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-MAB
JOHN BALDWIN, MELVIN HINTON, and STEVE MEEKS,	)	
Defendants.	)	

DEFENDANTS' RESPONSE TO PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

The Defendants, ROB JEFFREYS,[1] MELVIN HINTON, and STEVE MEEKS, by and through their attorney, Kwame Raoul, Attorney General for the State of Illinois, provide the following response in opposition to Plaintiffs' motion for a preliminary injunction [d/e 123]:

Introduction

The five Plaintiffs[2] in this suit are inmates in the custody of the Illinois Department of Corrections. On January 31, 2018, they filed this suit as a putative class action against Defendants in their official capacities only, and are seeking equitable relief. [d/e 1].

On May 2, 2019, Plaintiffs filed a motion and memorandum seeking a preliminary injunction [d/e 123] and a motion and memorandum seeking class certification [d/e 124]. Defendants are now responding to Plaintiff's motion for preliminary injunction. [d/e 123].

[1] Plaintiffs sued John Baldwin in his official capacity as Acting Director of the Illinois Department of Corrections. In June 2019, Baldwin was replaced by Rob Jeffreys, who is the current Acting Director of IDOC. Pursuant to Federal Rule of Civil Procedure 25(d), Rob Jeffreys is automatically substituted as a party to this action.

[2] Plaintiffs acknowledge in their brief that Ebony Stamps is no longer in IDOC custody and is no longer a remaining Plaintiff. [d/e 123, p. 28, n. 6].

As listed in their motion, Plaintiffs are requesting the following preliminary injunctive relief:

a) For IDOC to cease using the Transgender Committee—a multidisciplinary body—to make decisions regarding transgender inmates' requests;

b) To cease a purported policy and practice of denying and delaying hormone therapy for unrecognized treatment reasons;

c) To cease a purported policy and practice of refusing to evaluate and provide surgery to treat gender dysphoria;

d) To cease a purported policy and practice of depriving gender dysphoric prisoners of "medically-necessary social transition";

e) "[A]ccess to clinicians who meet the competency requirements stated in the [WPATH] Standards of Care to treat gender dysphoria";

f) Evaluation for gender dysphoria upon request or clinical indications of the condition;

g) "[T]imely medically-prescribed treatment for gender dysphoria, including, but not limited to, hormone therapy and monitoring, and gender affirming surgery";

h) Medically necessary social transition; and

i) Training for IDOC staff on the importance of social transition, including preferred names and pronouns.

[d/e 123, pp. 33-34]. These requests are incredibly broad and unnecessary. In their motion, Plaintiffs argue that IDOC's Transgender Committee "controls" all treatment decisions for individuals with gender dysphoria—but that is simply not the case. In their motion, Plaintiffs also imply that IDOC policy fails to provide for personal items or treatment necessary for gender dysphoria; however, the IDOC policy allows for review on a case-by-case basis so that individualized assessments may be made. In short, there are no policies to be enjoined here.

As set forth below, Plaintiffs are not entitled to the injunctive relief they seek. Plaintiffs cannot establish that a preliminary injunction is warranted in this case. The Plaintiffs fail to

meet either the threshold test or the balancing test necessary to support a motion for preliminary injunction. Furthermore, Plaintiffs' sweeping requests are barred by both the Eleventh Amendment and the Prison Litigation Reform Act, 18 U.S.C. § 3626.

Statement of Facts

The Illinois Department of Corrections (IDOC) is an agency of the State of Illinois. IDOC has an internal policy concerning the general review and treatment of transgender inmates in its custody: Administrative Directive 04.03.104. (Attached as Exhibit 1). The policy currently in place was effective on May 1, 2013. (Ex. 1). The policy is presently under revision. (*See* current "Key Draft" attached as Exhibit 2). When enacted, the Key Draft attached as Exhibit 2 will supersede the directive attached as Exhibit 1. Yet, the IDOC mental health standard operating procedure follows the newly drafted, but not yet implemented, policy. (Dep. of Dr. Reister, attached in entirety as Exhibit 3,[3] at p. 11). In revising the mental health section, Dr. Reister attempted to align it with the standards of the World Professional Association of Transgender Health (WPATH). (Ex. 3, at p. 11). In addition to WPATH standards of care, IDOC providers also provide the general medical and mental health standards. It is IDOC's intent to follow all applicable, current standards in providing care for transgender individuals. (Ex. 3, at p. 80). The mental health standards applied are to ensure appropriate care, sensitivity, and cultural awareness. (Ex. 3, at p. 79).

IDOC has a Transgender Care Review Committee (called "Transgender Committee" or "TCRC"). The TCRC is a multidisciplinary team in place to review placements, security concerns, and overall health-related treatment plans of transgender offenders or those diagnosed

[3] Doctors Reister and Puga were put forth as IDOC representatives pursuant to Federal Rule of Civil Procedure 30(b)(6) on various topics. Plaintiffs filed portions of both deposition transcripts with their motion for preliminary injunction; however, Plaintiffs did not file the transcripts in their entirety.

with gender dysphoria, and to oversee the gender-related accommodations for those offenders. (Ex. 1, p. 3, G.; Ex. 3, at p. 35). The current TCRC chairperson is Dr. William F. Puga. (Dep. of Dr. Puga, attached as Exhibit 4, at p. 14). Dr. Puga has held the chairperson role since July or August 2018. (Ex. 4, at p. 15). The Transgender Committee is familiar with WPATH standards. (Ex. 3, at p. 35). Dr. Puga is not a WPATH member, but plans to attend a WPATH conference in September 2019. (Ex. 4, at p. 36). The Transgender Committee does not ignore input from nonvoting members—everyone involved in the Committee presentation is able to give input. (Ex. 4, at p. 44). There has generally been consensus among the Committee members; but, not every member has an equal vote. (Ex. 4, at p. 125). Clinical decisions are not going to be made by people without clinical background. (Ex. 4, at p. 125).

In addition, there are monthly transgender care case teleconference meetings. (Ex. 3, at p. 32). Those meetings discuss site treatment plans, security plans, and any other issues that are raised for discussion. (Ex. 3, at p. 32). The facility mental health providers interview inmates and discuss complaints or grievances in preparation for discussion with the Committee. (Ex. 3, at p. 67).

Dr. Reister is the IDOC Southern Regional Psychologist Administrator. (Ex. 3, at p. 19). Dr. Reister is a WPATH member and has been for approximately five years, though he has not completed the WPATH certification. (Ex. 3, at p. 18). Dr. Reister is involved in the mental health staff training for transgender mental health care and the sensitivity training for all staff. (Ex. 3, at p. 22). The sensitivity training discusses the difference between sexual assignment at birth, gender identity, gender expression, and sexual orientation. (Ex. 3, at p. 23). The sensitivity training also discusses how to interpersonally communicate with transgender people, such as avoiding misgendering, what misgendering is, etc. (Ex. 3, at p. 23). In addition, the

training discusses the Prison Rape Elimination Act and how the transgender community may be disproportionately affected by sexual assault. (Ex. 3, at p. 23). The sensitivity training not only discusses gender dysphoria, but how to be mindful of interactions with individuals at various levels of care. (Ex. 3, at p. 24).

The Committee is familiar with the importance of using pronouns consistent with a patient's gender identity. (Ex. 4, at p. 66). The Committee expects facilities to use pronouns consistent with a patient's gender identity. (Ex. 4, at pp. 66-67). When someone speaking to the Committee has used the wrong pronoun, they have been corrected and the Committee reiterates the importance of using the pronoun requested by the patient. (Ex. 4, at p. 68). The TCRC reviews requests by inmates to go by chosen names and encourages facilities to use the names chosen by the individual to be consistent with their gender identity. (Ex. 4, at p. 68). Though, under Illinois law, felons are not allowed to legally change their names unless they meet certain criteria. 735 ILCS 5/21-101(b).

Inmate searches are not specifically addressed by the TCRC. The default is that the search is done by the gender that would normally do it, given the circumstance of the facility. (Ex. 3, at p. 131). Such issues are addressed from a site level. (Ex. 3, at p. 131). They are controlled by the Prison Rape Elimination Act (PREA). (Ex. 3, at p. 131). PREA contains standards for searches performed in adult prisons and jails. 28 C.F.R. § 115.15. PREA mandates training and education for employees, volunteers, contractors, and inmates. 28 C.F.R. §§ 115.31 - 115.35. It also contains audit requirements and disciplinary sanctions to enforce compliance with the standards. 28 C.F.R. §§ 115.76 – 115.78 & 115.93.

Treatment plans for gender dysphoric inmates are supposed to continue from one facility to the next. (Ex. 4, at p. 71; Ex. 3, at p. 38). The TCRC also reviews clothing requests related

to gender identity. (Ex. 4, at p. 74). Not all such requests come to the Committee—Wardens have been able to make the decision regarding bras for male inmates who identify as female since December 2018 or January 2019—but some requests are still presented to the TCRC. (Ex. 4, at pp. 74-77). The Committee considers requests for permanent hair removal; however, the Committee has not yet approved permanent hair removal and it is currently not available within IDOC. (Ex. 4, at p. 122).

As for hormone therapy, decisions regarding the type or dosage of hormone therapy are not necessarily referred to the Committee. (Ex. 4, at pp. 79, 95). There is no policy concerning the type or dosage of hormone therapy. (Ex. 1, Ex. 2). Those decisions are largely left to the professional judgment of the treating medical doctor, though the Committee may be consulted if the physician has questions. (Ex. 4, at p. 79). The Committee must be consulted before the initiation of hormone therapy, for questions of social transition, and requests for surgical treatment. (Ex. 4, at p. 81). The review process is in place to help ensure access to care and the quality of care across the state. (Ex. 3, at pp. 52-53). The Committee is not supposed to be a gatekeeper to stop access to hormones, but to help facilitate treatment for gender dysphoria. (Ex. 3, at p. 55). The standard at all receiving centers is that hormone therapy continues. (Ex. 3, at p. 105). There is no rule that inmates attend therapy to obtain hormone treatment. (Ex. 3, at p. 135). There is no hard rule as to who is denied hormone therapy. (Ex. 3, at pp. 94-95). As Dr. Reister, put forth as an IDOC 30(b)(6) representative, testified:

> Q: So if someone is deeply depressed, then you would not start them on hormone therapy.
>
> A: It depends. We have some people who are deeply depressed directly related to the gender dysphoria, and we—we have started hormones even though they were still symptomatic. But if somebody was on a crisis watch recently, we might want them to stabilize a little bit longer before we initiate hormones.

> Q: Are—isn't it true that someone with untreated gender dysphoria could be on crisis watch?
>
> A: And that's why it's a case-by-case basis. That's why we do it by committee and we don't just set rules out there. Because then we would discuss in the committee what the nature of the crisis watch was.

(Ex. 3, at pp. 94-95).

At this point, surgical treatment has not been approved by the IDOC Committee. (Ex. 4, at p. 99). Such determinations are made on an individual basis. (Ex. 4, at p. 100).

Argument

A preliminary injunction is a way to maintain the *status quo* until merits issues may be resolved at trial. *Michigan v. U.S. Army Corps of Engineers*, 667 F.3d 765, 783 (7th Cir. 2011). "[A] preliminary injunction is an exercise of a very far-reaching power, never to be indulged in except in a case clearly demanding it." *Girl Scouts of Manitou Council, Inc. v. Girl Scouts of the United States of Am., Inc.*, 549 F.3d 1079, 1085 (7th Cir. 2008). Mandatory injunctions—which require an affirmative act by a party—are "cautiously viewed and sparingly issued." *Graham v. Med. Mut. of Ohio*, 130 F.3d 293, 295 (7th Cir. 1997), *quoting Jordan v. Wolke*, 593 F.2d 773, 774 (7th Cir. 1978) and *citing W.A. Mack, Inc. v. Gen. Motors Corp.*, 260 F.2d 886, 890 (7th Cir. 1958) ("mandatory injunctions are rarely issued and interlocutory mandatory injunctions are even more rarely issued, and neither except upon the clearest equitable grounds").

I. Plaintiffs cannot establish that a preliminary injunction is warranted here.

Injunctions may only be granted when specific criteria are clearly met by the movant and based on substantial proof. *Mazurek v. Armstrong*, 520 U.S. 968, 972 (1997). To determine whether a preliminary injunction is warranted, the court must analyze the case in two stages: a threshold stage and a balancing stage. *Girl Scouts of Manitou Counsel*, 549 F.3d at 1086. Before consideration of the balancing stage, the party seeking the preliminary injunction must

satisfy the three requirements of the threshold stage: (1) that the party will suffer irreparable harm prior to final resolution of its claims; (2) that traditional legal remedies would be inadequate; and (3) that the party's claim has some likelihood of succeeding on the merits. *Id.* If the moving party fails to demonstrate any one of the three threshold requirements, the court must deny the injunction. *Id.* If, on the other hand, the moving party meets the initial threshold phase, then the court analyzes the balance of harms. *Id.* Here, Plaintiffs cannot meet their burden. They fail to establish that they will suffer irreparable harm, that traditional legal remedies would be inadequate, and that they have likelihood of succeeding on the merits of their claims. Even though they fail to meet the threshold phase, the balance of the harms also weighs in favor of the Defendants.

A. Plaintiffs fail to show that they face an existing threat sufficient to disturb the *status quo*.

A party seeking preliminary injunctive relief is required to demonstrate that he or she will suffer irreparable harm without an injunction in place prior to resolution of their claims. *Girl Scouts of Manitou Council, Inc.*, 549 F.3d at 1086. This requires a showing that harm is likely as opposed to a mere remote possibility. *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 22 (2008).

For a finding of irreparable harm, a party is not required to show that an alleged harm is occurring or certain to occur; however a "presently existing actual threat must be shown." *Michigan v. U.S. Army Corps of Engineers*, 667 F.3d at 789, *quoting* 11A Charles Alan Wright, et al., Federal Practice and Procedure, § 2948.1, at 154-55 (2d ed. 1995). The Supreme Court has held that an inmate-plaintiff must come forward with evidence to show that prison official-defendants were "knowingly and unreasonably disregarding an objectively intolerable risk of harm, and that they will continue to do so . . . during the remainder of the litigation and into the

future." *Farmer v. Brennan*, 511 U.S. 825, 846-47 (1994). A court may only grant appropriate injunctive relief if it finds the requesting party satisfied the required objective and subjective elements of deliberate indifference necessary for an Eighth Amendment violation. *Id*. at 846-47.

The Eighth Amendment standard above is not to be confused with a request for the community standard of care. Prisoners are not entitled to demand specific care or even the best possible care, rather they are entitled only to "adequate medical care." *See, e.g., Arnett v. Webster*, 658 F.3d 742, 758 (Prisoner not entitled to best or most appropriate treatment, but entitled only to measures sufficient to meet a substantial risk of serious harm); *Johnson v. Doughty*, 433 F.3d 1001, 1013 (7th Cir. 2006) (Prisoner entitled to adequate medical care—medical malpractice, negligence, nor gross negligence equate to deliberate indifference); *Forbes v. Edgar*, 112 F.3d 262, 266 (7th Cir. 1997) (The Eighth Amendment does not provide prisoners with specific medical treatment). Plaintiffs claim that IDOC policies are violating their rights; however, the IDOC policies are not presenting any threat to the Plaintiffs' care. The policies require individualized determinations. Plaintiffs fail to show a presently existing actual threat in this matter. Accordingly, they do not meet their burden with respect to that element.

B. Plaintiffs cannot show that traditional legal remedies would be inadequate here.

Only if a party will suffer irreparable harm in the interim—that is, harm that cannot be prevented or fully rectified by the final judgment after trial—can he or she get a preliminary injunction. In saying that the plaintiff must show that an award of damages at the end of trial will be inadequate, the standard is not whether damages are wholly ineffectual; rather, it requires a showing that damages are seriously deficient as a remedy for the harm suffered. *Roland Mach. Co. v. Dresser Indus., Inc.*, 749 F.2d 380, 386 (7th Cir. 1984).

As Plaintiffs point out in their motion, they are not seeking money damages in this action;

however, such a tactical decision does not rule out the potential that traditional legal remedies would be adequate here. The standard is not whether they have *requested* damages, but whether damages could be calculated and recoverable at the conclusion of the action. *Roland Mach. Co.*, 749 F.2d at 386. As for these named Plaintiffs, legal remedies may be all that they could recover for some of their claims. For instance, these Plaintiffs seek injunctive relief to control the initial prescription of hormone therapy; yet, these Plaintiffs have all received hormone therapy. Accordingly, any relief they could receive with respect to the receipt of hormone therapy would be limited only to monetary damages. The same holds true with respect to requests for transfer to a female prison for female-identifying Plaintiffs—Plaintiff Monroe has already been transferred to a female facility—therefore, she cannot seek injunctive relief compelling her transfer to a female facility. Plaintiffs put very little analysis in this section, but it is incumbent upon them to show that damages are seriously deficient to address any alleged harm.

C. Plaintiffs cannot show a better than negligible chance of prevailing.

For the third element in the threshold stage, a court is required to assess whether the moving party has some likelihood of succeeding on the merits. *Girl Scouts of Manitou Counsel*, 549 F.3d at 1086. This is an early measurement of the quality of the underlying lawsuit. *Michigan v. U.S. Army Corps of Engineers*, 667 F.3d at 787-788. A plaintiff need only show a better than negligible chance of prevailing as part of the discussion of probability of success. *D.U. v. Rhoades*, 825 F.3d 331, 338 (7th Cir. 2016). This burden is low. *Id.* Yet, the Plaintiffs here cannot show that they have likelihood of success on the merits of their claims. For instance, Plaintiffs complain of delays in receiving hormone therapy. The Seventh Circuit Court of Appeals recently analyzed a complaint about the length of time to receive hormone therapy while incarcerated. In *Mitchell v. Kallas*, a transgender prisoner who had identified as a

woman her entire life filed suit against officials in the Wisconsin Department of Corrections. 895 F.3d 492 (7th Cir. 2018). Mitchell claimed that it took over a year for her to receive hormone therapy and other treatments that she needed to express her gender identity. *Id*. at 495. The Seventh Circuit found that the district court had prematurely dismissed some claims, but affirmed the dismissal of her claim alleging a 13-month delay for evaluation for hormone therapy. *Id*. at 496. There, the court was critical of the claimed delay, but noted: "It is true that delays in care for 'non-life-threatening but painful conditions may constitute deliberate indifference if the delay exacerbated the injury or unnecessarily prolonged in inmate's pain.'. . . Yet prisons have limited resources, and that fact makes some delay inevitable." *Id*. at 500. There, the court was required to weigh the seriousness of the condition with the ease of providing treatment. *Id*. Although the serious nature of gender dysphoria was not disputed, there was little evidence of the ease of hormone evaluations. *Id*. Further, the Seventh Circuit cited to other courts, which had determined that delays over a year did not amount to deliberate indifference. *Id*., *citing Rowe v. Corr. Med. Svcs, Inc.*, 08-cv-827, 2010 WL 3779561 at *7 (W.D. Mich. Aug. 10, 2010) (15-month delay of hormone therapy in prison setting could not be considered deliberate indifference) & *Arnold v. Wilson*, 13-cv-900, 2014 WL 7345755 (E.D. Virginia Dec. 23, 2014) (nearly two-year delay in prescribing prisoner with hormones was not deliberate indifference). In dicta, the court discussed that denial of hormone therapy based on a blanket rule, rather than an individualized medical determination, could constitute deliberate indifference. *Id*. at 501. Yet, as addressed above, there is no blanket rule concerning hormone therapy in IDOC. The type or dosage is left to the professional judgment of the treating doctor. The TCRC is not a gatekeeper to stop access to hormones but to help facilitate treatment and

continuation of care. Allowing for continuity of care and individualized treatment is not constitutionally deficient.

As for surgery, there is little law that supports Plaintiffs' contention that sex reassignment surgery is constitutionally mandated. Just this year, the Fifth Circuit Court of Appeals held: "A state does not inflict cruel and unusual punishment by declining to provide sex reassignment surgery to a transgender inmate." *Gibson v. Collier*, 920 F.3d 212 (5th Cir. Mar. 29, 2019), *citing Kolisek v. Spencer*, 774 F.3d 63 (1st Cir. 2014) (en banc). The policies at issue in both *Gibson* (Texas) and *Kosilek* (Massachusetts) did not allow sex reassignment surgery.

In *Gibson*, the court discussed the WPATH Standards of Care. The Fifth District wrote: "As the First Circuit has concluded, however, the WPATH Standards of Care reflect not consensus, but merely one side in a sharply contested medical debate over sex reassignment surgery." 920 F.3d at 221. It found that there was no evidence that the WPATH-suggested treatment of sex reassignment surgery was so universally accepted, that to provide some but not all of the treatments recommended by WPATH amounted to deliberate indifference. *Id.* at 220.

With surgery—as with the other relief sought by Plaintiffs—the IDOC policy allows for individualized assessment. Because the policies here are less restrictive than those analyzed at the federal appellate level,[4] Plaintiffs cannot establish that they have a better than negligible chance of prevailing in this action.

D. The balance of the harms favors Defendants.

The second phase of the preliminary injunction analysis—the balancing phase—requires a court to attempt to minimize the cost of potential error by balancing "the nature and degree of the plaintiff's injury, the likelihood of prevailing at trial, the possible injury to the defendant if

[4] The Seventh Circuit Court of Appeals has not addressed such a claim.

the injunction is granted, and the wild card that is the public interest." *Girl Scouts of Manitou Council*, 549 F.3d at 1086 (internal citation and quotation omitted).

i. Public interest favors denying Plaintiffs' request for injunctive relief.

Plaintiffs argue that public interest favors granting their requested relief because the public has an interest in seeing that inmates receive proper medical care. That is correct, but it is not the only interest the public has in these matters. Section 1983 allows for equitable relief as well as damages, but a party seeking to enjoin the activity of a government agency "must contend with the well-established rule that the Government has traditionally been granted the widest latitude in the dispatch of its own internal affairs." *Rizzo v. Goode*, 423 U.S. 362, 378-79 (1976) (internal quotations omitted). Prison administrators have been charged with maintaining the security of their facilities and providing for the safety of all the inmates in the Department. Maintaining institutional security and preserving internal order and discipline are essential goals that may require limitation or retraction of the retained constitutional rights of prisoners. *Bell v. Wolfish*, 99 S.Ct. 1861, 1878 (1979). Prison officials must be free to take appropriate action to ensure the safety of inmates and correctional personnel. *Id*. The problems that arise in the day-to-day operation of a corrections facility are not susceptible to easy solutions and prison administrators should be given wide-ranging deference in the adoption and execution of policies that are in their judgment needed to preserve internal order and discipline and to maintain institutional security. *Id*.

The injunctive relief sought by the Plaintiffs would remove the Transgender Committee from the process of determining proper care and placement. The Department has to make these decisions taking into account the totality of each patient's circumstances, including other mental health or medical issues, as well as the needs of the Department and its other inmates. The

Committee has members who specialize in medicine, mental health, security and assigning inmates to specific prisons. Only by incorporating all of those concerns can the Department ensure its final decisions accommodate the needs of all parties. Logan Correctional Center, the Department's primary female facility, has over 1,500 inmates. The Defendants are equally responsible for the safety of those inmates as for any of the Plaintiffs in this action. The Department has not refused to transfer all transgender inmates to Logan, but reviews transfer requests in a deliberative manner. Any relief that impairs the Department's ability to consider the needs of all its inmates runs counter to the public's interest in letting the penological experts run their facilities as they determine is best. It is contrary to the public interest for prisoners to by-pass prison policies and procedures to dictate the conditions and terms of their confinement. *Aguado v. Godinez*, No. 13-cv-3378, d/e 76 (C.D. Ill. June 26, 2015). Similarly, allowing the Plaintiffs to dictate what medical treatment they receive is contrary to public interest. *See Siler v. Green*, No. 08-15077, 2009 WL 1393411 at *3 (E.D. Mich. May 18, 2009) ("The public would not be served by the Court ordering what might be unnecessary medical treatment or referrals.") Plaintiffs seek sweeping changes to the more measured approach, which is based on treatment on an individualized basis. Instead of allowing IDOC's medical, mental health, and security experts to weigh in, Plaintiffs seek to dictate all aspects of their care regardless of what is best for each individual patient-prisoner. The public interest does not favor such an approach.

II. Plaintiffs' requested relief is barred by sovereign immunity and the Prison Litigation Reform Act

Sovereign immunity bars federal courts from entering injunctive relief against state actors where there is no ongoing violation of federal law. *Green v. Mansour*, 106 S.Ct. 423, 427 (1985). This is true even where there may have been a violation of federal law at the time a case was filed. *Toney v. Burris*, 829 F.2d 622, 626 (7th Cir. 1987) (finding that the Eleventh

Amendment would bar injunctive relief if the Illinois Comptroller implemented new rules that comport with due process during the pendency of a claim). "When there is no continuing violation of federal law, injunctive relief is not part of a federal court's remedial powers." *Kress v. CCA of Tennessee, LLC*, 694 F.3d 890, 894 (7th Cir. 2012), quoting *Al-Alamin v. Gramley*, 926 F.2d 680, 685 (7th Cir. 1991).

Even where a court finds an ongoing violation of federal law, the ability to enter injunctive relief is strictly limited. The Prison Litigation Reform Act provides that:

> Prospective relief in any civil action with respect to prison conditions shall extend no further than necessary to correct the violation of the Federal right of a particular plaintiff or plaintiffs. The court shall not grant or approve any prospective relief unless the court finds that such relief is narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right. The court shall give substantial weight to any adverse impact on public safety or the operation of a criminal justice system caused by the relief.

18 U.S.C.A. 3626(a)(1)(A). The PLRA further provides:

> Preliminary injunctive relief must be narrowly drawn, extend no further than necessary to correct the harm the court finds requires preliminary relief, and be the least intrusive means necessary to correct that harm. The court shall give substantial weight to any adverse impact on public safety or the operation of a criminal justice system caused by the preliminary relief… Preliminary injunctive relief shall automatically expire on the date that is 90 days after its entry, unless the court makes the findings required under subsection (a)(1) for the entry of prospective relief and makes the order final before the expiration of the 90-day period.

18 U.S.C.A. 3626(a)(2).

Plaintiffs seek a range of injunctive relief. Much of that relief is directed to claims where there is no ongoing violation of the federal rights of the five Plaintiffs. The requested relief also extends beyond what is necessary to correct the alleged violations of federal law.

Transgender Committee

The Plaintiffs seek to compel the Defendants to cease allowing the Transgender Committee to make medical decisions regarding gender dysphoria that result in denials and delays of treatment. However, Plaintiffs make no showing that the use of the Transgender Committee itself is a violation of federal law. Despite the Plaintiffs' description of the Committee as "non-experts and laypeople," the members include a medical doctor, a psychiatrist and a psychologist. Additionally, Dr. Reister, a member of WPATH, despite not being a member of the Committee, regularly participates in its proceedings. The Committee and Dr. Reister, while admittedly not the foremost experts in the field of transgender care, do have broader experience with the concerns of transgender inmates than any other medical professional employed by the Department. They have the opportunity to review the treatment of transgender inmates from across the Department, as opposed to individual treaters who work at one or a few facilities. A medical professional's failure to follow instructions from a specialist can lead to the inference of deliberate indifference. *Zaya v. Sood*, 836 F.3d 800, 806 (7th Cir. 2016). Here, the Department and its medical staff seek and follow the advice of the more experienced Committee. That is the opposite of deliberate indifference.

The Plaintiffs challenge some of the specific medical decisions made by the Committee, but a disagreement among medical professionals as to the appropriate treatment is not grounds for a finding of deliberate indifference. *Estate of Cole v. Fromm*, 94 F.3d 254, 261 (7th Cir. 1996), *citing Estelle v. Gamble*, 429 U.S. 97, 107 (1976) & *White v. Napoleon*, 897 F.2d 103, 109-10 (3rd Cir. 1990). Even if those decisions amounted to malpractice, the Defendants would not be deliberately indifferent. *Estelle*, 429 U.S. at 106. Even if true, Plaintiffs' allegations regarding the role of the Transgender Committee would, at most, present only a claim for

malpractice, not a violation of the Eighth Amendment's prohibition of cruel and unusual punishment. Sovereign immunity bars injunctive relief to address issues of malpractice. The PLRA does not allow prospective relief, including the preliminary injunction sought by Plaintiffs, beyond what is required to correct the violation of a federal right. Plaintiffs' attempt to bar the operation of the Transgender Committee is beyond the scope of relief allowed by the PLRA.

Hormone Therapy

The Plaintiffs seek to compel the Defendants to cease delaying and denying the provision of hormone therapy to transgender inmates. However, in their motion for preliminary injunctive relief, the Plaintiffs admit that each of them is receiving hormone therapy. *See* Motion and Memorandum in Support of a Preliminary Injunction, d/e 123, pp. 15-16 and Kuykendall Decl. at d/e 123-6, ¶ 5. No injunctive relief is available in the absence of an ongoing violation of federal law. Even if there was an unconstitutional delay in providing hormone therapy to the Plaintiffs, they would be entitled to pursue damages, not injunctive relief. None of the Plaintiffs could benefit from an order compelling faster provision of hormone therapy as they are already receiving it.

Surgery

According to IDOC TCRC members, no transgender inmate has yet been approved for sex reassignment surgery while in IDOC custody. Yet, the criteria applied in IDOC is evaluated on an individual basis. There is no blanket ban that is either unconstitutional or that otherwise requires this Court's intervention. In the *Gibson* opinion—from just a few months ago—the Fifth Circuit Court of Appeals wrote in no uncertain terms—"But the unmistakable conclusion that emerges from the testimony is this: There is no medical consensus that sex reassignment

surgery is a necessary or even effective treatment for gender dysphoria." 920 F.3d at 222-23. Accordingly, the mere fact that no sex reassignment surgery has been approved by IDOC thus far is no basis for the issuance of an injunction requiring surgery as treatment for gender dysphoria.

Social Transition

The Plaintiffs seek to compel the Defendants to allow social transition for transgender inmates in the form of consideration for placement at female facilities, avoidance of cross-gender searches, and gender-affirming clothing and grooming supplies. The first of these is moot, as Plaintiffs admit one of them and another transgender inmate have been assigned to Logan Correctional Center, a female facility. The Department of Corrections is considering transgender inmates for placement at female facilities, but it requires a case-by-case evaluation. Thus, there is no further relief available in that regard.

As discussed above, IDOC's current policy follows the PREA guidelines. There is no ongoing violation of federal law related to searches that warrants this Court's intervention.

The Plaintiffs have also admitted that each of them has been provided with bras. *See* Kuykendall Decl. at d/e 123-6, p. 2, ¶ 7; Reed Decl. at d/e 123-7, p. 4, ¶ 13; Melendez Decl. at d/e 123-4, p. 3, ¶ 6; Vision Decl. at d/e 123-5, ¶ 16; and Monroe Decl. at d/e 123-3, p. 3, ¶ 8. Although each of the Plaintiffs would like additional items, there is not a blanket policy against transgender inmates having female personal items. Individual determinations are made as to what property is appropriate. Any injunctive relief would have to go further than the existing policy, requiring unlimited access to female items. There is no requirement under federal law that medical professional or security staff abandon their discretion and allow all such items.

Clinicians

The Plaintiffs seek to compel access to clinicians who meet the competency requirements stated in the Standards of Care to treat gender dysphoria. However, while failure to adhere to standards of care could be considered medical malpractice, it is not deliberate indifference or a violation of federal law. *Estelle*, 429 U.S. at 106. No injunctive relief is available to address alleged malpractice.

Evaluation

The Plaintiffs seek to compel the Defendants to evaluate them for gender dysphoria. However, four of the Plaintiffs admit they have been diagnosed and are receiving treatment. *See* Kuykendall Decl. at d/e 123-6, p. 2, ¶ 4; Melendez Decl. at d/e 123-4, p. 2, ¶ 4; Vision Decl. at d/e 123-5, pp. 1-2. ¶ 3; and Monroe Decl. at d/e 123-3, pp. 1-2, ¶ 2. The fifth Plaintiff does not explicitly state she has been diagnosed with gender dysphoria, but admits she has been receiving hormone treatments. *See* Reed Decl. at d/e 123-7, p. 2, ¶ 3. That therapy would only be provided if Reed has been diagnosed with gender dysphoria. As each of the Plaintiffs has already received the requested evaluation, there is no further action to compel.

Training

The Plaintiffs seek to compel the Defendants to train IDOC staff on the importance of social transition, including using proper names and pronouns for transgender inmates. As discussed above, Dr. Reister has already developed such training and has begun the process of providing that training to staff. This is another moot issue, as the training is in progress and there is nothing left to enjoin.

Conclusion

In conclusion, there is no basis for the preliminary injunction that Plaintiffs seek. Plaintiffs cannot meet their burden as to the necessity of an injunction against these Defendants, in their official capacities as officials of IDOC. Further, the balance of harms weighs in favor of the Defendants, as Plaintiffs' broad requests are contrary to public policy. Moreover, such requests are barred by the Eleventh Amendment's sovereign immunity and the Prison Litigation Reform Act.

WHEREFORE, Defendants respectfully request that this Court deny Plaintiffs' motion for preliminary injunction.

Respectfully submitted,

ROB JEFFREYS, MELVIN HINTON, and STEVE MEEKS,

Defendants,

KWAME RAOUL, Attorney General
State of Illinois

Attorney for Defendants,

By: s/Lisa A. Cook
Lisa A. Cook

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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-MAB
JOHN BALDWIN, MELVIN HINTON, and STEVE MEEKS,	)	
Defendants.	)	

CERTIFICATE OF SERVICE

I hereby certify that on June 13, 2019, the foregoing document, **Defendants' Response to Plaintiffs' Motion for a Preliminary Injunction**, was electronically filed with the Clerk of the Court using the CM/ECF system which will send notification of such filing to the following:

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Illinois Department of Corrections	ADMINISTRATIVE DIRECTIVE	Number	04.03.104
		Page	1 of 6
		Effective	5/1/2013

Section	04	Programs and Services
Subsection	03	Medical and Health Care
Subject	104	Evaluations of Offenders with Gender Identity Disorders

I. POLICY

A. Authority

730 ILCS 5/3-2-2, 5/3-7-2 and 5/3-8-2

B. Policy Statement

The Department shall:

- provide appropriate accommodations and treatment for all offenders who are identified as having gender identity issues, or who are diagnosed by the Department as having a gender identity disorder; and
- extensively evaluate offenders at a Reception and Classification Center to ensure appropriate facility placement.

II. PROCEDURE

A. Purpose

The purpose of this directive is to establish a written procedure for conducting medical and mental health examinations of offenders with gender identity disorders and to address adjustment to the prison environment related to the disorder throughout their incarceration.

B. Applicability

This directive is applicable to facilities within the Department.

C. Facility Review

A facility review of this directive shall be conducted at least annually.

D. Designees

Individuals specified in this directive may delegate stated responsibilities to another person or persons unless otherwise directed.

EXHIBIT 1

E. Definitions

Gender identity – a person's internal sense of being male or female regardless of anatomical genitalia at birth or sexual orientation. Gender identity is a result of genetics and environmental influences and may be manifested by appearance, behavior or other aspects of the individual's lifestyle.

Gender identity disorder – a specific mental health disorder characterized by a manifestation of all DSM-IV diagnostic criteria, including, a strong and persistent desire to be a member of the opposite gender; persistent discomfort with his or her gender or a sense of inappropriateness with the gender role; clinically significant distress or impairment in occupational, social or other important areas of functioning; and absence of evidence of intersex (hermaphroditism) whereby a congenital disorder in which the development of chromosomal or anatomical sex is atypical.

NOTE: The offender may have had cosmetic or other surgery to enhance appearance, undergone hormonal therapy, and frequently lived as a person of the opposite gender in the free community in spite of genetically being a male or female. A transvestite (cross-dresser) or non-transsexual homosexual is not considered a person with a gender identity disorder for purposes of this directive.

Sexual orientation: a pattern of sexual attraction to a specific gender or genders or lack of sexual attraction to a specific gender or genders.

NOTE: Sexual orientation and gender identity are distinct and separate concepts.

F. General Provisions

1. In accordance with Administrative Directive 05.07.101, all offenders shall undergo a detailed medical history, physical examination and mental health examination during the reception and classification process. Offenders self-identified as or suspected of having a gender identity disorder shall undergo the above within 24 hours of arrival at Reception and Classification (R&C).

2. The Department shall not perform or allow the performance of any surgery for the specific purpose of gender change, except in extraordinary circumstances as determined by the Director who has consulted with the Agency Medical Director. Offenders who may have gender identity issues shall be informed of this policy by the Facility Medical Director.

3. Hormone therapy shall require prior approval of the Agency Medical Director.

G. Gender Identity Disorder Committee (GIDC)

1. The Agency Medical Director shall establish and head a committee for the purpose of reviewing placements, security concerns and overall health-related treatment plans of offenders with gender identity disorders; and to oversee the gender related accommodation needs of these offenders. At a minimum, the committee shall be comprised of the:

a. Agency Medical Director (no designee);

b. Chief of Mental Health (no designee);

c. Transfer Coordinator; and

d. Chief of Operations.

2. The committee shall meet within 30 days of the admission of an offender who presents with gender identity issues to his or her parent facility to make final recommendations.

3. Additional follow-up meetings shall be scheduled on an as needed basis.

H. Requirements

1. The Chief Administrative Officer shall establish and maintain a written procedure for detailed medical and mental health examinations to be conducted during the reception and classification process for any offender who is self-identified or diagnosed with a gender identity disorder. The procedure shall provide for the following:

a. Medical History

(1) As part of the detailed medical history obtained from the offender by a physician, including information about past illnesses and family medical history, the physician shall also elicit information about:

(a) Sexual activity, specifically homosexual, heterosexual or bisexual activity;

(b) Previous operative procedures; and

(c) Hormone therapy.

(2) The physician shall also ask the offender questions that would:

(a) Illuminate the offender's own sense of gender identity;

(b) Reveal any plans the offender may have with regard to future surgery and life style; and

(c) Reflect whether the offender has amended or plans to amend the original birth certificate.

b. Physical Examination

(1) As part of the detailed physical examination, specific attention shall be given to the genitalia.

(a) Offenders shall be examined in the standing position as well as on an examining table.

(b) The physical examination report shall include a concise description of the present genitalia.

(2) If possible, the physician shall contact the physician who was managing the offender's gender related treatment prior to incarceration for verification of the course of treatment and to obtain relevant medical records.

(3) The Facility Medical Director shall inform the offender of the Department's policy regarding gender reassignment surgery. Hormone therapy shall only be provided after consultation with and approval by the Agency Medical Director.

c. Mental Health Examination

(1) As part of the mental health examination, a psychiatrist shall evaluate the offender using the DSM-IV criteria to determine if he or she has a gender identity disorder and determine:

(a) The offender's competency;

(b) The offender's sexual activity, sexual preference and current gender identification;

(c) The regularity and history of legitimate prescribed hormone therapy; and

(d) The presence or absence of any counseling activities and goals prior to incarceration.

(2) A vulnerability or predatory risk assessment shall be completed.

2. Upon conclusion of the medical history and physical examination:

a. The R&C Facility Medical Director shall telephone to the Agency Medical Director the results of the history and physical examination including:

(1) Anatomical description;

(2) Preference for sexual partners; and

(3) History of any medical or surgical treatment received for the gender identity disorder, including hormone therapy or gender reassignment surgery.

b. The Agency Medical Director shall make his or her preliminary determination of gender and recommendations, including, but not limited to, housing, showering restrictions and hormone therapy.

c. Upon receipt, the R & C Facility Medical Director shall:

(1) Document the determination of gender and the any recommendations of the Agency Medical Director in the progress notes of the medical record; and

(2) Notify the Health Care Unit Administrator and Mental Health Administrator of the offender's gender and the preliminary recommendations of the Agency Medical Director.

3. The Health Care Unit Administrator shall notify the Supervisor or Administrator of the R & C of the determination of the offender's gender.

4. The Supervisor or Administrator of the R & C shall ensure the offender is housed in accordance with the offender's gender-related needs.

5. Within 30 days of an offender arriving at his or her assigned parent facility:

a. A mental health professional shall complete a social history interview and review any relevant documentation regarding real-life experience the offender may have had in the gender role of the opposite gender. The history shall include, but may not be limited to, the offender's experiences in social situations such as employment, efforts to legally change his or her name, hormone therapy and gender reassignment surgery or procedures for preparation for surgery, and experiences during any previous incarcerations, if applicable.

b. The GIDC shall review the case and make the final recommendation for housing and any additional matters that may be of issue such as, but not limited to, hormone therapy, clothing, showers, searches, etc. The review and recommendations shall be documented on the Gender Identity Disorder Committee Recommendation, DOC 0400.

6. The GIDC shall conduct follow-up reviews on an as needed basis.

Authorized by:

s/S.A. Godinez

S.A. Godinez
Director

Supersedes:

Illinois *Department of* ***Corrections***

ADMINISTRATIVE DIRECTIVE	**Effective** **5/1/2013**	**Page** **6 of 6**	**Number** **04.03.104**

04.03.104	AD	5/1/2003

	Illinois Department of Corrections **Administrative Directive**	
Number: **04.03.104**	Title: **Evaluations of Transgender Offenders ~~with Gender Identity Disorders~~**	Effective: **Key draft**

Authorized by:	**John R. Baldwin** Acting Director
Supersedes:	04.03.104 effective 5/1/2013

Authority:	**Referenced Policies:**	**Referenced Forms:**
730 ILCS 5/3-2-2, 5/3-7-2 and 5/3-8-2	04.01.301 05.07.101	DOC 0282 – Mental Health Progress Note DOC 0400 – Transgender Care Review Committee Recommendation ~~DOC 0452 – Transgender Care Review Committee Follow-up~~ DOC 0494 – Screening for Potential Sexual Victimization or Sexual Abuse

I. POLICY

The Department shall~~:~~

- evaluate offenders at a Reception and Classification Center to ensure appropriate facility placement; and provide appropriate accommodations and treatment for all offenders who are self identified or suspected ~~of~~identified as having gender identity incongruence issues, are transgendered or who are diagnosed by the Department as having Gender Dysphoria~~a gender identity disorder; and~~

- ~~extensively evaluate offenders at a Reception and Classification Center to ensure appropriate facility placement~~.

II. PROCEDURE

A. Purpose

The purpose of this directive is to establish a written procedure for conducting medical and mental health evaluations ~~examinations~~ of offenders self-identified as transgendered or suspected of having Gender Dysphoria or other concerns related to ~~with~~ gender identity~~, disorders~~ and to address adjustment to the prison environment related to gender identity ~~the disorder~~ throughout their incarceration.

B. Applicability

This directive is applicable to all facilities within the Department.

C. Facility Review

A facility review of this directive shall be conducted at least annually.

D. Designees

Individuals specified in this directive may delegate stated responsibilities to another person or persons unless otherwise directed.

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EXHIBIT 2

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E. Definitions

Gender identity – a person's internal sense of being male, ~~or~~ female, or an alternative gender regardless of anatomical genitalia at birth or sexual orientation. Gender identity is a result of genetics and environmental influences and may be manifested by appearance, behavior or other aspects of the individual's lifestyle.

Gender Dysphoria~~identity disorder~~ – a specific mental health disorder meeting diagnostic criteria of the current version of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM) that includes a marked incongruence between an individual's experienced or expressed gender and his or her assigned gender; ~~characterized by a manifestation of all DSM-IV diagnostic criteria, including~~, a strong and persistent desire to be a member of the opposite or alternative gender; persistent discomfort with his or her assigned gender or a sense of inappropriateness with the gender role.; Gender Dysphoria is typically associated with clinically significant distress or impairment in occupational, social or other important areas of functioning; and absence of evidence of intersex characteristics (hermaphroditism), or ~~whereby~~ a congenital disorder in which the development of chromosomal or anatomical sex is atypical.

NOTE: The offender may have had cosmetic or other surgery to enhance appearance, undergone hormonal therapy, and frequently lived as a person of the opposite gender in the free community in spite of genetically being a male or female. A transvestite (cross-dresser) or non-transgender ~~non-transsexual~~ homosexual ~~is~~ shall not be considered a person with Gender Dysphoria~~a gender identity disorder~~ for purpose~~s~~ of this directive.

Medical Provider – for the purpose of this directive, shall mean a Physician, Physician's Assistant, or a Nurse Practitioner.

Sexual orientation: a pattern of sexual attraction to a specific gender or genders or lack of sexual attraction to a specific gender or genders. Sexual orientation and gender identity are distinct and separate concepts.

~~**NOTE:** Sexual orientation and gender identity are distinct and separate concepts.~~

Transgender – an individual whose gender identity is different from his or her assigned gender at birth.

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Transvestite – an individual who chooses to dress as the opposite gender without drawing their primary gender into question.

F. General Provisions

1. In accordance with Administrative Directive 05.07.101, all offenders shall undergo a detailed medical history, physical examination and mental health screening ~~examination~~ during the reception and classification process. This shall be competed within 24 hours of arrival at a Reception and Classification Center (R&C) for any offender~~Offenders~~ self-identified or for whom there are questions regarding~~as or suspected of having a~~ gender identity ~~disorder~~ or Gender Dysphoria~~shall undergo the above within 24 hours of arrival at Reception and Classification (R&C)~~.

2. All requests for surgery for the specific purpose of gender reassignment must be submitted in writing to the Transgender Care Review Committee. The Agency Medical Director, in consultation with an interdisciplinary team of medical and mental health professionals, shall make a recommendation to the Director regarding the offender's request for surgery. The Director, after a review of the recommendation, shall make the final determination as to whether the Department will perform or allow the performance of the surgery.~~The Department shall not perform or allow the performance of any surgery for the specific purpose of gender~~

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changereassignment, except in extraordinary circumstances as determined by the Director who has consulted with the Agency Medical Director and Chief of Psychiatry. Offenders who request gender reassignment surgerymay have gender identity issues shall be informed of this policy by the Facility Medical Director.

3. Hormone therapy shall require prior approval of the Agency Medical Director or Chief of Psychiatry.

G. Transgender Care ReviewGender Identity Disorder Committee (TCRCGIDC)

1. The Agency Medical Director or, in the absence of or at the designation of the Agency Medical Director, the Chief of Psychiatry (no other designee) shall establish and head a committee for the purpose of reviewing placements, security concerns and overall health-related treatment plans of transgender offenders or and offenders diagnosed with Gender Dysphoriagender identity disorders; and to oversee the gender related accommodations for needs of these offenders. At a minimum, the committee shall be comprised of the:

   a. Agency Medical Director or Chief of Psychiatry (no designee);

   b. Chief of Mental Health (no designee);

   c. Transfer Coordinator; and

   d. Chief of Operations.

2. The committee shall meet within 30 days of the admission of an offender who presents with gender identity issues to his or her parent facility to make final recommendations.

3. Additional follow-up meetings shall be scheduled on an as needed basis.

H. Requirements

1. The Chief Administrative Officer shall ensure establish and maintain a written procedure is established and maintained that requires a for detailed medical examinations and mental health screeningsexaminations to be conducted during the reception and classification process for any offender who is self-identified as transgender or for whom there are questions of gender identity or Gender Dysphoria is established and maintained diagnosed with a gender identity disorder. The procedure shall provide for the following:

   a. Medical History

      (1) As part of the detailed medical history obtained from the offender by a medical providerphysician, including information about past illnesses and family medical history, the medical providerphysician shall also elicit information about:

         (a) Sexual activity, specifically homosexual, heterosexual or bisexual activity;

         (b) Previous operative procedures related to gender identity; and

         (c) Hormone therapy.

      (2) The medical providerphysician shall also ask the offender questions that would:

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(a) Clarify~~Illuminate~~ the offender's ~~own~~ sense of gender identity; and

(b) Reveal any plans the offender may have with regard to future surgery and life style.~~; and~~

~~(c) Reflect whether the offender has amended or plans to amend the original birth certificate.~~

b. Physical Examination

(1) The physical examination report shall provide a concise description of the presence of genitalia including the presence or absence of natal primary sexual characteristics. If necessary, additional diagnostic testing may be performed.~~As part of the detailed physical examination, specific attention shall be given to the genitalia.~~

~~(a) Offenders shall be examined in the standing position as well as on an examining table.~~

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~~(b) The physical examination report shall include a concise description of the present genitalia.~~

(2) If possible, the medical provider~~physician shall contact the physician~~ who was managing the offender's gender related treatment prior to incarceration shall be contacted for verification of the course of treatment and to obtain relevant medical records.

(3) The Facility Medical Director shall inform the offender of the Department's policy regarding gender reassignment surgery, as necessary. Hormone therapy shall only be provided after consultation with, and approval by the Agency Medical Director or Chief of Psychiatry.

c. Mental Health ~~Examination~~Screening

(1) As part of the mental health screening ~~examination~~, a psychiatrist shall evaluate the offender using current

~~the~~ DSM ~~IV~~ criteria to determine if he or she has ~~a gender identity disorder~~Gender Dysphoria ~~and determine~~:

(a) The consistency of the offender's gender identity other than that assigned at birth;

(b) The offender's capacity to give informed consent ~~competency~~;

(c~~b~~) The offender's sexual activity, sexual preference and current gender identification;

(d~~c~~) The regularity and history of any ~~legitimate prescribed~~ hormone therapy; and

(e~~d~~) The presence or absence of any gender related counseling activities and goals prior to incarceration.

	Illinois Department of Corrections Administrative Directive	Page **5** of **6**
Number: 04.03.104	Title: Evaluations of Transgender Offenders	Effective:

(2) If applicable, the offender's mental health symptoms and psychiatric stability shall be evaluated for consideration of readiness for any requested hormone therapy.

(~~3~~2) In accordance with Administrative Directive 04.01.301, a Screening for Potential of Sexual Victimization or Sexual Abuse, DOC 0494, shall be compelted~~A vulnerability or predatory risk assessment shall be completed~~.

2. Upon conclusion of the medical history and physical examination:

a. The R&C Facility Medical Director shall contact ~~telephone to~~ the Agency Medical Director or Chief of Psychiatry ~~the results of the~~to review the offender's medical history and physical examination including:

(1) Gender identification;

(2) Anatomical description;

(~~3~~2) Preference for sexual partners; and

(~~4~~3) History of any gender identity related medical or surgical treatment received ~~for the gender identity disorder~~, including hormone therapy or gender reassignment surgery.

b. The Agency Medical Director or Chief of Psychiatry, as applicable, shall make a ~~his or her~~ preliminary determination of gender and recommendations, including, but not limited to, housing, showering restrictions and hormone therapy.

c. The~~Upon receipt, the~~ R & C Facility Medical Director shall:

(1) Document the determination of gender and ~~the~~ any recommendations of the Agency Medical Director or Chief of Psychiatry, as applicable, in the ~~progress notes of the~~offender's medical record; and

(2) Notify the Health Care Unit Administrator and Mental Health Administrator of the ~~offender's~~ gender determination and the preliminary recommendations ~~of the Agency Medical Director~~in accordance with Paragraph II.H.2.b. above.

3. The Health Care Unit Administrator shall notify the Supervisor or Administrator of the R & C of the determination of the offender's gender identity.

4. The Supervisor or Administrator of the R & C shall ensure the offender is housed and provided with necessary gender specific clothing in accordance with the offender's gender-related needs.

5. Within 30 days of an offender identified under Paragraph II.H.1. arriving at ~~his or her~~the assigned parent facility or new disclosure of transgender or alternate gender identity at the parent facility, a mental health professional shall:

a. ~~A mental health professional shall c~~Complete a social history interview and review any relevant documentation regarding gender expression or ~~real~~ life experience the offender may have had in the gender role ~~of the opposite gender or alternative~~ other than the gender ~~from that~~ assigned at birth. The history shall be documented on the Mental Health Progress Note, DOC 0282, and shall include, but may not be limited to~~,~~ the offender's:

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(1) Mental health history;

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(2) Current mental health status;

(3) General adaptive functioning;

(4) Gender identity and the development of gender identity or gender dysphoria, as applicable;

(5) ~~offender's~~ Positive or stigma experiences in social situations;

(6) The availability of support in the community and in the correctional setting ~~such as employment,~~;

(7) Experiences during any previous incarcerations, if applicable, and

(8) Any efforts to legally change his or her name, efforts to obtain hormone therapy or~~and~~ gender ~~reassignment~~ reassignment, or gender affirming cosmetic surgery or procedures including ~~for~~ preparation for surgery~~, and experiences during any previous incarcerations, if applicable~~.

b. With the assistance of a representative from Health Care, complete Sections I through IX of the Transgender Care Review Committee Recommendation, DOC 0400.~~, shall be completed by the mental health professional and a representative from Health Care.~~ The completed DOC 0400 shall be submitted to the Transgender Care Review Committee ~~Chairperson~~Chairperson who shall schedule a meeting of the Committee during which the case shall be presented.

b. The ~~GIDC~~ TCRC shall review the case and make the final recommendation for housing and any additional matters that may be of issue such as, but not limited to, hormone therapy, gender specific clothing, showers, searches, etc. The review and recommendations shall be documented on the Transgender Care Review~~Gender Identity Disorder~~ Committee Recommendation, DOC 0400.

6. The ~~GIDC~~ TCRC shall conduct follow-up reviews on an as needed basis. Follow-up reviews shall be documented on the ~~Transgender Care Review Committee Follow-up, DOC 0452, and shall be maintained in the offender's medical file.~~DOC 0400.

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,	)	Case No.
vs.	)	18-CV-156-DRH-DGW
BRUCE RAUNER, JOHN BALDWIN, STEVE MEEKS, and MELVIN HINTON,	)	
Defendants.	)	

Videotaped Deposition of DR. SHANE REISTER

Chicago, Illinois

Friday, April 19, 2019 - 9:01 a.m.

Reported by:

ELIA E. CARRIÓN, CSR, RPR, CRR, CRC

Job No. 25002

EXHIBIT 3

The videotaped deposition of DR. SHANE REISTER, called as a witness herein for examination, taken pursuant to the Federal Rules of Civil Procedure of the United States District Courts pertaining to the taking of depositions, taken before ELIA E. CARRIÓN, CSR, RPR, CRR, CRC, CSR No. 084.004641, a Certified Shorthand Reporter of said state, at Kirkland & Ellis LLP, 300 North LaSalle Street, Chicago, Illinois, on Friday, the 19th day of April, 2019, at 9:01 A.M.

PRESENT:

ROGER BALDWIN FOUNDATION OF ACLU, INC.
150 North Michigan, Suite 600
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jknight@aclu-il.org
gguidetti@aclu-il.org
JOHN KNIGHT, ESQ.
GHIRLANDI GUIDETTI, ESQ.
-and-
KIRKLAND & ELLIS LLP
300 North LaSalle Street
Chicago, Illinois 60654
scott.lerner@kirkland.com
SCOTT LERNER, ESQ.
appeared on behalf of the Plaintiffs;

OFFICE OF THE ATTORNEY GENERAL, STATE OF ILLINOIS, ATTORNEY GENERAL KWAME RAOUL
500 Second Street
Springfield, Illinois 62701
chiggerson@atg.state.il.us
CHRIS HIGGERSON, ESQ.
appeared on behalf of the Defendants.

VIDEOTAPED BY: JEAN-LOUIS ZIESCH, CLVS

INDEX
EXAMINATION

EXHIBITS

THE VIDEOGRAPHER: This is Tape No. 1 of the videotaped deposition of Dr. Reister in the matter of Janiah Monroe, Marilyn Melendez, et al., versus Bruce Rauner, John Baldwin, et al., in the U.S. District Court for the Southern District of Illinois, Case No. 18-cv-156-DRH-DGW.

This deposition is being held at 300 North LaSalle in Chicago, Illinois, on April 19, 2019, at approximately 9:01 A.M. My name is Jean-Louis Ziesch from the firm of TransPerfect, and I am the certified legal video specialist. The court reporter is Elia Carrión in association with TransPerfect.

Will counsel please introduce yourself.

MR. KNIGHT: John Knight for the plaintiffs.

MR. GUIDETTI: Ghirlandi Guidetti for the plaintiffs.

MR. LERNER: Scott Lerner for the plaintiffs.

MR. HIGGERSON: And Chris Higgerson for the defendants.

THE VIDEOGRAPHER: Will the court reporter please swear in the witness.

(WHEREUPON, the witness was duly sworn.)

DR. SHANE REISTER,

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

EXAMINATION

BY MR. KNIGHT:

Q. Morning, Dr. Reister -- or Reister.

A. Reister.

Q. Can you state the name -- your name for the record?

A. I'm Dr. Shane Reister.

Q. Okay.

MR. KNIGHT: And do you need to him to spell that? No.

Q. (By Mr. Knight) Okay. Have you been -- you have been deposed before?

A. Yes, several times.

Q. And how many of those cases have involved transgender prisoners?

A. There was another case. I don't know --

THE WITNESS: Am I allowed to say the other case or --

Q. (By Mr. Knight) Yeah.

A. Yeah. I was involved in the Hampton case.

Q. (By Mr. Knight) Right.

A. Yeah.

Q. Any other than that?

A. No.

Q. Okay. And have you been involved in -- have you had any other -- or been involved in -- in any other cases involving transgender individuals?

A. No.

Q. Have you -- and I believe in -- in the Hampton matter, you testified in a proceeding?

A. Yes.

Q. What -- that was a preliminary injunction hearing?

A. Yes.

Q. And have you testified in any other hearings or trials?

A. I have testified in other -- I've done other depositions for general mental illness but not related to transgender care.

Q. Okay. All right. So just to -- you -- I'm sure you've been told this, and you've done this before. But just to --

A. Uh-huh.

Q. -- remind you, please answer verbally.

Please answer, if possible, without nods of the head or using uh-huh because that's a little hard for the transcript to be clear. Instead, use yes or no.

A. Yes.

Q. If you don't understand my question, please let me know that and I will reask it or try to clarify. If you go ahead and answer, I'm going to assume you understood my question.

And just to confirm, are you represented by Mr. Higgerson today?

A. Yes, I am.

Q. Okay. Is there any reason you can think of why you would not be able to answer my questions truthfully today?

A. No.

Q. Did you meet with your attorneys in preparation for the deposition?

A. Yes.

Q. When and for how long?

A. Ooh.

THE WITNESS: Do you have the dates?

A. It was within the last month. I -- I'll be honest, I don't have those dates memorized.

Q. (By Mr. Knight) Okay. I'm not sure I

need the exact date, but --
A. Uh-huh.
Q. -- how many times?
A. Probably one or two times.
Q. And how long was -- did you meet for each -- each time?
A. Oh, I don't know. At least 15 or 30 minutes, something like that. But we could correspond a lot through email as well, and that's kind of hard to add up those times.
Q. You corresponded via email about the deposition?
A. About particularly trainings I've been developing that is related to the case.
Q. Okay. Were you -- did you review any documents to prepare for the deposition?
A. I have -- went over the standards of care for WPATH. I reviewed my trainings in -- in preparation as well.
Q. Anything else?
A. Administrative directives, standard operating procedure manuals.
Q. Okay. In which admin -- there -- of course, we'll be talking about an administrative

directive that deal -- that addresses transgender individuals.
A. Yeah. There's a transgender care directive. But the current one is under revision, and it's in Springfield, and it's in the process of approval. The mental health standard operating procedure manual already has the updates in it. And when I was revising and -- and creating that section, I aligned it with the world professional association of transgender health. I did the mental health piece, and Dr. -- Dr. Dempsey did the psychiatrist's piece.
Am I speaking loud enough?
Q. You are. I just would remind you to let me finish my question before --
A. Oh. Oh, okay.
Q. -- you answer it. It's -- it's common to talk over one another, but it's better for the transcript and everything for you to let me finish the question first.
Okay. So you looked at the administrative directive about transgender health.
A. Uh-huh.
Q. Any other administrative directives?

A. On a regular basis, I review the mental health directives. I refer to those frequently.
Q. Okay. Are there -- there any of those that relate specifically to transgender individuals other than the one that's under revision now?
A. Well, most of the transgender offenders that we work with also have mental illnesses. And so they're related to the total -- totality of care that we provide, because you can't deal with gender dysphoria without also dealing with other mental illnesses and substance use disorders. So they all apply to the care; otherwise, you're not actually following WPATH standards.
Q. But are any of the other ones other than the one that's under revision specific to transgender healthcare?
A. Those are not specific. It's cis and transgender offenders.
Q. Okay. And you -- you mentioned -- and I'm not sure my notes are clear --
A. Uh-huh.
Q. -- a transgender health section of a larger document. What was that called again?
A. The standard operating procedure manual

for mental health.
Q. Okay. And you're saying that has been revised recently?
A. I revised that I think a couple of years ago, actually. The latest revision was in 2017 in December, but that section was still relevant. I don't believe I updated anything in that section --
Q. Okay.
A. -- to the best of my knowledge.
Q. Did you review any other documents other than the ones we've already talked about?
A. Oh, goodness. Those are the main documents that -- that I recall. I don't recall other ones.
Q. Okay. Were you involved in responding to the discovery requests? And that -- and by that I mean the written discovery requests to the department?
A. I was asked information, and I sent emails and things like that directing -- like they -- one of the things they wanted was data on the size of the transgender population. So like I provided information of, you know, where to get

that.
Q. Okay.
A. Or are you referring to something more specific?
Q. No, that's -- that's it. That's it.
Is there -- did you make any notes in preparing for the deposition?
A. I made some -- a few notes to myself, yeah.
Q. Okay.
A. Yes.
Q. Could we see those?
A. Sure.
THE WITNESS: Is that --
MR. HIGGERSON: Yes.
A. They're a mess. They're handwritten.
Q. (By Mr. Knight) All right. Okay. Well, maybe we -- we won't start with this. Maybe we'll -- if -- we'll get a copy and --
A. It's kind of a map of what we do and what I do.
Q. Got it. Okay. All right. Back to the standards of care.
A. Back to the standards of care.

Q. Okay. I'd like to talk a little bit about your education. Where did you go to college, Dr. Reister?
A. I went to undergrad at University of Wisconsin-Milwaukee. And then I went to graduate school at the Illinois School of Professional Psychology. Halfway through, after I finished the master's, they became Illinois School of Professional Psychology at Argosy University. So they were incorporated between my master's and the doctorate.
Q. And so you completed a doctorate at Argosy University?
A. Yes.
Q. And -- and was there any specialty in your doctorate?
A. My specialty was involved in the externships.
Q. Okay.
A. I had an externship in severe mental illness, and that was at the -- at the family services of McHenry County. And then my practicum were -- was an LGBT specialty site, and that was the office of Dr. Greg Sarlo.

(Court reporter clarification.)
THE WITNESS: The office of Dr. Greg -- Gregory Sarlo, S-A-R-L-O.
Q. (By Mr. Knight) Any other graduate training or -- I'm sorry.
Other than -- once you finished your PhD, was there any further training that you've had?
A. In my postdoc years, I worked at the treatment detention facility. And when I did my postdoc, it was located at the -- in Joliet, Illinois. And then after I became a psychologist there, I moved into a team leader position. It was moved over to Rushville, Illinois. And while I was there, I organized and developed an LGBT group therapy so that we could incorporate an awareness of LGBT culture and needs into their treatment.
I also -- are you wanting like conferences? 'Cause I -- like, for example, I went to the WPATH conference in Chicago a few years ago.
Q. Sure. When -- when would -- you went to the Chicago --
A. The Chicago --
Q. -- conference?
A. -- WPATH conference. It was a couple

years ago.
Q. And we're talking about the -- the conference --
A. World --
Q. I -- I understand what -- what WPATH is --
A. Okay.
Q. -- but you're talking about the -- the conference, was it a -- a specific training or was it the --
A. Yeah.
Q. -- the conference -- the once-a-year conference or annual conference?
A. It was a -- a three-day conference for training purposes. So we had a number of speakers that -- that talked about issues from mental healthcare assessment, explaining the medical side of transgender health. It was a very comprehensive conference. The --
Q. And then they do -- I'm sorry.
A. I'm sorry.
They do it periodically, and they do it over -- in different locations around the world. Like the September one that I'm going to go to is in

Washington, D.C.
Q. And was this conference in Chicago a part of their certification program?
A. You know, I'm not -- I think it would qualify, but that was before they did the certification, I think.
Q. Was this the first WPATH conference you've been to?
A. That was the first WPATH conference I've been to.
Q. And -- okay. And are you a WPATH member?
A. Yes, I am.
Q. And how long have you been?
A. Approximately five years.
Q. Have you continuously been a member for five years?
A. Yes.
And in addition, we get training information through the LISTSERV of WPATH. So they talk about issues, people have questions, and then I get updated information.
Q. You -- you have not completed their WPATH certification though?
A. No.

Q. Any other conferences or training since your PhD?
A. I've gone to conferences regarding care of sexually violent persons, ethics training, continuing education. I'm a regular speaker, and I also attend the Southern Illinois Drug Awareness Conference.
Q. And these are -- these other conferences you're talking about are not about transgender health specifically?
A. Yeah, it's -- it's -- because to be good at transgender health, you have to be good clinically in general. So I cover all trainings in various areas.
Q. And what is your current position?
A. I'm the southern regional psychologist administrator for the Illinois Department of Corrections.
Q. And you oversee the -- well, tell me what you do. You --
A. I oversee 11 prisons and 2 boot camps of Southern Illinois. And so I oversee the mental health programming and quality assurance, how the corrective action plans are going, training, and

development. I also work on various statewide projects.
Q. Did you learn about or treat any gender dysphoria in -- at the Illinois School of Professional Psychology?
A. Yeah. We had that LGBT class coursework that we did, so it was covered. Also, dealing with the intersection of identity is throughout all classes as well.
Q. And at Dr. Sarlo's office, was that a fellowship?
A. That was --
Q. Or you said externship?
A. Well, I had a diagnostic practicum, a therapy practicum, an advanced practicum that merged both, and then an internship.
Q. And did you work with any transgender patients in that practice?
A. We had gender nonconforming individuals. They did not necessarily identify as transgender.
Q. Did you have any experience working specifically with transgender people while in school?
A. No.

Q. And in -- and not -- you mentioned Dr. Sarlo's office, specific transgender patients you treated.
A. It wasn't any specific transgender.
Q. Okay.
A. That wasn't until I worked at the treatment detention facility.
Q. Okay. So that was the first time you saw transgender --
A. Yes.
Q. -- individuals?
A. Uh-huh.
Q. And when was that?
A. That was after I graduated. That would have been 2004?
Q. And how many -- well, you were treating all individuals at the detention center? And I'm sorry, which detention center was this?
A. The treatment and detention facility, it's a Department of Human Services facility. And it is for the civil commitment of sexually violent persons.
Q. Okay. So you're saying among the -- and you've treated all of the individuals there? You

were not focused on transgender individuals?
A. There was a group for LGBT individuals, and there was a transgender person within that group. And we were working on identifying how -- the intersection of culture into their interpersonal skills.
Q. Okay. So going back to your -- your current position, you are -- you said you cover 11 prisons and 2 boot camps?
A. And 2 boot camps.
Q. Okay. And that's in the Southern Illinois area?
A. That's in the Southern Illinois -- Illinois area.
Q. And you mentioned some other projects, so what are those projects?
A. I am on the project for updating our training program for crisis responding. I'm involved in our training program for transgender mental health care, as well as sensitivity training for all staff.
Q. And the sensitivity training, is that sensitivity training -- what type? Sensitivity to -- to what?

A. What it is, is it's -- it's a comprehensive training that I developed. It's an hour and a 45 approximate minute training that goes through legal issues, helping individuals in the department understand the difference between sexual assignment at birth, gender identity, gender expression, sexual orientation.
So the individuals, first of all, understand who we're talking about and the various issues. It goes into the intersection of identity, and it talks about implicit bias. And it talks about how to interpersonally communicate with transgender people, subjects like not misgendering and what does misgendering mean, those sorts of topics.
Q. Okay.
A. We go over and explain in general the model that we use in the department for transgender care and security management. We talk about Prison Rape Elimination Act measures that we utilize and how that applies to the transgender community, because they are at a higher risk of a sexual assault. And we talk about that.
We educate the staff on the importance of

mental illness and talk about our rates in mental illness and how important it is to keep in mind -- for example, I have national alliance of mentally ill training that helps with understanding mental illness and then talking about, you know, how mental illness applies to this population.
So you're not just dealing with somebody with gender dysphoria -- and I do define gender dysphoria also in the training -- but also those interpersonal skills need to incorporate how to interact with people of severe mental illness. We have individuals at various levels of care, and so they need to be mindful of that as well.
Q. And when -- is this training complete that you're talking about?
A. I have completed the voice-over work and the slides. I have some editorial things. There's a couple periods I want to delete, and I accidentally wrote couch instead of coach on one of the slides. But those are just typographical errs -- errors. And so it's basically ready. We could launch it as it is, but I want to just kind of fine-tune it a little bit.
And we have it planned to be launched in

May with the train-the-trainer trainings. And then I'm going to go -- we have basically three sites with large transgender population: Dixon Correctional Center in Northern Illinois; and Logan Correctional Center, that's in a central area; and then we have Pinckneyville Correctional Center.
The bulk of our transgender male population is at Logan Correctional Center, and the bulk of the female clients that we work with are at Dixon and at Pinckneyville. And so I'm going to go in with those trainers and just make sure that they're understanding the training, able to field questions. 'Cause there is a 15-minute segment at the end so people can ask questions.
Then the trainers can communicate with me through a SharePoint-type communication to answer questions that people may have for follow-up. And then we're going to incorporate that into our cycled training that we do on -- and we're going to incorporate it on the day that we cover mental health issues. So they're going to just add that piece into our exist -- our existing annual cycled training.
Q. Who is the training for?

A. The training is for all staff.
Q. And what is the cycled -- the cycled training you mentioned?
A. Annually, IDOC staff get trainings on a variety of different topics, from administrative directives to mental health issues; you know, things as detailed as, you know, like if you're using a State vehicle, that sort of thing, things that you might need to know about that. So it's comprehensive reminder training.
Sexual harassment's talked about annually. We do CPR, I believe, every other year. So things like that that would be comprehensive to the care and what we do at IDOC.
Q. So this is new? You've not done training of staff on trans individuals in the past?
A. The NAMI training -- and again, I -- I believe, I don't want to state definitely, but I'm pretty sure it covers transgender people to a degree but not what was necessary. We -- what -- this training is really fleshing out the topic --
Q. What is --
A. -- specifically.
Q. What is the NAMI training?

A. National alliance of mentally ill training. So the national alliance of mentally ill work -- worked with IDOC to provide a two-day training on mental health issues so that the -- all the staff were aware of mental health. 'Cause we have a -- a large mental health population.
And then they incorporated pieces of that into the annual cycled training. So in addition to those two days of training, they incorporate that in.
Q. Okay. You -- do you see transgender patients currently?
A. No. I have not seen a transgender patient for therapy purposes since I worked at Dixon Correctional Center as a staff psychologist for Wexford Health Sources. Now I'm in an administrative position as a State worker for my current position. So I worked initially for the contract company and now I work for the State.
Now, I do interview transgender offenders, and I also have begun going into the support groups that we have. I went into the support group at Dixon Correctional Center, and I also went to Pinckneyville Correctional Center

because I -- and I've also interviewed Ms. Hampton for that case, Ms. Monroe for this case.
And what I'm trying to do is communicate and help them understand what we're doing and the direction we're going as a department. And I'm also trying to get feedback in terms of, you know, do they see a difference in what we're doing? Taking in ideas and suggestions. So it's kind of a -- a dialogue process. And then I address any issues that I see within the group process as well, if something's going on in the group itself.
Q. Okay. So you -- you don't actually treat patients --
A. No.
Q. -- but you have been to some of the groups where transgender individuals are?
A. Yes.
Q. And then you have interviewed, you mentioned, two people.
A. Yes.
Q. Ms. Hampton and Ms. Monroe?
A. Yes.
Q. Okay. Let me ask about the -- the groups.

A. Uh-huh.
Q. These are trans group sessions at these specific prisons?
A. Yes.
Q. And where are those currently happening?
A. Dixon Correctional Center has a group, Pinckneyville Correctional Center has a group, Logan Correctional Center has a group, and I believe Lawrence Correctional Center also has a group running.
The groups -- it depends on the inmate population as well. Because we do move offenders from facility to facility, and we have to have enough offenders to run the group, as well as interest. They're not required to go to these groups. They're optional groups.
Q. How many -- how many times have you been to a group?
A. I went one time at Dixon Correctional Center and one time at Pinckneyville Correctional Center. I have yet to go to the Logan one, but I plan to do that.
Q. And -- and you haven't been to the Lawrence one?

A. No.
Q. And you're -- it sounds like you're not sure there is, in fact, one going on at Lawrence; is that right?
A. I -- I would have to check the group list to make sure that's currently running. It was running last fall.
Q. Do you ever meet with transgender individuals because of a suicide attempt?
A. I have not.
Q. Are you aware of suicide attempts among transgender individuals?
A. There was one up north, but that was not within my region. We have also had some acting-out behaviors across the state. People will consult on our monthly case conference and ask questions and share information, ideas. And it's a general case con -- consultation where we pull in various clinicians from around the state and do it via a -- a telephone.
Q. And you mentioned one up north, and you said you had had a conference with that person -- the mental health staff about that suicide attempt?
A. Not specifically about that. I know that

there is a process that individuals do at facilities and at MHPs; but no, that -- that was not something I was involved with.
Q. Do you know when that happened?
A. No, I don't.
Q. Are you not -- are -- are you not generally involved in reviewing or doing autopsies of suicide attempts?
A. I do not provide those, in general, if it's not a completed suicide. And if it's a completed suicide, it would generally be one in my region, not one in the central or northern region.
Q. How much of your time is spent on trans healthcare as opposed to the other things that you do?
A. Well, it's consumed a lot of time lately as I've been trying to get all the resources and research necessary to do the all-staff training. It's -- it's hard to estimate how much, but it's -- like in the last month alone, it was probably a good sizable chunk, if not the majority. Over 50 percent of my time because it's very labor intensive. Not only --
Q. What -- sorry.

A. -- did I have to write the slide, I had to research the slides, I had to write the slides. I had to do voice-over work for the slides.
Q. Okay.
A. And so that took a lot of time.
Q. Understood. So prior to working on the training session that you've talked about, how much -- what percentage, approximately, of your time was spent working on transgender healthcare issues?
A. Well, it would probably -- it's hard to estimate the percentage without getting out a calculator. You figure I do an hour training as long as there isn't a conflict -- well, it's not a training, but it's a consultation every month for the transgender care case conference. So we're focusing then.
I respond to emails quite frequently. Some weeks it's more than other weeks. Every month I am on a transgender care review committee. We take a look at whether the site's treatment plan, security plans -- you know, treatment for both medical as well as mental health -- and any other issues that they would like to discuss.
And that takes multiple hours once a

month. I mean those can be three hours long. It depends on the number, but we have a very large population. So those have tended to be multi-houred consults.
Q. Okay. Well, I've got emails, one hour for the transgender conference.
A. Uh-huh.
Q. And then three hours with the --
A. Three hours plus, yeah.
Q. So that sounds like actually a fairly small percentage unless there's something else.
A. Well, and also the training and development. And when I do the mental health, I try annually to update mental health trainings and --
Q. Okay.
A. -- that sort of thing. We are now up to an eight-hour training that I've developed. So -- but again, it's -- it's hard to estimate because I have my regular duties and then I do these projects as well. So I chunk out my time, but I don't track that.
Q. Okay.
A. So it's hard to say, but it's an eight-hour training. So you figure there are many,

many hours involved for each of those hours.
Q. But you're generally responsible for all mental health needs of the people --
A. Yes. It is --
Q. -- in the southern prison --
A. Yes.
MR. HIGGERSON: And again, let him finish.
THE WITNESS: Oh, I'm sorry.
Q. (By Mr. Knight) Okay. Okay. And the -- you mentioned the transgender committee meetings. Are you actually a member of that committee?
A. Yes.
Q. Because the notes reflect you as a participant as opposed to a member.
A. I --
Q. That is, the committee records show that you're -- you're a participant, not a member.
A. The primary people are -- it's going to be the chief of medical, the chief of psychiatry, and the chief of mental health. I'm not a chief, so I wouldn't be listed as a primary group member. But there's also the transfer coordinator's office, various operational people, all of the individuals on the site. There's gotta be a representative from

medical, a representative from mental health, a representative from the administrative team.
And we all work as a multidisciplinary team and as a multidisciplinary staffing. And every one of them I'm invited to, and they would like me to be on them. And I've been doing that for over six years.
Q. Okay. Well, so you're saying there are key members. You're not one of those, but you're there --
A. An ongoing --
Q. -- and they want you to be there on an --
A. Yes.
Q. -- ongoing basis?
A. Uh-huh.
Q. Are you always there?
A. I'm not always there.
Q. And is the -- the transgender committee familiar with the WPATH standards?
A. Yes.
Q. And how do you say that? Why do you say that?
A. Because I wrote the standards into the SOP, in the standard operating procedure manual that

we utilize for the mental health. It's -- it's written in there.
We also discuss it, and I provide consultation and -- you know, now the committee members are -- are familiar. But, you know, the criteria -- for example, I -- I remind people about the criteria that you would use.
Q. When you say you remind people, you remind people on the committee about the WPATH standards?
A. Yes. Because we have changes in operational people, that sort of thing. We want the -- everybody to be well-educated. So occasionally, people will ask questions and I can answer those.
Q. And so does the committees follow the standards of care?
A. Yes.
Q. And I -- you're -- right, the -- we're talking about -- just to be clear, we're talking about the WPATH Standards of Care; is that --
A. The WPATH Standards of Care.
Q. Okay. And you -- you, I assume, are familiar with the fact that there are three

different kinds of medical treatments that are provided to treat gender dysphoria; is that right?
A. Uh-huh. You can have a therapeutic approach. You can use a medical approach. We use a systems approach as well. That fits into dealing with the stigma management. So we're dealing on multiple level -- on multiple levels with the care.
Q. So specifically, though, when it comes to medical treatment for gender dysphoria --
A. Uh-huh.
Q. -- there are three forms?
A. Uh-huh.
Q. Would you agree? Social -- social transition?
A. Uh-huh.
Q. Hormone therapy?
A. Uh-huh.
Q. And surgical treatment?
A. Yes.
Q. And those are set out in the standards of care as --
A. That --
Q. -- as a part of the treatment for the condition; is that right?

A. Yes.
Q. And I take it you understand that the social transition would include things like name and pronoun usage?
A. Uh-huh. Yes.
Q. Usage of sex-segregated facilities consistent with a person's gender identity?
A. We are -- we review --
Q. I'm -- I'm just asking whether that's in the standards of care, first of all?
A. Well, the standard of care specifically for institutions, one of the things it talks about is assessment. When somebody gets on, we need to continue the hormone treatments and the treatments that are available.

We will -- we have to classify -- the classification centers classify into which division: the male division, the female division. And we've had transgender individuals who are transgender men in both the female and male division. We've had transgender women in the male and female division. It's a case-by-case basis that it's looked at.
Q. Okay. I'm just asking whether that's a social transition, as a part of the treatment --

A. Yes.
Q. -- in general --
A. Uh-huh.
Q. -- includes use of sex-segregated facilities consistent with one's gender identity, like restrooms and locker rooms as --
A. Uh-huh.
Q. -- well as other kinds of activities or facilities.
A. Yes. I believe I am understanding your question.
Q. Well, in -- in other words, if we were -- in general, if we were talking about a school that is set aside for girls --
A. Uh-huh.
Q. -- then a -- a girl who is transgender would want to go to the girl -- or should have access to the girls' facility. That would be part of her social transition, living as --
A. Uh-huh.
Q. -- a girl in all ways --
A. Uh-huh.
Q. -- is that right?
A. If an individual in -- who is an offender

would like to transfer to the other division and they are not currently placed at that division, then they would use -- utilize the mental health provider at the facility who serves kind of like a linkage capacity to prep and communicate this request to the transgender care review committee.

And then we would determine -- we would interview the individual and then determine through the committee whether a switch and placement is necessary. So it's a case-by-case basis if the assignment of the facility is incongruent with somebody's sense of where they feel they should be placed.
Q. Right. Again, I'm asking about the treatment as opposed to your application of it. So that's --
A. Oh, okay. Yes.
Q. And so that the availability of the ability to live fully consistent with one's gender identity is a part of social transition?
A. Yes, it is.
Q. Okay. And that may include things like clothing, for example?
A. Uh-huh.

Q. Feminine clothing for someone who identifies as a -- who has a female gender identity, for example?
A. Uh-huh. Yes. Yes, it would.
Q. That was a -- that may not have been very clear, but that was a question.
A. Yes.
Q. And social transition can include electrolysis, for example, permanent hair removal?
A. Yes. Those are -- that's listed as options.
Q. Breast binding for men who are transgender?
A. Yes.
Q. And genital tucking for women who are transgender?
A. Yes.
Q. So you -- you talked some about the -- this case-by-case assignment process.
A. Uh-huh.
Q. Has any woman who's transgender, other than Ms. Hampton and Ms. Monroe, been placed in a female facility?
A. Yes.

Q. Who?
A. I'm going to try to pronounce it correctly -- Ms. [redacted].
Q. Okay. Wasn't that because Ms. -- there was the understanding that Ms. [redacted] had had genital surgery?
A. There was an understanding about that.
Q. And that's the reason she was transferred to the female facility?
A. Well -- and she requested it.
Q. Right, but -- but --
A. Yes.
Q. -- she was --
A. Uh-huh.
Q. -- her -- her request was granted because she was seen as someone who was not able -- or -- or -- or had had genital surgery?
A. That was one of the -- of the things that we looked at. We try to look at the whole person. Most -- most importantly was, you know, that we worked as a committee and discussed all the various options, and that was identified as the one that was appropriate.
Q. Other than Ms. [redacted] and -- and

ultimately, Ms. [redacted] was actually transferred back to Lawrence, wasn't she?
A. Uh-huh. Yes.
THE WITNESS: And am I allowed to talk about like the specifics of that? Or is that like private in terms of the reason? It's -- it's kind of private information about what --
MR. HIGGERSON: She's not a -- a plaintiff at this point.
MR. KNIGHT: Well, she's a class representative. I mean, she's a part of the class. We represent the entire class, so it's --
MR. HIGGERSON: It hasn't been certified.
MR. KNIGHT: It -- if you -- if you want to -- I don't think that the notion of -- well, first of all, I mean, it's relevant to what the committee does. So -- and this is about the committee process. So I -- it seems to me we --
But secondly, we have a putative class. We have documents for those class members. I think it's -- it would be a complete waste of time for us to -- I mean, we could -- we could certainly call the magistrate about it if you like.
MR. HIGGERSON: Well, but the documents you

were provided were under a Protective Order with the understanding that it's useful to evaluate the class, but not -- you're not allowed to use those otherwise at this point. They're under a Protective Order.
MR. KNIGHT: If -- if you want to designate these parts of the transcript as confidential, you're free to do that under the Confidentiality Order, but there's nothing that prohibits us from asking about any of the documents.
MR. HIGGERSON: But you're not asking about a document. You're asking him his knowledge of somebody.
MR. KNIGHT: I'm asking about those individuals, and I -- I don't think there's anything that would prohibit that.
Why don't -- why don't we do this? Why don't we do this, is -- if we would like to leave out the names and -- I mean, we've already had this particular name.
THE WITNESS: Uh-huh.
MR. KNIGHT: -- but to the extent that we talk about any other individuals, maybe we can identify Bates numbers as opposed to use the name. Or at

least we can try to do that.
MR. HIGGERSON: Yes.
MR. KNIGHT: But it seems to me you can also just redact those. We -- you can mark that as confidential. We could also redact the names.
MR. HIGGERSON: That's fine. First, let's --
MR. KNIGHT: The easiest would -- the easiest would be to do the latter, but I'll try to avoid using names to the --
MR. HIGGERSON: To the extent we can. And if we can't, yeah, then we can worry about the -- the designation.
MR. KNIGHT: Okay.
THE WITNESS: Yeah. 'Cause I -- the reason why I asked this is it's very private information about this particular person. I'm just concerned about any negative ramifications if this information --
MR. HIGGERSON: Okay.
THE WITNESS: -- gets outside of -- you know, and 'cause it's -- it's very private, what occurred there. So I don't want to do more harm in addressing the issue. Does that make sense?
MR. KNIGHT: Well, okay. So why don't we just agree we're going to designate this information as

confidential.
Q. (By Mr. Knight) But I think it would be helpful if you could at least give me a summary of what -- of the reason why she was transferred back?
A. She had a mis -- sexual misconduct while at that particular facility.
Q. Okay. The -- well, have there been anyone other than those three?
A. Not during my stay on the committee.
Q. Are you aware of anybody prior to your stay on the committee?
A. I don't want to state -- I mean, because I don't know if it's accurate or not. So --
Q. You -- you --
A. -- that -- I just want to speak to my -- I thought there might have been one. But I'll be honest, I'm not sure.
Q. Okay.
A. But on my committee, those are the individuals that I was involved with.
Q. And the -- Ms. Monroe and Ms. Hampton --
A. Uh-huh.
Q. -- had brought legal action to seek transfer; is that right?

A. Yes.
Q. That's your understanding?
A. Uh-huh.
Q. Are you aware of the amendment qualifications in the -- set out in the WPATH Standards of Care for mental health professionals?
A. We need individuals who are trained and licensed. They need to follow ethical standards for care.
Q. Well, I believe that -- I mean, I can show them to you, but I believe the minimum qualifications listed are a master's degree or --
A. Uh-huh.
Q. -- equivalent in clinical behavioral science field.
A. Yeah, that would --
Q. Are you familiar with that?
A. Yes. That would be all of our clinicians. We have master's and -- and doctorate level individuals who are assigned to work with this population for their mental health groups and their one-on-one care.
Q. And are -- you're saying all individuals who provide mental health treatment to the

transgender individuals have master's degrees?
A. For transgender-specific care, yes.
Q. And so that would be -- that -- I -- I -- my understanding is that not all of the mental health professionals are master's degree level at the facilities.
A. The -- there are behavioral health technicians who are a bachelor level people that provide psychoeducational kind of programming. We also have some rec therapists as well who are a lower level of training. Again, these individuals would be working with other -- other needs beyond gender dysphoria.
Q. Okay. So then --
A. So --
Q. -- the bachelor's -- bachelor's level, you -- you're only going to have transgender people being treated by master's level people? Is that --
A. Treated --
Q. -- your statement?
A. No. I'm saying that -- treated for gender dysphoria.
Q. Oh.
A. Does that -- because we provide more than

just treatment for gender -- than gender dysphoria, because individuals with gender dysphoria also have other mental health issues that also are addressed.
Q. Okay. Well, so in general, are you telling me that the department is following these mental health standards for professionals in terms of the people who are treating transgender individuals? That's your understanding?
A. Yes, we are. We have master's level clinicians and doctorate level clinicians that are providing the therapy groups and are providing the one-on-one as well. And then they are all -- we all work together and consult as well so that we're not operating in a bubble. So we operate as a team of individuals sharing information, consulting, asking questions.
Q. Okay. But I'm -- I'm -- I'm sorry.
But I'm asking about the people that are actually treating the individuals. For those people, you are saying it's your understanding that they are all master's level --
A. Yeah.
Q. -- if they are treating a prisoner for --
A. Uh-huh.

Q. -- gender dysphoria?
A. Yes. If they're treating for gender dysphoria, they are master's or doctorate level clinicians.
Q. And have these individuals received continuing education in assessing and treating gender dysphoria?
A. Well, in terms of continuing education credits, I do not know specifically what these individuals have been doing. I don't monitor their continuing ed. I provide them trainings and we do case consultations as well.
Q. Okay. Well, that's one of the minimum standards, is this continuing education.
A. Uh-huh.
Q. You understand that?
A. Yes. The department is -- actually has the ability to provide continuing education credits. We're authorized to provide those.
Q. Okay. But my question is: Do you know whether those MHPs who are treating prisoners have had continuing education?
A. They should be --
Q. In the assessment --

A. -- getting continuing education.
Q. They -- they should be, but you're not sure?
A. I have not surveyed and collected the specific data.
MR. KNIGHT: Okay. Why don't we mark this.
(WHEREUPON, discussion was had off the record.)
(WHEREUPON, a certain document was marked Reister Exhibit 1, for identification, as of April 19, 2019.)
Q. (By Mr. Knight) If you could just take a look, Dr. Reister -- first of all, would you identify for the record, what are these?
A. These are the WPATH Standards of Care for Health of Transsexual, Transgender, and Gender Nonconforming People.
Q. And this is what we were talking about before that the department governs --
A. Uh-huh.
Q. -- its care on?
A. Yes.
Q. Okay.

A. And this is a primary source that I use for trainings as well as for AD development.
Q. Okay. And taking a look at -- and -- and maybe you're familiar with this, but just --
A. Uh-huh.
Q. -- if you would just take a look at page 25. I take it you would agree and understand that the standards of care clarify -- and again, this would be on page 25 --
A. Uh-huh.
Q. -- in that last paragraph -- that for -- that it's important for mental health professionals to recognize that decisions about hormones are first and foremost the client's decision?
A. Yes.
Q. And is that true at the Department of Corrections, in your mind?
A. Yes.
Q. And -- and yet there's this review process through the committee about whether one can get hormones?
A. The review -- the review process -- how -- how should I put this? The review process helps ensure access to care and the quality of care

across the state. So we have an oversight quality to it; and that way, we can ensure that offenders -- offenders' mental health providers and the team are required to be prepped within 30 days of arrival at any parent institution to address the security, medical, and mental health needs.
This way, the committee is able to ensure consistency of care, access to care. It provides an opportunity to ensure that offenders aren't having unnecessary lapses within 24 hours. You know, we want to ensure that there's proper bridging. So we make sure that we contact the medical director on receiving centers to ensure that we have continuity of care.
And the committee also is there to ensure that we prepare individuals who do not have -- either they were on black market hormones or perhaps they're just an identity clarification.
The individual I worked with at -- at Dixon went from identifying as a gender male and being in the closet. And I worked with her on identity formation and working through the process of living as a woman. And today, she gets hormone treatment.

So working with an individual wherever they're at in the process of transition is what this committee ensures. So that way, because of how it's written, we're not restricted just to people who are transgender. The AD and the SOP are written in a way so that it's transgender or people suspected of. So you don't have to have a clarified identity. You can be somebody who's exploring and questioning, and we can help with that process to get that clarification and help them get whatever course is needed.

For some individuals, they may choose no hormones or they may not be medically stable or psychiatrically stable for hormones. For other individuals, they'll need hormones. And then for other individuals, they may need surgery. And so we're constantly assessing and reassessing people in terms of are they ready for it.

And we have a -- a large number of individuals that come into our system having never had the -- an actual script. And we get them through the process. So they leave IDOC, and we help link them up -- usually with Howard Brown, because I work with Howard Brown. I've -- I'm

forging liaisonship, so we have good continuity of care into the community.

And so the process of the committee isn't supposed to be a gatekeeper to stop the hormones. It's supposed to help facilitate treatment for gender dysphoria. So I wouldn't characterize it quite how you worded that.

Q. The -- you -- and you would agree that the standards of care provide that hormone therapy can be provided to individuals who do -- do not wish to make an actual social gender role transition?

A. Individuals --

Q. And I can show you the page where it says that.

A. No, I understand exactly what you're saying. So individuals who may want to be on hormone therapy may have various expressions of gender and gender roles and conceptions. And -- and -- and also keep in mind, individuals may not have a dichotomous sense of gender as well. And they also may want hormone treatment, or maybe they don't.

I mean, that's the reason for the committee, is to ensure that the sites have

consistent access, that the offenders have consistent access across all the sites depending on what their own specific need is.

MR. KNIGHT: Can -- and I'm sorry. Can -- could you read back my question?

(WHEREUPON, the record was read by the reporter.)

A. Yes. Yes.

I didn't understand the question. Sorry.

Q. (By Mr. Knight) You would agree that the standards of care provide that it's unethical to deny people with HIV hormone therapy?

A. Yes.

Q. And you mentioned bridging. Let me talk specifically about persons who were on hormones, say, from the internet. They were not from -- prescribed from a physician.

A. Uh-huh.

Q. Does the committee agree that there should be hormones provided immediately to someone who was on black market hormones?

A. What happens is we don't get offenders very often directly from the streets unless they're a parole violation. We're ensuring that individuals

have access to those hormones, and then that's a decision that's communicated with the medical doctor. So they'll gather the information, and then they will contact the medical director. And then the medical director will make the decision about that continuance.

But just because they're on black market doesn't mean that they're not going to have access. Even if they have never been on hormones, we will help them access hormone if that treatment is needed. And the vast majority of offenders that we work with do, and we get them onto medically supervised hormone treatments.

Q. Okay. Well, I guess my point is that you understand that the standards of care discuss bridging and the importance --

A. Uh-huh.

Q. -- of ensuring that someone who's already been taking hormones, including hormone -- black market hormones, are able to continue taking those hormones?

A. It doesn't specifically -- it's not something that I would be able to answer because I don't know. I'm not privy of those calls. Those

are directly to the medical director.
Q. I understand, but I'm -- I'm not asking you whether that happens or what -- I'm just asking whether your --
A. You would want --
Q. -- about your understanding of the standards of care?
A. -- to continue hormone treatments that are necessary; but if they weren't prescribed, again, I don't -- I -- I -- I'm almost out of my area of competence. But you would want to make sure, 'cause we don't know exactly what people may be coming in taking.
Q. So you're saying if someone wasn't on prescribed hormones, then your understanding is the committee would not continue them on hormones?
A. The initial is not done by the committee. The initial is a contact with the medical director, so I wouldn't be in on any -- or -- or making any comments on that initial receiving. So that -- that's why I'm not able to really speak to that. The TCRC happens after they're at the parent institution.
Can I make an additional comment?

Q. If it's a response to my question, yeah. It's really important that you answer my question; otherwise, we may be here --
A. Forever.
Q. -- forever.
Okay. If you could just take a look at page 43. And again, I'm not asking you about your competence to prescribe hormones but just about your expertise about the standards of care.
A. Okay.
Q. Okay. And so you would see -- you see that there's a -- a reference to bridging here?
A. Uh-huh.
Q. And -- and in the first sentence, it talks about -- actually these first couple sentences, it talks about providing care to ensure that there's not a -- a cessation in the hormone therapy. Do you see where I'm reading? And that includes hormones purchased over the internet.
A. The wording of this -- again, I -- I'm not a medical doctor. That's not my expertise. I'm a psychologist. And so I would refer that it does speak to can provide a limited one- to six-month prescription. Whether or not that's being done is

something I can't speak to, but it says can. It does not say must.
Q. Okay. And do you know whether the -- are you familiar with the qualifications for physicians prescribing hormone therapy that are set out in the standards of care?
A. That is not something that I review. I leave that to the medical staff, like Dr. Puga --
Q. And do you know --
A. -- to take care of those standards.
Q. And do you know whether -- have -- have you spoken to them and advised them about those mental health -- I'm sorry -- about those minimum standards?
A. I -- I advise them to review the standards of care.
Q. Okay. But you don't know whether he did?
A. I know -- well, I have not seen him review it, no. But he would be able to speak to that; Dr. Puga would be able to speak to that.
Q. And is it your understanding that Dr. Puga oversees the physicians who are prescribing hormone therapy?
A. Dr. Puga runs the TR -- the TC -- the

transgender care review committee. And so the clinicians can contact him for, you know, questions and information.
Q. Okay. Well, so there are a number of ways in which the standards of care we're talking about talk about hormone therapy. Are you saying I should pose those -- or ask those of Dr. Puga?
A. Yeah. The medical side, I -- I would be operating out of -- outside of my scope of practice to be referring to how we utilize hormones. The area that I'm looking at is in terms of making sure that we properly assess people, we stabilize people and have, you know, relatively well-managed mental health issues so that they're able to access any necessary hormone treatments.
So my side is the mental health preparation. My side is helping to make sure that offenders, you know, are well-educated so they can have fully informed consent. So we provide that kind of educational piece, working with the culture of the prisons. So the medical side would be Dr. Puga's arena.
Q. Right. Do you receive grievances filed by the -- or -- or made by the prisoners who are

transgender?
A. I received one. I don't know whether it was on an official form or not. It's been too long. But I responded, and I interviewed Offender Hampton based on complaints I received from her. So I went into the facility and --
Q. I'm -- I'm sorry. I just want to ask --
A. Yes or no?
Q. -- and do you get them? Do you receive them? And you mentioned one.
A. I -- I --
Q. Do you know --
A. -- received --
(Court reporter clarification.)
MR. KNIGHT: I'm sorry.
Q. (By Mr. Knight) My question is: I'm just asking whether you receive them?
A. Yes.
Q. In general or -- or from time to time?
A. From time to time.
Q. How many have you received?
A. I've received one direct grievance; and then we also received with Ms. Monroe, through this process. So then I also interviewed her as well.

So they can come through either an initial grievance or they can come through a legal pathway. They could come through a consultive pathway from a mental health provider.
Q. Is it -- are they normally provided to you? I mean, you mentioned two. So it sounds like they're not normally provided to you.
A. Usually what happens, if an offender has a request, I ask the MHP to schedule an update for the TCRC. So it usually comes through the transgender care review committee process, and then we'll review it as a team.
And occasionally, like in those two situations, if we need to, either myself or Dr. Puga or both of us can interview the -- the client if that -- if that's required. Some of the requests can be just approved through the committee. It depends on what it is.
Q. So I believe you said that some of those will simply go to the facility medical staff; is -- is that right?
A. I'm -- I'm not quite sure.
Q. Some of those grievances will not come to you but go to the facility medical staff?

A. Yeah, or -- or the facility mental health staff. The mental health providers kind of survey a consultive advocacy role. So if they have a concern -- like, for example, if there's a concern about getting a bra, that might be directed to the MHP if it's not happening in a timely fashion. And the MHP will talk to the various parties about how to facilitate that so that there isn't a delay.
So some -- it -- it -- they form like a -- a central person the transgender client can go to to try to address or at least get direction on where to go and how to get a particular grievance met. Does --
Q. Okay.
A. Does that make sense?
Q. And so the -- so the committee does from time to time learn of grievances; is that right?
A. I -- I missed the one word, but we -- we --
Q. The committee does --
A. -- we deal with --
Q. -- learn about grievances sometimes?
A. -- grievances.
Learn, okay.

Q. Not always, but they -- they come to the attention of the committee sometimes?
A. Yes. If they can't deal with it, the -- to the offender's satisfaction within the facility, then what will happen is they can shoot it up to the transgender care review committee. That's that oversight component that I was talking about.
MR. KNIGHT: Okay. I'd like to mark this as exhibit -- Reister Exhibit 2.
(WHEREUPON, a certain document was marked Reister Exhibit 2, for identification, as of April 19, 2019.)
A. Uh-huh.
Q. (By Mr. Knight) Okay.
MR. KNIGHT: Oh, I'm sorry.
MR. HIGGERSON: Thank you.
Q. (By Mr. Knight) Okay. Dr. Reister --
A. Uh-huh.
Q. -- could you identify Reister Exhibit 2?
A. This is the gender dysphoria disorder committee, which is the old name for the transgender care review committee, for -- the offender's name, according to the records, are -- is [redacted].

Or [redacted].
Q. Could we use the -- the name she goes by, which is --
A. Yeah, that's what I'm saying, I don't know the name that she goes is the problem, and I doubt it's [redacted].
Q. It's Lydia.
A. Lydia. Uh-huh.
Q. So there's a reference -- and -- and is this -- so this is a form used by the committee; is that right?
A. This is an update form. We usually use the DOC 0400 form; but yes, this is -- this is an update form. It's -- it's one that we could potentially use.
Q. And is this used when a -- an update is being provided about a prisoner who's already come to the attention of the committee?
A. Yes. However, a site sometimes will just use a DOC 0400 form, even though they've been seen before. So you might see either form for an update.
Q. Okay. And if you'll take a look, I believe this mentions that this came to the attention because of a grievance.

A. Uh-huh, yes.
Q. Do you see that?
A. Yes. It's in the very first line.
Q. And -- and in fact, it says she's filed several grievances?
A. Yeah, that's what it says here.
Q. Right. Right.
A. Uh-huh.
Q. So did the committee have access to those grievances or see those? Or is that just information provided by the -- in general, background information from the people who fill this out?
A. It is general background information. And the mental health provider would be talking with the offender about the grievances in preparation for presenting the case to the committee.
Q. So -- okay. So the -- so mental health -- did the mental health provider fill this out then?
A. This would be filled out by the committee. The mental health provider would interview the offender. And it's a teleconference, so then they would present the case and discuss what

the relevant concerns and -- and requests are.
Q. So all of this document was prepared by the committee?
A. It would have been prepared by, I -- Dr. Meeks.
Q. Now --
A. I'm -- I'm looking here to see. Yes.
Q. Okay. And -- and this document looks like, we should clarify, is not -- is multiple committee notes; is that right?
A. Yes. I just noticed that.
Q. So this looks like it's November 18, 2016; March 8, 2016 --
A. Uh-huh.
Q. -- those two.
A. Uh-huh.
Q. And again, my -- my understanding was that the mental health provider filled out some of this. Is that not right?
A. They provide information, and then what generally happens is that information is utilized to type out the final document that's produced. So --
Q. So you're saying Dr. Meeks reviews some other information and fills -- and fills this out?

A. I can't speak to exactly how he does it. But in general, what would happen is -- for example, if -- can I refer to one of the other pages?
Q. Sure.
A. Okay. So if you go to the third sheet of paper on the frontside, that --
MR. HIGGERSON: You can identify that by the Bates number at the bottom, just so we know. See these numbers here?
THE WITNESS: What -- this?
MR. HIGGERSON: Yeah.
A. Okay. 001316.
So a site would -- likely they would -- what they were going to do is fill out this section, answer these basic questions so that the committee has a basic understanding. And then they would talk about what that information is and do any clarifications of that information.
And what happens is that the committee chair is going to write it up officially and consolidate that information into a final report for -- of what occurred at the committee.
Q. (By Mr. Knight) And -- and I'm sorry. You -- you said this, and I just missed it.

You're saying the mental health professional will provide some information --
A. In writing --
Q. -- in writing?
A. -- in advance.
Q. Okay.
A. And -- so that the chairperson has basic written-out things that they can, you know, already go through without transcribing everything that's said, basically.
Q. And what form is that information provided in?
A. It's usually on the 4 -- DOC 0400 form and --
Q. So it's not these forms?
A. No, no. It is -- 001316 is the DOC 400 form. When you look it up on the computer, add the zero in front of the 4.
Q. Okay. So -- so the 131 -- Bates No. 1316 was -- that was typed up by the mental health professional?
A. I would assume that that is. I'm trying to find a signature. At least portions of it would have been submitted in advance, and then Dr. Shicker

may have utilized that in his report. It looks like this is Dr. Shicker's report. But the MHPs actually provide basic information on the form, so -- as a reference point so that the chairperson can actually fill in their section.
We're actually updating the form just to make it easier. And the new form, which has not been approved yet, will actually just have a section for the various departments in the facility and then will have a section at the end so there isn't all this transcription.
So our new form will look -- our new 0400 form will -- will make it a little bit easier. 'Cause the site will just fill this out, and it will be really clear that the site did the wording in the one section and then the committee chair did it in the other section.
Q. Okay. And the -- on the last page, there's a -- a psych exam.
A. Uh-huh.
Q. And that -- that was from the physician, psychiatrist?
A. The psychiatrist.
Q. So -- so this is Bates No. 1319? The

very last page --
A. 1319 --
Q. -- that's at the bottom, 131 --
A. Yes, uh-huh.
(Court reporter clarification.)
Q. Okay. The -- I'll just ask the question again.
So Bates No. 1319 is the last page; is that right?
A. That is correct.
Q. And that is -- has handwriting. Whose handwriting is that?
A. I would assume it matches the -- the typed Dr. Noorani.
Q. And this is a -- a progress note. Is this something -- what is a progress note? Is that --
A. A progress note -- and this is an older form, it's not our current psychiatric progress note, but it's a form that documents a session that a psychiatrist would have where they're doing a diagnostic eval. They might be updating meds or determining what meds might be appropriate.
Q. Okay. Were you a part of this committee

meeting?
A. What year is this? Let's see. Let me make sure there's not two committee meetings here.
Q. Well, you're -- right, there are two committee meetings. So let me ask that again.
A. It look --
Q. Were you a part of either of these committee meetings?
A. Yes.
Q. Okay. And so you were a part of the -- the March 18, 2016, meeting; is that right? Because I see your name there.
A. There is the March 17, 2017, meeting. I was there. And then I was also at a meeting on 11/18/16 'cause my name is also there.
Q. Okay. So you were at both of these meetings?
A. Yes.
Q. Got it. And it's -- but it's -- I see. I see. I'm conf -- right. So this -- the two different meetings were -- I'm looking at the wrong dates. The two different meetings were March 17, 2017, and November 18, 2016?
A. Correct.

Q. Okay. And at the initial meeting, the recommendations -- actually, let me just clarify one thing.

So if you're at a meeting, your name would be on the -- on the committee meeting notes; is that right?

A. Yes.

Q. And -- and then looking at the November 2016 --

A. Uh-huh.

Q. -- meeting, the -- a decision of the committee is reflected in the recommendations?

A. Yes.

Q. And that's on page 1315?

A. Uh-huh.

Q. Is that right?

A. 1314 has a recommendation for 11/18/16 and -- oh, I think it's a duplicate on both sides of the sheet.

Q. Okay. I apologize for the copy issue; but yes, it looks like we have two of the same page.

A. Yeah. That's what's confusing me.

Q. I think that's just the way it was produced to us.

A. Yeah.

Q. In any event, let's stick with 1315.

A. Uh-huh.

Q. And again, my question is: Are the -- is the decision of the committee reflected in this recommendation section?

A. Yes.

Q. And I -- I assume that this is -- well, maybe you can read and explain to me what an IM is.

A. IM is an abbreviation IDOC has classically used designated inmate.

Q. Okay. So the -- if it -- I'll just read this, and you'll tell me if this is accurate.

The committee is concerned that the inmate has not addressed PTSD -- and what is that sign?

A. Symptoms.

Q. -- symptoms and the trauma of sexual abuse as a child. Am I -- did I read that correctly?

A. Yes.

Q. Okay.

She is isolative and has no support system; correct?

A. Yes. Uh-huh.

Q. Okay. And while she, quote, wants hormones regardless of what others think, there is the potential for further victimization and isolation as the physical effects of feminizing hormones become apparent --

A. Uh-huh.

Q. -- correct?

A. That is what it says.

Q. Okay. And the committee is not in agreement with starting estrogens but would require -- I'm sorry -- but would reconsider once inmate appears to have developed a peer group for support and has engaged in regular therapy to develop insight and coping; correct?

A. Yes.

Q. Okay. So this -- the committee denied hormones --

A. Uh-huh.

Q. -- to this inmate, and it's for those reasons?

A. It -- yes.

Q. Okay. So -- okay.

MR. KNIGHT: Could we take a break?

THE VIDEOGRAPHER: It is 10:29 A.M. We go off the record.

(A recess was had from 10:29 a.m. to 10:46 a.m.)

THE VIDEOGRAPHER: It is the beginning of Tape No. 2 of the testimony of Dr. Reister. It is 10:46 A.M. We are back on the record.

Q. (By Mr. Knight) Okay. And you understand you're still on the record -- still under oath --

A. Yes.

Q. -- Dr. Reister? Okay.

And I actually would like to go back to Exhibit 1. The -- just -- and take -- and -- and maybe you -- you know this in general, but the -- the -- the section that's applicable to people in institutional environments --

A. Uh-huh.

Q. -- provides that they apply in their entirety to transgender people, irrespective of their housing situation --

A. Uh-huh.

Q. -- including prisons. You understand that?

A. Yes.
Q. Okay.
A. Yeah. There's -- specifically on page 67 --
Q. Right.
A. -- is living in institutions.
Q. Right. And so you said -- in your testimony earlier, you suggested there was something different about the institutional environment in terms of how the standards of care would apply. And I just -- so that seems a little inconsistent with what the standards actually say.
A. I'm not quite sure what I said. It --
Q. Well, I guess --
A. Yeah.
Q. And why don't we just -- as opposed to going back to what you said before --
A. Yeah.
Q. -- your -- when you say that the department of correction applies the standards of care, you mean in their whole to the prison environment? So in other words, you're not treating the institutional environment as the care is going to be different because it's the institutional

environment; is that right?
A. Yes. We want to treat gender dysphoria in a way that is in a consistent manner with WPATH, and so that's how I wrote the mental health treatment.
Q. Right. And are there -- other than the WPATH Standards of Care, are there any other standards that -- that the Department of Corrections applies to its care of transgender individuals?
A. Well, the mental health standards, I think, are important to make sure that they're getting appropriate care, sensitivity, cultural awareness.
Q. And I'm sorry. Which mental health standards are you talking about?
A. Social workers have standards. Counsel --
Q. Did --
A. -- counselor associations have standards. There's standards in the APA, the American Psychological Association, American Psychiatric Association. So each -- each specialty has ethical standards, but they basically have similar themes about quality of care and competency and in terms of

doing no harm, those kinds of ethical standards.
Q. So is the Department of Corrections' intent to follow all applicable standards and the -- the latest standards --
A. Uh-huh.
Q. -- in providing care for transgender individuals?
A. Yeah.
Q. And by med -- I mean medical standards. Let me be clear: Is it the department's intent to follow all prevailing applicable mental health standards to trans -- to the medical -- medical treatment of transgender individuals?
A. In terms of how I'm writing the mental health standards and the standard operating procedure manual, the intent is to follow the standards.
Q. And --
A. So the mental health care which falls under my jurisdiction is designed to do that.
Q. Okay. And one of those standards would be the WPATH Standards of Care?
A. Yes.
Q. Are there any other specific standards

that are specific to the treatment of gender dysphoria that the committee applies other than the standards -- the WPATH Standards of Care?
A. The WPATH standard is what we utilize.
Q. Okay. And looking again at Exhibit 2 --
A. Uh-huh.
Q. -- did the committee follow the standards of care when it reviewed and made the decision about treatment for -- for this inmate?
A. Yes. Because an individual did not have sufficient stability in terms of the coping skills, and so they were gonna work on the PTSD symptoms to get those better under control so the coping was sufficient to be able to transition.
Q. And so it's your -- your belief that that would be consistent with the standards of care?
A. Yes.
MR. KNIGHT: I'd like to mark this as Reister exhibit -- actually, I realize that since we have two deponents, should we -- does it make sense to call this 30(b)(6) exhibits or --
MR. HIGGERSON: I think you could show Dr. Puga -- Puga Reister 1 and still call it that.
MR. KNIGHT: Yeah. Okay.

MR. HIGGERSON: I think that --
MR. KNIGHT: All right. Well, in any event, we'll identi -- could we identify this as Reister Exhibit 3.
(WHEREUPON, a certain document was marked Reister Exhibit 3, for identification, as of April 19, 2019.)
MR. HIGGERSON: Thank you.
Q. (By Mr. Knight) And have you seen this document before, Dr. Reister?
A. I believe it's the same document I received in an email.
Q. Okay. And this, for the record, is the Notice of 30(b)(6) Deposition for the case; is that right?
A. Yes.
Q. And looking at Schedule A, this identifies certain topic areas. And so first of all, I just want to make sure that you understand that your answers today are as to the knowledge of the Department of Corrections, not just your personal knowledge.
A. I think I understand the -- the

difference. Can you -- say that again and --
Q. Well, what I mean is that you're -- you are answering questions today on behalf of the Department of Corrections.
A. Yes.
Q. Not on behalf of yourself as somebody who works there.
A. Yes.
Q. Okay. And so the question -- the answers you've already given me are in that -- are consistent with that?
A. Yes.
Q. Okay. And you are answering questions -- we've asked questions about training or -- your specific training or expertise. So this is No. 1.
A. Uh-huh.
Q. And the other topic areas you're addressing are -- let me make sure we're on the same page about this -- are No. 2; is that right?
A. Yes.
Q. Okay. And then No. 5, 6, 7, and 8?
A. Uh-huh.
Q. Is that right?
A. Yes.

Q. Okay. And in preparing to answer those topic areas --
A. Uh-huh.
Q. -- who did you speak to other -- to prepare --
A. I --
Q. -- other than counsel. I'm --
A. Oh, other than --
Q. -- I'm asking about --
A. -- counsel?
Q. -- other people than counsel.
A. Well, we have an ongoing discussion, but I didn't discuss the specifics of this case with -- with other people. I mean, I -- Dr. Puga and I were coordinating our schedules, and we both interviewed the plaintiff as well. So we would have those discussions.
Q. The plaintiff, you mean Ms. Monroe?
A. Monroe, yes.
Q. Any of the other plaintiffs that you interviewed?
A. Well, in the other case that we talked about, we also interviewed together Ms. Hampton as well.

Q. Okay.
A. Yes.
Q. But any -- any other of the named plaintiffs in this case have you interviewed?
A. Well, no. I haven't -- I haven't interviewed any of the other ones.
Q. Okay. So you spoke to Dr. Puga in terms of scheduling, but you didn't speak to anyone else about the -- to prepare for -- to respond to these questions?
A. The preparation that I did was based on, you know, sitting on so many transgender care review committees.
Q. Okay.
A. Is -- is basically the preparation in consultation with the other individuals.
Q. So it's your -- it's your previous experience on -- sitting on the committee?
A. Yes.
Q. But you didn't have specific conversations beyond that --
A. Not that I can recall.
Q. -- about -- to --
A. No.

Q. -- to respond to these questions in the deposition?
A. Oh, to -- no. No, not to respond to the questions. These are -- are things that -- I reviewed the questions beforehand and gave some thought to it, and you saw my notes and different things.
Q. Are there ways in which the Department of Corrections is not following the standards of care?
A. I think one of the challenges with the department is some of the things that individuals would do out in the community are not accessible in -- in, you know, the department due to like property restrictions, movement restrictions, things like that. You know --
Q. So I -- I --
A. -- for like -- for example --
Q. I -- I'm sorry.
A. Oh.
Q. I am -- I -- actually, it would be helpful if you would answer my question. And then you can explain, but I'm just --
A. Oh.
Q. -- I'm really just asking: Does the

Department of Corrections follow this -- are there ways in which the Department of Corrections does not follow the standards of care?
A. The Department of Correction is consistent with the standards of care for how the department operates in terms of what is accessible within the department.
Q. So I -- I still don't know. Does -- does it follow them or does it not?
A. I would argue yes.
Q. Okay. And -- and you don't think there are any ways in which they are failing to live up to the standards?
MR. HIGGERSON: You're asking him as the department's representative?
MR. KNIGHT: I am.
MR. HIGGERSON: And not his personal opinion on that; right?
MR. KNIGHT: Yes. Correct.
MR. HIGGERSON: Yeah.
A. From the department's perspective, it is consistent with the standards.
Q. (By Mr. Knight) And from your personal perspective?

MR. HIGGERSON: I'm going to object to that. He's not here as a -- as an individual witness. He's here as the department's representative.
MR. KNIGHT: Okay. Well, of course we can depose him individually and -- if that's what you'd like, so...
MR. HIGGERSON: If you want his individual opinions, yes, we'll have to do a separate deposition.
MR. KNIGHT: Well, I -- I mean, if -- is there -- is there not any reason why he can't go ahead and answer these questions in his individual capacity so long as we make that clear?
MR. HIGGERSON: Yeah. The reason is we're just here to present him as a 30(b)(6) witness. He hasn't been prepared as an individual witness. He's been prepared to answer those topics for the department.
MR. KNIGHT: So you're not going to let him answer with respect to his individual opinions?
MR. HIGGERSON: We're not.
MR. KNIGHT: You're instructing him not to answer the question?
MR. HIGGERSON: Yes.

Q. (By Mr. Knight) Does -- does your personal opinion differ in any way from the institutional opinion?
MR. HIGGERSON: Objection. That's the --
Q. (By Mr. Knight) From the Department of Corrections' opinion?
MR. HIGGERSON: That's the same question. He's not going to answer that either.
MR. KNIGHT: And you're instructing him not to answer?
MR. HIGGERSON: I am.
Q. (By Mr. Knight) Is there -- so in terms of the committee process, is there ever dissent on the committee, that someone doesn't agree with the ultimate decision that the committee takes?
A. The committee has various opinions, and it has to arrive at a final decision.
Q. Okay. But my question was: Is there ever dissent from the final decision of the committee?
A. There have been differing opinions, and then the committee will make a final decision.
Q. And who, if -- if one person on the committee -- or disagrees with what the committee is

doing, who makes the final decision? Who gets to say, oh, this is the committee's decision even though you disagree what's -- this is the committee's decision?

A. At the end of the day, the committee works as a team to come up with a common understanding of -- of what those recommendations are going to be.

Q. Okay. But who has the last word? If there's -- if there's disagreement, who gets to say, well, this is what the committee's doing?

A. I think that -- that the core committee members will definitely have a say in terms of the final write-up of what the recommendations are.

Q. So that would be Dr. Meeks, the -- Dr. Meeks and Dr. Hinton?

A. Um --

Q. They're the chief -- I believe they are the chief people on the committee; is that right?

A. Yes. They ultimately would have the decision.

Q. And so if -- if it came to just be -- they could ultimately say, well, this is what we're gonna do because they're --

A. I don't think there's been a major conflict. But at the end of the day, they have to come up with a finalized document.

Q. And they would be -- and they would be the ones who would have that --

A. They would --

Q. -- authority?

A. They're the ones that write the final document.

Q. In terms of the WPATH Standards of Care, in general, in terms of the decision about hormone therapy --

A. Uh-huh.

Q. -- are -- are there -- what are -- would be the reasons consistent with those standards of denying approval for the care?

A. The standards needs to show a -- a persistence of the gender dysphoria. It would require capacity to make an informed consent. And then the consent -- an actual informed consent was made. You would need the age of majority, which would apply to IDOC offenders. And then you would also have to have a reasonably well-controlled mental health.

And so -- but it's reasonable. So -- because sometimes we will need to -- somebody may not be fully stabilized because they might need hormones to deal with the gender dysphoria to get the symptoms fully attenuated. So sometimes we'll do it, and the standards of care allow us to implement hormones earlier than complete stability.

Q. So tell -- what do you mean by persistence?

A. Persistence shows you're -- you're basically talking about a six-month period where somebody has the -- the difference between their natal gender and either an opposite gender or another sense of gender that is different than the gender assigned at birth.

Q. So someone who has for six months said, I am a woman --

A. Uh-huh.

Q. -- should -- that would fulfill that persistence requirement?

A. Yes.

Q. And in terms of -- and capacity would be someone's -- well, tell me more about capacity.

A. Well, there could be a couple of

different ways. The capacity issue is really about their ability to understand to make the informed consent. So they would have to understand what they're requesting. And so we may need to help them either -- if mental illness is getting in the way of their understanding, we would have to work on their mental illness.

If there's a problem with communication, we have to help them understand it. And we would work through that so that they're able to understand the procedures that they're requesting to deal with the gender dysphoria. And then we would have them do a -- an informed consent via a treatment plan consent.

Q. When -- how is it -- I don't understand mental health getting in the way. How does mental health get in the way of capacity?

A. The -- if somebody is floridly psychotic would be an example, right? And -- and we really haven't had problems with capacity being the issue. That -- that really hasn't been a problem, to my knowledge; and I've been on the committee a long time. But somebody who is floridly psychotic, for example, no. There might be one offender -- no.

They're -- because keep in mind, our offenders at Dixon Correctional Center, if they're in STC, the special treatment unit, or in the psychiatric unit, they might be destabilized enough to not have capacity due to their mental health.

Q. Okay.

A. But an example would be psychoticism where they're just aren't having reality contact.

Q. Right.

A. And so you would need to stabilize their medications before you could give hormones. But somebody with a psychotic disorder can receive hormone treatment, but they have to be stabilized enough to do informed consent.

Q. And the -- when you talk about reasonably well-controlled --

A. Uh-huh.

Q. -- I -- I'm not -- what -- what does that mean? And I -- and when you say "reasonably well-controlled," you're talking about what?

A. We're talking about symptoms, social functioning.

Q. Symptoms. So if someone is deeply depressed, then you would not start them on hormone

therapy?

A. It depends. We have some people who are deeply depressed directly related to the gender dysphoria, and we -- we have started hormones even though they were still symptomatic. But if somebody was on a crisis watch recently, we might want them to stabilize a little bit longer before we initiate hormones.

Q. Are -- isn't it true that someone with untreated gender dysphoria could be on crisis watch?

A. And that's why it's a case-by-case basis. That's why we do it by committee and we don't just set rules out there. Because then we would discuss in the committee what the nature of the crisis watch was.

Q. So if someone were in crisis or depressed --

A. Uh-huh.

Q. -- because of their untreated gender dysphoria, then it would be proper to go ahead and start --

A. Oh, yes.

Q. -- hormone therapy?

A. Yes. And we have actually started

hormones on people that were not completely stabilized because they needed it in -- in order to deal with the depression 'cause it was related to the gender dysphoria.

And those are the kinds of discussions that we have when we talk about, you know, putting in different ideas in there.

Q. Is -- so I'd like to turn to talking about the committee's knowledge --

A. Uh-huh.

Q. -- regarding the risks associated with failing to provide med -- adequate medical treatment.

A. Yes.

Q. Is the -- is the committee -- the -- the committee is -- I'm sorry.

Is the committee aware of the heightened risk of suicidality among transgender individuals?

A. Yes.

Q. And is it aware of the heightened risk among people with -- transgender people with gender dysphoria?

A. Yes.

Q. And can suicidality be a symptom of

untreated or poorly treated gender dysphoria?

A. Yes.

Q. And how long has the committee been aware of these heightened risks of suicidality?

A. Well, I would assume for -- I -- I couldn't give you a date, but it's -- I've been aware of it since I've been on the committee. I mean, it's one of those reasons why we are prescribing when individuals aren't completely -- they may still be symptomatic, because of the risk of suicide.

Q. So I guess my question is really: Do -- is it your understanding -- and you're speaking for the committee -- or the department, I guess?

A. Uh-huh.

Q. -- that the department and certainly the committee would be -- would have been aware of those heightened risks as long as you've been on the committee?

A. Yes.

Q. Okay. Is the committee made aware of specific individuals who have engaged in self-harm who would -- because of gender dysphoria?

A. When they present a case, they talk about

the mental health history, which would include self-harm if that is something that we're aware of. So that would happen -- again, the site has to be prepared and it has to submit within that 30-day period after arrival at a parent institution. So when they were preparing that, that should be part of that because there's supposed to be a full mental health assessment that's submitted.

Q. And is the -- has the committee been made aware of individuals with gender dysphoria who engaged in self-harm because of the treatment for gender dysphoria they were getting? In other words, they weren't getting the treatment that was adequate and they engaged in self-harm as a result?

A. I don't know the history of when -- I know there are cases. And I spoke Offender Monroe. When we talked, she -- is it okay for me to talk specifically about what she shared? Is that okay?

Q. Well, I guess I'd like to --

A. I mean --

Q. -- if you could answer in -- in general, it sounds like you are aware at least of one case.

A. I'm aware of at least one case where that was something that was discussed.

Q. And was it brought to the attention of the committee, as far as you know?

A. Yes. And it was part of our decision process as well.

Q. So the part of the decision in the sense that --

A. For transfer to Logan.

Q. Okay. And -- and what about in terms of starting hormone therapy, was it a part of the decision then?

A. I would assume so, but I -- I don't recall. Is -- I don't think there was a delay with Offender Monroe. I can't remember the specifics, though. I'll be honest, I -- I would have to review the chart.

Q. Are you aware of any time in which the committee has been made aware of offenders engaging in self-harm because they weren't getting the treatment they felt they needed for gender dysphoria?

A. I can't recall a specific case, but I would have to research that to be able to answer for sure on that.

Q. But it may have happened?

A. It -- it -- without reviewing it --

Q. Okay.

A. Yeah.

Q. Are you aware of suicide -- completed suicides of transgender individuals?

A. My understanding -- and again, it was not in my region -- I believe there might have been one.

Q. Do you know when?

A. No. And I may not be correct on that, but I'm pretty sure that there was an offender who was transgender.

Q. Were you aware of a transgender inmate at Lawrence who went -- who's name was [redacted] who committed suicide?

A. I'm not familiar with [redacted].

Q. And I believe that that took place in December 2017? Were you --

A. In Lawrence?

Q. -- were you in this position in overseeing --

A. Yes.

Q. -- Lawrence in December 2017?

A. Yeah. I'm -- well, I should have been aware of that. I would have to look at -- at the

name. It may not just be -- I'm not aware that there was a transgender completed suicide -- a transgender person with completed suicide.

Q. Okay. And who would know -- you mentioned a -- another suicide. Who would be -- who would know about that suicide?

A. Potentially, we should have that in our records, it -- in their -- the psychological autopsies, so we should be able to get that.

MR. HIGGERSON: Are you referring specifically to the northern district --

THE WITNESS: Yeah.

MR. HIGGERSON: -- that has been --

THE WITNESS: He --

MR. HIGGERSON: I'm -- I'm just trying to understand the question.

MR. KNIGHT: I believe -- I assume it's in northern district that's --

Q. (By Mr. Knight) You said in the north, so not in your district.

A. Yeah.

Q. So I assumed the northern district. There are just two districts; right?

A. Yes.

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Q. Northern and southern?
A. No, there's three. Central.
Q. Oh, there's three?
A. Central. Yeah, but I believe it was the north. Yeah. But I'm not 100 percent certain.
Q. But you were not involved in a review of the circumstances of that suicide?
A. If I was, I'm not recalling.
Q. Okay.
A. It's possible that I was. And you're certain that that is the correct institution?
Q. Well, I'm asking now about the one in the north.
A. Oh, the one in the north. Oh, okay. Ask the question again, please.
Q. The question is: Were you engaged in review of the circumstances of that suicide?
A. No. No, I'm not.
Q. Do you do psychological autopsies?
A. I -- I do. That's why I'm -- I'm trying to recall the [redacted] one that's -- yeah.
Q. Do you do them just for your region or throughout the system?
A. Just for my region, yes.

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Q. And are -- if someone comes in to intake, so for -- for the south, would that be Menard, for the --
A. That would be Menard.
Q. -- the intake process?
A. Yeah.
Q. Okay. So if someone comes in to -- to intake at Menard and identifies as transgender --
A. Uh-huh.
Q. -- when does the committee learn about that?
A. Usually they will transfer fairly quickly from Menard, and they will get to the parent institution. And then the mental health provider within 14 days does a mental health evaluation and they'll start prepping and doing another interview.
The mental health evaluation takes about one hour, and it's a comprehensive psychological interview. And that's given to every offender within 14 days. And then --
Q. So that -- and I'm sorry. That happens at the --
A. Parent institution.
Q. -- once the --

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MR. HIGGERSON: One at a time.
Q. (By Mr. Knight) That happens at the parent institution?
A. Yes.
Q. And -- is that right?
A. Yes.
Q. And that happens after the transfer from the intake facility?
A. Yes.
Q. Okay. Now -- and you're saying that's supposed to happen how quickly?
A. The transfers from Menard usually, on average, take about maybe a few weeks to a month or so.
Q. Okay. So -- but in that few weeks to a month, there's no review -- or there's no trans -- care for the transgender individual?
A. They will receive -- we screen them and we provide basic mental health according to our -- our mental health standard operating procedures. And usually, Menard historically has been able to do a mental health evaluation before they leave. They try to do that, but -- if they're there for more than 14 days. But if they're going out very

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quickly, then that will rest on the parent institution to do that mental health evaluation.
Q. And what about hormone therapy? What if someone was on hormone therapy prior to the -- prior to entry at Menard?
A. We would continue the -- the hormone therapy. That's -- the medical will contact -- the medical director would contact the chief of medical, and then that would continue the -- the hormones. And that's a standard at all the receiving centers.
Q. Do you know if that happens?
A. I believe it happens. I haven't heard any complaints from the offenders that it's not happening -- at least not that I can recall.
MR. KNIGHT: I'd like to mark this as -- what are we up to, deposition -- or Reister Deposition Exhibit 4.
(WHEREUPON, a certain document was marked Reister Exhibit 4, for identification, as of April 19, 2019.)
Q. (By Mr. Knight) Would you identify this for the record?
A. This is a gender dysphoria committee

write-up for an update for Offender Reed. I'm assuming that's the name.

Q. Okay. Why don't we just -- and why don't we identify this as Bates No. 1330 to 1348. Okay.

And then looking at page 1338, looking at the bottom again --

A. Yes.

Q. -- who is Tiffany Hill?

A. Tiffany Hill is a former mental health provider in the Menard mental health team. She's no longer in the mental health department.

Q. Did she have a graduate degree, by the way?

A. Yes. She had a --

Q. And --

A. -- master's degree.

Q. And so this is an email to the -- Dr. Dempsey?

A. Uh-huh.

Q. And Dr. Dempsey was the previous chief of psychiatry?

A. That is correct.

Q. And -- well, you know, how does this specific email relate to the committee meeting?

A. Can I have a minute to read it?

Q. Sure.

A. Okay. Okay.

Okay. And what was your question again?

Q. How does this email to Dr. Dempsey relate to -- to the committee? I mean, is this --

First of all, I want to ask a different question: Is this information that's -- that was provided to the committee?

A. I would assume so. Because Dr. Dempsey, at the time, was heavily involved in the committee. So I'm assuming that it is.

Q. Okay.

A. I can't be certain --

Q. Okay.

A. -- because it doesn't say specifically anywhere that it's related directly to the committee.

Q. Okay. Well, you would agree, though, on page 1338, that --

A. Uh-huh.

Q. -- there are references to the inmate or offender being suicidal?

A. Yes.

Q. And those came to the attention of the committee, at least would because they're part of this --

A. Yeah.

Q. -- committee meeting notes?

A. Yes.

Q. And I believe it -- at the bottom of the page, it talks about three separate crisis watches?

A. Yes.

MR. KNIGHT: Okay. Let's identify this as Reister Exhibit 5.

(WHEREUPON, a certain document was marked Reister Exhibit 5, for identification, as of April 19, 2019.)

THE WITNESS: Thank you.

Q. (By Mr. Knight) Okay. So -- and this is also a committee update; is that right?

A. Yes.

Q. And this would be for Ms. Monroe?

A. Yes.

Q. And this -- the first page is dated November 2016?

A. Uh-huh.

Q. So that was an update. And then the second page looks like it's June 17, 2016?

A. Uh-huh.

Q. And then back in February 19, 2016 --

A. Uh-huh.

Q. -- you'll see that there are references to self-harm. So, for example, she says -- or the notes say if -- that offender made statements such as I'd rather die than live -- live with a penis. I'm -- and then it -- a note from, it looks like a licensed clinical social worker? Is that -- that's a reference to the medical records?

A. Yes.

Q. And -- and is this -- I believe you said this is prepared by the facility medical staff? Or there's information from the facility medical staff that goes into the report?

A. Well, generally what would happen is Ms. Thomas would submit the basic information about the case to the committee, and then Dr. Shicker would've taken that information to help generate this report, combining the information submitted with why it was discussed in the TCRC meeting.

Q. Okay. But you -- you -- and you would --

you understand from this that the committee was made aware of Ms. Monroe's cutting of her genitals?
A. Yes. I believe it's in here. Yes.
Q. And her plan to cut them off?
A. Yes.
Q. And it goes on to say -- and that she no longer wants to live?
A. Uh-huh. Yes.
Q. Okay. So the committee then obviously in -- as of that date, February 2016, was made aware that Ms. Monroe was suicidal and engaging in self-harm and intending to engage in self-harm?
A. Yes.
Q. Okay. So I'd like to turn to your -- the committee's response to the topic of training on the treatment of gender dysphoria or regarding transgender individuals provided to Department of Corrections staff, whether those staff work for the Department of Corrections or for Wexford.
Now, there can be transgender inmates in all of the facilities; is that right?
A. That is correct.
Q. And that could be true for the boot camp as well?

A. Yes. We had somebody successfully complete the boot camp who was transgender, a transgender woman.
Q. So have the mental health professionals at the facilities been trained to treat transgender individuals?
A. I offer trainings on a regular basis. The last set of trainings that I did were four-hour trainings. It's the current Part 1.
Q. So I'm -- I'm sorry. My question was: Have you provided it?
A. Yes.
Q. Okay. And when did -- when -- in what form do you provide that?
A. We will gather together in different regions. The last time I did it, I did it in the -- I believe it was Dixon Correctional Center. So we will get mental health providers, we'll shoot out an email that we're having it on a certain date, and then those who need the training will come to the facility, and then we will discuss.
So it'll be, you know, talking about cases, talking about how to assess, talking about how to work and how to prepare somebody and ready

them for receiving hormones, how to deal with gender identity confusion, that sort of thing.
Q. Is this -- and is this training offered both to Wexford staff and to Department of Corrections staff?
A. Both staff are offered that they can come to the trainings, yes.
Q. Okay. And it -- it is -- it sounds like it's voluntary. They're offered the training; is that right?
A. Yes. The Wexford staff are not my direct staff, so they don't fall under my line. So I can strongly recommend for them to come; and at the end of the day, they are Wexford Health Sources employees.
Q. So but you can't --
A. Yeah.
Q. -- require them to be there?
A. No. But they generally will -- they generally request to come. So I don't usually hear of problems with individuals wanting to get trained.
Q. Has every mental health --
And -- and when did this training start?
A. Ooh, I'll be honest, I don't have the

dates. I've done this training last year in the three regions and I believe the -- maybe the year before or the year before that. And I have requests to do it again, the Part 1, up north.
We have a turnover of staff, so sometimes I will need to periodically do it. So I'll probably get that one done relatively soon so that they're ready for Part 2 when they go to the north of Part 2.
Q. So I'm a little unclear. It started -- so we're in 2019. You're saying you did training in 2018?
A. Yeah. The -- I believe -- yes, 2018. And then I don't recall when I did the other -- the other trainings. So a lot of the training has been through the transgender care case conference that happens once a month.
Q. Okay. But in terms of this training we're talking about --
A. This is --
Q. -- it may have started in 2018; you're not sure?
A. Oh, no, no. We did it in 2018.
Q. Right.

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A. And I can't remember the one prior to that. I can't remember exactly when that happened.
Q. All right. So it may have started in 2018, you're not sure. It may have had -- there may have been one previous year?
A. Well, there was one in a previous year. It -- for sure, a follow-up occurred in 2018. Yeah, that -- that was not the first one 'cause I -- I adapted the slides from the previous ones.
Q. Are Department of Corrections mental health staff -- although what's the percentage of mental health professionals who work for the Department of Corrections? Do you know?
A. The percentage of Wexford versus State?
Q. Correct.
A. Oh, by far, the vast majority are Wexford. The psych administrators that oversee and take a look at the compliance are State workers. And most of the facilities are exclusively Wexford for direct care providers. There are a few exceptions, but the vast majority are Wexford.
Q. Is there a reporting process with respect to who does the training? In other words, is -- is there a list of people who have actually engaged in

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the training?
A. The training department may have a listing of who attended, 'cause we do take attendance. So that may be located in Pathlore, which is our electronic training attendance database.
Q. And so you've mentioned two parts to the training, a Part 1 and a Part 2?
A. Yes.
Q. Is that -- is that --
A. Yes. And those are currently being reviewed by Howard Brown. I already received feedback from somebody from Department of Juvenile Justice. Howard -- are you familiar -- I'm sure you're familiar with Howard Brown. Or should I describe who they are?
Q. Yeah, I'm very -- very familiar with --
A. Okay.
Q. And you're saying they're reviewing the revisions to the new training?
A. Yeah. The -- the -- I wanted a training that actually specified the kinds of things we talk about. Because the other training was really -- it was like a visual aid, but it wasn't an actual --

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the way I really wanted it, like the all-staff training.
So the current training that I -- that I have basically has like scripts. And then of course, people ask questions and there's a dialogue process as I go through it. So I submitted that. It's around 200 slides. And so I've submitted that for outside review to get other people's comments and opinions.
Q. Who at Howard Brown is reviewing it?
A. Caitlin Williams.
Q. Do you know her title?
A. Oh --
Q. Do you know her training?
A. I -- no. I -- I'm sorry. She -- she works with transgender people. She's their expert. But I'll be honest, I couldn't tell you off the top of my head.
Can I make -- make one comment on that? Clarifying that Howard Brown is a major training site for LGBT care too. So --
Q. Okay.
A. -- she would be getting ongoing training within that, I'm sure. But I can't speak for sure

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to that, but that's a major training site.
Q. So -- so -- but in other words, you don't -- you don't know whether --
A. I --
Q. -- she's a PhD psychologist or a --
A. I can't tell you --
Q. -- bachelor's --
MR. HIGGERSON: Wait a sec.
THE WITNESS: Okay.
Q. (By Mr. Knight) Again -- yes.
You don't know her actual licensing or specific qualifications in that sense?
A. I apologize. I have it written down somewhere, but I --
Q. Okay.
A. -- just don't recall.
Q. Okay. What -- what is the name of this training? 'Cause we're not sure we've seen it.
A. You haven't seen it, for sure, 'cause I haven't released it to the department yet because it's under review. I can't remember the exact title. Can I give you a rough title?
Q. Please.
A. Okay. It's -- it's something along the

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lines of transgender mental health care in corrections.
Q. What -- yeah, right.
What about the 2018 training? What is that called?
A. Same title, but it's not like a training/training like we're talking about with scripts and things like that. It's really more just kind of we're talking about a specific topic and then we -- then I talk about it. So it doesn't have the same --
Q. I -- I guess --
A. -- like -- yeah, it's -- it's -- it's not a training. The slides themselves aren't the training. The slides are like the points that we're talking about. Does that make sense?
Q. Not clear. There's --
A. Yeah.
Q. Is there -- there are slides that are a part of this 2018 training that you're talking about?
A. Oh, this '18, those slides -- yes, I have those slides, yes.
Q. And that -- and you're saying that's

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called transgender melth -- mental health in corrections?
A. In corrections, yes. The Part 1 slides, yes. But I have since updated those slides. And I sent the updates -- basically, I have -- Part 1 and Part 2, I sent as a package to be reviewed. So they're -- they're updated now.
Q. The -- so the -- the Part 1 is -- is what, again? Four hours?
A. Four hours.
Q. And that was -- the 2018 was a four-hour training?
A. That was Part 1. It's a four-hour training, yes.
Q. And Part 2, what kind of training are we talking about? How --
A. It's -- it's --
Q. -- many hours?
A. -- four -- four --
Q. Again, please let me finish.
A. Okay.
Q. How many hours?
A. Four.
Q. And they're both called transgender

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mental health in corrections?
A. Yes.
Q. One is Part 1 and one -- the other is Part 2?
A. Part 2, yes.
Q. Okay. Do you know how many of the -- so the -- are the -- the psych administrators --
You're a psych administrator; is that right?
A. No. I am a regional administrator. Psych administrators, I'm referring to the site level State employees.
Q. Okay. So the psych administrator at the different -- there's a psych administrator at each facility?
A. If the position is filled. There are vacancies.
Q. And what training do those individuals have? What kind of qualifications?
A. They're either licensed clinical social workers or licensed clinical psychologists.
Q. So are those graduate-degree level people?
A. Yes. One is a master's and the second

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one is a doctorate level.
MR. KNIGHT: Okay. I'd like to mark this as Reister Exhibit 6.
(WHEREUPON, a certain document was marked Reister Exhibit 6, for identification, as of April 19, 2019.)
MR. HIGGERSON: Thank you.
THE WITNESS: Thank you.
Q. (By Mr. Knight) Okay. Dr. Reister, could you identify this for the record.
A. The name of this is: The Rehabilitation, Safety Management and Care for Transgender People in Correctional Settings, which is an all-staff training that I developed.
Q. Is this different from the training that you were just talking about?
A. This is fairly similar to the Part 1 slides. There are a few things I might go into more detail for the mental health providers, like when we're talking about -- in these slides, it goes very generally -- like when it talks about in June was a more -- I can't remember the wording I put in it. But when it talks about the beginning of more

outward LGBT movement, I will go into more details about what that event was, like that was the Stonewall uprising.

And I'll describe what actually happened when that occurred. And it basically started off some very visible LGBT rights movement. And so I'll go into more details about these more general topics for Part 1.

Q. All right.

(WHEREUPON, discussion was had off the record.)

Q. (By Mr. Knight) And so if you just take a look at Slide No. 3 --

A. Yes.

Q. -- this is -- this is, I assume, a PowerPoint?

A. Yes.

Q. And so I believe you said this -- you haven't started -- this is just developed, you're not -- you haven't actually done this training?

A. This was presented to the -- one very similar to this was presented to the wardens, to all the wardens at their latest wardens' meeting. I forgot the date of when that was, but that was only

like a month or two ago.

I took their feedback and their questions. And they asked to make sure that the -- basically, to word things that were a little scientific and to provide some context that might be a little easier for people to learn. So I updated some of the slides, trying to simplify the concepts and using, like, analogies and things like that so that it was a little more accessible. Because the scientific terms alone, they didn't feel was accessible enough.

And so I updated. These are the slides that were updated from the feedback I received from the wardens. And I also added at the very end of these slides commonly asked questions. Because they asked for commonly asked questions, like a -- a Q and A, question-and-answer section.

Q. Okay.

A. So I added those commonly asked questions.

Q. Okay. And then looking at page 3, there's a reference to internationally recognized standards of care. Is that the WPATH Standards of Care?

A. Yeah, that's the WPATH standards.

Q. And on page -- let's see. I guess it's Slide 49? And this talks about language.

A. Yes.

Q. And -- and so this would be -- this would be a reference to things like misgendering?

A. Yes.

Q. And using terminology -- certain kinds of offensive terminology for transgender individuals is what --

A. Yes.

Q. So do you talk to them about what things should not be -- what kinds of specific things should not be said to prisoners?

A. Yes. Let me -- let me look at the slide. 'Cause there's a specific slide that I talk about basically things that we have to make sure we address. There's a slide that specifically states that. I've just got to find it.

Q. Well, No. 50, if you'll look at that one --

A. Yeah. It's --

Q. -- so No. 50 --

A. Yes, I'm --

Q. -- this talks about how misgendering is psychologically harmful, stressful, and interferes with treatment?

A. Yes.

Q. Okay. And that's something that you have talked -- have said to the wardens? Was this a part of what you showed the wardens?

A. Yes.

Q. But it's -- it's something you intend to -- to say to all staff?

A. Yeah. The only changes that we are gonna do if -- and we may launch it just as-is if we can't get it done before -- we already basically are setting the dates for the -- the training. I'm -- I'm going to try to go through -- 'cause there's a typo in here. I wrote couch instead of coach on some -- one of the slides.

And then we're going to clean up. And basically, like on this slide where it has a period after pronoun and after woman, after he-she, I'm going to eliminate the punctuation on that.

So there are some grammatical punctuation things that we're going to try to get done, as long as it doesn't mess up the audio. There was some

concern in the training department that we may be better off just launching it with the grammatical problems if it messes up the audio.

'Cause this autoplays. Once you hit the -- once you press forward to the second slide, it autoplays. If you mess with the slides, it out of syncs everything and you have to start over.

So they're concerned it may change it. So it may go exactly as-is. But if we change it -- so long as there's no complaints. But the department is planning on launching it with just a -- slight grammar punctuation changes. And it's going to all the staff, regardless of your position, whether you're an office assistant, a correctional officer, everybody.

Q. And what about the Wexford staff?

A. And Wexford staff are required to go to this training. And this is a requirement.

Q. How -- how -- how is it that they are required to go to it?

A. They have to -- they are required to go to certain of our cycled trainings. And this is embedded into the one that all staff must go to. And so, therefore, they have to go to this training.

Q. Okay. And then Slide 53 talks about gender dysphoria being triggered. Do you -- are you there?

A. Yes.

Q. It talks about gender dysphoria being triggered if the desired physical interventions by means of hormones and/or surgery are not available.

A. Yes.

Q. And so that would be, for example, the need for surgery but not -- that not being available?

A. Yes.

Q. Okay. And it also talks about culturally prescribed attire and cosmetics that -- that need -- or the access to that may cause negative emotional status [verbatim]?

A. This is a problem which individuals do communicate to the mental health department.

Q. So that -- that, for -- that would be social transition --

A. Related.

Q. -- related? For example, access to clothing consistent with gender identity?

A. Yes.

Q. Okay. And then in Slide 54, there's a -- a -- a reference to the fact that the degree of confirmation impacts psychological well-being. And then it references medical interventions and social environment.

A. Yes.

Q. And so that would be the -- the -- that your -- your -- this slide is indicating or teaching that the inability to -- to have medical -- medical interventions would have a harmful impact on psychological well-being?

A. Yes.

Q. And the same would be true of social environment issues?

A. Yes.

Q. Is that -- and those social environments are the --

A. Uh-huh.

Q. -- that's a reference to -- to the social transition that we talked about?

A. Yes.

Q. Okay. And then looking at Slide 58, this talks about the increased risk of suicide among transgender -- transgender individuals?

A. Yes.

Q. And the studies that support that?

A. Yes.

Q. Looking at Slide 67 -- oh, I -- so I guess there's a reference to the various things that the Department of Corrections provides and -- okay. All right.

Well, I don't know if you're familiar with this slide. Apparently what's on the slide that was given to us has different information than what shows up on the printout. So in the -- in the information there, it looks like it says IDOT provides nationally recognized medical interventions to address --

A. Uh-huh.

Q. -- gender dysphoria. So do you see what I'm saying?

A. Yeah, it --

Q. Or it -- or I'm sorry. It's not there?

A. Yeah, the script is missing on --

Q. Okay. But -- but that's what you recognize -- you know that that's what it -- in fact, it indicates?

A. Yeah. It would be written on there

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'cause I read it when I was -- I read it verbatim when I was doing the slides. So what's written there is probably what's missing off of here.
Q. Okay. Okay. Well, in terms of medical interventions, what is it that the Department of Corrections provides?
A. We provide hormone treatment for gender dysphoria. And then we haven't yet to, but we have not ruled out, if gender dysphoria symptoms are not abated, use of other procedures as well, such as surgeries.
Q. Okay. But you -- you haven't provided surgery at this point?
A. Not at this point, but it is -- not that it is not available.
Q. Looking at Slide 74, so this references searches, but it doesn't reference the -- the gender of the person who should be conducting this search.
A. The department --
Q. Is that -- is that right, what I -- what I just said?
A. Yes. It doesn't specifically state the gender. What this is talking about is PREA standards where you have to have a single person

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doing the search.
Q. Well, the PREA standards also talk about cross-gender searches, don't they?
A. I don't know the quote of where that would be, but -- so --
Q. So the -- so the -- this doesn't address --
A. It doesn't address.
Q. -- it doesn't address the gender of the searching. It doesn't prohibit transgender women being searched by men?
A. It does not specifically address that issue.
Q. And does the committee address that?
A. That is addressed from a site level. It is done by the gender that would normally do it, given the circumstance of the facility. Both men and women are authorized to do searches in both the male and female division, and the -- each site has a standard that they generally will use. And that's decided at the site level. Offenders are allowed to file a grievance form for review -- for administrative review if there's a concern.
Q. About the gender of the -- of the

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individual conducting searches?
A. Correct.
Q. So you're saying that in male facilities, men would be conducting the searches?
A. Yes. In general, it would unless there was a specific change that would be based on a -- an offender grievance or an emergent situation where they would need multiple genders doing the searches.
Q. And -- and what do you mean by "multiple genders doing the searches"?
A. If there was an emergency and we had to quickly evacuate, for example, we -- we reserve the right to be able to have either gender do searches so as long as they're following professionalism. And everybody's been trained on professionalism --
Q. Okay. But how --
A. -- who would be doing that.
Q. Right. But outside of that emergency --
A. Uh-huh.
Q. -- you're saying that a woman who's transgender in a male facility will be searched by men?
A. Yes.
Q. And is that -- that's not something the

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committee addresses? Is that what you're saying?
A. That's not something that we would address.
Q. Isn't that a part of social transition?
A. That is determined -- has been determined that this is a security matter that's being driven by meeting of PREA standards, in terms of searches.
Q. Looking at Slide 94, so the question asks: Aren't offender --
(Court reporter clarification.)
Q. (By Mr. Knight) The question asks: Aren't offender who say for the first time they are transgender just faking to get something?
A. Uh-huh. Yes.
Q. And is that an issue that happens at the facilities, that facility staff think that someone's faking?
A. I haven't heard official kinds of comments like that. What I will generally hear when people know that I, you know, work with this kind of training and what have you is they ask questions about whether or not individuals are just faking.
Some of them will ask, well, do they just want to go over to the female division, they're not

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really transgender, they're cisgender; but, you know, they just want to be with women? Those -- those are the kind of questions that I have to dispel, on occasion.

Q. So the -- so the -- the thing they're faking to get would be to go to the female facility?

A. Yes. Or special treatment, where they're going to be seeing a therapist. There's any number of things that the staff are assuming that they're wanting, right?

Q. And -- and you tell them that that's, in fact, not a --

A. It's not.

Q. -- correct way to review -- you -- in other words, you tell them that's not correct?

A. I tell them that's not correct.

Q. Okay. And on Slide 99, there's a reference to not everyone needing therapy groups. Do you see that?

A. Yes.

Q. And so that is -- is that -- is that an issue that has come up?

A. Yes. There is an offender at one of my facilities in my region, and she was talking to the

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therapist. She says, I don't want to be in these groups, I'm fine; I just want to do my time, kind of keep a low profile, and then go home. I don't have a long sentence. I don't want to get involved in those sorts of things.

'Cause the therapist was really concerned about, well, don't all offenders have to go to this group? And I was explaining that this is voluntary. We can talk about the advantages and disadvantages, but if this is not particularly something that this person finds useful, then that's okay too.

I had a similar conversation with a transgender man that's in the male division. And he also communicated a lack of interest, at least at that time. But I reminded -- but every offender is reminded that it's not a one-shot deal. If you change your mind, it's available.

Q. And but -- and that -- these participant and therapy groups is not a condition or should not be a condition on someone being able to get care such as hormone therapy; is that right?

A. That's exactly what I'm trying to communicate, that you don't have to do the therapy to get the hormone treatment. If you want to do the

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therapy, it's available. If you need treatment, some individuals have some mental illnesses that need be treated, then again, we'll strongly encourage. But -- but there are many individuals that we have that don't need the therapy component.

Q. In looking at Slide 102, these -- these are sites that are provided for the facility staff? For the medical staff? For the facility staff in general?

A. Everybody gets access. This is a training for all staff. So these are additional information. Quite honestly, it's probably going to be the -- the mental health and the medical staff, I would anticipate, would be the most interested. But it provides some resources for people who want to learn more, so that's why these are provided.

Q. And -- and you're -- they're provided because you believe they're helpful and authoritative?

A. Yes. I think these are helpful sites and authoritative. And they provide different angles on different topics that were discussed in here if people want to get further information about why we're suggesting these are really important topics.

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Q. Okay. And the -- so there was a point where you were not doing training. Are you saying you are doing training now?

A. Yes. We're doing training now. I have a significant amount of time that -- that I am allowed to go and spend and travel and -- and do this across the state.

Q. And does -- is there training at facilities on transgender health every year?

A. This is newly launched.

Q. Right, I guess --

A. This training will be annual because it's a part of that annual cycled training. So they're going to just take this and put it right, you know, wherever something else was. And they'll make the time frames.

Q. Right.

A. Maybe they'll extend it longer.

Q. And is the --

A. This is being added on the mental health day.

Q. In the past, was training with respect to transgender health something that happened every year?

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A. No. This is new.
Q. Okay. And did it happen -- how -- how oft -- you know, let's -- how often did it happen? I mean, once every five years? Once every -- I mean, you've only mentioned two different years where you've provided -- you've provided training prior to this year at this point.
A. Yeah, I don't want to -- I'm trying to be conservative so I don't overstate what I'm doing.
Q. Okay.
A. Dealing with an LGBT community is part of other trainings but not enough to address the issues for the -- the treatment. It doesn't have the -- the level of detail. It's -- it's kind of like -- like a slide or two. Don't quote me on that exact number, but it wasn't sufficient, in my opinion, to really help people with proper management and rehabilitation and helping launch the transgender offender successfully into the community and for good reentry. So that's why I went into more detail, and it's -- an hour and 45 minutes was needed.
MR. KNIGHT: Okay. I would -- I'd -- I'd like to take a break at some point. Are -- are we at a

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place where we could take a break?
MR. HIGGERSON: I believe so. I mean --
MR. KNIGHT: I mean, it's -- you know.
MR. HIGGERSON: It's your questions. I don't know.
MR. KNIGHT: No, no. I -- I'm just asking.
MR. HIGGERSON: Yeah.
MR. KNIGHT: Because it would be convenient to take a -- a break for lunch now and then complete with Dr. Reister after lunch, and then turn to Dr. Puga.
MR. HIGGERSON: That's fine. How long are you going to be? Do you know how long Puga is going to be compared to this? Or -- I'm just...
MR. KNIGHT: I'm guessing a similar length, maybe longer. I don't know.
MR. HIGGERSON: Okay.
MR. KNIGHT: I mean, he's -- he is -- there are a number of specifics to his -- the topic areas he's addressing in terms of the directives, et cetera. So I think it may take even longer, frankly.
MR. HIGGERSON: Okay.
MR. KNIGHT: Okay.
THE VIDEOGRAPHER: So you still want me to go

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off?
MR. KNIGHT: I actually would like to -- so let -- can we just go ahead and take a break? And should we take -- how long, an hour or 45 minutes or --
MR. HIGGERSON: Let's take less, if that's okay with you.
THE COURT REPORTER: Should we go off the record?
MR. KNIGHT: Sure. Let's go off the record.
THE VIDEOGRAPHER: It's 12:18 P.M. We go off the record.
(A recess was had from 12:18 p.m. to 12:56 p.m.)
THE VIDEOGRAPHER: It is the beginning of Tape No. 3 of the testimony of Dr. Reister. It is 12:56 P.M. We are back on the record.
Q. (By Mr. Knight) Okay. Dr. Reister, you're still under oath.
THE COURT REPORTER: Reister.
A. Yes.
MR. KNIGHT: Reister. Thank you for correcting me.
I would like to mark this as Reister Exhibit 7.

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(WHEREUPON, a certain document was marked Reister Exhibit 7, for identification, as of April 19, 2019.)
Q. (By Mr. Knight) Okay. Dr. Reister, could you identify exhibit -- Reister Exhibit 7?
A. These are my notes that I wrote when I was preparing and I was trying to think about what I do --
Q. Uh-huh.
A. -- in terms of the department and the transgender community as a whole. And so these are kind of like the various things I spend time addressing. And I just wanted to make sure that I had in my mind things that sometimes are forgotten, I guess is a good way. So these are like the things you might forget kind of list that I had.
So like, for example -- do you want me to describe what the notes are?
Q. I -- I --
A. Or do you --
Q. Let me ask some specific questions about them.
A. Okay.

Q. What are SIDAC speeches? This is on the left.
A. That's an acronym for Southern Illinois Drug Awareness Conference. Like one of the things that we do is we talk about -- I integrate diversity and awareness of -- of transgender issues into this conference because this is a community education opportunity.
And so, you know, like I'll just put in side comments, for example. You know, I talked about 12-step facilitation this week at the conference. I was a presenter. I presented to three cohorts of individuals. And I would just kind of -- you -- you weave in the learning within the topic, and I make comments about the importance of transgender care in corrections. I remind them that -- that there are populations outside of who they may see.
We've had people come in -- like the director came down to -- to -- this is an annual event. I'm -- I'm a committee member -- and talked about the importance of, you know, making sure that the community supports funding for corrections. Because we're trying to do all these, you know,

enhancements of programming. We've -- we've enhanced programming a lot.
Q. Okay.
A. And so communication and education of the community helps get us the support we need so that we get the funding that we need from the community and the enthusiasm.
Q. Okay. So -- and -- and just to remind you, I just asked you what it was. So --
A. Oh, that's what it was. Okay.
Q. Right. And -- and I'm -- I'm not intending to --
A. Yeah.
Q. -- chide you for answering beyond --
A. Okay.
Q. -- that, except that I -- I'd like if you could --
A. Okay. Just --
Q. -- just on the other questions just answer what it is.
A. Perfect.
Q. The -- in the center, it says -- looks like sharing. And then it mentions WPATH and Mass?
A. Yeah. I mean --

Q. What -- what are those?
A. Massachusetts. You saw the three slides I pulled out of Massachusetts. So --
Q. Okay. So you -- so you've relied on some information from Massachusetts?
A. Yeah. They're -- they're indicated on there. There's -- there's three slides that were indicated. You can tell because I literally put on there it was courtesy of Massachusetts.
Q. Okay. And -- I'm sorry. Sorry, was there something more about --
A. Well, you asked about WPATH as well.
Q. Okay.
A. And that was the reminder about the LISTSERV 'cause I didn't want to forget that that's something else I'm involved in.
Q. Right. Okay. And there's a -- below that, it says future. And it looks like Wisconsin, Missouri?
A. Yeah. We've reached --
Q. Is that what -- is -- I mean, just first of all, is that what it --
A. Yes.
Q. -- what it says?

A. Uh-huh.
Q. Okay. And what is that?
A. What I'm trying to do is reach out to the Wisconsin correctional system, as well as Missouri. I've identified somebody in Wisconsin, and so we're just kind of communicating. 'Cause, you know, we're investing a lot of time and money in developing these trainings; and I want to be able to share so other people can benefit.
That's why I'm sending these -- these slides and information out for comment from like Howard Brown and -- you know, and Dr. Goldman. So I want to share, is -- the idea is to share the knowledge --
Q. Uh-huh.
A. -- with other people so we work together as kind of like a Midwest community.
MR. KNIGHT: Okay. So -- let's see. I'd like to identify this as Reister Deposition Exhibit 11 -- no --
MR. HIGGERSON: 8.
MR. KNIGHT: 8.
(WHEREUPON, a certain document was marked Reister Exhibit 8, for

identification, as of
April 19, 2019.)

Q. (By Mr. Knight) Okay. And just for the record, this Exhibit 8 is Bates-numbered 12 -- 120741 at the bottom; is that right?

A. Yes.

Q. Through 120748?

A. Yes.

Q. What is this?

A. It's the office of health services' quarterly meeting. So that would be the medical departments at -- both the mental health and the medical department have quarterly meetings. I'm not involved in the quarterly meetings for medical that -- I would be going to and -- and helping organize the mental health ones.

Q. So this is not something you created, but -- is that right?

A. No. No.

Q. And it -- and so, but this was -- what was it? Train -- you said it was training? It was slides for some kind of training?

A. This is not what I was talking about earlier.

Q. No, I understand. You -- but is this in your -- do you -- are -- are you familiar with this?

A. I'm not familiar with these slides at all.

Q. Okay. So you -- you --

A. This is the first time I've seen them.

Q. Okay. Got it.

But you're saying from your knowledge that this would be something that the medical providers would provide?

A. Yeah. I'm doing that based on the fact that it's an office of health services' quarterly meeting. I gathered that from the very first slide.

Q. I see. Where -- where -- that's -- that's easy, as it would -- it mentions that Dr. Shicker, the -- a former med -- former agency medical director was the first person listed.

And he's the presenter, typically, at those meetings?

A. I don't know. I've never gone.

Q. Oh, you've never been?

A. Yeah.

Q. Okay. Yeah, would you actually take a look at page 3 of this document? And obviously,

there's a -- the top slide has -- mentions the word transgenders. Is there anything you'd changed about that slide?

A. Yeah. I actually have a -- I have a slide -- talking about grammar in my slides -- about kind of using somebody's identity as kind of like a name, right? We have people who happen to be transgender.

Q. Uh-huh.

A. Does that make sense? So...

Q. So -- so you're -- you're saying -- I'm sorry.

A. Yes.

Q. This -- this is something that you would not recommend using, this terminology?

A. Yeah. I -- I mean, I would word it a little differently.

Q. And what about the photo itself?

A. Well --

Q. Would you use a photo like that in this -- in the training that you do?

A. No.

MR. KNIGHT: Okay. So I'd like to mark this as Reister Exhibit 9.

(WHEREUPON, a certain document was marked Reister Exhibit 9, for identification, as of
April 19, 2019.)

Q. (By Mr. Knight) Okay. Dr. Reister, exhibit -- have you seen Exhibit 9 before?

A. Not that I can recall.

Q. And this, for the record, is Bates No. 122998 to 123052; is -- is that right?

A. I'm sorry. I -- I -- I was reading.

Q. I just was --

A. I didn't hear what you said.

Q. -- identifying for the record the first and last page of it, 122998 up through 123052.

A. Can I revise what I just said?

Q. Sure.

A. It -- it's possible these are slides from a webinar from the Federal Bureau of Prisons that I -- I went to. So -- or I didn't go to, it was a webinar. It's possible, but I cannot guarantee you that this is the one. Let me look.

Q. Okay. So you -- you're not sure whether you've seen it, but you might have seen it; is that right?

A. But I've -- I've been to a webinar from the Federal Bureau of Prisons. I -- I don't know if this is the one I went to, but I have been to one.
Q. Okay. And so I guess my question, then, is: Do you know how this was used, whether anyone else other than you may have seen it?
A. I -- it's been awhile. I can't remember who attended the webinar is the problem. I'm trying to see. 'Cause some of these are stock photos, so I'm not sure if this is the same one or not.
Q. Okay. I'd like to turn to the last topic area, which is whether the transgender committee or IDOC in general 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 and the reasons for the engagement.
So have they engaged outside professionals? And -- and again, they, I mean has the committee or the Department of Corrections engaged outside professionals?
A. Yes. As a -- as part of my job, I recently was given an opportunity to reach out to Howard Brown and Caitlin Williams. And what we were

trying to do is forge a good continuity of care because they're a primary healthcare provider and mental health provider upon release.
Most of our transgender offenders are coming from the Chicagoland area. And so she showed me the comprehensive services that they have. She showed me two different locations on the South Side and showed what was all available. We talked about some of our challenges, some of the economic disadvantages that our clients have.
And she assured us that they were comfortable, and they have been. And I know they have been working well with our clients 'cause when they come back, the clients really like the services they're getting there. So we continue to recommend follow-up through them.
Q. So my question was not about whether you've had conversations with respect to follow-up, but whether you've had conversations -- and -- and I guess that would be in general. So the conversations you're describing are with W -- with -- I'm sorry -- with Howard Brown with respect to where you might recommend prisoners get services after they leave, after they're released?

A. Not -- not just that, but we're also talking about making sure that we get good communication both from clients that they have that we receive, as well as clients we re -- reenter into the community.
And, for example, I learned through them that they need to be on their medical caseload in order to be assigned for the mental health services.
So in other words, we were just -- we were trying to figure out how to make sure that the psych meds and the -- the psychiatric care was also dealt with in addition to the healthcare. So they helped explain about how we can get appointments. You get the appointment by going to the health services, not trying to get them -- 'cause we've been kind of, you know, not quite understanding how their system worked.
So trying to get a mental health appointment was problematic. Well, the -- it's because we didn't understand how their system worked. So by doing that, we could do that.
Q. All right.
A. And then I got them to -- you know, and again, they're still reviewing it. But they're

reviewing the mental health provider slides so that we can get some outside thoughts and comments on the slides that we're providing.
Q. So you spoke to Caitlin Weiss [verbatim] when?
A. It was early -- it was basically late in winter.
Q. Late winter of this year?
A. Of this year, yes. This is a more recent availability for me to be able to kind of forge these liaisons. And that's why I'm -- I'm reaching out to the other correctional systems, to them. I also talked with a treatment provider in St. Louis.
Q. And are they -- so you've spoken to Ms. -- or Caitlin Weiss and -- but Caitlin Weiss, what kind of position does she have? What kind of training does she have?
A. She is a therapist is what she is, and I believe she's a psychologist.
Q. Is this the person we talked about earlier?
A. Yes.
Q. Okay. And --
A. Caitlin Williams, uh-huh.

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Q. -- how many conversations have you had with her?
A. We had a conversation earlier in the year, and then we got together and I exchanged some information. I sent slides over to her, and then I went and I visited those two sites all in one day. And...
Q. So that sounds like a conversation and a -- one meeting?
A. Yes. We're just forging this relationship with them.
Q. Okay. And this is a relationship for purposes of creating -- or helping offenders when they leave, when they are released; is that right?
A. It's two -- it's twofold. It's to help -- actually threefold if you think about it. It's to help with reentry. It's also to help if one of their clients become incarcerated, as well as to get some outside opinions on our trainings and to help -- again, I'm trying to forge so that we can have like some speakers come in and different things like that. I'm trying to build that network.
Q. Have you -- and then you mentioned somebody in St. Louis?

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A. Yes. I was talking with Dr. Prelutsky in St. Louis about challenges in terms of if we have a client from Southern Illinois. And basically, he was educating me that part of the problem with the healthcare is making sure that there's some funding; that there has to be insurance or Medicare or, in the St. Louis area, there could be problems with getting services like at his place. He's a major LGBT provider in St. Louis.
So that basically told me that we're going to have to find another provider in there. 'Cause a lot of our individuals don't come out with that. So we either need to figure out a way to get Medicare, Medicaid activated or we need to find a different provider than like a big name in -- in St. Louis. So --
Q. Okay. So --
A. -- it's problem solving, is what I'm trying to do.
Q. Okay. So these are -- this is, again, a conversation about -- or at least that conversation is about what would happen -- what will happen for people when they're released?
A. Yes, that --

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Q. What kind of medical treatment -- or where will they get medical treatment when they're released?
A. Yes.
Q. Okay. Have you -- has the department -- and have you hired these people or just spoken to them?
A. I'm consulting with them, yes.
Q. And you're paying them --
A. No. We're -- we're --
Q. You're just speaking to them, and they're agreeing to speak with you --
A. Yes.
Q. -- for free?
A. Yeah. And they're consulting and -- and, you know, Caitlin's looking over the -- the slides for free. That's --
Q. Okay.
A. Yeah.
Q. And my -- I guess my question is: Have you -- has the department or the committee hired an outside expert to help it provide better medical care?
A. Not to my knowledge, although I'm not

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sure what -- if the health services has done something I'm not aware of, but I'm not aware of any outside.
Q. Okay. So they're -- so you're not aware of any outside experts being hired to review the treatment plan, for example, or -- or the -- for a particular individual with gender dysphoria?
A. No, I'm not aware of that.
Q. Okay. So as far as you know, that has not happened?
A. As far as I know.
MR. KNIGHT: Okay. Can I just have a minute?
MR. HIGGERSON: Uh-huh.
Q. (By Mr. Knight) All right. So you -- Dr. Reister, you understand this is a specialized area of care, the --
A. Yes.
Q. -- care for transgender individuals?
A. Uh-huh.
Q. Yes?
A. Yes.
Q. Okay. And -- and I guess the -- you -- you understand there were some -- there are a number of experts out there in terms of providing the care?

A. Yes.
Q. Dr. Ettner, for example, is --
A. Yes.
Q. -- an expert in that area?
A. She is a top person, and I use a lot of her information from her resources that she provides. And I also have seen her speak.
Q. Have you had a situation with a transgender inmate in which you felt like we could really benefit from outside consultation with an out -- with an expert on the outside?
A. If there is an issue that we were to need to do that, I have ways of consulting through the LISTSERV. We haven't had to do that yet, and there's two of us that potentially have access. There's two of us that are WPATH members, so...
Q. Who -- who else other than you is a WPATH --
A. Kellie Gage just became a -- a WPATH member. She's over at Robinson Correctional Center.
Q. Okay. But you -- you're saying while you have access to that, it's not something that you've done at this point?
A. No. I tried reaching out and sending an

email for assistance, but I didn't get a response from WPATH.
Q. And what was that case about?
A. It was recently -- I was just trying to reach out to them to see if they might be willing to provide some assistance with the programming and the stuff that we're trying to do as a result of the -- these two court cases.
Q. And --
A. Which is why I went to Howard Brown.
MR. KNIGHT: All right. Okay. Can we just have five minutes --
MR. HIGGERSON: Yep.
MR. KNIGHT: -- and then...
THE VIDEOGRAPHER: It is 1:19 P.M. We go off the record.
(A recess was had from 1:19 p.m. to 1:22 p.m.)
THE VIDEOGRAPHER: It is 1:22 P.M. We are back on the record.
Q. (By Mr. Knight) Okay. Dr. Reister, in Exhibit 7 -- I'm not sure you actually have to see it, you may remember -- but there's a reference to phone consults as needed.

A. Uh-huh.
Q. Is this this monthly availability -- you make yourself available to the mental health professionals to speak about transgender healthcare issues?
A. They also call in between. Yeah, so that -- that there is a transgender care case conference where we talk about cases and we share information and what have you. And then there's also if they want to call me up, I'm also available 'cause I have a State cell. So as long as I have a cell signal, if they need to, they can give me a call.
Often, they'll just shoot me an email, hey, can we talk? And then we --
Q. Okay.
A. -- we'll do a phone consult.
Q. The -- this transgender care committee conference -- I'm sorry -- transgender care --
A. Case conference.
Q. -- case conference is voluntary?
A. It's voluntary.
Q. Okay. And the -- these -- making yourself available for calls is, of course,

voluntary. If they -- if they want to reach out to you, they can?
A. Yes.
Q. And how many of those do you get a month, approximately?
A. I don't -- I'm not sure how many. Maybe -- it depends on what's going on. Maybe one.
Q. Okay.
A. Yeah. One, two. It depends on -- it -- it varies.
Q. Are there any kind of minutes or notes kept of these care conference meetings?
A. We've been -- that's something that we've been doing more recently. My office assistant has minutes available. That's Stacey Agans.
Q. And --
(Court reporter clarification.)
THE WITNESS: Agans, A-G-A-N-S.
Q. (By Mr. Knight) Okay. And how long did that -- how long have you done that?
A. Oh, goodness. It's more recently. I -- we've been really upping and modifying what we do recently, after the Hampton case. So it's more recent. It was --

Q. So in the last two months, three months?
A. Something like that, yeah. It's very -- it's more recent. Yeah.
MR. KNIGHT: Okay. We'll -- I mean, just for the record, we would like to see those.
MR. HIGGERSON: Okay.
MR. KNIGHT: All right. I'd like to identify that as Reister Exhibit 10.
(WHEREUPON, a certain document was marked Reister Exhibit 10, for identification, as of April 19, 2019.)
THE WITNESS: Thank you.
Q. (By Mr. Knight) Okay. Dr. Reister, would you identify Reister Exhibit 10?
A. This is the -- and let me look at the date on it. Okay.
This is the administrative directive. And we -- this is -- it looks like it's one of the updates that we've submitted to update the 0 -- the Directive 04.03.104, which is related to transgender care. I had concerns with how the other one was written and so we changed and updated the language.
And we focused it also on updates because

the gender identity disorders is an outdated term, so I wanted that changed. And I also wanted -- for evaluation of transgender offenders, 'cause I just think that it's important to state exactly what policies we're looking at. And so I just thought that was a better title.
And then we basically are doing a lot of revisions. There's some text revisions in here. I updated the -- am I going in too much detail?
Q. Well, I -- I --
A. I'm sorry.
Q. I -- I -- I didn't actually ask you to tell me all -- everything you did.
A. Okay.
Q. I don't think, but --
A. Okay.
Q. -- but it's fine.
A. Okay.
Q. I guess since you've -- let me -- let me ask some other questions about it, though.
A. Okay.
Q. Are you doing the updating of it?
A. It's a collaborative effort. And this was -- I -- I don't know which draft this is, to be

honest. And we were -- we've been trying to get this thing updated since 2013, and so I'm not sure which draft this is. But as of late, this might be the one that I did with Dr. Dempsey, but I -- I'm not sure exactly. It could be Puga.
Q. Okay. Well, it was provided to us, I believe, with the understanding that this was the most recent draft.
A. Okay, perfect.
Q. But I --
A. Then that would be --
Q. -- but I -- I just tell you that. If you tell me that's not right, please -- please do. Or do you know?
A. I don't know for sure. But if they said it was the most recent, it's probably what they just pulled out from the most recent list. So...
Q. List, what -- what -- what do you mean by list?
A. Well, somebody's keeping track of where these are going. So...
Q. Okay. Do you -- do you know who? Who is in control of the --
A. I have --

Q. -- of the modifications to this?
A. Basically, we turn this into -- the psychiatrist submits it however they submit it. Because at -- at some point, it has to go from our drafts to Echo Beekman's group in policy and directives. And then they do whatever they need to do. Because it is an administrative directive, it -- all those kind of flow through that department.
Q. I'm sorry. Echo?
A. Echo is -- is her name, Echo Beekman. It's -- it's -- it's a -- it's a name, and I don't know the spelling.
MR. HIGGERSON: Two Es.
THE WITNESS: Okay.
MR. HIGGERSON: Two Es.
Q. (By Mr. Knight) The reception and classification center terminology, is that -- does that refer to the intake -- the place where intake occurs?
A. Yes.
Q. Okay. And -- and so that would be -- I'm blanking on that -- the -- Menard for the southern region; correct?

A. Menard for the southern region.
Q. Okay. Is -- are there additional changes that you're asking to be made in this?
A. Well, you can kind of see some of the changes. Like -- like I didn't like the transgendered for reasons we discussed earlier, and so I wanted that changed. You know, there's some content changes that I wanted in there as well so it was a little clearer.
Like if you look on 241494, I wanted it to be more specific and fleshed out about what areas the mental health providers are supposed to be taking a look at. That way -- and -- and I do have it also in the SOP, but sometimes people very quickly will -- you know, will go there, and I wanted some consistency so that it was very clear that this is an administrative directive to do a full history and to make sure that there are not missing things, like -- liking stigma and positive social experiences.
I wanted it very specified in here so that, you know, they would be very clear that -- that there are standards that we need to do. And then they can refer to the SOP for more detailed

information about, well, how would you -- how would that look. So this is the AD. It provides a -- a general overview; and then they can refer to the standard operating procedure to flesh this out from a mental health provider perspective.
Q. So turning to the last page, 241495.
A. Yes.
Q. So at -- at least on the copy I'm looking at, there's some changes that show up in blue and some in purple.
A. Okay.
Q. Do you see that?
A. Yes.
Q. Are yours the blue ones or the purple?
A. I have no idea. I'll -- I'll be honest. I wonder if the blue means that they were changes and purple were the original script, but I can't promise you that that's what that represents.
Q. Well, there's black text there as well, which I assumed was the original script.
A. Uh-huh.
Q. That's okay. If you --
A. It's just the --
Q. -- if you don't know, it doesn't --

A. Yeah, I don't know.
Q. Okay.
A. Yeah.
MR. KNIGHT: All right. I think -- I think we're finished.
MR. HIGGERSON: Okay.
THE VIDEOGRAPHER: So it's the end of the testimony of Dr. Reister. It is 1:33 P.M. We go off the record.
FURTHER DEPONENT SAITH NOT.
(Time noted: 1:33 p.m.)

REPORTER'S CERTIFICATION

I, ELIA E. CARRIÓN, CSR, RPR, CRR, CRC, a Certified Shorthand Reporter in and for the state of Illinois, do hereby certify:

That the foregoing witness was by me duly sworn; that the deposition was then taken before me at the time and place herein set forth; that the testimony and proceedings were reported stenographically by me and later transcribed into typewriting under my direction; that the foregoing is a true record of the testimony and proceedings taken at that time.

That before the conclusion of the deposition, the witness has not requested a review of this transcript pursuant to Rule 30(e)(1).

IN WITNESS WHEREOF, I do hereunto set my hand of office at Chicago, Illinois, this 23rd day of April, 2019.

C.S.R. Certificate No. 084.004641.

*** ERRATA SHEET ***
TRANSPERFECT DEPOSITION SERVICES
216 E. 45th Street, Suite #903
NEW YORK, NEW YORK 10017
(212) 400-8845

CASE: Monroe v. Baldwin
DATE: April 19, 2019
WITNESS: Dr. Shane Reister REF: 25002

PAGE	LINE	FROM	TO

_____

Dr. Shane Reister

Subscribed and sworn to before me

this ____ day of _____, 20__.

_____

Notary Public

Q

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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,	)	Case No.
vs.	)	18-CV-156-DRH-DGW
BRUCE RAUNER, JOHN BALDWIN, STEVE MEEKS, and MELVIN HINTON,	)	
Defendants.	)	

Videotaped Deposition of WILLIAM F. PUGA, M.D.

Chicago, Illinois

Friday, April 19, 2019 - 1:41 p.m.

Reported by:

ELIA E. CARRIÓN, CSR, RPR, CRR, CRC

Job No. 25002

EXHIBIT 4

The videotaped deposition of WILLIAM F. PUGA, M.D., called as a witness herein for examination, taken pursuant to the Federal Rules of Civil Procedure of the United States District Courts pertaining to the taking of depositions, taken before ELIA E. CARRIÓN, CSR, RPR, CRR, CRC, CSR No. 084.004641, a Certified Shorthand Reporter of said state, at Kirkland & Ellis LLP, 300 North LaSalle Street, Chicago, Illinois, on Friday, the 19th day of April, 2019, at 1:41 P.M.

PRESENT:

ROGER BALDWIN FOUNDATION OF ACLU, INC.
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JOHN KNIGHT, ESQ.
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SCOTT LERNER, ESQ.
appeared on behalf of the Plaintiffs;

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CHRIS HIGGERSON, ESQ.
appeared on behalf of the Defendants.

VIDEOTAPED BY: JEAN-LOUIS ZIESCH, CLVS

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EXAMINATION

EXHIBITS

THE VIDEOGRAPHER: This is Tape No. 1 of the videotaped deposition of Dr. Puga in the matter of Janiah Monroe, Marilyn Melendez, et al., versus Bruce Rauner, John Baldwin, et al., in the U.S. District Court for the Southern District of Illinois, Case No. 18-cv-156-DRH-DGW.

This deposition is being held at 300 North LaSalle in Chicago, Illinois, on April 19, 2019, at approximately 1:41 P.M.

My name is Jean-Louis Ziesch from the firm of TransPerfect, and I am the certified legal video specialist. The court reporter is Elia Carrión in association with TransPerfect.

Will counsel please introduce yourself.

MR. KNIGHT: John Knight for the plaintiffs.

MR. GUIDETTI: Ghirlandi Guidetti for the plaintiffs.

MR. LERNER: Scott Lerner for the plaintiffs.

MR. HIGGERSON: Chris Higgerson for the defendants.

THE VIDEOGRAPHER: Will the court reporter please swear in the witness.

(WHEREUPON, the witness was duly sworn.)

WILLIAM F. PUGA, M.D.,
called as a witness, having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. KNIGHT:

Q. Dr. Puga, good afternoon. Can you state your name for the record?

A. Yes. William Puga.

Q. And you've been deposed before, I assume?

A. Yes.

Q. How many of those cases have involved transgender individuals?

A. None.

Q. Have you testified in any case in court or in another kind of proceeding that -- where the case involved transgender individuals?

A. No, I haven't.

Q. Okay. And just to remind you, it's important for you to answer verbally as opposed to answering my question with a nod of the head. It's helpful if you will answer yes or no as opposed to uh-huh just to -- for the clarity of the transcript.

Are you represented by Mr. Igger -- Mr. Higgerson today?

A. Yes, I am.

Q. And I -- I would ask that if you don't understand my question, you'll let me know, and I'll repeat the question or -- or try to answer it -- ask it differently.

A. Very well.

Q. And if you do go ahead and answer, I'm going to assume that you understood my question. Is that fair?

A. Yes, it is.

Q. Okay. And is there any reason why you can think of why you wouldn't be able to answer the questions today truthfully?

A. No.

Q. Did you meet with your attorneys or attorney or -- attorney or attorneys to prepare for today?

A. We had a verbal discussion, phone call.

Q. Once? More than once?

A. I believe it was once.

Q. And how long did that phone call last?

A. It might have been 20 to 30 minutes.

Q. Was that with Mr. Higgerson?

A. Yes. And another attorney, but I'm -- I'm forgetting her name.

Q. Okay. Did you review any documents to prepare for the deposition?

A. What type of documents?

Q. Any -- any documents that -- that you reviewed to help you be prepared to answer my questions today?

A. Regarding legal documents? Or clinical documents?

Q. Any -- any documents.

A. I've reviewed the questions that were -- that were possibly going to be discussed. I've reviewed WPATH Standards of Care. I reviewed our AD regarding transgender care. I don't -- I don't recall other things in specific that -- that -- that I've reviewed.

Q. Okay. Did you review medical records to prepare for today?

A. No.

Q. Did you review transgender committee notes to prepare?

A. To prepare, no, but I've reviewed transgender care notes this week, but not necessarily for -- for -- in preparation for this.

Q. Right. I'm just asking about what you reviewed to prepare today. Can you think of anything else that you reviewed to prepare for today's deposition?

A. No. I think that's about -- that's about the summary.

Q. Can -- there in front of you, I ask you to take a look at Exhibit 3. I don't know if they're in order. Maybe they are. There they -- there it is.

Have you seen this document before?

A. Yes.

Q. Okay. And when you were talking about the questions, reviewing the questions to prepare, that's -- is that what you're talking about?

A. Yes. Uh-huh.

Q. So -- so taking a look at those, your -- you understand that you are answering on behalf of the Department of Corrections when you respond to questions today?

A. Yes, I am.

Q. And you're answering in these various topic areas?

A. Yes.

Q. Okay. And so I -- I believe that your -- you will be asking -- I'll be -- you'll be responding to questions Topic Areas 1; is that right? The first one, 1?
A. I was told 4 --
Q. 4 --
A. 3, 4, and 9, but...
Q. So you were not told to be prepared for No. 1?
A. Right.
Q. Okay. All right. Well, we were advised that you would be the one to respond to question -- to Topic Area 1.
A. Uh-huh.
Q. So I'm going to ask you some questions in that area, and -- and we'll -- we'll see how it goes.
A. Uh-huh.
Q. Okay. I'd like -- a little bit about your educational background. And you're a physician, Dr. Puga?
A. Yes.
Q. Am I saying your name correctly? Puga or Puga?

A. Puga.
Q. Puga. Okay.
So -- and where did you attend medical school?
A. University of Illinois Chicago.
Q. And when did you complete medical school?
A. 1985.
Q. And what kind of fellowship did you do? Was that in psychiatry?
A. I did a residency in psychiatry, in general psychiatry from '85 to '88, and then after that I did two additional years for child psychiatry in '88 to '90.
Q. And where did you do the residency?
A. Lutheran General Hospital, which was affiliated with the University of Illinois at the time, and then Medical College of Virginia for child psychiatry.
Q. Did you study gender dysphoria in -- in medical school?
A. I don't remember that coming up in medical school, but it was something that we -- that I did learn about in fellowship.
Q. In your psychiatry fellowship?

A. In my child psychiatry fellowship.
Q. I'm sorry. The child psychiatry fellowship?
A. Yes. Uh-huh.
Q. And what about your psychiatry fellowship? Was it something that you addressed or learned about in the fellowship -- I'm sorry -- in the residency?
A. In the -- in the -- in the mid '80s, it wasn't a -- it wasn't a prominent issue, and they -- I don't -- I don't -- and that was not a topic that we covered from my -- my recollection.
In child -- there's always -- I'm sorry.
Q. In -- in -- I'm sorry. No, go ahead.
A. There's always training in psychosexual development, but in particular, transgender was -- didn't seem to be -- I don't recall specifically. Certainly psychosexual development and development in general in the -- in child adolescent population is more -- was more -- more of an emphasis.
Q. And in -- you said you had some -- you learned something about it in your fellowship. What -- what part of that -- or -- or how did that come up?

A. Now you're -- you're talking about 30 years ago.
Q. Okay.
A. And, you know, the -- in the basis of -- of psychiatry with -- if you look at -- at Freud, he started talking about psychosexual development in -- in children. And, in fact, he wrote a book that -- that was in particular describing childhood sexuality. And so the whole notion of childhood sexuality, sexual development, sexual identity is something that -- that begins in childhood and has been recognized for -- quote/unquote, forever in the field of psychiatry. So it's something that -- that -- that comes up. I -- I --
Q. Was it a focus of yours at all in the fellowship in Virginia?
A. It -- it wasn't a -- a -- a prominent thing. I know I -- I -- I served as an expert on The Jenny Jones Show back in the early '90s, but -- regarding transsexual families, but that was -- I did some extra study during that time to prepare for that, but that was -- I -- there wasn't as much literature about that, there wasn't as much known about that, but there was -- there was some degree

of knowledge, but certainly not -- not the knowledge that we have today about it.
Q. Did you treat transgender patients in the fellowship?
A. Not that I recall.
Q. You mentioned a -- you mentioned doing a speaking engagement about it. But I -- I guess specifically, did you treat transgender individuals at that point?
A. No.
Q. Okay.
A. It was all based on research and learning and more theoretical than -- than -- than by ex -- from experience.
Q. Okay. And so are you a member of the transgender committee?
A. Yes, I am.
Q. And are you a member or a participant? 'Cause I've seen both of those terminologies -- terms -- terms used.
A. I -- I started out as a participant and then I was asked to be the chair. The medical director, Dr. Meeks, appointed me as the chairman of the committee.

Q. When did that happen?
A. I believe -- somewhere around, I believe, either July or August of last year.
Q. So July, August of 2018 --
A. Yes.
Q. -- you became the chair?
A. Yes.
Q. And prior to that, it had been Dr. Meeks?
A. Yes.
Q. Who is the medical director?
A. Correct.
Q. Dr. Meeks is still on the committee?
A. Yes.
Q. And so was Dr. Hinton?
A. Yes.
Q. And what -- what is the difference between a member and an attendee?
A. The -- the members of the committee are -- are -- vote and -- and -- and are able to make decisions for the -- for the department.
The attendees can provide information, can provide a rebuttal, can present concerns, and they will present information and -- and then we discuss it as -- as a committee and -- and we'll

make decisions for the department.
Q. And so you're saying you -- you then -- so the -- the members would include the agency medical director, Dr. Meeks; you, Dr. Puga --
A. As a chief of psychiatry. And then the chief of -- of operations.
Q. So that -- so it would also include the chief of operations, Sandy Funk?
A. She recently retired, yes.
Q. When did Sandy Funk retire?
A. I believe the beginning of this month or the end of this last month, end of March.
Q. And who has replaced -- I'm sorry. Does Sandy identify as female or --
A. Yes.
Q. -- male? Okay.
Who replaced her?
A. Chief Eilers, E-I-L-E-R-S.
Q. Okay. And -- and then the committee would also include?
A. Transfer coordinator.
Q. The transfer coordinator. Is that Doug Stephens?
A. Yes, it was. I believe Ms. Wortley, I

don't remember her first name -- W-O-R-T-L-E-Y, I believe is current -- currently sits on the committee. Yeah, I'm -- I'm not sure if that's by designation, if she was assigned to that, or -- but she usually sits on the committee. And also Dr. Hinton, chief of mental health and addictions.
Q. Okay. So -- so you've listed off five committee members?
A. Yes.
Q. Including you?
A. Yes.
Q. Okay.
A. Now, aside from us, we ask the regionals to participate. And our -- our three regionals -- regional psychologists include Dr. Reister, Dr. Fairless, Dr. Horn.
Q. You asked those three regional administrators to participate?
A. Right.
Q. Okay. And Dr. Reister is the southern region; is that right?
A. That's right.
Q. And doc -- and Dr. Fairless is?
A. Central region.

Q. Central. And doctor -- I'm --
A. Horn.
Q. I'm sorry. Are these all psy -- PhD psychologists?
A. Yes.
Q. Okay. So Dr. Fairless is central and Dr. Horn is northern?
A. Yes.
Q. And so you've got attendees. If you're making a decision, though, that will be a vote among the five committee members?
A. Right.
MR. KNIGHT: I'd like to mark this as Puga Exhibit 11. Okay.
(WHEREUPON, a certain document was marked Puga Exhibit 11, for identification, as of April 19, 2019.)
Q. (By Mr. Knight) Okay. Dr. Puga, would you -- can you identify Puga Exhibit 11?
A. Yes.
Q. What is it?
A. This is -- per facility, these are the people that are in -- charged with the treatment for

the transgender population.
Q. So are these -- what is -- are they physicians? Are they mental health professionals? What -- what are their positions?
A. These are mental health professionals.
Q. And are these all master's level?
A. At least, yes.
Q. Okay.
A. Some -- some are doctoral levels.
Q. Are all these people still working for the Department of Corrections -- or working in the Department of Corrections?
A. Yes. I don't know if this is updated; but, yes, from -- they're all in -- in the department from -- I -- I -- I don't know all of them personally. And I -- I -- I can't tell you if this is the latest updated version.
Q. Are these people who also may attend the committee meetings?
A. Yes.
Q. And do they do that by phone?
A. Yes. And the -- the committee meetings are -- have -- have many people that are involved. And typically, for example, you know, we'll have

our -- our monthly meeting. The -- the -- the five members are -- are there, are present. Every -- every time I've been on -- on a call, Dr. Reister's been on it, and most of the time -- the vast majority of the time, the other two regionals are on.
Every facility has representatives, including the therapists that are listed here. The assistant warden of programs, sometimes the warden. The medical -- someone from the medical department and their facility, whether that's the HCUA, the healthcare unit administrator, or the -- the physician. And those are -- those are the people that are -- that -- that will be part of the presentation.
So most -- many of these people, when they're presenting, will stay for the whole duration of the -- of the committee time, which is typically two, two and a half hours. And -- and most of -- most people will be participating. Not all of them have -- you know, and -- and anybody can -- can -- can give input and give help to the understanding of the situation, but -- but it is a -- the committee is -- is -- is -- it's a large committee that --

that -- that is very well attended.
MR. KNIGHT: I'd like to mark this as Puga Exhibit 12.
(WHEREUPON, a certain document was marked Puga Exhibit 12, for identification, as of April 19, 2019.)
Q. (By Mr. Knight) Dr. Puga, Exhibit 12, have you seen this?
A. Yes.
Q. And can you identify Exhibit 12?
A. Yes. This is a listing per facility of the -- the medical administration, the administra -- warden administration, as well as medical administration.
Q. And are these the additional people who might be at meetings?
A. Yes.
Q. Is there anyone else, other than the people listed on Exhibit 11 and Exhibit 12, who is present at meetings?
A. From time to time, there will be a -- you know, we've had nurse -- a nurse practitioner in place of the -- the medical director, you know,

because, you know, the medical director was -- was unavailable. So sometimes there'll -- there'll be designees. But -- but typically, the -- the structure is the facil -- the facility-designated therapists, mental health provider, and the -- the health providers and the wardens, someone representing the wardens.

Q. And if you could just help me understand a couple of the terminol -- some of the terminology. Looks like, for example, at Lawrence Correctional on the bottom right?

A. Uh-huh.

Q. I understand warden, but what is AWO -- OPS?

A. Assistant warden of operations. So security.

Q. And then the next one would be assistant warden of --

A. -- programs. So in -- in charge of mental health and physical health.

Q. And then the medical director, which is vacant at this point -- is that still vacant?

A. I'm -- I'm -- I'm not sure.

Q. And then HCUA?

A. Healthcare unit administration -- administrator.

Q. And what's -- what is that position?

A. That's an -- it's typically a nursing person who is in charge of the -- the -- the medical -- the -- in -- the nursing medical director of the -- the facility.

Q. Okay. And DON?

A. Director of nursing.

Q. And what about med -- medical --

A. Record director.

Q. -- record director? What -- what is that? And why are they on this list?

A. There, again, this is not a list of everyone who attends 'cause the medi -- the medical records director does not attend our -- our -- our meeting. But this would be, you know, who would -- the person would be identified if -- if we need medical records, if we need to -- if we need to gather information from, you know, the medical record. They're the keepers of that.

Q. Okay. And then privacy officer?

A. I -- I -- you know what? I'm -- I'm -- I'm not clear as far as their -- their

responsibility.

Q. Are they a part of committee meetings?

A. No.

Q. So Dr. Meeks as medical director would be responsible for all the medical issues throughout the system, the Department of Corrections; is that right?

A. That's correct.

Q. And mental health responsibilities are separate from the medical. Is that the way that works?

A. There's -- there's a lot of overlap, and -- and the way the -- the structure is, is that the psychiatry is a subset of -- of -- of -- of -- of medical and mental health, and addictions is alongside.

Q. The -- do the -- and -- and do you answer to -- as chief of psychiatry, do you answer, then, to Dr. Meeks or Dr. Hinton?

A. Both to doctor -- Dr. Meeks and to Dr. Bazil-Sawyer. Dr. Hinton is -- Dr. Hinton has been in the department and -- and has -- has trained me in -- in -- has been training me in my position, and I -- I consider him someone that I -- I will --

I -- I will defer to. I'm relatively new in the -- this position. The position of -- of chief of psychiatry is relatively new to the department. And -- but -- but -- but I do -- I do -- I do answer to Dr. Meeks, and I -- I -- I defer a lot to Dr. Hinton --

Q. But --

A. -- and above us [unintelligible] --

Q. -- you're -- you're not a direct report to doctor --

(Court reporter clarification.)

MR. KNIGHT: I'm sorry.

Q. (By Mr. Knight) You're not a direct report to Dr. Hinton?

A. No.

Q. Okay. You mentioned a Dr. Sawyer --

A. Yes.

Q. -- who you report to? Who is that?

A. That's the -- that's the chief of -- chief of operations. So she is over medical and psy -- and psychiatry and mental health. And she reports directly to the director.

MR. HIGGERSON: I think you -- she's not chief

of operations, is she?
THE WITNESS: I'm sorry. Did I say "operations"? I'm sorry.
A. Chief of programs.
THE WITNESS: Sorry. Thank you.
Q. (By Mr. Knight) Did you start at the Department of Corrections in 2016?
A. No.
Q. When did you start?
A. March 1, 2018.
Q. That's the wrong person. Ah. So I believe it was Dr. Meeks who started in 2016.
Okay. March 2018, it was when you started?
A. Yes.
Q. Okay. Okay. And then in terms of committee members, Mr. Stephens and now I guess it's Gina Wehmhoff, they're -- they're -- she is -- Gina is now the transfer coordinator and Doug was the transfer coordinator?
A. I -- I believe so.
Q. Now, do -- do either of them have medical training?
A. I don't think so. I -- I'm not -- I'm

not certain. I -- I -- my -- my interaction with them is -- is -- is primarily -- is -- is periodic and -- and I don't know that they have medical training.
Q. They're -- they're not a part of -- as far as you know, they're not a part of the medical staff?
A. Right.
Q. And the same question with respect to the chief of operations: That was Sandy Funk, but is now somebody else, I believe?
A. Chief Eilers. Uh-huh.
Q. Chief Eilers?
A. Yes.
Q. So neither of them has medical training, do they?
A. I believe that's correct, yes.
Q. Have you had any treatment regarding treatment of persons with gender dysphoria?
A. I'm sorry. Can you repeat the question?
Q. Have you had any training with respect to treatment of persons with gender dysphoria?
A. I would say yes.
Q. What training have you had?

A. I've -- I've gone to continuing medical education. I have done a lot of literature review. I've done a -- a lot of self-learning, as well as in my private practice, I've -- I've had patients with gender dysphoria. I've had -- when I worked at the hospital, I -- I worked with people with gender dysphoria.
So I have experience and -- and -- and -- and learning and some -- and much of what happens after you leave formal training is -- is that you learn on your own and you learn -- you -- you gather resources and -- and -- and -- and I have other people such as Dr. Reister who has a lot of experience who I've used in consultation and -- and also further learning.
Q. You mentioned a continuing medical education?
A. Yes.
Q. When was that?
A. That has been more so since I -- I got into this -- in -- into this role, but at the NCCHC, the national commission for healthcare and corrections, I just attended something last week and I attended something last fall.

Q. So there -- you went to a conference, is that what you're talking about?
A. Yes.
Q. At the -- the NCCHC conference?
A. Right.
Q. And you've -- and you've mentioned two different ones?
A. Right.
Q. And at each of those, there was a session about medical care for tran -- for gender dysphoria, is that what you're saying?
A. Gender dysphoria treatment in corrections, yes.
Q. When were those trainings?
A. Exactly when -- last week was -- was one. And I believe it might have been in, you know, August of last year. I'd have to review that.
Q. Where were -- where was the one last week?
A. In Nashville.
Q. How long was the training?
A. That particular -- it was a lecture. I don't remember if it was an hour and a half or two hours. It was at least an hour and a half.

Q. And who conducted the training -- or the lecture?
A. A psychologist. I -- I -- I don't recall his name offhand. I'd have to look -- look that up.
Q. And the one in August, where was that?
A. That was in Minneapolis.
Q. And how long was the session that addressed transgender healthcare?
A. It -- it was probably about an hour and a half, I believe.
Q. And do you know who provided that training -- or that lecture?
A. A psychologist out of California. I don't -- I don't recall his name. There's -- different than the one I heard speak last week.
Q. You mentioned -- so was the -- the session last week provided by Jennifer Sexton and Theresa --
A. No.
Q. -- Wickham?
A. No. It -- I believe it was a male.
Q. Male.
Okay. You mentioned seeing patients in private practice. When were you in private

practice?
A. I continue to have a small private practice, but since 1990.
Q. How many transgender patients have you seen?
A. Just in private practice or hospital also?
Q. Yes. I'm talking about private practice right now.
A. I have one active patient. A wife of a transgender patient, and parents of a transgender patient.
Q. Currently, have you had any other patients other than the one you mentioned that you have now?
A. In -- in a hospital setting, I've had --
Q. Okay. I'm talking about private practice right now. We'll talk about the hospital next.
A. Yes. One other.
Q. So two while in private practice?
A. Yes, I believe so.
Q. And are you overseeing -- I -- do you prescribe hormone therapy?
A. No.

Q. Do you -- and then -- let's see. In -- in the hospital setting, when -- when were you working at a hospital?
A. Until -- from 1990 till 20 -- 2017.
Q. Was that a full-time position?
A. For the 16 years prior to -- yeah, from 20 -- from the year 2000 to 2016, 2017, yes. So...
Q. Okay. And then prior to the 2001 to 2016, it was part-time?
A. Yes. It was along with my private practice, so it was -- I wasn't an employed physician. I was an employed physician at a hospital from about year 2000 to 2017.
Q. And over the time that you worked in the hospital, how many transgender pat -- patients did you treat?
A. There were only about three.
Q. And were you treating them for gender dysphoria or for other issues?
A. Other issues.
Q. In your career, is there any other time that you have treated transgender -- or patients with gender dysphoria for gender dysphoria?
A. I have consulted with a school regarding

transgender care and -- of -- of a student. I think one, two, three -- probably three, three students.
Q. And what kind of consultation were you providing?
A. Psychiatric consultation to the -- to the administration, District 155 in Crystal Lake.
Q. And just to clarify, when you mentioned having a transgender patient -- having two transgender patients in your private practice, were you treating them for gender dysphoria?
A. They -- they see therapists -- they've seen -- they had seen therapists. My role was more limited, as far as dealing with their mood disorders. And part of what I do in -- in -- when I -- in con -- when I see them as patients is that I -- I -- I -- I do a lot of supportive psychotherapy, but mostly my role was medication management of their psychiatric illness.
In the school context, it was -- it was trying to help the staff understand the -- the dynamics of -- of -- of -- of the individual and how to support them, how to help them in -- in -- acclimating to their -- to their environments.
Q. So the school context was to help

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acclimating the student as a -- as someone with gender dysphoria to the school climate?
A. Yes. Helping them -- helping the staff to understand the dynamics, helping them to understand the -- you know, their -- their -- their potential roles and how to be supportive and how to -- how to -- how to -- how to make that a smooth transition in dealing with the psychosocial aspects.
Q. Have you -- we talked about two conferences that you attended and went to sessions. Have you attended any other training or -- about treatment of gender dysphoria?
A. Not specifically that I -- that I -- that I can recall. You know, I -- I -- the transgender issues have been more -- more of a focus in -- in our society lately, and so though I may have had, you know -- I -- and I don't recall where my prior training is.
Certainly when I encounter a situation that I'm not familiar with, no matter what it is in my professional life, I will research it, study it, review the literature, take a look at and learn as much as I can about it because I want to -- I want to -- I want to do the best I can with a particular

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patient. So, you know, that's -- that's part of what we do in medicine.
Q. Do you see yourself as an expert in the treatment of gender dysphoria?
A. I -- I think I have developed an expertise that -- that if I compared myself to other people in -- in -- in my field, I think I probably -- I would -- I would say I probably have more experience and -- and more working knowledge than the -- than the average person -- the average psychiatrist.
Q. And is that because of your experience on the transgender committee?
A. Partially, yes.
Q. Anything else?
A. As -- as -- as you can see, I've -- I've had experiences in -- in -- in multiple different aspects of the -- of -- of gender dysphoria, whether it means supporting a spouse, supporting family, supporting the individual, supporting them academically or at the academic setting, working, you know, with severe mental illness in -- in that population.
So, you know, I -- I've had a lot of

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experience. This is -- this is not something that is very common in the world, and -- and I've -- and I've had relatively, you know, a fair amount of experience with this -- with this population.
Q. Okay. The -- so there's -- is there anything else that you believe makes you an expert in this field, other than the things we've already talked about?
A. No. I -- I think I have a good working knowledge, and I'm -- and I'm still learning and I'm still growing in -- in -- in all areas, and -- including this one.
Q. Are you a WPATH member?
A. No.
Q. Have you ever been to a WPATH conference?
A. No. I plan to go in September.
Q. Have you ever -- are -- are you aware of some of the experts in the field, Dr. Ettner, for example?
A. No. I can't say that I -- I've read -- I -- I don't know who the authors were of things I've read, and I -- I -- I can't say I can -- I can name experts. I'm sorry.
Q. Are there anyone -- is there anyone you

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can identify as an expert in the field; that is, in terms of people who do research or people who see transgender people on a -- on a regular basis?
A. I consider Dr. Reister an expert, and I -- I -- I -- he has -- he has probably more experience than anybody I know of.
Q. Is he more of an expert in the field than you are?
A. Yes, I would say so.
Q. Outside of Dr. Reister, is there anyone else you would identify as an expert in the field?
A. Not that I know of.
Q. And in your position, you oversee all of the Department of Corrections' psychiatrists?
A. Yes. Psychiatry is under my -- is -- is -- is under my care, yes. We have a vendor, Wexford, that employs and -- and supervises the -- the psychiatrists, but -- but they, as State of Illinois, they -- they answer to -- to us and so -- too psychiatry answers to me.
Q. And those are the psychiatrists at the various facilities?
A. Yes.
Q. And you oversee the -- the paperwork, the

medications, you do all that for all of the psychiatrists and -- and their -- and their work; is that right?
A. Well, certainly I can't -- I can't be -- I can't see everything specifically individually, but I will -- I -- I do set -- my job is to set the standards for that.
Q. Do the psychiatrists have any role in treating transgender individuals for gender dysphoria?
A. Treating specifically, no. Diagnosing and helping with the diagnosis, yes.
Q. So the psychiatrists would be involved in diagnose in -- in diagnosing gender dysphoria?
A. Yes.
Q. And is -- is it true that the main role of the -- of the psychiatrist is psychopharmacology?
A. Yes. In our department.
Q. So that would include antidepressants, antipsychotics, that sort of thing?
A. Yes.
Q. Those aren't -- you understand those aren't treatments for gender dysphoria, are they?
A. That's correct.

Q. Are they the ones who prescribe hormone therapy?
A. No.
Q. Do you meet with individual patients at all?
A. Rarely.
Q. And -- and by individual patients, I'm talking about prisoners who are -- who are -- who are being treated by the medical staff at the Department of Corrections.
A. Rarely.
Q. Okay. How often?
A. Direct patient care isn't what I -- what I am doing in the department. But, for example, I have reviewed -- met with Ms. Monroe and -- and another transgender offender. I have sat in some groups, a particular transgender group. I have -- when I -- when I am at different facilities, I might -- I might speak with people more in passing or -- or -- or if a -- there's a specific concern, I might spend a little more time and -- and I might speak with them, but that's -- but -- but I am not doing direct clinical work with them.
Q. Okay. You mentioned meeting Ms. Monroe.

You weren't -- you were -- you met her, but you weren't treating her?
A. Correct.
Q. And you mentioned another patient who's transgender. Who is that?
THE WITNESS: Am I allowed to say?
MR. HIGGERSON: Yeah, if we need to -- if we get --
THE WITNESS: Confidential.
MR. HIGGERSON: If we get beyond anything that should be on the record, we can make that part confidential, so you're okay.
THE WITNESS: Okay.
A. Ms. Hampton.
Q. (By Mr. Knight) Okay. And were you treating her?
A. No.
Q. And -- and you said something about going to groups. Are you talking about transgender groups?
A. Yes. I've sat in --
Q. How many of those have you been to?
A. Only two.
Q. And where were those?

A. Dixon and -- it -- it might have been Centralia.
Q. You're not sure?
A. Right. It was in that region, one of them.
Q. When -- I'm sorry. When -- when did you attend those sessions?
A. In Dixon, it may have been either December or January. And Centralia, again, November or December.
Q. So recent?
A. Yes.
Q. Sounds like if I'm understanding you correctly, that would have -- you're saying December or January -- December of 2019 or January of 2019?
A. December 2018, January 2019.
Q. That's -- that's when the two sessions were?
A. Uh-huh.
Q. Okay. Just going back to Exhibit 11, these -- the mental health staff that are listed there, they're -- they're not the ones who will make the final decision about the treatment for gender dysphoria, are they?

A. That's correct.
Q. The committee will make that decision?
A. Right.
Q. And similarly, that would be true for Exhibit 12, the people listed on that list are not making the final decision?
A. Right.
Q. I believe you said, then, that the committee -- the five members of the committee will make decisions by vote?
A. Yes.
Q. So they'll be recommendations from the different facilities and then the committee will discuss and there's a -- there's a telephone conference, is that -- I think you said?
A. Yes.
Q. There's a telephone conference. And there will be people -- the mental health staff professionals from the facility will be on the phone?
A. Yes.
Q. And -- and they'll be making recommendations for the treatment they think should be provided? Is that the way that works?

A. Yes. Well, whenever -- whenever a transgendered individual arrives at their parent facility, within 30 days they will be brought up to the committee. And so during -- prior to that, the -- the primary therapist, who will be one of the people on the transgender health staff, will -- will see them and complete our -- our form DOC 0400, which will provide details of -- of the offender. More or less a snapshot of them. Mental healthwise, healthwise, sexual history, and -- and any requests or any concerns. And then -- and then that -- that is sent to the committee ahead of time.

Their -- their MAR, so medical administration record, is also sent. And I have -- and -- and -- and so that -- that's presented. And so they present concerns or -- or if there's no concerns, they will present the -- the -- the case, quote/unquote.

And from there, we'll -- we'll hear about it, we'll hear -- we'll identify any concerns, any problems, what have you, any -- we will give some direction. You know, if there's a request for hormones, if there's a request for anything in particular, you know, we'll take a look at that.

And we'll take a look at anything that seems problematic, and -- and then we will make a decision.

Now, just because the five of us are, quote/unquote, voting members, you know, we -- it doesn't mean that -- that -- that -- that -- that -- that we -- we will ignore input. We take other people's input and -- and in order to -- in order to make the decision.

Q. Okay. So you take into account the input of the facility staff who are on the phone, you might take into account the input of one of the psychological administrators; is that right?
A. Yes.
Q. And -- but then you'll ultimately make the decision?
A. Right.
Q. Are there any other kinds of medical conditions where the decision is made by a committee?
A. Informally, yes.
Q. What do you mean -- and -- and what decisions are made by a committee?
A. Sometimes if it's complicated medical

condition, medical/psychiatric, or, you know, we've had issues of dementia, we've had issues of other things that kind of impact that we're looking at, you know, we -- we -- we -- we convene as a -- as a -- as a committee, so to speak, of administrators, and we take a look at what -- what would be important in the -- in the treatment of that particular individual.

So there are times when, you know, complicated medical or psychiatric conditions have come up that we -- that we -- that we form a -- a small committee and make -- and make decisions.

Q. And there's a formal committee or --
A. No. Informal.
Q. Okay.
A. It's an informal.
Q. So I'm asking: This is a formal committee?
A. Yes.
Q. Is there any other any medical decision that is made by a formal committee?
A. That I know of, no.
Q. And the -- the -- what you're talking about in terms of complicated mental health cases,

that -- who are these administrators that -- who might be a part of that discussion about what kind -- what kind of treatment should be provided?

A. Very often Dr. Meeks, Dr. Hinton, you know. We had something come up this morning. We had the -- the local warden and the -- and the psychology administrators there, and the regional psychologists and -- so -- so -- as -- as needed, we'll invite people. Well, actually, if there's a legal issue there, we have an attorney as part of that committee too.

Q. Is -- is this a meeting by phone or --

A. Yes, this one was.

Q. A conference call?

A. Yes.

Q. And how often does that happen, where you have a complicated mental health issue where there's a phone call with other people to decide what to do?

A. Uh-huh. It -- it comes up randomly. There was -- there were a couple months where frequent -- it would come up frequently, but I would say on average every two or three weeks, if you were to average it all out.

We encourage complicated situations to be

brought up to -- to that level so we can discuss it, and -- and, you know, we want people to seek consultation. We want them to -- to not operate alone. And we want to be part of decisions that are made, especially if they're difficult.

Q. So you mentioned mental health conditions where there's this conference call meeting. What kind of medical conditions are discussed in a conference call, or are there any? Are there any, I guess I should say?

A. Periodically, yes. We had somebody with a neurologic -- a deteriorating neurologic condition. We had someone with dementia. We had -- we've had patients that have been self-injurious, and -- and -- and it would require outside medical care. So yeah -- so there's -- there's a lot of overlap.

Q. Those sound like -- that sounds like another mental health condition.

A. Sounds like?

Q. Another mental health condition, the -- the -- the circumstances you were just describing?

A. Yeah, yeah.

Q. Okay.

A. Were you referring specifically to transgender?

Q. No. I'm -- I'm talking about any other kinds of decisions that are made through a conference call of this sort in the medical area as opposed to the mental health area?

MR. HIGGERSON: I think you're a bit outside of his -- what he -- what he's in charge of at the department and what he's supposed to address here as a 30(b)(6) witness.

MR. KNIGHT: Okay.

Q. (By Mr. Knight) Do you know? And if you don't, obviously --

A. No. I'd have to ask Dr. Reister.

Q. Okay. So are you familiar with the minimum mental health standards applicable to mental health professionals who treat gender dysphoria?

A. It -- I'm -- I'm not sure what you're referring to.

Q. Well, there's a -- within the -- are you familiar with the WPATH Standards of Care?

A. Yes.

Q. And are you aware that they have -- they set out what -- what are considered to be the

minimum qualifications for providing mental health treatment for someone with gender dysphoria?

A. Yes.

Q. Do you know what those are?

A. Offhand, all of them, no. I know they recommend master's level -- master's level training and -- but I don't know the other details at this point.

Q. Are you aware of the standards in place for medical staff prescribing hormone therapy?

A. No. I'm -- I'm not sure.

Q. You're not aware of what those minimum standards are?

A. Right.

Q. Okay. So let's see.

MR. KNIGHT: You can mark this as Puga Exhibit 13, I guess.

(WHEREUPON, a certain document was marked Puga Exhibit 13, for identification, as of April 19, 2019.)

Q. (By Mr. Knight) So I -- I want to turn now to the -- the next area, which is the meaning and implementation of any administrative directives

or other Illinois Department of Corrections policies or procedures that relate to -- to the transgender committee or IDOC's evaluation of treatment of gender dysphoria. That's your -- another topic area for you?

A. Uh-huh. Yes.

Q. Is that right? 3?

A. Yes.

Q. So what is Puga Exhibit 13?

A. That's our administrative directive as it -- as it -- as it relates to the gender identity disorder.

Q. And this is the current one?

A. Yes. I -- I don't know the status of the -- of the revision, but we've been working on a revision for quite some time. I'm not sure why it hasn't been out yet.

Q. And this has been in place since 2013?

A. Yes.

Q. Do you know why it's -- it was put in place?

A. I don't know -- I would -- I would -- I would have to guess that it --

Q. Okay. Do you know why it exists? I

guess that's the same question. Let me --

And is this directive currently followed?

A. Yes.

Q. And this applies throughout all 40 -- or all the prisons?

A. Yes.

Q. Also applies -- are there other facilities -- does it apply to boot camp, for example?

A. I don't know.

Q. And this talks about gender identity disorders, but would this be applied to persons diagnosed with gender dysphoria?

A. There's a modification. A lot has changed in our understanding and -- and even our definitions, and -- and -- but -- but yes, that's -- I guess there's a revision that -- that -- that's been -- that's been in the works for more than a year, and I'm not sure why it isn't out just yet.

Q. Okay. But this one currently is what would apply to prisoners with gender dysphoria?

A. Yes.

Q. There's a reference to facility review?

A. Yes.

Q. Does -- and it says it'll be conducted annually?

A. Yes.

Q. Does that happen?

A. I -- I believe all the wardens -- I need to review all the ADs on an annual basis, and I think there -- from my understanding, they're faithful with completing that.

Q. Do you -- do you know whether they do?

A. I -- I couldn't tell you exactly. I -- I know that that's -- that's their responsibility as warden to do that.

Q. Have you -- has the committee done anything to find out for sure that it happens?

A. Not to my knowledge.

Q. Are there any records kept of facility review?

A. I don't know.

Q. What is facility review?

A. Each -- each facility -- each correctional center will look at the -- in this case, this -- this particular administrative directive and -- and make sure that they -- they go over it, and make sure that they're following the --

the -- the directive.

It's pretty much a reinforcement of -- of each administrative directive, and that's why we want to -- we want all the facilities to do that.

Q. This provides that there's supposed to be an evaluation -- and this is on page 2 -- of prisoners with gender identity disorder within 24 hours of arrival of reception classification.

Does that occur?

A. I believe it does. And I believe that is tracked. Yes, all offenders undergo --

Q. Do you -- and -- and how do you know that it's tracked and that it occurs?

A. That's something that all the receiving centers will -- you know, are -- are charged with and, from what I understand, when -- when those have been reviewed, there -- there haven't been problems with -- with that occurring.

Q. Does the committee review records to show that those exams are happening within 24 hours?

A. No. It's another -- it's a -- it's another entity that reviews that.

Q. What entity reviews that?

A. We have what's called the "CQI,"

continuous quality improvement, and -- and -- program that -- that reviews that. We have a federal monitor that has been at our R&C centers and they reviewed that recently. They have not found it to be problematic.

Q. What -- what -- what kind of federal monitor is there?

A. It's a -- from our Rasho settlement, we have a federal monitor that's -- that -- that's been working with the department.

Q. Does the -- that -- the -- that Rasho monitor is -- is -- you're -- you're saying that the 24-hour review is supposed to happen for all prisoners, not just those with gender dysphoria?

A. That's correct.

Q. And you're saying the Rasho monitors reviewed that?

A. Yes.

Q. And is that reported to the committee?

A. That's reported to the department. I've read -- I've read that, I've spoken with them about that, and --

Q. Right. I'm asking about the committee, though. Does the committee -- does the committee

get reports to ensure that these exams are happening within 24 hours?

A. No. That's not the scope of the committee, but -- but no, they don't -- the individuals on the committee, I think all -- all of us do get that feedback, but -- but not as a committee itself.

Q. And on page 2, there's the provision F1 that says -- I'm sorry -- F2, it says that the department shall not perform or allow the performance of any surgery for the specific purpose of gender change, except in extraordinary circumstances. Do you see where I'm reading?

A. Yes.

Q. And that would be determined by the -- the director, Director Baldwin?

A. Yes.

Q. And are there any other medical treatments -- and -- and so this is talking about surgery to treat gender dysphoria?

A. Correct.

Q. Are there any other -- are you aware of any other forms of surgery where -- that require the review of Director Baldwin?

A. I -- I'm not sure.

Q. Okay. You're not aware of any?

A. I'm not aware.

Q. Are you aware of why this is such a high standard and requires this level of review?

A. Am I aware of why? No.

Q. Can you think of any other treatment that -- or medical procedure that -- where this standard must be met, the extraordinary circumstances standard?

A. You'd have to ask Dr. Meeks. I'm not -- I'm not sure.

Q. You can't think of any?

A. You know, I'd -- I'd -- I'd just be speculating.

Q. Okay. And -- and there's never been approval of surgical treatment for gender dysphoria, has there, by the committee?

A. That I know of, there has not been.

Q. And then No. 3 says: Hormone therapy will require higher approval of the agency medical director. You see where I'm reading?

A. Yes.

Q. Is -- are there other kinds of treatments

that require approval of the medical director?

A. I -- I can't speak for the medical director. I'm not sure.

Q. Well, I mean, you provide other kinds of care and you prescribe anti -- I should say not you personally, but the -- the psychiatrists that work for you -- prescribe antipsychotics or antidepressants or other kinds of -- of medical treatments; right?

A. Uh-huh, yes. And we do have some control over that. We have a formulary and -- and there are reasons why some things are restricted. They're not -- we don't say necessarily no to -- to -- to anything in particular, but there are -- are -- are some treatments that are -- that are problematic in our department. So I took off the formulary a medication that was being very highly abused, for example, and -- and trafficked -- trafficked, and I made it a little less easy to access because we have other options. And so --

Q. They are -- and I'm sorry.

Let's say we're talking about a medication that's on the formulary, are there any medications that the psychiatrists who work for you

are required to get agen -- the agency medical director sign-off on before they can be prescribed?
A. Not if they're on the formulary.
Q. And what if they're not on the -- what if they're off the formulary, does that require --
A. There's a procedure.
Q. -- agency medical review, or does it require Wexford review?
A. It requires Wexford review, but then I can appeal -- they can appeal to me.
Q. Okay. So -- so that doesn't go to the agency medical director either if it's off formulary?
A. Right.
Q. Okay. That would go to Wexford for approval?
A. Right.
Q. Okay. Okay. And then the -- at the bottom of the page, there's a provision which talks about establishing the committee and that it -- it sets out a purpose. So its purpose of reviewing placements, security concerns, overall health-related treatment plans, and oversee gender-related accommodation needs of these

offenders.
So is that your understanding of the purpose of the committee, is that what -- what's written there?
A. Yes. Uh-huh.
Q. And then this sets out the members of the committee. It actually identifies four people. You're saying that even though this identifies four people, you're now a fifth member of the committee?
A. Right. My position didn't exist when this was written.
Q. And up until the time that you became the head of the committee, Dr. Meeks was the head of the committee?
A. Yes.
Q. What are gender-related accommodation needs?
A. There are times when we may have to look at providing a -- a -- for example, for the male to female sports bras. There are times when -- when they will need shower accommodations and shower separately or shower somewhere else. There are times when -- there'll -- there'll be requests for certain -- certain things, and so we -- we -- we

will -- we will look at all those things that we -- sometimes an accommodation has been switching to another facility.
Q. What do you mean by "switching to another facility"?
A. We've had -- we've had several transgender patients who would do better having more services, for example, available. Some of the facilities don't have much, as far as how many transgender patients there are or the -- the -- the availability of groups, and so we've -- we've -- we've transferred, you know -- from -- better access to treatment. We've had a couple of transgender individuals that we've moved to a female facility.
Q. Okay. And those two, though, were done because of court actions requesting transfer; right?
A. We did it because we -- we thought it was appropriate as --
Q. Well, there -- there were court actions requesting transfer in both of those cases, though, weren't there?
A. Yes.
Q. Okay. And then on page 3, there's a reference to the chief administrative officer, under

requirements. Is that Director Baldwin?
A. No. That's the warden at the facility.
Q. And do you know -- are you aware of whether the wardens at the facilities have maintained a written procedure for -- that's -- as set forth here?
A. I don't know specifically. I know that there -- I've seen notes kind of highlighting these and -- and -- and the -- the medical doctor filling them out.
Q. The committee doesn't do anything to ensure that those happen --
A. The --
Q. -- that those procedures are put in place?
A. The DOC 0400 is fairly comprehensive and it does have a medical piece there and the medical provider is -- is at the committee meeting and so we -- you know, we have been -- you know, we have access to them and their information, and -- and...
Q. Okay. But my question was: Do you, the committee -- does the committee do anything to ensure that those -- that policy is in place at the facilities?

A. Not directly. The 0400 will -- does cover these, though, and -- and will have all this information. Whether they get that from the medical history or the patient themselves, I'm not quite sure?
Q. The 0400 you mentioned earlier, this is something that the mental health professionals at the facility prepare?
A. Yes.
Q. And they provide that to -- to the committee before a committee meeting?
A. Yes.
Q. And is that different than from the -- the committee notes that are prepared?
A. No. The committee notes are added on to -- to the 0400.
Q. Okay. So that's -- the 0400 comes to the committee and then the committee adds its recommendations to that 0400?
A. That's correct.
MR. KNIGHT: Okay. Could we mark this as Puga Exhibit 14.
(WHEREUPON, a certain document was marked Puga Exhibit 14, for

identification, as of April 19, 2019.)
Q. (By Mr. Knight) Actually, before we turn to this, the -- in Exhibit 13, on the -- on page 4 at the bottom, there's a reference to the R&C facility medical director telephoning the agency medical director?
A. Yes.
Q. And -- and I'm just wondering, does -- do you know if that happens?
A. I -- I -- I -- you know, there again, that -- that would be Dr. Meeks. In Dr. Meeks' absence, I -- I have gotten a couple of calls when I've covered for him, so I -- I -- I know -- I -- I believe it does happen.
Q. Okay. But you -- you -- you don't know for sure because you're saying Dr. Meeks gets that?
A. Right.
Q. And the committee doesn't do anything to -- the committee as a whole doesn't do anything to find out if that happens?
A. Right. That -- when somebody comes in for -- with hormones, for example, they will have their hormones continued, but they need to contact

Dr. Meeks and they need to contact me -- or me, if -- if he's not available.
Q. So normally it would go to Dr. Meeks, but then sometimes you would cover for him?
A. Right.
Q. How often do you cover -- is that right?
A. Uh-huh.
Q. Okay.
A. Yeah, I -- I -- when he's -- when he's out of town, it's been a periodic thing. In the year I've been in the department, it's maybe been three -- three times. Three weeks.
Q. And of the -- so I'm sorry. You've gotten three calls or three weeks?
A. For -- I've probably covered for at least three weeks in the year.
Q. And in those three weeks, how many calls did you get from agency medical directors about this issue; that is, transgender -- the results of an exam of a transgender inmate?
A. Uh-huh. I think twice.
Q. And in -- in those two times, did -- what was the call about? Was it about continuing hormone therapy? Was it about something else?

A. Yes, both were -- were about that. One was about hormones that they were continuing, and another one was about whether -- whether they should or could continue injectable hormones versus oral hormones.
Q. And what -- and what was -- what did you tell them to do?
A. To continue what they had come in with.
Q. Okay. We -- you were handed Exhibit 14, Puga Exhibit 14, and this is -- can you identify this?
A. Uh-huh.
Q. You've seen this before?
A. Yes. The second version of the standard operating procedure for mental health written by Dr. Hinton.
Q. Okay. And there's a section on -- starting on page 55 that references transgender mental health care. Are you familiar with that section?
A. I've -- I've read it in the past, uh-huh. Yes.
Q. Was this written by Dr. Reister?
A. I'm not sure. I know -- I'm not sure.

Dr. Hinton was at least the editor. I don't know if he had input from Dr. Reister.

Q. Is this -- what -- what is the purpose of this document?

A. To standardize care, mental health throughout the department, to serve as a guide for questions of how the department would like -- would like mental health to proceed.

Q. Are the facilities expected to follow the -- the -- the standard operating procedure?

A. The mental health providers are, yes.

Q. The mental health providers at the facilities are expected to follow this SOP?

A. Yes.

Q. The -- is the committee familiar with the importance of using pronouns consistent with a patient's gender identity?

A. Yes.

Q. And -- and you try to -- to do so --

A. Yes.

Q. -- the committee does? Is that right?

A. Yes.

Q. And you expect the facilities to have to do that?

A. Yes.

Q. Would you consider that to be a -- a part of the -- the adequacy of the medical care; in other words, adequate medical care for a transgender individual would involve using proper hormones?

A. Proper hormones?

Q. I'm sorry. Proper pronouns. The correct pronouns?

A. We think that's respectful, and it's a -- it's a -- it's -- it's to show that you respect the person and -- and -- and approach their care in a dignified manner. So we -- we certainly expect that.

Q. Is it a part of the treatment for gender dysphoria.

A. If they -- if they request it. Not everyone wants that. But if they -- if -- we will do that, but with their permission.

Q. Right. Assuming that it is -- the patient has sought to live consistent with their gender identity and requests that pronouns and names be used that are consistent with their gender identity, would you understand or agree that's a part of the treatment for the condition?

A. Yes.

Q. What about name usage? Isn't having -- being able to use a name that's consistent with someone's gender identity important treatment for some individuals with gender dysphoria?

A. Yes.

Q. Does the -- does the committee review that and advise facilities to -- to use the names that are -- that -- that, for example, are chosen by an individual to be consistent with their gender identity?

A. Yes. We certainly encourage that. And some -- I tell you, sometimes at our com -- at our committee someone has accidentally or -- or misspoken and -- and used the wrong pronoun and -- and they get corrected, and -- you know, and -- and so we -- and if that continues in that presentation, we, you know, stop and we -- we reiterate the importance of it. That has happened on one of the committee -- one -- at one committee meeting.

Q. There is in this document information about transfers. And this is for the transgender medical care. Do you know why that's there?

A. Where is -- where is that exactly?

Q. Page 57. At the bottom, the continuity of care for transgender patients.

A. The -- we want to make sure that -- that the care remains consistent and -- and -- and the transgendered patient doesn't have -- their needs aren't overlooked. And although you can have a committee that will meet and make some decisions for -- for support of care, that's at that facility and that's understood at that facility.

But we want to make sure if they go to another facility, that they -- that they -- that they can be consistent with it, that they recognize, you know, what has been helpful, what -- what -- what they need to continue to do. And so we want to reinforce -- reinforce the fact that their treatment will continue at the next -- the next receiving facility.

Q. Do anything -- do anything -- does the committee do anything to make sure that that happens?

A. That it gets --

Q. That the care is continued -- is -- is continued at the new facility?

A. Yeah. Well, we review -- you know,

again, they have to provide an 0400 and they have to present and we have to take a look at the -- the -- the details of what they're -- what they're seen at this facility and will often review the previous facility's notes and -- and so that's a -- that's why this was written here, that when there's a transfer, that it needs to happen.

Q. Do -- so I'm a little bit unclear. You see the -- you're saying you see committee notes prior to someone's transfer and then you may see committee notes after their transferred?

A. After their transferred, they have to provide another 0400. And so then they'll provide the 0400, and we have -- we have archives of the old 0 -- of the previous 0400s that we can take a look at. They do also in their medical record, but then -- but then we'll -- we'll review that in the committee.

Q. And what happens in terms of care before -- at the new facility before the -- the prisoner comes before the committee again?

A. Uh-huh. So that's a -- it's about -- it's a 30-day-process or less. And so they're just beginning to get to know them. So the assumption is

that they reviewed the chart, they've met with the individual at least once or twice and -- and they will begin -- you know, they're learning about the individual and their needs.

Q. Are they supposed to continue the treatment that they had at the previous facility in that initial 30-day period, or does --

A. Yes.

Q. -- their treatment stop until they've met with a --

A. No, no. The treatment plan continues from one facility to the next. Now -- and that's what needs to be looked at because if there's a difference in what's offered at one facility versus the next, then we have to take a look at, okay, what do we need to do in the best interest of our patient? So sometimes --

Q. Does that -- does that always happen, that the treatment continues at the new facility?

A. Treatment always continues. The -- the -- the degree of treatment will depend on what is available. And -- and that's something that, you know, we -- we take a look at.

Q. How do you know that the treatment

continues at the new facility? Is there -- is there a -- is there some -- some measure or some kind of reporting to ensure that the treatment continues when someone gets to the new facility?

A. Uh-huh. Yeah, there's a treatment plan. But say, for example, the treatment plan is that the person attends a certain group or attends a certain amount of sessions or, you know, they have certain things that the receiving facility may not have access to. You know, then we look at, okay, then how do we accommodate, and do we need to do anything different? You know, sometimes we transfer because of -- a facility has more services. Sometimes we transfer for different reasons, whether it's security, whether it's -- you know, I -- I -- I don't know what other reasons there may be.

But if there's a transfer, we -- we -- we take a look at what the needs are and then -- and how to accommodate based on what we're hearing.

Q. Are there any other policies or written procedures other than related to the treatment of gender dysphoria, other than the two that we've looked at?

A. Not at this point, no.

THE VIDEOGRAPHER: Can we change the tape?

MR. KNIGHT: Sure. Maybe we should -- we've been going for a while. Should we take a short break?

MR. HIGGERSON: That's fine.

THE VIDEOGRAPHER: Thank you. It's 3:28 P.M. We go off the record.

(A recess was had from 3:28 p.m. to 3:47 p.m.)

THE VIDEOGRAPHER: It is the beginning of Tape No. 2 of the testimony of Dr. Puga. It is 3:47 P.M. We are back on the record.

MR. KNIGHT: Let's mark this as Puga Exhibit 15.

(WHEREUPON, a certain document was marked Puga Exhibit 15, for identification, as of April 19, 2019.)

Q. (By Mr. Knight) Okay. Dr. Puga, do you recognize this exhibit, Puga Exhibit 15?

A. No. I haven't seen this before.

Q. Do you know Ryan Nottingham?

A. I've heard his name. I don't know him personally. I don't think I've met him before.

Q. Okay. And there is -- I just wanted to ask you: There's a reference here, the bullet point -- the third bullet point, about providing direction to provide -- excuse me -- identified transgendered offenders with State-issued clothing specific to his or her gender identity. Do you see that?

A. Yes.

Q. Is that -- is -- I mean, you -- I understand you haven't seen you this document before. But is that something that the committee does? Does it review requests to have clothing consistent with a person's gender identity?

A. Yes. Although, I -- I -- I think we've given further direction recently to give more of the -- a -- a blanket approval, pending any -- any -- any concerns at the individual -- at the individual facilities; in -- in other words, for issuing bras and what have you. It doesn't necessarily need to come to committee. You know, we are -- we are empowering the -- the -- the wardens to be able to make that decision.

Q. The wardens would make that decision?

A. They -- they give approval for, you know,

obtaining -- obtaining of -- of material and being able to allow them to have that in their cell. And so, you know, there are security risks with that, obviously. And, you know, there are some people who may -- you know, it may not be ap -- approved, potentially. They're suicidal or if they're -- and -- and they may use that or -- or what have you.

I mean, there are reasons why we can limit that, but for -- for -- in general, we want to -- we want to encourage the use and the -- and -- and not -- not providing obstacles to have -- allowing them to have it. So that's a more recent direction that we've given.

Q. When -- and I'm sorry. When -- when have you given that direction?

A. We started probably around December, January.

Q. And December or -- of 2018 or January 2019, you -- the committee directed the facilities that they could make their own decisions about allowing transgender prisoners to have bras?

A. Yes.

Q. And is that -- that's a medical decision, though, isn't it?

A. No. I'm relatively new in this department. We're -- we're -- it's a department in -- in -- in -- in transition, and we have been looking at being more -- more liberal with -- with -- with -- and give greater access and -- and be more responsive to -- to our population.

And so whereas prior to the last few months, the direction has been, you know, make sure it's medically necessary. And -- like, for example, if the physical exam indicates that there is -- there are breasts -- breast tissue, whatever, then absolutely, it's required.

If it's not medically indicated, as far as if there's no breast development or whatever, in the past, it used to be -- we used to think that -- that -- that it wasn't medically necessary. You know, we understand that there's a psychological piece to that. And so if it's requested, we want to allow -- be more allowing of that for psychological reasons and -- and not necessarily medical reasons.

And so --

Q. I'm sorry.

A. So -- so yes, so we -- we have been -- we -- we have been evolving. This is an evolving

topic and evolving issue in our department.

Q. And was there -- how did that directive come out? Was that an email? Was that a memo to the different facilities from the committee saying you can now provide bras for transgender individuals even if it's not considered medically necessary based on breast development?

A. Uh-huh. No. At this point it's been a verbal directive, and -- and we've repeated it several times within our committees. And as I mentioned, you know, the -- the facilities, most of them stay on and -- and -- and there are -- there are -- with the wardens and -- or assistant wardens are there and we've been communicating that -- that -- that to them.

Q. So when the -- this would be, then, only for those facilities who have contacted you or who have come before the committee because of requests for treatment of somebody with gender dysphoria?

A. For those who -- who have -- who -- yes, who come before the committee which is -- you know, like I said, it's a two, two-and-a-half hour process, so there are -- each facility presents -- how many facilities are -- have transgender

individuals? Quite a bit of them.
Q. So --
A. I'm thinking, but I'm not sure how many.
Q. Okay. And so all of those facilities come before the committee every time? That's a lot of facilities.
A. Yeah.
Q. And you're saying all --
A. The committee --
Q. What is it? 35 facilities --
A. No.
Q. -- are presenting to the committee each -- each month?
A. No, no. There are a number of facilities that don't have transgender patients.
Q. That you're aware of?
A. Correct.
Q. So it's possible there are some there, but they -- they have not come to the attention of the committee?
A. Correct.
Q. I'd like to turn to the next topic area, Topic No. 4. And this is the transgender committee's role and decision-making criteria for

providing treatment to prisoners with gender dysphoria, including whether to start a prisoner with gender dysphoria on hormone therapy, the type and/or dosage of hormone therapy, the type and frequency of blood testing for prisoners on hormone therapy, whether a prisoner should be provided social transition, including, but not limited to, gender-affirming clothes and commissary items, and whether a prisoner should be provided surgical treatment.

Okay. And -- the -- these are all issues that are presented -- that would come before the committee; is that right?
A. Not necessarily. We -- we -- type and/or dosage of hormone therapy sometimes come to the committee. If -- if the physician has questions about it or needs consultation, it -- it comes to committee. The -- the -- we don't micromanage the -- the hormone therapy, but we look at it sometimes when it seems relevant, type and frequency of blood testing for prisoners. That's at -- at this point, that's not something that we -- we do. That's, again, is -- is the -- the role of the treating medical doctor.

Q. Okay. You understand those are parts of the medical treatment -- those are aspects of the medical treatment for gender dysphoria?
A. Right.
Q. So -- but you're saying that those two things will come if somebody presents questions to you?
A. Right.
Q. And if a -- they would come if a mental health professional brings that to your attention; is that right?
A. Whether they do or the -- or the -- or the physician. As I mentioned, the physicians are part of the committee.
Q. So that when --
A. They're the doctor -- prescribing doctor.
Q. Right. So when -- when a committee -- I'm sorry. Yeah. When a facility presents something to the -- to the committee, there will be the medical staff involved in that presentation?
A. Correct.
Q. And they're the ones who would be presi -- prescribing the hormone therapy?
A. Correct.

Q. And ultimately, their -- in terms of their medical treatment, with respect to hormone therapy, they are ultimately answering to the committee?
A. Correct.
Q. So do the -- with -- with that caveat, did the remainder of these things come before committee, starting prisoners on hormone therapy?
A. Yes.
Q. Social transition?
A. Yes.
Q. And surgical treatment?
A. Yes.
Q. And the -- and the other two, B and C, might come up as -- as we were just talking about?
A. Correct.
Q. So -- the -- the committee would review medical treatment for all transgender prisons -- prisoners throughout the system?
A. Correct.
Q. Okay. And when you make decisions in these five areas, are those decisions governed by the W -- WPATH Standards of Care?
A. As I reviewed the WPATH standards, I -- I

think we are meeting their needs, yes.
Q. Can you -- but the committee intends to make its decisions consistent with WPATH Standards of Care?
A. Consistent with -- with good treatment of -- of the individual, which as we -- as we look at it, it's consistent with WPATH standards, yes.
Q. Well, other than the WPATH Standards of Care, are there any other standards that the committee is make -- guiding or using to guide its decisions?
A. I -- I have -- I've reviewed literature and I have -- I have used -- used literature to try to help formulate some of how we -- how we do things. I have reviewed other state's policies, and so I -- as I mentioned, we are continuing to make progress and continuing to -- to adapt in the best way that we -- best way to -- to treat our -- our -- our -- this population.
Q. Okay. So you mentioned two other things in addition to the WPATH Standards of Care.
A. Uh-huh.
Q. And -- and are those things that you follow instead of the WPATH standards?

A. So as I came into this committee, there were already some -- some set ways that we've been doing things. And as I look at the WPATH standards, I -- I -- I find that my predecessors that set this up, including Dr. Reister, I think were -- were -- seem to -- to follow the WPATH standards. And it seems -- it seems appropriate.
There are some other things that I'd like to continue to do and continue to -- to modify in -- in making things better. As my role as an administrator, my -- my role is to continue to -- to look at things, to continue to make progress, to continue to improve, and -- and continue to -- to -- to strive for, you know, doing the best quality work we can do.
So I continue to strive for that, and I will continue to -- to -- to keep a pulse on the literature and on -- on the trends and -- and this is an evolving process. And so what we have today may not be what we have in a year or two years, and it's certainly not something that -- it certainly is different than a year ago when I started.
Q. Okay. Well, I'm asking about currently, not about whether these things will change in the

future, just to be clear.
A. Uh-huh. Uh-huh.
Q. And so currently, you'd mentioned the WPATH standards as governing the committee, that they -- that they were already governing the committee; is that right?
A. It -- it appears so, yes.
Q. And at least that's your understanding?
A. Yes.
Q. That -- that the committee was intending to follow the standards of care?
A. It appears to me that -- that that's the case. And in my conversations with Dr. Reister, who has been probably most influential in setting this, you know, he -- he -- he has used that as a guide to -- to -- to help develop what we have today.
Q. And you mentioned reviewing literature. What other literature have you reviewed?
A. I reviewed hormone treatments in -- in -- in -- in transgender. I've reviewed surgical procedures in transgender. I -- I've reviewed the correctional literature in -- in -- in transgender. I reviewed some of the legal experiences of other states.

Q. What hormone therapy literature have you reviewed?
A. That was early on in -- in -- in my work with the committee. I looked at the potential side effects. I looked at medications that are -- that are typically used. I looked at contraindications for medications. I looked at dosing that -- that was appropriate. You know, both -- you know, transition from male to female and female to male. I reviewed experiences, as far as potential consequences, side effects of -- of -- of surgery -- surgical procedures and -- and --
Q. I'm just asking about what's the specific literature that you reviewed?
A. Oh, I did a Google search in medical -- medical literature. I -- I -- there's a chapter in -- in -- in the Oxford Textbook of Correctional Psychiatry. I know that one for certain. The others have been journal articles and -- and other articles. I -- I have -- I might be able to produce a pile of it that I have in my office, but I -- I don't know if I've kept all of them.
Q. And you mentioned other states' policies. What states' policies did you review?

A. I've seen and I've reviewed California's policy, and I -- I -- I -- I don't remember if the other one was Ohio. Those are a little more readily available. I think it might have been Ohio.
Q. And are you saying the committee decisions are influenced by those other state policies?
A. No. No, not necessarily. I --
Q. Or I should say, are they guided by those other state policies?
A. No. They're -- they're used as a -- a reference point. I think some -- some of what they have available has been very helpful, as far as helpful models, because they've been further along in this process than Illinois has. And --
Q. So have -- you mentioned that you reviewed it. Are you saying all of the committee members have reviewed these -- this literature and these other state policies that you're talking about?
A. I -- I don't know who in the committee has. I --
Q. You're -- you're not aware that they have reviewed it?

A. I sent out some of that to Dr. Meeks, Dr. Hinton, I believe Dr. Reister. I -- I've sent some of that to them. And so, you know, I -- I -- so I -- I don't know what other committee members have -- have reviewed.
Q. Okay. Well, you know, my questions are about what the committee guides its decisions based on. And if the other committee members haven't seen those or you don't know if they've seen them, it's a little hard for me to understand how they could make decisions based on those.
A. Uh-huh. Uh-huh.
Well, on the committee there's always Dr. Reister, myself, who -- who are able to -- to cite those -- the literature and cite the -- you know, to -- to bring that -- bring that to the committee. I -- you know, that we -- I think it's incumbent on both of us -- both of us feel a sense of responsibility for this committee to -- to -- to know as much as we can and -- and -- and be as up to date as we can with this. So both of us are committed to that and -- and so we provide that kind of structure.
Q. How does the committee decide whether to

start a prisoner with gender dysphoria on hormone therapy?
A. We -- we look at a number of things. You know, first of all, is it -- is it the correct diagnosis? Is it -- is the -- is the person psychologically ready for -- for that? Do they understand the potential benefits and consequences? Is -- are their -- is their understanding realistic? Is there anything that would prevent them from -- from going on, whether it means medical conditions?
It -- as far as the psychological readiness for it, are they ready to have this kind of transition occur, which encompasses a whole lot of other details. And -- and if there aren't -- are they psychologically -- or psychiatrically -- I'm sorry -- are they -- are they at a -- at a place that hormones would be -- would be okay to introduce? And so there are a number of questions that we have to -- have to have answered before we say, yes, it sounds like it makes sense.
Q. So you listed out a whole bunch of things. Are you saying that these criteria come from the WPATH standards?
A. Some.

Q. And what -- and what doesn't come from the WPATH standards?
A. You know, I think if you read the WPATH standards, I -- actually, I think all of those are going to be highlighted as far as relative psyc -- psychiatric stability, you know, the -- the ruling out, for example, thromboembolism history, psychologically readiness, the actual diagnosis that fits. You know, all those -- all those are -- I think are -- are consistent with WPATH. I don't -- yeah, I'd have to review what other -- what other things I've told you, but I think -- I think all of that is consistent with WPATH.
Q. And so the -- the committee hasn't actually met with the prisoner; right? No one in the committee has met with the -- with the prisoner; is that right?
A. The -- the five of us, no. The -- the people that would have met with them is going to be their -- the MHP, the mental health professional, the -- the medical doctor, and probably the warden, and probably -- you know, the team that's presenting. I -- I would -- I would think that just about everyone on -- on that team has met the -- met

the individual.
Q. Right. But the committee has not? That's all I'm asking.
A. Correct.
Q. And -- and you're, then, saying, for example, that to start someone on hormones, if a -- if the facility says this individual is ready to start hormones, you're gonna assess these various things and then decide whether they can start it, even if the -- if the facility is recommending? Is that the way it works?
A. Correct.
Q. And when you make that assessment and make that decision, you -- do you see their medical records for the prisoner?
A. Their -- their medical -- sometimes. Sometimes we'll ask them to -- to review the chart and -- and they usually -- when they present, they'll have the chart there. So someone will, you know, go take a look at their labs or take a look at the physical exam or take a look at what have you. We have access to that at that time if we have questions about that.
Q. But you don't always have the

medical records as a committee when you make a decision?
A. We have the medical administration records. So the -- what we call the MARs. And so it'll tell you what medications they're taking, whether they're complaint with it, and -- and -- so the record of medications will have that.
Q. Right. But you don't have the entire medical records for that prisoner?
A. Right. We have the summary of the medical in the 0400.
Q. And that's a summary in this form that is provided to you by the facility?
A. Yes. Uh-huh. And then we have access to, like I said, the medical personnel who can -- who can give us more information.
And -- and there are times that we've said, you know, get us more information or get a blood level, get whatever, come back to this committee, and report back in 30 days, in 60 days, 90 days, what have you.
Q. And in terms of the -- the committee's decision about the type or dosage of hormone therapy, you -- you said earlier that that would

only come to you if the facility medical staff want advice?
A. Right.
Q. And how do you make a decision, then, as a committee about the type or dosage of hormone therapy?
A. Well, at that point, you know, we serve as more or less a second opinion to the doctor. Just to give you an example, one time recently there was a transgender female who was requesting injectable estrogen as opposed to oral estrogen because she didn't feel that the oral estrogen was helping.
Well, literature indicates that injectable and oral seem to be -- you know, this doesn't seem to be a benefit to doing that necessarily. However, we requested the hormone levels. And so they provided us the -- the hormone levels and -- the -- the results of the hormone testing, the -- and the amount of medication and what was recommended -- and there, again, that's Dr. Meeks's realm -- to -- to increase the dosing of medications, recheck levels, and then report to us to see how -- how -- how she would do.

And so, in essence, that served as a second opinion and gave us some oversight into treatment. We're -- we're able to hear her concerns of, you know, inadequate med -- medication res -- response, and so we were gonna do that and have her -- have the doctor report back in -- I don't remember if it was 30 or 60 days -- with another blood level and -- and we were going to review response and make sure she was getting adequate treatment.
Q. And the committee, when it's assessing the hormone level, is it following the standards of the Endocrine Society?
A. I -- I believe so.
Q. Are you familiar with those standards?
A. I -- I -- I have a copy of it in my -- you know, I -- I have a reference that I take a look at. Like I said, I'm not -- I'm -- I'm psychiatric and obviously that's medical, but it's -- I -- I don't know that in specific. I do have -- I do have reference -- a reference to that that I have during the committee that I look at but...
Q. Right. I'm -- I'm just asking about the -- I understand that you're -- you're -- you're

not prescribing hormone therapy. But I'm asking -- again, you're -- you're answering questions on behalf of the committee and the Department of Corrections and --

A. Yes.

Q. -- so my questions are: What does the committee decide or govern its decisions about hormone levels by?

A. Uh-huh. Uh-huh.

Q. And -- and my question is: Are they the Endocrine Society standards?

A. Uh-huh. I believe they are, yes. I -- yes. That's -- that's -- that's one of the things I've reviewed, and I actually have in my -- my -- my folder of things that I look at when I -- they have access to during the committee.

Q. And as to the -- the questions about type and frequency of blood testing, again, that's one of those areas where you said that might come to your attention from a physician sometimes?

A. Yes.

Q. It comes to the committee?

A. Sometimes we -- we request it, sometimes we'll -- we'll -- we will look at it, sometimes

they'll provide it in their presentation, but...

Q. And again, my question is about how often this prisoner's blood level should be tested?

A. Uh-huh.

Q. That would be something that would come to the committee at some point; right?

A. At -- prior -- at -- at this point, we've left a lot of this to the discretion of the treating physician -- treating physician. And -- and it -- it -- it may not be that way in the future, but at this point, you know, we've left it to the discretion of the treating --

Q. But if --

A. -- doctor.

Q. Okay. But if the treating doctor has questions about how often should I conduct testing for this prisoner, the committee would be the resource that the -- those physicians would come to?

A. Correct.

Q. And would those decisions also be guided by the Endocrine Society standards?

A. We would look at the -- those standards, yes. Uh-huh.

Q. How does the committee make decisions

about whether a prisoner should be provided social transition? So this is D.

A. The committee expects it.

Q. The committee expects what?

A. Assistance in social transition. So --

Q. And assistance from the facility in social transition?

A. Yes. As far as therapy, as far as whether it means individual or group. Now, there will be -- periodically, there'll be people who -- who refuse it and who don't feel they need and who don't want to have access to it, but -- but that's something that it's not a matter of whether they need social transition support, it's a matter of we feel that it's important for them to have it. And we're going to encourage it. They can refuse, but -- but -- but -- but for the most part, we're going to encourage it.

Q. Right. And so you're saying that the social transition that the committee would consider is whether someone should be in group therapy?

A. That's part of it.

Q. And what about access to clothing consistent with -- for -- feminine clothing for a

woman who is transgender?

A. Uh-huh. That's a -- the therap -- that's the therapist's and -- and patient decision. And if they request it, you know, we -- like I said, we -- we -- we've talked about allowing the -- the -- the facility to make that decision, but we generally rubber-stamp it and -- and -- with the caveat, like I said, if there's any danger associated with it, then that's -- that's -- then it can be limited, but -- but aside from that, we're gonna -- we're gonna allow it.

Q. Right. But I think you talked about bras only. You haven't -- you didn't reference things like underwear, for example, feminine underwear, feminine grooming items. Is that something that the committee approves for prisoners who are transgender? That's part of social transition, you understand?

A. Yeah, yeah. Yes, we have. Yeah, I -- I -- I don't remember.

Q. The committee has approved feminine underwear for a transgender woman?

A. I don't remember that coming up. I -- I don't remember that coming up.

Q. But that's the kind of thing that would come to the attention of the committee?
A. It could, yes. Uh-huh.
Q. And you don't remember what -- what the committee has done about that?
A. Right. I don't remember that being brought up in my -- my time in the committee.
Q. And when you make a decision about social transition, would that be guided by the WPATH standards?
A. I'd have to take a look at -- at -- at -- at the specific question because, you know, we're -- we're -- we're in a -- in a correctional setting which -- which sometimes has -- has its own nuances that we certainly don't want to compromise security and -- and -- and some things may not be appropriate in -- in -- in -- in -- in Department of Corrections versus in the -- in the free world.
Q. Well, assuming for the particular prisoner who is seeking clothing, for example, that there's no concern about security for that particular prisoner -- prisoner, if -- in that instance, is the committee guiding its decision based on the WPATH standards?

A. I believe so.
Q. Has the committee -- can you think of a time when the committee has ever approved any kind of clothing -- feminine clothing for a transgender female in a male facility other than a bra?
A. I don't remember that coming up. In -- in -- in my time on the committee, I don't remember that coming up.
Q. And on the last category, whether prisoner should be provided surgical treatment, that's come before the committee; right?
A. Yes.
Q. And that's never been approved, has it?
A. At -- at this point, no.
Q. What's -- what -- why is that? What's the criteria that the committee is applying to that decision?
A. Well, there were a couple who had requested castration, but their release date was coming up very soon and -- and that -- that -- it wouldn't allow us to -- you know, we couldn't provide good quality of care and -- and couldn't guarantee aftercare and couldn't -- you know, it was -- it -- it would have been -- you know, there

are complications that can occur, there are adjustments that occur. And -- and because they were leaving relatively soon, it didn't -- it didn't make sense clinically.
Q. Right. I'm not asking about specific instances. I'm just asking -- well, I guess maybe this is the way to answer, but what is the criteria that the committee applies to the decision of that surgery?
A. That has to be an individual -- on an individual basis.
Q. And is that guided by the WPATH standards?
A. To -- to some degree. To some degree it is because certainly there are some reasons that the WPATH gives that would not be a good -- a good -- an appropriate thing to do.
Q. I don't -- I don't understand. What do you mean by that?
A. If someone has active psychosis, for example, and can't give proper informed consent because of -- because of their -- their active psychosis, for example.
Q. Well, I think the WPATH standards address

that, don't they?
A. Yes.
Q. So -- so not providing surgery to someone who is actively psychotic, it's consistent with the WPATH standards?
A. Right, right.
Q. So is there anything other than the WPATH standards that guides the committee's decision?
A. Certainly we have to take a look at it on an individual basis of -- of -- of, you know -- you know, I don't -- I don't -- you know, the -- the department doesn't say absolutely no, it's not going to approve, but I think it has to be reviewed on an individual basis.
Q. Right. That's consistent with the WPATH Standard, isn't it, individualized assessment and treatment?
A. Yes.
Q. Have you ever engaged an -- an outside specialist to advise the committee?
A. No.
Q. So that -- that would be true with respect to surgery, too, you've not asked that

someone be evaluated for surgery by a specialist outside the system?
A. Correct.
Q. I'd like to look -- I'd like you to look back at Exhibit No. 13, page 4, Section 3, at the top of the page. The facility medical director shall inform the offender of the department's policy regarding gender assignment surgery.
You see what I'm reading?
A. Yes.
Q. So facility and med -- medical directors are required to tell offenders who are transgender about this extraordinary -- this -- this -- the standard for being able to have surgery; is that right?
A. According to this, yes.
Q. Would you agree that that would discourage prisoners from seeking surgery to treat their gender dysphoria?
A. I don't know that -- I -- I don't know that -- I don't know if that would or not.
Q. The committee meets once a month; right?
A. At least once a month, yes.
Q. Are there times when it's met more than

once?
A. Yes.
Q. When is that?
A. When considering -- when -- we've had consideration of other -- of -- of -- other circumstances.
Q. And there are committee records for every time the committee meets; is that right?
A. Yes.
Q. And there are months when the committee does not meet; is that right?
A. We have set a -- a first Monday -- or first Tuesday of the month standing time. And from -- from the time I've been there, it has been scheduled irregular times, but I believe it's been on a monthly basis.
Q. Well, I believe there was no committee meeting in December of 2018.
A. I don't know. I'd -- I'd have to take a look --
Q. Here --
A. -- but I don't think we've --
Q. Okay.
A. I don't think we've skipped, but I'm

not -- I mean...
Q. Who decides which prisoners' cases are presented? Do you decide that now?
A. No. You know, there, again, by -- by AD, whenever there's a new person who's identified, whether that means have -- has been in the facility for a while or enters through an R&C or transfers from one facility to the next, or whenever one of the treating MHPs, his request -- or the individual has a request to -- to bring something to the committee, so -- or whenever there's a concern from an MHP. So there's some -- there's some things that absolutely it gets presented and some as needed and will be -- will be open for presentation.
Q. And how long is the discussion of each prisoner?
A. Well, because we have so many to discuss, we -- we schedule them every six minutes. Now, it -- it -- these committee mi -- committee meetings go long oftentimes and there have been times we've had half hour or more or sometimes we've had to say, you know, this is something we have to take -- you know, we'll have to -- we'll have to spend a little more time with it elsewhere. So -- but --

Q. But sometimes they only last six minutes?
A. Yeah, yeah. If it's relatively easy, brief, what have you, yes.
Q. What happens if the members of the committee don't agree on what kind of treatment should be provided?
A. We'll have to make some sort of decision. And, you know, we, as the committee members, we'll -- we'll -- we'll -- we'll make that decision and -- and -- and we -- we may ask to reconvene again at the next meeting and re-present them at the next meeting.
Q. Okay. But I mean, ultimately, I guess there are five people on the committee, so the majority prevails? Is that the way it works?
A. Yes. Yeah. And then the --
Q. 'Cause each -- I'm sorry?
A. And the MHPs, you know, take direction from -- from Dr. Hinton and me --
Q. Right.
A. -- as far as treatment.
Q. Right. And then does the committee -- is there a -- is -- the committee is the final word, though; right?

A. Yes.
Q. There's no -- there's no appeal of the committee decision, is there?
A. I guess it could be appealed to the director. And -- but -- it's not stated anywhere, but it -- but it could always be -- I think it could always be appealed to the director, I would imagine.
Q. Director Baldwin?
A. Yes, I would imagine.
Q. Okay. Has that ever happened?
A. Not that I know of. I -- I'm -- I'm relatively new at the committee, so not that I've seen.
Q. So if a prisoner is concerned about their care and believes their care is inadequate, they can't request a meeting, can they?
A. Sure.
Q. They -- they can call up the committee and say -- or some -- contact the committee directly and say, we'd like -- I'd like you to meet about my case?
A. Sure. We would -- we would do that.
Q. Has that ever happened?
A. Has that ever happened? You know,

with -- there have been some concerns that -- yeah, we had a couple of concerns that came up recently that, you know, I -- I had Dr. Reister see them, and -- and then we had a phone call with Dr. Reister, the treating MHP, the mental health authority there, and myself, and so --
Q. The prisoner contacted the committee members directly?
A. No. Through their therapist, they -- they -- they sent a message that they had some concerns, that we needed to follow up.
Q. So their process would be if a prisoner is conc -- believes their care is inadequate, they would contact the mental health professional who would then contact the committee. Is that the way it works?
A. Right, right. Because they are -- they are their advocate, and so -- they -- they play the role of their advocate.
Q. And the committee records themselves -- I believe you've called this a Form 400?
A. 0400, yes.
Q. 0400?
A. Yes.

Q. Is -- so the committee notes would be the recommendations added to that Form 0400?
A. Correct.
Q. Are there any other records that are kept by the committee, other than that -- those committee notes?
A. There are times when we've -- you know, when -- when -- when we've had meetings where we have -- we have recorded them and documented them.
Q. You have recorded meetings and documented them? Is that what you said?
A. There -- there was one in particular, yes. Uh-huh.
Q. And what happened to those -- to that recording or that -- that -- this is a recording?
A. It was transcribed.
Q. There was a transcription of a recording of that meeting; is that right?
A. Right. Yes.
Q. And that -- and what happened to that? And what --
A. We -- we -- we saved it, and, you know, we made this -- it was a -- it was a -- a meeting we made decisions on and -- and we wanted to save it

and -- in case we needed it and we --
Q. So that's a part of the committee records, this transcription?
A. Yes.
Q. And when did that happen, that you transcribed a committee meeting?
A. It might have been January.
Q. January of this year?
A. Yes. It might have been.
Q. What was the reason for transcribing -- or taping and transcribing a committee meeting?
A. We were making a decision in moving an offender, changing the offender placement.
Q. And was this -- what kind of change in placement was this?
A. From a male family to a female facility.
Q. So was this the Hampton matter?
A. Yes.
Q. Have there been any other committee meetings that have been recorded in this way?
A. No.
Q. So it's not a normal thing?
A. No. But it's available. If it -- if it -- if it feels like it's important for us to do,

we can do that.
Q. Are there -- are there any other records that are made of the committee meetings, other than the committee note -- the committee records that we talked about, as well as this one time there was a transcription?
A. Yeah, after -- after each presentation, depending on what we -- what we decide, I -- I will send a -- a letter to the facility right afterward kind of defining, you know, what -- what we're asking or what -- what -- what -- what the committee wants to do.
So, for example, if we approve hormones, there's a -- there's a section where we check off hormones approved, and I sign it and send it back. If we want them to follow up and re-present in a certain amount of time, there's a checkbox to -- to ask them to do that. There's a couple of open checkboxes that if we say we want hormone levels or we want to follow up on such and such a thing or we want a certain thing done -- done, you know, we send that off right after our committee, because in the past, it used to come to the committee, committee had to -- you know, we'll fill in the response to

the 0400 and have to get signatures before it went to the facility. We didn't want a lag time, so we wanted it immediately, you know, whatever we -- we -- we decided to do to get carried out. So --
Q. When -- when did this process that you just described start?
A. You know, it might have been December, January. So it's relatively new.
Q. Yeah, I don't think -- I don't think I've -- we've seen forms like that.
This is -- so this is a -- is this a form or is this -- and you fill out this form? This is like a standard form that you fill out?
A. Yes. It's a letter to -- you know, a -- a response -- it's -- some of it is preprinted and it says dear, whoever we -- we address it to, such and such individual at whatever committee meeting and the committee recommends the following.
And so one of them checkboxes may start hormone treatment, another one is re-present in such and such. And, like I said, open boxes because, you know, I -- I want them to have in writing -- have on paper, you know, what the committee is requesting and what the committee is approving,

you know, and I want them to have it immediately, so they get it kind of in real-time almost.
Q. And is this form that you're sending to the facility with what the committee has approved, is it the same as what will ultimately go in the committee notes?
A. Yes.
Q. It's just a different form to make it -- to get it to the facility more quickly?
A. Right.
Q. Are there any other forms that the committee makes?
A. Well, in -- informally, I take notes as we're talking and we're -- and -- and there's this little spreadsheet that I fill out, but that -- but that is to make sure that we're -- you know, I'll -- I'll -- I'll take a look at my spreadsheet and what I filled out versus what, you know, is documented on the -- on the 04 -- 0400 response, and so just as a double-check, you know, I -- I -- you know, I -- I will do that; but...
Q. And how long have you done this, keeping a spreadsheet and taking notes?
A. A few months. I -- I -- I -- I started

doing it on -- on a computer and it was a little difficult to -- working on a template, and then I started writing it out, so it's been a few months.
Q. Do the committee records contain all the materials that are reviewed by the committee in making its decision?
A. I don't believe so.
Q. What else -- what other materials are reviewed, other than ones that are included or mentioned in the committee records -- or in the committee notes?
A. Whoa, whoa.
Q. Yes.
A. I'm sorry. I thought you meant is it documented, what -- what is reviewed? I -- I don't think there's an area to document what is exactly reviewed. But like I said, sometimes we'll ask to -- to -- to look at the medical record, to give us results of what have you, to, you know -- you know, there are other things that we can review. And like I said, they're verbal -- verbal -- verbal reports. They're not detailed records, but they're -- it's a brief summary, and --
Q. Well, the brief summary I think you said

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was in the 0400.
A. Right.
Q. So I'm asking again about records that are reviewed. You mentioned that there are a few times when medical records have been reviewed. And my question is: Which -- are the materials reviewed, the written materials reviewed, included in the committee notes?
A. Are the comm -- are -- so your question is: Are they included in the committee notes? I -- I don't think they're detailed, as far as what's reviewed.
Q. So you're saying the committee reviews something other than what is in the cited committee notes? The 0400, plus the attachments and the recommendations from the committee?
A. Some -- sometimes it does, yes.
Q. Does the committee consider disciplinary records for prisoners in making its decision about medical treatment?
A. Sometimes, yes.
Q. Why?
A. To see if it's relevant to -- to the particular situation, to the --

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Q. And how would it be relevant?
A. Well, there was a situation where someone was -- had -- had tickets because they were engaging into conflicts with -- with patient -- with other inmates and -- and yet, you know, we had to inquire whether that was due to gender issues and -- and -- and what have you. And -- and -- and we had to make sure that that -- that's factored into decisions that are made on a -- on a disciplinary basis.
Q. So you would -- the committee would -- might, for example, deny someone hormone therapy because they had been engaging in actions for which they were disciplined?
A. No, no, no. Absolutely not.
Q. So that would be inappropriate to deny someone hormone therapy because they're -- they're engaging in misconduct?
A. Well, female to male, you can have more aggression with testosterone. Now, if that were the case, it would be inappropriate to see more aggression and continue testosterone.
Q. So if someone were enga -- if a male who is transgender were engaged in aggressive behavior, you would deny them testosterone therapy?

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A. No. We would have to take a look at -- see if there's a causality, if that's a side effect with the testosterone. It would -- it would beg the question of: Is this due to this new treatment?
Q. And what would you do -- what would you do with that information? How would that make a decision with respect to medical treatment for the individual?
A. It -- then it becomes a clinical decision as far as if they felt that it was causing the aggression, then at that point, they would look at the possibility that maybe that's -- that's -- that's -- that's either -- either it's not the right dose or it's not the -- it's not appropriate medication for that patient at that -- at that time.
Q. So you might change -- the committee might change the medication or change the dosage because someone was engaged in aggressive behavior?
A. No. Medicat -- the committee doesn't change doses or medications. They may recommend and they may recommend evaluation and they would -- we would probably then say, you know, if in this -- in this potential situation or this -- then they would say, take a look at this, you know, do something

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different, report in -- in -- at the next committee meeting, or report back to us in a week or whatever, or whatever the time frame is that we deem appropriate and let us know how this is coming along.
Q. So you might recommend that the medical staff change the hormone therapy or the dosage?
A. We might recommend for them to -- to look at it, yes.
As a committee, we're -- we're not directly treating the patient. We don't have direct eyes and hands on them, but -- but -- but we will -- with the help of the people that do, we will -- we will -- we -- our goal is to ensure that they're being properly addressed.
Q. But -- but you would be the final word about whether someone gets a particular kind of treatment?
A. If the committee were to -- were to deny something, you know -- and -- and sometimes we've denied hormones. You know, usually it has to -- you know, we'll -- we'll -- we'll -- we'll also include a -- you know, let's look at this and then come back and -- and -- and -- and -- and report

back. We want to do what's most appropriate for our patients.

Q. Would the -- does -- would it be appropriate for the committee to deny initiation of hormone therapy for a patient to -- to undergo counseling?

A. We -- we never deny counseling. We always encourage it.

Q. No. My question is: Would you -- would the committee deny a request to start hormone therapy because someone has not completed counseling?

A. In -- in the scenario where there's ambivalence and -- and -- and there's -- or a person doesn't -- isn't secure in their gender identity -- still have issues of that that -- that isn't very clear, I think the -- the committee sometimes will say, you know what, make sure they're ready for this. Make sure that they are committed, and it's -- it's not an ambivalent decision. Make sure that it's -- you know, that -- that -- that you -- you know, that they make progress to the point where they're -- they're making a good, informed consent rather than an am -- ambivalent one or -- you know,

this medical treatment is serious, and -- and we need to make sure that they're -- that it's appropriate.

Q. Would it be appropriate for the committee to deny a prisoner hormone therapy because the prisoner's obese?

A. If it's -- if -- if it's medically potentially complicating, then that's -- that's the decision of the medical provider.

Q. Is it -- is it something that the committee does, denies hormone therapy to a prisoner because they're obese?

A. If the committee sees medical problems that -- that would be a potential harm to the patient, then -- then the -- the committee may say, you know, that's dangerous, that's not appropriate.

Q. Would it be appropriate for the committee to deny a prisoner hormone therapy because they are HIV positive?

A. No. Unless, you know, they felt it would interfere with their -- with their medical treatment and -- and -- and you would have to weigh the risks versus the benefits.

Q. Would it be appropriate for the committee

to deny a prisoner hormone therapy because the prisoner delayed identifying themselves as transgender?

A. Transgender is usually something that starts very early in life and if clinically it doesn't seem like this is a transgender situation and -- I -- I -- I could see the committee questioning whether that's an accurate diagnosis. And if they came out -- they -- they'd say they're transgender at 35, but they didn't have a history of it early on in childhood, that's not consistent with what transgender is usually like.

I could see the committee say, you know, make sure you closely look at this and review this with them and make sure this is an accurate diagnosis, and -- and it's that he's coming out now at 35 versus, you know -- but it's always been there, it's been -- it's consistent with what happens in transgender and it isn't a different type of issue of transvestism or who -- or -- or what have you. So you'd want to make a -- a good decision.

Q. So you can imagine that if someone said -- identified as transgender when they were

older, then the committee might deny them hormone therapy?

A. The committee may ask for more information and clarification and -- and -- and look at that more closely, because that's not consistent with what happens in -- in the transgender population.

Hormone treatment can, you know, certainly have a -- a lot of potential side effects, and, you know, can do some very permanent -- have very permanent effects on a person, and -- and it shouldn't be taken lightly.

MR. KNIGHT: Could we take a few-minute break?

MR. HIGGERSON: Yeah.

THE VIDEOGRAPHER: It is 4:58 P.M. We go off the record.

(A recess was had from 4:58 p.m. to 5:07 p.m.)

THE VIDEOGRAPHER: It is the beginning of Tape No. 3 of the testimony of Dr. Puga. It is 5:07 P.M., and we're back on the record.

Q. (By Mr. Knight) Dr. Puga, is a request for permanent hair removal something that comes before the committee?

A. Yes.
Q. And is that something that the committee approves?
A. It hasn't yet.
Q. Is it currently not available at the Department of Corrections?
A. Correct.
Q. And turning to the -- our last topic area, this is No. 9: Any oversight, such as quality assurance reviews performed by the transgender committee or anyone else at IDOC regarding the medical treatment of gender dysphoria, whether those staff work for IDOC or for the -- for Wexford.
Do you -- do you see which one I'm looking at?
A. Yes, No. 9.
Q. I see you looking at it.
A. Yes.
Q. Okay. Is there any quality assurance review performed by the committee regarding this -- the medical treatment of gender dysphoria?
A. Not to date. That's something that's in the works.
Q. And -- and where is it in the works?

A. There -- I have had some communication with our CQI director about this a couple months back and -- and I've just developed a few bullet points that -- that's -- it's -- it's on my to-do list.
Q. Okay. So you've had a conversation. Anything beyond that?
A. No, not at this point. It's early in its -- in its stages.
Q. Okay. So it sounds like the kind of thing that's not going to happen any time soon?
A. Depends on how you describe that. Probably within -- within a few months, yes.
Q. Okay. And -- but that's going to depend on other people other than yourself?
A. Yes.
Q. And is this something that you've done, or is this something the committee is -- has talked about, having quality -- or having quality assurance reviews of transgender medical care?
A. That's something that I've -- I've done. The CQI committee in our department is relatively new. So we're -- we're -- we're beginning to formulate the details on -- on -- on -- on what we

look at and how often we look at it, and so this is part of it.
Q. The CQI committee, what is the CQI committee?
A. Continuous quality improvement.
Q. And you're on that committee?
A. No.
Q. Okay. But it -- so it's something that you brought to the attention of the CQI committee?
A. Yes.
Q. And who did you bring it to it -- whose attention did you bring it to?
A. Dr. Sim.
Q. Okay. And again, the -- you did that yourself as opposed to the committee doing that?
A. Yes.
Q. Has the committee been consulted about whether that's something that should happen?
A. No.
Q. Okay.
MR. KNIGHT: I have nothing further.
MR. HIGGERSON: Okay. I just have one thing I want to clarify.
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EXAMINATION
BY MR. HIGGERSON:
Q. You testified earlier that when there's a disagreement among the committee that it might go to a majority vote. Do all members of the committee have equal say on all issues that come before it?
A. The only time we haven't had a consensus -- well, I'm sorry. We -- we generally have had a consensus.
Now, does everyone have an equal vote? It hasn't come to that, but I think with clinical decisions, I don't think we're going to take the -- the transfer coordinator input and -- and -- and the chief of operations, you know, may not weigh in as heavily with clinical and -- and they -- they -- they really know their roles, and so they're able to say -- you know, defer it to -- to those of us who -- you know, who -- who -- who know the clinical and -- and are responsible for the clinical.
So do they have an equal vote? It hasn't come to that, as far as having that kind of a scenario, but -- but I would say that if it's a clinical thing, there -- you know, we -- it's going to be more weighted toward the clinical people --

MR. HIGGERSON: Thank you. That's all I had.
A. -- so...
MR. KNIGHT: Okay.
THE VIDEOGRAPHER: It is the end of the testimony of Dr. Puga. It is 5:12 P.M. We go off the record.
FURTHER DEPONENT SAITH NOT.
(Time noted: 5:12 p.m.)

REPORTER'S CERTIFICATION

I, ELIA E. CARRIÓN, CSR, RPR, CRR, CRC, a Certified Shorthand Reporter in and for the state of Illinois, do hereby certify:

That the foregoing witness was by me duly sworn; that the deposition was then taken before me at the time and place herein set forth; that the testimony and proceedings were reported stenographically by me and later transcribed into typewriting under my direction; that the foregoing is a true record of the testimony and proceedings taken at that time.

That before the conclusion of the deposition, the witness has not requested a review of this transcript pursuant to Rule 30(e)(1).

IN WITNESS WHEREOF, I do hereunto set my hand of office at Chicago, Illinois, this 23rd day of April, 2019.

C.S.R. Certificate No. 084.004641.

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DATE: April 19, 2019
WITNESS: William F. Puga, M.D. REF: 25002

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William F. Puga, M.D.

Subscribed and sworn to before me

this ____ day of _____, 20__.

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Notary Public

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