IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS

JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELÉNA VISION, SORA KUYKENDALL, and SASHA REED, individually and on behalf of a class of similarly situated individuals, Plaintiffs, v. ROB JEFFREYS, MELVIN HINTON, and STEVE MEEKS, Defendants.	)	Case No. 3:18-cv-00156-NJR

PLAINTIFFS' OPPOSITION TO DEFENDANTS'
MOTION FOR SUMMARY JUDGMENT

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Defendants ignore their heavy burden on summary judgment. To avoid a trial, Defendants must establish that there is no genuine issue of material fact and that they are entitled to judgment as a matter of law. FED. R. CIV. P. 56(c). In other words, they must show that the evidence, viewed in the light most favorable to the Plaintiffs and drawing all reasonable inferences therefrom, could not support a judgment in Plaintiffs' favor. *E.g., Egan v. Freedom Bank*, 659 F.3d 639, 642 (7th Cir. 2011). Defendants' burden is insurmountable given the record in this case, including Defendants' concession that Plaintiffs' gender dysphoria is an objectively serious medical condition, this Court's findings that "IDOC is well-aware that transgender inmates are at a high risk of suffering from mental health issues and resorting to self-harm," and that "[d]espite these known risks, there is evidence that IDOC denies and delays the diagnosis and treatment of gender dysphoria without a medical basis or penological purpose." Dkt. 186, PI Mem. & Op. at 32–33.

Defendants want this Court to rule that they are entitled to judgment as a matter of law, but they cannot show that this Court's findings were wrong, let alone that they were contrary to undisputed facts. And far from proving, as a matter of law, that there is no longer a federal interest in protecting Plaintiffs' Eighth Amendment rights, that Plaintiffs and the class no longer face substantial irreparable harm, or that there is an adequate legal remedy, there is ample evidence that the treatment of transgender prisoners remains the same and that Defendants' have not implemented the changes required to eliminate their ongoing constitutional violations.

To defeat Defendants' motion, Plaintiffs need not discredit Defendants' evidence, nor prove their case. Nevertheless, it bears noting that the named Plaintiffs' testimony alone establishes that treatment of transgender prisoners continues to cause unthinkable suffering.

Plaintiffs and the class remain at a high risk of self-harm and suicide—the tragic, irreversible consequences of Defendants' continued failure to meet their Constitutional responsibilities.

STATEMENT OF FACTS

Thirteen months after this Court entered its preliminary injunction, Defendants admit that "IDOC has not yet finalized the new directive pertaining to the care and treatment of transgender prisoners." Dkt. 238, Defs.' Motion for Summary Judgment ("Mot.") at 27. Defendants' assertion that the Department's revised directive—once approved and implemented at some unknown date in the future—"may entirely moot Plaintiffs' complaints," *id.*, ignores Plaintiffs' evidence that the treatment of transgender prisoners remains the same and continues to cause ongoing and irreparable harm. And IDOC's compliance with any future directive is far from certain given their undisputed delay in implementing the preliminary injunction. The existence and efficacy of Defendants' "changes" are disputed facts that cannot be resolved as a matter of law.

A. Cross-Gender Placement Continues To Cause Plaintiffs Substantial Harm.

Although Defendants have continued in the last thirteen months to transfer prisoners among facilities, it is undisputed that in that period, Defendants have not transferred any transgender prisoners, nor assigned any incoming transgender prisoners, to a gender-appropriate facility. (Ex. 1, Porter Dep. at 90:23–91:2, 160:22–161:10; Ex. 2, Wortley Dep. at 116:20–117:12.) IDOC has refused to complete these transfers, despite Plaintiffs' numerous requests. (*See, e.g.*, Ex. 3, Kuykendall Dep. at 64:7–20 ("[M]ultiple mental health counselors" and "one of the doctors" have told her transfer to female facility "was not going to happen.").)

The evidence shows that, as a result, Plaintiffs suffer undue psychological stress, torment, and humiliation. For example, in cross-gender facilities, Plaintiffs lack access to gender-appropriate grooming and other personal items, which prevents medically necessary social transition treatment. (Ex. 4, Ettner Dec. ¶¶ 63, 66–68.) In addition, multiple Plaintiffs testified

about the constant sexual harassment they endure while housed in facilities not aligned with their gender. Named Plaintiff Sora Kuykendall testified that she continues to experience "nonstop sexual harassment" from male prisoners at her facility and that, as a result, she rarely interacts with others. (Kuykendall Dep. at 66:2–7; *id.* 69:19–22 ("I've had sexual harassment from, basically, everybody . . . . [I]t's kind of a constant thing here. It's a men's prison where there are no women,"); *id.* 88:1-15 (explaining that transgender women are considered "untouchables" among the general prison population, and the only people who talk to her sexually harass her).) Ms. Kuykendall was also told by IDOC employees that it was too unsafe for her to hold a job at her facility. (*Id*. at 72:3–14 ("I can't get a job here because it wouldn't be safe for me to get a job here. . . . I've been told that, if I did put in for a job, I wouldn't get it.").) In addition, named Plaintiff Sasha Reed testified that other prisoners "walk past my cell that harass me, sexual harass me, and make little statements to me," and that she does not feel safe at her current facility as a result. (Ex. 5, Reed Dep. at 52:10–20, 83:2–9.)

Plaintiffs housed in facilities not aligned with their gender are also at risk of being housed with cellmates that pose substantial threats to their well-being, and prison authorities often disregard that risk. Named Plaintiff Marilyn Melendez testified that, after her cellmate attempted to sexually assault her, she was placed on single cell status. (Ex. 6, Melendez Dep. at 13:25–14:21.) Since then, IDOC staff has asked her on four separate occasions to accept a cellmate "to either make room or accommodate somebody." (*Id*. at 16:21–17:3.) When asked to accept a cellmate—despite her documented need to be single celled—Ms. Melendez asked to have input into the choice of cellmate, but was told in response "we knew you would say that sissy, you're just trying to have somebody so you can have sex." (*Id.* at 15:10–25.)

Additionally, multiple Plaintiffs testified about the complete lack of privacy and protection while showering. Ms. Reed explained that, although she is allowed to shower by herself, "there's no privacy" because the shower stall has "open bars." (Reed Dep. at 54:11–17.) As a result, "[other inmates] come back looking and making comments and stuff like that. So there's no privacy at all." (*Id.*) Ms. Kuykendall is so uncomfortable using the showers—where the wall "only comes up to [] waist level" and don't "give you privacy at all"—that she no longer uses them. (Kuykendall Dep. at 123:20–124:3.) She instead chooses to "shower" in her cell, using a rag to wipe herself down and washing her hair in the sink. (*Id.*)

IDOC witnesses acknowledged the threat posed to transgender prisoners from inappropriate housing placements. According to Dr. Steven Bowman, IDOC's acting chief of the Office of Health Services, "[b]eing at an all-male facility as a transgender woman is difficult." (Ex. 7, Bowman Dep. at 42:20–43:7.) Dr. Bowman testified that "there's a risk for being a woman in a male facility," and that "transgender individuals may be more vulnerable to harassment, particularly by . . . other offenders." (*Id.*) Yet Plaintiffs' cross-gender housing placements remain unchanged, at great risk to their health and safety.

B. Defendants Continue To Subject Plaintiffs To Cross-Gender Searches.

In its order granting preliminary injunction, this Court identified Plaintiffs' evidence that cross-gender strip searches deny Plaintiffs social transition and are deeply traumatizing. *See, e.g.*, Dkt. 186 at 26. Yet IDOC has made no efforts to stop, or even minimize, the prevalence of this practice. (*See* Ex. 8, Nottingham Dep. at 178:22–179:6, 187:4–20.)

Since the preliminary injunction hearing, Ms. Kuykendall was on two occasions required to expose her naked body to male officers. First, Ms. Kuykendall was told that she was required to submit to a strip search by a male officer when meeting with a visitor, and was subjected to that search even after she refused the visit: "I was told that I had to get a strip search and I had to go

on my visit and, if I refused, I would be taken to seg and get strip searched anyways. And I asked if I could go back to my cell and just refuse my visit, but I was -- I was told, no, I have to go or I will be taken to seg." (Kuykendall Dep. at 114:20–115:20.) During the search, two additional officials entered the room and observed the entire search. (*Id.*) Second, Ms. Kuykendall was forced to sit through a breast exam in a room entirely devoid of curtains, while IDOC officials looked in through the windows. (*Id.* at 54:1–7.) When Ms. Kuykendall told the nurse practitioner performing the exam that she was uncomfortable, she was told "that was the way I had to do it" and "if I refuse a breast exam, then they can take my hormones away." (*Id.* at 54:11–19.)

Ms. Melendez similarly testified that she continues to be strip searched by male officers, despite repeated requests for same-gender searches:

> [T]his month already twice we've been stripped down . . . I ask here, is there a female officer here? They're saying yeah. I say well can you bring her here so I can get strip searched? He said that they don't do cross gender searches. I said what do you mean? ***He's like basically it has to be male-male searches. I said okay, man, I'm transgender.*** I said . . . ***at least give me the option of having another staff search me. He says that's not going to happen, are you gonna strip or not?*** . . . If not, we'll just Mace you, open your door and restrain you.

(Melendez Dep. at 84:22–85:25 (emphasis added).) Ms. Reed likewise testified that when she asked to be searched by a female employee, IDOC officials told her "I'm in a male facility, I don't need no female officer to pat me down." (Reed Dep. at 89:5–14; *see also* Ettner Dec. ¶ 111 (noting that Ms. Reed continues "to be strip-searched exclusively by male officers").)

Plaintiffs' expert Dr. Ettner has explained that cross-gender searches can exacerbate gender dysphoria "and lead to serious mental health complications, including worsening depression, anxiety, and hopelessness." (Ettner Dec. ¶ 67.) Plaintiffs' testimony confirmed Dr. Ettner's opinion. For example, Ms. Melendez explained that these searches often result in unwanted groping and harassment. (Melendez Dep. at 86:14–87:1.) Ms. Reed testified that searches from male officers make her feel "really uncomfortable." (Reed Dep. at 89:5–14.) And Ms. Kuykendall

described the experience as "[t]errible . . . . usually during it, I breakdown into tears and I'm shaking. And then when I get back to my cell, I do the same thing." (Kuykendall Dep. at 116:14–18.) In addition, Plaintiffs' security expert James Aiken—a former member of the National Prison Rape Elimination Commission that drafted the Prison Rape Elimination Act ("PREA")—likewise stated that "[o]ur intent in these [PREA] regulations was to prohibit the practice currently being followed by the IDOC." (Ex. 9, Aiken Rpt. at 17.) And that instead "sound correctional practices" supported "[r]equiring [IDOC to provide] transgender prisoners the option of being searched by correctional staff of the same gender." (*Id.* at 16.)

C. Access To Gender-Affirming Clothing And Grooming Items Remains Speculative, At Best.

In support of their motion, Defendants rely on their recent adjustments to the list of available commissary items, which they claim has been in effect since November 5, 2020. Mot. at 5. The impact of this change has yet to be seen, and, regardless, it does not provide class-wide relief. *Id.* (policy only effects transgender women in male facilities.) But, critically, the change is well-past due, coming only on the eve of summary judgment. Given Defendants' longstanding and repeated refusals to make gender-affirming clothing and hygiene items available to Plaintiffs, it is far from guaranteed that IDOC's implementation of this change will prove effective.

For example, named Plaintiff Lydia Helena Vison testified that she was told she was not allowed access to any female-specific hygiene items, including "soap, shampoos, deodorants, razors, [and other] things of that nature." (Ex. 10, Vision Dep. at 26:1–10.) Ms. Kuykendall likewise testified that she has filed multiple grievances requesting gender-affirming hygiene items, but all were either ignored or denied. (Kuykendall Dep. at 106:13–17.) And Ms. Melendez testified that she even approached the warden of her facility to request these items, but was told "don't get my hopes up anytime soon." (Melendez Dep. at 76:22–77:5.)

Without consistent and continuing access to these items, Plaintiffs will continue to be denied proper social transition treatment and suffer harm. Ms. Reed explained that IDOC's refusal to provide these items "caused me to [] think about harming myself." (Reed Dep. at 86:17–25.) Dr. Ettner likewise explained that "[t]he physical changes facilitated by hormones in these patients make gender-affirming clothing and grooming items necessary not only for the mental health of these patients, but also for their basic physical comfort and dignity." (Ettner Dec. ¶ 69.) And there is not—and never was—any security justification for IDOC's denial. According to Mr. Aiken, "Defendants cannot use prison security as an excuse or justification to deny grooming items to transgender women in male facilities while simultaneously selling female grooming items to women in their female facilities." (Aiken Rpt. at 7.)

D. IDOC Does Not Properly Administer Hormone Therapy While Monitoring Remains Infrequent And Incomplete.

Defendants assert that they "have made continuing efforts to ensure that prisoners diagnosed with gender dysphoria continue to receive timely and appropriate hormone therapy." Mot. at 5. But the evidence tells a starkly different story. For example, class-member Chonna Anderson, has been requesting hormones since she was first placed into IDOC's custody 2007, (Ex. 11, Anderson Dec. ¶¶ 4, 8, 11), and was recognized by IDOC as "transsexual" in 2018, if not earlier.[1] Nonetheless, she has yet to receive hormones. (*Id.* ¶ 12.) Ms. Anderson was told that her prior cancer treatment precludes her from receiving hormone, (*Id.* ¶ 8), but a history of cancer is not a legitimate medical basis for denying hormone therapy. (Tangpricha Dec. ¶ 9 (explaining that Ms. Anderson's cancer is not hormone-sensitive and there was thus no reason to delay hormone

[1] (Ex. 12, Tangpricha Dec. ¶ 6.) Plaintiffs' expert Dr. Vin Tangpricha noted that that the terminology "transsexual" is "no longer used," but this diagnosis "clearly indicates that IDOC medical staff were on notice by then that Ms. Anderson should be promptly evaluated for gender dysphoria and hormone therapy." (*Id.* ¶ 6.)

therapy.) IDOC finally ***approved*** her request for hormones on November 5, 2020, but she has yet to ***begin*** this life-saving treatment. **(***See* Ex. 13, Bates 314634-7; Anderson Dec. ¶ 12.)

In addition, Plaintiffs' expert Dr. Vin Tangpricha, a certified endocrinologist and current president of WPATH, reviewed Plaintiffs' medical records produced between April 2019 and August 2020. He found that "the significant majority of class members continue to have bloodwork testing that demonstrates levels of estrogen and/or testosterone outside of the therapeutic ranges recommended under the [WPATH] Guidelines." (Ex. 14, Tangpricha Rpt. ¶ 80.) He additionally found that IDOC "rarely" performed "corrective action," "and many of the class members have only had one laboratory test conducted in the past year, while some have had none at all." (*Id.* ¶ 81.) The same is true for the named Plaintiffs, as almost all had estrogen and/or testosterone levels outside of the medically recommended range. (*Id.* ¶ 75.) Dr. Tangpricha also noted that IDOC administered some class members—including Ms. Kuykendall and Ms. Melendez—conjugated estrogen, an "outdated and unaccepted form of estrogen" that "can jeopardize the safety and health of the prescribed patient." (*Id.* ¶ 82; *see also* Kuykendall Dep. at 105:2–14.) Moreover, Plaintiffs have reported inexcusable gaps in hormone administration, sometimes going as long as a month without receiving them. (Melendez Dep. at 50:4–6; Ex. 15, Kuykendall Dec. ¶ 7.)

Dr. Tangpricha's review of the medical records also confirmed that IDOC still does not properly or regularly test for electrolytes, potassium, creatinine, and prolactin. (Tangpricha Rpt. ¶¶ 76, 85.) "Roughly half of all class members have no record of being tested for these levels since mid-2019. Shockingly, this is approximately the same number of class members that had no record of being tested for these levels at the time of my April 2019 Report." (*Id.*) Dr. Tangpricha

also observed that, among those who did receive testing, some demonstrated what he deemed to be unsafe levels, but there was no corresponding responsive action from IDOC. (*Id.*)

As a result of IDOC's deficient administration of hormone therapy, Plaintiffs' gender dysphoria continues to be exacerbated. For example, Ms. Melendez testified that she continues to experience erections and ongoing hair growth, (Melendez Dep. at 43:21–46:5), and explained that going prolonged periods without hormones causes her anxiety, hot flashes, and nausea, (*id.* at 54:7–55:12). And, critically, IDOC's failure to properly monitor Plaintiffs' bloodwork is a ticking time bomb. In one alarming example, Ms. Reed reported to IDOC officials in April 2020 that she was experiencing bilateral breast pain and headaches—symptoms signaling complications from her hormone therapy, including hyperprolactinemia or prolactin-producing tumors. (Tangpricha Rpt. ¶ 69.) IDOC conducted no follow up, such as bloodwork, an MRI, or a mammogram. (*Id.*; *see also* Reed Dep. at 88:4–23 (testifying that IDOC staff initially ordered a mammogram to examine her breast pain, but Wexford denied the request).)

E. Plaintiffs Are Consistently Misgendered And Subject To Harassment From IDOC Staff.

Misgendering—the act of referring to a person by the incorrect gender—remains a rampant problem among IDOC staff. All named Plaintiffs testified that they continue to experience near-constant misgendering. (Ex. 16, Monroe Dep. at 47:16–48:21; Melendez Dep. at 69:10–70:1; Vision Dep. at 30:9–1; Reed Dep. at 83:10–84:21; Kuykendall Dep. at 85:23–86:3.) Indeed, Ms. Kuykendall testified that "everybody" misgenders her, (*id.* at 85:23–86:3), while Ms. Monroe testified that she is misgendered by medical staff, superior officers, and sergeants, (Monroe Dep. at 47:16–48:21). Dr. Ettner has stated that misgendering "is harmful to the mental health of transgender persons. It threatens their identity and exacerbates the mental health problems attendant to Gender Dysphoria." (Ettner Dec. ¶ 65.)

But IDOC staff's demeaning and harmful behavior extends beyond misgendering. Plaintiffs also report that the majority of IDOC staff subjects them to verbal harassment that causes them great mental and emotional distress. For example, Ms. Reed testified that she does her best to "stay out of [IDOC staff's] way, because I deal with them harassing me and making sexual comments towards me." (Reed Dep. at 54:18–23). Ms. Melendez testified that the few staff members that have tried to address her by the correct gender and treat her with respect "get [] cursed out or chewed out or ma[de] fun of saying oh, you got a crush on the sissy, you're calling it a girl." (Melendez Dep. at 72:12–73:2.) Ms. Kuykendall described an incident where a lieutenant woke her up in the middle of night, banged on the bars of her cell, and said to her:

> I'm tired of this . . . shit. Going to put a stop to this. ***And then he asked me, do you have a dick***, and then I was silent. And then he said -- he had two COs with him and ***he said, if you don't answer, we're going to come in there***. And then -- so I said -- I answered him and then he said you're a man and then left.

(Kuykendall Dep. at 81:17–82:5 (emphasis added).) There can be no doubt that this psychological torture is extremely harmful to Plaintiffs. Indeed, Ms. Kuykendall testified that her treatment by IDOC staff makes her feel like she "doesn't matter," (*id.* at 113:23), describing it as "dehumanizing" because "the people who are supposed to be keeping me safe were behaving like that," (*id.* at 111:6–112:6). She explained, "I can't escape this in here." (*Id.* at 113:13–23.)

F. Defendants Do Not Contest That They Continue To Deny Plaintiffs Gender-Affirming Surgery.

Defendants do not dispute that no class member or named Plaintiff has received gender-affirming surgery despite Plaintiffs' repeated and continuing requests to allow them this medically necessary social transition. Ms. Vision testified that she has requested gender-affirming surgery "dozens" of times since 2016, but she has yet to receive a response from IDOC mental health or medical staff. (Vision Dep. at 23:8–24:17.) Ms. Kuykendall likewise testified that she has requested surgery from multiple staff members at her facility, including "most, if not all, of the

mental health counselors" and "all of the doctors" she has seen, but has been "ignored or told that we can't do that or we'll see." (Kuykendall Dep. at 63:13–64:1.) Ms. Reed has also been told by multiple mental health professionals that IDOC does not provide gender-affirming surgery. (Reed Dep. at 46:5–8.) Although Ms. Monroe has heard that she was approved for surgery, that same staff member told her that Dr. Reister "stopped her." (Monroe Dep. at 41:1–24.)

As to the purported effect of COVID-19 on Defendants' compliance with the injunction, there is no evidence in the record that IDOC has declined to approve other medically necessary surgeries since the pandemic began. Nor is there evidence that anything related to COVID-19 prevents IDOC medical staff from ***evaluating*** Plaintiffs for surgery. Defendants have not contended, for example, that all physician and mental health visits have ceased since March 2020. What the evidence does suggest, however, is "an ignorance on the part of IDOC officials of the fact that gender-affirming surgery may be a medically necessary treatment for Gender Dysphoria." (Ettner Dec. ¶ 146.) Indeed, IDOC has not taken even minimal steps to make surgery possible in the future: it has not even ***considered*** any surgeons to consult on drafting a surgical plan, (Ex. 17, Conway 30(b)(6) Dep. at 151:13–19), let alone ***contracted*** a surgeon to perform operations, (*id*. at 211:19-212:1). Nor has it even begun to draft a policy with respect to pre-surgery preparation or post-surgical care. (*Id*. at 212:2–215:12.) Without this medically necessary treatment, Plaintiffs will continue to suffer ongoing harm and exacerbation of their gender dysphoria. (*See*, *e.g.*, Ettner Dec. ¶¶ 125, 138 (describing serious risk of self-harm and suicide for Plaintiffs if IDOC does not provide gender-affirming surgery).)

G. Plaintiffs Are Suicidal And At Serious Risk Of Imminent Self-Harm.

Given the absence of improvements in IDOC's treatment and care of transgender prisoners, Plaintiffs continue to suffer from mental distress, suicidal thoughts, and a great risk of self-harm. For example, Ms. Monroe testified that she continues to "struggle with suicidal ideations,"

(Monroe Dep. at 35:19–24), while Ms. Vision testified that she has felt suicidal in recent months (Vision Dep. at 32:8–10). Ms. Melendez explained during her deposition that she has attempted suicide five times, most recently on August 5, 2020, which she attributes to her untreated gender dysphoria. (Melendez Dep. at 25:2–13, 27:1–23.) Ms. Reed likewise testified that she experiences depression and anxiety because she is "not receiving adequate medical treatment." (Reed Dep. at 85:2–15.) And Ms. Kuykendall was recently placed on "crisis watch" due to suicidal ideation, despite pleas to her counselor that this would serve to only further deteriorate her mental health. (Kuykendall Dec. ¶¶ 3-5.) Ms. Kuykendall's fears turned out to be true. While on "crisis watch," she was denied access to her prescribed hormone therapy, as well as an electric razor, which undoubtedly exacerbated her gender dysphoria and mental anguish. (*Id.* ¶¶ 7, 11.) Nor was she timely provided soap or eating utensils, which prevented her from eating for two days. (*Id.* ¶ 8.)

As Dr. Ettner explains, and the evidence shows, "Gender Dysphoria left untreated or inadequately treated, will result in serious physical harm. The depression and hopelessness associated with the condition causes suicidal ideation, which will result in actual suicide for many individuals." (Ettner Dec. ¶ 75.)[2]

ARGUMENT

I. STANDARD OF REVIEW.

To prevail on their motion, Defendants must establish that there is no genuine issue as to any material fact and that they are entitled to judgment as a matter of law. FED. R. CIV. P. 56(c). A fact is material if it would affect the outcome of the suit under governing law. *See Valance v. Wisel*, 110 F.3d 1269, 1274-75 (7th Cir. 1997). "A dispute is 'genuine' 'if the evidence is such

[2] If anything, this risk is understated, as Defendants have yet to comply with this Court's order on December 17, 2020 to produce suicide records. Dkt. 242.

that a reasonable jury could return a verdict for the nonmoving party.'" *Zaya v. Sood*, 836 F.3d 800, 804 (7th Cir. 2016) (quotation omitted). In evaluating a summary judgment motion, courts may not make credibility determinations nor weigh the evidence. *Payne v. Pauley*, 337 F.3d 767, 770 (7th Cir. 2003) (courts should "avoid[] the temptation to decide which party's version of the facts is more likely true"). The Court must deny the motion unless Defendants establish that there is no evidence, when viewed in the light most favorable to the Plaintiffs and drawing all reasonable inferences therefrom, that would support a judgment in Plaintiffs' favor. *Id.*; *see also Egan v. Freedom Bank*, 659 F.3d 639, 642 (7th Cir. 2011).

Plaintiffs, have identified substantial evidence supporting their Eighth Amendment claim and their entitlement to an injunction, so Defendants' motion must fail. A fact-finder is not required to believe Defendants' version of the facts, such as their description of purported efforts to comply with the Court's preliminary injunction, characterization of named Plaintiffs' deposition testimony regarding treatment, and assessment of the credentials and opinions of the parties' witnesses. Mot. at 4–14. Defendants' brief simply confirms that there are multiple disputed issues of fact precluding summary judgment. *Cf. Pourghoraishi v. Flying J, Inc.*, 449 F.3d 751, 753–54 (7th Cir. 2006) ("[S]ummary judgment briefs that present different versions of the facts arouse our attention . . . . [M]ultiple versions of the facts increase the chances that at least one of those conflicting facts will be material to the outcome of the case."); *Payne*, 337 F.3d at 770 ("Where the parties present two vastly different stories . . . it is almost certain that there are genuine issues of material fact in dispute.").

II. NUMEROUS ADDITIONAL DISPUTED FACT ISSUES PRECLUDE SUMMARY JUDGMENT ON PLAINTIFFS' EIGHTH AMENDMENT CLAIMS.

"'[W]hen the State takes a person into its custody and holds [them] there against [their] will, the Constitution imposes upon it a corresponding duty to assume some responsibility for

[their] safety and general well being.'" *Helling v. McKinney*, 509 U.S. 25, 32 (1993) (citations omitted). "[T]he Eighth Amendment safeguards the prisoner against a lack of medical care that 'may result in pain and suffering which no one suggests would serve any penological purpose.'" *Petties v. Carter*, 836 F.3d 722, 727 (7th Cir. 2016) (en banc) (quoting *Estelle v. Gamble*, 429 U.S. 97, 103 (1976)). "[D]eliberate indifference to serious medical needs of prisoners violates the Amendment because it constitutes the unnecessary and wanton infliction of pain contrary to contemporary standards of decency." *Helling*, 509 U.S. at 32; *see also Zaya*, 836 F.3d at 805.

"To determine if the Eighth Amendment has been violated in the prison medical context, [the court] perform[s] a two-step analysis, first examining whether a plaintiff suffered from an objectively serious medical condition, and then determining whether the individual defendant was deliberately indifferent to that condition." *Petties*, 836 F.3d at 727–28 (*citing Farmer v. Brennan*, 511 U.S. 825, 834 (1994)). Defendants concede that Plaintiffs meet the first step of this analysis—*i.e.*, that Plaintiffs' gender dysphoria is an objectively serious medical condition. Mot. at 15.

The second step—deliberate indifference—requires "evidence that an official *actually* knew of and disregarded a substantial risk of harm." *Petties*, 836 F.3d at 728 (citing *Farmer*, 511 U.S. at 837). The Supreme Court has explained that, whether a prison official "had the requisite knowledge of a substantial risk" is not a legal question, it is "***a question of fact*** subject to demonstration in the usual ways, including inference from circumstantial evidence, and a factfinder may [for example] conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious." *Farmer*, 511 U.S. at 834 (emphasis added); *Zaya*, 836 F.3d at 805; *see also Monroe v. Baldwin*, 424 F. Supp. 3d 526, 542 (S.D. Ill. 2019), *on reconsideration in part sub nom. Monroe v. Meeks*, 2020 WL 1048770 (S.D. Ill. Mar. 4, 2020). Plaintiffs are not

required "to show that the official intended harm or believed that harm would occur." *Petties*, 836 F.3d at 728.[3]

A. Plaintiffs' Evidence Is Sufficient To Support A Finding That Defendants Consciously Disregarded A Substantial Risk of Harm.

Plaintiffs put forth a wealth of evidence—direct as well as circumstantial[4]—sufficient to raise a disputed issue on whether defendants "actually knew of and disregarded" a substantial risk of harm. *See Zaya*, 836 F.3d at 805. The Seventh Circuit has found that a factfinder could reasonably infer deliberate indifference (and that "no exercise of professional judgement actually occurred") "if the defendant's chosen 'course of treatment' departs radically from 'accepted professional practice.'" *Zaya*, 836 F.3d at 805 (citation omitted). *See also, e.g.*, *Roe v. Elyea*, 631 F.3d 843, 861 (7th Cir. 2011) ("[T]he choice of an 'easier and less efficacious treatment' can demonstrate that the actor displayed 'deliberate indifference.'") (quoting *Estelle*, 429 U.S. at 104 n.10); *Petties*, 836 F.3d at 729–30 (noting that "minimally competent medical judgment" could be inferred where "a prison official persists in a course of treatment known to be ineffective"); *Zaya*, 836 F.3d at 806 ("[A factfinder] can infer conscious disregard of a risk from a defendant's decision to ignore instructions from a specialist.").

Indeed, Defendants cannot seriously contend that they are unaware of the substantial risk of harm to Plaintiffs, as the Court already found that "IDOC is well-aware that transgender inmates

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[3] Defendants' suggestion that there is no violation without "some sort of punishment or subjective cruelty" is unhelpful. Mot. at 15–17. The "punishments" aspect of the Eighth Amendment in a case alleging failure to provide adequate medical care is reflected in the requirement that deliberate indifference refers to a subjective state of mind. *See Farmer*, 511 U.S. at 837.

[4] Circumstantial evidence is no less probative than direct evidence, and is sufficient to establish conscious disregard if a factfinder could reasonably infer that the fact at issue is more likely true than not. *See Piercy v. Warkins*, 2017 WL 1477959, at *11 (N.D. Ill. April 25, 2017) (J. Pallmeyer) (denying summary judgment on deliberate indifference claim because "[c]ircumstantial evidence may always be considered, and in some circumstances has more weight than direct evidence"). *See also Michalic v. Cleveland Tankers, Inc.*, 364 U.S. 325, 330 (1960) (overturning directed verdict because trial court did not properly consider circumstantial evidence, which was "not only sufficient, but may also be more certain, satisfying and persuasive than direct evidence").

are at a high risk of suffering mental health issues and resorting to self-harm." Dkt. 186, at 32. And yet Plaintiffs' evidence shows that the treatment this Court found inadequate remains the same. *See supra*, Statement of Facts; *see also Petties*, 836 F.3d at 732 (affidavit from plaintiff testifying to harm experienced was sufficient to create factual dispute warranting denial of summary judgment on Eighth Amendment claim).

Defendants' plea to the Court that it must "take into account" their efforts made following the preliminary injunction are unavailing. Mot. at 23. As noted, Defendants admit that they have not yet finalized a new directive for the care and treatment of transgender prisoners. *See id*. at 27. Thus, despite Defendants' assertions that they have taken "steps" to remedy the harms previously recognized by the Court, and that "various aspects of Plaintiffs' suit have been mooted," *id.*, Defendants have not even changed the policies, let alone the practices, that have caused, and continue to cause, transgender prisoners the serious harm and injury this Court identified. As a result of Defendants' failure to identify the scope and specifics of the new administrative directive, this Court cannot evaluate the adequacy of what they ultimately plan to do, or their progress toward implementing any such plan.[5] Moreover, Defendants' prolonged delay in implementing a new directive—13 months and counting since the preliminary injunction was entered—is more than enough to create a factual dispute about the current and future risk of harm to Plaintiffs. *See Petties*, 836 F.3d at 729–30 (finding evidence that "a prison official persists in a course of treatment known to be ineffective" could establish deliberate indifference).

In the meantime, the "steps" they have purportedly taken during the last year fall far short of what they were ordered to do. Many of "these steps" are, in fact, plans for future actions yet to

[5] To be clear, Defendants have yet to produce any drafts of the new administrative directive that post-date April 2020, let alone the final administrative directive.

be implemented, making it impossible to judge their effectiveness or sufficiency. *See* Mot. at 23 (citing to IDOC's planned "restructuring" of the TCRC committee and to additional training that has not yet been delivered). The few tangible efforts actually effected by the Department in the past year are far from certain to alleviate Plaintiffs' harm. For example, Defendants engaged consultants, Dr. Erica Anderson and The Moss Group, who are providing "services and assistance in drafting a new [d]irective," Mot. at 5, but these consultants have no authority to effect meaningful change. Dr. Anderson and IDOC witnesses testified that her charge is only to provide suggestions to IDOC, which the Department is free to disregard should it so choose. (Ex. 18, Anderson Dep. at 58:5–59:13 ("A. [T]hey are free to disregard my advice, yes."); Ex. 19, Reister Dep. at 158:1–10 ("Q. [Dr. Anderson]'s making recommendations, but it's still not the personnel that are having to make the decisions, right? A. At the end of the day, what the director says goes. So everything is ultimately his decision, responsibility.").) Moreover, despite The Moss Group's recommendation in mid-2019 that IDOC "[i]mmediately review current practice in addressing the transgender population" at Logan Correctional Center, the Group's corporate representative—Wendy Leach—was "not aware" of anything IDOC had done to address this at the time of her deposition in August 2020. (Ex. 20, Moss Group Dep. at 127:11–14, 128:2–3; Ex. 21, Moss Group Report at 12.)

Critically—even assuming that IDOC has, in good faith, considered and accepted recommendations from their consultants on the new directive—neither has been retained to oversee the ***implementation*** of the new policies, whenever they are finally approved. (Ettner Dec. ¶ 148.) Ms. Leach testified that on June 4, 2020, she sent IDOC a proposal to continue and complete her work to help IDOC finalize and implement a new policy, including by training IDOC staff. But, by the time of her deposition several months later, IDOC had not agreed to continue

The Moss Group's work. (Moss Group Dep. at 191:16–192:11.) Defendants' motion does not suggest otherwise; it cites only to Defendants' January 2020 report on compliance. Mot. at 5.

Defendants also point to training that has been conducted for all IDOC staff, as well as "targeted training" for mental health providers. Mot. at 6. Plaintiffs' evidence raises genuine disputes on whether this training is sufficient to prevent harm to Plaintiffs, or whether it will ever occur. IDOC's corporate representative, Dr. Lamenta Conway, testified that mental health providers currently receive only one gender dysphoria-specific training per year, even though diagnosis and treatment of gender dysphoria is a specialized area of medicine that requires more than such a cursory annual primer. (Conway 30(b)(6) Dep. at 26:10–15.) And, even under the new administrative directive, medical providers—who are responsible for prescribing and administering hormones—would receive only an ***optional*** training from IDOC. (*Id.* at 121:16–122:7.) This training—should providers opt to take it—is a WPATH "foundations" course, (*Id.* at 109), which is insufficient on its own to qualify providers to diagnose or treat gender dysphoria, (Ex. 22, Ettner Dep. at 53:3–19 (describing this course as a "first step")). Indeed, IDOC witnesses concede that they have no oversight over the qualifications of Wexford employees, who provide the majority of healthcare to all Plaintiffs. (Reister Dep. at 104:15–22, 249:18–24.)

In addition, the effectiveness of ***the single training*** administered to all IDOC staff on misgendering is disputed by the very IDOC employee who developed and conducted the training, Dr. Shane Reister. (Reister Dep. at 133:8–14 ("[The two-hour staff training is] received once. And then that's why I'm working on some follow-up trainings because it will take more than one exposure to the information.").) IDOC's consultant testified that this training was not "suited for correction staff" because it does not include important information such as how to conduct searches, and corrections staff may simply "reject it all." (Moss Group Dep. 202:1–203:10.)

Finally, Defendants assert that "IDOC has updated its commissary items for transgender prisoners," but concede that the revised list applies only to transgender female prisoners. Mot. at 5. In other words, Defendants admit their changes fail to address the social transition needs of transgender men, and therefore have no class-wide impact. Regardless, even as to transgender women, the impact of this new policy—however incomplete—is disputed as none of the Plaintiffs have yet received access to social transition treatment. *See* Statement of Facts, Section C, *supra*.

But even if Defendants had implemented meaningful changes to their treatment and care of Plaintiffs, there would *still* be remaining issues of fact regarding the adequacy of that treatment and whether Defendants have eliminated the substantial risk of harm of which they are now aware. Although Defendants' "current attitudes and conduct" are relevant in deciding deliberate indifference, *Farmer*, 511 U.S. at 845; *Helling*, 509 U.S. at 36 (1993), this Court cannot on summary judgment determine whether to believe Defendants' evidence over Plaintiffs'.

Put simply, viewing all evidence in the light most favorable to Plaintiffs, a factfinder could reasonably determine that IDOC is presently "knowingly and unreasonably disregarding an objectively intolerable risk of harm, and that they will continue to do so." *Farmer*, 511 U.S. at 846. That is all that is required of Plaintiffs to survive summary judgment. *Id.*

B. Defendants' Admission That They Do Not Meet The WPATH Standards Of Care Is Sufficient To Raise A Triable Fact Precluding Summary Judgment.

Defendants argue that they are not constitutionally required to follow the WPATH Standards of Care ("SOC"). Mot. at 19. They appear to believe that unless courts announce agreement on what medical treatment for gender dysphoria would satisfy the Eighth Amendment, then, as a matter of law, there can be no constitutional violation. Not so. As noted above, deviation from the applicable professional standards is relevant evidence of deliberate indifference. *See Petties*, 836 F.3d at 727 ("While published requirements for health care do not create constitutional

rights, such protocols certainly provide circumstantial evidence that a prison health care gatekeeper knew of a substantial risk of serious harm.") (quoting *Mata v. Saiz*, 427 F.3d 745, 757–58 (10th Cir. 2005) ("'[C]ontemporary standards and opinions of the medical profession . . . are highly relevant in determining what constitutes deliberate indifference to medical care'") (citation omitted)). The weight of this evidence is for the trier of fact to determine, and thus will vary depending on the particular circumstances of the case.

Defendants also ignore this Court's prior holding in its preliminary injunction orders adopting the WPATH standards as "guidelines for constitutionally adequate care."

> Unless Defendants offer an alternative constitutionally adequate standard of treatment or an expert who can speak to differing medically accepted treatment criteria regarding gender dysphoria, ***the Court will continue to use the WPATH Standards of Care as guidelines for constitutionally adequate care under the Eighth Amendment***.

Dkt. 211 at 6–7 (emphasis added). Yet Defendants have not suggested, let alone provided undisputed evidence of, an alternative SOC by which to measure their conduct. Instead, they argue that the WPATH SOC do not control.

Because Defendants failed to provide an alternative SOC, the Court's decision to rely on the WPATH SOC is law of the case. *See AM Gen. Corp. v. DaimlerChrysler Corp.*, 246 F. Supp. 2d 1030, 1035 (N.D. Ind. 2003) (interpretation of contract for purposes of preliminary injunction was law of the case for purposes of summary judgment) (citing *Commodity Futures Trading Comm'n v. Bd. of Trade of City of Chi.*, 701 F.2d 653, 657–658 (7th Cir. 1983) (recognizing that findings made during a preliminary injunction hearing could be given preclusive effect)).[6]

[6] According to the Seventh Circuit, the court can decide that findings made in preliminary injunction proceedings bar relitigation "if the circumstances make it likely that the findings are accurate [and] reliable." *Id.* at 657; *cf. Hawksbill Sea Turtle v. Fed. Emerg. Mgmt. Agency*, 126 F.3d 461, 474 n.11 (3d Cir. 1997) (holding that treating the holdings as final is "particularly appropriate in a second action seeking the same injunctive relief") (citing Wright & Miller, 18A Fed. Prac. & Proc. Juris. § 4434 (3d ed.)).

Here, the circumstances surrounding this Court's adoption of the WPATH SOC demonstrate that the Court decided this issue. *See AM Gen. Corp.*, 246 F. Supp. 2d at 1034–35 (considering "the nature of the decision (i.e., that it was not avowedly tentative), the adequacy of the hearing, and the opportunity for review") (quoting *Lummus Co. v. Commonwealth Oil Refin. Co.*, 297 F.2d 80, 89 (2d Cir. 1961)). The Court heard both sides at the preliminary injunction hearing regarding the appropriate standard of care, including testimony from Plaintiffs' two qualified experts who endorsed the WPATH SOC. The Court agreed and wrote a detailed opinion, even reconsidering and reconfirming its decision a second time. Dkt. 211 at 6–7. And Defendants could have appealed the preliminary injunction order, but chose not to do so. Nor did Defendants come forward with expert evidence of an alternative SOC, as this Court suggested. Dkt. 186 at 31. Although this Court is free to modify its previous holdings in connection with preliminary injunction, Defendants may not simply ignore the Court's prior decision. Their untimely argument to reject the SOC is not a sufficient reason to disregard the law of the case. That the WPATH SOC govern here was indeed "a thing decided."

Even if it were not contrary to the law of the case, Defendants have not established that, ***as a matter of law***, "they are not constitutionally mandated to comport with WPATH Standards of Care." Mot. at 19. Plaintiffs have provided evidence that the WPATH standards are the minimally acceptable treatment for gender dysphoria; Defendants disagree, but have offered no evidence.[7] For example, Defendants rely on "history with respect to the care and treatment of gender dysphoria," which they claim shows "there is no set treatment, let alone one that may easily be

[7] Moreover, IDOC's consultant, Dr. Erica Anderson, testified that the WPATH standards of care "constitute the standards of care for transgender healthcare around the world," and that WPATH's guidance for the treatment of transgender individuals in prison is "similar to the guidance general[ly] for transgender people, that they should be treated with respect and accorded the opportunity to live in their . . . identified gender and given access to needed medical and psychological care." (Anderson Dep. at 30:1–17.)

determined in the prison environment." *Id.* at 20. They also claim the case law "articulates no set Eighth Amendment standard for the care and treatment of gender dysphoria," and they "have set no clear lines," even stating that "recent cases involving similar claims have pulled in different directions." *Id.* Defendants' arguments that the WPATH SOC are—at most—not universally accepted, simply highlights the existence of a material factual dispute.

Furthermore, one of Defendants' principal cases expressly adopted the WPATH SOC and found deliberate indifference. *See* Mot. at 20–21 (analyzing *Campbell v. Kallas*, 936 F.3d 536, 545 (7th Cir. 2019)). Just six days after Defendants filed their motion, the district court in that case, on remand, enjoined the Wisconsin prison to provide gender reassignment surgery. *See Campbell v. Kallas*, 2020 WL 7230235, at *8 (W.D. Wis. Dec. 8, 2020) (finding conscious disregard by IDOC for refusing inmate the one effective treatment as a matter of policy). *Campbell* found "that the diagnostic and treatment criteria in the WPATH standards of care represent the ***consensus of qualified medical professionals*** regarding the appropriateness of various treatments for gender dysphoria, including sex reassignment surgery." *Id.* at *4 (emphasis added).

The WPATH standards' weight is a matter for the factfinder, as is the evaluation of the credibility of Defendants' assertions that "any order that imposes WPATH requirements on every provider would be ***too difficult to achieve***." Mot. at 28 (emphasis added). These factual disputes preclude summary judgment on Plaintiffs' Eighth Amendment claim.

III. PLAINTIFFS HAVE PROVIDED SUFFICIENT EVIDENCE TO ESTABLISH EACH OF THE REQUIREMENTS FOR A PERMANENT INJUNCTION.

Defendants assert that summary judgment must be granted because Plaintiffs "cannot meet the accompanying burden to warrant the imposition of injunctive relief." Mot. at 14. The showings required for a preliminary and permanent injunction are essentially the same, except that "[t]he standard for preliminary injunctive relief requires only a showing of a likelihood of success

on the merits, whereas permanent relief requires a determination on the merits." *City of Chi. v. Barr*, 961 F.3d 882, 893 (7th Cir. 2020). As discussed above, Plaintiffs have sufficient evidence to prevent summary judgment on the merits. Plaintiffs have already presented evidence from which this Court found (1) irreparable injury; (2) inadequacy of available remedies at law; (3) that the balance of hardships supports a remedy in equity; and (4) that an injunction serves the public interest. Dkt. 186; *see eBay Inc. v. MercExchange, L.L.C.*, 547 U.S. 388, 391 (2006) (setting out elements of permanent injunction). Just as Defendants' new evidence fails to establish a lack of disputed facts regarding deliberate indifference, it also falls far short of establishing the other elements in their favor as a matter of law. In short, Plaintiffs' arguments regarding their entitlement to a permanent injunction raise, at bottom, disputed fact issues precluding summary judgment. *See Casey v. Uddeholm Corp.*, 32 F.3d 1094, 1098 (7th Cir. 1994) ("It is axiomatic that when there are contested issues of material fact, the district court is precluded from granting summary judgment.").

A. The Record Evidence Supports A Finding Of Irreparable Harm.

Defendants assert that "[t]hroughout this suit, Plaintiffs have merely hinted at the *possibility* that IDOC's policies lead to a risk of harm." Mot. at 24. Not so. As Defendants' own brief makes clear, there is ample evidence of past, present, and ongoing irreparable harm caused by Defendants' policies and practices. *See, e.g.*, *id*. at 8 (describing Ms. Melendez's multiple suicide attempts); *id.* at 14 ("Dr. Ettner has opined that all five of the representative Plaintiffs in this action are at a serious risk of self-harm.").

If anything, the evidence is undisputed that Plaintiffs have suffered—and will continue to suffer—these injuries absent injunctive relief. Testimony from each named Plaintiff demonstrates that there is a continuing and substantial risk of suicide, self-harm, and psychological decompensation associated with IDOC's continued failure to provide adequate treatment for their

gender dysphoria. *See* Statement of Facts, *supra*. Critically, Defendants have put forth no evidence to dispute any of these injuries or harms. Accordingly, viewing the evidence in the light most favorable to Plaintiffs, as the Court must, a jury could reasonably find that Plaintiffs will continue suffering irreparable harm absent an injunction. *See, e.g.*, *Edmo v. Corizon, Inc.*, 935 F.3d 757, 798 (9th Cir. 2019) (affirming finding of irreparable harm where plaintiff demonstrated "profound, persistent distress" caused by gender dysphoria), *cert. denied sub nom., Idaho Dep't of Corr. v. Edmo*, 2020 WL 6037411 (Oct. 13, 2020); *see also Hicklin v. Precynthe*, 2018 WL 806764, at *10, *14 (E.D. Mo. Feb. 9, 2018) (plaintiff showed irreparable harm based on evidence of worsening emotional distress and a substantial risk of self-harm).[8]

Defendants' brief does not dispel the existence of disputed facts. Their reliance on *Michigan v. United States Army Corps of Engineers* to support their assertion that Plaintiffs must "show that there is a 'presently existing actual threat' as a result of IDOC policies" is misplaced. Mot. at 25 (citing 667 F.3d 765, 789 (7th Cir. 2011)). In that case, the Seventh Circuit *overruled* the district court's denial of a preliminary injunction because the district court was too exacting on the question of risk of irreparable harm. *Id.* at 788–89. According to the Seventh Circuit, the harm at issue in *Michigan*—the presence of Asian carps in Lake Michigan—was irreparable because it was "difficult—if not impossible—to reverse." *Id.* at 788. The same is undoubtedly true here.

Orr v. Schicker, 953 F.3d 490, 502 (7th Cir. 2020), is likewise unavailing. There—ruling on a request for a preliminary injunction—the court found that the evidence was "equivocal"

[8] Further, Defendants' continual deprivation of Plaintiffs' Eighth Amendment rights, as described in Section I, is in itself an irreparable harm sufficient to warrant a permanent injunction. *See, e.g.*, *Edmo v. Corizon, Inc.*, 935 F.3d 757, 798 (9th Cir. 2019) (noting that "the deprivation of Edmo's constitutional right to adequate medical care [was also] sufficient to establish irreparable harm," and upholding permanent injunction); *City of Chi. v. Sessions*, 321 F. Supp. 3d 855, 878 (N.D. Ill. 2018) (granting permanent injunction and noting "a constitutional injury alone can constitute irreparable harm"), *aff'd and remanded sub nom. City of Chi. v. Barr*, 961 F.3d 882 (7th Cir. 2020).

because multiple doctors testified that the medical condition at issue—hepatitis C—was a "slow-moving disease" and that "there was probably not significant harm" absent plaintiff's requested treatment. *Id.* (internal quotations omitted). In contrast, the Court here has already granted Plaintiffs preliminary relief, finding "there [was] no doubt that Plaintiffs face irreparable harms that cannot be compensated by monetary damages." Dkt. 186 at 36. And the evidence developed since the preliminary injunction shows—at a minimum—that material factual disputes remain on the question of whether Plaintiffs currently, and will continue to, experience that same harm.

Defendants also raise a number of factual arguments to support their assertion that Plaintiffs cannot show irreparable harm, but their efforts only highlight the factual disputes that preclude summary judgment. First, Defendants attempt to discount the record evidence by claiming that Dr. Ettner "finds the same [as she does here] in nearly all of the forensic analyses." Mot. at 24. But, "[o]n summary judgment a court may not make credibility determinations, weigh the evidence, or decide which inferences to draw from the facts; these are jobs for a factfinder." *Payne*, 337 F.3d at 770 (reversing summary judgment where district court erroneously weighed the credibility of competing expert testimony) (citing *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 255 (1986)).[9] Moreover, even if these criticisms were appropriate on summary judgment, Defendants offer no persuasive reason to discount this expert testimony. Defendants do not proffer their own expert in response to Dr. Ettner, and their own witness has conceded Dr. Ettner's expertise. (*See* Reister Dep. at 157:22–158:7.) This Court has also already expressly rejected these arguments, finding Dr. Ettner to be qualified and credible. Dkt. 186 at 30–32.

Second, Defendants argue that COVID-19 has disrupted and delayed appointments with physicians, transfers, and gender-affirming surgeries. Mot. at 25. But, as noted, the merit of this

[9] To be clear, Defendants have not filed to exclude or bar expected testimony from Dr. Ettner.

excuse for the continued failure to provide adequate medical care presents—at most—a dispute of material fact for trial. The evidence is far from clear that COVID-19 prevents IDOC from enacting new policies or practices. For example, although no transgender prisoner has been transferred or placed in a facility matching their gender identity since December 2019, IDOC's own witnesses admitted transfers were still occurring generally during the pandemic. *See* Statement of Facts, Section A, *supra*. Likewise, IDOC provides no explanation for why COVID-19 precludes surgery or, at a minimum, evaluation for surgery, as there is no evidence that physician visits ceased altogether once the pandemic began. The fact remains that—COVID delay or not—Plaintiffs continue to suffer irreparable harm from IDOC's policies and practices. Accordingly, Defendants' assertion that Plaintiffs cannot as a matter of law show irreparable harm does nothing but highlight disputes of material fact for trial, and is therefore unmeritorious.

B. Defendants Concede That The Adequacy Of A Remedy At Law Is Disputed.

It is difficult to imagine harms less adequately addressed by monetary damages than psychological distress, self-harm, suicide, and serious medical complications. Defendants do not seriously suggest otherwise. Nor could they.

Defendants expressly concede that "a risk of suicide or self-harm related to an unconstitutional policy could be sufficient to establish that there are no adequate remedies at law." Mot. at 26. Because the evidence of Plaintiffs' risk of suffering those harms is, at the very least, disputed, this should end the inquiry. *See Whitaker ex rel. Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1045-46 (7th Cir. 2017) (finding suicide and diminished well-being are irreparable harms within an adequate remedy at law); *Hicklin*, 2018 WL 806764, at *14.

Nevertheless, Defendants contend, for the first time, that this lawsuit is too "vague" and "general," which therefore means Plaintiffs are "unable to establish that traditional legal remedies are inadequate." Mot. at 26. But as the Court has found, Defendants are well aware of the

irreparable harms alleged here (to which Plaintiffs and experts alike have testified at great length). *See, e.g.*, Dkt. 186 at 36 ("[T]here is no doubt that Plaintiffs face irreparable harms that cannot be compensated by monetary damages."). Defendants provide no case law or evidence to explain why the Court's previous finding was erroneous and should be disregarded.

Equally without merit is Defendants' claim that Plaintiffs have not made it "clear that injunctive relief will resolve any one individual prisoner's feelings of self-harm." Mot. at 27. The court in *Whitaker*—Defendants' only citation in support of this assertion—did not impose any such requirement. It instead required the plaintiff to demonstrate "that any award would be 'seriously deficient as compared to the harm suffered.'" *Whitaker*, 858 F.3d at 1046 (citation omitted). The court found the plaintiff's assertion "that the policy caused him to contemplate suicide," which was credited by an expert report, was sufficient to establish no adequate remedy at law. *Id.* As detailed above, a trier of fact could find IDOC's policies and practices have caused Plaintiffs to contemplate suicide. Hence, plaintiffs have not established that Plaintiffs cannot show an inadequate remedy at law.

C. Defendants Fail To Show That, As A Matter Of Law, The Balance Of Harms Tips In Their Favor.

Defendants seem to suggest that the ongoing harm to Plaintiffs should be altogether discounted because IDOC's forthcoming policies and practices "*may* entirely moot Plaintiffs' complaints." Mot. at 27 (emphasis added). Their argument fails on both the law and the facts. "It is well settled that a defendant's voluntary cessation of a challenged practice does not deprive a federal court of its power to determine the legality of the practice. If it did, the courts would be compelled to leave the defendant free to return to his old ways." *Friends of the Earth, Inc. v. Laidlaw Envt'l Servs. (TOC), Inc.*, 528 U.S. 167, 189 (2000). As a result, the standard to show mootness due to voluntary cessation is demanding: "Under settled law, we may dismiss the case

for [mootness] only if 'it is impossible for a court to grant any effectual relief whatsoever' to [plaintiffs] assuming [they] prevail[]." *Mission Prod. Holdings, Inc. v. Tempnology, LLC*, 139 S. Ct. 1652, 1660 (2019) (citation omited). "The 'heavy burden of persua[ding]' the court that the challenged conduct cannot reasonably be expected to start up again lies with the party asserting mootness." *Friends of the Earth, Inc.*, 528 U.S. at 189 (citation omitted).[10]

Defendants have not met that burden here. At most, Defendants have raised a triable issue of fact on the cessation of their harmful policies. Defendants are still operating under the same unconstitutional policy that this Court reviewed over one year ago. Defendants themselves recognize that, without a revised administrative directive, the Court should not grant summary judgment: "IDOC should be allowed to fully implement its new policies before this Court intervenes." Mot. at 27.

But, critically, the sufficiency of any new directive—once implemented—would also be a question of fact. *See Square D Co. v. Fastrak Softworks, Inc.*, 107 F.3d 448, 451 (7th Cir. 1997) ("The issue of whether a claim for specific injunctive relief is moot is a fact-specific one."). As Defendants point out, Mot. at 27, the Seventh Circuit has held that a revised ordinance did not moot a plaintiff's claim where the plaintiff "would still face a variety of injuries stemming from the new ordinance," and "the new ordinance ke[pt] several requirements from the original ordinance that would continue to injure" the plaintiffs. *ADT Sec. Servs., Inc. v. Lisle-Woodridge Fire Prot. Dist.*, 724 F.3d 854, 863–64 (7th Cir. 2013). Moreover, IDOC's pattern of willful and

[10] Even assuming that Defendants had complied with the Court's preliminary injunction—which Plaintiffs do not concede—case law is clear that complying with an order does not moot a case. *See Ind. Emp. Sec. Div. v. Burney*, 409 U.S. 540, 545 (1973) ("[I]t is well established that compliance with a court order pendente lite does not moot the underlying controversy."); *Milwaukee Police Ass'n v. Jones*, 192 F.3d 742, 747 (7th Cir. 1999) ("Temporary compliance with a decree pending appeal . . . clearly should not moot a case unless other circumstances show that official policies really have changed."); *United Air Lines, Inc. v. Air Line Pilots Ass'n, Int'l*, 563 F.3d 257, 275 (7th Cir. 2009) (holding the "district court . . . was within its discretion to find that an agreement signed only after a lawsuit has been filed is not voluntary, and that even a voluntary cessation is not determinative.").

deliberate indifference shows that—assuming a new directive is eventually implemented—their compliance with that directive cannot be assumed.

Defendants also argue that they will be impermissibly burdened from a permanent injunction. Mot. at 29. Yet Defendants do not identify a single cognizable harm—much less irreparable harm—they will suffer from providing medically necessary care consistent with their constitutional obligation. Instead, Defendants raise frivolous arguments, none of which tips the balance of harms in their favor as a matter of law.

Defendants argue that they are "entitled to substantial deference . . . in managing and fulfilling their public obligations." Mot. at 27. The authority they quote, however, is the *dissenting* opinion in *Johnson v. California*. 543 U.S. 499, 529 (2005) (Thomas, J., dissenting) ("[E]xperienced prison administrators, and not judges, are in the best position to supervise the daily operations of prisons across this country."). The majority in *Johnson* denounced this standard as "too lenient," and expressly stated it was ***not*** applicable to Eighth Amendment claims in the prison context. *Id.* at 513 (majority opinion). And not only is Defendants' stated legal standard wrong, their argument is perverse. Defendants' failure to enact and implement constitutional policies cannot be a reason to ***dismiss*** this case. Defendants' failure to implement new policies (despite a court order issued over a year ago) is precisely why the Court ***needs*** to intervene and enjoin Defendants permanently from continuing to harm the Plaintiff class.

Defendants also argue that imposing "WPATH requirements on every provider would be too difficult to achieve." Mot. at 28. But this burden is not a cognizable harm, and certainly not one that would tip the balance in their favor as a matter of law. *See, e.g.*, *Mortland v. Lights Out Devs., LLC*, No. 2020 WL 3577867, at *2 (S.D. Ind. July 1, 2020) (finding the balance of harms weighs in favor of plaintiffs when defendants articulate no hardship beyond the cost of complying

with the law). Moreover, Defendants' position is undermined by its argument that there is more than one way to obtain competency. Mot. at 28–29. This would make obtaining competency ***less burdensome***, not more. Even if obtaining competency were too burdensome (though it is not), "prisons regularly refer prisoners to specialists when they are unable to fully treat them." *Foster v. Ghosh*, 4 F. Supp. 3d 974, 984 (N.D. Ill. 2013) (finding the cost to defendants associated with providing adequate care to plaintiff did not outweigh the harm plaintiff will endure if plaintiff's medical issues remain untreated.). And Defendants' "no workable metrics" argument has no stopping point. Taken to its logical conclusion, it would mean that no court could ever order a prison to remedy its refusal to provide adequate medical care to a class of prisoners.

In sum, a trier of fact could clearly find the balance of harms favors Plaintiffs. *See, e.g.*, *Edmo v. Idaho Dep't of Corr.*, 358 F. Supp. 3d 1103, 1128, *aff'd by Edmo v. Corizon, Inc.* 935 F.3d 757, 803 (9th Cir. 2019); *Farnam v. Walker*, 593 F. Supp. 2d 1000, 1017-18 (C.D. Ill. 2009) (granting preliminary injunction after finding that the burden on the prison of administrating medical treatment was greatly outweighed by plaintiff's prolonged pain, suffering, and decreased quality of life); *Gammett v. Idaho State Bd. of Corr.*, 2007 WL 2186896, at *15–16 (D. Idaho July 27, 2007) (finding balance of harms "sharply" favored plaintiff, who would experience suicidality and mental harm without gender dysphoria treatment).

D. Granting A Permanent Injunction Does Not Disserve The Public Interest.

The public has the "highest" interest in preventing the violation of a party's constitutional rights. *See United States v. Raines*, 362 U.S. 17, 27 (1960). Here, the public interest strongly favors injunctive relief because Plaintiffs seek to vindicate their right to medically adequate treatment under the Eighth Amendment. *See, e.g.*, *Flynn v. Doyle*, 630 F. Supp. 2d 987, 993 (E.D. Wis. 2009) ("The public has a strong interest in the provision of constitutionally-adequate health care to prisoners."); *Phillips v. Mich. Dep't of Corr.*, 731 F. Supp. 792, 801 (W.D. Mich. 1990)

(finding "the public interest will be served by safeguarding Eighth Amendment rights" of prisoners with gender dysphoria), *aff'd*, 932 F.2d 969 (6th Cir. 1991). Thus, far from a "disservice" to the public, the public interest actually compels injunctive relief here.

The cases relied on by Defendants do not hold otherwise. The decision in *Horne v. Flores*, Mot. at 30, related to an injunction which "dicta[ed] state or local budget priorities," and thus the "highest public interest" was not implicated. 557 U.S. 433, 448 (2009). And *Lewis v. Casey*, Mot. at 30, is inapposite. 518 U.S. 343 (1996). The language cited by Defendants relates to standing, not public interest. *Lewis* stands for the proposition that Court intervention is not appropriate when a claimant has suffered ***no*** injury.[11] Defendants do not—and cannot—contend that Plaintiffs have suffered no injury here. Thus, summary judgment must be denied.

IV. DEFENDANTS' REMAINING ARGUMENTS DO NOT ENTITLE THEM TO SUMMARY JUDGMENT

Defendants make two final arguments in support of their motion: (1) the Eleventh Amendment bars Plaintiffs' requested relief; and (2) Plaintiffs' requested relief is not sufficiently narrowly tailored under the Prison Litigation Reform Act ("PLRA"). Mot. at 30, 32. Neither argument is supported by the case law nor justifies summary judgment.

A. Defendants Are Not Entitled To Summary Judgment On Their Eleventh Amendment Defense.

"In determining whether the doctrine of *Ex parte Young* avoids an Eleventh Amendment bar to suit, a court need only conduct a 'straightforward inquiry into whether [the] complaint alleges an ongoing violation of federal law and seeks relief properly characterized as prospective.'"

[11] In *Lewis v. Casey*, the plaintiffs had not suffered any injury as a result of any constitutional violation. The court analogized the case to "a healthy inmate who had suffered no deprivation of needed medical treatment [being] able to claim violation of his constitutional right to medical care, simply on the ground that the prison medical facilities were inadequate." *Lewis*, 518 U.S. at 350 (internal citation omitted).

Verizon Md., Inc. v. Pub. Serv. Comm'n of Md., 535 U.S. 635, 645 (2002) (citation omitted); *see also Council 31 of the Am. Fed'n of State, Cnty. & Mun. Emps., AFL-CIO v. Quinn*, 680 F.3d 875, 882 (7th Cir. 2012).

Here, Plaintiffs allege and have provided evidence that Defendants have violated Plaintiffs' Eighth Amendment rights, and continue to do so. *See supra* Argument, Section II. Defendants even admit they have not discontinued the conduct found unlawful nor fulfilled the requirements of the preliminary injunction. Their contrary assertion that their purported "substantial steps to improve the care offered to transgender inmates" make injunctive relief unnecessary in order to enforce federal law—therefore making *Ex parte Young* in applicable—is mistaken. Mot. at 31.

Any doubt over whether Plaintiffs will be able to prove their allegations is immaterial for determining application of *Ex parte Young*. *See Verizon Md., Inc.*, 535 U.S. at 646 ("[T]he inquiry into whether suit lies under *Ex parte Young* does not include an analysis of the merits of the claim.") (citation omitted); *Idaho v. Coeur d'Alene Tribe of Idaho*, 521 U.S. 261, 281 (1997) ("An allegation of an ongoing violation of federal law where the requested relief is prospective is ordinarily sufficient . . . ."). Indeed, Defendants' admission that they have not complied with the preliminary injunction, and their many objections to the proposed reforms, demonstrate that the federal interests protected by *Ex parte Young* are far from eliminated. *Cf. Vickery v. Jones*, 100 F.3d 1334, 1348 (7th Cir. 1996) ("When a party, in response to an interlocutory order, refrains from engaging in the challenged practice, yet provides no assurance that the moratorium on implementing that practice is permanent, the federal interest in asserting authority to enforce federal law does not vanish as a result.").

Finally, Defendants object to the "fiscal consequences to state treasuries" that would be necessary to comply with the injunction. These fiscal consequences, however, are "the necessary result of compliance with decrees" prospectively enforcing federal law:

> State officials, in order to shape their official conduct to the mandate of the Court's decrees, would more likely have to spend money from the state treasury than if they had been left free to pursue their previous course of conduct. Such an ancillary effect on the state treasury is a permissible and often an inevitable consequence of the principle announced in *Ex parte Young*.

Edelman v. Jordan, 415 U.S. 651, 668 (1974) (holding that injunction and declaratory relief seeking payment of retroactive welfare benefits was outside *Ex parte Young*). The Defendants here identify no more that the inevitable "ancillary" effects of bringing their programs into compliance with the Constitution, and are therefore not entitled to summary judgment on Eleventh Amendment immunity. *Cf. Council 31 of the Am. Fed'n of State, Cnty. & Mun. Emps., AFL-CIO*, 680 F.3d at 882 (*Ex parte Young* did not apply where plaintiffs sought injunction challenging state employees' pay freeze as violation of Contract Clause, and the "essence" of the relief was payments from the treasury to employees).

B. Defendants' Objection Under The PLRA Is Premature And Unmeritorious.

"The PLRA circumscribes the scope of the court's authority to enter an injunction in the corrections context. ***Where prison conditions are found to violate federal rights***, remedial injunctive relief must be 'narrowly drawn, extend no further than necessary to correct the violation of the Federal right, and use the least intrusive means necessary to correct the violation of the Federal right.'" *Westefer v. Neal*, 682 F.3d 679, 683 (7th Cir. 2012) (emphasis added). That is, the PLRA does not bear on the determination of Defendants' constitutional violation nor on Plaintiffs' entitlement to injunctive relief. Instead, it bears only on the Court's crafting of the scope of an injunction. This is why the Seventh Circuit has upheld findings of Eighth Amendment violations and the necessity of injunctive relief, even when it simultaneously remanded with

instructions to narrow the scope of an injunction. *See, e.g., Lindell v. Frank*, 377 F.3d 655, 660 (7th Cir. 2004) (finding that the district court was "correct to award . . . injunctive relief on this claim," but remanding to "modify the injunction to make it conform more closely to the violation that was found"). Because the Court has not yet issued a permanent injunction here, Defendants' objection is premature.

Moreover, Defendants' objection is without merit. Defendants assert that this lawsuit is composed of a "patchwork of individualized complaints," Mot. at 32, but Plaintiffs have presented a clear account of IDOC's myriad failures to provide constitutionally adequate medical treatment for gender dysphoria. Contrary to Defendants' assertions that "reforms [] were not needed in 2019 and are not needed now," *id.*, the evidence is clear that Plaintiffs continue to suffer at the hands of Defendants. Across the class, IDOC does not provide for adequate hormone treatment, does not permit social transition, and has no plan in place for patients to receive medically necessary surgery. Plaintiffs' request is simple: IDOC must provide constitutionally adequate medical care. This request is properly remedied with injunctive relief. Indeed, the Seventh Circuit has upheld an injunction enforcing such care specifically for prisoners with gender dysphoria. *Fields v. Smith*, 653 F.3d 550 (7th Cir. 2011). Defendants simply have not shown that the Court is unable to do the same here. As the Supreme Court makes clear, "[c]ourts may not allow constitutional violations to continue simply because a remedy would involve intrusion into the realm of prison administration." *Brown v. Plata*, 563 U.S. 493, 511 (2011).

CONCLUSION

WHEREFORE, Plaintiffs request that this Court deny Defendants' Motion for Summary Judgment. Defendants cannot show an absence of material disputes of fact nor that they are entitled to summary judgment as a matter of law.

Dated: January 15, 2021

By: /s/ Amelia H. Bailey

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CERTIFICATE OF SERVICE

I certify that on January 15, 2021, I electronically filed the foregoing document and any attachments with the Clerk of this Court by using the CM/ECF system, which will accomplish service through the Notice of Electronic Filing for parties and attorneys who are Filing Users.

/s/ Amelia H. Bailey

EXHIBIT 1

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS

JANIAH MONROE, et al.,	)	
	)	
Plaintiffs,	)	
	)	
vs.	)	No. 18-156-NJR
	)	
ROB JEFFREYS, STEVE MEEKS,AND MELVIN HINTON,	)	
	)	
Defendants.	)	

The Videotaped deposition of TANGENISE PORTER, taken before Deborah A. Rannells, CSR, Illinois License No. 084-003408, via virtual videoconference, on Friday, June 26, 2020, commencing at the hour of 9:00 a.m.

Reported for
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Deborah A. Rannells, C.S.R.

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strength of the prisoner?
A No, I don't think so.
Q Okay. And then moving on to Page 7. So here we have Dr. Reister speaking, and he says, "It seems like as a committee, they are not very clear on what their criteria is."
And you would agree with that statement, right, that there needs to be some clarification about what the criteria is for transfer; correct?
A You said, do I agree that there needs to be some clarification about the criteria?
Q Right.
A I don't even know if a criteria exists.
Q Okay. So now we're going to go on to Page 9. So -- sorry. Just one second.
So on Page 9, Dr. Puga is speaking and they're talking about the same prisoner. And Dr. Puga says, "So they will move forward with the transfer and figure out what they need to do to make that happen and the details to go along with that."
Do you see that, Ms. Porter?
A Yes.
Q Since you started your job on February 1st, 2020, have any prisoners been transferred from a male

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facility to Logan?
A No. Not that I'm aware of.
Q That's fair.
MS. BAILEY: Okay. I'm going to show you a second document, which we will mark as Porter Exhibit 2.
(Porter Deposition Exhibit No. 2 was marked for identification.)
BY MS. BAILEY:
Q And can you see that document, Ms. Porter?
A Yes.
Q It's appearing on your screen just fine?
A Yes.
Q And do you recognize this document?
A Yes.
Q Is this the document that Chris sent you to review last night?
A Yes.
Q And if we look at the list of attendees here, I see your name right here. So am I safe in assuming you attended this meeting?
A Yes.
Q And this was the transgender committee meeting that occurred via phone, right? That's what you testified earlier.

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A Yes.
Q And up here it says, "Transgender Requests for Transfer Meeting."
A Yes.
Q Just to the best of your knowledge, is this group different than another transgender committee or is this the transgender committee, as far as you know?
A As far as I know, this is -- as far as I know, this is the committee -- as far as what I know as the committee, this is the committee.
Q Okay. Okay. So if we start on Page 1, Dr. Puga says, "The first person is Finnegan who is requesting transfer and surgery."
Do you see that, Ms. Porter?
A Yes.
Q So then moving on to Page 2, Nikki Robinson right here asks, "What are her physical characteristics?"
And, Ms. Porter, I know you didn't ask that question, but I just want to make sure, did Chief Robinson explain to you why she wanted to know about the physical characteristics of Finnegan before discussing transfer?
A No.
Q And then Dr. Pittman says, "Her last labs from

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November 13, 2019, showed her testosterone at 293 and her estrogen was 85."
Do you see that?
A Yes.
Q And based on your knowledge and background, you're not sure if those are high or low for a transgender female; correct?
A No.
Q So Nikki Robinson goes on to ask, "Did she miss some of her doses?" And Dr. Pittman says, "She did due to med delays and not through noncompliance."
Do you see that?
A Mm-hmm.
Q What is your understanding of what he meant by a med delay?
A I don't know.
Q Did you think to ask what he meant during this phone call?
A No.
Q And then if we look at the bottom of the page, you ask, "Is she on any mental health medications?"
Do you see that?
A Yes.
Q Why did you ask that?

transgender individuals; right?
A Well, no. I don't know -- I don't know if the -- the personnel that we have inside of IDOC, because I'm not really familiar with what -- everything that they specialize in and things of that nature. So I can't make a -- I can't comment on whether or not I think some additional guidance or information from the outside would be helpful. I don't know.
Q Who provides treatment for prisoners in IDOC that have other specialized medical issues other than being diagnosed with gender dysphoria?
A I don't know.
Q So do you know who provides treatment for IDOC prisoners with cancer?
A Oh, no.
Q Or for IDOC prisoners with Type 1 diabetes?
A No.
Q But you'd agree that for an IDOC prisoner with cancer, they would most likely see a doctor that specialized in cancer, an oncologist; right?
A I imagine.
Q So why shouldn't a prisoner diagnosed with gender dysphoria see a doctor specialized in gender dysphoria?

MR. HIGGERSON: I'm going object to the form of the question. I think it's argumentative. And to some extent you're building an assumption into the question as far -- to something she's already said she doesn't know what happens.
BY MS. BAILEY:
Q You can answer, Ms. Porter.
A Repeat the question.
Q Sure. So I believe you answered that you would imagine that an IDOC prisoner diagnosed with cancer would see a doctor that specialized in cancer; correct?
A Yes.
Q So do you see any reason why a prisoner diagnosed with gender dysphoria shouldn't see a doctor that specializes in gender dysphoria?
A I don't know.
Q You don't know if there is or isn't a reason why a prisoner diagnosed with gender dysphoria should see a doctor specialized in gender dysphoria?
A I don't know what the -- the doctors that work in IDOC, I don't know what their specializations are. So I mean, I would imagine, I guess. I don't know.
Q Do you think that would benefit a prisoner diagnosed with gender dysphoria to see a doctor that

specialized in that medical condition?
A I don't know. I don't know enough about gender dysphoria to know what it would actually warrant in terms of its care.
Q Do you think it would be helpful for the transgender committee to -- Actually, strike that.
In your opinion, who should be making decisions about gender-affirming surgery at IDOC?
A I don't have an opinion about that. The decisions that are made for different things that happen within IDOC is made by the head of IDOC.
Q And that would be Director Jeffreys?
A Yes. I imagine.
Q Okay. Just one second.
(Whereupon, a brief pause was had.)
MS. BAILEY: Okay. That's all I have, counsel.
MR. HIGGERSON: I just have one thing I want to follow up on.
EXAMINATION
BY MR. HIGGERSON:
Q Chief Porter, you said several times during your testimony that since you've started working for the Department of Corrections there haven't been any

transfers of inmates from the male facilities to a female facility.
Have there been transfers of any inmates within the Illinois Department of Corrections since you started working?
A Yes, yes. We had transfers up until COVID -- you're just talking about regular transfers; right?
Q Yes.
A Yes. So up until transfers were put on hold because of COVID, yes, we have had some transfers.
Q Okay. When did the hold go into place?
A I think it was maybe the second week in March. Sometime in March.
Q And have there been any transfers of inmates within the Department of Corrections since then?
A No, sir.
MR. HIGGERSON: Thanks. That's all I have.
MS. BAILEY: Okay. No further questions for me either.
THE VIDEOGRAPHER: Okay. The time now is 2:41 p.m. We are off the record, and that's the end of the deposition.
THE COURT REPORTER: Is there a signature on this, counsel?

EXHIBIT 2

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS

JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELENA VISION, SORA KUYKENDALL and SASHA REED,	)	
Plaintiffs,	)	
vs.	)	3:18-cv-00156-NJR
ROB JEFFREYS, STEVE MEEKS and MELVIN HINTON,	)	
Defendants.	)	

The Zoom videotaped deposition of GLENDA WORTLEY, where the attorneys, the witness, the videographer and the court reporter all appeared remotely, via virtual videoconferencing, taken pursuant to the United States District Court Rules, reported by Jodi Stout, C.S.R., on Monday, July 27th, 2020, at 9:00 a.m.

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though, right?
A Yes, they're -- they're -- yeah, they're fairly recent forms. It's the same stuff they were reviewing all along but it's a form that goes through the stuff that they review.
Q Are you aware that there is -- I'm sorry. Go ahead and say that again.
A It's in -- it's in form style. It's a form, yeah.
Q Right. Are you aware that at the end of that form there are signature lines for the participants of the Committee?
A Yes.
Q And do you sign for the Transfer Coordinator's Office?
A I have not physically signed any.
Q Does the lack of your signature mean that you did not participate in a discussion about that prisoner?
A No, because from the meeting minutes would say I participated in the meeting, was present.
Q This form that we're discussing, where are those, typically, kept, where are they stored?

A Would be in the file, the offender's file.
Q Would you keep -- in addition to keeping it in the offender's file, would you keep a copy in your office --
A No.
Q -- the Transfer Coordinator's Office?
A Oh, wait. That new form I do. I just stick it in their file. Yeah, I stick it in their file.
Q Along with the Transfer Request Form, is that right?
A I don't believe there's been any -- since they've been using that particular form that I'm speaking of that there's been a transfer request but it would be in their file. And a transfer request would not come 'til later I wouldn't think if they're being reviewed for a transfer.
Q We discussed earlier whether the Committee considers a prisoner's genitalia -- a transgender prisoner's genitalia in deciding whether they should be transferred, right?
A Yes, we talked about that.
Q What's -- what's your understanding,

in the context of these Committee meetings, of what's meant by genitalia?
A A penis, a vagina. That's what genitalia is.
Q And what about testicles?
A Okay. Yeah.
Q So when the Committee discusses genitalia, which are they referring to?
A I -- I don't know. Genitalia to me would mean both.
Q And I think you used the term was it potency, whether -- whether someone's potent is relevant?
A Yes, that would be relevant.
Q Is that fertility or reproductive ability?
A Yes.
Q Has the Committee's practice changed at all since December -- strike that.
When considering whether to transfer someone to a facility that matches their gender identity, has the Committee's practice changed at all since December of 2019?
A I -- I -- not that I can recall. I

don't believe we've moved any offenders either male to female or female to male since December, but I don't know. I can't say that. I don't remember.
Q Okay. That would be pretty unusual if you did, right?
A If we did move, yes. We -- that doesn't happen every day. That's correct.
Q Do you think you would remember if it had happened?
A Maybe, probably. You know, there's been a lot going on this year, a lot of stuff going on.
Q I hear you.
A Yes.
Q It's been a strange year for sure.
A Yes.
Q But that would be really unusual and you might remember it?
A I might, yeah.
Q Okay. Do you have 165646?
A 165646?
MS. TOLBERT: Glenda, that should be in the new batch that was brought in --
THE WITNESS: I got it.

EXHIBIT 3

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS
EAST ST. LOUIS DIVISION

JANIAH MONROE, MARILYN MELENDEZ, EBONY STAMPS, LYDIA HELENA VISION, SORA KUYKENDALL, and SASHA REED,

Plaintiffs,

vs.) NO. 18-156-NJR

ROB JEFFREYS, MELVIN HINTON, and STEVE MEEKS,

Defendants.

DEPOSITION OF SORA KUYKENDALL

MONDAY, AUGUST 31, 2020
9:00 A.M.

Via Webex

INDEX

(No exhibits marked.)

APPEARANCES:

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ALSO PRESENT:
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IT IS HEREBY STIPULATED AND AGREED by and between Counsel for the Plaintiffs and Counsel for the Defendants that this deposition may be taken in shorthand by JOYCE D. LAWRENCE, an Illinois Certified Shorthand Reporter, and afterwards transcribed into typewriting, and the signature of the Witness is WAIVED.

****

(All counsel stipulate to the reporter swearing in the witness remotely.)

SORA KUYKENDALL,
called as a witness, being first duly sworn, was examined and testified as follows:

EXAMINATION
BY MS. TOLBERT

Q. Ms. Kuykendall, are you ready to get started?

A. I am.

Q. Okay. We met briefly earlier, but my name is Carla Tolbert. I am one of the Assistant Attorney Generals here in the Swansee/Belleville office and I represent the defendants in this case. Have you ever been deposed before?

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A. Well, like I said, I don't know if it's -- he's the one who is prescribing those.
Q. Okay. Got it.
A. I don't know if he's prescribing the blockers either.
Q. Got it.
So how do you feel on your current dose? Do you feel like it's high enough?
A. No.
Q. Okay. So why don't you feel like it's high enough?
A. Because it's -- my hormone levels are supposed to be between 100 and 200 and my last result was way below that.
Q. When was that last lab test that you recall?
A. During the last lab or the last lab where I got the results?
Q. Well, where you said it was -- it was too low. Do you remember when that lab was? That blood test?
A. It was a couple months ago. I got the results. I think it was a couple months ago.
Q. Okay.
A. I might be off. But I got the results a

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few weeks ago. I had a breast exam and, during the breast exam, they didn't have any curtains on the windows at all.
Q. Okay.
A. And someone walked by.
Q. When was that?
A. That was a few weeks ago.
Q. A few weeks ago. And was that Ms. Zimmer or Dr. Siddiqui?
A. Ms. Zimmer.
Q. Okay. And did you tell her that you were uncomfortable or ask her to cover the windows?
A. I was told that that was the way I had to do it.
Q. Okay.
A. I didn't have any other option. And I have also been told that, if I refuse a breast exam, then they can take my hormones away. So I didn't have a choice.
Q. And who told you that?
A. Ms. Zimmer told me.
Q. Ms. Zimmer told you. Okay.
At that exam, did you discuss your -- your dosage and your hormone levels with her?
A. We talked about my hormone levels, not my

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dosage.
Q. Okay. And what did she say?
A. She said they were fine and they were -- I think it was 32, or around there, which is not fine.
Q. Okay. And that's based on your knowledge?
A. Right.
Q. Okay. And are you still getting information on dosage and things like that from your mom?
A. No, I know that it's supposed to be between 100 and 200 from Dr. Ettner.
Q. And when did you see Dr. Edmond?
A. Ettner.
Q. Ettner. I'm sorry. When did you see her?
A. I saw her a couple years ago now, but I talked to her recently.
Q. And do you speak to her by phone?
A. I have.
Q. Do you ever see her in-person?
A. I have.
Q. How often does she come to Menard?
A. She's only been up here once.

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Q. Okay. And do you recall when that was? About.
A. A couple years ago now, I think.
Q. Okay.
A. I could be wrong.
Q. Okay. It's not a memory test. It is just to the best of your recollection. Okay.
MS. BAILEY: Carla, I don't want to interrupt anything. I just want to make sure, Sora, do you want to take a break or are you okay?
WITNESS: I think I need a drink real quick, if that's fine.
MS. BAILEY: Is now an okay time, Carla?
MS. TOLBERT: Yeah. Yeah. Any time is good.
MS. BAILEY: Okay. Why don't we take, like, five minutes or however long?
MS. TOLBERT: Yeah, that's fine.
MS. BAILEY: Okay. Thank you.
(Recess taken from 10:20 to 10:24 a.m.)
MS. TOLBERT: We are back on the record.
BY MS. TOLBERT:
Q. So Ms. Kuykendall, we were talking about Dr. Ettner and your interaction with her. Are you -- what other treatment, psychiatric, mental

long time and I had already had breasts.
Q. Okay. And if you're aware, did that bra have to be ordered by the medical doctor or how did it come to be given to you?
A. I mean, I got a permit through the doctor.
Q. Okay.
A. I don't know how it came into the facility.
Q. And then they just gave it to you, correct?
A. Right.
Q. Okay. And how many bras are you allowed to have?
A. I don't know what the limit is. We can't buy bras, though, so --
Q. No, I understand. But you can have more than one at any given time, correct?
A. Right.
Q. Okay. And how many are they allowing you to keep in your possession?
A. I'm not sure what the number is. I think it's four.
Q. Okay.
A. I mean, we can't buy them or anything.

Q. Oh, no, I understand. I just wanted to know how many do you have?
A. I have three.
Q. Okay.
A. They give me whatever I get and then they say go.
Q. Okay. How about other women's undergarments; do you have any of those?
A. No.
Q. I'm sorry, yes?
A. No.
Q. No. Okay. All right.
Your hair is long, correct? When did you first start growing your hair long?
A. While I was in county.
Q. Okay. Are you allowed anything else to transition or to appear feminine at Menard? Your hair and the bra?
A. Nothing else.
Q. Okay. So you can't -- you don't have makeup?
A. No.
Q. Okay. And the clothing -- excuse me -- the clothing you're wearing is the same as the male inmates, correct?

A. Right. And the t-shirts are see-through. You can see through them. They're white shirts. Even with a bra on, you can see through them. So I always have to wear this blue shirt everywhere I go. Even when I'm in my cell.
Q. Can you buy the t-shirts in commissary or are you given those?
A. You can buy the t-shirts in commissary, but they're see-through, though.
Q. Sure. I understand.
A. I buy these blue shirts in commissary. You are issued them and that's it.
Q. Okay. Have you ever asked for surgery at Menard?
A. I have.
Q. And who did you discuss that with?
A. I have discussed it with a number of different people.
Q. Okay. Well, can you tell me who?
A. Most of the -- most, if not all, of the mental health counselors. And then I'm pretty sure I have mentioned it to all of the -- all of the doctors that I have had, it's come up.
Q. And what are you told?
A. I've been either ignored or told that we

can't do that or we'll see.
Q. Okay. Do you know if your request for surgery was ever presented at -- at the committee, the Transgender Care Review Committee? Do you know if they ever presented it?
A. I can't know what they did.
Q. Okay. All right. Have you ever requested to go to Logan?
A. I have.
Q. Okay.
A. I have requested to be transferred to a women's facility, but I'm pretty sure that's the only maximum security women's facility.
Q. What have you been told about Logan?
A. It's not going to happen or nothing.
Q. Who told you it wasn't going to happen?
A. I have had multiple mental health counselors tell me that and I've had one of the doctors tell me he didn't think that was going to happen.
Q. Do you recall what doctor told you that?
A. Siddiqui.
Q. Do you recall when that conversation was?

A. I do not.
Q. And based on your previous answer, I think I know the answer to this, but do you know whether your request to transfer to Logan was ever presented to the Transgender Care Review Committee?
A. As far as I know, for this one, I actually did get some feedback. It was in the process of being done, allegedly, and then it has been on hold indefinitely.
Q. Is the hold related to COVID or did they give you a reason?
A. They transferred other people during COVID for medical reasons.
Q. Okay. Were they transgender women that got transferred or other medical problems?
A. It hasn't been transgender women, to my knowledge.
Q. Okay. All right. Is it your understanding that, once the COVID restrictions are lifted, that you will transfer to Logan?
A. I don't think that they'll approve it.
Q. Okay. All right.
You told me earlier you had been single celled your entire time at Menard, right?

A. Right.
Q. In general, how are your interactions with the male prisoners?
A. So it's -- it's kind of nonstop sexual harassment.
Q. Okay.
A. I keep to myself.
Q. So what is your current housing unit?
A. North 2.
Q. North 2.
So when you go to eat, you go with the rest of the offenders from that housing unit.
A. I do not ever go to lunch or dinner. I eat in our cells.
Q. All of you or just you by choice?
A. No. No. Everyone gets breakfast in their cells.
Q. Uh-huh.
A. And then I've been fed in. But that has expired right now. But everybody is fed in during COVID. So I haven't renewed it because we are all being fed in anyways. It seemed kind of pointless to renew it.
Q. Fair point.
And have they told you when the COVID

restrictions are going to be lifted or at least relaxed at Menard?
A. They have not.
Q. Okay. Having nothing to do with your case, but do you know the status at Menard? Like, it's planning on staying tight; is that your understanding?
A. Sorry. Could you rephrase?
Q. Do you know the status of Menard in general? You said that they haven't been lifted, but are there any plans to that you are aware of?
MS. BAILEY: Objection. Calls for speculation.
But you can answer the question based on your knowledge, Sora.
BY MS. TOLBERT:
Q. Sure. I just kind of -- what's going on at Menard?
A. I mean, there's no way I could know.
Q. Yeah. Once the restrictions get lifted, are you going to have to go back to medical and get another permit to eat in?
A. That's right. But I've been watching kind of the outside and seeing how to determine, like -- you know, just to kind of guesstimate when

it's going to happen.
Q. Sure.
A. So we previously knew they were letting people go to yard and so I'm assuming that they're going to let people go to yard before they open everything back up, that it's going to be a gradual process, because it's a prison.
Q. Yep. Yep.
Now, is anybody going to yard right now?
A. No.
Q. Prior to the COVID response --
A. Not to my knowledge.
Q. Okay. Fair enough. Your housing unit is not?
A. Nobody I know is going to yard.
Q. Got it. Prior to COVID, were you going to yard?
A. For years and years, I did not and I didn't talk to anyone and it kind of -- the loneliness got to me to the point where --
(connection failed)
BY MS. TOLBERT:
Q. I was asking you if, before COVID, you were going to yard and you said you had not for years and years and then you were talking about

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being lonely, and I think that's where you dropped.
A. The loneliness got to me and then I started talking to people some and eventually was going to yard. But that's not something that -- that is something that I was stopping doing right before we went on COVID. I completely stopped talking to people because the situation -- there are just so many bad situations that come from talking to people that it's not worth it.
Q. And who were you talking to? Were they people from your housing area or just other people in yard or what?
A. Well, I mean, people go to yard with their gallery.
Q. Just with your gallery?
A. Yeah.
Q. Okay. And so it was people from that gallery who were harassing you?
A. I've had sexual harassment from, basically, everybody. I mean, it's kind of a constant thing here. It's a men's prison where there are no women, so --
Q. Okay. Are there -- are you in a cell with people on either side of you or an end cell or how is it configured?

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A. Yeah, I've got cells on either side of me.
Q. Okay. And do you have any interaction? Do you at least talk to those people or does that not happen?
A. I don't get on the gallery. If somebody needs me to pass something, I will do that, but that is it.
Q. What do you mean to pass something?
A. Like, if somebody is not eating something on their tray.
Q. Okay. All right. So what do you do during the day?
A. I meditate. I read. I used to draw, but I've just kind of shut down and stopped doing that. I listen to music.
Q. Where are you getting the books? The prison library or is it something that family or friends are sending you?
A. I read the same books over and over.
Q. Okay. Do you have -- are there books available at Menard?
A. There are -- there are books, but we can't get them right now.
Q. Okay.

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A. COVID.
Q. Is anybody from outside sending you anything?
A. Like at this moment or, like, what do you mean by that?
Q. No. I mean, have you been sent books or anything to read or like that from the outside?
A. I have, yes.
Q. Okay. And is that still happening? Has it happened recently?
A. Yeah.
Q. Okay.
A. It's not too, too often.
Q. Okay. Is that coming from your mom?
A. It does, but I also order books.
Q. Where do you order them from?
A. Bargain Books.
Q. Okay. All right.
And -- okay. Are the other inmates on your gallery aware that you are a woman, a transgender woman.
A. Well, I don't talk to most of them, so, I mean, I would assume that when they -- I mean, I can't know what other people think, but I would think that they know.

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Q. Okay.
A. There aren't many people who do.
Q. Okay. All right. Have you ever had a job when you were at Menard?
A. I have not.
Q. Okay. All right. And is that by choice or that you haven't been assigned one?
A. That's by choice.
Q. Okay. And have you --
A. I can't get a job here because it wouldn't be safe for me to get a job here.
Q. Okay.
A. I've been told that, if I did put in for a job, I wouldn't get it.
Q. Okay. And have you ever gone -- had any kind of education, gone to school or any classes or anything while you have been at Menard?
A. As far as I know, they only offer, like, for people who dropped out of high school, classes for them and that's --
Q. GED?
A. Yeah.
Q. Okay. All right. And I'm fairly certain I know the answer to this, but have you ever had any kind of a romantic relationship with anybody there

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yes.
Q. Okay. So do you know who those officers were?
A. I know Hood.
Q. Hood. Okay. Well, the next paragraph talks about Officer Hood. Was there anybody else involved?
A. Yeah. Lots. But I don't know everyone's name around here.
Q. Okay. And did you do grievances about that?
A. About?
Q. About that whether they were trying to startle you when you were sleeping?
A. With Hood.
Q. Okay.
A. There was another incident where I was woken up while I was sleeping by -- I think he was a lieutenant. He might have been a major. I think he was a lieutenant, though. I think his name was Hasslemyer, who came up to my cell when I was sleeping and banged on the bars and said, I'm tired of this -- I'm quoting. I don't know if it's exact, but it's from my memory -- tired of this shit. Going to put a stop to this. And then he asked me,

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do you have a dick and then I was silent. And then he said -- he had two COs with him and he said, if you don't answer, we're going to come in there. And then -- so I said -- I answered him and then he said you're a man and then left.
Q. And do you remember -- I'm sorry. Do you remember when that was, approximately?
A. I think that was 2016.
Q. Okay. Well, this letter is December of 2016, so that makes sense.
The next paragraph says, since I have -- since I began recording these happenings, the perpetrator is almost always Officer Hood. To date, I have 27 recorded instances of Officer Hood behaving in this harassing and unprofessional behavior.
Do you recall telling your mom that there was 27 instances?
A. I don't know if the number was exactly 27. I'm sure if that's what she wrote, that was probably it.
Q. So how were those recorded? Go ahead.
A. I wrote them down.
Q. Okay. Did you submit those?
A. There was so much with him -- and it's

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not unusual for me to be harassed when I come out to -- when I'm on a pass or something. But during this time and with him in particular, he would, like, come into my cell and do that.
Q. So -- okay. Do you still have that recorded list of those 27 times?
A. I do not.
Q. Okay. Did you throw it away?
A. I don't know where it is. So I -- as far as I know, I don't have it.
Q. Okay. And then it says, in addition, I was sexually harassed by Officer Hoffman on October 7, 2016. I wrote the counselor two times about this issue and have since filed seven grievances.
Did you make a PREA call or a PREA report about Officer Hoffman.
A. I think I did a -- I don't remember if I actually called for that one.
Q. Okay.
A. But I remember -- I remember talking to -- being called down and being talked to by someone.
Q. Pamela Gillespie; do you recall that name?
A. I do not, but I think, in that instance,

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I did get seen by PREA.
Q. Okay. All right. And what did they tell you about an outcome of that PREA?
A. Like I said, I'm not 100 percent sure if I saw someone or not.
Q. Okay.
A. I don't remember the contents of the conversation. Nothing would have happened. I would remember if something had happened, so I'm sure nothing happened.
Q. Is or do you know if Officer Hoffman is still at Menard?
A. I do not.
Q. Okay. Did you see Officer Hoffman at any time after October 7, 2016?
A. Oh, yeah.
Q. And how were the interactions after that?
A. It was worse.
Q. Okay. Is -- does every CO harass you?
A. No, not every single one, but it's very, very prevalent.
Q. Okay.
A. Every single -- just about every single CO, with the exception of one time, calls me --

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always misgenders me.
Q. Okay. Are there any COs that you would say treat you appropriately?
A. There are a few, yeah.
Q. Okay. Can you give me any names?
A. I don't know. Inglotti.
Q. Anybody else?
A. I can't hear what you said.
Q. I'm sorry. We were losing video and audio there.
What was the name of the first person you gave me?
A. The only person I said was Inglotti.
Q. Inglotti.
And then you kind of broke up. Was there anybody else, other than Inglotti, who you feel treated you appropriately?
A. I mean, I don't -- I don't have interactions with the COs except when I come out and so it's either harassment or nothing.
What do you mean by appropriately?
Q. Well, I mean, you said they nearly all harass you and I asked if anybody, you felt, treated you appropriately, addressed you by the appropriate gender, did not harass you.

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A. No. None.
Q. Everybody misgenders you?
A. Yes.
Q. Okay. Do all of the COs harass you?
A. Not every single one.
Q. Okay. Okay. Are there any COs who currently work in your housing unit who treat you better, who don't harass you?
MS. BAILEY: Objection. Asked and answered.
But you can go ahead and answer, Sora.
WITNESS: Are there ones who don't harass me?
BY MS. TOLBERT:
Q. I mean, of the officers currently assigned to your housing unit, you said 100 percent, across the board, they are all harassing you?
A. No, not all of them.
Q. Okay. Is Inglotti currently a CO in your housing unit?
A. I actually don't know. I saw him a little while back.
Q. Okay. But you -- you said they are not -- they don't all harass you, but that's the only name you can give me, right?

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A. Right.
Q. Okay. Is there anything else that I haven't asked you about, in general, how you're treated at Menard? Anything else that you want to tell me that you think I should know?
A. Just in general?
Q. Uh-huh.
A. Yeah.
Q. Okay.
A. I mean, my -- I don't know where to start. So my interactions with other prisoners, I guess. That is -- I've had threats before. I've had people try to grab me through the bars before. I've had -- they will play mind games, like telling me somebody wants to beat me up because I'm talking to so and so, or that's like rumor monitoring. It's kind of nonstop. And that, in and of itself -- I mean, that's not okay but it's not that big of deal except -- or it wouldn't be that big of deal except that, because I'm transgender in here, I'm a magnet for that kind of stuff. Like it's not going to stop with me. I mean, I can't escape that.
Q. Okay. What is it that you -- I'm sorry. Go ahead.
A. And then it's hard to get the idea across

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because, now that you're in prison, but, basically, LBGT people, in general, but especially women who are transgender are sometimes -- sometimes it's called untouchables; but, basically, on the whole, like, we can't be interacted with by an enormous percentage of the population. And then there are other people who, because there's just so much discrimination and so much, you're not supposed to associate with someone who is LBGT in here. It's like one of the unwritten rules and so I'm pretty much isolated, for the most part. And the people who do talk to me or have talked to me -- I haven't been talking to anyone for a long time -- but those people, I mean, it's usually all sexual harassment. So it's kind of an either/or situation.
Q. You said it's an unwritten rule that no one associates with an LBGT inmate?
A. And that's not -- that's not, like, across the board. But if somebody is out, then it will be interacted with, really.
Q. And that's the other inmates?
A. What do you mean by that?
Q. You said it's an unwritten rule. You believe that's among the other inmates?
A. Yeah. I mean, that's like a -- it's like

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A. 2015.
Q. Okay. And since you have been receiving hormones, you've been taking Premarin as your form of estrogen, correct?
A. Right. I would be -- I would prefer to be taking estradiol.
Q. And why would you prefer estradiol?
A. It's the recommended one and it's safer. Premarin is made from horse urine.
Q. And have you asked anyone at IDOC to be switched to estradiol?
A. I have. I was told that my hormone numbers were fine so they weren't going to do that, and the numbers were not fine.
Q. And then you mentioned that a couple weeks ago, you got lab results back, right?
A. I did.
Q. And I think you said today one of your levels was at 32?
A. That's more or less. I think it was 32. I'm not 100 percent sure if that was the exact number.
Q. Okay. Was that your estrogen or testosterone level?
A. That was my estrogen level.

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Q. And then you spoke today a lot about certain hygiene and clothing items, gender-affirming items that you would like access to. So, for example, you mentioned women's underwear. Have you filed a grievance requesting access to women's underwear?
A. I have put in clothing.
Q. You said clothing, okay.
A. I don't count underwear as clothing.
Q. Fair enough. Have you filed a grievance requesting gender-affirming hygiene items?
A. I have.
Q. And what were the -- what was the response to those grievances?
A. They were ignored for a long time and then denied. So it's been a mixed bag of both. Ignored and denied.
Q. And we also spoke today about surgery, right?
A. Yes.
Q. Have you filed grievances requesting surgery?
A. I have.
Q. And what was the response you got to those grievances?

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A. Either ignored or forwarded it to the committee and then never hearing anything back.
Q. And have you filed grievances requesting transfer to a women's facility?
A. I'm actually not sure if I have or not.
Q. Okay. That's no problem.
But safe to say, you have filed a number of grievances related to your treatment as a transgender woman over the past couple of years, right?
A. Oh, yeah.
Q. And have any of -- have any of those grievances been granted? Have you ever gotten what you asked for in the grievance?
A. I mean, I grieved the bra issue. I don't know if I was given that because of the grievance, though. Because, I mean, I grieved that, I'm pretty sure, multiple times and it took them forever to get it to me.
Q. Other than your bras, have you ever gotten anything that you requested in a grievance that's related to your gender dysphoria?
A. When I was trying to get my spironolactone increased.
Q. Sora, just hold on one second.

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MS. BAILEY: Carla, I know you -- I don't want to be rude. Maybe you could mute yourself. There's a lot of papers and wrestling from you.
MS. TOLBERT: I don't think it's coming from me, but okay.
BY MS. BAILEY:
Q. Go ahead, Sora.
A. That was it.
Q. I will just repeat the question.
So other than when you received your bras, is there anything else that you requested in a grievance related to your gender dysphoria that you have since gotten?
A. I don't remember if I requested in a grievance or not, but -- so I just want to be clear on the record for that. As far as the spironolactone increase, because it was way too low at first. But again, that took months and months and months and months and months. And other than that, if that did happen, if I did grieve that, and the bra, that's it.
Q. So then you also spoke today about that you, for a period of time, were not going to the yard, right?
A. Right. For years.

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Q. Why did you not want to go to the yard?
A. Because -- partly because of the incident with -- where I was groped before. I didn't like -- I still don't like getting in lines. And then there is also harassment that -- the sexual harassment. Just all of the other -- all of the other stuff that goes on because I'm transgender.
Q. How do you -- when you used to go to the yard, how did that make you feel?
A. Could you go back? What do you mean?
Q. Sure. Well, I can say it this way: Did it make you feel anxious to be in the yard?
A. Oh, yeah. But I kind of -- we don't always have access to a phone, you know. So it's like something that I would blank out to put myself through that.
Q. Why did you feel like you had to put yourself through that?
A. So I could get on the phone. They come around every once in a while, they are passed around. But in the past, that has been kind of hit or miss. Sometimes it would be kind of often and sometimes not really at all. So, you know, if I have a phone call I need to make, I have to go out.

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Q. When you went to yard, did you feel unsafe?
A. There were times, yeah.
Q. But you would do it anyway because up wanted the chance to take a phone call and speak to someone on the phone; is that right?
A. For years and years, when I was staying in, that was always the case. And then later, I was coming out kind of regularly. So during that time, that was just loneliness.
Q. And then we also talked today about harassment you've experienced from the correctional officers. Did that include verbal harassment?
A. Yes.
Q. And did it include some physical harassment?
A. No.
Q. But did you experience physical harassment from other offenders?
A. It did. I have. On several occasions.
Q. And then we also spoke today about one disciplinary incident you had, right? Do you remember when that happened, Sora?
A. I think that was December of 2018. I'm not 100 percent sure. Or no, it was either the end

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of November or the beginning of December 2018, I think. I think it might have been December 3.
Q. And you haven't had any disciplinary incidences since then, correct?
A. No.
Q. And then we also spoke about, I think it's two incidents that happened with Officer Hoffman?
A. Uh-huh.
Q. And I know this -- I apologize. This is probably a little bit uncomfortable. But I just want to be clear that the first incident, did he say to you tits, tits, tits; is that right?
A. I don't know which one came first.
Q. Okay.
A. Especially during that time, there was just so much going on with -- with Hood and -- I mean, the COs were just being really ridiculous then around that time.
Q. But at one point, those are the words that he said to you, right?
A. Right.
Q. And then we spoke about another incident, and I just didn't catch this. What did he say to you in the second incident?

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A. Show me your boobs.
Q. And how did those incidents make you feel?
A. I mean, I was upset because the people who are supposed to be keeping me safe were behaving like that. It's dehumanizing.
Q. And then we also talked about a letter that your mom wrote that I think is included with a PREA report related to some harassment that you experienced. But it sounds like you didn't know that your mom wrote that letter; is that right?
A. I'm not sure on whether or not she wrote that. I mean, I remember talking to her about it and so I can tell you that that was definitely not word-for-word, if there was some discussion of a letter.
Q. And when you talked to your mom and told her about what was happening, did she seem concerned?
A. Yeah.
Q. Did she seem worried?
A. Yeah. I mean, she kind of tries not to -- to show those kind of emotions.
Q. Did she seem concerned for your safety?
A. Oh, yeah.

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Q. And did she seem concerned for your mental health?
A. Yes.
Q. And then we also spoke today or you told us about how every correctional officer misgenders you, correct?
A. Right.
Q. How does that -- go ahead?
A. Most of the medical staff does, too. I just want to be clear on that. Like, it's -- it's kind of everywhere and, you know, other prisoners and --
Q. So is it safe to say that the vast majority of people you interact with misgender you?
A. Right.
Q. And how does that make you feel?
A. Like -- like how I feel doesn't matter. Like, I feel trapped about it. That I can't do anything about it. That I can't get to a situation, change my circumstances to where, like, I blend in or that I can just avoid these people, because I can't. I can't escape this in here.
Q. And you mentioned one incident today where you were getting a breast exam and the curtain

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was left open and other people?
A. There was no curtain.
Q. There was no curtain. Sorry. No curtains. And I think you mentioned that others walked by when you were getting your breast exam and could see what was happening; is that right?
A. Someone walked by while I was getting the breast exam and the windows did not have curtains on them.
Q. Had there been other occasions where either if it -- whether it was a medical exam or maybe a strip search, where others came in and viewed things that made you uncomfortable?
A. Yes. One would be during the castration attempt. For whatever reason there had to be -- yeah, for whatever reason, there had to be three COs in there while the nurse checked to see, like, if there was any marks or whatever.
And then another instance during a strip search. During a strip search, somebody -- I was told that I -- I had to get a strip search, when, in the past, that hadn't been the case. I just received a pat down and that had been how it was many times previously. That's how I was told it was supposed to be done. And then I came out for a

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visit and I was told that I had to get a strip search and I had to go on my visit and, if I refused, I would be taken to seg and get strip searched anyways. And I asked if I could go back to my cell and just refuse my visit, but I was -- I was told, no, I have to go or I will be taken to seg. So I went on my visit and then, on the strip search from returning from the visit, because it was before and after, while I was -- while I was being strip searched, two people came in. And when I grieved this issue and when I reported it to PREA, I don't recall ever hearing back from PREA at all. And when I reported it, I was told by the counselor, you're not going to like my answer to this. And then when I got the response, they were saying that there's a curtain in the shakedown room. But the way it's set up is that curtain is between the cells and I was in the cell on this side and the door is here. So they came in and they could see everything while I was completely naked.
Q. When you say they, does that mean other correctional officers?
A. It was a correctional officer and a prisoner.
Q. And were they all males?

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A. Both were males.
Q. And the officer that strip searched you, was that a male officer, as well?
A. Yes, they always -- they always strip me by -- they always have me stripped by a male. And if I refuse, I was told -- once, when I asked, what if I refuse, I was told that I would be held down and they would forcibly strip me, so I needed to cooperate.
Q. And have you ever filed grievances requesting to not be strip searched by male correctional officers?
A. Yes.
Q. How does that make you feel when you are strip searched by a male correctional officer?
A. Terrible. I -- usually during it, I breakdown into tears and I'm shaking. And then when I get back to my cell, I do the same thing.
Q. And then you mentioned that you've requested to have a cellie, right?
A. Yeah. Could we take a break?
Q. Sure. Sure. Yeah.
MS. BAILEY: Is that okay, Carla?
MS. TOLBERT: Yeah, that is fine. Whatever you want.

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that.
Q. Okay. And at that point, you had been on the hormones since you thought January or February of '15, correct?
A. That's right.
Q. So you got to Menard in November of '14?
A. Right.
Q. And by either January or February of '15, you were prescribed hormones, correct?
A. Because I castrated myself.
Q. Okay. And then you later on were given the bra. Got it.
Tell me about the results --
A. I developed breasts months before I actually got the bra, though, and I was -- I told them that and that I needed a bra and I was still ignored.
Q. Okay. Tell me about the effects of your self castration. Like, what's the -- what's the permanent effect?
A. There is no permanent effect.
Q. No permanent effect. Okay. You didn't lose any part of your genitals because of your attempt to do that, correct?
A. Right.

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Q. Okay. All right.
You've been -- well, since the time you have gotten to Menard, have you had any discussions with any of the wardens about your situation?
A. I've written kites.
Q. Okay. Right. Do the wardens make rounds through your housing unit?
A. They come to the housing units, I think, but they never come on the galleries, at least I've never seen -- I've seen a warden once, actually.
Q. Okay. But you haven't had any conversation with any of the wardens since you've been at Menard?
A. I've been written back before. I don't remember about what. And I don't remember when that was. I don't know if it was related to any of this or not.
Q. Okay.
A. But I've been written one time.
Q. Got it. Have you -- go ahead?
A. That I remember.
Q. Okay. Have you spoken with any other trans woman who is living in a women's division about how they feel about life there?
A. I mean, I don't think I can speak for

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anybody else or how they feel.
Q. No. My question was, have you spoken with any of them about how they feel?
A. Oh, yeah.
Q. Who have you talked to about who has lived at Logan?
A. Wait. At Logan?
Q. Or anywhere in the women's division.
My question was, have you spoken to any transgender woman who has lived in the women's division.
A. Okay. Now -- so I misheard that.
Q. Okay.
A. I have not heard or talked to any.
Q. Okay. All right. That's all I need to know there.
I did forget to ask you earlier: Tell me how showering works for you. Or do you shower alone or in medical; how does it work?
A. So you can get a shower permit, but the showers are on the gallery and there's a wall, but it only comes up to, like, waist level. So they can see everything above. There are no curtains. So I do not -- I do not shower. I shower in my cell with a rag and I wipe myself down and I wash my hair in

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my sink because I won't go to the showers with the men and the shower on the gallery doesn't -- doesn't give you privacy at all.
Q. Have you ever asked to shower in medical?
A. I can't -- I can't recall if I have.
Q. Okay. All right. And I wanted to go back. We both asked you about the incident where you were having a breast exam by Ms. Zimmer in medical and there was no curtain on the window, right?
A. There was no curtain.
Q. No curtain, right. And there were --
A. The room has windows on three sides and there are no curtains on any of them.
Q. Okay. Fair enough.
Were you alone in the room with Ms. Zimmer at the time?
A. No, there was a CO in the room, but he had his back -- he had to be in there during the procedure, but --
Q. All right.
A. But you know what I mean?
Q. Right.
A. But he was facing away.

EXHIBIT 4

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS

JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELÉNA VISION, SORA KUYKENDALL, and SASHA REED, individually and on behalf of a class of similarly situated individuals, Plaintiffs, v. ROB JEFFREYS, MELVIN HINTON, and STEVE MEEKS, Defendants.	)	Civil No. 3:18-cv-00156-NJR

DECLARATION OF DR. RANDI ETTNER, Ph.D.

I, Dr. Randi Ettner, hereby state:

1. I am a clinical and forensic psychologist with expertise concerning the diagnosis and treatment of Gender Dysphoria. I am the Secretary and a member of the Board of Directors of the World Professional Association of Transgender Health ("WPATH"), the preeminent professional organization dedicated to the understanding and treatment of Gender Dysphoria worldwide. I have extensive experience treating transgender individuals with Gender Dysphoria in my clinical practice, and have published numerous books and articles on the topic.

2. I have been retained by counsel for the named plaintiffs and class in this case to provide the Court with my expert evaluation and opinion regarding the appropriateness of the treatment for Gender Dysphoria provided by the Illinois Department of Corrections ("IDOC"). This declaration provides my opinions and conclusions, including (i) scientific information regarding Gender Dysphoria and its impact on the health and well-being of individuals living with Gender Dysphoria; (ii) information regarding best practices and the generally accepted standards

of care for individuals with Gender Dysphoria; and (iii) the results of my review of the named plaintiffs' treatment for Gender Dysphoria. I have actual knowledge of the matters stated herein and could and would so testify if called as a witness.

I. QUALIFICATIONS AND BASIS OF DECLARATION

3. I am a licensed clinical and forensic psychologist with a specialization in the diagnosis, treatment, and management of gender dysphoric individuals. I received my doctorate in psychology (with honors) from Northwestern University in 1979. I am a Fellow and Diplomate in Clinical Evaluation of the American Board of Psychological Specialties, and a Fellow and Diplomate in Trauma/Post-Traumatic Stress Disorder.

4. During the course of my career, I have evaluated, diagnosed, and treated between 2,500 and 3,000 individuals with Gender Dysphoria and mental health issues related to gender variance from 1977 to present.

5. I have published four books related to the treatment of individuals with Gender Dysphoria, including the medical text entitled Principles of Transgender Medicine and Surgery (co-editors Monstrey & Eyler; Rutledge 2007); and the 2nd edition (co-editors Monstrey & Coleman; Routledge, 2016). In addition, I have authored numerous articles in peer-reviewed journals regarding the provision of health care to the transgender population.

6. I have served as a member of the University of Chicago Gender Board, and am on the editorial boards of *Transgender Health* and the *International Journal of Transgender Health*. I am the Secretary and a member of the Board of Directors of WPATH, and an author of the WPATH Standards of Care for the Health of Transsexual, Transgender and Gender-nonconforming People (7th version), published in 2011. WPATH is an international association of 2,500 medical and mental health professionals worldwide specializing in the treatment of gender

diverse people. I chair the WPATH Committee for Incarcerated Persons, and provide training to medical professionals on healthcare for transgender inmates.

7. I have lectured throughout North America, Europe, and Asia on topics related to Gender Dysphoria and have given grand rounds on Gender Dysphoria at university hospitals. I am the honoree of the externally-funded Randi and Fred Ettner Fellowship in Transgender Health at the University of Minnesota. I have been an invited guest at the National Institute of Health to participate in developing a strategic research plan to advance the health of sexual and gender minorities, and in November 2017 was invited to address the Director of the Office of Civil Rights of the United States Department of Health and Human Services regarding the medical treatment of Gender Dysphoria. I received a commendation from the U.S. Congress House of Representatives on February 5, 2019 recognizing my work for WPATH and Gender Dysphoria in Illinois.

8. I have been a consultant to news media and have been interviewed as an expert on Gender Dysphoria for hundreds of television, radio, and print articles throughout the country.

9. I have been retained as an expert regarding Gender Dysphoria and the treatment of Gender Dysphoria in multiple court cases and administrative proceedings, including cases involving the treatment of individuals with Gender Dysphoria in prison settings. I was deposed as an expert in the following cases over the past four years: *Soneeya v. Turco*, No. 07-12325-DPW (D. Mass. 2019); *Edmo v. Idaho Dep't of Corr.*, No. 1:17-CV-00151-BLW (D. Idaho 2018); *Faiella v. Am. Med. Response*, No. HHD CV-15-6061263 (Conn. Super. Ct. 2015); *Broussard v. First Tower Loan*, No. 2:15-CV-011-61 (D. La. 2016); *Carrillo v. U.S. Dep't of Justice Exec. Office of Immigr. Rev.* (2017); *Jane Doe v. Clenchy, et al.*, No. CV-09- 201 (Me. Super. Ct. 2011); *Kothmann v. Rosario*, No. 13-CV-28-OC22 (D. Fla. 2013); *Gore v. Lee*, No. 3:19-cv-00328 (M.D.

Tenn. 2020); *Williams v. Allegheny Cty.*, No. 2:17-cv-01556-MJH (W.D. Pa. 2020); *Eller v. Prince George's Cty. Pub. Schs.*, No. 8:18-cv-03649-TDC (D. Md. 2020); *Ray v. Himes*, No. 2:18-cv-00272-MHW-CMV (S.D. Ohio).

10. I previously provided expert testimony at the Preliminary Injunction hearing in the above-captioned matter. *See* Dkt. 158, PI Hearing Tr. at 229:4-324:15.

11. I previously submitted a sworn declaration in the above-captioned matter on April 26, 2019 ("April 2019 Report"). I then submitted a sworn supplemental declaration in the above-captioned matter on September 23, 2019 ("September 2019 Supplemental Report"). On January 6, 2020, I submitted an additional sworn declaration providing an update on plaintiff Janiah Monroe's condition, as ordered by this Court ("January 2020 Supplemental Report"). The declaration I submit today presents my opinions and conclusions regarding Defendants' documents produced since August 2019 and is not intended to alter the conclusions contained in my initial or supplemental declarations in any way.

12. A true and correct copy of my *Curriculum Vitae*, which provides a complete overview of my education, training, and work experience and a full list of my publications, is attached hereto as Appendix A.

13. My clinical consulting fee in this case is 300 USD per hour. My retention agreement in this case is attached hereto as Appendix C.

II. MATERIALS CONSIDERED

14. I have considered information from various sources in forming my opinions enumerated herein, in addition to drawing on my extensive experience and review of the literature related to Gender Dysphoria over the past three decades. Attached as Appendix B is a bibliography of relevant medical and scientific materials related to transgender people and Gender Dysphoria.

I generally rely on these materials when I provide expert testimony, in addition to the documents specifically cited as supportive examples in particular sections of this declaration.

15. In preparing this declaration and expert report, I also reviewed and relied on the following: the named Plaintiffs' medical and mental health records; the class members' medical records; Transgender Committee/GID Committee ("Committee") records; records of IDOC grievances; IDOC policies, procedures, training materials, and correspondence related to transgender prisoners and prisoners with Gender Dysphoria; Wexford policies, procedures, training materials, and correspondence related to transgender prisoners and prisoners with Gender Dysphoria; the responses of the Defendants in this litigation to the Plaintiffs' interrogatories; and the deposition transcripts for Plaintiffs' deposition of IDOC's Rule 30(b)(6) designees, Dr. Shane Reister, Dr. La Menta Conway, Dr. Erica Anderson, Mr. Mike Chappell, and Dr. Neil Fisher.

16. Lastly, I conducted and relied on interviews of the named plaintiffs in this case. In May 2018, I conducted in-person interviews of the named plaintiffs. During those interviews, I conducted and subsequently reviewed and considered the following psychodiagnostic tests: the Beck Anxiety Inventory; the Beck Depression Inventory-II: the Beck Hopelessness Scale; and the Traumatic Symptom Inventory-II. Since May 2018, I have conducted additional occasional telephone interviews with the named plaintiffs. Most recently, I telephonically interviewed Sasha Reed and Sora Kuykendall on August 26, 2020, Marilyn Melendez and Lydia Heléna Vision on August 27, 2020, and Janiah Monroe on August 28, 2020.

III. GENDER DYSPHORIA

17. The term "gender identity" is a well-established concept in medicine, referring to one's internal sense of oneself as belonging to a particular gender. All human beings develop this elemental internal conviction of belonging to a particular gender, such as male or female.

18. At birth, infants are typically classified as male or female. This classification becomes the person's birth-assigned gender. Typically, persons born with the external physical characteristics of males psychologically identify as men, and those with the external physical characteristics of females psychologically identify as women. However, for transgender individuals, this is not the case. For transgender individuals, the sense of one's self—one's gender identity—differs from the birth-assigned gender, giving rise to a sense of being "wrongly embodied."

19. For some, the incongruence between gender identity and assigned gender does not create clinically significant distress. However, for others, the incongruence results in Gender Dysphoria, a serious medical condition characterized by a clinically significant and persistent feeling of stress and discomfort with one's assigned gender.

20. In 1980, the American Psychiatric Association introduced the diagnosis Gender Identity Disorder (GID) in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). The diagnosis GID was maintained in a revised version of DSM, known as DSM-III-R (1987), as well as in DSM-IV which was issued in 1994.

21. In 2013, with the publication of DSM-5, the Gender Identity Disorder diagnosis was removed and replaced with Gender Dysphoria. This new diagnostic term was based on significant changes in the understanding of the condition of individuals whose birth-assigned sex differs from their gender identity. The change in nomenclature was intended to acknowledge that gender incongruence, in and of itself, does not constitute a mental disorder. Nor is an individual's *identity* disordered. Rather, the diagnosis is based on the distress or *dysphoria* that some transgender people experience as a result of the incongruence between assigned sex and gender identity and the social problems that ensue. The DSM explained that the former GID diagnosis

connoted "that the patient is 'disordered.'" American Psychiatric Association, Gender Dysphoria (2013), https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-5-Gender-Dysphoria.pdf. But, as the APA explained, "[i]t is important to note that gender nonconformity is not in itself a mental disorder. The critical element of Gender Dysphoria is the presence of clinically significant distress associated with the condition." *Id*. By "focus[ing] on dysphoria as the clinical problem, not identity per se," the change from GID to Gender Dysphoria destigmatizes the diagnosis. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (5th ed. 2013).

22. In addition, the categorization of Gender Dysphoria and its placement in the DSM system is different for Gender Dysphoria than it was for GID. In every version of DSM prior to 2013, GIDs were a subclass of some broader classification, such as Disorders Usually First Evident in Infancy, Childhood, or Adolescence, or alongside other subclasses such as Developmental Disorders, Eating Disorders, and Tic Disorders. For the first time ever, DSM-5 categorizes the diagnosis separately from all other conditions. Under DSM-5, Gender Dysphoria is classified on its own. And as recently as June 16, 2018, the World Health Organization (WHO) likewise reclassified the gender incongruence diagnosis in the forthcoming International Classification of Diseases-11 ("ICD-11"). This is significant because the new classification removes gender incongruence form the chapter on mental and behavioral disorders, recognizing that it is not a mental illness.

23. The diagnostic criteria for Gender Dysphoria in Adolescents and Adults in DSM-5 are as follows:

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 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.

24. In addition to renaming and reclassifying Gender Dysphoria, the medical research that supports the Gender Dysphoria diagnosis has evolved. Unlike DSM's treatment of GID, the DSM-5 includes a section entitled "Genetics and Physiology," which discusses the genetic and hormonal contributions to Gender Dysphoria. *See* DSM-5 at 457 ("For individuals with gender dysphoria . . . some genetic contribution is suggested by evidence for (weak) familiarity of transsexualism among nontwin siblings, increased concordance for transsexualism in monozygotic compared with dizygoticsame-sex twins, and some degree of heritability of gender dysphoria").

25. There is now a scientific consensus that gender identity is biologically based and a significant body of scientific and medical research that Gender Dysphoria has a physiological and biological etiology. It has been demonstrated that transgender women, transgender men, non-transgender women, and non-transgender men have different brain composition, with respect to the white matter of the brain, the cortex (central to behavior), and subcortical structures. *See*, *e.g.*, Rametti et al., *White Matter Microstructure in Female to Male Transsexuals Before Cross-Sex*

Hormonal Treatment: A Diffusion Tensor Imaging Study, 45 J. Psychiatric Res. 199–204 (2011); Rametti et al., *The Microstructure of White Matter in Male to Female Transsexuals Before Cross-Sex Hormonal Treatment: A DTI Study*, 45 J. Psychiatric Res. 949–54 (2011); Luders et al., *Gender effects on cortical thickness and the influence of scaling*, 2 J. Behav. & Brain Sci. 357, 360 (2006); Krujiver et al., *Male-to- female transsexuals have female neuron numbers in a limbic nucleus*, 85 J. Clin. Endocr. Met., 2034–41 (2000). Interestingly, differences between transgender and non-transgender individuals primarily involve the right hemisphere of the brain. The significance of the right hemisphere is important because that is the area that relates to attitudes about bodies in general, one's own body, and the link between the physical body and the psychological self.

26. In addition, scientific investigation has found a co-occurrence of Gender Dysphoria in families. Gomez-Gill et al. concluded that the probability of a sibling of a transgender individual also being transgender was 5 times higher than someone in the general population. Gomez- Gil et al., *Familiarity of gender identity disorder in non-twin siblings*, 39 Arch Sex Behav., 265–69 (2010). And, in identical twins, there was a very high likelihood (33%) of both twins being transgender, even when reared apart, demonstrating the role of genetics in the development of Gender Dysphoria. *See* Diamond, *Transsexuality among twins: identity concordance, transition, rearing, and orientation*, 14 Int'l J. Transgenderism 24 (2013) (abstract: "[t]he responses of our twins relative to their rearing along with our findings regarding some of their experiences during childhood and adolescence show their [gender] identity was much more influenced by their genetics than their rearing."). *See also* Green, *Family co-occurrence of "gender dysphoria": ten siblings or parent-child pairs*, 29 Arch Sex Behav. 499–507 (2000).

27. It is now believed that Gender Dysphoria evolves as a result of the interaction of the developing brain and sex hormones. For example, one study found that:

> [d]uring the intrauterine period a testosterone surge masculinizes the fetal brain, whereas the absence of such a surge results in a feminine brain. As sexual differentiation of the brain takes place at a much later stage in the development than sexual differentiation of the genitals, these two processes can be influenced independently of each other. Sex differences in cognition, gender identity . . . , sexual orientation . . . , and the risks of developing neuropsychiatric disorders are programmed into our brain during early development. There is no evidence that one's postnatal social environment plays a crucial role in gender identity or sexual orientation.

Garcia-Falgueras & Swaab, *Sexual Hormones and the Brain: As Essential Alliance for Sexual Identity and Sexual Orientation*, 17 Pediatric Neuroendocrinology 22–25 (2010).

Similarly, Lauren Hare et al. finds that:

> a decrease in testosterone levels in the brain during development might result in incomplete masculinization of the brain . . . , resulting in a more feminized brain and a female gender identity.

Hare et al., *Androgen Receptor Repeat Length Polymorphism Associated with Male-to-Female Transsexualism*, 65 Biological Psychiatry 93, 93, 96 (2009). Because Gender Dysphoria is biologically based, efforts to change a person's gender identity are futile, cause psychological harm, and are unethical.

IV. TREATMENT OF GENDER DYSPHORIA

A. WPATH Standards of Care

28. Gender Dysphoria can be ameliorated or even effectively cured through medical treatment. The standards of care for treatment of Gender Dysphoria are set forth in the *World Professional Association for Transgender Health (WPATH) Standards of Care* (7th version, 2011). The WPATH promulgated Standards of Care (SOC) (hereafter, "SOC") are the internationally recognized guidelines for the treatment of persons with Gender Dysphoria, and inform medical treatment throughout the world. The American Medical Association, the Endocrine Society, the American Psychological Association, the American Psychiatric Association, the World Health

Organization, the American Academy of Family Physicians, the American Public Health Association, the National Association of Social Workers, the American College of Obstetrics and Gynecology and the American Society of Plastic Surgeons all endorse protocols in accordance with the SOC. *See, e.g.*, American Medical Association (2008) Resolution 122 (A-08); Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2009); American Psychological Association Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination (2009).

29. As part of the SOC, many transgender individuals with Gender Dysphoria undergo a medically-indicated and supervised gender transition in order to ameliorate the debilitation of Gender Dysphoria and live life consistent with their gender identity. The SOC recommend an individualized approach to gender transition, consisting of one or more of the following protocol components of evidence-based care for Gender Dysphoria:

- 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.

SOC at 9–10.

30. The treatment of incarcerated persons with Gender Dysphoria has been addressed in the SOC since 1998. As with protocols for the treatment of diabetes or other medical disorders, medical management of Gender Dysphoria for incarcerated individuals does not differ from protocols for non-institutionalized persons. For this reason, the SOC expressly state that all

elements of the prescribed assessment and treatment are equally applicable to patients in prison (Section XIV) and the National Commission on Correctional Health (NCCHC) recommends treatment in accordance with the SOC for people in correctional settings. *See* NCCHC Position Statement, Transgender, Transsexual, and Gender Non-Conforming Health Care in Correctional Settings (October 18, 2009, reaffirmed with revisions April, 2015), http: //www.ncchc.org/transgender-transsexual-and gender-nonconforming health-care).

31. Under the SOC, while it is true that "[r]easonable accommodations to the institutional environment can be made in the delivery of care consistent with the [Standards of Care]," "[d]enial 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 . . . ." SOC at 68.

32. Once a diagnosis of Gender Dysphoria is made, a treatment plan should be developed based on an individualized assessment of the medical needs of the particular patient.

33. The development of any treatment plan and all subsequent treatment must be administered by clinicians qualified in treating patients with Gender Dysphoria. The SOC specify the qualifications that professionals must meet in order to provide care to gender dysphoric patients. *See* Section VII. In particular, the SOC provide that all mental health professionals should have certain minimum credentials before treating patients with Gender Dysphoria, including a master's degree (or equivalent) in a clinical behavioral science field; competencies in using the DSM-5 and/or the International Classification of Diseases for diagnostic purposes; ability to recognize and diagnose co-existing mental health concerns and to distinguish these from Gender Dysphoria; documented supervised training and competence in psychotherapy or counseling; knowledge of gender nonconforming identities and expressions, and the assessment and treatment

of Gender Dysphoria; and continuing education in the assessment and treatment of Gender Dysphoria. SOC at 22.

34. Importantly, the SOC require that "[m]ental 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." *See* SOC at 22–23. Self-study cannot substitute for first-hand clinical experience in treating the range of clinical presentations of Gender Dysphoria, or the mentorship and supervision of an expert in this field.

35. In addition to these minimum credentials, clinicians working with gender dysphoric patients should develop and maintain cultural competence to provide optimal care. A growing body of scientific literature underlies this specialized area of medicine and presents advances in treatment that inform care.

36. Treatment plans generated by providers lacking the requisite experience can result in inappropriate care, or place patients at significant risk.

37. While psychotherapy or counseling can provide support and help with the personal and social aspects of a gender transition, they are not a substitute for medical intervention where medical intervention is needed, nor are they preconditions for such intervention. By analogy, in Type One diabetes, counseling might provide psychoeducation about living with a chronic condition, and information about nutrition, but it does not obviate the need for insulin.

38. For many individuals with Gender Dysphoria, changes to gender expression and role to feminize or masculinize one's appearance, often called the "real life experience" or "social transition," are an important part of treatment for the condition. This involves dressing, grooming and otherwise outwardly presenting oneself through social signifiers of gender consistent with

one's gender identity. This is an appropriate and necessary part of identity consolidation. Through this experience, the shame of growing up living as a "false self" and the grief of being born into the "wrong body" can be ameliorated. (Greenberg & Laurence 1981; Ettner 1999; Devor 2004.)

B. Hormone Therapy

39. For almost all individuals with persistent, well-documented Gender Dysphoria, hormone therapy is essential and medically indicated treatment to alleviate the distress of the condition. The Standards of Care specify that "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 non-conforming individuals with gender dysphoria." SOC at Section VIII, p. 33.

40. Hormone therapy is a well-established and effective means of treating Gender Dysphoria. The American Medical Association, the Endocrine Society, the American Psychiatric Association and the American Psychological Association all agree that hormone therapy in accordance with the WPATH Standards of Care is medically necessary treatment for many individuals with Gender Dysphoria. *See* American Medical Association (2008), Resolution 122 (A-08); Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2009); American Psychological Association Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination (2009).

41. The goals of hormone therapy for individuals with Gender Dysphoria are (i) to significantly reduce hormone production associated with the person's sex assigned at birth and, thereby, the secondary sex characteristics of the individual's sex assigned at birth and (ii) to replace circulating sex hormones associated with the person's sex assigned at birth with feminizing or masculinizing hormones, using the principles of hormone replacement treatment developed for hypogonadal patients (*i.e.*, non-transgender males born with insufficient testosterone or non-

transgender females born with insufficient estrogen). *See* Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2009).

42. The therapeutic effects of hormone therapy are twofold: (i) with endocrine treatment, the patient acquires congruent sex characteristics, *i.e.* for transgender women, breast development, redistribution of body fat, cessation of male pattern baldness, and reduction of body hair; and (ii) hormones act directly on the brain, via receptors sites for sex steroids, which produces an attenuation of dysphoria and attendant psychiatric symptoms, and the promotion of a sense of well-being. *See, e.g.*, Cohen-Kettenis & Gooren 1993. Hormone therapy induces desired physical changes for transgender men as well, such as a deepened voice, growth in facial and body hair, cessation of menses, and atrophy of breast tissue, among other changes. SOC at 36.

43. The efficacy of hormone therapy to treat Gender Dysphoria is observed clinically and is well documented in the literature. For example, in one study, researchers investigated 187 transgender individuals who had received hormones and compared them with a group of transgender individuals who did not. Untreated individuals showed much higher levels of depression, anxiety, and social distress than those who received hormone therapy. *See* Rametti, et al. 2011; *see also* Colizzi et al. 2014; Gorin-Lazard et al. 2014; Gorin-Lazard et al. 2011.

44. Some individuals with Gender Dysphoria experience profound relief from hormone therapy alone such that further treatment, such as surgical intervention, is not required. *See* SOC at 8–9.

45. While the WPATH Standards indicate that significant mental health concerns must be reasonably well-controlled prior to initiation of hormone therapy, co-occurring mental health conditions should only be a reason to delay therapy in the most exceptional circumstances. For example, a physician might not initiate hormone therapy in a patient who is actively pyschotic or so delusional as to be unable to consent to the treatment plan. Otherwise, it is extremely common for

gender dysphoric patients to present with co-existing mental health issues and past trauma, which usually are a result of their underlying Gender Dysphoria. There is no legitimate medical basis for denying treatment simply because a patient also has been diagnosed with, for example, clinically significant anxiety, depression, or PTSD.

C. Gender-Affirming Surgery

46. For some individuals with severe Gender Dysphoria, hormone therapy alone is insufficient. Relief from their dysphoria cannot be achieved without surgical intervention to modify primary sex characteristics, *i.e.*, genital reconstruction. Under the contemporary understanding of gender identity, transition-related medical treatments confirm, not "change," an individual's sex by aligning primary and secondary sex characteristics with a person's gender identity. The WPATH Standards state: "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 . . . . 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." SOC at 54–55.

47. Genital reconstruction surgery for transgender women has two therapeutic purposes. First, removal of the testicles eliminates the major source of testosterone in the body. Second, the patient attains body congruence resulting from the uro-genital structures appearing and functioning as is typical for non-transgender women. Both are critical in alleviating or eliminating Gender Dysphoria. Other forms of gender-affirming surgeries, such as bilateral mastectomy for transgender men, allow the individual to attain body congruence with respect to secondary sex characteristics.

48. Decades of careful and methodologically sound scientific research have demonstrated that gender-affirming surgery is a safe and effective treatment for severe Gender Dysphoria and, indeed, for many people, it is the only effective treatment. *See, e.g.*, Pfäfflin & Junge 1998; Smith et al. 2005; Jarolím et al. 2009.

49. WPATH, the American Medical Association, the Endocrine Society, and the American Psychological Association all support surgery in accordance with the SOC as medically necessary treatment for individuals with severe Gender Dysphoria. *See* American Medical Association (2008), Resolution 122 (A-08); Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2009) ("For many transsexual adults, genital sex reassignment surgery may be the necessary step towards achieving their ultimate goal of living successfully in their desired gender role."); American Psychological Association Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination (2009) (recognizing "the efficacy, benefit and medical necessity of gender transition treatments" and referencing studies demonstrating the effectiveness of gender-affirming surgeries).

50. Surgeries are considered "effective" from a medical perspective if they "have a therapeutic effect." *See* Monstrey et al. 2007. More than three decades of research confirms that gender-affirming surgery is therapeutic and therefore an effective treatment for Gender Dysphoria.

51. In a 1998 meta-analysis, Pfäfflin and Junge reviewed data from 80 studies, spanning 30 years, from 12 countries. They concluded that "reassignment procedures were effective in relieving Gender Dysphoria. There were few negative consequences and all aspects of the reassignment process contributed to overwhelmingly positive outcomes." *See* Pfäfflin & Junge 1998.

52. Numerous subsequent studies confirm this conclusion. Researchers reporting on a large-scale prospective study of 325 individuals in The Netherlands concluded that after gender-affirming surgery there was "a virtual absence of gender dysphoria" in the cohort and "results substantiate previous conclusions that sex reassignment is effective" *See* Smith et al. 2005. Indeed, the authors of the study concluded that the surgery "appeared therapeutic and beneficial" across a wide spectrum of factors and "[t]he main symptom for which the patients had requested treatment, Gender Dysphoria, had decreased to such a degree that it had disappeared."

53. In 2007, Gijs and Brewayes analyzed 18 studies published between 1990 and 2007, encompassing 807 patients. The researchers concluded: "Summarizing the results from the 18 outcome studies of the last two decades, the conclusion that [gender-affirming surgery] is the most appropriate treatment to alleviate the suffering of extremely gender dysphoric individuals still stands: Ninety-six percent of the persons who underwent [surgery] were satisfied and regret was rare."

54. Studies conducted in countries throughout the world conclude that surgery is an extremely effective treatment for Gender Dysphoria. For example, a 2001 study published in Sweden states: "The vast majority of studies addressing outcome have provided convincing evidence for the benefit of sex reassignment surgery in carefully selected cases" *See* Landen 2001. Similarly, urologists at the University Hospital in Prague, Czech Republic, in a Journal of Sexual Medicine article concluded, "Surgical conversion of the genitalia is a safe and important phase of the treatment of male-to-female transsexuals" *See* Jarolím 2009.

55. Patient satisfaction is an important measure of effective treatment. Achieving functional and normal physical appearance consistent with gender identity alleviates the suffering of Gender Dysphoria and enables the patient to function in everyday life. Studies have shown that

by alleviating the suffering and dysfunction caused by severe Gender Dysphoria, gender-affirming surgery improves virtually every facet of a patient's life. This includes satisfaction with interpersonal relationships and improved social functioning (Rehman et al. 1999; Johansson et al. 2010; Hepp et al. 2002; Ainsworth & Spiegel 2010; Smith et al. 2005); improvement in self-image and satisfaction with body and physical appearance (Lawrence 2003; Smith et al. 2005; Weyers et al. 2009); and greater acceptance and integration into the family (Lobato et al. 2006).

56. Studies have also shown that surgery improves patients' abilities to initiate and maintain intimate relationships (Lobato et al. 2006; Lawrence 2005; Lawrence 2006; Imbimbo et al. 2009; Klein & Gorzalka 2009; Jarolím et al. 2009; Smith et al. 2005; Rehman et al. 1999; De Cuypere et al. 2005).

57. Multiple long term studies have confirmed these results. *See, e.g.*, "Transsexualism in Serbia: a twenty-year follow-up study" (Vujovic et al. 2009); "Long-term assessment of the physical, mental, and sexual health among transsexual women" (Weyers et al. 2009); "Treatment follow-up of transsexual patients" (Hepp et al. 2002); "A five-year follow-up study of Swedish adults with gender identity disorder" (Johansson et al. 2010); "A report from a single institute's 14 year experience in treatment of male-to-female transsexuals" (Imbimbo et al. 2009); 'Followup of sex reassignment surgery in transsexuals: a Brazilian cohort" (Lobato et al. 2006).

58. Given the extensive experience and research supporting the effectiveness of gender-affirming surgery spanning decades, it is clear that surgery is a medically necessary, not experimental, treatment for severe Gender Dysphoria as demonstrated by its inclusion as a medically necessary treatment in the SOC.

59. In 2008, WPATH issued a "Medical Necessity Statement" expressly stating: "These medical procedures and treatment protocols are not experimental: decades of both clinical and medical research show they are essential to achieving well-being for the transsexual patient."

60. Similarly, Resolution 122 (A-08) of the American Medical Association states: "Health experts in GID, including WPATH, have rejected the myth that these treatments are 'cosmetic' or 'experimental' and have recognized that these treatments can provide safe and effective treatment for a serious health condition."

61. On September 25, 2013 the Department of Health Care Services of the State of California Health and Human Services Agency issues All Plan Letter 13-011, which makes clear that gender confirmation surgery was a covered service for Medi-Cal beneficiaries when the surgery was not cosmetic in nature and referred providers to the WPATH Standards of Care for the "criteria for the medical necessity of transgender services." Illinois recently joined the states that will provide gender confirmation surgery for Medicaid recipients. *See* https://www.chicagotribune.com/business/ct-biz-medicaid-gender-reassignment-surgery-20190405-story.html.

62. On May 30, 2014, the Appellate Division of the Departmental Appeals Board of the United States Department of Health and Human Services issued decision number 2576, in which the Board determined that a Medicare regulation denying coverage of "all transsexual surgery as a treatment for transsexualism" was not valid under the "reasonableness standard." The Board specifically concluded that "transsexual surgery is an effective treatment option for transsexualism in appropriate cases."

D. Living Consistently with Gender Identity

63. The SOC establish the therapeutic importance of changes in gender expression by means of social signifiers that align with gender identity. Gender Dysphoria, like many medical

conditions, often requires more than a single intervention for effective treatment. For example, clothing and grooming that affirm one's gender identity, such as bras for transgender females, and the use of congruent pronouns are critically important components of treatment protocols. (Greenberg & Laurence 1981; Ettner 1999; Devor 2004.)

64. The SOC also specifically provide that permanent body hair removal, the elimination of a visible secondary sex characteristic, is significant in alleviating Gender Dysphoria for transgender women. Other gender-appropriate grooming items for transgender women such as feminine deodorant, moisturizer, hair care, and make-up may also be necessary for treatment. Similarly, male grooming items are important components of social role transition for transgender men. These accoutrements are critical to the mental well-being and social transition of gender dysphoric people.

65. "Mis-gendering"—the act or referring to a transgender person by the incorrect gender—is harmful to the mental health of transgender persons. It threatens their identity and exacerbates the mental health problems attendant to Gender Dysphoria. It is therefore important, especially for those charged with the medical treatment and mental health care of transgender persons with Gender Dysphoria, to refer to transgender people using the correct, gender-affirming names and pronouns. (Bauer et al. 2015; Frost et al. 2015; Bockting 2014.)

66. Gender dysphoric prisoners are at heightened risk. In addition to the concerns outlined above, it is important for correctional facilities to consider appropriate housing and shower/bathroom facilities for transgender individuals. Each individual's gender identity and role, dignity, and personal safety should be taken into account in housing and other assignments. *See* SOC at 68. If the institution fails to do so, there can be serious consequences for mental and physical health. (Seelman, 2016.)

67. The act of showering with a person of a different gender or being subject to a pat-down or strip search by an officer of a different gender can be a frightening and demeaning experience for transgender individuals. For those suffering from Gender Dysphoria, the experience can exacerbate their condition and lead to serious mental health complications, including worsening depression, anxiety, and hopelessness.

68. Moreover, transgender inmates who are housed in a facility that does not match their gender identity may be subject to increased instances of physical and sexual assault by other inmates and officers.

69. Clothing and grooming items are particularly important to provide to transgender patients with Gender Dysphoria who have initiated hormone therapy. The physical changes facilitated by hormones in these patients make gender-affirming clothing and grooming items necessary not only for the mental health of these patients, but also for their basic physical comfort and dignity. For example, for transgender women, female undergarments allow testicles to be tucked and less visible, reducing symptoms of Gender Dysphoria. Likewise, regardless of breast development, a bra may be an important and affirming symbol of femininity for gender dysphoric women. Similarly, transgender men should be provided with male undergarments and male clothing.

70. Transgender individuals in the correctional environment sometimes are disciplined for attempts at grooming that effectively amount to self-treatment of their Gender Dysphoria. For example, transgender women may be disciplined for tattooing makeup, for wearing a ponytail, or modifying their clothing to match their gender identity.

71. Social role transition—including, for example, transgender women appearing feminine—has an enormous impact in the treatment of Gender Dysphoria. An early seminal study

emphasized the importance of aligning presentation and identity and its benefits to mental health. Greenberg and Laurence compared the psychiatric status of gender dysphoric individuals who had socially transitioned with those who had not. Those who had implemented a social transition showed "a notable absence of psychopathology" compared to those who were presenting in their birth-assigned sex role. *See* Greenberg & Laurence 1981. In addition, social transition should include use of facilities (restrooms, showers, etc.) that are consistent with one's gender identity.

E. Risks of Providing Inadequate Care

72. Without adequate treatment, adults with Gender Dysphoria experience a range of debilitating psychological symptoms such as anxiety, depression, suicidality, and other attendant mental health issues. They are frequently socially isolated as they carry a burden of shame and low self-esteem, attributable to the feeling of being inherently "defective." This leads to stigmatization, and over time proves ravaging to healthy personality development and interpersonal relationships. Without treatment, many gender dysphoric people are unable to adequately function in occupational, social or other areas of life. Many gender dysphoric women without access to appropriate care are often so desperate for relief that they resort to life-threatening attempts at auto-castration (the removal of one's testicles) in the hopes of eliminating the major source of testosterone that kindles the dysphoria. Brown & McDuffie 2009. A recent survey found a 41% rate of suicide attempts among this population, which is far above the baseline rates for North America.

73. Gender dysphoria intensifies with age. As cortisol rises with normal aging, the ratio of DHEA to cortisol is affected, which acts to alter brain chemistry and intensify Gender Dysphoria. With the passage of time, inmates who require surgical treatment will experience greater distress, and no means of relief. *See* Ettner 2013; Ettner & Wiley 2013. This is particularly deleterious for transgender inmates serving long sentences.

74. Because Gender Dysphoria entails clinically significant and persistent feeling of stress and discomfort with one's assigned gender, if it is not treated, those feelings of stress and discomfort will increase and may become critical. The results are serious and debilitating symptoms of anxiety, depression, and hopelessness. Without treatment, these individuals may not be capable of accomplishing simple everyday tasks, and may become increasingly socially withdrawn and isolated, which only serves to further exacerbate their symptoms.

75. Gender Dysphoria left untreated or inadequately treated, will result in serious physical harm. The depression and hopelessness associated with the condition causes suicidal ideation, which will result in actual suicide for many individuals. SOC at 67. Research shows that the risk of suicide can be significantly diminished with prompt and effective treatment. Bauer 2015.

76. Moreover, gender dysphoric individuals have a profound discomfort with their genitalia. Without effective treatment as outlined above, this often leads to attempts at auto-castration, which can result in lasting physical trauma or even death in more serious cases. *See* Brown & McDuffie 2009.

77. In sum, the results of providing inadequate treatment are predictable and dire, and take one of three paths: profound psychological decompensation, surgical self-treatment, or suicide.

V. DEFICIENCIES IN THE TREATMENT FOR GENDER DYSPHORIA IDOC HAS PROVIDED TO THE NAMED PLAINTIFFS

78. I assessed whether the treatment provided to the named class representatives in this case by IDOC was appropriate, and to identify and describe any deficiencies in that treatment or instances where the treatment deviated from the accepted standards set forth in the SOC. To undertake this analysis, I reviewed the named plaintiffs' medical records as kept by IDOC and the

meeting minutes from IDOC's "Gender Identity Disorder Committee," or Transgender Committee, through which all treatment decisions for Gender Dysphoria are routed. I conducted in-person interviews, including a psychological evaluation and administration of psychological tests, for each named plaintiff in this matter in May 2018. Since then, I have conducted additional telephone interviews with the named plaintiffs on occasion. Most recently, I telephonically interviewed Sasha Reed and Sora Kuykendall on August 26, 2020, Marilyn Melendez and Lydia Heléna Vision on August 27, 2020, and Janiah Monroe on August 28, 2020.

79. My analysis revealed that each of the named plaintiffs in this case is receiving treatment for Gender Dysphoria that deviates significantly from the well-accepted standards in the SOC, and that falls well below providing competent care. At bottom, none of the plaintiffs' Gender Dysphoria is being adequately treated. This means they continue to suffer unnecessarily, and also that they are at heightened risk of self-harm or suicide. There are commonalities among the deficiencies in care among the named plaintiffs, including: failure to timely initiate hormone therapy; failure to timely provide social transition, including through gender-affirming clothing and/or grooming items; and failure to evaluate plaintiffs for gender-affirming surgery.

A. Janiah Monroe

Review of IDOC Medical and Committee Records

80. Ms. Monroe is a 31-year-old transgender person currently incarcerated in Logan Correctional Center. She has identified as a female since a very young age, from the time she was a child living in the South Side of Chicago. Her family, and particularly her father, was hostile toward her female gender identity. Although she was never treated by a physician or other healthcare provider for Gender Dysphoria prior to entering IDOC, she took hormones when she could get access to them, and she informed IDOC of her status as a transgender woman upon entering custody.

81. Ms. Monroe was diagnosed with Gender Dysphoria by an IDOC mental healthcare provider in November of 2011. This was only after she complained of symptoms of Gender Dysphoria for years to IDOC staff, including severe depression and hopelessness. Ms. Monroe's history of self-harm, suicidal ideation, and attempted suicide is well-documented in her IDOC records. She has attempted auto-castration and tried to commit suicide on multiple occasions. She described several different methods of attempts to commit suicide to me during our interview. The clinical term for attempted suicide by varying methods is called "method-switching," and it is a strong indicator that the person is likely to carry out a successful suicide in the future.

82. The Committee notes regarding Ms. Monroe acknowledge her history of Gender Dysphoria, documenting that she was diagnosed with dysphoria by an IDOC mental health professional in 2011. The Committee also acknowledges Ms. Monroe's suicide attempts and attempts at auto-castration. After Ms. Monroe requested hormone therapy to treat her diagnosed Gender Dysphoria, the Committee met in March of 2012 to discuss her case. Those records indicate that, despite her diagnosis and despite IDOC's own mental health professional opining that hormone therapy should be considered, the Committee denied her hormone treatment. The Committee's only rationale was that if Ms. Monroe were to start hormone treatment, others might "follow [her] lead." The Committee met again in April of 2012 to discuss Ms. Monroe, and again denied her request for hormone therapy. The next available Committee records, from June 2015, indicate that Ms. Monroe was approved for hormone therapy at some point between April and June in 2012. Likewise, her medical records show that she began receiving cross-sex hormones sometime in mid-2012, after the Committee denied the therapy at least twice. I have seen nothing in the records to reflect Ms. Monroe has been evaluated for surgery by a mental health professional qualified to do so under the SOC.

83. Ms. Monroe's medical records address Ms. Monroe's extreme anxiety, which stems from her inadequately treated Gender Dysphoria, prolonged social isolation, and being singled out from the other female prisoners. Ms. Monroe reported on multiple occasions that being housed for months on end without a cellmate in D wing and segregated housing, as well as having restrictions on her ability to communicate with the outside world, was causing panic attacks and severe anxiety.

In-Person Interview and Psychological Examination

84. I administered an in-person psychological exam to Ms. Monroe on May 11, 2018 at Dixon Correctional Center, designed to measure her levels of anxiety, depression, and hopelessness. On the exam, Ms. Monroe demonstrated moderate levels of anxiety. On depression and hopelessness, which are the strongest predictors of whether a person will commit suicide, she scored extremely high. On hopelessness, she scored above a range at which a patient will normally go on to complete suicide.

85. Ms. Monroe showed no evidence of psychosis. It is my opinion that her severe mental health issues—namely, her depression and feelings of hopelessness—stem from her Gender Dysphoria, which roughly 8 years after her initial diagnosis by IDOC is still not being adequately treated. IDOC grievance records reflect that Ms. Monroe has made formal requests for surgery, but IDOC repeatedly failed to evaluate or even consider her as a candidate for surgery. The reason, according to IDOC, was that "there is no policy in place" to provide surgery. Despite acknowledging that fact, the records also indicate that Ms. Monroe previously was denied transfer to an all-female facility because she has not had gender-affirming surgery performed. I understand that Ms. Monroe was transferred to a female facility in April 2019, but that at some point steps were taken to transfer her back to a male facility.

Telephonic Interviews and Evaluation

86. On July 9, 2020 I spoke with Ms. Monroe by phone. Ms. Monroe's condition has significantly deteriorated due to the restrictions and isolation imposed on her due to her extended placement in D-wing. Ms. Monroe has been living in D Wing without a cellmate or in segregating housing for approximately nine months. Although Ms. Monroe is incarcerated in a female facility, she is not treated like the other women. Unlike the other prisoners on "D Wing", Ms. Monroe is the only person who is not allowed to have a cellmate. Ms. Monroe has also been housed in D Wing much longer than any other female prisoner. Absent the ability to interact with the other prisoners at Logan Correctional Center and to be treated like the other female prisoners at the facility, Ms. Monroe's demise is inevitable. She is rapidly decompensating and experiencing extreme hopelessness: a better predictor of suicide than depression. Ms. Monroe has already attempted suicide on several occasions, including while at Logan Correctional Center.

87. On August 28, 2020, I again spoke with Ms. Monroe, who remains housed on D Wing without a cellmate. Being isolated and treated as, in Ms. Monroe's words, "less than human" has prevented her from socially transitioning. Ms. Monroe continues to be harassed and provoked by IDOC staff, including being mis-gendered and called derogatory names, which further limits her ability to socially transition.

88. Further, Ms. Monroe urgently requires surgical intervention to treat her Gender Dysphoria, but has not been properly evaluated by a mental health professional qualified to do so under the SOC.

89. Prolonged isolation causes devastating psychological damage. In Ms. Monroe's case, it will inevitably lead to a continually worsening course of psychiatric illness that will –

absent some change in circumstances – result in self-harm or death. Ms. Monroe maintains a consistent level of hopelessness and depression that is not sustainable, despite brief moments of hope, such as when being presented with the prospect of receiving surgery or being moved off D-wing. I am alarmed at her level of despair, the severity of her suicide attempts, and the unremitting suicidal ideation that Ms. Monroe is currently exhibiting. Unless immediate changes are made to preserve Ms. Monroe's life, my professional opinion is that she will end her life.

Deficiencies in Treatment and Related Risks

90. Ms. Monroe's treatment falls far outside of what is recommended by the SOC, and IDOC personnel have routinely ignored her serious medical needs.

91. The long delay in authorizing hormone treatment for Ms. Monroe is inexcusable and without any legitimate medical basis. The Committee records indicate treatment initially was denied because IDOC feared others would follow Ms. Monroe's lead. This is not a medically recognized or clinically appropriate reason, under WPATH guidelines or in my professional experience as a psychotherapist specializing in treatment of Gender Dysphoria, to deny hormone treatment to a gender dysphoric individual. This excuse does not even purport to relate to a medical concern.

92. Moreover, based on my years of practice, research, and clinical expertise, people do not request hormone therapy unless they actually need it and believe it would help them overcome their Gender Dysphoria. There are no secondary gains to treatment with cross-sex hormones; and in fact, when they are used incorrectly, or used in the absence of a legitimate medical need, they can be harmful. A hormone therapy regimen in a non-transgender person would make that person ill and profoundly uncomfortable.

93. IDOC records show that Ms. Monroe was repeatedly denied gender-appropriate clothing and grooming items while housed in male facilities. Without access to such items, she was unable to transition socially. It is my understanding that on April 1, 2019, Ms. Monroe was transferred to Logan Correctional Center ("Logan"), a women's facility. This was an important step in facilitating her social role transition, but because she has been singled out and isolated at Logan, she is still unable to fully transition. As a result, unless these barriers to social transition are lifted, she will continue to be at serious and risk of self-harm and possible suicide even if she receives the other medically necessary treatment for Gender Dysphoria, including ongoing and appropriate hormone therapy and gender-affirming surgery.

B. Sora Kuykendall

Review of IDOC Medical and Committee Records

94. Ms. Kuykendall is a 28-year-old transgender woman currently incarcerated in Menard Correctional Center. She first identified as female at around 6 years of age. She told her family, but her brother treated her badly and bullied her for her female mannerisms, and she began hiding her gender identity. Her family did not provide her with any medical or mental health support, so she was never evaluated for hormones or any other treatment as a child or adolescent. Her feelings of depression and hopelessness increased as she reached puberty and her body began to change in ways she did not recognize and that were not consistent with her gender identity.

95. Ms. Kuykendall informed an IDOC mental health professional of her transgender identity when she entered IDOC custody in November of 2014. In December 2015, she requested hormones, and a mental health treatment plan from January 2015 indicates that she would "[b]egin transitioning process from male to female." A mental health progress note from February 2015 noted that Ms. Kuykendall was experiencing depression as a result of Gender Dysphoria. Since being incarcerated, she has attempted auto-castration.

96. The Committee met in February 2015 to discuss Ms. Kuykendall, and acknowledged her Gender Dysphoria diagnosis, her history of self-harm, and her request for treatment.

97. Ms. Kuykendall began receiving hormones on February 27, 2015. However, her records indicate that she continued to experience serious symptoms of Gender Dysphoria. In June 2015, she requested gender-affirming surgery and gender-appropriate clothing items. She also complained repeatedly of strip searches by male officers, and requested that her searches be conducted by female officers only.

98. In January and February 2017, she continued to make many of the same requests of mental health professionals in the prison, including requests for feminine grooming products, gender-appropriate clothing, gender-affirming surgery, and transfer to an all-female facility. She renewed her request for surgery as recently as August of 2017. There is no record that she has ever been evaluated or otherwise considered by IDOC as a candidate for surgery.

In-Person Interview and Psychological Examination

99. I conducted an in-person evaluation of Ms. Kuykendall on May 22, 2018 at Menard Correctional Center. Ms. Kuykendall presents as self-aware and intelligent, with feminine physical characteristics. While she was happy to be on hormones and she believed they help her mood, she exhibited symptoms of severe anatomical dysphoria, which was confirmed by her acts of self-harm and attempts at auto-castration. On the psychological test I administered, she exhibited extremely high anxiety and had high suicidal ideation. Her depression and feeling of hopelessness both measured at clinically significant levels.

100. Because of Ms. Kuykendall's discomfort around male inmates and correctional officers, she almost never leaves her cell, and she resides by herself. This self-imposed solitary

confinement has been harmful to her mental well-being. She appeared to be exceptionally pale and rarely showers.

Telephonic Interviews and Evaluation

101. On August 26, 2020, I spoke with Ms. Kuykendall by telephone. Ms. Kuykendall is still exhibiting symptoms of severe and inadequately treated Gender Dysphoria, including high levels of depression and feelings of hopelessness.

Deficiencies in Treatment and Related Risks

102. Ms. Kuykendall's self-imposed solitary confinement is related to her Gender Dysphoria and the extreme discomfort she experiences around men, particularly during searches of her person by male correctional officers. She is still searched exclusively by male officers, which continues to be humiliating and traumatic. Her clinically significant hopelessness and depression, and her high anxiety, are all symptoms of her underlying Gender Dysphoria.

103. Ms. Kuykendall is unable to socially transition because she continues to be harassed and mis-gendered by IDOC staff and other prisoners. Also, while she has been issued a bra, items necessary to socially transition such as women's underwear and personal grooming items remain unavailable for purchase at the commissary.

104. Ms. Kuykendall likely requires gender-affirming surgery, and should be evaluated for such surgery immediately by a mental health professional qualified to do so under the SOC. When I met with her in May 2018, she met all the diagnostic criteria for surgery and continues to do so as of August 2020. As long as evaluation for surgery is delayed, Ms. Kuykendall will continue to be at serious risk for self-harm and suicide, and will continue to experience feelings of hopelessness, depression and anxiety.

C. Sasha Reed

Review of IDOC Medical and Committee Records

105. Ms. Reed is a 28-year-old female currently incarcerated in Menard Correctional Center. She identified as female starting at around 11 years old, but did not receive any mental health support or medical treatment relating to transgender issues. Ms. Reed reported her transgender status and her desire for treatment to an IDOC mental health professional in November 2015. She reported that prior to her incarceration, she had been dressing as a woman. Her medical records indicate a history of self-harm and attempted suicide.

106. The Committee met on December 18, 2015 and, despite Ms. Reed's history and indications of related mental health issues, the Committee determined that she did not meet the criteria for dysphoria and denied her treatment, including denial of hormone therapy. The Committee met next on February 19, 2016, and denied Ms. Reed therapy again. The Committee stated that rather than recommending hormones, it needed to "clearly rule out a psychotic process and investigate offender's conceptualization of gender identity."

107. Throughout 2016, Ms. Reed's records show she continued to report symptoms of mental distress attendant to her Gender Dysphoria. She also repeatedly requested hormone therapy and gender-appropriate clothing, and reported depression to mental health professionals. Committee records from a meeting in November 2016 show that the committee again denied hormone therapy for Ms. Reed's Gender Dysphoria, citing as the basis for denial mental health issues generally.

108. In December 2016, Ms. Reed filed a grievance for gender-affirming surgery and gender-appropriate clothing and grooming items, which was denied as "moot." The denial deferred entirely to the "Transgender Care Committee," providing no further rationale for the denial.

109. The Committee finally approved Ms. Reed for hormone therapy in March of 2017, well over a year after she first requested treatment.

In-Person Interview and Psychological Examination

110. I conducted an in-person evaluation of Ms. Reed on May 23, 2018 at Lawrenceville Correctional Center. She exhibited severe levels of depression on the tests I administered. In our interview, Ms. Reed described symptoms consistent with Gender Dysphoria that first manifested in childhood. She also expressed a desire for female grooming items that she was not receiving, including body-hair removal items and makeup. She reported extreme distress resulting from being strip-searched by male correctional officers at Lawrenceville.

Telephonic Interviews and Evaluation

111. On August 26, 2020, I spoke with Ms. Reed by telephone. She continues to exhibit symptoms of inadequately treated Gender Dysphoria, as well as similar levels of depression as in May 2018. She continued to express her desire for female personal care items and women's underwear to be available for purchase at the commissary. She noted that she continues to be harassed and mis-gendered by correctional officers and other prisoners, including continuing to be strip-searched exclusively by male officers.

Deficiencies in Treatment and Related Risks

112. The delay in initiating hormone treatment for Ms. Reed was inexcusable, and the Committee's stated reasons for the delay have no basis whatsoever in the Guidelines. It is unclear what the committee meant when it wrote that it must "investigate offender's conceptualization of gender identity," but that is not a medically valid reason to deny treatment.

113. The Committee provided no specific evidence that Ms. Reed's mental health issues were not well-managed, and I did not identify any such evidence in my own review of Ms. Reed's

medical records. Indeed, mental health professionals were actively prescribing her Zoloft, Sertraline, and Loxitane to alleviate her purported mental health issues. In my in-person evaluation of Ms. Reed in May 2018, I noted no indication of any psychosis, and it is my clinical opinion that her mental health symptoms are a result of her Gender Dysphoria, not the result of a "psychotic process."

114. Ms. Reed has repeatedly requested gender-affirming surgery and the records indicate that IDOC has consistently ignored or denied those requests. She appears to meet the criteria for surgery, and should be evaluated immediately by a mental health professional qualified to do so under the SOC. If IDOC continues to ignore her requests, her Gender Dysphoria will persist and worsen, and Ms. Reed will remain at serious risk of self-harm and suicide.

D. Lydia Heléna Vision

Review of IDOC Medical and Committee Records

115. Ms. Vision is a 41-year-old transgender female currently incarcerated in Centralia Correctional Center. She identified as a female from a very young age, but her family did not support her gender identity. Around the age of 8 or 9, she attempted auto castration. Because of her family's lack of support, she suppressed her gender identity for many years afterward. Ms. Vision informed IDOC as early as January 2015 that she was transgender. She told mental health professionals that she felt incapable of fully expressing her feminine side due to her environment in the prison and her past experiences of being stigmatized for her female characteristics.

116. The Committee met on March 18, 2016, and noted that Ms. Vision was "mentally stable per MHP opinion." Providing a short overview of Ms. Vision's medical history, the Committee noted that she identified as female for the previous 8 years and had been diagnosed with Gender Dysphoria by an IDOC psychiatrist.

117. Despite acknowledging her diagnosis of Gender Dysphoria, the Committee nevertheless denied her hormone therapy, stating that her Gender Dysphoria "may not fully manifest itself in the correctional environment." The Committee further noted, without elaboration, that it had concerns regarding her purported anger and aggression that "can be tied to PTSD." The Committee also repeatedly referred to Ms. Vision as "he," despite her identification as a female.

118. Ms. Vision continued to request hormones and gender-appropriate clothing and grooming items in 2016. The Committee met again in November of 2016 and again denied Ms. Vision hormone therapy. While still acknowledging her diagnosis of Gender Dysphoria, the Committee remained fixated on Ms. Vision's purported PTSD, indicating that she had admitted to being sexually abused as a child. The Committee wrote that it was concerned about the "potential for further victimization and isolation as the physical effects of feminizing hormones become apparent." The Committee did not explain the basis of its conclusion that Ms. Vision suffered from PTSD, nor elaborate on that diagnosis in any material way.

119. Ms. Vision's records show that after this Committee meeting, she continued to report increased depression and anxiety as a result of not being approved for hormone therapy. The Committee met again in March of 2017. They acknowledged Ms. Vision's requests for female undergarments, feminine grooming supplies, and hormones, and continued to deny her treatment. The only explanation provided was that the Committee had "concerns about [Ms. Vision's] mental health and capacity to undergo the physiologic changes associated with feminizing hormones in an environment where she has little to no support."

120. Ms. Vision's records indicate she began receiving them around November of 2018, representing a delay of over 2 years after she first requested treatment for Gender Dysphoria.

In-Person Interview and Psychological Examination

121. My psychological evaluation of Ms. Vision revealed no clinically significant indicators of psychological symptomology of post-traumatic stress disorder (PTSD): she scored low on the tests I administered for anxiety, depression and feelings of hopelessness. She has also developed effective coping mechanisms, such as working out and reading, and has successfully implemented various self-improvement techniques while in prison, such as earning a college degree.

122. Despite her excellent coping skills, she also fits the criteria for persistent and early-onset Gender Dysphoria. She does not feel "at home" in her own body, and she had attempted auto-castration at a very young age. During my evaluation, I administered a test to Ms. Vision designed to diagnose PTSD, and she does not have the disorder. One of the Committee's primary justifications for repeatedly delaying hormone therapy for Ms. Vision was her supposed PTSD, a condition that the members of the Committee did not even attempt to diagnose in person.

Telephonic Interviews and Evaluation

123. On August 27, 2020, I spoke with Ms. Vision by telephone. She continues to display excellent coping skills, earning a paralegal certificate in addition to the degrees she had earned already when I interviewed her in May 2018. Nevertheless, Ms. Vision exhibits symptoms of hopelessness and depression, describing the sensation of struggling to stay afloat each day so she does not "drown" in depression. These symptoms are a reflection of her inadequately treated Gender Dysphoria.

Deficiencies in Treatment and Related Risks

124. Even if Ms. Vision did suffer from PTSD, it was not a legitimate reason to delay or defer treatment for Gender Dysphoria. Chronic PTSD is persistent and is unlikely to resolve, even

with therapy and prescription drugs. None of the records explain why Ms. Vision's supposed PTSD should act as a contraindication to hormone therapy or other relief.

125. Given her severe and persistent anatomical Gender Dysphoria, Ms. Vision should immediately be evaluated for gender-affirming surgery by a mental health professional qualified to do so under the SOC. IDOC's failure to do so is a clear departure from the SOC, puts Ms. Vision at serious risk of self-harm, and amounts to effectively ignoring her serious medical needs.

126. Ms. Vision is prevented from social transition in a number of ways. Her request to transfer to a women's facility was denied, she experiences constant harassment and mis-gendering from correctional officers and other prisoners, and she is still subjected to strip searches by male officers. In addition, female clothing and personal care items such as women's underwear, cosmetics, and other personal grooming items remain unavailable for purchase at commissary.

E. Marilyn Melendez

Review of IDOC Medical and Committee Records

127. Ms. Melendez is a 26-year-old transgender woman currently incarcerated in Pontiac Correctional Center. She identified as female from a young age, and only her mother was supportive of her gender identity. Ms. Melendez did not receive formal medical treatment or counseling for transgender issues, but she took cross-sex hormones on occasions, whenever her mother was able to provide them to her. She entered IDOC custody as a juvenile at the age of 14.

128. Ms. Melendez informed IDOC of her transgender status and began seeking hormone therapy as early as February of 2015. She began discussing feelings of depression and other issues with IDOC healthcare professionals and was diagnosed with Gender Dysphoria on March 6, 2015. An IDOC mental health professional recommended she be referred to the Committee for potential hormone therapy.

129. The Committee met on March 27, 2015 and acknowledged Ms. Melendez's history of living as a female and feeling as if she was in the "wrong body." The Committee nevertheless denied hormone therapy, stating only that Ms. Melendez "need[ed] counseling on real life situations of living as opposite gender."

130. Ms. Melendez promptly filed a grievance relating to the denial of her hormone therapy. That grievance was denied, and the denial deferred entirely to the Committee, without any further reasoning or explanation. The Committee ultimately approved hormone therapy in July of 2015, after a 4-month delay.

131. Ms. Melendez requested access to a bra in March of 2016, which IDOC did not approve until a full year later. Ms. Melendez also requested gender-affirming surgery in October of 2016. Her records indicate that IDOC refused that request and has not even evaluated her as a candidate for such surgery.

In-Person Interview and Psychological Examination

132. At our interview on May 25, 2018 at Pontiac Correctional Center, Ms. Melendez presented as intelligent, articulate, and self-assured. However, Ms. Melendez also has a history of attempted suicide. On the psychological tests I administered, she exhibited clinically significant anxiety and depression, and extremely high feelings of hopelessness with suicidal ideation.

133. Ms. Melendez expressed a strong feeling that she hated her male genitalia and wanted them removed. Her Gender Dysphoria has persisted despite the initiation of hormone therapy, and in fact is becoming more severe. Ms. Melendez also reported to me that she still had not received a bra from IDOC that fits her properly.

Telephonic Interviews and Evaluation

134. On August 27, 2020, I spoke with Ms. Melendez by telephone. She continues to experience depression and anxiety, as well as high levels of hopelessness and suicidal ideation. She is also displaying symptoms of inadequately treated Gender Dysphoria in that she describes a strong repulsion from her genitals. Her Gender Dysphoria is particularly exacerbated by continued unwanted erections, which indicates a deficiency with her hormone treatment.

Deficiencies in Treatment and Related Risks

135. The 4-month delay in initiating hormone therapy for Ms. Melendez was without any legitimate medical basis. The Committee's stated reason for delay—that she needed "counseling on real life situations of living as opposite gender"—is not a rationale for denying therapy, nor should such a factor even play into a decision about whether to initiate hormones. It is not clear from the records that such "counseling" was ultimately provided to Ms. Melendez.

136. The mental symptoms that Ms. Melendez continues to exhibit—in particular her extreme feelings of hopelessness and suicidal ideation—are symptoms of her Gender Dysphoria, which is worsening without effective treatment. It is also important for gender dysphoric individuals to have the appropriate clothing and grooming items that affirm their genders. As with hormone treatment, there was no legitimate medical basis to deny Ms. Melendez a bra for a year after she was diagnosed by an IDOC mental health professional with Gender Dysphoria. While Ms. Meledez was eventually issued a bra, women's clothing, underwear, and feminine personal care items continue to remain unavailable for purchase at the commissary.

137. Further, Ms. Melendez exhibits severe anatomical dysphoria and experiences revulsion from her genitals. She meets the criteria for gender-affirming surgery and should be

evaluated immediately for surgery by a mental health professional qualified to do so under the SOC.

138. It is my opinion that IDOC's failure to evaluate Ms. Melendez for surgery, its unjustified delay in initiating hormone therapy, and its unjustified delay in providing her with clothing and personal care items necessary to socially transition have all needlessly exacerbated her already-severe Gender Dysphoria. As long as she continues to have requests for gender-affirming accoutrements and surgery denied, and as long as the pattern of ignoring or delaying her requests continues, Ms. Melendez will remain in severe mental distress and at risk of suicide.

F. Putative Class Members

139. In my review of the medical records, Committee notes relevant to the class members, I observed many of the same deficiencies in treatment that I have discussed above regarding the named plaintiffs.

140. Many of the class member inmates have been diagnosed with Gender Dysphoria, but have hormone treatment arbitrarily or unreasonably withheld by the Committee. The unnecessary denial or delay of hormone therapy can have severe consequences to the mental health of gender dysphoric patients. Without effective treatment, the course of Gender Dysphoria leads to one of three outcome in patients: psychological decompensation, surgical self-treatment (such as auto-castration in transgender women), or suicide.

141. The Committee's reasons for denial of treatment vary, but in all cases I reviewed, their reasons were not recognized under the SOC for denying or delaying treatment, and were not medically sound. One of the most fundamental errors repeatedly made by the Committee is to confuse the symptoms of Gender Dysphoria with having a co-occurring mental illness, and then denying treatment for a lack of "stability" or the need to address prior "trauma" before treatment

can commence. Other times, the Committee denies treatment simply because there has been no IDOC psychiatric evaluation of the putative class member.

142. One of the minimum criteria for treating Gender Dysphoria is the ability to "recognize and diagnose coexisting mental health concerns and to distinguish these from gender dysphoria." SOC at 22. The Committee, which has no contact with the patient, lacks the necessary information to make this determination—and in any event its members do not have the specialized training to make this critical distinction. Relatedly, the Committee misunderstands or misapplies the requirement that co-occurring conditions be "reasonable well-controlled." Absent active psychosis, or a patient so delusional as to be unable to consent to the treatment plan, treatment for Gender Dysphoria almost always should promptly follow a diagnosis. It is expected that "trauma" will present in most gender dysphoric patients, and by no means should be weaponized as a reason to deny treatment. Relatedly, the Committee misunderstands and mischaracterizes self-injurious behavior as something other than a manifestation of Gender Dysphoria—when a specialist in the field would understand that behavior to be a symptom showing that the condition is untreated or poorly treated.

143. Additional common examples of inappropriate rationales for denial and delay that appeared repeatedly in the records of the putative class members include: need for historical corroboration of gender incongruence beyond the patient's medical records; the patient's disciplinary history; the patient's need for "community support" or the need for more "real-life experience" living as a transgender individual; and "sexual potency." None of these justifications have a basis in the SOC, and competent practitioners would not deny or delay treatment on these bases. The Committee routinely takes into account these and other irrelevant factors in rendering a treatment decision.

144. In some cases, the Committee improperly discounted a putative class member's claim of transgender status or Gender Dysphoria diagnosis because the person had only recently disclosed to IDOC that they were transgender. The Committee overlooks or does not understand that transgender individuals often experience tremendous fear about revealing or displaying gender non-conformance. This is especially true in the correctional setting, and many of these putative class members' records indicate that transgender inmates are afraid of other inmates and correctional officers. The skepticism with which IDOC approaches Gender Dysphoria is completely unfounded: it is virtually unheard of that a patient who is not gender dysphoric will seek treatment.

145. The Committee's decisions to deny treatment often include denial of requests for gender-appropriate clothing or grooming items. While the Committee has approved the issuance of bras to transgender female prisoners, this often occurs only after they have taken hormones and exhibited breast development. Additionally, men's facilities still not do carry commissary items necessary to socially transition, such as gender-appropriate underwear, clothing, soaps, shampoos, and deodorants, makeup and cosmetic items, or permanent hair removal. This is contrary to the SOC and deprives prisoners the social transition that the medical community recognizes as medically necessary.

146. None of the Committee records I examined authorized or recommended a medical evaluation of a putative class member for gender-affirming surgery, despite the fact that many transgender inmates requested such surgery. I understand that IDOC never has provided gender-affirming surgery. The records suggest an ignorance on the part of IDOC officials of the fact that gender-affirming surgery may be a medically necessary treatment for Gender Dysphoria. Based on my review of the records in this case, IDOC, through the Committee and the actions of its health

care professionals, maintains a de facto policy of summarily denying access to gender-affirming surgery, even in cases where it would be indicated as a medically necessary treatment.

147. Overall, the reasons for denying or delaying treatment, when given, may not even reflect medical judgments: they are often administrative decisions made by a deliberative body that provides minimal or cursory explanations regarding their decisions, which have the effect of depriving transgender individuals with serious medical needs of much-needed treatment. For example, there is no indication in the Committee notes that the Committee considered or even reviewed the medical administration records of the individual inmates before rendering decisions (and often denying hormone treatment or asserting that an individual is not gender dysphoric).

148. Dr. Conway testified that the Committee will be reformed into two committees: the Health and Wellness Committee, which will oversee medical and mental health treatment of Gender Dysphoria, and the Administrative Committee, which will oversee commissary, housing transfers, and PREA issues. I understand that the structure of these Committees and IDOC's new policies for treating Gender Dysphoria have not been finalized or implemented. I also understand that IDOC has retained the Moss Group and Dr. Anderson as consultants, but neither has been retained to oversee implementation of any new policies.

149. Even if implemented, IDOC's future plans for evaluating, approving, and providing surgical treatment for Gender Dysphoria also reflect a misunderstanding of the aspects necessary for a patient to safely undergo and recover from surgery. For example, the policies described by Dr. Conway do not take into account important logistics such as the provision of genital hair removal, which is a prerequisite for genital surgeries that occurs over several months. Similarly, the policies do not seem to contemplate where and how patients will recover after the operation, including who will oversee ongoing post-operative care.

150. Dr. Conway testified that medical providers at each correctional facility are currently diagnosing and providing treatment for Gender Dysphoria, overseen by the medical directors without additional oversight from any Committee. Nothing in the materials I reviewed indicate that the IDOC or Wexford medical staff are qualified under the SOC to adequately treat Gender Dysphoria or to appropriately prescribe and monitor hormone therapy. The SOC provide certain minimum criteria that healthcare providers should have before treating gender dysphoric patients. Simply being a licensed clinical psychologist or a licensed physician does not make a person qualified to practice this specialized area of medicine. From my review of the medical records, I found that medical providers mis-gendered patients and displayed a general misunderstanding of Gender Dypshoria. Additionally, Wexford-employed medical providers cannot always prescribe the treatment determined to be appropriate due to cost constraints imposed by Wexford, which could include recommendations for surgical treatment of Gender Dysphoria. Further, the optional training program for medical staff that Dr. Conway hopes to implement has not occurred and would not be sufficient to qualify medical staff to treat Gender Dysphoria under the SOC even once provided. Similarly, Dr. Reister's training program and materials would be insufficient to qualify medical staff under the SOC.

151. In an institutional setting, "[i]f the in-house expertise of health professionals . . . does not exist to assess 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." SOC at 67. I understand that IDOC has not engaged outside specialists to evaluate or treat gender dysphoric patients.

152. Further, the members of the Health and Wellness Committee seemingly are not qualified to treat transgender patients with Gender Dysphoria under the SOC. Dr. Conway, who

will be overseeing the Health and Wellness Committee, has no experience treating Gender Dysphoria has not completed training or mentorship sufficient to provide competent treatment under the SOC.

153. Similarly, IDOC's mental health professionals who directly treat gender dysphoric prisoners appear to lack the qualifications to do so. While I understand that those individuals have masters or doctorate level degrees, I have seen no indication that they have specific training and expertise in Gender Dysphoria. All indications, based on the care decisions I have seen, are that they do not. In fact, medical notes reflect that many practitioners do not even know the name of the condition—sometimes calling it "tg [transgender] disorder" and "sex dysphoria," among other names that never have been accepted in medical literature. These same practitioners routinely refer to their own patients with incorrect names and pronouns.

154. I understand that IDOC has plans to implement new guidelines and training materials for treating prisoners with gender dysphoria. I also understand that Wexford prepared the guidelines and training materials based on materials other than the SOC. Based on my review, these guidelines and training materials significantly differ from the SOC. For example, Wexford's guidelines require the prisoner's co-existing medical and mental health conditions to be "well controlled," instead of the SOC's standard of "reasonably well controlled," which imposes an unnecessary barrier to a prisoner receiving hormone therapy under IDOC's care.

155. The American Psychological Association's Ethical Principles of Psychologists and Code of Conduct directs psychologists to "provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence . . . ." The Code of Ethics goes on to direct psychologists as follows: "Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with . . . gender

[and] gender identity . . . is essential for effective implementation of their services or research, psychologists have or obtain the training, experience consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals . . . ."

156. The Administrative Committee will oversee issues relating to housing placement, cross-gender searches, and commissary, which impact prisoners' ability to socially transition within IDOC. Nevertheless, the members of this Committee are not qualified to oversee this important aspect of treating Gender Dysphoria. None possess the minimum qualifications to treat Gender Dysphoria under the SOC. For example, Mr. Chappell votes on transfer issues, but believes that housing prisoners based on a prisoner's genitals, size, and his own assessment of that prisoner's aggression level is appropriate. Additionally, Mr. Chappell believes that electrolysis is a cosmetic procedure, revealing his complete lack of knowledge about Gender Dysphoria.

157. Taken together, the records in this case form a clear pattern: IDOC, Committee and future Committees, and medical and mental health staff fundamentally misunderstand the serious medical condition of Gender Dysphoria, and lack expertise and understanding to provide effective care. The care that is provided falls well outside the range of acceptable treatment, and puts patients' health in serious danger.

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

Dated: August 31, 2020

Dr. Randi Ettner Ph.D.

Dr. Randi Ettner, Ph.D.

APPENDIX A

RANDI ETTNER, PHD
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POSITIONS HELD

Clinical Psychologist
Forensic Psychologist
Fellow and Diplomate in Clinical Evaluation, American Board of Psychological Specialties
Fellow and Diplomate in Trauma/PTSD
President, New Health Foundation Worldwide
Secretary, World Professional Association for Transgender Health (WPATH)
Chair, Committee for Institutionalized Persons, WPATH
Global Education Initiative Committee, WPATH
University of Minnesota Medical Foundation: Leadership Council
Psychologist, Center for Gender Confirmation Surgery, Weiss Memorial Hospital
Adjunct Faculty, Prescott College
Editorial Board, *International Journal of Transgender Health*
Editorial Board, *Transgender Health*
Television and radio guest (more than 100 national and international appearances)
Internationally syndicated columnist
Private practitioner
Medical adjunct staff; Department of Medicine: Weiss Memorial Hospital, Chicago IL
Advisory Council, National Center for Gender Spectrum Health

EDUCATION

PhD, 1979	Northwestern University (with honors) Evanston, Illinois
MA, 1976	Roosevelt University (with honors) Chicago, Illinois
BA, 1969-73	Indiana University Bloomington, Indiana Cum Laude Major: Clinical Psychology; Minor: Sociology
1972	Moray College of Education Edinburgh, Scotland International Education Program
1970	Harvard University Cambridge, Massachusetts Social Relations Undergraduate Summer Study Program in Group Dynamics and Processes

CLINICAL AND PROFESSIONAL EXPERIENCE

2016-present	Psychologist: Weiss Memorial Hospital Center for Gender Confirmation Surgery
	Consultant: Walgreens; Tawani Enterprises Private practitioner
2011	Instructor, Prescott College: Gender-A multidimensional approach
2000	Instructor, Illinois Professional School of Psychology
1995-present	Supervision of clinicians in counseling gender non conforming clients
1993	Post-doctoral continuing education with Dr. James Butcher in MMPI-2 Interpretation, University of Minnesota
1992	Continuing advanced tutorial with Dr. Leah Schaefer in psychotherapy
1983-1984	Staff psychologist, Women's Health Center, St. Francis Hospital, Evanston, Illinois
1981-1984	Instructor, Roosevelt University, Department of Psychology: Psychology of Women, Tests and Measurements, Clinical Psychology, Personal Growth, Personality Theories, Abnormal Psychology
1976-1978	Research Associate, Cook County Hospital, Chicago, Illinois, Department of Psychiatry
1975-1977	Clinical Internship, Cook County Hospital, Chicago, Illinois, Department of Psychiatry
1971	Research Associate, Department of Psychology, Indiana University
1970-1972	Teaching Assistant in Experimental and Introductory Psychology Department of Psychology, Indiana University
1969-1971	Experimental Psychology Laboratory Assistant, Department of Psychology, Indiana University

INVITED PRESENTATIONS AND HOSPITAL GRAND ROUNDS

Working With Medical Experts, The National LGBT Law Association, webinar presentation, 2020

Legal Issues Facing the Transgender Community, Illinois State Bar Association, Chicago, IL, 2020

Providing Gender Affirming Care to Transgender Patients, American Medical Student Association, webinar presentation, 2020

Foundations in Mental Health for Working with Transgender Clients; Advanced Mental Health Issues, Ethical Issues in the Delivery of Care, Center for Supporting Community Development Initiatives, Vietduc University Hospital, Hanoi, Vietnam, 2020

The Transgender Surgical Patient, American Society of Plastic Surgeons, Miami, FL 2019

Mental health issues in transgender health care, American Medical Student Association, webinar presentation, 2019

Sticks and stones: Childhood bullying experiences in lesbian women and transmen, Buenos Aires, 2018

Gender identity and the Standards of Care, American College of Surgeons, Boston, MA, 2018

The mental health professional in the multi-disciplinary team, pre-operative evaluation and assessment for gender confirmation surgery, American Society of Plastic Surgeons, Chicago, IL, 2018; Buenos Aires, 2018

Navigating Transference and Countertransference Issues, WPATH global education initiative, Portland, OR; 2018

Psychological aspects of gender confirmation surgery International Continence Society, Philadelphia, PA 2018

The role of the mental health professional in gender confirmation surgeries, Mt. Sinai Hospital, New York City, NY, 2018

Mental health evaluation for gender confirmation surgery, Gender Confirmation Surgical Team, Weiss Memorial Hospital, Chicago, IL 2018

Transitioning; Bathrooms are only the beginning, American College of Legal Medicine, Charleston, SC, 2018

Gender Dysphoria: A medical perspective, Department of Health and Human Services, Office for Civil Rights, Washington, D.C, 2017

Multi-disciplinary health care for transgender patients, James A. Lovell Federal Health Care Center, North Chicago, IL, 2017

Psychological and Social Issues in the Aging Transgender Person, Weiss Memorial Hospital, Chicago, IL, 2017.

Psychiatric and Legal Issues for Transgender Inmates, USPATH, Los Angeles, CA, 2017

Transgender 101 for Surgeons, American Society of Plastic Surgeons, Chicago, IL, 2017.

Healthcare for transgender inmates in the US, Erasmus Medical Center, Rotterdam, Netherlands, 2016.

Tomboys Revisited: Replication and Implication; Models of Care; Orange Isn't the New Black Yet- WPATH symposium, Amsterdam, Netherlands, 2016.

Foundations in mental health; role of the mental health professional in legal and policy issues, healthcare for transgender inmates; children of transgender parents; transfeminine genital surgery assessment: WPATH global education initiative, Chicago, IL, 2015; Atlanta, GA, 2016; Columbia, MO, 2016; Ft. Lauderdale, FL, 2016; Washington, D.C., 2016, Los Angeles, CA, 2017, Minneapolis, MN, 2017, Chicago, IL, 2017; Columbus, Ohio, 2017; Portland, OR, 2018; Cincinnati, OH, 2018, Buenos Aires, 2018

Pre-operative evaluation in gender-affirming surgery-American Society of Plastic Surgeons, Boston, MA, 2015

Gender affirming psychotherapy; Assessment and referrals for surgery-Standards of Care-Fenway Health Clinic, Boston, 2015*Gender reassignment surgery*- Midwestern Association of Plastic Surgeons, 2015

Adult development and quality of life in transgender healthcare- Eunice Kennedy Shriver National Institute of Child Health and Human Development, 2015

Healthcare for transgender inmates- American Academy of Psychiatry and the Law, 2014

Supporting transgender students: best school practices for success- American Civil Liberties Union of Illinois and Illinois Safe School Alliance, 2014

Addressing the needs of transgender students on campus- Prescott College, 2014

The role of the behavioral psychologist in transgender healthcare – Gay and Lesbian Medical Association, 2013

Understanding transgender- Nielsen Corporation, Chicago, Illinois, 2013

Role of the forensic psychologist in transgender care; *Care of the aging transgender patient*-University of California San Francisco, Center for Excellence, 2013

Evidence-based care of transgender patients- North Shore University Health Systems, University of Chicago, Illinois, 2011; Roosevelt-St. Vincent Hospital, New York; Columbia Presbyterian Hospital, Columbia University, New York, 2011

Children of Transsexuals-International Association of Sex Researchers, Ottawa, Canada, 2005; Chicago School of Professional Psychology, 2005

Gender and the Law- DePaul University College of Law, Chicago, Illinois, 2003; American Bar Association annual meeting, New York, 2000

Gender Identity, Gender Dysphoria and Clinical Issues –WPATH Symposium, Bangkok, Thailand, 2014; Argosy College, Chicago, Illinois, 2010; Cultural Impact Conference, Chicago, Illinois, 2005; Weiss Hospital, Department of Surgery, Chicago, Illinois, 2005; Resurrection Hospital Ethics Committee, Evanston, Illinois, 2005; Wisconsin Public Schools, Sheboygan, Wisconsin, 2004, 2006, 2009; Rush North Shore Hospital, Skokie, Illinois, 2004; Nine Circles Community Health Centre, University of Winnipeg, Winnipeg, Canada, 2003; James H. Quillen VA Medical Center, East Tennessee State University, Johnson City, Tennessee, 2002; Sixth European Federation of Sexology, Cyprus, 2002; Fifteenth World Congress of Sexology, Paris, France, 2001; Illinois School of Professional Psychology, Chicago, Illinois 2001; Lesbian Community Cancer Project, Chicago, Illinois 2000; Emory University Student Residence Hall, Atlanta, Georgia, 1999; Parents, Families and Friends of Lesbians and Gays National Convention, Chicago, Illinois, 1998; In the Family Psychotherapy Network National Convention, San Francisco, California, 1998; Evanston City Council, Evanston, Illinois 1997; Howard Brown Community Center, Chicago, Illinois, 1995; YWCA Women's Shelter, Evanston, Illinois, 1995; Center for Addictive Problems, Chicago, 1994

Psychosocial Assessment of Risk and Intervention Strategies in Prenatal Patients- St. Francis Hospital, Center for Women's Health, Evanston, Illinois, 1984; Purdue University School of Nursing, West Layette, Indiana, 1980

Psychonueroimmunology and Cancer Treatment- St. Francis Hospital, Evanston, Illinois, 1984

Psychosexual Factors in Women's Health- St. Francis Hospital, Center for Women's Health, Evanston, Illinois, 1984

Sexual Dysfunction in Medical Practice- St. Francis Hospital, Dept. of OB/GYN, Evanston, Illinois, 1980

Sleep Apnea - St. Francis Hospital, Evanston, Illinois, 1996; Lincolnwood Public Library, Lincolnwood, Illinois, 1996

The Role of Denial in Dialysis Patients - Cook County Hospital, Department of Psychiatry, Chicago, Illinois, 1977

PUBLICATIONS

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"The Role of Psychological Tests in Forensic Settings," *Chicago Daily Law Bulletin,* 1997.

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"Post-traumatic Stress Disorder," *Chicago Daily Law Bulletin*, 1995.

"Compensation for Mental Injury," *Chicago Daily Law Bulletin*, 1994.

"Workshop Model for the Inclusion and Treatment of the Families of Transsexuals," Proceedings of the Harry Benjamin International Gender Dysphoria Symposium; Bavaria, Germany, 1995.

"Transsexualism- The Phenotypic Variable," Proceedings of the XV Harry Benjamin International Gender Dysphoria Association Symposium; Vancouver, Canada, 1997.

"The Work of Worrying: Emotional Preparation for Labor," Pregnancy as Healing. A Holistic Philosophy for Prenatal Care, Peterson, G. and Mehl, L. Vol. II. Chapter 13, Mindbody Press, 1985.

PROFESSIONAL AFFILIATIONS

University of Minnesota Medical School–Leadership Council
American College of Forensic Psychologists
World Professional Association for Transgender Health
World Health Organization (WHO) Global Access Practice Network
TransNet national network for transgender research
American Psychological Association
American College of Forensic Examiners
Society for the Scientific Study of Sexuality
Screenwriters and Actors Guild
Phi Beta Kappa

AWARDS AND HONORS

University of Minnesota, Program of Human Sexuality Award in Sex and Gender, 2020
Letter of commendation from United States Congress for contributions to public health in Illinois, 2019
WPATH Distinguished Education and Advocacy Award, 2018
The Randi and Fred Ettner Transgender Health Fellowship-Program in Human Sexuality, University of Minnesota, 2016
Phi Beta Kappa, 1972
Indiana University Women's Honor Society, 1970-1972
Indiana University Honors Program, 1970-1972
Merit Scholarship Recipient, 1970-1972
Indiana University Department of Psychology Outstanding Undergraduate Award Recipient, 1970-1972
Representative, Student Governing Commission, Indiana University, 1970

LICENSE

Clinical Psychologist, State of Illinois, 1980

APPENDIX B

BIBLIOGRAPHY

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APPENDIX C

KIRKLAND & ELLIS LLP
AND AFFILIATED PARTNERSHIPS

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February 6, 2017

Dr. Randi Ettner
1214 Lake Street
Evanston, IL 60201
rettner@aol.com

Dear Dr. Ettner:

As you know, Kirkland & Ellis LLP, the American Civil Liberties Union Foundation ("ACLUF"), and the Roger Baldwin Foundation of ACLU, Inc. ("RBF") represent transgender prisoners in the custody of the Illinois Department of Corrections ("IDOC") for purposes of investigation and intend to represent transgender prisoners for possible litigation in connection with the adequacy of medical care provided by the IDOC to transgender prisoners.

This letter confirms that the ACLUF, RBF, and Kirkland & Ellis LLP have retained you as an expert in this case, and we have agreed to pay your customary pro bono fee of $300 per hour, up to a maximum of $2,400 per day, plus reasonable expenses you incur in connection with your work on this matter. The same rate applies for report writing, phone conferences, face-to-face meetings, and travel time. You will charge us the rate of $425 per hour for trial and deposition testimony. In addition to professional fees, we will compensate you for reasonable direct out-of-pocket expenses, such as charges for travel. You will inform us if you anticipate total fees will exceed $10,000 prior to incurring those costs in excess of that amount.

You should send your bills directly to Kirkland & Ellis LLP. You have advised us that no conflicts exist with your taking on this assignment. You agree that you will not provide expert witness services in this case or matters directly connected with this case for any person or entity, other than the plaintiffs and their attorneys, without the advance written approval of the plaintiffs' attorneys. In addition, you agree that while this matter is still active you will not provide expert services for any person or entity who has asserted or proposes to assert any position antagonistic to that of the plaintiffs in this case, without the advance written approval of the plaintiffs' attorneys.

In the course of your retention, we may call upon you to provide information, prepare studies or reports, participate in meetings, review materials, and undertake other tasks for ACLUF, RBF, and Kirkland & Ellis LLP as counsel to transgender prisoners. We intend that your work, opinions, conclusions and communications will be covered by the attorney-client

privilege and attorney work product rule to the extent provided by law, and you agree to do all things necessary to preserve those privileges.

You agree that documents and information of any kind that you (or anyone assisting you) acquire will be maintained in strict confidence and not disclosed to any other person or party without our prior written consent. All documentary material provided to you (or to anyone assisting you) together with all copies thereof must be returned immediately upon request. In addition, any activities that you perform under this agreement and any conclusions or judgments that you reach or have reached must be maintained as confidential in the same way. You should understand that these restrictions will continue even after the termination of your consulting work for us and after the termination of the matter.

You agree that while the matter is still active, neither you nor anyone assisting you will engage in any activities that are adverse to the interests of transgender prisoners in IDOC custody or ACLUF, RBF, and Kirkland & Ellis LLP's representation of these prisoners in this matter.

Reports and other documents generated, or obtained by you, in the course of your work on this matter will be the property of the ACLUF, RBF, and Kirkland & Ellis LLP. If authored by you, the work will be considered "Works Made For Hire" and all right, title and interest in such works is hereby assigned by you to the ACLUF, RBF, and Kirkland & Ellis LLP.

The nature and duration of your retention will be determined by the ACLUF, RBF, and Kirkland & Ellis LLP and may be modified or terminated by us at any time for any reason. This agreement may not be amended or modified, nor any provision waived by any means other than an express writing to such effect which is signed by you and ACLUF, RBF, and Kirkland & Ellis LLP.

* * *

KIRKLAND & ELLIS LLP

We greatly appreciate your help in this matter, and we are looking forward to working with you.

Sincerely yours,

KIRKLAND & ELLIS LLP

By: Erica Zolner /d.e.
Name: Erica B. Zolner

Agreed and accepted this 6th day of February, 2017.

Dr. Randi Ettner

By: Dr Randi Ettner

Agreed and accepted this 9th day of February 201 .

Jan. 22, 2018

The American Civil Liberties Union Foundation

By: James D Esseks

Name: JAMES D. ESSEKS

Agreed and accepted this 22nd day of January, 2018.

The Roger Baldwin Foundation of ACLU, Inc.

By: John A. Knight

Name: John A. Knight

EXHIBIT 5

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS
EAST ST. LOUIS DIVISION

JANIAH MONROE, MARILYN MELENDEZ, EBONY STAMPS, LYDIA HELENA VISION, SORA KUYKENDALL, and SASHA REED,

Plaintiffs,

vs.) NO. 18-156-NJR

ROB JEFFREYS, MELVIN HINTON, and STEVE MEEKS,

Defendants.

DEPOSITION OF SASHA REED

MONDAY, AUGUST 31, 2020
1:00 P.M.

Via Webex

INDEX

(No exhibits marked.)

APPEARANCES:

FOR THE PLAINTIFF SASHA REED:
MS. SYDNEY SCHNEIDER
Kirkland & Ellis, LLP
300 North LaSalle
Chicago, Illinois 60654
Sydney.schneider@kirkland.com

FOR THE DEFENDANTS:
MS. CARLA TOLBERT
Assistant Attorney General
201 West Pointe Drive, Suite 7
Belleville, Illinois 62226

ALSO PRESENT:
Joyce D. Lawrence, CSR, CCR, RPR
CSR# 84-1716 CCR# 1329
Alaris Litigation Service
15 S. Old State Capitol Plaza
Springfield, Illinois 62701

IT IS HEREBY STIPULATED AND AGREED by and between Counsel for the Plaintiffs and Counsel for the Defendants that this deposition may be taken in shorthand by JOYCE D. LAWRENCE, an Illinois Certified Shorthand Reporter, and afterwards transcribed into typewriting, and the signature of the Witness is RESERVED.

****

(Deposition commenced at 12:54 p.m.)

COURT REPORTER: Do both counsel agree and stipulate that it is acceptable that I swear in the witness remotely?

MS. TOLBERT: We do for the Defendants.

MS. SCHNEIDER: We do for the Plaintiff.

SASHA REED,

called as a witness, being first duly sworn, was examined and testified as follows:

EXAMINATION

BY MS. TOLBERT

Q. Great. Hi, Ms. Reed. How are you?

A. I'm all right.

Q. All right. You'll pop up here. You pop up when you start talking.

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A. I never discussed it with them until I got to Menard.
Q. All right. Had you ever heard of a transgender woman taking hormones before that?
A. Yes.
Q. Okay. All right. Have you -- have you talked to any medical provider at any facility about having surgery?
A. Yes.
Q. Okay. What kind of surgeries did you talk about?
A. I talked to Ms. Low about having bottom surgery. I filed grievances, which got denied.
Q. Okay. And where was that? Was that at Menard or was that before?
A. Menard and Lawrence.
Q. And was that Menard the first time or this time?
A. The first time.
Q. Have you talked to Dr. Siddique or anybody at Menard this time about having surgery?
A. Yes.
Q. Okay. Who did you talk to?
A. My last mental health doctor, Ms. Myers.

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Q. Courtney Myer?
A. No. No, not her. It's another Myers.
Q. Okay.
A. She doesn't work here anymore, though.
Q. Got it.
And what did -- what did Ms. Myers say?
A. She told me that IDOC don't do those type of surgeries.
Q. Are you aware of the Transgender Care Review Committee? Have you ever heard that term?
A. Yes.
Q. Okay. Are you aware of whether any requests for surgery from you has been addressed by the committee?
A. No.
MS. SCHNEIDER: Objection. Foundation.
BY MS. TOLBERT:
Q. Are you aware, Ms. Reed?
A. No.
Q. Okay. Have you ever requested to go to Logan or Lincoln, to the women's division?
A. Yes.
Q. Okay. When did you first request that?
A. In some previous grievances that I filed and I requested and the request went through, but it

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hasn't got approved yet this time around since I've been here.
Q. Got it. So you're -- you're waiting to go to -- is it Logan?
A. Well, they submitted me. They -- I don't know. They submitted -- they recommended or whatever. I don't know. I guess I got approved or whatever. So I don't want to say that I got approved or anything but --
Q. Got it. So you haven't been told if you're going to go soon?
A. No. They just said I was put in for it.
Q. Okay. All right. So -- all right. Who told you that?
A. Mental health and my attorney.
Q. Since you started taking hormones in 2017, what kind of physical changes have you had?
A. My breasts, my hands are a little softer and I don't grow, like, hair as much as I used to. And like, I -- my face is a little more feminine.
Q. Okay. Okay. Do you still have to shave?
A. Sometimes, yes.
Q. Okay. Do you have access to a shaver or

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the razors to shave?
A. No.
Q. So how do you shave?
A. Okay. I get what you're saying. Sorry. I have my -- I have my own personal.
Q. You have an electric razor?
A. Yes. My personal, yes.
Q. Okay. And how good of a job does that do on your facial and body hair?
A. Not so good. It breaks my skin out. I always have, like, little bumps and stuff like that. So it doesn't do a good job.
Q. Okay. All right. How about, have you been given permission to wear a bra?
A. Yes.
Q. Okay. Did you have to get that -- get a slip from medical?
A. A permit, yes.
Q. And when did you get that?
A. When I first got down here.
Q. Okay. The first time or the second time?
A. Actually, I got a permit when I was here and at Lawrence.
Q. Okay. So you had had that permit for

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several years?
A. Yes.
Q. Okay. All right. How many bras are you allowed to have in your possession at any one time?
A. Four.
Q. Four. How about other women's undergarments, are you allowed to have those?
A. No.
Q. Okay. Now, tell me what you're wearing. It looks like a scrub top. But what kind of -- is that a top that you buy in the commissary?
A. No. This is the -- the state-issued uniform.
Q. Okay. And is that the same uniform top that the male prisoners would use or would wear?
A. Yes. Everybody wear the same uniform.
Q. Got it. Got it.
Ms. Reed, how tall are you?
A. Like, 5' 10.
Q. And do you know approximately how much you weigh?
A. 169.
Q. What size is your -- your blue top. Do you know offhand?

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A. A large.
Q. It's a large, okay.
And then how about pants, do they have pants that fit you?
A. Yeah.
Q. Okay. And -- go ahead.
A. I just got a pair of pants that I feel that fit me for my -- and that's a medium.
Q. So they did have smaller sizes?
A. Yes.
Q. Before that, were you wearing larger ones?
A. Yes.
Q. Okay. And did you have problems with the fit on those?
A. Yes.
Q. Okay. All right. And then do they have shoes that fit? Do you have smaller feet or bigger feet?
A. I wear a size 9.
Q. Okay. So they probably have shoes that fit you there, right?
A. Yeah. You can buy your own shoes.
Q. Yeah. Are you issued shoes at all or do you have to buy them?

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A. You buy your own shoes.
Q. Okay. All right.
So what's your current housing unit?
A. I stay in North 2 cell house.
Q. Uh-huh. What gallery?
A. North 2-7 gallery.
Q. 7? I'm sorry.
A. 7 gallery.
Q. 7 gallery. And do you have a cell mate?
A. No.
Q. No. Have you ever had a cell mate at Menard?
A. No.
Q. Okay. How about at Lawrence?
A. No.
Q. How about at Pontiac?
A. Yep.
Q. You did at Pontiac?
A. Yep.
Q. Did you have the same cellie the entire time you were there or did you have more than one?
A. I had a cellie for two months, until I got out of seg, and that was the same one.
Q. So the only time you had a cellie at

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Pontiac was when you were in segregation, right?
A. Yes.
Q. And how did you get along with the cellie?
A. It was okay.
Q. Okay. I mean, he didn't fight or hurt you or say bad things?
A. No.
Q. Okay. All right.
How, in general, are you treated by the other inmates at Menard?
A. Horrible.
Q. Okay.
A. Like, you know, Menard is an old prison, whatever. It's not like other facilities where they got, like, solid doors, whatever. And we have bars here. So anybody that walks past your cell, they can look in your cell. So, you know, I have guys that walk past my cell that harass me, sexual harass me, and make little statements to me. Pretty bad.
Q. Okay. So is -- and not to discount verbal harassment, but is the harassment from the other inmates verbal or have you had any physical kind of assault happen?
A. Since I have been here, it has been

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verbal.
Q. Okay. How about before you got to Menard this time?
A. When I was at Lawrence.
Q. What happened -- I'm sorry. Go ahead.
A. I had two fights.
Q. Two fights?
A. Yes.
Q. And why -- why were you fighting?
A. Because one inmate attacked me for no apparent reason.
Q. Okay.
A. And the other fight I had was because I was going through the --
Q. Could you repeat that?
A. I had one fight that was because someone attacked me and I had stitches and stuff like that. And another fight was because I was going through some little issues as far as my transgender issues and stuff and I was stressed out and whatever.
Q. Okay. All right. And were you attacked by other offenders or how did those two things happen?
A. Yeah. I was attacked.
Q. Okay. Now, at Menard, now days, because

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of the COVID, it's my understanding that you're not going to the chow hall; is that correct?
A. No. Just showers.
Q. Okay. So you're taking all of your meals in your cell, right?
A. Correct. Yes.
Q. Okay. Who is delivering meals? Is it a porter or is it staff?
A. Sometimes it's the COs, sometimes it's the workers.
Q. Okay. And then you mentioned showers. How are you showering at Menard?
A. I shower by myself, but there's no privacy because open bars. People who are out on the hall passes, they come back looking and making comments and stuff like that. So there's no privacy at all.
Q. Okay. All right. How is your relationship with the correctional staff?
A. Not good. I mean, I just stay out of their way because I deal with them harassing me and making sexual comments towards me. So I just try to stay out of their way.
Q. And is that every staff member that you encounter?

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A. Not every staff member I encounter, but a majority of the staff members I encounter, they always have something to say.
Q. Okay. Can you name any staff members who don't harass you?
A. I know one officer I'm cool with. His name is -- his name is Help or something. I don't know how to pronounce his name.
Q. That's okay.
A. There's a few I'm cool with and there's others that pick with me.
Q. Okay. How about the -- the senior officers -- sergeants, the lieutenants, the majors, do you have any encounters with them?
A. Not really, no.
Q. Okay. Have you ever had any conversation with any Menard -- well, any Menard warden since you have been there?
A. Yes.
Q. Okay. About issues you were having being a transgender woman?
A. Yes.
Q. Okay. Who did you talk to?
A. The head warden. I don't know his name. I think it's Franklin.

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Q. Frank Lawrence, maybe?
A. I don't know his name.
Q. Okay. And what did you tell him?
A. I asked him, I said, hey, do you know when the female cosmetics is supposed to be coming on commissary or whatever and he told me he don't know when, just keep putting it on my commissary slip. If I get it, I get it. That's about it.
Q. Okay. But did you tell him or talk to any warden about problems with staff?
A. No.
Q. Okay. So it's your understanding that the female commissary items are coming to Menard, right?
A. Right.
MS. SCHNEIDER: Objection.
BY MS. TOLBERT:
Q. You can answer.
A. You said, do I think they're coming?
Q. No. Do you know that they're coming?
A. They say they're coming, but there's --
Q. You haven't been told when, right?
A. (Shakes head).
Q. Okay. And do you know what kind of items are going to be available?

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groups every month, all of the transgenders, and we talked about, like, different little things and stuff. And, like, right now, there is none of that going on here.

Q. Okay. Do you personally know any of the transgender women that are housed at Lawrence?

A. I did a few of them.

Q. I'm sorry. Go ahead.

A. I knew a few of them that was there when I was there.

Q. Okay. Do you know any of the transgender women who are currently housed at Logan?

A. Janiah.

Q. You know Janiah. Have you had any contact with Janiah since she has been at Logan?

A. No.

Q. Okay. Has anyone told you how she's doing?

A. I heard that -- from what I read in, like, transcripts or whatever, she's -- her story that she told, all of that court hearing or whatever, that she -- she's okay and just that she has issues, or whatever.

Q. So when you say transcripts, you mean of the preliminary injunction hearing?

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A. Yeah.

Q. Okay.

A. I wasn't there to hear, so I read everything.

Q. Sure. Sure. Okay.

MS. TOLBERT: I think that's all I have right now. I might have some redirect, but --

MS. SCHNEIDER: Okay, Sasha, are you doing okay or do you want another break.

WITNESS: I'm cool.

EXAMINATION

BY MS. SCHNEIDER

Q. I'm just going to ask you some questions. It will probably be very brief but I just want to ask some clarifying questions and just about your experience primarily in the last few months when you have been at Menard.

Just for the record, we talked a lot about your different stays at places. Do you know approximately when you were transferred from Lawrence to Menard this time around?

A. I left Lawrence in, I would say, October of last year.

Q. So October 2019 or 2018?

A. 2019. I think it was November or

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October. I can't remember.

Q. And just generally speaking, Sasha, since you have been at Menard this time around, do you feel safe there?

A. No.

Q. Why not?

A. Because of the harassment, sexual harassment, and the threats that I get from inmates and stuff.

Q. Do inmates call you by female pronoun -- she, her -- or male pronoun -- he, him?

A. No. They -- majority of the inmates call me -- use male pronouns.

Q. How does that make you feel?

A. Don't feel -- makes me feel not a woman to say, yeah, him or he.

Q. What about the guards at Menard, Sasha, do they call you by female or male pronouns?

A. No.

Q. Do they call you by male pronouns, the guards?

A. Yeah, they use male pronouns.

Q. How does that make you feel?

A. Less of a woman. You may have, like, maybe, one or two officers that use female pronouns,

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but the majority of them use male pronouns.

Q. When an officer uses a male pronoun, in the past, have you corrected he or she?

A. Yes. I correct them. Like, you mean Mrs. Reed, and they'll tell me, no, Mr. Reed. You are in a male facility, you is not a woman.

Q. What about the medical staff, do -- have you encountered nurses or doctors at Menard who have called you by male pronouns?

A. Yes, I have.

Q. About how many?

A. The majority of the ones that I see use male pronouns, yeah.

Q. And have you tried to correct the nurses or doctors when they use male pronouns?

A. Yes.

Q. And what do they say in response or what have they said?

A. Majority of them will, like, ignore me when I say it and then some -- like, only one of them, like, oh, I'm sorry Miss -- Mrs. Reed.

Q. I believe you talked about this earlier, but I just want to clarify. Do you have access to any sort of transgender group therapy at Menard?

A. No. From what I was told is that they

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not doing it down here.
Q. Since Menard -- since you came to Menard, have you experienced depression or anxiety?
A. Yes.
Q. What do you attribute -- I'm sorry. What do you attribute that depression or anxiety to?
A. Sorry. Can you say that again?
Q. Why have you experienced depression or anxiety?
A. Because I'm not receiving adequate medical treatment.
Q. And when you say adequate medical treatment, treatment for what?
A. Like, for my, like, transfer hygiene items and stuff like that.
Q. Let's talk about hygiene items. What hygiene items have you requested at Menard?
A. I requested soap, shampoo, lotion deoderant, makeup.
Q. And have you received any of those items?
A. No.
Q. Have you been told when those items will be available to you at Menard?
A. No. They tell me that it's coming, but

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it never comes. Just -- I just get the runaround every time.
Q. So when was the first time -- since your time at Menard, taking a step back, since October 2019, when was the first time that you requested gender affirming grooming items?
A. In some of the grievances that I filed.
Q. Since January 2020, have you filed grievances or requested gender affirming items from IDOT staff?
A. Yes.
Q. And what was the response to your request?
A. That they're coming.
Q. And have they come, to your knowledge?
A. Nope.
Q. And how does it make you feel to not have access to these gender affirming grooming items?
A. Like, I be feeling like -- like, I need those items on a daily basis so that, you know, take care of my routine and as stuff like that. But not being able to have those things, you know, it caused me to, like, think about harming myself and just -- I don't know. Just don't feel right not being able to have those things.

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Q. Let's talk about -- you mentioned your showering and you say you shower by yourself; is that right, Sasha?
A. Yes.
Q. Is the shower private?
A. No.
Q. Why -- why isn't it private?
A. It's an open bar cell.
Q. Just --
A. It's like a cell, but it's a shower there. So if you walk past, anybody can look in there.
Q. Is there a shower curtain?
A. No. I requested a shower curtain in my grievances and stuff like that and they lied and said they were being utilized, which they're not.
Q. So you filed a grievance asking for a shower curtain and they said you had access to a shower curtain; is that right?
A. Yes.
Q. And to this day, do you have access to a shower curtain when you shower?
A. No.
Q. How does it make you feel to not have a private shower?

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A. Very uncomfortable because everybody that walks past always look in there.
Q. Sorry. I just have a few more questions. Sasha, when was the last time, to your knowledge, that you got your hormone levels tested?
A. Sometime this year.
Q. And this year, since that hormone testing, have you experienced any sort of, like, pain or discomfort in your breasts?
A. Yeah. I be having breast pain a lot. Yeah.
Q. And have you reported that pain to any staff at IDOT?
A. Yes, I reported it and they ordered a mammogram to be done and they -- but they denied it.
Q. When you say they denied it, what did you hear when you asked -- when you were told the mammogram was denied?
A. They sent me a form saying that Wexford -- I don't remember the doctor's name -- but it said that it was denied and I filed a grievance about it.
Q. And do you recall, like, on what day you got that form that the mammogram was denied?

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A. Like, two weeks ago.
Q. Do you get pat-down searches at Menard, Sasha?
A. Yes.
Q. And do male or female officers conduct the pat-down searches?
A. Male officers.
Q. How does that make you feel to have male officers conduct those searches?
A. Really uncomfortable. When I asked them to -- can I have a female officer pat me down or strip search me or whatever, or a nurse, they always tell me, no, I'm in a male facility, I don't need no female officer to pat me down.
Q. When was the last time you were patted down by a male officer?
A. When I was in seg.
Q. What about strip searches? Do you get stripped searched by male officers?
A. If they are necessary, yeah, they do it.
Q. And how does that make you feel?
A. Uncomfortable.
Q. All right. Have you requested hormone injections, Sasha?

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A. Yes.
Q. And do you recall approximately when you made that request?
A. I made it when I filed some grievances when I got down here and I also requested through mental health.
Q. And what were the responses to these requests that you received?
A. That IDOC don't do hormone injections.
MS. SCHNEIDER: Okay. That's all the questions I have. Thank you, Sasha.
MS. TOLBERT: I have just a -- just a very brief redirect.
Are you doing okay, Ms. Reed?
WITNESS: Yes.
FURTHER EXAMINATION
BY MS. TOLBERT
Q. Okay. So your attorney asked you about medical treatment, things that you were dissatisfied or what -- you mentioned you wanted transfer and hygiene items.
A. Yes.
Q. Do you consider transfer to be medical care?
MS. SCHNEIDER: Objection. Foundation.

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Form.
MS. TOLBERT: Well, he testified -- she testified to it.
BY MS. TOLBERT:
Q. Do you consider a transfer to be a medical treatment?
MS. SCHNEIDER: Same objection, but you can answer.
MS. TOLBERT: Okay.
WITNESS: No, that's not medical treatment.
BY MS. TOLBERT:
Q. And how about hygiene items?
A. No.
MS. SCHNEIDER: Objection to foundation. Form.
BY MS. TOLBERT:
Q. Okay. And you mentioned you had complained of breast pain. When was that?
A. I complained of breast pain sometime last month.
Q. Okay. I apologize. Who did you tell that to?
A. The nurse and the nurse practitioner, Ms. Zimmer.

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Q. Okay. And was -- did Ms. Zimmer put you in -- make a request for Wexford to send you for that or did Dr. Siddique or do you know?
A. Ms. Zimmer did.
Q. Okay. And Wexford denied you that, correct?
A. Yes.
Q. Okay. Are you aware of whether anyone in the IDOC denied you that?
A. No. Wexford.
Q. Got it. Have you spoken to Ms. Zimmer since that denial?
A. No.
Q. Okay. So -- well, I know the answer, but I need to ask it anyway. Are you aware of whether she had resubmitted that request to Wexford?
A. Well, I don't know. I was seen today by a -- before I came up here, I was seen by another nurse practitioner and they said that -- I forgot what he said, but there was some doctors going to look into the breast pain I'm having or whatever.
Q. Okay. All right. So you have discussed it with other medical providers since you have been denied, correct?
A. Yes.

EXHIBIT 6

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS
EAST ST. LOUIS DIVISION

JANIAH MONROE, MARILYN)
MELENDEZ, LYDIA HELENA)
VISION, SORA KUYKENDALL,)
and SASHA REED,)
)
Plaintiffs,)
)
vs.) No. 18-156-NJR
)
ROB JEFFREYS, MELVIN)
HINTON, and STEVEN BOWMAN,)
)
Defendants.)

The videoconference deposition of MARILYN MELENDEZ, called by the Defendants for examination, taken pursuant to the Rules of Civil Procedure for the United States District Courts pertaining to the taking of depositions, taken before Verla A. Todd, Certified Shorthand Reporter in and for the State of Illinois, CSR License No. 084-003498, taken via Webex on the 20th day of August, 2020, commencing at approximately 9:10 a.m.

APPEARANCES

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Appeared on behalf of the Defendants

INDEX TO TRANSCRIPT

INDEX TO EXHIBITS

ID

NONE MARKED

(Witness sworn)

MARILYN MELENDEZ,

called as a witness herein, having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MS. COOK:

Q. Ms. Melendez, you know you are here for a deposition in a lawsuit that you are a party to in the Southern District of Illinois, correct?

A. Yes, ma'am.

Q. And can you go ahead -- just so the record is clear, can you state and spell your legal name?

A. My legal name is XXX Rico Melendez, X-X-X-X-X, R-I-C-O, M-E-L-E-N-D-E-Z

Q. And, Ms. Melendez, what name do you go by?

A. Marilyn.

Q. And can you spell that, too?

A. M-A-R-I-L-Y-N.

Q. And I did see in some of your records your name was noted as Maryland, like the state. You're looking confused. Would that -- to your knowledge would that have been a mistake?

A. Probably.

Q. Have you ever had your deposition taken before?

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because while I'm in seg, a lot of my legal envelopes, some papers were taken. They said they were torn or altered or got thrown away. A bunch of my materials are jumbled up along with my mail. I'm still trying to sort it out.

Q. And so has anybody tried to put a cellmate in with you since 2018?

MS. ROSE: Objection, form, vague.

BY MS. COOK:

Q. Has security staff attempted to put a cellmate in your cell with you since 2018?

A. There has been a few times where they'll come by asking me if I could help them out and get a cellie since some cells obviously -- it's an old facility, either the cell leaks or something is wrong with the cell. And I will tell them like if it's somebody you'll let me recommend that I get along with, I don't have a problem, but if you're trying to throw a random individual in there, no, because, you know, that's like you're just asking me like hey can you have a cellie and I say yeah and then you put somebody in here and we end up fighting or whatever disagreement and I end up going to seg over something that they did.

Q. So what happens in that scenario?

A. Well, for one scenario, for example, they put

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me in a cell with a guy named Davonte [phonetic]. At first he seemed okay. Then eventually he started asking me disturbing sexual questions. I said look man, just leave me alone, I have to be in a cell with you, you have to be the cell, you don't have to talk to me, you can do your prison bit, I'll do mine, leave me alone. Then eventually he started saying that if I do not, forgive me, suck his dick that he will take it. So I said what are you trying to say, that you're going to rape me? And he got aggressive and tried to hit me and we fought and went to seg over that. I told staff about it because I didn't want to be in a cell with him from the beginning, but at that time it's like okay if I don't want to be in here with him, he doesn't want me, I'm not going to be the one to walk myself from [inaudible] housing and do some time in seg over this stuff that staff can easily fix. They could have easily put me in a cell with somebody else, and they chose not to. His exact words, which was Lieutenant Bennett [phonetic] at the time, he says you can either, excuse my language, fuck or fight.

Q. And when did that happen?

A. That was in 2016.

Q. And what you described earlier where staff will say hey will you help us out and take a cellmate

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right now, if you say only if I can select the inmate as my cellmate, then what does staff do then?

MS. ROSE: Objection, calls for speculation, foundation.

BY MS. COOK:

Q. You can answer if you understand.

A. I'm fine.

Q. Do you understand the question?

A. Can you rephrase the question?

Q. Sure. So let's say an officer comes up to you and asks you can you help us out and take a cellmate, we're trying to move people around right now, and you say I will only accept a cellmate if -- something like I will only accept a cellmate if I can select him and I have some input, then what does security staff do or say to you after that?

MS. ROSE: Same objections. Go ahead and answer if you understand the question.

THE WITNESS: They will either say that if I say yes that I don't get to pick and choose because either it's the fact that I don't dictate their pace, they make the rules, they set their scenarios and boundaries, or it's the other ones who say we knew you would say that sissy, you're just trying to have somebody so you can have sex.

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BY MS. COOK:

Q. Do they put -- do they end up putting somebody in with you in that scenario?

A. They have tried, but I know you can always -- in my position I've learned that I can ask for a crisis team. That way something is either documented, or mental health will explain to them, you know, I'm transgender, the issues and situation. I can ask to have a PREA filed, and then once I start doing that, they're like oh we were just playing with you. Or it's that they tried to and as the person got to my cell, I'll tell them look man, I don't know you, I don't want you in here. If you come in here, I'm letting you know. I'm not playing with the staff. I told them if anyone who's in here I'm not comfortable with, I'm not letting you in the door, get in a fight. So the person will tell the lieutenant look I'm not trying to go to seg if they're going to fight me, and they will put them somewhere else, magically find an open cell or space or cellmate or something.

Q. And has staff asked you to accept a cellmate in your cell with you since 2018?

A. They have even though they know that I am single cell status, and having that status I'm not even supposed to have a cellmate. So they shouldn't even be

asking me that if on my paper single cell status, but that's what they do to either make room or accommodate somebody.

Q. How many times have they asked you since you've been on single cell status?

A. Four times.

Q. In those four times since 2018, have you just said no?

A. I mean, yeah. If they're not going to allow me to pick somebody that I feel comfortable with or I have known for a while, then I'm fine, don't give me a cellie. But if you're asking me to help you out, if I'm helping you out, why would you put me in a messed up situation or why would you put me in a situation that's going to be harmful to me if I'm the one helping you out?

Q. And have you been disciplined because you said no?

A. I mean, there's the occasional my cell will get shook down after it's been shaken down and stuff like that. I will go in there some stuff will be missing, you know. It's tricky. They do things in ways to punish an individual and make it seem like it's according to their 504 rules, just like this ticket that I'm in seg for.

Q. And when you were put on single cell status, was this something that was verbally communicated to you, or did you receive a letter informing you of that?

A. No. When I wrote Emily Ruskin, they eventually have what call cadet training or tours where they have people walk galleys or floors with the staff, and she was walking by and she told me, she said hey, don't worry, you're getting your single cell status. With Emily Ruskin anything that tells you it's usually the best of her knowledge what she's doing or something that's gonna be done. So when she said it, I took her for her word and eventually -- at five gallery they have a cage where they have a board -- a dry erase board with a list of people who either have permanent cells or whatever they have, and they'll put single cell if you're not allowed to have cellies in your single cell and eventually that was put on there.

Q. And you're talking about like a dry erase board for staff?

A. Yes, so they know -- like if somebody moves from 17 cell to 20 cell, they put their name, erase it and put it here or whoever their cellie is. If they have permits, if they're handicap and stuff like that, they use that to know.

Q. I want to switch now a little bit to your past medical and mental health history. I will talk about gender dysphoria separately, but I just want to know based on your records you do have some -- a psych history; is that correct?

MS. ROSE: Objection, form, vague. You can answer if you understand nine question.

BY MS. COOK:

Q. You can answer.

A. My psych history, are you saying that I have mental illnesses or disorders or that I take psychotropic medication? I don't completely understand.

Q. Well, all of that. So you have -- have you been diagnosed with mental health or psychiatric disorders?

A. Yes.

Q. And what are those?

A. Bipolar, depression, anxiety.

Q. And when were you first diagnosed with those?

A. Bipolar and anxiety at a very early age. Depression was never actually done because, you know, as a juvenile getting in trouble at school, sometimes they will recommend that oh your child needs anger management or they need to go to therapy or counseling for their issues. And from there my mom would have me see people. That's where I was being bipolar, that I had anxiety.

And before anything else was done, shortly afterwards I had got incarcerated.

Q. So have you received prescription medications for the diagnoses?

A. Yes. Outside of the world, yes, and then coming to prison, St. Charles and IYC Joliet said -- their exact words were since I'm a ward of the state, certain medications aren't listed on their approved psychotropics to give to inmates. So the medication I was on in the world they -- if it's not approved in here, they will not give it to me. So they gave me other medication that they deemed was necessary for me to help me with my disorder.

Q. And then what happened when you came into the adult system?

A. Basically the same thing. They said that I have a history here and they have reviewed it and said that we're going to keep the same medications that you had back then, it seems to be working fine.

Q. The same medication that you had in the juvenile system or the same medication you had in the world?

A. In the juvenile system.

Q. And what has your access to mental health staff been like for your bipolar disorder, depression

Q. Well, I guess I can split it up in two ways. Have you attempted suicide?
A. Yes.
Q. And when have you done that?
A. How many times or do you want like the year?
Q. Both. So how many times have you attempted suicide?
A. A few times. At least five about now.
Q. When was the last time you attempted suicide?
A. Let's see. So the day I went on watch was the 5th of this month.
Q. So August 5?
A. Yes.
Q. Was it before -- did you attempt suicide before or after the basis for your discipline?
MS. ROSE: Objection, vague, form and foundation.
BY MS. COOK:
Q. You can answer.
A. Do I have to answer that question?
Q. I'm not trying to ask you anything that is not relevant to this case, but part of the case has to do with self harm and suicide of transgender prisoners. And so I just want to get a sense of the timing. I'm not trying to ask you anything to upset you, but I would

like to know what precipitated the suicide attempt.
MS. ROSE: Marilyn, would it be helpful for Ms. Cook to repeat the question?
THE WITNESS: Can you --
BY MS. COOK:
Q. How about I ask it this way. Approximately what time of the day on August 5 did you attempt suicide?
A. It was before med lines in the morning, so med lines come anywhere from four to six. So before that I had woken up and tried. I didn't look at the clock really.
Q. So probably before 4:00 a.m. you think?
A. I'm going to be hones with you. It's tricky because med lines aren't always done at 4:00. That's why they have 4:00 to 6:00 range. They might start from a different cell house and make their way to other sell houses. That's why all I know is that I had woken up, you know what I'm saying? I tried something I wasn't in -- and me trying to kill myself I'm not worried about time or looking at what time it is. If that's what you're asking, I don't know.
Q. No. So it was the early morning hours. Was it still dark outside?
A. Yes.

Q. And what were you feeling that caused you to try to commit suicide?
A. My gender dysphoria.
Q. What about gender dysphoria?
A. I mean, I don't want to sound rude but what about it? It's happy, something that you want to live.
Q. Was there anything in particular or was it just, you know, a general feeling?
A. I will try to sum it for you. Reflecting on my life of constantly being ridiculed, disrespected, looked at as a freak, as an abomination, as some COs say something that my mother should have swallowed instead of birthed. Maybe the fact that I have to take medications. I have to attempt to get surgeries so I can feel aligned with myself. The disturbing fact that I have testicles, that I have a penis, that I have an Adam's apple, that I've gone through male puberty, things like that.
Q. When you tried to commit suicide on August 5, was that all you were thinking of when you tried, or were there other things on your mind as well?
A. I mean, I thought maybe it's easier to get the suffering over with. Yeah, I thought about that.
Q. Are there people who you can talk to when you feel like that?

A. You mean staff in prison, or do you mean family members and friends?
Q. Anybody.
A. Well, in my current situation I can't have video visits. I can't message my family. I'm only given the phone once a week and their system is messed up so we can't even use the phone. As of right now all I can do is write, and sometimes having to wait that long to communicate with somebody through snail mail, no, not right now.
Q. You mean while you're in segregation you're limited in how you can communicate with others outside?
A. Yes.
Q. Before being in segregation -- I know COVID has kind of messed up like in-person visitations, but even while COVID was underway and when you were in just protective custody status, could you have phone calls with your family?
MS. ROSE: Objection, form.
THE WITNESS: Yes.
BY MS. COOK:
Q. How often?
A. I'm sorry, how does this have to do with the suicide, conversation with my family?
Q. I just want to know how often you're able to

whoop-de-doo, I have gender dysphoria.

Q. Ms. Melendez, I'm sorry to interrupt you. I don't -- I'm not arguing whether you have gender dysphoria or not. I just want to understand if you have received a diagnosis that was documented because, as you pointed out, often the prison goes by the records they've already received. So I just want to know at what point it was recorded that you have gender dysphoria. And I don't have your juvenile records and I don't have your childhood records.

So I just want to know if, to your knowledge, before you came into the adult system you had been diagnosed with gender dysphoria?

A. Like I had said, IYC Joliet and St. Charles were not doing mental health evaluations. They weren't doing evaluations for anything. So that's why there wouldn't be any records because is there is no mental health staff there, how can they write anything down if there is no people to document it?

Q. So you don't have a reason to suspect that your records would say anything about gender dysphoria? Is that what I'm getting?

A. They wouldn't say anything about it because when I asked about hormones or about being housed separately, it's this is what it is. You are here,

you're doing your time, we don't do that. These counselors never wrote that stuff down, and I can almost guarantee if you find these records, they won't have anything to say about mental health evaluations, transgender. Mostly you will find paperwork that will say they came from detention center, these medications were prescribed, continue medication.

Q. And again -- and I think I asked you this last year, but I just want to confirm that nothing has changed. You haven't seen your IDOC medical or mental health records; is that correct?

A. No, not really.

Q. What do you mean by not really?

A. I haven't physically seen them. I've been told by staff when I see them that this what the levels are, this, this and this. Sometimes they'll say that I'm doing fine off what they've written. I will ask what does that mean, and they won't really tell me that. I had one scenario where I just got switched over to a medication. They did blood tests, and I asked how is it going and they said that it looks okay. And I asked, well, what are the dosages, what's the levels, do I need to go up, down or readjustments? Well, you look fine. Everything has to be working fine apparently. And I asked well is my liver or kidney at risk? Am I losing

bone density, osteoporosis, something regarding blood loss or my health. Oh, well, you know, that's really Tilden's job, I'm just here to tell you you're doing fine. Scenarios like that happen.

Q. Just so it's clear, you had been raising gender dysphoria issues with prison staff when you got into the adult system; is that right?

A. Correct.

Q. But you weren't actually diagnosed with gender dysphoria until 2015?

A. That is correct.

Q. And that same year is when you began receiving hormones?

A. Yes, that is correct.

Q. So the hormones that you're taking, do you have any current complaints about your hormones?

A. The current ones as of now?

Q. Yes.

A. Yes.

Q. What are they?

A. I have been on hormone medications for five years and I'm still getting frequent erections, which being on proper dosages from what I -- I'm not a doctor, but from what I've read is that that shouldn't be happening. Still growing excessive hairs in places.

Even though it doesn't stop growing, it should thin out. Isn't happening. I was switched over from Menest to estradiol, and then I believe one or two months, not even beknownst to me, I was switched to Premarin, which I don't know even know why. I put in a medical request to see Tilden about it, and then before I ever get seen, out of nowhere it got switched back to estradiol.

They did one blood test, and I didn't even see it. I don't even know what my testosterone levels are, what my estrogen levels are. For all I know, I don't know if there's anything wrong with me. Am I at risk for blood clots right now? I don't even know. Am I at risk for osteoporosis? Is there any risks, side effects, complications that I could be facing that could be permanent? I don't even know because they won't even show me the paper when I went.

A nurse brought it to me and said this is it, didn't show it to me, said that that's Tilden's job. But Tilden hasn't seen me. I've requested to see Tilden for several months now, medical request to see medical director. Every time my medication prescription hormones run out, he's the one I see to renew them. Recently he hasn't been coming in. I just put in a medical request slip three days ago about the same issue again. He still has not seen me or even told me what my

levels are or what my risks are, if my kidneys are all right, is my liver all right, is the blood pressure and cholesterol all right from the testosterone blocker, none of that.

I even suggested that -- you know, he's telling me that 200 milligrams already is too much, and I explained to him there's other testosterone blockers that if they don't work, there is other options you can give me. It's either oh, they're implants or patches and we don't do that or it's too expensive. I don't understand where expense comes into a problem with that. If there is someone right now who needs cancer surgery, eventually they're going to get that surgery. It costs money to do it, but they don't tell him it's too expensive. So why should I be told that my medication or any surgery that I'm having is expensive if I'm a ward of the state? If somebody had cancer right now, they would do a CAT scan, MRI, chemo, radiation, whatever they need to do to help the person here. I don't understand that -- I think that's more expensive than the simple medication I'm asking for. They won't even do it because it's expensive.

I even said okay, you can't give me gender reassignment surgery, you said you're not approved, okay give me an orchiectomy. If you remove my

testes, my gonads, my testosterone is basically little to none. I don't need testosterone blockers. They save money with that. The estrogen has to be lower now. They save money off that. Still, oh well, that's an expensive surgery.

Q. So you mentioned you had one blood test. When was that?

A. It was before COVID hit. It might have been -- I think it was around March.

Q. But you don't know the results of that lab check?

A. No.

Q. And is Dr. Tilden the only medical doctor who is coming in to Pontiac right now?

MS. ROSE: Objection, foundation. Go ahead if you know.

THE WITNESS: As of right now I haven't even gone to medical, so I can't tell you who's coming in or out or if they have another medical director coming in because after five years I've been here, that's who I've always see, Dr. Tilden. That's all I know. That's all I see.

As of right now -- because I asked other inmates or staff or nurses when they do their rounds who is the medical director today, and it always ends up

being Tilden, which it's usually done -- examinations or hormones or like the stuff regarding me were done on first shift, before 3:00, anywhere from 8:00 to 3:00. So that's all I know.

BY MS. COOK:

Q. And when you want a request to see a physician, do you put in a specific request, like an M.D. request?

A. Well, they have -- they call it medical request slip and basically put your name, number, date and cell. Then they have a list. It could be stomach or bowel issue, allergies, back pain, knee pain, eye issues, you know. They don't say. Then they'll say legal medications. Nothing that has to -- they don't put anything transgender, so what I do I put an X by the box that says other and I will attach a piece of paper explaining what's going on.

So what I did recently, since I only have one month for my hormones, I put renew medication, the number, the dosage of the medication, how many times I take it a day. Then at the bottom I'll put need to see Tilden regarding blood test, need to know what's going on with test results to know about health, know of adjustment of hormones. That's basically what I have to submit.

When that's put in, routinely anywhere from five to seven days a nurse or a nurse practitioner is supposed to have us pulled out, but with COVID you don't go to health care. So it's somewhere in the cell house in a little room where they read it, asks us what's going on. You explains what's going on, and most of the time with me, with transgender, they will put refer to Tilden. That's usually what happens. The only time it doesn't happen with me is if it's to renew cream or shampoo or antibiotic or something that doesn't have to do with transgender, date and sign off.

Q. So you just haven't heard anything back about when you will see Dr. Tilden?

A. No. They always tell me that either he's not here or he's here, he's extremely busy, that he can't come over to the cell house, that he's in the health care taking care of severe patients and that with COVID I won't be going to health care unless it's an emergency or something that's extremely threatening.

Q. So it sounds like in the past -- so you had your blood test possibly in March of this year, but when was the last time you actually spoke with a medical provider about your hormones?

A. The hormones in regards as in what? Like adjustment or exactly what?

Q. Adjustment or complaints about how you're reacting with the hormones.

A. I mean, when the nurses walk by in the morning or at med line, they will tell you like look, whatever you're trying to tell me, you have to put in a sick call. So that has to be done to see that nurse. I put in three sick calls since I've been in seg from this month on the 5th. Still have not been pulled out to see a nurse. I'm being told to be patient, they will come see me.

Q. And before that -- you were talking about this month, but before this month when was the last time you spoke with a medical provider about adjusting or complaints with your hormones?

A. The last time I saw Tilden was -- when I tell sick call staff, hey, all we know is you got to see Tilden, he's not here yet or he will get to you when he gets to you or he's busy or whatever.

Q. And you do you recall about when that was, the last time you spoke with Dr. Tilden?

A. That was probably maybe March -- no, no. It had to have been toward the end of January, beginning of February, because I had seen him about the medication. He had renewed it for six months and then he said that since you've been on it for a while, I'm going to order

a blood test. That was during the time where I had went to seg and staff or medical had lost my hormones for over a month.

Q. So there was a month where you were not given hormones?

A. Yes, that is correct.

Q. And when was that?

A. The last time I went to seg before this infraction. The incident occurred in the jail where me and another inmate were fighting. They cuffed me up, took me to seg. It's routine that staff packs a seg pack, which they grab a laundry bag, put -- what they're supposed to do is two sheets, two pillow cases, two shirts, two bottoms, two bras, my fan and at least one soap, a towel and a washcloth and if they have -- the inmate has blister packs, that as well. So if I have an inhaler, that comes with it. If I have medication for whether it's hormones, cholesterol, diabetes or anything like that that's in a pack, they put that in there as well.

With me for some reason whenever I come to seg, my hormones are never ever in my seg bag. They're never brought to me. I ask staff. Oh, well, they should have put it in there, but it's not. I ask them can they check. Oh, ask the nurse, that's medication. I will ask the nurse when they do med runs,

oh we don't know where it's at. I ask property. Property says oh, we sent it to health care. So I tell health care well here is the paper from property saying it's at health care. Oh, it must be first shift that has it, we don't have it, we're second shift. I ask first shift where's my hormones? Oh, second shift must have it, we don't know where they put it at.

Miraculously nobody knows where my hormones are, but I guarantee you, and I have seen it time and time again, if there is an inmate who is diabetic, whether he takes a pill or insulin, that day when they run med lines, depending on what time they come because they give insulin shots from 3:00 to 4:00 and they do that mornings from I want to say after breakfast, so anywhere from 5:00 to 7:00 they do insulin shots. He just got here that day, hasn't even been 24 hours, it's documented he has diabetes, he needs his pill or his insulin.

Me, I'm documented with gender dysphoria. I've been on hormones for over five years, but yet every time I go to seg they somehow disappear. Oh, they're lost. Oh, we have to reorder them. The minute a hunger strike is done, the minute I need a crisis team or the minute I file a grievance, oh wait, we're going to find them. I thought they were lost. Oh

yeah, we found them. Property said they sent them to health care and they were misplaced.

If it's a medication I'm supposed to have, it should be in my seg pack. And if you think that it's not mine, they will say my name on there. The staff, wanting to be prejudiced towards me, ripped apart the stuff with my name and ID on it. Medical staff said we finally got it, but he name was ripped off so we don't know if they're really yours. I said well you guys know every month you bring me blister packs that have my hormones and the dosages. Why don't you just look on my chart and see if I get these exact medications? Yeah, but even if you do, how do we know that these are yours? What?

Q. Well, so do you -- you take estrogen and then you have the testosterone blocker. Are both of those given to you in a blister pack?

A. Yes.

Q. So the nursing staff, when they run medications, they don't bring either of those to you, correct?

A. No. They bring a month's worth supply. So let's just say they start my meds over and I have five days left. So anywhere from three to five days, they will bring the new ones. They do it enough to where you

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have enough for 30 days, and at least they add four more days in there in case it gets late coming from the medical company here. That's how they do it. They do it like that because, you know, before I seen other transgender inmates go through the problem of nurses will bring meds in the packages that they do at health care and put them in a cup and give it to you. Sometimes nurses -- I don't know why -- forget to put hormones in there. I see them go through it multiple times.

With me, instead of me going through that, I said look, you have no documents of me ever abusing medication or anything like that, just give me my hormones in a pack. That way, one, you don't have to worry about you misplacing them because I'll always have them in my cell. If nurses don't come or some excuse happens, I always have them.

Q. And when this most recent time when you went to segregation this month, did you have that same problem?

A. Yes.

Q. Have you received your hormones?

A. Eventually, yes.

Q. Do you know about how long it took that you were without them?

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A. A week.

Q. But when they brought them to you this time in August, did they bring you a whole new blister pack, or did they find your old one again?

A. They found it after they said it was lost or thrown away.

Q. Can you tell a difference in how you feel when you don't have the hormones?

A. Yes.

Q. Can you explain what the difference is?

A. Well, you know, it's kind of difficult to fully explain, but it's like, you know, knowing that I'm not getting the medication causes obviously distress, you know what I'm saying, causes my anxiety to go up because I already know in my mind they're using some excuse for not giving them to me for whatever reason, they're trying -- you know, there's that factor, and there's the one where I went for a month without having them. You know, even though that they're not what you call an addictive medication or like pain killers or anything like that, just like with all medications, if you go a certain amount of time without taking them, there are side effects of not taking them.

It's just like if you have high blood pressure and you don't want to take them no more, you

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can't just stop. You have to gradually go down to smaller dosages, just like with psychotropic medications. If they switch you over to a new medication, they give you some of your old one with the new one until you adjust. They just don't stop it completely, and I started feeling that. I started getting like -- I just get hot flashes. I just start sweating out of nowhere. I feel anxious, like I just can't sit still. My hands shake. I don't feel right. My stomach goes -- discomfort, you know. It's like when you feel like throwing up but when you do it's I guess like a dry vomit. Nothing comes out.

Q. So you have distress just by knowing you're not getting medication, and then you have these other symptoms.

Aside from -- you mentioned specifically hot flashes, hand shaking, nausea, anxiety. Are there any other physical symptoms that you have?

A. At that time, not -- no, nothing more really happened further.

Q. About how long from when you took your last hormone pills until you start experiencing these side effects?

A. You mean when did I notice that they started happening from not taking them?

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Q. Correct.

A. Within at least two weeks. That's when I started, you know, like -- you just know when you don't feel right, like I feel a headache coming, I'm getting a headache, but you can just tell when something isn't right with you.

Q. So you mentioned some conversations with staff members about the expense of the hormone or testosterone blocker. Do you remember when those conversations occurred?

A. The most recent one was when I had just seen Tilden January -- around towards the end of January, beginning of February, and, you know -- because he said that with the estradiol, even though it's the same dosage that was the Menest, obviously they're different medications and that he would do a blood test to see if my estrogen was going up or down, side effects, testosterone. He told me that if the testosterone and frequent erections continue to be a problem that he doesn't really know what he can do because, you know, the other testosterone blockers, whether it's an implant or the patch or the other one that is too expensive, saying that, you know, we can't have those.

So then I said okay, why don't you include micronized progesterone. They're known to, from

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they have to not like me and at least still respect me. Some staff don't feel comfortable saying she. So what they'll do is to have a respect thing, you don't want to call me she? Okay, you can just say Melendez is my last name, or if you feel comfortable, they, them. That way you don't have to misgender me. Some do that. Some still are -- obviously it's not a perfect world. You're going to have idiotic people who don't understand or don't want to understand other people.

Q. And so at least this year, in 2020, has the misgendering improved at all for you?

A. It's the same. I'm still getting misgendered. It's tricky. Like I said, you have some staff who obviously either in the world or in here do not have a problem with saying Ms., she or proper pronunciations to me. They don't have a problem with it. And you have some who do. Then you have other ones who I don't know what their issue is. It's like I guess they hate me. They literally -- you can see it in their face and their eyes, the way they speak to me. Some go out their way, okay sir, go to your cell. I say you don't have to call me sir, you can say Melendez. I don't want you to misgender me. All right, man, go to your cell. Say man, you don't have to disrespect me, you can just call me by last name. Okay, go to your cell sissy, how about

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that, that's not man or girl. You have those.

The minute I start misgendering them, okay miss have a nice day, now I'm getting written up a ticket. Now I'm the bad person. Now I'm wrong, just how I'm in seg for this bogus ticket right now.

Q. And when you push back or if you misgender somebody, have you actually been disciplined for that?

A. Yeah. I'm either told you're going to call me by my name and I'm a man, you're going to call me that, give me my respect. And I will tell them, okay, well respect is a two-way street. Staff are trained in their protocols to not be confrontational or aggressive or intimidate inmates, yet they do. How can you get mad at me for treating you the same way you treat me? If you call me a fag and I ask don't call me that and you call me a sissy, and I say okay you're the fag. Now you want to cuff me up for insolence and then add on to the -- oh, inmate was being threatening and intimidating toward me, they called me a sissy, fag or they'll say other things and add on, talking about that I would beat them up or that I would assault them, stuff like that. They will add things like that because certain tickets do not carry seg time. So they will add stuff that are deemed worthy. Plus a lot of the time it's the officer's word over the inmate. That's usually how it goes. So they

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know that it's my word against him, I'm going to win or it's my word against hers, I'm going to win.

Q. What kind of penalties have you faced because of something like that, an interaction like that?

A. As a ticket right now, I was going to the yard any other day. Staff shook me down, found a comb. They let me go to the yard. Lieutenant Torres said come here, go in your cell. Why? Because I said so. If I didn't commit any 504 DR rule infraction, what is the justification of me going to my cell? He said I had a comb. I'm like okay, every other time I go to the yard and I pass by you I take a comb either to braid my hair or braid somebody else's hair and it's never been an issue.

Torres is one of those people who, for whatever reason, does not like me and hates me being transgender. I hardly even speak to this man, and when I do, I'm always respectful even though he's not to me. He's saying -- you know, swearing at me go to your F'ing cell because F'ing said so. I said why? Then he starts saying the whole fag and sissy stuff. I'm like you know what, if you want to be petty and take my yard over this, you know -- I don't really want to swear, but basically I said this is some bogus ass sugar honey ice tea and F you. And he said oh, you're intimidating,

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cuff up, intimidation threats.

I never once approached him. I never once touched my fist. I never raised my voice, looked or talked to him in an aggressive or threatening or intimidating manner, but he wrote it up. These people believed it and yet here I am sitting in seg because of a lie he did.

Q. At least the staff you deal with at Pontiac, you know, what proportion of them are the ones that aren't respectful to you versus the ones who will listen to you and be respectful?

A. I mean, the ones that are respectful and are understanding or at least do their jobs to their extent and not be prejudiced is -- they're outweighed by the ones that are. And then there has been times where staff will call me Ms. Melendez or she in front of other staff and they get either cursed out or chewed out or make fun of saying oh, you got a crush on the sissy, you're calling it a girl, and they get made fun of. That's why some of them don't even say it no more. They're like man, I'm trying to be polite and here are these guys ridiculing me for being nice to somebody. That's why so many people, you know, they try not do it in front of others that will make fun of them.

Q. So in your experience the vast majority of the

staff is at least disrespectful to you?

A. Yes.

Q. And what proportion of those are just the ones who you think are malicious, who you think hate you?

A. That number is smaller because, you know, some of them aren't as older brass as others. Some might show that hate but not go to the full extent of expressing it or portraying it and doing it. You know what I mean? So like you might have one who will walk by and look at give me a look and just I hate you. They choose not to speak to me.

Like there's been times this one guy -- I forgot his name, but I'm asking him about my legal call. I said hey officer. He looked at me, gave me a nasty look and kept walking. On the way back I said hey, I'm supposed to have a legal call. He says look here, do not talk to me, do your time and I'm going to do my job, leave me alone, leave it at that. I said hey, man, I'm just asking about my legal call. You say you want to do your job, okay, find out about my legal call so I'm not late. He says hey, I told you stop talking to me. I said you said you're going to do your job, I'm just asking you to do your job. He's like okay, you're talking to me again, I'm asking you to stop talking to me. What I mean about this is you don't ever

talk to me, you don't look at me. When it's your time for the shower, I will bring you over, you go in, then I let you out or you go to the yard and come back. Other than that, do not talk to me. I'm not going to do nothing for you except for what I'm required to do. And I left it at that because I'm not going to sit here and waste my time arguing with an idiotic person like that.

Q. So in your experience none of that type of conduct has improved over this past year?

A. Over the past year, no. The stage I'm at now, I've got to go through five years of this for at least to have some people be like you know what, they just are who they are, man, just be respectful.

Q. And are you aware of any of the people who have been -- some of the examples you've given where they're just highly unprofessional, are you aware of them being reported at all for discipline?

A. I mean, obviously inmates and staff rumors pass around, gossiping and stuff like that, but as far as actually hearing and knowing about it, I can't tell you because that's usually an internal affairs thing where there's staff assigned to that specific thing and I don't know about it.

MS. COOK: Well, I think now might be a good time for a break. Is everybody good with that?

MS. ROSE: Yes, sure. Is this like lunch? Do you anticipate having a longer afternoon? Should we make this a lunch break?

MS. COOK: I don't have that much longer, so if everybody is okay pushing through, we could just do that. I don't know what Ms. Melendez's lunch situation is like there. I don't know if they have a bag waiting for her or what.

MS. ROSE: Okay. Are you okay to continue with just a short break and then just continuing? It doesn't seem like we're going to be that much longer.

THE WITNESS: That will be fine.

MS. ROSE: So let's meet back in like 10 minutes.

(Recess taken)

MS. COOK: Back on the record.

BY MS. COOK:

Q. I know that in the preliminary injunction hearing you noted that you had been requesting women's clothing. Has anything about that changed in the past year?

A. No. The only thing they still provide is a sports bra.

Q. Have you heard anything about changes in commissary that may be occurring in the Department of

Corrections?

A. No. I have written two commissary supervisors, Ms. Stooks and Ms. Wolf. I have written them letters asking about it, and either I don't get heard back and I can't personally speak to them anymore. Because of COVID our commissary is brought to our cell now. We don't go over there.

Before, before Emily Ruskin left, she was trying to have it to where -- you know, she would grab items, put them through the TAC team, because it's a max prison, so certain things we won't be able to get. For example, like an emery board they say we can't get because it's like a sandpaper and if anybody purchases it, they can use it to sharpen objects. So certain stuff like that she said we wouldn't get. She was trying to get it like -- you know, try to get us everything we could to have, and that's when she had left. The new warden, Leonta Jackson, isn't doing anything about it. When I was in seg, he did a walk-through. I asked him about it. He says don't get my hopes up anytime soon.

Q. Is that about clothing and hygiene items, or did you just ask him -- what did you ask Mr. Jackson?

A. When I saw him, I asked him if I could speak with him. I asked like man, before the previous warden

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had left, she was in process of trying to get items as far as cosmetic, hygiene, clothing, you know, stuff like that we're allowed, and I was trying to go into depth and explain better shampoo and stuff like that. He says don't get my hopes up anytime soon.

Q. You had mentioned that you could get some hygiene items, like soap or shampoo or lotion maybe, by asking medical staff. Are you able to get any medical prescriptions for the hygiene items you want?

A. As of right now the only thing I'm getting is supposed to be -- they call is T/Gel Shampoo, anti-dandruff charcoal, and it's basically like if you have sensitive scalp, irritation, rash, dandruff. I think psoriasis is one of them. They prescribe it for that, and they give me Minerin Creme, which is for like diabetics or people with severely dry sensitive skin. So they gave it to me because the testosterone blocker dries the skin out, so they gave it to me for that. Plus the soaps they sell here, it's -- even though they're for men, the main issue is that they dry me out. The skin cracks or it makes me just itch all over. So that's why they prescribed it.

Q. So do you still get the Minerin Creme, too?

A. Yes.

Q. But has anything changed with -- I think you

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discussed that you were seeking different soap. Are they offering different soaps to you at the commissary?

A. They do have a variety of soaps, yes, but as far as them actually being usable for me, no. Like for now I have to settle with a mild soap that, even though it's unscented, still dries me out but does me make -- like right now it doesn't make me oh, I've got to scratch all over, it's bearable, versus -- because they had another soap, Palmer's cocoa butter soap, that worked fine, but they stopped selling it and put a different soap on there. Then the Lever, which is the other soap I could use, they stopped selling that and put another soap on there. So now I'm stuck with having to pick a soap that I guess I could tolerate until -- that isn't that the bad I guess. I have to make it work. I don't have a choice.

Q. You also mentioned issues with the brush that you were offered at Pontiac Correctional Center. Have they offered any other brushes that work better for you?

A. No. All they have is little small palm brushes, like little plastic bristles, and the problem with that is I have thick hair. It's not -- I can't untangle my hair with that. Like right now they've taken my combs that I had. They've taken them. All they give me is a palm brush. I have to use my fingers

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to try to untangle and comb my hair.

Q. When you were in protective custody, did you have a comb that you could use?

A. Yeah. I've had these three combs for four years when they were selling them. I tried to take care of them because they don't sell them anymore. It's hard to get them. And I went to seg over a comb, lost that one. The other two I had in my property they're trying to say they are unauthorized. For whatever reason I don't know. But, you know, I basically explain the property like how is it that it's unauthorized if it was once sold on commissary? They have a rule that anything that was once sold they cannot take from us unless it is deemed extremely dangerous. So if they were selling something that had like a real hard piece of plastic that you could use to stab somebody, they would look at anybody who buy it, shake the cell down or do a whole prison shakedown and take them. Every time TAC team shakes my cell down or has shaken my cell down, the combs aren't taken. Certain people, like whoever is in property, are just doing it because they know oh screw it, let's take their comb.

Q. Are they plastic combs?

A. Yes, they are. It's a black plastic comb about three or four inches.

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Q. Is it like a wide tooth comb?

A. No, it's like a little pocket comb. It's about that wide and about this long [indicating]. That's it, small teeth, but it's -- the label says unbreakable, so it's extremely hard.

Q. Just so the record is clear, when you said how big it is, can you just say what those approximate dimensions are?

A. It's about three or four inches in length and maybe at the most one, one and a half inch wide, not that much really. Fits in your pocket.

Q. And you mentioned that you wrote to the commissary supervisors. What were you writing to them about?

A. Asking if there was any followup of approval items from the previous warden, Emily Ruskin, regarding the products. I had written a list down. I said I don't know exactly what she could have or didn't submit, but here is a list of certain things. And it's frustrating because I don't know if they're doing it out of spite or if they're being lazy or maybe they just feel whatever they have or selling now is adequate I guess. If you're selling deodorant and I'm asking for the same solid deodorant or clear deodorant that's sold but the only difference is it might be Lady Speed Stick,

not even not even used different, and they're not trying to approve it. Certain things like I don't even understand why you wouldn't just approve it. If it's something that -- like maybe you could say nail polish remover. Somebody might try to drink it or kill themselves or throw it at staff or metal tweezers.

You know, certain things that would actually pose a security issue, I could understand. I'm in a max prison. It's not a minimum. So that's understandable. It's just the things that we do get in here, the only difference would be they would be for women. It's like they're not even trying to do it.

Q. Do you remember what specific things you had asked about?

A. I had asked for shampoo, and they said that they have a new rule that the shampoo bottles have to be four ounces. Why I don't understand because they sell us 20 ounce pop bottle. But I said okay. So I have the catalog that the prison orders from. I specifically wrote the company and they sent me a catalog. I've listed three shampoos that are four ounces or less. I've listed various four ounce lotions. I've listed picks, combs and brushes, vented brushes, better hair ties, lotions, deodorants, better soaps, better -- even body wash that's four ounces, as far as clothes,

undergarments, shoes, average stuff like that.

Q. So did you go through the catalog and write down exactly what you wanted from that vendor?

A. Well, the vendor that I wrote the stuff down from, the IDOC at Pontiac at times orders from them, so like the bras that they order for us to purchase is from this company. Like some of the commissary food or shoes they order from this company. So I found out about the company through Ms. Brooks. She's like look this is where we order from. So I wrote the address down and wrote them. I had to pay $10 for the catalog. Every year they have a new catalog come out, and on the catalog they say all of these items have been tested and approved at the prison, don't have chemical or alcohol compound, because you know if it has alcohol people will drink it or set it on fire or stuff like that, that they're safe.

So I pointed out and wrote stuff down saying you guys are already ordering this deodorant, this and this from here, why can't you order this? And it's like we have to wait to get approved. I'm like well who approves it? Oh, TAC team, because tactical team review it or the people that work in task force are the ones who search the facility, cells, compound and look through commissary items for stuff that we receive

here and they deem if it's something that can be altered, broken or used as a weapon to cause harm to any of their staff. You know, if it's actually them that does that commissary approval, I don't know. This is what I'm being told.

Q. So you wrote a letter to the commissary staff, right? Do you have a copy of that letter?

A. I did. I have to go look. I have to see what I have. I know I wrote one to the commissary. I wrote one to the warden. I even wrote some grievance where I basically listed them on there.

Q. Did you put the brand name and everything?

A. Yes. What I did -- because if they send an order from that company, what I did I put the item, its size. So let's just say it's deodorant four ounces. I deodorant, the name of it, four ounces, and then I put slash, the ordering or shipping weight or whatever it is they -- you know, how they order it in bulk or individual from the company. That way when they look through the pages, they know where to go and which ones specifically I'm talking about so they can't get it confused.

Q. The response that you got back, was your response in writing or did somebody come speak with you?

A. Most of the time they usually come speak to

me. That way it's verbal and their response isn't on paper.

Q. When was the last time somebody came to speak with you about these commissary things?

A. The only time that was recently was with the warden when he was doing a walk by.

Q. Do you still shower alone?

A. Yes. Well, in the max prison cell they have showers that are individual. You go in one at a time.

Q. Last time you mentioned that it was open bars. Has that changed at all, on the shower door?

A. They still have -- the showers are always behind the bars, but they had did in south house -- as far as I know it's the only cell house that does it. They have shower doors where you can open and close it, and that covers you basically from chest to calf. In seg they have no shower doors, and east house they have no shower doors. I don't know why.

Q. Before you went into segregation, what house were you living in?

A. South house, protective custody.

Q. You also testified about searches by staff members. Has the way that you're strip search changed at all?

A. No.

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Q. Has anybody ever asked you your preference on the gender of the person searching you?

A. They never ask it. In general I usually have to be the one to say something. Like this month already twice we've been stripped down by TAC team where basically they suit up, tell us to cuff up, and before they do they strip us, and I ask hey, is there a female officer here? They're saying yeah. I say well can you bring her here so I can get strip searched? He said that they don't do cross gender searches. I said what do you mean? He's like basically it has to be male-male searches. I said okay, man, I'm transgender. I said they have a PREA guideline thing that came out that specifically says you aren't supposed to search me and to at least give me the option of having another staff search me. He says that's not going to happen, are you gonna to strip or not? If not, let me know. If not, we'll just Mace you, open your door and restrain you. Let me know what you're going to do.

So to avoid all that, I'm like you know what, come on, let's just get this over, because I'm not going to waste my time arguing with him and he's constantly not trying to hear it. The next thing he's saying is either I do it or I don't and he's talking about macing me. That's happened twice.

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Q. And both times was it with the TAC team?

A. Yes, and not in seg. When we go to yard, basically we walk down the galleries. We can go out. They can do one to two what they call pat-down or searches where they'll feel your side your, pocket or want to see your shoes, whatever you have. And on that it's -- there'll be a few staff. Sometimes it will be men and women, so usually I'll gravitate toward the women. It's never a problem, but it's never an option, though. If they're not there and I for it, it's not going to be an option. If they're there and I go to them, it's not a problem, but if I request it on a shakedown or strip search, then it's a problem.

Q. So when you request it, has your request always been denied?

A. Yeah, always. Their excuse is they can't do cross gender searches even though time and time again I've basically explained to them part of the PREA guideline thing that came out was to prevent this and there's supposed to be at least one female staff who can do this. The issue with that is they don't it. Then you got some guys that they're disrespectful. They're supposed to do a pat in a search, not supposed to do a grope. You're not supposed to do a squeeze and then say fag or sissy or like bitch, stuff like that, whore and

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other words they're not supposed to be saying.

Q. Leaving out the tactical team searches, how often are you strip searched a month?

A. Well, strip search, those are only done on like particular circumstances. So an example is if staff believe that I have dangerous contraband, which could be anything from, I guess, drugs, alcohol, prison made hooch or weapons, they will cuff me up, take me to the shower. They will have officers go in my cell, shake it down, and while I'm in the shower they will ask me like hey, you've got to strip search. They'll cuff me, give me clothes, behind the ears, open my mouth, turn around, spread, cough, stuff like that. That doesn't always happen. Sometimes it happens, you know. There's people here who -- you know, they're A holes. That's just what they feel like doing to get a reaction out of a person to have an excuse to send somebody to seg by doing that, you know.

There was one time they had a five day officer. Every five days he's there, and they just -- I don't know what it is. I hardly spoke to him, and at least once every two weeks he insists upon searching my cell for contraband and putting me in the shower and strip searching me. Now, I can't really complain about it because if it's something that, oh well, they deem

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that it's necessary and they're giving me a shakedown slip, what can I say? I can't refuse a shakedown. That's a violation. I can go to seg for that, plus I know I don't have anything in there. But at the same time, you know, sometimes there's things that are borderline harassment that you -- I can't really tell that they are, if they're following rules or if it's just to mess with me.

Q. Have you made any PREA complaints about staff harassment?

A. I have made one and it took six months investigation and basically it was thrown out saying that there wasn't enough sufficient data to basically prove my claims or allegations against the officer.

Q. And when was that?

A. This was last year, and this was regarding -- what is his name? Sergeant Ellinger, he was one of them, and he -- it was in seg. He asked me to move to a cell and I didn't want to. So this time he didn't write a ticket but he took me to the shower and grabbed one of my bras, walked up and down the gallery saying that there is bra wearer fag in this cell. He's walking around with my bra spinning it on his finger saying that if you guys throw shit on him, I won't write a ticket. He put me back in the cell, threw my bra back in there,

EXHIBIT 7

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS

JANIAH MONROE, MARILYN MELENDEZ, EBONY STAMPS, LYDIA HELENA VISION, SORA KUYKENDALL, and SASHA REED,	)	
Plaintiffs,	)	
vs.	)	18-CV-00156-NJR-MAB
JOHN BALDWIN, STEVE MEEKS, and MELVIN HINTON,	)	
Defendants.	)	

Videotaped deposition of DR. STEVEN BOWMAN, pursuant to the applicable provisions of the Code of Civil Procedure of the State of Illinois and the rules of the Supreme Court thereof, taken before Janet L. Brown, CSR No. 84-002176, via Magna Legal Vision videoconference on July 28, 2020, at 9:23 AM.

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a visit to Logan, but I don't have names.
Q. Do you know how many transgender prisoners there are in the IDOC system?
A. Approximately I do.
Q. And how many, approximately, transgender prisoners are there in the IDOC system?
A. About 150.
Q. And how many overall prisoners are there in the IDOC system?
A. Approximately 33,000.
Q. Would you consider yourself knowledgeable about the issues that transgender prisoners face in the IDOC system?
A. I am knowledgeable, yes.
Q. Do you agree that transgender prisoners require additional protection to keep them safe?
A. I agree.
Q. How is life different for a transgender prisoner in IDOC compared to other prisoners that are non-transgender?
A. How is life different? It's different in several ways. And, again, it depends on the

individual, certainly. I think the first thing is security. I think transgender individuals may be more vulnerable to harassment, particularly by their -- by other offenders because they may not fit in. Being at an all-male facility as a transgender woman is difficult. I can understand that.

Being, you know, segregated -- I mean, being in that close environment sometimes the measures that may be sought to protect an individual may be difficult, you know, in terms of isolation. I do understand that might be a program, again, with the goal of trying to protect people and keep them away from others that may do them harm.

I do understand that with all offenders there's a lack of privacy, and that may be particularly difficult with transgender individuals.

Even, you know, movement and recreation. Again, you're frequently in the same space with, you know, many individuals who may have their biases or, you know, misunderstand or not know or be informed or even potentially

hostile toward transgender individuals. I can understand how difficult that situation might be.

Certainly there are special accommodations and needs that I think transgender women, particularly in the community, would have access to that offenders may not have as ready access to in terms of, you know, clothing, personal supplies, grooming supplies, you know, makeup, nails, hair, any cosmetics, other matters like that, other -- underwear, under gear.

Even accessing healthcare. You know, providers may or may not be aware of needs, you know, of transgender patients.

So, I mean, those are some of the things that, you know, I have thought about and I do understand.

And, I guess, then the converse is true. I think -- I tend to think more about transgender women, but I imagine that transgender men are under the, you know, similar -- under similar pressures as well depending on, you know, which facilities they are assigned to, so.

Q. So breaking that down a little bit, you said that being a trans woman in a male

prison can be difficult; right?
A. Uh-huh.
Q. And you --
A. Yes.
Q. -- mentioned specifically privacy. Would that include difficulties in terms of showering protocol?
A. Potentially that could be difficult.
Q. And in cell assignment as well?
A. Yes.
Q. Safety and security?
A. Yes.
Q. Are transgender individuals at an increased likelihood of self-harm in IDOC?
A. I don't know if I have the answer to that. That is a number. I don't know if it's been studied. I don't have that data. In terms of the likelihood of self-harm, I don't actually know that answer with respect to IDOC.
Q. Based on your understanding of IDOC, do you think transgender individuals have a more difficult time accessing needed healthcare services than non-transgender individuals?
A. I don't know the answer to that

EXHIBIT 8

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS

JANIAH MONROE, MARILYN MELENDEZ, EBONY STAMPS, LYDIA HELENA VISION, SORA KUYKENDALL, and SASHA REED,	)	
Plaintiffs,	)	18-CV-00156-NJR-MAB
vs.	)	
JOHN BALDWIN, STEVE MEEKS, and MELVIN HINTON,	)	
Defendants.	)	

Videotaped deposition of RYAN NOTTINGHAM, called as a witness herein, pursuant to the applicable provisions of the Federal Rules of Procedure governing the taking of depositions, taken before Janet L. Brown, CSR No. 84-002176, via Magna Legal Vision videoconference, on Tuesday, June 30, 2020, at 9:04 AM.

prohibition to that as well, but I cannot recall specific about pat searches. I --

Q. And what about pat searches in men's facilities?

Sorry. What about pat-down searches in women's facilities?

A. I know at women's facilities it was prohibited for male staff to do a pat search or a body or strip search, unclothed search.

Q. And IDOC also has a requirement that any cross-gender search only be performed in exigent circumstances; correct?

A. That is correct.

Q. And in your time as -- strike that.

Very rarely, if ever, will there be an exigent circumstance to justify a cross-gender search; correct?

A. That is correct.

Q. So routine searches are not exigent circumstances; correct?

A. Correct.

Q. So how does IDOC determine what constitutes a cross-gender search with respect to transgender prisoners?

A. The policy still stands. So if they are -- regardless of gender identity, if IDOC has housed them in, for example, a male facility, that they would be strip searched by male staff unless that protocol was initiated and a case was reviewed and decided otherwise.

Q. Okay. So IDOC ignores a transgender prisoner's gender identity entirely for the purposes of cross-gender searches; correct?

A. I don't think entirely.

Q. IDOC ignores -- how does it consider a person's gender identity for the purpose of cross-gender searches?

A. Well, so we do have, I guess, two transgender females at a female facility, so I don't know if that would exclude that or not, but --

Q. Well, I believe you just stated that it doesn't -- it's irrelevant how a transgender prisoner identifies. What constitutes a cross-gender search is determined by the facility in which they're placed.

A. Correct.

Q. So, phrased differently, IDOC ignores

a transgender prisoner's gender identity and searches them in accordance with the gender of the facility; correct?

A. I think it's taken into consideration, but the transgender care committee decided to house them at that facility.

Q. How does IDOC interpret what a cross-gender search is?

A. Is by staff of the opposite gender.

Q. And you mentioned that the policy is that in a male prison, search by men -- male staff will not constitute a cross-gender search?

A. Correct.

Q. In a female prison, any search by female staff will not constitute a cross-gender search?

A. Correct.

Q. So whether or not a prisoner is a transgender woman or a transgender man is not taken into consideration when determining whether the cross-gender search protections are triggered; correct?

A. Correct.

Q. Now, I'd like to turn your attention

to Bates 185373. And this is marked as Nottingham Exhibit 2.

(Nottingham Exhibit No. 2 marked.)

BY MS. ROSE:

Q. This is a memo dated April 11th, 2018; correct?

A. I can't see it.

Q. Apologies. Are you able to see it now, Mr. Nottingham?

A. Yes.

Q. Do you recognize -- so this is Bates 185373. Do you recognize this document?

A. I do not.

Q. So you've never seen this document which appears to be a PREA compliance roll call memo sent out in the Illinois Department of Corrections; correct?

A. Can you scroll down? I might have seen it, but, I mean, it was drafted by the warden at Taylorville Correctional Center to Taylorville staff.

Q. Okay. Well --

A. I've seen similar roll --

to be conducted in a way that is the least intrusive manner possible?

A. Well, it follows the guidelines that, you know, the -- the gender of the facility, as that discusses, but, you know, in a private manner.

Q. Okay. So the only difference between a transgender search -- strike that.

Okay. So the only difference between the search of a transgender prisoner and a cisgender prisoner is that a transgender prisoner in IDOC must be searched in a private setting?

A. No. That's -- that goes for all offenders.

Q. Okay. So there's no difference then between the way that a transgender prisoner is searched and the way that a non-transgender person is searched in IDOC; correct?

A. Correct.

Q. So there's no protection afforded to transgender prisoners under the PREA regulation specific to transgender prisoners; correct?

A. Can you repeat that? I'm sorry.

Q. I'll rephrase. That was a poorly framed question.

So searches -- strike that.

The memo also provides that "Searches should be completed in accordance with facility policy based upon the gender of the facility (male facility equals male offender). Unless given other direction."

So --

A. Correct.

Q. -- a transgender woman housed in a men's facility can be searched by a male guard without triggering the cross-gender search protections; correct?

A. Correct.

Q. And this is the current practice and policy that's in effect; correct?

A. Correct.

Q. How long has this been IDOC's policy?

A. I think for quite some time.

Q. And you mentioned earlier that transgender women are women; correct?

A. Correct. They identify as a woman.

Q. So is there any reason why subjecting

a transgender woman to a search by a man wouldn't be a cross-gender search?

A. I guess it could be interpreted either way.

Q. And there's no reason why IDOC could not -- strike that.

So this allows transgender -- strike that.

So under IDOC's current policy, transgender women assigned to men's prisons can be routinely searched by male officers; correct?

A. Correct.

Q. And under IDOC's current policy, transgender women assigned to men's prisons are not protected against cross-gender searches; correct?

A. Well, they are protected because they've gone through the transgender care committee process, and the transgender -- you know, they were reviewed on a case-by-case basis per the PREA standards, and that committee decided their appropriate placement was at that male facility. So there were safeguards in place, but that search is going to be conducted

by a male staff member.

Q. Okay. So after -- well, I guess, two questions. First of all, transgender women are placed in men's facilities prior to their being reviewed by the committee in some locations; correct?

A. Potentially. Like I said, I'm not for sure on how fast that process reacts.

Q. And so is it your view that because the committee decides to place a trans- -- strike that.

Okay. So it's your opinion that the committee is the appropriate safeguard for searches of transgender prisoners?

A. I think so. I mean, they consider it on a case-by-case basis, also including management and security concerns, and they make the final determination of whether or not that person will be housed in a male or a female facility.

Q. So once that determination is made, there's no reason to evaluate whether a transgender woman should be searched by a man or a woman?

EXHIBIT 9

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS

JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELÉNA VISION, SORA KUYKENDALL, and SASHA REED, individually and on behalf of a class of similarly situated individuals, Plaintiffs, v. ROB JEFFREYS, MELVIN HINTON, and STEVE MEEKS, Defendants.	)	Civil No. 3:18-cv-00156-NJR

EXPERT WITNESS REPORT OF JAMES EVANS AIKEN
JAMES E. AIKEN & ASSOCIATES, Inc.

August 31, 2020

I, James E. Aiken, have prepared this expert report pursuant to Fed. R. Civ. P. 26(a)(2) in the case of *Monroe, et al. v. Jeffreys et al*. I was retained as an independent consultant with expertise on issues related to the administration, operation, and management of correctional facilities to provide an expert opinion regarding the treatment by the Illinois Department of Corrections (IDOC) of the transgender prisoners with gender dysphoria within its custody.

I. PROFESSIONAL QUALIFICATIONS AND EXPERIENCE

I have over 48 years of experience in the management of confinement facilities and correctional systems. I have decades of direct experience and knowledge regarding correctional strategies in the management of persons held in lawful confinement. Moreover, a major focus of my career has been to assess, redirect, and restore confinement facilities and systems that have

experienced chronic/acute program and security shortfalls and staff misconduct related to all aspects of a confinement system.

My experience in the administration, operation, and management of correctional facilities, including as the Director of the Bureau of Corrections for the United States Virgin Islands (1992-1994), the Commissioner of the Indiana Department of Corrections (1989-1992), and in various positions in the South Carolina Department of Corrections (1971-1989).

In the United States Virgin Islands, I was given the specific task to remedy overcrowding, gang problems, lack of medical/mental health care, random and systemic violence, and general mismanagement. As the Commissioner of the Indiana Department of Corrections, I was responsible for the overall administration of the Indiana corrections system that consisted of 46 separate adult and juvenile facilities with a population of 14,000 inmates. As a Deputy Regional Administrator of the South Carolina Department of Corrections (1987-1989), I supervised 16 South Carolina institutions at all security levels. I was also Warden of the Central Correctional Institution (state penitentiary, 1982-1987), the largest correctional facility in South Carolina with 1,800 medium and maximum-security custody male inmates and the South Carolina death row. Prior to that I was the Warden of the South Carolina Women's Correctional Institution (1979-1982) responsible for all aspects of female inmate welfare and rehabilitation. These facilities and systems were in various states of major dysfunction related to public protection, security, programming, as well as the provision of required medical/mental health delivery to inmates.

Further, I have consulted with the United States Department of Justice, National Institute of Corrections, and federal, state, and local prisons on a variety of subjects, including, but not limited to: inmate classification, management of women offenders, management of youthful offenders in adult prisons, general management of prison security systems, objective assessments

of security operational performance, prison critical event avoidance, riot/gang management, management of super-maximum prisons, correctional leadership, objective/internal classification, seamless delivery integration of prison components to ensure reasonable safety and security, and updating wardens regarding more effective methods to manage prisons at all security levels.

In 2004 the United States Congress appointed me to be one of nine Commissioners of the National Prison Rape Elimination Commission (the "Commission") established pursuant to 34 U.S.C.A. § 30306 (detailing establishment and objectives of Commission). The Commission held hearings throughout the country and was responsible for the development of standards that would lead to the prevention, detection, and elimination of prison rape. *See* 34 U.S.C.A. § 30306(d)(3)(B)(ii). The Commission issued the National Prison Rape Elimination Commission Report (the "Report") in June 2009 that became the basis for regulations issued by the Department of Justice in 28 C.F.R. § 115, the Prison Rape Elimination Act National Standards.

The Commission's investigation and its Report accounted for the long under recognized reality that transgender inmates (as well as lesbian, gay and bisexual inmates) are particularly vulnerable to a prison's specific perils of intimidation, harassment, and random and systemic violence, including sexual assault. The Commission, over a five-year period, carefully considered the appropriate standard for the safe housing and placement of transgender inmates.

I am attaching a copy of my current C.V., which lists my qualifications and experience, as Appendix A to this report. A full list of of my publications over the past 10 years is included as Appendix B to this report. A list of all cases where I have testified as an expert in the past 4 years is attached as Appendix C.

II. COMPENSATION

I am being compensated at an hourly rate of $175.00 per hour for my expert services in this case. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide. My retention agreement is attached hereto as Appendix D.

III. MATERIALS REVIEWED

I have reviewed the following documents: TCRC records from January 2020 to May 2020; emails, medical records, counseling summaries, grievances, PREA documents, and other documents related to Janiah Monroe; PREA-related documents related to Sasha Reed, Sora Kuykendall, Marilyn Melendez, Lydia Heléna Vision, and Skylar Motley; IDOC directives/policies; IDOC commissary lists; and Moss Group documents. I have also reviewed court filings from the current case: Complaint (Dkt. 1); 8/23/2019 and 8/30/2019 proposed findings of fact and conclusions of law and responses exchanged by Plaintiffs and Defendants; Memorandum and Order granting PI (Dkt. 186); PI Order (Dkt. 187); Defendants' Report on Compliance with PI Order (Dkt. 202); Plaintiffs' Response to Defendants' Report on Compliance (Dkt. 207); Defendants' Reply Regarding Report on Compliance (Dkt. 210); Amended PI Memo and Order (Dkt. 211); Amended PI (Dkt. 212); and Memorandum and Order Regarding Defendants' Compliance with PI (Dkt. 215).

I have reviewed the following documents from two other cases: PI Opinion (Dkt. 132) in *Tay v. Dennison*, No. 3:19-cv-00501-NJR (S.D. Ill.); and Order (Dkt. 41) in *Monroe v. Jeffreys*, No. 1:19-cv-01060-MMM-JEH (C.D. Ill.). I have reviewed the following depositions from this case: 4/19/2019 Shane Reister 30(b)(6) Deposition Transcript and Exhibits; 4/19/2019 William Puga 30(b)(6) Deposition Transcript and Exhibits; 7/22/2019 Glen Austin Deposition Transcript; 6/25/2020 Melvin Hinton Deposition Transcript and Exhibits; 6/30/2020 Ryan Nottingham Deposition Transcript and Exhibits; 8/12/2020 Moss Group (Wendy Leach) 30(b)(6) Deposition

Transcript and Exhibits; 7/27/2020 Glenda Wortley Deposition Transcript and Exhibits; 8/17/2020 Shane Reister Deposition Transcript; 8/19/2020 James Michael Chappell Deposition Transcript (rough transcript) and Exhibits; and 8/24/2020 William Puga Deposition Transcript (rough transcript).

I also reviewed the following transcripts for other cases: 9/25/2019 and 10/15/2019 Transcripts (3 vols.) from Preliminary Injunction Hearings in *Tay v. Dennison*, No. 3:19-cv-00501-NJR (S.D. Ill.); 1/29/2020 Dan Pacholke Deposition Transcript in *Monroe v. Jeffreys*, No. 1:19-cv-01060-MMM-JEH (C.D. Ill.); 1/31/2020 George Brown Deposition Transcript in *Monroe v. Jeffreys*, No. 1:19-cv-01060-MMM-JEH (C.D. Ill.); 2/6/2020 and 2/7/2020 Transcripts (2 vols.) from the Preliminary Injunction Hearing in *Monroe v. Jeffreys*, No. 1:19-cv-01060-MMM-JEH (C.D. Ill.). Finally, I have reviewed statutes from Massachusetts and Connecticut that related to housing transgender prisoners.

IV. OPINIONS

In preparing this report, I have also relied upon my more than 48 years of experience and related training and education in the corrections field as well as my review of materials provided to me about the IDOC.

A. Opinion: There is no security justification for denying transgender prisoners medically necessary social transition.

Defendants' denial of medically necessary social transition to transgender prisoners cannot be justified by prison security or safety considerations. In fact, in my experience, a respectful prison culture promotes the safety of all prisoners. As I understand it, refusing to treat a transgender woman as a woman is not only a denial of the medical care she needs, but also disrespectful and unprofessional to her. The same is of course true for refusing to treat a transgender man as a man.

Prisoners are intensely observant of staff's verbal and nonverbal gestures in order to measure their degree of safety and security. Derogatory comments and behaviors by staff can even deteriorate into violent episodes and loss of professional trust. Therefore, it is essential that correctional staff communicate with the inmate population in a manner that does not imply disrespect or devalue a prisoner's status as a human being.

A correctional facility is also required to provide necessary medical care for all incarcerated persons. I assume for purposes of my analysis that social transition is medically necessary to properly treat prisoners diagnosed with gender dysphoria. I further assume that, for a transgender woman, social transition may include, for example, having a female hairstyle, wearing female clothing and makeup, using a female name and pronouns, using female toiletries, and using a female bathroom. Despite this, IDOC does not provide transgender women with female clothing (outside of a sports bra) or grooming items or female toiletries, and transgender prisoners are often misgendered by correctional staff and even medical personnel.

There is no security reason to deny transgender individuals clothing consistent with their gender. IDOC offers female clothing items to prisoners in female facilities, but they do not provide transgender women in male facilities with access to those same clothing items. *See, e.g.*, 6/25/2020 Hinton Dep. Ex. 4 at 4. I understand from IDOC's deposition testimony that it is attempting to change the list of items available for sale at the commissary of each facility. *See, e.g.*, 8/19/2020 Chappell Rough Dep. Tr. at 75:6–10; *see also* Chappell Dep. Ex. 4, draft commissary list. For example, Mike Chappell—who is an Operations Security Specialist, a member of the TCRC, and a member of the Commissary Committee at IDOC—testified that Dr. Puga is reviewing a revised list of items, but that he has "no idea" when it will be implemented, although he speculated that approval may be "pretty close." Chappell Rough Dep. Tr. at 75:17–76:5. IDOC is using this new

policy, however, as a basis to further delay providing gender affirming items to transgender prisoners. TCRC records show that at least one prisoner (Legel) requested women's underwear in February 2020 but that the Committee denied her request "until [the] new policy [goes] in[to] effect." Chappell Dep. Ex. 3 at 4.

Defendants cannot use prison security as an excuse or justification to deny grooming items to transgender women in male facilities while simultaneously selling female grooming items to women in their female facilities. Defendants operate commissaries within their prisons. *See* Approved Commissary Lists (Bates 005226–005520). Consistent with most prison systems, the items offered at each facility vary based on the facility's security level. The Women and Family Approved Commissary List includes female clothing and grooming items such as lipstick, perfume, mascara, and female hair products. *Id.* at 54–55, 63–66. Any item sold at a prison commissary has already been reviewed and authorized by security personnel, and there is no reason why an item that is safe in a women's facility would not be equally safe in a men's facility.

At the very least, items provided to prisoners in female facilities should be available to transgender female prisoners when medical staff determines that these items are necessary to support their social transitions. If additional social transition items are deemed necessary by medical personnel, they should be sourced, reviewed for safety risks, and provided to transgender prisoners. Sourcing medically necessary items that meet a facility's security needs is an essential function of a prison healthcare system, and this task is commonly performed for other medically necessary devices like casts, canes, walkers, and back braces. It is an operational/security mandate to accommodate the medical needs of the prisoners. IDOC's consultant, the Moss Group, agrees that transgender prisoners "need to be allowed to have basic things that they need to live their gender identity." Moss Group Dep. Tr. at 97:11–13.

Transgender prisoners are subject to higher levels of harassment and abuse in prisons than non-transgender individuals, but this must not serve as a reason to deny them medically necessary social transition. Defendants must ensure that transgender prisoners who are socially transitioning are protected from harassment and abuse by other prisoners and by prison staff. Misgendering of transgender prisoners by correctional staff reinforces the stigma against transgender individuals and can actually facilitate violence within the prison and compromise the safety of prisoners and staff. This increases the risk for transgender individuals of abuse or assault by other prisoners, self-harm, and suicide.

B. Opinion: There are no legitimate security reasons for denying transgender prisoners medically-recommended housing placements.

Currently, the IDOC is denying transgender prisoners placement in prisons consistent with their gender identities. Wortley Dep. Tr. at 116:20–117:12; Nottingham Dep. Tr. at 133:8–134:9. The only recent exceptions to this rule have been two transgender women who IDOC transferred to a women's facility after they filed lawsuits. Nottingham Dep. Tr. at 133:8–134:9. In addition, Dr. Reister mentioned one transgender man who IDOC placed in a male facility because he had genital surgery prior to being placed in IDOC custody, but did not provide any details about when this took place. 8/17/2020 Reister Dep. Tr. at 28:5–12 ("[G]enitalia was used for a trans man without going to the committee, and he wanted to go into the male division and that was granted."). IDOC officials' testimony objectively and operationally indicates that IDOC continues to place transgender individuals in facilities based on their genital status, rather than their gender identity. Indeed, Mr. Chappell agreed that placement decisions about transgender prisoners at IDOC are based upon genitalia alone. Chappell Rough Dep. Rough Tr. at 27:17–28:12.

A housing policy and practice based on genital status creates significant threats to inmate health and safety. For example, when a person who lives and presents as a woman and has female

secondary sex characteristics is placed by prison officials in a male correctional facility, she is perceived and treated by male inmates and staff as a woman. For this reason, the Prison Rape Elimination Commission rejected the use of "genital status" as the sole basis to determine housing placements for transgender inmates. *See* Report at 77 ("The facility makes individualized determinations about how to ensure the safety of each inmate. Lesbian, gay, bisexual, transgender, or other gender-nonconforming inmates are not placed in particular facilities, units, or wings solely on the basis of their sexual orientation, genital status, or gender identity.").

The rejection of a housing standard or practice based solely on a transgender prisoner's genital status is reflected in the Department of Justice regulations that provide "[i]n deciding whether to assign a transgender or intersex inmate to a facility for male or female inmates, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the inmate's health and safety, and whether the placement would present management or security problems." 28 C.F.R. § 115.42 (c). In addition, the Department of Justice regulations require that "[a] transgender or intersex inmate's own views with respect to his or her own safety shall be given serious consideration." 28 C.F.R. § 115.42 (e). The IDOC's policy of placing transgender individuals based on genital status alone shows that they are currently failing to comply with these regulations.

In addition, a prison system must be capable of providing adequate medical care and treatment, as prescribed by medical professionals, to individuals who are under its custody and control. The Prison Rape Elimination Commission did not prescribe what medical treatment a transgender prisoner must receive. Rather, the purpose of the PREA Standards pertained to elimination of sexual violence and other violence associated with sexual misconduct. In addition to fulfilling the goals of PREA, IDOC must also fulfill its responsibility to provide the medical

treatment recommended for transgender prisoners and should not allow security-related concerns to prevent it from doing so. Medical treatment for transgender prisoners may require more from a prison system than what the PREA Standards require. While correctional staff and IDOC must have some flexibility in responding to a prisoner's medical needs, security concerns cannot stand in the way of the treatment recommended by qualified medical professionals. If that treatment includes placement of these prisoners in facilities consistent with their gender identity, then correctional staff must create and implement a plan for achieving those placements.

The role of IDOC operations and security staff pertains to mitigating and monitoring the actual and/or potential operational issues that may arise in achieving the medical needs of a prison population. Those corrections professionals do not have the expertise or the discretion to make medical decisions. Non-medical authorities within the chain of command of a prison system must ensure inmate medical treatment is achieved.

Glenda Wortley, who works in IDOC's Transfer Coordinator office and is a member of the Transgender Care Review Committee, testified that IDOC transfers prisoners for medical reasons, including transfers that may require IDOC to place a prisoner at a facility with a different security level (from a maximum to a medium level of security, for example). Wortley Dep. Tr. at 22:3-10, 22:15–19, 22:20–23:6, 23:7–11. She also testified that the wardens at the receiving facilities do not refuse such medical transfers. Wortley Dep. Tr. at 140:16–22. This is sound correctional practice and is what IDOC should do with transgender prisoners who have a medical need for placement at a facility based on their gender identity.

To make these transfers successful, it is essential for IDOC to train correctional staff and prisoners at the women's facility about transgender individuals. I know from experience that any time there are changes in the correctional environment, staff and prisoners must be trained about

what is taking place and the reasons for those changes. In addition, staff and prisoner points of view regarding how to make those changes work effectively must be solicited, considered and addressed, but any objections or concerns that are raised are not a basis for refusing to move forward with these transfers. Therefore, I agree with IDOC's Moss Group consultant who stated that transgender women housed in women's facilities will "have a better outcome" when "training [is provided for] the staff who are working in women's facilities who are going to be supervising transgender women . . . ." Moss Group Dep. Tr. at 25:20–26:4.

Unfortunately, it appears that neither staff nor prisoners at the women's facility were trained before two transgender women, Ms. Hampton and Ms. Monroe, were transferred there from a male prison. Austin's Dep. Tr. at 12:25–13:11, 51:22–52:12. IDOC's Moss Group consultant confirmed this problem in her conversations with staff at the women's facility where these women were housed. She stated that one of her "takeaways" from those calls was that:

> [T]hey felt certainly that a lot of the correctional staff in the women's facility don't understand transgender people and what they're going through. So they don't understand that, for example, you can be very agitated and difficult, but that might be as a result of you transitioning. It might be as a result of just you being in a different environment that you're not used to.

Moss Group Dep. Tr. at 32:17–33:4.

I agree with this consultant that staff training at the women's facility must address these issues. A transgender woman who is transferred from a men's to a women's facility is going to experience significant changes that staff must be prepared to assist her with. Corrections staff can only be prepared if they receive the proper training they need to understand the challenges these women are facing both because they are transgender and because of the nature of the transfer itself.

Unfortunately, IDOC's current decision-making process regarding the placement of transgender prisoners is inconsistent with sound correctional practice. It relies on security-related

concerns to deny placements recommended by medical staff. Rather than denying placements, IDOC must address any security concerns operationally within the medically recommended facility. For example, documents memorializing meetings on "Transgender Requests for Transfer" show that IDOC considers and discusses the following factors as it relates to transfers:

a. a strong personality;
b. conflicts with other prisoners;
c. violent or threatening;
d. manipulative;
e. vulnerable;
f. issues with correctional staff;
g. the ability to make penetration upon female prisoner;
h. a disciplinary history;
i. a military background;
j. compliant with medication;
k. actively involved with support group;
l. a certain size or appearance;
m. conviction(s) for violent crimes; and
n. an interest in genital surgery.

See, *e.g.*, Feb. 18, 2020 Transgender Requests for Transfer Meeting (Bates 323719–323728); Jan. 27, 2020 Transgender Requests for Transfer Meeting (Bates 323706–323718).

It is inappropriate for IDOC to deny a medically recommended transfer for any of these reasons. In addition, it is unclear whether some of these concerns even present a security concern. For those that do, they can easily be addressed through standard correctional procedures at the facility where these individuals are transferred. But what the records and testimony reflect is that both correctional and medical staff are voting on whether transfers should be taking place. 8/17/2020 Reister Dep. Tr. at 28:24–29:7; Feb. 18, 2020 Transgender Requests for Transfer Meeting (Bates 323719–323728); Jan. 27, 2020 Transgender Requests for Transfer Meeting (Bates 323706–323718). IDOC allows operational staff to vote in order to prevent transfers that medical staff believe should take place. 8/17/2020 Reister Dep. Tr. at 178:19-179:11. This is improper.

Further, it creates operational dysfunction and endangers the transgender prisoner as well as the general order of facilities and the system itself.

While it appears that IDOC has failed to put in place any kind of factual process to properly achieve the placement of transgender prisoners in facilities that match their gender identity, the Moss Group provided IDOC with a list of factors to consider when evaluating whether to place a transgender prisoner in such a facility. Those factors include:

a. Classification's housing decision;
b. The offender's documented choice of whether male or female facility is safest for him or her;
c. The offender's prior institutional history (to include incidents and grievances);
d. The offender's prior violent or sexual crime history;
e. The offender's physical appearance, age, and physical build;
f. The offender's PREA risk screening information;
g. The offender's compliance with medical and mental health treatment plans, such as hormone therapy compliance (if applicable);
h. Any relevant information obtained about the offender from security staff or medical and mental health staff since arrival;
i. The ability of security staff to house and supervise the offender to ensure his or her safety and the safety of the population in each environment;
j. The services available to meet the needs of the offender in each environment;
k. Any management problems that can be identified in each facility;
l. Any other relevant information about the offender's ability to positively or negatively manage him or herself in each type of environment.

Moss Group Dep. Ex. 9.

These and other factors are important considerations for planning a transgender prisoner's transfer, but these factors may not be used to justify denying a transfer that has been medically prescribed as treatment. These factors can instead help operations staff to prepare for a transfer in order to monitor staff and prisoners to achieve the goal of the transfer. They must not be used to circumvent or delay a transgender prisoner's medical treatment that has been medically prescribed. IDOC must plan, develop, implement, and monitor practices that will achieve the medical requirements and objectives while reasonably protecting the order and safety of all concerned.

In addition, the experiences of transgender women held in IDOC custody in men's facilities demonstrate and validate the very real security concerns of keeping women in men's prisons. For example, in *Monroe v. Jeffreys* the court found that Ms. Monroe "provided credible testimony to establish that she has suffered assault, sexual assault, and sexual harassment at men's prisons" and that she would likely suffer those same harms again if she were transferred back. Dkt. 41 at 20, No. 1:19-cv-01060-MMM-JEH (C.D. Ill. Apr. 1, 2020). Similarly, in *Tay v. Dennison*, the court concluded that Ms. Tay Tay "has been forced to endure constant sexual abuse and harassment at various men's facilities." Dkt. 132 at 53, No. 3:19-cv-00501-NJR (S.D. Ill. May 1, 2020).

It is well-documented and accepted in the field of corrections that transgender persons are at a greater risk for violence and sexual assault in correctional facilities. For example, in a 2007 study commissioned by the California Department of Corrections and Rehabilitation, 4% of randomly sampled prisoners in California state prisons are males reported being sexually assaulted, while 59% of transgender prisoners in male prisons reported being sexually assaulted. Valerie Jenness, et al., *Violence in California Correctional Facilities: An Empirical Examination of Sexual Assault* at 27 (Apr. 27, 2007), https://www.prearesourcecenter.org/sites/default/files/library/54-cafinalpreareport.pdf. Similarly, a 2014 report from the United States Department of Justice Bureau of Justice Statistics found that between 2007 and 2012, 34% of transgender inmates in federal, state prisons and local jails experienced sexual victimization. Allen J. Beck, U.S. Department of Justice, Bureau of Justice Statistics, *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011 – 12, Supplemental Tables: Prevalence of sexual victimization among transgender adult inmates, by type of victimization, National Inmate Survey, 2007, 2008–09, and 2001–12*, at 2 (Dec. 2014), https://www.bjs.gov/content/pub/pdf/svpjri1112_st.pdf.

It is extremely concerning to me that IDOC's security personnel do not seem to accept these factors in the planning, establishing, implementing and monitoring of their protocols and practices. *See* Chappell Rough Dep. Tr. at 33:13–23 (incorrectly claiming there is no increased risk of sexual assault), 31:12–18 (can't generalize experiences for transgender population), 29:21–30:3 (same). Mr. Chappell, IDOC's Operations Security Specialist, testified on August 19, 2020 that he does not take into account the safety or security of a prisoner who is being considered for transfer when making transfer decisions. Chappell Rough Dep. Tr. at 113:3–12, 116:12–23,. Not only is this contrary to common sense, it is clearly contrary to sound correctional practice. And the result at IDOC is that transgender prisoners continue to be placed and kept in facilities based on their genital status, rather than their gender identity. This undermines the medical treatment many of these individuals have been prescribed and place them at extremely high risk of needless harm.

There is no correctional justification that I can think of for continuing this practice. Based on my experience, I can only assume that there are non-transgender women at the women's correctional facility in Illinois who present the same risk factors. This includes:

- Some non-transgender women who have violent criminal histories and some who have been violent against other prisoners and prison staff.
- Some who have the size and strength to be, or to at least appear to be, a threat to other prisoners and staff.
- Some who have engaged in sex with other women and some have even sexually assaulted or raped other women either prior to being imprisoned or while in confinement status.

Prison officials at the women's prison must prepare and manage transgender female prisoners with these behavioral factors (actual and potential) that I have found to be no different than the women at other correctional facilities that I have managed. IDOC officials understand that it is their job to keep safe their staff and the prisoners in their custody at the women's prison. Austin Dep. Tr. at 32:1–11. IDOC staff also understand this to be true even though there are non-transgender female prisoners of all sizes and strengths, some of whom have been convicted of very

serious violent crimes, have had long histories of disciplinary problems in prison, and even "violent tendencies towards other women." Chappell Rough Dep. Tr. at 93:6–14; Austin Dep. Tr. at 32:12–33:7. In general, transgender women simply do not present any security-related concerns that correctional staff at women's facilities are not already equipped to handle.

C. Opinion: Requiring transgender prisoners the option of being searched by correctional staff of the same gender is supported by sound correctional practices.

IDOC staff currently search prisoners "in accordance with facility policy based upon the gender of the facility … [u]nless given other direction." Nottingham Dep. Ex. 2; Nottingham Dep. Tr. 187:4–10, 187:16–18. As a result, male corrections officers ordinarily search a transgender woman housed in a facility for males. Nottingham Dep. Tr. at 188:9–12. Under IDOC's policy, female corrections staff search a transgender man housed in a facility for females. Defendants' policy provides for prisoners to "voice the[ir] concerns" about the default search procedure, in which case the issue is referred to the "Gender Dysphoria Management and Treatment Committee." Nottingham Dep. Tr. at 197:12–19; Nottingham Dep. Ex. 2.

Defendants' search policy and practice is contrary to PREA and basic sound correctional protocols. As stated in the PREA Standards "*Limits to cross-gender viewing and searches*":

> (a) The facility shall not conduct cross-gender strip searches or cross-gender visual body cavity searches (meaning a search of the anal or genital opening) except in exigent circumstances or when performed by medical practitioners.
>
> ***
>
> (d) The facility shall implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. Such policies and procedures shall require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showing, performing bodily functions, or changing clothing.

> (e) The facility shall not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner.

28 C.F.R. § 115.215.

The Standards are explicit, precise, and descriptive regarding the prohibition of cross-gender searches of transgender prisoners. As a former member of the Prison Rape Elimination Commission, I recall the discussions with other Commission members that provided the foundation to the regulations. Our intent in these regulations was to prohibit the practice currently being followed by the IDOC. Stopping sexual assaults and violence required that this practice of allowing female transgender prisoners to undergo strip or body cavity searches by male correctional staff be stopped, with very detailed exceptions regarding emergencies. To be clear, in the context of cross-gender searches, a prisoner's "gender" is based on their gender identity. Thus, PREA forbids allowing male officers to conduct strip or body cavity searches of transgender women, and female officers to conduct strip or body cavity searches of transgender men.

However, as noted above, the PREA regulations are aimed at stopping sexual violence rather than addressing the medical needs of transgender prisoners. If medical treatment for transgender prisoners requires more than the PREA regulations, then correctional staff must respond appropriately. Where medical staff determine that a transgender woman should be searched by women only, then operational staff must comply, absent an emergency situation. There is no security or operations-based reasons why IDOC cannot achieve this requirement. Defendants' current stated policy shows this is true. An exception to the default practice of performing cross-gender searches when corrections officers are "given other direction," shows that

there is no legitimate security justification for allowing male correctional staff to search female transgender prisoners, and female correctional staff to search male prisoners, as they currently do.

Other states have put this kind of policy into law. In Connecticut, state law gives prisoners with gender dysphoria "the right to be searched by a correctional staff member of the same gender identity, unless the inmate requests otherwise or under exigent circumstances." CONN. GEN. STAT. ANN. § 18-81ii. Similarly, in Massachusetts, gender dysphoric prisoners must be "[strip] searched by an officer of the same gender . . . provided, however, that the officer's gender identity shall be consistent with the prisoner's request…." MASS. GEN. LAWS ANN. ch. 127, § 32A. In my experience working on cases on behalf of transgender women in the Massachusetts prisons, I am unaware of any problems that have resulted as a result of the search practices this law requires.

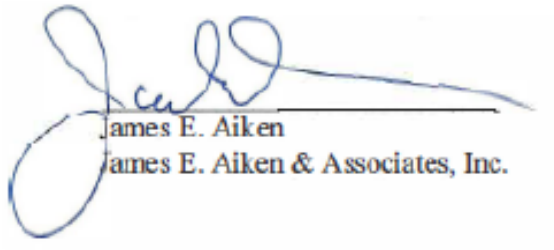
V. CONCLUSION

Based on my knowledge, experience, and educational qualifications, I have concluded to a reasonable degree of certainty that IDOC is inappropriately relying on alleged security concerns to deny transgender prisoners in its custody access to the medical care that has been recommended for them.

The security concerns presented by IDOC represent the normal daily issues that correctional facilities are already required to address. Sound correctional practices require that operations staff respond to and facilitate the medical treatment needs of prisoners, rather than creating barriers to the delivery of that care. IDOC operations staff have simply failed to offer any legitimate correctional basis for preventing transgender prisoners from getting the medical care they need.

I reserve the right to supplement the opinions set out in this report as required to address any additional information provided to me regarding IDOC's treatment of transgender prisoners.

Dated: August 31, 2020



APPENDIX A

CURRICULUM VITAE OF JAMES E. AIKEN

I maintain a consulting concern in prison management and adjustment matters as James E. Aiken & Associates, Inc. I also served as Director of Corrections for the United States Virgin Islands, and Commissioner for the Indiana Department of Correction. I began my corrections career in 1971 at the South Carolina Department of Corrections as a counselor with the Comprehensive Drug Abuse Treatment Program. Also, while with the South Carolina Department of Corrections, I held positions as Deputy Regional Administrator in the Midlands Correctional Region (managing 16 prisons), Deputy Warden and Administrative Assistant to the Warden of the Manning Correctional Institution, Deputy Warden and Warden at the Central Correctional Institution (state penitentiary), and Warden of the Women's Correctional Center. While serving in these positions, I received extensive experience in the areas of prison classification and management of inmate population. During my years in prison work, I have conducted thousands of inmate classification evaluations relative to their adjustment to prison and current/future danger to the public, prison staff, and other inmates. These reviews included minimum custody (low security offenders) to maximum security (violent, high profile, disruptive, predatory, aggressive inmates). Additionally, I participated in the development of prison classification systems designed to better protect inmate population from other more violent inmates and the public.

The United States Congress appointed me, in July 2004 to the National Prison Rape Elimination Commission. Over a five (5) year period, the Commission conducted comprehensive hearings and examined all penological, economic, physical, mental, medical and social issues relating to prison rape in America. At the conclusion of its review, the Commission issued a comprehensive report on the subject, including a recommended set of national standards to reduce and eliminate prison rape. Also, a grant program made annual grants (up to $40 million each year) to state and local programs that enhanced the prevention and punishment of prison rape and

maintain safe and secure prisons despite budget reductions. The Commission had authority to issue subpoenas, and the statue allows for the Attorney General to seek enforcement of subpoenas in district court. The Federal Bureau of Prisons must have total compliance to the final standards.

I received a Master Degree in Criminal Justice from the University of South Carolina and Bachelors of Arts Degree from Benedict College, Columbia, South Carolina. I have also taught a number of courses in corrections at the university and technical college levels.

I have consulted with the U.S. Department of Justice, National Institute of Corrections, as well as served as a private contract provider to federal, state and county jurisdictions (jails and prisons) in a number of areas to include but not limited to inmate classification, managing violent youthful offenders in adult prisons, management of women offenders, managing prison security systems, correctional leadership development, assessment of security operational performance, executive training for new and experienced wardens, prison critical event avoidance, management of super-maximum-security prisons, management of the hard to manage-violent inmate, STG/gang management, and riot management.

I have also consulted with attorneys and rendered expert testimony in capital, criminal and civil cases. I have been qualified as an expert and provided such testimony in the states of Washington, Ohio, Georgia, Arizona, Delaware, North Carolina, Montana, Pennsylvania, New York, South Carolina, Indiana, Virginia, Maryland, Louisiana, Oregon, New Hampshire, Missouri, Alabama, Mississippi, Florida, Texas and the United States District Courts of Massachusetts, Maryland, New York, Connecticut, Virginia, Ohio, South Carolina, Michigan, Arizona, West Virginia, Florida, Texas, Georgia, Alabama, Missouri, Tennessee, Louisiana, District of Columbia and Pennsylvania as well as the Court of Queen's Bench, Canada relative to: future danger posed to inmates, staff and the community by trial defendants, the ability of inmates to adjust to prison,

classification of inmates to determine proper confinement levels, prison conditions, and other matters generally relating to prisons, jails, and criminal justice matters.

More specific overview of background qualifications is submitted: From August 1992 to August 1994, I was Director of the Bureau of Corrections for the United States Virgin Islands. My responsibilities encompassed the overall administration of the bureau which included jail and prison facilities. I also worked closely with other territorial agencies, the legislature, courts, and federal governmental entities. In the Virgin Islands, I had a specific mission to re-establish a correctional system (prison and jail) which was diminished by overcrowded conditions, gang problems, random and systematic violence, escapes, non-compliance with court orders (to include medical care and delivery issues), general mismanagement, and public mistrust.

From March 1989 until August 1992, I was Commissioner for the Indiana Department of Corrections. I was responsible for the overall administration of the Indiana corrections system that consisted of 46 separate adult and juvenile facilities with a population of 14,000 inmates and parole services with a population of 3,490 parolees. I reported directly to the Governor of Indiana and worked closely with the state legislature. Also, during my Indiana administration, I created a Division of Security to address gang problems, contraband control, drug testing, and other concerns. My administration also initiated an Offender Relations Division to resolve offender grievances and complaints, and to reduce court involvement.

From September 1971 until March 1989, I was with the South Carolina Department of Corrections in a variety of capacities including Deputy Regional Administrator, and different times as Warden of the Central Correctional Institution, Warden of the Women's Correctional Institution and as an inmate social worker.

As Deputy Regional Administrator from April 1987 to March 1989, I supervised sixteen South Carolina institutions at all security levels including maximum. I supervised a workforce of 2,500 with an annual budget of $97 million. This position required that I select institution heads, and I was intimately involved with new facility design.

As Warden of the Central Correctional Institution (state penitentiary) from May 1982 until April 1987, I operated the largest correctional facility in South Carolina with 1,800 medium and maximum custody inmates, 530 staff members, and an annual budget of $8 million. I was personally responsible for all activities involving security and treatment staff, as well as coordinating and supervising all welfare and morale services for inmates. CCI is now closed. At the time it was where the South Carolina death row was located and where executions were carried out. I was called upon to carry out two executions. From September 1976 until September 1979, I was Deputy Warden of this institution.

As Warden of the Women's Correctional Institution from September 1979 until May 1982, I was chief administrator of a state women's prison. I was responsible for all employee hiring, evaluation, and supervision as well as, all aspects of inmate welfare. During my tenure, I studied and reviewed all available records and files on assigned inmates to evaluate their behavior changes and rehabilitation progress.

From about 1990 to 1992, I was also Adjunct Professor at the Indiana University-Purdue University in Indianapolis, teaching corrections related criminal justice courses.

I am able to render an expert opinion, in an operational context, regarding future danger and adaptability of inmates and issues pertaining to prison/jail safety, operations, administration and security.

A. Summary of Qualifications

I have over forty-eight (48) years of experience in correctional administration, facility operations/management, inspection/assessment of facility performance and technical assistance consultations with clients in the United States, Dutch Kingdom, Canada, Costa Rica, Puerto Rico, and U.S. Virgin Islands. He has provided services to federal, state, county and local correctional facilities and jurisdictions in the areas of correctional leadership/organizational development, management of prison disturbances, system productivity, cost containment, enhancing prison security systems, managing the violent youthful offender in adult prisons, gang/security threat group (STG) management, new warden's training, super maximum security facility management training, inmate classification, assessment of prison security/operational performance, prison staffing analyses, management of women offenders, reduction of prison critical security events (murder/suicide/riot/hostage situation) and advising governments relative to prison privatization transactions/productivity.

B. Employment History

August 1994 to present, president, James E. Aiken and Associates, Inc. (correctional consultant firm); August, 1992 to August 1994, Director, Bureau of Corrections, United States Virgin Islands and consultant; March, 1989 to August, 1992, Commissioner, Indiana Department of Correction; April, 1987 to March 1989, Deputy Regional Administrator, South Carolina Department of Corrections; May, 1982 to April, 1987, Warden, Central Correctional Institution (state penitentiary) South Carolina Department of Corrections; September, 1979 to May, 1982, Warden, Women's Correctional Center, South Carolina Department of Corrections; September, 1976 to September, 1979, Deputy Warden for Administration, Central Correctional Institution(state penitentiary) South Carolina Department of Corrections; February, 1974 to September, 1976, Deputy Warden for Institutional Operations, Manning Correctional Institution,

South Carolina Department of Corrections; September, 1972 to February 1974 Administrative Assistant to Warden, Manning Correctional Institution, South Carolina Department of Corrections; September, 1971 to September, 1972, Social Worker for Substance Abuse Treatment, South Carolina Department of Corrections.

C. Relevant Experience

I have provided direct professional and consultant services in almost every aspect of the correctional field. A major focus of my career has been the assessment and restoration of facilities and systems that have experienced chronic and acute security critical events and management shortfalls. These have included issues of:

- Inmate management and security,
- staff malfeasance,
- corruption,
- prison violence,
- sexual misconduct potential and actual critical events in confinement settings
- security critical-event prevention, evaluation, and management,
- budget shortfalls,
- public loss of trust in the confinement system,
- inmate loss of trust in the professionalism of confinement facility staff,
- staff loss of trust in the professionalism of administrators,
- emergency response and preparedness,
- inmate disruptive and violent behavior management,
- confinement facility and system culture assessment and improvement,
- confinement facility and system overall performance assessment,
- performance of death penalty executions of condemned inmates,

- inmate classification system (design, implementation and monitoring),
- addressing civil legal complaints,
- adherence with court orders,
- inmate disciplinary system performance assessments,
- confinement facility security technology (development, implementation and monitoring),
- new prison construction,
- renovation of existing confinement facilities to enhance security performance,
- confinement facility operational policy and procedure issues,
- post order development, reassessment, interpretation, and monitoring,
- facility operational performance assessments,
- policy development and interpretation,
- contraband control,
- staff training and development,
- evaluation of training,
- employee productivity evaluations,
- employee discipline,
- confinement facility cost containment strategies,
- use of force and restraint evaluation and implementation,
- criminal and administrative investigations (operational evaluations) of confinement setting critical incidents,
- staff supervision, and
- Gang/SGT management.

I have also assisted the legislative and executive branches of government on the state and federal levels by providing expert advice concerning budgetary issues and statutory reforms regarding confinement facilities and systems.

Additionally, I have provided consulting services to the U.S. Department of Justice, National Institute of Corrections, as well as served as a private contract provider to federal, state and county jurisdictions in a number of areas including, but not limited to:

- inmate classification,
- management of women offenders,
- managing violent youthful offenders in adult prisons,
- managing prison security systems,
- prison culture change,
- correctional leadership development,
- assessment of security operational performance,
- executive training for new and experienced wardens,
- prison critical event avoidance,
- management of super-maximum-security prisons,
- management of the hard-to-manage violent inmate,
- riot/gang management,
- use of force evaluation and application, and
- post critical event evaluations.

I have over 48 years of experience in the management of confinement facilities and correctional systems. I have decades of direct experience and knowledge regarding correctional strategies in the management of persons held in lawful confinement. Moreover, a major focus of my career has been to assess and restore confinement facilities and systems that have experienced chronic/acute security shortfalls and staff misconduct related to all aspects of a confinement system. More specifically, my scope of expertise includes the following:

1. **Director, Bureau of Corrections, United States Virgin Islands**

Held the position as Director that encompassed authority and responsibility for the overall administration of the Corrections Bureau for the United States Virgin Islands (jails and prison). Worked closely with other territorial agencies, the legislature, courts and federal governmental agencies.

My task was to coordinate a project to re-establish a jail/prison correctional system which was diminished by overcrowded conditions, lack of medical care, escapes, and noncompliance to court orders, corruption, general mismanagement, negative media, gang involvement, work force dysfunction, and public mistrust.

2. **Commissioner, Indiana Department of Correction**

The position encompassed the overall administration of the Department of Correction for the State of Indiana, which consisted of forty-six (46) separate adult and juvenile facilities (population 14,000) and parole services (population 3, 490) with an operations budget of $305 Million.

As Commissioner, reported directly to the Governor of the State of Indiana and worked closely with the legislature, other state and federal agencies, the courts and the public. My tasks were to establish an operational mission and priority of issues for the agency; establish agency mission goals; manage overpopulation, develop a new basic employee supervision program; and reorganized daily operations to ensure a more responsive and efficient structure.

My accomplishments included but were not limited to:

- *Offender Health Care Delivery*: The department contracted with the Indiana University School of Medicine to provide a medical director for clinical services. Developed and implemented a program to reduce cost and increase the quality of medical care.

- *Security*: Created the Division of Security to address agency security needs. Initiated a gang intelligence network to tract and evaluate their activities. Increased contraband control efforts by additional searches, drug testing, use of K-9 units, provided additional training and equipment, and increased prosecution efforts. Designed 650 bed maximum security unit that conformed to modern correctional security management and Court mandates. Conducted meetings with the National Guard, State Police, as well as other mutual aid agencies to coordinate and develop an emergency response and disaster preparedness program. Conducted full response drills to evaluate the agency's response capability. Evaluated and enhanced escape prevention/ apprehension measures. Conducted security audits and inspections of facilities.

- *Offender Relations*: Established an Offender Relations Division and appointed a coordinator. This division functions as part of Internal Audits and works in tandem with the Division of Internal Affairs, the Operations Division and the Division of Legislative and Information Services. The task of this division is to resolve offender grievances and

complaints that originate from inside the agency and resolve them prior to court involvement.

- ***Prison Population:***
  - Completed site selection, plans and construction of a new maximum-security Institution
  - Increased community corrections coverage from 35 to 50 counties (from 3,500 to 7,000 clients)
  - Established community service/restitution programs
  - Established county work release programs
  - Established residential treatment programs and created home detention utilizing electronic monitoring
  - Created over five hundred (500) new emergency prison beds within the first nine months of tenure
- ***Juvenile Justice:***
  - Reduced Indiana Boy's School population from a high of 670 in 1989 to a low of 380 in 1990
  - Conducted comprehensive reviews using several committees of community representatives concerning treatment programs, educational programs and employee training programs
  - Established a Research Department at the Indiana Boy's School.
  - Group home placements had tripled during 1992.
  - Community involvement and recreational programs have been increased at both Indiana Boy's School and Indiana Girl's School.
- ***Cost Containment:*** Developed a plan to increase participative management and input to the budget process. Meetings were held with State Budget Agency personnel on a regular basis in an effort to increase the Budget Agency's participation in the department's budget preparation regarding cost control. Reduced the operational budget of 305 million dollars by 41 million dollars for fiscal year 1992.

3. **Deputy Regional Administrator, Midlands Correctional Region, South Carolina Department of Corrections**

Served as the Deputy Chief Administrator for the following: Directly planned, prescribed and supervised activities of sixteen (16) institutions, including minimum, medium and work

release, shock probation (boot camp), restitution centers and maximum-security facilities. Also, had general supervision of a ninety-seven (97) million dollars budget, as well as a work force of 2,500 employees. Duties also included policy development and interaction with lawmakers, management of over population, the community and other departmental agencies concerning long-range agency planning and developing agency future needs. Additionally, made selections of institutional heads, as well as being involved in new facility design, reviewed all use of force actions, and provided supervision to prison wardens during emergency situations and normal operations.

4. **Warden, Central Correctional Institution, South Carolina Department of Corrections**

The previous largest correctional facility in South Carolina with 1800 medium/-maximum/super maximum custody inmates, 530 staff members, and an operating budget of eight (8) million dollars. Served as the chief administrator for the following areas/activities:

- Directly planned, prescribed and supervised all security control and safety activities/operations, as well as, conducted announced and unannounced inspections of the institution.

- Interviewed, selected and evaluated employee's performance and effected other personnel actions as required.

- Personally responsible for all activities involving population management, security and treatment staff, as well as, coordinated and supervised all welfare/morale services for inmates to include medical delivery and access.

- Supervised and coordinated all activities with representatives from non-departmental agencies.

Duties also involved emergency preparedness, operationally interpreting all laws, policies, rules and regulations, compliance with court orders (conditions of confinement) and operating procedures for employees and inmates. Studied and analyzed long-range department requirements for institutions, as well as participating in litigation action involving the South Carolina Department of Corrections.

Duties also included meeting with the Inmate Advisory Council and acting on recommendations received from the Inmate Grievance Committee, as well as meeting with members of the legislature on matters relating to corrections. Also, was responsible for carrying out the capital punishment laws for the state of South Carolina. This facility also provided high security management for population that were under the jurisdiction of the South Carolina Department of Mental Health and for population that were in pre-adjudication status that required more intense security to which the jail system could not provide.

5. **Warden, Women's Correctional Institution, South Carolina Department of Corrections**

Served as the chief administrator for the following: Directly planned, prescribed and supervised all security, control and safety activities and operations, personally responded to all disturbances and emergencies, interviewed/selected and evaluated employee's performance, counseled employees, supervised and coordinated all activities of the security and treatment staff, management of overpopulation, coordinated and supervised all welfare and morale services for female inmates including clothing, food service, mail service, visitation, medical services, religious services, educational programs and recreational programs. Supervised the implementation and executing of all laws, policies, rules, regulations and operating procedures applicable to the Women's Correctional Center. Also, studied and reviewed all available records/files on assigned inmates to evaluate their behavioral changes and rehabilitation progress. Duties included meeting with the Inmate Advisory Council as well as receiving and acting upon recommendations received from the Inmate Grievance Committee.

6. **Deputy Warden/Administration, Central Correctional Institution, South Carolina Department of Corrections**

Served as the Institutional Coordinator for the following areas/activities: Maintenance/construction, boiler room/energy, food service, employee parking, canteen services, Adjustment Committee, mail service, all security systems, transportation, pest control, criminal investigations and emergency response.

7. **Deputy Warden/Institutional Operations, Manning Correctional Institution South Carolina Department of Corrections**

Served as the Institutional Coordinator for the following areas: Youthful Offender Division, medical services, living areas, maintenance/construction, laundry services, visitation, emergency response, security, transportation, food service, commissary, administrative/punitive segregation, officer's quarters, classification teams, inmate interview/correspondence, recreation programs, energy (usage/conservation), Parole Board (prepared parole evaluations), supervision of security staff of fifty-five (55) employees, Chairman of Employee Evaluation Committee, purchasing, inmate pay and Chairman of Adjustment Committee. Prepared correspondence for the warden, conducted the majority of institutional investigations, coordinated all escape apprehension efforts and remained on twenty-four (24) hour call.

8. **Administrative Assistant/Institutional Operations, Manning Correctional Institution, South Carolina Department of Corrections**

Responsibilities included vocational rehabilitation, alcoholics anonymous, Project Mate (Paraprofessional Counseling Program), Classification Team #2, Pastoral Care, Drug Abuse Treatment Program, Recreation Program, Occupational Safety and Health Act (O.S.H.A.), Emergency Response, Work Release Program, Education Program, tours, Employee Evaluation Committee member and inmate interviewing/correspondence.

Performed duties of deputy warden in his absence and remained on twenty- four (24) hour call at all times.

9. **Social Worker/Drug Abuse Treatment Program, Manning Correctional Institution, South Carolina Department of Corrections**

Responsibilities included conducting group therapy and individualized counseling to offenders with drug problems. Conferred with the warden and staff to integrate the Drug Abuse Program with other institutional activities. Member of the Adjustment committee and the Warden's Treatment Team.

APPENDIX B

PUBLICATIONS

The following list includes all publications of the past ten years for which I was principal or contributing author:

- "Classification: A Tool for Managing Today's Offenders" Co-Author, Kirby Lithographic Company, Arlington, Virginia (American Correctional Association), 1993

- "Management and Treatment of the Hard to Manage Violet Inmate"; This Document was Designed Under a Cooperative Agreement Project Number OOP04 from The National Institute of Corrections, United States Department of Justice, 2001

- "National Prison Rape Elimination Commission Report & Executive Summary", Published June, 2009 -Commission Member*

- "National Prison Rape Elimination Commission Report-Standards for the Prevention, Response, and Monitoring of Sexual Abuse in Adult Jails-Including Supplemental Standards for Facilities with Immigration Detainees", Published June, 2009 - Commission Member*

- "National Prison Rape Elimination Commission Report-Standards for the Prevention, Response, and Monitoring of Sexual Abuse in Lockups", Published June, 2009 - Commission Member*

- "National Prison Rape Elimination Commission Report-Standards for the Prevention, Response, and Monitoring of Sexual Abuse in Community Corrections", Published June, 2009 - Commission Member*

- "National Prison Rape Elimination Commission Report-Standards for the Prevention, Response, and Monitoring of Sexual Abuse in Juvenile Facilities", Published June, 2009 - Commission Member*

APPENDIX C

PRIOR EXPERT WITNESS EXPERIENCE

To the best of my present knowledge, listed below are cases in which I have provided testimony at trial or deposition, including all cases in which I have testified as an expert within the last four years. This list will be supplemented as necessary.

- State of Indiana v. Larry Newton, Cause No.: 18D01-9410-CF-46
- Nowlin v. DC, et al., 2015-CV-00524 (CRC)
- State of South Carolina v. Deddrick Ervin, 2014-CP-03-185
- Linda Beth Weddle v. Charleston County Sheriff's Office
- Jeffrey A. Weisheit v. State of Indiana
- Charmon Sinkfield v. State of Georgia
- David Ray Bartol v. Oregon
- Poole vs. South Carolina Department of Correction, South Carolina Court of Common Pleas, 2014-CP-18-2021
- State of Arizona vs. Robert Smith
- Angela Parker Chavis, Individually and as Personal Representative for the Estate of James Parker, v. Willie Bamberg, et al.
- Nathan Lorenzo Holden v. State of N.C., 14 CRS 208087-88
- United States v. Joseph Carlton Meek, 15-cr-0063-CRI-1 (D.S.C.)
- State of Arizona v. Jason Noonkester, CR20011-138281
- State of Texas v. Erbie Bowser, Cause Nos. F16-00688-W, F13-20749-W, F13-58899-W, F13-58900-W, F13-58901-W, F13-20953-W, F13-20945-W
- Brenda Hylemann, As Guardian of Marthann Morris v. Correct Care Solution, LLC and Dr. Edmund Higgins, Civil Action Number: 2016-CP-40-01465
- Brenda Hylemann, As Guardian of Marthann Morris v. Richland County, Civil Action Number-2015-CP-40-610
- State of Georgia v. Christopher Keith Calmer, Case No.: 2015-CR-111
- Steven Spencer v. South Carolina Department of Corrections, Case No.: 2015-CP-31-0229

- State of Arizona v. Samantha Lucille Allen
- State of Florida v. Sean Bush
- Commonwealth of Pennsylvania v. David Phillips
- Myrtis Boatwright, Individually and as Personal Representative for the Estate of Anthoni M. Boatwright aka Anthony M. Boatwright, v. Deloris Charlton, et al., C/A:4:16-CV-2496-MGL-TER
- North Carolina v. Eric Campbell, 15 CRS 50053-54
- Commonwealth of Pennsylvania v. Steven Northington
- Commonwealth of Pennsylvania v. Kenneth Parnell
- Commonwealth of Pennsylvania v. Robert Clark, CP-51-CR-00120121-1980
- State of Mississippi v. William Wilson
- State of Florida v. Donald Smith, Case No: 16-2013-CF-5781-AXXX-MA
- State of Ohio v. Christopher L. Whitaker, Court of Common Pleas Case No: 614021-17-CR
- State of Arizona v. Jesus Busso-Estopellan; Case No.: CR2011-133622-001SE
- Civil Action: No. 15-cv-2184-RM-NYW; Prison Legal News v. Federal Bureau of Prisons
- Juan Alex Randolph, Jr. v. Officer Potter et.al. (D. Md. Case No. PWG-16-2739)
- State of North Carolina vs. Lamorris Chapman
- State of Georgia v. Jomekia Pope
- Soneeya v. Turco, Civil Action No: 07-12325-DPW (D. Mass.)
- Angela Taylor, Individually and as PR of the Estate of Joey Tyner vs. Kershaw County, et. al., Case Nos: 2016-CP-28-01790-BHH-MGB
- State of North Carolina vs. Emmanuel Sanders
- State of North Carolina vs. Jahrheel Ikle May
- State of North Carolina vs. Steven Craig English
- State of Ohio vs. George Brinkman

- Brewer v. South Carolina Department of Corrections, et al
- State of Florida v. Jackson
- Coats vs. Pope et al
- State of Delaware v. Baynes
- Kough, et al. v. South Carolina Department of Corrections, et al.
- State of North Carolina v. Seaga Edward Gilliard
- State of Florida vs. James Leon Jackson - Case No.: 16-2013-CF-1332-AXXX-MA, Division: CR-F
- Norman Mitchell v. SCDC
- State of Delaware v. Abednego Baynes
- State of Missouri vs. Randy G. Teter - No.16AC-CR00723, PA File No.: 051077258
- David Ray Tant v. William Frick, et al. C/A No.: 2012-CP-40-06008
- LaKrystal Coats as Personal Representative of the Estate of Demetric Cowan v. Ray Pope, FNU Nichols, FNU Cardarelli,, FNU White, Gerald Brook, Sidney Montgomery, Roy Murray, Pamela Osborne, Tony Davis
- Commonwealth of Pennsylvania v. Jacob Sullivan. Case Number CP-09-CR-0001333-2017
- United States District Court, Eastern District of California: Case No.: 1:15-CV-0`749-MCE-JLT Anthony Weston Smith v. County of Kern, Donny Youngblood
- State of N.C. vs. Jon Frederick Sander, 16 CRS 2016046; 16 CRS 1582-83
- State of Arizon v. Jason Noonkester; CR2011-238281
- State of North Carolina v. James Opelton Bradley -16 CRS 007232
- State of North Carolina v. David Isaiah Goodwin – 16 CRS 52931
- Ronald Brewer v. SCDC. et, al, C/A No.: 1:17-cv-02212-AMQ-SVH
- Estate of Patricia Parrish v. Georgetown County, et al
- George W. Johnson, as Personal Representative of the Estate of Oliver Gabriel Johnson vs. South Carolina Department of Corrections

- Ohio v. Matthew Nicholson
- State of Florida vs Snelgrove
- Ray v. SCDC
- Huckabee v. SCDC
- Dexter Crawford vs. SCDC of Corrections et.al, CA No: 6-18-cv-2407-DCN-KFM
- State of Texas vs. Burnches Mitchell
- Renciu v. SCDOC

APPENDIX D

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CONFIDENTIAL

May 19, 2020

Via Email

Mr. James E. Aiken
36 Tsiya Court
Brevard, North Carolina 28712
Email: jea1assocs@aol.com

Dear Mr. Aiken:

As you know, Kirkland & Ellis LLP, King & Spalding LLP, the American Civil Liberties Union Foundation ("ACLUF"), and the Roger Baldwin Foundation of ACLUF, Inc. ("RBF") represent the plaintiff class of transgender prisoners in the custody of the Illinois Department of Corrections ("IDOC") in the *Monroe, et al. v. Rouner, et al.* in connection with the adequacy of medical care provided by the IDOC to transgender prisoners. Acting on behalf of the plaintiff class, we have discussed with you the possibility of your serving in this matter as a testifying expert. Thank you for agreeing to serve as an expert witness in this case. The terms of your retention are set forth below. Please signify your agreement to these terms by countersigning this letter and returning it to me.

This letter confirms that the ACLUF, RBF, Kirkland & Ellis LLP, and King & Spalding LLP, have retained you as an expert in this case and we have agreed to pay your customary fee plus reasonable expenses you incur in connection with your work on this matter. Your customary fee is $175 per hour for report writing, phone conferences, face-to-face meetings, and trial testimony. For depositions, your customary fee is $1500 per day or any portion of a day. In addition to professional fees, we will compensate you for reasonable direct out-of-pocket expenses, such as charges for travel. You will inform us if you anticipate total fees will exceed $5000 prior to incurring those costs in excess of that amount, and inform us of the same for every additional $5000 thereafter prior to incurring those costs in excess of that amount.

You should send your bills directly to my attention at Kirkland & Ellis LLP, and bills should be issued no less frequently than every other month. You have advised us that no conflicts exist with your taking on this assignment. You agree that you will not provide expert witness services in this case or matters directly connected with this case for any person or entity, other than the plaintiffs and their attorneys, without the advance written approval of the plaintiffs' attorneys. In addition, you agree that while this matter is still active you will not

provide expert services for any person or entity who has asserted or proposes to assert any position antagonistic to that of the plaintiffs in this case, without the advance written approval of the plaintiffs' attorneys.

In the course of your retention, we may call upon you to provide information, prepare studies or reports, participate in meetings, review materials, and undertake other tasks for ACLUF, RBF, Kirkland & Ellis LLP, and King & Spalding LLP as counsel to transgender prisoners. We intend that your work, opinions, conclusions and communications will be covered by the attorney-client privilege and attorney work product rule to the extent provided by law, and you agree to do all things necessary to preserve those privileges.

You agree that documents and information of any kind that you (or anyone assisting you) acquire will be maintained in strict confidence and not disclosed to any other person or party without our prior written consent. All documentary material provided to you (or to anyone assisting you) together with all copies thereof must be returned immediately upon request. In addition, any activities that you perform under this agreement and any conclusions or judgments that you reach or have reached must be maintained as confidential in the same way. You should understand that these restrictions will continue even after the termination of your consulting work for us and after the termination of the matter.

Reports and other documents generated, or obtained by you, in the course of your work on this matter will be the property of the ACLUF, RBF, Kirkland & Ellis LLP, and King & Spalding LLP. If authored by you, the work will be considered "Works Made For Hire" and all right, title and interest in such works is hereby assigned by you to the CLUF, RBF, Kirkland & Ellis LLP, and King & Spalding LLP.

The nature and duration of your retention will be determined by the ACLUF, RBF, Kirkland & Ellis LLP, and King & Spalding LLP and may be modified or terminated by us at any time for any reason. This agreement may not be amended or modified, nor any provision waived by any means other than an express writing to such effect which is signed by you and the ACLUF, RBF, Kirkland & Ellis LLP, and King & Spalding LLP.

* * *

We greatly appreciate your help in this matter, and we are looking forward to working with you.

Sincerely yours,

KIRKLAND & ELLIS LLP

By: _____
Name: Jordan M. Heinz

Agreed and accepted this 19th day of May, 2020.

Mr. James E. Aiken

By: _____

Agreed and accepted this 21st day of May, 2020.

The American Civil Liberties Union Foundation

By: _____
Name: Printed Name James D. Esseks

Agreed and accepted this 20 day of May, 2020.

The Roger Baldwin Foundation of ACLUF, Inc.

By: _____
Name: John A. Knight

Agreed and accepted this 20th day of May, 2020.

KING & SPALDING LLP

By: _____
Name: Brent P. Ray

EXHIBIT 10

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS
EAST ST. LOUIS DIVISION

JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELENA VISION, SORA KUYKENDALL, and SASHA REED,

Plaintiffs,

vs.) Case No. 18-156-NJR

ROB JEFFREYS, MELVIN HINTON, and STEVEN BOWMAN,

Defendants.

The deposition via videoconference of ERIC PADILLA a.k.a LYDIA HELENA VISION, taken before Alyssa N. Kuipers, Certified Shorthand Reporter and Registered Professional Reporter, commencing at 9:00 a.m. on the 25th day of August, 2020.

I N D E X

E X H I B I T S

(NO EXHIBITS MARKED.)

APPEARANCES:

ACLU OF ILLINOIS
MR. GHIRLANDI GUIDETTI (via videoconference)
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On behalf of the Plaintiffs;

ILLINOIS ATTORNEY GENERAL
MS. LISA A. COOK (via videoconference)
500 South Second Street
Springfield, Illinois 62701
Phone: (217) 782-4445
E-mail: lcook@atg.state.il.us
On behalf of the Defendants.

* * * * * *

(Witness sworn.)

WHEREUPON:

ERIC PADILLA a.k.a LYDIA HELENA VISION, called as a witness herein, having been first duly sworn, was examined and testified via videoconference as follows:

DIRECT EXAMINATION

BY MS. COOK:

Q. Can you just start off by stating your name for the record; and you can say your preferred name, if you wish.

A. Lydia Helena Vision.

Q. Okay. So it's Vision?

A. Yeah.

Q. I've been adding the accent to it, so I apologize for that.

A. It's okay.

Q. Okay. So, Ms. Vision, we're here for your deposition for a case that you're a plaintiff in in the Southern District of Illinois, Case No. 18-156. Did you know that before we started today?

A. Yes.

Q. And are you having any problems

trip to take a shower in a place where I had to file a PREA complaint in a different prison doesn't real appeal to me.

Q. Okay. So at other facilities, were you given the option to shower in a more private setting?

A. Yes.

Q. Like, so at Danville, where would you shower?

A. At Danville, I did walk across the camp to shower in the medical unit, which led to, in my opinion, being assaulted by a lieutenant while naked in the shower, so you can see why I wouldn't want to do that anymore.

Q. So is it that you're worried that if you went to a different location, you could be at risk of assault?

A. I'm at risk of assault all the time.

Q. And when you say that, do you mean by other inmates or staff or both?

A. Both.

Q. Have you been having issues at Centralia with other inmates?

A. Can you please clarify?

Q. Like threats from other inmates at Centralia?

A. Yes.

Q. What kind of threats?

A. I don't understand.

Q. Are the threats related to your transgender status?

A. Yes.

MR. GUIDETTI: Objection, foundation.

BY MS. COOK:

Q. And have you been receiving threats from staff at Centralia Correctional Center?

A. I'm not at liberty to discuss it.

Q. And you requested a transfer to a female facility, correct?

A. Correct.

Q. And have you been told anything about that request?

A. Yes.

Q. And what have you been told?

A. It was intimated to me that it was approved in February, but because of the COVID thing, it didn't happen.

Q. Do you think that a transfer to a female facility will alleviate some of your concerns about threats?

A. Yes.

Q. Where you are currently, do you have access to transgender groups?

A. No.

Q. Have you made a request with IDOC staff for gender-affirming surgery?

A. Yes.

Q. And what surgery are you seeking?

A. An orchiectomy and electrolysis.

Q. And do you remember when you made those requests?

A. 2016 maybe.

Q. Do you remember when in 2016?

A. No. When I -- No, I don't remember.

Q. Have you requested surgery since 2016?

A. Yes.

Q. Do you remember when?

A. Can you clarify?

Q. Well, how many times since 2016 have you renewed your request?

A. Dozens.

Q. And how do you renew it? Do you write letters, grievances?

A. I've brought it up to the mental health staff, to the medical staff, written grievances.

Q. And so when you bring it up to medical and mental health staff, do you do that verbally?

A. I've done it verbally and in writing.

Q. And has mental health staff given you a response on your request?

A. No.

Q. Has medical staff given you a response on your request?

A. No.

Q. And in the grievances you write, do you get a response to those?

A. Sometimes, sometimes not.

Q. Do you keep copies of all the grievances that you send?

A. I've kept what I could.

Q. So has anybody told you, you know, a

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definitive yes or no on your surgery requests?
A. No, they have not.
Q. What about requests for female clothing items? Have you requested female clothing items?
A. Yes.
Q. Have you received any women's clothing items?
A. Just two bras.
Q. Has anybody told you anything about changes in allowable property at male facilities to allow for female items?
A. Can you clarify?
Q. Yeah. So have you heard any -- from medical or mental health staff, have you heard there might be changes in the lists for allowable property at male facilities?
A. From them, on the issue, I always get a denial and a form of delay. "Wait. We're working on it." Things of that nature.
Q. And is that the same for like the administrative staff, like the warden, assistant wardens?
A. If they respond at all.

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Q. Have you requested any female-specific hygiene items?
A. Yes.
Q. And what are those?
A. Any specific female hygiene items, soap, shampoos, deodorants, razors, things of that nature.
Q. And have you been allowed any of the hygiene items you've requested?
A. No.
Q. And, again, has any DOC staff, either, you know, on the medical/mental health side or the administrative side, told you of any upcoming changes?
A. In as much as they always say: Wait, wait, wait.
Q. At Centralia, are you strip-searched by staff?
A. Can you clarify?
Q. Yeah. Are there any times at Centralia where you've been strip-searched by staff?
A. Yes.
Q. How often does that occur?

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A. When I first got here, any visits that I've had while I was here. I don't know exactly how often.
Q. And do male or female staff do the strip-searches?
A. Male.
Q. Have you asked for female staff to do it?
A. Yes.
Q. And when do you ask?
A. I asked when I first got here. I got transferred here, they strip-search you out; I asked right then.
Q. And do you remember the response you got?
A. It's not pleasant.
Q. So when you say "not pleasant," what do you mean?
A. I'm not at liberty to discuss security staff.
Q. Are you concerned because there's other staff in the room with you?
A. Correct.
Q. Well, I just want to know -- So, I

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mean, when you've asked, has it been, you know, the search is just starting and then you ask, or have you asked like the warden or assistant wardens about the searching?
A. I don't understand the question.
Q. Have you raised your search concerns with the warden or assistant wardens?
A. I believe I've written a grievance on the issue.
Q. Do you remember when you wrote that?
A. No.
Q. Do you remember if you got a response?
A. No.
Q. Do you know if you have a copy of that grievance?
A. No, I do not. I don't know if I do or not. I would have to review my paperwork.
Q. Do you keep track of the grievances that you send?
A. As much as possible.
Q. Do you send any letters or kites?
A. Excuse me?
Q. Do you send any letters or kites to

the warden or assistant wardens?
A. No.
Q. Is there any other treatment that you've requested for gender dysphoria that you've not received?
A. I don't understand.
Q. Besides the items I've already asked you about, is there any treatment that you've requested that you have not received?
A. Yes.
Q. And what's that?
A. Mental health counseling in accordance with the WPATH standards.
Q. And what do you mean by that?
A. What do I mean by that? Excuse me?
Q. Yeah. What exactly do you mean?
A. Half of the staff here have hardly any knowledge on gender dysphoria, so, yeah.
Q. So you want treatment providers who have more experience with gender dysphoria?
A. Correct. I believe I also requested voice coaching also.
Q. And did you get a response on your request for voice coaching?

A. Same as always, no response, delayed, or denial.
Q. When you've gotten a response where staff say "we're working on it," you know, that type of thing, do they ever tell you what steps they're taking to work on it?
A. No. To be honest, some of them say it in a joking manner.
Q. At Centralia, does the staff misgender you?
A. Yes.
Q. Do you communicate, you know, that you wish to be called she/her?
A. Sometimes.
Q. And when you do let staff know, will they change how they refer to you?
A. Again, I don't feel comfortable talking about security staff.
Q. Well, I understand to a certain point, but I think that this has been enough of a topic. I do have to ask you about this. I'm not asking you about specific people right now. I just want to know, overall, like if you can give me a percentage, you know. When you let

people know that you want to be treated female, do they more often than not act respectfully towards you or disrespectfully?
A. They do not act respectfully of that request.
Q. Because of -- Well, I'm going to rephrase that.
Do you feel -- I think I saw somewhere in your records that maybe in the beginning, you thought you were on a spectrum of gender?
MR. GUIDETTI: Objection to form. You can answer if you understand the question.
BY THE WITNESS:
A. I don't understand.
Q. When you first described some of the symptoms of gender dysphoria, did you feel at that time like you fully associated as female?
A. Yes.
Q. And do you still feel that you fully associate as female?
A. Yes.
Q. In recent months, do you feel like

you want to harm yourself?
A. I don't understand.
Q. While I know you mentioned that you don't have a history of self-harm, but is that something that you feel currently or in recent months?
A. I don't believe -- I don't know.
Q. Have you felt suicidal in recent months?
A. Yes.
Q. When you feel suicidal, when has that occurred?
A. I don't know the dates. I don't understand the question. What do you mean?
Q. Well, I am looking for dates, but can you give me an approximate time?
A. Like time of the day? I don't understand.
Q. Like, you know, six months ago or --
A. Within six months.
Q. Within six months.
Were you able to reach out to any staff for assistance?
A. No, I was not.

EXHIBIT 11

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS

JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELÉNA VISION, SORA KUYKENDALL, and SASHA REED, individually and on behalf of a class of similarly situated individuals,	)	
Plaintiffs,	)	Case No. 3:18-cv-00156-NJR
v.	)	
ROB JEFFREYS, STEVE MEEKS, and MELVIN HINTON,	)	
Defendants.	)	

DECLARATION OF CHONNA ANDERSON

I, Chonna Anderson, hereby state:

1. I am a 38-year-old woman from Chicago, Illinois, and am currently imprisoned at Centralia Correctional Center.

2. I was assigned a male gender at birth, but have understood my gender is female since I was very young. Around the age of twelve or thirteen, I came out as transgender to my mother. She was very supportive and concerned about my wellbeing. I had been engaging in self-harm because I didn't understand my body and was unhappy with it.

3. Around that time, my mother took me to see a doctor who explained I had "gender identity disorder." My mother did not have healthcare insurance, so I was unable to receive the treatment recommended by the doctor as a prescription. But my mother was able to find medication for me in the community. I think it was Premarin and something else in a white bottle, but I can't remember what it was called. I took these medications as regularly as I could when my mother could find them.

4. I was incarcerated in April 2007. Soon after being admitted to Stateville Correctional Center, I requested to continue the hormones (estrogen) I had been taking pretty consistently for the last four years (except for one lapse of less than six months when I couldn't find my medication). Prison officials at Stateville told me at that time that IDOC did not provide hormone therapy.

5. Learning that I could not receive my hormones in prison was devastating to me. I thought my life was over with, and seriously considered doing harm to myself because of it. I was put on suicide watch for about eight days (this was two or three days after my admission to Stateville). When I was taken off suicide watch, I asked again for hormones and was told there was nothing IDOC could do for me. I remember being very emotional, crying, and feeling completely hopeless. I was put on suicide watch again for about 15 days. After that, I gave up on asking for hormones, but I couldn't stop thinking about how I did not feel like myself and struggled to function.

6. In June 2011, I was diagnosed with non-Hodgkin's lymphoma and treated with chemotherapy from July 2011 to December 2011, when I was told I was in remission. I discovered my cancer had returned in February 2013, received six treatments of radiation from June to October 2013, and have been living cancer-free since then.

7. Around 2014, while I was housed at Western Correctional Center, I heard that other transgender prisoners were receiving hormone therapy. I got really excited thinking that I would be able to start taking hormones again and could be the woman I have always known I am.

8. I was getting PET scans about every six months at that time to monitor my cancer remission. I asked the doctor at Western CC (I think his name was Dr. Shaw) who was overseeing

my medical care about starting hormones again. He told me I could not receive hormone therapy because it would put me at higher risk of the cancer returning.

9. The doctors I was seeing outside of IDOC – I think it was oncologist Dr. Greco in Swansea, Illinois with St. Elizabeth's hospital and Dr. Ali at the cancer center in Quincy, Illinois – told me they did not think hormones would have an effect on the cancer. When I raised this with the doctor at Western, every six months when I returned from my PET scans, he would give me the runaround and told me I had to go through mental health for hormone therapy. The mental health person told me I needed approval from my doctor and a committee. I was told I was on the docket for the committee starting in early or mid-2015 but nothing ever came of it. I don't know if the committee ever reviewed my request for hormone therapy.

10. I felt like IDOC would never give me hormones. My excitement turned back into depression and I was put on suicide watch again. I felt like there was no use trying.

11. I requested hormone therapy again in 2018 while at Pinckneyville Correctional Center and was told that my request needed to be reviewed by a committee. I have been waiting for a response ever since then.

12. I do not know if IDOC ever formally diagnosed with gender dysphoria. I am still not receiving hormones and no one from IDOC has provided me any information about why.

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

Dated: January 11, 2021

/s/ *Chonna Anderson*
Chonna Anderson[1]

[1] Plaintiffs' counsel spoke with Ms. Anderson on January 11, 2021 by telephone. During this conversation Ms. Anderson authorized Plaintiffs' counsel to file this declaration on her behalf. Plaintiffs' counsel will supplement this declaration with a signed copy from Ms. Anderson once it is returned to them by U.S. Mail from Ms. Anderson.

EXHIBIT 12

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS

JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELÉNA VISION, SORA KUYKENDALL, and SASHA REED, individually and on behalf of a class of similarly situated individuals, Plaintiffs, v. ROB JEFFREYS, MELVIN HINTON, and STEVE MEEKS, Defendants.	)	Case No. 3:18-cv-00156-NJR

DECLARATION OF DR. VIN TANGPRICHA, M.D.

I, Dr. Vin Tangpricha, hereby state:

1. I am a medical doctor with special expertise in treatment of transgender patients with gender dysphoria. I am the immediate past President of the World Professional Association for Transgender Health ("WPATH"), the preeminent professional organization dedicated to the understanding and treatment of gender dysphoria worldwide. I have published extensively on issues relating to treatment of individuals with gender dysphoria and I treat transgender patients as part of my clinical practice.

2. I have been retained by counsel for the named Plaintiffs and the class in the above-captioned matter to provide the Court with scientific and medical information about gender dysphoria and the standard of care for treatment, and to evaluate the current hormone therapy provided by IDOC to the named Plaintiffs and the class members based primarily upon analysis of their medical records.

3. I have recently reviewed the Illinois Department of Corrections' medical records for *Monroe* class-member Chonna Anderson for the period from March 2015 through August 2020. (Bates nos. 320727-321397, 343764-343767, and 355838-355897). These records include "Offender Physical Examination" forms, medical histories, progress notes, mental health and psychiatric notes, transfer summaries, "Medical Special Services Referral and Report[s]" and laboratory resting results.

4. I also reviewed the Declaration of Chonna Anderson dated January 8, 2021.

5. Ms. Anderson stated in her declaration that she first requested hormones in April 2007. I have seen nothing in Ms. Anderson's medical records that explains or provides any medical justification for the incredibly long delay Ms. Anderson has experienced in receiving hormone therapy. There are no contraindications to hormone therapy identified in any of Ms. Anderson's laboratory testing results of medical notes.

6. The records I have reviewed indicate that IDOC identified her as "transsexual" as early as July 2018. While this terminology is no longer used, it clearly indicates that IDOC medical staff were on notice by then that Ms. Anderson should be promptly evaluated for gender dysphoria and for hormone therapy.

7. However, it was not until November 2019 that Ms. Anderson's care was reviewed by the "Transgender Care Review Committee," which approved her to begin hormone therapy.

8. There is nothing in the medical records offering a medical justification for the fact that she is still not receiving hormones.

9. In her declaration, Ms. Anderson states that IDOC doctors told her in 2014 that she could not receive hormones because of her history of non-Hodgkin's lymphoma. However, the treatment of this type of cancer is not a medical justification for denying someone hormone therapy. Hormone replacement therapy has no effect on this form of cancer or its treatment. It does not make the treatment any less effective, nor does it increase the likelihood that the cancer will return.

10. Ms. Anderson medical records indicate that she has been in remission since 2013, so her history of having cancer history is not a reason to deny her hormone therapy.

11. Ms. Anderson states in her declaration that she had been taking hormones before her imprisonment in 2007. This history should have resulted in the continuation of hormones while in care absent some medical contraindication. However, nothing in her medical records suggests any contraindication or otherwise explains this decade-long delay in diagnosing Ms. Anderson with gender dysphoria and starting her on hormone therapy.

Dated: January 14, 2021

Dr. Vin Tangpricha, M.D., Ph.D

EXHIBIT 13

ILLINOIS DEPARTMENT OF CORRECTIONS

Transgender Care Review Committee Recommendation

PNKCC
Facility

☒ Initial Recommendation ☐ Follow-up (Reason) _____

Section I: Offender Information

Name: Anderson, Machon ID#: R09312 D.O.B: [redacted]

Section II: Gender Identity Information

(Check One)

☒ Male to Female Transgender ☐ Female to Male Transgender
☐ Intersex ☐ Other (Explain below)

- Natal Gender at Birth: ☒ Male ☐ Female ☐ Intersex
- Natal Genitalia: ☐ Male ☐ Female ☐ Intersex

Explain: _____

Section III: Gender Identity History

- Has the offender ever strongly desired to have the sexual characteristics of the gender opposite his or her natal gender? ☒ Yes ☐ No
- Has the offender had the strong desire to be treated as a gender other than his or her assigned natal gender? ☒ Yes ☐ No
- Outside of IDOC, did the offender dress as a gender other than his or her assigned natal gender? ☒ Yes ☐ No
  - If yes, did the offender dress as a gender other than his or her assigned natal gender ☐ Exclusively or ☐ Occasionally
- Does or has the offender felt upset by family, friends or society's lack of acceptance of their sense of gender? ☒ Yes ☐ No
- At what age did the offender begin thinking of self as the opposite or alternative gender? 8yrs old
- Has the offender ever felt like getting rid of their natal genitals or sexual characteristics? ☒ Yes ☐ No
- Has the offender had the strong desire to be treated as the opposite or alternative gender? ☒ Yes ☐ No

Comments: Patient reported that she has attempted in the past to cut on her genitals and remove them.

Section IV: Hormone Therapy

- Has the offender taken hormones for: Masculinization? ☐ Yes ☐ No
  Feminization? ☒ Yes ☐ No
  - If yes, at what age did the offender begin taking the hormones? 14yrs old
  - Were the hormones legitimately prescribed by a medical provider? ☒ Yes ☐ No
  - Identify the hormones the offender has/is taking:
  - Is the offender currently receiving hormones? ☐ Yes ☒ No
    - If yes, were the hormones prescribed by IDOC? ☐ Yes ☐ No
  - Is the offender aware of the reproductive implications (reduced fertility), options and decisions related to the use of masculinizing or feminizing hormones? ☒ Yes ☐ No

ILLINOIS DEPARTMENT OF CORRECTIONS
Transgender Care Review Committee Recommendation

Section V: Reassignment Surgical Procedures

Female to Male

- Has the offender had surgery for breast reduction? ☐ Yes – At age: _____ ☐ No
- Has the offender had surgery for removal of ovaries? ☐ Yes – At age: _____ ☐ No
- Has the offender had surgery for removal of uterus? ☐ Yes – At age: _____ ☐ No

Male to Female

- Has the offender had surgery for breast augmentation? ☐ Yes – At age: _____ ☒ No
- Has the offender had surgery for removal of the penis? ☐ Yes At age: _____ ☒ No
- Has the offender had surgery for removal of the testes? ☐ Yes – At age: _____ ☒ No
- Has the offender had injection(s) of silicone into face buttocks, hips? ☒ Yes – At age: 17yrs ☐ No
  - If yes, identify area(s) of injection: Buttocks - silicone parties
- Has the offender had surgery to shave the Adam's apple? ☐ Yes – At age: _____ ☒ No

Section VI: Sexual Preference and Potency

Sexual Preference (Check One)
☒ Males exclusively ☐ Females Exclusively ☐ Both, Males & Females ☐ None

- Has the offender retained the ability to reproduce? ☒ Yes ☐ No
- Does the offender have biological children? ☐ Yes – Age(s) _____ ☒ No
- Is the offender able to have a penile erection? ☐ Yes ☒ No ☐ N/A

Section VII: Mental Health and Substance Use History

- Is the offender currently receiving treatment through IDOC for mental health symptoms? ☒ Yes ☐ No
  - If yes, what is the diagnosis? MDD w/psychosis
- Has the offender ever been treated with medication for:
  ☒ Depression ☒ Anxiety ☒ Psychosis ☐ Other (Identify) _____
  - If the offender has been treated with medication for one of the above, what was/is the diagnosis? MDD w/ psychosis
- What substance(s) has the offender used regularly? (Check all that apply)
  ☒ Cannabis ☐ Cocaine ☐ Opioids ☐ Alcohol ☐ Amphetamines
  ☐ Crystal Meth ☐ PCP ☐ Ketamine ☐ Hallucinogens
  ☐ Tobacco or other nicotine products ☒ Other (Identify) Ecstacy
  - What is the offender's drug of choice? Marijuana
  - When was it last used? 12yrs ago, 2007
- Does the offender plan to resume using any of the above substances upon/ if released? ☐ Yes ☒ No
  - If yes, specify: _____
- Is there a relationship between substance abuse and the offender's gender identity? ☒ Yes ☐ No
- Has the offender attempted suicide or self-injury? ☒ Yes ☐ No
  - If yes, identify the number of times and lethality of attempts: 2x, 2002 - hung herself and overdose
- Does the offender frequently think of suicide or not wanting to live anymore? ☐ Yes ☒ No
  - If yes, explain: _____

ILLINOIS DEPARTMENT OF CORRECTIONS
Transgender Care Review Committee Recommendation

- Is the offender mentally stable? ☒ Yes ☐ No
  - If no, explain: _____
- Is the offender currently prescribed psychotropic medication? (If yes, attach most recent MAR) ☒ Yes ☐ No

Section VIII: Medical History (Attach a copy of the offender's physical examination)

- Has the offender been diagnosed with: (Check all that apply)
  ☐ HIV+ ☐ Hepatitis B ☐ Hepatitis C ☐ Cirrhosis ☐ HTN ☐ Diabetes
  ☐ Obesity ☐ CAD ☐ Other(s) (Identify): _____
- Is the offender currently prescribed non-psychotropic medication? ☒ Yes (Attach most recent MAR) ☐ No

Section IX: Predator/Vulnerable Status

- Is the offender considered to be: ☐ Vulnerable ☐ Predator ☐ Both
  -OR - ☐ Status is still under review
- What is the offender's current housing situation: ☒ Functions well in general population
  ☐ Housed in segregation ☐ Housed separately
  ☐ Other (explain) _____
- Is the offender currently receiving special accommodations for showering?
  ☐ Yes, offender is showered separately and in private from other offenders.
  ☐ No, it has been determined no showering accommodations are necessary.

Section X: Sections I – IX Completed by:

Anthony Williams, LCPC	Anthony Williams	Digitally signed by Anthony Williams Date: 2019.10.08 18:17:20 -05'00'	09/02/2019
MHP Name (Print)	Signature		Date
Health Care Representative (Print)	Signature		Date

Date presented to TCRC: 10/5/19

Presented by: MHP: tony Williams, Health Care Rep.: _____

Committee Recommendations

Clothing - Based on the most recent physical examination, the TCRC:+

- ☐ Recommends the issuance and use of a sports bra.
- ☐ Does not recommend the issuance and use of a sports bra.

Justification for the decision: _____

Hormone supplementation - At this time the TCRC:

- ☒ Has no objection to the prescription of hormonal supplementation.
- ☐ Does not support the prescription of hormonal supplementation.

Justification for the decision: Stable psychiatrically, no medical concern, family support

Distribution: Offender Medical File
Transfer Coordinator
Chief Administrative Officer

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ILLINOIS DEPARTMENT OF CORRECTIONS
Transgender Care Review Committee Recommendation

Support/Treatment – At this time it is the recommendation of the TCRC to refer the offender:

- ☐ For general support for living as a transgender or intersex person in a correctional environment.
- ☐ For individual or group treatment for: (Check all that apply)
  - ☐ Gender identification
  - ☐ Sexual identification
  - ☐ Gender Dysphoria Treatment/Support/Monitoring
  - ☐ Internalized Transphobia
  - ☐ Internalized Heterosexism
  - ☐ Minority Stress Management and Interpersonal Effectiveness
  - ☐ Therapy R/T living safely in a manner consistent with one's inner sense of gender
  - ☐ Treatment of other mental health concerns
  - ☐ Release planning and transgender aftercare needs

Additional TCRC Recommendations: _____

TCRC Participants:

Agency Medical Director/Chief of Psychiatry:
William Puga, MD (Print Name) _____ (Signature)

Chief of Mental Health:
Dr. Melvin Hinton (Print Name) ON File (Signature)

Transfer Coordinator Representative:
Glenda Worthey (Print Name) _____ (Signature)

Chief of Operations
Chief Eilers (Print Name) Not Present (Signature)

Chief Administrative Officer
_____ (Print Name) _____ (Signature)

Primary Care Provider
_____ (Print Name) _____ (Signature)

Additional Participant(s)
Medical Coordinator (Print Title) Janette Candido (Print Name) ON File (Signature)
Southern & Central Regionals (Print Title) Drs. Reister & Fairless (Print Name) _____ (Signature)

Distribution: Offender Medical File
Transfer Coordinator
Chief Administrative Officer

Printed on Recycled Paper

DOC 0400 (Rev 6/2019)

EXHIBIT 14

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS

JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELÉNA VISION, SORA KUYKENDALL, and SASHA REED, individually and on behalf of a class of similarly situated individuals, Plaintiffs, v. ROB JEFFREYS, MELVIN HINTON, and STEVE MEEKS, Defendants.	)	Case No. 3:18-cv-00156-NJR

DECLARATION OF DR. VIN TANGPRICHA, M.D.

I, Dr. Vin Tangpricha, hereby state:

1. I am a medical doctor with special expertise in treatment of transgender patients with gender dysphoria. I currently serve as President of the World Professional Association for Transgender Health ("WPATH"), the preeminent professional organization dedicated to the understanding and treatment of gender dysphoria worldwide. I have published extensively on issues relating to treatment of individuals with gender dysphoria and I treat transgender patients as part of my clinical practice.

2. I have been retained by counsel for the named Plaintiffs and the class in the above-captioned matter to provide the Court with scientific and medical information about gender dysphoria and the standard of care for treatment, and to evaluate the current hormone therapy provided by IDOC to the named Plaintiffs and the class members based primarily upon analysis of their medical records.

Qualifications and Basis of Declaration

3. I received my M.D. from Tufts University School of Medicine in Boston, Massachusetts in 1996. I subsequently earned a Ph.D. in Molecular Medicine from Boston University School of Medicine in 2004. I am Board Certified in Internal Medicine and in Endocrinology, Diabetes, and Metabolism by the American Board of Internal Medicine.

4. Since January 2004, I have served as Professor of Medicine, Division of Endocrinology, Metabolism, and Lipids at the Emory University School of Medicine in Atlanta, Georgia. I became a full professor in September 2017. I have also been the Director of the Transgender Clinic and a staff physician at Emory since 2004, and have treated patients as a staff physician at the Department of Veterans' Affairs Medical Center ("VA") in Atlanta, Georgia since 2006.

5. Over the past 10 years, in my capacity as an endocrinologist, I have treated approximately 260 transgender patients with gender dysphoria at Emory, and approximately 100 additional transgender patients with gender dysphoria at the Atlanta VA Medical Center. I also participate in an initiative known as the WPATH Global Education Initiative, in which I deliver lectures three to four times a year on topics relating to hormone therapy for transgender persons.

6. I have authored or co-authored numerous scholarly articles and contributed to several books on topics relating to endocrinology in general and treatment of transgender patients in particular, including several guideline publications relating to endocrine treatments for transgender patients. My CV containing a full list of my publications inclusive of the past 10 years is included with this declaration as Appendix A.

7. From 2007 to 2009, I served as one of eight authors on the first hormone guidelines for transgender persons as a member of the Endocrine Society Task for Transgender Health Guidelines. This was one of the first such set of guidelines for hormone treatment of transgender persons published by a professional society, and continues to be the authoritative reference regarding hormone therapy for transgender persons. I have also served on committees of other relevant professional organizations, including with the American Association of Clinical Endocrinologists.

8. I previously submitted a sworn declaration in the above-captioned matter on April 26, 2019 ("April 2019 Report"). I also submitted a sworn supplemental declaration in the above-captioned matter on August 23, 2019. This declaration presents my opinions and conclusions regarding Defendants' documents produced since August 2019, but it also incorporates and assumes the opinions previously provided in my prior declarations. This report is not intended to alter the conclusions contained in my initial or supplemental declarations in any way.

9. I previously provided expert testimony at the Preliminary Injunction hearing in the above-captioned matter. *See* Dkt. 157, PI Hr'g Tr. at 87:24–184:4. I have not previously provided expert testimony at deposition or at trial in any other matter.

10. My clinical consulting fee in this case is $400 USD per hour. My full retention agreement is included with this declaration as Appendix B.

11. In preparing this declaration and expert report, I relied on my review of each of the named Plaintiffs' medical records (including records of their prescriptions and laboratory results), the medical records of class members (including records of their prescriptions and laboratory results), my extensive medical expertise in the area of endocrinology, and my review of the

relevant medical literature related to hormone therapy and treatment of gender dysphoria, including the WPATH Standards of Care and the Endocrine Society Guidelines. Additional medical literature on which I have relied is cited and referenced throughout this report. I have also reviewed and relied on the materials from IDOC's Transgender Committee/GID Committee, as well as my phone interviews with each of the named Plaintiffs conducted prior to submitting my April 2019 Report. The materials I have relied upon in preparing this declaration are the same types of materials that experts in my field regularly rely upon when forming opinions on these subjects.

Background on Gender Dysphoria

12. Gender dysphoria, previously known as gender identity disorder, is a serious medical condition recognized in both the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) and the World Health Organization's International Statistical Classification of Diseases and Related Health Problems (11th rev. 2018).

13. Not all transgender individuals experience gender dysphoria. Rather, individuals with gender dysphoria are those transgender individuals who experience an incongruence between their innate sense of belonging to a particular gender and the sex assigned to them at birth, accompanied by clinically significant distress or impairment of functioning because of the incongruence. Transgender patients sometimes describe this feeling informally as not feeling "at home" in their own bodies.

General Guidelines for Treatment for Gender Dysphoria

14. The medically accepted standards of care for treatment of gender dysphoria are set out in the WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People (7th ed. 2011) (hereafter, "WPATH Standards"). These are internationally recognized guidelines for the treatment of persons with gender dysphoria, and inform proper medical treatment for healthcare professionals around the world.

15. The Endocrine Society promulgates its own guidelines for hormone therapy for use in treating transgender persons with gender dysphoria. The Endocrine Society is a global group of healthcare professionals dedicated to the clinical practice of endocrinology and to researching and advancing hormone therapy for treatment of a variety of hormone disorders, including those that may accompany gender dysphoria.

16. These guidelines, which I co-authored, are entitled Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline (hereinafter, "Guidelines"), and they establish a framework for treatment of gender dysphoria, and in particular, hormone therapy. The Guidelines are recognized around the world as the authoritative guide for hormone therapy in treatment of transgender persons with gender dysphoria. WPATH endorses the hormone regimens from the Guidelines.

Hormone Therapy Guidelines for Treatment of Gender Dysphoria

17. Both the WPATH Standards of Care and the Endocrine Society Guidelines identify hormone therapy as an important treatment for gender dysphoria, as such treatment is used to feminize or masculinize the body in order to reduce the distress caused by the discordance between

a person's gender identity and their sex assigned at birth. WPATH Standards at 33; Guidelines at 3869.

18. Hormone therapy works to treat gender dysphoric persons by (1) suppressing endogenous sex hormone secretion determined by chromosomes, and (2) maintaining sex hormone levels within the normal range for the person's affirmed gender. Guidelines at 3869.

19. Hormone therapy in transgender adults is safe if it is correctly administered at proper therapeutic doses, and if patients are properly supervised according to the applicable guidelines. *See* Katrien Wierckx et al., *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*, 2014 J. SEX MED. 1999 (hereafter, "Cross-Sex Hormone Therapy"); *see also* Jamie D. Weinand & Joshua D. Safer, *Hormone Therapy in Transgender Adults is Safe with Provider Supervision; A Review of Hormone Therapy Sequelae for Transgender Individuals*, 2015 J. CLINICAL & TRANSLATIONAL ENDOCRINOLOGY 55.

20. The criteria for hormone therapy are (1) persistent, well-documented gender dysphoria; (2) capacity to make a fully informed decision and to consent for treatment; (3) being the age of majority; and (4) if significant medical or mental health concerns are present, then they are reasonably well-controlled. Guidelines at 3878; WPATH Standards at 34. Those criteria are the same for all transgender individuals.

21. The criteria's reference to "well-documented" gender dysphoria is not intended to screen out those people who have exhibited symptoms of gender dysphoria but were only recently diagnosed with the condition. Rather, this criterion in practice generally is understood to mean that the symptoms of gender dysphoria must have been present for at least six months. Typically

when a patient is diagnosed as gender dysphoric, hormone therapy begins immediately because a person whose symptoms have reached the point that they have contacted a health care professional usually has experienced symptoms for greater than a six month period.

22. The presence of mental health concerns or other medical issues does not normally preclude access to hormone therapy. The accepted contraindications to starting hormone therapy are "previous venous thrombotic events related to an underlying hypercoagulable condition, history of estrogen-sensitive neoplasm, and end-stage chronic liver disease." WPATH Standards at 44. The presence of these conditions mean that they need to be addressed prior to the initiation of hormone therapy, but they do not represent an absolute contraindication to hormone therapy. Mental health issues must be reasonably well-controlled prior to initiation of hormones, but should not prevent immediate initiation of hormone therapy, except in extreme circumstances. WPATH Standards at 34; Guidelines at 3878. Indeed, given the nature of gender dysphoria, mental health concerns in patients are not uncommon, and effective treatment of mental health concerns may be inextricably linked to effective treatment of underlying gender dysphoria. Anxiety, depression, and hopelessness are associated with gender dysphoria and are reasons to initiate hormone therapy rather than delay it. Unless a patient is unequipped to provide informed consent, hormone therapy typically should not be delayed. IDOC's practice of denying or delaying hormone therapy by requiring counseling beforehand is not a requirement that I have as a practitioner and is not medically accepted. IDOC's practice of denying or delaying hormone therapy on the basis of some co-existing mental illness is similarly misguided; symptoms such as depression and anxiety likely only can be addressed if the underlying gender dysphoria is addressed.

23. Once hormone therapy is initiated, clinicians should supervise their patients to maintain physiologic levels of the gender-appropriate hormones, and monitor patients for known

risks and complications. Hormone therapy should be continued without interruption as stopping therapy leads to a condition termed "hypogonadism" which is the absence of any sex steroid hormone (either testosterone or estrogen). This can lead to deleterious medical conditions like osteoporosis, hot flashes, lipid abnormalities, and mood instability. For this and other reasons, it is critical that clinicians treating gender dysphoria have expertise or training in transgender-specific diagnostic criteria, hormone treatment, and other treatments specific to transgender patient needs. Guidelines at 3869–70, 3877–78; WPATH Standards at 41.

24. In some instances, transgender patients will self-medicate by taking hormones purchased or given to them without a prescription. When treating physicians encounter such patients, it is important to continue hormone therapy, even if the patient's prior hormone regimen was sub-optimal. The physician should assess the information from the patient's self-reporting, available records and laboratory results, and any other available information and start a hormone regimen promptly, making modifications in the prescribed regimen as appropriate, until the patient establishes care under a clinician who will institute a long-term plan for hormone therapy. This practice is known as "bridging." WPATH Standards at 43. Absent a medical contraindication, bridging care should be provided in order to ensure symptoms of gender dysphoria are addressed and the body is not re-feminized or masculinized (which can have cause significant distress in gender dysphoric patients), and in order to avoid effects of a lapse in hormones, which can include menopause-like symptoms such as hot flashes. In adolescents, bridging may be critical to avoid permanent changes to the body.

Medically Recommended Hormones for Transgender Females

25. Recommended hormone treatment for transgender females typically involves estrogen and a testosterone blocker (also known as an anti-androgen) called spironolactone. Guidelines at 3887–88.

26. The recommended hormones and dosages under the Guidelines for transgender females is an estrogen-derivative known as estradiol (if oral route, 2-6 mg/d, or milligrams per day) and spironolactone (if oral route, 100-300 mg/d). Research suggests that the most common effective therapeutic dose of estradiol for treatment of gender dysphoria is 4 mg/d, and that this generally is a safe and effective dosage under proper supervision. *See* Cross-Sex Hormone Therapy at 2008. Our forthcoming publication in Endocrine Practice (in press 2020) provides data that the oral estradiol dose of 4-5 mg daily provides a mean estradiol level that reaches the minimum effective range of close to 100 pg/mL. *See* Panicha Chantrapanichkul et al., *Serum Hormone Concentrations in Transgender Individuals Receiving Gender Affirming Hormone Therapy: A Longitudinal Retrospective Cohort Study*, ENDOCRINE PRACTICE (publication forthcoming) (included with this declaration as Appendix C).

27. Ultimately, the optimal dose of estrogen will depend upon the patient. For some transgender females, 4 mg/d of estradiol may be insufficient to alleviate symptoms of gender dysphoria. The dose of estrogen should be at a level that maintains the desired sex characteristics and relieves gender dysphoria, but is also adequate to prevent osteoporosis, hot flashes, and mood disorders. *See* Vin Tangpricha & Martin den Heijer, *Oestrogen and Anti-androgen Therapy for Transgender Women, in* LANCET DIABETES ENDOCRINOL (Apr. 2017) (hereafter, "Tangpricha Lancet Article"). If a particular dose is not meeting these goals, it may be medically necessary to increase the estradiol dosage beyond 4 mg/d. The only limiting factor in this regard is that a

patient's estrogen levels should not exceed the peak level 400 pg/mL (pictograms per milliliter) typically seen in cisgender women. *See id.* at 5.

Medically Recommended Hormones for Transgender Males

28. Recommended hormone treatment for transgender males typically involves provision of testosterone, either parenterally (through injection) or transdermally (through the skin). Guidelines at 3887.

29. The recommended form and dosages of testosterone under the Guidelines for transgender males when delivered parenterally is either (1) 100-200 mg SQ (IM) every 2 weeks; or (2) testosterone undecanoate, 1000 mg every 12 weeks. When delivered transdermally, the recommended form and dosage of testosterone is either (1) 50-100 mg/d of testosterone gel of 1.6% concentration, or (2) 2.5-7.5 mg/d of testosterone through transdermal patch. Guidelines at 3887.

30. Ultimately, the optimal dose of testosterone will depend upon the patient. As with estradiol, it is often necessary to titrate the dose until blood tests and physical changes show the desired therapeutic goals are being met.

Medical Importance of Monitoring Hormone Levels

31. All transgender individuals receiving hormone therapy should receive regular clinical evaluation for potential adverse changes in response to treatment. The Standards of Care direct that "clinicians who prescribe hormone therapy . . . [p]rovide ongoing medical monitoring, including regular physical and laboratory examination to monitor hormone effectiveness and side effects." WPATH Standards at 42. Similarly, the Endocrine Society recommends "appropriate regular medical monitoring [is] recommended for both transgender males and females during the

endocrine transition and periodically thereafter," Guidelines at 3889, including patient evaluations every 2-3 months in the first year of hormone or endocrine treatment and then 1-2 times per year thereafter. Guidelines at 3871. The laboratory monitoring should include measurement of testosterone and estradiol (a derivative of estrogen) levels for females, and of testosterone levels for males. Guidelines at 3871, 3890.

32. Hematocrit and hemoglobin levels should be monitored as part of this testing in transgender patients receiving testosterone, because hematocrit concentration level of above 55% presents with increased red blood cell concentrations leading to increased "viscosity of blood." This leads to an increased risk of heart attack and stroke that can result in serious injury or death.

33. Testosterone may have side effects that lead to certain physiological changes in patients. Examples are clitoral enlargement, increased muscle mass, changes in voice, and increased perspiration.

34. It is essential to monitor blood levels after hormone therapy begins. In addition to safety concerns, if the patient starts on the lower end of the range of a recommended dosage and gender dysphoria persists or worsens, it may be medically necessary to increase the dosage within the range to achieve the desired therapeutic outcome.

Monitoring in Transgender Females and Related Health Concerns

35. The recommended therapeutic range of testosterone levels for transgender females is less than 50 ng/dL. Guidelines at 3890.

36. The recommended estradiol levels for transgender females should rest within the physiologic range, which is between 100-200 pg/mL. Guidelines at 3890. However, if symptoms

of gender dysphoria are not alleviated in this range, then a higher dosage of hormones should be provided, since estradiol levels higher than 200 pg/mL are safe for someone under qualified supervision for so long as they do not exceed 400 pg/mL. *See* Tangpricha Lancet Article at 5.

37. Transgender females on spironolactone should have their electrolytes tested as part of their regular evaluations, with potassium levels being particularly important. Potassium levels in excess of 5 mmol/L put patients at increased risk for cardiac arrhythmia/hyperkalemia, which can lead to cardiac arrest and even death.

38. Creatinine should also be monitored in these patients since spironolactone is a diuretic. Levels outside the acceptable range may indicate potential danger to kidney function that can lead to serious injury or even death in severe cases. Spironolactone also may cause dry skin, which should be addressed by lotions and moisturizing products.

39. Transgender females' prolactin levels should be monitored periodically as well. Without proper monitoring of prolactin levels, there is a risk of unchecked growth of the pituitary gland, which can cause serious complications, including loss of eyesight.

40. In addition to the potential adverse health effects described above relating to hormone levels outside of therapeutic ranges, it is also important to monitor hormone levels to know whether existing therapy is effectively treating gender dysphoria. For example, it may be necessary to increase a patient's estradiol dosage in order to induce the desired changes to secondary sex characteristics and to increase the patient's mental well-being. Guidelines at 3886.

41. Furthermore, certain formulations of hormones—namely, conjugated forms of estrogen—are inconsistent with the standards of care for treatment of gender dysphoria.

Conjugated estrogens such as Premarin and Menest are not recommended for transgender (or cisgender) females because of the inability to regulate doses by measuring serum levels and the risk of thromboembolic disease (also known as blood clots). *See, e.g.*, Guidelines at 3889; *id.* at 3887 at Table 11 (recommended hormone regimens in transgender persons, reflecting variations of oral, transdermal, and parenteral estradiol, but no conjugated hormones); L. J. Seal et al., *Predictive Markers of Mammoplasty and a Comparison of Side Effect Profiles in Transwomen Taking Various Hormonal Regimens, in* 2012 J. CLINICAL ENDOCRINOL METABOLISM 4422; Yana Vinogradova et al., *Use of Hormone Replacement Therapy and Risks of Venous Thromboembolism: Nested Case-control Studies Using the QResearch and CPRD Databases*, 2019 BMJ 1, 13. Blood clots pose significant risk that can result in death. Thus, transgender (or cisgender) female patients should not be treated with conjugated estrogens because of the serious risks caused by their use, and the lack of any countervailing benefit as compared with estradiol. Oral estradiol also happens to be much less expensive than conjugated estrogens.

Monitoring for Transgender Males

42. For transgender males, blood tests should measure levels of testosterone, in addition to hemoglobin. The physiological range for testosterone is 400-700 ng/dL.

43. Testosterone has a stimulating effect on hemoglobin (red blood cells). High hemoglobin can lead to severe adverse health outcomes, including blood clots, heart attack and stroke. These conditions can be fatal. It is therefore important to monitor testosterone levels to ensure they do not exceed the high end of the physiologic range, and to monitor hemoglobin specifically in transgender males.

Treatment of Named Plaintiffs

44. I have reviewed the medical records of the named Plaintiffs and observed severely inadequate provision of hormone therapy in many respects. I also conducted phone interviews of each named Plaintiff during which we discussed their gender dysphoria, their medical histories, and the related medical care they were receiving while incarcerated.

45. As detailed in my April 2019 Report, IDOC was at that time providing each named Plaintiff with hormone therapy that did not meet the Guidelines for treatment set forth by the Endocrine Society, which are the authoritative reference in the medical community regarding hormone therapy for transgender persons. Indeed, the treatment fell well outside of accepted medical practice standards.

46. IDOC delayed providing hormone therapy to the named Plaintiffs for reasons that are not medically accepted, and are not contraindications to treatment. Several Plaintiffs were at that time receiving inappropriate forms of hormones (conjugated hormones) that carry increased risks of serious adverse health consequences. Others were receiving appropriate forms of hormones but at inadequate dosages that are failing to provide effective treatment. Moreover, hormone level monitoring was not being provided in accordance with the Guidelines for any named Plaintiff, meaning that clinicians remained unaware of the appropriate therapeutic dose, thereby placing all Plaintiffs at risk of extremely harmful health consequences.

47. Based on my review of the medical records produced since August 2019, the named Plaintiffs continue to receive hormone therapy treatment outside of accepted medical standards. The frequency of bloodwork and testing remains below the level recommended in the Guidelines. When testing has been conducted, all but one of the named Plaintiffs had either estradiol or

testosterone levels outside of the recommended therapeutic range at the time of their most recent bloodwork. Two of the named Plaintiffs continued to receive conjugated estrogen into 2020, and one continues to receive it ***to this day***. Moreover, IDOC has failed to appropriately adjust hormone treatment to alleviate gender dysphoria symptoms, or, in one case, address potentially concerning side effects.

Janiah Monroe

48. I have been provided and reviewed the medical records for Ms. Monroe as I understand they are maintained by IDOC. Ms. Monroe was diagnosed with gender dysphoria in November 2011 as recognized by IDOC's "Gender Identity Disorder" Committee ("GID Committee"). However, initiation of hormone therapy was delayed, resulting in extreme suffering and attempts at autocastration, as reflected in Ms. Monroe's medical records. Ms. Monroe was not approved for hormone therapy until mid-2012, without any explanation. I have not seen anything in Ms. Monroe's medical records that provides an accepted medical rationale for this delay. The Committee's stated reasoning—that if Ms. Monroe were to obtain treatment, other prisoners might also seek treatment—is not a medically accepted rationale for denying or delaying necessary treatment.

49. Ms. Monroe's hormone dosages had remained constant since she began hormone therapy until at least April 2019, namely, 3 mg/d of estradiol and 150 mg/d of spironolactone, which is below the typical therapeutic dosage of 4 mg estradiol and at the lower end of the recommended dosage for spironolactone. Her medical records do not indicate when her dosage changed, but, by June 2020, she was prescribed 200 mg/d of spironolactone. She is currently taking estrogen via injection every two weeks at a concentration of 5 mg/mL, but I was unable to determine her dosage level based on the medical records produced by IDOC.

50. Prior to April 2019, Ms. Monroe's medical records showed that her hormone levels had not been monitored in accordance with the Guidelines since she initiated therapy. In the six years between starting hormone therapy and my April 2019 Report, monitoring of her levels was rare.

51. Ms. Monroe first had her hormone levels checked on April 23, 2015—roughly 3 years after she began her hormone regimen. Ms. Monroe's second hormone level test was on June 3, 2016, more than a year after the first test. The June 3, 2016 records indicated an estradiol level of 86.9 pg/mL, below the recommended physiologic range for transgender females of 100-200 pg/mL. Ms. Monroe's next blood test measuring hormone levels was on November 4, 2016. This record indicated an even lower estradiol level of 66.3 pg/mL, well below the recommended range for transgender females. The next hormone level test occurred on April 21, 2017. The relevant records indicate an estradiol level of 95.8 pg/mL, still below the recommended range for transgender females of 100-200 pg/mL. The final record of a blood test measuring Ms. Monroe's hormone levels that I reviewed prior to submitting my April 2019 Report was from October 20, 2017. This time her estradiol levels were even lower than in April, at 87 pg/mL. Despite consistently low readings, and continued documented symptoms of gender dysphoria, Ms. Monroe's hormone prescriptions remained unchanged.

52. The amount and frequency of Ms. Monroe's testing prior to April 2019 fell well outside of recommended and accepted practice, which counsels for laboratory monitoring of hormone levels at least once every 3 months during the first year of treatment, and afterwards at least once or twice yearly. Ms. Monroe received no tests for years after initiating hormone therapy, and went for over a year without being tested after her initial test. The irregular testing of her

hormone levels represents a serious departure from the Guidelines and put Ms. Monroe's physical health at serious risk.

53. Since I submitted my April 2019 Report, Ms. Monroe's bloodwork has been checked more frequently. However, based on the medical records produced by IDOC, no testing has been performed to measure her potassium, creatinine, or prolactin levels since 2019.

54. Ms. Monroe's hormone levels improved through 2019. Specifically, her estradiol level reached 161 pg/mL in June 2019. However, by January 2020, it had dropped back down to 102 pg/mL, technically within the recommended therapeutic range, but a significant drop from her level just a few months earlier.

55. This low level of estradiol is concerning when considered in combination with Ms. Monroe's continued symptoms of gender dysphoria, including depression, anxiety, and increasing potential risks of suicidality. It is my opinion that a higher dosage of hormones should be provided to Ms. Monroe to raise her estradiol level and alleviate her symptoms of gender dysphoria. As previously stated in my April 2019 Report, the overall quality of her care is among the worst cases I have encountered for an individual with gender dysphoria, and shows either a profound lack of knowledge about providing hormone therapy or indifference about treating gender dysphoria.

Marilyn Melendez

56. I have been provided and reviewed the medical records for Ms. Melendez as I understand they are maintained by IDOC. IDOC personnel officially diagnosed Ms. Melendez with gender dysphoria in March of 2015. After a delay of several months, IDOC personnel finally initiated hormone therapy to treat Ms. Melendez's gender dysphoria in August 2015. I have not seen anything in Ms. Melendez's medical records that offers an accepted medical rationale for this

months-long delay. The rationale provided by the GID Committee—that Ms. Melendez first needed counseling about living as the opposite gender—is not a medically-accepted reason to deny or delay treatment.

57. IDOC personnel prescribed Ms. Melendez Menest and Premarin, both conjugated estrogens. Her doses of Menest and Premarin ranged from 1.25 mg/d to 5.0 mg/d. She was also initially prescribed spironolactone at 200 mg/d. As noted previously, conjugated estrogens are not a recommended treatment for any transgender individual, and pose significant risks that estradiol does not.

58. Following submission of my April 2019 Report, Ms. Melendez continued to receive conjugated estrogen through September 2019, when she was finally prescribed the medically accepted form of estrogen. In November 2019, Ms. Melendez was prescribed 5 mg/d of estradiol and 200 mg/d of spironolactone.

59. Ms. Melendez's hormone levels have been tested irregularly and not in accordance with the Guidelines. A blood test in April 2017 indicated an estradiol level of 82.9 pg/mL, below the low end of the acceptable therapeutic range. However, because Ms. Melendez was prescribed a conjugated estrogen at the time, it is impossible to know if that result is accurate, meaning her estradiol levels could have been even lower than this number or very far above the safe range, including dangerously high.

60. Ms. Melendez did not again have her hormone levels tested until March 2019, almost two years later. At that time, her estradiol had dropped to 65 pg/mL, indicating that her estrogen dosage needs to be adjusted. It is my understanding that IDOC has not produced any records indicating any additional bloodwork since that time. I also understand that Ms. Melendez

continues to report erections—which suggests that her testosterone is not adequately suppressed and her current dosage is failing to treat her gender dysphoria.

Sora Kuykendall

61. I have been provided and reviewed the medical records for Ms. Kuykendall as I understand they are maintained by IDOC. After an autocastration attempt, IDOC diagnosed Ms. Kuykendall with gender dysphoria and began hormone therapy around February 2015. Ms. Kuykendall was prescribed Premarin, a conjugated estrogen, at 5 mg/d, and eventually spironolactone at 200 mg/d.

62. Initially, Ms. Kuykendall received no blood testing of her hormone levels. It was not until May 2017 that IDOC appears to have ordered laboratory work for her blood. The tests showed an estradiol level of 112 pg/mL. At that time, Ms. Kuykendall was being treated with a conjugated estrogen, a departure from the Guidelines that puts her health and safety at risk.

63. Since issuing my April 2019 Report, Ms. Kuykendall's hormone treatment has not meaningfully changed. She is still prescribed Premarin, now at 6 mg/d, as well as spironolactone at 200 mg/d. As previously stated, Premarin is a conjugated estrogen not medically accepted as appropriate treatment for gender dysphoria.

64. Moreover, Ms. Kuykendall's most recent blood work—completed in November 2019—shows her estradiol level at 51 pg/mL, a significant decline from her level in May 2017. An estradiol level of 51 pg/mL is well below the low end of the acceptable therapeutic range of 100-200 pg/mL.

Sasha Reed

65. I have been provided and reviewed the medical records for Ms. Reed as I understand they are maintained by IDOC. Ms. Reed was diagnosed by IDOC personnel with gender dysphoria in November of 2015. Despite well-documented and persistent gender dysphoria in her records, Ms. Reed was not provided hormone therapy for almost a year and a half until April of 2017. I have not seen anything in Ms. Reed's medical records that provides an accepted medical rationale for this long delay. The Committee's explanation that doctors first needed to investigate her conceptualization of gender identity is not a medically-recognized reason to deny or delay treatment. This unjustified delay represents an easily preventable failure to initiate much-needed medical treatment for Ms. Reed's recognized and serious medical need.

66. Ms. Reed was initially prescribed estradiol at 2 mg/d and spironolactone at 200 mg/d. The first records of a blood test are from July of 2017 and showed a very low estradiol level at 45 pg/mL that is well below the recommended therapeutic range of 100-200 pg/mL. In addition, her testosterone levels were at 400 ng/dL, well above the recommended therapeutic level of 50 ng/dL for patients with gender dysphoria.

67. In October of 2018—15 months after her initial blood test showed hormone levels far outside the therapeutic range—IDOC finally increased Ms. Reed's prescription to 3 mg/d of estradiol and 300 mg/d of spironolactone. A follow-up blood test a week later showed her estradiol at 281 pg/mL and her testosterone at 234 ng/ml. Thus, even after the long delay in titrating her dosages, Ms. Reed's testosterone levels remained far above the 50 ng/dL recommended therapeutic level.

68. In August 2019, Ms. Reed's dosage of estradiol was increased to 4 mg/d, while her spironolactone remained at 300 mg/d. Nonetheless, when her bloodwork was tested in January 2020, her estradiol level was 92 pg/mL—still below the recommended therapeutic levels.

69. In April 2020, Ms. Reed reported to IDOC medical staff that she had been experiencing bilateral breast pain for the past six months. Several months later, in June 2020, Ms. Reed reported to IDOC medical staff that she was experiencing headaches. According to her medical records, IDOC medical staff told her to return if her breast pain worsened and prescribed Tylenol for her headaches. There is no indication that anyone at IDOC has followed up with Ms. Reed regarding her report of breast pain in April 2020. This is concerning, as experiencing both breast pain and headaches could be a sign of complications from her hormone therapy, including hyperprolactinemia or prolactin producing tumors. It is my opinion that IDOC should have ordered an MRI to determine if Ms. Reed was experiencing any side effects from her hormone therapy.

70. In addition to the long delay in starting Ms. Reed's hormone therapy, the failure to regularly monitor Ms. Reed's bloodwork, bring her levels within the therapeutic range, and follow up on her concerning reports of breast pain and headaches amount to grossly inadequate treatment of her gender dysphoria and needlessly put her health at serious risk.

Lydia Heléna Vision

71. I have been provided and reviewed the medical records for Ms. Vision as I understand they are maintained by IDOC. Ms. Vision was diagnosed with gender dysphoria by IDOC in March of 2016. Despite repeated requests for hormone treatment, she was denied it for over two years. I have not seen anything in Ms. Vision's medical records that provides an accepted

medical rationale for this long delay. Ms. Vision was denied hormones for numerous reasons that have no medical foundation and are not contraindications to treatment: that her gender dysphoria "may not fully manifest itself in the correctional environment"; that she had "potential for further victimization and isolation as the physical effect of feminizing hormones become apparent"; that she had insufficient support to "undergo the physiologic changes associated with feminizing hormones"; and a suggestion that she experienced post-traumatic stress syndrome as a result of prior sexual abuse. The delay in providing Ms. Vision with hormone therapy is entirely unjustified, and is a remarkable departure from accepted medical practice.

72. In November of 2018, IDOC finally prescribed Ms. Vision hormone therapy. Since November 2019, she has been prescribed 8 mg/d of estradiol and 200 mg/d of spironolactone. Ms. Vision's estradiol levels have not been tested since November 2019, when they measured 101 pg/mL. According to documents produced by IDOC, her testosterone levels have not been tested since April 2018, when they measured 54 ng/dL. This testosterone level is above the recommended therapeutic range. Because IDOC has not tested Ms. Vison's testosterone levels in over two years, it is impossible to know if her testosterone levels have since declined.

Conclusions Regarding Named Plaintiffs

73. None of the named Plaintiffs has received even a baseline of medical care adequate to alleviate their gender dysphoria. More alarming, their care has not meaningfully improved since my previous evaluation was conducted in April 2019. The care, and specifically the hormone therapy, administered by IDOC personnel is grossly inadequate in a number of ways and constitutes a severe departure from guidelines widely accepted by medical professionals in the field for treating patients with gender dysphoria. Not only does this poor treatment fail to treat

Plaintiffs' gender dysphoria, it puts their lives at risk, most notably by increasing their risk for blood clots, stroke, myocardial infarction, and cardiac arrhythmia.

74. The named Plaintiffs experienced unjustified delays in initiation of hormone therapy. Delays of months, or in some cases over a year, are completely unjustified. Generally, hormone therapy should immediately follow a gender dysphoria diagnosis. The presence of mental health issues typically should not preclude access to hormone therapy for gender dysphoric individuals who otherwise fit the diagnostic criteria for hormone treatment. WPATH Standards at 34. The reasons provided by the Transgender Committee for delaying hormone therapy for the named Plaintiffs are not medically-accepted.

75. The Plaintiffs' hormone dosages are inadequate and not properly monitored or administered. After Plaintiffs' bloodwork revealed levels outside of the therapeutically accepted levels, titrating was not performed. In addition, two named Plaintiffs inexplicably were initially prescribed a conjugated estrogen compound that cannot be measured in bloodwork and thus is not an accepted form of estrogen. Following my April 2019 Report, both of these named Plaintiffs—Ms. Melendez and Ms. Kuykendall—continued to receive conjugated estrogen for at least several months. Ms. Kuykendall continues to receive conjugated estrogen ***to this day***.

76. Finally, inadequate, sporadic, and ineffective hormone level testing puts Plaintiffs' safety at risk. Bloodwork remains sporadically performed for all but one named Plaintiff. This lack of testing reveals gross inadequacies of the medical care for gender dysphoria.

Conclusions Regarding Class Members

77. My review of the named Plaintiffs' files revealed patterns of treatment: that IDOC delayed or denied hormone therapy for reasons that are not recognized by medical professionals;

that IDOC failed to monitor hormone levels with the regularity that is necessary to ensure that gender dysphoria is treated and that dangerous side effects are avoided; that IDOC failed to titrate Plaintiffs' dosages to ensure that they were within therapeutically appropriate and effective ranges; and that IDOC prescribed to at least some patients outdated and unaccepted forms of estrogen. These patterns have remained consistent since I submitted my April 2019 Report.

78. In order to evaluate whether these deficiencies persisted throughout the class, I reviewed the relevant medical records produced by IDOC from the class members and observed the same deficiencies described above as to the named Plaintiffs in this case. My review principally focused on reviewing prescription records and bloodwork testing, which is useful in evaluating whether IDOC has prescribed an effective course of hormone therapy and whether it is testing to ensure proper dosages and to guard against hormone imbalances and side effects that can result therefrom.

79. As with the named class representatives, the records of the class members show hormone levels that are insufficient to treat gender dysphoria, the continued use of conjugated estrogens, and irregular and infrequent testing of hormone levels.

80. Since submitting my April 2019 Report, the significant majority of class members continue to have bloodwork testing that demonstrates levels of estrogen and/or testosterone outside of the therapeutic ranges recommended under the Guidelines. After reviewing several dozen medical records produced by IDOC in this case, including those for the named Plaintiffs, I saw only six laboratory reports that demonstrated both estradiol and testosterone levels within the recommended range. Indeed, several class members have had no laboratory work conducted since

April 2019. This demonstrates that IDOC has made no meaningful change in its monitoring or titration of hormone dosages since my last report.

81. These results would signal to any knowledgeable medical professional that the dosages required titration and that follow-up testing should be done promptly to bring the levels within effective ranges. As was the case in April 2019, I rarely observed any such corrective action, and many of the class members have only had one laboratory test conducted in the past year, while some have had none at all. The fact that the vast majority of gender dysphoric patients' hormone levels consistently fall outside of the therapeutic ranges demonstrates that IDOC is providing treatment that is not treating their gender dysphoria and would not be expected to treat their gender dysphoria.

82. Moreover, IDOC has continued to prescribe some class members Premarin, a conjugated estrogen. IDOC continued to prescribe at least two inmates—including named Plaintiff Ms. Kuykendall—conjugated estrogen as of the date of their most recent medical records. Another inmate was prescribed Premarin through March 2020. There is no medically accepted reason why IDOC should continue to prescribe this outdated and unaccepted form of estrogen, as it can jeopardize the safety and health of the prescribed patient.

83. The class members' records further indicated infrequent hormone testing that did not meet the standards set out in the Guidelines. The Guidelines indicate that hormone testing should be performed every 2-3 months in the first year of hormone or endocrine treatment and then 1-2 times per year thereafter.

84. Based on the medical records produced by IDOC since August 2019, at least five class members have had ***no hormone testing*** performed in over a year. At least fifteen additional

class members have had their hormone levels tested ***only once*** during that same period. In other words, IDOC has not meaningfully improved their hormone level testing since my last report, and its practices continue to depart from the Guidelines. This poses a significant risk to these patients.

85. Moreover, testing for electrolytes, potassium, creatinine, and prolactin has likewise not substantially improved since my last report. Roughly half of all class members have no record of being tested for these levels since mid-2019. Shockingly, this is approximately the same number of class members that had no record of being tested for these levels at the time of my April 2019 Report. And, as was the case in April 2019, of those who received testing, some demonstrated unsafe creatinine, potassium, and/or prolactin levels, yet seemingly no responsive action has been taken to bring the levels within a safe range.

86. My observations concerning the class members are consistent with the severe deficiencies in care that I identified as to the named Plaintiffs in this case. These deficiencies have continued since the time of my previous report. In other words, it is my observation that meaningful changes have not been made to IDOC's administration and monitoring of hormone therapy treatment. IDOC's practices remain outside of the medically accepted treatment for gender dysphoria. Both the named Plaintiffs and the class members continue to face substantial risks to their physical and mental health from the grossly inadequate treatment of their gender dysphoria.

87. I reserve the right to supplement the opinions set out in this declaration as required to address any additional information provided to me regarding IDOC's treatment of transgender prisoners.

Dated: August 30, 2020

Dr. Vin Tangpricha, M.D., Ph.D

APPENDIX A

EMORY UNIVERSITY SCHOOL OF MEDICINE
STANDARD CURRICULUM VITAE FORMAT

Revised: September 1, 2020

1. Name: Vin Tangpricha

2. Office Address:
Division of Endocrinology, Metabolism and Lipids
101 Woodruff Circle NE-Woodruff Memorial Research Building 1301
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3. E-mail Address: vin.tangpricha@emory.edu

4. Citizenship: United States of America

5. Current Titles and Affiliations:

a. Academic Appointments:

i. Primary Appointments:

Professor of Medicine, Division of Endocrinology, Metabolism and Lipids, Department of Medicine, Emory University School of Medicine, September 1, 2017-Present

ii. Joint and Secondary Appointments:
Faculty in Nutrition Health Sciences, Laney Graduate School, Emory University, 2005-Present

b. Clinical Appointments:
i. Associate Director, Osteoporosis Clinic, The Emory Clinic, 2004-Present
ii. Director, Transgender Clinic, The Emory Clinic, 2004-Present
iii. Staff Physician, The Emory Clinic, 2004-Present
iv. Staff Physician, Veterans Administration (VA) Hospital, Atlanta, GA, 2006-Present
v. Director, Adult Endocrinology, Emory Cystic Fibrosis Center, 2007-Present

c. Other Administrative Appointments:
i. Director, Clinical Research Unit, Division of Endocrinology, Diabetes & Lipids, Emory Department of Medicine, 2004-2009
ii. Associate Program Director, Emory Endocrinology Fellowship Program, Division of Endocrinology, Diabetes & Lipids, Emory Department of Medicine,2007-2009
iii. Recruitment Coordinator, Nutrition Health Sciences Program, Graduate Division of Biological & Biomedical Sciences, 2009-2013
iv. Course Director, Translation to Clinical Medicine (EPI 501M), HHMI Med into Grad Program, Laney Graduate School, 2010-Present
v. Program Director, Emory Endocrinology Fellowship, Division of Endocrinology, Diabetes & Lipids, Emory Department of Medicine, 2011-Present
vi. Program Director, ABIM Clinician Scientist Pathway (Research Track), Internal Medicine Residency, Emory Department of Medicine, 2013-2019

6. Previous Academic and Professional Appointments:
a. Instructor in Medicine, Boston University, 2002-2003

b. Assistant Professor of Medicine, Division of Endocrinology, Metabolism and Lipids, Emory University, 2004-2009
c. Associate Professor of Medicine, Division of Endocrinology, Metabolism and Lipids, Department of Medicine, Emory University School of Medicine, 2009-2017

7. Previous Administrative and/or Clinical Appointments:
   a. Staff Physician, Boston Medical Center, 2002-2003

8. Licensures/Boards:
   a. Massachusetts Medical License, 1998
   b. Georgia Medical License, 2003

9. Specialty Boards:
   a. ABIM, Board Certified in Internal Medicine, 1999
   b. ABIM, Board Certified in Endocrinology, Diabetes and Metabolism, 2001, Recertified 2011
   c. Certified Clinical Densitometrist, International Society for Clinical Densitometry, 2003

10. Education:
    1989 - 1992 **B.A.** (Anthropology and Biology, double major)
    Case Western Reserve University, Cleveland, Ohio

    1992 – 1996 **M.D.**
    Tufts University School of Medicine, Boston, Massachusetts

    2000 – 2003 **Ph.D.** (Molecular Medicine, Advisor Michael F. Holick)
    Boston University School of Medicine, Boston, Massachusetts

11. Postgraduate Training:
    1996 – 1999 Intern & Resident, Internal Medicine, Boston University/Boston Medical Center, Boston, MA, (Program Director: David Battinelli, M.D., Chair of Medicine: Joseph Loscalzo, M.D., Ph.D.)

    1999 – 2001 Clinical Fellow, Endocrinology, Diabetes & Nutrition, Boston University School of Medicine, Boston, MD, (Program Director: Alan Malabanan, M.D., Chief of Endo. Lewis E. Braverman, M.D.)

12. Continuing Professional Development Activities:
    Physician Executive Program, Emory University, 2008-2009

13. Committee Memberships:

    a) National and International

    i) Member, Endocrine Society Task Force for Transgender Health Guidelines, 2007-2009
    I served as one of 8 authors on the first hormone guidelines for transgender persons released by a professional society. This task force published guidelines in 2009 for the hormone treatment of transgender persons, which is the current authoritative reference for hormone therapy.

    ii) Member, American Association of Clinical Endocrinologists, Publications Committee, 2008- 2017
    I served on this committee for 9. We reviewed all official position statements and guidelines of the American Association of Clinical Endocrinologists prior to publication.

    iii) Member, National Council, American Federation for Medical Research, 2008-2010
    I served on the national council for AFMR for 2 years.

iv) Co-chair, Vitamin D Guidelines Committee, Cystic Fibrosis Foundation, 2010-2012
I was the co-chair of the vitamin D guidelines that updated and revised recommendations on the diagnosis and treatment of vitamin D deficiency in children and adults with CF. This resulted in a guidelines publication for the CF Foundation.

v) Member, American Association of Clinical Endocrinologists (AACE), Reproductive Hormone Committee, 2010-2017
I was a member of this committee for 7 years. We provide input on behalf of AACE the on topics related to sex steroid hormones

vi) Member American Association of Clinical Endocrinologists, Nutrition Committee, 2010-2017
I have served on the nutrition committee for AACE for over 7 years. I was the expert on the committee focused on vitamin D and calcium. We provide educational modules for the association by publishing white papers and creating online learning modules on nutrition.

vii) Member, Cystic Fibrosis Therapeutics Development Network (TDN), Publications Committee, 2011-2014
I served a 3 year term on the CF TDN Publications committee. My role was to review manuscripts from clinical trials supported by the CF TDN (a clinical trials network) prior to their publication. We provided our input to these manuscripts to increase their chance for publication at national journals.

viii) Councilor, Association of Program Directors in Endocrinology and Metabolism (APDEM), 2012-2014
I was elected to a 3-year term as a councilor to this group that represents all of the endocrinology program directors in the United States.

ix) Member, Academic Endocrinologists Committee, American Association for Clinical Endocrinologists, 2012-2013, Chair, 2014-2015
I served as a member then chair of this committee that met quarterly for AACE to provide input to the association on topics related to academic endocrinology.

x) Chair, Communication and Technology Committee, World Professional Assoc. for Transgender Health, 2012-2013
I was appointed chair to this committee to help improve communications to the members of WPATH.

xi) Member, Endocrine Society Continuing Medical Education and Maintenance of Certification Committee, 2013-2016
I was appointed to 8 person committee to help with the medical education activities for the members of the Endocrine Society.

xv) Member, Domestic Membership Committee, American Association of Clinical Endocrinologists, 2015-2108
I served as a member of this committee for AACE which meets every 3 months by teleconference to discuss ways to recruit members and enhance benefits for members.

xvi) Member, Revision Committee for Guidelines for Hormone Therapy in Gender Dysphoria and Gender Incongruent Persons, Endocrine Society, 2015-2017
I was reappointed to the guidelines committee to update and revise the hormone therapy guidelines for the Endocrine Society. The new guidelines were published September 2017.

xxvii) Chair, Education Oversight Committee, American Association for Clinical Endocrinologists, 2017-2020
I was appointed by the AACE president to serve a 3 year term to oversee all of the educational activities of our society.

xxviii) Member, International Society for Clinical Densitometry, Guidelines for bone densitometry in transgender and gender non-conforming peoples, 2018-2019
I was appointed by the ISCD workgroup chair and produced a guidelines document for the society.

xxix) Chair, Hormone Chapter, Standards of Care, World Professional Association for Transgender Health, 2018-
I was selected to chair this guidelines committee to put forth recommendations for gender affirming hormone therapy in transgender and gender non-conforming youth and adults.

b) Regional and State

i) Chairman, Southern Section, American Federation for Medical Research, 2008-2010
I served as the chairman of the Southern Section of the AFMR for 2 years. My role was to help with the membership of AFMR and to coordinate the planning of the Southern Regional Meeting.

ii) Vice-President, 2008-2009 then President, Georgia Chapter, American Association of Clinical Endocrinologists, 2009-2010
I have been active in my local endocrinology community as well as nationally.

iii) Chair, Website Committee, Southern Society for Clinical Investigation, 2015-Present
I was asked by the president of this society to chair the website committee to completely overhaul the society website which was successfully implemented in January 2016.

c) Institutional

i) Member, Emory Atlanta Clinical and Translational Institute Scientific Advisory Committee (ACTSI), 2005-Present
I have served on the SAC (formally GCRC) review committee for over 10 years. We review, discuss and approval protocols that are conducted in the ACTSI.

ii) Member, Endocrinology Fellow Curriculum and Selection Committee, 2005-Present
I have been involved in the endocrinology fellow selection committee for over 10 years. I interview 15-20 fellow candidates each year for our program.

iii) Enrichment Coordinator, Emory Center for Clinical and Molecular Nutrition, 2006-2009
I was the past coordinator for this monthly seminar series

iv) Emory World AIDS Day, Organizing Committee, 2007
I was a member of this committee and hosted former Surgeon General Jocelyn Elders as a guest speaker to speak at the event.

v) Member, Department of Medicine, Medical Student Education Committee, 2007-2010
I served as a member of this committee under Dr. Erica Brownfield. We reviewed and arbitrated academic cases related to students

vi) Member, Faculty Development Committee, Department of Medicine, 2008-2010

I served as a member of this committee under Dr. Kathy Griendling

vii) Chair, Awards Sub-Committee, Department of Medicine 2008-2010
I was the chair of the committee to recognize faculty in the DOM

viii) Member, Executive Committee, Emory Nutrition and Health Sciences Program, 2009-2013, I served for 4 years on the Executive committee for NHS

ix) Member, Rheumatology and Immunology Division Director Search Committee, 2010-2011
I served on the DOM committee that led to the hiring of Dr. Sanz

x) Chair, Clinical Interactions Network (CIN), Scientific Review Panel, Emory ACTSI, 2010-Present
I am currently 1 or 3 co-chairs that review, triage and approve research protocols for the ACTSI.

xi) Member, Medical Student Research Committee, 2010-2015, I reviewed Discovery project proposals and final papers for 5 years

xii) Emory Physician Scientist Training Program (M.D./Ph.D.) Admissions Committee, 2015-2018

xiii) Emory Department of Medicine, Promotions and Tenure Committee. 2018- present, I am a member of this committee to review promotions packets for the DOM.

xiv) Medical Student Research Education Committee (Discovery). 2019-present. I serve on the Emory SOM Discovery committee to review research projects to be conducted during the Discovery program.

14. Peer Review Activities:

a. Grants:

i. National and International:

a) Ad Hoc Reviewer, NIH Special Emphasis Section, Chemo-Dietary Prevention (CDP), 2006
b) Ad Hoc Reviewer, Thrasher Foundation, 2009
c) Ad Hoc Reviewer, Diabetes UK, 2009
d) Ad Hoc Reviewer, UAB Diabetes Research Training Center, Pilot Grant Program, 2010
e) Ad Hoc Reviewer, Arthritis Research UK, 2010
f) Ad Hoc Reviewer, NIH Special Emphasis Section, Ancillary Studies in Clinical Trials, 2010-2011
g) Ad Hoc Reviewer, American Association for the Advancement of Science's Research Competitiveness Program, 2011
h) Regular reviewer, Clinical Research Awards, Cystic Fibrosis Foundation, 2011-Present, I have been a regular reviewer for the CF Foundation for their clinical research awards. We review letters of intent twice a year and then meet in person at the national CF Foundation headquarters to discuss grants in person.
i) Ad Hoc Reviewer, NIH/NHLBI SEP, Low Cost Pragmatic Clinical Trials, 2014
j) Ad hoc reviewer, NIH/SEP, Neurological, Aging and Musculoskeletal Epidemiology, 2014

ii. Institutional:

a) Reviewer, Emory University KL2 Grant Review Committee, 2008-2009
b) Reviewer, University Research Committee (URC), 2009 – 2010
c) Reviewer, Emory Egleston Children's Research Center, 2011
d) Georgia CTSA Pilot Grants Program, 2019

b. Manuscripts reviewer:

Endocrine Practice, 2004-present
American Journal of the Medical Sciences, 2008-present
European Journal of Clinical Nutrition, 2008-present
Journal of Nutrition, 2008-2013
Chest, 2008-2014
American Journal of Clinical Nutrition, 2008 - present
Journal of Sexual Medicine, 2009- present
Clinical Endocrinology, 2009-2011
Journal of Clinical Endocrinology and Metabolism 2011-present
Journal of Cystic Fibrosis, 2014-present

c. Conference Abstracts:
   i. National and International:
   1. Abstract reviewer, North American Cystic Fibrosis Conference Annual meeting, 2009-Present
   I have been a regular reviewer of the endocrine and/or diabetes abstracts submitted to the North American CF Conference for many years.

   2. Abstract reviewer, American Society of Nutrition, Experimental Biology Annual meeting, 2009-2011
   I reviewed abstracts for the American Society of Nutrition for 3 years for presentation at the Experimental Biology Meeting.

   3. Abstract reviewer, American Association for Clinical Endocrinologists (AACE) Annual Meeting, 2013-Present
   I review abstracts annually for the AACE annual meeting

   3. Abstract reviewer, National Transgender Health Summit, Oakland, CA, 2013, I served as an abstract reviewer for this transgender meeting

   4. Abstract reviewer, World Professional Association for Transgender Health (WPATH), Biennial Meetings, 2011, 2014, 2016, 2018, 2020. I have been a regular abstract reviewer for the Biennial Meeting for WPATH.

   5. Abstract reviewer, Endocrine Society Meeting, 2018, 2019, 2020.

   ii. Regional:
   1. Abstract reviewer, Southern Society for Clinical Investigation, Annual Meeting, 2008-Present
   I have reviewed abstracts in endocrinology and nutrition topics for the SSCI/Southern Regional Meeting.

15. Consultantships:

1. Member, AquADEK advisory Committee, Cystic Fibrosis Foundation, 2012-2014
I was asked by the CF Foundation to become a member of a committee to advise the foundation on what vitamins should be included in their multivitamin preparations. We met at the foundation for the kick off meeting and regularly by telephone and email.

2. World Anti-Doping Agency (WADA) Therapeutic Use Exemptions Expert Group, Testosterone use in transgender athletes, 2012
I was asked by WADA to provide input regarding hormone use in transgender athletes and edit their policy manual.

16. Editorships and Editorial Boards:

a. Editorships

1. Guest Editor, Special Issue on "Vitamin D", International Journal of Endocrinology, 2008
I was invited to coordinate a special issue on vitamin D. This was the first special issue for this journal. I oversaw the review of 15 manuscripts that were eventually published. Our rejection rate was approximately 50%.

2. Associate Editor, Journal of Sexual Medicine, 2008-2014
I was appointed by Editor in Chief, Irwin Goldstein, to be the Associate Editor to oversee the review of all manuscripts submitted on the topic of transgender or differences of sexual development (formally known as disorders of sexual development or DSD). During my term, I oversaw the review of over 100 manuscripts submitted to the journal.

3. Section Editor, Annual December issue on Disorders of Calcium and Bone, Current Opinion in Endocrinology, Diabetes, and Obesity, 2009-Present
I was appointed by Dr. Lewis Braverman, Editor in Chief, to oversee the December issue of Current Opinion in Endocrinology, Diabetes and Obesity. My role is to organize and invite authors to write reviews for this yearly issue focused on disorders of calcium, vitamin D and bone.

4. Guest Editor, Special Issue on "Vitamin D", Dermato-endocrinology, 2012
I was a special guest editor for this issue on vitamin D.

5. Editor in Chief, Journal of Clinical and Translational Endocrinology, 2013-2020
I was appointed by Elsevier to be the Editor in Chief of this new open access journal in endocrinology. This was one of the publisher's first open access endocrinology journals. We have published over 100 original research and review manuscripts over the past 3 years. We expect to have an ISI Impact Factor in the next 1-2 years.

6. Associate Editor, Sexual Medicine Reviews, 2015-Present
I am currently an associate editor for Sexual Medicine Reviews and oversee manuscripts dealing with transgender, hormone therapy or DSD.

7. Guest Editor, Reviews in Endocrine & Metabolic Disorders, 2018
I served as a guest editor for a special issue on transgender medicine.

8. Guest Editor, Endocrinology & Metabolism Clinics, 2018
I served as a guest editor for a special issue on transgender medicine.

9. Editor in Chief, Endocrine Practice, 2021-

b. Editorial Boards

1. Endocrine Practice, The Official Journal of the American Association for Clinical Endocrinologists, 2007-Present

2. International Journal of Endocrinology, 2009-2013

3. Nutrition and Food Science, 2015-2017

4. Transgender Health, 2017- Present

17. Honors and Awards:

2004	Fellow of the American Association of Clinical Endocrinologists (FACE)
2006	New Investigator Award, Emory Center for Clinical and Molecular Nutrition
2007	NIH K23 Mentored Physician-Scientist Award
2009	Gender Identity Research and Education Society, Scientific Citation Award
2011	Transgender Advocate Award, Emory University
2011	"We are Emory", 100 community builders at Emory University (only DOM awardee)
2011	U.S. News and World Report, Top Endocrinologist (top 10% of endocrinologists voted by peers)
2011	Gender Identity Research and Education Society, Scientific Citation Award
2012	Best Mentor Award, Thai-American Physicians Foundation
2013	One in 100, Outstanding Post-Doctoral Fellow Mentor, Emory University
2013	Academy of Medical Educators, Emory University Department of Medicine
2016	Outstanding Service Award for the Promotion of Endocrine Health of an Underserved Population (Transgender), American Association for Clinical Endocrinologists
2016	Top 90th percentile, Patient Satisfaction, Press Ganey, Atlanta VA Medical Center
2016-2020	"Top Doctors in Atlanta", Castle Connolly, Atlanta Magazine
2017	Distinguished Emory Physician
2017	Top 90th percentile, Patient Satisfaction, Press Ganey, Atlanta VA Medical Center
2018	Best Endocrinology Fellowship Mentor
2018	Top 99th percentile, Patient Satisfaction, Press Ganey, Emory Healthcare
2019	Best Endocrinology Fellowship Mentor

18. Society Memberships:

1. Massachusetts Medical Society, 1996 – 2007

2. Endocrine Society, 2000-Present

3. American Association of Clinical Endocrinologists, 2000-Present

Advisory Member, Board of Directors, American Association for Clinical Endocrinologists, 2013. I served a 1 year term as an advisory member to AACE prior to my election to a full board member

Member, Board of Directors, American Association for Clinical Endocrinologists, 2014-present
I am currently serving a 3 year term as a member of the Board of Directors for AACE, an association that represents over 7,000 clinical endocrinologists in the U.S. and internationally (aace.com). We have in person meetings every 3 months across the United States to discuss important topics related to clinical endocrinology. I was re-elected for a second 3-year term in 2017 and will complete my term on the board in 2020.

4. World Professional Association for Transgender Health, 2000-Present

Secretary/Treasurer, World Professional Association for Transgender Health, 2014-2016
I was elected as an officer for WPATH as Secretary/Treasurer. In my position, I also served on the Executive Committee for WPATH

President Elect then President, World Professional Association for Transgender Health, 2016-Present
I was elected to become president of WPATH. My presidency term started in November 2018.

5. International Society for Clinical Densitometry, 2003-2006

6. American Society for Bone and Mineral Research, 2004-2016

7. American Society for Nutrition, 2007-2017

8. Southern Society of Clinical Investigation, 2008-Present

Councilor, Southern Society of Clinical Investigation, 2013-Present
I have served as a councilor then elected as treasurer in 2018 for SSCI for the past 5 years

19. Organization of Conferences:

a. National and International:

Administrative positions:

2007 Member, Local Organizing Committee, 20th Biennial Symposium, World Professional Association for Transgender Health, **Chicago, IL**, September 5-10, 2007
Course Director, Contemporary Management of Transgender Patients, Emory CME, Chicago, IL, September 5, 2007, As member of the local organizing committee of this international conference, I oversaw the CME program and the planning of the conference of this meeting. This conference was attended by over 600 people from around the world.

2008 Co-Program Chair, Annual Meeting, Georgia Chapter, American Association of Clinical Endocrinologists, February 1-3, 2008, **Atlanta, GA**

2009 Program Chair, Annual Meeting, Georgia Chapter, American Association of Clinical Endocrinologists, **Atlanta, GA**, Feb 14-15, 2009

2011 Chair, Local Organizing Committee, 22nd Biennial Symposium, World Professional Association for Transgender Health, **Atlanta, GA**, September 24 – 28, 2011
I received the winning bid to host the Biennial WPATH symposium at Emory. This was attended by over 1000 professionals from all over the world. President Wagner was the keynote speaker at this conference.

2012 Course Faculty and Judge, SSCI Osteoporosis & Bone Health Young Investigators' Forum, **New Orleans, LA,** February 8, 2012

2014 Scientific Co-Chair, World Professional Association for Transgender Health, **Bangkok, Thailand**, February 14-18, 2014
I was honored to be appointed as the scientific co-chair for this international meeting. My role was to organize the scientific programming for this meeting.

2015-present Member, Annual Program Committee, American Association of Clinical Endocrinologists
I was invited to be a member of the annual program committee in 2015 and 2016. The role of the committee members is to plan and organize the AACE annual meeting held in **Nashville and Orlando**, respectively.

2017 Annual Meeting Program, 2016-Present, Vice-Chair, American Association of Clinical Endocrinologists, **Austin, TX**.
I was invited to serve as 1 of 3 vice-chairs for the AACE annual meeting. The job of the vice-chairs is to oversee programming for the 2017 annual meeting. My specific task for this year has been to oversee the plenary talks at the annual meeting.

2017 U.S. Professional Association of Transgender Health (USPATH), annual program committee.
I served on the inaugural annual program committee for the USPATH annual meeting held in

Los Angeles, CA. This was attended by over 600 professionals from all over the U.S.

2018 Annual Meeting Program, 2017-2018, Chair, American Association of Clinical Endocrinologists.
I was appointed by the president of the organization to serve as the annual program meeting chair for my clinical endocrinology association for the meeting in **Boston, MA** in May 2018.

2019 Co-Chair, World Professional Association for Transgender Health, November 5-9, 2020, **Changed to Virtual**. I was appointed to serve as the scientific co-chair.

Sessions as Chair

2007 and 2009 Course Director, Advances in Endocrinology for the Practicing Physician, Emory CME, **Atlanta, GA**
I raised funds and organized a CME program for practicing physicians in the Southeast United States. This was a full day program comprised of lectures from Emory Faculty in the endocrine division.

2008 Course Director, Comprehensive Review of Vitamin D for Optimal Health, Emory CME, **Atlanta, GA**
I raised funded and organized a special full day CME meeting on vitamin D attended by over 100 participants from all over the Southeast.

2009 Chair, World Professional Association for Transgender Health, Bi-ennial meeting, Endocrinology, Gynecology and Urology Session, June 17-20, 2009, **Olso, Norway**

2009 Co-Chair, North American Cystic Fibrosis Conference, Endocrinology and Bone Session, **Minneapolis, Minnesota**, October 21-23, 2009

2010 Co-Chair, Vitamin D Symposium, Experimental Biology Meeting, April 28, 2010, **Anaheim, CA**

2010 Course Director, Physician Career Development Conference, Emory CME**, Stone Mountain, GA**
This was a very special Emory CME career development program that I organized and raised funds that focused on early career physicians.

2011 Course Director, Advances in Pediatrics and Medicine (CME), Emory CME, **San Diego, CA**

2012 Course Director, Update in Medicine and Pediatrics (CME), Emory CME**, Las Vegas, NV**

2012 Co-chair, Adult Bone and Mineral Working Group, American Society for Bone and Mineral Research Annual Meeting, October 12, 2012, **Minneapolis, MN**

2013 Co-Chair, Transgender Medicine, 2013 Endocrine Society Annual Meeting, June 15 – 18, 2013, **San Francisco, CA**

2013 Co-chair, Adult Bone and Mineral Working Group, American Society for Bone and Mineral Research Annual Meeting, October 6, 2013, **Baltimore, MD**

2013 Co-Chair, North American Cystic Fibrosis Conference, Sex Steroids in Cystic Fibrosis, October 16 – 19, 2013, **Salt Lake City, UT**

2013 Course Director, Update in Medicine and Global Health (CME), Emory CME, **St. Louis, MO**

2014 Course Director, Advances in Medicine and Pediatrics (CME), Emory CME, **Anaheim, CA,**

2014 Co-Chair, Transgender Medicine, 2014 Endocrine Society Annual Meeting, June 20 – 24, 2014, **Chicago, IL**.

2014 Co-chair, Adult Bone and Mineral Working Group, American Society for Bone and Mineral Research Annual Meeting, September 14, 2014, **Houston, TX**

2014 Co-Chair, North American Cystic Fibrosis Conference, Endocrine and Diabetes Workshop, October 9-11, 2014, **Atlanta, GA**

2015 Course Director, Advances and Research in Medicine & Pediatrics, **Atlantic City, NJ**
I have organized an annual meeting focused on general topics in medicine and pediatrics for Emory CME for several years.

2015 Co-Chair, North American Cystic Fibrosis Conference, Endocrine and Bone Workshop, October 8-10, 2015, **Phoenix, AZ**

2016 Chair, Transgender Symposium: What an Endocrinologist Should Know, Annual Meeting for the American Association of Clinical Endocrinologists, May 27, 2016, **Orlando, FL**.

2016 Co-Chair, North American Cystic Fibrosis Conference, Endocrine Workshop, October 27-29, 2016, **Orlando, FL**

2017 Chair, Community Based Care Workshop, U.S. Professional Association of Transgender Health, February 2-5, 2017, **Los Angeles, CA.**

2018 Co-Chair, Endocrine Society, Adult Transgender, Sex Determination, and Reproductive Axis Development, March 19, 2018**, Chicago, IL.**

2019 Chair, American Association of Clinical Endocrinologists, Transgender Symposium, April 26, 2019, **Los Angeles, CA**.

b. Regional
Administrative position:

2009 – 2016 Moderator, Endocrine Club, Annual Southern Regional Meeting
I was responsible for the Endocrine Club for several years. I organize the endocrine meeting with speaker as part of the SSCI/Southern Regional meeting.

Sessions as Chair

2009 Co-Chair, Endocrinology Session, Southern Regional Meeting, Southern Society for Clinical Investigation Annual Meeting, February 14, 2009. **New Orleans, LA**

2010 Co-Chair, Endocrinology Session, Southern Regional Meeting, Southern Society for Clinical Investigation Annual Meeting, February 26, 2010, **New Orleans, LA**

2012 Judge, Osteoporosis Young Investigators Forum, Southern Society for Clinical Investigation Annual Meeting, February 8, 2012, **New Orleans, LA**

c. Institutional
2008 - present Division of Endocrinology, Weekly Grand Rounds Conference
I have been the coordinator for our division's grand rounds since 2008. I am responsible for the schedule, obtaining CME credits for the course and evaluations.

2008 - 2009 Faculty Development, Monthly Seminar Series
As part of the DOM faculty development committee, I was a coordinator of a monthly seminar series focused on faculty development of junior faculty

2009 - 2013 Monthly Atlanta Vitamin D Research Group Seminars
I organized a monthly seminar on various topics on vitamin D for 4 years.

2009 – 2013 Coordinator, Department of Medicine Faculty Research Day, 2009-2013, I served 4 years as the DOM coordinator for research day

20. Clinical Service Contributions:

1. Transgender Medicine Clinic: I started the first transgender medicine clinic at Emory in 2004. We now service over 250 patients who are seeking gender reaffirming therapies. I have assisted the Grady Memorial Hospital in starting their own dedicated multi-specialty transgender clinic which opened in 2017. I have also started a smaller clinic at the Atlanta VA Medical Center in 2006 and at Emory Midtown in 2017.

2. Endocrinology Clinic in the Emory Cystic Fibrosis Clinic: I am one of the only adult trained endocrinologists in the United States who focuses on the care of endocrine issues in cystic fibrosis. I was recently awarded a grant from the CF Foundation to train other adult endocrinologists around the country.

21. Community Outreach:

1. Little League Baseball Head Coach, Druid Hills Youth Sports (Spring and Fall seasons), 2012-current, I have coached over 12 seasons of baseball and over 100 boys and girls

2. Basketball Coach, Glenn Memorial and Clairmont Presbyterian Church Leagues, 2012- 2017, I have coached over 4 seasons of baseball and over 40 boys and girls

3. Baseball League Director, Druid Hills Youth Sports, 2013-2014, I was responsible for organizing 3 seasons of baseball for children aged 7 years old

4. Registrar, Druid Hills Youth Sports, 2013-2015, I served as the registrar for the baseball program and oversaw registration of over 1000 children

5. Board of Directors, Druid Hills Youth Sports, 2013- 2017, I am a very active member of this local board of directors who organize youth baseball for children in Dekalb county

6. Chair, External Boosters, Druid Hills Youth Sports, 2015-2017, I have raised over $50,000 in sponsorships to help support youth baseball in Dekalb county

7. Atlanta Braves Fan Council (Appointed position by the Atlanta Braves), 2014-2017. I have been a critical member of this committee who provides input to the Atlanta Braves front office in terms of the move from Turner Field to Suntrust Park. I completed my term on opening day 2017 for the Braves.

8. Atlanta Hawks Diversity Committee (Appointed position by the Atlanta Hawks), 2015-2019, I was appointed by Atlanta Hawks CEO Steve Koonin to serve on this committee to help provide input to the team regarding issues surrounding diversity. We meet monthly on conference calls and quarterly in person and participate in community events. I was reappointed again in 2017.

22. Formal Teaching:

a. Undergraduate

1. Problem Based Learning (MEDI 556), small group leader, Emory M2 medical students, 3 hours of small group instruction monthly, 2005-2007
2. Endocrine section, Clinical Pharmacology (MED 640), small group leader, Emory M2 medical students, annually, 2 hours of small group instruction, 2005-2006
3. "Vitamin D", Course: Introduction to Predictive Health (Course Director: Dr. Michelle Lambl), upper class Emory undergraduate students, annually, 2 hour lecture, 2009-Present
4. Evidence Based Medicine, Emory 2nd year medical students, 2 hour group session, annually, 2016-2018.

b. Graduate Program

1. "Vitamin D and Calcium", Course: Clinical Nutrition II, (Core course for Emory Ph.D. students in nutrition), annually, 2 hour lecture, 2006-2017.

c. Medical Student Teaching

1. "Vitamin D", Course: Medical Nutrition (MEDI 651), required course for Emory M2 medical students, annually, 1 hour lecture, 2005-2008
2. "Disorders of Calcium/Parathyroid", Course: Medical Pathophysiology (MEDI 650), required course for Emory M2 medical students, annually, 1 hour lecture, 2005-2008
3. "Disorders of Endocrinology", Course: Introduction to Emory Third Year Clerkships (Course Director: Ercia Brownfield, MD), annually, 1 hour lecture, 4 times a year, 2006-2007.
4. "Disorders of Calcium", Course: Foundations Abnormal (MEDI111), Emory M2 medical students, annually, 2 hour lecture, 2008-2011

d. Residency Program

1. "Disorders of Vitamin D and Calcium", Emory Residency Noon conference, 1 hour lecture, annually, 2006-2010

e. Endocrinology Fellowship Program

1. Rotating topics on Vitamin D, Calcium, Transgender, Emory Endocrinology Fellowship Core Curriculum Lectures, 1 hour lecture annually, 2004-Present

f. Other: Examination Preparation and Grading

1) Emory Nutrition Health Sciences Program, Ph.D. Program, Qualifying examination, 2005-2016.
2) Prepared, administered, and graded the Observed Structured Clinical Examinations for all Emory endocrinology fellows on an annual basis, 2011-Present

23. Supervisory Teaching:

Advisee	*Degree earned*	*Current Position*	*Years Mentored*
<u>Ph.D. Thesis Mentor</u>			
1. Suzanne E. Judd	Ph.D.	Associate Professor, and Assistant Dean of Undergraduate Education at UAB,	2006-2008
2. Ruth E. Grossmann	Ph.D.	Assistant Professor, College of Nursing, University of Iowa,	2009-2012
3. Ellen M. Smith	Ph.D.	Completed Ph.D., Defended Ph.D. 10/12, 2016; now working as a nutrition scientist at Kellogg	
<u>Ph.D. Committee Member</u>			
1. Veronika Fedirko	Ph.D.	Assistant Professor, Emory,	2008-2009
2. Juna Konomi	Ph.D.	Post-Doc, Emory,	2012-2014
3. Jennifer Frediani	Ph.D.	Post-Doc, Emory,	2012-present.
4. Kathryn Coakley	Ph.D.	Assistant Professor, Univ of NM,	2013-2015

Master's Students

1. Prakash Chandra	M.S.	Private Practice, Canada	2005-2007
2. Wendy Hermes	M.S.	Registered Dietician, CA	2012-2015

Undergraduate, medical students, post-doctoral fellows, medical residents and fellows directly mentored. Number of publications in brackets.

Undergraduate Students:

Dates	*Trainee*	*Program*	*Current Position*
2006	Tia Renee Sides	SURE program	Technician, U of Maryland
2008 - 2009	Sara Raiser (1)	SURE program	Faculty, Emory
2008 - 2009	Cynthia Michael	Research Elective	Dentist
2009	Jim Lu	Research Elective	Dentist
2009 - 2010	Lindsey Colman	SURE program	Research Coordinator
2009 - 2010	Eric Gottlieb (2)	Research elective	Internist, Providence, RI
2010 - 2013	Aneesha Thobani (1)	SIRE program	Cardiology Fellow, Emory
2011	Breanne Wright	SURE program	Ph.D. Graduate Student, Purdue
2012 - 2015	Moon Lee (4)	Student research	Ophthalmology Resident
2013	Ivana Stojkic	Summer research	Pediatrics Resident, Hopkins
2014 - 2015	Emily Galdun	Research elective	Medical Resident, Virginia
2015 - 2018	Shiven Patel (1)	Research elective	Medical Student, UCF
2016 - 2018	Nick Lee (1)	Research elective	Emory Undergrad
2018 -	Neha Arora (1)	SURE program	Emory Undergrad
2019 -	Anirudh Bhimavarapu (1)	Research elective	Emory Undergrad

Medical Students:

2004 - 2007	Arun Krishnamoorthy, M.D.	Medical student	Cardiologist, Piedmont
2005 - 2013	Ken Sutha, M.D., Ph.D.	Medical student	Faculty, Stanford
2012 - 2015	Malcolm Kearns, M.D. (5)	Discovery student	Internist, CA
2012 - 2015	Jennifer Whitehead, M.D.	Medical student	Pediatric Physician, Atlanta
2014 - 2015	Supavit Chesdachai, M.D (4).	Medical student	ID Fellow, Mayo
2017 - 2019	Marta Bean M.D. (1)	Discovery student	Intern, UPenn

School of Public Health:

2013 - 2014	Daud Lodin (2)	M.P.H. Candidate	Medical student
2015 - 2017	Jiabei He	M.P.H. Candidate	Graduate student
2018 – 2019	Qiao Deng (1)	M.P.H. Candidate	Graduate student
2019 - 2020	Yuhan Ji (1)	M.P.H. Candidate	Graduate student

Post-doctoral fellows directly supervised:

2006 - 2007	Era Shah, M.D. (1)	Fellow (NRSA)	Private Practice, Endocrinology
2006 - 2008	Natasha Khazai, M.D.(4)	Endocrine fellow	Instructor, Harvard, Joslin Clinic
2007 - 2009	Sasha Yamshchikov, M.D.(4)	ID fellow (NRSA)	Assistant Professor, Rochester
2007 - 2010	Meena Kumari, M.D. (10)	Fellow (NRSA)	Faculty, Morehouse Sch of Med
2008 - 2009	Yevgeniy Kantor, M.D.	Endocrine fellow	Private Practice, Endocrinology
2009 - 2011	Shabnam Seydafkan M.D.(6)	Research fellow	Post-Doctoral Fellow, Cardiology
2009 - 2012	Russell Kempker, M.D. (7)	ID fellow	Assistant Professor, Emory SOM
2009 - 2012	John Payne, M.D. (2)	Opthalmol. Fellow	Private Practice
2009 - 2012	Michael Witkamp, M.D. (1)	Peds Pulm Fellow	Instructor, University of Kentucky
2010 - 2012	James D. Finklea, M.D. (1)	Pulmonary fellow	Assistant Professor, UTSW
2011 - 2014	Saira Adeel, M.D. (2)	Endocrine fellow	Private Practice, Atlanta
2011 - 2014	Jessica Alvarez, Ph.D. (24)	Fellow (NRSA)	Assistant. Prof. Emory SOM
2011 - 2013	Jordan Kempker, M.D. (3)	Pulmonary fellow	Assist Professor, Emory SOM
2011 - 2014	Julia Rosebush, M.D. (1)	Peds ID fellow	Assist. Prof., Univ of Chicago
2012 - 2014	Shahid Nadeem, M.D.	Peds renal fellow	Assist. Prof., LSU Shreveport

2012 - 2014	Robert Simek, M.D. (1)	Peds GI fellow	Private Practice, Lubbock
2014 - 2016	Kelly Stephens, M.D. (1)	Endocrine fellow	Instr Harvard Brigham&Womans
2015 – 2017	Mansi Kanhere, M.D. (3)	Peds Endo fellow	Assist. Prof. Virginia Comm. Univ
2017 - 2019	Mary Stevenson (3)	Endocrine fellow	Assist. Prof. Emory
2017 -	Malinda Wu (3)	Peds Endo fellow	Pediatric endocrine fellow
2018 -	Connell Knight		

Internal Medicine Residency Program:

2006 - 2008	Kara Pepper, M.D. (2)	Research elective	Private Practice, Atlanta
2007 - 2008	Reshma Shah, M.D. (2)	Research elective	Private Practice, Atlanta
2007 - 2009	Aliya Heliyer, M.D. (1)	Research elective	Private Practice, Annapolis
2007 - 2009	Leo Jeng, M.D. (2)	Research elective	Private Practice, Dallas
2008 - 2010	Jennie Law, M.D. (1)	Research elective	Faculty, Emory St. Josephs
2008 - 2010	Nirali Desai, M.D. (2)	Research elective	Medicine Faculty, UPenn

Mentoring of Faculty:

2008 - 2013 Marian Evatt, M.D., M.S., Assistant Professor of Neurology
2008 - 2013 Ify Osunkwo, M.P.H., M.D., Assistant Professor of Pediatrics
2007 - 2010 Lindy Wolfenden, M.D., Assistant Professor of Medicine
2009 - 2014 Allison Ross, M.D., Assistant Professor of Pediatrics, NIH K grant award, co-sponsor
2010 - 2013 Susu Zughaier, Ph.D., Instructor of Pediatrics
2011 - 2013 Laura Delong, M.D., Assistant Professor of Dermatology
2011 - 2013 Oranan Siwamogsatham, M.D., Faculty on Sabbatical from Thailand
2013 – 2018 Corrilynn Hileman, M.D., Assistant Professor of Medicine, Case Western, NIH K-award, co-sponsor
2017 - Jessica Abramowitz, M.D., Assistant Professor of Medicine, UTSW
2019 - Jenna Sarvaideo, M.D., Assistant Professor of Medicine, University of Wisconsin
2019 - Howa Yeung, M.D., Assistant Professor of Dermatology, Emory University, NIH K-award mentoring committee
2019 - Carl Streed, M.D., Assistant Professor of Medicine, Boston University, NIH K-award mentoring committee

Bedside Teaching

Endocrinology consult attending at Emory University Hospital and the Atlanta VA Medical Center, 8-12 weeks/year, student, residents and fellows, 2004-present

24. Lectureships, Seminar Invitations, and Visiting Professorships:

a. National and International:

1. Thammasat University, Visiting Professor, “Osteoporosis and Vitamin D”, January 17-20, 2006, **Bangkok, Thailand.**

2. Mahidol University, Ramathibodi Hospital, Visiting Professor, “Vitamin D and Colon Cancer Prevention”, January 21, 2006, **Bangkok, Thailand**.

3. Mahidol University, Siriraj Hospital, Visiting Professor, “Osteoporosis Update: 2006”, January 23, 2006, **Bangkok, Thailand.**

4. Mahidol University, Siriraj Hospital, Visiting Professor, “T-cells and the RANKL Signaling System in Osteoporosis”, July 2, 2007, **Bangkok, Thailand.**

5. Thammasat University, Visiting Professor, “Update in Vitamin D”, July 4, 2007, **Bangkok, Thailand.**

6. Theptarin Hospital, Guest speaker, “Current Opinion in Osteoporosis”, July 5, 2007, **Bangkok,**

Thailand.

7. Mahidol University, Ramathibodi Hospital, Visiting Professor, "Role for T-cells and RANKL in Osteoporosis", July 6, 2007 **Bangkok. Thailand.**

8. Beth Israel Deaconess Medical Center, Harvard University, Visiting Professor, Endocrinology Grand Rounds, "Vitamin D and Cardiovascular Disease", September 19, 2008, **Boston, MA.**

9. Brown University, Visiting Professor, Endocrinology Grand Rounds, "Vitamin D Insufficiency: Importance to Cystic Fibrosis", October 15, 2008, **Providence, RI.**

10. Boston University, Visiting Professor, Endocrinology Grand Rounds, "Vitamin D Insufficiency: Importance to Cystic Fibrosis", October 20, 2008, **Boston, MA.**

11. Tufts University School of Medicine, Endocrinology Grand Rounds, "Vitamin D Deficiency and Risk for Cardiovascular Disease", March 23, 2009, **Boston, MA.**

12. Massachusetts Institute of Technology, Knight Science Journalism Program, Medical Evidence Boot Camp, Guest Speaker, "Advances in the Field of Vitamin D", March 24, 2009, **Cambridge, MA.**

13. Vitamin D Deficiency and Risk of TB, US-Georgia Workshop: Infectious Disease Research Conference, "Implementation Science and Strengthening In-Country Partnerships", May 27-28, 2009. **Tbilisi, Republic of Georgia.**

14. Endocrinology Grand Rounds, Case Western Reserve University, Guest Speaker, "Vitamin D: An update in the guidelines and importance for cystic fibrosis", October 12, 2011, **Cleveland, OH.**

15. Weekly Cystic Fibrosis Conference, Case Western Reserve University, Guest Speaker, "An Overview of Vitamin D Metabolism in Cystic Fibrosis", October 14, 2011, **Cleveland, OH.**

16. Monthly HIV/AIDS Conference, Dartmouth Medical School, Guest Speaker, "Vitamin D in HIV Infection", May 14, 2012, **Lebanon, NH.**

17. Endocrinology Grand Rounds, Guest Speaker, Henry Ford Hospital, "Transgender Medicine", January 9, 2015, **Detroit, MI.**

18. Endocrinology Grand Rounds, Guest Speaker, Boston University School of Medicine, "Update on Vitamin D Clinical Trials", April 13, 2015, **Boston, MA**.

19. Endocrinology Conference, Guest Speaker, Mahidol University, Division of Endocrinology, Ramathibodi Hospital, "Update on Transgender: 2016", January 26, 2016, **Bangkok, Thailand**.

20. Prince Mahidol Scholars Award Program, "Vitamin D in Infections", January 27, 2016, **Bangkok, Thailand**

I was honored to be invited to provide seminars in a conference in the name of the grandfather of the King of Thailand and was hosted at the Grand Palace by the Thai Royal family

22. University of Texas, Southwestern, Endocrinology Grand Rounds, "Transgender Medicine: What An Endocrinologist Needs to Know", March 10, 2017, **Dallas, TX**.

23. Brown University, Endocrinology Grand Rounds, "Transgender Medicine 2018", March 19, 2018, **Providence, RI.**

23. Robert M. Levin Memorial Lecture, Boston University Medical Grand Rounds, "Vitamin D: A Bright Future For Cystic Fibrosis?", September 15, 2017, **Boston, MA.**

b. Regional:

1. The Medical Center, Visiting Professor, Medical Grand Rounds, "Vitamin D: An Update". August 17, 2004. ***Columbus, GA.***

2. Atlanta Bone Club, Guest Speaker (CME). "Clinical Uses of BMD 2005", July 22, 2005, ***Atlanta, GA.***

3. The University of Tennessee, Visiting Professor, Metabolic Bone Conference, "Vitamin D and Skeletal Health", July 13, 2005, ***Memphis, TN.***

4. Atlanta Medical Center, Visiting Professor, Internal Medicine Residency, "Osteoporosis: Diagnosis, Treatment and Therapy". August 2, 2005, ***Atlanta, GA.***

5. Southern Comfort Conference Guest speaker, "Osteoporosis Prevention and Treatment in the Transgendered Community", September 22, 2005, **Atlanta, GA.**

6. Medical University of South Carolina, Visiting Professor, Endocrine Grand Rounds, "Vitamin D: Skeletal and Non-Skeletal Health", May 18, 2006, ***Charleston, SC.***

7. Ochsner Clinic, Visiting Professor, Weekly Endocrinology Conference, "Vitamin D: Skeletal and Non-Skeletal Health", November 29, 2006, ***New Orleans, LA.*** .

8. Ochsner Clinic, Visiting Professor, Rheumatology Grand Rounds, Vitamin D: Skeletal and Non-Skeletal Health", November 29, 2006, ***New Orleans, LA.***

9. Wake Forest University, Symposium on Vitamin D: Classical and Emerging Roles in Health, May 18, 2007, **Asheville, NC.**

10. Solvay Pharmaceucticals, Guest Speaker, Annual Meeting, "Endocrine and Exocrine Dysfunction in Cystic Fibrosis", June 29, 2007, **Stone Mountain, GA**.

11. Mercer University School of Medicine, Obstetrics and Gynecology Grand Rounds, Guest Speaker, "Osteoporosis Update 2008", September 19, 2008. **Macon, GA**.

12. Georgia State Nutrient Fortification Group, "Challenges in Improving Vitamin D Status by Fortification and Supplementation", April 22, 2011, **Atlanta, GA.**

c. Institutional:

1. Wesley Woods Hospital, weekly conference, Guest speaker, "Vitamin D Deficiency: A Silent Epidemic in the Elderly", February 8, 2006, **Atlanta, GA**.

2. Emory University School of Medicine. Annual Internal Medicine Board Review (CME) Course, Disorders of Calcium, August 2, 2006, **Atlanta, GA.**

3. Understanding Bone Imaging and Bone Strength, Atlanta Bone Club Symposium moderator, November 16, 2006, **Atlanta, GA.**

4. Emory University School of Medicine. Annual Internal Medicine Board Review (CME) Course, Disorders of Calcium, August 8, 2007, **Atlanta, GA.**

5. Cystic Fibrosis Family Education Day, Emory University, Guest Speaker, "Cystic Fibrosis Related

Diabetes", February 10, 2007, **Atlanta, GA.**

6. Emory Rheumatology Grand Rounds, Guest speaker, "Vitamin D: Bones and More". March 7, 2007, **Atlanta, GA.**

7. Emory Department of Pediatrics, Division of Pulmonary, Monthly Research Conference. Guest speaker, "Translational Vitamin D Research: Importance in Cystic Fibrosis and Respiratory Diseases", February 20, 2008, **Atlanta, GA.**

8. Emory University Hospital Nursing Staff, Guest speaker, "Cystic Fibrosis Related Diabetes", July 30, 2008, **Atlanta, GA.**

9. Emory University School of Medicine. Annual Internal Medicine Board Review (CME) Course, Disorders of Calcium, August 6, 2008, **Atlanta, GA.**

10. Emory Clinical Outcomes and Epidemiology Conference, Guest speaker, "Vitamin D and Cardiovascular Diseases", August 15, 2008, **Atlanta, GA**.

11. Southern Comfort Conference, Guest speaker, "Low dose hormone therapy for MTF and FTM transgendered individuals", October 3, 2008, **Atlanta, GA.**

12. Emory University, Division of General Medicine, 1525 Practice, Guest Speaker, "Vitamin D: Skeletal and Extra-skeletal Health", October 28, 2008, **Atlanta, GA.**

13. Morehouse School of Medicine, Department of Family Medicine, Grand Rounds, "Vitamin D for Optimal Health", April 28, 2009, **Atlanta, GA.**

14. Emory Rheumatology Grand Rounds, "Vitamin D: Skeletal and Extra-Skeletal Health", May 6, 2009, **Atlanta, GA.**

15. Emory University Medicine Grand Rounds, "Vitamin D Insufficiency Increases the Risk of Chronic Medical Disease: Fact or Fiction", May 12, 2009, **Atlanta, GA.**

16. Geriatric Medicine Updates, Emory/VA Weekly Geriatric Conference, "Vitamin D and Its Implications in the Elderly", September 24, 2009, **Atlanta, GA.**

17. Emory Division of Infectious Diseases Weekly Research Conference, "Vitamin D Deficiency and Risk of Infections", March 11, 2010, **Atlanta, GA.**

18. Centers for Disease Control, Influenza Division, "Vitamin D Deficiency and Risk for Infections", June 9, 2010, **Atlanta, GA**.

19. Emory Rheumatology Grand Rounds, "Vitamin D Update on Clinical Trials at Emory", May 27, 2015, **Atlanta, GA.**

20. Emory Geriatrics Grand Rounds, "Vitamin D Update on Clinical Trials at Emory", August 20, 2015, **Atlanta, GA.**

21. Emory GI Grand Rounds, ""Clinical Trials in Vitamin D at Emory: What have we learned?", September 28, 2015, **Atlanta, GA.**

22. Emory Endocrinology Grand Rounds, "Transgender Medicine: 2015", October 19, 2015, **Atlanta, GA**.

23. Emory DOM Grand Rounds, "Transgender Medicine: What an Internist Needs to Know", April 11, 2017, **Atlanta, GA**.

24. Emory Endocrinology Grand Rounds, "Vitamin D for Cystic Fibrosis, September 18, 2017**, Atlanta, GA.**

25. 25th Anniversary of the Emory Nutrition Health Sciences Program, Faculty Speaker, "Vitamin D for Cystic Fibrosis: A Bright Future", February 1, 2018, **Atlanta, GA.**

26. Transgender Day of Remembrance, "Gender Affirming Hormone Therapy", November 20, 2019, **Atlanta, GA**.

25. Invitations to National/International, Regional, and Institutional Conferences:

a. National and International:

1. Society of Nuclear Medicine 53rd Annual Meeting, Update in Diagnosis and Treatment of Osteoporosis: Beyond T-scores and New Therapies, June 6, 2006, **San Diego, CA.**

2. North American Cystic Fibrosis Conference, Vitamin D and Mineral Workshop, Invited speaker, "Evaluation of ergocalciferol, cholecalciferol and UV light to treat vitamin D insufficiency in CF patients", October 23, 2008, **Orlando, FL.**

3. North American Cystic Fibrosis Conference, Bone Symposium, "Re-thinking the Vitamin D guidelines: What was right and what was wrong?", October 14, 2009, **Minneapolis, MN.**

4. American Academy of Physician Assistants, 38th Annual Meeting, "Review of Hypercalcemia and Hypocalcemia", June 2, 2010, **Atlanta, GA**.

5. American Academy of Physician Assistants, 38th Annual Meeting, "Medical Therapy of Transgender Patients", June 2, 2010, **Atlanta, GA**.

6. Infectious Disease Society of America, 48th Annual Meeting, "Vitamin D Deficiency and Risk for Infections", October 24, 2010, **Vancouver, Canada**.

7. American Society of Nutrition, Advances and Controversies in Nutrition, "Assessment and Management of Vitamin D", February 25, 2011, **San Francisco, CA**.

8. North American Cystic Fibrosis Conference, 25th Annual Meeting, "An Overview of Vitamin D Metabolism", November 3, 2011, **Anaheim, CA.**

9. Killarney 13th Annual Cystic Fibrosis Meeting, "Vitamin D in Cystic Fibrosis: A review of the guidelines and future directions", January 31, 2013, **Killarney, Ireland**.

10. 7th Annual Cystic Fibrosis Nutrition & Social Work Consortium, Cystic Fibrosis Foundation, "Vitamin D for Cystic Fibrosis", March 22, 2013, **Atlanta, GA.**

11. 12th Colombian Congress of Endocrinology, "Vitamin D for Skeletal and Extra-Skeletal Health", "Drug Combinations for the Treatment of Osteoporosis", "Endocrine Management of the Transgender Patient", May 30-31, 2013, **Medellin, Colombia**.

12. Endocrine Society, 2015 Annual Meeting, Transgender Symposium, "Challenging Transgender Cases", March 8, 2015, **San Diego, CA**.

13. European Professional Association for Transgender Health, Annual Meeting, "Update on the Endocrine Standards of Care", Panelist, March 13, 2015, **Ghent, Belgium**.

14. 18th Vitamin D Workshop, "Vitamin D in Cystic Fibrosis", April 22, 2015, **Delft, The Netherlands**.

15. 5th Annual International Conference on Vitamin D Deficiency, "Vitamin D in Infections" and "Vitamin D in Chronic Kidney Disease", March 23-24, 2016**, Abu Dhabi, United Arab Emirates**.

16. American Academy of Insurance Medicine, 126th annual meeting, "Transgender Medicine", October 18, 2017, **Atlanta, GA**

17. North American Cystic Fibrosis Conference, "Vitamin D in Cystic Fibrosis", November 2, 2017, **Indianapolis, IN**.

18. Brazilian Association for Transgender Health, "Update on Endocrine Guidelines for Transgender Medicine", November 4, 2017, **Sao Paolo, Brazil.**

19. Endocrine University, American Association of Clinical Endocrinologists, "Transgender Medicine", March 6, 2018, Mayo Clinic, **Rochester, MN**.

20. Endocrine Society, "Guidelines for Gender Dysphoria/Gender Incongruence", March 19, 2018, **Chicago, IL**.

21. American Society for Colposcopy and Cervical Pathology Annual Meeting 2018, "Transgender Medicine: How to Provide Gender Affirming Care", Keynote Plenary Address, April 20, 2018, **Las Vegas, NV**.

22. American Society of Andrology Annual Meeting 2018, "Transgender: Epidemiology, Etiology, and Endocrinology", April 21, 2018, **Portland, OR**.

23. National Lipid Association Annual Meeting 2018, "Management of Lipids and CVD in Transgender Populations", April 27, 2018, **Las Vegas, NV**.

24. Cleveland Clinic Board Review Course, "Transgender Medicine", September 22, 2018, **Cleveland, OH.**

25. Endocrine University, American Association of Clinical Endocrinologists, "Transgender Medicine", March 5, 2019, Mayo Clinic, **Rochester, MN**.

26. HIV & Aging: From Mitochondria to the Metropolis, Emory School of Nursing, "Older Transgender People Living with HIV", April 11, 2019, **Atlanta, GA**.

27. 23rd Vitamin D Workshop, "Impact of Vitamin D on the Microbiome in Patients with Cystic Fibrosis", May 31, 2019, **New York, NY**.

28. 13th Annual Meeting of the American Association of Clinical Endocrinologists, Philippine Chapter, "Transgender Medicine for Practicing Endocrinologists", August 15-17, **Manila, Philippines.**

29. Endocrine Society of Thailand, Annual Meeting, "Transgender Medicine" and "Vitamin D in CKD", August 24, 2019, **Hua Hin, Thailand.**

30. Cleveland Clinic Board Review Course, "Transgender Medicine", September 21, 2019,

Cleveland, OH.

31. Endocrine University, American Association of Clinical Endocrinologists, "Transgender Medicine", November 9, 2019, Mayo Clinic, **Rochester, MN**.

32. Endocrine Society, Meet the Professor, "Healthcare of the Transwoman Across the Lifespan", March 30, 2020, San Francisco. Virtual presentation due to cancellation of live meeting.

33. Endocrine Society, Symposium Speaker, "Transition of Care for Transgender Youth", March 30, 2020, San Francisco. Cancelled due to COVID-19.

b. Regional:

1. Houston Bone Club, Guest Speaker, "Vitamin D: Bones and More", March 5, 2007, ***Houston, TX.***

2. Georgia Chapter, American Association of Clinical Endocrinologists, Guest Speaker (CME), "An update in vitamin D: Skeletal and Non-Skeletal Health", September 27, 2007, **Atlanta, GA.**

3. Southern States Chapter Annual Meeting, American Association for Clinical Endocrinologists, Guest Speaker, "Vitamin D for Health", March 13-15, 2008, **Birmingham, AL.**

4. Internal Medicine News®: Endocrinology in the News, "Differential Diagnosis of Osteoporosis: How to Evaluate Low Bone Mineral Density in Adults", April 13, 2008, **Philadelphia, PA.**

5. Boston University, 24th Annual Controversies in Internal Medicine, "Vitamin D: Is there an epidemic?", "Paget's Disease of Bone", "Osteoporosis", "Chronic Kidney Disease: an Endocrine Perspective", May 5-7, 2008, **Hilton Head Island, SC.**

6. Genzyme Corporation, Medical Education Partners Program, Guest Speaker, "Vitamin D and Cardiovascular Disease", September 4, 2008, **Cambridge, MA.**

7. Southern Regional Meeting, "State of the Art: Vitamin D and the Heart". February 12-14, 2009, **New Orleans, LA.**

8. 53rd Annual Greenville Postgraduate Seminar: A Primary Care Update (CME course), Guest Speaker, "What is New in Osteoporosis", April 23, 2009, **Greenville, SC.**

9. Delaware Chapter, American College of Physicians Annual Meeting, Guest Speaker, "Vitamin D Increases Risk for Chronic Disease: Fact or Fiction", February 20, 2010, **Wilmington, DE.**

10. Southern Regional Meeting, Mentored Abstract Discussion, "Vitamin D Deficiency in Children: What are the Long Term Implications", February 26, 2010, **New Orleans, LA**.

11. 54rd Annual Greenville Postgraduate Seminar: A Primary Care Update (CME course), Guest Speaker, "Vitamin D Deficiency: How Common Is It?", April 14, 2010, **Greenville, SC.**

12. Georgia Chapter, American Society for Enteral and Parenteral Nutrition, Guest Speaker, "Vitamin in Health and Disease: 2010 Update", June 3, 2010, **Atlanta, GA.**

13. 55nd Annual Greenville Postgraduate Seminar: A Primary Care Update (CME course), Guest Speaker, "Osteoporosis: Update Diagnosis and Treatment", April 13, 2011, **Greenville, SC.**

14. Greater Atlanta Dietetic Association, "Vitamin D: 2011 Update", September 21, 2011, **Atlanta, GA.**

15. Southern States Chapter of the American Association of Clinical Endocrinologists, Annual Meeting, "Vitamin D: Hope or Hype", March 4, 2012, **New Orleans, LA.**

16. 56th Annual Greenville Postgraduate Seminar: A Primary Care Update (CME course), Guest Speaker, "Vitamin D Deficiency and Treatment", April19, 2012, **Greenville, SC.**

17. Division of Laboratory Science Summer Symposium, Centers for Disease Control, Keynote speaker, "Vitamin D Testing: Is this just a fad?", August 14, 2013, **Atlanta, GA**.

18. Southern Comfort Conference, Guest speaker, "Guidelines for Treatment of Transgendered Individuals", September 5, 2013, **Atlanta, GA.**

19. Michigan Chapter Annual Meeting, American Association of Clinical Endocrinologists, "Transgender Medicine: What an Endocrinologist Should Know", October 31, 2015, **Lansing, MI**.

20. World Professional Associate for Transgender Health, Certified Training Course for Healthcare Providers, "Advanced Hormones Therapy", November 6, 2015, **Chicago, IL**.

21. World Professional Associate for Transgender Health, Certified Training Course for Healthcare Providers, "Introduction and Advanced Hormones Therapy", January 20, 2016, **Atlanta, GA**.

22. Rheumatology Alliance of Louisiana, 4th Annual Meeting, "Vitamin D for the Skeleton and Beyond", August 28, 2016, **New Orleans, LA**.

23. Wake Forest School of Medicine, Transgender Health Conference, "Hormone Therapy for Trans* Populations", September 29, 2017, **Winston-Salem, NC.**

24. Georgia Chapter, American Association of Clinical Endocrinologists, Guest Speaker (CME), Transgender Medicine 2018: What an Endocrinologist Needs to Know", January 26, 2018, **Atlanta, GA.**

25. Ohio Chapter of the American Association of Clinical Endocrinologists, Guest Speaker (CME), Transgender Medicine 2019, July 27, 2019, **Columbus, OH.**

26. Texas Chapter of the American Association of Clinical Endocrinologists, Guest Speaker (CME), Transgender Medicine 2019, August 2, 2019, **Austin, TX.**

26. Abstract Presentations at National/International, Regional, and Institutional Conferences:

a. National and International:

1. Endocrine Society Annual Meeting, Turner A, Chen TC, Barber TW, Malabanan AO, Holick MF, **Tangpricha V***. Testosterone Increases Bone Mineral Density at the Hip and Spine in Female to Male Transsexuals, June 16-19, 2004, **New Orleans, LA.**

2. **Tangpricha V***. Harris M. Harry Benjamin International Gender Dysphoria Association Annual Meeting, Congenital Adrenal Hyperplasia in a FTM transsexual patient, April 6-9, 2005, **Bologna, Italy.**

27. Research Focus:

My research focus is translational research in areas of vitamin D, chronic kidney disease and cystic fibrosis. I am interested in the impact of vitamin D supplementation on extra-skeletal diseases such as infections and anemia. I am also interested in the endocrine care of patients with gender

dysphoria and non-conforming gender identity.

28. Grant Support:

ACTIVE

Federally funded:

Source and Title **Dates, yearly direct costs, % effort**

UL1 RR025008 (PI: David Stephens) 09/17/2007 - 05/31/2022*
NIH/NCRR, Atlanta Clinical and Translational Science Institute (ACTSI), $5,147,598, 13%
Dr. Tangpricha serves as a scientific advisory committee chair. His committee reviews protocols submitted to the ACTSI Clinical Interactions Network sites for approval.
Role: **Scientific Advisory Committee Co-Chair**
*renewed in 2017

NIH/1R01DK115473 (PI: Markland) 04/01/2018-03/31/2022
Role of Vitamin D in the Prevention and Progression of Urinary Incontinence
The aim of this grant is to investigate the role of vitamin D on the risk of urinary incontinence using two large prospective cohorts, including the Nurses Health Study and the VITAL trial.
Role: **Co-investigator**

NIH/R01HD079603-01A1 (PI: Walter Bockting) 09/25/2014 – 06/30/2019
Identity Development, Risk and Resilience among Gender Diverse Populations, $2000 per annum
The goal of this study is to describe the process of transgender identity development based on qualitative lifeline interviews with a sample of 90 transgender individuals ages 16 and older, and identify periods of acute vulnerability and characteristics of resilience.
Role: **Consultant**

NIH/R01 A1140988-01A1 (PI: Kraft) 6/1/2019-5/31/2024
"Understanding the rectal mucosal effects of cross-sex hormone therapy among US & Thai trangender women"
The goal of this proposal will be to understand the impact of gender affirming hormone therapy on HIV transmission in the rectal mucosa and the GI microbiome in transwomen in the US and Thailand.
Role: **Co-investigator**

Private foundation funded:

TANGPR19A0-I (PI: Tangpricha) 9/1/2019 – 8/31/2021
Cystic Fibrosis Foundation
"Vitamin D and Prebiotics in Cystic Fibrosis" $160,000 5%

Cystic Fibrosis Foundation Center Grant (PI: Hunt) 07/01/2007 – 06/30/2019
"Emory University Cystic Fibrosis Center" $310,320 4.5%
Dr. Tangpricha serves as a co-investigator on this center grant. He is the director of adult endocrinology for the Emory CF center.
Role: **Co-Investigator**

Cystic Fibrosis Foundation (PI:Tangpricha) 10/01/2016 – 09/30/2022

Emerging Leaders in CF Endocrinology Program $48,546 10%
The purpose of this award is to provide support for Dr. Tangpricha to train early career academic endocrinologists in research and clinical care of patients with CF across the United States. He has been assigned three mentees from VCU, Harvard, and University of Kansas in the first cohort and 4 mentees from the University of Washington, Oregon Health Sciences, GW and Harvard in the second cohort.
Role: **Co-Investigator**

PREVIOUS SUPPORT (in chronological order)

NIH T32DK007201 (PI Ruderman) 4/1/00 – 3/1/03
Metabolism, Endocrinology and Obesity Training Grant
Boston University School of Medicine,
Role: **Trainee**

Clinical Research Feasibility Funds (CReFF) Award 10/1/03 – 12/31/03
Boston University/GCRC $10,000
"Vitamin D Deficiency in Cancer Patients"
The aim of this grant was to determine the prevalence of vitamin D insufficiency in patients with cancer
Role: **Principal Investigator**

UV Foundation 05/01/05 – 12/31/07
Physician-Scientist Research Career Development Award $45,000
The aim of this grant was to support the research career of Dr. Tangpricha in becoming a physician-scientist
Role: **Principal Investigator**

Novartis Pharmaceuticals 11/01/04 – 04/30/07
"Study to Compare the Effect of 24 weeks Treatment with Vildagliptin to Placebo as Add-On Therapy" $19,038
Role: **Site Principal Investigator**

Atlanta Research and Education Foundation 07/01/2006 –6/30/2008
"A Randomized Controlled Double Blinded Trial to Evaluate Cholecalciferol $50,000 5%
Treatment on Reducing Blood Pressure in Middle Aged Men with Stage I Hypertension and Vitamin D Deficiency"
The aim of this grant was to examine the effect of vitamin D treatment on blood pressure
Role: **Principal Investigator**

Proctor and Gamble Pharmaceuticals 12/01/06 – 11/30/07
"Prevalence of osteoporosis and vertebral fractures and its impact on pulmonary function in cystic fibrosis patients: A cross sectional study" $13,000
The aim of this grant was to determine the prevalence of vitamin D insufficiency and osteoporosis in patients with CF
Role: **Principal Investigator**

Emory University Research Committee 07/01/2007 –6/30/2008
"Optimizing Vitamin D Status in Cystic Fibrosis Patients" $30,000
The aim of this grant was to determine the optimal replacement strategy for vitamin D in cystic fibrosis patients.
Role: **Principal Investigator**

Emory Center for Clinical and Molecular Nutrition 01/1/07 – 12/31/07
"Tumor Necrosis Factor α induces vitamin D resistance in small intestinal calcium absorption" $15,000
The aim of this grant was to determine the effect of inflammation that occurs in IBD on calcium absorption
Role: **Principal Investigator**

K23 AR054334 02/01/2007 – 1/31/2013
NIH/NIAMS $641,250 75%
Mentored Research Career Development Award, "Role of T-cells in Post-Menopausal Osteoporosis in Women Undergoing Surgical Menopause"
The aims of this grant are to examine the role of T-cells in post-menopausal osteoporosis and to support Dr. Tangpricha's career as a physician scientist
Role: **Principal Investigator**

Emory University Research Committee (PI: Evatt) 03/01/2008 –2/28/2009
Emory University $30,000 1%
"Vitamin D Repletion for Optimal Health in Patients with Parkinson's disease"
The aims of this grant are to 1) to determine the prevalence of vitamin D insufficiency in patients with Parkinson's disease 2) to perform a randomized placebo controlled trial to determine whether optimal vitamin D status improves neurocognitive function in patients with Parkinson's disease
Role: **Co-Investigator**

Parkinson Study Group (PI: Evatt) 07/01/2008 – 06/30/2009
"Vitamin D Insufficiency: Prevalence & Clinical Correlates in DATATOP Cohort" $50,000 1%
The aims of this grant is to correlate vitamin D status with clinical outcomes in a cohort of subjects with Parkinson's disease.
Role: **Co-Investigator**

Emory Global Health Institute (PI: Ziegler) 07/01/2008 – 6/30/2011
Emory University $250,000 2.5%
Impact of Vitamin D Supplementation on Host Immunity to Mycobacterium Tuberculosis and Response to Treatment: Building Translational Research Capacity in Nutrition and Infectious Diseases in the Republic of Georgia"
The aims of this grant are to: 1) evaluate the role of vitamin D as an adjunctive therapy in patients infected with TB and 2) enhance the research infrastructure in the Republic of Georgia
Role: **Co-Principal Investigator**

Emory University Research Committee (PI: Wasse) 02/01/2009– 1/31/2010
Emory University $30,000 1%
"Impact of Extra-renal 1-alpha hydroxylase expression and vitamin D polymorphisms on arteriovenous fistula maturation"
The aims of this grant are to 1) to demonstrate that serum vitamin D predicts AVF maturation, 2) to demonstrate that greater local expression of vitamin D activity and responsiveness increases likelihood of AVF maturation, to demonstrate that patients with activating VDR polymorphisms are more likely to experience AVF maturation.
Role: **Co-Investigator**

Emory Center for Aids Research (CFAR) (PI: Ross) 03/15/2010 – 3/14/2011
Emory University
"Prevalence and predictors of vitamin D deficiency and vitamin D's relationship to inflammatory and endothelial activation markers in a cohort of HIV-infected children and young adults."
The aims of this grant are to examine vitamin D status and their relationship to CVD risk factors in HIV infected children and adults
Role: **Co-Investigator**

GlaxoSmithKline (PI: Ross) 06/01/10-05/31/11
HIV Collaborative Investigator Research Award
Vitamin D and cardiovascular biomarkers in HIV-infected children and young adults.
This study evaluates the relationship between vitamin D levels and cardiovascular biomarkers in HIV-infected children and young adults from 1-25 years of age.

Role: Co-investigator

Emory University Research Committee (PI: Ross) 07/01/2011 – 6/30/2012
Emory University
Establishing Optimal Vitamin D Repletion Strategies in HIV-Infected Children and Young Adults: a Pilot Study
Role: **Co-Investigator**

R21HL110044-01/NIH/NHLBI (PI: Gregory Martin) 08/01/2011– 07/31/2014
High-dose vitamin D and antimicrobial peptide expression in lung failure
The major aim of this grant is to demonstrate a beneficial effect of high dose vitamin D given to subjects admitted to intensive care units with critical illness.
Role: **Co-Investigator**

R01HD070490 09/01/2011 – 08/30/2016
NIH/NICHD (PI: Grace McComsey) $1,709,989 5%
Vitamin D, drug metabolism, and cardiovascular complications in pediatric HIV
The aims of this grant are to examine the role of vitamin D on cardiovascular risk in adolescents with HIV disease
Role: **Sub-Contract to Emory, Co-investigator**

P30AR047363 (PI: Susan Thompson, Site-PI: Angela Robinson)
"Vitamin D and Response to Atorvastatin in Pediatric SLE" 4/1/2012 – 6/30/2016
The aims of this subaward are to determine the relationship between vitamin D status and markers of innate immunity in pediatric subjects with SLE.
Role: **Sub-contract awardee**

R21DK096201 (PI: Alayne Markland) 09/19/2013 – 05/31/2015
Vitamin D Supplementation in Older Adults with Urinary Incontinence
The aims of this grant are to examine the role of vitamin D treatment in elderly patients and its impact on urinary incontinence.
Role: **Co-Investigator**

R21HD076387-01 (PI: Michael Goodman) 08/01/2013 – 05/31/2015
Cohort study of mortality and morbidity in transgender persons $261,359 2%
The goal of this study is to establish a cohort of transgender persons in the VA and Kaiser Healthcare systems and to determine the risk of a number of co-morbid conditions and to obtain data on the rates of mortality.
Role: **Co-Investigator**

PCORI (PI: Michael Goodman) 01/01/2013 – 12/31/2016
Comparative Risks and Benefits of Gender Reassignment Therapies $2,103,856 5%
The goal of this study is to understand the short- and long-term health issues among transgender persons who had or are planning to have a sex change treatment.
Role: **Co-Investigator**

Cystic Fibrosis Foundation 07/01/2011 – 06/30/2018
Clinical Research Award $780,000 25%
"Vitamin D for enhancing the immune system in cystic fibrosis"
The aims of this grant are to examine the role of vitamin D in improving the host defense system in adult and adolescent patients with CF and who are admitted with an acute pulmonary exacerbation in a randomized, multi-center trial design.
Role: **Principal Investigator**

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Guideline Publications
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Other on-line publications:

1. Transgender Hormone Therapy, Up to Date, 2010-Present
   I have written, edited, and updated the Up to Date section on Transgender for over 5 years.

2. Dyamed Plus, Scoping Document, Transgender Hormone Therapy for Adolescents and Adults and Osteoporosis, 2016-Present
   I have been asked to assist with the Dyamed Plus evidence based web search engine for topics related to transgender and osteoporosis.

3. Vitamin D Deficiency and Related Disorders., Web MD (formally eMedicine), 2006-Present
   I have written, edited, and updated the section on vitamin D on Web MD for over 10 years

4. Transitions for Transgender Youth, Endocrine Society Website, 2019-Present. I co-authored a set of physician and patient tools to assist youth transition to adult care.

5. National VA LMS Training on Gender Affirming Hormone Therapy. I wrote and presented 2 online workshops available for VA providers to learn about hormone therapy for transgender veterans.

APPENDIX B

KIRKLAND & ELLIS LLP
AND AFFILIATED PARTNERSHIPS

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January 24, 2017

Dr. Vin Tangpricha
101 Woodruff Circle NE- WMRB1301
Atlanta GA 30322
Email vin.tangpricha@emory.edu

Dear Dr. Tangpricha:

As you know, Kirkland & Ellis LLP, the American Civil Liberties Union Foundation ("ACLUF"), and the Roger Baldwin Foundation of ACLU, Inc. ("RBF") represent transgender prisoners in the custody of the Illinois Department of Corrections ("IDOC") for purposes of investigation and intend to represent transgender prisoners for possible litigation in connection with the adequacy of medical care provided by the IDOC to transgender prisoners.

This letter confirms that the ACLUF, RBF, and Kirkland & Ellis LLP have retained you as an expert in this case, and we have agreed to pay your customary fee of $400 per hour plus reasonable expenses you incur in connection with your work on this matter. The same rate applies for report writing, phone conferences, face-to-face meetings, travel time, and trial and deposition testimony. In addition to professional fees, we will compensate you for reasonable direct out-of-pocket expenses, such as charges for travel. You will inform us if you anticipate total fees will exceed $10,000 prior to incurring those costs in excess of that amount.

You should send your bills directly to Kirkland & Ellis LLP. You have advised us that no conflicts exist with your taking on this assignment. You agree that you will not provide expert witness services in this case or matters directly connected with this case for any person or entity, other than the plaintiffs and their attorneys, without the advance written approval of the plaintiffs' attorneys. In addition, you agree that while this matter is still active you will not provide expert services for any person or entity who has asserted or proposes to assert any position antagonistic to that of the plaintiffs in this case, without the advance written approval of the plaintiffs' attorneys.

In the course of your retention, we may call upon you to provide information, prepare studies or reports, participate in meetings, review materials, and undertake other tasks for ACLUF, RBF, and Kirkland & Ellis LLP as counsel to transgender prisoners. We intend that your work, opinions, conclusions and communications will be covered by the attorney-client privilege and attorney work product rule to the extent provided by law, and you agree to do all things necessary to preserve those privileges.

You agree that documents and information of any kind that you (or anyone assisting you) acquire will be maintained in strict confidence and not disclosed to any other person or party without our prior written consent. All documentary material provided to you (or to anyone assisting you) together with all copies thereof must be returned immediately upon request. In addition, any activities that you perform under this agreement and any conclusions or judgments that you reach or have reached must be maintained as confidential in the same way. You should understand that these restrictions will continue even after the termination of your consulting work for us and after the termination of the matter.

You agree that while the matter is still active, neither you nor anyone assisting you will engage in any activities that are adverse to the interests of transgender prisoners in IDOC custody or ACLUF, RBF, and Kirkland & Ellis LLP's representation of these prisoners in this matter.

Reports and other documents generated, or obtained by you, in the course of your work on this matter will be the property of the ACLUF, RBF, and Kirkland & Ellis LLP. If authored by you, the work will be considered "Works Made For Hire" and all right, title and interest in such works is hereby assigned by you to the ACLUF, RBF, and Kirkland & Ellis LLP.

The nature and duration of your retention will be determined by the ACLUF, RBF, and Kirkland & Ellis LLP and may be modified or terminated by us at any time for any reason. This agreement may not be amended or modified, nor any provision waived by any means other than an express writing to such effect which is signed by you and ACLUF, RBF, and Kirkland & Ellis LLP.

* * *

KIRKLAND & ELLIS LLP

We greatly appreciate your help in this matter, and we are looking forward to working with you.

Sincerely yours,

KIRKLAND & ELLIS LLP

By: Erica B. Zolner
Name: Erica B. Zolner

Agreed and accepted this 24th day of January, 2017.

Dr. Vin Tangpricha

By: _____

Agreed and accepted this 22 day of January, 2018.

The American Civil Liberties Union Foundation

By: James D Esseks

Name: JAMES D. ESSEKS
Print Name

Agreed and accepted this 25th day of January, 2017.

The Roger Baldwin Foundation of ACLU, Inc.

By: _____

Name: John A. Knight

APPENDIX C

Serum hormone concentrations in transgender individuals receiving gender affirming hormone therapy: A longitudinal retrospective cohort study

Panicha Chantrapanichkul, MD[a], Mary O. Stevenson, MD[b], Pichatorn Suppakitjanusant, MD[c], Michael Goodman, MD[d], Vin Tangpricha, MD, PhD[b,e]

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Abstract

Objective: To examine the association of various gender affirmation hormone therapy (GAHT) regimens with blood hormone concentrations in transgender individuals.

Methods: This retrospective study included transgender persons receiving GAHT between January 2000 and September 2018. Data on patient demographics, laboratory values, and hormone dose and frequency were collected. Non-parametric tests and linear regression analyses were used to identify factors associated with serum hormone concentrations.

Results: Overall 196 subjects (134 trans women, 62 trans men) with a total of 941 clinical visits were included into this study. Trans men receiving transdermal testosterone had a significantly lower median value of total serum testosterone when compared to those who were receiving injectable preparations (326.0 vs. 524.5 ng/dL respectively, p=0.018). Serum total estradiol concentrations of trans women was higher in those receiving intramuscular estrogen compared to those receiving oral and transdermal estrogen (366.0 vs. 102.0 vs. 70.8 pg/mL respectively, p<0.001). A dose dependent response in hormone levels was observed for oral estradiol (p<0.001) and injectable testosterone (p=0.018), but not for intramuscular estradiol and not for transdermal formulations. Older age and history of gonadectomy in both trans men and women were associated with significantly higher concentrations of serum gender-affirmed hormone.

Conclusion: In trans men, all routes and formulations of testosterone appear to be equally effective in achieving concentrations in the male range. Intramuscular injections of estradiol resulted in the highest serum concentrations of estradiol whereas transdermal estradiol resulted in the lowest concentration. Dose was directly related to hormone levels for oral estradiol and injectable testosterone.

Keywords: transgender, gender affirming hormone therapy, serum testosterone level, serum estradiol level

Introduction

Many transgender and gender non-binary people (TGNB) people receive gender affirming hormone therapy (GAHT) to align their gender identity with their secondary sex characteristics [1]. Other ways that TGNB people affirm their gender identity include social transitioning, voice therapy, and gender affirmation surgery [2]. The goal of GAHT is to closely mirror the sex steroid concentrations found within the reference range of the affirmed gender [3]. Over a period of 2-3 years, GAHT typically results in physical changes expected for the affirmed gender. In transfeminine individuals, GAHT produces increased volume of breast tissue, redistribution of subcutaneous fat, and changes in skin and hair. In transmasculine individuals, GAHT causes deepening of the voice, an increase in muscle mass, redistribution of subcutaneous fat, and increased facial and body hair [4-6].

Although GAHT is considered safe under medical supervision [7-11], evidence indicates that TGNB people may have potential adverse effects, such as polycythemia secondary to testosterone administration, and venous thromboembolism due to estrogen use [9, 12]. The Endocrine Society guidelines suggest monitoring and adjusting hormone medications to maintain hormone levels within the desired sex-specific physiologic range of the affirmed gender to minimize these risks [1, 2]. However, published data on hormone dosing and corresponding blood concentrations are limited in the literature [7, 13, 14]. It is important for clinicians to have a better understanding of the impact of the dose of the hormone preparation, route of administration and frequency of dosing on blood hormone levels to ensure safety of GAHT regimens [11, 15].

The purpose of this study was to examine the effect of various GAHT regimens on blood hormone concentrations in transfeminine and transmasculine individuals receiving care at a single center. We included all subjects who were receiving GAHT over a 15 year period and had data on the details of the hormone regimen and hormone concentrations.

Methods

Study population

This is a retrospective study of patients identifying as transgender who received GAHT at the [redacted] between January 1, 2000, and September 6, 2018. The protocol for this study was approved by the [redacted] Institutional Review Board. All subjects were treated in accordance with the Endocrine Society clinical practice guidelines for the treatment of gender-dysphoric/gender-incongruent persons [2, 11]. Trans women received estrogen in various types of preparations, including oral, intramuscular, and transdermal routes. Some trans women also received testosterone lowering agents such as spironolactone. Trans men were prescribed testosterone which in most instances was administered as an intramuscular injection.

Data collection

The information abstracted from the medical records included patient demographic characteristics (gender identity, current age, age at hormone initiation and race/ethnicity), clinical and general health-related variables (body mass index and history of gonadectomy) as well details of GAHT (medication type, dose, frequency, and route of administration). Transdermal preparations of sex steroid hormones included patches and gels. All subjects had regular hormone testing during outpatient visits. Serum total estradiol was performed by tandem mass spectrometry as a send out test to ARUP Laboratories (Salt Lake City, Utah) and testosterone analyses were performed by tandem mass spectrometry by Emory Medical Laboratories in both trans men and women. According to the guidelines of the Endocrine Society, blood testing was performed every 3-6 months in subjects initiating on GAHT and approximately 6-12 months for subjects who have already been on a stable regimen after 2 years from initiation of GAHT. The dates of hormone level testing and test results were obtained from the laboratory reports.

Statistical analysis

The data were analyzed by using SPSS Statistics version 20 (SPSS, Inc., Chicago, IL, USA). Descriptive statistics were used to summarize demographic data. Means ± standard deviations (SD) and medians ± interquartile ranges (IQR) were used to describe the distributions continuous variables respectively, while categorical variables were characterized in terms of frequencies and proportions. Differences between groups were compared using $\chi 2$ test for categorical variables. Due to skewed distributions of hormone levels non-parametric Kruskal-Wallis or Mann-Whitney U tests were used to compare serum concentrations of testosterone across categories of trans men and estradiol concentrations across categories of trans women. In addition, simple linear regression models were used to examine the relation between GAHT dose and serum sex hormone levels. The dose-response analyses were performed separately for each route of hormone administration. A two-sided *p*-value of less than 0.05 was considered as evidence of statistical significance.

Results

Study subjects

The study dataset included 244 patients; however, 48 patients had missing data thus leaving 196 subjects in the final cohort. These subjects included 134 trans women and 62 trans men. After excluding visits in which subjects were not on GAHT, the outpatient clinic visits were divided into two groups: 647 transfeminine hormone treatment visits and 294 transmasculine hormone treatment visits (Figure 1).

Table 1 presents baseline demographic characteristics of the study participants. Trans men were younger than trans women with 40% vs. 11% under the age of 21 years and 24% vs 43% over the age of 35 years in the two respective groups (p=0.001). The race/ethnicity distributions (60% non-Hispanic whites in both groups, p=0.927) and the percentages of subjects undergoing gonadectomy in trans women and trans men were similar (21.6% vs 29.0%, p=0.283). Compared to trans women, trans men included a greater proportion of participants with BMI of 30kg/m^2 of greater (42% vs. 30%), but the difference was not statistically significant (p=0.095).

Factors influencing blood sex steroid hormone concentrations

As shown in Table 2 more advanced age and a history of gonadectomy were associated with higher sex hormone levels in both trans men and trans women. For example, median serum testosterone concentration in trans men who did and did not have gonadectomy were 603 (IQR: 437-936) ng/dL and 481 (IQR: 276-686) ng/dL, respectively (p=0.030). The corresponding median (IQR) estradiol concentrations were 186 (114-359) for trans women who underwent gonadectomy and 116 (63-276) for trans women who did not have the procedure (p<0.001) There was also a statistically significant difference in serum estradiol concentrations in trans women on anti-androgen therapy compared to the levels in trans women not taking anti-androgen therapy (120 pg/mL vs 163 pg/mL, p=0.006).

Gender Affirming Hormone Therapy Regimens

The majority of blood test values came from trans men taking injectable testosterone with approximately half of the trans men using the equivalent dose of higher than 75 mg/week (Table 3). Injectable testosterone represented both intramuscular testosterone in 97.5% of the observations and subcutaneous testosterone in 2.5%. Trans men receiving transdermal GAHT had a significantly lower median concentration of total serum testosterone when compared to those who were receiving injectable preparations (326.0 vs 524.5 ng/dL respectively). Higher doses of injectable testosterone were associated with higher hormone concentrations with median (IQR) estimates of 442.5 (257.5 – 644.3) for ≤50 mg/week; 483.0 (317.8 – 645.3) for 51-75 mg/week and 588.0 (380.3 – 840.3) for >75 mg/week (p for trend = 0.018). By contrast, the difference between levels associated with lower and higher doses of transdermal testosterone levels was not statistically significant (p=0.66).

Table 4 summarizes serum concentrations of total estradiol according to route and dose of GAHT among trans women. Oral and intramuscular preparations of estradiol were more common among trans women compared to transdermal route (n= 366, 242, and 39, respectively). Among trans women taking oral estradiol, the majority of the subjects received

a dose of 15-30 mg/week (45.6%) or greater than 30 mg/week (36.3%). Among trans women taking intramuscular estradiol, the majority received a dose of 10 mg/week or more. There were 488 visits (75.9%) in trans women using anti-androgenic agents, most of whom were taking spironolactone alone (n=468, 72.8%) or in addition to progesterone (n=43, 6.7%). Very few trans women were taking GnRH analogues (n=4, 0.7%).

Among trans women, serum total estradiol concentrations were higher in those receiving intramuscular estradiol compared to those receiving oral or transdermal estradiol (366.0 vs. 102.0 vs. 70.8 pg/mL respectively, p<0.001). Women with a higher oral dose of estradiol had a higher concentration of serum estradiol in a dose dependent fashion with median (IQR) estimates of 58.0 (47.6 - 104), 90.7 (58.7 - 138.8), and 140.0 (91.6 - 215.5) for doses of ≤14 mg/week, 15-30 mg/week, and >30 mg/week, respectively (p for trend <0.001). The same analyses showed little evidence of dose-response for intramuscular (p for trend =0.481) and transdermal (p for trend = 0.157) routes of estradiol administration (Table 4)

We examined daily regimens of estradiol and their corresponding serum estradiol concentrations in three commonly prescribed ranges for trans women (Figure 2). There was again a dose dependent increase in serum estradiol concentrations with increasing dose of estradiol. A total daily dose of estradiol in the range of 4-5 mg resulted in estradiol concentrations near the minimum suggested level for trans women, 93.5 pg/mL (IQR 58.6 – 146.8) (Figure 2).

Discussion

This study reports data on GAHT types and doses and the corresponding blood hormone concentrations among transgender individuals receiving care at a large specialized clinic in the United States. In both trans men and women, injectable GAHT was associated with significantly higher serum hormone levels when compared to oral or transdermal preparations. In both transgender men and women, factors that resulted in higher serum estradiol and testosterone concentrations included greater age (>35years) and a history of gonadectomy.

In our study, intramuscular and subcutaneous testosterone administration resulted in in the median serum total testosterone concentration of approximately 525 ng/dL. This level of serum total testosterone is consistent with levels found in other cohorts of trans men [13, 14, 16, 17]. Pelusi et. al reported even higher serum concentrations of total testosterone in trans men receiving intramuscular and transdermal formulations (median = 739.0 and 589.0 ng/dL respectively) [18]. Higher serum testosterone concentrations found in that study could be explained by the higher median age of their population and lower BMI compared to our study. In our study, we found that greater age was associated with higher serum testosterone concentrations. The relationship between serum total testosterone concentration and BMI remains unclear. One previous study reported that patients with a lower BMI had significantly higher serum testosterone concentrations [19]. In contrast, our data seems to suggest a V-shaped curve whereby persons with a BMI in the 25-29.9 kg/m^2 range had higher hormone concentrations than those whose BMI was less than 25 kg/m^2 and those with the BMI of 30 kg/m^2 or greater.

Serum estradiol concentrations of trans women in our study are also comparable with those reported in previous studies conducted in Europe [7, 13, 20]. One important distinction between studies conducted in the US and studies based in Europe is the use oral estradiol in combination with cyproterone, which is common in European clinical practice but not in the US. Cyproterone has been shown to increase sex hormone binding globulin and serum estradiol concentrations [21]. Some studies have reported a negative correlation between total testosterone level and sex hormone binding globulin [22, 23], while spironolactone is not known to have any impact on serum estradiol concentrations. Interestingly, serum estradiol concentrations in trans women receiving testosterone lowering agents were significantly lower compared to trans women not taking anti-androgen therapy. This is consistent with Leunig et al study of oral estradiol [24]. The likely explanation for a higher estradiol concentration in trans women not taking anti-androgen therapy is that the majority of trans women not taking anti-androgen therapy had previously undergone gonadectomy.

Monitoring sex steroid hormone concentrations in transgender people receiving GAHT is recommended by the Endocrine Society to decrease the risk of potential complications. Venous thromboembolism (VTE) and ischemic stroke are serious adverse outcomes in transgender individuals receiving GAHT, especially in transgender females taking oral estradiol [27, 28]. The reported incidence of VTE in trans women ranges from 1- 6% [9, 10, 29, 30]. One previous study reported transgender females taking oral estradiol had a 3-times higher rate of VTE and a 2-times higher rate of ischemic stroke, compared to cisgender male referents of the same age and race/ethnicity [31]. Although no studies have examined the association between serum estradiol dose and risk of VTE in trans women, it is presumed that higher hormone concentrations would increase risk. In trans men, GAHT is associated with an increase in hematocrit, a decrease in HDL, an increase in TG, LDL and inflammatory parameters [32-35]. However, clinical outcomes such as VTE, cardiovascular disease and cerebrovascular accidents do not appear to be increased in this population [31]. Most studies report that receiving GAHT under the supervision of medical providers is safe [7, 8]. One possible explanation for this safety is that serum hormone concentrations of TGNB persons are routinely monitored and kept within the recommended ranges. The precise serum hormone levels that produce adequate gender-affirming results (both physical and psychological) with the lowest risk of complications are still unknown [15]. However, most guidelines recommend keeping serum hormone levels within physiologic ranges of the affirmed gender [1, 2].

We found that serum estradiol levels increased in a dose dependent fashion according to oral estradiol dose in trans women. We also observed that doses of estradiol between 4 and 5 mg/day primarily in combination with spironolactone resulted in a median concentration at the minimum of recommended range of 100-200 pg/mL and doses of 2 mg/day might not be sufficient to achieve target concentrations[2]. Clinicians may consider starting at lower doses of oral estradiol and up titrate to 4-5 mg daily to reach recommended therapeutic levels of estradiol. Higher doses of estradiol (6 mg and above) may be reserved for those who still do not reach target levels but may result in supraphysiologic levels greater than 200-300

pg/mL Injectable estradiol and transdermal estradiol did not result in a dose dependent increase in estradiol concentrations. This may be since injectable estradiol leads to larger fluctuations of estradiol making timing of the measurement important and since transdermal estradiol may have significant variability in skin absorption between individuals. We also found that intramuscular injections of estradiol lead to mean estradiol concentrations above the reference range when given in doses of more than 5 mg weekly. In addition, trans women who underwent gonadectomy had higher serum estradiol concentrations which supports the common belief that estradiol dose can be decreased following removal of gonads. Although oral estradiol has many advantages, including ease of administration and low cost, current evidence suggests that oral estradiol may lead to a higher risk of thrombotic events compared to transdermal estradiol [9, 10, 29, 30]. Our observation that serum estradiol concentrations in trans women using transdermal estradiol were significantly lower when compared to other routes of administration may partly explain this difference in risk.

All routes of testosterone are equally effective in raising serum hormone concentrations into the male reference range; however, injectable testosterone appeared to be more likely to raise median testosterone concentrations into the range of 400-700 ng/dl recommended by the Endocrine Society. Intramuscular testosterone was the most popular route among trans men in our clinic. Testosterone doses of 100-200 mg every 1 or 2 weeks resulted in target concentrations. Transdermal preparations resulted in lower serum testosterone concentrations that were not in the recommended range.

The strengths of this study include the relatively large number of different observations with various hormone preparations and resultant hormone concentrations. Some limitations include variability of the timing of the hormone concentrations. In practice, this clinic prefers measuring the trough hormone concentrations in patients taking intramuscular injections to assess the efficacy of the hormone regimen; however, some subjects may not have had blood testing at that time point. We did not have enough numbers of lab tests done in trans men taking subcutaneous testosterone, so we are unable to compare serum testosterone levels to men taking intramuscular testosterone. Also, serum estradiol concentrations may vary

according to the time of day when the oral estradiol dose is ingested. Our cohort primarily used twice daily dosing when estradiol doses were greater than 2 mg daily. This may be very important when comparing studies in trans women on once daily to twice daily dosing of estradiol. Furthermore, some trans women may take estradiol sublingually as opposed to orally without informing their physician. We do not have any information regarding this route in our study. Another important point is that we do not have any information on sex hormone binding globulin (SHBG). Although measurement of SHBG is not recommended by Endocrine Society, administration of sex steroids will alter SHBG concentrations. Testosterone therapy will lower SHBG which may result in more bioavailable testosterone whereas estradiol therapy will increase SHBG which may result in less bioavailable estradiol. Using SHBG as a guide to adjust GAHT should be evaluated in future studies. Almost all our subjects were adults and thus these findings may not apply to transgender youth. Finally, these results may differ from findings in Europe as the main anti-androgen in the United States is spironolactone as opposed to cyproterone.

In conclusion, several routes and formulations of sex steroid hormones used in the United States produced target hormone concentrations in our patient population. In trans men, all routes and formulations of testosterone appear to be equally as effective in achieving target hormone concentrations. In trans women, there was a dose dependent increase in serum estradiol concentration with increasing oral dose of estradiol with a dose of at least 5 mg daily appearing to be effective in achieving adequate estradiol concentrations. Intramuscular injections of estradiol resulted in the highest serum concentrations of estradiol whereas transdermal estradiol resulted in the lowest concentration of estradiol. Trans women undergoing bilateral orchiectomy had higher serum estradiol concentrations which confirms the expectation that estradiol dose can be lowered after gonadectomy.

Conflict of interest

This study was not supported by any funding. All authors declare no personal or professional conflicts of interest relating to any aspect of this study.

Figure 1. Flow diagram of study participants

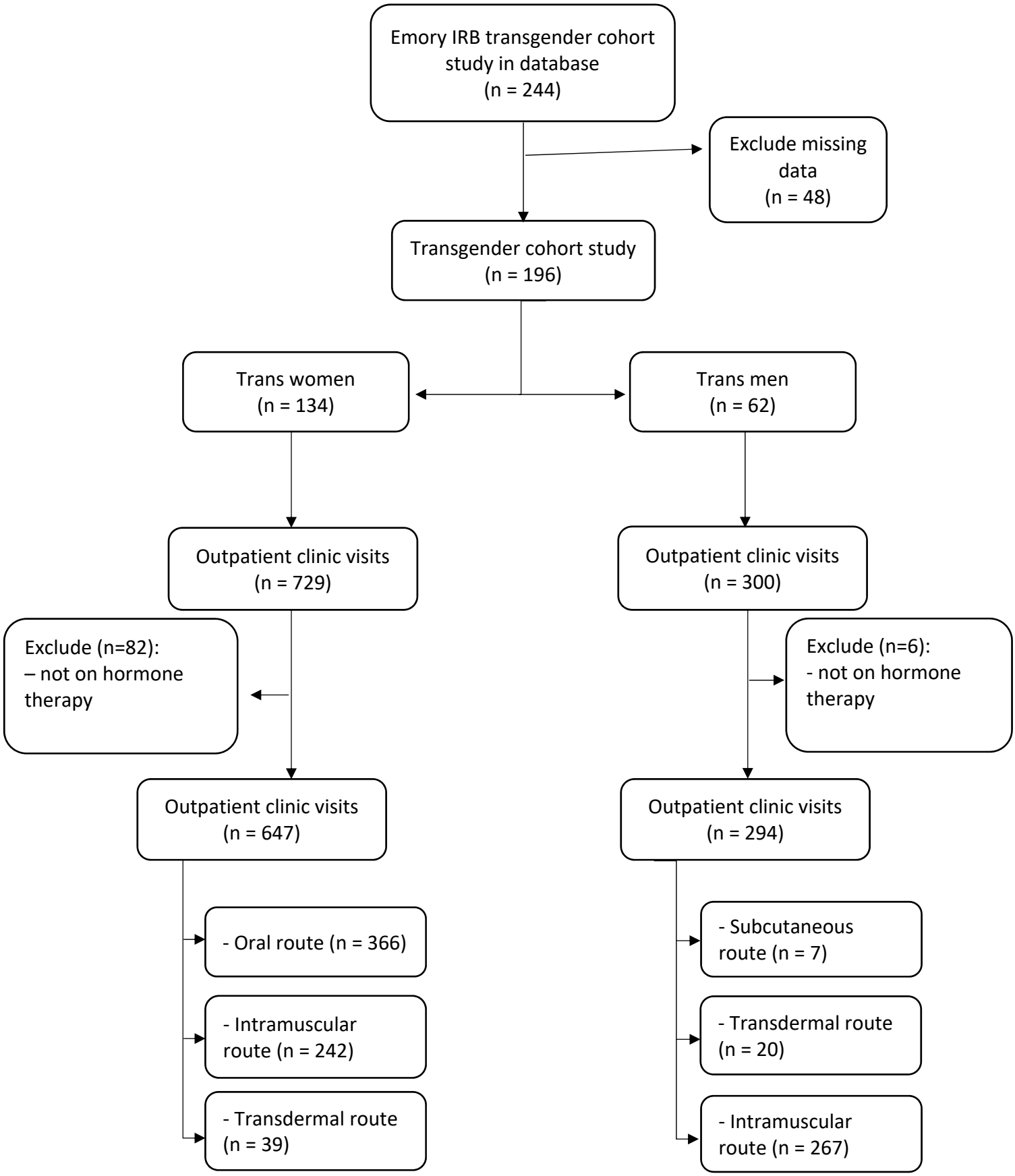

Figure 2

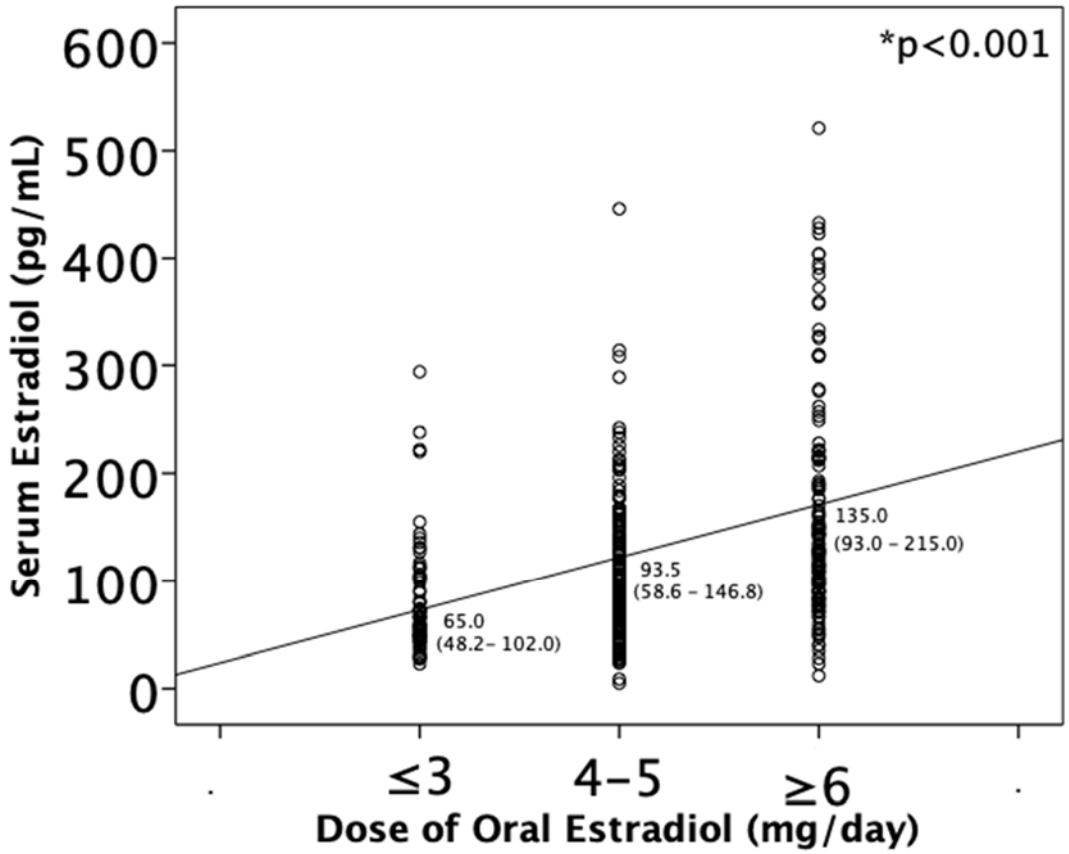

Figure 2 Total daily dose of oral estradiol and the corresponding serum estradiol concentration in trans women taking gender affirming hormone therapy Serum estradiol concentrations demonstrated a dose dependent increase with increasing total daily dose of oral estradiol ($p < 0.001$, Kruskal-Wallis). A total daily dose of between 4 and 5 mg daily resulted in a median estradiol concentration of 93.5 pg/mL (IQR 58.6 – 146.8), which is near the minimum recommended therapeutic range for trans women.

Table 1 Characteristics of transgender subjects at cohort entry

Participant Characteristics	**Trans men (n=62) N (%)**	**Trans women (n=134) N (%)**	**P-value***
Age (years)			
<21	19 (40.6%)	15 (11.3%)	0.001
21- 34	28 (45.2%)	62 (46.3%)	
≥35	15 (24.2%)	57 (42.9%)	
BMI category (kg/m^2)			
<25 (normal/underweight)	21 (33.8%)	63 (47.0%)	0.095
25-29.9 (overweight)	13 (21.0%)	27 (20.1%)	
≥ 30 (obese)	26 (41.9%)	40 (29.9%)	
Race/ethnicity			
Non-Hispanic White	37 (59.7%)	80 (59.7%)	0.927
African American	11 (17.7%)	27 (20.1%)	
Other/Unknown	14 (22.6%)	26 (20.1%)	
History of gonadectomy			
Yes	18 (29.0%)	29 (21.6%)	0.283
No	44 (31.0%)	105 (78.4%)	

* Chi-square test

Table 2. Sex Steroid Hormone Concentrations in trans men and women according to demographic characteristics.

Participant Characteristics	**Testosterone levels in trans men Median (IQR)**	**P-value***	**Estradiol levels in trans women Median (IQR)**	**P-value***
Age (years)				
<21	446.5 (255.7 – 652.0)	0.027	76 (50.2 – 153.5)	0.001
21- 34	508.0 (314.0 – 685.5)		123.0 (70.7 – 294.0)	
≥35	563.0 (364.0 – 864.0)		146.0 (74.0 – 309.0)	
BMI category (kg/m^2)				
<25 (normal/underweight)	496.0 (340.0 - 731.0)	0.857	145.0 (70.7 - 327.0)	0.171
25-29.9 (overweight)	515.0 (284.0 - 729.0)		153.0 (74.0 - 281.5)	
≥ 30 (obese)	495.0 (309.5 - 668.5)		119.5 (66.2 - 234.5)	
Race/ethnicity				
Non-Hispanic White	515.0 (288.0 - 755.0)	0.160	135.5 (74.9 - 309.0)	0.097
African American	582.0 (398.5 - 832.0)		119.0 (52.3 - 466.0)	
Other/Unknown	956.0 (352.25 - 1378.25)		55.8 (42.3 - 77.5)	
History of gonadectomy				
Yes	603.0 (437.00 - 936.00)	0.030**	186.0 (114.0 - 359.0)	<0.001**
No	481.0 (276.25 - 686.25)		116.0 (63.00 - 276.00)	

*Kruskal-Wallis test
**Mann-Whitney U test

Table 3 Serum concentrations of total testosterone in trans men by route of administration and dose*

Regimen characteristics	**Level (ng/dL) Median (IQR)**	**Route-specific P-value** by dose**
Injectable (n=274)	524.5 (333.8 – 756.0)	
≤50 mg/week (n=80)	442.5 (257.5 – 644.3)	0.018
51-75 mg/week (n=50)	483.0 (317.8 – 645.3)	
>75 mg/week (n=144)	588.0 (380.3 – 840.3)	
Transdermal (n=20)	326.0 (85.5 - 441.0)	
≤50 mg/week (n=13)	303 (61.5 – 442.0)	0.660
51-75 mg/week (n= 0)	-	
>75 mg/week (n=7)	349.0 (188.0 - 447.0)	
P-value for all routes, by dose	0.006 **	
P-value for all doses, by route	<0.001***	

* Based on individual visits
**Simple linear regression analysis
***Mann-Whitney U test

Table 4 Serum concentrations of total estradiol in trans women by route of administration and dose*

Regimen characteristics	**Level (ng/dL) Median (IQR)**	**Route-specific P-value** by dose**
Oral (n=366)	102.0 (61.8 - 155.0)	
≤14 mg/week (n=66)	58.0 (47.6 - 104)	<0.001
15-30 mg/week (n=167)	90.7 (58.7 - 138.8)	
>30 mg/week (n=133)	140.0 (91.6 - 215.5)	
Intramuscular (n=242)	366.0 (159.5 - 629.0)	
≤5 mg/week (n=24)	155.5 (62.28 - 605.0)	0.481
6-9 mg/week (n=29)	371.0 (227.5 - 550.0)	
≥10 mg/week (n=189)	365.0 (165.3 - 633.0)	
Transdermal (n=39)	70.8 (38.1 -119.0)	
≤2 mg/week (n=24)	71.5 (35.1 – 115.0)	0.157
2.1-5 mg/week (n=9)	105.0 (50.9 – 159.5)	
>5 mg/week (n=6)	50.3 (28.9 – 83.6)	
P-value for all doses, by route	<0.001***	

* Based on individual visits
** Simple linear regression analysis
***Kruskal-Wallis test

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EXHIBIT 15

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS

JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELÉNA VISION, SORA KUYKENDALL, and SASHA REED, individually and on behalf of a class of similarly situated individuals,	)	
Plaintiffs,	)	Case No. 3:18-cv-00156-NJR
v.	)	
ROB JEFFREYS, STEVE MEEKS, and MELVIN HINTON,	)	
Defendants.	)	

DECLARATION OF SORA KUYKENDALL

I, Sora Kuykendall, hereby state:

1. I am a 27-year old woman. I am a named Plaintiff in the above-captioned matter.

2. On Monday, January 4, 2021, I met with my assigned mental health counselor.

3. During our meeting, my mental health counselor told me she thought I needed to be placed on "crisis watch" because I was having suicidal thoughts.

4. I told my mental health counselor that I did not want to be placed on "crisis watch" because it would serve only to further deteriorate my mental health state.

5. Nonetheless, I was placed on "crisis watch" on January 4, 2021 despite my repeated statements that this would be extremely detrimental to me. I remained there until January 10, 2021.

6. The room I was placed in during my time on "crisis watch" had stains across the walls that I believed were from feces. I attempted to clean the stains, but I was unable to remove them completely.

7. During my time on "crisis watch," I was entirely denied access to my hormones, despite my repeated requests to correctional staff to retrieve them from my cell. I was likewise denied access to an electric razor, meaning I was unable to shave my legs for six days.

8. I was also denied access to soap for the first forty-eight hours, and I was not provided any eating utensils at any point during my time on "crisis watch." Because of this—as well as the state of my cell, my fear of contamination, and the COVID-19 pandemic—I did not eat anything for almost two days.

9. Even prior to being placed on "crisis watch," my mental and physical health were suffering greatly from my untreated gender dysphoria. I struggled with constant thoughts of self-harm and suicide.

10. My time on "crisis watch" greatly exacerbated my gender dysphoria, including my mental anguish, depression, anxiety, and suicidal ideation. I am more depressed now than I was prior to being placed on "crisis watch," and I could not feel more strongly that I should never be placed on "crisis watch" again.

11. Going without my hormones for almost six days was an excruciating experience that made me feel out of control, anxious, and hopeless. These feelings were made worse by the deplorable conditions of my cell while on "crisis watch," as well as IDOC's denial of the most basic items, such as soap, an electric razor, and my life-saving prescribed medication, hormone therapy.

12. My ongoing and constant-state of distress was made much worse after my treatment while on "crisis watch." It has strengthened my belief that those who are supposedly here to help me do not have my best interests at heart.

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

Dated: 1/15/2021

/s/ *Sora Kuykendall*[1]
Sora Kuykendall

[1] Plaintiffs' counsel spoke with Ms. Kuykendall on January 15, 2021 by telephone. During this conversation Ms. Kuykendall authorized Plaintiffs' counsel to file this declaration on her behalf. Plaintiffs' counsel will supplement this declaration with a signed copy from Ms. Kuykendall once it is returned to them by U.S. Mail from Ms. Kuykendall.

EXHIBIT 16

ANDRE PATTERSON a.k.a JANIAH MONROE 8/24/2020

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS
EAST ST. LOUIS DIVISION

JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELENA VISION, SORA KUYKENDALL, and SASHA REED,

Plaintiffs,

vs.

ROB JEFFREYS, MELVIN HINTON, and STEVEN BOWMAN,

Defendants.

) Case No.) 18-156-NJR

The deposition via videoconference of ANDRE PATTERSON a.k.a JANIAH MONROE, taken before Alyssa N. Kuipers, Certified Shorthand Reporter and Registered Professional Reporter, commencing at 9:26 a.m. on the 24th day of August, 2020.

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EXHIBITS

(NO EXHIBITS MARKED.)

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On behalf of the Plaintiffs;

ASSISTANT ATTORNEY GENERAL
MR. CHRISTOPHER HIGGERSON (via videoconference)
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On behalf of the Defendants.

* * * * * *

(Witness sworn.)

WHEREUPON:

ANDRE PATTERSON a.k.a JANIAH MONROE, called as a witness herein, having been first duly sworn, was examined and testified via videoconference as follows:

DIRECT EXAMINATION

BY MR. HIGGERSON:

Q. Could you please state your name for the record.

A. Janiah Monroe.

Q. And that is your chosen name, correct?

A. Yes.

Q. Can you tell us your inmate number just so that we have you properly identified?

A. Y35508.

Q. Okay. Thank you. How long have you been in the Illinois Department of Corrections?

A. Since 2008.

Q. And what was the crime you were convicted of?

A. My original charge?

Q. Yes, the one that led you to come to

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some minor tickets for insolence.
Q. During the time since December, when you've been on D wing, have you ever gone to segregation or have you been on D wing the entire time?
A. Yeah. I went to seg for the sexual and for the assault, that I remember. Yeah.
Q. When was the time you were in segregation?
A. I was in seg from January, I believe, to like February. I don't know. I got out of seg -- I just know I just got out of seg in April. I got out of seg in April. I've been out of seg since April. I haven't went back to seg since April.
Q. Okay. So you've only been in D wing continuously since -- from April to August because you were in segregation before that?
A. I've been in and out.
Q. You have been diagnosed with gender dysphoria, correct?
A. Yes.
Q. Do you see a mental health professional to be treated for that?

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A. Yes, I do.
Q. Who do you see right now that's treating you for gender dysphoria?
A. Dr. Post.
Q. What was the last time you saw Dr. Post?
A. Last week.
Q. What was -- Why did you see her last week?
A. To talk about anger management groups.
Q. Are you part of an anger management group right now?
A. I've been part of the anger management group. It's supposed to be starting back up.
Q. Is that what you were talking to her about, about it starting back up?
A. Yes.
Q. Was there anything else you talked to her about?
A. Not last week, no. She just said that she was happy that I was doing better, that I've been doing good. She's proud that

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I've been staying out of trouble and I'm in school and stuff like that.
Q. When was the last time you saw her to talk about the gender dysphoria?
A. Like, last month, I think.
Q. Is that a regularly scheduled appointment? Do you see her every so often?
A. Yeah.
Q. How often do you see her?
A. Like every month when she come in to check on me. Like, every month.
Q. Do you have any other type of treatment for gender dysphoria from the mental health people?
A. I mean, it's not really, like, a form of treatment for this gender dysphoria. She just asks me like how am I doing. It's just to check in, a wellness check-in. You know what I'm saying? It's not like she's treating my gender dysphoria. She is just checking on me to see how I'm doing because, like, I struggle with suicidal ideations. I've attempted suicide multiple times since I have been down here. She's concerned about me, so

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she comes in to check on me because -- and she knows that I'm trying to get my surgery.
And the last time I talked to her last month, I spoke to her about being displeased that Dr. Reister is putting my surgery on hold, because Dr. Sang had said I could have my surgery, but Dr. Reister is saying that he has to speak to me, and I don't understand. So my surgery is not happening, so they just keep giving me the runaround, so, like, they just keep --
Q. Who is Dr. Sang?
A. She's the medical director.
Q. Okay. Do you participate in any group therapy for your gender dysphoria?
A. Before we went on quarantine, there was a group for gender dysphoria.
Q. And how often did you participate in that?
A. It was every week.
Q. And who led that group?
A. Dr. Post.
Q. Is there any other mental health treatment that you are receiving for your

Q. Okay. Do you know if anybody has reached a conclusion that you are appropriate for surgery?

A. Dr. Sang said that she was approving me for surgery and that she wanted to schedule me to go out to be evaluated for surgery, but then Dr. Reister stopped her.

Q. Have you talked to Dr. Reister about that?

A. Dr. Reister came to this prison and spoke to all the trans men, but would not talk to me.

Q. Okay. Was it Dr. Sang who told you that Dr. Reister stopped her?

A. Yes. She told me that she was prepared to have me sent out and evaluated for surgery and scheduled, but that Dr. Reister said he wanted her to wait until he could speak to me.

Q. Do you know when that was?

A. She told me this in June.

Q. And you have not spoken to Dr. Reister since then?

A. No.

Q. What property have you had access to -- have you been able -- What have you been able to buy on the commissary that you were not able to buy before you came to Logan Correctional Center?

A. Makeup, female cosmetics, and perfume.

Q. That's all sold through the commissary at Logan?

A. Yes.

Q. Is there anything else you've been able to buy that you were not able to buy at Pontiac?

A. Perms, a lot of hair care products and stuff like that.

Q. Has what's been available on commissary changed since you've been at Logan or is it the same as when you first arrived?

A. I mean, different items become available at different times, yes, but, basically, the female products are still the same. The female products haven't changed.

Q. Has the clothing that you're able to wear changed since you've been at Logan?

A. The clothing that I'm able to wear?

Q. Yes.

A. Versus the clothing I was able to wear in the men's prison?

Q. Yes?

A. Yeah. Like, these are -- jogging pants and stuff, these are female jogging pants and female shoes, you know, stuff like that.

Q. What makes them female jogging pants as opposed to male or unisex jogging pants?

A. Because they fit different. Men's pants fit different; they're cut different. Female pants, they hug, they show your figure, your shape. Men don't want pants that's going to show off their body, they butt, and everything like that. Like, if you put on some female jogging pants, I don't think you're going to like how they fit you.

Q. What's the difference between male and female shoes?

A. It's not really a big difference between male and female shoes. It's just -- for me, I just -- like, it's a psychological thing. You know, it's a psychological thing.

Like, it's just a psychological thing, knowing that I have female clothes on versus having men's stuff on. It's reassuring to me. But some of the female shoes do look different than the men's shoes.

Q. Different in what way?

A. In, like, the styles. Some female shoes are made to look cuter versus, like, men's shoes are made -- some men's shoes are made to look more like functional or sporty, and some female shoes are made to look more cute and, you know, stuff like that.

Q. Is there any other property that you need for social transitioning that you do not have access to at Logan?

A. That I need?

Q. Yes.

A. I can't say that there's any other thing that I need. There may be some things that I would like. Like, because -- like, I feel, like, inadequate without it because it's a problem. Like, the main thing that I would want because -- like, okay. I feel like there's going to be issues with -- Like, you

got people who are in different situations than I am. Like, I don't grow a lot of facial hair. I don't grow a lot of body hair. You see what I'm saying? But you got other people that are way more masculine than I am and they have a lot more different needs than I have. See what I'm saying?

You got some trans women who -- like, hormones does not stop -- does not replace male pattern baldness. It will stop hair that you already lost. Like, you won't grow back the hair that you lost, but you won't lose any more hair. You see what I'm saying?

But at the same time, hair can be a big factor in making you feel feminine. It can be a big part of how you feel. And when you walk around a female prison and you see all these girls that got this long hair and then you sit up here with a bald-head and you're like: I'm bald-headed and look like a man and my hair fell out.

That's going to be a problem for other people when you got them transitioning to female and they're probably bald-headed and

they transitioning from female. I think they might want wigs or something like that.

It's not a problem for me because my hair grows. My hair grows as long as I want it to grow. I'm just saying that would be an issue. I know because I had a friend who was in a men's prison and she started taking hormones and she was trying to transition, but no matter what she did, she felt inadequate because she had went bald and she didn't feel like a woman and she killed herself.

And I know that's a major insecurity that some people cannot overcome. Your hair plays a major part in how you feel as a woman. I feel like, you know, I don't want to be bald-headed, you know. So that's a big thing. Your hair has a lot to do with how you feel as a woman.

Q. Are hair removal products available at Logan?

A. Hair removal products are available, yes.

Q. Is that just razors or is it other things?

A. Razors. Yeah, razors and (inaudible) shave are available.

Q. How are strip-searches done at Logan?

A. Are you asking like what the routine is like, or are you asking by who?

Q. Who does a strip-search of you?

A. Females.

Q. Do men ever do strip-searches of you?

A. No. If I was sent to a men's prison, a man would strip-search me.

Q. That's the way it was the last time you were at a men's prison, right?

A. Yes.

Q. Do you experience misgendering at Logan Correctional Center?

A. Sometimes.

Q. How common is it?

A. It's not as common as it was in the men's prison, but it still happens from time to time.

Q. Has the frequency changed since you arrived at Logan until today?

A. I mean, like, you have some officers that are just assholes, like, that are just jerks who refuse to see me as a woman, who, every time they see me, they call me Mr. Patterson or Andre or things like that. And they know that I identify as female. And I just try not to let it get under my skin, you know, but it's not something that the majority does. I still experience misgendering on a daily basis, depending on which officer I encounter.

Q. Do the officers who do the misgendering, do they do it in front of their superior officers or the administrators or do they only do it when it's just them talking to you?

A. Sometimes, it will be some of the superior officers that do it.

Q. Sergeants do it?

A. There has been a sergeant that does it.

Q. Are there lieutenants who do it?

A. No.

Q. Majors? Any majors that do it?

EXHIBIT 17

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS

JANIAH MONROE, MARILYN MELENDEZ, EBONY STAMPS, LYDIA HELENA VISION, SORA KUYKENDALL, AND SASHA REED	)	
Plaintiffs,	)	No. 18-CV-00156-NJR-MAB
vs.	)	
JOHN BALDWIN, STEVEN MEEKS, AND MELVIN HINTON,	)	
Defendants.	)	

The remote videotaped deposition via ZOOM of

LAMENTA CONWAY, M.D.

September 11, 2020

10:00 CST

professionals received with respect to diagnosing gender dysphoria?
A. Depending on the persons that you are referring to, there have been different. Any one in particular?
Q. Is there any training that every single MHP has received in terms of diagnosing gender dysphoria?
A. Yes.
Q. What is that training that every single mental health professionals has received?
A. There's annual training that every mental health professional receives that reviews the diagnostic criteria for gender dysphoria and for the care of the transgender patient.
Q. And how long have these annual trainings occurred?
A. I don't know the answer to that. I'm sorry. I know that I can say that these have occurred prior to my start with IDOC a year ago. At least that long and much likely significantly before but I just don't know the specific answer to that.
Q. And when did these -- when did this annual training that you mentioned occur for the

year 2020?
A. For the year 2020, I do not know the date. I'm sorry. I don't know the date that it has occurred.
Q. Has the training already occurred for 2020 for all the mental health professionals?
A. In the wake of the pandemic, I do not know the answer to that. I do believe that it has occurred within the past year. But in the year 2020, I can't get specifics to that date.
Q. And Dr. Conway, again, you understand that you are offered to testify about any action taken by staff IDOC and of Wexford to comply with the preliminary injunction; is that correct?
A. Yes, I do understand that.
Q. And you understand that as part of your obligations, you were to prepare yourself to be able to answer my questions around all of the topics that you are offered; is that right?
A. The specifics of dates, I did not know that I would be asked that so I do know that training -- you asked me for a specific date. I don't have that. But you asked do I know if it has taken place in 2020. I don't believe that it has.

That's my best answer. I do believe that it has happened within one year.
Q. And does IDOC record when these trainings occur?
A. I don't believe that they are recorded, but I believe that the actual training is a recorded training or includes a recorded training but the actual training itself I don't believe was recorded.
Q. Does IDOC take attendance at these annual trainings for mental health professionals?
A. Typically, yes.
Q. What instances would they not take attendance?
A. Well, I will say this: For all of our IDOC meetings, we take attendance. So I can't think of any -- in any instance where they would not take attendance.
Q. And what is the format of this annual training that mental health professionals receive with respect to diagnosing gender dysphoria?
A. My understanding is that part of the training is conversational with Dr. Reister, but also they are provided a video which I believe is about two hours.

Q. Let's talk about the conversation with Dr. Reister. Are these in-person conversations?
A. I don't know the answer to that. Are you talking about with myself or with respect to their training?
Q. I'm talking about with respect to the training that the mental health professionals receive with respect to diagnosing gender dysphoria and trying to get an understanding of what IDOC has provided and what the mental health professionals have taken.
So with respect to the format of the annual training that you said that all mental health professionals take and which covers the diagnostics of gender dysphoria, what is the format of that training?
A. Because we are all spread out, it is my belief that this is via webinar, but I would have to confirm that.
Q. Who designs this webinar?
A. It would be Dr. Reister.
Q. Does anyone else review or is involved in the designing and implementation of this presentation?

Q. Does she -- has she received any training that's specific to the treatment of gender dysphoria?
A. She is a part of our larger group that will be receiving training, WPATH-led training. She does have extensive training, however, as it relates to quality improvement initiatives.
Q. As of today, she has not yet received any specific training around treating gender dysphoria; is that correct?
A. Not that I'm aware of.
Q. Along with these presentations, is there other information that will be presented alongside the information specific to the treatment of gender dysphoria?
A. Other information that would be presented where? I'm sorry.
Q. I'll rephrase my question. At these presentations where the aggregated data on treatment of gender dysphoria for hormones will be presented, are there other topics besides hormone therapy that will be discussed?
A. I'm not sure if you are referring to the transgender health and wellness meetings or if you

are referring to other places where they have quality control meetings. So if you were referring to places -- I'm sorry. Go ahead.
Q. I'm referring to when the presentations are given to the Health and Wellness Committee, does the presentation or does the meeting itself include other information besides just the hormone therapy?
A. Yes. We will be evaluating grievance processes that are medical. What else. We will be evaluating patients who are requesting surgery.
Q. Will the Health and Wellness Committee be overseeing anything else with respect to transgender care?
A. We oversee training, which currently is going to be a year-long opportunity for all of our providers, mental health, medical, to be trained by WPATH with the -- basically with the global education initiative that's been customized for our community.
Q. What is the community that you're defining?
A. IDOC.
Q. So for this training, in what way has the GEI training been customized for IDOC?

A. Only in the sense it is focused on adult care as opposed to adolescents or child transgender health needs, so focused primarily on adult care.
Q. Besides the age group at issue in the training, are there other changes that have been made to customize for IDOC?
A. No, not that I recall.
Q. Who are the individuals who will be on the Health and Wellness Committee?
A. The individuals on the Health and Wellness Committee would include the deputy, the deputy chief, the acting medical director of health services, the chief of psychiatry, chief of psychology, a designated regional coordinator. That is on the IDOC side I'm referring to, our regional -- our nurse regional coordinators. And an assortment of providers who have expressed interest and have some -- have more experience in terms of transgender healthcare matters so basically those providers who have a particular heart and passion for the transgender community and want to take on additional learning opportunities and also be a resource to other providers.
Q. Let's start with the deputy chief. Is

that referring to you in your current role?
A. Yes.
Q. Since August 1st, have you received any additional specialized training in the treatment of gender dysphoria?
A. I have personally begun my training with WPATH. This is a training that I had paid for and registered for some time ago and it was disrupted because of the pandemic. In the month of August only, they actually converted to an online platform. So I began my training.
Q. What is the name of the training if you know it?
A. It's the WPATH GEE -- GEI course.
Q. What is your understanding of the content and nature of that course?
A. I don't understand that question.
Q. What information will be covered in the GEI course that you're taking?
A. It's one of their foundations courses or it's a foundations course. So the purpose of the course is to help provide a -- provide proficiency and knowledge as it relates to the care of transgender patients.

primary care provider.
Q. And has Ms. Griffin received any training specific to gender dysphoria treatment?
A. She would be the same as the others. Her training would be the collaborative -- the collaborative experience and training that all of the nurse and nurse leadership have had with others who are providing care.
Q. And to clarify, that collaborative experience would be referring to collaborating with other IDOC and Wexford professionals; is that right?
A. Yes, IDOC and Wexford professionals who are providing care to transgender health of which they will be involved.
Q. When is this GEI training that you mentioned scheduled to be provided to these individuals?
A. Friday, I believe September the 25th, and then I would have to take a look but Friday September the 25th, and then I believe a month later on the 23rd.
Q. What are you looking at to refer? I see you are looking down at a document.
A. I'm looking at a calendar on my phone.

Q. Have you looked at anything else besides your phone for the calendar for answering your question?
A. Just now I looked at the calendar to answer your question as to the date.
Q. I just ask that you please don't refer to any documents or your phone or anything unless you let me know first, okay. Is that all right?
A. That is just fine. I'll ask permission next time.
Q. Thank you. So for the training that's going to take place on the 25th of September and then again in October, is that two days of the same training or is it two one-day trainings?
A. Two one-day trainings. I don't know if -- let me make sure I understand your question.
Q. Sure. Are the two dates you mentioned, is that a two-day training with a month long gap or is that two repetitions of the same one day training?
A. They're not repetitions.
Q. And how will the content differ between the October training and the November GEI training?
A. I did not mention November.

Q. I'm sorry. October. Between the September and October trainings, what is the difference in content?
A. So it will be a continuation of all of the items that were not covered in the first training.
Q. And who at IDOC has reviewed the GEI training that will be provided in September and October?
A. Myself, Dr. Anderson, Fanning, Chief Fanning, I'm not sure if Dr. Puga has seen it, possibly, but us three for certain.
Q. And what is Dr. Fanning's title or Chief Fanning? Sorry. What is Chief Fanning's title?
A. Chief of legal.
Q. Did you sign off on the GEI curriculum that will be presented to IDOC staff?
A. Yes.
Q. And did Dr. Anderson review and sign off on the GEI training that will be provided?
A. Yes.
Q. And did Chief Fanning also review and sign off on the training?
A. Yes.

Q. And is Chief Fanning qualified to treat gender dysphoria?
A. I don't believe that he would meet the typical criteria.
Q. And has Chief Fanning received any training on the medical treatment --
A. I can't speak to his training.
Q. Can you describe the review process for the three individuals you mentioned including yourself?
A. The review process is we looked at the GEI Foundations course and its typical offerings and we determined what part would be applicable to our population, which is adults, and we essentially mirrored their usual GEI Foundations course.
Q. And are there any individuals for whom this GEI training is mandatory?
A. I'm sorry.
Q. Are there any individuals who are required, that is, it is mandatory for them to complete the GEI training?
A. Within Wexford, we -- within Wexford, it is not possible with the bargaining units to actually make it mandatory for all providers,

particularly the nurses that are in bargaining units. It has to be offered voluntarily.
Q. Are there any individuals who are -- whom the training is mandatory?
A. There are no one that it is actually listed as mandatory, but there are persons for whom it is listed as expected.
Q. Who is listed as expected?
A. All medical providers, all medical providers, be they nurse practitioners or whomever, all medical providers are requested and expected; however, we can't make it mandatory for those who are in bargaining units.
Q. And for all medical providers, does IDOC have a plan in place to ensure that all of the medical providers regardless of who employs them is qualified to treat gender dysphoria?
A. Yes.
Q. What is that?
A. That is done through the Wexford training and it will be also be done through the WPATH training.
Q. IDOC understands that the combination of the Wexford training and the non-mandatory GEI

training will be sufficient to get all of the medical providers sufficiently competent to treat gender dysphoria?
A. Yes.
Q. Apart from the Wexford training and the WPATH training, is anything else scheduled to be provided or planning to be provided with regards to the treatment of gender dysphoria with any IDOC professionals?
A. With IDOC professionals?
Q. Yes.
A. Can you define what you mean by IDOC professionals?
Q. With any IDOC staff.
A. Okay. We are planning to provide case presentations on a monthly or quarterly basis. We haven't determined the interval. So that's one thing that we will be doing for difficult or challenging patients and those will be presented with one of our endocrine consultants along with the providers and those who are on the committee or the transgender Health and Wellness Committee.
Q. Who are the endocrinologists that will be going to be giving the presentation?

A. We are working on securing our endocrinologists.
Q. What the criteria that IDOC is using to decide which endocrinologist to use?
A. We are taking the advice and the suggestions of our endocrine -- I mean, of our consultant, Dr. Anderson, who is a WPATH member and has given us some recommendations. We are preferring to choose an endocrinologist who is WPATH-trained, certified, or a member ideally, or someone who has extensive experience in leadership in management of transgender patients.
Q. And has any endocrinologist been contacted yet?
A. Yes.
Q. Has any endocrinologist verbally agreed to serve a role in these case presentations?
A. Can you define "verbally agreed"?
Q. Sure. I'll ask it a different way.
Has any endocrinologist been retained to participate in these case presentations?
A. Those negotiations are still ongoing.
Q. And when does IDOC expect to formally retain one or more endocrinologists?

A. Our hope is that this will be completed in the next one to two months.
Q. When did IDOC first contact any endocrinologist?
A. I can't recall the exact month. It was this year in 2020. It was beyond.
Q. Was it within this month?
A. No, it was before that. So it was -- I just can't tell you the month. It was after the preliminary injunction, and after we met with Dr. Anderson, but I cannot tell you the exact month.
Q. Has the THAW or the transgender Health and Wellness Committee met yet?
A. No.
Q. When is the first meeting?
A. After our administrative directives have been approved then we will set up our first meeting.
Q. Who needs to approve the administrative directive before THAW can meet?
A. That would be not just THAW, that would be THAW and the administrative committees. That would go through Chief Fanning, or Chief Fanning's office and legal team and from there to the policies and procedures committee.

subheadings of the areas I want to actually have defined in the policies and procedures and what areas we want to deal with and address.

Q. I have one more question about the consultants that will be on the Health and Wellness Committee and then I think it will be a good time to take a break so since we've been going for an hour 15.

You mentioned there will be some consultants who are also members of the Health and Wellness Committee; is that right?

A. Yes.

Q. Who will be those members?

A. Someone -- a representative in endocrinology and a representative in surgery, in gender affirming surgery.

Q. Has the endocrinologist that will be a member of committee been identified?

A. No. Identified? What do you mean by identified?

Q. Has anyone ever been retained?

A. No one has been retained.

Q. Has anyone been contacted to be retained?

A. There have been persons that have been

discussed, yes.

Q. Has anyone from IDOC contacted the endocrinologist?

A. Yes.

Q. And who are the endocrinologists that are being considered?

MR. HIGGERSON: Objection. This is getting into the deliberative process too far. They don't have somebody designated yet. The Department doesn't have a position on who that person is, just that there will be an endocrinologist.

BY MS. WALD:

Q. For the surgical consultants, has anyone been retained?

A. No.

Q. Has anyone been contacted?

A. No. Not to my knowledge.

Q. Has IDOC discussed a surgeon?

A. IDOC has not discussed a surgeon.

Q. And what is the role -- will the endocrinologist and the surgical consultant when retained be a voting member?

A. They will not.

Q. And what will be their, their role with

respect to the Health and Wellness Committee?

A. Provide, you know, a needed and necessary consultation in the area of question for the patient in question.

Q. And will the consultant be expected to attend every meeting?

A. We have not formalized that.

Q. And has there been any other details that have been formalized with respect to how the consultants will participate in the Health and Wellness Committee?

A. We know that they will be -- that they will participate in respect, as I mentioned before, the questions -- the clinical questions or queries that are being presented. But aside from that, no.

MS. WALD: Let's go off the record and just take a ten-minute -- let's call it 15, and come back at 2:50 I guess.

THE VIDEOGRAPHER: The time is now 2:37 p.m. This ends media unit No. 3.

(Whereupon, a break in the proceedings was taken.)

THE VIDEOGRAPHER: The time is now 3:04. This begins media unit No. 4. We're back on the

record.

BY MS. WALD:

Q. Dr. Conway, did you speak to anyone during the break besides counsel?

A. No.

Q. Did you review any documents during the break?

A. No.

Q. Presently is everyone in IDOC currently receiving an appropriate hormone treatment for gender dysphoria under the WPATH standards of care and the Endocrine Society guidelines?

A. It is our belief of care that they are.

Q. Is that your belief that they are. Is IDOC certain that that's the case?

A. IDOC is not certain at present if that's the case.

Q. Currently is there any committee that is making or approving decisions regarding hormone therapy?

A. When you say regarding hormone therapy, can you tell me what you mean by regarding hormone therapy?

Q. Is there any committee that's making or

those are the reasons and the ways we would decide if we will move forward and recommend the patient for surgery.

And also we will make certain -- I just want to complete this. We'll make certain that that we are apprised of the minimum guidelines required for referring patients for certain surgeries as far as insurance coverage because it is covered, but we want to make sure we follow those guidelines.

Q. And for the medical providers writing a letter recommending surgery for their patients, will they receive any additional training or guidance with respect to surgical treatment of gender dysphoria?

A. There is no additional training beyond the WPATH training that everyone is going to receive and the Wexford training that they have already received.

Q. And is that the case for mental health professionals as well with regard to surgical treatment?

A. There's no additional training beyond what they have already received. They have been

trained to my understanding.

Q. So my question is so once the two letters are obtained and presented to the Health and Wellness Committee, will the Health and Wellness Committee members then vote on whether to approve surgery?

A. And whether or not to forward the patient on further, yes, we will have a conversation, a consensus conversation, and then vote ultimately, yes.

Q. And is it a majority vote or a unanimous vote or some other way?

A. A majority.

Q. And then if a candidate receives a majority vote in the Health and Wellness Committee approving them to move on for surgery, what is the next step going to be under the administrative directive?

A. They will be referred to the surgeon who would do the further evaluation.

Q. Who is the surgeon they will be referred to?

A. I don't know the answer to that.

Q. Has anyone been retained or contracted?

A. No.

Q. Does the administrative directive address how presurgical care is administered with respect to treatment of gender dysphoria?

A. Can you be specific? Presurgical care.

Q. For example, for a vaginoplasty it's required that some -- that a patient undergo permanent hair removal on their genital region prior to surgery. Does the administrative directive address that?

A. The administrative directives don't address that, and they wouldn't address it.

Q. Does any other policy that exists address that?

A. No.

Q. Is any policy being drafted to address that?

A. No. That would be at the hands of the surgeon. So if the patient is being considered for a particular surgery, then that will be in the hands of the surgeon, what their requirements are prior to those particular procedures.

Q. Has IDOC retained any providers to perform permanent hair removal in preparation for

genital surgeries?

A. We haven't referred anyone for surgery so we have not -- we have not contracted a surgeon. So we have not contracted anyone that provides permanent hair removal for a surgery that we haven't actually referred someone for as of yet. That is one of the things that a surgery consultant can assist us with in terms of any specifics, which is one of the reasons why we would look to have a surgical consultant with the specialty of gender affirming surgeries on our committee or on our committee.

Q. Are there any other criteria that will -- that is in progress as far as being drafted with respect to a presurgery plan?

A. Not at this time.

Q. Is any policy being drafted with respect to post surgery plans?

A. It hasn't been drafted but the discussions on the type of post surgical plans that is going to be needed have been discussed.

Q. And when have those discussions taken place?

A. At previous meetings that we have had

with our consultant Dr. Anderson.
Q. How many meetings with Dr. Anderson did IDOC have to discuss surgical post care?
A. We didn't have specific meetings that were just for postsurgical planning. They were just for comprehensive care in general and included that.
Q. And what does IDOC consider to be necessary components of a postsurgical plan that will need to be developed?
A. We are working on that.
Q. What stage is that work at?
A. Beginning.
Q. And who will be drafting the policy around most postsurgical care?
A. I will be drafting the policy with the assistance and the help of our coordinator -- not our coordinator but our consultant and along with the guidelines for WPATH and/or the Endocrine Society that's applicable and with any input from our endocrinologists in terms of post care and/or our surgeon consultant.
Q. And the endocrinologist and the surgeon that you reference here have not yet been retained?
A. They have not.

Q. And the consultant you referenced, was that Dr. Anderson or somebody else?
A. Dr. Anderson.
Q. And has Dr. Anderson specifically been retained to assist with drafting and developing a postsurgical care plan?
A. No.
Q. Has IDOC contacted a hospital or hotel to discuss options for patients to recover immediately after surgery?
A. We have not discussed with a hospital or hotel making arrangements. No, we have not.
Q. Dr. Conway, are you a surgeon?
A. No.
Q. Do you have any surgical experience with surgical treatment of gender dysphoria?
A. No.
Q. Does anyone assisting with the drafting of the policies for the surgical care plans have surgical experience?
A. We will have -- as we formalize those plans, we will have the consultation of a WPATH member or similar.
Q. Will that WPATH member or similar have

experience with surgical treatment of gender dysphoria?
A. Yes.
MS. WALD: Let's take a five-minute break. I think I'm pretty close to being done. So let's just go off the record quickly and then I can evaluate.
THE VIDEOGRAPHER: The time is now 4:58 and we're off the video record.
(Whereupon, a short break in the proceedings was taken.)
THE VIDEOGRAPHER: The time is 5:09 we're. Back on the video record.
MS. WALD: Dr. Conway, did you talk to anyone on the break besides counsel?
THE COURT REPORTER: You're on mute, Dr. Conway.
THE VIDEOGRAPHER: Do you want to go back off?
MS. WALD: Yeah, let's do that.
THE VIDEOGRAPHER: The time is now 5:10. Going off the video record.
(Whereupon, a break in the proceedings was taken.)

THE VIDEOGRAPHER: The time is now 5:12. We're back on the video record.
BY MS. WALD:
Q. I'm going to share my screen with you again. Do you recognize this document that I showed you earlier?
A. What's the date on this one?
Q. The date of this one, it was filed on December 19th of 2019.
A. Yes.
Q. And do you recall that we discussed in particular Paragraph 3 regarding social transition; is that right?
A. Yes.
Q. At that time, I did not designate this as an exhibit. I would like to please enter this as Exhibit 2. This is the preliminary injunction. I should only have two exhibits and I will send them to you after the deposition.
(Document marked as Deposition Exhibit No. 2.)
MS. WALD: I actually have no further questions.
MR. HIGGERSON: I don't have any

EXHIBIT 18

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS

JANIAH MONROE, MARILYN MELENDEZ, EBONY STAMPS, LYDIA HELENA VISION, SORA KUYKENDALL, and SASHA REED,	)	
Plaintiffs,	)	
vs.	)	18-CV-00156-NJR-MAB
JOHN BALDWIN, STEVE MEEKS, and MELVIN HINTON,	)	
Defendants.	)	

Videotaped deposition of DR. ERICA ANDERSON, called as a witness herein, pursuant to the applicable provisions of the Code of Civil Procedure of the State of Illinois and the rules of the Supreme Court thereof, taken before Janet L. Brown, CSR No. 84-002176, via Magna Legal Vision videoconference on July 29, 2020, at 10:02 AM.

MAGNA LEGAL SERVICES
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Q. And what are the WPATH standards of care?
A. Those are the standards that are published by WPATH that constitute the standard of care for transgender healthcare around the world.
Q. Do the WPATH standards of care include any specific guidance regarding treatment of transgender individuals in prisons?
A. Yes.
Q. And what is -- what is that guidance?
A. It's similar to the guidance general for transgender people, that they should be treated with respect and accorded the opportunity to live in their preferred -- in their identified gender and given access to needed medical and psychological care.
Q. Would you agree that trans prisoners are entitled to the same medical care as the transgender community outside of prison?
A. Yes.
Q. Now, you're -- you currently -- you've been hired as a consultant with IDOC. That's right? Correct? That's why we're here today?

A. That's right.
Q. Now, before starting your work with IDOC, had you worked with prisons before?
A. Only nominally in individual cases.
Q. I understand that you worked as an expert for an inmate in a case arising from a county jail in California?
A. That's correct.
Q. And what was the subject of that lawsuit?
A. It was a criminal action. There was an individual who was charged with a series of crimes, and I was contacted by the public defender to advise them on whether the individual was transgender and to what extent that had a bearing on the case.
Q. And did you reach an -- were you retained as an expert?
A. Yes.
Q. Did you file an opinion in that matter?
A. I wrote several reports.
Q. Were you found qualified as an expert by the Court?

A. I don't know, as I never testified.
Q. Okay. Did you take a deposition in that case?
A. No.
Q. Have you been retained as an expert in any other cases?
A. In general or specific to transgender people?
Q. Let's start with specific to transgender people.
A. I'm currently an expert retained on a case in the state of Washington.
Q. And what is the subject of that lawsuit?
A. Employment discrimination against a transgender woman.
Q. And were you retained by the plaintiff in that case?
A. Yes.
Q. Have you issued a report in that case?
A. Not yet.
Q. Have you been deposed in that case?
A. Not yet.
Q. Are there any other cases where you've

been retained as an expert relating to transgender individuals?
A. Not currently, no.
Q. What about in the past?
A. No.
Q. Now, do you personally know any transgender prisoners in the Illinois Department of Corrections?
A. Not personally, no.
Q. Have you spoken or had interactions with any transgender individuals within IDOC?
A. No.
Q. Would you consider yourself to be knowledgeable about the issues that transgender prisoners face in the IDOC system?
A. Generally, yes.
Q. And how did you gain that -- that knowledge?
A. I read medical records for two cases. They're pretty extensive medical records. I've reviewed some of the legal documents in this matter and one other one, and I've had conversations with people in IDOC about the issues facing transgender offenders and IDOC.

"Dr. Anderson shall provide expert consultation and assistance in assessing all IDOC policies and training related to dysphoria care and treatment."

Dr. Anderson, under this contract as part of your assessment do you have the authority to make or change IDOC policies?

A. Not unilaterally.

Q. You can make suggestions, but -- right?

A. Yes.

Q. But they would have to be approved?

A. Yes.

Q. Under this contract IDOC does not have an obligation to act on your assessment or recommendation; is that right?

A. I think that's correct.

Q. Is there anything else that creates an obligation for IDOC to act on your recommendation or assessment?

A. Moral authority.

Q. Other than moral authority, is there anything that requires IDOC to act on your recommendation or assessment?

A. I think, as we can all recognize, there's a very big incentive for them to treat seriously all my recommendations and as is appropriate incorporate them, and that's my experience is what they're doing.

Q. But you'd agree there's nothing that creates -- that requires them to act on your recommendation, incentive aside?

A. I would agree.

Q. Do you agree that IDOC is free to disregard your advice if they choose?

A. They are hiring me, and they are free to disregard my advice, yes.

Q. Now, I'd like to discuss more -- in more detail the steps you've taken in this assessment.

A. Uh-huh.

Q. Now, I believe you mentioned you've had extensive communications with various individuals as part of this assessment; is that right?

A. Yes.

Q. In general, how do you typically communicate with IDOC?

A. Usually it's phone conversations and review of documents.

Q. Let's start with just the conversation. Who is your -- who are the main individuals that you talk to at IDOC?

A. My point of contact is Robert Fanning, and -- but I now have a, I would say, close working relationship with Drs. Conway, Puga, and Reister.

Q. Let's start with Dr. -- with Mr. Fanning. About how often do you communicate with Mr. Fanning?

A. Generally once a week, possibly more.

Q. And what topic do you discuss in your conversations?

A. The ongoing activities that we are concerned with and any initiatives that we're working on to review or change things.

Q. And what are some of those initiatives?

A. To look at the policy documents on how transgender offenders are treated, to review and change the structure of how decisions are made regarding care that transgender offenders

receive, to -- to conceive and then plan and execute training for medical and mental health professionals throughout IDOC. These would be probably the biggest ones.

Q. And you said that you spoke with Mr. Fanning approximately once a week. Has that been consistent since January?

A. Yes.

Q. And how long are your conversations with Mr. Fanning each week?

A. Half an hour to an hour.

Q. Now, what -- you also said that you communicated with Dr. Conway. About how often do you speak with Dr. Conway?

A. Couple times a month.

Q. And what are the topics that you discuss with Dr. Conway?

A. We've been -- we've been working on carrying out a series of training programs for IDOC medical and mental health professionals. We have worked on the administrative procedures, administrative directives, and we've worked on -- more recently we've worked on -- oh, we've worked on putting together an expert panel of advisors

EXHIBIT 19

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS

JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELENA VISION, SORA KUYKENDALL and SASHA REED,	)	
Plaintiffs,	)	Civil No. 3:18-cv-00156-NJR
vs.	)	
ROB JEFFREYS, STEVE MEEKS and MELVIN HINTON,	)	
Defendants.	)	

The videotaped videoconference deposition of DR. SHANE REISTER called by the Plaintiffs for examination, pursuant to notice and pursuant to the Rules of Civil Procedure for the United States District Courts pertaining to the taking of depositions, taken before Diane J. Corona, CSR, License No. 084-00257, via Magna Legal Vision, on Monday, August 17, 2020, commencing at the hour of 8:59 clock a.m. CST.

Magna Legal Services
866.624.6221
www.MagnaLS.com, by:
Diane J. Corona, CSR

they are Wexford employees.
Q Just to make sure the record is clear, that with some rare exception, the -- well, you are an IDOC employee. The mental health providers that you oversee are Wexford employees?
A Yes, that I provide consultation for. I have no -- I have no human resources jurisdiction over them.
Q Okay. And you also don't have access to their personnel files and résumés?
A That's correct.
Q Okay. So when -- if you are under the -- you have no way to know one way or the other then what the qualifications are of a particular mental health provider because you don't have access to that file?
A I know the basics that we talked about earlier in terms of in order for them to qualify. Because they do have contractual obligations in terms of getting us individuals who can do that differential diagnosis, people who are DSM-V competent. So those basic clinical requirements that are listed in the competency, you know, having supervised practicums, those are

requirements of the contract. But some of the other transgender specific, I wouldn't have access to that because that would be part of the résumé, not the basic contract that we have.
Q Okay. So you -- so is it your -- is it your testimony then that it is not a basic requirement to be hired by Wexford to be a mental health provider within IDOC to have met all minimum requirements under the WPATH Standard of Care competency requirements?
A No. That's not what I'm saying. What I'm saying is I am not privy to the additional requirements that they might have in terms of their recruitment and hiring of employees. I can't speak to those additional requirements that are outside of our contract. The reason I can speak to the contract is -- items is it's written specifically in our contract. So I can't speak to the additional employment pieces that are beyond the contract.
Q Okay. So maybe let me ask it a different way. You assume that the -- well, let me ask it this way.
Based upon your knowledge of

the contract that Wexford has with IDOC to supply mental health providers to IDOC, does someone who has -- meets those basic requirements guarantee that they will be competent under the WPATH Standards of Care?
A I cannot speak directly to that. But I can say that employees, that they do have an initial trial and training period. And if they don't meet those standards, um, of competency, that they do have it so that they can actually terminate employment of individuals that aren't meeting competency standards. It's up to them to determine competency standards for individuals and trainability.
Q So are you saying then that Wexford will not hire anybody who doesn't meet the WPATH Standards of Care and minimum competency requirements?
A I can't say whether that's part of their hiring process. I have no way of knowing if that's one of their required areas that are beyond the State's contract with them.
Q Okay.
A So I have no way of knowing.

Q Is IDOC compliant with the WPATH Standards of Care when it comes to assessing gender dysphoria in transgender prisoners?
A Yes. We are all -- I provide screening on the assessment domain so that the clinicians can do proper assessments. I utilize a combination. They first start off with our mental health evaluation form, and that is due 14 days after arrival at a parent institution. Or if it's been done 60 days prior to a transfer, then they would review that -- that mental health evaluation.
That's a starting point. It provides basic demographics, basic background, histories on family. It provides an ability for people to determine addiction recovery issues and mental health problems. And then -- because proper assessments of co-occurring disorders, which would be, you know, intellectual disabilities and substance abuse and mental health addiction issues is part of the basic care that's provided, it's also part of the WPATH Standards of Care as well. And then they will do additional interviewing to gather WPATH transgender specific

things like, you know, what is their gender identity over time, you know, what is their -- the extent and how gender dysphoria has presented itself. I ask them to address in their assessment their minority stress management in general.

Because remember, transgender people aren't just transgender. They are the intersectionality of all of their identities. So they may be impacted by racism, Islamaphobia, or any number of other prejudice and all of those combined. And they may have different ways of managing different elements, different aspects of their identity, or there may be a consistent form.

So I want to know the different ways that they're coping and whether they're healthy or unhealthy. We have individuals, for example, that relieve emotional distress through, you know, cutting behavior. They're enacting the emotional pain with physical. There's a lot of psycho dynamics as to why that is. There's a lot of individuals that also have addiction recovery issues because they're managing those feelings through chemicals. Some individuals may engage in fighting behavior and

other forms of acting out. Some people may be social support seekers. Those are just a few examples of the types of stress management they may use. There are other coping skills. We use that to determine whether we need to help them develop additional healthy coping.

The other element that I wanted --

Q Okay.

A Oh, do you want me to go over everything, or do you want just kind of a skimming over?

Q Well, I mean, I don't mean to interrupt, but I did just want to pipe in on something here just to clarify a point then.

I mean, it is the -- it is the site mental health providers who are responsible for assessing whether or not a -- whether or not an inmate has gender dysphoria, correct?

A That is correct.

Q Okay. And it's the same site mental health providers that are going to be educating, for example, those inmates on what options might be available for them for treatment?

A Yes. But they would be referring out ultimately the medical interventions.

Q Right.

A They might mention medical, but they're going to refer out to medical those.

Q Understood.

Is there a written sort of guide so that these mental health providers know how to do this? Are they provided something?

A There are three sources to gather information. Obviously -- well, not obviously. But the administrative directives do provide some basic guidance on major areas, but it's very brief and vague. So it's expanded upon in the standard operating procedure manuals. But do keep in mind that manual is based on the old ideas and it's going to need to be updated. But these assessment criteria won't change. It will be more some of the other specifics that we talked about that we're changing earlier.

And in addition, part one and part two mental health and corrections training that I've talked about earlier, is on our mental health SharePoint. So if they want to re-review

the materials, they can. And I do periodically update those. You know, I've, you know, basically rearranged the slides so I thought it was more user friendly so that they can have ready access. Some individuals may choose to print off certain pages like on assessment or certain pages on the DSM assessment or, you know, that sort of thing.

So it's available through those three sources. And I also talk with them that they should be printing off the WPATH Standards of Care, or at least using the electronic version because that's free and available off of WPATH.com. And so the clinicians will take a look at that as well. But probably the most user friendly is the slides from my training.

Q And what quality assurance do you have that these 35 to 40 mental health providers are going about this in the right way?

MS. COOK: And I'll object to that. Outside the scope. Dr. Conway will talk about quality assurance.

MR. RAY: I think that as part of WPATH -- I mean, your objection is noted. But as

part of being compliant with WPATH is also making sure that the things are getting done right.
BY MR. RAY:
Q So I'm asking the 35 to 40 mental health professionals under your supervision, what quality assurance do you have that they're doing this and going about assessing gender dysphoria and educating inmates in the proper manner?
A We have a division of mental health -- and do keep in mind, I'm not speaking to medical. We do have a separate division within mental health that provides our QI for the mental health services. A lot of those criteria that showed competency are directly applied. You know, for example, the -- you know, dealing with co-occurring disorders and mental health assessment.
In terms of the oversight, you know, of gender dysphoria, everybody is required to do proper diagnosing, and so we do look at those mental health evaluations. That should have gender dysphoria listed. It should meet -- and individuals are supposed to be identifying why they came up with the diagnoses. So that should

be in there and in that.
So our quality assurance piece is within those departments.
Q So you personally don't --
A And that's conducted -- I'm sorry. And that's conducted by the State.
Q Okay. So you personally are not reviewing their records to make sure that they're doing it correctly. That's a separate department that is -- that is doing quality checking?
A The quality assurance piece that you were asking about in terms of how you phrased it and how I understood it is done by a separate department. However, I do, when I go into facilities, look at charts and take samples as I'm working with those.
For example, when offender Monroe -- when we were making the decision to transfer to the female division, Dr. Puga and I both looked at the chart, and gender dysphoria was clearly identified. So we didn't just go by our interview when we went to interview the offender at Pontiac. We also looked at the chart to, you know, see that this individual meets gender

dysphoria.
In general, I haven't found a lot of problems with gender dysphoria diagnosing with the mental health team. The criteria are pretty straightforward. It's just really a matter of following our assessment, interview guides. And they're pretty straightforward, too.
Q Okay. So just to make sure I have this straight. When an inmate is being assessed for gender dysphoria, is being educated about the things that they have, the options available to them when they're being looked at, for example, for potential referrals for hormone treatment and the like, it is obviously the site level mental health provider who is doing that work, correct?
A Correct.
Q Okay. And the quality assurance of that work is being done by a separate department by the State, although you may from time to time also see those records for certain inmates, correct?
A Correct.
Q Okay. The people who are doing the quality assurance checking at the State, are any

of those people -- do they meet the minimum competency requirements under WPATH Standards of Care?
A I wouldn't know that because that doesn't fall under my job tasks. They -- if they have attended my training, they would have at least those base information. But I can't say specifically their job qualifications in terms of WPATH standards.
Q And are the quality assurance people you are talking about, those are employees of IDOC and not Wexford?
A They're IDOC employees. And all of them are -- are experts in terms of DSM-V which is where you get the gender dysphoria diagnosis. So they all are competent in gender dysphoria diagnosing.
Q Okay. Is IDOC, when it comes to the topic of hormone therapy, currently compliant with all applicable WPATH Standards of Care?
A That's outside of my scope of practice, so I can't tell you. And I don't assess the medical department because it's outside my scope.

Q Okay. You are here to testify about whether the committee follows and applies the WPATH Standards of Care or any other medical standards to its treatment decisions, correct?

A I can't tell you about the medical side of whether that care meets medical compliance. That would be something that Dr. Puga could speak to. I can basically speak to the fact that they are all required to follow that. But in terms of quality assurance for their care, I can't determine their quality assurance for medical. Mental health doesn't oversee that quality assurance piece. But they are all required to -- they're supposed to be following WPATH standards.

MR. RAY: Okay. All right. Maybe, Ms. Cook, you and I can take that up offline if perhaps Mr. Puga is able to address other parts of these topics at his deposition on Monday.

BY MR. RAY:

Q But let me try and stay on hormone therapy for a bit. When a mental health provider does a referral letter and -- as it relates to hormone treatment, is that process done fully in compliance with WPATH Standards of Care as of

today?

A They do it via a multidisciplinary team staffing of the individuals, and that would be documented again in terms of the criteria that's used for it in medical. So they are supposed to work with medical in a multidisciplinary in person or via the telemedicine. So that is actually done in person and documented on IDOC forms rather than a traditional, like, letter like I would do for surgery. That letter I wouldn't do on an IDOC form because it's going to outside individuals.

Q Okay.

A So that will be a form specific to, you know, how you would see it in the community.

Q Okay. So when IDOC mental health providers issue a referral for hormone therapy, it's done in relation to filling out a specific form; is that right?

A Whenever they come into the facility, offenders get a 0400 form, and the mental health providers are filling that out. They are -- they use a multidisciplinary approach with medical. So there are medical components to that and there are

mental health components to it. And in fact, there is actually administrative components as well. Like, shower separately and privately, for example.

So it's a multidisciplinary process. I -- that's documented on an IDOC 0400 form. And that is also through verbal. I know that in my region the -- like, for example, at Menard, I know there's a lot of conversations between mental health and the medical providers in terms of those decisions.

Q Okay. So then does the 0400 form that a mental health provider at least partially completes with the help of others, is that essentially the referral letter for when hormone treatment should be considered by a medical professional?

A Yes. I would consider that similar to a referral letter, although it's much more -- it's basically like a form format. It will ask sections like right out of DSM and that sort of thing. So it's got content. And a lot of our offenders actually come into the system having already been on hormones as well. So, you know,

those individuals, we wouldn't stop their hormone use obviously when they came into the facility.

Q And then for surgery, when a transgender inmate is being attended to by a mental health professional, is there another form for when a -- there is a referral letter relating to surgery?

A You cut out a little bit, but -- if I don't answer the completely. But my understanding of what you're asking was that does mental health provide that letter, and the mental health providers on-site would not be the ones to write that letter. I would consult with them. I would consult with the record. And I would interview the offender as well for that beforehand.

I've also trained staff about the importance of preparing offenders who want the surgery to make sure they are, you know, gathering information, talking with their medical providers. So we also provide that pre-procedure just to talk with offenders about the importance of preparing themselves, having some basic idea to communicate with medical providers, that sort of thing. If they have difficulty, you know, communicating with

medical providers, then we can talk about those issues about, you know, maybe it might be helpful to write it down what you want to talk about before, you know, in case you get nervous. So we also provide that as assistance for medical so medical can -- can provide, you know, optimal services.

Q Okay. And this is going back to the process that I think you were talking about earlier today where all surgery referal letters would come from either you or Dr. Puga and then ultimately go to Dr. Conway for approval; is that right?

A Yes.

Q Okay. Is there a particular format that those letters -- well, let me back up. Have you written, or Dr. Puga, has he written, any such referral letters for surgery yet?

A I have not written that letter, which is why Erica Anderson is going to help me write the letter. Of course, it was discussed at WPATH. However, I want somebody to actually review it to make sure that it has everything that the surgical team would need.

Q All right. And just following up on hormone treatment then, you are not able to testify today as to whether or not IDOC is compliant with all relevant WPATH Standards of Care on hormone treatment, correct?

A We are supposed to be. However, I don't audit that, so I can't speak for certain other than they need to have basic competency for providing all their medical services.

Q Okay. And so -- and you are not also able to testify today whether any or all of the physicians within IDOC who are prescribing hormones are competent to do so?

A It's outside of my scope of practice.

Q All right. And I'm going to assume then you are also unable to testify today regarding whether or not IDOC is in compliance with all WPATH Standards of Care relating to surgery?

A We haven't actually done a referral for surgery yet. So therefore, there's -- there is not a way to assess that. I know that it's part of the new policy.

Q That is hopefully going to be

finalized soon?

A Yes.

Q Okay. Do you know whether or not IDOC is in compliance with all WPATH Standards of Care relating to postoperative care and follow-up after surgery?

A We haven't provided that, and it's out of my scope of practice. Mental health will be providing aftercare and helping individuals with that process in terms of mental health care.

Q Dr. Reister, are you aware that there is a specific section within the WPATH Standards of Care relating to the applicability of these standards to people living in institutionalized environments?

A Yes.

Q Is IDOC, as we sit here today, fully compliant with all provisions of that chapter?

A I reviewed it. It's been a minute since -- or a little bit of time since I reviewed it. At the time it was not completely in compliance. It's -- my understanding is it's actually going to be expanded in revision eight, and so I -- having an expert from USPATH is going

to help us so that we are compliant with standards. So that's one of the other advantages of having somebody from USPATH helping us with policies.

Q And when you had done this review and had determined yourself that IDOC was not in compliance, when did this review occur?

A Oh, goodness. It was a couple of years ago. And one of the things that I was concerned about is the ability for individuals to live in their gender and their gender congruent manner just because of the things we talked about earlier that make it a challenge. And we have made movement in terms of those things, but it's been a little time and I can't remember all the points from it. I just, you know, recall that there were some things that might be helpful to modify.

Q Okay. And are those -- strike that.

MR. RAY: It's a little bit after noon. We've been going for about an hour. How about we take a lunch break now?

Dr. Reister, I see you brought some food with you today. But how long would you

like to take for lunch?
THE WITNESS: I only need ten minutes, so you probably will take longer than I will.
MR. RAY: Well, why don't we take a half hour? Is that all right with everybody? And we'll try to do a half hour so we can keep moving today? Lisa, is that all right with you?
MS. COOK: Yes.
MR. RAY: Okay. Diane, is that all right with you, too?
THE REPORTER: That's fine.
MR. RAY: Okay. Let's try and come back around 12:40 or so and resume then.
THE VIDEOGRAPHER: The time now is 12:07. We are off the video record.
(After a lunch recess, the deposition continued as follows:)
THE VIDEOGRAPHER: The time now is 12:41 p.m. Central time. We are back on the video record.
BY MR. RAY:
Q Dr. Reister, welcome back. I hope

you had a good lunch.
I now would like to talk a bit about training for IDOC staff. And so what I'd first like to talk about is prior to 2020, so setting this year aside.
What was the required training for IDOC staff on issues relating to transgender individuals?
A Well, all staff have an initial training that we go through. Mental health calls it PSOT. And it goes over IDOC policies and general function. That training is very, very general in terms of diversity awareness and PREA. And then additionally, every staff member will get what we call cycle training and -- again, sexual harassment, abuse. Professional standards is covered again. But again, that's not intensive trans specific. It would be sort of like a subgroup discussion of the larger topics.
And so what we developed -- there was a court action that required me to develop an all-staff training to deal specifically with transgender concerns. And so that training was a two-hour training. It was implemented in

the previous fiscal year. It was completed. And that training involved topics -- would you like me to go over the topics? I'm not sure if you want me to go over them.
Q Yeah. But just to make sure we have a timeline here. So this is training that you put together and was completed in 2019.
A Yes.
Q Okay. Was it --
A And 2020. Because the fiscal year goes from July 1st through the end of June the following year. So it was in 2019 through 2020.
Q Okay. Do you recall what month you began working on that -- on that training?
A November of 2018.
Q Okay. So this is training that you started working on November 2018 that wound up getting deployed within the last fiscal year, correct?
A Yes.
Q Okay. And does this training bear any correlation to the part one or the part two that you had talked about earlier?
A That's correct. A lot of the

sections of it actually came from the part one and part two. I only had a few months to write it, according to the courts. So I wanted to -- I had that as a starting point. And then I put it again through the review process. I talked about with those outside consults. And so I basically crunched down the topics that were specific to trauma, emotional distress related to transphobia, as well as other forms of discrimination. We went into legal issues, existing court cases of discrimination. I spent a lot of time on misgendering, how to use proper pronouns, and mental health issues in general.
So the -- basically I pulled out the mental health provider specific topics and gave the basic definitions of the various terms and -- so that they were using those terms correctly. Discussed, in addition what I talked about a minute ago, you know, what kind of terminology would be not appropriate for use with this population.
Q Okay. For the part one and part two trainings that you're talking about, those are trainings that were created for mental health

professionals, correct?
A Yes.
Q All right. And then --
A And then I took excerpts out of that for the all-staff training.
Q For the all-staff training. Okay.
And when were part one and part two trainings created?
A Those were in development over multiple years, and I kept adding to them. I know I started working when I was in this position before I worked as a contract person for the department. I would say that they were started in 2013, but a majority of it was really basic information, and it wasn't as developed as what it is today.
So there was a revision that got completed in 2018 right after I came back from the WPATH conference, and I added some information about voice work, what kinds of topics might somebody use. I went and -- in terms of if you were a voice therapist with trans women in particular. And I added a little bit more in terms of helping people understand risks and

benefits and basically realistic expectations about the time frames that it would take. I pulled those -- that information right out of the WPATH Standards of Care, but I wanted to make sure that the MHPs were aware of the medical interventions.
Q Since --
A So that was the latest topics that I added.
Q Okay. So since 2018, the part one and part two trainings for the MHPs has remained the same?
A In content. I changed the -- what do you call it -- the background, the designs, and I rearranged a couple of the slides so -- because I felt like, you know, if I moved them to another section, it would read better. But yeah, the content has stayed the same.
Q Okay. And so other than the all-staff training that was completed in the last fiscal year and the part one and part two training for the MHPs, is there any other training for IDOC personnel at any level on transgender issues?
A We brought in Caitlin Williams that I

spoke about earlier from Howard Brown, and she came to one of our quarterly mental health meetings and she did a presentation as well. It was also one of the topics covered when we had one of our psychiatrists was dealing with diversity issues, and she incorporated it into her larger discussion. So there have been additional.
I also did another quarterly mental health meeting where I had talked about transgender issues and transgender training and helping people understand the additional needs of this population several years ago. So they've had a few other trainings primarily through quarterly mental health meetings.
Q All right. Do you know if there is any specific training for medical professionals relating to transgender health issues?
A I don't know. I heard rumors that there were. But I'll be honest, I don't know. I don't track that as much.
Oh, can I go back and say, we also had a -- Federal Bureau of Prisons did a training a few years ago. Probably like five or six years ago they did a training as well that was

attended by many of us.
Q Okay. So just to make sure the record is clear, though, you know, as the designee for the State on this issue, you're not aware of any specific training for medical professionals regarding the treatment of gender dysphoria or regarding transgender individuals?
A I'm told that Wexford Healthcare has something, but I'm not aware -- it's not something that I have tracked. But Wexford Health Sources, it's my understanding, has been -- has either completed it or they're working on it. I don't know where in the process it is. But that's a side issue that probably would be better directed to Dr. Puga because he would have that information about where they're at in that process, or Dr. Conway.
Q Okay.
MR. RAY: And, Lisa, I think we'll follow up on that after the deposition today. It seems like maybe there's a couple of things that Dr. Puga can address on Monday.
BY MR. RAY:
Q Okay. Are you aware of any training

relating to the treatment of gender dysphoria or regarding transgender individuals that is provided specifically to correction officers?

A I only -- the training -- the two-hour training was for correctional staff. It was every single staff member no matter what your position was. So that is the training that they received.

Q Okay. So that training was not specific for correction officers. That training was for everybody?

A Including correctional officers. I, in particular, want -- a lot of the issues were related to security issues and concerns, so that training, when I was developing it, was having that in mind. Because the issues that were brought up in the other court case was regarding security staff, behaviors of misgendering in particular. And so it was actually designed -- and that's one of the reasons why I had Len Meyers take a look at it as well because I wanted to make sure it met the needs of correctional officers staff.

And do keep in mind, I am

planning this to be a multiyear process because social psychology research says that you make small, incremental changes. So I'm going to be continuing to develop trainings and information for people and the correctional officers as well. But I can only work on so many projects at once. So that's going to be, you know, once I finish some of the ones that we are talking about right now.

Q So just to make sure the record is clear, although correction officers were among the population of IDOC employees that received the all-staff training, that training was not specifically directed towards correction officers, correct?

A It was directed specifically towards correction officers, but a lot of the material was also appropriate for other non-security professionals and they received it as well. But it was designed specifically for correctional officers in particular to the other staff.

Q Okay. Did you receive any feedback from the Moss Group relating to your all-staff training materials?

A I don't recall any feedback having received. I am always appreciative of any feedback, particularly since I'm going to be revising.

Q Okay. So you don't recall even in the last couple of months receiving any feedback from Wendy Leach or anybody at the Moss Group regarding your training materials?

A I have information and feedback from Erica Anderson. Most of the feedback that I received was regarding perhaps using examples and different things that might be -- how should I put it -- not at a master's level, there were some things that they were suggesting to maybe include some other things that might capture the attention of non-mental health staff. Because it was pulled out of the mental health staff due to the time constraints. But it had all the information, and then I did get that feedback from other correctional people.

So all the feedback -- I'm going to look, and I will -- when I go to actually revise those materials, I'm actually going to solicit from, you know, all of our sources. The

Moss Group wasn't working with us at the time that those slides were due.

Q When do you anticipate having a revised version of that training available?

A I'm going to work on that in probably 2020. I'm also working on some other projects as well.

Q Okay. And does that all-staff training session that's two hours, are they just -- do they receive that once?

A It's received once. And then that's why I'm working on some follow-up trainings because it will take more than one exposure to the information. Clearly, the training lieutenants have been exposed, and there are opportunities to talk about diversity and intersection of identity. So it will be covered, but I want some more specific training as well as -- particularly in racism as well. Because I want to address that intersectionality.

We have a very large black trans population, particularly in the female division, and so I want to make sure we're dealing with the intersectionality. Particularly when you

take a look at the research and some of the stats. The murder rate for that population is very, very high. And so, you know, I want to talk a little bit more about that kind of information. So things like that that may capture people's attention.

I'm also going to probably beef up a little bit regarding and do something to make it stand out in people's mind that even biology is not dichotomous. And, you know, I did cover that, but also I want to do something, and I'm still in the creation to really make that stand out. Because I do think it's easier to understand gender not fitting into cultural -- typical cultural ideas. If you can take a look at -- even biology doesn't -- isn't that simple.

And I know that that caught a lot of people's attention, and so I want to take the things that I keep getting feedback from people that catch their attention and help explain working with this population and take some of that feedback and maybe -- and maybe, you know -- you know, increase it a notch or two so that, you know, it really captures people's attention.

Q So when there is a -- when the all-staff does the training session, is there a -- do they all sit in a room and do it together? Do they do it on their computer? How is it delivered?

A I actually recorded the dialogue -- the script basically. So I did the -- it's on a PowerPoint platform. I did -- basically I wrote a script and I recorded it. I got a professional mic and I recorded it for everybody. And again, there were time constraints. There were only so many, you know, takes I could do. So I will probably also work on the delivery and getting maybe more of a professional sound studio, that sort of thing, to make it a little bit easier to be more animated, for example, in the delivery. I think that would help so it doesn't come across as so dry.

Due to the nature of the recording studio I created to do it, it's -- I think it will be more engaging, you know, to record it again and really up it a notch to capture people's attention.

Q Did you receive any feedback from

anybody who received -- who had the training that it wasn't -- it needed to be more engaging or it wasn't -- they didn't understand it?

A They didn't like the inflections in my voice. I was too monotone. And it had to do with how I recorded it and the fact that I, you know, could only do so many takes to get it done on time. Because it was two hours worth of recording. And so that's something I'm going to work on.

I do a lot of public speaking, and one of the comments people said I'm so animated normally, and it wasn't kind of my normal animated style of presenting. And so they were suggesting to, you know, basically get the right conditions and take the time necessary to get that inflection more animated to, you know, capture people's attention. So that was the feedback that I received in terms of engagement.

Q Okay. I'm going to share a document with you that I wanted to follow up on a point regarding the Moss Group, so bear with me as I attempt to share my screen once again.

(Reister Exhibit No. 6 was marked for identification.)

BY MR. RAY:

Q Can you see a document that's marked at the top Reister Exhibit 6?

A If you could enlarge it, it -- because it's too small for me to read.

There you go. Yes, I can read that.

Q Okay. This is a document -- I know that the logo is really difficult to see in the upper right-hand corner, but it says the Moss Group up here. Do you see that?

A I do.

Q Okay. And this is entitled "Review of IDOC staff training on transgender offenders," and gives the title of the presentation dated May 18, 2020. My question is have you seen this document before?

A If I have, I have not had a chance to incorporate it. Because in May of this time of year I was on medical leave around that time period. So I can double-check the huge amount of e-mails that I received during that time period

because I was off for a few weeks. So it's possible I missed it or I went through so many that I can't remember it.

Because I've been planning to revise the materials, so I may have just tabled it and stuck it in my training ideas folder.

Q As you sit here today, you don't know whether you reviewed this document or not?

A I can't remember whether I reviewed it. I definitely at that date wouldn't have been able to review it in the time that I would have received it. It's probably to be reviewed. I'm basically -- I've got so many different projects I'm doing. I can only do so many at once.

And that time period was designing, you know, things like the specialized unit and what have you. So I basically put things in folders, and when I'm ready to work on those projects, I'll go through. So I would have basically skimmed over it if I read it and then stuck it in a folder for when I revised training.

Q Okay. I mean, do you have any help to put together these training materials within IDOC? I mean, obviously Dr. Anderson is available

for you now at least in a part-time consultancy role. But otherwise, does it really just fall on your shoulders to put these things together?

A No. The -- for example, the information on microaggressions is coming from our training academy. They do deal with racism and, you know, other issues of diversity. And they would go and we would share, you know, appropriate documents. Implicit bias was one of the trainings I utilized. Also, Dr. Christian Gillespie and I developed a different training called the Intersectionality of Identity, and that heavily influenced -- and she gave me permission to utilize our training that we made for a conference to utilize it in these materials.

So, you know, I had those other individuals that are also consultants on diversity issues, and in particular implicit bias, minority stress, and those particular topics. So those were not specifically just mine, or some of them were actually not mine. They were borrowed from the training department's implicit bias training.

Q When the staff received the training

earlier this year and maybe even late in 2019, the two-hour training, how did they receive that? Is it -- I think I asked this already, but maybe we got off on a different topic. Do they all sit in the room and watch the video together with your voice-over, or is it on them to find it, you know, click on a link in their e-mail and watch the video themselves?

A I believe that the training department, which implemented it -- I provided the slides and they implemented, were going to have this presented in a class. However, it was designed to do either -- either method. So either one would work given the didactic nature of it. I designed it specifically depending on the needs.

Particularly with COVID, you know, at the -- you know, recently since March, we wouldn't have been able to do those trainings. So it would have had to have been done -- if somebody hadn't completed it, it would have had to have been done via the online version just because we can't get those people into the rooms to do that training. Only recently have we opened up, and they're very small groups so -- but I don't track

specifically. I was told it was finished by the end of the year.

Q Okay. As part of that two-hour training for all staff, as well is there like a quiz or something either spaced throughout the presentation or at the end to confirm that some of the content was understood and received?

A There was not a quiz to pass. There was basically a myth section at the end. If you had been paying attention, you would be able to answer the question. But there was no recording of, like, for example, a quiz. You know, if people think I should incorporate that, I definitely could incorporate it into the revisions.

Q You said a myth section; is that right?

A Yeah, different topics that people, you know -- basically turning the discussion points into misconceptions that people may have. They were basically different topics if you've been paying attention that you would be able to identify if that was true or not true.

And I can't remember the

specifics, but it would be basically something where whether it was a definition, whether it was, you know, a particular topic. But basically I would turn it into, you know, a question that would be more or less designed if somebody thought X, Y, Z, is that true or is that false, and then the answer would float into the slide of what that answer was. So it would give you a second to think what your answer would be and then to -- then to generate your answer.

Q Okay. But it's not like they had to answer that question correctly to demonstrate that they had actually taken the training?

A No. No. But I know how to do that, and I can incorporate that if somebody would like me to incorporate that in.

Q Well, see, maybe today was productive after all then, you know, so -- you know, have open minds about depositions, right? And I know you sat through a few of them already so...

A Uh-huh.

Q Okay. So did Dr. Anderson review any of these training materials and provide feedback?

A Yes.

Q Okay.

A Yes. She reviewed the training materials. She liked the training materials. She found a couple of redundant slides in them. When I'm presenting, if I find a slide that's redundant, I either skip it or I bring up a new topic. I do sometimes repeat topics or little mini questions to make sure people are, you know, paying attention, that sort of thing. I kind of just take a look at the audience and how they're doing, or -- you know, as kind of a warm-up when you come back from a break -- a little bathroom break or something, then, you know, quiz them to see what's going on in terms of their learning process.

But again, not written. It's really more of a group format.

Q Okay.

A Like for example, I might ask the group what's wrong with this treatment plan, you know. And like last week when I did the training, basically they were written in psychobabble, and I wanted people to basically come up with how would you say that treatment plan item in everyday terms

that would be more understandable by the average offender.

So those are the types of quizzes I would be doing to kind of see if they're getting the concepts.

Q Other than some redundancy in the presentations, did Dr. Anderson have any other constructive criticism for you?

A She didn't have content changes to be made.

Q Anything else?

A She said it was comprehensive. It was basic. It was their more advanced training. And it was designed to be a basic understanding. I mean, one of the things that I go over is the importance of further education and consultation and, you know -- so that's part of the training. And so that is -- part is to acknowledge that this is preliminary. This isn't all you do.

And so that was really the springboard for her to work with WPATH experts in the field, to provide the advanced training that would follow up. So the plan is people have part one and part two. That provides a basic

foundation. And then the advanced training will happen in Zoom trainings that various experts are working on for us.

In addition, I also am working -- I think I mentioned this earlier, but in case I didn't -- but I'm also working with somebody on transgender issues and autism. There's an increased rate of transgender identity with this population. I also want to make sure that people can in general work well with this population. So -- and Dr. Anderson gave me that referral and this individual, and I have been corresponding planning that for 20 -- for 2021.

Q Okay. So basically the WPATH training that Dr. Anderson is working on with WPATH grew out of a -- her comments that the part one and part two training that you had for mental health professionals was basic, but perhaps something more advanced would be good for them?

A Yes.

Q And forgive me if I asked this before. Is there an ETA on when the WPATH training will be ready for mental health professionals?

A I know that they were wanting to get it launched this fall.
Q Have you seen any drafts of this presentation or training?
A I have not seen drafts. I don't know if Erica has drafts. But I imagine this is coming out of the global education initiative that these experts do, so I'm assuming it's going to be similar presentations and slides to what I saw last fall, maybe updated for any new research that came out.
Again, these are assumptions on my part. But given the fact that people kind of create their conference materials in certain ways and -- and, you know, when I'm doing conferences, I will, you know, utilize slides and things that might be relevant. Like when I'm doing my intersection of identity, I don't always redo every slide if I repeat that training.
Q Okay. Did Wexford have any input into any of your training materials?
A No.
Q Did you seek their input at all?
A They did not provide somebody with

the expertise. Wexford staff obviously have gone to the trainings. I've had administrative level Wexford in terms of mental health go to the training and give feedback. The feedback has been positive.
Q So when you say they didn't provide input because they didn't have somebody with expertise, what do you mean?
A They didn't offer anyone -- anyone from their training department. They have an entire training department, and I didn't have any resources from them, which is why I went and I got outside people to take a look at it.
Q Okay.
A The other thing, too, is a lot of those trainings are -- that they have are -- they're intellectual property, so I -- it would require a -- how should I put it? We would have to write a separate contract, I imagine, to be able to merge those trainings and for me to implement Wexford material. Due to dual employment and union issues, that could be a challenge. It would be much easier to do like we did and have, you know, Erica Anderson or an

outside group provide the feedback and training and what have you, or feedback on the training.
Q So does -- do the mental health professionals who are Wexford employees that work under you, do they get separate training on this issue from Wexford?
A I'm not aware of the mental health providers getting separate training. However, Wexford does provide some -- I've been told that Wexford provides some continuing education credits through some -- through some trainings. And I don't know whether those training materials include this topic or not. I imagine there are some online topics in particular that would be available right now. But, you know, most -- all the in-person conferences are basically are closed down right now.
But again, that -- that goes into their HR, and I don't tread into Wexford HR issues, but they do have additional continuing education credits.
Q Okay. So you are aware that there is some continuing education efforts by Wexford generally, but you don't know the effects of what

they get trained with or what they get told?
A Yes.
Q Okay. So --
A And can I make a further comment? And that's why the State does our trainings. That way we can, you know, further their education in terms of this training. So that was one of the reasons why I started working on these trainings and why we're continuing to invest in getting outside experts to help us out. You know, that way we don't have to impinge on HR issues, and yet we can provide that training to the Wexford employees.
Q Okay. Going back to the WPATH training that Dr. Anderson is putting together, have you seen any outlines of what's going to be covered or do you have any --
A Yes. I did see an outline on what was covered. It's been a while since I saw that outline. It all looked really good. It covered a lot of the issues that, you know, was in the conferences. So basically what it looked like to me is they took, you know, the global education initiative topics and then the WPATH global

education initiative topics, and then just tailored it to our adult correctional population.

Q Okay. Were you involved in the selection and retention of Dr. Anderson by IDOC?

A I was told that they were looking at experts, and then -- and they named off some experts, and I was very pleased to see Dr. Anderson on that list and I did express that. So yes, I was involved with that.

At the end of the day -- again, HR issues, I might make comments on, but at the end of the day, you know, the powers that be have to decide on those positions. But I'm very, very pleased with their selection. It was really a dream consult for somebody like me to be able to have somebody like Dr. Anderson.

Q Have you ever requested that IDOC bring on somebody like Dr. Anderson as a consultant before and play a more beneficial role other than having you just having to go it on your own and talk to people?

A Well, I'll be honest. I wish that was my idea, but I -- but it wasn't. I didn't even realize that, you know, there was a way to

bring a consultant in like this. So somebody was aware of that and utilized that approach.

I would say that they were very supportive of me going to WPATH, you know, utilizing that as part of my training and what have you. So they are very supportive of giving additional training. But to get the extra staff member is just -- it was a huge positive step.

Q What other names do you recall were on the list?

A Oh, goodness. I can't remember the other names. You know, when they had that name -- there was somebody that was in child adolescence, and I just didn't think that was appropriate for an adult population. So I can't remember. And I don't know who they eliminated before they came up with those names. So that is something that -- that once -- once I saw Dr. Anderson, that was pretty much it. That seemed like a perfect person.

Q Whose decision ultimately was it on who to hire?

A That's a really good question. We do have somebody in a position. The chief of staff

ultimately would have to approve it. I'll be honest. I'm not really sure. The director may have been involved, but I -- I don't know who all was involved. Obviously the chief of staff would have to sign off. Legal would want to make sure that person met our needs in terms of, you know, supporting a, you know, positive legal support for feedback we've received in court, so...

But the exact people, I don't know.

Q Okay. And you're not aware of the terms of Dr. Anderson's engagement with IDOC in terms of payment or duration of -- of the engagement?

A I don't know how long the current contract goes for. I have been given the impression that this is an indefinite, but I'm sure as with other people who are non-union, you know, they have contracts that periodically are reviewed and renewed, but I don't have any of those terms.

Q Okay. What is the nature of IDOC's engagement with the Moss Group?

A They are providing us suggestions on

various ways to enhance our correctional transgender care. And so, again, like the exhibit that you provided, they are providing us, you know, obviously with training suggestions that we'll incorporate into future training revisions.

The one I was reviewing from them and modifying currently was their recommendation for a specialized -- a specialized unit that both transgender and other populations -- because, again, we talked about the PREA laws prohibit having a specific unit without a court order or a settlement agreement, and we don't have either of those.

So I took a look at their -- their suggestions. And they had a write-up, and then I took those and I modified them to address populations like I talked about -- those who were susceptible to bullying, for example, lower functioning offenders -- and taking a look at how would we implement that, what would it look like at a facility, what kinds of facilities would work really well. And so I had to take a look at some facilities and take a look at their structure, like their physical design, to see if it made

sense for the size population that might be interested in volunteering for such a unit.

So that was the current Moss Group write-ups that I've been working with.

Again, I take a project at a time, and then I save up the other information. And when I start that one, I move on to the next one.

Q When was the Moss Group engaged?

A Well, I started getting those write-ups in spring of this year. I don't know when they actually engaged them. And I'll be honest. I don't even know if they are volunteering this information or whether they are contracted. I'm not sure exactly our relationship with them. But they have provided some, you know, good information, so -- and again, any time we can get a consult, it's helpful.

Q So I'm asking you right now some of this information in relation to topic No. 8, which is, "Whether the Transgender Committee or IDOC has engaged outside medical or mental health professionals with expertise in the treatment of gender dysphoria. And if so, the name of any such

outside professional, the reasons for engagement, and the terms of the engagement."

So did you do anything to prepare to testify on that topic today?

A Yes. And I have relayed, you know, Erica Anderson, Moss Group, Caitlin Williams, Len Meyers, [sic] and all of these individuals that we've been talking about throughout the day are individuals that we were consulting with.

Now, the financial arrangement is something that I'm not -- it is not within my ranking within the department.

Q Right. But I mean, when you identified those people and certainly were interested in the terms of the engagement, did you try and educate yourself as to what the terms of the engagement of each one of these individuals was?

A My understanding is that Dr. Anderson is an ongoing arrangement, and, you know, our non-union staff have contracts that last a period of time and then are renewed.

Q Does Mr. --

A It's the same as with our Wexford

contract. It's done for a period of time. It's agreed upon mutually and then it gets re-reviewed.

For example, they've been employed by the department through many, many contracts over the 12 years I've worked for the department. So just because the contract is designed to be reviewed at a certain point, you know, clearly -- with Wexford, for example -- it is ongoing, you know, into the future.

Q Does Caitlin Williams have a contract with IDOC?

A No. She was kind enough to just volunteer her time.

Len Meyers, part of her -- part of her funding or contract is to educate community professionals. For example, I actually -- I'm sorry. I met them at a training for, like, sheriffs and police departments and corrections. And so working with IDOC is part of the Planned Parenthood funding and that part of their job, you know, whereas Caitlin was volunteering some of her time to go over the materials and talk about those with me and coming in -- I don't know whether or not she got paid to come in and do the quarterly

mental health meeting. I assume that she got paid for that because it was during the week and during the workweek.

So those are the only arrangements that I am, you know, aware of.

Q Does Dr. Anderson have any ability to make any decisions, or is she just providing recommendations?

A She has the ability to be on the committees if we need some assistance with decision-making. And she also can be utilized to help, you know, people with the main issues that would be involved in making such issues. So -- and she has made comments in the past about reasons why -- you know, for example, the IDs. I was explaining the importance of helping the staff to be aware of pronouns for those offenders that want to voluntarily come out, and that that would, you know, probably most sufficiently be done on a modified ID. And then she also supported that and educated people about why I might recommend that as an option.

So that's the sort of thing that she would weigh in on, and it affects policy.

Q But ultimately, the decisions are for somebody else to actually decide whether to take action, right? She's making recommendations, but it's still not the personnel that are having to make the decisions, right?

A At the end of the day, what the director says goes. So everything is ultimately his decision, responsibility. He has been very supportive of our work and -- and, you know, really using, you know, consultation.

I can't speak beyond that, you know, because I don't want to speak for the director as the regional. But all of this is dependent upon the director's approval. And I don't foresee any problems because we are basing it on so much consultation.

Q Did Dr. Anderson have any recommendations or suggestions that were not adopted?

A Not that I'm aware of. If I am -- you know, I'm not always in the operations meetings, but I haven't heard of any operations decision that appear to be out of sync. And even some of the ones that were discussed in front of

me were in sync with the direction she was suggesting.

So the department is really trying to be doing its homework, basically, to try to ensure that we are utilizing the WPATH standards. Now, obviously we don't have WPATH Standards of Care aid, and so it may require some changes, but I don't think so since we are using an expert that is so closely involved in these -- in this process.

Q Would you agree with me that since Dr. Anderson was engaged, that the welfare of transgender prisoners under IDOC's care has improved?

A Oh, yes.

Q Okay. Why did it take Dr. Anderson to be hired for that to occur?

A I believe that what happened was when we went to court, it really highlighted areas that we could improve upon. And then they employed Dr. Anderson to be able to help us effectively remedy care standards and trying to make policies that make sense. So that was really the beginning. And it's not to say that I didn't, you

know, have -- like, for example, the Minahal (phonetic) provider trainings, that was initiated by me, not Dr. Anderson. So over the years I've tried to move the department along helping people understand the importance of misgendering. But bringing Dr. Anderson aboard basically skyrocketed the speed of these changes.

Q Why didn't these changes get adopted before?

A I don't know why the changes weren't adopted before. I for sure think that the courts had an influence on people realizing the importance of these changes.

Q Were you -- did you find yourself in prior years frustrated by the lack of progress by IDOC in relation to the care of transgender individuals?

MS. COOK: I'll object to this question. It's beyond the scope.

BY MR. RAY:

Q You can answer.

A Am I representing the State or myself?

Q No. I can -- I'll take this one out

of scope right now and ask you personally. Did you find yourself at any time in the past frustrated by IDOC's lack of progress or the status of their treatment -- level of treatment of transgender individuals?

MS. COOK: I'll just object again and ask that we just -- why don't you save that question for the next deposition.

MR. RAY: We're doing both depositions today, right?

MS. COOK: Yeah.

MR. RAY: Okay. So I'm telling you, it's outside the scope, fine. He's sitting here right now. It's in this line of questioning, and I want to ask it now.

MS. COOK: Well, I think it's very confusing for the witness.

MR. RAY: It's not confusing at all. He just asked am I asking him on behalf of the State or as a private individual. I'm saying this as an individual. If we go back on topic 8, I'll let you know that we're going to go back into topic 8. I'm asking him right now...

BY MR. RAY:
Q In the past, have you ever found yourself frustrated by the level of care of transgender individuals by IDOC?
MS. COOK: You can answer.
THE WITNESS: Did you say I can answer?
MR. RAY: You may answer.
MS. COOK: Yes, you may answer.
THE WITNESS: Okay. I was frustrated by the commissary items in particular. It was really hard for my clinicians to work on some of the interventions if they were out in the community, it would be much easier. For example, an assignment that somebody who wasn't ready to come out of the closest might do is to wear female undergarments under their clothing so that they psychologically knew that they were in feminine attire, or that trans men were in masculine attire, yet they didn't have to publicly come out with it.
So having those separations, you know, not having makeup in the male division, those sorts of things limited the amount of the

assignments that we could do as mental health for the social transition.
Also, the policy -- I am very pleased to move the medical decisions to, you know, a medical scope of practice. So yeah, on a personal level, getting these changes has been a big relief so that the policy is in line with the kinds of standards of care that I would do and the kinds of assignments I would do with a client in the community if I were to start a private practice.
BY MR. RAY:
Q Other than commissary items not being available as needed for gender-affirming and the policy of having medical decisions being made potentially outside of the medical scope of practice, any other frustrations you had over the years regarding the level of treatment of transgender individuals in IDOC's care?
A Well, I think it's been a great improvement that we're no longer using genitalia as the sole criteria for transfer between the gender divisions. I think that that was an enhancement in our care. You know, and the fact

that we're doing it on an individual-by-individual basis is allowing us to do it in a way that is appropriate to, you know, various needs so we can really look at it in detail in a multidisciplinary manner.
So those are the big issues. You know, getting that training component in definitely reduced frustration. Because I received many complaints about misgendering. And so being able to address that has been a relief. Because it was something that was -- something that mental health were having to deal with. And it's, you know, more efficient to deal with helping people understand the importance of that and the legal requirements to not misgender. So those are the kinds of things that I would find frustrating.
And, you know, change takes time in a large institution. And what I found is you focus, you know, on one thing and then you get that, and then you, you know, evaluate that effect, and that's when you work on the next thing. So we have been improving over the years, and, you know, it's just really, again,

skyrocketed with the support that we have today.
Is that what you're asking?
Q Yeah. I mean, you've got the -- sort of the history here to see sort of in your own mind how things have changed over time. But, you know, I asked because it sounds like -- though I'm not trying to put words in your mouth, but it sounds like that there's been some changes made, you know, after some court decisions, and then Dr. Anderson has come along and helped.
But I -- you know, you have said yourself that you've been involved in this field for a while. And I'm just trying to get a sense of when things weren't as good, what your frustrations were with the care of the individuals within IDOC. That was the reason for me asking.
A Yeah.
Q Following up then as well about the policy of having medical decisions within the medical scope of practice, do you mean that you were frustrated that it was a committee making medical decisions that wasn't necessarily qualified to do so?
A Yes.

Q So let's move on to --
MR. RAY: Actually, we've been going -- time flies when you're having fun -- just about an hour again. Why don't we take a short break and come back in five minutes.
THE VIDEOGRAPHER: The time now is 1:47. We are off the record.
(After a brief recess, the deposition continued as follows:)
THE VIDEOGRAPHER: Time now is 1:53 p.m. We are back on video record.
BY MR. RAY:
Q Dr. Reister, I would now like to spend a little time talking about transfer issues, and specifically topic 10 of our 30(b)(6) notice.
So in your experience, why -- and I know every case is different, but you've been around long enough. You've been in IDOC long enough. Why do transgender prisoners seek to transfer to different facilities consistent with their gender identity?
A What I'm told from those offenders is two major reasons. One is that -- well, one could

split the one into two -- so three reasons. One is due to complaints about transphobia and comments that are made at the division that the individuals are in. Most of the requests are in the -- they are starting they're trans women in the male division wanting to transfer to the female division.
The other issue that some, but not all, have brought up is how expressing your true inner self can be less -- you're less nervous doing that in a facility that matches that gender expression largely. Now, of course, there are trans men in the female division. You know, and people do vary in terms of stereotypical expressions of masculinity, femininity. And of course, people vary. And we look at those on different continuums in terms of masculinity, femininity, and other conceptions. You can be high or low in two of them.
But they feel that it would be easier in terms of being their genuine self in a setting that is supportive of living in your true gender. Whereas, peers may make comments on, you know, gender expression. People who, you know,

don't understand, for example, and aren't educated in trans issues, like a lot of their peers are not, may not even understand, you know, that their expression is about gender, not about sexual orientation. Just really basic information.
The other -- the other thought that individuals have is that, you know -- a lot of individuals are aware of, you know, sexual, you know, propositions and things like that. And they are hoping -- whether this is accurate or not -- but they perceive that that might be easier to manage in the female division.
I know there is also a trans man who wants to transfer to the female division, and he is in particular interested in -- very similar reasons, but also wants some specific programming as well in addiction recovery. So we talked a little bit about -- about what kinds of institutions would have that and that sort of thing.
So those are the major reasons why individuals may request that transfer. I would say that it's a small -- or smaller group of individuals making that particular request.

Q You mean to say that -- that it's only a subset of the transgender prisoner population that actually requests a transfer?
A Correct. And in fact, some of the trans men specifically were concerned about being forced into the male division, and so I had to have a discussion with them that this would require their request before we would make that change.
Q So in the current policy right now upon intake, how are prisoners assigned a facility regarding -- you know, if they identify as transgender at that time?
A Well, for individuals -- like, for example, we had a trans man who had bottom surgery and requested to be in the male division. We accommodated that request. And, um, for individuals that haven't been determined to that degree, what we would do is have those individuals taken a look at by the external committee for a request to transfer between divisions. So that occurred in a couple of cases.
There was also a trans woman who, I believe, was put immediately into the

female division as well. There have been -- (audio disruption). That was before my time, but I did hear about that.

MR. RAY: Let me stop you there. I'm sorry, Dr. Reister. I think you cut out there just for a moment. And I think, Diane, you were --

THE WITNESS: What I was saying is there was also a trans woman, I believe, before I started working in this capacity at IDOC as well. So it's happened for both a trans man and trans woman according to my best knowledge.

BY MR. RAY:

Q Would that --

A I actually knew the trans man from working with him.

Q Okay. And the trans man who came in on intake and was assigned to his desired gender facility, he had already had -- he was post-op? He'd already had surgery, correct?

A Yes, he was post-op.

Q Had the trans woman also had surgery?

A Yes.

Q Okay. Are you aware of any prisoner

coming in on intake who identified as transgender and was assigned to anything other than their -- a facility consistent with their -- sort of lack of a better term -- assigned gender at birth other than these two individuals?

A We have transferred individuals without bottom surgery on two occasions. And we have -- and I can't remember. I think it's like two or three individuals that are pending transfer, but have been approved.

So there have been, but not immediately upon entry, which I believe was the question.

Q Yes.

A So the ones who have, that was subsequent via request, and the TCRC reviewed those individuals for transfer.

Q Now, let's go back to the reasons that you delineated for why, in your experience, transgender prisoners do request transfer. And one of them is a complaint about transphobia. Do you believe that that's a legitimate concern that transgender prisoners have in IDOC?

A Yes.

Q And do you think that transphobia, if it got to a certain degree, could be harmful to their health?

A Yes.

Q How can it be harmful to their health?

A Well, it can be traumatizing depending on the person's coping capacities and the nature of it. You know, it can be associated with sexual violence, physical violence, emotional abuse. And there -- you know, basically any of those can create a trauma reaction, stress reaction, and potentially PTSD symptoms as well.

So that creates a risk, and that's what I talk a lot about in my all-staff training and in my mental health trainings is we need to follow the legal rules about this because it traumatizes individuals.

Q When you say "legal rules about this," you mean -- what do you mean?

A There were previous court cases. The Department of Justice actually a few years ago came out with basically a comprehensive overview of LGBT legal cases. And there were some -- and

again, I'm not a lawyer, so I don't remember them. But I do remember the content about you don't want to out somebody, you don't want to misgender them, you want to -- you know, maintain safe housing and what have you. Basic human rights to prevent harm.

Q And those type of risks can be more prevalent for transgender inmates if they are in a facility that might be congruent to their assigned gender at birth, but not their gender as they are currently incarcerated?

A Correct. Like, there is a research that shows a 13 percent higher rate of a PREA event. Again, you can reference that with the Department of Justice report.

Q Okay. You also mentioned a reason for transfer about inmates wanting to be in an environment where they felt more free to express their true genuine internal self in a facility that matches that gender. Is that, do you think, a viable reason also to transfer?

A Yes. That's one of the criteria that I would consider and that I have considered.

Q Okay. And if inmates are not in an

environment where they feel like they are able to be themselves, especially when it relates to their gender, can that be harmful to their health?

A That can be harmful to their mental health.

Q How so?

A Again, if they are trying to have that tension between who they are -- some individuals may be in the closet -- it creates a lot of internal stress and unhealthy acting-out behaviors as well. You know, for example, individuals who are in the closet in the community engage in, you know, substance use disorders to manage that. Well, in a correctional setting, you know, those people utilizing hootch, for example, which is homemade liquor, are they trying to do that. You know, are -- you know, are they doing other unhealthy behaviors like self-injurious behavior to relieve emotional distress. So it leaves people at risk of depression, is one of the consequences. Increased gender dysphoria can be one of the consequences.

Just the -- just being in the institution that is the same as they were assigned

at birth in terms of the gender of the institution, some individuals talk about that alone being a misgendering. Some of them view it as an institutional form of transphobia and dismissing their sense of gender. And so that can have an impact of any internalized transphobia they have, would be an example.

Q Okay. You had also talked about an increased risk of -- it sounds like sexual propositioning as being something that some prisoners mention when talking about desires to transfer. Is that a viable reason in your mind as well?

A Yes. That's a viable reason that some might want to transfer. And remember, all of these things are individualized and all of these impacts, you know, have a lot of intersection with coping skills and prior experience if you've been abused in the past before, for example.

Q As part of that sexual propositioning or the increased risk of it, is there also an increase risk of sexual assault of transgender prisoners in facilities that don't match their gender?

A 13 percent higher likelihood.

Q Okay. And so then -- so then what is the actual criteria then for when a transgender prisoner says, hey, here are my concerns, here is what I'm going through, I would like to be considered for transfer. What is the process as it exists today to handle that request?

A The mental health provider team will be the case manager, in effect, in terms of getting that request information to either the TCRC currently or to the Transgender Administrative Review Committee once that launches. Mental health provides that referal, and then it would be reviewed by the committee. And what would happen is if it is founded -- and so far they've all been appropriate -- then Dr. Puga and I will interview the offender, take a look at the chart, and talk about issues like the trauma. That came up really strong in one of the cases that we decided to transfer.

So -- you know, so we would look at that. We would also look at coping skills. We would also make sure that they have an informed consent to their request when we talk

about different people will have varying experiences. We can't guarantee that there wouldn't be sexual propositioning or aggression or misgendering; that they need to be aware that those behaviors, you know, are choices that individuals make, and that there are going to be people, you know, in the female division that vary in terms of antisocial attitudes and behaviors. So they just need to be aware that, you know, we can't guarantee that some negativity wouldn't happen.

We would also, you know, talk about the process, helping them understand that, you know, what would be the next step in terms of making those decisions.

So those decisions -- and we haven't had individuals change their minds during these things because we try to be balanced and there are a lot of benefits. And we'll talk about basically risks and benefits and expectations. And then so far we've had people say yes to continue with the process.

And then we would bring this information back to the committee and also speak

to the stability to transfer, whether or not what the level of care would need to be and what have you. So far we've had people who are very stable, didn't need to be transferred to the RTU section of Logan or anything like that. But we have to consider all of those possibilities as well as are they safe for physically transferring.

Then once -- the committee will also bring in people from the security, internal affairs side, and they would discuss concerns and issues. People representing the female division would talk about, you know, things like housing, readiness issues to bring somebody over, that sort of thing.

But, you know, our role in mental health would be basically to talk about the things that we've been talking about today in terms of risks and benefits.

Q So it's -- so it sounds like then, from your experience, that every time that somebody has -- any time that mental health provides a referral and you've interviewed that person, you've substantiated the mental health professional's referral to say this is a viable

request; is that right?

A Yes. We have approved multiple individuals. Some of them have been delayed due to COVID-19. And there was a case that we had a disagreement on. Mental health voted one way. Operations voted a different way than mental health. We voted for transfer. And so that decision, I believe, was -- I'm doing it from memory. I think we tabled that for re-review. And so, you know, I'm very familiar with that case. My opinion hasn't changed.

Q Okay. So --

A And that's my personal, not my IDOC, just to be clear.

Q Well, I mean, let's talk about that case. So I mean, did you feel like the concerns that were provided by the operations side of the committee were valid?

A I cannot remember their arguments. I didn't -- as a mental health provider, I didn't see them as something that would make me change my opinion. But I can't remember their exact arguments, but I didn't see them as something that I agreed with.

Q I mean, in your mind -- again, looking out for the best interests of the inmate to put them in the best position of care -- should IDOC be considering things like whether they've gotten any tickets recently?

A The nature of those tickets may be relevant to a placement, so that might be something to consider. For example, violent sexual assault might be something that operations may have comments upon, something like that. But we -- we don't take any one piece of information as a disqualifier. It's basically you pull the pieces together including the site's ability to manage, you know, safely.

The other thing is whenever a decision is rendered, it's not the final decision. Offenders are permitted to resubmit those same questions to be reviewed again.

Q By the same committee?

A By the same committee. And, like, for example, that person will eventually be reconsidered. I know this person. They're in my region, and I've talked with that individual.

Q In your history at IDOC, has the

committee ever changed its mind upon resubmission for transfer?

A We haven't gotten to that point yet. I would anticipate that we probably will in this case. But I cannot tell you what the votes of other people might be, but I would assume so.

Q Not for this particular case. But in your experience as a whole with this process, are you aware of the committee ever changing its mind for an inmate who has submitted an original transfer request and it was denied and submitted another request? Has the committee ever changed its mind, in your experience?

A These -- these transfers are a new option in IDOC. They actually grew out of another case that made clear that genitalia can't be the sole exclusionary criteria for transfer from the male -- I'm sorry -- from the female to the male division, so it had to be taken a look at in context.

Because it's so new, we haven't had a chance to take another look at this particular case. I'm just looking at the, you know -- I would suspect that that -- that this

probably would be changed at some point.
Q Okay.
A And this individual is going to -- has requested surgery as well, so I'm sure that also will have an impact. My guess is we'll probably transfer before then. But I don't know. I'm not sure which process would occur. With them splitting the committees up, I'm not sure. But anyway, it could be reviewed. I have no doubt that we have change decisions at times. Most likely the decisions will be tabled rather than a final decision, and probably people will come back with additional information. It's probably the most common.
But again, I'm doing some -- looking into the future based on the past, there have been individuals that we have already basically tabled rather than make a final decision because we want to gather more information.
Q Okay. But the individual where mental health thought the transfer should occur but operations did not, do you feel there is a risk of that person's well-being in their current incarceration situation rather than be

transferred?
A I've had discussions about this issue with this particular individual. They have a strong -- she's got a lot more hope than what she had in the past. Particularly surgeries, you know, the idea of that is something that has provided a lot of hope for this individual. Albeit, gender dysphoria is very high, she's also very well engaged with mental health for support. But she will request to go again in addition to she's already submitted for surgery. That request officially went out a few weeks ago, so...
Q Is that a request to be considered for surgery, or is she past --
A Yes. She requested surgery -- bottom surgery, and she has been on hormones and stable for quite a while. And so Dr. Puga and I would have to go out and interview her. I know her very well because she is in my region, and I just -- I know her from going into the groups before and meeting with her -- with her therapist.
And so we would go out there because we have to write the letter of recommendation that we talked about earlier.

Q As we sit here today, August 17, 2020, has the committee ever approved anyone for surgery before?
A No. But I'm pretty confident we are going to fairly soon.
Q Okay. Is it frustrating to you, as somebody who has some history with this subject matter and knowing that surgery can be, for some transgender individuals, medically necessary, that there still has been no approval of surgery here in 2020?
MS. COOK: And again, you're asking his personal opinion?
MR. RAY: Right.
MS. COOK: You may answer.
THE WITNESS: From a personal opinion, it can be frustrating, particularly for individuals who are having a lot of suffering from gender dysphoria. However, as a department, we've made so much progress that I have a lot of hope. And this is -- this is already -- in my opinion, this ship has sailed and we're just in the process of figuring out how to do it, so -- and we figured out a process, so now it's basically about coming

up and getting the final paperwork done trying to figure out the logistics and that sort of thing.
But, you know, the fact that we already have identified a top-notch surgical team that I would send any friend to get, you know, surgery -- gender confirmation surgery, I think really speaks to the movement. And so my frustration has been relieved. I'm not frustrated anymore. Historically I was.
I think that we basically have a plan in place that are going to allow us to address these issues that were unaddressed. I'll be honest. I'm very proud of where -- how far we've come in such a short amount of time in terms of, you know, IDOC. I mean, one of my facilities was built in the 1870s, and just in this short amount of time we've just made so much progress. And I'm full of so much hope that I -- I think that you're finding that a lot of offenders, what they were lacking was hope, and that's really what they needed.
So I think that our process, and I think once the AD comes out, I think you're going to be seeing a whole lot of hope. The fact

that we're asking the questions and developing a list and we haven't excluded any type of bottom surgery that they might be requesting, the fact we're showing care enough and indicating that their medical needs are important, that has a lot of symbolic meaning for the offenders. And they've directly told me that. And they've told me that the hope is much higher.

And I receive feedback that the misgendering is even a little bit better. It's not that we don't have ways to go in terms of that, but it's getting better. They're seeing steps in the right direction. And because a lot of them were in need of medical interventions, this is -- the fact that we are gathering this information is very meaningful and...

So yeah, I -- I am very pleased with where we are at. And the frustration that I'm sure they also felt, you know --- but remember. I have more information. Right? So their frustration in terms of they don't have information. Because we don't promise offenders things that we can't deliver on. And so when this -- when this change gets published, it's

really going to even skyrocket more. I think that there's indications that it's really going to be exciting for a lot of the offenders.

BY MR. RAY:

Q Now that in the future surgery might be allowed or at least not categorically excluded, is there going to be any specific training for mental health providers or medical providers at IDOC on how to recognize and refer transgender prisoners for surgery?

A I have already begun in my trainings, like the one I just did to talk about the importance of understanding and to take a look at the ongoing gender dysphoria as well as the sense of -- particularly like dysphoria in terms of individuals might look in the mirror and that might be very difficult. Some individuals may not even want to, you know, have contact with their genitalia. Of course, when you shower, you know, that can be triggering. So talking with and training individuals on listening to what their client is saying is really important, and making note of that information.

However, I've also talked with

them about that I don't want them gatekeeping those requests. So that's why I got the list on what the offenders and where the offenders are at in that process. Because I don't want gatekeeping happening.

So, you know, we can assess people if they aren't ready. You know -- you know, that's fine. I've talked with offenders, you know, about some of the criteria like 12 months on hormone, for example. I've talked with them about, you know, they have to be medically stable enough, so they have to talk to their doctor, is surgery a bad idea given maybe other health conditions that they have that are unrelated to gender dysphoria, and, you know, making sure that they have those conversations with their medical providers.

Stability factors, I encourage offenders not to wait until their mental health issues are a crisis. Early intervention can prevent a destabilization and prevent them from not meeting the criteria of well stabilized. Obviously, we'd be concerned if somebody was recently on a crisis watch, for example. So that

would be scrutinized and taken a look at. And those can be avoided by early communication with their mental health providers.

And it seemed like -- it seems like individuals are really understanding. The requests are coming in from offenders that have -- a lot of the ones that I've talked to -- and granted, I'm still gathering that list -- have educated themselves on the various procedures. And I just talk with them about, well, what are your thought processes, have you, you know -- why do you consider like a vaginoplasty over an orchiectomy and vice versa, and trying to have discussions with them about making decisions based on what they need. And to be able to communicate that clearly to providers so that they understand where they're coming from in their perspective.

Not every offender comes in with the best communication skills. And so sometimes we have to work with offenders about, well, how do you talk with individuals, how do you manage anxieties. Because there is a power differential between an offender and somebody who's going to go home at the end of the evening.

You know, staff by just the very nature that they get to leave, that creates a dynamic. And we talk with them about how to do that and how do be able to communicate clearly.

Q Okay. Why does the possibility of surgery -- you mentioned this hope that you've seen in transgender prisoners. Why does the possibility of surgery suddenly give them hope?

A Well, not every offender is going home at any time soon. We have some individuals that are lifers or have such a long sentence -- you know, that's one of the challenges with the one case I was referring to earlier. She has such a long period that she's, like, trying to live in this body -- I mean, you know, paraphrasing her -- and since I have such a long sentence, you know, I'm going to be, you know, old. And I'm not -- I'm going to be spending my whole youth basically in a body that I'm not comfortable with, that I'm uncomfortable with looking at, touching, and what have you. So the prospect of that continuing on, you know, for, you know, more than a decade is very concerning for individuals, just the length of time of having to tolerate the gender

dysphoria. You know, people who are going home relatively soon, they can envision being able to seek out those medical interventions. Like the gentleman I spoke to the other day who basically went home the next day after my interview, you know, this individual was, you know, seeing the opportunities available for medical interventions in the community. And so that instilled plenty of hope versus individuals -- you know, if you were to talk years ago, they would have thought it was impossible. By other institutions around the nation having performed a couple of surgeries, it's still -- they thought it was out of the realm of possibilities.

And so seeing this current interest in understanding and hearing -- being heard, basically -- being heard about what their needs are has been very helpful.

Q Okay. Going back to the transfer procedure, I know there's a number of criteria that the committee looks at in discerning whether or not a prisoner should be transferred. But I just wanted to kind of rattle off a few. And again, as a witness for the State on this topic, I

wanted to get your testimony as to whether or not you think these are valid considerations and, again, whether the State thinks it's valid considerations.

Is a prisoner's criminal history relevant to whether or not they should be transferred?

A I will give an example -- the answer is yes. Can I give an example to explain that? Because it sounds strange until you hear the example. And again, we're talking not just one factor.

We have an individual, a trans woman in the department, who had a very, very violent rape, sexual -- well, it was a rape, and then murdered the woman involved. You know, as somebody who used to do sex offender-specific therapy, you know, I may have some questions; you know, has this individual been sexually fantasizing on rapes and murders for the past, you know -- you know, time period. I think it's been like one or two decades, you know. Individuals that I've worked with who spend a lot of time with those kind of sexual fantasies could be at a

higher risk. Well, you know, I -- I don't know that. You know, you would need specific sex offender assessments to be done to know for sure.

Now, is that the only criteria? No. But I just want to point out I was working with individuals at the treatment detention facility. All of those individuals had served an entire sentence in IDOC that were still struggling with, you know, sexually deviant fantasies. Not all of them were obviously like this case. But that's an example of how a criminal history interacts with a mental health or behavioral concern. That, you know, needs to at least be considered, you know. Maybe not the whole criteria. But something we want to think about. You know, if somebody has that kind of history, how would you manage that? How triggered would they be around so many women? How isolating would it be to single-cell this person? You know, are there risks? Trying to consider would this person be appropriate maybe for a cellie with a trans man. You know, there are lots of questions, and we have to -- to take it, you know, individualized. But yes, that's just one example

where, you know, we have to consider their criminal history.

Q But you are building that into your list of considerations when you are working with the mental health provider to determine, hey, is this a request that should go to the committee or not. You and -- you and -- if I understand your testimony correctly, you --

A I would still have them present the case. And in fact, we did, and we tabled the decision.

You know, I wanted the case to be presented because I think it's important not just to pull out the criminal history out of the context of the whole person. So we would still present the case, but that would be one of the factors that we would take into consideration.

Now it's very different. What if this individual is not listed in a predatory status, but has that criminal history? Because we do have a classification of predator/vulnerable, and this is specific to sexual assaultive behavior or both. And so we can't just pull out the criminal history. We also have to look at their

classification in terms of predatory/vulnerability or both behavior. So you see how we would still need to present, and operations would present some of that information to the committee.

Q Okay. I'm just trying to get a sense of, you know, what is a valid consideration and what is not.

What about an inmate's age? Is that relevant?

A In terms of age, there's a number of things that would make that a consideration. For example, it's possible for a younger person to have fewer stigma management skills. Or perhaps a younger person might have very fresh -- a history of sexual abuse as a child, you know, and maybe they are still working through that very heavily. And the risk of sexual assault for that person may be very anxiety provoking, or maybe some of the abusive behaviors might be triggering of that event.

So, you know, age is something that I would want other information in combination, but it's something that I'm going to want in my interview to be mindful of and see if

there's some other factors that we needed to look into in terms of risk.

So yes, I would want to take a look at age and any interactions of age and their need for that environment.

Q Let me ask you this way. In your experience dealing with transfer discussions with the committee, has anyone ever brought up something that you said to yourself, hey, I know we're looking at all angles here, but we shouldn't be using this as a consideration or criteria for determining whether or not we're going to transfer this person?

A I don't recall any of those sorts of questions. If I had that concern, I would voice it. I'm a very vocal person. And if I had a concern, I would definitely raise it in real time. You know, I would basically suggest, well, this is the implication, and have you considered with that factor that this could be, you know, whatever the alternative would be -- would be at play.

So the fact that I'm very vocal with alternate -- alternate perspectives. And I'm also one that talks about you can have

more than one factor simultaneously occurring, and let's consider not just this factor, but another factor.

So to answer your question, I can't recall. But if something were -- like that were to occur, I would voice my objection and I would vote accordingly.

Q Have you had anybody in your conversations with people at IDOC and in your career try and suggest to you that people who identified as transgender were sort of making it up, that it wasn't real?

MS. COOK: This is --

THE WITNESS: I've had to address that --

MR. RAY: It's personal.

THE WITNESS: Oh, I'm sorry. What -- do you need to finish?

MR. RAY: No. You can answer.

THE WITNESS: I've had those training discussions. I like to go and get my -- some of my cycle training done at one of my facilities in my area, which is Menard. It's a maximum security facility. And -- and people will ask me because

they know that I may, you know, be the all-staff training. And they, you know, will pose questions like that, you know, off line like while we're waiting, and they'll, you know, sometimes ask question and that sort of thing. And I will usually -- and my go-to is usually the -- the nonbinary nature of physiological sex; how you have to look at the chromosomes and body parts to -- when they're doing gender assignments at birth, and how some people are now choosing not to identify a gender for those children and letting them choose for themselves. And I talk about why that might be and have them think about it, and it makes them take pause. When you see that biology isn't that simple, then they will consider that perhaps something as complex as one's identity isn't that simple either.

So that's how I would address that. And that's how mental health providers -- I'll be honest. I think some of those side conversations -- if you can make a safe environment for staff to actually talk about that, I think that some of those little side conversations that I and my mental health

providers have can sometimes really do a lot for moving that bar of understanding.

BY MR. RAY:

Q Have you had anybody other than a correctional officer have these conversations with you? Anybody who is a warden or assistant warden or somebody at your level or above?

MS. COOK: And I just object for the same reason. Are we truly going to have two depositions today, or is -- are you going to ask all of the questions now?

MR. RAY: I don't understand. I'm telling him he can answer in his personal capacity. And then when we go back into topic 10, I'll let him know. We've done this before without any issues today.

MS. COOK: Well, that's because when we discussed it earlier, I was under the impression, as we had agreed, that we would do the 30(b)(6), stop, and then have a personal deposition that --

MR. RAY: We've been through this already today. I'm telling him he can answer in his personal capacity. He's had no difficulty

doing this earlier today. Stop trying to get in the way of the testimony right now because I'll tell you when we are going back into topic 10. For right now I want to ask him this. There's nothing in the rule that says I can't do this.

MS. COOK: I want to know when one of the depositions ends and when one begins. And it's after this many instances where I have not made any objection or we've just let it proceed, I'm now believing that that's not going to happen --

MR. RAY: No.

MS. COOK: -- as we agreed before.

MR. RAY: You're wrong. And you can make your objections, outside the scope, and I don't contest that. I'm asking in his personal capacity.

MS. COOK: No. I'm going to stop this.

MR. RAY: Let's finish. I'm going to ask my question again. If you would like to object, then fine. Otherwise, we're going to proceed.

BY MR. RAY:

Q So again, the question is to you, Dr. Reister, has any of these conversations that you've had or people coming to you asking, hey, is this real, you know, expressing doubts about whether transgender was a real thing, were any of the people that came to you more than just a correctional officer-level individual, such as a warden, assistant warden, or anybody else, you know, at your level, above your level that has had these conversations with you?

MS. COOK: And again, I will object. I will ask that this be reserved for his personal deposition today, and that you continue on the topics.

BY MR. RAY:

Q Okay. You can answer.

MS. COOK: No. He cannot answer.

MR. RAY: I just want to make sure we're clear on this, Lisa. You're instructing him not to answer?

MS. COOK: I'm going to conclude this deposition, and we can take a break and call the Court or work it out as we can.

MR. RAY: I'm sorry. So just to make sure, you're instructing him not to answer and you're going to seek a protective order? I want to make sure I'm clear on what you're doing.

MS. COOK: I want to conclude this deposition and we can discuss this further. We can get the Court on the phone and see how they want to proceed. But this is -- this is too intermingled. The depositions are too intermingled.

MR. RAY: No. They're not. And I'm going to ask my question one more time and I want you to think about what you're doing.

MS. COOK: No. Because --

MR. RAY: What you're doing is not only against the rules, if you -- as you know, Lisa, if you instruct him not to answer a question and you don't have the basis to do so, it's sanctionable.

So I'm going to ask my question one more time. And if you want to instruct him not to answer, okay, then you're going to have to go seek a protective order. And we will suspend this deposition, and then we will

come back and it will be worse than when we left it for you.

So let me ask my question one more time.

MS. COOK: No, Mr. Ray --

BY MR. RAY:

Q Dr. Reister, okay, you just talked about having conversations with people who expressed doubts or at least had questions for you, hey, is this real, do people really transgender, is this something that actually happens. All I am asking you is do you recall having any of these conversations with somebody who wasn't just at a correctional officer level?

MS. COOK: And, Mr. Ray, again, I object. And you know that while I can't instruct him not to answer unless it's a privilege, we can absolutely conclude the deposition, and that's appropriate under the case law.

So I would prefer to work this out with you. However, if we cannot work it out, I will conclude the deposition right now.

MR. RAY: You are concluding the deposition unilaterally?

MS. COOK: Yes.

MR. RAY: I just want to make sure I'm clear on what you're doing. Because I'm telling him right now he can answer this to his personal capacity. This is one follow-up question I have. And then I'm going to finish up with topic 10. And then we're going to hit the rest of his personal deposition. There's no question whatsoever in what capacity I am asking him this question. And in no way, shape, or form will I make it reflect upon the State or any other defendant in this matter. I'm asking him, Dr. Reister.

MS. COOK: I don't understand why you can't wait until his personal deposition, though.

MR. RAY: I just -- you didn't object to the first -- I mean, you objected to the first question and let me ask it, which you should have. And now you're essentially -- are you instructing him not to answer or not?

MS. COOK: I've told you I don't believe that this will end. I gave you leeway because I'm not trying to be difficult. But eventually I have come to the conclusion that I

don't know how many more times this is going to occur. And since we're already doing the personal deposition as soon as this one is over, I don't understand why you can't wait until then and ask all these questions then. Because I don't know how many more questions you're going to do this to. It's very confusing for the transcript.

We asked repeatedly, and you and I discussed today that we need to have them separated. And there -- there are times I've let a lot go through because I'm not trying to conclude the deposition or end things. I'm trying to resolve it.

MR. RAY: Okay. So your position right now, after I have asked my question now, I think, three times -- are you going to let the witness answer the question?

MS. COOK: When -- during his personal deposition, of course.

MR. RAY: Are you instructing him not to answer the question now?

MS. COOK: I would like you to proceed on the topics, and then we'll proceed with his individual deposition. So I'm instructing him

to defer this question until his individual deposition.
BY MR. RAY:
Q Dr. Reister, you may answer the question.
MS. COOK: I'm -- Mr. Ray, I'm going to stop this deposition, yes. We can try to get the Court on the phone, but we need to conclude it now.
MR. RAY: Okay. This is highly not only objectionable, but, also, I don't think I have ever seen this in my entire career. You have no ability to do this, Lisa, particularly since the record is absolutely crystal clear I'm asking him this question which is a direct follow-up from the last one, okay, in his personal capacity.
MS. COOK: Then wait --
MR. RAY: Now you are unilaterally -- let me finish. You are unilaterally terminating a deposition with no ability or responsibility to do so.
MS. COOK: I have the ability to do.
MR. RAY: I have never seen this in my career.

BY MR. RAY:
Q You can answer the question, Dr. Reister.
MS. COOK: No. If you will proceed on to the topics, he can answer your questions. If you want to proceed with his individual deposition, then we should conclude and begin his individual deposition.
MR. RAY: We're going to take a break.
THE VIDEOGRAPHER: It's 2:53 p.m. We are off the video record.
(After a brief recess, the deposition continued as follows:)
THE VIDEOGRAPHER: The time now is 3:01 p.m. We are back on the record.
MR. RAY: All right. So to -- let me state for the record, I think that any insinuation to end the deposition early over this would be improper on multiple levels. However, I took the break so that I could check my outline to see what I had remaining on topic 10, and it's not very much. So I'm going to go back to that, and then I

will switch into personal deposition land, unless there is something that comes up the street relating to the topic that -- any of the topics that Dr. Reister brings up again.
But otherwise, in an effort to move past this, I will go ahead and finish my questioning on topic 10. So let me do that now, and then we will address the remainder of the questions. But I do not appreciate the insinuation, nor the -- what I frankly think is a -- beyond a speaking object at this point in time. But let's move past it.
BY MR. RAY:
Q I wanted to raise a couple of other considerations for you, Dr. Reister, relating to transfer. Is an inmate's sexual orientation a valid consideration for transfer?
A I don't see the relevance of sexual orientation beyond the risk of potential trauma because the -- the gay, lesbian, bisexual, and particularly gay men and trans people are targeted for, you know, PREA events, assault, that sort of thing. They may come in and it's something that Dr. Puga and I will have to assess to see if

there's any -- due to minority stress issues as well -- that the emotional impact of heterosexism -- we do need to consider if those are part of some of the negativity or violence.
For example, somebody who is an offender may think that the individual identifies as gay or bisexual when they're actually transgender because the offenders may not know the difference, and may be saying very heterosexist comments about same-sex behavior, for example. And, you know, that could be very extensive, and it could be something that is worth us being aware of the traumatic impact, that that could be something that might make us -- well, that would be one of the reasons why it would potentially be a consideration for transfer to a different setting. So it's -- I would call it as breadcrumbs as a clue; in other words, leading to potential concerns that we need to consider.
Q Okay. But as you know, there are LGBT prisoners in every facility, right?
A Different individuals may pull for more bullying and abuse, as well as some individuals may have better coping skills to deal

with that and more support. So it really is a case-by-case basis whether or not an individual may need a transfer because they're just not able to adapt to that kind of bullying. And one of the possibilities might be a transfer to Logan.

So again, any piece of information to a psychologist or psychiatrist is an avenue that we explore the meaning. Because they are clues of potential traumas is one of the most common things that I'm going to be concerned about.

So maybe there isn't any problem with that, but it's something that as a psychologist I just -- I have to look into it.

Q What about a particular inmate's physical appearance or stature? Is that a consideration when looking to transfer?

A Some individuals may feel unsafe due to their size. They may feel that -- given the abuse level or their experiences they're having, they may feel particularly vulnerable and be more comfortable in the female division because the average height of women is shorter than the average height of men. So those individuals may

feel safer, and that might be one of the other potential reasons somebody may request a transfer.

Q Okay. Do you think somebody's appearance or stature is a reason to deny transfer?

A Not in and of itself. I could see it being a consideration for operations in terms of placement. At Logan if there is somebody who has a history of violence and they are still in therapy and they have a maximum security status and they're still in need of some therapy, I could see them having to think about, well, how do we do this placement so that everybody is safe and this person doesn't set themselves up for a disciplinary if -- if acting out is a problem for them violence-wise.

So I could see operation using that in their planning. Because a TCRC is also a place where we discuss, you know, what kind of things in terms of planning for change do we need to do.

Q Okay. All right. So I think at this point in time -- sorry. Just a couple quick follow-ups.

So would you agree with me, though, that if a transfer proceeding is coming before the committee for consideration that -- I know that you and -- have just one vote on that committee, but -- and, you know, others may have a vote -- but if it's at least past your gatekeeping function to say this is a, on its face, valid request, let's see what other people think.

A Can you word that differently? 'Cause I'm not quite sure what your question is getting at.

Q Sure.

A I may have -- I'm missing something.

Q Sure. When you -- let me back up for a moment. The MHPs who work underneath you field transfer requests from the prisoners that they see, correct?

A Yes.

Q And then those MHPs meet with you to say, hey, I have an inmate who is interested in transferring, let's talk about it. Right?

A Yes. And usually it's about how we could prepare this individual since they're going to make the request, what kinds of skills might

make the transition more successful. Because I want them -- an offender has the right to request it. So the MHP's job is not to gatekeep. You know, the committee will meet and make the decision. So the job of the MHP is to consult and figure out how can you best prepare somebody or this particular client for success given their history.

Q Okay. But then after that meeting takes place where you talk about the concerns with the inmate and you prepare -- help them prepare their request to go to the committee, at least from a mental health standpoint looking out for the welfare of that inmate, you at least personally are of the mindset at that point in time, this is at least worth the consideration of the committee, correct?

A Yes. And I think the whole committee believes it's worth reviewing the request. I think everybody gets gender dysphoria and those kind of factors at this point. Even wardens get it.

Q Okay. So wardens didn't get it before?

A I haven't talked with the majority of the wardens, so I can't speak to everybody. But I don't think that was a standard part of their training beforehand. You know, I've got a lot of positive feedback from the training that was helpful for their learning.

Q Okay. Is it fair to say that for any transfer request that you bring to the committee from a mental health standpoint that checks enough boxes for you, that you think that the inmate would benefit from transfer?

A Let me -- let me -- because I'm still not sure I got it, but let me answer and see if this is what you're saying.

I have the ability to vote what I feel is the correct transfer decision, and I also have the ability to ask for more time to further consider -- I have the ability to further -- to abstain from answering if that's something that is necessary. So I have those abilities.

Is that your question?

Q Not really. My question is --

A Okay. I'm not getting it. Say it

again.

Q Okay. So as I understand the process, the transfer request comes to the TCRC Committee, as is currently composed, from you, correct?

A No. It comes through the mental health providers at the site. They submit a DOC 0400 form, and they submit that over to Chief Puga's exec secretary. And then she gets them on the roster for the next -- for the next committee.

So it comes actually not necessarily through me -- because I've educated, you know, the team go ahead and do a DOC 400 and so that we can begin the process. I don't want them to wait for me because -- you know, what if I'm out on vacation or what if I'm out sick or something like that?

I had a medical thing going on late last year and earlier in the year, and I didn't want them to wait for me to get back. So I told them, you know -- and I don't want that kind of extra layer, you know, of delay. So I have them go ahead and submit it, and then we'll take a look at it. But sometimes they just have

questions along the way, and they may consult just for their own personal knowledge.

Q Okay. We're going to move on. Time to go back to the question that I had pending before we went on the break.

And recalling back to your conversations with individuals who had doubts about whether people were really transgender, I wanted to know if there were any individuals who you had spoken with about that topic who were either director-level individuals or wardens or assistant wardens or anybody in a managerial role?

A No, no individual. And I interact with a lot of different administrators, and nobody's questioned that.

Q Has anyone questioned whether gender dysphoria is real?

A No, nobody's questioned that. I think for one thing, by the time you get to be an administrator, you've been around for a while, and we've always had out transgender people. So I'm guessing that's probably why I don't hear those because you got more experienced staff in those positions.

Q If people had been, though, you know, around for a while and seen transgender individuals throughout their career, why was there a categorical exclusion for surgery?

MS. COOK: I'm going to object --

THE WITNESS: Well --

MS. COOK: I mean, I thought you were following up on his questions about the training and conversations about the training. What topic does your next question have to do with?

MR. RAY: We're on to the personal dep now.

MS. COOK: Well, I'd like to clean up some things from the 30(b)(6) deposition.

MR. RAY: You want to do -- you want to stop and do redirect, and then I begin his personal deposition?

MS. COOK: Yes.

MR. RAY: Okay. Let me finish this line of questioning and you may do so.

BY MR. RAY:

Q Go ahead.

A Can you repeat the question?

Q Sure.

A It was a little bit of a delay. No problem. So if, like, you know, nobody was really questioning gender dysphoria and nobody was, as you say, questioning whether transgender individuals were real, and people had administrative abilities who were setting these policies were, you know, aware of a transgender population, why the categorical exclusion for surgery? I don't know. It's one of the things that, you know, I've been talking with people about over the years, that sometimes hormones are not sufficient for every person in general, you know. And so I'm not certain. I think the education process is a process, and I think there is a continuum of understanding and learning that people do. And I also think that a lot of people look too much towards those external finds about being read correctly. So they might think something along the lines of this person is on hormones, you know, everybody can see they are transgender, they're growing secondary female characteristics, and yet not understand that it's not about just external. You have to think about the person's internal sense of their body. Even

though people may not see their genitalia does not mean that that -- that they don't have a gender dysphoria -- dysphoric reaction to their genitalia. And they may not stop to think about, you know, the impact that has on healthy sexual expression, on, you know, just their general sense of themselves when they see their body. That -- it may be so out of somebody's frame of reference that they don't even think about that. And you know, part of my job as a psychologist is to help people kind of step outside of their own -- their own cultural viewpoint, their own privilege, to not even have to think about that and to help them to ask good questions about how somebody else in a different gender identity might view something that they take for granted like looking at their body, you know, and the reaction that might have.

And so I think some of that is just the process of education and something that, you know, people need to consider. It's more than what an external person sees. It's what the person feels like inside -- what the transgender person feels inside about their body and how that is a -- oftentimes a lot of the clients will talk

about a mistake of nature and things like that. Everybody has their own kind of terminology. But it's that mismatch between their body and how they feel inside. And that's something that you have to actually have a conversation. And when we're an operations person, have a sound, confidential location to ask those kind of questions, and it wouldn't be an appropriate conversation for them to educate themselves on.

And so since a lot of prisons are in rural areas, they may not have as much access as somebody like me who lives, you know, in a metropolitan community, has friends. You know, I can literally ask the questions. My friends and I are very open and -- you know, whereas somebody that -- I don't know. Name a prison. Like Robinson may not -- keep in mind, I don't know all the staff there. There could be a transgender staff there. But they may not have access the way some of us have access to ask those questions, you know, of individuals, or they may not think to check You Tube.

There's a lot of people that give personal accounts of being transgender, but,

of course, you don't know, you know, if this is real or not. Although, I think that when you hear from those individuals, you can tell that they're -- they're really talking from a genuine space and can give you things to think about in terms of the privilege that might make you not consider that kind of internal sense of one's self.

So I think it's really about just how the human mind works.

MR. RAY: One quick follow-up, Lisa, and then I'll let you ask your redirect.

BY MR. RAY:

Q When was the first time that you can remember raising a concern about the categorical exclusion on surgery?

A I'm trying to remember whether it came up with my client at Dixon. Because at one point in my career I was an administrator. I did direct care. Or whether it was after I was on the committee.

I can't remember exactly. It was pretty early on. It was either -- it was either in the late 2000s or early after I was on

the committee.
And I'll be honest. I don't remember when. My questions were really along the lines of a medical director making that decision doesn't make a lot of sense to me, and so I raised that concern pretty early on. But I don't remember when I read that -- that section of the AD specifically and raised that concern, but -- I don't remember exactly when it was.
MR. RAY: Okay. I have no further questions on the 30(b)(6) portion of this. I will note there were some aspects of the topics, namely the terms of the engagement relating to certain of the third parties that have engaged, where we didn't get right answers. We also had some issues relating to certain topics were relating to medical providing that Dr. Reister couldn't answer. So we're going to --
Lisa, I'll have a conversation with you after the deposition about seeing if Dr. Puga can cover some of those topics. Otherwise, we're going to leave the deposition open on those segments of the topics that were inadequately covered today.

But with that, I will pass the witness for the 30(b)(6) topics for today, and we will continue after with the 30(b)(1) portion of the deposition.

E X A M I N A T I O N

BY MS. COOK:

Q Okay. So Dr. Reister, I want to follow up on some of the questions you were asked. And just so it's clear, the TCRC that was in place and the administrative directive that were in place, they have been -- or been in the process of changing since the Court's order in this case, correct?

MR. RAY: Objection. Lacks foundation.

THE WITNESS: Correct. I'm sorry. I didn't --

MS. COOK: I think the court reporter got it down.

THE WITNESS: Okay.

BY MS. COOK:

Q So the transgender committee has still been working in some form until the new administrative directive is in place, correct?

A Correct.

Q And one of the things you were asked about was about the transgender committee overseeing hormone treatment. Does the Transgender Care Review Committee still oversee any hormone treatment?

A No. That's on the site level.

Q And so as far as WPATH standards concerning hormone treatment, that's not applicable to the Transgender Care Committee at this --

A That's correct.

MR. RAY: Object -- I'm sorry. Objection. Leading.

BY MS. COOK:

Q And then as far as any committee reviews of surgery, you anticipate that the THAW Committee that you discussed will be following WPATH standards?

MR. RAY: Objection.

THE WITNESS: Yes.

BY MS. COOK:

Q As far as you know, will the committee oversee aftercare of any prisoners who

do receive gender-affirming surgery?

A The site level would take care of aftercare needs, as well as the surgical team may have specific recommendations. But that -- that medical care would be taken care of at the site level, to the best of my knowledge.

Q And you mentioned that the department is in the process of engaging with University of Illinois Chicago Transgender Health Clinic?

A Yes.

Q Do you know exactly what that clinic is called?

A I don't know the exact name, to be honest.

Q Has the department finalized that relationship?

A No, it has not. Again, this is all in the works. We're moving as quickly as we can.

Q And you also explained that many of the commissary items will be available at facility regardless of the gender of the population, correct?

MR. RAY: Objection. Leading.

THE WITNESS: Correct.

BY MS. COOK:
Q And so what kind of commissary items will be -- will the department be offering, say, to transgender females who are at a male facility?
A The common request of the female division, lotions and cosmetic products that have a certain scent that our culture perceives as feminine scents. And things like the makeup, we've talked about the importance of not concealing one's identity with how one uses those cosmetic products. So that also would be something that individuals would have to take some responsibility for how they utilize it, so that implies that those are going to be on there as well.
I believe the female division has different bras that are available, you know, and other female products that might be on there. The male division, the offenders are wanting more masculine clothing, and the masculine-scented cosmetic products is what they're asking for and they would get by the merger.
Q So many of the changes that are taking place are not reflected in the current

administrative directive that's in place?
MR. RAY: Objection. Leading.
THE WITNESS: No.
BY MS. COOK:
Q And so I wanted to ask a little bit more about training just so that it's clear.
So WPATH, through its global education initiative, is going to offer training to IDOC staff; is that right?
MR. RAY: Objection. Leading.
THE WITNESS: Yes.
BY MS. COOK:
Q And that training, is that going to be for only mental health or medical and mental health?
MR. RAY: Objection. Leading.
THE WITNESS: Mental health.
BY MS. COOK:
Q If Dr. Bowman and Dr. Anderson testified that it was for medical staff and mental health staff, would you dispute that, or are they different trainings?
MR. RAY: Objection. Assumes facts not in evidence, and also leading again. Lacks

foundation. Also outside the scope of my testimony.
BY MS. COOK:
Q You may answer.
A I only track the mental health training, so I -- I wouldn't be in on any meetings with Dr. Anderson about the medical. So anything they have going, I wouldn't be in on those meetings.
Q When the department does trainings like the transgender health training that you have been putting on, are those solely for State employees, or are contractual employees also doing those trainings?
A Both State and contractual employees. Also the chief of chaplain services attended one of them. So we get requests, and I will consider those requests. But yes, both Wexford Health Sources and State mental health are invited, and it's designed specifically for them.
Q And so the only trainings that maybe people who work under you or who work with gender dysphoria patients in IDOC, the only trainings you don't know about are Wexford's proprietary

trainings?
MR. RAY: Objection.
THE WITNESS: Correct.
MR. RAY: I don't know how he can know what he doesn't know. Also, objection, leading.
BY MS. COOK:
Q Do you know as far as other WPATH trainings, are staff members trying to take -- have they been trying to take WPATH conference trainings?
A One individual was able to do it. And I'm so sorry. I'm blanking on her name. I'm sorry. Webb. I'm sorry. Debbie Webb took a WPATH training. I know that a number of people signed up for the May Kansas City training. Unfortunately, that was cancelled due to COVID-19, including myself. I was also going to go to that. So like, for example, Dr. Fairless signed up for that training.
So yes, staff are -- are -- you know, as an interest is -- they are going to get additional education.
Q And will the State pay for that, or

do people have to pay on their own?
A If you want it paid for the State, you have to be a State worker, and you have to submit a request and a rationale why. And -- for example, they agreed to pay for mine. Now, I didn't submit for that, but I could have submitted for it. So I know that at least in one case, my own, they were willing to pay for it.
Q And the department also has a training department, correct?
A They do.
Q And so that is who often gives the training that you created?
A Yes. That is -- and they coordinate tracking the all-staff training. They also track my trainings as well. I had to submit my trainings to them, and they keep it on file and what have you. We have an entire training system so that we can keep track of that. As well as my -- as well as my executive secretary, she keeps a list of individuals as well so that we can create and generate from the waiting list who would like training or retraining.
Q And you mentioned that your -- you

know, you consider your training to be a work in progress. Do you intend to incorporate all the notes you've been collecting into the training as you revise it?
A Well, what I -- what I do is as I go and I give a training and I get a new piece of information, I just quickly try to put it in. But the notes -- the feedback I get goes into a pile, and then there are some times I'll keep a little pile in my office of journals and different books. I've had to expand the length of the training as I expand the materials. So I can't guarantee you -- we're up to ten hours now, so it may go even higher over time as different things come out. So it really depends on the feedback and the, you know, research I do or the trainings I go to. Because I do this on an ongoing basis.
Intersectionality of identity is a specialty area I'd like to gather further information on. Not just transgender, but race and all the other forms of identity.
Q You were asked also about housing decisions. You know, you mentioned some of the decisions could be tabled. Do you know, is it up

to those offenders to re-raise the -- their request to be moved to a different facility, or is that something that staff can do?
A Staff can definitely do that. When we've tabled things, we'll usually give a specified time frame. You know, it would be a case-by-case basis. But my survey includes that question, so we're very soon going to have a list of people who have that request. Of course, we'll have to cross reference in case there's somebody who is already approved, but it's been delayed due to COVID-19. But that's pretty easy to do that.
So I'll have a list of everybody outstanding who has not moved divisions who are wanting to be moved.
Q Are any inmates being moved to different facilities right now during COVID-19?
A We have emergency transfers to, like, our inpatient units and our residential treatment units, and then we have a quarentine process. But no, and we're having an upswing in our cases that's pretty significant, particularly in Southern Illinois, but also at places like East Moline and some of the other sites.

So COVID-19 is a concern right now because of the upswing of cases, offenders and staff.
Q And in addition, has Logan Correctional Center asked that transfers be staggered?
A I believe they have asked for it to be staggered so that they can -- they can prepare and also acclimate offenders who are received there. And that allows us to address any individual concerns those individuals have. So they have requested that, but with COVID-19 we're basically backlogged on transfers. Even transfers to the RTUs are being held or only doing the emergency ones at this point in time.
MS. COOK: Those are all the follow-up questions I had.
MR. RAY: I didn't have any follow-ups on the 30(b)(6) portion. I think we can move on to the personal deposition.
THE REPORTER: Can we go off the record for just a minute. I'm having some technical difficulties.
MR. RAY: Why don't we take a two- or

three-minute break.
THE REPORTER: That would be great. Thank you.
THE VIDEOGRAPHER: The time is 3:40. We are off the video.
(After a brief recess, the deposition continued as follows:)
THE VIDEOGRAPHER: The time now is 3:43 p.m. We are back on the video record.
MR. RAY: All right. We're now going to begin the personal deposition portion of today. Dr. Reister, thank you for your time and patience already today, and we will see if we can move quickly through the rest of the content today.
DR. SHANE REISTER,
having been first duly sworn, was examined and testified as follows:
EXAMINATION
BY MR. RAY:
Q So I just wanted to confirm, in terms of your conferences and training, you have attended two WPATH conferences in your life; is

that right?
A Yes.
Q Have you done any other sort of WPATH-sanctioned training sessions or workshops in addition to those two conferences?
A No workshops. I do get the journals and Listserv information where people are talking about cases, but nothing like other workshops.
Q And you do not consider yourself an expert in hormone therapy, correct?
A No, I'm not.
Q Within IDOC, who do you turn to with questions about hormone therapy?
A Dr. Puga would be somebody that I might talk to, or Dr. Conway. I haven't had to do so, but those would be the people I might go to. I do reference -- Dr. Puga had a handy outline of risk/benefits for offenders. And so that's a reference source that we utilize because it goes over some of the basics, which is about the level of knowledge that a mental health provider would need to familiarize themselves with.
Q You're also not an expert in surgery for transgender individuals, correct?

A Correct.
Q And who do you defer to or turn to with questions about surgery?
A I would refer that over to medical, and then they would have to refer it over to an outside surgeon. We don't have any actual surgeons on staff. That would require a contract being written up for that service.
Q What did you do -- and this -- actually this question is relevant actually to both sides of the deposition, but it's just one sort of the nucleus of questions. What did you do to prepare for today's deposition?
A I looked over some of our new directives. I looked at the basic structure and design. I reviewed my training materials on the part one and the part two, so -- I looked over the -- the um -- Lisa Cook sent out a listing of the major topics. So those are the kind of things that I did to prepare for today.
Q What kind of list was this?
A It was the list that was what you were putting up there on the screen when you were talking about the 1 through 10.

Q Yes. Okay. Since it didn't draw a privilege objection, I figured that's probably what it was.
Did you discuss the deposition with Ms. Cook prior to today?
A Yes.
Q When did you do that discussion?
A Oh, goodness. It was within the last, I think, week or so. She may know off the top of her head better than I do. But it was recently.
Q And did this occur via phone or in person?
A Phone.
Q And how long did you meet with Ms. Cook?
A Again, I didn't really time it, to be honest. I don't know. It could have been like 30 minutes or an hour. But I'll be honest, I really don't know. I didn't even see what time the clock was during the call.
Q During that session with Ms. Cook, did you review any documents?
A No. But we, you know, talked about

the questions in there. So, you know, obviously, you know, standards of care would be discussed.

Q Okay. Have you had any conversations with Dr. Puga, for example, about this case?

A Not specifically about this case. I mean, we consult all the time on issues. But I don't recall this offender being discussed any time soon. But this offender has been discussed so much, I mean it's hard to say whether this case has come up in terms of recent discussions. But this is one of the cases that come up on a regular basis.

We periodically review how she's doing over at Logan. So one of those reviews, I can't remember when we last had one. But we do -- we consult on a regular basis about the offender and how she's doing over in Logan currently. I don't believe there's any problems. And I was just over at Logan and they didn't identify any problems.

Q Okay. Earlier during the deposition Ms. Cook had mentioned an order, and I know you've talked about some orders from the courts. I know there's a couple of different lawsuits that have

been filed over the years. But are you familiar with the preliminary injunction that the Court in this case handed down in December of 2019?

A Um, I'm going to be honest. I sometimes mix up the different court cases. You know, there's basically three cases that have been involved with various decisions like that, and I can't remember the details of what came out of which case, to be honest. Some things I'll remember, but some things just kind of go into the back of my mind as you got to do X, Y, Z.

Q Okay. Let me show you the preliminary injunction in this case. Take a look at that to refresh your recollection. I will make this bigger now.

(Reister Exhibit No. 3 was marked for identification.)

BY MR. RAY:

Q Okay. Dr. Reister, does this particular document that I'm scrolling through slowly look familiar to you?

A Yes.

Q Okay. And what -- please describe sort of the first time you had seen this document

and what happened after that?

A It was -- I received copies once it posted. Probably it would have come from the legal department, and then it would have been discussed by the transgender committee.

And is this the one that has the medical providers that has to be done on site? I think it may be, but I could be wrong. Again, I haven't read this in a while.

Yeah. It has the gatekeeping thing, about the committee would kind of delay getting those.

Q So I'm happy to flip through the remainder of this. There's some additional points here down on the second page of the document.

But it sounds like you're familiar with this as an order handed down by the Court in this case, correct?

A Yes.

Q Okay. And this was things that the Court was ordering the defendants or IDOC to do in response to a preliminary injunction motion. Is that your understanding?

A That is my understanding.

Q Okay. And have you been asked to look at what IDOC has done or is doing to comply with this order ever to compare and contrast what is the -- the Court has ordered IDOC to do versus what it is doing?

A The Transgender Care Review Committee is -- has been particularly recently really taken a look at all of the requirements as well as, you know, trying to foresee if there might be anything else that hasn't been ordered. And so we've been trying to anticipate, you know, and talk about in discussions about issues and taking a look at the orders as well.

I don't believe that any of the orders required us to merge the commissary items, but we thought that that would be a good way to go about addressing the gender-affirming clothing and grooming items. So that's an example where we tried to anticipate what might be helpful beyond what was ordered.

Q Okay. And I know you're not a lawyer, but is it your personal view that IDOC is fully in compliance with every part of this order?

A Well, we're not yet, but I do think

that we are going to be within compliance. I do think that the parts about misgendering is not an instant fix. I think that this is going to take time, and it's going to require repetition as well. And I've talked about that earlier when I talked about training and attitudinal research showing that attitude change happens in small increments toward a more positive view. And so I really view that part to be -- to be a process over time that I'm going to be investing in.

So, you know, not everything is an instant fix. There's -- definitely attitudes can be read by people. I mean, people can read facial expressions. It's not just about words that come out of people's mouths. And so I'm hoping over time we'll get more and more culturally competent if we continue to do the training. And the training department's implicit bias training is really important for the work I'm trying to do as well.

So again, it's not just my trainings. My trainings interact with other trainings. And some other things that I want to work on, such as racism, those -- and a lot on

privilege -- you know, those kind of things interact. And the mental health department also has a share point with lots of information. And our quarterly mental health meetings incorporate a lot of different topics, all of which will interact with various staff growing in terms of cultural competence.

Q So Dr. Reister, I appreciate the answer, but you agree with me that on -- in this order it says the Court orders defendants to immediately do these things, correct?

A Yes. And that's why I was saying that it's really an in-progress part in terms of being able to do that. Getting those changes implemented is not something that can always immediately happen.

I give the example of I can't even get quarters where I live because of logistics problems distributing to the stores and the banks. So in the middle of COVID trying to get, like, for example, commissary items logistics planned out I imagine would probably be more challenging than other points in IDOC history.

So again, some of them you

wouldn't be able to do immediately, and some of them would require, I suspect, having different contracts to even do that piece.

So immediately we have -- you know, in terms of where we're going is we've made these decisions, and now we're just in the process of finalizing, is the impression I get. Keeping in mind that I don't know what all the details and intricacies involved in things like logistics or all the details in the operations side. But they're all in the works currently.

Q So the -- I just want to make sure I'm clear, too, in the timeline here. The all-staff training that you put together that addresses misgendering, that was --

A Uh-huh.

Q -- was that training complete as of the date of this order in December of 2019, or was it finished later?

A No. I had to actually write up that material. It took me several months to write up material that would be appropriate for all of the staff. And plus, recording it took time. There was no way I could get it done immediately. But I

did immediately start with the writing of it and the -- because remember, I have to remove psychobabble that -- tech terms that, you know, might confuse people. I have to figure out how am I going to communicate some of these concepts that perhaps may be closer to my master's level clinician's, you know, training level that somebody with a high school diploma may not have that kind of background, like in biology and things like that.

So I had different considerations, and it took time for me to do that. Plus, having somebody take a look at the materials also takes time as well. So I -- I have to, um -- I couldn't immediately do it, but I could immediately start the process of it.

Now, not being a lawyer, I don't know whether or not being in process counts as immediate, but I do know that immediately, you know, I started working on it as soon as I was asked to work on -- on it.

And, you know -- so that's as fast as I can do it. I can't -- you know, I can't just pull out of a hat material that's appropriate

for all staff.
Q But it was ultimately you who was working on all this material, right? You were tasked with it?
A Yes. Yes. And I had a considerable amount of my time that I set aside to do this because it was so labor intensive.
Q But I would also like to refer to another section of this order to -- and it's No. 1 on the screen right now -- to develop policies and procedures which allows transgender inmates access to clinicians who meet the competency requirements stated in the WPATH Standards of Care to treat gender dysphoria.
You have already said that you believe that you meet the competency requirements stated in the standards of care, correct?
A Uh-huh.
Q Okay. But you do not treat -- you are not a primary treating clinician for any transgender inmate, correct?
A That's correct.
Q And Dr. Anderson is -- you believe also meets the competency requirements in the

WPATH Standards of Care, correct?
A Yes.
Q But she is a part-time consultant at IDOC, and she does not have primary responsibility for any transgender inmate, correct?
A Correct.
Q Okay. So my question is this. What other clinicians exist within IDOC who meet the competency requirements stated in the WPATH Standards of Care who have primary responsibility for transgender inmates?
A I'm not a lawyer, but every clinician at some point starts working with new populations for the first time, whether it's of an internship or on a job. And so meeting competency requires lots of consultation for individuals.
If I start working with a new population, I have to go and do the research, not having the client teach me about that particular issue or concern. So, you know, there are always areas where individuals need to grow in competency, reach out, do consultations or work with other clinicians on growing.
So having access to clinicians

who meet the competency requirements, if somebody were to need me to come out and deal with a particular issue -- and I have done that before, not with this particular, you know, person -- but with other people I have gone out and worked with the clinician and doing basically a supervised therapy session with them to help work through concerns that they had. And the offenders can always write the central office or they can ask their clinician for, you know, additional support.
We have a grievance process in the IDOC that allows them to have a look at concerns. And the mental health caseload clients regularly use that process to draw attention to issues. So that is something that we definitely can address so that they have access --
Q My question is --
A -- if necessary.
Q Okay. I appreciate the answer. My question was different, through, and is --
A Okay. Let me try again.
Q That's okay. It's been a long day. But it's an important question.
A Yes.

Q Well, so can you name one clinician who has primary responsibility for treatment of inmates who meets the competency requirements stated in the WPATH Standards of Care?
A I can't -- I can't attest to the fact that they meet all the standards of care. I do believe that they're providing competent care and that they are in the process of training and growing as a clinician.
So that is something that is a standard practice in terms of people working with new populations. That's part of all of our ethics standards is to do those kind of consultations and supervisions and working with other people more knowledgeable and going to trainings. So that is part of any standard of care, whether it's WPATH or any other organization.
Q Are you aware of Wexford hiring any individuals for the specific purpose of having a clinician who could primarily treat inmates who met the competency requirements of WPATH Standards of Care?
A They have not informed me of doing that.

Q I'd like to do now sort of a couple of basic hypotheticals. And in the first one, presume an inmate shows up at intake and they are currently on hormones. And I'm asking if -- let's say the prisoner had obtained those hormones on the street, not from a doctor. Would it be appropriate for IDOC to stop that hormone treatment?

MS. COOK: I'll object to foundation.

But you may answer.

THE WITNESS: Our offenders come into our system through county jails primarily. We try to get them linked up. Those who are parole violators should already be linked up with aftercare, so they would be coming in -- to my knowledge, they're coming in on non-street hormones. Because we talk with them about the importance of knowing where their hormones are coming from. They don't know what's happening in terms of is -- what they're receiving is actually correct.

So most of them are going to be coming from the Chicago area, so they would get it from Howard Brown because they do have the

ability to work with people who don't have jobs and access to funding.

BY MR. RAY:

Q My question was slightly different. My question was, if you have a prisoner coming in on intake, so new to the system, and you find out that that prisoner is taking hormones that they got off the streets. Okay? Is it appropriate for IDOC to stop hormone treatment after learning that fact?

MS. COOK: And I just want to repeat my foundation objection.

But you may answer.

THE WITNESS: Well, when they come into the facility on hormones and we do the intake, the medical doctor is supposed to contact the medical director -- and I believe Dr. Conway would qualify, and I think Dr. Puga can act as a backup because he's also a medical doctor, but you'd have to check with him -- to make a decision about, you know, and to confirm what that decision is.

So if they had an objection to those hormones being discontinued, they could

provide that feedback to the primary care physician or the medical professional that would be deciding whether to continue or discontinue.

I'll be honest. I'm not aware of this scenario ever happening. But again, they wouldn't be consulting with me on such an occurrence. So it would be basically conjecture because I'm not aware. But there would be an opportunity for that to be -- to get a consult.

BY MR. RAY:

Q So obviously part of the WPATH Standards of Care relates to things like hormone therapy and surgery. And obviously there is a significant medical part of that which is outside of your expertise, correct?

A Yes --

Q Okay. So --

A -- outside.

Q So who is it within IDOC then, who from the medical standpoint, has the expertise on hormone treatment and surgery? Is it Drs. Puga and Conway?

A My understanding is that Wexford has competent physicians at the R and Cs so that when

somebody like this would come in, that they could make the decision to continue the hormones assuming that the level was safe and that there weren't contraindications. If somebody has, for example, a blood clot, it might be dangerous and the offender may not know that, and so there could be reasons why that wouldn't happen.

But again, the specifics, I'm not aware of a scenario to point to for how we would respond. But that, I believe, is the process according to our administrative directives that already exist to ensure, you know, continuity of care. So that's already indicated in the ADs.

Q Okay.

A Because they're supposed to be doing a consult, and that would -- any gatekeeping or concerns about that would be caught during that consult. But again, the actual specifics is outside of my scope of practice for how they implement that.

Q Okay. And it's really Wexford's bailiwick to make sure that its physicians are properly trained on that, right?

A Correct.

Q Dr. Reister, do you believe that IDOC has consistently sufficient initial screening to serve the needs of transgender prisoners?
A The initial screenings when I first started were not sufficient. We even had to change the wording of gender on the forms that were utilized. So the assessment process has improved greatly from when I started working for the department.
Q Does IDOC have a consistently sufficient referral system by correction officers and other non-mental health professionals to serve the needs of transgender prisoners?
A Yes. Yeah. We already have existing for multidisciplinary communication between the various departments. Mental health receives calls. We receive paper notices. We receive e-mails getting ahold of mental health who coordinate the case management side and can make sure that the various components are addressed. We have communications very easily and regularly with the other departments.
Q Do you believe that IDOC has a consistently effective quality assurance process

in place to serve the needs of transgender prisoners?
A Well, we could --
MS. COOK: Object to form.
THE WITNESS: I'm sorry.
MS. COOK: That's okay. You can go.
THE WITNESS: I think that, you know, we could beef that side up when we get the -- particularly when we get the changes in place we're doing. I think that taking a look at how we might be able to utilize a very similar process for quality can be very helpful to the system. So that would be definitely something that we could look into improving.
We're constantly improving our quality assurance process and mental health, and our audit tools change all the time, and we are always working towards that process of improvement. So that would be helpful to take a look at how we might do that.
MR. RAY: Okay. Let's do this. Let me -- let's go ahead and take a five-minute break and try and see what I have left.
THE VIDEOGRAPHER: Time now is 4:16.

We are off the record.
(After a brief recess, the deposition continued as follows:)
THE VIDEOGRAPHER: The time now is now 4:24 p.m. We are back on the video record.
BY MR. RAY:
Q Dr. Reister, just one quick follow-up with you. It actually relates to the transfer procedures that we talked about earlier.
Is there a written document that sets forth, that you're aware of at least, the criteria for determining whether or not to transfer a transgender individual?
A I would frame it as a document -- I believe Dr. Puga was the author of it -- that gives some considerations to have. It's not intended to be a -- you know, there's not a scoring system, for example, for it. You have to basically just think about those considerations at minimum.
Also, you know, obviously, I would use my clinical skills for some of the aspects of transfer. And we've talked about a lot

of the considerations for that. And, um, so I believe it was Dr. Puga who authored that document.
Now, do keep in mind that that's not in the AD, and it's not in our standard operating procedure manual for mental health. This was just something to help people, um, you know, give some thought to what they might want to consider.
Q Do you recall what that document is called, if it's got a title?
A Oh, I don't remember the title of the document. I don't remember the title or -- I'm not even sure it had a title or not because it wasn't an official form. But, you know -- so no, I don't recall the title of it.
Q If you were asked to go look for it, could you find it easily, though?
A No. That was produced a little while ago. I kind of felt like they were pretty straightforward things that a psychologist would look at and consider. I think it is probably the most helpful for non-mental health people. I think that they're pretty straightforward for us,

so -- and I can't remember if I was involved in creating that list or not. It was quite a while ago. But they were pretty straightforward things to think about.

Q So that list you're thinking about, though, from Dr. Puga and you believe he created it, that document is still used today to guide transfer discussions?

A It's things to consider to help guide people's transfer decisions.

Q Okay. Thank you for that clarification at the end.

With that, I have no further questions for today.

I pass the witness.

MS. COOK: Okay. I do have some questions and just some cleaning up, but it shouldn't be too long.

EXAMINATION

BY MS. COOK:

Q I did want to clarify, just so the record is clear, you and I spoke more than once this month --

A Yes.

Q -- about the deposition.

A Yes. I'm sorry. I've been really busy this month.

Q I will not take offense to you not remembering.

And then I want to ask about -- so the preliminary injunction order, you were asked some questions about it, and it was Exhibit 3. And so the Court ordered the defendant, the Department of Corrections, to stop -- immediately cease the policy and practice of allowing the transgender committee to make medical decisions regarding gender dysphoria. Did the transgender committee follow that order?

A Yes.

MR. RAY: Objection. Lacks foundation.

BY MS. COOK:

Q And the Court ordered defendants to cease the policy and practice of denying and delaying hormone therapy for reasons that are not recognized as contraindications to treatment.

I understand you're not a medical doctor, but as far as you know, has the

department been working to fulfill that?

A Yes. And I believe it was just that same thing that I received was distributed to the medical side as well. So I wasn't the only -- mental health wasn't the only one to receive that to work on each of our pieces of that order.

Q But from what you know in your perspective, the transgender Care Committee immediately ceased having --

A Yes.

MR. RAY: Objection. Leading.

THE WITNESS: Yeah. The Transgender Care Review Committee immediately stopped doing that. And the information that I had received from sites is that they also would do that. And we would just simply refer it back to the mental health -- I'm sorry -- to the medical provider if a site were to mistakenly do that.

Of course, if they need a consult, you know, they can contact Dr. Conway or Dr. Puga. They're both readily available by phone, you know, State cell, 24/7.

BY MS. COOK:

Q And the Court also ordered

immediately that the defendants cease the policy and practice of depriving gender dysphoric prisoners of medically necessary social transition, including biomechanically assigning housing based on genitalia and/or physical size or appearance. It was kind of two different things.

But you did mention in your other deposition that the department has quit assigning prisoners mechanically based on their genitalia, correct?

A That's correct.

Q And as far as social transition, has the department been depriving prisoners of social transition?

MR. RAY: Objection. Lacks foundation. You can answer.

BY MS. COOK:

Q You may answer.

A Okay. In terms of social transition, the offenders are already socially transitioning. However, they are requesting additional things like we discussed earlier for that transition. A large, large number of individuals have -- are out of the closet, you know. They -- if staff are

unaware of their gender identity, they will correct them on pronouns, that sort of thing.

Q And I know you -- we talked already about the commissary items. But do you -- in your opinion and based on your experience, has that been held up a little bit by COVID-19?

A Definitely.

Q And so then the other items we talked about -- so Page 2 is stuff the Court ordered the defendants to start doing, and I just want to get it clear on the training.

So you had already begun developing training before December of 2019; is that right?

A That's correct. And a lot of that material became the core, so I didn't have to do from scratch the all-staff training.

Q And as far as allowing inmates access to clinicians to fall under the WPATH Standards of Care, do -- in your opinion, do prisoners have access to you?

A Yes. And in fact, I -- to ensure that they do, I do visit even prisons outside of my region, and I go into their transgender care

support groups on a regular basis. So obviously COVID-19 has curtailed that significantly. There were -- basically from March until -- oh, goodness. What was that -- the end of or middle of June, I was one of the State workers that had to work out of my house and not enter facilities to prevent the spread of COVID-19, and so that curtailed that. That's why recently I have resumed going -- for example, Pinckneyville has a very large population of trans women. Logan obviously has a large population of trans men and some -- a trans woman as well who we're familiar with from this case.

So yes, it has been curtailed, but they do have access. And if they were to request, I can actually go to any of the sites. I'm out of Concordia as a southern regional, and so I can travel outside of my region to do those kind of consults.

Q And is it the goal that through the UIC clinic that prisoners will have direct access to providers?

A Yes. For the medical side, that will provide to specialized surgical teams, medical

people.

Q And as far as the standard of care on the mental health side -- you know, so the first bullet point in the WPATH standards, and it's Page 21 which we already discussed -- is a master's degree or its equivalent in a clinical behavioral science field.

A Uh-huh.

Q Do the mental health providers in facilities have that accreditation?

A Yes. That's a requirement.

Q And then so just going down to No. 2, competence in using the DSM and/or International Classification of Diseases, do mental health providers in the facilities have to meet that?

A Yes.

Q And so ability to recognize and diagnose coexisting mental health concerns and to distinguish these from gender dysphoria, are you -- is training geared to help providers do that?

MR. RAY: Objection. Vague.

THE WITNESS: Well, it is to provide it. But also to get licensed, you have to

demonstrate DSM competency. So that's part of everybody's training.

BY MS. COOK:

Q So in -- just so I understand, so the people who are already accredited to work as mental health providers, through the DSM they have to be able to distinguish those?

A Yeah. You have to -- to pass licensure, you're responsible for the whole DSM, so not just portions of it. And what we're doing is really highlighting those differences and making sure that they understand the differences. That's not usually where the challenge is in terms of training. Most clinicians are very adept, and it's very well written and easy to follow. Usually they're wanting more information on, you know, gender nonbinary, treatment planning, that sort of thing.

Q And so going to 4, it's the documented supervised training and competence in psychotherapy or counseling. Do the providers need to have that?

A Yes. And that's a requirement for the schools that we graduate from, so everybody

has to have that. Now, the schools vary on how much. Obviously I have a doctorate, so I have many more years of supervised training as well as my post doc. But everybody has to do that. And also, to, you know, qualify to even, you know, take the licensure exam, there are basic requirements like that.

Q And then being knowledgeable about gender nonconforming identities and expressions and the assessment and treatment of gender dysphoria, what about that?

A That is --

MR. RAY: Wait. Objection.

THE WITNESS: Oh. Can I answer?

BY MS. COOK:

Q Yes, you may answer.

A That is something that I include in my trainings so that I'm certain they received it regardless of the school that they might have graduated from or their practicum site that they might have gone to.

Q And No. 6 is continuing education in assessment and treatment of gender dysphoria. Do you know if people in DOC facilities meet that?

A Yes. That's why we're doing the transgender specific case conferences. That way we can distribute information and also train them on clinical care using actual case examples that they bring into that training. So that is part of that training.

So -- and they're also welcome to retake the part one and part two. They're also -- the WPATH is working on that other training for more advanced. So there are lots of opportunities for them to improve their skills and continue their education. And, you know, those don't require them, you know, having, you know, money from their own personal budgets going to, like, global education initiative conferences if they can't afford that. We are trying to provide those kind of trainings for free.

Q And then as far as, you know, working with somebody in the field, is that something that you're able to do with your providers right now?

MR. RAY: Objection. Form.

BY MS. COOK:

Q You may answer.

A You know, that's part of the reason

why I go around. That's part of the reason why I want Dr. Anderson to be at our case conferences. I want people to be growing as clinicians continuously. Even if they've been doing this work, you know, for years and years, I still want people to grow as a clinician. It keeps people's skills fresh and it keeps people aware of new research that comes out. And by, you know, collaborating and sharing new resources, sometimes a mental health provider will have a good resource. They can talk about what they've read and provide people ideas.

So that sharing of information is a big core part of working with any population in mental health.

Q Okay. And then as far as the mental health side, what steps does an inmate have to take before they may be diagnosed with gender dysphoria, like with the mental health staff?

A Many of the offenders actually come into our system with a gender dysphoria diagnosis through the county jail system, in particular Cook County. You know, and if they also have been through our system before, like many of them have,

they may have already received that diagnosis in the past. So if they have those diagnoses confirmed, that's how they would receive a gender dysphoria diagnosis the fastest.

If somebody does need to get that diagnosis clarified, then we already know who the out transgender offenders are via a couple of routes. The first one is we have a PREA screen to look at PREA risk factors for classification; like we talked about earlier, the predator/vulnerable or both classifications. And one of the questions is explicit about their -- about being transgender.

So that could trigger communication with mental health. That will provide case management. And if the offender would like, they can also receive mental health support. Or if they have another mental health condition, they can also receive that mental health care as well. Because a very large percentage of our population has other serious mental illnesses or mental illnesses that require monitoring and treatment.

The other way is through

disclosures to other staff. Staff will fill out forms, send e-mails to communicate with mental health, and so that might be a mode for a mental health provider to do an assessment.

Frequently what will happen is individuals will disclose their gender identity while working with a mental health provider. Many will seek that support. And during the process of the interview process -- I believe I talked a little bit about the 14-day mental health evaluation and then the additional questions that they can readily find in my trainings and the SOP and the AD -- to be available to fill out their case conceptualization, and that is another mode for getting that gender dysphoria diagnosis.

Psychiatrists and medical doctors very often will make those diagnoses as well. And because we use a multidisciplinary approach, you know, everybody will communicate that. If somebody happens to give a diagnosis before a different person, they can consult on the reason for that diagnosis with the other providers.

Q And so if -- you know, have you seen

where a mental health provider at one facility might reach out to somebody at a new facility and say you're getting so and so, you know, we should talk about his or her care?

A Correct.

MS. COOK: Those are all the questions I had.

MR. RAY: I had just one quick follow-up.

FURTHER EXAMINATION

BY MR. RAY:

Q Talking about your level of access -- or the level of access that transgender prisoners had to you, They also had access to you before December 2019, correct?

A Yes, they also had that. And in fact, the one consult I talked about as an example with the therapist and the client was actually before that time period. Since then, both the client and the clinician have left IDOC. But yes, it happened before as well.

I think I'm better known today due to the number of lawsuits we're dealing with, and so I think offenders are better educated on my

availability and my openness to address concerns that they have. So I think that, you know, it may be easier for them.

But, you know, usually what is really happening is when I'm coming into sites, I always like to ask about how it's going. And I like to ask about how we can improve our system as a whole so we can get feedback and make changes. They sometimes have really great ideas. And, you know, if it works, we can definitely consider those ideas.

So that's one of the reasons why I ask those kind of questions to make sure that we get feedback from the consumer of our services.

Q But you did those site visits and asked those questions before December of 2019 as well, right?

A Yes.

MR. RAY: No further questions.

MS. COOK: Okay. I don't have anything else. I guess we can go off the record.

THE VIDEOGRAPHER: Okay. The time now is 4:48 p.m. You're off the record. And that

is the end of the deposition.

(Off the video record.)

MS. COOK: Did you want to review it and sign it?

THE WITNESS: I think I'm comfortable with it. Do you think I need to? I think I was pretty clear. But if you think I should do that, I am more than comfortable doing it. What's your recommendation?

(Discussion off the record.)

MS. COOK: As long as she thinks she got it, I would waive.

THE WITNESS: I will go ahead and waive that.

THE REPORTER: Brent, do you need a rough ASCII right away?

MR. RAY: Whatever our order is.

THE REPORTER: And Lisa, do you need a copy of the deposition?

MS. COOK: I will take a copy, but I can't pay for exhibits or anything extra.

FURTHER DEPONENT SAITH NOT. . .

STATE OF ILLINOIS)
) SS.
COUNTY OF C O O K)

I, Diane J. Corona, a certified shorthand reporter in the State of Illinois, do hereby certify that DR. SHANE REISTER was by me first duly sworn to testify to the truth, and that the above matter was recorded stenographically by me and reduced to writing by me.

I FURTHER CERTIFY that the foregoing transcript of the said matter is a true, correct and complete transcript of the testimony given by the said witness at the time and place specified herein before.

I FURTHER CERTIFY that I am not a relative or employee of any of the parties, nor a relative or employee of the attorneys of record, or financially interested directly or indirectly in the action.

IN WITNESS WHEREOF, I have hereunto set my hand at Chicago, Illinois this 23rd day of August, 2020.

Certified Shorthand Reporter
Illinois CSR License No. 084-00257

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EXHIBIT 20

UNITED STATES DISTRICT COURT

FOR THE SOUTHERN DISTRICT OF ILLINOIS

JANIAH MONROE, et al.,	:	
Plaintiffs,	:	
-vs-	:	Civil Action
ROB JEFFREYS, MELVIN HINTON,	:	18-CV-156
and STEVEN MEEKS,	:	
Defendants.	:	

Videotape 30(b)(6) Deposition of

THE MOSS GROUP

By and Through

WENDY LEACH

Wednesday, August 12, 2020

10:10 a.m.

Job No.: 617914

Pages 1 - 281

Reported by: Tammy S. Newton

Two-day assessment, April 22nd to 23rd, 2019.
Q So --
A Typically --
Q Go ahead.
A So that would be the end of April. So typically, and I'm totally guessing here, it's going to take at least two months to get a report out at least, because we've got to write it and then we've got to go through the review process. So that's the end of June. And so let's say sometime in maybe in July or August this would have been probably produced is my guess based on our typical timeline. Yeah.
Q Okay. So sometime in July or August of 2019, The Moss Group told IDOC that it needs to review its training programs and orientations to protect transgender prisoners. Is that -- is that what we're saying here?
A That's what it appears to be to me.
Q Do you know if that happened?
A I'm sure Illinois has done some things, but I can only know what I have worked on

with them. So I'm sure they've done some things, but I would not know what all they were.
Q Based on what you've seen in your current work as their consultant, have the recommendations that were made in 2019 been -- been meaningfully followed?
MS. COOK: I'll object to the form of the question.
MR. GUIDETTI: I can rephrase it.
BY MR. GUIDETTI:
Q Based on what you have seen in your role as consultant for IDOC, have the problems identified in this report been addressed?
A I can't say, and I'm not trying to be swishy here. I haven't been there enough to do enough of an assessment to be able to tell you. It would be nice if we could get a follow-up assessment to say these are the things we found, these are the things we recommended.
And then it's always nice to go back a year later and say, "How did you do?" Maybe they have some documented information on their

progress that I just have never seen or maybe you could ask for it. But I don't know. It's possible they've done some things. Nothing I'm aware of.
Q Okay. Let's look at another document now. Let's mark this -- if I can get it up, Plaintiff's Leach Exhibit 3.
(Plaintiff's Leach Exhibit Number 3 was marked for identification and attached to the transcript.)
BY MR. GUIDETTI:
Q Can you see my screen?
A Yes. Yes.
Q And what is this document?
A I'm guessing this is our contract for the current work we just did in May and June and July.
Q Let me -- I have not tried this before, but I'm going to give you control of the document. Have you done this before? I have not.
A No, I haven't, but we can keep our

fingers crossed.
Q See if you can -- yeah, see if you can scroll through the document now.
A Okay. Yep. It's working.
Q Okay. So take a look at the document as you would if it was, you know, a paper in front of you, and then -- then let me know if you recognize this document.
A I mean, just generally from a look, it looks similar to our contracts. Yeah, it's signed by the director here.
So -- yeah, it's our contract for services for this particular contract on transgender policy and [audio distortion] --
Q Okay.
COURT REPORTER: What was the last part? Transgender policy?
THE WITNESS: I said and stuff. That's not really the technical term. Transgender policy works.
BY MR. GUIDETTI:
Q Is this the only contract that you

need to hear to do their job more effectively. So then that would be the next piece.

Writing the two standard operating procedures I mentioned earlier about the two-committee process, so that's would be attached to the policy basically, sort of separate documents, and that would be a how-to. Here's how this committee works. Here's how they make their decisions. Here's the forms that they use. We create forms as well.

And then the special population unit is an option. If they decide they want to do something with a special population unit, we could come up with some staff training for that, and we've already got the framework we wrote for them. So it's really just a matter of implementing that as a pilot, and I would do that as a pilot in one unit in a small way to see how it worked to make sure it works, to tweak it, and then possibly you could do a special population unit in every prison or in selected prisons. And finally --

Q Have you gotten -- please, go ahead.

A Sorry. The last one was just the training of staff for the women's facility. Again, if you're going to place transgender women in the women's facility, make sure the staff are prepared for that and have some training and that goes forward in sort of a structured way. Then that would be it.

Q That's a lot.

A Yeah, I know. But you got -- you got to do it. You got to do all of it. You can't -- I mean, you can't leave training out and do policy. You have to do both.

Q Of course.

A Yes.

Q Have you -- so where are we now? Did you send a proposal for the second round of work to the department?

A Yes, we did.

Q When was that sent?

A Probably in July would be my best guess. I can get a date for you.

Q July is fine.

A July -- yeah, it's probably July. It laid out all of that information that I just --

Q Have you gotten any kind of response?

A The -- actually, I just want to confirm that was June 4th when we sent that. I'm checking. It was June 4th.

No. I mean, I checked in with the department, and they just said they have a lot going on, but they're definitely going to let me know. Because we have a lot of very positive feedback on the work we provided for them, so I know the work was good. But we deal a lot of times with procurement processes that are sometimes complicated in states. And so I never try to guess what's in people's way.

They may have a procurement issue because certainly the amount of work I just described to you is a lot more than what we just did. And so a dollar amount, of course, would be higher, and those sometimes take a little bit longer. But beyond that, I don't know what's

going on with that.

Q Illinois procurement is a beast.

A I'm sure.

Q How long -- the work that you described for the -- what would be the next contract, how long would that take?

A Probably -- I mean, my guess is around 18 months total, if you kind of include everything. I think certain things wouldn't take as long, like I mentioned the 60 to 90 days for policy if you could get your -- all of your people together, get everything moving. I think some of the -- some of that wouldn't take very long.

I think in terms of creating training, 6 to 12 months probably to, you know, rely on -- rely on the policy creating the training, doing a training of the trainers, which is when you teach their trainers how to train it so that they don't constantly need you to come in and do it. They have their own people trained on how to do it.

I think the training for the women in

that there's anything that's wrong. I just didn't feel that it was really suited for correction staff.

So things like searches are not even included in here, and searches of a transgender inmate is pretty important. Staff needs to know how to do them and what to do and what not to do. Some people search transgender people by having male staff search the bottom and female staff search the top. That's the kind of stuff we don't want people doing, but we want to cover searches in training about transgender people.

I definitely think some of the respectful communication stuff is here, but it's the way that you can cover it makes people really listen to you and makes people really rethink the way that they talk to people.

So I feel like some of this stuff is pretty also high-end, high-level. I don't necessarily think -- even though I know it's cisgender and I use cisgender, I don't necessarily think a correctional sergeant knows

about cisgender, needs to know about it. What we want to make sure they know is the basics and that they do those correctly and right.

And sometimes when you pile so much information that's so complicated on people, I find that they reject it all. They just push it all away, and I'd rather give them what they can digest and get them to understand it and do it and then come back and we can always build on the training a little bit more. But that -- this to me was just too much intense gender language that they -- they are going to have a hard time digesting.

And I also think that you need more activities for people. The adult learning style really, you need to keep people engaged and busy. So we like to do activities in small groups and different things to keep people engaged. I felt like a little bit more of that would have been great. But TurningPoint is a technology we use. You can click it. Nobody knows what your answer is. When you're talking about how you feel about

transgender people, sometimes that's -- an anonymous answer is good, but it also helps us know who's in our audience so we can really tailor our message to them.

So I just -- I guess -- again, it's accurate information, but I just think it's not really for the right audience, and I would like to see training that was built around policy and that was built for correctional staff. They tend to listen to it more. They tend to say, "Oh, you understand my world. You understand what I do." and so when you tell them something, they're more likely to listen to you.

If you come at it from a very clinical, social justice level, they say, "Oh, you don't understand what we really do every day," and then they just tend to reject it all. So that -- I just -- I want to encourage them to do something that's more catered to correctional staff. Let's teach them what they really need to know, and let's let them retain it so they'll actually use it.

Q You mentioned earlier that thinking of the two committees, one dealing with things like hormone therapy and surgery and the other making these classification housing decisions, I think you said that the committee dealing with housing and classification should be informed by the medical committee; is that right?

A Yes.

Q Is that concept reflected anywhere in this training outline?

A No, it wouldn't -- it wouldn't be in this training outline. This training outline is more for just correctional staff. So it would be reflected in those SOPs I talked about where you'd have the kind of instruction on how those committees work and how they talk to each other and share information. It definitely would be included in there.

We can do a little bit in the training if we were going to do a training for staff on how does the case-by-case determination process work. I think you can do a low-level description

EXHIBIT 21

THE MOSS GROUP, INC.
Experienced Practitioners Committed to Excellence in Correctional Practice

Illinois Department of Corrections Targeted Assessment Report

Logan Correctional Center

2019

Funded by Cooperative Agreement #2015-RP-BX-K001

Table of Contents

Acknowledgments

This report is provided by The Moss Group (TMG), in partnership with the PREA Resource Center (PRC) for the Illinois Department of Corrections (IL DOC) and two of its facilities: Pontiac Correctional Center and Logan Correctional Center. This project was supported by Grant No. 2015-RP-BX-K001 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, and the Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice nor those of Impact Justice, which administers the National PREA Resource Center (PRC) through a cooperative agreement with the Bureau of Justice Assistance.

TMG would like to thank PRC for its continued support in working together to address the implementation of the Prison Rape Elimination Act and to create cultures of safety in confinement settings. We wish to especially thank the Illinois Department of Corrections and its leadership and staff at Pontiac Correctional Center and Logan Correctional Center for their commitment to implementing best practice and to maintaining a culture of sexual safety.

The Moss Group, Inc. (TMG) is a Washington, DC-based criminal justice consulting firm. Our mission is to be a trusted partner to leaders and their organizations in creating optimal safety and well-being for staff and those persons under their care. We specialize in assisting state, local, federal, and private organizations in developing strategic solutions to often sensitive issues that face correctional administrators. We are a partner of the National PREA Resource Center.

Project Purpose and Background

The Illinois Department of Corrections (IL DOC) requested training and technical assistance (TTA) from the PREA Resource Center (PRC) in the form of a targeted assessment. A "targeted assessment" for TMG is an assessment that focuses on a presenting problem rather than a comprehensive cultural assessment. The purpose of this assessment was to better understand patterns of reports made under PREA policies and systems and the influencing factors that define the day to day operational and programmatic life that support or hinder sexual safety and reporting. The work was designed to observe and review reporting systems for sexual safety and the cultural norms that define the "reporting culture."

This report reflects strengths and challenges in the policies reviewed, operational practices observed and reported, and themes that emerged as of the date of the assessment at Logan Correctional Center (Logan CC). The report provides feedback and actionable recommendations related to the ongoing enhancement of sexual safety related to PREA allegations and the use of reporting mechanisms; however, this process is not designed to determine compliance or non-compliance with the PREA standards. Only a formal PREA audit can determine compliance.

A Presenting Issue for Sexual Safety: PREA Reporting Resulting in Confirmed and Increasing False Allegations

The request for technical assistance from the department was defined by a concern for a high level of PREA allegations that appeared to be unfounded or unsubstantiated. The overall concern was that PREA reporting is misused and that there is a pattern of "bad faith reporting". This concern is at the core of our technical assistance project. Our team found that the majority of allegations at Logan CC are unsubstantiated, not unfounded or substantiated. The burden of proof for determining allegations is by the preponderance of the evidence—or that there is a greater than 50 percent chance that the incident occurred. Without being able to prove for certain that an incident occurred or not, the administration is appropriately not disciplining the inmate. Our team found that the implementation of PREA is taken seriously both by the department and by the facility level staff. However, the successful and sustainable implementation of PREA and sexual safety is hindered by a number of influencing factors. The importance of understanding the "mix" of operational practice and influencing factors shaping the culture at the facility is a critical approach to better understanding the patterns of reporting at Logan CC. The importance of understanding correctional practice through a gender responsive lens at Logan CC is also critical in the development of any observations or recommendations.

Methodology

The TMG assessment model has been shaped by research and evidence-based literature, practitioner experience, knowledge of organizational culture dynamics, and collaborative partnerships with federal, state, and private entities. TMG's approach is built on nationally accepted best practices related to safety, including the PREA Standards for Prisons and Jails, American Correctional Association (ACA) Standards for Adult Correctional Facilities, key DOJ Guidance in Restrictive Housing, as well as federal guidelines in gender-responsive best practice from the National Institute of Corrections, Bureau of Justice Assistance, and the National Resource Center for Justice Involved Women.

The targeted assessment at Logan CC was accomplished through the following process:

- Communicating with IL DOC representatives, as well as leadership to gain a full understanding of the presenting issues and the desired outcomes
- Selecting TMG subject matter experts from its cadre of consultants who have the experience and credibility to fit the needs of the facility and scope of work
    - The project team for this assessment consisted of four team members deployed based on expertise in investigations, operations, culture, gender-responsiveness, and project management.
- Requesting a comprehensive selection of documents designed to gather documentation from IL DOC and each facility, including policy, procedural guidelines, forms and checklists, as well as grievances, disciplinary, and investigative reports (See Appendix A.)
- Reviewing any historical or current influencing factors that impact the facility culture and related operational practice
- Using the data gathered from the document request, TMG worked collaboratively to construct an agenda that will support the goals of the assessment
- Conducting a two-day onsite assessment at Logan Correctional Center April 22-23, 2019. The key tasks conducted while onsite include the following:
    - Structured observations of operations
    - Interviews with agency and facility leadership and management staff members
    - Focus groups with a random sample of custody and non-custody staff members
    - Individual and group discussions with a random sample of inmates

Following the onsite assessment, the project team conducted a thematic analysis with all of the data gathered during each of the stages listed above. Themes are drawn from patterns across data sets. Those themes are then summarized, and subject matter experts provide practical and appropriate recommendations in alignment with best practices, PREA implementation and actionable solutions.

NOTE: Immediately following our assessment, numerous organizational changes were made on the facility and agency level. We welcome the opportunity to update any themes documented within the report.

Agency Influencing Factors

Litigation (Both Facilities)

One of the most significant influencing factors affecting the daily operation and culture of Pontiac and Logan is the active application of the *Ashoor Rasho V. John Baldwin* settlement agreement. The agreement is a comprehensive remedy for the treatment and management of mentally ill inmates. Under the agreement, the implementation of the operational practices related to the handling of grievances, disciplinary reports, and sexual abuse allegations require careful attention to supporting inmates involved in the population classified as mental health or those who may report that they are impacted by circumstances that initiate mental health evaluation. This careful consideration of an inmate's mental health status, while clinically critical, has also been a hard balance for discerning the response to allegations under PREA. There is a strong belief by many staff, including clinical staff, that a number of inmates are feigning mental illness and misusing PREA allegations. This influencing factor is one of the most significant drivers of the patterns of reporting sexual abuse in both facilities.

The IDOC has implemented significant initiatives to enhance the delivery of mental health services, including the following examples to date:

- Implementation of a definition of serious mental illness (SMI)
- Development of an evaluation and referral process

- Increased staffing of licensed mental health professionals and behavioral technicians by over 300 clinical staff positions to provide both long-term and acute care
- Construction and space retrofits to create four (4) residential treatment units
- Revised mental health protocols and policies, including incorporation of clinical mental health input into the disciplinary system
- Central committee review of SMI inmates who are segregated more than 60 days
- Enhanced clinical contacts, programming, and out-of-cell time for the most seriously mentally ill offenders.

Generally, while we do not offer a clinical opinion it appears that the nature and scope of these operational enhancements are in alignment with best practices and will continue to assist the IL DOC in effectively treating mentally ill offenders and provide a more adequate level of mental health care. However, the operational implementation of these initiatives from our observations has created unintended consequences to facility operations and the perceptions of safety. For example, designation as SMI has affected how the facility can hold inmates accountable for behavior, which has created for a number of staff the perception or experience of a lack of control of the facility by security staff.

Further, Section XXV of the *Rasho V. Baldwin* settlement places injunctions with regards to the disciplining of seriously mentally ill inmates. As a result, some inmates and staff reported to our team that inmates found it advantageous to be labeled as SMI. Prior to sanctioning an inmate for a disciplinary infraction, a mental health professional must make a determination whether or not placing the inmate in a restrictive housing status adversely impacts the inmate. Although they may determine that restrictive housing is not injurious to the inmate, many staff report they have been instructed by IL DOC's mental health director to recommend no segregation time. We heartily support national best practice guiding restrictive housing yet recommend a review of this practice.

Many staff report that beyond the Rasho lawsuit, numerous experiences of litigation or the threat of litigation over a period of years has left facility staff feeling that the agency is largely run by decree and policy and procedure is dictated by settlement agreements. This perceived disconnection between intention and application of policy and procedure was strongly presented to the consultants as a significant factor impacting the staff and population in both facilities.

Definition of SMI

As a result of *Rasho V. Baldwin*, IL DOC redefined the criteria for designating an inmate with a serious mental illness. The SMI definition appears broad when compared to other settlement agreements,[1] thus, creating a broader net for inmates to be designated SMI. With an increased SMI designated population, some staff report that mental health staff caseloads are over capacity and there is a concern by many that inmates are not being held accountable for behavior. It is beyond the scope of this assessment to offer clinical observations yet the operational impact on reporting requires careful consideration of this facility dynamic in better understanding the "reporting" environment and the influence of staff and inmate perceptions of "bad faith" reporting.

Changes in Leadership

Over the past eight years, the IL DOC has had five agency directors, with one resigning after two months. This trend continues into Logan Correctional Center with eight wardens in eight years since the transition of the facility from a male to a female facility. (At the time of the assessment, there had been seven wardens over eight years, but another leadership transition has recently occurred.)

[1] For example, Massachusetts's Mental health settlement agreement (Disability Law Center V Mass DOC) defines SMI under the DSM IV - Axis I: Schizophrenia, Delusional Disorder, etc.

While consistent turnover of administration in corrections is a national trend due to the political appointment of the commissioner-level position and the election cycle, it is important to understand the implications of persistent change on initiative fatigue, staff confidence, and facility safety for the staff working in institutions, as well as those housed in them. This influencing factor may be hard to fully avoid but "anchoring" change and strengthening facility culture with career staff through intentional strategies can help to lessen the impact of rapid change in leadership, such as an agency-level plan for working with woman offenders. This change leadership work is highly recommended.

The drivers that create sexual safety and a positive reporting culture will only be sustainable with a well communicated model of gender responsive practice that does not confuse staff with mixed messages. Logan staff have a lot to build on with past initiatives but the disruption in leadership has left many staff uncertain about implementation of best practice.

State Funding

The state of Illinois had a 793-day budget impasse from July 1, 2015 to August 1, 2017, and prior to that had not had a budget in place since 2013. The state has been in a prolonged budget crisis with an estimated $2 billion deficit in fiscal year 2019. The financial instability of the state has its state employees concerned about retirement pensions and job security. This also has implications on staff retention due to the changes between the Tier 1 and Tier 2 retirement packages. Any staff member who started after June 2011 is in the Tier 2 retirement program and will be required to complete more years of service and work to an older age than those in the Tier 1 program. Tenured and new staff commented on how this impacts retention. It is important to note that while this change in retirement benefits was a significant concern, in general, staff still indicated that the benefits and the pay were significant factors in why staff continue their employment with IL DOC.

The backlog of Illinois vendor payments was estimated to be near $7.5 billion in June 2018. As a result, facility leadership reports that many vendors refuse to do business with the department. Without the support of vendors, the safety of the staff and inmates is at risk as it jeopardizes the provision of essential products and services, such as inmate programming, inmate clothing, commissary and hygiene supplies, staff uniforms and tactical gear, community service providers, medications, as well as inmate money management and video visitation providers.

In addition to retirement and vendor payment concerns, the state's financial crisis has also contributed to the conditions of plant maintenance and inmate housing, including plumbing, roofing, temperature control, and pest control. The facilities are old, and the structural conditions are in need of significant repair based on our observations and feedback from staff. Disrepair can contribute to unsanitary conditions, lack of personal wellness, and overall feelings of devaluation that can cause inmates and staff to act out and jeopardize safety and security. In addition, when the temperature outside gets hot, facilities have to use large fans to cool the housing units, which are loud and create situations where staff report they can miss important radio calls or alerts of inmates in distress. Staff report that the heat also creates situations where inmates may choose to remove articles of clothing for comfort. This combination of disorder will be addressed under PREA implications.

Limited Consequences for Filing False Reports

Illinois currently does not file charges against inmates who report allegations of sexual misconduct against staff or other inmates that are determined to be unfounded. There are limited consequences to inmates who make confirmed false allegations. Some states have had a great deal of success in enacting disciplinary actions when allegations are proven false—not unsubstantiated—rather than filing charges. TMG and PRC can provide suggested state resources for consideration.

Logan Correctional Center Observations and Recommendations

Logan CC is an adult women's facility in Lincoln, Illinois, with a capacity of 2,284, and a current population of 1,657. It was originally constructed in 1920 as a mental health facility. In 1978, in was converted into an adult correctional facility for men. In 2013, it was repurposed as a women's facility and in one day the male inmates were transported out and the women were brought in. The facility encompasses 150 acres with 57 acres enclosed by fencing. Logan CC serves a multifaceted population consisting of reception and classification, segregation, protective custody and mental health units, as well as a state-of-the-art medical facility designated to provide care to pregnant and critically or terminally ill woman inmates. Logan CC participated in and passed a PREA audit in 2016.

Leadership and Facility Culture

At the time of the assessment. it was reported that Logan CC has had seven wardens in the last eight years. In the last year, the administrative team has doubled in size, adding three new associate warden positions. Staff are unclear regarding the purpose of the additional facility management positions. Some staff reported that under previous leadership the facility operated with a "kinder and gentler" form of corrections and yet others perceived that the past administration was reluctant to address intimate relationships among the population, which undermined safety, as well as staff authority, from their perspective.

An important strength to note at Logan CC is the strong sense of community and camaraderie among staff. Many staff work well together and support one another. The consultants were impressed with observed staff interactions and noted a strong relationship with the mental health administrator and the custody leadership and supervisors. Most Logan staff stated that there is a family-type atmosphere among each other, as well as with supervisory staff. Many staff feel that things are improving at the facility and have a sense that the new administrative team in place at the time of the assessment will make changes that will support both the staff and inmates.

The National Institute of Corrections defines an institution's culture as "the values, assumptions, and beliefs people hold that drive the way the institution functions and the way people think and behave." It is reflected in such things as the institution's mission, vision, policies, procedures, and rituals, and it is often what unites an institution. It also refers to underlying assumptions, and expectations, which characterize the institution. The facility's culture affects the way staff and inmates think, feel, and behave. All facilities have formal and informal cultures. For instance, a published organizational chart is formal. How decisions are made may have an informal process that is found in who really influences decisions that may not be organizationally in the decision process. It is founded on what individuals perceive as factual or true. Default or informal cultures can emerge in the absence of a strong formal culture, or when the formal culture fails to meet the needs of the staff and inmates by placing unrealistic or untenable mandates. While all organizations have some informal culture, morale and effectiveness can decline if organizational disorder is allowed to occur. While not a full cultural assessment the trends below were noted in this technical assistance initiative. These trends and influencing factors are critical in understanding root causes of the cultural norms of the facility and the reporting culture.

Women, Relationships, and Concerns for Creating Sexual Safety
Based on the document review coupled with staff and inmate statements both inmates and staff reported awareness of active sexual behavior. Many of the PREA incident reports indicated that inmates acknowledged consensual sexual behavior.

It "is difficult to determine if sexual activity among women is consensual or coerced, in part because of the history of relationship trauma."[2] Women do heal from engaging in supportive relationships and this can be misunderstood and assumed to be sexual in nature when in fact it is a close emotional bond but not particularly sexual. However, under PREA all sexual activity must be investigated even if it appears consensual. In one study, over 71 percent of woman inmates believed that sexual relationships were based on manipulation rather than genuine attraction or affection. Motivations for such relationships included economic manipulation, loneliness, curiosity, peer pressure, sexual release, and diversion from boredom.[3] It is only recently that experts in gender-responsive practice and practitioners have raised concerns about the parallel of some relationships in women's facilities to a mirroring of domestic violence in some prison "family" structures.[4]

In the implementation of PREA the standards address working with various populations. The employee training requirements address the importance of training staff on sexual safety specific to the population staff serve. Understanding the dynamics of women and their relationships is a useful approach to enhance in training offerings to all staff. Logan staff have had the opportunity to attend a number of various gender-responsive training events. A review of training offerings as the material relates to sexual safety is warranted however.

Consistency, Policy Implementation and Supervisory Practice
As noted, the rapid change of administration both for the department and the facility is an influencing factor in shaping the culture at Logan. The facility's policies, procedures, and post orders govern how the facility operates but leadership and supervisory approaches impact implementation of policy. Additionally, staff and inmates perceive that practices often change without a supporting policy or procedure. Staff are concerned that practices change randomly and often during or after facility management team tours, impacting supervisors' authority and facility consistency.

Understanding of the Population and Creating a Gender-responsive Model of Correctional Practice
Implementing and sustaining a well-run facility for women is often misunderstood as correctional staff are asked to recognize the differences in responding to a population that is so much smaller than the larger male population. Through the years, many correctional agencies have made strides to work effectively with women based on research and the experience of dedicated staff and stakeholders. Often that success is tied to internal and external advocates for the women. One of the greatest barriers to working effectively with women is debunking the myth that responding to women through a gender-specific lens means being soft or "coddling" women. A research-based approach to working with the women's population recognizes that responding to women's needs is no different than acknowledging the differences of any population and its characteristics. There is ample research-based practice to support operations and programming that result in positive outcomes for women specifically to their presenting needs. This approach further supports staff effectiveness and engagement in our experience.

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[2] National Institute of Corrections. *Safety Matters: Managing Relationships in Women's Facilities*. Washington, DC.
[3] Greer, K. R. 2000. *The Changing Nature of Interpersonal Relationships in a Women's Prison. The* Prison Journal, 80. 442-468,
[4] National Institute of Corrections. *Safety Matters: Managing Relationships in Women's Facilities.* Washington, DC.

Historically the IL DOC has had strong advocacy within and external to the department in addressing this population. At the time of the assessment the agency level position with policy responsibility for family and women's services was filled through a contractual position. The individual in the position was retiring and an update on the department's status in the management structure of this position has been requested. In our experience this is a crucial management position for any correctional state level agency.

Recent Gender-responsive Initiatives

There are a number of initiatives over the last few years that demonstrate the agency and facility efforts to build a gender-responsive model of service to the population at Logan. Strides have been made in facility-based training, attending the National Institute of Corrections (NIC)-related offerings, and working with experts in gender-responsive practice. Non-custody staff responsible for programming show an impressive interest in working effectively with the women in addressing their needs. Additionally, the agency has a position to provide a resource and programmatic oversight for services for women; however, at the time of the assessment, this position was soon to be vacant due to a retirement.

Grounding Gender-responsive Practice and Staffing

The lack of a transition process to include staff training, population orientation, and a review of gender-responsive operational practice when Logan became a facility that housed women may be one of the crucial root causes of current challenges to gender-responsive best practice. For instance, the current staffing remains very over represented with male correctional line staff, which most experts would say is uncommon for a women's facility.

It is clear that many facility mission changes are undertaken due to pressure and are urgent, resulting in a dearth of planning for successful transition.

Some gender-responsive experts recommend that the male to female staff ratio in women's facilities approximate 40 percent male and 60 percent female. It is important to note, however, that in our view having both professional and respectful male and female staff in the facility is vitally important to provide appropriate role models and replicate the experience women will have in the community. The recommended ratio does not diminish the role of male staff, rather accounts for same gender staff availability to address sensitive issues and adequately provide same sex supervision to ensure appropriate privacy during sensitive times. At the time of the assessment, Logan had a high overrepresentation of male line staff. The Logan staffing model we understand is impacted by numerous issues including union guidelines. The ability to address this issue, however, is an important consideration in the overall development of a gender-responsive model of correctional practice.

Transgender Population

At the time of the assessment, a major impact on the culture of the facility was the introduction of two transgender females into the facility. It appeared that little to no prework was done to manage staff and inmate's readiness to support the new practice. A myriad of staff expressed an irritation with the decision and felt as though the transgender inmates were "gaming the system" to be moved to different facilities in the state. Many woman inmates complained that the transgender inmates would be moving into the general population living units, which reportedly makes the woman inmates uncomfortable. This lack of planning or implementation activity can increase the disorder and impact a misuse of PREA as an emotional weapon for allegations.

In the case of transgender individuals housed in women's facilities, there is evolving correctional law and operational practice. While the PREA standards provide guidance and requirements in assessing housing and a case-by-case safety approach, many systems are not prepared with clear policy direction, staff training, and inmate orientation to support the needs of transgender individuals. A lack of preparation of the staff and inmate population in receiving transgender

individuals into the population is a common and unfortunate mistake. In prison environments that are not grounded in gender-responsive principles, it is less likely that the transgender community will be understood.[5]

Recommendations

1. Through the support and clinical guidance of mental health leadership explore the current training and supervisory guidance in addressing accountability for SMI designated inmates.

2. Coordinate efforts and revisit the work on inmate discipline from the NIC program attended to determine current understanding of effective strategies to address inmate discipline in women's facilities.

3. Engage key staff in reviewing the restrictive housing policy and the patterns of decisions in the use or non-use of restrictive housing. "Cross-walk" this review with the guidance from the related U.S. Department of Justice Guiding Principles and the requirements of *Rasho V. Baldwin*. Identify and/or clarify the guidance from clinical leadership.

4. Review opportunities to design scenario-based training for first line supervisors consistent with safety, security, and clinical considerations in the response to PREA allegations.

5. Consider developing "myths" handout regarding the restrictions or misconceptions of the settlement agreement.

6. Consider developing "myths" handout regarding the implementation of PREA and sexual safety practices.

7. Review available data to verify the increase in the use of the SMI designation and explore avenues to strengthen communication to supervisors and line staff in supporting strategies to assure accountability of behavior where indicated.

8. Include a review of the trends in the SMI population and PREA allegations with the PREA review team and ensure a clarification of interpretation of SMI requirements under the *Rasho V. Baldwin* settlement.

9. Develop an agency-level strategic plan for the department's response to the female population. (TMG can provide state examples.)

10. Consider a facility executive team leadership development initiative to anchor facility goals and alignment with best practices to include programmatic, operational and clinical practices. This model would contribute to the commitment and sustainability of best practice in women's facilities. We recommend this as a two-part, two-day facilitated event. With the constant change of leadership at Logan this model of team building is recommended as one we have implemented in similar scenarios as facility leadership strives to build a gender responsive facility culture throughout the organization. This short term but useful strategy contributes to order and sexual safety.

11. Through the support of the PREA Resource Center and its partners identify and review practices in state correctional jurisdictions regarding their response strategies to verified false allegations.

[5] Testimony of Anadora Moss to the United States Civil Rights Commission on Women in Prison: Seeking Justice Behind Bars.

12. An update on the implementation of various training initiatives at Logan and the review of current material and design elements is recommended for quality assurance and fidelity of the training objectives.

13. Explore the purpose of team tours and review the practices and expectation of team members.

14. Ensure the current PREA Compliance Manager (PCM) has the capacity, time, and resources necessary to do the work.

15. Establish a routine schedule for PREA review team meetings with clear team objectives and goals and ensure commitment to this work by all team members.

16. Create a written process for living unit staff to communicate between shifts regarding mediation agreements made between inmates on other shifts. This documentation should also be made available to investigators.

17. Update annual refresher training to ensure it clearly indicates the protections of PREA, such as which allegations fit the definition of PREA, appropriate use of language, statistical breakdowns, and resources for staff.

18. Ensure that the retaliation monitor is provided the names of inmates and staff who report or cooperate with a PREA investigation in addition to the alleged victim so that incidents of retaliation can be monitored pursuant to PREA requirements.

19. Continue the central office management structure for an identified senior position for family and women services oversight and support.

20. Review current staffing rosters and explore feasibility of addressing the staff ratios understanding the parameters and concerns of the union and other stakeholders. Revisit the criteria and expectations of the PREA standards and issues of cross gender supervision and privacy.

21. Immediately review current practice in addressing the transgender population in reviewing each individual case consistent with PREA standards and promising practice in operational, clinical and operational considerations. The National PREA Resource Center can provide additional guidance and experts as resources.

22. Immediately review staff and supervisory training in working with transgender individuals. Additional guidance available through PRC.

23. Immediately review inmate orientation and avenues to prepare the population for respectfully responding to transgender individuals. Guidance available through PRC partners, including TMG.

Prison Rape Elimination Act: Implementation at Logan Correctional Center

The department has in place Administrative Directive 04.03.301 Sexual Abuse and Harassment Prevention Program, as well as a program manual for additional guidance toward implementing its zero-tolerance policy. Throughout the facility, staff at Logan CC were knowledgeable about PREA, its purpose, and their role in ensuring sexual safety. Staff reported receiving training on the requirements of PREA and were informed and comfortable responding to reports of sexual abuse and sexual harassment.

The current implementation of the PREA policy and procedures, while consistent with PREA standards as noted earlier appears to have also created unintended consequences in the reporting culture of the facility. Staff feel, and our team verified through document review and onsite observations, that PREA can be a vehicle for the population to manage a variety of aspects of facility "life." Specifically, staff and inmates report that PREA provides a tool to either gain an audience with administrative staff or used to work through or around practices that are intended to bring facility order and response to the population. This is most evident in reviewing inmate grievances, disciplinary processes, or inmate requests. This is true in both facilities assessed though the dynamics are different within the male and female populations

Many staff feel that the unintended consequences embedded in PREA implementation have created an effective tool to remove staff who attempt to enforce institutional or agency rules or relocate inmates who threaten a relationship or who interfere in one. The input we received from the population indicated a mixed sentiment in the degree to which the population "played" the system and the realities of how safe they felt in the environment. Many women acknowledged that PREA reporting is problematic as it is a tool to gain a solution to other operational or facility issues as indicated above. We suggest the research of Dr. Allen Beck at the U.S. Department of Justice, Bureau of Statistics suggesting that facility disorder and a lack of trust creates a heightened vulnerability to creating a healthy reporting culture. For instance, from the mission change of the facility, the multiple changes of administration, the mental health settlement, the severe budget constraints, limited programming space, and the management of the housing units with limited staff supervision all add to the disorder of the facility. Disorder erodes trust. Trust erodes reporting.

The following section documents specific observations regarding PREA implementation, followed by recommendations:

PREA Compliance Manager
It appears that a contributing factor in inconsistent application of PREA policy is due to the PREA Compliance Manager (PCM) being changed frequently; more specifically, four PCMs in two years. On a positive note, staff appear excited with the choice of the new PCM. The past PCM began the process of organizing the facility's PREA response and reporting and the new PCM has hit the ground running, which is encouraging.

PREA Review Team
Staff involved in the PREA review team have all commented that the constant change in review team staff has led to inconsistencies in how PREA policy is applied and how discipline is given. Names of victims and reporters are given to the retaliation monitor by the PCM or the investigative supervisor and this exchange of information is not always timely. A lack of PREA

review team meetings causes doubt that the appropriate information is being shared, which may hinder all team members' ability to complete their tasks.

Peer Mediation

Inmates do not have an opportunity for peer mediation; therefore, using PREA is often the only way to get a room change. Many staff and inmates stated that they believe many inmate allegations are made in an effort to remove a roommate or to be moved closer to another friend. Some staff stated that they try to mediate between roommates but, when a new shift starts, there is no consistency or documentation of the mediation and behaviors return.

Misperceptions of PREA

Another challenge, which is consistently reported across the country, is the notion that PREA and other mandates provide more protections to inmates than to staff. Some staff don't understand why they are not more protected by PREA, which indicates among other challenges a lack of trust in the investigative process. Some staff believe inmates should be charged or disciplined for a PREA violation; for instance, when an inmate intentionally exposes him or herself to staff, the inmate should be charged with exposure. Sexually inappropriate behavior may be directed at staff, but it does not fall under the purpose of PREA. Staff need to be reminded what behaviors are covered under the PREA standards. If inmates are exposing themselves to staff, they should be held accountable for public exposure through the general disciplinary procedures.

Staff and inmates also tend to refer to PREA as a verb with phases such as "I was PREA'd" or "I want to report a PREA." When this terminology is used, it can be dismissive of the seriousness of sexual abuse and sexual harassment. It allows the inmates and staff to be less connected to the actual purpose of PREA. This practice also contributes to the confusion and excessive allegations when inmates or staff use this terminology and misrepresent behaviors that would otherwise not rise to the level of sexually abusive or harassing behavior.

Retaliation Monitoring

Staff stated that witness or reporter retaliation monitoring is not being done. The retaliation monitor acknowledged that this task is not currently required by facility administration. The retaliation monitor only monitors inmates whose names are provided by investigations staff and these have been the names of alleged victims only.

Pursuant to PREA Standard §115.67, protections against retaliation extend beyond the victim and include the reporter, which may not be the victim, and anyone who cooperates with the investigation, including witnesses. ILDOC Administrative Directive 04.01.301 (p. 12) II G 9a, outlines the agency retaliation process and it covers inmates who report; as per PREA standard, the reporter does not need to be the victim. All inmate and staff reporters shall be checked for possible retaliation for 90 days.

As with most members of Logan's PREA team, the Retaliation Monitor is new to the team. This staff member has a variety of tasks in the job description with retaliation being one of many. All team members acknowledged that the team needs to meet more consistently to discuss roles and tasks. All team members need to have access to applicable investigative information in order to complete their assigned PREA duties.

Physical Plant

Portions of the facility are in a state of major disrepair. Plumbing is not working in many areas, leading to units being closed, showers not working, faucets running for days without repair; paint is needed; and some ceilings are falling. Staff report having aa difficult time taking pride in their place of work due to the state it is in. When employees don't feel supported by their employer, it is hard to show inmates that they care. Some inmates believe that they have been locked up and forgotten

due to their living conditions. Many staff did acknowledge that they know the state of Illinois is in a financial crisis. Administration staff acknowledged that repairs have been slow due to funding and a recent loss of maintenance staff.

Inmate Movement

Logan CC lacks fundamental gender-responsive operational prison practices and security standards. Both staff and inmates commented that boundaries between staff and inmates are lax. Operational practice for yard movement lacks basic order. While it is a fundamental reality that women thrive on relationships, the avenues for more positive outlets rather than negative cross - group banter during movement need strengthening. Basic facility order will reassure staff and the women that safety is increased.

Except for the intake and the restrictive housing units, most of the living units are multi-bed dorm style housing. There are three locked wings, two wings housing 66 inmates and one wing housing 24 inmates. Although the staffing plan calls for two officers during the 1st and 2nd shifts, often there is only one staff seated at a desk near the unit's main entry. Despite the fact the officer conducts staggered 30-minute checks, this rotation leads to female inmates often being left unsupervised.

When the women enter the housing unit, they surround the unit staff, asking questions and commenting all at once in front of the desk. This prevents the officer from seeing what is happening in other areas of the unit or the lobby. Adding lines around the staff desk will help to prevent inmates from crowding the desk or sitting on the desk. Lines, or painted footprints, should also be added in the phone area to give inmates privacy when talking to family, attorneys, or making a PREA call. These guidelines are not to be punitive but to assist in creating order that will contribute to women and the staff feeling greater safety.

Classification

Despite the fact only 1.5 percent of the inmates at Logan CC are classified as maximum security, the staff note that maximum security inmates are housed throughout the institution with lower security inmates. They point to a rise in staff and inmate assaults to support this assertion. Many of the woman inmates reported that the open housing of inmates with varying custody levels adds to the chaos and low-level inmates are being intimidated or learning new criminogenic behaviors from the higher-custody inmates.

Currently inmates of all custody levels, not housed in a control living unit, are mixed together in housing that does not offer a large variety of programming. Staff believe if the higher custody inmates were housed together, the fighting, sexual pressure and bullying would decrease. Administration stated that staff believe there is a high number of maximum custody inmates causing issues, however, as noted above, this belief is not substantiated.

Communication: Disrespectful Language and Safety[6]

It was reported by staff and inmates that communication between staff and inmates and sometimes between staff is very disrespectful. It was reported that staff routinely refer to women using derogatory terms. One of the biggest inmate complaints about staff is the way they say staff talk to them. Supervisors have acknowledged that many new staff are very disrespectful in their dialogue with inmates and their perception is that no one holds staff accountable. The administrative team articulated that it does not doubt the inmates' complaints are true and struggle with steps to hold line staff accountable. Our team observed, and staff and inmates reported, instances of inmates and staff members yelling at each other.

[6] National Institute of Corrections. *Safety Matters: Managing Relationships in Women's Facilities*. Washington, DC.

Select staff at Logan CC participated in an NIC program titled *Safety Matters: Managing Relationships in Women's Facilities* that focuses on effective communication skills for staff to address the complexities of managing relationships in female institutions. As part of this program, some staff were trained as trainers of this curriculum to enhance sustainability of concepts and skills to support staff and enhance safety within the facility. It is unclear if this training has been introduced to staff.

Other NIC and consultant assistance has occurred in the last few years. Staff attended the NIC program on a gender-responsive disciplinary model in women's prisons, NIC's case management model was introduced in the last year, and the training department has worked with a consultant model of communication that has been delivered to a number of staff.

Mental Health—Crisis Status

Many staff believe that the agency does not have any way to hold offenders accountable for false PREA claims; staff believe this is due to the new rules for the use of segregation. Inmates call for a "crisis" when heading to segregation and staff believe this prohibits any discipline. "False reporting" is a 300 series ticket and if an inmate is defined as seriously mentally ill, 300 tickets are dismissed. We acknowledge the reality that SMI inmates must be understood in light of clinical dynamics in any reporting process.

While our team did not conduct a clinical review, our onsite work included the opportunity to meet with the clinical director and clinical staff. We recommend a deeper review of the clinical response to "crisis" status. It would appear that an inmate requesting "crisis" assistance should not immediately be considered to be SMI and incapable of understanding or being accountable for the behavior prior to the "crisis." An individual review should determine if the inmate knew what they were doing when they violated a rule to include filing false (not unsubstantiated) PREA claims with appropriate discipline to follow. While we were impressed with the clinical leadership there may be some inconsistency among staff in the interpretation of reporting practice related to "crisis" status.

PREA Allegations and Addressing Myths

A common challenge with an influx of allegations that are unsubstantiated yet often perceived as false allegations is the tendency for staff to stop taking allegations seriously over a period of time. However, it is important to note that staff reported that all allegations are taken seriously and handled accordingly, and this sentiment was expressed throughout the facility, which is a strength to the facility and the importance of sexual safety.

One strong opinion a number of experienced staff shared is that they do have knowledge of the population and effective communication strategies, which is critical to a healthy reporting environment. There was an interest in continuing and expanding staff training for less experienced staff working with the women so that unintended conflict in interpersonal interactions could be avoided or minimized. For instance, the staff had good things to say about some of the initiatives related to gender-responsive models of communication, disciplinary practice, etc. but conveyed they weren't sure if the strategies are as available to some of the staff who most need it.

Day Room Restriction

Inmates also misuse the discipline process and commit minor infractions to be placed on day-room restriction status. When inmates are on this restriction, they are given additional access to the phones. This practice should be revisited to eliminate perceivable incentives to being on restriction and to misuse PREA.

Investigations
Staff working in the investigative unit are new to the unit and appear to be taking their new jobs very seriously. Facility staff are hopeful that this new team is effective.

Confidentiality
Staff and inmates reported that the rumor mill at Logan is strong, but of course not always accurate, which is problematic when misinformation is circulating, and decisions or repercussions are perceived as lenient or unjust. Inmates do not feel that their reports are confidential. It was reported to our team that staff talk about reports in front of other inmates and send victims to investigations in front of other inmates. All of which is in violation of confidentiality and this leads to inmates not wanting to come forward to report or to be a witness. The investigation process is hindered when inmates are not willing to come forward. Confidentiality practices are paramount for protecting the integrity of operational systems within the institution. When inmates know that information will not be protected, they are less likely to file reports of sexual abuse or sexual harassment. Inmates should also be made aware of the limits to confidentiality.

Inmate Discipline
As commonly found in female facilities, Logan CC has excessive numbers of disciplinary reports. The facility has had 7,500 disciplinary reports in 2018 and 1,900 disciplinary reports as of April 2019. Most of those disciplinary reports are for insolence, such as refusing a direct order, and assault.

Some staff at Logan CC appear not to know how to administer discipline. The recourse, therefore, is to either resort to yelling or to manage via disciplinary reports. An assault on staff has included a simple brush against a staff member to, in one case, droplets of water from an inmate's cup hitting an officer's uniform. As a result of some staff over-using or misusing disciplinary reports, administration and disciplinary hearing staff often find themselves dismissing or downgrading disciplinary reports. When this occurs, the consequences are two-fold: one, staff are then left feeling unsupported by the administration and, two, the population may become empowered and less likely to adhere to staff member instructions.

Staffing
Although having an administrative presence in the facility is beneficial, supervisors and managers do not have enough decision-making power to be effective daily. Inmates are aware of this and use it to their advantage. Inmates said they can go directly to the warden to have discipline changed and staff complained about this issue. In addition, ranking shift supervisors are not authorized to approve bed movements—all bed requests have to be approved by administration. This dynamic further exemplifies the perceived powerlessness of staff, encourages inmates to circumvent and be non-compliant with security staff, and is concerning to staff who interact more with the inmates and feel the administration is making decisions with partial or inaccurate information. Again, this is a contributing factor to facility disorder and lack of trust in both the population and the staff.

Recommendations

1. Create and share with staff a list of capital improvement requests and plans to help build support for the facility and it mission. A culture of safety includes the confidence that the environment is conducive to basic human dignity.

2. Enhance operational practice during inmate movement in and out of the living units and throughout the facility.

3. Add boundary lines on the floor in the housing units—around the staff desk and inmate phones.

4. Create a working group to address staff and inmate safety concerns and strengthen positive outcomes for the population and the staff, particularly in creating sexual safety and the benefits of a gender-responsive implementation of PREA.

5. Develop an inmate orientation program enhanced by creating a video made by the women to increase their investment in sexual safety and an understanding of PREA as a tool for safety.

6. The PCM should meet with his facility team to educate them on the responsibilities they each are assigned.

7. Consider creating an inmate advisory council per housing unit where inmates can channel information to address concerns and to communicate with staff.

8. Ensure all staff are trained on and understand the importance of professional boundaries on safety, de-escalation strategies, and effective communication skills.

9. Review the status of outcomes from initiatives implemented through NIC and other resources to determine the level of implementation; the strengths and the barriers to supporting the staff in creating a stronger model in responding to women, the staff, and PREA implementation.

10. Include the population in being part of the solution. Several successful strategies nationally that have supported the population's involvement in addressing false allegations have been the following:

    - Staff training to include scenario-based examples of addressing operational practices with a trauma-informed approach. This requires all staff being trained in how operational practice and being trauma and gender informed work as a model of success—not as separate initiatives. Often the implementation of a trauma-informed approach is lacking the integration of what it really means in correctional operational practice.
    - Inmate involvement in trauma-informed, gender-responsive programming that addresses healthy relationships and personal boundaries
    - Inmate involvement in developing orientation materials and participating in peer education regarding sexual safety in the facility
    - Inmate advisory groups or dorm representation to meet with administration to participate in operational solutions
    - Increased access to individual or group treatment or psychoeducational groups
    - Strong presence of external stakeholder and non-profit organizations

11. Revisit policies on phone access to ensure inmates don't have to be sanctioned to use the phone.

12. Ensure that all investigative staff have taken specialized PREA Investigative training that is both gender and trauma informed.

13. Ensure staff understand the importance of confidentiality and enforce confidential matters to be handled appropriately.

14. In an effort to reduce the number of disciplinary reports, there should be a continuity of the work started with the NIC model of disciplinary practice in women's facilities.

15. Provide additional training for staff on the appropriate use of the disciplinary system.

16. Review any action taken as a result of the NIC team attendance and subsequent work with former facility administration.

17. In order to minimize the belief that disciplinary reports are arbitrarily dismissed, an informational sheet should be provided to staff indicating the reasons for the dismissal or downgrading of a disciplinary report.

18. Consider reviewing and revising the decision-making authority of key personnel.

19. Consider targeted training for first line supervisors with emphasis on the expectations of their supervisory role.

Summary Statement

The Logan CC is a facility where the staff and the population have experienced many challenges since the transitioning of the facility from a male population to one housing and responding to women. Significant efforts to become a well-established gender-responsive facility based on policy, staff training, and services for the female offender population have been met with uneven results due to many competing issues to include a severe lack of continuity of leadership on both the facility and agency level.

While the challenges raised in this report are focused on the factors that are underlying the "reporting culture" specific to allegations of sexual safety and the implementation of the Prison Rape Elimination Act, the influencing factors or "drivers "of reporting trends are systemic. That is the barriers or influencing factors that determine the level of success in creating cultures of safety cannot be separated from the day-to-day operations of the facility generally. Our work draws on the research of the U.S. Department of the Bureau of Justice Statistics (BJS) that stresses the importance of facility characteristics that either represent order or disorder. A lack of order (grievances, disciplinary practice, opportunities for programming, etc.) results in a lack of trust within the facility and a poor response to creating a culture of safety and healthy reporting practices. Conversely, we suggest that staff training, operational practice and inmate programming and services that meet the needs and cultural realities of the population create a healthy reporting environment.

In our research and through our federal partnerships, the TMG team of consultants is aware of a number of initiatives that have recently been undertaken by the department to address the implementation of gender-responsive practice at Logan CC. Each of these initiatives at best are building blocks in shaping a culture of safety at Logan CC. We commend the department for participating in these initiatives and urge a review of the status of related action steps.

Most significantly, this facility was reviewed very comprehensively through federal funding in October 2016 to develop a baseline for the development of a three-year strategic plan to address the implementation and sustainability of a gender-responsive approach at Logan and throughout the system. A team of 18 consultants trained in the National Institute of Correction's *Gender Informed Practice Assessment (GIPA)* completed a facility-specific report that documents 12 domains of gender-responsive policy and practice. The data collection accomplished for GIPA informed our work, as well as a separate TMG document review of material.

The GIPA report documents key findings and recommendations after an extensive review of documentation, onsite work on all shifts, and a research-based overview of best practice.

Members of the TMG team are familiar with and have contributed to the NIC GIPA model nationally and strongly suggest that the framework of these recommendations continue to guide the agency. TMG's team's recommendations are not in conflict with the work of the GIPA team. Our task was specific to understanding the "reporting culture" related to PREA allegations and the GIPA confirms much of our documentation of influencing factors that create barriers to reporting, as well as impacting misguided use of the reporting process under PREA.

Other initiatives in recent years have included additional support from the National Institute of Corrections, the National Resource Center of Justice Involved Women (GIPA funding), and various national expert consultations and trainings.

An impressive cadre of external stakeholders committed to justice-involved women within the state have influenced legislation, policy, and initiatives to reduce incarceration and to raise the voices of women with lived experience. (Women's Justice Institute and the Statewide Women's Justice Task Force – see press release of June 5, 2019, "McLean County Statewide Women's Justice Task Force Listening Session on Reducing Illinois Women's Prison Population by 50%.")

The interest in supporting women involved in the criminal justice system is impressive in the state of Illinois and a hallmark of collaborative efforts within the community of reform-minded individuals and organizations. The ability to respond to and benefit from the external stakeholders will require the agency to strengthen the management structure and the leadership continuity within the Family and Women's Services Division, as well as the Logan CC facility management team.

TMG's approach to the need for systemic strategic planning outlined in the GIPA and this report would suggest more opportunities to involve every level of staff in the change process. For instance, the GIPPA report suggest that two separate cultures exist at the facility—security and non-security. We do not disagree that the predominant philosophies may be one of being gender responsive/trauma informed and one of an "inmate is an inmate." Our view, however, of culture change initiatives and the opportunity to enhance cultures of safety that are gender responsive would suggest multiple subcultures that include the culture within the population of women at Logan CC. We warn against a binary definition of the facility culture and suggest thoughtful engagement of various levels of staff, as well as strategies to involve the women in creating safety, including sexual safety of the facility. A very successful strategy in some systems in addressing safety for the women has been the development of an orientation video that can be a very engaging project that the women design and develop under staff supervision to implement a peer facilitation component to orientation. In our work, we did not verify if peer trainers are used in inmate orientation at Logan CC, but we do highly recommend that the population be involved in communicating the values of a "reporting culture" that encourages the importance of reporting abuse and contributing to safety.

If the effective use of the PREA reporting process is to provide for sexual safety and not be used for other operational concerns of the population, then far greater credibility in the grievance process and the day-to-day operations of the facility, to include housing assignments, use of segregation, response to the SMI population, and "crises" reports, must continue to improve.

Idleness of the population and the limitations of available programming further contribute to escalation of incidents that frustrate the women and contribute to the need to find some avenue to gain response from staff. This is often how PREA becomes involved in the "mix" of disorder within the facility.

Finally, in a recent conversation with the newly appointed commissioner our team was assured of his commitment to build a sustainable approach to the department's strategic goals in focusing on

positive outcomes for women in the system, particularly with a focus on reentry. We recognize that much work has been done in Illinois to address the issues of justice-involved women. Given this combination of external and internal commitment to improving practice at Logan CC that is characterized by a gender-responsive and trauma-informed approach, we have confidence that more focus on the implementation of practice will be forthcoming. Vacancies in the management structure of the chain of command for the facilities should receive an urgent focus and resolve.

Until the significant issues raised by multiple reports gain momentum with a strategic plan and a departmental management structure, the remedies for safety at Logan CC, to include the patterns of reporting under the Prison Rape Elimination Act, will lack grounding, sustainable change, and credibility.

Finally, we recommend that the National PREA Resource Center consider funding to immediately develop an inmate orientation project to engage the population in developing value in the reporting practices and the safety of women entering the system. Because of the robust initiatives that have been identified, the challenges and strengths of Logan CC, and because the state has developed legislation and recommendations for the management of women's services, we believe the partnership of the National PREA Resource Center is an important part of a larger systemic plan for positive outcomes of the women's services system in Illinois. The PRC support in this technical assistance event, we believe, has been important, as the implementation of PREA and the understanding of the "reporting culture" ensuring sexual safety specifically is not a focus of the GIPA. We urge this report supplement the plans to build a strategic plan for the agency response to justice-involved women.

Appendix A: Document Request List

IL DOC Targeted and Cultural Assessment Document Request

The following items will assist The Moss Group consulting team in preparation for the onsite targeted assessment regarding PREA sexual abuse and sexual harassment allegations and the cultural undertones and implications of the potential misuse of reporting mechanisms.

Please send the following materials electronically by Monday, April 1, 2019.

Agency-level Documents:

1. Agency vision, mission, and value statements

2. The agency code of conduct or code of ethics and any other agency guiding principles

3. Formal written guidance informing facility operations that would support implementation or sustainment of PREA standards or gender-responsive practice addressing the following topics:
    a. PREA, including zero-tolerance
    b. Sexual harassment
    c. Gender-specific practice, such as cross-gender supervision, cross-gender searches, and safety for LGBTI inmates
    d. Searches, including clothed searches, unclothed searches, and room searches
    e. Staffing to include gender-specific posts or tasks
    f. Investigations
    g. Retaliation monitoring procedures
    h. Employee discipline procedures
    i. Employee grievance procedures
    j. Inmate discipline and sanctions
    k. Inmate grievance processes
    l. Medical and mental health

4. Organizational chart for agency administration, including both position titles and names of individuals assigned to each key position

5. Overview of current data collection methodology and reporting mechanisms (including phone numbers, addresses, third party mechanisms, etc.), as it relates to reporting of sexual abuse and sexual harassment, current analysis of the data collected, and any training (including training plans and/or curricula) provided to supervisory staff on the use of the data

6. Curriculum for the PREA specialized investigations training and the PREA specialized medical and mental health training

7. Major incidents or lawsuits related to sexual abuse/sexual safety/PREA, as well as any claims or settlements from the past five years.

Facility Document Request

The following items will assist The Moss Group consulting team in preparation for the onsite targeted assessment regarding PREA sexual abuse and sexual harassment allegations and the cultural undertones and implications of the potential misuse of reporting mechanisms. Please send the following materials electronically by April 1, 2019.

1. Facility specific vision, mission, and value statements
2. Copies of memorandums from leadership communicating about PREA, safety, or gender-responsive practice to facility staff and stakeholders
3. Organizational chart for the facility, including both position titles and names of individuals assigned to each key position (e.g., management team, department heads, etc.), including lines of supervision.
4. Current facility staffing plan
5. Facility schema or map, including footprints of buildings and housing units identified. This can be provided onsite if preferred.
6. Incident reports related to sexual abuse and sexual harassment of inmates over the past 12 months. Please indicate any incidents that were referred for criminal prosecution
7. Disciplinary reports for inmates related to sexual abuse or sexual harassment over the past 12 months, including a breakdown summary for, at least, the last 3-6 months listing: inmate, charge, finding sanction (if any), staff, and shift written.
8. Staff disciplinary reports related to PREA issues from the past 12 months.
9. Employee grievances related to sexual abuse over the past 12 months
10. Inmate grievances related to sexual abuse or sexual harassment over the past 12 months, including bed change and move requests.
11. Investigation reports related to sexual abuse or sexual harassment from the past 12 months
12. Retaliation monitoring reports from the past 12 months
13. Internal audits or quality assurance reports conducted by internal staff related to PREA allegations and investigative findings from the past 12 months
14. Facility staff shift rosters for the dates of the assessment. Preferably, in a format that includes demographic information, such as name, position title, gender, race, age, and—if possible—years of service at the facility. (Used to randomly select staff focus groups.)
15. List of inmates in the facility listing, at minimum, housing location, length of sentence, and indication of any known transgender or intersex inmates as well as any youthful inmates. (Used to randomly select inmates for discussion groups. Does not need to be provided in advance.)

EXHIBIT 22

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS
EAST ST. LOUIS DIVISION

JANIAH MONROE, MARILYN MELENDEZ, EBONY STAMPS, LYDIA HELENA VISION, SORA KUYKENDALL, and SASHA REED,

Plaintiffs,

vs.) NO. 18-156-NJR

JOHN BALDWIN, MELVIN HINTON, and STEVE MEEKS,

Defendants.

DISCOVERY DEPOSITION OF DR. RANDI ETTNER

TUESDAY, OCTOBER 13, 2020
9:00 A.M.

Via Webex

INDEX

(No exhibits marked.)

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IT IS HEREBY STIPULATED AND AGREED by and between Counsel for the Plaintiffs and Counsel for the Defendants that this deposition may be taken in shorthand by JOYCE D. LAWRENCE, an Illinois Certified Shorthand Reporter, and afterwards transcribed into typewriting, and the signature of the Witness is RESERVED.

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(Deposition commenced at 9:02 a.m.)

DR. RANDI ETTNER,

called as a witness, being first duly sworn, was examined and testified as follows:

EXAMINATION

BY MS. COOK

Q. Okay. And Dr. Ettner, since this is remote, I know you've done depositions before, but if you have any problems hearing me, please let me know. And if you at any point need to take a break, just let me know. I'll ask that you finish whatever we're talking about at the time and then we can take a break whenever you need one, okay?

A. Thank you.

Q. And did you review any documents to

A. I'm aware that the first part of it, four hours, has occurred online.

Q. Okay. And so is this -- it's through the Global Education Initiative, but is it WPATH approved training or is it just affiliated with WPATH in some way?

A. It's offered through WPATH by WPATH's trainers.

Q. And do you think that the four-hour training will assist providers with proficiency?

A. I think the four-hour training and the second day of the additional four-hour training is a good introduction and overview to the field.

Q. But do you consider it overall adequate training or a first step?

A. I consider it a first step.

MS. WALD: Objection. Form.

You can go ahead, Dr. Ettner.

WITNESS: I consider it a first step.

BY MS. COOK:

Q. Do you know of any other correctional systems in the United States that have brought the WPATH training into their facilities like this?

A. I know of other correctional facilities that have brought experts in, Care, who are

specialists and WPATH members of the Institutionalized Care Committee into their institutions to do training.

Q. Has the Global Education Initiative been brought into other state prison systems?

A. No.

Q. When the -- the examples that you gave that you know of providers, WPATH members, going into correctional institutions and doing trainings, are those part of WPATH or are they the providers, you know, going on their own time to do these trainings?

A. In alignment with the standards of care, the section that you referred to earlier, this aligns with the area where the correctional system did not have the in-house expertise to provide the necessary care and so they sought out individuals who were very knowledgeable about institutional care to come in and provide training.

Q. And as far as you know, are those consultants brought in just for training purposes or do they come --

MS. COOK: I think we lost Dr. Ettner.

MS. WALD: Yeah, I think we lost her.

WITNESS: Sorry. I think I blanked out

for a minute there.

MS. COOK: Yes, you did.

Do you all want to take another break or wait a bit? Is everybody doing all right?

MS. WALD: Dr. Ettner, do you need a break?

WITNESS: I don't.

MS. WALD: Lisa, what time were you thinking -- I'm not sure how much you have left or anything like that, but what are you thinking in terms of, like, a lunch break?

MS. COOK: I think that we could probably finish before lunch, but if you go and anybody gets hungry or needs a break at any time, just tell me.

MS. WALD: Okay. Thanks.

MS. COOK: Okay.

BY MS. COOK:

Q. Okay. So I think I was asking you, Doctor, if you know of instances -- you know, the examples that you were talking about. Do these consultants come in and provide training or do they provide training and then are available for questions or assistance?

A. It depends. I can provide an example, if you want.

Q. I would appreciate that.

A. So at one time, I was aware that the state of Texas was sending prisoners who needed assessments specifically for surgery to the hospital in Galveston, Texas, where Dr. Walter Meyer and his team were providing those assessments. There are other examples where people would have different roles, depending on the need of the institution.

Q. And did you see in the testimony you reviewed any references to attempts to work out a relationship with the University of Illinois Chicago Transgender Health Clinic?

A. I saw that there was mentioned that there were physicians and an endocrinologist and a urologist who work at the University of Illinois and a plastic surgeon who would potentially -- I believe it was to be considered to consult or provide some consultation or care.

Q. Okay. So you did see an illusion to it, even though nothing had been finalized; is that fair?

A. Yes.

Q. Do you think that after some of the things in the works are finalized, or the department's administrative directive is finalized,