United States Constitution

83. The Board is the final policymaker for Gloucester County Public Schools, acting under color of state law.

84. By excluding Gavin from using the same restrooms that every other boy is allowed to use and relegating him to separate restroom facilities, the Board treated Gavin differently from similarly situated students in violation of the Equal Protection Clause of the Fourteenth Amendment.

85. By excluding Gavin from using the same restrooms that every other boy is allowed to use and relegating him to separate restroom facilities, the Board discriminated against Gavin on the basis of gender, which is subject to heightened scrutiny under the Equal Protection Clause.

86. By excluding Gavin from using the same restrooms that every other boy is allowed to use and relegating him to separate restroom facilities, the Board discriminated against

Gavin on the basis of transgender status, which is also subject to heightened scrutiny under the Equal Protection Clause.

a. People who are transgender as a class have historically been subject to discrimination.

b. People who are transgender as a class have a defining characteristic that frequently bears no relation to an ability to perform or contribute to society.

c. People who are transgender as a class exhibit immutable or distinguishing characteristics that define them as a discrete group.

d. People who are transgender as a class are a minority with relatively little political power.

87. By excluding Gavin from using the same restrooms that every other boy is allowed to use and relegating him to separate restroom facilities, the Board discriminated against Gavin based on invidious stereotypes, moral disapproval, and unfounded fears about people who are different.

88. By refusing to update Gavin's official school transcript to match the male designation on his updated birth certificate, the Board has discriminated—and continues to discriminate—against Gavin.

89. The Board's discrimination against Gavin is not narrowly tailored to advance a compelling government interest.

90. The Board's discrimination against Gavin is not substantially related to any important government interest.

91. The Board's discrimination against Gavin is not rationally related to any legitimate government interest.

92. The Board is liable for its violation of Gavin's Fourteenth Amendment rights under 42 U.S.C. § 1983.

COUNT II
Title IX of the Education Amendments of 1972
20 U.S.C. § 1681 *et seq*.

93. Title IX provides that "[n]o person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance." 20 U.S.C. § 1681(a).

94. Gloucester County Public Schools and Gloucester High School are education programs receiving Federal financial assistance.

95. By prohibiting Gavin from using the same restrooms that every other boy is allowed to use and relegating him to separate restroom facilities, the Board violated his rights under Title IX.

96. By refusing to update Gavin's official school transcript to match the male designation on his updated birth certificate, the Board violated—and continues to violate—his rights under Title IX.

REQUEST FOR RELIEF

For the foregoing reasons, Plaintiff respectfully requests that the Court grant the following relief:

A. A declaration that the Board's policy violated Gavin's rights under the Fourteenth Amendment to the United States Constitution and Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681, *et seq.*, on the day the policy was first issued and throughout the remainder of his time as a student at Gloucester High School;

B. A declaration that the Board's refusal to update Gavin's official school transcript to match the "male" designation on his updated birth certificate violated—and continues to violate—Gavin's rights under the Fourteenth Amendment to the United States Constitution and Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681, *et seq.*

C. Nominal damages in an amount determined by the Court;

D. A permanent injunction requiring the Board to update Gavin's official school records to match the male designation on his updated birth certificate;

E. Plaintiff's reasonable costs and attorneys' fees pursuant to 42 U.S.C. § 1988; and

F. Such other relief as the Court deems just and proper.

Dated: February 15, 2019

Respectfully submitted,

AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF VIRGINIA, INC.

/s/
Nicole Tortoriello (VSB No. 91129)
Eden B. Heilman*
Jennifer Safstrom**
ACLU of Virginia
701E. Franklin Street, Suite 1412
Richmond, VA 23219
(804) 644-8022 (Phone)
(804) 649-2733 (Fax)
ntortoriello@acluva.org
eheilman@acluva.org
jsafstrom@acluva.org

AMERICAN CIVIL LIBERTIES UNION
FOUNDATION
Joshua A. Block*
Leslie Cooper*
Shayna Medley-Warsoff*
125 Broad Street
18th Floor
New York, NY 10004
(212) 549-2627 (Phone)
(212) 549-2650 (Fax)
jblock@aclu.org
lcooper@aclu.org
smedley@aclu.org

* Admitted pro hac vice
**Admission pending, notice of appearance forthcoming

Counsel for Plaintiff Gavin Grimm

CERTIFICATE OF SERVICE

I hereby certify that on the 15th day of February 2019, I electronically filed the foregoing with the Clerk of the Court for the U.S. District Court for the Eastern District of Virginia by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

/s/ Nicole Tortoriello
Nicole Tortoriello (VSB No. 91129)
ACLU Foundation of Virginia
701 E. Franklin Street, Suite 1412
Richmond, VA 23219
(804) 644-8022 (Phone)
(804) 649-2733 (Fax)
ntortoriello@acluva.org

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM,

Plaintiff,

v. Case No. 4:15-cv-54

GLOUCESTER COUNTY SCHOOL BOARD,

Defendant.

ANSWER TO SECOND AMENDED COMPLAINT

Defendant Gloucester County School Board ("School Board") states as follows for its Answer to the Second Amended Complaint filed by Plaintiff Gavin Grimm ("Grimm"):

1. The School Board admits that Grimm is 19 years old, asserts that he is transgender, but is without sufficient knowledge to form a belief as to the truth or falsity of the remaining allegations contained in Paragraph 1 of Grimm's Second Amended Complaint. As such, those allegations are hereby denied.

2. Upon information and belief, the School Board admits that Grimm changed his name to Gavin and that Gavin received a document entitled "treatment documentation letter," which speaks for itself. The School Board is without sufficient knowledge to form a belief as to the truth or falsity of the remaining allegations contained in Paragraph 2 of Grimm's Second Amended Complaint in the manner and form alleged. As such, those allegations are hereby denied.

3. The School Board admits that Grimm used the boys' restrooms at Gloucester High School for a period of time; however, the School Board denies the remaining allegations

contained in Paragraph 3 of Grimm's Second Amended Complaint in the manner and form alleged.

4. The School Board admits that it received complaints and inquiries from students, parents of students, and other adults, but denies the remaining allegations contained in Paragraph 4 of Grimm's Second Amended Complaint in the manner and form alleged.

5. The School Board denies the allegations contained in Paragraph 5 of Grimm's Second Amended Complaint in the manner and form alleged.

6. The School Board denies the allegations contained in Paragraph 6 of Grimm's Second Amended Complaint in the manner and form alleged.

7. The School Board denies the allegations contained in Paragraph 7 of Grimm's Second Amended Complaint in the manner and form alleged.

8. The School Board denies the allegations contained in Paragraph 8 of Grimm's Second Amended Complaint in the manner and form alleged.

9. The School Board denies the allegations contained in Paragraph 9 of Grimm's Second Amended Complaint in the manner and form alleged.

10. The School Board is without sufficient knowledge to form a belief as to the truth or falsity of the allegations contained in the first sentence of Paragraph 10 of Grimm's Second Amended Complaint. The School Board denies the allegations contained in the second sentence of Paragraph 10 of Grimm's Second Amended Complaint in the manner and form alleged.

11. The School Board denies the factual allegations contained in Paragraph 11 of Grimm's Second Amended Complaint in the manner and form alleged, and further denies that it has violated the Equal Protection Clause of the Fourteenth Amendment or Title IX of the Educational Amendments of 1972.

12. The School Board denies the allegations contained in Paragraph 12 of Grimm's Second Amended Complaint in the manner and form alleged.

13. The School Board denies that Grimm is entitled to the relief requested or any relief.

JURISDICTION AND VENUE

14. Paragraph 14 of Grimm's Second Amended Complaint contains legal conclusions to which no response is required. The School Board, however, denies that it has violated the Equal Protection Clause of the Fourteenth Amendment or Title IX of the Educational Amendments of 1972.

15. Paragraph 15 of Grimm's Second Amended Complaint contains legal conclusions to which no response is required. The School Board, however, denies it took any act in violation of the Equal Protection Clause of the Fourteenth Amendment or Title IX of the Educational Amendments of 1972.

PARTIES

16. The School Board admits the allegations contained in Paragraph 16 of Grimm's Amended Complaint.

17. The School Board admits the allegations contained in Paragraph 17 of Grimm's Amended Complaint.

FACTUAL ALLEGATIONS

18. The School Board is without sufficient knowledge to form a belief as to the truth or falsity of the allegations contained in Paragraph 18 of Grimm's Second Amended Complaint. As such, those allegations are hereby denied.

19. The School Board admits that at birth Grimm's gender was identified as female in conformity with his biological sex. The School Board is without sufficient knowledge to form a belief as to the truth or falsity of the remaining allegations contained in Paragraph 19 of Grimm's Second Amended Complaint. As such, those allegations are hereby denied in the manner and form alleged.

20. The allegations contained in Paragraph 20 of Grimm's Second Amended Complaint are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations as stated. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

21. The School Board does not possess sufficient information to form a belief as to the truth or falsity of the factual allegations contained in Paragraph 21 of Grimm's Second Amended Complaint pertaining specifically to Grimm. As such, those allegations are hereby denied. Further, the remaining allegations in Paragraph 21 are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations as stated. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

22. The allegations contained in Paragraph 22 of Grimm's Second Amended Complaint are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations as stated. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

23. The allegations contained in Paragraph 23 of Grimm's Second Amended Complaint are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations as stated. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

24. The allegations contained in Paragraph 24 of Grimm's Second Amended Complaint are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations as stated. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

25. The allegations contained in Paragraph 25 of Grimm's Second Amended Complaint are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations as stated. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

26. The allegations contained in Paragraph 26 of Grimm's Second Amended Complaint are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations as stated. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

27. The allegations contained in Paragraph 27 of Grimm's Second Amended Complaint are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations as

stated. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

28. The allegations contained in Paragraph 28 of Grimm's Second Amended Complaint are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations as stated. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

29. The allegations contained in Paragraph 29 of Grimm's Second Amended Complaint are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations as stated. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

30. The allegations contained in Paragraph 30 of Grimm's Second Amended Complaint are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations as stated. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

31. The allegations contained in Paragraph 31 of Grimm's Second Amended Complaint are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations as stated. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

32. The allegations contained in Paragraph 32 of Grimm's Second Amended Complaint are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations as stated. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

33. Paragraph 33 of Grimm's Second Amended Complaint contains legal conclusions to which no response is required. The School Board denies any factual allegations contained in Paragraph 33 in the manner and form alleged, and further denies that it has discriminated against Grimm.

34. The School Board is without sufficient knowledge to form a belief as to the truth or falsity of the allegations contained in Paragraph 34 of Grimm's Second Amended Complaint. As such, those allegations are hereby denied.

35. The School Board is without sufficient knowledge to form a belief as to the truth or falsity of the allegations contained in Paragraph 35 of Grimm's Second Amended Complaint. As such, those allegations are hereby denied.

36. The School Board is without sufficient knowledge to form a belief as to the truth or falsity of the allegations contained in Paragraph 36 of Grimm's Second Amended Complaint. As such, those allegations are hereby denied.

37. The allegations contained in Paragraph 37 of Grimm's Second Amended Complaint are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

38. The School Board is without sufficient knowledge to form a belief as to the truth or falsity of the allegations contained in Paragraph 38 of Grimm's Second Amended Complaint.

39. The School Board is without sufficient knowledge to form a belief as to the truth or falsity of the allegations contained in Paragraph 39 of Grimm's Second Amended Complaint.

40. The School Board admits, upon information and belief, that Grimm changed his name to Gavin and began using male pronouns. The School Board is without sufficient knowledge to form a belief as to the truth or falsity of the remaining allegations contained in Paragraph 40 of Grimm's Second Amended Complaint.

41. The School Board admits that Grimm and his mother met with a guidance counselor near the beginning of the 2014-2015 school year; however, the School Board denies the remaining allegations contained in Paragraph 41 of Grimm's Second Amended Complaint in the manner and form alleged.

42. The School Board admits that, at a later time, the school principal was shown a copy of the "treatment documentation letter," which speaks for itself, and at some point a copy of that letter was given to the guidance counselor; however, the School Board is without sufficient knowledge to form a belief as to the truth or falsity of the remaining allegations contained in Paragraph 42 of Grimm's Second Amended Complaint. As such, those allegations are hereby denied.

43. In answer to Paragraph 43 of Grimm's Second Amended Complaint, the School Board avers that its policy related to student restroom use applied equally to all students and did not violate the Equal Protection Clause or Title IX. The School Board denies all remaining allegations contained in Paragraph 43 of Grimm's Second Amended Complaint in the manner and form alleged.

44. In response to the allegations contained in Paragraph 44 of Grimm's Second Amended Complaint, the School Board admits that Gavin requested to use the restroom in the nurse's office; however, the School Board is without sufficient knowledge to form a belief as to the truth or falsity of the remaining allegations contained in that paragraph; and therefore those allegations are hereby denied.

45. The School Board admits the allegations contained in Paragraph 45 of Grimm's Second Amended Complaint.

46. The School Board admits that on or about October 20, 2014, Grimm began using the male restrooms with the principal's permission**;** however, the School Board denies the remaining allegations contained in Paragraph 46 in the manner and form alleged.

47. The School Board admits that Grimm requested to complete his physical-education requirements through virtual classes, but is without sufficient knowledge to form a belief as to the truth or falsity of the remaining allegations contained in Paragraph 47 of Grimm's Second Amended Complaint; and therefore those allegations are hereby denied.

48. In response to the allegations contained in Paragraph 48 of Grimm's Second Amended Complaint, the School Board admits that the principal authorized Grimm to use the boys' restrooms, the superintendent informed the School Board of that decision, and both the principal and the superintendent otherwise kept the matter confidential; however, the School Board denies the remaining allegations contained in that paragraph in the manner and form alleged.

49. The School Board denies the allegations contained in Paragraph 49 of Grimm's Second Amended Complaint in the manner and form alleged.

50. Upon information and belief, the School Boards admits that a pastor in the community who is a Gloucester High School employee made statements, not in his capacity as a school employee, to the Washington Post as set forth in Paragraph 50 of the Second Amended Complaint.

51. The School Board denies the allegations contained in Paragraph 51 of Grimm's Second Amended Complaint in the manner and form alleged.

52. The School Board admits a board member proposed the quoted resolution, which speaks for itself, at the School Board's November 11, 2014, but denies the remaining allegations contained in Paragraph 52 of Grimm's Second Amended Complaint in the manner and form alleged.

53. The School Board denies the allegations contained in Paragraph 53 of Grimm's Second Amended Complaint in the manner and form alleged. The School Board avers that, in a December 9, 2014 Board meeting, it enacted a resolution, which speaks for itself, concerning the use of restroom facilities by all students, including those students that question their gender identities.

54. In response to the allegations contained in Paragraph 54 of Grimm's Second Amended Complaint, the School Board avers that the resolution speaks for itself. The remaining allegations contained in that paragraph are conclusory as they call for an expert opinion. The School Board is without sufficient personal knowledge to form a belief as to the truth or falsity of these allegations as stated. As such, these allegations are hereby denied, and the School Board calls for strict proof thereof.

55. The School Board is without sufficient knowledge to form a belief as to the truth or falsity of the allegations contained in the first sentence of Paragraph 55 of Grimm's Second

Amended Complaint; however, the School Board denies the allegations contained in the second sentence of that paragraph in the manner and form alleged.

56. The School Board admits that an excerpt of Grimm's comments is set forth in Paragraph 56 of Grimm's Second Amended Complaint.

57. The School Board admits the allegations contained in Paragraph 57 of Grimm's Second Amended Complaint.

58. The School Board admits that it issued a press release on December 3, 2014, which speaks for itself.

59. The School Board denies the allegations contained in Paragraph 59 of the Second Amended Complaint in the manner and form alleged.

60. The School Board denies the allegations contained in Paragraph 60 of Grimm's Second Amended Complaint in the manner and form alleged. The School Board avers that any allegations related to the comments of public attendees to the School Board's meeting are not properly directed to the School Board. The School Board further avers that those comments speak for themselves.

61. The School Board is without sufficient knowledge to form a belief as to the truth or falsity of the allegations contained in Paragraph 61 of Grimm's Second Amended Complaint. As such, those allegations are hereby denied.

62. The School Board admits the allegations contained in Paragraph 62 of Grimm's Second Amended Complaint.

63. The School Board admits that after the December 9, 2014 School Board meeting, the principal told Gavin he could not use the boys' restroom; however, the School Board denies

the remaining allegations contained in Paragraph 63 of Grimm's Second Amended Complaint in the manner and form alleged.

64. The School Board denies the allegations contained in Paragraph 64 of Grimm's Second Amended Complaint in the manner and form alleged. The School Board avers that, in a December 9, 2014 Board meeting, it enacted a resolution, which speaks for itself, concerning the use of restroom facilities by all students, including those students that question their gender identities.

65. In response to the allegations contained in Paragraph 65 of the Second Amended Complaint, the School Board admits that it made three single-user restrooms available to all students and that these restrooms included a restroom that had previously been designated for teacher and staff use; however, the School Board denies the remaining allegations contained in that paragraph in the manner and form alleged.

66. The School Board denies the allegations contained in Paragraph 66 of Grimm's Second Amended Complaint in the manner and form alleged.

67. The School Board denies the allegations contained in Paragraph 67 of Grimm's Second Amended Complaint in the manner and form alleged.

68. The School Board denies the allegations contained in Paragraph 68 of Grimm's Second Amended Complaint in the manner and form alleged.

69. The School Board is without sufficient knowledge to form a belief as to the truth or falsity of the allegations contained in Paragraph 69 of Grimm's Second Amended Complaint. As such, those allegations are hereby denied.

70. The School Board is without sufficient knowledge to form a belief as to the truth or falsity of the allegations contained in Paragraph 70 of Second Grimm's Amended Complaint. As such, those allegations are hereby denied.

71. The School Board denies the allegations in Paragraph 71 of Grimm's Second Amended Complaint in the manner and form alleged.

72. The School Board admits that there were no single-user restrooms in the Gloucester High School football stadium; however, the School Board is without sufficient knowledge to form a belief as to the truth or falsity of the remaining allegations contained in Paragraph 72 of Grimm's Second Amended Complaint, and therefore denies those allegations.

73. The School Board denies the allegations contained in Paragraph 73 of Grimm's Second Amended Complaint in the manner and form alleged. The School Board avers that, in a December 9, 2014 Board meeting, it enacted a resolution concerning the use of restroom facilities by all students, including those students that question their gender identities.

74. The School Board does not possess sufficient information to form a belief as to the truth or falsity of the allegations contained in Paragraph 74 of Grimm's Second Amended Complaint. As such, those allegations are hereby denied.

75. The School Board does not possess sufficient knowledge to form a belief as to the truth or falsity of the allegations contained in Paragraph 75 of Grimm's Second Amended Complaint.

76. The School Board does not possess sufficient information to form a belief as to the truth or falsity of the allegations contained in Paragraph 76 of Grimm's Second Amended Complaint. As such, those allegations are hereby denied. Further, the allegations contained in

Paragraph 76 of Grimm's Second Amended Complaint improperly call for an expert opinion, and the School Board calls for strict proof of those allegations.

77. The School Board, upon information and belief, admits that an Order was entered by the Gloucester County Circuit Court which speaks for itself. The School Board denies the remaining allegations contained in Paragraph 77 of Grimm's Second Amended Complaint in the manner and form alleged.

78. The School Board denies the allegations contained in Paragraph 78 of Grimm's Second Amended Complaint in the manner and form alleged.

79. In response to Paragraph 79 of Grimm's Second Amended Complaint, the School Board admits that Plaintiff's biological sex is female, but denies the remaining allegations contained therein in the manner and form alleged.

80. In response to Paragraph 80 of Grimm's Second Amended Complaint, the School Board admits that in November of 2016, Grimm provided a different Virginia birth certificate listing Grimm's sex as male; however, the School Board denies that the birth certificate was issued in conformity with Virginia law based upon the School Board's understanding of the Code of Virginia and applicable administrative regulations. The School Board admits that Grimm's official school transcript was not altered and is consistent with Grimm's original birth certificate and sex upon enrolling in high school. The School Board denies the remaining allegations contained therein in the manner and form alleged.

81. The School Board is without sufficient information to form a belief as to the truth or falsity of the allegations contained in Paragraph 81 of Grimm's Second Amended Complaint. As such, those allegations are hereby denied.

82. The School Board admits that Grimm graduated high school on June 10, 2017. The School Board denies the remaining allegations contained in Paragraph 82 of Grimm's Second Amended Complaint.

CLAIMS FOR RELIEF

COUNT I
Fourteenth Amendment to the United States Constitution

83. Paragraph 83 of Grimm's Second Amended Complaint contains legal conclusions to which no response is required.

84. The School Board denies the allegations contained in Paragraph 84 of Grimm's Second Amended Complaint.

85. The School Board denies the allegations contained in Paragraph 85 of Grimm's Second Amended Complaint.

86. The School Board denies the allegations contained in Paragraph 86 of Grimm's Second Amended Complaint, including all subparts.

87. The School Board denies the allegations contained in Paragraph 87 of Grimm's Second Amended Complaint.

88. The School Board denies the allegations contained in Paragraph 88 of Grimm's Second Amended Complaint.

89. The School Board denies the allegations contained in Paragraph 89 of Grimm's Second Amended Complaint.

90. The School Board denies the allegations contained in Paragraph 90 of Grimm's Second Amended Complaint.

91. The School Board denies the allegations contained in Paragraph 91 of Grimm's Second Amended Complaint.

92. The School Board denies the allegations contained in Paragraph 92 of Grimm's Second Amended Complaint.

COUNT II

Title IX of the Education Amendments of 1972
20 U.S.C. § 1681 *et seq.*

93. Paragraph 93 of Grimm's Second Amended Complaint contains a quotation of 20 U.S.C. § 1681(a) and does not require a response.

94. The School Board admits the allegations contained in Paragraph 94 of Grimm's Second Amended Complaint.

95. The School Board denies the allegations contained in Paragraph 95 of Grimm's Second Amended Complaint.

96. The School Board denies the allegations contained in Paragraph 96 of Grimm's Second Amended Complaint.

REQUEST FOR RELIEF

97. The School Board denies any factual allegations contained in the unnumbered paragraph, including all subparts, related to Grimm's request for relief, and further denies that Grimm is entitled to the remaining requested relief or any other relief.

DEFENSES

98. The School Board denies all allegations contained in Grimm's Second Amended Complaint not specifically admitted herein.

99. The School Board denies any wrongdoing and further denies that it violated Grimm's Constitutional Rights or Title IX (20 U.S.C. § 1681 *et seq.*) in any way.

100. The School Board avers that Grimm's claims are moot and fail for that reason.

101. The School Board avers that the notice requirement of the Spending Clause of the United States Constitution (Art. I, § 8, cl. 1) precludes a finding that the School Board violated Title IX, and Grimm's Title IX claims fail for that reason.

102. The School Board avers that it has an interest in protecting the privacy rights of all of its students, that the resolution adopted during the December 9, 2014 School Board meeting serves this important governmental objective, and that any alleged discriminatory conduct of the School Board is substantially related to achieving that objective. For these reasons, the School Board avers that Grimm's Equal Protection Clause claims fail.

103. The School Board denies that Grimm suffered a compensable injury caused by the School Board.

104. The School Board avers that it acted lawfully and with legal justification at all times referenced in Grimm's Second Amended Complaint.

105. The School Board denies that it is liable to Grimm in the amount claimed or any amount, for the reasons stated or for any other reasons.

106. The School Board reserves the right to amend this Answer at any time, including not limited to, any amendment necessary in the event that evidence becomes available during the course of discovery or at trial that may warrant assertion of a new defense, including affirmative defenses.

WHEREFORE, for the foregoing reasons, Defendant Gloucester County School Board, by counsel, respectfully requests judgment in its favor together with costs expended herein.

GLOUCESTER COUNTY SCHOOL BOARD

By Counsel

/s/ ________________________________
David P. Corrigan (VSB No. 26341)
Jeremy D. Capps (VSB No. 43909)
Attorneys for Gloucester County School Board
Harman, Claytor, Corrigan & Wellman
P.O. Box 70280
Richmond, Virginia 23255
804-747-5200 - Phone
804-747-6085 - Fax
dcorrigan@hccw.com
jcapps@hccw.com

C E R T I F I C A T E

I hereby certify that on the 1st day of March, 2019, I filed a copy of the foregoing document with the Clerk of the Court using the CM/ECF system, which will automatically send a Notice of Electronic Filing to all counsel of record.

Claire G. Gastañaga
American Civil Liberties Union of Virginia Foundation, Inc.
701 E. Franklin Street, Suite 1412
Richmond, VA 23219
804-644-8080 - Phone
804-649-2733 - Fax
claire@acluva.org

Joshua A. Block, Esq. (Pro hac vice)
Leslie Cooper, Esq. (Pro hac vice)
American Civil Liberties Union
125 Broad Street, 18th Floor
New York, NY 10004
212-549-2627 - Phone
212-549-2650 – Fax
jblock@aclu.org
lcooper@aclu.org

Clare P. Wuerker, Esq.
VSB 79236
United States Attorney's Office
101 West Main Street
Suite 8000
Norfolk, VA 23510
757-441-6331 - Phone
757-441-6689 – Fax
Claire.Wuerker@usdoj.gov

Victoria Lill, Esq. (Pro hac vice)
United States Department of Justice
950 Pennsylvania Ave., N.W.
Educational Opportunities Section, PHB
Washington, DC 20530
202-514-4092 - Phone
202-514-8337 - Fax
Victoria.Lill@usdoj.gov

/s/________________________________
David P. Corrigan (VSB No. 26341)
Jeremy D. Capps (VSB No. 43909)
Attorneys for Gloucester County School Board
Harman, Claytor, Corrigan & Wellman
P.O. Box 70280
Richmond, Virginia 23255
804-747-5200 - Phone
804-747-6085 - Fax
dcorrigan@hccw.com
jcapps@hccw.com

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM,	)	
	)	
	)	
Plaintiff,	)	
	)	Civil Case No. 4:15-cv-54
v.	)	
	)	
GLOUCESTER COUNTY SCHOOL BOARD,	)	
	)	
	)	
Defendant.	)	

DECLARATION OF GAVIN GRIMM

1. I am the plaintiff in the above-captioned action. I have actual knowledge of the matters stated in this declaration.

2. My name is Gavin Elliot Grimm.

3. I was born in Gloucester County on May 4, 1999, and lived in Gloucester County all my life until January 2018.

4. I currently reside in Berkeley, California where I attend school at Berkeley City College and engage in community activism work.

5. I was a student at Gloucester High School and graduated on June 5, 2017.

My Early Childhood Before Transition

6. I have always known that I am a boy. I always saw myself as a boy, identified with male cartoons, and related to male characters. During imaginary play as a young child, I always cast myself in a male role with a traditionally male or gender-neutral name.

7. Around the time that I reached school age, I first started to understand that others perceived me as a girl. I also began to recognize that society perceives large differences between

men and women, including different expectations about their social roles. In part, this realization developed as I expressed interest in activities that were not available to me because I was seen by others as a girl. At that point, I had an understanding that the female physical and social role I was assigned were inaccurate. But I did not have the language at the time to vocalize those feelings.

8. Starting in elementary school, I was bullied throughout my entire school career, in part because I did not conform to traditionally feminine gender expectations. Peers threw things at me, called me horrible names, refused to sit near me, and excluded me from activities. I was called names frequently, at least once or twice a day. Students would call me "faggot," "dyke," "homo," "weirdo," and make references to my weight.

9. I recall one instance when students were asked to line up boy, girl, boy, girl. I remember the person assigning students placed me in one of the "boy" positions. This was a moment of great joy for me.

10. Throughout my childhood I would request boys' clothing, but was told it was not appropriate for me. As I grew older, I would fight with my mom to let me shop in the boys' aisle. I remember a particularly distressing experience when my sister got married and my mother insisted I wear a dress. That was a painful, drawn-out process. For every store we went to, I would walk in, take one look, and say I hated them all. I really fought hard not to wear a dress and eventually, after a lot of tears, I wore one that was very plain and black, like a square with straps. I was incredibly distressed, and the first thing I greeted my relatives with was "please don't call me pretty," because I did not want to be perceived as feminine in any way.

11. At around age 12, I was able to exercise more control over my clothing and hairstyle. I cut my hair short in a style traditionally associated with boys, and wore clothing exclusively from the boys' section of stores.

12. When I was 13, I also began using a compression garment, often referred to as a chest binder, to flatten my breasts. I never left the house without wearing the compression garment.

13. Everyone who knew me still assumed that I was a girl because I had not at that time discovered the word transgender and how that related to who I was. But, outwardly, I presented very masculine, and that was not something that was unnoticed by peers and friends. When I went in women's restrooms, I was chased out or yelled at by girls or women saying "you are not supposed to be in here," or telling me that I was in the wrong place and needed to leave.

My Gender Transition and Coming Out

14. Around the same time, I first learned about the term "transgender" from the internet, and realized that there was a word for the feelings I had felt all my life. I had not known about gender transition before, and I was ecstatic to discover it was something a person could do.

15. I had very few friends when I was younger, but as I acknowledged my male gender identity to myself and began to feel more comfortable with who I am, I began to form a group of close friends. One time in ninth grade, before I had revealed to any of my friends that I was transgender, I remember a friend saw another student and remarked, "that looks like the male version of Gavin." My other friend said in response, "Gavin is the male version of Gavin." (This was before I changed my name, so they actually used said my old name instead of "Gavin" when they talked.) I was elated that one of my closest friends perceived me as male, even before I had revealed my gender identity to them.

16. During ninth grade, I gradually began disclosing to friends that I was a boy. Since the reactions of my friends were generally positive and supportive, I disclosed my gender identity to more friends. By the end of ninth grade, most of my friends were aware of my gender identity, and I lived openly as a boy when socializing with friends away from home and school.

17. But I was still afraid to reveal to my family or teachers that I was transgender. My home and community environment was very conservative and also religious. The teachings of the churches in our community were that being gay or transgender was wrong and evil.

18. This made my ninth grade year very difficult for me. Continuing to be seen by others as a girl was incredibly distressing to me. When I would raise my hand to answer a question in class, teachers would say "yes, ma'am." Teachers continued to refer to me by a female name. Using the girls' restrooms was also a constant source of anxiety, so I began avoiding the restrooms at school.

19. The cumulative stress of being constantly misgendered caused depression and anxiety so severe that I could not attend school during the spring semester of my freshman year. My ability to function at school became so diminished that it was not possible for me to continue going to school. My social anxiety related to being gendered incorrectly was so bad that I was afraid to go outside, where I might encounter other people. I was miserable, and as a result, could not focus academically. Instead, I took classes through a home-bound program that follows the public high school curriculum through online classes.

20. In April 2014 I finally came out to my mother as a boy. I had previously downloaded a PDF on a reading tablet with information about what it means to be transgender, but I had been too nervous to show it to her. That day, we were in the kitchen talking about something else, and she said the word "transgender." I did not think she was aware of that word.

When she said the word "transgender," I ran off to find the tablet—but I couldn't find it. So I came back and told her that I am transgender, and a boy.

21. My mom told me she loved me and would support me, but she told me not to tell the rest of my family yet. She also helped pick a new name for me: Gavin.

22. We ended up telling the rest of my family a few weeks later at a party for my fifteenth birthday. The morning of the party I was overwhelmed by grief and anxiety. I had locked myself in my bedroom, deeply traumatized by the thought of experiencing another birthday as a "birthday girl." My father knocked, and he asked me what the problem was. I told him, "Mom said I wasn't allowed to tell you." So he asked my mom, and she told him I was a boy. My mom then called the rest of my relatives who were on the way to the party to tell them that I was a boy. She wiped off my old name from the birthday cake, and wrote "Gavin" in its place.

23. My mother made clear to my dad and my brother that she expected them to respect that I am a boy and to use my correct name and pronouns. That was not a point of negotiation in our household. It took a few months for my father and brother to get used to it. But they eventually shifted from tacitly accepting my identity to fully supporting me. My father and brother would comfortably say to other people "he's my son," or "he's my brother."

24. At my request, I began therapy with a psychologist who had experience with working with transgender patients. The psychologist diagnosed me with gender dysphoria. The psychologist recommended that I immediately begin living as a boy in all respects. That included using a male name and pronouns and using boys' restrooms. The psychologist gave me a "treatment documentation letter" to confirm I was receiving treatment for gender dysphoria and that, as part of that treatment, I should be treated as a boy. A copy of that treatment

documentation letter is attached as Exhibit A. In addition, the psychologist recommended that I see an endocrinologist to begin hormone treatment for gender dysphoria.

25. In July 2014, I petitioned the Circuit Court of Gloucester County to change my legal name to Gavin Elliot Grimm, and the court granted the petition.

Starting Tenth Grade as a Boy

26. Before the beginning of tenth grade, my mother and I met with Gloucester High School guidance counselor Tiffany Durr to explain that I was a boy and needed to socially transition at school as part of my medical treatment. Ms. Durr expressed support for me and a willingness to ensure a welcoming environment for me at school.

27. Ms. Durr and I agreed that I would send an email to teachers explaining that I was to be addressed using the name Gavin and to be referred to with male pronouns. This was to avoid the potential of misgendering (a practice of unintentionally or maliciously misidentifying my gender) or deadnaming (a practice of using a transgender person's birth name, instead of their chosen name).

28. I did not personally experience malicious misgendering from staff, but there were small groups of students who would make a point to greet me by my dead name, and deliberately identify me as a girl. I recall one instance where my name, "Gavin," was called for attendance, and a classmate started laughing. I heard him tell everyone, "that's a chick, that's a chick," and repeatedly tried to call my attention by yelling my old name. But after I complained to the teacher, she made sure that the student did not harass me in class again.

29. I initially agreed to use a separate restroom in the nurse's office, but once I began school, I soon found it stigmatizing to use a separate restroom. I began to feel anxiety and shame surrounding my travel to the nurse's office. The location of the nurse's office made it difficult

for me to use the restroom between classes, as it was located in a different part of the building and was very inconvenient to reach from my classrooms. I recall my frustration with missing instructional time in class.

30. I was also embarrassed by how long it would take for me to get to and return from the nurse's office. On at least one occasion a teacher commented on my lengthy disappearance when I reentered the classroom. The teacher made a big public point about how long I had been gone in a way that I felt was humiliating. Other times, students would say, "what took you so long," and other snide remarks.

31. I was allowed to use a faculty restroom that was closer to my classes, but I was even more embarrassed to use the faculty restroom than the restroom in the nurse's office. I was worried that another student would see me go into a faculty restroom, which would have been even more uncommon than my going to the nurse's office.

32. After a few weeks, I asked Ms. Durr and Principal Nate Collins to be allowed to use the boys' restrooms. I expressed to Mr. Collins that it was stigmatizing and embarrassing to have to travel to a separate restroom, and that it was also detrimental to my instructional time to have to travel so far to use the restroom. I said that it identified me as different and as a target for harassment.

33. I did not need to use the locker rooms because I had elected to continue completing my physical education classes through an online program.

34. I also informed Mr. Collins that I was expecting to begin hormone therapy. My family and I had met with a pediatric endocrinologist at Virginia Commonwealth University to begin hormone therapy treatment. But my initial blood tests revealed that my body was already producing an unusually high amount of testosterone. Before I could begin hormone therapy I had

to wait several weeks while the doctors made sure that I did not have an endocrine disorder that was incompatible with hormone therapy.

35. Mr. Collins told me he would check with others. A few weeks later, Mr. Collins met with me again and said that I could use the same restrooms as other boys.

36. I started using the restrooms on October 20, 2014. For approximately the next seven weeks, I used the boys' restrooms at school. During the time I used the boys' restrooms, I never encountered any problems from other students. Over the course of those seven weeks, I had a single conversation with a student in the restroom. He asked me if I liked his socks, and I said yes.

37. At the time I was granted permission to use the boys' restroom at school, I had already been using the boys' restroom in public places in Gloucester and outside of Gloucester, so this was very natural to me.

38. After being respected as a boy and allowed to use the same restrooms as other boys, I was excited about the prospect of living out the rest of my school year as just another student. The seven weeks when I had been respected and treated like other boys were the most comfortable I ever felt at school.

The School Board's New Policy

39. On November 10, 2014, my mother and I learned that the School Board would be discussing my use of the boys' restrooms at its meeting on November 11, 2014. No one from the Gloucester High School administration or the School Board informed us of this discussion. We learned about it through a Facebook post encouraging people to attend and speak out against me using the boys' restrooms, with many vile comments about a girl being in the boys' restroom.

My mom and I were frustrated, and we felt it was wrong that we were not given advanced notice that the question of my bathroom use was going to be debated at a public school board meeting.

40. My parents and I attended the meeting to speak against the policy. After having the experience of being treated just like other boys, I could not sit on the sidelines and let the School Board take it away from me. If I did not speak up, the conversation would have been held without me and with no one to support me. Since it was a conversation about my future, I wanted to be included.

41. I also attended the School Board's meeting on December 9, 2014.

42. Members of the public who spoke at the meetings made openly hostile comments about me, calling me "a freak," "a dog," and all sorts of hateful horrible language. Many of these individuals went to great lengths to refer to me with female pronouns or honorifics such as young lady, little miss, ma'am, or missus.

43. As a result of the school board meetings and the new transgender restroom policy, I felt like I had been stripped of my privacy and dignity. Having the entire community discuss my genitals and my medical condition in a public setting has made me feel like a public spectacle. Everyone could now identify me as "the transgender student who wants to use the boys' restroom," which made me incredibly anxious and fearful.

44. The day after the school board meeting, Mr. Collins told me that I would no longer be allowed to use the boys' restrooms and that there would be disciplinary consequences if I tried to do so.

45. After having had the opportunity to live consistent with my gender identity, I was devastated when it was taken away from me. It was humiliating for the School Board to take the

position that there was something wrong with me, and that I should not be allowed to be with my peers in common spaces.

46. Although the Board had announced that it would construct three new single-user restrooms, those restrooms were not completed until about a week after the policy went into effect. At one point during that week, I stayed after school for an event and realized that the nurse's office was locked and it would be several hours before my parents could pick me up. I was very distraught—totally devastated—that I had nowhere to use the restroom in my own school, so I broke down and went sobbing to the library to ask for help. One of the librarians drove me home so that I could use the restroom.

47. After the three single-stall restrooms were constructed at Gloucester High School, I looked inside the restrooms once or twice just to see what they looked like, but I never used them. The single-stall restrooms made me feel even more stigmatized and isolated than using the nurse's office because everyone knew that they were installed for me in particular, so that other boys would not have to share the same restroom as me.

48. Although the school said that all students could use the single-stall restrooms, I was the only student mandated to use them. I never saw any other student use the single-stall restrooms either. Two of the restrooms were near the lunchroom, and when my friends and I sat down for lunch we could see the restrooms, but I never saw any student use them.

49. Unlike some of the boys' restrooms, none of the new single stall restrooms were located near my classes. Only one of the single-stall restrooms is located anywhere near the restrooms used by other students. Because all three facilities are clustered near each other, they were not much closer or more convenient than the nurse's restroom.

50. Instead of using the separate restrooms, I tried to avoid using the restrooms entirely while at school. When that was not possible, I used the nurse's restroom. Every time I had to walk to the nurse's room, I felt like I was doing a walk of shame. I was embarrassed that everyone who saw me enter the nurse's office knew exactly why I was there: because I am transgender, and I was prohibited from using the same restrooms as other boys.

51. I tried to limit the amount of liquids I drank and tried to "hold it" when I needed to urinate during the school day. Avoiding the restroom was distracting when I was trying to focus in class. And, as a result of trying to avoid using the restroom, I repeatedly developed painful urinary tract infections. The only time I developed these infections was during the school year when I had to avoid using the restroom; I did not develop infections during summer vacations, and now that I have graduated from Gloucester High School, that problem has disappeared.

52. The restroom policy also interfered with my involvement in school events and activities, making me feel even more targeted and isolated. There was no restroom I could use when attending football games because there were no single-user facilities by the athletic field and school buildings were locked after-hours, so I tried very hard to plan ahead so that I would not have to use the restroom during the game. But there were a few occasions when I needed to use the restroom, and I had to leave the game early. One time, a friend had to drive me down the road to use a restroom at a nearby Lowe's or Home Depot. Another time, my mother just came and took me home.

53. Shortly after the policy went into effect, I met with Ms. Durr and told her that I felt humiliated and distressed by the Board's policy. But I knew that she could not do anything to change it. After that, I realized that talking to school counselors and administrators was pointless

because the Board had already decided that it didn't care about my wellbeing. Counselors and administrators could not give me permission to use the boys' restroom, and I did not have faith in the school system to protect me.

54. By the time I started eleventh grade, the stress was unbearable. I was in an environment every single day, five days a week, where I felt unsafe, anxious, and disrespected. I told my mom that I was having suicidal thoughts, and I was hospitalized briefly at Virginia Commonwealth University (VCU) Medical Center Critical Care Hospital for mental health treatment for suicidality, depression, and anxiety.

55. Instead of returning to Gloucester High School to resume classes, I completed the rest of eleventh grade in an independent study program at the "T.C. Walker" building, which is a separate location where students could complete course credits through an online computer program. At the "T.C. Walker" building, all the students in the independent study program used a single-stall restroom that was near the classroom. I was able to use this restroom without being singled out and treated differently from everyone else.

56. When I was in twelfth grade, the independent study program was no longer offered at "T.C. Walker." I returned to Gloucester High School, but I had stored up enough credit from online courses that I had a reduced course load. For all of twelfth grade, I continued to use the nurse's restroom when I absolutely had to, and I stayed away from campus as much as possible.

57. I graduated Gloucester High School on June 5, 2017.

58. Living through this experience has made me stronger than I ever thought I could be, but I am still deeply hurt and upset about what the School Board put me through for all those years. At the beginning of tenth grade, I finally had a chance to have a normal high school

experience just like any other boy. The School Board took that away from me, and I will never get it back.

Additional Medical and Legal Steps in My Gender Transition

59. During tenth, eleventh, and twelfth grade, I also continued to take medical and legal steps as part of my gender transition.

60. In December 2014, shortly after the Board's policy went into effect, I began hormone therapy, which has deepened my voice, increased my growth of facial hair, and given me a more masculine appearance.

61. In June 2015—at the end of tenth grade—the Virginia Department of Motor Vehicles issued a state I.D. card for me identifying me as male with an "M" gender marker. A copy of the DMV letter confirming my gender marker change is identified as Exhibit B.

62. In June 2016—at the end of eleventh grade—I underwent chest-reconstruction surgery, as part of my treatment for gender dysphoria.

63. On September 9, 2016—at the beginning of twelfth grade—the Gloucester County Circuit Court issued an order declaring that my sex is male and directed the Virginia Department of Health to issue me a birth certificate listing my sex as male. A copy of that court order is attached as Exhibit C.

64. On October 27, 2016, the Virginia Department of Health issued a birth certificate listing my sex as male. A copy of that birth certificate is attached as Exhibit D.

65. Despite all of this, I was still not allowed to use the same restrooms as other boys at Gloucester High School.

66. After I received my updated birth certificate, my mother and I provided the school with a copy and asked them to update my school records to match the gender marker on my birth certificate. I was planning to apply to colleges, and I wanted my school transcript to be updated so that it identified me as "male" instead of "female."

67. I went to the guidance office several times to ask when my school records would be updated, but I never received an answer. Finally, someone from the guidance office told me that they had been instructed to tell me: "We have received your request. Thank you."

68. As a result of Gloucester County Public Schools' refusal to update my school records, my official school transcript still identifies my sex as "female" even though all of my other identification documents identify me as male. A copy of my transcript is attached as Exhibit E.

69. I am currently attending community college at Berkley City College, but I plan to eventually transfer to a four-year school. Every time I have to provide a copy of my transcript to a new school or employer, I will have to show them a document that negates my male identity and marks me as different from other boys. I am still tethered to high school by this document, and I think it is unfair that a high school that put me through so much is able to wield that much negative influence over my adult life.

70. I was shocked and angry when I learned the School Board recently testified that their policy turned on students' current birth certificate. If the Board really is interpreting its policy this way, then it makes what they did to me even worse. Under what they now say the

policy means, I should have been allowed to use the same restrooms as other boys starting in late October 2016 when I provided them with my new birth certificate. I could have had a normal high school experience for most of my senior year. I jumped through hoop after hoop, and I did everything I was supposed to do even under the Board's discriminatory policy. If the Board really thought something was wrong with my documents, why didn't they just tell me what the problem was so I could address it? It feels like they were playing games with my life, and I do not understand how a group of adults could treat a high school student that way.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on: 3/19/19

Gavin Grimm

CONFIDENTIAL

Lisa Griffin, Ph.D.
Clinical Psychologist

14 S. Auburn Av. • Richmond, VA 23221
(704) 458-0433 • lisa@drlisagriffin.com
www.drlisagriffin.com

Treatment Documentation Letter

Name: Gavin [REDACTED] Grimm
Date of birth: REDACTED 1999
Date of letter: 5-26-2014

I am a clinical psychologist licensed in Virginia (#0810004568) and North Carolina (#2072) and a specialist in gender identity and gender dysphoria in children and teens.

The purpose of this letter is to certify that Gavin Grimm, assigned female at birth, is under my care for gender dysphoria. Best mental health/medical practices recommend that he present as a male in all activities of daily living.

Gavin should be afforded all the rights of a natal male and be considered and treated as male in every respect. This includes restroom usage and ability to express himself in gender-specific manners. His male name and male pronouns should be used exclusively.

Lisa Griffin, Ph.D.

COMMONWEALTH of VIRGINIA
Department of Motor Vehicles
2300 West Broad Street

Richard D. Holcomb
Commissioner

Post Office Box 27412
Richmond, VA 23269-0001

June 5, 2015

Dear

The Department of Motor Vehicles (DMV) has approved your request to have the gender indicator on your credential changed from F to M.

Please visit your local DMV to complete this transaction. Please present this letter to the Customer Service Representative (CSR) as it will help to expedite your request. You will then be issued a new credential with the new gender indicator.

Please retain this letter in the event you need to return to a Customer Service Center for a replacement or reissue credential.

If you or the CSR has any questions regarding the re-issuance of your credential or our gender change policy, you may contact us Monday-Friday from 8:15 a.m. until 5:00 p.m. at (804) 367-6203.

Sincerely,

R. Smalls

R. Smalls
Medical Evaluator Senior
Medical Review Services

VIRGINIA:

IN THE CIRCUIT COURT OF GLOUCESTER COUNTY

In Re: Amendment of a Vital Record
for Gavin Elliot Grimm Pursuant to 32.1-269 of the Code of Virginia

Change of Gender: from Female to Male
Date of Birth [redacted]

CL16-326

ORDER

This matter comes before the court based on the petition of Gavin Elliot Grimm, a minor, by and through his parents David Wayne Grimm and Deirdre Anne Grimm. The petition requests that the court enter an order that amends a vital record in accordance with Virginia Code Section 32.1-269. Specifically, the petitioners ask the court to enter an order directing the State Registrar to amend the birth certificate of Gavin Elliot Grimm to show a change of sex from female to male.

The court finds that the petitioner resides in Gloucester County, Virginia and that the Gloucester County Circuit Court is a court of competent jurisdiction to hear this matter. The court also finds that an order was previously entered by the Gloucester County Circuit Court on July 25, 2014 in case number [redacted] that changed the petitioner's name to Gavin Elliot Grimm to comport with his gender. The court finds that Gavin Elliot Grimm underwent gender reassignment surgery in June 2016; that the surgery was successful; and that Gavin Elliot Grimm is now functioning fully as a male. Therefore, the court finds that the sex of Gavin Elliot Grimm has been properly changed by a medical procedure and that it is in his best interests to amend his birth certificate.

As a result of the foregoing, the court does hereby ORDER that the State Registrar be and hereby is authorized and directed to amend the birth certificate of Gavin Elliot Grim to show the change of sex from female to male.

The clerk shall send a copy of this order to the petitioner and to the State Registrar.

This cause is ended and shall be stricken from the Court's docket.

ENTER: 9/9/2016

Jeffrey W. Shaw
JUDGE

WE ASK FOR THIS:

Gavin Elliot Grimm

David Wayne Grimm

Deirdre Anne Grimm

Bary W. Hausrath, Esq. (VSB #73013)
The Law Office of Bary W. Hausrath, PLLC
P.O. Box 13890, Richmond, VA 23225
122 Granite Avenue, Richmond, VA 23226
(T) 804-482-1649
(F) 888-583-4991

I certify that the document(s) to which this authentication is affixed are true copies of a record in the Gloucester County Circuit Court, that I have custody of the record and that I am the custodian of that record.
Margaret Walker, Clerk
By________________ Dep. Clerk

CERTIFICATE OF VITAL RECORD

VERIFY PRESENCE OF WATERMARK HOLD TO LIGHT TO VIEW

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HEALTH – DIVISION OF VITAL RECORDS

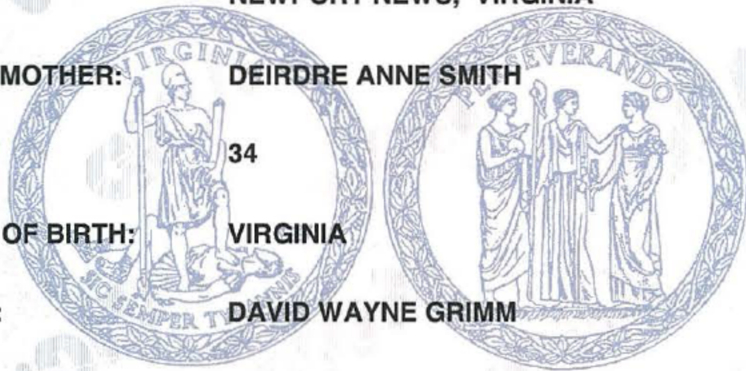
CERTIFICATE OF LIVE BIRTH

STATE FILE NUMBER: [redacted]

NAME OF REGISTRANT: GAVIN ELLIOT GRIMM

DATE OF BIRTH: [redacted] SEX: MALE

PLACE OF BIRTH: NEWPORT NEWS, VIRGINIA



MAIDEN NAME OF MOTHER: DEIRDRE ANNE SMITH

AGE OF MOTHER: 34

MOTHER'S PLACE OF BIRTH: VIRGINIA

NAME OF FATHER: DAVID WAYNE GRIMM

AGE OF FATHER: 38

FATHER'S PLACE OF BIRTH: PENNSYLVANIA

DATE RECORD FILED: MAY 17, 1999

This is to certify that this is a true and correct reproduction or abstract of the official record filed with the Virginia Department Of Health, Richmond, Virginia

DATE ISSUED October 27, 2016

Janet M. Rainey
Janet M. Rainey, State Registrar

Do not accept unless on security paper with the seal of Virginia Department of Health, Vital Statistics in the lower left hand corner. Section 32.1-272, Code of Virginia, as amended.

VS 15B

VOID WITHOUT WATERMARK OR IF ALTERED OR ERASED

VOID IF ALTERED OR ERASED

SEE REVERSE SIDE FOR OPENING INSTRUCTIONS

Department of Health
P.O. Box 1000
Richmond, VA 23218-1000

GRIMM, GAVIN ELLIOT

Graduation date: 06/10/2017
Diploma type: Standard

Student		Student Address	School
State ID:	[redacted]	[redacted]	Gloucester High School Gloucester County Public Schools 6680 Short Lane Gloucester, VA 23061 804-693-2526 (Tel) 804-693-7685 (Fax) Virginia School ID: 036-0260
Birth Date:	[redacted]		
Gender:	Female		
Grade Level:	Graduated		

Year: 2011-2012 Grade Level: 7
Peasley Middle School
2885 Hickory Fork Road Gloucester VA, 23061 804-693-1499 tlawson@gc.k12.va.us

ID	Course Title	Attributes	FG	Credits Earned	Verified Credits
12005	KEYBOARDING		[redacted]	0.50	
Totals:				0.50	

Year: 2013-2014 Grade Level: 9
Gloucester High School
6680 Short Lane Gloucester VA, 23061 804-693-2526 wbrasher@gc.k12.va.us

ID	Course Title	Attributes	FG	Credits Earned	Verified Credits
01001	VLC ENGLISH 9	DL	[redacted]	1.00	
02052	VLC ALGEBRA I	DL	[redacted]	0.00	
03001	VLC EARTH SCI	DL	[redacted]	1.00	1.00
04052	VLC WORLD I	DL	[redacted]	1.00	1.00
08001	VLA PE 9	DL	[redacted]	0.50	
08051	VLA HEALTH 9	DL	[redacted]	0.50	
Totals:				4.00	2.00

Year: 2014-2015 Grade Level: 10
Gloucester High School
6680 Short Lane Gloucester VA, 23061 804-693-2526 wbrasher@gc.k12.va.us

ID	Course Title	Attributes	FG	Credits Earned	Verified Credits
01002	ENGLISH 10		[redacted]	1.00	
02052	ALGEBRA I		[redacted]	1.00	1.00
03051	BIOLOGY I		[redacted]	1.00	1.00
04052	WORLD HIST II		[redacted]	1.00	1.00
05052	THEATER I		[redacted]	1.00	
05154	ART FOUNDATION		[redacted]	1.00	
08016	VLC PE 10	DL	[redacted]	0.50	
08201	HEALTH PE DR ED 10		[redacted]	1.00	
Totals:				7.50	3.00

Year: 2015-2016 Grade Level: 11
Gloucester High School
6680 Short Lane Gloucester VA, 23061 804-693-2526 wbrasher@gc.k12.va.us

ID	Course Title	Attributes	FG	Credits Earned	Verified Credits
01003	VLC ENG 11	DL	[redacted]	1.00	2.00
01104	CREAT WRITING		[redacted]	1.00	
02072	VLC GEOMETRY	DL	[redacted]	1.00	
03005	VLC OCEANOGRAPHY	DL	[redacted]	1.00	
04102	VLC US HISTORY	DL	[redacted]	1.00	
04254	VLC PSYCH	DL	[redacted]	1.00	
Totals:				6.00	2.00

Year: 2016-2017 Grade Level: 12
Gloucester High School
6680 Short Lane Gloucester VA, 23061 804-693-2526 wbrasher@gc.k12.va.us

ID	Course Title	Attributes	FG	Credits Earned	Verified Credits
01004	ENGLISH 12		[redacted]	1.00	
02902	ALG FUN DATA		[redacted]	1.00	
04151	US GOVERNMENT		[redacted]	1.00	
19262	ECON PERS FIN		[redacted]	1.00	
Totals:				4.00	

Summary

GPA (Cumulative Weighted):	[redacted]
Rank (Cumulative Weighted):	
Credits Attempted:	23.00
Credits Earned:	22.00
Verified Credits Earned:	7.00
2011 Absences:	6
2013 Absences:	7
2014 Absences:	32
2015 Absences:	96
2016 Absences:	24

Standardized Tests

Test	Subtest	Date	Score

Credentials

Code	Name	Date
9303	Workplace Readiness Skills	02/27/2017

Official Signature and Title (Required): ______________________ Date: ____________

(A) Advanced (AC) Accelerated (AP) Advanced Placement (DE) Dual Enrollment (IB) International Baccalaureate (CC) Commonwealth College Course Collaborative (H) Honors (S) Summer (SC) Credits earned by substitution (DL) Distance Learning

07/19/2018 12:43:06 EDT

GCSB - 04283

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM, Plaintiff, v. GLOUCESTER COUNTY SCHOOL BOARD, Defendant.	)	Civil No. 4:15-cv-00054

DECLARATION OF DEIRDRE GRIMM

1. I am the mother of Plaintiff Gavin Grimm in the above-captioned action. I have actual knowledge of the matters stated in this declaration.

2. My name is Deirdre Anne Grimm.

3. I live in Gloucester County, Virginia.

4. I have been a Licensed Practical Nurse ("LPN") for 30 years. I currently work for the American Addiction Treatment Center and Sentara Wound Care Center.

5. I understood for most of Gavin's early life that he struggled with something, but he wasn't able to put a name to it until later.

6. As a child Gavin was anxious. He never felt fully comfortable around people, and he had trouble being around big crowds at parties and events. Gavin's demeanor changed noticeably when he transitioned and started to live authentically as a boy. He is now confident and comfortable with himself. He is not that shy, anxious kid anymore.

7. In April 2014, Gavin came out to me as transgender. I inadvertently opened the door by telling him about a conversation that I had recently had with another adult about their

transgender child. Gavin seized the moment, and said he had to tell me something. He was very nervous when he came out to me as transgender.

8. Gavin's coming out did not change a thing about my love and support. I told him it didn't change anything about how I felt about him. But I know it was a big deal for him because he wasn't sure what to expect.

9. I was committed to supporting Gavin from day one. The first thing I did was spend three days and nights reading about transgender children and how I could support Gavin. My husband took a longer time to deal with it and really understand what Gavin was going through. He tried very hard to show support from the beginning, and his support for Gavin really transformed over several months.

10. At Gavin's request, I took him to see a psychologist who specialized in treating transgender youth. She diagnosed him with gender dysphoria and gave us a treatment documentation letter advising that he should be treated as a boy in all respects.

11. Before Gavin began tenth grade in the fall of 2014, Gavin and I met with the school guidance counselor, Ms. Tiffany Durr, about Gavin's transition. I presented her with Gavin's legal name change order and his treatment documentation letter. Ms. Durr was very supportive of Gavin and was fully "on board" with using Gavin's correct name and pronouns.

12. Gavin used the nurse's bathroom for some time that fall, but he expressed concerns to me. Gavin said that it took him a long time to walk across the school to the nurse's bathroom from his classes in D-hall. He also said he felt singled out and embarrassed, and that other students made comments pointing out that he was using a separate restroom, saying things like "what took you so long?" Gavin and I met with Ms. Durr and Principal Nate Collins and discussed Gavin's concerns. Mr. Collins was very open to allowing Gavin to use the boys'

restroom. We all had a very reassuring conversation about Gavin's safety, and I felt fully supported by Mr. Collins.

13. Gavin, Mr. Collins, and I all set a date on which Gavin would begin using the boys' restrooms at school. Gavin began using the boys' restrooms in October 2014.

14. On November 10, 2014, a friend of mine sent me a Facebook message, in which someone was urging people to go the Gloucester County School Board meeting the following evening, on November 11th. The message said that the School Board would be discussing and voting on Gavin using the boys' restrooms.

15. I don't remember if the message named Gavin, but I remember it was clear they were talking about my child and whether he should be allowed in the boys' restroom. The post was clearly rallying people to go to the meeting and oppose a transgender student using the restrooms. Some of the comments were really terrible.

16. No one on the School Board ever contacted me or Gavin about the meeting. The first time I became aware of any problem was from the Facebook message I received.

17. After seeing the Facebook post, I started making a booklet of educational materials on what it means to be transgender. I included medical literature, information on suicide rates for transgender children, and information pulled from transgender equality websites. I made one booklet for every School Board member and took those booklets to the meeting and gave them to the members.

18. When Gavin and I spoke about it, we never considered not going to the School Board meeting. They were going to be talking about Gavin, my child, and I had no doubt that I had to be there. Gavin was also set on going. He has always been the kind of kid who will fight for himself if people are going to be making decisions about his life.

19. Prior to the meeting I knew nothing about the School Board's proposal. All I knew was that they were discussing my son and whether or not he should be allowed to use the boys' restroom. I was not aware of any plans to restrict boys' and girls' restrooms by "biological sex," or to create a third restroom option for "unisex" usage.

20. I didn't really know what to expect at the School Board meeting, but I really didn't expect it to be as brutal as it was. Gavin and I sat and listened to adult members of our community stand up and insult Gavin. I remember them calling my child an "it" and a "freak," and I remember thinking I worked in this community for 17 years as a nurse. I have been at many of these people's houses taking care of their moms and dads. I loved my community, and I remember thinking, how could people be calling my kid these names?

21. I remember one adult after another getting up there and talking about things that I don't even think were appropriate for them to be talking about. These people were talking about his private body parts. I just remember how appalled I felt for Gavin and how scared it made me that he wouldn't be able to struggle and live through all of this. Based on what I had read about transgender youth and the suicide risks, I was already scared for Gavin's life. Then we went to this horror show of a school board meeting, and it just made me even more fearful of the impact on him of his community not accepting him.

22. When the School Board said it would be installing separate single-stall restrooms Gavin and I talked about the new restrooms, and he was very upset about it. He didn't want to use them because he is not "unisex;" he is a boy. I remember him saying they may as well put a flashing light that says "Gavin" above the new restrooms, because everyone knew they were created for him, and only he was forced to use them.

23. The School Board voted on December 9, 2014, to issue a policy preventing Gavin from using the boys' restrooms. Gavin was seriously distressed by this policy. He felt so validated when he was allowed to use the boys' bathroom at school, just like a normal boy. He had never felt like a normal boy up to that point because he hadn't been validated that way. They gave him that validation, and then they took it away.

24. From that point, high school was especially difficult for Gavin. One night at the beginning of his year in eleventh grade, I found him sobbing on the bathroom floor, and he begged me to take him somewhere because he was having thoughts of suicide. So I took him to Virginia Commonwealth University Medical Center to get him help. They put him on the boys' ward, which was very validating to him. He was treated like any other boy.

25. One time, Gavin called me and asked me to pick him up from a football game because there was no bathroom for him to use after school. There was no single-user restroom at the football field, and he wasn't allowed to use the men's room. Gavin told me he felt like his bladder was about to burst. It was like a gut punch to me, as a mom. If you don't have an issue accessing bathrooms, you don't think about how hard it is for somebody who does. But Gavin lived that reality every day in high school.

26. Gavin had frequent urinary tract infections during his high school years. He would hold his urine during the day and have to use the restroom as soon as he got home. We kept boxes of AZO, an over-the-counter medication for urinary tract infections, always stocked at home to in order to give him some relief from the pain.

27. Not only has the School Board ruined my son's high school years, but now they're affecting his college years too. Gavin wanted to have the gender marker on his school records changed to "male" before he applied to college. When Gavin was issued an updated birth

certificate listing his gender as male, it was a celebration for us because we thought he could finally get his school records changed too. I personally walked an official copy of that document into the Gloucester High School guidance department and handed it to the office secretary. They gave me the impression it would be no problem for them to update Gavin's records, but when Gavin started requesting his transcript to apply to colleges, he realized they had refused to list his gender as male.

28. When I learned the Board is now saying Gavin could have used the boys' restroom his senior year if they thought he had presented a valid birth certificate, I was furious. In all these years, no one from the High School or the School Board ever said a word to me or Gavin indicating there was any problem with his birth certificate. For them to come back and say that now feels like a slap in the face. It makes me so upset that they have treated my kid this way.

29. Gavin is a strong kid, but this whole experience has taken a big toll on him and on our entire family. As a parent, you want to protect your child and keep him from harm. It broke my heart to watch him suffer and not be able to do anything to stop it. And he was being hurt by his own School Board, which should have been protecting him.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on: 3-21-19

[signature]

Deirdre Grimm

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM, ,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Civil Case No. 4:15-cv-54
	)	
GLOUCESTER COUNTY SCHOOL BOARD,	)	
	)	
	)	
Defendant.	)	
	)	

DECLARATION OF SHAYNA MEDLEY-WARSOFF

I, Shayna Medley-Warsoff, submit the following declaration in support of Plaintiff Gavin Grimm's motion for summary judgment. I am one of the attorneys for Gavin Grimm, and I have personal knowledge of the facts in this attorney declaration. If called upon to testify, I could competently testify to the matters set forth in this declaration.

1. A copy of Defendant's Answers to Plaintiff's First Set of Interrogatories is attached to this Declaration as Exhibit 1.

2. A copy of Defendant's Supplemental Answer to Plaintiff's Interrogatory No. 1. is attached to this Declaration as Exhibit 2.

3. A copy of the Expert Report and Declaration of Dr. Melinda Penn is attached to this Declaration as Exhibit 3.

4. A copy of Dr. Melinda Penn's curriculum vitae, which was originally attached as Exhibit A to the Expert Report and Declaration of Dr. Melinda Penn, is attached to this Declaration as Exhibit 4.

5. A copy of the World Professional Association for Transgender Health ("WPATH)" Standards of Care, which was originally attached as Exhibit B to the Expert Report and Declaration of Dr. Melinda Penn, is attached to this Declaration as Exhibit 5.

6. A copy of the Endocrine Society's Clinical Practice Guideline for Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons, which was originally attached as Exhibit C to the Expert Report and Declaration of Dr. Melinda Penn, is attached to this Declaration as Exhibit 6.

7. A copy of the Expert Report of Dr. Quentin Van Meter is attached to this Declaration as Exhibit 7.

8. A copy of the Rebuttal Expert Report and Declaration of Dr. Melinda Penn is attached to this Declaration as Exhibit 8.

9. A copy of the deposition of Nathan Collins in this case is attached to this Declaration as Exhibit 9.

10. A copy of the deposition of Walter Clemons in this case is attached to this Declaration as Exhibit 10.

11. A copy of the deposition of Tiffany Durr in this case is attached to this Declaration as Exhibit 11.

12. A copy of the deposition of Matthew Lord in this case is attached to this Declaration as Exhibit 12.

13. A copy of the 30(b)(6) deposition of Troy Anderson in this case is attached to this Declaration as Exhibit 13.

14. A copy of the deposition of Quentin Van Meter is attached to this Declaration as Exhibit 14.

15. A copy of Mr. Collins's memorandum to Deirdre Grimm dated October 14, 2014, which was originally produced as GCSB 0894 and attached as Exhibit 8 to the Deposition of Nathan Collins, is attached to this Declaration as Exhibit 15.

16. A copy of Dr. Clemons's email to the School Board dated October 22, 2014, originally produced as WAVY TV FOIA 007 and attached as Exhibit 5 to the Deposition of Walter Clemons, is attached to this Declaration as Exhibit 16.

17. A copy of Mr. Collins's memorandum to Dr. Clemons dated October 23, 2014, which was originally produced as GCSB 4121-22 and attached as Exhibit 2 to the Deposition of Dr. Clemons, is attached to this Declaration as Exhibit 17.

18. A copy of the emails from Carla Hook to a constituent dated October 24-27, 2014, which were originally produced as GCSB 0853-55, is attached to this Declaration as Exhibit 18.

19. A copy of the email from Carla Hook to a constituent dated October 31, 2014, which was originally produced as GCSB 0844, is attached to this Declaration as Exhibit 19.

20. A copy of the email from Carla Hook to the School Board dated November 4, 2014, which was originally produced as GCSB 0513, is attached to this Declaration as Exhibit 20.

21. A copy of the email and attachment from Carla Hook to the School Board dated November 9, 2014, which was originally produced as GCSB 0507-08, is attached to this Declaration as Exhibit 21.

22. A copy of the School Board's press release dated December 3, 2014, which was originally produced as GCSB 0592-94 and attached as Exhibit 10 to the Deposition of Dr. Clemons, is attached to this Declaration as Exhibit 22.

23. A copy of the Recorded Minutes of Gloucester County School Board meeting on December 9, 2014, which is available online at http://gets.gc.k12.va.us/Portals/Gloucester/District/docs/SBAgenda2014/Minutes2014/MIN-12-09-2014.pdf, is attached to this Declaration as Exhibit 23.

24. A copy of the Mr. Collins's memorandum to Deirdre and David Grimm dated December 10, 2014, which was originally produced as GCSB 0893 and attached as Exhibit 15 to the Deposition of Nathan Collins, is attached to this Declaration as Exhibit 24.

25. A copy of an email from Amy Bergh to Mr. Collins dated November 14, 2014, which was originally produced as GCSB 3932 and attached as Exhibit 12 to the Deposition of Nathan Collins, is attached to this Declaration was Exhibit 25.

26. A copy of Gavin's final transcript, which was originally produced as GCSB 4283 and attached as Exhibit 22 to the Deposition of Nathan Collins, is attached to this Declaration as Exhibit 26.

27. A copy of the presentation given at the 2014 Virginia School Board Association conference, originally produced as GCSB 4221-31 and attached as Exhibit 9 to the Deposition of Walter Clemons, is attached to this Declaration as Exhibit 27.

28. A copy of the map of Gloucester High School, originally produced as GCSB 1276 and attached as Exhibit 4 to the Deposition of Nathan Collins, is attached to this Declaration as Exhibit 28.

29. An annotated copy of the Gloucester High School map, on which I have marked the locations of school restrooms based on pages 33-36 and 94-108 of the Deposition of Nathan Collins, is attached to this Declaration as Exhibit 29.

30. A copy of the list of restrooms at Gloucester High School, which was originally produced as GCSB 03944 and attached as Exhibit 5 to the Deposition of Nathan Collins, is attached to this Declaration as Exhibit 30.

31. A copy of the letter from Joshua Block to David Corrigan dated December 23, 2016, is attached to this Declaration as Exhibit 31.

32. A copy of the letter from David Corrigan to Joshua Block dated January 18, 2017, is attached to this Declaration as Exhibit 32.

33. A copy of the letter from Joshua Block to Denise McNerney dated January 18, 2017, is attached to this Declaration as Exhibit 33.

34. A copy of the letter from Kyle Duncan to Denise McNerney dated January 19, 2017, is attached to this Declaration as Exhibit 34.

35. A copy of the Gloucester County School Board press release dated February 13, 2019, is attached to this Declaration as Exhibit 35.

36. A copy of the Gloucester County School Board press release dated February 21, 2019, is attached to this Declaration as Exhibit 36.

37. A copy of the Recorded Minutes of Gloucester County School Board meeting on November 11, 2014, which is available online at http://gets.gc.k12.va.us/Portals/Gloucester/District/docs/SBAgenda2014/Minutes2014/MIN-11-11-2014.pdf, is attached to this Declaration as Exhibit 37.

38. A copy of the Amicus Brief of American Academy of Pediatrics, et al. in support of Plaintiff-Appellant, *G.G. v. Gloucester Cty. Sch. Bd.*, No. 15-2056, ECF No. 244 (4th Cir.), is attached to this Declaration as Exhibit 38.

39. A copy of the Amicus Brief of School Administrators from Thirty-Three States and the District of Columbia in support of Plaintiff-Appellant, *G.G. v. Gloucester Cty. Sch. Bd.*, No. 15-2056, ECF No. 155 (4th Cir.), is attached to this Declaration as Exhibit 39.

40. A copy of the Amicus Brief of the National PTA, et al. in support of Plaintiff-Appellant, *G.G. v. Gloucester Cty. Sch. Bd.*, No. 15-2056, ECF No. 145-1 (4th Cir.), is attached to this Declaration as Exhibit 40.

41. A copy of the American Psychological Association & National Association of School Psychologists' 2015 *Resolution on Gender and Sexual Orientation Diversity in Children and Adolescents in Schools*, available online at https://goo.gl/AcXES2, is attached to this Declaration as Exhibit 41.

42. A copy of Gender Spectrum's 2016 *Transgender Students and School Bathrooms: Frequently Asked Questions*, available online at https://goo.gl/Z4xejp, is attached to this Declaration as Exhibit 42.

43. A copy of the National Association of Secondary School Principals' 2016 *Position Statement on Transgender Students*, available online at https://goo.gl/kcfImn, is attached to this Declaration as Exhibit 43.

44. I have reviewed the video recording of the Gloucester County School Board meeting dated December, 9, 2014, which is available online at http://gloucester.granicus.com/MediaPlayer.php?view_id=10&clip_id=1090. At 42:20, a person identified as Savannah Williams says, "I just filled out my voter's registration card a week ago and I can tell you that you can make any decision you want but if you don't vote to protect your constituents you will not be reelected. I can certainly say that my vote will go to someone else. Fact. If you choose to vote that Gloucester County public school restrooms

should be made coed, you will be replaced and we the citizens of Gloucester will reverse your decision with a new School Board."

45. At 50:53, a person identified as Andrew Palas says, "We do have the power to vote you out of office and we will do that."

46. At 59:53, a person identified as Karen Pauley says, "And like many have said, I also have a voter's card and I'm not afraid to use it. And I will vote every single one of you off of this Board if you do not protect our children."

47. At 1:18:00, a person identified as Janet West says, "I have a voter's card and all will lose their job."

48. At 1:17:40, Janet West says, "Now we're here talking about this young lady, where's my child respect?"

49. At 1:22:55, a person identified as Don Mitchell says, "Here we have a thousand students versus one freak."

50. At 1:23:25, Don Mitchell says, "If you want to consider yourself a dog, must we use tax dollars to install fire hydrants where you can publicly relieve yourselves?"

51. At 58:56, Karen Pauley says, "Put him in a separate bathroom if that's what it's going to take."

52. I have reviewed the video recording of the Gloucester County School Board meeting dated February 19, 2019, which is available online at http://gloucester.granicus.com/MediaPlayer.php?view_id=10&clip_id=2043. At 10:34, David Corrigan, attorney for the Gloucester County School Board, says, "the proposed resolution would allow those students to use the restroom consistent with their new gender identity as long as they meet three criteria: First, the student must have a medical diagnosis

from a health care provider, with expertise in the gender identity field. Second the student must have been living as the new gender identity for a period of at least 6 months, and third, the student must have been receiving treatment in the form of social transition or hormones for a period of 6 months."

53. At 11:20, Corrigan says, "The proposed resolution comes as result of discussions that have occurred between representatives of the school board, along with me as the school board attorney for Gloucester County in this litigation, the plaintiff and legal counsel for the plaintiff, under the supervision of a federal magistrate judge from Newport News named Douglas Miller. Judge Miller is not seeking to force a settlement or enforce a settlement, but he's been instrumental in helping the parties develop language which the plaintiff has agreed to and which the school board has agreed to present here tonight."

54. At 11:57, Corrigan says, "A significant issue raised previously was that a student could just, on a whim, decide for a day to use the restroom of the opposite sex. This resolution eliminates that possibility."

55. At 12:10, Corrigan says, "With the changes already made to existing restrooms ensuring greater privacy and the creation of the single-stall restrooms throughout the high school, the issue of individual privacy is also addressed."

56. At 1:59:35, an individual identified as Brian Bird says, "our sons are being demasculinated by this country. Our daughters are being defeminized. I don't want to see us promote that."

57. At 59:24, an individual identified as Kenny Smith says, "when we talk about social transition and gender identity we're talking about issues that we've created. God didn't create those."

58. At 47:53, an individual identified as a current Gloucester High School student named Elizabeth S. says, "I've heard some transgender students say that they have to wait till they get home in order to use the restroom because they're scared of what the security guards are going to say."

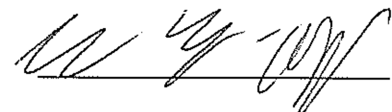
59. At 1:05:52, an individual identified as a Gloucester High School student named Marie Hutchins says, "I see every single day people that are afraid to use the bathroom and that do not want to due to discrimination, and I just don't think that's right."

60. At 1:05:15, an individual identified as a transgender student at Gloucester High School named Vincent Staples says, "I'm in favor of the current proposition that is being discussed tonight so that I can feel like I belong in my school."

61. At 1:36:07, an individual identified as Jonathan Hargis says he is the "proud parent of a transgender child" in the Gloucester public schools. At 1:37:00, he says, "I'm quite certain that I will never be able to convince those of you that think that it's a mental disorder. I can tell you there's no medication for it, there's no praying it out of them, and there's no beating it out of them. They are who they are, and they deserve the opportunity to be treated with respect and dignity."

I declare under penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct.

Dated: March 25, 2019



Shayna Medley-Warsoff

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM,

Plaintiff,

v. Case No. 4:15-cv-00054

GLOUCESTER COUNTY SCHOOL BOARD,

Defendant.

DEFENDANT'S ANSWERS TO PLAINTIFF'S FIRST INTERROGATORIES

Comes now the defendant, Gloucester County School Board ("School Board"), and for its Answers to Plaintiff's First Interrogatories, states as follows:

GENERAL OBJECTIONS

A. Defendant objects to the Instructions contained in Plaintiff's interrogatories to the extent they alter, amend, or exceed the scope of the Federal Rules of Civil Procedure.

B. The information supplied in these answers is not based solely on the knowledge of the executing party but includes knowledge of the party, its agents, representatives, and attorneys, unless privileged. Such knowledge may or may not be known to the Defendant other than as provided.

C. The word usage and sentence structure may be that of the attorney and staff assisting in the preparation of these answers and thus do not necessarily purport to be the precise language of the executing party.

D. These answers will be supplemented in accordance with the Rule 33 of the Federal Rules of Civil Procedure, the Local Rules of the Eastern District of Virginia, and any Orders regarding discovery.

E. Defendant objects to interrogatories, etc., that invade or attempt to invade the attorney/client, work product, or any other applicable privilege.

ANSWERS TO INTERROGATORIES

1. Identify all complaints received by Gloucester County School Board ("the Board") or its employees related to transgender students' use of restrooms during the 2014-2015 school year, and for each complaint identify the date of the complaint, the recipient of the complaint, the content of the complaint, how the complaint was communicated or transmitted, whether the complainant was from a Gloucester High School student or parent of a Gloucester High School student, and whether the complaint related to any incident in which a student reported being in the restroom at the same time as Plaintiff.

OBJECTION: The School Board objects on the grounds that this Interrogatory is overly broad and unduly burdensome. Further, the School Board objects on the grounds that the use of the term "complaint" is vague and ambiguous. Finally, the School Board objects to the extent that this Interrogatory seeks the discovery of information protected pursuant to the Agreed Confidentiality Protective Order (ECF Doc. 85) entered in this matter.

ANSWER: Without waiving and subject to the foregoing objection,[1] Gloucester County High School Principal Nate Collins gave Grimm permission to use the male restroom on October 20, 2014. Two to three days later, Superintendent Dr. Walter Clemons received two complaints from parents regarding a transgender student using the restroom inconsistent with that student's biological sex. Dr. Clemons does not recall the identity of those parents. The parents indicated that they did not approve of a biologically female student using the male restroom. Additionally, a male student met with Collins in person and expressed concern about a biologically female student using the male restroom and a lack of privacy. Collins does not recall the specific identity of this student.

Moreover, after Grimm began to use the male restroom, Dr. Clemons, Collins and the individual members of the School Board received numerous complaints via email, which are listed below.

Emails sent to all members of the School Board

- **On October 23, 2014, Kathryn Lindsay, a parent of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On October 23, 2014, Stacie and Paul Martin, parents of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School Board an email regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

---

[1] The School Board specifically reasserts its objection that Plaintiff's use of the term "complaint" in this Interrogatory is vague and ambiguous. The School Board has included in its Answer communications with individuals who generally opposed a transgender student using a restroom inconsistent with that student's biological sex. The School Board's Answer includes communications with individuals who did not agree with Gloucester High School allowing a transgender student to use a restroom inconsistent with that student's biological sex and communications with individuals who supported the School Board's December 9, 2014 resolution and the School Board's litigation of this matter.

- **On October 27, 2014, Susannah Hogge sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On October 27, 2014, Jennifer Spears, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On October 28, 2014, Season Palas, upon information and belief a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 10, 2014, Elisa Nelson, a parent of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 10/11, 2014, Stuart and Seth Bunting, parents of student(s) enrolled in Gloucester High School, sent the School Board an email regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 11, 2014, Mary Diggs, upon information and belief a resident of Gloucester County, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 11, 2014, David Turner sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 12, 2014, Haley Poulson, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 12, 2014, Kelly Williams, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 13, 2014, Melissa Alexander, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 17, 2014, Kelly Cooper, a parent of student(s) enrolled in Gloucester High School, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 7, 2014, Jenny Poole, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 8, 2014, Mike Enz, a parent of student(s) enrolled in Gloucester High School, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 8, 2014, Heather Schott, a parent of student(s) enrolled in the Gloucester County Public School System, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 10, 2014, Tommie Thompson, a resident of Gloucester County, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 10, 2014, Paul Martin, a parent of student(s) enrolled in Gloucester High School, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 20, 2014, Chuck Thompson, a resident of Gloucester County, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 20, 2014, Clayton Rogers sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On January 2, 2015, an individual named Jena sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On July 10, 2015, Tim Tompkins sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On April 21, 2016, Kathryn Lindsay, a parent of students(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On April 21, 2016, Paul Martin, parent of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On May 12, 2016, Kenneth Larson sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

<u>Emails sent to Troy Anderson</u>

In addition to receiving emails sent to the entire School Board, Mr. Anderson received the following communications:

- **On December 7, 2014, Ginger Enz, parent of student(s) enrolled in Gloucester High School, sent Mr. Anderson an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On July 27, 2015, Leland Pike, a resident of Kentucky, sent Mr. Anderson an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On July 14, 2016, Florence Alpert, a resident of New York, sent Mr. Anderson an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

<u>Emails sent to Randy Burak</u>

In addition to receiving emails sent to the entire School Board, Mr. Burak received the following communications:

- **On November 12, 2014, Gina Thayer, a parent of student(s) enrolled in Gloucester High School, sent Mr. Burak an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 3, 2014, Lisa Wood, a resident of the Abingdon District, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 7, 2014, Mike Enz, a parent of student(s) who attended Gloucester High School, sent the Mr. Burak an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 8, 2014, a resident of Gloucester County named Ginger emailed Mr. Burak regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 11, 2014, Sharon Kass, a resident of Washington D.C., emailed Mr. Burak regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Emails sent to Kimberly Hensley

In addition to receiving emails sent to the entire School Board, Ms. Hensley received the following communications:

- **On November 19, 2014, Tracey Parks Carter, a parent of student(s) at Gloucester High School, emailed Ms. Hensley regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 13, 2014, Cliff and Brandi Blackwood, parents of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, emailed Ms. Hensley regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Emails sent to Carla Hook

In addition to receiving emails sent to the entire School Board, Ms. Hook received the following communications:

- **On December 7, 2014, Steven Davis, a parent of high school student(s) in the York District, sent an email to Ms. Hook regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Emails sent to Charles Records

In addition to receiving emails sent to the entire School Board, Mr. Records received the following communications:

- **On April 21, 2016, Jean Lassiter sent an email to Mr. Records regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Emails sent to Dr. Clemons

In addition to receiving some of the emails sent to the entire Board, Dr. Clemons received the following communications:

- **On October 22, 2016 Season Palas, upon information and belief a parent of student(s) enrolled in Gloucester County Public Schools, sent Dr. Clemons an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 7, 2016, Ralph VanNess sent Dr. Clemons an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Additionally, the following School Board members received complaints via telephone, which are listed below.

Telephone Complaints made to Carla Hook

- **Upon information and belief, before October 28, 2014, Ms. Hook spoke with Season and Andrew Palas, whose children were enrolled in Gloucester County Public Schools, regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Additionally, the issue of transgender bathroom use was discussed at public School Board meetings on November 11, 2014 and December 9, 2014. Video links to those meetings are available at: http://www.gloucesterva.info/640/Meeting-Portal.

The following individuals spoke regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex during the November 11, 2014 meeting:

- **Ralph Van Ness (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Eddie Aliff**
- **Savannah Williams (student at Gloucester High School)**
- **Terry Brennan**
- **Joy Sampson (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Kelly Williams (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Marc Jenkins (parent of student(s) enrolled in Gloucester County Public Schools)**

- **Drew Palas (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Kathryn Lindsay (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Brian Byrd (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Tricia Ray**
- **Kim Ward (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Melissa Wamsley (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Ray Wamsley (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Season Palas (parent of student(s) enrolled in Gloucester County Public Schools)**

The following individuals spoke regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex during the December 9, 2014 meeting:

- **Ralph Van Ness (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Scott Williams (student at Gloucester High School)**
- **Savannah Williams (student at Gloucester High School)**
- **Kathryn Lindsay (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Drew Palas (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Karen Pauly**
- **Mike Enz (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Katherine Foley (parent of student(s) enrolled at Gloucester High School)**
- **Howard Mowry**
- **Janet West (parent of student(s) enrolled at Gloucester High School)**
- **Linda Walk**
- **Don Mitchell**

- **Terry Brennan**
- **Marista Cooper (grandparent of student(s) enrolled in Gloucester County Public Schools)**
- **Kelly Williams**

The School Board also incorporates by reference any additional "complaints" not described herein that are contained in the documents the School Board has produced in response to Plaintiff's First Request for Production of Documents.

2. State whether any of the complaints identified in Interrogatory No. 1 were from the student (or the parent of the same student) identified in GCSB 03541 in the email subject "Gavin and [redacted]."

<u>OBJECTION</u>: The School Board objects on the grounds that this Interrogatory is overly broad and unduly burdensome. Further, the School Board objects on the grounds that the use of the term "complaint" is vague and ambiguous. Finally, the School Board objects to the extent that this Interrogatory seeks the discovery of information protected pursuant to the Agreed Confidentiality Protective Order (ECF Doc. 85) entered in this matter.

<u>ANSWER</u>: Without waiving and subject to the foregoing objection, upon information and belief, neither the student nor the parent of the student referenced in this Interrogatory made a "complaint" to the School Board.

3. State whether any of the complaints identified in Interrogatory No. 1 were from the student (or the parent of the student) identified in GCSB 03541 as "[redacted] – NOT reliable."

<u>OBJECTION</u>: The School Board objects on the grounds that this Interrogatory is overly broad and unduly burdensome. Further, the School Board objects on the grounds

that the use of the term "complaint" is vague and ambiguous. Finally, the School Board objects to the extent that this Interrogatory seeks the discovery of information protected pursuant to the Agreed Confidentiality Protective Order (ECF Doc. 85) entered in this matter.

ANSWER: Without waiving and subject to the foregoing objection, upon information and belief, neither the student nor the parent of the student referenced in this Interrogatory made a "complaint" to the School Board.

4. State whether any of the complaints identified in Interrogatory No. 1 were from a student (or the parent of a student) named Austin.

OBJECTION: The School Board objects on the grounds that this Interrogatory is overly broad and unduly burdensome. Further, the School Board objects on the grounds that the use of the term "complaint" is vague and ambiguous. Finally, the School Board objects to the extent that this Interrogatory seeks the discovery of information protected pursuant to the Agreed Confidentiality Protective Order (ECF Doc. 85) entered in this matter.

ANSWER: Without waiving and subject to the foregoing objection, upon information and belief, the School Board does not know whether a student named Austin, or the parent of a student named Austin, made a "complaint" as is referenced above.

5. State whether there is an "alternative appropriate private facility" available for "students with gender identity issues" within 200 feet of the most remote location of Gloucester High School.

OBJECTION: The School Board objects on the grounds that the phrase "within 200 feet of the most remote location of Gloucester High School" is vague and ambiguous. The School Board further objects on the grounds that the Interrogatory is overly broad, vague, and ambiguous because it does not set forth a time frame for the School Board's Answer.

ANSWER: Without waiving and subject to the foregoing objection, there are locations of Gloucester High School that are farther than 200 feet away from the single-user restrooms installed at Gloucester High School.

6. Identify all documents and resources relied upon by Defendants in creating the "biological gender" restroom policy passed by the School Board in 2014.

OBJECTION: The School Board objects on the grounds that Plaintiff's Interrogatory is vague and ambiguous. Further, the School Board objects to the extent this Interrogatory seeks information and/or materials protected from disclosure by the attorney-client privilege, the attorney work-product doctrine, and/or as materials prepared in anticipation of litigation.

ANSWER: Without waiving and subject to the foregoing objection, Carla Hook prepared the resolution at issue in this litigation. Upon information and belief, Ms. Hook did not rely on any documents or resources in preparing the resolution.

7. Identify all persons consulted in creating the "biological gender" restroom policy passed by the School Board in 2014.

OBJECTION: The School Board objects on the grounds that Plaintiff's Interrogatory is vague and ambiguous. Further, the School Board objects to the extent this Interrogatory

seeks information and/or materials protected from disclosure by the attorney-client privilege, the attorney work-product doctrine, and/or as materials prepared in anticipation of litigation.

ANSWER: Without waiving and subject to the foregoing objection, Carla Hook prepared the resolution at issue in this litigation. Upon information and belief, Ms. Hook did not consult with any persons in preparing the resolution.

GLOUCESTER COUNTY SCHOOL BOARD

By ____________________________

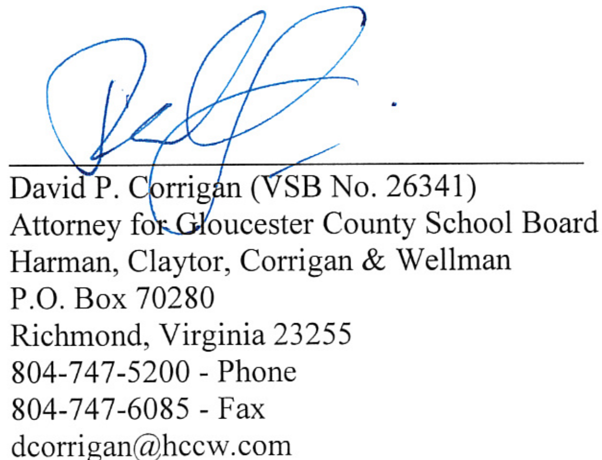
David P. Corrigan
VSB No. 26341
Jeremy D. Capps
VSB No. 43909
Douglas E. Pittman
VSB No. 87915
Attorney for Gloucester County School Board
Harman, Claytor, Corrigan & Wellman
P.O. Box 70280
Richmond, Virginia 23255
804-747-5200 - Phone
804-747-6085 - Fax
dcorrigan@hccw.com
jcapps@hccw.com
dpittman@hccw.com

CERTIFICATE

I hereby certify that on the 13th day of December, 2018, I emailed the document to the following:

Joshua A. Block, Esq. (Pro hac vice)
NYSB No. 4370573
Leslie Cooper, Esq. (Pro hac vice)
NYSB No. 2759835
Shayna Medley-Warsoff, Esq. (Pro hac vice)
NYSB No. 5558382
American Civil Liberties Union
125 Broad Street
18th Floor
New York, NY 10004
212-549-2627 - Phone
212-549-2593 - DD
212-549-2650 - Fax
jblock@aclu.org
lcooper@aclu.org
smedley@aclu.org

Eden B. Heilman, Esq. (Pro hac vice)
LSBA No. 30551
Nicole Tortoriello, Esq.
VSB No. 91129
ACLU
701 E. Franklin Street
Suite 1412
Richmond, VA 23219
804-726-6013 – DD
804-649-2733 – Fax
eheilman@acluva.org
ntortoriello@acluva.org



David P. Corrigan (VSB No. 26341)
Attorney for Gloucester County School Board
Harman, Claytor, Corrigan & Wellman
P.O. Box 70280
Richmond, Virginia 23255
804-747-5200 - Phone
804-747-6085 - Fax
dcorrigan@hccw.com

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM,

Plaintiff,

v. Case No. 4:15-cv-00054

GLOUCESTER COUNTY SCHOOL BOARD,

Defendant.

DEFENDANT'S SUPPLEMENTAL ANSWER TO PLAINTIFF'S INTERROGATORY NO. 1

Comes now the defendant, Gloucester County School Board ("School Board"), and for its Supplemental Answer to Plaintiff's Interrogatory, states as follows:

GENERAL OBJECTIONS

A. Defendant objects to the Instructions contained in Plaintiff's interrogatories to the extent they alter, amend, or exceed the scope of the Federal Rules of Civil Procedure.

B. The information supplied in these answers is not based solely on the knowledge of the executing party but includes knowledge of the party, its agents, representatives, and attorneys, unless privileged. Such knowledge may or may not be known to the Defendant other than as provided.

C. The word usage and sentence structure may be that of the attorney and staff assisting in the preparation of these answers and thus do not necessarily purport to be the precise language of the executing party.

D. These answers will be supplemented in accordance with the Rule 33 of the Federal Rules of Civil Procedure, the Local Rules of the Eastern District of Virginia, and any Orders regarding discovery.

E. Defendant objects to interrogatories, etc., that invade or attempt to invade the attorney/client, work product, or any other applicable privilege.

ANSWERS TO INTERROGATORIES

1. Identify all complaints received by Gloucester County School Board ("the Board") or its employees related to transgender students' use of restrooms during the 2014-2015 school year, and for each complaint identify the date of the complaint, the recipient of the complaint, the content of the complaint, how the complaint was communicated or transmitted, whether the complainant was from a Gloucester High School student or parent of a Gloucester High School student, and whether the complaint related to any incident in which a student reported being in the restroom at the same time as Plaintiff.

OBJECTION: The School Board objects on the grounds that this Interrogatory is overly broad and unduly burdensome. Further, the School Board objects on the grounds that the use of the term "complaint" is vague and ambiguous. Finally, the School Board objects to the extent that this Interrogatory seeks the discovery of information protected pursuant to the Agreed Confidentiality Protective Order (ECF Doc. 85) entered in this matter.

ANSWER: Without waiving and subject to the foregoing objection,[1] Gloucester County High School Principal Nate Collins gave Grimm permission to use the male restroom on October 20, 2014. Two to three days later, Superintendent Dr. Walter Clemons received two complaints from parents regarding a transgender student using the restroom inconsistent with that student's biological sex. Dr. Clemons does not recall the identity of those parents. The parents indicated that they did not approve of a biologically female student using the male restroom. Additionally, a male student met with Collins in person and expressed concern about a biologically female student using the male restroom and a lack of privacy. Collins does not recall the specific identity of this student.

Moreover, after Grimm began to use the male restroom, Dr. Clemons, Collins and the individual members of the School Board received numerous complaints via email, which are listed below.

Emails sent to all members of the School Board

- On October 23, 2014, Kathryn Lindsay, a parent of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On October 23, 2014, Stacie and Paul Martin, parents of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School Board an email regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

---

[1] The School Board specifically reasserts its objection that Plaintiff's use of the term "complaint" in this Interrogatory is vague and ambiguous. The School Board has included in its Answer communications with individuals who generally opposed a transgender student using a restroom inconsistent with that student's biological sex. The School Board's Answer includes communications with individuals who did not agree with Gloucester High School allowing a transgender student to use a restroom inconsistent with that student's biological sex and communications with individuals who supported the School Board's December 9, 2014 resolution and the School Board's litigation of this matter.

- **On October 27, 2014, Susannah Hogge sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On October 27, 2014, Jennifer Spears, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On October 28, 2014, Season Palas, upon information and belief a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 10, 2014, Elisa Nelson, a parent of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 10/11, 2014, Stuart and Seth Bunting, parents of student(s) enrolled in Gloucester High School, sent the School Board an email regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 11, 2014, Mary Diggs, upon information and belief a resident of Gloucester County, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 11, 2014, David Turner sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 12, 2014, Haley Poulson, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 12, 2014, Kelly Williams, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 13, 2014, Melissa Alexander, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 17, 2014, Kelly Cooper, a parent of student(s) enrolled in Gloucester High School, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 7, 2014, Jenny Poole, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 8, 2014, Mike Enz, a parent of student(s) enrolled in Gloucester High School, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 8, 2014, Heather Schott, a parent of student(s) enrolled in the Gloucester County Public School System, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 10, 2014, Tommie Thompson, a resident of Gloucester County, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 10, 2014, Paul Martin, a parent of student(s) enrolled in Gloucester High School, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 20, 2014, Chuck Thompson, a resident of Gloucester County, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 20, 2014, Clayton Rogers sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On January 2, 2015, an individual named Jena sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On July 10, 2015, Tim Tompkins sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On April 21, 2016, Kathryn Lindsay, a parent of students(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On April 21, 2016, Paul Martin, parent of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On May 12, 2016, Kenneth Larson sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Emails sent to Troy Anderson

In addition to receiving emails sent to the entire School Board, Mr. Anderson received the following communications:

- **On December 7, 2014, Ginger Enz, parent of student(s) enrolled in Gloucester High School, sent Mr. Anderson an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On July 27, 2015, Leland Pike, a resident of Kentucky, sent Mr. Anderson an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On July 14, 2016, Florence Alpert, a resident of New York, sent Mr. Anderson an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Emails sent to Randy Burak

In addition to receiving emails sent to the entire School Board, Mr. Burak received the following communications:

- **On November 12, 2014, Gina Thayer, a parent of student(s) enrolled in Gloucester High School, sent Mr. Burak an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 3, 2014, Lisa Wood, a resident of the Abingdon District, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 7, 2014, Mike Enz, a parent of student(s) who attended Gloucester High School, sent the Mr. Burak an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 8, 2014, a resident of Gloucester County named Ginger emailed Mr. Burak regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 11, 2014, Sharon Kass, a resident of Washington D.C., emailed Mr. Burak regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Emails sent to Kimberly Hensley

In addition to receiving emails sent to the entire School Board, Ms. Hensley received the following communications:

- **On November 19, 2014, Tracey Parks Carter, a parent of student(s) at Gloucester High School, emailed Ms. Hensley regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 13, 2014, Cliff and Brandi Blackwood, parents of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, emailed Ms. Hensley regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Emails sent to Carla Hook

In addition to receiving emails sent to the entire School Board, Ms. Hook received the following communications:

- **On December 7, 2014, Steven Davis, a parent of high school student(s) in the York District, sent an email to Ms. Hook regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Emails sent to Charles Records

In addition to receiving emails sent to the entire School Board, Mr. Records received the following communications:

- **On April 21, 2016, Jean Lassiter sent an email to Mr. Records regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Emails sent to Dr. Clemons

In addition to receiving some of the emails sent to the entire Board, Dr. Clemons received the following communications:

- **On October 22, 2016 Season Palas, upon information and belief a parent of student(s) enrolled in Gloucester County Public Schools, sent Dr. Clemons an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 7, 2016, Ralph VanNess sent Dr. Clemons an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Additionally, the following School Board members received complaints via telephone, which are listed below.

Telephone Complaints made to Carla Hook

- **Upon information and belief, before October 28, 2014, Ms. Hook spoke with Season and Andrew Palas, whose children were enrolled in Gloucester County Public Schools, regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Additionally, the issue of transgender bathroom use was discussed at public School Board meetings on November 11, 2014 and December 9, 2014. Video links to those meetings are available at: http://www.gloucesterva.info/640/Meeting-Portal.

The following individuals spoke regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex during the November 11, 2014 meeting:

- **Ralph Van Ness (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Eddie Aliff**
- **Savannah Williams (student at Gloucester High School)**
- **Terry Brennan**
- **Joy Sampson (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Kelly Williams (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Marc Jenkins (parent of student(s) enrolled in Gloucester County Public Schools)**

- **Drew Palas (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Kathryn Lindsay (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Brian Byrd (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Tricia Ray**
- **Kim Ward (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Melissa Wamsley (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Ray Wamsley (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Season Palas (parent of student(s) enrolled in Gloucester County Public Schools)**

The following individuals spoke regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex during the December 9, 2014 meeting:

- **Ralph Van Ness (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Scott Williams (student at Gloucester High School)**
- **Savannah Williams (student at Gloucester High School)**
- **Kathryn Lindsay (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Drew Palas (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Karen Pauly**
- **Mike Enz (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Katherine Foley (parent of student(s) enrolled at Gloucester High School)**
- **Howard Mowry**
- **Janet West (parent of student(s) enrolled at Gloucester High School)**
- **Linda Walk**
- **Don Mitchell**

- **Terry Brennan**
- **Marista Cooper (grandparent of student(s) enrolled in Gloucester County Public Schools)**
- **Kelly Williams**

The School Board also incorporates by reference any additional "complaints" not described herein that are contained in the documents the School Board has produced in response to Plaintiff's First Request for Production of Documents.

SUPPLEMENTAL ANSWER:

In its Answers to Plaintiff's First Interrogatories, the School Board provided a list of email communications between board members and various individuals regarding the use of restrooms by transgender students. Further, the School Board provided the emails identified in those Answers in response to Plaintiff's First Requests for Production of Documents. The emails speak for themselves, and each School Board member's knowledge of any "complaint" sent by email relating to the use of restrooms by transgender students is consistent with the contents of those emails.

Further, in addition to the information provided in the School Board's Answers to Plaintiff's First Interrogatories, the following School Board members recall receiving non-email communications from individuals concerning the use of school restrooms by transgender students:

- **Carla Hook received approximately five (5) telephone calls from parents of students enrolled in Gloucester County Public Schools who said their children were uncomfortable with a girl using the boys' restroom. Ms. Hook does not recall the names of either the parents with whom she spoke or their children. To Ms. Hook's knowledge, the children had no direct interaction with Grimm in the boys' restroom.**
- **Kevin Smith received dozens of communications before the December 9, 2014, School Board meeting regarding a transgender student using the restroom**

inconsistent with that student's biological sex. To Mr. Smith's best recollection, approximately seventy-five (75) percent of those communications came from parents of students enrolled in Gloucester County Public Schools. Mr. Smith does not recall the names of either the individuals with whom he spoke or their children. The individuals indicated that they were not in favor of a transgender student using the restroom inconsistent with that student's biological sex. Additionally, parents indicated that they did not want their children using the same bathroom as a member of the opposite sex. To Mr. Smith's knowledge, the children had no direct interaction with Grimm in the boys' restroom.

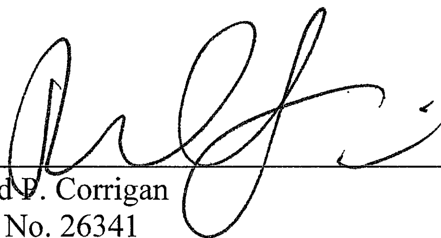
- **Troy Andersen received approximately five (5) telephone calls from parents of students at Gloucester County Public Schools regarding a transgender student using the restroom inconsistent with that student's biological sex. Mr. Andersen does not recall the names of either the parents or their children. The parents did not want their children using the same bathroom as a member of the opposite sex, and they were concerned about the privacy and safety of students, including their children. Mr. Andersen believes that he followed any telephone conversation on this issue with an email to the parent, and that the telephone conversations were substantively similar to the email exchanges. To the best of Mr. Andersen's knowledge, the children had no direct interaction with Grimm in the boys' restroom.**

- **Randy Burak received two telephone calls on October 20, 2014, from parents of students at Gloucester County Public Schools regarding a transgender student using the restroom inconsistent with that student's biological sex. One telephone call came from "Mr. Wood," a parent of two boys enrolled in Gloucester County Public Schools. Mr. Burak does not recall the first name of Mr. Wood. Mr. Wood indicated that he and his children were not in favor of a girl using the same restroom as boys. The other telephone call came from a parent, whose name Mr. Burak cannot recall, who likewise did not approve of a transgender student using the restroom inconsistent with that student's biological sex. This parent expressed concern that young male students would be uncomfortable with a student who was biologically female using the male restroom. Mr. Burak does not know whether or not the children of the two parents had any direct interaction with Grimm in the boys' restroom.**

This Answer will be supplemented further as additional information is received.

GLOUCESTER COUNTY SCHOOL BOARD

By ___________________________



David P. Corrigan
VSB No. 26341
Jeremy D. Capps
VSB No. 43909
Douglas E. Pittman
VSB No. 87915
Attorney for Gloucester County School Board
Harman, Claytor, Corrigan & Wellman
P.O. Box 70280
Richmond, Virginia 23255
804-747-5200 - Phone
804-747-6085 - Fax
dcorrigan@hccw.com
jcapps@hccw.com
dpittman@hccw.com

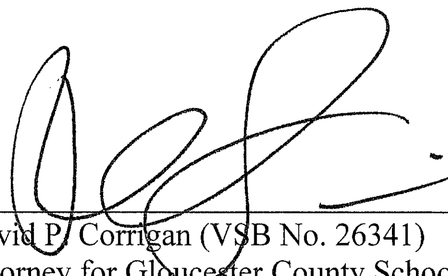
CERTIFICATE

I hereby certify that on the 11th day of January, 2019, I mailed and emailed the document to the following:

Joshua A. Block, Esq. (Pro hac vice)
NYSB No. 4370573
Leslie Cooper, Esq. (Pro hac vice)
NYSB No. 2759835
Shayna Medley-Warsoff, Esq. (Pro hac vice)
NYSB No. 5558382
American Civil Liberties Union
125 Broad Street
18th Floor
New York, NY 10004
212-549-2627 - Phone
212-549-2593 - DD
212-549-2650 - Fax
jblock@aclu.org

lcooper@aclu.org
smedley@aclu.org

Eden B. Heilman, Esq. (Pro hac vice)
LSBA No. 30551
Nicole Tortoriello, Esq.
VSB No. 91129
ACLU
701 E. Franklin Street
Suite 1412
Richmond, VA 23219
804-726-6013 – DD
804-649-2733 – Fax
eheilman@acluva.org
ntortoriello@acluva.org



David P. Corrigan (VSB No. 26341)
Attorney for Gloucester County School Board
Harman, Claytor, Corrigan & Wellman
P.O. Box 70280
Richmond, Virginia 23255
804-747-5200 - Phone
804-747-6085 - Fax
dcorrigan@hccw.com

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM, Plaintiff, v. GLOUCESTER COUNTY SCHOOL BOARD, Defendant.	Civil No. 4:15-cv-00054-AWA-RJK

EXPERT REPORT AND DECLARATION OF
DR. MELINDA PENN, M.D.

1. I, Melinda Penn, M.D., have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

PROFESSIONAL BACKGROUND

2. My professional background, experience, and publications are detailed in my curriculum vitae ("CV"), attached as Exhibit A.

3. I am a pediatric endocrinologist currently practicing at Children's Hospital of the King's Daughters in Norfolk, Virginia. I am board certified in pediatric endocrinology by the American Board of Pediatrics, and I specialize in transgender health and Type-1 diabetes.

4. After graduating from Eastern Virginia Medical School in 2004, I completed my residency at Medical University of South Carolina in 2007, followed by a fellowship at Children's Hospital of Philadelphia in 2010.

5. After completing my medical training, I returned to Virginia and worked for 8 years as a practicing pediatric endocrinologist at Virginia Commonwealth University ("VCU") in

Richmond. I began treating transgender patients in 2013, and I founded and co-directed VCU's Pediatric and Adolescent Transgender Clinic in 2016 with an adolescent psychiatrist.

6. In July 2018, I moved to the Hampton Roads area to practice at the Children's Hospital of the King's Daughters.

7. As part of my practice, I provide transition-related endocrine care to transgender adolescents in accordance with the World Professional Association for Transgender Health ("WPATH") Standards of Care (attached as Exhibit B) and the Endocrine Society's Clinical Practice Guideline for Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons (attached as Exhibit C).

8. I am a member of WPATH and the Pediatric Endocrine Society. I am also a member of the Pediatric Endocrinology Society's Special Interest Group for Transgender Health and have attended several of their meetings at the annual Pediatric Endocrinology Society conferences, and stay involved in communications among members. I currently serve as a part of my hospital's Transgender Working Group which is made up of health professionals committed to increasing compassionate and knowledgeable care for transgender patients.

9. Over the past 5 years, I have treated over 100 transgender youth and adolescents in Virginia.

10. In my work with transgender youth, I collaborate closely with mental health professionals to provide comprehensive care. My clinic at VCU was a multidisciplinary clinic with a pediatric psychiatrist who specializes in transgender care, and we frequently collaborated with a psychologist who specializes in pediatric and adolescent LGBT care. Currently, I work with a social worker who is available to see my patients and can offer mental health resources and referrals.

11. I regularly keep up to date with the professional literature on the treatment of children and adolescents with gender dysphoria.

12. In preparing this report, I relied on my scientific education and training, my professional experience, clinical guidelines that represent the contemporary standard of care for treating transgender youth, and scientific literature on the topic.

13. The materials I have relied upon in preparing this report are the same types of materials that experts in my field regularly rely upon when forming professional opinions.

14. I may supplement these opinions in response to information produced by Defendants in discovery or in response to Defendant's expert disclosures.

15. I have not testified as an expert at a trial or deposition in the last four years.

16. I am being compensated at an hourly rate of $300 per hour. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

OPINIONS

17. The term "gender identity" refers to a person's innate sense of belonging to a particular gender. Although the precise etiology of gender identity is unknown, biological and environmental factors are believed to contribute to this fundamental aspect of human development.

18. A person's gender identity usually matches the sex they were designated at birth based on their external genitalia. The terms "sex designated at birth" or "sex assigned at birth" are more precise than the term "biological sex" because all of the physiological aspects of a person's sex are not always aligned with each other. For example, some people with intersex characteristics may have chromosomes typically associated with males but genitalia typically

associated with females. For these reasons the Endocrine Society warns practitioners that the terms "biological sex" and "biological male or female" are imprecise and should be avoided.

19. Most boys were designated male at birth based on their external genital anatomy, and most girls were designated female at birth based on their external genital anatomy. But transgender children have a gender identity that differs from the sex assigned to them at birth. A transgender boy is someone who was assigned a female sex at birth but persistently, consistently, and insistently identifies as male. A transgender girl is someone who was assigned a male sex at birth but persistently, consistently, and insistently identifies as female.

20. Gender identity is a deeply rooted early in life. For some children, a transgender identity presents early in childhood. For others, the onset of puberty, and the resulting physical changes in their bodies, may lead them to recognize that their gender identity is not aligned with their sex assigned at birth.

21. According the American Psychiatric Association's Diagnostic & Statistical Manual of Mental Disorders ("DSM V"), "gender dysphoria" is the diagnostic term for the condition experienced by some transgender people of clinically significant distress resulting from the lack of congruence between their gender identity and the sex assigned to them at birth. In order to be diagnosed with gender dysphoria, the incongruence must have persisted for at least six months and be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning.

22. Being transgender is not itself a mental disorder or a medical condition to be cured. But gender dysphoria is a serious medical condition that, if left untreated, can result in crippling anxiety, severe depression, self-harm, and suicidality. Spack NP, Edwards-Leeper L, Feldmain HA, et al. *Children and adolescents with gender identity disorder referred to a*

pediatric medical center. Pediatrics. 2012; 129(3):418-425. Olson KR, Durwood L, DeMeules M, McLaughlin KA. *Mental health of transgender children who are supported in their identities.* Pediatrics 2016/137:1-8.

23. WPATH and the National Endocrine Society have published widely accepted standards of care for treating gender dysphoria. The medical treatment for gender dysphoria is to eliminate the clinically significant distress by helping a transgender person live in alignment with their gender identity. This treatment is sometimes referred to as “gender transition,” “transition related care,” or “gender affirming care.” The American Academy of Pediatrics agrees that this care is safe, effective, and medically necessary treatment for the health and wellbeing of children and adolescents suffering from gender dysphoria.

24. The precise treatment for gender dysphoria depends on each person’s individualized need, and the medical standards of care differ depending on whether the treatment is for a pre-pubertal child, an adolescent, or an adult.

25. Before puberty, gender transition does not include any drug or surgical intervention and is limited to “social transition,” which means allowing a transgender child to live and be socially recognized in accordance with their gender identity. Typically, social transition can include allowing children to wear clothing, to cut or grow their hair, to use names and pronouns and restrooms and other sex-separated facilities in line with their gender identity instead of the sex assigned to them at birth.

26. Under the Endocrine Society Clinical Guidelines, hormone therapy may become medically necessary and appropriate as transgender youth reach puberty. In providing hormone therapy pediatric endocrinologists must work in close consultation with qualified mental health professionals experienced in diagnosing and treating gender dysphoria.

27. For many transgender adolescents, going through puberty in accordance with the sex assigned to them at birth can cause extreme distress. Puberty blocking hormone treatment allows transgender youth to avoid going through puberty in accordance with the sex assigned to them at birth, along with the heightened gender dysphoria and permanent physical changes that puberty would cause.

28. Under the Endocrine Society Clinical Guidelines, transgender adolescents may be eligible for puberty-blocking hormone therapy if:

- A qualified mental health professional has confirmed that:
    - the adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed),
    - gender dysphoria worsened with the onset of puberty,
    - any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment,
- The adolescent:
    - has sufficient mental capacity to give informed consent to this (reversible) treatment, and
    - has been informed of the effects and side effects of treatment (including potential loss of fertility if the individual subsequently continues with sex hormone treatment) and options to preserve fertility, and
    - has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,
- And a pediatric endocrinologist or other clinician experienced in pubertal assessment:
    - agrees with the indication for GnRH agonist treatment,

  - has confirmed that puberty has started in the adolescent, and
  - has confirmed that there are no medical contraindications to GnRH agonist treatment.

29. Once a transgender adolescent establishes maturity and competence to make decisions about treatment, often around the age of 14, it may then be medically necessary and appropriate to provide gender-affirming hormone therapy to allow them to go through puberty consistently with their gender identity.

30. Under Endocrine Society Clinical Guidelines, transgender adolescents may be eligible for gender-affirming hormone therapy if:

- A qualified mental health professional has confirmed:
  - the persistence of gender dysphoria,
  - any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start sex hormone treatment,
  - the adolescent has sufficient mental capacity to estimate the consequences of this (partly) irreversible treatment, weigh the benefits and risks, and give informed consent to this (partly) irreversible treatment,
- And the adolescent:
  - has been informed of the (irreversible) effects and side effects of treatment (including potential loss of fertility and options to preserve fertility),
  - has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,
- And a pediatric endocrinologist or other clinician experienced in pubertal induction:
  - agrees with the indication for sex hormone treatment,

- has confirmed that there are no medical contraindications to sex hormone treatment.

31. Adolescents who receive gender-affirming hormones after puberty blockers never go through puberty in accordance with the sex assigned to them at birth and, instead, go through puberty that matches their gender identity. Pre-pubertal boys and girls are indistinguishable with respect to secondary sex characteristics. If a pre-pubertal child receives puberty blockers, they will never develop the secondary sex characteristics of the sex assigned to them at birth, and when they are provided hormones in accordance with their gender identity, they will develop only the secondary sex characteristics that match their gender identity.

32. For example, transgender boys treated with puberty blockers and gender affirming hormones will receive the same amount of testosterone during puberty that non-transgender boys generate with their gonads or testes. They will develop the phenotypic features of non-transgender boys such as muscle mass, fat distribution, facial and body hair, along with lower vocal pitch. Likewise, transgender girls treated with puberty blockers and gender affirming hormones will receive the same amount of estrogen during puberty that non-transgender girls generate endogenously. They will develop the same muscle mass, fat distribution, skin and female hair patterns, and breasts typically associated with other girls.

33. Under the WPATH standards of care, boys and girls who are transgender may also receive medically necessary chest reconstructive surgeries once they turn 16 and genital surgery once they reach the age of majority.

34. When provided medical treatments in accordance with the standards of care before and during puberty, transgender boys do not resemble and are not perceived as girls in

their day to day life, and transgender girls do not resemble and are not perceived as boys in their day to day life.

35. Blocking a transgender youth from going through puberty in accordance with the sex assigned to them at birth and providing gender-affirming hormones can be lifesaving treatment and change the short and long term health outcomes for transgender youth.

36. Offering safe, healthy, medically supervised gender transition is critical to the healthy growth and development of many transgender children and adolescents who experience gender dysphoria. Transgender youth are a high risk population with increased risk for poor mental health outcomes including suicide, homelessness and becoming a victim of violence. Psychological functioning has been shown to improve with hormone and surgical therapy. Guss, Carly, Shumer, Daniel; Katz-Wise, Sabra L. *Transgender and gender nonconforming adolescent care: psychosocial and medical considerations*. Current Opinions in Pediatrics: August 2015-Volume 27-Issue 4. p 421-426; Lopez, Ximena; Marinkovic, Maja; Eimicke, Toni; Rosenthal, Stephen; Olshan,Jerrold. *Statement on gender-affirmative approach to care from the pediatric endocrine society special interest group on transgender health*. Current Opinions in Pediatrics: August 2017-Volume 29,Issue 4. 475-480; Cohen-Kettenis PT,Schagn SEE, Steensma TD, de Vries ALC, Delemarre-van de Waal HA; *Puberty suppression in a gender dysphoric adolescent: a 22-year follow-up*. Arch Sex Behav. 2011;40(4): 843-847.

37. I have seen these dramatically improved health outcomes in my own practice as a pediatric endocrinologist. Many of my patients with gender dysphoria have a history of significant depression and anxiety requiring medications and often hospitalizations prior to initiating endocrine care. My patients and their parents have all reported improvement—often dramatic improvement– in the adolescent's functioning and reduction in their gender dysphoria

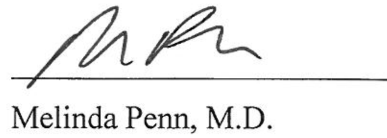
after initiating care. Many are able to stop or reduce their psychiatric medications and report improved socialization and increased participation in school and other activities. Adolescents who had previously been withdrawn open up and start having goals and making plans for their futures. Parents describe having their happy kid back.

38. The well-being of adolescents with gender dysphoria depends on more than access to medical care to medically transition: The patients who have the most positive outcomes are those who are supported and respected as the gender they identify with by their families, peers, and school. This includes being referred to by the name and gender pronouns that match their identity and being able to participate in activities and access facilities consistent with their gender identity. deVries AL, McGuire JK, Steensma TD, et al. *Young adult psychological outcome after puberty suppression and gender reassignment*. Pediatrics 2014; 134:696-704.

39. Many of my patients wish to use the restroom for their affirmed gender and do not want to be singled out as different or inconvenienced by having to go to a separate restroom that other students are not required to use. While some students – particularly those who are early in their transition – feel safer or more comfortable using a private restroom, forcing transgender students to do so can be harmful to their wellbeing by calling them out as different and rejecting their gender. Many of my patients express that it is important to them to be seen as the boys and girls that they are and not be singled out as transgender. For some, being required to use a separate restroom is a constant reminder that they are different and not accepted as the boy or girl they know they are.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: 1/18/2019



Melinda Penn, M.D.

Eastern Virginia Medical School
Curriculum Vitae

Melinda Penn, MD
601 Children's Lane
Norfolk, VA 23507
(757) 668-7237 phone
(757) 668-8215 fax
melinda.penn@chkd.org

Personal Contact Information:
1018 Colonial Avenue
Norfolk, VA 23507
(804) 305-7242

Education

Fellow, Pediatric Endocrinology — 7/2007-8/2010
Children's Hospital of Philadelphia
Philadelphia, PA

Resident, General Pediatrics — 7/2004-7/2007
Medical University of South Carolina
Charleston, SC

Degree: MD — 8/2000-5/2004
Eastern Virginia Medical School
Norfolk, VA

Degree: BS, Biology — 8/1996-5/2000
Virginia Commonwealth University
Richmond, VA

Professional Experience

Physician, Pediatric Endocrionology — 7/2018-present
Children's Specialty Group
Norfolk, VA

Academic Appointments

Assistant Professor, Department of Pediatrics — 9/2010-7/2018
Virginia Commonwealth University
Richmond, VA

Associate Program Director, Pediatric Residency — 7/2013- 7/2018
Virginia Commonwealth University
Richmond, VA

Certification and Licensure

American Board of Pediatrics - General Pediatrics — 10/2007

American Board of Pediatrics- Pediatric Endocrinology	11/2011
South Carolina Limited Training Medical License	7/2004-7/2007
Pennsylvania Medical License	7/2007-8/2010
Pennsylvania Medical Training License	7/2007-8/2010
Virginia Medical License	6/2010-present

Professional Memberships and Activities

Lawson Wilkins Pediatric Endocrinology Society	2007-present
World Professional Association for Transgender Health	2014-present
Endocrine Society	2007-2010

Honors and Awards

Virginia Commonwealth University Presidential Scholarship	8/1996-5/2000
Virginia Commonwealth University, University Honors	5/2000
LWPES Fellow Travel Grant	2008,2009,2010
Ruth L. Kirschstein National Research Service Award Institutional Training Grant Recipient Children's Hospital of Philadelphia	7/2008-7/2009
Novo Nordisk Research Fellowship Grant Recipient Lawson Wilkins Pediatric Endocrine Society	7/2009-7/2010
Marilyn Fishman Grant for Diabetes Research Recipient Endocrine Fellows Foundation	7/2009-7/2010
Richmond Magazine "Top Doc"- Pediatric Endocrinology	2014- 2017

Committee Assignments and Administrative Services

Transgender Working Group CHKD	7/2018-present
Diabetes Center Team CHKD	7/2018-present
Laboratory Utilization Committee VCU Health System	7/2017-7/2018
DREAM Team- Inpatient Diabetes Committee VCU Health System	2011

Central Virginia JDRF Board of Directors 2011-2017

Educational Activities

Pediatric Endocrinology Resident Lecture 12/2018
Transgender Medicine
CHKD

Pediatric Endocrinology Fellowship Lecturer 2011-2018
Children's Hospital of Richmond at VCU

Pediatric Resident Lecturer 2011-2017
Pediatric Endocrinology lectures
Children's Hospital of Richmond at VCU

Endocrinology Grand Rounds 2012, 2015
Virginia Commonwealth University

MS2 Lecturer 2015, 2016
Puberty
Virginia Commonwealth University School of Medicine

ACGME Residency Orientation 2016
Walk the Walk
Virginia Commonwealth University School of Medicine

Medical Student Interest Group Lecturer 2016
Pediatric Transgender Medicine
Virginia Commonwealth University School of Medicine

Pediatric Endocrinology Fellow Clinical Mentor 2011-2018
Virginia Commonwealth University School of Medicine

Clinical Educator for Pediatric Endocrinology Fellows, 2010-2018
Pediatric Residents and Medical students
Children's Hospital of Richmond at VCU

Clinical Activities

Director of Pediatric Transgender Health Clinic 2014-2018
Children's Hospital of Richmond at Virginia Commonwealth University

Grants and Contract Awards

Ruth L. Kirschstein National Research Service Award 2008-2009
Institutional Training Grant Recipient
Children's Hospital of Philadelphia

Novo Nordisk Research Fellowship Grant Recipient, $10,000 2009-2010
Lawson Wilkins Pediatric Endocrine Society

Marilyn Fishman Grant for Diabetes Research Recipient, $10,000 — 2009-2010
Endocrine Fellows Foundation

Publications

Kameswaran V, Bramswig NC, McKenna LB**, Penn M,** Schug J, Hand NJ, Chen Y, Choi I, Vourekas A, Won KJ, Liu C, Vivek K, Naji A, Friedman JR, Kaestner KH. *Epigenetic regulation of the DLK1-MEG3 microRNA cluster in human type 2 diabetic islets.*
Cell Metab. 2014 Jan 7;19(1):135-45.
PMID: 24374217

Book Chapters

Penn, M. *Type 1 Diabetes.* Encyclopedia of inflammatory Disease.
Springer Online Publication, 2014

Penn, M, Grimberg A. *Patient Encounters: The Inpatient Pediatrics Work-Up. Chapter 11: Diabetic Ketoacidosis.*
Lippincott Williams and Wilkins, 2009.

Abstracts and Presentations

National
Oral Platform Presentation, LWPES/ESPE — 2010
MicroRNA Profile in Type 2 diabetes.

Regional
JDRF TypeOneNation Summit — 10/2017
Expert Panel

Virginia TIES Conference — 10/2017
Transgender Medical Care for Children and Adolescents

Peds at the Beach — 7/2016
Transgender Healthcare for Children and Adolescents

Animas Diabetes Family Conference — 4/2011
Expert Panel

Poster Presentations

Penn M, Hsu Y, Hughes N, DeLeon D. *Transitioning Infants with Monogenic Diabetes to Oral Sulfonylurea Therapy*. Abstract for poster presentation, University of Pennsylvania, Institute of Diabetes and Metabolism Research Day,
March 2009.

Penn M, Hsu Y, Hughes N, DeLeon D. *Transitioning Infants with Monogenic Diabetes to Oral Sulfonylurea Therapy*. Abstract for poster presentation, LWPES/ESPE, New York, NY 2009.

Penn M, Koren D, Hughes N, Kelly A, DeLeon D. *Neonatal diabetes due to KCNJ11 Mutations.* Abstract for poster presentation, Pediatric Academic Society, Honolulu, HI 2008.

Penn M, Koren D, Hughes N, Kelly A, DeLeon D. *Neonatal diabetes due to KCNJ11 Mutations.* Abstract for poster presentation, CHOP Fellows Research Day, February 2008.

Professional Development

Diabetes Technology Society- Certified Diabetes Technology Clinician 2013

Community Service

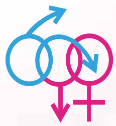
Camp Adam Fisher 2005, 2006
Diabetes Camp- Medical staff volunteer
Marion, SC

Setebaid Diabetes Camp- Medical staff volunteer 2008
Shickshinny, PA

ADA Diabetes Camp Donovan McNabb- Medical Supervisor 2008-2010
Philadelphia, PA

Camp WannaCure- Medical Director 2011-2018
Richmond, VA

Central Virginia JDRF Board of Directors 2011-2017



WPATH WORLD PROFESSIONAL ASSOCIATION for TRANSGENDER HEALTH

Standards of Care

for the Health of Transsexual, Transgender, and Gender Nonconforming People

The World Professional Association for Transgender Health

7th Version

Standards of Care

for the Health of Transsexual, Transgender, and Gender Nonconforming People

The World Professiona Association for Transgender Health

7th Version[1] | www.wpath.org

1 This is the seventh version of the Standards of Care. The original SOC were published in 1979. Previous revisions were in 1980, 1981, 1990, 1998, and 2001.

Table of Contents

I. Purpose and Use of the Standards of Care 1
II. Global Applicability of the Standards of Care 3
III. The Difference between Gender Nonconformity and Gender Dysphoria 4
IV. Epidemiologic Considerations 6
V. Overview of Therapeutic Approaches for Gender Dysphoria 8
VI. Assessment and Treatment of Children and Adolescents with Gender Dysphoria 10
VII. Mental Health 21
VIII. Hormone Therapy 33
IX. Reproductive Health 50
X. Voice and Communication Therapy 52
XI. Surgery 54
XII. Postoperative Care and Follow-Up 64
XIII. Lifelong Preventive and Primary Care 65
XIV. Applicability of the *Standards of Care* to People Living in Institutional Environments . . . 67
XV. Applicability of the *Standards of Care* to People With Disorders of Sex Development . . . 69

References 72

Appendices:

A. Glossary 95
B. Overview of Medical Risks of Hormone Therapy 97
C. Summary of Criteria for Hormone Therapy and Surgeries 104
D. Evidence for Clinical Outcomes of Therapeutic Approaches 107
E. Development Process for the *Standards of Care, Version 7* 109

Purpose and Use of the Standards of Care

The World Professional Association for Transgender Health (WPATH)[1] is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect for transgender health. The vision of WPATH is to bring together diverse professionals dedicated to developing best practices and supportive policies worldwide that promote health, research, education, respect, dignity, and equality for transsexual, transgender, and gender nonconforming people in all cultural settings.

One of the main functions of WPATH is to promote the highest standards of health care for individuals through the articulation of *Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People*. The *SOC* are based on the best available science and expert professional consensus.[2] Most of the research and experience in this field comes from a North American and Western European perspective; thus, adaptations of the *SOC* to other parts of the world are necessary. Suggestions for ways of thinking about cultural relativity and cultural competence are included in this version of the *SOC*.

The overall goal of the *SOC* is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment. This assistance may include primary care, gynecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counseling, psychotherapy), and hormonal and surgical treatments. While this is primarily a document for health professionals, the *SOC* may also be used by individuals, their families, and social institutions to understand how they can assist with promoting optimal health for members of this diverse population.

WPATH recognizes that health is dependent upon not only good clinical care but also social and political climates that provide and ensure social tolerance, equality, and the full rights of citizenship. Health is promoted through public policies and legal reforms that promote tolerance and equity

---

1 Formerly the Harry Benjamin International Gender Dysphoria Association

2 *Standards of Care (SOC), Version 7* represents a significant departure from previous versions. Changes in this version are based upon significant cultural shifts, advances in clinical knowledge, and appreciation of the many health care issues that can arise for transsexual, transgender, and gender nonconforming people beyond hormone therapy and surgery (Coleman, 2009a, b, c, d).

for gender and sexual diversity and that eliminate prejudice, discrimination, and stigma. WPATH is committed to advocacy for these changes in public policies and legal reforms.

The Standards of Care Are Flexible Clinical Guidelines

The *SOC* are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender nonconforming people. While flexible, they offer standards for promoting optimal health care and guiding the treatment of people experiencing gender dysphoria – broadly defined as discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

As for all previous versions of the *SOC*, the criteria put forth in this document for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable for the accumulation of new data, which can be retrospectively examined to allow for health care – and the *SOC* – to evolve.

The *SOC* articulate standards of care but also acknowledge the role of making informed choices and the value of harm reduction approaches. In addition, this version of the *SOC* recognizes and validates various expressions of gender that may not necessitate psychological, hormonal, or surgical treatments. Some patients who present for care will have made significant self-directed progress towards gender role changes, transition, or other resolutions regarding their gender identity or gender dysphoria. Other patients will require more intensive services. Health professionals can use the *SOC* to help patients consider the full range of health services open to them, in accordance with their clinical needs and goals for gender expression.

Global Applicability of the Standards of Care

While the *SOC* are intended for worldwide use, WPATH acknowledges that much of the recorded clinical experience and knowledge in this area of health care is derived from North American and Western European sources. From place to place, both across and within nations, there are differences in all of the following: social attitudes towards transsexual, transgender, and gender nonconforming people; constructions of gender roles and identities; language used to describe different gender identities; epidemiology of gender dysphoria; access to and cost of treatment; therapies offered; number and type of professionals who provide care; and legal and policy issues related to this area of health care (Winter, 2009).

It is impossible for the *SOC* to reflect all of these differences. In applying these standards to other cultural contexts, health professionals must be sensitive to these differences and adapt the *SOC* according to local realities. For example, in a number of cultures, gender nonconforming people are found in such numbers and living in such ways as to make them highly socially visible (Peletz, 2006). In settings such as these, it is common for people to initiate a change in their gender expression and physical characteristics while in their teens, or even earlier. Many grow up and live in a social, cultural, and even linguistic context quite unlike that of Western cultures. Yet almost all experience prejudice (Peletz, 2006; Winter, 2009). In many cultures, social stigma towards gender nonconformity is widespread and gender roles are highly prescriptive (Winter et al., 2009). Gender nonconforming people in these settings are forced to be hidden, and therefore may lack opportunities for adequate health care (Winter, 2009).

The *SOC* are not intended to limit efforts to provide the best available care to all individuals. Health professionals throughout the world – even in areas with limited resources and training opportunities – can apply the many core principles that undergird the *SOC*. These principles include the following: Exhibit respect for patients with nonconforming gender identities (do not pathologize differences in gender identity or expression); provide care (or refer to knowledgeable colleagues) that affirms patients' gender identities and reduces the distress of gender dysphoria, when present; become knowledgeable about the health care needs of transsexual, transgender, and gender nonconforming people, including the benefits and risks of treatment options for gender dysphoria; match the treatment approach to the specific needs of patients, particularly their goals for gender expression and need for relief from gender dysphoria; facilitate access to appropriate care; seek patients' informed consent before providing treatment; offer continuity of care; and be prepared to support and advocate for patients within their families and communities (schools, workplaces, and other settings).

Terminology is culturally and time-dependent and is rapidly evolving. It is important to use respectful language in different places and times, and among different people. As the *SOC* are translated into other languages, great care must be taken to ensure that the meanings of terms are accurately translated. Terminology in English may not be easily translated into other languages, and vice versa. Some languages do not have equivalent words to describe the various terms within this document; hence, translators should be cognizant of the underlying goals of treatment and articulate culturally applicable guidance for reaching those goals.

The Difference Between Gender Nonconformity and Gender Dysphoria

Being Transsexual, Transgender, or Gender Nonconforming Is a Matter of Diversity, Not Pathology

WPATH released a statement in May 2010 urging the de-psychopathologization of gender nonconformity worldwide (WPATH Board of Directors, 2010). This statement noted that "the expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally-diverse human phenomenon [that] should not be judged as inherently pathological or negative."

Unfortunately, there is stigma attached to gender nonconformity in many societies around the world. Such stigma can lead to prejudice and discrimination, resulting in "minority stress" (I. H. Meyer, 2003). Minority stress is unique (additive to general stressors experienced by all people), socially based, and chronic, and may make transsexual, transgender, and gender nonconforming individuals more vulnerable to developing mental health concerns such as anxiety and depression (Institute of Medicine, 2011). In addition to prejudice and discrimination in society at large, stigma can contribute to abuse and neglect in one's relationships with peers and family members, which in turn can lead to psychological distress. However, these symptoms are socially induced and are not inherent to being transsexual, transgender, or gender nonconforming.

Gender Nonconformity Is Not the Same as Gender Dysphoria

Gender nonconformity refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex (Institute of Medicine, 2011). *Gender dysphoria* refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b). Only *some* gender nonconforming people experience gender dysphoria at *some* point in their lives.

Treatment is available to assist people with such distress to explore their gender identity and find a gender role that is comfortable for them (Bockting & Goldberg, 2006). Treatment is individualized: What helps one person alleviate gender dysphoria might be very different from what helps another person. This process may or may not involve a change in gender expression or body modifications. Medical treatment options include, for example, feminization or masculinization of the body through hormone therapy and/or surgery, which are effective in alleviating gender dysphoria and are medically necessary for many people. Gender identities and expressions are diverse, and hormones and surgery are just two of many options available to assist people with achieving comfort with self and identity.

Gender dysphoria can in large part be alleviated through treatment (Murad et al., 2010). Hence, while transsexual, transgender, and gender nonconforming people may experience gender dysphoria at some point in their lives, many individuals who receive treatment will find a gender role and expression that is comfortable for them, even if these differ from those associated with their sex assigned at birth, or from prevailing gender norms and expectations.

Diagnoses Related to Gender Dysphoria

Some people experience gender dysphoria at such a level that the distress meets criteria for a formal diagnosis that might be classified as a mental disorder. Such a diagnosis is not a license for stigmatization or for the deprivation of civil and human rights. Existing classification systems such as the *Diagnostic Statistical Manual of Mental Disorders (DSM)* (American Psychiatric Association, 2000) and the *International Classification of Diseases* (*ICD*) (World Health Organization, 2007) define hundreds of mental disorders that vary in onset, duration, pathogenesis, functional disability, and treatability. All of these systems attempt to classify clusters of symptoms and conditions, not the individuals themselves. A disorder is a description of something with which a person might struggle, not a description of the person or the person's identity.

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 208 of 371Total Pages:(208 of 1263)

Thus, transsexual, transgender, and gender nonconforming individuals are not inherently disordered. Rather, the distress of gender dysphoria, when present, is the concern that might be diagnosable and for which various treatment options are available. The existence of a diagnosis for such dysphoria often facilitates access to health care and can guide further research into effective treatments.

Research is leading to new diagnostic nomenclatures, and terms are changing in both the *DSM* (Cohen-Kettenis & Pfäfflin, 2010; Knudson, De Cuypere, & Bockting, 2010b; Meyer-Bahlburg, 2010; Zucker, 2010) and the *ICD*. For this reason, familiar terms are employed in the *SOC* and definitions are provided for terms that may be emerging. Health professionals should refer to the most current diagnostic criteria and appropriate codes to apply in their practice areas.

IV

Epidemiologic Considerations

Formal epidemiologic studies on the incidence[3] and prevalence[4] of transsexualism specifically or transgender and gender nonconforming identities in general have not been conducted, and efforts to achieve realistic estimates are fraught with enormous difficulties (Institute of Medicine, 2011; Zucker & Lawrence, 2009). Even if epidemiologic studies established that a similar proportion of transsexual, transgender, or gender nonconforming people existed all over the world, it is likely that cultural differences from one country to another would alter both the behavioral expressions of different gender identities and the extent to which gender dysphoria – distinct from one's gender identity – is actually occurring in a population. While in most countries, crossing normative gender boundaries generates moral censure rather than compassion, there are examples in certain cultures of gender nonconforming behaviors (e.g., in spiritual leaders) that are less stigmatized and even revered (Besnier, 1994; Bolin, 1988; Chiñas, 1995; Coleman, Colgan, & Gooren, 1992; Costa & Matzner, 2007; Jackson & Sullivan, 1999; Nanda, 1998; Taywaditep, Coleman, & Dumronggittigule, 1997).

For various reasons, researchers who have studied incidence and prevalence have tended to focus on the most easily counted subgroup of gender nonconforming individuals: transsexual individuals who experience gender dysphoria and who present for gender-transition-related care at specialist gender clinics (Zucker & Lawrence, 2009). Most studies have been conducted in European

3 **incidence**—the number of new cases arising in a given period (e.g., a year)
4 **prevalence**—the number of individuals having a condition, divided by the number of people in the general population

countries such as Sweden (Wålinder, 1968, 1971), the United Kingdom (Hoenig & Kenna, 1974), the Netherlands (Bakker, Van Kesteren, Gooren, & Bezemer, 1993; Eklund, Gooren, & Bezemer, 1988; van Kesteren, Gooren, & Megens, 1996), Germany (Weitze & Osburg, 1996), and Belgium (De Cuypere et al., 2007). One was conducted in Singapore (Tsoi, 1988).

De Cuypere and colleagues (2007) reviewed such studies, as well as conducted their own. Together, those studies span 39 years. Leaving aside two outlier findings from Pauly in 1968 and Tsoi in 1988, ten studies involving eight countries remain. The prevalence figures reported in these ten studies range from 1:11,900 to 1:45,000 for male-to-female individuals (MtF) and 1:30,400 to 1:200,000 for female-to-male (FtM) individuals. Some scholars have suggested that the prevalence is much higher, depending on the methodology used in the research (for example, Olyslager & Conway, 2007).

Direct comparisons across studies are impossible, as each differed in their data collection methods and in their criteria for documenting a person as transsexual (e.g., whether or not a person had undergone genital reconstruction, versus had initiated hormone therapy, versus had come to the clinic seeking medically-supervised transition services). The trend appears to be towards higher prevalence rates in the more recent studies, possibly indicating increasing numbers of people seeking clinical care. Support for this interpretation comes from research by Reed and colleagues (2009), who reported a doubling of the numbers of people accessing care at gender clinics in the United Kingdom every five or six years. Similarly, Zucker and colleagues (2008) reported a four- to five-fold increase in child and adolescent referrals to their Toronto, Canada clinic over a 30-year period.

The numbers yielded by studies such as these can be considered minimum estimates at best. The published figures are mostly derived from clinics where patients met criteria for severe gender dysphoria and had access to health care at those clinics. These estimates do not take into account that treatments offered in a particular clinic setting might not be perceived as affordable, useful, or acceptable by all self-identified gender dysphoric individuals in a given area. By counting only those people who present at clinics for a specific type of treatment, an unspecified number of gender dysphoric individuals are overlooked.

Other clinical observations (not yet firmly supported by systematic study) support the likelihood of a higher prevalence of gender dysphoria: (i) Previously unrecognized gender dysphoria is occasionally diagnosed when patients are seen with anxiety, depression, conduct disorder, substance abuse, dissociative identity disorders, borderline personality disorder, sexual disorders, and disorders of sex development (Cole, O'Boyle, Emory, & Meyer III, 1997). (ii) Some crossdressers, drag queens/kings or female/male impersonators, and gay and lesbian individuals may be experiencing gender dysphoria (Bullough & Bullough, 1993). (iii) The intensity of some people's gender dysphoria fluctuates below and above a clinical threshold (Docter, 1988). (iv) Gender nonconformity among FtM individuals tends to be relatively invisible in many cultures, particularly to Western health

professionals and researchers who have conducted most of the studies on which the current estimates of prevalence and incidence are based (Winter, 2009).

Overall, the existing data should be considered a starting point, and health care would benefit from more rigorous epidemiologic study in different locations worldwide.

V

Overview of Therapeutic Approaches for Gender Dysphoria

Advancements in the Knowledge and Treatment of Gender Dysphoria

In the second half of the 20th century, awareness of the phenomenon of gender dysphoria increased when health professionals began to provide assistance to alleviate gender dysphoria by supporting changes in primary and secondary sex characteristics through hormone therapy and surgery, along with a change in gender role. Although Harry Benjamin already acknowledged a spectrum of gender nonconformity (Benjamin, 1966), the initial clinical approach largely focused on identifying who was an appropriate candidate for sex reassignment to facilitate a physical change from male to female or female to male as completely as possible (e.g., Green & Fleming, 1990; Hastings, 1974). This approach was extensively evaluated and proved to be highly effective. Satisfaction rates across studies ranged from 87% of MtF patients to 97% of FtM patients (Green & Fleming, 1990), and regrets were extremely rare (1-1.5% of MtF patients and <1% of FtM patients; Pfäfflin, 1993). Indeed, hormone therapy and surgery have been found to be medically necessary to alleviate gender dysphoria in many people (American Medical Association, 2008; Anton, 2009; The World Professional Association for Transgender Health, 2008).

As the field matured, health professionals recognized that while many individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither (Bockting & Goldberg, 2006; Bockting, 2008; Lev, 2004). Often with the help of psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body. For others, changes in gender role and expression are sufficient to alleviate

gender dysphoria. Some patients may need hormones, a possible change in gender role, but not surgery; others may need a change in gender role along with surgery, but not hormones. In other words, treatment for gender dysphoria has become more individualized.

As a generation of transsexual, transgender, and gender nonconforming individuals has come of age – many of whom have benefitted from different therapeutic approaches – they have become more visible as a community and demonstrated considerable diversity in their gender identities, roles, and expressions. Some individuals describe themselves not as gender nonconforming but as unambiguously cross-sexed (i.e., as a member of the other sex; Bockting, 2008). Other individuals affirm their unique gender identity and no longer consider themselves either male or female (Bornstein, 1994; Kimberly, 1997; Stone, 1991; Warren, 1993). Instead, they may describe their gender identity in specific terms such as transgender, bigender, or genderqueer, affirming their unique experience that may transcend a male/female binary understanding of gender (Bockting, 2008; Ekins & King, 2006; Nestle, Wilchins, & Howell, 2002). They may not experience their process of identity affirmation as a "transition," because they never fully embraced the gender role they were assigned at birth or because they actualize their gender identity, role, and expression in a way that does not involve a change from one gender role to another. For example, some youth identifying as genderqueer have always experienced their gender identity and role as such (genderqueer). Greater public visibility and awareness of gender diversity (Feinberg, 1996) has further expanded options for people with gender dysphoria to actualize an identity and find a gender role and expression that is comfortable for them.

Health professionals can assist gender dysphoric individuals with affirming their gender identity, exploring different options for expression of that identity, and making decisions about medical treatment options for alleviating gender dysphoria.

Options for Psychological and Medical Treatment of Gender Dysphoria

For individuals seeking care for gender dysphoria, a variety of therapeutic options can be considered. The number and type of interventions applied and the order in which these take place may differ from person to person (e.g., Bockting, Knudson, & Goldberg, 2006; Bolin, 1994; Rachlin, 1999; Rachlin, Green, & Lombardi, 2008; Rachlin, Hansbury, & Pardo, 2010). Treatments options include the following:

- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity);
- Hormone therapy to feminize or masculinize the body;

- Surgery to change primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring);

- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience.

Options for Social Support and Changes in Gender Expression

In addition (or as an alternative) to the psychological and medical treatment options described above, other options can be considered to help alleviate gender dysphoria, for example:

- Offline and online peer support resources, groups, or community organizations that provide avenues for social support and advocacy;

- Offline and online support resources for families and friends;

- Voice and communication therapy to help individuals develop verbal and non-verbal communication skills that facilitate comfort with their gender identity;

- Hair removal through electrolysis, laser treatment, or waxing;

- Breast binding or padding, genital tucking or penile prostheses, padding of hips or buttocks;

- Changes in name and gender marker on identity documents.

VI

Assessment and Treatment of Children and Adolescents with Gender Dysphoria

There are a number of differences in the phenomenology, developmental course, and treatment approaches for gender dysphoria in children, adolescents, and adults. In children and adolescents, a rapid and dramatic developmental process (physical, psychological, and sexual) is involved and

there is greater fluidity and variability in outcomes, particular in prepubertal children. Accordingly, this section of the *SOC* offers specific clinical guidelines for the assessment and treatment of gender dysphoric children and adolescents.

Differences between Children and Adolescents with Gender Dysphoria

An important difference between gender dysphoric children and adolescents is in the proportion for whom dysphoria persists into adulthood. Gender dysphoria during childhood does not inevitably continue into adulthood.[5] Rather, in follow-up studies of prepubertal children (mainly boys) who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6-23% of children (Cohen-Kettenis, 2001; Zucker & Bradley, 1995). Boys in these studies were more likely to identify as gay in adulthood than as transgender (Green, 1987; Money & Russo, 1979; Zucker & Bradley, 1995; Zuger, 1984). Newer studies, also including girls, showed a 12-27% persistence rate of gender dysphoria into adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008).

In contrast, the persistence of gender dysphoria into adulthood appears to be much higher for adolescents. No formal prospective studies exist. However, in a follow-up study of 70 adolescents who were diagnosed with gender dysphoria and given puberty suppressing hormones, all continued with the actual sex reassignment, beginning with feminizing/masculinizing hormone therapy (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2010).

Another difference between gender dysphoric children and adolescents is in the sex ratios for each age group. In clinically referred, gender dysphoric children under age 12, the male/female ratio ranges from 6:1 to 3:1 (Zucker, 2004). In clinically referred, gender dysphoric adolescents older than age 12, the male/female ratio is close to 1:1 (Cohen-Kettenis & Pfäfflin, 2003).

As discussed in section IV and by Zucker and Lawrence (2009), formal epidemiologic studies on gender dysphoria – in children, adolescents, and adults – are lacking. Additional research is needed to refine estimates of its prevalence and persistence in different populations worldwide.

5 Gender nonconforming behaviors in children may continue into adulthood, but such behaviors are not necessarily indicative of gender dysphoria and a need for treatment. As described in section III, gender dysphoria is not synonymous with diversity in gender expression.

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 214 of 371Total Pages:(214 of 1263)

Phenomenology in Children

Children as young as age two may show features that could indicate gender dysphoria. They may express a wish to be of the other sex and be unhappy about their physical sex characteristics and functions. In addition, they may prefer clothes, toys, and games that are commonly associated with the other sex and prefer playing with other-sex peers. There appears to be heterogeneity in these features: Some children demonstrate extremely gender nonconforming behavior and wishes, accompanied by persistent and severe discomfort with their primary sex characteristics. In other children, these characteristics are less intense or only partially present (Cohen-Kettenis et al., 2006; Knudson, De Cuypere, & Bockting, 2010a).

It is relatively common for gender dysphoric children to have co-existing internalizing disorders such as anxiety and depression (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003; Wallien, Swaab, & Cohen-Kettenis, 2007; Zucker, Owen, Bradley, & Ameeriar, 2002). The prevalence of autistic spectrum disorders seems to be higher in clinically referred, gender dysphoric children than in the general population (de Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers, 2010).

Phenomenology in Adolescents

In most children, gender dysphoria will disappear before or early in puberty. However, in some children these feelings will intensify and body aversion will develop or increase as they become adolescents and their secondary sex characteristics develop (Cohen-Kettenis, 2001; Cohen-Kettenis & Pfäfflin, 2003; Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008; Zucker & Bradley, 1995). Data from one study suggest that more extreme gender nonconformity in childhood is associated with persistence of gender dysphoria into late adolescence and early adulthood (Wallien & Cohen-Kettenis, 2008). Yet many adolescents and adults presenting with gender dysphoria do not report a history of childhood gender nonconforming behaviors (Docter, 1988; Landén, Wålinder, & Lundström, 1998). Therefore, it may come as a surprise to others (parents, other family members, friends, and community members) when a youth's gender dysphoria first becomes evident in adolescence.

Adolescents who experience their primary and/or secondary sex characteristics and their sex assigned at birth as inconsistent with their gender identity may be intensely distressed about it. Many, but not all, gender dysphoric adolescents have a strong wish for hormones and surgery. Increasing numbers of adolescents have already started living in their desired gender role upon entering high school (Cohen-Kettenis & Pfäfflin, 2003).

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 215 of 371Total Pages:(215 of 1263)

Among adolescents who are referred to gender identity clinics, the number considered eligible for early medical treatment – starting with GnRH analogues to suppress puberty in the first Tanner stages – differs among countries and centers. Not all clinics offer puberty suppression. If such treatment is offered, the pubertal stage at which adolescents are allowed to start varies from Tanner stage 2 to stage 4 (Delemarre-van de Waal & Cohen-Kettenis, 2006; Zucker et al., in press). The percentages of treated adolescents are likely influenced by the organization of health care, insurance aspects, cultural differences, opinions of health professionals, and diagnostic procedures offered in different settings.

Inexperienced clinicians may mistake indications of gender dysphoria for delusions. Phenomenologically, there is a qualitative difference between the presentation of gender dysphoria and the presentation of delusions or other psychotic symptoms. The vast majority of children and adolescents with gender dysphoria are not suffering from underlying severe psychiatric illness such as psychotic disorders (Steensma, Biemond, de Boer, & Cohen-Kettenis, published online ahead of print January 7, 2011).

It is more common for adolescents with gender dysphoria to have co-existing internalizing disorders such as anxiety and depression, and/or externalizing disorders such as oppositional defiant disorder (de Vries et al., 2010). As in children, there seems to be a higher prevalence of autistic spectrum disorders in clinically referred, gender dysphoric adolescents than in the general adolescent population (de Vries et al., 2010).

Competency of Mental Health Professionals Working with Children or Adolescents with Gender Dysphoria

The following are recommended minimum credentials for mental health professionals who assess, refer, and offer therapy to children and adolescents presenting with gender dysphoria:

1. Meet the competency requirements for mental health professionals working with adults, as outlined in section VII;

2. Trained in childhood and adolescent developmental psychopathology;

3. Competent in diagnosing and treating the ordinary problems of children and adolescents.

Roles of Mental Health Professionals Working with Children and Adolescents with Gender Dysphoria

The roles of mental health professionals working with gender dysphoric children and adolescents may include the following:

1. Directly assess gender dysphoria in children and adolescents (see general guidelines for assessment, below).

2. Provide family counseling and supportive psychotherapy to assist children and adolescents with exploring their gender identity, alleviating distress related to their gender dysphoria, and ameliorating any other psychosocial difficulties.

3. Assess and treat any co-existing mental health concerns of children or adolescents (or refer to another mental health professional for treatment). Such concerns should be addressed as part of the overall treatment plan.

4. Refer adolescents for additional physical interventions (such as puberty suppressing hormones) to alleviate gender dysphoria. The referral should include documentation of an assessment of gender dysphoria and mental health, the adolescent's eligibility for physical interventions (outlined below), the mental health professional's relevant expertise, and any other information pertinent to the youth's health and referral for specific treatments.

5. Educate and advocate on behalf of gender dysphoric children, adolescents, and their families in their community (e.g., day care centers, schools, camps, other organizations). This is particularly important in light of evidence that children and adolescents who do not conform to socially prescribed gender norms may experience harassment in school (Grossman, D'Augelli, & Salter, 2006; Grossman, D'Augelli, Howell, & Hubbard, 2006; Sausa, 2005), putting them at risk for social isolation, depression, and other negative sequelae (Nuttbrock et al., 2010).

6. Provide children, youth, and their families with information and referral for peer support, such as support groups for parents of gender nonconforming and transgender children (Gold & MacNish, 2011; Pleak, 1999; Rosenberg, 2002).

Assessment and psychosocial interventions for children and adolescents are often provided within a multi-disciplinary gender identity specialty service. If such a multidisciplinary service is not available, a mental health professional should provide consultation and liaison arrangements with a pediatric endocrinologist for the purpose of assessment, education, and involvement in any decisions about physical interventions.

Psychological Assessment of Children and Adolescents

When assessing children and adolescents who present with gender dysphoria, mental health professionals should broadly conform to the following guidelines:

1. Mental health professionals should not dismiss or express a negative attitude towards nonconforming gender identities or indications of gender dysphoria. Rather, they should acknowledge the presenting concerns of children, adolescents, and their families; offer a thorough assessment for gender dysphoria and any co-existing mental health concerns; and educate clients and their families about therapeutic options, if needed. Acceptance and removal of secrecy can bring considerable relief to gender dysphoric children/adolescents and their families.

2. Assessment of gender dysphoria and mental health should explore the nature and characteristics of a child's or adolescent's gender identity. A psychodiagnostic and psychiatric assessment – covering the areas of emotional functioning, peer and other social relationships, and intellectual functioning/school achievement – should be performed. Assessment should include an evaluation of the strengths and weaknesses of family functioning. Emotional and behavioral problems are relatively common, and unresolved issues in a child's or youth's environment may be present (de Vries, Doreleijers, Steensma, & Cohen-Kettenis, 2011; Di Ceglie & Thümmel, 2006; Wallien et al., 2007).

3. For adolescents, the assessment phase should also be used to inform youth and their families about the possibilities and limitations of different treatments. This is necessary for informed consent, but also important for assessment. The way that adolescents respond to information about the reality of sex reassignment can be diagnostically informative. Correct information may alter a youth's desire for certain treatment, if the desire was based on unrealistic expectations of its possibilities.

Psychological and Social Interventions for Children and Adolescents

When supporting and treating children and adolescents with gender dysphoria, health professionals should broadly conform to the following guidelines:

1. Mental health professionals should help families to have an accepting and nurturing response to the concerns of their gender dysphoric child or adolescent. Families play an important role in the psychological health and well-being of youth (Brill & Pepper, 2008; Lev, 2004). This also applies to peers and mentors from the community, who can be another source of social support.

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 218 of 371Total Pages:(218 of 1263)

2. Psychotherapy should focus on reducing a child's or adolescent's distress related to the gender dysphoria and on ameliorating any other psychosocial difficulties. For youth pursuing sex reassignment, psychotherapy may focus on supporting them before, during, and after reassignment. Formal evaluations of different psychotherapeutic approaches for this situation have not been published, but several counseling methods have been described (Cohen-Kettenis, 2006; de Vries, Cohen-Kettenis, & Delemarre-van de Waal, 2006; Di Ceglie & Thümmel, 2006; Hill, Menvielle, Sica, & Johnson, 2010; Malpas, in press; Menvielle & Tuerk, 2002; Rosenberg, 2002; Vanderburgh, 2009; Zucker, 2006).

Treatment aimed at trying to change a person's gender identity and expression to become more congruent with sex assigned at birth has been attempted in the past without success (Gelder & Marks, 1969; Greenson, 1964), particularly in the long term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.

1. Families should be supported in managing uncertainty and anxiety about their child's or adolescent's psychosexual outcomes and in helping youth to develop a positive self-concept.

2. Mental health professionals should not impose a binary view of gender. They should give ample room for clients to explore different options for gender expression. Hormonal or surgical interventions are appropriate for some adolescents, but not for others.

3. Clients and their families should be supported in making difficult decisions regarding the extent to which clients are allowed to express a gender role that is consistent with their gender identity, as well as the timing of changes in gender role and possible social transition. For example, a client might attend school while undergoing social transition only partly (e.g., by wearing clothing and having a hairstyle that reflects gender identity) or completely (e.g., by also using a name and pronouns congruent with gender identity). Difficult issues include whether and when to inform other people of the client's situation, and how others in their lives should respond.

4. Health professionals should support clients and their families as educators and advocates in their interactions with community members and authorities such as teachers, school boards, and courts.

5. Mental health professionals should strive to maintain a therapeutic relationship with gender nonconforming children/adolescents and their families throughout any subsequent social changes or physical interventions. This ensures that decisions about gender expression and the treatment of gender dysphoria are thoughtfully and recurrently considered. The same reasoning applies if a child or adolescent has already socially changed gender role prior to being seen by a mental health professional.

Social Transition in Early Childhood

Some children state that they want to make a social transition to a different gender role long before puberty. For some children, this may reflect an expression of their gender identity. For others, this could be motivated by other forces. Families vary in the extent to which they allow their young children to make a social transition to another gender role. Social transitions in early childhood do occur within some families with early success. This is a controversial issue, and divergent views are held by health professionals. The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood. Outcomes research with children who completed early social transitions would greatly inform future clinical recommendations.

Mental health professionals can help families to make decisions regarding the timing and process of any gender role changes for their young children. They should provide information and help parents to weigh the potential benefits and challenges of particular choices. Relevant in this respect are the previously described relatively low persistence rates of childhood gender dysphoria (Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008). A change back to the original gender role can be highly distressing and even result in postponement of this second social transition on the child's part (Steensma & Cohen-Kettenis, 2011). For reasons such as these, parents may want to present this role change as an exploration of living in another gender role, rather than an irreversible situation. Mental health professionals can assist parents in identifying potential in-between solutions or compromises (e.g., only when on vacation). It is also important that parents explicitly let the child know that there is a way back.

Regardless of a family's decisions regarding transition (timing, extent), professionals should counsel and support them as they work through the options and implications. If parents do not allow their young child to make a gender role transition, they may need counseling to assist them with meeting their child's needs in a sensitive and nurturing way, ensuring that the child has ample possibilities to explore gender feelings and behavior in a safe environment. If parents do allow their young child to make a gender role transition, they may need counseling to facilitate a positive experience for their child. For example, they may need support in using correct pronouns, maintaining a safe and supportive environment for their transitioning child (e.g., in school, peer group settings), and communicating with other people in their child's life. In either case, as a child nears puberty, further assessment may be needed as options for physical interventions become relevant.

Physical Interventions for Adolescents

Before any physical interventions are considered for adolescents, extensive exploration of psychological, family, and social issues should be undertaken, as outlined above. The duration of this exploration may vary considerably depending on the complexity of the situation.

Physical interventions should be addressed in the context of adolescent development. Some identity beliefs in adolescents may become firmly held and strongly expressed, giving a false impression of irreversibility. An adolescent's shift towards gender conformity can occur primarily to please the parents and may not persist or reflect a permanent change in gender dysphoria (Hembree et al., 2009; Steensma et al., published online ahead of print January 7, 2011).

Physical interventions for adolescents fall into three categories or stages (Hembree et al., 2009):

1. *Fully reversible interventions*. These involve the use of GnRH analogues to suppress estrogen or testosterone production and consequently delay the physical changes of puberty. Alternative treatment options include progestins (most commonly medroxyprogesterone) or other medications (such as spironolactone) that decrease the effects of androgens secreted by the testicles of adolescents who are not receiving GnRH analogues. Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses.

2. *Partially reversible interventions*. These include hormone therapy to masculinize or feminize the body. Some hormone-induced changes may need reconstructive surgery to reverse the effect (e.g., gynaecomastia caused by estrogens), while other changes are not reversible (e.g., deepening of the voice caused by testosterone).

3. *Irreversible interventions*. These are surgical procedures.

A staged process is recommended to keep options open through the first two stages. Moving from one stage to another should not occur until there has been adequate time for adolescents and their parents to assimilate fully the effects of earlier interventions.

Fully Reversible Interventions

Adolescents may be eligible for puberty suppressing hormones as soon as pubertal changes have begun. In order for adolescents and their parents to make an informed decision about pubertal delay, it is recommended that adolescents experience the onset of puberty to at least Tanner Stage 2. Some children may arrive at this stage at very young ages (e.g., 9 years of age). Studies

evaluating this approach only included children who were at least 12 years of age (Cohen-Kettenis, Schagen, Steensma, de Vries, & Delemarre-van de Waal, 2011; de Vries, Steensma et al., 2010; Delemarre-van de Waal, van Weissenbruch, & Cohen Kettenis, 2004; Delemarre-van de Waal & Cohen-Kettenis, 2006).

Two goals justify intervention with puberty suppressing hormones: (i) their use gives adolescents more time to explore their gender nonconformity and other developmental issues; and (ii) their use may facilitate transition by preventing the development of sex characteristics that are difficult or impossible to reverse if adolescents continue on to pursue sex reassignment.

Puberty suppression may continue for a few years, at which time a decision is made to either discontinue all hormone therapy or transition to a feminizing/masculinizing hormone regimen. Pubertal suppression does not inevitably lead to social transition or to sex reassignment.

Criteria for puberty suppressing hormones

In order for adolescents to receive puberty suppressing hormones, the following minimum criteria must be met:

1. The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed);
2. Gender dysphoria emerged or worsened with the onset of puberty;
3. Any co-existing psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment;
4. The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

Regimens, monitoring, and risks for puberty suppression

For puberty suppression, adolescents with male genitalia should be treated with GnRH analogues, which stop luteinizing hormone secretion and therefore testosterone secretion. Alternatively, they may be treated with progestins (such as medroxyprogesterone) or with other medications that block testosterone secretion and/or neutralize testosterone action. Adolescents with female genitalia should be treated with GnRH analogues, which stop the production of estrogens and

progesterone. Alternatively, they may be treated with progestins (such as medroxyprogesterone). Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses. In both groups of adolescents, use of GnRH analogues is the preferred treatment (Hembree et al., 2009), but their high cost is prohibitive for some patients

During pubertal suppression, an adolescent's physical development should be carefully monitored – preferably by a pediatric endocrinologist – so that any necessary interventions can occur (e.g., to establish an adequate gender appropriate height, to improve iatrogenic low bone marrow density) (Hembree et al., 2009).

Early use of puberty suppressing hormones may avert negative social and emotional consequences of gender dysphoria more effectively than their later use would. Intervention in early adolescence should be managed with pediatric endocrinological advice, when available. Adolescents with male genitalia who start GnRH analogues early in puberty should be informed that this could result in insufficient penile tissue for penile inversion vaginoplasty techniques (alternative techniques, such as the use of a skin graft or colon tissue, are available).

Neither puberty suppression nor allowing puberty to occur is a neutral act. On the one hand, functioning in later life can be compromised by the development of irreversible secondary sex characteristics during puberty and by years spent experiencing intense gender dysphoria. On the other hand, there are concerns about negative physical side effects of GnRH analog use (e.g., on bone development and height). Although the very first results of this approach (as assessed for adolescents followed over 10 years) are promising (Cohen-Kettenis et al., 2011; Delemarre-van de Waal & Cohen-Kettenis, 2006), the long-term effects can only be determined when the earliest treated patients reach the appropriate age.

Partially Reversible Interventions

Adolescents may be eligible to begin feminizing/masculinizing hormone therapy, preferably with parental consent. In many countries, 16-year-olds are legal adults for medical decision-making and do not require parental consent. Ideally, treatment decisions should be made among the adolescent, the family, and the treatment team.

Regimens for hormone therapy in gender dysphoric adolescents differ substantially from those used in adults (Hembree et al., 2009). The hormone regimens for youth are adapted to account for the somatic, emotional, and mental development that occurs throughout adolescence (Hembree et al., 2009).

Irreversible Interventions

Genital surgery should not be carried out until (i) patients reach the legal age of majority in a given country, and (ii) patients have lived continuously for at least 12 months in the gender role that is congruent with their gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention.

Chest surgery in FtM patients could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression.

Risks of Withholding Medical Treatment for Adolescents

Refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization. As the level of gender-related abuse is strongly associated with the degree of psychiatric distress during adolescence (Nuttbrock et al., 2010), withholding puberty suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents.

VII
Mental Health

Transsexual, transgender, and gender nonconforming people might seek the assistance of a mental health professional for any number of reasons. Regardless of a person's reason for seeking care, mental health professionals should have familiarity with gender nonconformity, act with appropriate cultural competence, and exhibit sensitivity in providing care.

This section of the *SOC* focuses on the role of mental health professionals in the care of adults seeking help for gender dysphoria and related concerns. Professionals working with gender dysphoric children, adolescents, and their families should consult section VI.

Competency of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria

The training of mental health professionals competent to work with gender dysphoric adults rests upon basic general clinical competence in the assessment, diagnosis, and treatment of mental health concerns. Clinical training may occur within any discipline that prepares mental health professionals for clinical practice, such as psychology, psychiatry, social work, mental health counseling, marriage and family therapy, nursing, or family medicine with specific training in behavioral health and counseling. The following are recommended minimum credentials for mental health professionals who work with adults presenting with gender dysphoria:

1. A master's degree or its equivalent in a clinical behavioral science field. This degree or a more advanced one should be granted by an institution accredited by the appropriate national or regional accrediting board. The mental health professional should have documented credentials from a relevant licensing board or equivalent for that country.

2. Competence in using the *Diagnostic Statistical Manual of Mental Disorders* and/or the *International Classification of Diseases* for diagnostic purposes.

3. Ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria.

4. Documented supervised training and competence in psychotherapy or counseling.

5. Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria.

6. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

In addition to the minimum credentials above, it is recommended that mental health professionals develop and maintain cultural competence to facilitate their work with transsexual, transgender, and gender nonconforming clients. This may involve, for example, becoming knowledgeable about current community, advocacy, and public policy issues relevant to these clients and their families. Additionally, knowledge about sexuality, sexual health concerns, and the assessment and treatment of sexual disorders is preferred.

Mental health professionals who are new to the field (irrespective of their level of training and other experience) should work under the supervision of a mental health professional with established competence in the assessment and treatment of gender dysphoria.

Tasks of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria

Mental health professionals may serve transsexual, transgender, and gender nonconforming individuals and their families in many ways, depending on a client's needs. For example, mental health professionals may serve as a psychotherapist, counselor, or family therapist, or as a diagnostician/assessor, advocate, or educator.

Mental health professionals should determine a client's reasons for seeking professional assistance. For example, a client may be presenting for any combination of the following health care services: psychotherapeutic assistance to explore gender identity and expression or to facilitate a coming out process; assessment and referral for feminizing/masculinizing medical interventions; psychological support for family members (partners, children, extended family); or psychotherapy unrelated to gender concerns or other professional services.

Below are general guidelines for common tasks that mental health professionals may fulfill in working with adults who present with gender dysphoria.

Tasks Related to Assessment and Referral

1. Assess gender dysphoria

Mental health professionals assess clients' gender dysphoria in the context of an evaluation of their psychosocial adjustment (Bockting et al., 2006; Lev, 2004, 2009). The evaluation includes, at a minimum, assessment of gender identity and gender dysphoria, history and development of gender dysphoric feelings, the impact of stigma attached to gender nonconformity on mental health, and the availability of support from family, friends, and peers (for example, in person or online contact with other transsexual, transgender, or gender nonconforming individuals or groups). The evaluation may result in no diagnosis, in a formal diagnosis related to gender dysphoria, and/or in other diagnoses that describe aspects of the client's health and psychosocial adjustment. The role

of mental health professionals includes making reasonably sure that the gender dysphoria is not secondary to or better accounted for by other diagnoses.

Mental health professionals with the competencies described above (hereafter called "a qualified mental health professional") are best prepared to conduct this assessment of gender dysphoria. However, this task may instead be conducted by another type of health professional who has appropriate training in behavioral health and is competent in the assessment of gender dysphoria, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy. This professional may be the prescribing hormone therapy provider or a member of that provider's health care team.

2. Provide information regarding options for gender identity and expression and possible medical interventions

An important task of mental health professionals is to educate clients regarding the diversity of gender identities and expressions and the various options available to alleviate gender dysphoria. Mental health professionals then may facilitate a process (or refer elsewhere) in which clients explore these various options, with the goals of finding a comfortable gender role and expression and becoming prepared to make a fully informed decision about available medical interventions, if needed. This process may include referral for individual, family, and group therapy and/or to community resources and avenues for peer support. The professional and the client discuss the implications, both short- and long-term, of any changes in gender role and use of medical interventions. These implications can be psychological, social, physical, sexual, occupational, financial, and legal (Bockting et al., 2006; Lev, 2004).

This task is also best conducted by a qualified mental health professional, but may be conducted by another health professional with appropriate training in behavioral health and with sufficient knowledge about gender nonconforming identities and expressions and about possible medical interventions for gender dysphoria, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy.

3. Assess, diagnose, and discuss treatment options for co-existing mental health concerns

Clients presenting with gender dysphoria may struggle with a range of mental health concerns (Gómez-Gil, Trilla, Salamero, Godás, & Valdés, 2009; Murad et al., 2010) whether related or unrelated to what is often a long history of gender dysphoria and/or chronic minority stress. Possible concerns include anxiety, depression, self-harm, a history of abuse and neglect, compulsivity, substance abuse, sexual concerns, personality disorders, eating disorders, psychotic disorders, and autistic spectrum disorders (Bockting et al., 2006; Nuttbrock et al., 2010; Robinow, 2009). Mental health professionals should screen for these and other mental health concerns and incorporate

the identified concerns into the overall treatment plan. These concerns can be significant sources of distress and, if left untreated, can complicate the process of gender identity exploration and resolution of gender dysphoria (Bockting et al., 2006; Fraser, 2009a; Lev, 2009). Addressing these concerns can greatly facilitate the resolution of gender dysphoria, possible changes in gender role, the making of informed decisions about medical interventions, and improvements in quality of life.

Some clients may benefit from psychotropic medications to alleviate symptoms or treat co-existing mental health concerns. Mental health professionals are expected to recognize this and either provide pharmacotherapy or refer to a colleague who is qualified to do so. The presence of co-existing mental health concerns does not necessarily preclude possible changes in gender role or access to feminizing/masculinizing hormones or surgery; rather, these concerns need to be optimally managed prior to or concurrent with treatment of gender dysphoria. In addition, clients should be assessed for their ability to provide educated and informed consent for medical treatments.

Qualified mental health professionals are specifically trained to assess, diagnose, and treat (or refer to treatment for) these co-existing mental health concerns. Other health professionals with appropriate training in behavioral health, particularly when functioning as part of a multidisciplinary specialty team providing access to feminizing/masculinizing hormone therapy, may also screen for mental health concerns and, if indicated, provide referral for comprehensive assessment and treatment by a qualified mental health professional.

4. If applicable, assess eligibility, prepare, and refer for hormone therapy

The *SOC* provide criteria to guide decisions regarding feminizing/masculinizing hormone therapy (outlined in section VIII and Appendix C). Mental health professionals can help clients who are considering hormone therapy to be both psychologically prepared (for example, has made a fully informed decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (for example, has been evaluated by a physician to rule out or address medical contraindications to hormone use; has considered the psychosocial implications). If clients are of childbearing age, reproductive options (section IX) should be explored before initiating hormone therapy.

It is important for mental health professionals to recognize that decisions about hormones are first and foremost the client's decisions – as are all decisions regarding healthcare. However, mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared. To best support their clients' decisions, mental health professionals need to have functioning working relationships with their clients and sufficient information about them. Clients should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services.

Referral for feminizing/masculinizing hormone therapy

People may approach a specialized provider in any discipline to pursue feminizing/masculinizing hormone therapy. However, transgender health care is an interdisciplinary field, and coordination of care and referral among a client's overall care team is recommended.

Hormone therapy can be initiated with a referral from a qualified mental health professional. Alternatively, a health professional who is appropriately trained in behavioral health and competent in the assessment of gender dysphoria may assess eligibility, prepare, and refer the patient for hormone therapy, particularly in the absence of significant co-existing mental health concerns and when working in the context of a multidisciplinary specialty team. The referring health professional provides documentation – in the chart and/or referral letter – of the patient's personal and treatment history, progress, and eligibility. Health professionals who recommend hormone therapy share the ethical and legal responsibility for that decision with the physician who provides the service.

The recommended content of the referral letter for feminizing/masculinizing hormone therapy is as follows:

1. The client's general identifying characteristics;

2. Results of the client's psychosocial assessment, including any diagnoses;

3. The duration of the referring health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;

4. An explanation that the criteria for hormone therapy have been met, and a brief description of the clinical rationale for supporting the client's request for hormone therapy;

5. A statement about the fact that informed consent has been obtained from the patient;

6. A statement that the referring health professional is available for coordination of care and welcomes a phone call to establish this.

For providers working within a multidisciplinary specialty team, a letter may not be necessary, rather, the assessment and recommendation can be documented in the patient's chart.

5. If applicable, assess eligibility, prepare, and refer for surgery

The *SOC* also provide criteria to guide decisions regarding breast/chest surgery and genital surgery (outlined in section XI and Appendix C). Mental health professionals can help clients who are considering surgery to be both psychologically prepared (for example, has made a fully informed

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 229 of 371Total Pages:(229 of 1263)

decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (for example, has made an informed choice about a surgeon to perform the procedure; has arranged aftercare). If clients are of childbearing age, reproductive options (section IX) should be explored before undergoing genital surgery.

The *SOC* do not state criteria for other surgical procedures, such as feminizing or masculinizing facial surgery; however, mental health professionals can play an important role in helping their clients to make fully informed decisions about the timing and implications of such procedures in the context of the overall coming out or transition process.

It is important for mental health professionals to recognize that decisions about surgery are first and foremost a client's decisions – as are all decisions regarding healthcare. However, mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared. To best support their clients' decisions, mental health professionals need to have functioning working relationships with their clients and sufficient information about them. Clients should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services.

Referral for surgery

Surgical treatments for gender dysphoria can be initiated with a referral (one or two, depending on the type of surgery) from a qualified mental health professional. The mental health professional provides documentation – in the chart and/or referral letter – of the patient's personal and treatment history, progress, and eligibility. Mental health professionals who recommend surgery share the ethical and legal responsibility for that decision with the surgeon.

- One referral from a qualified mental health professional is needed for breast/chest surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty).
- Two referrals – from qualified mental health professionals who have independently assessed the patient – are needed for genital surgery (i.e., hysterectomy/salpingo-oophorectomy, orchiectomy, genital reconstructive surgeries). If the first referral is from the patient's psychotherapist, the second referral should be from a person who has only had an evaluative role with the patient. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be sent. Each referral letter, however, is expected to cover the same topics in the areas outlined below.

The recommended content of the referral letters for surgery is as follows:

1. The client's general identifying characteristics;

2. Results of the client's psychosocial assessment, including any diagnoses;

3. The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;

4. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery;

5. A statement about the fact that informed consent has been obtained from the patient;

6. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.

For providers working within a multidisciplinary specialty team, a letter may not be necessary, rather, the assessment and recommendation can be documented in the patient's chart.

Relationship of Mental Health Professionals with Hormone-Prescribing Physicians, Surgeons, and other Health Professionals

It is ideal for mental health professionals to perform their work and periodically discuss progress and obtain peer consultation from other professionals (both in mental health care and other health disciplines) who are competent in the assessment and treatment of gender dysphoria. The relationship among professionals involved in a client's health care should remain collaborative, with coordination and clinical dialogue taking place as needed. Open and consistent communication may be necessary for consultation, referral, and management of postoperative concerns.

Tasks Related to Psychotherapy

1. Psychotherapy is not an absolute requirement for hormone therapy and surgery

A mental health screening and/or assessment as outlined above is needed for referral to hormonal and surgical treatments for gender dysphoria. In contrast, psychotherapy – although highly recommended – is not a requirement.

The *SOC* do not recommend a minimum number of psychotherapy sessions prior to hormone therapy or surgery. The reasons for this are multifaceted (Lev, 2009). First, a minimum number of sessions tends to be construed as a hurdle, which discourages the genuine opportunity for personal growth. Second, mental health professionals can offer important support to clients throughout all

phases of exploration of gender identity, gender expression, and possible transition – not just prior to any possible medical interventions. Third, clients differ in their abilities to attain similar goals in a specified time period.

2. Goals of psychotherapy for adults with gender concerns

The general goal of psychotherapy is to find ways to maximize a person's overall psychological well-being, quality of life, and self-fulfillment. Psychotherapy is not intended to alter a person's gender identity; rather, psychotherapy can help an individual to explore gender concerns and find ways to alleviate gender dysphoria, if present (Bockting et al., 2006; Bockting & Coleman, 2007; Fraser, 2009a; Lev, 2004). Typically, the overarching treatment goal is to help transsexual, transgender, and gender nonconforming individuals achieve long-term comfort in their gender identity expression, with realistic chances for success in their relationships, education, and work. For additional details, see Fraser (Fraser, 2009c).

Therapy may consist of individual, couple, family, or group psychotherapy, the latter being particularly important to foster peer support.

3. Psychotherapy for transsexual, transgender, and gender nonconforming clients, including counseling and support for changes in gender role

Finding a comfortable gender role is, first and foremost, a psychosocial process. Psychotherapy can be invaluable in assisting transsexual, transgender, and gender nonconforming individuals with all of the following: (i) clarifying and exploring gender identity and role, (ii) addressing the impact of stigma and minority stress on one's mental health and human development, and (iii) facilitating a coming out process (Bockting & Coleman, 2007; Devor, 2004; Lev, 2004), which for some individuals may include changes in gender role expression and the use of feminizing/masculinizing medical interventions.

Mental health professionals can provide support and promote interpersonal skills and resilience in individuals and their families as they navigate a world that often is ill prepared to accommodate and respect transgender, transsexual, and gender nonconforming people. Psychotherapy can also aid in alleviating any co-existing mental health concerns (e.g., anxiety, depression) identified during screening and assessment.

For transsexual, transgender, and gender nonconforming individuals who plan to change gender roles permanently and make a social gender role transition, mental health professionals can facilitate the development of an individualized plan with specific goals and timelines. While the experience of changing one's gender role differs from person to person, the social aspects of the experience are usually challenging – often more so than the physical aspects. Because changing

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 232 of 371Total Pages:(232 of 1263)

gender role can have profound personal and social consequences, the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role.

Many transsexual, transgender, and gender nonconforming people will present for care without ever having been related to or accepted in the gender role that is most congruent with their gender identity. Mental health professionals can help these clients to explore and anticipate the implications of changes in gender role, and to pace the process of implementing these changes. Psychotherapy can provide a space for clients to begin to express themselves in ways that are congruent with their gender identity and, for some clients, overcome fear about changes in gender expression. Calculated risks can be taken outside of therapy to gain experience and build confidence in the new role. Assistance with coming out to family and community (friends, school, workplace) can be provided.

Other transsexual, transgender, and gender nonconforming individuals will present for care already having acquired experience (minimal, moderate, or extensive) living in a gender role that differs from that associated with their birth-assigned sex. Mental health professionals can help these clients to identify and work through potential challenges and foster optimal adjustment as they continue to express changes in their gender role.

4. Family therapy or support for family members

Decisions about changes in gender role and medical interventions for gender dysphoria have implications for not only clients, but also their families (Emerson & Rosenfeld, 1996; Fraser, 2009a; Lev, 2004). Mental health professionals can assist clients with making thoughtful decisions about communicating with family members and others about their gender identity and treatment decisions. Family therapy may include work with spouses or partners, as well as with children and other members of a client's extended family.

Clients may also request assistance with their relationships and sexual health. For example, they may want to explore their sexuality and intimacy related concerns.

Family therapy might be offered as part of the client's individual therapy and, if clinically appropriate, by the same provider. Alternatively, referrals can be made to other therapists with relevant expertise to work with family members, or to sources of peer support (e.g., online or offline support networks of partners or families).

5. Follow-up care throughout life

Mental health professionals may work with clients and their families at many stages of their lives. Psychotherapy may be helpful at different times and for various issues throughout the life cycle.

6. Etherapy, online counseling, or distance counseling

Online or etherapy has been shown to be particularly useful for people who have difficulty accessing competent psychotherapeutic treatment and who may experience isolation and stigma (Derrig-Palumbo & Zeine, 2005; Fenichel et al., 2004; Fraser, 2009b). By extrapolation, etherapy may be a useful modality for psychotherapy with transsexual, transgender, and gender nonconforming people. Etherapy offers opportunities for potentially enhanced, expanded, creative, and tailored delivery of services; however, as a developing modality it may also carry unexpected risk. Telemedicine guidelines are clear in some disciplines in some parts of the United States (Fraser, 2009b; Maheu, Pulier, Wilhelm, McMenamin, & Brown-Connolly, 2005) but not all; the international situation is even less defined (Maheu et al., 2005). Until sufficient evidence-based data on this use of etherapy is available, caution in its use is advised.

Mental health professionals engaging in etherapy are advised to stay current with their particular licensing board, professional association, and country's regulations, as well as the most recent literature pertaining to this rapidly evolving medium. A more thorough description of the potential uses, processes, and ethical concerns related to etherapy has been published (Fraser, 2009b).

Other Tasks of the Mental Health Professional

1. Educate and advocate on behalf of clients within their community (schools, workplaces, other organizations) and assist clients with making changes in identity documents

Transsexual, transgender, and gender nonconforming people may face challenges in their professional, educational, and other types of settings as they actualize their gender identity and expression (Lev, 2004, 2009). Mental health professionals can play an important role by educating people in these settings regarding gender nonconformity and by advocating on behalf of their clients (Currah, Juang, & Minter, 2006) (Currah & Minter, 2000). This role may involve consultation with school counselors, teachers, and administrators, human resources staff, personnel managers and employers, and representatives from other organizations and institutions. In addition, health providers may be called upon to support changes in a client's name and/or gender marker on identity documents such as passports, driver's licenses, birth certificates, and diplomas.

2. Provide information and referral for peer support

For some transsexual, transgender, and gender nonconforming people, an experience in peer support groups may be more instructive regarding options for gender expression than anything individual psychotherapy could offer (Rachlin, 2002). Both experiences are potentially valuable, and all people exploring gender issues should be encouraged to participate in community activities, if possible. Resources for peer support and information should be made available.

Culture and its Ramifications for Assessment and Psychotherapy

Health professionals work in enormously different environments across the world. Forms of distress that cause people to seek professional assistance in any culture are understood and classified by people in terms that are products of their own cultures (Frank & Frank, 1993). Cultural settings also largely determine how such conditions are understood by mental health professionals. Cultural differences related to gender identity and expression can affect patients, mental health professionals, and accepted psychotherapy practice. WPATH recognizes that the *SOC* have grown out of a Western tradition and may need to be adapted depending on the cultural context.

Ethical Guidelines Related to Mental Health Care

Mental health professionals need to be certified or licensed to practice in a given country according to that country's professional regulations (Fraser, 2009b; Pope & Vasquez, 2011). Professionals must adhere to the ethical codes of their professional licensing or certifying organizations in all of their work with transsexual, transgender, and gender nonconforming clients.

Treatment aimed at trying to change a person's gender identity and lived gender expression to become more congruent with sex assigned at birth has been attempted in the past (Gelder & Marks, 1969; Greenson, 1964), yet without success, particularly in the long term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.

If mental health professionals are uncomfortable with or inexperienced in working with transsexual, transgender, and gender nonconforming individuals and their families, they should refer clients to a competent provider or, at minimum, consult with an expert peer. If no local practitioners are available, consultation may be done via telehealth methods, assuming local requirements for distance consultation are met.

Issues of Access to Care

Qualified mental health professionals are not universally available; thus, access to quality care might be limited. WPATH aims to improve access and provides regular continuing education opportunities to train professionals from various disciplines to provide quality, transgender-specific health care. Providing mental health care from a distance through the use of technology may be one way to improve access (Fraser, 2009b).

In many places around the world, access to health care for transsexual, transgender, and gender nonconforming people is also limited by a lack of health insurance or other means to pay for needed care. WPATH urges health insurance companies and other third-party payers to cover the medically necessary treatment to alleviate gender dysphoria (American Medical Association, 2008; Anton, 2009; The World Professional Association for Transgender Health, 2008).

When faced with a client who is unable to access services, referral to available peer support resources (offline and online) is recommended. Finally, harm reduction approaches might be indicated to assist clients with making healthy decisions to improve their lives.

VIII
Hormone Therapy

Medical Necessity of Hormone Therapy

Feminizing/masculinizing hormone therapy – the administration of exogenous endocrine agents to induce feminizing or masculinizing changes – is a medically necessary intervention for many transsexual, transgender, and gender nonconforming individuals with gender dysphoria (Newfield, Hart, Dibble, & Kohler, 2006; Pfäfflin & Junge, 1998). Some people seek maximum feminization/masculinization, while others experience relief with an androgynous presentation resulting from hormonal minimization of existing secondary sex characteristics (Factor & Rothblum, 2008). Evidence for the psychosocial outcomes of hormone therapy is summarized in Appendix D.

Hormone therapy must be individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Hormone therapy can provide significant comfort to patients who do not wish to make a social gender role transition or undergo surgery, or who are unable to do so (Meyer III, 2009).

Hormone therapy is a recommended criterion for some, but not all, surgical treatments for gender dysphoria (see section XI and Appendix C).

Criteria for Hormone Therapy

Initiation of hormone therapy may be undertaken after a psychosocial assessment has been conducted and informed consent has been obtained by a qualified health professional, as outlined in section VII of the *SOC*. A referral is required from the mental health professional who performed the assessment, unless the assessment was done by a hormone provider who is also qualified in this area.

The criteria for hormone therapy are as follows:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *Standards of Care* outlined in section VI);
4. If significant medical or mental health concerns are present, they must be reasonably well-controlled.

As noted in section VII of the *SOC*, the presence of co-existing mental health concerns does not necessarily preclude access to feminizing/masculinizing hormones; rather, these concerns need to be managed prior to or concurrent with treatment of gender dysphoria.

In selected circumstances, it can be acceptable practice to provide hormones to patients who have not fulfilled these criteria. Examples include facilitating the provision of monitored therapy using hormones of known quality as an alternative to illicit or unsupervised hormone use or to patients who have already established themselves in their affirmed gender and who have a history of prior hormone use. It is unethical to deny availability or eligibility for hormone therapy solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis B or C.

In rare cases, hormone therapy may be contraindicated due to serious individual health conditions. Health professionals should assist these patients with accessing non-hormonal interventions for gender dysphoria. A qualified mental health professional familiar with the patient is an excellent resource in these circumstances.

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 237 of 371Total Pages:(237 of 1263)

Informed Consent

Feminizing/masculinizing hormone therapy may lead to irreversible physical changes. Thus, hormone therapy should be provided only to those who are legally able to provide informed consent. This includes people who have been declared by a court to be emancipated minors, incarcerated people, and cognitively impaired people who are considered competent to participate in their medical decisions (see also Bockting et al., 2006). Providers should document in the medical record that comprehensive information has been provided and understood about all relevant aspects of the hormone therapy, including both possible benefits and risks and the impact on reproductive capacity.

Relationship between the Standards of Care and Informed Consent Model Protocols

A number of community health centers in the United States have developed protocols for providing hormone therapy based on an approach that has become known as the Informed Consent Model (Callen Lorde Community Health Center, 2000, 2011; Fenway Community Health Transgender Health Program, 2007; Tom Waddell Health Center, 2006). These protocols are consistent with the guidelines presented in the WPATH *Standards of Care, Version 7*. The *SOC* are flexible clinical guidelines; they allow for tailoring of interventions to the needs of the individual receiving services and for tailoring of protocols to the approach and setting in which these services are provided (Ehrbar & Gorton, 2010).

Obtaining informed consent for hormone therapy is an important task of providers to ensure that patients understand the psychological and physical benefits and risks of hormone therapy, as well as its psychosocial implications. Providers prescribing the hormones or health professionals recommending the hormones should have the knowledge and experience to assess gender dysphoria. They should inform individuals of the particular benefits, limitations, and risks of hormones, given the patient's age, previous experience with hormones, and concurrent physical or mental health concerns.

Screening for and addressing acute or current mental health concerns is an important part of the informed consent process. This may be done by a mental health professional or by an appropriately trained prescribing provider (see section VII of the *SOC*). The same provider or another appropriately trained member of the health care team (e.g., a nurse) can address the psychosocial implications of taking hormones when necessary (e.g., the impact of masculinization/feminization on how one is perceived and its potential impact on relationships with family, friends, and coworkers). If indicated, these providers will make referrals for psychotherapy and for the assessment and treatment of co-existing mental health concerns such as anxiety or depression.

The difference between the Informed Consent Model and *SOC, Version 7* is that the *SOC* puts greater emphasis on the important role that mental health professionals can play in alleviating gender dysphoria and facilitating changes in gender role and psychosocial adjustment. This may include a comprehensive mental health assessment and psychotherapy, when indicated. In the Informed Consent Model, the focus is on obtaining informed consent as the threshold for the initiation of hormone therapy in a multidisciplinary, harm-reduction environment. Less emphasis is placed on the provision of mental health care until the patient requests it, unless significant mental health concerns are identified that would need to be addressed before hormone prescription.

Physical Effects of Hormone Therapy

Feminizing/masculinizing hormone therapy will induce physical changes that are more congruent with a patient's gender identity.

- In FtM patients, the following physical changes are expected to occur: deepened voice, clitoral enlargement (variable), growth in facial and body hair, cessation of menses, atrophy of breast tissue, increased libido, and decreased percentage of body fat compared to muscle mass.

- In MtF patients, the following physical changes are expected to occur: breast growth (variable), decreased libido and erections, decreased testicular size, and increased percentage of body fact compared to muscle mass.

Most physical changes, whether feminizing or masculinizing, occur over the course of two years. The amount of physical change and the exact timeline of effects can be highly variable. Tables 1a and 1b outline the approximate time course of these physical changes.

TABLE 1A: EFFECTS AND EXPECTED TIME COURSE OF MASCULINIZING HORMONES [A]

Effect	**Expected Onset**[B]	**Expected Maximum Effect**[B]
Skin oiliness/acne	1-6 months	1-2 years
Facial/body hair growth	3-6 months	3-5 years
Scalp hair loss	>12 months[C]	variable
Increased muscle mass/strength	6-12 months	2-5 years[D]
Body fat redistribution	3-6 months	2-5 years
Cessation of menses	2-6 months	n/a
Clitoral enlargement	3-6 months	1-2 years
Vaginal atrophy	3-6 months	1-2 years
Deepened voice	3-12 months	1-2 years

[A] Adapted with permission from Hembree et al.(2009). *Copyright 2009, The Endocrine Society.*
[B] Estimates represent published and unpublished clinical observations.
[C] Highly dependent on age and inheritance; may be minimal.
[D] Significantly dependent on amount of exercise.

TABLE 1B: EFFECTS AND EXPECTED TIME COURSE OF FEMINIZING HORMONES [A]

Effect	Expected Onset[B]	Expected Maximum Effect[B]
Body fat redistribution	3-6 months	2-5 years
Decreased muscle mass/ strength	3-6 months	1-2 years[C]
Softening of skin/decreased oiliness	3-6 months	unknown
Decreased libido	1-3 months	1-2 years
Decreased spontaneous erections	1-3 months	3-6 months
Male sexual dysfunction	variable	variable
Breast growth	3-6 months	2-3 years
Decreased testicular volume	3-6 months	2-3 years
Decreased sperm production	variable	variable
Thinning and slowed growth of body and facial hair	6-12 months	> 3 years[D]
Male pattern baldness	No regrowth, loss stops 1-3 months	1-2 years

[A] Adapted with permission from Hembree et al. (2009). *Copyright 2009, The Endocrine Society.*
[B] Estimates represent published and unpublished clinical observations.
[C] Significantly dependent on amount of exercise.
[D] Complete removal of male facial and body hair requires electrolysis, laser treatment, or both.

The degree and rate of physical effects depends in part on the dose, route of administration, and medications used, which are selected in accordance with a patient's specific medical goals (e.g., changes in gender role expression, plans for sex reassignment) and medical risk profile. There is no current evidence that response to hormone therapy – with the possible exception of voice deepening in FtM persons – can be reliably predicted based on age, body habitus, ethnicity, or family appearance. All other factors being equal, there is no evidence to suggest that any medically approved type or method of administering hormones is more effective than any other in producing the desired physical changes.

Risks of Hormone Therapy

All medical interventions carry risks. The likelihood of a serious adverse event is dependent on numerous factors: the medication itself, dose, route of administration, and a patient's clinical characteristics (age, co-morbidities, family history, health habits). It is thus impossible to predict whether a given adverse effect will happen in an individual patient.

The risks associated with feminizing/masculinizing hormone therapy for the transsexual, transgender, and gender nonconforming population as a whole are summarized in Table 2. Based on the level of evidence, risks are categorized as follows: (i) likely increased risk with hormone therapy, (ii) possibly increased risk with hormone therapy, or (iii) inconclusive or no increased risk. Items in the last category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Additional detail about these risks can be found in Appendix B, which is based on two comprehensive, evidence-based literature reviews of masculinizing/feminizing hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009), along with a large cohort study (Asscheman et al., 2011). These reviews can serve as detailed references for providers, along with other widely recognized, published clinical materials (Dahl, Feldman, Goldberg, & Jaberi, 2006; Ettner, Monstrey, & Eyler, 2007).

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 242 of 371Total Pages:(242 of 1263)

TABLE 2: RISKS ASSOCIATED WITH HORMONE THERAPY. BOLDED ITEMS ARE CLINICALLY SIGNIFICANT

Risk Level	**Feminizing hormones**	**Masculinizing hormones**
Likely increased risk	**Venous thromboembolic disease**[A] Gallstones Elevated liver enzymes Weight gain **Hypertriglyceridemia**	**Polycythemia** Weight gain Acne Androgenic alopecia (balding) Sleep apnea
Likely increased risk with presence of additional risk factors[B]	Cardiovascular disease	
Possible increased risk	**Hypertension** Hyperprolactinemia or prolactinom[A]	Elevated liver enzymes **Hyperlipidemia**
Possible increased risk with presence of additional risk factors[B]	**Type 2 diabetes**[A]	**Destabilization of certain psychiatric disorders**[C] Cardiovascular disease Hypertension Type 2 diabetes
No increased risk or inconclusive	Breast cancer	Loss of bone density Breast cancer Cervical cancer Ovarian cancer Uterine cancer

[A] Risk is greater with oral estrogen administration than with transdermal estrogen administration.
[B] Additional risk factors include age.
[C] Includes bipolar, schizoaffective, and other disorders that may include manic or psychotic symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone.

Competency of Hormone-Prescribing Physicians, Relationship with Other Health Professionals

Feminizing/masculinizing hormone therapy is best undertaken in the context of a complete approach to health care that includes comprehensive primary care and a coordinated approach to psychosocial issues (Feldman & Safer, 2009). While psychotherapy or ongoing counseling is not required for the initiation of hormone therapy, if a therapist is involved, then regular communication among health professionals is advised (with the patient's consent) to ensure that the transition process is going well, both physically and psychosocially.

With appropriate training, feminizing/masculinizing hormone therapy can be managed by a variety of providers, including nurse practitioners and primary care physicians (Dahl et al., 2006). Medical visits relating to hormone maintenance provide an opportunity to deliver broader care to a population that is often medically underserved (Clements, Wilkinson, Kitano, & Marx, 1999; Feldman, 2007; Xavier, 2000). Many of the screening tasks and management of co-morbidities associated with long-term hormone use, such as cardiovascular risk factors and cancer screening, fall more uniformly within the scope of primary care rather than specialist care (American Academy of Family Physicians, 2005; Eyler, 2007; World Health Organization, 2008), particularly in locations where dedicated gender teams or specialized physicians are not available.

Given the multidisciplinary needs of transsexual, transgender, and gender nonconforming people seeking hormone therapy, as well as the difficulties associated with fragmentation of care in general (World Health Organization, 2008), WPATH strongly encourages the increased training and involvement of primary care providers in the area of feminizing/masculinizing hormone therapy. If hormones are prescribed by a specialist, there should be close communication with the patient's primary care provider. Conversely, an experienced hormone provider or endocrinologist should be involved if the primary care physician has no experience with this type of hormone therapy, or if the patient has a pre-existing metabolic or endocrine disorder that could be affected by endocrine therapy.

While formal training programs in transgender medicine do not yet exist, hormone providers have a responsibility to obtain appropriate knowledge and experience in this field. Clinicians can increase their experience and comfort in providing feminizing/masculinizing hormone therapy by co-managing care or consulting with a more experienced provider, or by providing more limited types of hormone therapy before progressing to initiation of hormone therapy. Because this field of medicine is evolving, clinicians should become familiar and keep current with the medical literature, and discuss emerging issues with colleagues. Such discussions might occur through networks established by WPATH and other national/local organizations.

Responsibilities of Hormone-Prescribing Physicians

In general, clinicians who prescribe hormone therapy should engage in the following tasks:

1. Perform an initial evaluation that includes discussion of a patient's physical transition goals, health history, physical examination, risk assessment, and relevant laboratory tests.

2. Discuss with patients the expected effects of feminizing/masculinizing medications and the possible adverse health effects. These effects can include a reduction in fertility (Feldman & Safer, 2009; Hembree et al., 2009). Therefore, reproductive options should be discussed with patients before starting hormone therapy (see section IX).

3. Confirm that patients have the capacity to understand the risks and benefits of treatment and are capable of making an informed decision about medical care.

4. Provide ongoing medical monitoring, including regular physical and laboratory examination to monitor hormone effectiveness and side effects.

5. Communicate as needed with a patient's primary care provider, mental health professional, and surgeon.

6. If needed, provide patients with a brief written statement indicating that they are under medical supervision and care that includes feminizing/masculinizing hormone therapy. Particularly during the early phases of hormone treatment, a patient may wish to carry this statement at all times to help prevent difficulties with the police and other authorities.

Depending on the clinical situation for providing hormones (see below), some of these responsibilities are less relevant. Thus, the degree of counseling, physical examinations, and laboratory evaluations should be individualized to a patient's needs.

Clinical Situations for Hormone Therapy

There are circumstances in which clinicians may be called upon to provide hormones without necessarily initiating or maintaining long-term feminizing/masculinizing hormone therapy. By acknowledging these different clinical situations (see below, from least to highest level of complexity), it may be possible to involve clinicians in feminizing/masculinizing hormone therapy who might not otherwise feel able to offer this treatment.

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 245 of 371Total Pages:(245 of 1263)

1. Bridging

Whether prescribed by another clinician or obtained through other means (e.g., purchased over the internet), patients may present for care already on hormone therapy. Clinicians can provide a limited (1-6 month) prescription for hormones while helping patients find a provider who can prescribe long-term hormone therapy. Providers should assess a patient's current regimen for safety and drug interactions and substitute safer medications or doses when indicated (Dahl et al., 2006; Feldman & Safer, 2009). If hormones were previously prescribed, medical records should be requested (with the patient's permission) to obtain the results of baseline examinations and laboratory tests and any adverse events. Hormone providers should also communicate with any mental health professional who is currently involved in a patient's care. If a patient has never had a psychosocial assessment as recommended by the *SOC* (see section VII), clinicians should refer the patient to a qualified mental health professional if appropriate and feasible (Feldman & Safer, 2009). Providers who prescribe bridging hormones need to work with patients to establish limits as to the duration of bridging therapy.

2. Hormone therapy following gonad removal

Hormone replacement with estrogen or testosterone is usually continued lifelong after an oophorectomy or orchiectomy, unless medical contraindications arise. Because hormone doses are often decreased after these surgeries (Basson, 2001; Levy, Crown, & Reid, 2003; Moore, Wisniewski, & Dobs, 2003) and only adjusted for age and co-morbid health concerns, hormone management in this situation is quite similar to hormone replacement in any hypogonadal patient.

3. Hormone maintenance prior to gonad removal

Once patients have achieved maximal feminizing/masculinizing benefits from hormones (typically two or more years), they remain on a maintenance dose. The maintenance dose is then adjusted for changes in health conditions, aging, or other considerations such as lifestyle changes (Dahl et al., 2006). When a patient on maintenance hormones presents for care, the provider should assess the patient's current regimen for safety and drug interactions and substitute safer medications or doses when indicated. The patient should continue to be monitored by physical examinations and laboratory testing on a regular basis, as outlined in the literature (Feldman & Safer, 2009; Hembree et al., 2009). The dose and form of hormones should be revisited regularly with any changes in the patient's health status and available evidence on the potential long-term risks of hormones (See *Hormone Regimens,* below).

4. Initiating hormonal feminization/masculinization

This clinical situation requires the greatest commitment in terms of provider time and expertise. Hormone therapy must be individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Although a wide variety of hormone regimens have been published (Dahl et al., 2006; Hembree et al., 2009; Moore et al., 2003), there are no published reports of randomized clinical trials comparing safety and efficacy. Despite this variation, a reasonable framework for initial risk assessment and ongoing monitoring of hormone therapy can be constructed, based on the efficacy and safety evidence presented above.

Risk Assessment and Modification for Initiating Hormone Therapy

The initial evaluation for hormone therapy assesses a patient's clinical goals and risk factors for hormone-related adverse events. During the risk assessment, the patient and clinician should develop a plan for reducing risks wherever possible, either prior to initiating therapy or as part of ongoing harm reduction.

All assessments should include a thorough physical exam, including weight, height, and blood pressure. The need for breast, genital, and rectal exams, which are sensitive issues for most transsexual, transgender, and gender nonconforming patients, should be based on individual risks and preventive health care needs (Feldman & Goldberg, 2006; Feldman, 2007).

Preventive care

Hormone providers should address preventive health care with patients, particularly if a patient does not have a primary care provider. Depending on a patient's age and risk profile, there may be appropriate screening tests or exams for conditions affected by hormone therapy. Ideally, these screening tests should be carried out prior to the start of hormone therapy.

Risk assessment and modification for feminizing hormone therapy (MtF)

There are no absolute contraindications to feminizing therapy *per se*, but absolute contraindications exist for the different feminizing agents, particularly estrogen. These include previous venous thrombotic events related to an underlying hypercoagulable condition, history of estrogen-sensitive neoplasm, and end-stage chronic liver disease (Gharib et al., 2005).

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 247 of 371Total Pages:(247 of 1263)

Other medical conditions, as noted in Table 2 and Appendix B, can be exacerbated by estrogen or androgen blockade, and therefore should be evaluated and reasonably well controlled prior to starting hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009). Clinicians should particularly attend to tobacco use, as it is associated with increased risk of venous thrombosis, which is further increased with estrogen use. Consultation with a cardiologist may be advisable for patients with known cardio- or cerebrovascular disease.

Baseline laboratory values are important to both assess initial risk and evaluate possible future adverse events. Initial labs should be based on the risks of feminizing hormone therapy outlined in Table 2, as well as individual patient risk factors, including family history. Suggested initial lab panels have been published (Feldman & Safer, 2009; Hembree et al., 2009). These can be modified for patients or health care systems with limited resources, and in otherwise healthy patients.

Risk assessment and modification for masculinizing hormone therapy (FtM)

Absolute contraindications to testosterone therapy include pregnancy, unstable coronary artery disease, and untreated polycythemia with a hematocrit of 55% or higher (Carnegie, 2004). Because the aromatization of testosterone to estrogen may increase risk in patients with a history of breast or other estrogen dependent cancers (Moore et al., 2003), consultation with an oncologist may be indicated prior to hormone use. Co-morbid conditions likely to be exacerbated by testosterone use should be evaluated and treated, ideally prior to starting hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009). Consultation with a cardiologist may be advisable for patients with known cardio- or cerebrovascular disease.

An increased prevalence of polycystic ovarian syndrome (PCOS) has been noted among FtM patients even in the absence of testosterone use (Baba et al., 2007; Balen, Schachter, Montgomery, Reid, & Jacobs, 1993; Bosinski et al., 1997). While there is no evidence that PCOS is related to the development of a transsexual, transgender, or gender nonconforming identity, PCOS is associated with increased risk of diabetes, cardiac disease, high blood pressure, and ovarian and endometrial cancers (Cattrall & Healy, 2004). Signs and symptoms of PCOS should be evaluated prior to initiating testosterone therapy, as testosterone may affect many of these conditions. Testosterone can affect the developing fetus (Physicians' Desk Reference, 2011), and patients at risk of becoming pregnant require highly effective birth control.

Baseline laboratory values are important to both assess initial risk and evaluate possible future adverse events. Initial labs should be based on the risks of masculinizing hormone therapy outlined in Table 2, as well as individual patient risk factors, including family history. Suggested initial lab panels have been published (Feldman & Safer, 2009; Hembree et al., 2009). These can be modified for patients or health care systems with limited resources, and in otherwise healthy patients.

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 248 of 371Total Pages:(248 of 1263)

Clinical Monitoring during Hormone Therapy for Efficacy and Adverse Events

The purpose of clinical monitoring during hormone use is to assess the degree of feminization/masculinization and the possible presence of adverse effects of medication. However, as with the monitoring of any long-term medication, monitoring should take place in the context of comprehensive health care. Suggested clinical monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009). Patients with co-morbid medical conditions may need to be monitored more frequently. Healthy patients in geographically remote or resource-poor areas may be able to use alternative strategies, such as telehealth, or cooperation with local providers such as nurses and physician assistants. In the absence of other indications, health professionals may prioritize monitoring for those risks that are either likely to be increased by hormone therapy or possibly increased by hormone therapy but clinically serious in nature.

Efficacy and risk monitoring during feminizing hormone therapy (MtF)

The best assessment of hormone efficacy is clinical response: Is a patient developing a feminized body while minimizing masculine characteristics, consistent with that patient's gender goals? In order to more rapidly predict the hormone dosages that will achieve clinical response, one can measure testosterone levels for suppression below the upper limit of the normal female range, and estradiol levels within a premenopausal female range but well below supraphysiologic levels (Feldman & Safer, 2009; Hembree et al., 2009).

Monitoring for adverse events should include both clinical and laboratory evaluation. Follow-up should include careful assessment for signs of cardiovascular impairment and venous thromboembolism (VTE) through measurement of blood pressure, weight, and pulse; heart and lung exams; and examination of the extremities for peripheral edema, localized swelling, or pain (Feldman & Safer, 2009). Laboratory monitoring should be based on the risks of hormone therapy described above, a patient's individual co-morbidities and risk factors, and the specific hormone regimen itself. Specific lab monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009).

Efficacy and risk monitoring during masculinizing hormone therapy (FtM)

The best assessment of hormone efficacy is clinical response: Is a patient developing a masculinized body while minimizing feminine characteristics, consistent with that patient's gender goals? Clinicians can achieve a good clinical response with the least likelihood of adverse events by maintaining testosterone levels within the normal male range while avoiding supraphysiological

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 249 of 371Total Pages:(249 of 1263)

levels (Dahl et al., 2006; Hembree et al., 2009). For patients using intramuscular (IM) testosterone cypionate or enanthate, some clinicians check trough levels while others prefer midcycle levels (Dahl et al., 2006; Hembree et al., 2009; Tangpricha, Turner, Malabanan, & Holick, 2001; Tangpricha, Ducharme, Barber, & Chipkin, 2003).

Monitoring for adverse events should include both clinical and laboratory evaluation. Follow-up should include careful assessment for signs and symptoms of excessive weight gain, acne, uterine break-through bleeding, and cardiovascular impairment, as well as psychiatric symptoms in at-risk patients. Physical examinations should include measurement of pressure, weight, pulse, and skin; and heart and lung exams (Feldman & Safer, 2009). Laboratory monitoring should be based on the risks of hormone therapy described above, a patient's individual co-morbidities and risk factors, and the specific hormone regimen itself. Specific lab monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009).

Hormone Regimens

To date, no controlled clinical trials of any feminizing/masculinizing hormone regimen have been conducted to evaluate safety or efficacy in producing physical transition. As a result, wide variation in doses and types of hormones have been published in the medical literature (Moore et al., 2003; Tangpricha et al., 2003; van Kesteren, Asscheman, Megens, & Gooren, 1997). In addition, access to particular medications may be limited by a patient's geographical location and/or social or econonomic situations. For these reasons, WPATH does not describe or endorse a particular feminizing/masculinizing hormone regimen. Rather, the medication classes and routes of administration used in most published regimens are broadly reviewed.

As outlined above, there are demonstrated safety differences in individual elements of various regimens. The Endocrine Society Guidelines (Hembree et al., 2009) and Feldman and Safer (2009) provide specific guidance regarding the types of hormones and suggested dosing to maintain levels within physiologic ranges for a patient's desired gender expression (based on goals of full feminization/masculinization). It is strongly recommend that hormone providers regularly review the literature for new information and use those medications that safely meet individual patient needs with available local resources.

Regimens for feminizing hormone therapy (MtF)

Estrogen

Use of oral estrogen, and specifically ethinyl estradiol, appears to increase the risk of VTE. Because of this safety concern, ethinyl estradiol is not recommended for feminizing hormone therapy. Transdermal estrogen is recommended for those patients with risks factors for VTE. The risk of adverse events increases with higher doses, particular those resulting in supraphysiologic levels (Hembree et al., 2009). Patients with co-morbid conditions that can be affected by estrogen should avoid oral estrogen if possible and be started at lower levels. Some patients may not be able to safely use the levels of estrogen needed to get the desired results. This possibility needs to be discussed with patients well in advance of starting hormone therapy.

Androgen reducing medications ("anti-androgens")

A combination of estrogen and "anti-androgens" is the most commonly studied regimen for feminization. Androgen reducing medications, from a variety of classes of drugs, have the effect of reducing either endogenous testosterone levels or testosterone activity, and thus diminishing masculine characteristics such as body hair. They minimize the dosage of estrogen needed to suppress testosterone, thereby reducing the risks associated with high-dose exogenous estrogen (Prior, Vigna, Watson, Diewold, & Robinow, 1986; Prior, Vigna, & Watson, 1989).

Common anti-androgens include the following:

- Spironolactone, an antihypertensive agent, directly inhibits testosterone secretion and androgen binding to the androgen receptor. Blood pressure and electrolytes need to be monitored because of the potential for hyperkalemia.

- Cyproterone acetate is a progestational compound with anti-androgenic properties. This medication is not approved in the United States because of concerns over potential hepatotoxicity, but it is widely used elsewhere (De Cuypere et al., 2005).

- GnRH agonists (e.g., goserelin, buserelin, triptorelin) are neurohormones that block the gonadtropin releasing hormone receptor, thus blocking the release of follicle stimulating hormone and luteinizing hormone. This leads to highly effective gonadal blockade. However, these medications are expensive and only available as injectables or implants.

- 5-alpha reductase inhibitors (finasteride and dutasteride) block the conversion of testosterone to the more active agent, 5-alpha-dihydrotestosterone. These medications have beneficial effects on scalp hair loss, body hair growth, sebaceous glands, and skin consistency.

Cyproterone and spironolactone are the most commonly used anti-androgens and are likely the most cost-effective.

Progestins

With the exception of cyproterone, the inclusion of progestins in feminizing hormone therapy is controversial (Oriel, 2000). Because progestins play a role in mammary development on a cellular level, some clinicians believe that these agents are necessary for full breast development (Basson & Prior, 1998; Oriel, 2000). However, a clinical comparison of feminization regimens with and without progestins found that the addition of progestins neither enhanced breast growth nor lowered serum levels of free testosterone (Meyer III et al., 1986). There are concerns regarding potential adverse effects of progestins, including depression, weight gain, and lipid changes (Meyer III et al., 1986; Tangpricha et al., 2003). Progestins (especially medroxyprogesterone) are also suspected to increase breast cancer risk and cardiovascular risk in women (Rossouw et al., 2002). Micronized progesterone may be better tolerated and have a more favorable impact on the lipid profile than medroxyprogesterone does (de Lignières, 1999; Fitzpatrick, Pace, & Wiita, 2000).

Regimens for masculinizing hormone therapy (FtM)

Testosterone

Testosterone generally can be given orally, transdermally, or parenterally (IM), although buccal and implantable preparations are also available. Oral testosterone undecenoate, available outside the United States, results in lower serum testosterone levels than non-oral preparations and has limited efficacy in suppressing menses (Feldman, 2005, April; Moore et al., 2003). Because intramuscular testosterone cypionate or enanthate are often administered every 2-4 weeks, some patients may notice cyclic variation in effects (e.g., fatigue and irritability at the end of the injection cycle, aggression or expansive mood at the beginning of the injection cycle), as well as more time outside the normal physiologic levels (Jockenhövel, 2004). This may be mitigated by using a lower but more frequent dosage schedule or by using a daily transdermal preparation (Dobs et al., 1999; Jockenhövel, 2004; Nieschlag et al., 2004). Intramuscular testosterone undecenoate (not currently available in the United States) maintains stable, physiologic testosterone levels over approximately 12 weeks and has been effective in both the setting of hypogonadism and in FtM individuals (Mueller, Kiesewetter, Binder, Beckmann, & Dittrich, 2007; Zitzmann, Saad, & Nieschlag, 2006). There is evidence that transdermal and intramuscular testosterone achieve similar masculinizing results, although the timeframe may be somewhat slower with transdermal preparations (Feldman, 2005, April). Especially as patients age, the goal is to use the lowest dose needed to maintain the desired clinical result, with appropriate precautions being made to maintain bone density.

Other agents

Progestins, most commonly medroxyprogesterone, can be used for a short period of time to assist with menstrual cessation early in hormone therapy. GnRH agonists can be used similarly, as well as for refractory uterine bleeding in patients without an underlying gynecological abnormality.

Bioidentical and compounded hormones

As discussion surrounding the use of bioidentical hormones in postmenopausal hormone replacement has heightened, interest has also increased in the use of similar compounds in feminizing/masculinizing hormone therapy. There is no evidence that custom compounded bioidentical hormones are safer or more effective than government agency-approved bioidentical hormones (Sood, Shuster, Smith, Vincent, & Jatoi, 2011). Therefore, it has been advised by the North American Menopause Society (2010) and others to assume that, whether the hormone is from a compounding pharmacy or not, if the active ingredients are similar, it should have a similar side-effect profile. WPATH concurs with this assessment.

IX
Reproductive Health

Many transgender, transsexual, and gender nonconforming people will want to have children. Because feminizing/masculinizing hormone therapy limits fertility (Darney, 2008; Zhang, Gu, Wang, Cui, & Bremner, 1999), it is desirable for patients to make decisions concerning fertility before starting hormone therapy or undergoing surgery to remove/alter their reproductive organs. Cases are known of people who received hormone therapy and genital surgery and later regretted their inability to parent genetically related children (De Sutter, Kira, Verschoor, & Hotimsky, 2002).

Health care professionals – including mental health professionals recommending hormone therapy or surgery, hormone-prescribing physicians, and surgeons – should discuss reproductive options with patients prior to initiation of these medical treatments for gender dysphoria. These discussions should occur even if patients are not interested in these issues at the time of treatment, which may be more common for younger patients (De Sutter, 2009). Early discussions are desirable, but not always possible. If an individual has not had complete sex reassignment surgery, it may be possible to stop hormones long enough for natal hormones to recover, allowing the production of mature

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 253 of 371Total Pages:(253 of 1263)

gametes (Payer, Meyer III, & Walker, 1979; Van den Broecke, Van der Elst, Liu, Hovatta, & Dhont, 2001).

Besides debate and opinion papers, very few research papers have been published on the reproductive health issues of individuals receiving different medical treatments for gender dysphoria. Another group who faces the need to preserve reproductive function in light of loss or damage to their gonads are people with malignances that require removal of reproductive organs or use of damaging radiation or chemotherapy. Lessons learned from that group can be applied to people treated for gender dysphoria.

MtF patients, especially those who have not already reproduced, should be informed about sperm preservation options and encouraged to consider banking their sperm prior to hormone therapy. In a study examining testes that were exposed to high-dose estrogen (Payer et al., 1979), findings suggest that stopping estrogen may allow the testes to recover. In an article reporting on the opinions of MtF individuals towards sperm freezing (De Sutter et al., 2002), the vast majority of 121 survey respondents felt that the availability of freezing sperm should be discussed and offered by the medical world. Sperm should be collected before hormone therapy or after stopping the therapy until the sperm count rises again. Cryopreservation should be discussed even if there is poor semen quality. In adults with azoospermia, a testicular biopsy with subsequent cryopreservation of biopsied material for sperm is possible, but may not be successful.

Reproductive options for FtM patients might include oocyte (egg) or embryo freezing. The frozen gametes and embryo could later be used with a surrogate woman to carry to pregnancy. Studies of women with polycystic ovarian disease suggest that the ovary can recover in part from the effects of high testosterone levels (Hunter & Sterrett, 2000). Stopping the testosterone briefly might allow for ovaries to recover enough to make eggs; success likely depends on the patient's age and duration of testosterone treatment. While not systematically studied, some FtM individuals are doing exactly that, and some have been able to become pregnant and deliver children (More, 1998).

Patients should be advised that these techniques are not available everywhere and can be very costly. Transsexual, transgender, and gender nonconforming people should not be refused reproductive options for any reason.

A special group of individuals are prepubertal or pubertal adolescents who will never develop reproductive function in their natal sex due to blockers or cross gender hormones. At this time there is no technique for preserving function from the gonads of these individuals.

Voice and Communication Therapy

Communication, both verbal and nonverbal, is an important aspect of human behavior and gender expression. Transsexual, transgender, and gender nonconforming people might seek the assistance of a voice and communication specialist to develop vocal characteristics (e.g., pitch, intonation, resonance, speech rate, phrasing patterns) and non-verbal communication patterns (e.g., gestures, posture/movement, facial expressions) that facilitate comfort with their gender identity. Voice and communication therapy may help to alleviate gender dysphoria and be a positive and motivating step towards achieving one's goals for gender role expression.

Competency of Voice and Communication Specialists Working with Transsexual, Transgender, and Gender Nonconforming Clients

Specialists may include speech-language pathologists, speech therapists, and speech-voice clinicians. In most countries the professional association for speech-language pathologists requires specific qualifications and credentials for membership. In some countries the government regulates practice through licensing, certification, or registration processes (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia; Vancouver Coastal Health, Vancouver, British Columbia, Canada).

The following are recommended minimum credentials for voice and communication specialists working with transsexual, transgender, and gender nonconforming clients:

1. Specialized training and competence in the assessment and development of communication skills in transsexual, transgender, and gender nonconforming clients.

2. A basic understanding of transgender health, including hormonal and surgical treatments for feminization/masculinization and trans-specific psychosocial issues as outlined in the *SOC*; and familiarity with basic sensitivity protocols such as the use of preferred gender pronoun and name (Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia).

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 255 of 371Total Pages:(255 of 1263)

3. Continuing education in the assessment and development of communication skills in transsexual, transgender, and gender nonconforming clients. This may include attendance at professional meetings, workshops, or seminars; participation in research related to gender identity issues; independent study; or mentoring from an experienced, certified clinician.

Other professionals such as vocal coaches, theatre professionals, singing teachers, and movement experts may play a valuable adjunct role. Such professionals will ideally have experience working with, or be actively collaborating with, speech-language pathologists.

Assessment and Treatment Considerations

The overall purpose of voice and communication therapy is to help clients adapt their voice and communication in a way that is both safe and authentic, resulting in communication patterns that clients feel are congruent with their gender identity and that reflect their sense of self (Adler, Hirsch, & Mordaunt, 2006). It is essential that voice and communication specialists be sensitive to individual communication preferences. Communication – style, voice, choice of language, etc. – is personal. Individuals should not be counseled to adopt behaviors with which they are not comfortable or which do not feel authentic. Specialists can best serve their clients by taking the time to understand a person's gender concerns and goals for gender role expression (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia).

Individuals may choose the communication behaviors that they wish to acquire in accordance with their gender identity. These decisions are also informed and supported by the knowledge of the voice and communication specialist and by the assessment data for a specific client (Hancock, Krissinger, & Owen, 2010). Assessment includes a client's self-evaluation and a specialist's evaluation of voice, resonance, articulation, spoken language, and non-verbal communication (Adler et al., 2006; Hancock et al., 2010).

Voice and communication treatment plans are developed by considering the available research evidence, the clinical knowledge and experience of the specialist, and the client's own goals and values (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia; Vancouver Coastal Health, Vancouver, British Columbia, Canada). Targets of treatment typically include pitch, intonation, loudness and stress patterns, voice quality, resonance, articulation, speech rate and phrasing, language, and non-verbal communication (Adler et al., 2006; Davies & Goldberg, 2006; de Bruin, Coerts, & Greven, 2000; Gelfer, 1999; McNeill, 2006; Oates & Dacakis, 1983). Treatment may involve individual and/or group sessions. The frequency and duration of treatment will vary according to a client's needs. Existing protocols for voice and

communication treatment can be considered in developing an individualized therapy plan (Carew, Dacakis, & Oates, 2007; Dacakis, 2000; Davies & Goldberg, 2006; Gelfer, 1999; McNeill, Wilson, Clark, & Deakin, 2008; Mount & Salmon, 1988).

Feminizing or masculinizing the voice involves non-habitual use of the voice production mechanism. Prevention measures are necessary to avoid the possibility of vocal misuse and long-term vocal damage. All voice and communication therapy services should therefore include a vocal health component (Adler et al., 2006).

Vocal Health Considerations after Voice Feminization Surgery

As noted in section XI, some transsexual, transgender, and gender nonconforming people will undergo voice feminization surgery. (Voice deepening can be achieved through masculinizing hormone therapy, but feminizing hormones do not have an impact on the adult MtF voice.) There are varying degrees of satisfaction, safety, and long-term improvement in patients who have had such surgery. It is recommended that individuals undergoing voice feminization surgery also consult a voice and communication specialist to maximize the surgical outcome, help protect vocal health, and learn non-pitch related aspects of communication. Voice surgery procedures should include follow-up sessions with a voice and communication specialist who is licensed and/or credentialed by the board responsible for speech therapists/speech-language pathologists in that country (Kanagalingam et al., 2005; Neumann & Welzel, 2004).

XI

Surgery_

Sex Reassignment Surgery Is Effective and Medically Necessary

Surgery – particularly genital surgery – is often the last and the most considered step in the treatment process for gender dysphoria. While many transsexual, transgender, and gender nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria (Hage

& Karim, 2000). For the latter group, relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity. Moreover, surgery can help patients feel more at ease in the presence of sex partners or in venues such as physicians' offices, swimming pools, or health clubs. In some settings, surgery might reduce risk of harm in the event of arrest or search by police or other authorities.

Follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well being, cosmesis, and sexual function (De Cuypere et al., 2005; Gijs & Brewaeys, 2007; Klein & Gorzalka, 2009; Pfäfflin & Junge, 1998). Additional information on the outcomes of surgical treatments are summarized in Appendix D.

Ethical Questions Regarding Sex Reassignment Surgery

In ordinary surgical practice, pathological tissues are removed to restore disturbed functions, or alterations are made to body features to improve a patient's self image. Some people, including some health professionals, object on ethical grounds to surgery as a treatment for gender dysphoria, because these conditions are thought not to apply.

It is important that health professionals caring for patients with gender dysphoria feel comfortable about altering anatomically normal structures. In order to understand how surgery can alleviate the psychological discomfort and distress of individuals with gender dysphoria, professionals need to listen to these patients discuss their symptoms, dilemmas, and life histories. The resistance against performing surgery on the ethical basis of "above all do no harm" should be respected, discussed, and met with the opportunity to learn from patients themselves about the psychological distress of having gender dysphoria and the potential for harm caused by denying access to appropriate treatments.

Genital and breast/chest surgical treatments for gender dysphoria are not merely another set of elective procedures. Typical elective procedures involve only a private mutually consenting contract between a patient and a surgeon. Genital and breast/chest surgeries as medically necessary treatments for gender dysphoria are to be undertaken only after assessment of the patient by qualified mental health professionals, as outlined in section VII of the *SOC*. These surgeries may be performed once there is written documentation that this assessment has occurred and that the person has met the criteria for a specific surgical treatment. By following this procedure, mental health professionals, surgeons, and of course patients, share responsibility for the decision to make irreversible changes to the body.

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 258 of 371Total Pages:(258 of 1263)

It is unethical to deny availability or eligibility for sex reassignment surgeries solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis C or B.

Relationship of Surgeons with Mental Health Professionals, Hormone-Prescribing Physicians (if Applicable), and Patients (Informed Consent)

The role of a surgeon in the treatment of gender dysphoria is not that of a mere technician. Rather, conscientious surgeons will have insight into each patient's history and the rationale that led to the referral for surgery. To that end, surgeons must talk at length with their patients and have close working relationships with other health professionals who have been actively involved in their clinical care.

Consultation is readily accomplished when a surgeon practices as part of an interdisciplinary health care team. In the absence of this, a surgeon must be confident that the referring mental health professional(s), and if applicable the physician who prescribes hormones, are competent in the assessment and treatment of gender dysphoria, because the surgeon is relying heavily on their expertise.

Once a surgeon is satisfied that the criteria for specific surgeries have been met (as outlined below), surgical treatment should be considered and a preoperative surgical consultation should take place. During this consultation, the procedure and postoperative course should be extensively discussed with the patient. Surgeons are responsible for discussing all of the following with patients seeking surgical treatments for gender dysphoria:

- The different surgical techniques available (with referral to colleagues who provide alternative options);
- The advantages and disadvantages of each technique;
- The limitations of a procedure to achieve "ideal" results; surgeons should provide a full range of before-and-after photographs of their own patients, including both successful and unsuccessful outcomes;
- The inherent risks and possible complications of the various techniques; surgeons should inform patients of their own complication rates with each procedure.

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 259 of 371Total Pages:(259 of 1263)

These discussions are the core of the informed consent process, which is both an ethical and legal requirement for any surgical procedure. Ensuring that patients have a realistic expectation of outcomes is important in achieving a result that will alleviate their gender dysphoria.

All of this information should be provided to patients in writing, in a language in which they are fluent, and in graphic illustrations. Patients should receive the information in advance (possibly via the internet) and given ample time to review it carefully. The elements of informed consent should always be discussed face-to-face prior to the surgical intervention. Questions can then be answered and written informed consent can be provided by the patient. Because these surgeries are irreversibile, care should be taken to ensure that patients have sufficient time to absorb information fully before they are asked to provide informed consent. A minimum of 24 hours is suggested.

Surgeons should provide immediate aftercare and consultation with other physicians serving the patient in the future. Patients should work with their surgeon to develop an adequate aftercare plan for the surgery.

Overview of Surgical Procedures for the Treatment of Patients with Gender Dysphoria

For the male-to-female (MtF) patient, surgical procedures may include the following:

1. Breast/chest surgery: augmentation mammoplasty (implants/lipofilling);

2. Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty;

3. Non-genital, non-breast surgical interventions: facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), hair reconstruction, and various aesthetic procedures.

For the female-to-male (FtM) patient, surgical procedures may include the following:

1. Breast/chest surgery: subcutaneous mastectomy, creation of a male chest;

2. Genital surgery: hysterectomy/ovariectomy, reconstruction of the fixed part of the urethra, which can be combined with a metoidioplasty or with a phalloplasty (employing a pedicled or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses;

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 260 of 371Total Pages:(260 of 1263)

3. Non-genital, non-breast surgical interventions: voice surgery (rare), liposuction, lipofilling, pectoral implants, and various aesthetic procedures.

Reconstructive Versus Aesthetic Surgery

The question of whether sex reassignment surgery should be considered "aesthetic" surgery or "reconstructive" surgery is pertinent not only from a philosophical point of view, but also from a financial point of view. Aesthetic or cosmetic surgery is mostly regarded as not medically necessary and therefore is typically paid for entirely by the patient. In contrast, reconstructive procedures are considered medically necessary – with unquestionable therapeutic results – and thus paid for partially or entirely by national health systems or insurance companies.

Unfortunately, in the field of plastic and reconstructive surgery (both in general and specifically for gender-related surgeries), there is no clear distinction between what is purely reconstructive and what is purely cosmetic. Most plastic surgery procedures actually are a mixture of both reconstructive and cosmetic components.

While most professionals agree that genital surgery and mastectomy cannot be considered purely cosmetic, opinions diverge as to what degree other surgical procedures (e.g., breast augmentation, facial feminization surgery) can be considered purely reconstructive. Although it may be much easier to see a phalloplasty or a vaginoplasty as an intervention to end lifelong suffering, for certain patients an intervention like a reduction rhinoplasty can have a radical and permanent effect on their quality of life, and therefore is much more medically necessary than for somebody without gender dysphoria.

Criteria for Surgeries

As for all of the *SOC*, the criteria for initiation of surgical treatments for gender dysphoria were developed to promote optimal patient care. While the *SOC* allow for an individualized approach to best meet a patient's health care needs, a criterion for all breast/chest and genital surgeries is documentation of persistent gender dysphoria by a qualified mental health professional. For some surgeries, additional criteria include preparation and treatment consisting of feminizing/masculinizing hormone therapy and one year of continuous living in a gender role that is congruent with one's gender identity.

These criteria are outlined below. Based on the available evidence and expert clinical consensus, different recommendations are made for different surgeries.

The *SOC* do not specify an order in which different surgeries should occur. The number and sequence of surgical procedures may vary from patient to patient, according to their clinical needs.

Criteria for breast/chest surgery (one referral)

Criteria for mastectomy and creation of a male chest in FtM patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a pre-requisite.

Criteria for breast augmentation (implants/lipofilling) in MtF patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

Criteria for genital surgery (two referrals)

The criteria for genital surgery are specific to the type of surgery being requested.

Criteria for hysterectomy and ovariectomy in FtM patients and for orchiectomy in MtF patients:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled.
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before the patient undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these procedures for medical indications other than gender dysphoria.

Criteria for metoidioplasty or phalloplasty in FtM patients and for vaginoplasty in MtF patients:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled;
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).
6. 12 continuous months of living in a gender role that is congruent with their gender identity;

Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

Rationale for a preoperative, 12-month experience of living in an identity-congruent gender role:

The criterion noted above for some types of genital surgeries – i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity – is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery. As noted in section VII, the social aspects of changing one's gender role are usually challenging – often more so than the physical aspects. Changing gender role can have profound personal and social consequences, and the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role. Support from a qualified mental health professional and from peers can be invaluable in ensuring a successful gender role adaptation (Bockting, 2008).

The duration of 12 months allows for a range of different life experiences and events that may occur throughout the year (e.g., family events, holidays, vacations, season-specific work or school experiences). During this time, patients should present consistently, on a day-to-day basis and across all settings of life, in their desired gender role. This includes coming out to partners, family, friends, and community members (e.g., at school, work, other settings).

Health professionals should clearly document a patient's experience in the gender role in the medical chart, including the start date of living full time for those who are preparing for genital surgery. In some situations, if needed, health professionals may request verification that this criterion has been fulfilled: They may communicate with individuals who have related to the patient in an identity-congruent gender role, or request documentation of a legal name and/or gender marker change, if applicable.

Surgery for Persons with Psychotic Conditions and Other Serious Mental Illnesses

When patients with gender dysphoria are also diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated. Reevaluation by a mental health professional qualified to assess and manage psychotic conditions should be

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 264 of 371Total Pages:(264 of 1263)

conducted prior to surgery, describing the patient's mental status and readiness for surgery. It is preferable that this mental health professional be familiar with the patient. No surgery should be performed while a patient is actively psychotic (De Cuypere & Vercruysse, 2009).

Competency of Surgeons Performing Breast/Chest or Genital Surgery

Physicians who perform surgical treatments for gender dsyphoria should be urologists, gynecologists, plastic surgeons, or general surgeons, and board-certified as such by the relevant national and/or regional association. Surgeons should have specialized competence in genital reconstructive techniques as indicated by documented supervised training with a more experienced surgeon. Even experienced surgeons must be willing to have their surgical skills reviewed by their peers. An official audit of surgical outcomes and publication of these results would be greatly reassuring to both referring health professionals and patients. Surgeons should regularly attend professional meetings where new techniques are presented. The internet is often effectively used by patients to share information on their experience with surgeons and their teams.

Ideally, surgeons should be knowledgeable about more than one surgical technique for genital reconstruction so that they, in consultation with patients, can choose the ideal technique for each individual. Alternatively, if a surgeon is skilled in a single technique and this procedure is either not suitable for or desired by a patient, the surgeon should inform the patient about other procedures and offer referral to another appropriately skilled surgeon.

Breast/Chest Surgery Techniques and Complications

Although breast/chest appearance is an important secondary sex characteristic, breast presence or size is not involved in the legal definitions of sex and gender and is not necessary for reproduction. The performance of breast/chest operations for treatment of gender dysphoria should be considered with the same care as beginning hormone therapy, as both produce relatively irreversible changes to the body.

For the MtF patient, a breast augmentation (sometimes called "chest reconstruction") is not different from the procedure in a natal female patient. It is usually performed through implantation of breast prostheses and occasionally with the lipofilling technique. Infections and capsular fibrosis are rare complications of augmentation mammoplasty in MtF patients (Kanhai, Hage, Karim, & Mulder, 1999).

For the FtM patient, a mastectomy or "male chest contouring" procedure is available. For many FtM patients, this is the only surgery undertaken. When the amount of breast tissue removed requires skin removal, a scar will result and the patient should be so informed. Complications of subcutaneous mastectomy can include nipple necrosis, contour irregularities, and unsightly scarring (Monstrey et al., 2008).

Genital Surgery Techniques and Complications

Genital surgical procedures for the MtF patient may include orchiectomy, penectomy, vaginoplasty, clitoroplasty, and labiaplasty. Techniques include penile skin inversion, pedicled colosigmoid transplant, and free skin grafts to line the neovagina. Sexual sensation is an important objective in vaginoplasty, along with creation of a functional vagina and acceptable cosmesis.

Surgical complications of MtF genital surgery may include complete or partial necrosis of the vagina and labia, fistulas from the bladder or bowel into the vagina, stenosis of the urethra, and vaginas that are either too short or too small for coitus. While the surgical techniques for creating a neovagina are functionally and aesthetically excellent, anorgasmia following the procedure has been reported, and a second stage labiaplasty may be needed for cosmesis (Klein & Gorzalka, 2009; Lawrence, 2006).

Genital surgical procedures for FtM patients may include hysterectomy, ovariectomy (salpingo-oophorectomy), vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, and phalloplasty. For patients without former abdominal surgery, the laparoscopic technique for hysterectomy and salpingo-oophorectomy is recommended to avoid a lower-abdominal scar. Vaginal access may be difficult as most patients are nulliparous and have often not experienced penetrative intercourse. Current operative techniques for phalloplasty are varied. The choice of techniques may be restricted by anatomical or surgical considerations and by a client's financial considerations. If the objectives of phalloplasty are a neophallus of good appearance, standing micturition, sexual sensation, and/or coital ability, patients should be clearly informed that there are several separate stages of surgery and frequent technical difficulties, which may require additional operations. Even metoidioplasty, which in theory is a one-stage procedure for construction of a microphallus, often requires more than one operation. The objective of standing micturition with this technique can not always be ensured (Monstrey et al., 2009).

Complications of phalloplasty in FtMs may include frequent urinary tract stenoses and fistulas, and occasionally necrosis of the neophallus. Metoidioplasty results in a micropenis, without the capacity for standing urination. Phalloplasty, using a pedicled or a free vascularized flap, is a lengthy, multi-stage procedure with significant morbidity that includes frequent urinary complications and

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 266 of 371Total Pages:(266 of 1263)

unavoidable donor site scarring. For this reason, many FtM patients never undergo genital surgery other than hysterectomy and salpingo-oophorectomy (Hage & De Graaf, 1993).

Even patients who develop severe surgical complications seldom regret having undergone surgery. The importance of surgery can be appreciated by the repeated finding that quality of surgical results is one of the best predictors of the overall outcome of sex reassignment (Lawrence, 2006).

Other Surgeries

Other surgeries for assisting in body feminization include reduction thyroid chondroplasty (reduction of the Adam's apple), voice modification surgery, suction-assisted lipoplasty (contour modeling) of the waist, rhinoplasty (nose correction), facial bone reduction, face-lift, and blepharoplasty (rejuvenation of the eyelid). Other surgeries for assisting in body masculinization include liposuction, lipofilling, and pectoral implants. Voice surgery to obtain a deeper voice is rare but may be recommended in some cases, such as when hormone therapy has been ineffective.

Although these surgeries do not require referral by mental health professionals, such professionals can play an important role in assisting clients in making a fully informed decision about the timing and implications of such procedures in the context of the social transition.

Although most of these procedures are generally labeled "purely aesthetic," these same operations in an individual with severe gender dysphoria can be considered medically necessary, depending on the unique clinical situation of a given patient's condition and life situation. This ambiguity reflects reality in clinical situations, and allows for individual decisions as to the need and desirability of these procedures.

XII
Postoperative Care and Follow-up

Long-term postoperative care and follow-up after surgical treatments for gender dysphoria are associated with good surgical and psychosocial outcomes (Monstrey et al., 2009). Follow-up is important to a patient's subsequent physical and mental health and to a surgeon's knowledge about the benefits and limitations of surgery. Surgeons who operate on patients coming from long

distances should include personal follow-up in their care plan and attempt to ensure affordable local long-term aftercare in their patients' geographic region.

Postoperative patients may sometimes exclude themselves from follow-up by specialty providers, including the hormone-prescribing physician (for patients receiving hormones), not recognizing that these providers are often best able to prevent, diagnose, and treat medical conditions that are unique to hormonally and surgically treated patients. The need for follow-up equally extends to mental health professionals, who may have spent a longer period of time with the patient than any other professional and therefore are in an excellent position to assist in any postoperative adjustment difficulties. Health professionals should stress the importance of postoperative follow-up care with their patients and offer continuity of care.

Postoperative patients should undergo regular medical screening according to recommended guidelines for their age. This is discussed more in the next section.

XIII
Lifelong Preventive and Primary Care

Transsexual, transgender, and gender nonconforming people need health care throughout their lives. For example, to avoid the negative secondary effects of having a gonadectomy at a relatively young age and/or receiving long-term, high-dose hormone therapy, patients need thorough medical care by providers experienced in primary care and transgender health. If one provider is not able to provide all services, ongoing communication among providers is essential.

Primary care and health maintenance issues should be addressed before, during, and after any possible changes in gender role and medical interventions to alleviate gender dysphoria. While hormone providers and surgeons play important roles in preventive care, every transsexual, transgender, and gender nonconforming person should partner with a primary care provider for overall health care needs (Feldman, 2007).

General Preventive Health Care

Screening guidelines developed for the general population are appropriate for organ systems that are unlikely to be affected by feminizing/masculinizing hormone therapy. However, in areas such

as cardiovascular risk factors, osteoporosis, and some cancers (breast, cervical, ovarian, uterine, and prostate), such general guidelines may either over- or underestimate the cost-effectiveness of screening individuals who are receiving hormone therapy.

Several resources provide detailed protocols for the primary care of patients undergoing feminizing/masculinizing hormone therapy, including therapy that is provided after sex reassignment surgeries (Center of Excellence for Transgender Health, UCSF, 2011; Feldman & Goldberg, 2006; Feldman, 2007; Gorton, Buth, & Spade, 2005). Clinicians should consult their national evidence-based guidelines and discuss screening with their patients in light of the effects of hormone therapy on their baseline risk.

Cancer Screening

Cancer screening of organ systems that are associated with sex can present particular medical and psychosocial challenges for transsexual, transgender, and gender nonconforming patients and their health care providers. In the absence of large-scale prospective studies, providers are unlikely to have enough evidence to determine the appropriate type and frequency of cancer screenings for this population. Over-screening results in higher health care costs, high false positive rates, and often unnecessary exposure to radiation and/or diagnostic interventions such as biopsies. Under-screening results in diagnostic delay for potentially treatable cancers. Patients may find cancer screening gender affirming (such as mammograms for MtF patients) or both physically and emotionally painful (such as Pap smears offer continuity of care for FtM patients).

Urogenital Care

Gynecologic care may be necessary for transsexual, transgender, and gender nonconforming people of both sexes. For FtM patients, such care is needed predominantly for individuals who have not had genital surgery. For MtF patients, such care is needed after genital surgery. While many surgeons counsel patients regarding postoperative urogenital care, primary care clinicians and gynecologists should also be familiar with the special genital concerns of this population.

All MtF patients should receive counseling regarding genital hygiene, sexuality, and prevention of sexually transmitted infections; those who have had genital surgery should also be counseled on the need for regular vaginal dilation or penetrative intercourse in order to maintain vaginal depth and width (van Trotsenburg, 2009). Due to the anatomy of the male pelvis, the axis and the dimensions

of the neovagina differ substantially from those of a biologic vagina. This anatomic difference can affect intercourse if not understood by MtF patients and their partners (van Trotsenburg, 2009).

Lower urinary tract infections occur frequently in MtF patients who have had surgery because of the reconstructive requirements of the shortened urethra. In addition, these patients may suffer from functional disorders of the lower urinary tract; such disorders may be caused by damage of the autonomous nerve supply of the bladder floor during dissection between the rectum and the bladder, and by a change of the position of the bladder itself. A dysfunctional bladder (e.g., overactive bladder, stress or urge urinary incontinence) may occur after sex reassignment surgery (Hoebeke et al., 2005; Kuhn, Hiltebrand, & Birkhauser, 2007).

Most FtM patients do not undergo vaginectomy (colpectomy). For patients who take masculinizing hormones, despite considerable conversion of testosterone to estrogens, atrophic changes of the vaginal lining can be observed regularly and may lead to pruritus or burning. Examination can be both physically and emotionally painful, but lack of treatment can seriously aggravate the situation. Gynecologists treating the genital complaints of FtM patients should be aware of the sensitivity that patients with a male gender identity and masculine gender expression might have around having genitals typically associated with the female sex.

XIV

Applicability of the Standards of Care to People Living in Institutional Environments

The *SOC* in their entirety apply to all transsexual, transgender, and gender nonconforming people, irrespective of their housing situation. People should not be discriminated against in their access to appropriate health care based on where they live, including institutional environments such as prisons or long-/intermediate-term health care facilities (Brown, 2009). Health care for transsexual, transgender, and gender nonconforming people living in an institutional environment should mirror that which would be available to them if they were living in a non-institutional setting within the same community.

All elements of assessment and treatment as described in the *SOC* can be provided to people living in institutions (Brown, 2009). Access to these medically necessary treatments should not be denied on the basis of institutionalization or housing arrangements. If the in-house expertise of health professionals in the direct or indirect employ of the institution does not exist to assess

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 270 of 371Total Pages:(270 of 1263)

and/or treat people with gender dysphoria, it is appropriate to obtain outside consultation from professionals who are knowledgeable about this specialized area of health care.

People with gender dysphoria in institutions may also have co-existing mental health conditions (Cole et al., 1997). These conditions should be evaluated and treated appropriately.

People who enter an institution on an appropriate regimen of hormone therapy should be continued on the same, or similar, therapies and monitored according to the *SOC*. A "freeze frame" approach is not considered appropriate care in most situations (Kosilek v. Massachusetts Department of Corrections/Maloney, C.A. No. 92-12820-MLW, 2002). People with gender dysphoria who are deemed appropriate for hormone therapy (following the *SOC*) should be started on such therapy. The consequences of abrupt withdrawal of hormones or lack of initiation of hormone therapy when medically necessary include a high likelihood of negative outcomes such as surgical self-treatment by autocastration, depressed mood, dysphoria, and/or suicidality (Brown, 2010).

Reasonable accommodations to the institutional environment can be made in the delivery of care consistent with the *SOC*, if such accommodations do not jeopardize the delivery of medically necessary care to people with gender dysphoria. An example of a reasonable accommodation is the use of injectable hormones, if not medically contraindicated, in an environment where diversion of oral preparations is highly likely (Brown, 2009). Denial of needed changes in gender role or access to treatments, including sex reassignment surgery, on the basis of residence in an institution are not reasonable accommodations under the *SOC* (Brown, 2010).

Housing and shower/bathroom facilities for transsexual, transgender, and gender nonconforming people living in institutions should take into account their gender identity and role, physical status, dignity, and personal safety. Placement in a single-sex housing unit, ward, or pod on the sole basis of the appearance of the external genitalia may not be appropriate and may place the individual at risk for victimization (Brown, 2009).

Institutions where transsexual, transgender, and gender nonconforming people reside and receive health care should monitor for a tolerant and positive climate to ensure that residents are not under attack by staff or other residents.

XV
Applicability of the Standards of Care to People With Disorders of Sex Development

Terminology

The term *disorder of sex development* (DSD) refers to a somatic condition of atypical development of the reproductive tract (Hughes, Houk, Ahmed, Lee, & LWPES1/ESPE2 Consensus Group, 2006). DSDs include the condition that used to be called *intersexuality*. Although the terminology was changed to *DSD* during an international consensus conference in 2005 (Hughes et al., 2006), disagreement about language use remains. Some people object strongly to the "disorder" label, preferring instead to view these congenital conditions as a matter of diversity (Diamond, 2009) and to continue using the terms *intersex* or *intersexuality*. In the *SOC*, WPATH uses the term *DSD* in an objective and value-free manner, with the goal of ensuring that health professionals recognize this medical term and use it to access relevant literature as the field progresses. WPATH remains open to new terminology that will further illuminate the experience of members of this diverse population and lead to improvements in health care access and delivery.

Rationale for Addition to the SOC

Previously, individuals with a DSD who also met the *DSM-IV-TR's* behavioral criteria for Gender Identity Disorder (American Psychiatric Association, 2000) were excluded from that general diagnosis. Instead, they were categorized as having a "Gender Identity Disorder - Not Otherwise Specified." They were also excluded from the WPATH *Standards of Care*.

The current proposal for *DSM-5* (www.dsm5.org) is to replace the term *gender identity disorder* with *gender dysphoria*. Moreover, the proposed changes to the *DSM* consider gender dysphoric people with a DSD to have a subtype of gender dysphoria. This proposed categorization – which explicitly differentiates between gender dysphoric individuals with and without a DSD – is justified: In people with a DSD, gender dysphoria differs in its phenomenological presentation, epidemiology, life trajectories, and etiology (Meyer-Bahlburg, 2009).

Adults with a DSD and gender dysphoria have increasingly come to the attention of health professionals. Accordingly, a brief discussion of their care is included in this version of the *SOC*.

Health History Considerations

Health professionals assisting patients with both a DSD and gender dysphoria need to be aware that the medical context in which such patients have grown up is typically very different from that of people without a DSD.

Some people are recognized as having a DSD through the observation of gender-atypical genitals at birth. (Increasingly this observation is made during the prenatal period by way of imaging procedures such as ultrasound.) These infants then undergo extensive medical diagnostic procedures. After consultation among the family and health professionals – during which the specific diagnosis, physical and hormonal findings, and feedback from long-term outcome studies (Cohen-Kettenis, 2005; Dessens, Slijper, & Drop, 2005; Jurgensen, Hiort, Holterhus, & Thyen, 2007; Mazur, 2005; Meyer-Bahlburg, 2005; Stikkelbroeck et al., 2003; Wisniewski, Migeon, Malouf, & Gearhart, 2004) are considered – the newborn is assigned a sex, either male or female.

Other individuals with a DSD come to the attention of health professionals around the age of puberty through the observation of atypical development of secondary sex characteristics. This observation also leads to a specific medical evaluation.

The type of DSD and severity of the condition has significant implications for decisions about a patient's initial sex assignment, subsequent genital surgery, and other medical and psychosocial care (Meyer-Bahlburg, 2009). For instance, the degree of prenatal androgen exposure in individuals with a DSD has been correlated with the degree of masculinization of gender-related *behavior* (that is, *gender role and expression*); however, the correlation is only moderate, and considerable behavioral variability remains unaccounted for by prenatal androgen exposure (Jurgensen et al., 2007; Meyer-Bahlburg, Dolezal, Baker, Ehrhardt, & New, 2006). Notably, a similar correlation of prenatal hormone exposure with gender *identity* has not been demonstrated (e.g., Meyer-Bahlburg et al., 2004). This is underlined by the fact that people with the same (core) gender identity can vary widely in the degree of masculinization of their gender-related behavior.

Assessment and Treatment of Gender Dysphoria in People with Disorders of Sex Development

Very rarely are individuals with a DSD identified as having gender dysphoria *before* a DSD diagnosis has been made. Even so, a DSD diagnosis is typically apparent with an appropriate history and basic physical exam – both of which are part of a medical evaluation for the appropriateness of hormone therapy or surgical interventions for gender dysphoria. Mental health professionals should ask their clients presenting with gender dysphoria to have a physical exam, particularly if they are not currently seeing a primary care (or other health care) provider.

Most people with a DSD who are born with genital ambiguity do not develop gender dysphoria (e.g., Meyer-Bahlburg et al., 2004; Wisniewski et al., 2004). However, some people with a DSD will develop chronic gender dysphoria and even undergo a change in their birth-assigned sex and/or their gender role (Meyer-Bahlburg, 2005; Wilson, 1999; Zucker, 1999). If there are persistent and strong indications that gender dysphoria is present, a comprehensive evaluation by clinicians skilled in the assessment and treatment of gender dysphoria is essential, irrespective of the patient's age. Detailed recommendations have been published for conducting such an assessment and for making treatment decisions to address gender dysphoria in the context of a DSD (Meyer-Bahlburg, in press). Only after thorough assessment should steps be taken in the direction of changing a patient's birth-assigned sex or gender role.

Clinicians assisting these patients with treatment options to alleviate gender dysphoria may profit from the insights gained from providing care to patients without a DSD (Cohen-Kettenis, 2010). However, certain criteria for treatment (e.g., age, duration of experience with living in the desired gender role) are usually not routinely applied to people with a DSD; rather, the criteria are interpreted in light of a patient's specific situation (Meyer-Bahlburg, in press). In the context of a DSD, changes in birth-assigned sex and gender role have been made at any age between early elementary-school age and middle adulthood. Even genital surgery may be performed much earlier in these patients than in gender dysphoric individuals without a DSD if the surgery is well justified by the diagnosis, by the evidence-based gender-identity prognosis for the given syndrome and syndrome severity, and by the patient's wishes.

One reason for these treatment differences is that genital surgery in individuals with a DSD is quite common in infancy and adolescence. Infertility may already be present due to either early gonadal failure or to gonadectomy because of a malignancy risk. Even so, it is advisable for patients with a DSD to undergo a full social transition to another gender role only if there is a long-standing history of gender-atypical behavior, and if gender dysphoria and/or the desire to change one's gender role has been strong and persistent for a considerable period of time. Six months is the time period of full symptom expression required for the application of the gender dysphoria diagnosis proposed for *DSM-5* (Meyer-Bahlburg, in press).

Additional Resources

The gender-relevant medical histories of people with a DSD are often complex. Their histories may include a great variety of inborn genetic, endocrine, and somatic atypicalities, as well as various hormonal, surgical, and other medical treatments. For this reason, many additional issues need to be considered in the psychosocial and medical care of such patients, regardless of the presence of gender dysphoria. Consideration of these issues is beyond what can be covered in the *SOC*. The interested reader is referred to existing publications (e.g., Cohen-Kettenis & Pfäfflin, 2003; Meyer-Bahlburg, 2002, 2008). Some families and patients also find it useful to consult or work with community support groups.

There is a very substantial medical literature on the medical management of patients with a DSD. Much of this literature has been produced by high-level specialists in pediatric endocrinology and urology, with input from specialized mental health professionals, especially in the area of gender. Recent international consensus conferences have addressed evidence-based care guidelines (including issues of gender and of genital surgery) for DSD in general (Hughes et al., 2006) and specifically for Congenital Adrenal Hyperplasia (Joint LWPES/ESPE CAH Working Group et al., 2002; Speiser et al., 2010). Others have addressed the research needs for DSD in general (Meyer-Bahlburg & Blizzard, 2004) and for selected syndromes such as 46,XXY (Simpson et al., 2003).

References

Abramowitz, S. I. (1986). Psychosocial outcomes of sex reassignment surgery. *Journal of Consulting and Clinical Psychology, 54*(2), 183-189. doi:10.1037/0022-006X.54.2.183

ACOG Committee of Gynecologic Practice. (2005). Committee opinion #322: Compounded bioidentical hormones. *Obstetrics & Gynecology, 106*(5), 139-140.

Adler, R. K., Hirsch, S., & Mordaunt, M. (2006). *Voice and communication therapy for the transgender/transsexual client: A comprehensive clinical guide*. San Diego, CA: Plural Pub.

American Academy of Family Physicians. (2005). *Definition of family medicine*. Retrieved August 10, 2009, from http://www.aafp.org/online/en/home/policy/policies/f/fammeddef.html

American Medical Association. (2008). *Resolution 122 (A-08)*. Retrieved from http://www.ama-assn.org/ama1/pub/upload/mm/471/122.doc

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders DSM-IV-TR* (4th ed., text rev.). Washington, DC: Author.

American Speech-Language-Hearing Association. (2011). *Scope of practice*. Retrieved from www.asha.org

Anton, B. S. (2009). Proceedings of the American Psychological Association for the legislative year 2008: Minutes of the annual meeting of the council of representatives, February 22-24, 2008, Washington, DC, and August 13 and 17, 2008, Boston, MA, and minutes of the February, June, August, and December 2008 meetings of the board of directors. *American Psychologist, 64*, 372-453. doi:10.1037/a0015932

Asscheman, H., Giltay, E. J., Megens, J. A. J., de Ronde, W., van Trotsenburg, M. A. A., & Gooren, L. J. G. (2011). A long-term follow-up study of mortality in transsexuals receiving treatment with cross-sex hormones. *European Journal of Endocrinology, 164*(4), 635-642. doi:10.1530/EJE-10-1038

Baba, T., Endo, T., Honnma, H., Kitajima, Y., Hayashi, T., Ikeda, H., . . . Saito, T. (2007). Association between polycystic ovary syndrome and female-to-male transsexuality. *Human Reproduction, 22*(4), 1011-1016. doi:10.1093/humrep/del474

Bakker, A., Van Kesteren, P. J., Gooren, L. J., & Bezemer, P. D. (1993). The prevalence of transsexualism in the Netherlands. *Acta Psychiatrica Scandinavica, 87*(4), 237-238. doi:10.1111/j.1600-0447.1993.tb03364.x

Balen, A. H., Schachter, M. E., Montgomery, D., Reid, R. W., & Jacobs, H. S. (1993). Polycystic ovaries are a common finding in untreated female to male transsexuals. *Clinical Endocrinology, 38*(3), 325-329. doi:10.1111/j.1365-2265.1993.tb01013.x

Basson, R. (2001). Towards optimal hormonal treatment of male to female gender identity disorder. *Journal of Sexual and Reproductive Medicine, 1*(1), 45-51.

Basson, R., & Prior, J. C. (1998). Hormonal therapy of gender dysphoria: The male-to-female transsexual. In D. Denny (Ed.), *Current concepts in transgender identity* (pp. 277-296). New York: Garland Publishing, Inc.

Benjamin, H. (1966). *The transsexual phenomenon*. New York: Julian Press.

Besnier, N. (1994). Polynesian gender liminality through time and space. In G. Herdt (Ed.), *Third sex, third gender: Beyond sexual dimorphism in culture and history* (pp. 285-328). New York: Zone Books.

Bockting, W. O. (1999). From construction to context: Gender through the eyes of the transgendered. *Siecus Report, 28*(1), 3-7.

Bockting, W. O. (2008). Psychotherapy and the real-life experience: From gender dichotomy to gender diversity. *Sexologies, 17*(4), 211-224. doi:10.1016/j.sexol.2008.08.001

Bockting, W. O., & Coleman, E. (2007). Developmental stages of the transgender coming out process: Toward an integrated identity. In R. Ettner, S. Monstrey & A. Eyler (Eds.), *Principles of transgender medicine and surgery* (pp. 185-208). New York: The Haworth Press.

Bockting, W. O., & Goldberg, J. M. (2006). Guidelines for transgender care (special issue). *International Journal of Transgenderism, 9*(3/4).

Bockting, W. O., Knudson, G., & Goldberg, J. M. (2006). Counseling and mental health care for transgender adults and loved ones. *International Journal of Transgenderism, 9*(3/4), 35-82. doi:10.1300/J485v09n03_03

Bolin, A. (1988). *In search of Eve* (pp. 189-192). New York: Bergin & Garvey.

Bolin, A. (1994). Transcending and transgendering: Male-to-female transsexuals, dichotomy and diversity. In G. Herdt (Ed.), *Third sex, third gender: Beyond sexual dimorphism in culture and history* (pp. 447-486). New York: Zone Books.

Bornstein, K. (1994). *Gender outlaw: On men, women, and the rest of us*. New York: Routledge.

Bosinski, H. A. G., Peter, M., Bonatz, G., Arndt, R., Heidenreich, M., Sippell, W. G., & Wille, R. (1997). A higher rate of hyperandrogenic disorders in female-to-male transsexuals. *Psychoneuroendocrinology, 22*(5), 361-380. doi:10.1016/S0306-4530(97)00033-4

Brill, S. A., & Pepper, R. (2008). *The transgender child: A handbook for families and professionals*. Berkeley, CA: Cleis Press.

Brown, G. R. (2009). Recommended revisions to The World Professional Association for Transgender Health's Standards of Care section on medical care for incarcerated persons with gender identity disorder. *International Journal of Transgenderism, 11*(2), 133-139. doi:10.1080/15532730903008073

Brown, G. R. (2010). Autocastration and autopenectomy as surgical self-treatment in incarcerated persons with gender identity disorder. *International Journal of Transgenderism, 12*(1), 31-39. doi:10.1080/15532731003688970

Bullough, V. L., & Bullough, B. (1993). *Cross dressing, sex, and gender*. Philadelphia, PA: University of Pennsylvania Press.

Callen Lorde Community Health Center. (2000). *Transgender health program protocols*. Retrieved from http://www.callen-lorde.org/documents/TG_Protocol_Request_Form2.pdf

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 277 of 371Total Pages:(277 of 1263)

Callen Lorde Community Health Center. (2011). *Transgender health program protocols.* Retrieved from http://www.callen-lorde.org/documents/TG_Protocol_Request_Form2.pdf

Canadian Association of Speech-Language Pathologists and Audiologists. http://www.caslpa.ca/

Carew, L., Dacakis, G., & Oates, J. (2007). The effectiveness of oral resonance therapy on the perception of femininity of voice in male-to-female transsexuals. *Journal of Voice, 21*(5), 591-603. doi:10.1016/j.jvoice.2006.05.005

Carnegie, C. (2004). Diagnosis of hypogonadism: Clinical assessments and laboratory tests. *Reviews in Urology, 6*(Suppl 6), S3-8.

Cattrall, F. R., & Healy, D. L. (2004). Long-term metabolic, cardiovascular and neoplastic risks with polycystic ovary syndrome. *Best Practice & Research Clinical Obstetrics & Gynaecology, 18*(5), 803-812. doi:10.1016/j.bpobgyn.2004.05.005

Center of Excellence for Transgender Health, UCSF. (2011). *Primary care protocol for transgender health care.* Retrieved from http://transhealth.ucsf.edu/trans?page=protocol-00-00

Chiñas, B. (1995). Isthmus Zapotec attitudes toward sex and gender anomalies. In S. O. Murray (Ed.), *Latin American male homosexualities* (pp. 293-302). Albuquerque, NM: University of New Mexico Press.

Clements, K., Wilkinson, W., Kitano, K., & Marx, R. (1999). HIV prevention and health service needs of the transgender community in San Francisco. *International Journal of Transgenderism, 3*(1), 2-17.

Cohen-Kettenis, P. T. (2001). Gender identity disorder in DSM? *Journal of the American Academy of Child & Adolescent Psychiatry, 40*(4), 391-391. doi:10.1097/00004583-200104000-00006

Cohen-Kettenis, P. T. (2005). Gender change in 46,XY persons with 5 -reductase-2 deficiency and 17 -hydroxysteroid dehydrogenase-3 deficiency. *Archives of Sexual Behavior, 34*(4), 399-410. doi:10.1007/s10508-005-4339-4

Cohen-Kettenis, P. T. (2006). Gender identity disorders. In C. Gillberg, R. Harrington & H. C. Steinhausen (Eds.), *A clinician's handbook of child and adolescent psychiatry* (pp. 695-725). New York: Cambridge University Press.

Cohen-Kettenis, P. T. (2010). Psychosocial and psychosexual aspects of disorders of sex development. *Best Practice & Research Clinical Endocrinology & Metabolism, 24*(2), 325-334. doi:10.1016/j.beem.2009.11.005

Cohen-Kettenis, P. T., & Kuiper, A. J. (1984). Transseksualiteit en psychothérapie. *Tijdschrift Voor Psychotherapie, 10*, 153-166.

Cohen-Kettenis, P. T., Owen, A., Kaijser, V. G., Bradley, S. J., & Zucker, K. J. (2003). Demographic characteristics, social competence, and behavior problems in children with gender identity disorder: A cross-national, cross-clinic comparative analysis. *Journal of Abnormal Child Psychology, 31*(1), 41-53. doi:10.1023/A:1021769215342

Cohen-Kettenis, P. T., & Pfäfflin, F. (2003). *Transgenderism and intersexuality in childhood and adolescence: Making choices*. Thousand Oaks, CA: Sage Publications, Inc.

Cohen-Kettenis, P. T., & Pfäfflin, F. (2010). The DSM diagnostic criteria for gender identity disorder in adolescents and adults. *Archives of Sexual Behavior, 39*(2), 499-513. doi:10.1007/s10508-009-9562-y

Cohen-Kettenis, P. T., Schagen, S. E. E., Steensma, T. D., de Vries, A. L. C., & Delemarre-van de Waal, H. A. (2011). Puberty suppression in a gender-dysphoric adolescent: A 22-year follow-up. *Archives of Sexual Behavior, 40*(4), 843-847. doi:0.1007/s10508-011-9758-9

Cohen-Kettenis, P. T., Wallien, M., Johnson, L. L., Owen-Anderson, A. F. H., Bradley, S. J., & Zucker, K. J. (2006). A parent-report gender identity questionnaire for children: A cross-national, cross-clinic comparative analysis. *Clinical Child Psychology and Psychiatry, 11*(3), 397-405. doi:10.1177/1359104506059135

Cole, C. M., O'Boyle, M., Emory, L. E., & Meyer III, W. J. (1997). Comorbidity of gender dysphoria and other major psychiatric diagnoses. *Archives of Sexual Behavior, 26*(1), 13-26.

Coleman, E., Colgan, P., & Gooren, L. (1992). Male cross-gender behavior in Myanmar (Burma): A description of the acault. *Archives of Sexual Behavior, 21*(3), 313-321.

Costa, L. M., & Matzner, A. (2007). *Male bodies, women's souls: Personal narratives of Thailand's transgendered youth*. Binghamton, NY: Haworth Press.

Currah, P., Juang, R. M., & Minter, S. (2006). *Transgender rights*. Minneapolis, MN: University of Minnesota Press.

Currah, P., & Minter, S. (2000). Unprincipled exclusions: The struggle to achieve judicial and legislative equality for transgender people. *William and Mary Journal of Women and Law, 7*, 37-60.

Dacakis, G. (2000). Long-term maintenance of fundamental frequency increases in male-to-female transsexuals. *Journal of Voice, 14*(4), 549-556. doi:10.1016/S0892-1997(00)80010-7

Dahl, M., Feldman, J. L., Goldberg, J. M., & Jaberi, A. (2006). Physical aspects of transgender endocrine therapy. *International Journal of Transgenderism, 9*(3), 111-134. doi:10.1300/J485v09n03_06

Darney, P. D. (2008). Hormonal contraception. In H. M. Kronenberg, S. Melmer, K. S. Polonsky & P. R. Larsen (Eds.), *Williams textbook of endocrinology* (11th ed., pp. 615-644). Philadelphia: Saunders.

Davies, S., & Goldberg, J. M. (2006). Clinical aspects of transgender speech feminization and masculinization. *International Journal of Transgenderism, 9*(3-4), 167-196. doi:10.1300/J485v09n03_08

de Bruin, M. D., Coerts, M. J., & Greven, A. J. (2000). Speech therapy in the management of male-to-female transsexuals. *Folia Phoniatrica Et Logopaedica, 52*(5), 220-227.

De Cuypere, G., T'Sjoen, G., Beerten, R., Selvaggi, G., De Sutter, P., Hoebeke, P., . . . Rubens, R. (2005). Sexual and physical health after sex reassignment surgery. *Archives of Sexual Behavior, 34*(6), 679-690. doi:10.1007/s10508-005-7926-5

De Cuypere, G., Van Hemelrijck, M., Michel, A., Carael, B., Heylens, G., Rubens, R., . . . Monstrey, S. (2007). Prevalence and demography of transsexualism in Belgium. *European Psychiatry, 22*(3), 137-141. doi:10.1016/j.eurpsy.2006.10.002

De Cuypere, G., & Vercruysse, H. (2009). Eligibility and readiness criteria for sex reassignment surgery: Recommendations for revision of the WPATH standards of care. *International Journal of Transgenderism, 11*(3), 194-205. doi:10.1080/15532730903383781

de Lignières, B. (1999). Oral micronized progesterone. *Clinical Therapeutics, 21*(1), 41-60. doi:10.1016/S0149-2918(00)88267-3

De Sutter, P. (2009). Reproductive options for transpeople: Recommendations for revision of the WPATH's standards of care. *International Journal of Transgenderism, 11*(3), 183-185. doi:10.1080/15532730903383765

De Sutter, P., Kira, K., Verschoor, A., & Hotimsky, A. (2002). The desire to have children and the preservation of fertility in transsexual women: A survey. *International Journal of Transgenderism, 6*(3), retrieved from http://www.wpath.org/journal/www.iiav.nl/ezines/web/IJT/97-03/numbers/symposion/ijtvo06no03_02.htm

de Vries, A. L. C., Cohen-Kettenis, P. T., & Delemarre-van de Waal, H. A. (2006). Clinical management of gender dysphoria in adolescents. *International Journal of Transgenderism, 9*(3-4), 83-94. doi:10.1300/J485v09n03_04

de Vries, A. L. C., Doreleijers, T. A. H., Steensma, T. D., & Cohen-Kettenis, P. T. (2011). Psychiatric comorbidity in gender dysphoric adolescents. *Journal of Child Psychology and Psychiatry*. Advance online publication. doi:10.1111/j.1469-7610.2011.02426.x

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 280 of 371Total Pages:(280 of 1263)

de Vries, A. L. C., Noens, I. L. J., Cohen-Kettenis, P. T., van Berckelaer-Onnes, I. A., & Doreleijers, T. A. (2010). Autism spectrum disorders in gender dysphoric children and adolescents. *Journal of Autism and Developmental Disorders, 40*(8), 930-936. doi:10.1007/s10803-010-0935-9

de Vries, A. L. C., Steensma, T. D., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2010). Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *The Journal of Sexual Medicine*. Advance online publication. doi:10.1111/j.1743-6109.2010.01943.x

Delemarre-van de Waal, H. A., & Cohen-Kettenis, P. T. (2006). Clinical management of gender identity disorder in adolescents: A protocol on psychological and paediatric endocrinology aspects. *European Journal of Endocrinology, 155*(suppl 1), S131-S137. doi:10.1530/eje.1.02231

Delemarre-van de Waal, H. A., van Weissenbruch, M. M., & Cohen Kettenis, P. T. (2004). Management of puberty in transsexual boys and girls. *Hormone Research in Paediatrics, 62*(suppl 2), 75-75. doi:10.1159/000081145

Derrig-Palumbo, K., & Zeine, F. (2005). *Online therapy: A therapist's guide to expanding your practice*. New York: W.W. Norton & Co.

Dessens, A. B., Slijper, F. M. E., & Drop, S. L. S. (2005). Gender dysphoria and gender change in chromosomal females with congenital adrenal hyperplasia. *Archives of Sexual Behavior, 34*(4), 389-397. doi:10.1007/s10508-005-4338-5

Devor, A. H. (2004). Witnessing and mirroring: A fourteen stage model. *Journal of Gay and Lesbian Psychotherapy, 8*(1/2), 41-67.

Di Ceglie, D., & Thümmel, E. C. (2006). An experience of group work with parents of children and adolescents with gender identity disorder. *Clinical Child Psychology and Psychiatry, 11*(3), 387-396. doi:10.1177/1359104506064983

Diamond, M. (2009). Human intersexuality: Difference or disorder? *Archives of Sexual Behavior, 38*(2), 172-172. doi:10.1007/s10508-008-9438-6

Dobs, A. S., Meikle, A. W., Arver, S., Sanders, S. W., Caramelli, K. E., & Mazer, N. A. (1999). Pharmacokinetics, efficacy, and safety of a permeation-enhanced testosterone transdermal system in comparison with bi-weekly injections of testosterone enanthate for the treatment of hypogonadal men. *Journal of Clinical Endocrinology & Metabolism, 84*(10), 3469-3478. doi:10.1210/jc.84.10.3469

Docter, R. F. (1988). *Transvestites and transsexuals: Toward a theory of cross-gender behavior*. New York: Plenum Press.

Drummond, K. D., Bradley, S. J., Peterson-Badali, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. *Developmental Psychology, 44*(1), 34-45. doi:10.1037/0012-1649.44.1.34

Ehrbar, R. D., & Gorton, R. N. (2010). Exploring provider treatment models in interpreting the standards of care. *International Journal of Transgenderism, 12*(4), 198-2010. doi:10.1080/15532739.2010.544235

Ekins, R., & King, D. (2006). *The transgender phenomenon*. Thousand Oaks, CA: SAGE Publications Ltd.

Eklund, P. L., Gooren, L. J., & Bezemer, P. D. (1988). Prevalence of transsexualism in the Netherlands. *British Journal of Psychiatry, 152*(5), 638-640.

Eldh, J., Berg, A., & Gustafsson, M. (1997). Long-term follow up after sex reassignment surgery. *Scandinavian Journal of Plastic and Reconstructive Surgery and Hand Surgery, 31*(1), 39-45.

Emerson, S., & Rosenfeld, C. (1996). Stages of adjustment in family members of transgender individuals. *Journal of Family Psychotherapy, 7*(3), 1-12. doi:10.1300/J085V07N03_01

Emory, L. E., Cole, C. M., Avery, E., Meyer, O., & Meyer III, W. J. (2003). Client's view of gender identity: Life, treatment status and outcome. *18th Biennial Harry Benjamin Symposium*, Gent, Belgium.

Ettner, R., Monstrey, S., & Eyler, A. (Eds.) (2007). *Principles of transgender medicine and surgery*. Binghamton, NY: The Haworth Press.

Eyler, A. E. (2007). Primary medical care of the gender-variant patient. In R. Ettner, S. Monstrey & E. Eyler (Eds.), *Principles of transgender medicine and surgery* (pp. 15-32). Binghamton, NY: The Haworth Press.

Factor, R. J., & Rothblum, E. (2008). Exploring gender identity and community among three groups of transgender individuals in the United States: MTFs, FTMs, and genderqueers. *Health Sociology Review, 17*(3), 235-253.

Feinberg, L. (1996). *Transgender warriors: Making history from Joan of Arc to Dennis Rodman*. Boston, MA: Beacon Press.

Feldman, J. (2005, April). *Masculinizing hormone therapy with testosterone 1% topical gel*. Paper presented at the 19th Biennial Symposium of the Harry Benjamin International Gender Dysphoria Association, Bologna, Italy.

Feldman, J. (2007). Preventive care of the transgendered patient. In R. Ettner, S. Monstrey & E. Eyler (Eds.), *Principles of transgender surgery and medicine* (pp. 33-72). Binghamton, NY: The Haworth Press.

Feldman, J., & Goldberg, J. (2006). Transgender primary medical care. *International Journal of Transgenderism, 9*(3), 3-34. doi:10.1300/J485v09n03_02

Feldman, J., & Safer, J. (2009). Hormone therapy in adults: Suggested revisions to the sixth version of the standards of care. *International Journal of Transgenderism, 11*(3), 146-182. doi:10.1080/15532730903383757

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 282 of 371Total Pages:(282 of 1263)

Fenichel, M., Suler, J., Barak, A., Zelvin, E., Jones, G., Munro, K., . . . Walker-Schmucker, W. (2004). *Myths and realities of online clinical work, observations on the phenomena of online behavior, experience, and therapeutic relationships. A 3rd-year report from ISMHO's clinical case study group.* Retrieved May 24, 2011, from https://www.ismho.org/myths_n_realities.asp

Fenway Community Health Transgender Health Program. (2007). *Protocol for hormone therapy.* Retrieved from http://www.fenwayhealth.org/site/DocServer/Fenway_Protocols.pdf?docID=2181

Fisk, N. M. (1974). Editorial: Gender dysphoria syndrome--the conceptualization that liberalizes indications for total gender reorientation and implies a broadly based multi-dimensional rehabilitative regimen. *Western Journal of Medicine, 120*(5), 386-391.

Fitzpatrick, L. A., Pace, C., & Wiita, B. (2000). Comparison of regimens containing oral micronized progesterone or medroxyprogesterone acetate on quality of life in postmenopausal women: A cross-sectional survey. *Journal of Women's Health & Gender-Based Medicine, 9*(4), 381-387.

Frank, J. D., & Frank, J. B. (1993). *Persuasion and healing: A comparative study of psychotherapy* (Third ed.). Baltimore, MD: Johns Hopkins University Press.

Fraser, L. (2009a). Depth psychotherapy with transgender people. *Sexual and Relationship Therapy, 24*(2), 126-142. doi:10.1080/14681990903003878

Fraser, L. (2009b). Etherapy: Ethical and clinical considerations for version 7 of The World Professional Association for Transgender Health's standards of care. *International Journal of Transgenderism, 11*(4), 247-263. doi:10.1080/15532730903439492

Fraser, L. (2009c). Psychotherapy in The World Professional Association for Transgender Health's standards of care: Background and recommendations. *International Journal of Transgenderism, 11*(2), 110-126. doi:10.1080/15532730903008057

Garaffa, G., Christopher, N. A., & Ralph, D. J. (2010). Total phallic reconstruction in female-to-male transsexuals. *European Urology, 57*(4), 715-722. doi:10.1016/j.eururo.2009.05.018

Gelder, M. G., & Marks, I. M. (1969). Aversion treatment in transvestism and transsexualism. In R. Green, & J. Money (Eds.), *Transsexualism and sex reassignment* (pp. 383-413). Baltimore, MD: Johns Hopkins Press.

Gelfer, M. P. (1999). Voice treatment for the male-to-female transgendered client. *American Journal of Speech-Language Pathology, 8*(3), 201-208.

Gharib, S., Bigby, J., Chapin, M., Ginsburg, E., Johnson, P., Manson, J., & Solomon, C. (2005). *Menopause: A guide to management.* Boston, MA: Brigham and Women's Hospital.

Gijs, L., & Brewaeys, A. (2007). Surgical treatment of gender dysphoria in adults and adolescents: Recent developments, effectiveness, and challenges. *Annual Review of Sex Research, 18*, 178-224.

Gold, M., & MacNish, M. (2011). *Adjustment and resiliency following disclosure of transgender identity in families of adolescents and young adults: Themes and clinical implications*. Washington, DC: American Family Therapy Academy.

Gómez-Gil, E., Trilla, A., Salamero, M., Godás, T., & Valdés, M. (2009). Sociodemographic, clinical, and psychiatric characteristics of transsexuals from Spain. *Archives of Sexual Behavior, 38*(3), 378-392. doi:10.1007/s10508-007-9307-8

Gooren, L. (2005). Hormone treatment of the adult transsexual patient. *Hormone Research in Paediatrics, 64*(Suppl 2), 31-36. doi:10.1159/000087751

Gorton, R. N., Buth, J., & Spade, D. (2005). *Medical therapy and health maintenance for transgender men: A guide for health care providers*. San Francisco, CA: Lyon-Martin Women's Health Services.

Green, R. (1987). *The"sissy boy syndrome" and the development of homosexuality*. New Haven, CT: Yale University Press.

Green, R., & Fleming, D. (1990). Transsexual surgery follow-up: Status in the 1990s. *Annual Review of Sex Research, 1*(1), 163-174.

Greenson, R. R. (1964). On homosexuality and gender identity. *International Journal of Psycho-Analysis, 45*, 217-219.

Grossman, A. H., D'Augelli, A. R., Howell, T. J., & Hubbard, S. (2006). Parent's reactions to transgender youth's gender nonconforming expression and identity. *Journal of Gay & Lesbian Social Services, 18*(1), 3-16. doi:10.1300/J041v18n01_02

Grossman, A. H., D'Augelli, A. R., & Salter, N. P. (2006). Male-to-female transgender youth: Gender expression milestones, gender atypicality, victimization, and parents' responses. *Journal of GLBT Family Studies, 2*(1), 71-92.

Grumbach, M. M., Hughes, I. A., & Conte, F. A. (2003). Disorders of sex differentiation. In P. R. Larsen, H. M. Kronenberg, S. Melmed & K. S. Polonsky (Eds.), *Williams textbook of endocrinology* (10th ed., pp. 842-1002). Philadelphia, PA: Saunders.

Hage, J. J., & De Graaf, F. H. (1993). Addressing the ideal requirements by free flap phalloplasty: Some reflections on refinements of technique. *Microsurgery, 14*(9), 592-598. doi:10.1002/micr.1920140910

Hage, J. J., & Karim, R. B. (2000). Ought GIDNOS get nought? Treatment options for nontranssexual gender dysphoria. *Plastic and Reconstructive Surgery, 105*(3), 1222-1227.

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 284 of 371Total Pages:(284 of 1263)

Hancock, A. B., Krissinger, J., & Owen, K. (2010). Voice perceptions and quality of life of transgender people. *Journal of Voice*. Advance online publication. doi:10.1016/j.jvoice.2010.07.013

Hastings, D. W. (1974). Postsurgical adjustment of male transsexual patients. *Clinics in Plastic Surgery, 1*(2), 335-344.

Hembree, W. C., Cohen-Kettenis, P., Delemarre-van de Waal, H. A., Gooren, L. J., Meyer III, W. J., Spack, N. P., . . . Montori, V. M. (2009). Endocrine treatment of transsexual persons: An Endocrine Society clinical practice guideline. *Journal of Clinical Endocrinology & Metabolism, 94*(9), 3132-3154. doi:10.1210/jc.2009-0345

Hill, D. B., Menvielle, E., Sica, K. M., & Johnson, A. (2010). An affirmative intervention for families with gender-variant children: Parental ratings of child mental health and gender. *Journal of Sex and Marital Therapy, 36*(1), 6-23. doi:10.1080/00926230903375560

Hoebeke, P., Selvaggi, G., Ceulemans, P., De Cuypere, G. D., T'Sjoen, G., Weyers, S., . . . Monstrey, S. (2005). Impact of sex reassignment surgery on lower urinary tract function. *European Urology, 47*(3), 398-402. doi:10.1016/j.eururo.2004.10.008

Hoenig, J., & Kenna, J. C. (1974). The prevalence of transsexualism in England and Wales. *British Journal of Psychiatry, 124*(579), 181-190. doi:10.1192/bjp.124.2.181

Hughes, I. A., Houk, C. P., Ahmed, S. F., Lee, P. A., & LWPES1/ESPE2 Consensus Group. (2006). Consensus statement on management of intersex disorders. *Archives of Disease in Childhood, 91*(7), 554-563. doi:10.1136/adc.2006.098319

Hunter, M. H., & Sterrett, J. J. (2000). Polycystic ovary syndrome: It's not just infertility. *American Family Physician, 62*(5), 1079-1095.

Institute of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. Washington, DC: The National Academies Press.

Jackson, P. A., & Sullivan, G. (Eds.). (1999). *Lady boys, tom boys, rent boys: Male and female homosexualities in contemporary Thailand*. Binghamton, NY: The Haworth Press.

Jockenhövel, F. (2004). Testosterone therapy-what, when and to whom? *The Aging Male, 7*(4), 319-324. doi:10.1080/13685530400016557

Johansson, A., Sundbom, E., Höjerback, T., & Bodlund, O. (2010). A five-year follow-up study of Swedish adults with gender identity disorder. *Archives of Sexual Behavior, 39*(6), 1429-1437. doi:10.1007/s10508-009-9551-1

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 285 of 371Total Pages:(285 of 1263)

Joint LWPES/ESPE CAH Working Group, Clayton, P. E., Miller, W. L., Oberfield, S. E., Ritzen, E. M., Sippell, W. G., & Speiser, P. W. (2002). Consensus statement on 21-hydroxylase deficiency from the Lawson Wilkins Pediatric Endocrine Society and the European Society for Pediatric Endocrinology. *Journal of Clinical Endocrinology & Metabolism, 87*(9), 4048-4053. doi:10.1210/jc.2002-020611

Jurgensen, M., Hiort, O., Holterhus, P. M., & Thyen, U. (2007). Gender role behavior in children with XY karyotype and disorders of sex development. *Hormones and Behavior, 51*(3), 443-453. doi:0.1016/j.yhbeh.2007.01.001

Kanagalingam, J., Georgalas, C., Wood, G. R., Ahluwalia, S., Sandhu, G., & Cheesman, A. D. (2005). Cricothyroid approximation and subluxation in 21 male-to-female transsexuals. *The Laryngoscope, 115*(4), 611-618. doi:10.1097/01.mlg.0000161357.12826.33

Kanhai, R. C. J., Hage, J. J., Karim, R. B., & Mulder, J. W. (1999). Exceptional presenting conditions and outcome of augmentation mammaplasty in male-to-female transsexuals. *Annals of Plastic Surgery, 43*(5), 476-483.

Kimberly, S. (1997). I am transsexual - hear me roar. *Minnesota Law & Politics, June*, 21-49.

Klein, C., & Gorzalka, B. B. (2009). Sexual functioning in transsexuals following hormone therapy and genital surgery: A review (CME). *The Journal of Sexual Medicine, 6*(11), 2922-2939. doi:10.1111/j.1743-6109.2009.01370.x

Knudson, G., De Cuypere, G., & Bockting, W. (2010a). Process toward consensus on recommendations for revision of the DSM diagnoses of gender identity disorders by The World Professional Association for Transgender Health. *International Journal of Transgenderism, 12*(2), 54-59. doi:10.1080/15532739.2010.509213

Knudson, G., De Cuypere, G., & Bockting, W. (2010b). Recommendations for revision of the DSM diagnoses of gender identity disorders: Consensus statement of The World Professional Association for Transgender Health. *International Journal of Transgenderism, 12*(2), 115-118. doi:10.1080/15532739.2010.509215

Kosilek v. Massachusetts Department of Corrections/Maloney, C.A. No. 92-12820-MLW (U.S. Federal District Court, Boston, MA, 2002).

Krege, S., Bex, A., Lümmen, G., & Rübben, H. (2001). Male-to-female transsexualism: A technique, results and long-term follow-up in 66 patients. *British Journal of Urology, 88*(4), 396-402. doi:10.1046/j.1464-410X.2001.02323.x

Kuhn, A., Bodmer, C., Stadlmayr, W., Kuhn, P., Mueller, M. D., & Birkhäuser, M. (2009). Quality of life 15 years after sex reassignment surgery for transsexualism. *Fertility and Sterility, 92*(5), 1685-1689. doi:10.1016/j.fertnstert.2008.08.126

Kuhn, A., Hiltebrand, R., & Birkhauser, M. (2007). Do transsexuals have micturition disorders? *European Journal of Obstetrics & Gynecology and Reproductive Biology, 131*(2), 226-230. doi:10.1016/j.ejogrb.2006.03.019

Landén, M., Wålinder, J., & Lundström, B. (1998). Clinical characteristics of a total cohort of female and male applicants for sex reassignment: A descriptive study. *Acta Psychiatrica Scandinavica, 97*(3), 189-194. doi:10.1111/j.1600-0447.1998.tb09986.x

Lawrence, A. A. (2003). Factors associated with satisfaction or regret following male-to-female sex reassignment surgery. *Archives of Sexual Behavior, 32*(4), 299-315. doi:10.1023/A:1024086814364

Lawrence, A. A. (2006). Patient-reported complications and functional outcomes of male-to-female sex reassignment surgery. *Archives of Sexual Behavior, 35*(6), 717-727. doi:10.1007/s10508-006-9104-9

Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families.* Binghamton, NY: Haworth Clinical Practice Press.

Lev, A. I. (2009). The ten tasks of the mental health provider: Recommendations for revision of The World Professional Association for Transgender Health's standards of care. *International Journal of Transgenderism, 11*(2), 74-99. doi:10.1080/15532730903008032

Levy, A., Crown, A., & Reid, R. (2003). Endocrine intervention for transsexuals. *Clinical Endocrinology, 59*(4), 409-418. doi:10.1046/j.1365-2265.2003.01821.x

MacLaughlin, D. T., & Donahoe, P. K. (2004). Sex determination and differentiation. *New England Journal of Medicine, 350*(4), 367-378.

Maheu, M. M., Pulier, M. L., Wilhelm, F. H., McMenamin, J. P., & Brown-Connolly, N. E. (2005). *The mental health professional and the new technologies: A handbook for practice today*. Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

Malpas, J. (in press). Between pink and blue: A multi-dimensional family approach to gender nonconforming chldren and their families. *Family Process.*

Mazur, T. (2005). Gender dysphoria and gender change in androgen insensitivity or micropenis. *Archives of Sexual Behavior, 34*(4), 411-421. doi:10.1007/s10508-005-4341-x

McNeill, E. J. M. (2006). Management of the transgender voice. *The Journal of Laryngology & Otology, 120*(07), 521-523. doi:10.1017/S0022215106001174

McNeill, E. J. M., Wilson, J. A., Clark, S., & Deakin, J. (2008). Perception of voice in the transgender client. *Journal of Voice, 22*(6), 727-733. doi:10.1016/j.jvoice.2006.12.010

Menvielle, E. J., & Tuerk, C. (2002). A support group for parents of gender-nonconforming boys. *Journal of the American Academy of Child & Adolescent Psychiatry, 41*(8), 1010-1013. doi:10.1097/00004583-200208000-00021

Meyer, I. H. (2003). Prejudice as stress: Conceptual and measurement problems. *American Journal of Public Health, 93*(2), 262-265.

Meyer, J. K., & Reter, D. J. (1979). Sex reassignment: Follow-up. *Archives of General Psychiatry, 36*(9), 1010-1015.

Meyer III, W. J. (2009). World Professional Association for Transgender Health's standards of care requirements of hormone therapy for adults with gender identity disorder. *International Journal of Transgenderism, 11*(2), 127-132. doi:10.1080/15532730903008065

Meyer III, W. J., Webb, A., Stuart, C. A., Finkelstein, J. W., Lawrence, B., & Walker, P. A. (1986). Physical and hormonal evaluation of transsexual patients: A longitudinal study. *Archives of Sexual Behavior, 15*(2), 121-138. doi:10.1007/BF01542220

Meyer-Bahlburg, H. F. L. (2002). Gender assignment and reassignment in intersexuality: Controversies, data, and guidelines for research. *Advances in Experimental Medicine and Biology, 511*, 199-223. doi:10.1007/978-1-4615-0621-8_12

Meyer-Bahlburg, H. F. L. (2005). Gender identity outcome in female-raised 46,XY persons with penile agenesis, cloacal exstrophy of the bladder, or penile ablation. *Archives of Sexual Behavior, 34*(4), 423-438. doi:10.1007/s10508-005-4342-9

Meyer-Bahlburg, H. F. L. (2008). Treatment guidelines for children with disorders of sex development. *Neuropsychiatrie De l'Enfance Et De l'Adolescence, 56*(6), 345-349. doi:10.1016/j.neurenf.2008.06.002

Meyer-Bahlburg, H. F. L. (2009). Variants of gender differentiation in somatic disorders of sex development. *International Journal of Transgenderism, 11*(4), 226-237. doi:10.1080/15532730903439476

Meyer-Bahlburg, H. F. L. (2010). From mental disorder to iatrogenic hypogonadism: Dilemmas in conceptualizing gender identity variants as psychiatric conditions. *Archives of Sexual Behavior, 39*(2), 461-476. doi:10.1007/s10508-009-9532-4

Meyer-Bahlburg, H. F. L. (in press). Gender monitoring and gender reassignment of children and adolescents with a somatic disorder of sex development. *Child & Adolescent Psychiatric Clinics of North America*.

Meyer-Bahlburg, H. F. L., & Blizzard, R. M. (2004). Conference proceedings: Research on intersex: Summary of a planning workshop. *The Endocrinologist, 14*(2), 59-69. doi:10.1097/01.ten.0000123701.61007.4e

Meyer-Bahlburg, H. F. L., Dolezal, C., Baker, S. W., Carlson, A. D., Obeid, J. S., & New, M. I. (2004). Prenatal androgenization affects gender-related behavior but not gender identity in 5–12-year-old girls with congenital adrenal hyperplasia. *Archives of Sexual Behavior, 33*(2), 97-104. doi:10.1023/B:ASEB.0000014324.25718.51

Meyer-Bahlburg, H. F. L., Dolezal, C., Baker, S. W., Ehrhardt, A. A., & New, M. I. (2006). Gender development in women with congenital adrenal hyperplasia as a function of disorder severity. *Archives of Sexual Behavior, 35*(6), 667-684. doi:10.1007/s10508-006-9068-9

Meyer-Bahlburg, H. F. L., Migeon, C. J., Berkovitz, G. D., Gearhart, J. P., Dolezal, C., & Wisniewski, A. B. (2004). Attitudes of adult 46,XY intersex persons to clinical management policies. *The Journal of Urology, 171*(4), 1615-1619. doi:10.1097/01.ju.0000117761.94734.b7

Money, J., & Ehrhardt, A. A. (1972). *Man and woman, boy and girl*. Baltimore, MD: The Johns Hopkins University Press.

Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/role in childhood: Longitudinal follow-up. *Journal of Pediatric Psychology, 4*(1), 29-41. doi:10.1093/jpepsy/4.1.29

Monstrey, S., Hoebeke, P., Selvaggi, G., Ceulemans, P., Van Landuyt, K., Blondeel, P., . . . De Cuypere, G. (2009). Penile reconstruction: Is the radial forearm flap really the standard technique? *Plastic and Reconstructive Surgery, 124*(2), 510-518.

Monstrey, S., Selvaggi, G., Ceulemans, P., Van Landuyt, K., Bowman, C., Blondeel, P., . . . De Cuypere, G. (2008). Chest-wall contouring surgery in female-to-male transsexuals: A new algorithm. *Plastic and Reconstructive Surgery, 121*(3), 849-859. doi:10.1097/01.prs.0000299921.15447.b2

Moore, E., Wisniewski, A., & Dobs, A. (2003). Endocrine treatment of transsexual people: A review of treatment regimens, outcomes, and adverse effects. *Journal of Clinical Endocrinology & Metabolism, 88*(8), 3467-3473. doi:10.1210/jc.2002-021967

More, S. D. (1998). The pregnant man-an oxymoron? *Journal of Gender Studies, 7*(3), 319-328. doi:10.1080/09589236.1998.9960725

Mount, K. H., & Salmon, S. J. (1988). Changing the vocal characteristics of a postoperative transsexual patient: A longitudinal study. *Journal of Communication Disorders, 21*(3), 229-238. doi:10.1016/0021-9924(88)90031-7

Mueller, A., Kiesewetter, F., Binder, H., Beckmann, M. W., & Dittrich, R. (2007). Long-term administration of testosterone undecanoate every 3 months for testosterone supplementation in female-to-male transsexuals. *Journal of Clinical Endocrinology & Metabolism, 92*(9), 3470-3475. doi:10.1210/jc.2007-0746

Murad, M. H., Elamin, M. B., Garcia, M. Z., Mullan, R. J., Murad, A., Erwin, P. J., & Montori, V. M. (2010). Hormonal therapy and sex reassignment: A systematic review and meta-analysis of quality of life and psychosocial outcomes. *Clinical Endocrinology, 72*(2), 214-231. doi:10.1111/j.1365-2265.2009.03625.x

Nanda, S. (1998). *Neither man nor woman: The hijras of India*. Belmont, CA: Wadsworth Publishing.

Nestle, J., Wilchins, R. A., & Howell, C. (2002). *Genderqueer: Voices from beyond the sexual binary*. Los Angeles, CA: Alyson Publications.

Neumann, K., & Welzel, C. (2004). The importance of voice in male-to-female transsexualism. *Journal of Voice, 18*(1), 153-167.

Newfield, E., Hart, S., Dibble, S., & Kohler, L. (2006). Female-to-male transgender quality of life. *Quality of Life Research, 15*(9), 1447-1457. doi:10.1007/s11136-006-0002-3

Nieschlag, E., Behre, H. M., Bouchard, P., Corrales, J. J., Jones, T. H., Stalla, G. K., . . . Wu, F. C. W. (2004). Testosterone replacement therapy: Current trends and future directions. *Human Reproduction Update, 10*(5), 409-419. doi:10.1093/humupd/dmh035

North American Menopause Society. (2010). Estrogen and progestogen use in postmenopausal women: 2010 position statement. *Menopause, 17*(2), 242-255. doi:10.1097/gme.0b013e3181d0f6b9

Nuttbrock, L., Hwahng, S., Bockting, W., Rosenblum, A., Mason, M., Macri, M., & Becker, J. (2010). Psychiatric impact of gender-related abuse across the life course of male-to-female transgender persons. *Journal of Sex Research, 47*(1), 12-23. doi:10.1080/00224490903062258

Oates, J. M., & Dacakis, G. (1983). Speech pathology considerations in the management of transsexualism-a review. *International Journal of Language & Communication Disorders, 18*(3), 139-151. doi:10.3109/13682828309012237

Olyslager, F., & Conway, L. (2007). On the calculation of the prevalence of transsexualism. Paper presented at the *World Professional Association for Transgender Health 20th International Symposium,* Chicago, Illinois. Retrieved April 22, 2010 from http://www.changelingaspects.com/PDF/2007-09-06-Prevalence_of_Transsexualism.pdf

Oriel, K. A. (2000). Clinical update: Medical care of transsexual patients. *Journal of the Gay and Lesbian Medical Association, 4*(4), 185-194. doi:1090-7173/00/1200-0185$18.00/1

Pauly, I. B. (1965). Male psychosexual inversion: Transsexualism: A review of 100 cases. *Archives of General Psychiatry, 13*(2), 172-181.

Payer, A. F., Meyer III, W. J., & Walker, P. A. (1979). The ultrastructural response of human leydig cells to exogenous estrogens. *Andrologia, 11*(6), 423-436. doi:10.1111/j.1439-0272.1979.tb02232.x

Peletz, M. G. (2006). Transgenderism and gender pluralism in southeast asia since early modern times. *Current Anthropology, 47*(2), 309-340. doi:10.1086/498947

Pfäfflin, F. (1993). Regrets after sex reassignment surgery. *Journal of Psychology & Human Sexuality, 5*(4), 69-85.

Pfäfflin, F., & Junge, A. (1998). Sex reassignment. Thirty years of international follow-up studies after sex reassignment surgery: A comprehensive review, 1961-1991. *International Journal of Transgenderism*. Retrieved from http://web.archive.org/web/20070503090247/http://www.symposion.com/ijt/pfaefflin/1000.htm

Physicians' desk reference. (61st ed.). (2007). Montvale, NJ: PDR.

Physicians' desk reference. (65th ed.). (2010). Montvale, NJ: PDR.

Pleak, R. R. (1999). Ethical issues in diagnosing and treating gender-dysphoric children and adolescents. In M. Rottnek (Ed.), *Sissies and tomboys: Gender noncomformity and homosexual childhood* (pp. 34-51). New York: New York University Press.

Pope, K. S., & Vasquez, M. J. (2011). *Ethics in psychotherapy and counseling: A practical guide* (Fourth ed.). Hoboken, NJ: John Wiley & Sons, Inc.

Prior, J. C., Vigna, Y. M., & Watson, D. (1989). Spironolactone with physiological female steroids for presurgical therapy of male-to-female transsexualism. *Archives of Sexual Behavior, 18*(1), 49-57. doi:10.1007/BF01579291

Prior, J. C., Vigna, Y. M., Watson, D., Diewold, P., & Robinow, O. (1986). Spironolactone in the presurgical therapy of male to female transsexuals: Philosophy and experience of the Vancouver Gender Dysphoria Clinic. *Journal of Sex Information & Education Council of Canada, 1*, 1-7.

Rachlin, K. (1999). Factors which influence individual's decisions when considering female-to-male genital reconstructive surgery. *International Journal of Transgenderism, 3*(3). Retrieved from http://www.WPATH.org

Rachlin, K. (2002). Transgendered individuals' experiences of psychotherapy. *International Journal of Transgenderism, 6*(1). Retrieved from http://www.wpath.org/journal/www.iiav.nl
/ezines/web/IJT/97-03/numbers/symposion/ijtvo06no01_03.htm.

Rachlin, K., Green, J., & Lombardi, E. (2008). Utilization of health care among female-to-male transgender individuals in the United States. *Journal of Homosexuality, 54*(3), 243-258. doi:10.1080/00918360801982124

Rachlin, K., Hansbury, G., & Pardo, S. T. (2010). Hysterectomy and oophorectomy experiences of female-to-male transgender individuals. *International Journal of Transgenderism, 12*(3), 155-166. doi:10.1080/15532739.2010.514220

Reed, B., Rhodes, S., Schofield, P. & Wylie, K. (2009). *Gender variance in the UK: Prevalence, incidence, growth and geographic distribution.* Retrieved June 8, 2011, from http://www.gires.org.uk/assets/Medpro-Assets/GenderVarianceUK-report.pdf

Rehman, J., Lazer, S., Benet, A. E., Schaefer, L. C., & Melman, A. (1999). The reported sex and surgery satisfactions of 28 postoperative male-to-female transsexual patients. *Archives of Sexual Behavior, 28*(1), 71-89. doi:10.1023/A:1018745706354

Robinow, O. (2009). Paraphilia and transgenderism: A connection with Asperger's disorder? *Sexual and Relationship Therapy, 24*(2), 143-151. doi:10.1080/14681990902951358

Rosenberg, M. (2002). Children with gender identity issues and their parents in individual and group treatment. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*(5), 619-621. doi:10.1097/00004583-200205000-00020

Rossouw, J. E., Anderson, G. L., Prentice, R. L., LaCroix, A. Z., Kooperberg, C., Stefanick, M. L., . . . Johnson, K. C. (2002). Risks and benefits of estrogen plus progestin in healthy postmenopausal women: Principal results from the women's health initiative randomized controlled trial. *JAMA: The Journal of the American Medical Association, 288*(3), 321-333.

Royal College of Speech Therapists, United Kingdom. http://www.rcslt.org/

Ruble, D. N., Martin, C. L., & Berenbaum, S. A. (2006). Gender development. In N. Eisenberg, W. Damon & R. M. Lerner (Eds.), *Handbook of child psychology* (6th ed., pp. 858-932). Hoboken, NJ: John Wiley & Sons, Inc.

Sausa, L. A. (2005). Translating research into practice: Trans youth recommendations for improving school systems. *Journal of Gay & Lesbian Issues in Education, 3*(1), 15-28. doi:10.1300/J367v03n01_04

Simpson, J. L., de la Cruz, F., Swerdloff, R. S., Samango-Sprouse, C., Skakkebaek, N. E., Graham, J. M. J., . . . Willard, H. F. (2003). Klinefelter syndrome: Expanding the phenotype and identifying new research directions. *Genetics in Medicine, 5*(6), 460-468. doi:10.1097/01.GIM.0000095626.54201.D0

Smith, Y. L. S., Van Goozen, S. H. M., Kuiper, A. J., & Cohen-Kettenis, P. T. (2005). Sex reassignment: Outcomes and predictors of treatment for adolescent and adult transsexuals. *Psychological Medicine, 35*(1), 89-99. doi:10.1017/S0033291704002776

Sood, R., Shuster, L., Smith, R., Vincent, A., & Jatoi, A. (2011). Counseling postmenopausal women about bioidentical hormones: Ten discussion points for practicing physicians. *Journal of the American Board of Family Practice, 24*(2), 202-210. doi:10.3122/jabfm.2011.02.100194

Speech Pathology Australia. http://www.speechpathologyaustralia.org.au/

Speiser, P. W., Azziz, R., Baskin, L. S., Ghizzoni, L., Hensle, T. W., Merke, D. P., . . . Oberfield, S. E. (2010). Congenital adrenal hyperplasia due to steroid 21-hydroxylase deficiency: An endocrine society clinical practice guideline. *Journal of Clinical Endocrinology & Metabolism, 95*(9), 4133-4160. doi:10.1210/jc.2009-2631

Steensma, T. D., Biemond, R., de Boer, F., & Cohen-Kettenis, P. T. (2011). Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study. *Clinical Child Psychology and Psychiatry*. Advance online publication. doi:10.1177/1359104510378303

Steensma, T. D., & Cohen-Kettenis, P. T. (2011). Gender transitioning before puberty? *Archives of Sexual Behavior, 40*(4), 649-650. doi:10.1007/s10508-011-9752-2

Stikkelbroeck, N. M. M. L., Beerendonk, C., Willemsen, W. N. P., Schreuders-Bais, C. A., Feitz, W. F. J., Rieu, P. N. M. A., . . . Otten, B. J. (2003). The long term outcome of feminizing genital surgery for congenital adrenal hyperplasia: Anatomical, functional and cosmetic outcomes, psychosexual development, and satisfaction in adult female patients. *Journal of Pediatric and Adolescent Gynecology, 16*(5), 289-296. doi:10.1016/S1083-3188(03)00155-4

Stoller, R. J. (1964). A contribution to the study of gender identity. *International Journal of Psychoanalysis, 45*, 220-226.

Stone, S. (1991). The empire strikes back: A posttransexual manifesto. In J. Epstein, & K. Straub (Eds.), *Body guards: The cultural politics of gender ambiguity* (pp. 280-304). London: Routledge.

Tangpricha, V., Ducharme, S. H., Barber, T. W., & Chipkin, S. R. (2003). Endocrinologic treatment of gender identity disorders. *Endocrine Practice, 9*(1), 12-21.

Tangpricha, V., Turner, A., Malabanan, A., & Holick, M. (2001). Effects of testosterone therapy on bone mineral density in the FTM patient. *International Journal of Transgenderism, 5*(4).

Taywaditep, K. J., Coleman, E., & Dumronggittigule, P. (1997). Thailand (muang thai). In R. Francouer (Ed.), *International encyclopedia of sexuality*. New York: Continuum.

The World Professional Association for Transgender Health, Inc. (2008). *WPATH clarification on medical necessity of treatment, sex reassignment, and insurance coverage in the U.S.A.* Retrieved from http://www.wpath.org/documents/Med%20Nec%20on%202008%20Letterhead.pdf

Thole, Z., Manso, G., Salgueiro, E., Revuelta, P., & Hidalgo, A. (2004). Hepatotoxicity induced by antiandrogens: A review of the literature. *Urologia Internationalis, 73*(4), 289-295. doi:10.1159/000081585

Tom Waddell Health Center. (2006). *Protocols for hormonal reassignment of gender.* Retrieved from http://www.sfdph.org/dph/comupg/oservices/medSvs/hlthCtrs/TransGendprotocols122006.pdf

Tsoi, W. F. (1988). The prevalence of transsexualism in Singapore. *Acta Psychiatrica Scandinavica, 78*(4), 501-504. doi:10.1111/j.1600-0447.1988.tb06373.x

Van den Broecke, R., Van der Elst, J., Liu, J., Hovatta, O., & Dhont, M. (2001). The female-to-male transsexual patient: A source of human ovarian cortical tissue for experimental use. *Human Reproduction, 16*(1), 145-147. doi:10.1093/humrep/16.1.145

van Kesteren, P. J. M., Asscheman, H., Megens, J. A. J., & Gooren, L. J. G. (1997). Mortality and morbidity in transsexual subjects treated with cross-sex hormones. *Clinical Endocrinology, 47*(3), 337-343. doi:10.1046/j.1365-2265.1997.2601068.x

van Kesteren, P. J. M., Gooren, L. J., & Megens, J. A. (1996). An epidemiological and demographic study of transsexuals in the Netherlands. *Archives of Sexual Behavior, 25*(6), 589-600. doi:10.1007/BF02437841

van Trotsenburg, M. A. A. (2009). Gynecological aspects of transgender healthcare. *International Journal of Transgenderism, 11*(4), 238-246. doi:10.1080/15532730903439484

Vancouver Coastal Health, Vancouver, British Columbia, Canada. http://www.vch.ca/

Vanderburgh, R. (2009). Appropriate therapeutic care for families with pre-pubescent transgender/gender-dissonant children. *Child and Adolescent Social Work Journal, 26*(2), 135-154. doi:10.1007/s10560-008-0158-5

Vilain, E. (2000). Genetics of sexual development. *Annual Review of Sex Research, 11*, 1-25.

Wålinder, J. (1968). Transsexualism: Definition, prevalence and sex distribution. *Acta Psychiatrica Scandinavica, 43*(S203), 255-257.

Wålinder, J. (1971). Incidence and sex ratio of transsexualism in Sweden. *The British Journal of Psychiatry, 119*(549), 195-196.

Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child & Adolescent Psychiatry, 47*(12), 1413-1423. doi:10.1097/CHI.0b013e31818956b9

Wallien, M. S. C., Swaab, H., & Cohen-Kettenis, P. T. (2007). Psychiatric comorbidity among children with gender identity disorder. *Journal of the American Academy of Child & Adolescent Psychiatry, 46*(10), 1307-1314. doi:10.1097/chi.0b013e3181373848

Warren, B. E. (1993). Transsexuality, identity and empowerment. A view from the frontlines. *SIECUS Report, February/March,* 14-16.

Weitze, C., & Osburg, S. (1996). Transsexualism in Germany: Empirical data on epidemiology and application of the German Transsexuals' Act during its first ten years. *Archives of Sexual Behavior, 25*(4), 409-425.

Wilson, J. D. (1999). The role of androgens in male gender role behavior. *Endocrine Reviews, 20*(5), 726-737. doi:10.1210/er.20.5.726

Winter, S. (2009). Cultural considerations for The World Professional Association for Transgender Health's standards of care: The Asian perspective. *International Journal of Transgenderism, 11*(1), 19-41. doi:10.1080/15532730902799938

Winter, S., Chalungsooth, P., Teh, Y. K., Rojanalert, N., Maneerat, K., Wong, Y. W., . . . Macapagal, R. A. (2009). Transpeople, transprejudice and pathologization: A seven-country factor analytic study. *International Journal of Sexual Health, 21*(2), 96-118. doi:10.1080/19317610902922537

Wisniewski, A. B., Migeon, C. J., Malouf, M. A., & Gearhart, J. P. (2004). Psychosexual outcome in women affected by congenital adrenal hyperplasia due to 21-hydroxylase deficiency. *The Journal of Urology, 171*(6, Part 1), 2497-2501. doi:10.1097/01.ju.0000125269.91938.f7

World Health Organization. (2007). *International classification of diseases and related health problems-10th revision*. Geneva, Switzerland: World Health Organization.

World Health Organization. (2008). *The world health report 2008: Primary health care - now more than ever*. Geneva, Switzerland: World Health Organization.

WPATH Board of Directors. (2010). *De-psychopathologisation statement released May 26, 2010.* Retrieved from http://wpath.org/announcements_detail.cfm?pk_announcement=17

Xavier, J. M. (2000). *The Washington, D.C. transgender needs assessment survey: Final report for phase two*. Washington, DC: Administration for HIV/AIDS of District of Columbia Government.

Zhang, G., Gu, Y., Wang, X., Cui, Y., & Bremner, W. J. (1999). A clinical trial of injectable testosterone undecanoate as a potential male contraceptive in normal Chinese men. *Journal of Clinical Endocrinology & Metabolism, 84*(10), 3642-3647. doi:10.1210/jc.84.10.3642

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 295 of 371Total Pages:(295 of 1263)

Zitzmann, M., Saad, F., & Nieschlag, E. (2006, April). *Long term experience of more than 8 years with a novel formulation of testosterone undecanoate (nebido) in substitution therapy of hypogonadal men*. Paper presented at European Congress of Endocrinology, Glasgow, UK, April 2006.

Zucker, K. J. (1999). Intersexuality and gender identity differentiation. *Annual Review of Sex Research, 10*(1), 1-69.

Zucker, K. J. (2004). Gender identity development and issues. *Child and Adolescent Psychiatric Clinics of North America, 13*(3), 551-568. doi:10.1016/j.chc.2004.02.006

Zucker, K. J. (2006). 'I'm half-boy, half-girl'': Play psychotherapy and parent counseling for gender identity disorder. In R. L. Spitzer, M. B. First, J. B. W. Williams & M. Gibbons (Eds.), *DSM-IV-TR casebook, volume 2* (pp. 321-334). Arlington, VA: American Psychiatric Publishing, Inc.

Zucker, K. J. (2010). The DSM diagnostic criteria for gender identity disorder in children. *Archives of Sexual Behavior, 39*(2), 477-498. doi:10.1007/s10508-009-9540-4

Zucker, K. J., & Bradley, S. J. (1995). *Gender identity disorder and psychosexual problems in children and adolescents*. New York: Guilford Press.

Zucker, K. J., Bradley, S. J., Owen-Anderson, A., Kibblewhite, S. J., & Cantor, J. M. (2008). Is gender identity disorder in adolescents coming out of the closet? *Journal of Sex & Marital Therapy, 34*(4), 287-290. doi:10.1080/00926230802096192

Zucker, K. J., Bradley, S. J., Owen-Anderson, A., Kibblewhite, S. J., Wood, H., Singh, D., & Choi, K. (in press). Demographics, behavior problems, and psychosexual characteristics of adolescents with gender identity disorder or transvestic fetishism. *Journal of Sex & Marital Therapy*.

Zucker, K. J., & Lawrence, A. A. (2009). Epidemiology of gender identity disorder: Recommendations for the standards of care of The World Professional Association for Transgender Health. *International Journal of Transgenderism, 11*(1), 8-18. doi:10.1080/15532730902799946

Zucker, K. J., Owen, A., Bradley, S. J., & Ameeriar, L. (2002). Gender-dysphoric children and adolescents: A comparative analysis of demographic characteristics and behavioral problems. *Clinical Child Psychology and Psychiatry, 7*(3), 398-411.

Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. *Journal of Nervous and Mental Disease, 172*(2), 90-97.

APPENDIX A
GLOSSARY

Terminology in the area of health care for transsexual, transgender, and gender nonconforming people is rapidly evolving; new terms are being introduced, and the definitions of existing terms are changing. Thus, there is often misunderstanding, debate, or disagreement about language in this field. Terms that may be unfamiliar or that have specific meanings in the *SOC* are defined below for the purpose of this document only. Others may adopt these definitions, but WPATH acknowledges that these terms may be defined differently in different cultures, communities, and contexts.

WPATH also acknowledges that many terms used in relation to this population are not ideal. For example, the terms *transsexual* and *transvestite* – and, some would argue, the more recent term *transgender* – have been applied to people in an objectifying fashion. Yet such terms have been more or less adopted by many people who are making their best effort to make themselves understood. By continuing to use these terms, WPATH intends only to ensure that concepts and processes are comprehensible, in order to facilitate the delivery of quality health care to transsexual, transgender, and gender nonconforming people. WPATH remains open to new terminology that will further illuminate the experience of members of this diverse population and lead to improvements in health care access and delivery.

Bioidentical hormones: Hormones that are *structurally* identical to those found in the human body (ACOG Committee of Gynecologic Practice, 2005). The hormones used in bioidentical hormone therapy (BHT) are generally derived from plant sources and are structurally similar to endogenous human hormones, but they need to be commercially processed to become bioidentical.

Bioidentical compounded hormone therapy (BCHT): Use of hormones that are prepared, mixed, assembled, packaged, or labeled as a drug by a pharmacist and custom-made for a patient according to a physician's specifications. Government drug agency approval is not possible for each compounded product made for an individual consumer.

Crossdressing (transvestism): Wearing clothing and adopting a gender role presentation that, in a given culture, is more typical of the other sex.

Disorders of sex development (DSD): Congenital conditions in which the development of chromosomal, gonadal, or anatomic sex is atypical. Some people strongly object to the "disorder" label and instead view these conditions as a matter of diversity (Diamond, 2009), preferring the terms *intersex* and *intersexuality*.

Female-to-Male (FtM): Adjective to describe individuals assigned female at birth who are changing or who have changed their body and/or gender role from birth-assigned female to a more masculine body or role.

Gender dysphoria: Distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

Gender identity: A person's intrinsic sense of being male (a boy or a man), female (a girl or woman), or an alternative gender (e.g., boygirl, girlboy, transgender, genderqueer, eunuch) (Bockting, 1999; Stoller, 1964).

Gender identity disorder: Formal diagnosis set forth by the *Diagnostic Statistical Manual of Mental Disorders, 4th Edition, Text Rev (DSM IV-TR)* (American Psychiatric Association, 2000). Gender identity disorder is characterized by a strong and persistent cross-gender identification and a persistent discomfort with one's sex or sense of inappropriateness in the gender role of that sex, causing clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Gender nonconforming: Adjective to describe individuals whose gender identity, role, or expression differs from what is normative for their assigned sex in a given culture and historical period.

Gender role or expression: Characteristics in personality, appearance, and behavior that in a given culture and historical period are designated as masculine or feminine (that is, more typical of the male or female social role) (Ruble, Martin, & Berenbaum, 2006). While most individuals present socially in clearly male or female gender roles, some people present in an alternative gender role such as genderqueer or specifically transgender. All people tend to incorporate both masculine and feminine characteristics in their gender expression in varying ways and to varying degrees (Bockting, 2008).

Genderqueer: Identity label that may be used by individuals whose gender identity and/or role does not conform to a binary understanding of gender as limited to the categories of man or woman, male or female (Bockting, 2008).

Male-to-Female (MtF): Adjective to describe individuals assigned male at birth who are changing or who have changed their body and/or gender role from birth-assigned male to a more feminine body or role.

Natural hormones: Hormones that are derived from natural *sources* such as plants or animals. Natural hormones may or may not be bioidentical.

Sex: Sex is assigned at birth as male or female, usually based on the appearance of the external genitalia. When the external genitalia are ambiguous, other components of sex (internal genitalia, chromosomal and hormonal sex) are considered in order to assign sex (Grumbach, Hughes, & Conte,

2003; MacLaughlin & Donahoe, 2004; Money & Ehrhardt, 1972; Vilain, 2000). For most people, gender identity and expression are consistent with their sex assigned at birth; for transsexual, transgender, and gender nonconforming individuals, gender identity or expression differ from their sex assigned at birth.

Sex reassignment surgery (gender affirmation surgery): Surgery to change primary and/or secondary sex characteristics to affirm a person's gender identity. Sex reassignment surgery can be an important part of medically necessary treatment to alleviate gender dysphoria.

Transgender: Adjective to describe a diverse group of individuals who cross or transcend culturally-defined categories of gender. The gender identity of transgender people differs to varying degrees from the sex they were assigned at birth (Bockting, 1999).

Transition: Period of time when individuals change from the gender role associated with their sex assigned at birth to a different gender role. For many people, this involves learning how to live socially in "the other" gender role; for others this means finding a gender role and expression that is most comfortable for them. Transition may or may not include feminization or masculinization of the body through hormones or other medical procedures. The nature and duration of transition is variable and individualized.

Transphobia, internalized: Discomfort with one's own transgender feelings or identity as a result of internalizing society's normative gender expectations.

Transsexual: Adjective (often applied by the medical profession) to describe individuals who seek to change or who have changed their primary and/or secondary sex characteristics through femininizing or masculinizing medical interventions (hormones and/or surgery), typically accompanied by a permanent change in gender role.

APPENDIX B
OVERVIEW OF MEDICAL RISKS OF HORMONE THERAPY

The risks outlined below are based on two comprehensive, evidence-based literature reviews of masculinizing/feminizing hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009), along with a large cohort study (Asscheman et al., 2011). These reviews can serve as detailed references for providers, along with other widely recognized, published clinical materials (e.g., Dahl et al., 2006; Ettner et al., 2007).

Risks of Feminizing Hormone Therapy (MtF)

Likely increased risk:

Venous thromboembolic disease

- Estrogen use increases the risk of venous thromboembolic events (VTE), particularly in patients who are over age 40, smokers, highly sedentary, obese, and who have underlying thrombophilic disorders.
- This risk is increased with the additional use of third generation progestins.
- This risk is decreased with use of the transdermal route of estradiol administration, which is recommended for patients at higher risk of VTE.

Cardiovascular, cerebrovascular disease

- Estrogen use increases the risk of cardiovascular events in patients over age 50 with underlying cardiovascular risk factors. Additional progestin use may increase this risk.

Lipids

- Oral estrogen use may markedly increase triglycerides in patients, increasing the risk of pancreatitis and cardiovascular events.
- Different routes of administration will have different metabolic effects on levels of HDL cholesterol, LDL cholesterol and lipoprotein(a).
- In general, clinical evidence suggests that MtF patients with pre-existing lipid disorders may benefit from the use of transdermal rather than oral estrogen.

Liver/gallbladder

- Estrogen and cyproterone acetate use may be associated with transient liver enzyme elevations and, rarely, clinical hepatotoxicity.
- Estrogen use increases the risk of cholelithiasis (gall stones) and subsequent cholecystectomy.

Possible increased risk:

Type 2 diabetes mellitus

- Feminizing hormone therapy, particularly estrogen, may increase the risk of type 2 diabetes, particularly among patients with a family history of diabetes or other risk factors for this disease.

Hypertension

- Estrogen use may increase blood pressure, but the effect on incidence of overt hypertension is unknown.
- Spironolactone reduces blood pressure and is recommended for at-risk or hypertensive patients desiring feminization.

Prolactinoma

- Estrogen use increases the risk of hyperprolactinemia among MtF patients in the first year of treatment, but this risk unlikely thereafter.
- High-dose estrogen use may promote the clinical appearance of preexisting but clinically unapparent prolactinoma.

Inconclusive or no increased risk: Items in this category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Breast cancer

- MtF persons who have taken feminizing hormones do experience breast cancer, but it is unknown how their degree of risk compares to that of persons born with female genitalia.
- Longer duration of feminizing hormone exposure (i.e., number of years taking estrogen preparations), family history of breast cancer, obesity (BMI >35), and the use of progestins likely influence the level of risk.

Other side effects of feminizing therapy:

The following effects may be considered minor or even desired, depending on the patient, but are clearly associated with feminizing hormone therapy.

Fertility and sexual function

- Feminizing hormone therapy may impair fertility.
- Feminizing hormone therapy may decrease libido.
- Feminizing hormone therapy reduces nocturnal erections, with variable impact on sexually stimulated erections.

Risks of anti-androgen medications:

Feminizing hormone regimens often include a variety of agents that affect testosterone production or action. These include GnRH agonists, progestins (including cyproterone acetate), spironolactone, and 5-alpha reductase inhibitors. An extensive discussion of the specific risks of these agents is beyond the scope of the *SOC*. However, both spironolactone and cyproterone acetate are widely used and deserve some comment.

Cyproterone acetate is a progestational compound with anti-androgenic properties (Gooren, 2005; Levy et al., 2003). Although widely used in Europe, it is not approved for use in the United States because of concerns about hepatotoxicity (Thole, Manso, Salgueiro, Revuelta, & Hidalgo, 2004). Spironolactone is commonly used as an anti-androgen in feminizing hormone therapy, particularly in regions where cyproterone is not approved for use (Dahl et al., 2006; Moore et al., 2003; Tangpricha et al., 2003). Spironolactone has a long history of use in treating hypertension and congestive heart failure. Its common side effects include hyperkalemia, dizziness, and gastrointestinal symptoms (*Physicians' Desk Reference*, 2007).

Risks of Masculinizing Hormone Therapy (FtM)

Likely increased risk:

Polycythemia

- Masculinizing hormone therapy involving testosterone or other androgenic steroids increases the risk of polycythemia (hematocrit > 50%), particularly in patients with other risk factors.
- Transdermal administration and adaptation of dosage may reduce this risk

Weight gain/visceral fat

- Masculinizing hormone therapy can result in modest weight gain, with an increase in visceral fat.

Possible increased risk:

Lipids

- Testosterone therapy decreases HDL, but variably affects LDL and triglycerides.
- Supraphysiologic (beyond normal male range) serum levels of testosterone, often found with extended intramuscular dosing, may worsen lipid profiles, whereas transdermal administration appears to be more lipid neutral.
- Patients with underlying polycystic ovarian syndrome or dyslipidemia may be at increased risk of worsening dyslipidemia with testosterone therapy.

Liver

- Transient elevations in liver enzymes may occur with testosterone therapy.
- Hepatic dysfunction and malignancies have been noted with oral methyltestosterone. However, methyltestosterone is no longer available in most countries and should no longer be used.

Psychiatric

Masculinizing therapy involving testosterone or other androgenic steroids may increase the risk of hypomanic, manic, or psychotic symptoms in patients with underlying psychiatric disorders that include such symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone

Inconclusive or no increased risk: Items in this category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Osteoporosis

- Testosterone therapy maintains or increases bone mineral density among FtM patients prior to oophorectomy, at least in the first three years of treatment.
- There is an increased risk of bone density loss after oophorectomy, particularly if testosterone therapy is interrupted or insufficient. This includes patients utilizing solely oral testosterone.

Cardiovascular

- Masculinizing hormone therapy at normal physiologic doses does not appear to increase the risk of cardiovascular events among healthy patients.
- Masculinizing hormone therapy may increase the risk of cardiovascular disease in patients with underlying risks factors.

Hypertension

- Masculinizing hormone therapy at normal physiologic doses may increase blood pressure but does not appear to increase the risk of hypertension.
- Patients with risk factors for hypertension, such as weight gain, family history, or polycystic ovarian syndrome, may be at increased risk.

Type 2 diabetes mellitus

- Testosterone therapy does not appear to increase the risk of type 2 diabetes among FtM patients overall.

- Testosterone therapy may further increase the risk of type 2 diabetes in patients with other risk factors, such as significant weight gain, family history, and polycystic ovarian syndrome. There are no data that suggest or show an increase in risk in those with risk factors for dyslipidemia.

Breast cancer

- Testosterone therapy in FtM patients does not increase the risk of breast cancer.

Cervical cancer

- Testosterone therapy in FtM patients does not increase the risk of cervical cancer, although it may increase the risk of minimally abnormal Pap smears due to atrophic changes.

Ovarian cancer

- Analogous to persons born with female genitalia with elevated androgen levels, testosterone therapy in FtM patients may increase the risk of ovarian cancer, although evidence is limited.

Endometrial (uterine) cancer

- Testosterone therapy in FtM patients may increase the risk of endometrial cancer, although evidence is limited.

Other side effects of masculinizing therapy:

The following effects may be considered minor or even desired, depending on the patient, but are clearly associated with masculinization.

Fertility and sexual function

- Testosterone therapy in FtM patients reduces fertility, although the degree and reversibility are unknown.
- Testosterone therapy can induce permanent anatomic changes in the developing embryo or fetus.
- Testosterone therapy induces clitoral enlargement and increases libido.

Acne, androgenic alopecia

Acne and varying degrees of male pattern hair loss (androgenic alopecia) are common side effects of masculinizing hormone therapy.

APPENDIX C
SUMMARY OF CRITERIA FOR HORMONE THERAPY AND SURGERIES

As for all previous versions of the *SOC*, the criteria put forth in the *SOC* for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable to accumulate new data, which can be retrospectively examined to allow for health care – and the *SOC* – to evolve.

Criteria for Feminizing/Masculinizing Hormone Therapy (one referral or chart documentation of psychosocial assessment)

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental concerns are present, they must be reasonably well-controlled.

Criteria for Breast/Chest Surgery (one referral)

Mastectomy and creation of a male chest in FtM patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a pre-requisite.

Breast augmentation (implants/lipofilling) in MtF patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

Criteria for genital surgery (two referrals)

Hysterectomy and ovariectomy in FtM patients and orchiectomy in MtF patients:

1. Persistent, well documented gender dysphoria;

2. Capacity to make a fully informed decision and to consent for treatment;

3. Age of majority in a given country;

4. If significant medical or mental health concerns are present, they must be well controlled;

5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before a patient undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these surgical procedures for medical indications other than gender dysphoria.

Metoidioplasty or phalloplasty in FtM patients and vaginoplasty in MtF patients:

1. Persistent, well documented gender dysphoria;

2. Capacity to make a fully informed decision and to consent for treatment;

3. Age of majority in a given country;

4. If significant medical or mental health concerns are present, they must be well controlled;

5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones);

6. 12 continuous months of living in a gender role that is congruent with their gender identity.

Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

The criterion noted above for some types of genital surgeries – i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity – is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery.

APPENDIX D
EVIDENCE FOR CLINICAL OUTCOMES OF THERAPEUTIC APPROACHES

One of the real supports for any new therapy is an outcome analysis. Because of the controversial nature of sex reassignment surgery, this type of analysis has been very important. Almost all of the outcome studies in this area have been retrospective.

One of the first studies to examine the post-treatment psychosocial outcomes of transsexual patients was done in 1979 at Johns Hopkins University School of Medicine and Hospital (USA) (J. K. Meyer & Reter, 1979). This study focused on patients' occupational, educational, marital, and domiciliary stability. The results revealed several significant changes with treatment. These changes were not seen as positive; rather, they showed that many individuals who had entered the treatment program were no better off or were worse off in many measures after participation in the program. These findings resulted in closure of the treatment program at that hospital/medical school (Abramowitz, 1986).

Subsequently, a significant number of health professionals called for a standard for eligibility for sex reassignment surgery. This led to the formulation of the original *Standards of Care* of the Harry Benjamin International Gender Dysphoria Association (now WPATH) in 1979.

In 1981, Pauly published results from a large retrospective study of people who underwent sex reassignment surgery. Participants in that study had much better outcomes: Among 83 FtM patients, 80.7% had a satisfactory outcome (i.e., patient self report of "improved social and emotional adjustment"), 6.0% unsatisfactory. Among 283 MtF patients, 71.4% had a satisfactory outcome, 8.1% unsatisfactory. This study included patients who were treated before the publication and use of the *Standards of Care*.

Since the *Standards of Care* have been in place, there has been a steady increase in patient satisfaction and decrease in dissatisfaction with the outcome of sex reassignment surgery. Studies conducted after 1996 focused on patients who were treated according to the *Standards of Care*. The findings of Rehman and colleagues (1999) and Krege and colleagues (2001) are typical of this body of work; none of the patients in these studies regretted having had surgery, and most reported being satisfied with the cosmetic and functional results of the surgery. Even patients who develop severe surgical complications seldom regret having undergone surgery. Quality of surgical results is one of the best predictors of the overall outcome of sex reassignment (Lawrence, 2003). The vast majority of follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well being, cosmesis, and sexual function (De Cuypere et al., 2005; Garaffa, Christopher, & Ralph, 2010; Klein & Gorzalka, 2009), although the specific magnitude of benefit is uncertain from

the currently available evidence. One study (Emory, Cole, Avery, Meyer, & Meyer III, 2003) even showed improvement in patient income.

One troubling report (Newfield et al., 2006) documented lower scores on quality of life (measured with the SF-36) for FtM patients than for the general population. A weakness of that study is that it recruited its 384 participants by a general email rather than a systematic approach, and the degree and type of treatment was not recorded. Study participants who were taking testosterone had typically being doing so for less than 5 years. Reported quality of life was higher for patients who had undergone breast/chest surgery than for those who had not ($p<.001$). (A similar analysis was not done for genital surgery). In other work, Kuhn and colleagues (2009) used the King's Health Questionnaire to assess the quality of life of 55 transsexual patients at 15 years after surgery. Scores were compared to those of 20 healthy female control patients who had undergone abdominal/pelvic surgery in the past. Quality of life scores for transsexual patients were the same or better than those of control patients for some subscales (emotions, sleep, incontinence, symptom severity, and role limitation), but worse in other domains (general health, physical limitation, and personal limitation).

It is difficult to determine the effectiveness of hormones alone in the relief of gender dysphoria. Most studies evaluating the effectiveness of masculinizing/feminizing hormone therapy on gender dysphoria have been conducted with patients who have also undergone sex reassignment surgery. Favorable effects of therapies that included both hormones and surgery were reported in a comprehensive review of over 2000 patients in 79 studies (mostly observational) conducted between 1961 and 1991 (Eldh, Berg, & Gustafsson, 1997; Gijs & Brewaeys, 2007; Murad et al., 2010; Pfäfflin & Junge, 1998). Patients operated on after 1986 did better than those before 1986; this reflects significant improvement in surgical complications (Eldh et al., 1997). Most patients have reported improved psychosocial outcomes, ranging between 87% for MtF patients and 97% for FtM patients (Green & Fleming, 1990). Similar improvements were found in a Swedish study in which "almost all patients were satisfied with sex reassignment at 5 years, and 86% were assessed by clinicians at follow-up as stable or improved in global functioning" (Johansson, Sundbom, Höjerback, & Bodlund, 2010). Weaknesses of these earlier studies are their retrospective design and use of different criteria to evaluate outcomes.

A prospective study conducted in the Netherlands evaluated 325 consecutive adult and adolescent subjects seeking sex reassignment (Smith, Van Goozen, Kuiper, & Cohen-Kettenis, 2005). Patients who underwent sex reassignment therapy (both hormonal and surgical intervention) showed improvements in their mean gender dysphoria scores, measured by the Utrecht Gender Dysphoria Scale. Scores for body dissatisfaction and psychological function also improved in most categories. Fewer than 2% of patients expressed regret after therapy. This is the largest prospective study to affirm the results from retrospective studies that a combination of hormone therapy and surgery improves gender dysphoria and other areas of psychosocial functioning. There is a need for further research on the effects of hormone therapy without surgery, and without the goal of maximum physical feminization or masculinization.

Overall, studies have been reporting a steady improvement in outcomes as the field becomes more advanced. Outcome research has mainly focused on the outcome of sex reassignment surgery. In current practice there is a range of identity, role, and physical adaptations that could use additional follow-up or outcome research (Institute of Medicine, 2011).

APPENDIX E
DEVELOPMENT PROCESS FOR THE STANDARDS OF CARE, VERSION 7

The process of developing *Standards of Care, Version 7* began when an initial *SOC* "work group" was established in 2006. Members were invited to examine specific sections of *SOC, Version 6*. For each section, they were asked to review the relevant literature, identify where research was lacking and needed, and recommend potential revisions to the *SOC* as warranted by new evidence. Invited papers were submitted by the following authors: Aaron Devor, Walter Bockting, George Brown, Michael Brownstein, Peggy Cohen-Kettenis, Griet DeCuypere, Petra DeSutter, Jamie Feldman, Lin Fraser, Arlene Istar Lev, Stephen Levine, Walter Meyer, Heino Meyer-Bahlburg, Stan Monstrey, Loren Schechter, Mick van Trotsenburg, Sam Winter, and Ken Zucker. Some of these authors chose to add co-authors to assist them in their task.

Initial drafts of these papers were due June 1, 2007. Most were completed by September 2007, with the rest completed by the end of 2007. These manuscripts were then submitted to the *International Journal of Transgenderism (IJT)*. Each underwent the regular *IJT* peer review process. The final papers were published in Volume 11 (1-4) in 2009, making them available for discussion and debate.

After these articles were published, a *Standards of Care* Revision Committee was established by the WPATH Board of Directors in 2010. The Revision Committee was first charged with debating and discussing the *IJT* background papers through a Google website. A subgroup of the Revision Committee was appointed by the Board of Directors to serve as the Writing Group. This group was charged with preparing the first draft of *SOC, Version 7* and continuing to work on revisions for consideration by the broader Revision Committee. The Board also appointed an International Advisory Group of transsexual, transgender, and gender nonconforming individuals to give input on the revision.

A technical writer was hired to (1) review all of the recommendations for revision – both the original recommendations as outlined in the *IJT* articles and additional recommendations that emanated from the online discussion – and (2) create a survey to solicit further input on these potential revisions. From the survey results, the Writing Group was able to discern where these experts stood in terms of areas of agreement and areas in need of more discussion and debate. The technical writer then (3) created a very rough first draft of *SOC, Version 7* for the Writing Group to consider and build on.

The Writing Group met on March 4 and 5, 2011 in a face-to-face expert consultation meeting. They reviewed all recommended changes and debated and came to consensus on various controversial areas. Decisions were made based on the best available science and expert consensus. These decisions were incorporated into the draft, and additional sections were written by the Writing Group with the assistance of the technical writer.

The draft that emerged from the consultation meeting was then circulated among the Writing Group and finalized with the help of the technical writer. Once this initial draft was finalized it was circulated among the broader *SOC* Revision Committee and the International Advisory Group. Discussion was opened up on the Google website and a conference call was held to resolve issues. Feedback from these groups was considered by the Writing Group, who then made further revision. Two additional drafts were created and posted on the Google website for consideration by the broader *SOC* Revision Committee and the International Advisory Group. Upon completion of these three iteratations of review and revision, the final document was presented to the WPATH Board of Directors for approval. The Board of Directors approved this version on September 14, 2011.

The plans are to disseminate this version of the *SOC* and invite feedback for further revisions. The WPATH Board of Directors decides the timing of any revision of the *SOC*.

Funding

The *Standards of Care* revision process was made possible through a generous grant from the Tawani Foundation and a gift from an anonymous donor. These funds supported the following:

1. Costs of a professional technical writer;

2. Process of soliciting international input on proposed changes from gender identity professionals and the transgender community;

3. Working meeting of the Writing Group;

4. Process of gathering additional feedback and arriving at final expert consensus from the professional and transgender communities, the *Standards of Care, Version 7* Revision Committee, and WPATH Board of Directors;

5. Costs of printing and distributing *Standards of Care, Version 7* and posting a free downloadable copy on the WPATH website;

6. Plenary session to launch the *Standards of Care, Version 7* at the 2011 WPATH Biennial Symposium in Atlanta, Georgia, USA.

Members of the Standards of Care Revision Committee[1]

Eli Coleman, PhD (USA)* - Committee chair
Richard Adler, PhD (USA)
Walter Bockting, PhD (USA)*
Marsha Botzer, MA (USA)*
George Brown, MD (USA)
Peggy Cohen-Kettenis, PhD (Netherlands)*
Griet DeCuypere, MD (Belgium)*
Aaron Devor, PhD (Canada)
Randall Ehrbar, PsyD (USA)
Randi Ettner, PhD (USA)
Evan Eyler, MD (USA)
Jamie Feldman, MD, PhD (USA)*
Lin Fraser, EdD (USA)*
Rob Garofalo, MD, MPH (USA)
Jamison Green, PhD, MFA (USA)*
Dan Karasic, MD (USA)
Gail Knudson, MD (Canada)*
Arlene Istar Lev, LCSW (USA)
Gal Mayer, MD (USA)
Walter Meyer, MD (USA)*
Heino Meyer-Bahlburg, Dr. rer.nat. (USA)
Stan Monstrey, MD, PhD (Belgium)*
Blaine Paxton Hall, MHS-CL, PA-C (USA)
Friedmann Pfaefflin, MD, PhD (Germany)
Katherine Rachlin, PhD (USA)
Bean Robinson, PhD (USA)
Loren Schechter, MD (USA)
Vin Tangpricha, MD, PhD (USA)
Mick van Trotsenburg, MD (Netherlands)
Anne Vitale, PhD (USA)
Sam Winter, PhD (Hong Kong)
Stephen Whittle, OBE (UK)
Kevan Wylie, MB, MD (UK)
Ken Zucker, PhD (Canada)

International Advisory Group Selection Committee

Walter Bockting, PhD (USA)
Marsha Botzer, MA (USA)
Aaron Devor, PhD (Canada)
Randall Ehrbar, PsyD (USA)
Evan Eyler, MD (USA)
Jamison Green, PhD, MFA (USA)
Blaine Paxton Hall, MHS-CL, PA-C (USA)

1 * Writing Group member
All members of the *Standards of Care, Version 7 Revision Committee* donated their time to work on this revision.

International Advisory Group

Tamara Adrian, LGBT Rights Venezuela (Venezuela)
Craig Andrews, FTM Australia (Australia)
Christine Burns, MBE, Plain Sense Ltd (UK)
Naomi Fontanos, Society for Transsexual Women's Rights in the Phillipines (Phillipines)
Tone Marie Hansen, Harry Benjamin Resource Center (Norway)
Rupert Raj, Shelburne Health Center (Canada)
Masae Torai, FTM Japan (Japan)
Kelley Winters, GID Reform Advocates (USA)

Technical Writer

Anne Marie Weber-Main, PhD (USA)

Editorial Assistance

Heidi Fall (USA)

ZSQUAREDESIGN LLC | MPLS, MN WWW.ZACHSCHAAR.COM

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 317 of 371 Total Pages:(317 of 1263)
Case 4:15-cv-00054-AWA-RJK Document 192-6 Filed 03/26/19 Page 1 of 35 PageID# 2018

Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline

Wylie C. Hembree,[1] Peggy T. Cohen-Kettenis,[2] Louis Gooren,[3] Sabine E. Hannema,[4] Walter J. Meyer,[5] M. Hassan Murad,[6] Stephen M. Rosenthal,[7] Joshua D. Safer,[8] Vin Tangpricha,[9] and Guy G. T'Sjoen[10]

[1]New York Presbyterian Hospital, Columbia University Medical Center, New York, New York 10032 (Retired); [2]VU University Medical Center, 1007 MB Amsterdam, Netherlands (Retired); [3]VU University Medical Center, 1007 MB Amsterdam, Netherlands (Retired); [4]Leiden University Medical Center, 2300 RC Leiden, Netherlands; [5]University of Texas Medical Branch, Galveston, Texas 77555; [6]Mayo Clinic Evidence-Based Practice Center, Rochester, Minnesota 55905; [7]University of California San Francisco, Benioff Children's Hospital, San Francisco, California 94143; [8]Boston University School of Medicine, Boston, Massachusetts 02118; [9]Emory University School of Medicine and the Atlanta VA Medical Center, Atlanta, Georgia 30322; and [10]Ghent University Hospital, 9000 Ghent, Belgium

*__Cosponsoring Associations:__ American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Pediatric Endocrinology, European Society of Endocrinology, Pediatric Endocrine Society, and World Professional Association for Transgender Health.

Objective: To update the "Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline," published by the Endocrine Society in 2009.

Participants: The participants include an Endocrine Society–appointed task force of nine experts, a methodologist, and a medical writer.

Evidence: This evidence-based guideline was developed using the Grading of Recommendations, Assessment, Development, and Evaluation approach to describe the strength of recommendations and the quality of evidence. The task force commissioned two systematic reviews and used the best available evidence from other published systematic reviews and individual studies.

Consensus Process: Group meetings, conference calls, and e-mail communications enabled consensus. Endocrine Society committees, members and cosponsoring organizations reviewed and commented on preliminary drafts of the guidelines.

Conclusion: Gender affirmation is multidisciplinary treatment in which endocrinologists play an important role. Gender-dysphoric/gender-incongruent persons seek and/or are referred to endocrinologists to develop the physical characteristics of the affirmed gender. They require a safe and effective hormone regimen that will (1) suppress endogenous sex hormone secretion determined by the person's genetic/gonadal sex and (2) maintain sex hormone levels within the normal range for the person's affirmed gender. Hormone treatment is not recommended for prepubertal gender-dysphoric/gender-incongruent persons. Those clinicians who recommend gender-affirming endocrine treatments—appropriately trained diagnosing clinicians (required), a mental health provider for adolescents (required) and mental health

ISSN Print 0021-972X ISSN Online 1945-7197
Printed in USA
Copyright © 2017 Endocrine Society
Received 24 July 2017. Accepted 24 August 2017.
First Published Online 13 September 2017

Abbreviations: BMD, bone mineral density; DSD, disorder/difference of sex development; DSM, Diagnostic and Statistical Manual of Mental Disorders; GD, gender dysphoria; GnRH, gonadotropin-releasing hormone; ICD, International Statistical Classification of Diseases and Related Health Problems; MHP, mental health professional; VTE, venous thromboembolism.

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 318 of 371 Total Pages:(318 of 1263)
Case 4:15-cv-00054-AWA-RJK Document 192-6 Filed 03/26/19 Page 2 of 35 PageID# 2019

professional for adults (recommended)—should be knowledgeable about the diagnostic criteria and criteria for gender-affirming treatment, have sufficient training and experience in assessing psychopathology, and be willing to participate in the ongoing care throughout the endocrine transition. We recommend treating gender-dysphoric/gender-incongruent adolescents who have entered puberty at Tanner Stage G2/B2 by suppression with gonadotropin-releasing hormone agonists. Clinicians may add gender-affirming hormones after a multidisciplinary team has confirmed the persistence of gender dysphoria/gender incongruence and sufficient mental capacity to give informed consent to this partially irreversible treatment. Most adolescents have this capacity by age 16 years old. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to age 16 years, although there is minimal published experience treating prior to 13.5 to 14 years of age. For the care of peripubertal youths and older adolescents, we recommend that an expert multidisciplinary team comprised of medical professionals and mental health professionals manage this treatment. The treating physician must confirm the criteria for treatment used by the referring mental health practitioner and collaborate with them in decisions about gender-affirming surgery in older adolescents. For adult gender-dysphoric/gender-incongruent persons, the treating clinicians (collectively) should have expertise in transgender-specific diagnostic criteria, mental health, primary care, hormone treatment, and surgery, as needed by the patient. We suggest maintaining physiologic levels of gender-appropriate hormones and monitoring for known risks and complications. When high doses of sex steroids are required to suppress endogenous sex steroids and/or in advanced age, clinicians may consider surgically removing natal gonads along with reducing sex steroid treatment. Clinicians should monitor both transgender males (female to male) and transgender females (male to female) for reproductive organ cancer risk when surgical removal is incomplete. Additionally, clinicians should persistently monitor adverse effects of sex steroids. For gender-affirming surgeries in adults, the treating physician must collaborate with and confirm the criteria for treatment used by the referring physician. Clinicians should avoid harming individuals (via hormone treatment) who have conditions other than gender dysphoria/gender incongruence and who may not benefit from the physical changes associated with this treatment. **(*J Clin Endocrinol Metab* 102: 3869–3903, 2017)**

Summary of Recommendations

1.0 Evaluation of youth and adults

1.1. We advise that only trained mental health professionals (MHPs) who meet the following criteria should diagnose gender dysphoria (GD)/gender incongruence in adults: (1) competence in using the Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or the International Statistical Classification of Diseases and Related Health Problems (ICD) for diagnostic purposes, (2) the ability to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) training in diagnosing psychiatric conditions, (4) the ability to undertake or refer for appropriate treatment, (5) the ability to psychosocially assess the person's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) a practice of regularly attending relevant professional meetings. (Ungraded Good Practice Statement)

1.2. We advise that only MHPs who meet the following criteria should diagnose GD/gender incongruence in children and adolescents: (1) training in child and adolescent developmental psychology and psychopathology, (2) competence in using the DSM and/or the ICD for diagnostic purposes, (3) the ability to make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (4) training in diagnosing psychiatric conditions, (5) the ability to undertake or refer for appropriate treatment, (6) the ability to psychosocially assess the person's understanding and social conditions that can impact gender-affirming hormone therapy, (7) a practice of regularly attending relevant professional meetings, and (8) knowledge of the criteria for puberty blocking and gender-affirming hormone treatment in adolescents. (Ungraded Good Practice Statement)

1.3. We advise that decisions regarding the social transition of prepubertal youths with GD/gender incongruence are made with the assistance of an MHP or another experienced professional. (Ungraded Good Practice Statement).

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 319 of 371 Total Pages:(319 of 1263)
Case 4:15-cv-00054-AWA-RJK Document 192-6 Filed 03/26/19 Page 3 of 35 PageID# 2020

1.4. We recommend against puberty blocking and gender-affirming hormone treatment in prepubertal children with GD/gender incongruence. (1 |⊕⊕○○)

1.5. We recommend that clinicians inform and counsel all individuals seeking gender-affirming medical treatment regarding options for fertility preservation prior to initiating puberty suppression in adolescents and prior to treating with hormonal therapy of the affirmed gender in both adolescents and adults. (1 |⊕⊕⊕○)

2.0 Treatment of adolescents

2.1. We suggest that adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment, and are requesting treatment should initially undergo treatment to suppress pubertal development. (2 |⊕⊕○○)

2.2. We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty. (2 |⊕⊕○○)

2.3. We recommend that, where indicated, GnRH analogues are used to suppress pubertal hormones. (1 |⊕⊕○○)

2.4. In adolescents who request sex hormone treatment (given this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule after a multidisciplinary team of medical and MHPs has confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16 years. (1 |⊕⊕○○).

2.5. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD/gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years. As with the care of adolescents ≥16 years of age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment. (1 |⊕○○○)

2.6. We suggest monitoring clinical pubertal development every 3 to 6 months and laboratory parameters every 6 to 12 months during sex hormone treatment. (2 |⊕⊕○○)

3.0 Hormonal therapy for transgender adults

3.1. We recommend that clinicians confirm the diagnostic criteria of GD/gender incongruence and the criteria for the endocrine phase of gender transition before beginning treatment. (1 |⊕⊕⊕○)

3.2. We recommend that clinicians evaluate and address medical conditions that can be exacerbated by hormone depletion and treatment with sex hormones of the affirmed gender before beginning treatment. (1 |⊕⊕⊕○)

3.3. We suggest that clinicians measure hormone levels during treatment to ensure that endogenous sex steroids are suppressed and administered sex steroids are maintained in the normal physiologic range for the affirmed gender. (2 |⊕⊕○○)

3.4. We suggest that endocrinologists provide education to transgender individuals undergoing treatment about the onset and time course of physical changes induced by sex hormone treatment. (2 |⊕○○○)

4.0 Adverse outcome prevention and long-term care

4.1. We suggest regular clinical evaluation for physical changes and potential adverse changes in response to sex steroid hormones and laboratory monitoring of sex steroid hormone levels every 3 months during the first year of hormone therapy for transgender males and females and then once or twice yearly. (2 |⊕⊕○○)

4.2. We suggest periodically monitoring prolactin levels in transgender females treated with estrogens. (2 |⊕⊕○○)

4.3. We suggest that clinicians evaluate transgender persons treated with hormones for cardiovascular risk factors using fasting lipid profiles, diabetes screening, and/or other diagnostic tools. (2 |⊕⊕○○)

4.4. We recommend that clinicians obtain bone mineral density (BMD) measurements when risk factors for osteoporosis exist, specifically in those who stop sex hormone therapy after gonadectomy. (1 |⊕⊕○○)

4.5. We suggest that transgender females with no known increased risk of breast cancer follow breast-screening guidelines recommended for non-transgender females. (2 |⊕⊕○○)

4.6. We suggest that transgender females treated with estrogens follow individualized screening according to personal risk for prostatic disease and prostate cancer. (2 |⊕○○○)

4.7. We advise that clinicians determine the medical necessity of including a total hysterectomy and oophorectomy as part of gender-affirming surgery. (Ungraded Good Practice Statement)

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 320 of 371 Total Pages:(320 of 1263)
Case 4:15-cv-00054-AWA-RJK Document 192-6 Filed 03/26/19 Page 4 of 35 PageID# 2021

5.0 Surgery for sex reassignment and gender confirmation

5.1. We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being. (1 |⊕⊕○○)

5.2. We advise that clinicians approve genital gender-affirming surgery only after completion of at least 1 year of consistent and compliant hormone treatment, unless hormone therapy is not desired or medically contraindicated. (Ungraded Good Practice Statement)

5.3. We advise that the clinician responsible for endocrine treatment and the primary care provider ensure appropriate medical clearance of transgender individuals for genital gender-affirming surgery and collaborate with the surgeon regarding hormone use during and after surgery. (Ungraded Good Practice Statement)

5.4. We recommend that clinicians refer hormone-treated transgender individuals for genital surgery when: (1) the individual has had a satisfactory social role change, (2) the individual is satisfied about the hormonal effects, and (3) the individual desires definitive surgical changes. (1 |⊕○○○)

5.5. We suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country. (2 |⊕⊕○○).

5.6. We suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement. (2 |⊕○○○)

Changes Since the Previous Guideline

Both the current guideline and the one published in 2009 contain similar sections. Listed here are the sections contained in the current guideline and the corresponding number of recommendations: Introduction, Evaluation of Youth and Adults (5), Treatment of Adolescents (6), Hormonal Therapy for Transgender Adults (4), Adverse Outcomes Prevention and Long-term Care (7), and Surgery for Sex Reassignment and Gender Confirmation (6). The current introduction updates the diagnostic classification of "gender dysphoria/gender incongruence." It also reviews the development of "gender identity" and summarizes its natural development. The section on clinical evaluation of both youth and adults, defines in detail the professional qualifications required of those who diagnose and treat both adolescents and adults. We advise that decisions regarding the social transition of prepubertal youth are made with the assistance of a mental health professional or similarly experienced professional. We recommend against puberty blocking followed by gender-affirming hormone treatment of prepubertal children. Clinicians should inform pubertal children, adolescents, and adults seeking gender-confirming treatment of their options for fertility preservation. Prior to treatment, clinicians should evaluate the presence of medical conditions that may be worsened by hormone depletion and/or treatment. A multidisciplinary team, preferably composed of medical and mental health professionals, should monitor treatments. Clinicians evaluating transgender adults for endocrine treatment should confirm the diagnosis of persistent gender dysphoria/gender incongruence. Physicians should educate transgender persons regarding the time course of steroid-induced physical changes. Treatment should include periodic monitoring of hormone levels and metabolic parameters, as well as assessments of bone density and the impact upon prostate, gonads, and uterus. We also make recommendations for transgender persons who plan genital gender-affirming surgery.

Method of Development of Evidence-Based Clinical Practice Guidelines

The Clinical Guidelines Subcommittee (CGS) of the Endocrine Society deemed the diagnosis and treatment of individuals with GD/gender incongruence a priority area for revision and appointed a task force to formulate evidence-based recommendations. The task force followed the approach recommended by the Grading of Recommendations, Assessment, Development, and Evaluation group, an international group with expertise in the development and implementation of evidence-based guidelines (1). A detailed description of the grading scheme has been published elsewhere (2). The task force used the best available research evidence to develop the recommendations. The task force also used consistent language and graphical descriptions of both the strength of a recommendation and the quality of evidence. In terms of the strength of the recommendation, strong recommendations use the phrase "we recommend" and the number 1, and weak recommendations use the phrase "we suggest" and the number 2. Cross-filled circles indicate the quality of the evidence, such that ⊕○○○ denotes very low–quality evidence; ⊕⊕○○, low quality; ⊕⊕⊕○, moderate quality; and ⊕⊕⊕⊕, high quality. The task force has confidence that persons who receive care according to the strong recommendations will derive, on average, more benefit than harm. Weak recommendations require more careful consideration of the person's circumstances, values, and preferences to determine the best course of action. Linked to each recommendation is a description of the evidence and the

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

doi: 10.1210/jc.2017-01658

values that the task force considered in making the recommendation. In some instances, there are remarks in which the task force offers technical suggestions for testing conditions, dosing, and monitoring. These technical comments reflect the best available evidence applied to a typical person being treated. Often this evidence comes from the unsystematic observations of the task force and their preferences; therefore, one should consider these remarks as suggestions.

In this guideline, the task force made several statements to emphasize the importance of shared decision-making, general preventive care measures, and basic principles of the treatment of transgender persons. They labeled these "Ungraded Good Practice Statement." Direct evidence for these statements was either unavailable or not systematically appraised and considered out of the scope of this guideline. The intention of these statements is to draw attention to these principles.

The Endocrine Society maintains a rigorous conflict-of-interest review process for developing clinical practice guidelines. All task force members must declare any potential conflicts of interest by completing a conflict-of-interest form. The CGS reviews all conflicts of interest before the Society's Council approves the members to participate on the task force and periodically during the development of the guideline. All others participating in the guideline's development must also disclose any conflicts of interest in the matter under study, and most of these participants must be without any conflicts of interest. The CGS and the task force have reviewed all disclosures for this guideline and resolved or managed all identified conflicts of interest.

Conflicts of interest are defined as remuneration in any amount from commercial interests; grants; research support; consulting fees; salary; ownership interests [*e.g.*, stocks and stock options (excluding diversified mutual funds)]; honoraria and other payments for participation in speakers' bureaus, advisory boards, or boards of directors; and all other financial benefits. Completed forms are available through the Endocrine Society office.

The Endocrine Society provided the funding for this guideline; the task force received no funding or remuneration from commercial or other entities.

Commissioned Systematic Review

The task force commissioned two systematic reviews to support this guideline. The first one aimed to summarize the available evidence on the effect of sex steroid use in transgender individuals on lipids and cardiovascular outcomes. The review identified 29 eligible studies at moderate risk of bias. In transgender males (female to male), sex steroid therapy was associated with a statistically significant increase in serum triglycerides and low-density lipoprotein cholesterol levels. High-density lipoprotein cholesterol levels decreased significantly across all follow-up time periods. In transgender females (male to female), serum triglycerides were significantly higher without any changes in other parameters. Few myocardial infarction, stroke, venous thromboembolism (VTE), and death events were reported. These events were more frequent in transgender females. However, the quality of the evidence was low. The second review summarized the available evidence regarding the effect of sex steroids on bone health in transgender individuals and identified 13 studies. In transgender males, there was no statistically significant difference in the lumbar spine, femoral neck, or total hip BMD at 12 and 24 months compared with baseline values before initiating masculinizing hormone therapy. In transgender females, there was a statistically significant increase in lumbar spine BMD at 12 months and 24 months compared with baseline values before initiation of feminizing hormone therapy. There was minimal information on fracture rates. The quality of evidence was also low.

Introduction

Throughout recorded history (in the absence of an endocrine disorder) some men and women have experienced confusion and anguish resulting from rigid, forced conformity to sexual dimorphism. In modern history, there have been numerous ongoing biological, psychological, cultural, political, and sociological debates over various aspects of gender variance. The 20th century marked the emergence of a social awakening for men and women with the belief that they are "trapped" in the wrong body (3). Magnus Hirschfeld and Harry Benjamin, among others, pioneered the medical responses to those who sought relief from and a resolution to their profound discomfort. Although the term transsexual became widely known after Benjamin wrote "The Transsexual Phenomenon" (4), it was Hirschfeld who coined the term "transsexual" in 1923 to describe people who want to live a life that corresponds with their experienced gender vs their designated gender (5). Magnus Hirschfeld (6) and others (4, 7) have described other types of trans phenomena besides transsexualism. These early researchers proposed that the gender identity of these people was located somewhere along a unidimensional continuum. This continuum ranged from all male through "something in between" to all female. Yet such a classification does not take into account that people may have gender identities outside this continuum. For instance, some experience themselves as having both a male and female gender identity, whereas others completely renounce any gender classification (8, 9). There are also reports of individuals experiencing a continuous and rapid involuntary alternation between a male and female identity (10) or men who do not experience themselves as men but do not want to live as women (11, 12). In some countries, (*e.g.*, Nepal, Bangladesh, and Australia), these nonmale or nonfemale genders are officially recognized (13). Specific treatment protocols, however, have not yet been developed for these groups.

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 322 of 371 Total Pages:(322 of 1263)
Case 4:15-cv-00054-AWA-RJK Document 192-6 Filed 03/26/19 Page 6 of 35 PageID# 2023

Instead of the term transsexualism, the current classification system of the American Psychiatric Association uses the term gender dysphoria in its diagnosis of persons who are not satisfied with their designated gender (14). The current version of the World Health Organization's ICD-10 still uses the term transsexualism when diagnosing adolescents and adults. However, for the ICD-11, the World Health Organization has proposed using the term "gender incongruence" (15).

Treating persons with GD/gender incongruence (15) was previously limited to relatively ineffective elixirs or creams. However, more effective endocrinology-based treatments became possible with the availability of testosterone in 1935 and diethylstilbestrol in 1938. Reports of individuals with GD/gender incongruence who were treated with hormones and gender-affirming surgery appeared in the press during the second half of the 20th century. The Harry Benjamin International Gender Dysphoria Association was founded in September 1979 and is now called the World Professional Association for Transgender Health (WPATH). WPATH published its first Standards of Care in 1979. These standards have since been regularly updated, providing guidance for treating persons with GD/gender incongruence (16).

Prior to 1975, few peer-reviewed articles were published concerning endocrine treatment of transgender persons. Since then, more than two thousand articles about various aspects of transgender care have appeared.

It is the purpose of this guideline to make detailed recommendations and suggestions, based on existing medical literature and clinical experience, that will enable treating physicians to maximize benefit and minimize risk when caring for individuals diagnosed with GD/gender incongruence.

In the future, we need more rigorous evaluations of the effectiveness and safety of endocrine and surgical protocols. Specifically, endocrine treatment protocols for GD/gender incongruence should include the careful assessment of the following: (1) the effects of prolonged delay of puberty in adolescents on bone health, gonadal function, and the brain (including effects on cognitive, emotional, social, and sexual development); (2) the effects of treatment in adults on sex hormone levels; (3) the requirement for and the effects of progestins and other agents used to suppress endogenous sex steroids during treatment; and (4) the risks and benefits of gender-affirming hormone treatment in older transgender people.

To successfully establish and enact these protocols, a commitment of mental health and endocrine investigators is required to collaborate in long-term, large-scale studies across countries that use the same diagnostic and inclusion criteria, medications, assay methods, and response assessment tools (*e.g.*, the European Network for the Investigation of Gender Incongruence) (17, 18).

Terminology and its use vary and continue to evolve. Table 1 contains the definitions of terms as they are used throughout this guideline.

Biological Determinants of Gender Identity Development

One's self-awareness as male or female changes gradually during infant life and childhood. This process of cognitive and affective learning evolves with interactions with parents, peers, and environment. A fairly accurate timetable exists outlining the steps in this process (19). Normative psychological literature, however, does not address if and when gender identity becomes crystallized and what factors contribute to the development of a gender identity that is not congruent with the gender of rearing. Results of studies from a variety of biomedical disciplines—genetic, endocrine, and neuroanatomic—support the concept that gender identity and/or gender expression (20) likely reflect a complex interplay of biological, environmental, and cultural factors (21, 22).

With respect to endocrine considerations, studies have failed to find differences in circulating levels of sex steroids between transgender and nontransgender individuals (23). However, studies in individuals with a disorder/difference of sex development (DSD) have informed our understanding of the role that hormones may play in gender identity outcome, even though most persons with GD/gender incongruence do not have a DSD. For example, although most 46,XX adult individuals with virilizing congenital adrenal hyperplasia caused by mutations in *CYP21A2* reported a female gender identity, the prevalence of GD/gender incongruence was much greater in this group than in the general population without a DSD. This supports the concept that there is a role for prenatal/postnatal androgens in gender development (24–26), although some studies indicate that prenatal androgens are more likely to affect gender behavior and sexual orientation rather than gender identity *per se* (27, 28).

Researchers have made similar observations regarding the potential role of androgens in the development of gender identity in other individuals with DSD. For example, a review of two groups of 46,XY persons, each with androgen synthesis deficiencies and female raised, reported transgender male (female-to-male) gender role changes in 56% to 63% and 39% to 64% of patients, respectively (29). Also, in 46,XY female-raised individuals with cloacal

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 323 of 371 Total Pages:(323 of 1263)
Case 4:15-cv-00054-AWA-RJK Document 192-6 Filed 03/26/19 Page 7 of 35 PageID# 2024

Table 1. Definitions of Terms Used in This Guideline

Biological sex, biological male or female: These terms refer to physical aspects of maleness and femaleness. As these may not be in line with each other (*e.g.*, a person with XY chromosomes may have female-appearing genitalia), the terms biological sex and biological male or female are imprecise and should be avoided.
Cisgender: This means not transgender. An alternative way to describe individuals who are not transgender is "non-transgender people."
Gender-affirming (hormone) treatment: See "gender reassignment"
Gender dysphoria: This is the distress and unease experienced if gender identity and designated gender are not completely congruent (see Table 2). In 2013, the American Psychiatric Association released the fifth edition of the DSM-5, which replaced "gender identity disorder" with "gender dysphoria" and changed the criteria for diagnosis.
Gender expression: This refers to external manifestations of gender, expressed through one's name, pronouns, clothing, haircut, behavior, voice, or body characteristics. Typically, transgender people seek to make their gender expression align with their gender identity, rather than their designated gender.
Gender identity/experienced gender: This refers to one's internal, deeply held sense of gender. For transgender people, their gender identity does not match their sex designated at birth. Most people have a gender identity of man or woman (or boy or girl). For some people, their gender identity does not fit neatly into one of those two choices. Unlike gender expression (see below), gender identity is not visible to others.
Gender identity disorder: This is the term used for GD/gender incongruence in previous versions of DSM (see "gender dysphoria"). The ICD-10 still uses the term for diagnosing child diagnoses, but the upcoming ICD-11 has proposed using "gender incongruence of childhood."
Gender incongruence: This is an umbrella term used when the gender identity and/or gender expression differs from what is typically associated with the designated gender. Gender incongruence is also the proposed name of the gender identity–related diagnoses in ICD-11. Not all individuals with gender incongruence have gender dysphoria or seek treatment.
Gender variance: See "gender incongruence"
Gender reassignment: This refers to the treatment procedure for those who want to adapt their bodies to the experienced gender by means of hormones and/or surgery. This is also called gender-confirming or gender-affirming treatment.
Gender-reassignment surgery (gender-confirming/gender-affirming surgery): These terms refer only to the surgical part of gender-confirming/gender-affirming treatment.
Gender role: This refers to behaviors, attitudes, and personality traits that a society (in a given culture and historical period) designates as masculine or feminine and/or that society associates with or considers typical of the social role of men or women.
Sex designated at birth: This refers to sex assigned at birth, usually based on genital anatomy.
Sex: This refers to attributes that characterize biological maleness or femaleness. The best known attributes include the sex-determining genes, the sex chromosomes, the H-Y antigen, the gonads, sex hormones, internal and external genitalia, and secondary sex characteristics.
Sexual orientation: This term describes an individual's enduring physical and emotional attraction to another person. Gender identity and sexual orientation are not the same. Irrespective of their gender identity, transgender people may be attracted to women (gynephilic), attracted to men (androphilic), bisexual, asexual, or queer.
Transgender: This is an umbrella term for people whose gender identity and/or gender expression differs from what is typically associated with their sex designated at birth. Not all transgender individuals seek treatment.
Transgender male (also: trans man, female-to-male, transgender male): This refers to individuals assigned female at birth but who identify and live as men.
Transgender woman (also: trans woman, male-to female, transgender female): This refers to individuals assigned male at birth but who identify and live as women.
Transition: This refers to the process during which transgender persons change their physical, social, and/or legal characteristics consistent with the affirmed gender identity. Prepubertal children may choose to transition socially.
Transsexual: This is an older term that originated in the medical and psychological communities to refer to individuals who have permanently transitioned through medical interventions or desired to do so.

exstrophy and penile agenesis, the occurrence of transgender male changes was significantly more prevalent than in the general population (30, 31). However, the fact that a high percentage of individuals with the same conditions did not change gender suggests that cultural factors may play a role as well.

With respect to genetics and gender identity, several studies have suggested heritability of GD/gender incongruence (32, 33). In particular, a study by Heylens *et al.* (33) demonstrated a 39.1% concordance rate for gender identity disorder (based on the DSM-IV criteria) in 23 monozygotic twin pairs but no concordance in 21 same-sex dizygotic or seven opposite-sex twin pairs. Although numerous investigators have sought to identify specific genes associated with GD/gender incongruence, such studies have been inconsistent and without strong statistical significance (34–38).

Studies focusing on brain structure suggest that the brain phenotypes of people with GD/gender incongruence differ in various ways from control males and females, but that there is not a complete sex reversal in brain structures (39).

In summary, although there is much that is still unknown with respect to gender identity and its expression, compelling studies support the concept that biologic factors, in addition to environmental factors, contribute to this fundamental aspect of human development.

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 324 of 371 Total Pages:(324 of 1263)
Case 4:15-cv-00054-AWA-RJK Document 192-6 Filed 03/26/19 Page 8 of 35 PageID# 2025

Natural History of Children With GD/Gender Incongruence

With current knowledge, we cannot predict the psychosexual outcome for any specific child. Prospective follow-up studies show that childhood GD/gender incongruence does not invariably persist into adolescence and adulthood (so-called "desisters"). Combining all outcome studies to date, the GD/gender incongruence of a minority of prepubertal children appears to persist in adolescence (20, 40). In adolescence, a significant number of these desisters identify as homosexual or bisexual. It may be that children who only showed some gender nonconforming characteristics have been included in the follow-up studies, because the DSM-IV text revision criteria for a diagnosis were rather broad. However, the persistence of GD/gender incongruence into adolescence is more likely if it had been extreme in childhood (41, 42). With the newer, stricter criteria of the DSM-5 (Table 2), persistence rates may well be different in future studies.

1.0 Evaluation of Youth and Adults

Gender-affirming treatment is a multidisciplinary effort. After evaluation, education, and diagnosis, treatment may include mental health care, hormone therapy, and/or surgical therapy. Together with an MHP, hormone-prescribing clinicians should examine the psychosocial impact of the potential changes on people's lives, including mental health, friends, family, jobs, and their role in society. Transgender individuals should be encouraged to experience living in the new gender role and assess whether this improves their quality of life. Although the focus of this guideline is gender-affirming hormone therapy, collaboration with appropriate professionals responsible for each aspect of treatment maximizes a successful outcome.

Diagnostic assessment and mental health care

GD/gender incongruence may be accompanied with psychological or psychiatric problems (43–51). It is therefore necessary that clinicians who prescribe hormones and are involved in diagnosis and psychosocial assessment meet the following criteria: (1) are competent in using the DSM and/or the ICD for diagnostic purposes, (2) are able to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) are trained in diagnosing psychiatric conditions, (4) undertake or refer for appropriate treatment, (5) are able to do a psychosocial assessment of the patient's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) regularly attend relevant professional meetings.

Because of the psychological vulnerability of many individuals with GD/gender incongruence, it is important that mental health care is available before, during, and sometimes also after transitioning. For children and adolescents, an MHP who has training/experience in child and adolescent gender development (as well as child and adolescent psychopathology) should make the diagnosis, because assessing GD/gender incongruence in children and adolescents is often extremely complex.

During assessment, the clinician obtains information from the individual seeking gender-affirming treatment. In the case

Table 2. DSM-5 Criteria for Gender Dysphoria in Adolescents and Adults

A. A marked incongruence between one's experienced/expressed gender and natal gender of at least 6 mo in duration, as manifested by at least two of the following:
1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
3. A strong desire for the primary and/or secondary sex characteristics of the other gender
4. A strong desire to be of the other gender (or some alternative gender different from one's designated gender)
5. A strong desire to be treated as the other gender (or some alternative gender different from one's designated gender)
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's designated gender)

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:
1. The condition exists with a disorder of sex development.
2. The condition is posttransitional, in that the individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one sex-related medical procedure or treatment regimen—namely, regular sex hormone treatment or gender reassignment surgery confirming the desired gender (*e.g.*, penectomy, vaginoplasty in natal males; mastectomy or phalloplasty in natal females).

Reference: American Psychiatric Association (14).

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

doi: 10.1210/jc.2017-01658

of adolescents, the clinician also obtains information from the parents or guardians regarding various aspects of the child's general and psychosexual development and current functioning. On the basis of this information, the clinician:

- decides whether the individual fulfills criteria for treatment (see Tables 2 and 3) for GD/gender incongruence (DSM-5) or transsexualism (DSM-5 and/or ICD-10);
- informs the individual about the possibilities and limitations of various kinds of treatment (hormonal/surgical and nonhormonal), and if medical treatment is desired, provides correct information to prevent unrealistically high expectations;
- assesses whether medical interventions may result in unfavorable psychological and social outcomes.

In cases in which severe psychopathology, circumstances, or both seriously interfere with the diagnostic work or make satisfactory treatment unlikely, clinicians should assist the adolescent in managing these other issues. Literature on postoperative regret suggests that besides poor quality of surgery, severe psychiatric comorbidity and lack of support may interfere with positive outcomes (52–56).

For adolescents, the diagnostic procedure usually includes a complete psychodiagnostic assessment (57) and an assessment of the decision-making capability of the youth. An evaluation to assess the family's ability to endure stress, give support, and deal with the complexities of the adolescent's situation should be part of the diagnostic phase (58).

Social transitioning

A change in gender expression and role (which may involve living part time or full time in another gender role that is consistent with one's gender identity) may test the person's resolve, the capacity to function in the affirmed gender, and the adequacy of social, economic, and psychological supports. It assists both the individual and the clinician in their judgments about how to proceed (16). During social transitioning, the person's feelings about the social transformation (including coping with the responses of others) is a major focus of the counseling. The optimal timing for social transitioning may differ between individuals. Sometimes people wait until they start gender-affirming hormone treatment to make social transitioning easier, but individuals increasingly start social transitioning long before they receive medically supervised, gender-affirming hormone treatment.

Criteria

Adolescents and adults seeking gender-affirming hormone treatment and surgery should satisfy certain criteria before proceeding (16). Criteria for gender-affirming hormone therapy for adults are in Table 4, and criteria for gender-affirming hormone therapy for adolescents are in Table 5. Follow-up studies in adults meeting these criteria indicate a high satisfaction rate with treatment (59). However, the quality of evidence is usually low. A few follow-up studies on adolescents who fulfilled these criteria also indicated good treatment results (60–63).

Recommendations for Those Involved in the Gender-Affirming Hormone Treatment of Individuals With GD/Gender Incongruence

1.1. We advise that only trained MHPs who meet the following criteria should diagnose GD/gender incongruence in adults: (1) competence in using the DSM and/or the ICD for diagnostic purposes, (2) the ability to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) training in diagnosing psychiatric conditions, (4) the ability to undertake or refer for appropriate treatment, (5) the ability to psychosocially assess the person's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) a practice of regularly attending relevant professional meetings. (Ungraded Good Practice Statement)

1.2. We advise that only MHPs who meet the following criteria should diagnose GD/gender incongruence in children and adolescents: (1) training in child and adolescent developmental psychology and psychopathology, (2) competence in using the DSM and/or ICD for diagnostic

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

Table 3. ICD-10 Criteria for Transsexualism

Transsexualism (F64.0) has three criteria:
1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatments.
2. The transsexual identity has been present persistently for at least 2 y.
3. The disorder is not a symptom of another mental disorder or a genetic, DSD, or chromosomal abnormality.

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 326 of 371 Total Pages:(326 of 1263)
Case 4:15-cv-00054-AWA-RJK Document 192-6 Filed 03/26/19 Page 10 of 35 PageID# 2027

Table 4. Criteria for Gender-Affirming Hormone Therapy for Adults

1. Persistent, well-documented gender dysphoria/gender incongruence
2. The capacity to make a fully informed decision and to consent for treatment
3. The age of majority in a given country (if younger, follow the criteria for adolescents)
4. Mental health concerns, if present, must be reasonably well controlled

Reproduced from World Professional Association for Transgender Health (16).

purposes, (3) the ability to make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (4) training in diagnosing psychiatric conditions, (5) the ability to undertake or refer for appropriate treatment, (6) the ability to psychosocially assess the person's understanding and social conditions that can impact gender-affirming hormone therapy, (7) a practice of regularly attending relevant professional meetings, and (8) knowledge of the criteria for puberty blocking and gender-affirming hormone treatment in adolescents. (Ungraded Good Practice Statement)

Evidence

Individuals with gender identity issues may have psychological or psychiatric problems (43–48, 50, 51, 64, 65). It is therefore necessary that clinicians making the diagnosis are able to make a distinction between GD/gender incongruence and conditions that have similar features. Examples of conditions with similar features are body dysmorphic disorder, body identity integrity disorder (a condition in which individuals have a sense that their anatomical configuration as an able-bodied person is somehow wrong or inappropriate) (66), or certain forms of eunuchism (in which a person is preoccupied with or engages in castration and/or penectomy for

Table 5. Criteria for Gender-Affirming Hormone Therapy for Adolescents

Adolescents are eligible for GnRH agonist treatment if:

1. A qualified MHP has confirmed that:
- the adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed),
- gender dysphoria worsened with the onset of puberty,
- any coexisting psychological, medical, or social problems that could interfere with treatment (*e.g.*, that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment,
- the adolescent has sufficient mental capacity to give informed consent to this (reversible) treatment,

2. And the adolescent:
- has been informed of the effects and side effects of treatment (including potential loss of fertility if the individual subsequently continues with sex hormone treatment) and options to preserve fertility,
- has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,

3. And a pediatric endocrinologist or other clinician experienced in pubertal assessment
- agrees with the indication for GnRH agonist treatment,
- has confirmed that puberty has started in the adolescent (Tanner stage ≥G2/B2),
- has confirmed that there are no medical contraindications to GnRH agonist treatment.

Adolescents are eligible for subsequent sex hormone treatment if:

1. A qualified MHP has confirmed:
- the persistence of gender dysphoria,
- any coexisting psychological, medical, or social problems that could interfere with treatment (*e.g.*, that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start sex hormone treatment,
- the adolescent has sufficient mental capacity (which most adolescents have by age 16 years) to estimate the consequences of this (partly) irreversible treatment, weigh the benefits and risks, and give informed consent to this (partly) irreversible treatment,

2. And the adolescent:
- has been informed of the (irreversible) effects and side effects of treatment (including potential loss of fertility and options to preserve fertility),
- has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,

3. And a pediatric endocrinologist or other clinician experienced in pubertal induction:
- agrees with the indication for sex hormone treatment,
- has confirmed that there are no medical contraindications to sex hormone treatment.

Reproduced from World Professional Association for Transgender Health (16).

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 327 of 371 Total Pages:(327 of 1263)
Case 4:15-cv-00054-AWA-RJK Document 192-6 Filed 03/26/19 Page 11 of 35 PageID# 2028

reasons that are not gender identity related) (11). Clinicians should also be able to diagnose psychiatric conditions accurately and ensure that these conditions are treated appropriately, particularly when the conditions may complicate treatment, affect the outcome of gender-affirming treatment, or be affected by hormone use.

Values and preferences

The task force placed a very high value on avoiding harm from hormone treatment in individuals who have conditions other than GD/gender incongruence and who may not benefit from the physical changes associated with this treatment and placed a low value on any potential benefit these persons believe they may derive from hormone treatment. This justifies the good practice statement.

1.3. We advise that decisions regarding the social transition of prepubertal youths with GD/gender incongruence are made with the assistance of an MHP or another experienced professional. (Ungraded Good Practice Statement).

1.4. We recommend against puberty blocking and gender-affirming hormone treatment in prepubertal children with GD/gender incongruence. (1 |⊕⊕○○)

Evidence

In most children diagnosed with GD/gender incongruence, it did not persist into adolescence. The percentages differed among studies, probably dependent on which version of the DSM clinicians used, the patient's age, the recruitment criteria, and perhaps cultural factors. However, the large majority (about 85%) of prepubertal children with a childhood diagnosis did not remain GD/gender incongruent in adolescence (20). If children have completely socially transitioned, they may have great difficulty in returning to the original gender role upon entering puberty (40). Social transition is associated with the persistence of GD/gender incongruence as a child progresses into adolescence. It may be that the presence of GD/gender incongruence in prepubertal children is the earliest sign that a child is destined to be transgender as an adolescent/adult (20). However, social transition (in addition to GD/gender incongruence) has been found to contribute to the likelihood of persistence.

This recommendation, however, does not imply that children should be discouraged from showing gender-variant behaviors or should be punished for exhibiting such behaviors. In individual cases, an early complete social transition may result in a more favorable outcome, but there are currently no criteria to identify the GD/gender-incongruent children to whom this applies. At the present time, clinical experience suggests that persistence of GD/gender incongruence can only be reliably assessed after the first signs of puberty.

Values and preferences

The task force placed a high value on avoiding harm with gender-affirming hormone therapy in prepubertal children with GD/gender incongruence. This justifies the strong recommendation in the face of low-quality evidence.

1.5. We recommend that clinicians inform and counsel all individuals seeking gender-affirming medical treatment regarding options for fertility preservation prior to initiating puberty suppression in adolescents and prior to treating with hormonal therapy of the affirmed gender in both adolescents and adults. (1 |⊕⊕⊕○)

Remarks

Persons considering hormone use for gender affirmation need adequate information about this treatment in general and about fertility effects of hormone treatment in particular to make an informed and balanced decision (67, 68). Because young adolescents may not feel qualified to make decisions about fertility and may not fully understand the potential effects of hormonal interventions, consent and protocol education should include parents, the referring MHP(s), and other members of the adolescent's support group. To our knowledge, there are no formally evaluated decision aids available to assist in the discussion and decision regarding the future fertility of adolescents or adults beginning gender-affirming treatment.

Treating early pubertal youth with GnRH analogs will temporarily impair spermatogenesis and oocyte maturation. Given that an increasing number of transgender youth want to preserve fertility potential, delaying or temporarily discontinuing GnRH analogs to promote gamete maturation is an option. This option is often not preferred, because mature sperm production is associated with later stages of puberty and with the significant development of secondary sex characteristics.

For those designated male at birth with GD/gender incongruence and who are in early puberty, sperm production and the development of the reproductive tract are insufficient for the cryopreservation of sperm. However, prolonged pubertal suppression using GnRH analogs is reversible and clinicians should inform these individuals that sperm production can be initiated following prolonged gonadotropin suppression. This can be accomplished by spontaneous gonadotropin recovery after

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 328 of 371 Total Pages:(328 of 1263)
Case 4:15-cv-00054-AWA-RJK Document 192-6 Filed 03/26/19 Page 12 of 35 PageID# 2029

cessation of GnRH analogs or by gonadotropin treatment and will probably be associated with physical manifestations of testosterone production, as stated above. Note that there are no data in this population concerning the time required for sufficient spermatogenesis to collect enough sperm for later fertility. In males treated for precocious puberty, spermarche was reported 0.7 to 3 years after cessation of GnRH analogs (69). In adult men with gonadotropin deficiency, sperm are noted in seminal fluid by 6 to 12 months of gonadotropin treatment. However, sperm numbers when partners of these patients conceive are far below the "normal range" (70, 71).

In girls, no studies have reported long-term, adverse effects of pubertal suppression on ovarian function after treatment cessation (72, 73). Clinicians should inform adolescents that no data are available regarding either time to spontaneous ovulation after cessation of GnRH analogs or the response to ovulation induction following prolonged gonadotropin suppression.

In males with GD/gender incongruence, when medical treatment is started in a later phase of puberty or in adulthood, spermatogenesis is sufficient for cryopreservation and storage of sperm. *In vitro* spermatogenesis is currently under investigation. Restoration of spermatogenesis after prolonged estrogen treatment has not been studied.

In females with GD/gender incongruence, the effect of prolonged treatment with exogenous testosterone on ovarian function is uncertain. There have been reports of an increased incidence of polycystic ovaries in transgender males, both prior to and as a result of androgen treatment (74–77), although these reports were not confirmed by others (78). Pregnancy has been reported in transgender males who have had prolonged androgen treatment and have discontinued testosterone but have not had genital surgery (79, 80). A reproductive endocrine gynecologist can counsel patients before gender-affirming hormone treatment or surgery regarding potential fertility options (81). Techniques for cryopreservation of oocytes, embryos, and ovarian tissue continue to improve, and oocyte maturation of immature tissue is being studied (82).

2.0 Treatment of Adolescents

During the past decade, clinicians have progressively acknowledged the suffering of young adolescents with GD/gender incongruence. In some forms of GD/gender incongruence, psychological interventions may be useful and sufficient. However, for many adolescents with GD/gender incongruence, the pubertal physical changes are unbearable. As early medical intervention may prevent psychological harm, various clinics have decided to start treating young adolescents with GD/gender incongruence with puberty-suppressing medication (a GnRH analog). As compared with starting gender-affirming treatment long after the first phases of puberty, a benefit of pubertal suppression at early puberty may be a better psychological and physical outcome.

In girls, the first physical sign of puberty is the budding of the breasts followed by an increase in breast and fat tissue. Breast development is also associated with the pubertal growth spurt, and menarche occurs ~2 years later. In boys, the first physical change is testicular growth. A testicular volume ≥4 mL is seen as consistent with the initiation of physical puberty. At the beginning of puberty, estradiol and testosterone levels are still low and are best measured in the early morning with an ultrasensitive assay. From a testicular volume of 10 mL, daytime testosterone levels increase, leading to virilization (83). Note that pubic hair and/or axillary hair/odor may not reflect the onset of gonadarche; instead, it may reflect adrenarche alone.

2.1. We suggest that adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment (Table 5), and are requesting treatment should initially undergo treatment to suppress pubertal development. (2 |⊕⊕○○)

2.2. We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty (Tanner stages G2/B2). (2 |⊕⊕○○)

Evidence

Pubertal suppression can expand the diagnostic phase by a long period, giving the subject more time to explore options and to live in the experienced gender before making a decision to proceed with gender-affirming sex hormone treatments and/or surgery, some of which is irreversible (84, 85). Pubertal suppression is fully reversible, enabling full pubertal development in the natal gender, after cessation of treatment, if appropriate. The experience of full endogenous puberty is an undesirable condition for the GD/gender-incongruent individual and may seriously interfere with healthy psychological functioning and well-being. Treating GD/gender-incongruent adolescents entering puberty with GnRH analogs has been shown to improve psychological functioning in several domains (86).

Another reason to start blocking pubertal hormones early in puberty is that the physical outcome is improved compared with initiating physical transition after puberty has been completed (60, 62). Looking like a man or woman when living as the opposite sex creates difficult

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 329 of 371 Total Pages:(329 of 1263)
Case 4:15-cv-00054-AWA-RJK Document 192-6 Filed 03/26/19 Page 13 of 35 PageID# 2030

barriers with enormous life-long disadvantages. We therefore advise starting suppression in early puberty to prevent the irreversible development of undesirable secondary sex characteristics. However, adolescents with GD/gender incongruence should experience the first changes of their endogenous spontaneous puberty, because their emotional reaction to these first physical changes has diagnostic value in establishing the persistence of GD/gender incongruence (85). Thus, Tanner stage 2 is the optimal time to start pubertal suppression. However, pubertal suppression treatment in early puberty will limit the growth of the penis and scrotum, which will have a potential effect on future surgical treatments (87).

Clinicians can also use pubertal suppression in adolescents in later pubertal stages to stop menses in transgender males and prevent facial hair growth in transgender females. However, in contrast to the effects in early pubertal adolescents, physical sex characteristics (such as more advanced breast development in transgender boys and lowering of the voice and outgrowth of the jaw and brow in transgender girls) are not reversible.

Values and preferences

These recommendations place a high value on avoiding an unsatisfactory physical outcome when secondary sex characteristics have become manifest and irreversible, a higher value on psychological well-being, and a lower value on avoiding potential harm from early pubertal suppression.

Remarks

Table 6 lists the Tanner stages of breast and male genital development. Careful documentation of hallmarks of pubertal development will ensure precise timing when initiating pubertal suppression once puberty has started. Clinicians can use pubertal LH and sex steroid levels to confirm that puberty has progressed sufficiently before starting pubertal suppression (88). Reference ranges for sex steroids by Tanner stage may vary depending on the assay used. Ultrasensitive sex steroid and gonadotropin assays will help clinicians document early pubertal changes.

Irreversible and, for GD/gender-incongruent adolescents, undesirable sex characteristics in female puberty are breasts, female body habitus, and, in some cases, relative short stature. In male puberty, they are a prominent Adam's apple; low voice; male bone configuration, such as a large jaw, big feet and hands, and tall stature; and male hair pattern on the face and extremities.

2.3. We recommend that, where indicated, GnRH analogues are used to suppress pubertal hormones. (1 |⊕⊕○○)

Evidence

Clinicians can suppress pubertal development and gonadal function most effectively via gonadotropin suppression using GnRH analogs. GnRH analogs are long-acting agonists that suppress gonadotropins by GnRH receptor desensitization after an initial increase of gonadotropins during ~10 days after the first and (to a lesser degree) the second injection (89). Antagonists immediately suppress pituitary gonadotropin secretion (90, 91). Long-acting GnRH analogs are the currently preferred treatment option. Clinicians may consider long-acting GnRH antagonists when evidence on their safety and efficacy in adolescents becomes available.

During GnRH analog treatment, slight development of secondary sex characteristics may regress, and in a later phase of pubertal development, it will stop. In girls, breast tissue will become atrophic, and menses will stop. In boys, virilization will stop, and testicular volume may decrease (92).

An advantage of using GnRH analogs is the reversibility of the intervention. If, after extensive exploration of his/her transition wish, the individual no longer desires transition, they can discontinue pubertal suppression. In subjects with

Table 6. Tanner Stages of Breast Development and Male External Genitalia

The description of Tanner stages for breast development:
1. Prepubertal
2. Breast and papilla elevated as small mound; areolar diameter increased
3. Breast and areola enlarged, no contour separation
4. Areola and papilla form secondary mound
5. Mature; nipple projects, areola part of general breast contour

For penis and testes:
1. Prepubertal, testicular volume <4 mL
2. Slight enlargement of penis; enlarged scrotum, pink, texture altered, testes 4–6 mL
3. Penis longer, testes larger (8–12 mL)
4. Penis and glans larger, including increase in breadth; testes larger (12–15 mL), scrotum dark
5. Penis adult size; testicular volume > 15 ml

Adapted from Lawrence (56).

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 330 of 371 Total Pages:(330 of 1263)
Case 4:15-cv-00054-AWA-RJK Document 192-6 Filed 03/26/19 Page 14 of 35 PageID# 2031

precocious puberty, spontaneous pubertal development has been shown to resume after patients discontinue taking GnRH analogs (93).

Recommendations 2.1 to 2.3 are supported by a prospective follow-up study from The Netherlands. This report assessed mental health outcomes in 55 transgender adolescents/young adults (22 transgender females and 33 transgender males) at three time points: (1) before the start of GnRH agonist (average age of 14.8 years at start of treatment), (2) at initiation of gender-affirming hormones (average age of 16.7 years at start of treatment), and (3) 1 year after "gender-reassignment surgery" (average age of 20.7 years) (63). Despite a decrease in depression and an improvement in general mental health functioning, GD/gender incongruence persisted through pubertal suppression, as previously reported (86). However, following sex hormone treatment and gender-reassignment surgery, GD/gender incongruence was resolved and psychological functioning steadily improved (63). Furthermore, well-being was similar to or better than that reported by age-matched young adults from the general population, and none of the study participants regretted treatment. This study represents the first long-term follow-up of individuals managed according to currently existing clinical practice guidelines for transgender youth, and it underscores the benefit of the multidisciplinary approach pioneered in The Netherlands; however, further studies are needed.

Side effects

The primary risks of pubertal suppression in GD/gender-incongruent adolescents may include adverse effects on bone mineralization (which can theoretically be reversed with sex hormone treatment), compromised fertility if the person subsequently is treated with sex hormones, and unknown effects on brain development. Few data are available on the effect of GnRH analogs on BMD in adolescents with GD/gender incongruence. Initial data in GD/gender-incongruent subjects demonstrated no change of absolute areal BMD during 2 years of GnRH analog therapy but a decrease in BMD z scores (85). A recent study also suggested suboptimal bone mineral accrual during GnRH analog treatment. The study reported a decrease in areal BMD z scores and of bone mineral apparent density z scores (which takes the size of the bone into account) in 19 transgender males treated with GnRH analogs from a mean age of 15.0 years (standard deviation = 2.0 years) for a median duration of 1.5 years (0.3 to 5.2 years) and in 15 transgender females treated from 14.9 (±1.9) years for 1.3 years (0.5 to 3.8 years), although not all changes were statistically significant (94). There was incomplete catch-up at age 22 years after sex hormone treatment from age 16.6 (±1.4) years for a median duration of 5.8 years (3.0 to 8.0 years) in transgender females and from age 16.4 (±2.3) years for 5.4 years (2.8 to 7.8 years) in transgender males. Little is known about more prolonged use of GnRH analogs. Researchers reported normal BMD z scores at age 35 years in one individual who used GnRH analogs from age 13.7 years until age 18.6 years before initiating sex hormone treatment (65).

Additional data are available from individuals with late puberty or GnRH analog treatment of other indications. Some studies reported that men with constitutionally delayed puberty have decreased BMD in adulthood (95). However, other studies reported that these men have normal BMD (96, 97). Treating adults with GnRH analogs results in a decrease of BMD (98). In children with central precocious puberty, treatment with GnRH analogs has been found to result in a decrease of BMD during treatment by some (99) but not others (100). Studies have reported normal BMD after discontinuing therapy (69, 72, 73, 101, 102). In adolescents treated with growth hormone who are small for gestational age and have normal pubertal timing, 2-year GnRH analog treatments did not adversely affect BMD (103). Calcium supplementation may be beneficial in optimizing bone health in GnRH analog–treated individuals (104). There are no studies of vitamin D supplementation in this context, but clinicians should offer supplements to vitamin D–deficient adolescents. Physical activity, especially during growth, is important for bone mass in healthy individuals (103) and is therefore likely to be beneficial for bone health in GnRH analog–treated subjects.

GnRH analogs did not induce a change in body mass index standard deviation score in GD/gender-incongruent adolescents (94) but caused an increase in fat mass and decrease in lean body mass percentage (92). Studies in girls treated for precocious puberty also reported a stable body mass index standard deviation score during treatment (72) and body mass index and body composition comparable to controls after treatment (73).

Arterial hypertension has been reported as an adverse effect in a few girls treated with GnRH analogs for precocious/early puberty (105, 106). Blood pressure monitoring before and during treatment is recommended.

Individuals may also experience hot flashes, fatigue, and mood alterations as a consequence of pubertal suppression. There is no consensus on treatment of these side effects in this context.

It is recommended that any use of pubertal blockers (and subsequent use of sex hormones, as detailed below) include a discussion about implications for fertility (see recommendation 1.3). Transgender adolescents may

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 331 of 371 Total Pages:(331 of 1263)
Case 4:15-cv-00054-AWA-RJK Document 192-6 Filed 03/26/19 Page 15 of 35 PageID# 2032

want to preserve fertility, which may be otherwise compromised if puberty is suppressed at an early stage and the individual completes phenotypic transition with the use of sex hormones.

Limited data are available regarding the effects of GnRH analogs on brain development. A single cross-sectional study demonstrated no compromise of executive function (107), but animal data suggest there may be an effect of GnRH analogs on cognitive function (108).

Values and preferences

Our recommendation of GnRH analogs places a higher value on the superior efficacy, safety, and reversibility of the pubertal hormone suppression achieved (as compared with the alternatives) and a relatively lower value on limiting the cost of therapy. Of the available alternatives, depot and oral progestin preparations are effective. Experience with this treatment dates back prior to the emergence of GnRH analogs for treating precocious puberty in papers from the 1960s and early 1970s (109–112). These compounds are usually safe, but some side effects have been reported (113–115). Only two recent studies involved transgender youth (116, 117). One of these studies described the use of oral lynestrenol monotherapy followed by the addition of testosterone treatment in transgender boys who were at Tanner stage B4 or further at the start of treatment (117). They found lynestrenol safe, but gonadotropins were not fully suppressed. The study reported metrorrhagia in approximately half of the individuals, mainly in the first 6 months. Acne, headache, hot flashes, and fatigue were other frequent side effects. Another progestin that has been studied in the United States is medroxyprogesterone. This agent is not as effective as GnRH analogs in lowering endogenous sex hormones either and may be associated with other side effects (116). Progestin preparations may be an acceptable treatment for persons without access to GnRH analogs or with a needle phobia. If GnRH analog treatment is not available (insurance denial, prohibitive cost, or other reasons), postpubertal, transgender female adolescents may be treated with an antiandrogen that directly suppresses androgen synthesis or action (see adult section).

Remarks

Measurements of gonadotropin and sex steroid levels give precise information about gonadal axis suppression, although there is insufficient evidence for any specific short-term monitoring scheme in children treated with GnRH analogs (88). If the gonadal axis is not completely suppressed—as evidenced by (for example) menses, erections, or progressive hair growth—the interval of GnRH analog treatment can be shortened or the dose increased. During treatment, adolescents should be monitored for negative effects of delaying puberty, including a halted growth spurt and impaired bone mineral accretion. Table 7 illustrates a suggested clinical protocol.

Anthropometric measurements and X-rays of the left hand to monitor bone age are informative for evaluating growth. To assess BMD, clinicians can perform dual-energy X-ray absorptiometry scans.

2.4. In adolescents who request sex hormone treatment (given this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule (see Table 8) after a multidisciplinary team of medical and MHPs has confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16 years (Table 5). (1 |⊕⊕○○)

2.5. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD/gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years. As with the care of adolescents ≥16 years of age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment. (1 |⊕○○○)

2.6. We suggest monitoring clinical pubertal development every 3 to 6 months and laboratory parameters every 6 to 12 months during sex hormone treatment (Table 9). (2 |⊕⊕○○)

Table 7. Baseline and Follow-Up Protocol During Suppression of Puberty

Every 3–6 mo
  Anthropometry: height, weight, sitting height, blood pressure, Tanner stages
Every 6–12 mo
  Laboratory: LH, FSH, E2/T, 25OH vitamin D
Every 1–2 y
  Bone density using DXA
  Bone age on X-ray of the left hand (if clinically indicated)

Adapted from Hembree *et al.* (118).

Abbreviations: DXA, dual-energy X-ray absorptiometry; E2, estradiol; FSH, follicle stimulating hormone; LH, luteinizing hormone; T, testosterone;

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 332 of 371 Total Pages:(332 of 1263)
Case 4:15-cv-00054-AWA-RJK Document 192-6 Filed 03/26/19 Page 16 of 35 PageID# 2033

Table 8. Protocol Induction of Puberty

Induction of female puberty with oral 17β-estradiol, increasing the dose every 6 mo:
- 5 μg/kg/d
- 10 μg/kg/d
- 15 μg/kg/d
- 20 μg/kg/d
- Adult dose = 2–6 mg/d
- *In postpubertal transgender female adolescents, the dose of 17β-estradiol can be increased more rapidly:*
  - 1 mg/d for 6 mo
  - 2 mg/d

Induction of female puberty with transdermal 17β-estradiol, increasing the dose every 6 mo (new patch is placed every 3.5 d):
- 6.25–12.5 μg/24 h (cut 25-μg patch into quarters, then halves)
- 25 μg/24 h
- 37.5 μg/24 h
- Adult dose = 50–200 μg/24 h
- *For alternatives once at adult dose, see Table 11.*
- *Adjust maintenance dose to mimic physiological estradiol levels (see Table 15).*

Induction of male puberty with testosterone esters increasing the dose every 6 mo (IM or SC):
- 25 mg/m^2/2 wk (or alternatively, half this dose weekly, or double the dose every 4 wk)
- 50 mg/m^2/2 wk
- 75 mg/m^2/2 wk
- 100 mg/m^2/2 wk
- Adult dose = 100–200 mg every 2 wk
- *In postpubertal transgender male adolescents the dose of testosterone esters can be increased more rapidly:*
  - 75 mg/2 wk for 6 mo
  - 125 mg/2 wk
- *For alternatives once at adult dose, see Table 11.*
- *Adjust maintenance dose to mimic physiological testosterone levels (see Table 14).*

Adapted from Hembree *et al.* (118).

Abbreviations: IM, intramuscularly; SC, subcutaneously.

Evidence

Adolescents develop competence in decision making at their own pace. Ideally, the supervising medical professionals should individually assess this competence, although no objective tools to make such an assessment are currently available.

Many adolescents have achieved a reasonable level of competence by age 15 to 16 years (119), and in many countries 16-year-olds are legally competent with regard to medical decision making (120). However, others believe that although some capacities are generally achieved before age 16 years, other abilities (such as good risk assessment) do not develop until well after 18 years (121). They suggest that health care procedures should be divided along a matrix of relative risk, so that younger adolescents can be allowed to decide about low-risk procedures, such as most diagnostic tests and common therapies, but not about high-risk procedures, such as most surgical procedures (121).

Currently available data from transgender adolescents support treatment with sex hormones starting at age 16 years (63, 122). However, some patients may incur potential risks by waiting until age 16 years. These include the potential risk to bone health if puberty is suppressed

Table 9. Baseline and Follow-up Protocol During Induction of Puberty

Every 3–6 mo
- Anthropometry: height, weight, sitting height, blood pressure, Tanner stages

Every 6–12 mo
- In transgender males: hemoglobin/hematocrit, lipids, testosterone, 25OH vitamin D
- In transgender females: prolactin, estradiol, 25OH vitamin D

Every 1–2 y
- BMD using DXA
- Bone age on X-ray of the left hand (if clinically indicated)

BMD should be monitored into adulthood (until the age of 25–30 y or until peak bone mass has been reached).
For recommendations on monitoring once pubertal induction has been completed, see Tables 14 and 15.

Adapted from Hembree *et al.* (118).

Abbreviation: DXA, dual-energy X-ray absorptiometry.

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

doi: 10.1210/jc.2017-01658

for 6 to 7 years before initiating sex hormones (*e.g.*, if someone reached Tanner stage 2 at age 9-10 years old). Additionally, there may be concerns about inappropriate height and potential harm to mental health (emotional and social isolation) if initiation of secondary sex characteristics must wait until the person has reached 16 years of age. However, only minimal data supporting earlier use of gender-affirming hormones in transgender adolescents currently exist (63). Clearly, long-term studies are needed to determine the optimal age of sex hormone treatment in GD/gender-incongruent adolescents.

The MHP who has followed the adolescent during GnRH analog treatment plays an essential role in assessing whether the adolescent is eligible to start sex hormone therapy and capable of consenting to this treatment (Table 5). Support of the family/environment is essential. Prior to the start of sex hormones, clinicians should discuss the implications for fertility (see recommendation 1.5). Throughout pubertal induction, an MHP and a pediatric endocrinologist (or other clinician competent in the evaluation and induction of pubertal development) should monitor the adolescent. In addition to monitoring therapy, it is also important to pay attention to general adolescent health issues, including healthy life style choices, such as not smoking, contraception, and appropriate vaccinations (*e.g.*, human papillomavirus).

For the induction of puberty, clinicians can use a similar dose scheme for hypogonadal adolescents with GD/gender incongruence as they use in other individuals with hypogonadism, carefully monitoring for desired and undesired effects (Table 8). In transgender female adolescents, transdermal 17β-estradiol may be an alternative for oral 17β-estradiol. It is increasingly used for pubertal induction in hypogonadal females. However, the absence of low-dose estrogen patches may be a problem. As a result, individuals may need to cut patches to size themselves to achieve appropriate dosing (123). In transgender male adolescents, clinicians can give testosterone injections intramuscularly or subcutaneously (124, 125).

When puberty is initiated with a gradually increasing schedule of sex steroid doses, the initial levels will not be high enough to suppress endogenous sex steroid secretion. Gonadotropin secretion and endogenous production of testosterone may resume and interfere with the effectiveness of estrogen treatment, in transgender female adolescents (126, 127). Therefore, continuation of GnRH analog treatment is advised until gonadectomy. Given that GD/gender-incongruent adolescents may opt not to have gonadectomy, long-term studies are necessary to examine the potential risks of prolonged GnRH analog treatment. Alternatively, in transgender male adolescents, GnRH analog treatment can be discontinued once an adult dose of testosterone has been reached and the individual is well virilized. If uterine bleeding occurs, a progestin can be added. However, the combined use of a GnRH analog (for ovarian suppression) and testosterone may enable phenotypic transition with a lower dose of testosterone in comparison with testosterone alone. If there is a wish or need to discontinue GnRH analog treatment in transgender female adolescents, they may be treated with an antiandrogen that directly suppresses androgen synthesis or action (see section 3.0 "Hormonal Therapy for Transgender Adults").

Values and preferences

The recommendation to initiate pubertal induction only when the individual has sufficient mental capacity (roughly age 16 years) to give informed consent for this partly irreversible treatment places a higher value on the ability of the adolescent to fully understand and oversee the partially irreversible consequences of sex hormone treatment and to give informed consent. It places a lower value on the possible negative effects of delayed puberty. We may not currently have the means to weigh adequately the potential benefits of waiting until around age 16 years to initiate sex hormones vs the potential risks/harm to BMD and the sense of social isolation from having the timing of puberty be so out of sync with peers (128).

Remarks

Before starting sex hormone treatment, effects on fertility and options for fertility preservation should be discussed. Adult height may be a concern in transgender adolescents. In a transgender female adolescent, clinicians may consider higher doses of estrogen or a more rapid tempo of dose escalation during pubertal induction. There are no established treatments yet to augment adult height in a transgender male adolescent with open epiphyses during pubertal induction. It is not uncommon for transgender adolescents to present for clinical services after having completed or nearly completed puberty. In such cases, induction of puberty with sex hormones can be done more rapidly (see Table 8). Additionally, an adult dose of testosterone in transgender male adolescents may suffice to suppress the gonadal axis without the need to use a separate agent. At the appropriate time, the multidisciplinary team should adequately prepare the adolescent for transition to adult care.

3.0 Hormonal Therapy for Transgender Adults

The two major goals of hormonal therapy are (1) to reduce endogenous sex hormone levels, and thus reduce

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 334 of 371 Total Pages:(334 of 1263)
Case 4:15-cv-00054-AWA-RJK Document 192-6 Filed 03/26/19 Page 18 of 35 PageID# 2035

the secondary sex characteristics of the individual's designated gender, and (2) to replace endogenous sex hormone levels consistent with the individual's gender identity by using the principles of hormone replacement treatment of hypogonadal patients. The timing of these two goals and the age at which to begin treatment with the sex hormones of the chosen gender is codetermined in collaboration with both the person pursuing transition and the health care providers. The treatment team should include a medical provider knowledgeable in transgender hormone therapy, an MHP knowledgeable in GD/gender incongruence and the mental health concerns of transition, and a primary care provider able to provide care appropriate for transgender individuals. The physical changes induced by this sex hormone transition are usually accompanied by an improvement in mental well-being (129, 130).

3.1. We recommend that clinicians confirm the diagnostic criteria of GD/gender incongruence and the criteria for the endocrine phase of gender transition before beginning treatment. (1 |⊕⊕⊕○)

3.2. We recommend that clinicians evaluate and address medical conditions that can be exacerbated by hormone depletion and treatment with sex hormones of the affirmed gender before beginning treatment (Table 10). (1 |⊕⊕⊕○)

3.3. We suggest that clinicians measure hormone levels during treatment to ensure that endogenous sex steroids are suppressed and administered sex steroids are maintained in the normal physiologic range for the affirmed gender. (2 |⊕⊕○○)

Evidence

It is the responsibility of the treating clinician to confirm that the person fulfills criteria for treatment. The treating clinician should become familiar with the terms and criteria presented in Tables 1–5 and take a thorough history from the patient in collaboration with the other members of the treatment team. The treating clinician must ensure that the desire for transition is appropriate; the consequences, risks, and benefits of treatment are well understood; and the desire for transition persists. They also need to discuss fertility preservation options (see recommendation 1.3) (67, 68).

Transgender males

Clinical studies have demonstrated the efficacy of several different androgen preparations to induce masculinization in transgender males (Appendix A) (113, 114, 131–134). Regimens to change secondary sex characteristics follow the general principle of hormone replacement treatment of male hypogonadism (135). Clinicians can use either parenteral or transdermal preparations to achieve testosterone values in the normal male range (this is dependent on the specific assay, but is typically 320 to 1000 ng/dL) (Table 11) (136). Sustained supraphysiologic levels of testosterone increase the risk of adverse reactions (see section 4.0 "Adverse Outcome Prevention and Long-Term Care") and should be avoided.

Similar to androgen therapy in hypogonadal men, testosterone treatment in transgender males results in increased muscle mass and decreased fat mass, increased facial hair and acne, male pattern baldness in those genetically predisposed, and increased sexual desire (137).

Table 10. Medical Risks Associated With Sex Hormone Therapy

Transgender female: estrogen
- Very high risk of adverse outcomes:
  - Thromboembolic disease
- Moderate risk of adverse outcomes:
  - Macroprolactinoma
  - Breast cancer
  - Coronary artery disease
  - Cerebrovascular disease
  - Cholelithiasis
  - Hypertriglyceridemia

Transgender male: testosterone
- Very high risk of adverse outcomes:
  - Erythrocytosis (hematocrit > 50%)
- Moderate risk of adverse outcomes:
  - Severe liver dysfunction (transaminases > threefold upper limit of normal)
  - Coronary artery disease
  - Cerebrovascular disease
  - Hypertension
  - Breast or uterine cancer

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

doi: 10.1210/jc.2017-01658

Table 11. Hormone Regimens in Transgender Persons

Transgender females[a]	
Estrogen	
Oral	
Estradiol	2.0–6.0 mg/d
Transdermal	
Estradiol transdermal patch (New patch placed every 3–5 d)	0.025–0.2 mg/d
Parenteral	
Estradiol valerate or cypionate	5–30 mg IM every 2 wk 2–10 mg IM every week
Anti-androgens	
Spironolactone	100–300 mg/d
Cyproterone acetate[b]	25–50 mg/d
GnRH agonist	3.75 mg SQ (SC) monthly 11.25 mg SQ (SC) 3-monthly
Transgender males	
Testosterone	
Parenteral testosterone	
Testosterone enanthate or cypionate	100–200 mg SQ (IM) every 2 wk or SQ (SC) 50% per week
Testosterone undecanoate[c]	1000 mg every 12 wk
Transdermal testosterone	
Testosterone gel 1.6%[d]	50–100 mg/d
Testosterone transdermal patch	2.5–7.5 mg/d

Abbreviations: IM, intramuscularly; SQ, sequentially; SC, subcutaneously.

[a]Estrogens used with or without antiandrogens or GnRH agonist.

[b]Not available in the United States.

[c]One thousand milligrams initially followed by an injection at 6 wk then at 12-wk intervals.

[d]Avoid cutaneous transfer to other individuals.

In transgender males, testosterone will result in clitoromegaly, temporary or permanent decreased fertility, deepening of the voice, cessation of menses (usually), and a significant increase in body hair, particularly on the face, chest, and abdomen. Cessation of menses may occur within a few months with testosterone treatment alone, although high doses of testosterone may be required. If uterine bleeding continues, clinicians may consider the addition of a progestational agent or endometrial ablation (138). Clinicians may also administer GnRH analogs or depot medroxyprogesterone to stop menses prior to testosterone treatment.

Transgender females

The hormone regimen for transgender females is more complex than the transgender male regimen (Appendix B). Treatment with physiologic doses of estrogen alone is insufficient to suppress testosterone levels into the normal range for females (139). Most published clinical studies report the need for adjunctive therapy to achieve testosterone levels in the female range (21, 113, 114, 132–134, 139, 140).

Multiple adjunctive medications are available, such as progestins with antiandrogen activity and GnRH agonists (141). Spironolactone works by directly blocking androgens during their interaction with the androgen receptor (114, 133, 142). It may also have estrogenic activity (143). Cyproterone acetate, a progestational compound with antiandrogenic properties (113, 132, 144), is widely used in Europe. 5α-Reductase inhibitors do not reduce testosterone levels and have adverse effects (145).

Dittrich *et al.* (141) reported that monthly doses of the GnRH agonist goserelin acetate in combination with estrogen were effective in reducing testosterone levels with a low incidence of adverse reactions in 60 transgender females. Leuprolide and transdermal estrogen were as effective as cyproterone and transdermal estrogen in a comparative retrospective study (146).

Patients can take estrogen as oral conjugated estrogens, oral 17β-estradiol, or transdermal 17β-estradiol. Among estrogen options, the increased risk of thromboembolic events associated with estrogens in general seems most concerning with ethinyl estradiol specifically (134, 140, 141), which is why we specifically suggest that it not be used in any transgender treatment plan. Data distinguishing among other estrogen options are less well established although there is some thought that oral routes of administration are more thrombogenic due to the "first pass effect" than are transdermal and parenteral routes, and that the risk of thromboembolic events is dose-dependent. Injectable estrogen and sublingual

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

estrogen may benefit from avoiding the first pass effect, but they can result in more rapid peaks with greater overall periodicity and thus are more difficult to monitor (147, 148). However, there are no data demonstrating that increased periodicity is harmful otherwise.

Clinicians can use serum estradiol levels to monitor oral, transdermal, and intramuscular estradiol. Blood tests cannot monitor conjugated estrogens or synthetic estrogen use. Clinicians should measure serum estradiol and serum testosterone and maintain them at the level for premenopausal females (100 to 200 pg/mL and <50 ng/dL, respectively). The transdermal preparations and injectable estradiol cypionate or valerate preparations may confer an advantage in older transgender females who may be at higher risk for thromboembolic disease (149).

Values

Our recommendation to maintain levels of gender-affirming hormones in the normal adult range places a high value on the avoidance of the long-term complications of pharmacologic doses. Those patients receiving endocrine treatment who have relative contraindications to hormones should have an in-depth discussion with their physician to balance the risks and benefits of therapy.

Remarks

Clinicians should inform all endocrine-treated individuals of all risks and benefits of gender-affirming hormones prior to initiating therapy. Clinicians should strongly encourage tobacco use cessation in transgender females to avoid increased risk of VTE and cardiovascular complications. We strongly discourage the unsupervised use of hormone therapy (150).

Not all individuals with GD/gender incongruence seek treatment as described (*e.g.*, male-to-eunuchs and individuals seeking partial transition). Tailoring current protocols to the individual may be done within the context of accepted safety guidelines using a multidisciplinary approach including mental health. No evidence-based protocols are available for these groups (151). We need prospective studies to better understand treatment options for these persons.

3.4. We suggest that endocrinologists provide education to transgender individuals undergoing treatment about the onset and time course of physical changes induced by sex hormone treatment. (2 |⊕○○○)

Evidence

Transgender males

Physical changes that are expected to occur during the first 1 to 6 months of testosterone therapy include cessation of menses, increased sexual desire, increased facial and body hair, increased oiliness of skin, increased muscle, and redistribution of fat mass. Changes that occur within the first year of testosterone therapy include deepening of the voice (152, 153), clitoromegaly, and male pattern hair loss (in some cases) (114, 144, 154, 155) (Table 12).

Transgender females

Physical changes that may occur in transgender females in the first 3 to 12 months of estrogen and antiandrogen therapy include decreased sexual desire, decreased spontaneous erections, decreased facial and body hair (usually mild), decreased oiliness of skin, increased breast tissue growth, and redistribution of fat mass (114, 139, 149, 154, 155, 161) (Table 13). Breast development is generally maximal at 2 years after initiating hormones (114, 139, 149, 155). Over a long period of time, the prostate gland and testicles will undergo atrophy.

Although the time course of breast development in transgender females has been studied (150), precise information about other changes induced by sex hormones is lacking (141). There is a great deal of variability among individuals, as evidenced during pubertal development. We all know that a major concern for transgender females is breast development. If we work with estrogens, the result will be often not what the transgender female expects.

Alternatively, there are transgender females who report an anecdotal improved breast development, mood, or sexual desire with the use of progestogens. However, there have been no well-designed studies of the role of progestogens in feminizing hormone regimens, so the question is still open.

Our knowledge concerning the natural history and effects of different cross-sex hormone therapies on breast

Table 12. Masculinizing Effects in Transgender Males

Effect	Onset	Maximum
Skin oiliness/acne	1–6 mo	1–2 y
Facial/body hair growth	6–12 mo	4–5 y
Scalp hair loss	6–12 mo	—[a]
Increased muscle mass/strength	6–12 mo	2–5 y
Fat redistribution	1–6 mo	2–5 y
Cessation of menses	1–6 mo	—[b]
Clitoral enlargement	1–6 mo	1–2 y
Vaginal atrophy	1–6 mo	1–2 y
Deepening of voice	6–12 mo	1–2 y

Estimates represent clinical observations: Toorians *et al.* (149), Asscheman *et al.* (156), Gooren *et al.* (157), Wierckx *et al.* (158).

[a]Prevention and treatment as recommended for biological men.

[b]Menorrhagia requires diagnosis and treatment by a gynecologist.

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 337 of 371 Total Pages:(337 of 1263)
Case 4:15-cv-00054-AWA-RJK Document 192-6 Filed 03/26/19 Page 21 of 35 PageID# 2038

Table 13. Feminizing Effects in Transgender Females

Effect	Onset	Maximum
Redistribution of body fat	3–6 mo	2–3 y
Decrease in muscle mass and strength	3–6 mo	1–2 y
Softening of skin/decreased oiliness	3–6 mo	Unknown
Decreased sexual desire	1–3 mo	3–6 mo
Decreased spontaneous erections	1–3 mo	3–6 mo
Male sexual dysfunction	Variable	Variable
Breast growth	3–6 mo	2–3 y
Decreased testicular volume	3–6 mo	2–3 y
Decreased sperm production	Unknown	>3 y
Decreased terminal hair growth	6–12 mo	>3 y[a]
Scalp hair	Variable	—[b]
Voice changes	None	—[c]

Estimates represent clinical observations: Toorians *et al.* (149), Asscheman *et al.* (156), Gooren *et al.* (157).

[a]Complete removal of male sexual hair requires electrolysis or laser treatment or both.

[b]Familial scalp hair loss may occur if estrogens are stopped.

[c]Treatment by speech pathologists for voice training is most effective.

development in transgender females is extremely sparse and based on the low quality of evidence. Current evidence does not indicate that progestogens enhance breast development in transgender females, nor does evidence prove the absence of such an effect. This prevents us from drawing any firm conclusion at this moment and demonstrates the need for further research to clarify these important clinical questions (162).

Values and preferences

Transgender persons have very high expectations regarding the physical changes of hormone treatment and are aware that body changes can be enhanced by surgical procedures (*e.g.*, breast, face, and body habitus). Clear expectations for the extent and timing of sex hormone–induced changes may prevent the potential harm and expense of unnecessary procedures.

4.0 Adverse Outcome Prevention and Long-Term Care

Hormone therapy for transgender males and females confers many of the same risks associated with sex hormone replacement therapy in nontransgender persons. The risks arise from and are worsened by inadvertent or intentional use of supraphysiologic doses of sex hormones, as well as use of inadequate doses of sex hormones to maintain normal physiology (131, 139).

4.1. We suggest regular clinical evaluation for physical changes and potential adverse changes in response to sex steroid hormones and laboratory monitoring of sex steroid hormone levels every 3 months during the first year of hormone therapy for transgender males and females and then once or twice yearly. (2 |⊕⊕○○)

Evidence

Pretreatment screening and appropriate regular medical monitoring are recommended for both transgender males and females during the endocrine transition and periodically thereafter (26, 155). Clinicians should monitor weight and blood pressure, conduct physical exams, and assess routine health questions, such as tobacco use, symptoms of depression, and risk of adverse events such as deep vein thrombosis/pulmonary embolism and other adverse effects of sex steroids.

Transgender males

Table 14 contains a standard monitoring plan for transgender males on testosterone therapy (154, 159). Key issues include maintaining testosterone levels in the physiologic normal male range and avoiding adverse events resulting from excess testosterone therapy, particularly erythrocytosis, sleep apnea, hypertension, excessive weight gain, salt retention, lipid changes, and excessive or cystic acne (135).

Because oral 17-alkylated testosterone is not recommended, serious hepatic toxicity is not anticipated with parenteral or transdermal testosterone use (163, 164). Past concerns regarding liver toxicity with testosterone have been alleviated with subsequent reports that indicate the risk of serious liver disease is minimal (144, 165, 166).

Transgender females

Table 15 contains a standard monitoring plan for transgender females on estrogens, gonadotropin suppression, or antiandrogens (160). Key issues include avoiding supraphysiologic doses or blood levels of estrogen that may lead to increased risk for thromboembolic disease, liver dysfunction, and hypertension. Clinicians should monitor serum estradiol levels using laboratories participating in external quality control, as measurements of estradiol in blood can be very challenging (167).

VTE may be a serious complication. A study reported a 20-fold increase in venous thromboembolic disease in a large cohort of Dutch transgender subjects (161). This increase may have been associated with the use of the synthetic estrogen, ethinyl estradiol (149). The incidence decreased when clinicians stopped administering ethinyl estradiol (161). Thus, the use of synthetic estrogens and conjugated estrogens is undesirable because of the inability to regulate doses by measuring serum levels and the risk of thromboembolic disease. In a German gender clinic, deep vein thrombosis occurred in 1 of 60 of transgender females treated with a GnRH analog and oral

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 338 of 371 Total Pages:(338 of 1263)
Case 4:15-cv-00054-AWA-RJK Document 192-6 Filed 03/26/19 Page 22 of 35 PageID# 2039

Table 14. Monitoring of Transgender Persons on Gender-Affirming Hormone Therapy: Transgender Male

1. Evaluate patient every 3 mo in the first year and then one to two times per year to monitor for appropriate signs of virilization and for development of adverse reactions.
2. Measure serum testosterone every 3 mo until levels are in the normal physiologic male range:[a]
   a. For testosterone enanthate/cypionate injections, the testosterone level should be measured midway between injections. The target level is 400–700 ng/dL to 400 ng/dL. Alternatively, measure peak and trough levels to ensure levels remain in the normal male range.
   b. For parenteral testosterone undecanoate, testosterone should be measured just before the following injection. If the level is <400 ng/dL, adjust dosing interval.
   c. For transdermal testosterone, the testosterone level can be measured no sooner than after 1 wk of daily application (at least 2 h after application).
3. Measure hematocrit or hemoglobin at baseline and every 3 mo for the first year and then one to two times a year. Monitor weight, blood pressure, and lipids at regular intervals.
4. Screening for osteoporosis should be conducted in those who stop testosterone treatment, are not compliant with hormone therapy, or who develop risks for bone loss.
5. If cervical tissue is present, monitoring as recommended by the American College of Obstetricians and Gynecologists.
6. Ovariectomy can be considered after completion of hormone transition.
7. Conduct sub- and periareolar annual breast examinations if mastectomy performed. If mastectomy is not performed, then consider mammograms as recommended by the American Cancer Society.

[a]Adapted from Lapauw *et al.* (154) and Ott *et al.* (159).

estradiol (141). The patient who developed a deep vein thrombosis was found to have a homozygous C677 T mutation in the methylenetetrahydrofolate reductase gene. In an Austrian gender clinic, administering gender-affirming hormones to 162 transgender females and 89 transgender males was not associated with VTE, despite an 8.0% and 5.6% incidence of thrombophilia (159). A more recent multinational study reported only 10 cases of VTE from a cohort of 1073 subjects (168). Thrombophilia screening of transgender persons initiating hormone treatment should be restricted to those with a personal or family history of VTE (159). Monitoring D-dimer levels during treatment is not recommended (169).

4.2. We suggest periodically monitoring prolactin levels in transgender females treated with estrogens. (2 |⊕⊕○○)

Evidence

Estrogen therapy can increase the growth of pituitary lactrotroph cells. There have been several reports of prolactinomas occurring after long-term, high-dose estrogen therapy (170–173). Up to 20% of transgender females treated with estrogens may have elevations in prolactin levels associated with enlargement of the pituitary gland (156). In most cases, the serum prolactin levels will return to the normal range with a reduction or discontinuation of the estrogen therapy or discontinuation of cyproterone acetate (157, 174, 175).

The onset and time course of hyperprolactinemia during estrogen treatment are not known. Clinicians should measure prolactin levels at baseline and then at least annually during the transition period and every 2 years thereafter. Given that only a few case studies reported prolactinomas, and prolactinomas were not reported in large cohorts of estrogen-treated persons, the risk is likely to be very low. Because the major presenting findings of microprolactinomas (hypogonadism and sometimes gynecomastia) are not apparent in transgender females, clinicians may perform radiologic examinations of the pituitary in those patients whose prolactin levels persistently increase despite stable or reduced estrogen levels. Some transgender individuals receive psychotropic medications that can increase prolactin levels (174).

Table 15. Monitoring of Transgender Persons on Gender-Affirming Hormone Therapy: Transgender Female

1. Evaluate patient every 3 mo in the first year and then one to two times per year to monitor for appropriate signs of feminization and for development of adverse reactions.
2. Measure serum testosterone and estradiol every 3 mo.
   a. Serum testosterone levels should be <50 ng/dL.
   b. Serum estradiol should not exceed the peak physiologic range: 100–200 pg/mL.
3. For individuals on spironolactone, serum electrolytes, particularly potassium, should be monitored every 3 mo in the first year and annually thereafter.
4. Routine cancer screening is recommended, as in nontransgender individuals (all tissues present).
5. Consider BMD testing at baseline (160). In individuals at low risk, screening for osteoporosis should be conducted at age 60 years or in those who are not compliant with hormone therapy.

This table presents strong recommendations and does not include lower level recommendations.

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 339 of 371 Total Pages:(339 of 1263)
Case 4:15-cv-00054-AWA-RJK Document 192-6 Filed 03/26/19 Page 23 of 35 PageID# 2040

4.3. We suggest that clinicians evaluate transgender persons treated with hormones for cardiovascular risk factors using fasting lipid profiles, diabetes screening, and/or other diagnostic tools. (2 |⊕⊕○○)

Evidence

Transgender males

Administering testosterone to transgender males results in a more atherogenic lipid profile with lowered high-density lipoprotein cholesterol and higher triglyceride and low-density lipoprotein cholesterol values (176–179). Studies of the effect of testosterone on insulin sensitivity have mixed results (178, 180). A randomized, open-label uncontrolled safety study of transgender males treated with testosterone undecanoate demonstrated no insulin resistance after 1 year (181, 182). Numerous studies have demonstrated the effects of sex hormone treatment on the cardiovascular system (160, 179, 183, 184). Long-term studies from The Netherlands found no increased risk for cardiovascular mortality (161). Likewise, a meta-analysis of 19 randomized trials in nontransgender males on testosterone replacement showed no increased incidence of cardiovascular events (185). A systematic review of the literature found that data were insufficient (due to very low–quality evidence) to allow a meaningful assessment of patient-important outcomes, such as death, stroke, myocardial infarction, or VTE in transgender males (176). Future research is needed to ascertain the potential harm of hormonal therapies (176). Clinicians should manage cardiovascular risk factors as they emerge according to established guidelines (186).

Transgender females

A prospective study of transgender females found favorable changes in lipid parameters with increased high-density lipoprotein and decreased low-density lipoprotein concentrations (178). However, increased weight, blood pressure, and markers of insulin resistance attenuated these favorable lipid changes. In a meta-analysis, only serum triglycerides were higher at ≥24 months without changes in other parameters (187). The largest cohort of transgender females (mean age 41 years, followed for a mean of 10 years) showed no increase in cardiovascular mortality despite a 32% rate of tobacco use (161).

Thus, there is limited evidence to determine whether estrogen is protective or detrimental on lipid and glucose metabolism in transgender females (176). With aging, there is usually an increase of body weight. Therefore, as with nontransgender individuals, clinicians should monitor and manage glucose and lipid metabolism and blood pressure regularly according to established guidelines (186).

4.4. We recommend that clinicians obtain BMD measurements when risk factors for osteoporosis exist, specifically in those who stop sex hormone therapy after gonadectomy. (1 |⊕⊕○○)

Evidence

Transgender males

Baseline bone mineral measurements in transgender males are generally in the expected range for their pretreatment gender (188). However, adequate dosing of testosterone is important to maintain bone mass in transgender males (189, 190). In one study (190), serum LH levels were inversely related to BMD, suggesting that low levels of sex hormones were associated with bone loss. Thus, LH levels in the normal range may serve as an indicator of the adequacy of sex steroid administration to preserve bone mass. The protective effect of testosterone may be mediated by peripheral conversion to estradiol, both systemically and locally in the bone.

Transgender females

A baseline study of BMD reported T scores less than −2.5 in 16% of transgender females (191). In aging males, studies suggest that serum estradiol more positively correlates with BMD than does testosterone (192, 193) and is more important for peak bone mass (194). Estrogen preserves BMD in transgender females who continue on estrogen and antiandrogen therapies (188, 190, 191, 195, 196).

Fracture data in transgender males and females are not available. Transgender persons who have undergone gonadectomy may choose not to continue consistent sex steroid treatment after hormonal and surgical sex reassignment, thereby becoming at risk for bone loss. There have been no studies to determine whether clinicians should use the sex assigned at birth or affirmed gender for assessing osteoporosis (*e.g.*, when using the FRAX tool). Although some researchers use the sex assigned at birth (with the assumption that bone mass has usually peaked for transgender people who initiate hormones in early adulthood), this should be assessed on a case-by-case basis until there are more data available. This assumption will be further complicated by the increasing prevalence of transgender people who undergo hormonal transition at a pubertal age or soon after puberty. Sex for comparison within risk assessment tools may be based on the age at which hormones were initiated and the length of exposure to hormones. In some cases, it may be

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 340 of 371 Total Pages:(340 of 1263)

reasonable to assess risk using both the male and female calculators and using an intermediate value. Because all subjects underwent normal pubertal development, with known effects on bone size, reference values for birth sex were used for all participants (154).

4.5. We suggest that transgender females with no known increased risk of breast cancer follow breast-screening guidelines recommended for those designated female at birth. (2 |⊕⊕○○)

4.6. We suggest that transgender females treated with estrogens follow individualized screening according to personal risk for prostatic disease and prostate cancer. (2 |⊕○○○)

Evidence

Studies have reported a few cases of breast cancer in transgender females (197–200). A Dutch study of 1800 transgender females followed for a mean of 15 years (range of 1 30 years) found one case of breast cancer. The Women's Health Initiative study reported that females taking conjugated equine estrogen without progesterone for 7 years did not have an increased risk of breast cancer as compared with females taking placebo (137).

In transgender males, a large retrospective study conducted at the U.S. Veterans Affairs medical health system identified seven breast cancers (194). The authors reported that this was not above the expected rate of breast cancers in cisgender females in this cohort. Furthermore, they did report one breast cancer that developed in a transgender male patient after mastectomy, supporting the fact that breast cancer can occur even after mastectomy. Indeed, there have been case reports of breast cancer developing in subareolar tissue in transgender males, which occurred after mastectomy (201, 202).

Women with primary hypogonadism (Turner syndrome) treated with estrogen replacement exhibited a significantly decreased incidence of breast cancer as compared with national standardized incidence ratios (203, 204). These studies suggest that estrogen therapy does not increase the risk of breast cancer in the short term (<20 to 30 years). We need long-term studies to determine the actual risk, as well as the role of screening mammograms. Regular examinations and gynecologic advice should determine monitoring for breast cancer.

Prostate cancer is very rare before the age of 40, especially with androgen deprivation therapy (205). Childhood or pubertal castration results in regression of the prostate and adult castration reverses benign prostate hypertrophy (206). Although van Kesteren *et al.* (207) reported that estrogen therapy does not induce hypertrophy or premalignant changes in the prostates of transgender females, studies have reported cases of benign prostatic hyperplasia in transgender females treated with estrogens for 20 to 25 years (208, 209). Studies have also reported a few cases of prostate carcinoma in transgender females (210–214).

Transgender females may feel uncomfortable scheduling regular prostate examinations. Gynecologists are not trained to screen for prostate cancer or to monitor prostate growth. Thus, it may be reasonable for transgender females who transitioned after age 20 years to have annual screening digital rectal examinations after age 50 years and prostate-specific antigen tests consistent with U.S. Preventive Services Task Force Guidelines (215).

4.7. We advise that clinicians determine the medical necessity of including a total hysterectomy and oophorectomy as part of gender-affirming surgery. (Ungraded Good Practice Statement)

Evidence

Although aromatization of testosterone to estradiol in transgender males has been suggested as a risk factor for endometrial cancer (216), no cases have been reported. When transgender males undergo hysterectomy, the uterus is small and there is endometrial atrophy (217, 218). Studies have reported cases of ovarian cancer (219, 220). Although there is limited evidence for increased risk of reproductive tract cancers in transgender males, health care providers should determine the medical necessity of a laparoscopic total hysterectomy as part of a gender-affirming surgery to prevent reproductive tract cancer (221).

Values

Given the discomfort that transgender males experience accessing gynecologic care, our recommendation for the medical necessity of total hysterectomy and oophorectomy places a high value on eliminating the risks of female reproductive tract disease and cancer and a lower value on avoiding the risks of these surgical procedures (related to the surgery and to the potential undesirable health consequences of oophorectomy) and their associated costs.

Remarks

The sexual orientation and type of sexual practices will determine the need and types of gynecologic care required following transition. Additionally, in certain countries, the approval required to change the sex in a birth certificate for transgender males may be dependent on having a complete hysterectomy. Clinicians should help patients research nonmedical administrative criteria and

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 341 of 371 Total Pages:(341 of 1263)

provide counseling. If individuals decide not to undergo hysterectomy, screening for cervical cancer is the same as all other females.

5.0 Surgery for Sex Reassignment and Gender Confirmation

For many transgender adults, genital gender-affirming surgery may be the necessary step toward achieving their ultimate goal of living successfully in their desired gender role. The type of surgery falls into two main categories: (1) those that directly affect fertility and (2) those that do not. Those that change fertility (previously called sex reassignment surgery) include genital surgery to remove the penis and gonads in the male and removal of the uterus and gonads in the female. The surgeries that effect fertility are often governed by the legal system of the state or country in which they are performed. Other gender-conforming surgeries that do not directly affect fertility are not so tightly governed.

Gender-affirming surgical techniques have improved markedly during the past 10 years. Reconstructive genital surgery that preserves neurologic sensation is now the standard. The satisfaction rate with surgical reassignment of sex is now very high (187). Additionally, the mental health of the individual seems to be improved by participating in a treatment program that defines a pathway of gender-affirming treatment that includes hormones and surgery (130, 144) (Table 16).

Surgery that affects fertility is irreversible. The World Professional Association for Transgender Health Standards of Care (222) emphasizes that the "threshold of 18 should not be seen as an indication in itself for active intervention." If the social transition has not been satisfactory, if the person is not satisfied with or is ambivalent about the effects of sex hormone treatment, or if the person is ambivalent about surgery then the individual should not be referred for surgery (223, 224).

Gender-affirming genital surgeries for transgender females that affect fertility include gonadectomy, penectomy, and creation of a neovagina (225, 226). Surgeons often invert the skin of the penis to form the wall of the vagina, and several literatures reviews have reported on outcomes (227). Sometimes there is inadequate tissue to form a full neovagina, so clinicians have revisited using intestine and found it to be successful (87, 228, 229). Some newer vaginoplasty techniques may involve autologuous oral epithelial cells (230, 231).

The scrotum becomes the labia majora. Surgeons use reconstructive surgery to fashion the clitoris and its hood, preserving the neurovascular bundle at the tip of the penis as the neurosensory supply to the clitoris. Some surgeons are also creating a sensate pedicled-spot adding a G spot to the neovagina to increase sensation (232). Most recently, plastic surgeons have developed techniques to fashion labia minora. To further complete the feminization, uterine transplants have been proposed and even attempted (233).

Neovaginal prolapse, rectovaginal fistula, delayed healing, vaginal stenosis, and other complications do sometimes occur (234, 235). Clinicians should strongly remind the transgender person to use their dilators to maintain the depth and width of the vagina throughout the postoperative period. Genital sexual responsivity and other aspects of sexual function are usually preserved following genital gender-affirming surgery (236, 237).

Ancillary surgeries for more feminine or masculine appearance are not within the scope of this guideline. Voice therapy by a speech language pathologist is available to transform speech patterns to the affirmed gender (148). Spontaneous voice deepening occurs during testosterone treatment of transgender males (152, 238). No studies have compared the effectiveness of speech therapy, laryngeal surgery, or combined treatment.

Breast surgery is a good example of gender-confirming surgery that does not affect fertility. In all females, breast size exhibits a very broad spectrum. For transgender females to make the best informed decision, clinicians should delay breast augmentation surgery until the patient has completed at least 2 years of estrogen therapy, because the breasts continue to grow during that time (141, 155).

Another major procedure is the removal of facial and masculine-appearing body hair using either electrolysis or

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

Table 16. Criteria for Gender-Affirming Surgery, Which Affects Fertility

1. Persistent, well-documented gender dysphoria
2. Legal age of majority in the given country
3. Having continuously and responsibly used gender-affirming hormones for 12 mo (if there is no medical contraindication to receiving such therapy)
4. Successful continuous full-time living in the new gender role for 12 mo
5. If significant medical or mental health concerns are present, they must be well controlled
6. Demonstrable knowledge of all practical aspects of surgery (*e.g.*, cost, required lengths of hospitalizations, likely complications, postsurgical rehabilitation)

laser treatments. Other feminizing surgeries, such as that to feminize the face, are now becoming more popular (239–241).

In transgender males, clinicians usually delay gender-affirming genital surgeries until after a few years of androgen therapy. Those surgeries that affect fertility in this group include oophorectomy, vaginectomy, and complete hysterectomy. Surgeons can safely perform them vaginally with laparoscopy. These are sometimes done in conjunction with the creation of a neopenis. The cosmetic appearance of a neopenis is now very good, but the surgery is multistage and very expensive (242, 243). Radial forearm flap seems to be the most satisfactory procedure (228, 244). Other flaps also exist (245). Surgeons can make neopenile erections possible by reinervation of the flap and subsequent contraction of the muscle, leading to stiffening of the neopenis (246, 247), but results are inconsistent (248). Surgeons can also stiffen the penis by imbedding some mechanical device (*e.g.*, a rod or some inflatable apparatus) (249, 250). Because of these limitations, the creation of a neopenis has often been less than satisfactory. Recently, penis transplants are being proposed (233).

In fact, most transgender males do not have any external genital surgery because of the lack of access, high cost, and significant potential complications. Some choose a metaoidioplasty that brings forward the clitoris, thereby allowing them to void in a standing position without wetting themselves (251, 252). Surgeons can create the scrotum from the labia majora with good cosmetic effect and can implant testicular prostheses (253).

The most important masculinizing surgery for the transgender male is mastectomy, and it does not affect fertility. Breast size only partially regresses with androgen therapy (155). In adults, discussions about mastectomy usually take place after androgen therapy has started. Because some transgender male adolescents present after significant breast development has occurred, they may also consider mastectomy 2 years after they begin androgen therapy and before age 18 years. Clinicians should individualize treatment based on the physical and mental health status of the individual. There are now newer approaches to mastectomy with better outcomes (254, 255). These often involve chest contouring (256). Mastectomy is often necessary for living comfortably in the new gender (256).

5.1. We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being. (1 |⊕⊕○○)

5.2. We advise that clinicians approve genital gender-affirming surgery only after completion of at least 1 year of consistent and compliant hormone treatment, unless hormone therapy is not desired or medically contraindicated. (Ungraded Good Practice Statement)

5.3. We advise that the clinician responsible for endocrine treatment and the primary care provider ensure appropriate medical clearance of transgender individuals for genital gender-affirming surgery and collaborate with the surgeon regarding hormone use during and after surgery. (Ungraded Good Practice Statement)

5.4. We recommend that clinicians refer hormone-treated transgender individuals for genital surgery when: (1) the individual has had a satisfactory social role change, (2) the individual is satisfied about the hormonal effects, and (3) the individual desires definitive surgical changes. (1 |⊕○○○)

5.5. We suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country. (2 |⊕⊕○○).

5.6. We suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement. (2 |⊕○○○)

Evidence

Owing to the lack of controlled studies, incomplete follow-up, and lack of valid assessment measures, evaluating various surgical approaches and techniques is difficult. However, one systematic review including a large numbers of studies reported satisfactory cosmetic and functional results for vaginoplasty/neovagina construction (257). For transgender males, the outcomes are less certain. However, the problems are now better understood (258). Several postoperative studies report significant long-term psychological and psychiatric pathology (259–261). One study showed satisfaction with breasts, genitals, and femininity increased significantly and showed the importance of surgical treatment as a key therapeutic option for transgender females (262). Another analysis demonstrated that, despite the young average age at death following surgery and the relatively larger number of individuals with somatic morbidity, the study does not allow for determination of

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

doi: 10.1210/jc.2017-01658

causal relationships between, for example, specific types of hormonal or surgical treatment received and somatic morbidity and mortality (263). Reversal surgery in regretful male-to-female transsexuals after sexual reassignment surgery represents a complex, multistage procedure with satisfactory outcomes. Further insight into the characteristics of persons who regret their decision postoperatively would facilitate better future selection of applicants eligible for sexual reassignment surgery. We need more studies with appropriate controls that examine long-term quality of life, psychosocial outcomes, and psychiatric outcomes to determine the long-term benefits of surgical treatment.

When a transgender individual decides to have gender-affirming surgery, both the hormone prescribing clinician and the MHP must certify that the patient satisfies criteria for gender-affirming surgery (Table 16).

There is some concern that estrogen therapy may cause an increased risk for venous thrombosis during or following surgery (176). For this reason, the surgeon and the hormone-prescribing clinician should collaborate in making a decision about the use of hormones before and following surgery. One study suggests that preoperative factors (such as compliance) are less important for patient satisfaction than are the physical postoperative results (56). However, other studies and clinical experience dictate that individuals who do not follow medical instructions and do not work with their physicians toward a common goal do not achieve treatment goals (264) and experience higher rates of postoperative infections and other complications (265, 266). It is also important that the person requesting surgery feels comfortable with the anatomical changes that have occurred during hormone therapy. Dissatisfaction with social and physical outcomes during the hormone transition may be a contraindication to surgery (223).

An endocrinologist or experienced medical provider should monitor transgender individuals after surgery. Those who undergo gonadectomy will require hormone replacement therapy, surveillance, or both to prevent adverse effects of chronic hormone deficiency.

Financial Disclosures of the Task Force*

Wylie C. Hembree (chair)—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared. **Peggy T. Cohen-Kettenis**—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared. **Louis Gooren**—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared. **Sabine E. Hannema**—financial or business/organizational interests: none declared, significant financial interest or leadership position: Ferring Pharmaceuticals Inc. (lecture/conference), Pfizer (lecture). **Walter J. Meyer**—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared. **M. Hassan Murad****—financial or business/organizational interests: Mayo Clinic, Evidence-based Practice Center, significant financial interest or leadership position: none declared. **Stephen M. Rosenthal**—financial or business/organizational interests: AbbVie (consultant), National Institutes of Health (grantee), significant financial interest or leadership position: Pediatric Endocrine Society (immediate past president). **Joshua D. Safer, FACP**—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared. **Vin Tangpricha**—financial or business/organizational interests: Cystic Fibrosis Foundation (grantee), National Institutes of Health (grantee), significant financial interest or leadership position, Elsevier *Journal of Clinical and Translational Endocrinology* (editor). **Guy G. T'Sjoen**—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared.* Financial, business, and organizational disclosures of the task force cover the year prior to publication. Disclosures prior to this time period are archived.**Evidence-based reviews for this guideline were prepared under contract with the Endocrine Society.

Acknowledgments

Correspondence and Reprint Requests: The Endocrine Society, 2055 L Street NW, Suite 600, Washington, DC 20036. E-mail: publications@endocrine.org; Phone: 202971-3636.

Disclosure Summary: See Financial Disclosures.

Disclaimer: The Endocrine Society's clinical practice guidelines are developed to be of assistance to endocrinologists by providing guidance and recommendations for particular areas of practice. The guidelines should not be considered inclusive of all proper approaches or methods, or exclusive of others. The guidelines cannot guarantee any specific outcome, nor do they establish a standard of care. The guidelines are not intended to dictate the treatment of a particular patient. Treatment decisions must be made based on the independent judgement of healthcare providers and each patient's individual circumstances.

The Endocrine Society makes no warranty, express or implied, regarding the guidelines and specifically excludes any warranties of merchantability and fitness for a particular use or purpose. The Society shall not be liable for direct, indirect,

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 344 of 371 Total Pages:(344 of 1263)
Case 4:15-cv-00054-AWA-RJK Document 192-6 Filed 03/26/19 Page 28 of 35 PageID# 2045

special, incidental, or consequential damages related to the use of the information contained herein.

References

1. Atkins D, Best D, Briss PA, Eccles M, Falck-Ytter Y, Flottorp S, Guyatt GH, Harbour RT, Haugh MC, Henry D, Hill S, Jaeschke R, Leng G, Liberati A, Magrini N, Mason J, Middleton P, Mrukowicz J, O'Connell D, Oxman AD, Phillips B, Schünemann HJ, Edejer T, Varonen H, Vist GE, Williams JW, Jr, Zaza S; GRADE Working Group. Grading quality of evidence and strength of recommendations. *BMJ*. 2004;**328**(7454):1490.
2. Swiglo BA, Murad MH, Schünemann HJ, Kunz R, Vigersky RA, Guyatt GH, Montori VM. A case for clarity, consistency, and helpfulness: state-of-the-art clinical practice guidelines in endocrinology using the grading of recommendations, assessment, development, and evaluation system. *J Clin Endocrinol Metab*. 2008;**93**(3):666–673.
3. Bullough VL. Transsexualism in history. *Arch Sex Behav*. 1975; **4**(5):561–571.
4. Benjamin H. The transsexual phenomenon. *Trans N Y Acad Sci*. 1967;**29**(4):428–430.
5. Meyerowitz J. *How Sex Changed: A History of Transsexuality in the United States*. Cambridge, MA: Harvard University Press; 2002.
6. Hirschfeld M. *Was muss das Volk vom Dritten Geschlecht wissen*. Verlag Max Spohr, Leipzig; 1901.
7. Fisk NM. Editorial: Gender dysphoria syndrome—the conceptualization that liberalizes indications for total gender reorientation and implies a broadly based multi-dimensional rehabilitative regimen. *West J Med*. 1974;**120**(5):386–391.
8. Diamond L. Transgender experience and identity. In: Schwartz SJ, Luyckx K, Vignoles VL, eds. *Handbook of Identity Theory and Research*. New York, NY: Springer; 2011:629–647.
9. Queen C, Schimel L, eds. *PoMoSexuals: Challenging Assumptions About Gender and Sexuality*. San Francisco, CA: Cleis Press; 1997.
10. Case LK, Ramachandran VS. Alternating gender incongruity: a new neuropsychiatric syndrome providing insight into the dynamic plasticity of brain-sex. *Med Hypotheses*. 2012;**78**(5): 626–631.
11. Johnson TW, Wassersug RJ. Gender identity disorder outside the binary: when gender identity disorder-not otherwise specified is not good enough. *Arch Sex Behav*. 2010;**39**(3):597–598.
12. Wibowo E, Wassersug R, Warkentin K, Walker L, Robinson J, Brotto L, Johnson T. Impact of androgen deprivation therapy on sexual function: a response. *Asian J Androl*. 2012;**14**(5):793–794.
13. Pasquesoone V. 7 countries giving transgender people fundamental rights the U.S. still won't. 2014. Available at: https://mic.com/articles/87149/7-countries-giving-transgender-people-fundamental-rights-the-u-s-still-won-t. Accessed 26 August 2016.
14. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Arlington, VA: American Psychiatric Association Publishing.
15. Drescher J, Cohen-Kettenis P, Winter S. Minding the body: situating gender identity diagnoses in the ICD-11. *Int Rev Psychiatry*. 2012;**24**(6):568–577.
16. World Professional Association for Transgender Health. Standards of care for the health of transsexual, transgender, and gender nonconforming people. Available at: http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=3926. Accessed 1 September 2017.
17. Kreukels BP, Haraldsen IR, De Cuypere G, Richter-Appelt H, Gijs L, Cohen-Kettenis PT. A European network for the investigation of gender incongruence: the ENIGI initiative. *Eur Psychiatry*. 2012;**27**(6):445–450.
18. Dekker MJ, Wierckx K, Van Caenegem E, Klaver M, Kreukels BP, Elaut E, Fisher AD, van Trotsenburg MA, Schreiner T, den Heijer M, T'Sjoen G. A European network for the investigation of gender incongruence: endocrine part. *J Sex Med*. 2016;**13**(6):994–999.
19. Ruble DN, Martin CL, Berenbaum SA. Gender development. In: Damon WL, Lerner RM, Eisenberg N, eds. *Handbook of Child Psychology: Social, Emotional, and Personality Development*. **Vol. 3**. 6th ed. New York, NY: Wiley; 2006;858–931.
20. Steensma TD, Kreukels BP, de Vries AL, Cohen-Kettenis PT. Gender identity development in adolescence. *Horm Behav*. 2013; **64**(2):288–297.
21. Rosenthal SM. Approach to the patient: transgender youth: endocrine considerations. *J Clin Endocrinol Metab*. 2014;**99**(12): 4379–4389.
22. Saraswat A, Weinand JD, Safer JD. Evidence supporting the biologic nature of gender identity. *Endocr Pract*. 2015;**21**(2): 199–204.
23. Gooren L. The biology of human psychosexual differentiation. *Horm Behav*. 2006;**50**(4):589–601.
24. Berenbaum SA, Meyer-Bahlburg HF. Gender development and sexuality in disorders of sex development. *Horm Metab Res*. 2015; **47**(5):361–366.
25. Dessens AB, Slijper FME, Drop SLS. Gender dysphoria and gender change in chromosomal females with congenital adrenal hyperplasia. *Arch Sex Behav*. 2005;**34**(4):389–397.
26. Meyer-Bahlburg HFL, Dolezal C, Baker SW, Ehrhardt AA, New MI. Gender development in women with congenital adrenal hyperplasia as a function of disorder severity. *Arch Sex Behav*. 2006; **35**(6):667–684.
27. Frisén L, Nordenström A, Falhammar H, Filipsson H, Holmdahl G, Janson PO, Thorén M, Hagenfeldt K, Möller A, Nordenskjöld A. Gender role behavior, sexuality, and psychosocial adaptation in women with congenital adrenal hyperplasia due to CYP21A2 deficiency. *J Clin Endocrinol Metab*. 2009;**94**(9):3432–3439.
28. Meyer-Bahlburg HFL, Dolezal C, Baker SW, Carlson AD, Obeid JS, New MI. Prenatal androgenization affects gender-related behavior but not gender identity in 5–12-year-old girls with congenital adrenal hyperplasia. *Arch Sex Behav*. 2004;**33**(2):97–104.
29. Cohen-Kettenis PT. Gender change in 46,XY persons with 5α-reductase-2 deficiency and 17β-hydroxysteroid dehydrogenase-3 deficiency. *Arch Sex Behav*. 2005;**34**(4):399–410.
30. Reiner WG, Gearhart JP. Discordant sexual identity in some genetic males with cloacal exstrophy assigned to female sex at birth. *N Engl J Med*. 2004;**350**(4):333–341.
31. Meyer-Bahlburg HFL. Gender identity outcome in female-raised 46,XY persons with penile agenesis, cloacal exstrophy of the bladder, or penile ablation. *Arch Sex Behav*. 2005;**34**(4):423–438.
32. Coolidge FL, Thede LL, Young SE. The heritability of gender identity disorder in a child and adolescent twin sample. *Behav Genet*. 2002;**32**(4):251–257.
33. Heylens G, De Cuypere G, Zucker KJ, Schelfaut C, Elaut E, Vanden Bossche H, De Baere E, T'Sjoen G. Gender identity disorder in twins: a review of the case report literature. *J Sex Med*. 2012;**9**(3):751–757.
34. Fernández R, Esteva I, Gómez-Gil E, Rumbo T, Almaraz MC, Roda E, Haro-Mora J-J, Guillamón A, Pásaro E. Association study of ERβ, AR, and CYP19A1 genes and MtF transsexualism. *J Sex Med*. 2014;**11**(12):2986–2994.
35. Henningsson S, Westberg L, Nilsson S, Lundström B, Ekselius L, Bodlund O, Lindström E, Hellstrand M, Rosmond R, Eriksson E, Landén M. Sex steroid-related genes and male-to-female transsexualism. *Psychoneuroendocrinology*. 2005;**30**(7):657–664.
36. Hare L, Bernard P, Sánchez FJ, Baird PN, Vilain E, Kennedy T, Harley VR. Androgen receptor repeat length polymorphism associated with male-to-female transsexualism. *Biol Psychiatry*. 2009;**65**(1):93–96.
37. Lombardo F, Toselli L, Grassetti D, Paoli D, Masciandaro P, Valentini F, Lenzi A, Gandini L. Hormone and genetic study in

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

male to female transsexual patients. *J Endocrinol Invest*. 2013;**36**(8):550–557.

38. Ujike H, Otani K, Nakatsuka M, Ishii K, Sasaki A, Oishi T, Sato T, Okahisa Y, Matsumoto Y, Namba Y, Kimata Y, Kuroda S. Association study of gender identity disorder and sex hormone-related genes. *Prog Neuropsychopharmacol Biol Psychiatry*. 2009;**33**(7):1241–1244.
39. Kreukels BP, Guillamon A. Neuroimaging studies in people with gender incongruence. *Int Rev Psychiatry*. 2016;**28**(1):120–128.
40. Steensma TD, Biemond R, de Boer F, Cohen-Kettenis PT. Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study. *Clin Child Psychol Psychiatry*. 2011;**16**(4):499–516.
41. Wallien MSC, Cohen-Kettenis PT. Psychosexual outcome of gender-dysphoric children. *J Am Acad Child Adolesc Psychiatry*. 2008;**47**(12):1413–1423.
42. Steensma TD, McGuire JK, Kreukels BPC, Beekman AJ, Cohen-Kettenis PT. Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study. *J Am Acad Child Adolesc Psychiatry*. 2013;**52**(6):582–590.
43. Cohen-Kettenis PT, Owen A, Kaijser VG, Bradley SJ, Zucker KJ. Demographic characteristics, social competence, and behavior problems in children with gender identity disorder: a cross-national, cross-clinic comparative analysis. *J Abnorm Child Psychol*. 2003;**31**(1):41–53.
44. Dhejne C, Van Vlerken R, Heylens G, Arcelus J. Mental health and gender dysphoria: a review of the literature. *Int Rev Psychiatry*. 2016;**28**(1):44–57.
45. Pasterski V, Gilligan L, Curtis R. Traits of autism spectrum disorders in adults with gender dysphoria. *Arch Sex Behav*. 2014;**43**(2):387–393.
46. Spack NP, Edwards-Leeper L, Feldman HA, Leibowitz S, Mandel F, Diamond DA, Vance SR. Children and adolescents with gender identity disorder referred to a pediatric medical center. *Pediatrics*. 2012;**129**(3):418–425.
47. Terada S, Matsumoto Y, Sato T, Okabe N, Kishimoto Y, Uchitomi Y. Factors predicting psychiatric co-morbidity in gender-dysphoric adults. *Psychiatry Res*. 2012;**200**(2-3):469–474.
48. VanderLaan DP, Leef JH, Wood H, Hughes SK, Zucker KJ. Autism spectrum disorder risk factors and autistic traits in gender dysphoric children. *J Autism Dev Disord*. 2015;**45**(6):1742–1750.
49. de Vries ALC, Doreleijers TAH, Steensma TD, Cohen-Kettenis PT. Psychiatric comorbidity in gender dysphoric adolescents. *J Child Psychol Psychiatry*. 2011;**52**(11):1195–1202.
50. de Vries ALC, Noens ILJ, Cohen-Kettenis PT, van Berckelaer-Onnes IA, Doreleijers TA. Autism spectrum disorders in gender dysphoric children and adolescents. *J Autism Dev Disord*. 2010;**40**(8):930–936.
51. Wallien MSC, Swaab H, Cohen-Kettenis PT. Psychiatric comorbidity among children with gender identity disorder. *J Am Acad Child Adolesc Psychiatry*. 2007;**46**(10):1307–1314.
52. Kuiper AJ, Cohen-Kettenis PT. Gender role reversal among postoperative transsexuals. Available at: https://www.atria.nl/ezines/web/IJT/97-03/numbers/symposion/ijtc0502.htm. Accessed 26 August 2016.
53. Landén M, Wålinder J, Hambert G, Lundström B. Factors predictive of regret in sex reassignment. *Acta Psychiatr Scand*. 1998;**97**(4):284–289.
54. Olsson S-E, Möller A. Regret after sex reassignment surgery in a male-to-female transsexual: a long-term follow-up. *Arch Sex Behav*. 2006;**35**(4):501–506.
55. Pfäfflin F, Junge A, eds. *Geschlechtsumwandlung: Abhandlungen zur Transsexualität*. Stuttgart, Germany: Schattauer; 1992.
56. Lawrence AA. Factors associated with satisfaction or regret following male-to-female sex reassignment surgery. *Arch Sex Behav*. 2003;**32**(4):299–315.
57. Cohen-Kettenis PT, Pfäfflin F. *Transgenderism and Intersexuality in Childhood and Adolescence: Making Choices*. Thousand Oaks, CA: SAGE Publications; 2003.
58. Di Ceglie D, Freedman D, McPherson S, Richardson P. Children and adolescents referred to a specialist gender identity development service: clinical features and demographic characteristics. Available at: https://www.researchgate.net/publication/276061306_Children_and_Adolescents_Referred_to_a_Specialist_Gender_Identity_Development_Service_Clinical_Features_and_Demographic_Characteristics. Accessed 20 July 2017.
59. Gijs L, Brewaeys A. Surgical treatment of gender dysphoria in adults and adolescents: recent developments, effectiveness, and challenges. *Annu Rev Sex Res*. 2007;**18**:178–224.
60. Cohen-Kettenis PT, van Goozen SHM. Sex reassignment of adolescent transsexuals: a follow-up study. *J Am Acad Child Adolesc Psychiatry*. 1997;**36**(2):263–271.
61. Smith YLS, van Goozen SHM, Cohen-Kettenis PT. Adolescents with gender identity disorder who were accepted or rejected for sex reassignment surgery: a prospective follow-up study. *J Am Acad Child Adolesc Psychiatry*. 2001;**40**(4):472–481.
62. Smith YLS, Van Goozen SHM, Kuiper AJ, Cohen-Kettenis PT. Sex reassignment: outcomes and predictors of treatment for adolescent and adult transsexuals. *Psychol Med*. 2005;**35**(1):89–99.
63. de Vries ALC, McGuire JK, Steensma TD, Wagenaar ECF, Doreleijers TAH, Cohen-Kettenis PT. Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*. 2014;**134**(4):696–704.
64. Cole CM, O'Boyle M, Emory LE, Meyer WJ III. Comorbidity of gender dysphoria and other major psychiatric diagnoses. *Arch Sex Behav*. 1997;**26**(1):13–26.
65. Cohen-Kettenis PT, Schagen SEE, Steensma TD, de Vries ALC, Delemarre-van de Waal HA. Puberty suppression in a gender-dysphoric adolescent: a 22-year follow-up. *Arch Sex Behav*. 2011;**40**(4):843–847.
66. First MB. Desire for amputation of a limb: paraphilia, psychosis, or a new type of identity disorder. *Psychol Med*. 2005;**35**(6):919–928.
67. Wierckx K, Van Caenegem E, Pennings G, Elaut E, Dedecker D, Van de Peer F, Weyers S, De Sutter P, T'Sjoen G. Reproductive wish in transsexual men. *Hum Reprod*. 2012;**27**(2):483–487.
68. Wierckx K, Stuyver I, Weyers S, Hamada A, Agarwal A, De Sutter P, T'Sjoen G. Sperm freezing in transsexual women. *Arch Sex Behav*. 2012;**41**(5):1069–1071.
69. Bertelloni S, Baroncelli GI, Ferdeghini M, Menchini-Fabris F, Saggese G. Final height, gonadal function and bone mineral density of adolescent males with central precocious puberty after therapy with gonadotropin-releasing hormone analogues. *Eur J Pediatr*. 2000;**159**(5):369–374.
70. Büchter D, Behre HM, Kliesch S, Nieschlag E. Pulsatile GnRH or human chorionic gonadotropin/human menopausal gonadotropin as effective treatment for men with hypogonadotropic hypogonadism: a review of 42 cases. *Eur J Endocrinol*. 1998;**139**(3):298–303.
71. Liu PY, Turner L, Rushford D, McDonald J, Baker HW, Conway AJ, Handelsman DJ. Efficacy and safety of recombinant human follicle stimulating hormone (Gonal-F) with urinary human chorionic gonadotrophin for induction of spermatogenesis and fertility in gonadotrophin-deficient men. *Hum Reprod*. 1999;**14**(6):1540–1545.
72. Pasquino AM, Pucarelli I, Accardo F, Demiraj V, Segni M, Di Nardo R. Long-term observation of 87 girls with idiopathic central precocious puberty treated with gonadotropin-releasing hormone analogs: impact on adult height, body mass index, bone mineral content, and reproductive function. *J Clin Endocrinol Metab*. 2008;**93**(1):190–195.
73. Magiakou MA, Manousaki D, Papadaki M, Hadjidakis D, Levidou G, Vakaki M, Papaefstathiou A, Lalioti N, Kanaka-Gantenbein C, Piaditis G, Chrousos GP, Dacou-Voutetakis C. The

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 346 of 371 Total Pages:(346 of 1263)
Case 4:15-cv-00054-AWA-RJK Document 192-6 Filed 03/26/19 Page 30 of 35 PageID# 2047

efficacy and safety of gonadotropin-releasing hormone analog treatment in childhood and adolescence: a single center, long-term follow-up study. *J Clin Endocrinol Metab*. 2010;**95**(1):109–117.

74. Baba T, Endo T, Honnma H, Kitajima Y, Hayashi T, Ikeda H, Masumori N, Kamiya H, Moriwaka O, Saito T. Association between polycystic ovary syndrome and female-to-male transsexuality. *Hum Reprod*. 2007;**22**(4):1011–1016.
75. Spinder T, Spijkstra JJ, van den Tweel JG, Burger CW, van Kessel H, Hompes PGA, Gooren LJG. The effects of long term testosterone administration on pulsatile luteinizing hormone secretion and on ovarian histology in eugonadal female to male transsexual subjects. *J Clin Endocrinol Metab*. 1989;**69**(1):151–157.
76. Baba T, Endo T, Ikeda K, Shimizu A, Honnma H, Ikeda H, Masumori N, Ohmura T, Kiya T, Fujimoto T, Koizumi M, Saito T. Distinctive features of female-to-male transsexualism and prevalence of gender identity disorder in Japan. *J Sex Med*. 2011; **8**(6):1686–1693.
77. Vujovic S, Popovic S, Sbutega-Milosevic G, Djordjevic M, Gooren L. Transsexualism in Serbia: a twenty-year follow-up study. *J Sex Med*. 2009;**6**(4):1018–1023.
78. Ikeda K, Baba T, Noguchi H, Nagasawa K, Endo T, Kiya T, Saito T. Excessive androgen exposure in female-to-male transsexual persons of reproductive age induces hyperplasia of the ovarian cortex and stroma but not polycystic ovary morphology. *Hum Reprod*. 2013;**28**(2):453–461.
79. Trebay G. He's pregnant. You're speechles. New York Times. 22 June 2008.
80. Light AD, Obedin-Maliver J, Sevelius JM, Kerns JL. Transgender men who experienced pregnancy after female-to-male gender transitioning. *Obstet Gynecol*. 2014;**124**(6):1120–1127.
81. De Sutter P. Donor inseminations in partners of female-to-male transsexuals: should the question be asked? *Reprod Biomed Online*. 2003;**6**(3):382, author reply 282–283.
82. De Roo C, Tilleman K, T'Sjoen G, De Sutter P. Fertility options in transgender people. *Int Rev Psychiatry*. 2016;**28**(1):112–119.
83. Wennink JMB, Delemarre-van de Waal HA, Schoemaker R, Schoemaker H, Schoemaker J. Luteinizing hormone and follicle stimulating hormone secretion patterns in boys throughout puberty measured using highly sensitive immunoradiometric assays. *Clin Endocrinol (Oxf)*. 1989;**31**(5):551–564.
84. Cohen-Kettenis PT, Delemarre-van de Waal HA, Gooren LJG. The treatment of adolescent transsexuals: changing insights. *J Sex Med*. 2008;**5**(8):1892–1897.
85. Delemarre-van de Waal HA, Cohen-Kettenis PT. Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects. *Eur J Endocrinol*. 2006;**155**:S131–S137.
86. de Vries ALC, Steensma TD, Doreleijers TAH, Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. *J Sex Med*. 2011;**8**(8):2276–2283.
87. Bouman MB, van Zeijl MCT, Buncamper ME, Meijerink WJHJ, van Bodegraven AA, Mullender MG. Intestinal vaginoplasty revisited: a review of surgical techniques, complications, and sexual function. *J Sex Med*. 2014;**11**(7):1835–1847.
88. Carel JC, Eugster EA, Rogol A, Ghizzoni L, Palmert MR, Antoniazzi F, Berenbaum S, Bourguignon JP, Chrousos GP, Coste J, Deal S, de Vries L, Foster C, Heger S, Holland J, Jahnukainen K, Juul A, Kaplowitz P, Lahlou N, Lee MM, Lee P, Merke DP, Neely EK, Oostdijk W, Phillip M, Rosenfield RL, Shulman D, Styne D, Tauber M, Wit JM; ESPE-LWPES GnRH Analogs Consensus Conference Group. Consensus statement on the use of gonadotropin-releasing hormone analogs in children. *Pediatrics*. 2009;**123**(4):e752–e762.
89. Roth CL, Brendel L, Rückert C, Hartmann K. Antagonistic and agonistic GnRH analogue treatment of precocious puberty: tracking gonadotropin concentrations in urine. *Horm Res*. 2005; **63**(5):257–262.
90. Roth C. Therapeutic potential of GnRH antagonists in the treatment of precocious puberty. *Expert Opin Investig Drugs*. 2002;**11**(9):1253–1259.
91. Tuvemo T. Treatment of central precocious puberty. *Expert Opin Investig Drugs*. 2006;**15**(5):495–505.
92. Schagen SE, Cohen-Kettenis PT, Delemarre-van de Waal HA, Hannema SE. Efficacy and safety of gonadotropin-releasing hormone agonist treatment to suppress puberty in gender dysphoric adolescents. *J Sex Med*. 2016;**13**(7):1125–1132.
93. Manasco PK, Pescovitz OH, Feuillan PP, Hench KD, Barnes KM, Jones J, Hill SC, Loriaux DL, Cutler GB, Jr. Resumption of puberty after long term luteinizing hormone-releasing hormone agonist treatment of central precocious puberty. *J Clin Endocrinol Metab*. 1988;**67**(2):368–372.
94. Klink D, Caris M, Heijboer A, van Trotsenburg M, Rotteveel J. Bone mass in young adulthood following gonadotropin-releasing hormone analog treatment and cross-sex hormone treatment in adolescents with gender dysphoria. *J Clin Endocrinol Metab*. 2015;**100**(2):E270–E275.
95. Finkelstein JS, Klibanski A, Neer RM. A longitudinal evaluation of bone mineral density in adult men with histories of delayed puberty. *J Clin Endocrinol Metab*. 1996;**81**(3):1152–1155.
96. Bertelloni S, Baroncelli GI, Ferdeghini M, Perri G, Saggese G. Normal volumetric bone mineral density and bone turnover in young men with histories of constitutional delay of puberty. *J Clin Endocrinol Metab*. 1998;**83**(12):4280–4283.
97. Darelid A, Ohlsson C, Nilsson M, Kindblom JM, Mellström D, Lorentzon M. Catch up in bone acquisition in young adult men with late normal puberty. *J Bone Miner Res*. 2012;**27**(10): 2198–2207.
98. Mittan D, Lee S, Miller E, Perez RC, Basler JW, Bruder JM. Bone loss following hypogonadism in men with prostate cancer treated with GnRH analogs. *J Clin Endocrinol Metab*. 2002;**87**(8): 3656–3661.
99. Saggese G, Bertelloni S, Baroncelli GI, Battini R, Franchi G. Reduction of bone density: an effect of gonadotropin releasing hormone analogue treatment in central precocious puberty. *Eur J Pediatr*. 1993;**152**(9):717–720.
100. Neely EK, Bachrach LK, Hintz RL, Habiby RL, Slemenda CW, Feezle L, Pescovitz OH. Bone mineral density during treatment of central precocious puberty. *J Pediatr*. 1995;**127**(5):819–822.
101. Bertelloni S, Baroncelli GI, Sorrentino MC, Perri G, Saggese G. Effect of central precocious puberty and gonadotropin-releasing hormone analogue treatment on peak bone mass and final height in females. *Eur J Pediatr*. 1998;**157**(5):363–367.
102. Thornton P, Silverman LA, Geffner ME, Neely EK, Gould E, Danoff TM. Review of outcomes after cessation of gonadotropin-releasing hormone agonist treatment of girls with precocious puberty. *Pediatr Endocrinol Rev*. 2014;**11**(3):306–317.
103. Lem AJ, van der Kaay DC, Hokken-Koelega AC. Bone mineral density and body composition in short children born SGA during growth hormone and gonadotropin releasing hormone analog treatment. *J Clin Endocrinol Metab*. 2013;**98**(1):77–86.
104. Antoniazzi F, Zamboni G, Bertoldo F, Lauriola S, Mengarda F, Pietrobelli A, Tatò L. Bone mass at final height in precocious puberty after gonadotropin-releasing hormone agonist with and without calcium supplementation. *J Clin Endocrinol Metab*. 2003;**88**(3):1096–1101.
105. Calcaterra V, Mannarino S, Corana G, Codazzi AC, Mazzola A, Brambilla P, Larizza D. Hypertension during therapy with triptorelin in a girl with precocious puberty. *Indian J Pediatr*. 2013; **80**(10):884–885.
106. Siomou E, Kosmeri C, Pavlou M, Vlahos AP, Argyropoulou MI, Siamopoulou A. Arterial hypertension during treatment with triptorelin in a child with Williams-Beuren syndrome. *Pediatr Nephrol*. 2014;**29**(9):1633–1636.
107. Staphorsius AS, Kreukels BPC, Cohen-Kettenis PT, Veltman DJ, Burke SM, Schagen SEE, Wouters FM, Delemarre-van de Waal

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

doi: 10.1210/jc.2017-01658

HA, Bakker J. Puberty suppression and executive functioning: an fMRI-study in adolescents with gender dysphoria. *Psychoneuroendocrinology*. 2015;**56**:190–199.
108. Hough D, Bellingham M, Haraldsen IR, McLaughlin M, Rennie M, Robinson JE, Solbakk AK, Evans NP. Spatial memory is impaired by peripubertal GnRH agonist treatment and testosterone replacement in sheep. *Psychoneuroendocrinology*. 2017; **75**:173–182.
109. Collipp PJ, Kaplan SA, Boyle DC, Plachte F, Kogut MD. Constitutional Isosexual Precocious Puberty. *Am J Dis Child*. 1964; **108**:399–405.
110. Hahn HB, Jr, Hayles AB, Albert A. Medroxyprogesterone and constitutional precocious puberty. *Mayo Clin Proc*. 1964;**39**: 182–190.
111. Kaplan SA, Ling SM, Irani NG. Idiopathic isosexual precocity. *Am J Dis Child*. 1968;**116**(6):591–598.
112. Schoen EJ. Treatment of idiopathic precocious puberty in boys. *J Clin Endocrinol Metab*. 1966;**26**(4):363–370.
113. Gooren L. Hormone treatment of the adult transsexual patient. *Horm Res*. 2005;**64**(Suppl 2):31–36.
114. Moore E, Wisniewski A, Dobs A. Endocrine treatment of transsexual people: a review of treatment regimens, outcomes, and adverse effects. *J Clin Endocrinol Metab*. 2003;**88**(8):3467–3473.
115. Krueger RB, Hembree W, Hill M. Prescription of medroxyprogesterone acetate to a patient with pedophilia, resulting in Cushing's syndrome and adrenal insufficiency. *Sex Abuse*. 2006; **18**(2):227–228.
116. Lynch MM, Khandheria MM, Meyer WJ. Retrospective study of the management of childhood and adolescent gender identity disorder using medroxyprogesterone acetate. *Int J Transgenderism*. 2015;**16**:201–208.
117. Tack LJW, Craen M, Dhondt K, Vanden Bossche H, Laridaen J, Cools M. Consecutive lynestrenol and cross-sex hormone treatment in biological female adolescents with gender dysphoria: a retrospective analysis. *Biol Sex Differ*. 2016;**7**:14.
118. Hembree WC, Cohen-Kettenis P, Delemarre-van de Waal HA, Gooren LJ, Meyer WJ 3rd, Spack NP, Tangpricha V, Montori VM; Endocrine Society. Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2009;**94**(9):3132–3154.
119. Mann L, Harmoni R, Power C. Adolescent decision-making: the development of competence. *J Adolesc*. 1989;**12**(3):265–278.
120. Stultiëns L, Goffin T, Borry P, Dierickx K, Nys H. Minors and informed consent: a comparative approach. *Eur J Health Law*. 2007;**14**(1):21–46.
121. Arshagouni P. "But I'm an adult now … sort of". Adolescent consent in health care decision-making and the adolescent brain. Available at: http://digitalcommons.law.umaryland.edu/cgi/viewcontent.cgi?article=1124&context=jhclp. Accessed 25 June 2017.
122. NHS. Prescribing of cross-sex hormones as part of the gender identity development service for children and adolescents. Available at: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/08/clinical-com-pol-16046p.pdf. Accessed 14 June 2017.
123. Ankarberg-Lindgren C, Kriström B, Norjavaara E. Physiological estrogen replacement therapy for puberty induction in girls: a clinical observational study. *Horm Res Paediatr*. 2014;**81**(4): 239–244.
124. Olson J, Schrager SM, Clark LF, Dunlap SL, Belzer M. Subcutaneous testosterone: an effective delivery mechanism for masculinizing young transgender men. *LGBT Health*. 2014;**1**(3): 165–167.
125. Spratt DI, Stewart I, Savage C, Craig W, Spack NP, Chandler DW, Spratt LV, Eimicke T, Olshan JS. Subcutaneous injection of testosterone is an effective and preferred alternative to intramuscular injection: demonstration in female-to-male transgender patients. *J Clin Endocrinol Metab*. 2017. doi:10.1210/jc.2017-00359
126. Eisenegger C, von Eckardstein A, Fehr E, von Eckardstein S. Pharmacokinetics of testosterone and estradiol gel preparations in healthy young men. *Psychoneuroendocrinology*. 2013;**38**(2): 171–178.
127. de Ronde W, ten Kulve J, Woerdeman J, Kaufman J-M, de Jong FH. Effects of oestradiol on gonadotrophin levels in normal and castrated men. *Clin Endocrinol (Oxf)*. 2009;**71**(6):874–879.
128. Money J, Ehrhardt A. Man & woman, boy & girl: differentiation and dimorphism of gender identity from conception to maturity. Baltimore, MD: Johns Hopkins University Press; 1972:202–206.
129. Heylens G, Verroken C, De Cock S, T'Sjoen G, De Cuypere G. Effects of different steps in gender reassignment therapy on psychopathology: a prospective study of persons with a gender identity disorder. *J Sex Med*. 2014;**11**(1):119–126.
130. Costa R, Colizzi M. The effect of cross-sex hormonal treatment on gender dysphoria individuals' mental health: a systematic review. *Neuropsychiatr Dis Treat*. 2016;**12**:1953–1966.
131. Gooren LJG, Giltay EJ. Review of studies of androgen treatment of female-to-male transsexuals: effects and risks of administration of androgens to females. *J Sex Med*. 2008;**5**(4):765–776.
132. Levy A, Crown A, Reid R. Endocrine intervention for transsexuals. *Clin Endocrinol (Oxf)*. 2003;**59**(4):409–418.
133. Tangpricha V, Ducharme SH, Barber TW, Chipkin SR. Endocrinologic treatment of gender identity disorders. *Endocr Pract*. 2003;**9**(1):12–21.
134. Meriggiola MC, Gava G. Endocrine care of transpeople part I. A review of cross-sex hormonal treatments, outcomes and adverse effects in transmen. *Clin Endocrinol (Oxf)*. 2015;**83**(5):597–606.
135. Bhasin S, Cunningham GR, Hayes FJ, Matsumoto AM, Snyder PJ, Swerdloff RS, Montori VM. Testosterone therapy in adult men with androgen deficiency syndromes: an endocrine society clinical practice guideline. *J Clin Endocrinol Metab*. 2006;**91**(6): 1995–2010.
136. Pelusi C, Costantino A, Martelli V, Lambertini M, Bazzocchi A, Ponti F, Battista G, Venturoli S, Meriggiola MC. Effects of three different testosterone formulations in female-to-male transsexual persons. *J Sex Med*. 2014;**11**(12):3002–3011.
137. Anderson GL, Limacher M, Assaf AR, Bassford T, Beresford SA, Black H, Bonds D, Brunner R, Brzyski R, Caan B, Chlebowski R, Curb D, Gass M, Hays J, Heiss G, Hendrix S, Howard BV, Hsia J, Hubbell A, Jackson R, Johnson KC, Judd H, Kotchen JM, Kuller L, LaCroix AZ, Lane D, Langer RD, Lasser N, Lewis CE, Manson J, Margolis K, Ockene J, O'Sullivan MJ, Phillips L, Prentice RL, Ritenbaugh C, Robbins J, Rossouw JE, Sarto G, Stefanick ML, Van Horn L, Wactawski-Wende J, Wallace R, Wassertheil-Smoller S; Women's Health Initiative Steering Committee. Effects of conjugated equine estrogen in postmenopausal women with hysterectomy: the Women's Health Initiative randomized controlled trial. *JAMA*. 2004;**291**(14):1701–1712.
138. Dickersin K, Munro MG, Clark M, Langenberg P, Scherer R, Frick K, Zhu Q, Hallock L, Nichols J, Yalcinkaya TM; Surgical Treatments Outcomes Project for Dysfunctional Uterine Bleeding (STOP-DUB) Research Group. Hysterectomy compared with endometrial ablation for dysfunctional uterine bleeding: a randomized controlled trial. *Obstet Gynecol*. 2007;**110**(6): 1279–1289.
139. Gooren LJ, Giltay EJ, Bunck MC. Long-term treatment of transsexuals with cross-sex hormones: extensive personal experience. *J Clin Endocrinol Metab*. 2008;**93**(1):19–25.
140. Prior JC, Vigna YM, Watson D. Spironolactone with physiological female steroids for presurgical therapy of male-to-female transsexualism. *Arch Sex Behav*. 1989;**18**(1):49–57.
141. Dittrich R, Binder H, Cupisti S, Hoffmann I, Beckmann MW, Mueller A. Endocrine treatment of male-to-female transsexuals using gonadotropin-releasing hormone agonist. *Exp Clin Endocrinol Diabetes*. 2005;**113**(10):586–592.

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

142. Stripp B, Taylor AA, Bartter FC, Gillette JR, Loriaux DL, Easley R, Menard RH. Effect of spironolactone on sex hormones in man. *J Clin Endocrinol Metab*. 1975;**41**(4):777–781.
143. Levy J, Burshell A, Marbach M, Afllalo L, Glick SM. Interaction of spironolactone with oestradiol receptors in cytosol. *J Endocrinol*. 1980;**84**(3):371–379.
144. Wierckx K, Elaut E, Van Hoorde B, Heylens G, De Cuypere G, Monstrey S, Weyers S, Hoebeke P, T'Sjoen G. Sexual desire in trans persons: associations with sex reassignment treatment. *J Sex Med*. 2014;**11**(1):107–118.
145. Chiriacò G, Cauci S, Mazzon G, Trombetta C. An observational retrospective evaluation of 79 young men with long-term adverse effects after use of finasteride against androgenetic alopecia. *Andrology*. 2016;**4**(2):245–250.
146. Gava G, Cerpolini S, Martelli V, Battista G, Seracchioli R, Meriggiola MC. Cyproterone acetate vs leuprolide acetate in combination with transdermal oestradiol in transwomen: a comparison of safety and effectiveness. *Clin Endocrinol (Oxf)*. 2016; **85**(2):239–246.
147. Casper RF, Yen SS. Rapid absorption of micronized estradiol-17 beta following sublingual administration. *Obstet Gynecol*. 1981; **57**(1):62–64.
148. Price TM, Blauer KL, Hansen M, Stanczyk F, Lobo R, Bates GW. Single-dose pharmacokinetics of sublingual versus oral administration of micronized 17β-estradiol. *Obstet Gynecol*. 1997;**89**(3): 340–345.
149. Toorians AWFT, Thomassen MCLGD, Zweegman S, Magdeleyns EJP, Tans G, Gooren LJG, Rosing J. Venous thrombosis and changes of hemostatic variables during cross-sex hormone treatment in transsexual people. *J Clin Endocrinol Metab*. 2003;**88**(12): 5723–5729.
150. Mepham N, Bouman WP, Arcelus J, Hayter M, Wylie KR. People with gender dysphoria who self-prescribe cross-sex hormones: prevalence, sources, and side effects knowledge. *J Sex Med*. 2014; **11**(12):2995–3001.
151. Richards C, Bouman WP, Seal L, Barker MJ, Nieder TO, T'Sjoen G. Non-binary or genderqueer genders. *Int Rev Psychiatry*. 2016; **28**(1):95–102.
152. Cosyns M, Van Borsel J, Wierckx K, Dedecker D, Van de Peer F, Daelman T, Laenen S, T'Sjoen G. Voice in female-to-male transsexual persons after long-term androgen therapy. *Laryngoscope*. 2014;**124**(6):1409–1414.
153. Deuster D, Matulat P, Knief A, Zitzmann M, Rosslau K, Szukaj M, am Zehnhoff-Dinnesen A, Schmidt CM. Voice deepening under testosterone treatment in female-to-male gender dysphoric individuals. *Eur Arch Otorhinolaryngol*. 2016;**273**(4):959–965.
154. Lapauw B, Taes Y, Simoens S, Van Caenegem E, Weyers S, Goemaere S, Toye K, Kaufman J-M, T'Sjoen GG. Body composition, volumetric and areal bone parameters in male-to-female transsexual persons. *Bone*. 2008;**43**(6):1016–1021.
155. Meyer III WJ, Webb A, Stuart CA, Finkelstein JW, Lawrence B, Walker PA. Physical and hormonal evaluation of transsexual patients: a longitudinal study. *Arch Sex Behav*. 1986;**15**(2): 121–138.
156. Asscheman H, Gooren LJ, Assies J, Smits JP, de Slegte R. Prolactin levels and pituitary enlargement in hormone-treated male-to-female transsexuals. *Clin Endocrinol (Oxf)*. 1988;**28**(6):583–588.
157. Gooren LJ, Harmsen-Louman W, van Kessel H. Follow-up of prolactin levels in long-term oestrogen-treated male-to-female transsexuals with regard to prolactinoma induction. *Clin Endocrinol (Oxf)*. 1985;**22**(2):201–207.
158. Wierckx K, Van Caenegem E, Schreiner T, Haraldsen I, Fisher AD, Toye K, Kaufman JM, T'Sjoen G. Cross-sex hormone therapy in trans persons is safe and effective at short-time follow-up: results from the European network for the investigation of gender incongruence. *J Sex Med*. 2014;**11**(8):1999–2011.
159. Ott J, Kaufmann U, Bentz EK, Huber JC, Tempfer CB. Incidence of thrombophilia and venous thrombosis in transsexuals under cross-sex hormone therapy. *Fertil Steril*. 2010;**93**(4):1267–1272.
160. Giltay EJ, Hoogeveen EK, Elbers JMH, Gooren LJG, Asscheman H, Stehouwer CDA. Effects of sex steroids on plasma total homocysteine levels: a study in transsexual males and females. *J Clin Endocrinol Metab*. 1998;**83**(2):550–553.
161. van Kesteren PJM, Asscheman H, Megens JAJ, Gooren LJG. Mortality and morbidity in transsexual subjects treated with cross-sex hormones. *Clin Endocrinol (Oxf)*. 1997;**47**(3): 337–343.
162. Wierckx K, Gooren L, T'Sjoen G. Clinical review: breast development in trans women receiving cross-sex hormones. *J Sex Med*. 2014;**11**(5):1240–1247.
163. Bird D, Vowles K, Anthony PP. Spontaneous rupture of a liver cell adenoma after long term methyltestosterone: report of a case successfully treated by emergency right hepatic lobectomy. *Br J Surg*. 1979;**66**(3):212–213.
164. Westaby D, Ogle SJ, Paradinas FJ, Randell JB, Murray-Lyon IM. Liver damage from long-term methyltestosterone. *Lancet*. 1977; **2**(8032):262–263.
165. Weinand JD, Safer JD. Hormone therapy in transgender adults is safe with provider supervision; a review of hormone therapy sequelae for transgender individuals. *J Clin Transl Endocrinol*. 2015;**2**(2):55–60.
166. Roberts TK, Kraft CS, French D, Ji W, Wu AH, Tangpricha V, Fantz CR. Interpreting laboratory results in transgender patients on hormone therapy. *Am J Med*. 2014;**127**(2):159–162.
167. Vesper HW, Botelho JC, Wang Y. Challenges and improvements in testosterone and estradiol testing. *Asian J Androl*. 2014;**16**(2): 178–184.
168. Asscheman H, T'Sjoen G, Lemaire A, Mas M, Meriggiola MC, Mueller A, Kuhn A, Dhejne C, Morel-Journel N, Gooren LJ. Venous thrombo-embolism as a complication of cross-sex hormone treatment of male-to-female transsexual subjects: a review. *Andrologia*. 2014;**46**(7):791–795.
169. Righini M, Perrier A, De Moerloose P, Bounameaux H. D-dimer for venous thromboembolism diagnosis: 20 years later. *J Thromb Haemost*. 2008;**6**(7):1059–1071.
170. Gooren LJ, Assies J, Asscheman H, de Slegte R, van Kessel H. Estrogen-induced prolactinoma in a man. *J Clin Endocrinol Metab*. 1988;**66**(2):444–446.
171. Kovacs K, Stefaneanu L, Ezzat S, Smyth HS. Prolactin-producing pituitary adenoma in a male-to-female transsexual patient with protracted estrogen administration. A morphologic study. *Arch Pathol Lab Med*. 1994;**118**(5):562–565.
172. Serri O, Noiseux D, Robert F, Hardy J. Lactotroph hyperplasia in an estrogen treated male-to-female transsexual patient. *J Clin Endocrinol Metab*. 1996;**81**(9):3177–3179.
173. Cunha FS, Domenice S, Câmara VL, Sircili MH, Gooren LJ, Mendonça BB, Costa EM. Diagnosis of prolactinoma in two male-to-female transsexual subjects following high-dose cross-sex hormone therapy. *Andrologia*. 2015;**47**(6):680–684.
174. Nota NM, Dekker MJHJ, Klaver M, Wiepjes CM, van Trotsenburg MA, Heijboer AC, den Heijer M. Prolactin levels during short- and long-term cross-sex hormone treatment: an observational study in transgender persons. *Andrologia*. 2017;**49**(6).
175. Bunck MC, Debono M, Giltay EJ, Verheijen AT, Diamant M, Gooren LJ. Autonomous prolactin secretion in two male-to-female transgender patients using conventional oestrogen dosages. *BMJ Case Rep*. 2009;**2009**:bcr0220091589.
176. Elamin MB, Garcia MZ, Murad MH, Erwin PJ, Montori VM. Effect of sex steroid use on cardiovascular risk in transsexual individuals: a systematic review and meta-analyses. *Clin Endocrinol (Oxf)*. 2010;**72**(1):1–10.
177. Berra M, Armillotta F, D'Emidio L, Costantino A, Martorana G, Pelusi G, Meriggiola MC. Testosterone decreases adiponectin

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

doi: 10.1210/jc.2017-01658

levels in female to male transsexuals. *Asian J Androl*. 2006;**8**(6): 725–729.
178. Elbers JMH, Giltay EJ, Teerlink T, Scheffer PG, Asscheman H, Seidell JC, Gooren LJG. Effects of sex steroids on components of the insulin resistance syndrome in transsexual subjects. *Clin Endocrinol (Oxf)*. 2003;**58**(5):562–571.
179. Giltay EJ, Lambert J, Gooren LJG, Elbers JMH, Steyn M, Stehouwer CDA. Sex steroids, insulin, and arterial stiffness in women and men. *Hypertension*. 1999;**34**(4 Pt 1):590–597.
180. Polderman KH, Gooren LJ, Asscheman H, Bakker A, Heine RJ. Induction of insulin resistance by androgens and estrogens. *J Clin Endocrinol Metab*. 1994;**79**(1):265–271.
181. Maraka S. Effect of sex steroids on lipids, venous thromboembolism, cardiovascular disease and mortality in transgender individuals: a systematic review and meta-analysis. Available at: http://press.endocrine.org/doi/abs/10.1210/endo-meetings.2016.RE.15.FRI-136. Accessed 3 July 2017.
182. Meriggiola MC, Armillotta F, Costantino A, Altieri P, Saad F, Kalhorn T, Perrone AM, Ghi T, Pelusi C, Pelusi G. Effects of testosterone undecanoate administered alone or in combination with letrozole or dutasteride in female to male transsexuals. *J Sex Med*. 2008;**5**(10):2442–2453.
183. Giltay EJ, Toorians AW, Sarabdjitsingh AR, de Vries NA, Gooren LJ. Established risk factors for coronary heart disease are unrelated to androgen-induced baldness in female-to-male transsexuals. *J Endocrinol*. 2004;**180**(1):107–112.
184. Giltay EJ, Verhoef P, Gooren LJG, Geleijnse JM, Schouten EG, Stehouwer CDA. Oral and transdermal estrogens both lower plasma total homocysteine in male-to-female transsexuals. *Atherosclerosis*. 2003;**168**(1):139–146.
185. Calof OM, Singh AB, Lee ML, Kenny AM, Urban RJ, Tenover JL, Bhasin S. Adverse events associated with testosterone replacement in middle-aged and older men: a meta-analysis of randomized, placebo-controlled trials. *J Gerontol A Biol Sci Med Sci*. 2005; **60**(11):1451–1457.
186. Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults. Executive summary of the Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III). *JAMA*. 2001;**285**(19):2486–2497.
187. Murad MH, Elamin MB, Garcia MZ, Mullan RJ, Murad A, Erwin PJ, Montori VM. Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes. *Clin Endocrinol (Oxf)*. 2010;**72**(2): 214–231.
188. Van Caenegem E, Wierckx K, Taes Y, Schreiner T, Vandewalle S, Toye K, Lapauw B, Kaufman JM, T'Sjoen G. Body composition, bone turnover, and bone mass in trans men during testosterone treatment: 1-year follow-up data from a prospective case-controlled study (ENIGI). *Eur J Endocrinol*. 2015;**172**(2): 163–171.
189. Turner A, Chen TC, Barber TW, Malabanan AO, Holick MF, Tangpricha V. Testosterone increases bone mineral density in female-to-male transsexuals: a case series of 15 subjects. *Clin Endocrinol (Oxf)*. 2004;**61**(5):560–566.
190. van Kesteren P, Lips P, Gooren LJG, Asscheman H, Megens J. Long-term follow-up of bone mineral density and bone metabolism in transsexuals treated with cross-sex hormones. *Clin Endocrinol (Oxf)*. 1998;**48**(3):347–354.
191. Van Caenegem E, Taes Y, Wierckx K, Vandewalle S, Toye K, Kaufman JM, Schreiner T, Haraldsen I, T'Sjoen G. Low bone mass is prevalent in male-to-female transsexual persons before the start of cross-sex hormonal therapy and gonadectomy. *Bone*. 2013;**54**(1):92–97.
192. Amin S, Zhang Y, Sawin CT, Evans SR, Hannan MT, Kiel DP, Wilson PW, Felson DT. Association of hypogonadism and estradiol levels with bone mineral density in elderly men from the Framingham study. *Ann Intern Med*. 2000;**133**(12):951–963.
193. Gennari L, Khosla S, Bilezikian JP. Estrogen and fracture risk in men. *J Bone Miner Res*. 2008;**23**(10):1548–1551.
194. Khosla S, Melton LJ III, Atkinson EJ, O'Fallon WM, Klee GG, Riggs BL. Relationship of serum sex steroid levels and bone turnover markers with bone mineral density in men and women: a key role for bioavailable estrogen. *J Clin Endocrinol Metab*. 1998;**83**(7):2266–2274.
195. Mueller A, Dittrich R, Binder H, Kuehnel W, Maltaris T, Hoffmann I, Beckmann MW. High dose estrogen treatment increases bone mineral density in male-to-female transsexuals receiving gonadotropin-releasing hormone agonist in the absence of testosterone. *Eur J Endocrinol*. 2005;**153**(1):107–113.
196. Ruetsche AG, Kneubuehl R, Birkhaeuser MH, Lippuner K. Cortical and trabecular bone mineral density in transsexuals after long-term cross-sex hormonal treatment: a cross-sectional study. *Osteoporos Int*. 2005;**16**(7):791–798.
197. Ganly I, Taylor EW. Breast cancer in a trans-sexual man receiving hormone replacement therapy. *Br J Surg*. 1995;**82**(3):341.
198. Pritchard TJ, Pankowsky DA, Crowe JP, Abdul-Karim FW. Breast cancer in a male-to-female transsexual. A case report. *JAMA*. 1988;**259**(15):2278–2280.
199. Symmers WS. Carcinoma of breast in trans-sexual individuals after surgical and hormonal interference with the primary and secondary sex characteristics. *BMJ*. 1968;**2**(5597):83–85.
200. Brown GR. Breast cancer in transgender veterans: a ten-case series. *LGBT Health*. 2015;**2**(1):77–80.
201. Shao T, Grossbard ML, Klein P. Breast cancer in female-to-male transsexuals: two cases with a review of physiology and management. *Clin Breast Cancer*. 2011;**11**(6):417–419.
202. Nikolic DV, Djordjevic ML, Granic M, Nikolic AT, Stanimirovic VV, Zdravkovic D, Jelic S. Importance of revealing a rare case of breast cancer in a female to male transsexual after bilateral mastectomy. *World J Surg Oncol*. 2012;**10**:280.
203. Bösze P, Tóth A, Török M. Hormone replacement and the risk of breast cancer in Turner's syndrome. *N Engl J Med*. 2006;**355**(24): 2599–2600.
204. Schoemaker MJ, Swerdlow AJ, Higgins CD, Wright AF, Jacobs PA; UK Clinical Cytogenetics Group. Cancer incidence in women with Turner syndrome in Great Britain: a national cohort study. *Lancet Oncol*. 2008;**9**(3):239–246.
205. Smith RA, Cokkinides V, Eyre HJ. American Cancer Society guidelines for the early detection of cancer, 2006. *CA Cancer J Clin*. 2006;**56**(1):11–25, quiz 49–50.
206. Wilson JD, Roehrborn C. Long-term consequences of castration in men: lessons from the Skoptzy and the eunuchs of the Chinese and Ottoman courts. *J Clin Endocrinol Metab*. 1999;**84**(12): 4324–4331.
207. van Kesteren P, Meinhardt W, van der Valk P, Geldof A, Megens J, Gooren L. Effects of estrogens only on the prostates of aging men. *J Urol*. 1996;**156**(4):1349–1353.
208. Brown JA, Wilson TM. Benign prostatic hyperplasia requiring transurethral resection of the prostate in a 60-year-old male-to-female transsexual. *Br J Urol*. 1997;**80**(6):956–957.
209. Casella R, Bubendorf L, Schaefer DJ, Bachmann A, Gasser TC, Sulser T. Does the prostate really need androgens to grow? Transurethral resection of the prostate in a male-to-female transsexual 25 years after sex-changing operation. *Urol Int*. 2005;**75**(3):288–290.
210. Dorff TB, Shazer RL, Nepomuceno EM, Tucker SJ. Successful treatment of metastatic androgen-independent prostate carcinoma in a transsexual patient. *Clin Genitourin Cancer*. 2007;**5**(5): 344–346.
211. Thurston AV. Carcinoma of the prostate in a transsexual. *Br J Urol*. 1994;**73**(2):217.

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

212. van Harst EP, Newling DW, Gooren LJ, Asscheman H, Prenger DM. Metastatic prostatic carcinoma in a male-to-female transsexual. *BJU Int*. 1998;**81**:776.
213. Turo R, Jallad S, Prescott S, Cross WR. Metastatic prostate cancer in transsexual diagnosed after three decades of estrogen therapy. *Can Urol Assoc J*. 2013;**7**(7–8):E544–E546.
214. Miksad RA, Bubley G, Church P, Sanda M, Rofsky N, Kaplan I, Cooper A. Prostate cancer in a transgender woman 41 years after initiation of feminization. *JAMA*. 2006;**296**(19):2316–2317.
215. Moyer VA; U.S. Preventive Services Task Force. Screening for prostate cancer: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med*. 2012;**157**(2):120–134.
216. Futterweit W. Endocrine therapy of transsexualism and potential complications of long-term treatment. *Arch Sex Behav*. 1998; **27**(2):209–226.
217. Miller N, Bédard YC, Cooter NB, Shaul DL. Histological changes in the genital tract in transsexual women following androgen therapy. *Histopathology*. 1986;**10**(7):661–669.
218. O'Hanlan KA, Dibble SL, Young-Spint M. Total laparoscopic hysterectomy for female-to-male transsexuals. *Obstet Gynecol*. 2007;**110**(5):1096–1101.
219. Dizon DS, Tejada-Berges T, Koelliker S, Steinhoff M, Granai CO. Ovarian cancer associated with testosterone supplementation in a female-to-male transsexual patient. *Gynecol Obstet Invest*. 2006; **62**(4):226–228.
220. Hage JJ, Dekker JJML, Karim RB, Verheijen RHM, Bloemena E. Ovarian cancer in female-to-male transsexuals: report of two cases. *Gynecol Oncol*. 2000;**76**(3):413–415.
221. Mueller A, Gooren L. Hormone-related tumors in transsexuals receiving treatment with cross-sex hormones. *Eur J Endocrinol*. 2008;**159**(3):197–202.
222. Coleman E, Bockting W, Botzer M, Cohen-Kettenis P, DeCuypere G, Feldman J, Fraser L, Green J, Knudson G, Meyer WJ, Monstrey S, Adler RK, Brown GR, Devor AH, Ehrbar R, Ettner R, Eyler E, Garofalo R, Karasic DH, Lev AI, Mayer G, Meyer-Bahlburg H, Hall BP, Pfaefflin F, Rachlin K, Robinson B, Schechter LS, Tangpricha V, van Trotsenburg M, Vitale A, Winter S, Whittle S, Wylie KR, Zucker K. Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *Int J Transgenderism*. 2012;**13**:165–232.
223. Colebunders B, D'Arpa S, Weijers S, Lumen N, Hoebeke P, Monstrey S. Female-to-male gender reassignment surgery. In: Ettner R, Monstrey S, Coleman E, eds. *Principles of Transgender Medicine and Surgery*. 2nd ed. New York, NY: Routledge Taylor & Francis Group; 2016:279–317.
224. Monstrey S, Hoebeke P, Dhont M, De Cuypere G, Rubens R, Moerman M, Hamdi M, Van Landuyt K, Blondeel P. Surgical therapy in transsexual patients: a multi-disciplinary approach. *Acta Chir Belg*. 2001;**101**(5):200–209.
225. Selvaggi G, Ceulemans P, De Cuypere G, VanLanduyt K, Blondeel P, Hamdi M, Bowman C, Monstrey S. Gender identity disorder: general overview and surgical treatment for vaginoplasty in male-to-female transsexuals. *Plast Reconstr Surg*. 2005;**116**(6): 135e–145e.
226. Tugnet N, Goddard JC, Vickery RM, Khoosal D, Terry TR. Current management of male-to-female gender identity disorder in the UK. *Postgrad Med J*. 2007;**83**(984):638–642.
227. Horbach SER, Bouman M-B, Smit JM, Özer M, Buncamper ME, Mullender MG. Outcome of vaginoplasty in male-to-female transgenders: a systematic review of surgical techniques. *J Sex Med*. 2015;**12**(6):1499–1512.
228. Wroblewski P, Gustafsson J, Selvaggi G. Sex reassignment surgery for transsexuals. *Curr Opin Endocrinol Diabetes Obes*. 2013; **20**(6):570–574.
229. Morrison SD, Satterwhite T, Grant DW, Kirby J, Laub DR, Sr, VanMaasdam J. Long-term outcomes of rectosigmoid neocolporrhaphy in male-to-female gender reassignment surgery. *Plast Reconstr Surg*. 2015;**136**(2):386–394.
230. Dessy LA, Mazzocchi M, Corrias F, Ceccarelli S, Marchese C, Scuderi N. The use of cultured autologous oral epithelial cells for vaginoplasty in male-to-female transsexuals: a feasibility, safety, and advantageousness clinical pilot study. *Plast Reconstr Surg*. 2014;**133**(1):158–161.
231. Li FY, Xu YS, Zhou CD, Zhou Y, Li SK, Li Q. Long-term outcomes of vaginoplasty with autologous buccal micromucosa. *Obstet Gynecol*. 2014;**123**(5):951–956.
232. Kanhai RC. Sensate vagina pedicled-spot for male-to-female transsexuals: the experience in the first 50 patients. *Aesthetic Plast Surg*. 2016;**40**(2):284–287.
233. Straayer C. Transplants for transsexuals? Ambitions, concerns, ideology. Paper presented at: Trans*Studies: An International Transdisciplinary Conference on Gender, Embodiment, and Sexuality; 7–10 September 2016; University of Arizona, Tucson, AZ.
234. Bucci S, Mazzon G, Liguori G, Napoli R, Pavan N, Bormioli S, Ollandini G, De Concilio B, Trombetta C. Neovaginal prolapse in male-to-female transsexuals: an 18-year-long experience. *Biomed Res Int*. 2014;**2014**:240761.
235. Raigosa M, Avvedimento S, Yoon TS, Cruz-Gimeno J, Rodriguez G, Fontdevila J. Male-to-female genital reassignment surgery: a retrospective review of surgical technique and complications in 60 patients. *J Sex Med*. 2015;**12**(8):1837–1845.
236. Green R. Sexual functioning in post-operative transsexuals: male-to-female and female-to-male. *Int J Impot Res*. 1998;**10**(Suppl 1): S22–S24.
237. Hess J, Rossi Neto R, Panic L, Rübben H, Senf W. Satisfaction with male-to-female gender reassignment surgery. *Dtsch Arztebl Int*. 2014;**111**(47):795–801.
238. Nygren U, Nordenskjold A, Arver S, Sodersten M. Effects on voice fundamental frequency and satisfaction with voice in trans men during testosterone treatment—a longitudinal study. *J Voice*. 2016;**30**(6):766.e23-766.e34.
239. Becking AG, Tuinzing DB, Hage JJ, Gooren LJG. Transgender feminization of the facial skeleton. *Clin Plast Surg*. 2007;**34**(3): 557–564.
240. Giraldo F, Esteva I, Bergero T, Cano G, González C, Salinas P, Rivada E, Lara JS, Soriguer F; Andalusia Gender Team. Corona glans clitoroplasty and urethropreputial vestibuloplasty in male-to-female transsexuals: the vulval aesthetic refinement by the Andalusia Gender Team. *Plast Reconstr Surg*. 2004;**114**(6): 1543–1550.
241. Goddard JC, Vickery RM, Terry TR. Development of feminizing genitoplasty for gender dysphoria. *J Sex Med*. 2007;**4**(4 Pt 1): 981–989.
242. Hage JJ, de Graaf FH, Bouman FG, Bloem JJAM. Sculpturing the glans in phalloplasty. *Plast Reconstr Surg*. 1993;**92**(1):157–161, discussion 162.
243. Thiagaraj D, Gunasegaram R, Loganath A, Peh KL, Kottegoda SR, Ratnam SS. Histopathology of the testes from male transsexuals on oestrogen therapy. *Ann Acad Med Singapore*. 1987; **16**(2):347–348.
244. Monstrey SJ, Ceulemans P, Hoebeke P. Sex reassignment surgery in the female-to-male transsexual. *Semin Plast Surg*. 2011;**25**(3): 229–244.
245. Perovic SV, Djinovic R, Bumbasirevic M, Djordjevic M, Vukovic P. Total phalloplasty using a musculocutaneous latissimus dorsi flap. *BJU Int*. 2007;**100**(4):899–905, discussion 905.
246. Vesely J, Hyza P, Ranno R, Cigna E, Monni N, Stupka I, Justan I, Dvorak Z, Novak P, Ranno S. New technique of total phalloplasty with reinnervated latissimus dorsi myocutaneous free flap in female-to-male transsexuals. *Ann Plast Surg*. 2007;**58**(5): 544–550.
247. Ranno R, Veselý J, Hýza P, Stupka I, Justan I, Dvorák Z, Monni N, Novák P, Ranno S. Neo-phalloplasty with re-innervated latissimus dorsi free flap: a functional study of a novel technique. *Acta Chir Plast*. 2007;**49**(1):3–7.

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

USCA4 Appeal: 19-1952 Doc: 20-1 Filed: 10/22/2019 Pg: 351 of 371 Total Pages:(351 of 1263)
Case 4:15-cv-00054-AWA-RJK Document 192-6 Filed 03/26/19 Page 35 of 35 PageID# 2052

248. Garcia MM, Christopher NA, De Luca F, Spilotros M, Ralph DJ. Overall satisfaction, sexual function, and the durability of neophallus dimensions following staged female to male genital gender confirming surgery: the Institute of Urology, London U.K. experience. *Transl Androl Urol*. 2014;**3**(2):156–162.
249. Chen H-C, Gedebou TM, Yazar S, Tang Y-B. Prefabrication of the free fibula osteocutaneous flap to create a functional human penis using a controlled fistula method. *J Reconstr Microsurg*. 2007;**23**(3):151–154.
250. Hoebeke PB, Decaestecker K, Beysens M, Opdenakker Y, Lumen N, Monstrey SM. Erectile implants in female-to-male transsexuals: our experience in 129 patients. *Eur Urol*. 2010;**57**(2):334–341.
251. Hage JJ. Metaidoioplasty: an alternative phalloplasty technique in transsexuals. *Plast Reconstr Surg*. 1996;**97**(1):161–167.
252. Cohanzad S. Extensive metoidioplasty as a technique capable of creating a compatible analogue to a natural penis in female transsexuals. *Aesthetic Plast Surg*. 2016;**40**(1):130–138.
253. Selvaggi G, Hoebeke P, Ceulemans P, Hamdi M, Van Landuyt K, Blondeel P, De Cuypere G, Monstrey S. Scrotal reconstruction in female-to-male transsexuals: a novel scrotoplasty. *Plast Reconstr Surg*. 2009;**123**(6):1710–1718.
254. Bjerrome Ahlin H, Kölby L, Elander A, Selvaggi G. Improved results after implementation of the Ghent algorithm for subcutaneous mastectomy in female-to-male transsexuals. *J Plast Surg Hand Surg*. 2014;**48**(6):362–367.
255. Wolter A, Diedrichson J, Scholz T, Arens-Landwehr A, Liebau J. Sexual reassignment surgery in female-to-male transsexuals: an algorithm for subcutaneous mastectomy. *J Plast Reconstr Aesthet Surg*. 2015;**68**(2):184–191.
256. Richards C, Barrett J. The case for bilateral mastectomy and male chest contouring for the female-to-male transsexual. *Ann R Coll Surg Engl*. 2013;**95**(2):93–95.
257. Sutcliffe PA, Dixon S, Akehurst RL, Wilkinson A, Shippam A, White S, Richards R, Caddy CM. Evaluation of surgical procedures for sex reassignment: a systematic review. *J Plast Reconstr Aesthet Surg*. 2009;**62**(3):294–306, discussion 306–308.
258. Selvaggi G, Elander A. Penile reconstruction/formation. *Curr Opin Urol*. 2008;**18**(6):589–597.
259. Dhejne C, Lichtenstein P, Boman M, Johansson ALV, Långström N, Landén M. Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. *PLoS One*. 2011;**6**(2):e16885.
260. Kuhn A, Bodmer C, Stadlmayr W, Kuhn P, Mueller MD, Birkhäuser M. Quality of life 15 years after sex reassignment surgery for transsexualism. *Fertil Steril*. 2009;**92**(5):1685–1689.e3.
261. Papadopulos NA, Lellé JD, Zavlin D, Herschbach P, Henrich G, Kovacs L, Ehrenberger B, Kluger AK, Machens HG, Schaff J. Quality of life and patient satisfaction following male-to-female sex reassignment surgery. *J Sex Med*. 2017;**14**(5):721–730.
262. Simonsen RK, Hald GM, Kristensen E, Giraldi A. Long-term follow-up of individuals undergoing sex-reassignment surgery: somatic morbidity and cause of death. *Sex Med*. 2016;**4**(1):e60–e68.
263. Djordjevic ML, Bizic MR, Duisin D, Bouman MB, Buncamper M. Reversal Surgery in regretful male-to-female transsexuals after sex reassignment surgery. *J Sex Med*. 2016;**13**(6):1000–1007.
264. Liberopoulos EN, Florentin M, Mikhailidis DP, Elisaf MS. Compliance with lipid-lowering therapy and its impact on cardiovascular morbidity and mortality. *Expert Opin Drug Saf*. 2008;**7**(6):717–725.
265. Forbes SS, Stephen WJ, Harper WL, Loeb M, Smith R, Christoffersen EP, McLean RF. Implementation of evidence-based practices for surgical site infection prophylaxis: results of a pre- and postintervention study. *J Am Coll Surg*. 2008;**207**(3):336–341.
266. Davis PJ, Spady D, de Gara C, Forgie SE. Practices and attitudes of surgeons toward the prevention of surgical site infections: a provincial survey in Alberta, Canada. *Infect Control Hosp Epidemiol*. 2008;**29**(12):1164–1166.

Downloaded from https://academic.oup.com/jcem/article-abstract/102/11/3869/4157558 by guest on 08 January 2019

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM,

Plaintiff,

v. Case No. 4:15-cv-54

GLOUCESTER COUNTY SCHOOL BOARD,

Defendant.

GLOUCESTER COUNTY SCHOOL BOARD'S RULE 26(a)(2) DISCLOSURE

NOW COMES the Defendant Gloucester County School Board ("School Board"), by counsel, and hereby discloses the following expert in accordance with Rule 26(a)(2) of the Federal Rules of Civil Procedure.

The School Board submits this disclosure without conceding that expert testimony is appropriate or needed with regard to the claims against the School Board, and without prejudice to or waiving the School Board's right to summary judgment and/or a judgment as a matter of law at the conclusion of plaintiff's evidence.

The following information is offered only as a summary of the respective expert's opinions and the grounds underlying those opinions. The School Board reserves the right to supplement, modify and/or change this expert disclosure as the expert continues to review this matter on behalf of the School Board and as additional discovery is conducted. The expert opinion is based on the expert's training, education and experience, as well as his review of the documents and other relevant materials noted in the reports. All opinions expressed will be offered to a reasonable degree of certainty in the witness' field of expertise unless stated

otherwise. The expert witness may render additional opinions or expound on the opinions listed in the reports at his depositions. The report and opinion testimony of the expert is incorporated in this Disclosure by reference.

Quentin L. Van Meter, M.D.
1800 Howell Mill Road NW
Suite 475
Atlanta, GA 30318

The School Board reserves the right to call as a witness, Dr. Quentin L. Van Meter, an expert in the field of pediatric endocrinology. Dr. Van Meter's expert report and CV are attached to this Disclosure and incorporated by reference as if fully set forth herein. (Exhibit 1).

GLOUCESTER COUNTY SCHOOL BOARD

By Counsel

David P. Corrigan (VSB No. 26341)
Jeremy D. Capps (VSB No. 43909)
Attorneys for Gloucester County School Board
Harman, Claytor, Corrigan & Wellman
P.O. Box 70280
Richmond, Virginia 23255
804-747-5200 - Phone
804-747-6085 - Fax
dcorrigan@hccw.com
jcapps@hccw.com

CERTIFICATE

I hereby certify that a true copy of the foregoing was emailed and mailed this 26th day of February, 2019 to:

Joshua A. Block, Esq.
NYSB 4370573
American Civil Liberties Union
125 Broad Street
18th Floor
New York, NY 10004
212-549-2627 - Phone
212-549-2593 - DD
212-549-2650 - Fax
jblock@aclu.org

Leslie Cooper, Esq.
NYSB 2759835
American Civil Liberties Union Foundation
125 Broad Street
18th Floor
New York, NY 10004
212-549-2500 - Phone
212-549-2584 - DD
212-549-2650 - Fax
lcooper@aclu.org

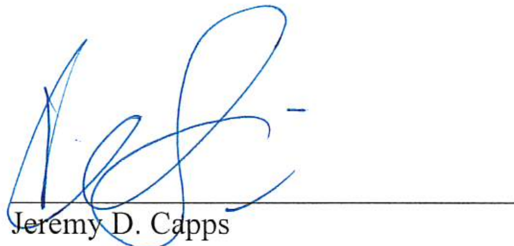
Shayna Medley-Warsoff, Esq.
American Civil Liberties Union Foundation
125 Broad Street
18th Floor
New York, NY 10004
212-549-2500 - Phone
212-549-2584 - DD
212-549-2650 – Fax
smedley@aclu.org

Clare P. Wuerker, Esq.
VSB No. 79236
United States Attorney's Office
101 West Main Street
Suite 8000
Norfolk, VA 23510
757-441-6361 - Phone
757-441-6689 - Fax
Clare.Wuerker@usdoj.gov

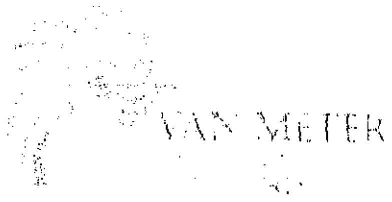
Victoria Lill, Esq.
DCBN1008599
United States Department of Justice
950 Pennsylvania Ave., N.W.
Educational Opportunities Section, PHB
Washington, DC 20530
202-514-4092 - Phone
202-307-6083 - DD
202-514-8337 - Fax
victoria.lill@usdoj.gov

Eden B. Heilman, Esq.
LSBA No. 30551
ACLU
701 E. Franklin Street
Suite 1412
Richmond, VA 23219
804-523-2152 - Phone
804-649-2733 - Fax
eheilman@acluva.org

Nicole Tortoriello, Esq.
VSB No. 91129
ACLU
701 E. Franklin Street
Suite 1412
Richmond, VA 23219
804-726-6013 - DD
804-649-2733 - Fax
ntortoriello@acluva.org



Jeremy D. Capps



1800 Howell Mill Road NW
Suite 475
Atlanta, Georgia 30318
678-951-2100
www.Pediatricendo.com

26 February, 2019

1. I have been retained by counsel for the Gloucester County School Board as an expert in connection with the above-captioned litigation. I have actual knowledge of the matters stated in this report. My professional background, experience, and publications are detailed in my curriculum vitae, which is attached as Exhibit A.

2. I received my B.A. in Science at the College of William and Mary, and my M.D. from the Medical College of Virginia, Virginia Commonwealth University.

3. I am currently a pediatric endocrinologist in private practice in Atlanta Georgia. I am the President of Van Meter Pediatric Endocrinology, P.C. I am on the clinical faculties of Emory University School of Medicine and Morehouse College of Medicine, in the role of adjunct Associate Professor of Pediatrics.

4. I am board certified in Pediatrics and Pediatric Endocrinology. I have been licensed to practice medicine in Georgia since 1991. I have been previously licensed to practice medicine in California, Louisiana, and Maryland.

5. I did my Pediatric Endocrine fellowship at Johns Hopkins Hospital from 1978-1980. The faculty present at that time had carried on the tradition of excellence established by Lawson Wilkins, M.D. Because of the reputation of the endocrine program as a center for exceptional care for children with disorders of sexual differentiation, I had well-above average exposure to such patients. As a Pediatric Fellow, I was also exposed to adults with Gender Identity Disorder, then called Trans-Sexuality, and received training from John Money, Ph.D., in his Psychohormonal Division.

6. I have maintained a continued interest in gender discordance since my fellowship years and have read extensively the literature in scientific peer-reviewed journals and have attended national and international pediatric endocrine conferences where this subject is presented and discussed. I am also familiar with the wide array of commentary on the subject.

7. My professional memberships include The Pediatric Endocrine Society, the Endocrine Society, the American Association of Clinical Endocrinologists where I held a position on the Pediatric Scientific Committee until it was disbanded one year ago, the American Diabetes Association, and I am a fellow of the American College of Pediatricians, currently serving on the Board of Directors as President. I am on the Advisory Board of Camp Kudzu, a non-profit organization which provides diabetes camp experience in Georgia.

8. My opinions expressed in this report are based upon my education, training, and experience in the subject matters discussed. The materials that I have relied upon are the same types of materials that

EXHIBIT
1

other experts in my field rely upon when forming opinions. Specific sources upon which I rely in this report are footnoted.

9. Over my career, I have served as an expert witness in medical malpractice cases for both plaintiff and defense. I have testified at Georgia State Legislative Committee hearings. In the past six years, I have testified by deposition in Harlen Schneider v. J. Enrique Lujan, M.D.et al., in the circuit court of the first judicial circuit of Okaloosa County, FL, Civil Division, on 7 Feb 2014; and in the case of plaintiff Kimora Gilmer, represented by attorneys at the Birmingham, AL, firm of Pittman Dutton on 22 May 2014.

10. I provided an expert declaration in the case of Carcano v McCorey and US vs North Carolina on 12 August 2016. I testified in Springfield. Illinois as a plaintiff's expert witness in the case of Cooley v. Paul for the firm of Kanoski Bresney, 3 Nov 2017. I testified in court in Hamilton County Ohio in February 2018 in regard to Jessica Siefert, a transgender teen who had been removed from the custody of her biologic parents. I testified via skype in Alberta Province, Canada on 14 June 2018 in regard to the matter of parents suing the school systems there for withholding information about transgender-promoting programs in the public schools from the parents. My publications include a textbook chapter, case studies, and articles generated by clinical research studies. I serve on the speaker's bureau of major pharmaceutical companies.

11. I am being compensated at an hourly rate for actual time devoted, at the rate of $350 per hour. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

Sexual Differentiation in the Fetus

12. From the moment of conception, a fetus is determined to be either a male (XY), female (XX), or in rare cases, to have a combination of sex-determining chromosomes, many of which are not compatible with life, and some of which are the cause of identifiable clinical syndromes. The presence of a Y chromosome in the developing fetus directs the developing gonadal tissue to develop as a testicle. The absence of a functional Y chromosome allows the gonadal tissue to develop as an ovary. Under the influence of the mother's placental hormones, the testicle will produce testosterone which directs the genital tissue to form a penis and a scrotum. Simultaneously, the testicle produces anti-Müllerian Hormone (AMH) which regresses development of the tissue that would otherwise develop into the uterus, fallopian tubes, and upper third of the vagina.

13. This combination of actions in early fetal development is responsible for what we subsequently see on fetal sonograms, and what we observe at birth as male or female genitalia. It is only when the genital structures are ambiguous in appearance that sex assignment is withheld until a thorough expert team evaluation has occurred.

14. For reasons most often occurring as random events, there are malfunctions of the normal differentiation. These aberrations of normal development are responsible for what we classify as Disorders of Sexual Differentiation (DSD) and they represent a very small fraction of the human population. The incidence of such circumstances occurs in 1:4500 to 1:5500 births[1]

---

1 Lee PA et al, Global Disorders of Sex Development Update since 2006: Perceptions, Approach and Care, 2016 Horm Res Paediatr

15. Sex is binary, male or female, and is determined by chromosomal complement and corresponding reproductive role. The exceedingly rare DSDs are all medically identifiable deviations from the human binary sexual norm. The 2006 consensus statement of the Intersex Society of North America and the 2015 revision of the Statement does not endorse DSD as a third sex.[2]

16. DSD outcomes range from appearance of female external genitalia in an XY male (complete androgen insensitivity syndrome) to appearance of male external genitalia in an XX female (severe congenital adrenal hyperplasia). As one would expect, there are variations of the degree of hormonally driven changes that create ambiguous genital development that prevent assigning of a specific classification as either male or female at birth.

17. DSD patients are not "transgender"; they have an objective, physical, medically verifiable, physiologic condition. Transgender people generally do not have intersex conditions or any other verifiable physical anomaly. People who identify as "feeling like the opposite sex" or "somewhere in between" do not comprise a third sex. They remain biological men or biological women.

18. "Gender" is a term that refers to the psychological and cultural characteristics associated with biological sex. It is a psychological concept and sociological term, not a biological one. The term gender possessed solely a linguistic meaning prior to the 1950s. This changed when sexologists of the 1950s and 1960s manipulated the term to conceptualize cross-dressing and transsexualism in their psychological practice.

19. "Gender identity" is a term coined by my former endocrine faculty member John Money in the 1970s and has come to refer to an individual's mental and emotional sense of being male or female. The norm is for individuals to have a gender identity that aligns with one's biological sex.

20. Gender discordance (formerly Gender Identity Disorder) is used to describe a psychological condition in which a person experiences marked incongruence between his experienced gender and the gender associated with his biological sex. He will often express the belief that he is the opposite sex.

21 Gender discordance occurs in 0.001% of biological females and in 0.0033% of biological males.[3] Exact numbers are hard to document since reporting is often anecdotal. Gender discordance is not considered a normal developmental variation.

22. "Gender Dysphoria" is a diagnostic term to describe the emotional distress caused by gender incongruity.[4]

---

2 Lee PA et al, Consensus Statement on Management of Intersex Disorders, Pediatrics 2006; 118 e488-e500.
3 Seaborg E, About Face, Endocrine News 2014 (May) 16-19.
4 American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed; 2013:451-459.

Etiology of Gender Disorders

23. Transgender affirming professionals claim transgender individuals have a "feminized brain" trapped in a male body at birth and vice versa based upon various brain studies. Diffusion-weighted MRI scans have demonstrated that the pubertal testosterone surge in boys increases white matter volume. A study by Rametti and colleagues found that the white matter microstructure of the brains of female-to-male (FtM) transsexual adults, who had not begun testosterone treatment, more closely resembled that of men than that of women.[5] Other diffusion-weighted MRI studies have concluded that the white matter microstructure in both FtM and male-to-female (MtF) transsexuals falls halfway between that of genetic females and males.[6] These studies, however, are of limited clinical significance due to the small number of subjects and failure to account for neuroplasticity.

24. Neuroplasticity is the well-established phenomenon in which long-term behavior alters brain microstructure. For example, the MRI scans of experienced cab drivers in London are distinctly different from those of non-cab drivers, and the changes noted are dependent on the years of experience.[7] There is no evidence that people are born with brain microstructures that are forever unalterable, but there is significant evidence that experience changes brain microstructure.[8,9] Therefore, any transgender brain differences would more likely be the result of transgender behavior than its cause.

25. Furthermore, infants' brains are imprinted prenatally by their own endogenous sex hormones, which are secreted from their gonads beginning at approximately eight weeks' gestation.[10,11,12] There are no published studies documenting MRI-verified differences in the brains of gender-disordered children or adolescents. The DSD guidelines also specifically state that current MRI technology cannot be used to identify those patients who should be raised as males or raised as females.[13]

---

5 Rametti G, Carrillo B, Gomez-Gil E, et al. White matter microstructure in female to male transsexuals before cross-sex hormonal treatment. A diffusion tensor imaging study. J Psychiatr Res 2011;45:199-204.

6 Kranz GS, Hahn A, Kaufmann U, et al. White matter microstructure in transsexuals and controls investigated b diffusion tensor imaging. J Neurosci 2014;34(46):15466-15475.

7 Maguire EA et al, Navigation-related structural change in the hippocampi of taxi drivers, PNAS 2000;97:4398- 4403.

8 Gu J, Kanai R. What contributes to individual differences in brain structure? Front Hum Neurosci 2014;8:262.

9 Sale A, Berardi N, Maffei L, Environment and Brain Plasticity: Towards an Endogenous Pharmacotherapy, Physiol Rev 2014; 94: 189 –234.

10 Reyes FI, Winter JS, Faiman C. Studies on human sexual development fetal gonadal and adrenal sex steroids. J Clin Endocrinol Metab 1973; 37(1):74-78.

11 Lombardo M. Fetal testosterone influences sexually dimorphic gray matter in the human brain. J Neurosci 2012; 32:674-680.

12 Campano A. [ed]. Geneva Foundation for Medical Education and Research. Human Sexual Differentiation;2016Availableat:www.gfmer.ch/Books/Reproductive_health/Human_sexual_differentiation.html. Accessed May 11, 2016.

13 Lee PA et al, Consensus Statement on Management of Intersex Disorders, Pediatrics 2006; 118 e488-e500.

26. Behavior geneticists have known for decades that while genes and hormones influence behavior, they do not hard-wire a person to think, feel, or behave in a particular way. The science of epigenetics has established that genes are not analogous to rigid "blueprints" for behavior. Rather, humans "develop traits through the dynamic process of gene-environment interaction. ... [genes alone] don't determine who we are." [14]

27. Regarding transgenderism, twin studies of adults prove definitively that prenatal genetic and hormone influence is minimal. The largest twin study of transgender adults found that only 10 percent of identical twins were both transgender-identified.[15] Since identical twins contain 100 percent of the same DNA from conception and develop in exactly the same prenatal environment exposed to the same prenatal hormones, if genes and/or prenatal hormones contributed to a significant degree to transgenderism, the concordance rates would be close to 100 percent. Instead, 80 percent of identical twin pairs were discordant. This would indicate that at least 80 percent of what contributes to transgenderism as an adult in one co-twin consists of one or more non-shared post-natal experiences including but not limited to non-shared family experiences.

28. These findings also mean that persistent GD is due predominately to the impact of nonshared environmental influences. These studies provide compelling evidence that discordant gender is not hard-wired genetically.

Gender Dysphoria vs. Gender Identity Disorder

29. Up until the recent revision of the DSM-IV criteria, the American Psychological Association (APA) held that Gender Identity Disorder (GID) was the mental disorder described as a discordance between the natal sex and the gender identity of the patient.

30. Dr. Kenneth Zucker, who is a highly respected clinician and researcher from Toronto carried on evaluation and treatment of GID patients for forty years. His works, widely published, found that the vast majority of boys and girls with GID identify with their biological sex by the time they emerge from puberty to adulthood, through either watchful waiting or family and individual counseling.[17] His results were mirrored in studies from Europe.[18,19] When the DSM-V revision of the diagnosis of GID was proposed by the APA committee responsible for revision, Dr. Zucker insisted that there be a medical term to replace Gender Identity Disorder, removing gender discordance as a mental disorder apart from the presence of significant emotional distress. With this revision, Gender Dysphoria describes the mental anguish which is experienced by the gender discordant patient.

---

14 Shenk, D. The Genius in All of Us: Why everything you've been told about genetics, talent, and IQ is wrong. (2010) New York, NY: Doubleday; p. 18.
15 Diamond, M. "Transsexuality Among Twins: identity concordance, transition, rearing, and orientation." nternational Journal of Transgenderism, 14(1), 24–38.
17 Zucker KJ, Gender Identity Disorder, in Rutter M, Taylor EA, editors. Child and Adolescent psychiatry, 4th ed, Malden Mass: Blackwell, 2006: 737-753.
18 Wallien MS, Cohen-Kettenis PT. Psychosexual outcome of gender-dysphoric children. J AM Academy Child Adolescent Psychiatry 2008; 47:1413-1423.
19 Schechner T. Gender Identity Disorder: A Literature Review from a Developmental Perspective. *Isr J PsychiatryRelated Sci* 2010; 47:42-48.

31. The theory that societal rejection is the root cause of Gender dysphoria was validly questioned by a study from Sweden which showed that the dysphoria was not eliminated by hormones and sex reassignment surgery even with widespread societal acceptance.[20]

Treatment of Gender Dysphoria

32. The treatment of the child and adolescent with gender discordance and accompanying gender dysphoria should include an in-depth evaluation of the child and family dynamics. This provides a basis on which to proceed with psychologic therapy. The entire biologic and social family should be involved in psychological therapy designed to assist the patient, if at all possible, to align gender identity with natal sex. Psychological support by competent counselors with an intent of resolving the gender conflict should be provided as long as the patient continues to suffer emotionally. Given the high degree of eventual desistance of gender discordance/dysphoria by the end of puberty, it would be ethical and logical to counsel the patient and family to rear the child in conformity with natal sex.

33. Erikson described the stage of adolescence as "Identity versus Role Confusion" during which the teen works at developing a sense of self by testing roles then integrating them into a single identity.[21] This process is often unpleasant regardless of the presence or absence of gender identity conflicts. The major benefit of enduring puberty in a GD patient is that it provides a strong likelihood of alignment of his gender identity with his natal sex. There is no doubt that these patients need compassionate care to get them through their innate pubertal changes. Scientific evidence shows that 80%-95% of pre-pubertal children with GD will come to identify with their biological sex by late adolescence. Some will require lifelong supportive counseling, and others will not.[22]

Science vs. Pseudoscience

34. The advent of "centers of excellence" for gender-disordered patients[23] combined with sociologic agenda in academia has created the impression that there is scientific validity to gender discordance as a variation of normal. There has been a flurry of non-peer-reviewed articles in journals and newsletters circulated to general pediatricians that promote the ideology of transgenderism without scientific support.[24,25,26,27] Mainstream clinicians and scientists who consider gender discordance to be a mental disorder have been deliberately excluded in the makeup of the steering committees of academic and medical professional societies which are promulgating guidelines that were previously unheard of.

---

20 Dhejne, Cecilia et al. Long-term Follow- up of transsexual Persons Undergoing Sex Reassignment Surgery:Cohort Study in Sweden *PLoS One* February 2011 Vol 6 Issue 2, e16885

21 Erikson, E. H. (1993). *Childhood and society*. WW Norton & Company. Erikson, E. H. (1993). *Childhood and society*. WW Norton & Company.

22 Zucker KJ, Gender Identity Disorder, in Rutter M, Taylor EA, editors. *Child and Adolescent psychiatry*, 4th ed, Malden Mass: Blackwell, 2006: 737-753.

23 Hsieh S and Leninger J, Resource List: Clinical Care Programs for Gender-Nonconforming Children and Adolescents, *Pediatr Ann* 2014:43:238-244.

24 Prager, LM, A boy who wants to be a girl, *Contemporary Pediatrics 2008*; 25:56-58.

25 Garafolo R Tipping points in caring for the gender-non-conforming child and adolescent, *Pediatr Ann* 2014;43:227-229.

26 Steever J, Cross-gender Hormone therapy in adolescents, *Pediatr Ann* 2014;43: e-138-e-144.

27 Simons LK et al, Understanding gender variance in Children and Adolescents, *Pediatr Ann*2014;43:e-126-e131.

35. The Endocrine Society published such a document in 2009.[28] Its recommendations promoted the use of psychological evaluation, counseling, blocking of pubertal maturation at the onset of puberty, the subsequent use of cross- sex hormones, and possible surgical intervention at the age of consent. Of the 22 recommendations contained in the document, only three were supported by scientific proof. These three warned of potential adverse effects of hormonal manipulation. The remaining 19 recommendations were nearly evenly split into a group that was based on very limited scientific evidence and a group that was based on no scientific evidence at all. The response to these guidelines was a burgeoning of Gender Identity Clinics in the United States from three to over forty-five in a period of seven years. Subsequently, the Endocrine Society revised the guidelines and the modifications were more permissive with the younger ages at which cross-sex hormones and surgical treatment could be recommended. They did add a concern that counseling regarding induced infertility should be included.[29]

The Pediatric Endocrine Society created their own guidelines[30] as did the American Academy of Pediatrics.[31] Each of these subsequent guidelines were more lenient and the AAP actually suggested that initial evaluation for undercurrent psychological issues be abandoned altogether.

36. WPATH is an agenda-driven advocacy organization whose membership consists of anyone who has an interest in the transgender social and political agenda. There are no requirements for specialty training or certification. Its guidelines and standards of care are not scientifically supported.

37. WPATH promotes "expert witnesses" and provides them with a bibliography replete with self-confirming references to opinion pieces and anecdotal case reports along with clinical case reviews with inherent selection bias.

38. WPATH's "peer-reviewed" journal is not reviewed by anyone with an opinion that is not in keeping with the philosophy of the organization itself.

39. I reviewed the legal complaint filed on behalf of the plaintiff, Gavin Grimm as well as the deposition of Gavin Grimm and the declaration by expert witness, Dr. Melinda Penn. I direct my strongest criticism at the information that was presented to support the affirmation of the gender incongruence through counseling, medical and surgical intervention. Statements were made that such action is clearly the only scientifically valid way to proceed, when the breadth of medical literature does not support this concept.

---

28 Hembree WC et al, Endocrine Treatment of Transsexual Persons: and Endocrine Society Clinical PracticeGuideline, *J Clin Endo Metab*2009; 94:3132-3154.

29. Hembree WC et al, Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: an Endocrine Society Clinical Practice Guideline, J Clin Endo Metab 2017 ;102:3869-3903.

30. https//www.pedsendo.org.../TG_SIG_%20Statement_10_220_16.pdf

31. Rafferty J, Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents, Pediatrics 2018;142:320182161

40. There are no scientifically validated gender incongruence training programs at universities in the United States. Under the guise of compassion for the bullied, endocrinologists are promoting chemical treatment that forever creates medical suffering, introducing complications such as sterility, increased stroke and cancer risk all to supposedly save the gender-incongruent person from taking his/her life to end the suffering imposed upon them by society. The suicide risk is hyper-inflated to as high as 50% when in reality it is actually 5%, as reported by the Williams Institute.[32] The mantra of "insistent, persistent and consistent" as a means to diagnose the entity of gender incongruence is not scientifically supported. The Nuremburg Guidelines are an established framework that have been overlooked by WPATH, the Endocrine Society, the Pediatric Endocrine Society and the American Academy of Pediatrics.

41. The requirement that society at large, and school systems in particular, should grant special regulatory privileges to a gender-incongruent person which is intended to further a student's belief that they are born into the body of the wrong sex is an endorsement of a form of medical "treatment" which has no scientific basis. Allowing a biologic female to use a male-designated bathroom facility is one of several "gender affirming" care options, but it is creating harm to at least two parties. The harm to the gender incongruent person is that it promotes a pathway to inevitable long-term medical and psychological morbidity. The premise of gender affirming care can be managed through other methods without requiring school systems to permit transgender students to use the restroom associated with their new gender identity. The second party harmed is the student without gender incongruence who must suffer emotionally while being told they must tolerate the presence of an opposite sex individual in a sexually segregated space and embrace the regulation which gives the gender incongruent person special privileges as if they were based on a civil right founded on immutable biology.

Quentin L. Van Meter, M.D.
Pediatric Endocrinologist

---

32. Wilson BDM et al, Characteristics and Mental Health of Gender Nonconforming Adolescents in California, Health Policy Fact Sheet, The Williams Institute UCLA School of Law December 2017

QUENTIN L. VAN METER, M.D. **updated 7 January 2019**
1800 Howell Mill Road NW, Suite 475
Atlanta, Georgia 30318 **(678) 961-2100**

PERSONAL

Home Address:	1080 Peachtree St. NE #3507, Atlanta, GA 30309
Home Phone:	(404) 963-5618
Date of Birth:	September 13, 1947
Place of Birth:	Laramie, Wyoming
Citizenship:	USA

EDUCATION:

Undergraduate:	College of William & Mary, 1969 B.S. – 1969
Medical School:	Medical College of Virginia, 1973 M.D. – 1973

CLINICAL TRAINING:

Institution: Hospital: Position:	The University of California, San Francisco Naval Regional Medical Center, Oakland Pediatric Intern – 1973 – 1974 Pediatric Resident – 1974 – 1976
Institution: Hospital: Position:	Johns Hopkins University Johns Hopkins Hospital Fellow, Pediatric Endocrinology 1978 – 1980 Fellowship Program Director: Claude Migeon, M.D.
Current Position:	Pediatric Endocrinologist Van Meter Pediatric Endocrinology, P.C. 1800 Howell Mill Road, Suite 475 Atlanta, Georgia 30318

PROFESSIONAL CERTIFICATION & SOCIETIES:

Diplomate, National Board of Medical Examiners, 1974

American Board of Pediatrics, certified in general pediatrics, 1978, sub-board certified in Pediatric Endocrinology, 1983

Fellow: American Academy of Pediatrics, Georgia Chapter 1975 -present
President, Uniformed Services West Chapter, 1987 – 1990
District VIII member, AAP Committee on Awards for Excellence in Research, 1990-1994
Editor, The Georgia Pediatrician, 1994 – 1998

Chairman, Georgia Chapter Legislative Committee, 1996 – 2006

Fellow: The American College of Pediatricians, 2007 – present
Member of the Board of Directors, 2008- present
Vice President/President, 2015-present

Member: Pediatric Endocrine Society, 1989 – present

Member: American Diabetes Association Professional Section, 1988 – present

Member: Endocrine Society, 1994-present

Member: Southern Pediatric Endocrine Society, 1992 – Present

Member: American Association of Clinical Endocrinologists, 2005 – present

Licensure: Georgia, #34734

FACULTY POSITIONS:

Institution: Morehouse School of Medicine
Position: Associate Clinical Professor, Pediatrics, 2004 – present

Institution: Emory University School of Medicine
Position: Associate Clinical Professor, Pediatrics, 1991 – present

Institution: University of California, San Francisco
Position: Associate Clinical Professor, Pediatrics, 1989 – 1991

Institution: University of California, San Diego, School of Medicine
Position: Assistant Clinical Professor, Pediatrics, 1980 – 1986

Institution: LSU School of Medicine, Clinical Instructor, Pediatrics, 1977 – 1978

MILITARY SERVICE:

Commission: Medical Corps, United States Navy, August 1971
Rank: Captain, retired
Duty Stations: Health Professional Scholarship Student, 1971 – 1974

Intern and Resident, Pediatrics, Naval Regional Medical Center, Oakland, 1973 – 1976

Staff Pediatrician, Naval Regional Medical Center, Oakland, 1976

Staff Pediatrician, Naval Regional Medical Center,
New Orleans, 1976 – 1978

Full time out-service fellow in Pediatric Endocrinology,
Johns Hopkins Hospital, 1978 – 1980

Staff Pediatric Endocrinologist, Naval Hospital San Diego,
1980 – 1986

Chairman and Director, Residency Training, Department of Pediatrics
Naval Hospital Oakland, 1986 – 1991

OTHER PROFESSIONAL ACTIVITIES:

Consultant, Pediatric Endocrinology,
Nellis Air Force Base Hospital, Las Vegas, Nevada
1981 – 1991

Consultant, Pediatric Endocrinology,
Naval Hospital Lemoore, CA
1986 – 1991

Consultant, Pediatric Endocrinology,
Letterman Army Medical Center, Presidio of San Francisco, CA
1990 – 1991

Consulting Endocrinologist,
Columbus Regional Medical Center, Columbus, GA
1991 – 1994

Pediatrician and Pediatric Endocrinologist, partner
Fayette Medical Clinic
Peachtree City, Georgia 30269
September 1991 – October 2003

Pediatric Endocrinologist Peer Reviewer 2006 – present
MCMC, LLC, Boston, MA
IMEDECS, Lansdale PA

Speaker's Bureau
Novo Nordisk, Pfizer, Endo, Abbvie
AAP Eqipp course on Growth- development committee- 2012

PUBLICATIONS: (Articles in Peer Reviewed Journals)

Riddick, JR, Flora R., Van Meter, QL: "Computerized Preparation of Two-Way Analysis of Variance Control Charts for Clinical Chemistry," Clinical Chemistry, 18:250, March 1972.

Van Meter, QL, Gareis FJ, Hayes, JW, Wilson, CB: "Galactorrhea in a 12 Year Old Boy with Chromophobe Adenoma," J. Pediatrics 90:756, May 1977.

Plotnick, LP, Van Meter, QL, Kowarski, AA, "Human Growth Hormone Treatment of Children with Growth Failure and Normal Growth Hormone Levels by Immunoassay: Lack of Correlation with Somatomedin Generation: Pediatrics 71:324, March 1983.

Brawley, RW, Van Meter, QL, "Mebendazole Ascaris Migration," W.J. Med, 145:514015, October 1986.

Van Meter, QL, "The Role of the Primary Care Physician in Caring for Patients with Type-1 Diabetes," Comp Ther 1998; 24(2):93–101

Midyett LK, Rogol AD, Van Meter QL, Frane J, and Bright GM, "Recombinant Insulin-Like Growth factor (IGF)-I Treatment in Short Children with Low IGF-I Levels: First-Year Results from a Randomized Clinical Trial," J Clin Endocrinol Metab, 2010;95:611–619.

ABSTRACTS:

Van Meter,Q L, & Lee, PA: "Evaluation of Puberty in Male and Female Patients with Noonan Syndrome," Pediatric Research 14:485, 1980.

Van Meter, QL, et al: "Characterization of Pituitary Function in Double Bolus GnRH Infusion as a Diagnostic Tool," Pediatric Research 32:111, 1984.

Van Meter, QL, Felix, SD, Lin, FL: "Evaluation of the Pituitary-Adrenal Axis in Patients Treated with nasal Beclomethasone," (Presented at the 1991 Annual Meeting of the Endocrine Society and the 6th Annual Naval Academic Research Competition, Bethesda, MD, 17 May, 1991).

Rogol AD Midyett LK Van Meter Q, Frane J, Baily J, and Bright GM, Recombinant Human IGF-1 for Children with Primary IGF-1 Deficiency (IGFD): Safety Data from Ongoing Clinical Trials (presented at the PAS 2007, Toronto).

Van Meter Q, Midyett LK, Deeb L et al, Prevalence of primary IGFD among untreated children with short stature in a prospective, multicenter study (Poster POO715) ICE Rio de Janeiro, Brazil 2008.

G.M. Bright[1], W.V.Moore[2], J.Nguyen[3], G. Kletter[4], B. S. Miller[5], Q. L. Van Meter[6], E. Humphriss[1], J.A. Moore[7] and J.L. Cleland[1] Results of a Phase 1b Study of a new long-acting human growth hormone (VRS-317) in pediatric growth hormone deficiency (PGHD). PAS 2014 May 2014

Van Meter Q, Welstead B and Low J, Characteristics of a Population of Obese Children and Adolescents: Suggesting a New Paradigm, presented at ESPE meeting, Dublin 2014.

Wayne V. Moore[1], Patricia Y. Fechner[2], Huong Jil Nguyen[3], Quentin L. Van Meter[4], John S. Fuqua[5], Bradley S. Miller[6], David Ng[7], Eric Humphriss[8], R. W. Charlton[8], George M. Bright[8], Safety and Efficacy of Somavaratan (VRS-317), a Long-Acting rhGH, in Children with Growth Hormone Deficiency (GHD): 3-Year Update of the VERTICAL & VISTA Trials, presented at the 2017 Endocrine Society meeting in Orlando FL

Bradley S. Miller[1], Wayne V. Moore[2], Patricia Y. Fechner[3], Huong Jil Nguyen[4], Quentin L. Van Meter[5], John S. Fuqua[6], David Ng[7], Eric Humphriss[8], R. W. Charlton[8], George M. Bright[8], 3-Year Update of the Phase 2a and Long-term Safety Studies (VERTICAL and VISTA) of Somavaratan (VRS-317), a Long-acting rhGH for the Treatment of Pediatric Growth Hormone Deficiency, presented at the 2017 IMPE meeting in Washington D.C.

Laidlaw MK, Van Meter QL, Hruz PW, Von Mol A, and Malone WJ, Letter to the Editor: "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline," J CLin Endo Metab 2019;104: 1-2.

ADDITIONAL PRESENTATIONS/LECTURES:

Pediatrics Update, CME Associates, San Diego – Orlando Annual Conferences: Lectures on Pediatric Endocrine Subjects – 1986 – 2001. Course Moderator, 1997, 1998, 1999, 2000, 2001

Endocrine and Gastroenterology Update, CME Associates, Maui HI Nov 2001, Lecturer and Course Moderator

Lecture on Panhypopitutarism, Pharmacia Conference, Nashville TN April 2002.

Family Medicine Review Course, Orlando, FL, 1992 – 2001

Pediatric Grand Rounds, Tanner Medical Center, October 1997

Pediatric Grand Rounds, Hughes Spaulding Children's Hospital, September, 2003

Pediatrics in the Park, Fall CME meeting for the Georgia Chapter of the American Academy of Pediatrics, November 2003

Pediatric Grand Rounds, Columbus Regional Medical Center, January 2004

Frontiers in Pediatrics CME Course, sponsored by the Atlanta Children's Health Network, Atlanta, March 2004.

Pediatric Grand Rounds, Eggleston Children's Hospital, May 2004.

Sue Schley Matthews Pediatric Conference, Columbus Regional Medical Center, September 2004

56th Annual Scientific Assembly and Exhibition of the Georgia Academy of Family Physicians, Nov 2004

Program Co-Chairman: Southern Pediatric Endocrine Society Annual meeting, Nov 2004, November 2014

Presentations on Diabetes, Growth Failure, and Thyroid Disease to the Postgraduate Pediatric Nurse Practitioner Program, Georgia State University, Nov 2005, June 2006, May 2007

Issues in Medicine, US Medical Congress Conference and Exhibition, Las Vegas, meeting planner and speaker, June, 2006

CME Presentations for the Georgia Chapter of the American Academy of Pediatrics Spring and Fall Meetings 2004-present

Pediatric Grand Rounds, Columbus Regional Medical Center, Columbus, GA, 2011-present

Human Growth Foundation Regional CME Conference, Atlanta GA March 2013, February 2014 Columbus Georgia

International Federation of Therapeutic Counseling Choice: Transgender Medicine, IFTCC Launch, October 15, 2018 London, Third International Congress, October 25 2018 Budapest.

Audio Digest Pediatrics - ① v. 41, no. 4; ② v. 41, no. 20; ③ v. 43, no. 17

Audio Digest Family Practice - ① v. 42, no. 5; ② v. 44, no. 11; ③ v. 44, no. 44; ④ v. 45, no 15

Audio Digest Otolaryngology - ① v. 32, no. 14

CURRENT HOSPITAL APPOINTMENTS:

Eggleston/Scottish Rite Children's Hospitals, active staff, Pediatric Endocrinology

PAST AND CURRENT CLINICAL RESEARCH:

2006	Sanofi-Aventis HMR1964D/3001	study completed 2007
2006	Tercica MS301-	study completed 2008
2007	Tercica MS310-	study completed 2008
2007	Tercica MS306-	study completed 2010
2007	Tercica MS316-	study completed 2012
2008	EMD Serono 28358	study completed 2009
2012	Versartis 12VR2	study completed 2014
2012	Debiopharm 8206-CPP-301	study started July 2012
2013	Versartis 13 VR3	study started Dec 2013
2014	Novo-Nordisk Elipse	study started 2014
2015	Versartis 14 VR4	study completed 2017
2017	Mannkind MKC-TI-155	study started 2017

LEGAL EXPERT WITNESS:

2017 North Carolina Legislature- transgender bathroom bill
2018 Jessica Siefert transgender case, Cincinnati, OH
2018 Alberta, Canada school system transgender case
2018 Decatur GA School Board transgender case

Customary charges for medical legal review, deposition and court testimony for
Quentin L. Van Meter, M.D.

Retainer- $1500

Record review- $350/h

Deposition and Testimony- $450/h

If testimony requires travel, lodging, and meals- reimbursement for full receipted cost

If testimony requires days away from the medical practice, flat fee of $3500 per day involved.

RECORD NO. 19-1952

In The
United States Court of Appeals
For The Fourth Circuit

GAVIN GRIMM,

Plaintiff – Appellee,

v.

GLOUCESTER COUNTY SCHOOL BOARD,

Defendant – Appellant.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
AT NEWPORT NEWS

JOINT APPENDIX
VOLUME II OF IV
(Pages 361 – 757)

David P. Corrigan
Jeremy D. Capps
M. Scott Fisher, Jr.
George A. Somerville
HARMAN CLAYTOR
CORRIGAN & WELLMAN
Post Office Box 70280
Richmond, Virginia 23255
(804) 747-5200

Counsel for Appellant

Joshua A. Block
Leslie Cooper
AMERICAN CIVIL LIBERTIES UNION
125 Broad Street, 18th Floor
New York, New York 10004
(212) 549-2593

Counsel for Appellee

Eden Brooke Heilman
Jennifer Marie Safstrom
Nicole Gloria Tortoriello
AMERICAN CIVIL LIBERTIES
UNION FOUNDATION OF VIRGINIA
701 East Franklin Street, Suite 1412
Richmond, Virginia 23219
(804) 532-2152

Counsel for Appellee

THE LEX GROUP ♦ 1108 East Main Street ♦ Suite 1400 ♦ Richmond, VA 23219
(804) 644-4419 ♦ (800) 856-4419 ♦ Fax: (804) 644-3660 ♦ www.thelexgroup.com

TABLE OF CONTENTS
VOLUME I OF IV

Appendix Page

Docket Entries **1**

Order of
The Honorable Arenda L Wright Allen
Re: Granting Consent Motion for Dismissal of Requests for Relief and Plaintiff's Motion to Vacate Order for Supplemental Briefing and Dismissing Request for Relief of Plaintiff's A mended Compliant
filed December 12, 2017 .... **29**

Order of
The Honorable Arenda L Wright Allen
Re: Denying Amended Motion to Dismiss
filed May 22, 2018 .... **35**

Order of
The Honorable Arenda L Wright Allen
Re: Granting Plaintiff's Motion for Leave to File Second Amended Complaint
filed February 15, 2019 .... **66**

Second Amended Complaint
filed February 15, 2019 .... **70**

Answer to Second Amended Complaint
filed March 1, 2019 .... **89**

Declaration of Gavin Grimm,
With Exhibits,
filed March 26, 2019 108

Exhibits:

A. Treatment Documentation Letter
dated May 26, 2014 123

B. Letter from
R. Smalls to
Virginia Department of Motor Vehicles
dated June 5, 2015 124

C. Order of
The Circuit Court of Gloucester County
dated September 9, 2016 125

D. Redacted Birth Certificate 127

E. Redacted Transcript of Gavin Grimm's Grades
various dates 128

Declaration of Deirdre Grimm
filed March 26, 2019 129

Declaration of Shayna Medley Warsoff,
With Exhibits,
filed March 26, 2019 136

Exhibits:

1. Defendant's Answer to Plaintiff's First Interrogatories
dated December 13, 2018 145

2. Defendant's Supplemental Answer to
Plaintiff's Interrogatory No. 1
dated January 11, 2019 159

3. Expert Report and Declaration of Dr. Melinda Penn, M.D.,
dated January 8, 2019 172

Exhibits, continued:

4. Eastern Virginia Medical School Curriculum Vitae of Melinda Penn, MD
various dates 183

5. Standards of Care for the Health of Transsexual Transgender, and Gender Nonconforming People
undated 188

6. Endocrine Society Guidelines
undated 306

7. Expert Report of Dr. Quentin Van Meter
dated February 26, 2019 341

TABLE OF CONTENTS
VOLUME II OF IV

Appendix Page

Declaration of Shayna Medley Warsoff,
With Exhibits,
filed March 26, 2019:

Exhibits, continued:

8. Rebuttal Expert Report and Declaration of Dr. Melinda Penn, MD dated March 4, 2019 361

9. Excerpts of Transcript of Deposition of Nathan Collins taken September 21, 2018 363

Examination 364

10. Excerpts of Transcript of Deposition of Walter Clemons, PhD taken September 21, 2018 408

Examination 409

11. Excerpts of Transcript of Deposition of Tiffany Durr taken October 10, 2018 426

Examination 427

12. Excerpts of Transcript of Deposition of Matthew R. Lord taken October 10, 2018 436

Examination 437

13. Transcript of Deposition of Troy Andersen taken March 12, 2019 443

Examination 447

Exhibits, continued:

14. Transcript of Deposition of Dr. Quentin Van Meter taken March 18, 2019 541

Examination by Mr. Block 547

TABLE OF CONTENTS
VOLUME III OF IV

Appendix Page

Declaration of Shayna Medley Warsoff,
With Exhibits,
filed March 26, 2019:

Exhibits, continued:

15. Mr. Collins's Memorandum to Deirdre Grimm
dated October 14, 2014 758

16. Dr. Clemons's Email to the School Board
dated October 22, 2014 759

17. Mr. Collins's Memorandum to Dr. Clemons
dated October 23, 2014 760

18. Emails from Carla Hook to a Constituent
dated October 24-27, 2014 762

19. Email from Carla Hook to a Constituent
dated October 31, 2014 765

20. Email from Carla Hook to the School Board
dated November 4, 2014 766

21. Email and Attachment from Carla Hook to the School Board
dated November 9, 2014 767

22. School Board's Press Release
dated December 3, 2014 769

23. Recorded Minutes of Gloucester County School Board Meeting
held December 9, 2014 772

24. Mr. Collins's Correspondence
to Deirdre and David Grimm
dated December 10, 2014 779

Exhibits, continued:

25. Email from Amy Bergh to Mr. Collins
dated November 19, 2014 780

26. Transcript of Deposition of Gavin Grimm
taken October 19, 2018 781

Examination by Mr. Corrigan 786
Examination by Mr. Block 948
Examination by Mr. Corrigan 952

27. Presentation Given at the
2014 Virginia School Board Association Conference 958

28. Map of Gloucester High School
dated 2009-2010 969

29. Gloucester High School Map, Locations of School Restrooms
dated 2009-2010 970

30. List of Restrooms at Gloucester High School
undated 971

31. Letter from Joshua Block to David Corrigan
dated December 23, 2016 972

35. Gloucester County School Board press release
dated February 13, 2019 973

36. Gloucester County School Board press release
dated February 21, 2019 974

37. Recorded Minutes of Gloucester County School Board Meeting
dated November 11, 2014 975

Declaration of Janet M. Rainey
filed March 26, 2019 982

Exhibits to Brief in Support of Defendant's Motion for Summary Judgment filed March 26, 2019:

Exhibits:

E. Declaration of Troy Andersen, With Supporting Documents, dated March 25, 2019 983

Attachments:

1. Gavin Grimm's Enrollment Records with The Gloucester County School System various dates 985

2. Gavin Grimm's freshman Report Card for the School Year 2013-2014 991

3. Gavin Grimm was Offered the Opportunity to Have a Hearing with the School Board on Iris Request to Change his School Records on January 18, 2017 992

I. Defendant's Supplemental Answer to Plaintiff's Interrogatory No. 1 dated January 11, 2019 994

Declaration of James H. Loving, With Attached Photographs, filed March 26, 2019 1007

Exhibits to Plaintiff's Memorandum of Law in Opposition to Defendant's Motion for Summary Judgment filed April 9, 2019:

1. Declaration of Shayna Medley Warsoff dated April 9, 2019 1021

A. Transcript of Deposition of Melinda Penn, MD taken March 14, 2019 1023

Examination by Mr. Capps 1028

C. Diagnostic and Statistical Manual of Mental Disorders, With Attachment, Fifth Edition, DSM-5 1115

Attachment:

Email from Amy Bergh to Nate Collins dated November 19, 2014 1118

Transcript of Motions Hearing before The Honorable Arenda L Wright Allen on July 23, 2019 1119

Order of The Honorable Arenda L Wright Allen Re: Granting Plaintiff's Motion for Summary Judgment, Denying the Board's Motion for Summary Judgment filed August 9, 2019 1165

Judgment in a Civil Case filed August 9, 2019 1193

Defendant's Notice of Appeal filed August 30, 2019 1194

TABLE OF CONTENTS
VOLUME IV OF IV – EXHIBIT

Appendix Page

Exhibits to Brief in Support of Defendant's Motion for Summary Judgment filed March 26, 2019:

Exhibits

F. Gavin Grimm's Enrollment Records with The Gloucester County School System various dates 1196

N. Redacted Birth Certificate 1218

O. Redacted Birth Certificate 1219

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM, Plaintiff, v. GLOUCESTER COUNTY SCHOOL BOARD, Defendant.	)))))))))	Civil No. 4:15-cv-00054-AWA-RJK

REBUTTAL EXPERT REPORT AND DECLARATION OF DR. MELINDA PENN, M.D.

1. I, Melinda Penn, M.D., have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

2. I have reviewed the expert disclosure report of Dr. Quentin Van Meter dated February 26, 2019, submitted by Defendant in the above-captioned matter.

3. I submit this rebuttal expert report and declaration in response.

REBUTTAL OPINIONS

4. As discussed in my initial expert declaration and report, I provide treatment to transgender adolescents in accordance with the World Professional Association for Transgender Health ("WPATH") Standards of Care and the Endocrine Society's Clinical Practice Guideline for Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons. The American Academy of Pediatrics recognizes that these reflect the accepted standards of care for the treatment of children and adolescents suffering from gender dysphoria.

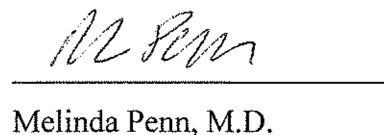
5. Pediatricians and endocrinologists rely on the American Academy of Pediatrics and the Endocrine Society for guidance on the prevailing standards of care for practicing physicians. The AAP and the Pediatric Endocrine Society are highly regarded and respected medical societies. AAP is the largest organization of pediatric physicians in the United States, and is dedicated to promoting the physical, mental, and social health and well-being of children and adolescents.

6. Dr. Van Meter is the President of the Board of Directors of the American College of Pediatricians. Although that organization has an official-sounding name, it is a small, fringe organization with policy positions and medical recommendations that contradict the recommendations of the American Academy of Pediatrics and other mainstream medical organizations.

7. I first learned about the American College of Pediatricians in the last few years following their issuance of position statements against LGBT parenting, vaccination against the HPV virus, and affirming treatment of LGBT youth. These positions stand in stark contrast to the positions of the AAP and the major medical organizations in the United States, and often cause confusion among the public because of the official-sounding name about what are the accepted standards of care or prevailing views of the medical community.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: 3/4/2019



Melinda Penn, M.D.

1 IN THE UNITED STATES DISTRICT COURT
2 EASTERN DISTRICT OF VIRGINIA
3
4 - x
5 GAVIN GRIMM :
6 Plaintiff : CASE NO.
7 v. : 4:15-CV-54
8 GLOUCESTER COUNTY SCHOOL BOARD :
9 Defendant :
10 - x
11
12 Deposition of NATHAN COLLINS
13 Glen Allen
14 Friday, September 21, 2018
15 9:32 a.m.
16
17
18
19
20 Job No.: 207622
21 Pages 1 - 177
22 Reported by: Lisa M. Blair, RMR

1 opportunities for students within the school to
2 explore their interests, and provide support for
3 students as they need it.
4 Q. Do you think it's important as a
5 principal to cultivate a welcoming environment for
6 all students?
7 A. Absolutely.
8 Q. And why is that?
9 A. I think fundamentally students learn
10 best when they feel safe and secure and
11 comfortable in their environment.
12 Q. And does having a welcoming
13 environment also have positive benefits for other
14 students who are not members of a minority group?
15 MR. CORRIGAN: Object to the form.
16 THE WITNESS: I believe it has benefits
17 for all students.
18 BY MR. BLOCK:
19 Q. What types of benefits?
20 A. Again, safety, security, comfort. I
21 believe that it helps students develop connections
22 within the school community. It helps them better

1 understand students of different backgrounds.
2 Q. And that's an important part of the
3 educational process, right?
4 MR. CORRIGAN: Object to the form.
5 THE WITNESS: I think it's generally
6 accepted that that's correct, yes.
7 BY MR. BLOCK:
8 Q. You can put this one aside. I'm
9 showing you a document marked at GCSB 04122. Do
10 you recognize this document?
11 A. May I have a second to read it?
12 Q. Sure.
13 A. (Witness reviewing document).
14 Yes, I do recognize it.
15 Q. What is it?
16 A. This is a memo that I prepared for my
17 superintendent at the time, Dr. Walter Clemons, in
18 October of 2014 providing background information
19 regarding a student at my school.
20 MR. BLOCK: I'll have the court reporter
21 mark it as Exhibit 2.
22

1 (Collins Exhibit Number 2 was marked for
2 identification)
3 Q. When was the first time you
4 personally heard about Gavin Grimm?
5 A. In late August or September of 2014,
6 sometime around the beginning of that school year.
7 Q. How did he come to your attention?
8 A. One of my school counselors told me
9 about him.
10 Q. And was that Tiffany Durr?
11 A. I believe it was, yes.
12 Q. And what did she say?
13 A. Ms. Durr told me that we had a
14 student who was transitioning from female to male,
15 and that the family had provided some information
16 to her regarding that transition.
17 Q. And did she say anything else?
18 A. I believe when Ms. Durr initially
19 discussed Gavin with me, we discussed his desire
20 to be referred to with male pronouns. I believe
21 we discussed a plan for him to use an alternative
22 restroom at Gloucester High School.

1 Q. In other schools in which you worked
2 where transgender students attended, do you know
3 if those students were referred to by pronouns
4 consistent with their gender identity?
5 A. I can't recall.
6 Q. Do you know if you personally ever
7 referred to a transgender student with pronouns
8 consistent with their gender identity?
9 A. Prior to Gavin, I can't recall.
10 Q. So when Ms. Durr came to you, did she
11 request your approval, or sign off on any of the
12 accommodations being made for Gavin?
13 A. She wanted to know if I agreed with
14 the plan she and Gavin had developed.
15 Q. So just to clarify, she and Gavin
16 developed it together first, and then she
17 presented it to you?
18 A. To my knowledge, yes, that's correct.
19 Q. And when she presented it to you, did
20 she give any further explanation for why she
21 thought this was an appropriate plan?
22 A. In the initial conversation I had

1 what did you say?
2 A. To who?
3 Q. To her.
4 A. I can't recall specifically what I
5 said.
6 Q. Okay. So back on Exhibit 2, the next
7 sentence -- and it's actually the last sentence in
8 that paragraph before the redaction say, "I
9 consulted with Dr. Clemons and with school
10 counseling staff members to review available legal
11 references." Did I read that right?
12 A. You did, yes.
13 Q. And what school counseling staff did
14 you consult with?
15 A. I talked to Matt Lord, our director
16 of school counseling specifically.
17 Q. Anyone else?
18 A. I talked to Dr. Clemons, the
19 superintendent.
20 Q. But he's not school counseling staff?
21 A. Correct. Yes.
22 Q. So what did Matt Lord recommend?

1 A. Mr. Lord provided me a couple of
2 documents with recommendations for transgender
3 students using the restrooms, and he recommended
4 that Gavin be allowed to use the male restrooms.
5 Q. Which documents did he provide you?
6 A. I can't recall specifically.
7 Q. What was the basis for his
8 recommendation that Gavin be allowed to use male
9 restrooms?
10 MR. CORRIGAN: Object to the form of the
11 question.
12 THE WITNESS: I can't speak to that. I
13 don't recall.
14 BY MR. BLOCK:
15 Q. Was he saying it in his capacity as a
16 school counselor?
17 MR. CORRIGAN: Object to the form. Go
18 ahead.
19 THE WITNESS: Yes.
20 BY MR. BLOCK:
21 Q. And you were asking for his opinion
22 as a school counselor, right?

1 A. Absolutely. Correct.
2 Q. Okay. And did he say anything
3 indicating that he thought as a school counselor
4 that using the male restrooms would be in Gavin's
5 best interest?
6 A. Yes, he did express that.
7 Q. And did -- what did you say in
8 response?
9 A. I can't recall specifically at that
10 time. I asked him to probably explain the reason
11 for his opinion. I asked him what information,
12 what guidance, what research informed his opinion,
13 probably.
14 Q. And what did he say in response?
15 A. Again, he shared with me at least two
16 guidance recommendation documents that he referred
17 to as a professional, and the specific issue with
18 the transgender use of restrooms as the basis for
19 his professional opinion.
20 Q. You also talked to Dr. Clemons; is
21 that right?
22 A. That's correct.

1 Q. Did you talk with anyone else from
2 the superintendent's office?
3 A. I don't recall that, no.
4 Q. Any of the assistant superintendents?
5 A. At that time, I don't believe so.
6 Q. And what did Dr. Clemons say?
7 A. Dr. Clemons and I had a conversation
8 in which we wanted to gather more information to
9 make sure we understood any existing policy,
10 regulations, laws, and then make the best
11 decision -- to help me make the best decision I
12 could regarding the request.
13 Q. And was it ultimately your decision
14 to make in this conversation with Dr. Clemons?
15 A. It was, yes.
16 Q. So it was -- during this conversation
17 with Dr. Clemons it was your understanding that
18 you were empowered as the principal to make this
19 decision?
20 MR. CORRIGAN: Object to the form. Go
21 ahead.
22 THE WITNESS: I would say I understood

1 it was my decision to make, yes.
2 BY MR. BLOCK:
3 Q. And it was your understanding that
4 there weren't any existing school policies that
5 prohibited you from allowing Gavin to use the boys
6 restrooms, correct?
7 MR. CORRIGAN: Object to the form. Go
8 ahead.
9 THE WITNESS: Correct.
10 BY MR. BLOCK:
11 Q. Now, did you talk to any
12 administrators in other school districts?
13 A. Not that I recall, no.
14 Q. Did you review any medical
15 literature?
16 A. I can't say specifically.
17 Q. During this time that you were making
18 your decision, did you speak with anyone who
19 advised you not to let Gavin use the boys
20 restrooms?
21 A. No.
22 Q. And so, after this consultation

1 process, what did you decide to do?
2 A. I ultimately decided after this
3 consultation process and after meeting with Gavin
4 directly that Gavin should be allowed to use male
5 restrooms at Gloucester High School.
6 Q. Why?
7 A. I felt it was in his best interest,
8 and it seemed to be in line with the guidance I
9 had received.
10 Q. So even if the law didn't require
11 that you let Gavin use the boys restroom, you
12 still thought it was in his best interest?
13 A. Yes.
14 MR. CORRIGAN: Object to the form. Go
15 ahead.
16 BY MR. BLOCK:
17 Q. And do you think permitting him to
18 use the boys restroom was the best decision for
19 his ability to succeed in school?
20 MR. CORRIGAN: Object to form. Go
21 ahead.
22 THE WITNESS: I don't know if it was the

1 MR. CORRIGAN: Object to the form of the
2 question.
3 THE WITNESS: I would say I would always
4 make an individualized decision, yes, as long
5 as it was consistent with the policy.
6 BY MR. BLOCK:
7 Q. By allowing Gavin to use the boys
8 room, did you think you were making a commitment
9 to allow transgender students to use locker rooms
10 consistent with their gender identity?
11 MR. CORRIGAN: Object to the form.
12 THE WITNESS: No, we were focused -- I
13 was focused on the restroom specifically, not
14 necessarily the locker room.
15 BY MR. BLOCK:
16 Q. Going back to your memo, Exhibit 2,
17 after the redacted portion it says, During a
18 meeting with the school principal, school
19 counselor and the student -- sorry, I'll say that
20 again so it's correct. "During a meeting with the
21 school principal, school counselor, the student
22 and the student's mother, the student was informed

1 by the school principal he may begin using student
2 male bathrooms at Gloucester High School on
3 October 20th, 2014, and a written plan for doing
4 so was developed;" is that right?
5 A. That's correct, yes.
6 Q. So I'll show you another document.
7 This document is marked GCSB 894. Is this the
8 written plan referenced in your memo?
9 A. It is, yes.
10 MR. BLOCK: Great. I'd like to have
11 this marked as Exhibit 8.
12 (Collins Exhibit Number 8 was marked for
13 identification)
14 Q. So if we go to the bullet point that
15 says restroom use, it says, "Gavin may go to any
16 male student restroom at Gloucester High School.
17 He will need a restroom stall with a door, one
18 which will be selected by Gavin. Gavin will
19 notify Ms. Durr if and when this need changes; is
20 that right?
21 A. That's correct.
22 Q. Now, question about the sentence that

1 time." What does this refer to?
2 A. I think that was a general -- we
3 asked generally in the meeting did Gavin have any
4 other needs regarding this issue or others in
5 using male restrooms at Gloucester High School.
6 So I just wanted to reflect that we had discussed
7 that, and there were no other needs.
8 Q. Did you discuss locker rooms during
9 your meeting with him?
10 A. No.
11 Q. Did you discuss sports teams?
12 A. Not that I recall.
13 Q. Did you make any promises about how
14 any other request related to him being transgender
15 would be resolved?
16 A. Not that I recall.
17 Q. Why does the memo say the decision
18 doesn't go into effect until October 20th?
19 A. That was agreed upon with Gavin's
20 mother and Gavin and I. I can't remember the days
21 of the week. I believe -- I can't recall why that
22 date was specifically selected.

1 appears to be an e-mail from a redacted person to
2 you with the subject line, "bathroom usage;" is
3 that right?
4 A. Yes.
5 Q. Do you remember this e-mail?
6 A. Not specifically, I'm sorry.
7 Q. Okay. So in an e-mail it says,
8 "Mr. Collins, I hope you're having a good day. I
9 want to address a story I heard with you to verify
10 if it's true or not. I was told today that a
11 female student has requested to use the boys
12 bathroom, and that request has been approved by
13 GHS administration. Apparently this female is
14 considering herself a transgender student,"
15 exclamation point.
16 And then you forward that to
17 Dr. Clemons saying, "FYI, this is the second
18 inquiry about this I've had today."
19 MR. CORRIGAN: That's a question mark,
20 not an exclamation point.
21 MR. BLOCK: Oh, yeah, sorry.
22 MR. CORRIGAN: That's all right.

1 BY MR. BLOCK:
2 Q. So when I was reading the earlier
3 quote, it was a question mark, not an exclamation
4 point.
5 So do you recall receiving an e-mail
6 like this and forwarding it to Dr. Clemons?
7 A. I do recall that, yes.
8 Q. Now, had you received any complaints
9 before Wednesday, October 22nd?
10 A. I don't recall the chronology. I
11 remember at least two parent concerns expressed to
12 me. In the e-mail I wrote to Dr. Clemons I said
13 "the second one today." So I don't recall that I
14 had any prior to that day necessarily.
15 Q. Now, did you personally receive any
16 complaints from anyone that wasn't a parent?
17 A. From a student.
18 Q. Okay. So a student personally
19 complained to you?
20 A. A student requested to meet with me
21 in my office regarding transgender use of the
22 restroom, yes.

1 provided. It's what you and I talked about.
2 MR. BLOCK: Right. Right.
3 MR. CORRIGAN: So there's going to be a
4 line here. And I'm not trying to be disruptive
5 in the deposition or anything like that, but I
6 have obligations to my client to respect
7 attorney-client privilege.
8 MR. BLOCK: Sure. And to clarify, she
9 is an attorney at the VSBA that provides legal
10 counsel to school boards?
11 MR. CORRIGAN: Correct. That is my
12 understanding. I don't know Elizabeth Ewing,
13 but that is my understanding. I'll just leave
14 it there.
15 BY MR. BLOCK:
16 Q. Then the sentence says, "Furthermore,
17 I will have Mr. Collins present tomorrow evening
18 so he can fill you in on his actions thus far
19 related to these issues."
20 Did you present to the School Board
21 the following evening?
22 A. I would read that as I will have

1 to see how he was doing, what his experience had
2 been, if there had been any issues, any concerns
3 directly from him.
4 Q. And when did this check-in occur?
5 A. I don't recall specifically when that
6 was. Sometime probably October, early November of
7 2014.
8 Q. And what did Gavin say?
9 A. He did not express any concerns to
10 me.
11 Q. Was Gavin ever informed that anyone
12 had complained about the fact that he was able to
13 use the restrooms?
14 A. Not by me.
15 Q. So before the November 11th meeting,
16 did Gavin -- was Gavin ever informed that any
17 members of the School Board had concerns about him
18 being allowed to use the boys restrooms?
19 A. Not by me.
20 Q. Do you know if he was informed by
21 anyone else?
22 A. I don't know.

1 Q. And for the previous question, too,
2 about parents or students having concerns, do you
3 know whether anyone else informed Gavin that
4 parents or students had concerns?
5 A. I don't know.
6 Q. So -- and then again between the
7 November meeting and the December School Board
8 meeting, did you meet with Gavin at all?
9 A. I can't recall specifically. I am
10 positive I interacted with him as a student in my
11 school. I can't recall if I met with him
12 specifically regarding his bathroom usage.
13 Q. So you can't recall whether you had
14 any other check-ins?
15 A. I can't recall.
16 Q. So did anyone, to the best of your
17 knowledge, have a conversation with Gavin saying
18 there has been some complaints; can we have a
19 meeting to see if there's a way to adjust the
20 accommodation somehow?
21 A. I don't know.
22 Q. So do you know if anyone had a

1 meeting with Gavin where they could discuss the
2 possibility of maybe him using a subset of
3 restrooms or something like that?
4 A. I don't recall that. I don't know.
5 Q. So to the best of your knowledge, was
6 Gavin ever given an opportunity to have a dialogue
7 with the administration or the board in working
8 out a solution to the problem?
9 MR. CORRIGAN: Object to the form.
10 THE WITNESS: The administration other
11 than me?
12 BY MR. BLOCK:
13 Q. Yes.
14 A. I don't know. I'm not aware.
15 Q. Okay. When did school administrators
16 begin discussing the possibility of creating new
17 single user student restrooms?
18 A. I believe that followed the November
19 School Board meeting.
20 Q. And what prompted those discussions?
21 A. I can't say that I know what prompted
22 that.

1 High School faculty meeting.
2 Q. And what happened?
3 A. At that meeting I shared a plan that
4 was being developed to convert some restrooms in
5 the school to single user restrooms for students.
6 Q. And what were the original plans for
7 the C-Hall restrooms?
8 A. On C-Hall there were I believe two
9 faculty restrooms, and I believe the original plan
10 was to convert one of those two to a student
11 single user restroom.
12 Q. Did the ultimate plan follow through
13 on that?
14 A. Not -- no. The plan was changed.
15 Q. What was changed?
16 A. Two other areas on C-Hall were
17 identified that could become student single user
18 restrooms so as not to reduce the availability of
19 faculty restrooms for teachers.
20 Q. So can we look at the map on
21 Exhibit 4. Can you tell me where the teacher
22 restrooms that -- one of which was going to be

1 new unisex, those are the new ones that were
2 created in front of the cafeteria; is that right?
3 A. Correct, I believe, yes.
4 Q. And what used to be in that location
5 where the new ones were created?
6 A. Those were locker rooms for custodial
7 staff.
8 Q. Could you tell me a little bit more?
9 What is a locker room for custodial staff?
10 A. So those were two rooms with lockers
11 and with restroom facilities for custodial staff
12 to use before or after their shift, during their
13 shift theoretically.
14 Q. So there already were toilets in
15 those restrooms, right?
16 A. Yes. Yes.
17 Q. And was it also a storage area for
18 custodians?
19 A. A storage area for?
20 Q. Well, did any -- yeah, sorry, like
21 cleaning equipment and things like that?
22 A. I don't know. I don't recall.

1 classes, do you think it would also be difficult
2 for a student to have to walk the same distance to
3 use the restroom between classes?
4 MR. CORRIGAN: Object to the form.
5 THE WITNESS: Between classes?
6 BY MR. BLOCK:
7 Q. Uh-huh.
8 A. It would make it more difficult to be
9 in class on time, yes.
10 Q. If you go to Ms. Bergh's e-mail again
11 near the bottom -- actually, two-thirds of the way
12 down a sentence starting, "Most of C-Hall
13 teachers;" do you see that near the right-hand
14 side?
15 A. Okay. Uh-huh. Yes.
16 Q. "Most of C-Hall teachers have at
17 least one day that we have no opportunities to use
18 the restroom, other than the five minutes during
19 class changes from before 8:00 with school until
20 our lunch at 12:30. That is a very long time for
21 anyone to wait, but pretty impossible for faculty
22 on diuretics."

1 document?
2 A. I do, yes.
3 Q. What is it?
4 A. It's a letter that I wrote to David
5 and Deirdre Grimm -- they were Gavin's parents --
6 regarding actions taken by the Gloucester School
7 Board, and the resulting impact on Gavin.
8 MR. BLOCK: I'd like to have this marked
9 as Exhibit 15.
10 (Collins Exhibit Number 15 was marked for
11 identification)
12 Q. So in this letter it says, Gavin will
13 no longer be able to use the male restrooms at
14 Gloucester High School effective immediately; is
15 that right?
16 A. That's correct.
17 Q. Now, at the time this letter was
18 sent, had the new unisex restrooms been installed
19 yet?
20 A. I can't recall the timeline.
21 Q. It's your understanding that Gavin
22 was prohibited from using all mens restrooms at

1 the school, correct?
2 A. That was my understanding, yes.
3 Q. Okay. I'd like to turn back to
4 the -- to Exhibit 4 and 5 again.
5 A. Okay.
6 Q. If you look on the list of restrooms
7 on Exhibit 5 under Gloucester High School, and you
8 go down past locker room to auditorium.
9 A. Uh-huh.
10 Q. It says auditorium boys, one non-ADA
11 restroom with single commode and sink; and
12 auditorium girls one non-ADA restroom with single
13 commode and sink; is that right?
14 A. Correct. Yes.
15 Q. So are those the two yellow squares
16 near -- in the room marked auditorium on the map?
17 A. Yes.
18 Q. So those are both single user
19 restrooms, right?
20 A. I can't recall, but based on the
21 description in Exhibit 5, yes.
22 Q. And was Gavin allowed to use the boys

1 girls dressing room in order to access the
2 restroom?
3 A. I can't recall the layout
4 specifically, and I can't tell from the map.
5 Q. Where is the third restroom that was
6 created as a single user restroom?
7 A. In addition to the two on C-Hall?
8 Q. Yes.
9 A. The third was located on the A-Hall.
10 So directly below the nurse's office labeled in
11 blue, there are two yellow areas that were male
12 and female student gang restrooms. To the right
13 of those there's a small single user restroom that
14 was a faculty restroom that was converted.
15 Q. So they're very close to the clinic;
16 is that right?
17 A. That's correct, yes.
18 Q. So if the clinic was difficult to get
19 to, presumably these would be equally difficult to
20 get to, right?
21 MR. CORRIGAN: Object to the form.
22 THE WITNESS: From where?

1 MR. CORRIGAN: Object to the form,
2 foundation.
3 THE WITNESS: Between classes
4 specifically?
5 BY MR. BLOCK:
6 Q. Yes.
7 A. I can't recall an instance
8 specifically during class when I saw a student
9 exit a single user restroom.
10 Q. Now, have you had any other
11 information, or inferences, or, you know, news
12 come to you that would lead you to believe that
13 students use the single stall restrooms between
14 classes?
15 MR. CORRIGAN: Object to the form.
16 THE WITNESS: I know they were used,
17 because they were dirty. They had to be
18 cleaned. They clearly had been used, but I
19 don't know -- I can't say specifically when
20 during the day they were used.
21 MR. BLOCK: We can mark this as 20.
22 (Collins Exhibit Number 20 was marked for

1 identification)
2 Q. I'm showing you a document produced
3 as GCSB 1349 and marked as Exhibit 20. At the
4 bottom of this e-mail thread is an e-mail from you
5 to Dr. Clemons dated November 16th, 2015; is that
6 right?
7 A. That's correct.
8 Q. And do you recall sending this
9 e-mail?
10 A. I do, yes.
11 Q. Okay. So I'll just read the first
12 paragraph with you. Before our discussion -- I'll
13 start that over and I'll read it correctly. "Per
14 our discussion last Friday, I would like to
15 provide you with some information regarding one of
16 our students who has requested to participate in a
17 VHSL sport as a transgender student."
18 What does VHSL stand for?
19 A. Virginia High School League.
20 Q. And is Gloucester High School a
21 member of the Virginia High School League?
22 A. It was at that time.

1 Q. Is it no longer?
2 A. I don't know.
3 Q. And then it says, "The student is a
4 tenth grade student who is biologically female and
5 who is identified at GHS as a female, but who is
6 apparently in the process of transitioning to a
7 male gender identity publicly."
8 So do you recall who this student is?
9 A. I do.
10 Q. So when you previously said you
11 weren't aware of -- specifically of transgender
12 students at Gloucester High School, and you just
13 knew information based on what students had told
14 you, does this, you know, refresh your
15 recollection?
16 A. It does, yes.
17 Q. Does it refresh your recollection
18 about whether there might be any other students
19 that you were aware were transgender, other than
20 hearing it from the student body?
21 A. No, I believe this is the only other
22 one I knew of specifically.

1 Q. Okay. The next sentence is, "The
2 student met with their school counselor in
3 September and informed her school counselor at
4 that time that she had come out as transgender to
5 her family, was not ready to do so publicly."
6 Do you know whether that student
7 ultimately did come out as transgender publicly?
8 A. If coming out publicly includes
9 formally requesting to compete as a different
10 gender athletically, then yes. And to my
11 knowledge, at least the student's friends were
12 aware of the transition, yes. And I know that at
13 least two of the student's instructors were aware
14 of the transition.
15 Q. And did the student adopt a name
16 consistent with his gender identity?
17 A. The student adopted a different name,
18 a preferred name, yes.
19 Q. And was the student's name changed in
20 school records?
21 A. As of the time I left Gloucester -- I
22 can't recall. I don't believe it had been as of

1 the time I left Gloucester High School.
2 Q. And do you know whether the student
3 had any medical treatment as part of the
4 transition?
5 A. To my knowledge, no.
6 Q. Do you know whether the student made
7 any request with respect to using restrooms?
8 A. Not to my knowledge, no.
9 Q. Do you know what restrooms the
10 student did use?
11 A. I do not know.
12 Q. Let's read -- continuing with the
13 e-mail it says, "The student and her parent
14 inquired as to the process necessary to allow her
15 to compete as a male member of our swim team
16 through our swim coach, and Kristy Hunter, GHS
17 Activities Director, met with the student and her
18 parent last week and shared with them the VHSL
19 policy regarding eligibility of transgender
20 student athletes."
21 How did you become aware of these
22 conversations and meetings?

1 A. I believe the activities director,
2 Ms. Hunter, who I referred to. I can't recall who
3 told me. I know I had a discussion with
4 Ms. Hunter regarding the meeting she had with the
5 student and parent. I cannot recall if the
6 counselor had also talked to me about it or not.
7 Q. And what is the VHSL policy regarding
8 the eligibility of transgender student athletes?
9 A. I can't say that I can quote it, but
10 I believe at that time the Virginia High School
11 League required a medical change before they would
12 approve a student competing as a transgender
13 individual.
14 Q. And was it your understanding -- what
15 was your understanding of whether this student had
16 had the appropriate treatment to qualify for
17 competing on --
18 A. Right.
19 Q. -- the team consistent with their
20 gender identity?
21 A. I don't believe it had occurred.
22 Q. If you would turn the page, you say,

1 "At this point, I have notified the Peninsula
2 District chairperson of the possibility of this
3 appeal being submitted for review by a District
4 Committee."
5 What is the Peninsula District?
6 A. The Peninsula District was the
7 district in which Gloucester High School competed
8 in Virginia High School League-sanctioned
9 competitions.
10 Q. Do you know whether the student
11 ultimately did file an appeal?
12 A. Yes.
13 Q. And what was the outcome?
14 A. At the district level the district
15 committee upheld the student's appeal, meaning
16 that the district agreed that the student could
17 compete as a male.
18 Q. And so, the student was allowed to
19 compete as a male on the Gloucester swim team?
20 A. Ultimately, no.
21 Q. Why not?
22 A. Because that decision also required

1 affirmation by the Virginia High School League,
2 who denied the appeal, to my recollection.
3 Q. All right. So there was an immediate
4 appeal to the District Committee?
5 A. Right. Correct.
6 Q. And the District Committee granted
7 it?
8 A. Correct.
9 Q. And then the VHSL had to review that
10 decision?
11 A. Correct.
12 Q. Now, does that review happen
13 automatically, or does someone have to request
14 that review?
15 A. I believe the district chairperson
16 would have submitted that to the Virginia High
17 School League for review.
18 Q. Meaning that happens automatically?
19 A. I believe it was part of the appeal
20 procedures for the Virginia High School League, so
21 yes.
22 Q. So to the best of your knowledge,

1 Gloucester County Public Schools didn't request
2 that appeal?
3 A. No. To the Virginia High School
4 League?
5 Q. Yes.
6 A. No. Yes, it was a part of the
7 procedure that was required.
8 Q. And if the appeal had -- if the
9 Virginia High School League had upheld the
10 decision of the District Committee, would that
11 student have been allowed to participate on the
12 male swim team --
13 A. Yes.
14 Q. -- at Gloucester High School?
15 A. Yes, correct.
16 Q. Did you confirm that that is
17 something that the superintendent's office agreed
18 with?
19 A. I don't recall that specifically, no.
20 Q. Was it your understanding that the
21 School Board would have to sign off on allowing
22 the student to compete if the VHSL said they

1 foundation.
2 THE WITNESS: I would say I recall
3 reading where it has been asserted that that's
4 occurred, but I can't say I've read that that
5 has occurred.
6 BY MR. BLOCK:
7 Q. In your reading and in your
8 conversations on the topic, have you ever heard of
9 a situation in which a transgender student was
10 using facilities consistent with their identity,
11 and that student saw someone else's genitals or
12 their genitals were exposed to another student?
13 A. No, I have not.
14 Q. You're aware that Gavin has obtained
15 a birth certificate reflecting that his sex is
16 male, right?
17 A. Yes.
18 Q. And you're aware that he has also
19 obtained a court order to that effect?
20 MR. CORRIGAN: Object to the form.
21 BY MR. BLOCK:
22 Q. Is that right?

1 A. I believe vital records require a
2 court order to be changed in Virginia. So yes, I
3 would say I'm aware of that.
4 Q. So how are you aware of that?
5 A. I can't recall.
6 Q. Did Gavin request that his school
7 records be updated to reflect the gender marker on
8 his birth certificate?
9 A. I don't recall if he made a specific
10 request, or if he or his parents provided the
11 information. I can't recall.
12 Q. And then what happened afterwards?
13 A. I can remember a discussion with Matt
14 Lord, with our director of student services,
15 regarding when records should be changed, and what
16 is necessary to change a student's gender in their
17 school record. I can't recall the outcome of
18 those discussions and whether it was changed or
19 not before leaving Gloucester.
20 Q. Who would be the one to make the
21 decision about whether it's changed?
22 A. I'm not sure.

1 A. Could you be more specific?
2 Q. Yeah, why would -- if that student's
3 sex assigned at birth let's say was female, and
4 they had two X chromosomes, then -- but they had
5 transitioned and had a male birth certificate, why
6 do you think that student would use the male
7 restrooms instead of the female ones?
8 MR. CORRIGAN: Object to the form and
9 foundation.
10 THE WITNESS: Because we would accept
11 that as their gender.
12 BY MR. BLOCK:
13 Q. And you would accept that as their
14 biological gender for purposes of the policy?
15 MR. CORRIGAN: Object to the form and
16 foundation. Calls for a legal conclusion.
17 THE WITNESS: I don't know that I can
18 speak to that specifically. We would accept
19 that as their gender assignment.
20 BY MR. BLOCK:
21 Q. Were you ever given any training on
22 how the policy applies to that sort of situation?

1 A. Which policy?
2 Q. How the restroom policy applies to
3 that sort of situation?
4 A. No.
5 Q. Were you ever given training on how
6 the policy applies to a student with intersex
7 conditions?
8 A. With, I'm sorry, what conditions?
9 Q. Intersex conditions. So they have
10 either genitals that are ambiguous or have other
11 parts of the anatomy that are typically not
12 aligned with their sex?
13 A. Was I given training?
14 Q. Yes.
15 A. No.
16 Q. Were you given any training on how
17 the policy would apply to a student who has had
18 transition-related surgery?
19 A. Training, no.
20 Q. So going back on all those questions,
21 had you had any informal conversations about how
22 the policy would apply in the context of a student

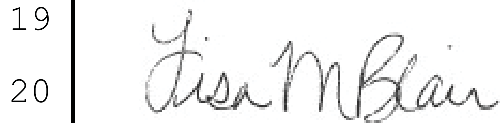
1 who had already transitioned and came to the
2 school?
3 A. I can't say there was any
4 conversation about speculative cases, no.
5 Q. And that's also true for students
6 with intersex conditions, you didn't have any
7 conversations about that?
8 A. Not that I recall.
9 Q. And that's also true for students who
10 might have had transition-related surgery, right?
11 A. Not that I recall, no.
12 Q. Is it your understanding that under
13 the policy a transgender girl who has had puberty
14 blockers, and so never went through puberty as a
15 boy, and had cross-sex hormones so she went
16 through puberty as a girl, and had breasts and
17 other anatomical characteristics that developed
18 during puberty, was it your understanding that
19 that student would have to use the boys restrooms
20 at Gloucester High School?
21 MR. CORRIGAN: Object to the form and
22 foundation.

1 THE WITNESS: I wouldn't say I ever
2 considered that scenario.
3 BY MR. BLOCK:
4 Q. So even though this was passed as a
5 policy, did you ever consider how it would apply
6 to anyone except Gavin?
7 MR. CORRIGAN: Object to the form,
8 foundation, legal conclusion.
9 THE WITNESS: Privately, yes.
10 BY MR. BLOCK:
11 Q. How so?
12 A. What do you mean?
13 Q. Well, you said privately you
14 considered how it would apply to someone besides
15 Gavin. So in what context?
16 A. How we would come to know that a
17 student was transgender, is this an enforceable
18 policy. Those two questions primarily.
19 Q. And what did you -- did you sort of
20 privately think it was an enforceable policy?
21 MR. CORRIGAN: Object to the form and
22 foundation.

1 THE WITNESS: I don't know that I drew a
2 conclusion.
3 BY MR. BLOCK:
4 Q. Did you have doubts?
5 A. I would say it would be difficult to
6 enforce, yes.
7 Q. And as a factual matter, to the best
8 of your knowledge, has the policy been applied to
9 anyone besides Gavin?
10 MR. CORRIGAN: Object to the form.
11 THE WITNESS: As of the time I left
12 Gloucester?
13 BY MR. BLOCK:
14 Q. Yes.
15 A. Not to my knowledge.
16 Q. Could the School Board have just
17 directed you to not let Gavin use the boys room
18 without creating a formal policy about it?
19 MR. CORRIGAN: Object to the form and
20 foundation.
21 THE WITNESS: I don't know if they can,
22 or could have.

1 foundation. Calls for speculation.
2 THE WITNESS: I don't know if I'm
3 qualified to answer that.
4 BY MR. BLOCK:
5 Q. Do you think it sends a message that
6 indicates they're not welcome?
7 MR. CORRIGAN: Object to the form,
8 foundation, legal conclusion.
9 THE WITNESS: I can't speak for other
10 students.
11 BY MR. BLOCK:
12 Q. Do you think it sent a message to
13 Gavin that Gavin wasn't welcome?
14 MR. CORRIGAN: Object to the form,
15 foundation, legal conclusion.
16 THE WITNESS: I believe he felt that,
17 yes.
18 BY MR. BLOCK:
19 Q. Do you think that was a reasonable
20 feeling?
21 MR. CORRIGAN: Object to the form,
22 foundation.

1 THE WITNESS: Reasonable in what way?
2 BY MR. BLOCK:
3 Q. Do you think Gavin was reasonable in
4 feeling that way?
5 MR. CORRIGAN: Object to the form,
6 foundation.
7 THE WITNESS: I can say I understood his
8 perception.
9 MR. BLOCK: I'll get this marked as
10 Exhibit 22.
11 (Collins Exhibit Number 22 was marked for
12 identification)
13 Q. This was produced as GCSB 4283, and
14 it appears to me to be the final transcript for
15 Gavin at Gloucester High School; is that right?
16 A. Final transcript? Yes.
17 Q. So is this the document that is sent
18 to colleges when a student applies?
19 A. It is required by the college for
20 admission, yes.
21 Q. And so under the top left box it says
22 student, and then it says, State ID, birth date,

1 CERTIFICATE OF SHORTHAND REPORTER-NOTARY PUBLIC
2 I,
3 LISA BLAIR, the officer before whom the foregoing
4 deposition was taken, do hereby certify that the
5 foregoing transcript is a true and correct record
6 of the testimony given; that said testimony was
7 taken by me stenographically and thereafter
8 reduced to typewriting under my direction; that
9 reading and signing was requested; and that I am
10 neither counsel for, related to, nor employed by
11 any of the parties to this case and have no
12 interest, financial or otherwise, in its outcome.
13 IN WITNESS WHEREOF, I have hereunto
14 set my hand and affixed my notarial seal this 22nd
15 day of September 2018.
16 My commission expires October 31, 2020.
17
18
19
20 
21 ____
22 Lisa Blair, RMR

1 IN THE UNITED STATES DISTRICT COURT
2 EASTERN DISTRICT OF VIRGINIA
3 CIVIL CASE NO. 4:15-CV-54
4 - x
5 GAVIN GRIMM :
6 Plaintiff :
7 v. :
8 GLOUCESTER COUNTY SCHOOL BOARD :
9 Defendant :
10 - x
11
12 Deposition of WALTER CLEMONS, PhD
13 Glen Allen
14 Friday, September 21, 2018
15 2:08 p.m.
16
17
18
19
20 Job No.: 207622
21 Pages 1 - 116
22 Reported by: Lisa M. Blair, RMR

1 Q. Was he a good principal?
2 A. I feel he was a good principal.
3 Q. You feel he had a successful tenure
4 at Gloucester High School?
5 A. Yes.
6 Q. And you could trust him to act in the
7 best interest of students?
8 MR. CORRIGAN: Object to form.
9 THE WITNESS: Yes.
10 BY MR. BLOCK:
11 Q. And you trusted him to be able to
12 handle day-to-day questions and concerns that
13 might come up at Gloucester High School?
14 MR. CORRIGAN: Object to the form. Go
15 ahead.
16 THE WITNESS: Yes.
17 BY MR. BLOCK:
18 Q. And you respect his judgment?
19 A. Yes.
20 Q. And the school did well under his
21 tenure, right?
22 A. Yes.

1 request?
2 A. I shared with him at that point in
3 time that that was, you know, an area that I was
4 unfamiliar with. So I would have to try to garner
5 some information to even have a discussion about
6 it.
7 Q. And what steps did you take to garner
8 that information?
9 A. From that point in time I contacted
10 the Virginia School Board Association and spoke
11 with Elizabeth Ewing.
12 Q. Is there any other source of
13 information you consulted?
14 A. Not at that point in time, no.
15 Q. Did you consult with material --
16 consult with any other professional organization
17 like organizations of school superintendents or
18 any other sort of professional resource?
19 A. No, I did not.
20 Q. And after -- did you consult at all
21 with either of the assistant superintendents?
22 A. No, I did not. Not at that point.

1 transgender students under all circumstances?
2 MR. CORRIGAN: Objection to the form and
3 foundation.
4 THE WITNESS: To my recollection, I was
5 allowing the principal to just have autonomy to
6 make decisions as, you know, he or she would on
7 any confidential student matter.
8 BY MR. BLOCK:
9 Q. And it would be determined on an
10 individualized basis; is that right?
11 A. That is correct.
12 Q. And did you tell Principal Collins
13 that you would support whatever decision he makes?
14 A. I support any principals on decisions
15 that they make after we've had discussion
16 regarding, you know, whatever the topics are.
17 They have autonomy to work and do what they see is
18 best, you know, based on their review of the
19 information and deciding what they feel is in the
20 best interest of moving students forward.
21 Q. Why is that? Why do you give
22 principals that autonomy?

1 the discussion about the preparation of the memo.
2 Q. Do you know why that memo was
3 prepared on that day?
4 A. I don't have a recollection at this
5 point in time.
6 MR. BLOCK: Let's mark this as Exhibit
7 4.
8 (Clemons Exhibit Number 4 was marked for
9 identification)
10 Q. I'm showing you a document produced
11 as GCSB 801, and it's an e-mail from a redacted
12 person. Do you recognize this document?
13 A. (Witness perusing document).
14 Yes.
15 Q. What is it?
16 A. It's an e-mail that came to School
17 Board members and myself from a concerned member
18 of the community.
19 Q. And do you -- at this time, had you
20 received any other e-mails directly?
21 A. Not to my recollection.
22 Q. Okay. And what was your reaction

1 School Board that was on the evening of Wednesday,
2 October 22nd.
3 Q. So near the bottom, the third line
4 from the bottom you write, "Finally, I will
5 forward you some literature on the transgender
6 issue that Elizabeth Ewing (VSBA) sent to me when
7 we had a discussion on this issue previously."
8 Is that the information that you
9 previously talked about in this deposition?
10 A. That's correct.
11 Q. And you say, "Furthermore, I will
12 have Mr. Collins present tomorrow evening so he
13 can fill you in on his actions thus far relating
14 to these issues."
15 Did you mean to say that he will
16 present or he will be present?
17 A. I can't recall at this point.
18 Q. Okay. I don't know how you write
19 that on the transcript.
20 Now, at the time you wrote this, had
21 any School Board members contacted you about the
22 issue?

1 attachment is?
2 A. From the title of it, it is a
3 document that speaks to looking at, you know,
4 accommodations for transgender students.
5 Q. And to the best of your recollection,
6 is this the information that the assistant --
7 former assistant county attorney passed on to
8 Ms. Hook, and that she was then forwarding to you
9 and the Board?
10 A. From the communication, that would
11 appear to be correct.
12 MR. BLOCK: Do you need a break?
13 MR. CORRIGAN: I think it's a good idea
14 to take a minute.
15 (Whereupon, a recess was taken).
16 BY MR. BLOCK:
17 Q. After the School Board passed its new
18 policy limiting students to -- transgender
19 students using the restroom based on their, quote,
20 biological gender, unquote, has any administrator
21 in the school system asked for guidance on how to
22 apply the policy?

1 A. Not to my -- not to my knowledge.
2 Q. To your knowledge is there any other
3 student in the school system who is transgender
4 and has -- we'll leave it at that. Is there any
5 other student in the school system who is
6 transgender?
7 A. At the present time, not that I'm
8 aware of.
9 Q. How about during your tenure there?
10 A. To my recollection, I think there
11 have been or there has been an incidence where one
12 student has declared or spoke about transgender
13 status.
14 Q. And do you know what restroom that
15 student uses?
16 A. I wouldn't have firsthand knowledge.
17 I do recall the student has graduated also.
18 Q. Now, what's your understanding of how
19 to determine what a student's biological gender
20 is?
21 A. Male/female.
22 Q. That's the term the policy uses. So

1 was that your answer?
2 A. Yes.
3 Q. Male or female. So what's your
4 understanding of how to determine whether a
5 student is male or female for purposes of the
6 biological gender policy?
7 MR. CORRIGAN: Object to form.
8 THE WITNESS: Genitalia.
9 BY MR. BLOCK:
10 Q. So does Gloucester County Public
11 Schools have a record of what each student's
12 genitals look like?
13 A. Not that I'm aware of.
14 Q. And is it your understanding that if
15 a student has had genital surgery, that that would
16 alter their biological gender?
17 MR. CORRIGAN: Object to the form and
18 foundation, legal conclusion.
19 THE WITNESS: I would speculate.
20 BY MR. BLOCK:
21 Q. So, then, do you want to change your
22 answer that you understand you would determine

1 biological gender by a student's genitalia?
2 MR. CORRIGAN: Object to the form and
3 foundation.
4 THE WITNESS: No. I mean, I meant male
5 or female organs when I said genitalia.
6 BY MR. BLOCK:
7 Q. Internal organs?
8 A. Well, just organs.
9 Q. Well, so what is your understanding
10 of the biological gender of someone who has
11 androgen insensitivity disorder where they don't
12 develop external genitals consistently with their
13 chromosomes and internal anatomy?
14 MR. CORRIGAN: Object to the form and
15 foundation, legal conclusion. Go ahead.
16 THE WITNESS: I really haven't given
17 that thought.
18 BY MR. BLOCK:
19 Q. To the best of your knowledge, has
20 anyone in the school district given that thought?
21 A. I would not have knowledge of that.
22 Q. Certainly no one has spoken to you

1 about it?
2 A. Not that I'm aware of.
3 Q. And if administrators did have a
4 question about the policy, you'd be the source
5 that they would ask, right?
6 MR. CORRIGAN: Object to the form,
7 foundation.
8 THE WITNESS: I could be a source.
9 BY MR. BLOCK:
10 Q. What other sources would someone ask?
11 MR. CORRIGAN: Object to the form,
12 foundation.
13 THE WITNESS: Possibly other
14 administrators.
15 BY MR. BLOCK:
16 Q. But you were the most -- you were at
17 the top of the pyramid for administrators, right?
18 A. As far as Gloucester County Public
19 Schools is concerned?
20 Q. Yes.
21 A. Yes, I would say yes.
22 Q. So is there any other person besides

1 you that an administrator within Gloucester County
2 Public Schools would ask for guidance on how to
3 apply the biological gender policy?
4 MR. CORRIGAN: Object to the form and
5 foundation. Legal conclusion.
6 THE WITNESS: I don't know the answer to
7 that question.
8 BY MR. BLOCK:
9 Q. Is it your understanding that if a
10 transgender girl, someone who is assigned a male
11 sex at birth, but has a female gender identity, is
12 it your understanding that if she has puberty
13 blockers so she never goes through puberty as a
14 boy, and has cross-sex hormones so that she goes
15 through puberty as a girl and develops breasts and
16 other features consistent with other girls who go
17 through puberty, that she would, under the
18 school's policy, have to use the boys restrooms?
19 MR. CORRIGAN: Object to the form and
20 foundation, legal conclusion.
21 THE WITNESS: I'd like you to repeat
22 that question.

1 BY MR. BLOCK:
2 Q. Yeah. So a transgender girl has had
3 puberty blockers, so never goes through puberty as
4 a boy, and has cross-sex hormones so that she
5 develops breasts and hips and fat disposition --
6 distribution consistent with other girls, that
7 that transgender girl with breasts should be using
8 the boys restroom?
9 MR. CORRIGAN: Object to the form and
10 foundation, legal conclusion.
11 THE WITNESS: I don't know the answer to
12 that question.
13 BY MR. BLOCK:
14 Q. Do you have any knowledge of what
15 sort of physiological effects hormone treatments
16 can have on transgender youth?
17 A. Not that I'm aware of, no.
18 Q. And to the best of your knowledge,
19 have you been in any discussions in which that
20 sort of information was provided to School Board
21 members?
22 MR. CORRIGAN: Object to the form,

1 foundation.
2 THE WITNESS: Not that I'm aware of.
3 BY MR. BLOCK:
4 Q. So during your deliberations or
5 during the School Board's deliberations around the
6 policy, did they ever consult with any medical
7 authorities?
8 MR. CORRIGAN: Object to the form.
9 THE WITNESS: Not to my recollection.
10 BY MR. BLOCK:
11 Q. If a student were to transfer to
12 Gloucester High School and that student had
13 previously transitioned at a different school
14 district and had a birth certificate reflecting a
15 gender that matched their gender identity, and
16 then post transition they transitioned to
17 Gloucester High School, what's your understanding
18 of what restroom that student should use?
19 MR. CORRIGAN: Object to the form and
20 foundation. Legal conclusion.
21 THE WITNESS: Can you repeat the
22 question again?

1 BY MR. BLOCK:
2 Q. Yeah, so if a student -- let's say a
3 student is a transgender girl from a different
4 school district who has transitioned from an early
5 age, gotten their birth certificate amended, and
6 transfers to Gloucester County Public Schools, and
7 the first time she enrolls she presents her birth
8 certificate that lists her as being female, what's
9 your understanding of which restroom she should
10 use under the biological gender policy?
11 MR. CORRIGAN: Same objections.
12 THE WITNESS: I don't know the answer to
13 that question.
14 BY MR. BLOCK:
15 Q. Why not?
16 MR. CORRIGAN: Same objections.
17 THE WITNESS: I just don't know.
18 BY MR. BLOCK:
19 Q. Have you ever had any discussions
20 about what the answer would be with anyone else at
21 the school?
22 A. Not that I can recall.

1 Q. -- existed?
2 MR. BLOCK: Did you get that?
3 THE REPORTER: Yes.
4 BY MR. BLOCK:
5 Q. So you're aware that Gavin has a
6 birth certificate now reflecting that his sex on
7 the birth certificate is male; is that right?
8 A. Yes.
9 Q. And how did you become aware of that?
10 A. That information was shared with me
11 by the building principal.
12 Q. By?
13 A. Mr. Collins.
14 Q. And why did he share that information
15 with you?
16 A. To keep me informed.
17 Q. And were you aware that Gavin
18 requested that his school records be updated to
19 reflect the gender marker on his birth
20 certificate?
21 A. I can't recall.
22 Q. Are you aware of any discussion or

1 deliberation with respect to whether Gavin's
2 school records should reflect the gender marker on
3 his birth certificate?
4 A. I don't remember.
5 Q. Do you know whether Gavin's school
6 records currently do reflect the gender marker on
7 his birth certificate?
8 A. I don't remember.
9 Q. Does Gloucester County Public Schools
10 have any policies for determining what gender
11 marker should be listed on a student's education
12 records?
13 MR. CORRIGAN: Object to the form and
14 legal conclusion. Go ahead.
15 THE WITNESS: Not that I can recall.
16 BY MR. BLOCK:
17 Q. Does Gloucester County Public Schools
18 keep records on whether the birth certificate on
19 file is the birth certificate issued at birth or
20 an amended one?
21 MR. CORRIGAN: Same objection.
22 THE WITNESS: I don't know the answer to

1 CERTIFICATE OF SHORTHAND REPORTER-NOTARY PUBLIC
2 I,
3 LISA BLAIR, the officer before whom the foregoing
4 deposition was taken, do hereby certify that the
5 foregoing transcript is a true and correct record
6 of the testimony given; that said testimony was
7 taken by me stenographically and thereafter
8 reduced to typewriting under my direction; that
9 reading and signing was requested; and that I am
10 neither counsel for, related to, nor employed by
11 any of the parties to this case and have no
12 interest, financial or otherwise, in its outcome.
13 IN WITNESS WHEREOF, I have hereunto
14 set my hand and affixed my notarial seal this 23rd
15 day of September 2018.
16 My commission expires October 31, 2020.
17
18
19
20
21 ____
22 Lisa Blair, RMR

1 IN THE UNITED STATES DISTRICT COURT
2 EASTERN DISTRICT OF VIRGINIA
3 CIVIL CASE NO. 4:15-CV-54
4 --------------------------------------X
5 GAVIN GRIMM :
6 Plaintiff :
7 v. :
8 GLOUCESTER COUNTY SCHOOL BOARD :
9 Defendant :
10 --------------------------------------X
11
12 Deposition of TIFFANY DURR
13 Glen Allen
14 Wednesday, October 10, 2018
15 9:36 a.m.
16
17
18 Job No.: 207625
19 Pages 1 - 58
20 Reported by: Lisa M. Blair, RMR
21
22

1 four years. I'm not sure exactly how many years
2 had passed when he became my direct supervisor.
3 Q. But he was your direct supervisor at
4 the time that Gavin Grimm was at --
5 A. Yes.
6 Q. -- Gloucester?
7 A. That is correct.
8 Q. Great. When did you first become
9 aware of Gavin Grimm?
10 A. I first became aware of Gavin Grimm
11 the summer prior to his sophomore year. He and
12 his mother came to the high school, and he
13 introduced himself to me.
14 Q. And did he or his mother contact you
15 in advance to set up a meeting?
16 A. No. They actually just happened to
17 come in and do a walk-in, and ask if they could
18 speak with his counselor for the upcoming school
19 year regarding some concerns they had.
20 Q. And you had already been assigned to
21 be his counselor for the upcoming school year?
22 A. Yes, by then I had.

1 Q. What did they say when they met with
2 you?
3 A. When they came in they shared that
4 Gavin had recently had a name change, a legal name
5 change, and they were wanting to -- they were
6 inquiring about the process to change his name on
7 the school documents.
8 Q. And did -- well, did they ask
9 anything else?
10 A. At that time, I don't recall. I
11 think that was the main purpose of their -- of
12 them visiting, and to also just I guess kind of
13 inquire about support and resources within the
14 school.
15 Q. Now, at the time that they came to
16 you for this meeting, had you had any experience
17 before working with transgender students?
18 A. Yes.
19 Q. What experience was that?
20 A. I had a few students in the past who,
21 you know, they identified not with their
22 birth-assigned gender, yes.

1 A. Well, I expressed, you know, that I
2 was a resource in the school that the student
3 could utilize, and the counseling office as a
4 whole, and that if there were any concerns, to
5 make sure to alert us.
6 Q. Did you -- had you received any
7 training on how to counsel transgender students?
8 A. No.
9 Q. Were you aware of any policies that
10 the school had with respect to transgender
11 students?
12 A. No.
13 Q. Did they express any concern about
14 whether Gavin would be addressed by male pronouns?
15 A. Yes.
16 Q. What did they say?
17 A. Well, Gavin stated that he, in
18 addition to wanting everybody to identify him by
19 his new name -- or the name change, that he also,
20 of course, wanted to be identified by male
21 pronouns.
22 Q. And what did you say in response to

1 that?
2 A. I acknowledged everything he said and
3 agreed, and told him I would, you know, honor his
4 wishes.
5 Q. So after you had this meeting with
6 Gavin -- actually, before we go to that, did Gavin
7 or his mother talk at all about his use of
8 restrooms during this first meeting?
9 A. I do not recall.
10 Q. And do you know whether he or his mom
11 talked about his enrollment in physical education
12 class during this first meeting?
13 A. Actually, I don't remember anything
14 regarding physical education, but I do remember
15 that we did speak about using the restroom, and we
16 came up with a plan for him to use the restroom,
17 the nurse's restroom in the nurse's office. And
18 then also the majority of his classes were down in
19 a hall called D-hall. And so, there is a
20 teacher's lounge there that had individual stalls,
21 and we said because most of the majority of his
22 classes were in that hall, or that section of the

1 school, that he was welcome to use restrooms in
2 that -- in the teacher's lounge.
3 Q. So who proposed that solution?
4 A. I do not remember.
5 Q. Did Gavin indicate what his
6 preference was?
7 A. At the time I believe he was -- you
8 know, he was fine. He never really stated a
9 preference, but I think he was okay with that
10 plan.
11 Q. So did Gavin say to you during that
12 conversation anything to indicate that he would
13 have been uncomfortable using the boys restroom?
14 A. Not during that conversation.
15 Q. During a later conversation did he
16 say anything to indicate he would be uncomfortable
17 using the boys restroom?
18 A. Using the boys restroom?
19 Q. Yeah.
20 A. Oh, no.
21 Q. So would it be -- I'm going to give
22 you two characterizations, and you tell me which

1 Q. Of course.
2 So when is the next time you spoke
3 with Gavin Grimm after your meeting with him in
4 August?
5 A. I don't recall.
6 Q. Okay. Did there come a point in time
7 when Gavin or his mother asked you about whether
8 he could start using the boys restrooms?
9 A. Yes, later, not in August, but it was
10 later. He came in and met with me. When he came
11 in, in August he had also informed us that he was
12 getting ready to start hormone therapy. And so he
13 came in and he, you know, shared with me that he
14 was going to start hormone therapy at some point
15 soon, and wanted to know, when he began his
16 therapy, if he could start using the male
17 restrooms.
18 Q. Now, did you have any other
19 interactions with him between your first meeting
20 with him in August and this meeting?
21 A. I can't recall specifics. I believe
22 so, but I can't recall anything specific.

1 Q. And did you speak at all during that
2 meeting?
3 A. Yes. Mr. Collins and I both, you
4 know, explained to Gavin what had been decided and
5 the reason for the meeting, which was to find out
6 his needs and to come up with a safety plan, yes.
7 Q. And did you think that allowing Gavin
8 to use the boys restrooms was the right decision?
9 MR. CORRIGAN: Object to the form,
10 foundation. Go ahead.
11 THE WITNESS: Yes.
12 BY MR. BLOCK:
13 Q. Why did you think that?
14 MR. CORRIGAN: Object to the form,
15 foundation.
16 THE WITNESS: Well, I felt like this is
17 how the student was identifying. And, you
18 know, in order for him to feel comfortable at
19 school, I felt like, you know, there needed to
20 be some consideration into what would make him
21 feel comfortable.
22 BY MR. BLOCK:

1 school counselor to advocate for their needs.
2 Q. And so in your capacity as the
3 student's counselor, did you disagree with the
4 School Board's decision to enact the new policy?
5 MR. CORRIGAN: Object to form.
6 THE WITNESS: Again, I chose to assist
7 my student based on the student's needs, and
8 not my personal views.
9 BY MR. BLOCK:
10 Q. And your understanding of the
11 student's needs was that using the boys restroom
12 was in his best interest; is that right?
13 MR. CORRIGAN: Object to form. Go
14 ahead.
15 THE WITNESS: Yes.
16 BY MR. BLOCK:
17 Q. Did you speak with Gavin at all about
18 his use of the restrooms after the School Board
19 enacted its policy?
20 A. I'm sorry, can you repeat that?
21 Q. After the School Board passed its new
22 policy, did you have further discussions with

1 CERTIFICATE OF SHORTHAND REPORTER-NOTARY PUBLIC
2 I,
3 LISA BLAIR, the officer before whom the foregoing
4 deposition was taken, do hereby certify that the
5 foregoing transcript is a true and correct record
6 of the testimony given; that said testimony was
7 taken by me stenographically and thereafter
8 reduced to typewriting under my direction; that
9 reading and signing was requested; and that I am
10 neither counsel for, related to, nor employed by
11 any of the parties to this case and have no
12 interest, financial or otherwise, in its outcome.
13 IN WITNESS WHEREOF, I have hereunto
14 set my hand and affixed my notarial seal this 16th
15 day of October 2018.
16 My commission expires October 31, 2020.
17
18
19
20
21 ___________________________________
22 Lisa Blair, RMR

1 IN THE UNITED STATES DISTRICT COURT
2 EASTERN DISTRICT OF VIRGINIA
3 CIVIL CASE NO. 4:15-CV-54
4 ---------------------------------------X
5 GAVIN GRIMM :
6 Plaintiff :
7 v. :
8 GLOUCESTER COUNTY SCHOOL BOARD :
9 Defendant :
10 ---------------------------------------X
11
12 Deposition of MATTHEW R. LORD
13 Glen Allen
14 Wednesday, October 10, 2018
15 11:14 a.m.
16
17
18 Job No.: 207625
19 Pages 1 - 64
20 Reported by: Lisa M. Blair, RMR
21
22

1 time doing that, because my role in that was
2 more as an administrator. Ms. Durr was his
3 counselor. And so I perceived myself as more
4 being as the director kind of working with
5 these two people to help them navigate through
6 the situation that was going on.
7 BY MR. BLOCK:
8 Q. So was there ever a time when you
9 were asked for your opinion about whether being
10 allowed to use the boys restroom was in the best
11 interest of Gavin?
12 A. By whom?
13 Q. Well, let's start with by anyone in
14 the administration.
15 A. If Mr. Collins had asked, I would
16 have said yes. You know, in all the conversations
17 that went on during that period, I am sure that
18 that came up. And if it had, I would have said
19 yes.
20 Q. And were you ever asked for your
21 opinion about whether it was in Gavin's best
22 interest by anyone from the School Board ever?

1 that the bathroom policy in particular was having
2 on him?
3 A. I don't think so, no.
4 Q. Do you know why Gavin, during his
5 senior year, wasn't taking as many classes through
6 distance learning?
7 A. He didn't take any in his 12th grade
8 year, because he and his mother, from what I
9 remember, decided that he was coming back to
10 school, to the high school full time to finish.
11 In fact, I believe at the end of his 11th grade
12 year they were back at the high school anyway.
13 That program had been moved back to the high
14 school. And so, he -- this is from what I
15 remember -- felt that he could go back into
16 classes and finish his school year that way.
17 Q. If you look at the top left corner of
18 the transcript, under gender it says female; is
19 that right?
20 A. That's what it says.
21 Q. Now, are you aware of Gavin's efforts
22 to have the school change his gender marker on his

1 student records?
2 A. Yes.
3 Q. How are you -- what do you know about
4 that?
5 A. I know that at one point Gavin had
6 asked about it, was told that he would need a
7 legal document, asked for it repeatedly, never
8 producing one, did then produce one and turned it
9 in to me, and I then gave it to Mr. Collins.
10 Q. So the legal document that he gave
11 you, was that -- what was that legal document?
12 A. I believe it was a birth certificate.
13 Q. And when you said he was asked before
14 about it and was told he needed a legal document,
15 who is the person that told him he would need a
16 legal document?
17 A. From what I remember, I had asked
18 Mr. Collins, and probably Mr. Collins, but
19 definitely I said it, because a lot of that
20 information comes through the counseling office.
21 That's where the registrar is, who is the records
22 person.

1 Q. So when Gavin gave you the legal
2 document and then you gave it to Mr. Collins, what
3 did Mr. Collins say?
4 A. He said he would have to call the
5 School Board office, and for us to not change
6 anything until we heard back.
7 Q. And were you surprised that that was
8 his response?
9 A. No.
10 Q. Why not?
11 A. Because it was a legal issue that the
12 School Board was fighting within the court system.
13 And so it wouldn't surprise me for people to say
14 stop, don't do anything.
15 Q. And what's the -- was there any
16 discussion within Gloucester High School, the
17 administration of Gloucester High School about
18 whether his gender marker should be updated?
19 MR. CORRIGAN: Objection to the form,
20 foundation, legal conclusion, expert opinion.
21 Go ahead.
22 THE WITNESS: There was discussion about

1 A. Not that I know of.
2 Q. So when -- did there come a point in
3 time in which Mr. Collins told you what the
4 decision would be with respect to whether Gavin's
5 gender marker would be changed on his transcript?
6 A. Yeah, there was a point somewhere in
7 that process where we were told not to change it.
8 Q. And were you given a reason why?
9 A. That the director from the School
10 Board office was to not change it.
11 Q. But no reason why was given?
12 A. No. I mean, just don't change it.
13 Q. Are there any other school documents
14 in which the student's gender is listed?
15 A. Everything is electronic. So
16 anything that would -- that would have that, you
17 know, box, would. I don't know what those all
18 are, but there's only one gender box in a
19 student's academic record online. And so, any
20 place that would ask for that, it would say that.
21 Q. Where does a student's transcript get
22 sent by the school?

1 CERTIFICATE OF SHORTHAND REPORTER-NOTARY PUBLIC
2 I,
3 LISA BLAIR, the officer before whom the foregoing
4 deposition was taken, do hereby certify that the
5 foregoing transcript is a true and correct record
6 of the testimony given; that said testimony was
7 taken by me stenographically and thereafter
8 reduced to typewriting under my direction; that
9 reading and signing was requested; and that I am
10 neither counsel for, related to, nor employed by
11 any of the parties to this case and have no
12 interest, financial or otherwise, in its outcome.
13 IN WITNESS WHEREOF, I have hereunto
14 set my hand and affixed my notarial seal this 17th
15 day of October 2018.
16 My commission expires October 31, 2020.
17
18
19
20

21 ________________________________
22 Lisa Blair, RMR

1 IN THE UNITED STATES DISTRICT COURT
2 EASTERN DISTRICT OF VIRGINIA
3 Newport News Division
4
5 - - - - - - - - - - - - x
6 GAVIN GRIMM, :
7 Plaintiff, :
8 v. : Civil Action No.
9 GLOUCESTER COUNTY : 4:15-cv-00054-AWA-DEM
10 SCHOOL BOARD, :
11 Defendant. :
12 - - - - - - - - - - - - x
13
14 Deposition of TROY ANDERSEN
15 Glen Allen, Virginia
16 Tuesday, March 12, 2019
17 10:00 a.m.
18
19
20 Job No.: 232148
21 Pages: 1 - 98
22 Reported By: Scott D. Gregg, RPR

1 Deposition of TROY ANDERSEN, held at the
2 offices of:
3
4
5 Harman Claytor Corrigan & Wellman, PC
6 4951 Lake Brook Drive, Suite 100
7 Glen Allen, Virginia 23060
8 (804) 747-5200
9
10
11
12
13 Pursuant to notice, before Scott D. Gregg, RPR,
14 Notary Public in and for the City of Norfolk.
15
16
17
18
19
20
21
22

1 A P P E A R A N C E S
2 ON BEHALF OF PLAINTIFF:
3 (Appearing via telephone)
4 JOSHUA A. BLOCK, ESQUIRE
5 LESLIE COOPER, ESQUIRE
6 SHAYNA MEDLEY-WARSOFF, ESQUIRE
7 AMERICAN CIVIL LIBERTIES UNION FOUNDATION
8 125 Broad Street, 18th Floor
9 New York, New York 10004
10 (212) 549-2627
11 and
12 FOUNDATION OF VIRGINIA
13 JENNIFER SAFSTROM, ESQUIRE
14 701 East Franklin Street, Suite 1412
15 Richmond, Virginia 23219
16 (804) 644-8022
17 ON BEHALF OF DEFENDANT
18 DAVID P. CORRIGAN, ESQUIRE
19 HARMON, CLAYTOR, CORRIGAN & WELLMAN, PC
20 4951 Lake Brook Drive, Suite 100
21 Glen Allen, Virginia 23060
22 (804) 762-8017

1 C O N T E N T S

2 EXAMINATION OF TROY ANDERSEN PAGE
3 By Mr. Block 5
4
5

6 E X H I B I T S

7 ANDERSEN DEPOSITION EXHIBIT PAGE
8 Exhibit A Supplemental Answers to 12
9 Interrogatory Number One
10 Exhibit B Answer to Second Amended 67
11 Complaint
12 Exhibit C Code of Virginia 32.1-269 81
13 Exhibit D 12 VAC 5-50-320 Document 81
14 Exhibit E Birth Certificate 82
15 Exhibit F 12 VAC 5-550-460 Document 87
16 Exhibit G School Board's Rule 26(a)(2) 92
17 Disclosure
18
19
20
21
22

1 P R O C E E D I N G S
2 TROY ANDERSEN, called as a witness, having
3 been first duly sworn, was examined and testified
4 as follows:
5 EXAMINATION
6 BY MR. BLOCK:
7 Q Good morning, Mr. Andersen. How are you?
8 A I'm good. How about yourself?
9 Q I'm good. My name is Joshua Block. I'm
10 an attorney for the plaintiff, Gavin Grimm, and
11 I'll be taking your deposition today.
12 Have you ever had your deposition taken
13 before?
14 A I have not.
15 Q Excellent. So this is -- since it's your
16 first time, I'll just go over some ground rules.
17 The first is that, as you know, the court
18 reporter is writing down everything that we're
19 saying, so it's important that all of your
20 responses be verbal, so full words, no nodding
21 your head, no saying uh-huh.
22 So can we agree that you'll try to have

1 all your responses be verbal?
2 A Yes, sounds good.
3 Q Terrific.
4 The second is that the court reporter
5 needs to write down what we're saying, one person
6 at a time, so it's important that we don't have
7 cross-talk. So to make that run more smoothly,
8 please wait until I finish asking the question
9 before you answer, and I will wait until you're
10 finished answering before I ask the next question.
11 Does that sound fair?
12 A Indeed, yes.
13 Q Great.
14 And the third is that it's my job to ask
15 questions that you understand and can answer. So
16 if there's anything unclear about my question,
17 please let me know and I will try to clarify it.
18 But if I ask a question and you answer it,
19 I'm going to take that to mean that you understood
20 the question, okay?
21 A Sounds fair.
22 Q Great.

1 Now, you are appearing today as the
2 30(b)(6) witness on behalf of Gloucester County
3 School Board; is that right?
4 A Yes, sir.
5 Q Great. And so did you do any preparation
6 in advance of this deposition to inform your
7 testimony as a 30(b)(6) witness?
8 A I did.
9 Q What -- did you review any documents to
10 prepare for this deposition?
11 MR. CORRIGAN: Josh, this is David. I'm
12 not sure where the line is on this, but when he
13 sits down with his lawyer and reviews documents, I
14 think all that is attorney-client privileged. But
15 the answer to the question, of course he reviewed
16 documents and he's prepared. But in terms of what
17 he reviewed -- but I don't want to answer for the
18 witness or impede the deposition.
19 MR. BLOCK: Yeah. My question is
20 basically what is the source of his knowledge as a
21 30(b)(6) witness.
22 BY MR. BLOCK:

1 Q So I'm not looking for information about
2 what your attorney specifically, you know,
3 provided you or prepared you for, but I want to
4 know when you're providing testimony as a 30(b)(6)
5 witness, did you -- what sources of information
6 did you consult?
7 MR. BLOCK: Is that a fair question,
8 David?
9 MR. CORRIGAN: To the extent you're not
10 asking for privileged information, it's a fair
11 question, yeah, so I'll let him answer the things
12 that are nonprivileged that he consulted.
13 THE WITNESS: Sure. So it was mainly just
14 a review of records previously submitted, and
15 those related to the Grimm case. And I reached
16 back into my files and made sure I was familiar
17 with our internal policies that form the crux of
18 a lot of discussion based on the information that
19 you seem interested in, and that probably would be
20 the bulk of it.
21 BY MR. BLOCK:
22 Q Great.

1 So were there any documents you've
2 reviewed that -- nonprivileged documents you've
3 reviewed that have not yet been produced in this
4 case?
5 A Not to my knowledge.
6 Q Okay. And did you speak with anyone else
7 besides your attorneys to prepare yourself for
8 this deposition?
9 A Yes, our superintendent, Dr. Walter
10 Clemons; our director of student services, Bryan
11 Hartley; those would be the two.
12 Q So you're a member of the Gloucester
13 County School Board; is that right?
14 A That's correct.
15 Q When did you first become a member of the
16 Gloucester County School Board?
17 A I think I was appointed in 2012 to begin a
18 term in 2013.
19 Q Did you have any other position at
20 Gloucester County Public Schools before becoming a
21 school board member?
22 A A student, kindergarten through 12th grade

1 there, that was it.
2 Q What year did you graduate?
3 A 1995.
4 Q And do you have any volunteer roles with
5 the schools at all before becoming a school board
6 member?
7 A No, sir.
8 Q And you've been a school board member
9 continuously since you were first elected?
10 A Correct.
11 Q When does your term expire?
12 A December 31st of this year, 2019.
13 Q Are you running for reelection?
14 A I have not decided yet.
15 Q All right. So during this deposition, I'm
16 going to use the phrase the "restroom policy" or
17 "the policy," and I want to make sure that, you
18 know, if I use that shorthand, that we're talking
19 about the same thing.
20 So when I refer to the phrase "the
21 restroom policy" or "the policy," I am referring
22 to the policy that was adopted by the Gloucester

1 County School Board on December 9th, 2014.
2 Are you familiar with that policy?
3 A I am, yes, sir.
4 Q And so can we agree that if I use the
5 phrase "the restroom policy" or "the policy" that
6 you understood that is the particular policy I'm
7 referring to; is that fair?
8 A Sounds good.
9 Q Great.
10 First thing I'd like to show you is --
11 MR. BLOCK: Jennifer, can you hand...
12 MS. SAFSTROM: Second amended complaint?
13 MR. BLOCK: No. The supplemental answer
14 to interrogatory number one.
15 MS. SAFSTROM: Supplemental answers to
16 interrogatory number one.
17 BY MR. BLOCK:
18 Q Have you seen this document before?
19 A I have, yes, sir.
20 Q What is it?
21 A This is the response back to the first
22 interrogatory. This looks like -- yep, the

1 supplemental one, so this is where it sounds like
2 you-all came back with some additional questions
3 to which our counsel provided some additional
4 answers.
5 Q And you have reviewed this document
6 previously?
7 A I have.
8 MR. BLOCK: So I'd like to mark this as
9 Exhibit A to the deposition.
10 (Exhibit A was marked for identification.)
11 BY MR. BLOCK:
12 Q All right. So if you turn to page two --
13 A Okay.
14 Q -- the paragraph that begins with the
15 number one, I'd like you to just follow along as I
16 read it.
17 It says, identify all complaints received
18 by Gloucester County School Board, quote, the
19 Board, or its employees related to transgender
20 students' use of the restrooms during 2014 to 2015
21 school year, and for each complaint identify the
22 date of the complaint, the recipient of the

1 complaint, the content of the complaint, how the
2 complaint was communicated or transmitted, whether
3 the complainant was from the Gloucester High
4 School student or parent of a Gloucester High
5 School student, and whether the complaint related
6 to any incident in which a student reported being
7 in the restroom at the same time as plaintiff.
8 Did I read that correctly?
9 A You did.
10 Q So I want to focus on the very end of that
11 paragraph, whether the complaint related to any
12 incident in which a student reported being in the
13 restroom at the same time as plaintiff.
14 Now, in reviewing the answers to the
15 interrogatories, I didn't see any reference
16 specifically to whether any of the complaints
17 related to any incident in which a student
18 reported being in the restroom at the same time as
19 the plaintiff.
20 So I'd like to know whether there were any
21 complaints in which the complaint related to an
22 incident in which a student reported being in the

1 restroom at the same time as plaintiff.
2 A No. My recollection is that there were no
3 complaints that stemmed from a particular student
4 being in the restroom at the same time as the
5 plaintiff.
6 Q Thank you. Now, I have a couple of
7 questions about the policy.
8 How does the school determine what a
9 student's biological gender is for purposes of the
10 policy?
11 A So we don't have any sort of process or
12 procedure for that. We rely and continue to rely
13 on social norms and binary sexes and people using
14 the restroom that corresponds with their
15 physiological sex.
16 Q Could you explain that, how those three
17 things interrelate? You identified social norms,
18 binary sexes, and people using the restroom
19 associated with their physiological sex.
20 Is there ever any conflict between, for
21 example, what the social norms are and what the
22 Board thinks someone's physiological sex is?

1 MR. CORRIGAN: Object to the form of the
2 question.
3 Go ahead. That will happen occasionally,
4 I'll object to the form of a question, but just go
5 ahead and answer.
6 THE WITNESS: Okay. Are you talking about
7 outside of this case? Because this would be the
8 only example I can think of where those three
9 things are at odds or in conflict.
10 BY MR. BLOCK:
11 Q I'm only talking for purposes of the
12 Board's policy.
13 MR. CORRIGAN: Same objection.
14 Go ahead.
15 THE WITNESS: Can you ask the question one
16 more time?
17 BY MR. BLOCK:
18 Q Sure. So I asked, how does the school
19 determine what a student's biological gender is
20 under the policy?
21 And you in your response said social norms
22 and you also said people using the restroom

1 associated with their physiological sex.
2 And so my question is whether there's ever
3 any conflict between those two things under the
4 Board's policy?
5 A With the exception of this particular
6 case, no, there's no conflict that I'm aware of.
7 Q And so can you explain how there's a
8 conflict in this particular case?
9 A In this case, we have a transgender
10 student -- or had a transgender student at
11 Gloucester County Public Schools who wished to use
12 the bathroom of the gender they identified with
13 instead of the gender corresponding to their
14 physiological sex.
15 Q So these conflicts between social norms
16 and what you describe as someone's physiological
17 sex only occurred in the context of transgender
18 students?
19 A I only have a sample size of one, but
20 that's the only time I've been involved with any
21 sort of conflict.
22 Q How does the Board determine what a

1 student's physiological sex is under the policy?
2 A I would say that's tied back to just their
3 student records. So the when you sign up for
4 schools in Gloucester County Public Schools, you
5 have to provide a birth certificate and what's on
6 that birth certificate about the marking on your
7 student records. Anything other than that,
8 there's no policy or procedure.
9 Q So for purposes of the policy, a student's
10 physiological sex is whatever the gender marker
11 was on their birth certificate at the time they
12 enrolled in the school?
13 A Yes, sir.
14 Q So if a student, let's say, moved to the
15 school from a different state and that state
16 allowed people to change the gender markers on
17 their birth certificates without having any
18 medical procedure, so at the time that the student
19 moved to Gloucester County, they had already had
20 an amended birth certificate from another state
21 that listed their sex as being the one consistent
22 with their identity instead of their sex assigned

1 at birth, Gloucester County Public Schools would
2 follow the sex listed on their birth certificate
3 as their biological gender for purposes of the
4 policy?
5 MR. CORRIGAN: I would object to form,
6 foundation, and calls for a legal conclusion.
7 He can answer.
8 THE WITNESS: Yes, that birth certificate
9 provided to the schools, that marking would serve
10 as our baseline for our student records. We don't
11 do any sort of background checks or anything like
12 that to figure out how they got to that, but
13 whatever is on that birth certificate would serve
14 as the baseline.
15 BY MR. BLOCK:
16 Q And they would be able to use whichever
17 restroom matches the gender marker on their birth
18 certificate at the time of registration?
19 A Correct.
20 Q All right. So let's -- I'm going to pose
21 a question, understanding this is a hypothetical,
22 so imagine two identical twins are put up for

1 adoption to different families; both twins are
2 assigned male sex at birth but both are
3 transgender and identify as women as they begin to
4 be able to articulate what their gender is; one of
5 the students is raised in California and one of
6 the students is raised in Gloucester County; the
7 one that's in California is able to amend her
8 birth certificate so that she is a female gender
9 marker on her birth certificate; she then moves to
10 Gloucester County where her identical twin has
11 lived; so at the time that she lined up to enroll
12 in Gloucester County Schools, everything about her
13 body is identical to her identical twin's body;
14 but unlike her identical twin, she has a female
15 gender marker on her birth certificate.
16 Under that hypothetical, the transgender
17 girl who moved from California, her biological
18 gender for purposes of the school policy is
19 female; is that right?
20 MR. CORRIGAN: Object to the form of the
21 question, object to foundation, object to calls
22 for speculation, legal conclusion, incomplete

1 hypothetical.
2 Go ahead.
3 THE WITNESS: If I understood all the
4 words you said, yes, provided that that was the
5 marker on the birth certificate, that would be
6 their associated gender in our student records.
7 BY MR. BLOCK:
8 Q So -- and she would be able to use the
9 girls restroom; is that right?
10 A Correct.
11 Q So even though she and her twin have
12 identical physiology, her -- she would have a
13 different biological gender than her twin for
14 purposes of the policy?
15 MR. CORRIGAN: Same objections as
16 previously stated.
17 Go ahead.
18 THE WITNESS: Yes.
19 BY MR. BLOCK:
20 Q So a student's biological gender for
21 purposes of using the restroom is based on what
22 the birth certificate said at the time of

1 registration, not based on any assessment of the
2 student's current physiology; is that right?
3 MR. CORRIGAN: Object to form -- go
4 ahead -- and the other bases as well.
5 THE WITNESS: Can you restate that one
6 more time, please?
7 BY MR. BLOCK:
8 Q Yeah. So a student's biological gender
9 for purposes of the school's policy is determined
10 by what is on the student's birth certificate at
11 the time of registration and not based on any
12 assessment of the student's current physiology; is
13 that right?
14 A Correct.
15 Q And Gloucester County Public Schools
16 doesn't keep track of what chromosomes each
17 student has; is that right?
18 A Correct, we don't.
19 Q And Gloucester County Public Schools
20 doesn't keep track of what each student's genitals
21 look like; is that correct?
22 A That's correct, certainly don't.

1 Q So what are the government -- what are the
2 governmental interests served by the Board's
3 restroom policy?
4 A So that would be entirely focused on the
5 privacy of all students in Gloucester County
6 Public Schools system.
7 Q So privacy is the only governmental
8 interest the Board is relying on; is that correct?
9 A That's what our policy is focused on,
10 privacy of all students in the Gloucester County
11 Public Schools system.
12 Q And is there any other governmental
13 interest that the policy advances?
14 A No.
15 Q Does the policy -- is the policy designed
16 to serve a governmental interest in student
17 safety?
18 A I would say there's a secondary --
19 potentially secondary depending on how you look at
20 it. That's more of a subjective thing that each
21 individual board member may feel differently
22 about. But from a policy perspective, it was

1 focused on privacy.
2 Q And does the policy serve a governmental
3 interest in listening to the views of
4 constituents? Is that a governmental interest
5 that the policy serves?
6 MR. CORRIGAN: Object to the form and
7 foundation.
8 THE WITNESS: Answer still?
9 MR. CORRIGAN: If you can.
10 THE WITNESS: I would say it's not an
11 interest, but it's a -- say the question one more
12 time. I'm not sure I heard it.
13 BY MR. BLOCK:
14 Q Sure. Is listening to the views of
15 constituents a governmental interest that the
16 policy is designed to serve?
17 MR. CORRIGAN: Object to form, foundation,
18 legal conclusion.
19 Go ahead.
20 THE WITNESS: I wouldn't use the term
21 "interest," but I would say that it's part of the
22 process of how policy is created and adopted.

1 BY MR. BLOCK:
2 Q Can you explain how it's part of the
3 process the policies are adopted?
4 A Sure. So whenever we have -- as a school
5 system, whenever we have policies, we rely and
6 solicit input from the citizens of Gloucester as
7 we've done in the cases of this and others.
8 Q And are the Board's policies always in
9 line with the views of a majority of the
10 constituents?
11 MR. CORRIGAN: Object to the form,
12 foundation, and speculation.
13 Go ahead.
14 THE WITNESS: I could never say with any
15 mathematical certainty whether it's the majority
16 or not, but there's been plenty of policies that
17 are very unpopular and don't fall in line with
18 what most speakers reflect at any sort of public
19 hearing or school board meeting.
20 BY MR. BLOCK:
21 Q What are some examples?
22 A Our recently passed cell phone policy and

1 our updated attendance policy.
2 Q What is your updated attendance policy?
3 A I mean, that's a long -- I would have to
4 get out my policy manual, but this changed the
5 number of days a person can be absent before they
6 are not able to pass the class regardless of what
7 their grade is.
8 Q So let's talk about the governmental
9 interest in protecting student privacy.
10 So what are they being protected from? Is
11 it from being seen naked?
12 MR. CORRIGAN: Object to form.
13 Go ahead.
14 THE WITNESS: It's -- in short, it's to
15 ensure their privacy of not having to share a
16 restroom with someone from an opposite
17 physiological sex.
18 BY MR. BLOCK:
19 Q So it doesn't matter whether or not
20 there's any risk of anyone being in a state of
21 undress; is that right?
22 MR. CORRIGAN: Object to form.

1 THE WITNESS: I would say that's a part of
2 it.
3 BY MR. BLOCK:
4 Q Okay. So in terms of protecting their
5 privacy, is it privacy from being seen naked? Is
6 that one of the things the policy is supposed to
7 protect?
8 A Correct.
9 Q And is it privacy from seeing someone else
10 naked? Is that something else that the policy is
11 supposed to protect?
12 A Correct, maintain privacy of all involved.
13 Q Okay. So if everyone is fully clothed at
14 all times and there's no risk of anyone being
15 naked, are there any other privacy interests that
16 the policy is designed to protect?
17 MR. CORRIGAN: Object to form, foundation,
18 legal conclusion.
19 Go ahead.
20 THE WITNESS: No. What I described and
21 what we described together was the primary focus
22 of the privacy.

1 BY MR. BLOCK:
2 Q So it's exclusively privacy interest
3 related to either being seen naked or seeing
4 someone else naked?
5 A Correct.
6 Q So if there's no state of undress
7 involved, then there's no privacy interest for the
8 policy to serve; is that right?
9 MR. CORRIGAN: Object to form.
10 THE WITNESS: If that were to be true,
11 yes, but I don't -- using the restroom while
12 not -- I guess depends on how you define the word
13 "undress." There's partial undress when you use a
14 restroom.
15 BY MR. BLOCK:
16 Q So is simply being in the same restroom
17 with someone of a different biological gender an
18 invasion of someone's privacy?
19 A It could be viewed that way. And, again,
20 I say it, the policy is protecting the privacy of
21 all students.
22 Q So the privacy that the policy is designed

1 to protect, is that a privacy from being in the
2 same restroom as someone with a different
3 biological gender?
4 A Yes, it's from having to share a restroom
5 with someone from the opposite physiological sex.
6 Q So when you said that in the restrooms
7 there's a state of partial undress, are you
8 talking about in front of a urinal or in front of
9 a toilet? Is that the partial state of undress
10 you're referring to?
11 A Correct, both.
12 Q Is there any other partial state of
13 undress that you're referring to?
14 A I would say I tuck my shirt in a weird way
15 when I was a kid, so outside of the stall I was in
16 a state of partial undress, so that would be
17 another one that popped into my head.
18 Q You would -- you would open your pants in
19 order to tuck in your shirt and then button up
20 your pants?
21 A You got it.
22 Q Is that what you're --

1 A Yes, sir.
2 Q Okay. So in terms of did you always do
3 that in the restroom or did you ever do it, you
4 know, in other places that were more public?
5 A No. It was always in a restroom.
6 Q So if we're focused on the privacy of
7 someone when they are on the toilet or in front of
8 a urinal, what additional protection does the
9 biological gender policy provide when there are
10 already dividers between the urinal stalls and
11 locked stall doors in front of the toilets?
12 A So at the time the policy was passed, I
13 don't believe the majority of the urinals had
14 dividers between them. That was some improvements
15 that we made for the privacy of all students in
16 conjunction which the three single-stall
17 restrooms.
18 Q So now that those additional privacy
19 improvements have been installed, does the policy
20 continue to serve an interest to protecting
21 student privacy related to nudity?
22 A I believe, yes.

1 Q How so?
2 A By affording them -- choose my words.
3 It continues to maintain privacy by
4 ensuring that a student does not have to share a
5 restroom with a person of the opposite
6 physiological sex.
7 Q But how does it serve an interest in
8 privacy related to nudity or being in a state of
9 undress?
10 A By accounting for any situations other
11 than the limited three that we've discussed, which
12 would be standing at a urinal, sitting on a
13 toilet, or tucking their shirt in away from a
14 stall.
15 So I'm sure there's others that we haven't
16 discussed, so it continues to remain the privacy
17 on that front.
18 Q Well, what others?
19 A I can't think of any other off the top of
20 my head.
21 Q So in terms of who -- who they are being
22 protected from, you said that the policy provides

1 privacy from being in a restroom with a member of
2 the opposite physiological sex; is that right?
3 A Correct.
4 Q So why does that pose a greater invasion
5 of privacy than being in the room with someone of
6 the same physiological sex, to use your term?
7 A I would say that it just goes back to us
8 relying on the social norms of binary sexes and
9 people using the restroom associated with the
10 physiological sex.
11 Q So the policy doesn't provide any
12 additional privacy protection for someone that
13 doesn't want to be seen in a state of undress
14 around members of the same sex; is that right?
15 MR. CORRIGAN: Object to form.
16 Go ahead.
17 THE WITNESS: I would agree to that.
18 BY MR. BLOCK:
19 Q So if -- let me start over.
20 So if a transgender person has the birth
21 certificate at the time of registration that is
22 consistent with their gender identity and not with

1 their sex assigned at birth, does it invade
2 another student's privacy to have to share the
3 restroom with that student consistent with the
4 student's gender marker on their birth
5 certificate?
6 MR. CORRIGAN: Object to form, foundation,
7 hypothetical.
8 Go ahead.
9 THE WITNESS: Can you say that one more
10 time, please?
11 BY MR. BLOCK:
12 Q Sure. So is it an invasion of someone's
13 privacy to be sharing the same restroom with
14 someone who had a different sex assigned to them
15 at birth if that person has had gender marker
16 changed on their birth certificate before
17 enrolling in Gloucester County Public Schools?
18 MR. CORRIGAN: Object to form, foundation,
19 speculation.
20 THE WITNESS: So from a policy
21 perspective, it has to be tied to something, and
22 we've already discussed that it's tied to the

1 gender marker on the birth certificate and their
2 student records. Whether it causes an additional
3 invasion of privacy is a subjective thing that
4 everybody is going to answer differently on. But
5 we have to have something as a baseline, and as we
6 discussed in the previous questions, that gender
7 marker on the birth certificate serves that
8 purpose.
9 BY MR. BLOCK:
10 Q So if, let's say, a student moves from
11 California and even though the student had a
12 female sex assigned to them at birth, they have a
13 male gender marker on their birth certificate and
14 they move to Gloucester and start going to school
15 and using the restroom, and so that student can
16 use the boys restroom even if that student has two
17 X chromosomes and has uterus and a vagina; is that
18 right?
19 MR. CORRIGAN: Object to form, foundation,
20 legal conclusion, incomplete hypothetical.
21 Go ahead.
22 THE WITNESS: Since we previously

1 established that we don't keep records or have any
2 information about chromosomes or physiological
3 traits, the basis would be based on that birth
4 certificate that they provide when they sign up
5 for schools in Gloucester County.
6 BY MR. BLOCK:
7 Q But does that student using the boys
8 restroom infringe on the privacy interests of
9 other boys using the boys restroom?
10 MR. CORRIGAN: Object to form -- same
11 objections.
12 Go ahead.
13 THE WITNESS: I can't answer that from a
14 policy perspective because it's a hypothetical
15 that you'd never know about because it's based on
16 their birth certificate.
17 BY MR. BLOCK:
18 Q So if the policy isn't designed to protect
19 any sort of privacy interests, that might arise in
20 that situation?
21 MR. CORRIGAN: Object to form.
22 THE WITNESS: Say the question again,

1 please.
2 BY MR. BLOCK:
3 Q So the policy isn't designed to protect
4 any privacy interest that might be involved in
5 sharing the restroom with someone who has, you
6 know -- let me start over.
7 So the policy isn't designed to protect
8 the privacy interest of a boy from using the same
9 restroom as a transgender boy who has a vagina and
10 uterus and two X chromosomes but has a male gender
11 marker on his birth certificate; is that right?
12 MR. CORRIGAN: Object to form,
13 foundation --
14 THE WITNESS: I would say --
15 MR. CORRIGAN: -- legal conclusion.
16 Go ahead.
17 THE WITNESS: -- it's designed to provide
18 the most amount of privacy as possible based upon
19 the limited information we have as a school
20 system.
21 BY MR. BLOCK:
22 Q So let's say there's a transgender girl at

1 Gloucester High School who at the time of
2 enrolling had a male gender marker on her birth
3 certificate, but she has had hormone blockers and
4 estrogen hormone therapy and is now 16 years old
5 and has fully developed breasts.
6 Does it invade the privacy interests of
7 boys for her to use the boys restroom?
8 MR. CORRIGAN: Object to form, foundation,
9 legal conclusion, incomplete hypothetical.
10 THE WITNESS: So when you say "transgender
11 girl," you mean that this person is -- their birth
12 certificate says male?
13 BY MR. BLOCK:
14 Q Correct.
15 A And your question was does that -- her
16 being in the boys restroom present privacy
17 concerns?
18 Q Right.
19 A So it would, again, be tied to their
20 gender marker on their student records.
21 Q So it doesn't violate boys' privacy to
22 have her in the boys -- to have him -- excuse

1 me -- it doesn't violate the boys' privacy to have
2 her in the boys restroom?
3 MR. CORRIGAN: Object to form, foundation,
4 legal conclusion, incomplete hypothetical.
5 Go ahead.
6 THE WITNESS: I'm struggling. I just want
7 to make sure I understand what you're saying.
8 Again, so since the focus of the policy is
9 to prevent people of physiological sexes from
10 having to share a restroom, that would still
11 present privacy issues because you have a
12 difference -- or you don't in this case. It's a
13 male using a males bathroom, correct? That's the
14 scenario you just presented?
15 BY MR. BLOCK:
16 Q The scenario I'm presenting is someone who
17 is assigned a male sex at birth but has gone
18 through puberty with estrogen and has fully
19 developed female breasts.
20 And is there privacy interest for the boys
21 using the boys restroom to not have to have her in
22 the restroom with them?

1 A The scenario I hear is still having a boy
2 in the boys restroom, so that policy is not
3 focused on that.
4 Q So if -- so if this transgender student
5 needs to change her shirt or something like that,
6 she can do that in the boys restroom without --
7 and expose her breasts, she can do that in the
8 boys restroom without it creating any infringement
9 on boys' privacy?
10 MR. CORRIGAN: Object to form, foundation,
11 speculation, incomplete hypothetical.
12 THE WITNESS: That's a scenario that
13 our -- that I've never considered. There were
14 a lot -- you know, you mentioned several of them
15 earlier, different scenarios, and changing clothes
16 was not a scenario we considered. Using a
17 restroom was the focus of the policy.
18 BY MR. BLOCK:
19 Q Well, so what if she wants to tuck in her
20 shirt and undoes like her pants in order to tuck
21 in her shirt better, would that violate the
22 privacy rights of boys in the restroom?

1 MR. CORRIGAN: Object to -- same
2 objections.
3 Go ahead.
4 THE WITNESS: Under the scenario you just
5 presented, which I heard a male in a males
6 bathroom tucking in their shirt, no, there's no
7 privacy there or no privacy issues.
8 BY MR. BLOCK:
9 Q How about in the locker room, if she's
10 using the boys' locker room and has to change
11 clothes, you know, and expose her breasts in the
12 process, does that violate the privacy of boys in
13 the boys' locker room?
14 MR. CORRIGAN: Let me object further on
15 this one that this case is not about locker rooms.
16 In fact, it's expressly not about locker rooms, so
17 I'm not going to have him answer any locker room
18 questions. He's not prepared, it's not part of
19 the 30(b)(6) designation, and he's not going to
20 answer questions about locker rooms.
21 MR. BLOCK: David, the policy applies to
22 restrooms and locker rooms, and locker rooms have

1 been repeatedly brought up in legal briefs.
2 So if there is a relevancy objection, I
3 don't think that's grounds for instructing the
4 witness not to answer.
5 MR. CORRIGAN: Did you put it in your
6 30(b)(6) designation that we were going to talk
7 about locker rooms?
8 MR. BLOCK: I asked about the biological
9 gender under the policy, and the policy applies to
10 locker --
11 MR. CORRIGAN: I understand. But you have
12 made a vivid point of not including locker rooms
13 in the case. It's not part of the case. You've
14 said so, talk about on brief and every other way,
15 so I don't think we should talk about locker
16 rooms.
17 MR. BLOCK: So are we stipulating here
18 that the Board will not rely on implications for
19 locker rooms as part of its defense of the policy?
20 MR. CORRIGAN: Yeah, I think the case is
21 about -- this is a case, a specific case about
22 Gavin Grimm and this policy and restrooms. And

1 you've made it that, and I don't think we have any
2 choice but to say that's what the case is about.
3 MR. BLOCK: Okay. So, yes, you're
4 stipulating that the Board is not relying on
5 implications that this case would have for locker
6 rooms as one of the bases for defending its
7 policy?
8 MR. CORRIGAN: I'm stipulating that this
9 case is only about restrooms, that's what I'm
10 stipulating.
11 BY MR. BLOCK:
12 Q Is it an invasion of the privacy rights of
13 girls or a transgender boy with facial hair and
14 lots of muscles to be in the girls restroom with
15 them?
16 MR. CORRIGAN: Object to the form,
17 foundation, calls for speculation, legal
18 conclusion.
19 Go ahead.
20 THE WITNESS: This seems like the inverse
21 of the last question, so now we have a girl in a
22 girls restroom, so, no, there's no -- not what the

1 policy is focused on.
2 BY MR. BLOCK:
3 Q So it's not an invasion of their privacy?
4 A If it's a girl in a girls restroom, no.
5 Q What if this transgender boy, he wanted to
6 undue his pants to tuck in his shirt, is that an
7 invasion of their privacy?
8 A Focused on a girl in a girls restroom, no.
9 Q How -- so what if the girls in the girls
10 restroom don't know that this transgender boy had
11 a female gender marker on his birth certificate at
12 the time he enrolled?
13 MR. CORRIGAN: Object to form, foundation,
14 legal conclusion, speculation, incomplete
15 hypothetical.
16 Go ahead.
17 THE WITNESS: Are you saying -- so what if
18 the girls didn't know that was a girl, they could
19 tell a teacher their concerns. But from -- that's
20 not covered under the policy.
21 BY MR. BLOCK:
22 Q And so under the policy, the teacher would

1 have to say to those girls, sorry, this is the
2 restroom that that person should be using?
3 MR. CORRIGAN: Object to form, foundation.
4 THE WITNESS: That would be handled at the
5 administrative level. And there's been no
6 scenarios I've been involved in other than this
7 one.
8 BY MR. BLOCK:
9 Q So what if the girls say, I really am
10 uncomfortable using this restroom with this person
11 who, you know, has facial hair and a ton of
12 muscles, I feel this is an invasion of my privacy,
13 what options are available for that girl?
14 A That's not something I can answer as a
15 board member because that would be handled at the
16 administrative level. The policy would serve as
17 the basis for that future discussion.
18 Q But under the policy, there's no
19 protection from -- the policy doesn't provide any
20 protection for a girl who feels that her privacy
21 is being violated by having to share the restroom
22 with someone with facial hair and a lot of muscles

1 because that person is a transgender boy; is that
2 right?
3 MR. CORRIGAN: Object to form, foundation,
4 speculation, inadequate opinion testimony.
5 Go ahead.
6 THE WITNESS: I'm not sure -- the
7 hypotheticals are kind of getting me a little
8 flustered.
9 BY MR. BLOCK:
10 Q Sorry. So the policy doesn't provide any
11 protection for a girl who does not want to share a
12 restroom with someone who is a transgender boy,
13 meaning that they were assigned a female sex at
14 birth but live as a boy and have facial hair and
15 a lot of muscles?
16 MR. CORRIGAN: Object to form, foundation.
17 Go ahead.
18 THE WITNESS: Let's take it back since the
19 focus of this is at the high school. Yes, the
20 policy -- well, the implications of the policy do
21 allow an alternate which is the single-stall
22 restrooms we added, so that's the relief there.

1 So they can be used by anybody. Those
2 single-stall unisex restrooms are available for
3 all students use.
4 BY MR. BLOCK:
5 Q So the girl who is uncomfortable using the
6 girls restroom with a transgender boy has the
7 option of using one of those single-stall
8 restrooms instead; is that right?
9 A Absolutely.
10 Q And so a boy who is uncomfortable using
11 the boys restroom with a transgender girl who has
12 fully developed breasts can use the single-user
13 restrooms instead; is that right?
14 A Correct.
15 Q And those single-user restrooms provide,
16 you know, adequate protection for students in that
17 situation; is that right?
18 MR. CORRIGAN: Object to form, foundation,
19 vague.
20 Go ahead.
21 THE WITNESS: Can you further define
22 "adequate protection"? You walk in, you're the

1 only person in the room, and the door is locked.
2 BY MR. BLOCK:
3 Q So the privacy objections of a boy who
4 doesn't want to share a restroom with a
5 transgender girl are fully addressed by having the
6 option of using a single-user restroom instead; is
7 that right?
8 MR. CORRIGAN: Object to form, foundation,
9 and inadequate speculation.
10 Go ahead.
11 THE WITNESS: So I still want to make sure
12 I understand what you're saying. So a boy at the
13 high school who doesn't want to use the restroom
14 with another boy with female characteristics and
15 traits, if they have a concern with that, they can
16 use the single-stall unisex restroom.
17 BY MR. BLOCK:
18 Q And that fully addressed whatever privacy
19 concerns that boy would have; is that right?
20 MR. CORRIGAN: Object to form, foundation,
21 and incomplete hypothetical.
22 Go ahead.

1 THE WITNESS: Under the scenario you
2 described, yes.
3 BY MR. BLOCK:
4 Q So what if someone is attending Gloucester
5 High School and doesn't want anyone to know they
6 are transgender? So under this hypothetical, they
7 previously went to a different school, they
8 transitioned, moved to Gloucester, have not had
9 their birth certificate amended, but appear
10 externally, you know, with their clothes on as
11 having all the same physiological characteristics
12 as anyone with their gender identity, so -- let me
13 rephrase that.
14 So a transgender girl transitions in
15 another school district, they then move to
16 Gloucester, registers for high school, and still
17 has a male birth certificate but, you know,
18 dresses and appears as a woman and has been on
19 hormone therapy and she wants to start school
20 without people knowing she's transgender, under
21 the policy what restrooms should she be using?
22 MR. CORRIGAN: Object to form, foundation,

1 incomplete hypothetical, and legal conclusion.
2 Go ahead.
3 THE WITNESS: Either the one associated
4 with their physiological sex or the single-stall
5 unisex restroom.
6 BY MR. BLOCK:
7 Q So if she uses the restroom that's based
8 on her birth certificate, that would be the boys
9 restroom, right?
10 A Correct.
11 Q And so by using the boys restroom, she
12 would have to be identifying herself as
13 transgender; is that right?
14 MR. CORRIGAN: Object to form, foundation,
15 calls for speculation.
16 Go ahead.
17 THE WITNESS: They would be making a
18 decision to do that instead of using the
19 single-stall unisex restroom.
20 BY MR. BLOCK:
21 Q And so her own -- but if she used the
22 single-stall restroom, she would then have to --

1 let me rephrase that question.
2 So what if she says that she doesn't want
3 to use the single-stall restroom because that just
4 draws attention to her and it's going to raise
5 questions in people's minds about why she is using
6 a different restroom than everyone else?
7 MR. CORRIGAN: Object to form, foundation,
8 incomplete hypothetical, calls for speculation.
9 Go ahead.
10 THE WITNESS: I don't understand the
11 question. The single-stall restrooms are open to
12 any student at Gloucester High School who wants to
13 use them. It's not just for transgender students.
14 BY MR. BLOCK:
15 Q What restroom is she supposed to use if
16 she's attending a football game and there aren't
17 any single-user restrooms available?
18 A Not a scenario I've considered or we
19 considered as a board.
20 Q So now that you're considering it now
21 under the policy, what restroom should she be
22 using at a football game?

1 A The one that corresponds with their
2 physiological sex.
3 Q So just to be clear, so this student who
4 has gone through puberty with estrogen and has
5 fully developed breasts and looks
6 indistinguishable from any other girl and is not
7 out to anyone else as being transgender should be
8 using the boys restroom at the football game if
9 she has to use the restroom; is that right?
10 MR. CORRIGAN: Object to form, foundation,
11 incomplete hypothetical, calls for speculation.
12 Go ahead.
13 THE WITNESS: I just want to repeat back
14 to you what I heard you say.
15 Now, we have the same scenario, the male
16 is still on the birth certificate and now the
17 scenario is at a football game?
18 BY MR. BLOCK:
19 Q Yes.
20 A So the three single-stall restrooms are
21 for purposes of this question not available, so,
22 yes, they would be using the restroom associated

1 with their physiological sex if they chose to use
2 the restroom.
3 Q And if the boys think that that's an
4 invasion of their privacy in the restroom, what
5 options do they have?
6 MR. CORRIGAN: Again, object to form,
7 foundation, incomplete hypothetical, calls for
8 speculation.
9 Go ahead.
10 THE WITNESS: What options do they have?
11 Wait, use an off-premises facility, same as any
12 person would have the same options.
13 BY MR. BLOCK:
14 Q What governmental interests are served by
15 having this be an official school board policy as
16 opposed to a one-off decision without a formal
17 policy being adopted?
18 MR. CORRIGAN: Object to form, foundation,
19 calls for legal conclusion.
20 THE WITNESS: Can you define what "one-off
21 decision" would translate into?
22 BY MR. BLOCK:

1 Q So for -- you know, when Gavin started
2 using the boys restroom, why did the Board adopt a
3 formal policy in response as opposed to just
4 directing the administration to stop letting Gavin
5 use the boys restroom?
6 A So we could capture it once and not have
7 to discuss it each individual time it came up.
8 Q So you wanted a policy that would be
9 comprehensive and addressing the situation if it
10 came up again with a different student?
11 A Correct.
12 Q So you weren't -- in passing the policy,
13 the goal was to go beyond the specific situation
14 with Gavin and have a generally applicable rule;
15 is that right?
16 A Correct. Because at the time this was
17 going around, the initial stages of it, no one on
18 the school board knew who Gavin was. So there was
19 no Gavin, there was only a student at Gloucester
20 High School.
21 Q All right. And so the policy was designed
22 to apply to future situations in which future

1 students that the Board didn't yet know about
2 would be attending Gloucester High School; is that
3 right?
4 A Correct. If it ever happened again,
5 here's the go-to policy.
6 Q So in these various scenarios I have been
7 asking that have been described as hypothetical
8 scenarios, was the policy drafted, you know, to
9 apply to those future hypothetical situations?
10 MR. CORRIGAN: Object to form, foundation,
11 calls for speculation.
12 Go ahead.
13 THE WITNESS: There weren't a lot of
14 hypo -- there weren't any hypothetical situations
15 considered, to my knowledge. It was focused on
16 dealing with students who wanted to use a restroom
17 of the gender they identified with instead of the
18 one associated with their physiological sex.
19 BY MR. BLOCK:
20 Q But can you explain to me why the privacy
21 interests in not sharing a restroom with someone
22 of a different sex turn on what's on a piece of

1 paper that's presented to the school at the time
2 the student registers and not based on what the
3 student's current physiology is?
4 A Explain that -- say that one more time,
5 please.
6 Q Yeah. So, you know, we discussed before
7 that for -- as you use the term "physiological
8 sex" is being determined by what is on their birth
9 certificate at the time they register; is that
10 right?
11 A Correct.
12 Q All right. It's not determined based on
13 what their current physiology actually is,
14 correct?
15 A Correct, because we have no procedures in
16 place for determining physiological features.
17 Q But the privacy interests you're
18 protecting is in the interest related to
19 physiological features; isn't that right?
20 MR. CORRIGAN: Object to form, foundation,
21 speculation.
22 Go ahead.

1 THE WITNESS: Correct.
2 BY MR. BLOCK:
3 Q So you're using what's on their birth
4 certificate at the time of registration as a proxy
5 for what their physiological features are likely
6 to be?
7 MR. CORRIGAN: Object to form.
8 Go ahead.
9 THE WITNESS: We're using the only piece
10 of information that's available to us when they
11 register.
12 BY MR. BLOCK:
13 Q But there might be times when what's on
14 their birth certificate doesn't actually match up
15 to what their current physiological features are;
16 is that right?
17 MR. CORRIGAN: Object to form, foundation,
18 speculation.
19 Go ahead.
20 THE WITNESS: I don't know about
21 physiological features. I'm talking about sex,
22 male or female, so I guess someone could go

1 through conversion and haven't had their birth
2 certificate amended yet, so there could be a time
3 when those two are technically out of sync.
4 BY MR. BLOCK:
5 Q So the confusion I have here is you're
6 using physiology and saying physiological sex, but
7 then you're referring to the birth certificate,
8 not to any current physiological feature; is that
9 right?
10 A The gender marking on the birth
11 certificate is how we define that because we have
12 nothing else.
13 Q Let's say a transgender 18-year-old girl
14 who has had hormone therapy and genital surgery
15 and is a senior at Gloucester High School, if her
16 birth certificate at the time that she registered
17 was female -- was male -- let me state the
18 question so the transcript is clean.
19 So if there's a transgender girl at
20 Gloucester High School who is 18 years old and has
21 had had hormone therapy and genital surgery, if
22 the birth certificate at the time that she

1 registered at Gloucester County Public Schools was
2 male, she is viewed as a biological male for
3 purposes of the school's policy; is that right?
4 MR. CORRIGAN: Object to form, foundation,
5 calls for speculation, incomplete hypothetical.
6 Go ahead.
7 THE WITNESS: Until when and if that
8 person would choose to append their gender marker
9 on their student records.
10 BY MR. BLOCK:
11 Q So the policy is determined by their
12 current birth certificate, not the birth
13 certificate that they had at the time they
14 registered?
15 MR. CORRIGAN: Object to form.
16 THE WITNESS: We wouldn't know what their
17 current birth certificate said unless it was
18 presented to us. So it's based on the birth
19 certificate they provided when they registered for
20 Gloucester County Public Schools.
21 BY MR. BLOCK:
22 Q But I'm talking about a student who

1 registered with a male birth certificate, then had
2 a transition process that included genital
3 surgery, and then got an amended birth certificate
4 or an updated birth certificate that listed her
5 gender marker as being female and she gives that
6 updated birth certificate to the school, does that
7 change what her biological gender is for purposes
8 of the school's policy?
9 MR. CORRIGAN: Object to form, foundation,
10 speculation, incomplete hypothetical.
11 Go ahead.
12 THE WITNESS: I just want to make sure I
13 heard the whole scenario right.
14 So they have had their birth certificate
15 amended, they have presented it to the school
16 system, and the school system has made the change
17 to the gender marker in their educational records;
18 is that the right scenario?
19 BY MR. BLOCK:
20 Q Well, everything except the last one. I
21 don't know what the school -- we can talk later
22 about what the school system does with the

1 information once they receive the amended birth
2 certificate.
3 But this is a situation where she's had
4 genital surgery, gets an amended birth
5 certificate, she gives it to the school.
6 Is her biological gender then whatever is
7 on her updated birth certificate?
8 A Her gender for the purposes of school
9 decisions are still tied to whatever record is on
10 file.
11 Q So if she gives the updated birth
12 certificate, does that birth certificate then
13 become on file or not?
14 MR. CORRIGAN: Object to form, foundation,
15 speculation.
16 Go ahead.
17 THE WITNESS: If she goes through policy
18 JO correction of educational records and there's
19 no issues found with the process used to obtain
20 that amended birth certificate, then, yeah, in
21 theory -- we haven't gone through one of these --
22 then it would change.

1 BY MR. BLOCK:
2 Q So does the school's policy for updating
3 educational records allow educational records to
4 be updated based on a changed birth certificate
5 with respect to the gender marker?
6 MR. CORRIGAN: Josh, I'll let him answer
7 this question, then I want to take a short break,
8 if that's all right?
9 MR. BLOCK: Sure.
10 THE WITNESS: Policy JO applies to all
11 educational records and wouldn't preclude any
12 changes based on an amended birth certificate.
13 BY MR. BLOCK:
14 Q But -- hold on one sec.
15 I'm confused about whether policy JO
16 allows someone to change the gender marker on
17 their school record ever.
18 Is that something covered by JO?
19 MR. CORRIGAN: We're kind of moving to a
20 new topic. Can we take a break just for a few
21 minutes and come back?
22 MR. BLOCK: Can we just get an answer to

1 the pending question and then we can take the
2 break?
3 MR. CORRIGAN: I tried to get it out
4 before the last pending question was, which I
5 allowed him to answer, so...
6 MR. BLOCK: Yeah.
7 MR. CORRIGAN: I don't think it's a big
8 deal.
9 Go ahead.
10 THE WITNESS: Your question is does policy
11 JO allow for a student's birth certificate to be
12 changed? Yes.
13 BY MR. BLOCK:
14 Q No. School records to be changed, the
15 gender marker on school records to be changed --
16 A Yeah.
17 Q -- based on a new birth certificate?
18 A Yeah.
19 MR. BLOCK: Okay. Thanks.
20 MR. CORRIGAN: All right. Be back in a
21 minute.
22 (A recess was taken.)

1 BY MR. BLOCK:
2 Q So apologies if this goes over some old
3 ground, but I'll try to keep it brief.
4 So you testified before that Gloucester
5 County Public Schools gives students a gender
6 marker on their school records based on the birth
7 certificate that the student gets at the time of
8 registration; is that right?
9 A Correct.
10 Q And does the school do any investigation
11 at that time to see if the gender marker on the
12 birth certificate is accurate?
13 A No.
14 Q So if Gavin had attended school in a
15 different school district, got in his amended
16 birth certificate before his senior year,
17 transferred to Gloucester County Public Schools
18 for his senior year, and presented them with his
19 updated birth certificate that listed his sex as
20 male, what would Gavin's school records have
21 listed his gender marker as being?
22 MR. CORRIGAN: Object to the form,

1 foundation, inaccurate, and incomplete
2 hypothetical.
3 Go ahead.
4 THE WITNESS: So I just want to make sure
5 again I heard what you said.
6 So when he transferred to Gloucester
7 County Public Schools, he provided a birth
8 certificate that said male, and the question is
9 what gender marker would he have on his Gloucester
10 County Public Schools' records?
11 BY MR. BLOCK:
12 Q Yes.
13 A Male.
14 Q And he would be allowed to use the boys
15 restrooms; is that right?
16 A Correct.
17 Q So does Gloucester County Public Schools
18 have any policies, practices, or procedures for
19 amending the gender marker on a student's school
20 records?
21 A Specifically focused on gender markers,
22 no. But policy JO deals with correction of

1 educational records in general, and that could be
2 anything to which a parent or student wants --
3 finds either to be inaccurate or wants changed.
4 Q So under policy JO, in order to have a
5 record changed, the student has to show that the
6 current record is inaccurate, misleading, or in
7 violation of the student privacy rights; is that
8 correct?
9 A I don't have that in front of me. It
10 looks like you're reading right off policy JO, but
11 that sounds correct.
12 Q So how would the school board determine
13 whether someone's gender marker is inaccurate or
14 misleading?
15 A By utilizing whatever information that
16 student provided to the administrative staff as a
17 part of the process outlined in JO.
18 Q What is the process by which the Board in
19 Gloucester County Public Schools officials decided
20 whether to update the gender marker in Gavin's
21 school records?
22 A So the superintendent, as the lead

1 administrative person for the school, consulted
2 with legal counsel, reviewed the documentation
3 provided, and made the decision.
4 Q But the superintendent had authority on
5 behalf of the Board to make that decision; is that
6 right?
7 A Correct.
8 Q So why did Gloucester County Public
9 Schools not update the gender marker on Gavin's
10 school records to update his birth certificate?
11 MR. CORRIGAN: To the extent the question
12 has anything to do with anything not provided as
13 legal counsel, he can answer.
14 THE WITNESS: Sure. So that was going to
15 be my first one, input from legal counsel. The
16 second was the information provided seemed to be
17 at odds with the process and procedures outlined
18 in Virginia law and the Virginia Administrative
19 Code as far as what an amended birth certificate
20 looks like. And also because the birth
21 certificate provided as part of the request was
22 stamped void, so it was those three reasons that

1 resulted in the denial of the change.
2 BY MR. BLOCK:
3 Q How was the process apparently at odds
4 with Virginia Code and regulations?
5 A I would have to pull out the Code, but my
6 recollection is if you look in the Code, it says
7 that amended birth certificates will have the
8 issue scratched out with the correct one written
9 next to it. And also somewhere on the document
10 the word "amended" is added to it.
11 Q So the Board -- so the concern is that
12 this could not -- could be a non authentic birth
13 certificate?
14 A Correct.
15 Q Have you seen the copy of the birth
16 certificate that was filed in this litigation?
17 A I've seen a version in a packet somewhere,
18 yes.
19 Q And does that copy have the same features
20 that you think call into question its
21 authenticity?
22 A I would have to look at it again. It's

1 not something I've looked at recently.
2 Q Did the Board or anyone from Gloucester
3 County Public Schools take any action to verify
4 the authenticity with the Department of Health?
5 A Not to my knowledge.
6 Q If -- I'd like to hand you a document
7 marked -- with the heading answer to second
8 amended complaint.
9 MS. SAFSTROM: One second. I'm getting
10 it.
11 MR. CORRIGAN: Do we need the second
12 amended complaint, too?
13 MS. SAFSTROM: Josh, would you like me to
14 give them both the second amended complaint and
15 the answers?
16 MR. BLOCK: Just the answer to the
17 second -- answer to second amended complaint. I'm
18 sorry if I said that incorrectly.
19 MS. SAFSTROM: And would you like that
20 labeled Exhibit B?
21 MR. BLOCK: Yeah, we can label it B now.
22 (Exhibit B was marked for identification.)

1 MR. BLOCK: Does the witness have the
2 document?
3 MS. SAFSTROM: Yes.
4 MR. BLOCK: Great.
5 BY MR. BLOCK:
6 Q Have you seen this document before?
7 A This one doesn't look familiar.
8 Q So if you turn to page 14, paragraph 80,
9 it says in response to paragraph 80 of Grimm's
10 second amended complaint the school board admits
11 in November of 2016 Grimm provided a different
12 Virginia birth certificate listing Grimm's sex as
13 male; however, the school board denies that the
14 birth certificate was issued in conformity with
15 Virginia law based upon the school board's
16 understanding of the Code of Virginia and
17 applicable administrative regulations.
18 Did I read that correctly?
19 A Yes, you did.
20 Q Okay. So without disclosing any
21 information from discussions with your attorney,
22 can you, please, identify all the ways that the

1 school board believes that the birth certificate
2 was not issued in conformity with Virginia law?
3 A That goes back to the -- my answer to the
4 previous question. The presence of the word
5 "void," the lack of the word "amended," and no
6 strike-through, and I believe there was a third
7 one. Without pulling out the Code or the VAC, it
8 said that the background information leading to
9 the change would also be amended to the updated
10 document.
11 Q I'm sorry. Can you say that again?
12 A Sorry. Without pulling out the particular
13 section of the Code of Virginia, in addition to
14 the three things I previously mentioned, the
15 fourth one was that I believe somewhere in there
16 it says that the background data or court orders
17 associated with the change would also be attached
18 to the amended document, so nothing -- there was
19 nothing attached to the amended document.
20 Q Are there any other ways that the school
21 board contends that the birth certificate was not
22 issued in conformity with Virginia law?

1 A No, sir.
2 Q Has the -- are you aware that there was an
3 order of the Circuit Court of Virginia in
4 Gloucester County declaring Gavin's sex to be male
5 and ordering the Department of Health to issue an
6 updated birth certificate?
7 A I am aware of that order, yes.
8 Q When did you become aware of it?
9 A I'm not sure. Late 2018.
10 Q And so why does the school board in light
11 of that order still take the position that the
12 birth certificate was not issued in conformity
13 with Virginia law?
14 MR. CORRIGAN: Object to form, foundation,
15 legal conclusion.
16 Go ahead.
17 THE WITNESS: Input from legal -- well,
18 your question is directly related to the validity
19 of the amended record. I personally haven't seen
20 one that addresses the three other things I
21 mentioned.
22 BY MR. BLOCK:

1 Q Have you -- you've taken no steps to
2 verify the authenticity within the Department of
3 Health?
4 A Correct.
5 Q And are you aware of the distinction
6 between long form birth certificates and short
7 form birth certificates?
8 A I'm not.
9 Q Okay. Are you aware that -- okay.
10 So you haven't taken any steps to
11 determine whether or not there is a long form
12 birth certificate in the custody of the Virginia
13 Department of Health that has those features?
14 A Correct, I have not --
15 Q Okay. Why have you not taken those steps?
16 A It's not my role as a board member.
17 That's an administrative -- if that's what needs
18 to take place, that's an administrative duty. And
19 then the second part would be input from legal
20 counsel.
21 Q Where are the specific defects that you're
22 identifying now recorded to Gavin or his family as

1 the basis for not updating his school records?
2 A There was a letter that went back to the
3 Grimm family. And I would have to look back at
4 the letter to find -- I recall there were four --
5 I think four bullets as to why the request was
6 denied. I'm not sure if one of those four was
7 what we just talked about. In the letter, I
8 actually might have misspoke. It went to you, not
9 the Grimms.
10 Q So that was the only response sent by the
11 school to explain why it did not update the birth
12 certificate; is that right?
13 A To my knowledge, correct.
14 Q And have you viewed the copy of the birth
15 certificate that was filed as an attachment to a
16 declaration that Gavin filed in this case?
17 A I would have to see it to see if I've ever
18 seen it prior to this question.
19 Q We'll get a copy e-mailed to --
20 MR. CORRIGAN: E-mail it to me and I'll
21 get it printed.
22 MR. BLOCK: Great. So Shayna will e-mail

1 it to you.
2 BY MR. BLOCK:
3 Q So is one of the bases that the school
4 board is relying on -- let me rephrase that.
5 So does the school board contend that the
6 medical procedures that Gavin has undergone are
7 insufficient to change the gender marker on his
8 birth certificate under Virginia law?
9 A No, that's not one of our arguments.
10 Q Okay. So you're not contending that his
11 chest surgery did not qualify as surgery that
12 warrants changing a birth certificate under
13 Virginia law?
14 A No, not one of our arguments and not
15 within our purview as a school board to determine.
16 Q So if you were presented today with a
17 birth certificate that did not have those markings
18 on it that you say that the initial birth
19 certificate that was filed with the school had,
20 would you update Gavin's gender marker on his
21 school records to match that birth certificate?
22 MR. CORRIGAN: Object to form, foundation,

1 calls for legal conclusion, and, frankly, I think
2 it's something that would be consulted with
3 counsel. I don't know what his answer is, but
4 that's my objection or concern.
5 Go ahead.
6 THE WITNESS: That's my answer, I would
7 take the information provided and give it to
8 Dr. Clemons, as the head administrative
9 superintendent for Gloucester County Public
10 Schools, and tell him to go forth and investigate,
11 and I'm sure he would consult with legal counsel
12 as well as ensuring that it's in accordance with
13 federal law, state law, and our own policy, just
14 like we did the first time.
15 BY MR. BLOCK:
16 Q So if -- so under the Board's policies, if
17 they are presented with an updated birth
18 certificate by a transgender student that has a
19 gender marker different than the gender marker
20 that was on the birth certificate at the time they
21 registered and there are no markings on the birth
22 certificate, to call its authenticity into

1 question, the school board would under those
2 circumstances change the student's school records
3 to match their updated birth certificate?
4 MR. CORRIGAN: Object to form, foundation,
5 calls for a legal conclusion.
6 Go ahead.
7 THE WITNESS: As long as all the I's were
8 dotted and T's were crossed in accordance with
9 federal law, state law, and policy JO, the policy
10 allows for the revision of the records so the
11 gender marker could be changed.
12 BY MR. BLOCK:
13 Q Two transgender students are in this
14 hypothetical. There are two transgender boys who
15 are both seniors at Gloucester High School in this
16 hypothetical; and their bodies look the same as
17 each other; they both had testosterone; both had
18 chest surgery; but one of them has had an updated
19 birth certificate and the other one hasn't.
20 Under the Board's policy, the one with the
21 updated birth certificate can use the boys
22 restroom, but the one who has not had an updated

1 birth certificate can use the women's restroom; is
2 that right?
3 A Correct.
4 MR. CORRIGAN: Object to form, foundation,
5 legal conclusion.
6 Go ahead.
7 THE WITNESS: Correct.
8 BY MR. BLOCK:
9 Q Even though their bodies are identical?
10 A Going back to what we spent the majority
11 of the morning talking about, it's tied back to
12 the gender marker on their records. So in the
13 hypothetical you just described, one matches and
14 one doesn't.
15 Q Do you know if the photocopy of the birth
16 certificate that was delivered to the school by
17 hand was produced in discovery in this case?
18 A I don't know.
19 Q What governmental interest is served by
20 the Board's refusal to update Gavin's birth
21 certificate?
22 MR. CORRIGAN: Object to form.

1 Go ahead.
2 THE WITNESS: It's our -- the policy JO is
3 in place to ensure that any changes to a student's
4 educational records are done in accordance with
5 all applicable federal and state laws.
6 BY MR. BLOCK:
7 Q And the Board despite now being aware of
8 the Virginia court order still takes the position
9 that the Gavin's sex was not changed in accordance
10 with Virginia law?
11 MR. CORRIGAN: Object to form, foundation,
12 and legal conclusion.
13 Go ahead.
14 THE WITNESS: I don't recall stating that.
15 We have to bring back in -- the question is have
16 the changes been made to the gender marker, and
17 the answer is no.
18 And then in addition to the state and
19 federal, there's input from legal counsel.
20 BY MR. BLOCK:
21 Q Does not updating the gender marker on his
22 birth certificate advance any interest in

1 protecting privacy?
2 MR. CORRIGAN: I think you misspoke. You
3 said "on his birth certificate."
4 MR. BLOCK: I'm sorry, Dave?
5 MR. CORRIGAN: I think you meant
6 transcript. I don't think the question is what
7 you intended it to be, but whatever, go ahead.
8 THE WITNESS: Can you ask your question
9 again?
10 BY MR. BLOCK:
11 Q Yeah. Does the school board's decision to
12 not update the gender marker on Gavin's school
13 records and transcript advance any governmental
14 interest in protecting privacy?
15 A It's not tied to privacy. It's just --
16 well, I guess FERPA -- the government interest is
17 tied to making sure that any changes are in
18 alignment with federal and local law and policy
19 JO.
20 Q So sitting here today, what other
21 information could be presented to you besides a
22 court order that would prompt the Board to update

1 Gavin's birth certificate? Sorry. Update Gavin's
2 transcript? I apologize.
3 A It would go back to that same process we
4 described, so the information provided to date
5 would be provided to Dr. Clemons, Dr. Clemons and
6 his staff would review, counsel would be talked
7 to, and then a decision on how to proceed would be
8 made from that process. There's nothing I can do
9 sitting right here today.
10 MR. BLOCK: David, can we take a break?
11 We have e-mailed you the copy.
12 MR. CORRIGAN: Okay.
13 (A recess was taken.)
14 MR. BLOCK: Back on the record.
15 BY MR. BLOCK:
16 Q All right. So I want to go back to the
17 things that you said to question the validity of
18 the birth certificate that was presented in
19 Gavin's senior year.
20 And so one of the things you said is it
21 was marked void; is that right?
22 A The previous version I saw, correct.

1 Q All right. And now is -- are you aware
2 whether any other birth certificate copies for
3 other students are marked void?
4 A I'm not aware.
5 Q Are you aware that any photocopy of birth
6 certificate produces the word "void" on it because
7 it's not the original document?
8 A I was not.
9 Q The second thing that you mentioned was
10 that the letter from the court or from the
11 treating physician -- sorry. Let me pause and
12 I'll get the exact language.
13 Another thing you mentioned was the
14 certified copy of the court order should accompany
15 the birth certificate; is that right?
16 A I don't think I ever said that. Again, I
17 would have to pull out the exact administrative
18 code and Virginia Code to see, but there was a
19 series of sections that described what amended
20 forms of birth certificates look like.
21 MR. BLOCK: Jennifer, can you give them
22 the -- let's give them both, the Code of Virginia

1 32.1-269.
2 Let's mark that as Exhibit C. And the
3 12 VAC 5-50-320, let's mark that as D.
4 (Exhibits C and D was marked for
5 identification.)
6 BY MR. BLOCK:
7 Q So I want to give you time to review
8 these.
9 Are these the provisions that you are
10 referring to a moment ago?
11 A 32.1-269, so Exhibit C is one I was
12 referring to. The second one you provided was in
13 there but doesn't contain -- is not the exact one
14 I was thinking of.
15 Q Okay. So where do you -- what part of
16 these documents provide the basis for your
17 understanding that the birth certificate that was
18 presented to the Board might not be valid?
19 A So 32.1-269, Section B, except in the case
20 of an amendment provided for in Subsection D which
21 deals with paternity, a vital record that is
22 amended under this section shall be marked amended

1 and the date of amendment -- so I'll stop there.
2 So even the version you've provided me, I
3 still don't see the word "amended" or the date of
4 the amendment.
5 MR. BLOCK: Let's -- since you're
6 referring to a document of the -- that was handed
7 to you, let's have that marked as Exhibit E for
8 the sake of the record. This is a document that
9 says that it's a birth certificate for Gavin
10 Elliot Grimm, and it says it was filed in Appeal
11 No. 15-2056 as Document 102.
12 (Exhibit E was marked for identification.)
13 MR. BLOCK: And even though there's an
14 Exhibit C in the photocopy, this is being marked
15 as Exhibit E in this deposition.
16 So...
17 THE WITNESS: I had more, but I wanted to
18 stop there because it's a long sentence. Again,
19 to restate that, shall be marked amended and the
20 date of amendment, so I don't see the word
21 "amended" or the date of the amendment. And to
22 continue, and a summary description of the

1 evidence submitted in support of the amendment
2 shall be endorsed on or made a part of the vital
3 record.
4 I don't see any description of evidence
5 submitted in support of the amendment. I'm not a
6 lawyer, so I don't know what "shall be endorsed
7 on" means, and I can only take a plain English
8 reading of what made a part of the vital record
9 is. To me that means amended, too.
10 BY MR. BLOCK:
11 Q So does the school board or the school
12 administration inspect every other birth
13 certificate that's presented to see if the word
14 is -- if the word "amended" is on it or not?
15 MR. CORRIGAN: Object to form, foundation.
16 Go ahead.
17 THE WITNESS: When documents are received
18 in accordance with policy JO, their validity is
19 looked at as part of the process. So making sure
20 that valid documents are included in the request
21 to change an educational record is part of the
22 process.

1 This is the same -- we're focused that
2 this particular case is dealing with a birth
3 certificate and a person's gender, but the process
4 is the same and it's afforded to every student
5 regardless of what the request is.
6 BY MR. BLOCK:
7 Q So you're not aware of whether or not
8 other photocopies of birth certificates in the
9 school's files also have the word "void" on
10 them --
11 A Correct, I'm not aware.
12 Q -- are you?
13 And so it's possible they do have the word
14 "void" on them; is that right?
15 MR. CORRIGAN: Object to foundation,
16 speculation.
17 Go ahead.
18 THE WITNESS: Possible, sure. I have -- I
19 mean, how does this one -- if every birth
20 certificate -- if you copy it, it gets the word
21 "void" on it, why does this one not have "void" on
22 it?

1 BY MR. BLOCK:
2 Q Well, I think it does on the -- if you
3 look to the left, there's -- it shows up more
4 clearly. It's faint, but it shows it more clearly
5 under state file, name of registrant, you can see
6 in horizontal a faint "void," v-o-i-d.
7 Do you see what I'm referring to?
8 A Huh-uh, no, sir.
9 Q Okay. Now, for the paragraph that you
10 read for me, if you look at the last sentence it
11 says, in a case of hermaphrodism or
12 pseudo-hermaphrodism, the certificate of birth may
13 be corrected at any time without being considered
14 as amended upon presentation to the state
15 registrar of such medical evidence as the Board
16 may require by regulation.
17 Is that right?
18 A That's the way the section reads. You
19 read it accurately, yes.
20 Q And I want to look at the other document
21 marked Exhibit D, the Virginia Administrative
22 Code.

1 Have you seen this before?
2 A I have.
3 Q You have?
4 A Yes.
5 Q Okay. Now, does this say anything about
6 whether or not a birth certificate that has a
7 change of sex on it -- excuse me -- does this
8 regulation say anything about whether a birth
9 certificate that has a change of sex needs to be
10 marked as amended on it?
11 A It does not.
12 Q I want to make sure the complete list of
13 the reason you've given for why the birth
14 certificate copy might appear facially irregular.
15 So we talked about the void issue, we talked about
16 it not being marked as amended, and we talked
17 about not having a description of the -- not
18 having the court order included on it.
19 And is there anything else?
20 A The strike-through. So I'd be happy to
21 reach into my box over there and pull out the
22 other Code, if that's acceptable. Again, you've

1 provided two, but there's more than two.
2 Q Sure. That's fine with me if it's fine
3 with your counsel.
4 MR. CORRIGAN: Yeah.
5 THE WITNESS: So it's 12 VAC 5-550-460,
6 methods of correcting or altering certificates.
7 MR. CORRIGAN: I have a clean copy of
8 that. Want to make copies of it?
9 MS. SAFSTROM: That would be great.
10 MR. CORRIGAN: Do you have that one? 460
11 is the number, Josh.
12 Can we take a second to make copies of
13 this? Is that all right?
14 (There was a pause in the proceedings.)
15 (Exhibit F was marked for identification.)
16 BY MR. BLOCK:
17 Q What part of that regulation did you want
18 to refer to?
19 A Certainly. It's pretty much all of
20 Subsection B or Part B. In all other cases,
21 corrections or alterations shall be made by
22 drawing a single line through the incorrect item,

1 if listed, and by inserting the correct or missing
2 data immediately above it or to the side of it, or
3 by completing the blank item, as the case may be,
4 and probably more importantly. In addition, there
5 shall be inserted on the certificate a statement
6 identifying the affidavit and documentary evidence
7 used as proof of the correct facts and the date
8 the correction was made.
9 Q And you testified that you don't have any
10 knowledge about whether there's a difference
11 between what's on long form birth certificates and
12 short form birth certificates?
13 A Correct.
14 Q When -- in the context of decisions about
15 who has legal decision-making authority for a
16 student if the parents are divorced, is the school
17 board ever presented with court orders regarding
18 custody or decision-making?
19 MR. CORRIGAN: Object to form, foundation.
20 THE WITNESS: Yeah, I'm not well-versed in
21 all the different types of situations that student
22 services deal with.

1 BY MR. BLOCK:
2 Q What's the typical method for responding
3 to requests to update student records? What's the
4 typical method by which the school communicates
5 its decisions?
6 A So the superintendent director of student
7 services would work through the issue and either
8 issue a letter indicating the record was changed
9 per the request or not changed per the request.
10 And if not, the reasons why.
11 Q And for the reasons why, does it -- does
12 the communication identify the specific things
13 that would need to be fixed in order to justify
14 having an amended record?
15 A If they can be easily identified, yes.
16 Q That would be typical practice?
17 A Yes.
18 Q And what is the typical time period for
19 responding to a request to update school records?
20 A That I don't know.
21 Q Has there ever been a previous request to
22 update the gender marker on a student's birth

1 certificate -- do that again.
2 Has there ever been a previous request to
3 update the student's gender marker on their school
4 records?
5 A Not to my knowledge.
6 Q Have there been previous requests to
7 update school records based on any type of change
8 to a student's birth certificate?
9 A Not to my knowledge.
10 Q And the only communication given to the
11 Grimms about the reasons for denying their request
12 to update the birth certificate was -- I keep
13 making that mistake. I'll say it again.
14 The only reason given to the Grimms -- say
15 it one more time.
16 The only communication to the Grimms
17 giving the reasons why the school did not update
18 his school records was the letter sent by the
19 Board's counsel to me; is that correct?
20 A Correct, to my knowledge.
21 Q So at school, the school board and school
22 administrators refer -- have honored Gavin's

1 request to refer to him by his name Gavin; is that
2 right?
3 A Correct.
4 Q And the school administrators also honored
5 his request to refer to him with male pronouns; is
6 that right?
7 A Correct.
8 Q Okay. Now, why have they done this?
9 A My understanding is the -- let's start
10 with pronouns because that's not hard. Pronouns
11 aren't a legal change to some sort of student
12 records. There's no student record associated
13 with pronoun for the name. My recollection is
14 that the name was changed based on the process of
15 the same policy JO.
16 Q Does the school board think that it's
17 harmful to refer to Gavin with male pronouns?
18 A Harmful to refer to Gavin with male
19 pronouns, no.
20 Q I'm going to show you a document that's
21 marked -- that the title of is Gloucester County
22 School Board's Rule 26(a)(2) disclosure.

1 MR. BLOCK: Do you have that, Jennifer?
2 MS. SAFSTROM: Yeah, just one second. The
3 26(a) disclosures?
4 MR. BLOCK: Yes.
5 MR. CORRIGAN: So, Josh, where does this
6 fit under the 30(b)(6) designation? What are we
7 talking about as what the witness was to discuss?
8 MR. BLOCK: It's the governmental
9 interests from the policy.
10 Can we have this marked as F for -- G,
11 great.
12 (Exhibit G was marked for identification.)
13 BY MR. BLOCK:
14 Q You haven't seen this before, have you?
15 A I have not.
16 Q I want to turn to one, two, three, four,
17 five, six pages in of the double-sided version, so
18 it's probably 12 if you have single-sided.
19 It's paragraph 41. Do you see that
20 paragraph 41?
21 A I do.
22 Q Okay. Just want to direct your attention

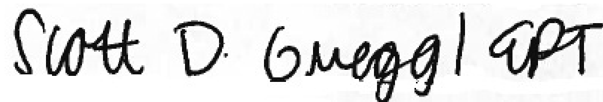
1 to the second sentence in that paragraph. It
2 says, allowing the biologic female to use a
3 male-designated bathroom facility is one of
4 several gender-affirming care options, but it is
5 creating harm to at least two parties, the harm to
6 the gender incongruent person is that it promotes
7 a pathway to inevitable long-term medical and
8 psychological morbidity.
9 So my question is, is this one of the
10 governmental interests that is served by the
11 school board's policy to prevent harm to the
12 transgender person from promoting a pathway to
13 inevitable long-term medical and psychological
14 morbidity?
15 A I'm not sure I even understand what that
16 statement that you just read means.
17 Q Does the school board contend that
18 allowing a transgender student to use the boys
19 restroom is harmful to the transgender student?
20 A That was not something considered when
21 this policy was voted on.
22 Q Are you relying on it as one of the

1 governmental interests served by the policy today?
2 A I would say no.
3 Q Thanks.
4 MR. BLOCK: Can we just go on mute for a
5 minute?
6 MR. CORRIGAN: Sure.
7 (A recess was taken.)
8 BY MR. BLOCK:
9 Q So under -- are you ready, Mr. Andersen?
10 A Yes, sir.
11 Q Great. Under the Board's policy, how does
12 it determine the biological gender of a student
13 with intersex characteristics such as genitals
14 that look either male nor female?
15 A That's not a scenario we ever discussed.
16 Q And does the policy apply to that
17 scenario?
18 A Yes.
19 Q Yes?
20 A Yes.
21 Q And so under the policy, how would that
22 person's biological gender be determined?

1 A I don't know the innerworkings of how
2 birth certificates work in that scenario, so I
3 don't have a good answer for that.
4 Q But it would be whatever is on their
5 current birth certificate?
6 A Correct.
7 Q And so just to clarify a previous line of
8 questioning, the biological gender policy turns on
9 what the student's current birth certificate is;
10 is that correct?
11 MR. CORRIGAN: Object to form, foundation,
12 legal conclusion.
13 Go ahead.
14 THE WITNESS: As I previously described,
15 it would be based on the gender marking in the
16 student's records as determined by either the
17 birth certificate they submitted when they signed
18 up or, if they want it changed, the one they
19 submitted as part of policy JO.
20 BY MR. BLOCK:
21 Q And how does the biological gender policy
22 apply to someone who's lost their genitals in an

1 accident?
2 A That would require additional discussion.
3 There's been no -- not a scenario we thought
4 through all the way when coming up with that
5 policy.
6 Q And so just to -- I apologize if this is
7 making me repeat something. This is my last
8 question.
9 So under the Board's policy, a student
10 could have estrogen for purposes of puberty and
11 hormone treatment and fully developed breasts and
12 a vagina through vaginoplasty, and even if that
13 student has all those things, the student would
14 still be designated as having a male biological
15 gender for purposes of the Board's policy if that
16 student's birth certificate still listed them as
17 male?
18 MR. CORRIGAN: Object to form, foundation,
19 legal conclusion, incomplete hypothetical.
20 Go ahead.
21 THE WITNESS: Correct.
22 BY MR. BLOCK:

1 Q So in that scenario, the boys in the boys
2 restroom could be in the same restroom as the
3 transgender girl with a vagina; is that right?
4 A Say that one more time, please.
5 Q Boys in the boys restroom could be in the
6 same restroom as a transgender girl with a vagina
7 under the school board's biological gender policy;
8 is that right?
9 MR. CORRIGAN: Object to form, foundation,
10 incomplete hypothetical, legal conclusion.
11 Go ahead.
12 THE WITNESS: Under the scenario you just
13 described, yes.
14 MR. BLOCK: All right. Thank you,
15 Mr. Andersen. I have no further questions.
16 MR. CORRIGAN: I don't have any questions.
17 He'll read.
18 MR. BLOCK: Could we get an expedited
19 version of the transcript as soon as possible.
20 Electronic is fine.
21 MR. CORRIGAN: I'll take it electronic.
22 (The deposition adjourned at 12:24 p.m.)

1 CERTIFICATE OF SHORT HAND REPORTER - NOTARY PUBLIC
2 I, Scott D. Gregg, RPR, a Notary Public,
3 the officer before whom the foregoing deposition
4 was taken, do hereby certify that the foregoing
5 transcript is a true and correct record of the
6 testimony given; that said testimony was taken by
7 me stenographically and thereafter reduced to
8 typewriting under my supervision; that reading and
9 signing was requested; and that I am neither
10 counsel for or related to, nor employed by any of
11 the parties to this case and have no interest,
12 financial or otherwise, in its outcome.
13 IN WITNESS WHEREOF, I have hereunto set my
14 hand and affixed my notarial seal this day of
15 2019.
16 My commission expires July 31, 2020.
17

18
19 __________________________________
20 NOTARY PUBLIC IN AND FOR THE
21 COMMONWEALTH OF VIRGINIA
22 Notary Registration No. 215323

Case 4:15-cv-00054-AWA-RJK Document 192-14 Filed 03/26/19 Page 1 of 56 PageID# 2210

Planet Depos
We Make It Happen™

Transcript of Dr. Quentin Van Meter

Date: March 18, 2019
Case: Grimm -v- Gloucester County School Board

Planet Depos
Phone: 888.433.3767
Email:: transcripts@planetdepos.com
www.planetdepos.com

WORLDWIDE COURT REPORTING | INTERPRETATION | TRIAL SERVICES

1 IN THE UNITED STATES DISTRICT COURT
2 EASTERN DISTRICT OF VIRGINIA
3 NEWPORT NEWS DIVISION
4 --------------------------x
5 GAVIN GRIMM, :CASE NO. 4:15-cv-54
6 Plaintiff, :
7 v. :
8 GLOUCESTER COUNTY SCHOOL :
9 BOARD, :
10 Defendant. :
11
12
13 Deposition of Dr. Quentin Van Meter
14 Atlanta, Georgia
15 Monday, March 18, 2019
16 10:03 a.m.
17
18
19
20 Job No.: 233197
21 Pages 1 - 219
22 Reported by: Robyn Bosworth, RPR, CRR, CRC, CCR

1 Deposition of Dr. Quentin Van Meter, held at:
2
3
4 Drew Eckl Farnham
5 303 Peachtree Street, NE
6 Suite 3500
7 Atlanta, Georgia 30308
8 404.885.6367
9
10
11
12
13 Pursuant to Notice, before ROBYN BOSWORTH, RPR,
14 CRR, CCR, CRC, CCR-B-2138.
15
16
17
18
19
20
21
22

1 A P P E A R A N C E S
2 ON BEHALF OF THE PLAINTIFF (Via
3 Videoconference):
4 JOSHUA A. BLOCK, ESQUIRE
5 LESLIE COOPER, ESQUIRE
6 SHAYNA MEDLEY-WARSOFF, ESQUIRE
7 American Civil Liberties Union
8 Foundation
9 125 Broad Street
10 18th Floor
11 New York, New York 10004
12 (212) 549-2627
13 -and-
14 EDEN B. HEILMAN, ESQUIRE
15 JENNIFER SAFSTROM, ESQUIRE
16 NICOLE TORTORIELLO, ESQUIRE
17 American Civil Liberties Union
18 Foundation of Virginia
19 701 East Franklin Street, Suite 1412
20 Richmond, Virginia 23219
21 (804) 644-8022
22

1 A P P E A R A N C E

2 ON BEHALF OF THE DEFENDANT:

3 DAVID P. CORRIGAN, ESQUIRE

4 Harman, Claytor, Corrigan & Wellman

5 P.O. Box 70280

6 Richmond, Virginia 23255

7 (804) 747-5200

8

9 A L S O P R E S E N T:

10 MARCY HAMPTON (via videoconference)

11

12

13

14

15

16

17 C O N T E N T S

18 EXAMINATION OF DR. QUENTIN VAN METER PAGE

19 By Mr. Block

20

21

22

1 E X H I B I T S
2 (Attached to Transcript)

DEPOSITION	EXHIBIT	PAGE
Exhibit 1	Gloucester County School Board's Rule 26(a)(2) Disclosure	7
Exhibit 2	Declaration of Quentin L. Van Meter, MD	17
Exhibit 4	American College of Pediatricians "About Us" from website	146
Exhibit 5	Gender Ideology Harms Children	149
Exhibit 6	On the Promotion of Homosexuality in Schools	167
Exhibit 8	Dr. Quentin Van Meter: How Faulty Research by a 1950's Sexual Revolutionist Guided the Modern Transgender Movement	158

17
18
19
20
21
22

1 P R O C E E D I N G S
2 DR. QUENTIN VAN METER,
3 having been first duly sworn, was examined and
4 testified as follows:
5 EXAMINATION
6 BY MR. BLOCK:
7 Q Good morning, Dr. Van Meter. My name is
8 Joshua Block. I'll be taking your deposition today.
9 I represent the plaintiff, Gavin Grimm, in this
10 lawsuit.
11 Have you ever had your deposition taken
12 before?
13 A I have.
14 Q Great. So you're familiar with the
15 procedure here. I'll be asking questions, and
16 you'll be providing answers. There's three ground
17 rules I'd like to go over with you.
18 The first, as you already know, is that we
19 have the court reporter writing down everything that
20 we say, so it's important that we don't talk over
21 each other, so I'd appreciate it if you could wait
22 for me to finish a question before you start

1 answering, and I will wait for you to finish
2 answering before I ask the next question. Agreed?
3 A Agreed.
4 Q Second, because the court reporter is
5 writing things down, and because the video is a
6 little fuzzy, it's important that you don't respond
7 with visual cues like nodding your head or saying
8 "uh-huh." All your answers need to be verbal so
9 they can appear on the transcript. Okay?
10 A Okay.
11 Q And third is it's my job to ask questions
12 that you can understand, so if I say anything that
13 is unclear or you would like me to repeat or
14 rephrase the question, please let me know. And if
15 you do answer my question, I'm going to take that to
16 mean that you understood it. Okay?
17 A Okay.
18 Q Great. So let's start with the document
19 that's been marked by the court reporter as Exhibit
20 Number 1.
21 (Exhibit 1 was marked for identification
22 and is attached to the transcript.)

1 BY MR. BLOCK:
2 Q If you turn to -- a couple pages into the
3 document there's a photocopy with your letterhead on
4 it. Let me know if you found that page.
5 A I have it here.
6 Q Great. Do you recognize this letter?
7 A I do.
8 Q What is it?
9 A This is a statement of my opinion
10 regarding information that I gleaned from reviewing
11 records on the Gavin Grimm case.
12 Q Great. And if you flip to the end of the
13 letter and look at the next page, there's a document
14 that appears to be your CV; is that right?
15 A That is correct.
16 Q Okay. So I'll be asking some questions
17 both about the letter and about your CV here.
18 So let's go back to the beginning of your
19 letter. If you look at paragraph 9.
20 A Okay.
21 Q The second sentence says: I have
22 testified at Georgia state legislative committee

1 hearings; is that right?
2 A That is correct.
3 Q What was the subject of your testimony?
4 A This was regarding obesity in children, as
5 I recall.
6 Q And how many times did you testify at the
7 Georgia state legislative committee hearings?
8 A I testified once, I believe.
9 Q And in your testimony did you discuss at
10 all any information related to transgender children?
11 A I did not.
12 Q Can you think of any way that the subject
13 matter of your testimony at the Georgia state
14 legislative committee hearings would have relevance
15 to the issues in this case?
16 A No.
17 Q Okay. So going to the next sentence, you
18 say: In the past six years, I have testified by
19 deposition in Harlen Schneider versus J. Enrique
20 Lujan, MD, in the Circuit Court of the First
21 Judicial Circuit of Okaloosa County, Florida, Civil
22 Division; is that right?

1 A That's correct.
2 Q And what was that case about?
3 A It was a medical malpractice case.
4 Q And what was your testimony about?
5 A It was in -- it was for the defense --
6 excuse me, for the plaintiff in regard to the
7 quality of medical care. Specific diagnosis, I do
8 not remember.
9 Q And was this for an endocrine condition?
10 A This was for an endocrine condition.
11 Q And to the best of your memory, was the
12 diagnosis at all related to either gender or sexual
13 differentiation?
14 A It was not.
15 Q The rest of that sentence after the
16 semicolon says that you also testified in the case
17 of plaintiff, Kimora Gilmer. What was that case
18 about?
19 A That case was about the death of a young
20 child who had acute onset of thyroid illness which
21 was not recognized by the medical treating facility
22 or the physician, and the patient died as a result.

1 Q What was your testimony?
2 A My testimony was as an expert witness
3 talking about the standard of care in a primary care
4 setting, and the need to have consulted
5 endocrinology appropriately, and that was not done.
6 Q Now, when you give expert testimony
7 regarding the standard of care, what sources do you
8 look to to determine what the standard of care is?
9 A Routinely, they will be referencing
10 textbooks. If there are published standards of care
11 outside of a textbook, if it's already outdated or
12 has been updated I will refer, after researching the
13 literature, to the most recent standards of care.
14 Q Are guidelines from the Endocrine Society
15 one of the sources you look to in other areas of
16 endocrine medical practice to determine what the
17 standard of care is?
18 A Yes, but I'd like to clarify, there's a
19 difference between guidelines and standards of care,
20 as I understand it. Guidelines are suggestions;
21 standards of care, in terms of my worldview, are
22 what are published and recognized as the -- as the

1 most common and generally accepted ways to treat a
2 patient.
3 Q So in your opinion the standards of care
4 would be found in this textbooks as opposed to
5 guideline recommendations?
6 A I am not sure.
7 Q But the guidelines from the Endocrine
8 Society are at least one source that you would
9 usually look to to determine the applicable standard
10 of care; is that fair?
11 A Not exactly.
12 Q Could you explain that further?
13 A Guidelines from the Endocrine Society are
14 based on opinion of the committee that developed the
15 guidelines. They are not necessarily accepted
16 across the board as standards of care.
17 Q So where would you find the accepted
18 standards of care in that case?
19 A Most likely they would be in published
20 textbooks.
21 Q In published textbooks?
22 A Yes.

1 Q So to find the standards of care for
2 treating gender dysphoria, would someone then look
3 to textbooks on treating gender dysphoria?
4 A They could. There are standards of care
5 published by the American Psychological Association
6 in their handbook published in 2014. The exact name
7 of that textbook, whether it's the Handbook of Human
8 Sexuality or -- it's a title very similar to that,
9 but it's a published textbook of guidelines.
10 Q Okay. So published textbooks of
11 guidelines from the American Psychological
12 Association would be a source for determining the
13 standards of care for treating gender dysphoria in
14 your opinion?
15 A Yes.
16 Q Is there anything else that would be a
17 source for determining the standards of care?
18 A You could look to articles across the
19 world's literature to see the broad spectrum of
20 opinion and come up with what would be the best-case
21 scenario for the patient.
22 Q And in general articles that are peer

1 reviewed would be the best source of articles to
2 look at; is that right?
3 A Yes. The whole concept of peer review
4 ideally is to have a team of, if you will, referees
5 that have a broad background that essentially go
6 through and check all the references to make sure
7 that they are valid, that the opinions stated from
8 the references match the information published in
9 the paper. So that would be -- and by peer review,
10 it's somebody in the field of endocrinology, and
11 perhaps in a field of subspecialty so that there is
12 a very critical assessment of the validity of what's
13 being published.
14 Q So when you say "look at the broad
15 spectrum of opinion," is there a way to quantify
16 what qualifies as a broad spectrum of opinion?
17 MR. CORRIGAN: Object to the form of the
18 question.
19 Go ahead.
20 A A broad spectrum --
21 BY MR. BLOCK:
22 Q Sorry. No, no, I'll clarify. Is there a

1 way to quantify what constitutes a broad spectrum of
2 opinion for purposes of identifying the standard of
3 care?
4 MR. CORRIGAN: Same objection.
5 Go ahead.
6 A Can you restate the question?
7 BY MR. BLOCK:
8 Q Sure. You referenced looking at articles
9 to find a broad spectrum of opinion in order to
10 derive a standard of care. Is there some sort of
11 number of articles that you would look at for that
12 purpose?
13 A More than the number of articles, the
14 number clearly is important if you were trying to
15 look at the balanced approach to review the subject
16 at hand, there is sort of a general process when you
17 review information and review literature that you
18 look at every side of the subject, every published
19 paper and the quality of that paper and lay them all
20 out in front of you, if you will, and come up with
21 what is a balanced approach to developing your
22 opinion based on different research, different sides

1 of an issue, so that you come up with what is best
2 for the patient.
3 Q So when you have determined your opinion
4 regarding treatment for gender dysphoria, did you
5 look at all sides of the research in forming your
6 opinion, including materials that supported your
7 view and materials that contradicted your view?
8 A Yes, I did.
9 Q What sources did you look to for finding
10 opinions that were different from your own?
11 A I looked at the bibliography for the
12 Endocrine Society guidelines, I looked at the
13 bibliography for the World Professional Association
14 of Transgender Health, I looked in the Handbook
15 of -- that I referred to published in 2014 by the
16 American Psychological Association, I looked at the
17 DSM-V criteria, I looked at articles published in
18 the Journal of Endocrinology and Metabolism, the
19 Journal of Pediatrics, a number of additional
20 journals that I could reference if you need the
21 specifics.
22 Q And when did you conduct this research?

1 A I've been doing this probably five or six
2 years in depth.
3 Q What research have you done since the time
4 that you filed your declaration in the Carcano
5 versus McCorey case?
6 A I've done a fair amount of additional
7 research because there have been articles published
8 since that time.
9 Q Let's look at your declaration in Carcano
10 versus McCorey, which is marked as Exhibit 2 by the
11 court reporter.
12 (Exhibit 2 was marked for identification
13 and is attached to the transcript.)
14 A I have it here.
15 BY MR. BLOCK:
16 Q Great. And does this appear to be a copy
17 of the declaration that you wrote for that case?
18 A It does.
19 Q Who first contacted you about being an
20 expert in the Carcano case?
21 A I actually do not remember.
22 Q Do you remember what organization they

1 were from?
2 A It would be a guess.
3 MR. CORRIGAN: Don't guess.
4 A Okay. I do not recall exactly, so I don't
5 want to misstate.
6 BY MR. BLOCK:
7 Q Well, can you describe, in the best of
8 your recollection, how you came to be an expert in
9 that case?
10 A We had published the American College of
11 Pediatricians guidelines for care of transgender
12 patients, and that was used, I think, as a reference
13 point for whoever contacted me to ask me to be -- to
14 provide information for this case.
15 Q To the best of your knowledge, has the
16 American College of Pediatricians ever been used as
17 a source for determining what the standard of care
18 is in a court proceeding?
19 A Yes, it has been -- the American College
20 has filed amicus briefs on a number of subjects, and
21 I do not know whether transgender specifically was
22 one of those. I don't know what level of court it

1 has ascended to, but I know it has been used as a
2 document in transgender cases.
3 Q But my question is not amicus briefs, but
4 if a physician or pediatrician was going about
5 determining the standards of care for a condition,
6 is the American College of Pediatricians publication
7 a source that they would look to?
8 A Yes, they would review it.
9 Q Are you aware of any instance in which an
10 expert witness testifying in a case has relied upon
11 them?
12 A They have mentioned them specifically. I
13 can't give you a specific case, but I know they have
14 been referenced.
15 Q So you say you don't recall who contacted
16 you about being an expert in the Carcano case. Is
17 it your recollection that you were contacted by
18 someone as opposed to you being the person that
19 initiated contact?
20 A Yes, I was contacted.
21 Q And if you look at your declaration. Go
22 back to your declaration in this case.

1 MR. CORRIGAN: So Exhibit 1, not Exhibit
2 2?
3 MR. BLOCK: Correct.
4 BY MR. BLOCK:
5 Q So paragraph 10 says: I provided an
6 expert declaration in the case of Carcano v. McCorey
7 and U.S. v. North Carolina on August 12, 2016; is
8 that right?
9 A That's correct.
10 Q And the declaration we just looked at as
11 Exhibit 2 is a copy of that declaration, correct?
12 A It is.
13 Q So next sentence says: I testified in
14 Springfield, Illinois, as a plaintiff's expert
15 witness in the case of Cooley versus Paul.
16 What was that case about?
17 A That was a case of a child, it had nothing
18 to do with transgender, it was a child who was
19 treated with excessive amounts of steroid over a
20 number of years who suffered severe medical
21 consequences as a result.
22 Q What was the subject of your testimony?

1 A Subject of the testimony was the standard
2 of care for treatment of children with steroids for
3 whatever reason and the monitoring of the side
4 effects of those drugs.
5 Q And for all of these -- all of the
6 malpractice cases we've discussed so far, did you
7 ever reference the American College of Pediatricians
8 as a source for determining your standard of care in
9 your testimony?
10 A I did not because the issues that were
11 raised were not issues where the College had a
12 position statement.
13 Q Did you reference the Endocrine Society in
14 any of your testimony in those cases?
15 A Not so much the Endocrine Society, but
16 endocrine -- published endocrine textbooks for
17 children.
18 Q The next sentence in your declaration
19 says: I testified in court in Hamilton County,
20 Ohio, on February 2018 in regard to Jessica Siefert,
21 a transgender teen that had been removed from the
22 custody of her biological parents.

1 Can you tell me about that case?
2 A I was to provide information to the judge
3 as an expert witness on the subject of transgender
4 medicine presenting the broad spectrum of opinion on
5 the appropriate treatment.
6 Q And you testified in court to a judge in
7 that case?
8 A I testified by Skype to a judge.
9 Q How did you come to be involved in that
10 case?
11 A The parents' attorney found me because of
12 the position statement of the American College of
13 Pediatricians.
14 Q And who was the parents' attorney?
15 A Let me think for one moment if I can
16 remember the name. I can provide it after the fact.
17 I don't want to guess.
18 Q What was the context in which this
19 teenager had been removed from the custody of her
20 biologic parents?
21 A The Hamilton County Child Protective
22 Services removed the child from the family at the

1 request of the clinic which was treating this young
2 lady because the parents would not give permission
3 for hormonal treatment for their female child. And
4 so the clinic brought charges, and the Hamilton
5 County DFCS assumed custody of the child and kept
6 her in their custody and were requesting that they
7 be able to grant custody to the grandparents, who
8 indicated they would allow hormone treatment to
9 continue.
10 And so the parents were requesting
11 returned custody to them from Hamilton County DFCS,
12 and the judge made the decision, after all the
13 proceedings, to give the child custody to the
14 grandparents.
15 Q And was that the end of the case?
16 A As far as I know.
17 Q Do you know if the judge made any findings
18 of fact regarding your testimony?
19 A I do not. I do know that she made a
20 specific request that the child be evaluated by
21 mental health practitioners who were completely
22 independent of the children's hospital who were part

1 of the mechanism for getting the child taken away
2 from her parents. The judge couldn't believe that
3 the evaluation was not done by an independent
4 practitioner because of the way their practitioners
5 testified about the care of that child.
6 Q But the independent practitioner that the
7 judge asked to do another evaluation ended up
8 agreeing with the clinic; is that right?
9 A I do not know. The child was 17 years and
10 10 months of age at the time of the proceedings, and
11 so it's a bit moot. Two months into the proceedings
12 she was age of consent, so she could pretty much do
13 whatever she chose.
14 Q Do you have a copy of the testimony that
15 you provided in that case?
16 A I do not.
17 Q What is -- in your declaration the next
18 sentence says: I testified via Skype in Alberta
19 Province, Canada.
20 What was that case about?
21 A That case was a suit by parents in the
22 school district in Alberta who had a child, an

1 autistic child, who was recruited into an
2 organization at school without the parents'
3 knowledge.
4 The child was approached by a teaching
5 assistant for the class with kids with special needs
6 and autism, and that -- without the parents' notice,
7 the teaching assistant told the girl that, first,
8 she was a lesbian, and then secondarily that she was
9 transgender. The parents were not aware of any of
10 this information, and so their concern was the
11 school did not share information that was important
12 for the parents to know about their child in the
13 school setting, and they thought that that was an
14 inappropriate thing for the school district to take
15 the responsibility without the knowledge of the
16 parents. So that was -- that was the crux of the
17 case.
18 Q So what was your testimony about?
19 A My testimony was just to give them some
20 background information about what transgenderism as
21 a concept is, the historical background of how it
22 has come to be as a concept in medicine, and to give

1 the broad spectrum of published literature
2 background for that case.
3 Q And did you testify in court too?
4 A No, this was just by Skype. This was --
5 actually, this -- I was interviewed -- was not in
6 court. I was interviewed by the plaintiffs'
7 attorneys.
8 Q Do you know what the --
9 A I'm sorry.
10 Q Do you know what the outcome of that case
11 was?
12 A I want to correct. I was interviewed by
13 the defense attorneys primarily, I'm sorry.
14 I do not know what the outcome is.
15 Q If we can turn to your CV. Do you have
16 any education or training related to gender
17 dysphoria or gender identity disorder?
18 A My training at my fellowship at Johns
19 Hopkins was the first introduction to me of what
20 then was called transsexualism, but which is now
21 referred to in current terminology as
22 transgenderism. So that was in 1978 that I was

1 introduced to that concept.
2 Q Have you had any other training?
3 A No specific training because there is not
4 a -- there is not a curriculum, if you will, to
5 teach transgender medicine that is available.
6 Q Did you have any clinical training?
7 A The clinical training was in the
8 fellowship years, and then subsequently meeting with
9 experts in the field, attending a conference of the
10 joint Pediatric Endocrine Society and European
11 Society of Pediatric Endocrinology in New York, but
12 it was not so much a course, it was just a
13 conversation.
14 Q And would conversations of that sort
15 generally in your field qualify as clinical
16 training?
17 A No.
18 Q Okay. So the only training that you had
19 related to transsexualism, gender identity disorder,
20 gender dysphoria, took place during your fellowship
21 at Johns Hopkins; is that right?
22 A That's correct.

1 Q So during your fellowship, did you
2 actually provide any treatment for people with
3 transsexualism, gender identity disorder or gender
4 dysphoria?
5 A I did not personally do so, but I was --
6 the attending physicians and -- were providing the
7 care. It was we were used as consultants to
8 evaluate the clinical status of these patients, but
9 we did not specifically write prescriptions for
10 medication, we did not make recommendations for
11 surgery.
12 Q You did a pediatric -- a fellowship in
13 endocrine pediatrics; is that right?
14 A That's correct.
15 Q So what role, if any, did you have in
16 providing recommendations for the treatment of
17 adults with transsexualism, gender identity disorder
18 or gender dysphoria?
19 A Well, we were sort of observers, if you
20 will, of the clinical circumstances because these
21 were adult patients, and we were pediatric trainees.
22 Johns Hopkins's adult endocrinology division did not

1 take care of these patients.
2 Dr. John Money was the professor on the
3 faculty, and he worked exclusively with the
4 pediatric department, developed his own protocol,
5 and treated adult patients, and we were taught about
6 that, and we were instructed about what was going on
7 with those patients, their clinical status, and
8 their response to therapy.
9 Q So you were -- in terms of how you were
10 informed about the treatment of those patients and
11 their responses, could you tell me the context in
12 which you were informed of that?
13 A That we were informed that with clinical
14 conference -- case conferences.
15 Q About how many of those?
16 A I recall four specific patients that we
17 learned about in a fair amount of detail at the
18 time. I remember I still have teaching slides from
19 those patients in my teaching slide library. There
20 were, I believe, as many as 12 patients overall in
21 the program during the time that I was there at
22 Johns Hopkins, and those cases were subsequently

1 reviewed and reported in the medical literature.
2 Q And did you provide any input in the
3 treatment of those patients?
4 A I did not.
5 Q Did not?
6 A I did not.
7 Q You say in your report that during your
8 time at Johns Hopkins you had above-average exposure
9 to children with disorders of sexual
10 differentiation; is that right?
11 A That's correct.
12 Q What do you mean by "above-average
13 exposure"?
14 A Well, the endocrine fellowship training
15 programs are essentially all university based, and
16 because Johns Hopkins was the place where steroid
17 biochemistry and physiology and the physiology of
18 sexual differentiation was primarily outlined, the
19 effect of steroid hormones on the development of the
20 fetus, patients were referred there because the
21 faculty were world renowned. And so comparing that
22 to another center in another city, we tended to get

1 more referrals there because of the reputation, if
2 you will, of the clinical faculty.
3 Q So how many children were you exposed to
4 regarding disorders of sexual differentiation?
5 A In the two years of my clinical fellowship
6 I would -- and this is an estimate -- would say
7 somewhere between 50 and 75 patients.
8 Q And did you treat any of those patients?
9 A Yes, I did.
10 Q How many of them did you treat?
11 A I would say almost all those patients that
12 I told you about are patients that I actually
13 treated or was involved in the treatment. There
14 were -- as a fellow you share the treatment
15 experience with other training fellows. Because of
16 the numbers of patients we all got to see most of
17 these very interesting patients.
18 Q Now, all of these patients were children
19 with DSDs, not transsexualism, gender identity
20 disorder or gender dysphoria; is that right?
21 A That's correct.
22 MR. CORRIGAN: What's a DSD?

1 THE WITNESS: Disorder of sexual
2 differentiation.
3 MR. CORRIGAN: Sorry.
4 BY MR. BLOCK:
5 Q The fellowship ended in 1980; is that
6 right?
7 A That is correct.
8 Q Have you had any training in psychiatry?
9 A No, I have not, other than its implication
10 and recognition of mental health disorders in the
11 general pediatric population and how mental health
12 issues are related to endocrine diseases, but not
13 specifically in the active treatment with
14 medication.
15 Q Have you had any training in psychology?
16 A As part of our pediatric residency
17 program, we were exposed to courses and information
18 on pediatric mental health issues with psychiatry
19 faculty, psychology faculty. In my Navy career of
20 20 years in the hospitals where I was stationed,
21 there were clinical psychologists on the faculty
22 that regularly integrated their work with the

1 endocrine population of patients, most notably the
2 diabetic patients.
3 Q But you did not personally receive any
4 training; is that right?
5 A I received training; I just did not have a
6 certification as a mental healthcare provider.
7 Q Would you feel qualified to appear as an
8 expert witness regarding psychology or psychiatry
9 for a condition other than gender dysphoria?
10 MR. CORRIGAN: Object to form.
11 Go ahead.
12 A No.
13 BY MR. BLOCK:
14 Q Have you done any scientific research
15 related to transsexualism, gender dysphoria or
16 gender identity disorder?
17 A I have not.
18 Q Have you done any scientific research
19 related to transgender people?
20 A I have not.
21 Q Have you done any scientific research
22 related to gender identity issues at all?

1 A I have not done any research, I have just
2 reviewed the literature.
3 Q Have you published any articles or books
4 addressing transsexualism, gender identity disorder
5 or gender dysphoria?
6 A Our letter in regard to the Endocrine
7 Society guidelines was just published in this
8 month's edition of the Journal of Clinical
9 Endocrinology and Metabolism, so that is published
10 in a peer-reviewed journal. I have submitted for
11 publication an article about the potential pathways
12 of treatment for transgenderism; do not know the
13 status of that acceptance.
14 Q Tell me the -- what you're referencing as
15 something published in the Journal of Endocrine and
16 Metabolism, that was a letter to the editor; is that
17 right?
18 A That's correct.
19 Q Is it your understanding that letters to
20 the editor are peer reviewed?
21 A They are.
22 Q And are letters to the editor based on

1 independent research?
2 A Letters to the editor are very
3 specifically required to have a number of
4 references, and they're reviewed before publication.
5 Q But my question is about research like
6 your independent research. The letter to the editor
7 wasn't based on that, right?
8 A No, this was not based on a research
9 study.
10 Q What is the nature of the peer review for
11 letters to the editor?
12 A The letters to the editor, as I
13 understand, are reviewed by peers for accuracy,
14 appropriateness of references, and content, and then
15 they are recommended for publication or not.
16 Q And the second publication you referenced
17 regarding -- was it pathways of treatment for gender
18 dysphoria?
19 A Yes.
20 Q What was the name of it? What was the
21 name of that article again?
22 A It's a commentary article bringing

1 transparency to treatment of transgender persons.
2 Q And where did you submit that article for
3 publication?
4 A It has just been submitted to a journal
5 that I do not recall the name of, I'm embarrassed to
6 say. It just was finished last week and sent to the
7 person who was to get it to the publication for
8 review. There was evidently a possibility of
9 several journals, and if it is not accepted or
10 reviewed appropriately, it will be sent to another
11 journal.
12 Q Is the journal that you submitted it to a
13 peer-reviewed journal?
14 A Yes, it is.
15 Q Is the journal called The New Atlantis?
16 A No.
17 Q Is it a journal that specializes in
18 endocrinology?
19 A I do not believe it is.
20 Q Is it the Journal -- what's the subject
21 matter of the publications in general?
22 A I don't want to misspeak, so I might -- I

1 think I have an idea of the name of the journal
2 called Issues in Law and Medicine.
3 Q Do you know who publishes it?
4 A I do not.
5 Q I'm sorry, did you answer? I couldn't
6 hear.
7 A I do not know.
8 Q So other than the letter to the editor, do
9 any of your publications listed on your CV address
10 transsexualism, gender dysphoria, gender identity
11 disorder or related issues?
12 A They do not.
13 Q Have you given any presentations about
14 gender dysphoria, gender identity disorder or
15 transgender issues?
16 A I have.
17 Q How many?
18 A 11 or 12.
19 Q And are any of those presentations listed
20 on your CV at all?
21 A I do not believe they are.
22 Q Why not?

1 A I didn't think about putting them on, and
2 most of them are in the past year, and I
3 specifically did not think about putting them on the
4 CV, not for any reason other than I was focusing on
5 publications more than anything else. There are a
6 list of presentations given on general endocrine
7 subjects in the past. If you need specifics of
8 those, I can provide that, I just didn't put it on
9 the CV.
10 Q So where -- in what context did you give
11 these presentations about transgender issues?
12 A I gave a series of lectures in Australia
13 on behalf of the Australian Family Association, I
14 gave a presentation at the International Federation
15 of Therapeutic Choice, I gave a presentation to the
16 Matthew Bulfin Conference -- joint conference at the
17 American College of Pediatricians, I gave -- and I'm
18 giving another one to this -- the same group this
19 year in early April, and I've given a talk on
20 transgender medicine in the Southern Pediatric
21 Endocrine Society meeting on two occasions.
22 Q Tell me about this -- the Southern

1 Pediatric Endocrine Society meeting. What sort of
2 meeting is that?
3 A It is -- it's a regional meeting of
4 pediatric endocrinologists which occurs -- has been
5 occurring annually. We had a year off last year.
6 It involves pediatric endocrinologists in Kentucky,
7 Tennessee, Virginia, South Carolina, North Carolina,
8 Georgia, Florida, Alabama, and Mississippi.
9 So they're inviting -- the invitation is
10 to pediatric endocrinologists in those areas to come
11 together and do a -- either a planning session or
12 case presentations.
13 Q When did you give your presentation?
14 A The first presentation was in 2016. The
15 most recent presentation was last month in Orlando,
16 Florida.
17 Q Do you have copies of your presentations?
18 A I do.
19 Q Is it easy for you to provide copies
20 without that being burdensome?
21 A They're PowerPoint presentations. I could
22 present --

1 THE WITNESS: I could give them to you.
2 MR. CORRIGAN: Okay.
3 MR. BLOCK: We'll follow up with counsel
4 about that.
5 BY MR. BLOCK:
6 Q So looking at the other organizations, I
7 want to make sure I have the list, so you have --
8 you gave presentations to the Australian Family
9 Association. Is that a medical organization?
10 A It is -- no, it's not.
11 Q And you gave a presentation at the
12 International Association of Therapeutic Choice; is
13 that correct?
14 A That's correct.
15 Q What is the International Association of
16 Therapeutic Choice?
17 A It's a consortium of mental health
18 providers around the world, so it's primarily based
19 on, again, mental health issues.
20 Q Is it fair to say that it's an
21 organization that supports the option of patients
22 seeking therapies to change their sexual

1 orientation?
2 MR. CORRIGAN: Object to form.
3 Go ahead.
4 A It's an organization that asks for ability
5 to provide counseling that the patients request.
6 BY MR. BLOCK:
7 Q To change their sexual orientation?
8 A That is often an outcome, but it's not the
9 goal.
10 Q And does the organization also support the
11 ability of patients to seek therapies that change
12 their gender identity?
13 A Again, it is at the beginning of this
14 subject, so they have no particular guidelines other
15 than those that are recommended by the American
16 Psychological Association, which they use as a
17 reference for standards of care for treatment.
18 Q What's your understanding of the American
19 Psychological Association's position on therapy to
20 change a person's sexual orientation or gender
21 identity?
22 A The concept of the idea is that there is

1 fluidity in both circumstances, and that's -- that
2 is their statement specifically, that there is
3 fluidity. It doesn't recommend, as I understand,
4 anything that should or should not be done, other
5 than things that are proven to be harmful.
6 Q Is there anything that this association
7 focuses on besides sexual orientation or gender
8 identity?
9 A I do not know.
10 Q So not that you're aware of?
11 A Not that I'm aware of.
12 Q The next organization you referenced
13 sounded like you said Matthew Bulfin. Am I hearing
14 that correctly?
15 A It's Matthew B-U-L-F-I-N.
16 Q And what's that?
17 A It's a conference that's given every other
18 year, I believe, and it involves issues of bioethics
19 in medicine.
20 Q Is that conference religiously affiliated?
21 A No, it is not.
22 Q What organization is the conference

1 affiliated with?
2 A It's affiliated with the American College
3 of Pediatricians and the American Association of
4 Pro-Life Obstetrics and Gynecology.
5 Q So are there any other organizations that
6 you gave conference presentations to other than the
7 ones that we've discussed?
8 A I gave a presentation on the history of
9 transgender medicine to the Teens for Truth
10 conference in I believe it was Houston, Texas, in
11 February of 2017, I believe. That could be a guess.
12 I don't want to state that on the record.
13 Q What is Teens for Truth?
14 A It was a conference for teens to come
15 together and learn about issues of human sexuality.
16 Q But what specifically were they learning?
17 A Things -- cases were presented to them by
18 individuals who had experienced certain issues in
19 their lives that they wished to let the teens know
20 that they needed to be open about these issues,
21 discuss them with their parents, discuss them with a
22 therapist, and hopefully resolve their depression

1 and anxiety.
2 Q So is this -- the presenters are people
3 who said that they formerly identified as being gay
4 or transgender, and that they no longer do so?
5 A There was no case of transgender in that
6 particular conference. There was a focus on the
7 family and adverse childhood events, so to
8 essentially get the kids to open up about things
9 that had happened in their lives and be able to have
10 a vehicle to bring those things up to their parents
11 or healthcare providers.
12 Q So the "truth" referenced in Teens for
13 Truth is that someone who struggled with same-sex
14 attraction could have treatment that makes them not
15 be gay; is that right?
16 A No.
17 MR. CORRIGAN: Object to the form of the
18 question.
19 Go ahead.
20 A The answer is no. It was essentially
21 aimed at trying to get kids to open up about the
22 truth of what was going on in their lives that

1 brought them to the point of depression or suicide
2 or severe anxiety.
3 BY MR. BLOCK:
4 Q But all of these children, their -- their
5 depression or other anxiety was related also to
6 same-sex attraction; is that right?
7 A Not all.
8 Q Many?
9 A Some.
10 Q So the conference had nothing to do with
11 overcoming same-sex attraction?
12 A That was a subject that was discussed.
13 Q What other subjects were discussed?
14 A As I recall, concept of sexual abuse was a
15 major topic, coming out from under the concept of
16 sexual abuse; stories of patients who had
17 experienced rape and how that affected their life,
18 and being able to come out whole on the other side
19 of those kind of issues; children who had grown up
20 in families where there was enormous amount of
21 psychological and behavioral malfunction of parents
22 in raising the child, a lot of it that had to do

1 with sexual activity and sexual abuse and trying to
2 bring this to the forefront as a reason to seek
3 therapy and to be healed. And the healing had to do
4 with resolution of depression and anxiety,
5 specifically.
6 Q Did it have anything to do with lessening
7 same-sex attraction?
8 A If that was -- if that was something that
9 happened, it was not -- it was not shunned as an
10 option, but the option was not specifically to focus
11 on that as the only -- only outcome, it was more on
12 trying to get these children to be able to be
13 functional kids in their lives. If part of the
14 resolution was that they changed their sexual
15 attraction to any degree at all, that was what was
16 viewed as an outcome, but the outcome was primarily
17 to avoid depression and suicide.
18 Q So what's your understanding of what the
19 name of the organization references with respect to
20 truth?
21 A The organization, I think, chose the title
22 to be able to allow kids to discuss things with

1 their parents, and to discuss things that were very
2 difficult that otherwise would be buried.
3 Q You're a pediatric endocrinologist,
4 correct?
5 A That's correct.
6 Q You have a private practice?
7 A I do.
8 Q What's the age range of your patients?
9 A From birth to completion of their first
10 undergraduate college degree.
11 Q Have you ever been sued for medical
12 malpractice?
13 A I have.
14 Q Have you ever treated or evaluated
15 patients with gender dysphoria, gender identity
16 disorder or gender discordance?
17 A I have.
18 Q How many?
19 A Within the past two years, I have about 12
20 patients, active patients. I had one patient in
21 1993 when I came to the Atlanta area. And a family
22 moved from Southern California -- it was a military

1 family, and they moved often, and they brought their
2 child in to ask me if I would provide estrogen
3 therapy for that child, who had been evaluated by a
4 psychiatrist in the Los Angeles area, and the
5 parents were advised that upon the next move that
6 that child should be allowed to assume the identity
7 of a female.
8 When the child came to see me, the patient
9 was 13 years old, had a female name and pronouns,
10 and dressed as a female. The school board of the
11 county asked me to help them develop a policy for
12 that child to be able to -- to have physical
13 education at a time of day when the child could go
14 home from school and not have to worry about sharing
15 locker facilities that did not match the biologic
16 sex. Fayette County School Board here in the
17 Atlanta area allowed the child access to a unisex
18 bathroom in the school. So I helped them develop a
19 policy for that child.
20 At that particular time I canvassed all of
21 my mentors across the country to ask them how to
22 handle the estrogen therapy, because there was no

1 appropriate FDA indication to treat such a child,
2 and there had been no standards of care set up for
3 that.
4 They advised me that they had no
5 experience in this field subsequent to the closure
6 of the clinic at Johns Hopkins -- no, there were no
7 recommendations professionally by any professional
8 societies in the United States, and so they
9 suggested that I use our practice attorneys to draw
10 up an informed consent for the parents to sign
11 indicating that they were choosing to have their
12 child treated with estrogen at their request, even
13 though we did not know about the potential adverse
14 outcomes that might happen over the long run.
15 I treated that child for six months, and
16 the family then moved out of the geographic region,
17 and I have no idea what happened to that child after
18 that.
19 So that was my very first case of a
20 transgender patient in my clinic, and there was no
21 reference source of standards of care or clinical
22 experience that I could find across the United

1 States at the time.
2 Q This was in 1993, you said?
3 A Yes.
4 Q So that was the first transgender patient
5 since your fellowship; is that correct?
6 A That's correct.
7 Q So when's the next time you treated a
8 transgender patient?
9 A Approximately two years ago I began
10 receiving referrals for transgender patients to my
11 private practice office.
12 Q And so this was after you filed your
13 declaration in Carcano versus McCorey?
14 A I might be off on the date. It might be
15 that as of three years ago I started seeing
16 transgender patients. It's in the past two years
17 that the numbers have increased.
18 Q Did these patients all come to you after
19 the American College of Pediatricians had published
20 statements disagreeing with providing hormone
21 therapy to transgender youth?
22 A They did.

1 Q And so what sort of treatment do these
2 people that come to you ask for?
3 A They ask for anything from hormone therapy
4 to -- hormone therapy specifically, because that's
5 in the purview of endocrinology.
6 Q In what context are these patients
7 referred to you?
8 A It's usually a self-referral.
9 Q Are they familiar with your position on
10 the American College of Pediatricians?
11 A None have stated so.
12 Q So what treatment do you provide these
13 people?
14 A I evaluate their history, I evaluate their
15 physical condition, their status in puberty, I
16 review the -- in depth the family and social
17 history, and then I request the ability to be able
18 to talk to their counselors who have evaluated them
19 in the first place. If they have not done so, I
20 refer them to a general counselor in their area to
21 evaluate the undercurrent emotional issues.
22 Q And then after that, what do you do? Do

1 you provide any treatment to them?
2 A I do not provide any hormone treatment.
3 Q So why make them go through this
4 evaluation if you don't provide that treatment?
5 A Because that treatment is harmful. It's
6 proven to be harmful. The vast majority of
7 scientific literature looks at the side effects
8 short-term and long-term, and mostly long-term, and
9 indicates that there is potential damage.
10 So I explain to the parents that I am very
11 much caring and compassionate for this child, and I
12 will do everything I can to help them through and be
13 sure that they have the appropriate evaluation of
14 their mental health issues that are brewing beneath
15 the surface. And I would say without question every
16 single patient that has come in has significant
17 emotional health history issues.
18 Q So you're not actually providing any
19 treatment to the patients yourself; is that right?
20 A I am not providing hormone therapy. I am
21 providing them information on what hormones do; I
22 explain the physiology of hormones; I explain the

1 history of treatment and the options that are --
2 that they read about; I discover from them, by
3 interview, what they have learned and what sources
4 they have used to learn that information.
5 Q So but you don't treat them?
6 MR. CORRIGAN: Object to form.
7 A That in my -- I'm not giving them
8 hormones, but I am treating them in the sense of
9 evaluation and continued contact to be sure that
10 their needs are being met in terms of emotional
11 evaluation.
12 BY MR. BLOCK:
13 Q What continued contact do you have with
14 them?
15 A I see them every three months.
16 Q What diagnostic code do you use to bill it
17 to insurance?
18 A There is -- there is a code for
19 transgenderism.
20 Q So you use the diagnostic code for
21 treating transgenderism for follow-up appointments
22 with patients after you tell them that you don't

1 provide hormone therapy?
2 A Well, I code out the physical exam, the
3 evaluation and the history on the initial exam, and
4 then I code out subsequent counseling appointments
5 where it's essentially a conference appointment. If
6 it requires an evaluation of their physical
7 condition and their stage of progression in puberty,
8 that is coded as a physical exam.
9 Q How many counseling appointments do you
10 have with a typical patient?
11 A Again, these particular patients are seen
12 every three months.
13 Q But how many times?
14 A Ongoing as far as possible.
15 Q I guess I'm confused about what the
16 check-in would be, like, for the second time.
17 A The check-in is to ask what they
18 understand. It is a very complex issue to deal
19 with. Particularly in the younger children, I find
20 that many things that we have -- I have interviewed
21 them and found information about from them as
22 individuals, both in private interview with them,

1 and also with their parents, is that they, many
2 times because of their age, do not understand a lot
3 of what we talked about and a lot of the information
4 we gathered previously.
5 So it is very important, based on the
6 maturity of the patient and their understanding, to
7 be able to go back and make sure they are on the
8 same page with me in terms of what I know they know,
9 and what I have taught them, and what I have
10 suggested for them, and how their counseling is
11 going.
12 Q And so you need to have -- so you need to
13 have, like, a third or fourth or a fifth check-in
14 for that purpose?
15 A I do not want these patients to be lost,
16 okay? That's the problem. If they're lost to care,
17 then I have not done my job to my best ability. So
18 it's like any condition where you are constantly in
19 touch with the patient, such as a patient with
20 obesity. You keep in touch with them, you bring
21 them back, you see what's going on with all of the
22 issues, school performance, et cetera, et cetera.

1 It's a complex review of history and any physical
2 changes, and I demonstrate to them the depth to
3 which I am trying to keep them in the fold and make
4 sure that their needs are being met appropriately.
5 Q By your phrase "keeping them in the fold,"
6 do you mean making sure that they're not receiving
7 gender-affirming hormone therapy?
8 A I wouldn't be providing that, so if they
9 share that with me, I would assume they're not --
10 that's not something that I can continue or
11 recommend for them, so I would probably part ways at
12 that point in time and say, you know, you have a
13 choice to come here, or you have a choice to go
14 someplace else. I've done to my best ability all I
15 can to help you. My door is open, you can call 24/7
16 and request to be in touch with me through my
17 practice, and I will be available to help you with
18 anything that I can.
19 Q Do you have any qualifications as a mental
20 health counselor?
21 A I do not.
22 Q And would you describe your meetings with

1 these patients as involving mental health
2 counseling?
3 A Not mental health counseling, but
4 evaluation of where they stand and how they are
5 doing both physically and emotionally because as an
6 endocrinologist we deal with depression and anxiety
7 in patients very frequently with chronic, nonfatal
8 illness.
9 Q Do you ever refer the patients to mental
10 health counselors?
11 A I do.
12 Q Which ones?
13 A Ones that are covered by their insurance.
14 Q Is there any -- is there any specific
15 counselors that you generally try to refer people
16 to, assuming that they're covered by insurance?
17 A I try to hook them up with a personality
18 that I believe would be a good fit in terms of the
19 child's level of comfort. Most often, adolescent
20 males I refer to male counselors, adolescent females
21 to female counselors.
22 Q And Allan Josephson, is he one of the

1 counselors you refer people to?
2 A I don't recognize that name.
3 Q Do you make sure that the counselor that
4 you're referring people to share your views about
5 the dangers of gender-affirming therapy?
6 A Not often. I basically try to find
7 somebody who is a general counselor who understands
8 anxiety and depression and who will delve into the
9 adverse childhood events which lie beneath the
10 surface.
11 Q Do you have a preference for referring
12 people to counselors who are members of the American
13 College of Pediatricians?
14 A They're -- no, I do not because there are
15 not very many members of the American College.
16 American College members, full members are
17 pediatricians, Board-certified pediatricians. There
18 are some ancillary associate members in fields of
19 surgery and mental health who have aligned
20 themselves with the College as being interested in
21 helping and aligning themselves with our guidelines,
22 but those are people from across -- they're not in

1 my geographic region.
2 Q Do you have a preference for referring
3 people to counselors who are members of the
4 Christian Medical and Dental Association?
5 A I do not.
6 Q Is that a no? Sorry, I didn't hear.
7 A That's a no.
8 Q Are you familiar with the Christian
9 Medical and Dental Association?
10 A I am.
11 Q Are you a member?
12 A I am not.
13 Q In your practice, your private practice,
14 do you treat children with DSDs?
15 A I do.
16 Q How many?
17 A I have, perhaps, four active patients who
18 qualify as having disorder -- no, I have six
19 patients who I follow currently.
20 Q Over the course of your career, on average
21 how many patients a year would you say you have with
22 DSDs?

1 A With DSDs? The six patients I mentioned
2 are patients that are in the practice that are
3 geographically in the Atlanta metro area or within
4 the state where we're the closest -- we are a
5 conveniently located practice. So the number is
6 fairly stable.
7 These are really rare kids. Those that
8 require any sort of team approach, we are developing
9 a DSD multi-specialty clinic at Emory University
10 locally where they can get essentially local care
11 for any urologic or gynecologic types of surgeries,
12 and so it's a newly developing entity we have put
13 together in the Atlanta metro area. It is brand
14 new.
15 Before that the cases were rare enough
16 that if -- I would refer back to Johns Hopkins a
17 number of the patients over the years I practiced in
18 Atlanta who required any surgical intervention.
19 MR. CORRIGAN: What do you think about a
20 break?
21 MR. BLOCK: We can -- that's okay, we can
22 do that. Five minutes?

1 MR. CORRIGAN: Sure.
2 THE WITNESS: Good.
3 MR. BLOCK: Okay, great.
4 (Recess 11:17-11:28 a.m.)
5 BY MR. BLOCK:
6 Q So before the break we were talking about
7 your treatment of transgender patients or patients
8 with gender dysphoria, and I just want to make sure
9 I have an understanding of the facts.
10 So from the date of your end of your
11 fellowship, the next time you treated someone with
12 gender dysphoria or gender identity disorder was in
13 1993; is that correct?
14 A That is correct.
15 Q And then since 1993, you haven't treated
16 any other transgender children until a couple of
17 years ago; is that correct?
18 A That is correct.
19 Q And by "couple of years," that means two
20 or three years?
21 A Yes.
22 Q And what is the total number of patients

1 with gender dysphoria that you've treated during
2 that time period?
3 A 12.
4 Q 12 total.
5 Are all 12 of them -- 12 of them currently
6 active patients?
7 A Let me think for a minute. I think one --
8 one patient has left the geographic area.
9 Q So you're currently seeing 11?
10 A I included the -- well, 11 is fine, yes.
11 Q Okay. And what is the longest that one of
12 these active patients has been seeing you for?
13 A Three years.
14 Q And how many appointments would you say
15 you've had with that patient over the course of
16 three years?
17 A That one has had six -- six visits.
18 Q And does that patient -- does that patient
19 expect to have more visits in the future?
20 A The visits tapered off. The patient is
21 primarily managed by the mental health provider.
22 Q When is the last time you've seen that

1 patient?
2 A About six months ago.
3 Q And how old is the patient?
4 A The patient would now be around 15.
5 Q And has the patient, to the best of your
6 knowledge, received any gender-affirming therapy?
7 A No.
8 Q Have any of your patients, to the best of
9 your knowledge, received gender-affirming therapy?
10 A I do not know of any who have.
11 Q Have any of the patients that you've seen
12 for transgender issues socially transitioned?
13 A Some were socially transitioned as they
14 presented. One is still socially transitioned. The
15 others have essentially stopped the social
16 transition.
17 Q But they had started the social transition
18 before seeing you, and after they saw you they
19 stopped?
20 A That's correct.
21 Q And would you say that you encouraged them
22 to stop social transition?

1 A Their mental health therapist made that --
2 helped them guide them toward that advice. I
3 specifically -- again, my role is to explain what
4 the options are and what I know about complications,
5 and I do not -- I do not force the patient to take
6 any particular route other than to stick with the
7 therapist. I'm very, very insistent on the fact
8 that they maintain their contact with the therapist.
9 And if the therapist ends up not being a good fit
10 not -- for any other reason other than they don't
11 get along, I find a new therapist.
12 I'm in a role, if you will, of sort of a
13 subset of primary care in that -- in the world of
14 transgender in that I am taking the responsibility
15 of making sure that the therapy is continuing, and
16 the patient is not lost to follow-up.
17 Q And when the patients come to you in the
18 first instance, how many of these 12 had therapists
19 that had already treated them and recommended that
20 they see an endocrinologist?
21 A It's an estimate of about half of them
22 were already seen by a therapist.

1 Q And half weren't?
2 A And half were not.
3 Q So the half that were already seen by the
4 therapist, how many of them did you encourage to
5 find a different therapist?
6 A All of them.
7 Q All of them?
8 A Yes.
9 Q And why did you encourage them to have a
10 different therapist?
11 A Because it was my sense that the therapist
12 that they were seeing was not dealing at all with
13 the basic issues that I could glean, was not paying
14 attention to the undercurrent depression and
15 anxiety.
16 Q And you saw yourself as being able to
17 diagnose that more than their therapist that they
18 had before seeing you?
19 A The patients gave the history of what they
20 were -- what the sessions were about, the parents
21 gave the history of their input and what was told to
22 them by the therapist, and it did not include any

1 treatment for depression or anxiety, it did not
2 include any evaluation in depth of what the parents
3 shared with me.
4 So in those cases I felt that it seemed
5 that they were being superficial and not actually
6 paying attention to the undercurrent mental health
7 issues, and so instead of trying to treat those
8 mental health issues and evaluate them in depth, I
9 referred them to somebody who could do a better job.
10 Q And that was your opinion for all of the
11 patients that you saw that had already been seeing a
12 therapist; is that right?
13 A That is correct.
14 Q So when you encouraged them to see a
15 different therapist, did you -- what was the
16 explanation you gave them for why you were
17 encouraging them to see a different therapist?
18 A Because I felt that their emotional health
19 history had not been adequately evaluated by
20 feedback given to me by either the patient or the
21 parents or both.
22 Q So the therapists that they were referred

1 to, did you have any prior knowledge of those
2 therapists' opinions with respect to treatment for
3 gender dysphoria?
4 A In one case I did.
5 Q And what was your knowledge of those
6 opinions?
7 A This particular individual essentially
8 said that they had had a good deal of clinical
9 experience, that they would not necessarily have an
10 agenda set ahead, but they wanted my -- they wanted
11 me to know that they might possibly suggest
12 affirmation therapy.
13 Q And you referred that patient to that
14 therapist?
15 A I did.
16 Q What are the age ranges of these patients
17 when they come to you?
18 A I have had a patient as young as six, and
19 patients as old as 17.
20 Q So in what context -- half of the patients
21 had not been seeing a therapist, so how do they come
22 to be in your office in that case?

1 A The parents either sought out an
2 endocrinologist and found me because I was on their
3 insurance plan, or they were referred by their
4 pediatrician.
5 Q Did any -- to the best of your knowledge,
6 any of the patients that came to you know in advance
7 of your opinions with regard to gender-affirming
8 therapy?
9 A I do not know.
10 Q Do you know if their parents knew?
11 A I do not know.
12 Q Did any of them come to you with -- did
13 all of them come to you seeking gender-affirming
14 therapy, or did any of them come to you to talk
15 someone out of seeking gender-affirming therapy?
16 MR. CORRIGAN: Object to the form of the
17 question.
18 Go ahead.
19 A All of them came to me with concern that
20 there were issues of gender incongruence to some
21 degree.
22 They asked what kinds of services I

1 provide, and I tell them that I provide an in-depth
2 evaluation of their physical condition, and a review
3 in depth of their family and social history with
4 siblings and adults in their lives, and that I am
5 fairly up front as I get to the end of my evaluation
6 to say that I do not provide hormone treatment
7 therapy, but that I do recommend before they go
8 anywhere that they seek out a very thorough,
9 in-depth evaluation of their mental health.
10 BY MR. BLOCK:
11 Q So to the best of your knowledge, none of
12 the parents of the patients knew in advance that you
13 would not be providing transition-related care?
14 A I did not know, and I did not ask.
15 Q So you had said that there was one
16 situation where you knew in advance the therapist's
17 views on gender-affirming care before you made the
18 referral, but for the other 11 therapists that you
19 referred people to, you didn't know their views in
20 advance?
21 A The one that I referred to was the very
22 first case that I asked among my mental health

1 practitioners in the Atlanta area who had referred
2 to me and I had referred to them in my medical
3 history of treating patients in Atlanta, and the one
4 psychiatrist, one child psychiatrist that I had the
5 most referrals from and who I referred to very often
6 suggested that this person was the counselor who had
7 the most clinical experience, and he knew her
8 personally and thought that she unquestionably would
9 review everything with an open mind, and that I
10 should consider talking with her, which I did, and I
11 found out that she -- the insurance that she accepts
12 is very limited, so it ends up not being possible
13 for the parents to get to her very often as a result
14 of that.
15 In the meantime, I began talking to the
16 other providers and asking them if they would help
17 me with evaluations of kids that came to me with
18 transgender issues in regard specifically to going
19 in and looking at the review of adverse childhood
20 events and family dynamics that would set up
21 depression and anxiety that needed to be evaluated,
22 and that's the depth of what I know about.

1 Many of these people say they had no
2 specific training in transgender issues, but I said,
3 that's not what I'm asking you to do. I'm asking
4 you to evaluate the undercurrent pathology,
5 emotional pathology that exists that I sense is
6 going on based on my clinical experience with these
7 patients, clinical literature which says that that's
8 the issue, and that I would like to have them
9 evaluated, and I've not had any pushback with those
10 practitioners.
11 Q So you've -- with the one exception of
12 this therapist that doesn't take a lot of insurance,
13 the other therapists you've referred people to don't
14 have any experience treating transgender
15 individuals?
16 A I don't know. They do have experience in
17 treating mental health in general, and this is a
18 mental health issue.
19 Q Right. But for transgender individuals,
20 they don't have any experience specifically with
21 respect to that; is that correct?
22 A I do not know.

1 Q And when you provide -- when you have a
2 conversation with the therapist that you're
3 referring them to, do you disclose that you do not
4 provide gender-affirming care in your practice?
5 A I do.
6 Q So -- and do they -- how do they respond
7 once you disclose that?
8 A They respond that they're very interested
9 in evaluating the patient, and they will provide
10 that service.
11 Q Have any therapists declined?
12 A I had one therapist who said that they
13 were not comfortable with the idea of treating
14 transgender patients; that they would prefer not to.
15 Q And did you have any prior knowledge
16 whether any of these therapists provided counseling
17 to people struggling with same-sex attraction?
18 A I do not.
19 Q Did any of the therapists that you talked
20 to indicate in advance that they agreed with your
21 views with respect to not providing gender-affirming
22 therapy?

1 A They respect the fact that I practice as I
2 do, and they would evaluate the patient, and if they
3 were unsuccessful with their endeavors would be
4 open-minded to recommend, if necessary, other places
5 to go to treat.
6 Q What do you mean by "unsuccessful with
7 their endeavors"?
8 A This is a long-term process of evaluation,
9 which is why these cases are all ongoing. This is
10 therapy that takes a long time to work with the
11 families and the patients to understand all the
12 dynamics. This is experience that's been published
13 by -- primarily by Kenneth Zucker in his extensive
14 work with these families.
15 It is not an easy problem to solve. It
16 takes a lot of attention and time. And so if at the
17 end of -- if they're not successful with getting
18 this child to improve their mental health, they're
19 going to try to find somebody else who can do that
20 for them if they're not -- if it's not working for
21 them.
22 Q So success would be defined as improving

1 mental health without having any gender-affirming
2 therapy?
3 A I think because of the fact they know I do
4 not provide gender-affirming therapy, that they
5 would let me know if the issue was beyond their area
6 of expertise and success, and they would refer to
7 somebody else.
8 Q So the only therapy that they personally
9 would be able to provide would be to address mental
10 health issues without providing gender-affirming
11 therapy, and if -- but they would not themselves as
12 part of their treatment be providing any
13 gender-affirming therapy, that wasn't an option for
14 what they would personally be providing?
15 A I don't know what they provide. I just
16 know that I refer to them to evaluate the
17 undercurrent issues, and that's where my focus is.
18 I think that they would rather -- well, I can't
19 speak for what they do.
20 Q Did you refer these patients just for
21 evaluation?
22 A Evaluation and treatment.

1 Q So to provide ongoing therapy also?
2 A Yes.
3 Q And if the -- and the therapists report
4 back to you on the state of their treatment?
5 A They do.
6 Q And for the patients, how many of the
7 patients would you view as having improved
8 psychologically?
9 A It's a process in the work. I would say
10 two patients of those have resolved their issues
11 successfully and moved on, and the rest are works in
12 progress.
13 Q So of the 12, two you would say have
14 successfully resolved their issues?
15 A Yes.
16 Q And how do you determine that; how do you
17 know that they've successfully resolved their
18 issues?
19 A Feedback from the therapist, and the
20 patient's own description of how they feel, and the
21 fact that their gender incongruence has resolved.
22 Q I'm sorry, are you still speaking?

1 A Yes. No, no, I finished. I said that --
2 Q Okay.
3 A -- the way I know is input from the
4 therapist, and also input from the patients
5 themselves in terms of what they describe of no
6 longer being -- feeling that they are born into the
7 wrong body.
8 Q How old were these two patients?
9 A One was 15, and one was 17.
10 Q You referenced Kenneth Zucker; is that
11 right?
12 A Yes.
13 Q Who is Kenneth Zucker?
14 A He is a Ph.D. psychologist from Toronto
15 who established a clinic for evaluation of children
16 with transgender issues. He coined the term "gender
17 identity disorder." I believe he's a member of the
18 World Professional Association of Transgender
19 Health. He is widely published, widely respected
20 for his opinions on evaluation and treatment with
21 mental health -- providing mental healthcare.
22 Q You would view him as an expert in the

1 field; is that right?
2 A Yes.
3 Q And you would view his therapy as being in
4 accordance with proper standards of care for
5 treating transgender youth; is that right?
6 A That is correct.
7 Q And you said he's a member of WPATH; is
8 that right?
9 A I believe he is. I don't know of the
10 status of that membership. I know he has been in
11 the past.
12 Q Are you aware of Dr. Zucker's views on the
13 appropriateness of hormone therapy for transgender
14 youth whose dysphoria persists through adolescence?
15 A I believe he indicates that as an adult
16 that those patients could be considered for therapy.
17 If their lifelong evaluation and therapy did not
18 bring about desistance of their gender incongruence,
19 that hormone therapy could be appropriate.
20 Q I want to just make sure we're talking
21 about terms like "adults," when we use that term.
22 My -- so my question is people whose gender

1 dysphoria persists through adolescence, not
2 necessarily legal age of majority in a given
3 country, is it your understanding -- what's your
4 understanding of his views in providing hormone
5 therapy for people whose dysphoria persists through
6 adolescence?
7 MR. CORRIGAN: Object to form of the
8 question.
9 Go ahead.
10 A My understanding is that if with
11 consistent therapy there is persistence of gender
12 incongruence, that those specific patients, and
13 there are a very small percentage of them -- it
14 might be warranted for them to be considered for
15 hormone therapy.
16 BY MR. BLOCK:
17 Q And do you think someone providing hormone
18 therapy to those patients is engaging in child
19 abuse?
20 A If they are treating a child, I would say
21 that that is essentially treating the patient and
22 causing harm. Whether I specifically use the term

1 "child abuse," it is known to have inappropriate
2 long-term effects, it is not evaluating -- it's not
3 paying attention to the core issue, it is preventing
4 that child from being able to make it through
5 natural puberty with their natal hormones to allow
6 them to resolve these issues through counseling and
7 personal experience of living in the biologic body
8 unaltered by opposite hormone therapy.
9 So it is -- I would say it is
10 inappropriate to do that.
11 Q So my question isn't about people who have
12 not yet come through puberty. My question is about
13 people whose dysphoria persist through puberty. So,
14 for example, someone who is 16 years old and falls
15 within that small category of people we referred to
16 earlier about for whom Dr. Zucker thinks treatment
17 might be appropriate, do you think it is child abuse
18 to provide that group of teenagers with
19 gender-affirming hormone therapy?
20 A So adolescence goes actually up through
21 age 21, technically. It happens that age of
22 majority sort of falls in the last stages of

1 adolescence in this country. I would think that
2 it's inappropriate for a patient to be treated while
3 they are still going through puberty.
4 Puberty goes up in boys -- the final
5 stages of an average travel through puberty for a
6 boy is 18 and for a girl is 16 and a half, so the
7 hormonal changes that are happening in the process
8 of puberty that is physiologic continues to that
9 point. The development of the brain, however,
10 continues up through age 25.
11 So there are things that are supposed to
12 happen as a result of going through puberty. If it
13 is altered, if it is stopped in any way, if it is
14 then changed with cross-sex hormones, you are
15 throwing into the human body hormones that are
16 incompatible with the physical biologic body, and
17 you are creating harm.
18 So I would say my purview of patients as
19 far as I can make recommendations is up through the
20 age of consent. If they come to me after, as one
21 patient has, I still recommend to them that they
22 consider carefully other options and pay attention

1 to other options instead of doing hormone-affirming
2 and surgical therapy. That's my advice to them at
3 that point in time.
4 Q Dr. Zucker's published research on rates
5 of persistence and desistance of gender dysphoria
6 among children; is that right?
7 A Yes, he has.
8 Q And what's your understanding of what his
9 research shows about the age at which persistence is
10 more likely than desistance?
11 A A persistence occurs at the end of puberty
12 as they have finished going through puberty.
13 Desistance occurs anywhere along the way.
14 Q So it's your understanding of Dr. Zucker's
15 research that rates of desistance remain high until
16 boys reach the age of 21 or girls reach the age of
17 16 or 16 and a half?
18 A No, there is a curve of slower amounts of
19 desistance. The vast majority of patients who are
20 allowed to go through natural puberty desist.
21 Q Yes, but for people who continue to have
22 gender dysphoria once they start going through

1 puberty, are you familiar with the rates of
2 desistance for that group of people?
3 A That group of people if left alone desist.
4 It's a smaller percentage as they get older and
5 farther along in puberty, but blocking puberty is
6 not an appropriate thing to do because it's not
7 physiologic.
8 So the desistance rates from his published
9 work show that there are -- as you got older and
10 older the desistance rate lessened, but that in the
11 group of all the patients, including those who
12 entered puberty, that desistance was remarkably
13 high.
14 Puberty is a six-and-a-half-year event for
15 a boy and about a five-year event for a girl. Five
16 or six years. And so that is a time spectrum during
17 which if you say if you enter puberty, he's talking
18 about people that have been in puberty, who have
19 been counseled, who have not had affirmation medical
20 therapy, that the majority of those kids desist. A
21 small percentage do not, and his recommendation
22 personally, based on his experience, is those would

1 be patients who would be candidates potentially for
2 hormone therapy.
3 Q And do you know either way about whether
4 he thinks the age where desistance rates are no
5 longer high comes around age 15 or so?
6 A That -- his opinion has changed as far as
7 I know. His first published studies in his paper in
8 2012 indicated older age. I have not had a direct
9 conversation with him but have had opportunity to
10 know his opinions, and he is waffling a little bit
11 on the upper end of that, saying that there are
12 patients in late adolescence versus young adulthood.
13 It's a matter of semantics more than anything else.
14 Q So but you disagree with his view that
15 hormone therapy should be considered for transgender
16 youth whose dysphoria persists until late
17 adolescence; is that right?
18 A Yes, I do. I'm not -- he is not an
19 endocrinologist. I am. I'm aware of the endocrine
20 side effects and the long-term morbidity that's
21 caused by cross-hormone therapy, and I could not
22 recommend it for any adult.

1 But I do not practice adult medicine. I'm
2 a pediatrician. I go up through my age range up
3 through age 21 or 22, and in no circumstance would I
4 recommend cross-hormone therapy personally as an
5 endocrinologist. That's my field of expertise.
6 Q But that's a view that Dr. Zucker does not
7 share?
8 A I don't know about his background in
9 endocrinology and why he makes that recommendation,
10 but -- and I don't know the exact age. I know it
11 was late adolescence because the desistance rates
12 that he published originally and that also come up
13 from studies in Europe show desistance is very, very
14 high.
15 Q I just want a yes-or-no question that
16 Dr. Zucker disagrees with you with respect to
17 providing hormone therapy for people whose gender
18 dysphoria persists until late adolescence.
19 MR. CORRIGAN: Object to form.
20 Go ahead.
21 A I think the term here is -- that we're
22 wrestling with is "late adolescence," what he means

1 by late adolescence, and what I mean by late
2 adolescence, and I don't personally know now what he
3 means by late adolescence. I knew what he published
4 before, and I don't know what his opinion is today.
5 BY MR. BLOCK:
6 Q He thinks hormone therapy could be
7 considered appropriate for some people, and you
8 think hormone therapy is never appropriate for
9 anyone; is that correct?
10 A Would you restate that question?
11 Q Yeah. So he thinks that gender-affirming
12 hormone therapy may be medically appropriate for
13 some people, and you think it is never medically
14 appropriate for anyone; is that right?
15 A That is correct.
16 Q Do you consider yourself to be an expert
17 in gender dysphoria?
18 A I am -- I consider myself an expert in the
19 endocrine management of patients with gender
20 dysphoria.
21 Q When do you think you became an expert?
22 A With experience of treating patients, with

1 experience of background at Johns Hopkins.
2 Essentially -- I consider myself as having more
3 experience than most because of my longevity of
4 clinical experience and training from Johns Hopkins.
5 So it could be argued what is an expert, and I guess
6 you can ask me specifically what you mean.
7 Q Well, at the time that a patient came to
8 you in 1993 seeking treatment, did you at that time
9 consider yourself to be an expert in treating gender
10 dysphoria?
11 A I considered myself having as much
12 clinical experience as anybody I knew, and I
13 verified that by talking to people in the field of
14 endocrinology across the United States and found
15 that what I knew they knew, and we forged together
16 forward with a treatment plan.
17 Q So in 1993, would you have put yourself
18 forward to be an expert witness in a case involving
19 the treatment of transgender individuals?
20 MR. CORRIGAN: Object to the form of the
21 question.
22 Go ahead.

1 A That was not a topic of medical treatment
2 at that time, that was a standard of care. So as
3 much as anybody could be defined as an expert, I
4 would have had as much clinical experience as most
5 people who were defined as experts at the time.
6 BY MR. BLOCK:
7 Q Wouldn't someone who had actually provided
8 hormone therapy to someone be more qualified as an
9 expert in 1993?
10 MR. CORRIGAN: Object to form.
11 Go ahead.
12 A There weren't people at that time that
13 were in the mainstream of medicine that we know of,
14 okay? Children were not treated with hormone
15 therapy that anybody in the field of pediatric
16 endocrinology was aware of at the time that I could
17 find in this country.
18 BY MR. BLOCK:
19 Q But you had not -- at that time you hadn't
20 treated adult transgender people with hormone
21 therapy either; is that right?
22 A No, I was aware and taught extensively

1 about hormone intervention of those adult patients.
2 Q But you hadn't treated them?
3 A I did not treat them specifically. I was
4 taught about the treatment, and the case studies
5 were reviewed as they were ongoing.
6 Q So your view is that once you finished
7 your fellowship in 1980, you had sufficient
8 qualification to be an expert in the treatment of
9 gender dysphoria?
10 A No.
11 Q So at what point did you develop
12 sufficient qualification to be an expert in the
13 treatment of gender dysphoria?
14 A Over the past six to 10 years, since the
15 publication of the guidelines of the Endocrine
16 Society in 2009, specifically, I began the
17 evaluation of the world's literature that I could
18 find and discussions among my endocrine peers to
19 gain as much knowledge as I possibly could, and I
20 was aware of the number of increases in gender
21 transition clinics that were growing and developing
22 in the United States. I was a little bit alarmed

1 about the fact that those clinics were established
2 without anybody who had had any training of any kind
3 in a formal curriculum, and I was worried about the
4 quality of medicine.
5 I began looking at the effects of -- I
6 already knew what we were doing in the field of
7 endocrinology trying to prevent the side effects of
8 opposite hormone effects on the human body as the
9 patients developed through adolescence and young
10 adulthood. Those are disease states for which we
11 had standards of care to treat.
12 So as I began seeing that these guidelines
13 were being implemented, I became concerned and
14 learned more and more and more about what was going
15 on and became then as much of an expert by
16 evaluation of literature; discussion amongst my
17 peers. And then I began treating patients -- these
18 patients as they came to my office as of about three
19 years ago.
20 So that is how I would say that I
21 understand the treatment of transgender patients,
22 the adverse effects of hormone therapy, and -- both

1 short term and long term, and so that's where I
2 would say that I would ask patients to come to see
3 me for the specific reason because of my expertise,
4 evaluation, and concern for those patients.
5 So the word "expert" is hard to nail down.
6 I would say experienced.
7 Q Did you say patients came to you for a
8 specific reason; did I hear that right?
9 MR. CORRIGAN: Object to form.
10 A They come to me because they have an issue
11 of concern about gender incongruence. They know
12 that I'm a endocrinologist, and that's where they're
13 supposed to go to get evaluated to look at their
14 stage of puberty, to find out what resources are
15 available to them.
16 BY MR. BLOCK:
17 Q So I have the time frame right, the first
18 Endocrine Society guidelines on treating trans kids
19 was published in 2009; is that right?
20 A That's correct.
21 Q So you said it was about five or six years
22 after that that you conducted the literature review

1 that has made you an expert in this area; is that
2 right?
3 A No, it was at that time when they were
4 published that I became quite concerned about the
5 recommendations being essentially 180 degrees out of
6 the mainstream of hormone evaluation and hormone
7 treatment effects in children, and so I began in
8 depth at that point in time starting to review the
9 literature and discuss among my peers.
10 Q Beginning around 2009?
11 A Yes.
12 Q If we can turn to your declaration in this
13 case, Exhibit 1, to paragraph 34. If we can look at
14 the second sentence: There has been a flurry of
15 non-peer-reviewed articles in journals and
16 newsletters circulated to general pediatricians that
17 promote the ideology of transgenderism without
18 specific support.
19 What non-peer-reviewed articles are you
20 referring to?
21 A There are articles in what we call
22 throwaway journals. They're called Pediatric

1 Annals, Contemporary Pediatrics, Pediatric News,
2 Endocrinology Today, these are -- Endocrinology
3 Today is aimed at endocrinologists. But these are
4 things that come to physicians' offices free of
5 charge, they're also available online now instead of
6 in the print versions. They are articles written
7 talking about transgender health, talking only
8 affirmation.
9 When they first started being published
10 back in as early as 19 -- excuse me, 2004, there was
11 mention up front in each of these articles about the
12 high desistance rate in children and adolescents,
13 and then, more recently, that has essentially
14 disappeared.
15 But these are articles that when you look
16 at the references, many times they are discussions
17 on Good Morning America, they are references to
18 conferences that WPATH provides teaching sessions or
19 local conferences in geographic regions, they're not
20 in peer-reviewed journals.
21 Q Is it your position that all of the
22 articles that are supportive of gender-affirming

1 therapy are published in non-peer-reviewed journals?
2 A No.
3 Q So, in fact, many of the articles are
4 published in peer-reviewed journals; is that right?
5 A No, some are.
6 Q Are any of these articles cited in your
7 report?
8 A The ones in peer-reviewed journals? Yes.
9 Q Yes. Which ones?
10 A Pediatrics, International Journal of
11 Transgenderism, Journal of the American Academy of
12 Child and Adolescent Psychiatry, PLoS One, Child and
13 Adolescent Psychiatry -- excuse me, that's not a
14 journal, that's a textbook. Those are the ones that
15 I've cited.
16 Q Which is the one that you said was a
17 textbook?
18 A It was Zucker's chapter, Child and
19 Adolescent Psychiatry.
20 Q So is Pediatrics a journal that is viewed
21 as a source of guidance in your field?
22 A Pediatrics is a peer-reviewed journal,

1 yes.
2 Q Is it viewed as a source of guidance by
3 practitioners in your field for --
4 A Yes, it is.
5 Q Yes?
6 A Yes.
7 Q Would you consult articles in Pediatrics
8 as part of your review of literature for determining
9 the standard of care?
10 A Yes, I would.
11 Q Now, when you previously discussed how you
12 determined standards of care and you talked about
13 conducting a broad survey, how do you decide which
14 of the opinions in that broad survey are going to
15 constitute the standard of care?
16 A I review the article thoroughly, I look at
17 the design of research if there is research
18 involved. If it's a summary view I look for what's
19 recommended in terms of breadth of opinion. There
20 are articles written that are ostensibly to cover
21 the entire field, all aspects of it, all opinions,
22 and come up with a sort of presentation at the end,

1 what we call a balanced presentation for the reader
2 then to make an assessment, and perhaps the writer
3 of that particular review article would do the same.
4 I look at things like the Endocrine
5 Society guidelines and the references they use, I
6 look -- and, again, when you go to the specific
7 references, that's a step beyond just reading the
8 article, it's actually looking at what studies are
9 referenced to look those up.
10 It's an arduous task, but on key issues,
11 many times I will request of my local medical
12 librarian copies of those articles so that I can see
13 whether or not what was gleaned from that reference
14 is actually proving the point or not.
15 In some cases I already know the articles,
16 and if I find that they're at odds with what the
17 author cites them to represent, that brings into
18 question the quality of the article.
19 So the design of the research, and then
20 the number of references and where they come from
21 allows me to make a personal opinion on -- and then
22 I discuss that amongst my endocrine -- pediatric

1 endocrine peers to find out what they feel and how
2 they approach things, and we go from there.
3 Q When you were conducting your research
4 regarding treating gender dysphoria, was anyone --
5 were you receiving any payment from any source while
6 conducting that research?
7 A No.
8 Q No?
9 A "No" is the answer, yeah.
10 Q So tell me if I am mischaracterizing this,
11 but my understanding from your earlier testimony is
12 you had said that standards of care means the most
13 generally accepted way of treating. Is that
14 something that you believe?
15 MR. CORRIGAN: Object to form.
16 Go ahead.
17 A Standards of care are somewhat fluid in
18 that sometimes they are published, sometimes they
19 are not, sometimes they are in development and
20 changed with new developments that come along, so
21 they are essentially a consensus across the board of
22 practitioners. Often they are guided by a

1 professional organization, hopefully with a balanced
2 approach so that the guidelines that they develop to
3 become or be considered standards of care represents
4 all aspects of the subject thoroughly reviewed and
5 brought to the table for consideration.
6 BY MR. BLOCK:
7 Q And is it your understanding that
8 standards of care are always supported by 30-year
9 long-term research studies?
10 A They are a combination of longstanding
11 review of literature, clinical research studies in
12 the past, and then new studies that have -- that
13 might be on the forefront of the issue.
14 Q So are there any standards of care
15 representing the general consensus of practitioners
16 that are not supported by long-term studies?
17 A Yes, the Endocrine Society guidelines are
18 not supported by any long-term studies of quality.
19 Q So I'm talking about -- by "Endocrine
20 Society guidelines" are you referring to guidelines
21 regarding treatment of transgender people or in
22 general Endocrine Society guidelines for other

1 conditions as well?
2 A The ones that I pay attention to are those
3 that are published that are germane to children, and
4 it just so happens having spent a lot of time
5 looking specifically at the transgender guidelines I
6 found, with critical review, that there was very
7 little scientific basis for the recommendation.
8 I have not done the same thing in depth
9 with every single one of the Endocrine Society
10 guidelines because many of them deal with patient
11 populations that are adult and disease states that
12 are in adults that do not pertain specifically to
13 children.
14 So in things like treatment of type 1
15 diabetes and those types of things, those
16 guidelines, again, are graded, and they generally
17 are based on good scientific evidence.
18 Q Sitting here today, you don't -- you don't
19 know whether the quality of research supporting the
20 Endocrine Society guidelines for gender dysphoria is
21 of higher or lower quality than the research of the
22 Endocrine Society guidelines for other conditions?

1 A In the guidelines that I have read, these
2 guidelines have very low scientific evidence
3 compared to the others that I reviewed.
4 Q Which others have you reviewed?
5 A Treatment of hypercortisolism, treatment
6 of thyroid disease in the perinatal period. Those
7 are some that come to the forefront in recent times.
8 Treatment of disorders of sexual differentiation is
9 another one.
10 Q Treatment disorders of sexual
11 differentiation guidelines are supported by
12 long-term research?
13 A Yes, they are.
14 Q And I asked a question asking about
15 standards of care, and you answered talking about
16 the Endocrine Society guidelines, so I want to get
17 an answer to my question about standards of care.
18 So my question is: Is it your
19 understanding that the standard of care with respect
20 to a particular issue is always supported by
21 long-term research?
22 MR. CORRIGAN: Object to form.

1 Go ahead.
2 A It should be.
3 BY MR. BLOCK:
4 Q But is it?
5 A No.
6 Q Why not?
7 A I would only be conjecturing as to why
8 not.
9 Q And yet a particular treatment might
10 represent the consensus of practitioners among a
11 field even if it is not supported by long-term
12 research; is that right?
13 A It's a consensus of some individuals in
14 the field, not all individuals in the field.
15 Q But I'm talking about consensus for
16 purposes of standard of care.
17 A I can't answer that. The standards of
18 care is a term that gets applied to things that are
19 published.
20 I am not -- my experience with standards
21 of care previously was in dealing with medical
22 malpractice and what the standard of care was in

1 terms of the disease state and the applied treatment
2 and whether or not it met that standard or if it was
3 outside the standard of care, and if it was, were
4 there extenuating circumstances as to why it was.
5 The standards of care from WPATH are
6 published as standards of care by that organization,
7 and they call them standards of care, they don't
8 call them guidelines. It's SOC. And so it's
9 basically use of the language to promote that as a
10 pathway for treatment by that organization.
11 Q What, in your view, is the accepted
12 standard of care for treating gender dysphoria in
13 adolescence?
14 A Accepted standards of care that has been
15 proven effective are -- well, my standard of care,
16 which is based on what has been proven to be
17 effective in allowing desistance to occur, is that
18 in-depth counseling be the predominant feature of
19 treatment, and that hormone manipulation is not.
20 Q I'm not asking about your standard of
21 care, I'm asking for what are the consensus
22 standards of care for treating gender dysphoria in

1 adolescence?
2 MR. CORRIGAN: Object to form.
3 Go ahead.
4 A All I know is my conversations with my
5 endocrine peers is that they are alarmed by what has
6 been reported as a standard of care by WPATH. I
7 would say that the majority of endocrinologists I
8 talk to do not understand the guidelines or why they
9 are recommended. They are labeled as standard of
10 care by an organization that calls them a standard
11 of care, and that's what they are, they are
12 recommendations.
13 BY MR. BLOCK:
14 Q Is there any written material or sources
15 that you think do represent the consensus standards
16 of care among practitioners for treating gender
17 dysphoria in adolescence?
18 A No, they are being developed.
19 Q By whom?
20 A Endocrinologists and mental healthcare
21 providers.
22 Q What do you mean by "being developed";

1 they're being written down?
2 A They're being developed, they're being put
3 together. Conversations are happening, groups are
4 getting together who are concerned about WPATH
5 recommendations, about the Endocrine Society
6 recommendations, and they're asking for a dialogue
7 so that everyone can basically come to the table and
8 open up a discussion instead of having it be
9 dictated from one side of the equation.
10 Q What organization are they having these
11 discussions in?
12 A It's nothing organized specifically. It's
13 a number of individuals who are concerned across the
14 country who are representatives from their field of
15 interest. We talked about it at length at the
16 Southern Pediatric Endocrine Society at that
17 meeting. Many, many concerned folks. Probably 75
18 percent of the people expressed significant concern
19 about the WPATH guidelines and wondered what should
20 or could be done to essentially come back to the
21 table and redevelop guidelines that took into
22 account the entire complexity of the issue.

1 Q Come back to the table and redevelop
2 guidelines in the Endocrine Society or through a
3 different organization?
4 A Well, this is the Southern Pediatric
5 Endocrine Society, so that's not -- that's its own
6 loose organization that represents pediatric
7 endocrinologists in the southeastern United States,
8 so cannot speak to the other subgroups.
9 The Pediatric Endocrine Society has a
10 special interest group in transgender health, and it
11 was our hope that at the annual meeting next month
12 in Baltimore that we could come together and have a
13 discussion with individuals in that special interest
14 group about our concerns.
15 It turns out that the special interest
16 group for transgender medicine is not meeting at the
17 Pediatric Endocrine national meeting in Baltimore.
18 There will be a session on disorders of sexual
19 differentiation, which I intend to attend.
20 Q So as far as you're aware, there are no
21 written drafts of any guidelines from a medical
22 organization that you think represents a consensus

1 standards of care for treating gender dysphoria in
2 adolescence?
3 A There are no written guidelines that is a
4 consensus of the broad spectrum of endocrinologists
5 across this country. There are guidelines written
6 by a special interest group, but not by the majority
7 of endocrinologists across the country.
8 Q Do you provide treatment for precocious
9 puberty in your practice?
10 A I do.
11 Q To delay puberty -- you do. Sorry.
12 And are there long-term studies on the
13 long-term effects of providing treatment for
14 precocious puberty?
15 A The treatment for precocious puberty is
16 usually short lived. It's on an average about a
17 year and a half to two years. It is rarely longer
18 than that.
19 Because of that, there are studies now of
20 18 years of experience, in particular with Depot
21 Lupron, that look at the effectiveness of treatment,
22 the restarting of puberty naturally, the fertility

1 of those individuals who have been treated, any
2 general health issues that happened, and in that
3 young child group -- age group who were not of the
4 age of puberty but are starting puberty, there
5 appears to be benefit socially in terms of,
6 particularly in females, of avoiding menstruation in
7 the very early primary grades, also preserving adult
8 height to some extent. And those are the two goals
9 for which we use that interruption of therapy.
10 But it is not approved or recommended for
11 long-term use, and it is not approved or recommended
12 for the age of adolescence when calcium bone
13 accretion occurs, and when brain development is very
14 dependent upon the presence of those hormones as the
15 body physiologically goes through puberty.
16 Q Are there long-term studies on the safety
17 of the treatment, though, the negative health
18 effects?
19 A There are long-term studies in adults
20 because the GnRH agonists, as they are called,
21 that's gonadotropin-releasing hormone agonists, were
22 used extensively and for longer periods of time in

1 adults with hormone-dependent tumors, prostate
2 cancer in males, and estrogen-dependent tumors in
3 females, and there are evidently mental health
4 issues that have surfaced in the long term that are
5 now being recognized and evaluated by the companies
6 that developed those therapies. We do not have any
7 long-term experience in children because the therapy
8 is not used for long term.
9 Q Going back to paragraph 35 of your
10 declaration, you say -- sorry, yeah, 35, about seven
11 or eight sentences in, the sentence begins with "The
12 response to these guidelines." It says: The
13 response to these guidelines was the burgeoning of
14 gender identity clinics in the United States from
15 three to over 45 in a period of seven years.
16 Do you see where I'm reading from?
17 A I do.
18 Q So is your opinion that the Endocrine
19 Society guidelines led to more gender identity
20 clinics?
21 A Yes.
22 Q So these hospitals with these clinics all

1 followed the Endocrine Society guidelines; is that
2 right?
3 A These clinics decided that they needed to
4 have gender identity clinics to treat patients who
5 would be coming into their practices. I do not know
6 why each of the individual clinics developed,
7 because I am not a part of those clinics, I don't
8 know what administrative decisions were made. It is
9 just an interesting phenomenon that once the
10 guidelines were published that there was literally
11 this very rapid increase in the number of centers
12 treating children.
13 Q And these centers treat the children in
14 accordance with the Endocrine Society guidelines; is
15 that right?
16 A I do not know each individual center, I
17 just know a few of the centers where I've had a
18 chance to have a dialogue with the clinic directors.
19 And in the case of the clinic in Cincinnati, I was
20 told that 100 percent of patients were affirmed. I
21 have tried to find out as best I can just by asking
22 people directly the percentage of patients that are

1 affirmed and those that are sent through counseling,
2 and I am not given a clear answer, but I have the
3 sense that the patients go in the door, and they're
4 affirmed.
5 Q By "affirmed" you mean provided hormone
6 therapy, cross-sex hormone therapy?
7 A Initially they are affirmed with
8 counseling to the family to allow the patient to
9 live in the role they wish to assume, trying to get
10 the family to adjust to that and accept that, and
11 then to work with the school systems to be sure that
12 the child is called by the pronouns they wish to be
13 called and the name that they wish to be called by,
14 and then when they -- they show the first signs of
15 puberty to have puberty blocked, and then at some
16 point in time after that, now as young as age 13 or
17 14, to receive cross-sex hormones, to have
18 mastectomies if they are a female wishing to trans
19 to a male identity, and then to wait, at least so
20 far in this country, to age 18 before they have any
21 additional surgical procedures done.
22 Q And these gender identity clinics are all

1 over the country; is that right?
2 A That is correct.
3 Q How many patients would you estimate
4 they're treating?
5 A I only have anecdotal evidence that in the
6 state of New York that there is 700 patients per
7 year. I don't know if it's a single clinic or a
8 multiplicity of clinics in a healthcare system.
9 I know that in the local system here in
10 Atlanta, that in 2016 they had 45 patients in that
11 calendar year that were maintained as patients. In
12 2017 that number increased to around 80. The data
13 for 2018 has yet to be published.
14 Those data I happen to know because it's
15 part of the U.S. News and World Report grading
16 system that if you have a transgender clinic that's
17 active, you get higher point scores on your area of
18 excellence in providing children's healthcare. So
19 that I know at least for our local healthcare system
20 is a strong motivation for them to maintain a
21 transgender clinic is because they get recognition
22 nationally as being a center of excellence at a

1 higher level the higher the points that they garner.
2 Q So -- but you know what the numbers are
3 for the upcoming year?
4 A I do not.
5 Q You do not.
6 At the Southern Pediatric Endocrine
7 meeting that you were at, were there these gender
8 identity clinics at any of the states where the
9 meeting participants came from?
10 A Yes.
11 Q About how many?
12 A I knew specifically of two in Florida, one
13 in Virginia, I knew of the Emory clinic as well, was
14 not -- there's a clinic -- a gender identity clinic
15 in South Carolina. There were no members from that
16 organization or that state at the meeting, as it
17 turned out. I don't specifically know about
18 Kentucky. Mississippi I'm not aware of. Alabama
19 has a gender identity clinic in Birmingham, although
20 the person that is in charge of that clinic, who I
21 know personally, was not in attendance at the
22 meeting.

1 Q You personally know the person in charge
2 of the clinic in Alabama, is that what you said?
3 A Yes. I personally know the two in
4 Florida, I do not personally know the person that
5 runs the clinic in Virginia, I do personally know
6 the person that runs the clinic in South Carolina,
7 don't know who runs it in Mississippi, and that's --
8 those are people I know personally.
9 Q So the people that you know personally who
10 run these clinics, do you think they are
11 practitioners of child abuse?
12 A I think they are misguided in terms of
13 recommending hormone therapy. The term "child
14 abuse" is a flashy term in my worldview to catch
15 attention. I would say that my concern for these
16 individuals is that there are going to be adverse
17 outcomes in their patient population because of what
18 they recommend and what they -- how they are
19 treating, and I don't think that they are
20 necessarily paying attention to the broader
21 literature, which says that that treatment is
22 harmful more than it is beneficial. They are very

1 much drawn to the Endocrine Society guidelines
2 because they are convenient, and they themselves
3 have no personal experience.
4 Q Do you consider them just in their -- as
5 practitioners to be unqualified as -- in general as
6 pediatric endocrinologists?
7 A Not at all.
8 Q You consider them to be conscientious
9 practitioners?
10 A I do.
11 Q And you think that they are acting in what
12 they believe is the best interest of their patients?
13 A I think that they are practicing in what
14 they do believe is the best interest, but I also
15 believe they are not informed. And when they have a
16 chance -- when I have a chance to talk with many of
17 them, they -- they are kind of taken aback by the
18 fact that there is so much evidence that shows what
19 the Endocrine Society guidelines recommend is
20 contrary to the long-term health of the patient.
21 They had not considered that. It was not
22 presented to them. They trusted the Endocrine

1 Society to be the voice of reason and assumed that
2 all this information had already been reviewed and
3 came out with a predominantly positive outcome, and
4 they are, a lot of them, quite astonished.
5 Q Is it your opinion that the Endocrine
6 Society guidelines do not discuss adverse health
7 effects?
8 A They discuss them in three of the
9 recommendations in the first iteration, and four in
10 the second iteration, the 2017. They are the only
11 scientifically valid graded recommendations that
12 carry literature with them, and all of them say that
13 there is concern that there are no long-term studies
14 of the long-term effects, that they are aware of, of
15 the hormone -- cross-hormone therapy and puberty
16 blocking, and that there must be studies designed to
17 assess that before they can -- they would assess as
18 being safe and sound. Despite those statements,
19 they recommend that the treatment be done.
20 Q If we look at paragraph 45 of your
21 declaration --
22 MR. CORRIGAN: It ends at 41.

1 A Mine ends at 41.
2 BY MR. BLOCK:
3 Q That's what I meant, 41. Apologies. The
4 second sentence in paragraph 41 says: Allowing a
5 biologic female to use the male-designated bathroom
6 facility is one of several, quote, gender affirming,
7 unquote, care options, but it is creating harm to at
8 least two parties. The harm to the gender
9 incongruent person is that it promotes a pathway to
10 inevitable long-term medical and psychological
11 morbidity.
12 And that's what you think, right; that's
13 your view?
14 A That is my opinion.
15 Q All right. So what if the student has
16 already completed puberty, has had surgery, and is
17 taking hormones, is that harm still present?
18 A The harm has been done.
19 Q So what additional harm is inflicted by
20 allowing that student to at that point use restrooms
21 consistent with their gender identity?
22 A Well, you are adding to the long-term

1 psychological morbidity of that patient, which is
2 proven to happen in the long-term studies of adults
3 who have lived 20 to 30 years in a transgendered
4 identity situation. Their mental health issues are
5 still quite high.
6 So if you -- your -- anything you do that
7 keeps the patient away from the therapy that they
8 need -- and all of these patients -- and
9 Dr. Zucker recommends exactly the same, despite
10 whether or not they are given hormone therapy, they
11 are never emotionally well, and they need long-term
12 mental health.
13 So if you add something that is -- we're
14 talking about -- in the case of the school system,
15 we're talking about kids that would not have had
16 surgery yet. So we're talking about kids that might
17 have had cross-hormone therapy and been socially
18 transitioned. At that point in time you are adding
19 affirmation that that is a beneficial -- proven
20 beneficial event to allow them to have a presence in
21 the bathroom of the opposite of their biologic sex.
22 And there are no studies that say that

1 that is true; there are no studies that say that
2 that is not true. There are no studies in
3 existence.
4 Q So you think -- in terms of adults you
5 think that affirming an adult transgender person's
6 gender identity is harmful to their health?
7 A I do.
8 Q Are there any long-term studies on the
9 mental health outcomes of people who identify as
10 being formerly transgender?
11 A No, they are beginning to develop at this
12 point in time. They have not been available on
13 those who have desisted subsequent to medical and
14 surgical because these patients are just now
15 beginning to come out to the forefront. A, it is
16 the age with which they approach this, they have
17 been transgendered long enough to recognize and to
18 have the strength to return back to their biologic
19 sexual identity and are now beginning to speak out,
20 write, publish, gather like-minded people together
21 so that they can publish their clinical experience.
22 But this is a brand-new group. This is

1 where -- this is the end point of people who did --
2 had these things only as adults, not as children,
3 back as far as 30 years ago.
4 Q So but -- so there are published studies
5 saying that even after receiving treatment, the
6 population of transgender people may have, as a
7 whole, poorer health outcomes than the population of
8 non-transgender people, right? Those are the
9 studies you were referring to previously; is that
10 right?
11 A That's correct.
12 Q But there are no studies on assessing what
13 their mental health outcomes would have been without
14 the gender-affirming care, right?
15 A No.
16 Q So what you're saying -- "no" means there
17 are no long-term studies, correct?
18 A There are no long-term reputable studies.
19 There are long-term things that are published, but
20 they are laced with -- as essentially a Cochrane
21 review of those -- all those studies shows that the
22 study design is extremely poor, that it is -- it's a

1 preselected population, does not represent 100
2 percent.
3 The only study that's published that has
4 100 percent of participants evaluated at the end is
5 the Swedish study, which is condemned outright
6 because it says what it says. There is incredible
7 amount of increase in mental health morbidity as a
8 result of medical and surgical transitioning. It's
9 the only study that had 100 percent of participants.
10 Q Sorry. That's your understanding of what
11 the Swedish study says, that as a result of
12 receiving care affirming their identity, the mental
13 outcomes are worse as a result of receiving that
14 treatment?
15 A It compares it to no one, unfortunately.
16 That's the one downside to that is it did not have a
17 control group of those who did not receive medical
18 and surgical care. It was a review of 100 percent
19 of the patients.
20 So it's called into question without a
21 control group to say that you're comparing itself to
22 itself, but the statistics are there that there's a

1 19-fold increase in completed suicides compared to
2 the general Swedish population.
3 Q So but there are -- so for the type of
4 treatment that you are recommending of just having
5 counseling for underlying health issues, there is no
6 scientifically valid study saying that those health
7 outcomes are better than what the health outcomes
8 would be if the same patient received
9 gender-affirming care?
10 A That's absolutely correct. We have one
11 study which is all affirmation which is Zucker's,
12 and we have the one study all surgical and medical
13 from Sweden, okay. We know Zucker reported all of
14 his patients, not just some of his patients. Sweden
15 reported all of their patients, not just some. What
16 has not been done is a longitudinal study of
17 side-by-side groups randomized to an arm of
18 counseling only versus affirmation with counseling,
19 medical treatment, and surgery.
20 No such study exists or has been designed.
21 There needs to be that study, and until that study
22 is completed and the results are evaluated 20 to 30

1 years post treatment, post beginning of treatment,
2 we will not be able to say without question that one
3 is better than the other in terms of long-term
4 outcome.
5 What we do -- what we do know is that
6 there are so many adverse side effects of the
7 medical and surgical side that creates medical
8 morbidity that would not otherwise exist that the
9 logical assumption is we are creating a disease
10 state by intervening that way, we are creating
11 mentally healthy individuals by doing the
12 affirmation pathway, and what we need to do is have
13 an unbiased study that looks side-by-side, and no
14 study exists.
15 Q If that study were conducted and the
16 evidence in that study showed that the mental health
17 outcomes for people receiving affirming --
18 gender-affirming care were better, would you then
19 provide gender-affirming hormones in your medical
20 practice?
21 A I would -- there are two issues here:
22 There's the mental health which is very important,

1 and there's the medical health in terms of side
2 effects. So I would have to have -- be shown that
3 the medical side effects and the mental health
4 effects were predominantly beneficial and the
5 downside and adverse effects on both sides were
6 minimal before I would recommend that.
7 Q So but if the evidence did show that, then
8 you would personally provide gender-affirming
9 hormone therapy?
10 A I probably wouldn't because I wouldn't be
11 practicing medicine at that time, I probably would
12 not be alive, so it's a theoretical question.
13 Q Yeah, but so asking a theoretical
14 question, let's say the study came out tomorrow,
15 would you in that situation personally provide
16 gender-affirming hormone therapy, or are there other
17 reasons why you may still not provide it?
18 MR. CORRIGAN: Object to form of the
19 question.
20 Go ahead.
21 A Yeah, if the medical and mental health
22 issues were better in the affirmed pathway, I

1 would -- I would likely change my mind.
2 BY MR. BLOCK:
3 Q Let's look at the paragraph 41 again.
4 Near to the bottom it says: The second party harmed
5 is the student without gender incongruence who must
6 suffer emotionally while being told they must
7 tolerate the presence of an opposite sex individual
8 in a sexually segregated space and embrace the
9 regulation which gives the gender incongruent person
10 special privileges as if it were based on civil
11 rights founded on immutable biology.
12 Did I read that right?
13 A Yes.
14 MR. CORRIGAN: Let me -- can I interrupt
15 for a second?
16 MR. BLOCK: Yeah.
17 MR. CORRIGAN: He's not going to offer
18 that opinion. I can tell you that in this case he's
19 not going to offer that opinion. I know it's in his
20 thing, and you can ask him about it, but he's not
21 going to offer that opinion at trial.
22 MR. BLOCK: Okay.

1 BY MR. BLOCK:
2 Q I'd still like to ask you a few questions.
3 So the harm that you're talking about there is not
4 harm limited to the possibility of exposure to
5 nudity; is that right?
6 A It is primarily harm due to exposure to
7 nudity, and that is just a general survey of asking
8 any adolescent males and females in a social
9 discussion, how would you feel if a naked person of
10 the opposite sex entered your locker room naked and
11 while you were naked? Would that bring you a zone
12 of comfort, would you grade it as neither one way or
13 the other or fantastically wonderful, can't wait
14 until it happens, or I wouldn't want that to happen?
15 And it's pretty much universal, I wouldn't want that
16 to happen.
17 That's just a nonscientific study. There
18 is no -- I am not aware -- I would just assume that
19 the standards that we have set up legally in
20 sexually segregated spaces is there for a reason for
21 privacy. And whoever has done any sociologic
22 studies of that -- we could go back. I am not aware

1 of those studies. At this point in time it has been
2 essentially what I would refer to as common sense.
3 Q So but talking about a restroom in
4 particular, not someone walking in naked into a
5 locker room, talking specifically about a restroom,
6 is it your opinion that there is harm to a
7 non-transgender person in having to tolerate the
8 presence of a transgender person in the restroom
9 even if there is no exposure to nudity?
10 A I have -- I'm not aware of any study that
11 says that. Outside of a courtroom if you ask my
12 opinion, exposure to -- if you're in a restroom
13 standing in front of a urinal and you have your
14 pants down around your ankles, and you've inserted a
15 device through which you can direct urine from your
16 vagina into the urinal, I think that would probably
17 cause some people to take notice, but there's no
18 study. I'm not aware of any study.
19 Q How about if someone uses a stall?
20 A What happens in a stall if it's got
21 floor-to-ceiling --
22 MR. CORRIGAN: Object to form.

1 Go ahead.
2 A If it's in privacy, I can't tell you.
3 BY MR. BLOCK:
4 Q So in that situation there would be no
5 harm to the non-transgender student?
6 MR. CORRIGAN: Object to form.
7 A I cannot say that.
8 BY MR. BLOCK:
9 Q So you don't know whether it would be
10 harmful?
11 A I do not know whether it would be harmful.
12 Q You say special privileges, as if they
13 were based on a civil right founded on immutable
14 biology. Do you think that civil rights should be
15 based only on immutable biology?
16 MR. CORRIGAN: Object to form, legal
17 conclusion.
18 Go ahead.
19 A So I think in terms of things like
20 religious faith, that is something that is not
21 immutable biology, and I think that intolerance of
22 religious faith becomes an issue of the right of

1 expression and -- personal right of expression.
2 I don't feel that something that is
3 furthering a detrimental mental health issue is a
4 civil right, especially when it is advertised as if
5 it is immutable biology and it's based on that that
6 we can treat that person as if that were a biologic
7 race or a biologic sex, which it is not.
8 BY MR. BLOCK:
9 Q Do you have a medical basis for an opinion
10 on what traits should be protected by civil rights
11 laws and which ones shouldn't?
12 MR. CORRIGAN: Object to the form. That's
13 why he's not giving the opinion.
14 Go ahead.
15 A Yeah, I mean, my personal opinion here in
16 this deposition is I would think that race and
17 gender -- and biologic sex are immutable and should
18 be considered to allow people to have specific
19 rights or not be denied rights.
20 BY MR. BLOCK:
21 Q So if the person using the boys' restroom
22 is a transgender teenage girl who has been having

1 affirming hormone therapy since before -- had
2 puberty blockers and affirming therapy and has fully
3 developed breasts, do you think that it is harmful
4 to the non-transgender boy to tolerate the presence
5 of her in the restroom?
6 MR. CORRIGAN: Object to form.
7 Go ahead.
8 A I cannot say that that person would be
9 harmed. It depends on the individual.
10 BY MR. BLOCK:
11 Q So what about the -- what about the
12 transgender girl who has been receiving affirming
13 hormone therapy, is changing in the school locker
14 room, do you think that's harmful to the
15 non-transgender boys in the locker room with her?
16 MR. CORRIGAN: Object to form. We're not
17 here to talk about locker rooms. He'll answer the
18 question.
19 Go ahead.
20 A I would personally assume that there would
21 be a level of discomfort of having opposite sex
22 nudity in the same locker room.

1 BY MR. BLOCK:
2 Q But their chromosomal sex is the same, so
3 if the opposite sex nudity is solely as a result of
4 hormone therapy, then is your answer the same?
5 MR. CORRIGAN: Same objection.
6 Go ahead.
7 A Yes, it would be.
8 BY MR. BLOCK:
9 Q So what -- so it would be -- it would be
10 better -- just to clarify that question and answer,
11 so it would be uncomfortable for a non-transgender
12 boy to be in a locker room with a transgender girl,
13 meaning someone who is assigned male at birth but
14 has fully developed breasts as a result of hormone
15 therapy?
16 A That would be --
17 MR. CORRIGAN: Object to form.
18 Go ahead.
19 A That would be uncomfortable in my opinion.
20 BY MR. BLOCK:
21 Q And do you have an opinion on whether it
22 would be harmful?

1 A I cannot opine on that. I think there
2 would be uncomfortableness. I don't -- it depends
3 on the individual.
4 I would imagine in the scheme of things
5 for a biologic male who has very large breasts that
6 have been induced by hormone therapy, that that
7 would cause people to notice, comment, to not be
8 comfortable, to try to figure out what's going on,
9 and that they might think that they would -- they
10 definitely would be uncomfortable. I don't know if
11 it causes mental harm. I'm not a mental health
12 practitioner.
13 Q Do you have a medical opinion on whether
14 that transgender girl with breasts who was assigned
15 male sex at birth should be using the boys' locker
16 room or a separate facility by herself?
17 MR. CORRIGAN: Object to form.
18 Go ahead.
19 A I think that for the sake of all parties
20 that there needs to be a private space for that
21 person to disrobe where they are comfortable in a
22 private space and other people are comfortable in

1 their private space. So a gender-neutral changing
2 space, if you will.
3 BY MR. BLOCK:
4 Q But the person who has to use that space
5 would be the transgender girl, not the
6 non-transgender boys; is that right?
7 A It would be available for anybody.
8 Q And it would be better if she used that
9 separate facility?
10 MR. CORRIGAN: Object to form.
11 Go ahead.
12 A It would be better if she used that
13 facility because of privacy of other individuals.
14 There are also biologic males who feel very
15 self-conscious about their physical appearance who
16 would like to have a gender-neutral space where they
17 are completely private where they don't have to
18 disrobe in front of anybody of either sex because of
19 how they feel about themselves. Adolescent boys who
20 have a small amount of breast development are very,
21 very sensitive about that and often very
22 embarrassed, and if they were -- if the school would

1 provide a neutral space for that person to disrobe,
2 shower, and redress, there would be benefit to both
3 parties.
4 BY MR. BLOCK:
5 Q How about the presence of a
6 non-transgender boy who is gay in the male locker
7 room --
8 MR. CORRIGAN: Object to form.
9 BY MR. BLOCK:
10 Q -- would that create harm to other boys
11 who have to tolerate his presence?
12 MR. CORRIGAN: We're far afield from the
13 designation.
14 Go ahead.
15 A No, I don't see that would. If that gay
16 boy were uncomfortable, I would like to have that
17 gay boy have a place to go where he is comfortable.
18 So if there were a private space for him to disrobe,
19 shower, and dress, that should be made available.
20 BY MR. BLOCK:
21 Q But if he prefers to shower and disrobe in
22 the same locker room that everyone else showers and

1 disrobe, you don't have any opinion that he
2 shouldn't be allowed to do that?
3 MR. CORRIGAN: Object to form.
4 A There should be no reason why he should
5 not be able to. He should be able to use that male
6 locker facility.
7 MR. BLOCK: This is an okay place for me
8 to take a break if it's okay with you. I can also
9 keep going if that's what you prefer.
10 MR. CORRIGAN: I'm always up for a break.
11 Any ideas on how long we'll be doing this?
12 MR. BLOCK: A couple hours.
13 MR. CORRIGAN: Okay. We'll take a break.
14 MR. BLOCK: Sorry, what?
15 MR. CORRIGAN: We'll take a break.
16 MR. BLOCK: Okay. So how about see you at
17 10 minutes?
18 MR. CORRIGAN: Sure. Are you going to
19 have lunch, or what are you going to do about that?
20 MR. BLOCK: We'll have a longer break for
21 lunch then, so come back at 1:30.
22 MR. CORRIGAN: That's fine. That should

1 be fine.
2 (Recess 1:02-1:39 p.m.)
3 BY MR. BLOCK:
4 Q Good afternoon, Dr. Van Meter.
5 You're a fellow with the American College
6 of Pediatricians; is that right?
7 A Yes.
8 Q And you've been a fellow since 2007,
9 correct?
10 A That is correct.
11 Q Did you have any role at the American
12 College of Pediatricians before 2007?
13 A No.
14 Q How did you first come into contact with
15 the American College of Pediatricians?
16 A The inaugural president was a personal
17 friend of mine. He encouraged me to join the
18 organization because it had very specific benefits
19 for children's health that were somewhat different
20 and more appropriate than the other major pediatric
21 professional organization, the American Academy of
22 Pediatrics.

1 Q Did he identify any particular
2 recommendations or positions that were more
3 appropriate than the recommendations of the American
4 Academy of Pediatrics?
5 A Well, the American Academy of Pediatrics,
6 I was a member during my residency and joined in
7 1976, was very active in local chapters, I was a
8 chapter chairman for the Uniformed Services West,
9 was the legislative committee director for the
10 Georgia chapter. I am still a member of the Georgia
11 chapter of the AAP because an awful lot of what they
12 do has a lot of benefit for children and also looks
13 after the ability for pediatricians to be able to
14 practice quality medicine.
15 Q So what made him think that you had a need
16 for looking at an organization with different policy
17 recommendations?
18 A The American College guidelines on a
19 number of subjects are essentially based on what is
20 purely the published science, and it's devoid of
21 political flavor. It basically says we're going to
22 be taking care of the needs of children, not the

1 wants of the adults. The American Academy had been
2 leaning toward paying more attention to the wants of
3 the adults in a number of areas.
4 I put together in 1994-1995, I believe,
5 what I sort of thought of as a children's Bill of
6 Rights for healthcare for the state of Georgia, and
7 we passed it through the House and the Senate
8 chambers in the Georgia legislature but not in the
9 same year because of the way the legislature ran,
10 and we were unable to get both houses to approve of
11 it and get it to the Governor's desk for signature.
12 We brought that document from Georgia to the
13 national AAP, where it was essentially devoured by
14 politics and thrown away.
15 And that was the beginning of my sense
16 that the American Academy of Pediatrics and its very
17 small executive group of district chairmen was not
18 speaking for pediatricians, and certainly not
19 speaking in some very important areas about the
20 welfare of kids.
21 So Joe Zanga knew that. Joe Zanga was
22 actually the president of the American Academy of

1 Pediatrics at the time that that resolution came to
2 the floor and was shouted down, and he just was
3 flabbergasted.
4 And I think that he knew how I felt about
5 that, so he asked me if I wanted to consider joining
6 another professional organization that was going to
7 be free from the political needs of the adults in
8 the room and essentially took care of the
9 biologically and scientifically proven needs of
10 children, and that's basically the motto of the
11 American College of Pediatricians is "Best for
12 Children," and that's -- everything we do is through
13 that filter.
14 Q So after 2007, were there any specific
15 policies of the American Academy of Pediatrics that
16 you disagreed with?
17 A There were issues of demeaning the value
18 of heterosexual parents adopting children versus
19 same-sex parents adopting children. They came out
20 with a policy statement which was really, really
21 unfortunately very poorly written and very badly
22 documented in the technical support documents which

1 favored -- at least favored, if not suggested, that
2 same-sex parenting was probably more beneficial than
3 heterosexual biologic parenting, and certainly more
4 than heterosexual families adopting children. That
5 was -- that was a statement that was very hard to
6 justify because it wasn't based on science.
7 So that was one issue, but that actually
8 happened before I even joined the College. I was
9 still -- I had a bad feeling about the American
10 Academy based on their rejection of our children's
11 Bill of Rights, which had broad political spectrum
12 support from both sides of the political aisle,
13 which was trashed.
14 And I thought knowing how the -- how those
15 things happen, how policies are made and how little
16 of the membership has input -- at no time as a
17 general member was I asked to give any input or
18 review policy statements that were being adopted by
19 the American Academy of Pediatrics.
20 They specifically condemned circumcision,
21 and then they turned around and then reapproved
22 circumcision, then they approved genital mutilation

1 of females, and then they quickly withdrew that, and
2 they were just following the political winds.
3 That's not good for any professional organization to
4 do flip-flops and make policy statements that are
5 embarrassing and clearly not based on science.
6 So that's why I finally relinquished my
7 membership in the American Academy. I held on as
8 long as I could to the national organization. The
9 Georgia chapter has its own unique ability to help
10 kids in Georgia deal with Medicaid issues and access
11 to care, things that are near and dear to all of our
12 hearts here as practitioners in the state of
13 Georgia. They're very effective, and they are
14 highly respected in our legislature, so I've
15 maintained my membership with them.
16 Q So you've been on the board of directors
17 since 2008, right?
18 A Yes.
19 Q When did you become vice president?
20 A Two and a half years ago.
21 Q And when did you become president?
22 A It was earlier than anticipated because we

1 restructured and developed the position of executive
2 director, and the current president was elevated to
3 that position as a paid employee, and so as vice
4 president, I assumed the presidency on the 1st of
5 July of 2018.
6 Q When was the American College of
7 Pediatricians formed?
8 A I believe it was 2002.
9 Q Why did it form?
10 A Dr. Zanga was very upset about the issue
11 before the recommendation in regard to the
12 condemning or belittling the benefits of
13 heterosexual parenting, which sociologic research
14 had shown was solid and beneficial to children. The
15 Academy refused to recognize that, and so that was
16 the turning point for, I guess, a nucleus of people
17 who decided that they wanted an organization that
18 actually, again, forgot the needs and political
19 wants of adults and looked after what is best for
20 children.
21 Q By belittling heterosexual parenting, you
22 mean that the American Academy of Pediatrics said

1 that parenting by same-sex couples is not harmful to
2 children?
3 A No, that's not -- they said that, but they
4 also essentially inferred that it was possibly
5 better than for heterosexual parenting. That's just
6 stepping across the line without any scientific
7 evidence at all.
8 What it did is it forced individuals to
9 critically go back through, and there was one
10 particular individual who went through every single
11 reference on the technical support paper for that
12 and found it completely full of holes,
13 misrepresenting science.
14 And, again, it was an agenda that seemed
15 to be pushed through by a very small nucleus of
16 individuals, perhaps 35 people at that time were
17 speaking for 60,000 members who were in the American
18 Academy of Pediatrics at the time as members. And I
19 was one at that time, and I never -- I never saw
20 anything published, it wasn't placed in any place
21 for review or discussion, it just happened, and so
22 that's -- that was the turning point.

1 Q Did Dr. Zanga believe that same-sex
2 couples should be allowed to legally adopt?
3 A Yes.
4 Q He did believe it should be legal?
5 A Yes.
6 Q Isn't it true that the American College of
7 Pediatricians filed a legal brief supporting
8 Florida's law prohibiting same-sex couples from
9 adopting?
10 A The problem is that there is subsequent
11 research that has been out that's -- that shows that
12 there are detrimental effects of that, and that if
13 there is a detrimental effect it should be explained
14 and not accepted as a -- an unharmful beneficial
15 thing when there is actual harm that happens.
16 So if there is a circumstance where there
17 is no other place for a child to go and
18 circumstances are that -- are as such that a
19 same-sex couple can adopt a child, but do not
20 advertise it as equal to or better than a
21 heterosexual couple.
22 Q Did the American College of Pediatricians

1 take a position defending a Florida law that
2 prohibited same-sex couples from adopting under any
3 circumstance?
4 MR. CORRIGAN: Let me interject here. Why
5 are we talking about this? How does this have
6 anything whatsoever to do with our case?
7 MR. BLOCK: He's the president of this
8 organization.
9 MR. CORRIGAN: But what does that have to
10 do with anything? I don't see how -- we're here
11 talking about transgender individuals, and we're
12 talking about restroom use, and that's what our case
13 is about, and this talking about whether or not the
14 organization that he's the president of filed a
15 brief in a case dealing with whether same-sex
16 couples can adopt children has nothing to do with
17 that.
18 I think -- I think we're wasting time, I
19 don't think there's anything related to the case, it
20 has nothing to do with anything in his report,
21 there's just no basis for it, Josh. And if you have
22 some basis for it, then please tell me.

1 MR. BLOCK: He's saying that this
2 organization has standards of care for treating
3 people with gender dysphoria that are better than
4 the American Academy of Pediatrics, they use this as
5 a reputable organization, more reputable than the
6 American Academy of Pediatrics. This is completely
7 fair game.
8 MR. CORRIGAN: But those things have
9 nothing to do with each other.
10 MR. BLOCK: David, if you want to -- this
11 is totally fair game. I'm going to be asking these
12 questions. You can object to their relevance.
13 MR. CORRIGAN: I think this deposition is
14 going off track to talk about things unrelated to
15 this case for a purpose having nothing to do with
16 this case, and I don't want that to happen, I don't
17 think it should happen. I don't think -- this would
18 not be legitimate cross-examination at trial.
19 There's zero chance a judge would say, let's talk
20 about the position of the American College on
21 whether or not same-sex couples can adopt. I just
22 can't imagine that's admissible testimony or ever

1 could be in this case.
2 MR. BLOCK: It goes to bias, and we're
3 allowed to develop a record on that.
4 MR. CORRIGAN: But what is the bias that
5 it goes to?
6 MR. BLOCK: Well, why don't you wait until
7 we finish asking questions about their positions,
8 and I think it will be shown.
9 MR. CORRIGAN: If you want to get to
10 questions that have anything to do with our case and
11 bias, that's fine. I don't think this bias has
12 anything to do with bias in our case.
13 So -- so let's make sure we're clear
14 because I'm -- at some point I'm going to instruct
15 him not to answer, and we're going to have to take
16 it to the judge, so you may want to be really
17 careful about how long you spend on things having
18 nothing to do with our case because I'm not going to
19 sit here and just have this deposition be about
20 thing that are unrelated to our case. I've been
21 very patient, and now you're crossing over.
22 BY MR. BLOCK:

1 Q So is it true that Joseph Zanga
2 characterized -- is it true that Zanga described the
3 organization as one with the Judeo-Christian
4 traditional values?
5 A That might be his opinion. There is
6 nothing in its charter that is based on any tenet of
7 religious faith. No particular faith is required
8 for membership. That is not a question that is
9 asked afore of members as they apply. The
10 membership criteria is Board-certification in
11 pediatrics. It does not require that you be a
12 person of faith of any strife or person without any
13 particular religious faith, any political strife,
14 without any sexual orientation, without -- there is
15 no -- that's not part of what makes up the
16 organization.
17 Q Let's go to Exhibit 4.
18 (Off-the-record discussion.)
19 (Exhibit 4 was marked for identification
20 and is attached to the transcript.)
21 BY MR. BLOCK:
22 Q Do you have that document in front of you?

1 A I do.
2 Q Do you recognize what this document is?
3 A It is, I believe, from the website,
4 College website.
5 Q It's on the part of the website that says
6 About Us; is that right?
7 A That's correct.
8 Q Would you turn to -- go down to Core
9 Values of the College. You see that. Yes?
10 A Yes.
11 Q Number 2 says: Recognizes that good
12 medical science cannot exist in a moral vacuum.
13 What does -- what do you mean by that?
14 A It means that ethics play an incredible
15 role in the practice of medicine and the application
16 of science to medicine.
17 Q So when it says that science cannot exist
18 in a moral vacuum, is the Academy -- the College's
19 position on care for transgender people based on a
20 moral principle?
21 A It's based on a scientific principle.
22 It's based on an ethical principle to do no harm,

1 yes.
2 Q So what -- just if you can explain the
3 relationship between science and the moral
4 principles. How -- are there ever situations where
5 the two come into conflict?
6 A Well, I think that there is an issue here
7 in terms of transgenderism of not paying attention
8 or avoiding the reality of solid science to promote
9 a social agenda, and that is -- there is harm as a
10 result of that, and that's not -- that's
11 objectionable in terms of a moral precept.
12 Q But what is the moral background that
13 science is located in when you say "can't exist in a
14 moral vacuum"?
15 A If you do not pay attention to concepts of
16 ethics you will likely do harm to your patients, and
17 that's to be avoided.
18 Q If you turn the page -- so the bottom of
19 this page says history. If you turn the page it
20 appears under history where it says -- if you look
21 to the third line down, third sentence, it says:
22 The College bases its policies and positions upon

1 scientific truths within a framework of ethical
2 absolutes.
3 What ethical absolutes does this refer to?
4 A This refers to sort of the Hippocratic
5 oath, if you will, again keeping to the basic
6 principles we all swear to when we accept our
7 medical degree of doing no harm to patients, not
8 ending life, the Hippocratic principles, but
9 overall, above all do no harm.
10 Q Let's look at -- so this'll be -- this is
11 Exhibit 5.
12 (Exhibit 5 was marked for identification
13 and is attached to the transcript.)
14 BY MR. BLOCK:
15 Q Do you recognize this document?
16 A I do.
17 Q Sorry, do you have the document in front
18 of you?
19 A I do.
20 Q Okay. Do you recognize this document?
21 A I do.
22 Q Okay. The title of the document is Gender

1 Ideology Harms Children, correct?
2 A That is correct.
3 Q And if you turn the page, there are --
4 there's three authors it's attributed to, and one of
5 them is you; is that correct?
6 A That's correct.
7 Q So at the very beginning of the document
8 it says: The American College of Pediatricians
9 urges healthcare professionals, educators, and
10 legislators to reject all policies that condition
11 children to accept as normal a life of chemical and
12 surgical impersonation of the opposite sex.
13 Did I read that right?
14 A Yes, you did.
15 Q So according to this document, schools
16 shouldn't be sending a message that gender
17 transition is normal, right?
18 A That is correct.
19 Q And schools should be discouraging
20 students from transitioning genders, correct?
21 A To their -- to their detriment to affirm.
22 Q So the schools should discourage it?

1 A It should not -- yeah, they should
2 discourage it.
3 Q Do you think that a school is acting in
4 the best interest of a child by calling the child by
5 pronouns that are different than the sex assigned to
6 them at first?
7 A We don't feel that that is appropriate or
8 beneficial to the child.
9 Q So you think it's harmful to the child?
10 A Yes.
11 Q And by agreeing to use the child's --
12 changing a child's new name as consistent with their
13 gender identity, you think that's harmful to the
14 child also, right?
15 A Yes.
16 Q And go to -- are you aware -- are you
17 aware about what Gloucester County School Board's
18 policies are with respect to what pronouns it uses
19 to refer to transgender children?
20 A I was aware in this particular case that
21 they allowed this patient to assume a new name and
22 new pronouns.

1 Q And you believe that allowing them to do
2 so was harmful to him, correct?
3 A I do.
4 MR. CORRIGAN: Just to be clear, he's not
5 being offered for those opinions. His only opinions
6 where he's being offered for are strictly with
7 respect to restroom use, which is the issue in the
8 case.
9 BY MR. BLOCK:
10 Q So is there any basis to conclude that
11 using the restroom as opposed to being referred to
12 by particular pronouns is uniquely harmful or -- to
13 a transgender student?
14 A It is part of the process of affirming
15 something which at the time is just a gender
16 confusion, a state of mind, not a biologic reality,
17 and anything that promotes that is not of benefit to
18 the child. And --
19 Q Turn the page to paragraph 8. It says:
20 Conditioning children into believing a lifetime of
21 chemical and surgical impersonation of the opposite
22 sex is normal and helpful is child abuse.

1 Did I read that right?
2 A You did.
3 Q So when I referenced the term "child
4 abuse" before you said it was a flashy term. Am I
5 accurately characterizing your testimony?
6 A Yes.
7 Q So why do you use that term here in this
8 paragraph?
9 A Primarily for emphasis.
10 Q The next sentence says: Endorsing gender
11 discordance as normal via public education and legal
12 policies will confuse children and parents, leading
13 more children to present to, quote, gender clinics,
14 unquote, where they will be given puberty-blocking
15 drugs. This, in turn, virtually ensures they will,
16 quote, choose a lifetime of carcinogenic and
17 otherwise toxic cross-sex hormones, and likely
18 consider unnecessary surgical mutilation of their
19 healthy body parts as young adults.
20 Did I read that right?
21 A You did.
22 Q So is one of the harms in allowing a

1 transgender student to change pronouns and names and
2 restroom usage consistent with their identity that
3 it will confuse non-transgender students as well?
4 A It is confusing to non-transgender
5 students because they do not understand, especially
6 at young ages, what is -- is happening to their
7 classmates, or they are in a state of mind with
8 Erikson's basic premise of being very concrete
9 thinkers, and they think a five-year-old child is
10 essentially, from what I've read, not being an
11 expert in the field of mental health, but what the
12 experts say, a five-year-old believes that if a man
13 leaves a room and comes back in dressed as a woman
14 and wearing women's makeup, to appear to be a woman,
15 that that man has changed into a woman. That's the
16 level of psychological assessment at that age.
17 By age seven there is an ability for a
18 child to recognize that perhaps that is just a
19 costume and not a real person of the opposite sex.
20 So if you were, at the elementary school
21 age, promoting aggressively that gender is whatever
22 you want it to be, you are basically bringing in an

1 ideology that is programming the child to be
2 confused and upset. And there are certainly
3 clinical cases where that's happened, and the
4 parents have brought legal action against school
5 systems.
6 Q Let's look at the last -- the very end of
7 the statement. So this is after the clarification
8 at the bottom of the paragraph, the bottom line is
9 the final sentence says: For this reason, the
10 College maintains it is abusive to promote this
11 ideology, first and foremost for the well-being of
12 the gender dysphoric children themselves, and
13 secondly, for all of their non-gender-discordant
14 peers, many of whom will subsequently question their
15 own gender identity, and face violations of their
16 rights to bodily privacy and safety.
17 Did I read that right?
18 A You did.
19 Q What do you mean by it will cause many of
20 their non-gender-discordant peers to question their
21 own gender identity?
22 A Well, there is a phenomenon with the

1 advent of social media where the incidence of gender
2 identity issues has exponentially -- has
3 geometrically increased, and the ratio has flipped
4 from two-to-one male to female to two-to-one female
5 to male. It's a social contagion phenomenon amongst
6 kids who are coming together as groups and deciding
7 that they are transgender and would like to have
8 their surgeries done together and travel to the
9 identity of the opposite sex.
10 These kids are coming out of the woodwork
11 literally in larger and larger numbers as a social
12 contagion phenomenon. Society itself, it's not that
13 it's just more acceptable. It exceeds that kind of
14 mathematical computation. So it is -- it is a
15 contagion that's happened, and it's certainly
16 promoted by Internet.
17 Q So if the school affirms the gender
18 identity of the transgender student, that
19 transgender student could spark a social contagion
20 that causes other students to say they're
21 transgender too?
22 A Absolutely. It has happened, and it's

1 documented.
2 Q So by not allowing the transgender student
3 to use the same restrooms as cisgendered students
4 with their gender identity, the school is stopping
5 the spread of a social contagion; is that right?
6 MR. CORRIGAN: Object to the form of the
7 question. The witness is not being called in this
8 case to discuss these very issues; he's not speaking
9 on behalf of the school board.
10 Go ahead.
11 A I have no proof to say that not allowing
12 use in a bathroom would make that difference.
13 Again, there is no study I'm aware of that says
14 using the gender-identified non-biologic sex
15 bathroom has any benefit or any detriment to the
16 long-term outcome of a patient. Those studies have
17 not been done.
18 BY MR. BLOCK:
19 Q So my question is that you believe that if
20 a transgender student is affirmed and allowed to use
21 the bathroom consistent with their identity, then
22 that is more likely to cause other students to think

1 they might be transgender too?
2 MR. CORRIGAN: Object to form of the
3 question.
4 Go ahead.
5 A It is theoretically quite possible.
6 BY MR. BLOCK:
7 Q So going to Exhibit -- going to jump ahead
8 here to Exhibit -- I think this is 8.
9 (Exhibit 8 was marked for identification
10 and is attached to the transcript.)
11 BY MR. BLOCK:
12 Q Do you have that document in front of you?
13 A Almost.
14 Q Do you have it in front of you now?
15 A I do.
16 Q The title of this article is, Dr. Quentin
17 Van Meter: How Faulty Research by a 1950's Sexual
18 Revolutionist Guided the Modern Transgender
19 Movement; is that right?
20 A Yes.
21 Q And do you recall giving an interview to
22 Breitbart for purposes of this article?

1 A I did.
2 Q Did you read this article when it came
3 out?
4 A Yeah, I saw it after it came out.
5 Q Was there anything in the article that you
6 thought was inaccurate or mischaracterized your
7 views?
8 A I had some questions about sort of
9 interpretive sentences when I read it. I would have
10 to read it back through completely to go back
11 through and pick those out again, but in general the
12 flavor and the purpose of the article was to -- was
13 to essentially discuss John Money and his influence
14 on the sexual health, mental health side of issues
15 in this country.
16 Q Sorry, if you give me one second. If you
17 turn to page 4 of 6.
18 A I have it.
19 Q So the second paragraph there, it says:
20 According to Van Meter, since the transgender
21 movement has developed every patient that come to
22 him claiming to be in the wrong body, quote, have

1 come from a totally dysfunctional family, unquote.
2 And just to continue this next paragraph
3 says, quote, there's nothing normal about the
4 environment where these children are brought up,
5 unquote, he said. Quote, there are emotional
6 traumas left and right. It's so obvious that what
7 we're doing is painting over the trauma, unquote.
8 Do those quotes accurately reflect what
9 you told the reporter for this article?
10 A Yes.
11 Q So do you think that if someone is
12 transgender or thinks they're transgender it's the
13 fault of the family?
14 MR. CORRIGAN: Object to form.
15 A If the child is transgender, they have
16 chosen this as an answer to relieve them of dealing
17 with a stress that is in their environment.
18 Sometimes it's the family, sometimes it's the
19 extended family or the social environment of the
20 child.
21 BY MR. BLOCK:
22 Q But if someone is transgender, that often

1 indicates that they come from a totally
2 dysfunctional family; is that right?
3 A The word "totally" might be a pejorative
4 type of word that was used in the interview. There
5 is always trauma, always emotional trauma, and
6 always a level of dysfunction in the family.
7 Divorce, separation, sexual abuse, death, all those
8 things affect the child.
9 Q You think that is true for all transgender
10 people?
11 A All the transgender patients I have cared
12 for.
13 Q So all 12 --
14 A Yes.
15 Q -- of them?
16 A Yes.
17 Q How about the one in 1993?
18 A There was a lot of trauma. This was a
19 military family that moved every six to nine months.
20 I did not broach the subject of sexual abuse by any
21 member of the family, siblings or adults, but the
22 child was severely traumatized by the rapidity and

1 frequency of moves from community to community.
2 Q Last paragraph of this article, which is
3 page 5, it says, quote, this is the recruitment of a
4 cult, unquote, Van Meter said. Quote, it's so
5 scary, and I'm so overwhelmingly worried about the
6 welfare of the population of people 30 years out,
7 unquote.
8 Is that quote accurate -- an accurate
9 reflection of what you told the reporter?
10 A Yes.
11 Q So can you explain what you mean by "this
12 is the recruitment of a cult"?
13 A This is an ideology which is promoted by
14 some to essentially use this as a valid medicalized
15 diagnosis to gather children and to treat them, and
16 their purpose is to see what happens when the
17 treatment is over and make a decision then, just
18 like John Money did some 40 years earlier with an
19 idea that was not based on any known science that --
20 to be beneficial, and then to come out with an
21 experimentation at the other end.
22 The cult aspect of it is what's happening

1 on the Internet and the recruitment of patients by
2 websites and blogs, and all that's happening as if
3 they're pulling in the kids unwittingly, most often
4 against their parents' wishes and without their
5 parents' knowledge, and then they are sucked into
6 the ideology, which is very much like a cult.
7 Q You think the American Academy of
8 Pediatrics is recruiting children into a cult?
9 A The American Academy of Pediatrics
10 produced a statement written by one individual
11 promoting this concept, and specifically and most
12 dangerously saying that under no circumstance is
13 there any need for psychological evaluation.
14 That is one individual, the author of that
15 paper, and 35 -- as many as 35, perhaps a little
16 less, of administrative people rubber stamping this
17 as a promotional position of the American Academy of
18 Pediatrics.
19 It is abysmal, it is embarrassing, it is
20 dangerous, and the fact that they say they represent
21 and are supported by all now 67,000 members is
22 entirely and completely untrue.

1 Q Do you think the author of that paper is
2 recruiting children into a cult?
3 A I don't know the author. I cannot speak
4 to that. I just know that he wrote a paper and a
5 position that's based on really essentially
6 fraudulent -- fraudulent information. He misquotes
7 papers. He ends up saying the papers say one thing
8 to support his point, and when you pull the
9 reference, you find out that it does not support the
10 paper.
11 The article was very carefully critiqued
12 by an independent psychologist in the field of
13 psychology and lesbian gay psychology, and he
14 himself is a pro -- a proponent, an advocate for gay
15 people, and he tore this apart as absolutely abysmal
16 trash.
17 Q So you believe that schools can help kids
18 by discouraging students from being transgender; is
19 that right?
20 MR. CORRIGAN: Object to form of the
21 question.
22 Go ahead.

1 A I believe schools can help kids by making
2 sure that the family is fully aware and that they
3 are aware that there is counseling going on and
4 there's an intervention that the family is involved
5 in, and I think that's as far as schools can go.
6 That's as much as I can say on that subject.
7 BY MR. BLOCK:
8 Q But they shouldn't be sending a message
9 that being transgender is an equally acceptable
10 lifestyle to have?
11 MR. CORRIGAN: Object to form, not
12 designated for this purpose.
13 Go ahead.
14 A Yes, I think that's inappropriate for them
15 to be promoting something which, as Kenneth Zucker
16 said, is not a delusional disorder but is a
17 delusion.
18 BY MR. BLOCK:
19 Q So would one way to send that message be
20 to stigmatize transgender students, would that be a
21 way of sending that message?
22 A No.

1 MR. CORRIGAN: Object to form, object to
2 foundation.
3 Go ahead.
4 A No.
5 BY MR. BLOCK:
6 Q So what are the ways they can send that
7 message that transgender students have a delusion?
8 A They could deal with the student
9 themselves and make sure the student is in the care
10 of a mental health provider.
11 Q I want to turn to -- actually, you said
12 before you're familiar with the Christian Medical
13 and Dental Association; is that right?
14 A Yes.
15 Q How are you familiar with them?
16 A I took -- A, I know they exist. I'm not a
17 member. I took a course from them on preparation
18 for speaking to the media. It's a generic course
19 that teaches you how to be interviewed, how to
20 respond most effectively to questions so that the --
21 your interview can be used more appropriately, to
22 not do run-on sentences, to not mumble, to face the

1 camera, and they basically train you on how to do
2 that appropriately and give you a critique of what
3 you've done in front of a camera or in front of a
4 microphone so that you can improve some of your bad
5 habits.
6 Q Have you read their position statement on
7 transgender identification?
8 A I have not.
9 Q I'd like to turn to Exhibit 6.
10 (Exhibit 6 was marked for identification
11 and is attached to the transcript.)
12 BY MR. BLOCK:
13 Q Do you have that document in front of you?
14 A I do.
15 Q Do you have that document in front of you?
16 A I do.
17 Q Do you recognize the document?
18 A I do.
19 Q It's called, On the Promotion of
20 Homosexuality in Schools; is that right?
21 A That's correct.
22 Q If you look in the right-hand column on

1 the fourth checkmark down it says: The homosexual
2 lifestyle carries grave health risks; is that right?
3 A Yes.
4 MR. CORRIGAN: Let me interject here.
5 This is something having to do with homosexuality in
6 schools. To my knowledge our case has nothing to do
7 with homosexuality in schools, okay? This is about
8 transgender bathroom -- transgender restroom use. I
9 don't see how this is in any way related, relevant,
10 has any significance whatsoever, so I object to any
11 questions regarding this.
12 MR. BLOCK: It goes to the credibility of
13 his opinion and whether or not it represents medical
14 mainstream.
15 MR. CORRIGAN: His opinion is that there's
16 no science to support the notion that using a
17 restroom of any description has any effect on a
18 transgender youth. I don't see how that opinion is
19 in any way influenced by whether or not this
20 American College has a paper on a promotion of
21 homosexuality in schools. Just completely
22 unrelated, not admissible, never going to be part of

1 our case.
2 Go ahead.
3 MR. BLOCK: You're proffering him as an
4 expert on what the mainstream medical view is, and
5 this goes to his views being outside the mainstream
6 and being based on ideology and not based on
7 science.
8 MR. CORRIGAN: I am not offering him as an
9 expert on what the mainstream view of anything is.
10 I'm just telling you that his opinion is, based on
11 his review of the literature and et cetera, that
12 there is no scientific basis, medical basis,
13 psychological or other basis for anyone saying that
14 using a particular restroom has any effect on that
15 person one way or the other.
16 That's what our case is about, and that's
17 what he's going to testify to. He's not going to
18 talk about any of this, and this has nothing to do
19 with our case.
20 MR. BLOCK: But we can explore bias, and
21 we can explore the ability to draw valid conclusions
22 from reviews of evidence.

1 MR. CORRIGAN: If they have anything to do
2 with the case that would be true, but when they have
3 nothing to do with the case, they're just -- it's
4 totally irrelevant, totally tangential, totally
5 collateral, and has nothing to do with the case. So
6 I just don't see the benefit of talking about these
7 types of things.
8 MR. BLOCK: Bias is always relevant and
9 not collateral.
10 MR. CORRIGAN: What's relevant?
11 MR. BLOCK: Bias.
12 MR. CORRIGAN: What's the bias? Our case
13 is about transgender, it's not about homosexual.
14 You're confusing two concepts.
15 MR. BLOCK: That he has opinions about
16 homosexuality and gender identity that are based not
17 on science but based on ideology or moral bias.
18 MR. CORRIGAN: But homosexual is not part
19 of our case, and you're asking questions about
20 homosexual. I just don't see how it has anything to
21 do with -- it's like saying the arm and the pancreas
22 are two parts of the body.

1 MR. BLOCK: You can't put forth an expert
2 and not allow me to build a record exploring bias.
3 MR. CORRIGAN: But again, the bias has to
4 be somehow related to the case. You can't just talk
5 about what kind of bias he may have that has nothing
6 to do with the case.
7 MR. BLOCK: If you want to take it to the
8 judge and explain why I shouldn't be able to ask him
9 about a document from this organization that is On
10 the Promotion of Homosexuality in Schools, you're
11 welcome to put that issue before the judge.
12 MR. CORRIGAN: Okay, I will.
13 MR. BLOCK: Excellent. So you're
14 instructing him not to answer any questions on, On
15 the Promotion of Homosexuality in the Schools?
16 MR. CORRIGAN: I'm instructing you to ask
17 a question that has something to do with our case.
18 If it's related to this document, I'm not going to
19 object to it, but if it has nothing to do with our
20 case I'm going to continue to object to you asking
21 questions about topics unrelated to the issues in
22 our case.

1 MR. BLOCK: You can object all you want.
2 I'm -- but my question -- I'm going to continue
3 asking questions.
4 MR. CORRIGAN: Ask your next question.
5 BY MR. BLOCK:
6 Q So let's look at the second sentence of
7 the bolded at the top, which is a sentence that is
8 very similar to a view that you express in this
9 case. It says, quote, these organizations recommend
10 promoting homosexuality as a normal, immutable trait
11 that should be validated during childhood as early
12 as kindergarten.
13 So you disagree -- just as you disagree
14 with being transgender as being promoted as a
15 normal, immutable trait, you also disagree with
16 schools promoting homosexuality as a normal,
17 immutable trait; is that right?
18 MR. CORRIGAN: Object to form.
19 Go ahead.
20 A That is correct because there is no
21 biologic basis for same-sex attraction. That has
22 been stated by both sides of political aisle. It is

1 a fact there is no biology. It is a combination of
2 things, but it is not biologically based. And
3 that's -- that's in published science, that's truth,
4 that's not a bias. It's been evaluated and scoured
5 and looked for by advocates for the gay community,
6 and they specifically state there is no such basis.
7 So, again, that is science, it's not a bias.
8 The College is about what is science, not
9 what is about hopeful things that you would wish
10 would be true, but you have to look at everything
11 that's actually biologically sound and proven, and
12 that's what that sentence is based on.
13 BY MR. BLOCK:
14 Q And so homosexuality is also not normal,
15 right?
16 MR. CORRIGAN: Object to form.
17 A The statement is that promoting it as an
18 immutable biologically based norm is not -- is not
19 based on valid science.
20 BY MR. BLOCK:
21 Q If we go to the second checkmark on the
22 right-hand column, just as affirming a transgender

1 student's identity can be harmful, this checkmark
2 says: Declaring and validating a student's same-sex
3 attraction during the adolescent years is premature
4 and may be harmful.
5 Is that right?
6 MR. CORRIGAN: Object to form.
7 Go ahead.
8 A This is based on the handbook of the APA,
9 which says that there is an incredible amount of
10 fluidity in and out of same-sex attraction, and that
11 validation is premature.
12 BY MR. BLOCK:
13 Q And can be harmful?
14 A If it's -- if it's premature and ends up
15 causing ill health, it's harmful.
16 Q And the next checkmark says that -- you
17 testified that many -- that all transgender people
18 have a dysfunctional -- dysfunction in their
19 background. This checkmark says: Many youths with
20 homosexual attractions have experienced a troubled
21 upbringing, including sexual abuse, and are in need
22 of therapy.

1 Is that right?
2 MR. CORRIGAN: Object to form of the
3 question, object to mischaracterization of prior
4 testimony.
5 Go ahead.
6 A The answer to that is yes, it's proven
7 based on published science.
8 BY MR. BLOCK:
9 Q So you agree -- and you agree with that.
10 You agree with what that checkmark says, right?
11 MR. CORRIGAN: Object to form.
12 Go ahead.
13 A Yes, I do.
14 BY MR. BLOCK:
15 Q And so when it says that youths with
16 homosexual attraction, quote, are in need of
17 therapy, what sort of therapy are they in need of?
18 A They're in need of therapy to evaluate and
19 treat their depression and anxiety.
20 Q And that their homosexuality is sort of
21 tapering over underlying depression and anxiety
22 resulting from trauma?

1 A No, it coexists and cannot be and should
2 not be validated as being purely due to societal
3 rejection or pressure.
4 That is such an important right of the gay
5 community to be able to be recognized that their own
6 suffering and anxiety and depression should be
7 treated as for exactly what it is and not to be
8 dismissed as unimportant or not even present.
9 It is a huge disservice to the mental
10 health of the gay community that that -- that is
11 glossed over as if those things don't exist when
12 they do.
13 The conservative estimates that I read are
14 that 40 percent of people with a gay lifestyle
15 suffer significant depression and anxiety, and
16 they're not getting the therapy they need.
17 So the advocates for the gay community
18 strongly are coming out to say they need this
19 therapy, they should be encouraged to go for that
20 therapy. It is not to change anything, it is to
21 make them be functional adults so that you lessen
22 the long-term suicide risk, which is the end of

1 severe depression in many cases.
2 Q And how did you acquire this knowledge?
3 A Reading standardized publications and
4 articles written today and available for anyone to
5 read.
6 Q And when you treat patients, do you
7 provide any counseling or discouragement from being
8 gay?
9 A No.
10 Q Do you ever talk to them about health
11 risks associated with the homosexual lifestyle?
12 A I generally try to talk to them first
13 about risks of sexual activity in general, then
14 specifically if there are things that put them at
15 specific risk based on their -- about the things
16 that they do in terms of sexual activity, I point
17 out those things, I talk about STDs, and I talk
18 about depression and anxiety.
19 Q So before we leave this document, is there
20 anything about this document Exhibit 6, that you
21 disagree with?
22 MR. CORRIGAN: Object to the form.

1 A The purpose of this document was in
2 response to the promotion at the letter of the
3 superintendent of the schools that was done through
4 the Obama Administration which the College felt was
5 a harmful avoidance of the serious and significant
6 issues associated with promotion of this as if it
7 were -- it had no downsides to it in any aspect.
8 So a statement needed to be brought out
9 that brought up conversations that talked about
10 STDs, that talked about depression and anxiety and
11 the adverse outcomes that can happen. It's not that
12 they always do, but it's a risk. It talks about the
13 risks that these kids face, and if you promote
14 something that has risks, you need to be up in the
15 forefront and mention those risks without glossing
16 over them as if they did not exist.
17 So that's -- that was the point of the
18 paper is to present the risks. The known,
19 scientifically proven risks.
20 BY MR. BLOCK:
21 Q Do you have any religious beliefs related
22 to being lesbian, gay, bisexual or transgender?

1 A I do not.
2 Q Does the -- do you have any religious
3 beliefs about acting on same-sex attraction?
4 MR. CORRIGAN: I'm going to object to
5 anything about his religious beliefs or his personal
6 beliefs. I don't see how it has relevance or
7 potential relevance.
8 Go ahead.
9 A I do not impose my religious faith on
10 anyone. It is my personal journey. I use my
11 religious faith to balance with science to keep me
12 with a compass of doing things that are, again, not
13 in a moral vacuum, that have -- again, focus on,
14 above all, doing no harm, behaving well, not hurting
15 the patient in any possible way that is intentional
16 or based on any bias, not based on any harmful --
17 harmful ideas I may have about behavior. So it's --
18 that's where my faith comes into my professional
19 life.
20 BY MR. BLOCK:
21 Q The American College of Pediatrician files
22 amicus briefs; is that right?

1 A They do.
2 Q And those amicus briefs express the views
3 of the College, right?
4 A They do.
5 Q I'm sorry, I didn't hear the answer.
6 A I do.
7 Q So do you play any role in approving the
8 content of amicus briefs?
9 A I know of some of them, particularly on
10 the transgender issue. Some of the other briefs I'm
11 not an author of, but they were filed. I'm not
12 aware of the absolute design and content, I just
13 know that they exist.
14 Q But is it fair to attribute statements
15 made in amicus briefs filed on behalf of the
16 American College of Pediatricians to the views of
17 the American College of Pediatricians?
18 MR. CORRIGAN: Object to form of the
19 question.
20 Go ahead.
21 A Yes.
22 BY MR. BLOCK:

1 Q So is it the belief of the American
2 College of Pediatricians that, quote, it's not
3 beyond the scope of a court to acknowledge the moral
4 foundation of God's laws when considering the
5 institution of marriage, unquote?
6 MR. CORRIGAN: Object to form.
7 A That is a philosophical, beneficial
8 concept that is -- it's looked at from its
9 scientific validity to have a benefit to the patient
10 or the family that marriage has a historical
11 construct that is based on society and most often
12 verified and sanctified by a religious faith germane
13 to the population, and that is to the benefit of the
14 child to have -- to come from an intact family, and
15 that anything that can be done to promote intact
16 biologic families is probably the most ideal of
17 circumstances. And if something is less than ideal,
18 so be it, but if you're trying to promote what is
19 ideal, you label that as ideal.
20 BY MR. BLOCK:
21 Q Does the moral foundation of God's law
22 have any relevance to the treatment of transgender

1 people?
2 A No, I'm basing it on -- purely on science.
3 I don't -- I think the way it would be looking at a
4 theologic concept is it is appropriate to harm
5 children, and if that is -- if your faith structure
6 or your theology suggests that there is harm to be
7 done to a patient and you are doing harm, perhaps
8 that's not within the precepts of what your faith
9 might guide you to do, so that's how it comes into
10 play.
11 Like it does -- it's an ethical structure
12 to be sure that we are paying attention and
13 validating what we do on science and not falling
14 into a trap of validating something on popularity or
15 social pressure.
16 Q Is it true that the American College of
17 Pediatricians told the Alabama Supreme Court it
18 should ignore the opinion of the Supreme Court in
19 Obergefell?
20 THE REPORTER: Supreme Court in...
21 MR. CORRIGAN: Obergefell. Obergefell.
22 MR. BLOCK: O-B-E-R-G-E-F-E-L-L.

1 A Yes, they did.
2 BY MR. BLOCK:
3 Q Do you agree with that?
4 A The point was, again, the concept of what
5 is best for children is an intact biologic family.
6 That does not have any potential for increased
7 adverse outcomes for the child. And so, again, it's
8 the foundation of the family in that regard and that
9 opinion that the College chose to say what is best
10 for children in an ideal circumstance, the ideal was
11 that the Obergefell decision should not be -- should
12 be ignored at the Alabama court level.
13 Q And you think that if a court says that
14 the school board in this case should let transgender
15 students use restrooms in line with their gender
16 identity that the school board should ignore that
17 court decision?
18 MR. CORRIGAN: Object to form, object to
19 foundation.
20 A I would not make that statement.
21 MR. CORRIGAN: Witness not being called
22 for that purpose.

1 Go ahead.
2 A I would not make -- I would not tell the
3 school to go against a court decision.
4 BY MR. BLOCK:
5 Q So if there's a conflict between what the
6 law requires and what your medical views are, you
7 would think that the school board would need to do
8 what the law requires, right?
9 MR. CORRIGAN: Object to form.
10 Go ahead.
11 A The school board should do what the law
12 requires, and if they are at odds with that law,
13 they should file suit and take it through legal
14 proceedings.
15 BY MR. BLOCK:
16 Q Going back to Exhibit 5 just one more
17 time, that's the On the Promotion of Homosexuality
18 in Schools. I just need to know is there anything
19 in this statement that you disagree with? I just
20 want to have that on the record.
21 MR. CORRIGAN: Object to form, object to
22 foundation.

1 Go ahead.
2 A I'm going to carefully go through each
3 point.
4 BY MR. BLOCK:
5 Q Yes, sir, take a minute.
6 A Okay, I concur with all points.
7 Q Thank you.
8 I want to take a couple minutes to revisit
9 what we were talking about before about these 12
10 patients that you've been treating over the past two
11 to three years related to gender dysphoria.
12 Is there -- was there any precipitating
13 event that you're aware of that caused people to
14 start coming to you two to three years ago for
15 treatment in connection with gender dysphoria?
16 A Nothing that I perceived as a specific
17 event. I thought it reflected just a general
18 increase in the number of transgender clinics and
19 the online presence of transgender-promoting
20 websites and blogs that would be responsible, but
21 that is my perception without any basis on
22 scientific research.

1 Q Do you identify yourself within your
2 medical network as an endocrinologist who provides
3 treatment for gender dysphoria?
4 A Yes.
5 Q And when did you start identifying
6 yourself that way?
7 A When I began accepting patients and
8 getting feedback from practitioners, when I began
9 discussing things amongst my endocrine peers, that's
10 when I began to make sure that people knew that I
11 was very willing and able to have these patients
12 come to my office for evaluation.
13 Q And did you start describing yourself as
14 someone who provides treatment for gender dysphoria
15 before or after the first of these 12 patients came
16 to see you?
17 A I was -- I was quiet and didn't say much
18 because I was gathering information, so it was until
19 actually perhaps a year before the first patient
20 came in at a time when I had put together enough of
21 my own review of the literature to feel very
22 strongly that there was a need for this service, and

1 it happened to coincide with the time that the Emory
2 University medical campus opened their transgender
3 clinic.
4 Q So before -- in the time period before you
5 started identifying yourself as a practitioner who
6 provides treatment for gender dysphoria, the only
7 transgender patient who had come to see you was this
8 one in 1993; is that right?
9 A That is correct.
10 Q Now, when you describe yourself as a
11 practitioner who provides treatment for gender
12 dysphoria, do you include in that description
13 your -- what your views are with respect to
14 providing gender-affirming hormone therapy?
15 A The people that I talk to professionally
16 who know me as endocrinology colleagues know how I
17 feel because I've spoken in front of them, so I am
18 assuming everyone knows how I feel.
19 Q Is there, like, insurance networks or your
20 medical groups that you're associated with, is there
21 like a lookup feature where patients can find a
22 doctor in an area that provides treatment for gender

1 dysphoria, and certain people's names pop up if they
2 identify as that sort of certain practitioner?
3 A I am not aware I am on such a list.
4 Q Is it on your website?
5 A No, it is not.
6 Q So of the 12 patients that come to you,
7 about how many were referred to you by -- referred
8 to you specifically?
9 A About half of them are referred, and the
10 other half spontaneously found me.
11 Q The half who spontaneously found you, to
12 the best of your knowledge, were they aware of your
13 views with respect to gender-affirming therapy?
14 A I was aware at least two of those. One of
15 the parents sought me specifically because they had
16 seen one of my talks on YouTube.
17 Q For the ones that were referred -- for the
18 patients who were referred specifically to you, who
19 made those referrals?
20 A Pediatricians.
21 Q Pediatricians that you knew?
22 A Yes.

1 Q In what capacity did you know them?
2 A From prior referrals from endocrine
3 patients over the span of the last 28 years. Up to
4 28 years.
5 Q Did those pediatricians -- do you know
6 whether those pediatricians shared your views with
7 respect to gender-affirming therapy?
8 A I do not.
9 Q Do you know whether they knew those views
10 at the time they referred the patients specifically
11 to you?
12 A I do not.
13 Q You said that two of the patients you
14 think have had success in resolving their dysphoria,
15 and 10 are work in progress; is that right?
16 A That's correct. One of them moved out of
17 the area, and I don't know what has happened in
18 follow-up with that patient.
19 Q Are there -- are there any patients who
20 saw you for an initial consultation but then decided
21 to seek treatment with someone else instead of
22 continuing to follow up with you?

1 A I am unaware of any.
2 Q And so the 10 that are in -- that are a
3 work in progress -- or are there nine that are a
4 work in progress? I just want to get the number
5 right.
6 A That's correct, it's nine.
7 Q Nine. The nine that are a work in
8 progress, have they reported any lessening of their
9 symptoms of gender dysphoria?
10 A They are working through issues and seem
11 to be in better mental health, but some of them are
12 still struggling with issues. Some of them are
13 young, so some of them are coming back and just we
14 are revisiting the same overall view, and they're
15 works in progress.
16 Q So did I get it right that some have shown
17 improvement with respect to depression and anxiety,
18 but at the same time not showing improvement in
19 resolving their feelings of gender discordance?
20 A I'm trying to specifically categorize
21 those which are not living affirming the
22 gender-incongruent lifestyle, and I think the

1 majority of them are back to being -- living in
2 their biologic body as that gender at least
3 outwardly for the school and for purposes of other
4 people outside the family. But the family is
5 working within the family to work these kids through
6 that process and to do healing amongst themselves.
7 Q For the follow-up visits after the initial
8 visit with these patients, do you conduct a medical
9 exam on the follow-up visit?
10 A I conduct a medical exam if I sense that
11 something is going wrong. For instance, several of
12 these children are obese and are increasing their
13 body weight significantly because every patient that
14 comes in is weighed and measured, and I want to
15 address that issue because it's a co-morbidity in
16 some ways, but it's also innate for them to become
17 obese. So I'm aware of, in kids like that, that I
18 want to pay attention to those issues.
19 If the parents describe something that
20 they think is puberty that's happening, I'll do a
21 physical exam. So it is very much case by case.
22 Q But there's some patients that for the

1 follow-up visits you don't conduct a medical
2 examination, correct?
3 A If it's -- particularly since the visits
4 are designed to try to be three months apart and
5 nothing physically is changing, I would sort of
6 mandatorily do a full physical exam at least once a
7 year.
8 Q So what happens at a visit like that where
9 there's no medical examination, it's a check-up
10 after three months?
11 A First it's an interview with everybody in
12 the room, and then it is permission to have the
13 child and either parent. If the parents are not --
14 are not functional together, I will interview the
15 parents individually, I will then sort of
16 reinterview them together to discuss the things that
17 I have permission to talk about between the two of
18 them that might be constructive of things that I
19 might learn about that situation, and then I ask
20 permission to interview the child individually
21 without the parents in the room.
22 Q And what do you bill that as to insurance?

1 A That's as a counseling visit as a parent
2 conference. It usually is about a 30-minute visit.
3 Sometimes it's longer if things are sort of opening
4 up and there are re-questions and re-education, or
5 in the case of a split family if it's the first time
6 I've been able to actually interview or take -- get
7 information from a parent who had previously been
8 absent it takes longer, so it's all based on time.
9 But it's done as a parent conference visit.
10 Q Do you have a license to provide
11 counseling?
12 A I have a license to provide evaluation of
13 children's health.
14 Q After the initial evaluation when you're
15 providing continued visits, is it -- would
16 counseling be a fair description of what occurs in
17 those visits?
18 A No, it's basically information gathering.
19 Q And what do you do with the information
20 that you gather?
21 A I record it in the record. If there is
22 education to be done in terms of questions and

1 answers about the medical side, those are explained,
2 reexplained.
3 Often because of the nature of the visits
4 there's a lot of emotional tension, and there's not
5 necessarily a lot of constructive listening, so I go
6 back over again and be sure that everyone
7 understands the medical aspects of what's going on
8 and what they might have read on the Internet, what
9 they might have new concerns about, and I address
10 those things, but I do not do counseling for
11 depression and anxiety.
12 Q You said you spoke about
13 transgender-related issues to the International
14 Association of Therapeutic Choice; is that right?
15 A That's correct.
16 Q How did you come to become familiar with
17 the International Association of Therapeutic Choice?
18 A I was approached by their director and
19 asked if I would be willing to come and talk on the
20 history of transgender health in the United States.
21 MR. BLOCK: If you'll just give me a
22 minute. We can go off the record for a second.

1 (Recess 2:59-3:02 p.m.)
2 BY MR. BLOCK:
3 Q So when you said before that you at some
4 point made it be known that you were interested in
5 seeing patients that were seeking care for gender
6 dysphoria, how did you communicate that to others?
7 A By word of mouth at regional meetings
8 mostly.
9 Q Regional meetings of endocrinologists?
10 A Yes.
11 Q Do any patients get referred to you
12 through the American College of Pediatricians?
13 A I -- I actually don't believe I've had a
14 patient come specifically referred from the College.
15 We do have a referral base for pediatricians who are
16 members so that if a family calls and said, is there
17 a pediatrician in my area who's a member of the
18 College, we can tell them who is in their geographic
19 region and hook the two of them up. So that is --
20 I'm not aware of actually having a family come to me
21 referred by the College.
22 Q Are you aware of having a family come to

1 you being referred by a pediatrician who's a member
2 of the College?
3 A Yes, because there are members in Georgia,
4 and I would -- I would guess that, yes, that has
5 happened, but I can't -- I don't have a
6 documentation of an individual's name.
7 Q So during the first visit when someone
8 comes to you for treatment for gender dysphoria, do
9 you conduct an examination to determine how far
10 along in puberty the patient is?
11 A Absolutely, yes.
12 Q And so what's the purpose of doing that if
13 you're going to not provide hormone therapy
14 regardless of what stage of puberty the individual
15 is in?
16 A Well, staging of puberty is in the DNA of
17 being an endocrinologist so that at any visit that
18 we do, whether they have a diagnosis of type 1
19 diabetes or hypothyroidism or vitamin D deficiency,
20 rickets, staging them in puberty is exceedingly
21 important because it's part of what affects their
22 growth.

1 Human growth, statural, and weight gain
2 are related and timed with puberty and are affected
3 by puberty, and so it is essentially, as I said, in
4 our DNA as endocrinologists to be sure we have
5 staged puberty no matter the age of the patient.
6 We do not assume that just because the
7 concept of a pubertal-related symptom is not brought
8 up that we should not verify that the patient is
9 indeed not pubertal or is pubertal and is in what
10 stage of puberty and how they are growing and how
11 they have grown before if we can gather the data and
12 watch them grow as they move forward.
13 Q So you do this initial evaluation, you
14 have a discussion where you warn the patients about
15 harms associated with gender-affirming therapy, you
16 encourage them to see a counselor, and then what's
17 the explanation you give for why they should come
18 back for a check-up in three months?
19 MR. CORRIGAN: Object to form.
20 Go ahead.
21 A My story to them is that I am there to
22 care for them, and that I will dedicate my time and

1 effort to absolutely everything that is beneficial
2 to them, and that I know this is a confusing,
3 painful experience for them, and that it is my job
4 to monitor how they are doing and how we are moving
5 in the direction that is to their greatest benefit,
6 and so that's why they come back.
7 And I say it's easy to get lost in the
8 woodwork, and if I don't -- it's the same thing I do
9 with my diabetic patients who don't come back for
10 follow-up, we contact them and make sure that they
11 do come back because we know there is a necessity
12 for them to be followed to be sure all is going as
13 beneficially as it possibly can be, so that's the
14 same principle.
15 BY MR. BLOCK:
16 Q But why followed by you instead of by the
17 psychologist or psychiatrist that you're referring
18 them to?
19 A The psychiatry part is one part of the
20 equation. The questions about what to do in terms
21 of endocrinologic intervention are always hovering
22 around the edge, and the psychologist is very

1 definitely interested in anchoring them back to me
2 to discuss anything that -- any questions the
3 parents may have. Particularly with the advent of
4 Internet access, the parents read over and over
5 again about new ideas, new concepts. They need
6 somebody to anchor to that talks about hormones and
7 the effects of hormones, and that's why they come
8 back.
9 Q So even after the first visit, a parent
10 might come back to you with repeated questions about
11 hormones possibly being a good course of treatment,
12 and you have to explain to the parent repeatedly why
13 they're not; is that right?
14 A In part, but it's also because most of
15 these families are split families, and one parent
16 will see doubt in the mind of the parent who is the
17 one who's been bringing them in, and the parent
18 needs to come back and be reassured, or the other
19 parent wants to come and hear what I have to say,
20 and we have not talked before.
21 So this is such a -- this is not something
22 where you have a sit down, one discussion, send them

1 to the counselor and you're done. This is a
2 multifaceted approach for a very complex
3 psychological issue that involves a lot of pain and
4 agony, and the patient -- here is the poor patient
5 in the middle trying to figure out what to do, what
6 the answer is.
7 And if they know that somebody is
8 dedicated to them from the medical side as well as
9 from the counseling side, it is our hope that that
10 gives them some place to hang on to and a sense that
11 somebody really does care, even if they don't
12 necessarily agree with the patient, that they want
13 them to be -- to understand how dedicated we are to
14 their welfare and how compassionate we really are.
15 It's very difficult to talk to a very
16 sullen 14- or 15-year-old who sees you for the first
17 time and convince them that you're on their team,
18 and so it takes time.
19 Q But from the very first meeting, though,
20 you make clear to the parents that under no
21 circumstances will you be recommending
22 gender-affirming hormones, right?

1 A That's correct.
2 Q And are there any other conditions that
3 you treat in which you have the series of follow-up
4 conferences without providing medical treatment as
5 part of it?
6 A It's not often, but diabetes would be one
7 of them. There is so much overlay of issues with
8 compliance and whatnot that don't have to do with
9 physical wellness at the moment that require visits
10 to come back and predominantly talk about behavioral
11 responses and things that are germane to our
12 clinical experience in the field of diabetes, so
13 those kids, we'll bring them back.
14 Normally they're every three months, but
15 it is not uncommon in the adolescent years for us to
16 see them back a month after they've been seen before
17 to give them a pep talk, try to give them the
18 responsibility for managing their diabetes, set them
19 up for success with telephone contact and office
20 website secure communications so that we can try to
21 invest this child back in their diabetes care.
22 There are often points in time where the

1 mental health issues are so overwhelming that we
2 literally jettison to primarily back to an
3 aggressive mental health intervention scheme and let
4 the diabetes kind of go for a while because it's
5 impossible for those kids to get their blood sugars
6 in control or even care about managing their
7 diabetes when they're overwhelmed with depression,
8 so that's another circumstance where often the visit
9 will be predominantly information gathering, team
10 building, putting together things like that.
11 Q And you said before that one of the
12 reasons why you decided you wanted to start making
13 it known that you would provide -- that you would
14 see patients seeking care for gender dysphoria was
15 because you thought there was a need for it; is that
16 right?
17 A That is correct.
18 Q To the best of your knowledge, is there
19 any other pediatric endocrinologist that you're
20 aware of that provides the same course of office
21 visits that you do to patients who have come to you
22 seeking care for gender dysphoria?

1 A It's very limited because the guidelines
2 have been so pervasive, and what happens is that --
3 and this was an admission by a number of the
4 pediatricians in our regional meeting last month in
5 Orlando is they say, I don't take care of these
6 patients, I send them to the centers. So that's --
7 they kind of punt. And they are -- they were
8 relieved.
9 My presentation of a case study of one
10 particular patient just all of a sudden brought into
11 their minds, and they shared this with me, thank
12 goodness. Thank goodness. How do we do this? How
13 do we do this? What have you got written? Can you
14 come talk to us in Birmingham? Can you give us a
15 presentation for pediatricians where we can -- we
16 can get the people in the community to understand
17 that there are other avenues than the transgender
18 clinics as they now exist?
19 Q But in terms -- but as far as you're
20 aware, are there any other endocrinologists that you
21 are aware of who provide the same course of
22 treatment for gender dysphoria that you provide?

1 A Yes. Yes.
2 Q Who?
3 A There's a pediatric endocrinologist, Paul
4 Hruz, in St. Louis, I believe Robert Hoffman in
5 Indianapolis. There's just a few of us because
6 we're just -- we're just starting to put together
7 communications that are effective among our
8 endocrine communities.
9 We can't -- you know, I can't get invited
10 to national endocrine meetings because they won't
11 have me. I've tried the American Association of
12 Clinical Endocrinologists on two occasions over the
13 past three years to do a balance -- what I call a
14 balanced-dialogue type of a presentation, and I
15 specifically have been told no, that that's not
16 going to happen, and it could not happen, so...
17 And at those very same meetings they had
18 transgender clinic directors do a presentation,
19 which is basically telling everybody, this is what
20 you do, this is how you do it, this is the only way
21 that's effective, send your patients to us, and
22 that's -- that's what happened.

1 So it's hard to get -- it's hard to get
2 colleagues unless you literally spend the time of
3 contacting them individually and saying, let us tell
4 you our experience.
5 I share my -- the paper that I've
6 submitted for publication with other
7 endocrinologists to let them know. When I presented
8 in Orlando, the positive feedback from the community
9 was about three out of four people coming to me
10 afterwards saying, please tell us more, please tell
11 us more, so that's it.
12 It's a slow -- this movement is just
13 beginning to get an anchor because of the validity
14 in science that we've been able to prove.
15 Q What's your understanding about why these
16 organizations refuse to let you provide a
17 presentation on the course of treatment you provide?
18 A I have -- sheer conjecture. I have not
19 been able to talk to the meeting directors directly.
20 I have communicated one way with them most recently
21 both by e-mail and telephone message, and that
22 individual for the meeting of the American

1 Association of Clinical Endocrinologists in Los
2 Angeles, I believe it's next week, that person chose
3 not to communicate back with me.
4 Q In your declaration if you go to paragraph
5 29 of it, going back to Exhibit 1. Are you at that
6 page now?
7 A I am.
8 Q Great. The paragraph 29 says: Up until
9 recent -- up until the recent revision of DSM-IV
10 criteria, the American Psychological Association
11 held that gender identity disorder (GID) was the
12 mental disorder described as a discordance between
13 the natal sex and gender identity of the patient.
14 Is that right?
15 A That's true except there is a
16 misstatement. It's the American Psychiatric
17 Association, and I apologize for that inaccuracy.
18 They both have the same initials, APA, but it is the
19 American Psychiatric Association that generates the
20 DSM criteria.
21 Q And do you have any opinion on whether it
22 was appropriate for the APA to no longer describe

1 gender dysphoria as a mental disorder?
2 A I'm not a mental health practitioner. I
3 really find it difficult to sometimes use the
4 correct words without offending people who are
5 licensed and trained in mental health issues.
6 I learned actually from Dr. Zucker that
7 the word "disorder" is very specifically chosen and
8 cherished in the mental health community for very
9 specific purposes. Prior to that conversation with
10 him I would -- was thinking that anybody who had
11 transgender or gender incongruence had the disorder,
12 and that, I learned, is not the case. It is sort of
13 living a delusion, but not living with a delusional
14 disorder. So I find that the removal of the "gender
15 identity disorder" is a disservice to the patients.
16 So did Dr. Zucker, from indirect
17 conversation as I learned in between my statement to
18 the Carcano case and this that when the APA group,
19 again, it doesn't represent all psychiatrists, but
20 it's the group that develops the criteria, and they
21 are -- they're parsed into interest groups, they
22 pushed very strongly to eliminate any pathologic

1 reference to gender identity issues.
2 And Dr. Zucker argued -- and, again, this
3 is not from a conversation with him, but through
4 second parties who talked to him about this
5 personally, he argued that if you remove it, the
6 suffering is going to be legendary as it is, and
7 it's going to be ignored and will not be allowed to
8 be treated by third -- and covered as a service by
9 third parties who cover healthcare costs, insurance
10 mainly, and that medications then wouldn't be
11 covered.
12 And it was a disservice to the patients to
13 eliminate the disorder, but if they were going to
14 pressure to do that, would they please replace it
15 with "gender dysphoria" so that there was a medical
16 condition that would allow that patient to seek and
17 be treated and have that as covered services by
18 government entities and private insurance.
19 Q So did I hear you right that one of
20 Dr. Zucker's reasons was to ensure that medicines
21 would be covered?
22 A That treatment of any kind would be

1 covered.
2 Q But including hormone therapy, correct?
3 A I assume that, yes, but, again, I didn't
4 write that policy, and I didn't talk to him directly
5 to know.
6 Q Have you ever talked to Dr. Zucker
7 directly?
8 A No, I have not.
9 Q So do you have any views on the APA's
10 decision to remove homosexuality as a mental
11 disorder?
12 MR. CORRIGAN: Now we're getting far
13 afield again --
14 A I do not.
15 MR. CORRIGAN: -- with the conversation
16 about homosexuality. We're not here to talk about
17 homosexuality. Has nothing to do with our case.
18 Go ahead.
19 A I do not have any issues with the removal.
20 My issue is that the mental health issues are being
21 overlooked, and that's a disservice to people who
22 are gay and lesbian, and that we should do

1 everything we can to help these individuals and
2 advocate for them to recognize things that need
3 treatment instead of pretending that they are not
4 there, and therefore worsening the quality of their
5 life overall.
6 BY MR. BLOCK:
7 Q Going back briefly to the formation of
8 American College of Pediatricians, is it accurate to
9 say that the catalyzing event for forming the
10 American College of Pediatricians was the AAP's
11 position on children raised by same-sex parents?
12 A As I understand it historically, it was.
13 Q One more minute. I may come back and
14 finish.
15 (Brief recess.)
16 BY MR. BLOCK:
17 Q One more line of questions. In terms of
18 the issues in this case with Mr. Grimm, do you think
19 that by preventing Mr. Grimm from being allowed to
20 use the boys' restroom, that that was actually
21 something that was to his medical and mental benefit
22 to prevent him from using the restroom?

1 A In the sense that it was an affirmation, I
2 personally believe that affirmation is harmful,
3 so -- that I would say that was a harmful concept to
4 let him use the bathroom of the sex he wished he
5 were.
6 Q So when the board decided to stop letting
7 him use the bathroom, you think that -- the bathroom
8 consistent with his gender identity, you think that
9 was to his benefit?
10 A Yes.
11 Q Is that right?
12 A Yes.
13 Q Okay. And is that because you think by
14 not affirming him, by not letting him use the
15 restroom, the school was making it any less likely
16 that he would continue to be transgender?
17 MR. CORRIGAN: Object to form of the
18 question.
19 A Can you restate the question again?
20 BY MR. BLOCK:
21 Q Sure. Is it your opinion that by not
22 allowing Mr. Grimm to use the boys' restroom, that

1 the school was making it less likely that he would
2 continue to identify as being transgender?
3 A That would be a -- an opinion of mine
4 personally based on the fact that anything that
5 pushes affirmation ends up pushing the patient
6 farther along on a spectrum which will inevitably
7 involve cross-sex hormones and eventually surgical
8 mutilation.
9 Q But -- so in Mr. Grimm's case, since he
10 has already had cross-sex hormones and already had
11 surgical chest surgery, and -- is it still your view
12 that preventing him from using the boys' restroom
13 would make it less likely that he would continue to
14 identify as being transgender?
15 MR. CORRIGAN: Object to form of the
16 question, beyond the scope.
17 Go ahead.
18 A So the concept is that, as Dr. Zucker has
19 pointed out in his opinions as well, is that
20 anything that you do that affirms the patient,
21 because there is no -- there's no avenue that is
22 successful up to that point in time in bringing the

1 patient to desistance, that you're essentially
2 pushing for ongoing mental health issues that need
3 to be continually addressed.
4 And I would say that anything that does
5 harm to that child -- the continuation of cross-sex
6 hormones, the acute effects are masculinization of
7 the body, the long-term effects for Mr. Grimm are
8 going to be increased risk for medical conditions
9 that he would not otherwise have as a result of that
10 continued treatment.
11 So anything that pushes him to continue
12 the hormone therapy, feeling that it is the only
13 avenue or the only beneficial avenue, is to his
14 harm. And therefore I would say if the school chose
15 to not affirm him with a bathroom, that gives him a
16 concept that perhaps there is not benefit in that,
17 there's no proven benefit, no proven harm as an
18 isolated event, but if it's part of the big picture
19 of affirmation, that the Gloucester County School
20 System should have no part of it.
21 BY MR. BLOCK:
22 Q But focused specifically on someone who is

1 17 or 18 -- which Dr. Zucker does not think that
2 hormones should be precluded for someone who is 17
3 and 18, correct?
4 MR. CORRIGAN: Object to form.
5 Go ahead.
6 A Dr. Zucker is not an endocrinologist. I'm
7 an endocrinologist. I know about the harmful
8 effects of hormones, and I disagree with that, that
9 opinion of his, if that's what he agrees at this
10 point in time.
11 Dr. Zucker's opinion on the persistence of
12 the -- of gender dysphoria has to do with children
13 who have started from young childhood and progressed
14 up through adolescence and, despite constant and
15 significant intervention, do not desist. He was not
16 in general talking about kids who in their mid teens
17 make a decision that they are now transgender and
18 are essentially wishing to be the opposite sex. So
19 it's comparing apples to oranges here.
20 BY MR. BLOCK:
21 Q So assuming that we're dealing with
22 someone who has consistently from an early age

1 identified with the opposite sex and has -- and
2 other therapies have proven not to be successful,
3 they are a junior or senior in high school, does
4 Dr. Zucker's views provide any support for
5 continuing to exclude that individual from using the
6 boys' restroom, that transgender boy?
7 MR. CORRIGAN: Object to the form of the
8 question.
9 Go ahead.
10 A I would say at any point during -- I
11 disagree with Dr. Zucker. If that's -- if that is
12 truly his opinion that the only route left is
13 affirmation, and nothing else should be done to deal
14 with that patient, then you let them go, I would
15 personally disagree based on the long-term effects
16 of affirmation and long-term hormones because
17 without persistence of the incongruity as a concept,
18 that patient is going to have to require the hormone
19 therapy that's eventually going to be causing them a
20 significant medical morbidity.
21 BY MR. BLOCK:
22 Q What if a patient has -- is 18 and has had

1 genital surgery so that they no longer have -- it's
2 a transgender woman and no longer has their male
3 gonads and needs hormones, in that case would you
4 still oppose gender-affirming hormone therapy for
5 that individual?
6 A I recommend that that patient go back on
7 the physiologic levels of their natal sex hormones
8 at that age to maintain their body's health without
9 harm.
10 Q And that would also be your view if the
11 patient were 40 instead of 18, right?
12 A Yes. Yes.
13 Q And you think that when it comes to the
14 issues of providing hormones, you are in a better
15 position to make judgments about the benefits and
16 risks than Dr. Zucker is because you are a trained
17 endocrinologist, and he's not; is that right?
18 A That is correct.
19 Q And so would the converse be true, that a
20 trained psychologist is in a better position to make
21 decisions about what psychological care a
22 transgender individual needs than an endocrinologist

RECORD NO. 19-1952

In The
United States Court of Appeals
For The Fourth Circuit

GAVIN GRIMM,

Plaintiff – Appellee,

v.

GLOUCESTER COUNTY SCHOOL BOARD,

Defendant – Appellant.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF VIRGINIA AT NEWPORT NEWS

JOINT APPENDIX
VOLUME III OF IV
(Pages 758 – 1195)

David P. Corrigan
Jeremy D. Capps
M. Scott Fisher, Jr.
George A. Somerville
HARMAN CLAYTOR CORRIGAN & WELLMAN
Post Office Box 70280
Richmond, Virginia 23255
(804) 747-5200

Counsel for Appellant

Joshua A. Block
Leslie Cooper
AMERICAN CIVIL LIBERTIES UNION
125 Broad Street, 18th Floor
New York, New York 10004
(212) 549-2593

Counsel for Appellee

Eden Brooke Heilman
Jennifer Marie Safstrom
Nicole Gloria Tortoriello
AMERICAN CIVIL LIBERTIES UNION FOUNDATION OF VIRGINIA
701 East Franklin Street, Suite 1412
Richmond, Virginia 23219
(804) 532-2152

Counsel for Appellee

THE LEX GROUP ♦ 1108 East Main Street ♦ Suite 1400 ♦ Richmond, VA 23219
(804) 644-4419 ♦ (800) 856-4419 ♦ Fax: (804) 644-3660 ♦ www.thelexgroup.com

TABLE OF CONTENTS
VOLUME I OF IV

Appendix Page

Docket Entries **1**

Order of
The Honorable Arenda L Wright Allen
Re: Granting Consent Motion for Dismissal of Requests for Relief and Plaintiff's Motion to Vacate Order for Supplemental Briefing and Dismissing Request for Relief of Plaintiff's A mended Compliant
filed December 12, 2017 .... **29**

Order of
The Honorable Arenda L Wright Allen
Re: Denying Amended Motion to Dismiss
filed May 22, 2018 .... **35**

Order of
The Honorable Arenda L Wright Allen
Re: Granting Plaintiff's Motion for Leave to File Second Amended Complaint
filed February 15, 2019 .... **66**

Second Amended Complaint
filed February 15, 2019 .... **70**

Answer to Second Amended Complaint
filed March 1, 2019 .... **89**

Declaration of Gavin Grimm,
With Exhibits,
filed March 26, 2019 108

Exhibits:

A. Treatment Documentation Letter
dated May 26, 2014 123

B. Letter from
R. Smalls to
Virginia Department of Motor Vehicles
dated June 5, 2015 124

C. Order of
The Circuit Court of Gloucester County
dated September 9, 2016 125

D. Redacted Birth Certificate 127

E. Redacted Transcript of Gavin Grimm's Grades
various dates 128

Declaration of Deirdre Grimm
filed March 26, 2019 129

Declaration of Shayna Medley Warsoff,
With Exhibits,
filed March 26, 2019 136

Exhibits:

1. Defendant's Answer to Plaintiff's First Interrogatories
dated December 13, 2018 145

2. Defendant's Supplemental Answer to
Plaintiff's Interrogatory No. 1
dated January 11, 2019 159

3. Expert Report and Declaration of Dr. Melinda Penn, M.D.,
dated January 8, 2019 172

Exhibits, continued:

4. Eastern Virginia Medical School
Curriculum Vitae of Melinda Penn, MD
various dates 183

5. Standards of Care for the Health of Transsexual Transgender, and Gender Nonconforming People
undated 188

6. Endocrine Society Guidelines
undated 306

7. Expert Report of Dr. Quentin Van Meter
dated February 26, 2019 341

TABLE OF CONTENTS
VOLUME II OF IV

Appendix Page

Declaration of Shayna Medley Warsoff,
With Exhibits,
filed March 26, 2019:

Exhibits, continued:

8. **Rebuttal Expert Report and Declaration of Dr. Melinda Penn, MD dated March 4, 2019 .... 361**

9. **Excerpts of Transcript of Deposition of Nathan Collins taken September 21, 2018 .... 363**

   Examination 364

10. **Excerpts of Transcript of Deposition of Walter Clemons, PhD taken September 21, 2018 .... 408**

    Examination 409

11. **Excerpts of Transcript of Deposition of Tiffany Durr taken October 10, 2018 .... 426**

    Examination 427

12. **Excerpts of Transcript of Deposition of Matthew R. Lord taken October 10, 2018 .... 436**

    Examination 437

13. **Transcript of Deposition of Troy Andersen taken March 12, 2019 .... 443**

    Examination 447

Exhibits, continued:

14. Transcript of Deposition of Dr. Quentin Van Meter taken March 18, 2019 541

Examination by Mr. Block.. 547

TABLE OF CONTENTS
VOLUME III OF IV

Appendix Page

Declaration of Shayna Medley Warsoff,
With Exhibits,
filed March 26, 2019:

Exhibits, continued:

15. **Mr. Collins's Memorandum to Deirdre Grimm dated October 14, 2014** 758

16. **Dr. Clemons's Email to the School Board dated October 22, 2014** 759

17. **Mr. Collins's Memorandum to Dr. Clemons dated October 23, 2014** 760

18. **Emails from Carla Hook to a Constituent dated October 24-27, 2014** 762

19. **Email from Carla Hook to a Constituent dated October 31, 2014** 765

20. **Email from Carla Hook to the School Board dated November 4, 2014** 766

21. **Email and Attachment from Carla Hook to the School Board dated November 9, 2014** 767

22. **School Board's Press Release dated December 3, 2014** 769

23. **Recorded Minutes of Gloucester County School Board Meeting held December 9, 2014** 772

24. **Mr. Collins's Correspondence to Deirdre and David Grimm dated December 10, 2014** 779

Exhibits, continued:

25. Email from Amy Bergh to Mr. Collins
dated November 19, 2014 780

26. Transcript of Deposition of Gavin Grimm
taken October 19, 2018 781

Examination by Mr. Corrigan 786
Examination by Mr. Block 948
Examination by Mr. Corrigan 952

27. Presentation Given at the
2014 Virginia School Board Association Conference 958

28. Map of Gloucester High School
dated 2009-2010 969

29. Gloucester High School Map, Locations of School Restrooms
dated 2009-2010 970

30. List of Restrooms at Gloucester High School
undated 971

31. Letter from Joshua Block to David Corrigan
dated December 23, 2016 972

35. Gloucester County School Board press release
dated February 13, 2019 973

36. Gloucester County School Board press release
dated February 21, 2019 974

37. Recorded Minutes of Gloucester County School Board Meeting
dated November 11, 2014 975

Declaration of Janet M. Rainey
filed March 26, 2019 982

Exhibits to Brief in Support of Defendant's Motion for Summary Judgment filed March 26, 2019:

Exhibits:

E. Declaration of Troy Andersen, With Supporting Documents, dated March 25, 2019 983

Attachments:

1. Gavin Grimm's Enrollment Records with The Gloucester County School System various dates 985

2. Gavin Grimm's freshman Report Card for the School Year 2013-2014 991

3. Gavin Grimm was Offered the Opportunity to Have a Hearing with the School Board on Iris Request to Change his School Records on January 18, 2017 992

I. Defendant's Supplemental Answer to Plaintiff's Interrogatory No. 1 dated January 11, 2019 994

Declaration of James H. Loving, With Attached Photographs, filed March 26, 2019 1007

Exhibits to Plaintiff's Memorandum of Law in Opposition to Defendant's Motion for Summary Judgment filed April 9, 2019:

1. Declaration of Shayna Medley Warsoff dated April 9, 2019 1021

A. Transcript of Deposition of Melinda Penn, MD taken March 14, 2019 1023

Examination by Mr. Capps 1028

C. Diagnostic and Statistical Manual of Mental Disorders, With Attachment, Fifth Edition, DSM-5 1115

Attachment:

Email from Amy Bergh to Nate Collins dated November 19, 2014 1118

Transcript of Motions Hearing before The Honorable Arenda L Wright Allen on July 23, 2019 1119

Order of The Honorable Arenda L Wright Allen Re: Granting Plaintiff's Motion for Summary Judgment, Denying the Board's Motion for Summary Judgment filed August 9, 2019 1165

Judgment in a Civil Case filed August 9, 2019 1193

Defendant's Notice of Appeal filed August 30, 2019 1194

TABLE OF CONTENTS
VOLUME IV OF IV – EXHIBIT

Appendix Page

Exhibits to Brief in Support of Defendant's Motion for Summary Judgment filed March 26, 2019:

Exhibits

F. Gavin Grimm's Enrollment Records with The Gloucester County School System various dates 1196

N. Redacted Birth Certificate 1218

O. Redacted Birth Certificate 1219

Gloucester High School

6680 Short Lane
Gloucester, VA 23061

Mr. T. Nathan Collins
Principal

TO: Mrs. Deirdre Grimm

FROM: Mr. T. Nathan Collins TNC

DATE: October 14, 2014

RE: Restroom use for Gavin Grimm at GHS

CC: Ms. T. Durr, Gavin Grimm

This is a follow up of our meeting from this morning in reference to Gavin Grimm having accommodations for restroom use at GHS. In attendance were: Mr. T. Nathan Collins, Mrs. Deirdre Grimm, Gavin Grimm, and Ms. Durr.

Effective Monday October 20, 2014

- *Restroom Use:*
  Gavin may go to any male student restroom at Gloucester High School. He will need a restroom stall with a door, one which will be selected by Gavin. Gavin will notify Ms. Durr if and when this need changes.

- *Responding to verbal harassment, threatening behavior, and other conflicts:*
  Gavin will ignore, or respond to questions with an appropriate response. Gavin will attempt to remove himself from the situation immediately. If Gavin believes a verbal harassment and or threatening language/behavior has been directed toward him, or if there is any other conflict, he will notify Ms. Durr immediately.

- *Other needs:*
  No other needs are needed at this time.

Phone (804) 693-2526
Fax (804) 693-7685

From:	"Dr. Walter R. Clemons" <wclemons@gc.k12.va.us>
Date:	October 22, 2014 7:31:18 PM
To:	"Randy Burak" <georgeburak@cox.net>; "Kevin Smith" <kevin.smith@rivhs.com>; "Kimberly Hensley" <kimberlyehensley@gmail.com>; "Anita Parker" <Anita.Parker@gc.k12.va.us>; "Charles Records" <charles.records@gc.k12.va.us>; "Carla Hook" <hookc@cox.net>; "Troy Andersen" <troyandersengp@cox.net>
Subject:	**Transgender Issue & GHS Pep Rally**

Attachments:

Just FYI. Two issues that I would like to discuss with you tomorrow in closed session include a transgender issue at GHS as well as student behaviors at the GHS pep rally last week. Contact has been made (to Mr. Collins and some Board members) regarding these issues and I want us all to be on the same page in our responses. Also, the paper has contacted Mr. Collins and a Board member (GloQuips)regarding student consequences as a result of student behavior from the pep rally last week. Mr. Collins informed me that some student actions were inappropriate and that he has shared with students that student behavior will be taken in consideration for future events. However, there has not been any action taken against any students at this time stemming from last week. Mr. Collins said he is still trying to identify some students for inappropriate conduct. Finally, I will forward you some literature on the transgender issue that Elizabeth Ewing (VSBA) sent to me when we had a discussion on this issue previously. Furthermore, I will have Mr. Collins present tomorrow evening so he can fill you in on his actions thus far relating to these issues. Have a great day!

Dr. Walter R. Clemons

From:	Nate Collins
Sent:	Thursday, October 23, 2014 12:05 PM
To:	Dr. Walter R. Clemons
Cc:	Tiffany Durr
Subject:	transgender info
Attachments:	GHS transgender.docx; bathroom plan.docx

Dr. Clemons,
Please find attached background information related to use of GHS restrooms by a transgender student: a memo with background information and a copy of the written plan developed regarding bathroom use. Please let me know if you need additional information.

Thanks,

Nate

October 23, 2014

To: Dr. Walter R. Clemons, Superintendent

From: Mr. Nate Collins, Gloucester High School Principal

Subject: Transgender Student Background Information

This is in reference to a tenth grade student at Gloucester High School who is transgender, and identifies as male and his use of male restrooms at GHS. GHS school counseling staff provided information included here.

The student's middle school and ninth grade counselors reported meeting with the student frequently in eight and ninth grade due to anxiety he experienced related to his identity. In ninth grade, because of the severe anxiety he experienced, the student was placed on homebound mid-year until the end of the 2013-2014 school year.

During the summer of 2014 the student provided the School Counseling Department at Gloucester High School with proof of a legal name change, in which the student's name was changed on school documents. The student stated by changing his name his identity is more accurately reflected. In addition to changing his name, the student requested that other students and staff identify him as "he" in oppose to "she". During the current academic school year, the student continues to report experiencing anxiety. The student has stated fear of not being identified by the correct pronoun(s) and possible lack of understanding by students and staff contributes to his anxiety at school. The student has also reported using the women's bathrooms is a concern as it relates to his identity.

At the beginning of the school year, a plan was put in place to accommodate the student's bathroom use concerns. An administrative decision was made and the student was informed by his school counselor he may use the bathroom in the school clinic. In the case of an emergency the student was given permission to use a staff bathroom on the D wing of the school, in which the majority of his classes are located. At the beginning of the school year, the student and his mother reported the student will begin hormone therapy during the month of October. In early October, prior to the anticipated date of the student beginning hormone therapy, the student met with his school counselor and requested permission to use male student bathrooms either before or once he begins hormone therapy. This request was brought to my attention. I consulted with Dr. Clemons and with school counseling staff members to review available legal references. Redacted

Redacted

Redacted During a meeting with the school principal, school counselor, the student, and the student's mother, the student was informed by the school principal he may begin using student male bathrooms at Gloucester High School on October 20, 2014 and a written plan for doing so was developed.

Subject: Re: Issue at GHS
From: Carla Hook <hookc@cox.net>
Date: 10/27/2014 2:29 PM
To: REDACTED @cox.net

I do not believe any plans exist to send home notification to parents.

Legal counsel is Reed Smith in Richmond. Like you, I questioned what legal basis there is to require this. This was an oral opinion given to the superintendent. We have asked for written opinion citing chapter and verse.

Thanks--Carla

On 10/27/2014 1:52 PM, REDACTED @cox.net wrote:

> More thoughts:
>
> 1. Is the SB planning on formally notifying the parents of these boys that they are sharing their bathroom with a female? They have the right to know!
>
> 2. Exactly what "legal counsel" was questioned? What law or precedent was their decision based upon as I find no such precedent or law within VA?
>
> Every parent except 1 that I have spoken to is OUTRAGED over this. A formal notice should be sent out from GHS informing the families at GHS what is occurring.
>
> REDACTED
>
> ---- Carla Hook <hookc@cox.net> wrote:
>
> > Hi REDACTED n.
> >
> > As of right now, transgendered students are allowed to use the restroom of their self-identifying gender. This decision was made at the building level and before the issue was brought to the attention of the school board. However, the building administrators did consult with executive staff in the superintendent's office before making any decision (ie the superintendent and assistants). They in turn consulted legal counsel. When this was brought to the attention of the school board, the majority declined to take any action at this time but did agree to seek a formal written opinion from legal counsel.
> >
> > Hope that helps clarify.
> >
> > Carla
> > On 10/24/2014 2:07 PM, REDACTED @cox.net wrote:
> >
> > > First of all, let me thank you for replying. I have sent 2 emails and you are the ONLY person decent enough to take the time to reply. To say the least, I am disappointed in the lack of response from GHS, Clemons and the entire school board.
> > >
> > > Certainly wish this brought me peace but it certainly does not. I appreciate your response and understand the steps that need to be taken.
> > >
> > > However, on Wednesday I emailed Principal Collins and have yet to receive any response. My email was simple and was only asking for an answer to whether this young lady is using the boys bathroom. And if so, who gave her permission. I would appreciate those questions being answered as they are not confidential regarding a single student but impacts my son as he is in the boys bathroom.
> > >
> > > Many thanks,
> > > REDACTED

---- Carla Hook <hookc@cox.net> wrote:

Thanks REDACTED n. The Board has taken no action on this issue as of this time. However, we have requested a legal opinion from counsel as to our legal obligations to transgendered students. There has been some suggestion that we may be legally obligated to allow cross-gendered use of restroom facilities. I find that difficult to believe, but we are checking into it.

I will also say that I oppose cross-gendered use of restroom facilities; however, mine is not the only opinion on the Board in this regard. I would strongly encourage you to attend the next meeting during pubic comment period, as well as any others concerned about this issue.

Thanks--Carla

On 10/24/2014 10:37 AM, REDACTED @cox.net wrote:

Carla,

Just following up with you as you suggested regarding last nights meeting and what ultimately became of the situation at GHS.

Thanks,
REDACTED

---- Carla Hook <hookc@cox.net> wrote:

There is nothing on the agenda tonight whereby this issue will be discussed in open session, and as I stated a policy change must be done in open session. We do have some student matters to discuss in closed session (after the regular work session) and given these emails and calls it is safe to assume such a student issue will be discussed.

As a work session, there is no public comment time, but there will be public comment time during our regular meeting in November.

Again, I would encourage you to contact us after the meeting. We cannot discuss specific students, but will be able to discuss policy implementation.

Carla

On 10/23/2014 10:49 AM, REDACTED@cox.net wrote:

Carla,

Thanks for replying. Will this be discussed tonight? If so, will it be open or closed session? I would love to be a part of that conversation but both of my kids of athletic activities tonight. This is not a road we need to go down.

Thanks,
REDACTED

---- Carla Hook <hookc@cox.net> wrote:

REDACTED

Thank you for your email. I had not heard about this particular issue until a phone call from another parent last night.

While it is true that we only discuss specific students in closed session, any issues of a policy nature are only done in open session. If this rumor it true, I can assure you it is of tremendous concern to me as well. As you know, I also have two sons. Rumors, particularly among teenagers, can take on a life of their own, so I look forward to

getting all the facts.

I would encourage you to contact me or other Board members again after our meeting tonight.

Thanks--Carla

On 10/23/2014 9:57 AM, REDACTED @cox.net wrote:

I have been told by numerous individuals that there is currently a young lady either using the boys bathroom or requesting permission to use the boys bathroom. Apparently this young lady is uncomfortable in the girls bathroom and was allowed to use a private admin bathroom last year as she wants to be a boy.

Words can not express how dumbfounded I will be if this proves true. For respect of this email I will have to assume it is and express my utmost concern on this issue. I am the mother of a GHS son and an elementary aged daughter. This should not be allowed to happen for reasons I would assume would be obvious:

When does 1 students comfort level or rights come before an entire student body?

If she is still biologically a female she should be using the female restroom. There is certainly more privacy in there than they boys.

Have you considered the possible reactions of what could transpire with her in the boys bathroom? She could be humiliated or physically assaulted by boys in the bathroom. That is certainly a possibility in todays world and a can of worms I would pray you would try to avoid. She could also accuse of boy or boys of a verbal of physical assault that never happened and I am smart enough to know that boy would be guilty until proven innocent!

Are you ok with letting a boy in the same circumstance enter the girls bathroom with his God given genitalia?

What's next the locker rooms? Why not let a boy claiming to be a female trapped in a girls body change close and shower with the girls in their respective locker room? Why don't we send the same young lady in question into the boys locker room to change, She doesn't need a private area. She could certainly use their restroom, change in the presence and shower with them, right?

Please consider all aspects of this issue before making any judgment. This school system has SO many important issues and failures to deal with and correct that I would certainly hope this should be an easy decision to deny this young ladies request. When you start treating one child different and allowing special treatment for one over all others that is an ugly path that you won't want to go down.

Respectfully,
REDACTED

Subject: Re: GHS Restrooms
From: Carla Hook <hookc@cox.net>
Date: 10/31/2014 8:34 AM
To: REDACTED @gmail.com>

There was no vote in this matter, as we are not allowed to vote in closed session. The closed session last night was to discuss a particular student. Nonetheless, a majority has still declined to intervene in the current practice at the high school. I was in the minority in that regard with Mr. Records. I believe that females should use the female restroom and males should use the male restroom. If there is a student that has difficulty with this arrangement, I believe there are other appropriate alternatives that take into consideration the needs of all students.

However, we will be seeking a public vote on this practice at our next regularly scheduled meeting, Nov. 11 at TCW.

Thanks for checking--Carla

On 10/31/2014 7:46 AM, REDACTED wrote:

> Good Morning, Carla,
>
> I received an email from Charles Records this morning regarding the transgender restroom situation. For the record, as obviously, I disagree with this outcome, I would like to know precisely how you voted on this matter, as Charles mentioned the decision was not unanimous.
>
> REDACTED

Diane Gamache

From:	Diane Gamache
Sent:	Wednesday, November 05, 2014 10:47 AM
To:	'Carla Hook'; John Hutchinson; JoAnne Wright; Betty Jane Duncan; Anita Parker; Charles Records; Dr. Walter R. Clemons; Kevin Smith; Kevin's Phone; Kimberly Hensley; Randy Burak; Troy Andersen
Cc:	Carol Dehoux; Randy@Office
Subject:	Proceeding w/Agenda
Importance:	High

As I now understand it, REDACTED following the 10-30 closed meeting – REDACTED REDACTED.

I believe that the Chair plans to determine if a majority of the Board wishes to revisit the matter, and if so, he will notify me of such. For now, I am going to proceed with publishing the agenda without the discussion being added.

Diane

From: Carla Hook [mailto:hookc@cox.net]
Sent: Tuesday, November 04, 2014 8:01 PM
To: Diane Gamache; John Hutchinson; JoAnne Wright; Betty Jane Duncan; Anita Parker; Charles Records; Dr. Walter R. Clemons; Kevin Smith; Kevin's Phone; Kimberly Hensley; Randy Burak; Troy Andersen
Cc: Shirley Chirch
Subject: Re: Draft Agenda for November 11th Monthly SB Meeting

I think we need to add appropriate use of restroom/locker room facilities to the agenda, discuss and vote and be done with this issue for now.

On 11/4/2014 1:16 PM, Diane Gamache wrote:

> Please let me know if you would like any additions or changes made as I plan to publish this tomorrow (Wednesday, November 5, 2014). Thanks!
>
> Diane

Dr. Walter R. Clemons

From:	Carla Hook <hookc@cox.net>
Sent:	Sunday, November 09, 2014 9:32 PM
To:	Anita Parker; Charles Records; Kevin Smith; Kimberly Hensley; Randy Burak; Troy Andersen; Dr. Walter R. Clemons
Subject:	FYI
Attachments:	motion.docx

Whereas the GCPS recognizes that some students question their gender identities, and

Whereas the GCPS encourages such students to seek support and advice from parents, professionals and other trusted adults, and

Whereas the GCPS seeks to provide a safe learning environment for all students and to protect the privacy of all students, therefore

It shall be the practice of the GCPS to provide male and female restroom and locker room facilities in its schools, and the use of said facilities shall be limited to the corresponding biological genders, and students with sincere gender identity issues shall be provided an alternative private facility.

Gloucester (Va.) County School Board

PRESS RELEASE

FOR IMMEDIATE RELEASE ON DECEMBER 3, 2014

CONTACT: George R. (Randy) Burak, Chairperson
Phone: (804) 695-6399
Email: Georgeburak@cox.net

Gloucester School Board prepares to discuss, likely vote at Dec. 9 meeting on restroom/locker room use for transgender students

Gloucester, Va. -- As the Gloucester County School Board members prepare to discuss and likely vote on how to handle the use of school restrooms and locker rooms by transgender students, they continue to seek guidance and input from many sources around the county, state and nation.

"Issues around transgender students are facing schools districts across the country, and we are seeking to learn from the best resources available," said School Board Chair George (Randy) Burak. "This issue is not about one student; rather, it's about all our students. We as a Board are seeking to do what's best for our district in an open, transparent manner."

Process and Perspectives

The Gloucester School Board has received legal guidance from several sources, both locally and around the state. It has reviewed guidance from the U.S. Department of Education's Office for Civil Rights, along with a variety of literature from interested organizations around the country.

The Board has received a great deal of input from the local public through emails, phone calls, comments at the Nov. 11 School Board meeting, and community meetings. Several Board members and Superintendent Walter Clemons recently attended the Virginia School Boards Association's annual conference in Williamsburg, which had an entire working session, "Transgender Protections in Public Schools: Recent Developments," presented by a law firm.

Burak said: "Our Gloucester School Board has undergone a very detailed, professional, and deliberative process, examining many differing opinions and guidance viewpoints. I believe that our district will become stronger for all our students as a result of the research we've done, the discussions we've had, and the ultimate conclusions we'll reach."

Current Situation and Options

While the Gloucester County Public School district adheres to general non-discrimination principles similar to most U.S. school districts, it currently does not have guidelines specifically addressing gender identity and the use of restrooms and locker rooms.

That means that the School Board could decide to adopt specific guidelines to address these issues; or the Board could further define what fully accommodating transgender students would look like and how it would operate on a daily basis.

Good news for all students

One positive outcome of all the discussion is that the District is planning to increase the privacy options for all students using school restrooms, according to Superintendent Dr. Walter Clemons.

Plans include adding or expanding partitions between urinals in male restrooms, and adding privacy strips to the doors of stalls in all restrooms. The District also plans to designate single-stall, unisex restrooms, similar to what's in many other public spaces, to give all students the option for even greater privacy.

"This situation has created the opportunity for us to make things better for all our students and to make our school buildings more accommodating to a wide variety of needs," said Dr. Clemons. **"We have listened to what our parents, students, and other constituents have told us, and we are working to act on their suggestions for the benefit of everyone."**

Background

This issue of restroom use consistent with gender identity first came to the attention of Gloucester schools in October when a transgender student asked campus leaders to use the bathroom of that student's gender identity. Due to student privacy concerns, the issue was initially handled confidentially, and the School Board was informed immediately afterward. While the Board is not legally required to act on the matter, the Board is taking the opportunity to consider developing new guidelines, or further defining the current general practice of non-discrimination.

Since that time, the Board has been reviewing the various options and determining how to best meet the needs of all students in Gloucester schools.

Next Steps

The Board will discuss and likely make a decision at their upcoming monthly meeting at **7 p.m. Tuesday, Dec. 9, at the T.C. Walker Auditorium**. As always, the public is invited to attend.

Anyone interested in expressing views on this or other matters to School Board members can email SchoolBoard@gc.k12.va.us, or call (804) 693-1424 to leave a message.

About the Gloucester (Va.) School Board

The Gloucester School Board is the official policy-making body for Gloucester County Public Schools. The elected Board is composed of seven members representing the five magisterial districts, along with two who serve at large. The 2014 School Board members are Randy Burak, chair; Kevin Smith, vice-chair; Troy Andersen; Kimberly Hensley; Carla Hook; Anita Parker; and Charles Records.

More information about the Gloucester School Board and the Gloucester County Schools may be found at http://gets.gc.k12.va.us/.

RECORDED MINUTES OF THE
GLOUCESTER COUNTY SCHOOL BOARD
GLOUCESTER, VIRGINIA

DECEMBER 9, 2014

The regular monthly meeting of the Gloucester County School Board was held on Tuesday, December 9, 2014. The Chairperson called the meeting to order at 5:30 pm at the Thomas Calhoun Walker Education Center.

I. ROLL CALL

Roll call was taken by the Acting Clerk, and the following persons were recorded as present: George R. (Randy) Burak, Chairperson, Troy M. Anderson, Kimberly (Kim) E. Hensley, Carla B. Hook, Anita F. Parker, Charles B. Records, and Kevin M. Smith, Members. Also present for the closed meeting: Walter R. Clemons, Ph.D., Superintendent of Schools, and John E. Hutchinson, Assistant Superintendent for Administrative Services and Acting Clerk.

II. CALL FOR CLOSED MEETING

At 5:42 pm, a motion was made by Mr. Records, seconded by Ms. Parker, and unanimously approved to adjourn for a closed session, pursuant to *Code of Virginia*, 1950, as amended, Section 2.2-3711 (A), Subsection 1, for the discussion of personnel matters (monthly appointments, resignations, etc.). At 6:32 pm, the Chairperson declared a recess, and the meeting was relocated to the Thomas Calhoun Walker Education Center auditorium.

III. RETURN TO OPEN MEETING/CERTIFICATION

Note: Ms. Diane Clements Gamache, Clerk, recorded the remainder of the meeting. The Clerk noted that all members were present for the open meeting.

At 7:00 pm, a motion was made by Mr. Smith to reconvene the meeting into open session and certify that the Gloucester County School Board, while in closed session, discussed only public matters lawfully exempted from open meeting requirements provided in Subsection A of Section 2.2-3711 and that only public business matters that were identified in the motion convening the closed session were heard, discussed or considered. The motion was seconded by Ms. Hensley and approved as follows:

Mr. Andersen	Aye	Mr. Records	Aye
Ms. Hensley	Aye	Mr. Smith	Aye
Mrs. Hook	Aye	Mr. Burak	Aye
Ms. Parker	Aye		

IV. MOMENT OF SILENCE/PLEDGE OF ALLEGIANCE – Ms. Campbell Farina, SAC representative, led the Board and citizens in a moment of silence followed by the Pledge of Allegiance to the flag of the United States of America.

V. PERSONNEL ITEMS

A. Approval of Monthly Personnel Actions — A motion was made by Mr. Records, seconded by Mr. Andersen, and unanimously adopted to approve the monthly listing of personnel appointments, staff leave, and contract changes **(approved copies attached to minutes)**.

VI. ADDITIONS/CHANGES/ADOPTION OF AGENDA

Dr. Clemons recommended the following changes to the *revised* agenda **(attached to minutes)** as published: Moving policy, File JHCH from Consent to Item C under Administrative Services' Items; and re-ordering School Board Members Items' immediately following Citizens' Comment Period. A motion was made by Mr. Smith, seconded by Mr. Records, and unanimously adopted to approve the agenda as amended.

VII. APPROVAL OF ITEMS CONTAINED IN THE CONSENT AGENDA

A motion was made by Mr. Smith to approve the Consent Agenda as amended (listed below). Motion was seconded by Mr. Andersen and approved with a roll call vote:

Mr. Andersen	Aye	Mr. Records	Aye
Ms. Hensley	Aye	Mr. Smith	Aye
Mrs. Hook	Aye	Mr. Burak	Aye
Ms. Parker	Aye		

ITEMS CONTAINED WITHIN THE CONSENT AGENDA:

A. Approval of Minutes of November 5, 2014 Special (3-Member Panel Hearing) Meeting
B. Approval of Minutes of November 11, 2014, Monthly Meeting
C. Approval of Policy Manual Update
   a. IF-R: Program of Studies (revision)
D. Informational Central Food Service Financial Report as of October 31, 2014
E. Informational Membership Report as of November 21, 2014
F. Informational Suspension Report for November, 2014
G. Informational Visiting Teachers Report for November, 2014
H. Informational Transportation Report for November, 2014

VIII. STAFF PRESENTATIONS/RECOGNITIONS

A. Presentation of Diplomas to GHS Winter Graduates – Dr. Toni Childress, GHS Staff, Mr. Nate Collins, GHS Principal, and Mr. Burak awarded diplomas to the GHS winter graduates. Students present who received their diplomas were: Rebecca Gayle Allen, John Raye Gaddis, Ashley Michelle Kearns, Alexandra Judith Rodriguez, Sebastian Leigh Sain (Advanced Diploma), Justin Raye Schultz, and Travor Jameel Wilson. Three other graduates were not present: Cassidy Reid Preston, James Jack Spence, and Keith Randall Thrift, Jr.

B. Recognition of Mr. Rusty West, Project Lead the Way Teacher – Dr. Wagner congratulated Rusty West for receiving the Project Lead the Way National Teacher of Excellence Award. Mr. West was one of six instructors recognized on the national level for their outstanding commitment to educating students in the STEM disciplines and preparing them with the skills to be successful in college and their careers.

C. Updates on Boards/Commissions by School Board Members – There were none.

IX. CITIZENS' COMMENT PERIOD

Mr. Burak asked if there were any persons present who wished to address the Board. He asked that all persons state their name, the district in which they reside and to limit their remarks to two (2) minutes or less. He stated that Mr. Ted Wilmot, County Attorney, would act as the official time-keeper. The following citizens came forward to speak:

Steve Sikes-Nova (teacher/GEA spokesperson)
Brian McGovern (President of GEA)
Ralph VanNess (Ware)
Donna Pierce Freeman (teacher/Ware)
Pastor Fred Carter (Gloucester)
Gavin Grimm (student)
Deirdre Grimm (Gloucester)
Jacklynn Lehiff (Abingdon)
Scott Williams (Abingdon)
Savannah Williams (Abingdon)
Kathryn Lindsay (Abingdon)
Dianne Carter deMayo (Hayes)
Andrew Palas (Gloucester Point)
Amy VonFossen (Ware)
Adam Carpenter (Gloucester Point)
Campbell Farina (Abingdon)
Karen Pauley (White Marsh)
Barbara King (Abingdon)
Mike Enz (Abingdon)
Catherine Foley (Abingdon)
Marc Farina (Abingdon)
Reese Williams (Ware)
Howard Mowry (Gloucester Point)
Paul Martin (Gloucester Point)
Janet West
Linda Wall (Buckroe Beach)
Don Mitchell (York)
David Wilcox (York)
Terry Brennan (Abingdon)
Michelle Larson (York)
Maritza Cooper (Petsworth)
Ira Johnson (Petsworth)
Gabrielle Johnson (Ware)
Christina Klein (Hayes)
Alex Westfall (Gloucester)
Jacob Hangdahl (Hayes)
Kelly Williams (Gloucester Point)

Note: Change in Order of Items

XII. SCHOOL BOARD MEMBERS ITEMS

A. VSBA Capital Conference – Monday, January 26, 2015 at the Richmond Marriott @ $170 per person. Board members should contact the Clerk for pre-registration purposes if they would like to attend.

XII. SCHOOL BOARD MEMBERS ITEMS – continued

B. Adoption of Resolution re: Funding of Public Education in Virginia – Mr. Burak stated that a resolution proposed in conjunction with the Virginia School Boards Association and the Virginia Association of School Superintendents, was included in the agenda regarding calling upon the Virginia General Assembly to immediately increase the state's share of funding for public education to the level of quality that is prescribed by them in the Standards of Quality and expected by all of the Commonwealth's citizens. A motion was made by Mr. Andersen and seconded by Ms. Parker to adopt the resolution as presented. The Clerk recorded the following vote:

Mr. Smith	Aye	Ms. Parker	Aye
Mr. Records	Aye	Ms. Hensley	Aye
Mr. Andersen	Aye	Mr. Burak	Aye
Mrs. Hook	Aye		

C. Other Matters as brought up by Board Members

1. Discussion of Use of Restrooms/Locker Room Facilities – Mr. Burak stated that a motion had been postponed at the November 11, 2014, until the December 9, 2014, meeting and was in order for consideration at this time. He read the motion to be considered as recorded in the November 11, 2014 minutes:

"Mrs. Hook read the following resolution and made a motion to adopt said resolution:

Whereas the GCPS recognizes that some students question their gender identities, and
Whereas the GCPS encourages such students to seek support, advice, and guidance from parents, professionals and other trusted adults, and
Whereas the GCPS seeks to provide a safe learning environment for all students and to protect the privacy of all students, therefore
It shall be the practice of the GCPS to provide male and female restroom and locker room facilities in its schools, and the use of said facilities shall be limited to the corresponding biological genders, and students with gender identity issues shall be provided an alternative appropriate private facility.

The motion was seconded by Mr. Records."

A motion was made by Mr. Records, and seconded by Mr. Andersen to bring the original motion back to the table for a vote.

Mr. Andersen stated that he would like to politely request from one Board member to another that anyone recuse themselves from voting if they felt they had a conflict of interest, pursuant to Code of Va, 1950, as amended, Section 2.2-3100 or Board policy, File BBFA.

Following comments by each Board member, the Clerk polled on the postponed motion under consideration (carried 6 to 1):

Ms. Parker	Aye	Mr. Smith	Aye
Ms. Hensley	Naye	Mr. Records	Aye
Mrs. Hook	Aye	Mr. Burak	Aye
Mr. Andersen	Aye		

X. STUDENT ADVISORY COMMITTEE (SAC) ITEMS) – Ms. Farina had no items.

RECESS – At 9:18 pm, the Chair called for a 5-10 minute recess. At 9:28 pm, he called the meeting back to order.

XI. SUPERINTENDENT'S ITEMS

A. Comprehensive Plan Update/Reminder of Next Meeting Date – Dr. Clemons reminded Board members and the public that the next Comprehensive Plan development meeting would be held on Wednesday, December 17, 2014, 7:00 pm at the Thomas Calhoun Walker Education Center. He stated that the School Board would have the final decision on the Comprehensive Plan.

B. Discussion of Possible Additional Budget Meeting with Board of Supervisors – Dr. Clemons stated that he would speak with Ms. Brenda Garton, County Administrator, about the possibility of holding another joint budget work session with the Board of Supervisors, as this was discussed at the September joint meeting and the School Board was again receptive.

Mrs. Hook asked if it might be possible to hold a 1-hour meeting with the local and state legislators prior to the opening of the General Assembly, and Dr. Clemons stated that he would check into it and get back to the Board.

XIII. HUMAN RESOURCES ITEMS

A. Monthly Departmental Report – Dr. Juanita Smith, Director of Human Resources, presented information on the activities of the department during the month, and expressed her appreciation to her staff. She also announced that Ms. Ashley Field had recently earned Nationally Board Certified Teacher status and Mr. Andersen asked that she be recognized at the January Board meeting.

XIV. ADMINISTRATIVE ITEMS

A. Monthly Departmental Report – Mr. Hutchinson reviewed departmental activities accomplished during the month.

B. Update on Redistricting Plans – Mr. Hutchinson stated that preliminary numbers would suggest that attendance zones would remain the same for middle schools when Page opens; however, they are continuing to monitor elementary school numbers.

Mr. Records asked if information on previous studies on the Page site, etc. had been sent to the Board of Supervisors. Dr. Clemons and Mr. Hutchinson both noted that they would check.

C. Policy JHCH: School Meals and Snacks (new) – A motion was made by Mr. Smith, seconded by Mr. Records and unanimously approved to adopt File JHCH: School Meals and Snacks as a first and second reading.

Mrs. Hook asked if Food Service could make a 10 minute presentation on the status of the School Lunch Act at a future work session, and Mr. Hutchinson agreed to pursue this.

XV. INSTRUCTIONAL ITEMS

A. Monthly Departmental Report – Dr. Wagner reviewed highlights of the month from Instructional Services.

XV. INSTRUCTIONAL ITEMS – continued

Mrs. Hook asked that a report be given to the Board in January on the Adaptive Tests for 6th graders.

B. Continued Discussion on Field Trip Policy (Policy ICA) – Dr. Wagner stated that a VML supplemental policy might be available on an annual basis to cover international travel but stated that there were several options available. It was agreed that he would present different options for the Board at a work session in January or February.

C. Update on Naviance: College and Career Readiness Solutions – Dr. Wagner informed the Board that staff would pursue using Naviance as a sole source since no others were available as a result of the RFP/bid process.

XVI. BUDGET AND FINANCE ITEMS

A. Monthly Departmental Report – Ms. Joanne Wright, Director of Budget and Finance, highlighted tasks and accomplishments of the Budget and Finance Office, and expressed her appreciation to her staff.

B. Acceptance of Donations -- Ms. Wright highlighted the donations received by the division totaling $564.44. A motion was made by Mr. Records and seconded Mr. Smith to accept with grateful appreciation the donations as outlined. The Clerk polled the Board as follows:

Ms. Parker	Aye	Mr. Smith	Aye
Ms. Hensley	Aye	Mr. Records	Aye
Mrs. Hook	Aye	Mr. Burak	Aye
Mr. Andersen	Aye		

C. Financial Reports – Ms. Wright presented the following reports that were accepted by the Board as information:

1. October 30, 2014 Financial Report
2. November 25, 2014 Construction Financial Report
3 November 25, 2014, HVAC/Roof Financial Report

XVII. PUBLIC ANNOUNCEMENTS

Mr. Burak read the following public announcements**:**

A. Next GCPS Comprehensive Plan Meeting – Wednesday, December 17, 2014, 7:00 pm @ the Thomas Calhoun Walker Education Center (Cafeteria)
B. Winter Break-Division Closed – Monday-Friday, December 22, 2014-January 2, 2015 – Note: Monday-Tuesday, December 22 (Full)-23 (Half), 2014, are 12-Month Employee Work Days
C. Teachers/Students Return from Winter Break – Monday, January 5, 2015
D. Next Monthly and Annual Organizational School Board Meeting – Tuesday, January 13, 2015, 7:00 pm @ the Thomas Calhoun Walker Education Center (Auditorium)

Mr. Burak asked Board members to consider leadership roles for the January 13, 2015, organizational meeting and let others know if they were interested the Chair/Vice Chair position.

Mr. Burak requested additional information on the use of a PR consultant for such items as redistricting, the new Page Middle School and the budget process. Dr. Clemons stated that he would bring back a recommendation to the Board.

Mr. Records asked if Dr. Clemons would be prepared to give an assessment/synopsis of his first 90 days at the January meeting and Dr. Clements assured him that he would.

XVIII. CALL FOR ADJOURNMENT

At 10:10 pm, there being no further business, a motion was made by Ms. Parker, seconded by Mrs. Hook, and unanimously approved to adjourn the regular monthly meeting of December 9, 2014, until the next monthly and annual organizational meeting at 7:00 pm on Tuesday, January 13, 2015, at the Thomas Calhoun Walker Education Center (Auditorium).

____
George R. (Randy) Burak, Chairperson

____
Diane Clements Gamache, Clerk

____
John E. Hutchinson, Acting Clerk

Attachments (3): To be bound with the official minutes once approved.

1. Bound Agenda for December 9, 2014, Monthly Meeting
2. Revised Agenda for December 9, 2014, Monthly Meeting
3. Approved Monthly and Supplemental Personnel Listing

END
DCG/JEH/:bjd
MIN-12-09-14

Gloucester High School

6680 Short Lane
Gloucester, VA 23061

Mr. T. Nathan Collins
Principal

December 10, 2014

Mr. and Mrs. David and Deirdre Grimm
3624 Fox Haven Drive
Gloucester, Virginia 23061

Dear Mr. and Mrs. Grimm,

This letter will provide notice to you that the Gloucester County School Board at its regularly scheduled meeting on December 9, 2014, adopted the following resolution: "It shall be the practice of the Gloucester County Public Schools to provide male and female restroom and locker room facilities in its schools, and the use of said facilities shall be limited to the corresponding biological genders, and students with gender identity issues shall be provided an alternative private facility."

As a result, Gavin will no longer be able to use the male restrooms at Gloucester High School effective immediately. I will work with you regarding Gavin and options for his restroom usage at GHS.

Please contact me at 804.693.2026 or at ncollins@gc.k12.va.us if you have any questions. Thank you.

Sincerely,

T. Nathan Collins

Phone (804) 693-2526 *Fax (804) 693-7685*

From: "Amy Bergh" <abergh@gc.k12.va.us>
Date: November 19, 2014 12:22:31 PM
To: "Nate Collins" <ncollins@gc.k12.va.us>
Subject: **Restrooms**

Attachments:

I am writing to express my deep concern for the planned changes to C-Hall restroom
s. I am not sure that the decision makers are aware of the high usage of those res
trooms. With the exception of between first and second block the woman's restroom
typically is fully occupied and has a line of several woman waiting to use the fac
ilities. I understand the faculty men's room is fairly heavily used also. On first
glance there may not appear to be that many staff members on C-Hall. It is easy t
o forget that we house a high number of Special Education students with a high num
ber of support staff. It's not just the teachers; but also the paraprofessionals,
therapist, drivers that use the C-Hall restrooms. C-Hall is also frequently used b
y Page staff during the day. Simply using the student restroom does not alleviate
the issue as there is almost always a line in there between classes. Most of C-Hal
l teachers have at least one day that we have no opportunities to use the restroom
other than the five minutes during class changes from before 8:00 a.m. with schoo
l starting until our lunch at 12:30 p.m. That is a very long time for anyone to wa
it but pretty impossible for faculty on diuretics. Of course we could always call
security to cover our classes but that seems to be a very poor use of our resource
s; a loss of instructional time; and they are not always available.

I am very aware of what a difficult issue this is but I truly feel that in the rus
h to fix one problem we are creating another. Perhaps other options could be more
fully examined prior to a final decision being made.

*I know there is a plan for A -Hall and that does make a little more sense because
they have six faculty restrooms and two student restrooms.
*The B-Hall restrooms are not even used during the day. Perhaps the doors could be
adjusted to accommodate this problem.
*I don't know if anyone is currently using the old Childcare "restroom" C162; perh
aps that could be converted as a long term solution.
*The main office has three staff restrooms not counting the principal's; perhaps a
door to the hall could be added to the back restroom.
*I believe the custodians even have two private restrooms in their locker rooms; i
s that still a need?

I know there is no easy solution to this problem but please consider that it is mu
ch easier to give a student a hall pass to travel across the school then for a sta
ff member to use the restroom.

Thank you for your considerations,
Amy

1 IN THE UNITED STATES DISTRICT COURT
2 FOR THE EASTERN DISTRICT OF VIRGINIA
3 NEWPORT NEWS DIVISION
4
5 - - - - - - - - - - - - - - - x
6 GAVIN GRIMM, :
7 Plaintiff, :
8 v. : Case No.
9 GLOUCESTER COUNTY SCHOOL : 4:15-cv-54
10 BOARD, :
11 Defendant. :
12 - - - - - - - - - - - - - - - x
13
14 Deposition of GAVIN GRIMM
15 Richmond, Virginia
16 Friday, October 19, 2018
17 9:40 a.m.
18
19
20 Job No.: 207940
21 Pages: 1 - 177
22 Reported By: Leslie D. Etheredge, RMR, CCR

1 Deposition of GAVIN GRIMM, held at the
2 offices of:
3
4 ACLU OF VIRGINIA
5 701 East Franklin Street, Suite 1412
6 Richmond, Virginia 23219
7 804.523.2157
8
9
10
11
12 Pursuant to Notice, before Leslie D.
13 Etheredge, Registered Merit Reporter, Certified
14 Court Reporter and Notary Public in and for the
15 Commonwealth of Virginia.
16
17
18
19
20
21
22

1 A P P E A R A N C E S
2
3 ON BEHALF OF THE PLAINTIFF:
4 JOSHUA A. BLOCK, ESQUIRE
5 SHAYNA MEDLEY-WARSOFF, ESQUIRE
6 AMERICAN CIVIL LIBERTIES UNION
7 125 Broad Street, 18th Floor
8 New York, New York 10004
9 212.549.2627
10 and
11 EDEN HEILMAN, ESQUIRE
12 NICOLE TORTORIELLO, ESQUIRE
13 JENNIFER SAFSTROM
14 ACLU OF VIRGINIA
15 701 East Franklin Street, Suite 1412
16 Richmond, Virginia 23219
17 804.523.2157
18
19
20
21
22

1 ON BEHALF OF THE DEFENDANT:
2 DAVID P. CORRIGAN, ESQUIRE
3 HARMAN, CLAYTOR, CORRIGAN & WELLMAN
4 4951 Lake Brook Drive, Suite 100
5 Glen Allen, Virginia 23060
6 804.747.5200
7
8
9 ALSO PRESENT:
10 Tracey R. Dunlap, VML Insurance Programs
11
12
13
14
15
16
17
18
19
20
21
22

1 C O N T E N T S

2 EXAMINATION OF GAVIN GRIMM PAGE
3 BY MR. CORRIGAN 6
4 BY MR. BLOCK 168
5 BY MR. CORRIGAN 172
6
7
8
9
10 E X H I B I T S
11 (Attached to transcript)
12 GAVIN GRIMM DEPOSITION EXHIBITS PAGE
13 Exhibit 1 October 28, 2014 email 92
14 from Amy Bergh
15
16
17
18
19
20
21
22

1 P R O C E E D I N G S
2 Whereupon,
3 GAVIN GRIMM,
4 being first duly sworn to testify to the truth,
5 the whole truth, and nothing but the truth, was
6 examined and testified as follows:
7 EXAMINATION BY COUNSEL FOR THE DEFENDANT
8 BY MR. CORRIGAN:
9 Q Would you state your full name, please.
10 A Gavin Grimm.
11 Q No middle name?
12 A Sorry. Gavin Elliot Grimm.
13 Q E-L-L-I-O-T-T?
14 A O-T.
15 Q One T. Okay. Gavin, we have met before.
16 I am going to be asking you questions related to
17 this lawsuit, and, typically, in a situation like
18 this, I like to lay out two rules, which I think
19 you have already gone over with your counsel.
20 The first one is, if your answer is yes or
21 no, please say yes or no and not uh-huh, huh-uh,
22 or shake and nod your head. Fair enough?

1 A Yes, sir.
2 Q Second one, you just did it, let me finish
3 before you start, I will let you finish before I
4 start, so we are not speaking at the same time, so
5 the court reporter can get everything down. Okay?
6 A Yes, sir.
7 Q Thank you. What is your current address?
8 A 20047 Stanton Avenue, Castro Valley,
9 California.
10 Q It doesn't matter. The zip doesn't
11 matter.
12 A Okay.
13 Q And who do you live with there?
14 A Three housemates.
15 Q How long have you lived there?
16 A Approximately 2 months.
17 Q Where were you living before that?
18 A Berkeley, California.
19 Q Do you remember the address?
20 A 1709 Shattuck Avenue.
21 Q S-H --
22 A A-T-T-U-C-K.

1 Q Okay.
2 A And that is Berkley, California.
3 Q Who did you live with there?
4 A I lived at varying times with different
5 roommates and on my own.
6 Q Is that a house, a freestanding house?
7 A It is an apartment complex.
8 Q Okay. How many bedroom apartment was
9 yours?
10 A One. Yes, one.
11 Q Before the Shattuck Avenue address in
12 Berkley, where did you live?
13 A Gloucester, Virginia.
14 (Interruption at the door and discussion
15 held off the record.)
16 Q What was the address in Gloucester?
17 A 3624 Foxhaven Drive, Gloucester, Virginia.
18 Q Who did you live with there?
19 A My brother, father and brother.
20 Q Their names?
21 A David, my father; Deirdre, my mother; and
22 David, my brother.

1 Q And how long did y'all live at that
2 particular address?
3 A From birth until moving to California.
4 Q What is your date of birth?
5 A [redacted] 1999.
6 Q Are you currently employed?
7 A I am not on an official payroll, I do some
8 freelance activism.
9 Q So what does that mean? What is freelance
10 activism?
11 A I may be invited to speak at a college or
12 at a conference, and sometimes there is monetary
13 compensation.
14 Q What determines whether there is monetary
15 compensation?
16 A The ability of the requester.
17 Q So give me an example of what you are
18 talking about.
19 A For example, should a middle school invite
20 me to talk to their GSA, I would never ask for
21 financial compensation, but should I go to a more
22 professional event, which would probably have a

1 larger budget, they may -- pardon me -- they may
2 offer me some kind of compensation.
3 Q What is the range of compensation, when
4 you are compensated, for your freelance activism?
5 A It is hugely variable, anywhere from 50
6 dollars to more than that.
7 Q 50 up to what?
8 A I -- sorry. I am trying to accurately
9 recall it.
10 Q Sure. If it is a ball park, I --
11 A A ball park of like a thousand dollars.
12 Q Okay.
13 A It is not frequently more than that or
14 even that.
15 Q Okay. How often are you engaged in
16 freelance activism?
17 A I would say average a fee times a month, a
18 few times a month. Sometimes more often,
19 sometimes less.
20 Q Since you have been in California, has
21 your freelance activism been restricted to
22 California?

1 A No.
2 Q Where have you been?
3 A Most recently, it was somewhere on the
4 East Coast, Philadelphia. Virginia at one point.
5 Beyond that, I can't recall any more individual
6 states.
7 Q Where in Virginia?
8 A I believe it was -- Actually, I don't
9 recall well enough to say with certainty.
10 Q Okay. Do you remember where you flew into
11 or where you -- how you traveled?
12 A I traveled by plane. It was not -- I
13 recall it was not close enough that it would have
14 been possible to visit home so it was probably --
15 well, in fact, pardon me. I won't speculate.
16 Q Okay.
17 A I just recall that I have been to Virginia
18 for business since moving to California.
19 Q Where did you fly into when you did
20 business in Virginia?
21 A I can't recall.
22 Q You don't remember whether it was Reagan

1 or Dulles or Richmond?
2 A I really don't recall, sir.
3 Q Okay. Are you currently in school?
4 A Yes, sir.
5 Q Where are you attending?
6 A Berkley City College.
7 Q Until you said that yesterday, I had never
8 heard of Berkley City College. Is that part of
9 the state community college system or is it a
10 local private school?
11 A It is a community college.
12 Q Okay. How long have you been going there?
13 A Since -- since the start of this current
14 semester, I don't recall what month it began.
15 Q So September or August, fall semester kind
16 of thing?
17 A Yes, sir.
18 Q Okay. Before attending Berkley City
19 College, did you attend any other college?
20 A No.
21 Q From the time -- when did you leave
22 Gloucester approximately?

1 A January of this year.
2 Q 2018?
3 A Yes, sir.
4 Q You graduated Gloucester High School June
5 of 2017.
6 A Yes, sir.
7 Q Is that correct? What did you do from
8 June of 2017 until January of 2018, when you moved
9 to California? When I say what did you do, were
10 you working, were you going to school?
11 Let me ask you this. Were you living at
12 home?
13 A Yes.
14 Q So what were you doing in terms of work or
15 anything like that?
16 A I was not working, I was also not in
17 school.
18 Q So what were you spending your time doing?
19 A I suppose -- well, rather, I won't
20 suppose. I -- I spent time with friends or stayed
21 around the house.
22 Q Your brother is a twin; is that right?

1 A Yes, sir.
2 Q And the full family is your mom, your dad,
3 your brother and you?
4 A In the household?
5 Q Yes.
6 A Yes, sir.
7 Q Are there other family members?
8 A There are extended family members, which
9 are not directly involved with my current family
10 life.
11 Q Okay. Are there any of the others blood
12 siblings or parents?
13 A I have three blood half-siblings.
14 Q Okay. The half-siblings are the children
15 of your mom or your dad?
16 A Two of them are children of my father and
17 one of them is a child of my mother.
18 Q Are they in the Gloucester area, the
19 children, your half-siblings?
20 A I do not know the whereabouts of either on
21 my father's side; however, the half sibling on my
22 mother's side lives not in the Gloucester area.

1 Q Tell me which schools you attended
2 starting as soon as you went to school.
3 A I do not recall the pre-K institutions I
4 went to; however, I started public school in
5 Bethel Elementary, I then went to Peasley Middle
6 School, and then Gloucester High School.
7 Q Peasley is P-E --
8 A A-S-L-E-Y.
9 Q So elementary was K to?
10 A 5.
11 Q 5, and middle was 6 to 8?
12 A Yes, sir.
13 Q Gloucester High School was 9 to 12?
14 A Yes.
15 Q Was your brother in your class, not in the
16 actual classes, but in the same grade as you
17 throughout?
18 A Yes.
19 Q Did he also graduate?
20 A Yes.
21 Q All right. Let's go to the elementary
22 school. At any time when you were in the

1 elementary school, at Bethel Elementary, did you
2 have -- I want to use the right terms and not in
3 any way sound like I am trying to be difficult;
4 but during that time, from kindergarten through
5 5th grade, did you at any time have the beginnings
6 of what you now perceive to be gender identity
7 issues?
8 A Absolutely.
9 Q Just tell me about that. When did that
10 first start? When do you first have any
11 recollection of thinking or believing or feeling
12 like you were male and not female?
13 A I believe myself to be a boy in my
14 internal dialogue until the point that I recognize
15 that there were -- that society perceives larger
16 differences between men and women, I suppose more
17 accurately when I entered school age and
18 recognized that men and women have different
19 expected societal roles.
20 At that point I had an understanding that
21 the one assigned to myself, of course, the female
22 social and physical role, was inaccurate; however,

1 I did not have the language at that time to
2 vocalize those feelings.
3 Q If I can try to express what you just
4 said, is it true that before you went to school,
5 you were not aware one way or the other, it was
6 like when you went to school is when it kind of
7 became I see, girls are one way, boys are
8 different, boys are treated differently?
9 A Not -- not exactly. If I can -- I
10 understood myself to be a boy in the sense that my
11 internal self-perception was that way in the sense
12 that the male cartoon characters, you know, that I
13 idolized, I felt that I was, you know, like them
14 in the sense of gender; however, when I hit an age
15 where social gender expectations came into play, I
16 recognized that other people perceived me as a
17 girl.
18 Q When was it that you first realized that
19 others perceive you as a girl?
20 A That would have been when I entered
21 school.
22 Q As we sit here today and you look back on

1 it, do you say -- I mean a moment, was there a
2 moment when a teacher said something or somebody
3 said something and you went she thinks I am a
4 girl?
5 A There were points in my childhood where I
6 would request to do something and get --
7 Gloucester is a socially conservative place, so
8 there were points in time, when I was younger,
9 where I would request to do something or show an
10 interest in doing something, which was
11 traditionally reserved for boys, and would be
12 refused, rejected, and at that point that was the
13 point in which I realized there were differences
14 and that I was assumed to be on sort of the wrong
15 side of the line there.
16 Q Let me ask you this. What specific
17 refusals or rejections are you referring to? I
18 mean what are we talking about?
19 A On one occasion, I wanted to walk down to
20 my friend's house, who was a 5-minute walk away on
21 the same street, he and I -- he -- he, myself and
22 my brother were all friends, and at one point my

1 father told me I could no longer go over to his
2 house, whereas my brother could, the reason being
3 I was, in his opinion, at the time a girl.
4 So examples like that. When I wanted to
5 do sports --
6 Q Let me interrupt you for a second.
7 A Yes, sir.
8 Q That specific occasion, when your father
9 said you can't go to the friend's house but your
10 brother can, how old were you?
11 A I was between 6 and 8. Well, I was
12 probably 8. I don't imagine they would have
13 allowed me to walk that far when I was 6, so
14 around 8.
15 Q What was your understanding of the reason
16 that you couldn't go and your brother could?
17 A I don't think I had a good understanding
18 of why that was a reasonable declaration.
19 Q Yes.
20 A However, I do --
21 Q With regards to whether it was reasonable,
22 what was the reason?

1 A Well, pardon. What I was saying, I
2 suppose, is I was not given a reason, it was -- it
3 was just that I was not allowed to and my brother
4 was.
5 Q And this was your father?
6 A Yes.
7 Q So that's one example of a refusal or
8 denial. What were the others?
9 A The most pertinent additional memory that
10 I have is when I wanted to play baseball and my
11 only options were softball on a female team, and
12 that caused me so much distress that, despite
13 already having bought a mitt and a ball, I did not
14 actually enter the sport.
15 Q How old were you at that point? Again,
16 approximately.
17 A Approximately 10.
18 Q It was little league?
19 A Oh, I don't recall.
20 Q Did your brother play baseball?
21 A I don't recall. I don't recall.
22 Q Did your brother play athletics as a child

1 or after childhood into high school and things?
2 A My brother -- Growing up, we both did tee
3 ball and he went on to play football later.
4 Q How far did he go in playing football?
5 A There is a league, the Gloucester Knights,
6 I believe, and he went up until the point of
7 beginning high school, I believe, that was when he
8 stopped playing football.
9 Q Okay. Did you ever express an interest in
10 playing football?
11 A Absolutely.
12 Q And what happened?
13 A I was told I could not.
14 Q And who told you that?
15 A Both of my parents at the time.
16 Q Did they tell you why?
17 A They said it was because I was a girl.
18 Q Any other examples of refusals or denials,
19 because of your perceived being female, that you
20 can think of besides we have talked about walking
21 to your friend's house, we have talked about
22 baseball versus softball and deciding not to play,

1 we have talked about not playing football.
2 A Can you clarify what time frame we are
3 looking at with this?
4 Q Any time.
5 A Any time. There are. There are quite a
6 few instances where, once I cut my hair short, I
7 was 12, I was told that it was not a style
8 appropriate for me. All throughout my childhood,
9 I would request boys' clothing and was told that
10 that was also not appropriate for me. Eventually,
11 I began to wear boys' clothing and was, of course,
12 told it was not appropriate for me, so I would say
13 that consistently throughout my life, I have
14 expressed masculinity and have been told that it
15 was inappropriate for the gender that I was
16 perceived as at the time.
17 Q All right. Let's talk about those. You
18 mentioned specifically your haircut. Who told you
19 it was not appropriate for you?
20 A People in -- people that I interacted
21 with. I could not recall individual names, I just
22 do recall that there were many comments, mostly

1 peers and family members.
2 Q Did that family members include your mom
3 and dad?
4 A My father, however, the other family
5 members are extended -- estranged family.
6 Q Okay. So your father did tell you you
7 shouldn't wear your hair short like that?
8 A Yes.
9 Q Did your mother say that?
10 A My mother was not excited about the
11 haircut, but she supported it.
12 Q How about your brother?
13 A He didn't -- we didn't -- he didn't have
14 an expression one way or the other that I recall.
15 Q What about the clothing, wearing what you
16 described as boys' clothes. Who expressed to you
17 that you shouldn't be wearing boys' clothes? Did
18 your father?
19 A My father and then my mother was perhaps
20 the primary person, as she was the one that would
21 most often take me clothes shopping.
22 Q So you would be shopping with her and you

1 would be saying I want these, and she'd say no,
2 you can't have those, you have to get these other
3 ones?
4 A Yes.
5 Q Okay. So did you end up buying what you
6 perceived to be girls' clothes instead of boys'
7 clothes?
8 A When I was younger and had a lesser degree
9 of control over what I was wearing, I conceded
10 more often than not; however, as soon as I was old
11 enough to know how to argue with my parents, I
12 was, you know, fighting for the boys' aisle.
13 Q Once you started fighting for the boys'
14 aisle, did they eventually give in and let you
15 wear boys' clothes?
16 A They did.
17 Q When was that approximately?
18 A I have been wearing pretty much
19 exclusive -- well, I have been wearing exclusively
20 clothes from the boys' section since I was 11 or
21 12.
22 Q So that's approximately when you learned

1 how to argue with your parents?
2 A Well, no. I argued far before that.
3 Q But you got better at it?
4 A Yes, I would say so.
5 Q Okay. Let's talk about your friends
6 during the same time frame, and let's go to just
7 around age 11 or 12, when you are now -- I mean
8 tell me if I am wrong, you are not presenting
9 yourself more as a boy than a girl. Is that true
10 or not?
11 A Everyone still understood -- everyone
12 still assumed that I was a girl, I had not at that
13 time discovered the word transgender and how that
14 related to who I was. However, outwardly, I did
15 present very masculinely, and that was not
16 something that was unnoticed by peers and friends.
17 Q And in that time frame, age 11 to 12,
18 what -- when you say it was noticeable, what
19 notice -- what awareness did you have of the
20 notice that people were taking?
21 A Well, I was bullied pretty seriously in --
22 throughout all of my school career, but elementary

1 and middle including. Part of this bullying was
2 centered around the fact that I was not
3 traditionally feminine.
4 Q The word bullying can cover a broad range
5 of activities, depending on the -- I am sure there
6 is a definition but there is also perceptions.
7 What did you consider to be bullying?
8 What bullying occurred?
9 A People threw things at me, people called
10 me horrible names, people would refuse to sit near
11 me, people would exclude me from activities.
12 Q Now, these people that you are talking
13 about, are those your peers?
14 A Yes.
15 Q Members of your age group?
16 A Yes.
17 Q Where would these things occur?
18 A Primarily in school.
19 Q What ages did this activity occur, like
20 what grades?
21 A Yes, sir. I have been bullied my entire
22 school career, so all of them.

1 Q Okay. K through 5, those things occurred?
2 A Absolutely.
3 Q 6 through 8, that occurred?
4 A Absolutely.
5 Q 9 through 12, those things occurred?
6 A Absolutely.
7 Q What would be the frequency you would say
8 with which those things occurred?
9 A In high school, I would say -- pardon. I
10 would say -- I mean I would say it was pretty
11 consistent. I had probably a daily event that
12 made me feel unsafe or unhappy, at least one thing
13 would happen pretty consistently, minor to major,
14 so the frequency was high.
15 Q K through 5, 6 through 8, 9 through 12,
16 every day --
17 A Yes.
18 Q -- something happened?
19 A Yes.
20 Q Okay.
21 A And to clarify -- pardon me. I'm sorry.
22 Q No. That's fine.

1 A That it was not necessarily that a major
2 event would happen every day, but there was
3 something that made me feel unsafe or -- or
4 disliked for sure every day.
5 Q So let's talk about major. What would you
6 perceive as major in the area of bullying?
7 A Well, when I -- I would say major would be
8 either an example where I have had something
9 thrown at me or a particularly public bout of
10 ridicule or cases where a group would ridicule me
11 publicly or perhaps a case where a chair was
12 pulled out from under me. Those are examples that
13 I can recall of things I consider more serious.
14 Q And how about what would be something that
15 was not major, that was minor, and yet made you
16 feel, as you said, unsafe or disliked?
17 A I was -- I was called names with such
18 frequency that I would consider an insult a minor
19 thing. I could expect to be called some kind of
20 unkind name at least once or twice a day in
21 school.
22 Q What kind of names? Look, I am sorry I am

1 asking you all these questions. I think it is all
2 relevant, and so that's why I am asking the
3 questions.
4 A Okay.
5 Q So what kind of names?
6 A Faggot, dike, homo, weirdo, references to
7 my weight.
8 Q Did you feel like there was any particular
9 group of people who were the ones more likely to
10 pick on you? I mean was it more boys than girls
11 who were picking on you, was it more -- and, you
12 know, we all went to high school, jocks versus
13 whoever, or did you feel like it was any -- any
14 identifiable group of people?
15 A I wouldn't know those people personally
16 enough to identify with groups they belong to.
17 Q So these are people that you don't
18 actually know?
19 A Well, I went to school with them. They
20 weren't my friends.
21 Q Right. So let's go in the other
22 direction. In K through 5, did you have friends?

1 A Very few.
2 Q How about middle school?
3 A Also very few.
4 Q How about high school?
5 A I had a very strong core group of friends
6 in high school.
7 Q In elementary school, were you and your
8 brother -- would you consider you and your brother
9 to be friends?
10 A No.
11 Q Middle school?
12 A No.
13 Q High school?
14 A No.
15 Q I might focus on the high school, but let
16 me just ask you about the elementary and middle
17 school. Did you -- I mean who were your friends?
18 How were -- how did you become -- The few friends
19 that you had, how did you feel like that worked,
20 that you became friends with those people?
21 Was there any particular activity or thing
22 that kind of helped you associate with them and

1 helped them associate with you?
2 A I had friends that were friends of mine
3 because our mothers were close, I didn't really
4 have personal friends, people that I bonded with
5 like organically and could spend time with.
6 Q But, in high school, these people actually
7 were your friends?
8 A Yes.
9 Q Okay. Can you tell me who those people
10 were?
11 A Do you need first and last names?
12 Q I would like first and last names, but if
13 you know them, sure.
14 A Evelyn Hronec.
15 Q Help me with Hronec.
16 A H-R-O-N-E-C. Olivia Pohorence,
17 P-O-H-O-R-E-N-C-E. Camille Gibson.
18 Q C-A-M-M-I-L-E?
19 A L-L. C-A-M-I-L-L-E.
20 Q That's what I wrote, it is not what I
21 said.
22 A And then Gibson.

1 Q Right.
2 A Alec Earwood, E-A-R-W-O-O-D. Caroline
3 Cox, that is just C-O-X. And I think that -- that
4 is sufficient for my core group.
5 Q That's the core group?
6 A Yes, sir.
7 Q How about in terms of the people at the
8 school, were there any people at the school that
9 you felt like were your supporters and people --
10 in particular, I am asking about the high school.
11 A In terms of staff or students?
12 Q I am asking about staff and faculty now
13 that were supporters of yours.
14 A Supporters of mine in what way?
15 Q Just personally, like you felt like they
16 were there to help you and supported you in terms
17 of whatever you were going through.
18 A Yes, I felt that there were a few staff
19 that were -- that served that role.
20 Q Who were they?
21 A The nurses.
22 Q Names?

1 A I am trying to recall. Beverly Sabourin
2 and Niki -- I just knew her as Miss Niki. The
3 three librarians as well, whose names escape me at
4 the moment.
5 And although I don't recall names, I do
6 recall that the office staff were always friendly
7 and kind, the women at the front desk.
8 Q What about the counselors and the
9 counseling staff?
10 A I would say Matthew Board would be one
11 person who I felt was a kind resource.
12 Q Who was assigned -- Who were you assigned
13 to or was assigned to you, freshman, sophomore,
14 junior, senior year?
15 A I don't really recall.
16 Q For sure, we know Tiffany Durr, sophomore
17 year; right?
18 A Yes, but I do not recall for the other
19 years.
20 Q Somebody named Neblett?
21 A John Neblett?
22 Q Yes. Was he ever your counselor?

1 A I don't recall. I recall having spoken to
2 him but not about what or why.
3 Q How about your senior year, did anybody
4 talk to you about going to college or where you
5 were going to college or, you know, any type of
6 counseling-type role like that?
7 A I really -- I don't recall.
8 Q With respect to Miss Durr, what do you
9 recall in terms of any interactions you had with
10 her?
11 A I really don't. I just recall that we had
12 spoken at various points. Oh, may I correct
13 myself?
14 Q Yes.
15 A Miss --
16 Q You can always correct yourself, just so
17 you know.
18 A Miss Durr was the person that my mother
19 and I contacted ahead of beginning sophomore year.
20 Q Right. I was going to talk to you about
21 that, and we will talk in detail about that.
22 Other than that, do you remember you and her

1 having conversations, her being supportive,
2 nonsupportive, helpful, not helpful, or how did
3 you perceive things between you and her during
4 that sophomore year, when she was, according to
5 her, assigned to you?
6 A I don't ever recall her being malicious;
7 however, I also cannot recall any individual
8 conversations that we had.
9 Q So would you say it was neutral, or would
10 you say it was unhelpful or just kind of just
11 really nothing?
12 A I would say that I don't recall.
13 Q Okay. Let's go to the specific
14 conversation at the start of sophomore year, which
15 you mentioned you and your mom and Miss Durr.
16 What do you recall about that?
17 A I recall that my mother and I approached
18 her and informed her that I am a boy and my name
19 is Gavin and had a discussion about what that
20 meant for starting the school year.
21 Q What do you recall about the discussion,
22 what was said?

1 A I really don't recall anything else.
2 Q And did you speak?
3 A I don't recall.
4 Q How was the meeting arranged, if you
5 recall?
6 A I don't. I'm sorry.
7 Q What was the result of the meeting, at
8 least your understanding of the result of the
9 meeting?
10 A I cannot recall clearly.
11 Q Any aspect that you recall?
12 A No. I am sorry, I can't.
13 Q At some point, you were -- it was agreed
14 that you would go to school as Gavin.
15 A Yes.
16 Q Is that correct?
17 A Yes.
18 Q And that you would be called by male
19 pronouns?
20 A Yes.
21 Q What else is your understanding
22 eventually, when school started, in terms of what

1 were the terms? I mean you would be starting
2 school related to this request.
3 A As I -- as I understood it, I would be
4 starting school as Gavin and with male pronouns, I
5 was assured that malicious intentional
6 misgendering was not going to be permitted and
7 that -- well, that malicious misgendering would
8 not be permitted, and I at that time had requested
9 use of the nurse's office bathroom and was
10 permitted to have access to that as well.
11 Q The term malicious, or excuse me,
12 intentional misgendering, what does that mean?
13 A Someone choosing to still refer to me with
14 female pronouns with the knowledge that that was
15 not appropriate.
16 Q And you were assured that that was not --
17 that they would make every effort to make sure
18 that didn't happen?
19 A Yes.
20 Q And tell me what happened. Did it happen?
21 A By peers, yes, absolutely.
22 Q So peers would intentionally misuse the

1 wrong gender?
2 A Yes.
3 Q How about any staff or faculty?
4 A I don't recall any intentional examples.
5 Q Do you recall any accidental examples? I
6 mean the thing that was mentioned previously was
7 that maybe your name was still another name on a
8 piece of paper and someone said that name, not
9 knowing, and then -- but that would not be
10 intentional.
11 A Right. I recall that there were a few
12 instances of what I assumed to be unintentional
13 misgendering or deadnaming; however, I do not
14 recall who or in what year that those things
15 occurred.
16 Q Deadnaming?
17 A For example, referring to me with the name
18 that was given to me at birth.
19 Q That's called deadnaming?
20 A Yes, sir.
21 Q So just to make sure we are clear, to your
22 recollection, there was no staff or faculty who

1 intentionally misgendered toward you?
2 A Not to my recollection.
3 Q In terms of students doing that,
4 intentional misgendering toward you, how frequent
5 was that?
6 A Daily.
7 Q Without asking you to repeat the litany of
8 things that they called you, what would that look
9 like other than name calling, if it wasn't name
10 calling, how would it happen?
11 A They would make a point to greet me by, of
12 course, the dead name.
13 Q Right.
14 A Or make a point to identify me as a girl,
15 for example, by saying isn't that a girl?
16 Things -- things designed to deliberately point
17 out the fact that I am transgender.
18 Q Again, were there any particular people or
19 groups of people who were doing this?
20 A It was, generally speaking -- well, I --
21 it was plenty of different people.
22 Q Okay. I guess what I am trying to figure

1 out is this. There is how many people in the
2 school, like 1800 students, 9 through 12?
3 A I don't know.
4 Q I think that's right. Are we talking
5 about 3 handfuls of people who did this, or is it
6 hundreds of people would do this? That's all I am
7 trying to figure out.
8 A It tended to be just groups, small groups
9 of people known to be unkind to others.
10 Particularly -- I just -- I really just would
11 rather not characterize --
12 Q I appreciate that. I don't like
13 stereotyping anybody either, it is not what we are
14 about. I am just trying to figure out, if you are
15 walking down the hall and you go I need to be over
16 here because I don't want to deal with those
17 people, or is it literally like anybody out of
18 nowhere could come up to you and all of a sudden
19 say something to you and like I don't even know
20 who that person is.
21 A It was traditionally the same group of
22 people. It wasn't three people, but it was also

1 not something that I expected from the entire
2 student body.
3 Q So most people would walk by and just mind
4 their own business?
5 A Yes.
6 Q But there were certain people that didn't?
7 A Yes.
8 Q I got it. I am going to talk about 9th
9 grade. You entered 9th grade, the records were
10 that you were female and you had not officially
11 made any request otherwise. Tell me about your
12 9th grade year in terms of how you functioned and
13 at some point you left school and that kind of
14 thing.
15 A My 9th grade year was difficult, I
16 understood myself at that point, I understood that
17 I was a boy but did not feel able to reveal that
18 to others, and so the pressure of pretending to be
19 someone who I was not and of being recognized as a
20 girl, when that was incredibly distressing to me,
21 made that year very difficult.
22 Q And in terms of being, as you say,

1 recognized as a girl, how often in the course of a
2 day would something happen that you would be --
3 feel like you were being recognized as a girl?
4 I mean, if you are in math class and
5 somebody says what is the answer to question
6 number 4, you are not recognized as a boy or a
7 girl, you are just a student, you are being asked
8 a question.
9 So how often was it that something would
10 happen and you would think I am being treated like
11 a girl as opposed to just a person?
12 A When I would be referred to as ma'am in
13 class, when I would raise my hand to answer the
14 question and the response would be yes, ma'am, for
15 example, when peers and teachers would refer to me
16 with a female name, for example.
17 Q So the name at some point became, I will
18 use the term a burden for you, I mean the fact
19 that was your name. I am not going to say it, we
20 agreed not to use it. Is that right, the name?
21 A Yes, the name from the -- the name has
22 always, because of its femininity, caused

1 distress.
2 Q When you say always, since when?
3 A I recall being very young, and although
4 not having the thought I am a boy, having the
5 thought this name is far too feminine for me, I
6 think I like Alex better, things like that, erring
7 towards neutral things.
8 Q Right. When do you think you first
9 expressed that concern about the name?
10 A I do not think it was something I ever
11 vocalized something to family; however, in
12 imaginary play, when I was very young, I was
13 always in a male role with a neutral name or a
14 male name, so that was an anxiety from very early.
15 Q So is there anything in particular that
16 happened in 9th grade that resulted in you
17 deciding that you couldn't stay at the school?
18 Was there a triggering event or was it just a
19 cumulative effect?
20 A I cannot recall if there was or was not a
21 triggering event; however, I do recall that the
22 cumulative stress was very -- was very great.

1 Q How would you describe how you felt at
2 that point in time?
3 A What point in time, sir?
4 Q When you made the decision that you were
5 going to not continue going full-time to school in
6 the 9th grade, or however that came about. I
7 don't even know how it came about.
8 Tell me how it came about I guess would be
9 a better foundation question.
10 A I am sorry. Do you mind reframing the
11 question?
12 Q Sure. At some point in time, in the
13 spring semester of your 9th grade year, you
14 stopped attending school daily; is that true?
15 A Yes.
16 Q How did that come about?
17 A My ability to function became so
18 diminished, that it was not actually possible for
19 me to continue to go to school.
20 Q So tell me what that means.
21 A It means I was -- I -- I was experiencing
22 major depression, my social anxiety related to

1 being gendered incorrectly was so bad that I was
2 afraid to go outside, where I might encounter
3 other people, for example. I academically could
4 not focus, I was just -- I was miserable.
5 Q And what occurred? What steps, as best
6 you can recall, occurred in terms of communicating
7 that with the school or with your parents
8 communicated, your father or mother?
9 A I really don't recall.
10 Q How long a period of time was it that you
11 were not attending school on a daily basis at that
12 9th grade spring semester?
13 A I can't recall. I -- I don't recall if it
14 was for the duration of the rest of that year or
15 not, I don't recall.
16 Q What was the level of support you were
17 receiving from your mother at that point in time
18 in terms of trying to help you through this?
19 A Regarding my difficulties at school or my
20 gender expression?
21 Q Just your ability to function, period,
22 whether it was difficulty at school or gender

1 expression or anything else?
2 A Well, at that time my mother was, of
3 course, willing to pull me out of school and allow
4 me to do an alternative program.
5 Q What is your recollection of the
6 alternative program? Was it home school?
7 A It -- it -- I think it was referred to as
8 homebound schooling and was online.
9 Q So did you complete your 9th grade classes
10 online?
11 A As far as I recall.
12 Q Did you -- Did the school, to your
13 understanding, have any understanding -- I'll
14 start over on that one.
15 What was your understanding of the
16 school's perception of what your issue was?
17 MR. BLOCK: Objection.
18 A I don't recall.
19 Q Did you speak to anybody in the
20 administration with respect to why it was that you
21 were going to go to an alternative program?
22 A I don't recall.

1 MR. CORRIGAN: We have been going a while.
2 Why don't we take a minute.
3 (Recess from 10:28 a.m. to 10:45 a.m.)
4 A Sir, I have recalled a few different
5 details to share with you.
6 Q Sure.
7 A The first being that, when I did meet with
8 Tiffany Durr, I do not think it is accurate that I
9 requested the use of the nurse's restroom, I --
10 more accurately, I believe it was an option
11 offered to me, which I then accepted.
12 Additionally, I have a few antidotes from,
13 you know, growing up, which follows the line of
14 inquiry about, you know, male expressions.
15 The first being in middle school -- I
16 expressed that I didn't really have friends in
17 middle school, and the group of friends I
18 mentioned in high school, we met in middle school;
19 however, at that point they had not become my core
20 groups of friends, which was why I phrased that
21 the way I did; however, at some point in --
22 actually, pardon me. Do you -- does --

1 When we were -- When Peasley was taken out
2 by a tornado and we went to school in a trailer,
3 this was when that happened, so actually this
4 could have been 9th grade. In fact, it was 9th
5 grade, so this was not middle school at all.
6 9th grade, my -- my friends and I, two of
7 my friends, I don't recall who of the two, we were
8 walking, and at that time I was presenting fully
9 as male, although I had not revealed that, I had
10 not revealed my gender identity to any of my
11 friends, and one of my friends saw a student,
12 presumably assigned male at birth, and made the
13 comment that looks like the male version of Gavin,
14 but using, of course, the name they knew me as at
15 the time; and my other friend said, in response,
16 Gavin is the male version of Gavin.
17 So on another occasion, when my sister got
18 married, one of -- the half sister on my mother's
19 side, my -- my mother insisted I wear a dress, and
20 that was a process that took hours and countless
21 stores because I would walk in, take one look,
22 nope, not doing any of them, hate them all, and

1 then we'd go to the next one.
2 I -- I really fought hard to not wear a
3 dress and eventually, after lots of tears and
4 fights, came to agree to wear one that was just
5 like completely black, was just like a square with
6 straps, and I was incredibly distressed, and at
7 the wedding the first thing that I greeted my
8 relatives with was please don't call me pretty,
9 please don't call me pretty, because I did not
10 want to be referred to in a femininely-aligned
11 way, and I do not recall what year my sister got
12 married, but that would have been probably -- I
13 was probably prepubescent at the time.
14 Q So 11, 12?
15 A Around, or perhaps earlier, I was -- it
16 was, yes, it was around in that range.
17 Q Okay.
18 A And then there was one example where, as a
19 class, I can't remember the parameters, but we
20 were asked to line up boy, girl, boy, girl. Or,
21 in fact, I -- so I don't recall the setting, if
22 this was gym or what have you or whatever, but I

1 remember that I had been just assigned to like
2 stand in line with the boys because visually,
3 looking at me, the person had assumed I was or
4 correctly determined that I was a boy, although at
5 the time I was still understood socially to be a
6 girl, and that was a moment of great joy for me,
7 so that's another sort of transitional antidote.
8 Q And that last antidote was at school?
9 A I believe so. Actually, I will say I
10 don't recall just because I can't say with
11 certainty.
12 Q But it was somewhere where you and other
13 children at the time were being asked to line up
14 and the adult in charge identified you as a boy?
15 A Yes.
16 Q And that was a source of joy for you?
17 A Yes.
18 Q How old approximately were you?
19 A I was -- I was -- this would have been
20 before transition, so I was in the range of 9 to
21 12.
22 Q But you don't recall whether that was

1 school or somewhere else?
2 A I don't.
3 Q Spring semester of 9th grade is kind of
4 where we left off. Physically, did you have any
5 facial hair at that time, in spring semester of
6 9th grade?
7 A I -- well, perhaps more than was common
8 for someone assigned female at birth, but it was
9 not -- pardon. At that time, I had not begun
10 hormone replacement therapy, but I -- yes, I did
11 have a little rat 'stache I was proud of.
12 Q I assume a rat 'stache --
13 A Pardon me.
14 Q -- is some hair on your upper lip?
15 A Just a tiny patchy little thing that I
16 just was -- I loved to not shave.
17 Q With that semester in school, you had not
18 come out to the school itself?
19 A The school itself, no; however, by the end
20 of that year, some of my friends knew.
21 Q And how did that happen? How did they
22 know?

1 A I -- I just informed them that, going
2 forward, I would like them to refer to me with
3 male pronouns and Gavin.
4 Q Where did the name Gavin come from?
5 A My mother chose it for me.
6 Q What do you recall about how that
7 occurred?
8 A Well, I -- I don't recall the moment where
9 Gavin was decided upon, but I just recall the
10 process was that my mother would be how about
11 this? No. How about this? Absolutely not. And
12 eventually we came to a point where I was okay
13 with what she had chosen.
14 Q Were you suggesting names to her as well
15 and getting her feedback?
16 A I don't recall. It was established at
17 that point that, in fact, she had made the
18 statement that she -- if I did not allow her to
19 choose my name, that it would not be changed. She
20 was --
21 Q Eventually, you were okay with that, as
22 long as you approved of the name?

1 A I would have preferred to self-identify;
2 however, I am not unhappy with the name Gavin.
3 Q Okay.
4 A They're -- well --
5 Q What were you going to say?
6 A It is -- I am not entirely sure how
7 relevant it is, it is just the name actually -- I
8 had given the name to a turtle my brother found in
9 the York River, I had called the turtle Gavin, and
10 my mother insists that she was not aware that that
11 was what the turtle's name was, because my brother
12 called it Bubba; however, I am somewhat of the
13 belief that I am named after a turtle.
14 Q Your mother swears that's not so?
15 A She will say that it is not so.
16 Q Okay. Did your brother or your father
17 participate in this renaming discussion?
18 A No.
19 Q At what point did you begin any type of
20 treatment which you understood as treatment for --
21 and eventually the term gender dysphoria is what
22 is identified. At what point did any treatment

1 for that occur, as your best recollection?
2 A Are you referring to specifically medical
3 steps or the beginning of like my attempts to
4 alleviate that dysphoria?
5 Q The beginning of your attempts to
6 alleviate.
7 A I was -- I believe I cut all of my hair
8 off when I was 12, which was one of the first
9 things that I did to begin a transition.
10 Following that, when I was 13, I purchased a
11 garment, which would flatten my breasts, and then,
12 when I was 14, I revealed to my mother that I was
13 a boy, and by the time I was I believe 15, I had
14 begun hormone replacement therapy in the form of
15 testosterone injections. Or perhaps, actually, I
16 believe I -- did I say 15?
17 Q Yes.
18 A Yes, sir, so that's correct.
19 Q At the time you cut your hair off, were
20 you seeing any healthcare provider who was
21 providing you with any sort of guidance with
22 respect to this question of what ultimately was

1 determined to be gender dysphoria?
2 A Are you asking if I was under any mental
3 healthcare at the time or if I was specifically
4 seeing someone for gender dysphoria?
5 Q I am asking if you had discussed anything
6 with regard to this with any healthcare provider.
7 A No.
8 Q When did that first occur? It doesn't
9 have to be a psychologist, it could have been your
10 family doctor, it could have been just any
11 healthcare provider.
12 A I actually want to correct myself. I had
13 a therapist when I was 8, who I at the time
14 expressed -- I did not use the language that I was
15 transgender; but I had expressed that I felt like
16 a boy, and that didn't go anywhere. It was a
17 religious counseling institution, and so it was
18 dissuaded rather than encouraged, or not
19 encouraged, but rather than respected, I suppose,
20 and so I did not vocalize that to a professional
21 after that point until -- until after I cut my
22 hair, I believe.

1 Q So sometime after you were 12 years old,
2 after you got --
3 A Yes, after I was 12.
4 Q Do you remember who you first spoke to
5 about it, healthcare provider?
6 A I --
7 MR. BLOCK: After he cut his hair?
8 MR. CORRIGAN: Yes.
9 Q After you cut your hair.
10 A There was one therapist, who I cannot
11 place on a timeline, it -- I don't recall when I
12 saw this person, and I also do not recall the name
13 of the doctor because I had a nickname for --
14 which I never said to her, but a nickname that
15 just was a feature of hers, that was helpful for
16 me to remember what doctor that was, but I don't
17 recall her name, and she was the first provider
18 that I had mentioned that to.
19 But the first provider that I actually
20 sought gender specific care from was Dr. Lisa
21 Griffin.
22 Q The person before Dr. Lisa Griffin, was

1 that someone in the Gloucester community?
2 A She was more local than Dr. Lisa Griffin,
3 but I cannot recall if she was within Gloucester
4 or outside of Gloucester.
5 Q When you say more local, it might have
6 been York, it might have been Hampton Roads,
7 Hampton or Newport News or --
8 A I -- I really don't recall. It was not --
9 for -- for example, Richmond would have been an
10 hour and a half of a drive, and it was much, much
11 less than that --
12 Q Right.
13 A -- from my home in Gloucester, so sort of
14 in that kind of 30-minute driving circle, that was
15 where they practiced.
16 Q This person, what were you seeing them
17 for?
18 A I -- at the time, what I recall of the
19 stated reasons was, of course, because at that
20 point, my mother was the one who contacted the
21 doctors --
22 Q Right.

1 A -- and communicated these things. The
2 understanding at the time was that the treatment
3 was for generalized anxiety and severe depression.
4 Q Who is it, as best you know, who referred
5 you to Dr. Lisa Griffin?
6 A I really don't recall. I -- I know that
7 it was, of course, somebody in the know of the
8 transgender community, but I do not recall who
9 that person was.
10 Q The term transgender you have said several
11 times, when you were younger, you didn't know that
12 term. When did you first learn that term?
13 A I was around 12, I would say, when I
14 discovered that term.
15 Q About the time you cut your hair?
16 A Probably; however, it was not -- I did not
17 immediately recognize that label as being
18 accurate, because it was something that was -- it
19 was not a concept that I had been introduced to in
20 a positive light, and that had caused anxiety
21 relating to my knowledge that that was accurate.
22 Q Right. So how was it, if it wasn't a

1 positive light, what light was it that the term
2 transgender was open to you?
3 A Well, my home environment as well as the
4 community environment was very conservative, and I
5 also grew up in an environment, which was very
6 religious and specifically religious in such a way
7 where the teachings of those churches were that,
8 for example, being gay is wrong and evil, and so
9 it was just in context of those sorts of things.
10 Just -- you know, my understanding of
11 trans people were that they were strange or bad,
12 or up until that point or that life, you know, is
13 difficult, and I don't think I ever held those
14 convictions personally but was fearful of the
15 reception of others.
16 Q So the term transgender, I mean did you
17 hear it at church, did you hear it at Sunday
18 school, did you hear it in your house, or was it
19 at school, or where was the first time that
20 someone said transgender and you went I know what
21 that means, I think that's what I am feeling?
22 A Yes. It was a YouTube video, it was an

1 individual on YouTube who made videos where they
2 would dress up as a character from a show I liked
3 at the time, and in one video that I saw, they
4 appeared physically female and in another video I
5 saw, which I later realized was dated a year after
6 the first one, they appeared physically male, and
7 I was totally -- I was just ecstatic that that was
8 something people could do.
9 Q Who was the individual, do you remember?
10 A The channel was called Twin Fools.
11 Q T-W-I-N, F-O-O-L-S?
12 A Yes. I don't know if it is still active
13 or anything like that.
14 Q And the individual was they were on a show
15 or it was just a video that they had done
16 themselves?
17 A They just made YouTube videos.
18 Q Okay. Do you know who the person was?
19 A No, not personally. It was --
20 Q Do you remember their name, did they have
21 a stage name?
22 A Oh, I have no idea. I don't know. I was

1 quite young.
2 (Discussion held off the record.)
3 Q So how old were you the first time you saw
4 Dr. Lisa Griffin?
5 A I believe 15.
6 Q So was that the spring of your 9th grade
7 year or was it later?
8 A I -- I did not -- I did not tell my mother
9 who I was until the summer before or the summer
10 after my 9th grade year, so that would have been
11 later.
12 (Discussion held off the record.)
13 Q Let's talk about telling your mother who
14 you were. When and where was that?
15 A My mother knows the calendar date, I do
16 not. I believe we were in the kitchen at my home
17 and she had said the word transgender, which is
18 not a word I knew or I was aware that she was
19 aware of, and I had previously downloaded a PDF
20 about what it means to be a transgender on a Nook,
21 and so when she said the word transgender, I ran
22 off to find the Nook, I couldn't find it, so I

1 came back and told her; and at that time she told
2 me that I was not allowed to tell my extended
3 family or the rest of my family.
4 Q So you told her I'm a boy, I'm a
5 transgender boy?
6 A Yes.
7 Q And what was her reaction other than --
8 Before she said don't tell anybody else, what was
9 her reaction?
10 A She hugged me and said she loved me and we
11 would get through this, those sorts of things.
12 Q Okay. Then she said we are not going to
13 tell your father, your brother or anybody else?
14 A Yes.
15 Q At what point in time did your father and
16 your brother become aware of this?
17 A Back to the turtle, at my 15th birthday
18 party, I -- you know, I was still sort of under
19 that gag order, and so I was prepared to
20 experience a birthday as a birthday girl again --
21 Q Right.
22 A -- which was intensely traumatic as a

1 concept, and so the morning of the party, I had --
2 I was nearly just totally catatonic with my grief
3 and anxiety.
4 And I had locked myself in my bedroom
5 because -- because I mean I didn't -- I wasn't
6 going to experience a birthday as a birthday girl,
7 that was my position, and so my father had knocked
8 on the door after that point and asked me what the
9 problem was; and I had informed him, I said well,
10 Mom said I am not allowed to tell you, and so, of
11 course, he goes outside, asks Mom what it is that
12 I am not allowed to tell him, and she told him and
13 then called all of my relatives.
14 Q Your mother did?
15 A Yes. Yes. Yes, sir. My mother told my
16 father that I was a boy, called all my relatives,
17 who were mostly on the way already, said that I
18 was a boy, and then later, at the party, was when
19 my brother found out, the name Gavin had been
20 written on the birthday cake, in lieu of the
21 incorrect name that had originally been there, my
22 mother had wiped the wrong one off and had written

1 Gavin, and my brother came down the stairs and
2 asked everyone why the turtle's name was on the
3 cake, because he was aware that the turtle's name
4 was Gavin but not that my name was Gavin, and so I
5 had to take him in the other room and explain, and
6 so basically everyone found out on the day of my
7 15th birthday.
8 Q And how did it go with you and your
9 brother with you explaining that to him?
10 A Well, I said that's not the turtle's name,
11 that's my name, I'm a boy, and he said no, you're
12 not, and he ran out of the room, but he didn't
13 mention the turtle after that.
14 And following that was supportive to
15 whatever degree. I mean he was never rah-rah
16 trans.
17 Q Right.
18 A However, he respected me as a man, as with
19 male pronouns, with the name Gavin. That was not
20 a point of negotiation in my household.
21 Q What was not?
22 A It was not an option for anybody living

1 under that roof to misgender me or dead name me
2 intentionally. It was something that my mother
3 had made very clear that she would not tolerate.
4 Q So would you say, from that point forward,
5 that your father and brother were supportive or
6 not, unsupportive?
7 A I would say not, unsupportive, remained
8 the dynamic for a little while there,
9 transitioning into just it's everyday life now and
10 he is my brother, he is my son, and that's the
11 extent of the conversation.
12 Q Okay. At what point do you think it
13 became he's my brother, he's my son?
14 A Perhaps after a few months of getting used
15 to it, and I -- and especially once I had began
16 hormone replacement therapy and they recognized
17 that it was something I was serious about.
18 Q How did that affect you when they -- when
19 it became he is my brother, he is my son, instead
20 of merely not, unsupportive?
21 A You know, being in a hostile environment
22 in the home is incredibly detrimental to one's

1 mental health, so having the shift from mild
2 hostility, you know, begrudging acceptance to, you
3 know, you are my brother, you are my son, greatly
4 alleviated some of my anxiety.
5 Q So approximately when would you say -- to
6 me, you identified three stages there just now of
7 mildly unsupportive, whatever you said, and then
8 kind of neutral, and then actually you are my
9 brother, you are my son.
10 A Yes.
11 Q Over what period of time do you think
12 those three stages occurred?
13 A I would say that full evolution was over
14 the course of perhaps a year.
15 Q So tell me about your relationship with
16 your brother before any of this came into being.
17 What -- how would you describe your relationship
18 with your brother?
19 A He -- we didn't have a relationship. He
20 and I ran in different circles, and we just didn't
21 communicate very often.
22 Q Okay. Let's go back to the meeting. I am

1 now going to get into the details of the case,
2 like from this point forward.
3 All right. The first meeting with the
4 guidance counselor, did you also meet with the
5 principal at the same time or did you just meet
6 first with the guidance counselor?
7 A As I recall, it was first with just the
8 guidance counselor.
9 Q That was Miss Durr?
10 A Yes.
11 Q Do you remember having an initial meeting
12 at some point in time with the principal Nate
13 Collins?
14 A I do remember speaking to him, yes. I do
15 not recall, however, if that was before the school
16 year began or after the school year began.
17 Q Okay. Was he involved in the initial plan
18 that you would use the nurse's office for the
19 restroom and be called by male pronouns, or was
20 that done with or without his knowledge, as best
21 you recall?
22 A I don't recall to what extent he was

1 involved in the decision to have me in the nurse's
2 bathroom; however -- pardon me.
3 Could you restate the second part?
4 Q Yes. What I am trying to figure out is
5 whether your recollection is that Mr. Collins was
6 involved in this initial decision, the initial --
7 A Right.
8 Q -- be called Gavin, male pronouns, use the
9 nurse's office, or whether his involvement came
10 later, when you were talking about using the boys'
11 restroom. In other words, was he involved in that
12 first set of conversations, as best you recall?
13 A As -- as best I can recall, there had been
14 a discussion with him wherein he assured me that
15 bullying was not going to be tolerated and that I
16 should report to him, should something like that
17 happen. I do not recall, however, at what point
18 that conversation happened.
19 Q In the time that you were -- let's go
20 before you identified and came to school in the
21 summer, so in 9th grade, did you ever report
22 bullying, did you ever go to the teachers or go to

1 the counselors or anybody to say something has
2 happened today, this is what's happened today,
3 something specific?
4 A So because I had been bullied throughout
5 my school career, I had felt consistently like it
6 didn't matter to the administration, I was
7 never -- I don't feel it was ever handled
8 appropriately, I had to be home schooled in 3rd
9 grade because no one handled the bullying, and so
10 by that time I feel that I had developed a
11 perception that no one was going to help me, and
12 so I think I reported these things with less
13 frequency -- certainly with less frequency than
14 they happened.
15 Q In 9th grade, the entire year, that fall
16 and spring semester, do you have any recollection
17 of ever actually reporting a specific incident of
18 what you believe was bullying to a teacher or
19 administrator?
20 A I know there was a lot, but I cannot
21 recall if I had ever reported anything.
22 Q Same question about 10th grade. In 10th

1 grade, was there ever any specific incident that
2 you reported to a teacher or administrator of
3 something that you believe was bullying?
4 A I don't -- I don't recall.
5 Q Same question for 11th grade.
6 A I don't recall.
7 Q And 12th grade.
8 A I don't recall.
9 Q So let's talk about 9th grade. You have
10 the conversation with Miss Durr, possibly
11 Principal Collins, it is agreed that you will use
12 the nurse's office, be called Gavin, be a male,
13 pronouns, and that, if anything comes up, you will
14 let them know.
15 So tell me, how does that go for that
16 first period of time. We know eventually you go
17 talk to him about using the boys' room, but in
18 that period of time before you start using the
19 boys' room, describe what was happening on a daily
20 basis.
21 A I believe you said 9th grade. That would
22 have been 10th grade.

1 Q I am sorry. 10th grade. I apologize.
2 That was a misstatement on my part.
3 A Yes, sir. I -- for the period of time
4 before I requested use of the men's facilities?
5 Q Yes.
6 A I -- I recall sort of an adjustment
7 period, where peers who had, for example, known me
8 previously as something else would -- it was, you
9 know, they slowly began to realize individually
10 that, clearly, something had changed and had, you
11 know, their own varying opinions on that.
12 I do recall an example where I had walked
13 into class and a previous classmate, after the
14 teacher had called out my name for attendance or
15 something, and I said here, you know, after having
16 been called Gavin, a former classmate of mine sort
17 of started laughing, and I heard him tell everyone
18 that's a chick, that's a chick, and then he said
19 hey, name, hey, name, hey, name, name, of course,
20 being my dead name, like trying to get my
21 attention with the incorrect name, and that is
22 something I did report.

1 Q Who did you report it to?
2 A The teacher in the classroom at that time,
3 I do not recall the name of the teacher.
4 Q Do you remember what class or what
5 subject?
6 A I don't. I do not.
7 Q Do you remember what action, if any, was
8 taken?
9 A I -- I recall that the teacher assured me
10 that, I believe it was a female teacher, that she
11 would speak to him, and nothing like that happened
12 afterwards in that class.
13 Q When you say nothing like that happened,
14 you are not saying she didn't speak to him, you
15 are saying that child never said that's a chick,
16 hey, name, again.
17 A Correct.
18 Q That never happened again?
19 A Correct.
20 Q So it was a one-time incident?
21 A From that child. There was other
22 ridicule, however.

1 Q That child. I wasn't trying to overstate
2 it.
3 A Right.
4 Q Just that particular incident with that
5 particular class occurred on one occasion, and you
6 reported it to the teacher; and, to your
7 knowledge, it never happened again; correct?
8 A Yes.
9 Q What else can you recall in that time
10 frame, in the first three or four weeks, maybe a
11 little longer, of 10th grade, your using the
12 nurse's restroom.
13 A I can recall that I began to feel anxiety
14 and shame and stigma surrounding traveling to the
15 nurse's restroom during that time. I can recall
16 frustration with missing class time because of it,
17 and perhaps some embarrassment, because I had the
18 perception, of course, that the other students
19 knew why I am going to the nurse, because, you
20 know, I am the transgender kid, so I remember that
21 being an anxiety that developed and intensified
22 during that period of time.

1 Q Okay. Was there ever anything specific
2 that happened, any statements by another student,
3 statements by a teacher, anyone else, that helped
4 create the anxiety, shame, stigma, embarrassment
5 that you mentioned?
6 A Yes.
7 Q What?
8 A There was one example of a teacher, I
9 cannot recall what teacher, but that the teacher
10 was male, who after a lengthy disappearance from
11 class to use the bathroom, because, of course, it
12 was farther from my class than the bathrooms
13 usually are, he made a big public point, when I
14 reentered the classroom, to comment on how long I
15 had been gone in a way that I felt was
16 humiliating.
17 Q Do you remember who the teacher was?
18 A I do not.
19 Q But it was one of your teachers the first
20 semester of 10th grade?
21 A Yes.
22 Q Other than that incident where the teacher

1 commented on how long you had been gone to the
2 restroom, do you remember any other specific
3 incidents with respect to events that occurred
4 that caused you anxiety, shame, stigma,
5 embarrassment?
6 A A point where I would miss valuable
7 instruction time, because I had to travel farther
8 for the restroom. Importantly as well, at the
9 time I had mentioned the compression garment, and
10 that is a garment that needs to be adjusted
11 throughout the day a few times, or else it can
12 physically damage my body including rib
13 deformation, respiratory issues, and so it was
14 important that I had access to a bathroom
15 frequently enough to make sure that I was not
16 harmed, and I recall that, because of that, I did
17 have anxiety over how much instructional time I
18 was missing.
19 Q So how often did you have to go to the
20 restroom?
21 A Well, I would say -- I would say, for
22 restroom functions, perhaps twice a day and then,

1 to adjust that garment, that is something that I
2 would have to do three or four times throughout a
3 school day, often times I would, you know, do that
4 when I went to the bathroom, but sometimes I
5 couldn't.
6 Q Why not?
7 A Or rather not sometimes that I couldn't,
8 but sometimes that it happened, it would
9 reposition itself in a way that I needed to
10 correct in a position where I -- I didn't need to
11 go to the bathroom for any other reason than to
12 fix that garment.
13 Q Did there come a time when they gave you
14 access to another restroom that was closer besides
15 the nurse's office in the D-Hall?
16 A So at one point, it was my understanding
17 that it was communicated to me that I was allowed
18 to access the male faculty restrooms on all halls;
19 however, I was then told that no, in fact, I had
20 only been given permission to use the ones on
21 D-Hall, but I think that -- I think I genuinely
22 was told that I had access to all staff bathrooms

1 initially, and then the D-Hall thing was raised
2 after the fact.
3 Q Tell me, as best you can recall, who told
4 you you could use any male faculty restroom?
5 A I really -- it would have been one of the
6 administrators or not -- one of -- either
7 counselors or the principal, someone in that
8 position, those positions, I don't recall exactly
9 who.
10 Q But your recollection is that someone told
11 you you could use any of the male faculty
12 restrooms?
13 A So my recollection was that yes, that I
14 was able -- I was permitted to use the male
15 faculty restrooms; however, I was later called
16 into either the guidance office or the office, I
17 can't recall who I had the conversation with, who
18 said no, in fact, you can only use the D-Hall.
19 Q Who was it who you had the conversation
20 with that restricted it to the D-Hall restroom?
21 A I really don't recall.
22 Q Your recollection is it was either someone

1 in counseling or someone in the administration?
2 A Yes. Either, for example, either like the
3 principal or one of the guidance counselors.
4 Q So Miss Durr, Mr. Lord, Mr. Collins. Who
5 were the other possibilities?
6 A I suppose Neblett would have been a
7 possibility, but, of course, I don't recall who.
8 Q Did anyone ever say anything to you -- let
9 me ask this question first. Did you ever use any
10 of the male faculty restrooms?
11 A I -- I don't -- I don't recall if I did or
12 did not, but I can say with certainty that, if I
13 did once or twice, it was not something I did with
14 frequency.
15 Q Why not?
16 A I was embarrassed. It was, in fact -- for
17 another student to see me go into a faculty
18 bathroom was more, obviously, I suppose uncommon
19 than should a student watch me walk into the
20 nurse's office, so it caused me more anxiety, in
21 fact.
22 Q On any occasion can you recount where

1 someone actually said something to you, any
2 student said something to you about what are you
3 doing in there in the nurse's office or what are
4 you doing going in the male faculty restroom or
5 any specific comment by a student about your
6 restroom use during this time frame?
7 A I recall a few sort of snide comments,
8 when I had a longer absence from class for the
9 bathroom, you know, what took you so long, in a
10 way that was, you know, probably implying high
11 school bathroom humor; and other snide things like
12 that are just things designed to point out that I
13 was not allowed to use the other restrooms.
14 Q Okay. How were you able, if somebody says
15 what took you so long, to know whether they're
16 trying to tease you about what function it was
17 that you were using versus which bathroom you were
18 using or any other concern?
19 A Well, in part, because of the individual
20 who would have said that, like these were
21 typically the kids that would commonly harass me,
22 and then, additionally, the tone of voice, but, of

1 course, additionally, the conversation they would
2 have thereafter about, you know, vulgar toilet
3 things so --
4 Q All right. So can you give me any
5 specifics where this happened, like what class you
6 were in, who the student was, what was said, any
7 details?
8 A I -- I mean I don't -- I don't recall what
9 classroom I was in when this happened, it could
10 have been any one of many.
11 I -- one of the -- one of the most
12 persistent harassers was a student named Austin, I
13 do not recall his last name. I do recall that
14 this was an event -- one of these sorts of
15 examples of ridicule was something he was involved
16 in, and then -- pardon me. You also asked
17 specific examples of dialogue.
18 Q Yes.
19 A For example, you know, that must have been
20 a big crap, you know, embarrassing things like
21 that, because it took me a while.
22 Q But you would agree, that must have been a

1 big crap doesn't have anything to do with
2 whether -- which restroom you used or anything
3 else, it is just talking about what you did while
4 you were in there.
5 MR. BLOCK: Objection.
6 A I wouldn't agree with that. That was just
7 one example of the dialogue that would follow.
8 Others would be laughter about there is a bathroom
9 right there, that kind of thing, so that's why --
10 the perception I have is that these were all
11 related to a knowledge of where I was using the
12 bathroom, and it was just various targeted
13 insults, whenever they felt like teasing me about
14 at that time; but there were examples where the
15 conversation erred less towards bathroom humor and
16 more towards why don't you go to that one, that
17 kind of thing.
18 Q Can you tell me who said why don't you go
19 to that one?
20 A I really couldn't.
21 Q Was that Austin or was it someone else?
22 A I don't recall, but it was -- the -- the

1 primary harassers were students like Austin and
2 that would frequently hang around with Austin or
3 other students in similar circles to Austin. So I
4 mean it was -- it was, you know, a few different
5 clusters of people that all sort of ran in the
6 same circles.
7 Q Did you report Austin's remarks or anybody
8 else's remarks to your teacher or anyone else?
9 A I don't recall what I did and did not
10 report. At that time I sort of had a
11 significantly diminished faith in the protections
12 that I would have, and so I felt a bit of a sense
13 that it was futile to report this harassment
14 because it was so consistent and I had been going
15 to administrators for my whole entire school
16 career about incredible bullying, and nothing had
17 ever been accomplished, so I felt like at that
18 point it was just not something that I was --
19 Q Let me ask you this. Specifically, had
20 you ever been to Principal Collins about bullying?
21 A I don't recall.
22 MR. BLOCK: Objection. Are we still

1 talking about this time period? About --
2 MR. CORRIGAN: I am talking about ever.
3 MR. BLOCK: You are?
4 MR. CORRIGAN: Yes.
5 A I don't recall.
6 Q Had you ever been to Miss Durr about
7 bullying?
8 A I don't recall.
9 Q Had you ever been to Matt Lord about
10 bullying?
11 A I don't recall.
12 Q Can you tell me anybody at the high school
13 that you went to about bullying?
14 A The only clear memory that I have of
15 reporting an incident would have been the one
16 where the student, you know, referred to me
17 incorrectly name wise.
18 Q The one we talked about with the teacher?
19 A Yes, sir.
20 Q And she addressed it?
21 A Yes. I -- I do not believe that that is
22 the only incident I ever reported; however, I

1 don't have a recollection of any other specific
2 event of reporting things like that.
3 Q Okay. At some point in time you went to
4 Miss Durr and advised her that you wanted to use
5 the boys' room, is that right, is that how that
6 started?
7 A I don't recall who I approached, but at
8 some point in time I did approach a member of
9 staff at the high school.
10 Q Tell me what you recall about how -- was
11 it you alone, was it with your mom, was it at
12 school, was there an email sent, or how did it go?
13 A I don't recall who was with me, and I do
14 not recall who I spoke with, although I believe at
15 some point Principal Collins or Nate Collins was
16 part of the conversation.
17 In fact, what I do recall of my
18 conversation with him was I -- actually, so I
19 suppose I do recall, he was part of this, at least
20 at some point. I remember expressing to him that
21 it was stigmatizing and embarrassing and also
22 detrimental to my instructional time, to have to

1 travel so far to the nurse's restroom, when my
2 classes on -- in that year were all as far from
3 the nurse's office on campus as they could have
4 been, and so it was even farther a journey, and I
5 expressed that it was just -- it was not ideal for
6 my needs, and I asked him if I could use the boys'
7 bathroom.
8 At that time he did not commit either way,
9 I think he told me that he would have to check
10 with others, and then we spoke again, and he said
11 essentially to go ahead.
12 Q Did you -- The word stigmatizing, when is
13 the first time you ever used that word or ever
14 heard that word?
15 A I was a verbose child, so I could have
16 been 8. I have no idea.
17 Q With respect to this, do you remember when
18 you first used the term stigmatizing, with using a
19 restroom being stigmatizing?
20 A No, sir, I don't.
21 Q Do you think it was your word?
22 A Yes, of course.

1 Q Okay. So is it your recollection you said
2 that to Mr. Collins when you spoke with him, that
3 specific word stigmatizing?
4 A I conveyed that I felt, you know, stigma.
5 I do not know necessarily that I said the word
6 stigmatizing.
7 Q Right.
8 A However, I expressed that I felt that it
9 identified me as different, as a target, it was,
10 you know, not right, you know, things which fall
11 under stigma; but I also cannot say with certainty
12 that I did not use the word stigmatizing.
13 Q Sure. Do you remember having a meeting
14 with Mr. Collins and Miss Durr, at which they
15 prepared a little memo? Have you seen the memo,
16 on October 14th, that says you will start on
17 October 20th and you will report if anything goes
18 wrong, and, if there is an incident, that you will
19 not increase it, you will come let us know
20 something happened. Does any of that ring a bell?
21 A I recall the conversation, I do not recall
22 getting any memo or anything about that.

1 Q And you may or may not have gotten it. It
2 may have been something that was generated
3 internally within the school. I just didn't know
4 if you had any recollection of a memo.
5 A Yes, I do remember that conversation.
6 Q Okay. And tell me what you recall.
7 A Essentially what you said, that it is --
8 starting now I can use the boys' restroom. Should
9 there be any issues, let us know right away, that
10 kind of thing.
11 Q Okay. October 20th was a Monday. Do you
12 recall whether the first time you used a boys'
13 restroom, when that was that day?
14 A I would have no idea.
15 Q Don't remember?
16 A No idea.
17 Q Do you remember which boys' restroom you
18 started using?
19 A No. It was a nonevent for me.
20 Q So when you went in the boys' restroom, I
21 assume you went in a stall every time that you
22 used the restroom?

1 A Yes.
2 Q But as we are sitting here today, you
3 can't tell me which one out of the many, if I have
4 got the math, and said here is all the restrooms,
5 you wouldn't be able to tell me which one --
6 A No.
7 Q -- on any given occasion?
8 A No. I had been using boys' bathrooms in
9 every public place in Gloucester and outside of
10 Gloucester for probably more than a year at that
11 point, so this was very natural to me and it was
12 not something I felt necessary to commit to
13 memory.
14 Q Okay. Did you -- how often were you using
15 the restroom?
16 A I suppose with the same frequency that I
17 was going to the nurse's room beforehand.
18 Q So two times a day to use the restroom and
19 then a few other times to adjust your garment?
20 A Yes, I would say 2 to 4 times a day would
21 be a fair sort of ball park.
22 Q At any time on any of those occasions in

1 the first week, which would be the 20th, 21st,
2 22nd, 23rd, did you have any conversation with any
3 student coming in, going out, while in the
4 bathroom about what are you doing, what are you
5 doing in here, anything?
6 A No. I had a single conversation with a
7 student during that time in the D-Hall bathroom in
8 which he asked me if I liked his socks, and that
9 was the only encounter that I have ever had in a
10 restroom at Gloucester High.
11 Q Beginning at the first of your sophomore
12 year, did you ever go in the girls' restroom?
13 A Absolutely not.
14 Q When did you last use the girls' restroom
15 at Gloucester High School?
16 A I began avoiding it before the end of
17 freshman year of high school, so perhaps sometime
18 towards the middle or end of that year.
19 Q Of 9th grade?
20 A Yes, sir.
21 Q So the -- that was the second part of that
22 year, in the spring semester, you went into the

1 homebound status, so it was before that is the
2 last time you think you used the girls' restroom?
3 A Yes. I began avoiding it before that
4 point, which -- in -- contributed to the overall,
5 you know, complication of remaining at school.
6 Q Because you didn't want to use the girls'
7 restroom?
8 A Right. However, it was not something I
9 could vocalize to others at that time because I
10 was not out, out being that I had not announced
11 myself as a boy to others yet.
12 Q And since then, you have not used the
13 girls' restroom at Gloucester High School?
14 A No.
15 Q Not at all in the 11th grade, not at all
16 in the 12th grade?
17 A No.
18 Q Correct?
19 A Correct.
20 Q Do you recall an incident in your art
21 class, Miss Bergh, where you and the student got
22 into an argument, it would have been in that

1 sometime in October of 2014?
2 A 2014?
3 Q I have a record I can show you, but the
4 person's name is blacked out, so I don't know who
5 it was.
6 A Okay.
7 Q And the allegation is something along the
8 lines of the student was saying something like,
9 you know, there is a girl going in the boys' room
10 and you said that's me and then it elevated
11 into -- does that ring a bell?
12 A It does. The conversation that I had
13 overheard was actually that the child was speaking
14 in explicit and highly, highly sexually
15 inappropriate detail about my genitals, talking
16 about what I had, what -- you know, how disgusting
17 I was, how freaky I was, other explicit, you know,
18 assumptions or observations or whatever about, you
19 know, possible genital situations and that kind of
20 thing.
21 At that time, I had walked over and I said
22 you really should stop saying things like this,

1 because he had identified me as my brother's
2 sister, and he -- I was in that class with him,
3 and he was aware that I was that person, and so I
4 was like this is disgusting, you need to stop.
5 At that point actually he stood up, who do
6 you think you are talking to. You know, my
7 position initially was to kind of ask him to like
8 please stop, and then his position was to yell and
9 escalate and continue to insult and berate me,
10 which resulted in disciplinary action for both of
11 us.
12 Q When was that, do you remember?
13 A No, not other than what you have, what you
14 have identified.
15 MR. CORRIGAN: Okay. I will go ahead and
16 get this marked.
17 (G. Grimm Deposition Exhibit 1 was marked
18 for identification and is attached to the
19 transcript.)
20 Q Okay. Take a minute and read that. That
21 has been marked as Exhibit 1. I am asking you, as
22 best you can recall, whether this is the incident

1 we were just discussing or describes the incident
2 we were just discussing.
3 A So reading this did remind me of a detail.
4 The statement that Miss Bergh had said to me at
5 the time, where she was recommending disciplinary
6 action, was that she was positive that it was
7 going to be a physical fight. I absolutely
8 dispute that, I had had no intentions of
9 physically fighting with anybody. I -- my only
10 position was to say like you -- like stop saying
11 these things, and his position was to escalate.
12 And also importantly, we were on other
13 sides of the table, and neither of us ever moved
14 to get closer to each other as well, so I contest
15 that there was a possibility of physical fight.
16 But I believe that was the grounds under
17 which she recommended disciplinary action.
18 Q Okay. Do you remember what the
19 disciplinary action was?
20 A I -- I don't -- I don't recall if I was
21 suspended in or out of school or for how many days
22 or if it was just detention or something, I really

1 don't recall, it was something to that effect.
2 Q Okay.
3 A I hadn't -- yes.
4 Q Had this individual, who you got in the
5 argument with, had he seen you in the restroom or
6 had you crossed paths in the restroom?
7 A Not that I was ever aware of. Perhaps in
8 context for this claim it is important in that
9 during the period of time -- in fact -- in fact,
10 most of these rumors began circulating even after
11 I was effectively banned from the boys' bathroom,
12 but it became very common for people to create
13 stories of Gavin bathroom encounters ranging from
14 fairly bizarre to, you know, just -- I mean, of
15 course, they were all fully fabricated, but
16 perhaps that was fueled by a rumor of that nature.
17 I don't know.
18 Q Okay. My question is did you ever cross
19 paths with this individual in the restroom before
20 or on October 28, 2014, to your best recollection?
21 A Well, absolutely -- Well, to my
22 recollection, I do not recall seeing him.

1 Q Okay. And what is his name?
2 A I believe he was a grade beneath me and so
3 I don't recall.
4 Q Okay. You -- Tell me about your Phys Ed
5 decision. What did you decide to do with Phys Ed
6 class?
7 A What grade?
8 Q 10th grade.
9 A 10th grade. I believe that was done
10 online.
11 Q Why was that?
12 A Because I was, of course, never going to
13 be allowed to use the correct facilities, being
14 the male facilities, and the humiliation of having
15 to use an alternative option or perhaps even being
16 forced into the girls' locker room was something I
17 was unwilling to take on.
18 In addition, I was wearing a garment, like
19 I mentioned at the time, to compress my breasts,
20 which it was utterly medically necessary and not
21 something that was optional but that restricted my
22 physical abilities pretty significantly because,

1 of course, the function is that it presses the
2 tissue down against your lungs, and so that does
3 restrict some movement, and then, on top of that,
4 that garment did not pair very well with the gym
5 uniform because the garment was slick and so were
6 the pants and the shirt, and so with the garment
7 on, the pants would not stay up and that kind of
8 thing.
9 Q Where did the garment -- describe the
10 garment for me.
11 A A tank top but that is of a somewhat
12 stretchy material but that is nonelastic enough
13 that it forces tissue to compress.
14 Q So did you request to do your PE class
15 online?
16 A I did.
17 Q Okay. Was there ever any discussion about
18 doing it any other way?
19 A What I recall of the conversation was that
20 I don't recall who I approached truthfully, but I
21 approached someone and said this is just not going
22 to be possible for me, what are my options, and

1 they at that time had offered the virtual program.
2 Q Was it the PE teacher or was it your
3 guidance people or was it someone else, as best
4 you can recall?
5 A I don't recall.
6 Q So there was no time in 10th grade you
7 actually attended a physical PE class at school;
8 is that correct?
9 A Not that I can recall.
10 Q Okay. What do you personally know about
11 any complaints that were received by teachers,
12 administrators or the Superintendent or the School
13 Board with respect to you using the boys'
14 restroom?
15 A Well, that question actually prompted me
16 of a detail that I had previously failed to
17 mention. Do you mind if I --
18 Q Sure.
19 A It is somewhat connected. When you asked
20 about, you know, if I received any adult ridicule
21 or was it peer ridicule and that sort of thing, at
22 both of the School Board meetings, which I

1 attended, which they discussed my, you know,
2 restroom usage, the adults in the community
3 present hurled insults, called me a freak, a dog,
4 all sorts of hateful horrible language, and also
5 many of them went to great lengths to refer to me
6 with female pronouns or honorifics such as young
7 lady, little miss, ma'am, Mrs., even going so far
8 as to, you know, reframe a sentence to where it
9 grammatically was not correct just to say ma'am
10 another extra time, so that was another example of
11 verbal abuse that I received.
12 Then I apologize. Could you restate the
13 question?
14 Q The question I asked you was are you
15 personally aware, personally, of any complaints --
16 I want to exclude anything that was said at those
17 meetings, --
18 A Right.
19 Q -- the public meetings, that were received
20 or concerns that were expressed to teachers or
21 counseling or administration at the school or the
22 Superintendent or the School Board.

1 MR. BLOCK: Objection. Are you specifying
2 complaints from students, complaints from parents
3 or both?
4 MR. CORRIGAN: Either one of those.
5 Q Any personal knowledge you have of any of
6 that? Not what you have heard, --
7 A Right.
8 Q -- not what the rumors were, but you know
9 from someone telling you or you being present,
10 whatever, where someone made a complaint.
11 A I do not have any direct knowledge of
12 anyone making a complaint. I do have a
13 recollection of -- I don't recall if it was
14 Collins or one of the guidance counselors or
15 whomever.
16 I recall at some point being told
17 something to the effect of we have had a
18 complaint, which time line wise, I would place
19 probably towards the end of the 7-week period, the
20 7-week period being, of course, when I was allowed
21 to use the boys' bathroom.
22 Q So the first day you were allowed,

1 according to all the information we have, is
2 October 20th, and you think at some point after
3 October 20th, Mr. Collins or someone else said we
4 have had a complaint?
5 A I do recall being told by some employee of
6 the school that they were -- their knowledge was
7 that there was a complaint.
8 I was never given any additional details,
9 how many complaints that was, from who it was or
10 anything like that; and beyond that, I have no
11 knowledge of anything.
12 Q I mean there is no reason why you would,
13 as a student, know --
14 A Right.
15 Q -- who complained of anything like that.
16 All right. So you start using the
17 bathroom on October 20th, and at some point do you
18 become aware that there is going to be a School
19 Board conversation about the use of a boys'
20 restroom by a -- what had been previously
21 considered to be a female student?
22 A I was made aware less than 24 hours before

1 the first School Board meeting because there was a
2 Facebook post that went around urging people to
3 show up and oppose me essentially.
4 My mother -- a friend of my mother's had
5 forwarded that post to her, and she -- well, and
6 so it was decided at that point that, of course,
7 we were going to go and -- so that was when I was
8 made aware, less than 24 hours before it was going
9 to happen, the first meeting.
10 Q So the first meeting, I think by all
11 accounts, was November 11, 2014. So less than 24
12 hours before the meeting on November 11, 2014, is
13 when you first became aware that the issue of the
14 bathroom/restroom use by a previously female
15 student who identified male was going to be
16 discussed?
17 A By a female -- or by a student assigned
18 female at birth, yes.
19 Q Okay. And how is it you became aware? I
20 know you just told me. Who is this friend of your
21 mother's?
22 A I would not know.

1 Q What Facebook post was it, do you remember
2 whose Facebook post it was or what it said?
3 A I do not recall who made the post or
4 anything to that effect. I just remember that it
5 was a post essentially saying, you know, there is
6 a girl in the boys' room and everyone show up and,
7 you know, make that -- you know, make that stop.
8 And, of course, there were many, many,
9 many vile comments underneath that post, none of
10 which I can however remember at this time.
11 Q And who showed you the post?
12 A My mother.
13 Q Tell me about any conversation you had
14 with your mother at that time about the post.
15 A My recollection is that we were frustrated
16 that we were not informed, in fact, we felt that
17 that was -- that was just wrong, that we had not
18 been informed.
19 We also basically spoke about next steps,
20 what do we do, and both sort of arrived at the
21 conclusion that no one would be there to support
22 me and they would not have the conversation

1 without someone telling my side of the story and
2 there would be no one to do that but us.
3 Q So you and your mother decided that the
4 two of you would show up at the School Board
5 meeting to discuss this restroom use issue?
6 A Yes, and I independently decided that I
7 specifically wanted to make a comment.
8 Q What was your thinking on deciding that
9 you wanted to make a comment?
10 A Well, I had already been identified as the
11 student in question, people that had spoken before
12 me had already turned to look directly at me, and,
13 you know, it was not a secret, it was not as if we
14 could pretend like we didn't know who the student
15 was, and so my thought process was that people
16 already have identified me as the transgender
17 child in question, and a decision about my future
18 should not be made without myself at least
19 expressing my input.
20 Q Before you went to the School Board
21 meeting, what information did you have that anyone
22 knew who you were, I mean specifically that this

1 was about you.
2 A Well, because the community had been
3 talking. I mean my peers recognized that,
4 malicious and friendly, all recognized that I was
5 the trans kid. You know, at that point gossip,
6 rumors had gotten around, I don't -- I recall
7 getting the sense that there were some comments.
8 I don't recall if they were on that thread;
9 however, I do remember me reading some kind of
10 social media comment that had identified my -- my
11 brother's -- it being my brother's sister, you
12 know, was the language that was used.
13 Q So you saw that somewhere?
14 A Yes, that was -- that was something I saw
15 at some point, where someone in the comment thread
16 had identified like there was -- and, to be clear,
17 currently, I am not necessarily speaking about the
18 comment thread underneath that post that went
19 around, there were other, you know, disparaging
20 social media posts, which were nasty, of other
21 people, that they didn't necessarily get shared as
22 widely, but in comments like those, I read things

1 like, you know, that is -- that is David's sister
2 or I know that chick or, you know, that kind of
3 thing, so it was understood fairly generally that
4 I was known to be the child.
5 Q Are you aware of any member of the School
6 Board who identified you before this meeting, in
7 other words, said this is who we are talking
8 about, this person?
9 A During the meeting?
10 Q No. Before the meeting.
11 A I didn't have any conversations with any
12 of them before the meeting.
13 Q I understand. My question, though, is are
14 you aware of any -- of any information that any
15 School Board member identified you before the
16 meeting as the person about whom this discussion
17 was occurring?
18 A No. However, one of the members of the
19 School Board, Kevin Smith, was previously a close
20 family friend, who had spoken to my mother, and I
21 don't know about what, but ahead of the School
22 Board meeting, and he assured her at that time

1 that he would recuse himself from the vote because
2 it was improper for him to make a distinction
3 because he knew us.
4 He then did not do that and, in fact,
5 voted against us instead. He voted, to be clear,
6 vowed to ban me from the boys' restroom instead.
7 Q He voted in favor of the resolution?
8 A Of the proposal that Miss Hook had brought
9 forward, yes. So there was at least one School
10 Board member who was aware of the identity of the
11 child.
12 Q You don't have any information that
13 Mr. Smith told anyone else that you were the
14 child?
15 A I don't have any information that that
16 happened, no. But I -- I also have nothing to,
17 you know, present that ensures that it was not
18 something that happened as well.
19 Q You just don't know?
20 A I don't know.
21 (Discussion held off the record.)
22 Q When did you first see the policy, the

1 proposed policy?
2 A I -- I don't recall exactly. I do
3 remember hearing at -- I believe at the first
4 School Board meeting, where one of the members of
5 the School Board read the proposed policy. I
6 don't recall if I had seen it before that time.
7 Q So your best recollection is the first
8 time you heard the policy was out loud, it wasn't
9 in writing?
10 A To my best recollection, yes.
11 Q Again, that's the best we can do.
12 A Right.
13 Q At the first meeting, you spoke; correct?
14 A Yes, sir.
15 Q Do you remember how many people spoke
16 before you?
17 A I don't.
18 Q Was it a large number, small number --
19 A It --
20 Q -- before you got up and spoke?
21 A I can remember feeling like it was ages
22 and ages, but that was -- that could be affected

1 by how anxious I was, of course, so I really
2 wouldn't be able to give a good metric.
3 Q Did you speak first or did your mom speak
4 first?
5 A I don't recall.
6 Q Had you prepared your remarks?
7 A Yes, I had; however, I went primarily off
8 script. I don't -- and I have not ever retained a
9 copy of what I was prepared to say.
10 Q So you don't have your original notes?
11 A I do not.
12 Q When you decided to attend this first
13 School Board meeting, which was on November 11 of
14 2014, who else did you discuss that with besides
15 your mom?
16 A I don't recall.
17 Q Like you don't -- is it you don't recall
18 because it may have been a bunch of people, you
19 just don't know who they are, or you don't think
20 you talked to anybody else?
21 A I don't believe I spoke to anybody else,
22 but I do not recall that with certainty.

1 Q Sure. When did you first speak to any
2 person who was an attorney or who was looking at
3 this from kind of a legal standpoint?
4 A I do not recall if that happened before
5 the second meeting or after the second meeting, I
6 can't place that.
7 Q Do you remember how it occurred, like
8 whether it was a phone call or in person?
9 A I cannot clearly recall how I was
10 initially connected with the ACLU.
11 Q Was it the ACLU the first people you
12 talked with?
13 A Yes.
14 Q Tell me about your recollection of that
15 first meeting. We've kind of talked about it. So
16 was it a full house in the meeting room?
17 A The individual comments, I referenced
18 being called a freak, someone likening me to a dog
19 peeing on a hydrant, those kind of things --
20 THE COURT REPORTER: I am sorry. A dog?
21 I couldn't hear you.
22 MR. CORRIGAN: Peeing on a hydrant.

1 A A dog urinating on a hydrant.
2 THE COURT REPORTER: Thank you.
3 A Comments like that, I do not recall if
4 they were in the first or second meeting.
5 Q I think it was the second, but I am just
6 adding, your recollection is what matters.
7 A Right. However, in the first meeting,
8 what I do recall is that there were fewer people
9 than in the second meeting, but that there were
10 still -- it still seemed fairly full.
11 Q And do you remember where -- did other
12 students speak at the first meeting, or, again, do
13 they run together?
14 A I -- I really -- they -- to some extent,
15 they do run together. I do not recall if any
16 student spoke at the first meeting.
17 Q Do you remember what happened after the
18 first or the result at the first meeting, what the
19 School Board did?
20 A They postponed the decision to rule for
21 the next meeting, following.
22 Q At this time, on November 11 of 2014, had

1 you started any hormone therapy at that time?
2 A I do not -- I do not recall. I know that
3 the -- that me and my family were actively working
4 on, you know, the goal of getting that treatment
5 from -- essentially from the point at which the
6 rest of my family became aware of who I was, and
7 from that point on we looked at next steps being
8 hormone replacement therapy and that sort of
9 thing, so --
10 Q Where did you receive hormone therapy?
11 Who was guiding it, I guess is what I am asking.
12 A A doctor in Richmond at the VCU -- on the
13 VCU campus. I do not -- she was a pediatric
14 endocrinologist, I do not recall her name, but
15 that she was a woman.
16 Q Have you gone back and watched the video
17 of either of the two School Board meetings?
18 A Not -- not deliberately. The footage has
19 been used in other videos that I have participated
20 in, for example, like a voting PSA, where they
21 will use a 3-second clip or whatever; however, I
22 have not watched those clips from start to finish

1 at any point.
2 Q Do you have any recollection of how many
3 people spoke at either occasion?
4 A No.
5 Q In your lawsuit, on paragraph 53, it says
6 the policy does not define biological gender and
7 the term has no common or accepted meaning. There
8 are many biological components of sex, including
9 chromosomal, anatomical, hormonal and reproductive
10 elements, some of which could be ambiguous or in
11 conflict within an individual, either because that
12 individual has intersex traits or because that
13 individual has undergone medical care for gender
14 dysphoria.
15 That's what the paragraph says. So I have
16 some questions that I want to ask you, just to
17 make sure I am clear and that the record is clear
18 on this.
19 Do you have intersex traits?
20 A I have never been diagnosed as intersex.
21 Q The terms that are used here, chromosomal,
22 anatomical, hormonal and reproductive elements,

1 what is your understanding of your chromosomal
2 elements?
3 A I -- well, I was assigned female at birth,
4 so I would assume that there are two X
5 chromosomes; however, differences in that are very
6 common, and often you go your whole life without
7 knowing them, so, to my knowledge, XX; however, I
8 don't know that that's ever been formally tested.
9 Q How about anatomical elements. What is
10 your understanding of your anatomical elements?
11 A With respect to what, sir?
12 Q With respect to the many biological
13 components of sex.
14 A Do you mind rephrasing the question?
15 Q Again, the allegation is there are many
16 biological components of sex including
17 chromosomal, anatomical, hormonal and reproductive
18 elements, some of which could be ambiguous or in
19 conflict within an individual, either because that
20 individual has intersex traits or because that
21 individual has undergone medical care for gender
22 dysphoria.

1 So the question I am asking is, with
2 respect to the anatomical elements, your
3 particular anatomical elements, is there any
4 indication, I guess, reading this paragraph,
5 intersex traits, which I think we've said there
6 isn't, and then other ambiguities of any sorts?
7 MR. BLOCK: I am going to object, before
8 you answer, which is that this is a legal
9 allegation in the Complaint, not a prior statement
10 by Gavin, so, you know, you can -- he can answer
11 to the extent he is saying his understanding of
12 those terms but --
13 MR. CORRIGAN: Absolutely.
14 MR. BLOCK: But he is not the author.
15 MR. CORRIGAN: That's all I am asking.
16 A But pardon me for still being confused,
17 but are you asking me what my understanding of
18 that would be?
19 Q Yes. With respect to -- I am breaking it
20 down into chromosomal, anatomical, hormonal and
21 reproductive because that's how it is broken down
22 in the allegation.

1 A Okay.
2 Q That's what I am trying to understand.
3 A And my apologies, I hate to ask you to
4 restate this, but just because there are some
5 dialogue and my train of thought has been
6 disrupted, but, please, I'm sorry --
7 Q I don't mind at all.
8 A Thank you, sir.
9 Q Because this is not a normal type of
10 question that gets asked in a deposition, I can
11 tell you.
12 A Right.
13 (Recess from 12:10 p.m. to 12:15 p.m.)
14 Q All right. So the question has to do with
15 your understanding of whether -- The term
16 biological gender is what is in the policy, of
17 course; and the allegation is there are many
18 biological components of sex including, I asked
19 you about chromosomal, and you have answered as
20 best you understand, which is all I am asking,
21 this is not you kind of speaking as a lawyer, you
22 are not speaking as a doctor, you are speaking as

1 Gavin.
2 So the question is, with respect to your
3 anatomical elements, some of which could be
4 ambiguous or in conflict, what is your
5 understanding of your anatomical elements?
6 A My understanding of my anatomical elements
7 are that -- well, first and foremost, the --
8 growing up, even when I still had long hair and
9 would wear girls' clothing, I would be asked
10 sometimes by other students, I remember one time
11 on the elementary school bus, some kid asked me if
12 I was a boy or a girl, and at that time I was even
13 presenting as a girl, and that has persisted
14 throughout my life.
15 As soon as I cut my hair, I was gender
16 male pretty much in every facet of public life,
17 and so at that point I looked pretty much like a
18 boy, even before hormone replacement therapy.
19 So -- so my understanding of that would be
20 that I suppose I did look masculine enough that,
21 for example, when I did go into women's restrooms,
22 I was chased out or scrutinized or yelled, you

1 know, you are not supposed to be in here, that
2 happened a few times in public, where women would
3 say that I was in the wrong place and I needed to
4 leave.
5 Q All right. How about specific -- your
6 specific -- I guess that goes over to reproductive
7 elements.
8 Same question. What are the -- your
9 reproductive elements.
10 A If I may clarify, are you asking what
11 procedures I may or may not have had?
12 Q Sure.
13 A Okay. I do not have breasts, and I do not
14 have the ability to bear children because of
15 hormone replacement therapy, basically making that
16 not something that I can do.
17 Q Let's go back to on November 11, 2014 and
18 December 9, 2014, in terms of your reproductive
19 elements, what was the status then?
20 A In 2014 you said?
21 Q Yes, sir.
22 A That would have been that I had present

1 breasts and was by -- I had yet to go through
2 hormone replacement therapy; however, I -- again,
3 I used a chest-binding garment every single
4 solitary time I stepped out of the house, so the
5 appearance to pretty much everyone was that I did
6 not have breasts.
7 Q Okay. What about the actual reproductive
8 elements at that time?
9 A Well, I had gone -- at that point I had
10 gone through female puberty and had done nothing
11 to disrupt the functions of those organs, so those
12 were fully functioning.
13 Q Okay. Then the last one is hormonal is
14 the other term that is used in the description of
15 the many biological components of sex.
16 What are the hormonal elements in December
17 or November 11th and December 9th of 2014?
18 A Well, the hormonal elements would be that
19 I was yet to -- I was not yet receiving
20 testosterone injections and that my body was
21 producing estrogen; however, that my free
22 testosterone levels were elevated enough for a

1 person assigned female at birth, that it delayed
2 treatment for hormone replacement because I was so
3 naturally high in testosterone, that they thought
4 there could be another issue.
5 Q When they said they thought there could be
6 another issue, what was the other issue they
7 thought there could be?
8 A Perhaps a tumor on my pituitary gland and
9 increasing testosterone production or polycystic
10 ovarian syndrome, which would increase
11 testosterone production in some people. I was
12 tested and was cleared of everything.
13 Q But you just naturally had higher levels
14 of testosterone than most females?
15 A Most people assigned female at birth, yes.
16 Q All right. We got through that. All
17 right.
18 After the November 11 meeting, there is
19 a -- this is paragraph 57 of the Complaint -- it
20 talks about the press release and the plans to
21 designate single stall, unisex restrooms, to give
22 all students the option for even greater privacy.

1 Do you remember becoming aware of that in
2 this time frame, that the School Board had
3 announced that they were going to be doing that?
4 A What I was aware of in that situation -- I
5 heard the announcement by the School Board at that
6 time. My recollection is that they announced that
7 the restrooms were ready; however, I was aware of
8 their construction before that point because they
9 were, you know, being constructed while we were
10 going to school, and, in fact, those restrooms,
11 however, were as they were stated to be completed,
12 they were absolutely not completed or usable for I
13 think around a week after the statement was that
14 they were ready.
15 Q Sure. In fairness, the press release
16 occurs after the November 11 meeting, that they're
17 going to do it, and then we have documents in the
18 case that show when they bid it out and somebody
19 took the job and then the job was done, and it
20 is -- it is December, possibly even later, when it
21 is actually completed.
22 A So I misunderstood --

1 Q My question is when did you become aware
2 they were going to do that.
3 A Yes, sir. I misunderstood. Press release
4 wise, I thought you were referring to what was
5 said at the meeting, I apologize.
6 When I became aware that those bathrooms
7 were being constructed was I suppose when they --
8 when the construction began, which was before the
9 second School Board meeting, as far as I can
10 recall.
11 Q Okay. When you became aware that they
12 were, in fact, going to create single stall,
13 unisex restrooms for all students, not designated
14 Gavin's restroom, but the statement is for all
15 students, did you consider that as whether that
16 would meet your needs?
17 A Absolutely not.
18 Q And what did you consider? What did you
19 decide, who did you speak with about that?
20 A I -- I don't recall who I approached or if
21 I approached anyone from school at that point. I
22 believe somewhere in that time period was when I

1 was contacted -- we -- my family was in contact
2 with the ACLU, I -- my recollection at the time
3 was that was the final decision, and there was
4 nothing -- no one I could talk to and nothing I
5 could do to change that within the school.
6 Q What about the idea of just going along
7 with that and saying I can live with this
8 alternative, this single stall, unisex restrooms,
9 don't have to go to the girls' room, I can -- I
10 can go to these other restrooms.
11 A Part of -- so certainly, the language was
12 that they were for all students to use; however, I
13 was the only student mandated to use them, I was
14 the only student that had no option in the school
15 other than in a single stall restroom, and that
16 was part of the reason why I did not think that
17 was an appropriate thing to go along with.
18 The other reason being I am a boy and it
19 felt to me that it was humiliating and
20 stigmatizing for the school to or not the school
21 perhaps, the School Board to take the position
22 that there was something wrong with me that made

1 me not allowed, not permitted to be with my peers
2 in common spaces.
3 In addition to that, the unisex restrooms
4 were all -- were mostly all clustered together and
5 not really very much closer than the nurse's
6 office from my D-Hall classes, and so the idea was
7 that they were more convenient, but, in fact, they
8 were not.
9 Q Okay. Who did you discuss this with in
10 this initial time frame?
11 A This initial time frame?
12 Q Did you discuss it with your mom, did you
13 discuss it with anyone else? I am talking about
14 the time frame around November 11, before the
15 work -- before it is done, the fact it is going to
16 be done and whether you are going to continue to
17 object.
18 If they're going to do this, it is
19 conceivable that someone in your position might
20 say it is not what I want but that's good enough,
21 but you reached the conclusion that -- it was not
22 what you wanted, so who were you talking to about

1 that at that time?
2 A I -- it wasn't something that I discussed
3 in terms with anybody in terms of, you know, hey,
4 Mom, what should I do. It was more like -- for
5 example, I approached my mother, and I said I
6 cannot be discriminated against in this way, I
7 cannot go for three years of my high school career
8 being shoved off into, you know, a converted broom
9 closet where only I am mandated to go.
10 That -- staring down three years of that
11 was so devastating to me, that there was not a
12 question of if or not I would stand for that, so
13 when I had conversations with, for example, with
14 my mother about next steps, I said this is wrong,
15 this hurts me, what can we do.
16 Those were the conversation that we had.
17 Q Did you ever talk to any other transgender
18 youths, not necessarily in Gloucester, but just
19 anywhere, about restrooms and about -- again, in
20 this time frame between November 11 and
21 December 9, accommodations, whether it -- how big
22 of a deal this is, how much trouble this is, that

1 kind of thing?
2 A I did not.
3 Q Okay. Were you talking to your counselor
4 or other -- not school counselor but the person
5 you were consulting with, Miss Griffin or someone
6 else about it?
7 A I -- I didn't -- I don't -- I didn't seek
8 counsel from them. I do not recall any individual
9 conversations that I had with any of my mental
10 healthcare providers.
11 Q It was clear to you from the start, this
12 was not an option that you were interested in?
13 A Yes. If I may.
14 Q Sure.
15 A Part of that -- part of that
16 decision-making process was also that for that
17 7-week period, where I was respected as a boy and
18 able to use the boys' bathroom, I was -- I was
19 excited about the prospect of living out the rest
20 of my school year as just another student, without
21 having to face down discrimination every time I
22 had to use the bathroom, and that 7-week sort of

1 grace period was when I was most comfortable in
2 that school, and so having experienced that and
3 then to have it taken away was part of the reason
4 why I was aware that it just was not -- it was
5 just not acceptable for what I thought was
6 correct.
7 Q Again, moving through the Complaint,
8 paragraph 59 talks about the second meeting at
9 which a speaker calls you a freak, a dog urinating
10 on hydrants, that kind of thing.
11 Do you have a recollection of there being
12 approximately 28 to 30 people who spoke?
13 A That's not a number I would contest, but I
14 didn't count.
15 Q Do you remember how many of them you felt
16 like were disrespectful towards you?
17 A I felt that barring the party that was
18 with me and one individual, who seemed fairly
19 supportive, perhaps neutral, I feel like every
20 single -- every other person was absolutely in
21 opposition. Of those people, I mean the
22 statements were all, you know, I felt personally

1 offended.
2 They generally all -- generally speaking,
3 they all came from a viewpoint that I was a girl,
4 which is offensive to me, but then, for sure,
5 there was a minority of those who were
6 specifically malicious, for example, like the
7 hydrant.
8 Q At any point did you regret going forward
9 for yourself, like appearing at the first meeting,
10 appearing at the second meeting?
11 A Absolutely not.
12 Q Why not?
13 A I understood that, if I did not, that that
14 conversation would be held without me and with no
15 one to support me, and if it is a conversation
16 about my future, I felt that I should be included.
17 Q It says, in paragraph 60, you felt like
18 you had been turned into a public spectacle.
19 If you had not appeared, would you have
20 been a public spectacle?
21 A I believe so.
22 Q How so?

1 A The community, like I stated previously,
2 the community was already aware of who it was that
3 was in question, the rumors had already spread.
4 I was in the position where it was common
5 knowledge, to my understanding, it was my
6 understanding that the community -- it was
7 community common knowledge that I was the
8 individual, and I was willing to assume additional
9 risk just because I had already been -- I had
10 already been discriminated against, I had already
11 been humiliated, I had already been gossiped about
12 widely, and I felt that not speaking on my behalf
13 would not have served me.
14 Q Have you ever been in the single stall
15 restrooms?
16 A Not that I can recall.
17 Q Okay. I mean have you seen the layout?
18 A Yes, I -- yes.
19 Q How did you see the layout, if you didn't
20 go in?
21 A I mean I looked, the door was open and I
22 looked. Well, perhaps may I reframe? I never

1 used them.
2 Q Right.
3 A But, of course, I looked once or twice,
4 just to see what they look like, but I did never
5 use them.
6 Q There is a claim in here that no one else
7 ever used them. Do you know whether other people
8 used those restrooms or not, I mean of your own
9 personal knowledge?
10 A The -- the area that those bathrooms were
11 positioned in was visible from where I would
12 often, me and my friend group would often sit for
13 lunch, and I never really saw any traffic in that
14 time. Of course, I did not monitor those
15 bathrooms 24/7, and I could not say that they were
16 never used ever; however, it did not appear to be
17 a high traffic area.
18 Q All right. After the second meeting, on
19 December 9, word was passed to you about what the
20 decision was, and you had a meeting, I think with
21 the principal, is that right, or do you recall?
22 A I don't recall.

1 Q Okay. Do you remember having any
2 conversation with anyone about here is the system
3 going forward, you are not going to be allowed to
4 use the boys' restrooms any more, you can go in
5 the ladies room or you can go to these three
6 single stall or the nurse's office?
7 A I -- I -- I do recall that conversation
8 with Nate Collins.
9 Q Okay.
10 A The conversation where he explained the
11 new parameters.
12 Q Okay. From that point forward, did you
13 follow the parameters?
14 A Yes.
15 Q One of the allegations in here is that you
16 had painful urinary tract infections. Is that --
17 tell me about that.
18 A I had -- so part of the anxiety in school
19 was that, of course, the trip is long, I don't
20 want to miss instructional time and it is
21 embarrassing, and so often times, I would just do
22 my best to avoid having to use the bathroom at

1 school because it didn't feel like a safe or
2 welcoming environment, and, as a result of that
3 anxiety and as of holding that urine, I had
4 urinary tract infections pretty consistently off
5 and on through high school, to the extent that I
6 assumed that it was just a problem that I, as a
7 person, have; however, as soon as I left high
8 school and, of course, used bathrooms freely, that
9 problem disappeared.
10 Q You had mentioned safe and welcoming
11 environment. The bathroom that you used at school
12 when you went was in the nurse's office; is that
13 right?
14 A Yes.
15 Q Was that unsafe?
16 A The nurse's office bathroom was not
17 unsafe. When I say safe and welcoming
18 environment, I am speaking about the broader
19 culture of the bathroom policies in the school
20 and -- and of, you know, being fearful to opening
21 myself to more ridicule, you know, like I said,
22 when I take so long or when students see me go

1 into the nurse's office bathroom, as well, if I
2 may clarify, how the nurse's office is set up is
3 that, to go to the bathroom, you walk through sort
4 of an infirmary, and so students may see me go
5 into the bathroom, you know, as opposed to, you
6 know, being at the nurse for any other reason, and
7 so that identifies me, you know, in my opinion,
8 per my anxiety, that felt to me like that was
9 identifying me, again, as a student who was not
10 capable of using shared spaces and I had to go to
11 this place.
12 Q So if you went to the hallway where the
13 three single stalls are, there is not a lot of
14 classrooms there; is that right?
15 A Yes, it is not in a hallway that has many
16 classrooms.
17 Q So the likelihood of encountering another
18 student outside of lunch time would be pretty
19 minimal, wouldn't it?
20 A No, sir. I mean students, for whatever
21 reason, may be walking down the hall at any time,
22 to go to the office, to go to another class. I

1 mean there is pretty consistent foot traffic in
2 the hallways throughout the day.
3 Q All right. Is there something about going
4 into a communal restroom that you wanted to have
5 that experience?
6 A I --
7 Q I am not asking that facetiously. I mean,
8 literally, an argument could be made, having a
9 single stall restroom is preferable to going in a
10 joint restroom and going to the bathroom.
11 A Perhaps not when it is a discriminatory
12 practice. I -- There was no aspect of the
13 communal nature of the men's bathroom that I was
14 attracted to, it was the fact that I was a male
15 student and that is where the male students go to
16 the bathroom, and, you know, anything short of me
17 doing that communicated to me that, you know, not
18 necessarily the school, the School Board's
19 decision, but that the administration felt that,
20 in fact, my identity was not correct and,
21 therefore, I was not permitted to be in the spaces
22 that other boys were permitted to be in.

1 Q Let me ask you this question. If you had
2 been allowed to go in the boys' room or the single
3 stall restroom, would you have ever used the
4 single stall restrooms?
5 A No, I would go in the boys' room because
6 they were closer to my classes.
7 Q What about if you were at lunch time and
8 it was closer to your class to use the single
9 stall?
10 A Perhaps in that case, if it was the
11 closest option and I wasn't being actively forced
12 to use those and those alone, but I mean the --
13 again, for example, if I was in D-Hall, where
14 those bathrooms are, it's almost as far as going
15 to the nurse's office, I would, of course, use
16 those.
17 MR. CORRIGAN: Sure. I understand.
18 Lunch is here?
19 (Recess from 12:35 p.m. to 1:15 p.m.)
20 BY MR. CORRIGAN:
21 Q Now, the urinary tract infections, we
22 talked about that. It is in paragraph 68 of your

1 Complaint.
2 Did any doctor ever diagnose you as having
3 urinary tract infections?
4 A I -- I do not recall if there had ever
5 been a formal diagnosis.
6 Q Did you seek treatment?
7 A I -- I used over-the-counter solutions
8 designed for urinary tract infections, which
9 improved the condition.
10 Q What did you use?
11 A One example being a medication called Azo,
12 that is A-Z-O.
13 Q Did any doctor ever prescribe anything for
14 you for urinary tract infections?
15 A I do not recall.
16 Q Did any doctor ever tell you that your
17 urinary tract infections were caused by your not
18 using the restroom during the day at school?
19 A I do not recall.
20 Q So when you say you do not recall, do you
21 ever remember speaking to any doctor at any time
22 about urinary tract infections?

1 A I do not recall if I did or did not, but I
2 also do not recall not having seen a doctor. I --
3 I -- it may have come up in an appointment, I just
4 do not recall definitively enough to say yes or
5 no.
6 Q Okay. Where does this notion come from
7 that you have urinary tract infections because of
8 not using the restroom as frequently as you felt
9 like you might have needed to during the day?
10 A In part, because it is -- as I understood
11 it, it is something that is -- can be known to
12 increase urinary tract infections.
13 In addition, the second that I was in an
14 environment for any extended period of time where
15 I did not have restrictions for bathroom use, for
16 example, summer vacation or post graduation, the
17 problem eliminated itself entirely.
18 Q Okay. During your 11th grade year, did
19 you use the restroom regularly then?
20 A I --
21 MR. BLOCK: Objection. If you could
22 specify a time period within that year.

1 Q Just during the year, in 11th grade.
2 A I suppose I don't understand the question.
3 Are you asking did I use the bathroom?
4 Q Regularly.
5 A Do you mind reframing?
6 Q Sure. In the 11th grade, where did you
7 attend school?
8 A Gloucester High School.
9 Q During any part of that school year, did
10 you go to T.C. Walker and were you part of the
11 SOAR or some other program?
12 A Yes. I don't recall what it was called,
13 however, the program.
14 Q Tell me what you recall, what part of the
15 year you were at Gloucester High School and what
16 part of the year you were at T.C. Walker or some
17 other location.
18 A I don't recall when I went to T.C. Walker.
19 I -- I -- I don't recall at what point in that
20 school year that I started going to T.C. Walker.
21 It coincides with a month-long absence from
22 school, and following that I returned in the

1 capacity of the program at T.C. Walker.
2 Q Okay. Let's go back and talk about the
3 foundation. The 10th grade, your entire 10th
4 grade year, you were at Gloucester High School; is
5 that correct?
6 A To the best of my recollection, yes.
7 Q Was there any extended absence during your
8 10th grade year?
9 A I don't recall.
10 Q All right. 11th grade. We have already
11 talked a little bit, and some portion of that year
12 you were at T.C. Walker, which is a separate
13 building in a -- in a separate program; is that
14 correct?
15 A Yes, sir.
16 Q Was there also an extended period of time
17 when you were out of school?
18 A Yes.
19 Q Okay. When was that?
20 A I do not recall the date.
21 Q Fall of 2015?
22 A I don't recall.

1 Q Do you remember the fall or spring
2 semester?
3 A No, I do not.
4 Q Where were you?
5 A I was in a -- a VCU hospital.
6 Q What was it that resulted in you spending
7 time at a VCU hospital?
8 A I had -- I was struggling with mental
9 health.
10 Q What was the struggle?
11 A Do you mind reframing the question?
12 Q You said you were struggling with mental
13 health, that's why you were hospitalized at VCU,
14 for an extended period of time during 11th grade.
15 I am trying to figure out what was the
16 issue, what was the mental health issue that you
17 were struggling with?
18 A I see. I am sorry. I misunderstood you
19 the first time.
20 I was admitted for suicidality and treated
21 for a range of things including depression,
22 anxiety, suicidality.

1 Q We are here on this case, obviously. Does
2 any of that relate in your mind to the bathroom
3 use/restroom use at Gloucester High School?
4 A Yes.
5 Q In what way?
6 A It -- to be -- to have to go to an
7 environment every single day, five days of the
8 week, where I felt unsafe, the environment made me
9 anxious, I didn't feel respected, it had a massive
10 impact on my overall mental health and ability to
11 function.
12 Q In what way does the restroom,
13 specifically the restroom use make you feel
14 unsafe?
15 A It -- the policy of segregating me from my
16 peers sets a -- an environment where I understand
17 that I will not be fully respected as who I am,
18 and that contributes to an overall feeling that it
19 is not an environment I will be safe in, it is
20 not, and by safe, I do not mean fear of my peers
21 doing anything or anything to that effect, I mean
22 mentally safe as in I did not feel confident that

1 was an environment where my best interests were
2 kept at heart and where I was able to function in
3 a way that was most conducive to my mental health
4 and success.
5 Q Did you have check-ins with any of your
6 counselors during this school year?
7 MR. BLOCK: During his junior school year?
8 MR. CORRIGAN: Yes.
9 A I don't recall if it was during -- if I
10 had any during junior year.
11 Q Did at any point, and then let's talk
12 about 10th, 11th or 12th grade, did you check in
13 with any of the counseling staff, specifically
14 Miss Durr and Mr. Lord?
15 A I believe -- I believe there were
16 instances where I -- we had had a -- a brief
17 meeting, to touch base, a few different times. I
18 don't recall with who, was it Miss Durr or
19 Mr. Lord, I don't recall exactly, but --
20 Q Were you a member of any clubs?
21 A I was the -- I believe vice president of
22 the Gender and Sexuality Alliance or, rather, we

1 called it the Equality Club, I do not recall what
2 year that I was in the position.
3 Q Gender and Sexuality Alliance, GSA?
4 A Yes, sir.
5 Q But y'all called it the Equality Club?
6 A Yes, sir.
7 Q Was it actually known as the Equality Club
8 or was that kind of a nickname?
9 A Well, when I began in the GSA, it was
10 called the Gay-Straight Alliance, and I personally
11 raised the concern that that did not honor the
12 diversity of students that might seek the service,
13 and so at that time we called it the Equality
14 Club.
15 Q Was it formally changed to Gender and
16 Sexuality Alliance at any point?
17 A GSA currently stands for Gender and
18 Sexuality Alliance only, as far as their national
19 branding goes.
20 Q But back when you were in 10th, 11th, 12th
21 grade, it was Gay-Straight Alliance and then later
22 Equality Club?

1 A Yes, sir.
2 Q Was there a faculty advisor for that
3 group?
4 A Yes.
5 Q Who was that?
6 A Matthew Lord.
7 Q So when you had meetings, was Mr. Lord
8 typically there?
9 A Are you asking if those meetings took
10 place at the Equality Club meetings?
11 Q I am asking if the Gay-Straight Alliance
12 or Equality Club had a meeting, would Mr. Lord be
13 present?
14 A I don't recall that -- oh, pardon. I
15 misunderstood what you were asking.
16 He was present for all of our -- you know,
17 we met like once a week after school, and he was
18 present every time.
19 Q What time of day would you meet?
20 A I don't recall exactly the time, it was
21 after school hours.
22 Q Okay. Where would you meet?

1 A I don't recall.
2 Q How many people approximately would attend
3 the meetings? I mean I am trying to see, is it 5
4 or 20, 50?
5 A Between 5 and 10 --
6 Q Okay.
7 A -- traditionally.
8 Q Were the other members people you
9 identified as your friends, or were there people
10 besides that?
11 A Not necessarily. I was acquainted with
12 most of them but was not close personal friends
13 with any of them that I recall.
14 Q What would you -- what would the
15 meetings -- What would happen at the meetings?
16 A I really don't remember.
17 Q I mean conversation, were there
18 activities?
19 A I don't recall. I -- I really couldn't
20 tell you. The only thing I do recall is that
21 ahead of something like the Day of Silence, we
22 discussed what our role would be in that, but, as

1 far as traditional meetings, I don't recall.
2 Q What was the Day of Silence?
3 A The Day of Silence is a day designated
4 nationally, not necessarily not a national
5 holiday, but it is a designated day where students
6 can voluntarily remain silent and, in so doing,
7 recognizing the people, LGBTQ people who have been
8 either silenced or victims of violence because of
9 who they are, and so it is just a day of
10 remembrance.
11 Q The idea is those people have been
12 silenced so we are going to be silent?
13 A Yes.
14 Q Mr. Lord, was he somebody at these
15 meetings who made you feel welcome?
16 A Yes, I would say so.
17 Q Have you kept up with him at all since you
18 left?
19 A The only further correspondence that I
20 have had is to request transcripts, when I went to
21 apply for college.
22 Q Any conversation at all with him other

1 than that?
2 A Not that I can recall.
3 Q Did you feel like he was supportive of you
4 as a student and a person in the Gloucester County
5 High School?
6 A I did.
7 Q One of the paragraphs in here talks about
8 football games. Did you ever go to any football
9 games?
10 A I did.
11 Q How many?
12 A I wouldn't have a number for you.
13 Q I mean I guess we are talking three
14 seasons, your sophomore year, your junior year,
15 your senior year. Did you attend more than one
16 game --
17 A Yes.
18 Q -- each year?
19 A Yes.
20 Q It says here that you went home early.
21 Was that always the case?
22 A I tried very -- I tried very hard to plan

1 so that I would not have to use the restroom while
2 I was there, because I did not have an option, on
3 that -- on the football field, you know, in that
4 campus; however, there were a few occasions where,
5 regardless, I did end up having to use the
6 bathroom, and I was forced to leave.
7 Q Tell me about those occasions, when you
8 say you were forced to leave, what did you do?
9 A On one occasion, I had a friend drive me
10 down the road to, it is either Lowe's or Home
11 Depot that is on the corner, so that I could use
12 the bathroom there. On another occasion, I
13 believe my mother just picked me up.
14 Q When your friend drove you, did you go
15 back to the game?
16 A I -- I -- we did. I was with a group of
17 friends and that friend was the person who was
18 driving all of us.
19 Q So you left the game and then came back?
20 A Yes, after I had used the bathroom
21 offsite.
22 Q Did you do anything else while you were

1 out besides go to Lowe's or Home Depot and use the
2 restroom?
3 A Not that I can recall.
4 Q Did you stop and get something to eat,
5 anything like that?
6 A Not that I can recall.
7 Q The allegation is, in December 2014, you
8 began hormone therapy. Where did you begin the
9 hormone therapy?
10 A At a -- it was -- a VCU facility.
11 Q Okay. You mentioned a pediatric --
12 A Endocrinologist.
13 Q -- endocrinologist.
14 A Yes, sir.
15 Q Do you remember that person's name?
16 A I do not.
17 Q How did that work in terms of how did you
18 do hormone therapy, what is physically involved
19 with that?
20 A Well, you must first get a recommendation
21 from a professional saying that, in fact, you --
22 that the person is trans and hormone replacement

1 therapy is the best practice for having them live
2 happily.
3 Q Who gave you that recommendation?
4 A That would have been Dr. Lisa Griffin.
5 Q Okay.
6 A And then once you produce those or that
7 document to the doctor willing to administer the
8 medication, they will walk you through how do --
9 it is an injection, subcutaneously meaning in the
10 fat rather than in the muscle, and they walk you
11 through how to administer that injection; and,
12 from that point on, I self-administered an
13 injection.
14 Q How frequently?
15 A Once a week.
16 Q How frequently did you see the pediatric
17 endocrinologist?
18 A In the first year or so, as the process
19 was beginning, fairly often, I don't recall
20 exactly with what frequency but fairly often; and,
21 following that, we haven't been back in -- from
22 the point in which the dosage of my medication was

1 agreed upon and stable, we have not been back.
2 Q Are you still taking it?
3 A Yes.
4 Q How frequently do you take it?
5 A Once a week.
6 Q Still the same?
7 A Yes.
8 Q Is it something that will continue for the
9 rest of your life kind of thing or foreseeable
10 future, or how does that work?
11 A I -- I will take it for as long as I
12 desire, and for my purposes that would probably be
13 for the rest of my life.
14 Q When did you last see the endocrinologist?
15 A I really wouldn't have any way of telling
16 you.
17 Q Approximately, sophomore year, junior
18 year, senior year?
19 A I --
20 Q Don't recall?
21 A I don't recall.
22 Q In paragraph 74, it talks about the DMV

1 issued a state ID card in June 2015, which would
2 have been at the end of your sophomore year; is
3 that correct?
4 A Yes, sir.
5 Q Tell me about that process.
6 A I -- I don't really recall. I -- as far
7 as I remember -- I don't remember what
8 supplementary documentation I had to provide to
9 prove that I was permitted to have a male
10 designation on that ID; however, I do recall that
11 there was some kind of supplementary information
12 that I had to provide. I don't recall if it was
13 mailed in or brought up physically, but then,
14 after that point, it was just a matter of going to
15 the DMV and taking the picture and receiving the
16 card.
17 Q So the actual receiving of the card, you
18 remember being at the DMV, having a picture taken,
19 and them handing you a card?
20 A Yes. Well, to clarify, I don't recall if
21 I was handed the card at that time, but I remember
22 I had to be at the DMV for part of that process.

1 Q And did anyone accompany you?
2 A My mother.
3 Q Chest reconstruction surgery in June 2016;
4 is that correct?
5 A Yes.
6 Q Who performed?
7 A Dr. Hope Sherie.
8 Q How do you spell Sherie?
9 A S-H-E-R-I-E.
10 Q Was that at VCU?
11 A No. That was not at VCU.
12 Q Where was that?
13 A That was in either Charlotte or
14 Charlottesville, I don't recall -- I have the
15 names mixed up, but it was in North Carolina.
16 Q Okay. Was that a double mastectomy
17 essentially?
18 A Yes.
19 Q What documentation or other information
20 did Dr. Sherie require before she performed that
21 surgery?
22 A As I was a -- I believe, if I am recalling

1 correctly, I was -- pardon me. I am sorry.
2 Do you mind reminding me of the date?
3 Q Yes. June of 2016 is what it says.
4 A So, yes, so as I was a minor --
5 Q You were 16 years old at the time?
6 A In June, yes, 16.
7 Q Or just 17?
8 A 17. Just 17.
9 Q I wasn't trying to be tricky. Your
10 birthday is in May.
11 A I appreciate that.
12 As I was a minor, I believe there was some
13 degree of parental consent necessary. Barring
14 that, I don't think -- or rather, I will say I
15 don't recall any other documentation that I had to
16 provide beyond parental consent; however, there
17 may have been.
18 Q Did you meet with Dr. Sherie about why
19 this was happening or why you were going to have
20 the procedure?
21 A I -- I don't -- I don't recall if I had
22 any kind of in-person visitation with her before

1 the procedure or if -- in fact, I don't recall if
2 it was -- if we spoke over the phone or what have
3 you because it was a very far drive.
4 It was understood, of course, that she
5 recognized that she was performing a double
6 mastectomy on a transgender patient, it was
7 something her practice was known for doing.
8 Q Okay. September 9, 2016, Gloucester
9 Circuit Court issued an order. What do you recall
10 about the hearing and the order that occurred on
11 September 9, 2016? Was there a hearing?
12 A Just -- just giving me the dates, I -- it
13 is not prompting any recollection of anything. I
14 apologize.
15 Q Do you remember going to court, the actual
16 Gloucester Circuit Court, which would have been in
17 Gloucester?
18 A Yes. Yes, I do -- I remember, yes.
19 Q What do you remember about the hearing?
20 A I don't remember much of anything.
21 Q Did you speak or did just your lawyer
22 speak?

1 A I don't recall.
2 Q Did you present these documents, any of
3 these documents, the ID card or the order from the
4 court or the birth certificate at school?
5 A I don't recall if I provided the ID or --
6 what was -- pardon me -- the first thing you
7 mentioned.
8 Q The first one was the ID?
9 A ID.
10 Q Then the second one was the order from the
11 court, and the third one is the birth certificate.
12 Did you present those?
13 A I don't recall if I presented the ID or
14 the court order, however, I did provide the birth
15 certificate.
16 Q You actually went to school with the birth
17 certificate?
18 A Yes.
19 Q Who did you give it to?
20 A I don't recall.
21 Q Do you remember walking into the front
22 office kind of thing, to say I want to speak to

1 the principal, or did you go to your guidance
2 counselor or --
3 A I don't recall.
4 Q What, if anything, do you remember -- if
5 you say that you know that you presented it, what
6 do you recall about any aspect of that then?
7 A Well, I recall -- I recall recognizing
8 that my records had failed to be changed and I
9 recall going on more than one occasion to the
10 guidance office and asking why my records weren't
11 being changed, when my documents had been amended,
12 and asking when it would happen, if it would
13 happen, and I was at that point told -- I do not
14 recall by whom in the guidance office, but I was
15 informed that the response was -- the response
16 that that person was instructed to give me was
17 that we received your request, thank you, which
18 I -- which is what I remember about that.
19 Q Have you personally ever spoken to any
20 members of the Gloucester County School Board?
21 A Current or former members?
22 Q Either.

1 A Yes.
2 Q Who?
3 A Kevin Smith.
4 Q Tell me any conversations you ever had
5 with Kevin Smith.
6 A Kevin Smith was a family friend, he was
7 around growing up, here and again as a friend of
8 my mother's, I don't -- I cannot recall any
9 conversations generally speaking; however, there
10 is one conversation that I do recall in which
11 Kevin approached myself and my mother and said
12 that, since he was a friend of the family, that he
13 would certainly recuse himself from the School
14 Board's vote.
15 Q Well, that's the conversation you
16 remember?
17 A That's the extent of that conversation I
18 remember.
19 Q As you said earlier, he then did not --
20 A He did not.
21 Q -- recuse himself.
22 Have you spoken with him since then?

1 A I have not.
2 Q Have you had any communications with him?
3 A I have not.
4 Q Other than the fact that Kevin Smith was a
5 family friend and the conversation about him
6 recusing himself, have you had any other
7 conversations with any members of the Gloucester
8 County School Board, past or present?
9 A Not that I can recall.
10 Q Any other communication with any other
11 members of the Gloucester County School Board,
12 email, text, anything of that nature?
13 A Not that I can recall.
14 Q One of the physicians you mentioned in
15 your interrogatory answers is Melinda Penn at
16 Children's Hospital of the King's Daughters. Who
17 is that person?
18 A So Melinda Penn --
19 MR. BLOCK: I am going to object. To
20 clarify, that's the list of their current
21 locations, so she is currently at that hospital,
22 but that's not where she was when she treated

1 Gavin.
2 Q So what do you know about Melinda Penn?
3 MR. CORRIGAN: Thank you for the
4 clarification.
5 A I know that I saw her at some point, but I
6 cannot recall --
7 Q Is she the pediatric endocrinologist?
8 A I don't recall. I don't recall the name
9 of that person, so she may or may not be.
10 Q Okay. We talked about Lisa Griffin
11 previously. Her address here is 14 South Auburn
12 Avenue, Richmond, Virginia.
13 Is that, when you saw her, is that where
14 you saw her, in Richmond?
15 A She was in Richmond, I don't know the
16 street address.
17 Q How many times have you seen her?
18 A I don't recall exactly how many times.
19 Q Well, less than ten?
20 A I -- I don't remember.
21 Q I am just trying to get a magnitude. It
22 could be once or it could be 200 times.

1 A Right.
2 Q You have no ability to estimate between
3 one and 200 how many times you saw Lisa Griffin?
4 A I did not see her on a long-term ongoing
5 basis, so I assume 200 would be a high number;
6 however, I also cannot estimate if it was 10 times
7 or 50 times.
8 Q Okay.
9 A I just don't recall the span of time that
10 I saw her for.
11 Q All right. Eva Abel, Chesapeake
12 Counseling Associates, do you remember seeing her?
13 A Yes.
14 Q How often have you seen her?
15 A She was my -- I had fairly weekly --
16 pardon me. Either weekly or monthly.
17 So either weekly or monthly, I can't
18 recall which of the two visits with her for -- I
19 don't recall the duration, but it was -- it was
20 quite a while.
21 Q During high school?
22 A During high school and as well after.

1 Q And after, but not before high school?
2 A No, not before high school.
3 Q Okay. Are you still seeing her?
4 A I am not.
5 Q Are you currently seeing anyone? When I
6 say anyone, I mean are you seeing any
7 psychologists, psychiatrists, counselor, Licensed
8 Clinical Social Worker, anybody with respect to
9 gender dysphoria or your transgender status or
10 anything of that nature?
11 A I am not currently seeing anybody with
12 respect to my gender identity. I have a general
13 care physician who prescribes my testosterone, but
14 my reason for care with him is not gender related.
15 Q Who is that physician?
16 A His name is Jess Pinder.
17 Q P-I-N-D-E-R?
18 A Yes, sir.
19 Q Where is he located?
20 A One Medical on Shattuck Avenue in Berkley,
21 California.
22 Q One of your interrogatory answers says

1 someone named Thomas Aberli, principal, Atherton
2 High School, Louisville, Kentucky, is a witness
3 with knowledge about his experience as an
4 administrator with policies that allow boys and
5 girls who are transgender to use the same restroom
6 as other boys and girls.
7 Do you know anything about Mr. Aberli?
8 A I -- I don't recall having spoken to him.
9 Q Do you know of any current students at
10 Gloucester High School who are transgender?
11 A Yes.
12 Q What do you know? Not who, but what.
13 A Okay. So there -- there is at least -- I
14 won't speak to hearsay, but I know for certain
15 that there is one student who is a freshman this
16 year who identifies as a boy and has had moderate
17 success with requesting that his teachers refer to
18 him with male pronouns and with the name he
19 prefers, however, he has not made any kind of
20 greater administrative push.
21 Q Do you have any idea what that child is
22 doing with respect to restroom use?

1 A I don't. I have not asked him.
2 Q How about any upper classmen or upper
3 classpeople at Gloucester High School at current
4 who are transgender, do you know of any?
5 A Current -- current right now?
6 Q Yes.
7 A I do not, however, a friend of mine is a
8 transgender student who graduated last year, well,
9 last school year, who was transgender while at
10 Gloucester High School or is trans and went there.
11 Q Gotcha. So there is a student who
12 graduated in June of '18, a year after you --
13 A Yes.
14 Q -- who is transgender?
15 A Yes.
16 Q What restroom did that student use, if you
17 know?
18 A He said that he would either avoid them
19 altogether or use the nurse's office or single
20 stall restrooms but generally preferred to avoid
21 them.
22 Q Do you know whether that student ever

1 raised the issue beyond just using those in terms
2 of trying to get a change in the rule or address
3 the rule?
4 A He did not because he did not have
5 parental support.
6 Q Was he a transgender boy?
7 A Yes.
8 Q Was he called by his male name and male
9 pronouns at school, to your knowledge?
10 A To my knowledge, that was something that
11 he had discussed with teachers and arranged on his
12 own, and that is what seemed to be the status quo.
13 Q So he did that without his parental
14 support was your understanding or not?
15 A I don't have a knowledge of what degree
16 his parents were involved in that.
17 Q Okay. Any other transgender students that
18 you are aware of from the time you approached the
19 school in late summer of 2014 until the present?
20 A Yes. I can think of three off the top of
21 my head.
22 Q Three others?

1 A Yes. There were two additional
2 transgender boys and one transgender girl.
3 Q Did they graduate?
4 A The two other boys were one grade below me
5 and so graduated when -- graduated this previous
6 year.
7 Q Right.
8 A And then the girl was in my grade, and she
9 graduated with our class.
10 Q The girl, did she -- that graduated with
11 your class, what was her restroom arrangements, if
12 you understood it?
13 A She had even fewer opportunities to
14 express herself truly, as her parents were even
15 more opposed to who she is, and so she, I believe,
16 as far as I was aware, just sort of accepted the
17 men's restrooms or avoided them at all costs.
18 Q So she was identifying female and wanted
19 to use the girls' restrooms but either used the
20 boys' restrooms or -- Did she use the single
21 stall?
22 MR. BLOCK: I am just going to object to

1 characterizing the testimony as her wanting to use
2 the girls' restrooms.
3 MR. CORRIGAN: Okay. Go ahead.
4 A I -- she was not able to socially
5 transition, and so she was not able to reveal to
6 the greater community that she was a girl, and so
7 that was knowledge only within people that were
8 close to her or in her circle.
9 Q So she had not approached the schools to
10 have her pronouns changed and her name changed?
11 A Not that I was aware.
12 Q But she graduated with you?
13 A Yes.
14 Q In terms of the use of the restroom, your
15 understanding was she was using the boys' room or
16 avoiding it?
17 A She told me that she at all possible costs
18 avoided using them; however, in emergencies, she
19 would go to the boys' room.
20 Q Did she ever go to the single stalls --
21 A I have no knowledge.
22 Q -- to your knowledge? You don't know?

1 A I don't know.
2 Q The two transgender boys you identified,
3 in addition to the ones we have previously talked
4 about, graduated last year is your understanding?
5 A Yes.
6 Q What was your understanding of their
7 restroom use?
8 A I did not know.
9 Q Do you know them?
10 A They were not close personal friends,
11 however, they were both close personal friends of
12 one of my close friends, and so there were
13 environments in which we had hung out together and
14 had become acquainted on a more than -- on a more
15 than peer basis.
16 Q So did you ever ask them about their
17 restroom use?
18 A No.
19 MR. CORRIGAN: I would like to take a
20 minute. I am going to talk to Tracey a little
21 bit.
22 (Recess from 1:53 p.m. to 2:01 p.m.)

1 MR. CORRIGAN: No further questions.
2 MR. BLOCK: I have a couple questions.
3 EXAMINATION BY COUNSEL FOR THE PLAINTIFF
4 BY MR. BLOCK:
5 Q So do you remember when Mr. Corrigan was
6 asking you about the construction of the
7 additional single user restrooms?
8 A Yes.
9 Q Do you remember that you discussed how,
10 even though the school had said they were ready at
11 a particular time, they were not actually ready?
12 A Yes.
13 Q Is there anything you want to say about
14 what occurred during that week when the policy was
15 in effect but the restrooms weren't ready for you?
16 A Yes. There was one occasion where I
17 stayed after for an event, I don't recall what
18 event, but it was -- it was -- the -- it was
19 before these restrooms were finished being
20 constructed and, therefore, my only option was the
21 nurse's restroom, which is locked after school
22 hours, and I recognized that I had to go to the

1 bathroom and it would be a while before my parents
2 could have picked me up, and by that time it would
3 have been an emergency, and so I was very
4 distraught, really just totally devastated that I
5 had nowhere to use the bathroom in my own school,
6 and so I broke down really bad and went sobbing to
7 the library, where I knew I had friends, and one
8 of the librarians actually drove me home so that I
9 could use the bathroom.
10 Q Do you remember, when Mr. Corrigan asked
11 you about what memories you have with respect to
12 bringing your birth certificate to school?
13 A Yes.
14 Q And you testified about your memory
15 regarding checking up on your school records; is
16 that right?
17 A Yes.
18 Q Do you have a specific memory of who
19 handed the birth certificate in?
20 A If I -- if I may clarify, I don't recall
21 exactly who, if it was myself or my mother, but I
22 do remember it was, in fact, handed in and that I

1 was the one who checked up after that fact.
2 Q Do you remember talking to Mr. Corrigan
3 about other students at Gloucester High School who
4 were transgender?
5 A Yes.
6 Q Do you remember saying that one of the
7 students you discussed, the transgender girl, had
8 not socially transitioned?
9 A Yes.
10 Q Of the other students that you discussed
11 with Mr. Corrigan, were there any other students
12 who were transgender but had not socially
13 transitioned?
14 A Yes.
15 Q Who was that?
16 A One other student had not socially
17 transitioned and was presenting himself as a boy
18 only to his friend group, however, not to teachers
19 or administrators.
20 Q Did he tell you why he was not
21 transitioning more broadly?
22 MR. CORRIGAN: I object to the form. Go

1 ahead.
2 A He expressed in part that the school did
3 not feel like an environment where he would be
4 safe transitioning in, he also expressed that it
5 would have been difficult just regarding the
6 situation he was in privately, I didn't inquire as
7 to the details, his family were less on board than
8 he would have liked, but he had expressed that
9 there was anxiety over not feeling like he was
10 safe to transition within the school and
11 especially not having a bathroom, if he did.
12 Q Do you recall Mr. Corrigan asking you
13 about check-in meetings you would have with
14 Miss Durr or Mr. Lord?
15 A I do.
16 Q And during those meetings, did you report
17 any distress that you were experiencing as a
18 result of the school's restroom policies?
19 A I believe I did.
20 Q And can you speak to whatever occasions
21 you did make that report?
22 A There was one occasion in which I spoke to

1 Tiffany Durr, where I had expressed that I was
2 experiencing pain because of the situation at the
3 school; however, I -- there was also a tendency in
4 following meetings, for me to underreport the
5 trauma that I was going through or examples of
6 bullying or harassment, because I felt that it was
7 not something that -- they could not resolve those
8 issues, they could not give me the ability to use
9 the boys' bathroom, and so I failed to report much
10 of what I was experiencing because I did not have
11 faith in the school system to protect me from
12 those things that I was worried about.
13 MR. BLOCK: No further questions from me.
14 MR. CORRIGAN: I have a question.
15 EXAMINATION BY COUNSEL FOR THE DEFENDANT
16 BY MR. CORRIGAN:
17 Q With respect to Miss Durr, can you tell me
18 approximately when you think you spoke with her?
19 A It -- it would have been earlier in the --
20 the -- earlier in that school year or perhaps
21 towards the middle of my sophomore year, somewhere
22 in that range.

1 Q Okay.
2 A It was earlier.
3 Q So earlier as in could have been in the
4 fall or in the early part of the spring semester?
5 A Correct, that would be where I would
6 estimate it.
7 Q And do you remember where the conversation
8 took place?
9 A I -- I don't, but typically those
10 conversations were had in the office of the
11 person; however, I cannot recall it explicitly
12 that it was or was not.
13 Q Do you recall what you said to her?
14 A I -- I don't recall specifically phrases
15 that were used, I do, however, recall expressing
16 general distress about the policy and how it was
17 affecting me negatively.
18 Q When you say the policy, what policy?
19 A Pardon. The discriminatory policy that
20 the School Board had put in place.
21 Q With respect to the restrooms?
22 A Yes, sir.

1 Q Did you use the word pain earlier, when
2 you were talking to Mr. Block, what pain were you
3 talking about?
4 A Can you --
5 Q You said to him that you spoke to her one
6 time and told her about the pain --
7 A Right.
8 Q -- because of the situation. What does
9 that mean?
10 A Mental anguish, I mean pain being
11 emotional distress--
12 Q So you weren't talking about physical like
13 your stomach hurt or something like that?
14 A Yes, sir, pain being emotional distress
15 and trauma.
16 Q Did you ever have any conversations with
17 Miss Durr or Mr. Lord or anyone else in counseling
18 about emotional distress and trauma that you were
19 having that was unrelated to the restrooms?
20 A I don't recall.
21 Q To the best of your recollection, you
22 never spoke with Mr. Lord about the restroom

1 policy; is that correct?
2 A I don't recall.
3 Q You don't recall one way or the other?
4 A Correct.
5 Q What did Miss Durr say to you after you
6 expressed these concerns?
7 A I don't recall.
8 MR. CORRIGAN: That's all the questions.
9 MR. BLOCK: Same here.
10 You will have an opportunity to review the
11 transcript and to make any corrections, if
12 anything is incorrect.
13 MR. GRIMM: Okay.
14 Thank you very much.
15 MR. CORRIGAN: Thank you.
16
17 (Off the record at 2:10 p.m.)
18
19
20
21
22

1 ACKNOWLEDGEMENT OF DEPONENT
2 I, GAVIN GRIMM, do hereby acknowledge
3 that I have read and examined the foregoing
4 testimony, and the same is a true, correct and
5 complete transcription of the testimony given by
6 me and any corrections appear on the attached
7 Errata sheet signed by me.
8
9 ______________________ ___________________________
10 (DATE) (SIGNATURE)
11
12
13
14
15
16
17
18
19
20
21
22

1 CERTIFICATE OF SHORTHAND REPORTER - NOTARY PUBLIC

2 I, LESLIE D. ETHEREDGE, Registered Merit
3 Reporter, Certified Court Reporter and Notary
4 Public, the officer before whom the foregoing
5 deposition of GAVIN GRIMM was taken, do hereby
6 certify that the foregoing transcript of the
7 deposition is true and correct to the best of my
8 ability; that said testimony was taken by me
9 stenographically and thereafter reduced to
10 typewriting under my direction; that reading and
11 signing was requested; and that I am neither
12 counsel for, related to, nor employed by any of
13 the parties to this case and have no interest,
14 financial or otherwise, in its outcome.

15 IN WITNESS WHEREOF, I have hereunto set my
16 hand this 5th day of November, 2018.

17

18

19 LESLIE D. ETHEREDGE, Notary Public in
20 and for the Commonwealth of Virginia
21 Registration No: 116406
22 My commission expires February 28, 2019

13

11/19/2014

TRANSGENDER PROTECTIONS IN PUBLIC SCHOOLS: RECENT DEVELOPMENTS

Bradford A. King
(804) 783-7263
Bking@sandsanderson.com
Nicole S. Cheuk
(804) 783-7267
Ncheuk@sandsanderson.com

SANDS ANDERSON

What does "transgender" mean?

- A transgender person has a gender identity (one's internal sense of gender) that is different from the gender identification listed on the individual's birth certificate.
- A "transgender male" is a person born female, transitioning to or living as a male.
- Transgender individuals may or may not seek medical intervention, including hormone treatment or sex-reassignment surgery.

Protections for Students: Federal Law

- Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681 et seq. (Title IX):
  - "No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance."
  - U.S. Department of Education's Office for Civil Rights ("OCR") interprets this to include gender-based harassment.
  - Gender-based harassment includes verbal, non-verbal or physical aggression, intimidation, or hostility based on sex or sex stereotyping, including failing to conform to stereotypical notions of masculinity or femininity.

Protections for Students: Title IX

- School divisions are not liable for one student harassing another, but may be liable for failing to respond adequately, ***whether or not the harassed student makes a complaint or asks the school to take action.***
- School division may violate Title IX if:
  - Harassing conduct is sufficiently serious to deny or limit the student's ability to participate in or benefit from the educational program;
  - The division knew or reasonably should have known about the harassment; and
  - The division failed to take appropriate responsive action.

Protections for Students: Title IX

- When a school division knows or reasonably should know of possible harassment, it must take immediate and appropriate steps to investigate or otherwise determine what occurred.
- If an investigation reveals that the harassment created a hostile environment, the school district must then take prompt and effective steps reasonably calculated to:
  - End the harassment;
  - Eliminate the hostile environment;
  - Prevent its reoccurence; and
  - As appropriate, remedy its effects.

Office for Civil Rights Complaints

- Arcadia Unified School District (CA) – July 2013 landmark OCR decision.
- Complaint alleged discrimination on the basis of sex against a student, born female but identified as male.
  - Specifically, school division prohibited him from accessing (1) sex-specific facilities designated for male students, and (2) sex-specific student cabins for male students during a school-sponsored overnight camp.
- Without admitting unlawful conduct, school division entered into a resolution agreement agreeing to create "a safe, nondiscriminatory learning environment for students who are transgender or do not conform to gender stereotypes."

Office for Civil Rights Complaints

- Downey Unified School District (CA) – OCR Resolution Agreement issued October 14, 2014:
  - The complaint alleged descrimination based on sex.
    - 1) transgender student born male subjected to different treatment and harassment by District employees because of her gender identity and gender nonconformance; and
    - 2) subjected to sexual and gender-based peer harassment and the District failed to provide a prompt and equitable response to the notice of harassment.
  - OCR investigated the complaint under its Title IX authority.
  - Prior to the conclusion of the investigation, the District expressed interest in voluntarily resolving the case and entered into a Resolution Agreement.

Downey Investigation

- Transgender girl first informed District of her gender identity in kindergarten.
- During the years K-5, the student continued to assert a female gender identity but had not made a gender transition to attend school as a girl – continued to use male name, pronouns, etc.
- She began coming to school dressed as a girl in the fifth grade.
- Complainant asserted that make-up was confiscated, had to write an apology letter for making male students uncomfortable by wearing make-up.
- She was also discouraged from discussing her gender identity with her friends.

Downey Investigation

- Complainant asserted that after her non-surgical gender transition, school pictures reflected the Student's male name even though wearing a dress and used female name on the picture forms.
- Frequently verbally harassed by her peers – "fag, whore, bitch," etc.
- After complaint, elementary administrators suggested she transfer to another school where no one knew she was a transgender girl.

Downey Investigation

- Prior to start of middle school, Complainant requested to be called by female name and given option of using female restroom or staff restroom.
- Middle school administrator receptive to her requests and she used female restroom and locker room without incident.
- However, she continued to experience peer harassment, being called her former male name, and questioned often about her anatomy.
- The District denied her request for school-wide assembly on gender-based harassment/bullying.

Downey Unified School District Resolution Agreement – October 2014

- Memorializes the Student's use of female-designated facilities.
- District agrees to otherwise treat the Student as a girl in all respects.
- District agrees to amend policies and procedures, train staff, provide age-appropriate instruction to students, survey parents and students about harassment, and ensure appropriate supports for the Student and other transgender students who request it.

State Law Protections for Transgender Students (not exhaustive)

- Maine – Maine Human Rights Act
- Arizona – High School League recently approved its first transgender athlete.
- California (August 2013) – Requires pupils be permitted to participate in sex-segregated school programs and activities, including athletic teams and competitions, and use facilities consistent with their gender identity, irrespective of the gender listed on their pupil records.
- Colorado, Hawaii, Illinois, Iowa, Maryland, Minnesota, New Jersey, New York, North Carolina, Oregon, Vermont, Washington and D.C. all have laws specifically protecting transgender students in public schools from harassment and/or discrimination.

11/19/2014

Transgender Student Athletes

- February 2014 – Virginia High School League adopted transgender student-athlete policy.
  - When a school identifies a transgender student who seeks to participate it must submit a letter requesting an appeal to the district chairman and VHSL Director.
  - A transgender student-athlete may compete in the gender of their birth certificate unless they have undergone sex reassignment.
  - A student-athlete who has undergone sex reassignment may participate in the re-assigned gender when the student has undergone the surgery (1) before puberty; or (2) after puberty under certain conditions:
    - Surgical anatomical changes have been completed;
    - Hormonal therapy is being administered in a verifiable manner and for a sufficient length of time; and
    - If student stops hormonal treatment, they will be required to participate in sport consistent with birth gender.

Transgender Student Athletes

- VHSL rule mirrors the International Olympic Committee requirements.
- Currently, 18 other states have transgender student-athlete policies, although not all require gender reassignment surgery.
- Florida requires:
  - A written statement from the student affirming the consistent identity and expression to which the student self-relates;
  - Documentation from individuals such as, but not limited to, parents /legal guardians appointed by a court of competent jurisdiction, friends and/or teachers, which affirm that the actions, attitudes, dress and manner demonstrate the student's consistent gender identification and expression;
  - A complete list of all the student's prescribed, non-prescribed or over the counter, treatments or medications;
  - Written verification from an appropriate health-care professional (doctor, psychiatrist, and psychologist) of the student's consistent gender identification and expression.

Case law

- Doe v. Regional School Unit 26 (Also – Doe v. Clenchy)– Maine Supreme Judicial Court (January 30, 2014)
  - Suit filed pursuant to Maine Human Rights Act (MHRA) – prohibits discrimination based on sexual orientation in public accommodations, educational opportunities, employment, housing, and other areas.
  - Transgender female had been allowed to use girl's restroom pursuant to a 504 plan that addressed her gender identity issues and upcoming transition to fifth grade – "gender dysphoria."
    - Gender dysphoria – medical term for psychological distress resulting from having a gender identity different from the sex that one was assigned at birth.
  - In fifth grade a male student followed her into the restroom on two occasions claiming he was entitled to use it also.

Case law

- Doe, continued.
  - The Court had to consider the relationship between MHRA and a provision of the state Sanitary Facilities law, which requires schools to provide clean toilets that are separated according to sex.
  - Court found that Sanitary Facilities law does not establish guidelines for the use of school bathrooms, rather it establishes cleanliness and maintenance requirements.
  - The school division's decision to ban student from the girl's bathroom, based not upon a change in student's status but on others' complaints, constituted discrimination prohibited by MHRA.

Case law

- Doe, continued.
  - Over the student's parents' objections, the school required her to use the single-stall, unisex staff bathroom.
  - The 504 team met again to discuss transition to middle school and determined student would not use girl's bathroom in middle school.
  - Court acknowledged that many of the school officials exhibited tremendous sensitivity and insight over several years, but the school came under intense public scrutiny which caused it to reconsider the steps it had taken and reverse course.
  - First time a state court declared it unlawful to deny a transgender student access to the bathroom that matches the gender with which she identifies.

Case law

- Coy Mathis v. Fountain-Fort Carson School District 8 – June 17, 2013 decision of Colorado Division of Civil Rights
  - Found sufficient evidence to find that the school district "discriminatorily denied the Charging Party equal terms and conditions of goods, services, benefits, or privileges; equal treatment based on harassment; and the full and equal enjoyment of the goods, services, facilities, privileges, advantages or accommodations in a place of public accommodation due to the Charging Party's sex and sexual orientation."

11/19/2014

Case law

- Mathis, continued.
  - Charging Party – six year-old transgender girl who had, since 18-months old, non-verbally expressed her female gender identity through her likes and dislikes.
  - Between ages of 4 and 6 began articulating her belief that she was a girl.
  - Enrolled in kindergarten as a boy, but wore girl's clothes, chose female playmates.
  - Between August 2012 and December 2012 (in first grade) – Charging Party used the girl's restroom, accompanied by a female classmate without issue.

Case law

- Mathis, continued.
  - Superintendent found out and instructed the Principal to inform the family that the Charging Party could no longer use the girl's restroom, but could use the boy's restroom or adult staff single-user restrooms. (changed to gender-neutral after the Mathis family left school).
    - School district had received only one complaint from a former district parent regarding her use of the girl's restroom.
  - The division of civil rights relied on the fact that Charging Party identifies as female and possesses documents identifying her sex as female in finding that school district discriminated against student.
  - The evidence demonstrated that socially, legally and medically the Charging Party is considered female (without gender reassignment surgery), and therefore she was discriminated against.

Hypothetical

- How would you handle the following: a school club is going on an overnight excursion underwritten by the parents, where they plan to bunk four students per hotel room. What accommodations if any would your school districts make for a transgender student in terms of sleeping arrangements?

11/19/2014

Transgender Student Records

- Arises often with transgender alumni seeking employment or applying to other educational institutions after graduation.
- The Family Educational Rights and Privacy Act (FERPA) allows parents or eligible students to review education records and request that the school change records that are inaccurate, misleading or in violation of the student's privacy.
  - 1991 Family Policy Compliance Office opinion letter concluded that FERPA does not apply to a transgender former student requesting a name and gender change in his or her education records.
  - Rationale is that the change is substantive decision of the school division.
  - This rationale may be changing based on privacy standard.
- Changing the records avoids the possibility of a discrimination claim and maintains the student's privacy. By not changing the records, school is essentially disclosing that student's transgender status to anyone who sees their records.

Transgender Student Records

- Declining to update records is simple, consistent approach, less administrative burden.
- However, not changing the records may cause the person viewing them to question the applicant's honesty, forcing the individual to disclose their status.
- If a district would amend or change a record for a change in name based on marital status, then it should process a name change based on gender status in the same manner.
- It is not unlawful to require a court order or amendment of state/federally issued identification prior to changing records.

Trending

- Non-binary students – neither male nor female, sometimes known as "genderqueer".
  - Genderqueer was one of 56 gender identity options added to Facebook in February 2014.
- Pennsylvania school division reports that a student requested to be called by a different name from the female name previously used and have all pro-nouns be non-gender specific.
- Argument: the legal construct of how gender is tracked and recorded is Binary (male/female), therefore there is no legal authority for the accommodation requested.

Best Practices

- Respond immediately to claims of harassment/bullying.
- Permit use of facilities based on gender identification.
- Provide training/professional development.
- Provide school-wide assemblies on gender-based harassment/bullying.

Protections for Employees – Federal Law

- Title VII of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.) prohibits discrimination in employment on the basis of sex.
- The Courts have been inconsistent about whether this includes discrimination based on gender-identity.
- The Equal Employment Opportunity Commission (EEOC), has recently interpreted Title VII to include discrimination on the basis of gender identity.
- No federal law expressly prohibits LGBT bias, despite Congress having proposed the Employment Nondiscrimination Act, prohibiting sexual orientation and gender identity bias in the workplace almost every year for past 20 years.

Macy v. Holder, Appeal No. 0120120821 (U.S. EEOC, Apr. 20, 2012).

- In December 2010, Macy, a transgender woman then presenting as a man, applied for a Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF) position at a crime laboratory.
- Macy asserted that after a discussion of her credentials and experience, the director of the lab told her that position was hers, assuming no problems arose during her background check.
- In March 2011, Macy informed the background check investigator that she was in the process of transitioning from male to female.
- Five days later, she was told that the position was no longer available.
- Three months later, Macy filed an EEOC charge against the ATF, alleging discrimination on the basis of her sex, gender identity, and sex stereotyping.

11/19/2014

Macy v. Holder, cont'd

- The EEOC held that gender-identity based discrimination is banned under Title VII.
- The case then went back to the Department of Justice, which has jurisdiction over discrimination complaints against ATF.
- On July 8, 2013, the DOJ issued its finding that "ATF discriminated against complainant based on her transgender status, and thus her sex."

Lambda Legal and Freedom to Work

- In July 2013, Lambda Legal and Freedom to Work announced that it had reached a settlement with a private employer, also a government contractor, on behalf of a Maryland transgender woman.
- The woman filed a charge with the EEOC alleging that she was subjected to physical and verbal harassment in the workplace over a two year period, including comments such as "tranny," "drag queen," and "faggot."

Lambda Legal and Freedom to Work

- The EEOC issued a letter with a determination of reasonable cause to believe the company violated Title VII of the Civil Rights Act, stating:
  - The investigation revealed that Charging Party was subjected to derogatory gender-based comments that were frequently made by both co-workers and supervisors. Both Charging Party and witness interviews revealed that Respondent's management failed to take corrective action despite being fully aware of the harassment Charging Party was being subjected to. This lack of corrective action enabled the harassment and offensive atmosphere to continue.

LGBT Bias Charges, Resolutions Up

- EEOC Commissioner Feldblum shared at an October Employment Law Institute that in calendar year 2013 the EEOC received 834 charges raising allegations of sexual orientation discrimination ("GO") and 199 charges alleging gender identity or transgender bias ("GT").
  - 417 resolved, 9 cause findings.
- In first six months of 2014 – EEOC received 459 GO charges and 81 GT Charges, 11 cause findings.
- Feldblum acknowledged that the increase has more to do with the change in the agency's attitude toward the handling of such claims than with legal developments internally or in the courts.

Protections for Employees – State law

- On January 4, 2014, Governor McAuliffe signed Executive Order Number 1, prohibiting discrimination based on sexual orientation and gender identity.
- The Executive Order applied to all state agencies, not school boards.
- Same-sex marriage is permitted in Virginia as of October 6, 2014.

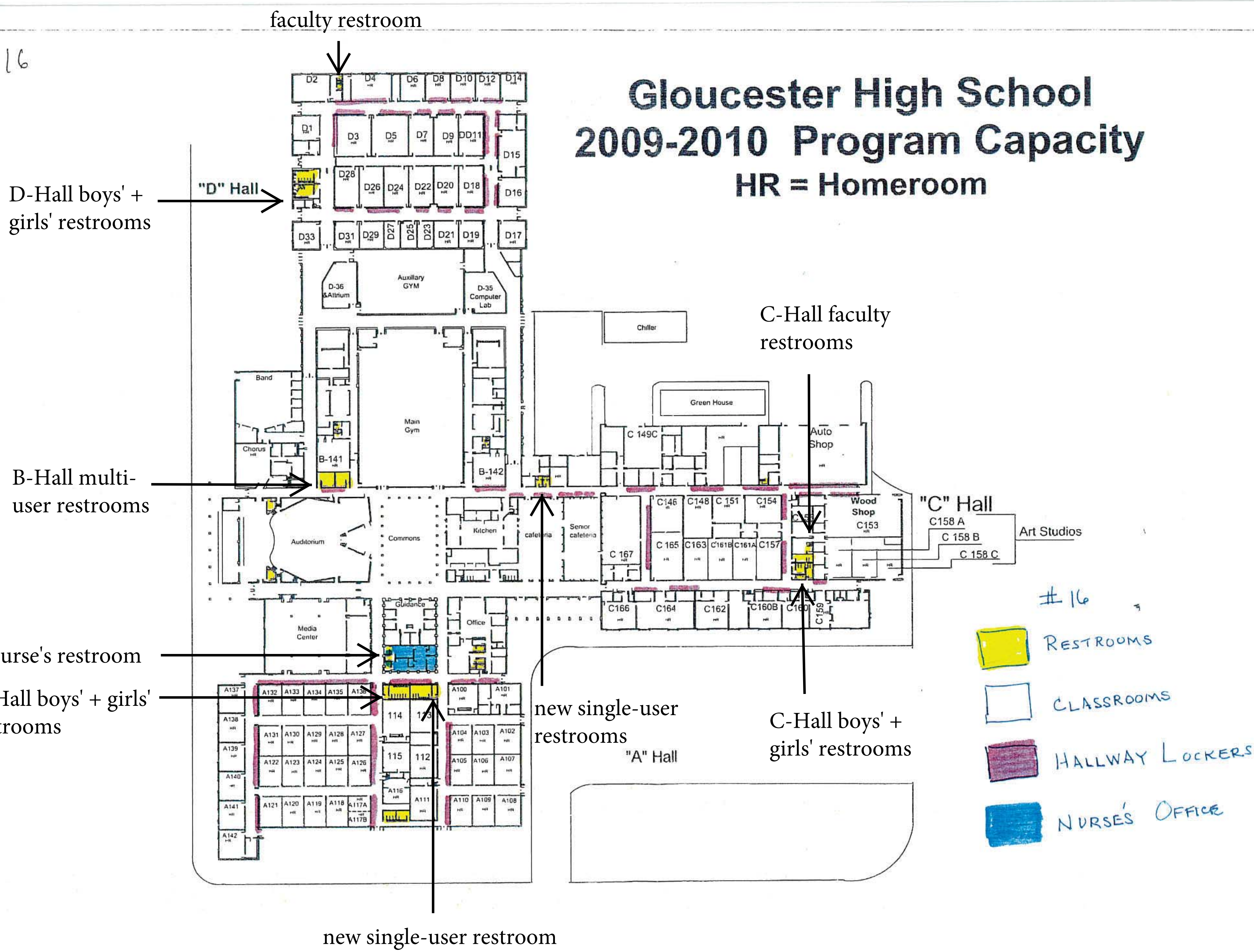
Best Practices - Employees

- Updating nondiscrimination policies to expressly include LGBT bias.
- Training for supervisors and employees on gender-based discrimination and harassment.
- Equal employee benefits to same-sex couples (possible special open enrollment for couples married prior to Virginia's legalization of gay marriage).
- Make sure updated nondiscrimination policies include a process for workers who are transitioning from male to female or vice versa, and information regarding name changes, and restroom use.

16

Gloucester High School
2009-2010 Program Capacity
HR = Homeroom

#16
Restrooms
Classrooms
Hallway Lockers
Nurses' Office


16
Gloucester High School
2009-2010 Program Capacity
HR = Homeroom
faculty restroom
D-Hall boys' + girls' restrooms
"D" Hall
B-Hall multi-user restrooms
nurse's restroom
A-Hall boys' + girls' restrooms
new single-user restrooms
"A" Hall
C-Hall faculty restrooms
C-Hall boys' + girls' restrooms
"C" Hall
Art Studios
new single-user restroom
Auxiliary GYM
D-35 Computer Lab
D-36 &Atrium
Main Gym
Band
Chorus
Auditorium
Commons
Kitchen
cafeteria
Senior cafeteria
Media Center
Guidance
Office
Chiller
Green House
Auto Shop
Wood Shop
#16
Restrooms
Classrooms
Hallway Lockers
Nurses' Office

6th Grade Wing – Teachers' Room – 1 non-ADA restroom with single commode and sink
Main Office – Principal's Office – 1 non-ADA restroom with single commode and sink
Main Office (staff) – unisex – 1 non-ADA restroom with single commode and sink
Clinic – 1 ADA restroom with single commode and sink
By Gym (staff) – men – 1 non-ADA restroom with single commode and sink
By Gym (staff) – women – 1 non-ADA restroom with single commode and sink
By Gym – boys – 1 ADA stall; 1 regular; 3 urinals without partitions
By Gym – girls – 1 ADA stall; 1 regular
Boys' Locker Room – 2 non-ADA stalls; 4 urinals without partitions; 8 individual showers
Boys' Locker Room – Coach's Office – 1 non-ADA restroom with commode and sink and shower
Girls' Locker Room – 4 non-ADA stalls; 8 individual showers
Girls' Locker Room – Coach's Office – 1 non-ADA restroom with commode and sink and shower
Custodial Office – 1 non-ADA restroom with single commode and sink
Kitchen – 1 non-ADA restroom with single commode and sink
Industrial Arts – boys – 2 non-ADA stalls; 3 urinals without partitions
Industrial Arts – girls – 3 non-ADA stalls

Gloucester High
A Hall – boys – 3 non-ADA stalls; 7 urinals with partitions
A Hall – unisex – 1 non-ADA stall; 1 urinal with partition
A Hall – girls – 6 non-ADA stalls
A Hall (staff) – women – 2 non-ADA stalls
A Hall (staff) – women – 3 non-ADA stalls
A Hall (staff) – men – 1 non-ADA stall; 3 urinals without partitions
B Hall – boys – 1 ADA stall; 1 regular; 4 urinals with partitions
B Hall – girls – 1 ADA stall; 1 regular
C Hall – boys – 2 non-ADA stalls; 2 urinals with partitions
C Hall – girls – 3 non-ADA stalls
C Hall (staff) – women – 2 non-ADA stalls
C Hall (staff) – men – 1 non-ADA stall; 1 urinal with partition
C Hall – new unisex – 1 non-ADA stall and sink
C Hall – new unisex – 1 non-ADA stall and sink
D Hall – boys – 1 ADA stall; 2 regular; 3 urinals with partitions
D Hall – girls – 1 ADA stall; 5 regular
Teachers' Lounge – men – 1 non-ADA restroom with single commode and sink (has 1 grab bar)
Teachers' Lounge – women – 1 non-ADA restroom with single commode and sink (has 1 grab bar)
Main Office – unisex – 1 ADA restroom with single commode and sink
Main Office (staff) – men – 1 ADA restroom with single commode and sink
Main Office (staff) – women – 1 ADA restroom with single commode and sink
Locker Room - Main – boys – 1 gang shower; 1 non-ADA restroom without stall; 3 urinals without partitions
Locker Room – JV – boys – no shower; 1 ADA stall; 2 regular; 2 urinals with partitions
Locker Room – Main – girls – 26 stall shower (not used); 2 non-ADA stalls
Locker Room – JV – girls – no shower; 1 ADA stall; 3 regular
Auditorium – boys – 1 non-ADA restroom with single commode and sink
Auditorium – girls – 1 non-ADA restroom with single commode and sink
Clinic – boys – 1 ADA restroom with single commode and sink
Clinic – girls – 1 ADA restroom with single commode and sink
Kitchen – unisex – 1 non-ADA restroom with single commode and sink
Main Hall (across from Office) – boys – 1 ADA stall; 2 regular; 4 urinals with partitions
Main Hall (across from Office) – girls – 1 ADA stall; 2 regular

LEGAL DEPARTMENT
LESBIAN GAY
BISEXUAL
TRANSGENDER &
AIDS PROJECT

December 23, 2016

David P. Corrigan
Harman Claytor Corrigan & Wellman
Post Office Box 70280
Richmond, VA 23255

Via email to dcorrigan@hccw.com

RE: School records for Gavin Grimm

Dear David,

Pursuant to our conversation, I am writing to request that Gavin Grimm's school records be updated so that any school records submitted in connection with Gavin's college applications identify him as male, in accordance with his amended birth certificate. Some college applications are due as early as January 3, 2017.

I make this request in the hopes that we can amicably resolve this discrete issue in time for Gavin's applications to college. As discussed, in making this specific request, I am not waiving or limiting Gavin's legal rights under Title IX or any other source of law to be treated consistently with his male gender identity and the male designation on his birth certificate in other respects.

Sincerely,

/s/ Joshua A. Block

Joshua A. Block
Senior Staff Attorney
LGBT and HIV Project
American Civil Liberties Union
125 Broad St., New York, NY 10004
■ 212.549.2593 ■ jblock@aclu.org

AMERICAN CIVIL LIBERTIES UNION FOUNDATION
LESBIAN GAY BISEXUAL TRANSGENDER & AIDS PROJECT

PLEASE RESPOND TO:
NATIONAL OFFICE
125 BROAD STREET, 18TH FL.
NEW YORK, NY 10004-2400
T/212.549.2627
F/212.549.2650
WWW.ACLU.ORG/LGBT

SAN FRANCISCO OFFICE:
39 DRUMM STREET
SAN FRANCISCO, CA 94111

CHICAGO OFFICE:
180 NORTH MICHIGAN AVENUE
SUITE 2300
CHICAGO, IL 60601-7401

WASHINGTON, D.C. OFFICE:
915 15TH STREET, NW
WASHINGTON, D.C. 20005

OFFICERS AND DIRECTORS
SUSAN N. HERMAN
PRESIDENT

ANTHONY D. ROMERO
EXECUTIVE DIRECTOR

RICHARD ZACKS
TREASURER

GLOUCESTER COUNTY SCHOOL BOARD
The Thomas Calhoun Walker Education Center
6099 T.C. Walker Road
Gloucester, Virginia 23061

William "Jarret" Lee, 2019 Chairperson
Member At Large
Robin M. Rice, 2019 Vice Chairperson
Ware District
Troy M. Andersen, Gloucester Point District

George R. Burak, Abingdon District
Brenda F. Mack, Member At Large
Elisa A. Nelson, York District
Anita F. Parker, Petsworth District

For Immediate Release

Date: February 13, 2019
To: All Local Media Outlets
From: Gloucester County School Board
Subject: Notice of Public Hearing

Notice is hereby given that the GLOUCESTER COUNTY SCHOOL BOARD will hold a public hearing on **Tuesday, February 19, 2019, at 6:30 p.m.,** or as soon thereafter as the matter may be heard, in the Auditorium of the Thomas Calhoun Walker Education Center, 6099 T.C. Walker Road, Gloucester VA 23061, for the purpose of obtaining the public's views on and considering the following:

Discussion of a School Board policy on the use of restroom facilities related to the resolution that was adopted on December 9, 2014.

The policy to be discussed would allow transgender students to use the restroom consistent with the student's asserted gender identity when the following criteria have been met:

(1) the student has appropriate medical documentation from a licensed, treating healthcare provider who specializes in the treatment of transgender individuals; and
(2) the student has consistently asserted the student's gender identity for a period of at least six months; and
(3) the student has undergone treatment recommended by the student's healthcare provider, which may include social transition or hormonal therapy for at least six months.

The December 9, 2014 resolution states:

Whereas the GCPS recognizes that some students question their gender identities, and
Whereas the GCPS encourages such students to seek support, advice, and guidance from parents, professionals and other trusted adults, and
Whereas the GCPS seeks to provide a safe learning environment for all students and to protect the privacy of all students, therefore
It shall be the practice of the GCPS to provide male and female restroom and locker room facilities in its schools, and the use of said facilities shall be limited to the corresponding biological genders, and students with gender identity issues shall be provided an alternative appropriate private facility.

All interested persons are invited to attend the hearing. **Public comment is expected to be received beginning at 7:00 p.m., or as soon thereafter as may be heard.**

Meetings are broadcast via Cable Channel 47

GLOUCESTER COUNTY SCHOOL BOARD
The Thomas Calhoun Walker Education Center
6099 T.C. Walker Road
Gloucester, Virginia 23061

William "Jarret" Lee, 2019 Chairperson
Member At Large
Robin M. Rice, 2019 Vice Chairperson
Ware District
Troy M. Andersen, Gloucester Point District

George R. Burak, Abingdon District
Brenda F. Mack, Member At Large
Elisa A. Nelson, York District
Anita F. Parker, Petsworth District

For Immediate Release

Date: February 21, 2019
To: All Local Media Outlets
From: Gloucester County School Board
Subject: Restroom Resolution

The Gloucester County School Board will not be taking any action at its February 21 work session on the possible alternative restroom resolution that was presented at its work session on February 19. In addition, the School Board has not set a time frame for when any action will be taken or when any further discussion will be held regarding the resolution. Finally, the School Board will not be providing any additional comments on this matter at this time.

RECORDED MINUTES OF THE
GLOUCESTER COUNTY SCHOOL BOARD
GLOUCESTER, VIRGINIA

NOVEMBER 11, 2014

The regular monthly meeting of the Gloucester County School Board was held on Tuesday, November 11, 2014. The Chairperson called the meeting to order at 5:35 pm at the Thomas Calhoun Walker Education Center.

I. ROLL CALL

Roll call was taken by the Acting Clerk, and the following persons were recorded as present: George R. (Randy) Burak, Chairperson, Troy M. Anderson, Kimberly (Kim) E. Hensley, Carla B. Hook, Anita F. Parker, Charles B. Records, and Kevin M. Smith, Members. Also present for the closed meeting: Walter R. Clemons, Ph.D., Superintendent of Schools, and John E. Hutchinson, Assistant Superintendent for Administrative Services and Acting Clerk.

II. CALL FOR CLOSED MEETING

At 5:36 pm, a motion was made by Ms. Hensley, seconded by Mrs. Hook, and unanimously approved to adjourn for a closed session, pursuant to *Code of Virginia*, 1950, as amended, Section 2.2-3711 (A), Subsection 1, for the discussion of personnel matters (monthly appointments, resignations, etc.) and Subsection 7, for consultation with legal counsel. At 6:50 pm, the Chairperson declared a recess, and the meeting was relocated to the Thomas Calhoun Walker Education Center auditorium.

III. RETURN TO OPEN MEETING/CERTIFICATION

Note: Ms. Betty Jane Duncan, Deputy Clerk, recorded the open meeting.
The Deputy Clerk noted that all members were present for the open meeting.

At 7:00 pm, a motion was made by Mr. Smith and seconded by Ms. Hensley to reconvene the meeting into open session. The motion was approved as follows:

Mr. Andersen	Aye	Mr. Records	Aye
Ms. Hensley	Aye	Mr. Smith	Aye
Mrs. Hook	Aye	Mr. Burak	Aye
Ms. Parker	Aye		

There was no certification for the closed session at this time. The Chairperson stated that the Board had recessed from the closed session and would resume that closed session at the conclusion of the opening meeting.

IV. MOMENT OF SILENCE/PLEDGE OF ALLEGIANCE – Mr. Burak noted that today was Veterans' Day and extended thanks to all veterans who had served our country. Ms. Campbell Farina, SAC representative, led the Board and citizens in a moment of silence followed by the Pledge of Allegiance to the flag of the United States of America.

V. PERSONNEL ITEMS – (moved to consideration after closed session)

VI. ADDITIONS/CHANGES/ADOPTION OF AGENDA

There were no changes to the agenda as previously revised and published. A motion was made by Ms. Hensley, seconded by Mr. Records, and unanimously adopted to approve the agenda as revised and published.

VII. APPROVAL OF ITEMS CONTAINED IN THE CONSENT AGENDA

A motion was made by Ms. Hensley to approve the Consent Agenda (listed below). Motion was seconded by Mr. Andersen and approved with a roll call vote.

Mr. Andersen	Aye	Mr. Records	Aye
Ms. Hensley	Aye	Mr. Smith	Aye
Mrs. Hook	Aye	Mr. Burak	Aye
Ms. Parker	Aye		

ITEMS CONTAINED WITHIN THE CONSENT AGENDA:

A. Approval of Minutes of October 14, 2014, Monthly Meeting
B. Approval of Minutes of October 23, 2014, Special (Work Session) Meeting
C. Approval of Minutes of October 30, 2014 Special (Closed) Meeting
D. Approval of Disposal of Equipment Valued in Excess of $500
E. Approval of Policy Manual Update (1st/2nd Readings)
   1. FF: Public Dedication of New Facilities (new)
   2. FFA: Naming of School Facilities (new)
   3. BBFA: School Board Members Conflict of Interest (revision)
   4. BDDF: Voting Method (revision)
   5. EFB: Free and Reduced Price Food Services (revision)
   6. FE: Playground Equipment (revision)
   7. FG: Retirement of Facilities (revision)
   8. JO: Student Records (revision)
   9. KFB: Administration of Surveys and Questionnaires (revision)
   10. KH: Public Gifts to Schools (revision)
   11. KKA: Service Animals in Public Schools (revision)
   12. LCA: Charter Schools (revision)
   13. LCA-E: Charter School Application Addendum (form revision)
F. Informational Central Food Service Financial Report as of September 30, 2014
G. Informational Membership Report as of October 30, 2014
H. Informational Suspension Report for October, 2014
I. Informational Visiting Teachers Report for October, 2014
J. Informational Transportation Report for October, 2014

VIII. STAFF PRESENTATIONS/RECOGNITIONS

A. Presentation of VSBA Academy Awards – Dr. Clemons presented the following VSBA Academy Awards:

Mr. Burak	Achievement	Mrs. Hook	Excellence
Mr. Andersen	Achievement	Ms. Parker	Honor
Ms. Hensley	Recognition	Mr. Smith	Recognition

B. Updates on Boards/Commissions by School Board Members

Ms. Hensley gave a report on WHRO. Ms. Parker provided information on the Education Foundation. Mrs. Hook made remarks regarding the Chesapeake Bay Governor's School.

IX. CITIZENS' COMMENT PERIOD

Mr. Burak asked if there were any persons present who wished to address the Board. He asked that all persons state their name, the district in which they reside and to limit their remarks to three (3) minutes or less. A number of citizens addressed the issue of accommodations for transgender students including:

Ralph Van Ness (Ware)
Rev. Eddy Aliff (Virginia Assembly of Independent Baptists)
Savannah Williams (Abingdon)
Terry Brennan (Abingdon)
Deidre Grimm
Gavin Grimm
Joy Sampson (Petsworth)
Kelly Williams (Abingdon)
Mark Faulkner (Ware)
Lorraine Walsh (Abingdon)
Drew Palas (Gloucester Point)
Kathryn Lindsay (Gloucester Point)
Jacklynn Laniff (Abingdon)
Brian Byrd (Gloucester Point)
Ira Johnson (Petsworth)
Patricia Ray (Petsworth)
Kim Ward (Ware)
Melisa Wamsley (Petsworth)
Ray Wamsley (Petsworth)
Season Palas (Gloucester Point)
Paul Martin (Gloucester Point)
Christi Jackson Feliciano (White Marsh)
Elisa Nelson (Abingdon)
Amy VanFossen (Ware)
David Grimm
Robert Teagle
Howard Mowry (Gloucester Point)

Mr. Burak thanked all citizens who came forward to speak regarding this matter.

X. STUDENT ADVISORY COMMITTEE (SAC) ITEMS) – Ms. Farina offered remarks regarding the transgender accommodation issue.

XI. SUPERINTENDENT'S ITEMS

A. Comprehensive Plan Update/Reminder of Next Meeting Date – Dr. Clemons reminded Board members and the public that the next Comprehensive Plan development meeting would be held on Monday, November 17, 2014, at 7:00 pm at the Thomas Calhoun Walker Education Center (Cafeteria). He expressed thanks to all who have attended previous meetings and provided valuable input in the process.

XII. SCHOOL BOARD MEMBERS' ITEMS

A. VSBA Annual Convention – November 19-21, 2014 at Doubletree by Hilton Williamsburg. The Clerk has registered all School Board members who are able to attend. Opening session begins at 2:00 pm on Wednesday, November 19, 2014, followed by a break from 4:00-4:30 pm, followed by the President's Reception at 5:30 pm, followed by dinner at 7:00 pm.

B. Other Matters as Brought Up by Board Members

1. Discussion of Use of Restrooms/Locker Room Facilities – Mrs. Hook read the following resolution and made a motion to adopt said resolution:

Whereas the GCPS recognizes that some students question their gender identities, and

Whereas the GCPS encourages such students to seek support, advice, and guidance from parents, professionals and other trusted adults, and

Whereas the GCPS seeks to provide a safe learning environment for all students and to protect the privacy of all students, therefore

It shall be the practice of the GCPS to provide male and female restroom and locker room facilities in its schools, and the use of said facilities shall be limited to the corresponding biological genders, and students with gender identity issues shall be provided an alternative appropriate private facility.

The motion was seconded by Mr. Records.

A motion was made by Ms. Parker and seconded by Ms. Hensley to postpone action on the resolution and motion offered by Mrs. Hook until the December 9 meeting of the Board. A roll call vote was called for, and the Deputy Clerk recorded the following vote:

Mr. Andersen	Nay	Mr. Records	Nay
Ms. Hensley	Aye	Mr. Smith	Aye
Mrs. Hook	Nay	Mr. Burak	Aye
Ms. Parker	Aye		

Motion was carried by a vote of 4-3. Motion offered by Mrs. Hook will be considered at the December 9 meeting of the Board.

XIII. ADMINISTRATIVE ITEMS

A. Recommendation to Restrict Outside Food Sharing at Elementary Schools – Ms. Shirley Chirch, Environmental Health and Safety Manager, and Ms. Lauren Giddings, School Health and Safety Board representative, reviewed the recommendation from the Board regarding the restriction of outside food sharing at the elementary schools. Due to an increasing number of students with life threatening food allergies and the potential for fatal reactions from unintended exposure to them, the following guidelines were recommended by the School Health Advisory Board:

USCA4 Appeal: 19-1952 Doc: 20-3 Filed: 10/22/2019 Pg: 233 of 449 Total Pages:(1012 of 1263)
Case 4:15-cv-00054-AWA-RJK Document 192-37 Filed 03/26/19 Page 5 of 8 PageID# 2317

XIII. ADMINISTRATIVE ITEMS (continued)

• During the normal instructional day, no homemade or commercially prepared treats or food items, which are intended to be shared with students, will be allowed at the elementary level. This will not include food items that are part of the instructional process or school sponsored activities which are planned in advance.

A motion was made by Mr. Andersen, seconded by Ms. Hensley, and unanimously approved to adopt the guidelines as recommended by the School Health Advisory Board.

B. Discussion of Redistricting Plans – Mr. Hutchinson stated that the Redistricting Committee would be reactivated in preparation for the opening of the new Page Middle School. The first meeting of the committee will be held in January 2015 with a presentation and recommendation to the Board in March. School Board members are needed to serve on the committee. Mr. Andersen and Mr. Records agreed to serve on this committee. Mr. Records stated that this would be an opportunity for the Board to consider restructuring grade levels among the schools throughout the school system.

At 8:55 pm, the Chairperson called for a brief recess. The meeting was reconvened at 9:07 pm.

C. Monthly Departmental Report – Mr. Hutchinson reviewed departmental activities accomplished during the month.

XIV. INSTRUCTIONAL ITEMS

A. Recommended GCPS Local Assessment Plan – Dr. Bess Worley, Instructional Supervisor, provided information on the Virginia Department of Education Local Assessment Guidelines. It was the consensus of the Board to move forward with plans for developing local assessments in accordance with state guidelines.

B. Monthly Departmental Report – Dr. Wagner reviewed highlights of the month from Instructional Services. Ms. Hensley asked for further information on requirements for lesson plans on the elementary level. Dr. Wagner will provide this information to Board members through e-mail.

XV. BUDGET AND FINANCE ITEMS --- CONSIDERED OUT OF ORDER FROM PUBLISHED AGENDA

A. Monthly Departmental Report – Ms. Joanne Wright, Director of Budget and Finance, highlighted tasks and accomplishments of the Budget and Finance Office.

B. Acceptance of Donations -- Ms. Wright highlighted the donations received by the division totaling $11,055.00. A motion was made by Mr. Records and seconded by Ms. Parker to accept with grateful appreciation the donations as outlined. The Deputy Clerk polled the Board as follows:

Ms. Parker	Aye	Mr. Smith	Aye
Ms. Hensley	Aye	Mr. Records	Aye
Mrs. Hook	Aye	Mr. Burak	Aye
Mr. Andersen	Aye		

XV. BUDGET AND FINANCE ITEMS (continued)

C. Informational Financial Reports – Ms. Wright presented the following reports which were accepted by the Board as information:

1. September 30, 2014, Financial Report
2. October 30, 2014, Construction Financial Report
3. October 30, 2014, HVAC/Roof Financial Report

Ms. Hensley inquired what process the Board would follow if they wished to consider hiring a public relations person. Ms. Wright explained the process of bidding for services. Dr. Clemons will bring back a recommendation on this matter at the next meeting.

XIV. INSTRUCTIONAL ITEMS (continued)

The Board considered the remainder of the Instructional Items at this time.

C. Update on Naviance: College and Career Readiness Solutions – Dr. Wagner stated that Mr. Bill Lindsey with the County Purchasing Department had been consulted and would be soliciting bids for college and career readiness services/programs. Further information will be provided to the Board in December.

D. Approval of Proposal to Assess Dual Enrollment Fees to Students for 2015-16 – The Board discussed the proposal to assess dual enrollment fees beginning in 2015-16. A motion was made by Mr. Andersen and seconded by Ms. Hensley to approve the proposal to assess dual enrollment fees in the amount of $15.00 ($5.00/credit hour) to students beginning in 2015-16. The Deputy Clerk recorded the following roll call vote:

Ms. Parker	Aye	Mr. Smith	Aye
Ms. Hensley	Aye	Mr. Records	Aye
Mrs. Hook	Aye	Mr. Burak	Aye
Mr. Andersen	Aye		

E. Update on Year-Round Program Proposal at Abingdon Elementary – Dr. Wagner apprised the Board on the status of the year-round program grant. Funds allocated by the state are insufficient to provide the program as written in the grant. After considerable discussion, a motion was made by Mrs. Hook and seconded by Mr. Smith to stop the planning process for a year-round program at this time and allow the grant funds to revert to the VDOE. Upon a voice vote, the motion was approved by the majority of the Board with Mr. Records voting nay.

F. Continued Discussion on Field Trip Policy (File IICA) – Dr. Wagner informed the Board that the division's insurance carrier had indicated that supplemental insurance plans were available for purchase to provide certain coverages for international trips. After discussion, it was the consensus of the Board to have Dr. Wagner obtain further information from the carrier to bring back to the Board in December. Revisions to the policy to cover international travel also will be considered at a future meeting.

G. VDOE Academic Review for Schools Accredited with Warning (GHS/Page) – Dr. Wagner outlined the process by which the VDOE will conduct academic reviews for schools accredited with warning. Teams/contractors will visit the schools on December 11 to observe classrooms, review lesson plans and curriculum, and meet with school staff. At the conclusion of the site visit, the team will present a report with recommendations to the VDOE.

XVI. PUBLIC ANNOUNCEMENTS

Mr. Burak read the following public announcements:

A. Next GCPS Comprehensive Plan Meeting – Monday, November 17, 2014, 7:00 pm @ the Thomas Calhoun Walker Education Center (Cafeteria)
B. G.H.S. Fall Athletic Awards Ceremony – Tuesday, November 18, 2014, 7:00 pm, G.H.S. (Auditorium)
C. Professional Days (Students Off) – Monday-Tuesday, November 24-25, 2014
D. Professional Work @ Home Day (Students Off)/SBO Open ½ Day – Wednesday, November 26, 2014
E. Thanksgiving Holidays-All GCPS Schools and Offices Closed, Thursday-Friday, November 27-28, 2014
F. Next Monthly School Board Meeting – Tuesday, December 9, 2014, 7:00 pm @ the Thomas Calhoun Walker Education Center (Auditorium)

CLOSED MEETING

At 10:52 pm, the Board resumed the closed session.

At 10:59 pm, a motion was made by Ms. Hensley, seconded by Mr. Records, and unanimously approved to extend the meeting to 11:15 pm.

At 11:14 pm, a motion was made by Ms. Parker, seconded by Mrs. Hook, and unanimously approved to extend the meeting to 11:30 pm.

At 11:30 pm, a motion was made by Mr. Records, seconded by Mrs. Hook, and unanimously approved to extend the meeting to 11:45 pm.

At 11:36 pm, a motion was made by Mrs. Hook to reconvene the meeting into open session and to certify that the Gloucester County School Board, while in closed session, discussed only public matters lawfully exempted from open meeting requirements provided in Subsection A of Section 2.2-3711 and that only public business matters that were identified in the motion convening the closed session were heard, discussed or considered. The motion was seconded by Ms. Hensley and approved as follows:

Mr. Andersen	Aye	Mr. Records	Aye
Ms. Hensley	Aye	Mr. Smith	Aye
Mrs. Hook	Aye	Mr. Burak	Aye
Ms. Parker	Aye		

V. PERSONNEL ITEMS – (agenda item moved to be considered after closed session)

A. Approval of Monthly Personnel Actions — A motion was made by Mr. Smith, seconded by Ms. Hensley and unanimously adopted to approve the monthly listing of personnel appointments, staff leave, and contract changes. **(Approved copies attached to minutes)**

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM, Plaintiff, v. GLOUCESTER COUNTY SCHOOL BOARD, Defendant.	)	Civil No. 4:15-cv-00054

DECLARATION OF JANET M. RAINEY

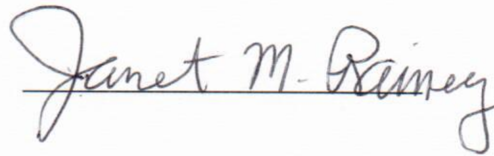
1. I am the State Registrar and Director of the Division of Vital Records. I have actual knowledge of the matters stated in this declaration.

2. In my capacity as State Registrar, I administer Virginia's system of vital records as set out in Virginia Code §§ 32.1-249 through 32.1-276 and the *Board of Health Regulations Governing Vital Records*, 12 VAC5-550. I am responsible for administering those laws and regulations in a manner that will ensure the uniform and consistent administration of the system of vital records as provided in Virginia Code § 32.1-252A1.

3. On October 27, 2016, I issued a birth certificate to Gavin Elliot Grimm. The birth certificate states his sex as male.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on March 19, 2019



Janet M. Rainey

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM,

Plaintiff,

v. Case No. 4:15-cv-54

GLOUCESTER COUNTY SCHOOL
BOARD,

Defendant.

DECLARATION OF TROY ANDERSEN

On this 25th day of March, 2019, I, Troy Andersen, make the following declaration pursuant to 28 U.S.C. § 1746:

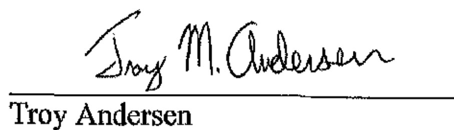
1. I am over the age of eighteen, surfer no legal disabilities, have personal knowledge of the facts set forth below, and am competent to testify.
2. This affidavit fairly and accurately sets forth information within my personal knowledge and is true and accurate to the best of my recollection.
3. I am currently a member of the Gloucester County School Board and have been since I was appointed in 2012.
4. Gavin Grimm was enrolled with the Gloucester County School System in 2004. A true and correct copy of Gavin Grimm's enrollment records with the Gloucester County School System is attached as Exhibit 1. Gavin Grimm's freshman Report Card for the School Year 2013-2014 is attached as Exhibit 2.
5. On December 16, 2014, there were three unisex single stall bathrooms available for use for all students in the Gloucester County High School.

EXHIBIT
E

6. Gavin Grimm was offered the opportunity to have a hearing with the School Board on his request to change his school records on January 18, 2017 attached as Exhibit 3. Gavin Grimm did not request a hearing with the School Board while he was a student at Gloucester High School or after his graduation in 2017.

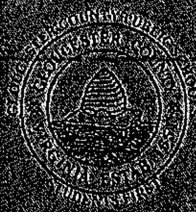
Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing statements are true and correct.

Executed on: 3/25/2019 (date)



Troy Andersen

CONFIDENTIAL



BETHEL ELEMENTARY
School Name

STUDENT REGISTRATION FORM

Student ID#: REDACTED
Entry Date:
YOG:
Conditional Enrollment:
Entry Code:
Homeroom #:
Counselor/Teacher:
Team:

Former Student of Gloucester County Public Schools: YES / NO If yes, School N... REDACTED

Student's Name: REDACTED Last Nickname

Social Security #: REDACTED Bus #:

Is English the primary language spoken at home? YES / NO If no, specify REDACTED

Gender: (Circle) Male Female Grade: K Date of Birth: REDACTED

Place of Birth: N.N. City/County VA State USA Country Birth Certificate #: REDACTED

Ethnic Group: (Circle One) Unspecified American Indian Asian Black Hispanic White Native Hawaiian

Mailing Address: REDACTED City/State/Zip:

Home Phone #: REDACTED 911 Address: (If Different From Mailing Address)

Child Resides With: (Circle) Both Parents One Parent Legal Guardian(s)

Circle One: Mother Father Stepparent Guardian/Custodian	Circle One: Mother Father Stepparent Guardian/Custodian
Name:	Name:
Address (If different than student):	Address (If different than student):
Place of Employment:	Place of Employment:
Work Phone #: REDACTED	Work Phone #: REDACTED
Cell Phone/Pager #:	Cell Phone/Pager #:
E-Mail Address:	E-Mail Address:
Education:	Education:

EMERGENCY CONTACT INFORMATION

Contact Person 1: (Other than parent/guardian) Phone #: Relationship to Student:

Contact Person 2: (Other than parent/guardian) Phone #: Relationship to Student:

Family Physician: Phone #:

Please list any medical information concerning your child that school personnel should know. (Allergies, Asthma, etc.)

Previous School:
Mailing Address: Phone #:
City/State/Zip: Fax #:

PLEASE COMPLETE THE BACK OF THIS FORM

CONFIDENTIAL

Other Children in the Family:

Name	Living In Home	Date of Birth	Grade	Age
REDACTED	YES / NO	REDACTED	10	15
	YES / NO		6	11
	YES / NO			
	YES / NO			

Others In the Home:

Name	Relationship to Student	Place of Employment

Is your child receiving any specialized service(s)? (Special Education including Speech, 504, Gifted, etc.) YES / NO
If yes, specify which service(s): ______

Directions to Home:
(Please give the location of your home. Include the route number, neighborhood, landmarks, or any information that will be helpful.)

Before enrolling your child in Gloucester County Public Schools, you must provide the following:

1. Certified Copy of Birth Certificate
2. Social Security Card
3. Updated Immunization Records
4. Physical Exam Report
5. Transcript from Former School - Can Be Unofficial (HIGH SCHOOL ONLY)
6. IEP and/or 504 (if applicable)
7. Court Orders Referencing Student (if applicable)

I have willfully and knowingly provided you the correct information. I will provide you any new information concerning my child as it occurs.

[signature] 05/21/04

Parent / Legal Guardian Signature | Date

No student can be prevented from participation in any program solely because of his/her race, color, national origin, sex, age, religion, or disability. A procedure for resolving complaints alleging discrimination on the basis of race, color, national origin, sex, age, religion, or disability may be found in the manual of Policies and Regulations of the Gloucester County Public Schools. The Section 504 and Title IX Coordinator for the Gloucester County Public Schools is: Mr. William W. Fox, Coordinator - Section 504 and Title IX - Gloucester County Public Schools - 6489 Main Street - Building Two, Suite F - Gloucester, VA 23061 - (804) 693-7866

REDACTED

CONFIDENTIAL

Name of Child: [REDACTED]

STUDENT REGISTRATION FORM (Continued)

New Federal Legislation, the No Child Left Behind Act, requires that all school divisions report student information regarding the areas listed below. Please read each statement, or have the registrar read the statements for you, and answer each question as requested.

Your child is considered to be Neglected/Delinquent if one of the following is true:

In order to be eligible to be counted as neglected/delinquent, a child age 5 through 17 must live in an "institution for neglected children and youth," which means a public or private residential facility, other than a foster home, that is operated primarily for the care of children and youth who (a) have been committed to the institution or voluntarily placed in the institution under applicable State law due to abandonment, neglect, or death of their parents or guardians; and (b) have had an average length of stay in the institution of at least 30 days;
or
must live in an "institution for delinquent children and youth," which means a public or private residential facility that is operated for the care of children and youth who (a) have been adjudicated to be delinquent or in need of supervision and (b) have had an average length of stay in the institution of at least 30 days.

Is your child Neglected/Delinquent? Yes_____ No ✓

Your child is considered to be Homeless if one of the following is true:

- Shares the housing of others due to loss of housing, economic hardship or similar reason;
- Lives in motels, hotels, trailer parks or camping grounds due to lack of alternative adequate accommodations;
- Lives in emergency or transitional shelters;
- Abandoned in hospitals;
- Awaits foster care placement;
- Has a primary residence that is a public place or a place not designed for or ordinarily used as regular accommodation;
- Lives in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations or similar settings.

Is your child Homeless? Yes_____ No ✓

Form continues on next page

CONFIDENTIAL

Name of Child:

Your child is considered to be a Migratory Child if one of the following is true:

The term 'migratory child' means a child who is, or whose parent or spouse is, a migratory agricultural worker, including a migratory dairy worker, or a migratory fisher, and who, in the preceding 36 months, in order to obtain, or accompany such parent or spouse, in order to obtain, temporary or seasonal employment in agricultural or fishing work—

(A) has moved from one school district to another;
(B) in a State that is comprised of a single school district, has moved from one administrative area to another within such district; or
(C) resides in a school district of more than 15,000 square miles, and migrates a distance of 20 miles or more to a temporary residence to engage in a fishing activity.

Is your child a Migratory Child? Yes________ No ✓

Your child is considered to be a Refugee if the following is true:

An individual who is outside his/her country and is unable or unwilling to return to that country because of a well-founded fear that she/he will be persecuted because of race, religion, nationality, political opinion, or membership in a particular social group. This does not include persons displaced by natural disasters or persons who, although displaced, have not crossed an international border or persons commonly known as "economic migrants," whose primary reason for flight has been a desire for personal betterment rather than persecution.

Is your child a Refugee? Yes________ No ✓

Your child is considered to be an Immigrant if all of the following are true:

The term 'immigrant children and youth' means individuals who—

(A) are aged 3 through 21;
(B) were not born in any State; and
(C) have not been attending one or more schools in any one or more States for more than 3 full academic years.

Is your child an Immigrant? Yes________ No ✓

I have willfully and knowingly provided you with the correct information. I will provide you any new information concerning my child as it occurs.

Deirdre Grimm [signature] — Parent/Legal Guardian Signature

05-21-04 — Date

No student can be prevented from participation in any program solely because of his/her race, color, national origin, sex, age, religion, or disability. A procedure for resolving complaints alleging discrimination on the basis of race, color, national origin, sex, age, religion, or disability may be found in the manual for Policies and Regulations of the Gloucester County Public Schools. The Section 504 and Title IX Coordinator for the Gloucester County Public Schools is: Mr. William W. Fox, Coordinator - Section 504 and Title IX - Gloucester County Public Schools - 6489 Main Street - Building Two, Suite F - Gloucester, VA 23061 - (804) 693-7856

WELCOME TO
GLOUCESTER COUNTY PUBLIC SCHOOLS

Student Registration Form

School's Name: Bethel Elementary School

CONFIDENTIAL
FOR OFFICE USE ONLY
Student ID#
Entry Date:
YOG:
Entry Code: ___ PK Code ___ PK Time ___
Homeroom #:
Counselor/Teacher:
Team:
Bus #:

PLEASE PRINT ALL INFORMATION

Are you a resident of Gloucester County? ☑ Yes ☐ No Items accepted as proof of residency: lease/deed and current utility bill

Has your student ever attended a Gloucester County Public School? (Yes) ☐ No If yes, which school did your child attend?
☐ Abingdon ☐ Achilles ☑ Bethel ☐ Botetourt ☐ Petsworth ☐ T. C. Walker ☐ Page Middle ☐ Peasley Middle ☐ High School

Student's Legal Name: Grimm REDACTED
LAST FIRST MIDDLE NICKNAME

Gender: ☐ Male ☑ Female

Student's Ethnicity: ☐ American Indian ☐ Asian ☐ Black ☐ Hispanic ☐ Native Hawaiian ☑ White ☐ Unspecified

Student's Birth D REDACTED 1999 Place of Birth: Newport News, VA Birth Certificate #

Student's Grade Level: 5 If kindergarten, did your child have any pre-kindergarten education? ☐ Yes ☐ No
If yes, please provide brief description (i.e., licensed daycare provider, head start)

Primary language spoken by students: ☑ English ☐ Spanish ☐ French ☐ Russian ☐ Chinese ☐ Vietnamese ☐ Other

Primary language spoken at home: ☑ English ☐ Spanish ☐ French ☐ Russian ☐ Chinese ☐ Vietnamese ☐ Other

Student's Mailing Address: **REDACTED**

Student's Home Phone Num

Student's 911 Address-required:
(If different than mailing): Number Street Name City Zip Code

Does your child currently receive special services? ☐ YES ☑ NO If yes, please check all that apply:
☐ Speech ☐ Special Education ☐ 504 ☐ Gifted ☐ ESL ☐ Occupational Therapy/Physical Therapy ☐ Other

Student Resides With: ☑ Mother & Father ☐ Mother only ☐ Father only ☐ Grandparents ☐ Foster Parent(s)
☐ Mother & Stepfather ☐ Father & Stepmother ☐ Guardian/Custodian ☐ Other

Name: David + Deirdre Grimm	Name:
Address (if different from student): same	Address (if different from student):
Place of Employment: Norfolk Naval Shipyard Center / mother	Place of Employment:
Work Phone #: **REDACTED**	Work Phone #:
Cell Phone #:	Cell Phone #:
Email address: drumommma@cox.net	Email address:

If the student is NOT residing with BOTH biological/adoptive parents, please list other parent's information (i.e., name, address, etc.)

EMERGENCY CONTACT INFORMATION
(Our schools attempt to contact the parent/guardian first – the following information is for OTHER than parent/guardian)

Contact Person 1: **REDACTED** Phone #: REDACTED Relationship to Student: Friend

Contact Person 2: Phone #: (cell) Relationship to Student: older sister

GCSB - 1151

CONFIDENTIAL

Name of Student **REDACTED** Gmm

STUDENT REGISTRATION FORM (continued)

New Federal legislation, the No Child Left Behind Act, requires that all school divisions report student information regarding the areas listed below. Please read each statement, or have the registrar read the statements for you, and answer each question as requested.

Your child is considered to be Neglected/Delinquent if one of the following is true:

In order to be eligible to be counted as neglected/delinquent, a child age 5 through 17 must live in an "institution for neglected children and youth," which means a public or private residential facility, other than a foster home, that is operated primarily for the care of children and youth who (a) have been committed to the institution or voluntarily placed in the institution under applicable State law due to abandonment, neglect, or death of their parents or guardians; and (b) have had an average length of stay in the institution of at least 30 days;
OR
Must live in an "institution for delinquent children and youth," which means a public or private residential facility that is operated for the care of children and youth who (a) have been adjudicated to be delinquent or in need of supervision and (b) have had an average length of stay in the institution of at least 30 days.

Is your child Neglected/Delinquent? Yes____ No ✓

Your child is considered to be Homeless if one of the following is true:

1) Shares the housing of others due to loss of housing, economic hardship or similar reason;
2) Lives in motels, hotels, trailer parks or camping grounds due to lack of alternative adequate accommodations;
3) Lives in emergency or transitional shelters;
4) Abandoned in hospitals;
5) Awaits foster care placement;
6) Has a primary residence that is a public place or a place not designed for or ordinarily used as regular accommodation;
7) Lives in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations or similar settings.

Is your child Homeless? Yes____ No ✓ If yes, which item above applies to your situation?____

Your child is considered to be a Migratory Child if one of the following is true:

The term "migratory child" means a child who is, or whose parent or spouse is, a migratory agricultural worker, including a migratory dairy worker, or a migratory fisher, and who, in the preceding 36 months, in order to obtain, or accompany such parent or spouse, in order to obtain temporary or season employment in agricultural or fishing work:
(a) has moved from one school district to another;
(b) in a State that is comprised of a single school district, has moved from one administrative area to another within such district; or
(c) resides in a school district of more than 15,000 square miles, and migrates a distance of 20 miles or more to a temporary residence to engage in a fishing activity.

Is your child a Migratory Child? Yes____ No ✓

1

GCSB - 1152

CONFIDENTIAL

Gloucester County Public Schools
Report Card

Gloucester High School
6680 Short Lane
Gloucester, VA 23061

Report Card Printed on June 17, 2014

School Year: 2013-2014

Reporting Period: Q4

REDACTED GRIMM - REDACTED
REDACTED

Grade: 9
Counselor: HARRIS
Homeroom: HOMEBOUND

Course	Teacher	Q1	Q2	S1	Q3	Q4	S2	Y1	ABS	TAR	Comment
HOMEBOUND	STAFF, GHS		REDACTED						0	0	
VLA HEALTH 9	WYATT, WENDY S								0	0	
VLA PE 9	WYATT, WENDY S								0	0	
VLC ALGEBRA I	WYATT, WENDY S								0	0	
VLC WORLD I	WYATT, WENDY S								0	0	
VLC ENGLISH 9	WYATT, WENDY S								0	0	
VLC EARTH SCI	WYATT, WENDY S								0	0	

Total Daily Absences Q4: 0.000

This is the Final report card of the 2013 – 2014 school year.

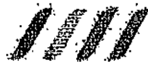
SUMMER SCHOOL RECOMMENDED____ YES ✓ NO (If yes, form enclosed)

SUMMER SCHOOL CLASS RECOMMENDED ______________________________

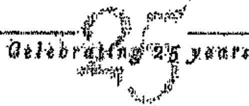
Summer school registration deadline is July 1, 2014 at 3 p.m. Summer school will begin July 7 and end August 7, 2014. Gloucester High School summer hours are 7:00 am to 4:30 pm Monday through Thursday (closed on Friday). Visit the Gloucester High School website for updated information: gets.gc.k12.va.us

GLOUCESTER HIGH SCHOOL

GCSB - 1117



harman claytor corrigan wellman
THE CIVIL LITIGATION FIRM



DAVID P. CORRIGAN
804.762.8017
dcorrigan@hccw.com

January 18, 2017

VIA EMAIL
Joshua A. Block, Esq.
American Civil Liberties Union
125 Broad Street
18th Floor
New York, NY 10004

RE School Records for G.G.

Dear Josh:

I am writing in response to your December 23, 2016 letter with respect to school records for G.G. I apologize for taking so long to get back to you, but I was waiting for a School Board meeting, and one finally occurred on January 17, 2017. The previous meeting was snowed out.

In considering your request that "G.G.'s school records be updated so that any school records submitted in connection with G.G.'s college applications identify him as a male, in accordance with his amended birth certificate," the School Board considered the following:

(1) The copy of the birth certificate that you provided, (attached);

(2) The relevant school policy JO, (attached);

(3) Virginia Code §32.1-269, (attached); and

(4) Virginia Administrative Codes §12VAC5-550-320, §12VAC5-550-450 and §12VAC5-550-460, (attached).

Based on the School Board's review of these materials, the School Board declines to change the official school records.

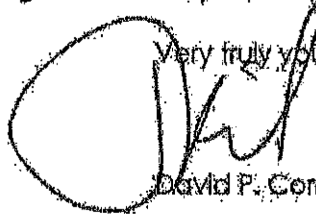
Please feel free to submit additional materials, and, of course, your client has the right under school policy JO, see page 8 Correction of Education Records, to a hearing

POST OFFICE BOX 70280 | RICHMOND, VA 23255
4951 LAKE BROOK DR. | SUITE 100 | GLEN ALLEN, VA 23060
OFFICE 804.747.5200 | FAX 804.747.6085 | WEB HCCW.COM
member of the harmonie group

to challenge the information believed to be "inaccurate, misleading or in violation of the student's rights."

I look forward to hearing further from you.

Very truly yours,



David P. Corrigan

DPC/kns
Enclosures

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM,

Plaintiff,

v. Case No. 4:15-cv-00054

GLOUCESTER COUNTY SCHOOL BOARD,

Defendant.

DEFENDANT'S SUPPLEMENTAL ANSWER TO PLAINTIFF'S INTERROGATORY NO. 1

Comes now the defendant, Gloucester County School Board ("School Board"), and for its Supplemental Answer to Plaintiff's Interrogatory, states as follows:

GENERAL OBJECTIONS

A. Defendant objects to the Instructions contained in Plaintiff's interrogatories to the extent they alter, amend, or exceed the scope of the Federal Rules of Civil Procedure.

B. The information supplied in these answers is not based solely on the knowledge of the executing party but includes knowledge of the party, its agents, representatives, and attorneys, unless privileged. Such knowledge may or may not be known to the Defendant other than as provided.

C. The word usage and sentence structure may be that of the attorney and staff assisting in the preparation of these answers and thus do not necessarily purport to be the precise language of the executing party.

EXHIBIT
I

D. These answers will be supplemented in accordance with the Rule 33 of the Federal Rules of Civil Procedure, the Local Rules of the Eastern District of Virginia, and any Orders regarding discovery.

E. Defendant objects to interrogatories, etc., that invade or attempt to invade the attorney/client, work product, or any other applicable privilege.

ANSWERS TO INTERROGATORIES

1. Identify all complaints received by Gloucester County School Board ("the Board") or its employees related to transgender students' use of restrooms during the 2014-2015 school year, and for each complaint identify the date of the complaint, the recipient of the complaint, the content of the complaint, how the complaint was communicated or transmitted, whether the complainant was from a Gloucester High School student or parent of a Gloucester High School student, and whether the complaint related to any incident in which a student reported being in the restroom at the same time as Plaintiff.

OBJECTION: The School Board objects on the grounds that this Interrogatory is overly broad and unduly burdensome. Further, the School Board objects on the grounds that the use of the term "complaint" is vague and ambiguous. Finally, the School Board objects to the extent that this Interrogatory seeks the discovery of information protected pursuant to the Agreed Confidentiality Protective Order (ECF Doc. 85) entered in this matter.

ANSWER: Without waiving and subject to the foregoing objection,[1] Gloucester County High School Principal Nate Collins gave Grimm permission to use the male restroom on October 20, 2014. Two to three days later, Superintendent Dr. Walter Clemons received two complaints from parents regarding a transgender student using the restroom inconsistent with that student's biological sex. Dr. Clemons does not recall the identity of those parents. The parents indicated that they did not approve of a biologically female student using the male restroom. Additionally, a male student met with Collins in person and expressed concern about a biologically female student using the male restroom and a lack of privacy. Collins does not recall the specific identity of this student.

Moreover, after Grimm began to use the male restroom, Dr. Clemons, Collins and the individual members of the School Board received numerous complaints via email, which are listed below.

Emails sent to all members of the School Board

- On October 23, 2014, REDACTED, a parent of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On October 23, 2014, REDACTED parents of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School Board an email regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

---

[1] The School Board specifically reasserts its objection that Plaintiff's use of the term "complaint" in this Interrogatory is vague and ambiguous. The School Board has included in its Answer communications with individuals who generally opposed a transgender student using a restroom inconsistent with that student's biological sex. The School Board's Answer includes communications with individuals who did not agree with Gloucester High School allowing a transgender student to use a restroom inconsistent with that student's biological sex and communications with individuals who supported the School Board's December 9, 2014 resolution and the School Board's litigation of this matter.

- **On October 27, 2014, REDACTED sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On October 27, 2014, REDACTED a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On October 28, 2014, REDACTED upon information and belief a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 10, 2014, REDACTED a parent of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 10/11, 2014, REDACTED parents of student(s) enrolled in Gloucester High School, sent the School Board an email regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 11, 2014, REDACTED upon information and belief a resident of Gloucester County, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 11, 2014, REDACTED sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 12, 2014, REDACTED, a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 12, 2014, REDACTED a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 13, 2014, REDACTED a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 17, 2014, REDACTED a parent of student(s) enrolled in Gloucester High School, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 7, 2014, REDACTED a parent of student(s) enrolled in Gloucester County Public Schools, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 8, 2014, REDACTED a parent of student(s) enrolled in Gloucester High School, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 8, 2014, REDACTED a parent of student(s) enrolled in the Gloucester County Public School System, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 10, 2014, REDACTED a resident of Gloucester County, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 10, 2014, REDACTED a parent of student(s) enrolled in Gloucester High School, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 20, 2014, REDACTED a resident of Gloucester County, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On December 20, 2014, REDACTED sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On January 2, 2015, an individual named REDACTED sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On July 10, 2015, REDACTED sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On April 21, 2016, REDACTED a parent of students(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On April 21, 2016, REDACTED parent of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- On May 12, 2016, REDACTED sent the School Board an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

Emails sent to Troy Anderson

In addition to receiving emails sent to the entire School Board, Mr. Anderson received the following communications:

- On December 7, 2014, REDACTED parent of student(s) enrolled in Gloucester High School, sent Mr. Anderson an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On July 27, 2015, REDACTED a resident of Kentucky, sent Mr. Anderson an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On July 14, 2016, REDACTED a resident of New York, sent Mr. Anderson an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

Emails sent to Randy Burak

In addition to receiving emails sent to the entire School Board, Mr. Burak received the following communications:

- On November 12, 2014, REDACTED a parent of student(s) enrolled in Gloucester High School, sent Mr. Burak an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On December 3, 2014, REDACTED a resident of the Abingdon District, sent the School Board an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On December 7, 2014 REDACTED a parent of student(s) who attended Gloucester High School, sent the Mr. Burak an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On December 8, 2014, a resident of Gloucester County named REDACTED emailed Mr. Burak regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On December 11, 2014, REDACTED a resident of Washington D.C., emailed Mr. Burak regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

Emails sent to Kimberly Hensley

In addition to receiving emails sent to the entire School Board, Ms. Hensley received the following communications:

- On November 19, 2014, REDACTED a parent of student(s) at Gloucester High School, emailed Ms. Hensley regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

- On December 13, 2014, REDACTED , parents of student(s) enrolled in Gloucester County Public Schools, including Gloucester High School, emailed Ms. Hensley regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

Emails sent to Carla Hook

In addition to receiving emails sent to the entire School Board, Ms. Hook received the following communications:

- On December 7, 2014, REDACTED a parent of high school student(s) in the York District, sent an email to Ms. Hook regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

Emails sent to Charles Records

In addition to receiving emails sent to the entire School Board, Mr. Records received the following communications:

- On April 21, 2016, REDACTED sent an email to Mr. Records regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.

Emails sent to Dr. Clemons

In addition to receiving some of the emails sent to the entire Board, Dr. Clemons received the following communications:

- **On October 22, 2016 REDACTED upon information and belief a parent of student(s) enrolled in Gloucester County Public Schools, sent Dr. Clemons an email regarding her opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

- **On November 7, 2016, REDACTED sent Dr. Clemons an email regarding his opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Additionally, the following School Board members received complaints via telephone, which are listed below.

Telephone Complaints made to Carla Hook

- **Upon information and belief, before October 28, 2014, Ms. Hook spoke with REDACTED REDACTED whose children were enrolled in Gloucester County Public Schools, regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex.**

Additionally, the issue of transgender bathroom use was discussed at public School Board meetings on November 11, 2014 and December 9, 2014. Video links to those meetings are available at: http://www.gloucesterva.info/640/Meeting-Portal.

The following individuals spoke regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex during the November 11, 2014 meeting:

- **Ralph Van Ness (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Eddie Aliff**
- **Savannah Williams (student at Gloucester High School)**
- **Terry Brennan**
- **Joy Sampson (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Kelly Williams (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Marc Jenkins (parent of student(s) enrolled in Gloucester County Public Schools)**

- **Drew Palas (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Kathryn Lindsay (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Brian Byrd (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Tricia Ray**
- **Kim Ward (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Melissa Wamsley (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Ray Wamsley (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Season Palas (parent of student(s) enrolled in Gloucester County Public Schools)**

The following individuals spoke regarding their opposition to a transgender student using the bathroom inconsistent with that student's biological sex during the December 9, 2014 meeting:

- **Ralph Van Ness (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Scott Williams (student at Gloucester High School)**
- **Savannah Williams (student at Gloucester High School)**
- **Kathryn Lindsay (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Drew Palas (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Karen Pauly**
- **Mike Enz (parent of student(s) enrolled in Gloucester County Public Schools)**
- **Katherine Foley (parent of student(s) enrolled at Gloucester High School)**
- **Howard Mowry**
- **Janet West (parent of student(s) enrolled at Gloucester High School)**
- **Linda Walk**
- **Don Mitchell**

- **Terry Brennan**

- **Marista Cooper (grandparent of student(s) enrolled in Gloucester County Public Schools)**

- **Kelly Williams**

The School Board also incorporates by reference any additional "complaints" not described herein that are contained in the documents the School Board has produced in response to Plaintiff's First Request for Production of Documents.

<u>SUPPLEMENTAL ANSWER</u>:

In its Answers to Plaintiff's First Interrogatories, the School Board provided a list of email communications between board members and various individuals regarding the use of restrooms by transgender students. Further, the School Board provided the emails identified in those Answers in response to Plaintiff's First Requests for Production of Documents. The emails speak for themselves, and each School Board member's knowledge of any "complaint" sent by email relating to the use of restrooms by transgender students is consistent with the contents of those emails.

Further, in addition to the information provided in the School Board's Answers to Plaintiff's First Interrogatories, the following School Board members recall receiving non-email communications from individuals concerning the use of school restrooms by transgender students:

- **Carla Hook received approximately five (5) telephone calls from parents of students enrolled in Gloucester County Public Schools who said their children were uncomfortable with a girl using the boys' restroom. Ms. Hook does not recall the names of either the parents with whom she spoke or their children. To Ms. Hook's knowledge, the children had no direct interaction with Grimm in the boys' restroom.**

- **Kevin Smith received dozens of communications before the December 9, 2014, School Board meeting regarding a transgender student using the restroom**

inconsistent with that student's biological sex. To Mr. Smith's best recollection, approximately seventy-five (75) percent of those communications came from parents of students enrolled in Gloucester County Public Schools. Mr. Smith does not recall the names of either the individuals with whom he spoke or their children. The individuals indicated that they were not in favor of a transgender student using the restroom inconsistent with that student's biological sex. Additionally, parents indicated that they did not want their children using the same bathroom as a member of the opposite sex. To Mr. Smith's knowledge, the children had no direct interaction with Grimm in the boys' restroom.

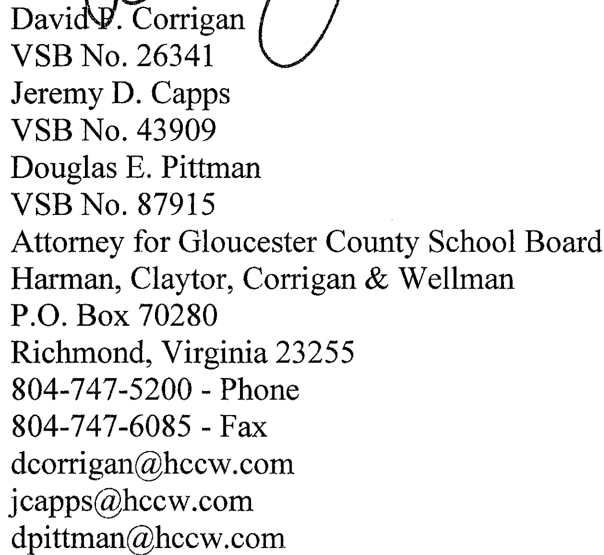
- **Troy Andersen received approximately five (5) telephone calls from parents of students at Gloucester County Public Schools regarding a transgender student using the restroom inconsistent with that student's biological sex. Mr. Andersen does not recall the names of either the parents or their children. The parents did not want their children using the same bathroom as a member of the opposite sex, and they were concerned about the privacy and safety of students, including their children. Mr. Andersen believes that he followed any telephone conversation on this issue with an email to the parent, and that the telephone conversations were substantively similar to the email exchanges. To the best of Mr. Andersen's knowledge, the children had no direct interaction with Grimm in the boys' restroom.**

- **Randy Burak received two telephone calls on October 20, 2014, from parents of students at Gloucester County Public Schools regarding a transgender student using the restroom inconsistent with that student's biological sex. One telephone call came from "REDACTED," a parent of two boys enrolled in Gloucester County Public Schools. Mr. Burak does not recall the first name of REDACTED indicated that he and his children were not in favor of a girl using the same restroom as boys. The other telephone call came from a parent, whose name Mr. Burak cannot recall, who likewise did not approve of a transgender student using the restroom inconsistent with that student's biological sex. This parent expressed concern that young male students would be uncomfortable with a student who was biologically female using the male restroom. Mr. Burak does not know whether or not the children of the two parents had any direct interaction with Grimm in the boys' restroom.**

This Answer will be supplemented further as additional information is received.

GLOUCESTER COUNTY SCHOOL BOARD

By ___________________________



David P. Corrigan
VSB No. 26341
Jeremy D. Capps
VSB No. 43909
Douglas E. Pittman
VSB No. 87915
Attorney for Gloucester County School Board
Harman, Claytor, Corrigan & Wellman
P.O. Box 70280
Richmond, Virginia 23255
804-747-5200 - Phone
804-747-6085 - Fax
dcorrigan@hccw.com
jcapps@hccw.com
dpittman@hccw.com

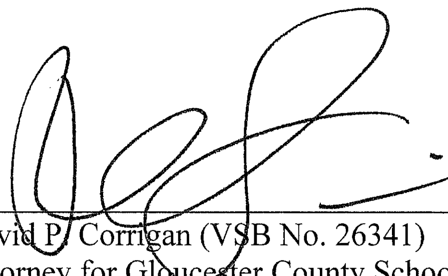
CERTIFICATE

I hereby certify that on the 11th day of January, 2019, I mailed and emailed the document to the following:

Joshua A. Block, Esq. (Pro hac vice)
NYSB No. 4370573
Leslie Cooper, Esq. (Pro hac vice)
NYSB No. 2759835
Shayna Medley-Warsoff, Esq. (Pro hac vice)
NYSB No. 5558382
American Civil Liberties Union
125 Broad Street
18th Floor
New York, NY 10004
212-549-2627 - Phone
212-549-2593 - DD
212-549-2650 - Fax
jblock@aclu.org

lcooper@aclu.org
smedley@aclu.org

Eden B. Heilman, Esq. (Pro hac vice)
LSBA No. 30551
Nicole Tortoriello, Esq.
VSB No. 91129
ACLU
701 E. Franklin Street
Suite 1412
Richmond, VA 23219
804-726-6013 – DD
804-649-2733 – Fax
eheilman@acluva.org
ntortoriello@acluva.org



David P. Corrigan (VSB No. 26341)
Attorney for Gloucester County School Board
Harman, Claytor, Corrigan & Wellman
P.O. Box 70280
Richmond, Virginia 23255
804-747-5200 - Phone
804-747-6085 - Fax
dcorrigan@hccw.com

USCA4 Appeal: 19-1952 Doc: 20-3 Filed: 10/22/2019 Pg: 261 of 449 Total Pages:(1040 of 1263)

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF VIRGINIA
Newport News Division

031819

GAVIN GRIMM,)
)
)
Plaintiff,)
) Civil Case No. 4:15-cv-54
v.)
)
GLOUCESTER COUNTY SCHOOL)
BOARD,)
)
Defendant.)

DECLARATION OF JAMES H. LOVING

Background Information

1. My name is James H. Loving.

2. I am the photographer who took pictures of the Gloucester High School restroom facilities on behalf of Mr. Grimm, the plaintiff in the above-captioned action. I have actual knowledge of the matters stated in this declaration.

Photographs

3. I took the twelve photographs attached to this declaration and have first-hand knowledge of when and how the photographs were taken.

4. The photographs were taken on July 28, 2016 at Gloucester High School, located at 6680 Short Ln, Gloucester, VA, 23061.

5. The photographs depict the hallways and restroom facilities at Gloucester High School. There are five photos of the single-user restroom, three photos of a multi-user boys' restroom, and four photos of another multi-user boys' restroom.

6. I took the photographs using a Nikon D750 FX-format Digital SLR Camera.

USCA4 Appeal: 19-1952 Doc: 20-3 Filed: 10/22/2019 Pg: 262 of 449 Total Pages:(1041 of 1263)

7. I certify that the camera I used was in good working order and condition at the time these photos we taken.

8. I certify that the photographs are a fair and accurate representation of the facilities at Gloucester High School at the time the pictures were taken.

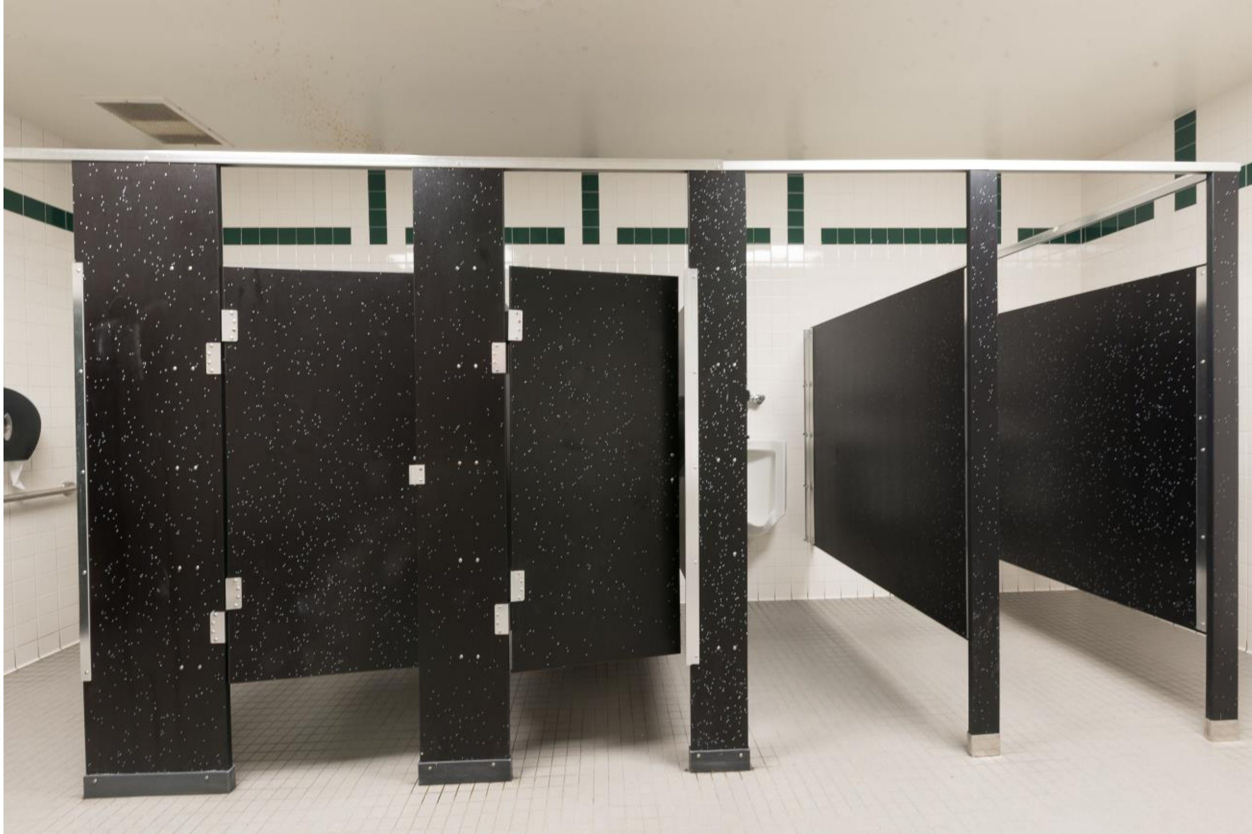
9. I certify that no methods were used during photography, processing, or display that would modify or distort these images.

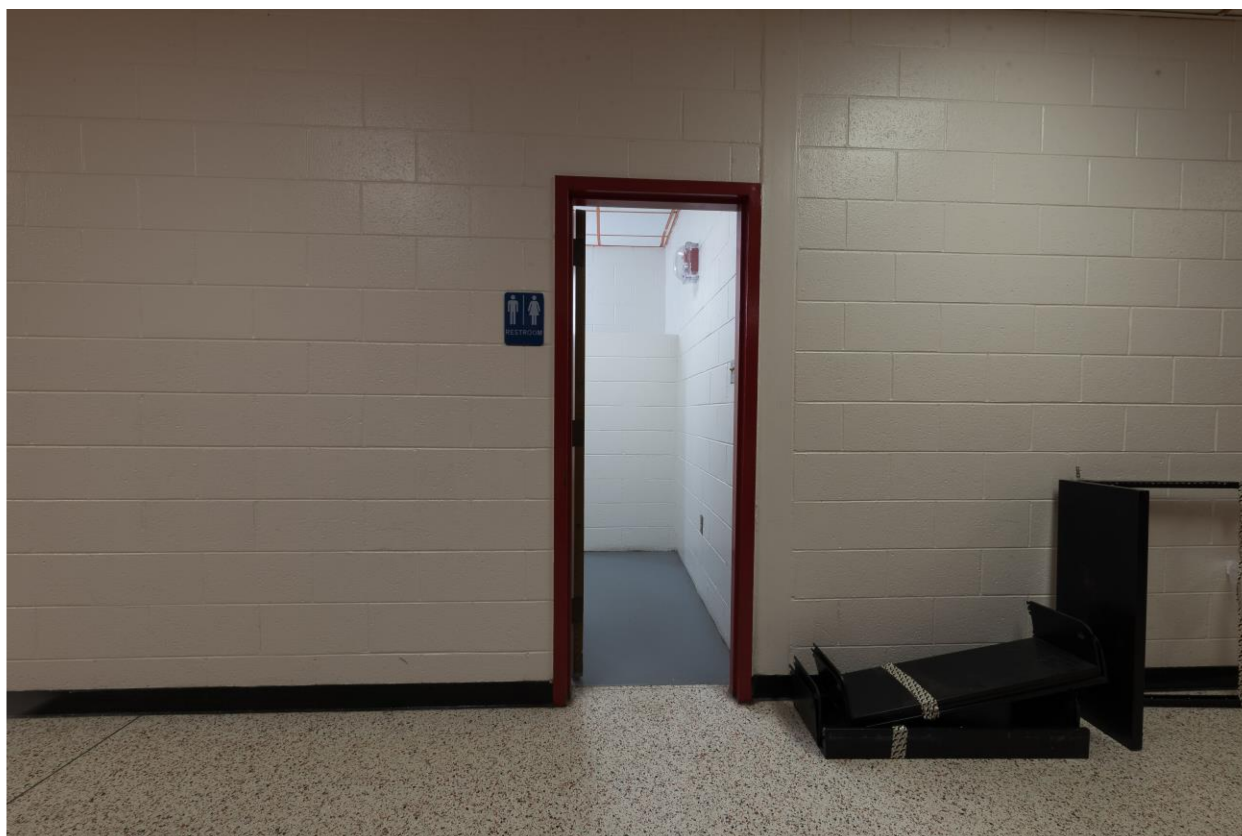
10. I certify the photographs have not been manipulated or altered in any way since they were taken.

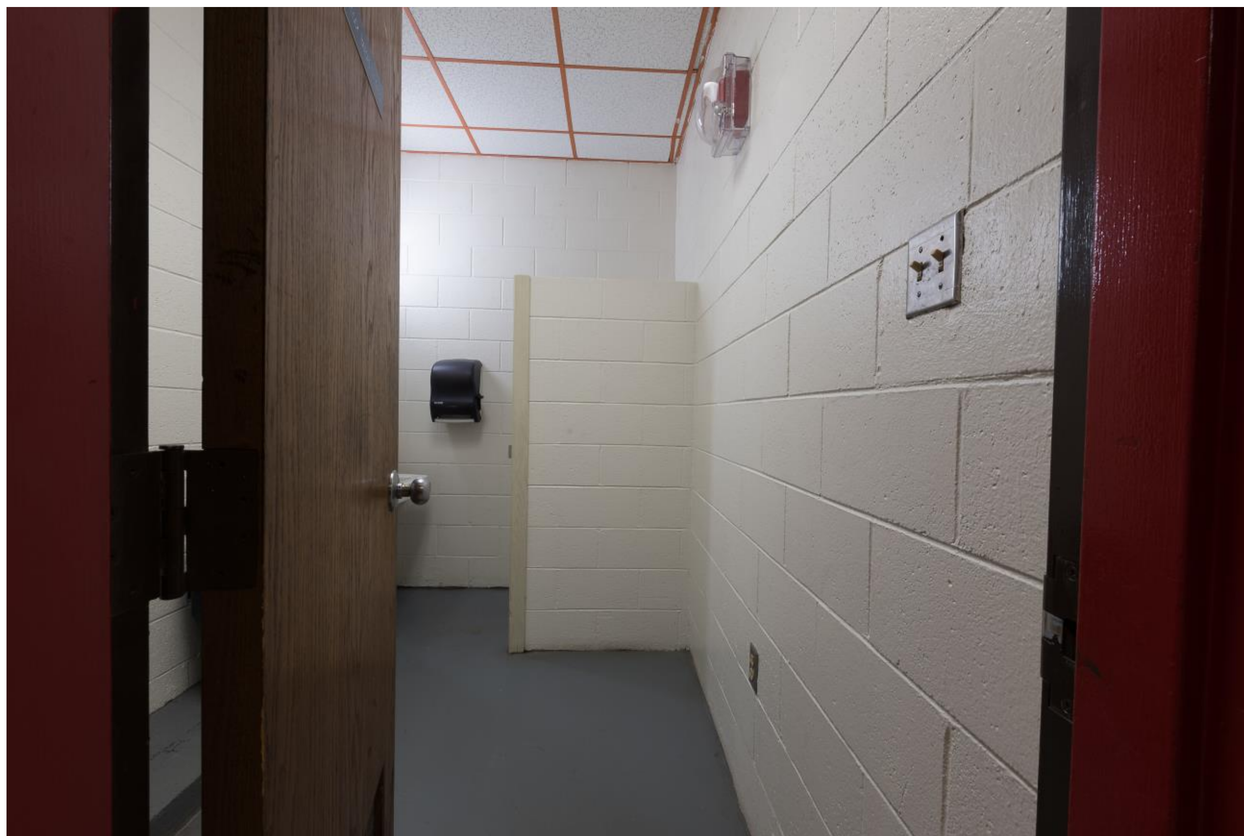
Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

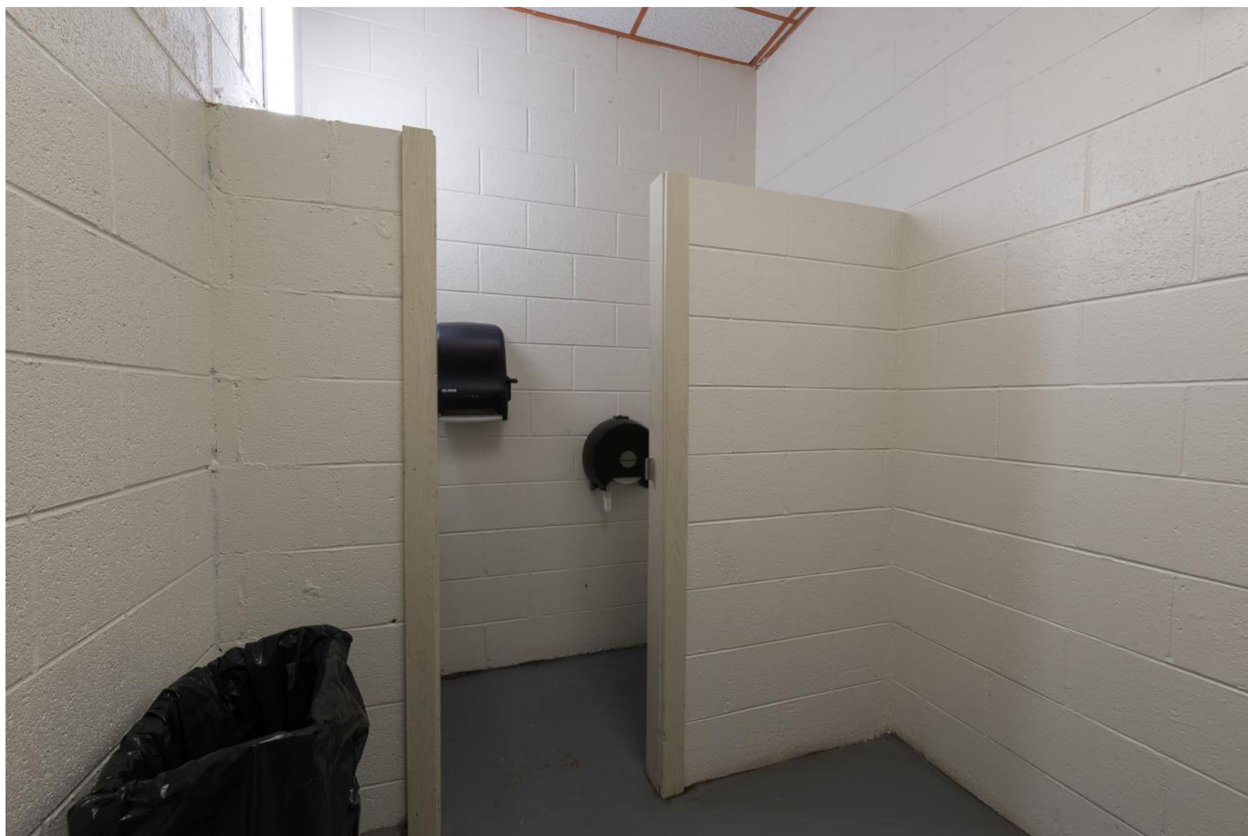
Executed on 03/21/2019

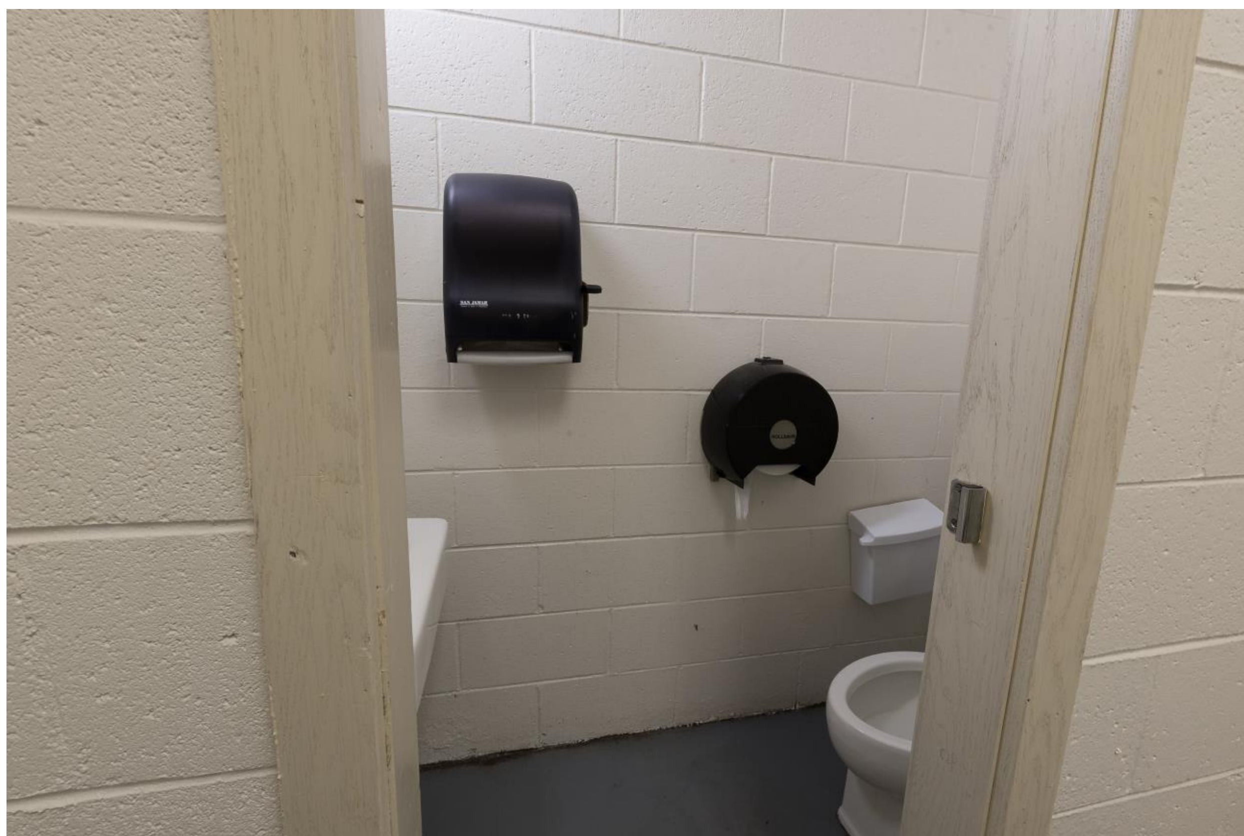
James H. Loving




RESTROOM







IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM, ,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Civil Case No. 4:15-cv-54
	)	
GLOUCESTER COUNTY SCHOOL BOARD,	)	
	)	
Defendant.	)	
	)	

DECLARATION OF SHAYNA MEDLEY-WARSOFF

I, Shayna Medley-Warsoff, submit the following declaration in support of Plaintiff Gavin Grimm's opposition to Defendant's motion for summary judgment. I am one of the attorneys for Gavin Grimm, and I have personal knowledge of the facts in this attorney declaration. If called upon to testify, I could competently testify to the matters set forth in this declaration.

1. A copy of the deposition of Dr. Melinda Penn is attached to this Declaration as Exhibit 1.

2. A copy of the deposition of Gavin Grimm is attached to this Declaration as Exhibit 2.

3. A copy of page 451 of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-V), originally produced as Exhibit L to Defendant's Motion for Summary Judgment, is attached to this Declaration as Exhibit 3.

4. A copy of pages 452-53 of the DSM-V is attached to this Declaration as Exhibit 4.

5. A copy of the email from Amy Bergh to Nate Collins dated October 28, 2014, originally produced as GCSB 03541 and attached as Exhibit 1 to the deposition of Gavin Grimm, is attached to this Declaration as Exhibit 5.

6. I have reviewed the video recording of the Gloucester County School Board meeting dated February 19, 2019, which is available online at http://gloucester.granicus.com/MediaPlayer.php?view_id=10&clip_id=2043. At 11:03, David Corrigan, attorney for the Gloucester County School Board, says, "This standard that is under consideration is based on upon what the Virginia High School League, of which all of Gloucester County schools are members, already has in place with respect to athletic competition involving transgender students among the members of the VHSL."

I declare under penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct.

Dated: April 9, 2019

Shayna Medley-Warsoff

1 IN THE UNITED STATES DISTRICT COURT
2 FOR THE EASTERN DISTRICT OF VIRGINIA
3 NEWPORT NEWS DIVISION
4 ---------------------------------X
5 GAVIN GRIMM, :
6 Plaintiff, :
7 v. : CASE NO.:
8 GLOUCESTER COUNTY SCHOOL : 4:15-cv-54
9 BOARD, :
10 Defendant. :
11 ---------------------------------X
12
13 Deposition of MELINDA PENN, M.D.
14 Richmond, Virginia
15 Thursday, March 14, 2019
16
17 10:15 a.m.
18
19
20 Job No.: 234511
21 Pages 1 - 92
22 Reported by: Helen B. Yarbrough, RPR, CCR

1 Deposition of MELINDA PENN, M.D., held at the
2 offices of:
3
4 ACLU OF VIRGINIA
5 701 East Franklin Street, Suite 1412
6 Richmond, Virginia 23219
7
8
9
10 Pursuant to agreement, before Helen B.
11 Yarbrough, RPR, CCR, Notary Public in and for the
12 Commonwealth of Virginia.
13
14
15
16
17
18
19
20
21
22

1 A P P E A R A N C E S
2
3 ON BEHALF OF PLAINTIFF GAVIN GRIMM:
4 JOSHUA A. BLOCK, ESQUIRE
5 LESLIE COOPER, ESQUIRE (Via Telephone)
6 SHAYNA MEDLEY-WARSOFF, ESQUIRE
7 AMERICAN CIVIL LIBERTIES UNION
8 125 Broad Street, 18th Floor
9 New York, New York 10004
10 212-549-2500
11 and
12 JENNIFER SAFSTROM, ESQUIRE
13 AMERICAN CIVIL LIBERTIES UNION
14 701 East Franklin Street, Suite 1412
15 Richmond, Virginia 23219
16 804-644-8080
17
18
19
20
21
22

1 A P P E A R A N C E S (Continued)
2
3 ON BEHALF OF DEFENDANT GLOUCESTER COUNTY
4 SCHOOL BOARD:
5 JEREMY D. CAPPS, ESQUIRE
6 HARMAN, CLAYTOR, CORRIGAN & WELLMAN
7 4951 Lake Brook Drive, Suite 100
8 Glen Allen, Virginia 23060
9 804-747-5200
10
11
12
13
14
15
16
17
18
19
20
21
22

1 I N D E X

2 PAGE

3 EXAMINATION OF MELINDA PENN, M.D.

4 By Mr. Capps 6

5

6

7 E X H I B I T S

8

9 PAGE

10 Exhibit 1 Expert Report 10

11 Exhibit 1A Curriculum Vitae 11

12 Exhibit 1B WPATH Standards of Care 37

13 Exhibit 1C Endocrine Society Guidelines 41

14 Exhibit 2 Rebuttal Expert Report and 86

15 Declaration

16

17

18

19

20

21

22

1 P R O C E E D I N G S
2 Whereupon,
3 MELINDA PENN, M.D.,
4 being first duly sworn or affirmed to testify to
5 the truth, the whole truth, and nothing but the
6 truth, was examined and testified as follows:
7 EXAMINATION BY COUNSEL FOR THE DEFENDANT
8 BY MR. CAPPS:
9 Q Dr. Penn, my name is Jeremy Capps. I
10 represent the Gloucester County School Board in a
11 lawsuit that was brought by Gavin Grimm.
12 You have been disclosed as an expert in
13 this case. Are you aware of that?
14 A Yes.
15 Q Can you state your full name for the
16 record?
17 A Melinda Penn.
18 Q And have you testified as an expert
19 before?
20 A No.
21 Q Have you ever given deposition
22 testimony before?

1 A Yes.
2 Q So you're familiar with the ground
3 rules. If I ask you a question that you don't
4 understand, please feel free to stop me, and I'll
5 try to rephrase it.
6 I will be sometimes inarticulate in
7 medical terminology. You are welcome to correct
8 me if you want, and we'll make sure that we are on
9 the same page. Okay?
10 A Okay.
11 Q Who engaged you for this case?
12 A Josh Block.
13 Q And when were you engaged?
14 A I believe it was over the summer, 2018.
15 Q And have you reviewed any materials in
16 preparing your expert report?
17 A Yes.
18 Q What did you review?
19 A The Endocrine Society guidelines on
20 transgender care and the WPATH guidelines and then
21 various articles that have been published about
22 transgender adolescence.

1 Q As you sit here today, can you remember
2 what articles you've reviewed?
3 A Not specifically. It's different ones
4 on medical health outcome and mental health
5 concerns in transgender adolescence.
6 Q Did you print those articles out after
7 you reviewed them and save them?
8 A Not specifically for this case. I have
9 articles that I have for my patients and for
10 endocrinology care.
11 Q But as you sit here now, you are not
12 able to name the titles of those articles?
13 A No.
14 Q Did you review the second amended
15 complaint for this case?
16 A Is that from Dr. Van Meter?
17 Q That would be Dr. Van Meter's report.
18 A Yes.
19 Q So you reviewed Dr. Van Meter's report;
20 is that correct?
21 A Yes.
22 Q Did you review the lawsuit, the paper

1 that was filed by Gavin Grimm?
2 A No.
3 Q Did you review any discovery in this
4 case?
5 A No.
6 Q Other than your original report and the
7 rebuttal report that you prepared, have you
8 prepared any other materials related to Gavin
9 Grimm's lawsuit against Gloucester County School
10 Board?
11 A No.
12 Q As you sit here now, do you know how
13 many hours of time you have put into this case
14 serving as an expert?
15 A Not exactly. I've written down when
16 I've spoken about the case, but I haven't added it
17 up yet.
18 Q And you're charging $300 an hour; is
19 that correct?
20 A Yes.
21 Q Do you have a ballpark figure about how
22 much time you have in it?

1 A Probably under ten hours.
2 Q Have you reviewed the Gloucester County
3 School Board Restroom Resolution?
4 A No.
5 Q Have you received any information from
6 Mr. Grimm's attorneys that you relied on in
7 forming your opinions in this case?
8 A We've reviewed my expert --
9 Q I'm not asking you that, and I'm not
10 asking you for the comments on your report. What
11 I'm asking is, did they -- did Mr. Grimm's lawyers
12 give you any factual information that you relied
13 on in coming to your opinions?
14 A No.
15 (Penn Deposition Exhibit 1 was marked
16 for identification and is attached.)
17 Q I'm going to show you what's been
18 previously marked as Exhibit 1. Is that the
19 expert report that you prepared in this case?
20 A Yes.
21 Q And in looking at that report, you
22 agree that there are not any specific opinions

1 that refer to or relate to Gavin Grimm?
2 MR. BLOCK: Objection.
3 A Can you state that question again?
4 Q Sure. You agree that in your report,
5 you don't mention Gavin Grimm?
6 A Yes.
7 Q And you agree that in the opinion
8 section of your report, you have not expressed any
9 opinions specific to Gavin Grimm?
10 A Yes.
11 (Penn Deposition Exhibit 1A was marked
12 for identification and is attached.)
13 Q You can go ahead and put that to the
14 side for the moment. We'll get back to it.
15 I'm going to show you what's been
16 marked as Exhibit 1A. That is the Attachment A to
17 the binded report that I received. Is that your
18 current CV?
19 A Yes.
20 Q Are there any additions to your CV
21 since you provided it back in January?
22 A I have done some additional

1 presentations locally at EVMS and CHKD, Eastern
2 Virginia Medical School and Children's Hospital of
3 the King's Daughters.
4 Q What are the presentations that you
5 gave?
6 A I gave a presentation for the pediatric
7 residents about transgender health care, and I
8 presented at a recent safe zone presentation for
9 the Children's Hospital.
10 Q The presentation to the pediatric
11 residents, when was that?
12 A That was, I believe, November or
13 December of 2018.
14 Q And the safe zone?
15 A That was last week.
16 Q And have you published any articles or
17 chapters that are not included on your current CV?
18 A No.
19 Q I asked you if you had ever -- I'm not
20 sure what I asked, what my first question was
21 about an expert. I think I asked if you'd ever
22 served as an expert before. Have you ever served

1 as an expert involving a transgender case?
2 A No.
3 Q Have you ever served as an expert in a
4 case involving appropriate psychological treatment
5 for a transgender adolescent?
6 A No.
7 Q So I get my terminology straight,
8 what's -- is there a difference from your
9 treatment between a child and an adolescent, or
10 are their terms interchangeable?
11 A We only provide endocrine care for
12 patients who have begun puberty. They have to
13 have begun puberty to receive treatment. They
14 would all be adolescents to receive hormone
15 therapy.
16 Q So if I use the word "adolescent," does
17 that mean a child who has begun puberty?
18 A Yes.
19 Q And if I just use the term "child" or
20 "children," that's someone that has not begun
21 puberty?
22 A In general.

1 Q And then if we use the term "adult," is
2 that someone that's reached the age of majority,
3 someone that's over 18?
4 A I think in most cases that would be
5 used.
6 Q Looking at your CV, you received your
7 medical degree in 2004 from Eastern Virginia
8 Medical School?
9 A Yes.
10 Q When you were at Eastern Virginia
11 Medical School, were there any courses taught on
12 transgender individuals?
13 A Not full courses.
14 Q Was there any instruction on medical
15 care for transgender individuals?
16 A I remember having a presentation that
17 was about LGBT patients.
18 Q And was that a one-day presentation?
19 A Yes.
20 Q One day? While you were at Eastern
21 Virginia Medical School, did you receive any
22 training on gender identity disorder?

1 A No.
2 Q Did you receive any training on gender
3 dysphoria?
4 A No.
5 Q Other than the presentation, did you
6 receive any training on the medical treatment of
7 transgender individuals?
8 A No.
9 Q It looks like you did your residency in
10 general pediatrics from July 2004 to July of 2007
11 at the Medical University of South Carolina. Is
12 that correct?
13 A Yes.
14 Q And while you were at the Medical
15 University of South Carolina, did you receive any
16 training on the medical treatment of transgender
17 individuals?
18 A Not that I recall.
19 Q Did you receive any training on the
20 medical treatment of gender dysphoria?
21 A No.
22 Q And while you were at the Medical

1 University of South Carolina, did you receive any
2 training on the medical treatment of gender
3 identity disorder?
4 A No.
5 Q What did your residency at the Medical
6 University of South Carolina consist of?
7 A General pediatric education.
8 Q What does that mean?
9 A The care and health care of pediatric
10 patients.
11 Q Did you, during your residency at the
12 Medical University of South Carolina, participate
13 in any research studies involving transgender
14 individuals?
15 A No.
16 Q Then again looking at your CV, it looks
17 like you had your fellowship at Children's
18 Hospital of Philadelphia?
19 A Yes.
20 Q From July 2017 through August of 2010?
21 MR. BLOCK: Objection.
22 A July 2007 to August 2010.

1 Q I'm sorry. Did I misstate it?
2 A Uh-huh.
3 Q So you had your fellowship from
4 July 2007 through August of 2010; is that correct?
5 A Yes.
6 Q What was your fellowship in?
7 A Pediatric endocrinology.
8 Q And what is pediatric endocrinology?
9 A It's the study of hormones and hormone
10 disorders.
11 Q In persons under the age of 18?
12 A Yes. Well, we continue up until about
13 21.
14 Q So in your practice in pediatric
15 endocrinology, you would treat patients up to
16 approximately the age of 21?
17 A Yes.
18 Q And during your fellowship in pediatric
19 endocrinology, did you receive any training on the
20 treatment of transgender individuals?
21 A We didn't have formal education, but
22 there was discussion.

1 Q And so when you say you had discussion,
2 what did that involve?
3 A Speaking about patients and discussing
4 the care that was occurring at other facilities.
5 Q And is that -- would that be like on
6 rounds, presenting on special --
7 A Yes.
8 Q I'm sorry.
9 -- presenting on individual patients?
10 A As we came across them in outpatient
11 clinic or inpatient, and then just discussing in
12 general the literature that was coming out.
13 Q During your fellowship, did you have
14 any medical training on the treatment of gender
15 identity disorder?
16 A No.
17 Q Did you have, during your fellowship,
18 any medical training on the treatment of gender
19 dysphoria?
20 A Just in what I just stated.
21 Q The discussion?
22 A Just the discussions and conferences

1 that I had attended.
2 Q And as you sit here today, do you
3 remember any conferences that you attended on --
4 during your fellowship that involved the treatment
5 of transgender individuals?
6 A Yes.
7 Q What were those?
8 A Dr. Norman Spack from Boston Children's
9 has a gender clinic and spoke at -- I believe it
10 was a Pediatric Endocrine Society meeting.
11 Q Do you remember when that occurred?
12 A Not specifically.
13 Q Other than the conference with
14 Dr. Norman Spack --
15 Can you spell that?
16 A S-P-A-C-K.
17 Q -- that Dr. Norman Spack presented, do
18 you recall any other conferences that you attended
19 that involved the treatment of transgender
20 individuals?
21 A I believe at the Endocrine Society
22 national conference I attended some discussions

1 about gender dysphoria.
2 Q Did you have any formal education other
3 than those conferences on gender dysphoria?
4 A No.
5 Q During your fellowship, did you
6 participate in any research studies on gender
7 dysphoria or transgender individuals?
8 A No.
9 Q During your fellowship, did you
10 participate in preparing any articles or
11 literature on gender dysphoria or transgender
12 individuals?
13 A No.
14 MR. BLOCK: Jeremy, is now a good time
15 to call Leslie?
16 MR. CAPPS: Yes. Let's take a break.
17 I meant to say if you want a break at any time,
18 tell me.
19 (A recess was taken.)
20 (Ms. Cooper joins the deposition by
21 telephone.)
22

1 BY MR. CAPPS: (Continuing)
2 Q You are licensed to practice medicine
3 in Virginia?
4 A Yes.
5 Q And are you board certified?
6 A Yes.
7 Q What are you board certified in?
8 A General pediatrics and pediatric
9 endocrinology.
10 Q And when did you become board certified
11 in pediatric endocrinology?
12 A Pediatric endocrinology was 2011.
13 Q Do you have any other certificates or
14 licenses -- strike that.
15 Is there any certificate or degree
16 relative to the treatment of transgender
17 individuals?
18 A I believe WPATH is in the process of
19 creating a certificate.
20 Q And do you have a certificate relative
21 to the treatment of transgender care?
22 A No.

1 Q Is there any certification at present
2 concerning the treatment of transgender
3 individuals?
4 A I don't believe there's one that
5 formally is available yet.
6 Q What do you do now in your practice?
7 A I practice general pediatric
8 endocrinology at the Children's Hospitals of the
9 King's Daughters.
10 Q What is your general patient
11 population?
12 A I see patients for a number of
13 endocrine disorders. The majority of my practice
14 is made up of patients with Type 1 diabetes, but
15 we also care for children and adolescents with
16 growth hormone deficiency, thyroid disorders,
17 puberty disorders, adrenal dysfunction, obesity,
18 Type 2 diabetes, and then I see transgender
19 patients as well.
20 Q And do you consider yourself as having
21 a specialty?
22 A I see -- I tend to specialize in Type 1

1 diabetes and transgender care.
2 Q How long have you been at the
3 Children's Specialty Group?
4 A I have been there since July of 2018.
5 Q And since you joined Children's
6 Specialty Group, what's the percentage of your
7 patients that you treat who are transgender?
8 A It's hard to estimate since it's a new
9 practice for me. I see several a month. But
10 because all of the patients are new to me and I'm
11 building the practice, it's difficult to determine
12 exactly how many I'm seeing currently.
13 Q So are you able to say how many
14 transgender children or adolescents that you've
15 treated since you've gone to Children's Specialty
16 Group?
17 A I would estimate that currently I've
18 had probably about 25 patients.
19 Q And what is your involvement in the
20 treatment of those patients?
21 A When I joined Children's Specialty
22 Group, there was a previous pediatric

1 endocrinologist who retired, and he was previously
2 seeing the transgender patients and providing
3 endocrine care for them. So I've taken over his
4 practice and continued the care that he was
5 providing, as well as seeing new patients.
6 Q I guess what I'm getting at now -- so
7 when you say you are providing endocrine care, you
8 are providing medical treatment; is that correct?
9 A Yes.
10 Q And are you providing -- when you say
11 "endocrine care," does that mean you're providing
12 hormone --
13 A Yes.
14 Q -- therapy? Maybe I'm using the wrong
15 term.
16 A No. So, it varies what we do for
17 transgender patients. But if they choose to
18 undergo hormone therapy and feel that they'll
19 benefit from hormone therapy, that can include
20 pubertal suppression where we stop the development
21 of -- production of pubertal hormones. And then
22 we can do gender-affirming hormone therapy, which

1 means that we will provide estrogen or
2 testosterone to have feminizing or masculinizing
3 effects.
4 Q Does your practice now involve any
5 other types of care other than -- strike that.
6 Does your practice now, involving
7 transgender individuals, provide any other type of
8 medical treatment other than the hormone therapy
9 that you just described?
10 A So, when I see patients who are
11 transgender and have gender dysphoria, some choose
12 not to proceed with any treatment; and some
13 patients, I'm just meeting with and giving them
14 the options of what's available. So there are
15 patients that I see and I follow who haven't
16 decided to embark on hormone therapy. But if they
17 want endocrine care, then that's what's provided.
18 Q All right. And before you went to the
19 Children's Specialty Group, you worked at Virginia
20 Commonwealth University?
21 A Yes.
22 Q And you started at VCU when you ended

1 your fellowship?
2 A Yes. September 2010.
3 Q So that was your first job out of --
4 after your fellowship?
5 A Yes.
6 Q And what did you do at VCU?
7 A I provided pediatric endocrine care for
8 patients.
9 Q And while you were at VCU, did you
10 receive any training on the treatment of
11 transgender individuals?
12 A I attended workshops and conferences
13 that discussed transgender care.
14 Q Have you had any formal education
15 during your time at VCU on the treatment of
16 transgender individuals?
17 A Just the attendance of conferences.
18 Q When did you begin treating transgender
19 individuals?
20 A I believe it was 2013.
21 Q And tell me, how did that come about?
22 A There was a local psychologist who

1 specialized in LGBT adolescent care, and she had
2 adult hormone providers but no pediatric hormone
3 providers in the area, and the adult providers
4 knew of me and recommended that she speak with me,
5 so I started discussions with her.
6 Q And who is the local psychologist?
7 A Dr. Lisa Griffin.
8 Q And it says on your CV that you --
9 maybe it was in your report -- but, that you
10 started a pediatric transgender health clinic at
11 VCU?
12 A Yes.
13 Q And who did you start that with?
14 A Dr. Susan Jones, a child and adolescent
15 psychiatrist.
16 Q Were there any other endocrinologists
17 associated with the program?
18 A When I left VCU, another
19 endocrinologist joined and took part in the
20 program. But while I was there, I was the only
21 endocrinologist taking care of the transgender
22 patients.

1 Q When you took care of the transgender
2 patients at VCU, were they all under 21, or were
3 there adults?
4 A When I began their care, they were
5 under 21. Some may have been over 21 while they
6 were still in my care.
7 Q After you opened the pediatric
8 transgender health clinic, did you receive any
9 specialized training in the treatment of pediatric
10 transgender individuals?
11 A Just attendance at conferences and
12 speaking to other endocrinologists who had had
13 prior experience with transgender care.
14 Q And in providing your treatment at VCU,
15 did you rely on any standards of care or
16 guidelines?
17 A Yes. The Endocrine Society standards
18 of care and WPATH guidelines.
19 Q And in your treatment of transgender
20 individuals at VCU, did you provide any mental
21 health care?
22 A No, not in my -- I didn't provide it.

1 I worked with mental health providers who provided
2 it.
3 Q Right. But you're not a licensed
4 mental health provider?
5 A No.
6 Q And as you sit here now, do you
7 remember the conferences that you attended
8 concerning the treatment of transgender
9 individuals while you were at VCU?
10 A The Pediatric Endocrine Society has a
11 national conference and typically has a couple
12 lectures that are about transgender care, and the
13 Philadelphia Transhealth conference is an annual
14 conference, and I attended that. I'd have to look
15 back to see exactly what year it was. And they
16 had a health care and medical path in that
17 conference that I attended.
18 Q And your treatment of transgender
19 individuals while you were at VCU, was that any
20 different than your current treatment of these
21 individuals now that you're at the Children's
22 Specialty Group?

1 A No.
2 Q Same type of hormone therapy treatment,
3 endocrine treatment?
4 A Yes.
5 Q While you were at VCU, did you
6 participate in any research studies involving
7 transgender individuals?
8 A No.
9 Q Did you track in any formal way the
10 progress of the transgender individuals that you
11 treated at the pediatric transgender health clinic
12 at VCU?
13 A Not in any formal way.
14 Q Did you participate in any research --
15 strike that.
16 Did you participate in any -- in
17 preparing any written articles or literature
18 involving the treatment of transgender individuals
19 while you were at VCU?
20 A No.
21 Q How did you leave VCU to go to the
22 Children's Specialty Group?

1 A I wanted a new position and felt like
2 this position gave me more support as a
3 specialist.
4 Q Is the transgender health clinic still
5 operating at VCU?
6 A I believe so. The endocrinologist who
7 came on after me, I think, has left VCU, so I'm
8 not sure who's heading that now.
9 Q So at least as of right now, you do not
10 have any collaboration with VCU's transgender
11 health clinic?
12 A No.
13 Q All right. Have you ever participated
14 in any peer-reviewed research studies involving
15 transgender individuals?
16 A No.
17 Q Have you ever participated in any
18 peer-reviewed research studies involving gender
19 identity disorder?
20 A No.
21 Q Have you ever participated in any
22 peer-reviewed research studies involving gender

1 dysphoria?
2 A No.
3 Q As you sit here now, have you published
4 any articles or literature or books related to the
5 treatment of transgender individuals?
6 A No.
7 Q Have you published any articles,
8 literature, or chapters in books regarding the
9 treatment of gender dysphoria?
10 A No.
11 Q Have you published any articles,
12 literature, or chapters in books related to the
13 treatment of gender identity disorder?
14 A No.
15 Q Have you ever received any state or
16 federal grant funding to conduct research into the
17 treatment of transgender individuals?
18 A No.
19 Q All right. In your report, you state
20 that you are a member of WPATH.
21 A Yes.
22 Q What is WPATH?

1 A It's an international society for
2 people who provide health care for transgender
3 individuals.
4 Q What is the purpose of the WPATH
5 organization?
6 A I don't know exactly what their stated
7 purpose is, but it's to promote education about
8 transgender health care.
9 Q Is it a medical organization?
10 A It's a professional society.
11 Q What's that mean?
12 A I believe you have to be a health care
13 provider to join it, but that can include mental
14 health providers as well.
15 Q Do you know, as you sit here now, what
16 the qualifications are to be a member of WPATH?
17 A I believe you had to have a medical
18 license of some sort or some sort of professional
19 licensure.
20 Q Did you fill out an application to be a
21 member?
22 A Yes.

1 Q And are there annual dues to be a
2 member?
3 A Yes.
4 Q What are the annual dues?
5 A I don't recall.
6 Q Have you participated in preparing the
7 standards of care issued by WPATH?
8 A No.
9 Q You also state that you are a member of
10 the Pediatric Endocrine Society?
11 A Yes.
12 Q What is that?
13 A It's a professional society for
14 pediatric endocrinologists in the U.S.
15 Q And do you have to be a pediatric
16 endocrinologist to join?
17 A Yes.
18 Q And did you participate in preparing
19 the Pediatric Endocrine Society guidelines
20 concerning the treatment of transgender
21 individuals?
22 A No.

1 Q Did you offer any comments on the
2 development of the guidelines issued by the
3 Pediatric Endocrine Society concerning the
4 treatment of transgender individuals?
5 A No.
6 Q Is there a difference between a
7 standard of care and a guideline?
8 A Not that I'm aware of.
9 Q So would you treat a standard of care
10 as the same -- in the same manner as -- strike
11 that. I'll be more specific.
12 Do you treat the standards of care
13 issued by WPATH as -- in the same manner as you
14 treat the guidelines issued by the Endocrine
15 Society?
16 A I use them both as kind of guides for
17 how to provide care for those patients. I tend to
18 refer to the Endocrine Society guidelines more
19 often because they specifically -- more
20 specifically relate to what I'm doing.
21 Q Do you know whether the standards of
22 care issued by WPATH were peer-reviewed by

1 endocrine professionals?
2 A I do not.
3 Q Do you know who authored the standards
4 of care?
5 A No.
6 Q Did you review the underlying
7 literature that is used to support the WPATH
8 standards of care?
9 A I have in the past.
10 Q And do you recall what literature it is
11 that you reviewed?
12 A No.
13 Q Do you know whether WPATH took into
14 consideration any contrary or dissenting views on
15 the treatment of transgender individuals in
16 creating their standards of care?
17 A I do not.
18 Q Do you know what methodology was used
19 by WPATH in creating these standards of care?
20 A No.
21 Q And did you have any involvement in the
22 adoption of the standards of care by WPATH?

1 A No.
2 MR. CAPPS: Do you want to take a quick
3 break? I'm going to transition into those --
4 we're okay to take a quick break if you want.
5 (A recess was taken.)
6 (Penn Deposition Exhibit 1B was marked
7 for identification and is attached.)
8 BY MR. CAPPS: (Continuing)
9 Q I'm showing you what's been marked as
10 Exhibit 1B, which was attached to your expert
11 report. Is that the most current standards of
12 care issued by WPATH that you have been referring
13 to?
14 A Yes.
15 Q And you agree that the WPATH standards
16 of care are intended to be a flexible guideline?
17 A Yes.
18 Q And you agree that the WPATH standards
19 of care state that treatment for gender dysphoria
20 is intended to be individualized?
21 A Yes.
22 Q And the WPATH standards of care state

1 that what helps one person alleviate gender
2 dysphoria might be very different from what helps
3 another person?
4 A Yes.
5 Q And is that true in your practice?
6 A Yes.
7 Q So in your practice, the treatment of
8 transgender adolescents or children varies from
9 one child to another?
10 A Yes.
11 Q And it may depend on what the parents
12 want?
13 A I talk with the patients and the
14 parents and come up with the best plan.
15 Q And that plan, though, may depend on
16 what the parents want instead of what the child
17 wants?
18 A In order to proceed with any
19 treatments, I have to have -- I require that all
20 parents or guardians agree to the plan.
21 Q And if a parent disagrees with the
22 adolescent that you're treating, does that mean

1 you don't proceed with the treatment?
2 A Yes.
3 Q And if the child that you're treating
4 disagrees with how the parents want the treatment
5 to proceed, does that mean you don't provide the
6 medical treatment to the individual?
7 MR. BLOCK: Objection. You said
8 "child," and we previously talked about children
9 versus adolescents, so I wanted to clarify.
10 Q Maybe I got my terms confused. Are you
11 treating adolescents or children?
12 A If I'm providing medical hormone
13 therapy, then they would be adolescents.
14 Q And you treat children in your practice
15 that are -- that you would not consider to be
16 adolescents?
17 A In my endocrine practice. And I do see
18 some transgender children as initial consults, but
19 I don't provide any medical treatment for them
20 until they've had some degree of puberty.
21 Q So let me see if I can get my question
22 out right.

1 MR. BLOCK: Sorry.
2 MR. CAPPS: That's all right.
3 Q If the transgender adolescent that
4 you're treating does not agree with the parents'
5 preferred method of medical treatment, does that
6 mean you do not provide medical treatment to the
7 adolescent?
8 A In order to get treatment, the parents
9 have to have agreed, as well as the adolescent, to
10 proceed with treatment.
11 Q Are you aware of any formal studies,
12 scientific studies, that have documented the
13 prevalence of transgender adolescents?
14 A There have been some research studies,
15 but I don't think that we have any current ones
16 that adequately address the current population of
17 transgender patients.
18 Q Do you know who participated in
19 creating the clinical guidelines for the Endocrine
20 Society?
21 A There are a number of endocrinologists
22 from different areas across the U.S. and

1 internationally that were consulted.
2 (Penn Deposition Exhibit 1C was marked
3 for identification and is attached.)
4 Q I'm going to show you what's been
5 marked as Exhibit 1C. Is that the Pediatric
6 Endocrine Society guidelines that you rely on?
7 MR. BLOCK: Objection. It's not the
8 Pediatric Endocrine Society. It's the Endocrine
9 Society.
10 Q Sorry. The Endocrine Society
11 guidelines that you rely on?
12 A Yes.
13 Q Are there guidelines that are specific
14 to pediatric transgender patients?
15 A Within the Endocrine Society
16 guidelines, they specifically discuss pediatric
17 care.
18 Q Are you a member of the Endocrine
19 Society?
20 A I'm not currently an Endocrine Society
21 member, but I'm a member of the Pediatric
22 Endocrine Society.

1 Q Has the Pediatric Endocrine Society put
2 out guidelines for the treatment of transgender
3 pediatric patients?
4 A They have supported these Endocrine
5 Society guidelines.
6 Q Do you know what the scientific
7 methodology was used -- strike that.
8 Do you know what scientific methodology
9 was used in creating the Pediatric Endocrine
10 Society guidelines?
11 A They reviewed studies that are
12 available and came up with best practices.
13 Q And do you know what percentage of
14 Endocrine Society members agreed with the
15 guidelines?
16 A No.
17 Q Do you know whether the guidelines were
18 adopted by a vote?
19 A No.
20 Q In your report, in paragraph 9 you
21 stated that in the five -- the past five years,
22 you've treated approximately -- well, you've

1 treated over a hundred transgender youth and
2 adolescents in Virginia?
3 A Yes.
4 Q Have you done any follow-up studies on
5 the patients, the individuals -- transgender --
6 strike that, and I'm going to try again.
7 Have you done any follow-up studies on
8 the transgender individuals that you have treated
9 in the last five years?
10 A No, only through clinical follow-up.
11 Q You have not documented their outcomes
12 after you have provided your treatment; is that
13 correct?
14 A I document as I'm seeing them
15 clinically, but I haven't collected that data.
16 Q Have you, in your practice over the
17 last five years, conducted any studies to
18 determine the benefits to the transgender
19 individuals -- strike that.
20 Have you conducted any studies to
21 determine the benefits of your medical treatment
22 to any of the transgender individuals that you

1 have provided care to?
2 A No.
3 Q I know I'm jumping around, but if you
4 look at your report at paragraph 12, you stated,
5 "In preparing this report, I relied on . . .
6 scientific literature on this topic."
7 Do you see that?
8 A Yes.
9 Q What is the scientific literature that
10 you relied on?
11 A Some of the studies that are referred
12 to in the guidelines.
13 Q And as you sit here now, can you tell
14 me what studies those are?
15 A Can I refer to the guidelines?
16 Q Yeah, of course.
17 A The ones that we referred to in my
18 document are ones that I've referred to
19 specifically.
20 Q So the literature that you relied on is
21 set out in your expert report; is that correct?
22 A Yes. And in addition, I've reviewed

1 other documents that are referred to in the
2 guidelines. Specifically for my report, those are
3 documented in here.
4 Q So looking at your opinions, if you
5 look at paragraph 17, you state that, "The term
6 'gender identity' refers to a person's innate
7 sense of belonging to a particular gender."
8 A Yes.
9 Q Where did you get that definition?
10 A The endocrine guidelines.
11 Q And you then state that the precise
12 etiology of gender identity is unknown?
13 A Yes.
14 Q What do you mean by that?
15 A There are no precise causes that have
16 been identified that guarantee your gender
17 identity.
18 Q So does that mean there's no scientific
19 data that can determine an individual's gender
20 identity?
21 A Yes. There's no specific test that you
22 can do.

1 Q So there's not a diagnostic test that
2 can be performed that would determine an
3 individual's gender identity?
4 A No.
5 Q Is there a biological test that could
6 determine gender identity?
7 A No.
8 Q As you sit here now, is there a
9 biological basis for gender identity?
10 A Not a direct one.
11 MR. BLOCK: Can we stop for a second?
12 MR. CAPPS: Yes.
13 (A discussion was held off the record.)
14 BY MR. CAPPS: (Continuing)
15 Q In paragraph 18 of your report, you
16 state that the terms "sex designated at birth" or
17 "sex assigned at birth" are more precise than
18 "biological sex."
19 A Yes.
20 Q Why is that?
21 A There are a number of different
22 components that make up what is determined to be

1 the sex at birth, and the biological sex is
2 imprecise and doesn't address all of those.
3 Q So you would agree that a -- that sex
4 is determined by chromosomal makeup and
5 reproductive organs, correct?
6 MR. BLOCK: Objection.
7 A Those are two components that can
8 contribute to the sex that's assigned at birth,
9 but there's chromosomal, hormonal, anatomic
10 conditions that all have to align to help with the
11 sex assigned at birth.
12 Q Have you ever, as a pediatrician, been
13 asked to determine the sex of an infant at birth?
14 A Yes. As a pediatric endocrinologist,
15 we are involved with the diagnosis of children
16 with ambiguous genitalia.
17 Q Is that different than the phrase
18 "intersex"?
19 A That's related to intersex.
20 Q Outside of a case where an infant has
21 ambiguous genitalia, are you asked to recognize
22 the sex at birth as a pediatrician?

1 A As a pediatrician, yes; but in
2 pediatric endocrinology I typically am not
3 involved in that unless there's questions.
4 Q So when you were a pediatrician, did
5 you recognize the sex of an infant at birth based
6 upon the appearance of external genitalia?
7 A Yes. We would examine patients and
8 describe the appearance of the genitalia.
9 Q And then you would designate the
10 infant's sex based on that external genitalia,
11 correct?
12 A Yes.
13 Q If there is a question concerning the
14 sex of an infant at birth, can medical providers
15 perform a chromosomal testing?
16 A Yes, you can perform that. There's a
17 number of different tests that we'll do if there's
18 question about the appearance of the genitalia.
19 Q And what are those tests?
20 A We'll perform chromosomes; we'll do
21 investigations to look at the internal anatomy in
22 genitalia; we'll perform hormone levels.

1 Q And when you say "looking at the
2 internal anatomy," does that mean the reproductive
3 organs?
4 A Yes.
5 Q And the chromosomal testing, that would
6 be the XX chromosome or the XY chromosome?
7 A Yes.
8 Q And if the infant has an XX chromosome,
9 that's recognized as a biological basis for a
10 female?
11 A Not always.
12 Q In what cases would it not be?
13 A There are times when you can have a
14 portion of the Y be present in an XX individual.
15 There are times that you have an XY individual who
16 won't respond to testosterone and therefore would
17 look very feminine on the outside. So it's not
18 always clear.
19 Q And if there is an XX chromosome
20 without a portion of a Y, does -- is that the
21 biological basis for a female?
22 A In general, yes.

1 Q And in situations where you look to the
2 reproductive organs to determine the sex of an
3 infant born at birth, that is a biological basis
4 for your determination, correct?
5 A Can you say that again?
6 Q When you look to the reproductive
7 organs to determine the sex of an infant born at
8 birth, that is a biological basis for your
9 determination, correct?
10 A Yes. But there are cases where just
11 the appearance of the genitalia are not always
12 aligned and appropriate.
13 Q I was talking about the internal
14 reproductive organs that you discussed.
15 A Not always.
16 Q That's not always a biological basis?
17 A Yes.
18 Q And how is that?
19 A There are cases where there are people
20 who have XY chromosomes but don't respond to
21 androgens or to testosterone. They would have no
22 internal uterus. They would have testes, but

1 they're not responding to the testosterone, so
2 their external genitalia is very feminine, but
3 they wouldn't have the internal female uterus or
4 ovaries.
5 Q And what would the medical diagnosis
6 for that be?
7 A Androgen insensitivity.
8 Q And how often does that occur?
9 A I would have to review for
10 specifically -- specific numbers.
11 Q How often did you see it in your
12 practice?
13 A I've seen it about three times.
14 Q You agree that choosing a gender
15 identity does not cause any chromosomal changes in
16 the body, correct?
17 A Yes.
18 Q And a person's innate sense of
19 belonging to a particular gender does not cause
20 any biological changes in the body?
21 A That's correct.
22 Q In paragraph 20 of your report, you

1 state that, "Gender identity is deeply rooted
2 early in life."
3 Do you see that?
4 A Yes.
5 Q What is that opinion based on?
6 A There's -- many pediatric patients have
7 very distinct gender identity and identify with a
8 specific gender at a young age as a normal part of
9 pediatric development.
10 Q And when you say it's rooted early in
11 life, does that mean in both gender identity that
12 is consistent with the sex recognized at birth and
13 inconsistent with the sex recognized at birth?
14 A It can be, yes.
15 Q Have there been any empirical studies
16 or data that identify when a child has a sense of
17 gender identity?
18 A I'm not aware. There has been research
19 describing it, but I'm not sure of the specifics.
20 Q DSM-V --
21 A Yes.
22 Q -- describes gender dysphoria; is that

1 correct?
2 A Yes.
3 Q And what, to your understanding, is
4 gender dysphoria?
5 A That's the distress that a patient or a
6 person experiences when their gender identity
7 doesn't align with the sex assigned at birth.
8 Q Okay. And you're aware that the DSM-V
9 defines sex as it refers to the biological
10 indicators of male and female such as in sex
11 chromosomes, gonads, sex hormones, and
12 nonambiguous internal or external genitalia?
13 A Yes.
14 Q And you agree with that, correct?
15 A Yes.
16 Q So the treatment that you provide as a
17 pediatric endocrinologist, is that to treat gender
18 dysphoria, or is it to treat a transgender
19 individual?
20 A Yes, it's to treat the gender dysphoria
21 that occurs in transgender individuals.
22 Q So your practice, medical practice,

1 seeks to medically treat a transgender
2 individual's distress?
3 A Yes. We're helping to decrease the
4 distress and the dysphoria.
5 Q Do you need a break?
6 A Yes.
7 (A recess was taken.)
8 BY MR. CAPPS: (Continuing)
9 Q In your practice, do you diagnose
10 gender dysphoria?
11 A I rely on the mental health providers
12 that I work with to do the official diagnosis, but
13 I review with the patients why they're seeking
14 hormone therapy.
15 Q Is there any objective test that can
16 diagnose gender dysphoria?
17 A Not that I'm aware of.
18 Q So a diagnosis would be based on a
19 conversation with the transgender individual?
20 A There are guidelines and criteria that
21 you have to meet for the diagnosis of gender
22 dysphoria, and that's with discussion by the

1 patient.
2 Q But it's based upon the subjective
3 information that the patient gives you; is that
4 correct?
5 A Yes.
6 Q Do you agree that not all transgender
7 individuals express distress in their gender
8 identity choice?
9 A Yes.
10 Q Do you dispute the DSM-V statement that
11 for natal adult males, the prevalence ranges for
12 gender dysphoria range between .005 percent to
13 .014 percent of natal adult males?
14 A It sounds appropriate. I'm not sure
15 exactly what they are referring to for this data.
16 Q How about the prevalence ranges for
17 natal females range from .002 percent to
18 .003 percent? Do you dispute that data?
19 A Again, I don't know where it comes from
20 and how that research is done, but it sounds
21 appropriate.
22 MR. BLOCK: Could she be provided a

1 copy of the DSM, even with your markings?
2 MR. CAPPS: Yes. That's fine. I'm
3 not . . .
4 A I don't know how old the data is or how
5 they obtained the information. That can really
6 vary from -- by determining what population they
7 looked at.
8 Q Is there a difference in the treatment
9 that you provide to transgender individuals with
10 gender dysphoria that do not have a disorder of
11 sex development, versus having a disorder of sex
12 development?
13 A I guess it would depend on what
14 disorder of sexual differentiation you are
15 referring to. Many of those patients need
16 different treatment than what we would provide for
17 gender dysphoria.
18 Q And the reason I ask is the DSM-V has a
19 section that differentiates. It says gender
20 dysphoria without a disorder of sex development
21 and gender dysphoria with a disorder of sex
22 development. So I was curious whether your

1 treatment is different under those scenarios.
2 A Yes, it would be different. But it
3 would apply to the individual. It's not
4 distinctly different.
5 Q In paragraph 23 of your report, you
6 identify medical treatment for gender dysphoria
7 that involves helping a transgender person live in
8 alignment with their gender identity. Do you see
9 that?
10 A Yes.
11 Q You say, "This treatment is sometimes
12 referred to as 'gender transition, 'transition
13 related care,' or 'gender-affirming care.'"
14 Do you see that?
15 A Yes.
16 Q As part of your medical practice, do
17 you provide medical treatment that involves
18 gender-affirming care?
19 A Yes.
20 Q And what is the medical treatment that
21 you provide related to gender-affirming care?
22 A I provide pubertal suppression where we

1 give hormones that stop the production of pubertal
2 hormones in the body. And then I can also provide
3 hormones that would promote the development of
4 secondary sex characteristics that align with the
5 person's gender identity.
6 Q Do you provide any medical treatment
7 related to any transgender individual's social
8 transition?
9 A Can you restate it?
10 Q Do you, in your treatment of
11 transgender individuals, provide a treatment plan
12 that includes social transition?
13 A Not directly. We discuss the social
14 transition and what they've done with their social
15 transition, but I don't directly.
16 Q So you're not involved in creating
17 treatment plans related to a transgender
18 individual's social transition related to their
19 gender identity?
20 A No. I do assist with some of the
21 paperwork that they require to do name change and
22 gender change, and some of the legal documents

1 require a medical provider to sign off, and I
2 assist with that.
3 Q But on a day-to-day basis, do you
4 outline a treatment plan that relates to a
5 transgender individual's social transition?
6 A No.
7 Q Do you document a patient's
8 participation in social transition as a part of
9 your medical treatment of transgender individuals?
10 A I typically discuss with the patients
11 what social transitions have occurred, and we
12 discuss family support, school support, and
13 friends' support, and that sort of information.
14 Q Do you agree that transgender patients
15 also have an alternative medical plan that would
16 involve just counseling?
17 A The treatment for transgender
18 individuals varies greatly, and some of my
19 patients ultimately have done well with counseling
20 and just social transition.
21 Q Have you had any patients participate
22 in just counseling without engaging in social

1 transition?
2 A I can't think of anyone in particular.
3 Typically, in order for a patient to come to me,
4 they have some desire of the social transition
5 because they need the hormones to be able to
6 display their signs of their gender. So I have a
7 biased patient population in that way.
8 Q Are you aware of a treatment approach
9 that's kind of been described as a
10 "let's-wait-and-see approach"?
11 A Yes.
12 Q And do you have an opinion on that
13 medical approach to treating transgender
14 individuals?
15 A In general, I think the wait-and-see
16 discusses seeing what happens at puberty; and
17 typically, since I'm seeing the patients at
18 puberty who are still displaying the gender
19 identity, that's been my experience, that those
20 patients are now coming to me for treatment of
21 their dysphoria.
22 Q Do you agree that the wait-and-see

1 approach can be an appropriate medical treatment?
2 MR. BLOCK: Can I just object just in
3 terms of the foundation about what you're
4 referring to as the wait-and-see approach?
5 MR. CAPPS: I thought I'd done that
6 when I asked her if she was aware of it.
7 Q What is your understanding of what I
8 refer to as a "counseling" or sometimes referred
9 to as a "wait-and see approach"? What is your
10 understanding?
11 A In my experience -- well, in general,
12 we're not making any permanent changes until a
13 child has begun to have pubertal changes. I think
14 the wait-and-see sometimes can be determined as
15 just social changes or limited social changes, and
16 then more definitive gender care once puberty has
17 started and their gender identity has persisted.
18 Q In paragraph 25 of your report, we
19 talked about the social transition plan; and in
20 it, you said it can include allowing children to
21 wear clothing, to cut or grow their hair, to use
22 names and pronouns and restrooms and other

1 sex-separated facilities in line with their gender
2 identity. Do you see that?
3 A Yes.
4 Q The social transition that you're
5 talking about, is that part of a medical treatment
6 plan?
7 A It's not typically a part that I'm
8 involved in, because most of the patients are
9 coming to see me at the onset of puberty.
10 Q And whose plan, if anybody's, would
11 that be -- that social transition be a part of?
12 A It's oftentimes something that's
13 discussed with the mental health provider and the
14 families.
15 Q And the social transition plan is used
16 to address the treatment of gender dysphoria; is
17 that correct?
18 A Yes.
19 Q And you would agree, then, that the use
20 of restrooms that are in line with a transgender
21 patient's gender identity instead of the sex
22 designated at birth is one component of the social

1 transition plan?
2 A Yes, it can be a part of that.
3 Q And that there are other components of
4 the social transition plan that can be provided or
5 recommended by a mental health provider to treat
6 gender dysphoria?
7 A Yes.
8 Q I looked at Exhibit 1B, the WPATH
9 standard of care guidelines, and I don't see in
10 those guidelines where the standard of care refers
11 to the use of restrooms in line with a transgender
12 patient's gender identity instead of the sex
13 recognized at birth. Can you tell me if the WPATH
14 standards of care provide any guidance on the use
15 of restrooms to treat gender dysphoria in
16 transgender individuals?
17 A I'd have to review it again to look if
18 there's specific mention about restroom use.
19 Q I'm going to give you that opportunity.
20 A (Witness reviewing document.)
21 MR. BLOCK: Jeremy, since it's a long
22 document, can I help?

1 MR. CAPPS: Yes, that's fine. I don't
2 mind you saying where you think in the document it
3 is.
4 MR. BLOCK: All right. So I'll
5 identify the points; I'll refer to the pages.
6 So, you might want to look at page 68.
7 There's one other page you might want to look at.
8 MR. CAPPS: Document.
9 A On page 17 there's a section about the
10 social transition in early childhood, and it just
11 refers to the safe and supportive environment for
12 their transitioning, that maintaining a safe and
13 supportive environment in their transitioning
14 child -- for example, in school, peer group
15 settings. It doesn't specifically say restrooms
16 but in general the environment.
17 Q Right. So on page 17 of a -- of the
18 WPATH "Social Transition In Early" -- I'm sorry.
19 I'm going to start over.
20 On page 17 of the WPATH standards of
21 care under the title "Social Transition in Early
22 Childhood," there is a section at the bottom of

1 the page that states, "If parents do allow their
2 young child to make a gender role transition, they
3 may need counseling to facilitate a positive
4 experience for their child. For example, they may
5 need support in using correct pronouns,
6 maintaining a safe and supportive environment for
7 their transitioning child (e.g. in school, peer
8 group settings), and communicating with other
9 people in their child's life."
10 Do you see that? Yes?
11 A Yes.
12 Q And that standard of care relates to
13 the parents of a transgender child, correct?
14 A Yes.
15 Q And that standard of care does not
16 state anything about the use of restrooms
17 consistent with the child's expressed gender
18 identity, correct?
19 A Not specifically.
20 Q And that standard of care does not
21 relate to the use of a bathroom at a school --
22 strike that. That standard of care -- strike

1 that.

2 Anywhere else in the document that you

3 believe the standard of care expressed by WPATH

4 references restroom use for transgender

5 individuals?

6 A There's a section in applicability of

7 the standards of care to people living in

8 institutional environments on page 68. Is says

9 that, "Housing and shower/bathroom facilities for

10 transsexual, transgender, and gender nonconforming

11 people living in institutions should take into

12 account their gender identity and role, physical

13 status, dignity, and personal safety."

14 Q So the WPATH standard of care that you

15 just referenced relates to transsexual,

16 transgender, and gender nonconforming people

17 living in institutional environments such as

18 prisons, or long-term health care facilities,

19 correct?

20 A Yes.

21 Q WPATH does not have a standard of care

22 related to the use of restrooms by transgender

1 students at schools, correct?
2 A Not that I see.
3 Q In Exhibit 1C, which is the Endocrine
4 Treatment -- Clinical Practice Guidelines of
5 Gender-Dysphoric/Gender-Incongruent Persons -- do
6 you see that?
7 A Yes.
8 Q And you relied on this document in
9 coming to your opinions, correct?
10 A Yes.
11 Q Do the guidelines issued by the
12 Endocrine Society refer to the use of the
13 restrooms by a transgender person?
14 A Let me review. It's mostly discussing
15 the medical treatment, and I don't think that
16 there's a lot of discussion about social, but let
17 me review it again.
18 I don't think there's a specific
19 reference to the bathroom facility.
20 Q All right. So you would agree, then,
21 that there are no guidelines issued by the
22 Endocrine Society related to transgender students

1 using restrooms consistent with their gender
2 identity in the school?
3 MR. BLOCK: Objection.
4 MR. CAPPS: What's the objection?
5 MR. BLOCK: "Related to" versus
6 "specifically mentioned."
7 Q Okay. You would agree that the
8 Endocrine Society has not issued clinical
9 guidelines for the use of restroom facilities for
10 transgender students consistent with their gender
11 identity in schools?
12 A I believe there's a pediatric endocrine
13 statement in support of transgender care, but I
14 don't know if it specifically states restrooms.
15 Q What I'm asking is, in the guidelines
16 that you relied on, you would agree that there is
17 no guideline on the use of a restroom by a
18 transgender student that is consistent with a
19 student's gender identity in school?
20 A Yes, there's no specific reference to
21 "restroom."
22 Q If, as part of the treatment plan for

1 gender dysphoria, a transgender student wants to
2 use the restroom that is consistent with their
3 recognized sex at birth, is that medically
4 appropriate?
5 A Say that again.
6 Q If a transgender student wants to use
7 the restroom that is consistent with their
8 recognized sex at birth, is that medically
9 appropriate?
10 A Yes.
11 Q Are you aware of any studies that show
12 how many transgender students want to use --
13 continue to use the restroom consistent with their
14 recognized sex at birth?
15 A I'm not aware of any studies that have
16 looked at that.
17 Q Are you aware of whether there has been
18 any research or studies into whether transgender
19 students want -- who want to use the restroom
20 consistent with their recognized sex at birth?
21 A I'm not aware of any studies.
22 Q If a transgender student wants to use a

1 single user restroom at school instead of the
2 restroom that is consistent with their gender
3 identity, is that medically appropriate?
4 A If that's the patient's choice, yes.
5 Q Are you aware of whether there have
6 been any studies or research into how many
7 transgender students would prefer to use a single
8 user restroom instead of the restroom that is
9 consistent with their gender identity?
10 A I'm not aware of any studies.
11 Q Are you aware of any scientific or
12 medical research studies into the effect of not
13 permitting a transgender student to use the
14 bathroom consistent with his gender identity in
15 school?
16 A Not specifically looking at the
17 bathroom.
18 Q You would agree that if a student,
19 transgender student, is not permitted to use the
20 bathroom consistent with his gender identity in
21 school, there are other methods of social
22 transition that can be used to help treat that

1 student's gender dysphoria?
2 A There are a number of components that
3 go into the social transition, and what's required
4 is individual for each person.
5 Q Are you aware of any medical research
6 or studies into the effect of implementing a plan
7 of gender-affirming care that allows a transgender
8 student to wear the clothing that he wants, to
9 change his name to be consistent with his gender
10 identity, and to be referred to with pronouns
11 consistent with his gender identity but not be
12 permitted to use a restroom consistent with his
13 gender identity at school?
14 A I don't think that any of the studies
15 have looked at that precise situation. There are
16 studies that have looked at the effect of social
17 transition on transgender health, but I don't know
18 which specific components they addressed.
19 Q Have you ever treated a transgender
20 student that was not permitted to use the restroom
21 that corresponded with the student's gender
22 identity at school?

1 A Yes.
2 Q How many students?
3 A I couldn't estimate. We speak in
4 general, but I don't always discuss specifically
5 what bathrooms they're using.
6 Q And in those students that you treated,
7 was there a continued social transition plan to
8 address gender dysphoria?
9 A Yes.
10 Q In those patients that you were
11 treating, did you see a lessening of the patient's
12 gender dysphoria?
13 A Yes.
14 Q And in those patients, you saw an
15 improvement in their gender dysphoria, correct?
16 A Yes. Most of my patients who have
17 undergone some social transition relate that it
18 leads to some gender dysphoria improvement.
19 Q Are you aware of any objective tests or
20 diagnostic tools that measure the distress in a
21 transgender student who is not able to use the
22 restroom consistent with his gender identity in

1 school?
2 A No.
3 Q Are you aware of any scientific studies
4 or empirical data that measures the impact or
5 effect on gender dysphoria by permitting
6 transgender students to use a single user restroom
7 at school?
8 A No.
9 MR. CAPPS: Can we just take a minute?
10 MR. BLOCK: Yes. Sure.
11 MS. COOPER: Just letting you know I'm
12 going to drop off right now.
13 (A recess was taken.)
14 BY MR. CAPPS: (Continuing)
15 Q So if we look at paragraphs 27 and 28
16 of your report, in these paragraphs, you're
17 outlining your opinions on the use of
18 puberty-blocking hormone treatment; is that
19 correct?
20 A Yes.
21 Q And that's what you do in your
22 practice; is that correct?

1 A Yes. That's one of the components of
2 what I can do.
3 Q And you provide this medical treatment
4 to transgender adolescents in order to address
5 their gender dysphoria; is that correct?
6 A Yes.
7 Q And when you provide the
8 puberty-blocking hormone treatment, do you see an
9 improvement in the transgender adolescent's gender
10 dysphoria?
11 A Yes. In some patients, with pubertal
12 suppression alone, I see improvement in their
13 dysphoria.
14 Q And are there patients that you have
15 treated that you have not seen an improvement in
16 gender dysphoria?
17 A Yes. Some persist with gender
18 dysphoria.
19 Q Have you seen transgender patients
20 whose gender dysphoria did not improve in any
21 measurable way despite all of the medical
22 treatment that was provided to the patient?

1 A I have had patients who continue to
2 have some dysphoria, but in general they have
3 improvements in some way.
4 Q And then in paragraphs 29 and 30 and, I
5 guess, 31, you talk about providing
6 gender-affirming hormone therapy?
7 A Yes.
8 Q And who makes the decision whether
9 that's medically necessary and appropriate?
10 A I discuss with the patient and their
11 guardians and their mental health provider about
12 whether we should proceed with that treatment.
13 Q And what does gender-affirming hormone
14 therapy do, again?
15 A It causes the secondary sex
16 characteristics that align with their gender
17 identity. So it's using testosterone to
18 masculinize the body of a person who identifies as
19 male or using estrogen to feminize the body for a
20 person who identifies as female.
21 Q And is that treatment used to address
22 the gender dysphoria in transgender individuals?

1 A Yes.
2 Q So you use gender-affirming hormones to
3 treat the distress of a transgender adolescent?
4 A Yes.
5 Q In paragraph 33 you also state that,
6 "Under WPATH standards of care, boys and girls who
7 are transgender may also receive medically
8 necessary chest reconstructive surgeries once they
9 turn 16 . . . ."
10 Do you see that?
11 A Yes.
12 Q Does the Endocrine Society have
13 guidelines on chest reconstructive surgery?
14 A Let me review again. I think they have
15 a section on surgery, yes. They have a section on
16 surgery. I don't know specifically --
17 MS. SAFSTROM: Is it all right to share
18 a page number again?
19 MR. CAPPS: Yeah, I think we are
20 looking at the same thing. I'm looking at 3893,
21 but if there was another section --
22 A So there's breast surgery. I don't

1 know if it specifically has an age that they refer
2 to.
3 MS. SAFSTROM: I believe there's some
4 additional information on 3872.
5 A On 3872, 5.5, "We suggest that
6 clinicians delay gender-affirming genital surgery
7 . . . until the patient at least is 18 years," or
8 older." That's for genital.
9 MR. BLOCK: Before you get to the 5.6
10 on that same page.
11 MS. SAFSTROM: 3872.
12 A 3894, "The most important masculinizing
13 for the transgender male is mastectomy . . . ."
14 And then later it says, "Because some transgender
15 male adolescents present after significant breast
16 development has occurred, they may also consider
17 mastectomy 2 years after they begin androgen
18 therapy and before the age of 18." (As read.)
19 Q So the guidelines provide that
20 clinicians should provide individualized treatment
21 in those cases; is that correct?
22 A Yes.

1 Q So what is chest reconstructive
2 surgery?
3 A So, that can either be in transgender
4 males where they have a mastectomy and all the
5 breast issue is removed and reconstructed to
6 appear more masculine, or in transgender females
7 it can include breast augmentation.
8 Q Okay. In the situation where there is
9 a mastectomy for a transgender male, is there --
10 does that procedure create any biological changes
11 in the transgender individual?
12 A It's just physical changes.
13 Q And is that treatment part of a medical
14 treatment plan to address the gender dysphoria or
15 distress associated with gender identity?
16 A It can be, but it is all determined by
17 the individual, whether that's something that they
18 desire.
19 Q And then you state in paragraph 33 that
20 under the WPATH standards of care there can be
21 genital surgery once they reach the age of
22 majority?

1 A Yes.
2 Q What does that mean?
3 A There are genital surgeries that can be
4 performed to make the external genitalia more
5 similar to the gender identity, and then there are
6 surgeries that can remove the internal genitalia,
7 or the gonads, the testes or the ovaries, to
8 prevent production of those hormones.
9 Q And so under the WPATH standards of
10 care, surgical gender reassignment procedures
11 cannot be completed until the transgender
12 individual is at least 18 years of age, correct?
13 A Yes. In general, any surgical
14 procedure that would affect the fertility is held
15 off until 18.
16 Q I assume as part of your practice you
17 don't perform surgery; is that correct?
18 A Yes. I don't.
19 Q So make sure I've got it clear. So if
20 you have -- if a transgender boy has chest
21 reconstructive surgery, they still have the female
22 genitalia in place; is that correct?

1 A Yes.
2 Q I think you told me that in the five
3 years that you've been treating transgender
4 patients you have had some patients reach the age
5 of majority?
6 A Yes.
7 Q And have any of those patients elected
8 to undergo genital surgery?
9 A Yes.
10 Q How many?
11 A I can think of two.
12 Q And did you continue to see them after
13 the surgical genital procedure?
14 A Yes.
15 Q What was your role?
16 A Continuing to provide hormone . . .
17 Q And at that time was the hormone
18 therapy that you provided, providing for gender
19 dysphoria, or was it for some other purpose?
20 A With one of the patients, her gonads
21 were removed; and you, therefore, have to receive
22 sex hormones of some sort to maintain good bone

1 density and health. So it was medically required
2 to provide estrogen.
3 Q What about the other case?
4 A The other case was a transgender male,
5 and -- and I don't recall if he had his ovaries
6 removed, but he was continuing the testosterone to
7 relieve gender dysphoria, because -- in order to
8 continue to have masculinization, and for the
9 masculinization, you need to continue the
10 testosterone.
11 Q What happens if you stop taking
12 testosterone?
13 A Over time, some of the physical changes
14 will slowly revert back to more feminine features,
15 but some of the changes are permanent and would
16 remain.
17 Q Have you seen any studies or research
18 which show that some transgender adolescents
19 return to a gender identity that is consistent
20 with their sex at birth?
21 A There've been case reports, but I'm not
22 aware of any major studies.

1 Q Have you taken those case reports into
2 consideration when you treat transgender
3 individuals?
4 A I've not had any patients that have
5 desisted or seen that in my clinical practice.
6 Q Other than in gender identity issues,
7 are there any other medical diagnoses that use the
8 criteria "persistently, consistently, and
9 insistently" for the medical diagnosis?
10 A Not that I'm aware of.
11 Q Other than in gender identity, are
12 there any other mental health diagnoses that use
13 the criteria "persistently, consistently, and
14 insistently" as a basis to make a mental health
15 diagnosis?
16 A Not that I'm aware of, but I'm not a
17 mental health provider.
18 Q In paragraph 36 of your report, you
19 state that transgender youth are at a high risk --
20 are a high risk population, with increased risk
21 for poor mental health outcomes, including
22 suicide. Do you see that?

1 A Yes.
2 Q What is your basis for that opinion?
3 A There are multiple studies looking at
4 mental health in adolescents. And in the LGBTQ
5 population, there is increased risk for those, and
6 there have been studies that have stated the
7 increased prevalence of suicide in transgender
8 youth.
9 Q Do you know whether the suicide rate in
10 transgender youth is greater or less than that in
11 autistic youth?
12 A I'm not sure.
13 Q Are there any studies that separate the
14 suicide rate in transgender individuals from the
15 underlying mental health conditions --
16 MR. BLOCK: Objection.
17 Q -- sorry -- that the individual may
18 suffer from?
19 A Not that I'm aware of. There are
20 studies looking at transgender youth who have
21 undergone transition, and their degree of mental
22 health disorders are decreased back to their

1 peer-adjusted -- similar to their peers, their
2 non-transgender peers.
3 Q This is kind of an inarticulate
4 question, I guess. But what I'm wondering is, is
5 there a way to determine whether a transgender
6 individual committed suicide because of gender
7 dysphoria versus maybe bipolar disorder?
8 A I don't know if any of them
9 specifically look at the other conditions.
10 Q That's what I mean. Is there any way
11 to determine whether a suicide that was committed
12 by a transgender individual was related to the
13 gender dysphoria versus depression or bipolar or
14 some other underlying mental health condition?
15 MR. BLOCK: Are you asking for the
16 individual or for the population studies?
17 MR. CAPPS: Population studies.
18 A I'm not aware of specific studies on
19 that.
20 Q In paragraph 39 of your report -- in
21 paragraph 39 of your report, you state that some
22 students, particularly those who are early in

1 transition, "feel safer and more comfortable using
2 a private restroom, forcing transgender students
3 to do so can be harmful to their well-being by
4 calling them out as different or rejecting their
5 gender."
6 What do you base that opinion on?
7 A I have patients who, they don't want to
8 be seen as the transgender boy or the transgender
9 girl. They just want to be seen as a boy or a
10 girl. And so if they had to go to their own
11 special restroom, that just is another way of kind
12 of saying that they aren't a boy or not completely
13 affirming their gender identity.
14 Q Are there any studies that show that it
15 can be harmful to their well-being that you're
16 aware of?
17 A Just the studies that have shown that
18 there's improvement in well-being if socially
19 supported and with full support and full
20 affirmation of their gender.
21 Q And so "full affirmation" means if the
22 student wants to use the restroom, then the

1 medical treatment plan is the student should use
2 the restroom?
3 A The studies, I don't think, have
4 specifically looked at the restroom, but in
5 general, fully affirming the patient's identity
6 and supporting it.
7 (Penn Deposition Exhibit 2 was marked
8 for identification and is attached.)
9 Q Let me show you Exhibit 2 to your
10 deposition. So Exhibit 2 is your rebuttal report
11 that you submitted; is that correct?
12 A Yes.
13 Q All right. And you state that the
14 American College of Pediatricians is a fringe
15 organization?
16 A Yes.
17 Q And on what basis do you state that?
18 A It's a small medical society that
19 generally disagrees with the mainstream pediatric
20 and the Academy -- American Academy of Pediatrics'
21 beliefs.
22 Q And do you know what the criteria is

1 for being a member in the American College of
2 Pediatricians?
3 A No.
4 Q Have you reviewed any research studies
5 for articles published by the American College of
6 Pediatricians?
7 A I've seen some of their statements
8 before, but I don't know -- I can't recall the
9 specific -- or any specific studies that I've seen
10 of theirs.
11 Q Have you reviewed any publications by
12 Dr. Van Meter?
13 A I recently saw a letter to the editor
14 that he had published.
15 Q And did you look at the underlying data
16 to that letter, the underlying citations that were
17 in the letter to the editor?
18 A No.
19 Q Have you taken into consideration any
20 of Dr. Van Meter's publications in the treatment
21 of transgender adolescents?
22 A No, none of his specific publications

1 that I'm aware of.
2 Q Are you aware of whether WPATH
3 advocated for the American Psychiatric Association
4 to eliminate a gender dysphoria diagnosis in
5 DSM-V?
6 A No.
7 Q You're not aware of whether that
8 occurred or not?
9 A No.
10 Q You're aware that the Endocrine Society
11 revised its guidelines in 2017; is that correct?
12 A Yes.
13 Q Did the revisions in 2017 from the
14 original 2009 guidelines change the manner in
15 which you provided medical treatment to
16 transgender adolescents?
17 A No. The practice didn't change very
18 much. There were some lessened restrictions about
19 laboratory follow-up, but my practice hasn't
20 changed.
21 Q And do you know whether the revised
22 2017 guidelines added to or changed the social

1 transition guidelines from 2009 -- strike that.
2 Maybe I could ask this: Were there
3 social transition guidelines in the 2009 version
4 of the Endocrine Society guidelines?
5 A I think there was a brief mention of
6 it, but I don't remember the specifics of it, no.
7 Q So would it be true that the 2017
8 revised guidelines are different as it relates to
9 social transition for transgender individuals?
10 A I don't think that they significantly
11 differ. It was in general that the social
12 transition should be individual and supported
13 the -- necessary for that individual.
14 MR. CAPPS: One second. I'm going to
15 look through my notes.
16 Dr. Penn, thank you very much. Those
17 are all the questions I have. I appreciate your
18 patience.
19 MR. BLOCK: We don't have any questions
20 either, and she'll review her transcript.
21 MR. CAPPS: I want to order expedited
22 if I can.

1 THE COURT REPORTER: How expedited?
2 MR. CAPPS: As expedited as your
3 schedule allows.
4 (A discussion was held off the record.)
5 THE COURT REPORTER: Expedited as well?
6 MR. BLOCK: Yes.
7 AND FURTHER THIS WITNESS SAITH NOT
8 (Off the record at 1:04 p.m.)
9
10
11
12
13
14
15
16
17
18
19
20
21
22

1 COMMONWEALTH OF VIRGINIA,
2 ______________________________, to wit:
3
4 I, Melinda Penn, M.D., do hereby certify
5 that I have read the foregoing pages of typewritten
6 matter numbered 1 through 90, and that the same
7 contains a true and correct transcription of the
8 deposition given by me on the 14th day of March,
9 2019, with the exception of the noted corrections,
10 to the best of my knowledge and belief.
11
12 ________________________ ________________________
13 Date Melinda Penn, M.D.
14
15
16 Subscribed and sworn to before me this
17 _____ day of ___________________________, 201__.
18
19 _______________________
20 Notary Public
21 My commission expires __________________
22 Notary Registration Number: ____________

1 CERTIFICATE OF SHORTHAND REPORTER - NOTARY PUBLIC
2 I, Helen B. Yarbrough, Registered
3 Professional Reporter, Certified Court Reporter,
4 and Notary Public, the officer before whom the
5 foregoing deposition was taken, do hereby certify
6 that the foregoing transcript is a true and
7 correct record of the testimony given, to the best
8 of my ability; that said testimony was taken by me
9 stenographically and thereafter reduced to
10 typewriting under my supervision; that reading and
11 signing was requested; and that I am neither
12 counsel for, nor related to, nor employed by any
13 of the parties to this case and have no interest,
14 financial or otherwise, in its outcome.
15 IN WITNESS WHEREOF, I have hereunto set my
16 hand and affixed my notarial seal this 17th day of
17 March 2019.
18
19
Helen B. Yarbrough, RPR, CCR
20 VCRA Certification #0313016
21 My Commission Expires:
July 31, 2021
22 Notary Registration Number: 158897

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

FIFTH EDITION

DSM-5®

EXHIBIT
L

AMERICAN PSYCHIATRIC ASSOCIATION

Gender Dysphoria

In this chapter, there is one overarching diagnosis of gender dysphoria, with separate developmentally appropriate criteria sets for children and for adolescents and adults. The area of sex and gender is highly controversial and has led to a proliferation of terms whose meanings vary over time and within and between disciplines. An additional source of confusion is that in English "sex" connotes both male/female and sexuality. This chapter employs constructs and terms as they are widely used by clinicians from various disciplines with specialization in this area. In this chapter, *sex* and *sexual* refer to the biological indicators of male and female (understood in the context of reproductive capacity), such as in sex chromosomes, gonads, sex hormones, and nonambiguous internal and external genitalia. Disorders of sex development denote conditions of inborn somatic deviations of the reproductive tract from the norm and/or discrepancies among the biological indicators of male and female. *Cross-sex* hormone treatment denotes the use of feminizing hormones in an individual assigned male at birth based on traditional biological indicators or the use of masculinizing hormones in an individual assigned female at birth.

The need to introduce the term *gender* arose with the realization that for individuals with conflicting or ambiguous biological indicators of sex (i.e., "intersex"), the lived role in society and/or the identification as male or female could not be uniformly associated with or predicted from the biological indicators and, later, that some individuals develop an identity as female or male at variance with their uniform set of classical biological indicators. Thus, *gender* is used to denote the public (and usually legally recognized) lived role as boy or girl, man or woman, but, in contrast to certain social constructionist theories, biological factors are seen as contributing, in interaction with social and psychological factors, to gender development. *Gender assignment* refers to the initial assignment as male or female. This occurs usually at birth and, thereby, yields the "natal gender." *Gender-atypical* refers to somatic features or behaviors that are not typical (in a statistical sense) of individuals with the same assigned gender in a given society and historical era; for behavior, *gender-nonconforming* is an alternative descriptive term. *Gender reassignment* denotes an official (and usually legal) change of gender. *Gender identity* is a category of social identity and refers to an individual's identification as male, female, or, occasionally, some category other than male or female. *Gender dysphoria* as a general descriptive term refers to an individual's affective/cognitive discontent with the assigned gender but is more specifically defined when used as a diagnostic category. *Transgender* refers to the broad spectrum of individuals who transiently or persistently identify with a gender different from their natal gender. *Transsexual* denotes an individual who seeks, or has undergone, a social transition from male to female or female to male, which in many, but not all, cases also involves a somatic transition by cross-sex hormone treatment and genital surgery (*sex reassignment surgery*).

Gender dysphoria refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. Although not all individuals will experience distress as a result of such incongruence, many are distressed if the desired physical interventions by means of hormones and/or surgery are not available. The current term is more descriptive than the previous DSM-IV term *gender identity disorder* and focuses on dysphoria as the clinical problem, not identity per se.

USCA4 Appeal: 19-1952 Doc: 20-3 Filed: 10/22/2019 Pg: 371 of 449
Case 4:15-cv-00054-AWA-RJK Document 201-5 Filed 04/09/19 Page 1 of 1 PageID# 3098
Total Pages:(1150 of 1263)

Gender Dysphoria

Diagnostic Criteria

Gender Dysphoria in Children **302.6 (F64.2)**

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least six of the following (one of which must be Criterion A1):
   1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
   2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
   3. A strong preference for cross-gender roles in make-believe play or fantasy play.
   4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
   5. A strong preference for playmates of the other gender.
   6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
   7. A strong dislike of one's sexual anatomy.
   8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

B. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

Specify if:

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as 255.2 [E25.0] congenital adrenal hyperplasia or 259.50 [E34.50] androgen insensitivity syndrome).

Coding note: Code the disorder of sex development as well as gender dysphoria.

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

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:
   1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
   2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
   3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
   4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
   5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
   6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as 255.2 [E25.0] congenital adrenal hyperplasia or 259.50 [E34.50] androgen insensitivity syndrome).

Coding note: Code the disorder of sex development as well as gender dysphoria.

Specify if:

Posttransition: The individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen—namely, regular cross-sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in a natal male; mastectomy or phalloplasty in a natal female).

Specifiers

The posttransition specifier may be used in the context of continuing treatment procedures that serve to support the new gender assignment.

Diagnostic Features

Individuals with gender dysphoria have a marked incongruence between the gender they have been assigned to (usually at birth, referred to as *natal gender*) and their experienced/expressed gender. This discrepancy is the core component of the diagnosis. There must also be evidence of distress about this incongruence. Experienced gender may include alternative gender identities beyond binary stereotypes. Consequently, the distress is not limited to a desire to simply be of the other gender, but may include a desire to be of an alternative gender, provided that it differs from the individual's assigned gender.

Gender dysphoria manifests itself differently in different age groups. Prepubertal natal girls with gender dysphoria may express the wish to be a boy, assert they are a boy, or assert they will grow up to be a man. They prefer boys' clothing and hairstyles, are often perceived by strangers as boys, and may ask to be called by a boy's name. Usually, they display intense negative reactions to parental attempts to have them wear dresses or other feminine attire. Some may refuse to attend school or social events where such clothes are required. These girls may demonstrate marked cross-gender identification in role-playing, dreams, and fantasies. Contact sports, rough-and-tumble play, traditional boyhood games, and boys as playmates are most often preferred. They show little interest in stereotypically feminine toys (e.g., dolls) or activities (e.g., feminine dress-up or role-play). Occasionally, they refuse to urinate in a sitting position. Some natal girls may express a desire to have a penis or claim to have a penis or that they will grow one when older. They may also state that they do not want to develop breasts or menstruate.

Prepubertal natal boys with gender dysphoria may express the wish to be a girl or assert they are a girl or that they will grow up to be a woman. They have a preference for dressing in girls' or women's clothes or may improvise clothing from available materials (e.g., using towels, aprons, and scarves for long hair or skirts). These children may role-play female figures (e.g., playing "mother") and often are intensely interested in female fantasy figures. Traditional feminine activities, stereotypical games, and pastimes (e.g., "playing house"; drawing feminine pictures; watching television or videos of favorite female characters) are most often preferred. Stereotypical female-type dolls (e.g., Barbie) are often favorite toys, and girls are their preferred playmates. They avoid rough-and-tumble play and competitive sports and have little interest in stereotypically masculine toys (e.g., cars, trucks). Some may pretend not to have a penis and insist on sitting to urinate. More

From: "Amy Bergh" <abergh@gc.k12.va.us>
Date: October 28, 2014 7:18:05 PM
To: "Nate Collins" <ncollins@gc.k12.va.us>
Subject: **Gavin and** REDACTED

Attachments:

Today at the end of B4 Gavin Grimm and REDACTED stood up and began yelling at each other across their tables. They were mutually clearly ready to physically fight. As near as I could tell it had something to do with Gavin using the boys restroom today. Both students were visibly upset and cursing at each other stating they didn't have to put up with this "fucking shit" and other similar comments. I don't remember exact comments but something to the effect that REDACTED didn't believe that Gavin should use the boys room because he we a girl and Gavin stating that he didn't have to put up with people saying negative things. They were equal partners in escalating the situation.

I yelled at them to stop several times and then sent Gavin to Clark Barkley's class to wait for me and took REDACTED to my office hallway.

I asked REDACTED what had happened. He stated that he had anger issues. He said something to the effect that he had asked Gavin's brother about seeing his sister going into the boys restroom. REDACTED swore he did not know that Gavin was transgender.

I then asked Gavin what had happened and Gavin said that REDACTED knew all about it and was just saying things to upset him.

Other students sitting around them include:
REDACTED – NJROTC student and probably reliable
REDACTED –
REDACTED – Probably reliable
REDACTED –
REDACTED – NOT reliable

-Amy Bergh

1 IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
2 Newport News Division

3

4

GAVIN GRIMM,
5
Plaintiff, CIVIL ACTION NO.
6 4:15cv54
v.
7
GLOUCESTER COUNTY SCHOOL
8 BOARD, et al.,

9 Defendants.

10

11
TRANSCRIPT OF PROCEEDINGS
12
Norfolk, Virginia
13
July 23, 2019
14

15
BEFORE: THE HONORABLE ARENDA WRIGHT ALLEN
16 United States District Judge

17

18
APPEARANCES:
19
AMERICAN CIVIL LIBERTIES UNION OF VIRGINIA
20 By: Nicole G. Tortoriello
Eden B. Heilman
21 Jennifer M. Safstrom
Joshua A. Block
22 Shayna Medley-Warsoff
Counsel for the Plaintiff
23
HARMON CLAYTOR CORRIGAN & WELLMAN
24 By: David P. Corrigan
Jeremy D. Capps
25 Counsel for Gloucester County School Board

1 (Hearing commenced at 9:04 a.m.)
2 THE CLERK: Gavin Grimm versus Gloucester County
3 School Board, civil case number 4:15cv54.
4 Mr. Block, is the plaintiff ready to proceed?
5 MR. BLOCK: Yes.
6 THE CLERK: Mr. Corrigan and Mr. Capps, is the
7 defendant ready to proceed?
8 MR. CORRIGAN: Yes, we are.
9 THE COURT: All right. Gentlemen, it's good to see
10 you all.
11 Mr. Block, if you can please introduce your team to
12 the Court, I'd appreciate it.
13 MR. BLOCK: Sure. My name is Joshua Block. I
14 represent Gavin Grimm from the ACLU. This is Mr. Grimm with
15 us today. This is my co-counsel, Shayna Medley.
16 THE COURT: Good to meet you.
17 MR. BLOCK: This is my co-counsel, Eden Heilman.
18 THE COURT: Good to meet you, as well.
19 MR. BLOCK: And Jennifer Safstrom and Nicole
20 Tortoriello.
21 THE COURT: It's good to meet you all. Thank you
22 for being here.
23 Then Mr. Corrigan, is it?
24 MR. CORRIGAN: Yes, ma'am.
25 THE COURT: That's mister, who is with you?

1 MR. CORRIGAN: Mr. Jeremy Capps.
2 THE COURT: Mr. Capps, it's good to meet you, as
3 well.
4 MR. CAPPS: Yes, ma'am. Thank you.
5 THE COURT: All right. We are here on the
6 cross-motions for summary judgment and a motion to strike,
7 and as I think we e-mailed you guys regarding the motion to
8 strike, I'd like to take that up first. I'm going to give
9 the Board first 10 minutes, and then Mr. Grimm 10 minutes
10 thereafter.
11 Then regarding the two summary judgments, we did
12 want to take up the Title IX first, and then the equal
13 protection clause. We are going to start with the
14 plaintiff, 30 minutes; defendant, 30 minutes; plaintiff
15 rebuttal; and then defendant rebuttal. So that's the order
16 that I'd like to hear the argument.
17 All right. So we can start with the motion to
18 strike.
19 MR. CORRIGAN: Your Honor, David Corrigan on behalf
20 of the Gloucester County School Board. We filed the motion
21 to strike and exclude certain exhibits because the exhibits
22 do not comply with the Court's order or Rule 26 or otherwise
23 improper.
24 There are four categories of exhibits or evidence
25 we seek to exclude: First, the business records of Dr. Lisa

1 Griffin, Dr. Hope Sherie, and Dr. Melinda Penn; second, the
2 To Whom It May Concern, the treatment documentation letter,
3 the hormone recommendation letter from Dr. Griffin, as well
4 as To Whom It May Concern letter from Dr. Sherie, and a
5 letter from Eva Abel; third, the WPATH standards of care,
6 the Endocrine Society guidelines, the amicus briefs and all
7 policy statements; and, fourth, the statements made in
8 February 2019 at a public hearing by counsel for the
9 Gloucester County School Board. These issues have been
10 thoroughly briefed, and we rely on that briefing, and I will
11 just hit the highlights.
12 Dr. Penn was disclosed to offer opinions on the
13 standard of care for treating individuals with gender
14 dysphoria. She did not give testimony or have her expert
15 report specifically related to this plaintiff. No expert
16 was timely disclosed, offer opinions regarding the
17 plaintiff's diagnosis or treatment or causation or
18 prognosis.
19 Rule 803(6) permits medical records to be
20 introduced but does not absolve a party of obligation to
21 comply with Rule 26(a)(2)(C), which is the rule regarding
22 testifying experts in which this Court has an order in place
23 which says you must identify your testifying experts by a
24 certain date, and that was done with respect to Dr. Penn
25 doing -- with respect to her general opinions about the

1 treatment but not specific to Mr. Grimm, and there was no
2 introduction of any testifying reports for any of the other
3 people that we've mentioned.
4 The diagnosis of gender dysphoria is an opinion and
5 so are the testimony about the treatments medically
6 necessary to treat the condition and the causation of any
7 damages specific to the use of restroom use. None of this
8 has been provided by the plaintiff with respect to a
9 testifying expert in a timely fashion.
10 Rule 902(11) requires the proponent of records to
11 provide written notice of the intent to offer a record.
12 That also was not done here, another basis for excluding the
13 testimony. Neither Dr. Griffin nor Dr. Sherie was
14 identified as an expert or as a healthcare provider who
15 would provide expert testimony; therefore, they should not
16 be allowed to offer any opinions, and their record should
17 not be introduced as evidence of expert opinions. That's on
18 diagnosis, medical necessity, causation, prognosis.
19 The records of Dr. Griffin and Dr. Sherie are also
20 not admissible because the letters addressed To Whom It May
21 Concern are not records prepared for regular business
22 purposes. We cite cases for this concept, the idea being in
23 physicians' records, you see insurance information and notes
24 taken during a visit and things of that nature. But these
25 types of To Whom It May Concern letters are not regularly

1 prepared for business purposes, and the cases say that they,
2 therefore, should not be allowed. That's a back-up reason.
3 That's not the primary reason they should not be allowed.
4 The primary reason is what we have previously said about
5 Rule 26.
6 The WPATH and Endocrine Society guidelines are not
7 admissible as substantive evidence in this case. They are
8 purely hearsay opinions. Not even Dr. Penn can make them
9 admissible because she, like all other experts, cannot
10 testify to others' opinions. As in every case, she can
11 testify to what her opinions are, and she can say I relied
12 on WPATH, Endocrine, and other things, but she can't say
13 what those things say. So those guidelines are not
14 admissible and cannot be made admissible even by Dr. Penn.
15 With respect to the settlement-related statements,
16 which is the fourth category, there was a February 2019
17 school board meeting. It was held after settlement
18 conference with Judge Doug Miller. Plaintiff and
19 plaintiff's counsel agreed to the process, including having
20 a public hearing as part of that process. At the hearing I
21 was the speaker, and I introduced the topic of what we were
22 going to be talking about. It was all said in the interest
23 of attempting to resolve the case, and nothing said was
24 intended to be binding in terms of the substantive of the
25 case, and the Gloucester County School Board itself did not

1 speak or vote.
2 To consider the 2019 statements in that hearing,
3 when discussing events related to what happened back in
4 2014, '15 and '16 is simply not relevant, and, more
5 importantly, to consider this effort to resolve the case
6 when determining the merits violates the purpose and spirit
7 of Rule 408 which calls for things that are related to
8 settlement not to be used against a party who is having a
9 conversation about settlement.
10 So those are all the reasons that we would ask that
11 the Court exclude the evidence. Thank you.
12 THE COURT: All right. Now, how is the statement,
13 "I diagnosed Grimm with gender dysphoria" an expert opinion?
14 MR. CORRIGAN: Pardon?
15 THE COURT: How is the statement, "I diagnosed
16 Grimm with gender dysphoria" an expert opinion? You don't
17 have to agree with the wisdom of the diagnosis but isn't
18 that a statement of fact?
19 MR. CORRIGAN: No, ma'am. It's a statement of
20 opinion. Whether someone has that condition or not is not
21 something that the normal lay person can testify to. It has
22 to be something that someone with expertise to do that. So
23 that would be an opinion, not a statement of fact. To say
24 that he has identified as male, that he has claimed -- his
25 statement is that my gender identity is male, they can say

1 that, but that doesn't make it a diagnosis, and the
2 diagnosis is what is not present in the record.
3 THE COURT: Were the statements made at this public
4 meeting following the settlement conference really
5 statements made "during a compromise negotiation"?
6 MR. CORRIGAN: To say it was during a compromise
7 negotiation would be not entirely accurate. It was in the
8 context. As I said, the parties had agreed that the next
9 step was going to be this public hearing, and in order for
10 the proposal that was on the table to be brought forward, it
11 needed to be introduced. So it was in that context, but I
12 wouldn't say it met that specific definition.
13 THE COURT: Your answer is no?
14 MR. CORRIGAN: Not in that context, no.
15 THE COURT: All right, sir. Thank you very much.
16 Mr. Block, I'd like to hear from you, please.
17 MR. BLOCK: Thank you, Your Honor. The Board's
18 motion to strike is all built around this flawed premise
19 that we are using Gavin's medical records to show that it
20 was medically necessary for him to use the boy's restroom at
21 school. That is not something we have to prove, and that's
22 not something we are trying to prove here.
23 All we are trying to do is document as a historical
24 fact that the following four events occurred: Dr. Griffin
25 diagnosed him with gender dysphoria. She gave him the

1 treatment documentation letter that's attached to his
2 declaration. He had hormone therapy, and he had chest
3 reconstruction surgery. These are statements of historical
4 fact, not statements of expert opinion, and the reason why
5 they are relevant has nothing to do with us proving it was
6 medically necessary for him to use the restroom.
7 They are relevant for two reasons: The first is to
8 respond to the Board's continued attempt to mischaracterize
9 Gavin's claims as seeking to use the restrooms based solely
10 on a self-declaration or gender identity. That's not true,
11 and the Board knows that's not true. The Board admits that
12 it received the treatment documentation letter from Gavin.
13 Gavin didn't forge that letter.
14 The business records confirm that Dr. Griffin wrote
15 it to him, and, therefore, he was seeking to use the
16 restroom based not just on him strolling into the office and
17 saying I want to use the boy's restroom. He had this
18 documentation.
19 Whether the Board agrees or disagrees with the
20 expert opinions in that documentation, we are simply
21 establishing that this isn't just based on evaluation of one
22 person's subjective claims of having a particular gender
23 identity. The hormone therapy and surgery are relevant in
24 order to respond to the Board's arguments that it assigned
25 students to restrooms based on physiological sex

1 characteristics.
2 As a result of hormone therapy and surgery, Gavin
3 has physiological and anatomical characteristics that align
4 with his gender identity and not the sex assigned to him at
5 birth. So if the Board isn't objecting to those four facts,
6 then there is no reason to look at the medical records at
7 all. We are not seeking to introduce them for any other
8 purpose.
9 In fact, in reviewing the Board's answer, the Board
10 actually admits in its answer that Gavin received a
11 document that's -- yeah, that Gavin received a document
12 entitled "Treatment documentation letter." So I think these
13 are really just uncontroversial facts that we are not trying
14 to use them for the reasons the Board is saying we are
15 trying to use them.
16 To respond to some of the subsidiary points that we
17 just heard, Rule 902(11), about giving notice of business
18 records, my understanding is that's a notice before trial,
19 not for purposes of a summary judgment hearing. And then
20 even if we were wrong that these are records of statements
21 of fact, not opinion, the Board's argument that business
22 records under 803(6) have to be evaluated pursuant to 702
23 for expert opinion, and then disclosed as expert testifying
24 witnesses, they've identified one case saying that but
25 that's very much the minority opinion.

1 The majority opinion is that these documents are
2 evaluated for overall trustworthiness, and if they are
3 overall trustworthy, you don't perform a second analysis.
4 That makes sense because the disclosure requirements talk
5 about testifying experts, and 803(6) business records are
6 records that are produced regardless of whether the
7 declarant is available to testify or not.
8 No one is being presented, besides Dr. Penn, for
9 purposes of talking about the standards of care to provide
10 expert testimony. And then the last thing I'd say is in our
11 disclosures, we do disclose as fact witnesses all four of
12 these witnesses, and we say they have information regarding
13 his diagnosis.
14 So the fact that we consider his diagnosis to be a
15 statement of fact opinion, and it is in our disclosures, I
16 don't think there is any unfair surprise here. With respect
17 To Who It May Concern letters not being trustworthy, the
18 cases Mr. Corrigan cites are cases in which To Whom It May
19 Concern letter was written subsequent to treatment at some
20 later date for purpose of use in the litigation.
21 That's not what happened here. This is contemp --
22 excuse me, at the same time that Dr. Griffin is treating
23 Gavin, she is writing referral letters for hormone therapy,
24 she's writing a carry letter for school. This is like a
25 prescription. These aren't *post hoc* letters To Whom It May

1 Concern.
2 With respect to the WPATH standards and the
3 Endocrine Society guidelines, Dr. Penn includes them as
4 attachments to her expert testimony. She is testifying
5 about the standards of care that pediatricians in the field
6 follow that are endorsed by the American Academy of
7 Pediatrics. Again, it's an uncontested fact that these are
8 the standards that the American Academy of Pediatrics
9 follows. The Board's expert witness disagrees with those
10 standards, but the fact that these are the standards is just
11 an admitted fact.
12 And then with respect to the remaining *amicus*
13 briefs, we have simply attached them for the Court's
14 convenience in an attorney declaration. We are not
15 submitting them into evidence. They are just available for
16 reference as the medical views of these organizations. Once
17 again, whether or not the Board agrees with those
18 organizations' views, the fact is that these are those
19 organizations' views and that there are children across
20 Virginia being treated in accordance with those protocols.
21 With regard to statements at the council meet at
22 the hearing, there is no requirement that they had this
23 public hearing. They could have agreed to any settlement
24 agreement without going through that process. Ultimately, I
25 don't think it's ultimately necessary to rule in our favor,

1 that I think on its face the policy violates Title IX and is
2 insubstantially related to an important governmental
3 interest.
4 If, however, we have to establish as a disputed
5 fact that the Board's stated rationales are pretext, then I
6 think they would be relevant at that stage. But in order
7 for the Court to grant summary judgment in our favor, I
8 don't think the Court has to consider it.
9 THE COURT: All right. Now, the first full
10 paragraph of your second amended complaint states that
11 Mr. Grimm's medical providers assisted him in transitioning
12 "to living in accordance with his male identity as part of
13 medically necessary treatment for gender dysphoria."
14 So my question is, are you or are you not asserting
15 that Mr. Grimm's use of the boy's restroom was medically
16 necessary?
17 MR. BLOCK: Well, we are asserting a couple of
18 things. We are asserting that it was prescribed as his
19 medically necessary treatment plan, but we are not
20 asserting, you know, for the Court to find as a matter of
21 fact that it was medically necessary.
22 THE COURT: All right. Thank you, Mr. Block.
23 Now if we could start with the Title IX, and we
24 will hear from you. You have 20 to 30 minutes.
25 MR. BLOCK: Sure. Thank you, Your Honor. The

1 Court has already decided the fundamental legal questions in
2 this case, and all that's left is to apply those legal
3 principles to the undisputed summary judgment record. And
4 although the Board says it disputes a lot of things, almost
5 all of its disputes are legal disputes or objections to
6 admissibility that are resolved by this Court, not by a
7 finder of fact.
8 The Board doesn't actually produce any independent
9 evidence from which a finder of fact could rule in its favor
10 or contradict Gavin's testimony. The elements of a Title IX
11 claim are that Gavin was at an educational program receiving
12 federal financial assistance, that he was discriminated
13 against on the basis of sex, and that he experienced harm.
14 The Board concedes it receives federal financial
15 assistance, and this Court already ruled as a matter of law
16 that a policy prohibiting transgender students from using
17 restrooms that align with their gender identity
18 discriminates against them on the basis of sex.
19 So the only factual question here is did Gavin
20 suffer harm, and we have identified two forms of harm here:
21 The first is the humiliation and stigma of having to use a
22 restroom that is different from everyone else, and the
23 second is the physical pain and discomfort of not being able
24 to go to the bathroom when he needed to.
25 Now, those harms are detailed in excruciating

1 detail in his declaration. The Board hasn't presented any
2 evidence to contradict them. In fact, the school principal
3 testified that he could understand why Gavin felt that way.
4 The Board does quibble with Gavin's competence to diagnose
5 himself as having a UTI. I think it's the experience of a
6 lot of people with a female sex assigned at birth, that they
7 know when they have a UTI, and they don't need a doctor to
8 tell them.
9 But even if we put that issue aside, the physical
10 pain and discomfort of feeling like his bladder is going to
11 burst is more than sufficient here. The Board's main
12 argument is it's not enough that he felt humiliated, it's
13 not enough that he felt that his bladder was going to burst,
14 Gavin needs to provide expert testimony saying that it was
15 medically necessary for him to use the restroom and that the
16 exclusion interfered with his medically necessary treatment.
17 That certainly would be an additional type of harm,
18 but it is just not the harm we are relying on for our
19 claims. This isn't a case seeking hundreds of thousands of
20 dollars in damages for acute psychiatric pain from
21 interfering with his medical treatment. That is a case we
22 could have pursued but decided not to.
23 So this is narrowly tailored to just be a case
24 about the humiliation and stigma and the physical harm, and
25 those injuries are more than sufficient to establish a Title

1 IX violation, and our request for nominal damages is a
2 perfect remedy for that where harm has been experienced but
3 it's difficult to prove.
4 I don't have any further things to offer unless the
5 Court has questions.
6 THE COURT: Hold on for one second, sir.
7 What is the impact of the distance of the restrooms
8 from the places where his classes were located? I've never
9 been there so help me see what he had to experience when he
10 was in class and then thereafter had to go to the bathroom
11 and then thereafter return back to class so he could be
12 there timely?
13 MR. BLOCK: Yeah, absolutely, Your Honor. To be
14 clear, you know, we do think that the stigma of having to
15 use separate facilities is by itself enough to constitute a
16 Title IX violation, but in addition to that, we've attached
17 as exhibits to the summary judgment motion a map of the
18 school that the locations to the restrooms are notated there
19 and that hasn't been disputed by the School Board.
20 The way that the high school is set up is there is
21 four halls, A hall, B hall, C hall, D hall with the
22 cafeteria near the center. Now, every single one of those
23 halls, A, B, C, and D, all have a common boy's room, a
24 common girl's room and a faculty restroom. But there is no
25 single use or restroom available on B hall, C hall or D

1 hall. The nurse's office is in A hall, and one of the
2 single user restrooms is located very close to the nurse's
3 office. And then the two other restrooms are located in the
4 cafeteria area near the center of the building.
5 So we know not just from looking at the map that
6 that is inconvenient to access, but we actually have
7 complaints from faculty at Gloucester High School who were
8 on C hall where when the school initially considered using
9 one of the faculty restrooms in C hall and changing it into
10 a single user restroom, the faculty complained, and they
11 said we don't have time to use the bathroom if it's not
12 located on C hall between classes. They said we'd have to
13 avoid using the restroom for several hours a day, and that's
14 very difficult for anyone to do without concentrating.
15 Of course, when we asked the school principal,
16 well, wouldn't those same concerns apply to Gavin, and he
17 said, yes, they would. The difference is when a teacher has
18 to use the bathroom, the whole class misses class, but when
19 one person has to use the bathroom, only that one person has
20 to miss class.
21 That's an inappropriate answer for a school
22 principal who has to juggle those competing interests, but
23 it doesn't change the fact that by preventing Gavin from
24 using the boy's restroom on B hall, C hall and D hall, they
25 were forcing him to take a significant break from his

1 classes.
2 We also have Gavin's testimony about one time when
3 a teacher actually humiliated him in front of class, saying
4 what took so long for you to use the bathroom? Then, of
5 course, in addition to all of that, at football games there
6 weren't any single user restrooms available at all.
7 So when Gavin had to use the restroom, he had to be
8 picking up and driven him or taken to Lowe's down the street
9 to use the toilet. Now, the Board has said, well, this
10 doesn't matter because Gavin said he wouldn't use those
11 single user restrooms anyway, but it absolutely does matter.
12 First of all, it confirms that the nurse's office
13 is a significant distance from the rest of the school. But
14 the second is, you know, the Board is proposing these
15 restrooms as an alternative solution, and I think in this
16 Court's opinion it said it is insufficient for two reasons;
17 one is the stigma and the other is the distance. And so
18 distance isn't necessary for us to win but is an additional
19 reason why we should win here.
20 THE COURT: And it's true that he was told that he
21 would be disciplined if he ever used the boy's bathroom?
22 MR. BLOCK: Yes. Yes. Of course, we have the
23 official letter that Principal Collins wrote to him after
24 the fact. I think, you know, the facts in this case are
25 really extraordinary in that this is someone who did

1 everything right, went through all the steps, met with
2 counselors before school when he wanted to use the boy's
3 restroom, set up another meeting with the principal.
4 The principal, you know, went through all the steps
5 of checking with the superintendent, checking with the
6 Virginia -- I forget the name of the organization -- and
7 they checked with -- it's even disclosed through one of the
8 e-mails that they checked with council and allowed Gavin to
9 use the restroom.
10 Now, this might be bleeding over a little bit into
11 the equal protection claim, but, you know, I think the only
12 evidence in the record of any, you know, problems with him
13 using the restrooms are the fact that the Board received
14 complaints from parents, which are in their disclosures, and
15 we don't dispute that those exist, and that one student
16 complained in person to the principal and expressed
17 discomfort with using a restroom with someone who is
18 transgender.
19 THE COURT: Then I think there was another student
20 that asked Mr. Grimm whether or not Mr. Grimm liked his
21 socks.
22 MR. BLOCK: Yes. That was -- I didn't view that as
23 a -- that is the only interaction where --
24 THE COURT: There was seven weeks of using the
25 male's bathroom and no incidents other than the sock

1 incident in which the parents got on board and one other
2 student went to the principal.
3 MR. BLOCK: Right. There is -- I don't think this
4 is actually necessarily admissible, but there was argument
5 in one of the classrooms where a student was calling Gavin
6 freaky and disgusting and they got into a yelling match.
7 The information about that is in an e-mail from a
8 faculty member, and they haven't produced a witness. It is
9 hearsay, but, in any event, it wasn't about an actual
10 incident encountering Gavin in the restroom at all.
11 Also, the student complaint or the student
12 expression of discomfort was at the very beginning before
13 the added privacy protections were installed. Would the
14 Court like me to talk about --
15 THE COURT: I have another question for you. If
16 the single-stall restrooms were plentiful and closer to the
17 classrooms, would this case be different?
18 MR. BLOCK: Well, I think then we would have one
19 grounds for winning, which would be the inherent stigma of
20 having to use separate facilities.
21 THE COURT: How about if other students would then
22 use those single -stall restrooms?
23 MR. BLOCK: Well, I think the answer would be the
24 same because even though other students might be able to use
25 them if they want to, Gavin is the only student required to

1 use them. There is testimony in the record, just as --
2 THE COURT: Required to use them, and if he didn't,
3 he would be punished if he used the boy's?
4 MR. BLOCK: That's correct. That's correct. Now,
5 it is true that Principal Collins testified that the single
6 user restrooms had been used because they had to be cleaned
7 up at the end of the day. But it's also true that he
8 testified he never actually saw anyone using them so -- and
9 Gavin's own testimony says he never saw anyone using them.
10 THE COURT: Could you talk more about how the facts
11 of this case relate to the sex stereotyping standard
12 articulated in *Price*?
13 MR. BLOCK: Yes, Your Honor. So, you know, in
14 *Pricewaterhouse*, the Supreme Court made clear that sex
15 discrimination doesn't simply include discrimination against
16 all men for being men or women for being women, it includes
17 discrimination against individuals for being the wrong type
18 of man or the wrong type of woman or not looking or
19 appearing the way that someone thinks a man or a woman
20 should look.
21 So I think that is actually the sex stereotyping
22 going on here in that, you know, the Board is not only
23 regarding, you know, Gavin's treatment documentation letter,
24 his name change, the fact that he has an I.D. that says he
25 is male, the fact that, you know, he lives his whole life as

1 a man, but they are even saying that the Virginia Court got
2 it wrong in declaring Gavin's legal sex to be male because
3 the Board says he needs to have some undefined surgery in
4 order to actually be a man.
5 So it all relates to the stereotype about --
6 frankly, I'm not sure if it's about genitals or chromosomes
7 because they say chest surgery isn't a biological change,
8 but genital surgery -- I'm not sure what the biological
9 means, but genital surgery doesn't change your chromosomes
10 either. So I think that is why it fits in.
11 It also is literally discrimination on the basis of
12 sex that it's, you know, because they refuse to acknowledge
13 him as a man, he is being treated a certain way. There is
14 one more point. Actually, I do think is important to add to
15 the sex stereotyping theory, which is the facial claim of
16 equality here, rests on the idea that everyone, whether they
17 are transgender or not, can use the restroom that matches
18 their sex assigned at birth.
19 That is what's put forward as what makes us
20 facially equal. As we have said, if that's how the policy
21 operates, then it doesn't serve the asserted interests in
22 keeping students' privacy from having to share restrooms
23 with people with different physiological sex characteristics
24 because a transgender woman with breasts would be using the
25 boy's room, and a transgender boy like Gavin would be using

1 the girl's room. And the Board's response to that in the
2 summary judgment motion is to say, of course, those things
3 won't occur because we have the single user restrooms, which
4 I think is an admission that the policy is actually a policy
5 that's saying transpeople are so gender non-conforming that
6 that they really can't use the same restrooms as anyone
7 else, that they don't fit into our restrooms and they are
8 going to have to use separate ones. So I think that's
9 another way that this policy fits into the sex stereotyping
10 framework of *Pricewaterhouse*.
11 THE COURT: All right. Thank you, sir, very much.
12 All right. Mr. Corrigan, your turn.
13 MR. CORRIGAN: Thank you, Your Honor.
14 THE COURT: You're welcome.
15 MR. CORRIGAN: Gloucester County School Board has
16 treated this plaintiff with respect and attempted to
17 accommodate his gender identity based on his assertions to
18 school staff. In this case when the facts moved from the
19 allegations to actual material disputed facts, undisputed
20 facts, Grimm's case falls short. Grimm has offered no
21 expert to prove he is a boy or has been diagnosed with
22 gender dysphoria or that the use of the boy's restroom was a
23 medical necessity for him or that the use of single-stall
24 restroom or other alternative restroom adversely affected
25 his gender dysphoria.

1 Even if the Court considers the WPATH and Endocrine
2 Society guidelines, there is no standard of care related to
3 the use of restrooms by students who identify as transgender
4 at school. The Gloucester County School Board policy is
5 based on a binary concept of sex. There are two sexes, male
6 and female. These are based on physiological or anatomical
7 characteristics. The Gloucester County School Board policy
8 permits every student to have two choices when it comes to
9 restroom use; either use the restroom associated with your
10 sex, male or female, or use one of the single stall
11 restrooms available for use by any student for any reason.
12 No consideration is given under the Gloucester
13 County School Board policy to whether a student appears
14 masculine or feminine or identifies with his or her physical
15 sex or not. Two choices for all. The Gloucester County
16 School Board does not take the position that their policy is
17 the only way to conform with Title IX or the equal
18 protection clause. Rather, this policy is simply not a
19 violation of either Title IX or the equal protection clause.
20 The School Board does not have to show that its policy is
21 the least intrusive means of achieving a relevant
22 governmental objective.
23 The plaintiff conflates whether school district, as
24 a matter of social policy, should permit transgender
25 students to use the restroom consistent with their gender

1 identity with whether their Gloucester County School Board
2 has violated Title IX of the equal protection clause by
3 providing separate restrooms based on physiological
4 differences between males and females along with the
5 single-stall restrooms for all.
6 Relevant facts is that the plaintiff is born female
7 with female genitalia and reproductive organs, was issued a
8 female birth certificate, is not intersex, enrolled in high
9 school as a girl, used female restrooms as a freshman, later
10 identified as a boy. Grimm had chest reconstruction surgery
11 in the fall of his senior year, but that surgery, according
12 to the plaintiff's own expert, did not create any biological
13 changes nor did it complete gender reassignment.
14 Under these facts, the binary Gloucester County
15 School Board policy providing restrooms for all males,
16 another for all females, and single stall restrooms for
17 anyone to choose from is not discriminatory, does not
18 violate Title IX, and does not stereotype anyone. No
19 consideration is given to male or female appearance based on
20 physiology alone.
21 Interestingly, the plaintiff's expert was not
22 designated to diagnose his gender dysphoria or the medical
23 necessity of any treatment or the causation of any
24 psychological or medical problem that plaintiff alleges he
25 has experienced.

1 Plaintiff's case is basically unsupported by any
2 medical or psychological expert testimony. Plaintiff has
3 presented no expert to say he has been diagnosed with gender
4 dysphoria, that his gender dysphoria required that he be
5 allowed to use the boy's restroom or that the failure to
6 allow him to use the boy's restroom caused him distress,
7 only have his own opinion.
8 Finally, the plaintiff has identified no expert to
9 support his claim that he experienced harm as a result of
10 this policy limiting his restroom options to the female or
11 single-stall restrooms. At lunch two single-stall restrooms
12 are nearby, and the plaintiff was allowed to use a staff
13 restroom on D wing where many of his classes were held.
14 In fact, as has been mentioned, the plaintiff
15 refused to use any single-stall restrooms after consulting
16 with the ACLU. Title IX prohibits exclusion of any person
17 from participation in any educational program on the basis
18 of sex.
19 To decide the claim, the Court has to define sex,
20 in our opinion, and based on dictionary definitions,
21 legislative history, and even the case law, the definition
22 of "on the basis of sex" is a binary concept that does not
23 consider the societal construct of gender identity.
24 Implementing regulation 34 C.F.R. 106.33 allows for separate
25 restrooms for each sex.

1 Nothing in Title IX itself or the regulation states
2 on its face that the Gloucester County School Board, based
3 on physiological sex, violates Title IX. Those are our
4 statements with respect to the Title IX claim, Your Honor.
5 THE COURT: All right. As I understand the gist of
6 Mr. Grimm's humiliation and shame, he was -- helped
7 stigmatize to use separate restrooms, and that the nurse's
8 and the other -- or the faculty restroom that we have heard
9 about, of the distance that he had to travel to and fro, so
10 from class and to the bathroom and back, which caused him to
11 be late sometimes. He uses the word humiliation and
12 distress detrimental to his instructional time.
13 As I mentioned earlier to counsel, he was told he
14 would be disciplined if he used the boy's restroom, uses the
15 word isolated, distraught, quote, felt like a walk of shame,
16 end quote. Embarrassed that everyone who saw him enter the
17 nurse's office knew exactly why he was there because he was
18 transgender.
19 He explains how he had to limit his liquid intake
20 such that he wouldn't have to go to the bathroom throughout
21 the course of his day. He describes holding himself at
22 school activities, and as alluded to by his counsel, he
23 couldn't -- he would go to a Lowe's or a Home Depot to use
24 the bathroom or have his mother come and pick him up and
25 take him to the bathroom.

1 There is unsafe suicidal and depressive feelings,
2 and then for his entire 12th grade class, he had to continue
3 to go to class and conduct himself in this manner, and in
4 his declaration, I was looking at Paragraphs 29 through 32,
5 44, 46 through 53, and 54 and 56.
6 So my question to you, sir, does he really need
7 expert testimony to show that he felt humiliated and shamed?
8 MR. CORRIGAN: I think his feelings are not
9 something he needs expert testimony for, Your Honor, I think
10 that's true. I think the question is whether or not --
11 THE COURT: So you acknowledge that all that
12 establishes humiliation, stigma and shame?
13 MR. CORRIGAN: That in his feelings, and, of
14 course, it's related directly --
15 THE COURT: Wait. Answer my question, please. You
16 acknowledge everything that I just put on the record equals
17 shame and humiliation and pain?
18 MR. CORRIGAN: I acknowledge that that is his
19 testimony, yes. And what I'm saying is that in the context
20 of this case, he was provided with options, and as a result
21 of his own decision, his choices, that is the result that
22 occurred for him on this occasion.
23 THE COURT: Now, his suffering, does that warrant
24 nominal damages?
25 MR. CORRIGAN: I think the question of nominal

1 damages, I think the answer is yes. Again, I don't think we
2 can say that there is no nominal damages here.
3 THE COURT: Is there anything short of surgical
4 gender reassignment surgery that the Board would consider?
5 MR. CORRIGAN: My understanding of the Board's
6 position is that as long as an individual has the primary
7 genitals and sex characteristics of a particular gender,
8 male or female, that they will be considered that, and that
9 is what the policy gender -- what it talks about in the
10 policy, that is what they are considering.
11 THE COURT: But anything lower than that they will
12 not, correct?
13 MR. CORRIGAN: As my understanding, yes.
14 THE COURT: So dress, they wouldn't consider;
15 mustache, they wouldn't consider; removing one's breasts,
16 they wouldn't consider?
17 MR. CORRIGAN: Correct.
18 THE COURT: Okay. So all or nothing is the Board's
19 position?
20 MR. CORRIGAN: Yes, ma'am.
21 THE COURT: All right, sir. Thank you. I have
22 nothing further. If we can do equal protection now, please.
23 MR. BLOCK: Thank you, Your Honor. For equal
24 protection this Court has already determined that
25 discrimination against transpeople is subject to heightened

1 scrutiny under the equal protection clause, which means the
2 Board has the heavy burden of showing that its policy is
3 substantially related to an important governmental interest.
4 And other than the facts that Your Honor and I discussed
5 about student complaints, the Board hasn't submitted any
6 evidence whatsoever to carry that burden.
7 The Board's 30(b)(6) witness made clear that the
8 Board is relying on a privacy interest related to nudity and
9 preventing unwarranted exposure to nudity around students of
10 different physiological sex characteristics, and there are
11 two problems with that justification. The first is that
12 there is no risk of exposure to nudity in the restrooms.
13 The Board could have put on any testimony it
14 wanted, any evidence it wanted to say that there is an
15 actual risk of exposure to nudity in these restrooms, and it
16 hasn't done so. And especially in light of the privacy
17 protections that have been installed, attached to
18 Mr. Loving's declaration, there are pictures of the urinal
19 dividers that provide incredible protection for privacy for
20 anyone who wants it.
21 Now, and then in talking to the 30(b)(6) witness
22 about, well, how is this privacy interest implicated, he
23 discussed nudity when someone uses the urinal or toilet, and
24 he also said that he sometimes in high school unbuckled his
25 pants to tuck in his shirt, which is, of course, something

1 that someone can do in a stall if they want added privacy
2 for it.
3 When we asked are there any other situations
4 involving nudity, and he said none that I can think of off
5 the top of my head. This is at a 30(b)(6) deposition where
6 the Board has had four years to think about how its policy
7 implicates nudity. So I think that, you know, that alone is
8 sufficient to resolve the case, that, you know, they are
9 claiming a privacy interest related to nudity. They say
10 it's not about simply being in the presence of a
11 transperson, and if that's the case, that has nothing at all
12 to do with restrooms.
13 The second problem with the justification is, as I
14 alluded to before, the policy doesn't stop people from
15 sharing restrooms with people with different physiological
16 sex characteristics, that under the policy, you know, a boy
17 who is not transgender might not have to share a restroom
18 with the boy who is transgender but they have to share a
19 restroom with a transgender girl who has breasts as a result
20 of hormone therapy.
21 When asked what about that boy's privacy interests,
22 the School Board said, well, they have the option of using
23 one of the single-user restrooms if they want greater
24 privacy. So if that boy's privacy in not wanting to share
25 the restroom with a transgender girl is sufficiently

1 addressed by the single-user restrooms, then there is no
2 rational reason why the interest of a sex gender boy who
3 doesn't want to use the same restrooms as another boy who is
4 transgender isn't also addressed by the availability of the
5 single-user restrooms.
6 Now, we think that even the context of locker
7 rooms, the *M.A.B.* case shows that these policies aren't
8 really substantially related to an interest in locker rooms
9 either, but this is a very easy case as a result of the
10 Board's explicit statements during the deposition that this
11 is only about restrooms. And if it's only about restrooms,
12 then there is no interest related to exposure to nudity at
13 all.
14 Now, one thing I wanted to harken back to for one
15 second is this issue of the D hall faculty restroom where my
16 understanding is that that was before Gavin began using the
17 boy's restroom. He could use the nurse's restroom or the
18 faculty restroom, and, in fact, faculty subsequently
19 complained that they didn't want him using it. So I don't
20 think the record shows that he had -- he wasn't going to use
21 the faculty restroom anyway, but I don't think the record
22 shows that it was an option for him. I'd hate for that to
23 be a disputed question that avoid summary judgment. So as
24 far as I'm concerned, the Court could assume what they are
25 saying here is true, although I don't think the record

1 supports it.
2 Now, I do have to acknowledge there are disputed
3 questions in the record about how the policy interacts with
4 birth certificates, but those are disputes between the
5 30(b)(6) witness and counsel. They are not, for purposes of
6 our affirmative motion for summary judgment, I don't think
7 the Court has to get into any questions of what inconsistent
8 answers or pretext or how the policy relates to birth
9 certificates because no matter what the policy is with
10 respect to birth certificates, it's not substantially
11 related to the asserted governmental interest.
12 And so for purposes of our affirmative summary
13 judgment motion, I think all the confusion created by what
14 we think are discrepancies between the 30(b)(6) witness's
15 testimony and the other statements we have heard from
16 counsel, they are not material to our affirmative
17 complaints -- I'm sorry, our affirmative claims.
18 They are only material if we had to get to the
19 stage of proving that the Board's asserted interest is
20 pretextual. But this is heightened scrutiny. All we need
21 to show is that it's not tailored to meet the interest. We
22 don't have to show invidious motive, even though we think in
23 a factual finder of fact setting a finder of fact could
24 conclude that. We are not asking the Court to do that for
25 our affirmative motion.

1 Does the Court want me to address the transcript
2 issue also at this time?
3 THE COURT: Yeah, you can. That's great.
4 MR. BLOCK: So for the transcript issue, again, I
5 think there's -- you know, some confusion has been created
6 as a result of the 30(b)(6) witness's testimony about what
7 would have happened if we had pursued a FERPA hearing in
8 January.
9 THE COURT: Why didn't you go to the hearing?
10 MR. BLOCK: Well, because our understanding was the
11 Board was requiring genital surgery, and that anything short
12 of that would be irrelevant. We didn't have anything else
13 to produce, and we'd never heard anything about -- the
14 30(b)(6) witness was the first time we ever heard the
15 Board's objections to the birth certificate could possibly
16 be related to a confusion about whether it was authentic,
17 like this nonsense about it saying "void" on it.
18 Before then, our understanding is they just thought
19 the birth certificate, you know, either didn't comply with
20 regulations or wasn't legally valid because Gavin hadn't had
21 genital surgery. So all the confusion in the record was
22 just based on this suggestion at the 30(b)(6) testimony that
23 maybe there was an authenticity question. I think it's
24 clear now that's not on the table, that their objection is
25 to -- they think the registrar didn't comply with

1 regulations and statute, and they disagree with the Circuit
2 Court's statutory interpretation.
3 If we were seeking damages based on the specific
4 action taken in January, that maybe we would have to get
5 into their heads about what they were doing then, but the
6 Board has continued to deny him updated transcript to this
7 day. So we don't really need to get into the factual
8 nuances about, you know, what was or was not said in
9 January. They have known for years that he has this birth
10 certificate, and he has a Court order, and, yet, they are
11 still refusing to provide him a transcript that matches his
12 birth certificate.
13 THE COURT: Tell me about how that affects him, why
14 that hurts him.
15 MR. BLOCK: Well, he's been -- well, he wants to go
16 to college, a four-year college, and, you know, he's been
17 putting it off. He doesn't want to go to a -- his current
18 college, Berkeley City College, doesn't require a
19 transcript, and that's one of the reason he goes there.
20 So the idea of starting college with this, like,
21 old document being chained to him, is something that's very,
22 you know, painful and distressing to him, and, you know,
23 it's a document that follows him all his life, and it's sort
24 of a constant reminder of what he went through at school,
25 and it's a constant, like, declaration that no matter what

1 he does, the Board is going to refuse to recognize him as a
2 boy.
3 I think that the Board's refusal to issue the
4 transcript is another incidence of sex stereotyping under
5 *Pricewaterhouse* because it's explicitly based on this idea
6 that despite whatever other legal document you say, we think
7 that you are only a boy if you have the genital surgery. We
8 think you should have, although there are many types of
9 genital surgeries, and it's not clear, like metoidioplasty
10 phalloplasty, it's not clear the Board even knows what type
11 of surgery it requires, but that's their basis for not
12 giving him a transcript matching all those other legal
13 documents.
14 THE COURT: All right. Thank you, sir.
15 All right. Mr. Corrigan, I'll be glad to hear from
16 you. Before you start, is it the Board's job to determine
17 if a birth certificate complies with Virginia law or is it
18 the state registrar and the Director of Division of Vital
19 Statistic records, their job?
20 MR. CORRIGAN: So with respect to that question --
21 THE COURT: No, just answer my question. Is it the
22 Board's job, yes or no?
23 MR. CORRIGAN: To?
24 THE COURT: Determine if a birth certificate
25 complies with Virginia law? Is that the Board's job? Yes

1 or no?
2 MR. CORRIGAN: Yes, in the context that the Board
3 has this policy, and they are receiving a birth certificate
4 that, again, it didn't say amended. It didn't have void --
5 it had "void" on it, and the Board was aware that the
6 requirement for surgical gender reassignment procedure,
7 which is part of what was supposed to have occurred in order
8 for an order to be entered and a birth certificate to have
9 been provided, had not occurred.
10 THE COURT: So when Board members are elected, are
11 they -- how do they get on the Board? How does a Board
12 member become a Board?
13 MR. CORRIGAN: They are elected.
14 THE COURT: So is there a question when somehow the
15 voters let them know, they say, hey, you may have to usurp
16 the powers of a Circuit Court Judge or usurp the powers of
17 the state registrar or the Director of Division of Vital
18 Statistics, is that something that is part of the electoral
19 process?
20 MR. CORRIGAN: Not that I'm aware of.
21 THE COURT: Okay.
22 MR. CORRIGAN: So that equal protection claim, the
23 equal protection clause is not a source of substantive
24 rights but, rather, a right to be free of invidious
25 discrimination. Neither Title IX nor the equal protection

1 clause gives plaintiff the substantive right to governmental
2 assistance.
3 THE COURT: Before you go on, just answer me this.
4 So did they usurp the power of the Circuit Court Judge? Is
5 that a violation of the law when you have the Circuit Court
6 Judge say this is legal and you as a Board is saying no,
7 it's not?
8 MR. CORRIGAN: I don't know that they are usurping
9 the power.
10 THE COURT: Are they complying with the law?
11 MR. CORRIGAN: For their purposes, what they are
12 doing is attempting to take a look at what they have been
13 presented and determine whether or not it complies with the
14 law and determine whether or not it complies with their
15 policy.
16 THE COURT: The Circuit Court Judge, they have
17 documentation saying he is a boy, right?
18 MR. CORRIGAN: Yeah, there is an order that says
19 male, yes.
20 THE COURT: So are they complying with the Circuit
21 Court Judge's order? They are saying, no, he's not.
22 MR. CORRIGAN: They are saying for purposes of
23 bathroom use in their schools, that that does not determine
24 his sex. That is what they are saying.
25 THE COURT: Okay.

1 MR. CORRIGAN: We continue to argue that the
2 Gloucester County School Board policy is simply not
3 discriminatory. There is no invidious discrimination based
4 on similarly situated students. All are treated the same.
5 In order for the plaintiff to prevail, the Court must find
6 under heightened scrutiny, because transgender is a new
7 suspect class, but neither the United States Supreme Court
8 nor the Fourth Circuit has ever recognized transgender as a
9 suspect class.
10 This Court previously referred to transgender
11 status as immutable, however, the Gloucester County School
12 Board expert, Dr. Van Meter, has testified that 80 to 95
13 percent of prepubertal children with gender identity order
14 desist, meaning they identify with their biological sex by
15 the time they emerge from puberty to adulthood. The Court
16 should apply the rational basis test, and under that test --
17 THE COURT: I already ruled that it was not
18 rational.
19 MR. CORRIGAN: I'm kind of preserving my position
20 on that.
21 THE COURT: Okay.
22 MR. CORRIGAN: I understand. Even under the
23 intermediate scrutiny, the Gloucester County School Board's
24 competing interest is the privacy of all students in the
25 restroom, and the school has provided numerous examples of

1 those concerns being expressed to School Board members by
2 parents on behalf of their students saying that the privacy
3 was infringed by the presence of a member of the opposite
4 biological sex in the restroom when they were using the
5 restrooms.
6 I refer you to our summary judgment brief on Page
7 3, Paragraph 8. Within two days parents of students in the
8 community learned that a gender -- that a transgender boy
9 was using the boy's restroom and complained. The student
10 complained about the lack of privacy in the bathroom.
11 Principal Collins talked about that.
12 Grimm was also involved in an altercation with a
13 fellow student concerning his use of the restroom. The
14 Board received 39 e-mails and numerous oral communications
15 expressing concerns from parents. One parent wrote, "I
16 respectfully ask that you act to protect the rights and
17 privacy of students who are not transgender. I have a son
18 who attends school and cannot imagine how he would feel if a
19 transgender student began to utilize the boy's restroom.
20 All students, not just one, should have their privacy
21 upheld. This is not a discrimination issue. It is a
22 privacy issue."
23 Another family wrote, "The decision regarding any
24 transgender student using the restroom they assigned to
25 themselves should be considered based on the needs and

1 privacy of all students in the school. Our boys are
2 mortified by the idea that any female, including their
3 mother or sister, would be in a bathroom with them while
4 they are using it. Surely, there is a place somewhere in
5 the school that can be remodeled to include two or three
6 stalls and designated as a unisex bathroom by anyone who
7 feels the need."
8 The school also was advised on December 9, 2014
9 that the ACLU website at that time noted with approval that
10 some school administrators offered transgender students the
11 use of employee single-stall restroom, noted that with
12 approval. So at that time in 2014, that was a position on
13 the website of the ACLU. And it's well-known and
14 established in this case by all the experts that many
15 transgender students prefer the option that the Gloucester
16 County School Board has offered. So this goes to the
17 weighing of the interest.
18 The feelings of students of all ages that their
19 privacy is compromised in the restroom by the presence of a
20 member of the opposite sex has been recognized for
21 generations, and we have -- the Board has interest in
22 protecting the privacy rights of its students. "Students
23 had significant privacy interest in their unclothed bodies."
24 That's from the *Beard v. Whitmore* case.
25 Men and women simply are not physiologically the

1 same for purposes of physical fitness programs. The Court
2 in Virginia, which is the *VMI* case, recognized that some
3 differences between the sexes are real, not perceived, and,
4 therefore, could require accommodation. The Board's
5 interest in student privacy that justifies segregation of
6 restroom and locker rooms arise from the physiological
7 differences between boys and girls and not from differences
8 in gender identity.
9 The *Faulkner v. Jones* case says, "Society's
10 undisputed approval of separate public restrooms for men and
11 women based on privacy concerns." So there are privacy
12 concerns that exist. There are privacy concerns that are
13 legitimate to consider, and the privacy concerns are not
14 outweighed in this case. That's the position of the Board
15 with respect to the equal protection claim.
16 THE COURT: How does Mr. Grimm walking into a stall
17 in the boy's bathroom and shutting the door harm the privacy
18 rights of other students?
19 MR. CORRIGAN: Well, I mean, in any individual
20 case, if that is all that happens, then that could be, but
21 we don't know what's going to happen.
22 THE COURT: Repeat your answer, please.
23 MR. CORRIGAN: Anyone inside of a stall, as long as
24 the stall is completely -- no one can see in or see out,
25 then you could clearly -- then clearly there is no

1 interaction --
2 THE COURT: There is no privacy violation.
3 MR. CORRIGAN: -- to be of concern.
4 THE COURT: There is no privacy violation, is that
5 what you just said?
6 MR. CORRIGAN: But that --
7 THE COURT: Is that what you just said?
8 MR. CORRIGAN: I'm saying that there would not be
9 the specific concern that is raised here, which, again, is
10 privacy, but it is also the notion that these individuals in
11 the bathroom of the opposite sex, it is upsetting to those
12 individuals, and there is a privacy concern.
13 You can't envision every circumstance under which
14 something might occur that would cause a concern; at a
15 urinal, someone changing, or just, you know, un --
16 re-establishing their pants, all these different
17 circumstances that exist. It's made to consider, and it is
18 a legitimate privacy concern.
19 With respect to the birth certificate --
20 THE COURT: Yes.
21 MR. CORRIGAN: -- the School Board policy providing
22 separate restrooms for boys and girls based on anatomy is
23 based on social norms, binary sexes and students using the
24 restroom that corresponds to their biological sex or the
25 alternative single-stall restrooms.

1 Before this case, the Gloucester County School
2 Board has never dealt with the conflict between a student's
3 biological sex and the sex on an amended birth certificate.
4 So it's not something that anyone had ever thought about,
5 considered, or otherwise. The argument on this issue is
6 straightforward. First Grimm's amended birth certificate
7 does not change his physiological anatomical sex, which
8 remain female. Grimm's own expert, Melinda Penn, confirms
9 that after the chest reconstruction surgery, Grimm remained
10 biologically and physiologically female the entire time he
11 was a student at Gloucester County High School, and even
12 until this day.
13 Second, the birth certificate that Grimm provided
14 was not in conformity with Virginia law. As I already said,
15 there was no gender reassignment surgery with respect to the
16 transcript. Counsel received a letter on January 18, 2017,
17 declining to change the official school records based on a
18 review of the certificate itself had "void" on it and did
19 not say amended in various places where it was required to
20 do so. School policy JO and the Virginia Code and
21 administrative code, and all the relevant documents, were
22 attached to the letter, and that letter concludes, "Please
23 feel free to submit additional materials, and, of course,
24 your client has the right under policy JO, see Page 8,
25 correction of education records, for a hearing to challenge

1 the information believed to be inaccurate, misleading, or in
2 violation of the student's right."
3 So that was offered, the explanation was given, and
4 that was offered, and that was never undertaken, and to this
5 day has never been undertaken.
6 THE COURT: All right. Thank you very much.
7 MR. CORRIGAN: Thank you.
8 THE COURT: Anything additional, sir?
9 MR. BLOCK: Just say one more thing, Your Honor.
10 THE COURT: You may.
11 MR. BLOCK: Counsel just spoke about how the school
12 can't anticipate every possible scenario that might arise.
13 But this is a case about a real person, an individual, and
14 the school admits it never encountered this problem before
15 Gavin. So I think that's a perfect example of this policy
16 being driven about abstractions and hypotheticals and
17 ignoring the real individual who was in front of them and
18 not analyzing whether any of those abstract concerns
19 actually applied to this person who has individual rights
20 under Title IX and the Constitution.
21 THE COURT: All right. Thank you.
22 Anything additional from you?
23 MR. CORRIGAN: No, ma'am.
24 THE COURT: Well, thank you both very much. It was
25 a pleasure meeting everybody. I'm going to take the matter

1 under advisement, and I want you to have a good rest of your
2 week and a great weekend.
3 (Hearing adjourned at 10:02 a.m.)
4 CERTIFICATION
5
6 I certify that the foregoing is a correct transcript
7 from the record of proceedings in the above-entitled matter.
8
9
10 X_________________/s/__________________________x
11 Jody A. Stewart
12 X_______9-27-2019 _________x
13 Date
14
15
16
17
18
19
20
21
22
23
24
25

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM, Plaintiff, v. GLOUCESTER COUNTY SCHOOL BOARD, Defendant.	Civil No. 4:15cv54

ORDER

Pending before the Court are a Motion to Strike Exhibits (ECF No. 213) and Cross-Motions for Summary Judgment filed by Plaintiff Gavin Grimm (ECF No. 184) and Defendant Gloucester County School Board ("the Board") (ECF No 191). For the following reasons, the Board's Motion to Strike is **GRANTED IN PART** and **DENIED IN PART**, Mr. Grimm's Motion for Summary Judgment is **GRANTED**, and the Board's Motion for Summary Judgment is **DENIED**.

I. FACTUAL BACKGROUND

Gavin Grimm is a twenty-year-old man who attended Gloucester High School, a public high school in Gloucester County, Virginia, from September 2013 until his graduation in June 2017. *See* Gavin Grimm Decl. ¶¶ 3, 5, ECF No. 186. When Mr. Grimm was born, hospital staff identified him as female. *Id.* ¶ 7. Despite this designation, Mr. Grimm has always "related to male characters" and "ha[s] always known that [he is] a boy." *Id.* ¶ 6.

When Mr. Grimm enrolled in the Gloucester County School System, he was listed as a girl. He began his freshman year in 2013 at Gloucester High School with a female birth certificate. Andersen Decl., ECF No. 196-6.

In April 2014, Mr. Grimm disclosed to his parents that he was transgender. Gavin Grimm Decl. ¶ 20; Deirdre Grimm Decl. ¶ 7, ECF No. 187. According to Dr. Melinda Penn, M.D.,[1] "gender identity" refers to "a person's innate sense of belonging to a particular gender." Penn Expert Rep. and Decl. ¶ 17, ECF No. 192-3. She opines that people's gender identity usually matches the sex consistent with their external genitalia possessed at birth, but that transgender individuals have a gender identity different from the one assigned to them at birth. *Id.* ¶¶ 18–19.

At Mr. Grimm's request, he began therapy in May 2014 with Dr. Lisa Griffin, Ph.D., a psychologist with experience counseling transgender youth. Gavin Grimm Decl. ¶ 24. Dr. Griffin diagnosed Mr. Grimm with gender dysphoria. *Id.* Dr. Griffin prepared a treatment documentation letter stating that Mr. Grimm has gender dysphoria, that he should present as a male in his daily life, that he should be considered and treated as a male, and that he should be allowed to use restrooms consistent with that identity. ECF No. 186-1 at 1.

The American Psychiatric Association's Diagnostic & Statistical Manual of Mental Disorders ("DSM V") defines "gender dysphoria" as a condition experienced by some transgender people that inflicts clinically significant stress because their gender identity differs from the sex assigned to them at birth. Penn Expert Rep. and Decl. ¶ 21. Dr. Penn's report explains that "to be diagnosed with gender dysphoria, the incongruence [between gender identity and assigned sex] must have persisted for at least six months and be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning." *Id.*

[1] Mr. Grimm retained Dr. Penn to "provide expert testimony on the applicable standards of care and treatment guidelines for transgender youth." ECF No. 214-2 at 1. Dr. Penn is a pediatric endocrinologist with the Children's Hospital of the King's Daughters in Norfolk, Virginia, holds a medical degree from Eastern Virginia Medical School, and is board certified in pediatric endocrinology by the American Board of Pediatrics. ECF No. 192-3 ¶¶ 3–4. One of her specialties is transgender health. *Id.*

During the course of his treatment for gender dysphoria, Mr. Grimm changed his first name legally to Gavin and began using male pronouns to describe himself. Gavin Grimm Decl. ¶¶ 23, 25. He also began using men's restrooms in public venues. *Id.* ¶¶ 37, 38. Dr. Griffin referred Mr. Grimm to an endocrinologist for hormone treatment around this time. *Id.* ¶ 24.

In August 2014, before the beginning of Mr. Grimm's sophomore year, Mr. Grimm and his mother met with Ms. Tiffany Durr, a school guidance counselor. *Id.* ¶¶ 26–27. They gave Ms. Durr a copy of Dr. Griffin's treatment documentation letter and requested that Mr. Grimm be treated as a boy at school. *Id.* Mr. Grimm and Ms. Durr agreed that Mr. Grimm would use the restroom in the nurse's office. *Id.* ¶ 29.

Mr. Grimm "soon found it stigmatizing to use a separate restroom," however, and "began to feel anxiety and shame surrounding [his] travel to the nurse's office." *Id.* He also found that the distance to this bathroom caused him to be late to class. *Id.*

After a few weeks of using the restroom in the nurse's office, Mr. Grimm met with Ms. Durr and sought permission to use the school's male restrooms. *Id.* ¶ 33; Durr Dep. 23:6–17, ECF No. 192-11. Ms. Durr relayed Mr. Grimm's request to Principal Nate Collins. Durr Dep. 24:1–17. Principal Collins spoke with Superintendent Walter Clemons, who offered to support Principal Collins' ultimate decision. Collins Dep. 49:7–50:1, ECF No. 192-9; Clemons Dep. 24:4–20, ECF No. 192-10. Principal Collins allowed Mr. Grimm to use the male restrooms. Collins Dep. 50:22–51:13.

Mr. Grimm used the male restrooms at Gloucester High School for seven weeks. Gavin Grimm Decl. ¶ 36. During this time, there were no incidents in the restrooms involving Mr. Grimm and other students. *Id.* Mr. Grimm was given permission to complete his physical education

courses online and never needed to use the locker rooms at school. Gavin Grimm Dep. 96:14–97:9.

Subsequently, however, Dr. Clemons, Principal Collins, and Board members began receiving complaints from adult members of the community who had learned that a transgender boy was using male restrooms at the high school. *See* Collins Dep. 66:1–22; Clemons Dep. 32:16–33:6; Def.'s Response to First Set of Interrogatories ¶ 1, ECF No. 192-1. Some members of the community demanded that the transgender student be barred from the male restrooms. *Id.* One student personally complained to Principal Collins. ECF No. 192-1 ¶ 1.

Following these complaints, Board member Carla Hook proposed the following policy at the Board's public meeting on November 11, 2014:

> Whereas the GCPS recognizes that some students question their gender identities, and
>
> Whereas the GCPS encourages such students to seek support, advice, and guidance from parents, professionals and other trusted adults, and
>
> Whereas the GCPS seeks to provide a safe learning environment for all students and to protect the privacy of all students, therefore
>
> It shall be the practice of the GCPS to provide male and female restroom and locker room facilities in its schools, and the use of said facilities shall be limited to the corresponding biological genders, and students with gender identity issues shall be provided an alternative appropriate private facility.

Hook Nov. 9, 2014 Email, ECF No. 192-21.

Mr. Grimm and his parents spoke against the proposed policy at the November 11, 2014 meeting. Gavin Grimm Decl. ¶ 40. The Board voted 4-3 to defer a decision regarding the policy until the next Board meeting on December 9, 2014. Recorded Minutes of the Board, Nov. 11, 2014 at 4, ECF No. 192-37.

The Board passed the proposed policy on December 9, 2014 by a 6-1 vote. Recorded Minutes of the Board, Dec. 9, 2014, at 3, ECF No. 192-23. The Board also announced that it would construct single-stall, unisex restrooms for all students to use. *Id.* The following day, Principal Collins told Mr. Grimm that his further use of the male restrooms at Gloucester High School would result in disciplinary consequences. Collins Dec. 10, 2014 Memo to Deirdre and David Grimm, ECF No. 192-24; Gavin Grimm Decl. ¶ 44.

In December 2014, Mr. Grimm began hormone therapy. This "deepened [his] voice, increased [his] growth of facial hair, and [gave him] a more masculine appearance." Gavin Grimm Decl. ¶ 60.

Single-user restrooms had not yet been constructed when the Board enacted the policy. Gavin Grimm Decl. ¶ 46. Mr. Grimm has recounted an incident when he stayed after school for an event, realized the nurse's office was locked, and broke down in tears because there was no restroom he could use comfortably. *Id.* A librarian witnessed this and drove him home. *Id.*

Mr. Grimm also declared that when the single-user restrooms were built, they were located far from classes that he attended. *Id.* ¶ 49. A map of the school confirms that no single-user restrooms were located in Hall D, where Mr. Grimm attended most classes. ECF Nos. 192-28, 192-29. There was also no single-user restroom at the school's stadium, limiting Mr. Grimm's ability to attend events there. Gavin Grimm Decl. ¶ 52.

The single-stall restrooms made Mr. Grimm feel "stigmatized and isolated." *Id.* ¶ 47. He never saw any other student use these restrooms. *Id.* ¶ 48. Principal Collins testified at his deposition that he never saw a student use the single-user restrooms, but that he assumed that they were used because they were cleaned daily. Collins Dep. 132:7–20.

Mr. Grimm avoided using restrooms at school and later developed urinary tract infections. Gavin Grimm Decl. ¶¶ 51–52. This caused him to become distracted and uncomfortable in class. *Id.* Mr. Grimm's mother kept medication for urinary tract infections "always stocked at home." Deirdre Grimm Decl. ¶ 26.

In June 2015, the Virginia Department of Motor Vehicles issued Mr. Grimm a state identification card identifying him as male. Gavin Grimm Decl. ¶ 61; ECF No. 41-2.

During his junior year of high school, Mr. Grimm was admitted to the boys' ward at the hospital at Virginia Commonwealth University "because he was having thoughts of suicide." Deirdre Grimm Decl. ¶ 24.

In June 2016, Mr. Grimm underwent chest-reconstruction surgery. Grimm Decl. ¶ 62.

On September 9, 2016, the Gloucester County Circuit Court issued an order declaring Mr. Grimm's sex to be male and directing the Virginia Department of Health to issue him a birth certificate listing his sex as male. *Id.* ¶ 63; ECF No. 41-3. The order referred to Mr. Grimm's chest reconstruction surgery as "gender reassignment surgery" and concluded that Mr. Grimm is "now functioning fully as a male." ECF No. 41-3.

On October 27, 2016, the Virginia Department of Health issued a birth certificate listing Mr. Grimm's sex as male. Gavin Grimm Decl. ¶ 64; ECF No. 41-4. After receiving an updated birth certificate, Mr. Grimm and his mother provided Gloucester High School with a photocopy of it and asked that his school records be updated. Gavin Grimm Decl. ¶ 66. The school has declined to correct Mr. Grimm's transcript, which still reflects his sex as female. ECF No. 41-5.

Troy Andersen, the Board's 30(b)(6) witness,[2] testified that the Board has declined to update Mr. Grimm's transcripts because it believes that the amended birth certificate does not accord with Virginia law and because the photocopy presented was marked "void." Andersen Dep. 65:8–66:1, ECF No. 192-13.

On January 18, 2017, the Board informed Mr. Grimm that he had a right to a hearing related to the Board's decision not to amend his official transcript and educational records. ECF No. 171-1. Mr. Grimm did not request a hearing.

Mr. Grimm graduated high school on June 10, 2017. Gavin Grimm Decl. ¶ 57. He is now attending Berkeley City College in California and intends to transfer to a four-year college. *Id.* ¶ 69.

II. PROCEDURAL BACKGROUND

Mr. Grimm commenced this action against the Board on June 11, 2015, at the end of his sophomore school year, alleging that the Board's policy of assigning students to restrooms based on their biological sex violated Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681(a), and violated the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution. ECF No. 1. This Court considered the Board's motion to dismiss Mr. Grimm's Amended Complaint. On May 22, 2018, this Court denied the motion to dismiss. ECF No. 148.

In doing so, this Court held that a plaintiff's claim of discrimination on the basis of transgender status constitutes a viable claim of sex discrimination under Title IX. *Id.* at 13–21. Specifically, this Court relied on *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989), which held

[2] Under Federal Rule of Civil Procedure 30(b)(6), if an organization is named as a deponent in a civil matter, the organization must designate one or more persons who consent to testify on its behalf. The Board designated Troy Andersen, a Board member, to testify on its behalf.

that Title VII of the Civil Rights Act of 1964 bars discrimination not only based on a person's gender, but also based on whether the person conforms to stereotypes associated with the person's gender.[3] This Court joined the District of Maryland in concluding that under Title IX "discrimination on the basis of transgender status constitutes gender stereotyping because 'by definition, transgender persons do not conform to gender stereotypes.'" *M.A.B. v. Bd. of Educ. of Talbot Cty.*, 286 F. Supp. 3d 704, 714 (D. Md. 2018) (quoting *Finkle v. Howard Cty.*, 12 F. Supp. 3d 780, 787–88 (D. Md. 2014)).[4]

This Court also held that state action that discriminates against transgender individuals is subject to intermediate scrutiny under the Constitution's Equal Protection Clause for two reasons. ECF No. 148 at 25–28. First, transgender individuals constitute at least a quasi-suspect class. *See M.A.B.*, 286 F. Supp. 3d at 718–20. Second, discrimination based on sex stereotypes constitutes a sex-based classification of a type subject to intermediate scrutiny. *Id.* at 718–19.

On February 15, 2019, this Court permitted Mr. Grimm to file a Second Amended Complaint. This filing added a claim that the Board continues to discriminate against Mr. Grimm in violation of Title IX and the Equal Protection Clause by refusing to update his official school transcripts to reflect his sex as male. ECF No. 177.

---

[3] Courts may, and frequently do, look to case law interpreting Title VII for guidance in evaluating a claim brought under Title IX. *See, e.g., G.G. ex rel. Grimm v. Gloucester Cty. Sch. Bd.* ("*Grimm I*"), 822 F.3d 709, 718 (4th Cir. 2016), *vacated and remanded,* 853 F.3d 729 (Apr. 17, 2017) (citing *Jennings v. Univ. of N.C.*, 482 F.3d 686, 695 (4th Cir. 2007)).

[4] The First, Sixth, Ninth, and Eleventh Circuits have all relied on *Price Waterhouse* in holding that claims of discrimination based on transgender status constitute *per se* sex discrimination under Title VII or other civil rights laws. *See EEOC v. R.G. & G.R. Harris Funeral Homes, Inc.*, 884 F.3d 560, 574–75 (6th Cir. 2018) *cert. granted* 139 S. Ct. 1599 (2019) (Title VII); *Glenn v. Brumby*, 663 F.3d 1312, 1316–19 (11th Cir. 2011) (Title VII and Equal Protection Clause); *Smith v. City of Salem*, 378 F.3d 566, 573–75 (6th Cir. 2004) (Title VII and Equal Protection Clause); *Rosa v. Park W. Bank & Trust Co.*, 214 F.3d 213, 215–16 (1st Cir. 2000) (Equal Credit Opportunity Act); *Schwenk v. Hartford*, 204 F.3d 1187, 1201–03 (9th Cir. 2000) (Gender Motivated Violence Act).

The parties filed motions for summary judgment. ECF Nos. 184, 191. The Board has also moved to strike certain exhibits relied upon by Mr. Grimm. ECF No. 213. On July 23, 2019, this Court heard argument on these pending motions. ECF No. 228. The motions are now ripe for consideration.

III. LEGAL STANDARDS

Rule 56 of the Federal Rules of Civil Procedure permits a party to move for summary judgment and directs a court to grant such motion "if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). The party "seeking summary judgment always bears the initial responsibility of informing the [court] of the basis for its motion, and identifying those portions of the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, which it believes demonstrate the absence of a genuine issue of material fact." *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986) (quotations omitted). Subsequently, the burden shifts to the non-moving party to present specific facts demonstrating that a genuine dispute of material fact exists for trial. *See Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 (1986) ("When the moving party has carried its burden under Rule 56(c), its opponent must do more than simply show that there is some metaphysical doubt as to the material facts."). For the evidence to present a "genuine" dispute of material fact, it must be "such that a reasonable jury could return a verdict for the nonmoving party." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). When deciding a motion for summary judgment, courts must view the facts, and inferences to be drawn from the facts, in the light most favorable to the non-moving party. *Id.* at 255.

> [A] party asserting that a fact cannot be or is genuinely disputed must support the assertion by: (A) citing to particular parts of materials in the record, including depositions, documents, electronically stored information, affidavits or declarations, stipulations (including those made for purposes of the motion only),

> admissions, interrogatory answers, or other materials; or (B) showing that the materials cited do not establish the absence or presence of a genuine dispute, or that an adverse party cannot produce admissible evidence to support the fact.

Fed. R. Civ. P. 56(c).

When ruling on a summary judgment motion, "a court may also give credence to other facts supporting the movant, regardless of their source, if such facts are not challenged by the non-moving party because a failure to challenge proffered facts may render such facts 'admitted.'" *XVP Sports, LLC v. Bangs*, No. 2:11cv379, 2012 WL 4329258, at *4 (E.D. Va. Sept. 17, 2012).

As specified in Local Civil Rule 56(B), "the Court may assume that facts identified by the moving party in its listing of [undisputed] material facts are admitted, unless such a fact is controverted in the statement of genuine issues filed in opposition to the motion." E.D. Va. Loc. Civ. R. 56(B).

The applicable standards for resolving the challenges raised by the Board's Motion to Strike are addressed where needed below.

IV. ANALYSIS

A. Motion to Strike Exhibits

In his Reply in support of his Motion for Summary Judgment, Mr. Grimm submitted the following records: (1) a treatment documentation letter written by Dr. Griffin on May 26, 2014; (2) a hormone documentation letter written by Dr. Griffin on May 26, 2014; (3) a "To Whom It May Concern" letter written by Dr. Griffin on July 1, 2014; (4) a "To Whom It May Concern" letter written by Dr. Eva Abel, Psy.D.; (5) treatment records prepared by Dr. Hope Sherie, M.D. FACS; (6) a "To Whom It May Concern" letter written by Dr. Sherie on June 21, 2016; and (7) treatment records from VCU Medical Center.

The Board has filed a Motion to Strike Exhibits submitted by Mr. Grimm in support of his Motion for Summary Judgment. ECF No. 213. The Board seeks to strike four categories of exhibits: (1) the medical records kept by Dr. Penn, Dr. Griffin, and Dr. Sherie that are referred to above; (2) the "To Whom It May Concern" letters; (3) policy statements and amicus briefs relied upon by Mr. Grimm; and (4) references to a public hearing that was held in February 2019. These challenges are addressed in turn.

1. Medical Business Records

The Board argues that Mr. Grimm's submission of medical records from Dr. Penn, Dr. Griffin, and Dr. Sherie constitute expert testimony and that these records must be stricken because Mr. Grimm did not disclose these experts under Federal Rule of Civil Procedure 26. Federal Rule of Civil Procedure 26 provides that a party must disclose, without awaiting a discovery request, any witness it may use to present evidence under Federal Rule of Evidence 702, 703, or 705 governing expert testimony. Fed. R. Civ. P. 26(a)(2)(A). When a party does not comply with Rule 26(a), "the party is not allowed to use that information or witness to supply evidence on a motion, at a hearing, or at a trial, unless the failure was substantially justified or is harmless." Fed. R. Civ. P. 37.

Mr. Grimm is not presenting these exhibits as expert opinion testimony and they are not governed by Rules 702, 703, or 705. Mr. Grimm has established that he is using these records only to demonstrate the fact that Mr. Grimm was diagnosed with gender dysphoria and received treatment pursuant to that diagnosis. ECF No. 216 at 1–6. The Court is not asked to determine whether that diagnosis was medically sound. Nor is the Court asked to determine whether it was medically necessary for Mr. Grimm to use the restrooms consistent with his gender identity. Mr. Grimm does not seek such a ruling and reiterated this at oral argument. Draft Tr. at 11–12.

To support its request to strike, the Board cited cases that excluded documents that differ from the evidence submitted in this case. *See* ECF No. 214 at 6–7. In these decisions, the courts excluded expert reports that were not timely disclosed. *See, e.g., United States ex rel. Lutz, et al. v. Berkeley Heartlab, Inc., et al.*, No. 9:11-CV-1593-RMG, 2017 WL 5957738, at *1 (D.S.C. Dec. 1, 2017) (excluding expert reports opining that certain laboratory tests were medically necessary).

By contrast, Mr. Grimm has submitted documents prepared contemporaneously to his treatment that detail the factual background attendant to his diagnosis and treatment. These documents are permissible. *Morris v. Bland*, 666 F. App'x 233, 239 (4th Cir. 2016) (holding that physicians testifying as fact witnesses may "discuss their examination of [a patient] and their diagnoses or findings," but may not offer expert opinions as to proximate cause).

These records also qualify as hearsay exceptions as defined in Federal Rule of Evidence 803(6). Under Federal Rule of Evidence 803(6), records of an act, event, condition, opinion, or diagnosis are excluded from the bar against hearsay if:

> (A) the record was made at or near the time by–or from information transmitted by–someone with knowledge;
>
> (B) the record was kept in the course of a regularly conducted activity of a business, organization, occupation, or calling, whether or not for profit;
>
> (C) making the record was a regular practice of that activity;
>
> (D) all these conditions are shown by the testimony of the custodian or another qualified witness, or by a certification that complies with [certain rules or statutes];
>
> and
>
> (E) the opponent does not show that the source of information or the method or circumstances of preparation indicate a lack of trustworthiness.

Fed. R. Evid. 803(6).

Medical records are quintessentially business records, and Mr. Grimm has identified adequate custodians for each record presented. For these reasons, the Court denies the Board's Motion to Strike Mr. Grimm's medical documentation.

2. "To Whom It May Concern" Letters

The Board also seeks to strike the "To Whom It May Concern" letters on the basis of hearsay. The Board asserts that such letters "are not the type of records regularly kept in the course of a medical practice . . . ." ECF No. 214 at 7–8. The Board also argues that the letters are untrustworthy because they are addressed to unknown recipients. *Id.* at 8.

The Board offers no support for its assertion that these letters are not the type of records kept regularly in the course of the medical practice. The fact that three different doctors prepared these types of letters contemporaneously with their treatment of Mr. Grimm suggests otherwise.[5]

Regarding trustworthiness, Rule 803(6) makes clear that the burden of showing untrustworthiness falls on the opponent of the records. The Board cites *Garrett v. City of Tupelo*, No. 1:16-cv-197, 2018 WL 2994808 (N.D. Miss. June 14, 2018) to assert that letters addressed to unknown recipients are untrustworthy. However, *Garrett* did not turn on the identity of the recipient of information, but instead turned on the identity of the source of such information. *Id.* at *4 (recognizing that documents may be untrustworthy when information comes from the patient, not the doctor, or when the "*source* of the information is unknown") (emphasis added). The Board has not met its burden of showing that these documents are untrustworthy. Accordingly, the Court declines to strike the "To Whom It May Concern" letters provided by Dr. Griffin, Dr. Abel, and Dr. Sherie.

[5] The Court also notes that the World Professional Association for Transgender Health acknowledges that the role of a health professional working with transgender youth encompasses providing referral letters for hormone therapy and includes advocacy on behalf of their patients at school. WPATH Standards of Care at 13, 31–32, ECF No. 192-5.

3. Policy Statements and Amicus Briefs

The Board seeks to strike evidence submitted by Mr. Grimm that include: (1) the World Professional Association for Transgender Health Standards of Care, (2) amicus briefs from a variety of organizations, including the American Academy of Pediatrics, the National Parent Teacher Association, and school administrators from thirty-three states and the District of Columbia; and (3) other documents reflecting the views of the American Psychological Association and National Association of School Psychologists, Gender Spectrum, and the National Association of Secondary School Principals. *See* ECF No. 214 at 9–13.

The Board does not dispute that the statements presented in these documents reflect the views of these organizations. Instead, the Board argues that Mr. Grimm cannot use these documents to prove the truth of the matters asserted. Mr. Grimm responds that he is using these documents only as evidence of these organizations' views. Given that there is no dispute regarding the propriety of the intended use of these documents, the Court need not strike them. The Court has considered these documents as evidence of the views of the organizations that prepared them, and not as substantive evidence of the accuracy of such views.

4. Public Hearing References

On February 19, 2019, the Board announced that it was considering a new policy that would allow transgender students to use restrooms consistent with their gender identity if certain criteria were met. Feb. 3, 2019 Press Release, ECF No. 192-35. The proposed policy arose out of settlement negotiations between the parties. Shayna Medley-Warsoff Decl. ¶ 53, ECF No. 192. The policy was ultimately rejected.

The Board argues that the Court should strike any evidence related to the February 2019 hearing under Federal Rule of Evidence 408, which prohibits the use of evidence related to

compromise negotiations. At the summary judgment hearing, counsel for Mr. Grimm stated that the Court need not consider the statements made at the February 2019 hearing. Draft Tr. at 11. Accordingly, the Court has not considered evidence related to that hearing and **GRANTS** the Board's Motion to Strike any evidence related to it.

B. Gavin Grimm's Motion for Summary Judgment

1. Title IX

Title IX provides that no person "shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any educational program or activity receiving Federal financial assistance." 20 U.S.C. § 1681(a); *see also* 34 C.F.R. § 106.31. To obtain relief for claims alleging a violation of Title IX, a plaintiff must demonstrate that (1) he or she was excluded from participation in an education program because of his or her sex; (2) the educational institution was receiving federal financial assistance at the time of his or her exclusion; and (3) the improper discrimination caused the plaintiff harm. *Grimm I*, 822 F.3d at 718 (citing *Preston v. Virginia ex rel. New River Cmty. Coll.*, 31 F.3d 203, 206 (4th Cir. 1994)). The Board does not dispute that it receives federal financial assistance. ECF No. 154 ¶ 91. Accordingly, only the first and third elements are disputed.

(a) Gavin Grimm was excluded from participation in an education program on the basis of sex.

In its May 22, 2018 Order, this Court concluded that claims of discrimination on the basis of transgender status are *per se* actionable under a gender stereotyping theory. ECF No. 148 at 20. The Board argues that this decision was made in error and that "the plain language of Title IX and its implementing regulation, 34 C.F.R. § 106.33," define sex as a binary term encompassing the physiological distinctions between men and women. ECF No. 200 at 27–28.

The Board presents no intervening case law that compels reconsideration of this decision. To the contrary, every court to consider the issue since May 22, 2018 has agreed with the analysis relied upon by this Court. *See Doe by & through Doe v. Boyertown Area Sch. Dist.*, 897 F.3d 518, 530 (3d Cir. 2018) (stating that a policy forcing transgender students to use separate facilities "would very publicly brand all transgender students with a scarlet 'T,' and they should not have to endure that as the price of attending their public school"); *Adams by & through Kasper v. Sch. Bd. of St. Johns Cty.*, 318 F. Supp. 3d 1293, 1325 (M.D. Fla. 2018) (holding that "the meaning of 'sex' in Title IX includes 'gender identity' for purposes of its application to transgender students" and that the transgender student proved a Title IX violation where a school board denied him from using male restrooms, causing him harm) *appeal docketed*, No. 18-13592 (11th Cir. Aug. 24, 2018); *Parents for Privacy v. Dallas Sch. Dist. No. 2*, 326 F. Supp. 3d 1075, 1106 (D. Or. 2018) ("Forcing transgender students to use facilities inconsistent with their gender identity would undoubtedly harm those students and prevent them from equally accessing educational opportunities and resources. Such a . . . District policy would punish transgender students for their gender noncomformity and constitute a form of sex-stereotyping.") *appeal docketed*, 18-35708 (9th Cir. Aug. 23, 2018). This Court believes that this reasoning is sound and correct and declines to revisit its prior holding.

In sum, there is no question that the Board's policy discriminates against transgender students on the basis of their gender noncomformity. Under the policy, all students except for transgender students may use restrooms corresponding with their gender identity. Transgender students are singled out, subjected to discriminatory treatment, and excluded from spaces where similarly situated students are permitted to go.

The Board responds that its policy treats all students equally on the basis of physiological or anatomical characteristics, and that these characteristics should not be considered sex stereotypes under *Price Waterhouse*. This argument is unpersuasive.

The Board's policy relies on the term "biological gender." *See* ECF No. 192-21. As this Court recognized previously, biological gender is not a medically accepted term. *See* ECF No. 148 at 14–15 (explaining that "sex" refers to biological attributes such as genes, chromosomes, genitalia, and secondary sex characteristics, and "gender" refers to the "'internal, deeply held sense' of being a man or woman'") (citing Wylie C. Hembree *et al.*, *Endocrine Treatment of Gender-dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102(11), J. CLIN. ENDOCRINOLOGY & METABOLISM 3869, 3875 (2017)). The policy's use of an ambiguous term obscures the basis for excluding transgender students from restrooms that they believe are appropriate and safe for them.

Moreover, the Board has inadequately explained the physiological and anatomical characteristics it relies upon to enforce its policy. For example, Mr. Grimm has had chest reconstruction surgery. The Gloucester County Circuit Court referred to Mr. Grimm's chest reconstruction surgery as "gender reassignment surgery," relying on that surgery in part in determining that Mr. Grimm is a male. However, this surgery is insufficient under the Board's policy. At the summary judgment hearing, counsel for the Board argued that an individual must have "the primary genitals and sex characteristic of a particular gender." Draft Tr. at 26. "Primary genitals" may be sufficiently clear, but "sex characteristic" is troublingly ambiguous. Many aspects of biology determine a person's sex, including genitalia, *and also* including hormones, genes, chromosomes, and other factors that comprise a person's biological makeup. The policy at issue uses some of these factors to define sex and ignores others. In determining the physical

characteristics that define male and female and the characteristics that are disregarded, the Board has crafted a policy that is based on stereotypes about gender. *See Brumby*, 663 F.3d at 1316 ("A person is defined as transgender precisely because of the perception that his or her behavior transgresses gender stereotypes. . . . There is thus a congruence between discriminating against transgender and transsexual individuals and discrimination on the basis of gender-based behavioral norms."); *City of L.A., Dep't of Water & Power v. Manhart*, 435 U.S. 702, 707 (1978) (stating that protections from sex discrimination are not limited to discrimination based on "myths and purely habitual assumptions," but also extend to discrimination based on generalizations that are "unquestionably true").

Additionally, Mr. Grimm has both a valid court order and a state-issued birth certificate identifying him as male. All other students with male birth certificates at Gloucester High School are permitted to use male restrooms. Mr. Grimm was the only student with a male birth certificate excluded from the male restrooms. This constitutes discriminatory treatment by the Board.

Furthermore, the Board has refused to update Mr. Grimm's transcripts and education documents, despite his amended birth certificate. The Board argues that his amended birth certificate does not comply with Virginia law and questions its authenticity. Such questions have been dispelled by the Declaration of Janet M. Rainey. ECF No. 195. Ms. Rainey is the State Registrar and Director of the Division of Vital Records and administers Virginia's system of vital records in accordance with Virginia law. She issued Gavin Grimm an amended birth certificate on October 27, 2016 that identifies him as male. *Id.* Regardless of prior concerns about the amended birth certificate's authenticity,[6] the Board's continued recalcitrance in the face of Ms.

---

[6] It is obvious from the face of the amended birth certificate that the photocopy presented to the Board was marked "void" because it was a copy of a document printed on security paper, not because it was fabricated. *See* ECF No. 184-6 (a copy of Mr. Grimm's birth certificate, stating that it the original is printed on security paper and is void

Rainey's Declaration and the court order from the Gloucester County Circuit Court is egregious. It is also discriminatory. Other students in the Gloucester County School system with male birth certificates also have male transcripts. Undeniably, the Board discriminates against Mr. Grimm in violation of Title IX in refusing to afford him the same dignity.

The Board also argues that Mr. Grimm has not proven that his use of male restrooms was medically necessary. However, the questions presented in this case do not require a finding that Mr. Grimm's use of a male restroom was medically necessary. The Board treated Mr. Grimm differently than other students on the basis of sex and, as established below, he suffered some measure of harm from that treatment. The existence of other methods of social transition for transgender individuals is, for the purposes of resolving the questions presented, irrelevant.

The Court concludes that the Board has discriminated against Gavin Grimm on the basis of his transgender status in violation of Title IX. The Court must next determine whether the improper discrimination caused Mr. Grimm harm.

(b) The Board's policy harmed Gavin Grimm.

In his Declaration, Mr. Grimm described under oath feeling stigmatized and isolated by having to use separate restroom facilities. Gavin Grimm Decl. ¶ 47. His walk to the restroom felt like a "walk of shame." *Id.* ¶ 50. He avoided using the restroom as much as possible and developed painful urinary tract infections that distracted him from his class work. *Id.* ¶ 51. This stress "was unbearable" and the resulting suicidal thoughts he suffered led to his hospitalization at Virginia Commonwealth University Medical Center Critical Care Hospital. *Id.* ¶ 54.

Despite this evidence, the Board contends that Mr. Grimm has suffered no harm. ECF No. 200 at 29–30. The Board has discounted Mr. Grimm's testimony that separate restroom facilities

---

without a watermark). In any event, given Ms. Rainey's Declaration, the Board rationalizes its continuing denial of Mr. Grimm's amended birth certificate on specious grounds: that a photocopy was marked void.

caused him mental distress because he has not identified an expert to testify that he suffered such distress.[7] *Id.* Similarly, the Board argues that Mr. Grimm cannot prove that he suffered from painful urinary tract infections because he presented no supporting medical evidence. *Id.*

The Board's argument that Mr. Grimm's testimony regarding his harm is inadequate because it is not bolstered by expert testimony is untenable.[8] The Board's argument has no basis in law. *See Adams*, 318 F. Supp. 3d at 1316 (relying on a transgender student's own testimony to conclude that the student suffered harm in the form of stigma and humiliation).

The Board's assertion that Mr. Grimm has suffered no harm as a result of its policy is strikingly unconvincing. Mr. Grimm broke down sobbing at school because there was no restroom he could access comfortably. After one breakdown, Mr. Grimm was hospitalized with suicidal thoughts. He avoided after-school activities such as football games. He experienced pain and discomfort as a result of avoiding restrooms while at school.[9] Further expert testimony is unnecessary to conclude that the Board's policy harmed Mr. Grimm during his high school years.

There is also sufficient evidence to conclude that the Board continues to harm Mr. Grimm by refusing to update his school records to reflect his male identity. Whenever Mr. Grimm has to provide a copy of his transcript to another entity, such as a new school or employer, he must "show them a document that negates [his] male identity and marks him different from other boys." Gavin

---

[7] The Board "disputes" Mr. Grimm's statements regarding his harm suffered because the Board labels his Declaration as "self-serving." Dismissing a party's testimony as self-serving while failing to present contradicting evidence is plainly insufficient to establish a genuine dispute of material fact.

[8] At the hearing, the Court read portions of Mr. Grimm's declaration into the record regarding the humiliation and stigma he suffered as a result of the Board's policy. The Court asked defense counsel whether that testimony could support a finding of harm, warranting at least an award of nominal damages. Counsel responded that "I think the answer is yes. . . . I don't think we can say there [are] no nominal damages here." Draft Tr. at 26.

[9] Medical documentation confirming that his discomfort was caused by urinary tract infections is irrelevant for the purposes presented here. There is sufficient evidence that Mr. Grimm suffered pain of some measure, for which he requests only injunctive relief and nominal damages.

Grimm Decl. ¶ 69. The Board continues to harm Mr. Grimm every time he is asked to furnish his records. This harm compels at least an award of injunctive relief and nominal damages.

Mr. Grimm has established (1) that he was excluded from the restrooms at Gloucester High School on the basis of gender stereotypes; (2) the educational institution received federal financial assistance at the time of his exclusion; and (3) improper discrimination caused him harm. For these reasons, summary judgment is **GRANTED** in favor of Mr. Grimm regarding his claim asserting a violation of Title IX (Count Two).

2. Equal Protection Clause

Mr. Grimm also alleges that the Board's actions violated the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution, which provides that "[n]o State shall . . . deny to any person within its jurisdiction the equal protection of the laws." U.S. Const. amend. XIV § 1. The Equal Protection Clause "is essentially a directive that all persons similarly situated should be treated alike." *Whitaker by Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1050 (7th Cir. 2017) (quoting *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 439 (1985)).

In its May 22, 2018 ruling, this Court held that intermediate scrutiny must be applied in analyzing claims of discrimination against transgender individuals. ECF No. 148 at 24. Although the Board seeks reconsideration of this holding, it presents no authorities that compel a different result.[10] Other courts that have considered this issue since May 2018 have agreed that heightened scrutiny applies. *See, e.g., Karnoski v. Trump,* 926 F.3d 1180, 1200–02 (9th Cir. 2019) (holding that intermediate scrutiny applies to alleged discrimination against transgender individuals in the

[10] Instead, the Board's citations include out-of-circuit cases from the 1980s and 1990s, cases that interpret Title VII instead of the Equal Protection Clause, and cases that pertain to sexual orientation, not gender identity. The Board's citations are unpersuasive.

military); *Adams by & through Kasper*, 318 F. Supp. 3d at 1296, 1312–13 (applying intermediate scrutiny and noting that "federal courts around the country have recognized the right of transgender students to use the bathroom matching their gender identity"). In light of these rulings, this Court rejects defense counsel's argument that it is "step[ping] out on its own." *See* ECF No. 200 at 32.

When applying intermediate scrutiny to a sex-based classification, the Board bears the burden of demonstrating that its proffered justification for its use of the classification is "exceedingly persuasive." *United States v. Virginia*, 518 U.S. 515, 533 (1996). The Board is required to demonstrate that the classification "serves important governmental objectives and that the discriminatory means employed are substantially related to the achievement of those objectives." *Id.* at 524.

In response, the Board asserts an interest in protecting the privacy rights of students, specifically privacy interests that students have in protecting their unclothed bodies.[11] ECF No. 200 at 33. There is little doubt that students have a privacy right in avoiding exposure of their unclothed bodies.

Defendant makes no showing, however, that the challenged policy is "substantially related" to protecting student privacy. First, it is undisputed that the Board received no complaints regarding any encounter with Mr. Grimm in a restroom. Andersen Dep. 13:20–14:5. The fact that Mr. Grimm used male restrooms for seven weeks without incident is evidence suggesting that the Board's privacy concerns are unwarranted. *Cf. Whitaker*, 858 F.3d at 1052 (noting that the school district's privacy argument was undermined by the fact that a transgender boy used male restrooms for six months without incident).

---

[11] The Board cites a case involving strip searches of students. *See* ECF No. 200 at 33 (citing *Doe v. Renfrow*, 631 F.2d 91, 92–93 (7th Cir. 1980)). Those situations are starkly distinct from transgender students seeking to use a restroom.

The Board's privacy argument also ignores the practical realities of how transgender individuals use a restroom. *See Grimm I*, 822 F.3d at 723 n.10 (expressing doubt that "G.G.'s use . . . or for that matter any individual's appropriate use of a restroom" would involve the types of intrusions present in other cases where privacy abuses were found); *Whitaker*, 858 F.3d at 1052 (holding that a similar policy "ignores the practical reality of how [the plaintiff], as a transgender boy, uses the bathroom: by entering a stall and closing the door"); *Adams*, 318 F. Supp. 3d at 1296, 1314 ("When he goes into a restroom, [the transgender student] enters a stall, closes the door, relieves himself, comes out of the stall, washes his hands, and leaves.").

At the summary judgment hearing, defense counsel conceded that there is no privacy concern for other students when a transgender student walks into a stall and shuts the door. Draft Tr. at 38. However, the Board's 30(b)(6) witness, Troy Andersen, testified that privacy concerns are implicated when students use the urinal, use the toilet, or open their pants to tuck in their shirts. Andersen Dep. 30:10–20. When asked why the expanded stalls and urinal dividers could not fully address those situations, Mr. Andersen responded that he "was sure" the policy also protected privacy interests in other ways, but that he "[couldn't] think of any other off the top of [his] head." *Id.* This Court is compelled to conclude that the Board's privacy argument "is based upon sheer conjecture and abstraction." *See Whitaker*, 858 F.3d at 1052.

Even if there were a plausible risk of exposure to nudity, transgender individuals often undergo a variety of procedures and treatments that result in anatomical and physiological changes, such as puberty blockers and hormone therapy. Such treatments can result in transgender girls developing breasts or transgender boys developing facial hair. If exposure to nudity were a real concern, forcing such a transgender girl to use the male restrooms could likely expose boys to

viewing physical characteristics of the opposite sex. From this perspective, the Board's privacy concerns fail to support the policy it implemented.

When asked why transgender students present a greater risk of invasion of privacy to students than the risk from someone of the same physiological sex, Mr. Andersen answered "I would say that it just goes back to [bathroom] use relying on the social norms of binary sexes." Andersen Dep. 31:4–10. However, "mere negative attitudes, or fear, unsubstantiated by factors which are properly cognizable . . . are not permissible bases" for discrimination. *Cleburne Living Ctr.*, 473 U.S. at 448. The Board has failed to meet its burden to provide an "exceedingly persuasive justification" for its policy. Accordingly, its policy must be found unconstitutional under the Equal Protection Clause.

Moreover, the Board's continued refusal to update Mr. Grimm's school records implicates no privacy concerns. The Board has put forward no justification for refusing to correct these records other than alleged concerns about his amended birth certificate's compliance with law and authenticity. These unsubstantiated doubts are easily dispelled by Janet Rainey's Declaration.

For these reasons, summary judgment must be **GRANTED** in favor of Gavin Grimm on his claim for a violation of the Equal Protection Clause (Count One).

3. Mr. Grimm's request for a permanent injunction

Mr. Grimm seeks an injunction requiring the Board to update his school records to reflect his male identity. To obtain a permanent injunction, a plaintiff must show: "(1) irreparable injury, (2) remedies at law are inadequate to compensate for that injury, (3) the balance of hardships between the plaintiff and defendant warrants a remedy, and (4) an injunction would not disserve the public interest." *Raub v. Campbell*, 785 F.3d 876, 885 (4th Cir. 2015) (internal quotations

omitted). "[T]he deprivation of constitutional rights unquestionably constitutes irreparable injury." *Melendres v. Arpaio*, 695 F.3d 990, 1002 (9th Cir. 2012) (internal quotations omitted).

The Court has already determined that Mr. Grimm has suffered injury that is ongoing and thus cannot be compensated by mere monetary damages. The balance of hardships also weighs in Mr. Grimm's favor. The Board has not identified any difficulty in altering Mr. Grimm's records. Nor has it identified any other governmental interest in refusing to update Mr. Grimm's records other than those already addressed in this Order. By contrast, Mr. Grimm suffers great hardship when he presents school records that negate his male identity. Finally, an injunction would serve the public's interest in upholding constitutional rights. *See Centro Tepeyac v. Montgomery Cty.*, 722 F.3d 184, 191 (4th Cir. 2013) (en banc) (internal quotations omitted). For these reasons, a permanent injunction requiring the Board to update Mr. Grimm's school records is warranted.

C. Gloucester County School Board's Motion for Summary Judgment

The Board also moves for summary judgment. ECF No. 195. The Board first argues that Title IX's prohibition of discrimination "on the basis of sex" does not encompass the Board's policy and that the definition of sex in the statute and its implementing regulation do not account for gender identity. ECF No. 196 at 10–30. The Court rejected this argument on May 22, 2018 and it reaffirms that holding today.[12]

Regarding the Equal Protection Clause, the Board argues that its policy should not be subjected to heightened scrutiny but should be subjected to a lower level of scrutiny: rational basis review.[13] *Id.* at 32–37. The Board argues that its policy survives such review. *Id.* The Court

---

[12] Much of the Board's Summary Judgment Motion is an attempt to relitigate this Court's prior holdings. For example, the Board argues that if "sex" were equated with "gender identity," Title IX and its regulations would be invalid for lack of clear notice. ECF No. 196 at 29–30 (citing *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981)). This Court found this exact argument "unavailing." ECF No. 148 at 20 n.11.

[13] Under rational basis review, a court analyzes whether a law is "rationally related to a legitimate governmental interest." *U.S. Dep't. of Agric. v. Moreno*, 413 U.S. 528, 533 (1973).

again rejects this argument. The Board also reasserts that its policy survives intermediate scrutiny for the same reasons advanced in opposition to Mr. Grimm's Motion for Summary Judgment, as addressed above. Those arguments remain unavailing. Accordingly, the Gloucester County School Board's Motion for Summary Judgment, ECF No. 195, is **DENIED**.

V. CONCLUSION

Parents, teachers and administrators share "a solemn obligation to guard the well-being of the children in their charge." *Adams*, 318 F. Supp. 3d at 1296.

> As recent events from around the country have tragically demonstrated, this is a very challenging job. Recognizing the difficulty of this task and that local school boards, answerable to the citizens of their community, are best situated to set school policy, federal courts are reluctant to interfere. Nevertheless, the federal court also has a solemn obligation: to uphold the Constitution and laws of the United States. That is why federal courts around the country have recognized the right of transgender students to use the bathroom matching their gender identity.

Id.

Nelson Mandela said that "[h]istory will judge us by the difference we make in the everyday lives of children." One need only trace the arduous journey that this litigation has followed since its inception over four years ago to understand that passion and conviction have infused the arguments and appeals along the way.[14] The Board undertook the unenviable

---

[14] A cursory collection of salient events docketed in this matter include the following: the initial Complaint, June 11, 2015; a Motion to Dismiss Complaint argued, July 27, 2015, and partially granted; Order denying Plaintiff's Motion for Preliminary Injunction, September 4, 2015; Order denying an injunction appealed to the United States Court of Appeals for the Fourth Circuit, September 8, 2015; the Memorandum Opinion granting dismissal and denying motion for injunction, September 17, 2015; the Fourth Circuit's partial reversal of dismissal Order, April 19, 2016; the Order permitting Plaintiff's use of male restrooms at Gloucester County High School, June 23, 2016; Defendant's appeal of the June 23, 2016 Order, June 27, 2016; the Order denying a stay pending appeal, July 6, 2016; the United States Supreme Court's stay of the injunction pending resolution of an anticipated petition for writ of certiorari, August 3, 2016; the Fourth Circuit vacating the preliminary injunction, April 7, 2017; reassignment of the case to the undersigned, June 6, 2017; an Amended Complaint, August 22, 2017; a Motion to Dismiss Amended Complaint, September 22, 2017; supplemental briefing ordered, October 26, 2017; an Amended Motion to Dismiss, January 5, 2018; an Order denying the Amended Motion to Dismiss, May 22, 2018; Order granting a Motion for Leave to take Interlocutory Appeal, June 5, 2018; a Second Amended Complaint, February 15, 2019; cross-motions for summary judgment, March 26, 2019; Defendant's Motion to Exclude and Strike Exhibits, April 30, 2019; and oral argument on cross-motions for summary judgment and on the Motion to Strike, July 23, 2019.

responsibility of trying to honor expressions of concern advanced by its constituency as it navigated the challenges presented by issues that barely could have been imagined or anticipated a generation ago. This Court acknowledges the many expressions of concern arising from genuine love for our children and the fierce instinct to protect and raise our children safely in a society that is growing ever more complex. There can be no doubt that all involved in this case have the best interests of the students at heart.[15]

At the same time, the Court acknowledges that for seven weeks, the student body at Gloucester High School accommodated Mr. Grimm without incident as he—assisted by compassionate school and medical representatives—took new paths in his everyday life. This Court is compelled to acknowledge too that some of the external challenges seeking to reroute these new paths inflicted grief, pain, and suicidal thoughts on a child.

However well-intentioned some external challenges may have been and however sincere worries were about possible unknown consequences arising from a new school restroom protocol, the perpetuation of harm to a child stemming from unconstitutional conduct cannot be allowed to stand. These acknowledgements are made in the hopes of making a positive difference to Mr. Grimm and to the everyday lives of our children who rely upon us to protect them compassionately and in ways that more perfectly respect the dignity of every person.

Therefore, the Board's Motion to Strike, ECF No. 213, is **GRANTED IN PART** and **DENIED IN PART**. Gavin Grimm's Motion for Summary Judgment, ECF No. 184, is **GRANTED**. The Board's Motion for Summary Judgment, ECF No. 191, is **DENIED**.

---

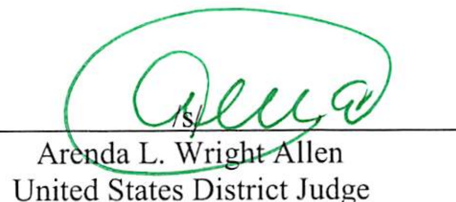
[15] "When confronted with something affecting our children that is new, outside of our experience, and contrary to gender norms we thought we understood, it is natural that parents want to protect their children. But the evidence is that [the plaintiff] poses no threat to the privacy or safety of any of his fellow students. Rather, [the plaintiff] is just like every other student . . . , a teenager coming of age in a complicated, uncertain and changing world." *Adams*, 318 F. Supp. 3d at 1297.

The Court **ORDERS** the following relief:

- The Court **DECLARES** that the Board's policy violated Mr. Grimm's rights under the Fourteenth Amendment to the United States Constitution and Title IX of the Education Amendments of 1972, on the day the policy was first issued and throughout the remainder of his time as a student at Gloucester High School;
- The Court **DECLARES** that the Board's refusal to update Mr. Grimm's official school transcript to conform to the "male" designation on his birth certificate violated and continues to violate his rights under the Fourteenth Amendment to the United States Constitution and Title IX of the Education Amendments of 1972;
- Nominal damages are awarded to Mr. Grimm in the amount of one dollar;
- The Court issues a permanent injunction requiring the Board to update Mr. Grimm's official school records to conform to the male designation on his updated birth certificate and to provide legitimate copies of such records to Mr. Grimm within ten days of the date of this Order;
- The Board shall pay Mr. Grimm's reasonable costs and attorneys' fees pursuant to 42 U.S.C. § 1988.

The Clerk is **REQUESTED** to forward a copy of this Order to all parties and counsel of record.

IT IS SO ORDERED.



/s/
Arenda L. Wright Allen
United States District Judge

August 9th, 2019
Norfolk, Virginia

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM,

Plaintiff,

v. **Civil Action No. 4:15cv54**

GLOUCESTER COUNTY SCHOOL BOARD,

Defendant.

JUDGMENT IN A CIVIL CASE

Decision by the Court. This action came for decision before the Court. The issues have been considered and a decision has been rendered.

IT IS ORDERED AND ADJUDGED that Gavin Grimm's Motion for Summary Judgment, ECF 184, is **GRANTED**. Gloucester County School Board's Motion for Summary Judgment, ECF 191, is **DENIED**.

The Court **ORDERS** the following relief:

- The Court **DECLARES** that the Board's policy violated Mr. Grimm's rights under the Fourteenth Amendment to the United States Constitution and Title IX of the Education Amendments of 1972, on the day the policy was first issued and throughout the remainder of his time as a student at Gloucester High School;
- The Court **DECLARES** that the Board's refusal to update Mr. Grimm's official school transcript to conform to the "male" designation on his birth certificate violated and continues to violate his rights under the Fourteenth Amendment to the United States Constitution and Title IX of the Education Amendments of 1972;
- Nominal damages are awarded to Mr. Grimm in the amount of one dollar;
- The Court issues a permanent injunction requiring the Board to update Mr. Grimm's official school records to conform to the male designation on his updated birth certificate and to provide legitimate copies of such records to Mr. Grimm within ten days of the date of this Order;
- The Board shall pay Mr. Grimm's reasonable costs and attorneys' fees pursuant to 42 U.S.C. § 1988.

Dated: August 9, 2019 FERNANDO GALINDO, Clerk

By: /s/
B. Peters, Deputy Clerk

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM,

Plaintiff,

v. Case No. 4:15-cv-54

GLOUCESTER COUNTY SCHOOL
BOARD,

Defendant.

NOTICE OF APPEAL

Defendant Gloucester County School Board ("School Board"), by counsel, hereby appeals to the United States Court of Appeals for the Fourth Circuit from the final judgment entered on August 9, 2019.

GLOUCESTER COUNTY SCHOOL BOARD

By Counsel

/s/

David P. Corrigan (VSB No. 26341)
Jeremy D. Capps (VSB No. 43909)
Attorneys for Gloucester County School Board
Harman, Claytor, Corrigan & Wellman
P.O. Box 70280
Richmond, Virginia 23255
804-747-5200 - Phone
804-747-6085 - Fax
dcorrigan@hccw.com
jcapps@hccw.com

CERTIFICATE

I hereby certify that on the 30th day of August, 2019, I filed a copy of the foregoing document with the Clerk of the Court using the CM/ECF system, which will automatically send a Notice of Electronic Filing to all counsel of record.

/s/
David P. Corrigan (VSB No. 26341)
Jeremy D. Capps (VSB No. 43909)
Attorneys for Gloucester County School Board
Harman, Claytor, Corrigan & Wellman
P.O. Box 70280
Richmond, Virginia 23255
804-747-5200 - Phone
804-747-6085 - Fax
dcorrigan@hccw.com
jcapps@hccw.com

RECORD NO. 19-1952

In The
United States Court of Appeals
For The Fourth Circuit

GAVIN GRIMM,

Plaintiff – Appellee,

v.

GLOUCESTER COUNTY SCHOOL BOARD,

Defendant – Appellant.

**ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
AT NEWPORT NEWS**

**JOINT APPENDIX
VOLUME IV OF IV – EXHIBIT
(Pages 1196 – 1219)**

**David P. Corrigan
Jeremy D. Capps
M. Scott Fisher, Jr.
George A. Somerville
HARMAN CLAYTOR
CORRIGAN & WELLMAN
Post Office Box 70280
Richmond, Virginia 23255
(804) 747-5200**

Counsel for Appellant

**Joshua A. Block
Leslie Cooper
AMERICAN CIVIL LIBERTIES UNION
125 Broad Street, 18th Floor
New York, New York 10004
(212) 549-2593**

Counsel for Appellee

**Eden Brooke Heilman
Jennifer Marie Safstrom
Nicole Gloria Tortoriello
AMERICAN CIVIL LIBERTIES
UNION FOUNDATION OF VIRGINIA
701 East Franklin Street, Suite 1412
Richmond, Virginia 23219
(804) 532-2152**

Counsel for Appellee

THE LEX GROUP ♦ 1108 East Main Street ♦ Suite 1400 ♦ Richmond, VA 23219
(804) 644-4419 ♦ (800) 856-4419 ♦ Fax: (804) 644-3660 ♦ www.thelexgroup.com

TABLE OF CONTENTS
VOLUME I OF IV

Appendix Page

Docket Entries 1

Order of
The Honorable Arenda L Wright Allen
Re: Granting Consent Motion for Dismissal of Requests for Relief and
Plaintiff's Motion to Vacate Order for Supplemental Briefing and
Dismissing Request for Relief of Plaintiff's A mended Compliant
filed December 12, 2017 29

Order of
The Honorable Arenda L Wright Allen
Re: Denying Amended Motion to Dismiss
filed May 22, 2018 35

Order of
The Honorable Arenda L Wright Allen
Re: Granting Plaintiff's Motion for Leave to
File Second Amended Complaint
filed February 15, 2019 66

Second Amended Complaint
filed February 15, 2019 70

Answer to Second Amended Complaint
filed March 1, 2019 89

Declaration of Gavin Grimm,
With Exhibits,
filed March 26, 2019 108

Exhibits:

A. Treatment Documentation Letter
dated May 26, 2014 123

B. Letter from
R. Smalls to
Virginia Department of Motor Vehicles
dated June 5, 2015 124

C. Order of
The Circuit Court of Gloucester County
dated September 9, 2016 125

D. Redacted Birth Certificate 127

E. Redacted Transcript of Gavin Grimm's Grades
various dates 128

Declaration of Deirdre Grimm
filed March 26, 2019 129

Declaration of Shayna Medley Warsoff,
With Exhibits,
filed March 26, 2019 136

Exhibits:

1. Defendant's Answer to Plaintiff's First Interrogatories
dated December 13, 2018 145

2. Defendant's Supplemental Answer to
Plaintiff's Interrogatory No. 1
dated January 11, 2019 159

3. Expert Report and Declaration of Dr. Melinda Penn, M.D.,
dated January 8, 2019 172

Exhibits, continued:

4. **Eastern Virginia Medical School**
Curriculum Vitae of Melinda Penn, MD
various dates 183

5. **Standards of Care for the Health of Transsexual Transgender, and Gender Nonconforming People**
undated 188

6. **Endocrine Society Guidelines**
undated 306

7. **Expert Report of Dr. Quentin Van Meter**
dated February 26, 2019 341

TABLE OF CONTENTS
VOLUME II OF IV

Appendix Page

Declaration of Shayna Medley Warsoff,
With Exhibits,
filed March 26, 2019:

Exhibits, continued:

8. Rebuttal Expert Report and Declaration of Dr. Melinda Penn, MD dated March 4, 2019 361

9. Excerpts of Transcript of Deposition of Nathan Collins taken September 21, 2018 363

Examination 364

10. Excerpts of Transcript of Deposition of Walter Clemons, PhD taken September 21, 2018 408

Examination 409

11. Excerpts of Transcript of Deposition of Tiffany Durr taken October 10, 2018 426

Examination 427

12. Excerpts of Transcript of Deposition of Matthew R. Lord taken October 10, 2018 436

Examination 437

13. Transcript of Deposition of Troy Andersen taken March 12, 2019 443

Examination 447

Exhibits, continued:

14. Transcript of Deposition of Dr. Quentin Van Meter taken March 18, 2019 541

Examination by Mr. Block.. 547

TABLE OF CONTENTS
VOLUME III OF IV

Appendix Page

Declaration of Shayna Medley Warsoff,
With Exhibits,
filed March 26, 2019:

Exhibits, continued:

15. Mr. Collins's Memorandum to Deirdre Grimm
dated October 14, 2014 758

16. Dr. Clemons's Email to the School Board
dated October 22, 2014 759

17. Mr. Collins's Memorandum to Dr. Clemons
dated October 23, 2014 760

18. Emails from Carla Hook to a Constituent
dated October 24-27, 2014 762

19. Email from Carla Hook to a Constituent
dated October 31, 2014 765

20. Email from Carla Hook to the School Board
dated November 4, 2014 766

21. Email and Attachment from Carla Hook to the School Board
dated November 9, 2014 767

22. School Board's Press Release
dated December 3, 2014 769

23. Recorded Minutes of Gloucester County School Board Meeting
held December 9, 2014 772

24. Mr. Collins's Correspondence
to Deirdre and David Grimm
dated December 10, 2014 779

<u>Exhibits</u>, continued:

25. Email from Amy Bergh to Mr. Collins
dated November 19, 2014 780

26. Transcript of Deposition of Gavin Grimm
taken October 19, 2018 781

Examination by Mr. Corrigan 786
Examination by Mr. Block 948
Examination by Mr. Corrigan 952

27. Presentation Given at the
2014 Virginia School Board Association Conference 958

28. Map of Gloucester High School
dated 2009-2010 969

29. Gloucester High School Map, Locations of School Restrooms
dated 2009-2010 970

30. List of Restrooms at Gloucester High School
undated 971

31. Letter from Joshua Block to David Corrigan
dated December 23, 2016 972

35. Gloucester County School Board press release
dated February 13, 2019 973

36. Gloucester County School Board press release
dated February 21, 2019 974

37. Recorded Minutes of Gloucester County School Board Meeting
dated November 11, 2014 975

Declaration of Janet M. Rainey
filed March 26, 2019 982

Exhibits to Brief in Support of Defendant's Motion for Summary Judgment filed March 26, 2019:

Exhibits:

E. Declaration of Troy Andersen, With Supporting Documents, dated March 25, 2019 983

Attachments:

1. Gavin Grimm's Enrollment Records with The Gloucester County School System various dates 985

2. Gavin Grimm's freshman Report Card for the School Year 2013-2014 991

3. Gavin Grimm was Offered the Opportunity to Have a Hearing with the School Board on Iris Request to Change his School Records on January 18, 2017 992

I. Defendant's Supplemental Answer to Plaintiff's Interrogatory No. 1 dated January 11, 2019 994

Declaration of James H. Loving, With Attached Photographs, filed March 26, 2019 1007

Exhibits to Plaintiff's Memorandum of Law in Opposition to Defendant's Motion for Summary Judgment filed April 9, 2019:

1. Declaration of Shayna Medley Warsoff dated April 9, 2019 1021

A. Transcript of Deposition of Melinda Penn, MD taken March 14, 2019 1023

Examination by Mr. Capps 1028

C. Diagnostic and Statistical Manual of Mental Disorders, With Attachment, Fifth Edition, DSM-5 1115

Attachment:

Email from Amy Bergh to Nate Collins dated November 19, 2014....1118

Transcript of Motions Hearing before The Honorable Arenda L Wright Allen on July 23, 2019 1119

Order of The Honorable Arenda L Wright Allen Re: Granting Plaintiff's Motion for Summary Judgment, Denying the Board's Motion for Summary Judgment filed August 9, 2019....1165

Judgment in a Civil Case filed August 9, 2019....1193

Defendant's Notice of Appeal filed August 30, 2019....1194

TABLE OF CONTENTS
VOLUME IV OF IV – EXHIBIT

Appendix Page

Exhibits to Brief in Support of Defendant's Motion for Summary Judgment filed March 26, 2019:

Exhibits

F. **Gavin Grimm's Enrollment Records with The Gloucester County School System various dates** 1196

N. **Redacted Birth Certificate** 1218

O. **Redacted Birth Certificate** 1219

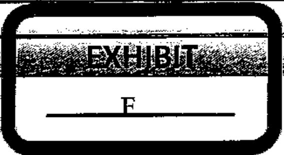
CONFIDENTIAL

Gloucester County Public Schools

25788
GRIMM, REDACTED
F
CAUCASIAN
REDA /99
C RE
REDACTED
REDACTED

ENTRANCE, WITHDRAWAL AND TRANSFER RECORD

FROM	TO	DATE	GRADE
	Bethel	9/04	K
Bethel	Home Instruction	4/24/08	4
Home instruction	Bethel	9/09	5th
Peasley M.S.	Page M.S.	6/2012	



GCSB - 1086

CONFIDENTIAL

Gloucester County Public Schools
Report Card

Gloucester High School
6680 Short Lane
Gloucester, VA 23061

Report Card Printed on June 17, 2014

School Year: 2013-2014

Reporting Period: Q4

REDACTED GRIMM - REDACTED

REDACTED

Grade: 9
Counselor: HARRIS
Homeroom: HOMEBOUND

Course	Teacher	Q1	Q2	S1	Q3	Q4	S2	Y1	ABS	TAR	Comment
HOMEBOUND	STAFF, GHS		REDACTED						0	0	
VLA HEALTH 9	WYATT, WENDY S		B						0	0	
VLA PE 9	WYATT, WENDY S								0	0	
VLC ALGEBRA I	WYATT, WENDY S								0	0	
VLC WORLD I	WYATT, WENDY S								0	0	
VLC ENGLISH 9	WYATT, WENDY S								0	0	
VLC EARTH SCI	WYATT, WENDY S								0	0	

Total Daily Absences Q4: 0.000

This is the Final report card of the 2013 – 2014 school year.

SUMMER SCHOOL RECOMMENDED____ YES ✓ NO (If yes, form enclosed)

SUMMER SCHOOL CLASS RECOMMENDED ________________

Summer school registration deadline is July 1, 2014 at 3 p.m. Summer school will begin July 7 and end August 7, 2014. Gloucester High School summer hours are 7:00 am to 4:30 pm Monday through Thursday (closed on Friday). Visit the Gloucester High School website for updated information: gets.gc.k12.va.us

GLOUCESTER HIGH SCHOOL

GCSB - 1117

Gloucester County Public Schools
Report Card

CONFIDENTIAL

Page Middle School
6636 Short Lane
Gloucester, VA 23061

Report Card Printed on June 11, 2013

School Year: 2012-2013

Reporting Period: Q4

REDACTED GRIMM - REDACTED

REDACTED

Grade: 8
Counselor: CROTTY
Homeroom: 201

Course	Teacher	Q1	Q2	S1	Q3	Q4	S2	Y1	ABS	TAR	Comment
ROBOTICS	WEST, ROSSER B	REDACTED							9	0	
MATH 8	COLLAZO, LUCY								8	2	
INQUIRY/HR	PICKETT, MURIEL K								0	0	
SCIENCE	BOND, ELIZABETH S								3	0	
ADV LANG ARTS	DRAKE, PATRICIA A								3	0	IS A PLEASURE TO HAVE IN CLASS
CIVICS AND ECON	STEWART, GLEN DOUGLAS								2	0	
GRAPHIC LITERATURE	FREYBERGER, THERESA M								0	0	
ART	EMDE, RACHEL J								3	0	

Total Daily Absences Q4: 1.000
Quarter 4 GPA: 4.0000

Have a wonderful summer!

PAGE

PROMOTED

GCSB - 1118

CONFIDENTIAL

Standards of Learning Assessment Data
End-of-Course Reports

Student's Name: GRIMM, REDACTED — First — Middle

Date of Birth: REDACTED 1999 REDACTED — ID Number

County/School System: Gloucester County

GRIMM, GAVIN E. — Grade: 11

DOB: REDAC 999 — School: 0260 - GLOUCESTER HS
Gender: Female — Division: 036 - GLOUCESTER COUNTY
STI: 1012738050 — Admin: Writing 2015-2016

Test	Performance Level	Scaled Score
EOC Writing (2010 SOL)	Pass/Proficient	REDACTED

GRIMM, REDACTED — Grade: 9

DOB: REDAC 999 — School: 0260 - GLOUCESTER HS
Gender: Female — Division: 036 - GLOUCESTER COUNTY
STI: 1012738050 — Admin: Spring 2014

Test	Performance Level	Scaled Score
Algebra I (2009)	Fail	REDACTED
Earth Science (2010)	Pass/Proficient	
World History I (2008)	Pass/Proficient	

GRIMM, GAVIN E. — Grade: 10

DOB: REDACTED 1999 — School: 0260 - GLOUCESTER HS
Gender: Female — Division: 036 - GLOUCESTER COUNTY
STI: 1012738050 — Admin: Spring 2015

Test	Performance Level	Scaled Score
Algebra I (2009 SOL)	Pass/Proficient	REDACTED
Biology (2010 SOL)	Pass/Proficient	
World History II (2008 SOL)	Pass/Proficient	

GRIMM, GAVIN E. — Grade: 11

DOB: REDA 1999 — School: 0260 - GLOUCESTER HS
Gender: Female — Division: 036 - GLOUCESTER COUNTY
STI: 1012738050 — Admin: Spring 2016

Test	Performance Level	Scaled Score
EOC Reading (2010 SOL)	Advanced/College Path	REDACTED
Geometry (2009 SOL)	No Score (NS)	
VA & US History (2008 SOL)	No Score (NS)	

GCSB - 1127

WELCOME TO
GLOUCESTER COUNTY PUBLIC SCHOOLS

Student Registration Form

School's Name: Bethel Elementary School

CONFIDENTIAL
FOR OFFICE USE ONLY
Student ID#
Entry Date:
Entry Code: PK Code PK Time
Homeroom #:
Counselor/Teacher:
Team:
Bus #:

PLEASE PRINT ALL INFORMATION

Are you a resident of Gloucester County? ☑ Yes ☐ No Items accepted as proof of residency: lease/deed and current utility bill

Has your student ever attended a Gloucester County Public School? (Yes) ☐ No If yes, which school did your child attend?
☐ Abingdon ☐ Achilles ☑ Bethel ☐ Botetourt ☐ Petsworth ☐ T. C. Walker ☐ Page Middle ☐ Peasley Middle ☐ High School

Student's Legal Name: Grimm LAST REDACTED

Gender: ☐ Male ☑ Female

Student's Ethnicity: ☐ American Indian ☐ Asian ☐ Black ☐ Hispanic ☐ Native Hawaiian ☑ White ☐ Unspecified

Student's Birth D REDACTED 1999 Place of Birth: Newport News, VA Birth Certificate #

Student's Grade Level: 5 If kindergarten, did your child have any pre-kindergarten education? ☐ Yes ☐ No
If yes, please provide brief description (i.e., licensed daycare provider, head start)

Primary language spoken by student: ☑ English ☐ Spanish ☐ French ☐ Russian ☐ Chinese ☐ Vietnamese ☐ Other

Primary language spoken at home: ☑ English ☐ Spanish ☐ French ☐ Russian ☐ Chinese ☐ Vietnamese ☐ Other

Student's Mailing Address: **REDACTED**

Student's Home Phone Num

Student's 911 Address-required:
(If different than mailing): Number Street Name City Zip Code

Does your child currently receive special services? ☐ YES ☑ NO If yes, please check all that apply:
☐ Speech ☐ Special Education ☐ 504 ☐ Gifted ☐ ESL ☐ Occupational Therapy/Physical Therapy ☐ Other

Student Resides With: ☑ Mother & Father ☐ Mother only ☐ Father only ☐ Grandparents ☐ Foster Parent(s) ☐ Mother & Stepfather ☐ Father & Stepmother ☐ Guardian/Custodian ☐ Other

Name: David & Deirdre Grimm	Name:
Address (if different from student): Same	Address (if different from student):
Place of Employment: Norfolk Naval Shipyard father / mother	Place of Employment:
Work Phone #: REDACTED	Work Phone #:
Cell Phone #:	Cell Phone #:
Email address: drgrimmomma@cox.net	Email address:

If the student is NOT residing with BOTH biological/adoptive parents, please list other parent's information (i.e., name, address, etc.)

EMERGENCY CONTACT INFORMATON
(Our schools attempt to contact the parent/guardian first – the following information is for OTHER than parent/guardian)

Contact Person 1: REDACTED Phone# REDACTED Relationship to Student: Friend

Contact Person 2: REDACTED Phone# (cell) Relationship to Student: older sister

GCSB - 1151

CONFIDENTIAL

REDACTED

Name of Student Gimm

STUDENT REGISTRATION FORM (continued)

New Federal legislation, the No Child Left Behind Act, requires that all school divisions report student information regarding the areas listed below. Please read each statement, or have the registrar read the statements for you, and answer each question as requested.

Your child is considered to be Neglected/Delinquent if one of the following is true:

In order to be eligible to be counted as neglected/delinquent, a child age 5 through 17 must live in an "institution for neglected children and youth," which means a public or private residential facility, other than a foster home, that is operated primarily for the care of children and youth who (a) have been committed to the institution or voluntarily placed in the institution under applicable State law due to abandonment, neglect, or death of their parents or guardians; and (b) have had an average length of stay in the institution of at least 30 days;
OR
Must live in an "institution for delinquent children and youth," which means a public or private residential facility that is operated for the care of children and youth who (a) have been adjudicated to be delinquent or in need of supervision and (b) have had an average length of stay in the institution of at least 30 days.

Is your child Neglected/Delinquent? Yes____ No ✓

Your child is considered to be Homeless if one of the following is true:

1) Shares the housing of others due to loss of housing, economic hardship or similar reason;
2) Lives in motels, hotels, trailer parks or camping grounds due to lack of alternative adequate accommodations;
3) Lives in emergency or transitional shelters;
4) Abandoned in hospitals;
5) Awaits foster care placement;
6) Has a primary residence that is a public place or a place not designed for or ordinarily used as regular accommodation;
7) Lives in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations or similar settings.

Is your child Homeless? Yes____ No ✓ If yes, which item above applies to your situation?____

Your child is considered to be a Migratory Child if one of the following is true:

The term "migratory child" means a child who is, or whose parent or spouse is, a migratory agricultural worker, including a migratory dairy worker, or a migratory fisher, and who, in the preceding 36 months, in order to obtain, or accompany such parent or spouse, in order to obtain temporary or season employment in agricultural or fishing work:
(a) has moved from one school district to another;
(b) in a State that is comprised of a single school district, has moved from one administrative area to another within such district; or
(c) resides in a school district of more than 15,000 square miles, and migrates a distance of 20 miles or more to a temporary residence to engage in a fishing activity.

Is your child a Migratory Child? Yes____ No ✓

GCSB - 1152

CONFIDENTIAL

REDACTED

BETHEL ELEMENTARY
School Name

STUDENT REGISTRATION FORM

Entry Date:
YOG:
Conditional Enrollment:
Entry Code:
Homeroom #:
Counselor/Teacher:
Team:

Former Student of Gloucester County Public Schools: YES / NO (If yes, School N...

Student's Name: REDACTED First Middle Name Last REDACTED Nickname

Social Security #: REDACTED Bus #:

Is English the primary language spoken at home? YES / NO If no, specify REDACTED

Gender: (Circle) Male Female Grade: Date of Birth: REDACTED

Place of Birth: City/County State Country Birth Certificate #: REDACTED

Ethnic Group: (Circle One) Unspecified American Indian Asian Black Hispanic White Native Hawaiian

Mailing Address: REDACTED City/State/Zip:

Home Phone #: REDACTED 911 Address: (If Different From Mailing Address)

Child Resides With (Circle): Both Parents One Parent Legal Guardian(s)

Circle One: Mother Father Stepparent Guardian/Custodian	Circle One: Mother Father Stepparent Guardian/Custodian
Name:	Name:
Address (If different than student):	Address (If different than student):
Place of Employment:	Place of Employment:
Work Phone #:	Work Phone #: REDACTED
Cell Phone/Pager #: REDACTED	Cell Phone/Pager #:
E-Mail Address:	E-Mail Address:
Education:	Education:

EMERGENCY CONTACT INFORMATION

Contact Person 1: (Other than parent/guardian) Phone #: Relationship to Student:

Contact Person 2: (Other than parent/guardian) Phone #: Relationship to Student:

Family Physician: Phone #:

Please list any medical information concerning your child that school personnel should know: (Allergies, Asthma, etc.)

Previous School:
Mailing Address: Phone #:
City/State/Zip: Fax #:

PLEASE COMPLETE THE BACK OF THIS FORM

GCSB - 1153

CONFIDENTIAL

Other Children in the Family:

Name	Living In Home	Date of Birth	Grade	Age
REDACTED	YES / NO	REDACTED	[illegible]	[illegible]
	YES / NO		[illegible]	[illegible]
	YES / NO			
	YES / NO			

Others in the Home:

Name	Relationship to Student	Place of Employment

Is your child receiving any specialized service(s)? (Special Education including Speech, 504, Gifted, etc.) YES / NO

If yes, specify which service(s) ________

Directions to Home:

(Please give the location of your home. Include the route number, neighborhood, landmarks, or any information that will be helpful.)

Before enrolling your child in Gloucester County Public Schools, you must provide the following:

1. Certified Copy of Birth Certificate
2. Social Security Card
3. Updated Immunization Records
4. Physical Exam Report
5. Transcript from Former School - Can Be Unofficial (HIGH SCHOOL ONLY)
6. IEP and/or 504 (if applicable)
7. Court Orders Referencing Student (if applicable)

I have willfully and knowingly provided you the correct information. I will provide you any new information concerning my child as it occurs.

Parent/Legal Guardian Signature — Date

No student can be prevented from participation in any program solely because of his/her race, color, national origin, sex, age, religion, or disability. A procedure for resolving complaints alleging discrimination on the basis of race, color, national origin, sex, age, religion, or disability may be found in the manual for Policies and Regulations of the Gloucester County Public Schools. The Section 504 and Title IX Coordinator for the Gloucester County Public Schools is: Mr. William W. Fox, Coordinator - Section 504 and Title IX - Gloucester County Public Schools - 6489 Main Street - Building Two, Suite F - Gloucester, VA 23061 - (804) 643-7866

REDACTED

CONFIDENTIAL

Name of Child: [REDACTED] G

STUDENT REGISTRATION FORM (Continued)

New Federal Legislation, the No Child Left Behind Act, requires that all school divisions report student information regarding the areas listed below. Please read each statement or have the registrar read the statements for you, and answer each question as requested.

Your child is considered to be Neglected/Delinquent if one of the following is true:

In order to be eligible to be counted as neglected/delinquent, a child age 5 through 17 must live in an "institution for neglected children and youth," which means a public or private residential facility, other than a foster home, that is operated primarily for the care of children and youth who (a) have been committed to the institution or voluntarily placed in the institution under applicable State law due to abandonment, neglect, or death of their parents or guardians; and (b) have had an average length of stay in the institution of at least 30 days,

or

must live in an "institution for delinquent children and youth," which means a public or private residential facility that is operated for the care of children and youth who (a) have been adjudicated to be delinquent or in need of supervision and (b) have had an average length of stay in the institution of at least 30 days.

Is your child Neglected/Delinquent? Yes ______ No ✓

Your child is considered to be Homeless if one of the following is true:

- Shares the housing of others due to loss of housing, economic hardship or similar reason
- Lives in motels, hotels, trailer parks or camping grounds due to lack of alternative adequate accommodations;
- Lives in emergency or transitional shelters;
- Abandoned in hospitals;
- Awaits foster care placement;
- Has a primary residence that is a public place or a place not designed for or ordinarily used as regular accommodation;
- Lives in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations or similar settings.

Is your child Homeless? Yes ______ No ✓

Form continues on next page

CONFIDENTIAL

Name of Child

Your child is considered to be a Migratory Child if one of the following is true:

The term 'migratory child' means a child who is, or whose parent or spouse is, a migratory agricultural worker, including a migratory dairy worker, or a migratory fisher, and who, in the preceding 36 months, in order to obtain, or accompany such parent or spouse, in order to obtain, temporary or seasonal employment in agricultural or fishing work—

(A) has moved from one school district to another;

(B) in a State that is comprised of a single school district, has moved from one administrative area to another within such district; or

(C) resides in a school district of more than 15,000 square miles, and migrates a distance of 20 miles or more to a temporary residence to engage in a fishing activity.

Is your child a Migratory Child? Yes______ No ✓

Your child is considered to be a Refugee if the following is true:

An individual who is outside his/her country and is unable or unwilling to return to that country because of a well-founded fear that she/he will be persecuted because of race, religion, nationality, political opinion, or membership in a particular social group. This does not include persons displaced by natural disasters or persons who, although displaced, have not crossed an international border or persons commonly known as "economic migrants," whose primary reason for flight has been a desire for personal betterment rather than persecution.

Is your child a Refugee? Yes______ No ✓

Your child is considered to be an Immigrant if all of the following are true:

The term 'immigrant children and youth' means individuals who—

(A) are aged 3 through 21;

(B) were not born in any State; and

(C) have not been attending one or more schools in any one or more States for more than 3 full academic years.

Is your child an Immigrant? Yes______ No ✓

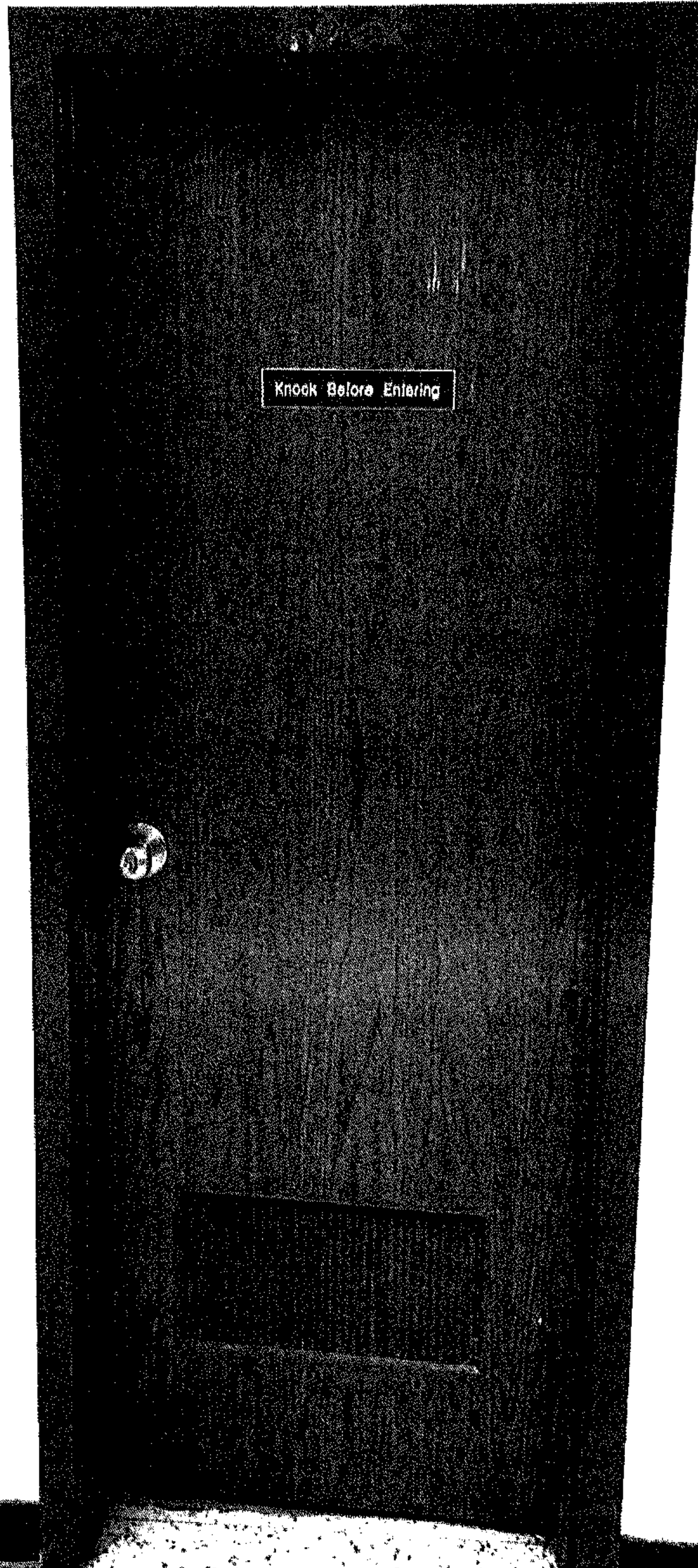
I have willfully and knowingly provided you with the correct information. I will provide you any new information concerning my child as it occurs.

[signature] — Parent/Legal Guardian Signature

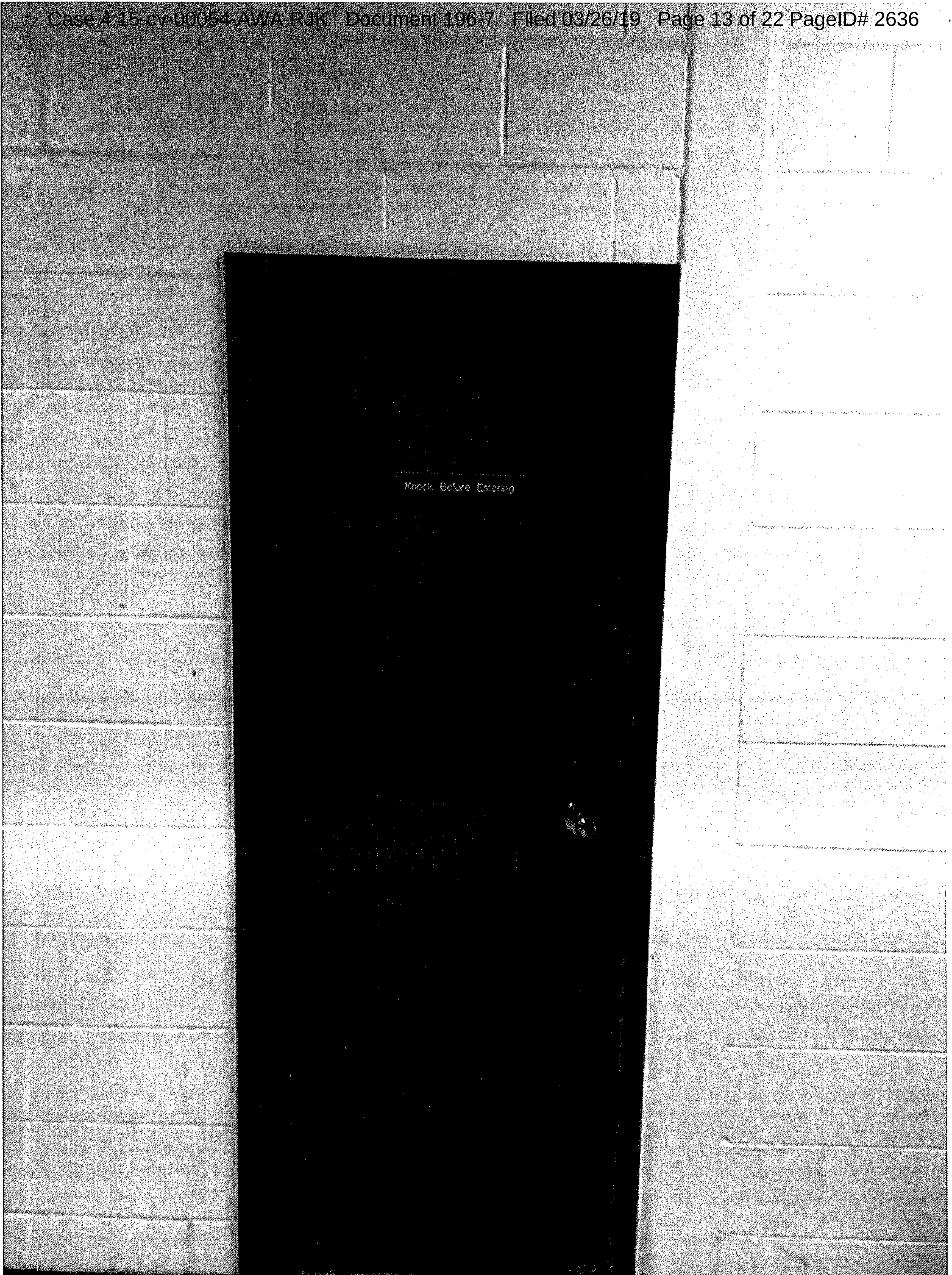
05-21-04 — Date

No student can be prevented from participation in any program solely because of his/her race, color, national origin, sex, age, religion, or disability. A procedure for resolving complaints alleging discrimination on the basis of race, color, national origin, sex, age, religion, or disability may be found in the manual for Policies and Regulations of the Gloucester County Public Schools. The Section 504 and Title IX Coordinator for the Gloucester County Public Schools is: Mr. William W. Fox, Coordinator - Section 504 and Title IX - Gloucester County Public Schools – 6489 Main Street - Building Two, Suite F - Gloucester, VA 23061 – (804) 693-7856

REST ROOM



GCSB - 1267



GCSB - 1271

Whereas the GCPS recognizes that some students question their gender identities, and

Whereas the GCPS encourages such students to seek support and advice from parents, professionals and other trusted adults, and

Whereas the GCPS seeks to provide a safe learning environment for all students and to protect the privacy of all students, therefore

It shall be the practice of the GCPS to provide male and female restroom and locker room facilities in its schools, and the use of said facilities shall be limited to the corresponding biological genders, and students with sincere gender identity issues shall be provided an alternative private facility.

From: REDACTED
Date: December 08, 2014 3:01:13 PM
To: "georgeburak@cox.net" <georgeburak@cox.net>; "kevinsmith914@gmail.com" <kevinsmith914@gmail.com>; "troyandersengp@cox.net" <troyandersengp@cox.net>; "kimberlyehensley@gmail.com" <kimberlyehensley@gmail.com>; "hookc@cox.net" <hookc@cox.net>; "anita.parker@gc.k12.va.us" <anita.parker@gc.k12.va.us>; "chalres.record@gc.k12.va.us" <chalres.record@gc.k12.va.us>; "SchoolBoard@gc.k12.va.us" <SchoolBoard@gc.k12.va.us>
Subject: **Transgender Student Policy**

Attachments:

Members of the School Board:

I have been following the story of the transgender student and the request to use male facilities. I respectfully ask that you act to protect the rights and privac y of students who are not transgender. I was greatly disturbed that the decision was made by the Gloucester High School principal to allow the transgender student to utilize male bathrooms. I have a son who attends REDACTED School, and c annot imagine how he would feel if a transgender student began to utilize the boys restroom. All students, not just one, should have their privacy upheld. Regardl ess of how a student "identifies" them self, reasonable accommodations were made a llowing the student to utilize the nurse's restroom. Please act on behalf of the entire student population, not just one student. This is not a discrimination iss ue, it is a privacy issue.

Thank you for your service to Gloucester citizens.

Sincerely,

REDACTED

Sent from my iPhone=

GCSB - 02630

From: "Amy Bergh" <abergh@gc.k12.va.us>
Date: October 28, 2014 7:18:05 PM
To: "Nate Collins" <ncollins@gc.k12.va.us>
Subject: **Gavin and** REDACTED

Attachments:

Today at the end of B4 Gavin Grimm and REDACTED stood up and began yelling at each other across their tables. They were mutually clearly ready to physically fight. As near as I could tell it had something to do with Gavin using the boys restroom today. Both students were visibly upset and cursing at each other stating they didn't have to put up with this "fucking shit" and other similar comments. I don't remember exact comments but something to the effect that REDACTED didn't believe that Gavin should use the boys room because he we a girl and Gavin stating that he didn't have to put up with people saying negative things. They were equal partners in escalating the situation.

I yelled at them to stop several times and then sent Gavin to Clark Barkley's class to wait for me and took REDACTED to my office hallway.

I asked REDACTED what had happened. He stated that he had anger issues. He said something to the effect that he had asked Gavin's brother about seeing his sister going into the boys restroom. REDACTED swore he did not know that Gavin was transgender.

I then asked Gavin what had happened and Gavin said that REDACTED knew all about it and was just saying things to upset him.

Other students sitting around them include:
REDACTED – NJROTC student and probably reliable
REDACTED -
REDACTED – Probably reliable
REDACTED
REDACTED NOT reliable

-Amy Bergh

GCSB - 03541

Subject: Interesting also - Bold lettering is mine not theirs

From: REDACTED

To: crecords@zandler-dev.com;

Date: Tuesday, December 9, 2014 12:48 PM

This is direct from an ACLU website! - Let me know if you want me to get the whole article to you.

"**Bathroom** and Locker Room Issues

Many LGBTQIA students find bathrooms and locker rooms a war zone fraught with anti-LGBTQIA slurs and physical abuse. If you are having difficulties using the restroom or locker room, report the troublemakers to your school administrator and request an increase in security in the problematic areas reminding them you are the target, are not breaking any school rules, and this behavior is creating an unsafe learning environment. **Although students have the legal right to access bathrooms and locker rooms, some school administrators seek alternatives to providing increased security. As a result, some school administrations offer LGBTQIA students the use of the employee single stall restroom. "**

Resource

"ACLU: Transgender resources

(back to top)"

<u>Odd ACLU calls it "bathroom" - but notice you have already done what ACLU says about making an appropriate accommodation – the nurse's rest room i.e. to avoid harassment</u>

-

-

This is why they offer the accommodation to single stall rest room.

School Harassment

Schools are legally obligated to provide a safe school environment to all students. Students can't learn if they worry about taunts, name-calling, or physical violence by their classmates or teachers. Most school administrators and teachers will help students who are being teased or bullied, but you must first tell them of the harassment. If you feel uncomfortable talking to school officials alone, there are other possibilities. You may e-mail school officials, for example. Also, Safe Schools NC board members are willing to go with you or speak for you. School administrators are legally obligated to protect students. If you feel that your requests for help are being ignored, there are organizations, such as the American Civil Liberties Union (ACLU) of North Carolina or Lambda Legal Defense, that can back you up in court.

ISSUES ACKNOWLEDGED BY ACLU

SAFE SCHOOL ENVIRONMENT

TAUNTS, NAME –CALLING, PHYSICAL VIOLENCE

HARASSMENT

November 13, 2014

Dear Gloucester County School Board Members,

Our family is writing to you in regard to REDACTED and the media attention the Grimm family is seeking to further their cause. We have signed a petition presented to us and feel the need to voice our concerns to you in writing.

We are tolerant people who accept that every individual has the right to live their own life. Working for REDACTED for 30 years and supporting "gay rights" long before it was popular is the example our grandmother set. She encouraged her children and grandchildren to do the same. REDACTED REDACTED We are the family that provides a safe place and listening ears for other teens who are either not ready to come out to their families or who are rejected by their families due to their choices.

Quite frankly, Gloucester High seems to have a disproportionately large number of students who identify themselves as lesbian, gay, and bisexual. Transgender is not as widely seen as of yet. The issue at hand should not be viewed as an attack on one child, as bullying, or as discrimination. The decision regarding any transgender student using the restroom they assign to themselves should be considered based on the needs and privacy of ALL STUDENTS in the school. REDACTED is not an anonymous person in a mall or theme park that just walks into a restroom of his/her choice.

REDACTED

REDACTED It is unfair to our children and our community for the Grimms to attempt to turn a privacy and safety issue into an act of bullying to gain additional attention. The request to be allowed in the men's bathroom should be examined separately from any claims of bullying.

We did not know that you were considering allowing an individual with female anatomy in the school's men's bathrooms until our sons who attend the school came home and told us. Our boys, gay or straight, are mortified by the idea that any female, including their mother or sister, would be in a bathroom with them while they are using it. Our daughter is concerned that a decision to allow Gavin Grimm into the men's restrooms will lead to a male student assigning himself as a female and being allowed in the women's restrooms. Furthermore, the men's restrooms do not all have working stall doors and urinal dividers or proper trash receptacles for soiled female items. REDACTED is physically a girl with female anatomy who wants to be allowed to use a men's bathroom in a public school. REDACTED has been known to Gloucester High's students as a girl for a long time and is making many students uncomfortable.

REDACTED should have a safe place to use the restroom. Gloucester High is a very large building so REDACTED should have access to more than one restroom; however, it should NOT be in the men's restrooms. The nurse's office is the universally accepted alternative for students with many different needs. We feel strongly that Gavin, as well as any other student who chooses to, should also have access to a second bathroom within the school, but not the men's restrooms. ***Surely there is a place somewhere in the school that can be remodeled to include two to three stalls and designated as a unisex bathroom and used by anyone who feels the need. Alternatively, if you cannot put the rights of the whole population ahead of the rights of one student, the least you can do is designate no less than half of the school's bathrooms as "male only' and "female only" so that the student body retains its rights as well.***

GCSB - 04189

Safety should also be a concern, especially if we all accept the Grimm family's statements that REDACTED is being bullied by Gloucester's school system and residents. Unfortunately, there is going to be someone who feels threatened or wants REDACTED to leave the bathroom so they have the privacy to use it. There are already incidents of bullying that occur in isolated and unmonitored areas of the school. How long will it be until there is a problem? Is the school able to provide a security person or staff member to monitor any restroom that Gavin may choose to use?

This is an issue that is dividing our school and our community. Please consider the rights of ALL of the students in Gloucester's schools as you make this decision.

Sincerely,

A Concerned Family*

*Name withheld due to our relationship with this family and involvement in the Gloucester community.

020323 modified

CERTIFICATE OF VITAL RECORD

VERIFY PRESENCE OF WATERMARK HOLD TO LIGHT TO VIEW

180852

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HEALTH - DIVISION OF VITAL RECORDS

CERTIFICATE OF LIVE BIRTH

STATE FILE NUMBER: REDACTED

NAME OF REGISTRANT: GAVIN ELLIOT GRIMM

DATE OF BIRTH: Redacted 1999 SEX: MALE

PLACE OF BIRTH: NEWPORT NEWS, VIRGINIA

MAIDEN NAME OF MOTHER: DEIRDRE ANNE SMITH

AGE OF MOTHER: 34

MOTHER'S PLACE OF BIRTH: VIRGINIA

NAME OF FATHER: DAVID WAYNE GRIMM

AGE OF FATHER: 38

FATHER'S PLACE OF BIRTH: PENNSYLVANIA

DATE RECORD FILED: MAY 17, 1999

This is to certify that this is a true and correct reproduction or abstract of the official record filed with the Virginia Department Of Health, Richmond, Virginia

DATE ISSUED October 27, 2016

Janet M. Rainey, State Registrar

Do not accept unless on security paper with the seal of Virginia Department of Health, Vital Statistics in the lower left hand corner. Section 32.1-272, Code of Virginia, as amended. VS 156

VOID WITHOUT WATERMARK OR IF ALTERED OR ERASED

GCSB - 04247

Date:12/16/2014 9:42 AM (GMT-05:00)
To: "Dr. Walter R. Clemons" <wclemons@gc.k12.va.us>
Subject: Re: RR

Just left high school. Restroom floors were painted things look pretty good. Custodians are venting out and putting in new ceiling tiles. Nate is playing it by ear he may open today or tomorrow morning. The hall bathroom is open.

Sent from my iPhone

On Dec 15, 2014, at 5:05 PM, Dr. Walter R. Clemons <wclemons@gc.k12.va.us> wrote:

Thanks!

Sent from my Verizon Wireless 4G LTE smartphone

-------- Original message --------
From: John Hutchinson <hutch@gc.k12.va.us>
Date:12/15/2014 4:25 PM (GMT-05:00)
To: "Dr. Walter R. Clemons" <wclemons@gc.k12.va.us>
Subject: Re: RR

Just talked with Nate. The restrooms are/were ready to open. The signs that didn't arrive were to indicate knock before entering and lock door behind you.

The unisex signs have been posted for a week, but were covered. There are some minor touch ups to be done, but nothing to stop the bathrooms and being open.

Nate will open the bathrooms tomorrow and put paper signs up until the official signs regarding entering and locking door arrive.
I'll touch base with Nate tomorrow a.m.

Sent from my iPhone

On Dec 15, 2014, at 3:43 PM, Dr. Walter R. Clemons <wclemons@gc.k12.va.us> wrote:

Give me an update on the signs. Thanks!

Sent from my Verizon Wireless 4G LTE smartphone

S2032B modified

CERTIFICATE OF VITAL RECORD

VERIFY PRESENCE OF WATERMARK HOLD TO LIGHT TO VIEW

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HEALTH – DIVISION OF VITAL RECORDS

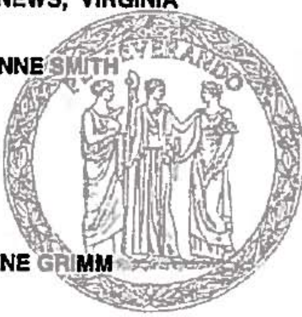
CERTIFICATE OF LIVE BIRTH

STATE FILE NUMBER: [redacted]

NAME OF REGISTRANT: GAVIN ELLIOT GRIMM

DATE OF BIRTH: [redacted] SEX: MALE

PLACE OF BIRTH: NEWPORT NEWS, VIRGINIA



MAIDEN NAME OF MOTHER: DEIRDRE ANNE SMITH

AGE OF MOTHER: 34

MOTHER'S PLACE OF BIRTH: VIRGINIA

NAME OF FATHER: DAVID WAYNE GRIMM

AGE OF FATHER: 38

FATHER'S PLACE OF BIRTH: PENNSYLVANIA

DATE RECORD FILED: MAY 17, 1999

This is to certify that this is a true and correct reproduction or abstract of the official record filed with the Virginia Department Of Health, Richmond, Virginia

DATE ISSUED October 27, 2016

Janet M. Rainey
Janet M. Rainey, State Registrar

Do not accept unless on security paper with the seal of Virginia Department of Health, Vital Statistics in the lower left hand corner. Section 32.1-272, Code of Virginia, as amended.

VS 158

VOID WITHOUT WATERMARK OR IF ALTERED OR ERASED

VOID IF ALTERED OR ERASED

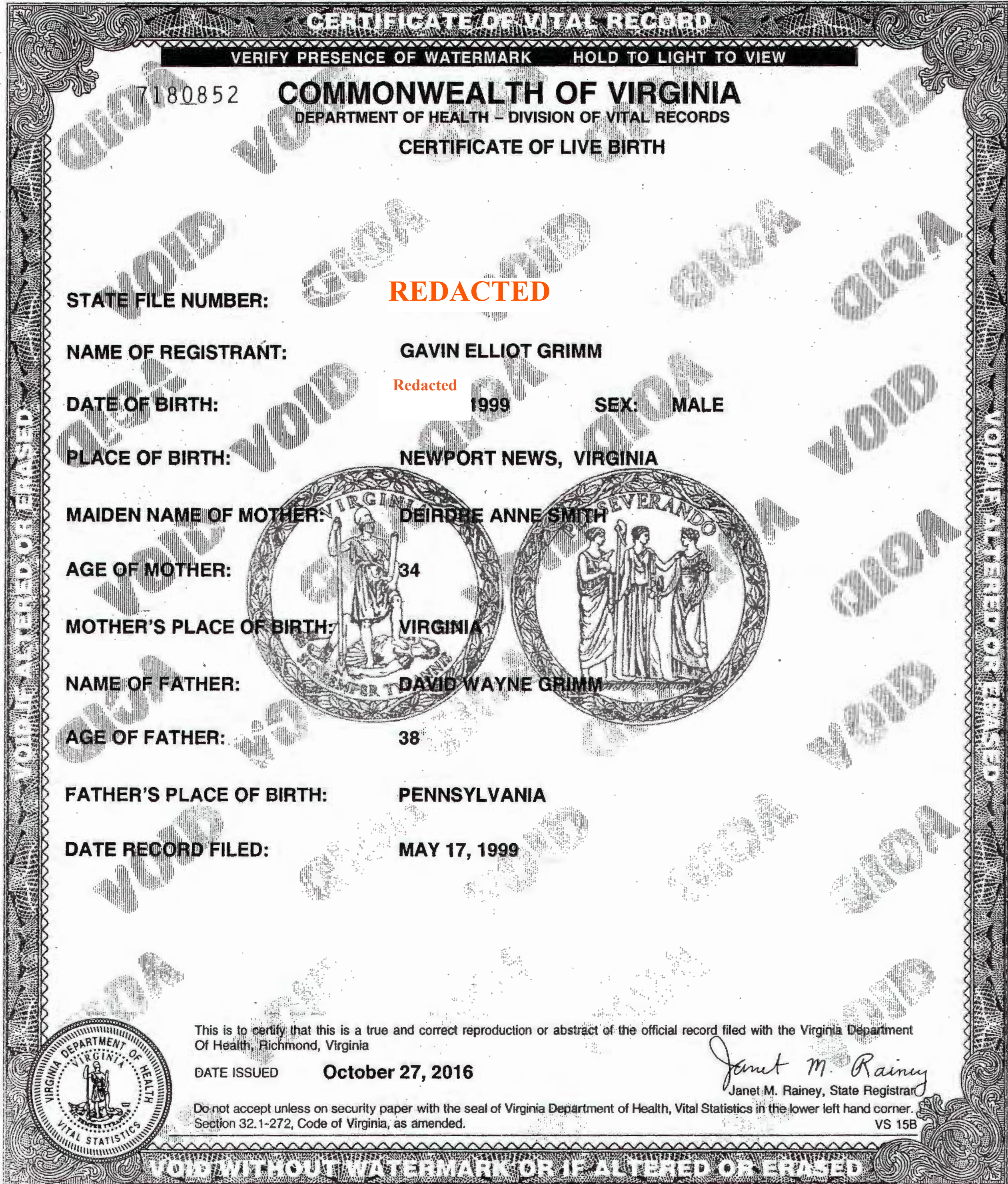
EXHIBIT N

SEE REVERSE SIDE FOR OPENING INSTRUCTIONS

EXHIBIT C

Department of Health
P.O. Box 1000
Richmond, VA 23218-1000

GRIMM 000678



S2032B modified

CERTIFICATE OF VITAL RECORD

VERIFY PRESENCE OF WATERMARK HOLD TO LIGHT TO VIEW

7180852

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HEALTH – DIVISION OF VITAL RECORDS

CERTIFICATE OF LIVE BIRTH

STATE FILE NUMBER: REDACTED

NAME OF REGISTRANT: GAVIN ELLIOT GRIMM

DATE OF BIRTH: Redacted 1999 SEX: MALE

PLACE OF BIRTH: NEWPORT NEWS, VIRGINIA

MAIDEN NAME OF MOTHER: DEIRDRE ANNE SMITH

AGE OF MOTHER: 34

MOTHER'S PLACE OF BIRTH: VIRGINIA

NAME OF FATHER: DAVID WAYNE GRIMM

AGE OF FATHER: 38

FATHER'S PLACE OF BIRTH: PENNSYLVANIA

DATE RECORD FILED: MAY 17, 1999

This is to certify that this is a true and correct reproduction or abstract of the official record filed with the Virginia Department Of Health, Richmond, Virginia

DATE ISSUED October 27, 2016

Janet M. Rainey, State Registrar

Do not accept unless on security paper with the seal of Virginia Department of Health, Vital Statistics in the lower left hand corner. Section 32.1-272, Code of Virginia, as amended. VS 15B

VOID WITHOUT WATERMARK OR IF ALTERED OR ERASED

VOID IF ALTERED OR ERASED

8610035092 RR Donnelley ©2014. All rights reserved. - 0221

EXHIBIT O