UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF ILLINOIS

JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELÉNA VISION, SORA KUYKENDALL, and SASHA REED, Plaintiffs, v. ROB JEFFREYS, STEVE MEEKS, and MELVIN HINTON, Defendants.	)	Civil No. 3:18-cv-00156-NJR-MAB

PLAINTIFFS' POST-HEARING BRIEF IN SUPPORT OF THEIR MOTION FOR PRELIMINARY INJUNCTION

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PROPOSED FINDINGS OF FACT

The Parties

1. Named Plaintiffs are individuals who are incarcerated by the Illinois Department of Corrections ("IDOC") who are seeking medical treatment for gender dysphoria.

2. Named Plaintiffs bring this action on behalf of themselves and a putative Class of all transgender individuals seeking medical treatment for gender dysphoria currently incarcerated in IDOC (collectively, "the Plaintiffs").

3. Defendants are Rob Jeffreys, Director of IDOC; Dr. Steve Meeks, Chief of Health Services at IDOC; and Dr. Melvin Hinton, Chief of Mental Health Services at IDOC.

Plaintiffs' Medical Condition

4. All named Plaintiffs were diagnosed by IDOC with gender dysphoria. Gender dysphoria is a serious medical condition. Tr. at 95:10–22, 236:14–16, 254:16–21 (Plaintiffs' experts described gender dysphoria and its symptoms). Defendants do not dispute that gender dysphoria is a serious medical condition. If left untreated, gender dysphoria causes severe psychological distress, and lack of access to treatment often results in efforts at surgical self-treatment (*i.e.*, removal of one's own genitalia); further psychological decompensation, including severe depression; and suicide. *Id.* at 250:21–251:1 (Dr. Ettner).

5. The World Professional Association for Transgender Health ("WPATH") Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (the "Standards of Care") provide the authoritative treatment protocol for gender dysphoria. *Id.* at 366:17–21 (Dr. Ettner).

6. Medically necessary treatments for gender dysphoria are gender-affirming hormone therapy, social transition (*e.g.*, appropriate housing, gender-affirming clothing and

grooming items, and gender-affirming names and pronouns), and for many individuals, gender-affirming surgery. *Id.* at 238:9–14 (Dr. Ettner).

Standards for Hormone Therapy

7. Hormone therapy is a well-established and effective means of treating gender dysphoria. The American Medical Association, the Endocrine Society, the American Psychiatric Association, and the American Psychological Association all agree that hormone therapy in accordance with the Standards of Care is medically necessary treatment for many individuals with gender dysphoria.

8. Hormone therapy should be administered by a qualified health professional and monitored in accordance with the Endocrine Society Guidelines (hereinafter, "the Guidelines"). *Id.* at 100:15–18, 102:13–103:2 (Dr. Tangpricha).

9. Hormone therapy is often medically necessary to treat gender dysphoria and should be initiated promptly after diagnosis. *Id.* at 101:4–9, 156:12–15 (Dr. Tangpricha).

10. The type of hormones that should be provided to an individual depends on the gender of the individual seeking treatment as well as the individual's gender assigned at birth. Individuals prescribed feminizing endocrine treatments require a dual course of hormone therapy: estrogen and a testosterone blocker (also known as an antiandrogen) called spironolactone. *Id*. at 106:5–10 (Dr. Tangpricha).

11. For transgender women, the Guidelines call for 2 to 6 mg per day of estradiol, while current research and best practice supports 4 mg per day as the most commonly effective therapeutic maintenance dose. *Id.* at 103:21–104:7 (Dr. Tangpricha). The Guidelines further call for a testosterone blocker called spironolactone in transgender females, in a range from 100 to 300 mg per day, although it is safe under qualified supervision and in some cases medically necessary to prescribe as much as 400 mg of spironolactone per day. *Id.* at 170:11–22 (Dr. Tangpricha).

12. Once hormone therapy is initiated in both transgender females and males, it is important to monitor serum levels in the patient's bloodstream. This is the only reliable indication available to verify that hormone therapy is working effectively to treat gender dysphoria. *Id.* at 101:24–102:12 (Dr. Tangpricha).

13. For transgender women, the physiological range of estradiol should be within 100 to 200 pg/mL, and testosterone should be below 50 ng/dL. *Id.* at 104:8–14 (Dr. Tangpricha). Recommended hormone therapy for transgender men typically involves provision of testosterone, either parenterally (through injection) or transdermally (through the skin). Tangpricha Decl. ¶ 27.

14. If a patient's values are consistently outside of the applicable therapeutic range, the patient is not receiving adequate treatment for gender dysphoria. Tr. at 105:2–7 (Dr. Tangpricha). Symptoms of gender dysphoria will persist, such as anxiety, depression, and feelings of hopelessness, as well as increased risk of self-harm, surgical self-treatment, and suicide. *Id.* at 125:2–10 (Dr. Tangpricha).

15. If monitoring demonstrates that hormone levels are not in the proper physiological ranges, it is often medically necessary to increase dosages in order to adequately treat the patient's gender dysphoria. *Id.* at 121:4–8 (Dr. Tangpricha).

16. Although hormone therapy is safe when properly administered and monitored, as with most drugs, there is the potential for adverse side effects. For patients on estradiol in particular, it is important to monitor serum levels because high estradiol increases a patient's risk for blood clots. Tangpricha Suppl. Decl. ¶ 12.

17. For hormone therapy in transgender women, it is also important to monitor patients' potassium, creatinine, and prolactin levels. Heightened levels of each are known side effects of spironolactone therapy. Tr. at 107:6–108:4 (Dr. Tangpricha). Monitoring potassium levels is

particularly important because high potassium increases a patient's risk of hyperkalemia and the potential for life-threatening heart arrhythmia. *Id.* at 107:9–17 (Dr. Tangpricha). High creatinine can be a marker for potential kidney failure or damage. *Id.* at 107:18–22 (Dr. Tangpricha). High prolactin may signal enlargement of the pituitary gland, which can lead to blindness. *Id.* at 107:18–108:4 (Dr. Tangpricha).

18. For both transgender men and women, the Guidelines call for monitoring of a patient's labs every three months for the first year they are on hormone therapy, and twice a year thereinafter. *Id.* at 102:3–12 (Dr. Tangpricha).

19. These standards as outlined in the Guidelines represent the minimum standards to adhere to in order to adequately treat gender dysphoria. *Id.* at 98:15–99:2 (Dr. Tangpricha).

IDOC's Diagnoses of Gender Dysphoria and Initiation of Hormone Therapy

20. IDOC puts transgender prisoners' health and lives as risk by regularly and substantially delaying their evaluation for gender dysphoria. *Id.* at 56:20–60:25 (Ms. Reed was diagnosed after approximately two years of delay; during this period she attempted suicide); *id.* at 19:9–20:20 (Ms. Melendez experienced a three year delay); *id.* at 199:11–14 (Ms. Monroe was diagnosed with gender dysphoria four years after she first sought treatment); Kuykendall Decl. ¶¶ 3–4 (Ms. Kuykendall requested an evaluation and hormone therapy at intake in 2013, but was denied. "The feeling of being trapped inside the wrong body was agonizing. In the midst of my despair, I attempted to castrate myself by tying my testicles in order to stop the flow of testosterone. It was only after my castration attempt that IDOC finally evaluated me and diagnosed me with gender dysphoria in February 2015."); Vision Decl. ¶ 3 (Ms. Vision experienced a delay between identification and diagnosis).

21. Even after prisoners are finally diagnosed with gender dysphoria, IDOC unjustifiably delays and denies the initiation of hormone therapy despite Plaintiffs' repeated

requests for treatment. Tr. at 61:3–64:5 (Ms. Reed repeatedly requested to begin hormone therapy and was repeatedly denied, and she was *misdiagnosed* with schizophrenia); Kuykendall Decl. ¶¶ 3–5 (Ms. Kuykendall identified as transgender and requested hormone therapy at intake in 2013, but it was only in 2015, after her castration attempt, that IDOC finally prescribed hormones); Vision Decl. ¶¶ 3–4, 13–16 (Ms. Vision was denied hormones for an unrelated PTSD diagnosis, despite over 20 requests and several doctor recommendations, she was forced to wait *two years* after she was diagnosed to begin treatment: "[T]wo years after my initial gender dysphoria diagnosis, I still had no access to hormone therapy or feminine products. I felt depressed and I started to feel hopeless."); Tr. at 200:1–21 (Ms. Monroe was prescribed hormones four years after she first sought treatment and only after she attempted self-castration); *id.* at 21:4–22:15 (Ms. Melendez was told she needed further counseling before hormone therapy could be initiated); *id.* at 261:20–262:23 (Dr. Ettner).

22. To make matters worse, IDOC routinely delays or denies hormones for reasons that have absolutely *no* medical basis. *Id.* at 261:20–262:23 (Plaintiffs' expert, Dr. Ettner, testified that delay or denial of cross-sex hormones for reasons that had no medical basis was common among the putative Class). Dr. Ettner testified about numerous examples of IDOC's inappropriate reasons for denying hormone therapy to Plaintiffs and putative Class members— none of these reasons are recognized by the medical community—such as "fear that others would follow [transgender inmate's] lead," "counseling on real-life situations of living as opposite gender," "need to investigate [transgender inmate's] conceptualization of gender identity," and the need to treat co-occurring conditions, such as PTSD, among others. *Id.* at 255:25–256:2, 256:18–24, 257:11–14, 286:15–21. Dr. Ettner testified that the Standards of Care "specifically state when coexisting conditions are present, they, along with gender dysphoria, should be treated." *Id.* at 276:23–25.

"By analogy," she explained, "if someone has diabetes and hypertension, you treat both conditions." *Id.* at 276:25–277:1.

IDOC's Transgender Committee

23. IDOC "presents" the cases of all its transgender prisoners to an official committee it calls the "Transgender Committee" or the "Gender Identity Disorder Committee" (hereinafter, "the Committee").

24. The Committee makes medical decisions on behalf of transgender patients and effectively controls every aspect of their care. *Id.* at 365:16–366:11 (Dr. Puga).

25. Yet, the Committee typically meets once a month via phone for approximately two hours, prisoners do not themselves appear before the Committee, and each case is allotted a default of six minutes of Committee time. *Id.* at 385:23–387:3 (Dr. Puga).

26. There is no formal process for a prisoner to appeal a decision of the Committee. *Id.* at 382:15–385:20 (Dr. Puga). A prisoner may ask to be "re-presented" to the Committee, but otherwise cannot contest the medical decisions the Committee makes regarding the treatment of their gender dysphoria. *Id.* (Dr. Puga).

27. The Committee frequently denies or delays necessary medical treatment for transgender patients, including social transition (housing related requests, requests for bras, and requests for grooming items for their gender); gender-affirming surgery; and initiation of hormone therapy. *Id.* at 273:14–274:9 (Dr. Ettner testified regarding her review of the Committee records).

28. The Committee must "green light" these medical treatments before an IDOC healthcare professional may provide them. IDOC has no other similar Committee for any other medical condition. *Id.* at 381:4–15 (Dr. Puga).

29. After the Committee approves hormone therapy for a prisoner, it may micro-manage how the therapy is administered, including denying requests for increased dosages of

hormones and requests for injectable versus oral hormones. *Id.* at 405:14–406:4 (Dr. Puga testified regarding the Committee's management of hormone therapy); *id.* at 118:16–120:12 (Dr. Tangpricha discussed examples he saw of the Committee denying hormone increases and hormone injections).

30. The Committee even questions or ignores IDOC mental health professionals who make initial diagnoses of gender dysphoria in transgender prisoners. *Id.* at 394:25–395:2 (Dr. Puga testified: "[W]e would have is go back and clarify this diagnosis. Take a look and see, is this really, truly a transgender issue or is it something else."); *id.* at 299:5–12 (Dr. Ettner observed the Committee contradicting diagnoses of gender dysphoria that were made by mental health professionals).

The Committee Members are Not Qualified to Treat Gender Dysphoria

31. Despite making important medical decisions for Plaintiffs, not a single member of the Committee is qualified to administer treatment for gender dysphoria.

32. The Committee makes decisions by a vote of 5 members, two of whom have no healthcare background. *Id.* at 378:17–379:5 (Dr. Puga testified there are five voting members); *id.* at 374:11–375:4 (Dr. Puga testified two voting members have no medical training).

33. Even the members who do have a medical background are not qualified to treat gender dysphoria. *Id.* at 253:15–25 (Dr. Ettner stated that the Committee members are not qualified to generate treatment plans for gender dysphoria); *id.* at 275:4–276:10 (Dr. Ettner testified regarding the lack of qualifications for the individual Committee members under the Standards of Care).

34. The Chair of the Committee, Dr. Puga, has never treated a patient primarily for their gender dysphoria, does not prescribe hormone therapy, has never presided over the social transition of a person with gender dysphoria, and is not familiar with the Standards of Care or the

Guidelines. *Id.* at 362:7–9 (Dr. Puga chairs the Committee); *id.* at 365:11–15 (Dr. Puga did not serve as primary medical professional for gender dysphoria); *id.* at 369:3–5 (Dr. Puga has never prescribed or monitored hormones); *id.* at 369:19–21 (Dr. Puga has never presided over a social transition); *id.* at 397:13–398:8 (Dr. Puga is not aware of the Guidelines); *id.* at 399:12–14 ("I don't know what the medical guidelines are…I don't know how medicine works, frankly.").

35. Dr. Puga does not hold himself out as an expert in the treatment of gender dysphoria, and has no idea whether he meets the minimum qualifications under the Standards of Care to treat the condition. *Id.* at 369:22–370:12.

36. The other two physicians on the Committee—Dr. Meeks and Dr. Hinton—each admitted that they are not experts in transgender healthcare. *Id.* at 372:2–374:10 (Dr. Puga).

37. Although Dr. Puga stated the Committee listens to Dr. Reister, a psychologist who attends some Committee meetings, Dr. Reister is also not an expert in gender dysphoria, does not prescribe hormones, does not get a vote, and is not familiar with the Guidelines. Defs.' Ex. 3, Reister Dep. Tr. at 59:14–61:22. Despite the fact that Dr. Reister has no expertise in gender dysphoria, Dr. Puga testified that Dr. Reister "probably has the most experience out of everybody [on the Committee] as far as working with this population." Tr. at 332:19–23. However, Dr. Reister admitted to his deficient training in treating gender dysphoria and testified that he defers to *Dr. Puga* on issues pertaining to the medical treatment of patients with gender dysphoria. Defs.' Ex. 3, Reister Dep. Tr. at 60:3–61:22 ("I leave that to the medical staff, like Dr. Puga…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."). What is abundantly clear from Dr. Puga's and Dr.

Reister's testimony is that no one on the Committee has the required qualifications, expertise, or training needed to treat patients with gender dysphoria.

38. The Committee's complete lack of qualified members manifests in the failure to provide medically necessary treatment to the Plaintiffs without any reasoned or medically acceptable basis. *See* Tr. at 253:15–25 (Dr. Ettner).

39. The many delays and denials of needed medical care for gender dysphoria put Plaintiffs' mental and physical health in jeopardy and places them at grave risk of suicide. *Id.* at 275:7–13 (Dr. Ettner testified to this effect); *id.* at 128:12–129:11, 142:5–143:5 (Dr. Tangpricha testified to this effect).

40. IDOC's deficient care has already caused substantial irreparable harm. For example, on October 14, 2015, members of an IDOC "Suicide Task Force," including one of the Defendants in this matter, Dr. Melvin Hinton, IDOC's Chief of Mental Health, met to discuss a recent suicide of a transgender prisoner at Pontiac Correctional Center. Pls.' Ex. 20 at 277144.

41. IDOC was aware that the inmate was transgender and required care for gender dysphoria. Dr. Louis Shicker, IDOC's Chief of Medical Services, stated that the prisoner "was in the process of getting evaluated as a Transgender Offender," but noted that "[t]he process was delayed that would have led to required medication." *Id*. at 277146.

42. Another meeting participant, Camile Lindsay, noted that the transgender prisoner "requested a [gender dysphoria] evaluation on 5/14/14, and over a year had passed in which her case had still not been presented to the [gender dysphoria] committee." *Id.*

43. Even after finally being diagnosed with gender dysphoria by an IDOC mental health professional on April 22, 2015, the prisoner was still not immediately "presented" to Committee. *Id.*

44. The prisoner committed suicide on May 31, 2015. As Defendant Hinton himself admitted, "[L]apse in presentation to Transgender Committee could have been a reason for the suicide." *Id.* [1]

45. As Plaintiffs' experts testified and the evidence showed, IDOC's pattern of deliberate indifference continued well beyond this prisoner's suicide in May 2015. The Committee continues to deny both the named Plaintiffs' and putative Class members' timely and adequate treatment for their diagnosed gender dysphoria. *See e.g*. Pls.' Ex. 1 (Melendez grievances and responses); Pls.' Ex. 2 (Reed grievances and responses); Pls.' Ex. 9 (Monroe grievances and responses); Pls.' Ex. 3 (Committee denied sports bra "due to safety concerns"); Pls.' Ex. 14 (Despite noting prisoner's "attempted self-castration" after being denied hormones and that "offender was on crisis watch [during intake] from 9/17 /18 until 9/23/18 after being denied hormones," Committee denied hormones because the prisoner "[n]eeds to show more stability before beginning hormones.").

46. For example, IDOC diagnosed named Plaintiff Lydia Vision with gender dysphoria in March 2016, but the Committee denied her hormone therapy for over two years, failing to authorize treatment until October of 2018. Vision Decl. ¶¶ 3, 15. The Committee's delay in authorizing necessary medical care, like so many of the Committee's decisions, was without any acceptable medical basis. *See* Tr. at 128:4–8 (Dr. Tangpricha); *id.* at 276:5–7 (Dr. Ettner).

[1] Defendants produced the document relating to this suicide on June 4, 2019, ***more than a year*** after Plaintiffs served discovery requests asking for, among other things, all records relating to the suicide of transgender prisoners. The document was buried within 25,274 pages of other electronically stored information contained in that production. Defendants never identified the prisoner as a putative Class member, nor did they produce her full medical and mental health records.

Deficiencies in IDOC's Provision of Hormone Therapy

47. IDOC systemically delays and denies medically necessary hormone therapy to transgender prisoners. The result of IDOC systemic deliberative indifference on this serious medical need renders IDOC's care inadequate.

48. Dr. Tangpricha testified that none of the named Plaintiffs were receiving hormone therapy in accordance with the Guidelines. *Id.* at 120:6–128:11. As a result, their therapy did not adequately treat their diagnosed gender dysphoria. *Id.* at 128:12–129:11. He also noted a pattern of similar deficiencies common to the putative Class members based on his review of their records. *Id.* at 142:10–143:5.

49. Not one of the named Plaintiffs received adequate monitoring under the Guidelines after initiation of hormone therapy. (Since Ms. Vision was denied hormones until very recently, Plaintiffs lack information necessary to determine if she is currently being adequately monitored.) Two of the named Plaintiffs, Ms. Melendez and Ms. Kuykendall, are receiving a conjugated form of estrogen. Conjugated estrogens, a form of treatment used in the past, have not been recommended for at least 10 years under the Guidelines and put patients at increased risk of blood clots. *Id.* at 145:5–12 (Dr. Tangpricha). This is because it is impossible to reliably monitor serum levels due to the makeup of these compounds, which are derived from pregnant horse urine. *Id.* at 110:5–17, 145:16–146:2 (Dr. Tangpricha described the dangers of conjugated estrogen generally, and specifically the increased risk of blood clots).

50. In the few instances in which IDOC monitored the named Plaintiffs' hormone blood levels, lab results showed, in almost every case, levels that were outside of the physiological ranges needed to treat gender dysphoria. *Id.* at 128:12–129:11 (Dr. Tangpricha).

51. Despite the fact that lab results showed consistently inadequate results, IDOC was unjustifiably slow to correct treatment. For example, in the case of Ms. Reed, her results from

July 2017 showed very low estradiol levels and very high testosterone; yet IDOC failed to adjust her dosages for roughly 15 months thereafter. *Id.* at 126:20–127:5 (Dr. Tangpricha).

52. IDOC's persistently inadequate treatment puts Plaintiffs' health at serious risk. Their symptoms of gender dysphoria have persisted even despite hormone therapy. *Id.* at 128:12–129:11, 127:4–17 (Dr. Tangpricha discussed the health effects of inadequate treatment generally, and also the specific effect on Ms. Reed).

53. The inadequate monitoring of non-hormonal values—like potassium, creatinine, and prolactin—also puts Plaintiffs' health at serious risk. *Id.* at 142:12–25 (Dr. Tangpricha).

54. The same deficiencies regarding hormone therapy are present in the putative Class. Plaintiffs' expert noted that, based on his review of all the pertinent medical records, putative Class members were receiving low dosages, conjugated estrogens, and being monitored irregularly and outside of the Guidelines. He testified that 90% of the putative Class member records showed frequency of monitoring that was not consistent with the Guidelines, and the monitoring that did occur suggested roughly 90% of putative Class members had hormone values outside of the physiological ranges under the Guidelines. *Id.* at 143:2–23.

55. The testimony of IDOC's own witness demonstrated the severe risk of improper monitoring. Dr. William Puga, IDOC's Chief of Psychiatry, testified that in April of this year, a transgender female patient on hormone therapy experienced a stroke resulting in partial paralysis, and that the cause was the hormone therapy she was receiving from IDOC. *Id.* at 341:19–342:2.

56. Defendants only produced records relating this patient *after* the hearing. Upon review of the same, Plaintiffs' expert found that IDOC had placed this patient on conjugated estrogen in 2015, and that it monitored her labs only once, in late 2018. Tangpricha Suppl. Decl. ¶ 23. This meant her estradiol levels might have been very high, putting her at a severely increased

risk for a blood clot and subsequent stroke. But because she was on a conjugated estrogen, IDOC would have no way of knowing the level of risk, even if it had monitored her levels properly. *Id.* ¶ 24.

57. In addition, two of the named Plaintiffs, Ms. Melendez and Ms. Kuykendall, are receiving a conjugated form of estrogen, exposing them to the risks discussed above. *See supra* at ¶ 49.

Social Transition

58. Social transition refers to individuals with gender dysphoria living in a way that is consistent with their gender identity, including access to things such as gender-affirming clothing, grooming items, housing and related facilities, use of gender-appropriate pronouns, chosen names, and other social signifiers of gender. Tr. at 240:2–20 (Dr. Ettner). In prison or jail settings, it also includes the right to be physically searched by staff of the same gender.

59. Social transition is an integral part of treatment for gender dysphoria, and is incredibly effective in alleviating the symptoms of the condition. Not being able to socially transition has an extremely demoralizing impact on patients, impedes their overall treatment, and exacerbates depression and other symptoms of gender dysphoria. *Id.* at 239:6–7, 241:20–242:6 (Dr. Ettner).

60. Despite the importance of social transition, IDOC routinely subjects transgender women to strip searches by male staff, misgenders transgender prisoners (*i.e.*, refers to an individual by the incorrect pronouns), denies transgender women access to gender-affirming clothing and grooming items, and maintains a *de facto* policy of not evaluating whether it is medically necessary and appropriate to house prisoners with gender dysphoria in facilities for individuals of their gender.

61. For example, IDOC regularly subjects named Plaintiffs to strip searches by male correctional officers despite their requests to be searched by female officers. *Id.* at 35:17–19 (Ms. Melendez is searched by male officers in front of other men); Kuykendall Decl. ¶ 10 ("Strip searches conducted by male officers in the presence of male inmates are humiliating and leave me feeling violated and unsafe. I have refused visitors because I was terrified of the violating experience of being searched by male officers." IDOC did not answer Ms. Kuykendall's grievance requesting to be searched by female guards); Tr. at 73:6–74:16 (Ms. Reed is searched and strip-searched by male officers and her requests to be searched by women were denied); Vision Decl. ¶ 18 (Ms. Vision is searched by male officers); Tr. at 197:4–5, 204:10–25 (Ms. Monroe was searched by male guards while in the men's facilities and was frequently inappropriately touched and harassed).

62. IDOC staff also regularly misgender the named Plaintiffs, and refuse to call them by their chosen names. Kuykendall Decl. ¶ 11 (stating that staff sometimes call her "it," and that even healthcare staff misgender her); Vision Decl. ¶ 18; Tr. at 72:3–8 (Ms. Reed); *id.* at 37:21–38:18 (Ms. Melendez); *id.* at 196:23–24 (Ms. Monroe was never addressed as a female while she was in a male facility).

63. Beyond the correctional officers, IDOC medical and mental health staff and even members of the Committee—the very people entrusted with making medical decisions on behalf of transgender prisoners—regularly misgender the Plaintiffs. Tr. at 28:2–8 (Ms. Melendez); Vision Decl. ¶ 18 ("[M]edical and mental health staff persistently misgender me. I feel hopeless and completely alone in a constant battle for treatment."); Kuykendall Decl. ¶ 11; Tr. at 279:24–280:8 (Plaintiffs' expert Dr. Ettner testified that Plaintiffs' medical records misgendered them).

Indeed, the chair of the Committee himself, Dr. William Puga, twice misgendered a former patient during his testimony in this case. Tr. at 328:1–8 (Dr. Puga).

64. Despite Plaintiffs' repeated requests, IDOC further denies transgender women access to medically necessary gender-affirming clothing and grooming items provided to cisgender (*i.e.*, a person whose gender identity matches the sex they were assigned at birth) women. Kuykendall Decl. ¶ 7; Vision Decl. ¶¶ 12, 13, 17, 18; Tr. at 64:8–66:10 (Ms. Reed made several requests for female grooming items and clothing); *id.* at 33:15–35:22 (Ms. Melendez testified regarding requests for these items and impact on her ability to socially transition); *id.* at 33:20–34:25 (Ms. Melendez is denied access to lotion to counteract the dry skin from her treatment, she has to comb her hair with her fingers with a spork, and is forced to use men's products even though she's not a man. "It's angering and depressing."); Vision Decl. ¶ 17 (Ms. Vision requested gender-affirming and grooming items three years ago, yet has still not been provided with the clothing and grooming items provided to non-transgender women). As Ms. Monroe testified, women in female facilities are provided access to "bras[,] panties, makeup, real brushes, combs," cosmetics, and comparatively, transgender women in male prisons "get nothing," except maybe a bra. Tr. at 203:23–204:9 (Ms. Monroe). As Dr. Ettner testified, these gender-affirming clothing items and grooming items are an important part of the medical treatment for gender dysphoria. Tr. at 240:2–11.

65. When IDOC finally supplies a sports bra, the only gender-affirming clothing item IDOC appears to provide, it is only after significant delay without any medical justification. *Id.* at 31:7–9, 32:17–19 (Ms. Melendez first requested a bra in 2015 and only received a bra in 2017); *id.* at 66:8–68:6 (Ms. Reed filed two grievances in 2016 and 2017 and only received bra almost a year after her first grievance); Kuykendall Decl. ¶ 7 (Ms. Kuykendall experienced a 6 month delay

from her first request); Vision Decl. ¶ 16 (Ms. Vision received a bra over ***two years*** after her first request and over three months after they were finally prescribed).

66. IDOC repeatedly refused to even evaluate several of the named Plaintiffs for transfer to a female facility in order to enable social role transition, despite their repeated requests and the fact that placing them in male facilities exposes them to daily and foreseeable risks of psychological and physical harm. Tr. at 64:8–12 (Ms. Reed requested transfer to a women's facility); *id.* at 194:14–196:22 (Ms. Monroe requested to be placed in a female facility around 2010, she filed several grievances, tried to kill herself, and yet was only transferred almost a decade later and only after she filed a lawsuit). IDOC denies these requests despite the fact that Plaintiffs feel unsafe and have been subjected to repeated harassment, cruelty, and even assault, both by male inmates and by IDOC staff. Vision Decl. ¶ 18 ("If I allowed myself to feel I would be crying all day because I am a woman in stuck in a male facility."); Kuykendall Decl. ¶ 12 (Ms. Kuykendall has repeatedly complained about being housed with male prisoners and expressed fears for her safety; she eats alone in her cell to stay safe); Tr. at 36:11–20 (despite a diagnosis of gender dysphoria over 4 years ago, Ms. Melendez has never been asked whether she'd like to be evaluated for transfer); *id.* at 74:23–75:12 (Ms. Reed has not been evaluated for transfer); *id.* at 194:14–196:22 (Ms. Monroe was assaulted several times and only transferred after she filed a lawsuit).

67. Defendant's own witness, Warden Glen Austin from Logan Correctional Center, a facility for women, testified that he believed transgender females should be transferred to the women's prison. Defs.' Ex. 7, Austin Dep. Tr. at 54:18–24. But Dr. Puga testified that only four transgender women had been transferred to female facilities and two were transferred only after lawsuits were filed on their behalf requesting that specific relief. Tr. at 403:9–23.

68. IDOC's denial or delay of necessary social transition has had a severely deleterious effect on the named Plaintiffs' physical and mental health. Put simply, they experience constant despair of being unable to experience life as women. Kuykendall Decl. ¶ 13 ("Every day my requests for gender affirming surgery, hormone monitoring, gender affirming clothing, and being able to be myself in a women's facility go ignored, I feel myself slipping into a deeper depression. I am struggling with constant thoughts of self-harm."); Vision Decl. ¶ 18 ("I am forced to dress, smell and look like 'a man' because I cannot get the gender affirming clothes, grooming items and medical care I need...I am trapped in a male prison where I do not feel safe and I am not fully able to transition."); Tr. at 35:10–22 (Ms. Melendez explained how "it's extremely upsetting" that regardless how hard she tries to socially transition, she's constantly called a man, given only men's clothing, celled with men, at yard with men, and strip searched by men in front of male inmates); *id.* at 68:4–6 (Ms. Reed feels "depressed every day").

69. IDOC's denial and delay of social transition is consistent across the records of the putative Class members. Plaintiffs' expert, Dr. Randi Ettner testified that, with the occasional exception of sports bras, IDOC's Transgender Committee denies the items that are needed for social transition. *Id.* at 273:17–274:7.

70. Dr. Ettner further stated that the result of denial of social transition is "extremely demoralizing, it impedes medical treatment, and it can lead to several very debilitating psychological and health effects" for gender dysphoric patients. *Id.* at 242:2–6.

IDOC's Denial of Gender-Affirming Surgery

71. Gender-affirming surgery is a medically necessary treatment for many individuals with gender dysphoria, and is recognized as such under the Standards of Care. *Id.* at 246:14–247:7 (Dr. Ettner testified that surgery is effective and medically necessary in certain cases under the

Standards of Care); *id.* at 109:18–20 (Dr. Tangpricha testified that surgery is medically necessary in some cases).

72. For individuals for whom gender-affirming surgery is medically necessary, social transition and adequate hormone therapy will be insufficient to treat their gender dysphoria. For example, although Ms. Monroe is the only named Plaintiff who has received treatment to enable her social role transition, she nevertheless requires gender-affirming surgery to treat her severe anatomical gender dysphoria according to Dr. Ettner. *Id.* at 256:5–12.

73. IDOC has never even evaluated, whether it is medically necessary, much less approved, a transgender prisoner for gender-affirming surgery. *Id.* at 345:16–346:5 (Dr. Puga admitted that IDOC has never approved or reviewed an inmate for surgery);[2] Defs.' Answer ¶ 100; Defs.' Ex. 4, Puga Dep. Tr. at 99:9–14. IDOC's Transgender Committee has never even referred a patient to a specialist for evaluation for such surgery. Tr. at 402:10–13 (Dr. Puga). The result is a *de facto* policy by IDOC of failing to consider or provide medically necessary treatment for gender dysphoria.

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[2] Full relevant excerpt from Dr. Puga's testimony regarding denial of gender-affirming surgery:

Q. Does the [IDOC] committee also make decisions regarding surgery for transgender inmates?

A. Do we make recommendations? We will entertain requests for it. And as I mentioned, I've been on the committee for a relatively short period of time, but -- we have had some requests, but at this point it's something that -- ***I'm still working on some of these -- the whole concept.***

Q. Have there been specific inmates who have been reviewed at all considered for this type of surgery?

A. ***Not today.*** I have an interview with somebody coming up in this -- sometime this month. And we were -- we will look at that specific question. But there were three from Dixon that had requested, orchiectomies, castration, and two were leaving relatively soon and the other, when we approached them again, they said they had decided not to pursue that.

Tr. at 345:16–346:5 (emphasis added).

74. IDOC's policy of denying gender-affirming surgery has a dire impact on the health and lives of IDOC's transgender population. For example, Ms. Kuykendall and Ms. Monroe both need surgery, requested surgery, and both made attempts at self-castration when IDOC failed to consider their requests. *Id.* at 256:9–12, 260:23–24 (Dr. Ettner testified that Ms. Monroe needs "vaginoplasty, genial reconstruction" and Ms. Kuykendall requires "an assessment for surgical treatment"); *id.* at 201:2–202:3 (Ms. Monroe testified that she has attempted self-castration and mutilation hoping that an infection forces IDOC to provide surgery, and she would rather die than live without the surgery); Kuykendall Decl. ¶¶ 2, 4, 9 (Ms. Kuykendall has made several requests for surgery since 2015, yet has never been evaluated. She continues to feel "extremely depressed and anxious because of [her] genitalia, and have frequent thoughts of self-harm."). In addition, Ms. Melendez testified that "she does not see future because it's really hard having something you're not supposed to have…something that brings you disgust and discomfort…every day when I use the restroom I have to touch it….I feel like a freak sometimes. I don't want to be a freak." Tr. at 26:6–27. Ms. Reed's repeated requests for surgery dating back to 2016 have been denied. These denials make her "feel suicidal," without hope, and like she wants to self-castrate. *Id.* at 68:16–69:24.

PROPOSED CONCLUSIONS OF LAW

75. This Court has jurisdiction pursuant to 28 U.S.C. § 1331, because this action arises under the laws and Constitution of the United States, and 28 U.S.C. § 2201, because an actual controversy exists within this Court's jurisdiction.

76. Venue is proper in this district pursuant to 28 U.S.C. § 1391, because the majority of the events giving rise to this action occurred in this district and because Defendants are subject to personal jurisdiction in this district.

77. Plaintiffs requested a preliminary injunction to end IDOC's deliberate indifference to their serious medical needs relating to gender dysphoria. In order to attain a preliminary injunction, Plaintiffs must establish (1) that they are likely to succeed on the merits, (2) that they are likely to suffer irreparable harm in the absence of the injunction, (3) that the "balance of equities" weighs in their favor, and (4) that an injunction would be in the public interest. *See, e.g.*, *Winter v. Nat. Res. Def. Council, Inc*., 555 U.S. 7, 20 (2008).

78. The Prison Litigation Reform Act requires that a preliminary injunction be "narrowly drawn, extend no further than necessary to correct the harm...," and "be the least intrusive means necessary to correct that harm." 18 U.S.C. § 3626(a)(2).

79. Plaintiffs' requested relief clearly meets the standard for preliminary injunction and is narrowly tailored to remedy the constitutional violations that Plaintiffs and putative Class members are suffering. Indeed, on August 23, 2019, the Ninth Circuit Court of Appeals affirmed the district court's grant of an injunction ordering the Idaho Department of Corrections to provide gender-affirming surgery to an inmate with gender dysphoria. The court held that "where, as here, the record shows that the medically necessary treatment for a prisoner's gender dysphoria is gender confirmation surgery, and responsible prison officials deny such treatment with full awareness of the prisoner's suffering, those officials violate the Eighth Amendment's prohibition on cruel and unusual punishment." *Edmo v. Corizon, Inc.* (7th Cir. No. 19-35017), Per Curium Op., Dkt. No. 96-1 (hereafter, "*Edmo* Op."), at 84. That case featured the same type of clear deliberate indifference to serious medical needs that IDOC has demonstrated in this case. IDOC's persistent and systematic deprivation of medically necessary care to treat Plaintiffs' and putative Class members' gender dysphoria is a violation of the Eighth Amendment's prohibition on cruel and

unusual punishment and an injunction is necessary to prevent irreparable harm to Plaintiffs and putative Class members.

Likelihood of Success on the Merits

80. To establish a likelihood of success on the merits, "[a] party moving for preliminary injunctive relief need not demonstrate that she has a likelihood of absolute success on the merits, but rather that her chances are 'better than negligible,' which is a 'low threshold.'" *Hampton v. Baldwin*, No. 3:18-CV-550-NJR-RJD, 2018 WL 5830730, at *10 (S.D. Ill. Nov. 7, 2018) (internal quotations omitted).

81. Plaintiffs need "only to present a claim plausible enough that (if the other preliminary injunction factors cut in their favor) the entry of a preliminary injunction would be an appropriate step." *See S./Sw. Ass'n of Realtors, Inc. v. Vill. of Evergreen Park*, 109 F. Supp. 2d 926, 927 (N.D. Ill. 2000).

82. Plaintiffs bring their claims under the Eighth Amendment to the Constitution, claiming that IDOC is deliberately indifferent to their serious medical needs. "[D]eliberate indifference to serious medical needs of prisoners violates the [Eighth] Amendment because it constitutes the unnecessary and wanton infliction of pain contrary to contemporary standards of decency." *Helling v. McKinney*, 509 U.S. 25, 32 (1993) (internal quotation marks omitted) (citing *Estelle v. Gamble*, 429 U.S. 97, 104 (1976)).

83. To demonstrate deliberate indifference, Plaintiffs must show that: (1) they suffer from a serious medical need which presents an objectively substantial risk of harm, *Greeno v. Daley*, 414 F.3d 645, 652 (7th Cir. 2005), and (2) Defendants knew that the risk existed and that Defendants either intentionally or recklessly ignored it and will continue to do so in the future. *Farmer v. Brennan*, 511 U.S. 825, 842 (1994); *Wellman v. Faulkner*, 715 F.2d 269, 272 (7th Cir. 1983) ("When systematic deficiencies in staffing, facilities or procedures make unnecessary

suffering inevitable, a court will not hesitate to use its injunctive powers.") (internal quotations and citations omitted).

84. Plaintiffs proved, through their own testimony and through the testimony of their experts, that gender dysphoria is a serious medical condition that poses an objectively substantial risk of harm. Defendants did not contest this fact. Nor could they—the Seventh Circuit first established that gender dysphoria constitutes an objectively serious medical need over thirty years ago, *Meriwether v. Faulkner*, 821 F.2d 408 (7th Cir. 1987), and has reaffirmed this holding in numerous subsequent cases, *e.g., Fields v. Smith*, 653 F.3d 550, 555 (7th Cir. 2011); *Mitchell v. Kallas*, 895 F.3d 492, 498 (7th Cir. 2018).

85. The evidence also showed that Defendants knew of the risk presented by Plaintiffs' gender dysphoria and intentionally or recklessly ignored it. Indeed, there is abundant evidence that IDOC knew of actual harm suffered by the Plaintiffs, yet still did nothing. For example, IDOC admitted that a potential reason for the suicide of a putative Class member in May of 2015 was a long "lapse in presentation" to the Committee. *See* Pls.' Ex. 20 at 277146.

86. IDOC officials directly acknowledged the risk of harm to Plaintiffs in their sworn testimony. For example, Dr. Reister testified that he was aware of Ms. Monroe's acts of self-harm, and aware of suicides involving transgender prisoners. *See* Defs.' Ex. 3, Reister Dep. Tr. at 100:4–102:24, 103:1–105:14. Warden Austin stated that he believed that Ms. Monroe would be safer in a women's prison when the Committee was discussing whether to authorize her transfer. Defs.' Ex. 7, Austin Dep. Tr. at 61:2–10.

87. Despite their knowledge of the risks of untreated gender dysphoria, the evidence showed that IDOC's pattern was to deny or delay medically necessary treatment to the Plaintiffs, repeatedly and without any medically accepted rationale. For example, even after the suicide of a

transgender prisoner in May 2015, Ms. Melendez was forced to wait for years for a sports bra (Tr. at 32:14–16), while Ms. Vision was forced to wait years for hormone therapy (Vision Decl. ¶ 16), despite both Plaintiffs' repeated requests. According to Plaintiffs' experts, these are medically necessary treatments that Plaintiffs required for their gender dysphoria, and IDOC's delays in providing them were without any acceptable medical justification. *See supra* ¶¶ 22, 64; Tr. at 156:12–15; *id.* at 266:2–11.

88. Plaintiffs' experts testified that these serious deficiencies in care—namely, arbitrary delays in providing hormone therapy, inadequate hormone therapy, arbitrary delays in provision of gender-affirming clothing and grooming items, denial of transfer, and denial of gender-affirming surgery—represented a pattern of systematic and grossly deficient care for gender dysphoria, with the Committee, although its members were entirely unqualified to treat patients with gender dysphoria, serving as the final word on important medical decisions. Tr. at 275:7–13 (Dr. Ettner); *id.* at 128:12–129:11, 142:5–143:5 (Dr. Tangpricha).

89. Where the evidence shows, as it does here, that Defendants systematically fail to provide adequate health care, "a prison official's failure to remedy systemic deficiencies in medical services … constitute[s] deliberate indifference to an inmate's medical needs." *Rasho v. Walker*, No. 07-1298, 2018 WL 2392847, at *18 (C.D. Ill. May 25, 2018) (citing *Cleveland-Perdue v. Brutsche*, 881 F.2d 427, 430–31 (7th Cir. 1989)); *see also Coleman v. Wilson*, 912 F. Supp. 1282, 1304 (E.D. Cal. 1995) (finding deliberate indifference where "defendants have known for years of the gross deficiencies in the provision of mental health care to inmates …, and that they have failed to take reasonable steps to avert the obvious risk of harm to mentally ill inmates that flows from the failure to remedy those deficiencies").

90. Courts routinely find deliberate indifference where, like here, prison officials: (1) deny access to care that medical professionals deem medically necessary, *e.g. Fields*, 653 F.3d at 557 ("[T]here was no evidence of uncertainty about the efficacy of hormone therapy as a treatment."); (2) inexplicably delay medically necessary treatment for no penological purpose, *e.g., Petties v. Carter*, 836 F.3d 722, 730 (7th Cir. 2016); *Perez v. Fenoglio*, 792 F.3d 768, 777–78 (7th Cir. 2015) ("A delay in treatment may show deliberate indifference if it exacerbated the inmate's injury or unnecessarily prolonged his pain," and "even brief, unexplained delays in treatment may constitute deliberate indifference."); (3) continue in a harmful course of conduct, *Petties*, 836 F.3d at 728, or persist in a course of treatment known to be ineffective, *e.g., Foster v. Ghosh*, 4 F. Supp. 3d 974, 981 (N.D. Ill. 2013) (treating physician "was 'persisting in a course of treatment known to be ineffective,' demonstrating deliberate indifference to Foster's serious medical need.") (citation omitted); or (4) make a treatment decision that constitutes a "substantial departure from accepted judgment, practice, or standards," *e.g., Petties*, 836 F.3d at 729 (citation omitted); *Edmo* Op. at 62 (finding deliberate indifference where defendants "did not follow the accepted standards of care in the area of transgender health care," nor "reasonably deviate from or flexibly apply them"); *Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1189 (N.D. Cal. 2015) (finding deliberate indifference where prison officials had access to the Standards of Care yet failed to provide a transgender prisoner with the appropriate treatment).

91. All of these four scenarios apply here, establishing a high likelihood that Plaintiffs will succeed on the merits in proving IDOC's deliberate indifference to their serious medical needs. Plaintiffs' experts testified that all the treatments Plaintiffs are seeking are medically necessary treatments. Tr. at 254:1–7, 156:12–15 (Dr. Ettner; Dr. Tangpricha). Those experts also testified to the arbitrary nature of IDOC's denials and delays in providing that medically necessary

care, including denial of hormones, denial of clothing and grooming items, denial of transfer, and denial of gender-affirming surgery, and that these decisions were contrary to all current standards for the treatment of gender dysphoria and lacked any basis in sound medical or psychological judgment. *Id.* at 261:20–262:5 (Dr. Ettner testified about the lack of medical basis for Committee decisions); *id.* at 129:4–11 (Dr. Tangpricha testified to the same). Even when IDOC knew or should have known that a course of care was ineffective, they often failed to do anything to correct the treatment. For example, the evidence showed that IDOC denied or delayed increases in hormone prescriptions, even when the prescription they had authorized was demonstrably inadequate. *Id.* at 126:13–127:5 (Dr. Tangpricha). In addition, IDOC failed to engage in the standard, medically-required testing for patients whom it had placed on hormone treatment, making it unable to assess the efficacy of treatment or the potential risks of treatment, including risks of blood clots and damage to major organs. It even continues to prescribe an outdated form of hormone (conjugated estrogen) whose levels cannot be tested at all. And Plaintiffs' experts testified at length regarding examples of IDOC's frequent and egregious deviations from the applicable Standards of Care. Dr. Puga acknowledged that he is aware of professional standards governing care for gender dysphoria, but he nevertheless demonstrated no familiarity with them. *Id.* at 369:25–370:12 (Dr. Puga admitted unfamiliarity with the minimum qualifications under WPATH); *id.* at 397:10–17 (Dr. Puga testified he does not know if the Committee refers to the Guidelines for hormone therapy). In fact, of the only eight transgender patients Dr. Puga has treated in the past, he treated none of them primarily for gender dysphoria. *Id.* at 365:11–15.

92. Despite their lack of expertise, the Committee fails to consult experts or send patients to consultations with experts in this area. Given the complete lack of expertise of anyone making treatment judgments for Plaintiffs and the putative Class members, IDOC should have

consulted or referred its patients with this condition to specialists, but has never done so. *Id.* at 280:9–11 (Dr. Ettner).

93. Courts find that tolerating deficiencies in care— just like the ones described above—amounts to deliberate indifference. *See, e.g., Hicklin v. Precynthe*, No. 4:16-cv-01357-NCC, 2018 WL 806764, at *14 (E.D. Mo. Feb. 9, 2018) (granting preliminary injunction and ordering defendant "to provide Ms. Hicklin with care that her doctors deem to be medically necessary treatment for her gender dysphoria, including hormone therapy, access to permanent body hair removal, and access to 'gender-affirming' canteen items"); *Edmo* Op. at 63 ("The record demonstrates that [prison physician] acted with deliberate indifference to [plaintiff's] serious medical needs. [Prison physician] knew, as of the time of his evaluation, that [plaintiff] had attempted to castrate herself. He also knew that [plaintiff] suffers from gender dysphoria; he knew she experiences 'clinically significant' distress that impairs her ability to function," yet "nonetheless continued with [plaintiff's] ineffective treatment plan."); *Norsworthy*, 87 F. Supp. 3d at 1189 (defendants acted with deliberate indifference by failing to provide transgender prisoners) with gender-affirming surgery when they had "access to the relevant Standards of Care and evidence that [gender-affirming surgery] was medically necessary for [plaintiff]").

Irreparable Harm Absent a Preliminary Injunction

94. There is abundant evidence of the likelihood of irreparable harm absent a preliminary injunction in this case. The named Plaintiffs all committed acts of self-harm, and Plaintiffs' testimony demonstrates that they are at great risk of suicide without immediate relief. Tr. at 38:19–39:15 (Ms. Melendez); *id.* at 58:6–16 (Ms. Reed); *id.* at 193:2–12 (Ms. Monroe); Monroe Decl. ¶¶ 3–5; Kuykendall Decl. ¶¶ 4, 9; Reed Decl. ¶ 2. Plaintiffs' experts testified that the named Plaintiffs will continue to commit such acts as long as IDOC's inadequate care persists. Dr. Ettner, in particular, testified that the named Plaintiffs were at risk of suicide if not evaluated

soon for gender-affirming surgery (Tr. at 254:1–21); that Ms. Kuykendall's condition has deteriorated since her evaluation in May 2018 (*id.* at 260:25–261:4); and that, for all gender dysphoric persons who do not receive adequate treatment, there are three typical trajectories: surgical self-treatment (*i.e.*, removal of one's own genitalia); psychological decompensation; and suicide (*id.* at 250:21–251:1). Other needless risks to which IDOC's conduct exposes Plaintiffs and the putative Class include the risks inherent in failure regularly and appropriately to test patients to whom hormones have been prescribed, and the risks inherent in prescribing an antiquated form of hormone that cannot be tested at all. *See supra* ¶ 90.

95. IDOC's own testimony confirms the potential for irreparable harm. Dr. Puga testified about a gender dysphoric patient that recently suffered a stroke and partial paralysis due to her hormone therapy. Tr. at 341:19–342:2. Plaintiffs' endocrinologist expert, Dr. Tangpricha, concluded that IDOC's deficient treatment of that patient put her at an increased and unacceptable risk of blood clots—a risk that IDOC repeatedly exacerbates and ignores through its inadequate provision of hormone therapy. Tangpricha Suppl. Decl. ¶ 26.

96. This evidence is more than sufficient to necessitate a preliminary injunction. Courts repeatedly hold that emotional distress, anxiety, depression, and physical harm resulting from inadequate medical treatment for gender dysphoria amount to irreparable harm. *See, e.g.*, *Hicklin*, 2018 WL 806764, at *10, *14 (enjoining prison system's denial of medically necessary transition-related treatments to transgender plaintiff in Eighth Amendment case, finding plaintiff showed irreparable harm based on evidence of worsening emotional distress and a substantial risk of self-harm, including "intrusive thoughts of self-castration" and suicidal ideation); *Edmo* Op. at 73 (finding transgender prisoner plaintiff satisfied the irreparable harm prong: "It is no leap to conclude that [Plaintiff's] severe, ongoing psychological distress and the high risk of self-

castration and suicide she faces absent surgery constitute irreparable harm"); *cf. Whitaker*, 858 F.3d at 1045–46 (affirming preliminary injunction enjoining school from enforcing policy barring transgender boy from using boys' restrooms, concluding that evidence that the policy caused plaintiff "significant psychological distress" constituted irreparable harm).

97. In addition, Defendants' continual deprivation of Plaintiffs' Eighth Amendment rights, as previously described, is in itself an irreparable harm sufficient to warrant a preliminary injunction. *See Preston v. Thompson*, 589 F.2d 300, 303 n.3 (7th Cir. 1978) ("The existence of a continuing constitutional violation constitutes proof of an irreparable harm, and its remedy certainly would serve the public interest."); *Vaquería Tres Monjitas, Inc. v. Irizarry*, 587 F.3d 464, 484 (1st Cir. 2009) (finding irreparable harm for "long-standing violations of constitutional rights for extensive protracted periods of time"); *Gordon v. Holder*, 721 F.3d 638, 653 (D.C. Cir. 2013) ("[A] prospective violation of a constitutional right constitutes irreparable injury.") (citation omitted); *Mills v. D.C.*, 571 F.3d 1304, 1312 (D.C. Cir. 2009) ("It has long been established that the loss of constitutional freedoms, for even minimal periods of time, unquestionably constitutes irreparable injury.") (internal quotations and citation omitted).

The Balance of Harms Favors Plaintiffs

98. The balance of harms substantially weighs in favor of granting injunctive relief. As evidenced by Plaintiffs' own testimony and the testimony of their experts, Defendants' refusal to provide Plaintiffs with medically necessary care caused them mental and physical anguish that they continue to suffer on a daily basis, and exposes them to further risks of substantial harm that include self-mutilation or even death. In contrast, Defendants will not suffer any harm—much less irreparable harm—from providing medically necessary care consistent with their constitutional obligations. *See, e.g., Gammett v. Idaho State Bd. of Corr.*, No. CV05-257-S-MHW, 2007 WL 2186896, at *15–16 (D. Idaho July 27, 2007) (finding balance of harms "sharply"

favored plaintiff, who would experience suicidality and mental harm without gender dysphoria treatment); *Farnam v. Walker*, 593 F. Supp. 2d 1000 (C.D. Ill. 2009) (granting preliminary injunction after finding that the burden on the prison of administrating medical treatment as greatly outweighed by plaintiff's prolonged pain, suffering, and decreased quality of life); *Edmo*, 358 F. Supp. 3d at 1128 (holding the balance of equities and public interest favor transgender plaintiff prisoner where she has established "irreparable harm in the form of unnecessary physical and emotional suffering and denial of her constitutional rights"), *aff'd by Edmo v. Corizon, Inc.* (7th Cir. No. 19-35017), Per Curium Op., Dkt. No. 96-1.

99. Indeed, at the evidentiary hearing, Defendants failed to identify even one tangible harm they would suffer as a result of providing adequate care for gender dysphoria.

The Public Interest Favors Preliminary Relief

100. The public interest also favors injunctive relief because Plaintiffs seek to vindicate their right to medically adequate treatment under the Eighth Amendment. *See Farnam*, 593 F. Supp. 2d at 1017 ("[T]he public has an interest in ensuring that the plaintiff's health is maintained during the pendency of the case, given that the plaintiff has shown a fair likelihood of success."); a*ccord Phillips v. Mich. Dep't of Corr.*, 731 F. Supp. 792, 801 (W.D. Mich. 1990) (finding "the public interest will be served by safeguarding Eighth Amendment rights" of prisoners with gender dysphoria), *aff'd*, 932 F.2d 969 (6th Cir. 1991); *Hobby Lobby Stores, Inc. v. Sebelius*, 723 F.3d 1114, 1145 (10th Cir. 2013) (en banc) ("[I]t is always in the public interest to prevent the violation of a party's constitutional rights.") (citation omitted), *aff'd sub nom. Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682 (2014).

Preliminary Injunctive Relief Should Apply to the Putative Class

101. Having met all the requirements for a preliminary injunction, Plaintiffs' requested relief should apply on a class-wide basis. The evidence relating to the putative Class members,

combined with the Plaintiffs' expert testimony, shows that the IDOC policies and practices caused Plaintiffs to receive delayed and inadequate care for gender dysphoria that similarly affects the putative Class, requiring preliminary injunctive relief.[3]

102. All medical decisions regarding gender dysphoria are routed through the Committee, for named Plaintiffs and putative Class members alike. The Committee, which lacks expertise in gender dysphoria and contains non-medical members, is profoundly unequipped to render treatment decisions. And as admitted by Dr. Puga, IDOC makes medical decisions by Committee vote for no other medical condition other than gender dysphoria. Tr. at 365:16–366:11.

103. Further, as both Dr. Tangpricha and Dr. Ettner testified, the deficiencies, denials, and delays in IDOC's treatment of Plaintiffs' gender dysphoria were common to the entire putative Class. *Id.* at 260:24–261:23 (Dr. Ettner testified that she "saw the same pattern of denial of appropriate care for reasons that had no medical basis" for putative Class members as she found with the named Plaintiffs); *id.* at 142:3–143:5 (Dr. Tangpricha testified that the care received by putative Class members is "parallel" to the deficient care received by the named Plaintiffs, and "the class members are at risk.") The entire putative Class is thus exposed to the same unacceptable risks of harm to which Plaintiffs are exposed.

[3] To the extent the Court addresses Plaintiffs' Motion for Preliminary Injunction prior to their Motion for Class Certification, it has the authority to issue class-wide injunctive relief to both the Plaintiffs and Plaintiff Class members pending class certification. *See Ill. League of Advocates for the Developmentally Disabled v. Ill. Dep't of Human Servs.*, No. 13 C 1300, 2013 U.S. Dist. LEXIS 90977, at *9 (N.D. Ill. June 28, 2013) ("District courts have the power to order injunctive relief covering potential class members prior to class certification."); *see also Lee v. Orr*, No. 13-cv-8719, 2013 WL 6490577, at *2 (N.D. Ill. Dec. 10, 2013) ("The court may conditionally certify the class or otherwise order a broad preliminary injunction, without a formal class ruling, under its general equity powers.") (citation omitted). Courts, including within the Seventh Circuit, grant preliminary injunctions that extend relief beyond the named parties where, like here, such an injunction serves the public interest in efficiency and is necessary to ensure the application of the law to and to protect constitutional or civil rights. *See Campbell v. Miller*, 373 F.3d 834, 840 (7th Cir. 2004) (collecting cases).

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Respectfully submitted,

By: /s/ *Jordan M. Heinz*

John A. Knight
Ghirlandi Guidetti
Carolyn M. Wald
ROGER BALDWIN FOUNDATION OF ACLU, INC.
150 North Michigan Avenue, Suite 600
Chicago, IL 60601
Telephone: (312) 201-9740
Facsimile: (312) 201-9760
jknight@ACLU-il.org
gguidetti@ACLU-il.org
cwald@aclu-il.org

Catherine L. Fitzpatrick
Jordan M. Heinz
Erica B. Zolner
Megan M. New
Sydney L. Schneider
Austin B. Stephenson
Sam G. Rose
KIRKLAND & ELLIS LLP
300 North LaSalle Street
Chicago, IL 60654
Telephone: (312) 862-2000
Facsimile: (312) 862-2200
catherine.fitzpatrick@kirkland.com
jordan.heinz@kirkland.com
erica.zolner@kirkland.com
megan.new@kirkland.com
sydney.schneider@kirkland.com
austin.stephenson@kirkland.com
sam.rose@kirkland.com

Brent P. Ray
King & Spalding LLP
444 West Lake Street, Suite 1650
Chicago, IL 60606
Telephone: (312) 764-6925
bray@kslaw.com

Thomas E. Kennedy III
Sarah Jane Hunt
KENNEDY HUNT P.C.
906 Olive Street, Ste. 200

Saint Louis, MO 63101
Telephone: (314) 872-9041
tkennedy@KennedyHuntLaw.com
sarahjane@KennedyHuntLaw.com

Attorneys for Plaintiffs