UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

BRIANNA BOE *et al.*, *Plaintiffs*, and UNITED STATES OF AMERICA, *Plaintiff-Intervenor*, v. STEVE MARSHALL, in his official capacity as Attorney General of the State of Alabama, *et al.*, *Defendants*.	)	No. 2:22-cv-00184-LCB-CWB Hon. Liles C. Burke **SUBMITTED UNDER SEAL**

DEFENDANTS' MOTION TO EXCLUDE
SELECTED TESTIMONY OF DR. ARON JANSSEN

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INTRODUCTION

At his deposition, Dr. Janssen repeatedly stated that topics discussed in his expert reports were beyond either his expertise or his personal knowledge. For example, although Dr. Janssen's expert reports purport to analyze numerous scientific studies, he stated at his deposition (four times, no less) that he was not testifying as an expert in the analysis of study designs and methodologies. The Court should take Dr. Janssen at his word and prohibit him from proffering testimony that relies on anything other than his clinical experience.

In addition, Dr. Janssen suggested his expert opinion was based on his experience in authoring the WPATH Standards of Care 8 (SOC-8), but he admitted during his deposition that he had no insight beyond the two chapters he worked on—the childhood chapter and the adult mental health chapter. He thus knows nothing about the chapter that matters most here—the adolescent chapter—or, indeed, any other part of the SOC-8 other than the childhood and adult mental health chapters. Indeed, during his deposition, Dr. Janssen said he did not even have enough knowledge to say whether the authors of the adolescent chapter *were experts* in the field. The Court should thus prohibit Dr. Janssen from attempting to offer testimony based on his personal involvement in drafting the SOC-8 regarding the evidence and methodology underpinning the adolescent chapter or any other component of SOC-8 other than the childhood and adult mental health chapters.

Separately, Dr. Janssen provides no reliable basis—indeed, no evidence whatsoever—for his opinion that gender identity is "biological." Additionally, although Dr. Janssen may have experience assessing patients in his own practice, he

admittedly knows nothing about the practice of medicine in Alabama. The Court should thus prohibit this testimony too. In sum, the Court should preclude Dr. Janssen from testifying about (1) scientific research studies, (2) the evidence and methodology underpinning the adolescent chapter of the SOC-8, (3) the source of an individual's gender identity, and (4) the practice of medicine in Alabama.

LEGAL STANDARD

To avoid duplication, Defendants respectfully incorporate the relevant legal standards in their Motion to Exclude Selected Testimony of Dr. Ladinsky. *See* Doc. 593 at 2-8.

ARGUMENT

I. Dr. Janssen Should Not Be Permitted To Offer Testimony Regarding Analysis of Research Studies.

Almost the entirety of Dr. Janssen's rebuttal report is aimed at Dr. Cantor's opinion that no reliable evidence supports the use of puberty blockers, cross-sex hormones, and surgeries to treat gender dysphoria in minors. *See Daubert*.DX13:¶¶5-29 (Janssen Supp. Rep.).[1] Dr. Cantor's analysis turns on his expertise assessing the design and methodology deployed in research studies—which, in turn, allows a researcher to assess the degree of bias in those studies. *See, e.g.*, SJ.DX.2:¶¶ 178-201 (Cantor Rep.). This type of critical assessment is necessary to understand the reliability of any particular study.

[1] Defendants use two main citations form in their *Daubert* briefing. The first—*Daubert*.DX#:##—refers to exhibits Defendants submit in support of their *Daubert* motions, where the first "#" refers to the exhibit number and the second "##" refers to the page numbers within that exhibit. The second citation form—SJ.DX#:##—refers to the exhibits Defendants submitted in support of their motion for summary judgment. *See* Docs. 557-60 (public exhibits) & 564 (sealed exhibits).

Dr. Janssen's reports repeatedly discuss the "research" behind the interventions at issue here. Indeed, his rebuttal report is almost entirely a study-by-study analysis. Janssen Rebuttal Rep. ¶¶7-22. His initial report likewise discusses "research" and studies in depth. *See, e.g.*, *Daubert*.DX12:8-10, 14 (Janssen Rep.). But during his deposition, Dr. Janssen admitted that he "would not be testifying here as an expert in study design or methodology." SJ.DX66:57:16-17 (Janssen Dep.). And this was not a drive-by misstatement; he asserted that he lacks expertise in assessing research studies several times. *See id.* at 60:10-11 ("Again, I'm not testifying as an expert in study methodology"); *id.* at 60:23 ("I'm not an expert in the study design."); *id.* at 250:14-15 ("I'm not testifying as an expert on the [GRADE] scale or on research methodology.").

Frankly, Dr. Janssen's lack of expertise in assessing study design shows. For example, when Dr. Janssen was asked if there are tools used to assess the degree of bias in individual studies, he responded: "I don't know." *Id.* at 70:19-21. And Dr. Janssen was "not familiar with" the Cochran Methods Group, *id.* at 70:22–71:1, which (as Dr. Cantor explained) is a "highly respected" institution in the field of evidence reviews, SJ.DX.2:¶85 (Cantor Rep.). Indeed, when asked, "[d]id you ever apply the [GRADE] scale to any of the studies that you cite in your expert reports," Dr. Janssen responded: "Not me personally, no." Janssen Dep. 250:18-21. Given Dr. Janssen's professed ignorance with respect to study design and his affirmative disavowal of providing expert testimony on study design, the Court should take Dr. Janssen at his word and preclude him from offering testimony that analyzes published research literature. *See United States v. Frazier*, 387 F.3d 1244, 1260 (11th

Cir. 2004) (en banc) (holding that to offer opinion testimony an expert must be "qualified to testify competently regarding the matters he intends to address").

II. Dr. Janssen Should Not Be Permitted To Offer Testimony Regarding the Evidence and Methodology Underpinning Any Part Of The WPATH SOC-8 Other Than The Childhood and Adult Mental Health Chapters.

WPATH's SOC-8 is an unreliable, ideologically motivated document that transgress the principles of evidence-based medicine. Specifically, as documents produced by WPATH have shown, the authors of SOC-8 made drafting decisions based on political, ideological, and legal considerations. *See* Doc. 561 at ¶¶19, 21 (Defs' Mot. for Summary Judgment); SJ.DX16:¶¶36-110 (Kaliebe Supp. Rep.); SJ.DX9:¶¶127-59 (Laidlaw 2nd Supp. Rep.); SJ.DX4:¶¶133-40 (Cantor Supp. Report App. A).[2] They failed to apply the most basic principles of evidence-based

[2] *See also* SJ.DX181:1 (WPATH 8) (SOC-8 author discussing "problem" "that medical practice is based on a diagnosis"—hence the "pragmatic" need for SOC-8's medical necessity statement to use "diagnostic criteria," even though many in WPATH would prefer that the statement simply "apply to any trans and gender diverse person, independent of age" or diagnosis); *id.* at 36 (SOC-8 author commending medical necessity statement for being broad enough that "any 'goodwilling' clinician can use" it for seemingly any purpose); *id.* at 143 (Dr. Karasic suggesting that the medical necessity statement in SOC-8 list "treatments in an expansive way, and also state that other treatments not listed may also be medically necessary" and commenting that he "cannot overstate the importance of SOC 8 getting this right at this important time" because of the "important lawsuits happening right now in the US"); *id.* at 64 (SOC-8 author stating that the "people in the US who need to see the fact of medical necessity" are the "lawyers, judges, politicians, insurance company representatives, HPs, and trans people themselves"); *id.* at 64 (Dr. Karasic encouraging WPATH to include a statement of medical necessity in SOC-8 because "[m]edical necessity is at the center of dozens of lawsuits in the US right now"); *id.* at 66 (Dr. Karasic opining that the inclusion of the medical necessity statement in SOC-8 is "incredibly important in the US" because "the right wing in the US is trying to force us back to" the years where "[t]he policy of the US federal government from 1981 to 2014 was that trans care was experimental, not medically necessary"); SJ.DX182:114-16 (WPATH 9) (SOC-8 author commenting on medical necessity statement: "Healthcare systems should provide gender affirming healthcare for transgender and gender diverse people: if someone expresses desire for it and it can be enabled safely and with informed consent, I argue it should be provided"); *id.* at 136 (SOC-8 author commenting on suggested eligibility criteria for performing transitioning surgery on adolescents: "[T]he idea that

medicine to the development and drafting of the SOC-8. Doc. 561 at ¶¶11-15; *see also* SJ.DX9:¶¶23-58 (Laidlaw 2nd Supp. Rep.); SJ.DX3:¶¶96-120 (Cantor Supp. Rep.); SJ.DX4:¶¶133-54; SJ.DX86:5 (*Clinical Guidelines*) (assessing SOC-8 under AGREE II standard and concluding that the guideline could not be recommended for practice because of its lack of "[r]igour of development," among other deficiencies).[3] And they concealed the weakness of the scientific evidence supporting their

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someone has to prove" that they had gender dysphoria for "'several years' or 'since early childhood' is a colonial, racist idea"); *id.* at 150 (WPATH president: "[I] will check what Rachel Levine's point of view is on these issues, when I meet with her next week."); SJ.DX184:1 (WPATH 11) (discussion of "'toolkit' to assist WPATH members in their advocacy efforts to oppose legislation (or pending legislation)"); *id.* at 15 (SOC-8 author noting that "[t]he wording of our section for Version 7 has been critical to our successes, and I hope the same will hold for Version 8" "when I go to court on behalf of TGD individuals to secure access to medically necessary health care"); *id.* at 54 (email discussing a "very productive call with Rachel Levine" and the "charge from the United States government to do what is required to complete the [SOC-8] project immediately" because "[t]he failure of WPATH to be ready with SOC8 is proving a barrier to optimal policy progress"); SJ.DX185:15 (WPATH 12) (email from WPATH president to SOC-8 chairs encouraging them to help WPATH "tak[e] advantage of what is probably a narrow and unique window of opportunity in and via the US" by "reassu[ring] [Admiral Levine] that we are on track" with SOC-8); SJ.DX186:11 (WPATH 13) (email recounting request from Admiral Levine about SOC-8 age limits for transitioning hormones and surgeries: "She asked us to remove them."); SJ.DX187:4 (WPATH 14) (email to SOC-8 chair about concessions WPATH was considering making in SOC-8: "I have no time for (further) political interference"); *id.* at 15-81 (last-minute comments from AAP regarding suggested changes to adolescent chapter); *id.* at 205-71 (WPATH's internal responses to AAP's demanded changes); *id.* at 308 (email noting that AAP "is satisfied with the proposed changes"—dropping all age restrictions for transitioning interventions—and "will not oppose the SOC 8"); *id.* at 330 (email from SOC-8 author regarding WPATH's removal of the age minimums due to outside political pressure: "Having been in the mountains when you all made this decision to make changes last minute, and reading and hearing that nobody had wanted to make them, and personally deeply not agreeing with the change, feels as the most strange experience."); SJ.DX188:1-34, 38-71 (AAP 2) (highlighting changes WPATH made to SOC-8 at the last minute, without going through the Delphi consensus process and without any evidence supporting the change but solely because AAP threatened to oppose the SOC-8 if WPATH did not acquiesce).

[3] *See also* SJ.DX182:2 (WPATH 9) (comment on hormone chapter draft: "Perhaps mention that this is still expert opinion and no one has looked at evidence surrounding hormone levels and health"); *id.* at 1-43 (early draft of hormone chapter that included suggested grading of evidence quality); *id.* at 62 (email about removing the statements concerning evidence quality from SOC-

recommendations. *See* Doc. 561 at ¶¶17-18, 23-25; SJ.DX9:¶¶23-84 (Laidlaw 2nd Supp. Rep.).[4] Discovery in this case has destroyed any veneer of scientific credibility regarding the SOC-8.

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8); *id.* at 91-97 (internal criticism of Eunuch chapter showing that it is not evidence-based—but was published in SOC-8 anyway); *id.* at 106 (example of non-systematic evidence collection: "I thought there was some data with progesterone also impacting mood negatively. I have to see if I can find the reference.").

[4] *See also* SJ.DX176:67-68 (WPATH 3) (WPATH president admitting that "no long-term studies" exist for puberty blockers, and recounting experience with adolescent patient who did not know what orgasm was: "I felt that our informed consent process might not be enough… It occurred to me that how could anyone truly know how important sexual function was to a relationship, to happiness?"); *id.* at 60 (WPATH leader explaining concern related to "problems caused when patients never experience orgasm due to puberty blockers and cross sex hormones"); *id.* at 120 (WPATH leader admitting that psychologists do in fact "go[] on 'what the children say'" and that there is "no assessment tool that captures all the ways internal signals can sometimes be misread as related to gender why they're not"); SJ.DX177:107 (WPATH 4) (co-lead of adolescent chapter discussing admitting privately that "social factors are indeed an aspect of identity development for adolescents, and some young people are more influenced than others," while emphasizing that "*we don't need to say that*" publicly and suggesting that "a possible approach to ROGD questions should involve a 'no duh, what else is new ... of course social factors influence an adolescent's wellbeing!"); SJ.DX179:41 (WPATH 6) (other co-lead of adolescent chapter admitting that while it is "[f]or sure" "that increasing numbers are asking for medical affirming treatment," "[w]hat the explanation for this increase is unknown and also methodologically challenging to study" but "social factors likely play a role"); *id.* at 14 (private admission that "de/retransitioners have always been a part of my community, and to a lesser degree my medical practice," and commenting that detransition is to be expected because of the "idea that different genders fit people better at different times and those things are fluid"); SJ.DX180:21 (WPATH 7) (SOC-8 author admitting that "most of the recommendation statements in SOC8 are not PICO format"—meaning were not supported by systematic evidence reviews—"but consensus based or based on weak evidence"); *id.* at 63 (WPATH leader admitting: "My understanding is that a global consensus on 'puberty blockers' does not exist"); *id.* at 72 (WPATH president discussing puberty blockers: "Interesting but highlights the difficulty in picking an endpoint for therapeutic efficacy and use of early puberty blockade—is it… A. Reduction in suicidality? Difficult to prove B. Improvement in psychosocial functioning? Easier to prove but at what cost…. As we learn more about the difficulties associated with confirming surgeries, adulthood and longterm happiness"); SJ.DX182:2 (WPATH 9) (member of hormone chapter admitting that "no one has looked at evidence surrounding hormone levels and health"); *id.* at 58-60 (SOC-8 author admitting that, when it comes to the safety of puberty blockers with regard to future sexual function, "I don't know what the evidence base is for this" and "[t]here isn't much published data on this topic"); *id.* at 62 (email about intentionally removing from SOC-8 notations of the quality of evidence underpinning recommendations); *id.* at 126 (SOC-8 author comment on draft recommending that health care professionals "discuss the

In his rebuttal report, Dr. Janssen attempts to rehab WPATH's image. Janssen Rebuttal Rep. ¶¶28-29. And in his main report, Dr. Janssen highlights his participation in the drafting of the SOC-8. Jassen Rep. 3, 5 ("My opinions contained in this report are based on … my work as a contributing author of the WPATH SOC"). Thus, directly after highlighting that he was "a contributing author to the Child and Adult Mental Health chapters" of SOC-8, Dr. Janssen opines: "The WPATH SOC provides clinical guidance for health professionals based on the best available science and expert professional consensus." *Id.* at 3.

At his deposition, however, Dr. Janssen admitted that his knowledge of SOC-8 was limited to the chapters he worked on—the child and adult mental health chapters. He made clear that he "was not involved in the other chapters." Janssen Dep. 46:9-17. And regarding the most pertinent chapter to this case—the adolescent chapter—Dr. Janssen unscored that he "was not involved in the drafting of the adolescent chapter." *Id.* at 76:16-20. He said he "can't" even "say with certainty that all of the authors" of "the adolescent chapter of the SOC 8 are experts." *Id.* at 48:7-17. He reiterated: "I just know the experience of my—my own [chapter]." *Id.* at 76:9-10.

Indeed, even within his *own* chapters, Dr. Janssen testified that he "lost visibility" on the process of grading the evidence behind the statements because "the

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impact of gender affirming treatments on sexual pleasure, function, and satisfaction": "In theory this is great but this place[s] a lot of pressure on the provider in the face of a paucity of evidence. I don't think that we have enough to be able to. I would be in favor of redirecting the statement to include a discussion about sexual function/satisfaction with gender affirming hormones treatment (this leaves room for a 'we don't know…' discussion)"); SJ.DX183:61, 68-69, 93 (WPATH 10) (emails showing that SOC-8 co-chairs disagreed "that some statements in [the child] chapter should be 'recommend', they should be 'suggest' as the text does not provide enough strong evidence," but the authors of the chapter disagreed and refused to change the recommendations: "I am opposed to switching the recommendations to suggestions").

chapter leads, in discussion with the editors, made that final determination through some process that I was not privy to." *Id.* at 67:8-16; *see id.* at 71:9-18 ("Q. So, basically, you lost visibility on the grading process once it went up to the chapter lead? A. I would say that is accurate, yes.").

Dr. Janssen cannot testify about subjects he does not know about and is not an expert in. And by his own admission, Dr. Janssen does not know about, and is not an expert in, anything relating to the drafting of the WPATH SOC-8 *other than* limited aspects of the two chapters he was involved in: the childhood chapter and the adult mental health chapter. The Court should limit his testimony accordingly.

III. Dr. Janssen Should Not Be Permitted To Testify That Gender Identity Is "Fixed" Or Has A Biological Basis.

In his report, Dr. Janssen opines that "[g]ender identity has a biological basis" and cannot be changed. Janssen Rep. 5. But he does not provide any data or specific studies to support his opinion—which, as a psychiatrist, he has not shown he is qualified to offer in any event.

Dr. Janssen seems to offer two theories for his opinion regarding the biological basis for a "static" gender identity. Janssen Dep. 104:19-20. The first appears to rely on sexual orientation and statements by professional organizations counseling against "conversion therapy." Janssen Rep. 6, 31-32. None of the position statements mention a biological basis for gender identity.[5] To the extent Dr. Janssen posits that

[5] *See See* Am. Psychological Ass'n, *APA Resolution on Gender Identity Change Efforts* (Feb. 2021), *available at* https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf; Am. Psychiatric Ass'n, *Position Statement on Conversion Therapy and LGBTQ Patients* (Dec. 2018), *available at* https://www.psychiatry.org/getattachment/3d23f2f4-1497-4537-b4de-fe32fe8761bf/Position-Conversion-Therapy.pdf; Am. Academy of Child &

research suggesting a potential biological basis for sexual orientation applies also to gender identity, he has not connected the dots and explained why he thinks that research in one area applies to another. "To be admissible under *Daubert*, an expert's opinion must be supported by good grounds for each step in the analysis." *Buland v. NCL (Bahamas) Ltd.*, 992 F.3d 1143, 1150 (11th Cir. 2021) (cleaned up). Among other disqualifications, this "analytical gap" makes Dr. Janssen's testimony on this point "unreliable." *United States v. Pon*, 963 F.3d 1207, 1221 (11th Cir. 2020).

Dr. Janssen's second theory for his opinion that gender identity is fixed and rooted in biology is based on an unfalsifiable claim regarding a purported distinction between gender identity and what he calls "gender expression." According to Dr. Janssen, "gender identity is static," "fixed," and "not a choice," whereas "gender expression" is a choice and culturally influenced. Janssen Dep. 102:15–104:24. Because Dr. Janssen assumes that gender identity cannot change, he emphasizes that the *only* aspect of gender that *can* change is gender expression—which includes one's own understanding of one's own gender identity. *Id.* at 106:12–107:4. As Dr. Janssen explained it: "I think people's understanding of gender identity and their expression of that gender identity changes over time," but "that fixed element of gender identity is not something that changes." *Id.* at 106:16-21.

Dr. Janssen thus agreed that "a natal female adolescent who identifies as a male, is diagnosed with gender dysphoria, and two years later the same individual says she now identifies as a female and does not have gender dysphoria, that person's

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Adolescent Psychiatry, *Conversion Therapy* (Feb. 2018), *available at* https://www.aacap.org/AACAP/Policy_Statements/2018/Conversion_Therapy.aspx.

gender identity has not changed." *Id.* at 107:5-12. And he seemed to agree that someone's gender identity could be unknowable—including by that person. *See id.* at 109:5-16 ("Q. So in the hypothetical of the natal female adolescent who identifies as male and then subsequently identifies as female, what is the individual's gender identity? A. I could not tell you. Q. Why not? A. One, the individual patient is going to have to tell me.").

This might make for interesting academic theory, but if there is no way to determine one's "fixed" gender identity—if, as Dr. Janssen agreed, "it's not possible to predict with certainty a child's ultimate gender identity," *id.* at 109:17-21, and all we and the child have to go by is "gender expression"—then it makes little sense to extrapolate from the unprovable assumption that gender identity is "fixed" to conclude that the "fixed" gender identity (whatever it might be) has a biological basis. "Scientific methodology today is based on generating hypotheses and testing them to see if they can be falsified; indeed, this methodology is what distinguishes science from other fields of human inquiry." *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 593 (1993) (citation omitted). Dr. Janssen's opinion "is unfalsifiable and of no practical value in the courtroom." *Brumley v. Pfizer*, 200 F.R.D. 596, 602 (S.D. Tex. 2001). It must be excluded.

IV. Dr. Janssen Should Not Be Permitted To Testify About Transitioning Care In Alabama.

Dr. Janssen spends much of his report discussing what he believes psychological assessments of gender dysphoric youth should look like. *See* Janssen Rep. 10-16. That's fine so far as it goes, but it can't go so far as to imply what psychological

assessments in Alabama look like. Although Dr. Janssen may have clinical experience with assessing children and adolescents with gender dysphoria in Chicago, he knows nothing about the practice of medicine in Alabama. Dr. Janssen made clear that he has never practiced in Alabama, merely "know[s] of the existence of" one gender clinic in Alabama—UAB's—but has never "been to that clinic," and does not "have any firsthand knowledge of that clinic's practices." Janssen Dep. 12:11–13:2. Nor did Dr. Janssen review any medical records of any plaintiffs in this case or otherwise become familiar with practices in Alabama. *Id.* at 304:5-7.

In short, Dr. Janssen has no idea how practitioners in Alabama operate or what standards they follow (or don't follow). He does not know what their practices may look like when assessing a child or adolescent for hormonal or surgical transitioning interventions. And given the evidence of how widely practices vary in this area and that some mental health practitioners intentionally *eschew* the kind of assessment Dr. Janssen describes in his report,[6] Dr. Janssen cannot simply assume that providers

[6] *E.g.*, SJ.DX179:12 (WPATH 6) (USPATH leader worrying "that as we have loosened standards and lost some control over the opportunistic nature of medicine in the US … we too started hearing increased concern of de-transition/regret" and discussing "the ill informed profiteers taking advantage of troubled youth with little reputable resource."); *id.* at 12-13 (USPATH president raising "concerns about how the door has swung away from more rigorous assessments in general over time" and worrying about "a wave of treatment-on-demand clinics and proponents"); *id.* at 34 (adolescent chapter author admitting that some clinicians use "the term *gender affirming* to mean a rushed process towards medical pathways only"); *id.* at 39 (WPATH president recognizing need to "better safeguard our clientele" from "opportunism by inexperienced and sometimes dangerous providers" and "exuberant immediacy which has apparently highlighted rare but important instances of regret"); SJ.DX177:95 (WPATH 4) (WPATH president raising concern about "unscrupulous schemes like TikTok" advertising "or premature intervention by practitioners"); SJ.DX180:48 (WPATH 7) (SOC-8 author noting that "within our field in the adolescent world, we have many anti-assessment colleagues calling people doing a comprehensive assessment" "'gender interrogators'"); SJ.DX182:163 (WPATH 9) (USPATH president raising concern that limiting assessment period for transitioning surgery "will fuel already opportunistic

across Alabama practice medicine in the same way that he does. Without more, his experience as a psychiatrist in Chicago provides no foundation on which he could testify about provider practices in Alabama or how children and adolescents are assessed for hormonal or surgical interventions in Alabama. His testimony on this point should be excluded.

CONCLUSION

For these reasons, the Court should prohibit Dr. Janssen from offering testimony regarding (1) scientific research studies, (2) the evidence and methodology underpinning the Adolescent Chapter of the SOC-8, (3) the source of an individual's gender identity, and (4) the practice of medicine in Alabama.

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and in some cases predatory practices by some surgeons in this field" and "open[] up the tap to what is effectively surgery on demand"); SJ.DX132:15 (Jarvie *Abortion Doctor*) (OB/GYN in Tuscaloosa providing transitioning hormones to children on first visit opining: "No, I don't need a psychologist or psychiatrist to evaluate" a minor patient seeking cross-sex hormones); SJ.DX26 (Abdul-Latif Dep.).

Dated: June 24, 2024

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CERTIFICATE OF SERVICE

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