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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.

NO. 1:17-cv-151-BLW

**DEFENDANTS’ JOINT PROPOSED  
FINDINGS OF FACT AND  
CONCLUSIONS OF LAW**

COME NOW Corizon Defendants and IDOC Defendants, by and through their respective counsel of record, and hereby jointly submit these proposed findings and conclusions of law.

**DEFENDANTS’ JOINT PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW - 1**

## **I. PROPOSED FINDINGS OF FACT**

### **A. Procedural Posture of the Case**

1. Plaintiff Adree Edmo filed a Motion for Preliminary Injunction (Dkt. 62) on June 1, 2018. While Ms. Edmo's motion sought injunctive relief on several issues, Ms. Edmo now only seeks an injunction ordering gender confirming surgery and as of yet undefined cessation of discipline related to Gender Dysphoria ("GD"). (Dkt. 111, fn. 2).

### **B. Edmo's Mental Health History Prior to Incarceration**

2. Prior to her most recent incarceration in 2012, Ms. Edmo demonstrated a significant history of mental health and substance abuse issues and was diagnosed with Major Depressive Disorder, Anxiety, and Alcohol Dependence. Ms. Edmo exhibited multiple serious mental health concerns. (Tr. 128:16-25, 209:21-25, 210:1-5; DEF Ex. 2007, DEF Ex. 2009, DEF Ex. 2010\_0045, 0046, 0073). Ms. Edmo was sexually abused repeatedly as a child and was a victim of domestic abuse by partners in her early twenties. (Tr. 129:1-6, DEF Ex. 2007\_0005; DEF Ex. 2010\_0067, 0071, 0082). Ms. Edmo has a history of cutting herself and several criminal offenses related to alcohol, including intoxicated driving. (DEF Ex. 2009; DEF Ex. 2010\_0004-0005, 0036-0038).

3. Also prior to her incarceration, Ms. Edmo made at least two serious suicide attempts, but reported to an IDOC clinician that she had attempted suicide as many as five times prior to 2012. (Tr. 207:18-21, 209:5-20; JT Ex. 1-379; DEF Ex. 2007; DEF Ex. 2009; DEF Ex. 2010). On one occasion, Ms. Edmo severely lacerated her right arm after a dispute with a boyfriend and was hospitalized afterward in the BHU in Pocatello. In another attempt, Ms. Edmo overdosed on prescription pills and alcohol. (Tr. 129:7-10, 210:6-9; DEF Ex. 2007; DEF Ex. 2009; DEF Ex. 2010).

4. Ms. Edmo's documented suicide attempts were related to her alcohol abuse, relationship problems, economic distress, sustained unemployment, legal troubles, and feelings of

worthlessness. (Tr. 210:6-25, DEF Ex. 2007; DEF Ex. 2009; DEF Ex. 2010). At the time of her first suicide attempt in 2010, Ms. Edmo was prescribed an anti-depressant and was recommended to treat her depression with psychiatry. (DEF Ex. 2007\_0001, 0006; DEF Ex. 2009\_0015). After her second suicide attempt in 2011, she expressed a desire to attend counseling and was referred for counseling and a medication evaluation. (DEF Ex. 2007\_0009).

5. Ms. Edmo's pre-incarceration records, including her PSI reports, hospital, and other mental health records demonstrate that her prior suicide attempts, substance abuse, depression, anxiety, and cutting were not related to GD. Further, there is no evidence in those records that Ms. Edmo was experiencing anatomical GD due to her genitals. Rather, Ms. Edmo's pre-incarceration records demonstrate that Ms. Edmo's depression and anxiety were related to substance abuse, relationship problems, personal failures, past trauma, impulsivity, sexual orientation, and anger. Ms. Edmo never reported gender identity issues during the PSI process nor in any of the records related to her suicide attempts. (Tr. 126:14-25, 127:1-25; DEF Ex. 2007; DEF Ex. 2009; DEF Ex. 2010\_0005, 0046, 0051, 0054, 0057, 0058, 0067, 0077, 0078, 0113). Despite her serious suicide attempts, Ms. Edmo failed to participate meaningfully in treatment to address her mental health issues, including cutting, major depression, anxiety, and substance abuse. (DEF Ex. 2007; DEF Ex. 2009; DEF Ex. 2010\_0048- 0051, 0067). In fact, when Ms. Edmo entered prison in 2012, she was taking anti-depressants and anti-anxiety medication, but was nevertheless still identified as having a significant risk for suicide. (JT Ex. 1-299-300; DEF Ex. 2010\_0045, 0057, 0067, 0071, 0077).

### **C. Credibility Issues with Ms. Edmo**

6. Ms. Edmo claims that she "began living full-time as a woman around the age of 20 or 21." (Dkt. 62-2, ¶7.) Ms. Edmo made similar claims regarding living as a woman pre-incarceration to her experts in this case. (Ettner Decl., Dkt. 62-1, p. 10, ¶16; Gorton Decl., Dkt. **DEFENDANTS' JOINT PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW - 3**

62-1, p. 59, ¶33). To the contrary, Ms. Edmo has made several statements inconsistent with those accounts. (Tr. 116:8-25, 117:1-6). Ms. Edmo's pre-incarceration records are notably silent as to her ever presenting as a female or living as a female. (DEF Ex. 2007; DEF Ex. 2009; DEF Ex. 2010). In the psychosexual evaluation conducted as part of her PSI report in 2012, Ms. Edmo denied ever cross-dressing. (DEF Ex. 2010\_56, 69). Likewise, on June 25, 2012, Dr. Eliason indicated in his initial assessment of Ms. Edmo that she "reported only dressing as a female during rare occasions." (Tr. 450:1-16; JT Ex. 1-321). Moreover, Ms. Edmo's probation officer, Cliff Cummings, who supervised her from June, 25, 2010, until February 8, 2011, and met with her in person fifteen times, never observed Ms. Edmo wearing women's clothing or makeup, nor did he observe Ms. Edmo wearing a feminine hairstyle. She did not present or appear as a woman in any way and did not ask Mr. Cummings to refer to her using female pronouns. (Cummings Decl., Dkt. 101-5, ¶¶ 1-7, Ex. 1).

7. Additionally, Ms. Edmo testified under oath at the evidentiary hearing that she was not aware of GD or Gender Identity Disorder ("GID") until she entered prison. (Tr. 194:6-10). This testimony is directly contradicted by Ms. Edmo's sworn declaration, filed in support of her *Motion*, where she testified that she first heard of GID during a visit with a psychiatrist at her own tribal health center. (Dkt. 62-2, ¶9). Ms. Edmo's Declaration further describes how, around the time that she first learned about GID from her psychiatrist, she met transgender people who informed her about hormone replacement therapy and surgical procedures to help her transition. (Dkt. 62-2, ¶10). Ms. Edmo also told Dr. Gorton that she was aware of GID prior to her incarceration and wanted hormone therapy and surgery, but knew that it was "a lengthy process." (Gorton Decl., Dkt. 62-1, p. 59, ¶32).

**D. Edmo's Incarceration, Early Diagnosis of GID, and Early Treatment**

8. Ms. Edmo entered IDOC custody on April 26, 2012, after pleading guilty to felony Sexual Abuse of a Child Under the Age of Sixteen Years. (DEF Ex. 2010\_0032; JT Ex. 04-6). Ms. Edmo was previously incarcerated in 2009 after felony convictions for Drawing a Check Without Funds. (DEF Ex. 2010\_0001; JT Ex. 04-1).

9. During her mental health intake screening upon entering prison, Ms. Edmo showed signs of depression, reported feelings of hopelessness and helplessness, and was overly anxious, afraid, or angry. (JT Ex. 1-299-300). As part of her intake suicide risk assessment, Ms. Edmo reported severe anxiety and depression and experienced recent suicidal ideations. She also stated that she had recently experienced a loss of a relationship and was fearful for her safety. (JT Ex. 1-301-306). Ms. Edmo stated that she believed that "relationship issues were the primary reasons for [her] depressed mood and suicide attempts." (JT Ex.1-311). During each of those mental health visits and intakes to screen her for mental health conditions, Ms. Edmo did not report having depression or anxiety related to her gender identity or genitals.

10. Less than three months after her incarceration, on or about July 19, 2012, Ms. Edmo was diagnosed with GD (formally GID) by Dr. Scott Eliason, the Corizon Director of Psychiatry. (JT Ex. 1-321). Dr. Eliason is a well-qualified psychiatrist with specialization in the correctional setting. He is Board Certified in Forensic and General Psychiatry. He also is a Certified Correctional Healthcare Provider (CCHP); he is a CCHP certified medical doctor and mental health provider. Before working in the Idaho prisons, Dr. Eliason shadowed a doctor in his residency who worked with transgender inmates at San Quentin in California. (Tr. 400:23-406:21; See DEF Ex. 2022.)

11. Dr. Eliason has been the Corizon Director of Psychiatry since about 2010. He sees patients and also oversees the psychiatric providers throughout the state, including other

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psychiatrists, nurse practitioners, and physician's assistants throughout the Idaho state prisons. He sees patients approximately 90% of the time and then the other 10% of his time is spent on administrative activities, such as peer reviews, reading credentialing interviews, and being involved in the hiring process. (DEF Ex. 2022).

12. Dr. Eliason was not the only provider to evaluate Ms. Edmo for GD. Dr. Claudia Lake, a Corizon Psychologist, also assessed Ms. Edmo and came to the same conclusion diagnosing her with GID. (JT Ex. 1-323-327). Both Dr. Eliason and Dr. Lake used the DSM-IV to assess GID and their assessments included a thorough transgender history of Ms. Edmo. (JT Ex. 1-321, 323-327). On August 23, 2012, a team of Corizon providers and IDOC employees met at a Management and Treatment Committee ("MTC") meeting and agreed Ms. Edmo could start hormone therapy, among other things. (JT Ex. 7-1-4).

13. The MTC continued to meet over the years to discuss Ms. Edmo's GD, her treatment and care, address her cooperation with mental health groups, recommend treatment, assess her behavior, and discuss housing options for Ms. Edmo. (JT Ex. 7-5-110).

14. Dr. Cathy Whinnery, M.D., who was the ISCI Medical Director at the time, started hormone therapy soon after Ms. Edmo was diagnosed with GID in 2012 and then appropriately managed her hormone therapy until early 2015. (Jt. Ex. 1-188, 223-224, 238-239, 690-692, 694-695, 699-702, 726-727, 731, 733). Ms. Edmo began to feel better after beginning hormones and felt as if her mind had cleared and a cloud had been lifted. She developed breasts, her body fat was redistributed, and her skin softened. (Tr. 196:15-25, 223:9-14).

15. To support her growing breasts, Ms. Edmo was issued a medical memo for and received a bra. (Tr. 224: 6-18; JT Ex. 1-729). Ms. Edmo was also provided a jock strap and some

pads, which supported Ms. Edmo's sensitive testicles and allowed Ms. Edmo tuck her penis. (Tr. 224:19-25, 225:1-7; JT Ex. 1-734).

16. Additionally, Ms. Edmo had numerous appointments with Dr. Eliason and other mental health medical providers over other the years regarding treatment of her other mental health issues, such as anxiety and depression. From about 9/19/12 to 1/27/16, Dr. Eliason had approximately 12 appointments with Ms. Edmo regarding addressing her mental health issues and managed her antidepressant medications, among other things. (E.g., JT Ex. 1-337, 1-339, 1-342, 1-347, 1-352, 1-425, 1-435, 1-438, 1-447, 1-452, 1-479, 1-527). At one point, around August 28, 2013, Dr. Eliason signed a letter to the Idaho Department of Transportation to help Ms. Edmo change her driver's license to reflect that she was female. (JT Ex. 1-370).

17. Ms. Edmo has also been permitted to feminize appropriately and, since 2013, has maintained a demonstrably feminine appearance and presentation while housed in male facilities. (Tr. 142:9-16; JT Ex. 4-1-8; Campbell Decl., Dkt. 101-4, ¶ 21; Yordy Decl., Dkt. 101-12, ¶ 6, Ex. 1-4). In addition, Ms. Edmo has obtained female underwear and will be permitted to order makeup and female grooming items from the prison commissary, pursuant to the revised IDOC policy and guidelines for the treatment of GD inmates. (Tr. 216:11-13; 348:10-23; JT Ex. 9-1-9).

18. After receiving her diagnosis of GD, Ms. Edmo was encouraged by IDOC mental health clinicians to attend group and individualized therapy specifically for inmates who have been diagnosed with GD. (Tr. 218:22-25, 219:1; JT Ex. 7-35, 37, 39, 40, 47, 93; Campbell Decl., Dkt. 101-4, ¶ 21; Stewart Decl., Dkt. 101-1, ¶ 8).

#### **E. Ms. Edmo's Disciplinary History**

19. Since her incarceration in 2012, Ms. Edmo has received 32 Disciplinary Offense Reports ("DORs") for various offenses, which is a very high number for an offender who has been incarcerated for six years. (JT Ex. 5-1-71; Yordy Decl., Dkt. 101-12, ¶¶ 10-11, Exs. 5, 6). Ms.

Edmo's DORs have been issued for various reasons, including sexual contact, destruction of property, and assault. Ms. Edmo has not been disciplined for appearing feminine *per se*. Rather, Ms. Edmo has been disciplined repeatedly for being openly disobedient to correctional officers' direct orders to remedy Ms. Edmo's inappropriate or sexually provocative appearance. (Tr. 213:5-25, 214:1-25, 215:1, 15-21; Yordy Decl., Dkt. 101-12, ¶¶ 10-11, Exs. 5, 6; JT Ex. 5-1-71). Ms. Edmo's significant disciplinary problems, notably her assaultive behavior, sexual acting-out, and disobedience to direct orders, demonstrate that Ms. Edmo's underlying mental health conditions are not well-controlled. Such behaviors demonstrate traits of borderline personality disorder. (Tr. 340:7-23, 341:10 - 343:2, 364:19 - 365:1-4; Watson Decl., Dkt. 101-3, ¶17).

**F. Ms. Edmo's Current Mental Health Concerns Unrelated to GD and Lack of Cooperation in her Treatment**

20. Ms. Edmo continues to suffer from depression, anxiety, and borderline personality traits and currently exhibits other maladaptive behaviors, including co-dependency, relationship issues, disobedient behaviors, and sexually acting-out. (Tr. 125:12-20, 130:21-25, 131:1-3; 200:6-15; 339:14 - 340:4, 345:24 - 346: 25, 528:16 - 529:16, 538:6-24, 542:19 - 543:11; DEF Ex. 2016; Campbell Decl., Dkt. 101-4, ¶ 25; Stewart Decl., Dkt. 101-1, ¶¶9-13; Watson Decl., Dkt. 101-3, ¶10, 17-19).

21. During her clinical interview with Ms. Edmo in March of 2018, Plaintiff expert Dr. Randi Ettner conducted testing, which revealed that Ms. Edmo exhibited severe anxiety, depressive symptoms, and feelings of worthlessness, along with moderately high hopelessness scores, and the highest possible score on the scale measuring suicidal ideation. (Tr. 125:7 - 128:15).

22. Ms. Edmo also demonstrates symptoms related to severe unresolved childhood trauma and borderline personality disorder. (Tr. 131:12-23, 635:9-14, 495:13-18, 640:10 - 641:20;

665:24-13, 667:5-19; Campbell Decl., Dkt. 101-4, ¶25; Stewart Decl., Dkt. 101-1, ¶10; Watson Decl., Dkt. 101-3, ¶17; Clark Decl., Dkt. 101-7, ¶112).

23. Despite several recommendations from her treating clinicians, Ms. Edmo has repeatedly not attended therapy to help her work through her serious underlying mental health issues and pre-incarceration history of trauma, abuse, and suicide attempts. Ms. Edmo has repeatedly refused to attend recommended groups such as Mood Management, Healthy Relationships, and Social Skills. (Tr. 134:8-25, 135:1-23, 218:21-25, 219:1-14, 220:17-20; 221:16-19; JT Ex.7-26-28, 34-36; Campbell Decl. Dkt., 101-4, ¶¶24, 29; Stewart Decl., Dkt. 101-1, ¶12; Watson Decl., Dkt. 101-3, ¶18; Clark Decl., Dkt. 101-7, ¶14). As with her pre-incarceration mental health issues, Ms. Edmo at times expressed a desire to attend counseling and groups for her significant mental health concerns, but did not follow through with those treatment recommendations (Tr. 219:15-25, 220:17-25, 221:1-19; DEF Ex. 2009\_0008-0016; DEF Ex. 2010\_0048- 0051, 0067; Watson Decl., Dkt. 101-3, ¶¶ 11, 12).

24. After assaulting another inmate with GD on two occasions, Ms. Edmo was prohibited from attending GD group for six months. She was later approved to return to the GD group so long as she also completed a Social Skills group, but Ms. Edmo refused. (JT Ex.7-26-27; Stewart Decl., Dkt. 101-1, ¶¶ 7, 8). In addition, Ms. Edmo has not completed her mandated sex offender treatment programming, making her ineligible for parole. (Tr. 219:8-10, 221:16-19; Watson Decl., Dkt. 101-3, ¶ 18; Jones Decl., Dkt. 101-6, ¶ 13).

25. Ms. Edmo has not developed healthy coping skills to address her major depressive disorder, anxiety, or GD. For example, Ms. Edmo engages in unhealthy coping strategies by cutting her arms. (Tr. 345:24 - 346: 25, 347:1-14, 529:7-16, 538:6-24, 546:3-9, 605:13-19; Watson Decl., Dkt. 101-3, ¶18; Stewart Decl., Dkt. 101-1, ¶10). In addition, on 9/30/15 and 12/31/16, Ms.

Edmo alleges to have unsuccessfully attempted self-castration (Edmo Decl., Dkt. 62-2, ¶¶31, 33), which further evidences her instability and poor coping skills. However, Ms. Edmo believes that it is important to preserve her male anatomy so that in the future, if surgery becomes appropriate, her genital tissue will be available to create female anatomy. (Tr. 218:7-14).

26. IDOC Clinical Supervisor and certified CCHP, Laura Watson, was one of Ms. Edmo's mental health clinicians from 2013 to 2015. Ms. Watson is a member of the MTC and also ran the GD group for which Ms. Edmo attended in 2013. Ms. Watson is qualified to treat GD and is familiar with Ms. Edmo's mental health history and treatment. (Watson Decl., Dkt. 101-3, ¶¶ 1-11). Ms. Edmo requested specifically to meet with Ms. Watson after allegedly having attempted to remove her testicles in 2015. Ms. Edmo admitted that she struggled with wanting and needing male attention, and although she wanted to remove her testicles, she knew it would not fix her long-standing mental health issues. Ms. Edmo also agreed that if she did not address her underlying mental health issues, she would still be broken inside, even after surgery. (JT Ex. 1-489-490; Watson Decl., Dkt. 101-3, ¶11, Ex. 1).

27. LCPC Krina Stewart has been Ms. Edmo's treating mental health clinician since 2016. Ms. Stewart also participates in the MTC. Ms. Stewart is qualified to treat GD and is familiar with Ms. Edmo's mental health history and treatment while in the custody of IDOC. (Stewart Decl., Dkt. 101-1, ¶¶ 1-8). During her clinical contacts with Ms. Edmo, Ms. Stewart observed that Ms. Edmo speculates that GD is the main cause of her depression and attempts at self-castration. However, Ms. Edmo has other stressors that contribute to her depression, including relationship issues, past trauma, and past abuse. In Ms. Stewart's experiences with Ms. Edmo, Ms. Edmo's dysphoria fluctuates depending on her life stressors, including her job, housing, and relationships. When Ms. Edmo experiences a stressful life event, such as a break-up with a boyfriend, Ms.

Edmo's dysphoria increases and she is unable to distinguish depression related to her major depressive disorder or GD. (Stewart Decl., Dkt. 101-1, ¶¶ 9, 10, 11).

**G. Corizon's Practices Related to Gender Dysphoria (formerly GID)**

28. Corizon has not issued any formal written policies and procedures regarding assessment and treatment for inmates with GD (formally GID), such as for sex reassignment surgery. Rather, Corizon defers to the clinical judgment of its providers and also follows the IDOC standard operating procedures. (Tr. 453:20-454:3). Corizon allows its providers to consider any and all treatment options that are necessary for an inmate with GD, including but not limited to psychotherapy, hormone therapy, and surgery (including sex reassignment surgery). (Tr. 453:5-19). Specifically, surgery as a treatment for GD is not prohibited by Corizon. (Tr. 453:9-11). As of March 2017, Corizon issued a Clinical Pathways regarding GD that is primarily focused on hormone replacement therapy. This document is available to Corizon providers and is a guideline, but not a mandatory policy, regarding such treatment and care. (Tr. 491:1-18). This Clinical Pathway document does not preclude surgery. (JT Ex. 14).

29. Starting in the winter of 2016, Corizon started utilizing an offsite physician, Dr. Alviso, who specializes in treatment of care of inmates with GD. Dr. Alviso is not an employee or contractor with Corizon. He has agreed to be a consultant for GD care and treatment. (Tr. 451:13-452:2). Dr. Alviso has seen and treated Ms. Edmo multiple times since winter of 2016. (E.g., JT Ex. 1-215; 1-1512-13; 1-1561-64; 1-1357; 1-1358, 1-1360; 1-1565; 1-1505-06; 1-1508; 1-1509; 1-1510; 1-1371; 1-1591; 1-1592; 1-1593).

30. In 2016, Corizon asked Dr. Alviso and another specialist, Dr. Stephen Levine, to present on GD. These presentations were not adopted as policy. Rather, they were presentations for consideration by treatment providers as they exercised their clinical judgment in treating GD inmates. (Tr. 433:21 - 436:15, 437:2-11, 493:10-17; 494:24 - 495:1-9).

**H. IDOC's 2011 Standard Operating Procedure (SOP) Regarding GD**

31. IDOC's SOP that governed the treatment of inmates with GD from 2011 to October, 2018, provided guidelines for the diagnosis, treatment, management, and placement of offenders diagnosed with GD as outlined in the DSM. (JT Ex. 08-3). That SOP expressly recognized that sex reassignment surgery was an available treatment option for prisoners, so long as it was deemed medically necessary by a qualified GD evaluator. (JT Ex. 08-1-9). The SOP recognized the treatment options recommended in the WPATH guidelines, including hormone therapy, mental health services, and surgery. (JT Ex. 08-1-9). The SOP explicitly stated that offenders diagnosed with GID (now GD) would be provided access to the full range of services and programs available within IDOC to the same extent as other offenders. (JT Ex. 08-9).

32. When surgery is requested, the IDOC defers to the decisions of Corizon medical providers, such as Dr. Eliason, who are qualified to evaluate whether sex reassignment surgery is medically necessary. (Tr. 419:5 - 420:13; Campbell Decl., Dkt. 101-4, ¶20). No Corizon medical provider ever determined that sex reassignment surgery is medically necessary for Ms. Edmo. (Tr. 217:9-13). If such a surgery was recommended by a medical provider, the IDOC would provide it. (Tr. 454:4 - 455:13).

33. Sex reassignment surgery as a treatment for GD is not prohibited by the IDOC, either by written policy or by a "de facto" policy based on training received by Dr. Levine. (Tr. 334:23-25, 335:1-5, 347:18-25, 348:1-9, 382:12-21, 433:21 - 436:15, 437:2-11, 493:10-17; 494:24 - 495:1-9). Indeed, should one of the approximately 30 GD inmates housed in IDOC facilities meet the criteria for surgery after an evaluation with a qualified GD evaluator, the IDOC will not prohibit such a surgery and will defer to the professional judgment of the providers assessing the inmate's condition. (Tr. 322:21-25, 323:1-3, 382:22-25, 383:1-13).

**I. Medical Standards or Guidelines for Treatment and Care of Patients with GD, including Criteria for Sex Reassignment Surgery/Vaginoplasty**

34. The World Professional Association for Transgender Health (WPATH) has established a document called Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. (JT Ex. 15). There are multiple versions over the years of these WPATH guidelines and Version 7, the most recent version, has been in effect since 2011. While the title of the WPATH guidelines are entitled “Standards of Care,” they are actually “flexible clinical guidelines.” (Tr. 118:16-24, 119:1-7, 8-25, 288:7-23). The WPATH guidelines explicitly state that they “are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender nonconforming people.” The same is true for the guidelines governing hormone therapy and surgery for GD: they are “clinical guidelines; individual health professionals and programs may modify them.” Clinical departures from the guidelines may be necessary due to a patient’s “unique social, or psychological situation.” (JT Ex. 15-8).

35. The WPATH guidelines further provide that it is important to address any coexisting mental health concerns for persons with GD. The guidelines dictate that mental health providers should screen for anxiety, depression, self-harm, a history of abuse and neglect, compulsivity, substance abuse, sexual concerns, and personality disorders, because those concerns can be “significant sources of distress and, if left untreated, can complicate the process of gender identity exploration and resolution of [GD].” (Tr. 122:16-25, 123:1-5; JT Ex. 15-31). Consistent with the guidelines, IDOC and Corizon providers constantly evaluated Ms. Edmo’s coexisting mental health concerns and made recommendations to address those concerns, in addition to treating Ms. Edmo’s GD. In other words, Ms. Edmo’s treatment providers considered her as a whole person, rather than just the individual GD diagnosis. (Tr. 652:25 – 653:14, 667:5-23; Clark, JT Ex. 1).

36. The WPATH guidelines also provide that the presence of co-existing mental health concerns does not necessarily preclude possible changes in gender role or access to surgery, “rather, these concerns need to be optimally managed prior to or concurrent with treatment of [GD]. In addition, clients should be assessed for their inability to provide educated and informed consent for medical treatments.” (Tr. 123:14-25; JT Ex. 15-31). Whether a patient has coexisting mental health concerns that need to be optimally managed is left to the clinical judgment of their qualified mental health providers. (Tr. 124:12-18). It is difficult to determine whether coexisting mental health concerns occur as a result of GD or due to other sources. (Tr. 171:1-14, 24-25, 172:1-5; 387:20-25, 388:1, 398:2-18, 601: 11- 602: 2; Campbell Decl., Dkt. 101-4, ¶¶ 30-33). Individual counseling and psychotherapy are useful ways to help identify the source of a patient’s coexisting mental health concerns, such as depression, borderline personality disorder, and trauma. (Tr. 640: 10 – 641:20, 642:1-8).

37. The WPATH guidelines state that options for psychological and medical treatment of GD include: (1) changes in gender expression and role, (2) hormone therapy to feminize the body, (3) surgical changes primary and/or secondary sex characteristics, (4) psychotherapy. (JT Ex. 15-15-16). According to the WPATH guidelines, for the male-to-female patient, surgical procedures may include a variety of options, including breast/chest surgery, genital surgery (penectomy, orchiectomy, vaginoplasty, cliteroplasty, vulvoplasty) and other options, such as facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation, and hair reconstruction. (JT Ex. 15-6).

38. The WPATH guidelines for vaginoplasty are: 1) Persistent, well documented gender dysphoria; 2) Capacity to make a fully informed decision and to consent for treatment; 3) Age of majority in a given country; 4) 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 (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones); 6) 12 continuous months of living in gender role that is congruent with their gender identity. Although not an explicit criterion, WPATH recommends that patients also have regular visits with a mental health or other medical professional. (JT Ex. 15-66-67).

39. The WPATH guidelines have a short (1 ½ page) section on "Applicability of the Standards of Care to People Living in Institutions Environments," but it is very general and applies broadly to "institutions," including prisons and health care facilities. (JT Ex. 15-73). The guidelines do not provide any specific guidance on how to apply surgical criteria in a correctional setting. (JT Ex. 15-73-74). Indeed, the WPATH guidelines were not developed based on extensive clinical experience with incarcerated persons. (JT Ex. 19-3).

40. The WPATH guidelines do not have the quality of evidence behind the recommendations that are typically seen with treatment guidelines, such as with Endocrine society guidelines for hormone therapy. (Tr. 531: 3-23). More specifically, the WPATH guidelines do not have an evidence-based grading system. (Tr. 531: 3-23). As a result, they have not been universally adopted. The Centers for Medicare and Medicaid Services ("CMS") decided not to adopt the WPATH guidelines as controlling because it did not believe that the evidence was strong enough and wanted to allow providers to either use WPATH or their own standards based on their decision-making. (Tr. 532:21-533:5). Although this CMS opinion related to the Medicare population, CMS performed a thorough review of all the studies and cited several issues with the quality of evidence regarding outcomes after surgery, including small sample sizes, different methodology, different outcomes that were studied, and significant loss of evidence to follow-up when a population is not analyzed in any way. (Tr. 532:2-20).

41. In addition, the American Psychiatric Association (“APA”) concluded that there were issues with the quality of the data and the quality of the evidence, including numbers of regret after surgery. (Tr. 533:6-17). In fact, some members of WPATH have raised concerns about the lack of scientific standards to ground the WPATH guidelines, which was one reason that WPATH in 2017 asked Johns Hopkins University to conduct an independent evidence-based review of those standards. (Tr. 147:7-25, 148:1-5).

42. Due to these deficiencies, the WPATH guidelines are a valuable resource, but are not so definitive that they can be equated with success. (Tr. 533:18-21). Accordingly, providers need to proceed cautiously in determining whether surgery is appropriate for an inmate in light of the lack of data. (Tr. 531:3-23; 534:4-7).

43. Given the flexibility of the WPATH guidelines and their deficiencies, medical and mental health providers can look to other resources for guidance on providing treatment and care. (Tr. 530:19 - 531:23). One such resource is an article entitled “Male Prison Inmates With Gender Dysphoria: When Is Sex Reassignment Surgery Appropriate?” by Cynthia S. Osborne and Anne A. Lawrence, published in the peer-reviewed journal, *The Archives of Sexual Behavior*. (JT Ex. 19-1). The WPATH guidelines cite to and rely upon a number of articles that have been published by the *Archives of Sexual Behavior*. (Tr. JT Ex. 15-81-84, 15-87-88, 15-90-92, 115-94-99 ).The WPATH guidelines also cite to several articles published and authored by Anne A. Lawrence (JT Ex. 15-12, 15-17, 15-69-70, 15-90, 15-99, 15-113).

44. The Osborne and Lawrence resource recommends additional eligibility requirements (permitted by the flexible application of the WPATH guidelines) to maximize the likelihood of successful outcomes and minimize regret: 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 responsible practitioner; and 5) Willingness to be assigned to a women's prison after SRS. (JT. Ex. 19-12-13).

**J. Assessment that Sex Reassignment Surgery (SRS) was Not Medically Necessary for Ms. Edmo.**

45. On April 20, 2016, Dr. Eliason evaluated Ms. Edmo for sex reassignment surgery. Dr. Eliason met the criteria for a "qualified GD evaluator" under the IDOC GD SOP. (Tr. 419:18 - 420:13). Dr. Eliason began his evaluation by stating Ms. Edmo's subjective complaints. Ms. Edmo reported she was doing alright. However, she said she was eligible for parole, but it had not been granted to date due to DORs. Dr. Eliason noted that she had been on hormone replacement, which improved her GD. Dr. Eliason documented that Ms. Edmo noted frustrations with current anatomy and mentioned she had attempted to cut her genitals the past fall. She also requested to be assigned to a different housing unit. (JT Ex. 1-538).

46. Dr. Eliason also noted Ms. Edmo's weight and that she was taking Effexor, for depression and anxiety, and Remeron, which is an antidepressant. Dr. Eliason spoke with staff about the Ms. Edmo's behavior, which was notable for animated affect and no observed distress at that appointment. (JT Ex. 1-538). Dr. Eliason made objective observations of Ms. Edmo, including that she appeared feminine in her demeanor and interaction style and that her mood was "doing alright." (JT Ex. 1-538).

47. Dr. Eliason began his assessment by noting that medical necessity for SRS is not well defined and is constantly shifting. He then noted some examples of situations that could meet medical necessity, which he indicated Ms. Edmo did not meet. Ultimately, Dr. Eliason determined that SRS was not medically necessary. (JT Ex. 1-538).

48. One reason for Dr. Eliason's decision was that he determined that Ms. Edmo's mental health concerns were not fully in adequate control. (Tr. 430:22 - 431:2). Dr. Eliason documented in his April 20, 2016 assessment note that Ms. Edmo had diagnoses of Major Depressive Disorder (MDD), GD, and Alcohol Use Disorder. (JT Ex. 1-538). Dr. Eliason did not conclude that all of her mental health issues stemmed from her GD, but did conclude that her major depression and alcohol use disorders were separate mental health issues that needed to be more adequately controlled. (Tr. 451:1-12). Indeed, Dr. Eliason's SRS assessment note indicated, among other things, that she needed further "supportive counseling." (JT Ex. 1-538.)

49. Another reason for determining that SRS was not medically necessary for Ms. Edmo at that time was Dr. Eliason's decision that he was not doing Ms. Edmo any service to rush through getting gender reassignment surgery in her current social situation in the prison. Dr. Eliason did not believe that Ms. Edmo had satisfied the 12-month period of living in her identified gender role under WPATH standards. Dr. Eliason was aware of a study that he understood suggested that patients, after SRS, were more likely than the general population to kill themselves, in part because people's social networks were not supporting patients enough through their transitions. At that time, Ms. Edmo was parole-eligible and Dr. Eliason believed it would be most helpful to have her experience as a woman with her real social network – family and friends – outside the prison. (Tr. 431:3 – 432:11).

50. Dr. Eliason then stated his plan was to continue to monitor Ms. Edmo and "For the time being it is my opinion that the combination of hormonal treatment and supportive counseling is sufficient for her gender dysphoria." (JT Ex. 1-538).

51. In assessing Ms. Edmo for SRS in April 2016, Dr. Eliason also staffed the issue of medical necessity of SRS with multiple other providers, including Dr. Jeremy Stoddart, another

Corizon psychiatrist; Dr. Murray Young, Corizon's Regional Medical Director in Idaho; and Jeremy Clark, LCPC, who all agreed with his assessment. (JT Ex. 1-538). Mr. Clark recalls his conversation with Dr. Eliason in April 2016 and remembers telling Dr. Eliason that he did not believe surgery was medically necessary for Ms. Edmo and explained his reasoning. (Tr. 340: 24 - 341:15, 344:20 - 245:23; 383:14-25, Clark Decl., Dkt. 101-7, ¶¶ 1-11).

52. Mr. Clark has been a WPATH member since 2013 and has attended several WPATH conferences and correctional health care trainings, reviewed articles and publications regarding the treatment of transgender inmates with GD, and provided clinical supervision and training to IDOC clinical staff regarding the treatment and assessment of GD inmates. Mr. Clark is qualified under the WPATH to provide treatment to GD inmates. (Tr. 325:7 - 334:6, 397:16 - 398:19; DEF Ex. 2019, Clark Decl., Dkt. 101-7, ¶ 3-7). Mr. Clark is also a member of the MTC, which is a multidisciplinary committee that meets monthly to evaluate the needs of GD inmates. Those needs include issues with housing, clothing, treatment, and requests for hormone replacement therapy. (Tr. 323:4-10; DEF Ex. 2019, Clark Decl., Dkt. 101-7, ¶ 3-7).

53. Mr. Clark believed, based on his review and understanding of Ms. Edmo's complete health history and mental health records, along with his discussions with Ms. Edmo's providers and clinicians over the years, that surgery was not appropriate for Ms. Edmo. (Tr. 340:24 - 341:1-15; Dkt. 101-7, ¶ 11). Mr. Clark was primarily concerned that Ms. Edmo's coexisting mental health issues were not well controlled, as required by WPATH. Mr. Clark was concerned that Ms. Edmo displayed behaviors, such as assault of other inmates; sexual acting-out with other inmates, anger management issues, and problems with interpersonal relationships, all of which demonstrated to him that Ms. Edmo was emotionally unstable. He also was concerned that Ms. Edmo demonstrated

borderline personality disorder traits, including sexual deviance, depression, relationship issues, and substance abuse. (Tr. 341:16 - 344:3; Dkt. 101-7, ¶ 12).

54. Mr. Clark also noted that Ms. Edmo's emotional instability gave him concerns about her ability to handle the stressful process of surgery and possibly relocating to a female prison after the procedure was complete. Ms. Edmo was noncompliant with prison rules and he noted that she refused to complete sex offender programming, both of which raised concerns about Ms. Edmo's ability to comply with the care required after surgery. (Tr. 343:3 - 344:3; Dkt. 101-7, ¶ 13). Moreover, Mr. Clark felt that Ms. Edmo had not addressed her underlying Major Depressive Disorder, Anxiety, and other mental health issues. For example, he noted that Ms. Edmo had refused to attend recommended Social Skills and Mood Management groups and had not consistently participated in individualized counseling. (Tr. 344:5-19, Dkt. 101-7, ¶ 14). Mr. Clark still has the above concerns today regarding to Ms. Edmo. (Tr. 347:1-14, 383:9-17; Dkt. 101-7, ¶ 16).

55. On May 18, 2016, Dr. Eliason met with Ms. Edmo and explained that he was planning to set up a committee of Corizon medical providers to further assess SRS. (JT Ex. 1-543). This committee was not formed, however, because the medical providers he was considering for the committee stopped working for Corizon. Nevertheless, the MTC, which was already in place, can still consider SRS if appropriate. (Tr. 452:3 - 453:4). Dr. Eliason has a long working relationship with the IDOC and believes it is highly professional and that, if a medical provider came to the IDOC recommending surgery as medically necessary, then the IDOC and the MTC would follow that advice. (Tr. 454:4 - 455:13).

**K. Sex Reassignment Surgery is Not Medically Necessary at this Time**

56. Defense Expert, Keelin Garvey, M.D., is well-qualified to offer opinions about all options of treatment and care for inmates with GD, including whether surgery is medically

**DEFENDANTS' JOINT PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW - 20**

necessary. (DEF Ex. 2032.) In fact, she is the only expert in this case who is a psychiatrist and, as such, is in the unique position to be able to opine about the standards of care and appropriateness of care of a psychiatrist, such as Dr. Eliason. (Tr. 617:6-12). Also, unlike Ms. Edmo's experts, Dr. Garvey has experience working and treating patients in correctional settings, including experience with GD treatment committees in a prisons. (Tr. 617:13 - 618:7).

57. Dr. Garvey has a bachelor degree from Yale University and graduated from the University of Massachusetts Medical School. She then attended Brown University for her general psychiatry residency, followed by a one-year forensic psychiatry fellowship at UC Davis in California. She is a licensed psychiatrist in eight states and board certified in general adult psychiatry and also in forensic psychiatry. (Tr. 504:10-25; DEF Ex. 2032). Dr. Garvey has education in correctional healthcare as well, including a residency and two-month elective in the prison system in Rhode Island. She also had a forensic fellowship at the University of California Davis that involved two and a half days per week of correctional treatment work, which was more than most fellowships. (Tr. 505:1-23). Moreover, Dr. Garvey is a Certified Correctional Health Professional (CCHP) under the National Commission on Correctional Health Care. (Tr. 525:15-23). As a psychiatrist, she was trained under DSM-4, trained all mental health staff in the Massachusetts system, and has conducted national trainings on DSM-V. (Tr. 505:24 - 506:17).

58. As for experience, Dr. Garvey was a staff psychiatrist with a full caseload of patients whom she followed and treated in the Massachusetts Department of Correction (MDOC). (Tr. 506:21-25). She was promoted to deputy medical director for psychiatry, where she took on administrative responsibilities as well as maintained her clinical work. (Tr. 507:1-4). Then, in August of 2015, she became the chief psychiatrist in the MDOC, where she still provided clinical treatment to inmates, but also oversaw other providers (approximately 11 to 16 or so psychiatrists

and nurse practitioners). As the Chief Psychiatrist in the MDOC, one of Dr. Garvey's roles was to serve as the chair of the GD Treatment Committee. (Tr. 508:10-11).

59. Dr. Garvey directly treated patients in the Massachusetts Department of Correction who had GD. She oversaw up to about 30 to 40 inmates with GD at any given time. (Tr. 508:13 - 509:1). In the Massachusetts prison system, Dr. Garvey was involved in all aspects of treatment for GD patients; all treatment options were on the table for inmates with GD, including access to a treating clinicians and mental health therapy, hormone therapy, and sex reassignment surgery. (Tr. 509:2 - 510:9).

60. Dr. Garvey is qualified to render opinions on sex reassignment surgery. She has experience in treating patients, has reviewed a lot of literature on the topic, and attended WPATH trainings. She also had some training in her residency. Additionally, she was the Director of Psychiatry for the Massachusetts prison system and on the GD treatment committee in that setting where they reviewed the treatment plans of every individual in the state who had GD and conducted the confirmatory evaluation for every patient that entered the system that reported gender issues. Moreover, she was on the supervision group that also met monthly and talked about the total treatment plan for everyone that was being treated for GD, including discussion of gender confirmation surgery for certain individuals and analysis of why SRS was not recommended for other individuals. WPATH guidelines also are discussed at her NCCHC conferences. Dr. Garvey also has presented at several national conferences regarding treatment and care of patients with GD, which includes Sex Reassignment Surgery options. (Tr. 618:8 - 619:10; 512:19 - 514:8; 525:15 - 526:16). This is significant experience in all aspects of treatment and care of inmates with GD, including assessment of Sex Reassignment Surgery, in the correctional setting, especially since only one inmate to date in the United States has received SRS surgery. (Tr. 514:9-11).

61. Dr. Garvey issued a report in this case and has rendered expert opinions about the treatment and care provided by Corizon's providers to Ms. Edmo and regarding the medical necessity of gender confirmation surgery. In doing so, she reviewed all records in this case, including the medical and mental health prison records for Ms. Edmo, the Second Amended Complaint, Ms. Edmo's expert's reports, Ms. Edmo's pre-incarceration records from Portneuf Medical Center, Sho-Ban Tribes, Indian Health Service, the presentence investigation reports from 2009 and 2011, discovery, IDOC records, and declarations filed and deposition transcripts in the case. She also reviewed a number of articles related to treatment and care of patients with GD. She also conducted a clinical interview with Ms. Edmo. (Tr. 515:25 - 517:15; Dkt. 100-2).

62. Dr. Garvey agrees that Ms. Edmo has GD. (Tr. 517:25 - 519:1). Dr. Garvey also diagnosed Ms. Edmo with major depressive disorder, alcohol use disorder, opioid use disorder, and stimulant use disorder. (Tr. 519:2-6).

63. Dr. Garvey opines that the assessment of GD by Dr. Eliason and the subsequent approval for hormone therapy for Ms. Edmo was appropriate and fairly quick. (Tr. 521:2 - 522:22). Dr. Garvey is qualified to discuss hormone therapy and she is of the opinion that the hormone therapy provided to Ms. Edmo was appropriate, including that she was placed on estrogen and antiandrogen medications. (Tr. 522:21 - 524:11).

64. Dr. Garvey notes that there are not quality studies regarding outcomes after SRS. Studies that report a low regret rate after SRS have small pool samples and a significant number of people that are lost to follow-up. There are other studies that report a higher regret rate of 19.1% when comparing post-SRS patients with the general population. (Tr. 527:23 - 528:12; 596:22 - 599:8).

65. Dr. Garvey opines that Dr. Eliason's assessment and determination that SRS was not medically necessary for Ms. Edmo was appropriate. Dr. Eliason appropriately used his clinical judgment and assessed her current clinical status as to this assessment of Ms. Edmo. He considered Ms. Edmo's attempted self-castration and consulted with additional medical professionals, including clinician Jeremy Clark, who was a WPATH member. (Tr. 526:23 - 17) Dr. Garvey opines that the treatment and care provided to Ms. Edmo was within the applicable standard of care. (Tr. 542:14-18).

66. Further, Dr. Garvey opines that SRS is not medically necessary at this time for Ms. Edmo. (528:13-17). There are three primary reasons for this opinion. First, Dr. Garvey believes that the first WPATH guidelines' criterion for SRS that she needs to have persistent, well documented GD is not met. While she has GD, there are inconsistencies between her self-report and her history regarding living as a female in the community that should be further investigated and discussed before sex reassignment surgery is considered. (Tr. 528:20 - 529:1).

67. Second, Dr. Garvey is of the opinion that Ms. Edmo's other mental health comorbidities are not sufficiently well controlled, hence not meeting another one of the WPATH criteria. She is actively self-injuring herself, including cutting herself on the arm this year. Dr. Garvey believes it is important for Ms. Edmo to develop further coping skills that she would be able to use following surgery so that she is not engaging in self-injury after the surgery. (Tr. 529:2-16). Self-injurious behavior is usually associated with trauma and is never seen as an effective coping strategy. Good coping skills are especially important with Ms. Edmo who would need them to manage a very stressful surgery, SRS, if indicated. (Tr. 538). Ms. Edmo's pre-incarceration records show that Ms. Edmo's mental health issues are not solely related to her GD. (Tr. 543:12 - 544).

68. Third, Dr. Garvey is of the opinion that Ms. Edmo has not satisfied the 12-month real-life experience criteria under the WPATH guidelines for SRS. The guidelines explain that a patient under consideration for SRS must experience all of the things they are going to experience outside of prison, such as social transition or their physical transition, work response, family parties, and the experiences that one would encounter in their life. Ms. Edmo has not been able to fully engage in such an experience in prison and she is scheduled to get out of prison in 2021. (Tr. 529:17 – 530:18).

69. Dr. Garvey is concerned about Ms. Edmo's risk of suicide after surgery if she does not work with mental health providers to develop more effective coping strategies for the stress that she is going to experience. Dr. Garvey does not believe that her risk of suicide will decrease based on her current state and is concerned that SRS at this time would not be successful for Ms. Edmo. (Tr. 545:19-546:9)

70. IDOC Chief Psychologist, Dr. Walter Campbell, is a licensed psychologist who received his Ph.D. in Counseling Psychology and his Masters of Sciences degree in Counseling and Counseling Education, both from Indiana University and has been the IDOC Chief Psychologist since 2016. Dr. Campbell is a member of the American Psychological Association and the Idaho Psychological Association. He has provided mental health services to incarcerated inmates since 2012. (Campbell Decl., Dkt. 101-4, ¶¶ 2-7).

71. Dr. Campbell is also a member of WPATH and has attended the 2017 WPATH conference. He has also received training on GD at two NCCHC annual conferences. Dr. Campbell has reviewed dozens of articles and publications regarding the treatment of transgender inmates, including inmates with GD. Dr. Campbell is familiar with the WPATH guidelines, along with statements and guidelines regarding GD and transgender persons set forth by the American

Psychological Association and the American Psychiatric Association. He is also familiar with the guidelines regarding GD offenders and transgender inmates as provided by the NCCHC, the National Institute of Corrections, and the Federal Bureau of Prisons. (Campbell Decl., Dkt. 101-4, ¶¶ 8-10).

72. Dr. Campbell also serves as chair of the MTC, which is a multidisciplinary committee that meets monthly to discuss and evaluate the needs of inmates who have been diagnosed with GD. The MTC also receives and reviews inmate requests to be assessed for GD. Dr. Campbell has directly conducted six GD assessments and has overseen the treatment and assessment of approximately fifty inmates who have requested GD evaluations, through his role as chair of the MTC and as the Chief Psychologist. (Campbell Decl., Dkt. 101-4, ¶¶ 13-14).

73. In his role as Chief Psychologist and chair of the MTC, he has reviewed Ms. Edmo's file, including Ms. Edmo's mental health treatment records, treatment plans, DORs, concern forms, and PSI reports. He is familiar with Ms. Edmo's treatment for GD while she has been in the custody of IDOC. (Campbell Decl., Dkt. 101-4, ¶ 23). Based on his review of the records, his experience, and training, Dr. Campbell believes that the clinical evidence demonstrates that Ms. Edmo's feelings of dysphoria have a very complex origin, related to trauma, relationship difficulties, and other unresolved life events, precisely as Ms. Edmo's IDOC mental health clinicians have described in treatment notes over the last several years. Furthermore, Ms. Edmo has not demonstrated a willingness to address these underlying mental health issues through treatment, making assessment of her full mental clinical picture difficult. (Campbell Decl., Dkt. 101-4, ¶ 29).

74. Dr. Campbell further believes that Ms. Edmo's mental health history, history of suicide attempts, and her inconsistent reports about living full time as a woman prior to entering

prison demonstrate that there are many unanswered questions that need to be explored to evaluate the root cause of Ms. Edmo's depressive symptoms and GD. Her serious and severe mental health concerns should not be ignored, overlooked, or downplayed when assessing the causes of her dysphoria. (Campbell Decl., Dkt. 101-4, ¶ 30).

75. Dr. Campbell believes that Ms. Edmo's overall clinical picture is not fully understood and it is not clear that Ms. Edmo's GD is the sole cause of her dysphoria. Until Ms. Edmo's dysphoria is fully understood, an extreme irreversible intervention such as sex reassignment surgery is not warranted, appropriate, or without a considerable risk of harm. Dr. Campbell is not convinced that there would be no adverse outcome if Ms. Edmo undergoes sex reassignment surgery, in light of the many unanswered questions posed by her complex mental health history. (Campbell Decl., Dkt. 101-4, ¶¶ 30-33).

76. Expert witness Dr. Joel T. Andrade, Ph.D., LICSW, CCHP-MH, is well-qualified to offer opinions about all options of treatment and care for inmates with GD, including whether sex reassignment surgery is medically necessary. (DEF Ex. 2021\_9-25). Dr. Andrade is a licensed independent clinical social worker and is a CCHP, with an emphasis in mental health. (Tr. 626:1-21). Dr. Andrade has over a decade of experience in providing and supervising the provision of correctional mental health care, including directing and overseeing the treatment of all inmates diagnosed with GD in the custody of the Massachusetts Department of Corrections in his role as clinical director, chair of the GD Supervision Group, and member of the GD Treatment Committee. (Tr. 627:2-14; DEF Ex. 2021\_9-25).

77. Over the last decade, Dr. Andrade has provided treatment to GD inmates in his role on the treatment committee and has evaluated and confirmed diagnoses of GD for over 100 inmates. Dr. Andrade has also provided treatment recommendations for all potential treatment for

GD inmates, including hormone therapy, and gender affirming surgery. On two occasions, Dr. Andrade has recommended surgery for incarcerated inmates. (Tr. 627-629:1-10). Dr. Andrade has further reviewed and relied upon dozens of publications, articles, guidelines, and position statements regarding transgender healthcare, the assessment and diagnosis of persons with GD, and the treatment options available for persons with GD, including surgery. (Tr. 624:15-20; DEF Ex. 2021\_5-8). These publications include the WPATH guidelines (JT Ex. 15) and the Osborne and Lawrence article (JT Ex. 19).

78. Dr. Andrade conducted a clinical interview with Ms. Edmo on July 31, 2018, and reviewed Ms. Edmo's complete mental health treatment record, including her pre-incarceration records, and interviewed Ms. Edmo's treating clinicians. (Tr. 630:12 - 634:24). Based on his review of the documents in this case, and his interview with Ms. Edmo, Dr. Andrade has concluded that Ms. Edmo does not meet the WPATH criteria for surgery (Tr. 639:3-16).

79. First, while Ms. Edmo claims that she lived full-time as woman and was well accepted as such in her community for years prior to entering prison, Dr. Andrade could find no support for that claim in Ms. Edmo's pre-incarceration medical records and PSI. Dr. Andrade is concerned that Ms. Edmo does not appreciate and understand what it means to fully live in the gender role consistent with her identity prior to being released from prison in 2021. Dr. Andrade believes that Ms. Edmo is at risk for increased harm if she enters the community after having received surgery without a real opportunity to assimilate to life full-time as a female outside of prison. (Tr. 639:17-25, 640:1-9, 643:3-21).

80. Dr. Andrade also believes that, due to Ms. Edmo's unresolved mental health issues, including borderline personality disorder traits, related to her early-life trauma and substance abuse, pursuing surgery at this time actually increases Ms. Edmo's risk for suicide post-surgery.

Ms. Edmo made representations to Dr. Andrade during the clinical interview that her feminine appearance enticed her abuser or led to her sexual abuse. It is apparent to Dr. Andrade that Ms. Edmo has not fully addressed in psychotherapy the relationship between her early childhood trauma and her mental health conditions; in particular, Ms. Edmo's GD. Working through those issues with a mental health provider is something that Ms. Edmo must do before she can fully and meaningfully elect to proceed with surgery. Otherwise, Ms. Edmo will not be able to successfully cope with the stressors of surgery, increasing her risk of harm. At this time, Ms. Edmo has not developed healthy coping strategies and instead deals with her depression and GD by cutting herself. Ms. Edmo must develop healthy tools to manage her depression, anxiety, and GD that do not involve maladaptive behaviors such as cutting, sexual acting out, and codependency. (Tr. 640:10- 642:8, 643:3-21).

81. Ms. Edmo's former and current treating clinicians Ms. Watson and Ms. Stewart also believe, based on their education, training, and experience, including experience providing individual and group counseling treatment to Ms. Edmo, their correctional experience treating inmates with complex and unique mental health concerns, their experience as members of the MTC, and their review of Ms. Edmo's PSI reports and mental health records, that surgery is not appropriate for Ms. Edmo at this time, due to her coexisting mental health concerns that are not well-controlled and her unwillingness to acknowledge or address those concerns while in prison. Ms. Watson believes that those coexisting mental health concerns complicate Ms. Edmo's treatment for GD. Ms. Stewart believes that Ms. Edmo's use of self-harm in the form of cutting to deal with emotional dysregulation and her belief that surgery will solve her depression and low sense of self demonstrate that Ms. Edmo may be worse off if she receives the surgery before

developing healthy coping mechanisms and addressing her coexisting mental health conditions. (Stewart Decl., Dkt. 101-1, ¶¶ 1-14; Watson Decl., Dkt. 101-3, ¶¶ 1-19).

**L. Dr. Gorton Credibility Issues**

82. Dr. Gorton has no experience providing treatment to inmates, has never worked in a prison, has never been part of a GD treatment committee at a prison, and has never provided treatment to an inmate with GD while incarcerated. (Tr. 269:23-269:17). Dr. Gorton is not a psychiatrist, psychologist, mental health clinician, or therapist. (Tr. 269:20 - 270:6). He is not a certified correctional healthcare professional. (Tr. 270:9-16). Dr. Gorton does not perform gender confirmation surgery. (Tr. 270:17-19). He utilizes mental health clinicians and psychiatrists sometimes when a patient has complex mental health issues. (Tr. 272:25 - 273:2).

83. Dr. Gorton realizes that getting documentation of a person's prior mental health treatment is important when assessing a person for SRS. However, when assessing Ms. Edmo and rendering opinions critical of Defendants, Dr. Gorton did not even attempt to obtain her prior mental health records and did not consider Ms. Edmo's PSI records, DORs, MTC records, sex offender treatment records, pre-incarceration medical and mental health records, Bannock County jail records, IDOC policies or procedures regarding GD, and IDOC PREA policy. (Tr. 276:20 – 281:2).

84. Dr. Gorton agrees that psychotherapy and participation in mental health groups is important for Ms. Edmo (Tr. 291:11-16).

85. Dr. Gorton does not believe that SRS for GD is emergent and testified that it is “kind of absurd” to think in such terms. (Tr. 301:6-23). Dr. Gorton also acknowledges that about three of his patients have attempted suicide after a vaginoplasty. He also estimates that a handful of his patients have attempted suicide after some kind of SRS. He recalls one patient expressing regret after an orchiectomy and then suing Dr. Gorton and his clinic. (Tr. 309:18 - 310:13).

86. Dr. Gorton was critical of Defendants, stating that they did not take an appropriate transgender history of Ms. Edmo. However, Dr. Gorton now admits that opinion is not correct. (Tr. 314:11 - 317:3).

**M. Dr. Ettner Credibility Issues**

87. Plaintiff's expert psychologist, Dr. Randi Ettner, is not a Certified Correctional Healthcare Professional (CCHP), nor does she have any experience treating inmates with GD who are currently incarcerated. (Tr. 106:21-24, 107:11-18). Dr. Ettner is not a board-certified psychiatrist nor is she a medical doctor (Tr: 153:9-13, 154:24-25). Dr. Ettner has never been employed by a prison and has no formal training on prison operations or security. (Tr. 106:25, 107:1-10). Dr. Ettner has never been published in a peer-reviewed journal on a topic related to providing care to transgender inmates in a correctional setting. (Tr. 108:14-22).

88. Prior to her deposition in this case and prior to forming her opinions regarding the medical necessity for sex reassignment surgery for Ms. Edmo, Dr. Ettner had never read the peer-reviewed article entitled "Male Prison Inmates With Gender Dysphoria: When Is Sex Reassignment Surgery Appropriate?" by Cynthia S. Osborne and Anne A. Lawrence. (Tr. 108:23-25; 109:1-5, 111:9-15).

89. Prior to forming her opinions, Dr. Ettner did not interview any of Ms. Edmo's medical or mental health providers, and is unaware of their qualifications and education (Tr. 112:2-5, 120:19-25, 121:1-10, 184:11-17). Also prior to forming her opinions in this case, Dr. Ettner had not reviewed any IDOC policies, Ms. Edmo's disciplinary records, MTC records, offender history, pre-incarceration records, PSI reports, or her complete medical and mental health records. (Tr. 112:6-25, 113:1-25, 114:1-5, 117:7-13).

**N. IDOC's 2018 Standard Operating Procedure for GD**

90. On October 5, 2018, IDOC implemented a revised GD SOP, which, among other things, updated references from GID to GD and included revised sections allowing female GD offenders to use makeup, wear their hair in traditionally female hairstyles, and have access commissary items available to other female inmates, including bras and underwear. (JT Ex. 9-1-9). The revised SOP also provides that inmates be referred to by medical and mental health staff as their preferred gender, while other IDOC staff is required to refer to GD inmates in gender neutral terms. (JT Ex. 9-6). The revised SOP still recognizes sex reassignment surgery as an available option for treatment, should it be deemed medically necessary by the treating physician and explicitly states that inmates diagnosed with GD will be provided access to the full range of services and programs available within IDOC to the same extent as other inmates. (JT Ex. 9-6).

**II. PROPOSED CONCLUSIONS OF LAW**

**A. Standard for Motion for Mandatory Injunction**

91. Ms. Edmo incorrectly seeks a preliminary injunction ordering the Defendants to provide her with gender confirmation surgery. In order to be awarded the relief sought on a preliminary injunction, a moving party must establish that they are likely to succeed on the merits, that they are likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in their favor, and that an injunction is in the public interest. *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20, 129 S. Ct. 365, 374, 172 L. Ed. 2d 249 (2008).

92. The basic function of a preliminary injunction is to preserve the status quo, pending a determination of the action on the merits. *Tanner Motor Livery, Ltd. v. Avis, Inc.*, 316 F.2d 804, 808–09 (9th Cir. 1963). Here, Ms. Edmo does not seek preservation of the status quo pending a trial on the merits of her claim. Rather, Ms. Edmo seeks an order altering the status quo and ordering the Defendants to take a particular action – providing her with a permanent, irreversible,

medical procedure. Mandatory injunctions ordering a party to take action are particularly disfavored. *Garcia v. Google, Inc.*, 786 F.3d 733, 740 (9th Cir. 2015). Indeed, courts should be extremely cautious about ordering mandatory relief. *Battelle Energy All., LLC v. Southfork Sec., Inc.*, 980 F. Supp. 2d 1211, 1216 (D. Idaho 2013), citing *Martin v. Int'l Olympic Comm.*, 740 F.2d 670, 675 (9th Cir.1984)).

93. This Court and the Ninth Circuit have recognized a separate, higher standard for the issuance of a mandatory injunction, such as the relief sought by Ms. Edmo in this case. See *Battelle Energy All., LLC*, 980 F. Supp. at 1216 (“An even more stringent standard is applied where mandatory, as opposed to prohibitory, preliminary relief is sought.”); *Garcia*, 786 F.3d 40 (mandatory injunctions go well beyond simply maintaining the status quo and the court should deny such relief unless the party establishes that the law and facts clearly favor their position). See also *Taiebat v. Scialabba*, No. 17-CV-0805-PJH, 2017 WL 747460, at \*2 (N.D. Cal. Feb. 27, 2017) (movant must meet a higher degree of scrutiny where the injunction will provide the movant with “substantially all of the relief that would be available after a trial on the merits.”).

94. As a result, mandatory preliminary relief should not issue unless both the facts and the law clearly favor the moving party and extreme or very serious damage will result. *Battelle Energy All., LLC*, 980 F. Supp. 2d at 1216, citing *Marlyn Nutraceuticals, Inc. v. Mucos Pharma GmbH & Co.*, 571 F.3d 873, 879 (9th Cir.2009)(emphasis added). Mandatory injunctions are not issued in doubtful cases, or where the party seeking an injunction could be compensated in damages. *Id.* In other words, it is not sufficient for a moving party seeking a mandatory injunction to establish a likelihood of success on the merits or a likelihood of irreparable harm, as set forth in the standard for a preliminary injunction. Rather, the party must demonstrate that both the facts and the law clearly favor their position and that they will suffer extreme or very serious damage.

95. The Prison Litigation Reform Act (“PLRA”) also governs prospective relief sought in civil actions concerning prison conditions. See *Gilmore v. People of the State of California*, 220 F.3d 987, 999 (9th Cir.2000) (“no longer may courts grant or approve relief that binds prison administrators to do more than the constitutional minimum.”). The PLRA defines “prospective relief” as “all relief other than compensatory monetary damages.” 18 U.S.C.A. § 3626(g)(7). In cases such as this, where a prisoner seeks a mandatory injunction seeking substantially all of the relief that would be available after a trial on the merits, the PLRA dictates that any prospective relief “shall extend no further than necessary to correct the violation of the Federal right of a particular plaintiff or plaintiffs.” 18 U.S.C.A. § 3626(a)(1)(A). Further, a court shall not order any prospective relief unless it finds that the relief is “narrowly drawn, extends no further than necessary to correct the Federal right, and be the least intrusive means necessary to correct the violation of the Federal right.” *Id.* The PLRA also 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 relief.” *Id.*

**B. The Law and Facts are not Clearly in Ms. Edmo’s Favor Regarding her Eighth Amendment Claim for Deliberate Indifference**

96. Ms. Edmo asserts that the Defendants were deliberately indifferent to her medical needs in violation of the Eighth Amendment. “[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 (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.*

97. 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.” *Id.*, at 1186. 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.* Mere negligence alone does not establish a valid Eighth Amendment claim. *Estelle*, 429 U.S. at 104, 97 S. Ct. at 291. Rather, 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)).

98. The subject matter of the Plaintiff’s Eight Amendment claim is her diagnosed GD, which is a mental health condition recognized by the DSM-V. This Court has very recently articulated that it is particularly difficult to establish deliberate indifference to a mental health need for numerous reasons, most notably because “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, (D. Idaho Feb. 22, 2018) (emphasis added).

99. The Defendants were not deliberately indifferent by not providing Ms. Edmo with gender confirmation surgery. The treatment and care provided by Defendants to Ms. Edmo was appropriate and within the applicable standard of care. The WPATH guidelines are flexible and Defendants have applied them as such in providing Ms. Edmo with every type of treatment recommended by the WPATH, including changes in gender expression and role, hormone therapy, and psychotherapy. IDOC's 2011 and 2018 policies expressly recognize that surgery is an available treatment if medically necessary.

100. The records, testimony, and evidence in this case do not demonstrate that the facts and the law are clearly in Ms. Edmo's favor on her claim for deliberate indifference for not recommending surgery at this time. There is no evidence of a blanket prohibition of surgery by any of the Defendants, nor have Defendants ignored or disregarded Ms. Edmo's GD. Rather, the evidence shows that the Defendants have taken thoughtful consideration of her request for surgery and have treated Ms. Edmo as a whole person with various mental health needs and a tragic history of abuse, trauma, and depression. As contemplated by the WPATH guidelines, Ms. Edmo's underlying mental health issues complicate the resolution of Ms. Edmo's GD and must be well-controlled before any surgical intervention is appropriate. The decision not to recommend surgery for Ms. Edmo was an exercise of professional judgment.

101. While Ms. Edmo's retained expert witnesses are certainly experienced in treating patients with GD in the community, they have no experience in a correctional setting and do not have the day-to-day contact and experience of treating mentally ill prisoners who are currently incarcerated. They rely heavily on their advocacy and will not recognize the difficulties of applying the WPATH guidelines in a correctional setting, particularly the requirement to live authentically in a preferred gender role for 12 months. For inmates like Ms. Edmo, who will be released in less

than three years, that experience cannot be fully accomplished in prison, which differs dramatically from the community. Furthermore, there is no evidence that she had lived 12 months as a female prior to her incarceration. A difference of professional opinion between Ms. Edmo's experts and Ms. Edmo's treatment providers does not constitute deliberate indifference, particularly in a correctional setting.

102. The U.S. Supreme Court has held that prison administrators should be accorded wide-ranging deference in the adoption and execution of policies and practices that in their judgment are needed to preserve internal order and discipline and to maintain institutional security. *See Whitley v. Albers*, 475 U.S. 312, 321–22, 106 S. Ct. 1078, 1085, 89 L. Ed. 2d 251 (1986). Such deference extends to “prophylactic or preventive measures” intended to reduce the incidence of breaches of prison discipline. *Id.* “It does not insulate from review actions taken in bad faith and for no legitimate purpose, but it requires that neither judge nor jury freely substitute their judgment for that of officials who have made a considered choice.” *Id.*

103. Here, the IDOC Defendants have not been deliberately indifferent to Ms. Edmo's needs by disciplining her for refusing direct orders to remove makeup or take down her hair, for destroying property to make thong underwear, for assaulting another GD inmate on two separate occasions. TMs. Inappropriate use of makeup and feminine hairstyles the alteration of female undergarments raises serious security and safety concerns, as does allowing offenders to appear or act sexual in prison. Ms. Edmo recognizes that her feminine appearance puts her at an additional risk for sexual assault and the IDOC Defendants must be allowed to set appropriate limits to prevent her from harm. “The duty of prison officials to protect the safety of inmates and prison personnel is a factor that may properly be considered in prescribing medical care for a serious medical need.” *Kosilek v. Maloney*, 221 F. Supp. 2d 156, 161 (D. Mass. 2002).

**C. The Law and Facts are not Clearly in Ms. Edmo’s Favor Regarding her Fourteenth Amendment Claims**

104. The standard regarding the validity of a prison regulation that allegedly impinges on an inmate’s Constitutional rights is whether such a regulation is “reasonably related to legitimate penological interests.” *Turner v. Safley*, 482 U.S. 78, 89, 107 S. Ct. 2254, 2261–62. However, in this case, the Court need not reach the question of whether the denial of surgery serves a penological interest because the Defendants do not have a policy, practice, or regulation that denies medically necessary care to Ms. Edmo based on her status as a transgender person. The evidence demonstrates that, since 2011, IDOC policy has specifically allowed for surgery when deemed medically necessary.

**D. The Law and Facts are Not Clearly in Ms. Edmo’s Favor Regarding her Affordable Care Act Claims**

105. Section 1557 of the Affordable Care Act 42 U.S.C. § 18116(a) (“ACA”) is not applicable to Ms. Edmo, as she and IDOC do not meet the requirements for applicability, including Section 1557. The ACA applies to an individual through either engaging with insurance companies on the free exchange or as an employee receiving insurance from an employer. The Federal Code specifically notes that incarceration is an eligibility disqualifier for a person to participate on the free exchange. 45 C.F.R. 155.305. Ms. Edmo is not employed by IDOC, nor does she receive health insurance from IDOC. Therefore, the ACA does not apply to Ms. Edmo as an individual.

106. Similarly, the ACA does not apply to IDOC as an entity. For the ACA to apply, IDOC would need to participate in a “health program or activity.” 42 USC §§ 18032(2)(A)&(B). According to the Department of Health and Human Services, an entity qualifies as participating in a “health program or activity” if it is principally engaged in the provision or administration of health-related services, health-related insurance coverage, or other health-related coverage, “such as a hospital, health clinic, community health center, group health plan, health insurance issuer, DEFENDANTS’ JOINT PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW - 38

physician's practice, nursing facility, or residential or community-based treatment facility." 81 Fed. Reg. 31375, 31385. IDOC is not "principally engaged" in providing or administering health services. Rather, IDOC is principally engaged in managing felony offenders housed in prisons and supervised on probation and parole. Accordingly, the ACA does not apply to the IDOC Defendants and the law and facts are not clearly in Ms. Edmo's favor on those claims.

**E. Plaintiff is Not Likely to Suffer Extreme or Serious Harm While Awaiting a Trial on the Merits**

107. This Court heard competing opinions regarding whether Ms. Edmo's overall mental health concerns would worsen, improve, or remain unchanged if she is provided surgery. Ms. Edmo has a long history of serious mental illness, including several serious suicide attempts, dating back to 2010. There are no reliable anecdotes or evidence-based studies to suggest that Ms. Edmo's depression, anxiety, dysphoria, or possibility of self-harm will decrease if she is provided surgery, especially in light of Ms. Edmo's incarceration and significant co-existing and uncontrolled mental health concerns. Accordingly, making any predictions as to whether, absent surgery now, Ms. Edmo will experience extreme or serious harm is speculative.

108. Ms. Edmo's significant unresolved history of trauma and abuse will not be resolved or alleviated through surgery and Ms. Edmo has not developed or attempted to develop healthy coping skills to address those stressors and the stressors that come with surgery. Without the requisite coping skills to handle the stressors of such a serious and irreversible surgery, and without yet having the opportunity to live as a woman in the community, a likelihood exists that Ms. Edmo will be at an increased risk of depression and suicide if she is provided the surgery at this time.

109. The evidence and testimony on the record supports the conclusion that Ms. Edmo will not suffer any irreparable – let alone extreme or serious harm – if she is not provided the surgery pending resolution of this dispute at a trial on the merits. Ms. Edmo has not made any

attempts at self-castration since 2016, and she testified that she now understands the importance of, and is committed to, preserving the tissue from her scrotum and penis for future use in a vaginoplasty procedure. Further, while Ms. Edmo's depression and anxiety appear to be at the same high levels as they were prior to her incarceration, she has not made any attempts to commit suicide since 2011. Moreover, Dr. Gorton, Plaintiff's own medical expert, testified that the surgery Ms. Edmo is requesting is not an emergency procedure requiring immediate attention.

110. For the foregoing reasons, Ms. Edmo has not made a clear showing that Defendants have been deliberately indifferent to her serious medical needs by not recommending gender confirmation surgery at this time. In addition, Ms. Edmo has not established that she is likely to suffer extreme or serious harm while awaiting a trial on the merits. Accordingly, Ms. Edmo's *Motion* is DENIED.

DATED this 26<sup>th</sup> day of October, 2018.

PARSONS BEHLE & LATIMER

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**CERTIFICATE OF SERVICE**

I HEREBY CERTIFY that on this 26<sup>th</sup> day of October, 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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