Case Nos. 19-35017 and 19-35019

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

ADREE EDMO,
Plaintiff-Appellee,
v.
IDAHO DEPARTMENT OF CORRECTIONS, ET AL.,
Defendants-Appellants.

On Appeal from Orders of the United States District Court
For the District of Idaho
(No. 1:17-cv-00151-BLW)

EXCERPTS OF RECORD
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Dated: March 6, 2019

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EXHIBIT 5

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

RECEIVED BY
MAY 2 7 2016
ISCI RECORDS

Offender Name: EDMO, MASON DEAN	Offender Number: 94691	DOR #: 163300
Offense Facility: ISCI	Report Date: 05/22/2016	Reporting Staff: NIMMO, ADAM W. #6163
Offense: TATTOO OR PIERCING	Class: CLASS B	Enhancement: NONE
Date/Time of Offense: 05/22/2016 20:00	Place of Offense: UNIT 16	

Description of Offense:
On 5-22-2016 around 20:00 Inmate Edmo #94691 was visually inspected for new tattoos. It was reported that Edmo recently received touch up work on a neck tattoo. Upon inspecting Edmo for evidence of a fresh tattoo, it was discovered Edmo has swelling, scabbing and inflamed lines consistent with recent tattoo activity. Upon comparing Edmo's CIS photographs, the tattoo I discovered on 5-22-2016 was modified after the photo entered into CIS system dated 05-12-2015. The tattoo I discovered on 5-22-2016 was two roses on the left side of Edmo's neck.

Description of Evidence:
Two photographs dated 05-12-2015 and 05-22-2016

Reviewing Supervisor: HOUSE, STAN #2003	Date/Time Reviewed: 05/23/2016 06:00
Delivering Staff: EVANCHO, JOSEPH #1725	Date/Time Delivered: 05/23/2016 06:26
Staff Hearing Assistant:	Assistance:
Witness statements were received for this hearing:	Yes [ ] No [X]

Scheduled Hearing Date: 05/25/2016	Final Hearing Date: 05/25/2016	Disciplinary Hearing Officer: HINES, BRYAN W #8862
Offense: TATTOO OR PIERCING	Offender Plea: ADMIT	Finding: CONFIRM

Sanctions: COMMISSARY RESTRICTION	Amount: 45 day(s)	End Date: 07/09/2016

Interventions: NO RECORDS FOUND	End/Due Date:

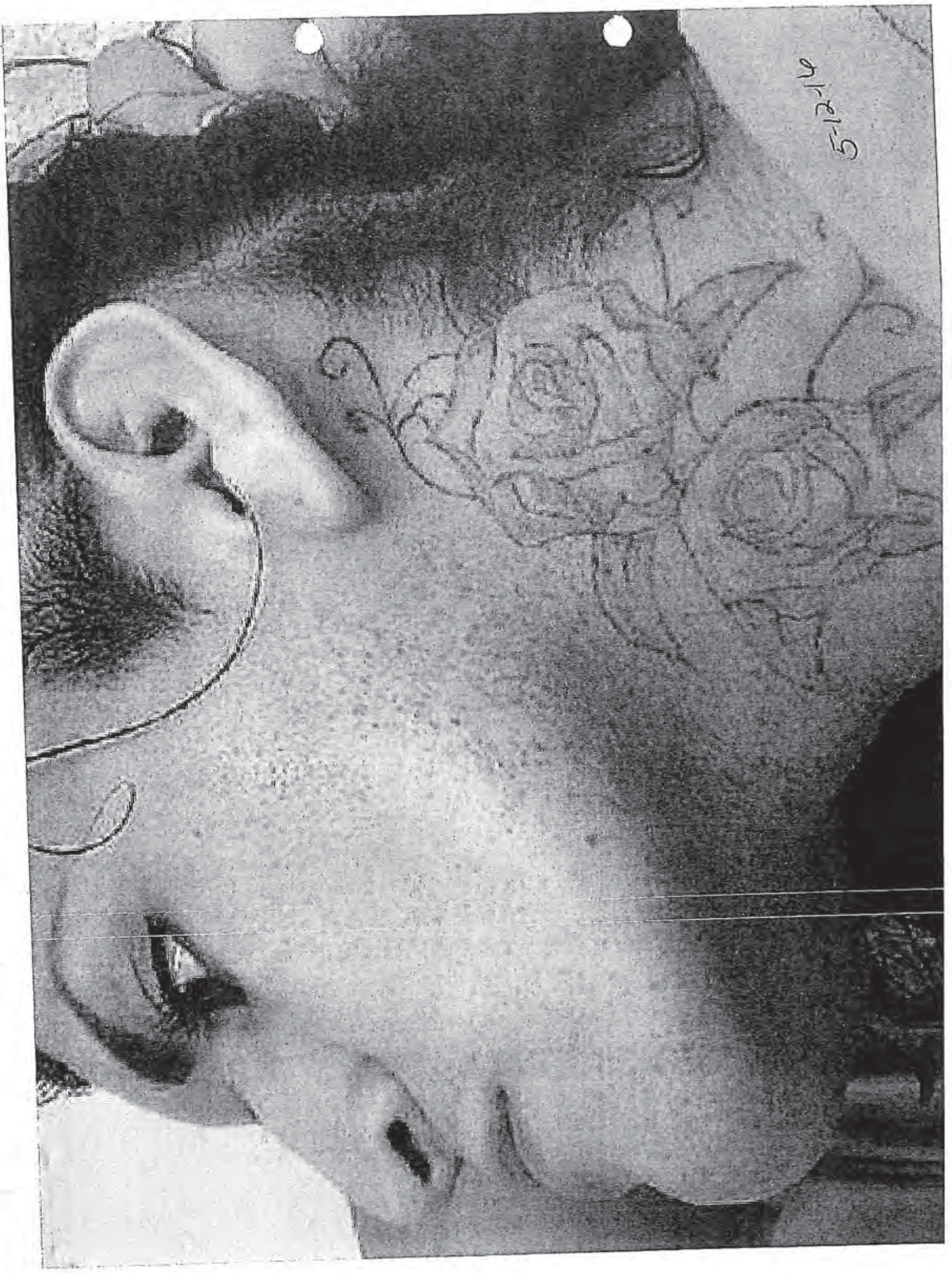
Administrative Review Authority: ROSENTHAL, TERRIE #3931	Review Date: 05/26/2016	Review Finding: AFFIRM

Appellate Authority: NO RECORDS FOUND	Appeal Date:	Finding Date:	Appellate Finding:

Date: 05/26/2016 14:17 Created By: trosenth

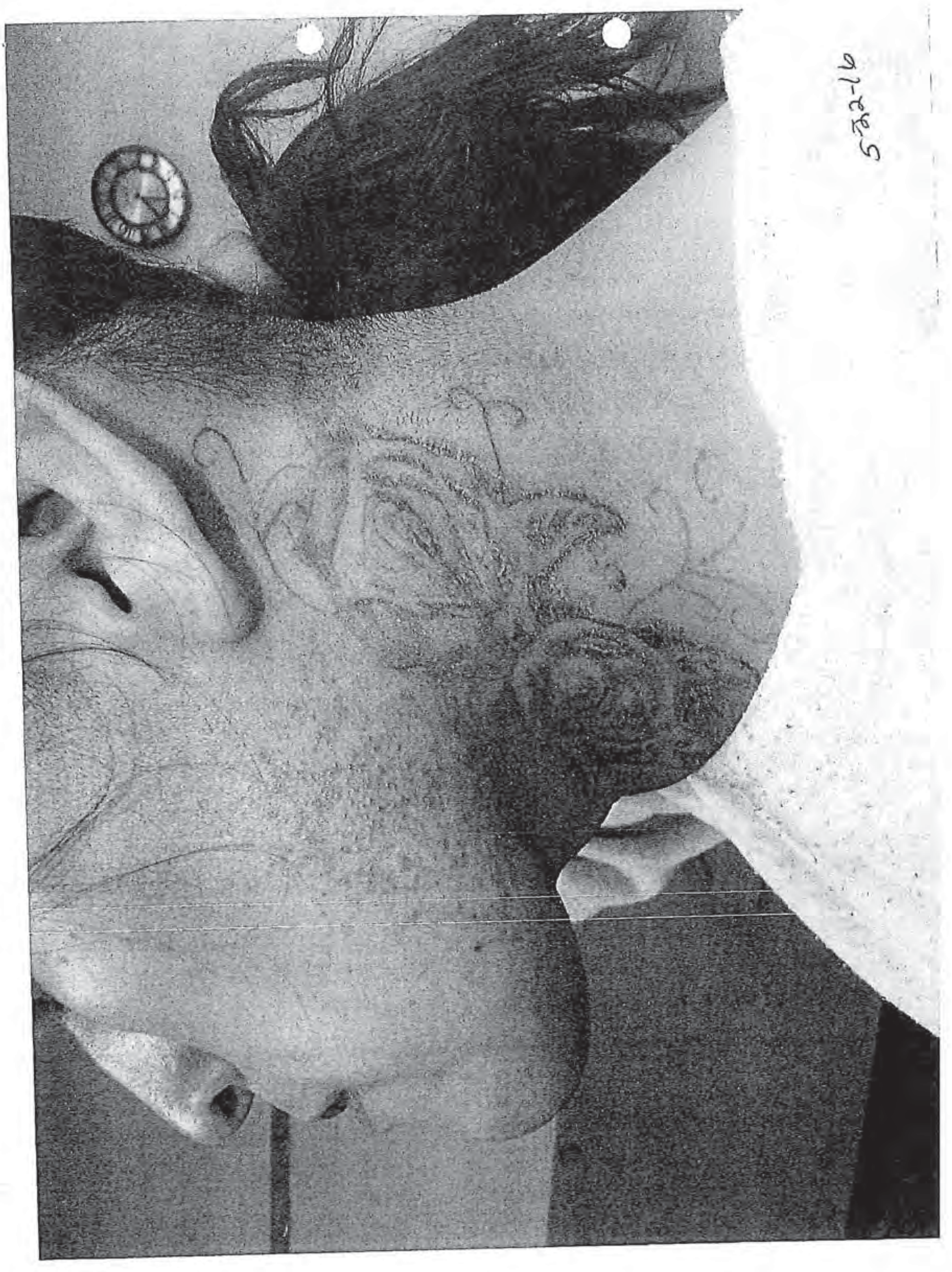
CIS/Facilities/Main/Discipline/Disciplinary Offense Report

EXHIBIT 5



IDOC_C_pg.45

EXHIBIT 5



IDOC_C_pg.46

EXHIBIT 5

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name: EDMO, MASON DEAN	Offender Number: 94691	DOR #: 164551
Offense Facility: ISCI	Report Date: 07/13/2016	Reporting Staff: LOMBARDI, BRIAN #6504
Offense: BATTERY	Class: CLASS B	Enhancement: NONE
Date/Time of Offense: 07/13/2016 12:18	Place of Offense: UNIT 16	

Description of Offense:
On 7-13-16 at 1218 I witnessed Edmo #94691 start striking another inmate in the face multiple times with a closed fist. Edmo was given direct orders to stop fighting and continued to throw the other Inmate on the floor. Once the other inmate was on the floor I witnessed Edmo kick the inmate in the face and head area multiple times. Once I approached Inmate Edmo stopped fighting and complied with orders.

Description of Evidence:

Reviewing Supervisor: HOUSE, STAN #2003	Date/Time Reviewed: 07/14/2016 06:00
Delivering Staff: ROMAN, RODOLFO NMI #1736	Date/Time Delivered: 07/14/2016 08:30
Staff Hearing Assistant:	Assistance:
Witness statements were received for this hearing:	Yes [ ] No [X]

Scheduled Hearing Date: 07/15/2016	Final Hearing Date: 07/15/2016	Disciplinary Hearing Officer: SEELY, COREY #9918
Offense: BATTERY	Offender Plea: ADMIT	Finding: CONFIRM

Sanctions:	Amount:	End Date:
DETENTION	10 day(s)	07/23/2016
RECREATION RESTRICTION	21 day(s)	08/05/2016

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority: ROSENTHAL, TERRIE #3931	Review Date: 07/18/2016	Review Finding: AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
NO RECORDS FOUND			

EXHIBIT 5

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

RECEIVED BY
... 24 2016
ISCI RECORDS

Offender Name: EDMO, MASON DEAN	Offender Number: 94691	DOR #: 164886
Offense Facility: ISCI	Report Date: 07/26/2016	Reporting Staff: SHERFEY, TYLER #A848
Offense: DESTRUCTION OF PROPERTY UNDER $25	Class: CLASS C	Enhancement: NONE
Date/Time of Offense: 07/26/2016 06:34	Place of Offense: LAUNDRY	

Description of Offense:
On 7/26/16 two bras and one pair of briefs came to laundry. All items had been altered by the cutting and removal of material and sewing to create patterns in the bra straps and to turn the briefs into thong underwear. The bra was tagged with Inmate Edmo's name and IDOC # and the sizes of all of the altered items matched clothing that Inmate Edmo was issued. It is apparent that these actions are deliberate because the cuts are clean as if a pair of scissors or another sharp instrument was used to cut the fabric. Also, the area and shape of the cuts are similar to a "V" neck and the back straps sewn together in a specific pattern. All of the items listed above are completely separate from the bra that was found on 7/14/16 also altered and tagged with Edmo's name and IDOC #. Because of the alteration of these items they are no longer suitable for use and will be discarded. The cost of two new bras is $7.14 and the cost of a pair of briefs is $1.02, therefore, $8.16 is being requested as restitution.

Description of Evidence:
Picture of damaged bras and briefs attached.

Reviewing Supervisor: HOUSE, STAN #2003	Date/Time Reviewed: 07/27/2016 06:00
Delivering Staff: ROMAN, RODOLFO NMI #1736	Date/Time Delivered: 07/27/2016 07:32
Staff Hearing Assistant:	Assistance:
Witness statements were received for this hearing:	Yes [ ] No [X]

Scheduled Hearing Date: 08/02/2016	Final Hearing Date: 08/02/2016	Disciplinary Hearing Officer: CHRISTON, BICK A #1379
Offense: DESTRUCTION OF PROPERTY UNDER $25	Offender Plea: DENY	Finding: CONFIRM

Sanctions:	Amount:	End Date:
RESTITUTION	$8.16	

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority: ROSENTHAL, TERRIE #3931	Review Date: 08/04/2016	Review Finding: AFFIRM

EXHIBIT 5

Appellate Authority: YORDY, HOWARD KEITH #3879	Appeal Date: 08/09/2016	Finding Date: 08/22/2016	Appellate Finding: AFFIRM

Offender Appeal Details:

This DOR should be dismissed and purged from my record because IDOC / Warden Yordy is deliberately indifferent to my serious medical condition of gender dysphoria by denying me female panties which are necessary and appropriate for my gender dysphoria symptoms. I would not have to modify my undergarments for additional support for tucking my testicles. I don't believe I should not have to pay the restitution of $8.16 without verifying that amount to receipts IDOC pays for such items. The receipt for such items was not in the DOR, therefore the restitution should be dismissed because no physical documentation was submitted.

Appellate Comments:

You clearly destroyed undergarments that had to be replaced. The cost of the items are what we pay for them and is reasonable restitution.

Warden Yordy

EXHIBIT 5

IDAHO DEPARTMENT OF CORRECTION
Offender Disciplinary Restitution Order

Offender Name: Edmo, Mason Offender #: 94691

Facility: ISCI Date of Offense: 7/26/16 DOR Number: 164886

It is hereby requested that the Idaho Department of Correction's Fiscal Unit garnish the offender's account until the restitution is paid in full. If the account balance does not cover full restitution, the remainder owed will be garnished at 50% of each deposit until the total cost of restitution is paid in full.

Type of Loss:

- ☒ Property Damage (IDOC or IDOC contract)
- ☐ Property Damage (other offender)
- ☐ Property Damage (private property)
- ☐ Property Damage (other government agency)
- ☐ Labor Cost (*non-IDOC agency)
- ☐ Theft (IDOC or IDOC contract)
- ☐ Theft (other offender)
- ☐ Theft (private party)
- ☐ Theft (other government agency)

Note: Restitution cannot be ordered for IDOC wages or overtime.
Restitution Amount: $8.16
Note: If the restitution is more than $250.00, it must be approved by the applicable division chief (or designee).

Description of damage or loss (type in cell below):
altered underwear

Method for determining restitution amount (type in cell below):
laundry clothing contract

Type of supporting documentation (type in cell below):
DOR

Party to be reimbursed if not IDOC or IDOC contract facility (type in cell below):

Note: Documentation must be attached to restitution order.

DHO: Sgt. B. Christon Associate Number: 1379 Date: 8/4/16

Email completed form to the department disciplinary coordinator (or designee).

Division Chief (or Designee's) Review

- ☐ Approved
- ☐ Denied
- ☐ Modified to _____

Division Chief (or Designee's) Signature Date

Note: After request is approved, denied, or modified, print; sign; convert to PDF, and return PDF via email to DHO. Mail original to records clerk at the offender's current facility to be attached to the *DOR* in the offender's central file.

Appendix H
318.02.01.001
(Appendix last updated 9/18/12)

EXHIBIT 5

IDAHO DEPARTMENT OF CORRECTION
Disciplinary Offense Report

Additional Staff Comments:

Based on the fact the items arrived together in laundry. The fact the bra had your name, and the sizes were all the same.

07/26/2016

Appendix C
318.02.01.001
(Appendix last updated 9/18/12)

EXHIBIT 5

IDAHO DEPARTMENT OF CORRECTION
Disciplinary Offense Report

Appendix C
318.02.01.001
(Appendix last updated 9/18/12)

EXHIBIT 5

9A-5A—

IDAHO DEPARTMENT OF CORRECTION
Disciplinary Offense Report

Name: Edmo Offender #: 94691 DOR # 164886

Offense Facility	Report Date	Reporting Staff
ISCI	7/26/16	SHERFEY #A848

Date	& Time of offense
7/26/16	0634

Offense	Place of Offense
Destruction of Property Under $25 C	ISCI LAUNDRY

Description of Offense (type in cell below):

On 7/26/16 two bras and one pair of briefs came to laundry. All items had been altered by the cutting and removal of material and sewing to create patterns in the bra straps and to turn the briefs into thong underwear. The bra was tagged with Inmate Edmo's name and IDOC # and the sizes of all of the altered items matched clothing that Inmate Edmo was issued. It is apparent that these actions are deliberate because the cuts are clean as if a pair of scissors or another sharp instrument was used to cut the fabric. Also, the area and shape of the cuts are similar to a "V" neck and the back straps sewn together in a specific pattern. All of the items listed above are completely separate from the bra that was found on 7/14/16 also altered and tagged with Edmo's name and IDOC #. Because of the alteration of these items they are no longer suitable for use and will be discarded. The cost of two new bras is $7.14 and the cost of a pair of briefs is $1.02, therefore, $8.16 is being requested as restitution.

Description of Evidence (type in cell below): Deny

Picture of damaged bras and briefs attached.

S. Hom #2083 — 7/27/16 0600

Reviewing Supervisor and Associate # (signature) — Date & Time Reviewed

Deliver Staff Steps. Ask the offender:

Do you want to request a staff hearing assistant?

Requested: Yes: ☐ No: ☑ Form Provided: Yes: ☐ No: ☐

Do you need witness statement forms? (Limit of 4 statements forms.)

Requested: Yes: ☐ No: ☑ Form(s) Provided: Yes: ☐ No: ☐ Number #: ☐

I hereby acknowledge receiving a copy of this DOR:

Edmo — 94691 7/27/16

Offender's signature — IDOC # & Date

[signature] 5474 — 27July2016 0732

Delivery Staff and Associate # (signature) — Date & Time Reviewed

Appendix C
318.02.01.001
(Appendix last updated 9/18/12)

Confirm
$8.16 restitution.

EXHIBIT 5

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

RECEIVED BY
DEC 0 5 2016
ISCI RECORDS

Offender Name: EDMO, MASON DEAN	Offender Number: 94691	DOR #: 167597
Offense Facility: ISCI	Report Date: 11/29/2016	Reporting Staff: DAVIS, KELSEY #B269
Offense: DESTRUCTION OF PROPERTY UNDER $25	Class: CLASS C	Enhancement: NONE
Date/Time of Offense: 11/28/2016 13:40	Place of Offense: UNIT 15	

Description of Offense:
On November 28, 2016 at approximately 1340 while conducting a cell search in cell 58, I found three green state underwear briefs that were altered into thongs. They were found in a grey storage bin that is given to the inmates to borrow from Unit 15 while in the Unit; which had Edmo's property in it.

Description of Evidence:
Pictures of destroyed, altered underwear.

Reviewing Supervisor: HOUSE, STAN #2003	Date/Time Reviewed: 11/29/2016 06:00
Delivering Staff: LARIOS, MICHAELA #1405	Date/Time Delivered: 11/29/2016 12:30
Staff Hearing Assistant:	Assistance:
Witness statements were received for this hearing:	Yes [ ] No [X]

Scheduled Hearing Date: 11/30/2016	Final Hearing Date: 11/30/2016	Disciplinary Hearing Officer: SEELY, COREY #9918
Offense: DESTRUCTION OF PROPERTY UNDER $25	Offender Plea: ADMIT	Finding: CONFIRM

Sanctions:	Amount:	End Date:
NO RECORDS FOUND		

Interventions:	End/Due Date:
DOR HEARING ITSELF	

Administrative Review Authority: ROSENTHAL, TERRIE #3931	Review Date: 12/01/2016	Review Finding: AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
NO RECORDS FOUND			

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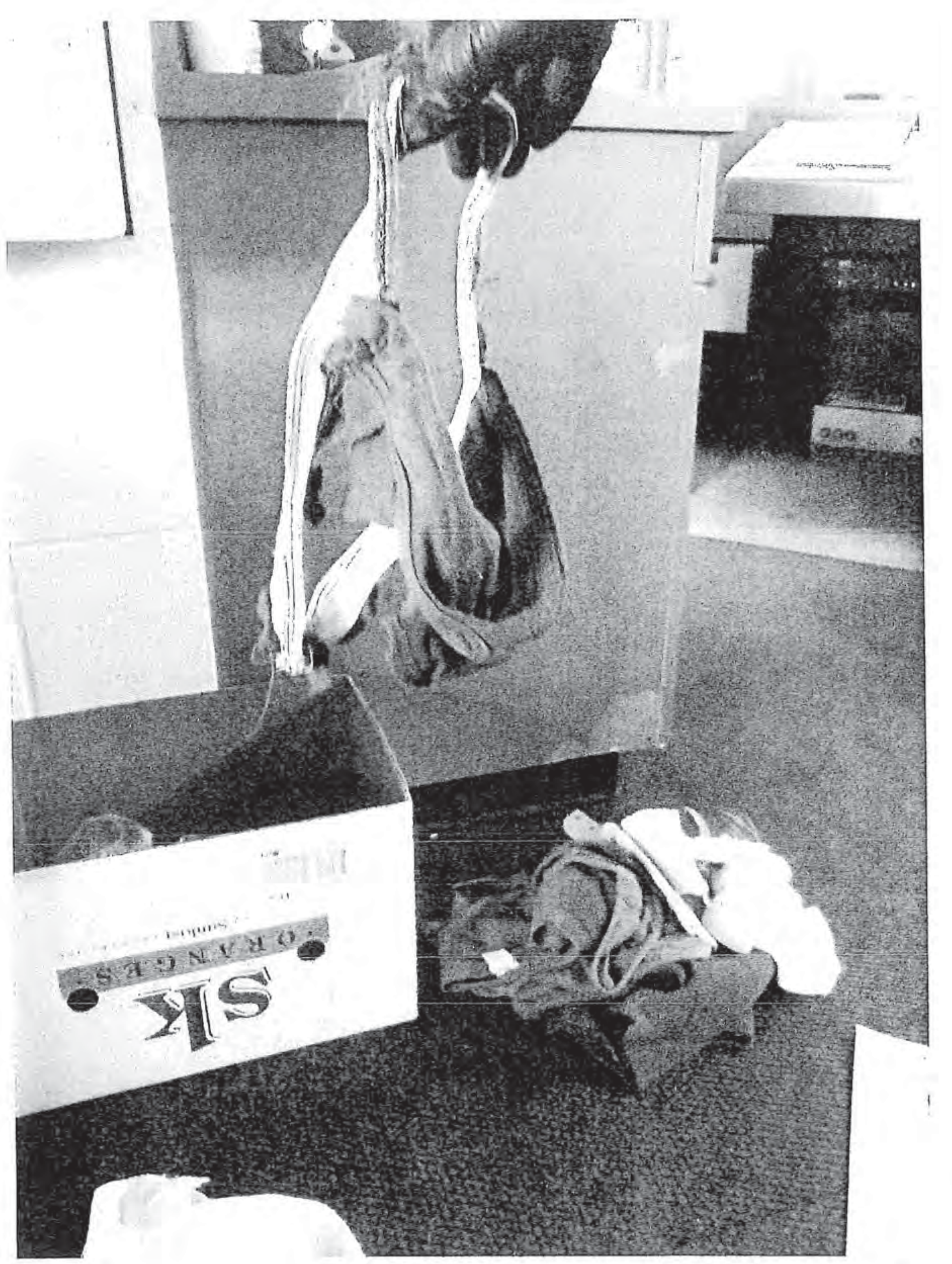
EXHIBIT 5



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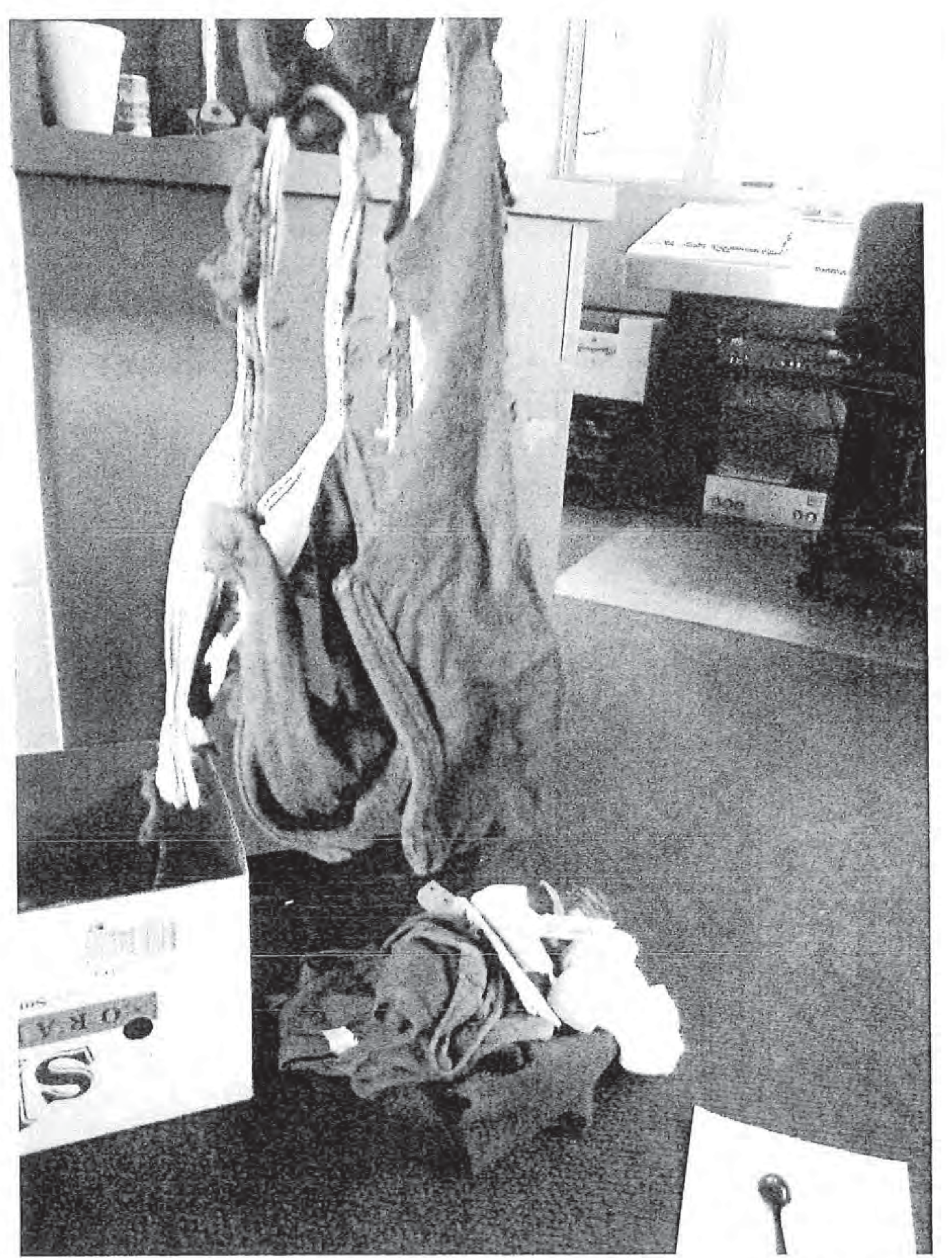

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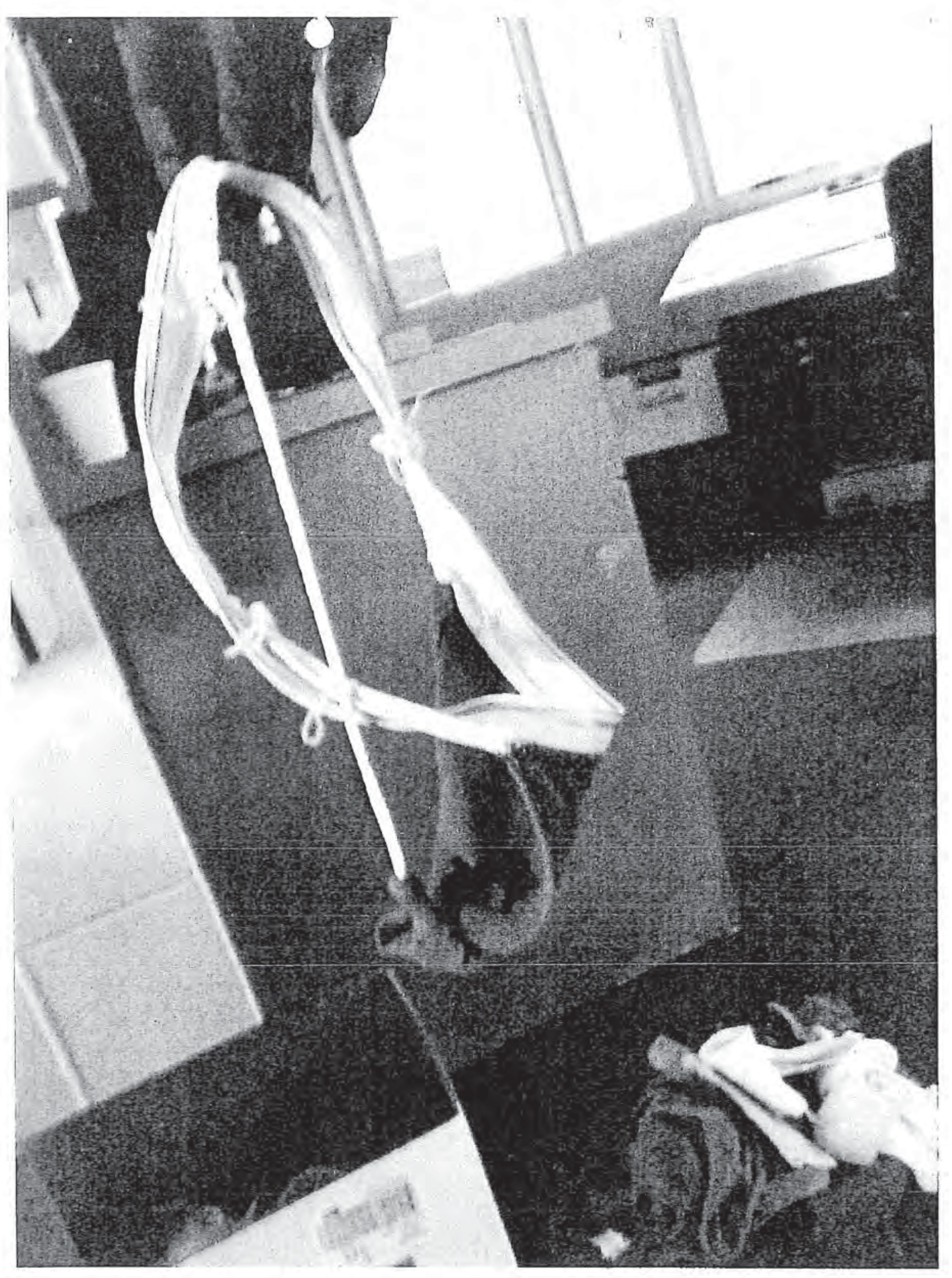


IDOC_C_pg.57

EXHIBIT 5

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name: EDMO, MASON DEAN	Offender Number: 94691	DOR #: 170267
Offense Facility: ISCI	Report Date: 01/09/2017	Reporting Staff: DAVIS, KELSEY #B269
Offense: SEXUAL ACTIVITY	Class: CLASS B	Enhancement: NONE
Date/Time of Offense: 01/09/2017 09:26	Place of Offense: UNIT 15	

Description of Offense:

On January 9, 2017 at approximately 0926 I was conducting a tier check on A tier of Unit 15. I was passing Cell 59 and saw inmate Edmo bouncing up and down on top of someone lying down on the bottom bunk. Edmo's bottom was covering the other inmates' torso. So it was basically Edmo sitting on a person's lap while they were lying down bouncing up and down but both parties were naked. As I got a hold of the door to open it I saw Edmo quickly slide to the side so the inmate under him could move and then Edmo covered his penis and laid flat on the bed looking at me.

Once the other inmate below Edmo got from under him I realized it was inmate who then attempted to bolt and hide up against the wall on the side of the toilet. So I had the door opened half way and looked over at and saw that his penis was wet and erect. Once realized that I saw everything he started to put on clothing along with Edmo. I called for Officer McCoy to assist me immediately on the tier. Once McCoy was on the tier and by my side I informed her of the situation and she escorted off the tier. I waited for Edmo to finish getting dressed and then escorted him off the tier as well. I questioned both inmates one at a time; asking if it was consensual. Both Edmo and stated that it was and then McCoy restrained escorting him to Unit 8. I restrained Edmo and also escorted him to Unit 8 where he was placed in a secure holding area. This was the end of my involvement. Pictures of Evidence will be attached to this form. End Of Report.

Description of Evidence:

Reviewing Supervisor: HOUSE, STAN #2003	Date/Time Reviewed: 01/10/2017 06:00
Delivering Staff: EVANCHO, JOSEPH #1725	Date/Time Delivered: 01/10/2017 10:08
Staff Hearing Assistant:	Assistance:
Witness statements were received for this hearing:	Yes [ ] No [X]

Scheduled Hearing Date: 01/12/2017	Final Hearing Date: 01/12/2017	Disciplinary Hearing Officer: SEELY, COREY #9918
Offense: SEXUAL ACTIVITY	Offender Plea: ADMIT	Finding: CONFIRM

Sanctions:	Amount:	End Date:
DETENTION	15 day(s)	01/24/2017
RECREATION RESTRICTION	30 day(s)	02/08/2017
NO CONTACT ORDER	90 day(s)	04/09/2017

Interventions:	End/Due Date:
NO RECORDS FOUND	

EXHIBIT 5

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	01/13/2017	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
NO RECORDS FOUND			

EXHIBIT 5

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name: EDMO, MASON DEAN	Offender Number: 94691	DOR #: 172212
Offense Facility: ISCI	Report Date: 04/09/2017	Reporting Staff: EVANCHO, JOSEPH #1725
Offense: FAILURE TO COMPLY WITH A DISCIPLINARY	Class: CLASS B	Enhancement: NONE
Date/Time of Offense: 04/09/2017 09:05	Place of Offense: MEDICAL (BLDG. 20)	

Description of Offense:

On April 9, 2017 at approximately 0905 while working response and escort I was in medical. I observed Inmate Edmo #94691 and Inmate sitting right next to each other on the last bench by the door. Their legs were almost touching each other. They were about one foot apart from each other violating the six foot separation they are supposed to keep. There were also other benches open for sitting. These inmates choose a bench all the way in the back by the brick wall sitting next to each other.

and Edmo have a no-contact order in place. They have violated the no-contact order by sitting next to each other in medical by not keeping the six foot barrier.

They also have been seen in recreation with each other violating the no contact order. They received a disciplinary offense report for violating the no-contact order on 2/3/2017. Also on 2/12/2017 they were observed in recreation with each other when it was not time to be in recreation with each other violating the no-contact order. disciplinary offense report for that was modified to outside authorized boundaries.

Also on 4/7/2017 and 4/8/2017 they were e-noted for sitting next to each other in chapel. For three days in a row these inmates violated their no contact order.

Even after medical staff collected their health services request and told them they could leave on 4/9/2017. They did not leave till staff was notified that there was a no-contact order in place and told both of them to return to their units.

Description of Evidence:

Reviewing Supervisor: HOUSE, STAN #2003	Date/Time Reviewed: 04/10/2017 06:00
Delivering Staff: FORURIA, JACOB #B703	Date/Time Delivered: 04/10/2017 08:40
Staff Hearing Assistant:	Assistance:
Witness statements were received for this hearing:	Yes [ ] No [ ]

Scheduled Hearing Date: 04/11/2017	Final Hearing Date: 04/11/2017	Disciplinary Hearing Officer: LEE, BENJAMIN K. #6103
Offense: FAILURE TO COMPLY WITH A DISCIPLINARY SANCTION-SECURE FACILITY	Offender Plea: DENY	Finding: CONFIRM

Sanctions:	Amount:	End Date:
RECREATION RESTRICTION	14 day(s)	04/25/2017
NO CONTACT ORDER	14 day(s)	04/25/2017

Interventions:	End/Due Date:
NO RECORDS FOUND	

EXHIBIT 5

Administrative Review Authority: COBURN, GARRETT #0455	Review Date: 04/12/2017	Review Finding: AFFIRM

Appellate Authority: YORDY, HOWARD KEITH #3879	Appeal Date: 04/15/2017	Finding Date:	Appellate Finding:

Offender Appeal Details:

I appeal this DOR for the following reason(s): The no-contact order given on 01/15/2017 for DOR # 170276, explicitly states "No contact order." "End date of 04/09/2017." The no contact order expired beginning 04/09/2017. Therefore, the DOR above should have not been issued. This is not within the "spirit" of SOP. Additionally, the sanctions for this DOR of an additional 14 days no contact is not within SOP directive #318. This directive explicitly states a maximum limit for no contact of 90 days. This additional 14 days would then make the no contact order 104 days. As, such, I request this DOR dismissed and purged from my offender file pursuant to directive #318. And / or any modifications you deem necessary. Thank you.

Appellate Comments:

EXHIBIT 5

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name: EDMO, MASON DEAN	Offender Number: 94691	DOR #: 177663
Offense Facility: ISCI	Report Date: 12/03/2017	Reporting Staff: LOVELACE, BRIAN #C468
Offense: DESTRUCTION OF PROPERTY UNDER $25	Class: CLASS C	Enhancement: NONE
Date/Time of Offense: 12/03/2017 20:15	Place of Offense: UNIT 15	

Description of Offense:
On December 3, 2017 at 2015 while conducting a cell search in cell 31 on Alpha Tier, I found three green state underwear briefs that were altered into thongs, three orange cloth thongs made from some unknown cloth. They were found in a hobby craft box under the bunk with Edmo's name on it.

Description of Evidence:
Photo's attached.

Reviewing Supervisor: HOUSE, STAN #2003	Date/Time Reviewed: 12/04/2017 06:00
Delivering Staff: THOMPSON, RYAN #5420	Date/Time Delivered: 12/04/2017 06:43
Staff Hearing Assistant:	Assistance:
Witness statements were received for this hearing:	Yes [ ] No [X]

Scheduled Hearing Date: 12/05/2017	Final Hearing Date: 12/05/2017	Disciplinary Hearing Officer: SEELY, COREY #9918
Offense: DESTRUCTION OF PROPERTY UNDER $25	Offender Plea: DENY	Finding: CONFIRM

Sanctions:	Amount:	End Date:
RECREATION RESTRICTION	7 day(s)	12/12/2017

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority: ROSENTHAL, TERRIE #3931	Review Date: 12/08/2017	Review Finding: AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
YORDY, HOWARD KEITH #3879	12/11/2017	12/29/2017	AFFIRM

Offender Appeal Details:

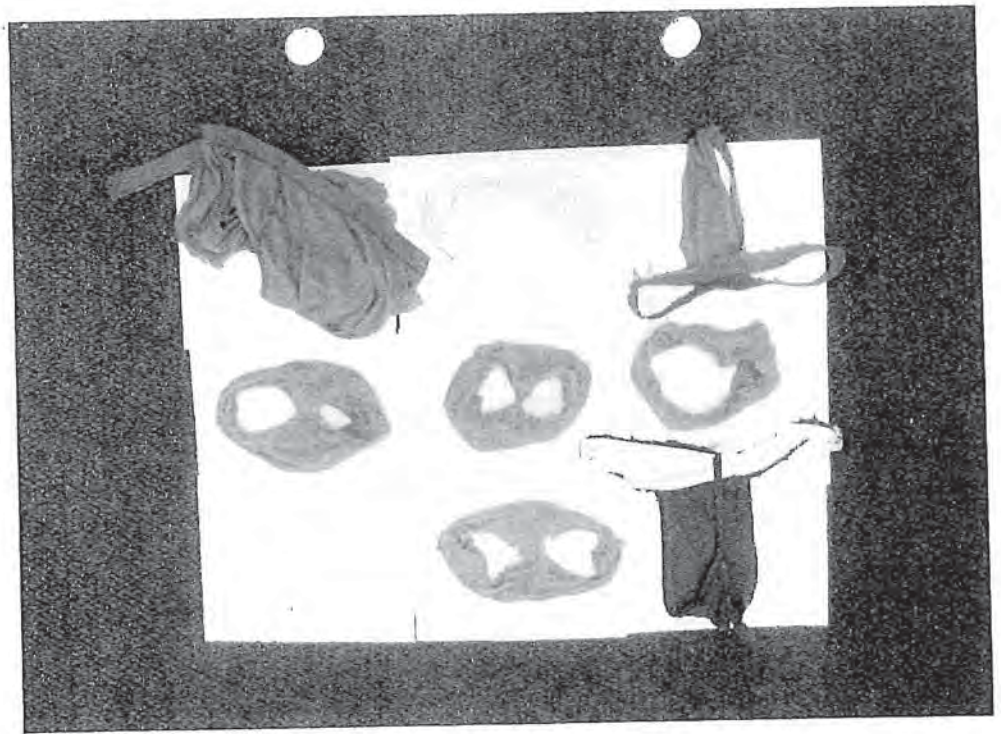
I appeal this DOR and request it removed from my file based on the fact that C/O Lovelace knew and knows I am a inmate suffering from gender dysphoria. This DOR should be removed/appealed because IDOC knows and has known that I've requested to have women's panties that provide the support of my damaged testicles and a more snug fit also while providing support to my mental health of giving me a better ego syntonic state of mind of becoming female/ These exact type of DOR's as this one are examples of sex discrimination prohibited by the 14th amendment, also it is unlawful to discriminate against people like me

EXHIBIT 5

who have gender dysphoria pursuant to American w? Disabilities Act, and section 504 [illegible] Rehab Act.

Appellate Comments: The DOR is affirmed because you know you're not authorized to alter property regardless of the reasons. If there is a medical need for such underwear, it will be provided. You will never be allowed to undertake that on your own. Staff should and will continue to hold you accountable. Warden Yordy

EXHIBIT 5



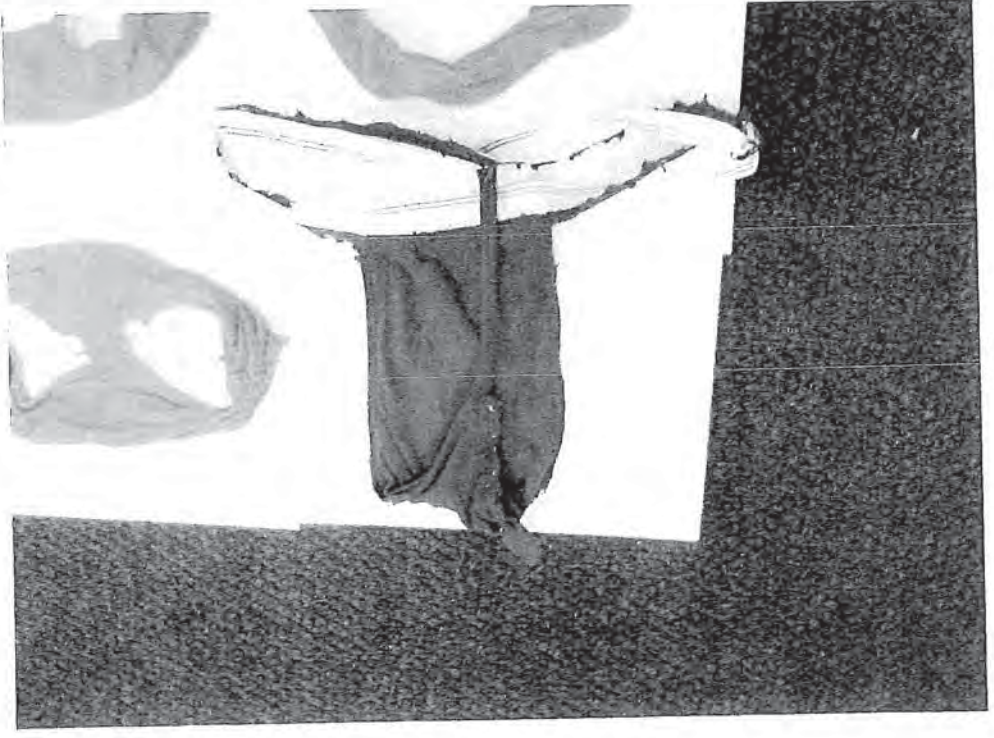


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EXHIBIT 5

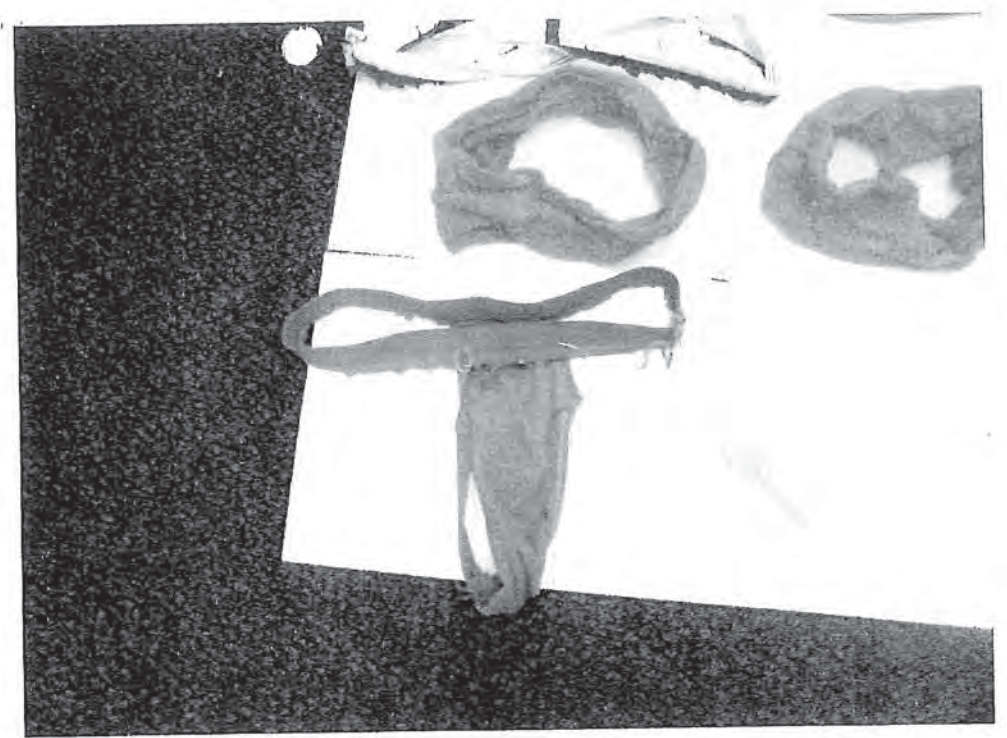

EXHIBIT 5

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name: EDMO, MASON DEAN	Offender Number: 94691	DOR #: 181563
Offense Facility: ICC	Report Date: 03/14/2018	Reporting Staff: ADAMS, JENNIFER #B362
Offense: UNAUTHORIZED COMMUNICATION LEVEL 2	Class: CLASS C	Enhancement: NONE
Date/Time of Offense: 03/14/2018 11:45	Place of Offense: OTHER	

Description of Offense:
On 03/14/18 I, Officer Adams intercepted a letter from Offender to Offender Edmo #94691.This letter was addressed to but was intended to be forwarded to Edmo. In the contents of the letter I was able to determine that this was unauthorized communication. In one part of the letter it says "8230we will never be in the same institution" and "My last message I got from you was on the 7th of March." I was able to do a search on JPay and I found that these two offenders are currently using a customer: as a middle person to pass message and photos between the two offenders, often and beginning January of 2018. is the mother of and was verified through his approved visitors.
In the contents of multiple messages, it implies that these two offenders are married and intend on continuing a relationship.

Description of Evidence:
JPay photos attached.

Reviewing Supervisor: PURCELL, MARGARET #9611	Date/Time Reviewed: 03/14/2018 15:25
Delivering Staff: EVANCHO, JOSEPH #1725	Date/Time Delivered: 03/14/2018 16:45
Staff Hearing Assistant:	Assistance:
Witness statements were received for this hearing:	Yes [ ] No [X]

Scheduled Hearing Date: 03/17/2018	Final Hearing Date: 03/17/2018	Disciplinary Hearing Officer: WAY, MARK #0721
Offense: UNAUTHORIZED COMMUNICATION LEVEL 2	Offender Plea: DENY	Finding: CONFIRM

Sanctions:	Amount:	End Date:
NO RECORDS FOUND		

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority: CASTLETON, MATHEL #5841	Review Date: 03/19/2018	Review Finding: AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
NO RECORDS FOUND			

Date: 03/22/2018 07:20 Created By: ayann Page 1 of 1
CIS/Facilities/Main/Discipline/Disciplinary Offense Report

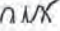

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EXHIBIT 5

Letter ID JPMSL 392746528

Inmate Name : MASON EDMO
Inmate ID : 94691
Housing : ISCI UNIT 11 POD 00-B
Date : 03/11/2018 6:10PM EST
Customer :
Customer ID : 16484162
Word(s) Found :
Attachment(s) :

I
Re
Rel

Yes the email was, I need your address info because I have a letter for you from

<< BACK

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EXHIBIT 5

Customer Information

Name:
Account ID:
Street:
City:
State:
Country:
ZipCode:
Phone Number
Cell Number:
Email:
Member Since: 04/23/2016 7:03PM EST

Export To File

No deposits were found for this user.

Media Transfers (from customer to inmate account)

Page 1 of 1

Date	Location	TransID	Inmate ID	Inmate Name	Amount	Type	Media Type
03/22/2017	ISCI				$20.00	Credit Card	JPayDollar

Letters Sent
Page 1 of 27

		Date	Letter ID	Inmate ID	Inmate Name	Location	View	IP Address	Delet By Inma
		03/14/2018	393910392	94691	MASON EDMO	ISCI	View	99.203.128.206	
		03/13/2018				ICC	View	174.255.8.87	

EXHIBIT 5

Letter ID JPMSL 390733767

Inmate Name : MASON EDMO

Inmate ID : 94691

Housing : ISCI UNIT 11 POD 00-B

Date : 03/06/2018 7:22PM EST

Customer :

Customer ID : 16484162

Word(s) Found :

Attachment(s) :

Snap 'n Send

<< BACK

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EXHIBIT 6

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	184729
Offense Facility: ISCI	Report Date: 07/24/2018	Reporting Staff: WATKINS, JOBY #8537
Offense: THEFT OVER $25	Class: CLASS B	Enhancement: NONE
Date/Time of Offense: 07/01/2018 07:26	Place of Offense: OTHER	

Description of Offense:
On 7/20/2018 I concluded an investigation into Jpay theft that began on 6/21/2018.Through this investigation I determined that the above offender exploited a defect in the programming of the Jpay system. This exploitation was done on the dates of: 6/25/18, 6/30/18, 7/01/18, . Through the course of the exploitation on the above dates, the above offender received a stolen amount of Jpay media funds to the sum of $886.67. Jpay was able to retrieve $652.25 of the funds that were obtained fraudulently.

Description of Evidence:
Negative Purchases report from Jpay

Reviewing Supervisor:	Date/Time Reviewed:
NIMMO, ADAM W #6163	07/24/2018 17:10
Delivering Staff: EVANCHO, JOSEPH #1725	Date/Time Delivered: 07/24/2018 20:25
Staff Hearing Assistant:	Assistance:
Witness statements were received for this hearing:	Yes [ ] No [X]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
08/03/2018	08/03/2018	RAMIREZ, SABINO J #5917
Offense: THEFT OVER $25	Offender Plea: DENY	Finding: CONFIRM

Sanctions:	Amount:	End Date:
PROPERTY RESTRICTION	60 day(s)	10/02/2018
COMMISSARY RESTRICTION	60 day(s)	10/02/2018
HOBBYCRAFT RESTRICTION	180 day(s)	01/29/2019
WORK RESTRICTION	180 day(s)	01/29/2019

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority:	Review Date:	Review Finding:
CASTLETON, MATHEL #5841	08/06/2018	AFFIRM

EXHIBIT 6

Appellate Authority: YORDY, HOWARD (KEITH) #3879	Appeal Date: 08/06/2018	Finding Date:	Appellate Finding:

Offender Appeal Details:

6/19/18 IDOC Check #743091 for $80 was applied to my media acc't; 7/05/18 $5 was also added to my media acct. A total of $85 was incorrectly added into the "negative purchases reports from Jpay" totaling $886.67. 8/02/18 Sgt. Ramirez calculated alleged stolen $886.67 subtracted $652.25, amount allegedly recovered, equaling $234.42. My jPay media acc't states $-234.12, a different amount. The fact that the two amounts reported in my DOR due not reflect the amount listed on my acc't as a negative dollar amount, shows an inaccurate false report, furthermore the DOR was not heard within the 7 day time limit as required by SOP with no notification form sent to me. I request this DOR dismissed in it's entirety, including the sanctions immediately. (DOR & W/D form attached)

Appellate Comments:

J. Kevin West, ISB #3337
Email: KWest@parsonsbehle.com
Dylan A. Eaton, ISB #7686
Email: DEaton@parsonsbehle.com
Parsons, Behle & Latimer
800 W. Main Street, Suite 1300
Boise, Idaho 83702
Telephone: (208) 562-4900
Facsimile: (208) 562-4901

Counsel for Defendants Corizon Inc., Scott Eliason, Murray Young, and Catherine Whinnery

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ADREE EDMO, Plaintiff, v. IDAHO DEPARTMENT OF CORRECTION; HENRY ATENCIO, in his official capacity; JEFF ZMUDA, in his official capacity; HOWARD KEITH YORDY, in his official and individual capacities; CORIZON, INC.; SCOTT ELIASON; MURRAY YOUNG; RICHARD CRAIG; RONA SIEGERT; CATHERINE WHINNERY; AND DOES 1-15; Defendants.	CIVIL ACTION FILE NO. 1:17-cv-151-BLW **CORIZON DEFENDANTS' RESPONSE TO PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION AND MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT THEREOF**

COME NOW Defendants, Corizon Inc., Scott Eliason, Murray Young, and Catherine Whinnery ("Corizon Defendants"), by and through their counsel of record, Parsons Behle &

As recent as this year, Plaintiff has not been cooperative with her providers and their recommended treatment, including refusing to meet with her assigned clinician and refusing to attend recommended mental health groups. (*See* Declaration of Dylan A. Eaton, Exhibit A, expert report of Keelin Garvey, M.D., CCHP ("Dr. Garvey Report"), p. 42.)

B. Plaintiff's history before prison.

Plaintiff claims in her declaration and to her experts that she lived full time as a woman prior to being incarcerated. However, Plaintiff has presented no evidence that she was living full time as a female prior to incarceration and she did not disclose such in her Pre-Sentencing Investigation reports that were presented to the Court before she was sentenced on her current crime. Her medical and mental health care records prior to incarceration are also silent regarding any references to her appearing to live like a female. Plaintiff 's inconsistency regarding how she lived pre-incarceration is significant for many reasons. Among other reasons, living as a female for a significant period of time (such as a year) is often one of several important criteria or factors before SRS is indicated.

Plaintiff also has a long history of mental health disorders, including major depression, anxiety, alcohol use disorder, stimulant use disorder, and opioid use disorder. (Dr. Garvey Report, pp. 19-20.)

IV. PRELIMINARY INJUCTION STANDARD

Under the Prison Litigation Reform Act ("PLRA"):

> In any civil action with respect to prison conditions, to the extent otherwise authorized by law, the court may enter a temporary restraining order or an order for preliminary injunctive relief. 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.

18 U.S.C. § 3626(a)(2).

"A plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Winter v. Natural Resources Defense Council, Inc.,* 555 U.S. 7, 20, 129 S.Ct. 365, 172 L.Ed.2d 249 (2008). "[S]erious questions going to the merits and a balance of hardships that tips sharply towards the plaintiff can support issuance of a preliminary injunction, so long as the plaintiff also shows that there is a likelihood of irreparable injury and that the injunction is in the public interest." *Alliance for the Wild Rockies v. Cottrell,* 632 F.3d 1127, 1135 (9th Cir.2011) (internal quotation marks omitted).

"A preliminary injunction is an extraordinary remedy never awarded as of right." *Winter,* 555 U.S. at 24, 129 S.Ct. 365. It may take two forms. "A prohibitory injunction prohibits a party from taking action and preserves the status quo pending a determination of the action on the merits." *Marlyn Nutraceuticals, Inc. v. Mucos Pharma GmbH & Co.,* 571 F.3d 873, 878 (9th Cir.2009) (internal alterations and quotation marks omitted). A mandatory injunction orders a party to take action. *Id.* at 879. Because a mandatory injunction "goes well beyond simply maintaining the status quo pendente lite [it] is particularly disfavored." *Id.* (internal alterations omitted). "In general, **mandatory injunctions 'are not granted unless extreme or very serious damage will result and are not issued in doubtful cases** or where the injury complained of is capable of compensation in damages.' " *Id.* (quoting *Anderson v. United States,* 612 F.2d 1112, 1115 (9th Cir.1979)) (emphasis added).

V. ANALYSIS

A. Plaintiff is Unlikely to Succeed on the Merits

i. Corizon Defendants are Not Deliberately Indifferent

1. Deliberate Indifference Standard

"[D]eliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain' proscribed by the Eighth Amendment." *Estelle v. Gamble,* 429 U.S. 97, 104, 97 S.Ct. 285, 50 L.Ed.2d 251 (1976) (internal citation omitted). Such indifference may be "manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed." *Id.* In the Ninth Circuit, a plaintiff alleging deliberate indifference must first "show a serious medical need by demonstrating that failure to treat a prisoner's condition could result in further significant injury or the unnecessary and wanton infliction of pain." *Jett v. Penner,* 439 F.3d 1091, 1096 (9th Cir.2006) (citing *Estelle,* 429 U.S. at 104, 97 S.Ct. 285) (internal quotation marks omitted). Second, she "must show the defendant's response to the need was deliberately indifferent." *1186 *Id.* This second prong "is satisfied by showing (a) a purposeful act or failure to respond to a prisoner's pain or possible medical need and (b) harm caused by the indifference." *Id.* An inadvertent or negligent failure to provide adequate medical care does not suffice to state a claim under Section 1983. *Estelle,* 429 U.S. at 105–06, 97 S.Ct. 285. "Medical malpractice does not become a constitutional violation merely because the victim is a prisoner." *Id.* at 106, 97 S.Ct. 285. Moreover, mere indifference, medical malpractice, or negligence will not support a cause of action under the Eighth Amendment. *Broughton v. Cutter Labs*., 622 F.2d 458, 460 (9th Cir.1980) (per curiam).

Additionally, there is no vicarious liability in 1983 actions. *See Monell v. Dept. of Social Services,* 436 U.S. 658, 98 S.Ct. 2018, 56 L.Ed.2d 611 (1978); *Bonner v. Lewis,* 857 F.2d 559, 565 (9th Cir.1988) (doctrine of *respondeat superior* is not applicable in prisoner's claim against Director of Arizona Department of Corrections). To assert a § 1983 claim against a private entity, such as Corizon, Plaintiff must meet the test articulated in *Monell v. Department of Social Services,* 436 U.S. 658, 690–94, 98 S.Ct. 2018, 56 L.Ed.2d 611 (1978); *see also Tsao v. Desert Palace, Inc.,* 698 F.3d 1128, 1139 (9th Cir. 2012) (applying *Monell* to private entities). Under *Monell,* the requisite elements of a § 1983 claim against a municipality or private entity performing a state function are the following: (1) the plaintiff was deprived of a constitutional right; (2) the municipality or entity had a policy or custom; (3) the policy or custom amounted to deliberate indifference to the plaintiff's constitutional right; and (4) the policy or custom was the moving force behind the constitutional violation. *Mabe v. San Bernardino Cnty.,* 237 F.3d 1101, 1110–11 (9th Cir.2001).

To create liability, an unwritten policy or custom must be so "persistent and widespread" that it constitutes a "permanent and well settled" practice. *Monell,* 436 U.S. at 691, 98 S.Ct. 2018 (quoting *Adickes v. S.H. Kress & Co.,* 398 U.S. 144, 167–168, 90 S.Ct. 1598, 26 L.Ed.2d 142 (1970)). "Liability for improper custom may not be predicated on isolated or sporadic incidents; it must be founded upon practices of sufficient duration, frequency and consistency that the conduct has become a traditional method of carrying out policy." *Trevino v. Gates,* 99 F.3d 911, 918 (9th Cir.1996). Further, a municipality or private entity performing a state function "may be held liable under § 1983 when the individual who committed the constitutional tort was an official with final policy-making authority or such an official ratified a subordinate's unconstitutional decision or

action and the basis for it." *Clouthier v. County of Contra Costa,* 591 F.3d 1232, 1250 (9th Cir.2010).

2. Analysis

Plaintiff focuses solely on the World Professional Association for Transgender Health (WPATH) manual in an attempt to establish the standards of care for treating individuals with Gender Dysphoria, including for SRS. While WPATH is one resource that practitioners can consider when treating GD patients, it does not establish the applicable standard of care. Indeed, some providers consult with WPATH guidelines and others have created their own criteria and requirements for surgery, which they think are best suited for their patients. WPATH even recognizes that its guidelines should be flexible. Further, as an example, the evidence, trials and peer reviews are low or non-existent in supporting WPATH guidelines, especially as to incarcerated individuals. (Dr. Garvey's Report, pp. 27-30; 40-42.) The cases cited by Plaintiff's counsel that relied on WPATH standards did not address these deficiencies. Accordingly, Corizon Defendants dispute that the WPATH establishes the applicable standard of care in treating GD patients and, more specifically, in treating Plaintiff. WPATH is no substitute for clinical judgment.

Corizon Defendants do not contest that Plaintiff has Gender Dysphoria. Corizon's psychologist, Dr. Lake, and its psychiatrist, Defendant Dr. Eliason, appropriately evaluated Plaintiff and determined in 2012 that Plaintiff had Gender Identity Disorder (now called Gender Dysphoria). Corizon's expert also opines that Plaintiff has Gender Dysphoria. (Dr. Garvey Report, pp. 17-18.)

Contrary to Plaintiff's representations, however, Corizon Defendants provided appropriate care and treatment to Plaintiff for her Gender Dysphoria. Plaintiff was quickly assessed and diagnosed with GD and then timely started receiving hormone therapy. The hormone therapy

VI. CONCLUSION

The facts and law will show that Corizon Defendants have properly treated and cared for Plaintiff and her Gender Dysphoria and that Plaintiff's Motion for Preliminary Injunction should be denied.

DATED this 14th day of September, 2018.

PARSONS BEHLE & LATIMER

By: *\/s/ Dylan A. Eaton*
Dylan A. Eaton
Counsel for Defendants Corizon Inc.,
Scott Eliason, Murray Young, and
Catherine Whinnery

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 14th day of September, 2018, I filed the foregoing electronically through the CM/ECF system, which caused the following parties or counsel to be served by electronic means, as more fully reflected on the Notice of Electronic Filing:

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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ADREE EDMO, Plaintiff, v. IDAHO DEPARTMENT OF CORRECTION; HENRY ATENCIO, in his official capacity; JEFF ZMUDA, in his official capacity; HOWARD KEITH YORDY, in his official and individual capacities; CORIZON, INC.; SCOTT ELIASON; MURRAY YOUNG; RICHARD CRAIG; RONA SIEGERT; CATHERINE WHINNERY; AND DOES 1-15; Defendants.	CIVIL ACTION FILE NO. 1:17-cv-151-BLW **DECLARATION OF DYLAN A. EATON**

I, Dylan A. Eaton, declare as follows:

1. I am more than eighteen years of age and I am legally competent to make this declaration. I have personal knowledge of the facts set forth herein, and can testify as to the truth

of the statements contained herein if called upon as a witness at the trial of this action.

2. I am duly licensed to practice law in the State of Idaho and before this Court. I am an attorney of record for Defendants Corizon Inc., Scott Eliason, Murray Young, and Catherine Whinnery in the above-referenced action.

3. Attached hereto as Exhibit A is a true and correct copy of the expert report prepared by Keelin Garvey, MD, CCHP.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

DATED this 14th day of September, 2018.

/s/ Dylan A. Eaton
Dylan A. Eaton

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 14th day of September, 2018, I filed the foregoing electronically through the CM/ECF system, which caused the following parties or counsel to be served by electronic means, as more fully reflected on the Notice of Electronic Filing:

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By: */s/ Dylan A. Eaton*
Dylan A. Eaton

EXHIBIT A

KEELIN GARVEY, MD, CCHP

August 31, 2018

Dylan A. Eaton
Parsons Behle & Latimer
800 West Main Street, Suite 1300
Boise, Idaho 83702

Re: *Edmo v. Corizon, et al.*
PBL File No. 20382.116

Dear Mr. Eaton:

At your request, I performed a psychiatric evaluation and reviewed mental health, medical and security records and associated legal filings for the purpose of providing an opinion on Corizon providers' treatment of inmate Adree Edmo since she has been in the custody of the Idaho Department of Correction (IDOC), and on the medical necessity of Gender Confirmation Surgery (GCS, also referred to as Sex Reassignment Surgery or SRS). In forming my opinion, I considered the following sources of information:

1. Clinical Interview with Ms. Adree Edmo on 08/10/2018 at Idaho State Correctional Institution (ISCI) , for two hours and 35 minutes; (audio-recorded)
2. Second Amended Complaint;
3. Corizon Medical Records (Corizon 0001-1599);
4. IDOC Standard Operating Procedure 401.06.03.501: Gender Identity Disorder: Healthcare for Offenders with;
5. IDOC Management Treatment Committee (MTC) and Administrative Review Committee (ARC) files pertaining to Ms. Edmo;
6. Plaintiff's Expert Disclosure (includes Ryan Gorton, MD and Randi Ettner, Ph.D.'s Declarations);
7. Plaintiff's Motion for Preliminary Injunction (and corresponding pleadings);
8. Plaintiff's responses to IDOC's Interrogatories;
9. Plaintiff's responses to IDOC's Requests for Production of Documents;
10. Plaintiff's corresponding document production (AE 0001-0153);
11. Plaintiff's responses to Corizon's Interrogatories;
12. Plaintiff's responses to Corizon's Requests for Production of Documents;
13. Plaintiff's corresponding document production (AE 0154-0593);
14. IDOC's responses to Edmo's Requests for Production of Documents;
15. IDOC's corresponding document production;
16. IDOC's supplemental responses to Edmo's Requests for Production of Documents;
17. IDOC's corresponding document production, including:
    a. Presentence Report dated 11/19/2009, authored by Nicole Osborn;
    b. Addendum to the Presentence Investigation dated 06/01/2010, authored by Keith Greenwalt;
    c. Presentence Report dated 11/23/2011, authored by Nicole Osborn;

   d. Psychosexual Evaluation dated 11/14/2011, authored by Dr. Linda Hatzenbuehler, Ph.D.;
   e. Bannock County Sheriff's Office Detail Incident Report dated 06/29/2011;
   f. Sho Ban Tribe Records, dated 11/26/2003 through 05/24/2011;
   g. Indian Health Services Records, dated 06/02/2008 through 06/01/2011;
   h. Portneuf Medical Center Records, dated 08/05/2010 through 08/07/2010 and 05/15/2011 through 05/19/2011;
   i. Bannock County Jail Records, dated 08/21/2011 through 04/18/2012;

18. Corizon's responses to Plaintiff's Requests for Production;
19. Corizon's corresponding document production;
20. PBL 1449-1498 Dr. Alviso PowerPoint;
21. PBL 1499-1521 Handout with Alviso PowerPoint: Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline, published in the Journal of Clinical Endocrinology and Metabolism in September 2009;
22. PBL 1522-1720 Handout with Alviso PowerPoint: Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People, published by the Center for Excellence for Transgender health in June 2016.

<u>Qualifications:</u>

1. I am a physician, licensed in the states of Massachusetts, Rhode Island, Pennsylvania, Minnesota, Arizona, Florida, Texas and California. I am board certified in general adult psychiatry and in forensic psychiatry. I earned my Doctor of Medicine (M.D.) degree at the University of Massachusetts Medical School in 2005. I completed a general psychiatry residency at Brown University in 2009, serving as Chief Resident during my fourth year. I completed a forensic psychiatry fellowship at the University of California, Davis, in 2010.
2. The majority of my career has been spent providing direct psychiatric care to inmates and detainees within correctional systems. I have provided psychiatric care to inmates and detainees within the states of Rhode Island, California, and Massachusetts. I was given administrative and supervisory responsibilities as the Deputy Medical Director for psychiatric services within the Massachusetts Department of Correction (MADOC) in 2011, and served as the Chief Psychiatrist for this system from 2015-2017. I am currently employed by InnovaTel Telepsychiatry as the Medical Director for Correctional and Forensic Psychiatry. My opinions in this case are my own, and are provided outside of my role with InnovaTel.
3. I provided direct psychiatric treatment to multiple inmates with Gender Identity Disorder/Gender Dysphoria within MADOC between 2010 and 2015.
4. I began performing evaluations of inmates with gender concerns within MADOC in 2013, presenting my findings to the Gender Identity Disorder Supervision Group.
5. I became Chair of the Gender Dysphoria Treatment Committee within MADOC in August of 2015 and continued in this role until I departed MADOC in August of 2017. In this role, I evaluated every individual entering or already in the custody of MADOC who reported gender identity concerns and/or gender dysphoria, for the purposes of diagnostic clarification and treatment planning. During this time period, I evaluated over

30 incarcerated individuals with reported gender issues. In collaboration with other policy-specified members of the Gender Dysphoria Treatment Committee, I formally considered the treatment requests and clinicians' recommendations for all established and newly diagnosed gender dysphoric individuals within MADOC, and made referrals to outside specialists for specific treatments I deemed medically necessary. These referrals included endocrinology consultation from Dr. Joshua Safer at Boston Medical Center, and dermatology consultation when individuals expressed severe dysphoria related to facial hair. The treatment committee also discussed the medical necessity of gender confirmation surgery on a case-by-case basis.

6. I have provided psychiatric treatment to individuals with Gender Dysphoria in the community, including at an outpatient mental health center and at a partial hospital program.
7. I attended a WPATH-sponsored conference entitled "Transgender Health: Best Practices in Medical and Mental Health Care" in Atlanta, Georgia in January 2016.
8. I have given formal lectures on the subject of treating and evaluating Gender Dysphoria in the correctional environment at three different national conferences: The National Commission on Correctional Health Care (NCCHC) in Boston, MA, in July of 2016; The American Academy of Psychiatry and the Law (AAPL) in Denver, CO, in October of 2017, and at the American Correctional Association (ACA) in Minneapolis, MN in August of 2018. I have also provided numerous trainings on Gender Dysphoria to mental health and medical staff within MADOC, and have given a lecture on Gender Dysphoria in the correctional system as part of the Brown University forensic fellowship didactic series.
9. I received monthly formal consultation from Dr. Stephen B. Levine, chairperson of the 5th version of the Harry Benjamin International Gender Dysphoria Association's (HBIGDA- now known as WPATH) Standards of Care, from July 2015 through August 2017, plus additional extended in-person training.
10. I have attended lectures by other presenters on the topic of Gender Dysphoria in the correctional environment at various conferences.

<u>Publications during the last 10 years:</u>

Articles:

1. Garvey K**,** Penn J, Campbell A, Esposito-Smythers C, Spirito A. Contracting for Safety with Patients: Clinical Practice and Forensic Implications. *Journal of the American Academy of Psychiatry and the Law 37(3): 2009.*
2. Recupero P, Price M, Garvey K, Daly B, Xavier S. Restraint and seclusion in psychiatric treatment settings: regulation, case law, and risk management. *Journal of the American Academy of Psychiatry and the Law 39(4): 2011.*

Book Chapter:

Garvey K, Newring K, Parham R, Pinals D (2013). The Roles and Limitations of Evidence-Based Psychotherapy in Correctional Settings, Volume II. In O. Thienhaus & M. Piasecki (Eds.), *Correctional Psychiatry Practice Guidelines and Strategies* (pp. 1-1 to 1-29). Kingston, NJ: Civic Research Institute.

Compensation:
I am compensated $600.00 per hour of time spent on this case, including reviewing records, research, performing examinations, interviews/contact with collateral sources, preparing reports, consulting with attorneys, phone calls, travel time, preparing for depositions and testimony, depositions, and testifying in court. For portions of the case that require driving more than two hours or 100 miles total in one work day, or require air travel, I receive a flat rate of $6000 per calendar day plus travel expenses.

Psychiatric Evaluation, 08/10/2018
I performed an Independent Medical Examination on Adree Edmo on 08/10/2018. I met with Ms. Edmo in a private attorney room within the visiting room of ISCI for approximately two hours and 35 minutes. Ms. Edmo was offered the opportunity to take a break at any time during the interview but did not choose to do so. Jacqueline Franolich, a paralegal representing the law firm of Stoel Rives, LLP, was present for the entire evaluation but did not participate in the interview. The interview was audio-recorded. Prior to beginning the evaluation, Ms. Edmo was advised that I am a psychiatrist retained by Corizon defense counsel for the purpose of conducting an Independent Medical Examination pertaining to her litigation against several Corizon healthcare providers. I explained to Ms. Edmo that the content of our evaluation would not be confidential and that I would be submitting a report to the court based on my findings. I also explained that I was not entering a doctor-patient relationship with Ms. Edmo and would not be providing direct treatment to her. I informed her that I would be asking many questions, and that she was welcome to decline answering a question at any time. Ms. Edmo stated her understanding of this and agreed to proceed with the interview.

At the time of our evaluation, Ms. Edmo listed her current medications as:
Estradiol 4 mg BID
Spironolactone 50 mg BID
Calcium Carbonate 1250 mg daily
Finasteride 10 mg daily
Vit B complex with biotin
Effexor XR 450 mg daily (Note: it appears that this dose was actually decreased on 05/18/2018)

Social History:
Ms. Edmo reported that she was born in Pocatello, Idaho, and raised on the Fort Hall Indian Reservation. She said she was the youngest of four siblings until another half-sister on her father's side was born two and a half years ago. She indicated that all of her siblings are half-siblings and that she does not have any full-siblings. Ms. Edmo told me that she grew up with two older sisters and one older brother. She reported that her parents were married, but divorced when she was about nine or ten years old. She described her childhood as "stable, to a point." She said that her family had all of the necessities but described the environment as "not nurturing." She explained that her mother was her primary caretaker, but also worked a lot in human resources for the tribal business department, and at a local casino. Ms. Edmo reported that her father worked as an autobody mechanic prior to his parents' divorce. She recalled seeing her parents drink to intoxication on a regular basis, and indicated that both had alcohol

and drug problems. She said that her parents are both still living; her mother lives in Pocatello and she has not had any contact with her father for 10-11 years.

Ms. Edmo described her relationships with her siblings growing up as “good.” Her brother was the oldest, and she was closest to the younger of her two older sisters. She said that they were all one to two years apart in age. She indicated that she has regular contact with the closer of her two sisters, but speaks with her brother and other sister only “here and there” now. Ms. Edmo reported that her family was very active in traditional religious practices on the reservation, and well-connected to her community.

Ms. Edmo reported that she attended elementary school at the Native American school on her reservation. She was not certain on the exact timing, but said that she transferred off the reservation to public school in early adolescence, for middle school and high school. She described her experience at the Native American school as “pretty positive,” but she was unable to recall what grades she received at that time. She stated that her transition into the public school system was “different,” and that she experienced “a lot of bias toward me” due to presenting as “feminine” and due to her Native American heritage. She said that she was not bullied physically but received many “snide comments” aimed in her direction. She reported that she was the first of her siblings to attend public school, as the rest of them had finished school on the reservation. She reported never having required special education services.

After her early difficulties fitting in at public school, Ms. Edmo said that things improved for her socially in high school. Ms. Edmo indicated that some of her old friends from the reservation transferred to public school at that time, and she was able to expand her social network and feel more accepted. She recalled earning B’s and C’s in her classes. Despite this reported adjustment, Ms. Edmo said that she opted to drop out of school in the 12th grade and complete a GED immediately thereafter, explaining that this actually resulted in her completing her schooling one year earlier than expected. When asked why she chose to stop going to school, Ms. Edmo indicated that she “wanted to get out of the house.” At that time, her siblings had all moved out and she was living with only her mother. She said that she had a “good” relationship with her mother at that time and there was no conflict; she felt “ready to start my own life.”

Ms. Edmo reported that she began working for the Indian Health Service as a contract health representative soon after high school. She eventually moved to Pocatello and lived in an apartment with a friend. She described this time period, from about 2005-2010, as a “good time” in her life, but also reported that she had begun to drink alcohol and use drugs by that time. She said that her drug and alcohol use became heavy at the end of this time period, and she began “bouncing around” between Idaho, Utah and Washington state, going “wherever the drugs were.” She stated, “I lost everything.” Ms. Edmo said that she did not have any clean/sober time prior to her arrest in 2009.

<u>Abuse History:</u>

Ms. Edmo described her home life as “not nurturing,” describing some elements of emotional neglect, but reported she had never been physically or sexually abused by anyone in her

immediate family. She told me that when she was nine or ten years old, she was sexually abused repeatedly over the course of one year by a 16 year old male cousin. Ms. Edmo said that she had never reported this abuse to anyone until 2012, when she told her mother. (Note: Ms. Edmo's records indicate that she has also reported sexual abuse by a stepbrother).

Substance Abuse History:

Ms. Edmo reported that she was raised in a home with significant alcohol and drug use, and witnessed her parents becoming intoxicated frequently when she was very young. She recalled that her own substance abuse began with alcohol around age 16. Initially, she drank 1-2 nights per week, always on weekends and in the context of partying with her friends, up to five to ten beers at a time. Ms. Edmo reported that she eventually began drinking every day, from around age 19 to 22. She said that her drinking lessened as she got further into her drug addiction and began replacing alcohol with drug use. She could not clearly recall the volume of alcohol she drank on a daily basis when drinking daily. She said that she last drank in 2011, prior to her incarceration.

Ms. Edmo indicated that she began smoking methamphetamines at age 18, and started injecting it soon thereafter. She reported that she used methamphetamines daily until age 22, stopping when she was incarcerated. She reported no use of methamphetamines since prior to her incarceration.

Ms. Edmo said that she began using opioids at age 19, initially in the form of oral opioids but progressing quickly to intravenous use as she had already been injecting methamphetamines at that time. Ms. Edmo reported her last use of heroin took place in 2011, before her incarceration.

Ms. Edmo stated that she experienced significant withdrawal symptoms when she first entered Bannock County Jail on her current charges. Her symptoms included headache, nausea, hot and cold sweats, and stomach cramps. She said that she has never gone to an inpatient facility for detoxification or rehabilitation from alcohol or drugs.

Ms. Edmo reported that she tried marijuana "a couple of times" around age 16, but never used it regularly. She reported no other use of illicit drugs or abuse of prescription medications. Ms. Edmo indicated that she was a lifetime nonsmoker and that she had never abused any substances while incarcerated. She acknowledged occasional cravings for drugs and said that these are triggered by seeing needles and having blood drawn.

Legal History:

Ms. Edmo reported that her controlling offense is sexual abuse of a minor under age 16. She indicated that she was detained on this charge on 07/11/2011 at Bannock County Jail. She said that she pleaded guilty and was sentenced in December 2011, and transferred to state prison (ISCI) in April of 2012. Ms. Edmo reported that this charge is related to sexual activity with a 16-year-old male peer she met at a house party when she was 21 years old. She said that they were both drinking and using methamphetamines, and that she does not remember much

about the incident. She reported that she has never been sexually attracted to children or prepubescent adolescents. She was asked about current sex offender treatment requirements and said that she is not required to complete any further programming prior to release in 2021, and that she is not sure if she has to register as a sex offender upon release. Of note, Ms. Edmo's records appear to indicate that she will be required to register as a sex offender upon release.

Ms. Edmo reported a history of four misdemeanor DUI charges, at age 16, 18 and two at age 19. She indicated that prior to the controlling offense, she had also been convicted on fraud and forgery charges related to writing checks from a closed account, which she attributed to her drug addiction at that time. Ms. Edmo said that she served six months in a diversion program at North Idaho Correctional Institution, which she believes to be a medium security men's prison. She indicated that she was released on "felony probation" for three years after completion of that program. Ms. Edmo reported that she was charged with violating this probation in 2011 in addition to her new felony charge of sexual abuse of a minor under age 16.

Ms. Edmo reported that she went before the parole board in 2014 and was given an "automatic open date" that included release on parole pending completion of her substance abuse and sex offender treatment programs. She stated that she was soon "kicked out" of both programs, however, due to a physical altercation with a gender dysphoric peer. She indicated that she was told at that time that she would see the parole board again one year after this fight and subsequent release from programs. Ms. Edmo said that she then got into a second physical altercation with the same peer, and subsequently received a letter from the parole board indicating that she would not be considered for parole again, and would instead have to serve her sentence to its completion date on 07/03/2021.

Work History:

Ms. Edmo reported she got her first job at age 17 as a representative for the Indian Health Service. She said that she stayed in this job for about six or seven months, and then became a floor attendant at a casino for a year. She indicated that she also worked as a legal secretary and as a cashier at a casino. She reported that she worked consistently up until her drug and alcohol use became heavier around age 19 or 20. She said that she had never received Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI).

Ms. Edmo indicated that she received her first prison job approximately six months prior to our evaluation, taking work orders for prison manufacturing. She said that she worked at that job until the week prior to our interview, when approximately 80% of the workers in this division were reportedly terminated due to evidence that someone was tampering with accounts. She stated that she hoped to return to this position once the investigation is complete.

Relationship History:

Ms. Edmo reported that she has always been exclusive attracted to males, and has never been attracted to or involved with a female. She recalled having had about three serious relationships during her life, beginning with her first relationship at age 16, with a 17 year old

male peer. She described this relationship as "not very intimate … emotionally intimate but not physically." When asked why they were not physically intimate, Ms. Edmo explained that they were more interested in "living like teenagers," and that she believed they were sexually active "I think a couple times." Ms. Edmo indicated that this partner identified as a heterosexual male attracted to women, and that this relationship lasted for about one year.

Ms. Edmo said that she was next in a serious relationship from age 20 to 22, with a man named Brady whom she had known in high school. She indicated that this relationship began at a time when she was heavily involved in drug and alcohol addiction, and that Brady was also abusing substances. Ms. Edmo reported that Brady was extremely physically abusive toward her. She described incidents in which Brady would punch, kick, and hit her, resulting in numerous criminal charges. Ms. Edmo said that this relationship lasted for about two and a half years despite this abuse. When asked why she stayed with Brady, Ms. Edmo replied, "Codependency, drug abuse, depression." She said that this relationship eventually ended when she was placed in the diversion program following her fraud and forgery charges.

Ms. Edmo reported that her current relationship, with a man named Jordan, began in 2016 while they were both incarcerated. She reported having known Jordan since prior to her incarceration. She indicated that her relationship with Jordan has been a very supportive one. She said that they were legally married on 12/27/2017. Ms. Edmo reported that Jordan had been released from prison and out in the community for six months, but later returned on a probation or parole violation and is now incarcerated again in a different facility. She said that she is not allowed to have contact with Jordan currently, but is pursuing approval for inmate-to-inmate contact through letters. Ms. Edmo indicated that she has regular contact with Jordan's mother, who is supportive of their relationship.

<u>Past Psychiatric History:</u>
Ms. Edmo reported a history of depression since childhood, but said that she did not seek mental health treatment until age 21 or 22. When asked why she did not seek treatment earlier, she ascribed it to a lack of health and mental health resources on her reservation rather than stigma associated with mental health treatment. She said that her depression began when she started to feel "different" from her siblings in early childhood. She reported feeling more similar to her sisters than her brother. Ms. Edmo indicated that this progressed to more significant depressed feelings when she transferred to public school and became more aware of the differences between herself and her peers. She discussed the lack of stigma associated with variance in gender expression on her Indian reservation as compared with the general population, stating that her depression worsened when she began to spend time with peers who were not Native American. When asked specifically about neurovegetative symptoms associated with depression, Ms. Edmo endorsed changes in sleep, appetite and concentration when she is depressed.

Ms. Edmo also reported a long history of intermittent suicidal ideation, beginning around age 15. She said that she had attempted suicide with lethal intent on three occasions. She described the first attempt as an intentional overdose on pills in 2009, during the time when she was

addicted to alcohol and multiple drugs. She recalled, "I believe they pumped my stomach and I was released after that." She indicated that she was not psychiatrically hospitalized at that time. Ms. Edmo reported a second suicide attempt occurring in 2010, again by overdose on pills. She said that after that attempt, she was referred to a Behavioral Health Unit in Pocatello, at the Portneuf Medical Center. She indicated that she was held for three days for "observation and evaluation," but was not committed. She stated, "I checked myself out" and was not prescribed any psychiatric medication. Ms. Edmo said that her third and most recent attempt was in early 2011, by "cutting my arm open all the way through," requiring 20-30 sutures. She recalled that she was committed to the Behavioral Health Unit at Portneuf Medical Center at that time, staying for one to two weeks. She stated she believes she was prescribed sertraline (Zoloft) and "something else," but she did not continue to take these upon release. Ms. Edmo indicated that these were her only two inpatient psychiatric admissions.

Ms. Edmo was asked whether she had ever received outpatient treatment of any kind, including by a primary care physician, prior to prison. She said that she had never received any kind of mental health or psychiatric treatment and had never had a psychiatric evaluation prior to her incarceration. She indicated that she did not see a primary care physician in the community prior to this either.

Ms. Edmo reported no other incidents of attempted suicide, but said that in 2014 while at Idaho Correctional Institution-Orofino (ICIO) she contemplated hanging herself due to "just gender dysphoria and a really bad episode of depression." She indicated that she did not tell anyone that she was contemplating hanging, but her cellmate became concerned about a change in her behavior and reported this to mental health staff, who placed Ms. Edmo on a suicide watch. She said that she never attempted to hang herself.

Ms. Edmo also reported several incidents of self-harm that did not involve suicidal intent. Ms. Edmo said that the first such incident occurred in September 2015, when she cut the right side of her scrotum with a razor blade due to "depression and gender dysphoria." She stated her intent behind this action as "to castrate my testicles" and thereby stop the production of testosterone in her body. Ms. Edmo reported that she planned this incident for about four days and did not tell anyone she was going to do it. When asked how this plan developed, she stated, "I had researched it a little bit" on the internet. She indicated that she was treated onsite with sutures and placed on a suicide watch in the behavioral health unit of ISCI for about ten days. Ms. Edmo also reported a second incident of attempting to cut off her testicles, occurring on 12/31/2016. She explained, "I cut open the same side and pulled the testicle through." She recalled that she stopped when she could no longer see what she was doing due to significant bleeding. She said that she used legally-acquired disposable razors to cut her testicles during both of these incidents. Ms. Edmo indicated that on the second occasion, in December 2016, she was taken to St. Alphonsus Regional Medical Center by emergency medical technicians, where a urologist repaired her scrotum. She said that upon return from the hospital, she spent one week in the medical infirmary and was subsequently returned to general population.

Ms. Edmo reported that she began cutting the inside of her wrists in early 2017. She described feelings of "mental anguish" prior to cutting, and "a release of the mental anguish" when she cuts. She denied suicidal intent behind this cutting behavior. Ms. Edmo said that as of the time of our interview, she had last cut herself approximately one month earlier.

Ms. Edmo was asked about a history or current symptoms of anxiety. She endorsed "a constant feeling of anticipation, like something is about to happen," lasting up to two hours at a time, associated with physical experiences including "my heart beats fast, body gets warm, breathing more heavy." She reported this happens at random and is not associated with any clear precipitants or triggers.

Ms. Edmo reported that she was severely physically abused by her boyfriend Brady prior to incarceration. She endorsed flashbacks of this abuse occurring since that time. When asked if she experiences nightmares or flashbacks of her childhood sexual abuse, Ms. Edmo stated that she was not currently experiencing these. She indicated that around 2010, she began to experience a heightened startle response and feelings of hypervigilance in her environment. When asked if she believes her abuse history affects her current relationships, Ms. Edmo responded affirmatively.

Ms. Edmo described her current depression, at the time of this evaluation, as "not being able to enjoy everything, not being interested in anything, feeling a sense of unworthiness, not seeing everything in a positive light; everything is a dread." She expressed her belief that this is due to "a combination of the depression and gender dysphoria." When asked specifically, she indicated that she experiences both; depression unrelated to gender and depression directly related to her gender dysphoria.

Ms. Edmo reported that she had never experienced auditory or visual hallucinations or any other perceptual disturbances. She was asked about a variety of delusional beliefs and did not endorse any of these beliefs, and did not make any statements indicative of past or current delusional beliefs. She did not report or endorse any past episodes of mania.

Family History:

Ms. Edmo reported that her mother has depression, and her sister had depression or possibly bipolar disorder. She said that neither had ever been psychiatrically hospitalized. Ms. Edmo reported that a third cousin had just completed suicide the week before our evaluation. This cousin had been abusing drugs and alcohol.

Ms. Edmo indicated that her mother takes some kind of blood-thinning medication for uncertain reasons, and is obese. She said both of her grandmothers had diabetes.

Gender Identity History:

Ms. Edmo reported that she has always identified with her older sisters more than with her older brother. She recalled feeling closest to the younger of her two older sisters when growing up, playing Barbies and dress-up together. She indicated that she can recall these behaviors

occurring since at least age five. She described her older brother, who was four years older than her, as "more protective than oppressive … because he knew … I think he knew that I was different." She added that her brother was "more like a stern protector."

Ms. Edmo reported that she began wearing her sisters' clothing, to include dresses and feminine shirts, around age five. She said that her mother and grandmother were her primary caregivers at that time and "were not opposed to it … letting me do what I do," and that they did not force him to wear more masculine clothing. She recalled having dressed in female clothing "here and there" until about age nine, when she began wearing female clothing more consistently. Prior to age nine, she said that she still wore her own more masculine clothing outside of the house most often. She indicated that she had always hung around with female peer groups, and had never had any close male friends, adding, "I was just considered one of them." Despite her reported difficulties fitting in at public school initially, Ms. Edmo indicated that she eventually developed strong female peer groups in high school as well and felt accepted by her female friends as "one of them." Ms. Edmo described her preferred style of dress as feminine jeans and shirts. She indicated that she had never really liked wearing dresses, which she indicated were not her style. She said that she began wearing makeup at age 15, initially consisting of mascara and foundation, and later progressing to other kinds of eye makeup.

Ms. Edmo reported that after high school, her style of dress and grooming "stayed the same," which included dressing in women's clothing and wearing makeup, but that she became "more into the whole female presentation" as she got older. She said that she began wearing female underpants and bras and brought breast prostheses around age 18 or 19. She indicated that she still dressed somewhat masculine on occasion, providing example of wearing "a shirt and sweats" if she was hungover. She reported that she wore "solid basic colors" including a lot of black feminine clothing to work at her Indian Health Services job at that time. She indicated that she went to a salon for facial hair waxing and eyebrow grooming while in the community.

Ms. Edmo was asked about her preferred hairstyle. She said that she had always had long hair, since childhood. She was asked if she had ever had short hair and stated she had not. Ms. Edmo was asked again whether she had ever had short hair and replied, "They made me shave my head" at the diversion program she attended in 2009. She added that had she pointed out her Native American heritage she would have been allowed to keep her long hair, but stated, "They thought I was Mexican" and she was forced to shave it. When asked how she felt about having short hair, she stated, "It was different … a lot more convenient."

When asked about her bathroom preferences, Ms. Edmo indicated that she had been sitting down to urinate since childhood. When asked which bathroom she used when out in public, she stated "it depended."

Ms. Edmo stated that she first became aware that she was different from her sisters when they went through puberty and developed feminine sex characteristics. She described it as "kind of depressing" to learn that she was not going to develop the way they were; that her masculine

features would only become more masculine. Ms. Edmo reported that she had never used her penis for sexual activity. She stated that she had never used it to penetrate a partner, and that she did not use her penis for masturbation. She was asked to elaborate on how she feels about her penis, and stated, "It's gross." She said she began to feel this way around age 15, and that "it's gotten worse." She reported thinking about her penis and testicles "constantly." She was asked about other parts of her body that she wants to change and indicated that she is primarily focused on being rid of her penis and testicles and having a vagina.

Ms. Edmo reported that her family and Native American community did not question or condemn her feminized appearance and behavior. She said that her mother asked her if she liked girls when she was about 14 years old, and she told her mother she did not. She indicated that her mother accepted this readily.

Ms. Edmo was asked whether she had ever sought or received treatment for gender dysphoria prior to her incarceration. She reported that she did not understand what it meant to be transgender until she entered county jail on the controlling charge and met a transgender woman. She recalled having been "labeled as a gay man" previously, explaining that this did not completely resonate with her but she did not know there was an alternative explanation to how she felt. She recalled knowing bisexual and homosexual peers, but never anyone else who identified as transgender. She stated that she remembered feminized men on her Indian Reservation, but she never spoke to them about their gender identity and now realizes they may have been transgender.

Ms. Edmo indicated that a transgender detainee at Bannock County Jail befriended her in 2011 and advised her to seek contact with mental health professionals and physicians at the jail so she could request cross-gender hormone treatment. She said that prior to meeting this individual, she did not really know what it meant to be transgender, and had never heard of cross-gender therapy. However, at another point in the interview she reported that she had started to discuss her gender identity with a correctional professional at the diversion program in 2009 but that she had been told "just not to mention it," so she never brought it up again. Ms. Edmo reported that she received minimal psychiatric care while in county jail awaiting transfer to state prison, so elected to wait until she got to state prison to discuss her gender identity. She was asked if she had had or sought contact with any outside agencies, penpals, etc. prior to seeking an evaluation of her gender issues, and she said she had not.

<u>Past and current GD treatment</u>

Regarding her current treatment, Ms. Edmo reported that she was diagnosed with Gender Identity Disorder in July 2012 by Dr. Lake, and started hormone therapy in September 2012, with estrogen and spironolactone. She indicated that the hormone therapy "helped me mentally … more a clearing of my mind," explaining that she felt like her thinking became clearer. She listed physical changes including weight loss, breast growth, a decrease in skin oiliness, a change in body odor, and changes in fat distribution. She said that the mental changes began about six months into hormone treatment, and the physical changes happened

over the course of a year. She indicated that she stopped noticing any further changes about one year prior to our appointment.

Ms. Edmo reported that she first saw gender dysphoria consultant Dr. Alviso in December 2015, and sees him annually. She said that the first time she saw Dr. Alviso, he increased her estrogen dose, continued spironolactone, and started progesterone. She indicated that this did not result in much additional change, other than "like a mental clearness" and modest additional breast growth. She reported having experienced weight gain and fatigue from the medroxyprogesterone so she stopped this medication by her own choice. She was asked about her experience with spironolactone including her history of elevated liver function tests. She reported that she had been restarted on spironolactone in mid-June 2018 and felt "a lot better," with a decrease in skin oiliness and "gritty" sensation she experienced when not taking it.

When asked about her current level of satisfaction with her gender dysphoria treatment, Ms. Edmo replied, "I feel it's maintenance … for me I feel like I've hit the most I'll ever get from the hormones." She reported feeling "content" but not satisfied with her response to hormone therapy, stating, "I think the treatment plan I'm on now … it's pretty much the same as I would get outside of prison." She clarified that she was referring only to her hormone therapy, and not to her whole gender dysphoria treatment plan. When asked what additional treatment she is seeking, she stated, "the whole thing." She was asked to clarify and indicated that she was primarily interested in genital gender confirmation surgery. She said that she was also interested in breast augmentation and laser hair removal and/or electrolysis specifically for facial hair, but these are lower priority to her than genital surgery. She added that her facial hair has become thinner since starting hormone therapy but she still shaves her face daily.

Ms. Edmo reported that she is not allowed access to anything that is not on the male property list, other than bras that are ordered by her medical providers. She reported that she had ordered female underpants from the commissary several months ago, however, and that she had received these without incident. She was unsure if there had been a policy change that allowed this, as she had previously not been allowed to have female underpants. Ms. Edmo reported that she was not allowed to purchase her own makeup, but that her family was allowed to buy her care packages that included makeup.

Ms. Edmo was asked to discuss her requests for transfer to the women's prison. She explained, "For me, that would be more comfortable, that's who I would get along with." She explained that her close friends had always been women, and that she had very few close male friends. When asked how she believes she would be received by peers at a women's prison, she stated, "Probably the same as here," explaining that she believes she would still be treated as different and something of an outcast, but that she would feel less "in the spotlight" and would not have to deal with unwanted attention from some male inmates. She was asked about any history of violence toward women and recalled having been in one physical altercation with a natal woman around age 21, due to the woman's reported jealousy when she was talking with the woman's boyfriend. She reported she has no history of violent charges against women. When

asked about the Department of Correction's concerns about her transferring to a women's prison, she stated, "I think their number one concern was if I was sexually attracted to women." She stated her belief that women are allowed to have limited makeup and some hair styling products at the women's facility.

Ms. Edmo was asked if she was participating in therapy for her mental health issues and gender dysphoria, and said that she does not. She indicated that she is assigned to "Clinician Stewart," but elected not to meet with her because "I feel like she doesn't understand me as a transgender." When asked to explain further, Ms. Edmo said that she does not agree with Clinician Stewart's recommendations to attend groups for depression and PTSD. She indicated that while she acknowledges having symptoms of depression and PTSD, her castrating thoughts are prominent. She was asked whether she has ever developed a good working relationship with a mental health clinician in prison and said that she worked well with Clinician Gruhot. She indicated that she had met with this clinician in group settings and in drop-in clinics but had never been assigned to work with her individually. She added that this clinician has since left IDOC.

Ms. Edmo reported that she reached out to several surgeons who do gender confirmation surgery and received information from the office of Dr. Marci Bowers. She indicated that the materials sent provided information on vaginoplasty, labioplasty and clitoroplasty surgeries, with detailed pictures. She was asked to explain her understanding of the surgical procedures, acknowledging awareness that the penis is most commonly used to create a neovagina. She expressed some understanding of the need to use dilators following surgery. She stated her awareness of risks of the procedure, including "a tear or something" and having the vagina be "not deep enough." We also discussed risks of bleeding and infection and she stated her understanding of this.

Ms. Edmo was asked how she would respond to a poor surgical outcome, and stated "It would be horrible … I hope I never have to deal with that." She indicated that she has learned from WPATH, however, that the complication rates of sex reassignment surgeries are very low, and that the regret rate is also very low. When asked if she would feel worse from never having surgery or from having surgery end in a bad outcome, she indicated that never having surgery would be worse for her.

Ms. Edmo reported that she speaks with her mother and one older sister regularly. She described them as supportive of her pursuit of gender confirmation surgery, but added, "I really haven't heard their actual opinions." When asked to clarify this statement, she explained that she is only able to speak with them by phone as they live about five or six hours away and do not visit. She said that they had not expressed a strong opinion in either direction about her pursuit of gender confirmation surgery.

Ms. Edmo was asked about her husband's opinion about her pursuit of gender confirmation surgery. She stated, "He's supportive more than anyone else … he's more concerned about my health," explaining that her husband's primary concern about the surgery was that she would

have a complication that put her health in jeopardy. She was asked how her husband would react if she never had the surgery, and stated, "It wouldn't affect our relationship but it would be my ultimate decision."

Ms. Edmo said that she would "definitely" pursue gender confirmation surgery if she is released without having this done. She said that she is not familiar with resources and insurance coverage, but her health care is covered by Indian Health Services and she believes this might help improve her chances of getting the surgery covered. She was asked if she would first seek to have an orchiectomy, and responded that she is seeking to have complete genital gender confirmation surgery and does not wish to have an orchiectomy without a penectomy and vaginoplasty.

Past Medical History:

Ms. Edmo reported that she did not have any active medical issues. She indicated that she has tested negative for Hepatitis C. She endorsed a history of multiple incidents of head trauma, some with loss of consciousness, resulting from domestic abuse during a two-and-a-half year relationship prior to her incarceration. Ms. Edmo said that she had to go to the hospital on several occasions due to severe beatings and head trauma during that relationship, and also experienced seizures "a couple times" following these incidents, most recently in 2009. She stated that she had never been prescribed medication to control seizures, and these resolved on their own.

Ms. Edmo was asked whether she has ever experienced a blood clot or any similar issue, and stated that she had not.

Prison past/current functioning:

Ms. Edmo reported that she had been working from 8 am to 4 pm Monday through Friday for six months prior to our evaluation, taking work orders for prison manufacturing, until her termination last week as described above. She indicated that her days were "pretty boring" since she stopped working. She reported attending a gender dysphoria process group with three other transgender women but opined that the group is "pretty shallow … it's just a process group, so you go in and say, 'This is how I feel today' and then you leave." Ms. Edmo said that she has been enrolled in other mental health groups recommended by clinicians, including groups for anxiety and for posttraumatic stress disorder, but has not been participating in them consistently.

Ms. Edmo reported a few physical altercations with transgender peers, including the two fights described above that negatively impacted her parole opportunities. She described these fights as being about "just catty stupid stuff."

Ms. Edmo reported that at the time of our evaluation, she was living in a cell with one cellmate. She said that she had just changed cellmates six days prior, and had been with her previous cellmate for one month. She indicated that it was common for the correctional staff to change their cellmates frequently, and that she had not been having difficulty with cellmates.

Regarding her current cellmate, she stated, “I’ve known him for a few years so we’re pretty close.” Ms. Edmo said that she feels safe in her current environment (“As safe as I can be—it’s prison”), but reported having been raped by a male inmate in August of 2016 when housed on a tier that reportedly had a lot of gang activity. She indicated that this incident was reported at the time and the alleged perpetrator was moved to another facility. She reported that she had not been sexually assaulted any other times in jail or prison. (Note: Incident reports indicate that Ms. Edmo reported that on 08/21/2016, a male peer “grabbed Edmo by the head and placed his penis against Edmo’s mouth until it penetrated him [sic] orally,” and that the peer had also stated on 08/31/2016 that he would be back the next day to engage in anal sex with Ms. Edmo.)

Ms. Edmo reported that she received a Disciplinary Offense Report (DOR) the week prior to our evaluation due to suspected misconduct by an unknown offender at her job, but that she had previously not received a DOR for one year. She indicated that her past DORs were all for feminizing, including wearing her hair “too feminine,” wearing makeup and modifying her underwear to look more like women’s underwear. She said that she had also received DORs for two separate fights with the same transgender peer, and that she had also received one DOR related to sexual activity with her now-husband. She reported never having had a PREA investigation initiated against her, and said she had no other DORs for sexual activity or violence (Note: Ms. Edmo received a DOR on 04/21/2015 for sexual activity with a peer other than her husband. She also received a DOR on 01/15/2016 after she reportedly “admitted … that while living on the same tier in Unit 16 Inmate Edmo had consensual sex on two different occasions during the evening time with another Inmate … admitted to giving this other Inmate sexually explicit letters that were confiscated by staff on 12-30-15 that also admits to the sexual relationship between the two.” It is unclear whether this incident involved her husband, as she reported to me that she began her relationship with her husband in 2016).

Ms. Edmo reported that she while she no longer feels suicidal, she struggles with chronic intermittent “castrating thoughts,” approximately four days per week. She was asked how she manages these and responded, “It depends on how severe.” She explained that if the thoughts are not severe, she can “talk myself out of it” using distraction techniques, but if they are severe, she has taken to cutting her wrists, which she reported having most recently done one month prior to our interview. When asked about the strength of her “castrating thoughts” at the time of our evaluation, she responded, “I guess, pretty moderate … not as bad as when I’m in an episode, but not completely gone.” She reported she does not experience any thoughts of harming others or homicidal thoughts.

At the conclusion of our evaluation, I asked visiting room officers Gomes and Archer to have Ms. Edmo evaluated briefly by mental health staff to ensure that she did not have any acute mental health concerns.

Mental Status Exam:

Ms. Edmo presented with a feminized appearance, with long curly hair, painted nails, eyeliner and groomed eyebrows. She was alert and grossly oriented. She was initially guarded,

appropriate to the circumstances of the interview, but remained pleasant and cooperative and engaged in the interview. Her speech was of normal rate and volume. Her thought process was linear. Her thought content was within normal limits, with no evidence of delusional beliefs or obsessions. She reported chronic intermittent thoughts of self-castration, occurring approximately four days per week, but reported no current intent or plan to harm herself in any way at the time of our interview. She reported having no homicidal ideation or thoughts of harming others. She reported she was not experiencing any hallucinatory phenomena, including hearing voices or seeing visual hallucinations. She did not demonstrate any objective evidence of responding to internal stimuli or other signs of psychosis. Her insight appeared fair and her judgment appeared to be reasonably intact at the time of our evaluation.

Future plans:
Ms. Edmo reported that she expects to release from prison in 2021, and will immediately begin looking for employment. She indicated that she completed a paralegal certificate while in prison and is slowly working toward a bachelor's degree. She would like to eventually work as a paralegal in the community. She said that she plans to live in Boise initially as her husband's parents live there and they are supportive of her relationship with their son. She expects that her husband will get out of prison soon, but stated it is possible that he will get out after she does, in 2022.

Ms. Edmo was asked to describe her plans in the event her relationship with her husband does not work out. She replied, "I would have to be single for a while," and indicated that she would still stay in Boise initially while she figured out where to go next. She acknowledged that the close friends she has in the community may still be using drugs. When asked how she planned to maintain her sobriety upon release, she stated, "Hopefully I'll have some resources closer to when I get out." She was asked to clarify which "resources" she was referring to and said that she would attend Alcoholics Anonymous meetings, seek mental health treatment and possibly trauma therapy. She indicated that she plans to initially seek Supplemental Security Income (SSI) and participate in ex-offender programs when she first gets out, but will in the meantime be looking for any job she can get.

Assessment
Diagnoses:
Gender Dysphoria in Adolescents and Adults, Posttransition
Major Depressive Disorder
Alcohol Use Disorder, severe, in full sustained remission in a controlled environment
Stimulant Use Disorder, severe, in full sustained remission in a controlled environment
Opioid Use Disorder, severe, in full sustained remission in a controlled environment

Gender Dysphoria in Adolescents and Adults, Posttransition
It is my opinion, with reasonable medical certainty, that Ms. Edmo meets DSM-5 criteria for a diagnosis of Gender Dysphoria. The following evidence supports my opinion:

1. Ms. Edmo reported experiencing a marked incongruence between her experienced gender (female) and her assigned gender (male), She indicated that she experiences this incongruence in the following ways:
    a. Ms. Edmo reported a marked incongruence between her experienced/expressed gender and her primary and secondary sex characteristics. She indicated that this began in early childhood, but worsened when she witnessed her older sisters go through puberty and develop female secondary sex characteristics. She explained that she found it "kind of depressing" to realize that she was not going to develop the same way they were.
    b. Ms. Edmo has reported and demonstrated a strong desire to be rid of her primary and secondary sex characteristics due to the incongruence she feels between these traits and her expressed gender. She has made two attempts to castrate her testicles and has reported that her intent was to rid herself of these undesirable body parts rather than to kill herself. She indicated that she believes her penis is "gross," and that she thinks about her penis and testicles "constantly."
    c. Ms. Edmo has expressed and demonstrated a strong desire for female primary and secondary sex characteristics. She reported that she wore breast prostheses prior to her incarceration, and has sought and obtained cross-gender hormone treatment for the purpose of attaining a more feminine appearance, to include breast development and fat redistribution. She also stated that her primary goal is to undergo gender confirmation surgery with penectomy/orchiectomy and vaginoplasty. She has reportedly written to surgeons who perform such procedures to gather information.
    d. Ms. Edmo has stated a strong desire to be female, as evidenced by her pursuit of cross-gender hormone treatment and gender confirmation surgery.
    e. Ms. Edmo has expressed and demonstrated a strong desire to be treated as female. She has legally changed her name to a more feminine one, and has requested that her identification card classify her as female. She has also sought permission to wear make-up and has demonstrated a preference for female hairstyles, to assist with her female gender expression.
2. Ms. Edmo's gender dysphoria has exceeded the required six months' duration necessary to meet criteria for the disorder. Ms. Edmo reported that her gender incongruence began during early childhood and became more pronounced in adolescence when she developed male secondary sex characteristics. The earliest documentation of her request for evaluation of her gender experience is found in 2012, and she has persistently maintained her female identity since that time.
3. Ms. Edmo's gender dysphoria is associated with clinically significant distress; she identified feeling depressed due to the incongruence between her assigned and expressed gender, and reported thinking about her dissatisfaction with her male body parts "constantly."

Major Depressive Disorder, moderate, with anxious distress
It is my opinion, with reasonable medical certainty, that Ms. Edmo meets DSM-5 criteria for a diagnosis of Major Depressive Disorder. The following evidence supports my opinion:

1. Ms. Edmo reported she began to experience depressed mood in early childhood, and has experienced depressed mood intermittently since that time.
2. Ms. Edmo reported she has experienced changes in her sleep habits during periods of depression.
3. Ms. Edmo reported variations in her appetite during periods of depression.
4. Ms. Edmo reported difficulty concentrating during periods of depression.
5. Ms. Edmo reported a long history of intermittent suicidal ideation beginning at age 15, and indicated that she had attempted suicide with lethal intent on three occasions.
6. Ms. Edmo reported experiencing “a constant feeling of anticipation, like something is about to happen,” lasting up to two hours at a time, with associated physical sensations of “my heart beats fast, body gets warm, breathing more heavy.” She indicated that this happens at random, without clear precipitant.
7. Ms. Edmo’s depressive symptoms cause clinically significant distress and impairment in functioning; she has reported three suicide attempts with lethal intent, requiring medical intervention.
8. While it is likely that her depression was at times triggered or worsened by substance abuse, Ms. Edmo appears to have experienced depressive episodes in the absence of substance use as well.
9. Ms. Edmo does not appear to have a psychotic illness that might explain her depressive episodes, and does not appear to have experienced an episode of mania or hypomania.
10. When asked directly if she believes she suffers from depression or if all of her depressed feelings come from her gender dysphoria, Ms. Edmo opined that she believes she has “both,” referring to a depressive disorder and Gender Dysphoria.

Alcohol Use Disorder, in sustained remission in a controlled environment
It is my opinion, with reasonable medical certainty, that Ms. Edmo meets DSM-5 criteria for a diagnosis of Alcohol Use Disorder. Ms. Edmo reported a problematic pattern of alcohol use leading to clinically significant impairment and distress, involving drinking five to ten beers one to two nights per week beginning at age 16, and later progressing to daily drinking from age 19 to 22. She indicated that she began drinking larger amounts over time, but was unable to quantify the amount. She reported she last drank in 2011.

Stimulant Use Disorder, in sustained remission in a controlled environment
It is my opinion, with reasonable medical certainty, that Ms. Edmo meets DSM-5 criteria for Stimulant Use Disorder. She reported she began smoking methamphetamines at age 18 and began to inject these drugs soon thereafter, despite known medical/infectious risks in doing so. Ms. Edmo reported using methamphetamines at the time of her crime, and indicated that prior to that, she “lost everything” as a result of her lifestyle chasing methamphetamines and opioids.

Opioid Use Disorder, in sustained remission in a controlled environment
It is my opinion, with reasonable medical certainty, that Ms. Edmo meets DSM-5 criteria for Opioid Use Disorder. She reported that she began using oral opioids at age 19 and quickly progressed to intravenous use despite the known medical/infectious risks in doing so. She reported that she experienced significant withdrawal symptoms when she first entered Bannock County Jail on her current charges, including headache, nausea, hot and cold sweats, and stomach cramps. She reported having "lost everything" during the time period when she was chasing methamphetamine and opioids from state to state. She indicated that she last used opioids in 2011, prior to her incarceration.

Differential Diagnosis:
Transvestic Disorder
In forming my opinion about Ms. Edmo's diagnoses, I also considered the possibility that she meets DSM-5 criteria for Transvestic Disorder. To qualify for this diagnosis, individuals must experience recurrent and intense sexual arousal from cross-dressing for a period of at least six months, manifested by fantasies, urges or behaviors that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Ms. Edmo has engaged in a significant amount of sexual activity despite the restrictive correctional environment, with numerous incident reports documenting physical and sexual contact with several male inmate peers over the course of her incarceration, and disciplinary reports for sexual activity. She has demonstrated a preference for wearing female undergarments, and ISCI records indicate that some of these undergarments have been modified to make them more revealing, e.g. bras with v-shaped cuts and underwear crafted into thongs. She has also been opined to create "a sexually charged environment" through her use of makeup and feminine hairstyles and her mannerisms.

It is my opinion, however, with reasonable medical certainty, that based on the information available to me I cannot conclude that Ms. Edmo meets criteria for Transvestic Disorder. The following evidence supports my opinion:

1. Through her repeated incidents of sexual activity, Ms. Edmo has demonstrated that she does indeed become sexually aroused while dressed as a woman, but there is little evidence that this arousal is directly caused by her female attire or by arousal to herself as female. She denies using her penis in any sexual capacity, including to masturbate, which is often a component of transvestic disorder. I have not viewed any incident reports or other prison documentation indicating that Ms. Edmo engages in masturbation while wearing women's clothing or undergarments.
2. Ms. Edmo reports wearing female undergarments (a bra and more recently, women's underpants) at all times, and not just when engaging in sexual activity. It does not appear that wearing women's clothing is "always or often" accompanied by sexual excitement for Ms. Edmo, as required by the DSM-5 to meet this diagnosis.
3. Ms. Edmo does not report or display distress associated with her cross-dressing behaviors. She reports having dressed as a woman in the community prior to her incarceration, and feminizes to the extent she is able in the correctional environment.

4. The majority of males with transvestic disorder identify as heterosexual[1] (as men attracted to women), and Ms. Edmo denies ever having been sexually attracted to women or involved in sexual activity with women. (Note: Ms. Edmo's psychosexual evaluation indicates that she did report sexual activity with two females in the past, but no further detail is known).
5. Gender Dysphoria and Transvestic Disorder can be comorbid, but the DSM-5 notes that "individuals with transvestic disorder do not report an incongruence between their experienced gender and assigned gender nor a desire to be of the other gender; and they typically do not have a history of childhood cross-gender behaviors, which would be present in individuals with gender dysphoria."[1] Ms. Edmo has reported strong incongruence between her experienced female gender and her assigned male gender and a strong desire to be female.

Ms. Edmo has been sexually active on multiple occasions, which is in violation of prison standards and expectations, but her sexual interest and behavior does not appear to be driven by Transvestic Disorder or another paraphilia.

<u>Consideration of Ms. Edmo's Psychiatric Treatment</u>

It is my opinion, with reasonable medical certainty, that Ms. Edmo's psychiatric treatment during this incarceration has been reasonable and appropriate, and does not fall below acceptable standards of care. Specifically, it is my opinion that her psychiatrists' approach to her reported gender dysphoria has been acceptable. In forming my opinion, I considered the following:

1. Time to evaluation: It is my opinion that Ms. Edmo's time to evaluation of her reported gender issues was well within acceptable standards. From available records, it appears that less than one month passed between her first documented request for evaluation of gender issues and her diagnosis, initially made by Dr. Scott Eliason. The timeline is as follows: On 06/01/2012, Ms. Edmo wrote an IDOC Offender Concern Form requesting to speak with healthcare staff about cross gender hormone medications and other issues related to reported Gender Identity Disorder. This concern form was stamped as having been received on 06/04/2012. She submitted additional, similar concern forms on 06/04/2012, 06/17/2012 ("I would like to understand why ISCI prison authorities are denying me proper medical treatment for my gender identity disorder. I have concerned this issue a number of times, put in HSR requests, but it seems to me that ISCI authorities are just being deliberately indifferent to my serious medical need in violation of the USA constitution, 8th amendment"), and 06/17/2012 (a second concern form on this date). Several Health Services Request forms were also received around that time, with the first mention of gender issues occurring on an HSR dated 06/04/2012. Of note, Ms. Edmo had been seen by Physician's Assistant Karen Barrett on 05/04/2012 and discussed issues with anxiety and depression, but documentation from this encounter

[1] American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.

does not indicate that Ms. Edmo reported any gender issues at that time. On 06/25/2012, Ms. Edmo was evaluated by Dr. Scott Eliason in response to her reported gender identity issues, and was diagnosed with Gender Identity Disorder (GID). Dr. Eliason's note indicates that Ms. Edmo "said he thinks a lot of his mood problems and suicide attempts in the past were because of his unhappiness over his male gender." Dr. Eliason concluded, "In my opinion he meets criteria for GID. His subjective report and feminine demeanor would be consistent with this. Also his dysphoria relating to his gender is consistent with GID." Per policy, Ms. Edmo was subsequently transferred to Idaho Maximum Security Institution (IMSI) for the purpose of evaluating her gender issues and clarifying her diagnosis. She was evaluated by Dr. Claudia Lake, Psy.D. on 07/19/2012, who confirmed her GID diagnosis.

2. Diagnostic process: Dr. Gorton's declaration dated 05/29/2018 notes, "Prior to Ms. Edmo's first appointment with Dr. Alviso in 2016, her medical records contain no real transgender history … I saw no notes prior to Dr. Alviso's 12/14/16 evaluation that had anything resembling a transgender history. Without knowing Ms. Edmo's history (e.g. how long she has experienced dysphoria, the focus and severity of her dysphoria, exacerbating and mitigating effects, whether she has social support, how she manages stress, the steps she has taken to transition, further medical and family history, etc.), it would be impossible to provide safe and effective care." It is my opinion that the diagnostic process used in evaluating Ms. Edmo's report of gender dysphoria met acceptable standards. The Standards of Care, Version 7 (SOC7), authored by the World Professional Association for Transgender Health (WPATH) notes that the evaluation of gender dysphoria in adults includes "assessment of gender identity and gender dysphoria, history and development of gender dysphoric feelings, the impact of stigma attached to gender nonconformity on mental health, and the availability of support from family, friends and peers."[2] These factors were initially explored by Dr. Eliason on 06/25/2012, less than one month after Ms. Edmo submitted her first request to discuss her gender, and expanded upon by Dr. Lake in her GID clarification evaluation on 07/19/2012. Dr. Lake also attempted to gather collateral information from Ms. Edmo's mother, but had not received a return call as of when she completed her report. Ms. Edmo's case was discussed by the Management Treatment Team Committee (MTC) on 08/23/2012, and her gender identity history was again reviewed, in the presence of the Health Services Director and the Director of Nursing. As is standard practice in a prison setting, mental health and medical professionals work together to evaluate and address medical needs, and have access to documentation across disciplines. I disagree with Dr. Gorton's declaration that Ms. Edmo's gender concerns were not properly evaluated.
3. Time to treatment: It is my opinion that Ms. Edmo was provided cross-gender hormone therapy in a timely fashion once she received a diagnosis of GID. Ms. Edmo's case was

[2] E. Coleman, W. Bockting, M. Botzer, P. Cohen-Kettenis, G. DeCuypere, J. Feldman, L. Fraser, J. Green, G. Knudson, W. J. Meyer, S. Monstrey, R. K. Adler, G. R. Brown, A. H. Devor, R. Ehrbar, R. Ettner, E. Eyler, R. Garofalo, D. H. Karasic, A. I. Lev, G. Mayer, H. Meyer-Bahlburg, B. P. Hall, F. Pfaefflin, K. Rachlin, B. Robinson, L. S. Schechter, V. Tangpricha, M. van Trotsenburg, A. Vitale, S. Winter, S. Whittle, K. R. Wylie & K. Zucker (2012) Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7, International Journal of Transgenderism, 13:4, 165-232, DOI: 10.1080/15532739.2011.700873.

initially discussed in a meeting of the MTC on 08/23/2012, approximately one month after her confirmatory evaluation with Dr. Lake. The MTC's recommended management plan included evaluation by a physician for suitability for hormone therapy within 30 days and clinician contact twice per week. According to records, Ms. Edmo's initial cross-gender hormone therapy was first ordered one week later, on 08/30/2012. The Endocrine Society Clinical Practice Guideline in effect at that time (published in 2009) followed the requirement described in WPATH's 6th version of the Standards of Care (SOC6) that adults applying for hormone treatment and surgery satisfy both eligibility and readiness criteria, which were stricter standards than those found in the SOC7 published in 2011. Eligibility criteria listed in these 2009 practice guidelines included a) fulfill DSM-IV-TR or ICD-10 criteria for GID or transsexualism, b) do not suffer from psychiatric comorbidity that interferes with the diagnostic work-up or treatment, c) demonstrate knowledge and understanding of the expected outcomes of hormone treatment, as well as the medical and social risks and benefits; and d) have experienced a documented RLE (real-life experience) of at least 3-month duration OR had a period of psychotherapy (duration specified by the MHP after the initial evaluation, usually a minimum of 3 months). The practice guidelines also listed required readiness criteria before cross-sex hormone treatment as a) has had further consolidation of gender identity during a RLE or psychotherapy, b) has made some progress in mastering other identified problems leading to improvement or continuing stable mental health, and c) is likely to take hormones in a responsible manner. The SOC7 removed the readiness requirements and eliminated the recommendation for the RLE prior to hormone treatment, but the endocrine society did not update their guidelines until 2017 to reflect this. It is my opinion that the speed with which Ms. Edmo was evaluated for and provided cross-gender hormone therapy was rather progressive for the time, and would still be within reasonably accepted standards today.

4. Other treatment considerations: In forming my opinion regarding the Corizon psychiatrists' management regarding Ms. Edmo's request for gender confirmation surgery (GCS), I considered many factors including WPATH SOC, evidence to support the benefits of GCS and limitations of available studies, additional publications regarding GCS, and Ms. Edmo's unique factors contributing to the likelihood of positive or negative outcomes following such surgery. This issue is discussed in greater detail below.

<u>Consideration of Ms. Edmo's Hormone Treatment</u>

My opinion regarding Ms. Edmo's cross-gender hormone treatment is based on my experience in evaluating gender dysphoric individuals for referral for hormone therapy, working on teams with other medical providers managing and prescribing cross-gender hormone therapy, attending a WPATH conference entitled "Transgender Health: Best Practices in Medical and Mental Health Care" in Atlanta, GA in January of 2016, and ongoing review of the literature and treatment guidelines on this topic.

Male-to-female Cross-Gender Hormone Regimen: General Concepts
The Endocrine Society Clinical Practice Guideline published in 2009[3] notes, "Most published clinical studies report the use of an antiandrogen in conjunction with an estrogen." Spironolactone's antiandrogen properties are described as working "by directly inhibiting testosterone secretion and by inhibiting androgen biding to the androgen receptor." The guideline indicates that Estrogen can be given orally as conjugated estrogens, or 17β-estradiol, as transdermal estrogen, or parenteral estrogen esters. In the Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People, published by the Center for Excellence for Transgender Health in June 2016, 5-alpha reductase inhibitors including finasteride are mentioned as a "common approach" to androgen blockade in cross-gender hormone treatment. These guidelines note that finasteride "blocks 5-alpha reductase type 2 and 3 mediated conversion of testosterone to the potent androgen dihydrotestosterone." The guidelines further note that "Since these medications block neither the production nor action of testosterone, their antiandrogen effect is less than that encountered with full blockade," but that 5-alpha reductase inhibitors "may be a good choice for those unable to tolerate, or with contraindications to the use of spironolactone." Regarding progestogens, these guidelines state, "There have been no well-designed studies of the role of progestogens in feminizing hormone regimens. Many transgender women and providers alike report an anecdotal improved breast and/or areolar development, mood, or libido with the use of progestogens. There is no evidence to suggest that using progestogens in the setting of transgender care are harmful. In reality some patients may respond favorably to progestogens while others may find negative effects on mood."

Ms. Edmo's Cross-Gender Hormone Therapy
On 08/29/2012, following two separate evaluations to verify Ms. Edmo's diagnosis of Gender Dysphoria and the multidisciplinary discussion at the MTC meeting on 08/23/2012, Ms. Edmo was seen by medical provider Dr. Catherine Whinnery, MD. Dr. Whinnery prescribed Estrace 0.5 mg twice daily and spironolactone 25 mg twice daily, consistent with endocrine society guidelines of combining estrogen therapy with antiandrogen medication. On 12/03/2012, Dr. Whinnery wrote a medical memo so that Ms. Edmo was authorized to wear a bra. Dr. Whinnery's note indicates that Ms. Edmo had questions about her medications, and that she answered Ms. Edmo's questions. On 03/26/2013, Dr. Whinnery quotes Ms. Edmo as stating, "I am doing pretty good," and indicates Ms. Edmo was experiencing some breast development. Dr. Whinnery increased Ms. Edmo's spironolactone and changed her estratab to estradiol. Dr. Whinnery's 07/01/2013 note indicates that Ms. Edmo had been started on finasteride (Proscar) in the interim, and was "happy" with this, and not having issues with her medication. Subsequent notes reflect additional adjustments in Ms. Edmo's hormone medication regimen and doses in response to her feedback and requests. In the interest of brevity, I will not discuss each change here. In 2016, Ms. Edmo was referred for an evaluation with community-based

[3] Wylie C. Hembree, Peggy Cohen-Kettenis, Henriette A. Delemarre-van de Waal, Louis J. Gooren, Walter J. Meyer, Norman P. Spack, Vin Tangpricha, Victor M. Montori; Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline, *The Journal of Clinical Endocrinology & Metabolism*, Volume 94, Issue 9, 1 September 2009, Pages 3132–3154.

physician Dr. Marvin Alviso, who made additional recommendations regarding her hormone regimen and has remained involved in Ms. Edmo's care since that time. Dr. Alviso also provided training to Corizon staff on 06/24/2016 entitled "Transgender Medicine."

The plaintiff's experts have voiced disagreement with the management of Ms. Edmo's cross-gender hormone treatment. In his declaration dated 05/29/2018, Dr. Gorton opines that IDOC and Corizon clinicians "failed to monitor the effect of HRT on her underlying condition." He notes that on several occasions, Ms. Edmo's laboratory values pertaining to her hormone therapy were incorrectly interpreted. While I agree with Dr. Gorton's statement that the provider (signature illegible) who indicated on 09/04/2015 that "normal female testosterone ranges from 230-189 in healthy 30 year old nonsmoker, moderate exercise" was incorrect, it is my opinion that this did not impact her treatment in a clinically significant way. Practitioner's Orders from that time period indicate that multiple changes were made to Ms. Edmo's hormone regimen over the following months, including an increase in estradiol from 3 to 4 mg on 10/09/2015 and an increase in spironolactone from 100 mg to 125 mg twice daily on 12/23/2015. It does not appear that this unknown provider's incorrect interpretation caused a significant change in the treatment plan or negatively impacted Ms. Edmo's hormone regimen to a clinically significant degree.

Dr. Gorton's strong disapproval of the way Ms. Edmo's laboratory values were interpreted invites a brief discussion of published guidelines regarding interpretation of laboratory values for cross-gender hormone therapy. The Endocrine Society guidelines "suggest" regular clinical and laboratory monitoring every three months during the first year of treatment, and then once or twice yearly. The Endocrine Society Guideline uses the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) method of weighing evidence, and indicates that this recommendation regarding lab monitoring is a "weak recommendation" based on "low quality" evidence, acknowledging that there is no evidence-based consensus regarding the appropriate laboratory monitoring schedule.

Similarly, the guidelines published by the Center of Excellence for Transgender Health in 2016 indicate that monitoring of hormone levels in response to cross-gender hormone therapy is not an exact science. These guidelines state that while physiologic hormone levels in non-transgender people are used as reference ranges, "the interpretation of hormone levels for transgender individuals is not yet evidence based." These guidelines discuss several different but acceptable approaches to the titration of estrogens and antiandrogens, and the authors state their belief that the Endocrine Society's guidelines recommending hormone level monitoring every three months are "not realistic and not likely to add value once a stable dosing has been achieved." The Center for Excellence's guidelines cite "a prospective study of transgender women taking 4 mg/day divided dose oral estradiol or 100 mcg transdermal estradiol, plus 100-200 mg/day divided dose spironolactone found that all women achieved physiologic estradiol levels, though only 2/3 of the women achieved female range testosterone levels." As of 10/09/2015, Ms. Edmo was receiving 4 mg per day of estradiol and 200 mg per day of spironolactone. The authors also note, "Once hormone levels have reached the target range for a specific patient, it is reasonable to monitor levels yearly, or only as needed as

described below. As with other situations involving maintenance of hormone therapy (menopause, contraception), annual visits are sufficient for transgender women on a stable hormone regimen." Regarding specific monitoring of estradiol levels, the Center for Excellence's guideline notes that the Endocrine Society's 2009 guideline's recommendation to maintain estradiol levels at the mid-cycle range for non-transgender women is "based on expert opinion only and may be overly conservative, and hormone levels are often not easy to tightly control." This guideline further states, "There is no evidence that higher estradiol levels in patients with adequate androgen suppression results in additional feminization or breast development."

At the time of my evaluation, Ms. Edmo reported that her cross-gender therapy had "helped me mentally … more a clearing of my mind," and noted she had experienced physical changes including weight loss, breast growth, a decrease in skin oiliness, a change in body odor, and changes in fat distribution. She indicated that an increase in estrogen and the addition of progesterone by Dr. Alviso had not resulted in much additional change, other than "like a mental clearness" and modest additional breast growth. When asked about her overall satisfaction with cross-gender hormone treatment, Ms. Edmo stated "I feel it's maintenance … for me I feel like I've hit the most I'll ever get from the hormones. She reported feeling "content" but not satisfied with her response to hormone therapy, and stated, "I think the treatment plan I'm on now … it's pretty much the same as I would get outside of prison," clarifying that by "treatment plan," she was referring solely to her hormone regimen. She indicated that she was prescribed estradiol 4 mg twice daily, spironolactone 50 mg twice daily, and finasteride 10 mg daily at the time of our evaluation. She reported having stopped medroxyprogesterone due to weight gain and fatigue, and said that she had restarted spironolactone in mid-June 2018 and felt "a lot better," with a decrease in skin oiliness and a "gritty" sensation she had experienced when not taking it.

<u>Evaluation of the Medical Necessity of Gender Confirmation Surgery for Ms. Edmo</u>
It is my opinion, with reasonable medical certainty, that gender confirmation surgery *is not* medically necessary for Ms. Edmo at this time. As discussed further below, it is my opinion that WPATH SOC provide a useful guideline on which to base decisions regarding transgender care, but do not override professional judgment. It is my opinion that experienced medical and mental health professionals can apply the SOC while also exercising their own professional judgment. Accordingly, it is my opinion that GCS is not medically necessary for Ms. Edmo at this time because she has not met the criteria as outlined by WPATH's Standards of Care version 7 for undergoing vaginoplasty surgery. The following evidence supports my opinion:

The WPATH SOC list the criteria for approval for vaginoplasty as follows:

1. Persistent, well documented gender dysphoria
2. Capacity to make a fully informed decision and to consent to treatment
3. Age of majority in a given country
4. If significant medical or mental health concerns are present, they must be well controlled
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals

6. 12 continuous months of living in a gender role that is congruent with their gender identity

Ms. Edmo meets criteria 2, 3 and 5, and further discussion is not needed on these topics. She is over 18 years old, demonstrates no evidence that her medical decision-making capacity is impaired, and has been taking cross-gender hormones for more than 12 continuous months. Criteria 1, 4, and 6 are not fully met, and will be discussed below.

Gender confirmation surgery: a review of the evidence
There is no doubt that gender confirmation surgery is a highly-effective, life-changing procedure or set of procedures for many individuals with gender dysphoria, and the discussion below is not intended to dispute the validity of this treatment option in general terms. Dr. Ettner's report outlines some of the positive literature supporting gender confirmation surgery and its beneficial effects on severe gender dysphoria. However, she does not provide a balanced overview of the limitations of these studies or discuss the patient-specific factors that have been found to positively or negatively affect postoperative outcomes. She also fails to acknowledge publications challenging the quality of these studies or of the body of evidence published regarding surgery. Examples include the following:

1. In her report, Dr. Ettner indicates that Medicare's policy barring coverage for transition-related surgeries was overturned in May of 2014. In follow-up, in December of 2015 the Centers for Medicare & Medicaid Services (CMS) accepted a formal request from a beneficiary to initiate a national coverage analysis (NCA) for gender reassignment surgery, and CMS undertook a thorough review of the evidence to determine whether or not gender reassignment surgery would be covered nationally.[4] CMS opined:

    > Based on a thorough review of the clinical evidence at this time, there is not enough evidence to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria. There were conflicting (inconsistent) study results – of the best designed studies, some reported benefits while others reported harms.

    CMS found the quality and strength of evidence to be low "due to mostly observational study designs with no comparison groups, subjective endpoints, potential confounding (a situation where the association between the intervention and outcome is influenced by another factor such as a co-intervention), small sample sizes, lack of validated assessment tools, and considerable lost to follow-up."

    CMS also questioned the generalizability of positive study results, both to the Medicare (generally older) population and other potentially less ideal candidates:

[4] https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=282

> Much of the available research has been conducted in highly vetted patients at select care programs integrating psychotherapy, endocrinology, and various surgical disciplines and operating under European medical management and regulatory structures … CMS strongly encourages robust clinical studies with adequate patient protections that will fill the evidence gaps delineated in this decision memorandum.

In reaching these conclusions, CMS cites limitations of the available evidence, including that most studies were observational, non-longitudinal, or did not include concurrent controls or testing prior to and after surgery. Positive results were noted to have less strength and confidence due to design flaws. CMS identified six studies that were assessed as being done sufficiently well to provide useful information, and found that "the four best designed and conducted studies that assessed quality of life before and after surgery using validated (albeit non-specific) psychometric studies did not demonstrate clinically significant changes or differences in psychometric test results after GRS." They opined:

> We believe at minimum study designs should have a pre-test/post-test longitudinal design accompanied by characterization of all patients lost to follow-up over the entire treatment series as well as those patients who did not complete questionnaires, and the use of psychometric quality-of-life tools which are well validated with linkage to "hard" (objective) patient outcomes in this particular patient population.

In regard to the WPATH SOC, the discussion regarding this NCA indicates that "several commenters suggested that CMS should recommend the WPATH Standards of Care as the controlling guideline for gender reassignment surgery. They asserted it could satisfy Medicare's reasonable and necessary criteria for determining coverage on a case-by-case basis." CMS responded:

> Based on our review of the evidence and conversations with the experts and patient advocates, we are aware that some providers consult the WPATH Standards of Care, while others have created their own criteria and requirements for surgery, which they think best suit the needs of their patients. As such, and given that WPATH acknowledges the guidelines should be flexible, we are not in the position to endorse exclusive use of WPATH for coverage. The MACs, Medicare Advantage plans, and Medicare providers can use clinical guidelines they determine useful to inform their determination of whether an item or service is reasonable and necessary. When making this determination, local MACs may take into account physician's recommendations, the individual's clinical characteristics, and available clinical evidence relevant to that individual.

2. The American Psychiatric Association (APA) published a report of the APA Task Force on Treatment of Gender Identity Disorder in 2012.[5] This task force was charged "to perform a critical review of the literature on the treatment of Gender Identity Disorder at different ages and to present a report to the Board of Trustees," for the purpose of determining whether or not there is "sufficient credible literature to support development by the APA of treatment recommendations for GID." The authors conclude, "The quality of evidence pertaining to most aspects of treatment in all subgroups was determined to be low; however, areas of broad clinical consensus were identified and were deemed sufficient to support recommendations for treatment in all subgroups," indicating that an APA practice guideline should, in fact, be developed. The authors also acknowledge factors that have been shown in the literature to be associated with poor outcomes and/or regret:

    > Interviews with subjects who express substantial regret following genital reassignment surgery, and related case reviews, have identified several correlates of regret. These include: inadequate diagnosis of major pathology (e.g., psychosis, personality disorder, alcohol dependency), misdiagnosis, absence of or a disappointing real-life experience, and poor family support.

3. In her report, Dr. Ettner quotes the Endocrine Society's Clinical Practice Guideline from 2009: "For many transsexual adults, genital sex reassignment surgery may be the necessary step towards achieving their ultimate goal of living successfully in their desired gender role." In the updated version of these guidelines, published in November of 2017[6] and co-sponsored by WPATH, the discussion of the evidence to support gender confirmation surgery is expanded. In this latest version, the authors discuss the positive studies but also acknowledge that there are gaps in knowledge, and that not all of the data is positive, noting "Several postoperative studies report significant long-term psychologic and psychiatric pathology." In this latest version of the guidelines, the authors also acknowledge the possibility of regret and the need for better research:

    > Further insight into the characteristics of persons who regret their decision postoperatively would facilitate better future selection of applicants eligible for sexual reassignment surgery. We need more studies with appropriate controls that examine long-term quality of life, psychosocial outcomes, and psychiatric outcomes to determine the long-term benefits of surgical treatment.

4. Dr. Ettner quotes a 2005 study by Smith et al as concluding that "after surgery there was 'a virtual absence of gender dysphoria' in the cohort and 'results substantiate previous

[5] Byne, W., Bradley, S.J., Coleman, E. et al; Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder. Arch Sex Behav (2012) 41: 759.

[6] Wylie C Hembree, Peggy T Cohen-Kettenis, Louis Gooren, Sabine E Hannema, Walter J Meyer, M Hassan Murad, Stephen M Rosenthal, Joshua D Safer, Vin Tangpricha, Guy G T'Sjoen; Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, *The Journal of Clinical Endocrinology & Metabolism*, Volume 102, Issue 11, 1 November 2017, Pages 3869–3903

conclusions that sex reassignment surgery is effective.'" While these quotes are accurate, the study's authors also emphasize that the study's purpose was two-fold; to investigate both the outcomes of sex reassignment and the prediction of favorable or poor outcomes. They listed several factors as being associated with poor outcomes, including greater psychopathology, non-homosexual orientation (with "homosexual" defined as sexual attraction to one's own natal gender), physical appearance, and inconsistencies in report of past and present gender dysphoria. Applying these findings to Ms. Edmo specifically, her risk factors include her degree of psychopathology and inconsistencies in her reported gender dysphoria history. Dr. Ettner emphasizes Ms. Edmo's degree of psychopathology in her argument in favor of gender confirmation surgery, but the Smith study actually cites psychopathology as a risk factor for poor outcomes. The study also included both male-to-female and female-to-male individuals, with the authors noting, "Comparing the sexes, the FMs showed better results, supporting the results of earlier studies," indicating that the study results may not have been quite as favorable if the sample was comprised entirely of male-to-female individuals.

5. Dr. Ettner also cites a study from Monstrey et al in 2007 in support of gender confirmation surgery. In a 2009 review of the literature on follow-up studies of gender confirmation surgery, also authored by Monstrey et al, the authors acknowledge a "lack of randomized clinical trials or high-quality follow-up studies on large numbers of operated transsexuals." They conclude:

> Because the literature shows a lack of randomized clinical trials or high-quality follow-up studies on large numbers of operated transsexuals, it offers no evidence-based research above evidence level B or C. Some minor recommendations can be made at the re-writing of seventh version of the *Standards of Care* of WPATH, but although they seem intuitively appropriate, they are more based on expert opinion without explicit critical approval from peer-reviewed literature.

It is my opinion that the poor quality of studies investigating GCS should not be used to deny the effectiveness or medical necessity of this treatment for the appropriate candidate. The high satisfaction rates reported in many studies attest to the safety and effectiveness of this intervention for the appropriate candidate. However, social factors that lead an individual to be lost to follow-up, and therefore not included in analysis of outcomes in these positive studies, are likely common in individuals like Ms. Edmo, and many gender dysphoric individuals who find themselves incarcerated.

Criterion 1: Persistent, well documented gender dysphoria
As discussed above, it is my opinion that Ms. Edmo meets criteria for Gender Dysphoria, but there are significant inconsistencies in her reporting that cast doubt on the veracity of her self-report. Ms. Edmo told me that she was not aware of the concept of being transgender until she met a transgender peer at Bannock County Jail while awaiting adjudication of her current

charges. However, she did state that she lived as a woman for years prior to her incarceration. Records have been reviewed from prior to her current incarceration and include the following:

1. North Idaho Correctional Institution (NICI): Ms. Edmo participated in the court-ordered Retained Jurisdiction Program at NICI from 02/08/2010 until 06/21/2010, at which time she was released on probation. Ms. Edmo's presentence report dated 11/23/2011 indicates that she was successful and earned positive reviews. She was noted to have "a very positive attitude" and was called "a very positive role model for other offenders." The report also indicates that she reported having "suffered from extreme depression and anxiety since he [sic] was placed on probation," and that she explained her past suicide attempts as occurring "because he was feeling upset about his past failed relationships, and he was having problems dealing with his family and alcohol problem." The report also indicated that Ms. Edmo reported he abused alcohol "because he was struggling to tell his family that he's homosexual." Ms. Edmo's 2011 explanation for her past depression and suicide attempts involved relationship stress, alcohol abuse, and her family's unwillingness to accept her sexual orientation and did not include any mention of gender issues. I did not find any discussion of Ms. Edmo's report of gender identity issues in these records, nor did these records contain any description of a feminized appearance or of dressing/presenting as a female. Male pronouns were used throughout the records.
2. Portneuf Medical Center records dated 08/05/2010-08/07/2010 and 05/16/2011-05/19/2011 (provided in response to subpoena): Ms. Edmo was admitted to PMC on 08/05/2010 following a suicide attempt by cutting her arm, and again on 05/16/2011 following a suicide attempt by overdose on amitriptyline while intoxicated. She reported at the time of these admissions that her suicide attempts were triggered by relationship issues, feelings of guilt and worthlessness, not having a job or being able to find a job, financial and legal struggles, and heavy alcohol use. I did not find any discussion of Ms. Edmo's report of gender identity issues during these two admissions. Male pronouns were used consistently throughout the records, and she was repeatedly referred to as a "gentleman." A psychiatric evaluation dated 08/05/2010 following Ms. Edmo's suicide attempt by cutting her arm included a physical description of "a 22-year-old Native American guy who has colored top of his head in a lighter color. He has painted nails." Ms. Edmo's painted nails do not appear to have been accompanied by other evidence of feminization, however, as her list of belongings on that date does not appear to include any feminine clothing: "1 brown long sleeve shirt, 3 white t-shirt [sic], 1 pair brown flip-flops, 3 pair white underwear, 1 pair blue sleeping pants, 1 brown short sleeve t-shirt, 1 black t-shirt, 2 pair khaki shorts, 1 pair black shorts, white Adidas shoes."
3. Shoshone-Bannock Tribe Counseling & Family Services Records dated 11/26/2003-07/14/2011 (provided in response to subpoena): Ms. Edmo missed an appointment scheduled on 11/26/2003 that had been scheduled in follow-up to an "apparent overdose." She missed another appointment on 12/17/2009, and then presented for a screening for alcohol and drug abuse on 07/19/2010, but missed her next four scheduled appointments on 08/13/2010, 08/19/2010, 09/30/2010, and 04/13/2011. She next presented on 05/19/2011, following her admission to Portneuf Medical Center

for an overdose. She missed or canceled several subsequent appointments. I did not find any discussion of Ms. Edmo's report of gender identity issues in these records, nor did these records contain any description of a feminized appearance or of dressing/ presenting as female. Male pronouns were used throughout these records.

4. Not-Tsoo Gah-Nee Indian Health Service records 12/02/2008-06/01/2011: Ms. Edmo presented to IHS for various medical issues during this time period. I did not find any discussion of Ms. Edmo's report of gender identity issues, nor did these records contain any description of a feminized appearance or of dressing/presenting as a female. Male pronouns were used consistently throughout the records.
5. Psychosexual Evaluation by Dr. Linda Hatzenbuehler, Ph.D., dated 11/14/2011: This evaluation was court-ordered following Ms. Edmo's guilty plea to the charge of Sexual Abuse of a Minor Under the Age of 16. Dr. Hatzenbuehler indicated that Ms. Edmo "approached the psychosexual testing with a tendency to present himself in a socially desirable light. However, his results were valid and interpretable." She noted that Ms. Edmo was "cooperative and open about his perpetration." Dr. Hatzenbuehler described Ms. Edmo's appearance, "Mr. Edmo appeared to be a 23-year-old, Native American male." She stated, "He denied ever cross-dressing," and reported that Ms. Edmo said he masturbated once or twice every two or three weeks. She also reported that Ms. Edmo had had sexual contact with two females in the past.
6. Ms. Edmo's IDOC identification photographs taken on 01/07/2010 and on 04/27/2012 do not demonstrate any observable evidence of feminization. Although the back of Ms. Edmo's hair is not visible in the photograph dated 04/27/2012, both photographs appear to show Ms. Edmo with very short hair and ungroomed eyebrows. The first sign of a feminized appearance can be seen in the photograph dated 08/14/2013, in which Ms. Edmo's hair has grown out slightly and her eyebrows are thinner. In contrast, Ms. Edmo's photographs from 12/10/2014 show a markedly more feminized appearance, with long curly hair, well-groomed eyebrows and possible makeup (difficult to discern in photocopied black-and-white photographs). When I asked Ms. Edmo in my interview whether she had ever had short hair, she said that she had not, but then when I asked her again, she indicated that she had been made to shave her head at the NICI program. From the available records, it appears that Ms. Edmo was in the NICI program from 02/08/2010 through 06/21/2010. This does not clearly explain why her hair was short on 01/07/2010 (before she arrived at the program) or on 04/27/2012 (when she arrived in prison on her current charge).

In addition to the inconsistencies listed above, Ms. Edmo's report to me that she was not aware of the concept of being transgender until she was detained at Bannock County Jail on her current charge and met another transwoman differs markedly from her report to Dr. Gorton as noted in his declaration dated 05/29/2018:

> By early adulthood, she had learned that there were other transgender people and that she could obtain a diagnosis regarding her gender dysphoria and obtain medical and surgical treatments to alter her body to better reflect her gender identity. She reports wanting to get HRT and SRS but that "I knew that was a lengthy process," and her intent

> to transition was interrupted both by her difficulty organizing herself due to concurrent substance abuse as well as eventually being imprisoned. She does report that a psychiatrist she had seen through the Indian Health Service mentioned the possibility of getting a diagnosis related to gender dysphoria and said that if she wanted treatment, they would have to send her to a specialist.

I was not able to find a record from a psychiatrist at IHS supporting Ms. Edmo's above statements. As noted above, my discussion with Ms. Edmo about past treatment for gender dysphoria yielded different information:

> Ms. Edmo was asked whether she had ever sought or received treatment for gender dysphoria prior to her incarceration. She reported that she did not understand what it meant to be transgender until she entered county jail on the controlling charge and met a transgender woman. She recalled having been "labeled as a gay man" previously, explaining that this did not completely resonate with her but she did not know there was an alternative explanation to how she felt. She recalled knowing bisexual and homosexual peers, but never anyone else who identified as transgender. She stated that she remembered feminized men on her Indian Reservation, but she never spoke to them about their gender identity and now realizes they may have been transgender.
>
> Ms. Edmo indicated that a transgender detainee at Bannock County Jail befriended her in 2011 and advised her to seek contact with mental health professionals and physicians at the jail so she could request cross-gender hormone treatment. She said that prior to meeting this individual, she did not really know what it meant to be transgender, and had never heard of cross-gender therapy. However, at another point in the interview she reported that she had started to discuss her gender identity with a correctional professional at the diversion program in 2009 but that she had been told "just not to mention it," so she never brought it up again.

Ms. Edmo's reported history does not match her records, and the reasons for this are known only to Ms. Edmo. There are many reasons that an individual with Gender Dysphoria might have to not dress in his/her preferred gender role, including fear of social rejection and lack of family acceptance. Gender Dysphoria can also arise later in life, or individuals with early realization of gender incongruence may not acknowledge or become fully aware of their gender dysphoria until years later. However, this is not the history Ms. Edmo provided; she indicated that despite her lack of awareness of Gender Dysphoria as a diagnosis, she was living as a woman in the community and presenting herself in a feminized fashion. The records listed above do not support this history. I did not have the records listed above prior to my evaluation of Ms. Edmo, and therefore did not have the opportunity to discuss these inconsistencies with her or ask for clarification. I have not seen documentation indicating that the plaintiff's experts reviewed the records listed above or sought to clarify these discrepancies with Ms. Edmo. While these inconsistencies do not "prove" that she does not have Gender Dysphoria, they represent important areas of exploration that should be considered prior to recommending irreversible surgery.

Ms. Edmo's report of her family's acceptance of her lifelong attraction to men (which she initially identified as homosexuality) has varied. As noted above, Ms. Edmo's presentence report from 2011 indicates that she stated she was abusing alcohol regularly "because he was struggling to tell his family that he's homosexual." In my interview, Ms. Edmo appeared to minimize this difficulty and stated that her family and the Native American community did not question or condemn her reportedly feminized appearance and behavior. She also said that her mother asked if she liked girls when she was 14 years old, and that her mother accepted her answer readily. Similarly, Ms. Edmo's psychosexual evaluation from November 2011 notes that Ms. Edmo has "always been very comfortable with his sexuality, and he has lived in an environment that is accepting of it."

Because of the inconsistencies in her reporting, I considered sources of secondary gain that may drive Ms. Edmo's report of gender dysphoria. Her records indicate she is required to register as a sex offender, so a change in her identity may be desirable. She asked about changing her gender identity to female on the Static-99, an actuarial risk assessment instrument designed for use with adult male offenders, which may be interpreted as an effort to decrease her overall risk projection. However, I did not find evidence that either of these issues have been areas of focus for Ms. Edmo, and can therefore not conclude that Ms. Edmo is intentionally misleading her treatment providers for the purpose of impacting her legal status. Notwithstanding the reasons for the inconsistencies above, it is important that Ms. Edmo be forthcoming and transparent about her history with her treatment providers, as poor engagement with treatment providers has been associated with worse outcomes following surgery.[7]

Criterion 4: Medical/Mental health concerns must be well controlled
It is my opinion, with reasonable medical certainty, that Ms. Edmo's persistent self-injurious behavior indicates that her mental health concerns are not well controlled. As of the date of my interview, Ms. Edmo indicated that she had been cutting herself without suicidal intent, as recently as one month earlier. Regardless of the reported trigger for her self-injurious behavior, mental health and medical professionals generally consider self-injurious behavior to be a maladaptive coping strategy that indicates that mental health concerns are not well controlled.

Ms. Edmo has also consistently reported chronic intermittent urges to castrate herself, and has engaged in two such attempts. Dr. Ettner refers to Ms. Edmo's two episodes of auto-castration as "surgical self-treatment." This term appears in Dr. George Brown's 2010 article reporting on "a case series of four inmates who engaged in attempted or completed surgical self-treatment of their gender dysphoria via autocastration, autopenectomy, or a combination in the absence of concomitant psychosis, intoxication, or other comorbidities that could reasonably account for this rare behavior." Dr. Brown notes that these behaviors "occurred in the context of

[7] P.T Cohen-Kettenis, L.J.G Gooren, Transsexualism: A review of etiology, diagnosis and treatment, Journal of Psychosomatic Research, Volume 46, Issue 4, 1999, Pages 315-333.

persistent denials of access to transgender health care in prison settings."[8] Dr. Gorton expands on this discussion to distinguish Ms. Edmo's attempts at autocastration from nonsuicidal self-injury (NSSI) done for the purpose of inflicting pain leading to emotional relief. He opines that self-surgery is a "health-seeking action." While I agree with Dr. Gorton's distinction—Ms. Edmo's attempts at autocastration differ from NSSI done for emotional relief by inflicting pain—Dr. Gorton's analysis does not acknowledge that there are other forms of self-injurious behavior that are commonly observed within the correctional environment. Self-injurious behavior within a prison or jail setting may indeed be driven by suicidal intent or by a desire to experience temporary emotional relief. It may also be manipulative in nature, a phenomenon that is well-known to experienced correctional health professionals. A 2008 article describes this as "self-mutilation through clearly planned strategies executed to manipulate desired environmental events."[9]

It is my opinion that even if the desired environmental event triggering her attempts at self-castration is truly orchiectomy/genital surgery, these incidents of self-injury should not be endorsed as "health-seeking" and should not be used as an argument in favor of gender confirmation surgery. The phenomenon of "surgical self-treatment" appears to be limited to the correctional environment, as there are few cases to be found of autocastration in the community in the absence of psychosis. Although access to appropriate transgender care has improved dramatically in recent years, it is unlikely that all individuals with severe genital anatomic gender dysphoria in the community have been able to access treatment to include orchiectomy/penectomy, thereby preventing their attempts to "surgically self-treat." This phenomenon, like several other forms of self-injury, appears to be uniquely related to the correctional environment, and not a common attribute of gender dysphoria proven to render an individual a good candidate for surgery. In my opinion, there is significant danger in referring to intentional self-harm in any form as "health-seeking," which is compounded by the plaintiff's experts' use of these gestures in support of Ms. Edmo's reported desire for surgery. The plaintiff's experts have not provided adequate evidence-based references to show that this form of "self-treatment" is later associated with positive surgical outcomes or with resolution of psychopathology following surgery, and using these incidents to support Ms. Edmo's case potentially reinforces this unsafe behavior.

Dr. Ettner further opines, "If Ms. Edmo does not receive gender confirmation surgery, she is at great risk of self-castration and other self-harm, including suicide." Cecilia Dhejne et al authored a commonly-cited cohort study of the long-term effects of gender confirmation surgery in Sweden in 2011.[10] The data available for this study provided the unique benefit of allowing interpretation of outcomes from all 324 sex-reassigned persons in Sweden from 1973-2003, and, unlike the majority of studies used to provide evidence in favor of gender

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[8] George R. Brown (2010) Autocastration and Autopenectomy as Surgical Self-Treatment in Incarcerated Persons with Gender Identity Disorder, International Journal of Transgenderism, 12:1, 31-39.
[9] Mario E. Martinez PsyD (1980) Manipulative Self-Injurious Behavior in Correctional Settings, Journal of Offender Counseling Services Rehabilitation, 4:3, 275-284.
[10] Dhejne C, Lichtenstein P, Boman M, Johansson ALV, Långström N, Landén M (2011) Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden. PLoS ONE 6(2): e16885.

confirmation surgery, was not limited by loss to follow-up. The study matched sex-reassigned persons to random population controls matched by birth year and birth sex initially, and later by reassigned sex, and found that the overall mortality for sex-reassigned persons was higher during follow-up than for controls, particularly for death by suicide (19.1-times higher risk for completed suicide in the sex-reassigned population). It is important to note that in this study, sex-reassigned individuals were compared with general population controls, not with gender dysphoric individuals who did not undergo gender confirmation surgery. It is therefore incorrect to conclude that gender confirmation *causes* an increase in completed suicide rate. The authors conclude:

> Persons with transsexualism, after sex reassignment, have considerably higher risks for mortality, suicidal behavior, and psychiatric morbidity than the general population. Our findings suggest that sex reassignment, although alleviating gender dysphoria, may not suffice as treatment for transsexualism, and should inspire improved psychiatric and somatic care after sex reassignment for this patient group.

There are a variety of follow-up discussions and interviews found in various locations, some involving the primary author, that protest the citation of this study as an argument against gender confirmation surgery. Likewise, this reference is notably absent in the reports of both of the plaintiff's experts. It is my opinion, however, that it would be irresponsible not to consider the findings in this study when weighing the medical necessity of GCS for a gender dysphoric individual, particularly in regard to suicide risk. Based on these findings, individuals who undergo genital confirmation surgery are at very high risk for completed suicide compared with the general population. I am not aware that the authors of this study or anyone else have reanalyzed the data to provide a direct comparison of post-operative gender dysphoric individuals with gender dysphoric individuals who have not undergone surgery. Such a study may indeed demonstrate that gender confirmation surgery reduces the risk of completed suicide in gender dysphoric individuals. The findings of this study should instead be used to raise awareness that gender confirmation surgery does not "cure" all gender dysphoric individuals of their suicidality, and that arguing for gender confirmation surgery as a means of managing or eliminating suicidality is not evidence-based.

Cynthia Osborne and Anne Lawrence[11] also argue against asserting the medical necessity of SRS on the grounds of treating suicidality or depression. They write:

> … health professionals and attorneys commonly argue that the reason SRS is medically necessary for inmates is to prevent or treat other psychiatric conditions, such as depression or suicidality, which are assumed to be consequences of GD … Unfortunately, SRS is not very effective in treating associated psychiatric conditions. Community-dwelling persons with GD display an elevated prevalence of comorbid mental health problems, including mood disorders, anxiety disorders, and suicidality,

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[11] Osborne S. & Lawrence A. (2016). Male Prison Inmates With Gender Dysphoria: Wen Is Sex Reassignment Surgery Appropriate? *Archives of Sexual Behavior* 45(7): 1649-1663.

> and these comorbid conditions do not significantly improve after SRS … while SRS usually ameliorates GD and increases overall life-satisfaction, it appears to confer little or no additional improvement in other psychiatric symptoms … the argument that SRS is medically necessary primarily to treat or prevent depression or suicidality is not supported by empirical evidence, and it is also problematic for other reasons. Such an argument invites the counterargument that inmates' complaints of depression or suicidal threats or gestures can simply be manipulative and that prison authorities cannot acquiesce to them without inviting further manipulation … Moreover, arguing that SRS is medically necessary to prevent suicide could establish an unhelpful precedent, with suicidal threats or gestures becoming de facto prerequisites for SRS.

Criterion 6: 12 continuous months of living in a gender role that is congruent with gender identity

The WPATH SOC version 7 describes the rationale for this requirement:

> The criterion noted above for some types of genital surgeries – i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity – is based on expert clinical consensus in that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery. As noted in section VII, the social aspects of changing one's gender role are usually challenging – often more so than the physical aspects. Changing gender role can have profound personal and social consequences, and the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role. Support from a qualified mental health professional and from peers can be invaluable in ensuring a successful gender role adaptation.
>
> The duration of 12 months allows for a range of different life experiences and events that may occur throughout the year (e.g., family events, holidays, vacations, season-specific work or school experiences.) During this time, patients should present consistently, on a day-to-day basis and across all settings of life, in their desired gender role. This includes coming out to partners, family, friends, and community members (e.g., at school, work, other settings). Health professionals should clearly document a patient's experience in the gender role in the medical chart, including the start date of living full time for those who are preparing for genital surgery. In some situations, if needed, health professionals may request verification that this criterion has been fulfilled: They may communicate with individuals who have related to the patient in an identity-congruent gender role, or request documentation of a legal name and/or gender marker change, if applicable.

While the description above outlines the rationale for this real-life experience, it does not provide guidance for its interpretation in the correctional environment. The authors of the

Standards of Care likely did not intend for this criterion to exclude detained or incarcerated individuals from receiving gender confirmation surgery; however, they did assert by expert consensus that they believe it is important that an individual considering genital confirmation surgery be faced with all of the social situations and challenges mentioned above, and did not explain how this can or should be accomplished in a correctional environment. It is a simple fact that while incarcerated, an individual who will one day be released from prison is not able to fully experience the "real life" that he or she will face in the community. He or she cannot attend family events, holidays with family and friends, vacations, work or school outside of the correctional setting when incarcerated or detained. Because of these restrictions, it is my opinion that the "real-life experience" must be considered on a case-by-case basis.

It is my opinion, with reasonable medical certainty, that Ms. Edmo has not yet met this criterion for genital surgery. The Standards of Care specifically indicate that in some situations, health professionals may request verification that this criterion has been fulfilled, recognizing that the individual's self-report may not be sufficient. As discussed above, Ms. Edmo's available outside records do not support her claim of having lived as a female in the community, and her self-report of her experience to support having met this criterion can therefore not be verified with the information available at this time.

It is also my opinion that Ms. Edmo's life was ruled by alcohol and drug use prior to her incarceration, limiting the validity of any real-life experience she may have had. Her records from prior to entering prison indicate that she voiced recognition of the profoundly negative impact of her substance abuse on her ability to live a successful life. By her own admission, the years leading up to this incarceration involved Ms. Edmo moving from state to state "wherever the drugs were," leaving room for little else in her life. If she did indeed present herself as female during the months and years leading up to her crime, the information that could be gleaned from this experience would be seriously shadowed by her admitted lack of sober time prior to her arrest. It is my opinion that the real-life experience is not valid if it occurs in the presence of heavy substance abuse, which would mask appropriate emotional responses to the difficulties of social transition and not allow for the development of healthy coping strategies in preparation for permanent transition.

As the care and treatment of gender dysphoric and gender non-conforming individuals in custody have evolved in recent years, some states and the federal system have recently begun to house individuals according to their identified rather than natal gender. Although not specifically considered for the purpose of living the real-life experience, the possibility of transferring Ms. Edmo to a women's facility has been discussed and considered by the Management Treatment Committee on several occasions. Ms. Edmo requested a transfer to Pocatello Women's Correctional Center (PWCC) and this request was considered by the MTC on 03/02/2016. The MTC notes from this date indicate that Ms. Edmo's reported reason for this request was that "Edmo has heard from many correctional staff that Edmo is at an increased safety risk associated with being in a male prison, and requests to be moved to a female prison since staff believe Edmo is unsafe in current prison." The notes also indicate, "Edmo denied being fearful for safety and denied safety concerns of Edmo's own involving staff or inmates."

The MTC concluded, "MTC discussed safety concerns that other inmates at PWCC may experience as a result of having a biological male be housed at PWCC," and cited IDOC policy 401.06.03.501 that "inmates shall be housed by their primary physical sexual characteristics." Of note, around the same time, Ms. Edmo had also requested to move out of the Behavioral Health Unit (BHU) at Idaho State Correctional Institution (ISCI) to general population at South Idaho Correctional Institution. The MTC concluded during the March 2016 meeting that Ms. Edmo must meet the established MTC housing requirements before moving out of the BHU, which she did not meet at that time due to having received three Class B DORs in the previous six months.

Ms. Edmo made another request to transfer to PWCC, to IDOC Chief Psychologist Dr. Campbell in 2017. This request was again considered by the MTC on 09/13/2017. The notes from this meeting indicate, "The MTC felt that Edmo has maintained the ability to reside in a male facility, and manage Edmo's Gender Dysphoria. The MTC has concerns with Edmo's history of violence and sexual activity, and whether those behaviors can be addressed in a female facility. Edmo has attended the groups for inmates with Gender Dysphoria for several years. The MTC does recommend that Edmo be moved to another male facility based on Edmo's request." The MTC cites considerations including "Edmo has three security concerns with other inmates. One of these inmates resides at ISCI, and Edmo is not to reside with this other inmate in the same living unit. Edmo had two security concerns with inmates who reside at ISCC, and Edmo is not supposed to reside in the same facility with one of the inmates, and cannot reside in the same living unit as the other. Edmo has 28 DORs, with 2 being in the last year for sexual activity and Destruction of Property. The inmate current [sic] resides in general population, and can be managed in a general population setting based on the inmate's security needs … It's the MTC's recommendation that Edmo be moved to ICI-O, as this is the only facility that can accommodate Edmo's custody level and safety concern needs." The 02/07/2018 MTC notes indicate that Ms. Edmo was subsequently moved from one unit to another within ISCI "due to behavioral problems in Unit 11," and that "MTC noted that there are numerous verbal reports of Edmo's misbehavior, but this has not been documented in CIS."

As described above, in addition to citing IDOC policy in support of keeping Ms. Edmo in a male prison facility, the MTC's documentation also indicates that they considered this question on an individual basis and concluded that Ms. Edmo should not be transferred to a women's facility for security reasons. Specifically, the MTC cited Ms. Edmo's history of violence and sexual activity, and each of these factors will be discussed below.

Ms. Edmo reported to me that she had been denied parole as a result of being removed from several programs due to fights with a transgender peer over "catty, stupid stuff." Disciplinary Offense Reports (DORs) were reviewed for these incidents. On 06/20/2014, Officer D. Thornton writes, "I observed Offender Edmo strike another offender with open and closed hands during a fight occurring in the Unit 16 A Tier Dayroom." Ms. Edmo appealed the sanctions that resulted from this DOR but did not dispute the incident details. On 11/15/2015, Brittany Fisher writes, "As I rounded cell 06 I observed inmates Edmo #94691 and X (redacted) fighting. Edmo had X pushed up against the wall. Edmo was delivering body punches to X. I radioed the emergency

and gave them verbal commands to stop fighting. They continued to fight with one another. I informed them to stop or O/C will be deployed. Edmo delivered one more punch before they complied with verbal commands … Both inmates admitted to throwing punches.” Although I have not seen documentation that Ms. Edmo has engaged in physical fighting since the second incident described above in November of 2015, it is my opinion that the severity of these incidents and that fact that according to Ms. Edmo, these incidents both involved a transgender female rather than a male inmate, should be taken into account when considering Ms. Edmo’s placement.

The MTC also cited Ms. Edmo’s history of sexual activity as a contraindication to her moving to a women’s facility. There are numerous incident reports documenting that Ms. Edmo has been involved in sexual activity with multiple male inmates throughout her prison sentence. I have not come across an incident report that describes Ms. Edmo using her penis for penetration or other sexual activity, and Ms. Edmo consistently reports being attracted to men exclusively. However, in her psychosexual evaluation dated 11/14/2011, Dr. Hatzenbuehler indicates that Ms. Edmo reported having been involved in sexual activity with two women in the past. Unfortunately, Ms. Edmo’s psychosexual evaluation became available to me only through the process of discovery, and I did not have it at the time of my evaluation of Ms. Edmo and therefore did not have the opportunity to ask for clarification or additional information about these encounters. It is notable that Ms. Edmo had also reported having been sexually involved with two women during a pre-polygraph interview around the same time. This warrants further exploration and should be considered in future discussions of a possible move to a women’s facility. While these reported incidents may not be deemed to contraindicate Ms. Edmo from such a transfer, it is significant that Ms. Edmo has consistently denied any history of sexual involvement with women and this discrepancy must be investigated.

As standards evolve, and correctional systems begin to accumulate and share data on the optimal housing of transgender inmates within the correctional environment, it is my opinion that Ms. Edmo’s treatment providers, along with IDOC, should consider whether Ms. Edmo can be safely placed in a women’s facility for the purposes of beginning the real-life experience. While such a placement cannot truly approximate her “real life” once she completes her sentence in 2021 and enters the community, it might provide Ms. Edmo with an opportunity to disengage from her struggle with correctional officials regarding safe feminization in a male prison, and to feminize to a greater extent. Assuming that her reported lack of sexual interest in women is accurately-reported, it might also allow her to separate her female identity from sexual opportunity, and focus more fully on herself as female and less so on relationships and sexual activity. My evaluation of Ms. Edmo did not include a comprehensive violence risk assessment or sexual violence risk assessment and does not substitute for a careful assessment of any potential security concerns, however.

Alternative and supplementary approaches to treatment of GD

While the WPATH Standards of Care are widely distributed and generally accepted by many healthcare professionals treating gender dysphoric individuals, not everyone agrees that they should be the only set of guidelines used, particularly in the prison setting. As discussed above,

CMS stated "we are not in the position to endorse exclusive use of WPATH for coverage" in response to stakeholder input during their National Coverage Analysis in 2016. CMS cited the lack of generalizability of available data to their unique Medicare population. It is my opinion that there is a similar lack of generalizability to the correctional population. In a 2016 article authored by Cynthia S. Osborne and Anne A. Lawrence and published in the Archives of Sexual Behavior, the question of sex reassignment surgery [sic] for natal male prisoners is directly discussed. Regarding the SOC, the authors write:

> … But the SOC are not without controversy. Although they were formulated by experienced clinicians and scholars, most SOC recommendations are based on low-quality evidence, such as case series and expert opinion. The SOC also do not represent the experiences and practices of all GD experts, and some provisions of the SOC seem to reflect political considerations rather than scientific evidence or clinical experience.
>
> Moreover, the SOC were not developed based on extensive clinical experience with incarcerated persons, many of whom have histories, characteristics, and vulnerabilities that differ substantially from community-dwelling persons with GD …

While agreeing that prisons must make "reasonable efforts to provide medically necessary treatments, including SRS, to inmates," the authors contest the SOC's assertion that "all provisions of the SOC are applicable to all persons in prisons and other institutions":

> … the unqualified statement that "all elements of assessment and treatment as described in the SOC can be provided to people living in institutions" does not reflect extensive clinical experience … Its confident simplicity may not adequately take account of the clinical and contextual complexities that inmates with GD present.
>
> Many inmates who seek treatment for GD in prison never sought treatment in the community. Many have lived troubled, chaotic lives characterized by early family and economic instability, substance abuse and other psychiatric problems, failed school and employment experiences, and early involvement in crime. Inmates who seek treatment for GD typically display little resemblance to the patients who present for treatment in the community, and prison life bears little resemblance to life in the community. The SOC were not developed with the complexities, vulnerabilities, and life circumstance of incarcerated persons in mind.

In their discussion of the process of determining the medical necessity of SRS for natal male inmates, Osborne and Lawrence emphasize the determination of medical necessity reflects the exercise of professional judgment, that SRS may be considered medically necessary for natal males when "their GD reflects intense distress about the incongruence between their external genitalia and their gender identity," and that "other grounds for asserting the medical necessity of SRS, such as treating suicidality or depression, are more problematic." The authors also argue that disputing the medical necessity of SRS in general is unsupportable, but note that regarding the literature in support of SRS:

> These favorable conclusions are derived from experience with community-dwelling patients. Although it is reasonable to assume that they would also apply to prison inmates, empirical evidence to support this assumption is lacking. SRS remains untested in incarcerated persons, who often differ in significant ways from community patients.

Osborne and Lawrence propose modification of SOC eligibility requirements when considering the medical necessity of SRS for inmates. They opine that “additional or more stringent eligibility requirements for SRS can be imposed in certain circumstances,” noting that some community clinics impose more stringent requirements. The authors write, “Because clinical experience with SRS in correctional settings is currently nonexistent, we believe that initially imposing additional eligibility requirements would be advisable,” including:

1. Prominent genital anatomic GD;
2. A long period of expected incarceration after SRS;
3. A satisfactory disciplinary record and demonstrated capacity to cooperate with providers and comply with recommended treatment;
4. A period of psychotherapy, if recommended by the responsible practitioner; and
5. Willingness to be assigned to a women’s prison after SRS.

If these proposed requirements are applied to Ms. Edmo, she appears to clearly meet the fifth requirement as she has expressed interest in transfer to a women’s prison. Her sentence is set to complete in July of 2021, so she appears to meet the second requirement as well. The other proposed criteria are not clearly met, however. Many of her disciplinary issues have surrounded her attempts to feminize, but she has also received DORs for physical fights, sexual activity, and unauthorized communication. She has not demonstrated the capacity to cooperate with providers and reported to me that she refuses to meet with her assigned clinician or attend recommended mental health groups. She reports prominent genital anatomic gender dysphoria, but her self-report does not appear reliable and must be explored further. Despite her report to me that she received no treatment for her gender issues outside of prison, she has not been willing to engage in psychotherapy to explore her gender identity and associated difficulties, appearing to equate any participation in therapy with efforts to dissuade her from identifying as female.

<u>Discussion of alleged negligence and deliberate indifference by Corizon:</u>
As discussed above, it is my opinion, with reasonable medical certainty, that Corizon and Corizon providers Scott Eliason, Murray Young and Catherine Whinnery have not been negligent in their treatment of Ms. Edmo. It is my opinion that her gender issues were evaluated promptly, that she was started on appropriate cross-gender hormone therapy relatively quickly, and that the management of her hormone therapy has not fallen below acceptable standards. I agree with Dr. Gorton’s declaration that lab values have not always been interpreted properly, but as discussed further above, laboratory monitoring of cross-gender hormone therapy is not evidence-based at this time. In reviewing Ms. Edmo’s orders

and the trajectory of her hormone regimen treatment, I believe she has received appropriate medications at appropriate dosages.

Further, I disagree with the second amended complaint filed by Ms. Edmo alleging that defendants "failed to enact appropriate standards and procedures that would have prevented the harm that she has experienced." When private healthcare companies are contracted to provide care for inmates in prison settings, they generally agree to practice within correctional policies and procedures. It is my opinion that Corizon and its providers working within IDOC had and have an obligation to assess and treat Ms. Edmo's gender dysphoria in a clinically appropriate manner, to include proposing policy changes if they felt unable to provide medically necessary treatment under the ruling policy. As discussed above, there is very little evidence to dictate the exact provision of Gender Dysphoria care in correctional settings, however, and policies differ substantially around the country. On a positive note, many systems are sharing information via academic and professional conferences and consultation, and continuously updating their policies to expand the treatment options available to inmates with Gender Dysphoria. Likewise, it is recommended that IDOC continue to review and update the provisions of their Gender Dysphoria policy as indicated, to include consideration of housing by preferred gender when indicated and appropriate. While there will always be room for modifications as more data becomes available, it is my opinion that IDOC's current policy has not prevented Corizon's providers from exercising professional judgment in Ms. Edmo's treatment decisions.

Accordingly, it is my opinion, with reasonable medical certainty, that Corizon and its providers Dr. Scott Eliason, Dr. Catherine Whinnery and Dr. Murray Young were not deliberately indifferent to Ms. Edmo's medical and mental health needs. Deliberate indifference occurs when a professional knows of and disregards an excessive risk to an inmate's health or safety.[12] In Ms. Edmo's case, she reported gender concerns, was evaluated in a timely fashion and started on hormone therapy relatively quickly, and her treatment has been adjusted according to her response. Her providers did not determine that gender confirmation surgery is medically necessary for Ms. Edmo, but this was an exercise in professional judgment and not a demonstration of deliberate indifference. Despite Ms. Edmo's dissatisfaction with her treatment, I believe that the defendants' assessment and treatment of Ms. Edmo met reasonable standards, and did not demonstrate disregard of a risk to her health or safety.

Conclusions:

The plaintiff's experts have an abundance of experience treating gender dysphoric individuals in the community, and should be applauded for the work they have done to expand access to care for this population. It is my strong opinion, however, that decisions regarding the care and treatment of gender dysphoric individuals in the correctional environment must also be informed by long-term experience working within the correctional setting in a treatment capacity, and by participation in multidisciplinary meetings regarding the care and treatment of inmates. Consulting in a legal context is insufficient to establish correctional expertise. The brevity of SOC7's discussion of institutional environments and cursory recommendation to provide the same treatment inside the prison setting as one would receive outside reveals a

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[12] *Farmer v. Brennan,* 511 U.S. 825 (1994

lack of appreciation for important and unique aspects of incarceration, and lack of attention to outcomes. As Osborne and Lawrence indicated in their 2016 article, there is no outcome data on gender confirmation surgery in a correctional setting. Correctional professionals would benefit from having this section expanded in a future version of the SOC, based on specific evidence rather than an uninformed perception of correctional systems. Gender confirmation surgery should not be outright prohibited in a correctional environment, but until more data is available, it is appropriate for correctional healthcare professionals to use caution in making determinations regarding gender confirmation surgery.

Decisions regarding Ms. Edmo's Gender Dysphoria treatment must be based on her own unique history and set of factors in order to optimize the likelihood that her specific treatment will be successful. These decisions should not be driven by a commitment to Gender Dysphoria as a cause, but by the individualized needs of the patient. It is notable that neither of the plaintiff's experts appear to have reviewed or made an effort to review any records predating her incarceration, and that these records were obtained only through subpoena. In Ms. Edmo's particular case, there are questions that must be answered, coping strategies that must be developed, and experiences that must be encountered before irreversible surgery can be considered medically necessary.

My opinion on this case is based on information available to me at the time of completing this report. I reserve the right to modify or change my opinion on some or all aspects of this case if additional information becomes available.

Respectfully submitted,

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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ADREE EDMO, Plaintiffs, vs. IDAHO DEPARTMENT OF CORRECTION; HENRY ATENCIO, in his official capacity; JEFF ZMUDA, in his official capacity; HOWARD KEITH YORDY, in his official and individual capacities; CORIZON, INC.; SCOTT ELIASON; MURRAY YOUNG; RICHARD CRAIG; RONA SIEGERT; CATHERINE WHINNERY; AND DOES 1-15; Defendants.	)	Case No. 1:17-cv-151-BLW **IDOC DEFENDANTS' RESPONSE TO PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION**

parole. *Watson Decl*., ¶ 18; *Declaration of Sandy Jones* ("*Jones Decl*."), ¶ 13.

On April 20, 2016, Ms. Edmo received an evaluation for sex reassignment surgery ("SRS") by qualified GD evaluator, Dr. Eliason. *Crecelius Decl*., Exh. C ("*Eliason Depo*"), p. 106-114. As part of that evaluation, Dr. Eliason consulted with IDOC Lead Clinician Jeremy Clark, who is a member of the World Professional Association for Transgender Health ("WPATH"), regarding whether Ms. Edmo met the criteria for SRS. *Eliason Depo*., p. 106-114; *Declaration of Jeremy Clark* ("*Clark Decl*.,) ¶¶ 3, 10. After an in-person visit with Ms. Edmo and consultation with mental health staff, Dr. Eliason determined that Ms. Edmo did not meet the criteria for SRS and it was therefore not medically necessary. *Eliason Depo*., p. 110.

LEGAL STANDARD

The IDOC Defendants incorporate the legal standard for deciding a preliminary injunction that is set forth in *Plaintiff's Motion for Preliminary Injunction* (Dkt, p.16), with the following additions. First, the standard for granting a preliminary injunction requires Plaintiff "to demonstrate that irreparable injury is likely in the absence of an injunction (not just a possibility of harm)." *Winter v. Nat. Res. Def. Council, Inc*., 555 U.S. 7, 22, 129 S. Ct. 365, 375 (2008) (emphasis added). To issue a preliminary injunction based only on a possibility of irreparable harm would be "inconsistent with our characterization of injunctive relief as an extraordinary remedy that may only be awarded upon a clear showing that the plaintiff is entitled to such relief." *Mazurek v. Armstrong*, 520 U.S. 968, 972, 117 S.Ct. 1865, 138 L.Ed.2d 162 (1997) (per curiam).

Furthermore, mandatory injunctions ordering a party to take action—such as the type sought by Ms. Edmo in this case—are particularly disfavored and are generally not granted unless extreme or very serious damage will result. *Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1185 (N.D. Cal.), *appeal dismissed and remanded*, 802 F.3d 1090 (9th Cir. 2015). Mandatory

injunctions are not issued in doubtful cases "or where the injury complained of is capable of compensation in damages." *Id*. Finally, the Prison Litigation Reform Act ("PLRA") provides that, in any civil action regarding prison conditions, 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 the harm…" 18 U.S.C.A. § 3626(a)(2). The PLRA further requires the Court to give "substantial weight to any adverse impact on public safety or the operation of a criminal justice system caused by the preliminary relief." *Id*.

ANALYSIS

Plaintiff moves for preliminary injunctive relief on the basis of her Eighth Amendment Claims alleging that the IDOC Defendants were deliberately indifferent to Ms. Edmo's medical needs and on the basis of her sex discrimination claims under the Fourteenth Amendment and the Affordable Care Act. For the reasons argued below, Plaintiff's *Motion for Preliminary Injunction* should be denied.

I. Plaintiff Cannot Establish That She Will Succeed on Her Claims

A. Eighth Amendment claims

Plaintiff asserts that the IDOC Defendants were deliberately indifferent to her medical needs in violation of the Eighth Amendment. Mere negligence alone does not establish a valid Eighth Amendment claim. *Estelle v. Gamble*, 429 U.S. 97, 104, 97 S. Ct. 285, 291 (1976). Rather, in order to succeed on such a claim, a plaintiff must first establish that a prison official was "deliberately indifferent" to a prisoner's serious medical need. *Colwell v. Bannister*, 763 F.3d 1060, 1066 (9th Cir. 2014). A prison official is deliberately indifferent only if the official "knows of and disregards an excessive risk to inmate health and safety." *Id*. (quoting *Toguchi v. Chung*, 391 F.3d 1051, 1057 (9th Cir. 2004)) (emphasis added). "[T]he official must both be

aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference." *Id*. (quoting *Farmer v. Brennan*, 511 U.S. 825, 837 (1994)).

This Court has very recently articulated the deliberate indifference standard as it applies to cases involving mental health care as follows:

> In the context of mental health care, courts have recognized that it is particularly difficult to establish deliberate indifference to a serious need for numerous reasons. "First, there is considerable room for disagreement and debate among psychiatrists and other mental health professionals as to what is a serious mental illness for which the denial of adequate treatment causes constitutionally cognizable pain." *Capps v. Atiyeh*, 559 F. Supp. 894, 917 (D. Or. 1982). For instance, mere anxiety may not be a serious medical need, as opposed to a part of the "routine discomfort" that is an inevitable consequence of the penalty of imprisonment. See, e.g., *Long v. Nix*, 877 F. Supp. 1358,1366 (S.D. Iowa 1995), aff'd, 86 F.3d 761 (8th Cir. 1996). Second, "[t]he diagnosis of mental illnesses is made tougher still because it is easy for inmates tired of their boring, restrictive and even harsh routines to feign the symptoms of mental illness to effect a change in their environment." *Id*. (internal quotation marks omitted). Third, "psychiatrists themselves differ on the underlying theories and thus on the methods of treatment." *Id*. "[T]he Constitution only requires that the courts make certain that professional judgment in fact was exercised. It is not appropriate for the courts to specify which of several professionally acceptable choices should have been made." *Id*. (internal quotation marks omitted) (quoting *Youngberg v. Romeo*, 457 U.S. 307, 314 (1982)).

Mintun v. Corizon Med. Servs., No. 1:16-CV-00367-DCN, 2018 WL 1040088, at *5 (D. Idaho Feb. 22, 2018)(emphasis added).

Here, the IDOC Defendants recognize that Ms. Edmo's GD is a "serious medical need" for purposes of her Eighth Amendment claim. Indeed, Ms. Edmo was first diagnosed with GD while in IDOC custody in 2012, less than three months after being incarcerated at ISCI. Her diagnosis has been treated with HRT and counseling and she has been provided the ability to feminize in prison, and is followed closely by a multi-disciplinary team. However, for the following reasons, Ms. Edmo cannot establish that the IDOC Defendants deliberately disregarded an excessive risk to Ms. Edmo's health and safety.

committed to the responsibility of prison administrators in the executive branch of government. *Oakleaf v. Martinez*, 297 F. Supp. 3d 1221, 1233 (D.N.M. 2018).Ordering the IDOC Defendants to provide medical care that is not medically necessary and runs counter to the treatment prescribed by Ms. Edmo's mental health and medical treatment providers after exercising their professional judgment weighs against the public interest. *See id*. Ms. Edmo's medical and mental treatment must be viewed, as her Corizon and IDOC providers have done, in the context of her entire mental health and personal history. To address her needs in a vacuum, based on incomplete information and without evaluating her entire clinical picture, does not serve the public's interest, and it certainly does not serve Ms. Edmo.

CONCLUSION

For the foregoing reasons, the IDOC Defendants respectfully request that this Court deny the *Plaintiff's Motion for Preliminary Injunction*.

DATED this 14th day of September, 2018.

Moore Elia Kraft & Hall, LLP

/s/Brady J. Hall
Attorneys for Defendants Idaho Department of Correction, Henry Atencio, Jeff Zmuda, Howard Keith Yordy, Richard Craig, and Rona Siegert

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 14th day of September, 2018, I filed the foregoing electronically through the CM/ECF system, which caused the following parties or counsel to be served by electronic means, as more fully reflected on the Notice of Electronic Filing:

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/s/Krista Zimmerman
Krista Zimmerman

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ADREE EDMO,

Plaintiffs,

vs.

IDAHO DEPARTMENT OF CORRECTION; HENRY ATENCIO, in his official capacity; JEFF ZMUDA, in his official capacity; HOWARD KEITH YORDY, in his official and individual capacities; CORIZON, INC.; SCOTT ELIASON; MURRAY YOUNG; RICHARD CRAIG; RONA SIEGERT; CATHERINE WHINNERY; AND DOES 1-15;

Defendants.

Case No. 1:17-cv-151-BLW

SCHEDULING ORDER

Pursuant to the parties' *Stipulated Discovery and Briefing Schedule*, filed on June 15, 2018,

NOW THEREFORE IT IS HEREBY ORDERED, that the Stipulation (docket no. 72) is APPROVED, and the parties shall follow the discovery and briefing deadlines set forth below in advance of the evidentiary hearing scheduled for October 10, 11, and 12, 2018:

1. The parties shall exchange Initial Disclosures consistent with the requirements of Rule 26(a)(1) of the Federal Rules of Civil Procedure ("FRCP") on or before June 29, 2018.

2. The Plaintiff shall disclose all expert testimony consistent with FRCP 26(a)(2)(A)-(C) on or before July 13, 2018.

3. The Defendants shall disclose all expert testimony consistent with FRCP 26(a)(2)(A)-(C) on or before August 31, 2018.

4. The parties shall disclose to each other the identities of each witness, including lay and expert witnesses, that the party intends to call at the evidentiary hearing on or before August

31, 2018. In lieu of and/or in addition to live testimony at the evidentiary hearing, the parties may submit by this date written testimony of any witness by sworn declaration.

5. All factual discovery shall be completed by August 31, 2018. All written discovery requests must be made far enough in advance to allow completion of the discovery with the applicable federal rules prior to this discovery cut-off date. Expert depositions must be completed by September 28, 2018.

a. Each side shall have the right to take ten fact depositions inclusive of parties. Each deposition shall last no longer than seven hours on the record. Pursuant to Local Rule 30.1, the parties' agreement or authorization by the Court is required if either the Plaintiff or the Defendants wish to take more than ten depositions or to spend more than seven hours conducting any deposition.

b. Each side (i.e., Plaintiff and Defendants) shall have the right to take the deposition of the other parties' disclosed expert witnesses. Each deposition shall last no longer than seven hours on the record.

c. In accordance with FRCP 45, the parties shall have the right to issue and serve subpoenas to third-parties.

6. If the Defendants wish to file a brief with the Court in response to Plaintiff's Motion for Preliminary Injunction, then Defendants shall file their response(s) on or before September 14, 2018.

7. If the Plaintiff elects to file a reply brief, the reply shall be filed on or before September 28, 2018.

The deadlines contained in this Order may be modified with the consent of the parties or by Court order upon a finding of good cause.

DATED: July 3, 2018

B. Lynn Winmill
Chief U.S. District Court Judge

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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ADREE EDMO, Plaintiffs, vs. IDAHO DEPARTMENT OF CORRECTION; HENRY ATENCIO, in his official capacity; JEFF ZMUDA, in his official capacity; HOWARD KEITH YORDY, in his official and individual capacities; CORIZON, INC.; SCOTT ELIASON; MURRAY YOUNG; RICHARD CRAIG; RONA SIEGERT; CATHERINE WHINNERY; AND DOES 1-15; Defendants.	)	Case No. 1:17-cv-151-BLW **STIPULATED DISCOVERY AND BRIEFING SCHEDULE**

COME NOW the Plaintiff and Defendants, by and through their respective attorneys of record, and pursuant to this Court's June 12, 2018 order directing counsel to meet and confer regarding a discovery and briefing schedule, do hereby submit this stipulation setting forth the agreed-upon discovery and briefing deadlines in advance of the evidentiary hearing scheduled for October 10, 11, and 12, 2018.

1. The parties shall exchange Initial Disclosures consistent with the requirements of Rule 26(a)(1) of the Federal Rules of Civil Procedure ("FRCP") on or before June 29, 2018.

2. The Plaintiff shall disclose all expert testimony consistent with FRCP 26(a)(2)(A)-(C) on or before July 13, 2018.

3. The Defendants shall disclose all expert testimony consistent with FRCP 26(a)(2)(A)-(C) on or before August 31, 2018.

4. The parties shall disclose to each other the identities of each witness, including lay and expert witnesses, that the party intends to call at the evidentiary hearing on or before August 31, 2018. In lieu of and/or in addition to live testimony at the evidentiary hearing, the parties may submit by this date written testimony of any witness by sworn declaration.

5. All factual discovery shall be completed by August 31, 2018. All written discovery requests must be made far enough in advance to allow completion of the discovery with the applicable federal rules prior to this discovery cut-off date. Expert depositions must be completed by September 28, 2018.

a. Each side shall have the right to take ten fact depositions inclusive of parties. Each deposition shall last no longer than seven hours on the record. Pursuant to Local Rule 30.1, the parties' agreement or authorization by the Court is required if either the Plaintiff or the Defendants wish to take more than ten depositions or to spend more than seven hours conducting any deposition.

b. Each side (i.e., Plaintiff and Defendants) shall have the right to take the deposition of the other parties' disclosed expert witnesses. Each deposition shall last no longer than seven hours on the record.

c. In accordance with FRCP 45, the parties shall have the right to issue and serve subpoenas to third-parties.

6. If the Defendants wish to file a brief with the Court in response to Plaintiff's Motion for Preliminary Injunction, then Defendants shall file their response(s) on or before September 14, 2018.

7. If the Plaintiff elects to file a reply brief, the reply shall be filed on or before September 28, 2018.

8. The deadlines contained in this stipulation may be modified with the consent of the parties or by Court order upon a finding of good cause.

DATED this 15th day of June, 2018.

/s/ Lori Rifkin
Lori Rifkin
Attorney for Plaintiff

DATED this 15th day of June, 2018.

/s/ Dylan Eaton
Dylan Eaton
Attorney for Corizon Defendants

DATED this 15th day of June, 2018.

/s/ Marisa S. Crecelius
Marisa S. Crecelius
Attorney for IDOC Defendants

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 15th day of June, 2018, I filed the foregoing electronically through the CM/ECF system, which caused the following parties or counsel to be served by electronic means, as more fully reflected on the Notice of Electronic Filing:

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From: ecf@id.uscourts.gov
To: CourtMail@idd.uscourts.gov
Subject: Activity in Case 1:17-cv-00151-BLW Edmo v. Corizon Incorporated et al Notice of Hearing on Motion
Date: Friday, June 15, 2018 2:29:51 PM

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U.S. District Court

District of Idaho (LIVE Database)Version 6.1

Notice of Electronic Filing

The following transaction was entered on 6/15/2018 at 2:28 PM MDT and filed on 6/15/2018

Case Name: Edmo v. Corizon Incorporated et al
Case Number: 1:17-cv-00151-BLW
Filer:
Document Number: 71(No document attached)

Docket Text:
DOCKET ENTRY NOTICE OF HEARING regarding [62] MOTION for Preliminary Injunction: A 3-day Evidentiary Hearing is scheduled to begin on 10/10/2018 at 8:30 AM in Boise - Courtroom 3 before Judge B. Lynn Winmill. (jlb)

1:17-cv-00151-BLW Notice has been electronically mailed to:

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1:17-cv-00151-BLW Notice will be served by other means to:

From:	ecf@id.uscourts.gov
To:	CourtMail@idd.uscourts.gov
Subject:	Activity in Case 1:17-cv-00151-BLW Edmo v. Corizon Incorporated et al Order on Motion for Extension of Time to File Response/Reply
Date:	Tuesday, June 12, 2018 1:24:16 PM

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District of Idaho (LIVE Database)Version 6.1

Notice of Electronic Filing

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Case Name:	Edmo v. Corizon Incorporated et al
Case Number:	1:17-cv-00151-BLW
Filer:	
Document Number:	70(No document attached)

Docket Text:
DOCKET ENTRY ORDER granting in part and denying in part [63] Motion for Extension of Time to File Response. The parties shall meet and confer, and provide the Court with a stipulation of deadlines for discovery and briefing on the pending motion for preliminary injunction consistent with the Court's statements at the status conference on June 12, 2018, and in preparation for the October 10-12 evidentiary hearing. The stipulation shall be filed on or before June 15, 2018. Signed by B. Lynn Winmill. (caused to be mailed to non Registered Participants at the addresses listed on the Notice of Electronic Filing (NEF) by (js)

1:17-cv-00151-BLW Notice has been electronically mailed to:

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UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO

Date: June 12, 2018
Judge B. Lynn Winmill
Case No. 1:17-cv-151
Place: Telephonic

Deputy Clerk: Jamie Bracke
ESR: Jamie Bracke
Time: 11:30 - 11:51 a.m.

ADREE EDMO v. CORIZON INCORPORATED, et al

Counsel for Plaintiff: Lori Rifkin, Deborah Ferguson, Julie Wilensky, and Craig Durham

Counsel for Corizon Defendants: Kevin West and Dylan Eaton

Counsel for State of Idaho Defendants: Brady Hall

Telephonic status conference held on 6/12/2018.

Counsel is directed to meet and confer regarding a discovery and briefing schedule. A proposed discovery and briefing schedule shall be submitted to the court by 5/15/2018.

An evidentiary hearing regarding Plaintiff's Motion for Preliminary Injunction (Dkt. 62) is scheduled for October 10, 2018 - October 12, 2018.

An order is forthcoming.

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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ADREE EDMO, Plaintiff, vs. IDAHO DEPARTMENT OF CORRECTION; HENRY ATENCIO, in his official capacity; JEFF ZMUDA, in his official capacity; HOWARD KEITH YORDY, in his official and individual capacities; CORIZON, INC.; SCOTT ELIASON; MURRAY YOUNG; RICHARD CRAIG; RONA SIEGERT; CATHERINE WHINNERY; AND DOES 1-15; Defendants.	)	Case No. 1:17-cv-151-BLW **DECLARATION OF COUNSEL BRADY J. HALL**

I, Brady J. Hall, hereby declare under penalty of perjury that the foregoing is true and correct:

1. I am over the age of eighteen and am competent to testify to the matters stated herein. I make this declaration based upon my own personal knowledge.

2. I am one of the attorneys of record for Defendants Idaho Department of Corrections, Henry Atencio, Jeff Zmuda, Howard Keith Yordy, Richard Craig, and Rona Siegert ("IDOC Defendants") in this action.

3. On December 12, 2017, Lori Rifkin, one of Plaintiff Adree Edmo's attorneys, emailed me in follow-up to a prior conversation during which Ms. Rifkin had asked if I would be able to provide her with a copy of Plaintiff's medical records. I recall telling Ms. Rifkin that I would need to talk to counsel for Defendant Corizon, Dylan Eaton, because the medical records would ultimately be organized and produced by Corizon's attorneys in discovery. I considered Ms. Rifkin's inquiry an informal and premature request for documents that would soon be disclosed in the Defendants' Rule 26 Initial Disclosures.

4. I responded to Ms. Rifkin's email on December 13, 2017, at which time I told her that, "I recall stating I would have to ask Corizon about releasing the records before the deadline for initial disclosures. I did, but I don't think we ever came to a decision. I will follow up with Dylan today." After connecting with Mr. Eaton, I emailed Ms. Rifkin back on December 18, 2017 stating that "the preference is to wait and provide everything at the time of the initial disclosure deadline." A true and correct copy of my email correspondence with Ms. Rifkin is attached hereto as **Exhibit A**.

5. I thought my response to Ms. Rifkin's request was reasonable in light of the logistical challenges of bates stamping and producing some records prematurely, and in believing (perhaps naively) that initial disclosure would be exchanged sooner than later. My response was not a deliberate effort to delay or stall. I was also not aware of any procedural rule

or practice that obligated Defendants to produced documents prior to exchanging initial disclosures. Moreover, offenders within the custody of the IDOC are generally not permitted to review his or her medical file pursuant to Idaho Code § 74-113(3)(e).

6. After our email correspondence in December 2017, Ms. Rifkin did not make another request for medical records until May 11, 2018 at which time Ms. Rifkin sent the letter attached hereto as **Exhibit B.** I was not previously aware of IDOC Directive 108.06.03.061, section 05.04.00, which states as follows:

05.04.00. Copies of Medical Records

Medical records or information - Under no circumstances shall any prisoner's or probationer's medical records be released to another offender.

Medical records or copies thereof will only be released to the following individuals and only under the following specific circumstances:

By court order;

By written request of the offender's designated attorney, upon the attorney's letterhead, with attached consent of release of information signed by the offender;

By written request of an offender's physician upon that physician's letterhead, with attached consent of release of medical records or information, signed by the offender.

Another state agency upon transfer or IDOC staff on a need to know basis – i.e.: Problem lists to those (social workers) responsible for parole plan preparation.

7. Upon receipt of Ms. Rifkin's letter, I reviewed the referenced policy and confirmed with the Attorney General's office as to the sufficiency of Ms. Rifkin's May 11, 2018 request. This was the first request for medical records made by Ms. Rifkin that was on Ms. Rifkin's letterhead and included an executed release of information completed by Plaintiff as required by the policy. The Attorney General's office expressed to me that they had no concerns with producing the medical records, so I requested that Mr. Eaton obtain updated medical records for production to Ms. Rifkin by May 30, the date that Ms. Rifkin requested that the records be produced.

8. On May 14, I emailed Ms. Rifkin stating that, "I have approval to release the records. Dylan Eaton represents Corizon. I understand Dylan will request updated records from his client for production and that the same should be ready on or before May 30. The records will likely come from Dylan's office."

9. Finally, on May 30, and consistent with Ms. Rifkin's request, Mr. Eaton provided copies of Plaintiff's complete medical file to Ms. Rifkin. Attached hereto as **Exhibit C** is a true and correct copy of email correspondence regarding the May 30, 2018 production of Plaintiff's medical records.

10. Also, prior to Plaintiff having filed the motion for preliminary injunction (Doc. 62) on June 1, 2018, I had previously arranged to travel to Coeur d'Alene, Idaho for the entire week of June 18, 2018 to participate in depositions in a separate civil action that I am defending, and to vacation with my family on the lake. I was not made aware prior to June 1, 2018 that Plaintiff would be filing a motion for preliminary injunction that would require Defendants to respond within 21 days.

DATED this 8th day of June, 2018.

/s/ Brady J. Hall

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 8th day of June, 2018, I filed the foregoing electronically through the CM/ECF system, which caused the following parties or counsel to be served by electronic means, as more fully reflected on the Notice of Electronic Filing:

Dan Stormer
dstormer@hadsellstormer.com
Lori Rifkin
lrifkin@hadsellstormer.com
Shaleen Shanberg
sshanberg@hadsellstormer.com
HADSELL STORMER & RENICK, LLP
(Counsel for Plaintiff)

Craig Durham
chd@fergusondurham.com
Deborah Ferguson
daf@fergusondurham.com
FERGUSON DURHAM, PLLC
(Counsel for Plaintiff)

Amy Whelan
awhelan@nclrights.org
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jwilensky@nclrights.org
NATIONAL CENTER FOR LESBIAN RIGHTS
(Counsel for Plaintiffs)

Dylan Eaton
deaton@parsonsbehle.com
J. Kevin West
kwest@parsonsbehle.com
PARSONS, BEHLE & LATIMER
(Counsel for

/s/Brady J. Hall
Brady J. Hall

Brady Hall

From: Brady Hall
Sent: Monday, December 18, 2017 2:24 PM
To: 'Lori Rifkin'
Subject: RE: Edmo v. IDOC et al; medical records

Lori:

I spoke with Corizon's attorney and the preference is to wait and provide everything at the time of the initial disclosure deadline.

Brady J. Hall

702 W. Idaho Street, Suite 800 | Boise, ID 83702
P.O. Box 6756 | Boise, ID 83707
Telephone: (208) 336-6900 Fax: (208) 336-7031
www.melawfirm.net

The information contained in this electronic transmission may be confidential and privileged. It is intended only for the use of the individual or entity named above. Any unauthorized distribution or copying of this message is prohibited, except by the intended recipient. Attempts to intercept this message are in violation of 18 U.S.C. 2511(1) of the Electronic Communications Privacy Act (ECPA), which subjects the interceptor to fines, imprisonment and/or civil damages. If you have received this communication in error, please notify me immediately at brady@melawfirm.net and delete the original message.

From: Lori Rifkin [mailto:lrifkin@hadsellstormer.com]
Sent: Monday, December 18, 2017 2:14 PM
To: Brady Hall
Subject: RE: Edmo v. IDOC et al; medical records

Brady,

I'm following up on the below request for Ms. Edmo's records. What did Corizon say?

Thanks,

Lori Rifkin

Hadsell Stormer & Renick LLP
626-585-9600
lrifkin@hadsellstormer.com

From: Lori Rifkin
Sent: Wednesday, December 13, 2017 9:48 AM
To: 'Brady Hall' <Brady@melawfirm.net>
Subject: RE: Edmo v. IDOC et al; medical records

Brady,

Thanks for the response. Please let me know what Dylan says.

From: Brady Hall [mailto:Brady@melawfirm.net]
Sent: Wednesday, December 13, 2017 7:05 AM
To: Lori Rifkin <lrifkin@hadsellstormer.com>
Subject: Re: Edmo v. IDOC et al; medical records

Lori:

I'm doing well, thank you. I recall stating I would have to ask Corizon about releasing the records before the deadline for initial disclosures. I did, but I don't think we ever came to a decision. I will follow up with Dylan today.

Brady Hall
702 West Idaho Street
Suite 800
Boise, Idaho 83702
208.336.6900
Brady@melawfirm.net

On Dec 12, 2017, at 5:05 PM, Lori Rifkin <lrifkin@hadsellstormer.com> wrote:

Hi Brady,

I hope you're doing well. We had spoken in October about getting Ms. Edmo's IDOC medical records and you had agreed to provide those. We have not received them yet - can you please confirm that we will receive them no later than December 20? Thank you.

Sincerely,

Lori Rifkin

Hadsell Stormer & Renick LLP
Tel: 626-585-9600
Fax: 626-577-7079
lrifkin@hadsellstormer.com

HADSELL
STORMER | LLP
RENICK

Denise Ballesteros
Isela Barrios
Springsong Cooper
Cornelia Dai
Valeria De Gonzalez
Barbara Enloe Hadsell
Nancy Hanna
Caitlan McLoon
Joshua Nuni
Brian Olney
Cindy Pánuco
Joshua Piovia-Scott
Shaleen Shanbhag
Randy Renick
Lori Rifkin
Dan Stormer

May 11,

VIA ELECTRONIC MAIL ONLY

Brady J. Hall (ISB No. 7873)
Moore Elia Kraft & Hall, LLP
Post Office Box 6756
Boise, Idaho 83707
Email: brady@melawfirm.net

Re: RECORDS REQUEST FOR ADREE EDMO (Inmate #94691)
***Edmo v. Idaho Department of Correction, et al.*, Case No.: 1:17-cv-00151-BLW**

Dear Mr. Hall,

Pursuant to IDOC Directive 108.06.03.061, section 05.04.00 (attached), I am requesting a full copy of my client's Adree Edmo's (legal name Mason Dean Edmo) medical records for the duration of her incarceration in IDOC. Attached is a release signed by Ms. Edmo. Please produce the records or make them available for copying no later than May 30, 2018.

Sincerely,

[signature]

Lori Rifkin

Enclosures

128 North Fair Oaks Avenue, Pasadena, California 91103
Tel: 626.585.9600 • Fax: 626.577.7079 • www.hadsellstormer.com
Pasadena | Los Angeles | Emeryville | Garden Grove

DEPARTMENT OF CORRECTION	INSTITUTIONAL SERVICES DIVISION	DIRECTIVE NUMBER: 108.06.03.061	PAGE NUMBER: 1 of 4
		SUBJECT: Medical Records Confidentiality	Adopted: 06-01-95 Revised: 07-01-00 Reformatted: 03-2001

01.00.00. POLICY OF THE DEPARTMENT

It is the policy of the Idaho Board of Correction that all records maintained by the Department of Correction shall be open to the public for inspection and copying at all reasonable times, unless the information is specifically exempted from disclosure by law.

02.00.00. TABLE OF CONTENTS

01.00.00. **POLICY OF THE DEPARTMENT**
02.00.00. **TABLE OF CONTENTS**
03.00.00. **REFERENCES**
04.00.00. **DEFINITIONS**
05.00.00. **PROCEDURE**
05.01.00. Medical Records
05.02.00. Inactive Medical Records
05.03.00. Information Sharing
05.04.00. Copies of Medical Records
05.05.00. Offender Right to Review Medical Records

03.00.00. REFERENCES

Department Policy 108, Public Access to Records.

Department Policy 401, Hospitalization, Institutional Clinical Services, and Treatment.

Idaho Code, Title 74, Chapter 1, Public Records, 74-101 through 74-126.

IDAPA 06.01.01., Rules of the Board of Correction, Section 108, Idaho Public Records Act.

Standards for Adult Correctional Institutions, Third Edition, Standards 3-4377.

Standards for Health Services in Prisons, P-61.

04.00.00. DEFINITIONS

Facility Health Authority: The on-site Health Authority or senior health staff assigned.

Inmate: An individual in the physical custody of the Board. (See also Offender)

Medical Authority: Idaho Department of Correction Health Services Chief.

Medical Director: A physician (M.D.) either employed by the Idaho Department of Correction or the physician in charge if medical services are privatized.

Offender: A person under the legal care, custody, supervision or authority of the Board of Correction including a person within or without the state pursuant to agreement with another state or a contractor.

Qualified Health Professional: Physician, physician assistant, nurse practitioner, nurse, dentist, mental health professional and others who by virtue of their education, credentials, and experience are permitted by law within the scope of their professional practice are to evaluate and care for patients.

Regional Health Manager: The individual assigned as the primary manager who is administratively responsible for the delivery of medical services if health services are privatized.

05.00.00. PROCEDURE

05.01.00. Medical records

The active medical record shall be maintained in the medical unit at the facility holding the offender. The medical record will be filed separately from the confinement record except during transit periods.

Access to the medical record shall be controlled by the medical health authority or his designee.

Any information gathered or recorded about alcohol or drug abuse shall be confidential under federal regulations.

05.02.00. Inactive Medical Records

The inactive medical record shall be maintained at the records section of IDOC central office when an offender leaves the custody of the Department of Correction.

DIRECTIVE NUMBER: 108.06.03.061	SUBJECT: Medical Records Confidentiality	PAGE NUMBER: 3 of 4

05.03.00. Information Sharing

The facility health authority shall share information which includes access to the medical file with the facility administrator (warden or superintendent) or designee on a need-to-know basis, concerning an offender's medical management and security requirements.

When divulging any information, the confidential relationship between physician and patient extends to offender patients and their physicians or other health providers.

There also may be circumstances which justify advising correctional staff concerning appropriate housing and/or working conditions resulting from an offender's health status, or to protect the health and safety of the offender, other offenders and the correctional staff.

In most instances, unless required by law, it is not necessary to reveal specific diagnosis.

For purposes of unit team management concerns the IDOC psychologists, social workers, and clinicians shall have access to the medical file in the medical units.

05.04.00. Copies of Medical Records

Medical records or information - Under no circumstances shall any prisoner's or probationer's medical records be released to another offender.

Medical records or copies thereof will only be released to the following individuals and only under the following specific circumstances:

By court order;

By written request of the offender's designated attorney, upon the attorney's letterhead, with attached consent of release of information signed by the offender;

By written request of an offender's physician upon that physician's letterhead, with attached consent of release of medical records or information, signed by the offender.

Another state agency upon transfer or IDOC staff on a need to know basis – i.e.: Problem lists to those (social workers) responsible for parole plan preparation.

DIRECTIVE NUMBER: 108.06.03.061	SUBJECT: Medical Records Confidentiality	PAGE NUMBER: 4 of 4

05.05.00. Offender Right to Review Medical Records

An offender does not have the right to review his medical file (Idaho Code, Title 9, Chapter 3, Public Records Act 9-342 (31)(e).

Administrator, Institutional Services Division

Date

**AUTHORIZATION TO RELEASE
RECORDS AND INFORMATION**

I, Adree Edmo (also known as Mason Dean Edmo), IDOC No. 94691, DOB [redacted] [redacted] hereby voluntarily consent to the American Civil Liberties Union of Idaho, and any of their agents, employees, or contractors, releasing any and all information or records regarding my medical and mental health care and treatment to the following attorneys, or their agents, upon request:

Ms. Lori Rifkin
Hasdell, Stormer, and Renick
128 N. Fair Oaks Ave.
Suite 204
Pasadena, CA 91103
T: 626-585-9600
F: 626- 577-7079

Ms. Amy Whelan
Nation Center for Lesbian Rights
870 Market Street Suite 370
San Francisco CA 94102
T: 415.392.6257
F: 415.392.8442

Mr. Craig Durham or Ms. Deborah Ferguson
FERGUSON/DURHAM, PLLC
223 N. 6th Street, Suite 325
Boise, ID, 83702
T: 208-345-5183
F: 208-906-8663

My authorization is limited to releasing information and records to counsel and their agents, and it extends to no other persons.

My authorization is freely given, and I understand that I may revoke permission at any time.

Signed this 29th day of June 2017.

Adree Edmo (a/k/a Mason Dean Edmo

Brady Hall

From: Dylan A. Eaton <DEaton@parsonsbehle.com>
Sent: Wednesday, May 30, 2018 6:48 PM
To: Lori Rifkin; Dan Stormer; awhelan@nclrights.org; daf@fergusondurham.com; chd@fergusondurham.com; Brady Hall; Shaleen Shanbhag; Julie Wilensky
Cc: J. Kevin West; Jennifer M. Cafferty; Lauri A. Ehredt; Jessica Valdenegro
Subject: RE: Adree Edmo v. IDOC, et al.

Ms. Rifkin:

You are welcome.

It is my understanding this is a complete copy of Ms. Edmo's medical records from the IDOC prison chart through about May 2018 as reflected in these records.

As I indicated, we were just trying to protect Ms. Edmo's privacy by redacting her date of birth from the records. Such redactions would need to be done anyway if any of the records are filed with the court per court rules. I have never had anyone complain about such redactions before and usually they are grateful we are trying to protect privacy and have already done it for them. Additionally, sometimes pro se inmates (which I understand Edmo is no longer) will file their own medical records with the court without making the redactions. So, we typically make such redactions in inmate cases at the outset - again to try to protect privacy. In any event, if you want these records produced without the dates of birth redacted, please just let me know.

Regards,
Dylan

From: Lori Rifkin [mailto:lrifkin@hadsellstormer.com]
Sent: Wednesday, May 30, 2018 6:04 PM
To: Dylan A. Eaton <DEaton@parsonsbehle.com>; Dan Stormer <dstormer@hadsellstormer.com>; awhelan@nclrights.org; daf@fergusondurham.com; chd@fergusondurham.com; Brady Hall <Brady@melawfirm.net>; Shaleen Shanbhag <sshanbhag@hadsellstormer.com>; Julie Wilensky <JWilensky@nclrights.org>
Cc: J. Kevin West <KWest@parsonsbehle.com>; Jennifer M. Cafferty <JCafferty@parsonsbehle.com>; Lauri A. Ehredt <LEhredt@parsonsbehle.com>; Jessica Valdenegro <jessicav@hadsellstormer.com>
Subject: RE: Adree Edmo v. IDOC, et al.

Mr. Eaton,

Thank you for these records. Can you please clarify whether the list below means that some documents from Ms. Edmo's medical file have been withheld? If so, please provide us with a list of what has been withheld and the basis. Please also explain why our client's own request for her records necessitated the redaction of her own date of birth.

In future correspondence, please also use professional courtesy in referring to our client with the appropriate title, which is Ms. Edmo.

Sincerely,

Lori Rifkin

Hall Decl._Exh. C_pg.1

Hadsell Stormer & Renick LLP
Tel: 626-585-9600
Fax: 626-577-7079
lrifkin@hadsellstormer.com
www.hadsellstormer.com

From: Dylan A. Eaton <DEaton@parsonsbehle.com>
Sent: Wednesday, May 30, 2018 4:48 PM
To: Lori Rifkin <lrifkin@hadsellstormer.com>; Dan Stormer <dstormer@hadsellstormer.com>; awhelan@nclrights.org; daf@fergusondurham.com; chd@fergusondurham.com; Brady Hall <Brady@melawfirm.net>
Cc: J. Kevin West <KWest@parsonsbehle.com>; Jennifer M. Cafferty <JCafferty@parsonsbehle.com>; Lauri A. Ehredt <LEhredt@parsonsbehle.com>
Subject: RE: Adree Edmo v. IDOC, et al.

Counsel:

Pursuant to the attached letter, the Authorization to Release Records and Information enclosed with the letter, and the correspondence below, you may access Edmo's prison medical chart/prison medical records per this secure FTP site: https://sft.parsonsbehle.com.

I will send you the login and password information in a separate email momentarily.

Your account expires 30 days from Wednesday, May 30, 2018.

Please keep this information private and confidential. If you received this email by accident, please do not read and access it and delete it immediately.

Edmo's dates of birth have been redacted to protect privacy.

These medical records generally cover approximately January 2010 through May 2018 (Bates Numbers: Corizon 1 – 1347) and specifically include the following types of records:

1. Problem List
2. Screenings
3. Health Service Requests
4. NETs (Nursing Encounter Tools)
5. Progress Notes
6. Orders
7. Labs
8. Mental Health Records
9. Behavior Watch Notes
10. Segregation Records
11. Chronic Care
12. LTC Records
13. Consult Requests-Reports
14. Emergency Dept. Referrals
15. Offender Medical Status Report
16. Dental
17. Ophthalmic
18. Medication Administration Records
19. Non-Formulary Drug Tracking Forms

20. Idaho Medication Non-Adherence
21. Intra-System Transfer Forms
22. Receipt for Medical Product
23. Consents-Refusals
24. Correspondence by Edmo to PharmaCorr
25. St. Al's RMC Records
26. Health Service Encounters
27. Condensed Health Service Encounters
28. Vital Signs
29. FMHC-Emerald Clinic Records

Let me know if you have any issues accessing these documents.

Regards,

Dylan Eaton
Attorney for Corizon Defendants

A Professional
Law Corporation

Dylan A. Eaton • Attorney at Law
Parsons Behle & Latimer
800 West Main Street, Suite 1300 • Boise, Idaho 83702
Main 208.562.4900 • Direct 208.562.4911 • Fax 208.562.4901

parsonsbehle.com • DEaton@parsonsbehle.com • vCard

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From: Brady Hall [mailto:Brady@melawfirm.net]
Sent: Monday, May 14, 2018 4:09 PM
To: 'Lori Rifkin' <lrifkin@hadsellstormer.com>
Cc: Dylan A. Eaton <DEaton@parsonsbehle.com>; Jessica Valdenegro <jessicav@hadsellstormer.com>
Subject: RE: Adree Edmo v. IDOC, et al.

Thanks, Lori. I have approval to release the records. Dylan Eaton represents Corizon. I understand Dylan will request updated records from his client for production and that the same should be ready on or before May 30. The records will likely come directly from Dylan's office. Please let me know if you have any questions.

Brady Hall
702 West Idaho Street
Suite 800
Boise, Idaho 83702
208.336.6900
Brady@melawfirm.net

From: Lori Rifkin [mailto:lrifkin@hadsellstormer.com]
Sent: Monday, May 14, 2018 3:36 PM
To: Jessica Valdenegro <jessicav@hadsellstormer.com>; Brady Hall <Brady@melawfirm.net>
Cc: Dan Stormer <dstormer@hadsellstormer.com>; Shaleen Shanbhag <sshanbhag@hadsellstormer.com>; Amy Whelan <AWhelan@nclrights.org>; chd@fergusondurham.com; daf@fergusondurham.com; Tami Galindo <tgalindo@hadsellstormer.com>; Norma Molina <nmolina@hadsellstormer.com>
Subject: Re: Adree Edmo v. IDOC, et al.

Counsel,

Attached please find Ms. Edmo's correct authorization, which was inadvertently omitted from the records request sent Friday. Please contact me should you have any questions.

Lori Rifkin

Hadsell Stormer & Renick LLP
626-585-9600
lrifkin@hadsellstormer.com

From: Jessica Valdenegro <jessicav@hadsellstormer.com>
Date: Friday, May 11, 2018 at 4:57 PM
To: "brady@melawfirm.net" <brady@melawfirm.net>
Cc: Dan Stormer <dstormer@hadsellstormer.com>, Lori Rifkin <lrifkin@hadsellstormer.com>, Shaleen Shanbhag <sshanbhag@hadsellstormer.com>, Amy Whelan <AWhelan@nclrights.org>, "chd@fergusondurham.com" <chd@fergusondurham.com>, "daf@fergusondurham.com" <daf@fergusondurham.com>, Tami Galindo <tgalindo@hadsellstormer.com>, Norma Molina <nmolina@hadsellstormer.com>
Subject: Adree Edmo v. IDOC, et al.

Counsel,
Please find attached correspondence from Lori Rifkin.

Regards,
Jessica Valdenegro
Paralegal
Hadsell Stormer & Renick LLP
128 N. Fair Oaks Ave.
Pasadena, CA 91103
Tel: (626) 585-9600
Fax: (626) 577-7079
Email: jessicav@hadsellstormer.com

LAWRENCE G. WASDEN
ATTORNEY GENERAL
STATE OF IDAHO

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SPECIAL DEPUTY ATTORNEY GENERAL
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marisa@melawfirm.net
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Post Office Box 6756
Boise, Idaho 83707
Telephone: (208) 336-6900
Facsimile: (208) 336-7031

Attorneys for Defendants Idaho Department of Corrections, Henry Atencio, Jeff Zmuda, Howard Keith Yordy, Richard Craig, and Rona Siegert

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ADREE EDMO, Plaintiff, vs. IDAHO DEPARTMENT OF CORRECTION; HENRY ATENCIO, in his official capacity; JEFF ZMUDA, in his official capacity; HOWARD KEITH YORDY, in his official and individual capacities; CORIZON, INC.; SCOTT ELIASON; MURRAY YOUNG; RICHARD CRAIG; RONA SIEGERT; CATHERINE WHINNERY; AND DOES 1-15; Defendants.	Case No. 1:17-cv-151-BLW **DECLARATION OF KRINA L. STEWART**

DATED this 7th day of June, 2018.

/s/ Krina L. Stewart

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 8th day of June, 2018, I filed the foregoing electronically through the CM/ECF system, which caused the following parties or counsel to be served by electronic means, as more fully reflected on the Notice of Electronic Filing:

Dan Stormer
dstormer@hadsellstormer.com
Lori Rifkin
lrifkin@hadsellstormer.com
Shaleen Shanberg
sshanberg@hadsellstormer.com
HADSELL STORMER & RENICK, LLP
(Counsel for Plaintiff)

Craig Durham
chd@fergusondurham.com
Deborah Ferguson
daf@fergusondurham.com
FERGUSON DURHAM, PLLC
(Counsel for Plaintiff)

Amy Whelan
awhelan@nclrights.org
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NATIONAL CENTER FOR LESBIAN RIGHTS
(Counsel for Plaintiffs)

Dylan Eaton
deaton@parsonsbehle.com
J. Kevin West
kwest@parsonsbehle.com
PARSONS, BEHLE & LATIMER

/s/ Brady J. Hall
Brady J. Hall

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ADREE EDMO (MASON EDMO),

Plaintiff,

v.

IDAHO DEPARTMENT OF CORRECTION, *et al.*,

Defendants.

Case No. 1:17-cv-00151-BLW

MEMORANDUM DECISION AND ORDER

INTRODUCTION

The Court has before it Defendants' First Motion for Dispositive Relief (Dkt. 39). The Court held a hearing on April 4, 2018, and the Court now issues the following Memorandum Decision and Order.

BACKGROUND

Edmo is a male-to-female transgender prisoner, in the custody of the Idaho Department of Corrections ("IDOC"). Edmo's medical records indicate diagnoses of Gender Identity Disorder (GID) and Gender Dysphoria (GD). Edmo remains anatomically male but identifies as female. As a result of IDOC's policy to assign an inmate's facility in accordance with the inmate's primary sexual characteristics, Edmo is currently incarcerated in a men's prison at Idaho State Correctional Institution ("ISCI"). According to Edmo, common treatments of GID/GD are the "real-life" experience of

living full-time within the desired gender, hormonal therapy, and sex reassignment surgeries. After being diagnosed with GID/GD, Edmo requested treatment including access to feminizing hormones, evaluation for sex affirming surgery, and the ability to live as a woman while incarcerated. Edmo alleges that Defendants denied certain necessary medical treatment resulting in Edmo's suffering harm, including two attempted self-castrations.

Edmo filed a complaint alleging that Defendants' actions violated the following: (1) the Eighth Amendment by failing to protect her from harm and it's prohibition on cruel and unusual punishment; the Fourteenth Amendment's guarantee of equal protection; (2) the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act by discriminating in provision of medical treatment and participation in programs and services; (3) the nondiscrimination provision of the Affordable Care Act (ACA) by discriminating based on sex, sex stereotyping, and/or gender identity; and (4) Idaho tort law by negligently failing to provide treatment. *Amended Complaint, Dkt. 36*.

Defendants now seek summary judgment on all claims for which administrative remedies were not exhausted, and dismissal under FRCP 12(b)(6) of statutorily time-barred claims, ADA claims, ACA claims, and state negligence claims.

LEGAL STANDARDS

1. Motion for Summary Judgment Standard

Summary judgment is appropriate where a party can show that, as to any claim or defense, "there is no genuine dispute as to any material fact and the movant is entitled to

judgment as a matter of law." Fed. R. Civ. P. 56(a). One of the principal purposes of the summary judgment "is to isolate and dispose of factually unsupported claims . . . ." *Celotex Corp. v. Catrett*, 477 U.S. 317, 323-24 (1986). It is "not a disfavored procedural shortcut," but is instead the "principal tool[ ] by which factually insufficient claims or defenses [can] be isolated and prevented from going to trial with the attendant unwarranted consumption of public and private resources." *Id.* at 327. "[T]he mere existence of some alleged factual dispute between the parties will not defeat an otherwise properly supported motion for summary judgment." *Anderson v. Liberty Lobby, Inc*., 477 U.S. 242, 247-48 (1986). There must be a genuine dispute as to any *material* fact – a fact "that may affect the outcome of the case." *Id.* at 248.

The evidence must be viewed in the light most favorable to the non-moving party, and the Court must not make credibility findings. *Id.* at 255. Direct testimony of the non-movant must be believed, however implausible. *Leslie v. Grupo ICA*, 198 F.3d 1152, 1159 (9th Cir. 1999). On the other hand, the Court is not required to adopt unreasonable inferences from circumstantial evidence. *McLaughlin v. Liu*, 849 F.2d 1205, 1208 (9th Cir. 1988).

The moving party bears the initial burden of demonstrating the absence of a genuine dispute as to material fact. *Devereaux v. Abbey*, 263 F.3d 1070, 1076 (9th Cir. 2001)(en banc). To carry this burden, the moving party need not introduce any affirmative evidence (such as affidavits or deposition excerpts) but may simply point out

the absence of evidence to support the nonmoving party's case. *Fairbank v. Wunderman Cato Johnson,* 212 F.3d 528, 532 (9th Cir.2000).

This shifts the burden to the non-moving party to produce evidence sufficient to support a jury verdict in her favor. *Deveraux*, 263 F.3d at 1076. The non-moving party must go beyond the pleadings and show "by her [ ] affidavits, or by the depositions, answers to interrogatories, or admissions on file" that a genuine dispute of material fact exists. *Celotex,* 477 U.S. at 324.

2. Motion to Dismiss Standard

Federal Rule of Civil Procedure 8(a)(2) requires only "a short and plain statement of the claim showing that the pleader is entitled to relief," in order to "give the defendant fair notice of what the . . . claim is and the grounds upon which it rests." *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 555, 127 S.Ct. 1955, 1964 (2007). While a complaint attacked by a Rule 12(b)(6) motion to dismiss "does not need detailed factual allegations," it must set forth "more than labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do." *Id*. at 555. To survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to "state a claim to relief that is plausible on its face." *Id*. at 570.

Providing too much in the complaint may also be fatal to a plaintiff. Dismissal may be appropriate when the plaintiff has included sufficient allegations disclosing some absolute defense or bar to recovery, such as a statute of limitations. *See Weisbuch v. County of L.A.*, 119 F.3d 778, 783, n. 1 (9th Cir. 1997) (stating that "[i]f the pleadings

establish facts compelling a decision one way, that is as good as if depositions and other . . . evidence on summary judgment establishes the identical facts").

A dismissal without leave to amend is improper unless it is beyond doubt that the complaint "could not be saved by any amendment." *Harris v. Amgen, Inc.*, 573 F.3d 728, 737 (9th Cir. 2009). The Ninth Circuit has held that "in dismissals for failure to state a claim, a district court should grant leave to amend even if no request to amend the pleading was made, unless it determines that the pleading could not possibly be cured by the allegation of other facts." *Cook, Perkiss and Liehe, Inc. v. Northern California Collection Service, Inc.,* 911 F.2d 242, 247 (9th Cir. 1990). The issue is not whether plaintiff will prevail but whether he "is entitled to offer evidence to support the claims." *Diaz v. Int'l Longshore and Warehouse Union, Local 13*, 474 F.3d 1202, 1205 (9th Cir. 2007)(citations omitted).

Under Rule 12(b)(6), the Court may consider matters that are subject to judicial notice. *Mullis v. United States Bank*, 828 F.2d 1385, 1388 (9th Cir. 1987). The Court may take judicial notice "of the records of state agencies and other undisputed matters of public record" without transforming the motions to dismiss into motions for summary judgment. *Disabled Rights Action Comm. v. Las Vegas Events, Inc.,* 375 F.3d 861, 866, n.1 (9th Cir. 2004). The Court may also examine documents referred to in the complaint, although not attached thereto, without transforming the motion to dismiss into a motion for summary judgment. *See Knievel v. ESPN*, 393 F.3d 1068, 1076 (9th Cir. 2005).

DISCUSSION

1. Exhaustion of Administrative Remedies

Inmates must exhaust their available administrative remedies before bringing civil rights actions based on prison conditions. The federal Prison Litigation Reform Act ("PLRA") requires exhaustion of administrative remedies for all federal claims brought by state prisoners who challenge the conditions of their confinement in a federal complaint. "No action shall be brought with respect to prison conditions under section 1983 of this title, or any other federal law, until such administrative remedies as are available are exhausted." 42 U.S.C. § 1997e(a). This requirement gives prison officials an opportunity to resolve disputes concerning the exercise of their responsibilities before being haled into court. *Jones v. Bock*, 549 U.S. 199, 218 (2007).

Exhaustion must be proper; meaning "a prisoner must complete the administrative review process in accordance with the applicable procedural rules, including deadlines, as a precondition to bringing suit in federal court." *Woodford v. Ngo*, 548 U.S. 81, 88 (2006). "The level of detail necessary in a grievance to comply with the grievance procedures will vary from system to system and claim to claim, but it is the prison's requirements, and not the PLRA, that define the boundaries of proper exhaustion." *Jones,* 549 U.S. at 204.

Failure to exhaust is an affirmative defense that, in rare situations, may be asserted in a Rule 12(b)(6) motion to dismiss. *Albino v. Baca*, 747 F.3d 1162 (9th Cir. April 3, 2014) (en banc) ("In a few cases, a prisoner's failure to exhaust may be clear from the

face of the complaint."). If, however, the material facts underlying the exhaustion issue are genuinely disputed, the Court may decide the issue on a motion for summary judgment under Rule 56. *Id.*

The defendant bears the ultimate burden of proving failure to exhaust. *See Brown v. Valoff*, 422 F.3d 926, 936 (9th Cir. 2005). If the defendant initially shows that (1) an available administrative remedy existed and (2) the prisoner failed to exhaust that remedy, then the burden of production shifts to the plaintiff to bring forth evidence "showing that there is something in his particular case that made the existing and generally available administrative remedies effectively unavailable to him." *Albino*, 747 F.3d at 1170-71.

Rule 56 prohibits the courts from resolving genuine disputes as to material facts on summary judgment. If a genuine dispute exists as to material facts relating to an exhaustion defense, the motion should be denied, and the "disputed factual questions relevant to exhaustion should be decided by the judge, in the same manner a judge rather than a jury decides disputed factual questions relevant to jurisdiction and venue." *Albino*, 747 F.3d at 1170-71. *See Lake v. Lake*, 817 F.2d 1416, 1420 (9th Cir. 1987) (the court has the discretion to take evidence at a preliminary hearing to resolve any questions of credibility or fact and that the plaintiff must establish the facts by a preponderance of the evidence, just as he would have to do at trial).

If a prisoner has failed to exhaust available administrative remedies, the appropriate remedy is dismissal without prejudice. *Wyatt v. Terhune*, 315 F.3d 1108, 1120 (9th Cir. 2003), *overruled in part on other grounds by Albino*, 747 F.3d 1162.

2. IDOC's Grievance Procedure

The IDOC grievance process is contained generally in IDOC Policy 316: Offender Grievance Process. The grievance procedure is contained in IDOC Division of Prisons Standard Operating Procedure 316.02.01.001. *See Maybon Decl., Dkt. 41 ¶ 3.*

The IDOC grievance procedure consists of three stages. *Id*. ¶ 5. First, an inmate must seek an informal resolution by filling out an Offender Concern Form, addressed to the most appropriate staff member. *Id.* ¶ 6. If the issue is not informally resolved, offenders are required under the Grievance Process to file a Grievance within thirty days of the incident or problem that is the basis for the Grievance. *Id.*¶ 7. Only one issue may be raised in each grievance and the offender must also suggest a solution or proposed remedy. *Id.* The grievance information is then entered into the Corrections Integrated System, and the Grievance Coordinator assigns the grievance to the staff member most capable of responding to and, if appropriate, resolving the issue. *Id.* ¶ 8. That staff member responds to the grievance and returns it to the Grievance Coordinator. *Id.*

The Grievance Coordinator then forwards the grievance to a "reviewing authority". *Id*. The reviewing authority returns the grievance to the Grievance Coordinator, who logs the response into the database and sends the completed grievance back to the inmate. *Id*.

The third step of the Grievance Process requires the offender to submit an appeal to the Grievance Coordinator within 14 days of the date the level two responder provided his/her reviewing authority response. *Id.* ¶ 9. Upon receipt of the appeal, the Grievance Coordinator provides the appeal to the appellate authority who is typically the Warden of the facility. If it is a medical grievance, the Health Services Director is the appellate authority. After the appeal is decided, the Grievance Coordinator returns the completed appeal form to the inmate. *Id*. The grievance process is exhausted at the end of all three of these steps. *Id*. ¶ 9.

Here, both Edmo and Defendants agree that Edmo properly exhausted administrative remedies for several issues in this case. These include the following: (1) an August 10, 2016 sexual assault, (2) being allowed to wear a feminine hairstyle, (3) IDOC staff use of masculine gender pronouns, (4) denial of electrolysis or hair remover, (5) alleged denial of a medical/mental health evaluation with a qualified gender identity disorder evaluator, (6) being housed in the Behavioral Health Unit, (7) and denial female underwear. *Dkt. 44*; *Dkt. 43*; *Maybon Decl. Dkt. 41*.

However, Defendants contend that Edmo failed to properly exhaust several claims including: (1) Claim for damages Edmo sustained as a result of a September 29, 2015 self-castration attempt, (2) Claim for damages sustained as a result of a December 31, 2016 self-castration attempt; (3) Claim for damages and/or equitable relief related to policy prohibiting Plaintiff from wearing women's makeup in a male prison; (4) Claim for damages or equitable relief regarding a legal name change while incarcerated; and

(5) Claim for damages and/or equitable relief related to the alleged failure to transfer Edmo to a women's correctional facility. *Dkt. 47. Maybon Decl. Dkt. 41, Exhibits C and D.*

A. *Self-Castration Attempts*

Edmo's First and Seventh claims seek damages for "harms" suffered. *Compl. Dkt. 36, ¶¶ 88, 113.* Although the alleged harms suffered are not specified within each claim for relief, Edmo references two self-castration attempts throughout the Complaint's Factual Allegations. *Id.at ¶¶ 5, 46-48.*

Defendants contend that Edmo did not independently raise self-castration as an issue the inmate sought to have addressed through IDOC's grievance process and thereby failed to exhaust administrative remedies. *Dkt. 47*. In response, Edmo points to several grievances that reference the castration attempts and argues that, even if not properly grieved, the attempts were "factual indicia" of Defendants' denial of care and thus not claims which require grieving. *Dkt. 44*.

The Ninth Circuit has made clear that a critical function of the grievance process is to provide prison officials with the opportunity to address the identified grievance and correct prison error accordingly. *Reyes v. Smith*, 810 F.3d 654, 657 (9th Cir. 2016). A grievance is not the equivalent of a "summons and complaint that initiates adversarial litigation," *see Johnson v. Johnson,* 385 F.3d 503, 522 (5th Cir.2004), and it need not "contain every fact necessary to prove each element of an eventual legal claim," *Griffin v. Arpaio,* 557 F.3d 1117, 1120 (9th Cir.2009.) It is instead sufficient if the prisoner

brings a problem to the prison's attention in compliance with the prison's administrative rules such that officials can understand the nature of the complaint and have the opportunity to fix it. *Houser v. Corizon*, 2014 WL 4249873, at *5 (D. Idaho Aug. 27, 2014).

The Court will first address whether the castration attempts were exhausted independently before deciding whether they may be properly classified as examples of denial of care which would not require specific grievances.

In Grievance II 15000117 Edmo sought the ability to wear makeup and a treatment plan which would accommodate such to avoid "future harm." *Maybon Decl., Dkt. 41-3, Ex. C.* This grievance is targeted at resolving a dispute regarding the ability to wear makeup, and does not raise the occurrence of self-castration so as to provide IDOC the opportunity to address the incident as part of the administrative dispute resolution process.

In Grievance II 150001166 Edmo sought reimbursement of a personal blanket that was lost after a self-castration attempt. *Id*. Similarly, this grievance did not raise the castration attempt as a matter Edmo sought to dispute in a manner which would provide opportunity for resolution.

In Grievance II 150001348, Edmo states "I am being denied an endocrinologist & medical treatment [to] wpath [sic] standards. This is creating a substantial risk of future harm of auto-castrating myself. I shouldn't have to wait for 30, 60, 90 days until next [appointment]." *Id*. In this grievance, Edmo specifically sought an appointment

with and treatment by an endocrinologist. The grievance was thus targeted at a perceived denial of medical care, not at resolving a castration attempt. Additionally, this grievance was filed 78 days after the first castration attempt and over one year before the occurrence of the second attempt. Therefore, this grievance could not properly cover either castration as its essential purpose.

Under these circumstances, the Court agrees with Defendants, and finds that Edmo did not exhaust administrative remedies regarding self-castration attempts.

However, the Court is persuaded by Edmo's argument that the castration attempts do not require separate grievances as they are claimed as a result of not receiving requested medical treatments which were properly grieved. *Dkt. 41-3*. Edmo also points to case law in which this Court has noted that exhaustive examples ("factual indicia") offered to support a specific claim need not be grieved separately. *See e.g. Spaude v. Corr. Corp. of Am.*, 2011 WL 5038922 (D. Idaho Oct. 21, 2011); *Houser v. Corizon*, 2014 WL 4249873 (D. Idaho Aug. 27, 2014); *Steece v. Corr. Corp. of Am.*, 2012 WL 761923 (D. Idaho Mar. 8, 2012). An inmate is not required to grieve every detail of how a perceived deprivation occurred. Instead, it is enough for an inmate to articulate the deprivation with enough specificity to allow prison officials the opportunity to investigate and correct the deficiency. *Steece,* 2012 WL 761923, at *5.

For example, in *Spaude*, a plaintiff who had properly grieved "institutional indifference to inmate safety" was not required to grieve each specific example of policy and procedure that exemplified indifference to inmate safety before alleging it in court.

2011 WL 5038922, at *3. Had prison officials addressed the plaintiff's initial grievance they would have discovered the mirrored reflections of indifference throughout. *Id*. In *Houser*, an inmate who properly grieved that Corizon stalled and delayed treatments was allowed to proceed with a count alleging a not-grieved example of treatment delay through "concealment of x-rays". *Houser v. Corizon*, No. 1:13-CV-00006-EJL, 2014 WL 4249873, at *5 (D. Idaho Aug. 27, 2014). Similarly, the *Steece* court found that inmates need not separately grieve each of a prison's policies that highlight institutional aversion to prisoner protection when "failure to protect from harm" is properly grieved. *Steece*, 2012 WL 761923, at *5. In each case the inmate's grievances were consistent with the PLRA and IDOC's requirement of providing prison officials with the opportunity to understand the nature of the complaint and address its essential purpose accordingly.

Here, Edmo alerted prison officials to her concerns regarding perceived denial of medical care through the grievance process prior to both castration attempts. Edmo argues that had gender reassignment surgery been provided as was requested through those grievances, self-castration would not have occurred.

Edmo first attempted self-castration on September 29, 2015. Prior to that, Edmo filed Grievance II 140000312 requesting evaluation by a specialist for gender reassignment surgery. This grievance should have served to provide prison officials opportunity to understand Edmo's complaint and address it accordingly. Though the

Court makes no finding regarding the prison's response to Edmo's grievance, it is undisputed that Edmo was not provided with gender reassignment surgery.

Edmo's second castration attempt occurred on December 31, 2016. Similarly, prior to that attempt, Edmo filed Grievance II 150001080 which specifically stated "I am being denied an endocrinologist & medical treatment [to] WPATH standards. This is creating a substantial risk of future harm of autocastrating myself." *Maybon Decl., Dkt. 41-3*. Although this grievance was ultimately denied by prison officials and filed over one year before the second castration attempt, it should have served to sufficiently alert prison officials to Edmo's complaint that gender reassignment surgery had not been provided.

Based on the information contained in these grievances, the exhaustion requirement was properly satisfied as related to the claims Edmo raises here. In particular, Edmo alerted prison officials of a desire to be provided with gender reassignment surgery and that a denial could result in self-castration.

As noted in *Spaude*, if a prisoner seeks relief based on facts or theories too far afield from the subject matter that was brought before prison officials, then the prisoner cannot be said to have exhausted remedies before raising those claims. 2011 WL 5038922, at *5. Here, however, Edmo's grievances provided enough information to allow prison officials to take appropriate responsive measures.

Defendants additionally argue that if a prisoner seeks monetary damages as a result of perceived injury, the incident of injury must be specifically grieved. In support,

Defendants point to *Daniels v. Blades*, which held that the plaintiff who was seeking monetary damages for injuries sustained during an alleged assault was required to exhaust administrative remedies pertaining to those injuries. 2017 WL 874567, * 2 (D. Idaho March 3, 2017). However, *Daniels* is factually distinguishable. In *Daniels*, not only had the prisoner failed to specifically grieve his injuries, but he failed to file a grievance after being moved to a prison tier that he knew housed members of a gang the prisoner had dropped out of and failed to file a grievance regarding the alleged assault by those gang members which had produced his injuries. *Id*. Thus, prison officials were not provided opportunity to address Daniels' issue before the lawsuit was filed. As discussed above, a lack of grievances regarding Edmo's concern over sex reassignment surgery is not the case here. Accordingly, Defendant's Motion to Dismiss will be denied regarding the castration claims.

B. *Access to Makeup*

Defendants assert that Edmo did not exhaust administrative remedies relating to a policy prohibiting males from wearing women's makeup. However, they admit that the policy about males wearing female hairstyles were properly exhausted.

Grievance II 150000395, which was fully processed, states a concern regarding makeup and hairstyle. Accordingly, the Court finds access to makeup has been properly grieved and Defendant's Motion to Dismiss this matter will be denied.

C. *Name Change*

Edmo has not provided evidence of having grieved a name change. Thus, Edmo has not properly exhausted administrative remedies regarding a name change. Accordingly, Defendant's Motion to Dismiss will be granted without prejudice.

D. *Transfer to Women's Facility*

Grievance II 170000899, which addresses Edmo's request for transfer to a women's facility, has not been fully exhausted through the grievance process. Accordingly, Defendant's Motion to Dismiss will be granted without prejudice.

3. Americans with Disabilities Act Claims

In order to state a claim under Title II of the ADA, a plaintiff must allege: (1) a disability, (2) consisting of a physical or mental impairment, (3) which substantially limits, (4) one or more major life activities, (5) that they were either excluded from participation in or denied the benefits of the public entity's services, programs, or activities, and (6) such exclusion, denial of benefits, or discrimination was by reason of the disability. 42 U.S.C. § 12101.

Section 12211(b)(1) goes on to provide: "Under this chapter, the term 'disability' shall not include (1) transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or other sexual behavior disorders."

Defendants argue that Edmo's diagnosis falls under gender identity disorder as specifically excluded from the ADA, and in the alternative that a diagnosis of gender dysphoria is interchangeable with that of gender identity disorder which it recently replaced in the psychiatric field. In contrast, Edmo argues that a diagnosis of gender dysphoria is different from that of gender identity disorder, and thus is not excluded.

As presented here, the issue of whether Edmo's diagnosis falls under a specific exclusion of the ADA presents a genuine dispute of material fact in this case. Therefore, Edmo's ADA claim will not be dismissed.

4. Affordable Care Act Claims

Defendants contend that Congress, in adopting the ACA, did not create a private right of action for discrimination, but instead relied upon enforcement mechanisms already available under such anti-discrimination statutes as Title VI, Title IX, § 504 of the Rehabilitation Act, and the Age Discrimination Act. *Dkt. 47*. The contrary view, of course, is that the ACA provides its own enforcement mechanism which stacks upon the enforcement mechanisms available under those statutes. *Dkt. 44*.

The Court must begin with the plain language of the statute. *Lamie v. United States Tr.*, 540 U.S. 526, 534 (2004). Congress may create a private right of action to enforce federal law through explicit language in the statute, or by implication. *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001). The Court must determine whether the statute manifests an intent to create both a private right and also a private remedy. *Id.* Statutory intent on this latter point is determinative. *Id*. Without it, a cause of action does not exist

and courts may not create one, no matter how desirable that might be as a policy matter. *Id.* at 286-87 (internal citations omitted). The text of the statute must be "phrased in terms of person benefitted" for a statute to create such private rights. *Gonzaga Univ. v. Doe*, 536 U.S. 273, 284 (2002).

Section 1557 expressly incorporates four federal civil rights statutes and includes similar rights-creating language found in those statutes. See 42 U.S.C. § 2000d ("No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."); 20 U.S.C. § 1681 ("No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance ..."); 42 U.S.C. § 6102 ("[N]o person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance."); 29 U.S.C. § 794 ("No otherwise qualified individual with a disability in the United States, as defined in section 705(20) of this title, shall, solely by reason of her or his disability, be excluded from the participation in, be denied benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance....").

Section 1557 cross-references these four federal civil rights statutes to provide the classes of those protected by the statute's non-discrimination provision. The cross

reference to these statutes and the use of similar rights-creating terms sufficiently manifests Congressional intent to create a private right. See 42 U.S.C. § 18116(a) ("an individual shall not, on the ground prohibited [under the federal civil rights statutes], be excluded from participation in, be denied the benefits of, or be subjected to discrimination under" a variety of programs and activities). In addition, 42 U.S.C. § 18116(a) expressly provides a private remedy by stating that the "enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act shall apply for purposes of violations of this subsection." Finally, 42 U.S.C. § 18116(b) states, "[n]othing in this title (or an amendment made by this title) shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under [the four federal statutes]." This reinforces the notion that Congress intended create a private right and remedy by not limiting the rights provided under the cross-referenced federal statutes. Therefore, cross-referencing the statutes and the express incorporation of the enforcement mechanisms from those statutes is probative of Congressional intent to provide both a private right and a private remedy for violations of Section 1557. Accordingly, Defendant's Motion to Dismiss this claim will be denied.

5. Statute of Limitation Issues

The statute of limitations period for filing a civil rights lawsuit under 42 U.S.C. § 1983 is determined by the statute of limitations period for personal injuries in the state where the claim arose. *Wilson v. Garcia*, 471 U.S. 261 (1985) (later overruled only as to

claims brought under the Securities Exchange Act of 1934, not applicable here). Idaho Code § 5-219 provides for a two-year statute of limitations for professional malpractice, personal injury, and wrongful death actions. Federal civil rights actions arising in Idaho are governed by this two-year statute of limitations.

Although the Court relies upon the state statute of limitations to determine the time for filing a claim, the Court uses federal law to determine when a claim accrues. *Elliott v. City of Union City*, 25 F.3d 800, 801-02 (9th Cir. 1994). The Ninth Circuit has determined that a claim accrues when the plaintiff knows, or should know, of the injury that is the basis of the cause of action. *See Kimes v. Stone*, 84 F.3d 1121, 1128 (9th Cir. 1996). Under this "discovery rule," the statute begins to run once a plaintiff knows of his injury and its cause. *Gibson v. United States*, 781 F.2d 1334, 1344 (9th Cir. 1986). A claim accrues upon awareness of an actual injury, "and not when the plaintiff suspects a legal wrong." *Lukovsky v. City and County of San Francisco*, 535 F.3d 1044, 1049 (9th Cir. 2008).

Here, Defendants argue that Edmo seeks to recover damages for injuries and "severe symptoms" that she allegedly suffered as a result of incidents that occurred more than two years prior to the filing of this civil rights lawsuit on April 6, 2017. *Dkt. 43.* (Pointing to *Dkt. 36*, ¶¶ 8, 9, 44-45, 64, 67, 79, 88, 93, 95, 101,108, and 113). Defendants specifically note that Edmo described an attempted suicide in February 2014 and "experienced severe symptoms" between 2012 to early 2015 as a result of Defendants'

having "denied and/or ignored Plaintiff's requests." *Dkt. 43*. (Pointing to *Dkt. 36*, ¶¶ 44(a)-(j), 45, and 49) (*SMF*, ¶¶ 5, 8).

Edmo does not dispute the effect of the applicable statute of limitations, but points out that the claims actually included in her complaint accrued less than two years prior to the filing of her complaint and are therefore not time barred. Accordingly, Defendant's request to preclude Edmo from seeking damages arising from events that occurred prior to April 6, 2015 will be granted. However, claims accruing after that date are not time-barred and will not be dismissed.

6. State Negligence Claims

Idaho Code § 6-905 of the Idaho Tort Claims Act states: All claims against the state arising under the provisions of this act and all claims against an employee of the state for any act or omission of the employee within the course or scope of his employment shall be presented to and filed with the secretary of state within one hundred eighty (180) days from the date the claim arose or reasonably should have been discovered, whichever is later."

Idaho Code § 6-907 goes on to provide that: "All claims presented to and filed with a governmental entity shall accurately describe the conduct and circumstances which brought about the injury or damage, describe the injury or damage, state the time and place the injury or damage occurred, state the names of all persons involved, if known, and shall contain the amount of damages claimed…"

Defendants claim that Edmo did not properly comply with the Idaho Tort Claims Act, cannot sue the state officials in their official capacity because of 11th Amendment immunity, and failed to plead Defendants' wrongdoing with sufficient specificity. *Dkt. 47*. Edmo provided only a limited response to these contentions, arguing only that the notice requirements of the ITCA were satisfied. Notably, she did not otherwise address whether she complied with other provisions of the statute.

Edmo's 11/24/2014 tort claim (Claim 1) identifies disciplinary reports issued regarding Edmo's feminine hairstyle as a violation of the Prison Rape Elimination Act. *Dkt. 42. Ex 1.* Although named defendants were not specifically listed in the filing of this tort, it served to notify the state of Edmo's underlying claim and was filed within 180 days of a DOR received on July 07, 2014.

Edmo's 12/12/2016 tort claim (Claim 2) does not provide a date on which the alleged injury was suffered, does not specify any alleged negligent acts, and does not specify anyone who was involved. *Dkt. 42. Ex. 2.* As such, it does not properly notify the state of Edmo's claim, nor does it comply with the 180 day filing mandate under Idaho Code § 6-905.

Edmo's 02/13/2017 tort claim (Claim 3) identifies a 09/29/2015 and a 12/31/2016 castration attempt. *Dkt. 42. Ex. 3.* The claim was not filed within 180 days of the 09/29/2015 attempt, but was properly filed as to the 21/31/2016 attempt. As such, Edmo may only proceed regarding the latter claim.

Accordingly, Defendant's request to dismiss Edmo's state negligence claims will be denied as to Claim 1, granted as to Claim 2, and denied regarding the first castration attempt and granted regarding the second attempt found in Claim 3.

ORDER

IT IS ORDERED:

1. Defendants' First Motion for Dispositive Relief (Dkt. 39) is **GRANTED IN PART and DENIED IN PART.**
    a. Defendants' Motion for Summary Judgment is GRANTED regarding a name change and transfer to a women's facility. Plaintiff may proceed on self-castration and access to makeup claims.
    b. Defendants' Motion to Dismiss Americans with Disabilities Act claims is DENIED without prejudice.
    c. Defendants' Motion to Dismiss Affordable Care Act claims is DENIED without prejudice.
    d. Defendants' Motion to Dismiss statutorily time-barred claims is GRANTED.
    e. Defendants' Motion to Dismiss State Negligence Claim 1 is DENIED without prejudice.
    f. Defendants' Motion to Dismiss State Negligence Claim 2 is GRANTED.

g. Defendants' Motion to Dismiss State Negligence Claim 3 is GRANTED regarding the 09/29/2015 castration attempt and DENIED regarding the 12/31/2016 attempt.

DATED: June 7, 2018

B. Lynn Winmill
Chief U.S. District Court Judge

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UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ADREE EDMO (a/k/a MASON EDMO),

Plaintiff,

v.

IDAHO DEPARTMENT OF CORRECTION; HENRY ATENCIO, in his official capacity; JEFF ZMUDA, in his official capacity; HOWARD KEITH YORDY, in his official and individual capacities; CORIZON, INC.; SCOTT ELIASON; MURRAY YOUNG; RICHARD CRAIG; RONA SIEGERT; CATHERINE WHINNERY; and DOES 1-15;

Defendants.

Case No.: 1:17-cv-00151-BLW

PLAINTIFF'S NOTICE OF MOTION AND MOTION FOR PRELIMINARY INJUNCTION AND MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT THEREOF

Complaint Filed:	April 6, 2017
Discovery Cut-Off:	None Set
Motion Cut-Off:	None Set
Trial Date:	None Set

ARGUMENT

I. Legal Standard for Preliminary Injunction

"A plaintiff seeking a preliminary injunction must establish that [s]he is likely to succeed on the merits, that [s]he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in [her] favor, and that an injunction is in the public interest." *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2009); *Pimentel v. Dreyfus*, 670 F. 3d 1096, 1105 (9th Cir. 2012) (applying *Winter* to claim under 42 U.S.C. § 1983). "[S]erious questions going to the merits and a balance of hardships that tips sharply towards the plaintiff can support issuance of a preliminary injunction, so long as the plaintiff also shows that there is a likelihood of irreparable injury and that the injunction is in the public interest." *Alliance for the Wild Rockies v. Cottrell*, 632 F. 3d 1127, 1135 (9th Cir. 2011) (internal quotation marks omitted).

While preliminary injunctions that order a party to take affirmative action are generally not granted "unless extreme or very serious damage will result," *see Marlyn Nutraceuticals, Inc. v. Mucos Pharma GmbH & Co.*, 571 F. 3d 873, 879 (9th Cir. 2009), this is exactly such a case. Defendants' ongoing refusal to provide necessary medical treatment to Ms. Edmo places her at imminent risk of serious harm. Ms. Edmo has a history of suicide attempts and twice risked her life in attempts to remove her testicles herself. As set forth in detail *infra*, and in the concurrently-submitted declarations, two of the preeminent experts in the field of medical treatment for patients with gender dysphoria have assessed Ms. Edmo and found Defendants' failure to appropriately treat her—including their denial of access to sex-reassignment surgery—to be life-threatening.

II. Plaintiff Will Succeed on the Merits of Her Claims

Ms. Edmo moves for preliminary injunctive relief on the basis of her Eighth Amendment claim for failure to provide adequate and necessary medical treatment for the serious medical condition of gender dysphoria, and on the basis of her sex discrimination claims under the

of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right." 18 U.S.C. § 3626(a)(2). "The Court shall give substantial weight to any adverse impact on public safety or the operation of a criminal justice system." *Id*. The Ninth Circuit has clarified that the PLRA "has not substantially changed the threshold findings and standards required to justify an injunction." *Gomez v. Vernon*, 255 F. 3d 1118, 1129 (9th Cir. 2001).

Here, an injunction granting Ms. Edmo "access to adequate medical care, including referral to a qualified surgeon for sex-reassignment surgery, is narrowly drawn, extends no further than necessary to correct the constitutional violation, and is the least intrusive means necessary to correct the violation. " *Norsworthy*, F. Supp. 3d at 1194-95. Further, "[t]here is no evidence that granting this relief will have any adverse impact on public safety or the operation of the criminal justice system." *Id.* at 1195; *see Fields*, 653 F. 3d at 556.

CONCLUSION

For the foregoing reasons, Plaintiff requests the Court issue a preliminary injunction: 1) ordering Defendants to provide her immediate access to necessary medical treatment, including (a) sex-reassignment surgery; (b) reinstatement of spironolactone, or an equivalent type of care; (c) access to gender-appropriate underwear, clothing, and commissary items; (d) any other treatment a medical professional qualified to assess and treat gender dysphoria determines to be medically urgent; and 2) prohibiting Defendants from (a) implementing their policy and/or practice of blanket denial of access to such treatment for transgender persons incarcerated in the Idaho Department of Corrections; and (b) disciplining or retaliating against Plaintiff for expressing her gender identity, including wearing gender-appropriate underwear and clothing, and adhering to female grooming standards with regards to makeup and hair styling.

Dated: June 1, 2018

Respectfully Submitted,
NATIONAL CENTER FOR LESBIAN RIGHTS
FERGUSON DURHAM
HADSELL STORMER & RENICK LLP

By: /s/ - Lori E. Rifkin
Lori E. Rifkin
Attorneys for Plaintiff

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 1st day of June, 2018, I filed the foregoing electronically through the CM/ECF system, which caused the following parties or counsel to be served by electronic means, as more fully reflected on the Notice of Electronic Filing:

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UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ADREE EDMO (a/k/a MASON EDMO),

Plaintiff,

v.

IDAHO DEPARTMENT OF CORRECTION; HENRY ATENCIO, in his official capacity; JEFF ZMUDA, in his official capacity; HOWARD KEITH YORDY, in his official and individual capacities; CORIZON, INC.; SCOTT ELIASON; MURRAY YOUNG; RICHARD CRAIG; RONA SIEGERT; CATHERINE WHINNERY; and DOES 1-15;

Defendants.

Case No.: 1:17-cv-00151-BLW

DECLARATION OF LORI RIFKIN AND EXHIBITS IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

Complaint Filed:	April 6, 2017
Discovery Cut-Off:	None Set
Motion Cut-Off:	None Set
Trial Date:	None Set

DECLARATION OF LORI E. RIFKIN

I, Lori E. Rifkin, hereby declare and state:

1. I am a partner at the law firm of Hadsell Stormer & Renick, LLP. I am an attorney licensed to practice law in the state of California and am admitted *pro hac vice* before this Court, and am counsel of record for plaintiffs in this action. The information contained herein is based on my personal knowledge, or upon review of files and documents generated or received and regularly maintained by my office in connection with this case. If called upon, I could testify in a court of law to the accuracy of the matters set forth herein.

2. After filing Plaintiff's Second Amended Complaint on September 1, 2017, Plaintiff's counsel sought Ms. Edmo's medical records from Defendants. I communicated about this request with IDOC's counsel several times, but Defendants refused to provide these records until initial disclosures are required after the Court's ruling on Defendants' Motion for Dispositive Relief. In May 2018, I again requested Ms. Edmo's medical records based on learning of an IDOC Directive permitting release of medical records to an incarcerated person's attorney. Defendants then agreed to provide the records and did provide them on May 30, 2018.

3. Because of the gravity of Ms. Edmo's medical condition, Plaintiff's counsel retained two highly qualified medical experts, Drs. Randi Ettner and Nicholas Gorton, to evaluate her and review the incomplete medical records accessible by Ms. Edmo.

4. Attached hereto as **Exhibit 1** is the Declaration of Dr. Randi Ettner, an expert retained on behalf of Plaintiff in this matter. Dr. Ettner is a licensed clinical and forensic psychologist with a specialization in the diagnosis, treatment, and management of gender dysphoric individuals. She was chief psychologist at the Chicago Gender Center from 2005 to 2016, and is now the sole psychologist for the Center for Gender Confirmation Surgery at Weiss Memorial Hospital. Dr. Ettner is one of the foremost experts in the United States on treatment of individuals with gender dysphoria and is the secretary and a member of the Board of Directors of the World Professional Association of Transgender Health (WPATH) and chairs the WPATH Committee for Institutionalized Persons.

5. Attached hereto as **Exhibit 2** is the Declaration of Dr. Nicholas Gorton, an expert retained on behalf of Plaintiff in this matter. Dr. Gorton is a physician who works in emergency medicine, and provides primary care and transition-related care to transgender patients. Dr. Gorton is an Emergency Medicine physician at Sutter Davis Hospital and a primary care physician at Lyon-Martin Health Services in San Francisco, and also serves as a clinician consultant for TransLine, a national transgender medical consultation service for clinicians needing expert advice about the care of their patients. Dr. Gorton is a preeminent expert on treatment of transgender health issues and is a member of WPATH and serves on the WPATH transgender medicine and research committee and the WPATH committee for institutionalized persons.

6. During a visit with Ms. Edmo on June 1, 2018, Plaintiff's counsel learned that Ms. Edmo has recently been told by her Unit Sergeant and another custody officer that if she wears her hair in a feminine manner and uses makeup before an attorney-client visit, she will not be permitted to attend the visit with her attorneys. Such harassment of Ms. Edmo for expressing her female identity and impermissible threat to interfere with her First Amendment right to access legal counsel further evidences the need for preliminary injunctive relief.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct. Executed June 1, 2018 in Emeryville, California.

/s/ - Lori E. Rifkin
Lori E. Rifkin

Rifkin Decl in Supp Pltf's Mtn for Preliminary Injunction

Exh. 1

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UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ADREE EDMO (a/k/a MASON EDMO),

Plaintiff,

v.

IDAHO DEPARTMENT OF CORRECTION; HENRY ATENCIO, in his official capacity; JEFF ZMUDA, in his official capacity; HOWARD KEITH YORDY, in his official and individual capacities; CORIZON, INC.; SCOTT ELIASON; MURRAY YOUNG; RICHARD CRAIG; RONA SIEGERT; CATHERINE WHINNERY; and DOES 1-15;

Defendants.

Case No.: 1:17-cv-00151-BLW

DECLARATION OF RANDI ETTNER, PhD, IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

Complaint Filed:	April 6, 2017
Discovery Cut-Off:	None Set
Motion Cut-Off:	None Set
Trial Date:	None Set

I, Randi C. Ettner, have been retained by counsel for Adree Edmo as an expert in connection with the above-captioned matter.

1. I have actual knowledge of the matters stated and would so testify if called as a witness. I reserve the right to supplement or amend this report based on any future information that is provided to me.

2. This report contains my opinions and conclusions, including (i) scientific information regarding gender dysphoria and its impact on health and well-being of individuals afflicted; (ii) information regarding best practices and the accepted standards of care for individuals with gender dysphoria, including the efficacy of gender confirmation surgery (previously referred to as sex reassignment surgery), and (iii) the results of my evaluation of Ms. Edmo and recommendations with regard to her treatment.

My Relevant Background and Qualifications

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

4. I was the chief psychologist at the Chicago Gender Center from 2005 to 2016, when it moved to Weiss Memorial Hospital. Since that time, I have held the sole psychologist position at the Center for Gender Confirmation Surgery at Weiss Memorial Hospital. A true and accurate copy of my curriculum vitae is attached as **Exhibit A** to this declaration.

5. I have evaluated, diagnosed, and treated between 2,500 and 3,000 individuals with gender dysphoria and mental health issues related to gender variance from 1980 to present. I have published four books related to the treatment of individuals with gender dysphoria, including the medical text entitled Principles of Transgender Medicine and Surgery (1st edition, co-editors Monstrey & Eyler; Rutledge 2007; and 2nd edition, co-editors Monstrey & Coleman; Routledge, June 2016). In addition, I have authored numerous articles in peer-reviewed journals regarding the provision of health care to the transgender population.

6. I have served as a member of the University of Chicago Gender Board, and am on the editorial boards of *The International Journal of Transgenderism* and *Transgender Health*. I am the secretary and a member of the Board of Directors of the World Professional Association of Transgender Health (WPATH), and an author of the WPATH *Standards of Care for the Health of Transsexual, Transgender and Gender-nonconforming People (7th version),* published in 2011. The WPATH promulgated Standards of Care ("Standards of Care") are the internationally recognized guidelines for the treatment of persons with gender dysphoria and serve to inform medical treatment in the United States and throughout the world.

7. I chair the WPATH Committee for Institutionalized Persons, and provide training to medical professionals on healthcare for transgender inmates. I have lectured throughout North America, Europe, and Asia on topics related to gender dysphoria and present grand rounds on gender dysphoria at university hospitals. I am the honoree of the externally-funded Randi and Fred Ettner Fellowship in Transgender Health at the

University of Minnesota. I have been an invited guest at the National Institute of Health to participate in developing a strategic research plan to advance the health of sexual and gender minorities, and in November 2017 was invited to address the Director of the Office of Civil Rights of the United States Department of Health and Human Services regarding the medical treatment of gender dysphoria.

8. I have been retained as an expert regarding gender dysphoria and the treatment of gender dysphoria in multiple court cases in both state and federal courts as well as administrative proceedings. I have also been a consultant to policy makers regarding appropriate care for transgender inmates.

9. Attached hereto as **Exhibit B** is a bibliography of relevant medical and scientific materials related to transgender people and gender dysphoria. I generally rely on these materials when I provide expert testimony, in addition to the documents specifically cited as supportive examples in particular sections of this declaration. I have also relied on my years of experience in this field, as set out in my curriculum vitae (**Exhibit A**), and on the materials listed therein. The materials I have relied on in preparing this declaration are the same type of materials that experts in my field of study regularly rely upon when forming opinions on the subject.

My Evaluation of Ms. Edmo

10. I reviewed the following documents for this report:

- *Diagnostic and Statistical Manual of Mental Disorders, fifth revision (DSM-5)* (2013)
- *The World Professional Organization for Transgender Health Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People,* Seventh Version, 2011

- Medical and mental health records for Adree Edmo, provided
- Ettner, Monstrey & Coleman (eds.) *Principles of Transgender Medicine and Surgery,* Routledge, New York: 2016

11. I administered the following psychodiagnostic tests to Ms. Edmo:

- *Beck Anxiety Inventory*
- *Beck Depression Inventory-II*
- *Beck Hopelessness Scale*
- *Traumatic-Symptom Inventory-2*

12. At the request of counsel, I met with Ms. Edmo at the Idaho Department of Correction (IDOC) in Boise, Idaho on March 19, 2018. The interview took place in a private visitors' area equipped with a table and chairs, and I was afforded all the necessary courtesies by staff.

Ms. Edmo's Relevant Background Information

13. Ms. Edmo was born in Pocatello, Idaho. She is one of five children; two of whom are half-siblings. Ms. Edmo spent her first two years in Texas, and then the family returned to Idaho to live on the Shoshone Bannock Native American reservation. She attended public elementary and high school and one year of college at Idaho State University, majoring in business administration. She received a paralegal certificate from the state university. Prior to her incarceration, Ms. Edmo was employed as a secretary.

14. At age 15, Ms. Edmo began abusing alcohol, and by age 20 she was using intravenous drugs. She was sentenced for her criminal conviction in 2011, and in 2012 she was incarcerated at the Idaho facility where she remains to date.

15. As a very young child, Ms. Edmo believed she was a girl, and assumed she

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would grow up to be as feminine as her two older sisters. She states her female gender identity was something she "never questioned…it's always been this way as long as I can remember." Ms. Edmo's father was "absent" during her childhood and her mother was accepting of the child's female behavior and display. Ms. Edmo describes her older brother as feeling "protective" of her, lest she be bullied for her gender non-conformity, but that never came to pass. Ms. Edmo played exclusively with girls as a youngster, and as she matured, she continued to associate exclusively with female peers.

16. By the age of 21, Ms. Edmo began to present as a female full time—she dressed in women's clothing, and wore make-up and nail polish. She was experiencing depression and was treated by the Native American health service providers with sertraline and fluoxetine.

17. In 2012, prison mental health professionals diagnosed Ms. Edmo with gender dysphoria (302.6), and appropriately prescribed cross sex hormonal therapy. She has a well consolidated female identity and has, to the best of her ability, made a successful social role transition, given the restrictions of presenting as a woman in the male prison where she resides.

18. Ms. Edmo is exclusively attracted to men and has a committed relationship with a male inmate whom she considers a life partner.

19. She has no paraphilic fantasies, and like all severely gender dysphoric individuals, she despises her genitals, "tucks" them and does not use them as a vehicle for sensuality. She refers to her genitals as "something attached that I hate…I feel deformed in some way and get nauseous." Ms. Edmo has attempted auto-castration on two occasions.

Relevant Medical History

20. Ms. Edmo has no chronic illnesses, save overweight/borderline obesity, with a BMI of 29.75. She has been substance free for seven years. She currently takes 450 mg venlafaxine, 8 mg estradiol, 5 mg finesteride, 5 mg medroxyprogesterone, calcium carbonate, vitamin D and vitamin B complex. In 2018, her laboratory results indicated elevated liver enzymes (ALT and AST) and spironolactone was discontinued from her hormone protocol.

Ms. Edmo's History of Suicidality

21. Ms. Edmo has a history of suicide ideation and multiple suicide attempts. At the behest of the Surgeon General, a plan for identifying populations at risk for suicide, and advancement of scientific methods to assess risk, has resulted in recent abundant scientific investigation. Several lines of research suggest that single suicide attempters differ significantly from multiple suicide attempters. Multiple attempters, and those who engage in method switching, as Ms. Edmo has, are far more likely to die by suicide than are single attempters. Ms. Edmo has attempted suicide by overdosing on pills, attempted hanging, and cutting her arms with a box cutter.

Mental Status Exam

22. Ms. Edmo appeared well groomed, wearing prison-issued garments. At 5 feet, seven inches and 190 pounds, with long hair, and minimal make-up, she makes an authentic and decidedly female presentation. Ms. Edmo was alert, cooperative, and oriented in all spheres. She was able to sit comfortably throughout the lengthy interview without a break, and with no agitation or restlessness. There are no disorders of thought,

and thought processes were logical, goal directed and without distortion. Thought content is within normal limits. Judgment and insight are adequate. Mood was calm, and affect was appropriate to context. Ms. Edmo maintained eye contact throughout, and rapport was easily established. Speech is well modulated and in a female range; language is fluent. Memory and abstract reasoning are well within normal limits. Intelligence (by estimation) is above average.

Cluster Analysis of Clinical Data

23. Anxiety and depression are symptoms that are present in many mental disorders. Like pain or fatigue, their mere presence does not provide sufficient information to be clinically useful. For example, an individual will experience pain from a head injury or a blockage in the ureter. The diagnosis and therapeutic interventions will differ in these two presentations.

24. Similarly, anxiety and depression are multi-faceted constructs, and clinicians endeavor to disentangle the affective, behavioral and somatic symptoms of these phenomena. This is critical in determining the nature of a disorder, its severity and appropriate treatment. Patterns of anxiety symptoms are often diagnostically relevant. Indeed, statistical analysis reveals four distinct symptom clusters that assist in making a differential diagnosis and inform treatment. These clusters reflect neurophysiological, subjective, panic and autonomic symptoms of anxiety. The inter-correlations of the four clusters are statistically significant (beyond the .001 level). Similarly, it is useful for clinicians to examine the overall pattern of depressive symptoms. Depressive symptoms are not only cognitive and affective, but also somatic and vegetative. Each patient displays

a unique depressive syndrome.

25. The administration of psychometric tests to measure various aspects of anxiety and depression in adult populations greatly assists with differential diagnosis, allowing the clinician to respond with a full range of appropriate therapeutic interventions.

Psychological Test Results

26. Four standardized psychometric indices with high levels of reliability and validity were administered to corroborate the clinical assessment: *The Beck Anxiety Inventory, The Beck Depression Inventory-II, The Beck Hopelessness Scale and The Traumatic Symptom Inventory-2.* The *Traumatic Symptom Inventory-2* includes extensive validity measures, which detect malingering, random response patterns, exaggeration of symptoms, or "faking good" i.e. an attempt to present oneself as overly virtuous. Ms. Edmo produced valid test protocols, demonstrating an honest and self-disclosing response style. I am confident, to a reasonable degree of medical certainty, that the data generated regarding her current status is valid and reliable.

27. The Beck Anxiety Inventory (BAI): Ms. Edmo experiences severe anxiety symptoms, including "feeling scared;" "fear of the worst happening;" "heart pounding;" "difficulty breathing;" etc. Most of these symptoms are somatic (physical sensations), and not subject to cognitive reappraisal (logical reinterpretation). In other words, because these symptoms are physiological, they are not within her conscious control. Ms. Edmo meets the diagnostic criteria for an anxiety disorder.

28. The Beck Depression Inventory-II (BDI-II): The BDI-II measures both the symptoms and severity of depression in twenty-one domains, with scores that range from

0-63. Ms. Edmo experiences severe depressive symptoms. These include changes in appetite and sleep, irritability, loss of energy, feelings of worthlessness, fatigue, and agitation. These symptoms represent somatic, affective and cognitive symptoms of depression.

29. Ms. Edmo scored a 36 on the *Beck Depression Inventory*. To put this in context, one study demonstrated that scores of 23 and above were predictive of patients who ultimately committed suicide. Ms. Edmo meets the diagnostic criteria for a depressive disorder.

30. The Beck Hopelessness Scale (BHS): Ms. Edmo scored moderately high on scales measuring the extent of hopelessness. Hopelessness is a psychological conditionthat underlies a variety of mental health disorders. Hopeless individuals believe that their important goals cannot be attained and that their worst problems cannot be solved. The BHS has utility as an indirect indicator of suicidal risk, and hopelessness has been repeatedly found to be a better predictor of suicide than depression. Ms. Edmo scored 11 on this instrument. A study of 1,969 outpatients who were administered the BHS found that of those who ultimately committed suicide, 93.8% had scores of 9 or higher.

31. The Traumatic Symptom Inventory-2 (TS-2): The TSI-2 is a test that measures acute and chronic symptomatology, and is used to evaluate adults in a variety of clinical settings. It measures trauma at any point in an individual's lifespan, and assesses a wide range of potentially complex symptomatology (a set of symptoms), ranging from posttraumatic stress, dissociation, somatization, insecure attachment styles, impaired self-capacities and dysfunctional behaviors.

32. A respondent's level of symptomatology is interpreted based on *T*-scores, which are linear transformations of raw scale scores, similar to percentages. Higher *T*-scores indicate greater symptomatology. *T*-scores in the range of 60-64 are considered problematic, and those at or above 65 are considered clinically elevated (sufficiently extreme to represent significant clinical concern).

33. Ms. Edmo has clinically elevated scores on several scales. Consistent with a diagnosis of a depressive disorder and Gender Dysphoria, her most substantially elevated scores are on scales that tap depression (D) and suicidality (SUI). Ms. Edmo scored a 100—the highest score possible—on the scale that measures suicide ideation and suicide behavior. Elevated scores on the suicidality scale are especially problematic, as they indicate a potential threat to life or the hopelessness of individuals in inescapable, highly adverse circumstances. Suicide is a particular concern in this case, as it is accompanied by Ms. Edmo's high scores on externalizing behavior (EXT) and tension reduction behavior (TRB) and her previous history of suicide attempts. This is alarming, given that Ms. Edmo is currently receiving the maximum dose of anti-depressant medication.

Gender Dysphoria

34. Gender dysphoria, formerly known as gender identity disorder (GID), is a serious medical condition codified in the *International Classification of Diseases* (ICD10th revision: World Health Organization) and the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders-5th edition* (DSM-5).

35. The condition is characterized by incongruence between one's experienced/expressed gender and assigned sex at birth, and clinically significant distress

or impairment of functioning that results. The suffering that arises from this condition has often been described as "being trapped in the wrong body." Gender dysphoria is also the psychiatric term used to describe the severe and unremitting pain associated with the condition.

36. The diagnostic criteria for gender dysphoria in adults are as follows:

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 month's duration, as manifested by at least two of the following:

i. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics.
ii. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender.
iii. A strong desire for the primary and/or secondary sex characteristics of the other gender.
iv. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
v. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
vi. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition is associated with clinically significant distress or impairement in social, occupational, or other important areas of functioning.

37. Gender dysphoria is a highly treatable condition. Without treatment, however, individuals with gender dysphoria experience anxiety, depression, suicidality, and other attendant mental health issues. They are also frequently isolated because they carry a burden of shame and low self-esteem, attributable to the feeling of being inherently "defective." This leads to stigmatization, and over time, ravages healthy personality development and interpersonal relationships. As a result, without treatment many such

individuals are unable to function effectively in daily life. Studies show a 41%-43% rate of suicide attempts among this population, far above the baseline for North America (Haas et al., 2014).

38. Gender dysphoric patients who are assigned a male sex at birth but identify as female and lack access to appropriate care, particularly those who are imprisoned, are often so desperate for relief that they resort to life-threatening attempts at auto-castration—removal of the testicles—in the hopes of eliminating the major source of testosterone that kindles the distress (Brown, 2010; Brown & McDuffie, 2009).

39. Gender dysphoria intensifies with age. As gender dysphoric individuals approach middle age, they experience an exacerbation of symptoms (Ettner, 2013; Ettner & Wiley, 2013).

Treatment of Gender Dysphoria

40. The standards of care for treating gender dysphoria are set forth in the WPATH Standards of Care. The *American Medical Association*, the *Endocrine Society*, the *American Psychological Association* the *American Psychiatric Association,* the *World Health Organization*, the *American Academy of Family Physicians*, the *American Public Health Association*, the *National Association of Social Workers,* the *American College of Obstetrics and Gynecology* and the *American Society of Plastic Surgeons* all endorse protocols in accordance with the WPATH standards. *See, e.g.*, American Medical Association (2008) Resolution 122 n(A-08); Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2017); American Psychological Association Policy Statement on Transgender, Gender Identity and Gender Expression

Nondiscrimination (2009).

41. The standards of care identify the following evidence-based protocols for the treatment of individuals with gender dysphoria:

- Changes in gender expression and role, consistent with one's gender identity (social role transition)
- Psychotherapy for purposes such as addressing the negative impact of stigma, alleviating internalized transphobia, enhancing social and peer support, improving body image, promoting resiliency, etc.
- Hormone therapy to feminize the body
- Surgery to alter primary and/or secondary sex characteristics (e.g. breasts, external genitalia, facial features, body contouring)

42. Once a diagnosis is established, a treatment plan should be developed based on the individualized assessment of the medical needs of the patient. WPATH specifies that treatment plans and provision of care must be undertaken by qualified professionals, with established competencies in the treatment of gender dysphoria (Section VIII). Regimens tendered by providers lacking the requisite experience can place patients at significant medical risk.

43. Like protocols for the treatment of diabetes or other medical conditions, medical management of gender dysphoria for incarcerated individuals does not differ from protocols for non-institutionalized persons. For this reason, the WPATH Standards of Care expressly state that all elements of the prescribed assessment and treatment are equally applicable to patients who are institutionalized or incarcerated in prisons (Section XIV), and the standards of care have also been recognized by the National Commission on Correctional Health Care (NCCHC) as the clinically accepted standards for the care of inmates with gender dysphoria. (NCCHC Policy Statement, Transgender Health Care in

Correctional Settings (October 18, 2009; reaffirmed with revision April, 2015), available at http://www.ncchc.org/transgender-health-care-in-correctional-settings.)

44. **Psychotherapy**: Psychotherapy can provide support and help with many issues that arise in tandem with gender dysphoria. However, psychotherapy alone is not a substitute for medical intervention when medical interventions are required, nor is it a precondition for medically indicated treatment. By analogy, counseling can be useful for patients with diabetes by providing psychoeducation about living with chronic illness and nutritional information, but counseling does not obviate the need for insulin.

45. **Social Role Transition:** The Standards of Care establish the therapeutic importance of changes in gender expression and presentation—the ability to feminize one's appearance— as a critical component of treatment. Known as the "real life experience," it requires dressing, grooming, and otherwise conveying, via social signifiers, a public face and role consistent with one's gender identity. This is an appropriate and essential part of identity consolidation. Through this experience, the shame of growing up living as a "false self" and the grief of being born in the "wrong body" can be ameliorated. (Greenberg and Laurence, 1981; Ettner, 1999; Devor, 2004; Bockting, 2007.)

46. The Standards of Care also specifically provide that permanent facial and body hair removal, which eliminates a visible secondary sex characteristic, is significant in alleviating gender dysphoria (Section V).

47. **Hormone Therapy:** For individuals with persistent, well-documented gender dysphoria, hormone therapy is an essential, medically indicated treatment to alleviate the distress of the condition. Cross sex hormone administration is a well-

established and effective treatment modality for gender dysphoria. The American Medical Association, the Endocrine Society, the American Psychiatric Association and the American Psychological Association all concur that hormone therapy, provided in accordance with the WPATH Standards of Care, is the medically necessary, evidence-based, best practice care for most patients with gender dysphoria.

48. The goals of hormone therapy are (1) to significantly reduce hormone production associated with the person's birth sex, causing the unwanted secondary sex characteristics to recede, and (2) to replace the natal, circulating sex hormones with feminizing hormones, using the principles of hormone replacement treatment developed for hypogonadal patients *(i.e.* those born with insufficient sex steroid hormones). (*See* Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline; 2009).

49. The therapeutic effects of hormone therapy are twofold: (1) with endocrine treatment, the patient acquires congruent secondary sex characteristics, *i.e.* breast development, redistribution of body fat, cessation of male pattern baldness, and reduction of body hair; and (2) hormones act directly on the brain, via receptor sites, attenuating the dysphoria and attendant psychiatric symptoms, and promoting a sense of well-being.

50. **Surgical Treatment:** For individuals with severe gender dysphoria, hormone therapy alone is insufficient. In these cases, dysphoria does not abate without surgical intervention. Genital confirmation surgery has two therapeutic purposes. First, removal of the testicles eliminates the major source of testosterone in the body. Second, the patient attains body congruence resulting from the normal appearing and functioning

female uro-genital structures. Both outcomes are crucial in attenuating or eliminating gender dysphoria.

51. Decades of methodologically sound and rigorous scientific research have demonstrated that gender confirmation surgery is a safe and effective treatment for severe gender dysphoria and, indeed, for many, it is the only effective treatment. The American Medical Association, the Endocrine Society, the American Psychological Association, and the American Psychiatric Association all endorse surgical therapy, in accordance with the WPATH Standards of Care, as medically necessary treatment for individuals with severe gender dysphoria. *See* American Medical Association (2008), Resolution 122 (A-08); Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2009) ("For many transsexual adults, genital sex reassignment surgery may be the necessary step towards achieving their ultimate goal of living successfully in their desired gender role."); American Psychological Association Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination (2009) (recognizing "the efficacy, benefit and medical necessity of gender transition treatments" and referencing studies demonstrating the effectiveness of sex-reassignment surgeries).

52. Surgeries are considered "effective" from a medical perspective, if they "have a therapeutic effect" (Monstrey et al. 2007). More than three decades of research confirms that gender confirmation surgery is therapeutic and therefore an effective treatment for gender dysphoria. Indeed, for many patients with severe gender dysphoria, gender confirmation surgery is the *only* effective treatment.

53. In a 1998 meta-analysis, Pfafflin and Junge reviewed data from 80 studies,

from 12 countries, spanning 30 years. They concluded that "reassignment procedures were effective in relieving gender dysphoria. There were few negative consequences and all aspects of the reassignment process contributed to overwhelmingly positive outcomes" (Pfafflin & Junge 1998).

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

55. Given the decades of extensive experience and research supporting the effectiveness of gender confirmation surgery, it is clear that reconstructive surgery is a medically necessary, not experimental, treatment for gender dysphoria. Therefore, it is included as a medically necessary treatment in the WPATH Standards of Care.

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

57. Similarly, Resolution 122 (A-08) of the American Medical Association states: "Health experts in GID, including WPATH, have rejected the myth that these

treatments are 'cosmetic' or 'experimental' and have recognized that these treatments can provide safe and effective treatment for a serious health condition."

58. On May 30, 2014, the Appellate Division of the Departmental Appeals Board of the United States Department of Health and Human Services issued decision number 2576, in which the Board determined that Medicare's policy barring coverage for transition-related surgeries was not valid under the "reasonableness standard." The Board found that the ban "was based principally on" a report from 1981 that has been rendered obsolete by numerous "medical studies published in the more than 32 years since issuance of the 1981 report." The Board specifically concluded that transition-related surgeries are "safe and effective and not experimental." As a result, Medicare's exclusion was struck down and Medicare was directed to consider surgeries on a case-by-case basis.

Assessment and Treatment Recommendations

59. Adree Edmo has persistent, well-documented and severe gender dysphoria. She has been receiving hormone therapy since 2012. As a result of ongoing endocrine treatment, she has been *hormonally confirmed*. In other words, she has the same circulating sex hormones and secondary sex characteristics as a typical adult female.

60. Ms. Edmo successfully consolidated her female identity long ago, as she never was socialized as a male. Rather, her mother and the Shoshone Bannock tribal community accepted her female identity at a young age and Ms. Edmo has always identified as female. She has also changed her name, and has relentlessly advocated for medical and surgical care. Ms. Edmo's intractable determination to live authentically and reduce her dysphoria is the impetus to wear facial make-up, despite disciplinary

consequences. There are instances in her file documenting that prison officials have disciplined her for expressing her gender identity.

61. Despite years of feminizing hormone therapy, Ms. Edmo continues to suffer from severe gender dysphoria and attendant depression. The long-term hormonal treatment she has undergone has served to intensify Ms. Edmo's anatomical dysphoria. Having a female appearance and male genitalia generates profound distress. Her inability to reduce or modulate this internal anguish is very likely to result in emotional decompensation and self-harm.

62. Ms. Edmo has twice resorted to attempting auto-castration. This is not an act of mutilation, but rather "surgical self-treatment" (SST). Auto-castration is not uncommon in prison settings, but it is a desperate act that occurs only in the absence of appropriate or adequate medical care. Unfortunately, most individuals who attempt to remove the testicles are unaware of the amount of blood that is generated and the elasticity of the vas deferens neuro-vascular bundle, which can retract into the body cavity. As a result, people often do not succeed with these surgeries given the extreme amounts of blood, or they can end up bleeding out and dying. Because of the amount of blood involved, it is not uncommon for individuals to be caught in an attempt and sent to a hospital where their condition is stablized.

63. The WPATH Standards of Care establish the following requirements for a patient in need of gender confirmation surgery:

- Persistent, well-documented gender dysphoria.
- Capacity to make a fully-informed decision and to consent for treatment.

- Age of majority in a given country.
- If significant medical or mental health concerns are present, they must be well controlled.
- Twelve months of hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated for the individual).
- Twelve continuous months of living in an identity-congruent gender role.

64. Despite the obvious severity of her gender dysphoria, the Idaho Department of Corrections has failed to provide the necessary care or to demonstrate an understanding of the severity of this medical condition. In May of 2016, a prison provider, Scott Eliason, told Ms. Edmo that sex-reassignment surgery was "not medically indicated." In January of 2017, following an attempt at auto-castration, a note in Ms. Edmo's chart states that she cut her scrotum "as she was confused about her gender… confusion happens a couple of times a year." These notes suggest that these providers are not qualified to provide appropriate care to Ms. Edmo and that they do not understand gender dysphoria generally or the severity of Ms. Edmo's medical issues in particular.

65. In fact, Ms. Edmo meets, and exceeds, the criteria for this medically necessary surgery: She has persistent, well-documented gender dysphoria. She is free of any disorders of thought or impaired reality testing, able to provide informed consent and to participate in decisions regarding her healthcare. She understands the irrevocable nature of surgery. Having been on hormonal therapy for years, irreversible anatomical changes are present. For years, Ms. Edmo has lived in her affirmed and well-consolidated female gender. She has no mental health or medical concerns that contraindicate surgery. On the contrary, surgery is the therapeutic intervention that would significantly improve her

emotional and physical health.

66. Owing to the severity of her gender dysphoria diagnosis, the ensuing clinically significant distress, and the limited efficacy of hormone therapy, gender confirmation surgery is medically indicated for Ms. Edmo and should be immediately performed. Surgery would create congruent genitalia, thereby eliminating the severe distress Ms. Edmo experiences due to her male genitalia. Moreover, removal of her testicles will eliminate 80% of androgen (male sex hormone) production. As a result, she will require lower dosages of feminizing hormones which will be particularly therapeutic given her recent history of elevated liver enzymes.

67. Gender dysphoria intensifies with age. If Ms. Edmo does not receive gender confirmation surgery, she is at great risk of succumbing to feelings of hopelessness and despair, leading to emotional destabilization and suicide.

68. While inexperienced providers might cite the administration of psychotropic drugs—anti-depressants and/or anti-anxiolytics—as treatment, these medications are not effective, and not the evidence-based treatment protocol for gender dysphoria. Merely giving psychotropic medications to a severely gender dyphoric patient is analogous to treating a cancer patient with anti-anxiety medication rather than chemotherapy. Likewise, placing gender dysphoric inmates in segregation in an attempt to prevent suicide or self-surgery is medically inadvisable, as it serves to kindle gender dysphoria and exacerbate symptoms.

69. The treatment Ms. Edmo is receiving falls far short of the Standards of Care. Ms. Edmo should have access to canteen items that are available to female inmates and a

means of safe and effective hair removal. These treatments are necessary to amerliorate her gender dysphoria.

70. Her hormonal regimen should be closely monitored, due to recent liver function test abnormalities. According to the Endocrine Society guidelines, Ms. Edmo should not be receiving medroxyprogesterone, which may have an androgenizing effect and increase cardiovascular risk, particularly given her elevated liver enzymes. She should be switched to transdermal estrogen (two 100 microgram patches per week) or parenteral estradiol valerate (5-20 mg every two weeks), or estradiol cypionate (2-10 mg weekly), with ongoing monitoring and medication adjustment, via laboratory follow-up. Although spironolactone has been discontinued, it is not known to cause an elevation of liver enzymes. Ms. Edmo may need a liver ultrasound to determine if there is hepatic injury.

71. There are no contraindications to the implementation of medically necessary surgical intervention for this inmate. The potential consequences of denying appropriate treatment however, are predictable and dire.

I declare under penalty of perjury under the laws of the United States of America and the State of Idaho that the foregoing is true and correct. Executed this 28th day of May, 2018 in Evanston, Illinois.

Dr. Randi C Ettner

Dr. Randi C. Ettner

Exhibit A

RANDI ETTNER, PHD
1214 Lake Street
Evanston, Illinois 60201
847-328-3433

POSITIONS HELD

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

EDUCATION

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

CLINICAL AND PROFESSIONAL EXPERIENCE

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

LECTURES AND HOSPITAL GRAND ROUNDS PRESENTATIONS

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

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

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

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

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

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

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

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

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

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

Foundations in mental health; role of the mental health professional in legal and policy issues, healthcare for transgender inmates; children of transgender parents; transfeminine genital surgery assessment: WPATH global education initiative, Chicago, 2015; Atlanta, 2016; Ft. Lauderdale, 2016; Washington, D.C., 2016, Los Angeles, 2017, Minneapolis, 2017, Chicago, 2017; Columbus, Ohio, 2017

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

Gender affirming psychotherapy; Assessment and referrals for surgery-Standards of Care-Fenway Health Clinic, Boston, 2015

Gender reassignment surgery- Midwestern Association of Plastic Surgeons, 2015

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

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

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

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

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

Understanding transgender- Nielsen Corporation, Chicago, Illinois, 2013

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

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

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

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

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

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

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

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

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

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

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

PUBLICATIONS

Ettner, R., White, T., Ettner, F., Friese, T., Schechter, L. (2018) Tomboys revisited: A retrospective comparison of childhood behaviors in lesbians and transment. *Journal of Child and Adolescent Psychiatry*, in press.

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

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

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

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

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

PROFESSIONAL AFFILIATIONS

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

AWARDS AND HONORS

The Randi and Fred Ettner Transgender Health Fellowship-Program in Human Sexuality, University of Minnesota, 2016
Phi Beta Kappa, 1971
Indiana University Women's Honor Society, 1969-1972
Indiana University Honors Program, 9-1972
Merit Scholarship Recipient, 1970-1972
Indiana University Department of Psychology Outstanding Undergraduate Award Recipient, 1970-1972
Representative, Student Governing Commission, Indiana University, 1970

LICENSE

Clinical Psychologist, State of Illinois, 1980

Exhibit B

BIBLIOGRAPHY OF RELEVANT SOURCES

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Rifkin Decl in Supp Pltf's Mtn for Preliminary Injunction

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UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ADREE EDMO (a/k/a MASON EDMO),

Plaintiff,

v.

IDAHO DEPARTMENT OF CORRECTION; HENRY ATENCIO, in his official capacity; JEFF ZMUDA, in his official capacity; HOWARD KEITH YORDY, in his official and individual capacities; CORIZON, INC.; SCOTT ELIASON; MURRAY YOUNG; RICHARD CRAIG; RONA SIEGERT; CATHERINE WHINNERY; and DOES 1-15;

Defendants.

Case No.: 1:17-cv-00151-BLW

DECLARATION OF RYAN NICHOLAS GORTON, MD, IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

Complaint Filed:	April 6, 2017
Discovery Cut-Off:	None Set
Motion Cut-Off:	None Set
Trial Date:	None Set

I, Ryan Nicholas Gorton, have been retained by counsel for Adree Edmo as an expert in connection with the above-captioned matter.

1. I have actual knowledge of the matters stated and would so testify if called as a witness. I reserve the right to supplement or amend this report based on any future information that is provided to me.

2. The purpose of my retention in this matter is to evaluate Ms. Edmo and offer my expert opinion as to what treatment is medically necessary to address her Gender Dysphoria, including whether she has a medical need to undergo genital sex reassignment surgery (SRS). SRS is also sometimes referred to as Gender Affirming Surgery and these terms can be used interchangeably.

My Relevant Background and Qualifications

3. I am a physician licensed in California. I received my medical degree from the University of North Carolina School of Medicine in 1998 and completed my residency and chief residency in emergency medicine at Kings County Hospital in Brooklyn, New York.

4. In addition to working as an Emergency Medicine physician at Sutter Davis Hospital, for over a decade I have also served as a primary care physician at Lyon-Martin Health Services ("Lyon-Martin") in San Francisco since 2005 where I have provided primary care and transition-related care to more than 400 transgender patients. I provide medical assessments including the diagnosis of Gender Dysphoria, initiate and monitor hormonal treatment, and refer for mental health treatments. I also determine whether and when patients are appropriate for referral for sex reassignment surgeries, provide pre-

operative preparation and clearance, and provide post-operative care in consultation with the appropriate surgeon. I also provide supervision to Nurse Practitioners, Nurse Practitioner Residents, and Physician Assistants treating transgender patients at Lyon-Martin. Lyon-Martin is an historically LGBT clinic that has been serving transgender patients for over 30 years. Lyon-Martin is also one of just a handful of sites in the United States that trains medical students, residents, and fellows to provide transgender primary care, and I have been a primary clinical instructor for these trainees including the 1 year Nurse Practitioner Residency that Lyon-Martin provides. I have provided extensive clinical instruction to over 100 trainees during this time.

5. I also serve as a clinician consultant for TransLine,[1] a national transgender medical consultation service for clinicians needing expert advice about the care of their individual patients. I am a member of the World Professional Association for Transgender Health (WPATH) and serve on their transgender medicine and research committee and institutionalized persons committee.

6. I have presented lectures and grand rounds on transgender health issues at numerous medical school and residency programs throughout the United States as well as national and international conferences. I have also co-authored numerous publications addressing transgender health, including professional journal articles and chapters and sections in professional texts, and publications aimed at the transgender community itself.

7. A copy of my *Curriculum Vitae* is attached to the declaration as **Exhibit A**.

[1] http://project-health.org/transline/.

Gender Dysphoria

8. Gender Dysphoria (GD) is a medical condition in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition ("DSM-V"). Individuals with Gender Dysphoria experience incongruence between their gender identity and birth-assigned sex and distress as a result.

9. The diagnostic criteria for Gender Dysphoria in the DSM-V for adults and adolescents are:

> A) A marked incongruence between one's experiences/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:
>
> 1. A marked incongruence between ones experienced/expressed gender and primary and/or secondary sex characteristics (or in younger adolescents, the anticipated secondary sex characteristics).
> 2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in younger adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
> 3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
> 4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
> 5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
> 6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
>
> B) The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

10. Individuals with Gender Dysphoria, if not treated, often suffer clinically significant emotional distress, including depression or suicidal thoughts, and/or impairment of functioning in their daily lives. Untreated, a significant proportion (30-40%)

become suicidal, with many attempting and completing suicide. In studies in European populations who have appropriate access to comprehensive transgender healthcare, suicidality rates are similar pre-treatment but decrease after treatment. For example, in a long term follow-up study of Belgian transgender people, suicide attempt rates declined from 29% to 5% after treatment.

11. The accepted medical protocols for treatment of people with Gender Dysphoria involve interventions to assist patients to live in accordance with their gender identity. The widely accepted standards of care in the U.S. and internationally are published by the World Professional Association for Transgender Health (WPATH SOC).

12. Medically necessary treatment for Gender Dysphoria often includes social transition, hormone therapy (medical transition), gender affirming surgeries (sex reassignment surgeries), and mental health care. Treatment plans are individualized based on the needs of the patient. For most patients who meet the clinical criteria, however, and unless contraindications exist, treatment plans generally include all four types of treatment.

13. Social transition is the process by which the patient lives their life in the gender role that corresponds with their gender identity. This typically involves adopting a new name, changing name and gender markers on identity documents, dressing and grooming appropriate to the patient's gender identity, using pronouns and other markers of their gender, and using restrooms and other sex-segregated spaces congruent with their gender identity.

14. Hormonal transition (generally called hormonal replacement therapy, or HRT) in transgender women results in development of female secondary sex characteristics

such as breast development, redistribution of body fat to a more female distribution, decreased muscle mass, decreased density and speed of growth of body hair, softening of skin and changes in sebum production and odor, changes in mood, decreased testicular size and decreased sperm production, emotional and some subtle neuropsychological changes.

15. Surgical transition with gender affirming surgeries is individualized, and the surgeries needed are dependent on individual patient needs and how well gender dysphoria is addressed with other treatments. While it is common for gender dysphoria to improve with social and hormonal transitions and with supportive mental health care, most often, surgery is needed to adequately and sufficiently address the dysphoria. In transgender women, surgery can include genital reconstructions (generally vaginoplasty which is the construction of a vagina, labia, and clitoris using the penis and scrotum, along with removal of the testicles), mammoplasty, facial and neck feminization surgery, vocal surgery, and other surgeries aimed at feminizing the body. In my experience, genital reconstruction (almost always by vaginoplasty) is the most often necessary surgery for transgender women and can dramatically improve gender dysphoria.

16. Mental health care can include individual or group counseling. This often focuses on two broad categories. First, a focus on the direct management of gender dysphoria, the primary symptom as well as name of the condition. Second, it can focus on supporting the patient throughout the medical, social, and surgical transitions.

17. These accepted medical protocols apply to incarcerated persons. *See* WPATH SOC at 67.

Terminology

18. In this report I will use a number of terms that are important to understand for an accurate depiction of my evaluation. These include the following:

Gender Dysphoria (GD), like Depression is both a diagnosis and the predominant symptoms of that diagnosis. The symptom of gender dysphoria is the psychological distress one feels when there is a conflict between one's internal gender identity and both one's physical body and how one is perceived and treated by others in society. Like depression, this can range from being mild to severe emotional distress.

Gender Identity is the hard-wired, internal sense of one's gender.

Sex Reassignment Surgery (SRS), A/K/A Gender Affirming Surgery is a class of surgical procedures performed for transgender patients to align their physical bodies with their Gender Identity. When used alone, I refer to the broad category. When speaking of specific subsets of procedures in that category I will provide a specifier. For example "Genital SRS" would refer to all procedures on the genitals of transgender patients (which itself is a category). I will also refer to specific surgeries by name.

Vaginoplasty is the surgical creation of a vagina in transgender women. In the vast majority of cases, this will be a penile inversion vaginoplasty which uses the skin of the penis to line the new vagina, head of penis as the new clitoris, and the scrotum to create labia majora.

Hormone Replacement Therapy (HRT) is the provision of sex hormones (and sometimes sex hormone antagonists) to change the body of transgender people to better reflect their gender identity.

Non-Suicidal Self Injury (NSSI) is intentionally harming one's physical body and is generally intended to get psychological relief from a painful emotional state by converting the emotional pain into physical pain. This is the classic "cutting" to relieve emotional distress and is best compared to a coping mechanism (albeit a poor one). Patients exhibiting this behavior have no intent to commit suicide by their self-harm although NSSI and suicidal behavior can be found in the same individual.

Self-Surgery, like NSSI, also does not involve any intent to end one's life. The motivation is distinctly different from NSSI, however. With self-surgery, the individual is attempting to provide a necessary surgical treatment to themselves that is otherwise unobtainable. Examples of this include Inés Ramírez Pérez, who performed her own cesarean section in

a remote region of Mexico,[2] and Aron Ralston (whose story was popularized in the movie "127 Hours") who amputated his own arm to free himself from a dislodged boulder that trapped him in Canyonland National Park. Self-surgery has been well documented in transgender women in prison and is a serious risk to these women when they are not provided medically necessary treatment. Self-surgery can also be distinguished from NSSI by the greater care and planning that patients put into these actions. While patients with NSSI may think a lot about the action and may even take steps to minimize the harm, the act and the pain it causes and the relief from emotional stress they provide is the ultimate goal of persons engaging in NSSI. In the case of self-surgery, thinking about the act often involves planning to perform it in the least harmful way possible and to diminish the risks associated with the procedure. Moreover the end goal of self-surgery is to achieve an appropriate surgical result rather than to directly cope with emotional distress. Suicidality, NSSI, and self-surgery can manifest in the same individual at different times, but have entirely different motivations and planned results.

Physical Examination of Ms. Edmo

19. Ms. Edmo is a 30 year old transgender woman who appears her stated age. She was dressed in a prison uniform, which was clean and well kept, but tight across her chest because of the male cut. She exhibited good hygiene. Her hair was kept in a feminine style. She had feminine mannerisms and speech pattern. She is of overweight but not obese build. Her breast development is small for her frame but is apparent through clothing. She has multiple tattoos on her distal upper extremities and neck. She has cutting scars on both forearms which while healed appear between 1-12 months old.

20. Ms. Edmo was pleasant and cooperative during the exam. She was alert and oriented to date and time. Her thought process was linear, clear, and well-ordered. Ms. Edmo was polite and attentive throughout the interview and requested only a brief bathroom break. She was provided a lunch by the COs as her visit with me ran through lunch.

[2] www.ncbi.nlm.nih.gov/pubmed/15001385.

21. She denied any active suicidal or homicidal ideations, and while she does report some vague thoughts of NSSI (explained below), she denies a concrete plan at present. She had no paranoid thinking and did not appear to be responding to any internal stimuli. She had no abnormal psychomotor behaviors. When asked to rate her symptoms on a 0-10 scale (with 0 being none and 10 being the worst possible symptoms she could imagine), she rated her current anxiety as 3/10, depression 4/10, and her gender dysphoria as 7/10 this morning. Her affect was full and appropriate to the situation, but multiple times she was tearful when discussing difficult topics.

22. When asked to list her current medications, Ms. Edmo was able to provide from memory without prompting, "Estrogen 4 mg twice daily, Medroxyprogesterone 5 or 10 mg daily, I'm not sure, 5 mg of Proscar, Vitamin D and calcium, Effexor 450 mg every morning" and notes "they stopped my spironolactone February 18th."

23. Her rate, flow, and intensity of speech were normal. She gave consistent and at times insightful answers to my questions. She appears to be of average to slightly above average intelligence and exhibited an average vocabulary and fair grammar, although her vocabulary when discussing mental health issues including her gender dysphoria was above average to superior for her level of education and intelligence. When we discussed aspects of her hormone treatment and surgical treatments, she asked appropriate and sometimes insightful questions. Her posture was good and her gait was normal. She had no gross motor deficits.

<u>Ms. Edmo's Childhood and Adolescence</u>

24. Ms. Edmo grew up in Pocatello Idaho. She was the youngest of 5 children

with two older sisters and two older brothers. Throughout her childhood and adolescence, she "identified mostly with my sisters" and is currently closest to her sister who is next closest in age to Ms. Edmo. Both parents were involved, although Ms. Edmo's father was in prison during her early to middle adolescence and both parents have had substance abuse problems. Ms. Edmo reported that growing up (and now) her belief system is both Native American and Catholic.

25. Ms. Edmo first had a sense that she was a girl at around age 5 or 6. She recalls seeing her sisters go through puberty and thinking "hey, I'm going to go through the same things." She had overall a good and supportive relationship with all of her siblings, but was closer to her sisters. They would allow Ms. Edmo to play with their Barbies and other traditionally girls' toys. They frequently played and would dress up Ms. Edmo (at her request) as a girl and apply makeup. She reports her sisters enjoyed this because it was like dressing a doll, and Ms. Edmo liked to do it because she could "be a girl" with them. She did report some mild teasing from her brothers who thought her feminine play was inappropriate. They would tell her to "quit being a sissy" and that "people are going to think you're gay" but there was never any physical abuse and generally all her siblings got on well. Ms. Edmo recalls that her mother asked her around age 11 or 12 "Do you like boys or girls?" Ms. Edmo responded asking her if it would matter if she liked boys, to which her mother replied "No, not at all." She reports hearing from her sisters that her mother had inquired if Ms. Edmo was "gay," to which her sister replied "it wouldn't matter if he [sic] was." While this was not specifically addressing Ms. Edmo's female gender identity, she already knew that her sexual/affectional preference was for boys. So while Ms. Edmo's

sexual orientation is heterosexual (a woman who has a sexual/affectional preference for men) she reports that knowing her family would accept her if she were a gay man was nonetheless very reassuring and important to her.

26. She also reports that she encountered only rare bullying at school. She reports that she had mostly female friends throughout her school years. They treated her "like one of the girls" and she would even use the girls' rest room sometimes in grade school. She reports this being unnoticed or overlooked by teachers but that a few students questioned her about it.

27. While Ms. Edmo was not openly transgender (and did not even know that word as a child), she was relatively happy and her feminine behaviors, dress, and play received little negative repercussions, and significant positive reactions from her sisters and some peers through most of school. She knew she was a girl inside and was allowed to express that fairly publicly. She attributes this in part to being Native American, which corresponds with the experiences of other Native American transgender people with whom I have worked who report greater acceptance by Native American communities of gender non-conforming people.

28. However in early adolescence, Ms. Edmo began having significant difficulties. A male family member began sexually assaulting her, which generally took the form of anal penetration. Ms. Edmo reported he would tell her "I'm going to show you what happens to girls" during those assaults.

29. Ms. Edmo also reported that at the onset of puberty and noticeable physical changes, her previous mild to moderate gender dysphoria became severe. Although she did

not have the words to describe her dysphoria at the time, she understands now that this is the term for what she was feeling. At about age 11-12 she began noticing changes in her voice, as well as hair growth on and enlargement of her genitals. As she saw her sisters' breasts develop at age 12 she "realized that my body isn't going to do the same as theirs." She reports holding out hope when she daydreamed that she was "just a late bloomer" and would develop like her sisters. This feeling was strong even after intellectually accepting this was not likely to happen. She also reports that at this age her understanding of herself as a girl in a boy's body was fully formed (although she didn't at the time have a word to describe this and was unaware of others being the same way). She states that when she had more significant pubertal development she finally "let go" of this daydream and "realized it's not going to happen" which caused a dramatic increase in her gender dysphoria. She also reports this is when she first became significantly depressed.

30. However, puberty, while difficult, was not entirely negative. Ms. Edmo had numerous female friends in junior high school and high school. She began wearing makeup to school - chiefly mascara and foundation. She reports this is when she started wearing more feminine clothing - sometimes girls pants and blouses and reports that she was "very picky" about the clothes that she wore - wanting even the boy's clothes she had to look feminine. She reports she was supported in this and that "all my friends who were girls liked it," and that they would trade makeup and tips. She felt she bonded with her female friends and felt like "one of them." Ms. Edmo reports that even before she learned that being transgender was "a thing," around mid-adolescence she contemplated getting breast implants as an adult.

Early Adulthood

31. Ms. Edmo reports she completed high school and some college. She also did a "correspondence course" to get a certificate to be a paralegal. After this, she worked as a receptionist in the Tribal Attorney's Office for the Shoshone Bannock Tribe in 2007-2008, followed by working in Tribal Gaming at a tribal owned casino.

32. By early adulthood, she had learned that there were other transgender people and that she could obtain a diagnosis regarding her gender dysphoria and obtain medical and surgical treatments to alter her body to better reflect her gender identity. She reports wanting to get HRT and SRS but that "I knew that was a lengthy process," and her intent to transition was interrupted both by her difficulty organizing herself due to concurrent substance abuse as well as eventually being imprisoned. She does report that a psychiatrist she had seen through the Indian Health Service mentioned the possibility of getting a diagnosis related to gender dysphoria and said that if she wanted treatment, they would have to send her to a specialist.

33. Even pre-treatment, as a young adult Ms. Edmo was more free to live as a woman. She reports wearing women's underwear almost exclusively and wearing either women's clothes or feminine men's clothes. She reports that she dressed most feminine when she would go out with friends or to parties—dressing fully in women's clothes including a bra stuffed to simulate breasts.

34. Ms. Edmo was incarcerated in July 2011 and arrived to the prison where she currently resides in April 2012.

35. In 2011, Ms. Edmo told her family that she was planning on being evaluated

for treatment of her gender dysphoria while in prison with the goal of transitioning to female. She reports that her mother was very supportive and told her, “If that’s what you need to move on in life, then I’m right behind you.” She also reports that one sister was very supportive. She is not in frequent contact with her other siblings and father, but her sister told her that they are generally supportive. Ms. Edmo finally spoke to her father in 2012 who she reports as being generally accepting: “You’re still my child.”

Ms. Edmo’s Experiences in Prison

36. We discussed in some depth Ms. Edmo’s ability to live authentically as a female while in prison. Clothing is a significant source of dysphoria—especially underwear. Ms. Edmo is allowed prison-issued bras as well as ones she has purchased from the commissary. In addition to being necessary support for her breast growth, she also reports bras help her dysphoria to some extent because “it makes me feel more female.” However she is not allowed to use prison-issued women’s underwear or to purchase women’s underwear from the commissary. Similarly she is only allowed to wear men’s outerwear (despite this being poorly fitting given the breast growth and change in body shape she’s achieved with HRT). She reports that wearing men’s clothes “makes me feel less of who I am, I don’t get to consolidate my identity,” and that “I don’t get to display what I feel like inside.” She reports the lack of women’s underwear and a “gaff” significantly exacerbates her dysphoria but that having to wear men’s outerwear, while still mildly exacerbating her dysphoria, is more of an “irritation.” A “gaff” is an undergarment often used by transgender women who have not had genital SRS which keeps the penis and testes firmly against the pubis and perineum so that they do not bulge out and give a

feminine look to pants worn over them. Many transgender women (including Ms. Edmo) also find keeping their genitals from moving and being noticed lessens their dysphoria about their genitals.

37. Despite restrictions on her gender presentation, Ms. Edmo has managed, like many transgender women in prison, to alter or obtain clothing that is more feminine. She reports that she has two pairs of women's underwear. She has also several times fashioned a gaff from her prison issued clothing. She has received a number of DORs for this and other conduct she has engaged in to achieve more appropriate gender presentations. She received several DORs for destruction of property under $25, all of which were for making changes to her prison issued clothing to make it resemble women's clothing. This includes altering her underwear to resemble a gaff or women's panties. She has also received DORs for wearing homemade makeup and on 9/27/15 for having a bottle of mascara.

38. When asked about the rules that limit her ability to present herself as a woman, Ms. Edmo reported that she's been told that the prison's "PREA policy says male offenders are not to present as women or appear feminine in any manner. No jewelry clothing, or makeup." She states that this is because if male inmates dressed that way, it would make them more likely to be raped because they would be "asking for it." PREA stands for the federal Rape Elimination Act.

39. In addition to DORs, Ms. Edmo has had medical complications of using homemade gaffs. She has had several episodes where she gets redness, swelling, and sometimes extreme pain from the gaff, though she reports this has diminished somewhat as she has had testicular volume decrease on HRT. Dr. Alviso documented this swelling

and redness in a note dated 1/4/18, as did RN Buckles on 9/30/17: "TWO AREAS OF SLIGHT REDNESS/SWELLING ON UPPER SIDES OF TESTICLES- VERY TENDER TO TOUCH, NO TEMPERATURE DIFFERENCE. PT STATES 'I WAS SEEN FOR THIS IN FEBRUARY AND NOW ITS BACK.'" With Ms. Edmo's recent discontinuation of her anti-androgen (discussed below), her testicular size is likely to increase, which in turn is likely to exacerbate her dysphoria.

40. In addition to clothes, Ms. Edmo has managed to wear some makeup. She reports extensive use of makeup before prison and that her female role models growing up (mother, grandmother, and sisters) always wore makeup "from the start to the end of the day." She reports when she cannot wear makeup, she feels "naked" and "like I'm missing something" and that "people are not seeing the real me." She feels that wearing makeup "signifies I'm a woman" and communicates this to others. Unfortunately while Ms. Edmo does wear makeup, she has experienced negative repercussion for it including several DORs as well as harassment—mostly from Corrections Officers (CO). She reports that she does the most she can do without drawing too much negative attention.

41. By wearing the clothes she's been given in the most feminine way possible, wearing makeup, and fashioning underwear, Ms. Edmo is trying to treat her dysphoria and notes that when she is dressed more femininely, she is "treated more like a female" by others (inmates to a greater extent than medical/mental health staff and COs).

The Prison's Failure to Treat Ms. Edmo's Gender Dysphoria

42. Ms. Edmo reports that her first formal diagnosis was in prison. She reports that she has attended a "GD group" periodically during prison, which she reports is

"basically a process group where we process feelings and that's the extent of it." When I asked if there were educational resources provided or discussions of specific treatment options or resources, she reported that these topics were addressed rarely or never. She noted specifically that the mental health staff's advice regarding Ms. Edmo living as a woman in a men's prison was simply not to do so until released because it was in violation of prison policy and PREA.

43. Ms. Edmo reports that she has specifically recommended that the mental health staff utilize the "APA Transgender Model," in which she seems to be describing the APA Guidelines for Psychological Practice With Transgender and Gender Nonconforming People.[3] She has also requested that she have more frequent individual therapy appointments that address her actual GD "with CBT, but nothing has come of it." When I asked what she understood CBT (cognitive behavioral therapy) to be, she understood the concept in layperson's terms. While she does not receive anything resembling CBT, she reports receiving therapy about every 90-120 days, but that her therapists focus on her depression and anxiety. When she brings up gender dysphoria, they talk about "coping in a men's prison," and uniformly tell her not to live as a woman and that she needs "to figure out a way to deal with [her] dysphoria that doesn't involve wearing makeup or violating policy."

44. Ms. Edmo's medical records confirm these statements and issues. Indeed, the medical records show that mental health staff have failed to address Ms. Edmo's gender

[3] https://www.apa.org/practice/guidelines/transgender.pdf.

dysphoria in any meaningful way, which has put her life at significant risk. Even if mental health providers wanted to provide appropriate and medically necessary treatment, prison policies and rules prevent them from doing so. A 12/17/15 note from Laura Watson, LCSW for instance, suggests she was prevented by policy from recommending medically necessary treatments for gender dysphoria such as wearing makeup and women's' clothing: "Edmo continued to state if Edmo gets a DOR, Edmo wants the hearing officer to know it was part of the [treatment] plan and that it plays a role in Edmo's dysphoria. We spoke at length about ways in which Edmo could feel feminine though going against policy but Edmo seemed resistant to this. I was honest with Edmo that I could not write a [treatment] goal that goes against policy." A note from Ms. Watson dated 11/28/17 was similar: "Edmo then stated a clinician stated that it was clinically recommended that Edmo wear makeup and even called unit 15 to verbalize the approval. I told Edmo I would look into this but if this was what was communicated, this was inaccurate as the current policy indicates this. Edmo states it is not clear in policy but we discussed 'not dressing in a feminine manner' as part of the PREA policy." Ms. Edmo reported to me that Dr. Aviso similarly told her that he was not allowed to recommend certain things for her, such as surgery, and that he can only "suggest" that she have access to women's clothing and commissary items. Other mental health and medical providers have also told Ms. Edmo that "if it was up to me I'd call you 'she' but we get memos telling us we can't."

45. As is apparent from Ms. Edmo's records and history of self-surgery, she experiences significant dysphoria that is focused on her genitals. When she requested women's underwear and other items to help conceal her genitalia, however, prison staff

offered her a jockstrap and ABD (Army Battle Dressing) pads to place in the jockstrap to provide "pressure" on her genitals. Ms. Edmo reports this did not help because the jockstrap was looser than even men's underwear. She was able to fashion underwear and a gaff from the jockstraps that provided more of what she needed, but she was penalized by staff when this was discovered and advised by her mental health providers to stop doing this. Because she has had to utilize makeshift gaffs from what she's been able to cobble together, she's had several episodes where she's developed redness, swelling, and pain to her genitals, which were documented at least once in her medical record but was not specifically treated. When this happens, Ms. Edmo faces the choice of continuing to "tuck," which causes pain and swelling, or stopping that practice, which exacerbates her dysphoria.

46. Ms. Edmo was also eventually provided with hormone replacement therapy (HRT) which has been modestly effective. Since starting HRT, she has experienced fairly typical results: breast growth, change in muscle and fat distribution to a more feminine body habitus, decreased testicular volume, decrease speed of growth and thickness of facial hair, and diminished libido—all of which she notes as positive effects. She denies any significant adverse effects from the HRT when administered properly.

47. Prior to Ms. Edmo's first appointment with Dr. Alviso in 2016, her medical records contain no real transgender history. The whole of the history section in the record reflecting her initial diagnosis states: "Hoping to be a GID treatment—never been on it. No hx of blood clots, no hx of bleeding [illegible word] etc. Generally healthy except above." The reference to "above" appears to be checkboxes on the form. I saw no notes prior to Dr. Alviso's 12/14/16 evaluation that had anything resembling a transgender

history. Without knowing Ms. Edmo's history (e.g. how long she has experienced dysphoria, the focus and severity of her dysphoria, exacerbating and mitigating effects, whether she has social support, how she manages stress, the steps she has taken to transition, further medical and family history, etc.), it would be impossible to provide safe and effective care. It is also possible, however, that prison officials failed to assess this history because, even if they had it, they are precluded by prison policy from providing adequate care (such as surgery and access to female commissary items).

48. Ms. Edmo has had enough time on HRT to realize physical changes, particularly after receiving HRT under the care of Dr. Alviso. While some of these could regress if HRT is stopped or diminished (as happened with the cessation of her anti-androgen medication this year, discussed below), Ms. Edmo understands that there is unlikely to be any further changes: "I've gotten the most out of what I've been prescribed. I know there's not really much more that can change" via HRT.

49. I agree that Ms. Edmo has likely seen the extent of the physical changes from HRT. I am alarmed, however, by the wholly insufficient and even dangerous monitoring and management of her medications, hormone levels and blood tests.

50. Indeed, before Ms. Edmo began seeing Dr. Alviso, her treatment was obviously provided by clinicians who are wholly unfamiliar with medical treatment for gender dysphoria. For example, an 8/31/15 note by a provider I cannot identify states, "testosterone well suppressed" and that "spironolactone is at max dose." Adequate suppression of testosterone means it is in the normal female range (15-70), while Ms. Edmo's level was 107. Moreover her spironolactone was only at 100 mg twice daily—a

fairly average dose for transgender women, but certainly not the maximum (200 mg twice daily). Ms. Edmo was in fact very poorly hormonally controlled. Reviewing her labs from 9/16/12 until her initial appointment with Dr. Alviso on 12/14/16, her testosterone level was checked 13 times. Of those times, only twice was her testosterone in the normal female range. It is not even apparent that all of her providers were aware of what a normal female level of testosterone is. On 9/4/15, a provider I cannot identify wrote, "Normal female testosterone ranges from 230-189 in healthy 30 year old nonsmoker, moderate exercise. Your testosterone level is well below these values!" Normal female testosterone values are actually 15-70 ng/dL (with some slight lab variation). While testosterone levels may be mildly higher among women who smoke, given Ms. Edmo is a non-smoker, any testosterone level above 70 would be considered elevated. Normal male levels of testosterone are 280-1100 ng/dL (with some slight lab variation).

51. Notably, medical staff did not recognize when Ms. Edmo's hormones were in the appropriate ranges. In a Chronic Disease Note on 3/16/16, Dr. Agler noted that her testosterone result "imply estrogen dose is too high. May also be associated with timing of meds. Change pills to pill call only to assist with timing (per pt request). No med dose change yet. If labs same next time will need to decrease estrogen." Dosage timing would not substantially affect testosterone levels, but what is most surprising is that despite this being one of only two times between 9/16/12 and 12/14/16 when Ms. Edmo's testosterone was finally at a reasonable level, Dr. Agler did not recognize this and believed her estrogen dosage should be lowered.

52. In addition to inadequate dosing, staff also failed to provide HRT even as

prescribed. For example, Ms. Edmo's Health Service Request on 11/22/15 states: "My GID meds still have not been given to me on a consistent basis. This is causing me to have heightened depression, anxiety, and extreme gender dysphoria. Specifically proscar and spironolactone." Ms. Edmo reported to me this was often a problem, though in the past year she has been getting her prescribed medications more regularly and with less difficulty.

53. Medical staff also failed to recognize obvious problematic health issues. In a Chronic Disease Note dated 9/8/16 by David Agler MD, he recorded "RRR" under Ms. Edmo's cardiac exam despite her heart rate being significantly elevated at 124. "RRR" stands for Regular Rate and Rhythm, which contradicts this significantly elevated heart rate. A 2/16/17 Chronic Disease note by "D Dics, PA" similarly reported "RRR" despite Ms. Edmo's elevated heart rate of 112. According to the records, medical staff never addressed Ms. Edmo's frequent tachycardia (abnormally rapid heart rate). At a minimum, this should have warranted a check of her thyroid function and inquiry into any signs or symptoms of a pulmonary embolism (blood clot in the lungs), which transgender women are at increased risk for because of taking estrogen.

54. In the interests of brevity, I will not detail every one of the following Chronic Disease Notes I reviewed dated 2/16/17, 11/29/2016, 9/8/16, 6/16/16, 3/16/16, 12/23/15, 6/26/15, 9/23/15, 4/6/15, 1/8/15, 10/8/14, 7/3/14, 3/6/14, 1/3/14, 9/13/13, 7/1/13, 9/13/13, 7/1/13, 3/26/13, and 12/3/12. There was one illegible note I did not review. In all of these notes specifically addressing her GD, there was not a single time that a psychiatric examination was included in the physical examination. This is significant because as

primary care doctors filling out Chronic Disease Notes, it is imperative to assess not only the physical efficacy of the hormones (hormone levels, side effects), but also whether HRT is ameliorating her gender dysphoria. As detailed above, the IDOC and Corizon clinicians utterly failed to monitor her labs in any effective way and, as these notes show, also failed to monitor the effect of HRT on her underlying condition. These failures placed Ms. Edmo at substantial risk of harm. In addition, four notes made the error I described above as showing a heart rate that was abnormally elevated but improperly noting "RRR" (with no indication that her abnormal vital signs were addressed in any way). None adequately assessed her gender dysphoria. Some actually suggested that her gender dysphoria is not a significant psychological issue for Ms. Edmo which, based on my evaluation and review of her medical records, has been a serious and ever present issue. In most of these notes, her disease control was listed as "good" or "fair," with a notable exception of 9/23/15 which listed it as "poor." That 9/23/15 note, however, fails to detail any issues except for a decrease in her blood estrogen levels. There is no assessment of her dysphoria or psychiatric examination. Six days later, Ms. Edmo made her first attempt at self-surgery. Had medical and mental health provided the requisite care detailed above, it is likely her self-surgery attempt could have been prevented by acute intervention.

55. One particularly egregious error in her medical care, which negatively affected her HRT and her overall health, began in December 2017. On 12/20/17 her labs were drawn and the initial report was received 12/22/17. Her labs showed new abnormalities: ALT 179 (elevated), AST 84 (elevated), Bicarbonate = 10 (low). The AST and ALT are tests of liver inflammation (which are included in what is called Liver

Function Tests or LFTs and in a Comprehensive Metabolic Panel or CMP). AST and ALT elevations can occur from viral infections (including hepatitis A, B, and C as well as other viruses), exposure to toxins (including medications), metabolic conditions, autoimmune disease, and other problems that cause injury to the cells in the liver. The bicarbonate also stood out as particularly low indicating her blood was significantly more acidic than usual. This "acidosis" merits calculation of the "anion gap" which is a way to determine what type of acidosis this was—which in Ms. Edmo's case was a "high anion gap metabolic acidosis" which implies that there may have been a toxin or chemical in her blood which was causing the acidosis and, given this was associated temporally, may have been related to the elevated AST/ALT. Causes of this type of acidosis include overdose on tylenol or aspirin, Lactic acidosis (which can be from low blood flow states, low oxygen, heart failure, infections and sepsis, thiamine deficiency, alcohols, and the side effects of many drugs and toxins).

56. When patients have elevated AST/ALT, it is important to promptly perform an adequate history and physical examination to help determine the cause. Particularly in Ms. Edmo's case because of the high anion gap metabolic acidosis, it was extremely important that she have a good history and examination performed promptly after the results were obtained, followed by additional focused labs based on this history and examination. I found no such evidence of an evaluation in her records and when asked, Ms. Edmo confirmed that this did not occur.

57. On 12/27/17, Ms. Edmo reported to sick call for cough and wheezing. This was her first clinical contact after the labs were obtained. She was seen by Danielle Young,

RN. There is no note that her abnormal labs were noted or addressed. She was instructed by Ms. Young to "CONTACT MEDICAL STAFF IF SYMPTOMS WORSEN OR DO NOT RESOLVE."

58. On 1/3/18, Ms. Edmo was seen in consultation by Dr. Marvin Alviso. I see no indication that Dr. Alviso either noted the labs or performed any focused history or examination relevant to a patient with the lab abnormalities that she had. In fact, he increased her estradiol from a total of 6 mg daily to 8 mg daily and continued her spironolactone and progesterone doses. It would be quite unusual to increase her estradiol if he was aware of the labs, as estradiol can infrequently cause elevated LFTs. In the context of these labs being abnormal, one would not increase a potentially hepatotoxic medicine. During this visit he did request repeat labs "Please Check BMP in 1 week. If normal, can increase spironolactone to 200 mg BID, Check BMP again In 1 week to make sure electrolytes are still normal." A BMP (basic metabolic panel) contains some of the labs that were done on 12/20/17, but do not include LFTs. A BMP plus LFTs is essentially what is contained in a CMP (Comprehensive Metabolic Panel) which was what was drawn on 12/20/17. Thus I do not believe Dr. Alviso had these results when he saw Ms. Edmo.

59. On 1/5/18, Dr. Emily Hutchison ordered an increase in Ms. Edmo's venlafaxine extended release dose from the maximum recommended dose of 375 mg daily to 450 mg daily. Venlafaxine is a medication to treat depression. On that same date, there was a notation: "Will increase venlafaxine to 450 mg po qam. RTC 3 months" and "side effects, access to mh." I could not find any indication that Dr. Hutchison took note of Ms. Edmo's labs from two weeks prior before she increased the dose of venlafaxine. Ms. Edmo

also could not recall Dr. Hutchinson questioning her about this. This medication change is extremely concerning since venlafaxine is the most likely medicine prescribed to Ms. Edmo that would cause elevations in LFTs.

60. On 1/13/18, Ms. Edmo had additional labs drawn. Her liver tests had jumped to significantly worrisome levels of ALT 1782 and AST 742, though her bicarbonate (indicative of the acidosis) had normalized.

61. A note entered on 1/17/18 is the first one that indicates any action on Ms. Edmo's abnormal labs. Nicolas Wise entered a verbal order "VO per Alviso/Eldredge. Stop Spironolactone for 5 days. Repeat state CMP to eval LFTs. Send Alviso labs, If normal then restart same dose 1/23/18. If not get new orders from Alviso." While Ms. Edmo's December LFTs were elevated and should have prompted further evaluation, the 1/13/18 levels are much more worrisome and suggest significant damage to the liver. Moreover, the fact that ALT was elevated higher than AST suggests a possible infectious cause—such as hepatitis A, B, or C. Lack of any evaluation at this point—at a minimum, a history and examination—is far below the standard of care. In my other practice as an emergency medicine physician I have had patients sent by their primary care provider for emergent evaluation based on acutely elevated LFTs that are far lower than this.

62. On 1/21/18, a nurse reviewed the chart and noted "Please review Effexor order, max daily dose is 375mg, prescribed 450mg." Effexor is the brand name for venlafaxine—the medication Dr. Hutchison increased beyond the recommended maximum dose prior to the dramatic increase in Ms. Edmo's LFTs. I see no indication that the risk of the increased venlafaxine dose was reconsidered or considered a possible cause of the

elevated LFTs.

63. Of the medications that Ms. Edmo takes, the one most likely to cause elevated AST/ALT is venlafaxine (which causes this complication in about 1% of those who take the medicine at normal doses of 37.5 - 375 mg daily). Oral estrogen and progesterone can rarely cause elevated AST/ALT. By contrast, elevated LFTs are extremely rare with Spironolactone. Spironolactone is a medicine that blocks the effects of testosterone and aldosterone, which Ms. Edmo was taking as part of her HRT regimen.

64. The unnecessary withdrawal of Ms. Edmo's spironolactone has caused significant problems. In addition to transient leg swelling, Ms. Edmo reports worsened gender dysphoria due to recurrent masculinization. She reports that she submitted a request on April 5, 2018 for a different antiandrogen to be started. As of the date of our meeting, she still did not have an antiandrogen prescribed.

65. If I had been Ms. Edmo's treating doctor on January 18, 2018 (when Dr. Alviso saw Ms. Edmo), I would have immediately discontinued her venlafaxine, halved her estrogen and left the spironolactone alone. I would have performed a focused history and examination, requested appropriate lab testing, and ordered tests for acute viral hepatitis infection (specifically hepatitis A and C, as she has immunity from B per her prior labs), as well as a liver ultrasound. Moreover since she is non-immune to hepatitis A as demonstrated by prior labs, I would have offered that vaccine (which Ms. Edmo reports she's never been offered) if this was not the cause of her symptoms. Based on my review of Ms. Edmo's medical records and my interview with her, the prison's medical response to her potentially life-threatening liver issues was to stop the HRT medication that was the

least likely to be the problem and increase the depression medication that was the mostly likely to be the problem (beyond even its maximum recommended dosage).

Ms. Edmo's Self-Surgery and Suicide Attempts

66. Self-surgery is performed by patients who are in desperate medical need. The purpose is to obtain, through self-treatment, the medical care a person needs but cannot access. Ms. Edmo has made two attempts at self-surgery with her goal being removing her testicles. She has also had thoughts of, but never attempted, self-surgery to amputate her penis. When asked why she wanted to remove her testicles, she said it was because they produce testosterone and "I had to stop it. It's not me and it's not supposed to be in me." Her first attempt was in September of 2015 and involved a relatively shallow incision which was repaired with steri-strips by prison medical staff. This was referred to as "Nonsuicidal self-injury" (NSSI)[4] in the chart, but staff placed Ms. Edmo on suicide watch. Ms. Edmo reports that this was neither suicidal ideation nor NSSI. Her intent was to remove her testicles (not to inflict pain or kill herself), but the excessive blood made her seek help. This is congruent with her statements as recorded in her medical record of 9/29/15: "Pt reports he 'hates it' referring to his penis/scrotum. 'When I saw so much blood I stopped.'" The record describes her as being "covered in blood." Ms. Edmo differentiates this self-surgery from NSSI in that her goal was not to inflict physical pain. In fact, it was the pain in addition to heavy bleeding that stopped her. She reports that her thoughts before doing

[4] NSSI refers to behaviors such as cutting, burning, scraping skin, or biting oneself, primarily to cause bleeding, bruising, or pain. People who engage in these behaviors find some emotional relief from the pain they inflict, but do not have any intent to end their life.

the self-surgery were: "It was making me sick in my body. It could kill me if I do this [removal of her testicles], but it's killing me slowly anyway."

67. The fact that medical staff do not appear to be able to distinguish between suicidality, NSSI, and self-surgery has placed Ms. Edmo at increased risk of harm. Her self-surgery attempts are assessed variously as either NSSI or suicidality, neither of which apply. For example, after her first attempt, she was placed on suicide watch even though there is no indication she was suicidal. A 10/1/15 "Suicide Risk Assessment" by T. Ruth states, "Inmate Edmo was placed on suicide watch 9/29/15 after Edmo attempted to remove Edmo's testicles." The note continues: "Edmo denied plan or intent to harm self," which is congruent with what is expected in an attempt at self-surgery. Unlike NSSI or suicidality, self-surgery is a desperate "health-seeking" action—in Ms. Edmo's case, disposing of the source of testosterone in her body.

68. The day after her self-surgery attempt, she was also seen by Laura Watson, LCSW. It appears that Ms. Watson met with Ms. Edmo for an extended period but that she also has no training in, or understanding of, gender dysphoria. Ms. Watson's note states, for example, "We discussed ways Edmo could begin to work more on Edmo's self and the issues Edmo has had throughout Edmo's life rather than only focusing on the outside. Explored insecurities that all men and women have and how fixing things on the outside, don't fix things on the inside the way we expect them to." In fact, gender dysphoria is a highly treatable condition. Research from the past four decades establishes that "fixing things on the outside" has dramatically beneficial effects on a person's mental health, including through HRT and surgery. Moreover, it is beyond dispute that all issues amenable

to treatment should be addressed in clinically appropriate ways. Rather than avoid treating Ms. Edmo's severe gender dysphoria, as Ms. Watson and other clinicians repeatedly have done, they should have treated that condition first. This is particularly true since Ms. Edmo's gender dysphoria has been persistent and well-documented throughout her life. Indeed, once appropriate care is provided for her gender dysphoria, there is every reason to believe that Ms. Edmo's ability to address other mental health issues will be substantially improved.

69. Because medical staff do not understand gender dysphoria or the standards of care, they missed obvious medical signs that portended Ms. Edmo's first attempt at self-surgery. A mental health note dated 10/5/15 (after that attempt) states: "Met with Edmo today…Spent quite a bit of time discussing Edmo's reported need to "feminize…" Edmo expressed frustration at medical stating Edmo knows Edmo's own body and knows the meds are not where they should be. Edmo states this is partly why Edmo decided Edmo would take things into Edmo's own hands by attempting to castrate Edmo's self." In fact, Ms. Edmo's last testosterone level prior to this attempt was double the maximum female level (70) at 153. Ms. Edmo was thus correct that her medication was not at the appropriate level.

70. It is apparent from Ms. Edmo's medical file that medical and mental health staff were well aware of her risk for self-surgery. Various medical professionals repeatedly documented her nearly constant thoughts of self-castration, including on 7/21/15, 8/20/15, 8/26/15, 12/3/15, 12/17/15, 12/28/15, 1/1/16, 1/2/16, 1/25/16, 1/27/16, 3/24/16, 5/20/16, 11/2/16, 12/27/16. For example, a treatment plan from 11/2/16, about two months before

her second self-surgery attempt, notes persistent risk for self-surgery and a goal that this will be decreased: "Edmo reports struggling with attempts/desire to self-castrate on average 4 days per week. Edmo will report a decrease in average frequency of thoughts of self-castration from 4 days/wk to 3 days/wk."

71. Another example is a treatment plan from 5/20/16, which reports, "Edmo reports some struggles with attempting to self-castrate or desires to self-castrate. Edmo struggles with dealing with the Dysphoria of Edmo's diagnosis and the limitations of feminizing." The plan continues: "Edmo will identify at least two ways Edmo could feel more feminine (within IDOC policy) and engage in these prior to giving into impulsive, self-harming thoughts," that "Edmo will use coping skills when struggling to manage symptoms and will notify staff if feeling suicidal wanting to engage in self-injurious behaviors." This plan fails to address the core and immediate issue of self-surgery. Self surgery is a health-seeking behavior; not a self-harming one. Asking Ms. Edmo to only report suicidal thoughts or self-harming thoughts thus fails to address her risk of self-surgery. The medically appropriate (and required) care at this point was to provide surgical intervention—a treatment that could not only significantly decrease, but potentially eliminate her gender dysphoria. Requiring Ms. Edmo to identify further ways to "feminize" in a prison environment that targets and punishes her for that behavior is also futile and even potentially dangerous since it exposes her to discipline, including solitary confinement.

72. The advice in the 5/20/16 note also conflicted with the counseling Ms. Edmo received in December of 2016 because she was reporting thoughts of self-surgery. A note

from Elizabeth Adkisson on 12/27/16, just *four days* before Ms. Edmo's second self-surgery attempt, states: "Edmo reports wanting panties because Edmo is tired of feeling the male genitalia between Edmo's legs. Edmo reports Dr. Alviso prescribed 'panties' for Edmo as a means of encouraging Edmo to identify with Edmo's 'authentic gender.' We discussed living as a female and how clothes nor make-up define who we are as women. We discussed living authentically, gender biology, sense of self, and the dimensions of being a trans-gender [sic] person in a male prison. ...We discussed gender as a binary concept beyond anatomy and Edmo expressed frustration at not being allowed to tuck. Edmo was encouraged to journal about Edmo's experience of becoming transgendered [sic] while incarcerated and how Edmo identifies gender norms within a male dominant culture."

73. A therapist who has training and experience with transgender clients would never minimize the importance of presenting consistently with one's gender identity. This note demonstrates a serious lack of understanding of transgender medical issues. There are significant and well-documented negative health outcomes for transgender women who are not allowed to present as women. Moreover, Ms. Adkisson's suggestion of journaling as a solution for a patient contemplating self-surgery is not only wrong, but likely directly contributed to Ms. Edmo's self-surgery attempt days later. Had Ms. Edmo been allowed a gaff and other necessities to present as a woman, her self-surgery attempt may have been prevented. At a minimum, her mental health provider should have provided supportive therapy acknowledging Ms. Edmo's gender dysphoria as well as a close mental health follow up appointment. Instead, mental health staff provided wholly deficient and

conflicting care in the run-up to Ms. Edmo's second-self surgery attempt, thereby placing Ms. Edmo at serious risk of the very self-surgery that triggered the appointment in the first instance.

74. As is somewhat typical in patients who attempt self-surgery, Ms. Edmo learned from her first attempt. For her subsequent attempt on 12/31/16, she had prepared for weeks before engaging in self-surgery. She accessed a medical reference guide in the prison's computer lab. She studied the anatomy of the scrotum and chose her incision site based on having the best chance to get to the testicle without injuring the epididymis (a term she used with me while questioning her pronunciation). She obtained gauze and alcohol swabs which she used to clean the area. She boiled the razor blade she used immediately before the procedure and scrubbed her hands with soap, so she would diminish the chance of infection. She also enlisted the help of another inmate in case she lost too much blood and was unable to call for help. She reports losing less blood and this time was able to exteriorize the testicle through the incision she made. She eventually had to abandon this attempt not due to pain (which she was this time prepared for) or a fear of bleeding out, but because the blood prevented her from seeing the proper anatomy: "It was bleeding too much and I couldn't see what I was doing anymore." She had made much more surgical headway during this attempt, which required transport to a hospital where a urologist was called to perform the repair. When asked about her hospital visit, I inquired if she had been informed of the risks, benefits, and alternatives for treatment, or asked to sign consent. She reports she signed nothing, and when staff started asking her about consent for the procedure, the correctional officer (CO) told the physician not to discuss consent with Ms.

Edmo and to instead speak with the Nurse Practitioner at the prison. She had not been told anything about risks, benefits, or alternatives to treatment.

75. Ms. Edmo was not placed in segregation after this attempt and reports she was provided medical treatments in the infirmary, but not acute mental health care. She cannot recall any mental health provider raising this issue since her self-surgery attempt.

76. While her providers conflate self-surgery with NSSI and suicidality, Ms. Edmo seems to be able to readily distinguish between the three. In a note dated 1/1/16 (which I believe from timing and placement in her chart was really 1/1/2017, or the day after her second self-surgery attempt), a clinician wrote: "When addressing the recent cutting of testicles, Edmo reported that Edmo wanted to get rid of the testes because they are neither wanted or needed. Edmo denied this as a suicide attempt and associated this with an increase in dysphoria due to a lack of support and treatment." I agree with this assessment that the lack of support and treatment for her GD resulted in increased dysphoria, which prompted her to attempt self-surgery. Another note that same day (1/1/17) states something similar "...the night previous (12/31/2016), Edmo attempted to castrate Edmo's self. Edmo stated that Edmo's actions were related to feeling angry/frustrated that Edmo was not receiving the help desired related to Edmo's gender dysphoria. Inmate Edmo's actions were reported as a method to stop/cease testosterone production in Edmo's body. Edmo denied suicidal Intention or any current plan. Inmate Edmo reported baseline depression symptoms related to Edmo's gender dysphoria diagnosis. Edmo was unwilling to discuss Edmo's depression apart from gender dysphoria symptoms." From a clinical perspective, I agree with Ms. Edmo that it made little sense at

that time to discuss her depression exclusive of her gender dysphoria, which was and is her primary, largely untreated medical issue.

77. In addition to these two distinct episodes of self-surgery, Ms. Edmo has had suicidal ideations and attempts, as well as NSSI (manifested as cutting her wrists). While the suicidal ideation with prior attempts (the first in 2009 and second in 2010) has been an issue in the past, Ms. Edmo denies any current significant suicidal ideations. She reported that her suicide attempts and ideation always involved her gender dysphoria. The most significant suicidality she reports was in 2014 when she submitted a request to have SRS and was told "we're never giving you that ever." She was placed in segregation on suicide watch. She describes this as significantly exacerbating her symptoms and for 4 days, she was stripped of most of her clothes and left in the cell with only a smock. Her only contact with anyone else was "a clinician [who] checked on me every 24 hours." Like many transgender patients, especially those like Ms. Edmo who have been denied access to medically necessary care, having to see her body unclothed is a significant trigger for her dysphoria. Thus, in addition to failing to provide any specific care to address her acute mental health condition and its origin (gender dysphoria), staff placed her in an isolation environment that would exacerbate nearly any mental health issue and was specifically detrimental to Ms. Edmo in that it forced her to confront the source of her mental anguish constantly.

78. Ms. Edmo reports that she has not had significant suicidal ideations in the past 2-3 years; however, she started resorting to NSSI more recently (in December 2017 or January 2018) on her forearms. She describes her motivation for this as distinct from her

motivation when she attempted self-surgery, although it does appear to be related to her dysphoria in that she is using it as a coping mechanism for her dysphoria. She describes feeling her genitals between her legs as "torment" and that when she cuts, she experiences "a relief of mental anguish, like slashing a tire and the negative emotions flow out of me like a tire going flat."

79. When we discussed the differences between suicidality, NSSI, and self-surgery, Ms. Edmo readily distinguished which was operative at the time of specific events. When I asked her about her mental health providers distinguishing between these, she reported that "they always lump it into suicide," which is congruent with my review of her records.

Ms. Edmo's Ongoing Risk of Harm

80. When I asked Ms. Edmo about the idea, raised by her therapist in her medical file, that gender is more about what is inside, she replied, "In a perfect world, I guess makeup and clothes wouldn't matter, but we're not in a perfect world, so it does." Unprompted, she made a correlation between this and racism—that her brown skin should not matter, but has a significant effect on how people treat her (both inside and outside of prison), which can have both mental health consequences and real world negative effects. In response to whether, if given the choice, she would eliminate racism or transphobia (for her personally rather than in the broader society), she immediately responded "transphobia" without hesitation.

81. Ms. Edmo estimates that her gender dysphoria has decreased 10-20 percent as a result of HRT and her ability (albeit heavily restricted) to present as a female in prison.

She reports that "about 90 percent" of her dysphoria is focused on her genitals. When asked about any mitigating factors for her gender dysphoria, she noted that her legal case has been helpful because it provides some hope that she will get the care she needs. When I posed the hypothetical of what she would do if she lost her lawsuit, or if the prison began more strictly enforcing rules about clothing, hair, and makeup, or if she lost access to hormones, she became visibly upset. She eventually answered that she would likely commit suicide.

Surgery is Medically Necessary to Treat Ms. Edmo's Gender Dysphoria

82. The World Professional Association for Transgender Health (WPATH) promulgates standards of care for transgender individuals. These are internationally recognized and the single most commonly used standards for the treatment of transgender people. In my experience as a provider, almost all insurance plans rely on WPATH's criteria or a variation for genital surgery in transgender patients in their coverage decisions. The criteria for vaginoplasty in transgender women are:

i. Persistent, well documented gender dysphoria;
ii. Capacity to make a fully informed decision and to consent for treatment;
iii. Age of majority in a given country;
iv. If significant medical or mental health concerns are present, they must be well controlled;
v. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).
vi. 12 continuous months of living in a gender role that is congruent with their gender identity.

83. In addition, WPATH notes that "[a]lthough not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other

medical professional."

84. Applying these criteria to Ms. Edmo's case, it is abundantly clear that she both needs and qualifies for surgery. Ms. Edmo reports a history of persistent gender dysphoria since childhood and has legally changed her name to a traditionally female name. Indeed, prison medical staff have themselves diagnosed her with GID. She is an adult and has mental capacity to consent to surgery. She has an above average understanding of the surgery and is able to speak about it in knowledgeable terms. In addition, Ms. Edmo does not appear to have any uncontrolled medical problem that would preclude surgery. In particular, I note she has had a substantial weight loss (from a peak of 260 obese, almost morbid obesity, to a current reported weight of 195, overweight but not obese) and attributes this to "getting on hormones and really understanding I also need to take care of my body" in addition to knowing that significant obesity can be an impediment to getting genital SRS. Her mental health issues are also reasonably well controlled. Finally, she has had multiple years of continuous HRT and has been living as a woman for many years. This is despite the fact that she has suffered frequent harassment, punishment as severe as solitary confinement, and multiple DORs for living authentically as a woman. As for the additional recommended criteria of "regular visits with a mental health or other medical professional," Ms. Edmo has availed herself of the mental health services offered and has advocated for more, such as requesting a clinician with broader experience in transgender medical treatments and requesting additional therapy sessions to focus on her GD. She has had over the years far more mental health and medical visits related to her GD than many transgender patients referred for this surgery.

85. Despite Ms. Edmo's obvious and urgent need for surgery, medical staff at the prison have denied this care. A note in her chart by Scott Eliason MD on 4/20/16 provides information about this decision. In this note, Dr. Eliason acknowledges that Ms. Edmo is suffering negative consequences, including potentially failing to get parole in order to live authentically as a woman in prison: "Is eligible for parole but this has not been granted due to multiple DORs related to use of makeup and feminine appearance." He notes that Ms. Edmo, "[c]ites an improvement in gender dysphoria on hormone replacement, though has ongoing frustrations stemming from current anatomy. Cites that she made attempts to mutilate her genitalia this past fall because of the severity of distress. ...emphasizes need for intact genitalia for successful SRS as a deterrent to self-mutilation. I spoke to prison staff about the inmate's behavior; which is notable for animated affect and no observed distress. I have also personally observed the inmate in these settings and did not observe significant dysphoria." Based on this note, Dr. Eliason either does not understand that gender dysphoria is, like depression or anxiety, a symptom that cannot be directly observed, or he believes that he can observe internal emotions accurately from behavior. Both of these conclusions are medically incorrect and, in Ms. Edmo's case, have placed her at significant risk of harm. Thus, while affect and behavior can be externally observed, mood must be assessed by questioning the patient.

86. Dr. Eliason's note concludes: "A: 27 year old male to female with Gender Dysphoria, Alcohol Use disorder, and Depression. Will continue current medications. Inmate has been observed to be functioning well in the correctional setting. Does not meet criteria for medical necessity for sex reassignment surgery. I staffed this case with Dr.

Jeremy Stoddart, Dr. Murray Young, Jeremy Clark LCPC (clinical supervisor and WPATH member) and they agreed with my assessment. That being said I will continue to monitor and assess this inmate for the medical necessity of SRS throughout there [sic] stay here- For the time being it is my opinion that the combination of hormonal treatment and supportive counseling is sufficient for her gender dysphoria. Medical Necessity for Sexual Reassignment Surgery is not very well defined and is constantly shifting but the following situations could meet medical necessity: 1) Congenital malformations or ambiguous genitalia would likely require sexual reassignment or reparative surgery. 2) Severe and devastating dysphoria that is primarily due to genitals could potentially meet criteria for gender reassignment surgery as well. 3) Some type of medical problem in which endogenous sexual hormones were causing severe physiological damage. There may also be other situations which could be determine as medically necessary as more information becomes available. This inmate does not meet any of those above criteria."

87. In fact, as detailed above, the medical necessity and criteria for sex affirming surgery is well-established and there is no question that Ms. Edmo meets it. Indeed, in her case, it may very well be life-saving care. In contrast, Dr. Eliason's examples of "medical necessity" are far afield from the medical standards. Although his third example seems to recognize that surgery stops the production of sex hormones, I cannot conceive of a situation where the endogenous hormone could cause "severe physiological damage" warranting surgery. His second example, which is most applicable to Ms. Edmo, is the most problematic. The standard for surgery is not "severe and devastating gender dysphoria that is primarily due to the genitals," as Dr. Eliason contends. Rather, as noted above, the

standard is "persistent, well documented gender dysphoria," among other criteria. A doctor would never, for instance, recommend surgery only for "severe and devastating" cancer. Required and medically necessary treatments are those that will alleviate and address the underlying medical condition. In short, Dr. Eliason's standard for surgery is wholly unsupported.

Medically Necessary Treatment Recommendations

88. Ms. Edmo has well established and persistent gender dysphoria, a substantial portion of which is related to her male genitalia. She meets criteria for genital SRS and is stable enough to undergo surgery. It is medically necessary that she be immediately referred to an appropriate surgeon skilled in performing penile inversion vaginoplasty as soon as possible, but at a minimum within the next 6 months. This is particularly important since Ms. Edmo remains at substantial risk for self-surgery or suicide if she is denied this medically necessary care.

89. Medical staff should ensure that Ms. Edmo's HRT achieves hormone levels within the appropriate ranges. It is apparent that Ms. Edmo's chronically inadequate HRT contributed to her first and possibly second attempt at self-surgery.

90. The prison should restart her spironolactone since there is virtually no chance this medication caused her elevated LFTs. Published medical studies on spironolactone show that Ms. Edmo's LFT elevations are far beyond those ever associated with that medication.[5] Staff should also monitor her LFTs every 2 months for 6 months then every

[5] https://livertox.nih.gov/Spironolactone.htm.

6 months for a year.

91. Regarding her elevated liver function tests, fortunately they have finally normalized as of the last labs that I have available. In order to prevent potential permanent liver damage, however, the prison should at a mimimum order hepatitis A and C serologies and provide appropriate care in light of those results.

92. Given her heightened risk for self-surgery, Ms. Edmo should have immediate access to appropriate female underwear, female clothing, and female grooming standards, especially with regards to makeup and hair styling. She should be allowed to purchase women's commissary items and be allowed to utilize these items without reprisals, including DORs.

93. Any DORs that Ms. Edmo accumulated for the health-seeking behavior of expressing her gender identity should be reconsidered and at a minimum, should not negatively influence her chance for parole.

I declare under penalty of perjury under the laws of the United States of America and the State of Idaho that the foregoing is true and correct. Executed this 29th day of May, 2018 in Davis, California.

Dr. Ryan Nicholas Gorton

Exhibit A

Ryan Nicholas Gorton, MD, DABEM
901 Douglass Ave, Davis CA 95616
(504) 261-8379 (mobile)
nickgorton@gmail.com

Professional Practice

February 2005 – Current | Emergency Medicine Physician
Sutter Davis Hospital
Davis, CA

July 2002 – February 2005 | Emergency Medicine Physician
St Tammany Parish Hospital
Covington, LA

Professional Practice: Volunteer Activities

March 2005 – Current | Primary Care Provider and Clinical Instructor
Lyon-Martin Health Services
San Francisco, CA.

August 2005 – February 2006 | Acting Medical Director
Lyon-Martin Health Services
San Francisco, CA.

September 2008 – Current | Executive Committee Member and Lecturer
Project HEALTH http://www.project-health.org/
San Francisco, CA.

January 2011 – Current | Consultant TransLine National Clinical Consultation Line

Medical-Legal Consultant: | Sylvia Rivera Law Project, New York, NY
Lambda Legal Defense and Education Fund, Inc., New York, NY
Transgender Law Center, San Francisco, CA
National Center for Lesbian Rights. San Francisco, CA
Northwest Justice Project, Seattle, WA
The Legal Aid Society, New York, NY
National Center for Transgender Equality, Washington, DC
TGI Justice Project, Oakland, CA.
ACLU Florida

Post Graduate Training

June 2001 – June 2002 | Chief Resident, Department of Emergency Medicine
Kings County Hospital Center/SUNY Downstate
Brooklyn, NY

July 1998 – June 2002 Emergency Medicine Residency
Kings County Hospital Center/SUNY Downstate
Brooklyn, NY

Education

August 1994 – May 1998 Doctor of Medicine
University of North Carolina School of Medicine
Chapel Hill, NC

August 1988 – August 1991 Bachelor of Science in Biochemistry, Summa Cum Laude
North Carolina State University
Raleigh, NC

Professional Affiliations

World Professional Association for Transgender Health (formerly HBIGDA)
- Transgender Medicine and Research Committee
- Institutionalized Persons Committee

University of California at San Francisco Center of Excellence for Transgender Health
- Medical Advisory Board 2010-2013 (during development of original Primary Care Protocols)

American Medical Association
- GLBT Advisory Committee 2009-2011

Gay and Lesbian Medical Association
- LGBT Medical Experts Panel

Licensure/Certification

Nov 2003 – Present Diplomate American Board of Emergency Medicine
Nov 2004 – Present CA State Medical License A89440
Feb 2002 – 2009 LA State Medical License 14466R
June 2001 – 2010 NY State Medical License 221808

Publications and Papers

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Gorton, R, Ettner, R, Brown, G, Bermudez, F, Orthwein, J and Mazur, T. "Orange isn't the New Black (Yet)". WPATH Symposium. Amsterdam, The Netherlands. June, 2016.

Gorton R. "Transgender Patient Care in the Emergency Department". American Academy of Emergency Medicine Scientific Assembly. Las Vegas, Nevada. February 2016.

Gorton R. "Transgender Patients in the Emergency Department". Stanford University Department of Emergency Medicine SimWars. Stanford, CA. February 2016.

Gorton R. "History of Transgender Medicine". UCSF School of Medicine Transgender Health elective. San Francisco, CA. February 2016.

Gorton R. "Free Silicone Complications and Management". National Transgender Health Summit. Oakland, CA. April 2015.

Gorton R. "History of Transgender Medicine". UCSF School of Medicine Transgender Health elective. San Francisco, CA. March 2015.

Gorton R. "Transgender Healthcare". UC Davis School of Medicine. Sacramento, CA.
December 2015.

Gorton R. "Engaging and Retaining Transgender Patients in Ongoing Primary Care". National Association of Community Health Centers Health Institute and Expo. San Diego, CA. August 2014.

Gorton R. "Sexual and Reproductive Health: A Focus on Transgender Patients". California Family Health Council. Webinar. March 2014.

Gorton, R, Green, J and Tescher, J. "California Dreaming: Two Decades of Change in Health Insurance Law and Policy". WPATH Symposium. Bangkok, Thailand. February, 2014.

Gorton, R and Chung, C. "From Grassroots Health Advocacy to Expanding Clinician Competency: Project HEALTH (Harnessing Education, Advocacy & Leadership for Transgender Health)". WPATH Symposium. Bangkok, Thailand. February, 2014.

Gorton, R and Tescher, J. "Minding the Gap: Development and Implementation of a
Clinical Rotation in Transgender Health". WPATH Symposium. Bangkok, Thailand. February, 2014.

Gorton R and Keenan C. "LGBT Sexual and Reproductive Health Issues". California
Family Health Council Women's Health Update. San Francisco, CA. April, 2013.

Gorton R. "Transgender Medicine". California AHEC Webinar. San Francisco, CA. April, 2013.

Gorton R. "Transgender Aging Issues". Institute on Aging Conference on LGBT Aging. San Francisco, CA. November, 2012.

Gorton R and Branning N. "Transgender Primary Care". California Academy of Physician Assistants Annual Conference. Palm Springs, CA.
October, 2012.

Gorton R. "Primary care and Hormonal Treatment for Transgender Clients".

Samuel Merritt University. Oakland, CA. June 2012.

Gorton R. "Primary care and Hormonal Treatment for Transgender Clients" Grand

Rounds for the VA Medical Center. San Francisco, CA. June 2012.

Gorton R and Wertz K. "Transgender Health Care" Webinar for the California Family Health Council. San Francisco, CA. June, 2012.

Eichenbaum J, Gorton R and May A. "Transgender Health, the VA, and Barriers to Care." San Francisco Veterans Administration Mental Health Services Grand Rounds. San Francisco, CA. May, 2012.

Gorton R and Wertz K. "Working With GLBT Clients" California Family Health Council Webinar. Los Angeles, CA. May, 2011.

Gorton R. "Improving Access to Transgender Health Care: Outcomes from Project HEALTH" World Professional Association for Transgender Health. Atlanta, GA. September, 2011.

Gorton R and Wertz K. "Trailblazing for Transgender Health" Southern Comfort Conference. Atlanta, GA. September, 2011.

Gorton R. "Nuts and Bolts of Transgender Primary Care" Gay and Lesbian Medical Association Annual Conference. Atlanta, GA. September, 2011.

Gorton R. "Transgender Medicine and Cultural Competency" Kaiser Department of OB/Gyn Grand Rounds. San Francisco, CA. April, 2011.

Gorton R. "Evidence Based Transgender Medicine" Opening Plenary UCSF National Transgender Health Summit. San Francisco, CA. January, 2011.

Green J and Members of the Center of Excellence for Transgender Health Medical Advisory Board. "Primary Care Protocols" Morning Plenary UCSF National Transgender Health Summit. San Francisco, CA. January, 2011.

Freshel K, Gorton R, Hansom C and Barnes A. "Communities Working Together

to Become Culturally Competent" California State Rural Health Association Conference. Sacramento, CA. November, 2010.

Gorton R, Spade D and Wilkinson W. "Transposium: Healthcare Access and Quality For Transgender Individuals" Shaking the Foundations: The West Coast Conference on Progressive Lawyering, Primary Care Associate Program, Stanford School of Law. Stanford CA. October, 2010.

Gorton R. "Improving Access to Transgender Healthcare: Outcomes from Project HEALTH (Harnessing Education, Advocacy, and Leadership for

Transgender Health)" Gay and Lesbian Medical Association Annual Conference. San Diego, CA. September 2010.

Gorton R, Gould D and Wertz K. "Trailblazing for Transgender Health" National Gay and Lesbian Task Force Creating Change Conference. March 2010.

Gorton R. "Grand Rounds: Transgender Medicine" Highland General Hospital Department of Internal Medicine. Oakland, CA. January, 2010.

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Keatley J and Gorton R. "Transgender Health Care Issues in California Today" Equality California and the California LGBT Legislative Caucus Briefing on LGBTI Health Care Issues. Sacramento, CA. December 2009.

Ehrbar R, Winters K, and Gorton R. "Revision Suggestions for Gender Related Diagnoses in the DSM and ICD" WPATH XXI Biennial Symposium. Oslo, Norway. June, 2009.

Gorton R. "A Place at the Table" American College Health Association Annual Meeting. San Francisco, CA. May, 2009.

Famula M, Hall A, Pardo S, Gorton R. "Providing Trans-Specific Health Care to Transgender Students in the College Setting." American College Health Association Annual Meeting. San Francisco, CA. May, 2009.

Gorton R. "Transgender Health" American Medical Student Association: Regional Conference. Lubbock, TX. March, 2009.

Gorton R. "Medical Ethics and Evidence Based Transgender Medicine" Equality and Parity II: A Statewide Action for Transgender HIV Prevention and Care.
Los Angeles, CA, January 2009.

Gorton R. "Transgender Medicine 101" AMSA Regional Conference. Lubbock, TX. December, 2008.

Gorton R, Djordjevic M, and Brownstein M. "Female to Male (FTM) Health Update" (Provider Session) The 7th Annual Mazzoni Center Trans-Health Conference. Philadelphia, PA. May 2008.

Gorton R. "FTM Hormones 201." (Community Session) The 7th Annual Mazzoni Center Trans-Health Conference. Philadelphia, PA. May 2008.

Green J, Gorton R, Razza R, and Tamar-Mattis A, "Healthcare and Access Issues

Panel." University of California Hastings College of the Law Transposium Conference. April 2008.

Arkles G, Gorton R, Sanchez D, Suarez C. "Trans Issues in Health Care Panel." Harvard Law School Lambda Legal Advocacy Conference. February 2008.

Gorton N, Thaler C, and Keisling M. "Drawing the Curtain: An Overview of Medical Privacy Protections and Risks for Transgender Patients and Providers " WPATH Symposium, 2007, Chicago.

Gorton R. "Transgender Medicine 2007: A Medical Ethics and Evidence Based Paradigm Shift." (Provider Session) The 6th Annual Mazzoni Center Trans-Health Conference. Philadelphia, PA. April 2007.

Gorton R. "FTM Hormones 201." (Community Session) The 6th Annual Mazzoni Center Trans-Health Conference. Philadelphia, PA. April 2007.

Gorton R. "Medical Ethics and Evidence Based Transgender Medicine." FORGE Forward. Milwaukee WI. March 2007.

Gorton R. "FTM Hormonal Treatment: Beyond 101." FORGE Forward. Milwaukee WI. March 2007.

Gorton R. "Transgender Healthcare in 2007: Its Time to Take it Seriously." Humboldt State University 13th Annual Diversity Conference and Education Summit. Arcata CA. March 2007.

Spade D, Gehi P, Arkles G, and Gorton R. "Barriers to health care access for transpeople." UCLA School of Law, Williams Institute Annual Update. Los Angeles, CA. February 2007.

Marksamer J and Gorton R. "Legal Support and Advocacy for Transgender Youth and Their Families." Gay and Lesbian Medical Association Annual Conference. San Francisco, CA. October 2006.

Gorton R. "Hormone Therapy 101." FTM-Gender Odyssey 2006. Seattle, WA. September 2006.

Gorton R. "Hormone Therapy 201." FTM-Gender Odyssey 2006. Seattle, WA. September 2006.

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Gorton R. "Primary Care and Hormonal Therapy for Transgender Males." (Provider Session) The 5th Annual Mazzoni Center Trans-Health Conference. Philadelphia, PA. March 2006.

Gorton R. "Health Maintainence for Transgender Men." (Community Session) The 5th Annual Mazzoni Center Trans-Health Conference. Philadelphia, PA. March 2006.

Gorton R. "Primary Care and Hormonal Therapy for Transgender Males." The 23rd Annual Conference of the Gay and Lesbian Medical Association. Montreal, Canada. September, 2005.

Spade, D, and Gorton R. "Medical-Legal Policy Update in the Quest for Trans Health Care and Justice." The 23rd Annual Conference of the Gay and Lesbian Medical Association. Montreal, Canada. September, 2005.

Arkles Z, and Gorton R. "Medical-legal Collaboration in the Quest for Trans Health Care and Justice" The 19th Biennial Symposium of the Harry Benjamin International Gender Dysphoria Association. Bologna, Italy. April, 2005.

Professional Advocacy

Supported as physician member of the American Medical Association for adoption of inclusive language for transgender people within AMA policy. "Recommendations to Modify AMA Policy to Ensure Inclusion for Transgender Physicians, Medical Students and Patients." Accepted by the AMA Board of Delegates July 2007. See "AMA Meeting: Anti-discrimination policy extended to transgendered." AMA News July 16, 2007. http://www.ama-assn.org/amednews/2007/07/16/prsk0716.htm. Policy amendment available at: http://www.ama-assn.org/ama1/pub/upload/mm/467/bot11a07.doc

Authored and proposed with Vernon A, and Maxey K. Resolution to amend the American College of Emergency Physicians 'Code of Ethics for Emergency Physicians.' Accepted as policy October 2005. Now reads (amended language underlined): "Provision of emergency medical treatment should not be based on gender, age, race, socioeconomic status, sexual orientation, real or perceived gender identity, or cultural background."

<u>Awards</u>

Claire Skiffington Vanguard Award. Transgender Law Center. San Francisco, CA. 2012.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 1st day of June, 2018, I filed the foregoing electronically through the CM/ECF system, which caused the following parties or counsel to be served by electronic means, as more fully reflected on the Notice of Electronic Filing:

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Attorneys for Plaintiff

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ADREE EDMO (a/k/a MASON EDMO),

Plaintiff,

v.

IDAHO DEPARTMENT OF CORRECTION; HENRY ATENCIO, in his official capacity; JEFF ZMUDA, in his official capacity; HOWARD KEITH YORDY, in his official and individual capacities; CORIZON, INC.; SCOTT ELIASON; MURRAY YOUNG; RICHARD CRAIG; RONA SIEGERT; CATHERINE WHINNERY; and DOES 1-15;

Defendants.

Case No.: 1:17-cv-00151-BLW

DECLARATION OF ADREE EDMO IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

Complaint Filed: April 6, 2017
Discovery Cut-Off: None Set
Motion Cut-Off: None Set
Trial Date: None Set

I, Adree Edmo, am the Plaintiff in the above-captioned matter. I have personal knowledge of the information set forth herein and if called upon to testify, I would testify to the truth of the following:

1. I was born on October 29, 1987 in Pocatello, Idaho and was raised as Mason Dean Edmo. I am a member of the Shoshone-Bannock Tribes, and lived at the Fort Hall Indian Reservation in Pocatello for most of my life.

2. I identify as a woman and female although I was assigned male at birth.

3. Around the age of 5 of 6, I remember first being aware of the feeling that I was a girl. At that time, I identified with my older sisters even though I was "supposed" to act like and identify with my older brothers. I wanted to be like my older sisters. I was much closer to them and shared more of their interests as compared to my older brothers. My sisters would let me play with their Barbies and other "girls'" toys. I felt accepted by my family.

4. Things became much harder when I started going through puberty. Growing up, I watched my older sisters become women and always hoped the same would happen to me. When I reached puberty, I had to come to terms with the fact that that was not how my body worked. It was a shocking and very depressing realization.

5. When I was 12 or 13, I started to feel more confident about expressing my female identity and moved towards accepting myself. At the age of 14 or 15, I started wearing girls' jeans. I remember experimenting with my mom's foundation and sister's mascara, and began wearing makeup to school. Dressing this way and wearing makeup made me feel liberated and more like myself.

6. While I knew that I was different, I never thought there was something wrong with me or what I was doing. My family was generally supportive. My grade school friends, who were all female, were also very supportive of me. In high school, I would usually go into the girls' bathroom with my friends.

7. I began living full-time as a woman around the age of 20 or 21. I wore makeup, women's outerwear, underwear, and bras, and styled my long hair. I would get my nails done with my mom and my sisters. By that point, my sisters, friends, and boyfriends were referring to me as "she," so the transition into living as a woman felt comfortable and natural.

8. Living as a woman and expressing my gender freely made me feel for the first time in my life like others saw me as the real person that I am—as the woman I am.

9. I first heard of Gender Identity Disorder ("GID") during a visit with the psychiatrist at my tribal health center. The psychiatrist asked me how long I had been living as a woman and if I had ever been diagnosed with GID. After I said no, he explained GID, and said that he thought I may have GID.

10. Around this time, I met a few transgender people and learned about hormone replacement therapy and surgical procedures that could help me transition. I was interested in sex-reassignment surgery, but was unsure of where to find resources. My substance abuse issues also prevented me from making progress toward medically transitioning at that time.

11. In 2012, I began going by the name "Adree," which is based on "Adrianna." I love the name "Adrianna" and suggested it to my cousin when he found out he was going

to have a daughter. It felt good to introduce myself as "Adree" and my new name helped affirm my female identity. I decided to legally change my name in September 2013. I saw the legal name change as another step in consolidating my identity.

My Experience at ISCI

12. I have been imprisoned at Idaho State Correctional Institution (ISCI) since April 2012. I was diagnosed with GID at ISCI in July 2012. My health providers also refer to me as having a diagnosis of gender dysphoria.

13. Being a woman housed in a men's prison causes me extreme mental pain, anxiety, and stress. Not only am I a target for sexual assault and harassment, which makes me feel perpetually unsafe, but I am also consistently denied recognition of my identity as a woman. This treatment, particularly because I was living freely as a woman before prison, feels like torture above and beyond my prison sentence.

14. I am forced to wear men's outwear and underwear. I am restricted from purchasing and wearing women's outerwear, underwear, and makeup. I am denied access to female commissary items. I am denied the basic items that female inmates are allowed.

15. The male clothing I am forced to wear does not accommodate my transitioning body, particularly in the chest area. In addition to being forced to wear ill-fitting and uncomfortable clothing, I am harassed by correctional officers for how my clothing fits—something I have no control over. I recall one instance in which a correctional officer said something like "men don't wear clothes that tight." When I tried to explain that my clothing was tight because of my hormone replacement therapy, the correctional officer said something to the effect of: "Well that's a medical choice."

16. Since arriving at ISCI, I experience frequent verbal harassment by prison staff who refuse to accept and treat me as a woman. The majority of the harassment consists of comments targeting my appearance, mannerisms, and transitioning body. For example, I have been told "You can't walk like that; guys don't walk like that." I have also been told on several occasions that I will be treated like a man because I am housed in a male prison. The prison staff's harassment of me encourages the same conduct by other inmates. I have noticed that other inmates often engage in verbal harassment when prison staff are also doing it. The harassment makes me feel humiliated, ashamed, degraded, and scared. It is also a constant reminder that my body does not match my feeling of being a woman and female.

17. IDOC correctional and medical staff never refer to me using female gender pronouns. They refer to me only my last name, "Edmo," or by male gender pronouns.

18. Until recently, I was permitted to use the showers when no male inmates were in the bathrooms. That is no longer the case. I am now forced to shower when male inmates are also showering. Some of the shower stalls do not have curtains, thus exposing my entire naked body to male inmates. I feel powerless and live in constant fear of being physically harmed or raped by male inmates.

19. I have received multiple disciplinary offense reports ("DORs") for expressing my female identity. Some of the DORs I received were for wearing makeup, modifying the prison-issued male underwear to resemble female underwear, and for my hair being "too feminine." These DORs are considered "disobeying orders." The discipline makes me feel dehumanized and degraded.

20. At my last parole board hearing, I was told that I am not eligible for parole because my disciplinary record was full of "disobeying orders."

Medical and Mental Health Treatment

21. Since being incarcerated, my gender dysphoria and depression have worsened substantially.

22. The only treatment I have been provided for my gender dysphoria at ISCI is hormone replacement therapy. I began hormone replacement therapy in September or October 2012, and see it as the first medical step in my transitioning process. But by itself, it is not enough to treat my gender dysphoria.

23. The medical professionals I have seen at ISCI refuse to use female gender pronouns when referring to me. Some healthcare professionals even use male pronouns when referring to me.

24. I am seen by a nurse practitioner once every three months. I see a doctor for gender dysphoria, Dr. Alviso, once a year. Whenever I ask for changes to my hormone doses, I am told I have to wait for my yearly appointment with Dr. Alviso.

25. The mental health professionals I have seen at ISCI admit they are not familiar with gender dysphoria. They tell me to "hold onto hope" and that I will get what I need when I am out of prison.

26. Earlier this year, I was taken off one of my feminizing hormones, spironolactone. I was told that spironolactone was a possible cause of the elevated liver enzymes on my blood test, but do not know if there were any tests done to determine the actual cause. Since they have stopped my spironolactone, I have experienced painful

testicular enlargement, rapid facial hair growth, and weight gain. This is agonizing for me. I requested to be put back on spironolactone, but was informed that I had to wait for my yearly appointment with Dr. Alviso.

27. I have made multiple attempts to remedy these serious problems. I have filed numerous grievances through Corizon and IDOC for necessary medical treatment, including sex-reassignment surgery, appropriate hormone treatment, facial hair electrolysis, and treatment by medical and mental health professionals with expertise in gender dysphoria. I have also made requests to medical professionals directly during my appointments. All of my efforts have been denied or ignored.

28. I also wrote a letter to the Warden asking him to allow me these necessary medical treatments. In response, I was told that I could receive any medical treatment recommended in a medical memo. When I relayed this information to medical professionals, they told me that IDOC policy prevents them from recommending any of my medically necessary treatments. It is extremely depressing and frustrating to be consistently denied access to the medical treatments that I need.

29. I attempted suicide in February 2014 after my first request to have sex-reassignment surgery was denied. The hormone replacement therapy was not having much effect at the time and I had been struggling to get the proper estrogen doses prescribed. Once my request to have the surgery was denied, I felt hopeless. I didn't think I would ever get the treatment I needed.

30. After my attempted suicide, I was placed on suicide watch. I was placed in an isolation cell and stripped down. Being naked and in the isolation cell increased my

gender dysphoria and suicidal thoughts, given my anatomy.

31. I attempted to perform self-surgery to remove my testicles in September 2015. I felt that this was the only choice I had because I was being continually denied the surgery that I need. Before I attempted self-surgery, I placed the following note in my cell: "I do not want to die, but I am a woman, and women do not have these." I wrote the note to make sure that correctional staff understood that I was trying to help myself, and not commit suicide. I then cut open my scrotum with a razor blade.

32. Despite my attempt to make clear that I was not suicidal, I was placed on suicide watch after I was found. This made my depression and gender dysphoria even worse. Moreover, mental health staff told me that if I tried the same thing again, I would be sent to maximum security. They did not seem to understand that this was my attempt to address my gender dysphoria. The prison's reaction to my self-surgery made me think that if there were going to be a next attempt, I needed to be successful.

33. My second self-surgery attempt was on December 31, 2016. Once again, I felt this was the only choice I had because the prison was not helping me get the treatment I needed. In preparation, I researched the best incision point to perform the surgery. I also asked my friend to call for help if I began to lose too much blood because I did not want to die. On the second attempt, I almost severed my entire right testicle. I had to be taken to the hospital for surgery to repair my testicle. None of the medical professionals talked to me about the possibility of finishing removal of the testicle and did not give me a choice about repairing it.

34. Both times I attempted to perform self-surgery, I was at a point beyond

mental anguish. I was thinking: "If I don't do this, I won't be able to keep going." I was not getting the treatment that I need to live and I felt an urgent need to take action and fix myself. When I performed self-surgery, I never intended to kill myself. I do not regret attempting self-surgery because I see self-surgery as self-treatment and self-help.

35. The first time I thought about self-surgery was in prison. I had never considered trying this to treat myself before because I had never felt that level of desperation about gender dysphoria. I had previously been able to live full time as a woman and express my gender identity freely. Being denied the treatment I need and being prohibited from living as a woman makes me feel hopeless.

36. Whenever my gender dysphoria gets worse, my urge to perform self-surgery increases. My male genitalia feels so alienated from the rest of my body and from my identity. Having that genitalia is a huge source of stress, anxiety, and depression, but it is something that can be removed. As I am getting older, my need to consolidate my female identity grows stronger.

37. The thought of never being able to have sex-reassignment surgery is too stressful to imagine. I would compare it to telling a cancer patient: "This treatment will cure you, but you can't have it." Without surgery, I feel like I am living, but dying inside

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38. More recently, I have started cutting my wrists as a way to deal with my mental anguish about my gender dysphoria. In those moments, I cut myself because I would rather feel physical pain than deal with the mental anguish of never receiving sex-reassignment surgery, and always being treated as someone I am not.

I declare under penalty of perjury under the laws of the United States of America and the State of Idaho that the foregoing is true and correct. Executed this 1st th day of June, 2018 in Kuna, Idaho.

Ms. Adree Edmo

Ms. Adree Edmo

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 1st day of June, 2018, I filed the foregoing electronically through the CM/ECF system, which caused the following parties or counsel to be served by electronic means, as more fully reflected on the Notice of Electronic Filing:

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/s/ Lori Rifkin
Lori Rifkin

MOTIONS, OBJECTIONS, ETC.

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO

Date: April 4, 2018
Judge B. Lynn Winmill
Case No. 1:17-cv-151
Place: Boise

Deputy Clerk: Jamie Bracke
Reporter: Tammy Hohenleitner
Time: 2:08 - 3:20 p.m.

ADREE EDMO v. CORIZON INCORPORATED, et al

Counsel for Plaintiff: Lori Rifkin, Craig Durham, and Deborah Ferguson

Counsel for IDOC Defendants: Brady Hall and Marisa Creceliuis

Counsel for Corizon Defendants: Dylan Eaton

Hearing held regarding IDOC Defendants' First Motion for Dispositive Relief (Dkt. 39).

After oral argument, the matter was taken under advisement. A written decision is forthcoming.

From:	ecf@id.uscourts.gov
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U.S. District Court

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Case Name: Edmo v. Corizon Incorporated et al
Case Number: 1:17-cv-00151-BLW
Filer:
Document Number: 59

Docket Text:
Minute Entry for proceedings held before Judge B. Lynn Winmill: Motion Hearing held on 4/4/2018 re [39] IDOC Defendants' First Motion for Dispositive Relief. The matter was taken under advisement. A written decision is forthcoming. (Court Reporter Tammy Hohenleitner.) (jlb)

1:17-cv-00151-BLW Notice has been electronically mailed to:

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6d20e51d3d70dd3515a7ea898dfb5998f2905fb294531c1358f248182e5a]]

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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ADREE EDMO, Plaintiffs, vs. IDAHO DEPARTMENT OF CORRECTION; HENRY ATENCIO, in his official capacity; JEFF ZMUDA, in his official capacity; HOWARD KEITH YORDY, in his official and individual capacities; CORIZON, INC.; SCOTT ELIASON; MURRAY YOUNG; RICHARD CRAIG; RONA SIEGERT; CATHERINE WHINNERY; AND DOES 1-15; Defendants.	)	Case No. 1:17-cv-151-BLW **IDOC DEFENDANTS' FIRST MOTION FOR DISPOSITIVE RELIEF**

COME NOW Defendants Idaho Department of Correction, Henry Atencio, Jeff Zmuda, Howard Keith Yordy, Richard Craig and Rona Siegert (collectively referred to as the "IDOC Defendants"), by and through their counsel of record, Moore Elia Kraft & Hall, LLP, and pursuant to Rules 12(b) and 56 of the Federal Rules of Civil Procedure, hereby respectfully move this Court for an Order dismissing the following claims and causes of action from Plaintiff Adree Edmo's Second Amended Complaint (Dkt. 36):

- All of Ms. Edmo's claims for damages sought under 42 U.S.C. § 1983 stemming from incidents that have not been properly exhausted pursuant to the Prison Litigation Reform Act of 1995, 42 U.S.C. § 1997e(a).
- All of Ms. Edmo's claims for damages sought under 42 U.S.C. § 1983 stemming from incidents that occurred more than two years prior to the filing of this lawsuit on April 6, 2017 pursuant to Idaho Code § 5-219(4);
- Ms. Edmo's "Fourth Claim for Relief" for alleged violations of the Americans with Disabilities Act, 42 U.S.C. § 12101;
- Ms. Edmo's "Fifth Claim for Relief" for alleged violations of the Affordable Care Act, 42 U.S.C. § 18116; and
- All of Ms. Edmo's state negligence claims for damages.

The grounds upon which this motion is based are set forth in the *Memorandum of Support of the IDOC Defendants' First Motion for Dispositive Relief* and *Declaration of Dana Maybon*. Pursuant to Dist. Local Rule Civ. 7.1(b)(1), this motion is also supported by a separate *Statement of Material Facts in Support of the IDOC Defendants' First Motion for Dispositive Relief*. Defendants request oral argument.

DATED this 1st day of November, 2017.

Moore Elia Kraft & Hall, LLP

/s/Brady J. Hall
Attorneys for Defendants Idaho Department of Correction, Henry Atencio, Jeff Zmuda, Howard Keith Yordy, Richard Craig, and Rona Siegert

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 1st day of November, 2017, I filed the foregoing electronically through the CM/ECF system, which caused the following parties or counsel to be served by electronic means, as more fully reflected on the Notice of Electronic Filing:

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From:	ecf@id.uscourts.gov
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Case Number: 1:17-cv-00151-BLW
Filer: Henry Atencio
Richard Craig
Rona Siegert
Howard Keith Yordy
Jeff Zumda
Document Number: 39

Docket Text:
First MOTION for Partial Summary Judgment *IDOC Defendants' First Motion for Dispositive Relief* Brady James Hall appearing for Defendants Henry Atencio, Richard Craig, Rona Siegert, Howard Keith Yordy, Jeff Zumda. Responses due by 11/22/2017 (Attachments: # (1) Appendix Statement of Material Facts)(Hall, Brady)

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6eb36924dbf4c498d94cdfe2acb711d98757aed4a6842eead3a05253dc996]]

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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ADREE EDMO, Plaintiffs, vs. CORIZON, INC.; KEVIN KEMPF, RICHARD CRAIG; RONA SIEGERT; HOWARD KEITH YORDY; SCOTT ELIASON; MURRAY YOUNG; AND CATHERINE WHINNERY Defendants.	)	Case No. 1:17-cv-151-BLW **JOINT MOTION AND STIPULATION RE: DEFENDANTS' ANSWERS/RESPONSIVE PLEADINGS**

COME NOW Defendants and Plaintiffs, by and through their respective attorneys of record, and based on the addition of new claims and defendants in *Plaintiff's Second Amended Complaint*, do hereby stipulate and respectfully move this Court to reset the current case management deadline so that Defendants' answers/responsive pleadings are due on November 1, 2017. Granting this stipulation and motion will permit the parties to address service issues and establish one date by which the Defendants will file answers/responsive pleadings to *Plaintiff's Second Amended Complaint*.

DATED this 21st day of September, 2017.

/s/Brady J. Hall
Counsel for Defendants Richard Craig, Rona Siegert, and Howard Keith Yordy

/s/ Dylan A. Eaton
Counsel for Corizion Inc., Scott Eliason, Murray Young, and Catherine Whinnery

/s/ Lori Rifkin
Counsel for Plaintiff Adree Edmo

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 21st day of September, 2017, I filed the foregoing electronically through the CM/ECF system, which caused the following parties or counsel to be served by electronic means, as more fully reflected on the Notice of Electronic Filing:

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/s/Brady J. Hall

From:	ecf@id.uscourts.gov
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Case Number:	1:17-cv-00151-BLW
Filer:	Richard Craig Kevin Kempf Rona Siegert Howard Keith Yordy
Document Number:	37

Docket Text:
MOTION for Extension of Time to File Answer *Responsive Pleading* Brady James Hall appearing for Defendants Richard Craig, Kevin Kempf, Rona Siegert, Howard Keith Yordy. Responses due by 10/13/2017 (Hall, Brady)

1:17-cv-00151-BLW Notice has been electronically mailed to:

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