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Administration of Donald J. Trump, 2025

Executive Order 14168—Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government

January 20, 2025

By the authority vested in me as President by the Constitution and the laws of the United States of America, including section 7301 of title 5, United States Code, it is hereby ordered:

Section 1. Purpose. Across the country, ideologues who deny the biological reality of sex have increasingly used legal and other socially coercive means to permit men to self-identify as women and gain access to intimate single-sex spaces and activities designed for women, from women's domestic abuse shelters to women's workplace showers. This is wrong. Efforts to eradicate the biological reality of sex fundamentally attack women by depriving them of their dignity, safety, and well-being. The erasure of sex in language and policy has a corrosive impact not just on women but on the validity of the entire American system. Basing Federal policy on truth is critical to scientific inquiry, public safety, morale, and trust in government itself.

This unhealthy road is paved by an ongoing and purposeful attack against the ordinary and longstanding use and understanding of biological and scientific terms, replacing the immutable biological reality of sex with an internal, fluid, and subjective sense of self unmoored from biological facts. Invalidating the true and biological category of "woman" improperly transforms laws and policies designed to protect sex-based opportunities into laws and policies that undermine them, replacing longstanding, cherished legal rights and values with an identity-based, inchoate social concept.

Accordingly, my Administration will defend women's rights and protect freedom of conscience by using clear and accurate language and policies that recognize women are biologically female, and men are biologically male.

Sec. 2. Policy and Definitions. It is the policy of the United States to recognize two sexes, male and female. These sexes are not changeable and are grounded in fundamental and incontrovertible reality. Under my direction, the Executive Branch will enforce all sex-protective laws to promote this reality, and the following definitions shall govern all Executive interpretation of and application of Federal law and administration policy:

1. "Sex" shall refer to an individual's immutable biological classification as either male or female. "Sex" is not a synonym for and does not include the concept of "gender identity."
2. "Women" or "woman" and "girls" or "girl" shall mean adult and juvenile human females, respectively.
3. "Men" or "man" and "boys" or "boy" shall mean adult and juvenile human males, respectively.
4. "Female" means a person belonging, at conception, to the sex that produces the large reproductive cell.
5. "Male" means a person belonging, at conception, to the sex that produces the small reproductive cell.

6. "Gender ideology" replaces the biological category of sex with an ever-shifting concept of self-assessed gender identity, permitting the false claim that males can identify as and thus become women and vice versa, and requiring all institutions of society to regard this false claim as true. Gender ideology includes the idea that there is a vast spectrum of genders that are disconnected from one's sex. Gender ideology is internally inconsistent, in that it diminishes sex as an identifiable or useful category but nevertheless maintains that it is possible for a person to be born in the wrong sexed body.

7. "Gender identity" reflects a fully internal and subjective sense of self, disconnected from biological reality and sex and existing on an infinite continuum, that does not provide a meaningful basis for identification and cannot be recognized as a replacement for sex.

Sec. 3. Recognizing Women Are Biologically Distinct From Men. (a) Within 30 days of the date of this order, the Secretary of Health and Human Services shall provide to the U.S. Government, external partners, and the public clear guidance expanding on the sex-based definitions set forth in this order.

1. Each agency and all Federal employees shall enforce laws governing sex-based rights, protections, opportunities, and accommodations to protect men and women as biologically distinct sexes. Each agency should therefore give the terms "sex", "male", "female", "men", "women", "boys" and "girls" the meanings set forth in section 2 of this order when interpreting or applying statutes, regulations, or guidance and in all other official agency business, documents, and communications.

2. When administering or enforcing sex-based distinctions, every agency and all Federal employees acting in an official capacity on behalf of their agency shall use the term "sex" and not "gender" in all applicable Federal policies and documents.

3. The Secretaries of State and Homeland Security, and the Director of the Office of Personnel Management, shall implement changes to require that government-issued identification documents, including passports, visas, and Global Entry cards, accurately reflect the holder's sex, as defined under section 2 of this order; and the Director of the Office of Personnel Management shall ensure that applicable personnel records accurately report Federal employees' sex, as defined by section 2 of this order.

4. Agencies shall remove all statements, policies, regulations, forms, communications, or other internal and external messages that promote or otherwise inculcate gender ideology, and shall cease issuing such statements, policies, regulations, forms, communications or other messages. Agency forms that require an individual's sex shall list male or female, and shall not request gender identity. Agencies shall take all necessary steps, as permitted by law, to end the Federal funding of gender ideology.

5. The prior Administration argued that the Supreme Court's decision in *Bostock v. Clayton County* (2020), which addressed Title VII of the Civil Rights Act of 1964, requires gender identity-based access to single-sex spaces under, for example, Title IX of the Educational Amendments Act. This position is legally untenable and has harmed women. The Attorney General shall therefore immediately issue guidance to agencies to correct the misapplication of the Supreme Court's decision

6. in *Bostock v. Clayton County* (2020) to sex-based distinctions in agency activities. In addition, the Attorney General shall issue guidance and assist agencies in protecting sex-based distinctions, which are explicitly permitted under Constitutional and statutory precedent.

7. Federal funds shall not be used to promote gender ideology. Each agency shall assess grant conditions and grantee preferences and ensure grant funds do not promote gender ideology.

Sec. 4. Privacy in Intimate Spaces. (a) The Attorney General and Secretary of Homeland Security shall ensure that males are not detained in women's prisons or housed in women's detention centers, including through amendment, as necessary, of Part 115.41 of title 28, Code of Federal Regulations and interpretation guidance regarding the Americans with Disabilities Act.

1. The Secretary of Housing and Urban Development shall prepare and submit for notice and comment rulemaking a policy to rescind the final rule entitled "Equal Access in Accordance with an Individual's Gender Identity in Community Planning and Development Programs" of September 21, 2016, 81 FR 64763, and shall submit for public comment a policy protecting women seeking single-sex rape shelters.

2. The Attorney General shall ensure that the Bureau of Prisons revises its policies concerning medical care to be consistent with this order, and shall ensure that no Federal funds are expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex.

3. Agencies shall effectuate this policy by taking appropriate action to ensure that intimate spaces designated for women, girls, or females (or for men, boys, or males) are designated by sex and not identity.

Sec. 5. Protecting Rights. The Attorney General shall issue guidance to ensure the freedom to express the binary nature of sex and the right to single-sex spaces in workplaces and federally funded entities covered by the Civil Rights Act of 1964. In accordance with that guidance, the Attorney General, the Secretary of Labor, the General Counsel and Chair of the Equal Employment Opportunity Commission, and each other agency head with enforcement responsibilities under the Civil Rights Act shall prioritize investigations and litigation to enforce the rights and freedoms identified.

Sec. 6. Bill Text. Within 30 days of the date of this order, the Assistant to the President for Legislative Affairs shall present to the President proposed bill text to codify the definitions in this order.

Sec. 7. Agency Implementation and Reporting. (a) Within 120 days of the date of this order, each agency head shall submit an update on implementation of this order to the President, through the Director of the Office of Management and Budget. That update shall address:

1. changes to agency documents, including regulations, guidance, forms, and communications, made to comply with this order; and
2. agency-imposed requirements on federally funded entities, including contractors, to achieve the policy of this order.

1. The requirements of this order supersede conflicting provisions in any previous Executive Orders or Presidential Memoranda, including but not limited to Executive Orders 13988 of January 20, 2021, 14004 of January 25, 2021, 14020 and 14021 of March 8, 2021, and 14075 of June 15, 2022. These Executive Orders are hereby rescinded, and the White House Gender Policy Council established by Executive Order 14020 is dissolved.

2. Each agency head shall promptly rescind all guidance documents inconsistent with the requirements of this order or the Attorney General's guidance issued pursuant to this order, or rescind such parts of such documents that are inconsistent in such manner. Such documents include, but are not limited to:

1. "The White House Toolkit on Transgender Equality";
2. the Department of Education's guidance documents including:
 1. "2024 Title IX Regulations: Pointers for Implementation" (July 2024);
 2. "U.S. Department of Education Toolkit: Creating Inclusive and Nondiscriminatory School Environments for LGBTQI+ Students";
 3. "U.S. Department of Education Supporting LGBTQI+ Youth and Families in School" (June 21, 2023);
 4. "Departamento de Educación de EE.UU. Apoyar a los jóvenes y familias LGBTQI+ en la escuela" (June 21, 2023);
 5. "Supporting Intersex Students: A Resource for Students, Families, and Educators" (October 2021);
 6. "Supporting Transgender Youth in School" (June 2021);
 7. "Letter to Educators on Title IX's 49th Anniversary" (June 23, 2021);
 8. "Confronting Anti-LGBTQI+ Harassment in Schools: A Resource for Students and Families" (June 2021);
 9. "Enforcement of Title IX of the Education Amendments of 1972 With Respect to Discrimination Based on Sexual Orientation and Gender Identity in Light of *Bostock v. Clayton County*" (June 22, 2021);
 10. "Education in a Pandemic: The Disparate Impacts of COVID–19 on America's Students" (June 9, 2021); and
 11. "Back-to-School Message for Transgender Students from the U.S. Depts of Justice, Education, and HHS" (Aug. 17, 2021);
3. the Attorney General's Memorandum of March 26, 2021 entitled "Application of *Bostock v. Clayton County* to Title IX of the Education Amendments of 1972"; and
4. the Equal Employment Opportunity Commission's "Enforcement Guidance on Harassment in the Workplace" (April 29, 2024).

Sec. 8. General Provisions. (a) Nothing in this order shall be construed to impair or otherwise affect:

1. the authority granted by law to an executive department or agency, or the head thereof; or
2. the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.
 1. This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

2. This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

3. If any provision of this order, or the application of any provision to any person or circumstance, is held to be invalid, the remainder of this order and the application of its provisions to any other persons or circumstances shall not be affected thereby.

Donald J. Trump

The White House, January 20, 2025.

[Filed with the Office of the Federal Register, 11:15 a.m., January 29, 2025]

NOTE: This Executive order was published in the *Federal Register* on January 30.

Categories: Executive Orders : Gender ideology extremism, efforts to defend women against.

Subjects: Attorney General; Bureau of Prisons; Gender identity; Office of Personnel Management; Secretary of Health and Human Services; Secretary of Homeland Security; Secretary of Housing and Urban Development; Secretary of State.

DCPD Number: DCPD202500135.

**U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons**



**PROGRAM STATEMENT
Reintegration Units**

Approved by	 William K. Marshall III Director, Federal Bureau of Prisons
DPI	RSD
Number	5218.01
Date	March 19, 2026

1. PURPOSE AND SCOPE

This program statement provides operational procedures, standards, and guidelines for the management of Reintegration Units (RUs). RUs, formerly referred to as Reintegration Housing Units, support the mission of the Bureau of Prisons (Bureau) by reducing restrictive housing unit placements for inmates who are in long-term Protective Custody (PC) status. RUs facilitate favorable institutional adjustment, and prepare inmates to reintegrate into a general population setting and/or a community placement. Inmates residing on a RU will have access to treatment groups, reentry programs, and other services typically unavailable in restrictive housing units.

a. Program Objectives.

- Provide safe, less restrictive housing environments for inmates with PC concerns.
- Assist inmates who have safety concerns with reintegration from restrictive housing into a general population or a community setting through gradual adjustment to an open housing unit.
- Increase access to positive interactions with staff, programming, and peer support opportunities for inmates with PC concerns.
- Reduce Special Housing Unit (SHU) placement for inmates with PC concerns.
- Decrease inmate suicide risk related to PC concerns and SHU placement.

b. Institution Supplement. None.

2. STAFFING

The RU is supported by a multidisciplinary team consisting of staff from Unit Management, Psychology Services, and Correctional Services. Psychology Services staffing ordinarily

includes one Reintegration Psychologist (i.e., RU Psychologist) and two Specialty Treatment Program Specialists (i.e., Treatment Specialists) for every two housing unit sides. Correctional Services staffing is consistent with general population staffing requirements. Staff from all disciplines provide support to RU inmates through increased interaction, services, and programs.

3. DESIGNATION CRITERIA

Inmates are designated to these units based on their need for a safe, structured environment less restrictive than a Special Housing Unit (SHU) that is not integrated with the general population. RUs are not Psychology Treatment Programs and therefore do not require inmates to sign the BP-A0940, Agreement to Participate in Psychology Treatment Programs form or to volunteer for programming or unit placement. Rather, they function as housing units where treatment is available and encouraged but not required.

a. **Target Population.** RUs target medium and high security inmates identified as verified or unverified PCs. The target inmate has consistently failed in attempting to integrate into a general population setting, ordinarily at multiple institutions. Information from Correctional Services documenting the inmate's classification as a PC case and detailing the inmate's placement in SHU at previous institutions will be considered when determining appropriateness for placement in a RU.

b. **Rationale for Placement.** The inmate must meet one of the following criteria to be considered for the RU:

- The inmate refuses to enter general population at multiple institutions and their PC status cannot be verified by staff.
- The inmate is considered a verified PC case, ordinarily at multiple institutions.

c. **Security Level.** Ordinarily, only inmates classified as medium or high security are appropriate.

d. **Disciplinary Segregation (DS).** Ordinarily, inmates will only be designated to a RU if they are in DS status for refusing to return to general population. In accordance with the Program Statement **Special Housing Units**, inmates can be released from SHU early if it is determined they no longer require DS status. This provision may be useful for inmates in DS status for refusing to return to general population and are otherwise appropriate for a RU. See section 6 of this program statement for information regarding inmates already at a RU who are placed in SHU for DS.

e. **Mental Health Care Level.** Inmates are typically designated to a RU at an institution commensurate with their mental health care level.

4. REFERRAL PROCEDURE

To make a referral to a RU, the following information will be forwarded to the Designation and Sentence Computation Center (DSCC) via email:

- EMS-A409, Request for Transfer/Application of Management Variable form, signed by the Warden.
- Supporting documentation, including the threat assessment investigative report and rationale for recommended RU placement.

Ordinarily, inmates with a Security Threat Group (STG) gang status will not be designated to a RU.

Notification of Referral. An inmate who is referred to a RU will be notified of the pending referral. The inmate will be given the opportunity to be escorted from their SHU cell to ask questions and be provided with information about the RU. A Psychology Services staff member will be present when the referral notification occurs.

5. CONDITIONS OF CONFINEMENT

RU inmates will be provided regular direct access to Food Service, Trust Fund, Health Services, Education, and Recreation staff.

Unit. The RU is to be separated from general population and solely house RU inmates. The appearance of the unit is notably different from general population, with art displays/murals on the walls, encouraging slogans, and posters. Considering safety and security limitations, the unit must have areas for groups, meditation, and exercise equipment (e.g., treadmill, elliptical). Ordinarily, inmates must also be given regular access to these areas.

Movement. When it becomes necessary for inmates housed in the RU to leave the unit, whether for programming or otherwise, it is imperative they be kept separate from all general population inmates. Safety and security considerations are paramount any time RU inmates leave the confines of the unit.

Visiting. RU inmates are offered in-person visitation in accordance with the Program Statement **Visiting Regulations** and applicable Institution Supplements.

Outside Recreation. Except in emergency situations, RU inmates are offered one hour of outside recreation separate from all general population inmates at least five times per week.

Meals. RU inmates must be given the opportunity to eat at least two meals per weekday and one meal per weekend day in the institution cafeteria, except in extenuating circumstances.

Programming. Education, Recreation, Chaplaincy Services, and Psychology Services will offer programming throughout the week in the RU or ensure RU inmates have access to services in their respective departments.

Programming will address First Step Act (FSA), reentry, and mental health needs. RU Psychologists and Treatment Specialists will ordinarily have offices in the unit affording inmates increased access to mental health providers. The RU Psychologist will work with other departments to develop a daily, weekly, and monthly schedule with various programs and activities that provide structure for the unit. To encourage engagement in programming, the RU Psychologist will develop, implement, and oversee a structured behaviorally oriented incentive program.

6. PSYCHOLOGY SERVICES

Duties of RU Psychologists. The RU Psychologist works under the direct supervision of the Chief Psychologist. The RU Psychologist oversees a variety of treatment opportunities and interventions for inmates in the RU. The RU Psychologist works with Unit Management staff to review and consider the need for an inmate to remain in a RU or recommend alternate placement.

The RU Psychologist is the primary provider of diagnostic and mental health assessments within the unit. The RU Psychologist will assess each inmate's individual mental health needs, goals, and interests.

The RU Psychologist or designee facilitates annual training for all institution staff. This training will focus on practical RU information and relevant evidence-based interventions (e.g., trauma informed care, the risk-need-responsivity model, readiness for change).

The RU Psychologist will chair a monthly RU meeting subsequent to the weekly SHU multidisciplinary meeting with the Associate Warden of Psychology Services' oversight. The meeting will include the Captain, representatives from SIS, and RU Unit Management, as well as any other relevant staff. The goal of the meeting is to assess RU inmates without validated security concerns programming progress, safety needs, and willingness to return to general population. The multidisciplinary team must review redesignation options for these RU inmates every 12 months. For inmates on the unit for 18 months or more, treatment and safety needs must also be reevaluated. A detailed plan addressing relevant treatment (e.g., coping skill deficits or medication management issues) and/or security concerns (e.g., related to Central Inmate Monitoring or STG status) must also be developed with the goal of the inmate reentering general population within six months. This plan must also be reviewed monthly and updated as needed to ensure progress occurs. Initial and updated plans must be submitted to the Psychology Services Branch (PSB) Mental Health Treatment Coordinator overseeing RUs unless directed otherwise. Any RU inmates currently in SHU for disciplinary reasons will also be reviewed to determine if RU placement continues to be warranted or if a transfer is needed.

The RU Psychologist is responsible for the clinical and administrative supervision of Treatment Specialists assigned to the unit. Clinical supervision is conducted no less than one time per month and must be documented. Clinical supervision focuses on the development of the Treatment Specialist as an interpersonally effective clinician who utilizes evidence-based interventions. Supervision includes instruction, supervisor modeling, direct observation, intervention by the supervisor in the actual clinical process, and feedback. Clinical supervision is typically provided one-on-one but may be offered in a group setting occasionally.

Duties of Treatment Specialists. Treatment Specialists conduct Evidence Based Recidivism Reduction (EBRR) and Productive Activity (PA) groups, or other treatment protocols identified by the RU Psychologist with oversight from the Chief Psychologist and approval from the Central Office PSB. Each Treatment Specialist provides a minimum of 15 clinical contact hours per week. Groups may vary in frequency, from once or twice a week to daily. Treatment Specialists may facilitate groups in areas other than the RU.

When necessary, Treatment Specialists conduct individual clinical contacts focusing on increasing treatment motivation and teaching cognitive behavioral skills to reintegrate from a restrictive housing setting into a general population unit. Treatment Specialists also routinely meet with inmates individually to discuss treatment progress and develop or update treatment plans and goals. All clinical contacts will be documented in the Electronic Health Record (EHR).

Treatment Specialists routinely conduct non-clinical contacts to promote problem solving and facilitate positive interaction with staff. Non-clinical contacts also include discussion of setting and achieving life goals, and resolution of minor interpersonal problems. Non-clinical contacts do not always require documentation in the EHR. The RU Psychologist will advise Treatment Specialists of documentation expectations.

Treatment Specialists organize RU community events, implement the unit schedule, and assist with the implementation of the incentive opportunities. RU community committees (e.g., Holiday, Birthday, Wellness, Unit Beautification) are ordinarily overseen by Treatment Specialists. Treatment Specialists will work closely with Reentry Affairs and Recreation staff to support RU inmate access to volunteer opportunities and recreation events.

Treatment Specialists maintain an active presence in the RU by conducting rounds throughout the unit once per duty shift. Treatment Specialists attend inmate program review meetings which are conducted by Unit Management and held in accordance with Program Statement **Unit Management and Inmate Program Review**. Under the direction of the RU Psychologist, Treatment Specialists may provide Unit Management with recommendations related to inmate work assignments.

Protocols. All services offered by Psychology Services in the RU will be consistent with national programming approved through PSB (e.g., EBRR and PA groups, cognitive behavioral

interventions designed to address skill deficits). Approval for supplemental materials must be granted by PSB prior to use. Motivational strategies are used to engage inmates in treatment services (e.g., motivational interviewing, incentives). The RU Psychologist will develop a unit structure to include group activities and other programming opportunities.

Purpose of Programming. RU Psychologists and Treatment Specialists facilitate programming opportunities and clinical interventions to assist inmates in learning the skills necessary to effectively reintegrate to a general population unit, manage mental health symptoms, manage substance use disorders, and reduce the risk of recidivism. Target areas of clinical intervention are prosocial thinking and skill building, to include communication, social, behavioral regulation, and emotional self-regulation skills.

Treatment Planning. Recommendations for participation in psychology programming are determined by the RU Psychologist with input from the Treatment Specialists. Specific recommendations for mental health treatment and/or programs will be conveyed to the inmate and documented in the EHR. The RU Psychologist will consider recommendations provided by Unit Management that are intended to facilitate positive adjustment to the general population and/or community. These recommendations are typically communicated during intake screening, inmate program review meetings, and SHU meetings.

Inmates in RUs vary widely in their need for specific mental health treatment or programming. The following recommendations may be in addition to identified FSA needs:

- **Inmates with no recommended psychology programs.** Often, inmates with validated security concerns will not have psychology program recommendations, and the focus will be other programming, work activities, and other goals developed with Unit Management in accordance with Program Statement **Unit Management and Inmate Program Review**.
- **Inmates with recommended psychology programs but not requiring an individualized treatment plan.** In some cases, inmates may be recommended for general mental health groups, EBRR and/or PAs facilitated by Psychology Services. Not all psychology programs require a treatment plan, therefore, there may be times when an inmate does not have a treatment plan on record.
- **Inmates with recommended psychology programs and requiring an individualized treatment plan.** The requirement for an individualized treatment plan is determined on a case-by-case basis by the RU Psychologist. In contrast to Psychology Treatment Programs, the majority of inmates in RUs do not require individualized treatment plans. Individualized treatment plans are only required in cases where the inmate demonstrates mental health issue(s) requiring on-going psychological intervention or demonstrates the need for skill acquisition across multiple behavioral domains

Inmates declining to volunteer for recommended services will be encouraged to participate by the Treatment Specialists and Unit Management. Motivational strategies will be used by

Treatment Specialists to promote participation among these inmates. Treatment Specialists will document these efforts in the EHR, which will occur at least once per month.

Inmates who are not recommended for treatment services by the RU Psychologist may volunteer for psychology programming on the unit, typically PAs, and other activities provided by the RU Psychologist or Treatment Specialists. These inmates will be given an opportunity to participate in therapeutic groups when space is available. In some cases, inmates in the RU will decline to participate in Psychology Services treatment necessary to ensure adequate adjustment in the unit. In these cases, the RU Psychologist will consult with PSB to discuss management strategies and/or referral options.

7. UNIT TRANSFER

Unit Management will discuss goals and placement options with the inmate during inmate program review meetings. The RU Psychologist and Treatment Specialists will provide relevant information regarding applicable treatment goals, progress, and/or participation in voluntary Psychology Services programming for the inmate program review meetings in the Insight Application Suite. When appropriate, RU inmates will be recommended for transfer to lesser security level institutions or institutions likely to support their success in a general population setting. Any of the following indicators may suggest an inmate's need for transfer from the RU:

- The inmate's security, mental health, or medical care level increases or decreases.
- The inmate displays confidence to navigate a general population setting.
- The inmate requests to return to an institution's general population.
- The inmate presents a safety concern and/or is disruptive to the unit, as determined by Special Investigative Services (SIS) or the Captain.
- The inmate successfully participates in and completes programming and/or treatment goals set by Unit Management and/or Psychology Services.

The DSCC may consider Public Safety Factor Waivers, Lesser Security transfers, and/or nearer release transfers when supported by Unit Management and/or the RU Psychologist. Transfers may occur at any time during the inmate's placement in RU.

Occasionally RU inmates will require extended placement in the unit if their presence is not detrimental to the placement of other inmates and is supported by the RU Psychologist. If an inmate is designated to a RU for 24 months or more, and does not have verified security concerns, the RU Psychologist must consult with PSB, Central Office. For inmates with verified security concerns and designated to a RU for 24 months or more, SIS must consult with the Correctional Services Branch. These consultations must be documented. An inmate may be removed at any time from the unit if their behavior creates an immediate and/or ongoing problem for staff and/or other inmates as determined by the shift Lieutenant, SIS Lieutenant, or the Captain.

REFERENCES

Program Statements

Visiting Regulations

Special Housing Units

Psychology Treatment Programs

Unit Management and Inmate Program Review

Bureau Forms

BP-A0940 Agreement to Participate in Psychology Treatment Programs

EMS-A409 Request for Transfer/Application of Management Variable

ACA Standards

Performance-Based Standards and Expected Practices for Adult Correctional Institutions (5th Edition): 5-ACI-2C-02, 5-ACI-2E-02, 5-ACI-3D-03, 5-ACI-3D-04, 5-ACI-3D-08, 5-ACI-3D-18, 5-ACI-4A-01, 5-ACI-4A-04, 5-ACI-4A-05, 5-ACI-4A-07, 5-ACI-4A-08, 5-ACI-4A-09, 5-ACI-4A-25, 5-ACI-4A-27, 5-ACI-4B-31, 5-ACI-5A-04, 5-ACI-5A-05, 5-ACI-5A-06, 5-ACI-5B-01, 5-ACI-5B-11, 5-ACI-6A-22(M), 5-ACI-6A-28(M), 5-ACI-7D-11, 5-ACI-7D-14, 5-ACI-7E-06, 5-ACI-7F-05.

Performance-Based Standards and Expected Practices for Adult Local Detention Facilities (5th Edition): 5-ALDF-2E-02M, 5-ALDF-2E-03, 5-ALDF-2E-04, 5-ALDF-2E-05, 5-ALDF-2E-06, 5-ALDF-2E-09, 5-ALDF-2E-12, 5-ALDF-2E-13, 5-ALDF-2E-15, 5-ALDF-2E-19, 5-ALDF-2E-21, 5-ALDF-2E-22, 5-ALDF-2E-24, 5-ALDF-4C-23M, 5-ALDF-4C-28M

Records Retention Requirements

Requirements and retention guidance for records and information applicable to this program are available in the Records and Information Disposition Schedule (RIDS) on the Bureau's intranet site.

**U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons**



**PROGRAM STATEMENT
Management of Inmates with Gender Dysphoria**

Approved by	 William K. Marshall III Director, Federal Bureau of Prisons
DPI	RSD
Number	5260.01
Date	February 19, 2026

1. PURPOSE AND SCOPE

To establish professional guidelines for the mental health evaluation and treatment of inmates meeting the diagnostic criteria¹ for Gender Dysphoria² (GD) to assist their progress toward recovery, while reducing or eliminating the frequency and severity of symptoms and associated negative outcomes.

a. Program Objectives. Expected results of this program are:

- To ensure inmates diagnosed with GD receive timely, appropriate mental health services and individualized treatment programming, as clinically indicated. Treatment shall target psychological distress/dysphoria as well as any co-occurring mental health disorders and be tailored to the unique needs of the inmate.
- To allocate sufficient staff and resources to deliver appropriate services to such inmates.
- To enhance staff's understanding of the mental health issues associated with individuals diagnosed with GD and the appropriate treatment that accounts for the evolving scientific understanding.

b. Institution Supplement. None required.

¹ As defined by the Diagnostic and Statistical Manual of Mental Disorders- 5th Edition, Text Revision (DSM-5-TR); American Psychiatric Association, (2022).

² *Id.* at 511-520.

2. DEFINITIONS

Clinical Group Psychotherapy: a cognitive behavioral process by which a group of persons is led by a psychologist, licensed mental health professional, or qualified treatment specialist to guide interpersonal and intrapersonal growth through an examination of the persons' thoughts, feelings, experiences, and skills.

Gender Dysphoria (GD): a mental health diagnosis currently defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5 TR), or its replacement. It is a psychological disorder caused by clinically significant distress or impairment due to the perceived discrepancy between a person's expressed/experienced gender identity and his or her biological sex.

Gender Identity: a fully internal and subjective sense of self, disconnected from biological reality and sex and existing on an infinite continuum, that does not provide a meaningful basis for identification and cannot be recognized as a replacement for sex.

Individual Therapy: a collaborative treatment based on the therapeutic relationship between the patient and psychologist, licensed mental health professional, or qualified treatment specialist, including, but not limited to, cognitive behavioral and dialectical behavioral therapy.

Multidisciplinary Review Team (MRT): a multidisciplinary group of staff representing different disciplines, which has the responsibility for ensuring access to necessary assessment, treatment, continuity of care, and services to inmates in accordance with their identified mental health needs, and which collaboratively develops, implements, reviews, and revises the treatment plan. Additionally, institutions may request a review by the MRT of individual inmates based on treatment concerns or clinical consultation needs. The MRT is coordinated by the Psychology Services Branch (PSB), which is responsible for scheduling meetings, maintaining records, and documenting official notes. The MRT will consist of the following members (or their designee): (1) Psychology Services Branch (PSB) Administrator; (2) PSB, Chief of Mental Health; (3) Health Services Division (HSD) Chief Psychiatrist; (4) HSD Chief of Health Programs; (5) HSD Chief Pharmacist; (6) HSD Chief Social Worker; and (7) Women and Special Populations Branch (WASP) Administrator.

Psychoeducational Group Intervention: a didactic form of group therapeutic services designed to teach patients about their disorder and help them learn how to manage the related symptoms, behaviors, and consequences. These services may include workbook or homework activities, medication management, stress/anger management, prosocial skills training, coping skills exercises, and managing activities of daily living in a carceral setting.

Sex Trait Modification Surgeries: surgical procedures that seek to modify the person's physical characteristics to appear to align with the person's "gender identity" rather than the person's sex.

Examples of these surgeries include vaginoplasty, phalloplasty, orchiectomy, vulvoplasty, hysterectomy, oophorectomy, mastectomy, metoidioplasty, chest reconstruction, breast augmentation, hair removal, facial feminization surgery, and voice modification. These surgeries are also called “cross-sex,” “sex reassignment,” or “sex rejection” surgeries.

Social Accommodations: items, including cosmetics and clothing, used to alter the person’s appearance to align with the person’s “gender identity.” Examples of “social accommodations” include buttock padding, breast padding, binders, undergarments, makeup, and wigs.

Social Transition: the process by which a person begins to try to live and present in a way that aligns with their “gender identity” rather than the person’s sex. This typically involves various non-medical actions, such as the use of “social accommodations” to alter the person’s appearance to align with the person’s “gender identity.”

3. STAFF RESPONSIBILITIES

The following Bureau of Prisons (Bureau) components are responsible for ensuring consistent establishment of the programs, services, and resource allocations necessary for inmates diagnosed with GD.

a. Central Office

The Psychology Services Branch (PSB), Reentry Services Division, provides oversight and consultation regarding services as they apply to inmates with a diagnosis of GD, including consultation, assessment, and the provision of advice and guidance related to the identification, evaluation, and recommendations for treatment needs of inmates with GD. Therapy will focus on reducing distress associated with GD, or any other mental health concerns that may be present. Mental health care is provided in the context of a collaborative therapeutic relationship with the inmate. Crisis intervention services are offered to inmates who may be experiencing acute distress or acute symptoms of mental illness to prevent self-directed harm (in accordance with Program Statement PS 5324.08, Suicide Prevention Program) or to provide relief from symptoms of mental illness and to prevent further decompensation.

The Health Services Division (HSD) oversees the treatment of inmates for all medical and psychiatric diagnoses. Services are offered to inmates in response to referrals by staff, inmate requests, or situational factors. Clinical guidance derived from the current body of research will be provided at the direction of the Medical Director and will be used to inform the clinical medical and psychiatric care of inmates.

The Women and Special Populations Branch (WASP) oversees the provision of non-medical services to meet the needs of federally incarcerated women and other federally incarcerated populations, including those individuals diagnosed with GD.

b. Regional Offices

Regional Offices provide oversight and consultation to institutions regarding services and care provided to inmates, including those diagnosed with GD.

c. Wardens

Wardens will establish a local multi-disciplinary approach for the management of inmates diagnosed with GD. The Chief Psychologist is the primary point of contact in the institution for issues related to this population and will consult, as needed, with the Executive Team, Captain, Clinical Director, Unit Manager, or other individuals, as appropriate. Institutions will consult with the Region, Central Office, and the MRT as necessary to ensure inmates diagnosed with GD receive clinically necessary mental health programming and medical services.

4. SCREENING AND EVALUATION

a. Screening

Diagnostic screening and evaluation of GD can occur at any time throughout an inmate's incarceration. All diagnostic evaluations are documented in the electronic health record as a *Diagnostic and Care Level Formulation* note. If primary care medical providers are diagnosing GD, the diagnosis will be documented in the electronic health record as a *Clinical Encounter* note.

If an inmate reports or presents a documented history of GD before incarceration, Psychology staff will request the inmate to complete a BP-A0171 Record of Information Release form to authorize the Bureau to obtain the inmate's prior mental health records from community providers who diagnosed or treated the inmate. Similarly, Health Services staff will request completion of a BP-A0621, Authorization for Release of Medical Information form, to obtain prior medical records relevant to the inmate's care. Signed documents will be added to the electronic health record. These signed documents will be added to the electronic health record and Psychology staff will enter as a *General Administrative Note*. If the inmate refuses to sign the records release form, this refusal will also be documented in the electronic health record as a *General Administrative Note*.

As appropriate, a diagnosis of GD will be made by a mental health clinician or primary care medical provider. The diagnosis will be added to the electronic health record. At a minimum, the inmate will be classified and maintained as a Mental Health Care Level 2.

If referral to medical or psychiatric staff is needed, the mental health clinician will complete an electronic referral to Health Services and document that request in the electronic health record as part of a *Clinical Contact or Consultation* note.

b. Evaluation

A diagnosis of GD can encompass a diverse array of conditions, with widely differing characteristics depending on the patient's age of onset, mental health, intelligence, environment, and motivation for identifying as the opposite sex. Like many DSM-V psychiatric conditions, GD is complex and often accompanied by other psychiatric comorbidities.

All inmates diagnosed with GD will be individually evaluated. Anxiety, depressive, personality, and posttraumatic stress disorders are mental health disorders that may coexist in those with GD. Because any co-occurring medical or psychiatric disorders may complicate the treatment of GD, a complete diagnostic and psychiatric/medical assessment of those with GD will be performed by Psychology Services clinicians and Health Services, respectively. Documentation of this evaluation will be entered into the electronic medical record.

Mental health clinicians or primary care medical providers will conduct a detailed clinical interview, and consider the use of the following instruments (as applicable) to evaluate the inmate:

- Clinical interview
- Beck Depression Inventory-II (BDI-II)
- Beck Anxiety Inventory (BAI)
- Wechsler Adult Intelligence Scale, 5th Edition
- Kaufman Brief Intelligence Test- 2nd Edition (KBIT-2)
- Montreal Cognitive Assessment (MoCA)
- Personality Assessment Inventory (PAI)
- Columbia Suicide Severity-Rating Scale Lifetime Recent (C-SSRS)
- Beck Scale for Suicidal Ideation (BSS)
- Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5)
- Utrecht Gender Dysphoria Scale- Gender Spectrum (UGDS-GS)
- If diagnosed with an autism spectrum disorder (ASD), the inmate may be additionally assessed with the Adaptive Behavior Assessment System 3rd edition (ABAS-3)

The evaluation and testing results will be documented in the electronic health records as *Psychological Testing* with results summarized in the *Diagnostic Care Level Formulation* note. Primary care medical providers may document their diagnosis and evaluation of additional medical concerns or treatment needs as a *Clinical Encounter* note.

5. TREATMENT

Executive Order 14,168, *Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government*, 90 Fed. Reg. 8,615 (Jan. 30, 2025), prohibits the Bureau from expending federal funds for “any medical procedure, treatment, or drug for the

purpose of conforming an inmate's appearance to that of the opposite sex" "to the extent consistent with applicable law." *Id.* at 8,617-18. The Bureau will comply with this Executive Order unless compliance with the Executive Order is prohibited by a court injunction or court order. Though Executive Order 14,168 supports this policy, the Bureau also adopts this policy independently of Executive Order 14,168.

a. **Individualized Treatment Plan**

If treatment for GD is likely to be necessary based on the results of the foregoing evaluation, the following treatment protocol should be followed:

All clinicians will review available documentation in combination with clinical interview(s) to determine the appropriate treatments addressing all identified medical and psychiatric concerns. Because treatment is individualized, treatment plans are tailored to the specific clinical needs of the inmate.

In general, identified medical and psychiatric comorbidities should be addressed before treatment for GD proceeds. As appropriate, medical and psychiatric comorbidities should be addressed through psychotherapy, psychotropic medication, or other appropriate medically accepted interventions. When comorbidities are addressed before GD, further treatment for GD may be necessary and may proceed once these medical and psychiatric comorbidities are resolved or ruled out as the potential cause of GD.

Psychotherapy should be prioritized. Treatment should include, at a minimum, therapy in accordance with their mental health care level as outlined in Program Statement PS 5310.16, **Treatment and Care of Inmates with Mental Illness**. Additionally, other treatments, such as psychoeducational group interventions, may be added as clinically indicated. Treatment interventions will focus on managing the psychological distress/dysphoria, assisting with adjustment to incarceration, community re-entry, and strengthening resilience. Follow-up mental health care should target any associated emotional or behavioral problems and should emphasize supportive treatment modalities.

All clinicians will ensure individuals with GD are not experiencing acute distress during any clinical contact. If the individual is experiencing suicidal ideation, a suicide risk assessment and appropriate protocols related to decreasing distress will be prioritized (in accordance with Program Statement PS 5324.08, **Suicide Prevention Program**). The psychologist may deem it appropriate to refer the individual for trauma treatment, if clinically indicated. Additional areas of focus may include adjustment to incarceration, other mental health diagnoses, community re-entry, and strengthening resilience. Follow-up mental health care should target any associated emotional or behavioral problems and should emphasize supportive treatment modalities.

Psychotropic medication should be considered to determine if its use may alleviate the symptoms of GD.

Diagnosis and treatment of GD will be discontinued if it is determined by a mental or medical health professional that the inmate no longer meets the criteria for the diagnosis based on clinical outcomes. The treatment plan will be updated, and a *Diagnostic Care Level Formulation* note will be entered into the electronic health record to reflect the diagnosis as “Resolved.”

All clinicians shall ensure that individuals with GD receive informed care. The medical provider is responsible for ensuring that the inmate understands and signs the informed consent form, before any medication orders. Consent must be voluntary, and the inmate must be able to understand and appreciate the risks and potential side effects of the prescription. If the required documented evidence is insufficient, or if the inmate fails to sign the consent form, the clinician shall not prescribe medication or provide the procedure.

b. Availability of Sex Trait Modification Surgeries to Address Gender Dysphoria

In instances when an inmate is diagnosed with GD, the Bureau will not provide sex trait modification surgeries to address GD and the inmate will not receive sex trait modification surgeries to address GD.

For inmates who have had sex trait modification surgery, medical care will be provided as necessary to address any complications or resulting conditions, such as urethral stricture and pelvic infections.

c. Availability of Hormones to Address Gender Dysphoria

i. Inmates Not Currently Receiving Hormones to Address Gender Dysphoria

In instances when an inmate is diagnosed with GD but is not currently receiving hormones to address GD, the Bureau will not provide hormones to address GD and the inmate will not receive hormones to address GD. Such inmates will continue to have an individualized treatment plan to meet the inmate’s needs. The individualized treatment plan may include psychotherapy, group counseling, psychiatric services, and psychotropic medications.

ii. Inmates Currently Receiving Hormones to Address Gender Dysphoria

In instances when an inmate is previously and currently diagnosed with GD and is currently receiving hormones to address GD, the MRT shall review and approve or disapprove the tapering plan submitted by the Primary Care Provider for all such inmates. Each tapering plan shall consider the appropriate factors, such as the duration the inmate

has been receiving hormones to address GD, the initial rationale for receiving the hormone intervention, the response by the inmate to the intervention, and whether the inmate has undergone sex trait modification surgery.

For inmates that have recently begun receiving hormones to address GD, the Primary Care Provider shall develop a tapering plan that includes a rapid discontinuation of the hormone intervention.

For inmates that have been receiving hormones to address GD for an extended period of time, the Primary Care Provider shall develop a tapering plan that includes an appropriately paced discontinuation of the hormone intervention.

For inmates who (1) are post sex trait modification surgery or (2) have been receiving hormones to address GD for an extended period of time and develop severe physiological and psychological withdrawal effects from tapering, it may not be appropriate in all cases for the initial tapering plan to include cessation of hormones. But tapering plans should be reevaluated regularly with respect to cessation of hormones, including during the inmate's chronic care clinic appointments.

Medical and mental health professionals shall evaluate the inmate before beginning tapering. Based on that evaluation and patient-specific needs, medical and mental health professionals shall develop a monitoring and follow-up evaluation plan. All inmates who are tapering and were receiving mental health treatment before tapering shall continue to receive counseling and pharmacological treatment as appropriate as part of the inmate's individualized treatment plan. Tapering plans may be adjusted as necessary based on monitoring and follow-up evaluations, but the adjusted tapering plans must still be consistent with the purpose of this policy and based on all relevant factors, including security and prison-administration concerns.

Patients may submit a request for additional medical or mental health care or evaluation if they have acute concerns during the tapering process. All requests shall be considered in a reasonable amount of time in accordance with standard procedure, and decisions concerning such requests shall be based on all relevant factors, including security and prison-administration concerns.

d. Social Accommodations

The Bureau will not provide social accommodations, including to inmates diagnosed with GD, and the inmate will not receive social accommodations. If the inmate currently has social accommodations, the Bureau shall no longer provide the social accommodations and, when practicable, remove or confiscate the social accommodations. When appropriate, and in accordance with standard procedure, inmates may still have access to purchase items on the standardized list of Commissary items available to inmates in their facility.

6. DOCUMENTATION AND TRACKING OF MEDICAL AND MENTAL HEALTH INFORMATION

Medical and mental health information for this population will be maintained in the current electronic recordkeeping system or health record system in accordance with PS 6090.04, **Health Information Management** and PS 5310.17, **Psychology Services Manual**. Medical and mental health information is considered confidential and may only be released in accordance with appropriate laws, rules, and regulations.

7. ADMINISTRATIVE REMEDIES

Inmates who wish to seek formal review of any issue relating to this policy may use the procedures in PS 1330.18, **Administrative Remedy Program**.

8. SEVERABILITY, APPLICATION OF THIS POLICY AND NO PRIVATE RIGHT OF ACTION

If any provision of this policy, or the application of any provision of this policy to any individual or circumstance, is held to be invalid, the remainder of this policy and the application of its provisions to any other individuals or circumstances shall not be affected. The intent of this policy is for federal funds to not be expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex to the maximum extent permitted by law, including the Eighth Amendment to the U.S. Constitution.

Nothing in this policy shall prevent a prison official from providing care required by federal law, including the Eighth Amendment to the U.S. Constitution. The Bureau shall ensure that all inmates diagnosed with GD receive care in accordance with federal law, including the Eighth Amendment to the U.S. Constitution.

Nothing in this policy is intended, nor shall it be construed, to create a private cause of action.

REFERENCES

Program Statements

1330.18	Administrative Remedy Program (1/6/2014)
5310.17	Psychology Services Manual (8/25/2016)
5310.16	Treatment and Care of Inmates with Mental Illness (2/18/2025)
5324.08	Suicide Prevention Program (4/5/2007)
6031.04	Patient Care (3/14/2025)
6090.04	Health Information Management (3/2/2015)

Additional Resources for Clinicians

Diagnostic and Statistical Manual of Mental Disorders (DSM), most current version.

Performance-Based Standards and Expected Practices for Adult Correctional Institutions, 5th

Edition: 5-ACI-1C-09, 5-ACI-1D-12, 5-ACI-1D-13, 5-ACI-2C-02, 5-ACI-1D-08, 5-ACI-3D-05, 5-ACI-3D-08(M), 5-ACI-3D-09, 5-ACI-3D-10, 5-ACI-3D-11, 5-ACI-3D-12, 5-ACI-3D-13, 5-ACI-3D-14, 5-ACI-3D-15, 5-ACI-3D-16, 5-ACI-6A-21(M), 5-ACI-6A-32(M), 5-ACI-6C-14(M).

Performance-Based Standards and Expected Practices for Adult Local Detention Facilities,

5th Edition: 5-ALDF-2A-27, 5-ALDF-2A-30, 5-ALDF-2A-32, 5-ALDF-6B-03, 5-ALDF-2C-03, 5-ALDF-4C-23M, 5-ALDF-4C-29M, 5-ALDF-4D-22, 5-ALDF-4D-23, 5-ALDF-4D-24, 5-ALDF-4D-25, 5-ALDF-4D-26, 5-ALDF-4D-27M, 5-ALDF-4D-28, 5-ALDF-4D-29, 5-ALDF-7B-08, 5-ALDF-7B-10, 5-ALDF-7B-11.

Records Retention

Requirements and retention guidance for records and information applicable to this program are available in the Records and Information Disposition Schedule (RIDS) on Sallyport.

[Oral Argument Not Yet Scheduled]

Nos. 25-5099, 25-5101, 25-5108 (consol.)

**IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT**

JANE DOE, et al.; JANE JONES, et al.; MARIA MOE,
Plaintiffs-Appellees,

v.

PAMELA BONDI, in her official capacity as Attorney General of the United States, et al.;
DONALD J. TRUMP, in his official capacity as President of the United States, et al.,
Defendants-Appellants.

On Appeal from the United States District Court for the District of Columbia

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CERTIFICATE OF PARTIES, RULINGS, AND RELATED CASES

Pursuant to D.C. Circuit Rule 28(a)(1), undersigned counsel certifies as follows:

A. Parties and Amici

Plaintiffs in district court, and appellees here, are nineteen people in the custody of the Federal Bureau of Prisons. With the permission of the district court, Plaintiffs-Appellees are proceeding pseudonymously in this litigation. *Jones v. Bondi*, Dkt Nos. 14, 47; *Doe v. Bondi*, Dkt. 7; *Moe v. Trump*, Dkts. 7, 67. Their pseudonyms are Jane Doe, Mary Doe, Sara Doe, Emily Doe, Zoe Doe, Tori Doe, Olivia Doe, Susan Doe, Lois Doe, Sally Doe, Wendy Doe, Rachel Doe, Ellen Doe, Jane Jones, Amy Jones, Barbara Jones, Carla Jones, Donna Jones, and Maria Moe.¹

Defendants in district court, and appellants here, are Donald J. Trump, in his official capacity as President of the United States; Pamela Bondi, in her official capacity as Attorney General of the United States; and William K. Marshall III, in his official capacity as Director of the Federal Bureau of Prisons.² Defendant Donald J. Trump is only a party in *Moe v. Trump*. There were no additional parties

¹ Plaintiff Sophia Doe voluntarily dismissed her claims on May 12, 2025. *Doe v. Bondi*, ECF No. 80.

² This action was originally brought against Defendant James R. McHenry, III, in his official capacity as Acting Attorney General of the United States, and William Lothrop, in his official capacity as Acting Director of the Federal Bureau of Prisons. Attorney General Bondi and Director Marshall were automatically substituted as parties under Federal Rule of Civil Procedure 25(d) and Federal Rule of Appellate Procedure 43(c)(2).

and no *amici curiae* in the district court. One *amicus curiae* brief was filed on May 16, 2025, by Idaho, Indiana, 23 other states, and the Arizona Legislature in support of Appellants. Dkt. No. 2116284.

B. Rulings Under Review

The Honorable Royce C. Lamberth issued initial orders granting Plaintiffs' motions for preliminary injunctions on February 18, February 24, and March 19, 2025, in *Doe v. Bondi* (Dkt Nos. 44, 55, 68); March 10, 2025, in *Moe v. Trump* (Dkt. No. 62); and February 24 and March 3, 2025, in *Jones v. Bondi* (Dkt Nos. 28, 46). Some of the orders are available at *Doe v. Bondi*, No. 1:25-cv-286, 2025 WL 596653 (D.D.C. Feb. 24, 2025); *Doe v. McHenry*, No. 1:25-cv-286, 2025 WL 596651 (D.D.C. Feb. 18, 2025); *Jones v. Bondi*, No. 1:25-cv-401, 2025 WL 923117 (D.D.C. Feb. 24, 2025); and *Jones v. Bondi*, No. 1:25-cv-401, 2025 WL 923755 (D.D.C. Mar. 3, 2025). *See also* JA168–69 (*Doe* Feb. 18 Order), JA185–88 (*Doe* Feb. 24 Order), JA240–43 (*Doe* Mar. 19 Order), JA333–34 (*Jones* Feb. 24 Order), JA445–49 (*Jones* Mar. 3 Order), and JA569–71 (*Moe* Mar. 10 Order). The district court issued renewed preliminary injunctions in all three cases on May 15, and May 22, 2025. *See* JA954–62.

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C. Related Cases

This case has not previously been before this Court. There is one related case for purposes of D.C. Circuit Rule 28(a)(1)(C): *Kingdom v. Trump*, No. 1:25-cv-00691-RCL (D.D.C.).

/s/ Kara Janssen

Kara Janssen

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GLOSSARY

APA	Administrative Procedure Act
BJS	Bureau of Justice Statistics
BOP	Federal Bureau of Prisons
EO	Executive Order
JA	Joint Appendix
PI	Preliminary Injunction
PLRA	Prison Litigation Reform Act
PREA	Prison Rape Elimination Act
SHU	Segregated Housing Unit
TEC	Transgender Executive Council
TRO	Temporary Restraining Order

INTRODUCTION

This case concerns nineteen transgender women whom the Federal Bureau of Prisons (“BOP”) previously determined, after individualized assessments, should be housed in women's facilities for their safety and security. The district court did not abuse its discretion by ordering the Government to maintain Plaintiffs’ housing status while their claims proceed.

These women are a very small subset—less than one percent—of all transgender individuals in BOP custody, and they were placed in women’s facilities due to their unique vulnerabilities. All have undergone extensive medical treatment to transition and live as women. Some have only ever been housed in women’s facilities due to their obvious vulnerability to sexual violence. Others were sexually assaulted when previously held in men’s prisons. All were placed in women's facilities based on BOP's careful evaluation of regulatory factors designed to protect vulnerable prisoners from violence.

That changed when President Trump issued Executive Order 14168 (“EO 14168” or “the Executive Order”) on January 20, 2025. The Executive Order requires BOP to transfer these women to men's prisons regardless of their individual circumstances. BOP concedes it has no discretion to consider the Plaintiffs’ safety or its own prior determinations when following this mandate. The Executive Order strips away individualized protections that took nearly a

decade to develop under the Prison Rape Elimination Act (“PREA”), replacing them with a categorical mandate that ignores the serious risks these particular women face.

The court’s preliminary injunctions were amply supported by Plaintiffs’ evidence of the violence and self-harm they are likely to suffer if transferred from women’s prisons. Plaintiffs are likely to succeed in showing that the categorical transfer policy mandated by the Executive Order violates their Eighth Amendment rights, and violates the Administrative Procedure Act by discarding duly promulgated PREA regulations without notice and comment, and by failing to provide any reasoned justification for the policy.

The preliminary injunctions should be affirmed. They preserve the housing arrangements that BOP itself determined were necessary to ensure these women's safety, pending resolution of Plaintiffs' constitutional and statutory claims.

JURISDICTIONAL STATEMENT

Plaintiffs invoked the district court’s jurisdiction under 28 U.S.C. §§ 1331, 2201, and 2202. JA201–02; JA340; JA461. The district court issued initial orders granting Plaintiffs’ motions for preliminary injunctions in February 2025, and the district court issued renewed preliminary injunctions on May 15, and May 22, 2025. JA954–62. The Government filed timely notices of appeal of those preliminary injunction orders, and this Court consolidated its appeals on June 12,

2025. This Court has jurisdiction under 28 U.S.C. § 1292(a)(1).

STATEMENT OF THE ISSUES

Did the district court abuse its discretion in finding that, based on their individual histories and circumstances, the evidence showed that these individual Plaintiffs would likely face a substantial risk of serious harm if they are transferred from women's facilities and that prison officials likely knew of and disregarded that risk?

Are Plaintiffs likely to succeed in showing that Defendants' adoption and implementation of the challenged EO violates the Administrative Procedure Act ("APA") because it directly conflicts with binding PREA regulations, was adopted and issued without notice and comment, lacks a reasoned explanation, and/or is arbitrary and capricious?

Did the district court abuse its discretion in finding that Plaintiffs are at immediate risk of irreparable harm and that the balance of equities and public interest weigh in favor of preliminary relief?

PERTINENT STATUTES AND REGULATIONS

Pertinent statutes and regulations are reproduced in the addendum to this brief.

STATEMENT OF THE CASE

I. Plaintiffs Are a Uniquely Situated Small Group of Transgender Women in BOP Custody Who Have Spent Extended Time (for Some, Their Entire Incarceration) Living in Women’s Facilities.

Plaintiffs³ are a uniquely situated group of transgender women⁴ incarcerated in BOP women’s facilities who have undergone extensive medical treatment to transition and live as women and are regarded as women by the facilities in which they reside. Every Plaintiff has been designated and placed in women’s housing by BOP. All Plaintiffs receive ongoing female hormone treatments from BOP. *See, e.g.*, JA645 ¶ 3; JA739–40 ¶¶ 4, 8; JA814 ¶ 3; JA903–05 ¶¶ 4–10. Some have been on hormones for decades, and many began hormone treatment long before their incarceration. *See, e.g.*, JA920, 969 ¶ 2. Many have also undergone surgical procedures as part of their transitions, including [REDACTED] [REDACTED]. *See, e.g.*, JA286, 740 ¶ 5; JA232, 703 ¶ 6; JA916, 965 ¶ 8; JA947, 996 ¶ 5; JA951, 1000 ¶ 3. They are referred to as women; most have legally changed their names or gender markers on official records and

³ Plaintiffs—assuming pseudonyms to protect their identities—are Jane, Mary, Sara, Emily, Zoe, Tori, Olivia, Susan, Lois, Sally, Wendy, Rachel, and Ellen Doe, *see* JA189; Jane, Amy, Barbara, Carla, and Donna Jones, *see* JA335; and Maria Moe, *see* JA490. Plaintiff Sophia Doe voluntarily dismissed her claims on May 12, 2025. *Doe v. Bondi*, ECF No. 80.

⁴ Plaintiffs use the term “transgender women” to describe themselves, which is consistent with the approach of the United States Supreme Court. *See United States v. Skrametti*, 145 S. Ct. 1816, 1830 n.2 (2025).

documents. *See, e.g.*, JA286, 740 ¶ 6; JA375, 809 ¶ 18; JA947, 996 ¶ 6; JA951, 1000 ¶ 3.

After individualized assessments of their health and safety risks, BOP assigned Plaintiffs to women's facilities, where they have consistently resided for long periods of time. *See, e.g.*, JA916, 965 ¶ 6 (Zoe Doe has been housed in women's prisons since [REDACTED]); JA385, 819 ¶ 10; JA943, 992 ¶ 6; JA947–48, 996–97 ¶ 6; JA951, 1000 ¶ 3 (Donna Jones, Wendy, Sara, and Mary Doe have been housed in women's prisons since [REDACTED]). Prior to EO 14168, Maria Moe, Jane Jones, Rachel Doe, Wendy Doe, and Sara Doe had only ever been housed with women. *See* JA233, 704 ¶ 7; JA286, 740 ¶¶ 8–10; JA492–93, 904–05 ¶¶ 7–9; JA947–48, 996–97 ¶ 6; JA951, 1000 ¶ 3.

BOP is aware that each Plaintiff has been diagnosed with gender dysphoria, which the agency has recognized as “a mental health diagnosis currently defined by DSM-5” that is “manifested by a stated desire to be the opposite sex and persistent discomfort with [one's] biologically assigned sex.” JA121. Gender dysphoria is a “serious medical condition” that is highly treatable through “transition, which enables a transgender person to live in a sex other than their birth sex, and hormone therapy to feminize or masculinize the body.” JA181–82 ¶¶ 3–4; *see also* JA17, 578 ¶ 6; JA92 ¶ 5. Treatment may also include “various surgeries.” JA182 ¶ 4. “[T]here are no alternative treatments for effectively

managing gender dysphoria.” *Id.* ¶ 6. Failure to treat gender dysphoria, or cessation of treatment, “constitutes a serious medical risk that can severely impact both physical and mental health,” including “[i]ncreased risk of suicidal ideation due to intensified gender dysphoria.” JA93 ¶ 10; *see also* JA95 ¶ 19 (“The medical community is well aware that the consequences of denying this care are predictable and dire.”). Based on their individual treatment histories, the district court found that transferring Plaintiffs from women’s prisons would exacerbate their gender dysphoria. JA186–87.⁵

II. Pursuant to BOP Policies and PREA Regulations, BOP Placed Plaintiffs in Women’s Facilities for Safety and Security Reasons.

PREA’s implementing regulations require BOP to conduct individualized assessments when housing transgender people, including whether to place them in women’s facilities. *See* 28 C.F.R. § 115.42. Under PREA, BOP must consider a variety of factors, including whether the individual has previously experienced sexual victimization and the individual’s perception of their own vulnerability, *id.* § 115.41(d)(8)–(9), and must use this information to make housing assignments based on “individualized determinations about how to ensure the safety of each

⁵ The district court explained that transferring these individuals from women’s prisons would exacerbate their gender dysphoria “because they will be subject to searches by male correctional officers, made to shower in the company of men, referred to as men, forced to dress as men, or simply because the mere homogenous presence of men will cause uncomfortable dissonance.” JA187 n.2.

inmate.” *Id.* § 115.42(a)–(b). The PREA regulations explicitly authorize housing transgender women in women’s facilities when doing so promotes safety and security. *Id.* § 115.42(c).

Until January 20, 2025, BOP used the “Transgender Executive Council” (“TEC”) to implement these PREA regulations and oversee facility designations. JA123–25. The TEC considered “an inmate’s security level, criminal and behavioral/disciplinary history, current gender expression, programming, medical, and mental health needs/information, vulnerability to sexual victimization, and likelihood of perpetrating abuse.” JA125. Since the Executive Order, BOP has disbanded the TEC and rescinded its policies implementing PREA’s individualized assessment requirements for housing transgender persons. *See* Appellants’ Opening Br. (“AOB”) at 9.

The district court made specific factual findings that “BOP determined that considering all statutorily and constitutionally required factors, a women’s facility was the appropriate facility” for these Plaintiffs. JA186. As the district court explained, BOP “is subjectively aware that transferring the plaintiffs to a male penitentiary would substantially increase the likelihood of them experiencing [a] parade of harms,” including “significantly elevated risk of physical and sexual violence,” and the exacerbation of “symptoms of their gender dysphoria.” JA164–65. BOP’s assessment under its prior policy that these Plaintiffs should be housed

in women's facilities reflects its awareness not only of the high risk of sexual violence for incarcerated transgender people in general,⁶ but that Plaintiffs' individual circumstances make this risk particularly acute. *Id.*

These safety concerns are not hypothetical. As detailed in their declarations, nearly all of the Plaintiffs who were previously housed in men's facilities were sexually assaulted when they were there, which ultimately resulted in their transfers to women's prisons to ensure their safety. *See, e.g.*, JA85, 646 ¶¶ 7–8; JA374–75, 808–09 ¶¶ 12, 17; JA382, 816 ¶ 8; JA385, 819 ¶¶ 6, 10; JA921, 970 ¶¶ 4, 6–7. Zoe Doe was stalked by a man in the showers of a medium-security men's facility. JA916, 965 ¶ 5. Donna Jones was raped in a shower at a men's facility, before she was transferred to a women's facility. JA385, 819 ¶ 6. Jane Doe was subjected to [REDACTED] while in a men's facility and continues to suffer from [REDACTED] as a result. JA85, 646 ¶¶ 7–8. Amy Jones was violently sexually attacked by three men while in a men's facility. JA374, 808 ¶ 12. Carla Jones was sexually assaulted in three separate men's facilities. JA382, 816 ¶ 8. Olivia Doe was “brutally raped” in a

⁶ For example, a 2014 study by the Department of Justice estimated that nearly 35% of transgender people incarcerated in state and federal prisons were sexually victimized between 2007 and 2012. Bureau of Just. Stats., U.S. Dep't of Just., *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12: Supplemental Tables*, 2 tbl. 1 (2014), https://bjs.ojp.gov/content/pub/pdf/svpjri1112_st.pdf.

men's facility, resulting in "medical complications." JA921, 970 ¶ 4. Emily Doe was raped while in a men's facility, JA934, 983 ¶ 4, as was Mary Doe "multiple times." JA943, 992 ¶ 6. And outside of BOP custody, Lois Doe was "raped twice" in a men's state facility. JA939, 988 ¶ 6.

Two of these assaults occurred in minimum-security men's facilities. JA374, 808 ¶¶ 10, 12; JA382, 816 ¶ 13. BOP knew of the assaults. *E.g.*, JA85, 646 ¶ 7; JA385, 819 ¶ 10; JA921, 970 ¶ 4; JA943, 992 ¶ 6. Such pervasive sexual assault is precisely the type of harm that PREA and its regulations seek to prevent. *See* 34 U.S.C. § 30302 (describing the first purpose of PREA as establishing "a zero-tolerance standard for the incidence of prison rape"). In addition, multiple Plaintiffs previously experienced suicidal ideation or engaged in suicide attempts or self-harm while housed in men's prisons. *See* JA381, 815 ¶ 5; JA915, 964 ¶ 4; JA921, 970 ¶ 5; JA934–35, 983–84 ¶¶ 3, 12. The district court was "unconvinced by the Government's proffered statistics attempting to show that a low-security men's facility" would be safe for these Plaintiffs. JA187 n.2.⁷

In sum, BOP determined that Plaintiffs' unique health and safety risks necessitated their placement in women's facilities. As part of that determination, BOP was also required to consider whether the placements would raise any

⁷ In addition, if any Plaintiffs are transferred by BOP, nothing restrains Defendants from transferring them to a men's prison with a higher security designation.

“management and security problems” for BOP staff or the other women housed with Plaintiffs. 28 C.F.R. § 115.42(c). The Plaintiffs’ housing assignments were repeatedly reaffirmed during the reassessments BOP was required to conduct at least twice a year. *Id.* § 115.42(d). BOP only sought to transfer Plaintiffs from women’s facilities after the issuance of the Executive Order.

III. EO 14168 Contravenes the PREA Regulations’ Mandatory Individualized Assessments and Strips BOP of its Discretion over Safe Housing Placements and Medical Care.

On January 20, 2025, President Trump issued Executive Order 14168, *Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government*, 90 Fed. Reg. 8615 (Jan. 20, 2025). The Order stripped BOP of discretion over housing assignments for transgender people, consistent with this Administration’s open disapproval of transgender people and its stated intention to deny them any legal recognition or protection. In relevant part, the Order: (1) categorically bars transgender women from women’s prisons, regardless of individual safety considerations; and (2) prohibits BOP from providing “any medical procedure, treatment, or drug for the purpose of conforming an inmate’s appearance to that of the opposite sex.” 90 Fed. Reg. at 8616–17 ¶¶ 4(a), (c).

EO 14168 is part of a broader pattern of targeted discrimination against transgender people by this Administration, including reversing protections for

transgender people in schools, healthcare, military service, federal funding, shelters, and more.⁸ In addition, federal agencies have systematically removed information about transgender individuals from government websites,⁹ including deleting the word “transgender” every time it appeared in agency documents. Most recently, the administration removed a dedicated suicide hotline available to transgender youth callers.¹⁰ BOP, for its part, issued a policy formalizing implementation of the Executive Order. Fed. Bureau of Prisons, Memorandum for All Chief Executive Officers (Feb. 21, 2025), <https://storage.courtlistener.com/recap/gov.uscourts.dcd.278186/gov.uscourts.dcd.278186.1.1.pdf>. And it

⁸ See, e.g., Exec. Order No. 14190, 90 Fed. Reg. 8853 (Jan. 29, 2025) (schools); Exec. Order No. 14187, 90 Fed. Reg. 8771 (Jan. 28, 2025) (healthcare); Exec. Order No. 14183, 90 Fed. Reg. 8757 (Jan. 27, 2025) (military service); Exec. Order No. 14168, 90 Fed. Reg. 8615 (Jan. 20, 2025) (federal funding and shelters).

⁹ See Mem. in Opp. to Pls.’ Mot. for Preliminary Injunction, *Doctors for America v. OPM*, No. 1:25-cv-00322-JDB, 2025 WL 1357700 (D.D.C. Mar. 24, 2025) (stating that “under Executive Order 14168, webpages could no longer use the word ‘gender’ or contain language promoting gender ideology” and that “every” federal agency “promptly began to implement” the Order); see also, e.g., Nico Lang, *Trump Is Purging Federal Websites of LGBTQ+ Content. Here’s What’s Been Affected So Far*, Them, (Feb. 7, 2025), <https://www.them.us/story/trump-administration-federal-websites-lgbtq-content-deleted-cdc-doe-usaid>; Judd Legum & Rebecca Crosby, *The NSA’s ‘Big Delete’*, Popular Information (Feb. 10, 2025), https://popular.info/p/the-nsas-big-delete?utm_campaign=post&utm_medium=web.

¹⁰ Devi Shastri, *Trump Administration Removing 988 Hotline Service Tailored to LGBTQ+ Youth in July*, Associated Press (June 18, 2025), <https://apnews.com/article/988-lgbtq-suicide-prevention-hotline-trump-382342828b381b6a32964f09fe9aa59c>.

announced the “[c]ancellation” of the Transgender Offender Manual that specified the risks transgender people face and the actions agency staff should take to mitigate those risks. *See* Fed. Bureau of Prisons, Program Statement Cancellation of Statement No. 5200.08, Cancellation No. PSC04-2025 (Feb. 25, 2025); *see also* JA120 (stating objective of Transgender Offender Manual is “[t]o enhance staff’s understanding of the increased risk of suicide, mental health issues and victimization”).

IV. Pursuant to EO 14168 and in Direct Violation of PREA Regulations, BOP Decided to Transfer Plaintiffs from Women’s Prisons.

In response to EO 14168, BOP officials moved rapidly to transfer transgender women housed in women’s prisons to men’s prisons. While BOP claims it undertook an individualized review of “the inmates’ assigned security level, disciplinary record, medical record, and psychology record” in making transfer decisions, *see* JA174, BOP’s review was triggered solely by the challenged Executive Order and was done for the sole purpose of removing transgender women from women’s facilities regardless of whether doing so would put them at increased risk of sexual violence. *See* JA186 (district court finding that “the *only* change in circumstances from when the initial housing determination was made to now is Executive Order 14168”). The timing and speed of the transfers further undercuts BOP’s claim that these decisions were based on a considered, individualized review.

BOP transferred Plaintiffs Ellen Doe, Rachel Doe, and Jane Jones from women's to men's facilities.¹¹ JA230, 701 ¶ 7; JA233, 704 ¶ 11; JA287, 741 ¶ 14. Once there, all three experienced continuous sexual harassment from male prisoners; invasive strip searches from male BOP officers; lack of access to women's clothing, including undergarments; and reasonably feared that they would be targeted for sexual violence.¹²

Male BOP officers conducted strip searches of Ellen Doe and Rachel Doe after they were moved from women's to men's prisons, requiring them to bend over, squat, and lift their breasts. JA230, 701 ¶ 7; JA233, 704 ¶ 10. Rachel Doe [REDACTED], and before EO 14168 she had only ever been housed in women's facilities, [REDACTED]. JA232-33, 703–04 ¶¶ 6–7. At the men's facility to which BOP transferred her after the Order, Rachel Doe experienced daily sexual harassment. JA233–34, 704–05 ¶ 11. She was not allowed to wear a bra, which made her even more vulnerable. JA234, 705

¹¹ BOP informed other Plaintiffs of their pending transfer to men's facilities due to the EO, and, through counsel, Plaintiffs quickly filed their complaints and applications for emergency relief before BOP had an opportunity to make the transfers. *See, e.g.*, JA930, 979 ¶ 8. BOP staff told certain Plaintiffs that they could not challenge the transfers because the transfers were required under the Executive Order. *See* JA494, 906 ¶ 12; JA88, 649 ¶ 14.

¹² Ellen, Rachel, and Jane were eventually transferred back to their assigned women's facilities and were protected from future transfers under the district court's preliminary injunctions. JA240–43, 333–34.

¶ 15. Ellen Doe's [REDACTED]

[REDACTED]; she experienced constant sexual harassment at the facility. JA230, 701 ¶ 8.

Plaintiff Jane Jones was transferred from a minimum-security women's facility to a medium-security men's facility. JA286–87, 740–41 ¶¶ 9, 14. Jane Jones has a vagina, and before her transfer she had never been housed in a men's prison. JA740 ¶¶ 5, 8. Officials held her in the Segregated Housing Unit (“SHU”) at the men's facility for four days in solitary confinement. JA288, 742 ¶ 16. She was made to wear male undergarments, held in a small cell with no outside or recreational time, permitted extremely limited communication with family members, told by BOP that her supply of female hormone medication would not be renewed, and subjected to 24-hour surveillance by male guards, including while using the restroom. JA287–88, 741–42 ¶¶ 15–17.

V. Plaintiffs Obtained Preliminary Injunctions Protecting Them from Transfers from Women's Prisons and Loss of Medication.

Plaintiffs brought three separate actions against the Government alleging that BOP, following the commands of EO 14168, had transferred or was preparing to transfer Plaintiffs from women's facilities and end Plaintiffs' access to necessary medical care, in violation of the Eighth Amendment, the Fifth Amendment, the Rehabilitation Act of 1973, the Administrative Procedure Act, and separation of powers principles. *See* JA213–23, 356–67, 472–81.

Plaintiffs sought a declaratory judgment that Sections 4(a) and 4(c) of EO 14168 violate their constitutional and statutory rights, as well as a permanent injunction prohibiting the Government from enforcing those provisions of EO 14168 and requiring BOP to maintain Plaintiffs' preexisting housing and medical treatment. JA223, 367, 481. In all cases, Plaintiffs obtained temporary restraining orders (TROs) and preliminary injunctions (PIs) to enjoin enforcement of Sections 4(a) and 4(c) as to the named Plaintiffs. *E.g.*, JA157–67.

The TROs and PIs were all supported by factual findings about the serious harms Plaintiffs would face in men's facilities. The Government mischaracterizes the basis for the PIs. For example, it suggests that the district court granted the second PI in *Doe* and the second PI in *Jones* solely because BOP had found women's facilities "appropriate" for them and "only reassessed their housing due to EO 14168." *See* AOB at 18, 20. In fact, in its second *Doe* PI order, the district court also relied on findings that the *Doe* Plaintiffs would be subjected to a significantly elevated risk of sexual assault as well as a predictable worsening of gender dysphoria if transferred. JA186 (incorporating reasoning from first *Doe* order); JA187 n.2 (referring to risk of sexual assault and exacerbated gender dysphoria). The second *Jones* PI order also relied on those factual findings, as well as the fact that "the named Plaintiffs here were housed in men's facilities early in their incarceration, during which period they experienced numerous

unspeakable harms including multiple rapes, suicide attempts, and severe psychological distress.” JA446–47.

The Government filed notices of appeal in all cases, challenging only the portion of the preliminary injunctions related to the Plaintiffs’ housing. AOB at 5. This Court consolidated the cases for appeal. Order at 2, No. 25-5099 (Apr. 30, 2025). The district court then granted Plaintiffs’ requests to issue renewed preliminary injunctions in all cases with the Government’s non-opposition. JA954–62. The renewed injunctions will expire on August 23, 2025. JA955, 958, 961. The Government filed notices of appeal from the renewed injunctions, and this Court consolidated those appeals with the Government’s appeals from the initial injunctions.

STANDARD OF REVIEW

“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. NRDC*, 555 U.S. 7, 20 (2008). On appeal from a preliminary injunction, this Court reviews the district court’s “findings of fact under the ‘clearly erroneous’ standard,” *Serono Lab ’ys, Inc. v. Shalala*, 158 F.3d 1313, 1318 (D.C. Cir. 1998), its “legal conclusions *de novo*,” and “its weighing of the four relevant factors for abuse of discretion.” *In re Fed.*

Bureau of Prisons' Execution Protocol Cases, 955 F.3d 106, 111–12 (D.C. Cir. 2020).

SUMMARY OF THE ARGUMENT

The district court properly granted preliminary injunctions to maintain the *status quo* and protect these uniquely situated Plaintiffs from sexual violence and other irreparable harm while this case proceeds.

Plaintiffs have demonstrated a strong likelihood of success on the merits of their Eighth Amendment claim. BOP previously conducted individualized assessments required by PREA and determined that these specific transgender women required placement in women's facilities for their safety and security. As the district court found, substantial evidence shows that these individuals are at risk of serious harm if transferred from women's to men's facilities. Defendants' disregard of these known risks is deliberate indifference.

Defendants' adoption of a new policy, replacing individualized determinations with a categorical rule that bars the placement of transgender women in a women's facility under any circumstances, also violates the APA. This new policy directly conflicts with existing PREA regulations, was adopted without the required notice and comment, and is arbitrary and capricious, as it reflects animus against transgender people and lacks any reasoned explanation.

The district court found that Plaintiffs face an imminent risk of irreparable

harm if transferred from women's facilities. The balance of equities and public interest favor Plaintiffs, as enforcement of an unconstitutional policy is never in the public interest, whereas Plaintiffs face serious irreparable harms including sexual violence and self-injury or suicide.

The Government's jurisdictional challenge fails. 18 U.S.C. § 3621(b) does not bar judicial review because Plaintiffs challenge a categorical policy mandated by Executive Order, not individual placement decisions under that statute.

Similarly, the Prison Litigation Reform Act ("PLRA") does not bar these claims because no administrative remedy was available. BOP lacked authority to provide relief from the Executive Order, and Plaintiffs faced immediate transfer without any opportunity to exhaust remedies.

The district court's preliminary injunctions are narrowly tailored, necessary to prevent irreparable harm, and contain adequate findings under the PLRA. The injunctions merely preserve the *status quo* by maintaining housing placements that BOP itself previously determined were appropriate for these specific individuals' safety and security.

ARGUMENT

I. PLAINTIFFS HAVE DEMONSTRATED A LIKELIHOOD OF SUCCESS ON THEIR CLAIMS.

A. The District Court Did Not Abuse its Discretion in Finding that Plaintiffs Are Likely to Succeed on the Merits of their Eighth Amendment Claim.

The U.S. Supreme Court made clear more than three decades ago that “prison officials have a duty ... to protect prisoners from violence at the hands of other prisoners.” *Farmer v. Brennan*, 511 U.S. 825, 833 (1994). “[D]eliberate indifference to serious medical needs of prisoners” violates the Eighth Amendment. *Estelle v. Gamble*, 429 U.S. 97, 104 (1976). To prove an Eighth Amendment claim, Plaintiffs must establish that the conditions of their incarceration “pos[ed] a substantial risk of serious harm” and that prison officials “kn[ew] of and disregard[ed] an excessive risk” to their “health or safety.” *Farmer*, 511 U.S. at 834, 837. The district court correctly found that Defendants’ decision to transfer Plaintiffs from women’s to men’s facilities—where Defendants know that Plaintiffs will face extremely high risks of physical and sexual violence, as well as excessive risks of self-harm and suicidality as a result of aggravated gender dysphoria—would likely violate the Eighth Amendment.

1. Plaintiffs Face Substantial Risks of Violence and Other Serious Harm If Transferred from Women’s Facilities.

To be clear, Plaintiffs do not argue that the Eighth Amendment requires every transgender woman to be housed in a women’s prison, nor did the district

court so find. Rather, as the district court found, the particular vulnerabilities of these women—the same vulnerabilities that led BOP to house them in women’s prisons in the first place—will result in predictable violence against them and a serious risk of self-harm if they are forced to live in men’s prisons. *See* JA164–65.

Every Plaintiff has been placed in women’s housing by BOP based on consideration of the relevant PREA factors. This distinguishes them both from other incarcerated transgender women and from men who may be vulnerable to sexual assault. If these Plaintiffs are transferred from women’s to men’s facilities, men in those facilities will know that BOP has transferred a woman to a men’s facility. As the district court found, this puts them at extremely high risk of sexual victimization.

BOP’s assessment that these Plaintiffs’ individual situations require placement in women’s facilities was well founded. Each has received extensive medical treatment in order to live as a woman. For all, this includes long-term hormone therapy. Some have had genital and other surgeries. Some have only ever been housed in women’s prisons. Many were previously sexually victimized in men’s facilities. This is an especially at-risk group, and all of these facts are known to BOP. That is why Plaintiffs are part of the small, unique group of transgender women whom BOP placed in women’s facilities.

Plaintiffs presented extensive evidence to the district court that they would

be at substantial risk of serious harm if BOP is permitted to move them from women's prisons. All Plaintiffs would be at an excessive and obvious increased risk of sexual assault in men's prisons because they have been classified and housed as women and have undergone significant medical treatment; many are outwardly indistinguishable from non-transgender women.¹³ *See supra* at 4–5. As set forth above, several Plaintiffs have had genital surgeries, and all receive female hormone therapy, which causes breasts to develop. *See supra* at 4.

Nearly all of the Plaintiffs who were previously housed in men's prisons were assaulted there (some multiple times), and they only escaped sexual violence when they were placed in women's prisons by the BOP. Olivia Doe was “brutally raped” in a men's facility; Amy Jones was violently attacked by two male prisoners; Donna Jones was raped in the shower; Jane Doe suffered [REDACTED]; [REDACTED]; Carla Jones was sexually assaulted in three separate men's facilities; Emily Doe was raped; Mary Doe was “raped multiple times.” *See supra* at 8–9. Others have a history of serious self-harm and suicidality when housed in men's facilities, as that placement caused their gender dysphoria symptoms to worsen. *See, e.g.*, JA815 ¶ 5; JA934 ¶ 3.

¹³ *Cf. Pichardo De Veloz v. Miami-Dade Cty.*, 756 F. App'x 869, 877 (11th Cir. 2018) (finding that housing a woman among men “poses an outrageous risk that she will be harassed, assaulted, raped, or even murdered”).

Plaintiffs' visible female characteristics, histories of sexual assault, and prior self-harm in men's facilities mark them as especially vulnerable members of a population that is already uniquely vulnerable to physical and sexual violence in men's facilities. *See, e.g.*, JA703 ¶ 6; JA808 ¶ 15; JA819 ¶ 6; *see also* Bureau of Just. Stats., U.S. Dep't of Just., *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12: Supplemental Tables*, 2 tbl. 1 (2014) (showing that from 2011 to 2012, 39.9% of transgender prisoners had experienced sexual violence in the past 12 months alone).¹⁴ When BOP undertook its individualized assessment of Plaintiffs pursuant to PREA, it determined that these nineteen highly vulnerable transgender women should each be assigned to a women's facility. BOP was required to reassess Plaintiffs' housing placements at least every six months thereafter, 28 C.F.R. § 115.42(d), and it opted to keep each Plaintiff in women's

¹⁴ The Supreme Court, federal courts of appeals, and federal district courts throughout the country have also recognized that transgender women face a high risk of sexual assault and abuse in men's prisons. *See, e.g.*, *Farmer*, 511 U.S. at 848-49; *Williams v. Kincaid*, 45 F.4th 759, 778–79 & n.11 (4th Cir. 2022); *Powell v. Schriver*, 175 F.3d 107, 115 (2d Cir. 1999); *Tay v. Dennison*, 457 F. Supp. 3d 657, 684 (S.D. Ill. 2020); *Doe v. District of Columbia*, 215 F. Supp. 3d 62, 77 (D.D.C. 2016); *Zollicoffer v. Livingston*, 169 F. Supp. 3d 687, 691, 696 (S.D. Tex. 2016); *Gilliam v. Dep't of Pub. Safety & Corr. Servs.*, No. MJM-23-1047, 2024 WL 5186706, at *12–13 (D. Md. Dec. 20, 2024); *Finnegan v. Kink*, No. 3:20-cv-00218-GCS, 2024 WL 1345632, at *11 (S.D. Ill. Mar. 29, 2024); *Doe v. Wash. State Dep't of Corr.*, No. 4:21-CV-5059-TOR, 2021 WL 2453099, at *5 (E.D. Wash. May 17, 2021); *Lojan v. Crumbsie*, No. 12-CV-0320 (LAP), 2013 WL 411356, at *4 (S.D.N.Y. Feb. 1, 2013).

facilities until the issuance of EO 14168.

The harms Plaintiffs face if removed from women's prisons are "sufficiently serious" to meet the objective element of the Eighth Amendment. *Farmer*, 511 U.S. at 834. As the Supreme Court has explained, "[b]eing violently assaulted in prison is simply not 'part of the penalty that criminal offenders pay for their offenses against society.'" *Id.* (quoting *Rhodes v. Chapman*, 452 U.S. 337, 347 (1981)). Federal courts of appeals have held that suicide and self-harm are also sufficiently serious to satisfy the Eighth Amendment's objective element. *See, e.g., Cope v. Cogdill*, 3 F.4th 198, 206 (5th Cir. 2021); *Comstock v. McCrary*, 273 F.3d 693, 703-04 (6th Cir. 2001); *Est. of Miller ex rel. Bertram v. Tobiasz*, 680 F.3d 984, 989 (7th Cir. 2012); *Disability Rts. Mont., Inc. v. Batista*, 930 F.3d 1090, 1098 (9th Cir. 2019); *Est. of Burgaz ex rel. Zommer v. Bd. of Cnty. Comm'rs*, 30 F.4th 1181, 1186 (10th Cir. 2022).

The district court did not clearly err in finding, based on the record in this case, that Plaintiffs, transgender women previously individually assessed and placed in women's facilities, were likely to succeed in showing that they would be exposed to a substantial risk of serious harm if transferred to men's prisons. This is especially true given the paucity of the evidence submitted by the Government. Instead of addressing Plaintiffs' individual circumstances, the Government's evidence consisted mainly of generalized statistics about overall rates of assault in

women's BOP facilities compared to rates of assault in men's BOP facilities. *See, e.g.,* JA658–59 ¶¶ 19–23; *see also* AOB at 36–39 (reiterating this evidence). But as the district court rightly found, the Government's "statistics do not disaggregate assaults against transgender inmates from overall rates of assault" and "are still consistent with the 'numerous government reports and regulations recognizing that transgender persons are at significantly elevated risk of physical and sexual violence,'" JA187, as well as the record evidence that Plaintiffs' individual circumstances make them even more vulnerable. The district court did not clearly err by concluding that it was "unconvinced by the Government's proffered statistics." *Id.*

Nor can the Government "minimize any risk to plaintiffs by, among other things, transferring them to low-security institutions with non-violent offenders." AOB at 49–50. The Government again ignores the specific risks these transgender women would face in men's facilities given their prior classification as women and their housing in women's facilities, medical histories, and past experiences of sexual assault in men's facilities. As described above, multiple Plaintiffs have been assaulted by men in minimum-security men's facilities, and others faced pervasive sexual harassment in low-security men's prisons. *See supra* at 9, 13. In addition, if reclassified and transferred, nothing restricts BOP from moving any Plaintiff to a men's facility with a different security designation.

The Government also did not contest Plaintiffs’ evidence that “forcing a transgender woman to reside in a men’s facility ... will predictably worsen gender dysphoria and cause severe psychological distress,” and that this harm will be especially acute for individuals who have “lived in a sex different than their birth sex for a significant amount of time, including through use of medications and surgeries.” JA313, 753 ¶ 5; *accord*, e.g., JA86 ¶ 12; JA382 ¶ 14; JA922 ¶¶ 8, 10; JA935 ¶ 12 (Plaintiffs’ declarations attesting to their fears that their gender dysphoria will worsen). The district court therefore did not clearly err when it found that “placement in a male penitentiary *by itself* will exacerbate the symptoms of [Plaintiffs’] gender dysphoria.” JA187. Plaintiffs’ histories of self-injury, self-surgery, and suicidal ideation in men’s prisons show that this worsening gender dysphoria would put them at significant risk of harm. *See*, e.g., JA815 ¶ 5.¹⁵

2. Defendants Knew of and Disregarded These Substantial Risks.

The district court also did not clearly err in finding that the Government knew of and disregarded these substantial risks when it decided to transfer Plaintiffs to men’s prisons regardless of their individual vulnerabilities. As the

¹⁵ Defendants suggest Plaintiffs did not assert these harms below. AOB at 40. But Plaintiffs set forth and relied on these harms in their initial and amended complaint, e.g., JA191 ¶ 5; JA259 ¶ 7, in declarations by Plaintiffs and experts, e.g., JA86 ¶ 12; JA753 ¶ 5, and in multiple rounds of briefing, e.g., *Doe v. Bondi*, ECF No. 50-1 at 6; *Jones v. Trump*, ECF No. 21-1 at 6; *Moe v. Bondi*, ECF No. 31-1 at 4.

district court found, the Government did not “dispute the plaintiffs’ allegations that BOP is subjectively aware that transferring the plaintiffs to a male penitentiary would substantially increase the likelihood of them experiencing [a] parade of harms” including sexual assault and worsening gender dysphoria. JA165. The Government has never claimed that BOP is unaware of any of the salient facts about Plaintiffs’ histories of assault and abuse in men’s prisons, their surgical and medical treatment, or the other evidence that shows Plaintiffs’ likelihood of serious harm if transferred to men’s facilities.

Indeed, in previously deciding that Plaintiffs needed to be housed in women’s facilities, BOP determined that placement in a women’s facility “would ensure [their] health and safety.” 28 C.F.R. § 115.42(c). BOP is also obligated by PREA regulations to consider Plaintiffs’ specific vulnerabilities and previous experiences of sexual victimization. *Id.* § 115.41(d)(1)–(9). BOP’s determinations that Plaintiffs were among the 1% of transgender women who should be housed in women’s facilities shows that BOP was aware of the risks Plaintiffs would face in men’s prisons.

Moreover, BOP’s own statistics show that Plaintiffs are uniquely at risk within an already high-risk population. The most recently available government-collected data shows that transgender incarcerated people experience about 10 times the rate of sexual victimization compared to the general population. Bureau

of Just. Stats., U.S. Dep’t of Just., *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12: Supplemental Tables*, at 2 tbl. 1 (2014), https://bjs.ojp.gov/content/pub/pdf/svpjri1112_st.pdf (showing sexual victimization rates for transgender incarcerated people at 39.9% from 2011 to 2012); Bureau of Just. Stats., U.S. Dep’t of Just., *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12*, at 6 (2014) (estimating sexual victimization rates for the general prison population at 4.0% during the same period). “The vulnerability of transgender prisoners to sexual abuse is no secret.” *Zollicoffer*, 169 F. Supp. 3d at 691. The heightened risk transgender women face in men’s prisons is widely acknowledged by federal courts. *See supra* n.14.

The Government argues it did not act with deliberate indifference because BOP considered the risks to Plaintiffs when it decided *which* men’s prison it would transfer them to. AOB at 42–43. But the Government’s choice not to place Plaintiffs in the most dangerous men’s prisons does not cure its deliberate indifference. *Cf. Hudson v. McMillian*, 503 U.S. 1, 9 (1992) (holding that the Eighth Amendment does not require further proof of “some arbitrary quantity of injury” once elements of violation are established).

The Government also argues that its prior placement of Plaintiffs in women’s facilities was “not based solely on safety considerations.” AOB at 46. But the Government does not dispute that it assessed Plaintiffs’ “vulnerability to

sexual victimization” and their medical and mental health needs when it decided that *these* individuals needed to be housed in women’s prisons. *See id.* Those assessments put BOP on notice of Plaintiffs’ specific histories and vulnerabilities to serious harm in men’s facilities, including the fact that many Plaintiffs have been physically and sexually assaulted in men’s facilities before. *See* 28 C.F.R. §§ 115.41(d), 115.42(c) (requiring BOP to consider past experiences of “sexual victimization” in determining housing placements and to “ensure” a transgender person’s “health and safety” in determining whether to place them in a men’s or women’s facility); *see also id.* § 115.42(e) (requiring BOP to give “serious consideration” to a transgender person’s “own views with respect to his or her safety” in determining housing placements). The Government’s *post hoc* claim that it also considered other information does not erase BOP’s knowledge that Plaintiffs would be at excessive risk of harm in men’s prisons.

Finally, the Government claims that the deliberate indifference cases Plaintiffs cited below are inapposite because “[i]n each case, the court found that additional, case-specific factors heightened the risk of assault.” AOB at 45. The Government misunderstands Plaintiffs’ claim, as demonstrated by its attempt to distinguish Plaintiffs’ cases.

Plaintiffs have never argued, and the district court has not concluded, that all transgender women must be housed in women’s prisons to comply with the Eighth

Amendment. Instead, there are “additional, case-specific factors” showing that Plaintiffs—the tiny group of transgender women whom BOP previously determined needed to be housed in women’s facilities—would be at heightened risk of assault and self-harm if placed in men’s prisons. *Id.* These factors include Plaintiffs’ history of victimization—as in *Zollicoffer*, 169 F. Supp. 3d at 689–90 and *Stover v. Corrs. Corp. of Am.*, No. 12-cv-393, 2015 WL 874288, at *7 (D. Idaho Feb. 27, 2015)—and their medical treatment that has caused them to develop female sex characteristics—as in *Doe*, 215 F. Supp. 3d at 65 and *Lojan*, 2013 WL 411356, at *1, 4. The Government knows of the specific, serious risks Plaintiffs would face in men’s prisons and has chosen to disregard those risks to comply with the Executive Order. Nothing more is required to prove Plaintiffs’ Eighth Amendment claim. *Farmer*, 511 U.S. at 837.¹⁶

B. Plaintiffs Are Also Likely to Prevail on Their Claims Under the Administrative Procedure Act.

This Court “review[s] the district court’s judgment, not its reasoning,” and “may affirm on any ground properly raised.” *Jones v. Bernanke*, 557 F.3d 670, 674 (D.C. Cir. 2009). Plaintiffs argued below that BOP’s implementation of EO

¹⁶ To the extent the Government suggests that BOP has unfettered discretion to reweigh policy priorities affecting housing assignments, *see* AOB at 47–48, that cannot justify its disregard of the known and substantial risks of serious harm to Plaintiffs. Although BOP has significant discretion to set prison housing policy, it still must comply with the Constitution.

14168 violates the APA, 5 U.S.C. § 706(2), because it is arbitrary and capricious, not in accordance with law, and revokes PREA regulations without following the procedures necessary to amend or rescind those regulations. *See, e.g., Doe v. Bondi*, ECF No. 81-1 at 8; ECF No. 50-1 at 19–23. Agency actions implementing an executive order are subject to APA review. *See, e.g., Nebraska v. Su*, 121 F.4th 1, 15–16 (9th Cir. 2024); *see also Chamber of Com. of U.S. v. Reich*, 74 F.3d 1322, 1327 (D.C. Cir. 1996).

BOP’s decision to transfer Plaintiffs to men’s prisons in compliance with EO 14168 is a final agency action. *See Bennett v. Spear*, 520 U.S. 154, 177–78 (1997); *see also* AOB at 12–13 (acknowledging that BOP decided to transfer Plaintiffs and told Plaintiffs they would be transferred).

1. Defendants’ Implementation of the Executive Order Violates Notice and Comment Requirements

PREA regulations have long required BOP to make individualized determinations, considering both men’s and women’s facilities, about where to house transgender individuals. *See* 28 C.F.R. § 115.42(c). These regulations were promulgated through notice and comment rulemaking. *See* National Standards to Prevent, Detect, and Respond to Prison Rape, 77 Fed. Reg. 37106, 37204 (June 20, 2012); *see also* 5 U.S.C. § 553.

The APA requires agencies to “use the same procedures when they amend or repeal a rule as they used to issue the rule in the first instance.” *Perez v. Mortg.*

Bankers Ass’n, 575 U.S. 92, 101 (2015). As this Court has explained, “‘an agency issuing a legislative rule is itself bound by the rule until that rule is amended or revoked’ and ‘may not alter [such a rule] without notice and comment.’” *Clean Air Council v. Pruitt*, 862 F.3d 1, 9 (D.C. Cir. 2017) (per curiam) (alteration in original) (quoting *Nat’l Fam. Plan. & Reprod. Health Ass’n, Inc. v. Sullivan*, 979 F.2d 227, 234 (D.C. Cir. 1992)).

BOP’s implementation of the Executive Order would repeal PREA regulations without following the necessary notice and comment procedures. The order instructs BOP to ensure that all transgender women in federal custody “are not detained in women’s prisons or housed in women’s detention centers,” regardless of their individual circumstances. EO 14168 § 4(a). This is directly contrary to PREA regulations that require BOP to make “case-by-case” determinations about “whether to assign a transgender or intersex inmate to a facility for male or female inmates” based on “the inmate’s health and safety, and whether the placement would present management or security problems.” 28 C.F.R. § 115.42(c).

Requiring “notice and comment before repeal of a final rule ‘ensures that an agency will not undo all that it accomplished through its rulemaking without giving all parties an opportunity to comment on the wisdom of repeal.’” *Humane Soc’y of the U.S. v. U.S. Dep’t of Agric.*, 41 F.4th 564, 568 (D.C. Cir. 2022)

(quoting *Consumer Energy Council of Am. v. FERC*, 673 F.2d 425, 446 (D.C. Cir. 1982)). For that reason, this Court has carefully scrutinized agency efforts to “effectively amend or withdraw the legal force of a rule without undergoing a new notice-and-comment rulemaking.” *Guedes v. Bureau of Alcohol, Tobacco, Firearms & Explosives*, 920 F.3d 1, 23 (D.C. Cir. 2019). An agency may not take action that “effectively repeal[s] a final rule while sidestepping the statutorily mandated process for revising or repealing that rule on the merits.” *Air All. Houston v. EPA*, 906 F.3d 1049, 1065 (D.C. Cir. 2018). Nor may it “substantively alter[.]” the requirements of the rule without following appropriate procedures for the rule’s amendment or repeal. *Liquid Energy Pipeline Ass’n v. FERC*, 109 F.4th 543, 548 (D.C. Cir. 2024); *see also NRDC v. EPA*, 643 F.3d 311, 320–21 (D.C. Cir. 2011).

These concerns are especially acute here. It took more than eight years after the enactment of PREA in 2003 to finalize the regulations that the Executive Order unravels. The housing requirements of the regulations reflect a deliberate balancing of the interests of prison administrators and the needs of incarcerated transgender people. BOP may not “simply disregard rules that are still on the books.” *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009). BOP’s choice to “depart from a prior policy *sub silentio*” violates its procedural obligations under the APA. *Id.*

2. BOP's Action is Arbitrary and Capricious and Not in Accordance with Law.

BOP's implementation of the Executive Order is also arbitrary and capricious and not in accordance with law. *See* 5 U.S.C. § 706(2)(A). BOP has provided no reasoned explanation for its new policy that categorically forbids Plaintiffs from ever being housed in their current facilities or other women's facilities—facilities to which BOP assigned Plaintiffs based on individualized determinations, *see* 28 C.F.R. § 115.42, and in which Plaintiffs have been housed for months or years.

The APA requires agencies “to engage in reasoned decisionmaking” through a “logical and rational” process. *Nw. Immigrant Rts. Project v. U.S. Citizenship & Immigr. Servs.*, 496 F. Supp. 3d 31, 70 (D.D.C. 2020) (quoting *DHS v. Regents of the Univ. of California*, 591 U.S. 1, 16 (2020) and *Allentown Mack Sales & Servs., Inc. v. NLRB*, 522 U.S. 359, 374 (1998)). When an agency departs from prior policy, it must show “that there are good reasons for [the new policy], and that the agency believes it to be better.” *Fox Television Stations*, 556 U.S. at 515. The agency cannot disregard the facts and circumstances that formed the basis of the prior policy without providing “a reasoned explanation.” *Id.* And an agency's decision is arbitrary or capricious if it “entirely failed to consider an important aspect of the problem.” *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

BOP failed to meet the requirements for reasoned decisionmaking, as it admits its decision started and ended with the Executive Order. Responding to Plaintiffs' APA claim before the district court, the Government failed to offer any justification independent of the Executive Order. Instead, the Government stated only that "[t]he Executive Order has articulated why the Executive has changed its policy." Defs' Resp. to Pls.' Mot. for TRO, *Doe v. Bondi*, ECF 53-1 at 36; Defs' Resp. to Pls.' Mot. for TRO, *Jones v. Trump*, ECF 24 at 34.

But an "executive order does not exempt [an agency] from basic APA requirements of reasoned decisionmaking." *Su*, 121 F.4th at 15; *see also AIDS Vaccine Advoc. Coal. v. U.S. Dep't of State*, 766 F. Supp. 3d 74, 83 (D.D.C. 2025). Indeed, courts considering agency action taken pursuant to *this* Executive Order (No. 14168) have already held it arbitrary and capricious when the agency's justification was the Executive Order. *See Orr v. Trump*, — F. Supp. 3d —, 2025 WL 1145271, at *19 (D. Mass. Apr. 18, 2025); *Kingdom v. Trump*, No. 1:25-cv-00691-RCL, 2025 WL 1568238, at *9–10 (D.D.C. June 3, 2025). *Orr* considered a new State Department passport policy, the record of which revealed "that the State Department considered virtually nothing aside from the Executive Order's directive when it developed the [new] [p]olicy." *Orr*, 2025 WL 1145271 at *18–19 (observing that the Department made no factual findings and did not explain why facts supporting prior policy "no longer carry weight"). Just so here: the

Executive Order constitutes BOP's only justification for its new policy.¹⁷

BOP has thus failed to provide “a satisfactory explanation for its action.” *State Farm*, 463 U.S. at 43. Plaintiffs’ current housing designations are the result of individualized determinations pursuant to 28 C.F.R. § 115.42 to “ensure the inmate’s health and safety.” Mandating that BOP *disregard* those safety determinations is not rational, and the Order provides no explanation to reconcile the apparent conflict. The Executive Order “entirely fail[s] to consider an important aspect of the problem”: the extreme risks of rape, sexual and physical violence, and self-harm that Plaintiffs will face if transferred to men’s facilities. *State Farm*, 463 U.S. at 43. Put differently, the Executive Order entirely ignores the people who will be transferred and the known dangers those transfers pose. “To be sure, agency action is not arbitrary and capricious merely because it is bad for some identifiable population,” but “the APA *does* require an agency to take

¹⁷ The administrative record for APA claims consists exclusively of the record the agency made *before* it acted. *AT&T Info. Sys., Inc. v. Gen. Servs. Admin.*, 810 F.2d 1233, 1236 (D.C. Cir. 1987) (per curiam) (citing *Camp v. Pitts*, 411 U.S. 138, 142 (1973)). Courts “bar introduction of litigation affidavits” that “offer post-hoc rationalizations” when the contemporaneous record revealed “no rationalization at the agency level.” *Id.* The government endorsed this position when defending a different agency action taken to comply with Executive Order 14168. *See* Defs.’ Opp. to Pls.’ Mot. to Stay Agency Action and for PI, *Orr v. Trump*, No. 1:25-CV-10313-JEK, ECF No. 53 at 15 (D. Mass. March 12, 2025). The declarations of Rick Stover submitted to the District Court are thus not proper subjects of consideration for Plaintiffs’ APA claim.

actions that are rationally and demonstrably related to its stated goals, ... and give consideration to the reliance interests of those who may be harmed by a new policy.” *Kingdom*, 2025 WL 1568238, at *10. Because the Executive Order falls short of *Fox Television Stations’* and *State Farm’s* requirements, it cannot save BOP’s otherwise unsupported arbitrary and capricious action.

BOP’s implementation of the Executive Order is also arbitrary and capricious or “otherwise not in accordance with law,” 5 U.S.C. § 706(A)(2), because it directly violates the PREA regulations’ requirement that BOP conduct individualized assessments when determining whether to house transgender people in men’s or women’s facilities. *See* 28 C.F.R. § 115.42(c); *Williams v. Kincaid*, 45 F.4th 759, 778 (4th Cir. 2022) (holding that a categorical approach to housing decisions “flouts the case-by-case analysis federal law requires”); *see generally United States ex rel. Accardi v. Shaughnessy*, 347 U.S. 260 (1954) (establishing that agencies must follow their own regulations).¹⁸

The Government also acts in an arbitrary and capricious manner when it acts based on animus. *Robbins v. Reagan*, 780 F.2d 37, 50 n.20 (D.C. Cir. 1985). Animus may take the form of a “desire to harm a politically unpopular group,”

¹⁸ *Accardi* claims can be brought through an APA cause of action. *See Damus v. Nielsen*, 313 F. Supp. 3d 317, 335–36 (D.D.C. 2018); *Fed. Defs. of N.Y., Inc. v. Fed. Bureau of Prisons*, 954 F.3d 118, 130 (2d Cir. 2020).

U.S. Dep’t of Agric. v. Moreno, 413 U.S. 528, 534 (1973), or it may reflect “negative attitudes,” “fear,” or “irrational prejudice,” *City of Cleburne, Tex. v. Cleburne Living Ctr.*, 473 U.S. 432, 448, 450 (1985).

The text and sweeping scope of the Executive Order demonstrate animosity against transgender people. It makes it the official “policy of the United States” to purposefully exclude transgender people from any legal recognition or protection. EO 14168 §§ 2, 2(a). It defines “gender ideology” as “permitting the false claim that males can identify as and thus become women and vice versa”; orders all agencies to “remove all statements, policies, regulations, forms, communications, or other internal and external messages that promote or otherwise inculcate gender ideology”; and orders agencies to “end the Federal funding of gender ideology.” EO 14168 §§ 2(g), 3(e); *see also id.* § 3(g).

In short, the Executive Order declares a federal policy of denying the existence of transgender people. *See Orr*, 2025 WL 1145271, at *19 (“[T]he language of the Executive Order is candid in its rejection of the identity of an entire group—transgender Americans.”); *S.F. A.I.D.S. Found. v. Trump*, No. 25-cv-01824-JST, 2025 WL 1621636, at *14–15 (N.D. Cal. June 9, 2025) (similar). The “principal purpose and the necessary effect” of the Order is to “demean those persons who are” transgender. *United States v. Windsor*, 570 U.S. 744, 774 (2013). Although the Executive Order sets out other alleged purposes—promoting

women’s “dignity, safety, and well-being”; advancing “scientific inquiry, public safety, morale, and trust in government”; and “protect[ing] freedom of conscience”—the “sheer breadth” of the Order “is so discontinuous” with these purposes that it can only be explained by animus. *Romer v. Evans*, 517 U.S. 620, 632 (1996).

The Government’s broader attack on transgender people removes any doubt that animus is the principal driver of the Government’s challenged housing policy. The President has issued Executive Orders designed to strip protections from transgender people across multiple domains. *See supra* n.8 (listing Executive Orders). “Although aimed at different policy goals,” each of the above-mentioned Executive Orders, “in tone and language, conveys a fundamental moral disapproval of transgender Americans.” *Orr*, 2025 WL 1145271, at *14. The Executive Orders, including EO 14168, attack transgender people “not to further a proper [governmental] end but to make them unequal to everyone else.” *Romer*, 517 U.S. at 635. The Government’s policy is borne of animus and thus is necessarily arbitrary and capricious.

C. Plaintiffs’ Claims are Not Barred by the PLRA Or Any Other Statute.

1. 18 U.S.C. § 3621(b) Does Not Bar Judicial Review.

Section 3621(b) does not bar Plaintiffs’ challenges to BOP’s categorical policy implementing the Executive Order. The statute prohibits judicial review of

“a *designation* of a place of imprisonment *under this subsection*.” 18 U.S.C.

§ 3621(b) (emphasis added). BOP’s transfer of Plaintiffs from women’s facilities was not an individualized placement decision under § 3621(b). BOP transferred Plaintiffs pursuant to a categorical policy mandated by the Executive Order, not based on the factors in § 3621(b). *See* EO 14168, § 4(a); AOB at 1, 12.

Accordingly, because BOP’s actions fall outside § 3621(b)’s scope, the statute’s bar of judicial review does not apply.

In addition, as the district court correctly held, § 3621(b) does not preclude judicial review of Plaintiffs’ constitutional claims. JA160. “[W]here Congress intends to preclude judicial review of constitutional claims its intent to do so must be clear ... to avoid the ‘serious constitutional question’ that would arise if a federal statute were construed to deny any judicial forum for a colorable constitutional claim.” *Webster v. Doe*, 486 U.S. 592, 603 (1988) (quoting *Bowen v. Mich. Acad. of Fam. Physicians*, 476 U.S. 667, 681 n.12 (1986)). Congress did not do so in § 3621.¹⁹

¹⁹ *McBryde v. Comm. to Review Cir. Council Conduct*, 264 F.3d 52, 58, 60 (D.C. Cir. 2001) does not support the Government’s argument. In *McBryde*, this Court found clear and convincing evidence that Congress intended to deny judicial review of judicial disciplinary proceedings. *Id.* at 62–63. None of the unusual factors the Court relied on to reach its conclusion apply here. *See Ralls Corp. v. Comm. on Foreign Inv. in U.S.*, 758 F.3d 296, 309–10 (D.C. Cir. 2014) (describing the unique statutory language and legislative history relied on by this Court in *McBryde*).

The cases cited by the Government are inapposite because they all involved individualized placement decisions. *See Wills v. Barnhardt*, No. 21-1383, 2022 WL 4481492, at *1 (10th Cir. Sept. 27, 2022) (declining to review BOP’s decision on plaintiff’s transfer request); *Touizer v. U.S. Att’y Gen.*, No. 21-10761, 2021 WL 3829618, at *1–2 (11th Cir. Aug. 27, 2021) (per curiam) (rejecting plaintiff’s request for home confinement); *Jiau v. Tews*, 812 F. App’x 638, 639 (9th Cir. 2020) (rejecting plaintiff’s claims to the extent they challenged her placement in a prison rather than a residential re-entry center).

Moreover, the Supreme Court has held that a provision limiting judicial review of individual agency decisions does not preclude judicial review of statutory or constitutional challenges to blanket policies. *McNary v. Haitian Refugee Ctr., Inc.*, 498 U.S. 479, 492 (1991) (holding that a provision like § 3621(b), which limited judicial review of individual amnesty applications by immigrants, did not bar pattern and practice challenges to the INS’s processing of such applications); *see also, e.g., Ahmad v. Jacquez*, 860 F. App’x 459, 462 (9th Cir. July 1, 2021) (stating that § 3621(b) strips jurisdiction over individual transfer decisions but “does not preclude review of all challenges that might implicate individual designation decisions,” including challenges to generally applicable BOP policies (citing *McNary*, 498 U.S. at 492)). Like the analogous provision in *McNary*, the language of § 3621(b) refers to judicial review of individual decisions

rather than to general “challenges to unconstitutional practices and policies used by the agency” in making such decisions. 498 U.S. at 492. Plaintiffs here are not seeking review of individual placement decisions under § 3621(b) but rather of BOP’s adoption of a blanket policy requiring their transfer to men’s facilities regardless of their individual circumstances. As such, § 3621(b) does not bar judicial review of their claims.

2. Section 3625 Similarly Does Not Bar Plaintiffs’ APA Claims.

Any argument that 18 U.S.C. § 3625 bars Plaintiffs’ APA claims fails for the same reasons. That provision makes the APA inapplicable “to the making of any determination, decision, or order” under Title 18, Part II, Chapter 229, Subchapter C, of which the only relevant section is § 3621(b). 18 U.S.C. § 3625. “§ 3625 bars review of individualized housing determinations, not ... a challenge to a broad policy that informs the designation decision.” *Love v. Bureau of Prisons*, No. 24-CV-2571 (APM), 2025 WL 105845, at *11–12 (D.D.C. Jan. 15, 2025) (holding § 3625 “no bar to review” because “[p]laintiffs are not challenging their individual housing placements. They contest the BOP’s alleged discriminatory treatment of [a subset of prisoners] in the decision-making process”); *see also Jasperson v. Fed. Bureau of Prisons*, 460 F. Supp. 2d 76, 84 (D.D.C. 2006) (holding § 3625 no bar where plaintiff “challenges the rulemaking leading to the BOP policy that informed his confinement determination, rather than challenging the determination itself”).

Multiple circuit courts have reached the same conclusion. *See Richmond v. Scibana*, 387 F.3d 602, 605 (7th Cir. 2004) (distinguishing between contesting a housing assignment and contesting “the rules that will be used to decide” that placement); *see also Martin v. Gerlinski*, 133 F.3d 1076, 1079 (8th Cir. 1998) (explaining that “§ 3625 does not divest this court of jurisdiction to review whether the BOP exceeded its statutory authority by categorically considering sentencing enhancement factors”); *Fristoe v. Thompson*, 144 F.3d 627, 630–31 (10th Cir. 1998) (holding that section 3625 did not prevent judicial review of a BOP rule affecting sentencing reduction).

It is also well settled that § 3625 does not bar judicial consideration of Plaintiffs’ challenge to BOP’s failure to comply with the rulemaking provisions of the APA. *E.g.*, 5 U.S.C. § 553. As both the statute’s text and judicial decisions make clear, § 3625 does not apply to agency rulemaking. *See* 18 U.S.C. § 3625; *Martin*, 133 F.3d at 1079 (“[I]t is apparent” that § 3625 does not bar review of “rulemaking decisions.”).

3. The District Court Correctly Found that No Administrative Remedy Was Available.

Failure to exhaust administrative remedies is an affirmative defense under the PLRA, *Jones v. Bock*, 549 U.S. 199, 215–16 (2007), which “the defendants have the burden of pleading and proving,” *Chandler v. Fed. Bureau of Prisons*, 226 F. Supp. 3d 1, 6 (D.D.C. 2016). The Government cannot show that this

affirmative defense makes Plaintiffs unlikely to succeed on the merits because it concedes that BOP must implement the categorical policy mandated by the Executive Order without discretion to do otherwise. AOB at 32 (stating that “BOP lacks discretion to continue housing plaintiffs in female facilities under EO 14168”).

An aggrieved incarcerated person “must exhaust available remedies, but need not exhaust unavailable ones.” *Ross v. Blake*, 578 U.S. 632, 642 (2016) (citing 42 U.S.C. § 1997e(a)). A remedy is unavailable “where the relevant administrative procedure lacks authority to provide any relief.” *Id.* at 643 (citing *Booth v. Churner*, 532 U.S. 731, 736 & n.4 (2001)). Such is the case when BOP acts pursuant to a mandatory directive that divests it of any authority to provide relief. *Kaemmerling v. Lappin*, 553 F.3d 669, 675 (D.C. Cir. 2008).

In *Kaemmerling*, petitioner sought injunctive relief against BOP’s enforcement of a federal statute under which “BOP ha[d] no discretion not to collect [his] DNA, as the statute’s mandatory language indicates and as the BOP conceded.” *Id.* at 675. There was thus “no administrative process to exhaust.” *Id.* Similarly, here, Plaintiffs seek injunctive relief against BOP’s implementation of an executive order with mandatory language that requires BOP to transfer Plaintiffs from women’s prisons, as BOP concedes. *See* AOB at 32; *see also* EO 14168, § 4(a).

Moreover, BOP staff told Plaintiffs it lacked authority to provide relief.

JA494 ¶ 12 (Maria Moe “was told that [she] did not have an ability to challenge the transfer because it was required by Executive Order”); JA649 ¶¶ 13–14 ([REDACTED]

[REDACTED]”). The text of the Executive Order, BOP’s interpretation of it, and BOP staff statements to Plaintiffs all point to the same conclusion: BOP’s administrative process “operate[d] as a simple dead end—with officers unable ... to provide any relief.” *Ross*, 578 U.S. at 643.

The Government suggests that Plaintiffs should have exhausted administrative remedies anyway because BOP could have taken actions unrelated to the Executive Order to “protect [Plaintiffs’] safety,” such as “changes to housing and programming assignments, and protective custody.” AOB at 32. This contention ignores that Plaintiffs’ complaint arises out of an Executive Order that BOP is required to implement. BOP’s administrative process is not capable of changing the terms of the Order or overruling its mandates—just as the grievance process in *Kaemmerling* could not alter or invalidate the text of a binding federal statute, *see* 553 F.3d at 676 (emphasizing that the plaintiff was challenging “the enforceability of a statute rather than the prison’s method of enforcement”). The Government also cites *Savage v. United States Department of Justice*, 91 F.4th 480

(D.C. Cir. 2024). But in that case, this Court held that administrative remedies were available to a plaintiff challenging the terms of an order issued by the Department of Justice, reasoning that the administrative process “ends with review by the Department of Justice, which has the authority to modify or rescind” the order. *Id.* at 484. Because BOP lacked that authority here, Plaintiffs faced “a dead end” in challenging the application of the Executive Order to them. *Ross*, 578 U.S. at 643.

Administrative remedies were unavailable in this case for another reason as well: Plaintiffs faced immediate danger and could not have received relief before being exposed to the substantial risk of serious harm posed by transfer. Some Plaintiffs were in fact transferred to men’s facilities without time or opportunity to file a grievance. JA230, 233–34. Others were moved to segregated housing and told they would be transferred imminently. *See, e.g.*, JA86, 88, 493–94.

Exhaustion is not required when the administrative process cannot possibly remedy the threatened harm in time. *Fletcher v. Menard Corr. Ctr.*, 623 F.3d 1171, 1173 (7th Cir. 2010) (“If a prisoner has been placed in imminent danger of serious physical injury by an act that violates his constitutional rights, administrative remedies that offer no possible relief in time to prevent the imminent danger from becoming an actual harm can’t be thought available.”).

II. PLAINTIFFS HAVE MET ALL OTHER REQUIREMENTS FOR PRELIMINARY INJUNCTIVE RELIEF

The district court did not abuse its discretion in weighing the *Winter* factors, *see Winter*, 555 U.S. at 20, and concluding that Plaintiffs met their burden on the remaining prongs for a preliminary injunction.

A. Plaintiffs Have Shown They Will Suffer Irreparable Harm if the Government Implements EO 14168 and Transfers them from Women's Prisons.

Plaintiffs must show that they “will likely suffer irreparable harm before the district court can resolve the merits of the case.” *Singh v. Berger*, 56 F.4th 88, 95 (D.C. Cir. 2022) (citing *Archdiocese of Wash. v. Wash. Metro. Area Transit Auth.*, 897 F.3d 314, 321 (D.C. Cir. 2018)). Here, Plaintiffs face irreparable harm arising out of the Government’s implementation of Section 4(a) of EO 14168, including the violation of their Eighth Amendment rights and substantial risks of sexual violence and physical harm.

1. BOP’s Prospective Violation of Plaintiffs’ Eighth Amendment Rights Causes Irreparable Harm.

Plaintiffs satisfy the irreparable harm standard where, as here, they face imminent violation of their Eighth Amendment right to be free from cruel and unusual punishment. As the district court properly recognized, “a prospective violation of a constitutional right constitutes irreparable injury.” JA166 (quoting *Davis v. District of Columbia*, 158 F.3d 1342, 1346 (D.C. Cir. 1998)). “Where a plaintiff requests injunctive relief ... that, if completed could ... alleviate harsh

conditions of confinement, the harm from detention surely cannot be remediated after the fact.” *Ramirez v. U.S. Immigr. and Customs Enf’t*, 310 F. Supp. 3d 7, 31 (D.D.C. 2018).

2. BOP’s Implementation of EO 14168 Exposes Plaintiffs to a High Risk of Sexual Violence and Other Serious Harms.

Plaintiffs face a substantial risk of irreparable bodily harm in the absence of injunctive relief. *See supra* Argument § I(A)(1). If Plaintiffs are transferred to men’s prisons, they will likely face physical violence and sexual harassment. Multiple Plaintiffs were physically attacked and sexually harassed in men’s prisons before they were placed in women’s facilities. *See, e.g.*, JA374–75, 382, 385. And two of the Plaintiffs who were transferred from women’s to men’s facilities under EO 14168 both suffered immediate and pervasive sexual harassment in those men’s facilities. JA230, 233–34.

In addition, Plaintiffs Maria Moe, Jane Jones, and Zoe, Rachel, Wendy and Sara Doe are at extremely high risk of assault in men’s prisons because they have undergone surgical treatment and/or appear indistinguishable from other women. *See* JA286, 703–04, 903, 965, 996, 1000. All Plaintiffs have been on female hormones for years and live as women.

Finally, the likelihood of irreparable harm is supported by the Government’s own data demonstrating an elevated risk for the transgender prisoner population, as well as the un rebutted declarations submitted by Plaintiffs and Plaintiffs’ experts

showing that Plaintiffs are at particularly high risk. *See supra* Argument § I(A).

The district court also did not clearly err in finding that, given the individual histories and vulnerabilities identified by these plaintiffs, “placement in a male penitentiary *by itself* will exacerbate the symptoms of [Plaintiffs’] gender dysphoria, *even if* they are not subject to physical or sexual violence in their new facility ... because the mere homogenous presence of men will cause uncomfortable dissonance.” JA187 n.2. As the district court found, this worsening of gender dysphoria will expose Plaintiffs to a serious risk of harm if they are moved to men’s prisons. *Id.*

Defendants’ reliance on *Citizens for Responsibility and Ethics in Washington (CREW) v. Federal Election Commission*, 904 F.3d 1014 (D.C. Cir. 2018) is misplaced. In *CREW*, this Court found no irreparable harm existed where the plaintiff campaign donors failed to provide “actual evidence” that the FEC’s new disclosure requirements had a “chilling effect” on their behavior or evidence of “any actual independent expenditures [they had] made this quarter” or were deterred from making. *Id.* at 1019. In contrast, here, Plaintiffs submitted more than 20 declarations from themselves and experts describing the harms they have already experienced in men’s prisons in addition to the imminent and certain harm they will face if forced to live in men’s prisons. *See* JA84, 91, 229, 232, 285, 292, 373, 377, 380, 384, 490, 915, 920, 925, 929, 934, 938, 942, 947, 951.

B. The Balance of Equities and Public Interest Weigh in Favor of Preliminary Injunctive Relief.

When the party opposing a preliminary injunction is the Government, the final two prongs merge. *Nken v. Holder*, 556 U.S. 418, 435 (2009). The district court did not abuse its discretion in concluding “the public interest in seeing the plaintiffs relocated *immediately* to male facilities is slight at best,” whereas “[t]he plaintiffs’ interests ... are not abstract at all,” as Plaintiffs face substantiated harms to their physical and psychological wellbeing if transferred under the challenged Executive Order. JA167. In addition, “enforcement of an unconstitutional law is always contrary to the public interest.” *Karem v. Trump*, 960 F.3d 656, 668 (D.C. Cir. 2020).

The Government now makes blanket, unsupported assertions on appeal that the Plaintiffs endanger the safety of others at the women’s prisons where they reside. AOB at 4. The Government did not submit any evidence to support this assertion in any of the six oppositions filed in response to the motions for TROs and PIs in the underlying cases. Nor is there any support for the suggestion that simply being transgender makes Plaintiffs a threat to women’s safety, privacy, or dignity.

Likewise, the Government cannot show that the injunctions undermine the public interest by forcing BOP to keep in place a housing policy “that no longer reflects its current ... thinking.” AOB at 53. In arguing to the contrary, the

Government relies on *MediNatura, Inc. v. FDA*, 998 F.3d 931, 945 (D.C. Cir. 2021). But *MediNatura* is inapposite. In that case, this Court denied a preliminary injunction seeking to retain a thirty-year-old agency guidance document, where the change in policy followed a multi-year review process that reflected the agency’s “current enforcement thinking” and involved scientific analysis and public input. *See id.* at 935–37, 945. In contrast, here, the Government has not provided any explanation or evidence to support the policy change other than the text of the Executive Order at issue. Nor could there be evidence-based decision making to support the abrupt policy change, which was issued on day one of the current presidential administration before any serious review of BOP policies and practices had been taken, and which explicitly contravenes PREA and its implementing regulations.

The Government’s analogy to *Hatim v. Obama*, 760 F.3d 54 (D.C. Cir. 2014) to argue that that the injunctions “impermissibly interfere with the government’s administration of its federal prisons and the execution of Executive Branch policy” also fails. AOB at 53. In *Hatim*, the plaintiffs did not challenge an Executive Order, but rather an on-the-ground policy change at a specific detention facility the Court found was “needed to preserve internal order and discipline and to maintain institutional security.” *Hatim*, 760 F.3d at 59 (internal citations omitted). There are no such findings here. In fact, the injunctions restore, rather

than interfere with, BOP's discretion to determine housing placements as needed to "ensure health and safety" for people in custody and maintain "security" in federal prisons. 28 C.F.R. § 115.42(c).

Defendants' position that this Court should defer to unfettered executive power also fundamentally misunderstands constitutional separation of powers. The Constitution represents the outer limits of deference to the Executive Branch; where a likely constitutional violation has been shown, deference is neither warranted nor in the public interest. *See Int'l Refugee Assistance Proj. v. Trump*, 857 F.3d 554, 603 (4th Cir. 2017) (en banc), *vacated on mootness grounds*, 583 U.S. 912 (2017) (explaining that "the issuance of a preliminary injunction which prevents [the government] from enforcing restrictions likely to be found unconstitutional" does not harm the government and likely "improve[s]" our system of government).

III. THE DISTRICT COURT'S ORDERS COMPLY WITH THE PRISON LITIGATION REFORM ACT

The operative preliminary injunctions contain ample PLRA findings and meet the requirements of the statute. *See* 18 U.S.C. § 3626(a)(2). Specifically, the court found that Plaintiffs are likely to succeed on the merits of their Eighth Amendment claim and that they will experience "serious and irreparable harm" if Defendants' implementation of the Executive Order proceeds; enjoining the application of the Order to Plaintiffs was therefore "necessary to correct the harm";

there was no less intrusive means of correcting the harm; and the injunction was narrowly drawn because it addressed only the specific harms to the individual Plaintiffs and did not extend to protect non-parties or enjoin other aspects of the EO 14168. JA955, 958, 961. The district court also found that the injunctions would not cause any “adverse impacts on public safety or the operation of the criminal justice system” because they simply maintained the status quo during the pendency of the litigation. JA955–56, 959, 961–62.

The district court’s articulation of its findings was nothing like the “one-sentence, boilerplate paragraph” the Government points to from *Hoffer v. Sec’y, Fla. Dep’t of Corr.*, 973 F.3d 1263, 1278 (11th Cir. 2020). Nothing in the PLRA “suggest[s] that Congress intended a provision-by-provision explanation of a district court’s findings,” and there is no reason to “read such an obligation into the statute.” *Armstrong v. Schwarzenegger*, 622 F.3d 1058, 1070 (9th Cir. 2010); *see also Fields v. Smith*, 653 F.3d 550, 558 (7th Cir. 2011) (reaching same conclusion and collecting cases).

The Government spends one paragraph arguing that the PIs were not in fact necessary to avert the harm threatened by the Executive Order. AOB at 56–57. This Court reviews for clear error the district court’s factual findings that the injunctions were necessary, narrowly tailored, and the least intrusive means of correcting the harm. *Brown v. Plata*, 563 U.S. 493, 541 (2011); *see also United*

States v. Hinds Cnty. Bd. of Supervisors, 128 F.4th 616, 626 (5th Cir. 2025); *Armstrong v. Newsom*, 58 F.4th 1283, 1293 (9th Cir. 2023). As the district court explained, its findings were amply supported by the evidence that (1) transferring Plaintiffs to men’s prisons would put them at a “significantly elevated risk of physical and sexual violence relative to other inmates,” JA164; (2) moving Plaintiffs to men’s prisons would “exacerbate the symptoms of their gender dysphoria,” potentially causing “numerous and severe symptoms,” JA165; (3) BOP had previously determined that “a women’s facility was the appropriate placement for each named plaintiff” based on the constitutional and statutory factors that required it to consider Plaintiffs’ risk of harm in men’s prisons, JA186; and (4) the fact that Rachel and Ellen Doe were “abused at their new facilities” after their brief transfer to men’s prisons could “only strengthen their claims of irreparable harm,” JA241–42. The Government’s cursory and unsupported argument that it is “self-evident” that less intrusive relief could avert the harm shows no clear error in these findings. AOB at 56–57.

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CONCLUSION

For the foregoing reasons, the preliminary injunctions should be affirmed.

DATED: June 30, 2025

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit of Federal Rule of Appellate Procedure 32 (a)(7)(B) because it contains 12,525 words. This brief also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because it was prepared using Word for Microsoft 365 in Times New Roman 14-point font, a proportionally spaced typeface.

/s/ Kara Janssen

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CERTIFICATE OF SERVICE

I hereby certify that on June 30, 2025, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the District of Columbia Circuit by using the appellate CM/ECF system.

/s/ Kara Janssen

Kara Janssen

ADDENDUM

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18 U.S.C. § 3621(b)**§ 3621. Imprisonment of a convicted person**

* * *

(b) Place of imprisonment.--The Bureau of Prisons shall designate the place of the prisoner's imprisonment, and shall, subject to bed availability, the prisoner's security designation, the prisoner's programmatic needs, the prisoner's mental and medical health needs, any request made by the prisoner related to faith-based needs, recommendations of the sentencing court, and other security concerns of the Bureau of Prisons, place the prisoner in a facility as close as practicable to the prisoner's primary residence, and to the extent practicable, in a facility within 500 driving miles of that residence. The Bureau shall, subject to consideration of the factors described in the preceding sentence and the prisoner's preference for staying at his or her current facility or being transferred, transfer prisoners to facilities that are closer to the prisoner's primary residence even if the prisoner is already in a facility within 500 driving miles of that residence. The Bureau may designate any available penal or correctional facility that meets minimum standards of health and habitability established by the Bureau, whether maintained by the Federal Government or otherwise and whether within or without the judicial district in which the person was convicted, that the Bureau determines to be appropriate and suitable, considering--

- (1) the resources of the facility contemplated;
- (2) the nature and circumstances of the offense;
- (3) the history and characteristics of the prisoner;
- (4) any statement by the court that imposed the sentence--
 - (A) concerning the purposes for which the sentence to imprisonment was determined to be warranted; or
 - (B) recommending a type of penal or correctional facility as appropriate; and
- (5) any pertinent policy statement issued by the Sentencing Commission pursuant to section 994(a)(2) of title 28.

In designating the place of imprisonment or making transfers under this subsection, there shall be no favoritism given to prisoners of high social or economic status. The Bureau may at any time, having regard for the same matters, direct the transfer of a prisoner from one penal or correctional facility to another. The Bureau shall make available appropriate substance abuse treatment for each prisoner the Bureau

determines has a treatable condition of substance addiction or abuse. Any order, recommendation, or request by a sentencing court that a convicted person serve a term of imprisonment in a community corrections facility shall have no binding effect on the authority of the Bureau under this section to determine or change the place of imprisonment of that person. Notwithstanding any other provision of law, a designation of a place of imprisonment under this subsection is not reviewable by any court.

* * *

18 U.S.C. § 3625**§ 3625. Inapplicability of the Administrative Procedure Act**

The provisions of sections 554 and 555 and 701 through 706 of title 5, United States Code, do not apply to the making of any determination, decision, or order under this subchapter.

18 U.S.C. § 3626(a)(1)-(2)**§ 3626. Appropriate remedies with respect to prison conditions****(a) Requirements for relief.--****(1) Prospective relief.—**

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

(B) The court shall not order any prospective relief that requires or permits a government official to exceed his or her authority under State or local law or otherwise violates State or local law, unless--

(i) Federal law requires such relief to be ordered in violation of State or local law;

(ii) the relief is necessary to correct the violation of a Federal right; and

(iii) no other relief will correct the violation of the Federal right.

(C) Nothing in this section shall be construed to authorize the courts, in exercising their remedial powers, to order the construction of prisons or the raising of taxes, or to repeal or detract from otherwise applicable limitations on the remedial powers of the courts.

(2) Preliminary injunctive relief.--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 caused by the preliminary relief and shall respect the principles of comity set out in paragraph (1)(B) in tailoring any preliminary relief. Preliminary injunctive relief shall automatically expire on the date that is 90 days

after its entry, unless the court makes the findings required under subsection (a)(1) for the entry of prospective relief and makes the order final before the expiration of the 90-day period.

* * *

5 U.S.C. § 553**§ 553. Rule making**

- (a) This section applies, according to the provisions thereof, except to the extent that there is involved--
- (1) a military or foreign affairs function of the United States; or
 - (2) a matter relating to agency management or personnel or to public property, loans, grants, benefits, or contracts.
- (b) General notice of proposed rule making shall be published in the Federal Register, unless persons subject thereto are named and either personally served or otherwise have actual notice thereof in accordance with law. The notice shall include--
- (1) a statement of the time, place, and nature of public rule making proceedings;
 - (2) reference to the legal authority under which the rule is proposed;
 - (3) either the terms or substance of the proposed rule or a description of the subjects and issues involved; and
 - (4) the Internet address of a summary of not more than 100 words in length of the proposed rule, in plain language, that shall be posted on the Internet website under section 206(d) of the E-Government Act of 2002 (44 U.S.C. 3501 note) (commonly known as regulations.gov).

Except when notice or hearing is required by statute, this subsection does not apply--

- (A) to interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice; or
 - (B) when the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rules issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest.
- (c) After notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments with or without opportunity for oral presentation. After consideration of the relevant matter presented, the agency shall incorporate in the rules adopted a

concise general statement of their basis and purpose. When rules are required by statute to be made on the record after opportunity for an agency hearing, sections 556 and 557 of this title apply instead of this subsection.

- (d)** The required publication or service of a substantive rule shall be made not less than 30 days before its effective date, except--
- (1)** a substantive rule which grants or recognizes an exemption or relieves a restriction;
 - (2)** interpretative rules and statements of policy; or
 - (3)** as otherwise provided by the agency for good cause found and published with the rule.
- (e)** Each agency shall give an interested person the right to petition for the issuance, amendment, or repeal of a rule.

5 U.S.C. § 706**§ 706. Scope of review**

To the extent necessary to decision and when presented, the reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action. The reviewing court shall--

- (1) compel agency action unlawfully withheld or unreasonably delayed; and
- (2) hold unlawful and set aside agency action, findings, and conclusions found to be--
 - (A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;
 - (B) contrary to constitutional right, power, privilege, or immunity;
 - (C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right;
 - (D) without observance of procedure required by law;
 - (E) unsupported by substantial evidence in a case subject to sections 556 and 557 of this title or otherwise reviewed on the record of an agency hearing provided by statute; or
 - (F) unwarranted by the facts to the extent that the facts are subject to trial de novo by the reviewing court.

In making the foregoing determinations, the court shall review the whole record or those parts of it cited by a party, and due account shall be taken of the rule of prejudicial error

42 U.S.C. § 1997e(a)**§ 1997e. Suits by prisoners****(a) Applicability of administrative remedies**

No action shall be brought with respect to prison conditions under section 1983 of this title, or any other Federal law, by a prisoner confined in any jail, prison, or other correctional facility until such administrative remedies as are available are exhausted.

* * *

28 C.F.R. § 115.41**§ 115.41 Screening for risk of victimization and abusiveness.**

- (a) All inmates shall be assessed during an intake screening and upon transfer to another facility for their risk of being sexually abused by other inmates or sexually abusive toward other inmates.
- (b) Intake screening shall ordinarily take place within 72 hours of arrival at the facility.
- (c) Such assessments shall be conducted using an objective screening instrument.
- (d) The intake screening shall consider, at a minimum, the following criteria to assess inmates for risk of sexual victimization:
 - (1) Whether the inmate has a mental, physical, or developmental disability;
 - (2) The age of the inmate;
 - (3) The physical build of the inmate;
 - (4) Whether the inmate has previously been incarcerated;
 - (5) Whether the inmate's criminal history is exclusively nonviolent;
 - (6) Whether the inmate has prior convictions for sex offenses against an adult or child;
 - (7) Whether the inmate is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming;
 - (8) Whether the inmate has previously experienced sexual victimization;
 - (9) The inmate's own perception of vulnerability; and
 - (10) Whether the inmate is detained solely for civil immigration purposes.
- (e) The initial screening shall consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the agency, in assessing inmates for risk of being sexually abusive.
- (f) Within a set time period, not to exceed 30 days from the inmate's arrival at the facility, the facility will reassess the inmate's risk of victimization

- or abusiveness based upon any additional, relevant information received by the facility since the intake screening.
- (g) An inmate's risk level shall be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the inmate's risk of sexual victimization or abusiveness.
 - (h) Inmates may not be disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section.
 - (i) The agency shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the inmate's detriment by staff or other inmates.

28 C.F.R. § 115.42**§ 115.42 Use of screening information.**

- (a) The agency shall use information from the risk screening required by § 115.41 to inform housing, bed, work, education, and program assignments with the goal of keeping separate those inmates at high risk of being sexually victimized from those at high risk of being sexually abusive.
- (b) The agency shall make individualized determinations about how to ensure the safety of each inmate.
- (c) In deciding whether to assign a transgender or intersex inmate to a facility for male or female inmates, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the inmate's health and safety, and whether the placement would present management or security problems.
- (d) Placement and programming assignments for each transgender or intersex inmate shall be reassessed at least twice each year to review any threats to safety experienced by the inmate.
- (e) A transgender or intersex inmate's own views with respect to his or her own safety shall be given serious consideration.
- (f) Transgender and intersex inmates shall be given the opportunity to shower separately from other inmates.
- (g) The agency shall not place lesbian, gay, bisexual, transgender, or intersex inmates in dedicated facilities, units, or wings solely on the basis of such identification or status, unless such placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such inmates.



U.S. Department of Justice
Federal Bureau of Prisons

PROGRAM STATEMENT

OPI: RSD/WASPB
NUMBER: 5200.08
DATE: January 13, 2022

Transgender Offender Manual

/s/

Approved: M.D. Carvajal
Director, Federal Bureau of Prisons

1. PURPOSE AND SCOPE

To ensure the Bureau of Prisons (Bureau) properly identifies, tracks, and provides services to the transgender population.

a. Program Objectives. Expected results of this program are:

- This policy provides guidance to staff in dealing with the unique issues that arise when working with transgender inmates.
- Institutions ensure transgender inmates can access programs and services that meet their needs as appropriate, and prepare them to return to the community.
- Sufficient resources will be allocated to deliver appropriate services to transgender inmates.
- Staff will complete training, enabling them to work effectively with transgender inmates.
- To enhance staff's understanding of the increased risk of suicide, mental health issues and victimization of transgender inmates.

b. Summary of Changes

Rescinded P5200.04 CN-1 Transgender Offender Manual (5/11/2018)

This reissuance incorporates the following modifications:

- Clarified duties and responsibilities of various staff.
- Added an institution requirement for maintaining a copy of the Case Management Activity (CMA) Assignment form BP-A1110, Consent Form for Transgender Inmates. Inmates can no longer request to have a CMA assignment removed, and then re-added at a later date.
- Clarified transfer, consultation, and program requirements.

- Updated guidance regarding initial designation and redesignation procedures for transgender offenders.
- Added information about gender affirming surgery.

c. **Institution Supplement.** None required. Should local facilities make any changes outside changes required in national policy or establish any additional local procedures to implement national policy, the local Union may invoke to negotiate procedures or appropriate arrangements.

2. DEFINITIONS

Gender – a construct used to classify a person as male, female, both, or neither. Gender encompasses aspects of social identity, psychological identity, and human behavior.

Gender identity – a person’s sense of their own gender, which is communicated to others by their gender expression.

Gender expression – includes mannerisms, clothing, hairstyle, and choice of activities.

Gender nonconforming – a person whose appearance or manner does not conform to traditional societal gender expectations.

Transgender – the state of one’s gender identity not matching one’s sex assigned at birth. For the purposes of this policy, a transgender inmate is one who has met with a Bureau Psychologist and signed the form indicating consent to be identified within the agency as transgender. This step allows accommodations to be considered.

Cisgender – the state of one’s gender identity matching one’s sex assigned at birth.

Sexual orientation – the direction of one’s sexual interest towards members of the same, opposite, or both genders (e.g., heterosexual, homosexual, bisexual, asexual). Sexual orientation and gender identity are not related.

Gender Dysphoria (GD) – a mental health diagnosis currently defined by DSM-5 as, “A strong and persistent cross-gender identification. It is manifested by a stated desire to be the opposite sex and persistent discomfort with his or her biologically assigned sex.” Not all transgender inmates will have a diagnosis of GD, and a diagnosis of GD is not required for an individual to be provided services.

Intersex – a person whose sexual or reproductive anatomy or chromosomal pattern does not seem to fit typical physiological definitions of male or female. Not all intersex people identify as

transgender; unless otherwise specified, this policy does not apply to intersex people who do not identify as transgender.

Transition – measures that change one’s gender expression or body to better reflect a person’s gender identity.

Gender Affirming – describes behaviors or interventions that support the gender identity of a person.

3. STAFF RESPONSIBILITIES

The following Bureau components are responsible for ensuring consistent establishment of the programs, services, and resource allocations necessary for transgender offenders.

a. Central Office

(1) The **Women and Special Populations Branch (WASPB)** is the agency’s primary source and point of contact on accommodation/transition, classification, management, and intervention/treatment programs and practices for transgender inmates in Bureau custody. The Branch is responsible for the following functions as they relate to transgender inmates:

- Engaging stakeholders, including serving as the primary point of contact on issues affecting transgender inmates with external entities including judges, congress, and advocacy groups.
- Ensuring the Bureau offers appropriate services to transgender inmates.
- Preparing budget requests to deliver national and pilot programs or services affecting transgender inmates.
- Providing guidance and direction to staff and institution, region, and agency leadership on transgender issues.
- Developing and implementing staff training on transgender issues.
- Building a research-based foundation for the Bureau’s work with transgender inmates, including implementation support and intervention services.
- Presenting at internal and external conferences/events regarding the agency’s transgender inmates’ practices.
- Developing and monitoring monthly reports on the transgender population and institutional programs.
- Conducting an annual survey of transgender inmates in the Bureau and sharing results with internal and external stakeholders.
- Providing national oversight of pilot programs and initiatives serving transgender offenders.
- Overseeing the Transgender Executive Council (TEC).
- Ensure that a National Program and Policy Coordinator is assigned to each Region who will meet quarterly to discuss staffing and programming needs of transgender inmates.

(2) The **Health Services Division** oversees all medical and psychiatric guidance and treatment as it applies to transgender inmates. Clinical guidance on the most current research-driven clinical medical and psychiatric care of transgender inmates will be provided at the direction of the Medical Director. The Medical Director only receives referrals from the TEC and determines whether gender affirming surgery requests will be referred to a surgeon.

(3) The **Psychology Services Branch** oversees all mental health programs and services as they apply to transgender inmates, to include providing advice and guidance on identification and evaluation of transgender inmates, and making recommendations for treatment needs of transgender inmates and/or inmates with GD.

(4) **Central Office Branches** of Correctional Services, Psychology Services, Education, Correctional Programs, Reentry Affairs, Residential Reentry Management, Health Programs, Litigation, Chaplaincy Services, Intelligence and Counter Terrorism Branch, and Trust Fund meet annually with the Women and Special Populations Branch to discuss transgender population needs and evaluate current gender-responsive services. The National Union and the Central Office LGBT Special Emphasis Program Manager will be invited to attend these meetings.

(5) The **Transgender Executive Council (TEC)** will consist of senior level staff members (GS-14 and above) from the Women and Special Populations Branch, the Psychology Services Branch, Health Services Division, and the Designation and Sentence Computation Center (DSCC). The team is led by the Senior Deputy Assistant Director, Reentry Services and also includes the Senior Deputy Assistant Director, Correctional Programs Division (DSCC), and the Senior Deputy Assistant Director, Health Services. The TEC is the agency's official decision-making body on all issues affecting the transgender population. It will meet a minimum of monthly to offer advice and guidance on unique measures related to treatment and management needs of transgender inmates and/or inmates with GD, including training, designation issues, and reviewing all transfers for approval. Staff or inmates may raise issues on specific inmates to the TEC through the Women and Special Populations Branch. The Office of General Counsel is consulted as needed.

b. Regional Offices

- Provide oversight to institutions regarding services and other relevant trends managing transgender inmates.

c. Institutions

The Warden will establish a multi-disciplinary approach to the management of transgender inmates. The Associate Warden of Programs is the primary point of contact in the institution for transgender issues and will consult as needed with the Chief Psychologist, Captain, Clinical

Director, Unit Manager, or other individuals as appropriate; and specifically to:

- Ensure transgender inmates have access to services.
- Enter tracking information for self-identified transgender inmates by updating SENTRY CMA assignments and other databases (e.g., PDS).
- Maintain a copy of the Case Management Activity (CMA) SENTRY Assignment Consent Form for Transgender Inmates (BP-A1110) in the Central File and Psychology Data System (PDS).
- Provide appropriate reentry resources that may be specific to the population.
- Advise the Local Union of transgender inmate management issues.
- Consult and refer transgender inmates to the TEC.
- Provide programming developed by the Reentry Services Division for transgender inmates.

4. STAFF TRAINING

Staff are provided specialized training in working with unique issues when managing transgender inmates as part of annual training. Institutions housing transgender inmates should provide additional training.

The Women and Special Populations Branch is responsible for developing training materials and current information on the management of transgender inmates. This information will be made available to staff via the Bureau's intranet.

In addition, the Prison Rape Elimination Act (PREA) regulations incorporated into the BOP Program Statement, **Sexually Abusive Behavior Prevention and Intervention Program** have training requirements concerning pat searches and communication skills for transgender inmates. See 28 C.F.R. § 115.15(f) and 115.31 (a) (9). Please refer to this Program Statement regarding implementation of those training requirements.

Staff will be provided adequate time to complete these trainings during duty hours. Staff will be provided proper relief to complete the training.

5. INITIAL DESIGNATIONS

The PREA regulations (section 28 C.F.R. § 115.42 (c)), incorporated into the Program Statement **Sexually Abusive Behavior Prevention and Intervention Program**, state:

“In deciding whether to assign a transgender or intersex inmate to a facility for male or female inmates...the agency shall consider on a case-by-case basis whether a placement would ensure the inmate's health and safety, and whether the placement would present management or security problems.”

Upon receipt of information from a Pre-Sentence Report, court order, U.S. Attorney's Office, defense counsel, the offender, or other source that an individual entering BOP custody is

transgender or intersex, designations staff will refer the matter to the TEC.

Institution staff managing pretrial or holdover offenders must also refer cases to the TEC for review. Any TEC recommendations concerning pretrial inmates will be coordinated with the appropriate United States Marshals Service District Office.

The TEC will consider factors including, but not limited to, an inmate's security level, criminal and behavioral/disciplinary history, current gender expression, programming, medical, and mental health needs/information, vulnerability to sexual victimization, and likelihood of perpetrating abuse. The TEC may also consider facility-specific factors, including inmate populations, staffing patterns, and physical layouts (e.g., types of showers available). The TEC will consider the wellbeing of all inmates while exploring appropriate options available to assist with mitigating risk to the inmate, to include but not limited to cell and/or unit assignments, application of management variables, programming missions of the facility, and security of the institution.

It will be documented on all SENTRY designation notes for transgender inmates that the TEC reviewed the inmate for appropriate institution designation.

6. HOUSING AND PROGRAMMING ASSIGNMENTS

During Initial Classification and subsequent Program Reviews, unit management staff will review the inmate's current housing unit status and programming available for transgender inmates. This review will be documented by Unit Management staff in the inmate central file and for holdovers in the holdover file, with institution oversight by the Associate Warden.

The reviews will consider on a case-by-case basis that the inmate placement does not jeopardize the inmate's wellbeing and does not present management or security concerns.

In making housing unit and programming assignments, a transgender or intersex inmate's own views with respect to his/her own safety must be given serious consideration.

Transgender inmates shall be given the opportunity to shower separate from other inmates when individual shower stalls are unavailable.

The agency shall not place transgender or intersex inmates in dedicated facilities, units, or wings solely on the basis of such identification or status. The only exception is if such placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such inmates.

Wardens will consult with WASPB prior to submitting a designation request to the DSCC for the redesignation of transgender inmates when the designation is related to the individual's

transition. The DSCC and Office of Medical Designations will consult with WASPB prior to the designation or redesignation of all transgender inmates.

In situations where the transfer request is related to progressing the individual inmate's transition (i.e., transfer to a different sex facility) the TEC will consider the case. Prior to considering the case, the Warden will submit documentation to the TEC showing the inmate has met the minimum standards of compliance with programs, medications and mental health treatment, and meeting hormone goal levels. Ordinarily, inmates will not be submitted to the TEC for consideration until they have maintained one year clear conduct for 100 and 200 series incident report sanctions, though they may be considered for submission on a case-by-case basis by the Warden, as appropriate.

It will be noted in all SENTRY designation notes that the TEC reviewed the inmate for appropriate institution designation.

7. DOCUMENTATION AND SENTRY ASSIGNMENTS

The PREA regulations in 28 C.F.R. part 115, Subpart A, incorporated into the Program Statement **Sexually Abusive Behavior Prevention and Intervention Program** and the Program Statement **Intake Screening**, address intake screening. Screening of transgender inmates will be conducted in accordance with these policies and all other applicable policies and procedures.

a. Medical and Mental Health Information. Medical and mental health information for transgender inmates will be maintained in the current electronic recordkeeping system or health record system in accordance with the Program Statements **Health Information Management and Psychology Services Manual**. Medical and mental health information is considered confidential, and may only be released in accordance with appropriate laws, rules, and regulations.

b. Initial Screening. For initial designations, staff will assign Case Management Activity (CMA) SENTRY assignments if information in the PSR or other documentation indicates a likely transgender identity. The screening codes are:

SCRN M2F – inmate should be screened for male to female transgender identification.

SCRN F2M – inmate should be screened for female to male transgender identification.

Any inmate arriving at the designated institution with a screening code is to be referred to the Chief Psychologist or designee for review within 14 days. If the code was assigned in error, the screening code will be removed by the Psychologist. If the inmate identifies as transgender, the psychologist will replace the screening code with an identifying code, as indicated below. Holdover facilities are exempt from this initial screening requirement, as limited available

records and brevity of stay do not typically allow for a comprehensive screening.

Any inmate who arrives without a screening code but identifies as transgender during intake, or at any time during the incarceration period, is referred to the Chief Psychologist or designee and interviewed within 14 days of the inmate notification. Inmates in pretrial status at Bureau facilities may also receive a transgender screening CMA SENTRY assignment.

c. Notification to Staff and Tracking. After consultation with Psychology Services, and if the inmate affirms his/her transgender identity, the screening code will be updated to a permanent assignment by a Psychologist:

TRN M2F – inmate identifies as male to female transgender (transgender female).

TRN F2M – inmate identifies as female to male transgender (transgender male).

The inmate must request to Psychology Services staff that the Case Management Activity (CMA) assignment be entered, and the inmate consents that all staff will therefore be notified that the individual is transgender. The inmate's request will be documented on a Case Management Activity (CMA) SENTRY Assignment Consent Form for Transgender Inmates (BP-A1110). Psychology Services shall maintain the form in the electronic mental health record.

Staff should consult the transgender CMA assignment when interacting with the inmate; e.g., use of pronouns and access to accommodations. All inmates have access to transgender treatment, regardless of assignment.

If there are questions about the need to continue a CMA assignment, the Warden will contact the WASPB. Inmates may request in writing to have CMA assignments removed. If this occurs, ordinarily the assignment will not be re-added at a later date.

8. HORMONE THERAPY AND MEDICAL TREATMENT

Hormone therapy or other medical treatment may be provided after an individualized assessment of the requested inmate by institution medical staff. Medical staff will request consultation from Psychology Services regarding the mental health benefits of hormone or other medical treatment. If appropriate for the inmate, hormone treatment will be provided in accordance with the Program Statement **Patient Care** and relevant Clinical Guidance. Questions concerning hormone treatment may be referred to the WASPB or the Health Services Division.

In the event this treatment changes the inmate's appearance to the extent a new identification card is needed, the inmate will not be charged for the identification card as is standard practice.

9. SURGERY

While not all inmates who identify as transgender may be interested in seeking surgical intervention, such a decision does not preclude them from obtaining other accommodations as described in this Program Statement. For transgender inmates in Bureau custody, surgery may be the final stage in the transition process and is generally considered only after one year of clear conduct and compliance with mental health, medical, and programming services at the gender affirming facility. Once that period elapses, an inmate may submit a request to his or her Warden requesting surgical consideration. The Warden will forward the request to the TEC. The TEC is the sole body who may determine that all milestones and individual goals for surgical consideration have been met. When this occurs, the case is referred to the agency's Medical Director for medical consideration. He or she may review existing records and/or interview the inmate, institution staff, and members of the TEC. After this individualized assessment, the Medical Director will determine if the surgery is medically appropriate for referral to a gender affirming surgeon.

10. OTHER MENTAL HEALTH SERVICES

Bureau Psychologists provide assessment and treatment services for transgender inmates, as appropriate. Guidance on assessment procedures is available on the Psychology Services intranet page.

If an inmate identifies as transgender, the Psychologist will provide the inmate with information regarding the range of treatment options available in the Bureau and their implications. In addition, based upon the Psychologist's preliminary assessment and the inmate's expressed interest, a referral to the Clinical Director and/or Chief Psychiatrist may be generated. While the initial interview must be scheduled within 14 days, an assessment may take longer in some instances.

In addition to a referral for medical services, a transgender inmate may be offered individual psychotherapy. Individual psychotherapy goals might include: (1) helping the inmate to live more comfortably within a gender identity and deal effectively with non-gender issues; (2) emphasizing the need to set realistic life goals related to daily living, work, and relationships, including family of origin; (3) seeking to define and address issues that may have undermined a stable lifestyle, such as substance abuse and/or criminality; and (4) addressing any co-occurring mental health issues. Mood disorders, anxiety disorders, substance use disorders, and personality disorders, etc., may also be present; any effective treatment plan will fully address these symptoms. Group treatment may also be recommended.

Common concerns of transgender inmates, which can be addressed effectively in a group setting, include self-esteem issues and relationship issues.

Psychologists who provide mental health treatment for transgender inmates address all mental health needs, including suicide risk, if present. If an inmate who identifies as a transgender harms, attempts to remove, or removes his or her genitalia or other gender-specific anatomy, a suicide risk assessment is conducted consistent with the Program Statement, Suicide Prevention Program. In addition, the treating psychologist notifies the Chief Psychologist who in turn notifies the Regional Psychology Services Administrator and the Psychology Services Branch.

Psychologists working with transgender inmates are encouraged to consult the Reentry Services Division in Central Office for additional resources.

11. SPECIAL POPULATIONS SERVICES

Some facilities have Special Populations Coordinators on staff. These individuals are responsible for delivering First Step Act and other programs, which includes programs developed specifically for inmates who identify as transgender. In the absence of such staff, the Warden will seek consultation from WASPB regarding the delivery of group interventions and services.

12. PRONOUNS AND NAMES

Staff interacting with inmates who have a CMA assignment of transgender, shall either use the authorized gender-neutral communication with inmates (e.g., by the legal last name or “Inmate” last name) or the pronouns associated with the inmate’s identified gender. Deliberately and repeatedly mis-gendering an inmate is not permitted.

The name entered on the inmate’s Judgment and Commitment Order is the official committed name for all Bureau records (incident reports, progress reviews, sentence calculations, etc.). An official committed name change while in BOP custody must be done consistent with the Program Statement **Correctional Systems Manual**. Any additional names or aliases should be entered into SENTRY, as appropriate.

13. PAT SEARCH ACCOMMODATIONS

Pat searches of transgender inmates will be conducted in accordance with the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas**.

Pat search information refers only to individuals at male facilities who identify as female. The Bureau does not offer “male only” pat searches.

Unless there is a history of inappropriate sexual behavior suggesting approval poses risks to staff, requests are ordinarily approved by the Warden’s Office. Inmates may request denials be reviewed by the TEC through the Administrative Remedy Program. Inmates who are granted this exception under policy may have it reversed by the Warden if found to have violated

institution rules concerning contraband.

In exigent circumstances, any staff member may conduct a pat search of any inmate consistent with the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas**.

14. VISUAL SEARCHES

For purposes of a visual search, inmates will be searched in accordance with the gender of the institution, or housing assignment, to which they are assigned. The visual search shall be made in a manner designed to ensure as much privacy to the inmate as practicable. Staff should consider the physical layout of the institution, and the characteristics of an inmate with a transgender CMA assignment, to adjust conditions of the visual search as needed for the inmate's privacy.

Transgender inmates may also request an exception to be visually searched by a staff member of the inmate's identified gender. The exception must be pre-authorized by the Warden, after consultation with staff from Health Services, Psychology Services, Unit Management, and Correctional Services. Exceptions must be specifically described (e.g., "visual search only by female staff"), clearly communicated to relevant staff through a memorandum, and reflected in SENTRY (or other Bureau database). Inmates should be provided a personal identifier (e.g., notation on identification, etc.) that indicates their individual exception, to be carried at all times and presented to staff prior to visual searches.

Inmates request an exception by submitting an Inmate Request to Staff (BP-A0148) to the Warden. The Warden will consult with the departments listed above, and the memo approving or denying the request will be generated by the Warden's Office. Inmates may request denials be reviewed by the TEC through the Administrative Remedy Program. Inmates who are granted this exception may have it reversed by the Warden if found to have violated institution rules concerning contraband.

Transgender inmates placed at an institution or in a housing unit that does not correspond with their identified gender, and who are granted an exemption as indicated above, will be searched by staff of the inmate's identified gender who consent to participate in the search, or Health Services clinical staff.

Transgender inmates placed at an institution or in a housing unit of their identified gender will be searched by staff of the inmate's identified gender who consent to participate in the search or medical staff.

Institutions should consider using available body scanning technology in lieu of visual searches of transgender inmates.

In exigent circumstances, any staff member may conduct a visual search of any inmate consistent with the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas**.

15. CLOTHING, COMMISSARY ITEMS, AND OTHER ACCOMMODATIONS

Consistent with safety and security concerns, inmates with the CMA assignment of transgender will have the opportunity to have undergarments of their identified gender even if they are not housed with inmates of the identified gender. Institutional laundry will have available institutional undergarments that fulfill the needs of transgender inmates. Undergarments will not have metal components.

Standardized lists of Commissary items for transgender inmates are available in accordance with the Program Statement **Trust Fund/Deposit Manual** and the information on the RSD intranet page.

Additional items based on an individualized assessment of the transgender inmate population may be approved by the Warden. Additional items may be provided by the institution or purchased by the inmate, as appropriate. Any concerns regarding such items are directed to the WASPB.

Inmates who purchase and/or are provided items under this section will be subject to disciplinary sanctions, including the removal of these items, if they are found to have violated institution rules relating to the possession of these items.

Any other accommodation requests are discussed with the TEC through the WASPB.

16. REENTRY NEEDS

In accordance with the Program Statement **Release Preparation Program**, institution staff assist transgender inmates in addressing reentry issues prior to release or placement in a Residential Reentry Center/Home Confinement.

During Initial Classification and Program Reviews, unit management formulates a pre-release plan that assists transgender inmates in obtaining identification, finding housing and employment, and providing community resources to assist with reintegration into the community.

The Reentry Affairs Coordinator will assist staff with identifying these resources. Community Treatment Services staff or Institution and/or Regional Social Workers may be contacted concerning the continuity of medical care.

The WASPB can be contacted to provide guidance and resources for any additional reentry

needs of transgender inmates. All accommodation and treatment decisions for inmates in community custody are made by the Residential Reentry Management Branch in consultation with the TEC.

17. ADMINISTRATIVE REMEDIES

Inmates who wish to seek formal review of any issue relating to this policy may use the procedures in the Program Statement **Administrative Remedy Program**.

REFERENCES

Program Statements

P1330.18	Administrative Remedy Program (1/6/14)
P4500.12	Trust Fund/Deposit Fund Manual (3/15/18)
P5100.08	Security Designation and Custody Classification Manual (9/4/19)
P5290.15	Intake Screening (3/30/09)
P5310.17	Psychology Services Manual (08/25/16)
P5310.16	Treatment and Care of Inmates with Mental Illness (5/1/14)
P5322.13	Inmate Classification and Program Review (5/16/14)
P5324.08	Suicide Prevention (4/5/07)
P5324.12	Sexually Abusive Behavior Prevention and Intervention Program (6/4/15)
P5325.07	Release Preparation Program (8/15/19)
P5521.06	Searches of Housing Units, Inmates, and Inmate Work Areas (6/4/15)
P5800.15	Correctional Systems Manual (9/23/16)
P6031.04	Patient Care (6/3/14)
P6090.04	Health Information Management (3/2/15)

Federal Regulations

28 CFR part 115

Additional Resources For Clinicians

Diagnostic and Statistical Manual of Mental Disorders (DSM), most current version. World Professional Association for Transgender Health (WPATH) standards.

ACA Standards

- American Correctional Association Standards for Adult Correctional Institutions, 5th Edition: 5-ACI-1C-09, 5-ACI-1D-12, 5-ACI-1D-13, 5-ACI-2C-02, 5-ACI-1D-08, 5-ACI-3D-05, 5-ACI-3D-08(M), 5-ACI-3D-09, 5-ACI-3D-10, 5-ACI-3D-11, 5-ACI-3D-12, 5-ACI-3D-13, 5-ACI-3D-14, 5-ACI-3D-15, 5-ACI-3D-16, 5-ACI-6A-21(M), 5-ACI-6A-32(M), 5-ACI-6C-14(M)
- American Correctional Association Performance Based Standards for Adult Local Detention Facilities, 4th Edition: 4-ALDF-2A-29, 4-ALDF-2A-32, 4-ALDF-2A-34, 4-ALDF-6B-03, 4-ALDF-2C-03, 4-ALDF-4C-22M, 4-ALDF-4C-30M, 4-ALDF-4D-22, 4-ALDF-4D-22-1, 4-

ALDF-4D-22-2, 4-ALDF-4D-22-3, 4-ALDF-4D-22-4, 4-ALDF-4D-22-5, 4-ALDF-4D-22-6M, 4-ALDF-4D-22-7, 4-ALDF-4D-22-8, 4-ALDF-7B-08, 4-ALDF-7B-10, 4-ALDF-7B-10-1.

- American Correctional Association Standards for Administration of Correctional Agencies, 2nd Edition: None.

- American Correctional Association Standards for Correctional Training Academies: None.

Records Retention

Requirements and retention guidance for records and information applicable to this program are available in the Records and Information Disposition Schedule (RIDS) on Sallyport.



U.S. Department of Justice
Federal Bureau of Prisons

PROGRAM STATEMENT

OPI: RSD/PSB

NUMBER: 5310.16

DATE: May 1, 2014

Treatment and Care of Inmates With Mental Illness

/s/

Approved: Charles E. Samuels, Jr.
Director, Federal Bureau of Prisons

1. PURPOSE AND SCOPE

This Program Statement provides policy, procedures, standards, and guidelines for the delivery of mental health services to inmates with mental illness in all Federal Bureau of Prisons (Bureau) correctional facilities.

For the purpose of this Program Statement, mental illness is defined as in the most current *Diagnostic and Statistical Manual of Mental Disorders*:

“A mental disorder is a syndrome characterized by clinical significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities.”

Classification of an inmate as seriously mentally ill requires consideration of his/her diagnoses; the severity and duration of his/her symptoms; the degree of functional impairment associated with the illness; and his/her treatment history and current treatment needs. Mental illnesses not listed below may be classified as seriously mentally ill on a case-by-case basis if they result in significant functional impairment.

The following diagnoses are generally classified as serious mental illnesses:

- Schizophrenia Spectrum and Other Psychotic Disorders.

- Bipolar and Related Disorders.
- Major Depressive Disorder.

In addition, the following diagnoses are often classified as serious mental illnesses, especially if the condition is sufficiently severe, persistent, and disabling:

- Anxiety Disorders.
- Obsessive-Compulsive and Related Disorders.
- Trauma and Stressor-Related Disorders.
- Intellectual Disabilities and Autism Spectrum Disorders.
- Major Neurocognitive Disorders.
- Personality Disorders.

The primary purpose of this Program Statement is to ensure that inmates with mental illness are identified and receive treatment to assist their progress toward recovery, while reducing or eliminating the frequency and severity of symptoms and associated negative outcomes of mental illness, such as exacerbation of acute symptoms, placement in restrictive housing, need for psychiatric hospitalization, suicide attempts, and death by suicide.

The secondary purpose of this Program Statement is to address dynamic risk factors associated with recidivism in inmates with mental illness to increase pro-social and adaptive living skills and the likelihood of successful reentry to the community.

a. Summary of Changes

Policy Rescinded

P5310.13 Institution Management of Mentally Ill Inmates (3/31/95)

This reissuance incorporates the following modifications:

- Evidence-Based Practices for the treatment and care of mentally ill inmates are detailed and Priority Practices are established.
- The mental health care level system is operationalized. Mental health care level definitions are provided, which include diagnostic, impairment, and intervention-based criteria. In addition, care level-based treatment and documentation requirements are noted.
- A team approach to mental health care is established, including introduction of an institution Care Coordination and Reentry (CCARE) Team with joint Psychology Services and Health Services membership.
- Enhanced procedures for screening, evaluation, and intervention with inmates in restrictive housing settings are detailed.

- Procedures for providing mental health training for staff are outlined, including basic training for all staff as well as specialty training for interested staff.
- A mental health companion program is established to provide peer assistance and support to inmates with mental illnesses.
- Achievement awards for inmate participation in mental health programming are introduced.
- Designation, transfer, and release procedures for mentally ill inmates are updated and refined, with an emphasis on continuity of care – both across institutions and to the community.

b. Program Objectives

- To identify inmates with mental illness through screening and classification upon their entry into the Bureau and again upon their arrival at an institution to achieve an accurate diagnosis and determine the severity of mental illness and suicide risk.
- To ensure Psychology Treatment Programs and mental health interventions prescribed in treatment plans ordinarily rely on evidence-based practices for the treatment of inmates with mental illness and rehabilitation needs.
- To extend support for inmates with mental illness beyond traditional professional services through creation of specific supportive communities, specialized staff training, inmate peer support programs, care coordination teams, and institutions with specialized mental health missions.
- To enhance continuity of care through a network of accessible, interrelated interventions and communication among care providers when inmates transfer between institutions, to a Residential Reentry Center (RRC), to home confinement, or to the community.
- To reduce the proportion of inmates with mental illness in restrictive housing settings through informed disciplinary processes, initial screening procedures, enhanced treatment in these settings, and strategies for successful reintegration into the general population.
- To increase rates of successful reentry among inmates with mental illness through accurate identification of at-risk inmates, effective skill building in prison, and comprehensive release plans.

2. RESPONSIBILITIES

a. **Psychology Services Branch and Health Services Division.** The Psychology Services Branch (Branch), Reentry Services Division, and Health Services Division (HSD) provide oversight and consultation regarding institution treatment and care of inmates with mental illness through remote reviews of the Psychology Data System (PDS) in the Bureau Electronic Medical Record (BEMR) and other BEMR documentation; remote reviews of inmates in restrictive housing; recommendations regarding transfers and designations of mentally ill inmates; and

direct consultation with Chief Psychologists, Psychiatrists, other Health Services staff, and Executive Staff.

The Branch is responsible for developing Annual Refresher Training lesson plans that provide staff with information about working with mentally ill inmates. They also develop and disseminate supplemental staff training materials for use by the Mental Health Treatment Coordinator during staff recalls, lunch and learn events, department head meetings, etc. The Branch also identifies and disseminates evidence-based practices, described below.

b. **Warden.** Each Warden is responsible for the appropriate management of mentally ill inmates in his/her institution. He/she must provide the Mental Health Treatment Coordinator with adequate time to educate staff about the need to detect and report any unusual inmate behaviors that might suggest mental illness. For example, this education should occur at department head meetings, staff recalls, lieutenants' meetings, and annual training.

c. **Chief Psychologist.** Each Chief Psychologist ensures the provisions of this Program Statement are implemented, including designation of a psychologist to serve as Mental Health Treatment Coordinator, and informing institution staff of the designation. The Chief Psychologist is also responsible for ensuring information about the availability of mental health services is disseminated to inmates during Admission and Orientation. Specifically, the Chief Psychologist ensures the Admission and Orientation lesson plan developed by the Psychology Services Branch is utilized to convey this information. In addition, the Chief Psychologist is responsible for ensuring basic psychological services (e.g., mental health screening, brief counseling), as detailed in the Program Statement **Psychology Services Manual**, are made available to inmates.

d. **Mental Health Treatment Coordinator.** The Mental Health Treatment Coordinator is a licensed doctoral-level psychologist who manages the treatment and care of inmates with mental illness and ensures that all provisions of this Program Statement are implemented. A licensed doctoral-level psychologist has satisfactorily completed all the requirements for a doctoral degree directly related to full professional work in psychology (i.e., a Ph.D. or Psy.D. in Clinical or Counseling Psychology), and has obtained a license to practice as a psychologist.

e. **Social Worker.** The institution Social Worker is a licensed professional who may provide individual or group counseling in support of this policy. Additionally, the institution Social Worker or Regional Social Worker may develop comprehensive release plans to ensure continuity of care for inmates with mental illness who transition to the community without the benefit of Residential Reentry or Home Confinement placement. In this capacity, Social Workers coordinate with United States Probation Officers, Courts, community mental health professionals, and families to identify appropriate placements and to address reentry needs.

f. **Psychiatrist/Psychiatric Nurse Practitioner.** Health Services organizes, conducts, and administers psychiatric services. The Psychiatrist/Psychiatric Nurse Practitioner accepts referrals through BEMR for cases believed to be in need of psychiatric medication evaluations. Regular interdisciplinary communication is maintained between the Mental Health Treatment Coordinator and Health Services staff, including contract psychiatrists, to optimize treatment efficacy.

g. **Health Services Administrator.** In facilities that use contract psychiatric services, the Health Services Administrator is responsible for contract development and oversight with input from the Mental Health Treatment Coordinator.

h. **Clinical Director.** The Clinical Director will ensure that the general medical needs of each inmate are addressed and that HSD staff rounding in the units and conducting sick call and clinics have received the necessary training to recognize signs and symptoms of mental illness.

i. **Community Treatment Services (CTS).** CTS is responsible for the establishment and oversight of community-based mental health, substance abuse, and sex offender treatment services.

j. **Residential Reentry Management Branch (RRMB).** RRMB is responsible for coordinating with the Psychology Services Branch, in particular CTS staff, to ensure mentally ill inmates releasing through Residential Reentry Centers and Home Confinement are placed appropriately.

j. **Care Coordination and Reentry (CCARE) Team.** The CCARE Team is a multidisciplinary team that uses a holistic approach to ensure that critical aspects of care for inmates with mental illness are considered and integrated. The CCARE Team is responsible for identifying potential concerns affecting inmates with mental illness in a correctional environment.

j. **All Staff.** Any staff member who observes unusual behavior in an inmate that may indicate mental illness should report these observations to the Chief Psychologist or Mental Health Treatment Coordinator.

3. RECOVERY-ORIENTED PROGRAM MODEL

Consistent with the recommendations of the President's New Freedom Commission on Mental Health, the Bureau has identified recovery as a guiding principle in the treatment and care of inmates with mental illness. Mental health recovery refers to the process by which people are able to live, work, learn, and participate fully in their communities. For some individuals,

recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms.

According to the National Consensus Statement on Mental Health Recovery, there are ten fundamental components of recovery. The Bureau strives to integrate these components into its Psychology Treatment Programs (PTPs), mental health interventions, and treatment plans for inmates with mental illness. The components of recovery are: self-direction, individualized and person-centered care, empowerment, holistic treatment, non-linear progression, strengths-based focus, peer support, respect, responsibility, and hope.

4. EVIDENCE-BASED PRACTICES (EBPs)

Psychology Treatment Programs, mental health interventions, and individualized treatment plans for inmates with mental illness rely on evidence-based clinical practices that have been demonstrated to reduce the symptoms of mental illness. EBPs are quickly evolving and cannot be fully listed in the present policy. Therefore, the Bureau maintains a database of EBPs on Sallyport, which is updated as indicated by professional literature. The Psychology Services Branch facilitates implementation of EBPs with materials, education, training, and consultation.

Holistic, recovery-oriented care for inmates with mental illness involves assessing their need for both mental health treatment and rehabilitation programs that reduce the risk of recidivism; services are provided in each of these areas as appropriate. EBPs are selected based on their adherence to this model. Consistent with evidence-based practice, the delivery of mental health services is prioritized for inmates classified as CARE2-MH, CARE3-MH, and CARE4-MH.

a. **Cognitive Behavioral Therapy (CBT).** The Bureau's treatment programs and mental health services are unified clinical activities organized to treat inmates' complex psychological and behavioral problems throughout the course of incarceration. The Bureau has chosen CBT as a theoretical model because of its proven effectiveness with inmate populations. This guiding model creates theoretical continuity, ensuring that learning and practice are built upon similar principles regardless of the institution, treatment provider, or treatment program in which they occur.

CBT emphasizes the learning and practice of skills associated with improved mental health and adaptive, pro-social behavior. Therefore, inmates who participate in CBT and related interventions (e.g., Dialectical Behavior Therapy [DBT]) are better able to achieve goals the Bureau has for all inmates, including responsibility, self-awareness, and independence.

b. **Group Treatment.** Group treatment has proven to be both clinically effective and an efficient use of resources in the treatment of mental illness. Group treatments have the benefit of modeling by the facilitator and other participants, building social support, and allowing the

immediate practice of new skills. A number of EBPs supported by the Bureau were designed specifically for or can be adapted to a group format. Mental health clinicians are encouraged to provide treatment using a therapeutic group format.

For the purposes of mental health care in the general population, therapeutic groups may be open or closed, are evidence-based, and ordinarily:

- Use an established Bureau protocol.
- Are facilitated by a mental health clinician (i.e., psychologist, psychiatrist, social worker, mental health treatment specialist, psychology intern).
- Meet at least every other week.
- Have a continuity in membership, no greater than 12 participants.
- Provide a therapeutic intervention (not just to “check in” with the therapist).
- Hold rapport building and mutual concern among members as a primary goal.

Following participation in therapeutic groups, it may be appropriate to place an inmate in a maintenance group. Maintenance groups have the same characteristics as therapeutic groups, except that their goal is to maintain progress on therapeutic goals and they may meet less frequently (but at least monthly).

c. **Priority Practices.** The Psychology Services Branch designates certain EBPs as Priority Practices – EBPs delivered in group format that address core needs of the inmate population. They prioritize services for inmates with the most severe forms of mental illness and give consideration to a balanced offering of groups that address mental illness and criminal thinking. They may differ across institutions, based on security level, care level, and mission. The Psychology Services Branch places information regarding Priority Practices for each type of institution on Sallyport.

Ordinarily, Psychology Services departments are actively engaged in the provision of Priority Practices as a vital function. Priority Practices are offered before other types of groups. At a minimum, Psychology Services departments offer at least one Priority Practice therapeutic group each quarter, in addition to groups offered in PTPs. For complexes, each institution is considered independently. Satellite facilities are excluded, unless a full-time clinical staff member is assigned.

d. **Skills Training.** The Bureau emphasizes the learning and practice of skills as an important component of treatment for inmates with mental illness. Treatments that emphasize developing new skills (e.g., CBT, DBT, Illness Management and Recovery, Anger Management) encourage responsibility, empowerment, and independence upon reentry.

e. **Criminal Thinking and Risk.** For most inmates with mental illness, the treatment of mental health symptoms is necessary but not sufficient to reduce the risk of recidivism. Holistic treatment considers which empirically validated dynamic risk factors associated with recidivism must be included in the treatment plan (e.g., criminal thinking errors, substance use, antisocial associates, lack of leisure and recreation activities, school or work functioning).

f. **Peer Support.** Peer support is an EBP and core component of the Mental Health Recovery Model; it functions as an adjunct to professional interventions by extending the mental health system. Inmates who underuse professional services may actively engage in peer support activities that benefit their mental health and that of their peers.

5. MENTAL HEALTH CARE LEVELS

Mental health care levels are used to classify inmates based on their need for mental health services. The contact frequencies described below refer to contacts where psychosocial interventions are provided.

a. Definitions

(1) **CARE1-MH: No Significant Mental Health Care.** An individual is considered to meet CARE1-MH criteria if he/she:

- Shows no significant level of functional impairment associated with a mental illness and demonstrates no need for regular mental health interventions; and
- Has no history of serious functional impairment due to mental illness or if a history of mental illness is present, the inmate has consistently demonstrated appropriate help-seeking behavior in response to any reemergence of symptoms.

(2) **CARE2-MH: Routine Outpatient Mental Health Care or Crisis-Oriented Mental Health Care.** An individual is considered to meet CARE2-MH criteria if he/she has a mental illness requiring:

- Routine outpatient mental health care on an ongoing basis; and/or
- Brief, crisis-oriented mental health care of significant intensity; e.g., placement on suicide watch or behavioral observation status.

(3) **CARE3-MH: Enhanced Outpatient Mental Health Care or Residential Mental Health Care.** An individual is considered to meet the criteria for CARE3-MH if he/she has a mental illness requiring:

- Enhanced outpatient mental health care (i.e., weekly mental health interventions); or

- Residential mental health care (i.e., placement in a residential Psychology Treatment Program).

(4) **CARE4-MH: Inpatient Psychiatric Care.** A mentally ill inmate may meet the criteria for CARE4-MH and require acute care in a psychiatric hospital if the inmate is gravely disabled and cannot function in general population in a CARE3-MH environment.

b. **Determination of Mental Health Care Levels.** All current mental health illnesses should be diagnosed in a Diagnostic and Care Level Formulation note in PDS, including personality disorders and intellectual disabilities. The cumulative impact of the disorders on functioning is taken into account when assigning a mental health care level.

To assign a care level, staff consider the inmate's current, recent, and historical need for services. However, this is not the only indicator, as it must be balanced with the inmate's diagnosis and anticipated need for future services. For example:

- Inmates diagnosed with major mental illnesses and/or currently taking antipsychotic medications are not ordinarily classified as CARE1-MH due to their risk of relapse and the lack of resources to address such a relapse at a CARE1-MH facility.
- Inmates releasing from Medical Referral Centers (MRCs) where they received treatment for acute mental health problems are ordinarily classified as CARE3-MH, due to the resources required to assist them in adjusting to a mainline institution.

Discrepancies in the Record. Occasionally there are diagnostic discrepancies between providers. When this occurs, the Mental Health Treatment Coordinator or treating psychologist attempts to reconcile these differences. The Mental Health Treatment Coordinator or treating psychologist reviews the record, consults with other treatment providers (including Health Services staff), performs a clinical interview, and observes symptoms and behaviors. The Coordinator or psychologist then integrates the data, noting alternate conceptualizations; attempts to reach consensus between care providers; enters a diagnosis in the Diagnostic and Care Level Formulation note in PDS; and provides a rationale for the decision. If the discrepancy cannot be resolved at this level, the Chief Psychologist and Chief Psychiatrist, if applicable, will review the case, resolve the discrepancy, and document their findings.

A supplemental Mental Health Care Level Training Guide is available on Sallyport. The guide is also disseminated during Psychologist Familiarization Training and annual mental health training events. This guide is designed to assist psychologists in determining appropriate mental health care levels.

c. **Treatment Requirements for Mental Health Care Levels.** The required treatment detailed below is not necessarily provided exclusively by the Mental Health Treatment Coordinator; for example, another psychologist may provide this care.

(1) **Mental Health Care Level One.** Inmates classified as CARE1-MH are not required to receive any regular mental health services or to have a treatment plan. When mental health services are provided to these inmates, they are documented in PDS.

(2) **Mental Health Care Level Two.** Required services include, but are not limited to:

- A diagnosis and mental health care level for each inmate will be documented in a Diagnostic and Care Level Formulation note in PDS.
- A rationale for the diagnosis and assigned care level will also be documented in the Diagnostic and Care Level Formulation note in PDS.
- A collaborative, individualized treatment plan that describes the inmate's problems and goals, and the interventions planned to assist with goal attainment will be developed, reviewed, and updated at least every 12 months.
- Evidence-based psychosocial interventions on at least a monthly basis (if group treatment is offered, it should occur at least every other week, to provide continuity of care).

(3) **Mental Health Care Level Three.** Required services include, but are not limited to:

- A diagnosis and mental health care level for each inmate will be documented in a Diagnostic and Care Level Formulation note in PDS.
- A rationale for the diagnosis and assigned care level will also be documented in the Diagnostic and Care Level Formulation note in PDS.
- A collaborative, individualized treatment plan that describes the inmate's problems and goals, and the interventions planned to assist with goal attainment, will be developed, reviewed, and updated at least every 6 months.
- Evidence-based psychosocial interventions on at least a weekly basis are provided via enhanced outpatient care or on a scheduled basis consistent with a residential Psychology Treatment Program.

(4) **Mental Health Care Level Four.** This treatment takes place only in a Medical Referral Center. Required services include, but are not limited to:

- A diagnosis and mental health care level for each inmate will be documented in the Diagnostic and Care Level Formulation note in PDS.
- A rationale for the diagnosis and assigned care level will also be documented in the Diagnostic and Care Level Formulation note in PDS.

- A collaborative, individualized treatment plan that describes the inmate’s problems and goals, and the interventions planned to assist with goal attainment will be developed, reviewed, and updated at least every 90 days.
- Evidence-based psychosocial interventions and/or individual mental health contacts will occur on at least a weekly basis.

At CARE4-MH sites, for inmates too cognitively impaired to engage in traditional psychosocial interventions (i.e., severe neurocognitive disorders), supportive contacts from a broad variety of providers may be the most appropriate care plan. Frequency and type of care will be determined on an individual basis for these cases.

d. Treatment Refusal. If an inmate declines treatment consistent with his/her mental health care level, a treatment plan is developed and implemented to frequently assess the inmate’s mental status, build rapport, and encourage engagement in a treatment process. Ordinarily, the treatment plan will include a monthly attempt to engage the inmate. Rapport building strategies may include: group leisure activities; visits to the inmate’s unit or work site; and “drop-in” group for informal socialization with peers.

An inmate who refuses mental health treatment consistent with his/her mental health care level may be considered for involuntary commitment.

6. IDENTIFICATION AND PLACEMENT OF MENTALLY ILL INMATES

All Bureau facilities employ psychologists skilled in the screening, diagnosis, and treatment of mental disorders. Although the Bureau concentrates mental health resources at some institutions, all institutions, regardless of care level, are expected to provide services for inmates with mental illness.

Psychology Services and Health Services departments within each institution ensure every inmate with a clinically identified need for psychological treatment has access to mental health care. They ensure inmates undergo appropriate screening, assessment, and referral to identify and address their mental health, substance abuse, and other behavioral health needs. Psychology Services departments offer a variety of services and programs for inmates – psycho-educational groups, brief counseling, individual and group psychotherapy, crisis intervention, suicide prevention, and residential treatment programs. Health Services departments provide inmates with access to appropriate psychiatric medications to address identified mental health conditions.

a. Pre-Designation Screening. Newly designated inmates are screened by Designation and Sentence Computation Center (DSCC) staff based on information in their Pre-Sentence Report (PSR). This screening matches the inmate’s estimated need for mental health services with an institution’s resources at the time of initial designation.

b. **Initial Care Level Assignment.** Mental health screen assignments (SCRNX-MH) are part of the designation process. The assignments are generated by DSCC staff using the medical calculator and are based on review of the PSR, information received from outside sources, a review of other records, etc.

c. **Medical Staff Screening.** Medical staff provide an initial screening for physical and mental health concerns, including suicide ideation, symptoms of mental illness, and sexual victimization. They document their findings in BEMR and advise Psychology Services of any concerns.

d. **Psychology Intake Screening.** Psychology Intake Screening occurs within the timeframes specified in the Program Statement **Psychology Services Manual** and is documented in PDS. At this time the mental health screen assignment is replaced with the mental health care level assignment in SENTRY, and the mental health care level is documented in Psychology Intake Screening, along with a rationale. If the care level is CARE2-MH, CARE3-MH, or CARE4-MH, a Diagnostic and Care Level Formulation note is entered into PDS. In addition, Psychology Services staff notify Health Services staff of any relevant concerns; e.g., a recommendation for a psychiatric medication consultation.

e. **Assignment and Change of Mental Health Care Level Assignment.** Bureau psychologists, psychiatrists, and qualified mid-level practitioners (i.e., a physician assistant or nurse practitioner who is licensed in his/her field of medicine and has specialized training in mental health care) can determine a mental health care level following a review of records and a face-to-face clinical interview. Therefore, assigned mental health care levels represent clinical information about an inmate and are not changed for administrative, designation, or transfer purposes. If there is not agreement regarding an inmate's mental health care level assignment, refer to Section 5b of this policy to resolve any discrepancies.

Mental health care levels are to be entered into SENTRY by Bureau psychologists. As applicable, information provided by Bureau psychiatrists will inform decisions regarding mental health care level assignments. To assign or change a mental health care level a psychologist, psychiatrist, and qualified mid-level practitioner must:

- Review the clinical record.
- Conduct a clinical interview.
- Establish a diagnosis or indicate the absence of a diagnosis.
- Indicate and explain the type and frequency of mental health care contacts required.
- Document this information in the Diagnostic and Care Level Formulation note.

Mental health care level assignments, and changes to these assignments, are not required for inmates housed in non-Bureau facilities; i.e., private correctional institutions, Residential Reentry Centers, and other contract facilities. In addition, these assignments are not required for inmates in transit. If it becomes clear that a mental health care level assignment needs to be updated to accurately represent the inmate's needs upon return to a Bureau facility, Psychology Services Branch staff update the code and enter a note in PDS describing what is known about the situation and the inmate's mental health needs.

f. Facilities with Pretrial Inmates. Psychology Services staff are not required to enter mental health care level assignments for all pretrial inmates. However, they must enter assignments for the following pretrial inmates:

- Inmates who undergo a Psychology Intake Screening on the basis of their endorsements on the Psychology Services Inmate Questionnaire (PSIQ).
- Inmates who self-refer or are referred to Psychology Services due to mental health symptoms.
- Inmates who have a recently completed forensic evaluation by a Bureau psychologist or psychiatrist.
- Inmates who require a Suicide Risk Assessment.

If a pretrial inmate does have a care level assignment, it is expected that he/she will receive mental health services consistent with the frequency requirements of that care level. The creation of a treatment plan is clinically appropriate for inmates for whom a long stay is anticipated. However, due to the rapid and unpredictable turnover associated with pretrial facilities, treatment plans are not required.

If the DSCC receives a request for an initial designation and a pretrial facility has already classified a mental health care level for the inmate, the DSCC does not modify this assignment or change it back to a screen code.

7. TEAM APPROACH TO CARE

Due to their potential vulnerability in a correctional setting, inmates with mental illness may require special accommodation in areas such as housing, discipline, work, education, designations, transfers, and reentry to ensure their optimal functioning. The Bureau uses a team approach to ensure the needs of inmates with mental illness are identified and addressed.

The institution Care Coordination and Reentry (CCARE) Team is a multidisciplinary team that uses a holistic approach to ensure critical aspects of care for inmates with mental illness are considered and integrated. It is a required component at all CARE2-MH, CARE3-MH, and CARE4-MH institutions. It is not required at pretrial facilities or Federal Transfer Centers.

The CCARE Team identifies potential concerns affecting inmates with mental illness in a correctional environment, such as:

- Mental health symptoms that are unreported or unidentified by the inmate.
- Housing problems or cellmate conflicts.
- Work and/or leisure time deficits.
- Criminal thinking and behavior.
- Bullying or abuse by other inmates.
- Escalating patterns of destructive or dangerous behavior.

The CCARE Team also identifies strategies and supports to mitigate potentially negative interactions between inmates with mental illness and the correctional environment, such as:

- Positive reinforcers for behavior consistent with treatment goals.
- Social supports (cellmates, positive staff relationships, spiritual community, mental health companion program).
- Housing accommodations.
- Meaningful ways to spend time (work, supported employment, recreation, drop-in group).

The CCARE team considers how these strategies and supports might be applied to improve functioning and enhance opportunities for recovery. Meetings are ordinarily held no less than once a month and may be held in conjunction with the SHU Meeting.

Every CARE4-MH inmate is reviewed by the team at least quarterly. Every CARE3-MH inmate is reviewed by the team as needed and at least semi-annually. CARE2-MH inmates are reviewed by the team as needed and at least annually. If an inmate participates in a residential PTP, his/her case may be staffed in that setting at the discretion of the Mental Health Treatment Coordinator.

At a minimum the CCARE Team includes:

- Mental Health Treatment Coordinator (CCARE Team co-leader).
- Provider of psychiatric services (CCARE Team co-leader).
- Treating psychologist.
- Institution Social Worker (if applicable).
- Pharmacist.

In addition, the Mental Health Treatment Coordinator invites the following staff, and others as deemed appropriate, to attend CCARE Team meetings:

- Clinical Director. Clinical Directors are strongly encouraged to attend, particularly at CARE4-MH facilities.
- Supervisor of Recreation.
- Applicable unit managers.
- Correctional Services Supervisor.
- Supervisory Chaplain.

The following staff serve on the CCARE Team in special circumstances, as detailed below:

- Regional Social Workers and Community Treatment Services (CTS) staff are required to attend only when reentry needs are being discussed. They may attend via video or teleconference.
- The Disciplinary Hearing Officer (DHO) may attend if a mentally ill inmate is facing serious disciplinary action.
- Depending on the focus of the meeting, other staff may be invited, such as work supervisors or teachers.

In Psychiatric Referral Centers team composition may vary. However, the team model is used.

8. RESTRICTIVE HOUSING

The Bureau strives to avoid prolonged placement of inmates with serious mental illness in settings such as Special Housing Units (SHU) and the Special Management Unit (SMU). However, sometimes such placement of inmates is required due to safety and security needs. If, due to safety and/or security needs, an inmate with a serious mental illness needs to be placed in restrictive housing, he/she will continue to receive mental health care commensurate with his/her treatment needs.

a. **Services for Inmates in Restrictive Housing.** Ordinarily, all critical contacts, regardless of an inmate's mental health care level, will, to the extent possible, be conducted in a private area. These include:

- Diagnostic assessments.
- Suicide risk assessments.
- Crisis intervention contacts.
- Protective custody reviews.
- Sexual assault prevention intervention.
- Mental health treatment contacts as indicated by the treatment plan.
- Any other service that addresses potentially sensitive issues or high-risk behaviors.

Additionally, all inmates with mental illness in restrictive housing units (e.g., SHU, SMU, ADX) will receive, at a minimum, face-to-face mental health contacts consistent with the type and

frequency indicated by their care level, to the extent feasible. These contacts take place in a manner that protects an inmate's privacy to the extent that safety and security of staff are not compromised. Contacts should be consistent with the goals of the treatment plan, and are in addition to any critical contacts or contacts required by policy (e.g., SHU Review).

Exceptions to private critical contacts and mental health treatment contacts should be made in cases where the inmate is behaving in an aggressive manner or when institutional safety and security considerations are determined to require an exception. Contacts should be suspended if an inmate becomes aggressive, such that the staff member is concerned about his/her safety. The contact is reinitiated once additional security is in place or when the inmate has regained control of his/her behavior. Exceptions are not made due to logistical issues concerning moving the inmate out of his/her cell or difficulty locating a private space.

The Bureau recognizes that an inmate's mental health may deteriorate during a restrictive housing placement. Potential issues are mitigated through a variety of strategies that are applied collaboratively by staff across disciplines:

- During rounds, all staff will make themselves available for brief conversations that demonstrate concern and their availability to provide assistance.
- Except in unique circumstances, mental health clinicians will not participate as a team member in a calculated use of force situation.
- Inmates are removed from their cells for private or extended interviews with Psychology and Psychiatry Services staff as a standard procedure.
- In-cell activities (e.g., books, puzzles, games, audio/video entertainment and programming [if applicable]) will be provided by the corresponding departments.
- Close attention will be paid to the importance of out of cell, unstructured recreation time specific to inmates' needs and encouraging inmates to take advantage of out of cell activities.

If restrictive housing appears to have a negative impact on the inmate's mental health, the Mental Health Treatment Coordinator actively works with the CCARE Team to mitigate the negative impact or identify an appropriately secure alternative placement.

b. Extended Restrictive Housing Placement Reviews. Inmates referred for extended placement in restrictive housing (i.e., SMU, ADX) must be reviewed by Psychology Services staff to determine if mental health issues exist that preclude placement in this setting. Psychiatry Services staff may be consulted in making this determination. In addition, inmates housed in restrictive housing for an extended period of time receive an enhanced mental health review, detailed below. The Psychology Services Branch provides oversight of mentally ill inmates in restrictive housing through the procedures and reviews described below.

(1) **SMU Referral Review Procedures.** The following SMU referrals are reviewed by the Psychology Services Branch in collaboration with the Chief Psychiatrist, Health Services Division, as applicable, prior to placement:

- Inmates classified as CARE2-MH, CARE3-MH, and CARE4-MH in SENTRY.
- Inmates classified as PSY ALERT in SENTRY.
- Inmates noted to be receiving psychiatric medications.
- Any inmate for whom the institution Chief Psychologist requests a review based on mental health or cognitive limitation concerns.
- Any inmate for whom the DSCC requests a review based on mental health or cognitive limitation concerns.

In conducting this review, the Branch applies the exclusionary criteria noted below (SMU/ADX Exclusionary Criteria) to identify any inmates precluded from SMU placement.

(2) **ADX Referral Review Procedures.** A mental health evaluation is a required component of **all** referral packets for the ADX Florence Control Unit and ADX Florence General Population (per the Program Statements **Control Unit Programs** and **Inmate Security Designation and Custody Classification**, respectively).

The mental health evaluation is conducted by a licensed doctoral level psychologist. An interview of the inmate and psychological testing (the current version of the Personality Assessment Inventory) are required components. In addition, screening for intellectual disability is required (the current version of the Kaufman Brief Intelligence Test) and, if indicated, further testing (the current version of the Wechsler Adult Intelligence Scale). Before the interview, a notice of psychological evaluation must be provided. Notification forms are BP-A1055, Notice of Psychological Evaluation – ADX Control Unit, and BP-A1056, Notice of Psychological Evaluation – ADX General Population. If the inmate refuses to cooperate with the interview or psychological testing, the evaluation proceeds. This refusal is noted in the report.

The required format for the mental health evaluation report is outlined below:

ADX Mental Health Evaluation

- **Identifying Data.** Identifying data includes: inmate name and register number, gender, race, ethnicity, languages spoken, date of birth and age, current sentence, and projected release date. In addition, the identifying data section indicates the date and place of the evaluation and the name of the evaluator.
- **Notice of Psychological Evaluation.** Confirms the inmate was provided with the Notice of Psychological Evaluation. If he/she refused to sign, the information is noted in this section.

- **Assessment Procedures.** Lists the assessment procedures used, including: Notice of Psychological Evaluation, clinical interview, PSR and Central File review, collateral information and observations by other staff, and psychological testing (specify tests administered; e.g., PAI, WAIS-IV, KBIT-2). *Note:* An attempt to interview the inmate and conduct psychological testing must occur in all cases. If the inmate refuses to cooperate, his/her refusal is noted in this section and in the psychological testing section.
- **Psychosocial History.** Briefly addresses the inmate's psychosocial history, as relevant to this report, noting not only significant deficits or limitations, but also areas of specific strength. Topics that may be addressed include:
 - **Family History.** Describes family of origin; any noteworthy criminal, psychiatric, or medical history of relatives; any history of abuse or trauma in the family; and marital history if applicable.
 - **Educational History.** Briefly notes the inmate's educational history, with emphasis on noted intellectual disabilities, cognitive impairments, and results of intelligence testing.
 - **Employment History.** Briefly describes the inmate's employment history, including any prior military experience.
- **Medical History.** Briefly notes significant medical conditions, such as chronic illnesses or disabilities.
- **Mental Health History.** Typically contains a greater level of detail and includes the following (if applicable): historical information related to psychiatric hospitalizations, past mental health diagnoses, use of psychiatric medication, history of suicidal behavior/gestures, mental health treatment history prior to and within the Bureau, and history of mental health deterioration during confinement in a restrictive housing setting. *Note:* PSR and PDS/BEMR review are mandatory in the preparation of this section.
- **Substance Abuse History.** Briefly describes any substance abuse issues.
- **Psychosexual History.** Briefly describes any deviant sexual interests, history of sexually abusive behavior or victimization, and history of sexual crimes.
- **Criminal History.** Describes the inmate's criminal history, including juvenile and adult crimes, escape attempts, and incident reports. Special attention is given to crimes, escape attempts, and incident reports contributing to the ADX referral. In addition, this section addresses the inmate's view of his/her criminal activity, including the incident(s) associated with the referral. *Note:* It is not necessary to list every arrest, conviction, and incident report in this section. The evaluator may summarize information. For example, "Inmate Smith has received 37 incident reports in the past 3 years, the majority of which involve insolence and possession of intoxicants."
- **Interview/Mental Status Examination.** Summarizes findings from the clinical interview and mental status examination. If the inmate refuses to participate in the clinical interview

and mental status examination, his/her refusal is noted in this section and all pertinent observations are recorded.

- **PAI Results.** Summarizes PAI results. If the inmate refuses to complete the PAI, his/her refusal is noted in this section.
- **Case Formulation.** Contains an analysis and synthesis of the data, which integrates psychological testing results with history, mental status, and clinical observations. Diagnostic impressions should be fully supported. If prior documentation of a mental illness exists, but is no longer valid, or if the evaluator believes it was never valid, this should be noted and supported by the evaluator. The case formulation also includes the evaluator's conclusion whether any psychological factors would preclude the inmate's placement at the ADX.
- **Diagnostic and Care Level Formulation.** Lists any diagnoses and notes the inmate's mental health care level.

The completed mental health evaluation report is entered in the PDS in the "Evaluations" section; the document is titled "ADX Referral Mental Health Evaluation." The report is entered directly into PDS; it is not entered as a Word attachment. Psychological testing data are scanned into PDS as an attachment linked to the evaluation note. Once the report is entered into PDS, an email notification is sent to the Psychology Services Branch at *BOP-RSD/Psychology SVCS*~. The inmate's name and register number are included in the subject line. The Psychology Services Branch reviews the report, psychological testing results, and the PDS records. Any concerns are discussed with the Chief Psychologist or Clinical Director at the inmate's facility. If no concerns are noted, a concurrence email is sent to the Chief Psychologist and the Warden for inclusion in the referral packet.

c. **SMU/ADX Exclusionary Criteria.** Ordinarily, seriously mentally ill inmates (classified as CARE3-MH) are diverted from SMU or ADX placement and CARE4-MH inmates are not placed in these facilities. Inmates who are identified as seriously mentally ill will not be designated to or housed at the ADX or SMUs, except as noted below. Placement of a seriously mentally ill inmate in the ADX or a SMU will only occur if extraordinary security needs are identified that cannot be managed elsewhere. In such circumstances, an individualized mental health treatment plan will be developed commensurate with the inmate's treatment needs. The decision to exclude a seriously mentally ill inmate from the ADX or a SMU is not contingent on his/her willingness to participate in a mental health treatment program. In addition, the Psychology Services Branch, in collaboration with the Chief Psychiatrist, Health Services Division, will generally recommend against SMU or ADX placement in the following instances:

- A review of documentation suggests SMU or ADX placement would interfere with the inmate's participation in necessary mental health treatment interventions.

- A review of documentation suggests the inmate's mental health disorder or cognitive limitations make it unlikely he/she could successfully progress through the phases of the SMU or ADX.
- A review of documentation suggests SMU or ADX placement is likely to exacerbate an inmate's mental health condition.

Inmates identified as in need of inpatient psychiatric care (CARE4-MH) are not referred for placement in a SMU or the ADX. The appropriate placement for these inmates is a Psychiatric Referral Center.

If a seriously mentally ill inmate is determined to be unable to function in a less restrictive setting due to special safety and security needs, he/she will continue to receive mental health services commensurate with his treatment needs while in restrictive housing.

d. Extended Restrictive Housing Reviews. Inmates in restrictive housing placements for an extended period will receive regular mental health evaluations. These evaluations occur when the inmate is continuously housed:

- In SHU for 6 months.
- In the ADX for 12 months.
- In a SMU for 18 months.

The mental health evaluation is completed by an institution psychologist and includes a review of the records, behavioral observations, clinical interview, and psychological testing if clinically indicated.

If the inmate refuses to cooperate with the interview or psychological testing, the evaluation proceeds and this refusal is noted in the report. The required protocols for the mental health evaluation reports are found in BP-A1057, Restrictive Housing Mental Health Evaluation – Initial Review, and BP-A1058, Restrictive Housing Mental Health Evaluation – Follow-Up Review; the results of these reports are documented in the Diagnostic and Care Level Formulation in PDS.

Updates are conducted for subsequent anniversaries; for example, an inmate continuously housed in SHU for 18 months would receive an evaluation when he/she has been housed in SHU for 6 months, with updates at 12 and 18 months.

The documentation associated with this review is entered in PDS under the note type "Restrictive Housing Mental Health Evaluation" and the results documented in PDS as an update of the

Diagnostic and Care Level Formulation note. This information is entered in PDS within 14 days of the applicable due date.

Based on the findings of this evaluation, the Chief Psychologist, in collaboration with the CCARE Team (if applicable) may immediately initiate local actions to address identified mental health concerns.

On a monthly basis, the Psychology Services Branch reviews Restrictive Housing Mental Health Evaluations to determine if mental health concerns are appropriately addressed. In conjunction with these reviews, Branch staff consult as necessary with institution staff and with the Bureau's Chief Psychiatrist. Branch staff also document concurrence with the evaluation findings or additional recommendations in PDS.

e. **SHU/SMU/ADX Removal Criteria.** If an inmate's mental health appears to have deteriorated during restrictive housing placement, the Mental Health Treatment Coordinator actively works with the CCARE Team (if applicable) and the Psychology Services Branch (if applicable) to mitigate the impact or identify an alternative placement. As necessary, the Psychology Services Branch will consult with the Bureau's Chief Psychiatrist. This deterioration may be identified through the mental health evaluation described above, or through more emergent factors; e.g., acute mental illness leading to the need for an emergency psychiatric transfer.

In addition, the Psychology Services Branch, in collaboration with the Chief Psychiatrist, Health Services Division, reviews inmates for possible removal from a SMU or the ADX in the following circumstances:

- Any inmate who is transferred from a SMU or the ADX to an MRC on an emergency psychiatric transfer.
- Any inmate who, upon arrival to a SMU or the ADX, is judged by the Chief Psychologist or Psychiatrist to have significant mental health issues or cognitive limitations that may make him/her inappropriate for this placement.
- Any inmate who begins to experience symptoms of a serious mental illness following placement in a SMU or the ADX.

f. **Discipline.** An inmate's mental health symptoms may contribute to institution rule infractions that could result in disciplinary sanctions, including SHU placement or the extension of SHU placement. In these cases it is the responsibility of the Mental Health Treatment Coordinator to provide consultation to the DHO to ensure the disciplinary process is applied appropriately to inmates with mental illness.

The DHO refers the following incident reports to a psychologist for determination of competence and responsibility:

- Any incident report received by a CARE3-MH or CARE4-MH inmate.
- Any incident report received by a CARE2-MH inmate where there appears to be a mental health concern.
- Any incident reports for Code 228 involving self-harm.
- Any incident report for Code 302, Misuse of Authorized Medication.

The Mental Health Treatment Coordinator indicates whether the inmate is competent or responsible and whether some types of sanctions are inappropriate based on his/her mental health needs. Sanctions that limit social support (e.g., SHU placement, loss of visits, or loss of phone calls) should be considered on a case-by-case basis and may not be appropriate for inmates with mental illness who use these supports as a component of their treatment or recovery.

9. MENTAL HEALTH TRAINING

Mental health training for all staff is included in Introduction to Correctional Techniques I and II and Annual Training. Mental health training is also provided on a quarterly basis to SHU officers.

Additional Mental Health Specialty Training will be made available in select CARE2-MH, CARE3-MH, CARE4-MH, and administrative institutions. To support this specialized training, adequate Psychology Services staffing must be in place. With adequate Psychology Services staffing and sufficient staff interest, this training is offered annually. This program supports the development of an optimal environment for effective treatment and care of offenders with mental illness, in which mental health professionals and other staff work collaboratively to support treatment. The training promotes early identification of mental health problems and more effective de-escalation and support when problems arise. While this training is not required to work a post on a mental health unit, it will be especially beneficial for staff who work these posts.

Staff may apply to take advantage of this additional Mental Health Specialty Training by submitting an application to the Human Resource Manager following the announcement of this training opportunity.

This additional Mental Health Specialty Training will include 24 hours of specialized mental health training, including suicide prevention, understanding mental illness, cultural diversity and sensitivity, psychiatric medications, behavior management principles, confidentiality, communication skills, de-escalation skills, and building collaborative relationships.

10. MENTAL HEALTH COMPANION PROGRAM

Mental Health Companions are trained inmates who provide assistance and support to inmates with mental illness under the direction of the Psychology Services Department. Mental Health Companion Programs are initiated at the discretion of the Warden. They may take a variety of forms, including a cadre residing on a mental health treatment unit, supporting a drop-in center, or participating in individual pairings with inmates who need additional support.

The Mental Health Treatment Coordinator is responsible for the selection, training, assignment, and removal of individual companions. Inmates selected as companions are considered to be on an institution work assignment when they are on their scheduled shift and receive performance pay for time spent providing support to inmates with mental illness.

a. **Selection of Inmate Mental Health Companions.** Because of the sensitive nature of such assignments, the selection of Mental Health Companions requires considerable attention. They must be able to provide companionship and assistance to mentally ill inmates, protect their privacy, and report significant safety concerns and suicide warning signs to staff. In the Mental Health Treatment Coordinator's judgment, they must be reliable individuals who have credibility with both staff and inmates and are able to perform their duties with minimal need for direct supervision. In addition, any inmate who is selected as a Mental Health Companion must not:

- Have committed a 100-level prohibited act within the last three years.
- Be in Financial Responsibility Program (FRP), GED, or Drug Ed Refuse status.
- Have a history of sex offense against an adult.

As part of the selection process, the Mental Health Treatment Coordinator takes the following steps and documents the findings in PDS:

- Interview the inmate.
- Review the inmate's disciplinary history.
- Review the inmate's PSR.
- Review the inmate's PDS documentation.
- Consult with the Special Investigative Supervisor (SIS).
- Consult with the inmate's current work supervisor.
- Consult with the Unit Team.

b. **Training Mental Health Companions.** Each companion receives at least four hours of initial suicide prevention training and an additional four hours of initial Mental Health Companion training before assuming Mental Health Companion duties. Each Companion also

receives at least four hours of refresher training every six months. Each training session reviews policy requirements and instructs the inmates on their duties and responsibilities as a Mental Health Companion, including:

- Basic information about mental illness.
- Modeling and supporting recovery from mental illness.
- Reducing stigma.
- Communication skills.
- Warning signs for suicide and other mental health problems that should be reported to staff immediately.

An inmate may serve as both a Mental Health Companion and a Suicide Watch Companion. However, these are separate work assignments with different tasks and challenges. Therefore, some portions of training may be combined and others must be individualized. Mental Health Companions may participate in the initial Suicide Watch Inmate Companion training provided by the Suicide Prevention Coordinator to complete the suicide prevention portion of their initial training. In semi-annual training, the components common to both Suicide Watch Companions and Mental Health Companions may be covered in a combined two-hour training, if two additional hours of specialized training are provided to each group.

c. **Meetings with Mental Health Treatment Coordinator.** Mental Health Companions with an active work assignment meet at least weekly with the Mental Health Treatment Coordinator or designee to debrief their work, review procedures, discuss issues, and supplement training. This meeting may occur in a group setting.

d. **Records.** The Mental Health Treatment Coordinator maintains a record in PDS containing:

- An agreement of understanding and expectations signed by each Companion.
- Documentation of attendance and topics discussed at semi-annual trainings and weekly meetings.

Verification of pay for those who have an assignment is also maintained.

e. **Supervision of Inmate Mental Health Companions.** Although Mental Health Companions are selected on the basis of their emotional stability and level of personal responsibility, they still require staff supervision while performing their duties. This supervision is provided by the Mental Health Treatment Coordinator during meetings. In support of the program, the Mental Health Treatment Coordinator provides staff with a roster of Companions (e.g., via TRUSCOPE, memorandum, or Sallyport).

f. **Removal.** The Mental Health Treatment Coordinator or designee may remove any Inmate Mental Health Companion from the program at his/her discretion. Removal of a companion is documented in the PDS records.

11. PTP ACHIEVEMENT AWARDS

Mental Health PTPs offer achievement awards for inmates who participate in them, as defined in the Program Statement **Psychology Treatment Programs**. Achievement awards are offered to participants who demonstrate behaviors that reflect a commitment to treatment, conformity with program norms, progress on treatment plan goals, and behaviors that are expected in the general society.

a. **Earning Achievement Awards.** Inmates enrolled in PTPs must:

- Be on time for all treatment activities.
- Have no unexcused absences.
- Not leave treatment activities without approval from the facilitator.
- Dress appropriately.
- Be an active participant in treatment activities.
- Put forth positive efforts in accomplishing treatment plan goals, as determined by the treatment provider.
- Comply with education and FRP obligations.
- Not receive a sanction for a sustained incident report.

b. **Specific Achievement Awards**

- **Limited financial awards.** An inmate may earn a financial award to offset time lost from work. The amount is \$50 for each phase of treatment, as defined in the Program Statement **Psychology Treatment Programs**. A financial award may be reduced by the treatment team based upon the inmate's unsatisfactory participation and progress. However, a financial award is never to exceed \$50.
- **Nearer release transfer.** Formal consideration may be given for a nearer release transfer following successful program completion.
- **Local incentives.** Institutions may offer incentives such as preferred living quarters, "early chow," washer/dryer or exercise equipment on unit, etc.
- **Tangible incentives.** With the Warden's approval, tangible incentives may be given (e.g., books, t-shirts, notebooks, pencil pouches, mugs with program logo, food and hygiene items that are not sold in commissary).
- **Token economy.** Mental Health PTPs may choose to run a token economy in which inmates are able to earn tangible incentives based on their participation.

- **Transition ceremony/ritual.** For the completion of a Mental Health PTP, institutions may offer a structured transition ceremony for the inmates.

12. MENTAL HEALTH TREATMENT ACHIEVEMENT AWARDS

Achievement awards are available to CARE3-MH inmates in all settings and CARE2-MH/CARE3-MH inmates at the ADX. Achievement awards are offered to participants who demonstrate behaviors that reflect sustained efforts toward recovery, progress on treatment goals, and pro-social attitudes and behaviors.

a. **Earning Achievement Awards.** Inmates must:

- Attend treatment activities on time.
- Make positive efforts in accomplishing treatment plan goals, as determined by the treatment provider.
- Comply with education and FRP obligations.
- Not receive a sanction for a sustained incident report.

b. **Specific Achievement Awards**

- **Local incentives.** Institutions may offer incentives such as preferred living quarters, “early chow,” washer/dryer or exercise equipment on a unit where CARE3-MH inmates live, etc.
- **Tangible incentives.** With the Warden’s approval, tangible incentives may be given, (e.g., books, t-shirts, notebooks, pencil pouches, mugs with program logo, food and hygiene items that are not sold in commissary).
- **Token economy.** CARE3-Mental Health sites may choose to run a token economy in which inmates are able to earn tangible incentives based on their participation in treatment.

13. REDESIGNATIONS OF INMATES WITH MENTAL ILLNESS

Inmates with mental illness are transferred using specialized procedures to ensure they are housed in institutions that have resources to meet their needs.

a. **CARE3-MH Inmates.** Ordinarily, designations of CARE3-MH inmates are processed at the DSCC and reviewed by Psychology Services staff, who recommend a placement or placements that have appropriate resources to meet the inmate’s mental health needs.

CARE3-MH inmates are, on occasion, transferred via program completion transfers (325) in order to manage the CARE3-MH populations at sites with PTPs for the mentally ill, such as the Mental Health Step Down Program and STAGES Program.

If a CARE3-MH inmate needs a transfer to a psychiatric referral center to manage acute psychiatric symptoms, the BP-A0770 (Medical/Surgical and Psychiatric Referral Request) is submitted to the Office of Medical Designations and Transfers (OMDT), Health Services Division. The mental health care level code is not changed to CARE4-MH by the sending institution.

Inmates classified as CARE3 in regard to both physical and mental health are referred for transfer and designation through OMDT.

b. Continuity of Care Between Bureau Institutions. To promote continuity of care for inmates with mental illness as they transfer, a Mental Health Transfer Summary must be completed in PDS every time a mentally ill (CARE2-MH, CARE3-MH, and CARE4-MH) inmate transfers within the Bureau – to an RRC, home confinement, or directly to the community. Pretrial facilities are exempt from this requirement if the inmate has been at the facility for less than six months.

- **Transfers between mainline institutions.** A Mental Health Transfer Summary must be entered into PDS by the Mental Health Treatment Coordinator, or treating psychologist, for all CARE2-MH, CARE3-MH, and CARE4-MH inmates before submission to the DSCC for transfer.
- **Psychiatric transfers to MRCs.** If an inmate is accepted for Emergency or Routine Psychiatric Transfer, the BP-A0770 is submitted to OMDT and entered into PDS; the Mental Health Transfer Summary is not required.
- **Psychiatric transfers from MRCs.** When psychiatric treatment at an MRC is complete, Psychology staff complete a treatment summary and update the Diagnostic and Care Level Formulation in PDS.

14. REENTRY

The Bureau is committed to helping inmates prepare for reintegration into their communities by transferring inmates with mental illness through RRCs or home confinement placements. However, each inmate should first be reviewed for suitability for community placement and continuity of care needs.

Each Warden is strongly encouraged to approve inmates who successfully complete Mental Health PTPs for RRC/Home Confinement placement, consistent with the recommendations of PTP staff.

a. Assessment of Psychological Suitability. The CCARE team considers community placement for all inmates with mental illness on an individual basis. However, some inmates may not be suitable for community placements. Others may be suitable, but may not benefit from community placements due to their mental health conditions, or may need special

consideration given to the type of community placement. The following conditions indicate an inmate is potentially unsuitable for RRC or home confinement placement:

- Ongoing inpatient psychiatric treatment.
- Uncontrolled mental health symptoms (e.g., psychosis with no insight, non-adherent with medication).
- Acute suicidal ideation with accompanying plans or recent attempts of moderate to high lethality.
- Inability to perform routine activities of daily living (bathing, dressing, eating, toileting, general hygiene, and mobility).

Continuity of care is also a primary consideration in placement decisions. For inmates who are particularly vulnerable to environmental changes or stressors, the following situations indicate caution should be taken regarding the inmate's placement and the inmate's needs, strengths, and weaknesses should be considered as part of the CCARE team planning process:

- There is no RRC in the inmate's community, causing him/her to have to relocate for RRC placement and again to return to his/her community.
- The inmate has a history of struggling to adapt to new environments.
- Community supports or mental health services are limited in the area to which the inmate is transferring.

At a minimum, the institution's CCARE Team assesses all CARE2-MH, CARE3-MH, and CARE4-MH inmates for suitability at the time of the RRC Referral Process and when the Mental Health Transfer Summary is prepared (30 to 60 days before RRC placement). If there are any concerns regarding the inmate's ability to be successful in a community placement, the team consults with CTS and Residential Reentry Management Branch staff.

Clinically manageable in the community is defined as having mental health symptoms that can be treated on an outpatient basis through pre-arranged linkages to family/community support, counseling, and psychiatric medications as needed.

When the CCARE Team determines the disposition for an inmate having one or more of the above-listed conditions, the team takes the actions below consistent with their decision:

- **Clinically manageable.** If an inmate's mental health needs are determined to be manageable in the community, the institution CCARE Team continues to monitor his/her status at intervals set by the team. If no complications arise, RRC or home confinement referral proceeds as planned by the Unit Team. If symptoms increase significantly, a reassessment occurs.
- **Clinically unmanageable.** If an inmate's mental health needs are determined to be unmanageable in the community, the Unit Manager will submit a request to Residential Reentry Management Branch staff to revoke or retard the RRC date. Clinically

unmanageable in the community is defined as not having the requisite family/social network, health care facility, clinical or specialty services, or access to prescribed medications to maintain or improve an inmate's mental health status as assessed at the time of release to RRC or home confinement placement. The institution CCARE Team continues to monitor the inmate's mental health at intervals set by the team and changes his/her status if his/her mental health improves such that he/she has clinically manageable needs.

If the inmate is releasing to supervision under the United States Probation Office (USPO) or Court Services Offender Supervision Agency (CSOSA), and his/her mental health needs remain unmanageable in the community up to the point of release from custody, the treating psychologist must ensure contact is made with USPO or CSOSA. The treating psychologist ensures they are informed of the inmate's status and provides the Mental Health Transfer Summary as documented in PDS. The treating psychologist then makes a referral to the social worker, who will develop a comprehensive release plan, as detailed below. If the inmate is releasing directly to the community with no supervision requirement, a Bureau social worker takes responsibility for coordinating a release plan, as detailed below.

If an inmate with mental illness is releasing from a CARE1-MH institution with no CCARE team, the Mental Health Treatment Coordinator coordinates with staff from other disciplines, as needed, and ensures continuity of care during the inmate's release is consistent with the practices described in this policy.

b. Community Treatment Services. CTS staff determine which inmates with moderate, serious, or acute mental health needs releasing to community placements are appropriate for community treatment services by consulting with institution CCARE teams and running rosters of CARE2-MH, CARE3-MH, and CARE4-MH and Psychology Alert assignments. CTS staff review inmate PDS files, including the Mental Health Transfer Summary, which recommend follow-up treatment in the community. They arrange appropriate services to support inmates with mental illness who are placed in RRCs or in home confinement.

c. Social Workers. Social workers, in collaboration with the inmate and the institution CCARE Team, create comprehensive release plans for inmates who are releasing from Bureau custody with no community placement. The release plan identifies community treatment providers in the areas of psychiatry, mental health treatment, family counseling, substance abuse, and sex offender treatment, as recommended by the treating psychologist and as available in the community. Some institutions have locally based social workers; those that do not rely on Regional Social Workers. Social workers may consult with CTS staff regarding resources available in the community to which the inmate is releasing.

d. Continuity of Care to Community Placements. Procedures for transfer to community placements are detailed below.

- **Transfers to RRCs and Home Confinement.** When CARE2-MH, CARE3-MH, and CARE4-MH inmates are between 30 and 60 days from an RRC date, the Mental Health Transfer Summary is completed by the treating psychologist and entered in PDS. If CTS staff determine this form is not present in PDS 30 days prior to the RRC date, they notify the Chief Psychologist of the discrepancy. The Chief Psychologist ensures the summary is completed before the inmate's transfer. If there is sufficient concern regarding the inmate's mental health condition, CTS staff also consult with the Residential Reentry Manager (RRM), who may retard the RRC date until adequate information is available to ensure continuity of care.
- **Release to the Community with Supervision.** When a CARE2-MH, CARE3-MH, or CARE4-MH inmate releases directly to the community under the supervision of the USPO or CSOSA, the treating psychologist completes the Mental Health Transfer Summary in PDS and ensures the supervising USPO or CSOSA receives a copy. The treating psychologist completes this summary 30-60 days before the inmate's release. If the inmate requires mental health aftercare services, the treating psychologist will make a referral to the institution Social Worker or Regional Social Worker, who will assist with reentry planning.
- **Release to the Community without Supervision.** When a CARE2-MH, CARE3-MH, or CARE4-MH inmate releases directly to the community with no supervision requirement, the treating psychologist completes the Mental Health Transfer Summary in PDS 30-60 days before the inmate's release. If the inmate requests, the treating psychologist forwards it to a community treatment provider, following completion of the release of information. Such a request can also be made by the inmate following his/her release. If the inmate is on psychiatric medication and needs linkage to community resources, the psychologist should make a referral to the institution Social Worker or Regional Social Worker to enhance continuity of care.

e. **Return to Custody Due to Mental Illness.** Sometimes inmates experience mental health crises or behavioral problems in an RRC setting and are no longer able to be managed in the community. When this occurs:

- The RRM staff must immediately notify and consult with CTS regarding any CARE2-MH, CARE3-MH, or CARE4-MH inmate **or** any CARE1-MH inmate exhibiting symptoms of mental illness, for whom the RRC placement or home confinement may be terminated.
- CTS staff in turn consult with Psychology Services Branch mental health staff and document the consultation in PDS.
- Psychology Services Branch mental health staff adjust the care level assignment, if necessary, by entering a mental health assignment that better approximates the inmate's need for services.
- Psychology Services Branch mental health staff make a recommendation regarding whether the inmate should be transferred to an MRC for treatment of acute mental illness, returned to

a mainline institution, continued in the current placement with additional supports, or housed in a contract facility until the end of his/her sentence.

- The RRM staff work with the OMDT or the DSCC to identify and return the inmate to the parent institution or, if necessary, identify an alternate institution. If the inmate needs emergency psychiatric care at a Psychiatric Referral Center, RRM staff prepare the BP-A0770 in consultation with CTS and the Psychology Services Branch.

If the inmate is returned to an institution, release planning begins again immediately upon his/her arrival.

15. AGENCY ACA ACCREDITATION PROVISIONS

- American Correctional Association Standards for Adult Correctional Institutions, 4th Edition: 4-4142, 4-4143, 4-4144, 4-4305, 4-4368, 4-4370, 4-4371, 4-4372, 4-4373, 4-4374, 4-4399, 4-4429, 4-4429-1.
- American Correctional Association Performance Based Standards for Adult Local Detention Facilities, 4th Edition: 4-ALDF-2A-32, 4-ALDF-4C-8, 4-ALDF-4C-19, 4-ALDF-4C-27, 4-ALDF-4C-28, 4-ALDF-4C-29, 4-ALDF-4C-30, 4-ALDF-4C-31, 4-ALDF-4C-32, 4-ALDF-4C-34, 4-ALDF-4C-40, 4-ALDF-6B-05, 4-ALDF-6B-06, 4-ALDF-6B-07, 4-ALDF-6B-08.
- American Correctional Association Standards for Administration of Correctional Agencies, 2nd Edition: 2-CO-4B-04.

REFERENCES

Program Statements

P5070.12	Forensic and Other Mental Health Evaluations (4/16/08)
P5100.08	Inmate Security Designation and Custody Classification (9/12/06)
P5212.07	Control Unit Programs (2/20/01)
P5270.09	Inmate Discipline Program (7/8/11)
P5270.10	Special Housing Units (7/29/11)
P5290.14	Admission and Orientation Program (4/3/03)
P5310.12	Psychology Services Manual (8/13/93)
P5324.08	Suicide Prevention Program (3/15/07)
P5330.11	Psychology Treatment Programs (3/16/09)
P5370.11	Inmate Recreation Programs (6/25/08)
P6031.03	Patient Care (8/23/12)
P6340.04	Psychiatric Services (1/15/05)

Other References

President's New Freedom Commission on Mental Health, 2003

National Consensus Statement on Mental Health, 2004

Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition, 2013

BOP Forms

BP-A0770	Medical/Surgical and Psychiatric Referral Request
BP-A1055	Notice of Psychological Evaluation – ADX Control Unit
BP-A1056	Notice of Psychological Evaluation – ADX General Population
BP-A1057	Restrictive Housing Mental Health Evaluation – Initial Review
BP-A1058	Restrictive Housing Mental Health Evaluation – Follow-Up Review

Records Retention Requirements

Requirements and retention guidance for records and information applicable to this program are available in the Records and Information Disposition Schedule (RIDS) on Sallyport.

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

ALISHEA KINGDOM, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, et al.,

Defendants.

Case No. 1:25-cv-00691-RCL

**PLAINTIFFS' MOTION FOR CLASS
CERTIFICATION**

HEARING REQUESTED

Plaintiffs Alishea Kingdom, Solo Nichols, and Jas Kapule, pursuant to Rule 23 of the Federal Rules of Civil Procedure, hereby move the Court for an order certifying the following class pursuant to Federal Rule of Civil Procedure 23(a) and (b)(1) and/or (b)(2):

All persons who are or will be incarcerated in the custody of BOP who are or will be diagnosed with gender dysphoria or meet the criteria for a gender dysphoria diagnosis and who are receiving, or would receive, gender-affirming health care absent such care being proscribed by EO 14168 and the Implementing Memoranda.

Dkt. 4-1 (hereinafter, "Compl.") ¶ 15.

The proposed class readily satisfies the requirements of Rule 23. Numerosity is present because, according to the BOP, there are approximately 2,000 people identified as transgender who are incarcerated in federal prisons, who are threatened by the challenged actions. Compl. ¶ 17. All class members suffer the same injury: a blanket denial of gender-affirming health care, regardless of their medical need for such care, in violation of the U.S. Constitution and federal law. *Id.* ¶ 19. And the class raises common questions that will generate common answers, including whether the government can categorically prohibit the provision of certain health care to Plaintiffs and class members regardless of their medical need for such care. The individual

named Plaintiffs' legal claims are typical of those persons whom they seek to represent. *Id.* ¶ 20. Plaintiffs will fairly and adequately protect the interests of the class, and they are represented by experienced counsel with significant expertise litigating class actions on behalf of incarcerated people and transgender people. *Id.* ¶ 21-22. The proposed class satisfies Rule 23(b)(1) because separate actions by individual plaintiffs would create a risk of inconsistent standards of conduct for defendants and adjudications that would, as a practical matter, be dispositive of the interests of others not before the court. And the proposed class satisfies Rule 23(b)(2) because Defendants have acted or refused to act on grounds that apply generally to the class.

Plaintiffs also respectfully request that the Court appoint Plaintiffs Alishea Kingdom, Solo Nichols, and Jas Kapule as class representatives; and appoint the undersigned as class counsel.

This motion is supported by the attached Memorandum of Points and Authorities; the Declarations of David Fathi, Shawn Thomas Meerkamper, and Michael Perloff; the Declarations of Dr. Dan H. Karasic, Dr. Cathy Thompson, Alishea Kingdom, Solo Nichols, and Jas Kapule; exhibits attached to Dkt. 7, Mot. for Prelim. Inj., filed contemporaneously herewith; the Proposed Order; all pleadings and files of record; and any evidence that the Court may receive at or before any hearing on this motion.

Defendants oppose this motion. Pursuant to LCvR 7(f), Plaintiffs request an oral hearing on the motion.

**MEMORANDUM IN SUPPORT OF PLAINTIFFS’ MOTION FOR CLASS
CERTIFICATION**

I. INTRODUCTION

Plaintiffs and the putative class they seek to represent are currently incarcerated in the custody of the Federal Bureau of Prisons (“BOP”). Plaintiffs have been diagnosed with gender dysphoria, a serious medical condition characterized by clinically significant distress resulting from the incongruence between their gender identity and the sex they were designated at birth. Until recently, Plaintiffs had received gender-affirming hormone therapy and accommodations (“gender affirming health care”) by BOP health care providers to treat their gender dysphoria. But now Plaintiffs, and those similarly situated to them, have been denied or face the imminent denial of medically necessary gender-affirming health care because of the BOP’s implementation of Executive Order 14168, entitled “Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government,” issued by Defendant Trump on January 20, 2025 (hereinafter the “EO 14168” or “the EO”).

EO 14168 mandates an across-the-board ban on gender-affirming health care for persons in BOP custody, irrespective of individual medical need or adverse health impacts. The EO was implemented in February 2025 via two memoranda (hereinafter “Implementing Memoranda”) issued by the BOP. *See* Dkt. 1, Exs. A & B. As a result of EO 14168 and BOP’s Implementing Memoranda, Plaintiffs have had their hormone therapy and/or access to accommodations discontinued or have been told that this withdrawal of care is imminent. This has exacerbated their gender dysphoria and otherwise negatively impacted their physical and mental health.

In this action, Plaintiffs seek injunctive relief that prohibits Defendants from enforcing EO 14168 as applied to BOP medical care and accommodations for individuals in BOP custody, prohibits Defendants from enforcing the Implementing Memoranda, and requires Defendants to

provide Plaintiffs and putative class members gender-affirming health care in accordance with BOP policy and practice immediately prior to EO 14168. *See* Dkt. 7, Mot. for Prelim. Inj., filed contemporaneously (hereinafter “Motion”).

Plaintiffs respectfully move for an order certifying the following class pursuant to Federal Rule of Civil Procedure 23(a) and (b)(1) and/or (b)(2):

All persons who are or will be incarcerated in the custody of BOP who are or will be diagnosed with gender dysphoria or meet the criteria for a gender dysphoria diagnosis and who are receiving, or would receive, gender-affirming health care absent such care being proscribed by EO 14168 and the Implementing Memoranda.

Dkt. 4-1 (hereinafter, “Compl.”) ¶ 15.

As detailed below, the proposed class readily satisfies the requirements of Rule 23. Numerosity is present because, according to the BOP, there are approximately 2,000 people identified as transgender who are incarcerated in federal prisons, who are threatened by the challenged actions. All class members suffer the same injury: a blanket denial of gender-affirming health care, regardless of their medical need for such care, in violation of the U.S. Constitution and federal law. And the class raises common questions that will generate common answers, including whether the government can categorically prohibit the provision of certain health care to Plaintiffs and class members regardless of their medical need for such care. The individual named Plaintiffs’ legal claims are typical of those persons whom they seek to represent. Plaintiffs will fairly and adequately protect the interests of the class, and they are represented by experienced counsel with significant expertise litigating class actions on behalf of incarcerated people and transgender people. The proposed class satisfies Rule 23(b)(1) because separate actions by individual plaintiffs would create a risk of inconsistent standards of conduct for defendants and adjudications that would, as a practical matter, be dispositive of the interests

of others not before the court. And the proposed class satisfies Rule 23(b)(2) because Defendants have acted or refused to act on grounds that apply generally to the class.

Plaintiffs also respectfully request that the Court appoint Plaintiffs Alishea Kingdom, Solo Nichols, and Jas Kapule as class representatives; and appoint the undersigned as class counsel.

Plaintiffs incorporate by reference the Statement of Facts set forth in their Motion, filed contemporaneously. *See* Dkt. 7. This motion is supported by the incorporated Statement of Facts and the following argument in support of class certification.

II. ARGUMENT

This case challenges EO 14168 and BOP's Implementing Memoranda, as applied to BOP medical care and accommodations, which affect and will continue to affect thousands of transgender adults in BOP custody. This case is appropriate for class certification pursuant to Federal Rule of Civil Procedure 23(a) and (b)(1)(A), (b)(1)(B), and/or (b)(2).

A. Legal Standard for Class Certification.

Rule 23 of the Federal Rules of Civil Procedure sets forth the requirements for class certification. *See Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 350 (2011); *Garcia v. Johanns*, 444 F.3d 625, 631 (D.C. Cir. 2006). This Court can certify a class upon a showing of the four Rule 23(a) requirements:

- (1) the class is so numerous that joinder of all members is impracticable;
- (2) there are questions of law or fact common to the class;
- (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class; and
- (4) the representative parties will fairly and adequately protect the interests of the class.

Fed. R. Civ. P. 23(a); *see also Dukes*, 564 U.S. at 349 (“Rule 23(a) ensures that the named plaintiffs are appropriate representatives of the class whose claims they wish to litigate.”).

Class certification also requires establishing that the proposed class action fits into one of the three categories listed in Rule 23(b). *See Ross v. Lockheed Martin Corp.*, 267 F. Supp. 3d 174, 190-191 (D.D.C. 2017). Here, class certification is appropriate under Rule 23(b)(2), because “the party opposing the class has acted or refused to act on grounds that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole.” Fed. R. Civ. P. 23(b)(2). Class certification is also appropriate under both Rule 23(b)(1)(A) and (b)(1)(B). The Rule 23(b)(1) requirements are:

(1) prosecuting separate actions by or against individual class members would create a risk of:

(A) inconsistent or varying adjudications with respect to individual class members that would establish incompatible standards of conduct for the party opposing the class; **or**

(B) adjudications with respect to individual class members that, as a practical matter, would be dispositive of the interests of the other members not parties to the individual adjudications or would substantially impair or impede their ability to protect their interests[.]

Fed. R. Civ. P. 23(b)(1) (emphasis added).

While the Court’s Rule 23 analysis may involve *some* overlap with the plaintiffs’ underlying claims, “[m]erits questions may be considered to the extent—but only to the extent—that they are relevant to determining whether the Rule 23 prerequisites for class certification are satisfied.” *Ramirez v. U.S. Immigr. & Customs Enf’t*, 338 F. Supp. 3d 1, 43-44 (D.D.C. 2018) (quoting *Amgen, Inc. v. Conn. Retirement Plans & Tr. Funds*, 568 U.S. 455, 466 (2013)). As such, the allegations in the complaint are presumed true for purposes of a motion for class certification. *McReynolds v. Sodexho Marriott Servs., Inc.*, 208 F.R.D. 428, 431 (D.D.C. 2002). And in determining whether class certification is proper, trial courts routinely consider material

beyond the pleadings and rely on supplemental evidentiary submissions by the parties, including declarations and other evidence that would be inadmissible at trial. *See, e.g., N.S. v. Hughes*, 335 F.R.D. 337, 353 & n.14 (D.D.C. 2020), *modified on clarification sub nom. N.S. v. Dixon*, 2020 WL 6701076 (D.D.C. Nov. 13, 2020) (rejecting argument that plaintiffs’ declarations constituted hearsay because this evidence is “routinely accept[ed] . . . at the class certification stage”). Here, the declarations and other evidence submitted by Plaintiffs demonstrate that Plaintiffs have established all requirements for class certification.

B. Plaintiffs’ Proposed Class Meets the Requirements of Rule 23(a).

1. The Proposed Class Is Sufficiently Numerous.

The numerosity requirement of Rule 23(a) is satisfied where the number of potential plaintiffs is “so numerous that joinder of all members” of the class would be “impracticable.” Fed. R. Civ. P. 23(a)(1). There is no fixed number required to meet the standard of numerosity, but a class of 20-40 generally suffices. *See Hinton v. D.C.*, 567 F. Supp. 3d 30, 52 (D.D.C. 2021) (there is no “magic number test,” but a class of at least 20 can satisfy the numerosity requirement); *N.S.*, 335 F.R.D. at 352 (numerosity is “presumptively” satisfied where class is 40 or more).

Moreover, future members of the putative class must be considered. Courts recognize that where, as here, “requests for prospective injunctive relief . . . would involve future class members,” that factor “make[s] joinder inherently impracticable.” *See, e.g., D.L. v. D.C.* (“*D.L. I*”), 302 F.R.D. 1, 11 (D.D.C. 2013), *aff’d* (“*D.L. II*”), 860 F.3d 713 (D.C. Cir. 2017) (quotation marks omitted) (collecting cases; holding numerosity was satisfied). “This is especially true when plaintiff seeks injunctive relief.” *N.S.*, 335 F.R.D. at 352. And the numerosity requirement also takes into account “non-numerical considerations” that affect Plaintiffs’ ability to bring individual suits. *J.D. v. Azar*, 925 F.3d 1291, 1323 (D.C. Cir. 2019). The proposed class here

includes unknown future persons in BOP custody who will suffer the same injury as Plaintiffs absent injunctive relief, rendering joinder impracticable.

According to the BOP, as of January 10, 2025, there were 2,198 transgender people incarcerated in BOP custody. *See* Declaration of Rick Stover ¶ 5, filed February 23, 2025 in *Doe v. McHenry*, Case No. 1:25-cv-00286-RCL (Dkt. 52-1, D.D.C.). Under BOP’s policy regarding the treatment of gender dysphoria immediately prior to the issuance of the EO and the Implementing Memoranda, transgender people with gender dysphoria were provided gender-affirming hormone therapy and accommodations when clinically indicated. *See* Declaration of Dr. Cathy Thompson (“Thompson Decl.”), Ex. C. All of these people have lost or will imminently lose access to this care due to BOP’s implementation of EO 14168. Compl. ¶ 17. The current numbers alone resolve the numerosity issue. But the proposed class will also include transgender people with gender dysphoria who will be incarcerated in BOP custody in the future and—as a direct result of the EO and Implementing Memoranda—will be denied access to gender-affirming health care regardless of their need for such care. *Id.* ¶ 18.

Moreover, joinder is impracticable not only because of the sheer numbers of the class, but also because the class members are geographically dispersed and incarcerated in federal prisons across the United States, and subject to transfer and movement at any time. *See* Compl. ¶¶ 24-26 (named Plaintiffs are incarcerated in New Jersey, Florida, and Minnesota); *see also J.D.*, 925 F.3d at 1323 (stating that joinder may be impracticable in light of “fluidity” of carceral custody, “the dispersion of class members across the country, and their limited resources”); *see also, e.g., Kifafi v. Hilton Hotels Ret. Plan*, 189 F.R.D. 174, 176 (D.D.C. 1999) (geographical dispersion relevant to impracticability of joinder); *Afghan & Iraqi Allies v. Pompeo*, 334 F.R.D. 449, 459 (D.D.C. 2020) (same). In sum, the proposed class is sufficiently numerous to satisfy the

requirement of Rule 23(a)(1).

2. The Class Presents Common Questions of Law and Fact.

The commonality requirement of Rule 23(a)(2) requires plaintiffs seeking class certification to show that their claims “depend upon a common contention” that “is capable of classwide resolution—which means that determination of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke.” *Dukes*, 564 U.S. at 350. “[C]ommonality requires a showing that the *members* of the class suffered an injury resulting from the defendant’s conduct.” *Bynum v. District of Columbia*, 214 F.R.D. 27, 34 (D.D.C. 2003) (emphasis in original).

Here, there are questions of law or fact common to the class, including whether the EO and Implementing Memoranda violate the Fifth and Eighth Amendments of the U.S. Constitution, the Rehabilitation Act, and the Administrative Procedure Act. If Defendants are permitted to enforce EO 14168 and the Implementing Memoranda, Plaintiffs and all members of the class will be subject to a common impact: the cessation or denial of gender-affirming health care regardless of their medical need for such care. All class members, including Plaintiffs, seek the same relief: an injunction preventing enforcement of the EO, as applied to BOP medical care and accommodations, and of the Implementing Memoranda, which mandate a categorical denial of gender-affirming health care for people in BOP custody regardless of individual medical need.

In other words, Plaintiffs have identified a single alleged practice—a blanket policy prohibiting certain health care from even being considered—that provides the basis for every class member’s injury. Courts in this circuit have uniformly certified classes under these circumstances. “[W]here plaintiffs allege widespread wrongdoing by a defendant . . . ‘a uniform policy or practice that affects all class members’” satisfies the commonality requirement. *Thorpe v. Dist. of Columbia*, 303 F.R.D. 120, 145 (D.D.C. 2014); accord *R.I.L.-R*, 80 F. Supp. 3d at 181;

see also Ramirez, 338 F. Supp. 3d at 46-47 (rejecting argument that circumstances of detention or differing procedural posture of immigration proceedings defeated commonality and typicality); *D.L. II*, 860 F.3d at 723-26 (affirming district court's certification of “three subclasses . . . each defined by reference to a ‘uniform policy or practice’ governing a specific stage of the special education process”). Answering these common legal questions will “drive the resolution of the litigation.” *Ramirez*, 338 F. Supp. 3d at 45 (cleaned up) (quoting *Dukes*, 564 U.S. at 350). Should the Court conclude that Defendants cannot categorically ban the provision of gender-affirming health care, all class members will benefit from the requested relief, which includes a declaration of the illegality of Defendants’ policy and an injunction preventing Defendants from implementing it.

3. Plaintiffs’ Claims Are Typical of Those of the Class.

The typicality requirement of Rule 23(a)(3) requires that the claims of the representative parties be typical of those of members of the class. *Dukes*, 564 U.S. at 349. The typicality requirement focuses on whether the *representatives* of the class suffered a similar injury from the same course of conduct.” *Bynum*, 214 F.R.D. at 34 (emphasis in original).

Typicality is satisfied here for largely the same reasons that commonality is satisfied. *See Ramirez*, 338 F. Supp. 3d at 46; *R.I.L.-R.*, 80 F. Supp. 3d at 181-82; *O.A. v. Trump*, 404 F. Supp. 3d 109, 155-56 (D.D.C. 2019). Each proposed class member, including the proposed class representatives, faces the same principal injury (the prohibition against the provision of certain medical care and accommodations regardless of their medical need), based on the same government practice (the EO and Implementing Memoranda), which is unlawful as to the entire class because it violates the Constitution and federal law. Plaintiffs thus “share an identical interest in invalidation of” EO 14168, as applied to BOP medical care and accommodations, and BOP’s Implementing Memoranda. *O.A.*, 404 F. Supp. 3d at 156. Moreover, as with

commonality, any factual differences that might exist between the named Plaintiffs and class members do not undermine or defeat typicality. *See Bynum*, 214 F.R.D. at 34-35; *Afghan & Iraqi Allies*, 334 F.R.D. at 461.

The EO and Implementing Memoranda do not allow for the consideration of a transgender patient's individualized medical needs; Defendants will enforce the ban on gender-affirming health care across the board as to all transgender people in BOP custody. Though each class member's treatment plan for gender dysphoria is individualized, Thompson Decl., ¶ 33, Ex. C, this is no barrier to class-wide relief, as the only issue here is the constitutionality of the uniform policy—the EO's and Implementing Memoranda's a categorical ban on gender-affirming health care—"that provides the basis for every class member's injury." *Ramirez*, 338 F. Supp. 3d at 46; *see also Daskalea v. Wash. Humane Soc'y*, 275 F.R.D. 346, 358 (D.D.C. 2011) ("[t]he facts and claims of each class member do not have to be identical to support a finding of typicality; rather, typicality refers to the nature of the claims of the representative, not the individual characteristics of the plaintiff" (quotation marks omitted)); *Howard v. Liquidity Servs. Inc.*, 322 F.R.D. 103, 118 (D.D.C. 2017) (even a single common issue will do); *Thorpe*, 303 F.R.D. at 145 (same). And given these common questions, "factual variations among the class members will not defeat the commonality requirement." *Damus v. Nielsen*, 313 F. Supp. 3d 317, 332 (D.D.C. 2018) (quoting *Hardy v. District of Columbia*, 283 F.R.D. 20, 24 (D.D.C. 2012)); 7A Wright et al., *Federal Practice and Procedure: Civil* § 1763 at 203.

4. The Proposed Class Representatives Will Fairly and Adequately Protect the Interests of the Class.

Rule 23(a)(4) requires that the class representatives "fairly and adequately protect the interests of the class." Fed. R. Civ. P. 23(a)(4). Adequacy of representation is a two-part inquiry: the named plaintiffs "(i) must not have antagonistic or conflicting interests with the unnamed

members of the class and (ii) must appear able to vigorously prosecute the interests of the class through qualified counsel.” *J.D.*, 925 F.3d at 1312 (internal quotation marks omitted) (quoting *Twelve John Does v. District of Columbia*, 117 F.3d 571, 575 (D.C. Cir. 1997)). Regarding the first prong, the proposed class representatives—the named Plaintiffs—have no antagonistic or conflicting interest with members of the class. Each of the named Plaintiffs has been diagnosed with gender dysphoria and wants and needs the gender-affirming health care that the EO and Implementing Memoranda ban. Plaintiffs have a substantial stake in the proceedings and the same interest as the putative class members in preventing the unconstitutional enforcement of the EO and Implementing Memoranda.

Regarding the second prong, Plaintiffs are competent to represent the class. The adequacy requirement “does not require either that the proposed class representatives have legal knowledge or a complete understanding of the representative’s role in class litigation.” *Garnett v. Zeilinger*, 301 F. Supp. 3d 199, 210 (D.D.C. 2018) (citation omitted). The class representatives need only have “some rudimentary knowledge of [their] role as a class representative and [be] committed to serving in that role in litigation.” *Id.* (citation omitted). Plaintiffs’ declarations demonstrate that they are sufficiently aware of the facts of this case. *See generally* Declarations of Alishea Kingdom, Solo Nichols, and Jas Kapule.

C. The Proposed Class Meets the Requirements of Rule 23(b).

Plaintiffs must show that one of the requirements of Rule 23(b) is met. Here, Plaintiffs satisfy the requirements for three components of Rule 23(b): Rules 23(b)(1)(A), 23(b)(1)(B), and 23(b)(2). Each subsection provides an independent basis for certifying the class.

1. Rule 23(b)(1)(A).

Under this subsection, class certification is appropriate if the prosecution of separate actions by individual members of the class would create the risk of “inconsistent or varying

adjudications with respect to individual class members that would establish incompatible standards of conduct for the party opposing the class.” Fed. R. Civ. P. 23(b)(1)(A). A “core example” of such an action is a “situation in which many individuals, all challenging a single government policy, bring separate suits for injunctive relief.” Newberg and Rubenstein on Class Actions § 4:11 (6th ed.).

Here, there are over 2,000 people incarcerated in BOP facilities who are affected by the challenged policies and each one could file suit for injuries arising from these systemwide policies. Thus, certification is appropriate under 23(b)(1)(A) because if each member of the proposed class litigated their claims individually there would be a risk that each individual case would impose a different standard on Defendants. *See, e.g., Ashker v. Governor of State of California*, 2014 WL 2465191, at *7 (N.D. Cal. June 2, 2014) (certifying prisoner class under Rule 23(b)(1)(A) to avoid risk of inconsistent judgments); *Franklin v. Barry*, 909 F. Supp. 21, 31 (D.D.C. 1995) (same); *see also Adair v. England*, 209 F.R.D. 5, 12 (D.D.C. 2002) (“Rule 23(b)(1)(A) certification is appropriate when the class seeks injunctive or declaratory relief to change an alleged ongoing course of conduct that is either legal or illegal as to all members of the class.”). Accordingly, the requirements for certification under 23(b)(1)(A) are met.

2. Rule 23(b)(1)(B).

Class certification under Rule 23(b)(1)(B) is appropriate when prosecuting “separate actions by or against individual class members would create a risk of ... adjudications with respect to individual class members that, as a practical matter, would be dispositive of the interests of the other members not parties to the individual adjudications or would substantially impair or impede their ability to protect their interests.” Fed. R. Civ. P. 23(b)(1)(B). This rule has been applied in actions by incarcerated people challenging the conditions of their confinement. *See Hilton v. Wright*, 235 F.R.D. 40, 53 (N.D.N.Y. 2006) (certification of class

challenging prison's Hepatitis C treatment policy under 23(b)(1)(B)); *Ingles v. City of New York*, 2003 WL 402565, at *7-8 (S.D.N.Y. Feb. 20, 2003) (certification under 23(b)(1)(B) of class of incarcerated people challenging prison's use of force policy and seeking injunctive relief); *Coleman v. Wilson*, 912 F. Supp. 1282, 1293 (E.D. Cal.1995) (certification of class challenging prison's mental health care policies under 23(b)(1)(B)).

Here, the class seeks injunctive relief that, if granted, would affect the rights of similarly situated potential plaintiffs who are affected by the same systemwide policies. If Plaintiffs do not succeed on their claims, the ability of future plaintiffs to challenge the same practice will be inhibited under *stare decisis*. See *Riley v. Nev. Sup. Court*, 763 F. Supp. 446, 453 (D. Nev. 1991) (certifying class of death-sentenced people challenging state court policies under 23(b)(1)(B) because "collateral estoppel would not bind a subsequent plaintiff to a finding of constitutionality. However, if the subsequent plaintiff ended up in this particular court, our previous finding of constitutionality would bind the subsequent plaintiff as a practical matter because of stare decisis."). Accordingly, the requirements for certification under 23(b)(1)(B) are met.

3. Rule 23(b)(2).

This provision requires that the party opposing certification has "acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive or corresponding declaratory relief with respect to the class as a whole."

Rule 23(b)(2)'s requirements are satisfied when, as here, members of a proposed class seek uniform injunctive and declaratory relief from policies and practices that are generally applicable to the class as a whole. "[T]he suit challenges a policy 'generally applicable' to all class members." *R.I.L.-R*, 80 F. Supp. 3d at 182; see *Dukes*, 564 U.S. at 360 ("The key to the (b)(2) class is the indivisible nature of the injunctive or declaratory remedy warranted"). Indeed,

the D.C. Circuit has recognized that “Rule 23(b)(2) exists so that parties and courts, *especially in civil rights cases like this*, can avoid piecemeal litigation when common claims arise from systemic harms that demand injunctive relief.” *D.L. II*, 860 F.3d at 726 (emphasis added); *see also In re District of Columbia*, 792 F.3d 96, 102 (D.C. Cir. 2015) (“Rule 23(b)(2) was intended for civil rights cases.”); *Amchem Products, Inc. v. Windsor*, 521 U.S. 591, 614 (1997) (“Civil rights cases against parties charged with unlawful, class-based discrimination are prime examples” of (b)(2) class actions (citations omitted)). And other courts routinely recognize that Eighth Amendment conditions of confinement cases are quintessential 23(b)(2) class actions. *See, e.g., Postawko v. Missouri Dep't of Corr.*, 2017 WL 3185155, at *14 (W.D. Mo. July 26, 2017), *aff'd*, 910 F.3d 1030 (8th Cir. 2018) (“Indeed, a case like this one in which a group of prisoners seeks to challenge the constitutionality of a prison policy is so well suited for Rule 23(b)(2) class treatment that the leading class-action and federal-practice treatises both use it as the exemplar of a case fitting within that subsection.”).

Here, Plaintiffs challenge an executive order and implementing memoranda of general applicability. Defendants’ enforcement of EO 14168 and the Implementing Memoranda to prohibit gender-affirming health care to people in BOP custody applies generally to the proposed class, and Plaintiffs seek only injunctive and declaratory relief. The relief sought would provide relief to each class member, and would in no way differentiate between class members. Such relief would resolve class members’ claims “in one stroke.” *Dukes*, 564 U.S. at 350. “The relief Plaintiffs seek” is thus both “generally applicable to the class” and “indivisible,” and certification under Rule 23(b)(2) is proper. *O.A.*, 404 F. Supp. 3d at 157; *accord, e.g., Huisha-Huisha v. Mayorkas*, 560 F. Supp. 146, 166 (D.D.C. 2021) (holding that Rule 23(b)(2) is satisfied when a class seeks relief that “is generally applicable to the class and is indivisible”)

(cleaned up).

D. The Court Should Appoint Plaintiffs’ Attorneys as Class Counsel.

Upon certifying the class, the Court must also appoint class counsel. Fed. R. Civ. P. 23(c)(1)(B). Under Rule 23(g), in appointing class counsel, a court considers (1) “the work counsel has done in identifying or investigating potential claims in the action;” (2) “counsel’s experience in handling class actions, other complex litigation, and the types of claims asserted in the action;” (3) “counsel’s knowledge of the applicable law;” and (4) “the resources that counsel will commit to representing the class.” Fed. R. Civ. P. 23(g)(1)(A)-(B). The court may also consider “any other matter pertinent to counsel’s ability to fairly and adequately represent the interests of the class.”

As set forth in the supporting declarations, Plaintiffs’ attorneys of record possess substantial expertise litigating constitutional and civil rights challenges to governmental action, including specific experience representing transgender plaintiffs in civil rights and prisoners’ rights litigation, as well as class actions. *See* Declarations of David Fathi, Shawn Thomas Meerkamper, and Michael Perloff. Plaintiffs’ attorneys are non-profits dedicated to civil rights work and will commit the resources necessary to pursue this litigation and represent the class. *See, e.g.,* Fathi Decl. ¶¶ 7-8. Accordingly, Plaintiffs’ attorneys are adequate class counsel and should be so appointed pursuant to Rule 23(g). *See, e.g., Howard v. Liquidity Servs. Inc.*, 322 F.R.D. 103, 141 n.23 (D.D.C. 2017) (evidence provided by plaintiffs weighed in favor of appointment of class counsel); *Samma v. United States Dep’t of Def.*, 2020 WL 4501000, at *10 (D.D.C. Aug. 4, 2020) (same).

III. CONCLUSION

The Court should certify the proposed Class under Rule 23(a) and 23(b)(1) and/or

23(b)(2), appoint the Individual Plaintiffs as Class Representatives, and appoint the undersigned as Class Counsel.

Dated: March 17, 2025

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Respectfully submitted,

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** *Pro hac vice application forthcoming.*

Counsel for plaintiffs and the proposed class

CERTIFICATE OF SERVICE

I hereby certify that, on this 17th day of March 2025, I served the foregoing PLAINTIFFS' MOTION FOR CLASS CERTIFICATION by emailing a copy to Defendants' counsel, John Robinson, listed below. Mr. Robinson provided written consent to receive email service on behalf of Defendants on March 17, 2025.

John Robinson
U.S. Department of Justice
John.J.Robinson@usdoj.gov
(202) 616-8489

/s/ Michael Perloff
Michael Perloff

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, et al.,

Plaintiffs

vs.

DONALD J. TRUMP, et al.

Defendants.

Case No. 1:25-cv-00691

**DECLARATION OF MICHAEL PERLOFF IN SUPPORT OF PLAINTIFFS' MOTION
FOR CLASS CERTIFICATION**

I, Michael Perloff, declare as follows:

1. I am over 18 years old and make this declaration based on my personal knowledge of the matters described.
2. I am a member of the bar of this Court, the District of Columbia, the State of New York, and the D.C. Circuit. I am also one of the attorneys for the Plaintiffs in this matter.
3. I graduated *cum laude* from Harvard Law School in 2017. After clerking on the D.C. Court of Appeals, I joined the American Civil Liberties Union Foundation of the District of Columbia (ACLU-DC) and have worked as a civil rights litigator there since 2018.
4. I have represented class plaintiffs in numerous civil rights class action proceedings in federal court. For example, I am lead counsel in *Cameron v. District of Columbia*, No. 21-cv-2908 (D.D.C.), a putative class action challenging the District's practice of retaining cell phones seized from arrestees for unreasonable periods of time. In *Cameron*, after the district court dismissed the class claims on the merits, I successfully challenged

the dismissal before the D.C. Circuit, which reversed the district court's dismissal and vacated its denial of class certification. See *Asinor v. District of Columbia*, 111 F.4th 1249, 1261 (D.C. Cir. 2024) (case consolidated with *Cameron*, No. 22-7130).

5. I am among the attorneys representing the class plaintiffs in *Davis v. United States Parole Commission*, 2025 WL 257779 (D.D.C. Feb. 11, 2025) (certifying class of individuals challenging defendants' failure to provide accommodations for people with disabilities on supervised release) and *Black Lives Matter D.C. v. Trump*, No. 20-cv-1469, slip op. at 33 (D.D.C. Mar. 14, 2025), ECF No. 261 (certifying class of protestors seeking damages for restriction of their First Amendment rights). I also was one of the lawyers representing the plaintiffs in *Banks v. Booth*, 468 F. Supp. 3d 101 (D.D.C. 2020) (granting preliminary injunction requiring D.C. Department of Corrections to improve conditions of confinement to address threat of COVID-19; class settlement later approved, April 2022).
6. Additionally, I was among the attorneys for the plaintiffs in *Hinton v. District of Columbia*, 567 F. Supp. 3d 30 (D.D.C. 2021), a case that sought relief for a class of incarcerated transgender individuals housed at the D.C. Jail in accordance with their sex assigned at birth rather than their gender identity. Likewise, I was an attorney in *Costa v. Bazron*, 464 F. Supp. 3d 132 (D.D.C. 2020) (suit on behalf of residents of Saint Elizabeths Hospital challenging repeated failure to adopt constitutionally adequate emergency response plans for health emergencies, including the COVID-19 pandemic). Although neither of these cases resulted in certified classes, the first yielded a settlement securing significant policy changes benefitting all putative class members, and the second resulted in a preliminary injunction, and ultimately a settlement, each of which provided relief benefitting the putative class as a whole.
7. My colleague Aditi Shah has been an attorney at the ACLU-DC since September 2024. Ms. Shah graduated *cum laude* in 2020 from Harvard Law School, where she worked for

Professor William B. Rubenstein, a leading national expert on class action law, on class actions and complex litigation for which he was hired as an expert consultant, including the National Prescription Opiate Litigation (MDL 2804). Ms. Shah also worked on updates to Professor Rubenstein's treatise, Newberg and Rubenstein on Class Actions, and his scholarship on class action law. After graduating from law school, Ms. Shah completed a federal appellate clerkship and a federal district court clerkship and worked as a fellow at the ACLU National Prison Project, where she served as counsel on class actions challenging conditions of confinement in prisons, jails, immigration detention centers, and juvenile detention, including *Alex A. v. Edwards*, No. 22-cv-00573 (M.D. La. 2022) (class action on behalf of children in the custody of the Louisiana Office of Juvenile Justice), *Castañeda Juarez v. Asher*, No. 20-cv-700 (W.D. Wash. 2020) (class action on behalf of people in immigration detention facility); *Coreas v. Bounds*, No. 20-cv-780 (D. Md. 2020) (same); *Fenty v. Penzone*, No. 2:20-cv-01192 (D. Ariz. 2020) (class action on behalf of people in jails in Maricopa County, AZ); *RomeroLorenzo et al. v. Koehn et al.*, No. 2:20-cv-00901 (D. Ariz. 2020) (class action on behalf of people under the custody of the U.S. Marshals Service at the Central Arizona Florence Correctional Complex).

8. Before joining ACLU-DC, Ms. Shah was an associate at Holwell Shuster & Goldberg LLP, where she worked on complex civil cases. Ms. Shah is barred in the Supreme Court of the United States, the United States District Court for the Southern District of New York, the United States Court of Appeals for the Seventh Circuit, and in New York. Her application for admission to the D.C. bar is pending.
9. I believe that Ms. Shah and I will fairly and adequately represent the interests of the class proposed to be certified in this case.

I declare under penalty of perjury that the foregoing is true and correct. Executed in Washington, D.C. on March 14, 2025.

/s/ Michael Perloff
Michael Perloff

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, et al.,

Defendants.

Case No. 1:25-cv-00691-RCL

**DECLARATION OF DAVID C. FATHI
IN SUPPORT OF PLAINTIFFS’
MOTION FOR CLASS
CERTIFICATION**

I, DAVID C. FATHI, DECLARE:

1. I am an attorney admitted to practice before the courts of the State of Washington. My application for admission *pro hac vice* in this matter is forthcoming. I am Director of the National Prison Project (“NPP”) of the American Civil Liberties Union Foundation (“ACLU”). I make this declaration in support of Plaintiffs’ Motion for Class Certification.

2. The ACLU is a nationwide, nonprofit, nonpartisan organization with more than 4 million members and supporters that is dedicated to defending the principles of liberty, equality, and justice embodied in the Constitution and this nation’s civil rights laws. Throughout its more than 100-year history, the ACLU has been deeply involved in protecting the rights of incarcerated people and LGBTQ people.

3. The National Prison Project, founded in 1972 as a project of the ACLU, is based in Washington, D.C. It has decades of experience in complex class action suits brought on behalf of people incarcerated in federal prisons and immigration detention

centers, state adult and juvenile prisons, and local jails and juvenile detention facilities. NPP has represented incarcerated people in five cases before the U.S. Supreme Court, including arguing the seminal case of *Farmer v. Brennan*, 511 U.S. 825 (1994). Since its founding, the NPP has litigated challenges to conditions of confinement in almost every U.S. state, as well as the District of Columbia and the U.S. Virgin Islands. I have been Director of NPP since 2010; I have also served as a staff attorney and senior staff attorney at NPP from 1990 to 1993 and 2000 to 2007.

4. Challenges to conditions of confinement in which NPP has been class counsel since 2000 include, among other cases: *Alex A. ex rel. Smith v. Edwards*, No. 3:22-cv-00573, 2023 WL 5628592 (M.D. La. Aug. 31, 2023) (challenge to practice of incarcerating children adjudicated delinquent in the former Death Row building at Louisiana State Penitentiary-Angola); *Favela Avendaño v. Asher*, No. 2:20-cv-00700, 2021 WL 1056113 (W.D. Wash. Mar. 18, 2021) (class action brought by ICE detainees challenging detention facility's failure to protect from COVID-19); *Fenty v. Penzone*, No. 2:20-cv-01192 (D. Ariz. Nov. 13, 2020) (class of all people detained in Maricopa County Jail challenging failure to protect from COVID-19); *Lucero-Gonzalez v. Kline*, No. 2:20-cv-00901 (D. Ariz. Nov. 3, 2020) (class of people detained by U.S. Marshals Service at Core Civic detention facility in Florence, Arizona); *Coreas v. Bounds*, No. 8:20-cv-00780, 2020 WL 5593338 (D. Md. Sept. 18, 2020) (class action brought by ICE detainees challenging detention facility's failure to protect from COVID-19); *Malam v. Adducci*, 475 F. Supp. 3d 721 (E.D. Mich. 2020) (class action brought by ICE detainees challenging detention facility's failure to protect from COVID-19); *Busby v. Bonner*, 466

F. Supp. 3d 821 (W.D. Tenn. 2020) (class action of people detained in Shelby County Jail challenging failure to protect from COVID-19); *Augusto v. Moniz*, No. 1:20-cv-10685, 2020 WL 3051778 (D. Mass. June. 8, 2020) (class action brought by ICE detainees challenging detention facility's failure to protect from COVID-19); *Yanes v. Martin*, 464 F. Supp. 3d 467 (D.R.I. 2020) (class action brought by ICE detainees challenging detention facility's failure to protect from COVID-19); *Ahlman v. Barnes*, No. 8:20-cv-00835 (C.D. Cal. May 26, 2020) (provisional certification of class of people detained in Orange County Jails challenging failure to protect from COVID-19); *Gomes v. U.S. Dep't of Homeland Sec.*, 460 F. Supp. 3d 132 (D.N.H. 2020) (provisional certification of a class of ICE detainees challenging detention facility's failure to protect from COVID-19); *Alcantara v. Archambeault*, 613 F. Supp. 3d 1337 (S.D. Cal. 2020) (provisional certification of class of ICE detainees challenging detention facility's failure to protect from COVID-19); *Teneng v. Trump*, Case No. 5:18-cv-01609 (C.D. Cal. filed Aug. 1, 2018) (case brought against President Trump and officials from the Bureau of Prisons and Immigration and Customs Enforcement challenging the practice of incarcerating newly-arrived asylum seekers at a medium security federal prison); *Parsons v. Ryan*, 289 F.R.D. 513 (D. Ariz. 2013), *aff'd*, 754 F.3d 657 (9th Cir. 2014) (statewide challenge to health care and solitary confinement conditions in Arizona state prisons); *Henderson v. Thomas*, 913 F. Supp. 2d 1267 (M.D. Ala. 2012) (challenge to Alabama Department of Corrections' policy of segregating and stigmatizing HIV-positive incarcerated people); *Graves v. Arpaio*, 633 F. Supp. 2d 834 (D. Ariz. 2009), *aff'd*, 623 F.3d 1043 (9th Cir. 2010) (challenge to conditions in Maricopa County Jail); *Gates v. Cook*, 376 F.3d 323

(5th Cir. 2004) (challenge to conditions of confinement for death-sentenced prisoners in Mississippi); *Flynn v. Doyle*, 2007 WL 805788 (E.D. Wis. Mar. 14, 2007) (challenge to conditions in women’s prison); *Inmates of the R.I. Training Sch. v. Martinez*, 465 F. Supp. 2d 131 (D.R.I. 2006) (challenge to conditions in juvenile facility); and *Jones’El v. Berge*, 164 F. Supp. 2d 1096 (W.D. Wis. 2001), 172 F. Supp. 2d 1128 (W.D. Wis. 2001), 374 F.3d 541 (7th Cir. 2004) (challenge to conditions in “supermax” prison).

5. The LGBTQ & HIV Project of the ACLU, founded in 1986, is dedicated to safeguarding the constitutional and civil rights of LGBTQ people and those living with HIV. The Project’s attorneys have litigated a wide variety of cases across the country involving the constitutional and civil rights of transgender people. The Project has been counsel in two cases before the U.S. Supreme Court involving transgender rights—*Bostock v. Clayton Cnty.*, 590 U.S. 644 (2020) (holding that Title VII covers discrimination based on transgender status) and *United States v. Skrametti*, Case No. 23-477 (U.S.) (pending) (challenge to state law banning gender-affirming medical care for minors)—and numerous cases before federal district courts and courts of appeals. *See, e.g., Poe v. Labrador*, No. 1:23-cv-00269-BLW (9th Cir.) (pending); *Hecox v. Little*, 104 F.4th 1061 (9th Cir. 2024); *Soule v. Conn. Ass’n of Sch., Inc.*, 90 F.4th 34 (2d Cir. 2023); *Brandt v. Rutledge*, 47 F.4th 661 (8th Cir. 2022); *Grimm v. Gloucester Cnty Sch. Bd.*, 972 F.3d 586 (4th Cir. 2020); *Doe v. Boyertown Area Sch. Dist.*, 897 F.3d 518 (3d Cir. 2018). The Project’s work on behalf of transgender people includes challenges to the conditions of confinement for incarcerated transgender people. *See, e.g., Keohane v. Dixon*, No. 4:24-cv-434-AW-MAF (N.D. Fla.) (pending); *Robinson v. Labrador*, No. 1:24-cv-00306-

DCN (D. Idaho) (pending); *Zayre-Brown v. N.C. Dep't of Pub. Safety*, No. 3:22-cv-191-MOC-DCK, 2024 WL 410243 (W.D.N.C. Feb. 2, 2024); *Iglesias v. Fed. Bureau of Prisons*, Case No. 19-CV-415-NJR, 2021 WL 6112790 (S.D. Ill. Dec. 27, 2021); *Keohane v. Fla. Dep't of Corr. Sec.*, 952 F.3d 1257 (11th Cir. 2020); and *Fields v. Smith*, 653 F.3d 550 (7th Cir. 2011).

6. The attorneys of the ACLU are committed to the vigorous, effective, and efficient prosecution of the interests of Plaintiffs and the proposed class (the “Class”), a commitment that the ACLU attorneys have demonstrated in their representation of Plaintiffs in the proceedings to date in this matter.

7. The ACLU, ACLU of the District of Columbia, and Transgender Law Center (collectively, “Plaintiffs’ counsel”) have dedicated many hours and significant financial resources to the investigation and research of Plaintiffs’ claims – including interviewing Plaintiffs and other members of the proposed Class to develop the factual record and legal issues underlying this case, interviewing potential expert witnesses, performing legal research about potential claims and relief available to the Class, and drafting a lengthy and detailed complaint as well as this class certification motion and motion for preliminary injunction.

8. The ACLU has dedicated, and will continue to commit, substantial resources to the representation of the Plaintiffs and Class in this case.

9. Plaintiffs’ counsel have agreed to act jointly as class counsel, if the Court so designates them.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 17th day of March, 2025, at Washington, D.C.

/s/ David C. Fathi
David C. Fathi
Attorney for Plaintiffs

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

ALISHEA KINGDOM, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, et al.,

Defendants.

Case No. 1:25-cv-00691-RCL

**DECLARATION OF SHAWN THOMAS MEERKAMPER IN SUPPORT OF
PLAINTIFFS’ MOTION FOR CLASS CERTIFICATION**

I, SHAWN THOMAS MEERKAMPER, DECLARE:

1. I am an attorney admitted to practice in the State of California, with an application to practice *pro hac vice* in this Court forthcoming. I am the Managing Attorney at Transgender Law Center (“TLC”), and counsel for the Plaintiffs in this litigation. I make this declaration in support of Plaintiffs’ Motion for Class Certification.

2. Founded in 2002, TLC is the largest national, trans-led organization advocating for self-determination for all people. We champion the right of all transgender and gender-nonconforming people to make their own choices and live freely, safely, and authentically.

3. TLC’s impact litigation work largely focuses on laws and policies that disproportionately impact and criminalize trans people; the impact of criminalization inside prisons, detention centers, and hospitals; and collateral consequences of convictions.

4. In addition to policy advocacy and legislation, TLC’s work on harm reduction for incarcerated transgender people includes serving as counsel in *Norsworthy v. Beard*, 87 F. Supp. 3d 1164 (N.D. Cal. 2015) and *Quine v. Beard*, No. 14-cv-02726 (N.D. Cal.)—companion cases

involving Eight Amendment and Equal Protection claims, which together led to significant progress in the California prisons' policy on medical treatment for gender dysphoria. TLC is also counsel for the intervenors in *Chandler v. Cal. Dep't of Corr. & Rehabs.*, No. 1:21-cv-01657-JLT-HBK, 2024 U.S. Dist. LEXIS 87164 (E.D. Cal. May 14, 2024), in which we represent four incarcerated transgender women and a transgender advocacy organization who intervened to defend a California law related to conditions of confinement for incarcerated transgender people.

5. TLC is class counsel in *Raven v. Polis*, 2021 CO 8, 479 P.3d 918, which resulted in an ongoing consent decree requiring the Colorado Department of Corrections to, *inter alia*, provide medical and mental health care for transgender women with gender dysphoria in line with community standards and pay \$2.15 million in damages to the class. *Raven v. Polis* is one of only a few class actions involving a class of transgender people, and to my knowledge only the second-filed class of incarcerated transgender people. *Raven v. Polis* brought claims including the Colorado analogues to the Eighth Amendment, Equal Protection Clause, and Rehabilitation Act.

6. TLC also operates a nation-wide prison mail program, through which we correspond with hundreds of transgender people incarcerated in state and federal prisons every year. In 2024, TLC responded to more than 800 such inquiries.

7. TLC has also litigated cases involving gender-affirming health care outside the prison context, including *Bos. All. of Gay, Lesbian, Bisexual & Transgender Youth (BAGLY) v. United States HHS*, 557 F. Supp. 3d 224, 244 (D. Mass. 2021) (holding “intermediate scrutiny applies to discrimination based on transgender status in the equal protection context” for purposes of an APA claim and the Fifth Amendment) and *Prescott v. Rady Children's Hosp.-San Diego*, 265 F. Supp. 3d 1090 (S.D. Cal. 2017) (holding that discrimination against transgender

patients constitutes sex discrimination under 42 U.S.C. § 18116(a)). Additionally, TLC has been counsel in cases finding that transgender discrimination constitutes sex discrimination in schools and employment. *See Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034 (7th Cir. 2017) (holding that heightened scrutiny applies to discrimination against transgender students in public schools and that discrimination against transgender students is sex discrimination under Title IX); *Macy v. Holder*, Appeal No. 0120120821 (E.E.O.C. 2012) (holding, for the first time, that EEOC would treat the failure to hire on the basis of transgender status as sex discrimination under Title VII); *Lusardi v. Dep't of the Army*, Appeal No. 0120133395 (E.E.O.C. 2015) (holding, for the first time, that EEOC would treat intentional misuse of transgender employee's gender pronouns and denial of restroom access as sexual harassment under Title VII).

8. TLC's attorneys are committed to the vigorous, effective, and efficient prosecution of the interests of Plaintiffs and the proposed class.

9. TLC has dedicated and will continue to commit substantial resources to the representation of the Plaintiffs in this case.

10. Plaintiffs' counsel have agreed to act jointly as class counsel, if the Court so designates them.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 14th day of March 2024.

s/ Shawn Thomas Meerkamper
Shawn Thomas Meerkamper

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

ALISHEA KINGDOM, *et al.*,
Plaintiffs,

v.

DONALD J. TRUMP, *et al.*,
Defendants.

Case No. 1:25-cv-00691-RCL

**[PROPOSED] ORDER GRANTING
PLAINTIFF'S MOTION FOR CLASS CERTIFICATION**

AND NOW, this ____ day of March, 2025, upon consideration of Plaintiffs' motion to certify a class and it appearing to the Court that all the relevant requirements of Federal Rule of Civil Procedure 23 have been satisfied, it is hereby:

ORDERED that the motion is granted. It is further

ORDERED that this case is certified as a class action on behalf of all persons who are or will be incarcerated in the custody of BOP who are or will be diagnosed with gender dysphoria or meet the criteria for a gender dysphoria diagnosis and who are receiving, or would receive, gender-affirming health care absent such care being proscribed by EO 14168 and the Implementing Memoranda. It is further

ORDERED that Plaintiffs' counsel, from the American Civil Liberties Union, Transgender Law Center, and the attorneys at the American Civil Liberties Union Foundation of the District of Columbia, are hereby appointed as counsel for the Plaintiff Class.

IT IS SO ORDERED.

HONORABLE ROYCE C. LAMBERTH

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

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SOLO NICHOLS
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JAS KAPULE
Reg. 97856-298
FCI Waseca
P.O. Box 1731
Waseca, MN 56093

*on behalf of themselves and all persons
similarly situated,*

Plaintiffs

vs.

DONALD J. TRUMP, in his official capacity
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PAMELA J. BONDI, in her official capacity
as Attorney General of the United States,
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WILLIAM W. LOTHROP, in his official
capacity as Acting Director of the Federal
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CHRISTOPHER A. BINA, in his official

Case No. 1:25-cv-00691

capacity as Assistant Director for the Health
Services Division of the Federal Bureau of
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DANA R. DIGIACOMO, in her official
capacity as Acting Assistant Director of the
Reentry Services Division of the Federal
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SHANE SALEM, in his official capacity as
Assistant Director of the Correctional
Programs Division of the Federal Bureau of
Prisons,
320 First St NW
Washington, D.C. 20534

Defendants.

CLASS ACTION COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

(Trump Administration and BOP's categorical ban on gender-affirming health care for people
with gender dysphoria in the custody of the Federal Bureau of Prisons)

Plaintiffs Alishea Sophia Kingdom, Solo Nichols, and Jas Kapule (“Plaintiffs”),¹ by and through their attorneys, bring this action on their own behalf and on behalf of a class of those similarly situated pursuant to Rules 23(a) and 23(b)(2) of the Federal Rules of Civil Procedure, and allege as follows.

INTRODUCTION

1. Plaintiffs and the putative class they seek to represent are currently incarcerated in the custody of the Federal Bureau of Prisons (“BOP”). Plaintiffs have all been diagnosed with gender dysphoria, a serious medical condition characterized by clinically significant distress resulting from the incongruence between a person’s gender identity and the sex they were designated at birth. BOP has been providing them with gender-affirming medical treatment and accommodations to address their gender dysphoria. But Plaintiffs, and those similarly situated to them, now have lost or face the imminent loss of this care that has been essential to their health because of BOP’s implementation of Executive Order 14168, entitled “Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government,” issued by Defendant Trump on January 20, 2025. (“EO 14168” or “the EO”).² EO 14168 mandates an across-the-board ban on such gender-affirming health care for individuals in BOP custody, regardless of the impact on their health.

2. Gender dysphoria is a serious condition. Absent treatment, it can impair an individual’s ability to function and cause depression, anxiety, self-harm, and suicidality.

3. For years, BOP has had a formal internal health care policy governing the treatment

¹ Plaintiffs are transgender and as such use their chosen names wherever possible. For identification purposes, Alishea Sophia Kingdom’s legal name is Joshua Mueller, and her BOP register number is 13131-089; Solo Nichols’s legal name is Latasha Nichols, and his BOP register number is 16212-040; and Jas Kapule’s legal name is Jasmine Kapule, and his BOP register number is 97856-298.

² Exec. Order 14168, *Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government*, 90 Fed. Reg. 8615 (Jan. 20, 2025).

of gender dysphoria which, in accordance with well-accepted protocols for treating this condition, provided for gender-affirming medical interventions including hormone therapy and surgeries when indicated for a patient, as well as clothing, commissary, and other accommodations to allow individuals to live consistently with their gender identity (collectively, “gender-affirming health care”).

4. Plaintiffs have all been diagnosed with gender dysphoria by BOP clinicians, who have prescribed hormone therapy and provided accommodations to address their gender dysphoria.

5. The gender-affirming health care they were receiving afforded Plaintiffs relief from the distress of gender dysphoria and significantly improved their mental health.

6. EO 14168 takes aim generally at so-called “gender ideology”—or what it calls “the false claim that males can identify as and thus become women and vice versa.” EO § 2(f). Section 3(e) of the EO directs agencies to “remove all . . . policies . . . that promote or otherwise inculcate gender ideology,” and to “take all necessary steps, as permitted by law, to end the Federal funding of gender ideology,” and Section 3(g) prohibits the use of federal funds “to promote gender ideology.” Section 4(c) of the EO, which focuses on BOP, requires BOP to “revise[] its policies concerning medical care to be consistent with” the EO and specifically prohibits the use of federal funds for “any medical procedure, treatment, or drug for the purpose of conforming an inmate’s appearance to that of the opposite sex.”

7. BOP issued two memoranda implementing EO 14168. The first, issued on February 21, 2025, is entitled “Compliance with Executive Order ‘Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government’,” (attached to the Complaint as Exhibit A), and prohibits the purchase of “any items that align with transgender ideology,” such as chest binders and hair removal devices; prohibits granting requests for other accommodations to address gender dysphoria such as “undergarments that do not align with an inmate’s biological sex”; and mandates that BOP staff members “must refer to individuals” with

“pronouns that correspond to their biological sex”.³ See Ex. A. On February 28, 2025, BOP issued a second memorandum entitled “Executive Order 14168 Compliance,” (attached to the Complaint as Exhibit B), which states that “[c]onsistent with Executive Order (EO) 14168 . . . no Bureau of Prisons funds are to be expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate’s appearance to that of the opposite sex.” The two memoranda are referred to collectively as the “Implementing Memoranda.”

8. As a result of EO 14168 and BOP’s Implementing Memoranda, Plaintiffs have already had their hormone therapy and/or access to accommodations discontinued, causing anxiety, thoughts of suicide and self-harm, sleeplessness, lethargy, and mood swings.

9. Defendants Lothrop and Bina are legally responsible for ensuring that health care provided to incarcerated people in BOP custody is in accordance with constitutional standards.

10. Defendants’ withdrawal and denial of gender-affirming health care to treat Plaintiffs’ serious medical needs, based on a blanket ban and without any individualized medical determination, violates the Eighth Amendment of the U.S. Constitution. And by targeting transgender people for the denial of medical treatment, Defendants’ actions violate the right to equal protection guaranteed by the Fifth Amendment of the U.S. Constitution. Defendants’ denial of medical care and gender-affirming accommodations needed to address Plaintiffs’ gender dysphoria violates the Rehabilitation Act of 1973. Furthermore, Defendants’ actions implementing the mandates of EO 14168 §§ 4(c), 3(e), & 3(g) violate the Administrative Procedure Act (“APA”) both because they are unconstitutional, and because the decision to categorically discontinue gender-affirming health care regardless of medical need is arbitrary and capricious, an abuse of discretion, and otherwise not in accordance with law.

11. Plaintiffs and the putative class they represent seek injunctive and declaratory relief to set aside the unlawful Implementing Memoranda, remediate Defendants’ violations of their civil

³ The February 21, 2025 memorandum also suspended “all transgender-specific programming,” pat search accommodations, and the Transgender Executive Council (a body that provided guidance on the care of transgender people in the custody of BOP).

and constitutional rights, and to preserve or restore their access to gender-affirming health care that they depend on for their health.

JURISDICTION AND VENUE

12. Plaintiffs bring this suit under the Fifth and Eighth Amendments of the U.S. Constitution, the Rehabilitation Act of 1973, and the APA. The Court has jurisdiction over this action under 28 U.S.C. §§ 1331 and 1346. Plaintiffs seek declaratory and injunctive relief for Defendants' violations of Plaintiffs' civil rights.

13. Venue is appropriate in the District of the District of Columbia under 28 U.S.C. § 1391(e) because the events giving rise to the claims occurred in this District and Defendants are headquartered in this District.

PARTIES

Class of Incarcerated People

14. Plaintiffs bring this action on their own behalf and on behalf of a class of those similarly situated pursuant to Rules 23(a) and 23(b)(2) of the Federal Rules of Civil Procedure.

15. The class is defined as: "All persons who are or will be incarcerated in the custody of BOP who are or will be diagnosed with gender dysphoria or meet the criteria for a gender dysphoria diagnosis and who are receiving, or would receive, gender-affirming health care absent such care being proscribed by EO 14168 and the Implementing Memoranda."

16. As defined, the class meets all the requirements of Rule 23(a).

17. The class is so numerous that joinder of all members is impracticable. Upon information and belief, at least 2,000 people incarcerated in the custody of BOP will lose access to hormone therapy and accommodations to address their gender dysphoria due to BOP's implementation of EO 14168.

18. Additional class members will become incarcerated in the custody of BOP in the future. They will not receive gender-affirming health care even if they meet the criteria for a diagnosis of gender dysphoria and such care is medically indicated for them. Regardless of need,

treatment will be denied because of Defendants' enforcement of the blanket ban on gender-affirming health care in EO 14168.

19. There are questions of law or fact common to the class. If Defendants are permitted to enforce EO 14168, then all members of the class will be subject to a common harm: the cessation of their gender-affirming health care and/or an inability to obtain gender-affirming health care necessary to treat their gender dysphoria. All members seek the same relief: an injunction preventing enforcement of EO 14168, as applied to BOP medical care and accommodations, and the Implementing Memoranda. This lawsuit also presents common questions of law, including whether Defendants' enforcement of EO 14168 and the Implementing Memoranda violate the Fifth and Eighth Amendments of the U.S. Constitution and the Rehabilitation Act, and whether BOP's Implementing Memoranda violate the APA.

20. Plaintiffs' claims are typical of those of the class. They are all transgender incarcerated people who have been diagnosed by BOP clinicians with gender dysphoria, and to whom BOP has provided, and would continue to provide, gender-affirming health care if it were not prohibited by EO 14168 and the Implementing Memoranda.

21. Plaintiffs are adequate representatives of the class. They do not have conflicts with other members of the class, they seek the same relief as other members of the class, and they will represent the class fairly and adequately.

22. The class representatives are also adequately represented by counsel. Counsel includes lawyers from the American Civil Liberties Union Foundation, Transgender Law Center, and ACLU Foundation of the District of Columbia. Counsel have extensive experience litigating class actions in federal courts, including civil rights lawsuits on behalf of transgender people and incarcerated people.

23. The requirements of Rule 23(b)(2) are met because Defendants have acted, or will act, on grounds generally applicable to the class, and final injunctive relief and declaratory relief are appropriate respecting the class as a whole. BOP has issued memoranda implementing EO

14168. Additionally, BOP health care staff have notified Plaintiffs and putative class members that their hormone therapy and accommodations have been or will be discontinued as a result of EO 14168 and the Implementing Memoranda. Defendants Bondi, Lothrop, Bina, DiGiacomo, and Salem will follow EO 14168's blanket prohibition on gender-affirming health care at BOP facilities.

Named Plaintiffs

24. **Named Plaintiff Alishea Sophia Kingdom** is a 34-year-old transgender woman with gender dysphoria incarcerated at Federal Correctional Institution ("FCI")-Fairton, in Fairfield Township, New Jersey. She has been receiving hormone therapy in BOP custody since 2016, as well as female-designated clothing and commissary items. BOP stopped her hormone therapy on January 26, 2025, and has informed her that she will no longer receive female-designated clothing or commissary items. Hormone therapy and gender-affirming clothing and commissary items have been critical to her health.

25. **Named Plaintiff Solo Nichols** is a 40-year-old transgender man with gender dysphoria incarcerated at FCI-Tallahassee, in Tallahassee, Florida. In BOP custody, Mr. Nichols has had access to gender-affirming accommodations including chest binders, boxers, and commissary items since 2018, and he has been prescribed hormone therapy by BOP health care providers since 2021. Mr. Nichols has been receiving mixed messages about when his hormone therapy will be ended and has received one reduced dose of treatment. Hormone therapy and gender-affirming clothing and commissary items have been critical to his health.

26. **Named Plaintiff Jas Kapule** is a 35-year-old transgender man with gender dysphoria incarcerated at FCI-Waseca in Waseca, Minnesota. He has been receiving hormone therapy and access to gender-affirming accommodations—including a chest binder, boxers, and commissary items—to treat his gender dysphoria since 2022. BOP staff have told Mr. Kapule that once his testosterone prescription runs out he will not receive any additional hormone treatments, and that he can no longer receive a chest binder through laundry services or purchase binders or

boxers at the commissary. Hormone therapy and gender-affirming clothing and commissary items have been critical to his health.

Defendants

27. Defendant Donald J. Trump is the President of the United States. He issued EO 14168 on January 20, 2025 and is responsible for overseeing its implementation. He is sued in his official capacity.

28. Defendant Pamela J. Bondi is the Attorney General of the United States. She oversees the U.S. Department of Justice, including BOP, and is responsible for the enforcement and implementation of EO 14168 in federal prisons. She is sued in her official capacity.

29. Defendant William W. Lothrop is the Acting Director of BOP. The Acting Director of BOP is responsible for the enforcement and implementation of EO 14168 in federal prisons. He is sued in his official capacity.

30. Christopher A. Bina is the Assistant Director of the Health Services Division of BOP. He issued BOP's February 28, 2025, memorandum titled "Executive Order 14168 Compliance." He is sued in his official capacity.

31. Dana R. DiGiacomo is the Acting Assistant Director of the Reentry Services Division of BOP. She co-issued BOP's February 21, 2025, memorandum titled "Compliance with Executive Order 'Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government'." She is sued in her official capacity.

32. Shane Salem is the Assistant Director of the Correctional Programs Division of BOP. He co-issued BOP's February 21, 2025, memorandum titled "Compliance with Executive Order 'Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government'." He is sued in his official capacity.

FACTUAL ALLEGATIONS

The Diagnosis and Treatment of Gender Dysphoria

33. "Gender identity" is a person's internal sense of belonging to a particular gender.

Everyone has a gender identity, and a person's gender identity is durable and cannot be altered voluntarily or changed through therapy or medical intervention.

34. A person's gender identity usually matches the sex they were designated at birth based on their external genitalia.⁴ But transgender people have a gender identity that differs from their sex designated at birth. A transgender man is someone who was designated a female sex at birth but has a male gender identity. A transgender woman is someone who was designated a male sex at birth but has a female gender identity.

35. While being transgender itself is not a disorder, the incongruence between one's gender identity and sex designated at birth can cause clinically significant distress for transgender people.

36. According to the American Psychiatric Association's Diagnostic & Statistical Manual of Mental Disorders, Fifth Edition, Text Revision ("DSM-5-TR"), "gender dysphoria" is the diagnostic term for the condition experienced by some transgender people of clinically significant distress resulting from the lack of congruence between their gender identity and their sex designated at birth. To be diagnosed with gender dysphoria, the incongruence must have persisted for at least six months and be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning.⁵

37. Gender dysphoria is a serious condition which, if left untreated, causes serious physical and psychological harm. Symptoms of untreated gender dysphoria can include, but are not limited to, anxiety, depression, eating disorders, socially-isolating behavior, self-harm, and suicidality.

38. The widely accepted approach to the treatment of gender dysphoria aims to resolve the distress associated with the incongruence between a transgender person's designated sex at

⁴ The terms "sex designated at birth" or "sex assigned at birth" are more precise than the term "biological sex" because there are many biological sex characteristics, and they do not always align with each other.

⁵ Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders, Text Revision F64.0 (5th ed. 2022).

birth and their gender identity by enabling the individual to live consistently with their gender identity. This can involve social transition (such as dressing, styling one's hair, and using a name and pronouns that match one's gender identity); hormone treatment to masculinize or feminize the body; and various surgeries to change primary and/or secondary sex characteristics.

39. Clinical practice guidelines for the treatment of gender dysphoria have been published by the World Professional Association for Transgender Health ("WPATH") and the Endocrine Society. WPATH is a professional organization of medical and mental health professionals focused on transgender health care and has been issuing these guidelines since 1979. The current version, the Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 ("WPATH SOC 8") was published in 2022.⁶ The Endocrine Society, which is a professional association of endocrinologists, first issued guidelines for the treatment of gender dysphoria in 2011 and updated the guidelines in 2017.⁷

40. These guidelines are supported by all major medical and mental health associations in the United States, including but not limited to the American Medical Association, the American Psychiatric Association, and the American Psychological Association.

41. While psychotherapy can be important to support individuals with gender dysphoria, psychotherapy is not a substitute for medical treatment of gender dysphoria for those for whom it is indicated. There are no psychotherapeutic modalities that have been shown to alleviate gender dysphoria.

42. The efficacy of gender-affirming health care—social transition, hormone therapy, and surgeries—in alleviating gender dysphoria is well-documented in decades of peer-reviewed research and clinical experience.

⁶ Eli Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 Int. J. of Transgender Health S1 (2022), available at <https://wpath.org/publications/soc8/>.

⁷ See Wylie C. Hembree et al., *Endocrine Treatment of Gender Dysphoric/Gender Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. of Clinical Endocrinology & Metabolism 3869 (2017), available at <https://www.endocrine.org/clinical-practice-guidelines/gender-dysphoria-gender-incongruence>.

43. Gender-affirming hormone therapy and surgeries are also well-documented to be safe and have low risks that are comparable to the risks associated with other types of medical treatments.

44. The well-accepted protocols for treatment of gender dysphoria set forth in the WPATH and Endocrine Society guidelines apply in institutional settings, including prisons, jails, and other carceral facilities. *See* WPATH SOC 8, chapter 11; *see also* National Commission on Correctional Health Care, Position Statement: Transgender and Gender Diverse Health Care in Correctional Settings 3 (2020) (“The clinical decision making to initiate or advance hormone medication treatment or candidacy for surgical interventions while incarcerated or upon release needs to be based on individual medical need, risks and benefits, analysis of alternatives, ruling out contraindications, accepted standards of care, and a thorough informed-consent process.”).

45. Withdrawing gender-affirming health care from or denying such care to individuals for whom it is medically indicated puts them at risk of significant harm to their health. For those who have seen this health care alleviate their gender dysphoria, withdrawing care can be expected to result in a return of the symptoms they were previously experiencing. Some of the effects of hormone therapy are reversible, so discontinuing that treatment would cause transgender men to lose masculinization and transgender women to lose feminization of their features, exacerbating their gender dysphoria. Suddenly discontinuing the use of hormone therapy can also lead to physical symptoms like headaches, hot flashes, and spikes in blood pressure. The withdrawal of accommodations that allow people to dress and otherwise live consistently with their gender identity would likewise worsen symptoms of gender dysphoria.

Treatment of People with Gender Dysphoria in BOP Custody Prior to the EO

46. It is BOP policy to “provide[] essential medical, dental, and mental health (psychiatric) services in a manner consistent with accepted community standards for a correctional environment.”⁸

⁸ Fed. Bureau of Prisons, *Medical Care* (Mar. 2025), <https://perma.cc/B299-3YAR>.

47. Until Defendant Trump’s issuance of EO 14168 on January 20, 2025, and BOP’s implementation of that EO, people incarcerated in BOP facilities who were diagnosed with gender dysphoria were provided treatments based upon individualized patient medical need. Prior to January 20, 2025, Plaintiffs and putative class members received treatment in accordance with well-accepted medical protocols, including the WPATH guidelines, which included gender-affirming medical treatments and accommodations as indicated for their medical needs.

48. For example, BOP’s June 2023 Clinical Guidance for “Gender-Affirming Care of Transgender and Gender Nonbinary Persons” (“2023 BOP Clinical Guidance”), states that it was updated to “more closely align with community standards.”⁹ The 2023 version of this document updated BOP’s previous Clinical Guidance from December 2016, entitled “Medical Management of Transgender Inmates” (“2016 BOP Clinical Guidance”).¹⁰

49. Consistent with BOP policy, prior to EO 14168 and BOP’s implementation of the EO, BOP’s provision of gender-affirming health care to incarcerated people was based upon individualized medical need. *See* 2016 BOP Clinical Guidance, at 6 (“Healthcare for [transgender] individuals requires a multidisciplinary approach. . . . The treatment and management of the [transgender] individual requires individualized care guided by treatment goals to allow for successful transition through education, counseling, real-life experience, medical evaluation, hormone treatment, and in some cases, sex reassignment surgery.”); 2023 BOP Clinical Guidance, at 5 (“A patient-centered multidisciplinary team approach is recommended for managing issues associated with the incarceration of [transgender] individuals. . . . It is important to have a system in place to allow for individualized treatment. Individuals requesting care for gender dysphoria should have access to a diverse range of treatment services. Patient-centered care explores

⁹ Fed. Bureau of Prisons, *Gender-Affirming Care of Transgender and Gender Nonbinary Persons* (June 2023), at i. These clinical guidelines were previously publicly available on the BOP website but were taken down as a result of EO 14168. The guidelines are now archived on a perma-CC website at <https://perma.cc/U5UT-S9PN>.

¹⁰ Fed. Bureau of Prisons, *Medical Management of Transgender Inmates* (Dec. 2016), <https://perma.cc/K7RQ-8NTU>.

individualized therapeutic options, which may vary from person to person.”).

50. The 2023 BOP Clinical Guidance explains that “[g]ender-affirming health care involves supporting individuals through social, psychological, behavioral, or medical (including hormonal treatment or surgery) treatments—to support and affirm an individual’s experienced gender identity.” *Id.* at 4. It also notes that “appropriate gender-affirming care, including medical and surgical care, can lessen psychiatric symptoms” associated with gender dysphoria. *Id.*

51. Pursuant to the 2016 and 2023 BOP Clinical Guidance, BOP had a Transgender Clinical Care Team comprised of “physicians (primary care and psychiatrists), pharmacists, and social workers devoted to advocating and advancing the treatment options for this population. The team provides education and the tools to institutional staff to develop clinical treatment plans for the [transgender] and gender nonbinary population.” *Id.* at 1.

52. Until Defendant Trump’s issuance of EO 14168 on January 20, 2025, and BOP’s implementation of the EO, BOP had a Transgender Utilization Review Advisory Group comprised of “physicians, psychiatrists, pharmacists, and social workers assigned by the Medical Director to provide clinical review of gender-confirming surgical requests.” *Id.*

53. BOP’s “Transgender Offender Manual,” initially issued in 2017 and updated on January 13, 2022, provided for individualized assessment for hormone therapy and other medical treatment in accordance with the BOP Clinical Guidance and also set forth the clothing and commissary policies applicable to incarcerated transgender people, as well as additional non-health care policies and practices in place related to the supervision of transgender incarcerated people.¹¹ As with health care needs, clothing, commissary items, and other accommodations were provided “based on an individualized assessment.” 2022 Transgender Offender Manual at 12.

54. Until Defendant Trump’s issuance of EO 14168 on January 20, 2025, and BOP’s implementation of the EO, BOP had a Transgender Executive Council, which was “the agency’s

¹¹ Shortly after the issuance of EO 14168, all references to the 2022 Transgender Offender Manual were removed from the BOP website. A perma-CC version of the manual is available at <https://perma.cc/4BP6-YWRP>.

official decisionmaking body on all issues affecting the transgender population,” including for individuals’ gender confirmation surgery, and met “a minimum of monthly to offer advice and guidance on unique measures related to treatment and management needs of transgender inmates and/or inmates with [gender dysphoria].” *Id.* at 4.

Executive Order 14168’s Categorical Denial of Gender-Affirming Health Care for Transgender People in BOP Custody and BOP’s Implementation of the EO

55. On January 20, 2025, just hours after his inauguration, Defendant Trump issued EO 14168, titled “Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government.”¹²

56. The stated purpose of the EO was to protect women from “men [who] self-identify as women . . . gain[ing] access to intimate single-sex spaces and activities designed for women,” which the EO says “fundamentally attack[s] women by depriving them of their dignity, safety, and well-being.” The EO’s title reflects this purpose of purportedly protecting women.

57. The EO opposes “gender ideology,” which it defines as “the false claim that males can identify as and thus become women and vice versa,” and prohibits federal funds that “promote gender ideology,” addressing a range of contexts. EO 14168 was one of a slew of anti-transgender Executive Orders issued by Defendant Trump in his first days and weeks in office.¹³

¹² Exec. Order No. 14168, *Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government*, 90 Fed. Reg. 8615 (Jan. 20, 2025).

¹³ See, e.g., Exec. Order No. 14148, *Initial Rescissions of Harmful Executive Orders and Actions*, 90 Fed. Reg. 8237 (Jan. 20, 2025) (rescinding several Biden administration orders that recognized rights of transgender people in schools, the workplace, housing, health care, and other settings, consistent with the Supreme Court’s decision in *Bostock v. Clayton County*); Exec. Order No. 14183, *Prioritizing Military Excellence and Readiness*, 90 Fed. Reg. 8757 (Jan. 27, 2025) (banning transgender people from serving in the U.S. military, accusing transgender servicemembers of expressing a “false” gender identity, and stating that being transgender “conflicts with a soldier’s commitment to an honorable, truthful, and disciplined lifestyle, even in one’s personal life.”); Exec. Order 14187, *Protecting Children from Chemical and Surgical Mutilation*, 90 Fed. Reg. 8771 (Jan. 28, 2025) (ordering the federal government to withhold all federal funding from any institution that provides gender-affirming care to people under the age of 19); Exec. Order No. 14190, *Ending Radical Indoctrination in K-12 Schooling*, 90 Fed. Reg. 8853 (Jan. 29, 2025) (banning K-12 schools in the U.S. from recognizing youth’s identities by using names or pronouns

58. Section 4(c) of EO 14168 directs the Attorney General to “ensure that the Bureau of Prisons revises its policies concerning medical care to be consistent with [the EO]” and ensure that “no Federal funds are expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate’s appearance to that of the opposite sex.”

59. Section 4(c) categorically bans gender-affirming health care for people incarcerated in BOP facilities, regardless of medical necessity, or the fact that they were already being provided such care by BOP clinicians and depending on such care for their health.

60. Section 4(c) prohibits BOP health care providers from evaluating and treating gender dysphoria on a patient-centered individualized basis, according to their professional judgment.

61. Section 3(e) of the EO directs all agencies to “remove all statements, policies, regulations, forms, communications, or other internal and external messages that promote or otherwise inculcate gender ideology,” and to “cease issuing such statements, policies, regulations, forms, communications or other messages.” It also directs agency “forms that require an individual’s sex” to “list male or female,” prohibiting such forms from “request[ing] gender identity,” and directs agencies to “take all necessary steps, as permitted by law, to end the Federal funding of gender ideology.”

62. Section 3(g) of the EO states that “Federal funds shall not be used to promote gender ideology.”

63. Upon information and belief, on or about January 31, 2025, BOP scrubbed its website of the Transgender Offender Manual, replacing the page with a link that redirects to a page reading that “This content is temporarily unavailable as we implement the Executive Order on ‘Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the

that align with their gender, threatening teachers who do not comply with criminal prosecution under laws banning sexual exploitation of minors and practicing medicine without a license); Exec. Order No. 14201, *Keeping Men Out of Women’s Sports*, 90 Fed. Reg. 9279 (Feb. 5, 2025).

Federal Government” as seen below:¹⁴



64. On information and belief, on or about January 31, 2025, BOP facilities posted a digital bulletin on a system available to incarcerated people announcing the disbanding of the Transgender Executive Council (TEC), described above in Paragraph 54.

65. On February 21, 2025, Defendants BOP Reentry Services Division Acting Assistant Director Dana R. DiGiacomo and Correctional Programs Division Assistant Director Shane Salem issued a memorandum implementing the EO with the exception of the application to medical treatments, citing a nationwide temporary restraining order that had been in effect.¹⁵ Exhibit A. Among other directives issued in the implementing memo, BOP expressly prohibits the purchase of “any items that align with transgender ideology,” such as chest binders and hair removal devices; prohibits the granting of requests for other accommodations such as “undergarments that do not align with an inmate’s biological sex”; and mandates that BOP staff members “must refer to individuals” with “pronouns corresponding to their biological sex.”

¹⁴ See <https://perma.cc/6Z8P-KKQ4>.

¹⁵ The nationwide temporary restraining order has been replaced with a preliminary injunction that applies only to the specific named Plaintiffs involved in the case in which the temporary restraining order was issued.

66. On February 28, 2025, BOP Health Services Division Assistant Director Chris A. Bina issued another implementing memorandum, which states in full:

Consistent with Executive Order (EO) 14168, Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government, no Bureau of Prisons funds are to be expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex.

This policy is to be implemented in a manner consistent with applicable law including the Eighth Amendment.

Exhibit B.

67. Both Implementing Memoranda were directed to all BOP Chief Executive Officers, and the February 25, 2025, memorandum also cc'ed the BOP Executive Team, Health Services Division Employees, Clinical Directors, and Health Services Administrators. The Implementing Memoranda represent BOP's directives enforcing EO 14168's blanket prohibition of gender-affirming health care at BOP facilities.

The Impact of EO 14168 and BOP's Implementing
Memoranda on Named Plaintiffs

68. **Plaintiff Alishea Sophia Kingdom**, is a 34-year-old transgender woman incarcerated at FCI – Fairton, in Fairfield Township, New Jersey. She has been incarcerated since 2014, and anticipates being incarcerated until 2028.

69. As early as age 8, Ms. Kingdom knew she was a girl. She preferred “girls” toys, would wear “girls” clothes when she could, and when she first learned that her body was not the same as other girls, she felt distressed, confused, and knew something was not right. Her mother believed Ms. Kingdom was either gay or too feminine, would tell her to act like a boy, and would send her to group homes and mental health facilities in hopes that Ms. Kingdom would become more masculine.

70. As she went through puberty, Ms. Kingdom began experiencing symptoms of gender dysphoria: she felt severe anxiety, would have panic attacks when she noticed facial hair, would feel physically sick when thinking about her body masculinizing, and was often unable to

sleep at night.

71. As a teenager, Ms. Kingdom started going by the name “Alishea Sophia,” and wore long hair, makeup, and typically feminine clothes whenever possible.

72. Ms. Kingdom was diagnosed with gender dysphoria by BOP clinicians in 2016. That same year, BOP clinicians determined that hormone therapy was medically indicated for her to treat her gender dysphoria, and she received hormone therapy from then until January 26, 2025. She was also able to access bras, panties, and gender-affirming commissary items.

73. Hormone therapy and access to feminine-typical clothing and commissary items reduced her symptoms of gender dysphoria and greatly improved her health and well-being. While receiving this treatment, Ms. Kingdom stopped experiencing panic attacks, her anxiety was controlled, and she was able to get a full night’s sleep. Hormone therapy has feminized Ms. Kingdom’s body: she has breasts, her body fat has redistributed to her hips and buttocks, and she grows significantly less facial and body hair. And access to feminine-typical clothing and commissary items further enabled her to live consistently with her female gender identity.

74. On January 26, 2025, Ms. Kingdom had an appointment to receive her hormone therapy, but FCI-Fairton staff told her that, because of President Trump’s Executive Order, they would no longer provide hormone therapy to treat gender dysphoria for transgender people at FCI-Fairton. Ms. Kingdom has not been provided this prescribed treatment for her gender dysphoria since then.

75. FCI-Fairton staff have also informed Ms. Kingdom that BOP will no longer provide her bras or panties and that she may no longer purchase gender-affirming commissary items.

76. Losing the effects of hormone therapy and seeing her appearance masculinize over time will cause Ms. Kingdom severe and irreparable harm. She is experiencing anxiety and panic attacks, insomnia, mood swings, and thoughts of self-harm and suicide as her body reacts to the change in hormone levels and her gender dysphoria worsens.

77. Last year, Ms. Kingdom went before the Transgender Executive Council (TEC) for

review for surgery to further alleviate her gender dysphoria. With the shutdown of the TEC, there is now no avenue for her to access gender-affirming surgery. She was due to be reevaluated for surgery by the TEC this month. This causes Ms. Kingdom extreme distress, and she now frequently considers self-castration.

78. **Plaintiff Solo Nichols** is a transgender man incarcerated at FCI-Tallahassee, in Tallahassee, Florida.

79. He has been incarcerated by BOP since 2013 and anticipates being incarcerated until August 8, 2029.

80. From a young age, Mr. Nichols has known himself to be male and would ask others to refer to him as a boy. He was in fifth grade when he first explained to a friend that he was a boy. Mr. Nichols socially transitioned and started wearing a chest binder and exclusively masculine-typical clothing around age 15.

81. Since 2018, BOP has recognized him as transgender, and allowed him access to chest binders, boxers, and other gender-affirming commissary items.

82. In 2021, BOP clinicians diagnosed Mr. Nichols with gender dysphoria. They prescribed him testosterone starting in mid-2021. He has been receiving this treatment ever since.

83. Mr. Nichols' hormone therapy and accommodations have reduced his symptoms of gender dysphoria, and greatly improved his health and well-being. Before starting hormone therapy, Mr. Nichols had been prescribed 13 different psychiatric medications since his teenage years. None of those medications were effective in treating his gender dysphoria and resultant anxiety, racing thoughts, and irritability. Testosterone is the only treatment that has managed to control those symptoms.

84. Before Defendant Trump issued EO 14168, BOP's medical director and system-wide Transgender Utilization Review Advisory Group (TURAG) had approved Mr. Nichols for gender-affirming surgery, a double mastectomy to masculinize his chest. He was awaiting consultation with a surgeon when EO 14168 was issued. The BOP's enforcement of the EO

precludes his surgery.

85. On February 12, 2025, Mr. Nichols was provided half of his regular dose of testosterone. FCI Tallahassee staff informed him that his next dose would be further reduced and would be his last. Mr. Nichols has not had any recent bloodwork, physical examination, or mental health evaluations that could have informed this decision about his medical treatment. Mr. Nichols is aware of three other transgender men who also received reduced doses of testosterone that day, under similar circumstances.

86. After receiving a reduced dose of testosterone, Mr. Nichols experienced lethargy and mood swings. On Friday, February 21, 2025, FCI Tallahassee staff changed course, and informed Mr. Nichols and other transgender men that they would again be receiving their full doses.

87. On February 26, FCI Tallahassee staff told him that the transgender men in the facility would be given the full amount of their prescribed doses, “as long as the restraining order lasts.”

88. Withdrawing Mr. Nichols from hormone therapy, denying him the mastectomy, and rescinding the accommodations he was receiving has already caused and will continue to cause Mr. Nichols severe and irreparable harm.

89. **Plaintiff Jas Kapule** is a transgender man incarcerated at FCI-Waseca in Waseca, Minnesota. He is 35 years old. He has been incarcerated since 2020 and anticipates being incarcerated until July 5, 2028.

90. Mr. Kapule knew he was a boy as a child but struggled to understand and accept himself. He began to live and present as a man starting at the age of 18 and began to feel more like himself after doing so.

91. Mr. Kapule was diagnosed with gender dysphoria by BOP clinicians in 2022. He has been provided hormone therapy and access to accommodations—including a chest binder, boxers, and other gender-affirming commissary items—by BOP to treat his gender dysphoria since

2022. He receives testosterone every two weeks. His hormone therapy has reduced his symptoms of gender dysphoria, and made an enormous improvement to his health and well-being. Being able to wear boxers and a chest binder has also helped to reduce his dysphoria.

92. Mr. Kapule has been told by BOP staff that once his testosterone prescription runs out, it will not be refilled. He finds this prospect devastating—he is finally in a place where he feels emotionally stable thanks to receiving appropriate care. Mr. Kapule particularly fears the return of his menstrual cycle if he is taken off of testosterone, as that caused him great distress each month before he was able to access care.

93. On or about February 24, 2025, BOP staff informed Mr. Kapule that he could no longer receive a chest binder through laundry services or purchase binders or boxers at the commissary. He has not worn panties or bras in years and the idea of wearing those feminine-typical items makes him deeply uncomfortable and exacerbates his gender dysphoria.

94. In 2024, Mr. Kapule was evaluated by a BOP psychologist for gender-affirming chest surgery and the Transgender Executive Council recommended initiating a surgical referral. Following the Executive Order, Mr. Kapule was told by Assistant Warden Davis that his surgery was no longer being evaluated and was on indefinite hold.

95. Mr. Kapule fears he will soon lose access to all of his care for gender dysphoria. He can feel his depression and anxiety increasing and is worried about the feelings of hopelessness that he used to have before his gender-affirming care started.

CLAIMS FOR RELIEF

COUNT 1

Challenge to EO 14168 as Applied to BOP Medical Care and Accommodations and the Implementing Memoranda

Eighth Amendment of the United States Constitution Against All Defendants in Their Official Capacities

96. Under the Eighth Amendment, Defendants must provide incarcerated people adequate and necessary health care that meets accepted standards of care and practice within the

medical community. The Eighth Amendment prohibits deliberate indifference by government officials to incarcerated persons' serious medical needs. An official who has knowledge of an incarcerated person's need for medical care that would place the incarcerated person at substantial risk of serious harm if not treated, and who denies, delays, or otherwise interferes with the provision of health care, is deliberately indifferent.

97. Plaintiffs have been diagnosed with the serious medical condition of gender dysphoria, which causes them serious clinical distress, and which, without medically necessary treatment, will predictably result in serious and irreparable physical and psychological harm to Plaintiffs.

98. Plaintiffs and putative class members have serious medical needs for hormone therapy and other gender-affirming health care for their gender dysphoria, including accommodations that enable them to dress and otherwise live consistently with their gender identity. The EO's and Implementing Memoranda's blanket termination of this medical treatment and accommodations for all Plaintiffs and putative class members, without regard to their individual medical needs, violates the accepted and applicable community standards of care for the treatment of gender dysphoria, and subjects Plaintiffs and putative class members to substantial risk of serious harm.

99. Withdrawing Plaintiffs' and putative class members' gender-affirming health care contravenes their health care providers' professional medical judgment, which had been made based on an assessment of patients' individualized medical needs, and in accordance with the accepted and applicable community standards of care. EO 14168 and the Implementing Memoranda establish a blanket prohibition that denies medically necessary treatment to Plaintiffs and putative class members, without consideration of any independent medical judgment formed by health care providers, in violation of the Eighth Amendment's prohibition on cruel and unusual punishments.

100. By denying Plaintiffs and putative class members medically necessary treatment

for their gender dysphoria, Defendants have caused and will continue to cause them harm by withholding effective treatment for an objectively serious medical condition.

101. Defendants’ deliberate actions of denying medically necessary care for Plaintiffs and putative class members has caused or will cause them serious physical and psychological harm, and puts them at grave risk for worsening physical and psychological symptoms.

102. Defendants have acted, and continue to act, with deliberate indifference to Plaintiffs’ serious medical needs, and to the substantial risk of serious harm to Plaintiffs.

103. As a result of Defendants’ actions described herein, in the absence of injunctive relief, Plaintiffs will continue to suffer irreparable harm.

COUNT 2

Challenge to EO 14168 as Applied to BOP Medical Care and Accommodations and the Implementing Memoranda

Fifth Amendment of the United States Constitution – Equal Protection Against All Defendants in Their Official Capacities

104. The Fifth Amendment provides that “[n]o person shall . . . be deprived of life, liberty, or property, without due process of law.” The Supreme Court has held that the Due Process Clause includes a guarantee against the United States of equal protection of the laws equivalent to that guaranteed against the States by the Equal Protection Clause of the Fourteenth Amendment.

105. EO 14168, as applied to BOP medical care and accommodations, and the Implementing Memoranda violate the Fifth Amendment’s equal protection guarantee.

106. EO 14168 and the Implementing Memoranda facially classify based on sex and transgender status.

107. EO 14168 declares that it is federal policy to recognize only two sexes, defining “sex” as “an individual’s immutable biological classification as either male or female,” determined based on the type of reproductive cell an individual, at the time of conception, is expected to produce. And it mandates that BOP “revise[] its policies concerning medical care to be consistent with this order” and prohibits BOP from expending any federal funds on any “medical procedure,

treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex." E.O. 14168 §§ 2(a) & 4(c). It also directs agencies, including BOP, to "remove all . . . policies . . . that promote or otherwise inculcate gender ideology," and to "take all necessary steps, as permitted by law, to end the Federal funding of gender ideology," and prohibits the use of federal funds "to promote gender ideology." *Id.* §§ 3(e) & 3(g).

108. EO 14168 and the Implementing Memoranda operate through facial sex classification, with a person's sex, as defined by the EO, determining whether they may receive certain medical treatments or accommodations.

109. By targeting for prohibition treatment prescribed "for the purpose of conforming an inmate's appearance to that of the opposite sex," and funding for any policies or accommodations "promot[ing]" the "claim that males can identify as and thus become women and vice versa," the EO and the Implementing Memoranda also facially classify based on sex by enforcing sex stereotypes. *Id.* §§ 2(f), 3(g), 4(c).

110. Under the Equal Protection Clause, sex classifications are subject to heightened scrutiny and are presumptively unconstitutional.

111. EO 14168 and the Implementing Memoranda also facially classify based on transgender status. They deny medical treatments and accommodations to individuals because they are transgender.

112. Discrimination based on transgender status is sex discrimination subject to heightened scrutiny.

113. Transgender status discrimination is subject to heightened scrutiny for the additional reason that transgender status is a quasi-suspect class warranting heightened scrutiny.

114. There is no legitimate purpose or basis for the EO's and the Implementing Memoranda's categorical ban on gender-affirming health care for people with gender dysphoria in BOP custody.

115. Prohibiting gender-affirming medical care and accommodations for individuals in

BOP custody is not substantially related to the EO’s stated purpose of protecting women from “men [who] self-identify as women . . . gain[ing] access to intimate single-sex spaces and activities designed for women”; nor is it even rationally related to that purpose. *Id.* § 1. Nor is this prohibition of such care substantially related to any important government interest, or rationally related to any legitimate government interest. Accordingly, EO 14168, as applied to BOP medical care and accommodations, and the Implementing Memoranda violate the right to equal protection guaranteed by the Fifth Amendment.

116. EO 14168 and the Implementing Memoranda are motivated by discriminatory animus and are unconstitutional under any level of scrutiny.

117. EO 14168, as applied to BOP medical care and accommodations, and the Implementing Memoranda are causing and will cause irreparable harm to Plaintiffs and the putative class, including serious physical, psychological, and emotional harm, distress, and mental anguish.

COUNT 3

Challenge to EO 14168 as Applied to BOP Medical Care and Accommodations and the Implementing Memoranda

Rehabilitation Act of 1973, Section 504

Against All Defendants in Their Official Capacities

118. Plaintiffs have a current diagnosis of gender dysphoria as well as a record of gender dysphoria that is known to BOP officials.

119. Gender dysphoria is a serious medical condition that qualifies as a disability.

120. BOP is an executive agency that falls within the definition of a covered public entity that is responsible for providing benefits, services, and programs to all individuals in its custody.

121. EO 14168 and the Implementing Memoranda categorically ban medical treatments and accommodations for people in BOP custody if the treatments and accommodations are provided to “conform[] an inmate’s appearance to that of the opposite sex.” That describes treatment for gender dysphoria. Thus, treatments and accommodations are banned only if they are

prescribed to treat gender dysphoria. This disparate treatment of Plaintiffs and putative class members based upon their gender dysphoria diagnosis discriminates against them based upon disability.

122. EO 14168 and the Implementing Memoranda discriminate based on disability by excluding people with gender dysphoria, including Plaintiffs and putative class members, from accessing certain medical treatments and accommodations that are provided to other people in BOP custody, solely based on their diagnosis.

123. Accordingly, EO 14168, as applied to BOP medical care and accommodations, and the Implementing Memoranda violate Section 504 of the Rehabilitation Act of 1973. The failure to provide accommodations to Plaintiffs and putative class members based upon their gender dysphoria diagnosis discriminates against them based upon disability.

COUNT 4

Challenge to the Implementing Memoranda Administrative Procedure Act, 5 U.S.C. §§ 500-596 & 706 Contrary to Constitutional Right, Power, Privilege or Immunity Against Agency Defendants

124. The APA, 5 U.S.C. §§ 500-596 & 706, provides that courts “shall . . . hold unlawful and set aside agency action, findings, and conclusions found to be . . . contrary to constitutional right, power, privilege, or immunity” 5 U.S.C. § 706(2)(B).

125. BOP has taken concrete steps to implement EO 14168 by issuing the Implementing Memoranda.

126. The Implementing Memoranda constitute final agency action. The Implementing Memoranda represent the consummation of the agency’s decision-making process: they were issued by agency leadership and do not contemplate any further consideration by the agency prior to implementation and enforcement. Rather than merely clarifying its existing duties, the Implementing Memoranda determine the rights of Plaintiffs and BOP’s obligations to Plaintiffs, both of which, as explained within, have direct and immediate legal consequences for the

Plaintiffs.

127. Pursuant to the Implementing Memoranda, BOP will no longer provide gender-affirming health care for Plaintiffs and the putative class members, even when such care is medically indicated. Regardless of need, treatment and accommodations will be denied because of Defendants' enforcement of the policies outlined in the Implementing Memoranda.

128. Actions taken by BOP to enforce the mandates of EO 14168 and the Implementing Memoranda are causing and will continue to cause irreparable harm to Plaintiffs and the putative class, including serious physical, psychological, and emotional harm, distress, and mental anguish.

129. For the reasons described in the preceding claims, and incorporated here, BOP's policies and agency actions taken under EO 14168 are "contrary to constitutional right, power, privilege, or immunity," and therefore must be held unlawful and set aside. 5 U.S.C. § 706(2)(B). In particular, as detailed above, those actions violate the Eighth Amendment and the right to equal protection guaranteed by the Fifth Amendment of the Constitution.

COUNT 5

Challenge to the Implementing Memoranda

Administrative Procedure Act, 5 U.S.C. §§ 500-596 & 706

Arbitrary and Capricious, Unlawful, and Unconstitutional Agency Action

Against Agency Defendants

130. The APA, 5 U.S.C. §§ 500-596 & 706, provides that courts "shall . . . hold unlawful and set aside agency action, findings, and conclusions found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law. . . ." 5 U.S.C. § 706(2)(A).

131. BOP has taken concrete steps to implement EO 14168 by issuing the Implementing Memoranda.

132. The Implementing Memoranda constitute final agency action. The Implementing Memoranda represent the consummation of the agency's decision-making process: they were issued by agency leadership and do not contemplate any further consideration by the agency prior to implementation and enforcement. Rather than merely clarifying its existing duties, the

Implementing Memoranda determine the rights of Plaintiffs and BOP's obligations to Plaintiffs, both of which, as explained within, have direct and immediate legal consequences for the Plaintiffs.

133. Actions taken by BOP to enforce the mandates of EO 14168 and the Implementing Memoranda are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," 5 U.S.C. § 706(2)(A), for multiple independent reasons.

134. The challenged agency actions are arbitrary and capricious, and an abuse of discretion because they are unsupported by any reasoned explanation:

- a. The Agency Defendants have provided no meaningful explanation for its prohibition and denial of access to medically indicated treatment for gender dysphoria, including hormone therapy, surgery, and accommodations, and the withholding of funding for "any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex." In fact, the Implementing Memoranda contain BOP's directives without any explanation for the policies beyond compliance with EO 14168, which itself provides no reasoned explanation or support for its mandates.
- b. The Agency Defendants have failed to explain what alternatives, if any, were considered to address any potential legitimate interests that the policies implementing EO 14168 could serve, nor does EO 14168 do so.
- c. The Agency Defendants provide no explanation for their denial of access to gender-affirming health care and accommodations to people experiencing gender dysphoria or for treating people with gender dysphoria differently than any other person with a medically recognized diagnosis, nor does EO 14168 do so.
- d. The Agency Defendants provide no explanation for their withholding of funding for medically indicated treatment of gender dysphoria or for allocating funding for the treatment of gender dysphoria differently than any other medically recognized

diagnosis, nor does EO 14168 do so.

- e. Relatedly, the Agency Defendants have failed to explain why the status quo ante—which the Bureau of Prisons implemented for years prior to EO 14168—was in any way flawed, let alone sufficiently flawed to warrant this abrupt and substantial change, nor does EO 14168 do so.
- f. The Agency Defendants have failed to explain why they are withdrawing from individuals in BOP custody medical treatment that BOP medical providers have deemed medically necessary for them.

135. Further, the challenged agency actions are arbitrary, capricious, and an abuse of discretion because they are irrational and unreasonable:

- a. BOP's policies implementing EO 14168 as outlined in the Implementing Memoranda represent a prohibition on medically indicated gender-affirming health care for incarcerated people in BOP custody, people who rely exclusively on BOP to provide medical care. Such a prohibition contradicts current scientific and medical understandings of the required standard of care for individuals with gender dysphoria.
- b. Section 4(c) of EO 14168, which seeks to prohibit treatment prescribed "for the purpose of conforming an inmate's appearance to that of the opposite sex," as enforced by the Implementing Memoranda's proscriptions against access to medically indicated treatment and social accommodation and the use of "Bureau of Prisons funds . . . for any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex," is not based on scientific or medical knowledge or evidence. To the contrary, it reverses, without explanation, BOP's longstanding formal internal health care policies governing the treatment of gender dysphoria which, in accordance with well-accepted protocols for treating this condition, provided for gender-affirming medical interventions

including hormone therapy and surgeries when indicated for a patient, as well as clothing, grooming, and other accommodations.

136. Pursuant to EO 14168 as executed by BOP in the Implementing Memoranda, BOP will no longer provide gender-affirming health care for Plaintiffs and putative class members, even when such care is medically indicated. Regardless of need, treatment and accommodations will be denied because of Defendants' enforcement of the blanket ban initiated by BOP's change in policy.

137. Actions taken by BOP to enforce the mandates of EO 14168 and the Implementing Memoranda are causing and will continue to cause irreparable harm to Plaintiffs and the putative class, including serious physical, psychological, and emotional harm, distress, and mental anguish.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs request that this Court grant the following relief:

- (A) Issue a judgment under 28 U.S.C. §§ 2201-02 declaring that EO 14168 and the Implementing Memoranda violate Plaintiffs' rights under the Fifth and Eighth Amendments to the United States Constitution, the Rehabilitation Act of 1973, and that the Implementing Memoranda violate the Administrative Procedure Act, for the reasons and on the Counts set forth above;
- (B) Enter preliminary and permanent injunctive and declaratory relief, including but not limited to setting aside both Implementing Memoranda issued by BOP as unlawful; enjoining Defendants, including their contractors, employees, and agents, from enforcing the Implementing Memoranda or EO 14168 as applied to medical care and accommodations for Plaintiffs and putative class members incarcerated in the custody and control of BOP; ordering Defendants, their contractors, employees, and agents, to provide and continue providing Plaintiffs and Class members gender-affirming health care, in accordance with BOP practice immediately prior to EO 14168 being issued by Defendant Trump on January 20, 2025; and declaring unconstitutional Defendants' practices in denying Plaintiffs and Class Members

adequate and necessary medical treatment;

- (C) Provisionally and permanently certify the Class;
- (D) Award Plaintiffs' their costs and reasonable attorneys' fees pursuant to 28 U.S.C. § 2412, 5 U.S.C. § 504, and 42 U.S.C. § 12205, and any other applicable source of law; and
- (E) Grant any other and further relief this Court deems just, proper, and appropriate.

Dated: March 10, 2025

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**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

ALISHEA KINGDOM, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, et al.,

Defendants.

Case No. 1:25-cv-00691-RCL

**PLAINTIFFS' MOTION FOR A
PRELIMINARY INJUNCTION, TO
STAY AGENCY ACTION, AND FOR
PROVISIONAL CLASS
CERTIFICATION**

Plaintiffs Alishea Kingdom, Solo Nichols, and Jas Kapule, pursuant to Rule 65(a) of the Federal Rules of Civil Procedure and LCvR 65, hereby move the Court for a preliminary injunction enjoining Defendants, their contractors, employees, and agents i) from enforcing Executive Order 14168¹ as applied to medical care and accommodations for people in the custody of the Bureau of Prison (“BOP”) and from enforcing the BOP’s memoranda implementing Executive Order 14168, and ii) to provide and continue providing Plaintiffs and members of the proposed class gender-affirming hormone therapy and accommodations in accordance with BOP policy and practice immediately prior to Defendant Trump’s issuance of Executive Order 14168 on January 20, 2025. Additionally, pursuant to 5 U.S.C. § 705, Plaintiffs move for a stay of enforcement of BOP’s memoranda implementing Executive Order 14168. Furthermore, Plaintiffs move to provisionally certify the class as defined in Plaintiffs’ motion for class certification, *see* ECF 8, for the purpose of emergency relief. This motion is supported by the attached Memorandum of Points and Authorities; the Declarations of Dr. Dan H. Karasic, Dr. Cathy Thompson, Alishea Kingdom, Solo Nichols, and Jas Kapule, and attached exhibits; the Proposed Order; all pleadings and files of record; and any evidence that the Court may receive at

¹ Exec. Order No. 14168, *Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government*, 90 Fed. Reg. 8615 (Jan. 20, 2025).

or before any hearing on this motion. Defendants oppose this motion.

Defendants oppose this motion. Pursuant to LCvR 7(f), Plaintiffs request an oral hearing on the motion.

Dated: March 17, 2025

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that, on this 17th day of March 2025, I served the foregoing PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION, TO STAY AGENCY ACTION, AND FOR PROVISIONAL CLASS CERTIFICATION by emailing a copy to Defendants' counsel, John Robinson, listed below. Mr. Robinson provided written consent to receive email service on behalf of Defendants on March 17, 2025.

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/s/ Michael Perloff
Michael Perloff

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

ALISHEA KINGDOM, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, et al.,

Defendants.

Case No. 1:25-cv-00691-RCL

**MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF
PLAINTIFFS' MOTION A PRELIMINARY INJUNCTION TO STAY
AGENCY ACTION AND FOR PROVISIONAL CLASS CERTIFICATION**

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INTRODUCTION

This Motion seeks to prevent irreparable injury inflicted by the federal government's dangerous denial of necessary health care to transgender people with gender dysphoria who are incarcerated in the custody of the Federal Bureau of Prisons ("BOP"), following President Trump's issuance of Executive Order 14168 (the "Executive Order" or "EO 14168") on January 20, 2025, and the BOP's implementation of EO 14168, which categorically preclude gender-affirming medical care and accommodations for these individuals regardless of their medical need for this care and the impact on their health.

Plaintiffs and the class they seek to represent are in BOP custody and have been diagnosed with gender dysphoria, a serious medical condition characterized by clinically significant distress resulting from the incongruence between a person's gender identity and sex they were designated at birth. Untreated gender dysphoria can cause depression, anxiety, post-traumatic stress disorder, self-harm, and suicidality. Well-accepted evidence-based protocols for the treatment of gender dysphoria include supporting social transition—whereby an individual dresses and otherwise lives consistently with their gender identity—and hormone therapy to bring one's physical features into alignment with their gender identity. Social transition and hormone therapy have been shown to greatly alleviate the distress of gender dysphoria and improve mental health.

Prior to President Trump's issuance of the Executive Order, Plaintiffs received treatment for their gender dysphoria in accordance with BOP's formal internal health care policies, which followed the well-established clinical protocols for treating this condition. Among other things, Plaintiffs received gender-affirming hormone therapy that BOP health care providers deemed medically necessary for them, as well as accommodations such as clothing and other items that enabled them to live and express themselves in a manner consistent with their gender identity. Plaintiffs received such treatment for years and have depended on it for their health, and they are not

alone. As detailed in Plaintiffs’ concurrently filed Motion for Class Certification, according to the BOP, there are approximately 2,000 transgender people who are incarcerated in federal prisons.

The Executive Order declares that “[f]ederal funds shall not be used to promote gender ideology,” which it defines as “the false claim that males can identify as and thus become women and vice versa,” and directs the Attorney General to “ensure that the Bureau of Prisons revises its policies concerning medical care” so that “no Federal funds are expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate’s appearance to that of the opposite sex.”¹ On February 21, 2025, BOP issued a memorandum entitled “Compliance with Executive Order ‘Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government.’” Dkt. 1-1. In the memo, BOP Chief Executive Officers are directed to cease the purchase of “any items that align with transgender ideology,” such as chest binders and hair removal devices; to prohibit granting requests for other accommodations to address gender dysphoria such as “undergarments that do not align with an inmate’s biological sex”; and to mandate that all BOP staff members “must refer to individuals” with “pronouns corresponding to their biological sex.” *Id.* The second memorandum, entitled “Executive Order 14168 Compliance,” was issued by BOP on February 28, 2025. That memo was again addressed to all Chief Executive Officers and stated:

Consistent with Executive Order (EO) 14168, Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government, no Bureau of Prisons funds are to be expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate’s appearance to that of the opposite sex.

Dkt. 1-2.

Since the issuance of the Executive Order and these two memoranda (the “Implementing Memoranda”), BOP health care staff have withdrawn hormone treatment from, or have stated that

¹ Exec. Order 14168, *Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government*, 90 Fed. Reg. 8615, §§ 2(f), 3(g), 4(c) (Jan. 20, 2025).

it will be imminently discontinued for, Plaintiffs and other putative class members. Plaintiffs have also been told they can no longer access gender-affirming accommodations, such as undergarments that accord with their gender identity, and chest binders.

This Court has recently reviewed EO 14168's application to transgender prisoners and found it likely infirm under the Eighth Amendment, such that preliminary relief as to several individual plaintiffs was warranted. *See Doe v. McHenry*, No. 1:25-CV-286-RCL, 2025 WL 388218, at *6 (D.D.C. Feb. 4, 2025) (temporarily enjoining, among other provisions, Section 4(c) of Executive Order 14168); *Doe v. Bondi*, No. 1:25-CV-286-RCL, 2025 WL 596653, at *2 (D.D.C. Feb. 24, 2025) (extending the injunction to several other named plaintiffs). The same conclusion applies to this case, which raises a similar challenge on behalf of a proposed class of all individuals in BOP custody impacted by the implementation of the Executive Order. Specifically, Defendants' categorical withdrawal and denial of gender-affirming health care—including the hormone treatment at issue in *McHenry* and accommodations to enable them to live consistently with their gender identity (collectively, "gender-affirming health care")—to transgender people with gender dysphoria regardless of their individualized medical need is paradigmatic deliberate indifference to a serious medical need, in violation of the Eighth Amendment. Denying this care to Plaintiffs and the members of the putative class places them at substantial risk of serious, irreparable harm and Defendants should be preliminarily enjoined from withholding it.

Plaintiffs are also entitled to immediate relief on a second, independent ground: The BOP's arbitrary, capricious, and unconstitutional actions implementing the mandates of EO 14168 violate the Administrative Procedure Act ("APA"). This violation of law justifies a preliminary injunction as well. Further, under 5 U.S.C. § 705, the Court can and should stay enforcement of the Implementing Memoranda.

To preserve the status quo as it existed before the Executive Order and issuance of the

Implementing Memoranda, and to prevent the unlawful infliction of irreparable harm, Plaintiffs seek emergency relief to preserve or restore Plaintiffs' access to gender-affirming hormone therapy and accommodations. They further ask the Court to provisionally certify the class, and to preserve or restore the unnamed class-members' access to the same.²

STATEMENT OF FACTS

I. Background on Gender Dysphoria

The term “gender identity” is a well-established concept in medicine, referring to “a person’s deeply felt, inherent sense of being a girl, woman, or female; a man, or male; a blend of male or female; or an alternative gender.” Declaration of Dr. Dan H. Karasic, M.D. (“Karasic Decl.”) ¶ 36 (citing American Psychological Association, 2015, at 834).

At birth, infants are typically assigned a sex, either male or female, based on the appearance of external genital characteristics. Sex has many factors though, such as chromosomes, hormones, gonads, and gender identity. These factors are not always in alignment, and gender identity does not always align with sex assigned at birth. *Id.* ¶¶ 32-37. Transgender people, who make up approximately 0.6% of the United States population age 13 or older, have a gender identity that differs from their sex assigned at birth. *Id.* ¶¶ 42-43.

Being transgender is widely accepted as a variation in human development and is not considered a mental illness. However, for many transgender people, the incongruence between gender identity and sex assigned at birth results in gender dysphoria,³ a serious medical condition characterized by clinically significant distress and/or impairment in social, occupational, or other important areas of functioning. *Id.* ¶ 44-51.

² Plaintiffs do not seek at this time a preliminary injunction with respect to the Executive Order and Implementing Memoranda’s prohibition of gender-affirming surgery.

³ The diagnosis of Gender Dysphoria is described in the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The current version, known as the *Fifth Edition, Text Revision* (DSM-5-TR), was released in 2022. *Id.* ¶ 48.

Without treatment, gender dysphoria can cause depression, anxiety, self-harm, and suicidality, and can impair a person's ability to function in all aspects of life, including in school, work, and family and other personal relationships. However, gender dysphoria is amenable to treatment, and the prevailing treatment for it is highly effective. With access to medically indicated care that enables them to live according to their gender identity, transgender people with gender dysphoria can experience significant and sometimes complete relief. *Id.* ¶¶ 50-52.

The well-accepted standards of care for treatment of gender dysphoria are set forth in clinical practice guidelines issued by the World Professional Association for Transgender Health (WPATH) and the Endocrine Society.⁴ *Id.* ¶¶ 53-61. The protocols set forth in these guidelines are endorsed by the major professional medical and mental health associations in the United States, including the American Medical Association, the American Psychiatric Association, the American Psychological Association, the American College of Obstetrics and Gynecology, and the American College of Physicians, among others. They are also relied upon by clinicians treating patients with gender dysphoria. *Id.* ¶ 62.

Under the WPATH and Endocrine Society guidelines, the overarching goal of treatment is to eliminate the distress of gender dysphoria by helping the patient live consistently with their gender identity by aligning the individual patient's presentation and body with their gender identity. This includes supporting social transition—where a patient dresses, uses pronouns, and otherwise lives in accordance with one's gender identity. Bringing one's presentation into alignment with their gender identity can help them see themselves and be recognized and treated by others consistently with their gender identity, which can help alleviate gender dysphoria. *Id.*,

⁴ The current versions of these clinical practice guidelines are: Eli Coleman et al., Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, 23 Int. J. of Transgender Health (2022); Wylie C. Hembree et al., Endocrine Treatment of Gender Dysphoric/Gender Incongruent Persons: An Endocrine Society Clinical Practice Guideline, 102 J. of Clinical Endocrinology & Metabolism 3869 (2017). Karasic Decl., Ex B.

¶¶ 63-65, 72.

While social transition alone can adequately address gender dysphoria for some people, many individuals with gender dysphoria cannot obtain relief without also receiving medical interventions to align the body with their gender identity. In accordance with the WPATH and Endocrine Society guidelines, medical interventions to treat adults with gender dysphoria may include, among other things, hormone therapy—testosterone for transgender men and estrogen and testosterone suppression for transgender women. *Id.* ¶¶ 66-68.

There is a substantial body of research and decades of clinical experience establishing that gender-affirming hormone therapy is effective in treating gender dysphoria. Medical treatment for gender dysphoria has been studied for over half a century, and there is substantial evidence that it improves quality of life and measures of mental health. There is also substantial evidence that the risks of these treatments are low and manageable, and comparable to the type of risks that exist in many other medical treatments. *Id.* ¶¶ 73-78.

For patients for whom gender-affirming medical care is indicated, no alternative treatments have been demonstrated to be effective. As documented by leading medical authorities, efforts to try to change a person's gender identity are not only ineffective, but can cause harm and are considered unethical. *Id.* ¶¶ 39, 70. And psychotherapy alone has not been shown to be an effective treatment. *Id.* ¶¶ 81, 83.

Denying patients with gender dysphoria the ability to socially transition or obtain gender-affirming medical care where indicated predictably will lead to significant deterioration in mental health. It will not only prolong their gender dysphoria, but also cause additional distress and pose other significant health risks, such as depression, anxiety, suicidal ideation, self-harm, and increased substance use. Some individuals try to self-treat by attempting to self-castrate or remove breasts. *Id.* ¶¶ 80-85.

Research and clinical experience specifically show the harms to incarcerated individuals with gender dysphoria who have not been able to receive necessary treatment, including attempts at self-castration and suicidality. *Id.* ¶¶ 84-85.

For individuals with gender dysphoria who have socially and medically transitioned, forcing them to detransition by withdrawing hormone therapy and the ability to socially transition would be expected to cause severe negative decompensation. *Id.* ¶¶ 72, 85.

II. EO 141 and the Implementing Memoranda Strip Plaintiffs and Proposed Class Members of Medically Necessary Health Care for Gender Dysphoria Placing Them at Substantial Risk of Serious Harm.

A. BOP's Treatment of Individuals with Gender Dysphoria Prior to the Executive Order

It is BOP policy to provide “essential medical, dental, and mental health (psychiatric) services in a manner consistent with accepted community standards for a correctional environment.”⁵ Prior to the issuance of EO 14168, under BOP's formal internal health care policies, people incarcerated in BOP facilities who were diagnosed with gender dysphoria received gender-affirming health care based on individualized patient need in accordance with well-accepted medical protocols, including the WPATH guidelines. Declaration of Dr. Cathy Thompson (“Thompson Decl.”), ¶¶ 20, 26-28 & Exs. B & C. In accordance with these BOP clinical guidance policies concerning the care of transgender people, which were first promulgated in 2016⁶ and periodically updated, BOP provided incarcerated people diagnosed with gender dysphoria with gender-affirming health care when clinically indicated for them. *Id.* ¶¶ 27-28, 33,

⁵ See Federal Bureau of Prisons, *Medical Care*, https://www.bop.gov/inmates/custody_and_care/medical_care.jsp.

⁶ See Fed. Bureau of Prisons, *Medical Management of Transgender Inmates* (Dec. 2016), https://perma.cc/K7R_-8NTU.

38; *id.*, Ex. C⁷ at 9 (“Gender-affirming health care involves supporting individuals through social, psychological, behavioral, or medical (including hormonal treatment or surgery) treatments—to support and affirm an individual’s experienced gender identity.”). The most recent update to the protocols aimed to more “closely align with community standards,” *id.*, Ex. C at i, and notes that “[p]roper medical practice necessitates that all cases are evaluated on an individual basis and that treatment decisions are patient-specific.” *Id.*, title page.

BOP’s “Transgender Offender Manual,” initially issued in 2017 and updated in March 2018 and January 2022, likewise provided for individualized assessment for hormone therapy and other treatment in accordance with BOP clinical guidance policies and also set forth the clothing and commissary policies applicable to incarcerated transgender people, as well as additional non-health care policies and practices in place related to the supervision of transgender incarcerated people. *Id.* ¶¶ 28-38 & Ex. B.⁸

To implement these policies, BOP had a Transgender Clinical Care Team comprised of physicians, pharmacists, and social workers. *Id.* ¶ 33, Ex. B at 1. It also had a Transgender Executive Council, which was the “decisionmaking body on all issues affecting the transgender population.” *Id.*, Ex. B at 4. Membership on this body included both senior correctional leaders from the BOP’s Women and Special Populations Branch as well as the senior psychologist, psychiatrist, security expert, and medical administrator in the agency. *Id.* ¶ 31.

These protocols for the care of transgender incarcerated people remained in force until the Executive Order was issued. *Id.* ¶ 39.

⁷ The most recent BOP clinical guidance policy was issued in 2023. Shortly after EO 14168, the 2023 policy was removed from the BOP website; however, it is archived on a perma-CC website at <https://perma.cc/U5UT-S9PN>. *Id.* ¶ 33.

⁸ Shortly after the issuance of EO 14168, the 2022 Transgender Offender Manual was removed from the BOP website; however, it is archived on a perma-CC website at <https://perma.cc/4BP6-YWRP>. *Id.* ¶ 28 n. 14.

According to Dr. Cathy Thompson, who was the Acting National Psychology Services Administrator of the BOP prior to her retirement in late 2023 and served as the most senior agency psychologist on the Transgender Executive Council, the BOP's policies were "consistent with the law and medical standards," and "served not only as a guide for BOP, but for other systems because [they were] effective." *Id.* ¶ 43. She explained:

Gender affirming care was consistently available when indicated, and transgender people were afforded greater opportunities for engagement and positive programming that reduced psychological distress, reduced sexual victimization, increased personal and institutional safety, and improved reentry outcomes. Agency policies direct consistent practice across all components and are reinforced by positive outcomes, and the [Transgender Offender Manual] was no different.

Id., at ¶ 38.

Dr. Thompson noted that before BOP implemented these policies, "transgender individuals in BOP custody were more likely to require services to manage mental health crises than incarcerated individuals who are not transgender. In cases of severe gender dysphoria, risks included attempts at self-surgery and suicide." *Id.*, at ¶ 27. These all create safety concerns "not only for people who are transgender, but for everyone who works or is incarcerated in the entire system." *Id.* at ¶ 44. Thus, Dr. Thompson concluded:

BOP's former approach of providing gender affirming health care when indicated, as well as accommodations that support social transition under the [Transgender Offender Manual], was effective in maintaining transgender individuals' health and promoting institutional safety. Providing this care improves the agency goals of security and rehabilitation. Prohibiting such care undermines these goals.

Id. ¶ 45.

According to the government, there were 1,488 transgender women and 710 transgender men in BOP custody as of February 20, 2025. *See McHenry*, 1:25-cv-00286, Dkt. 52-1 at ¶ 5. With the policies and committees discussed above in place, transgender people with gender dysphoria

in BOP custody received gender-affirming health care when clinically indicated, including hormone therapy and access to clothing and commissary items that accorded with their gender identity. Thompson Decl., ¶ 28-38; Declaration of Alishea Sophia Kingdom (“Kingdom Decl.”) ¶¶ 8-11; Declaration of Solo Nichols (“Nichols Decl.”) ¶¶ 6-9; Declaration of Jas Kapule (“Kapule Decl.”) ¶¶ 5-8.

B. BOP’s Treatment of Individuals with Gender Dysphoria Since the Executive Order and Implementing Memoranda

Hours after his inauguration on January 20, 2025, President Trump issued EO 14168, entitled “Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government.” The Executive Order is aimed at what it calls “gender ideology”, which it defines as “the false claim that males can identify as and thus become women and vice versa.” EO 14168 § 2(f). It mandates that “[f]ederal funds shall not be used to promote gender ideology.” *Id.* § 3(g); *see also* § 3(e) (directing all agencies to “remove all statements, policies, regulations, forms, communications, or other internal and external messages that promote or otherwise inculcate gender ideology,” and to “cease issuing such statements, policies, regulations, forms, communications or other messages.”). Most relevant here, § 4(c) of the Executive Order directs the Attorney General to “ensure that the Bureau of Prisons revises its policies concerning medical care” so that “no Federal funds are expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate’s appearance to that of the opposite sex.”⁹

⁹ The Executive Order was only one of several actions by the Trump administration targeting transgender people. On the same day President Trump issued the Executive Order, he rescinded several Biden Administration orders recognizing the rights of transgender people in schools, the workplace, housing, healthcare, and other settings. These Biden Administration orders were consistent with the Supreme Court’s decision in *Bostock v. Clayton County*, which held that Title VII of the Civil Rights Act of 1964 prohibits discrimination based on sexual orientation.⁹ *See Bostock*, 590 U.S. 644 (2020). Over the following two weeks, President Trump issued additional executive orders targeting transgender people. *See* Exec. Order No. 14183, *Prioritizing Military Excellence and Readiness*, 90 Fed. Reg. 8757 (Jan. 27, 2025) (banning transgender people from

On February 21, 2025, Defendants BOP Reentry Services Division Acting Assistant Director Dana R. DiGiacomo and Correctional Programs Division Assistant Director Shane Salem issued a memorandum implementing EO 14168 with the exception of the application to medical treatments, citing a nationwide temporary restraining order issued by this Court that had been in effect. Dkt. 1-1. Among other directives issued in the February 21 implementing memorandum, BOP expressly prohibits the purchase of “any items that align with transgender ideology,” such as chest binders and hair removal devices; prohibits the granting of requests for other accommodations such as “undergarments that do not align with an inmate’s biological sex”; and mandates that BOP staff members “must refer to individuals” with “pronouns that correspond to their biological sex.” *Id.*

After the issuance of the Executive Order, the 2023 BOP Clinical Guidance and the Transgender Offender Manual were removed from the BOP website. These pages were replaced with a link that redirects to a page stating that “This content is temporarily unavailable as we implement the Executive Order on ‘Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government.’”¹⁰

On February 28, 2025, BOP Health Services Division Assistant Director Chris A. Bina

serving in the U.S. military, accusing transgender servicemembers of expressing a “false” gender identity, and stating that being transgender “conflicts with a soldier’s commitment to an honorable, truthful, and disciplined lifestyle, even in one’s personal life”); Exec. Order 14187, *Protecting Children from Chemical and Surgical Mutilation*, 90 Fed. Reg. 8771 (Jan. 28, 2025) (ordering the federal government to withhold all federal funding from any institution that provides gender-affirming care to people under the age of 19); Exec. Order No. 14190, *Ending Radical Indoctrination in K-12 Schooling*, 90 Fed. Reg. 8853 (Jan. 29, 2025) (banning K-12 schools in the U.S. from recognizing youth’s identities by using names or pronouns that align with their gender and threatening teachers who do not comply with criminal prosecution under laws banning sexual exploitation of minors and practicing medicine without a license); Exec. Order No. 14201, *Keeping Men Out of Women’s Sports*, 90 Fed. Reg. 9279 (Feb. 5, 2025) (seeking to ban transgender women from competing in women’s athletic events, and characterizing transgender women’s participation in sports as “demeaning, unfair, and dangerous”).

¹⁰ See https://www.bop.gov/policy/policy_forms_unavailable.jsp.

issued another implementing memorandum, which states in full:

Consistent with Executive Order (EO) 14168, Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government, no Bureau of Prisons funds are to be expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex.

This policy is to be implemented in a manner consistent with applicable law including the Eighth Amendment.

Dkt. 1-2.

EO 14168 and the Implementing Memoranda ban transgender people incarcerated in BOP facilities from accessing gender-affirming health care, regardless of medical necessity. By banning gender-affirming health care, the BOP prohibits its health care providers from evaluating and treating gender dysphoria on a patient-centered individualized basis, according to their professional judgment. And it mandates withdrawal of care from individuals for whom BOP medical staff deemed such treatment to be clinically indicated.

Since the Executive Order and the Implementing Memoranda, Plaintiffs and others in BOP custody have been deprived of medically necessary health care for gender dysphoria. *See* Kingdom Decl. ¶¶ 12-22; Nichols Decl. ¶¶ 11-20; Kapule Decl. ¶¶ 9-15.

Dr. Dan Karasic, a psychiatrist, opined, based on the scientific research and his more than 30 years of clinical experience treating thousands of transgender patients, that “[d]enying patients with gender dysphoria the ability to socially transition or obtain gender-affirming medical care where indicated predictably will lead to significant deterioration in mental health,” including depression, anxiety, self-harm—including self-castration, and suicidality. Karasic Decl. ¶ 82.

And in the expert opinion of Dr. Thompson, the categorical ban on gender-affirming health care set forth in EO 14168 and the Implementing Memoranda is not only inconsistent with medical standards, it can “cause significant harm and danger.” *Id.* ¶ 44. As she explained, based on her

years of experience at BOP:

[D]enying hormone therapy and access to other accommodations and treatments for gender dysphoria will bring about the return of the dysphoric symptoms, potentially causing attempts to self-castrate, self-harm, suicide, and aggression. All of these create safety concerns not only for people who are transgender, but for everyone who works or is incarcerated in the entire system. And with BOP's staffing crisis, there simply are not enough clinicians to manage the increased suicide watches and crisis, which could be deadly.

[...]

BOP has the responsibility of managing and treating everyone in its custody, which means individuals with all sorts of health issues and conditions, including people who have gender dysphoria. . . .

Prisons that support individual needs are safer and have fewer crises. I have grave concerns about the well-being of transgender individuals in BOP custody and the continued safe operations within BOP, should its ban on providing individualized care to transgender persons continue.

Id. ¶¶ 44, 46-47.

C. Consequences of Defendants' Conduct for Plaintiffs

1. Alishea Sophia Kingdom

Plaintiff Alishea Sophia Kingdom is a 34-year-old transgender woman presently incarcerated at Federal Correctional Institution, Fairton ("FCI Fairton") in New Jersey. Kingdom Decl. ¶ 1. As early as age 7, Ms. Kingdom knew she was a girl. *Id.* ¶ 2. She preferred "girls'" toys, and when she first learned that her body was not the same as other girls, she felt sad and upset because she knew she was a girl, too. *Id.* ¶ 2. Her mother believed Ms. Kingdom was either gay or too feminine, would tell her to act like a boy, and sent her to group homes and mental health facilities starting around the age of 10 in hopes that Ms. Kingdom would become more masculine. *Id.* ¶ 3.

As she went through puberty, Ms. Kingdom began experiencing symptoms of gender dysphoria: she felt severe anxiety, would have panic attacks when she noticed facial hair, would feel

physically sick when thinking about her body masculinizing, and was often unable to sleep at night. As a teenager, Ms. Kingdom came out as a transgender woman and wore long hair, makeup, and typically feminine clothes whenever possible. *Id.* ¶¶ 4-5.

Ms. Kingdom has been in BOP custody since she was 23 years old. *Id.* ¶ 7. She was diagnosed with gender dysphoria by BOP clinicians in 2016. That same year, BOP clinicians prescribed her hormone therapy, and she was approved to get gender-affirming commissary items like women's undergarments and cosmetics. *Id.* ¶¶ 8-9. Hormone therapy and access to feminine-typical clothing and commissary items reduced her symptoms of gender dysphoria and greatly improved her health and well-being. *Id.* ¶ 10.

On January 26, 2025, Ms. Kingdom had an appointment to receive her hormone therapy, but FCI Fairton staff told her that, because of EO 14168, they would no longer provide hormone therapy to treat gender dysphoria for transgender people at FCI Fairton. Ms. Kingdom has not been provided this prescribed treatment for her gender dysphoria since then. *Id.* ¶¶ 12, 16, 19-21. FCI Fairton has also removed all gender-affirming commissary items that transgender women previously had access to. *Id.* ¶ 13. Losing the effects of hormone therapy will cause Ms. Kingdom severe and irreparable harm. Indeed, in the past several weeks alone, Ms. Kingdom has experienced anxiety and panic attacks, insomnia, mood swings, and thoughts of self-harm and suicide as her body reacts to the change in hormone levels and her gender dysphoria worsens. *Id.* ¶¶ 21-22.

2. Solo Nichols

Plaintiff Solo Nichols is a 40-year-old transgender man currently incarcerated at Federal Correctional Institution, Tallahassee ("FCI Tallahassee") in Florida. Nichols Decl. ¶ 1. He has been incarcerated by BOP since 2013 and anticipates being incarcerated until August 8, 2029. *Id.* ¶ 5. From a young age, Mr. Nichols has known himself to be male and would ask others to refer to him as a boy. He was in fifth grade when he first explained to a friend that he was a boy. Mr.

Nichols socially transitioned and started wearing a chest binder and exclusively masculine-typical clothing around age 15. *Id.* ¶¶ 2-4.

Since 2018, BOP has recognized him as transgender, and allowed him access to chest binders, boxers, and other gender-affirming commissary items. *Id.* ¶ 6. In 2021, BOP clinicians diagnosed Mr. Nichols with gender dysphoria and prescribed him hormone therapy, which he has been receiving ever since. *Id.* ¶ 7. Mr. Nichols' hormone therapy and accommodations have reduced his symptoms of gender dysphoria and greatly improved his health and well-being. Before starting hormone therapy, Mr. Nichols had been prescribed 13 different psychiatric medications since his teenage years. None of those medications were effective in treating his gender dysphoria and resultant anxiety, racing thoughts, and irritability. Testosterone is the only treatment that has managed to control those symptoms. *Id.* ¶ 8.

On February 12, 2025, Mr. Nichols was provided half of his regular dose of testosterone. FCI Tallahassee staff informed him that his next dose would be further reduced and would be his last. Mr. Nichols has not had any recent bloodwork, physical examination, or mental health evaluations that could have informed this decision about his medical treatment. Mr. Nichols is aware of three other transgender men who also received reduced doses of testosterone that day, under similar circumstances. *Id.* ¶¶ 13-15.

After receiving a reduced dose of testosterone, Mr. Nichols experienced fatigue and mood swings. *Id.* ¶ 16. On Friday, February 21, 2025, FCI Tallahassee staff changed course, and informed Mr. Nichols and other transgender men that they would again be receiving their full doses. On February 26, FCI Tallahassee staff told him that the transgender men in the facility would be given the full amount of their prescribed doses, but only as long as "the restraining order is up." *Id.* ¶ 17. The same week, FCI Tallahassee staff told Mr. Nichols they would no longer provide, and he would no longer be able to purchase, boxers or chest binders. *Id.* ¶ 19. Mr. Nichols

is very scared to live without hormone therapy and feels extremely anxious about the physical and mental health effects he will experience. *Id.* ¶ 18.

3. Jas Kapule

Plaintiff Jas Kapule is a 35-year-old transgender man currently incarcerated at the Federal Correctional Institution, Waseca (“FCI Waseca”) in Minnesota. Kapule Decl., ¶ 1. He has been incarcerated since 2020 and anticipates being incarcerated until July 5, 2028. *Id.* ¶ 4. Mr. Kapule knew he was a boy as a child. He struggled with dysphoria, experiencing depression. He began to live and present as a man starting at the age of 18. *Id.* ¶¶ 2-3. He still struggled with dysphoria, and if he had known about using hormones to treat gender dysphoria, he would have started then. *Id.* ¶ 3.

Mr. Kapule was diagnosed with gender dysphoria by BOP clinicians in 2022 and began receiving hormone therapy, which he has been receiving since then. *Id.* ¶ 5. Since around the same time, he has also been able to access commissary items that match his gender identity, such as chest binders and men’s underwear. *Id.* ¶ 7. Mr. Kapule’s access to hormone therapy has reduced his gender dysphoria and made an enormous improvement in his health and well-being, lifting his lifelong depression. Likewise, being able to wear boxers and a chest binder has also helped to ameliorate the symptoms arising from Mr. Kapule’s dysphoria. *Id.* ¶¶ 6-7.

After the Executive Order was issued, Mr. Kapule was told by BOP staff that once his testosterone prescription runs out, it will not be refilled. *Id.* ¶ 9. On or about February 24, 2025, BOP staff also informed Mr. Kapule that he could no longer receive a chest binder through laundry services or purchase binders or boxers at the commissary. *Id.* ¶ 12. The prospect of losing the medication that allows him to live as his true self and being forced to detransition has put him in a very bad place mentally. Mr. Kapule particularly fears the return of his menstrual cycle if he is

taken off of testosterone, as that caused him great distress each month before he was able to access care. *Id.* ¶ 13.

ARGUMENT

Fed. R. Civ. P. 65 authorizes courts to issue a preliminary injunction to preserve the status quo pending resolution of the underlying litigation. Fed. R. Civ. P. 65; *Dist. 50, United Mine Workers of Am. v. Int’l Union, United Mine Workers of Am.*, 412 F.2d 165, 168 (D.C. Cir. 1969). Similarly, the APA authorizes courts to “postpone the effective date of an agency action or to preserve status or rights pending conclusion” of APA proceedings, “to the extent necessary to prevent irreparable injury.” 5 U.S.C. § 705. “Motions to stay agency action pursuant to these provisions are reviewed under the same standards used to evaluate requests for interim injunctive relief.” *Affinity Healthcare Servs., Inc. v. Sebelius*, 720 F. Supp. 2d 12, 15 n.4 (D.D.C. 2010) (citing *Cuomo v. U.S. Nuclear Regulatory Comm’n*, 772 F.2d 972, 974 (D.C.Cir. 1985)). To obtain a preliminary injunction, plaintiffs 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. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2009). Courts employ a “sliding-scale” approach to weighing these factors, which “allow[s] that a strong showing on one factor could make up for a weaker showing on another.” *Sherley v. Sebelius*, 644 F.3d 388, 392 (D.C. Cir. 2011); *League of Women Voters of United States v. Newby*, 838 F.3d 1, 7 (D.C. Cir. 2016). The balance of equities and public interest factors “merge when the Government is the opposing party.” *Nken v. Holder*, 556 U.S. 418, 435 (2009).

Plaintiffs have established all of these factors and are therefore entitled to preliminary injunctive relief under Fed. R. Civ. P. 65 as well as a stay of enforcement of the Implementing Memoranda under 5 U.S.C. § 705.

I. Plaintiffs Are Entitled to Preliminary Injunctive Relief and a Stay Under the APA.

A. Plaintiffs Are Likely to Succeed on the Merits.

1. Plaintiffs are Likely to Succeed on Their Eighth Amendment Claims.

“Underlying the Eighth Amendment is the fundamental premise that [incarcerated people] are not to be treated as less than human beings.” *Spain v. Procunier*, 600 F.2d 189, 200 (9th Cir. 1979). Thirty years later, the Supreme Court reaffirmed this principle:

As a consequence of their actions, prisoners may be deprived of rights that are fundamental to liberty. Yet the law and the Constitution demand recognition of certain other rights. Prisoners retain the essence of human dignity inherent in all persons. Respect for that dignity animates the Eighth Amendment prohibition against cruel and unusual punishment. The basic concept underlying the Eighth Amendment is nothing less than the dignity of man.

Brown v. Plata, 563 U.S. 493, 510 (2011) (citations and internal quotation omitted).

Defendants violate Plaintiffs’ Eighth Amendment rights by imposing a blanket ban on any gender-affirming health care, without regard to individualized need for such care. The Executive Order, as implemented by BOP, places Plaintiffs at substantial risk of serious harm, and Defendants are deliberately indifferent to that risk of harm. Accordingly, Plaintiffs are likely to succeed on the merits of this claim.

a. Incarcerated People Challenging Conditions of Confinement Under the Eighth Amendment Must Show a Substantial Risk of Serious Harm to Which Government Officials are Deliberately Indifferent.

When challenging conditions of confinement under the Eighth Amendment, incarcerated people must satisfy a two-part test. *Farmer v. Brennan*, 511 U.S. 825, 834 (1994). The first, “objective” prong requires showing that a person “is incarcerated under conditions posing a substantial risk of serious harm.” *Id.* The second, “subjective” prong requires showing a government official “ha[s] a sufficiently culpable state of mind . . . of deliberate indifference to inmate health or safety.” *Id.*

Under the objective prong, incarcerated people must provide evidence of harms that deprive them of the “minimal civilized measure of life’s necessities.” *Farmer*, 511 U.S. at 834. These necessities include “food, clothing, shelter, medical care and reasonable safety.” *Helling v. McKinney*, 509 U.S. 25, 32 (1993).¹¹

Under the subjective prong of *Farmer*, deliberate indifference “[l]ies] somewhere between the poles of negligence . . . and purpose or knowledge . . .” *Farmer*, 511 U.S. at 836. Put another way, deliberate indifference “is the equivalent of recklessly disregarding” a “substantial risk of serious harm.” *Id.* Though the “Eighth Amendment requires consciousness of a risk,” *id.* at 840, “an Eighth Amendment claimant need not show that a prison official acted or failed to act believing that harm actually would befall an inmate; it is enough that the official failed to act despite his knowledge of a substantial risk of serious harm,” *id.* at 842, and “a factfinder may conclude that a prison official knew of a substantial risk from the very fact that it was obvious.” *Id.* Circumstantial evidence may be sufficient to establish deliberate indifference even without direct evidence of what prison officials knew or thought. *Id.* at 842-43.

In an injunctive case, such as this one, prison officials’ knowledge of the risk is not at issue, as the litigation itself puts them on notice. *See Hadix v. Johnson*, 367 F.3d 513, 526 (6th Cir. 2004) (“If [prison] conditions are found to be objectively unconstitutional, then that finding would also satisfy the subjective prong because the same information that would lead to the court’s conclusion was available to the prison officials”). Moreover, in an injunctive case, unlike a damages action, plaintiffs do not seek to impose individual liability on the defendants, but rather sue them in their

¹¹ In assessing whether a risk of harm violates “contemporary standards of decency,” courts rely on federal and state practices, as well as scientific studies. *See Hall v. Florida*, 572 U.S. 701, 709-10 (2014) (holding that it was “proper to consider the psychiatric and professional studies” to resolve an Eighth Amendment claim); *Graham v. Florida*, 560 U.S. 48, 62 (2010) (looking to federal and state practices to resolve Eighth Amendment claim); *Spain*, 600 F.2d at 200 (“[W]hen confronting the question whether penal confinement in all its dimensions is consistent with the constitutional rule, the court’s judgment must be informed by current and enlightened scientific opinion as to insure good physical and mental health for prisoners.”).

official capacity and seek a court order to remedy the problem. *See Hutto v. Finney*, 437 U.S. 678, 699 (1978) (holding that an injunctive suit is, for practical purposes, a suit against the state); *Kentucky v. Graham*, 473 U.S. 159, 166-67 (1985) (same). Thus, the focus on deliberate indifference is “broader and more generalized” than in damages cases, with an emphasis on the “combined acts or omissions” of government officials. *See Leer v. Murphy*, 844 F.2d 628, 633 (9th Cir. 1988). Liability can be premised on “‘repeated examples of negligent acts which disclose a pattern of conduct . . . ’ or by showing ‘systemic or gross deficiencies in . . . procedures.’” *French v. Owens*, 777 F.2d 1250, 1254 (7th Cir. 1985) (*quoting Ramos v. Lamm*, 639 F.2d 559, 575 (10th Cir. 1980), *cert denied* 450 U.S. 1041 (1981)).

Finally, “[t]hat the Eighth Amendment protects against future harm to inmates is not a novel proposition.” *Helling*, 509 U.S. at 33. In an injunctive case, plaintiffs need not show actual physical harm; rather, the Constitution is violated by an unreasonable *risk* of harm. *Id.* at 33, 34 (holding that it “would be odd to deny an injunction to inmates who plainly proved an unsafe, life-threatening condition in their prison on the ground that nothing yet had happened to them”); *see also Brown*, 563 U.S. at 531-32 (“Even prisoners with no present physical or mental illness may become afflicted, and all prisoners [] are at risk so long as the State continues to provide inadequate care. . . .”).

b. The BOP’s Blanket Ban on Gender-Affirming Health Care Demonstrates Deliberate Indifference to Plaintiffs’ Serious Health Needs and Places Them at Substantial Risk of Serious Harm.

The Eighth Amendment’s prohibition on “cruel and unusual punishments” extends to the failure to provide incarcerated people with minimally adequate health care. *Estelle v. Gamble*, 429 U.S. 97, 103 (1976); *see also Brown*, 563 U.S. at 510-11 (“Just as a prisoner may starve if not fed, he or she may suffer or die if not provided adequate medical care. A prison that deprives prisoners

of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society”).

Under the *Farmer* and *Estelle* analysis, the objective prong of the deliberate indifference analysis is met when an incarcerated person shows that they have “a known, serious medical condition.” *Bernier v. Allen*, 38 F.4th 1145, 1151 (D.C. Cir. 2022). The subjective component requires that government officials had “knowledge of the serious medical need and recklessly disregarded the excessive risk to inmate health or safety from that risk.” *Id.* (quoting *Anderson v. Dist. of Columbia*, 810 F. Appx. 4, 6 (D.C. Cir. 2020); *Baker v. Dist. of Columbia*, 326 F.3d 1302, 1306 (D.C. Cir. 2003)).

Plaintiffs meet the objective component. This Court and many others have recognized gender dysphoria as a serious medical condition. *See, e.g., Farmer v. Hawk*, 991 F.Supp. 19, 25 (D.D.C. 1998), *rev’d in part on other grounds sub nom. Farmer v. Moritsugu*, 163 F.3d 610 (D.C. Cir. 1998) (citing *Brown v. Zavaras*, 63 F.3d 967 (10th Cir. 1995); *Phillips v. Mich. Dep’t of Corrs.*, 731 F. Supp. 792 (W.D. Mich. 1990), *aff’d*, 932 F.2d 969 (6th Cir. 1991); *White v. Farrier*, 849 F.2d 322 (8th Cir. 1988); *Meriwether v. Faulkner*, 821 F.2d 408 (7th Cir. 1987); and *Supre v. Ricketts*, 792 F.2d 958 (10th Cir. 1986)); *Edmo v. Corizon, Inc.*, 935 F.3d 769, 785 (9th Cir. 2019); *De’Lonta v. Angelone*, 330 F.3d 630, 634 (4th Cir. 2013); *Cuoco v. Moritsugu*, 222 F.3d 99, 106 (2d Cir. 2000). The Executive Order’s categorical ban on federally funded gender-affirming health care precludes all treatment for this serious condition, including Plaintiffs’ prescribed hormone therapy and other care, as Plaintiffs and class members are wholly dependent upon Defendants for the provision of their health care.

Plaintiffs’ challenge to the blanket ban on gender-affirming health care for individuals with gender dysphoria also satisfies the subjective prong. Defendants plainly knew the necessity of providing gender-affirming care to people with gender dysphoria for whom it is clinically

indicated: Prior to the Executive Order, BOP policy required it and BOP doctors ordered it. Indeed, this was the case throughout Defendant Trump’s first administration.

But even if Defendants lacked subjective awareness of the risk, this case is one where the consequences of Defendants’ action are obvious. “[R]efusal to provide timely, available, and appropriate treatment for a known, serious medical condition posing excessive risk to an inmate’s health or safety [constitutes] deliberate indifference in violation of the Eighth Amendment.” *Bernier*, 38 F.4th at 1151. One cornerstone of minimally adequate prison health care is that incarcerated people receive necessary and appropriate medications, and courts repeatedly have held that prison systems’ failure to provide needed medication constitutes deliberate indifference to serious health care needs. *See, e.g., Board v. Farnham*, 394 F.3d 469, 484 (7th Cir. 2005) (asthma inhaler); *Sullivan v. Cnty. of Pierce*, No. 98-35399, 2000 WL 432368, at *1-2 (9th Cir. Apr. 21, 2000) (reversing and remanding for reconsideration of deliberate indifference where a jail detainee did not receive his HIV medication for at least two days); *Ralston v. McGovern*, 167 F.3d 1160, 1162 (7th Cir. 1999) (officials’ failure to provide prisoner with already prescribed pain medication for the pain of cancer and cancer treatment “borders on the barbarous”); *Steele v. Shah*, 87 F.3d 1266, 1269-70 (11th Cir. 1996) (deliberate indifference can be found in abrupt and unsupported discontinuation of medications); *Thomas v. Kippermann*, 846 F.2d 1009, 1010-11 (5th Cir. 1988) (noting that the plaintiff’s claim was viable “if he told jail authorities that he needed his prescribed medication . . . and if they did not have him examined or otherwise adequately respond to his requests”).

A blanket ban on gender-affirming health care—including hormone therapy and accommodations for social transition such as alternative undergarments and commissary items—regardless of individual medical need constitutes deliberate indifference. Indeed, over the past few weeks, this Court has held, and twice reaffirmed, that the Executive Order’s categorical ban on

gender-affirming health care likely violated the Eighth Amendment. *See McHenry*, 1:25-cv-00286, Dkt. 23 (issuing temporary restraining order, enjoining this component of the Executive Order), Dkt. 44 (preliminary enjoining the same provision), Dkt. 55 (extending the preliminary injunction to cover additional plaintiffs).

Accordingly, like this Court in *McHenry*, courts around the country have held that blanket bans on gender-affirming health care—including both hormone treatment and accommodations—violate the Eighth Amendment. The Eleventh Circuit recently held in the context of blanket bans on gender-affirming health care for incarcerated people that “responding to an inmate’s acknowledged medical need with what amounts to a shoulder-shrugging refusal even to consider whether a particular course of treatment is appropriate is the very definition of ‘deliberate indifference.’” *Keohane v. Fla. Dep’t of Corr. Sec’y*, 952 F.3d 1257, 1266-67 (11th Cir. 2020). Similarly, in *Fields v. Smith*, 653 F.3d 550, 559 (7th Cir. 2011), the Seventh Circuit held that a state law that barred hormone therapy and sex reassignment surgery as possible treatments for incarcerated people with gender dysphoria facially violated the Eighth Amendment. And in *De’Lonta*, 330 F.3d at 630, the Fourth Circuit held that an incarcerated person with gender dysphoria stated a claim for deliberate indifference where the prison system withheld hormone therapy under a blanket policy prohibiting such treatment and not based on the medical judgment of qualified providers. *See also Meriwether*, 821 F.2d at 410, 413 (reversing district court’s dismissal of case claiming the Michigan Department of Corrections had a blanket ban on any gender-affirming care, as the plaintiff had stated a claim that this blanket denial of treatment violated the Eighth Amendment); *Hicklin v. Precynthe*, No. 16-CV-01357, 2018 WL 806764, at *13 (E.D. Mo. Feb. 9, 2018) (granting preliminary injunction after concluding plaintiff is “likely to succeed on the merits as to her Eighth Amendment claim that Defendants were deliberately indifferent by failing to provide her with hormone therapy, ‘gender-affirming’ canteen items, and

permanent hair removal to treat her serious medical of gender dysphoria”); *Soneeya v. Spencer*, 851 F. Supp. 2d 228, 248-50 (D. Mass. 2012) (recognizing that women’s undergarments and canteen items can be medically necessary to address gender dysphoria of incarcerated transgender woman); *Barrett v. Coplain*, 292 F. Supp. 2d 281, 286 (D.N.H. 2003) (“A blanket policy that prohibits a prison’s medical staff from making a medical determination of an individual inmate’s medical needs [for treatment related to gender identity disorder] and prescribing and providing adequate care to treat those needs violates the Eighth Amendment.”); *see generally Colwell v. Bannister*, 763 F.3d 1060, 1063 (9th Cir. 2014) (“the blanket, categorical denial of medically indicated [treatment] solely on the basis of an administrative policy ... is the paradigm of deliberate indifference”).

To provide constitutionally adequate health care, prisons must provide treatment that meets “[a]ccepted standards of care and practice within the medical community.” *Edmo*, 935 F.3d 757, 786; *Howell v. Evans*, 922 F.2d 712, 719 (11th Cir. 1991) (“[T]he contemporary standards and opinions of the medical profession also are highly relevant in determining what constitutes deliberate indifference to medical care.”); *Smith v. Jenkins*, 919 F.2d 90, 93 (8th Cir. 1990) (holding that the incarcerated plaintiff could “prove his case by establishing that [his] course of treatment, or lack thereof, so deviated from professional standards that it amounted to deliberate indifference”). As detailed above at Sections I, II(A) and II(C) of the Statement of Facts, and in the Declaration of Dr. Thompson, the gender-affirming health care that BOP provided to transgender incarcerated people prior to the issuance of the Executive Order comported with community and contemporary standards of treatment for gender dysphoria. As this Court previously concluded, and several others have held, to deny such care is unconstitutional. Plaintiffs have therefore shown that they are likely to succeed on the merits of their Eighth Amendment claim, and an injunction is warranted.

2. Plaintiffs Are Likely to Succeed on the Merits of Their APA Claims.

A president’s Executive Order is not subject to the APA, but an agency’s actions implementing such an order are. *See O.A. v. Trump*, 404 F. Supp. 3d 109, 147 (D.D.C. 2019) (“The Court, moreover, need not pause over the fact that presidential actions are not themselves subject to APA review The fact that the Rule defines those who are ineligible for asylum by reference ‘to a presidential proclamation or other presidential order’ . . . does not insulate the Rule from APA review. . . .”); *Hawaii v. Trump*, 878 F.3d 662, 680–81 (9th Cir. 2017) (explaining that once an agency has “consummated” its implementation of a presidential directive such that “legal consequences will flow,” the agency’s action is final and reviewable under the APA), *rev’d on other grounds*, 585 U.S. 667 (2018).

The APA entitles “a person suffering legal wrong because of agency action, or adversely affected or aggrieved by agency action . . . to judicial review thereof.” 5 U.S.C. § 702. To be reviewable, the agency action must be “final,” meaning it “must mark the consummation of the agency’s decision-making process . . . [and] must be one by which rights or obligations have been determined, or from which legal consequences will flow.” *Bennett v. Spear*, 520 U.S. 154, 177–78 (1997) (internal quotation marks and citations omitted). The APA requires a reviewing court to set aside an agency action that is “arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law; [or] contrary to constitutional right, power, privilege, or immunity.” 5 U.S.C. § 706.

The Implementing Memoranda constitute final agency action. The memoranda are the consummation of BOP’s decision-making process for implementing the mandates of EO 14168. Both of the memoranda were issued by high-ranking members of BOP leadership and were addressed directly to all BOP Chief Executive Officers. By their express terms, the Implementing Memoranda dictate specific changes in BOP policy that directly impact the rights of transgender

people in BOP custody to access gender-affirming health care. Specifically, the February 28 memorandum cuts off all BOP funding “for any medical procedure, treatment, or drug” related to gender-affirming health care without consideration of medical necessity. Dkt. 1-2. Similarly, the February 21 memorandum expressly prohibits the procurement or provision of gender-affirming accommodations, such as access to undergarments, chest binders, or other items that were previously available to people with gender dysphoria in BOP facilities. Dkt. 1-1. These policy changes do not contemplate any further consideration by the agency prior to implementation and enforcement. As such, the Implementing Memoranda meet the *Bennett* test for final agency action. *See Bennett*, 520 U.S. at 177–78.

The Implementing Memoranda violate the APA on multiple independent grounds. First and foremost, the APA requires courts to set aside unconstitutional agency action, and here, BOP’s implementation of the Executive Order violates the Eighth Amendment for the reasons discussed above. Specifically, the Memoranda categorically ban federal funding for gender-affirming health care, thereby denying treatment for a serious medical condition to those for whom such treatment is medically indicated. The APA requires the Court to set aside such unconstitutional agency action.

The Implementing Memoranda should also be set aside because the actions are arbitrary and capricious. For one thing, neither the Implementing Memoranda, nor the Executive Order they purport to implement, provide a reasoned explanation for denying gender-affirming health care to transgender people experiencing gender dysphoria in BOP custody regardless of their medical need for such care. “The APA ‘requires agencies to engage in reasoned decisionmaking.’” *Nw. Immigrant Rts. Project v. United States Citizenship & Immigr. Servs.*, 496 F. Supp. 3d 31, 70 (D.D.C. 2020) (quoting *Dep’t of Homeland Sec. v. Regents of the Univ. of California*, 140 S. Ct. 1891, 1905, 207 L. Ed. 2d 353 (2020)). BOP fails to provide any bases for its actions beyond

reference to EO 14168 in either of the Implementing Memoranda. That leaves EO 14168 to supply the Court with justification for the BOP's actions, yet it also provides no reasoned explanation for its blanket prohibition and denial of access to the proscribed treatments. Instead, the Executive Order is directed at opposing "gender ideology," which it defines as "the false claim that males can identify as and thus become women and vice versa," and prohibits the recognition of transgender people's gender identity in a wide range of contexts.¹² Section 4(c) of EO 14168, which requires the Attorney General to ensure that "no Federal funds are expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex," is just another provision that opposes "gender ideology" and the Executive Order offers no medical evidence or reasoning to support the discontinuation of gender-affirming health care. BOP's implementation of the Executive Order is therefore demonstrably arbitrary and capricious because they have advanced no "rational connection between the facts found and the choice made." *AIDS Vaccine Advoc. Coal. v. U.S. Dep't of State*, 2025 WL 485324, at *5 (D.D.C. Feb. 13, 2025).

Additionally, "[a]gency action is arbitrary and capricious if the agency offers insufficient reasons for treating similar situations differently." *Love v. Bureau of Prisons*, No. 24-CV-2571 (APM), 2025 WL 105845, at *12 (D.D.C. Jan. 15, 2025) (internal quotation marks omitted) (citing *Muwekma Ohlone Tribe v. Salazar*, 708 F.3d 209, 216 (D.C. Cir. 2013)). Again, neither the Implementing Memoranda nor EO 14168 provide any explanation—let alone a reasoned one—for treating people with gender dysphoria or allocating funding for the treatment of gender dysphoria

¹² For example, the Executive Order mandates changes to policies concerning government-issued identification, including passports, to require that they "reflect the holder's sex, as defined [by the Executive Order]," as "an individual's immutable biological classification" determined at conception, EO 14168 §§ 2, 3(d), and rescinds policy allowing transgender people to access shelters that accord with their gender identity. § 2(b).

differently than any other person with a medically recognized serious condition requiring specific treatments and accommodations.

Compounding this lack of basic reasoning is BOP's abject failure to address its complete reversal from its prior policy of providing gender-affirming health care consistent with current medical understandings of the standard of care for the treatment of gender dysphoria. When changing prior policy, an agency must "supply a reasoned analysis indicating that prior policies and standards are being deliberately changed, not casually ignored." *Greater Bos. Television Corp. v. FCC*, 444 F.2d 841, 852 (D.C. Cir. 1970); *Nw. Immigrant Rts. Project.*, 496 F. Supp. 3d at 70 ("[I]f the rule departs from the agency's previous position, the agency must explain why it does so.") (citing *F.C.C. v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 16 (2009)). Here, the new policy directly contradicts BOP's prior policy of providing gender-affirming health care, which people in BOP custody with gender dysphoria have come to rely on for their health and wellbeing. BOP's complete failure to explain the reversal of policy, or to consider Plaintiffs' reliance interest in continuing to receive care provided under the prior policy is definitively arbitrary and capricious. *Id.* at 515 (holding "[i]t would be arbitrary or capricious to ignore such matters"); *AIDS Vaccine Advoc. Coal.*, 2025 WL 485324, at *5 (agency action implementing Executive Order was arbitrary and capricious "given the [agency's] apparent failure to consider immense reliance interests").

B. Plaintiffs Will Be Irreparably Harmed Absent an Injunction and or Stay.

To obtain a preliminary injunction, Plaintiffs must demonstrate that irreparable injury "is likely in the absence of an injunction." *Winter*, 555 U.S. at 22. Irreparable injury results where damages cannot adequately compensate for the loss if the injunction is denied. *Conservation Law Found. v. Ross* (D.D.C. 2019) 422 F. Supp. 3d 12, 34 (preliminary injunction appropriate where "remedies available at law, such as monetary damages, are inadequate to compensate for that

injury.”); *National Senior Citizens Law Center, Inc. v. Legal Services Corp.* (D.D.C. 1984) 581 F. Supp. 1362, 1372 (injunction appropriate where money damages could not adequately compensate for plaintiff’s injuries).

Here, this standard is met. Plaintiffs have either already had their medically necessary gender-affirming hormone therapy and/or accommodations discontinued due to the BOP’s implementation of the Executive Order or have been notified that this health care that they currently receive will be discontinued imminently. Denying gender-affirming hormone therapy and accommodations has caused or will imminently cause, and will continue to cause, irreparable injuries, including the exacerbation of their gender dysphoria and increased risk of depression, anxiety, self-harm (including attempts to self-castrate), and suicidality. Karasic Decl. ¶¶ 72, 83-86, Kingdom Decl. ¶¶ 21-22 (experiencing symptoms including anxiety, panic attacks, and thoughts of self-harm and suicide since care has been withdrawn).¹³ See *Edmo*, 935 F.3d at 797-98 (“severe, ongoing psychological distress” and a “high risk of self-castration and suicide” constitute irreparable harm). Without an injunction, Plaintiffs will also suffer irreparable harm via the deprivation of their constitutional rights. See *Davis v. Dist. of Columbia*, 158 F.3d 1342, 1346 (D.C. Cir. 1998) (holding that “a prospective violation of a constitutional right constitutes irreparable injury”); *Edmo*, 935 F.3d at 798 (deprivation of one’s “constitutional right to adequate medical care is sufficient to establish irreparable harm.”). Indeed, this Court recently held in *McHenry*, 2025 WL 388218, at *5, that plaintiffs, transgender women in the custody of BOP, had “straightforwardly demonstrated” that irreparable harm would follow if their request for a TRO enjoining enforcement of EO 14168 was denied.

¹³ The harms associated with withholding medically necessary care to treat gender dysphoria are extensively detailed in Dr. Karasic’s declaration. Plaintiffs’ personal experiences of these harms are detailed in their respective declarations.

C. The Balance of Hardships and Public Interest Favor Granting an Injunction.

The last two factors—balance of hardships and the public interest—also favor granting an injunction. In their balance of hardships analysis, courts must consider the hardships to plaintiffs if their request for an injunction is denied, as well as the hardships to defendants if the injunction is granted. *Pursuing America’s Greatness v. FEC*, 831 F.3d 500, 511 (D.C. Cir. 2016). Where, as here, “the Government is the opposing party,” the last two factors “merge”: “the government’s interest is the public interest.” *Nken*, 556 U.S. at 435. In assessing these factors, courts also consider “the impacts of the injunction on nonparties.” *TikTok Inc. v. Trump*, 490 F. Supp. 3d 73, 84 (D.D.C. 2020).

The balance of hardships strongly favors Plaintiffs. Absent an injunction that enjoins enforcement of the Implementing Memoranda and the Executive Order’s ban on gender-affirming health care, the harm Plaintiffs have suffered and will continue to suffer will be significant. Every day without access to the necessary gender dysphoria treatment will cause Plaintiffs significant distress and negatively impact their mental health, as well as increase the risk of suicidality and self-harm. Further, Plaintiffs have shown a strong likelihood of success on their Eighth Amendment claim, and “a prospective violation of a constitutional right constitutes irreparable injury.” *Davis*, 158 F.3d at 1346.

On the other side of the scale, Defendants will not suffer any harm from abiding by their constitutional duty to provide medically necessary health care to Plaintiffs and the proposed class; “the [government’s] responsibility to provide inmates with medical care ordinarily does not conflict with competing administrative concerns.” *Hudson v. McMillian*, 503 U.S. 1, 6 (1992). *See, e.g., Gammett v. Idaho State Bd. of Corrs.*, No. CV05 257, 2007 WL 2186896, at *15-16 (D. Idaho July 27, 2007) (balance of harms “sharply” favored plaintiff, who would experience extreme mental harm, including suicide attempts, without gender-affirming treatment, while defendants did

not allege that they would suffer harm from providing such treatment). BOP has been providing this care for years and continuing such care while the litigation proceeds will not cause any harm to Defendants. And in any event, being required to uphold its constitutional obligation to provide adequate medical care is not a “harm” suffered by the government. *Porretti v. Dzurenda*, 2020 WL 2857498 (D. Nev., May 31, 2020); *aff’d*, 11 F.4th 1037, 1047 (9th Cir. 2021).

Finally, the public interest strongly weighs in favor of Plaintiffs. The public has an interest in ensuring the continued dignity of incarcerated individuals, and “[i]nherent in that dignity is the recognition of serious medical needs, and their adequate and effective treatment’ pursuant to the Eighth Amendment’s mandated standard of care.” *Porretti v. Dzurenda*, 11 F.4th 1037, 1050 (9th Cir. 2021). It is “always in the public interest to prevent the violation of a party’s constitutional rights.” *Banks v. Booth*, 468 F. Supp. 3d 101, 124 (D.D.C. 2020) (internal citations omitted); *see also Leaders of a Beautiful Struggle v. Balt. Police Dep’t*, 2 F.4th 330, 346 (4th Cir. 2021) (en banc) (“It is well-established that the public interest favors protecting constitutional rights.”). Indeed, this Court has already concluded that “it is hard to cognize of any public interest in the immediate cessation” of hormone therapy being received by people in BOP custody. *McHenry*, 2025 WL 388218, at *5.

II. No Bond Should Be Required.

Fed. R. Civ. P. 65(c) vests the district court with broad discretion to determine the appropriate amount of an injunction bond, including no bond at all. *P.J.E.S. v. Wolf*, 502 F. Supp. 3d 492, 520 (D.D.C. 2020). Here, because Plaintiffs seek an injunction of unconstitutional conduct by a government entity, and because there is no risk of monetary harm to Defendants if they are eventually found to be wrongfully enjoined, the FRCP 65(c) bond is neither appropriate nor necessary in this case and should be waived.

III. Provisional Class Certification For Emergency Relief Purposes is Warranted.

For purposes of granting emergency relief, this Court should provisionally certify the class as defined in Plaintiffs’ motion for class certification: “All persons who are or will be incarcerated in the custody of BOP who are or will be diagnosed with gender dysphoria or meet the criteria for a gender dysphoria diagnosis and who are receiving, or would receive, gender-affirming health care absent such care being proscribed by EO 14168 and the Implementing Memoranda.” Dkt. 8.

“Plaintiffs . . . need only provisional class certification in order for the Court to grant their preliminary injunction” as to the class. *Damus v. Nielsen*, 313 F. Supp. 3d 317, 329 (D.D.C. 2018). The Rule 23 inquiry remains the same; the Court’s analysis is merely tempered “by the understanding that such certifications may be altered or amended before the decision on the merits.” *R.I.L.-R v. Johnson*, 80 F. Supp. 3d 164, 179–80 (D.D.C. 2015) (quotation marks omitted). Courts in this circuit routinely grant provisional class certification for purposes of entering injunctive relief. *See, e.g., Charles H. v. District of Columbia*, 2021 WL 2946127, at *14 (D.D.C. June 16, 2021); *P.J.E.S. by and through Escobar Francisco v. Wolf*, 502 F. Supp. 3d 492, 522 (D.D.C. 2020); *Damus*, 313 F. Supp. 3d at 335; *Kirwa v. U.S. Dept. of Def.*, 285 F. Supp. 3d 21, 44 (D.D.C. 2017).

Plaintiffs’ motion for class certification and accompanying exhibits, Dkt. 8, incorporated herein by reference, demonstrate that the proposed class satisfies the requirements of Rule 23(a) and (b)(2). The class is sufficiently numerous, as there were over 2,000 transgender individuals in BOP custody as of January 10, 2025. It satisfies the commonality requirement given the key legal issues common to the class, including but not limited to the constitutionality of the Executive Order and BOP’s Implementing Memoranda. It satisfies the typicality requirement, as Plaintiffs’ claims arise from the same conduct responsible for putative class members’ claims: Defendants’ enforcement of the Executive Order and BOP’s Implementing Memoranda. Provisional class certification under Rule 23(b)(2) is appropriate because the Executive Order and Implementing Memoranda apply to

all putative class members, and the injunctive relief Plaintiffs seek would benefit the whole class. Lastly, Plaintiffs' counsel are qualified to serve as counsel for the provisionally certified class. For these reasons the class should, at minimum, be provisionally certified and preliminary relief accorded to its members.

CONCLUSION

For the foregoing reasons, Plaintiffs respectfully request that the Court grant their Motion for a Preliminary Injunction, to Stay Agency Action, and For Provisional Class Certification.

A proposed order is attached.

Dated: March 17, 2025

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that, on this 17th day of March 2025, I served the foregoing MEMORANDUM OF POINTS & AUTHORITIES IN SUPPORT OF PLAINTIFFS' MOTION A PRELIMINARY INJUNCTION, TO STAY AGENCY ACTION, AND FOR PROVISIONAL CLASS CERTIFICATION and the exhibits and declarations cited therein by emailing a copy to Defendants' counsel, John Robinson, listed below. Mr. Robinson provided written consent to receive email service on behalf of Defendants on March 17, 2025.

John Robinson
U.S. Department of Justice
John.J.Robinson@usdoj.gov
(202) 616-8489

/s/ Michael Perloff
Michael Perloff

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

ALISHEA KINGDOM, et al.,

Plaintiff,

v.

DONALD J. TRUMP, et al.,

Defendants.

Case No. 1:25-cv-00691

**DECLARATION OF DR. DAN H. KARASIC IN SUPPORT OF
PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION**

I, Dan H. Karasic, M.D., hereby declare and state as follows:

1. I am over the age of 18, of sound mind, and in all respects competent to testify.
2. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.
3. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

I. BACKGROUND AND QUALIFICATIONS

A. Qualifications

4. I am a Professor Emeritus of Psychiatry at University of California – San Francisco (UCSF). I have been on faculty at UCSF since 1991. I have also had a telepsychiatry private practice since 2020.
5. I received my Doctor of Medicine (M.D.) degree from the Yale Medical School in 1987. In 1991, I completed my residency in psychiatry at the University of California – Los Angeles (UCLA) Neuropsychiatric Institute, and from 1990 to 1991, I was a postdoctoral fellow in a training program in mental health services for persons living with AIDS at UCLA.

6. For over 30 years, I have worked with patients with gender dysphoria. I am a Distinguished Life Fellow of the American Psychiatric Association and have been the chair of the American Psychiatric Association Workgroup on Gender Dysphoria, as well as the sole author of the chapter on transgender care in the American Psychiatric Press's Clinical Manual of Cultural Psychiatry, Second Edition.

7. Over the past 30 years, I have provided care for thousands of transgender patients.

8. I previously sat on the Board of Directors of the World Professional Association for Transgender Health (WPATH) and am a co-author of WPATH's Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Version 7, and the lead author on the Mental Health chapter of Version 8. The WPATH Standards of Care are the internationally accepted guidelines designed to promote the health and welfare of transgender, transsexual, and gender variant persons. I remain active in the work of WPATH.

9. As a member of the WPATH Global Education Initiative, I helped develop a specialty certification program in transgender health and helped train over 2,000 health providers.

10. At UCSF, I developed protocols and outcome measures for the Transgender Surgery Program at the UCSF Medical Center. I also served on the Medical Advisory Board for the UCSF Center of Excellence for Transgender Care and co-wrote the mental health section of the original Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People and the revision in 2016.

11. I have worked with the San Francisco Department of Public Health, helping to develop and implement their program for the care of transgender patients and conducting mental health assessments for gender-affirming surgery. I served on the City and County of San

Francisco Human Rights Commission's LGBT Advisory Committee, and I have been an expert consultant for California state agencies and on multiple occasions for the United Nations Development Programme on international issues in transgender care.

12. I have held numerous clinical positions concurrent to my clinical professorship at UCSF. Among these, I served as an attending psychiatrist for San Francisco General Hospital's consultation-liaison service for AIDS care, as an outpatient psychiatrist for HIV-AIDS patients at UCSF, as a psychiatrist for the Transgender Life Care Program and the Dimensions Clinic at Castro Mission Health Center, and the founder and co-lead of the UCSF Alliance Health Project's Transgender Team. In these clinical roles, I specialized in the evaluation and treatment of transgender, gender dysphoric, and HIV-positive patients.

13. I also regularly provide consultation on challenging cases to psychologists and other psychotherapists working with transgender and gender dysphoric patients. I have been a consultant in transgender care to the California Department of State Hospitals, which treats patients held by forensic commitment and psychiatric patients from the state prisons, and have been a consultant for the California Department of Corrections and Rehabilitation on the care of incarcerated transgender people. I am currently a consultant in transgender mental health to the Alameda County Jails. In my 29 years working with transgender patients in San Francisco public health clinics, I worked with many formerly incarcerated people, including those who spoke of their experiences being denied care while incarcerated.

14. As part of my psychiatric practice treating individuals diagnosed with gender dysphoria and who receive other medical and surgical treatment for that condition, as well as a co-author of the WPATH Standards of Care and UCSF's Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People, I am and must be familiar with

additional aspects of medical care for the diagnosis of gender dysphoria, beyond mental health treatment, assessment, and diagnosis.

15. In addition to this work, I have done research on the treatment of depression.

16. I have authored many articles and book chapters on the diagnosis and treatment of gender dysphoria and edited the book *Sexual and Gender Diagnoses of the Diagnostic and Statistical Manual (DSM): A Reevaluation*.

17. Since 2018, I have performed over 130 independent medical reviews for the State of California to determine the medical necessity of transgender care in appeals of denial of insurance coverage.

18. My professional background, experiences, publications inclusive of those authored in the past ten years, and presentations are detailed in my curriculum vitae (“CV”). A true and correct copy of my most up-to-date CV is attached as Exhibit A.

B. Compensation

19. I am being compensated for my work on this matter at a rate of \$400.00 per hour for preparation of declarations and expert reports. I will be compensated \$3,200.00 per day for any deposition testimony or trial testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

C. Previous Testimony

20. Over the past four years, I have given expert testimony by deposition or trial in the following cases: *L.B. v. Premera Blue Cross*, No. 3:20-cv-06145-RJB (W.D. Wash.); *Misanin v. Wilson*, No. 2:24-cv-04734-BHH (D.S.C.); *Voe v. Mansfield*, No. 1:23-CV-864-LCB-LPA (M.D.N.C.); *Boe v. Marshall*, No. 2:22-cv-184-LCB (N.D. Ala.); *Doe v. Ladapo*, No. 4:23-cv-00114 (N.D. Fla.); *Dekker v. Weida*, No. 4:22-cv-00325 (N.D. Fla.); *K.C. v. The Individual Members of the Medical Licensing Board of Indiana*, No. 1:23-cv-00595 (S.D. Ind.); *Brandt v.*

Rutledge, No. 4:21-cv-00450 (E.D. Ark.); *C.P. v. Blue Cross Blue Shield of Illinois*, No. 3:20-cv-06145 (W.D. Wash.); *Kadel v. Folwell*, No. 1:19-cv-00272 (M.D.N.C.); and *Fain v. Crouch*, No. 3:20-cv-00740 (S.D. W. Va.). To the best of my recollection, I have not given expert testimony at a trial or at a deposition in any other case during this period.

II. BASIS FOR OPINIONS

21. In preparing this report, I have relied on my training and my decades clinical experience as a psychiatrist treating patients with gender dysphoria, as well as my experience conducting research, as set out in my curriculum vitae (attached hereto as Exhibit A).

22. I have also relied on my knowledge of the peer-reviewed research regarding the treatment of gender dysphoria, which reflects advancements in the field of transgender health. I have reviewed the materials listed in the bibliography attached hereto as Exhibit B. The sources cited therein include authoritative, scientific peer-reviewed publications. They include the documents specifically cited as supportive examples in particular sections of this report.

23. I have also relied on my knowledge of the clinical practice guidelines for the treatment of gender dysphoria, including my work as a contributing author of the WPATH Standards of Care, Versions 7 and 8, and the UCSF Guidelines.

24. The materials I have relied upon in preparing this declaration are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject. I reserve the right to revise and supplement the opinions expressed in this report or the bases for them if any new information becomes available in the future, including as a result of new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

25. Additionally, I have reviewed Executive Order 14168, titled “Defending Women from Gender Ideology Extremism and Restoring Biological Truth to The Federal Government,”

issued on January 20, 2025 (“EO 14168”).

III. SUMMARY OF EXPERT OPINIONS

26. Gender dysphoria is a serious condition which, if left untreated, can impair a person’s ability to function and cause significant depression, anxiety, self-harm and suicidality.

27. EO 14168, by prohibiting “any medical procedure, treatment, or drug for the purpose of conforming an inmate’s appearance to that of the “opposite sex,” with “sex” being defined as immutable from the time of conception, prohibits treatments that are part of widely accepted protocols for the treatment of gender dysphoria that are supported by every major medical association in the country—social transition and gender-affirming medical care.

28. Decades of scientific research and clinical experience have demonstrated that social transition and gender-affirming medical care can significantly relieve the distress of gender dysphoria and are medically necessary for many people with this condition. I have seen first-hand, countless times over decades of practice, the many benefits of social transition and gender-affirming medical care.

29. For individuals for whom gender-affirming medical care is indicated, there are no alternative evidence-based treatments for gender dysphoria.

30. Prohibiting people with gender dysphoria from socially transitioning and withdrawing or denying gender-affirming medical care to those for whom it is indicated would put them at risk of significant harm to their health and well-being, including heightened risk of self-harm and suicidality.

31. When incarcerated people are unable to receive gender-affirming medical care to treat their gender dysphoria, some have resorted to self-castration or other self-harm to get relief, or have attempted to end their lives.

IV. EXPERT OPINIONS

A. Sex and Gender Identity

32. At birth, infants are assigned a sex, either male or female, based on the appearance of their external genitalia.

33. While the terms “male sex” and “female sex” are sometimes used in reference to a person’s genitals, chromosomes, and hormones, the reality is that sex is complicated and multifactorial. Aside from external genital characteristics, chromosomes, and endogenous hormones, other factors related to sex include gonads, gender identity, and variations in brain structure and function.

34. EO 14168 defines “sex” as “an individual’s immutable biological classification as either male or female,” that “does not include the concept of ‘gender identity.’” EO 14168 § 2(a). It further defines “Female” as “a person belonging, at conception, to the sex that produces the large reproductive cell,” and “[m]ale” as “a person belonging, at conception, to the sex that produces the small reproductive cell.” EO 14168 §§ 2(d), (e).

35. EO 14168’s definition of “sex” is not consistent with how it is commonly understood in medicine. According to the American Medical Association, sex is made up of many diverse components. (AMA, 2023). Similarly, the Endocrine Society notes that because a person’s sex characteristics “may not [always] be in line with each other ..., the terms biological sex and biological male or female are imprecise and should be avoided.” (Hembree, et al., 2017).

36. Gender identity is “a person’s deeply felt, inherent sense of being a girl, woman, or female; a man, or male; a blend of male or female; or an alternative gender” (American Psychological Association, 2015, at 834).

37. Gender identity does not always align with sex assigned at birth.

38. Gender identity, which has biological bases (Fischer and Cocchetti, 2020), is not merely a product of external influence, nor is it subject to voluntary change.

39. As documented by multiple leading medical authorities, efforts to change a person's gender identity are ineffective, can cause harm, and are unethical. (American Psychological Association, 2021, Byne, et al., 2018, Coleman, et al., 2012).

40. EO 14168 defines "gender identity" as "a fully internal and subjective sense of self, disconnected from biological reality and sex and existing on an infinite continuum, that does not provide a meaningful basis for identification and cannot be recognized as a replacement for sex." EO 14168 § 2(g).

41. EO 14168's definition of "gender identity" differs from how this term is commonly understood and used in medicine and science. Gender identity does provide a meaningful basis for identification and has been a basis for identification federally as well as in most states, and in many other countries, for years.

42. For most people, their sex assigned at birth, or assigned sex, matches their gender identity. For transgender people, their assigned sex does not align with their gender identity.

43. Based on data from the Williams Institute, approximately 0.6% of the United States population age 13 or older, or about 1.6 million people, identify as transgender. (Herman, et al., 2022).

44. Being transgender is widely accepted as a normal variation in human development. Simply being transgender or gender nonconforming is not a medical condition to be treated and is not considered a mental illness. People who are transgender have no impairment in their ability to be productive, contributing members of society simply because of their transgender status.

45. In the replacement of Gender Identity Disorder in DSM-IV with Gender Dysphoria in DSM-5, the American Psychiatric Association recognized that the clinically significant distress and social/occupational impairment of gender dysphoria is the disorder, not transgender identity. DSM-5 notes that diagnosis and treatment are “focus[ed] on dysphoria as the clinical problem, not identity per se.” (DSM-5, at 451). The World Health Organization, in placing Gender Incongruence outside the chapter of mental health conditions, states, “trans-related and gender diverse identities are not conditions of mental ill-health.” (World Health Organization, Gender Incongruence).

46. Similarly, WPATH’s Standards of Care, Version 8 states: “The expression of gender characteristics, including identities, that are not stereotypically associated with one’s sex assigned at birth is a common and a culturally diverse human phenomenon that should not be seen as inherently negative or pathological. ... It should be recognized gender diversity is common to all human beings and is not pathological. However, gender incongruence that causes clinically significant distress and impairment often requires medically necessary clinical interventions.” (Coleman, et al. 2022).

B. Gender Dysphoria

47. The term “gender dysphoria” is distress related to the incongruence between one’s gender identity and attributes related to one’s sex assigned at birth.

48. The diagnosis of Gender Dysphoria (capitalized) is a serious medical condition, and it is codified in the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The current version, known as the *Fifth Edition, Text Revision* (DSM-5-TR), was released in 2022.

49. The DSM’s diagnosis of Gender Dysphoria in Adolescents and Adults involves two major diagnostic criteria:

- A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least two of the following (one of which must be Criterion A1):
 - 1. A marked incongruence between one's experienced/expressed gender and primary or 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.
 - 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.

50. Gender dysphoria is a condition that is highly amenable to treatment, and the prevailing treatment for it is highly effective.

51. When untreated, gender dysphoria can cause significant distress including increased risk of depression, anxiety, self-harm and suicidality. It can also impair individuals' ability to function in all aspects of life, including school or work, and in family and other personal relationships. These risks decline when transgender individuals are supported and live according to their gender identity.

52. With access to medically-indicated care, transgender people can experience significant and potentially complete relief from their symptoms of gender dysphoria. Not only is this documented in scientific literature and published data, but I have witnessed this in thousands of patients over three decades.

C. Evidence-Based Guidelines for Treatment of Gender Dysphoria

53. The World Professional Association of Transgender Health (WPATH) has issued *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (“WPATH SOC”) since 1979. The current version, published in 2022, is WPATH SOC 8. The SOC 8 provides guidelines for multidisciplinary care of transgender individuals and describes criteria for medical interventions to treat gender dysphoria, including hormone treatment and surgery when medically indicated.

54. The SOC 8 utilized a rigorous evidence-based approach to developing the guidelines. (Coleman, et al., 2022). The process of developing the SOC 8 was a multistep, several years long effort that started in 2017. This process is outlined in great detail in Appendix A to SOC 8.

55. This “process for development of the SOC-8 incorporated recommendations on clinical practice guideline development from the National Academies of Medicine and the World Health Organization that addressed transparency, the conflict-of-interest policy, committee composition and group process.” (Coleman, et al., 2022, at S247 (citing Institute of Medicine Committee on Standards for Developing Trustworthy Clinical Practice, 2011; World Health Organization, 2019)). And “[t]he SOC-8 revision committee was multidisciplinary and consisted of subject matter experts, health care professionals, researchers and stakeholders with diverse perspectives and geographic representation.” (Coleman, et al., 2022, at S247).

56. WPATH SOC 8’s evidence-based recommendations were drafted “based on the results of the systematic, and background literature reviews plus consensus-based expert opinions.” (Coleman, et al., 2022, at S250). The recommendations were developed and are based on available evidence supporting interventions, a discussion of risks and harms, as well as feasibility and acceptability within different contexts and country settings. A consensus of the

final recommendations was attained using the Delphi process that included all members of the Standards of Care Revision committee, and supportive and explanatory text of the evidence for the statements was written.

57. The Delphi process is a procedure by which a panel of experts are asked for their opinion on a relevant issue, summarizing and presenting their collective responses and repeating this process for a certain number of rounds. (Shang, 2023; Hsu and Sanford, 2019). It is “a well-established approach to answering a research question through the identification of a consensus view across subject experts.” (Barrett and Healey, 2020).

58. The recommendations submitted to a vote under the Delphi process required approval of 75% of the authors of SOC 8 as a whole. More specifically, for a recommendation to be approved, a minimum of 75% of the voters had to approve the statement. (Coleman, et al., 2022, at S250). With regards to SOC 8, every member of the SOC revision committee voted for each statement. Following the aforementioned process, recommendations contained in SOC 8, as published in 2022, were approved by 75% or more of the revision committee.

59. A clinical practice guideline from the Endocrine Society (the Endocrine Society Guideline) provides similar guidelines for clinicians to provide safe and effective treatment for gender dysphoria. (Hembree, et al., 2017).

60. Each of these guidelines are evidence-based and supported by scientific research and literature, as well as extensive clinical experience.

61. The evidence base supporting the recommendations in these guidelines is comparable to the evidence base supporting treatment for other conditions.

62. The protocols and policies set forth by the WPATH Standards of Care and the Endocrine Society Guideline are endorsed and cited as authoritative by the major professional

medical and mental health associations in the United States, including the American Medical Association, the American Academy of Pediatrics, the American Psychiatric Association, the American Psychological Association, the American College of Obstetrics and Gynecology, the American College of Physicians, and the World Medical Association, among others. They are also relied upon by clinicians treating patients with gender dysphoria.

D. Treatment of Gender Dysphoria

63. Under the WPATH SOC and the Endocrine Society Guideline, the overarching goal of treatment is to eliminate the distress of gender dysphoria by helping the patient live consistently with their gender identity by aligning their presentation and body with their gender identity.

64. Social transition is an integral part of addressing gender dysphoria for transgender people. Social transition involves changing appearance (e.g. garments, hair, make-up) and social role, with change of signifiers of gender, including name and pronouns, and public presentation in the identified gender.

65. In earlier versions of the Standards of Care, social transition was required before medical interventions were considered. While the current WPATH SOC 8 recognizes the necessity for individualized paths for transition, social transition remains central to addressing gender dysphoria for many transgender people.

66. While social transition alone can adequately address gender dysphoria for some people, many individuals with gender dysphoria cannot obtain relief without also receiving medical interventions to align the body with their gender identity. In accordance with the WPATH SOC and the Endocrine Society Guidelines, medical interventions to treat adults with gender dysphoria may include hormone therapy and surgeries, based on a patient's individual needs.

67. For assessing an adult for gender-affirming medical care, WPATH SOC 8 states that the health professional should be licensed and trained in identifying gender dysphoria as well as co-existing mental health and psychosocial concerns, and that medical or surgical treatment should only be recommended when “gender incongruence is marked and sustained,” when there is capacity for consent, when other conditions that might affect outcomes have been assessed, and when diagnostic criteria for Gender Dysphoria of DSM 5-TR (in the US) or Gender Incongruence of ICD-11(outside the US) are met.

68. If a patient is assessed to have a medical need for hormone therapy, gender-affirming hormone therapy involves administering testosterone for transgender men and estrogen and testosterone suppression for transgender women. The purpose of this treatment is to attain the appropriate masculinization or feminization of the transgender person that matches as closely as possible to their gender identity. Gender-affirming hormone therapy is a partially reversible treatment.

69. Some transgender individuals need surgical interventions to help bring their phenotype into alignment with their gender. Surgical interventions may include, inter alia, vaginoplasty and orchiectomy for transgender female individuals, and chest reconstruction and hysterectomy for transgender male individuals.

70. For patients for whom gender-affirming medical care is indicated, no alternative treatments have been demonstrated to be effective.

71. The treatment protocols for gender dysphoria are comparable to those for other mental health and medical conditions. Indeed, these or similar procedures are provided for cisgender people with other diagnoses. For example, breast reduction surgery is much more commonly performed on cisgender males who have unwanted excess breast tissue

(gynecomastia), than on transgender males. Dai, et al. (2024) recently found that of the adolescents who had these surgeries, 97% were cisgender males and only 3% were transgender males. Testosterone treatment for transgender males, like for cisgender males with testosterone insufficiency (hypogonadism), involves administering testosterone to bring blood levels up to the normal male range.

E. Social Transition Has Been Shown to Help Alleviate Gender Dysphoria.

72. Social transition has been shown to positively affect mental health (Hughto, et al 2020). Bringing one's presentation into alignment with gender identity can help one see oneself and be recognized and treated by others consistent with one's gender identity. Recognition of chosen name with social transition has been associated with decreases in depression and suicidality. (Russell, et al 2018). In my work with thousands of transgender patients, social transition has been a critical step towards improved mental health. In patients who have been forced to socially detransition, while incarcerated or due to family or career, mental health impacts have been severe to my patients, with increased gender dysphoria, depression, anxiety and in some patients, suicidality and self-harm.

F. Gender-Affirming Medical Care Has Been Shown To Be Safe and Effective Treatment for Gender Dysphoria.

73. There is a substantial body of research and clinical evidence that gender-affirming medical care is effective in treating gender dysphoria. This evidence includes scientific studies assessing mental health outcomes for transgender people who are treated with these interventions, and decades of clinical experience, including my own.

74. The research and studies supporting the necessity, safety, and effectiveness of medical care for gender dysphoria are the same type of evidence that the medical community routinely relies upon when treating other medical conditions.

75. Medical treatment for gender dysphoria has been studied for over half a century, and there is substantial evidence that it improves quality of life and measures of mental health.¹ There is also substantial evidence that the risks of these treatments are low and manageable, and comparable to the type of risks that exist in the same treatments when given to cisgender patients and in many other medical treatments. For example, the cardiovascular risks associated with estrogen apply whether the person is receiving treatment for gender dysphoria, menopause, or other conditions. Regret rates for gender-affirming surgeries are very low, often much lower than for similar surgeries in cisgender patients. (Thornton, et al 2024).

76. The studies on gender-affirming medical care for treatment of dysphoria are consistent with decades of clinical experience of mental health providers across the U.S. and around the world. At professional conferences and other settings in which I interact with colleagues, clinicians report that gender-affirming medical care, for those for whom it is indicated, provides great clinical benefit. In my over 30 years of clinical experience treating gender dysphoric patients, I have seen the benefits of gender-affirming medical care on my patients' health and well-being. I have seen many patients show improvements in mental health, as well as in performance in school and work, in social functioning with peers, and in family relationships when they experience relief from gender dysphoria with gender-affirming medical care.

77. As part of the treatment process for gender dysphoria, patients provide informed consent to their care. In addition, a treating doctor will not offer gender-affirming medical

¹ See, e.g., Dopp, et al., 2024; Shelemy, et al., 2024; Ascha, et al., 2022; Aldridge, et al., 2021; Almazan, et al., 2021; Baker, et al., 2021; Murad, et al., 2010; Nobili, et al., 2018; Pfafflin & Junge, 1998; T'Sjoen et al. 2019; Turan, et al., 2018; van de Grift et al., 2018; Olson-Kennedy, et al., 2018; Cornell, What We Know, 2018; Nguyen, et al., 2018; Oda, et al., 2017; White, Hughto and Reisner, 2016; Fisher, et al., 2016; Keo-Meier, et al., 2015; Wierckx et al., 2014; Colizzi, et al., 2014; Colizzi, et al., 2013.

treatments unless they have concluded after weighing the risks and benefits of care that treatment is appropriate. The risks and benefits of care are discussed with the transgender patient, who must consent.

78. Gender-affirming medical interventions provided in accordance with the WPATH SOC 8 and Endocrine Society Guidelines are widely recognized in the medical community as safe, effective, and medically necessary for many people with gender dysphoria. (*See, e.g.*, the American Psychological Association, 2024 and 2021; American Academy of Pediatrics, 2018 (reaffirmed in 2023); the American Medical Association, 2021; the Pediatric Endocrine Society, 2021; the American College of Obstetricians and Gynecologists, 2021; the Endocrine Society, 2020; the American Academy of Family Physicians, 2020; the American Psychiatric Association, 2018; and WPATH, 2022).

79. For all the reasons above, I am aware of no basis in medicine or science for categorically prohibiting gender-affirming medical care.

G. Harms of a Blanket Prohibition Against Social Transition and Hormone Therapy²

80. The overarching goal of treatment is to eliminate the distress of gender dysphoria by aligning an individual patient's body and presentation with their internal sense of self. The denial of medically-indicated care to transgender people not only results in the prolonging of their gender dysphoria, but causes additional distress and poses other health risks, such as depression, post-traumatic stress disorder, and suicidality. In other words, lack of access to gender-affirming care directly contributes to poorer mental health outcomes for transgender people. (Owen-Smith, et al., 2018).

² Because the preliminary injunction motion does not seek relief related to gender-affirming surgeries, this portion of the declaration does not address surgery.

81. For patients for whom gender-affirming medical care is indicated, no alternative treatments have been demonstrated to be effective. To the extent one proposed alternative is psychotherapeutic treatment to encourage identification with a person's assigned sex at birth, the American Psychological Association has stated that such efforts provide no benefit and instead do harm. (APA, 2021). Or if an alternative approach is to treat the worsening dysphoria only with therapy, that has not shown to be effective in any research. (Dopp, et al., 2024). Psychotherapy is a critical treatment modality for many patients, but it does not address the underlying gender dysphoria, which when persistent can only be addressed by bringing a patient's body and sex characteristics into alignment with the patient's gender identity.

82. Denying patients with gender dysphoria the ability to socially transition or obtain gender-affirming medical care where indicated predictably will lead to significant deterioration in mental health.

83. I have had patients over the years who were unable to access gender-affirming medical care when it was clinically indicated, including in the years before this care was more widely available. In many of these patients, delayed or denied care resulted in increased depression, anxiety, suicidal ideation and self-harm, increased substance use, and a deterioration in school or work performance. Some patients attempted to self-castrate or remove breasts. For patients with severe distress due to their gender dysphoria, psychotherapeutic approaches did not alleviate this distress absent medical intervention. Some of my patients had years of intensive mental health interventions, including long-term psychotherapy, without relief of gender dysphoria until receiving medical intervention.

84. Research documents the harms to incarcerated individuals with gender dysphoria who have not been able to receive necessary treatment, including attempts at self-castration.

(Brown, 2010, Aldrich et al, 2023). I have provided care for transgender patients after incarceration who had suffered severe mental health consequences, including intolerable gender dysphoria, depression, anxiety, self-harm and suicidality, from denial of the ability to socially and medically transition.

85. A blanket policy withdrawing hormone therapy and the ability to socially transition from individuals with gender dysphoria currently receiving that care would be expected to cause severe negative impact on patients' mental health. I have cared for or consulted on patients who were forced to socially and medically detransition and I've seen the suffering that it caused. For example, I consulted on a patient who, while in the long-term custody of a forensic psychiatry unit, was forced to detransition—both medically and socially. He severely decompensated and attempted suicide. After obtaining legal representation to request that the institution bring in an expert in the treatment of gender dysphoria, he was able to resume gender-affirming hormone therapy and live consistently with his male identity, and his mental health greatly improved. Eventually he was able to have gender affirming surgery, and then be released, and he has flourished in his life and work after release.

V. CONCLUSION

86. Executive Order 14168, which categorically prohibits gender-affirming medical care and social transition for individuals with gender dysphoria who are in the custody of the Bureau of Prisons, regardless of their medical needs, is contrary to widely accepted evidence-based medical protocols for the treatment of gender dysphoria and puts these individuals at risk of significant harm, including heightened risk of depression, self-harm, and suicidality.

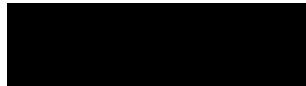
I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed this 14th day of March, 2025

A handwritten signature in black ink, appearing to read 'DK' followed by a stylized flourish.

Dan H. Karasic

E HIBIT A

University of California, San Francisco**CURRICULUM VITAE****Name:** Dan H. Karasic, MD**Position:** Professor Emeritus
Psychiatry
School of Medicine**EDUCATION**

1978 - 1982	Occidental College, Los Angeles	A.B.; Summa Cum Laude	Biology
1982 - 1987	Yale University School of Medicine	M.D.	Medicine
1987 - 1988	University of California, Los Angeles	Intern	Medicine, Psychiatry, and Neurology
1988 - 1991	University of California, Los Angeles; Neuropsychiatric Institute	Resident	Psychiatry
1990 - 1991	University of California, Los Angeles; Department of Sociology	Postdoctoral Fellow	Research Training Program in Mental Health Services for Persons with AIDS

LICENSES, CERTIFICATION

1990	Medical Licensure, California, License Number G65105
1990	Drug Enforcement Administration Registration Number BK1765354
1993	American Board of Psychiatry and Neurology, Board Certified in Psychiatry

PRINCIPAL POSITIONS HELD

1991 - 1993	University of California, San Francisco	Health Sciences Psychiatry Clinical Instructor
1993 - 1999	University of California, San Francisco	Health Sciences Psychiatry Assistant Clinical Professor

1999 - 2005	University of California, San Francisco	Health Sciences Psychiatry Associate Clinical Professor
2005 - 2020	University of California, San Francisco	Health Sciences Psychiatry Clinical Professor
2020-present	University of California, San Francisco	Professor Emeritus of Psychiatry

OTHER POSITIONS HELD CONCURRENTLY

1980 - 1980	Associated Western Universities / U.S. Department of Energy	Honors Undergraduate Research Fellow	UCLA Medicine
1981 - 1981	University of California, Los Angeles; Medicine American Heart Association, California Affiliate	Summer Student Research Fellow	UCLA
1986 - 1987	Yale University School of Medicine; American Heart Association, Connecticut Affiliate	Medical Student Research Fellow	Psychiatry
1990 - 1991	University of California, Los Angeles	Postdoctoral	Sociology Fellow
1991 - 2001	SFGH Consultation-Liaison Service; AIDS Care	Attending Psychiatrist	Psychiatry
1991 - 2001	AIDS Consultation-Liaison Medical Student Elective	Course Director	Psychiatry
1991 - present	UCSF Positive Health Program at San General Hospital (Ward 86)	HIV/AIDS Outpatient Psychiatrist	Psychiatry Francisco
1991 - present	UCSF AHP (AIDS Health Project/Alliance Health Project)	HIV/AIDS Outpatient Psychiatrist	Psychiatry
1994 - 2002	St. Mary's Medical Center CARE Unit. The CARE Unit specializes in the care of patients with AIDS dementia.	Consultant	Psychiatry
2001 - 2010	Depression and Antiretroviral Adherence Clinical Director Study (The H.O.M.E. study: Health Outcomes of Mood Enhancement)		Psychiatry and Medicine
2003 - 2020	Transgender Life Care Program and Clinic, Castro Mission Health	Psychiatrist Clinic Center	Dimensions Dimensions
2013 - 2020	UCSF Alliance Health Project, Co-lead, Transgender Team	Co-Lead and Psychiatrist	Psychiatry

HONORS AND AWARDS

1981	Phi Beta Kappa Honor Society	Phi Beta Kappa
1990	NIMH Postdoctoral Fellowship in Health Services for People with AIDS (1990-1991)	National Institute of Mental Health Mental
2001	Lesbian Gay Bisexual Transgender Leadership Award, LGBT Task Force of the Cultural Competence and Diversity Program	SFGH Department of Psychiatry
2006	Distinguished Fellow	American Psychiatric Association
2012	Chancellor's Award for Leadership in LGBT Health	UCSF
2023	Alumni Seal Award for Achievement	Occidental College Professional

MEMBERSHIPS

1992 - present Northern California Psychiatric Society

1992 - present American Psychiatric Association

2000 - 2019 Bay Area Gender Associates (an organization of psychotherapists working with transgendered clients)

2001 - present World Professional Association for Transgender Health

SERVICE TO PROFESSIONAL ORGANIZATIONS

1981 - 1982	The Occidental	News Editor
1984 - 1985	Yale University School of Medicine	Class President
1989 - 1991	Kaposi's Sarcoma Group, AIDS Project Los Angeles	Volunteer Facilitator
1992 - 1996	Early Career Psychiatrist Committee, Association of Gay Lesbian Psychiatrists	Chair and
1992 - 1996	Board of Directors, Association of Gay and Lesbian	Member Psychiatrists
1993 - 1993	Local Arrangements Committee, Association of Gay and	Chair Lesbian Psychiatrists
1994 - 1995	Educational Program, Association of Gay and Lesbian 1995 Annual Meeting	Director Psychiatrists,
1994 - 1998	Board of Directors, BAY Positives	Member
1994 - 2020	Committee on Lesbian, Gay, Bisexual and Transgender	Member

Issues, Northern California Psychiatric Society

- 1995 - 1997 Board of Directors, Bay Area Young Positives. BAY President
Positives is the nation's first community-based organization providing psychosocial and recreational services to HIV-positive youth
- 1995 - 1997 Executive Committee, Bay Area Young Positives. Chair
- 1996 - 2004 Committee on Lesbian, Gay, Bisexual and Transgender Chair Issues,
Northern California Psychiatric Society
- 1998 - 2002 City of San Francisco Human Rights Commission, Member Lesbian,
Gay Bisexual Transgender Advisory Committee
- 2000 - 2004 Association of Gay and Lesbian Psychiatrists. Vice President Responsible for
the organization's educational programs
- 2004 - 2005 Association of Gay and Lesbian Psychiatrists President-elect
- 2005 - 2007 Caucus of Lesbian, Gay, and Bisexual Psychiatrists of the Chair American
Psychiatric Association
- 2005 - 2007 Association of Gay and Lesbian Psychiatrists President
- 2007 - 2009 Association of Gay and Lesbian Psychiatrists Immediate Past
President
- 2009 - 2010 Consensus Committee for Revision of the Sexual and Member
Gender Identity Disorders for DSM-V, GID of Adults
subcommittee. (Wrote WPATH recommendations as
advisory body to the APA DSM V Committee for the Sexual
and Gender Identity Disorders chapter revision.)
- 2010 - 2011 Scientific Committee, 2011 WPATH Biennial Symposium, Member Atlanta
- 2010 -2022 World Professional Association for Transgender Care Member
Standards of Care Workgroup and Committee (writing seventh
and eighth revisions of the WPATH Standards of Care, which
is used internationally for transgender care.)
- 2010 - 2018 ICD 11 Advisory Committee, World Professional Member Association for
Transgender Health
- 2012 - 2014 Psychiatry and Diagnosis Track Co-chair, Scientific Member Committee,
2014 WPATH Biennial Symposium, Bangkok
- 2014 - 2016 Scientific Committee, 2016 WPATH Biennial Symposium, Member Amsterdam
- 2014 - 2018 Board of Directors (elected to 4 year term), World Member Professional
Association for Transgender Health
- 2014 - 2018 Public Policy Committee, World Professional Association Chair for Transgender
Health
- 2014 - 2018 WPATH Global Education Initiative: Training providers Trainer and and
specialty certification in transgender health Steering

Committee
Member

2014 - 2016 American Psychiatric Association Workgroup on Gender Member Dysphoria
2016 - present American Psychiatric Association Workgroup on Gender Chair Dysphoria
2016 USPATH: Inaugural WPATH U.S. Conference, Los Angeles, 2017 Conference Chair

SERVICE TO PROFESSIONAL PUBLICATIONS

2011 - present Journal of Sexual Medicine, reviewer
2014 - present International Journal of Transgenderism, reviewer
2016 - present LGBT Health, reviewer

INVITED PRESENTATIONS - INTERNATIONAL

2009	World Professional Association for Transgender Health, Oslo, Norway	Plenary Session Speaker
2009	World Professional Association for Transgender Health, Oslo, Norway	Symposium Speaker
2009	Karolinska Institutet, Stockholm Sweden	Invited Lecturer
2012	Cuban National Center for Sex Education (CENESEX), Cuba	Invited Speaker Havana,
2013	Swedish Gender Clinics Annual Meeting, Stockholm, Sweden	Keynote Speaker
2013	Conference on International Issues in Transgender care, United Nations Development Programme - The Lancet, Beijing, China	Expert Consultant
2014	World Professional Association for Transgender Health, Thailand	Track Chair Bangkok,
2014	World Professional Association for Transgender Health, Bangkok, Thailand	Invited Speaker
2014	World Professional Association for Transgender Health, Bangkok, Thailand	Invited Speaker
2015	European Professional Association for Transgender Health, Ghent, Belgium	Invited Speaker Health,
2015	European Professional Association for Transgender Health, Ghent, Belgium	Symposium Chair
2015	Israeli Center for Human Sexuality and Gender Identity,	Invited Speaker Tel Aviv
2016	World Professional Association for Transgender Health, Amsterdam	Symposium Chair
2016	World Professional Association for Transgender Health, Amsterdam	Invited Speaker

2016	World Professional Association for Transgender Health, Invited Speaker Amsterdam
2017	Brazil Professional Association for Transgender Health, Sao Paulo
2017	Vietnam- United Nations Development Programme Asia Transgender Health Conference, Hanoi
2018	United Nations Development Programme Asia Conference on Transgender Health and Human Rights, Bangkok
2018	World Professional Association for Transgender Health, Invited Speaker Buenos Aires
2021	Manitoba Psychiatric Association, Keynote Speaker
2022	World Professional Association for Public Health, invited speaker, Montreal

INVITED PRESENTATIONS - NATIONAL

1990	Being Alive Medical Update, Century Cable Television	Televised Lecturer
1992	Institute on Hospital and Community Psychiatry, Toronto	Symposium Speaker
1992	Academy of Psychosomatic Medicine Annual Meeting, San Diego	Symposium Speaker
1994	American Psychiatric Association 150th Annual Meeting, Philadelphia	Workshop Chair
1994	American Psychiatric Association 150th Annual Meeting, Philadelphia	Workshop Speaker
1994	American Psychiatric Association 150th Annual Meeting, Philadelphia	Paper Session Co-chair
1995	Spring Meeting of the Association of Gay and Lesbian Psychiatrists, Miami Beach	Symposium Chair
1996	American Psychiatric Association 152nd Annual Meeting, New York	Workshop Speaker
1997	American Psychiatric Association Annual Meeting, San Diego	Workshop Speaker
1997	Gay and Lesbian Medical Association Annual	Invited Speaker Symposium
1998	American Psychiatric Association Annual Meeting, Toronto	Workshop Chair
1998	American Psychiatric Association Annual Meeting, Toronto	Workshop Chair

1998	American Psychiatric Association Annual Meeting, Toronto	Media Session Chair
1998	American Psychiatric Association Annual Meeting, Toronto	Media Session Chair
1999	American Psychiatric Association Annual Meeting, Washington, D.C.	Symposium Chair
1999	American Psychiatric Association Annual Meeting, Washington, D.C.	Symposium Presenter
1999	American Psychiatric Association Annual Meeting, Washington, D.C.	Workshop Chair
2000	American Psychiatric Association Annual Meeting, Chicago	Workshop Chair
2000	National Youth Leadership Forum On Medicine, University of California, Berkeley	Invited Speaker
2001	American Psychiatric Association Annual Meeting, New Orleans	Workshop Chair
2001	American Psychiatric Association Annual Meeting, New Orleans	Media Program Chair
2001	Association of Gay and Lesbian Psychiatrists	Chair Symposium, New Orleans
2001	Harry Benjamin International Gender Dysphoria Association Biennial Meeting, Galveston, Texas	Invited Speaker
2002	American Psychiatric Association Annual Meeting, Philadelphia	Media Program Chair
2002	American Psychiatric Association Annual Meeting, Philadelphia	Workshop Chair
2002	American Psychiatric Association Annual Meeting, Philadelphia	Workshop Chair
2003	Association of Gay and Lesbian Psychiatrists CME	Chair Conference
2003	American Psychiatric Association Annual Meeting, San Francisco	Symposium Chair
2003	American Psychiatric Association Annual Meeting, San Francisco	Symposium Co- Chair
2003	American Psychiatric Association Annual Meeting, San Francisco	Workshop Chair
2003	American Public Health Association Annual Meeting, San Francisco	Invited Speaker
2004	Mission Mental Health Clinic Clinical Conference	Invited Speaker

2004	Association of Gay and Lesbian Psychiatrists Conference, New York	Co-Chair
2004	Mental Health Care Provider Education Program: Los Angeles. Sponsored by the American Psychiatric Association Office of HIV Psychiatry	Invited Speaker
2005	American Psychiatric Association Annual Meeting, Atlanta	Workshop Speaker
2005	Association of Gay and Lesbian Psychiatrists Saturday Symposium	Invited Speaker
2008	Society for the Study of Psychiatry and Culture, San Francisco	Invited Speaker
2009	American Psychiatric Association Annual Meeting, San Francisco	Symposium Speaker
2011	National Transgender Health Summit, San Francisco	Invited Speaker
2011	National Transgender Health Summit, San Francisco	Invited Speaker
2011	American Psychiatric Association Annual Meeting, Honolulu, HI	Symposium Chair
2011	American Psychiatric Association Annual Meeting, Honolulu, HI	Symposium Speaker
2011	World Professional Association for Transgender Health Conference, Atlanta, GA	Invited Speaker Biennial
2011	World Professional Association for Transgender Health Conference, Atlanta, GA	Invited Speaker Biennial

		Invited Speaker
2011	World Professional Association for Transgender Health Biennial Conference, Atlanta, GA	
2011	Institute on Psychiatric Services, San Francisco	Invited Speaker
2012	Gay and Lesbian Medical Association Annual Meeting	Invited Speaker
2013	National Transgender Health Summit, Oakland, CA	Invited Speaker
2013	National Transgender Health Summit, Oakland, CA	Invited Speaker
2013	National Transgender Health Summit, Oakland, CA	Invited Speaker
2013	American Psychiatric Association Annual Meeting, San Francisco	Invited Speaker
2013	Gay and Lesbian Medical Association, Denver, CO	Invited Speaker
2014	American Psychiatric Association Annual Meeting, New York	Invited Speaker
2014	Institute on Psychiatric Services, San Francisco	Moderator
2014	Institute on Psychiatric Services, San Francisco	Invited Speaker
2014	Institute on Psychiatric Services, San Francisco	Invited Speaker
2015	National Transgender Health Summit, Oakland, CA	Invited Speaker
2015	National Transgender Health Summit, Oakland, CA	Invited Speaker
2015	American Psychiatric Association Annual Meeting, Toronto	Workshop Speaker
2015	American Psychiatric Association Annual Meeting, Toronto	Course Faculty
2016	American Psychiatric Association Annual Meeting	Course Faculty
2016	World Professional Association for Transgender Health Global Education Initiative, Atlanta	Course Faculty
2016	World Professional Association for Transgender Health Global Education Initiative, Springfield, MO	Course Faculty
2016	World Professional Association for Transgender Health Global Education Initiative, Fort Lauderdale, FL	Course Faculty
2017	World Professional Association for Transgender Health, GEI, Los Angeles	Course Faculty
	World Professional Association for Transgender Health	

Surgeon's Training, Irvine, CA Course Faculty

2017	American Urological Association Annual Meeting, San Francisco CA Invited Speaker
2018	World Professional Association for Transgender Health GEI, Portland OR, Course Faculty
2018	World Professional Association for Transgender Health GEI, Palm Springs, Course Faculty
2019	American Society for Adolescent Psychiatry Annual Meeting, San Francisco, Speaker
2019	American Psychiatric Association Annual Meeting, San Francisco, Session Chair
2020	Psychiatric Congress, Invited Speaker
2022	World Professional Association for Transgender Health, Montreal, invited speaker
2023	National Transgender Health Summit, San Francisco, invited speaker
2023	American Psychiatric Association Annual Meeting, San Francisco, invited speaker
2023	US Professional Association for Transgender Health, speaker
2024	World Professional Association for Transgender Health, Lisbon

INVITED PRESENTATIONS - REGIONAL AND OTHER INVITED PRESENTATIONS

1990	Advanced Group Therapy Seminar, UCLA Neuropsychiatric Institute	Invited Lecturer
1991	Joint Project of the Southern California AIDS Interfaith Council and UCLA School of Medicine	Symposium Speaker
1991	Joint Project of the Southern California AIDS Interfaith Council and UCLA School of Medicine	Workshop Panelist
1992	Advanced Group Therapy Seminar, UCLA Neuropsychiatric Institute	Invited Lecturer
1993	UCSF School of Nursing	Invited Lecturer
1995	UCSF/SFGH Department of Medicine Clinical Care Conference	Invited Speaker
1996	UCSF School of Nursing	Invited Speaker

1996	Psychopharmacology for the Primary Care AIDS/Clinician, series of four lectures, UCSF Department of Medicine	Invited Speaker
1996	UCSF AIDS Health Project Psychotherapy Internship Training Program	
1996	UCSF/SFGH Department of Medicine AIDS Quarterly Update	Invited Speaker
1996	San Francisco General Hospital, Division of Addiction Medicine	Invited Speaker
1996	UCSF Langlely Porter Psychiatric Hospital and Clinics Rounds	Invited Speaker Grand
1997	UCSF School of Nursing	Invited Speaker
1997	UCSF Department of Medicine AIDS Program	Invited Speaker
1997	Northern California Psychiatric Society Annual Meeting, Monterey	Workshop Speaker
1997	San Francisco General Hospital Department of Psychiatry	Invited Speaker Grand Rounds
1997	San Francisco General Hospital Department of Psychiatry	Invited Speaker Grand Rounds
1997	Northern California Psychiatric Society LGBT Committee	Chair Fall Symposium
1997	Progress Foundation, San Francisco	Invited Speaker
1998	San Francisco General Hospital Department of Psychiatry	Invited Speaker Grand Rounds
1999	Northern California Psychiatric Society Annual Meeting,	Invited Speaker Santa Rosa
1999	Northern California Psychiatric Society Annual Meeting,	Invited Speaker Santa Rosa
1999	University of California, Davis, Department of Psychiatry	Invited Speaker Grand Rounds
1999	California Pacific Medical Center Department of	Invited Speaker Psychiatry Grand Rounds
1999	San Francisco General Hospital Department of Psychiatry	Discussant Departmental Case Conference
2000	Langlely Porter Psychiatric Hospital and Clinics	Invited Speaker Consultation Liaison Seminar
2000	San Francisco General Hospital, Psychopharmacology	Invited Speaker Seminar

2000	UCSF Transgender Health Conference, Laurel Heights Conference Center	Invited Speaker
2000	Psychiatry Course for UCSF Second Year Medical Students	Invited Lecturer
2000	Community Consortium Treatment Update Symposium, California Pacific Medical Center, Davies Campus	Invited Speaker
2000	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker
2001	Psychiatry Course for UCSF Second Year Medical Students	Invited Lecturer
2003	Tom Waddell Health Center Inservice	Invited Speaker
2003	San Francisco Veterans Affairs Outpatient Clinic	Invited Speaker
2004	San Francisco General Hospital Psychiatric Emergency Service Clinical Conference	Invited Speaker
2004	South of Market Mental Health Clinic, San Francisco	Invited Speaker
2005	Northern Psychiatric Society Annual Meeting	Invited Speaker
2005	Equality and Parity: A Statewide Action for Transgender Prevention and Care, San Francisco	Invited Speaker HIV
2005	San Francisco General Hospital Department of Psychiatry Grand Rounds.	Invited Speaker
2006	SFGH/UCSF Department of Psychiatry Grand Rounds	Invited Speaker
2007	UCSF Department of Medicine, HIV/AIDS Grand Rounds, Positive Health Program	Invited Speaker
2007	California Pacific Medical Center LGBT Health, San Francisco LGBT Community Center	Invited Speaker Symposium,
2007	UCSF CME Conference, Medical Management of HIV/AIDS, Fairmont Hotel, San Francisco	Invited Speaker
2008	UCSF Department of Medicine, Positive Health Program, HIV/AIDS Grand Rounds	Invited Speaker
2008	San Francisco General Hospital Psychiatry Grand Rounds	Invited Speaker
2008	UCSF CME Conference, Medical Management of HIV/AIDS, Fairmont Hotel, San Francisco	Invited Speaker
2010	Northern California Psychiatric Society Annual Meeting, Monterey, CA	Invited Speaker
2011	Transgender Mental Health Care Across the Life Span, Stanford University	Invited Speaker
2011	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker

		Invited Speaker
2012	UCSF AIDS Health Project Veterans Affairs Medical Center.	Invited Speaker 2012 San Francisco
2013	Association of Family and Conciliation Courts Conference,	Invited Speaker Los Angeles, CA
2014	UCSF Transgender Health elective	Invited Speaker
2014	UCSF Department of Psychiatry Grand Rounds	Invited Speaker
2014	California Pacific Medical Center Department of	Invited Speaker Psychiatry Grand Rounds
2014	UCLA Semel Institute Department of Psychiatry Grand	Invited Speaker Rounds
2015	UCSF Transgender Health elective	Invited Speaker
2015	Fenway Health Center Boston, MA (webinar)	Invited Speaker
2015	Transgender Health Symposium, Palm Springs	Invited Speaker
2015	Transgender Health Symposium, Palm Springs	Co-Chair
2015	Santa Clara Valley Medical Center Grand Rounds	Invited Speaker
2016	UCSF School of Medicine Transgender Health elective	Invited Speaker
2016	Langley Porter Psychiatric Institute APC Case Conference	Invited Speaker (2 session series)
2016	Zuckerberg San Francisco General Department of Psychiatry Grand Rounds	Invited Speaker
2016	UCSF Mini-Medical School Lectures to the Public	Invited Speaker
2021	Los Angeles County Department of Mental Health,	Invited Speaker
2023	Alameda County Department of Behavioral Health,	Invited Speaker

CONTINUING EDUCATION AND PROFESSIONAL DEVELOPMENT ACTIVITIES

2005	Northern California Psychiatric Society
2005	Northern California Psychiatric Society Annual Meeting, Napa
2005	Association of Gay and Lesbian Psychiatrist Annual Conference
2006	Annual Meeting, American Psychiatric Association, Atlanta
2006	Annual Meeting, American Psychiatric Association, Toronto
2006	Institute on Psychiatric Services, New York
2007	Association of Gay and Lesbian Psychiatrists Annual Conference

2007	American Psychiatric Association Annual Meeting, San Diego
2007	The Medical Management of HIV/AIDS, a UCSF CME Conference
2008	Society for the Study of Psychiatry and Culture, San Francisco
2009	American Psychiatric Association, San Francisco
2009	World Professional Association for Transgender Health, Oslo, Norway
2010	Annual Meeting of the Northern California Psychiatric Society, Monterey, CA
2011	Transgender Mental Health Care Across the Life Span, Stanford University
2011	National Transgender Health Summit, San Francisco
2011	American Psychiatric Association Annual Meeting, Honolulu, HI
2011	World Professional Association for Transgender Health Biennial Conference, Atlanta, GA
2011	Institute on Psychiatric Services, San Francisco
2012	Gay and Lesbian Medical Association Annual Meeting, San Francisco
2013	National Transgender Health Summit, Oakland, CA
2013	American Psychiatric Association Annual Meeting, San Francisco
2013	Gay and Lesbian Medical Association, Denver, CO
2014	American Psychiatric Association Annual Meeting, New York
2014	Institute on Psychiatric Services, San Francisco
2015	European Professional Association for Transgender Health, Ghent, Belgium
2015	National Transgender Health Summit, Oakland
2015	American Psychiatric Association Annual Meeting, Toronto
2016	American Psychiatric Association Annual Meeting, Atlanta
2016	World Professional Association for Transgender Health, Amsterdam

GOVERNMENT AND OTHER PROFESSIONAL SERVICE

1998 - 2002	City and County of San Francisco Human Rights Member Commission LGBT Advisory Committee

I am the chair of the American Psychiatric Association Workgroup on Gender Dysphoria, which developed a CME course for the 2015 and 2016 APA Annual Meetings, and has an larger educational mission to train American psychiatrists to better care for transgender patients. I have been leading education efforts in transgender health at APA meetings since 1998. On the APA Workgroup on Gender Dysphoria, I am a co-author of a paper of transgender issues that has been approved by the American Psychiatric Association as a resource document and is in press for the American Journal of Psychiatry. I am also the sole author of the chapter on transgender care in the American Psychiatric Press's Clinical Manual of Cultural Psychiatry, Second Edition.

I have been active internationally in transgender health through my work as a member of the Board of Directors of the World Professional Association for Transgender Health. I am an author of the WPATH Standards of Care, Version 7, and am Chapter Lead for the Mental Health Chapter of SOC 8.

I chaired of the WPATH Public Policy Committee and was a member of the Global Education Initiative, which developed a specialty certification program in transgender health. I helped plan the 2016 WPATH Amsterdam conference, and was on the scientific committee for the last four biennial international conferences. I was on the founding committee of USPATH, the national affiliate of WPATH, and I chaired the inaugural USPATH conference, in Los Angeles in 2017. As a member of the steering committee of the WPATH Global Educational Initiative, I helped train over 2000 health providers in transgender health, and helped develop a board certification program and examination in transgender health.

UNIVERSITY SERVICE UC SYSTEM AND MULTI-CAMPUS SERVICE

1991 – 2003 HIV/AIDS Task Force Member

1992 - 1993 HIV Research Group Member

1992 - 1997	Space Committee	Member

1992 - 2003	Gay, Lesbian and Bisexual Issues Task Force	Member

1994 - 1997	SFGH Residency Training Committee	Member

1996 - 1997	Domestic Partners Benefits Subcommittee.	Chair

1996 - 2000	Chancellor's Advisory Committee on Gay, Lesbian, and Transgender Issues.	Member Bisexual

1996 - 2003	HIV/AIDS Task Force	Co-Chair

1996 - 2003	Cultural Competence and Diversity Program	Member

2009 - present	Medical Advisory Board, UCSF Center of Excellence for Transgender Health	Member

2010 - 2013	Steering Committee, Child Adolescent Gender Center	Member

2011 – 2017 Mental Health Track, National Transgender Health Summit Chair

DEPARTMENTAL SERVICE

- 1991 - 2003 San Francisco General Hospital, Department of Psychiatry, Member HIV/AIDS Task Force
- 1992 - 1993 San Francisco General Hospital, Department of Psychiatry, Member HIV Research Group
- 1992 - 1997 San Francisco General Hospital, Department of Psychiatry, Member Space Committee
- 1992 - 2003 San Francisco General Hospital, Department of Psychiatry, Member GLBT Issues Task Force
- 1994 - 1997 San Francisco General Hospital, Department of Psychiatry, Member Residency Training Committee
- 1996 - 2003 San Francisco General Hospital, Department of Psychiatry, Member Cultural Competence and Diversity Program
- 1996 - 2003 San Francisco General Hospital, Department of Psychiatry, Co-Chair HIV/AIDS Task Force
- 2012 - 2020 San Francisco Department of Public Health Gender Member Competence Trainings Committee
- 2013 - 2020 San Francisco Department of Public Health Transgender Member Health Implementation Task Force
- 2014 - 2020 San Francisco General Hospital, Department of Psychiatry, Member Transgender Surgery Planning Workgroup

PEER REVIEWED PUBLICATIONS

1. Berliner JA, Frank HJL, **Karasic D**, Capdeville M. Lipoprotein-induced insulin resistance in aortic endothelium. *Diabetes*. 1984; 33:1039-44.
2. Bradberry CW, **Karasic DH**, Deutch AY, Roth RH. Regionally-specific alterations in mesotelencephalic dopamine synthesis in diabetic rats: association with precursor tyrosine. *Journal of Neural Transmission. General Section*, 1989; 78:221-9.
3. Targ EF, **Karasic DH**, Bystritsky A, Diefenbach PN, Anderson DA, Fawzy FI. Structured group therapy and fluoxetine to treat depression in HIV-positive persons. *Psychosomatics*. 1994; 35:132-7.
4. Karasic DH. Homophobia and self-destructive behaviors. *The Northern California Psychiatric Physician*. 1996; 37 Nov.-Dec. Reprinted by the Washington State Psychiatric Society and the Southern California Psychiatric Society newsletters.
5. Karasic D. Anxiety and anxiety disorders. *Focus*. 1996 Nov; 11(12):5-6. PMID: 12206111
6. Polansky JS, **Karasic DH**, Speier PL, Hastik KL, Haller E. Homophobia: Therapeutic and training considerations for psychiatry. *Journal of the Gay and Lesbian Medical Association*. 1997 1(1) 41-47.

7. Karasic DH. Progress in health care for transgendered people. Editorial. Journal of the Gay and Lesbian Medical Association, 4(4) 2000 157-8.
8. Perry S, **Karasic D**. Depression, adherence to HAART, and survival. Focus: A Guide to AIDS Research and Counseling. 2002 17(9) 5-6.
9. Fraser L, **Karasic DH**, Meyer WJ, Wylie, K. Recommendations for Revision of the DSM Diagnosis of Gender Identity Disorder in Adults. International Journal of Transgenderism. Volume 12, Issue 2. 2010, Pages 80-85.
10. Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., Fraser, L., Green, J., Knudson, G., Meyer, W., Monstrey, S., **Karasic D** and 22 others. (2011). Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th Version. International Journal of Transgenderism, 13:165-232, 2011
11. Tsai AC, **Karasic DH**, et al. Directly Observed Antidepressant Medication Treatment and HIV Outcomes Among Homeless and Marginally Housed HIV-Positive Adults: A Randomized Controlled Trial. American Journal of Public Health. February 2013, Vol. 103, No. 2, pp. 308-315.
12. Tsai AC, Mimmiaga MJ, Dilley JW, Hammer GP, **Karasic DH**, Charlebois ED, Sorenson JL, Safren SA, Bangsberg DR. Does Effective Depression Treatment Alone Reduce Secondary HIV Transmission Risk? Equivocal Findings from a Randomized Controlled Trial. AIDS and Behavior, October 2013, Volume 17, Issue 8, pp 2765-2772.
13. **Karasic DH**. Protecting Transgender Rights Promotes Transgender Health. LGBT Health. 2016 Aug; 3(4):245-7. PMID: 27458863
14. Winter S, Diamond M, Green J, **Karasic D**, Reed T, Whittle S, Wylie K. Transgender people: health at the margins of society. Lancet. 2016 Jul 23;388(10042):390-400. doi: 10.1016/S0140-6736(16)00683-8. Review./> PMID: 27323925
15. Grelotti DJ, Hammer GP, Dilley JW, **Karasic DH**, Sorensen JL, Bangsberg DR, Tsai AC. Does substance use compromise depression treatment in persons with HIV? Findings from a randomized controlled trial. AIDS Care. 2016 Sep 2:1-7. [Epub ahead of print]/> PMID: 27590273
16. Strang JF, Meagher H, Kenworthy L, de Vries AL, Menvielle E, Leibowitz S, Janssen A, Cohen-Kettenis P, Shumer DE, Edwards-Leeper L, Pleak RR, Spack N, **Karasic DH**, Schreier H, Balleur A, Tishelman A, Ehrensaft D, Rodnan L, Kushner ES, Mandel F, Caretto A, Lewis HC, Anthony LG. Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents. J Clin Child Adolesc Psychol. 2016 Oct 24:1-11. [Epub ahead of print]/> PMID: 27775428
17. Milrod C, **Karasic DH**. Age Is Just a Number: WPATH-Affiliated Surgeons' Experiences and Attitudes Toward Vaginoplasty in Transgender Females Under 18 Years of Age in the United States. J Sex Med 2017;14:624–634.
18. William Byne, Dan H. Karasic, Eli Coleman, A. Evan Eyler, Jeremy D. Kidd, Heino F.L. Meyer-Bahlburg, Richard R. Pleak, and Jack Pula. Gender Dysphoria in Adults:

An Overview and Primer for Psychiatrists. *Transgender Health*. Dec 2018;57-A3. <http://doi.org/10.1089/trgh.2017.0053>

19. Identity recognition statement of the world professional association for transgender health (WPATH). *International Journal of Transgenderism*. 2018 Jul 3; 19(3):1-2. Knudson KG, Green GJ, Tangpricha TV, Ettner ER, Bouman BW, Adrian AT, Allen AL, De Cuypere DG, Fraser FL, Hansen HT, **Karasic KD**, Kreukels KB, Rachlin RK, Schechter SL, Winter WS, Committee and Board of Direct
20. **Karasic, DH** & Fraser, L. Multidisciplinary Care and the Standards of Care for Transgender and Gender Non-conforming Individuals. Schechter, L & Safa, B. (Eds.) *Gender Confirmation Surgery, Clinics in Plastic Surgery Special Issue*, Vol 45, Issue 3, pp 295-299. 2018 Elsevier, Philadelphia. <https://doi.org/10.1016/j.cps.2018.03.016>
21. Milrod C, Monto M, **Karasic DH**. Recommending or Rejecting "the Dimple": WPATH-Affiliated Medical Professionals' Experiences and Attitudes Toward Gender-Confirming Vulvoplasty in Transgender Women. *J Sex Med*. 2019 Apr;16(4):586-595. doi: 10.1016/j.jsxm.2019.01.316. Epub 2019 Mar 2.
22. ICD-11 and gender incongruence of childhood: a rethink is needed. *Lancet Child Adolesc Health*. 2019 10; 3(10):671-673. Winter S, [Ehrensaft D](#), Telfer M, T'Sjoen G, Koh J, Pickstone-Taylor S, Kruger A, Griffin L, Foigel M, De Cuypere G, **Karasic D**. PMID: 31439494.
23. Gender Dysphoria in Adults: An Overview and Primer for Psychiatrists. *Focus (Am Psychiatr Publ)*. 2020 Jul; 18(3):336-350. Byne W, **Karasic DH**, Coleman E, Eyler AE, Kidd JD, Meyer-Bahlburg HFL, Pleak RR, Pula J. PMID: 33343244; PMCID: [PMC7587914](#).
24. WPATH Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. E. Coleman, A. E. Radix, W. P. Bouman, G. R. Brown, A. L. C. de Vries, M. B. Deutsch, R. Ettner, L. Fraser, M. Goodman, J. Green, A. B. Hancock, T. W. Johnson, **D. H. Karasic**... J. Arcelus (2022) Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, International Journal of Transgender Health, 23:sup1, S1-S259, DOI: 10.1080/26895269.2022.2100644

BOOKS AND CHAPTERS

1. **Karasic DH**, Dilley JW. Anxiety and depression: Mood and HIV disease. In: *The UCSF AIDS Health Project Guide to Counseling: Perspectives on Psychotherapy, Prevention, and Therapeutic Practice*. Dilley JW and Marks R, eds. Jossey-Bass. San Francisco, 1998, pp.227-248.
2. **Karasic DH**, Dilley JW. Human immunodeficiency-associated psychiatric disorders. In: *The AIDS Knowledge Base, Third Edition*. Cohen PT, Sande MA, Volberding PA, eds. Lippincott-Williams & Wilkins, Philadelphia, 1999, pp. 577-584.

3. **Karasic DH** and Drescher J. eds. Sexual and Gender Diagnoses of the Diagnostic and Statistical Manual (DSM): A Reevaluation. 2005. Haworth Press, Binghamton, NY. (Book Co-Editor)
4. **Karasic DH**. Transgender and Gender Nonconforming Patients. In: Clinical Manual of Cultural Psychiatry, Second Edition. Lim RF ed. pp 397-410. American Psychiatric Publishing, Arlington VA. 2015.
5. **Karasic DH**. Mental Health Care of the Transgender Patient. In: Comprehensive Care of the Transgender Patient, Ferrando CA ed. pp. 8-11. Elsevier, 2019.
6. **Karasic DH**. The Mental Health Assessment for Surgery. In: Gender Confirmation Surgery – Principles and Techniques for an Emerging Field. Schechter L ed. Springer Nature, in press 2019.

OTHER PUBLICATIONS

1. **Karasic DH**, Dilley JW. HIV-associated psychiatric disorders: Treatment issues. In: Cohen P, Sande MA, Volberding P, eds., The AIDS Knowledge Base. Waltham, MA: The Medical Publishing Group/ Massachusetts Medical Society. 1994. pp. 5.31-1-5.
2. **Karasic DH**, Dilley JW. HIV-associated psychiatric disorders: Clinical syndromes and diagnosis. In: Cohen P, Sande MA, Volberding P, eds., The AIDS Knowledge Base, Second Edition. Waltham, MA: The Medical Publishing Group/Massachusetts Medical Society. 1994 pp. 5.30-1-5.
3. **Karasic DH**. A primer on transgender care. In: Gender and sexuality. The Carlat Report Psychiatry. April 2012. Vol 10, Issue 4.
4. **Karasic D and Ehrensaft D**. We must put an end to gender conversion therapy for kids. Wired. 7/6/15.

EXPERT WITNESS AND CONSULTATION ON TRANSGENDER CARE AND RIGHTS

2008 Consultant, California Department of State Hospitals

2012 Dugan v. Lake, Logan UT

2012 XY v. Ontario <http://www.canlii.org/en/on/onhrt/doc/2012/2012hrto726/2012hrto726.html>

2014 Cabading v California Baptist University

2014 CF v. Alberta

<http://www.canlii.org/en/ab/abqb/doc/2014/2014abqb237/2014abqb237.html>

2017 United Nations Development Programme consultant, transgender health care and legal rights in the Republic of Vietnam; Hanoi.

2017- 2018 Forsberg v Saskatchewan; Saskatchewan Human Rights v Saskatchewan
<https://canliiconnects.org/en/summaries/54130>
<https://canliiconnects.org/en/cases/2018skqb159>

2018 United Nations Development Programme consultant, transgender legal rights in Southeast Asia; Bangkok.

2018 Consultant, California Department of State Hospitals

2019, 2021 Consultant/Expert, Disability Rights Washington

2019, 2021 Consultant/Expert, ACLU Washington

2021 Consultant, California Department of Corrections and Rehabilitation

2021 Expert, Kadel v. Folwell, 1:19-cv-00272 (M.D.N.C.).

2021 Expert, Drew Glass v. City of Forest Park - Case No. 1:20-cv-914 (Southern District Ohio)

2021-2022 Expert, Brandt et al v. Rutledge et al. 4:21-cv-00450 (E.D. Ark.)

2021-2022 Expert, Fain v. Crouch, 3:20-cv-00740 (S.D.W. Va.)

2022 Expert, C.P. v. Blue Cross Blue Shield of Illinois, No. 3:20-cv-06145-RJB (W.D. Wash.)

2022-3 Expert, Dekker, et al. v. Weida, et al., No. 4:22-cv-00325-RH-MAF

2019-2023 Expert, Disability Rights Washington v Washington State Department of Corrections

2023 Expert, K.C. et al. v Individual Members of the Indiana Licensing Board, et al- No. 1:23-CV-595

2023 Expert, Doe, et al v Ladapo -No. 4:23-cv-00114-RH-MAF

2023 Expert, Doe et al v Thornbury -No. 3:23-cv-00230-DJH

2024 Expert Voe v Mansfield, No. 1:23-CV-864-LCB-LPA

2024 Expert Boe v. Marshall, No. 2:22-cv-184-LCB (N.D. Ala.)

2024 Expert .B. v. Premera Blue Cross, No. 3:20-cv-06145-RJB (W.D. Wash.)

2024 Expert Misanin v. Wilson, No. 2:24-cv-04734-BHH (D.S.C.)

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**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

ALISHEA KINGDOM, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, et al.,

Defendants.

Case No. 1:25-cv-00691

**DECLARATION OF DR. CATHY
THOMPSON**

I, Cathy Thompson, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

INTRODUCTION AND SCOPE OF WORK

1. I am a licensed clinical psychologist and recently retired Federal law enforcement officer with more than 20 years' experience working in correctional settings. My experience includes providing direct mental health services to incarcerated individuals inside prison and jail facilities. I later served as a national administrator for the Department of Justice's Federal Bureau of Prisons (BOP) and therefore have extensive experience in developing programs and services and drafting and implementing policies specific to the safety and treatment of individuals in BOP custody. I was involved in the development and implementation of BOP's procedures for managing transgender inmates. I retired from federal service effective September 23, 2023, and I now work as a consultant.

2. I have been retained by counsel for Plaintiffs in the class action complaint for declaratory and injunctive relief in *Kingdom v. Trump* (Trump Administration and BOP's categorical ban on gender-affirming health care for people with gender dysphoria in the custody of the Federal Bureau of Prisons), Case No.: 1:25-cv-00691. I have been asked to provide expert testimony about BOP policies and practices for transgender people prior to the executive order, and my expert opinion on the current and future impact of BOP's recent policy changes pertaining to treatment and management of transgender individuals in BOP custody.

3. My opinion, which is explained in further detail below, addresses the history of BOP's approach to managing and treating transgender people and the ways in which the recent guidance and policy issued by the BOP 1) cause harm to both those individuals and the staff who work with them, and 2) are not consistent with standards and accepted practices applicable to BOP.

4. It is my understanding that since January 2025, the BOP has rescinded its policy about transgender individuals, issued guidance prohibiting accommodations for transgender people, and directed medical staff to cease provision of gender affirming care, including hormones for all persons in custody.

5. It is my opinion that (1) a blanket ban on treating individuals who are transgender or have gender dysphoria is neither safe nor consistent with accepted practices, and (2) providing gender affirming care promotes security efforts.

PROFESSIONAL BACKGROUND

6. In 2000, I obtained my doctorate in Clinical Psychology from Texas Tech

University. As part of this degree, I completed an internship with the BOP during 1999-2000. After graduating, I continued my career with the BOP which spanned over 23 years until my retirement in 2023.

7. During more than two decades with BOP, I held positions of increasing responsibility in both prisons and administrative offices across the United States wherein I not only practiced psychology, but worked collaboratively and closely with other disciplines to meet the agency's mission of operating facilities that were safe while also delivering quality, evidence-based services.

8. For approximately the first decade, I promoted through positions located inside prisons. I provided treatment to men and women with a wide range of presenting issues. I provided supportive counseling to individuals struggling with issues of gender identity and more intensive psychological interventions for comorbid gender dysphoria and depressive disorders, posttraumatic stress disorder (PTSD), or anxiety disorders. Consistent with the standards mandated by the Prison Rape Elimination Act (PREA), I conducted assessments and provided treatment to incarcerated victims of sexual abuse.

9. In 2009, I was chosen for my first administrative oversight position within the BOP. In this capacity, I began to not only provide safe treatment and management directly, but to start giving guidance to others on how to create and maintain proper correctional environments through reliance on policy and accepted practices.

10. Five years later, I was promoted to a national level mental health position. My primary responsibility was the oversight, development, and implementation of substance use and mental health treatment programs. My work included ensuring these

services were relevant and beneficial to all individuals in BOP custody and addressing the care of transgender individuals was a large part of that work.

11. I had primary responsibility for ensuring BOPs residential treatment programs operated as modified therapeutic communities (MTCs). This is an evidence-based approach to residential substance use treatment designed to maximize the positive benefits of a supportive community that welcomes all members.¹

12. While serving in this role, I was asked to be the acting national administrator for psychology services. During this time, BOP's policies regarding transgender inmates advanced significantly, and I was part of those efforts. I advised both my supervisors and institution staff on the accepted practices in caring for this population. I also provided input on policy development, and as it was implemented, I provided consultation and expertise to BOP's Transgender Executive Committee (TEC) regarding placement for transgender people that maximized opportunities for access to mental health treatment, reentry programming, and personal safety. I collaborated with other subject matter experts to develop lesson plans for annual training provided to all BOP staff on a wide range of psychological issues, including the accepted practices in the management of transgender people in secure settings. Most importantly, I was in a national leadership role advising on the importance of providing individualized and affirming services to transgender people, and I saw the benefits of this approach firsthand.

¹ De Leon, George. (2000). *The Therapeutic Community*. Springer Publishing Company.

13. Throughout the course of my BOP career, I remained engaged in scientific research which I published and presented outside the agency. I also taught courses at the college level. I retired in 2023 and do part-time consulting and treatment work. **My resume is attached as Exhibit A.**

14. I am being compensated at the rate of \$500 per hour for my time completing this declaration.

BASES FOR OPINIONS

15. In preparing this report, I have relied on my training; my years of experience working in correctional settings and my specific experience within the BOP making care decisions about individuals who are transgender; my knowledge of the policies and practices surrounding these issues in both BOP and other correctional systems; and my knowledge of the relevant literature and standards.

16. In addition, in preparing this report, I have reviewed the following information to inform my opinion: the class action complaint filed March 10, 2025 and the two associated exhibits. I also reviewed publicly available materials as cited in this document.

BRIEF HISTORY OF BOP'S TRANSGENDER PRACTICES AND STANDARDS

17. As part of operating safe facilities, over the last several decades correctional systems have begun to have a better understanding of how to provide care to transgender inmates, just as they have provided care to individuals with any other

medical, mental health, learning, or other need. These efforts are supported by data demonstrating transgender individuals are both more likely to become involved in the justice system, and also more likely to experience sexual assault while incarcerated.^{2 3} Thus, in service to operating a safe facility and meeting the agency mission, sound correctional practices have long included provision of individualized health care and accommodations to transgender or intersex persons.

18. In 2003, the Prison Rape Elimination Act (PREA) was signed into law, and in 2012, the Department of Justice published the PREA Final Rule, which included standards for implementing the statute.^{4 5} PREA drew national attention to the needs of the incarcerated transgender population, and was the first federal law identifying best care practices. Five standards specify requirements addressing transgender persons in carceral settings.

19. One of those standards, PREA standard 115.42(c) establishes the necessity of individualized assessments, stating, “the agency shall consider on a case-by-case basis whether a placement would ensure the inmate’s health and safety, and whether the placement would present management or security problems.” The Department of Justice

² Grant, Jaime M.; Mottet, Lisa A.; Tanis, Justin; Harrison, Jack; Herman, Jody L.; Keisling, Mara (2011). [Injustice at Every Turn: A Report of the National Transgender Discrimination Survey](#) (PDF) (Report). Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force.

³ Beck, A. J., & Shandler, S. (2013). *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011-2012*. U.S. Department of Justice, Bureau of Justice Statistics.

⁴ 28 CFR Part 115 National Standards To Prevent, Detect, and Respond to Prison Rape; Final Rule.

⁵ Prison Rape Elimination Act (PREA) of 2003 (P.L. 108-79).

also determined assigning housing to a transgender person based solely on genitalia is a violation of PREA.⁶

20. Mental health and medical treatment of transgender individuals was improving through the establishment of standards or accepted practices while PREA standards were being developed and issued. Research indicates, for example, that transgender individuals are at higher risk for suicide than non-transgender persons.⁷ In 2015, the American Psychological Association issued guidance on working with transgender and non-binary individuals, including a key principle that “Psychologists strive to recognize the influence of institutional barriers on the lives of [transgender] people and to assist in developing [transgender]-affirmative environments.”^{8 9} Similarly, the American Medical Association has made a number of public statements supporting the importance of and right to access gender affirming interventions.¹⁰

21. Meanwhile, BOP along with correctional systems across the country and world were developing procedures to ensure appropriate care for transgender inmates.

BOP POLICY AND PROCEDURES IMPACT

⁶ National PREA Resource Center. (2016). *FAQ: Does a policy that houses transgender or intersex inmates based exclusively on external genital anatomy violate Standard 115.42(c) & (e)*.

⁷ Marshall E, Claes L, Bouman WP, et al. (2016). *Non-suicidal self-injury and suicidality in trans people: A systematic review of the literature*. *Int Rev Psychiatry*. 28, 58–69.

⁸ American Psychological Association. (2015). *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*. *American Psychologist*, 70 (9), 832-864. Retrieved from <https://www.apa.org/practice/guidelines/transgender.pdf>

⁹ *Id.*, at 840.

¹⁰ See <https://transhealthproject.org/resources/medical-organization-statements/american-medical-association-statements/>

22. The BOP is the largest correctional system in the United States and operates 122 prison facilities across the country. Facilities are classified into four security-level categories, and men and women are housed in separate units or facilities. Over 35,000 employees work for BOP.

23. BOP, like most correctional systems, utilizes policy and training as dual methods to ensure staff are complying with the law and using the most accepted and safest practices available. Any policy is developed in response to a need for guidance and grounded in science, law, and safety.

24. Going back to the beginning of my BOP career in 1999, BOP has recognized that individuals who are transgender or intersex may not easily fit into BOP's housing structure. Thus, senior officials at the agency have made decisions about the most appropriate housing for these persons, based on the safety of both the individual and others. Yet, BOP did not have a policy, and while transgender people did receive treatment and in some cases were housed in accordance with their gender identity, , the lack of agency directive raised questions as to how to best make such decisions.

25. Following the passage of PREA in 2003, BOP updated its policy on sexual abuse to ensure it was compliant with the statute and standards.¹¹ In particular, the policy included language from the PREA standards and explained to staff in clear language the importance of individualized decision-making about the safety of transgender inmates.

26. While staff became familiar with these standards and recognized the

¹¹ DOJ-BOP. (2015). Program Statement 5324.12, Sexually Abusive Behavior Prevention and Intervention.

benefits of the individualized approaches, questions also arose as to how to make the best, fairest, and safest decisions with regard to housing and health care treatment. Many staff, particularly in remote locations, were not well acquainted with transgender terminology, for example, or were not familiar with external guidance documents, such as the standards from the World Professional Association for Transgender Health (WPATH).¹² Further, BOP data demonstrated a significant over-representation of transgender persons in restrictive housing settings, often for safety instead of disciplinary reasons.

27. Individuals with gender dysphoria experience significant clinical distress and, as noted previously, are at increased risk for suicide. Before BOP implemented national policy that was consistent with the accepted practices in the care and management of transgender people in prison settings, it was my experience that transgender individuals in BOP custody were more likely to require services to manage mental health crises than incarcerated individuals who are not transgender. In cases of severe gender dysphoria, risks included attempts at self-surgery and suicide.

28. Thus, in 2016, BOP began to develop national policy and guidance on the management and treatment of transgender persons in custody. This meant that, consistent with BOP labor relationships agreements, agency leadership began meeting with union representatives to develop what would be published in January 2017 as the Transgender

¹² World Professional Association for Transgender Health. Standards of care. Retrieved from <https://wpath.org/publications/soc8/>

Offender Manual (TOM).^{13 14}

29. Until recently, all policies issued by BOP underwent significant negotiation and review by both management and bargaining unit staff. Following several months of this review, the first TOM provided a great deal of information and direction to BOP staff. In addition to providing definitions, the policy set requirements for training, accommodations, pronoun usage, medical treatment, and housing placement.

30. I worked alongside the person leading TOM policy development, providing input specific to treatment and later helping her ensure implementation. Speaking about policy development, she described it as, “just a safe practice that comported with the law.”¹⁵ The key components of the policy were identifying how to implement accepted practices and ensuring any gender affirming services were provided based on individual need.

31. The TOM also established clear parameters around a decision-making body, known as the Transgender Executive Council (TEC). Membership on this body included senior leaders from the Women and Special Populations Branch as well as the senior psychologist, psychiatrist, security expert, and medical administrator in the

¹³ DOJ-BOP. (2017, 2018, 2020). Program Statement 5200.08, Transgender Offender Manual.

¹⁴ The TOM was updated two times. The first update clarified factors in placement and the second elucidated surgery processes. The BOP has since deleted all versions of the TOM from its website as a result of President Trump’s Executive Order. The most recent version, dated Jan. 13, 2022, is preserved and available at <https://perma.cc/4BP6-YWRP> and is **attached as Exhibit B**.

¹⁵ Schwartzapfel, B. (January 23, 2025). *Trump’s Order Takes Aim at Transgender People in Prison*. The Marshall Project.

agency.

32. Although BOP had provided mental health and medical care before the TOM was issued, once the policy was in place, national administrators began to roll out training and supports for staff to ensure implementation was done with fidelity. Training was delivered to all employees, and advanced continuing education sessions were delivered to clinicians who delivered therapy or prescribe hormones.

33. In keeping with these efforts to ensure treatment was tied to evidence and that guidance was available, the BOP's Health Services Division also created a Transgender Clinical Care Team (TCCT) made of experienced medical professionals who could offer guidance to prescribers working in the prisons who may not have expertise in endocrinology or the prescription of hormones. Importantly, clinical assessments for hormone medication or other medical treatments included assessments by both psychologists and medical providers for the presence of gender dysphoria. In other words, to receive medical treatment, a person must actually have a condition warranting such an approach. Hormones or surgeries were provided only based on individual clinical need. **Attached as Exhibit C** are the most recent version of the clinical guidelines for health care staff, dated June 2023. Again, these guidelines were taken down from the BOP website after President Trump's Executive Order, but are also preserved at <https://perma.cc/U5UT-S9PN>. These clinical guidelines were an update of the previous guidelines from health care staff that had been operative since December 2016.

34. At the same, mental health procedures were developed to guide psychologists in the best ways to treat transgender people. While psychologists do not

prescribe medication in BOP, they were taught the benefit of gender affirming care, including hormones, in improving safety and wellbeing. This same information was conveyed to all staff because gender affirming care can reduce distress.

35. Support groups and other types of mental health treatment were also developed, eventually becoming part of BOP's list of approved programs under the First Step Act.

36. Accommodations were also described in policy, again as ways to better care for and manage the inmate population. Accommodations included allowing for the use of preferred pronouns and the provision of undergarments to match gender identity. Individuals were also given the option to purchase gender affirming items other than medication and undergarments that were allowed inside prison but required the use of personal funds (such as make-up). As noted, these items were intended to improve individual functioning, decrease crises, and therefore not only improve individuals' health but also make prisons safer.

37. Finally, the TOM created clear processes and benchmarks for a transgender individual to potentially be housed at a facility that aligns with their gender identity. The TOM took an approach grounded in safety where decisions were made by the TEC based on a number of factors and requirements.

38. Within a few years of the TOM's issuance in January 2017, BOP staff had fully implemented the policy. Gender affirming care was consistently available when indicated, and transgender people were afforded greater opportunities for engagement and positive programming that reduced psychological distress, reduced sexual

victimization, increased personal and institutional safety, and improved reentry outcomes. Agency policies direct consistent practice across all components and are reinforced by positive outcomes, and the TOM was no different.

DISCUSSION AND ANALYSIS OF RECENT BOP POLICY CHANGES

39. In early 2025, BOP abruptly rescinded a number of policies, including the TOM, following a Presidential Executive Order. BOP staff were suddenly operating without a policy but no guidance about what services or practices were supposed to replace the policy.

40. On February 21, 2025, Dana DiGiacomo, Acting Assistant Director of the BOP Reentry Services Division, and Shane Salem, Assistant Director of the BOP Correctional Programs Division, two individuals with whom I worked at BOP, issued a memo clarifying that BOP had been temporarily blocked by legal action from removing medical and mental health care from transgender persons in custody, but was proceeding with other restrictions. (This memo is filed with the Court at Docket 1-1.) Specifically, the aforementioned accommodations of gender affirming pronouns, undergarments, and purchased personal items were to cease. Additionally, programs for transgender persons and training on accepted practices with them stopped. Finally, the TEC itself was renamed and repurposed. Despite being authored by two individuals with no professional expertise on transgender care and no clinical degrees, the memo also indicated the TEC would no longer refer people for surgery.

41. A week later, Chris Bina, a pharmacist who leads BOP's Health Services Division, issued a memo stating no BOP funds could be used to treat any transgender

person in a way that validates their gender identity. It specifically states that “no Bureau of Prisons funds are to be expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate’s appearance to that of the opposite sex.” (This memo is filed with the Court at Docket 1-2.)

42. The blanket ban on gender affirming care, is not only inconsistent with PREA and professional association guidance, it is also unsafe.

43. First, BOP’s TOM was consistent with the law and medical standards. It served not only as a guide for BOP, but for other systems because it was effective.¹⁶ The TOM was tied to PREA, whereas the new BOP approach is inconsistent with the individualized approach to housing required under PREA. Similarly, the new BOP approach is not consistent with psychological or medical association positions on the importance of delivering individualized gender affirming care and treatment to transgender persons who have a clinical need for that care.

44. Not only are these new BOP directives incompatible with accepted practices and law, they can cause significant harm and danger. Denying gender-affirming hormones to patients with a clinical need for such treatment has negative consequences, including causing or exacerbating distress and depression. Additionally, denying hormone therapy and access to other accommodations and treatments for gender dysphoria will bring about the return of the dysphoric symptoms, potentially causing

¹⁶Murphy, M., Et. al. (2023). *Implementing Gender-Affirming Care in Correctional Settings: A Review of Key Barriers and Action Steps for Change*. Journal of Correctional Health, 29(1).

attempts to self-castrate, self-harm, suicide, and aggression. All of these create safety concerns not only for people who are transgender, but for everyone who works or is incarcerated in the entire system. And with BOP's staffing crisis, there simply are not enough clinicians to manage the increased suicide watches and crisis, which could be deadly.¹⁷

45. Instead, BOP's former approach of providing gender affirming health care when indicated, as well as accommodations that support social transition under the TOM, was effective in maintaining transgender individuals' health and promoting institutional safety. Providing this care improves the agency goals of security and rehabilitation. Prohibiting such care undermines these goals.

CONCLUSION

46. BOP has the responsibility of managing and treating everyone in its custody, which means individuals with all sorts of health issues and conditions, including people who have gender dysphoria.

47. Treatment and care in BOP involves evidence-based approaches, and has

¹⁷ Separate from the changes specific to transgender policies, BOP for years has experienced a crisis of custody and health care staffing shortages. Staffing shortages are evident across every job type, from psychologists to correctional officers. Moreover, under the new Administration, BOP announced that it will "greatly reduce, and in some cases eliminate, retention incentives across the agency, effective March 23, 2025." *See* Testimony of Kathleen Toomey, BOP Associate Deputy Director, before the U.S. House Appropriations Subcommittee on Commerce, Justice, Science, and Related Agencies during a hearing on Oversight of the Federal Bureau of Prisons, Feb. 26, 2025, at <https://docs.house.gov/meetings/AP/AP19/20250226/117920/HHRG-119-AP19-Wstate-ToomeyK-20250226.pdf>. This cut in salaries is likely to worsen staffing problems. As a result of these staffing shortages, all incarcerated individuals – not only those who are transgender – are likely to receive less medical and mental health care than they need.

always been individualized. Not only does it comport with the law, but it is also an accepted practice to provide treatment and accommodations based on individual factors. Prisons that support individual needs are safer and have fewer crises. I have grave concerns about the well-being of transgender individuals in BOP custody and the continued safe operations within BOP, should its ban on providing individualized care to transgender persons continue.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 17th day of March, 2025.


Dr. Cathy Thompson

EXHIBIT A

EXHIBIT A – RESUME OF CATHY THOMPSON

EDUCATION

Ph.D. in Clinical Psychology – Texas Tech University (APA Accredited), 2000
Dissertation: Gender Effects, Consistency, and Assessment in Coping
Licensed Clinical Psychologist – Texas State Board of Examiners of Psychologists
(Since 2002)

M.A. in Clinical Psychology – Texas Tech University (APA Accredited), 1996

B.A. in Psychology (Summa Cum Laude) – Texas Tech University, 1992
Minor: Family Studies
Member of Psi Chi & National Golden Key Honor Society

PROFESSIONAL EXPERIENCE

2025 - Present
Consultant
AMM Solutions
Washington D.C.

Provide consultation, training and subject matter expertise to include investigative support, litigation support and expert witness testimony on a wide range of correctional and mental health topics. Analyze complaints to develop mitigation reports or strategy guidance. Deliver workshops and design curricula and interventions.

2024 - Present
Clinical Psychologist, Owner
Thompson & Associates Psychological Services, PLLC
North Richland Hills, TX

Provide comprehensive psychological services to a diverse client population. Administer psychological assessments to inform diagnosis and individualized treatment planning. Conduct individual therapy sessions for clients dealing with anxiety, depression, trauma, and relationship issues using evidence-based interventions. Offer expert guidance on substance use treatment, stress management, and behavioral interventions.

2024 - Present
Trainer and Consultant
The Change Companies
Carson City, NV

Develop and deliver training on evidence-based interventions, program fidelity, and best practices in behavioral health treatment. Consult with organizations and professionals to enhance the implementation of evidence-based practices in behavioral health and substance use treatment. Facilitate workshops and provide expert guidance on treatment effectiveness, compliance, and program development strategies.

2018 - 2023

National Chief of Drug Treatment Programs/Acting National Psychology Services
Administrator
Federal Bureau of Prisons (Department of Justice)
Washington, D.C.

Responsible for coordinating and evaluating all services and activities of the agency's substance use treatment programs (both residential and non-residential) for federal offenders incarcerated in over 120 correctional facilities. Coordinated a system of technical assistance and training to ensure compliance with policy and best standards of clinical practice as related to all facets of correctional psychology. Analyzed information and provided recommendations for the formulation, establishment, or modification of program objectives, plans, and policies. Managed a \$15M+ budget and supervised a diverse team of psychologists, clinicians, and administrative staff. Responded to high-level inquiries from various oversight bodies, including the Government Accountability Office (GAO) and the Office of the Inspector General (OIG). Served as senior agency psychologist on Transgender Executive Committee.

2015 - 2018

Supervisory Psychology Treatment Program Coordinator
Federal Bureau of Prisons (Department of Justice)
Washington, D.C.

Led teams of subject matter experts who provided on-site technical assistance and training to ensure compliance with policy and best standards of clinical practice as related to all facets of correctional psychology. Supervised a multidisciplinary team, including psychologists, clinicians, and administrative personnel. Spearheaded a major update of the agency's data analysis system to enhance tracking and ensure program utilization targets were met.

2013 - 2015 Psychology Treatment Program Coordinator
Federal Bureau of Prisons (Department of Justice)
Annapolis Junction, MD

Provided on-site technical assistance and training to ensure compliance with policy and best standards of clinical practice as related to all facets of correctional psychology. Served as the Employee Assistance Program Coordinator for Regional Office staff,

providing support and resources to enhance employee well-being. Engaged in staff recruitment efforts to attract and retain top talent within the agency.

2009 - 2013

Transitional Drug Abuse Program Coordinator
Federal Bureau of Prisons (Department of Justice)
Annapolis Junction, MD

Responsible for the procurement and administration of over 45 contracts for community-based substance use, mental health, and sex offender treatment, ensuring compliance with regulations, performance standards, and fiscal accountability. Managed a \$15M+ budget and supervised a diverse team of clinicians and administrative staff.

1999 - 2009 Additional Roles

Federal Bureau of Prisons (Department of Justice)

Internship Program Coordinator – Developed and implemented a pre-doctoral psychology internship program, gaining agency approval. Coordinated site registration, designed training rotations, and authored the Internship Brochure and Training Manual. Managed application reviews, interview processes, and applicant ranking. Provided clinical and administrative supervision of interns and psychologists.

Challenge Program Coordinator – Managed a large residential treatment program for high- security male offenders, addressing substance use and mental health needs. Provided therapy, crisis intervention, psychological evaluations, and suicide risk assessments for all incarcerated individuals, including women, transgender people, and veterans. Provided clinical and administrative supervision of subordinate staff.

Step-Down Program Coordinator – Managed a large residential treatment program for severely mentally ill male offenders. Provided therapy, crisis intervention, psychological evaluations, and suicide risk assessments for all incarcerated individuals, including special populations such as transgender people and veterans. Provided clinical and administrative supervision of subordinate staff.

Drug Abuse Program Coordinator – Managed a non-residential drug abuse program at a medium-security federal prison. Provided individual and group therapy, crisis intervention, and suicide risk assessments. Served as a Mental Health Consultant for the Hostage Negotiation Team. Provided clinical and administrative supervision of subordinate staff.

Post-Doctoral Psychologist – Conducted individual and group psychotherapy for male offenders. Completed forensic evaluations to determine competency and responsibility.

Managed the Suicide Prevention Program, conducted extensive audits of departmental operations, delivered staff training, and consulted with Human Resources regarding hiring of qualified personnel.

TEACHING EXPERIENCE

Contributing Faculty – Adtalem Global Education (2004–Present)

Responsible for instructing graduate foundational and advanced graduate psychology courses, serving as dissertation committee member, and overseeing practicum/internship field experiences.

Adjunct Instructor – South Plains Junior College (1995–1999)

Responsible for all phases of teaching undergraduate General Psychology and Human Growth and Development courses, including the preparation and administration of lectures, construction and administration of examinations, and the computation and assignment of course grades. Lecture format with approximately 25 undergraduate students per semester. Fourteen sections taught.

Adjunct Instructor – Texas Tech University (1995–1997)

Responsible for all phases of teaching a senior-level undergraduate Abnormal Psychology course, including the preparation and administration of lectures, construction and administration of examinations, and the computation and assignment of course grades. Lecture format with approximately 50 undergraduate students per semester. Five sections taught.

PROFESSIONAL AFFILIATIONS

Member, American Psychological Association (APA) (Since 1995)

Member, APA Division 18: Psychologists in Public Service (Since 2000)

PUBLICATIONS & PRESENTATIONS

Publications:

Cook, S. W., Thompson, C. L., & Coca-Lyle, V. A. (2000). The psychology of stress and coping. In *Management of Stress and Eating Disorders for Women and Children* (2nd ed.), CRC Press.

Selected Presentations:

Thompson, C. L. (2023, August). Substance use disorders and treatment options for justice-involved populations. Presentation given at the 2023 National Pretrial Services Leadership Conference.

Thompson, C. L. (2022, August). Meeting the needs of incarcerated women: Best

practices. Presentation given at the American Psychological Association National Convention, Minneapolis, MN.

Thompson, C. L. (2021, November). Treatment of substance use and associated mental illness in the federal prison system in the United States. Presentation given at the United Nations Office on Drugs and Crime technical consultation.

Thompson, C. L. (2019, August). Federal Bureau of Prisons: Drug abuse programs. Presentation given at the American Psychological Association National Convention, Chicago, IL.

Thompson, C. L. (2012, May). Evolving perspectives on reentry. Presentation given at the 2012 Mid-Atlantic Regional Contractors Conference, Nashville, Tennessee.

Thompson, C. L., & Cook, S. W. (2000, August). Dispositional versus situational assessment, consistency, and gender effects in coping. Poster presentation given at the American Psychological Association National Convention, Washington, DC.

KEY SKILLS & EXPERTISE

Clinical Psychology & Mental Health

- Licensed clinical psychologist with over 20 years of experience

- Expertise in psychological assessments, therapy, and crisis intervention

- Expertise in special populations, including women, veterans, and transgender people

- Specialized in substance use treatment, trauma, and evaluations

Corrections & Criminal Justice

- Extensive career in the Federal Bureau of Prisons, holding leadership roles

- Developed and managed residential and non-residential treatment programs for incarcerated individuals

- Expertise in correctional policy, reentry programs, and offender rehabilitation Program Development & Administration

Designed and implemented large-scale treatment programs for diverse correctional populations and settings

- Managed budgets exceeding \$15M and supervised multidisciplinary teams

- Developed training curricula for behavioral health professionals

- Ensured policy compliance and program effectiveness through auditing and technical assistance

Leadership & Executive Management

- Served as National Chief of Drug Treatment Programs for the Federal Bureau of Prisons

- Led national teams of psychologists, clinicians, and administrative staff

Provided expert consultation and support in correctional psychology
Experienced in soliciting, awarding, and managing federal contracts

Teaching & Academic Contributions

Contributing faculty member for graduate psychology programs since 2004
Extensive experience in curriculum development and dissertation advisement
Taught undergraduate and graduate courses in psychology for multiple institutions

Public Speaking & Expert Testimony

Speaker at national and international conferences on substance use, reentry, and correctional psychology
Presented at the American Psychological Association National Convention and United Nations Office on Drugs and Crime
Provided expert witness testimony and consultation on legal cases involving mental health and corrections

Publications & Research

Published works in psychology and behavioral health, focusing on stress, coping, and substance use disorders
Conducted research on gender effects in coping and correctional psychology

Dr. Thompson's expertise spans clinical psychology, correctional mental health, program administration, and policy development, making her a leader in the field of correctional psychology and behavioral health treatment.

EXHIBIT B



U.S. Department of Justice
Federal Bureau of Prisons

PROGRAM STATEMENT

OPI: RSD/WASPB
NUMBER: 5200.08
DATE: January 13, 2022

Transgender Offender Manual

/s/

Approved: M.D. Carvajal
Director, Federal Bureau of Prisons

1. PURPOSE AND SCOPE

To ensure the Bureau of Prisons (Bureau) properly identifies, tracks, and provides services to the transgender population.

a. Program Objectives. Expected results of this program are:

- This policy provides guidance to staff in dealing with the unique issues that arise when working with transgender inmates.
- Institutions ensure transgender inmates can access programs and services that meet their needs as appropriate, and prepare them to return to the community.
- Sufficient resources will be allocated to deliver appropriate services to transgender inmates.
- Staff will complete training, enabling them to work effectively with transgender inmates.
- To enhance staff's understanding of the increased risk of suicide, mental health issues and victimization of transgender inmates.

b. Summary of Changes

Rescinded P5200.04 CN-1 Transgender Offender Manual (5/11/2018)

This reissuance incorporates the following modifications:

- Clarified duties and responsibilities of various staff.
- Added an institution requirement for maintaining a copy of the Case Management Activity (CMA) Assignment form BP-A1110, Consent Form for Transgender Inmates. Inmates can no longer request to have a CMA assignment removed, and then re-added at a later date.
- Clarified transfer, consultation, and program requirements.

- Updated guidance regarding initial designation and redesignation procedures for transgender offenders.
- Added information about gender affirming surgery.

c. **Institution Supplement.** None required. Should local facilities make any changes outside changes required in national policy or establish any additional local procedures to implement national policy, the local Union may invoke to negotiate procedures or appropriate arrangements.

2. DEFINITIONS

Gender – a construct used to classify a person as male, female, both, or neither. Gender encompasses aspects of social identity, psychological identity, and human behavior.

Gender identity – a person’s sense of their own gender, which is communicated to others by their gender expression.

Gender expression – includes mannerisms, clothing, hairstyle, and choice of activities.

Gender nonconforming – a person whose appearance or manner does not conform to traditional societal gender expectations.

Transgender – the state of one’s gender identity not matching one’s sex assigned at birth. For the purposes of this policy, a transgender inmate is one who has met with a Bureau Psychologist and signed the form indicating consent to be identified within the agency as transgender. This step allows accommodations to be considered.

Cisgender – the state of one’s gender identity matching one’s sex assigned at birth.

Sexual orientation – the direction of one’s sexual interest towards members of the same, opposite, or both genders (e.g., heterosexual, homosexual, bisexual, asexual). Sexual orientation and gender identity are not related.

Gender Dysphoria (GD) – a mental health diagnosis currently defined by DSM-5 as, “A strong and persistent cross-gender identification. It is manifested by a stated desire to be the opposite sex and persistent discomfort with his or her biologically assigned sex.” Not all transgender inmates will have a diagnosis of GD, and a diagnosis of GD is not required for an individual to be provided services.

Intersex – a person whose sexual or reproductive anatomy or chromosomal pattern does not seem to fit typical physiological definitions of male or female. Not all intersex people identify as

transgender; unless otherwise specified, this policy does not apply to intersex people who do not identify as transgender.

Transition – measures that change one’s gender expression or body to better reflect a person’s gender identity.

Gender Affirming – describes behaviors or interventions that support the gender identity of a person.

3. STAFF RESPONSIBILITIES

The following Bureau components are responsible for ensuring consistent establishment of the programs, services, and resource allocations necessary for transgender offenders.

a. Central Office

(1) The **Women and Special Populations Branch (WASPB)** is the agency’s primary source and point of contact on accommodation/transition, classification, management, and intervention/treatment programs and practices for transgender inmates in Bureau custody. The Branch is responsible for the following functions as they relate to transgender inmates:

- Engaging stakeholders, including serving as the primary point of contact on issues affecting transgender inmates with external entities including judges, congress, and advocacy groups.
- Ensuring the Bureau offers appropriate services to transgender inmates.
- Preparing budget requests to deliver national and pilot programs or services affecting transgender inmates.
- Providing guidance and direction to staff and institution, region, and agency leadership on transgender issues.
- Developing and implementing staff training on transgender issues.
- Building a research-based foundation for the Bureau’s work with transgender inmates, including implementation support and intervention services.
- Presenting at internal and external conferences/events regarding the agency’s transgender inmates’ practices.
- Developing and monitoring monthly reports on the transgender population and institutional programs.
- Conducting an annual survey of transgender inmates in the Bureau and sharing results with internal and external stakeholders.
- Providing national oversight of pilot programs and initiatives serving transgender offenders.
- Overseeing the Transgender Executive Council (TEC).
- Ensure that a National Program and Policy Coordinator is assigned to each Region who will meet quarterly to discuss staffing and programming needs of transgender inmates.

(2) The **Health Services Division** oversees all medical and psychiatric guidance and treatment as it applies to transgender inmates. Clinical guidance on the most current research-driven clinical medical and psychiatric care of transgender inmates will be provided at the direction of the Medical Director. The Medical Director only receives referrals from the TEC and determines whether gender affirming surgery requests will be referred to a surgeon.

(3) The **Psychology Services Branch** oversees all mental health programs and services as they apply to transgender inmates, to include providing advice and guidance on identification and evaluation of transgender inmates, and making recommendations for treatment needs of transgender inmates and/or inmates with GD.

(4) **Central Office Branches** of Correctional Services, Psychology Services, Education, Correctional Programs, Reentry Affairs, Residential Reentry Management, Health Programs, Litigation, Chaplaincy Services, Intelligence and Counter Terrorism Branch, and Trust Fund meet annually with the Women and Special Populations Branch to discuss transgender population needs and evaluate current gender-responsive services. The National Union and the Central Office LGBT Special Emphasis Program Manager will be invited to attend these meetings.

(5) The **Transgender Executive Council (TEC)** will consist of senior level staff members (GS-14 and above) from the Women and Special Populations Branch, the Psychology Services Branch, Health Services Division, and the Designation and Sentence Computation Center (DSCC). The team is led by the Senior Deputy Assistant Director, Reentry Services and also includes the Senior Deputy Assistant Director, Correctional Programs Division (DSCC), and the Senior Deputy Assistant Director, Health Services. The TEC is the agency's official decision-making body on all issues affecting the transgender population. It will meet a minimum of monthly to offer advice and guidance on unique measures related to treatment and management needs of transgender inmates and/or inmates with GD, including training, designation issues, and reviewing all transfers for approval. Staff or inmates may raise issues on specific inmates to the TEC through the Women and Special Populations Branch. The Office of General Counsel is consulted as needed.

b. Regional Offices

- Provide oversight to institutions regarding services and other relevant trends managing transgender inmates.

c. Institutions

The Warden will establish a multi-disciplinary approach to the management of transgender inmates. The Associate Warden of Programs is the primary point of contact in the institution for transgender issues and will consult as needed with the Chief Psychologist, Captain, Clinical

Director, Unit Manager, or other individuals as appropriate; and specifically to:

- Ensure transgender inmates have access to services.
- Enter tracking information for self-identified transgender inmates by updating SENTRY CMA assignments and other databases (e.g., PDS).
- Maintain a copy of the Case Management Activity (CMA) SENTRY Assignment Consent Form for Transgender Inmates (BP-A1110) in the Central File and Psychology Data System (PDS).
- Provide appropriate reentry resources that may be specific to the population.
- Advise the Local Union of transgender inmate management issues.
- Consult and refer transgender inmates to the TEC.
- Provide programming developed by the Reentry Services Division for transgender inmates.

4. STAFF TRAINING

Staff are provided specialized training in working with unique issues when managing transgender inmates as part of annual training. Institutions housing transgender inmates should provide additional training.

The Women and Special Populations Branch is responsible for developing training materials and current information on the management of transgender inmates. This information will be made available to staff via the Bureau's intranet.

In addition, the Prison Rape Elimination Act (PREA) regulations incorporated into the BOP Program Statement, **Sexually Abusive Behavior Prevention and Intervention Program** have training requirements concerning pat searches and communication skills for transgender inmates. See 28 C.F.R. § 115.15(f) and 115.31 (a) (9). Please refer to this Program Statement regarding implementation of those training requirements.

Staff will be provided adequate time to complete these trainings during duty hours. Staff will be provided proper relief to complete the training.

5. INITIAL DESIGNATIONS

The PREA regulations (section 28 C.F.R. § 115.42 (c)), incorporated into the Program Statement **Sexually Abusive Behavior Prevention and Intervention Program**, state:

“In deciding whether to assign a transgender or intersex inmate to a facility for male or female inmates...the agency shall consider on a case-by-case basis whether a placement would ensure the inmate's health and safety, and whether the placement would present management or security problems.”

Upon receipt of information from a Pre-Sentence Report, court order, U.S. Attorney's Office, defense counsel, the offender, or other source that an individual entering BOP custody is

transgender or intersex, designations staff will refer the matter to the TEC.

Institution staff managing pretrial or holdover offenders must also refer cases to the TEC for review. Any TEC recommendations concerning pretrial inmates will be coordinated with the appropriate United States Marshals Service District Office.

The TEC will consider factors including, but not limited to, an inmate's security level, criminal and behavioral/disciplinary history, current gender expression, programming, medical, and mental health needs/information, vulnerability to sexual victimization, and likelihood of perpetrating abuse. The TEC may also consider facility-specific factors, including inmate populations, staffing patterns, and physical layouts (e.g., types of showers available). The TEC will consider the wellbeing of all inmates while exploring appropriate options available to assist with mitigating risk to the inmate, to include but not limited to cell and/or unit assignments, application of management variables, programming missions of the facility, and security of the institution.

It will be documented on all SENTRY designation notes for transgender inmates that the TEC reviewed the inmate for appropriate institution designation.

6. HOUSING AND PROGRAMMING ASSIGNMENTS

During Initial Classification and subsequent Program Reviews, unit management staff will review the inmate's current housing unit status and programming available for transgender inmates. This review will be documented by Unit Management staff in the inmate central file and for holdovers in the holdover file, with institution oversight by the Associate Warden.

The reviews will consider on a case-by-case basis that the inmate placement does not jeopardize the inmate's wellbeing and does not present management or security concerns.

In making housing unit and programming assignments, a transgender or intersex inmate's own views with respect to his/her own safety must be given serious consideration.

Transgender inmates shall be given the opportunity to shower separate from other inmates when individual shower stalls are unavailable.

The agency shall not place transgender or intersex inmates in dedicated facilities, units, or wings solely on the basis of such identification or status. The only exception is if such placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such inmates.

Wardens will consult with WASPB prior to submitting a designation request to the DSCC for the redesignation of transgender inmates when the designation is related to the individual's

transition. The DSCC and Office of Medical Designations will consult with WASPB prior to the designation or redesignation of all transgender inmates.

In situations where the transfer request is related to progressing the individual inmate's transition (i.e., transfer to a different sex facility) the TEC will consider the case. Prior to considering the case, the Warden will submit documentation to the TEC showing the inmate has met the minimum standards of compliance with programs, medications and mental health treatment, and meeting hormone goal levels. Ordinarily, inmates will not be submitted to the TEC for consideration until they have maintained one year clear conduct for 100 and 200 series incident report sanctions, though they may be considered for submission on a case-by-case basis by the Warden, as appropriate.

It will be noted in all SENTRY designation notes that the TEC reviewed the inmate for appropriate institution designation.

7. DOCUMENTATION AND SENTRY ASSIGNMENTS

The PREA regulations in 28 C.F.R. part 115, Subpart A, incorporated into the Program Statement **Sexually Abusive Behavior Prevention and Intervention Program** and the Program Statement **Intake Screening**, address intake screening. Screening of transgender inmates will be conducted in accordance with these policies and all other applicable policies and procedures.

a. Medical and Mental Health Information. Medical and mental health information for transgender inmates will be maintained in the current electronic recordkeeping system or health record system in accordance with the Program Statements **Health Information Management and Psychology Services Manual**. Medical and mental health information is considered confidential, and may only be released in accordance with appropriate laws, rules, and regulations.

b. Initial Screening. For initial designations, staff will assign Case Management Activity (CMA) SENTRY assignments if information in the PSR or other documentation indicates a likely transgender identity. The screening codes are:

SCRN M2F – inmate should be screened for male to female transgender identification.

SCRN F2M – inmate should be screened for female to male transgender identification.

Any inmate arriving at the designated institution with a screening code is to be referred to the Chief Psychologist or designee for review within 14 days. If the code was assigned in error, the screening code will be removed by the Psychologist. If the inmate identifies as transgender, the psychologist will replace the screening code with an identifying code, as indicated below. Holdover facilities are exempt from this initial screening requirement, as limited available

records and brevity of stay do not typically allow for a comprehensive screening.

Any inmate who arrives without a screening code but identifies as transgender during intake, or at any time during the incarceration period, is referred to the Chief Psychologist or designee and interviewed within 14 days of the inmate notification. Inmates in pretrial status at Bureau facilities may also receive a transgender screening CMA SENTRY assignment.

c. Notification to Staff and Tracking. After consultation with Psychology Services, and if the inmate affirms his/her transgender identity, the screening code will be updated to a permanent assignment by a Psychologist:

TRN M2F – inmate identifies as male to female transgender (transgender female).

TRN F2M – inmate identifies as female to male transgender (transgender male).

The inmate must request to Psychology Services staff that the Case Management Activity (CMA) assignment be entered, and the inmate consents that all staff will therefore be notified that the individual is transgender. The inmate's request will be documented on a Case Management Activity (CMA) SENTRY Assignment Consent Form for Transgender Inmates (BP-A1110). Psychology Services shall maintain the form in the electronic mental health record.

Staff should consult the transgender CMA assignment when interacting with the inmate; e.g., use of pronouns and access to accommodations. All inmates have access to transgender treatment, regardless of assignment.

If there are questions about the need to continue a CMA assignment, the Warden will contact the WASPB. Inmates may request in writing to have CMA assignments removed. If this occurs, ordinarily the assignment will not be re-added at a later date.

8. HORMONE THERAPY AND MEDICAL TREATMENT

Hormone therapy or other medical treatment may be provided after an individualized assessment of the requested inmate by institution medical staff. Medical staff will request consultation from Psychology Services regarding the mental health benefits of hormone or other medical treatment. If appropriate for the inmate, hormone treatment will be provided in accordance with the Program Statement **Patient Care** and relevant Clinical Guidance. Questions concerning hormone treatment may be referred to the WASPB or the Health Services Division.

In the event this treatment changes the inmate's appearance to the extent a new identification card is needed, the inmate will not be charged for the identification card as is standard practice.

9. SURGERY

While not all inmates who identify as transgender may be interested in seeking surgical intervention, such a decision does not preclude them from obtaining other accommodations as described in this Program Statement. For transgender inmates in Bureau custody, surgery may be the final stage in the transition process and is generally considered only after one year of clear conduct and compliance with mental health, medical, and programming services at the gender affirming facility. Once that period elapses, an inmate may submit a request to his or her Warden requesting surgical consideration. The Warden will forward the request to the TEC. The TEC is the sole body who may determine that all milestones and individual goals for surgical consideration have been met. When this occurs, the case is referred to the agency's Medical Director for medical consideration. He or she may review existing records and/or interview the inmate, institution staff, and members of the TEC. After this individualized assessment, the Medical Director will determine if the surgery is medically appropriate for referral to a gender affirming surgeon.

10. OTHER MENTAL HEALTH SERVICES

Bureau Psychologists provide assessment and treatment services for transgender inmates, as appropriate. Guidance on assessment procedures is available on the Psychology Services intranet page.

If an inmate identifies as transgender, the Psychologist will provide the inmate with information regarding the range of treatment options available in the Bureau and their implications. In addition, based upon the Psychologist's preliminary assessment and the inmate's expressed interest, a referral to the Clinical Director and/or Chief Psychiatrist may be generated. While the initial interview must be scheduled within 14 days, an assessment may take longer in some instances.

In addition to a referral for medical services, a transgender inmate may be offered individual psychotherapy. Individual psychotherapy goals might include: (1) helping the inmate to live more comfortably within a gender identity and deal effectively with non-gender issues; (2) emphasizing the need to set realistic life goals related to daily living, work, and relationships, including family of origin; (3) seeking to define and address issues that may have undermined a stable lifestyle, such as substance abuse and/or criminality; and (4) addressing any co-occurring mental health issues. Mood disorders, anxiety disorders, substance use disorders, and personality disorders, etc., may also be present; any effective treatment plan will fully address these symptoms. Group treatment may also be recommended.

Common concerns of transgender inmates, which can be addressed effectively in a group setting, include self-esteem issues and relationship issues.

Psychologists who provide mental health treatment for transgender inmates address all mental health needs, including suicide risk, if present. If an inmate who identifies as a transgender harms, attempts to remove, or removes his or her genitalia or other gender-specific anatomy, a suicide risk assessment is conducted consistent with the Program Statement, Suicide Prevention Program. In addition, the treating psychologist notifies the Chief Psychologist who in turn notifies the Regional Psychology Services Administrator and the Psychology Services Branch.

Psychologists working with transgender inmates are encouraged to consult the Reentry Services Division in Central Office for additional resources.

11. SPECIAL POPULATIONS SERVICES

Some facilities have Special Populations Coordinators on staff. These individuals are responsible for delivering First Step Act and other programs, which includes programs developed specifically for inmates who identify as transgender. In the absence of such staff, the Warden will seek consultation from WASPB regarding the delivery of group interventions and services.

12. PRONOUNS AND NAMES

Staff interacting with inmates who have a CMA assignment of transgender, shall either use the authorized gender-neutral communication with inmates (e.g., by the legal last name or “Inmate” last name) or the pronouns associated with the inmate’s identified gender. Deliberately and repeatedly mis-gendering an inmate is not permitted.

The name entered on the inmate’s Judgment and Commitment Order is the official committed name for all Bureau records (incident reports, progress reviews, sentence calculations, etc.). An official committed name change while in BOP custody must be done consistent with the Program Statement **Correctional Systems Manual**. Any additional names or aliases should be entered into SENTRY, as appropriate.

13. PAT SEARCH ACCOMMODATIONS

Pat searches of transgender inmates will be conducted in accordance with the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas**.

Pat search information refers only to individuals at male facilities who identify as female. The Bureau does not offer “male only” pat searches.

Unless there is a history of inappropriate sexual behavior suggesting approval poses risks to staff, requests are ordinarily approved by the Warden’s Office. Inmates may request denials be reviewed by the TEC through the Administrative Remedy Program. Inmates who are granted this exception under policy may have it reversed by the Warden if found to have violated

institution rules concerning contraband.

In exigent circumstances, any staff member may conduct a pat search of any inmate consistent with the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas**.

14. VISUAL SEARCHES

For purposes of a visual search, inmates will be searched in accordance with the gender of the institution, or housing assignment, to which they are assigned. The visual search shall be made in a manner designed to ensure as much privacy to the inmate as practicable. Staff should consider the physical layout of the institution, and the characteristics of an inmate with a transgender CMA assignment, to adjust conditions of the visual search as needed for the inmate's privacy.

Transgender inmates may also request an exception to be visually searched by a staff member of the inmate's identified gender. The exception must be pre-authorized by the Warden, after consultation with staff from Health Services, Psychology Services, Unit Management, and Correctional Services. Exceptions must be specifically described (e.g., "visual search only by female staff"), clearly communicated to relevant staff through a memorandum, and reflected in SENTRY (or other Bureau database). Inmates should be provided a personal identifier (e.g., notation on identification, etc.) that indicates their individual exception, to be carried at all times and presented to staff prior to visual searches.

Inmates request an exception by submitting an Inmate Request to Staff (BP-A0148) to the Warden. The Warden will consult with the departments listed above, and the memo approving or denying the request will be generated by the Warden's Office. Inmates may request denials be reviewed by the TEC through the Administrative Remedy Program. Inmates who are granted this exception may have it reversed by the Warden if found to have violated institution rules concerning contraband.

Transgender inmates placed at an institution or in a housing unit that does not correspond with their identified gender, and who are granted an exemption as indicated above, will be searched by staff of the inmate's identified gender who consent to participate in the search, or Health Services clinical staff.

Transgender inmates placed at an institution or in a housing unit of their identified gender will be searched by staff of the inmate's identified gender who consent to participate in the search or medical staff.

Institutions should consider using available body scanning technology in lieu of visual searches of transgender inmates.

In exigent circumstances, any staff member may conduct a visual search of any inmate consistent with the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas**.

15. CLOTHING, COMMISSARY ITEMS, AND OTHER ACCOMMODATIONS

Consistent with safety and security concerns, inmates with the CMA assignment of transgender will have the opportunity to have undergarments of their identified gender even if they are not housed with inmates of the identified gender. Institutional laundry will have available institutional undergarments that fulfill the needs of transgender inmates. Undergarments will not have metal components.

Standardized lists of Commissary items for transgender inmates are available in accordance with the Program Statement **Trust Fund/Deposit Manual** and the information on the RSD intranet page.

Additional items based on an individualized assessment of the transgender inmate population may be approved by the Warden. Additional items may be provided by the institution or purchased by the inmate, as appropriate. Any concerns regarding such items are directed to the WASPB.

Inmates who purchase and/or are provided items under this section will be subject to disciplinary sanctions, including the removal of these items, if they are found to have violated institution rules relating to the possession of these items.

Any other accommodation requests are discussed with the TEC through the WASPB.

16. REENTRY NEEDS

In accordance with the Program Statement **Release Preparation Program**, institution staff assist transgender inmates in addressing reentry issues prior to release or placement in a Residential Reentry Center/Home Confinement.

During Initial Classification and Program Reviews, unit management formulates a pre-release plan that assists transgender inmates in obtaining identification, finding housing and employment, and providing community resources to assist with reintegration into the community.

The Reentry Affairs Coordinator will assist staff with identifying these resources. Community Treatment Services staff or Institution and/or Regional Social Workers may be contacted concerning the continuity of medical care.

The WASPB can be contacted to provide guidance and resources for any additional reentry

needs of transgender inmates. All accommodation and treatment decisions for inmates in community custody are made by the Residential Reentry Management Branch in consultation with the TEC.

17. ADMINISTRATIVE REMEDIES

Inmates who wish to seek formal review of any issue relating to this policy may use the procedures in the Program Statement **Administrative Remedy Program**.

REFERENCES

Program Statements

P1330.18	Administrative Remedy Program (1/6/14)
P4500.12	Trust Fund/Deposit Fund Manual (3/15/18)
P5100.08	Security Designation and Custody Classification Manual (9/4/19)
P5290.15	Intake Screening (3/30/09)
P5310.17	Psychology Services Manual (08/25/16)
P5310.16	Treatment and Care of Inmates with Mental Illness (5/1/14)
P5322.13	Inmate Classification and Program Review (5/16/14)
P5324.08	Suicide Prevention (4/5/07)
P5324.12	Sexually Abusive Behavior Prevention and Intervention Program (6/4/15)
P5325.07	Release Preparation Program (8/15/19)
P5521.06	Searches of Housing Units, Inmates, and Inmate Work Areas (6/4/15)
P5800.15	Correctional Systems Manual (9/23/16)
P6031.04	Patient Care (6/3/14)
P6090.04	Health Information Management (3/2/15)

Federal Regulations

28 CFR part 115

Additional Resources For Clinicians

Diagnostic and Statistical Manual of Mental Disorders (DSM), most current version. World Professional Association for Transgender Health (WPATH) standards.

ACA Standards

- American Correctional Association Standards for Adult Correctional Institutions, 5th Edition: 5-ACI-1C-09, 5-ACI-1D-12, 5-ACI-1D-13, 5-ACI-2C-02, 5-ACI-1D-08, 5-ACI-3D-05, 5-ACI-3D-08(M), 5-ACI-3D-09, 5-ACI-3D-10, 5-ACI-3D-11, 5-ACI-3D-12, 5-ACI-3D-13, 5-ACI-3D-14, 5-ACI-3D-15, 5-ACI-3D-16, 5-ACI-6A-21(M), 5-ACI-6A-32(M), 5-ACI-6C-14(M)
- American Correctional Association Performance Based Standards for Adult Local Detention Facilities, 4th Edition: 4-ALDF-2A-29, 4-ALDF-2A-32, 4-ALDF-2A-34, 4-ALDF-6B-03, 4-ALDF-2C-03, 4-ALDF-4C-22M, 4-ALDF-4C-30M, 4-ALDF-4D-22, 4-ALDF-4D-22-1, 4-

ALDF-4D-22-2, 4-ALDF-4D-22-3, 4-ALDF-4D-22-4, 4-ALDF-4D-22-5, 4-ALDF-4D-22-6M, 4-ALDF-4D-22-7, 4-ALDF-4D-22-8, 4-ALDF-7B-08, 4-ALDF-7B-10, 4-ALDF-7B-10-1.

- American Correctional Association Standards for Administration of Correctional Agencies, 2nd Edition: None.

- American Correctional Association Standards for Correctional Training Academies: None.

Records Retention

Requirements and retention guidance for records and information applicable to this program are available in the Records and Information Disposition Schedule (RIDS) on Sallyport.

EXHIBIT C

GENDER-AFFIRMING CARE OF TRANSGENDER AND GENDER NONBINARY PERSONS

Federal Bureau of Prisons

Clinical Guidance

June 2023

Federal Bureau of Prisons (BOP) Clinical Guidance is made available to the public for informational purposes only. The BOP does not warrant this guidance for any other purpose and assumes no responsibility for any injury or damage resulting from the reliance thereof. Proper medical practice necessitates that all cases are evaluated on an individual basis and that treatment decisions are patient-specific. Consult the BOP Health Management Resources Web page to determine the date of the most recent update to this document: http://www.bop.gov/resources/health_care_mngmt.jsp.

WHAT'S NEW IN THIS DOCUMENT

This guidance on *Gender-Affirming Care of Transgender and Gender Nonbinary Persons* is an update to the BOP Clinical Guidance on *Medical Management of Transgender Inmates*, issued in December 2016. Significant changes were made throughout this document to more closely align with community standards and the World Professional Association for Transgender Health (WPATH) [Standards of Care for the Health of Transgender and Gender Diverse People, Version 8](#) published in 2022. While WPATH Standards of Care were referenced when updating this guidance, deviations due to the unique correctional environment were made when necessary. The key revisions include:

- Addition of *Transition Pathway for Transgender Inmate Patients* for guidance in patient care decisions found in [Section 4](#) and [Appendix 1](#).
- Added language in [Section 5](#) to describe the process for requesting designation to a cross/gender reaffirming institution according to BOP policy.
- New sections created with emphasis on care in correctional environment:
 - ▶ Preventative Health Screening ([Section 13](#))
 - ▶ Minimally or Non-Invasive ([Section 14](#)) and Invasive [Surgical] Procedures ([Section 15](#))
 - Information regarding facial hair removal expounded ([Facial Hair Removal](#))
 - Including description of the use of Transgender Utilization Review Advisory Group
 - ▶ Transitions of Care ([Section 16](#))

DOCUMENT ORGANIZATION

- The **ABBREVIATIONS** are now listed in a new section, [Key to Abbreviations](#), preceding the appendices. (This list does not replace the list of [Definitions](#) in Section 2.)
- The appendices summarizing **HORMONE TREATMENT** have been renumbered, as follows:
 - ▶ [Appendix 2](#). Summary Charts for Feminizing Hormone Therapy
 - ▶ [Appendix 3](#). Summary Chart for MASCULINIZING Hormone Therapy
- The main body of the **MEDICATION MONITORING** guidance is now in two new appendices:
 - ▶ [Appendix 4](#). Monitoring During FEMINIZING Hormone Therapy
 - ▶ [Appendix 5](#). Monitoring During MASCULINIZING Hormone Therapy
- The items in the [References](#) section are now listed alphabetically by author or source.

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1. PURPOSE

The Federal Bureau of Prisons (BOP) Clinical Guidance for *Gender Affirming Care of Transgender and Gender Nonbinary Persons* provides recommendations for the medical management and treatment of transgender and gender nonbinary federal inmates, referred to in this guidance as *transgender* and/or *gender nonbinary* and *individual(s)*, *patient(s)*, or *person(s)*.

2. DEFINITIONS

BISEXUAL: Refers to a person attracted to both sexes.

BIGENDER: Refers to those who identify with two genders or multigender.

BOP TRANSGENDER CLINICAL CARE TEAM: A group of physicians (primary care and psychiatrists), pharmacists, and social workers devoted to advocating and advancing the treatment options for this population. The team provides education and the tools to institutional staff to develop clinical treatment plans for the TG and gender nonbinary population. This team has no authority to review, approve or disapprove gender affirming surgery referrals.

BOP TRANSGENDER EXECUTIVE COUNCIL (TEC): A group of BOP management personnel who mitigate executive level administrative gender affirming issues.

BOP TRANSGENDER UTILIZATION REVIEW ADVISORY GROUP : A group of BOP physicians, psychiatrists, pharmacists, and social workers assigned by the Medical Director to provide clinical review of gender-confirming surgical requests.

CISGENDER: denoting or relating to a person whose sense of personal identity and gender corresponds with their sex assigned at birth.

COMPLEX AND INVASIVE GENDER CONFIRMING PROCEDURES: complex and invasive medical procedures will almost always require general anesthesia, and a surgeon with advanced skills. Most of these procedures carry the inherent risk for blood loss, infection, pain, multi-day hospitalization, and post-operative complications; in this guidance, these terms refer to all procedures listed in [Table 5](#), which require the approval of the Medical Director.

FEMALE-TO-MALE (FTM): Refers to a biological female who identifies as, or desires to be, a member of the male gender. The term **transgender male**, or **trans male** for short, is used to refer to the **GENDER IDENTITY** of a person who is **FTM**. (See the definition of **TRANSGENDER** below.)

GAY: Refers to a person who is romantically or sexually attracted to persons of the same gender. The term is mostly used to describe males. (See the definition of **LESBIAN** below.)

GENDER-AFFIRMING HORMONES: Hormonal therapy utilized to facilitate physiological change(s) during **TRANSITION** (see definition below). The term **CROSS-SEX HORMONES** is often utilized in the medical literature, but it is falling out of use.

GENDER-AFFIRMING SURGERY/GENDER-CONFIRMING SURGERY: The surgical component of an individual's **TRANSITION** (see definition below); these terms have replaced the outdated terminology of **SEX REASSIGNMENT SURGERY**.

GENDER BINARY: A system of viewing gender as consisting solely of two, opposite categories of gender, termed "male and female"

GENDER CONFORMITY: Behavior and appearance that adheres to the social expectations of a particular **GENDER**. (See the definition of **GENDER NONCONFORMITY** below.)

GENDER DYSPHORIA (GD): The condition of feeling that one's emotional and psychological identity as male or female is different from one's biological sex assigned at birth. **GD implies that there is a state of distress or anxiety directly related to this conflict.** In the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*, released in May 2013, people whose assigned sex at birth is contrary to the one they identify with *and* who are experiencing a state of distress should be diagnosed with **GD**.

➔ *This diagnosis of **GD** is a revision of the criteria in the DSM-IV for **GENDER IDENTITY DISORDER (GID)** and is intended to better characterize the experiences of affected individuals. The DSM-5 no longer uses the term **GID**.*

➔ *A Gender Dysphoria diagnosis may be necessary in some regions to access transition-related care.*

GENDER EXPRESSION: Includes mannerisms, clothing, hair style, and choice of activities that individuals use to express their **GENDER IDENTITY**.

GENDER FLUID: A changing or "fluid" gender identity.

GENDER IDENTITY: How one identifies oneself: female, male, both, or neither. **GENDER** encompasses aspects of social identity, psychological identity, and human behavior.

GENDER NONBINARY: someone who does not identify as exclusively male or female

GENDER NONCONFORMITY (ALSO KNOWN AS GENDER NONBINARY): Behavior or appearance that does not adhere to the social expectations of a particular **GENDER**.

GENDER QUEER: Denoting or relating to a person who does not subscribe to conventional gender distinctions but identifies with neither, both or a combination of male and female genders.

INFORMED CONSENT: A patient's ability to understand the risks, benefits, alternatives, unknowns, limitations, and risks of treatment pertaining to a specific healthcare intervention.

INTERSEX: Refers to a person whose sexual/reproductive anatomy or chromosomal pattern does not seem to fit the typical biological definition of male or female.

LESBIAN: Refers to a female who is romantically or sexually attracted to other females.

MALE-TO-FEMALE (MTF): Refers to a biological male who identifies as, or desires to be, a member of the female gender. The term **transgender female**, or **trans female** for short, is used to refer to the **GENDER IDENTITY** of a person who is **MTF**. (See the definition of **TRANSGENDER** below.)

MINIMALLY INVASIVE GENDER AFFIRMING PROCEDURES: minimally invasive medical procedures are usually same day office or hospital-based procedures that may require anesthesia and break skin or enter an organ; in this guidance, this term refers to professional facial hair removal services, and other procedures typically labeled as aesthetic in a non-trans population.

NON-INVASIVE GENDER AFFIRMING TREATMENT MODALITIES: non-invasive medical modalities typically do not break skin or enter a body part; in this guidance, this term refers to treatment modalities such as voice and communication training.

PATIENT-CENTERED CARE: Care in which patients are partners with their health care providers and health care decisions are driven by the patient's specific health needs and desired health outcomes.

SEX: A biological classification based on chromosomal composition, reproductive anatomy (primary sex characteristics), and the phenotypic characteristics that develop during pubertal maturation (secondary sex characteristics).

SEXUAL ORIENTATION: The direction of one's sexual interest. It is not defined by the person's gender identity. People of the same gender identity may have different sexual orientations.

TRANSGENDER (TG) (ALSO KNOWN AS TRANSSEXUAL) OR TRANS SPECTRUM: An umbrella term used for individuals whose **GENDER IDENTITY** does not conform to the typical expectations associated with the gender they were assigned at birth. It is important to note that terminology changes often and the latter term is falling out of use.

TRANSPHOBIA: Dislike of or strong prejudice against transgender people with attitudes such as fear, discomfort, distrust, or disdain.

TRANSITION: The period during which **TG** individuals change their physical, social, and legal characteristics to the gender with which they identify. **TRANSITION** may also be regarded as an ongoing process of physical change and psychological adaptation. Individuals may want to proceed to different stages of transition.

3. INTRODUCTION & GENERAL CONSIDERATIONS

TRANSGENDER (TG) people are those whose gender identity is different from the sex which they were assigned at birth. **GENDER DYSPHORIA (GD)**—previously known as **GENDER IDENTITY DISORDER (GID)**—is the *discomfort or distress* caused by a discrepancy between a person's gender identity and that person's gender assigned at birth.

- TG people have many of the same health needs as the general population. They may also have other special healthcare needs.
- Not all TG person(s) will be diagnosed with GD, and a diagnosis of GD is not required for access for all TG services. According to the American Psychological Association's guidelines (see [References](#) section), an individual's identification as **TG or GENDER NONBINARY** can be healthy and self-affirming and is not considered pathological.
- However, some **TG or GENDER NONBINARY** individuals experience distress associated with their gender identity, their body, or their sex assigned at birth. There is also distress associated with

societal stigma and discrimination. A systematic review of studies by Valentine, et al (2018) indicates significantly higher rates of mental health morbidity compared with the general population—particularly anxiety, depression, and suicidality.

- **Gender-affirming health care involves supporting individuals through social, psychological, behavioral, or medical (including hormonal treatment or surgery) treatments—to support and affirm an individual’s experienced gender identity.**

The **BOP TRANSGENDER CLINICAL CARE TEAM**. The team provides education and the tools to institutional staff to develop clinical treatment plans for the TG and gender nonbinary population. This team has no authority to review, approve or disapprove gender affirming surgery referrals. This team is composed of physicians (primary care physicians and psychiatrists), pharmacists, and social workers who are available to help institution providers. For example, when patients have medical contraindications (relative or absolute) to hormone treatments, consultation with the TCCT may be helpful. Institution staff may refer to their Regional Medical Director for a list of current team members and their contact information.

STIGMA

Stigma and prior negative experiences in institutions can contribute to healthcare disparities. Stigma commonly leads to prejudice and discrimination, which may also exacerbate mental health concerns in transgender and gender-nonconforming individuals.

Respect and trust are essential to the provider-patient relationship. Respectful language and terms should always be used, affirming the patient’s experienced gender identity. Once an individual has identified as **TG**, use of pronouns or salutations preferred by the **TG** individual is appropriate, especially for those patients with a Case Management Activity (**CMA**) Sentry assignment of **TRANSGENDER** (either TRN M2F or TRN F2M; see [TABLE 1](#) below). This practice is more likely to facilitate a cooperative relationship between the **TG** individual and others, and generally reduces the stress of gender transition.

- ➔ *Using this informal approach is distinct from a legal name change while in BOP custody; a legal name change must conform to the policy requirements in the **Program Statement 5800.15 Correctional Systems Manual** (or the most recent version).*

MENTAL HEALTH CONCERNS AND SUICIDALITY

As reported by Valentine, et al (2018), a higher prevalence of depression, anxiety, and suicidality is seen among TG adults compared to the general population. It has been suggested these elevated rates are linked to complex trauma, stigma, violence, and discrimination. A recent study by Baker, et al (2021) suggests that appropriate gender-affirming care, including medical and surgical care, can lessen psychiatric symptoms. Transgender adults with **GD** are at an increased risk of suicidal ideation and suicide prior to initiation of their gender transition, regardless of the clinical endpoint of their transition - whether that endpoint is living as the psychologically identified gender, hormone therapy, cosmetic treatments, breast augmentation/removal, and/or gender-affirming surgery (Wolford-Clevenger et al 2018). For many individuals, the risk of suicide may decrease after receiving the appropriate, individualized treatment (Turban et al 2022).

COMORBID CONDITIONS

- **Anxiety and Depression:** The most common mental health conditions seen in **TG** adults are anxiety and depression. A significant interdisciplinary approach between Psychology and Health Services is always required for **TG** patient care.
➔ See *BOP Program Statement 5310.16, Treatment and Care of Inmates with Mental Illness*, available at https://www.bop.gov/policy/progstat/5310_16.pdf.
- **HIV Infection:** Epidemiologic studies indicate a higher prevalence of HIV in the **TG** populations, specifically among **transgender male** persons. HIV services for TG people should address the specific biological, pathological, and social needs of this population (i.e., antiretroviral therapy, HIV prevention and care programs). Effective risk assessment requires obtaining an accurate sexual risk history, including anatomy-specific sexual behavior.
➔ See CDC's website on *HIV and Transgender People*, listed in the [References](#) section.

PATIENT-CENTERED MULTIDISCIPLINARY TREATMENT APPROACH

A patient-centered multidisciplinary team approach is recommended for managing issues associated with the incarceration of TG individuals. Incarcerated individuals may present to an institution with a well-established gender identity or begin their transgender or gender nonbinary journey while incarcerated. It is important to have a system in place to allow for individualized treatment. Individuals requesting care for gender dysphoria should have access to a diverse range of treatment services. Patient-centered care explores individualized therapeutic options, which may differ from person to person.

The BOP offers **TRAUMA-INFORMED CORRECTIONAL CARE (TICC)**, which incorporates an understanding that patient attitudes, behaviors, and concerns are likely to be affected by prior traumatic experiences. **TICC** includes both training and treatment programs, emphasizes the recognition of trauma in all forms, and incorporates the principle that all staff may have a role in reducing its impact.

HOUSING ASSIGNMENTS, PROGRAM ASSIGNMENTS, AND PAT SEARCHES

- ➔ Refer to the current version of *BOP Program Statement 5324.12, Sexually Abusive Behavior Prevention and Intervention Program*, available at https://www.bop.gov/policy/progstat/5324_012.pdf
- ➔ Refer also to the *BOP Program Statement 5200.08 Transgender Offender Manual*, available at <https://www.bop.gov/policy/progstat/5200-08-cn-1.pdf>

PRISON RAPE ELIMINATION ACT (PREA)

Per the national Prison Rape Elimination Act (PREA) Resource Center, *being transgender is a known risk factor for being sexually victimized in confinement settings*. Consequently, PREA regulations and BOP Program Statements provide ways to protect the transgender population through the following:

- **PREA** regulations, incorporated into **Program Statement 5324.12, Sexually Abusive Behavior Prevention and Intervention Program** (available at https://www.bop.gov/policy/progstat/5324_012.pdf), state that the intake screening shall assess the individual's risk of sexual victimization by considering, at a minimum, whether the individual is known or perceived to be gay, lesbian, bisexual, **TG**, intersex, or gender nonconforming.
- According to the PREA ([28 C.F.R. § 115.41 \(h\)](#)), *individuals may not be disciplined for refusing to answer, or for not disclosing complete information in response to*, [questions about being gay, lesbian, bisexual, **TG**, intersex, or gender nonconforming].
- According to the PREA ([28 C.F.R. § 115.15 \(e\)](#)), *staff shall not search or physically examine a transgender or intersex inmate for the sole purpose of determining the inmate's genital status. If the inmate's genital status is unknown, it may be determined as appropriate during conversations with the inmate, by reviewing medical records, or, if necessary, learning that information as part of a broader medical examination conducted in private by a medical provider.*

4. TRANSITION PATHWAY FOR TRANSGENDER PATIENTS

[Appendix 1](#) summarizes a pathway for TG patients to access gender-affirming mental health and medical care in the BOP. The order depicted in this table is not as important as the provision of individualized treatment, e.g., individuals may approach a medical professional before they approach a mental health professional and this should not preclude them or delay appropriate treatment if the medical provider is qualified in this area.

A gender dysphoria (GD) diagnosis is not necessary for hormone treatment, and TG patients may not be interested in following up with a mental health professional. However, the reverse might also occur: TG patients may seek out a mental health professional for months before they are ready to be referred for a medical evaluation. Not all gender non-binary patients will require gender-affirming hormone treatment and treatment is individualized to the patient's needs.

5. DESIGNATION TO A CROSS/GENDER-AFFIRMING INSTITUTION

In accordance with [Program Statement 5200.08 Transgender Offender Manual](#), transgender individuals may ask their respective warden to be considered for designation to a gender-affirming institution. All requests for designation are reviewed by the Transgender Executive Council (TEC). The memo is submitted from the Warden to the TEC indicating the patient is requesting re-designation to an institution able to provide full-time gender affirming life experiences in identified gender.

6. PRESENTATION OF GENDER NON-CONFORMITY

Gender non-conformity status is based on an individual's experienced gender identity, role, or expression differing from societal norms assigned to a particular sex. When an individual self-identifies as TG and requests referral or evaluation for treatment, an evaluation is conducted according to PS5200.08, and further referrals may be made, as clinically appropriate, to fully evaluate the individual's treatment needs.

Discussion of the following areas may be useful in helping a person describe their gender identity:

- Persistent and marked differences between experienced gender and their biologic or natal sex.
- Strong feelings about primary or secondary sex characteristics.
- Strong feelings about being treated as or becoming another gender.
- Belief that one's actions, feelings, or mannerisms are more characteristic of another gender.

Gender non-conformity often (but not always) presents with gender dysphoria, which denotes the discomfort or distress that is caused by the nonconformity of a person's gender identity, and that person's sex assigned at birth. Gender nonconformity may present in a spectrum of expressed or desired gender affirmation needs. Patients may experience:

- Strong desires to be treated as the identified gender
- Strong convictions that one has feelings and reactions typical of the identified gender
- Strong inclinations to look in a way that affirms the identified gender

Clinicians must accurately assess and document the patient's individual presentation. Attention should be given as to whether the level of distress meets criteria for a formal diagnosis of gender dysphoria, and/or if there are other coexisting mental or medical health disorders.

7. GENDER-AFFIRMING MENTAL HEALTH ASSESSMENT

When TG individuals present to mental health professionals it is important to conduct a thorough mental health evaluation. The mental health professional is encouraged to affirm the individual's experienced gender and whether there is gender dysphoria. The mental health professional should conduct a thorough evaluation including assessing for any mental health diagnosis. The clinician will develop an individualized treatment plan for the TG patient and collaborate with the medical provider.

A mental health assessment for TG individuals typically includes:

- Obtaining a gender identity history and screening for **GD**
- Screening for other mental health disorders related to mood, anxiety, autism, eating, personality, psychosis, and substance use
- Identifying a history of abuse or neglect
- Assessing any current or past self-harm ideations or attempts
- Performing an assessment of affective, cognitive, and psychosocial functioning
- Psychosocial treatment recommendations; and/or
- Medical referral, if indicated.

➔ Please also refer to the APA's *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, listed in the [References](#) section.

MENTAL HEALTH TREATMENT CONSIDERATIONS

The mental health team plays an important role in gender-affirming care. This can include screening for mental health disorders and assisting with treatment planning. Prior to engaging in treatment, conversations regarding the individual's realistic expectations of outcome are encouraged to identify realistic goals for treatment.

➔ *A collaborative approach with both mental health and medical services staff is highly recommended.*

Patients can also be referred to psychiatry services for mental health concerns or medication management of mental illness.

- **PSYCHOTHERAPY:** This is a general term for treating mental health problems; it includes a broad variety of techniques to help individuals with emotional difficulties or coexisting mental illnesses. Psychotherapy can be used to learn about and treat an individual's moods, thoughts, and behaviors. It can also be supportive to individuals experiencing distressing thoughts, feelings and/or behavior.
- **PSYCHIATRY SERVICES:** Individuals can also be referred to psychiatry services for mental health concerns or medication management of other mental illness in conjunction with **GD**. Appropriate pharmacotherapy is considered when indicated to optimally manage co-existing mental health concerns prior to, or concurrently with, treatment of **GD**.

GENDER DYSPHORIA (GD) CRITERIA

Individuals identifying as TG or gender nonbinary do not necessarily have GD. Although data regarding the prevalence rates of **GD** in the transgender population is limited, many clinicians anecdotally report that most **TG** individuals experience some degree of dysphoria in the absence of treatment.

Because untreated or under-treated **GD** is associated with increased morbidity and mortality (Jackson et al 2023), screening for **GD** in **TG** individuals is essential. Without treatment, this population may experience higher rates of depression, anxiety, self-harm, and suicidality. Gender-affirming treatment supports TG people throughout their lifespan. Treatment modalities are designed to meet the individual's unique goals and may include social supports, mental health treatment, and medical treatment (including hormone therapy and surgery). These interventions may improve medical and psychological health, increase social support, decrease **GD**, treat mental health comorbidities, and improve TG individuals' overall quality of life. The DSM-5 criteria may be used to make the diagnosis of **GD**.

➔ *Refer to The American Psychiatric Association [A Guide for Working With Transgender and Gender Nonconforming Patients](#) for guidance on diagnosis of GD.*

8. GENDER-AFFIRMING MEDICAL ASSESSMENT

A MEDICAL EVALUATION should include:

- **Thorough review of all co-occurring medical conditions and whether they are reasonably controlled.**
 - ➔ *Comorbidities are not necessarily a contraindication to therapy and must be assessed for each patient. See more about drug risks in [Table 2](#) (Feminizing Therapy) and [Table 3](#) (Masculinizing Therapy).*
- **Review of any mental health evaluations and coordination with mental health care providers.**
- **Physical Examination:** Healthcare providers should utilize a gender-affirming approach, including using the individual's preferred name and pronouns during each clinical encounter. This also includes using non-gender specific terminology (ex. genital instead of penis/vagina or chest instead of breast) for anatomical body parts or asking if the patient has a preferred term to be used. The physical exam should only be performed on parts of the body indicated for the medical reason for the specific visit.
- **Documentation of Previous Treatment:** Hormonal therapy, surgery, etc.
- **Informed Consent:** Individuals must be counseled on the risks and long-term effects of hormonal therapy. Use of gender-affirming hormones in the management of **TG** individuals is considered an off-label use and does not currently have FDA approval but is considered a community standard. Due to the irreversibility of some of the treatment options and the side effects, the individual's informed consent is required before initiating treatment and must be documented within the medical record.
 - ➔ See [Section 9. Patient Education & Informed Consent](#).
- **Contraindications and Precautions to Hormone Therapy:**
 - ➔ See also the Summary Charts for Hormonal Therapy in [Appendix 2. Feminizing Hormone Therapy](#) and [Appendix 3. Masculinizing Hormone Therapy](#) for medication-specific contraindications.

FEMINIZING THERAPY

- **CONTRAINDICATIONS:** Current diagnosis of estrogen-sensitive cancer (e.g., breast cancer); current diagnosis of thromboembolic disease (may consider after subspecialty consultation)
- **PRECAUTIONS:** History of estrogen-sensitive cancer or history of thromboembolic disease should prompt referral to expert specialist prior to initiation of therapy. Presence of liver, kidney, or heart disease/stroke (or risk factors for heart disease such as high cholesterol, diabetes, obesity, smoking); retinal vascular thrombosis, history of macroprolactinoma, strong family history of breast cancer or thromboembolic disease; gallbladder disease.

MASCULINIZING THERAPY

- **CONTRAINDICATIONS:** Pregnancy; breast feeding; trans men with current carcinoma of the breast
- **PRECAUTIONS:** Erythrocytosis (hematocrit >50%) History of breast or uterine cancer (testosterone may have anti-proliferative effects on most, but not all cancers-referral to expert specialist recommended prior to initiation of therapy). Androgen-sensitive epilepsy; migraines; sleep apnea; depression; cardiac failure; renal failure or severe hypertension susceptible to salt retention and fluid overload; significant liver disease; coronary artery disease (**CAD**) or risk factors for CAD; bleeding disorders (for injected testosterone); significant history of violent behavior.

ASSESSMENT & DOCUMENTATION OF ACCURATE EHR CODES

Appropriately diagnosing individuals as to their gender identity is imperative for accurate individual record keeping and continuity of care ensuring all individuals are receiving appropriate preventive and gender affirming care and management both as incarcerated individuals and upon release to their community. All BOP individuals who identify as **TG or gender nonbinary** or are identified by history or current presentation as **TG or gender nonbinary**, should be referred to appropriate mental health professionals and/or health service providers. Utilization of inclusionary diagnoses in the EHR helps clinicians provide patient-centered care and medical interventions specific to organs present and transgender care (e.g., a transgender male who has residual breast tissue or an intact cervix getting a mammogram or pap smear).

For purposes of providing appropriate medical treatment and management, all individuals who identify as **TG**—whether or not they are receiving hormone treatment—need to have an accurate diagnostic code entered into the EHR health problem list, as listed in [Table 1](#).

TABLE 1. ICD-10 EHR DIAGNOSTIC CODES FOR TRANSGENDER AND GENDER NONBINARY INDIVIDUALS

BOP Transgender Determination	ICD-10 EHR Codes	Corresponding Sentry CMA Codes
Transgender/Gender Identity DO/Gender Dysphoria - male to female	F64.0F ¹	TRN M2F
Transgender/Gender Identity DO/ Gender Dysphoria - female to male	F64.0M ¹	TRN F2M
Transgender/Gender Identity DO-Other-questioning/queer	F64.8Q ²	
Personal History of Sex Reassignment	Z87890 ³	
¹ Document the degree of distress or impairment in social, occupational, or other important areas of functioning. ² This respective code is to be applied to patients who may not have consolidated their gender identity (questioning), or who identified as gender fluid/queer. ³ If an individual has undergone gender-affirming surgery, use code Z87890 (Personal History of Sex Reassignment) along with the appropriate F64 code above. Document the type of surgery in detail.		

9. PATIENT EDUCATION AND INFORMED CONSENT

Patient education and informed consent are crucial to the treatment process.

- Consent forms for gender affirming hormone therapy are designed to guide counseling and can be found in [Appendix 6](#) and [Appendix 7](#). The information in these appendices is not all-inclusive and providers may add information to this document as clinically appropriate. Individuals should be provided with ample time to review this information and have all questions addressed prior to signing the document. Informed consent must be documented within the EMR.
- Securing consent for gender affirming surgery is the responsibility of the surgeon. Once the individual is approved by the Medical Director for surgical intervention for the treatment of GD, surgeons are responsible for discussing different surgical techniques, advantages and disadvantages of each, limitations of the different procedures, and a frank discussion of all the inherent risks and complications to include their own complication rates with each procedure.

10. HORMONE THERAPY: ELIGIBILITY, GOALS, OVERVIEW

Hormone therapy is an important part of gender affirming care. Studies demonstrate improved satisfaction (in the range of 70–80%) as it relates to mental health, quality of life, and sexual function for **TG** individuals who are receiving gender affirming hormone therapy (Siira et al 2023).

After a thorough and individualized evaluation, the medical provider may initiate hormone therapy after the risks and benefits have been discussed with the individual.

➔ Refer to the [Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline](#) for more detailed information.

ELIGIBILITY AND READINESS FOR GENDER-AFFIRMING HORMONE THERAPY

Patients do not need to meet the DSM criteria for **GD** to initiate gender-affirming hormone therapy. The eligibility for gender-affirming hormone treatment can be achieved by confirming gender incongruence, verifying transition is clinically appropriate, and patient understands the risks, and benefits of treatment through completion of the [Mental Health Assessment](#) and/or the [Medical Assessment](#).

- ➔ *Gender-nonconformity is based on the individual's self-report. Therefore, the history or subjective component of the evaluation serves as the primary source for identifying a person as TG.*
- ➔ *An important aspect of eligibility and readiness for gender-affirming hormone therapy while incarcerated is the understanding that fertility may be affected permanently. According to BOP **Program Statement 6031 Patient Care**: Inmates are not authorized for fertility preservation services (sperm or egg/banking), even when infertility is an expected side effect of medically necessary treatment e.g., chemotherapy, pelvic radiation, or gender affirming treatment. Inmates are not authorized to donate sperm or eggs.*

GENERAL GOALS OF HORMONE THERAPY

The goal of hormone therapy is to reduce characteristics of the natal sex and induce those of the identified gender, allowing individuals to project their **GENDER IDENTITY**. Hormone therapy is focused on

affirming a person's gender identity, which is not always binary. Patient-centered therapy is focused on meeting the patient's needs.

11. FEMINIZING HORMONE THERAPY

The goal of feminizing hormone therapy is generally to suppress male secondary sex characteristics and the development of female secondary sex characteristics. Most clinical studies and guidelines recommend combined therapy with an anti-androgen, estrogen, and sometimes a progestin adjunct.

EXPECTATIONS OF FEMINIZING HORMONE THERAPY

Prior to beginning treatment, patients should be educated on realistic expectations of results, as well as the timeline of when to expect them. Every case is different, and slow change can lead to frustration.

➔ *It is important to discuss realistic expectations with the patient to avoid any attempts to self-increase the dosage in hopes of speeding up results.*

- Within the first six months of treatment, changes may be seen in body fat redistribution, loss of muscle mass, breast growth (usually to Tanner stage 2 or 3), testicular atrophy, decreased erections, decreased sperm production, and a slowing of body/facial hair growth.
- The maximum effect of treatment may not be seen for more than two years.
- Treatment does not provide voice alteration.
- Feminizing hormone therapy may also bring about changes in emotional and social functioning.
- Most treatment results are reversible upon cessation of treatment, but breast growth is permanent, and infertility may be irreversible.
- Refer to [Figure 1](#) on for a general timeline of listed effects.

FIGURE 1. FEMINIZING EFFECTS IN TRANSGENDER FEMALES

Effect	Onset	Maximum
Redistribution of body fat	3–6 mo	2–3 y
Decrease in muscle mass and strength	3–6 mo	1–2 y
Softening of skin/decreased oiliness	3–6 mo	Unknown
Decreased sexual desire	1–3 mo	3–6 mo
Decreased spontaneous erections	1–3 mo	3–6 mo
Male sexual dysfunction	Variable	Variable
Breast growth	3–6 mo	2–3 y
Decreased testicular volume	3–6 mo	2–3 y
Decreased sperm production	Unknown	>3 y
Decreased terminal hair growth	6–12 mo	>3 y ^a
Scalp hair	Variable	— ^b
Voice changes	None	— ^c

Estimates represent clinical observations: Toorians *et al.* (149), Asscheman *et al.* (156), Gooren *et al.* (157).

^aComplete removal of male sexual hair requires electrolysis or laser treatment or both.

^bFamilial scalp hair loss may occur if estrogens are stopped.

^cTreatment by speech pathologists for voice training is most effective.

Note: Adapted from Table 13. Feminizing Effects in Transgender Females reprinted from Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline by W.C. Hembree, P.T. Cohen-Kettenis, L. Gooren, S. E. Hannema, W. J. Meyer, M. H. Muran, S. M. Rosenthal, J.D. Safer, V. Tangpricha, G. G. T'Sjoen, 2017, The Journal of Clinical Endocrinology & Metabolism 102(11):1-35.

SERUM HORMONE LEVELS FOR FEMINIZING HORMONE THERAPY

GOAL LEVELS FOR MTF: Serum Estradiol 100-200 pg/ml and Serum Total Testosterone <50 ng/dl

- While the goal of gender affirming hormone therapy is to suppress male secondary sex characteristics, serum estradiol levels should not exceed those of a premenopausal cis female (200 pg/ml); doses used to achieve an adequate level may be significantly higher than those used in hormone replacement therapy in menopausal women.
 - It is important to note there are individuals who do not require estradiol as part of their hormonal therapy regimen and do well on an anti-androgen therapy alone. Bone density considerations should be fully disclosed to the patient who is considering this approach.
 - There are individuals who require very little estrogen to obtain desired body characteristics and adequately treat any presenting dysphoria/incongruence (in these cases, a specific hormone level is NOT the patient's goal. Hormone levels are monitored to assure the level does not exceed 200 pg/ml).
 - **Patients should be treated with the lowest effective hormone doses.**
 - ▶ ***As stated above, estradiol levels should not routinely exceed a premenopausal level of 200 pg/ml.***
 - ▶ The same holds true for total testosterone levels. While the goal is <50 ng/dl, there is a subset of individuals who do poorly with levels below 35 ng/dl. The ideal levels for these individuals may be between 35–50 ng/dl.
- ➔ *Titration of dose is based on the individual's goals within the context of clinical response, hormone levels, and safety monitoring (e.g., risk factors such as smoking or renal function may warrant dose adjustments).*

The Endocrine Society recommends monitoring of hormone levels every 3 months, during the first year of therapy and/or when titrating treatment regimens or altering therapy before stabilization of dosages has been achieved. After the first year of therapy, hormone levels can be monitored every 6-12 months as clinically indicated.

➔ *The laboratory monitoring guide for feminizing hormone therapy is included in [Appendix 4](#).*

DOSE TITRATION

The science and interpretation of serum hormone levels for TG individuals is evolving. Titration of hormone therapy doses should be driven by patient goals and clinical response per individual. Monitoring for potential medication sided effects and hormone levels are critical components of adjusting treatment.

- The recommended titration approach for patients includes increasing both estrogen and antiandrogen medication dosing to achieve desired physiological changes, but not to exceed the premenopausal cis female physiologic ranges (100–200 pg/mL).
- Another approach includes maintaining current physiologic estrogen dosing, titration of antiandrogen therapy, and the addition of a progestin, if appropriate.
- Regardless of initial dosing regimen utilized, dosages may be titrated upwards over 3–6 months.

FEMINIZING MEDICATIONS

➔ See the Summary Tables for *TRANSGENDER FEMALE Hormone Therapy* in [Appendix 2](#) for information on each of the medication groups below.

ANTI-ANDROGENS

Anti-androgens reduce testosterone levels and allow estrogen therapy to be used in lower doses while still reaching a maximum effect. Medications with anti-androgen effects include spironolactone, finasteride, GnRH agonists, and progestins.

- **SPIRONOLACTONE** is a potassium-sparing diuretic that directly inhibits testosterone secretion and androgen binding to the androgen receptor. It is the most commonly prescribed anti-androgen for gender nonconforming individuals in the United States.
 - ▶ Spironolactone can suppress facial and body hair growth, male pattern baldness, libido, and sexually stimulated erections. It decreases symptoms of benign prostate hypertrophy (BPH) and can lead to modest breast growth.
 - ▶ Due to its diuretic effects, patients may also experience self-limited polyuria, polydipsia, or orthostatic hypotension.
 - ➔ *The use of spironolactone must be carefully monitored in renal insufficiency and is contraindicated in patients with a potassium value greater than 5.5 mEq/L. Spironolactone can cause severe hyperkalemia and hypotension. Caution should be used when prescribed in conjunction with angiotensin-converting enzyme (ACE) inhibitors or angiotensin-receptor blockers (ARBs). It is important to monitor potassium levels and blood pressure of individuals taking spironolactone.*
- **5 α -REDUCTASE INHIBITORS** (finasteride and dutasteride) inhibit 5-alpha reductase, the enzyme responsible for converting testosterone to its potent form, dihydrotestosterone.
 - ▶ Per WPATH SOC 8, data on the use of these medications in trans feminine populations is very limited: *It is unclear whether this class of medication could have any clinical benefit in trans feminine individuals whose testosterone and dihydrotestosterone levels have already been lowered with estrogen and an antiandrogen. We [WPATH] therefore do not recommend their routine use in trans feminine populations.* Rare use may be indicated in specific clinical circumstances such as for patients unable to tolerate spironolactone and which GnRH antagonists are not indicated or available.
- **GNRH AGONISTS** (goserelin, nafarelin, and leuprolide) suppress pituitary gonadotropin levels and gonadal steroids. They are most often used in adolescents for suppression of puberty but can be used to decrease testosterone levels and the amount of estrogen needed to achieve targeted physical effects.
 - ▶ Primary utilization in adult patients is for those who are unable to tolerate spironolactone due to hyperkalemia, increased frequency of urination, and/or a reduction in blood pressure or those who have some other contraindication to spironolactone use.
 - ▶ GnRH agonists do not carry a risk of thromboembolic disease, but use can result in osteoporosis if doses of estrogen given concurrently are insufficient.

- ▶ The high cost to the patient upon release should be considered in those with proximal release dates.
- ▶ In cases of persistent elevations of testosterone despite maximized spironolactone dosing, adherence must be thoroughly evaluated prior to consideration of a GnRH antagonist. Directly observed therapy should be considered. If complete adherence is determined to exist and levels are still elevated beyond reason, autonomous endogenous production (i.e., tumor) should be considered and appropriate evaluation should be conducted.
- **PROGESTINS** are a group of hormones that include medroxyprogesterone. Use of medroxyprogesterone is controversial and not routinely recommended. It is purported to aid in breast development at a cellular level as well as mood management, but its effect is mainly on the uterus. Evidence as an effective agent in gender-affirming hormone therapy is lacking. Per WPATH: *there is currently insufficient evidence the potential benefits of progesterone administration outweigh the potential risks*. Additionally, an association between progesterone use in transgender woman and VTE has also been identified.
 - ➔ *Medroxyprogesterone treatment comes with risk of developing mood disorders (depression/ irritability), lipid abnormalities, weight gain, and edema. There is also a concern of increased cardiovascular risk.*

ESTROGENS

Estrogens are used to provide feminization in the form of physical appearance and sexual characteristics. Effects include development of breasts, redistribution of body fat, softening of the skin, shrinkage of the testes, and testicular atrophy. Many formulations of estrogen are available, including parenteral, transdermal, sublingual, and oral. Estrogen may have positive health effects more generally, including increased high-density lipoprotein, decreased low-density lipoprotein, and preservation of bone mineral density. [Table 2](#) below lists conditions that can be exacerbated by gender-affirming estrogen therapy.

TABLE 2. MEDICAL CONDITIONS REQUIRING INCREASED MONITORING WITH ESTROGEN THERAPY

Contraindications	
• Current thromboembolic disease (may consider after subspecialty consultation) • Current diagnosis of estrogen-sensitive cancer	• Unstable ischemic cardiovascular disease
Precautions (Consider Subspecialist Consult)	
• History of prolactinoma • Breast cancer (non-estrogen dependent) • Severe liver dysfunction (<i>transaminases >3x upper limit of normal</i>)	• Coronary artery disease • Cerebrovascular disease • Severe migraine headaches • Retinal vascular thrombosis
Precautions (Recommend Increased Monitoring)	
• Obesity • History of cigarettes, tobacco, other nicotine use • Migraines or epilepsy • Diabetes • History of thromboembolic disease	• High cholesterol • High blood pressure • Heart, liver, kidney, or clotting disease • Hypoparathyroidism • Porphyria

- All estrogens come with a risk of thromboembolism, but lower doses and transdermal formulations are considered safer and should be used in populations at higher risk of thromboembolism (>40 years old, smoker, obese, etc.). Aspirin therapy may be considered for those at higher risk of thromboembolic disease.
 - Intramuscular (IM) injections can cause greater peaks and troughs in estrogen levels, causing more mood disturbances than oral and transdermal preparations, making oral and transdermal preparations preferable for some patients. Reductions in peak and troughs can be partially mitigated by more frequent dosing of the injections.
 - Use of estrogen should be individualized and adjusted regularly, based on serum estradiol levels and individual-specific goals or concerns. Estrogen should be started at low doses and titrated up as needed, based on hormone levels as well as individual tolerance and goals. If discontinuation is necessary, consider tapering therapy to alleviate mood disturbances.
 - In patients scheduled for surgery or an immobilizing event, the treatment team (i.e., assigned surgeon) should be made aware of current hormone therapy. Limited evidence suggests low risk for thrombotic events whether therapy is continued or temporarily held (Totaro et al 2021). An individualized risk assessment should be performed in determining the appropriate treatment plan.
 - Estrogens are partially metabolized by CYP3A4 and interactions may occur with agents that inhibit or induce CYP3A4. Refer to current drug interaction references and/or a pharmacist for additional information.
- ➔ *Conjugated and synthetic estrogen formulations cannot be measured through serum estradiol concentrations and are no longer recommended for gender-affirming hormone therapy.*
- ➔ *Synthetic estrogens, especially ethinyl estradiol, have been shown to have a higher risk of thromboembolism and should be avoided. Patients entering the BOP on synthetic estrogens should be transitioned to a more appropriate formulation.*

MONITORING

Gender-affirming hormone therapy may have risks up to and equivalent of those associated with hormone replacement therapy in biological females. Appropriate monitoring is crucial.

- Weight, blood pressure, physical exams, risk factors, medications, complete blood counts, renal and liver function, and lipid and glucose metabolism should be monitored for all TG individuals receiving gender-affirming hormone therapy.
 - In addition, individuals undergoing feminizing hormone treatment should be monitored for development of feminine characteristics, target blood levels, and any adverse effects of the medication.
- ➔ Refer to [Appendix 4. Monitoring During Feminizing Hormone Therapy](#) for additional guidance regarding monitoring.

12. MASCULINIZING HORMONE THERAPY

The goal of masculinizing hormone therapy is the development of male secondary sex characteristics and suppression/minimization of female sex characteristics; this is usually done by the administration of a testosterone formulation.

EXPECTATIONS OF MASCULINIZING HORMONE THERAPY

Prior to beginning treatment, patients should receive education on realistic expectations of the treatment results, as well as the timeline of when to expect them. Every case is different, and slow change can lead to frustration.

- Effects developing within the first 6 months of treatment (onset within the first 3 months) include body fat redistribution, an increase in libido, an increase in skin oiliness and acne, clitoral enlargement, vaginal atrophy, cessation of menses, and infertility. Maximum effect usually occurs in 1–2 years but may take up to 5 years in some cases.
- Effects developing in the 6–12 month time frame include increased facial and body hair, scalp hair loss, increased muscle mass and strength, and deepening of the voice. Maximum effect often occurring in 1–2 years.
- Uterine bleeding should cease within a few months of high-dose testosterone therapy, but treatments such as GnRH agonists, medroxyprogesterone, and endometrial ablation may be used to stop menses prior to starting testosterone therapy or to decrease estrogen levels, if not responding to standard treatment.
- Most effects are reversible upon cessation of treatment, but changes in hair, voice depth, and infertility may be irreversible.
- Refer to [Figure 2](#) below for a general timeline of listed effects.

FIGURE 2. MASCULINIZING EFFECTS IN TRANSGENDER MALES

Effect	Onset	Maximum
Skin oiliness/acne	1–6 mo	1–2 y
Facial/body hair growth	6–12 mo	4–5 y
Scalp hair loss	6–12 mo	— ^a
Increased muscle mass/strength	6–12 mo	2–5 y
Fat redistribution	1–6 mo	2–5 y
Cessation of menses	1–6 mo	— ^b
Clitoral enlargement	1–6 mo	1–2 y
Vaginal atrophy	1–6 mo	1–2 y
Deepening of voice	6–12 mo	1–2 y

Estimates represent clinical observations: Toorians *et al.* (149), Assche-man *et al.* (156), Gooren *et al.* (157), Wierdix *et al.* (158).

^aPrevention and treatment as recommended for biological men.

^bMenorrhagia requires diagnosis and treatment by a gynecologist.

Note: Adapted from Table 12. Masculinizing Effects in Transgender Males reprinted from Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline by W.C. Hembree, P.T. Cohen-Kettenis, L. Gooren, S. E. Hannema, W. J. Meyer, M. H. Muran, S. M. Rosenthal, J.D. Safer, V. Tangpricha, G. G. T'Sjoen, 2017, *The Journal of Clinical Endocrinology & Metabolism* 102(11):1-35.

SERUM HORMONE LEVELS FOR MASCULINIZING HORMONE THERAPY

GOAL LEVELS FOR MASCULINIZING HORMONE THERAPY: Serum Estradiol <50 pg/ml and Serum Total Testosterone 320–1000 ng/dl

Goal treatment levels are serum estradiol <50 pg/ml and serum total testosterone 320–1000 ng/dl (male physiologic range; some sources quote a normal reference range of 400–800 ng/dl). If a peak total testosterone level is drawn for injectable testosterone, the level should not exceed 1,000 ng/ml. If total testosterone levels exceed this range, refer to a transgender clinical care team physician or pharmacist for guidance in adjusting therapy.

→ *Free testosterone level monitoring is rarely required during gender affirming treatment. Dose adjustments are based on Serum Total Testosterone levels.*

MASCULINIZING HORMONE THERAPY DURING PREGNANCY

→ *Gender-affirming hormone therapy is contraindicated during pregnancy.*

- While therapy may lead to potentially irreversible infertility, it does not function as contraception, and pregnancy is still possible during treatment. Precautions should be taken to avoid pregnancy during treatment.
- A pregnancy test is obtained prior to starting treatment for all individuals with childbearing potential.

TITRATION OF MASCULINIZING HORMONE THERAPY

Titration of hormone therapy doses should be driven by patient goals and clinical response per individual, including hormone level and safety monitoring.

- Clinical response is measured objectively by the presence of amenorrhea by month 6 of therapy.
- Lab references for testosterone levels vary (e.g., 320–1000 ng/dl). However, TG men with levels on the lower end of the range may express concerns about slow progress in gender affirmation or may experience low energy, libido, or mood—and thus warrant increased doses.
- Titration of testosterone should be done slowly with close monitoring for adverse events. Evidence remains unclear on whether increased doses will have positive effects once testosterone levels are greater than the midpoint of the reference range.
- Daily testosterone levels in TG men do not fluctuate as they do in natal males; however, they may vary over the laboratory monitoring intervals.

MASCULINIZING MEDICATIONS

- ➔ See the Summary Charts for MASCULINIZING Hormone Therapy in [Appendix 3](#) for a full list of the different formulations of testosterone—including summarized information on dosing, adverse effects, contraindications, and interactions.
- ➔ Monitoring is covered in [Appendix 5. Monitoring During Masculinizing Hormone Therapy](#)

TESTOSTERONE

Androgen supplementation is used to induce male sex characteristics, including cessation of menses, voice changes, increased facial/body hair growth, increased muscle mass, hairline recession/baldness, changes in sweat and odor patterns, and clitoral enlargement. Other effects include increased libido and energy. Vaginal dryness will also likely occur. Higher doses of testosterone may be needed for TG men than for natal males who are being treated for low testosterone.

- Several formulations are available, ranging from IM injections to transdermal patches and gels. Due to the classification of all testosterone preparations as DEA-controlled substances and their associated risk of potential abuse and/or diversion, in the correctional environment, injectable formulations are the preferred method of administration.
- The IM injections release slowly from the muscle but may induce cyclical adverse effects that coincide with varying plasma concentrations. This can be mitigated by using a lower dose of IM testosterone given one to twice weekly (rather than every two or more weeks).
- While oral formulations are available, they are not used, due to extensive liver metabolism and the associated potential for hepatic complications.
- Androgen use should be individualized and adjusted based on serum total testosterone levels, tolerance, efficacy, and patient goals. Dosing should start low and be titrated up to an appropriate level while keeping the dose as low as possible to minimize adverse reactions.
- Ovulation may still be possible even when undergoing long-term testosterone therapy. Therefore, it is possible for a transgender man to become pregnant.

PROGESTINS AND GnRH AGONISTS

Medroxyprogesterone and GnRH agonists are not routinely used but may be treatment options in individuals wishing to cease menstruation and decrease estrogen levels prior to testosterone treatment. These medications may also have a use in individuals receiving high-dose testosterone therapy who still experience uterine bleeding after the first few months of treatment.

DRUG RISKS

TABLE 3 lists conditions that can be exacerbated by gender-affirming testosterone therapy.

TABLE 3. MEDICAL CONDITIONS REQUIRING INCREASED MONITORING WITH TESTOSTERONE THERAPY

Contraindications	
• Pregnancy • Breastfeeding • Trans Men with carcinoma of the breast	
Precautions	
• Severe liver dysfunction (transaminases >3x upper limit of normal) • Breast or uterine cancer • Erythrocytosis (hematocrit >50%) • Androgen-sensitive epilepsy • Migraines • Sleep apnea • Depression or significant history of violent behavior	

MONITORING

Masculinizing hormone therapy has the same risks associated with hormone replacement therapy in biological males. Appropriate monitoring is crucial.

The Endocrine Society recommends monitoring of hormone levels every 3 months, especially when titrating treatment regimens or altering therapy before stabilization of dosages has been achieved. Once stabilization of dosages has been achieved, hormone levels are typically done every 6-12 months or as clinically indicated.

- Weight, blood pressure, physical exams, risk factors, medications, complete blood counts, renal and liver function, and lipid and glucose metabolism should be monitored for all TG individuals receiving gender-affirming hormone therapy.
- In addition, individuals undergoing masculinizing hormone treatment should be monitored for development of masculine characteristics, target blood levels, and any adverse effects of the medication. Some of the adverse effects experienced with chronic testosterone therapy are erythrocytosis, liver dysfunction, hypertension, excessive weight gain, salt retention, lipid changes, excessive or cystic acne, and adverse psychological changes.

➔ Refer to [Appendix 5. Monitoring During Masculinizing Hormone Therapy](#) for additional guidance.

13. PREVENTIVE HEALTH SCREENINGS

Regardless of the patient's identified gender or gender-confirming procedures, if the patient has a particular body part or organ, they must continue to have preventative health screening of that organ per recommended guidelines. Additionally, TG patients who are currently on or have previously been on gender affirming hormone treatment are at increased risk for some medical conditions which may require more frequent preventative health screenings. It is important to obtain a thorough medication and surgical history to fully ascertain the individual's screening needs. [Table 4](#) provides an overview of preventive screening needs of TG patients.

TABLE 4. PREVENTATIVE HEALTH SCREENING FOR TG PATIENTS

Health Screening	Transgender Women	Transgender Men
Breast cancer	Screen patients age >50 years based on established clinical guidance.	- Intact breasts: Routine screening as for natal females. - Postmastectomy: Yearly chest wall and axillary exams.
Cardiovascular Disease	Recommended periodically in accordance with established guidance. Parameters should include weight, BMI, blood pressure, lipids, and blood sugar/A1C.	
Cervical cancer	Vaginoplasty: no screening.	- Cervix intact: Routine screening as for natal females. - Absent cervix: No screening
Colon cancer	Recommended in accordance with established guidance.	
Diabetes Mellitus	- Recommended periodically in accordance with established guidance. - If on estrogen: increased risk and frequency of screening may be increased.	Recommended periodically in accordance with established guidance.
Hyperlipidemia	- Recommended periodically in accordance with established guidance. - If on estrogen: annual lipid screening.	- Recommended periodically in accordance with established guidance - If on testosterone: annual lipid screening
Osteoporosis	- Testes intact: Routine screening as for natal males. - Postorchiectomy: Screen all patients > 65 years. - Screen all patients age 50-65 years if off hormones for >5 years	- Screen all patients age >65 years - Screen patients age 50-65 if off hormones for >5 years
Prostate cancer	Routine screening as for natal males.	Not applicable
Testicular cancer	Pre-orchiectomy with intact testes: Recommended periodically in accordance with established guidance.	Not applicable
Refer to UpToDate <i>Primary Care of Transgender Individuals</i> and BOP Clinical Guidance for Preventive Health Care for additional information.		

14. MINIMALLY INVASIVE AND NON-INVASIVE GENDER AFFIRMING TREATMENT MODALITIES

There are several minimally invasive and non-invasive gender-affirming treatment modalities available to TG patients such as voice and communication training, professional laser facial hair removal, and chondrolaryngoplasty (tracheal shaving). Lesser invasive or minor surgical procedures may be deemed medically necessary and considered on a case-by-case basis.

The purpose of these gender-affirming treatment modalities is to decrease or stabilize the gender dysphoria/incongruence experienced by the TG patient and improve the psychosocial functioning of the TG individual. The primary care treatment provider should use sub-specialty consultation requests in the electronic health record (EHR) to order these modalities. It is the responsibility of the medical provider to document the medical necessity, using accepted medical standards for gender-affirming treatment, for each of the requested lesser invasive and non-invasive interventions.

Requests for these treatment modalities (other than hormone treatment) such as voice and communication training, professional laser facial hair removal/electrolysis, will be reviewed in accordance with **Program Statement 6031 Patient Care**, section on Utilization Review; ***a subspecialty consult will be placed in BEMR and referred to the local Utilization Review committee for review. All procedures approved at the local URC meeting will require referral to the Regional Medical Director (RMD) for review and approval per PS 6031.***

[Appendix 1. Transition Pathway for Transgender Patients](#) lists the transition pathway for the affirmation treatment of the incarcerated TG individual from diagnosis to referral for major gender affirming surgery. These steps are not required to be fulfilled in chronological order before progressing to more invasive and non-reversible gender affirming treatment modalities but are an example of treatment modalities from least to most invasive.

VOICE AND COMMUNICATION TRAINING

Providers are encouraged to reach out to Regional Physical and Occupational Therapists, who can assist in finding appropriate resources. The American Speech-Language-Hearing Association (ASHA) has a provider directory for speech language pathologists who specialize in voice and communication therapy for transgender and gender diverse people.

FACIAL HAIR REMOVAL

Facial hair is often a source of distress and suffering for patients who identify as trans-female. Several noninvasive options are available to our incarcerated population. Patients can access the commissary to purchase extra razors, hygiene items such as hair removal creams and lotions, as well as foundation/coverage cremes/liquids to match the color of their skin; some of these products require special order purchases. Hair removal through waxing is a custody concern and is avoided in an incarcerated environment.

When commissary items fail to achieve desired results, and there is continued Gender Dysphoria, Health Services may provide over-the-counter laser hair removal devices as medically necessary. These are secured/maintained in Health Services and used by the patient under monitoring of staff.

Most laser hair removal devices marketed for at-home use are IPL (Intense Pulsed Light) devices. These devices cause a reduction in hair by emitting multiple wavelengths of light to the skin targeting melanin in the hair follicle, which then heats up the hair follicle causing it to weaken or be destroyed. IPL devices only work on hair that is in the growth phase and attached to the follicle therefore multiple treatments are often required. These devices work best on brown and black hair and typically do not provide results on white, grey, light blonde, or red hair. IPL devices work best on Fitzpatrick skin types I-IV which includes all skin tones except dark brown or black skin.

Another laser hair removal device marketed for at-home use is the diode laser. The diode laser works like the IPL devices, except instead of emitting multiple various wavelengths of light it emits a single wavelength of concentrated light. The diode devices are considered safer for all skin types as the IPL cannot be used on darker skin due to lower effectiveness and increased risk of skin burning. It is important to check what skin types the device can treat prior to obtaining the device.

Patients need to be educated on realistic expectations of these devices including: understanding that treatment often is not permanent; will require multiple treatments, often to the same areas; and different devices have varied effectiveness depending on skin and hair color, among other factors. Additionally, they are not without adverse reactions, sometimes causing skin irritation, pain, blistering or scarring. They should not be used on skin with large moles, birthmarks, or tattoos. All visible hair should be shaved in the area prior to use. Sun exposure, before and after treatments, should be avoided.

Prior to obtaining a laser hair removal device, institutions must check to see if the device is FDA cleared using the link: <https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm>. Search by device name and look for the designation of “Substantially Equivalent (SESE)” to determine if FDA cleared. In addition, institutions will need to consider the options for cleaning between patient use with each product.

If these measures fail to remove the facial hair or are contraindicated (e.g., documented allergy or repeated infections) and patient has persistent unresolved Gender Dysphoria/incongruence, a referral consultation for professional laser facial hair removal or electrolysis may be submitted to the local Utilization Review Committee for consideration.

15. INVASIVE AND COMPLEX GENDER-CONFIRMING SURGERIES

➔ *Gender-Confirming surgery has also been referred to as sex reassignment surgery. It is important to note terminology changes often and the latter term is falling out of use.*

TG patients who have been compliant with all aspects of gender affirming care may desire further gender affirming treatment by requesting consideration for invasive and complex gender-confirmation surgery.

Gender confirming surgery may be medically necessary and is considered on a case-by-case basis. The BOP strives to provide community standard medical and surgical care within the confines its systems.

Surgical confirmation for trans individuals in BOP custody may be the final stage in their transition process. While many individuals may not require any surgery, for some it is medically necessary to complete more than a single procedure to alleviate their gender dysphoria/incongruence. See [Table 5](#) for different examples of surgical procedures.

TABLE 5. GENDER CONFIRMING PROCEDURES

Feminizing Surgical Procedures	
• Breast Augmentation • Clitoroplasty • Labiaplasty • Penectomy • Orchiectomy	• Enlarging the breasts using breast implants • Surgical creation of a clitoris • Creation or reshaping of the labia around the vagina • Removal of all or part of the penis • Removal of one or both testicles
Masculinizing Surgical Procedures	
• Bilateral Mastectomy • Male Chest Contouring • Hysterectomy • Ovariectomy/Salpingo-oophorectomy • Penile Prosthesis • Phalloplasty • Scrotoplasty • Metoidioplasty • Permanent Hair Removal	• Removal of both breasts • Contouring the chest into a masculine shape • Removal of the uterus • Removal of ovaries/removal of ovaries and fallopian tubes • An erectile prosthetic device is placed to allow for an erection • Construction of a penis which may involve multiple surgeries • Creation of a scrotum • A surgical procedure that works with existing genital tissue to form a phallus, or new penis. • When clinically required in preparation for bottom surgery

In accordance with [Program Statement 5200.08 Transgender Offender Manual](#), the TEC reviews all general administrative criteria for major gender affirming surgery and reviews additional correctional/custody considerations. The request for invasive and complex gender confirming surgery requires executive level administrative approval (by TEC), and approval from the Medical Director.

The **Clinical Director's (or designee's) role** at the referral institution is to support and treat the trans patient according to this guidance and document it accordingly. In general, clinical criteria for gender confirming consideration in the Bureau include the following:

- The patient has received ongoing gender affirming treatment by assigned medical and mental health providers, and there is persistent well-documented GD.
- There is clinical documentation of patient-centered discussions and documented ongoing follow-up regarding the specific therapeutic and surgical needs.
- The patient has been deemed capable to make fully informed decisions.
- Any significant medical and mental health conditions are reasonably well controlled.
- There have been 12 continuous months of hormone therapy as appropriate to the patient's individual goals (unless medically contraindicated).
 - ▶ Hormone therapy in trans-males is NOT a prerequisite for mastectomy and male chest contouring.
 - ▶ Hormone therapy in trans-females will maximize breast growth when continued for at least 2-3 years. Some surgeons will only perform the breast augmentation surgery after this period of time has elapsed. While this may be ideal, there will be times when Gender Dysphoria symptoms may warrant breast augmentation surgery after a minimum of one year of gender-affirming hormone treatment.
 - ▶ Patients should undergo masculinizing hormone therapy for at least 12-24 months prior to clitoral enlargement.

- There have been 12 continuous months of living in a gender role that is congruent with their gender identity. This experience provides ample opportunity for patients to experience and socially adjust to their desired gender role before undergoing irreversible surgery.
- Per [Program Statement 5200.08 Transgender Offender Manual](#), the Warden submits a referral request to the TEC who will complete an administrative readiness review for gender-confirming surgery.
- When the TEC administratively approves a patient for surgical consideration, a referral is made to the Medical Director who remains the final authority in approving or disapproving a patient for gender confirming procedures. At the direction of the Medical Director, all pertinent clinical information will be reviewed by the Transgender Utilization Review Advisory Group to establish medical appropriateness for the procedure according to community standards.

TRANSGENDER UTILIZATION REVIEW ADVISORY GROUP REVIEW

The Transgender Utilization Review Advisory Group is made up of members of the Transgender Clinical Care Team. Each utilization medical review meeting will require one pharmacist, one psychiatrist, a primary care physician and one social worker from the Transgender Clinical Care Team.

All clinical information in the surgical referral packet submitted by the patient's treatment providers is reviewed. The Transgender Utilization Review Advisory Group may need to interview the patient and/or contact members of the treatment team at the referring institution for additional clinical information (EKG, Pulmonary Function Testing, etc). A targeted utilization review is conducted to assure the proposed procedure(s) are medically needed and appropriate according to community standard prior to making their recommendation to the Medical Director. The Medical Director has the final clinical authority, according to BOP Policy, for approving/disapproving patients for referral for Gender Confirming Surgery.

CLINICAL CONTENTS OF THE GENDER CONFIRMING SURGICAL REFERRAL PACKET

The **SURGICAL REFERRAL PACKET** should include the following items:

MENTAL HEALTH EVALUATION: the mental health professional (typically a Psychologist familiar with the patient) will document the patient's personal mental health and gender non-conformity history, progress, and suitability for surgery based on the stability of co-existing mental illness, and consolidation of one's identity. Recommended content of the mental health provider's referral for surgery include:

- The presenting general identifying characteristics.
- A list of all active mental health diagnoses.
- A review of history of suicidality, homicidality, history of violence, any psychiatric hospitalizations, and residential treatment for mental health or substance use.
- Any current and past substance use including nicotine.
- The duration of the mental health professional's relationship with the client, including the type of evaluation(s) and therapy or counseling to date.
- If and how long the patient has been living in the identified gender.
- An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery.

- Formal evaluation and documentation of capacity to give consent.
- Any issues regarding communication (e.g., English fluency, hearing impairments, an autism spectrum disorder, literacy level, learning differences, etc.)

MEDICAL EVALUATION: the objective of the medical evaluation of a pre-surgical candidate for gender-confirmation surgery is to establish medical suitability for the upcoming procedure. The medical evaluation will address both gender non-binary consolidation medical needs according to [WPATH](#), as well as a general pre-surgical evaluation according to community standard. Recommended content for the medical evaluation for referral for surgery should include documentation on:

- Presence of persistent gender dysphoria/incongruence.
- Type of surgery patient is requesting.
- General statement about patient's ability to understand the irreversible aspects of the procedure.
- General patient discussion regarding risks for surgery which will be dependent on what type of surgery is being done. Some general risks to discuss with the patient include but are not limited to:
 - ▶ Significant pain.
 - ▶ Suboptimal appearance.
 - ▶ Risk related to general anesthesia to include death.
 - ▶ Excessive blood loss and need for transfusion.
 - ▶ Blood clots.
 - ▶ Damage to surrounding structures.
 - ▶ Nerve damage and loss of sensation.
 - ▶ Hematomas.
 - ▶ Infection or abscess potentially resulting in necrosis.
 - ▶ Excessive scarring.
 - ▶ Patient should also be informed that any detailed surgical technique information, risks of the procedure, and complication rates will be discussed with the surgeon, who is responsible for obtaining surgical consent.
- Documentation that the patient understands expected aftercare plan, what is to be expected during the healing process, and how the plan may change based on surgical results and recommendations from the surgeon.
- Patient History
 - ▶ History of present illness
 - Current medical and mental health status.
 - Medical and mental health conditions are reasonably well controlled.
 - ▶ Past medical history
 - ▶ Allergies

- ▶ Medications
 - All active medications.
 - Dose and frequency.
 - Duration of hormone therapy (if applicable).
- ▶ Review of systems
- ▶ Family history
- ▶ Social history
- ▶ Surgical history
- ▶ Sexual reproductive history and wishes
- Physical Exam (complete)
 - ▶ Including HEENT, cardiac, pulmonary, abdominal, extremities and neurologic
 - ▶ Special attention to signs of conditions that would be absolute/relative contraindications to surgery
- Laboratory Studies
 - ▶ Complete blood count with differential, comprehensive metabolic panel with liver function tests
 - ▶ Applicable hormone levels
- Pre-Surgical Work-Up- this may be at the preference of the surgeon and may include:
 - ▶ Recent EKG/Chest x-ray
 - ▶ Stress test
 - ▶ Nutritional assessment

PSYCHOSOCIAL EVALUATION: The social work psychosocial assessment for gender affirming surgery is utilized to gain a comprehensive understanding of the patient within their environment, both while incarcerated and upon release. It is completed by the social worker in the EHR. The assessment addresses the following areas:

- Family relationships, past and current
- Education, work/vocation, military history
- Religious/spiritual and/or cultural needs
- Financial resources
- Mental health, substance use, and medical history
- Sexual orientation and gender identity history
- Expectations or concerns regarding surgery
- Psychosocial functioning, support, and aftercare

16. TRANSITIONS OF CARE

Quality care and treatment includes planning for what will happen when a patient leaves the institution and BOP custody. Consultation with Transitional Care Team (TCT) should be pursued to assist with release planning efforts for transgender individuals, especially as it pertains to medical needs and gender affirming hormone therapy. The TCT can coordinate with relevant stakeholders and connect patients transitioning into the community with appropriate services and resources to ensure continuity of care. Aftercare planning for transgender individuals should include the following considerations:

NOTE: *If the institution is without a staff social worker, regional social workers are available to assist with aftercare planning.*

- A *Consent for Release of Medical Information* should be obtained from the inmate patient, in accordance with BOP policy, so that the inmate patient's treatment plan can be discussed with the community health care provider.
- An adequate supply of medications should be provided to the inmate prior to release or during community placement, in accordance with BOP policy.
- Patients transferring to Residential Re-entry Centers (RRC) or Home Confinement (HC) will be referred to BOP Health Systems Specialists (HSS) and Community Treatment Specialists (CTS) for continuity of care while in the RRC or on HC.
- If a patient is receiving gender affirming hormone therapy and is not transferring to RRC or HC, an aftercare plan should be established to ensure continuity of care.

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KEY TO ABBREVIATIONS

Below is a list of abbreviations used throughout this guidance.

→ See [Section 2. Definitions](#) for explanation of the terms marked with an asterisk (*).

AEs	Adverse events
ARB	Angiotensin II receptor blocker
BMD	Bone mineral density
BMP	Basic metabolic panel, including glucose, calcium, sodium, potassium, CO ₂ , chloride, blood urea nitrogen, and serum creatinine
CAD	Coronary artery disease
CBC	Complete blood count
CCARE	BOP Care Coordination and Reentry Team
CMA	Case Management Activity (codes)
CV	Cardiovascular
DM	Diabetes mellitus
FSH	Follicle-stimulating hormone
GD*	Gender dysphoria
GnRH	Gonadotropin-releasing hormone
hCG	Human chorionic gonadotropin
IM	Intramuscular
LFT	Liver function test
LH	Luteinizing hormone
N/V	Nausea and vomiting
PCOS	Polycystic ovarian syndrome
PREA	Prison Rape Elimination Act (see Section 3)
q	“Every” (example: q2wk = every 2 weeks)
SHBG	Sex hormone-binding globulin
SQ	Subcutaneous
TCCT*	BOP Transgender Clinical Care Team
TEC*	BOP Transgender Executive Council
TICC	Trauma-Informed Correctional Care in the BOP
TG*	Transgender
VTE	Venous thromboembolism

APPENDIX 1. TRANSITION PATHWAY FOR TRANSGENDER PATIENTS

1	Patient self-identifies as TG or gender nonbinary to BOP staff member. Referral is made to a mental health professional or medical provider.	
2	The mental health professional completes an assessment and documents gender non-conformity and/or gender dysphoria as indicated. (Section 7) Initiate gender-affirming live experiences within the prison system.	
3	Referral to medical provider for evaluation if patient has indicated an interest in initiating gender affirming hormone treatment (Section 8). Hormone treatment can be initiated prior to mental health evaluation, when/if patient presents to medical provider first and meets treatment criteria.	
4	Initiation of gender affirming hormone treatment after appropriate counseling completed on expected risks, outcomes, and complications. If needed, case can be discussed with BOP TCCT prior to initiation, though not required. Obtain informed consent (Section 9).	
5	FEMINIZING THERAPY	MASCULINIZING THERAPY
	Begin hormonal therapy with anti-androgen (spironolactone first, unless contraindicated) and estradiol Start low and titrate (no more than every few weeks) to appropriate level while using lowest effective dose. ➔ See Section 11. Feminizing Hormone Therapy	Begin hormonal therapy with testosterone Start low and titrate (no more than every few weeks) to appropriate level while using lowest effective dose. ➔ See Section 12. Masculinizing Hormone Therapy
	If treatment has reached maximum estradiol dose without desired effects after appropriate amount of time, consider adding another anti-androgen such as finasteride, a GnRH agonist, or medroxyprogesterone. Consult BOP TCCT if needed.	If still experiencing uterine bleeding after 6 months of high-dose testosterone therapy, consider adding medroxyprogesterone or a GnRH agonist to suppress menstruation. Consult BOP TCCT if needed.
6	After initiation and compliance with continuous gender affirming hormone treatment, a patient may request further gender affirmation by living in agender affirming institution. e.g., trans-female desires to live in a female institution/ trans-male desires to live in a male institution. The warden at the respective institution will request an administrative review by the TEC	
7	If approved by the TEC, the patient will be designated to the gender affirming institution (aka institution of the identified gender)	
8	Institutions that house transgender or gender non-conforming patients should develop a multidisciplinary team ¹ who meet and discuss the patient’s needs and progress	
(table continues on next page)		

Transition Pathway for Transgender Patients (Cont.)**9**

After 12 months of living in the identified gender at the gender-affirming institution **or** original institution if the TG patient does not request transfer, compliance with continuous gender affirming hormone treatment and with documentation of persistent gender incongruence, the patient may benefit from lesser/non-invasive gender affirming treatment modalities or invasive/complex gender confirmation surgery²

For all lesser/non-invasive gender affirming treatment modalities (ex. voice and communication training, professional laser facial hair removal) the individual provider will place the appropriate consult in the EHR and refer to the local Utilization Review Committee for review. Referral to the RMD will be required.

For invasive/complex gender confirmation surgery- the warden at the respective institution will first request an administrative review by the TEC.

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The TEC determines whether general administrative criteria for gender confirming surgery is met and refers the case to the Medical Director for a medical review.

- The Medical Director will request review by the Transgender Utilization Review Advisory Group who will clinically review the surgical referral packet submitted by the Clinical Director. If the patient meets the clinical criteria for surgery, a memo, with all accompanying clinical supporting materials will be sent to the Medical Director, who is the final authority in approving a patient for referral to the gender confirming surgeon.

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Gender confirming surgical evaluation will be completed by the contracted community surgeon who is responsible to meet with the patient to confirm readiness and medical suitability for complex surgery. Informed consent surrounding all aspects of the surgery to include risks, complication rates, and expected outcomes is the responsibility of the surgeon.

¹ Treatment team should consist of the Clinical Director (or designee), psychiatrist (as needed), Primary Care APP, psychologist, social worker, and pharmacist. Other representative members may include unit team, captain, chaplain (or patient representative), and associate warden. The patient may be invited to attend to clearly articulate and establish his/her clinical needs.

² Individuals will desire to progress to different stages of the stepwise approach. Only a subset of all gender non-conforming patients will pursue a surgical intervention.

APPENDIX 2. SUMMARY TABLES FOR FEMINIZING HORMONE THERAPY

→ See [Section 11](#) for more discussion on the medications used in Feminizing Hormone Therapy.

→ These charts are not all-inclusive and are meant to summarize major considerations for medications. Refer to current drug interaction references, manufacturer information, and/or a pharmacist for additional information regarding drug dosing (to include renal and hepatic dosing), interactions, adverse effects, and contraindications.

Table 1A: Anti-Androgen Drugs for Feminizing Hormone Therapy

★ GOAL LEVELS FOR MtF: SERUM ESTRADIOL 100-200 PG/ML AND SERUM TESTOSTERONE <50 NG/DL ★				
DRUG	DOSE	MECHANISM OF ACTION	RISK CONSIDERATION /CONTRAINDICATIONS	NOTES
SPIRONOLACTONE	• Starting: 25mg QD or BID • Typical: 100-300mg/day in 2 divided doses • Max: 200 mg BID	• Potassium-sparing antihypertensive that directly inhibits testosterone secretion and androgen binding to the androgen receptor	• Renal insufficiency • Potassium >5.5 mmol/L (use with caution if patient has comorbid condition or medications known to increase potassium)	
FINASTERIDE	• Low: 1 mg daily (generally used to treat androgenetic alopecia if needed and desired after individualized target level of androgen blockade is achieved) • High: 5 mg daily (generally used in those who cannot tolerate spironolactone or as an adjunct to spironolactone)	• 5α reductase inhibitor that blocks the conversion of testosterone to the more active 5α dihydrotestosterone (DHT)	• None pertinent	• Predicted to have little utility if the testosterone levels are suppressed and there is no substrate to generate DHT. • WPATH recommends against routine use in patients where testosterone and dihydrotestosterone levels have already been lowered with estrogen and an antiandrogen. Note, this includes for the use of androgenetic alopecia. • Use in combo with spironolactone for rare individuals not achieving desired effects. • May be used after orchiectomy if hirsutism or male pattern baldness are present. • When compared to placebo, 5-alpha-reductase inhibitors have been associated with an increase in the incidence of high-grade prostate cancers.
APPENDIX 1, TABLE 1A, PAGE 1 OF 2 (see Key to Abbreviations in section preceding Appendices)				

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★ GOAL LEVELS FOR MtF: SERUM ESTRADIOL 100-200 PG/ML AND SERUM TESTOSTERONE <50 NG/DL ★				
DRUG	DOSE	MECHANISM OF ACTION	RISK CONSIDERATION/ CONTRAINDICATIONS	NOTES
GNRH AGONISTS: GOSERELIN LEUPROLIDE	- Goserelin: 3.6 mg SQ implant q4 weeks - Leuprolide: 3.75–7.5 mg SQ/IM monthly or 11.25mg SQ/IM q3 months - Lupron Depot® is administered IM - Eligard® is administered SQ	Blocks the GnRH receptor, thus decreasing levels of FSH & LH resulting in highly effective gonadal blockade	None pertinent	- Primary utilization is for patients who experience intolerable hyperkalemia, increased frequency of urination, and/or a reduction in blood pressure with spironolactone. - In cases of persistent elevations of testosterone despite maximized antiandrogen dosing, adherence must be thoroughly evaluated prior to consideration of GnRH Antagonist use. Directly observed therapy should be considered. If complete adherence is determined to exist, autonomous endogenous production (i.e., tumor) should be considered and appropriate evaluation should be conducted. - High cost should be considered in patients with proximal release dates. - Use can result in osteoporosis if doses of estrogen given concurrently are insufficient.
PROGESTIGENS: MEDROXYPROGESTERONE	Starting: 2.5 mg daily Typical: 5–10 mg daily Max: 10 mg daily	Inhibits secretions of pituitary gonadotropins	Similar to estrogen. See CHART 1B below.	- No well-designed studies documenting efficacy. - Use in standard care generally lack formal recommendation for use. - If a patient is to be placed on a progestin, goals of use should be clearly documented and periodically evaluated. If goals are not achieved, medication should be discontinued. - Antidotal reports improved breast development, mood, and libido. However, evidence of benefit is unlikely to outweigh risk, which includes VTE
APPENDIX 1, TABLE 1A, PAGE 2 OF 2 (see Key to Abbreviations in section preceding Appendices)				

TABLE 1B: ESTROGEN FOR FEMINIZATION

★ GOAL LEVELS FOR MtF: SERUM ESTRADIOL <200 PG/ML AND SERUM TESTOSTERONE <50 NG/DL ★				
DRUG	DOSE	MECHANISM OF ACTION	RISK CONSIDERATION/ CONTRAINDICATIONS	NOTES
ESTRADIOL	• Typical: 2-6 mg daily • Occasionally higher doses are used as clinically indicated (literature recommends maximum does of 6-8mg depending on source) • If greater than 2 mg/day, recommend divided twice-daily dosing.	• Estrogens modulate the pituitary secretion of gonadotropins, LH, and FSH through a negative feedback system	Absolute: • Estrogen-dependent cancer Precautions: • History of thromboembolic disease (e.g., stoke, MI, DVT, PE) • Coronary artery disease • Hepatic dysfunction • Hyperlipidemia • Diabetes mellitus • Cigarette smoking • Migraine • Epilepsy • Retinal vascular thrombosis • Hypoparathyroidism • Porpyria • Diseases exacerbated by fluid retention	• Transdermal formulations are preferred for persons > 40 years old or those with risk factors for thromboembolic disease • Inform treatment team prior to surgery of hormone therapy. Individual risk assessment to determine adjustments to therapy perioperatively. • Individuals who enter the BOP on conjugated estrogen should be switched to a different form of estrogen due to inability to monitor estrogen levels with this preparation • IM injections cause greater peaks and troughs in estrogen levels making oral and transdermal preparations preferable
ESTRADIOL VALERATE IM (DELESTROGEN)	• Typical: 5-30 mg IM q2wk • <i>May divide dose into weekly injections for cyclical symptoms.</i>			
ESTRADIOL CYPIONATE IM (DEPO-ESTRADIOL)	• Typical: 2–10 mg IM q1wk			
ESTRADIOL PATCH (CLIMARA, ESTRADERM, ALORA, VIVELLE-DOT)	• Typical: 0.025 mg – 0.2 mg/day • <i>Max single patch dose available is 0.1 mg per 24 hours. More than one patch can be applied at a time</i> • <i>Frequency of patch change is brand/product dependent.</i>	Same as above.		
APPENDIX 1, TABLE 1B, PAGE 1 OF 1 (see Key to Abbreviations in section preceding Appendices)				

APPENDIX 3. SUMMARY TABLE FOR MASCULINIZING HORMONE THERAPY

→ See [Section 12](#) for more discussion on the medications used in Masculinizing Hormone Therapy.

→ These charts are not all-inclusive and are meant to summarize major considerations for medications. Refer to current drug interaction references, manufacturer information, and/or a pharmacist for additional information regarding drug dosing (to include renal and hepatic dosing), interactions, adverse effects, and contraindications.

★ GOAL LEVELS FOR FTM: SERUM ESTRADIOL <50 PG/ML AND SERUM TESTOSTERONE 320–1000 NG/DL ★				
DRUG	DOSE	MECHANISM OF ACTION	RISK CONSIDERATION/ CONTRAINDICATIONS	NOTES
TESTOSTERONE CYPIONATE (in cottonseed oil) TESTOSTERONE ENANTHATE (in sesame oil)	• Typical: 50-100mg IM/SQ once weekly or 100-200mg IM every 2 weeks • Max: 200 mg q2wk or 100 mg/wk	• Maintains secondary sex characteristics in androgen-deficient patients	Absolute: • Pregnancy • Breast cancer (testosterone may have anti-proliferative effects on most, but not all, breast cancers) • Breastfeeding Precautions: • Erythrocytosis • Cardiac, hepatic, renal, or vascular disease with edema or risk of edema • Sleep apnea or high risk of sleep apnea due to obesity or chronic lung disease • Dyslipidemia • Migraines • Epilepsy • Depression, significant history of violent behavior	• Causes drop in blood glucose in DM individuals • May notice cyclic variation in mood with IM dosing Q 2–4 weeks. Use a lower, more frequent dose, or transdermal • Transdermal reaches same levels as IM, but in longer timeframe. • Menses typically stop in early months of treatment but may persist when using transdermals. • Testosterone is a DEA controlled substance. • For the first 3 to 9 months of treatment, total testosterone levels may be elevated with free testosterone levels remaining in the biological female range due to high sex hormone binding globulin levels in some biological women. • 15% of patients on testosterone will experience transient elevations in liver enzymes. If increase > 3x D/C and seek consultation. • Cypionate and enanthate formulations cannot be used interchangeably due to differences in duration of action.
TESTOSTERONE PATCH Available strengths: 2 mg, 2.5 mg, 4 mg, 5 mg	• Typical: 2.5-7.5 mg/day q PM • Max: 8 mg/day q PM			
TESTOSTERONE GEL (TESTIM 1%, ANDROGEL 1%)	• Typical:50-100mg/day			
TESTOSTERONE GEL (ANDROGEL 1.62%)	No published or anecdotal experience with these preparations			
TESTOSTERONE SOLUTION (AXIRON axillary solution)				
MEDROXYPROGESTERONE AND GnRH AGONISTS	Not routinely used. Refer to current drug references for dosing, mechanism of action, and contraindications/precautions.			• Use is recommended in patients who desire but have not yet begun testosterone therapy, or in conjunction with testosterone therapy for breakthrough bleeding
APPENDIX 2, PAGE 1 OF 1 (see Key to Abbreviations in section preceding Appendices)				

APPENDIX 4. MONITORING DURING FEMINIZING HORMONE THERAPY

Appropriate monitoring during gender-affirming hormone therapy is crucial to (1) ascertaining that target blood levels of hormones are being met and (2) assessing and maintaining the individual's health overall.

- **Clinical and laboratory monitoring** is appropriate every three months during the first year, and then as clinically indicated (typically once or twice yearly).
 - ▶ Monitor for development of feminine characteristics, for target blood levels, and for adverse effects of medication and other treatment.
- **Cardiovascular risk assessment** is recommended periodically for all patients treated with hormones in accordance with established guidelines and BOP guidance when available.
 - ▶ Specific parameters that should be monitored include weight and body mass index, blood pressure, lipids, and blood sugar and/or hemoglobin A1C levels, in accordance with established guidelines.
- **Serum ESTRADIOL and TESTOSTERONE levels** are obtained before starting those respective medications, and then every three months while on treatment.
 - ▶ **Target levels are <200 pg/ml for estradiol and <50 ng/dl for testosterone.** Higher levels of testosterone indicate inadequate suppression; higher levels of estradiol are associated with increased risks for thromboembolic disease, liver dysfunction, and development of hypertension.
- **Serum electrolytes, most importantly potassium, and renal function** are obtained prior to starting **SPIRONOLACTONE**, every three months during the first year of treatment, periodically thereafter, or more frequently with increases in dosage or as clinically indicated.
 - ▶ Dose adjustment or discontinuation of spironolactone is recommended for elevated potassium levels or serum creatinine >4 mg/dL.
- **Screening for colon and prostate cancer** is recommended in accordance with established guidelines and BOP guidance when available.
- **Breast cancer screening** guidelines for women are followed for transgender women treated with hormone therapy.
- **Screening for osteoporosis** with a DEXA scan may be appropriate in some cases. In addition, monitoring of hormone levels to ensure suppressed gonadotropin levels may serve as a surrogate marker to indicate adequate sex hormone levels in maintaining bone density in these patients.
 - ▶ In the absence of sufficient data to formulate evidence-based guidelines, it is considered appropriate to screen those who are at least five years post-gonadectomy, those who are 50 to 65 years old and have risk factors for osteoporosis, and all those who are 65 years or older.
 - ▶ Bone density measurements for transgender women are compared with standards for biological females.

- **Baseline and periodic monitoring of liver enzymes and prolactin levels** may be appropriate in those treated with **ESTRADIOL**, but there is insufficient data available to make a specific recommendation.

The following table below summarizes the monitoring schedule for individuals undergoing FEMINIZING hormone therapy.

→ See [Key to Abbreviations](#) in section preceding Appendices.

LABORATORY MONITORING DURING FEMINIZING HORMONE THERAPY

Lab Test	Comments	Baseline	3 Mos ¹	6 Mos ¹	12 Mos ¹	Yearly	PRN
BMP	For individuals on spironolactone	X	X	X	X	X	
Lipids	As clinically indicated	X					X
A1C/Glucose	As clinically indicated	X					X
Estradiol	Range: generally, 100–200 pg/mL, but should not exceed 200 pg/ml	X	X	X	X	X	
Total Testosterone²	Range: < 50 ng/dL		X	X	X	X	
Prolactin	Only if symptoms of prolactinemia						X
LFTs	After baseline, optional if on estrogen, progesterone, or medroxyprogesterone	X				X	
¹ In the first year of therapy only							
² Every 3 months in the first year then 1-2 times per year thereafter.							

APPENDIX 5. MONITORING DURING MASCULINIZING HORMONE THERAPY

Appropriate monitoring during gender-affirming hormone therapy is crucial to (1) ascertaining that target blood levels of hormones are being met and (2) assessing and maintaining the individual's health overall.

➔ *A pregnancy test is obtained prior to starting treatment for all persons assigned as female at birth and have child-bearing potential.*

- **Clinical and laboratory monitoring** is appropriate every three months during the first year, and then as clinically indicated (typically once or twice yearly).
 - ➔ *Monitor for development of masculine characteristics, for target blood levels, and for adverse effects of medication and other treatments.*
- Cardiovascular risk assessment is recommended periodically for all patients treated with hormones, in accordance with established guidelines and BOP guidance when available.
 - ▶ Specific parameters that should be monitored include weight and body mass index, blood pressure, lipids, and blood sugar and/or hemoglobin A1c levels.
- Serum testosterone levels are obtained before starting treatment with testosterone, and then every three months while on treatment.
 - ▶ Timing of the testosterone level is determined by the route of administration.
 - Testosterone enanthate/cypionate injections, testosterone levels should be obtained midway between injections. The target testosterone level is 400-700ng/dL.
 - Transdermal testosterone levels can be done any time after one week of therapy.
- Serum estradiol levels are obtained before starting hormone therapy, and then every three months while on treatment until estradiol levels are < 50 pg/ml and cessation of menses has been six months.
- A complete blood count (**CBC**) and liver panel are obtained prior to starting hormone therapy, every three months during the first year of treatment, once or twice yearly thereafter, or more frequently as clinically indicated.
 - ▶ Dose adjustment or discontinuation of testosterone is indicated if the hematocrit is > 54%.
- Screening for colon cancer is recommended in accordance with established guidelines and BOP guidance when available.
- Breast cancer screening guidelines for women are followed for **TG** individuals treated with hormone therapy and who have not had mastectomies.
- Cervical cancer screening is performed annually in those who are treated with hormone therapy and have cervical tissue (i.e., no hysterectomy).
- Screening for osteoporosis with a DEXA scan may be appropriate in some cases.
 - ▶ In the absence of sufficient data to formulate evidence-based guidelines, it is considered appropriate to assess bone mineral density prior to starting treatment in those with risk factors for osteoporosis, those who are at least five years status post-gonadectomy, and all those who are 60 to 65 years or older.

- ▶ Bone density measurements for transgender men are compared with standards for biological males.

The following table below summarizes the monitoring schedule for individuals undergoing hormone masculinizing therapy.

➔ See [Key to Abbreviations](#) in section preceding Appendices.

LABORATORY MONITORING OF MASCULINIZING HORMONE THERAPY

Lab Test	Comments	Baseline	3 Mos ¹	6 Mos ¹	12 Mos ¹	Yearly	PRN
CBC (Hgb & Hct)		X	X	X	X	X	
hCG (if child-bearing potential)		X					
Lipids	As clinically indicated	X					X
A1C/Glucose	As clinically indicated	X					X
LFTs		X		X	X	X	
Estradiol	Range: <50pg/mL		X				X
Total Testosterone ²		X	X	X	X	X	X
¹ In the first year of therapy only ² If IM/SQ – check midway between injections (target level is 400-700ng/dL). Alternatively measure peak and trough levels to ensure levels remain in the normal male range. If patch – check after 1 week. Monitor levels every 3 months until levels are at goal.							

**APPENDIX 6. FEMINIZING GENDER-AFFIRMING HORMONE
THERAPY – CONSENT AND COUNSELING FORM****FEMINIZING GENDER-AFFIRMING HORMONE THERAPY FOR TRANSGENDER PATIENTS
CONSENT AND COUNSELING FORM**

INSTITUTION NAME: _____

PATIENT NAME: _____ ID #: _____

You want to take estrogen and other medications to feminize your body. Once you start these medications, some of them will need to be taken for the rest of your life to maintain their effects. Before using these medications, you need to know more about how they might affect you, including possible benefits, side effects, risks, and warning signs. We have listed them here for you. It's important that you understand all this information before you start. Please notify your health care provider should you have any questions.

WHAT ARE THE DIFFERENT MEDICATIONS THAT CAN HELP TO FEMINIZE YOU?

ESTROGEN is the female gender-affirming hormone. There are also medications—called **ANDROGEN ANTAGONISTS** (or **ANTI-ANDROGENS** or **ANDROGEN BLOCKERS**)—that stop the production of male hormones and can help you appear less like a man.

WARNING — WHO SHOULD NOT TAKE ESTROGEN?

It should NOT be used by anyone who has a current diagnosis of:

- An estrogen-dependent cancer
- Blood clots that could or did travel to the lungs

It should be used WITH CAUTION, and only after a full discussion of risks, by anyone who:

- Has a personal or strong family history of breast cancer or other cancers that grow faster when estrogens are present
- History of previous clots and currently not on blood thinners
- Has diabetes
- Has eye problems such as retinopathy
- Has heart disease, heart valve problems, or a tendency to have easily clotted blood
- Has hepatitis
- Has high cholesterol
- Has kidney or liver disease
- Has migraines or seizures
- Is obese
- Smokes cigarettes

Please review and **initial each statement** to show you understand the benefits, risks, and changes that may occur from taking these medications. At the end of the document, **indicate your preference regarding hormone therapy, then sign and date it.**

FEMINIZING EFFECTS OF ESTROGEN AND ANTI-ANDROGENS:

_____ I know that estrogen or anti-androgens—or both—may be prescribed to help me appear less like a man and more like a woman.

_____ I know that it can take several months to years for the effects to become noticeable. I know that no one can predict how fast—or how much—change will happen.

_____ I know that if I am taking estrogen, I will probably develop breasts.

- I know it can take several years for breasts to get to their full size.
- I know the breasts will remain, even if I stop taking estrogen.
- I know I should examine my breasts for irregularities as soon as they start growing. I should also have a clinician examine them every year.
- I know I might have a milky discharge from my nipples (galactorrhea). If I do, I know I should have it evaluated by my clinician because it could be caused by the estrogen or by other medications or medical conditions. I know that no one knows if taking estrogen increases the risk of breast cancer.

_____ I know that the following changes are usually not permanent—they are likely to go away if I stop taking the medicines:

- I know my body hair will become less noticeable and will grow more slowly, but it won't stop completely, even if I take the medicines for years.
- I know I will probably have less fat on my abdomen and more on my buttocks, hips, and thighs. It will be redistributed to a more female shape, changing from an "apple" shape to more of a "pear" shape.
- I know that if I already have male pattern baldness, it may slow down, but will probably not stop completely. It is also unlikely that hair that has been lost will grow back.
- I know I may lose muscle and strength in my upper body.
- I know my skin may become softer.

_____ I know that my body will make less testosterone. Upon release, this may affect my sex life in different ways and my future ability to cause a pregnancy:

- I know this treatment may (but is not assured to) make me permanently unable to make a woman pregnant.
- I know my sperm may no longer reach maturity. This could make me less able to cause a pregnancy. I also know I might never produce mature sperm again, but I know that it's also possible that my sperm could still mature. So, I know that I might get someone pregnant if we have vaginal intercourse, and we don't use birth control.
- I know this treatment may cause permanent infertility, and I will not be able to preserve or donate my sperm while incarcerated.

- I know my testicles may shrink down to half their size. Even so, I know that I will need regular checkups for them.
- I know it is likely that my penis won't be hard in the morning as often as it has been before. It is also likely that I will have fewer spontaneous erections.
- I know I may lose the ability to obtain an erection for intercourse.
- I know I may have less sex drive.
- I know that sex between inmates, or between inmates and staff, is not permitted within the BOP.

_____ I know that some parts of my body will not change much by using these medicines.

- I know the hair of my beard and moustache may grow more slowly than before. It may become less noticeable, but it will not go away.
- I know the pitch of my voice will not rise, and my speech patterns will not become more like a woman's.
- I know my Adam's apple will not shrink.
- Although these medicines can't make these changes happen, there are other treatments that may be helpful.

RISKS OF TAKING FEMINIZING MEDICATIONS (ESTROGEN AND ANTI-ANDROGENS):

_____ I know that the side effects and safety of these medicines are not completely known. There may be long-term risks that are not yet known.

_____ I know that I should not take more medicine than I am prescribed. I know it increases health risks. I know that taking more than I am prescribed won't make changes happen more quickly or more significantly. I know my body can convert extra estrogen into testosterone which can slow down or stop my appearing more womanly.

_____ I know these medicines may damage the liver and may lead to liver disease. I know I should be checked for possible liver damage as long as I take them.

_____ I know these medicines cause changes that other people will notice. Some transgender people have experienced harassment, discrimination, and violence because of this. Others have lost the support of loved ones. I know I can reach out to psychology services to help me find support resources. I also know that the BOP does not tolerate harassment, discrimination, and violence in any circumstances. If I feel I am the recipient of any of these actions, I will notify a BOP staff member.

RISKS OF TAKING ESTROGEN:

_____ I know that taking estrogen increases the risk of blood clots that can result in:

- Chronic problems with veins in the legs
- Heart attack
- Pulmonary embolism (blood clot to the lungs), which may cause permanent lung damage or death
- Stroke, which may cause permanent brain damage or death

_____ I know that the risk of blood clots is much worse if I smoke cigarettes, especially if I am over 40. I know the danger is so high that I should stop smoking completely if I start taking estrogen and that I should not start to smoke again when I am released from a BOP institution.

_____ I know that taking estrogen can increase the deposits of fat around my internal organs. This can increase my risk for diabetes and heart disease.

_____ I know that taking estrogen can raise my blood pressure. I know that if my blood pressure goes up, my clinician can work with me to try to control it with diet, lifestyle changes, and/or medication.

_____ I know that taking estrogen increases my risk of getting gallstones. I know that I should talk with my clinician if I get severe or long-lasting pain in my abdomen.

_____ I know that estrogen can cause nausea and vomiting. I know that I should talk with my clinician if I have long-lasting nausea or vomiting.

_____ I know that estrogen can cause headaches or migraines. I know I should talk with my clinician if I have headaches or migraines often, or if the pain is unusually severe.

_____ I know that it is not yet known if taking estrogen increases the risk of prolactinomas. These are non-cancerous tumors of the pituitary gland. I know they are not usually life-threatening, but they can damage vision and cause headaches. I know this possibility needs to be checked periodically by a clinician for at least three years after I start taking estrogen.

_____ I know that I am more likely to have dangerous side effects if:

- I smoke.
- I am overweight.
- I am over 40 years old.
- I have a history of blood clots.
- I have a history of high blood pressure.
- My family has a history of breast cancer.

RISKS OF TAKING ANDROGEN ANTAGONISTS:

_____ I know that spironolactone affects the balance of water and salts in the kidneys, which may:

- Increase the amount of urine I produce, making it necessary to urinate more frequently.
- Increase thirst.
- Reduce blood pressure.
- Cause (although rarely) high levels of potassium in the blood, possibly leading to changes in heart rhythms that may be life-threatening.

_____ I know that some androgen antagonists make it more difficult to evaluate test results for cancer of the prostate. I know that if I am over 50, I should have my prostate evaluated every year with a prostate-specific antigen test, as applicable.

PREVENTION OF MEDICAL COMPLICATIONS:

- _____ I agree to take feminizing medications as prescribed, and I agree to tell my clinician if I have any problems or if I am unhappy with the treatment.
- _____ I know that the dose and type of medication that is prescribed for me may not be the same as for someone else.
- _____ I know that I need periodic physical exams and blood tests to check for any side effects.
- _____ I know that feminization medications can interact with other drugs and medicines—including alcohol, diet supplements, herbs, other hormones, and street drugs—causing complications. I know that I need to prevent complications because they can be life-threatening. That’s why I need to be honest with my clinician about whatever else I take or use. I also know that this will not interfere with my getting medical care; I will continue to get medical care here no matter what information I share about what I take.
- _____ I know that it can be risky for anyone with certain conditions to take feminizing medicines. I agree to be evaluated if my clinician thinks I may have such a condition. Then, we will decide if it’s a good idea for me to start or continue using these medications.
- _____ I know that there may be a risk for blood clots after surgery, especially if I will not be mobile for an extended period. I will need to talk with the surgeon and my doctor to decide if I need to stop taking estrogen before and/or after the surgery or immobilizing event.
- _____ I know that using these medicines to appear more womanly is an “off-label” use. I know that this means that using these medicines for this purpose is not approved by the Food and Drug Administration (FDA). I know that the medicine and dose that is recommended for me is based on the judgment and experience of the clinician.
- _____ I know that I can choose to stop taking these medicines at any time. I know that if I decide to do that, I should do it with the help of my clinician. This will help me make sure there are no negative reactions. I also know that my clinician may suggest that I cut the dose or stop taking it altogether if certain conditions develop. This may happen if the side effects are severe or if there are health risks that cannot be controlled.

MY SIGNATURE BELOW CONFIRMS THAT:

- My clinician has talked with me about:
 - ▶ The benefits and risks of taking feminizing medication.
 - ▶ The possible or likely consequences of hormone therapy.
 - ▶ Potential alternative treatments.

- I understand the risks that may be involved.
- I know that the information in this form includes the known effects and risks. I also know that there may be unknown long-term effects or risks.
- I have had enough opportunity to discuss treatment options with my clinician.
- All of my questions have been answered to my satisfaction.
- I believe I know enough to take, refuse, or postpone therapy with feminizing medications.
- I am 18 years old or older.

BASED ON ALL THIS INFORMATION:

_____ I understand the risks, and consent to taking estrogen.

_____ I understand the risks, and decided I do not consent to taking estrogen

_____ I understand the risks, and consent to taking androgen antagonists (e.g., spironolactone).

_____ I understand the risks, and decided I do not consent to taking androgen antagonists (e.g., spironolactone).

Patient's Signature

Date

Prescribing Physician's Signature

Date

Your health is important to us. If you have any questions or concerns, please come to sick call and an appointment with your provider will be made.

**APPENDIX 7. MASCULINIZING GENDER-AFFIRMING HORMONE
THERAPY – CONSENT AND COUNSELING FORM****MASCULINIZING GENDER-AFFIRMING HORMONE THERAPY FOR TRANSGENDER PATIENTS
CONSENT AND COUNSELING FORM**

INSTITUTION NAME: _____

PATIENT NAME: _____ ID #: _____

You have expressed a desire to take testosterone to masculinize your body. Before beginning treatment, there are several details about treatment that you need to be familiar with, including the possible advantages, disadvantages, risks, warnings, and alternatives. These topics are covered below. It is important that you understand all this information before initiating treatment. Please notify your health care provider should you have any questions.

WHAT IS TESTOSTERONE?

Testosterone is the hormone responsible for male features. It builds muscle, causes the development of facial hair, and is responsible for the deepening of a person's voice during puberty. Testosterone also may increase sex-drive.

HOW IS TESTOSTERONE TAKEN?

Testosterone is usually injected every one to four weeks. It is not used as a pill because the body may not absorb it properly, and it can cause liver problems. Some people use skin creams and patches, but these are not used in the correctional environment.

The doses used for injections differ from product to product, and from patient to patient. Doses may range from 100 mg to 400 mg. The injections are administered into a large muscle to slow the release of the hormone. There can be unwanted swings in hormone levels. This can be controlled by changing how often the dose is given, how much of a dose is given, or by changing formulations.

WARNING — WHO SHOULD NOT TAKE TESTOSTERONE?

Testosterone should **not** be used by anyone who is pregnant or has uncontrolled coronary artery disease.

It should be used **with caution and only after a full discussion of risks** by anyone who has: acne, family history of heart disease or breast cancer, blood clot history, high levels of cholesterol, liver disease, or high red-blood-cell count. Caution should also be used in obese patients and persons who smoke.

MONITORING:

Periodic blood tests to check on the effects of the hormone will be required for treatment. Routine breast exams and pelvic exams with pap tests should be continued, when applicable.

BENEFITS AND RISKS OF TESTOSTERONE TREATMENT:

Benefits	Risks
• Appearing more like a man: • Larger clitoris* • Coarser skin • Deeper voice* • Increased body hair* • Increased facial hair* • Increased muscle mass • Increased strength • Elimination of menstrual periods • Increased physical energy • Protection against bone thinning (osteoporosis) <i>*These are permanent changes.</i>	• Acne (may permanently scar) • Blood clots (thrombophlebitis) • Emotional changes • Headache • High blood pressure (hypertension) • Increased red-blood-cell count • Infertility • Inflamed liver • Interaction with drugs for diabetes and blood thinning, e.g., Coumadin and Warfarin • Male pattern baldness • Increased abdominal fat • Increased risk of heart disease • Swelling of hands, feet, and legs • Weight gain

Please review and **initial each statement** to show that you understand the benefits, risks, and changes that may occur from taking these medications. At the end of the document, **indicate your preference regarding hormone therapy, then sign and date it.**

MASCULINIZING EFFECTS OF TESTOSTERONE:

_____ I know that testosterone may be prescribed to make me appear less like a woman and more like a man.

_____ I know that it can take several months or longer for the effects to become noticeable.

_____ I know that no one can predict how fast or how much change will take place.

_____ ***I know that the changes may not be complete for two to five years after starting testosterone.***

_____ ***I know the following changes are likely to be permanent, even if I stop taking testosterone:***

- Bigger clitoris — typically about half an inch to a little more than an inch
- Deeper voice
- Growth of facial hair (moustache and beard)
- Hair loss at the temples and crown of the head and the possibility of becoming completely bald
- More, thicker, and coarser hairs on abdomen, arms, back, chest, and legs

_____ ***I know that the following changes are usually NOT permanent and will likely go away if I stop taking testosterone:***

- Acne (however, acne scars will be permanent)
- Elimination of menstrual periods (typically stop one to six months after starting testosterone)
- Increased abdominal fat (redistribution of fat to a more masculine shape)
- Decreased fat on buttocks, hips, and thighs
- More muscle mass and strength

- Vaginal dryness

_____ I know that the effects of testosterone on fertility are unknown and may cause permanent infertility. I have been told that I may or may not be able to get pregnant even if I stop taking testosterone. I know I might still get pregnant even after testosterone stops my menstrual periods. I know I cannot take testosterone if I am pregnant. By continuing treatment, I accept that I may never be able to biologically parent a child. I know this treatment may cause permanent infertility, and I will not be able to preserve or donate my eggs while incarcerated

_____ I know that some aspects of my body will not be changed:

- Losing some fat may make my breasts appear slightly smaller, but they will not shrink very much.
- Although my voice may deepen, other aspects of the way I speak will not change.

_____ I know that there are other treatments that may be helpful to make my breasts smaller or my speech manlier. If I have concerns, I can discuss treatment options with my clinician.

RISKS OF TESTOSTERONE:

_____ I know that the medical effects and safety of testosterone are not completely known. There may be long-term risks that are not yet known.

_____ I know not to take more testosterone than prescribed. I know this would be a risk to my health. I know that taking more testosterone than I am prescribed will not make changes happen more quickly or more significantly. I know that my body can convert extra testosterone into estrogen, which can slow down or reverse the progress of my transition.

_____ I know that testosterone can cause changes that increase my risk of heart disease. I know these changes include:

- Less good cholesterol (HDL), which is needed to protect against heart disease, and more bad cholesterol (LDL), which may increase the risk of heart disease
- Higher blood pressure
- Increased deposits of fat around my internal organs

_____ I know that my risk of heart disease is higher if people in my family have had heart disease, if I am overweight, or if I smoke.

_____ I know that I should have periodic heart-health checkups for as long as I take testosterone. I know I must watch my weight and cholesterol levels and have them checked by my clinician.

_____ I know that testosterone can damage the liver and possibly lead to liver disease. I know I should be checked periodically for possible liver damage for as long as I take testosterone.

_____ I know that testosterone can increase my red blood cell count and hemoglobin. I know the increase is usually only to the level that is normal for a man. I know normal levels would have no health risks; however, higher increases can cause problems that can be life-threatening. These problems include stroke and heart attack. As such, I know I need to have periodic blood checks for as long as I take testosterone.

- _____ I know that taking testosterone can increase my risk for diabetes. It may decrease my body's response to insulin, cause weight gain, and increase deposits of fat around my internal organs. I know I should have periodic checks of my blood glucose for as long as I take testosterone.
- _____ I know that my body can turn testosterone into estrogen. I know that no one knows if this could increase the risk of cancers of the breast, ovaries, or uterus.
- _____ I know that taking testosterone can thin the tissue of my cervix and the walls of my vagina. This can lead to tears or abrasions during vaginal intercourse. I know it does not matter if my partner is a woman or a man. This raises my risk of getting a sexually transmitted infection, including HIV. I know I should speak frankly with my provider regarding the best ways to prevent and check for infections.
- _____ I am aware that sex between inmates, or between inmates and staff, is not permitted.
- _____ I know that testosterone can give me headaches or migraines. I know it is best to talk with my clinician if I get them frequently or if the pain is unusually severe.
- _____ I know that testosterone can cause emotional changes. For example, I could become more irritable, frustrated, or angry. I know my provider can help me find resources to explore and cope with these changes.
- _____ I know that testosterone causes changes that other people will notice. Some transgender people have experienced harassment, discrimination, and violence because of this. Others have lost the support of loved ones. I know I can reach out to psychology services to help me find support resources. I also know that in the BOP, harassment, discrimination, and violence are not tolerated under any circumstances. If I feel I am the recipient of any of these actions, I will notify a BOP staff member.

PREVENTION OF MEDICAL COMPLICATIONS:

- _____ I agree to take testosterone as prescribed, and I agree to tell my clinician if I have any problems or am unhappy with the treatment.
- _____ I know that the dose and type of medication prescribed for me may not be the same as it is for someone else.
- _____ I know that I need periodic physical exams and blood tests to check for any side effects.
- _____ I know that testosterone can interact with other drugs and medicines, including alcohol, diet supplements, herbs, other hormones, and street drugs. This kind of interaction can cause complications. I know that I need to prevent complications because they can be life-threatening. I need to be honest with my clinician about other items I am taking. I also know that this will not interfere with my getting medical care; I will continue to get medical care here no matter what information I share about what I take.
- _____ I know that it can be risky for anyone with certain conditions to take testosterone. I agree to be evaluated if my clinician thinks I may have one of these conditions. Then, we will decide if it is a good idea to start or continue using testosterone.

_____ I know that using testosterone to appear more masculine is an “off-label” use. I know this means it is not approved by the Food and Drug Administration (FDA) for this purpose. I know the medicine and dose recommended for me is based on the judgment and experience of the clinician.

_____ I know that I can choose to stop taking testosterone at any time. I know if I decide to stop, I should discontinue with the help of my clinician to ensure there are no negative reactions. I know my clinician may suggest I cut the dose or stop taking it altogether if certain medical conditions develop. This may happen if the side effects are severe or if there are health risks that cannot be controlled.

MY SIGNATURE BELOW CONFIRMS THAT:

- My clinician has talked with me about:
 - ▶ The benefits and risks of taking testosterone.
 - ▶ The possible or likely consequences of hormone therapy.
 - ▶ Potential alternative treatments.
 - ▶ _____
 - _____
 - _____
- I understand the risks that may be involved.
- I know that the information in this form includes the known effects and risks. I also know that there may be unknown long-term effects or risks.
- I have had enough opportunity to discuss treatment options with my clinician.
- All of my questions have been answered to my satisfaction.
- I believe I know enough to take, refuse, or postpone testosterone therapy.
- I am 18 years old or older.

BASED ON ALL THIS INFORMATION:

_____ I understand the risks, and consent to taking testosterone.

_____ I understand the risks, and decided I do not consent to taking testosterone at this time.

Patient's Signature

Date

Prescribing Physician's Signature

Date

Your health is important to us. If you have any questions or concerns, please come to sick call and an appointment with your provider will be made.

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

ALISHEA KINGDOM, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, et al.,

Defendants.

Case No. 1:25-cv-00691-RCL

**DECLARATION OF ALISHEA
SOPHIA KINGDOM**

My name is Alishea Sophia Kingdom.¹ I am over the age of 18 and fully competent to make this declaration. Under penalty of perjury, pursuant to 26 U.S.C. § 1746, I declare:

1. I am a 34-year-old transgender woman in the custody of the Bureau of Corrections (“BOP”). I am currently incarcerated at Fairton Federal Correctional Institution (“FCI Fairton”).

2. I have been aware that my gender identity is female since childhood. Growing up in Wisconsin, around age 7, I remember being sad and upset when I learned that my body was not like my girl cousins’ bodies, because I knew I was a girl, too. When my uncles bought me G.I. Joes, I would dress them up in my sister’s Barbies’ clothes. My mom would buy “boy’s” bedspreads for me and “girl’s” bedspreads for my sister. I would sometimes borrow a princesses blanket from my sister and sleep with it underneath my Ninja Turtles blanket.

¹ My legal name is Joshua Mueller. My Federal Bureau of Prisons Register Number is 13131-089.

3. Because she thought I was either gay or too feminine, my mom started sending me to various mental health centers and boys' residential programs, starting when I was around age 10. While it hurt to know that she thought there was something wrong with me, I also found a certain sense of freedom in some of this time away from home. While my mom would always tell me to speak in a deeper voice or walk like a boy, I was free to express myself in some of the group homes.

4. When I started going through male puberty, I really knew something was wrong—that I should be growing into a woman. I started to feel intense anxiety. I had regular panic attacks, especially when I started to grow facial hair. I couldn't sleep, and I would break out into cold sweats as I lay awake worrying about my body and how uncomfortable I was with my body masculinizing.

5. I came out as a transgender woman when I was a teenager, and began wearing typically-female clothing, hairstyles and cosmetics.

6. Because I did not have access to doctors who could treat my gender dysphoria, starting around age 17, I would get estrogen pills from a friend. I did this because I was desperate to alleviate my dysphoria.

7. I was arrested when I was 19 years old, served a sentence in state prison, and I have been in BOP custody since I was 23 years old.

8. BOP providers diagnosed me with gender dysphoria in 2016. Later in 2016, I saw an endocrinologist who prescribed me hormone therapy.

9. I was also approved to get commissary items like women's undergarments and cosmetics to alleviate my gender dysphoria in 2016.

10. It was a huge relief to be able to be on hormones again and access items to help me present as the woman I know myself to be.

11. Last year I went before the Transgender Executive Council (TEC) so they could review me for surgery to further alleviate my gender dysphoria.

12. On January 26, 2025, I was supposed to receive my regular hormone shot but was denied care. BOP staff told me that, because of President Trump's Executive Order, they would no longer provide care to transgender people at FCI Fairton.

13. On or about January 26, 2025, FCI Fairton removed all commissary items that transgender women previously had access to in alignment with our gender identity.

14. On or about January 26, 2025, FCI Fairton changed its regulations for searches to allow male guards to do visual and pat down searches of trans women. BOP staff also stopped using correct pronouns or avoiding using pronouns (such as by calling someone inmate and their last name) and began to misgender people, saying that under the EO they are not allowed to use female pronouns for transgender women.

15. All books with LGBTQ+ themes have been removed from the FCI Fairton library. When I asked Administrative Supervisor Bergensen why the books were removed, he told me that the prison couldn't "promote" anything dealing with LGBTQ+ identity.

16. On February 6, 2025, I was supposed to receive another shot, but again was told that I could not receive care because of the Executive Order.

17. I submitted a BP-08 grievance on February 4, 2025, grieving that I was no longer able to access treatment for gender dysphoria because of the Executive Order.

18. I received a response to my BP-08 grievance on February 6, 2025, containing language from the Executive Order with no additional response to my grievance. The response

read, “Executive Order ‘Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government,’ signed by President Donald Trump on January 20, 2025, states in Section 4(c) that the Attorney General shall ensure that the Bureau of Prisons revises its policies concerning medical care to be consistent with this order and shall ensure that no federal funds are expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex.”

19. I had been scheduled to receive another shot on February 12, 2025, but again was denied care with BOP staff saying that the Executive Order did not allow me to access health care for my gender dysphoria.

20. On February 27, 2025, I spoke with Clinical Director Martin and asked when I would be receiving my hormone therapy. Director Martin informed me that I would not be receiving my shots, and that BOP was receiving new policies confirming the denial of hormone therapy.

21. After approximately a decade of receiving hormone therapy while in BOP custody, I have now been cut off from access to this medication. After more than a month without care, my gender dysphoria has become incapacitating. The distress of losing my care has caused me to experience anxiety, panic attacks, and mood swings, and I have been unable to sleep. Losing my care has caused me to feel hopeless, and I have begun having suicidal thoughts as a result. I frequently find myself thinking, I would rather not live than be forced to live as a man.

22. I was due to be further evaluated for surgical treatment for my gender dysphoria this March 2025, but with the shutdown of the TEC, there is now no avenue for me to continue

to seek surgery. This causes me extreme distress. I regularly think about taking a pair of scissors and removing my own genitals to end the pain of my dysphoria.

I, Alicia Sophia Kingdom, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and recollection.

Dated: 03/04/2025

/s/ Alishea Sophia Kingdom
Alishea Sophia Kingdom

I, Shawn Thomas Meerkamper, certify that I have read the foregoing to Alishea Kingdom, and that she affirmed that the foregoing is true and correct on 03/04/2025.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: 03/13/2025

/s/ Shawn Thomas Meerkamper
Shawn Thomas Meerkamper

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

ALISHEA KINGDOM, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, et al.,

Defendants.

Case No. 1:25-cv-00691-RCL

DECLARATION OF SOLO NICHOLS

My name is Solo Nichols.¹ I am over the age of 18 and fully competent to make this declaration. Under penalty of perjury, pursuant to 28 U.S.C. § 1746, I declare:

1. I am a 40-year-old transgender man in the custody of the Federal Bureau of Prisons (“BOP”). I am currently incarcerated at Federal Correctional Institution (“FCI”) Tallahassee.

2. Growing up in Michigan, even at a young age I knew I was a boy. I would tell people, “Don’t call me a girl. I’m a boy.” I was in fifth grade the first time I confidently told a friend that I was a boy.

3. As I grew, my gender dysphoria started causing depression and anxiety. I felt invisible, small, inadequate, mentally and physically weak. It was the worst when I would get my period. I felt exposed, and I felt like a fraud. Walking to the bathroom with a tampon, I would sweat and my heart would race. It felt like being naked in public.

¹ My legal name is Latasha Ann Nichols. My Federal Bureau of Prisons Register Number is 16212-040.

4. Starting around age 15, I began what I now understand to be called “social transition.” I wore exclusively men’s clothes and used men’s hygiene products. I also started wearing a chest binder to give my chest a more masculine appearance.

5. I have been in federal prison since 2013. My current release date is August 28, 2029.

6. Though I had known myself to be a man for a long time, it was in federal prison that I first heard the word “transgender.” Around 2016, I learned that if BOP recognized me as transgender, I could access boxers, chest binders, and men’s hygiene products—just as I had before coming to prison. It took BOP about two years to recognize me as transgender, and I was allowed access to these items in 2018.

7. A BOP healthcare provider diagnosed me with gender dysphoria in 2021, and I started testosterone hormone therapy around June 2021.

8. Being on testosterone has made me feel “normal” for the first time in my life. From ages 14 to 36 I was prescribed approximately 13 different psychiatric medications. Since starting testosterone, I have not had a need for any psychiatric medications. Other medications never controlled my anxiety or agitation. Before starting testosterone, I experienced constant racing thoughts, and I could not control my temper. Since starting testosterone, I feel “grounded” and in control of myself in a way I never did before. Testosterone has enabled me, for the first time in my life, to handle difficult situations in a measured way, and to take constructive criticisms not as attacks, but as opportunities to learn and grow. Testosterone has also stopped my period.

9. In 2022, BOP medical providers approved me for “top surgery”—a double mastectomy to further treat my gender dysphoria. That approval was the result of a long process

that included a chest x-ray, a mammogram, answering about 200 questions for a clinical director, a video conference with the Transgender Utilization Review Advisory Group. The TURAG and the BOP medical director approved me for surgery. I have been waiting for a consultation with a surgeon ever since.

10. Ever since President Trump issued the Executive Order, I have been living in fear that BOP will take away the medication that allows me to live as my true self.

11. The week of January 27, BOP psychologist Dr. Proulx informed me that she was aware of an email from officials at a BOP central office in Grand Prairie, TX directing BOP medical staff to discontinue hormone therapy at FCI Tallahassee. She apologized and said that this was not the decision she would make. However, I later spoke with Warden Pistro, and she told me that nothing was changing yet.

12. That same week, Dr. Proulx posted a message on an inmate bulletin board that included information about the effects of discontinuing testosterone hormone therapy. That message read, in part, “apart from endocrine problems, discontinuation of high-dose, long-term TRT can also lead to testosterone withdrawal symptoms, such as depression, uncontrollable desire to get back on T, sleep problems and insomnia, lack of energy and fatigue, lack of appetite, anorexia, decreased libido, muscle and joint pain, and headaches.”

13. Prior to February 12, 2025, I received a 100mg testosterone injection every other week. It is my understanding that 100mg is a lower dose than other transgender men require. It is my understanding that 100mg is effective for me because I previously underwent a partial hysterectomy. My injections are ordinarily administered by Nurse Practitioner Nelson.

14. On February 12, 2025, when I arrived to receive my regularly scheduled injection a new staff person, Mr. Goodman, was there to administer testosterone injections for me and

three other transgender men. We were all surprised to learn that our doses were reduced that day. Instead of 100mg, I received only 50mg. Mr. Goodman told me that on February 26, 2025, I would receive a 25mg injection and that that would be my last testosterone injection. Mr. Goodman said that this was happening because of President Trump's Executive Order.

15. I received no prior notice that my testosterone dosage would be reduced or discontinued. I have not had any recent lab work done, and no medical or mental health provider spoke to me about my course of treatment and what a reduction or discontinuation of my testosterone hormone therapy would mean for me individually.

16. After receiving my reduced dose on February 12, I experienced fatigue and mood swings. It feels like the other transgender men and I were walking around like zombies.

17. On Friday, February 21, 2025, the other transgender men and I were informed that our testosterone treatments would be restored to our full dosages. The staff said this would only last until "the restraining order is up."

18. I am very scared to live without testosterone hormone therapy. It feels like who I am and all of the progress I've made is being taken from me, and I feel extremely anxious. I fear losing muscle mass, I am scared to get my period again, and I worry what other detrimental physical and mental health effects I will experience.

19. The last week of February, BOP staff informed me that they would no longer provide, and I would no longer be able to purchase, boxers or chest binders.

20. I have filed BP-8, BP-9, and BP-10 grievances about the changes to our access to care for gender dysphoria.

I, Solo Nichols, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and recollection.

Dated: 03/05/2025

/s/ Solo Nichols
Solo Nichols

I, Shawn Thomas Meerkamper, certify that I have read the foregoing to Solo Nichols, and that he affirmed that the foregoing is true and correct on 03/05/2025.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: 03/13/2025

/s/ Shawn Thomas Meerkamper
Shawn Thomas Meerkamper

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

ALISHEA KINGDOM, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, et al.,

Defendants.

Case No. 1:25-cv-00691-RCL

DECLARATION OF JAS KAPULE

My name is Jas Kapule.¹ I am over the age of 18 and fully competent to make this declaration. Under penalty of perjury, pursuant to 28 U.S.C. § 1746, I declare:

1. I am a 35-year-old transgender man in the custody of the Federal Bureau of Prisons (“BOP”). I am currently incarcerated at Federal Correctional Institution (“FCI”) Waseca.

2. When people ask me why I’m trans, I just say I’ve always been like this. I knew I was a boy when I was five years old. When I was growing up, I tried to make my family happy and tried to be feminine, but it never felt right when people saw me as a girl. I was never comfortable with femininity and always wanted to present as a boy. People would mistake me for a boy sometimes, and I would be happy when they did.

3. After high school, when I was around 18 years old, I realized I wanted to be myself and try to be happy. I was deeply depressed trying to be someone I am not, and not accepting myself, so I started living as who I am, a man. I still struggled with dysphoria and

¹ My legal name is Jasmine Lalani Kapule. My Federal Bureau of Prisons Register Number is 97856-298.

started using drugs as a coping mechanism. If I had known about hormones to treat gender dysphoria, I would have started them then.

4. I have been in federal prison since 2020. My current release date is in 2028.

5. Shortly after I entered BOP custody in 2020, I began to seek hormone therapy for my gender dysphoria. In 2022, I was diagnosed with gender dysphoria and began receiving hormone replacement therapy. I have continued taking testosterone as a treatment for gender dysphoria since then.

6. Being on hormone therapy has dramatically changed my life for the better. My lifelong depression finally began to lift. When my period ended due to the hormone therapy, I felt like I had turned over a whole new leaf and finally began feeling comfortable in my body.

7. Since approximately 2022, I have also been able to access commissary items that matched my gender identity, such as men's underwear and chest binders. This has helped decrease discomfort with how I dress and present myself.

8. Last year, in 2024, I began pursuing "top surgery"—a double mastectomy to further treat my gender dysphoria. I met with Assistant Warden Davis, who evaluated me. Assistant Warden Davis referred me to Dr. Reyna, the facility's chief psychologist, who confirmed my gender dysphoria diagnosis and referred me to the Transgender Executive Council (TEC). On December 19, 2024, Assistant Warden Davis sent me a message saying that the TEC had reviewed my case and made the following recommendations: "Hormone levels are on target and have been consistent. Clear conduct since July 2023. *WASPB [Women and Special Populations Branch] to initiate a surgical referral to HSD [Health Services Department] for further review." I was waiting for a final response when the Executive Order was issued.

9. When I went to get my hormone shot on January 23, 2025, I asked if I would still be allowed to access care for gender dysphoria. BOP staff told me that I would get my shot that day, and that would continue until they heard how to implement the Executive Order from central office. BOP staff have since told me that my hormone therapy will be discontinued when my current prescription runs out. On March 12, 2025, I asked the staff person who gave me my injection when my prescription runs out, and she could not or would not tell me.

10. On January 31, 2025, BOP staff posted a bulletin about President Trump issuing an Executive Order. The bulletin said that inmates could no longer contact the Transgender Executive Council and that it is being ended.

11. The prison has also stopped offering a class led by a BOP staff member called Emerging Identities, where we discussed and learned about identity, including gender identity. The FCI Waseca staff member who used to lead the class later gathered us together told us the class was on hold due to the Executive Order.

12. On February 24, 2025, BOP staff told us that we could no longer receive or purchase chest binders to address dysphoria related to our chests. The next day, February 25, 2025, BOP staff told us that we had to turn in our boxers as we were now forbidden from wearing them. They gave us panties to wear. I did not even know what size to ask for, as I haven't worn them in years. It felt degrading to have even our underwear taken away from us.

13. Ever since President Trump issued the Executive Order, I have been afraid that that BOP will take away the medication that allows me to live as my true self. Now that I am finally in a place where I feel ok, I am scared that I will be forcibly detransitioned and taken back to a very bad place, mentally. I am particularly afraid of my period returning and the depression and dysphoria it will cause.

14. Because the TEC has been abolished, I will not be able to access surgery to alleviate my gender dysphoria, as I was awaiting a decision from them. When I asked Assistant Warden Davis about my surgery on February 25, 2025, I was told that everything is stopped and that I will not have surgery as it was still in process when the Executive Order was issued.

15. I submitted a BP-10 grievance form on February 12, 2025, by certified mail. I used a BP-10 regional grievance form because I knew that FCI-Waseca cannot remedy my situation because of the Federal policy change. I grieved the loss of access to surgical care and the impending loss of other care for my gender dysphoria. I received a response advising me to resubmit my grievance as a BP-08 grievance. I filed my BP-08 as instructed on March 3, 2025, and the unit manager received it on March 7, 2025. On March 12, 2025, I received a response to that BP-08 which stated, "Pursuant to President Trump's January 20, 2025 Executive Order, 'Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government,' the Transgender Offender Manual was rescinded. Until further notice, the Bureau of Prisons will follow any updated policies published by the Department of Justice.' I also appealed the response to my BP-10 by filing a BP-11 on March 6, again grieving the loss of access to surgical care and the impending loss of other care for my gender dysphoria.

I, Jas Kapule declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and recollection.

Dated: 03/12/2025

/s/ Jas Kapule
Jas Kapule

I, Shawn Thomas Meerkamper, certify that I have read the foregoing to Jas Kapule, and that he affirmed that the foregoing is true and correct on 03/12/2025.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: 03/13/2025

/s/ Shawn Thomas Meerkamper
Shawn Thomas Meerkamper

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, *et al.*,
Plaintiffs,

v.

DONALD J. TRUMP, *et al.*,
Defendants.

Case No. 1:25-cv-00691-RCL

**[PROPOSED] ORDER GRANTING PLAINTIFFS' MOTION FOR A
PRELIMINARY INJUNCTION, TO STAY AGENCY ACTION, AND FOR
PROVISIONAL CLASS CERTIFICATION**

Upon consideration of Plaintiffs' Motion for a Preliminary Injunction, to Stay Agency Action, and for Provisional Class Certification, and any opposition and reply,

It appearing to the Court that Plaintiffs are likely to succeed on the merits of their action, that they will suffer irreparable injury if the requested relief is not issued, that the balance of the equities and public interest favor the entry of such an order,

And it further appearing to the Court that the proposed class satisfies the requirements of Fed. R. Civ. P. 23 in that the class is sufficiently numerous, satisfies the commonality, typicality, and adequacy requirements, and that Plaintiffs' counsel are qualified to serve as class counsel for the provisionally certified class, and that the proposed class should therefore be provisionally certified for purposes of the preliminary injunction, it therefore is

ORDERED that Plaintiffs' motion is **GRANTED**, and it is further

ORDERED that this case is provisionally certified as a class action on behalf of all persons who are or will be incarcerated in the custody of BOP who are or will be diagnosed with

gender dysphoria or meet the criteria for a gender dysphoria diagnosis and who are receiving, or would receive, gender-affirming health care absent such care being proscribed by EO 14168 and the Implementing Memoranda. It is further

ORDERED that Plaintiffs' counsel, from the American Civil Liberties Union, Transgender Law Center, and the attorneys from the American Civil Liberties Union Foundation of the District of Columbia, are hereby appointed as counsel for the provisionally certified Plaintiff Class. It is further

ORDERED that both the February 21, 2025 memorandum from BOP Reentry Services Division Acting Assistant Director Dana R. DiGiacomo and Correctional Programs Division Assistant Director Shane Salem and the February 28, 2025 memorandum from BOP Health Services Division Assistant Director Chris A. Bina implementing Executive Order 14168 are stayed pursuant to 5 U.S.C. § 705. It is further

ORDERED that Defendants Donald J. Trump, Pamela J. Bondi, William W. Lothrop, Christopher A. Bina, Dana R. DiGiacomo, and Shane Salem, in their official capacities, and their contractors, employees, and agents (i) are enjoined from enforcing Executive Order 14168 as applied to medical care and accommodations for people in the custody of the BOP and from enforcing the BOP's memoranda implementing Executive Order 14168, and (ii) shall provide and continue providing Plaintiffs and members of the proposed class gender-affirming hormone therapy and accommodations in accordance with BOP policy and practice immediately prior to Defendant Trump's issuance of Executive Order 14168 on January 20, 2025.

It is further **ORDERED** that this injunction shall be effective upon service on the Defendants, and no bond shall be required.

SO ORDERED.

Date: _____, 2025

HONORABLE ROYCE C. LAMBERTH

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

ALISHEA KINGDOM, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, et al.,

Defendants.

Case No. 1:25-cv-00691-RCL

**SUPPLEMENTAL DECLARATION
OF ALISHEA
SOPHIA KINGDOM**

My name is Alishea Sophia Kingdom.¹ I am over the age of 18 and fully competent to make this declaration. Under penalty of perjury, pursuant to 28 U.S.C. § 1746, I declare:

1. On Friday, March 14, 2025, I was called to the medical department at FCI Fairton, along with approximately 9 other transgender women. We were each called in to speak with Dr. Dimonte one-on-one.

2. When I was called into the exam room, Dr. Dimonte informed me that the decision to end hormone therapy at FCI Fairton had been “out of [his] hands.” He explained that he had not agreed with that decision. Dr. Dimonte said that “this *Kingdom* case” was causing problems, and that after speaking with lawyers, he would be restarting hormone therapy for everyone at FCI Fairton who had previously been taken off their hormones.

3. On Tuesday, March 18, 2025, I picked up my testosterone blocker from medical. This was the first time I have had access to my testosterone blocker since before January 26,

¹ My legal name was Joshua Mueller. On March 6, 2025, I received in the mail a Cumberland County court order changing my legal name to Alishea Sophia Kingdom. My Federal Bureau of Prisons Register Number is 13131-089.

2025, when I was first told that I would no longer be receiving hormone therapy because of President Trump's Executive Order.

4. On Wednesday, March 19, 2025, I received my estrogen shot for first time since before January 26, 2025, when I was first told that I would no longer be receiving hormone therapy because of President Trump's Executive Order.

5. I do not know if or when my hormone therapy will be discontinued again.

6. As of April 3, 2025, FCI Fairton still will not provide feminine undergarments through laundry services and still will not allow me to purchase feminine commissary items.

I, Alicia Sophia Kingdom, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and recollection.

Dated: 04/03/2025

/s/ Alishea Sophia Kingdom
Alishea Sophia Kingdom

I, Shawn Thomas Meerkamper, certify that I have read the foregoing to Alishea Kingdom, and that she affirmed that the foregoing is true and correct on 04/03/2025.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: 04/03/2025

/s/ Shawn Thomas Meerkamper
Shawn Thomas Meerkamper

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, et al.,

Plaintiffs,

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DONALD J. TRUMP, et al.,

Defendants.

Case No. 1:25-cv-00691-RCL

**SUPPLEMENTAL DECLARATION
OF SOLO NICHOLS**

My name is Solo Nichols.¹ I am over the age of 18 and fully competent to make this declaration. Under penalty of perjury, pursuant to 28 U.S.C. § 1746, I declare:

1. When my hormone dosage was reduced without notice on February 12, 2025, all other transgender men at FCI Tallahassee who had been on hormone therapy also had their hormone dosages reduced at the same time. None of us met with a doctor or had an evaluation beforehand.

2. I informed FCI Tallahassee staff about a temporary restraining order in *Doe v. McHenry* the week of February 16, 2025.

3. On February 21, 2025, when my hormone dosage was restored, all other transgender men whose dosages had been reduced also had theirs restored at the same time.

4. I did meet with a doctor before my hormone dosage was restored. However, that doctor did not examine me, order lab work, or discuss my mental health with me. He simply

¹ My legal name is Latasha Ann Nichols. My Federal Bureau of Prisons Register Number is 16212-040.

confirmed that I wanted my dose restored and confirmed what my previous dosage was. He reviewed two-year-old blood work with me after I requested an increased dosage. This meeting, and the other transgender men's meetings with the same doctor, lasted between 2 and 5 minutes.

5. As I mentioned in my first declaration, the last week of February 2025, BOP staff informed me that they would no longer provide, and I would no longer be able to purchase, boxers or chest binders. When the boxers I currently have are no longer wearable, panties will be the only option I have for underwear.

6. Wearing boxers makes me feel normal. The thought of wearing panties when I run out of boxers makes me deeply uncomfortable, like I can't breathe. I would feel inadequate and embarrassed. Because of the ways in which hormone therapy has changed my body, wearing panties would be physically irritating in addition to mentally degrading. My gender dysphoria would be significantly worse.

7. It is my understanding that the transgender men in the Special Housing Unit FCI Tallahassee currently are only allowed to wear panties.

I, Solo Nichols, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and recollection.

Dated: 04/01/2025

/s/ Solo Nichols
Solo Nichols

I, Shawn Thomas Meerkamper, certify that I have read the foregoing to Solo Nichols, and that he affirmed that the foregoing is true and correct on 04/01/2025.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: 04/01/2025

/s/ Shawn Thomas Meerkamper
Shawn Thomas Meerkamper

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

ALISHEA KINGDOM, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, et al.,

Defendants.

Case No. 1:25-cv-00691-RCL

**SUPPLEMENTAL DECLARATION
OF JAS KAPULE**

My name is Jas Kapule.¹ I am over the age of 18 and fully competent to make this declaration. Under penalty of perjury, pursuant to 28 U.S.C. § 1746, I declare:

1. In my previous declaration, I said that I was diagnosed with gender dysphoria and started hormone therapy in 2022. Since executing that declaration, I have reviewed medical records that were previously not in my possession, and I now recall that it was in March 2023 that I was diagnosed with gender dysphoria and started hormone therapy.

2. In my previous declaration, I said that Dr. Reyna had confirmed my gender dysphoria diagnosis in 2024. Since executing that declaration, I have reviewed medical records that were previously not in my possession, and I now recall that Dr. Reyna did not comment on my diagnosis, but instead referred me directly to the TEC to discuss top surgery.

¹ My legal name is Jasmine Kapule. My Federal Bureau of Prisons Register Number is 97856-298.

3. As of April 3, 2025, it is still my understanding that my hormone therapy will be discontinued when my current prescription runs out. No BOP staff have informed me of when my current prescription ends.

4. The week of March 17, 2025, a group of new arrivals were intaked at FCI Waseca. Those new arrivals who were transgender men had their binders and boxers confiscated, regardless of whether they had purchased those items for themselves.

I, Jas Kapule, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and recollection.

Dated: 04/03/2025

/s/ Jas Kapule
Jas Kapule

I, Shawn Thomas Meerkamper, certify that I have read the foregoing to Jas Kapule, and that he affirmed that the foregoing is true and correct on 04/03/2025.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: 04/03/2025

/s/ Shawn Thomas Meerkamper
Shawn Thomas Meerkamper

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

ALISHEA KINGDOM, et al.,

Plaintiff,

v.

DONALD J. TRUMP, et al.,

Defendants.

Case No. 1:25-cv-00691

**SECOND DECLARATION OF DR. DAN H. KARASIC IN SUPPORT OF
PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION**

I, Dan H. Karasic, M.D., hereby declare and state as follows:

1. I am over the age of 18, of sound mind, and in all respects competent to testify.
2. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.
3. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion.
4. I submitted an expert declaration in this case on March 14, 2025. My background and qualifications are discussed in that declaration.
5. I submit this declaration to respond to a few points made in defendants' opposition to Plaintiff's motion and to provide observations regarding the subsequently filed amici brief.
6. First, defendants' brief asserts that there is "ongoing scientific and medical debate over the necessity and efficacy of hormone medication as a treatment for gender dysphoria." *See, e.g.*, Defendants' brief, at 2; *see also id.* at 15 (suggesting treating for gender dysphoria is a "highly controversial area of medical practice"). This is simply untrue. While there is some

discussion within the field about how to best care for minors with gender dysphoria,¹ there is no serious debate or controversy within the medical and mental health fields about the necessity and efficacy of hormone therapy to treat adults with gender dysphoria. As I explained in my first declaration, decades of research and clinical experience have shown the benefits of hormone therapy to individuals with gender dysphoria.

7. Defendants' brief suggests that if BOP were to discontinue hormone therapy, there will be no harm because, it says, there are alternative treatments that could be provided. *See* Defendants' brief, at 10. That is untrue. As I discussed in my first declaration, while not everyone with gender dysphoria needs hormone therapy, for those for whom it is clinically indicated, there is no alternative treatment. There is no evidence-based psychotherapeutic treatment to treat gender dysphoria. Withdrawing hormone therapy from those who have a medical need for it would be expected to result in an exacerbation of their gender dysphoria, putting them at significant risk of depression, anxiety, self-harm and suicidality.

8. The declaration of the Bureau of Prisons' Assistant Director of the Health Services Division, Chris Bina, suggests that if incarcerated people are taken off of hormone therapy, there will be no harm because he says they would "receive treatment for any symptoms they may experience as clinically indicated." *See* Bina declaration, par. 15. But the symptom that people would experience if hormones are withdrawn is a rise in gender dysphoria, and, as discussed above, there are no alternative treatments for gender dysphoria for those who need gender-affirming medical interventions. Thus, withdrawing or withholding such care when

¹ *See, e.g.*, The Cass Review, Independent Review of Gender Identity Services for Children and Young People: Final Report at 195 (April 2024) (the "Cass review") (recommending that puberty blockers be provided within the context of clinical research trials and that hormone therapy be provided "with caution" for youth ages 16 and 17). I do not reference the Cass Review to suggest that I agree with it; indeed, it has been widely criticized. *See, e.g.*, British Medical Association, "BMA to undertake an evaluation of the Cass Review on gender identity services for children and youth people," July 31, 2024, available at <https://www.bma.org.uk/bma-media-centre/bma-to-undertake-an-evaluation-of-the-cass-review-on-gender-identity-services-for-children-and-young-people>.

indicated puts people at risk of significant harm to their mental health.

9. Defendants cite the Cass Review’s finding that “while deaths by suicide in trans-identifying individuals are tragically above the national average, there is ‘no evidence that gender-affirmative treatments reduce this.’” Defendants’ brief, at 16. As an initial matter, suicide prevention is not the only reason for providing hormone therapy to individuals with gender dysphoria. This condition can cause other severe harms to mental health as I discussed in my first declaration. Moreover, the Cass Review and the cited passage are focused on minors. The cited passage that was excerpted in Defendants’ brief specifically refers to “risk of death by suicide among gender diverse youth.” Cass Review, at 94. It is difficult to get data on completed suicides for any population,² but there is substantial evidence that gender-affirming medical care reduces suicidal ideation and suicide attempts,³ which are significant risk factors for suicide (*see n. 2, supra*), and it is a serious mental health concern in its own right when people think about ending their lives.

10. I’d like to address some confusion reflected in the Defendants’ brief about the purpose of hormone therapy in the treatment of gender dysphoria. Defendants’ brief states that “[t]he Court apparently assumed that all hormone medication provided to treat gender dysphoria is ‘for the purpose of conforming an inmate’s appearance to that of the opposite sex,’ Exec.

² Because completed suicides are so rare, it’s difficult to get data. For example, in clinical trials of over 4400 youth receiving antidepressants, there were no suicides. Nevertheless, there’s a black box warning about increased risk of suicidality when antidepressants are used for people under the age of 25, which is based on increased suicidal ideation and attempts. *See* <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/suicidality-children-and-adolescents-being-treated-antidepressant-medications>

³ *See, e.g.* Kaltiala, R., Heino, E., Työläjärvä, M., & Suomalainen, L. (2019). Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria. *Nordic Journal of Psychiatry*, 74(3), 213–219. <https://doi.org/10.1080/08039488.2019.1691260>; Allen, et al 2019 Allen LR, Watson LB, Egan AM, Moser CN. Well-Being and Suicidality Among Transgender Youth After Gender-Affirming Hormones. *Clinical Practice in Pediatric Psychology*. 2019;7(3):302-311. doi:10.1037/cpp0000288 Turban et al 2022 <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0261039> Tordoff et al 2022 doi:10.1001/jamanetworkopen.2022.0978

Order No. 14168, § 4(c), regardless of the inmate’s individual medical condition.”” Defendants’ brief, at 13. Hormone therapy alleviates gender dysphoria by conforming an individual’s body to be consistent with their gender identity. Defendants appear to assert that medically necessary hormone treatment and hormone treatment “for the purpose of conforming an inmate’s appearance to that of the opposite sex” are separate things. They are not. The use of hormones to change the patient’s appearance is medically necessary for the treatment of gender dysphoria.

11. Defendants point to some statements suggesting that WPATH’s guidelines are based on ideology, not science or “extensive clinical experience.” *See* Defendants’ brief at 17. This is not true. As I discussed in my first declaration, WPATH’s guidelines were developed by experts in the field using a rigorous evidence-based approach. *See* Karasic initial declaration, pars. 53-62. The authors of the WPATH guidelines include university professors and individuals with extensive clinical experience in providing care for people with gender dysphoria. I myself have been involved in the development of the WPATH guidelines and have over 30 years of clinical experience treating individuals with gender dysphoria. Since the first WPATH guidelines in 1979, WPATH has drawn on the expertise of the most experienced clinicians. And these guidelines were developed using widely accepted methods recommended by the National Academy of Medicine that have been used to develop other medical guidelines such as all American Psychiatric Association’s practice guidelines for various psychiatric illnesses, such as schizophrenia, eating disorders, and alcohol use disorder, since 2011.⁴ The WPATH guidelines are recognized as authoritative by every major medical association in the United States, including the National Commission on Correctional Health Care.⁵

⁴ *See* <https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines/guideline-development-process>.

⁵ *See* National Commission on Correctional Health Care, Position Statement- Transgender and Gender Diverse Health Care in Correctional Settings, November, 2020, available at <https://www.ncchc.org/position-statements/transgender-and-gender-diverse-health-care-in-correctional-settings-2020/>.

12. Defendants’ brief also attempts to discredit the WPATH guidelines by citing references in Judge Lagoa’s concurring opinion in *Eknes-Tucker v. Governor of Alabama* in which she cites a publication entitled “The WPATH Files.” The WPATH Files is a collection of select out-of-context excerpts of communications among WPATH members on a message board over a four-year period that was obtained and published by a journalist and activist opposed to gender-affirming medical care, along with a narrative she created based on those cherry-picked excerpts in an attempt to discredit WPATH. These select, out-of-context statements do not permit the conclusions about WPATH asserted by the author. Moreover, the author is not someone within the field of medicine or mental health nor experienced in the treatment of gender dysphoria, and this document is not published in a scientific journal. It is an activist’s opinion piece based on a highly misleading presentation of excerpts of communications.

13. I have reviewed the amicus brief filed by several states in this case and have a few observations.

a. First, while the amicus brief claims that hormone therapy is a “controversial practice” and attempts to support that claim by citing three studies, none of those studies permit such a conclusion. The first study⁶ did not evaluate the evidence because the authors set criteria for inclusion in their review that excluded all of the studies. *See id.* (“We could not appraise the quality of the evidence because no studies met our review's inclusion criteria.”). The second study⁷ found that hormone therapy was associated with increased quality of life, decreased depression, and decreased anxiety. That the authors were unable to

⁶ Haupt et al, Antiandrogen or estradiol treatment or both during hormone therapy in transitioning transgender women, 11 Cochrane Database of Systematic Reviews, Art. No. CD013138, at 2, 11 (2020).

⁷ Kellan E. Baker, et al., Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review, 5 J. Endocrine Soc. 1, 12–13 (2021).

draw conclusions about the impact on death by suicide is an ongoing challenge in research. *See supra*, par. 9. Finally, the state amici suggest that a third study⁸ indicated that hormone therapy increased suicidality, but that study showed a “reduction in suicidality following gender-affirming treatment.” Within the medical and mental health fields, hormone therapy has long been widely recognized as an effective treatment for gender dysphoria.

b. The states’ amicus brief also suggests that that psychotherapy is “widely recognized” as an alternative treatment for gender dysphoria in lieu of gender-affirming medical care, citing Anderson et al., *Gender Dysphoria and Its Non-Surgical and Surgical Treatments*, 10 *Health Psych. Rsch.*, at 4 (2022). But that study, which notes the benefits of psychotherapy for patients with gender dysphoria (e.g. providing support, help with coming out), does not suggest that psychotherapy is a substitute for gender-affirming medical interventions when indicated. Indeed, the study cites to the WPATH Standards of Care and a paper that discusses psychotherapy in the context of preparation for gender-affirming surgery. As discussed above, there is no evidence-based psychotherapeutic treatment to treat gender dysphoria in lieu of hormones.

c. In sum, the amici states make baseless assertions about treatment for gender dysphoria based on a highly misleading characterization of the sources they cite.⁹

⁸ Daniel Jackson, *Suicide-Related Outcomes Following Gender-Affirming Treatment: A Review*, 15(3) *Cureus* 11–13 (2023).

⁹ The states’ amicus brief also offers a misleading presentation of the evidence on gender-affirming surgery, but since the motion before the court does not address surgery, I have not provided an analysis of that discussion.

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

Executed this 3rd day of March, 2025

A handwritten signature in black ink, appearing to read 'DK' followed by a stylized flourish.

Dan H. Karasic

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

ALISHEA KINGDOM, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, et al.,

Defendants.

Case No. 1:25-cv-00691-RCL

**DECLARATION OF AYANA
SATYAGRAHI**

My name is Ayana Satyagrahi.¹ I am over the age of 18 and fully competent to make this declaration. Under penalty of perjury, pursuant to 28 U.S.C. § 1746, I declare:

1. I am originally from Galveston, Texas. I am a 50-year-old transgender woman currently incarcerated at Federal Correctional Institution (“FCI”) Seagoville, a low-security facility. I am one of approximately 36 transgender women at FCI Seagoville. I have been in Federal Bureau of Prisons (“BOP”) custody since 2010.

2. I was diagnosed with gender dysphoria and started hormone therapy to treat my dysphoria in 2004, prior to being incarcerated. Since entering BOP custody in 2010, BOP has repeatedly confirmed my diagnosis and has been providing me with hormone therapy since 2010.

3. On February 24, 2025, Warden Phillips called all of the trans women at FCI Seagoville into the facility’s auditorium and announced that, because of President Trump’s Executive Order, the facility would be confiscating the dresses and undergarments we had

¹ Although a district court in Leavenworth County, Kansas legally changed my name to Ayana Satyagrahi, BOP has not changed my name in its system. My BOP Register Number is 43636-279.

received through the facility laundry; cutting off access to new bras and panties through either commissary or the laundry system, as well as access to cosmetics through commissary; ending programming aimed at supporting transgender people at the facility; and no longer providing electrolysis treatments or surgeries to treat gender dysphoria. Warden Phillips also said at that meeting that BOP would be weaning all of us off hormone therapy as soon as guidance was issued.

4. Before FCI Seagoville changed its policies to comply with President Trump's Executive order, I had been receiving laser hair removal treatments for approximately eight months. Because facial hair so severely exacerbates my gender dysphoria, BOP medical providers had determined that facial hair removal was medically necessary to treat my gender dysphoria. However, after February 24, 2025, BOP staff ended these treatments, and I have not had any since. No BOP medical provider spoke with me individually before stopping my laser hair removal treatments. Two other transgender women at FCI Seagoville also had their laser hair removal treatments stopped; as far as I know, they also did not speak with a medical provider before their treatments were stopped.

5. Since February 24, 2025, staff at FCI Seagoville have been consistently telling me that President Trump's Executive Order means that hormone therapy for gender dysphoria will be ended for everyone in BOP custody. All of the other transgender women I know at FCI Seagoville have also been told that hormone therapy will be ending for everyone because of the Executive Order. No one will tell us when this will happen, only that it is coming. BOP staff have told me this as recently as the week of March 24, 2025.

6. I have been receiving hormone therapy to treat my gender dysphoria for over twenty years. The fact that I may suddenly lose access to this care is devastating. Because of the

potential loss of hormones, the end of my facial electrolysis treatments, and denial of appropriate clothing, I have been having near constant thoughts of self-harm.

I, Ayana Satyagrahi, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and recollection.

Dated: 04/03/2025

/s/ Ayana Satyagrahi
Ayana Satyagrahi

I, Shawn Thomas Meerkamper, certify that I have read the foregoing to Ayana Satyagrahi, and that she affirmed that the foregoing is true and correct on 04/03/2025.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: 04/03/2025

/s/ Shawn Thomas Meerkamper
Shawn Thomas Meerkamper

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

ALISHEA KINGDOM, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, et al.,

Defendants.

Case No. 1:25-cv-00691-RCL

DECLARATION OF A.J. DICIESARE

My name is A.J. DiCiesare.¹ I am over the age of 18 and fully competent to make this declaration. Under penalty of perjury, pursuant to 28 U.S.C. § 1746, I declare:

1. I have been in BOP custody since April of 2019. In 2019, a BOP medical provider named Dr. Rogers diagnosed me with gender dysphoria and started me on hormone therapy.

2. I am currently incarcerated at FMC Carswell. There are approximately 50 other transgender men on hormone therapy here at FMC Carswell.

3. Since approximately January 21, 2025, BOP staff have consistently told me that BOP will be taking all of us off of our hormone therapy because of President Trump's Executive Order. They have been unwilling or unable to say when that will happen.

4. My doctor has told me that he does not know when my hormone therapy will be ended. He has said that the decision isn't his and he is waiting for instructions from his superiors.

¹ My legal name is Amber Diciesare. My Federal Bureau of Prisons Register Number is 78212-061.

5. On March 19, I asked a nurse if he had heard anything about the status of hormone therapy in BOP. He told me that he did not know when hormone therapy would be ending.

6. On February 27, 2025, FMC Carswell confiscated the boxers and chest binders that had been previously issued to us. My chest binder had been issued through the medical supply department. I asked the health administration supervisor why they were confiscating my medical device, and she explained that they were required to because of the Executive Order.

I, A.J. DiCiesare, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and recollection.

Dated: 04/03/2025

/s/ A.J. DiCiesare
A.J. DiCiesare

I, Shawn Thomas Meerkamper, certify that I have read the foregoing to A.J. DiCiesare, and that he affirmed that the foregoing is true and correct on 04/03/2025.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: 04/03/2025

/s/ Shawn Thomas Meerkamper
Shawn Thomas Meerkamper

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

ALISHEA KINGDOM, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, et al.,

Defendants.

Case No. 1:25-cv-00691-RCL

**DECLARATION OF REBECCA-
JAMES MESKILL**

My name is Rebecca-James Meskill.¹ I am over the age of 18 and fully competent to make this declaration. Under penalty of perjury, pursuant to 28 U.S.C. § 1746, I declare:

1. I am a transgender woman incarcerated at FCI Talladega. On or about March 13, 2025, I was supposed to receive a refill of my hormone therapy medication. Medical staff had been treating my gender dysphoria with this medication for about 18 months before that time.
2. Because I could not refill my hormone medication, I put in a sick call and spoke with the clinical director of FCI Talladega. When I asked him about my medication being taken away, he said to take it up with the White House.
3. I was not evaluated by any medical staff before they ended my access to hormone therapy.
4. I have asked medical and psychiatry staff for help in getting back on my medication to treat my gender dysphoria, but they have said that it is out of their control. One psychiatrist told me she thought this was an Eighth Amendment violation.

¹ My legal name is James Meskill. My Federal Bureau of Prisons Register Number is 27972-057.

5. I knew of four other trans women at FCI Talladega who were also prescribed hormones to treat their gender dysphoria. BOP staff cut off all of our access to our prescribed hormone medications when our prescriptions ran out.

I, Rebecca-James Meskill, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and recollection.

Dated: 05/08/2025

/s/ Rebecca-James Meskill
Rebecca-James Meskill

I, Milo Inglehart, certify that I have read the foregoing to Rebecca-James Meskill, and that she affirmed that the foregoing is true and correct on 05/08/2025.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: 05/08/2025

/s/ Milo Inglehart
Milo Inglehart

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

ALISHEA KINGDOM, et al.,

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v.

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Case No. 1:25-cv-00691-RCL

DECLARATION OF GRACE PINSON

My name is Grace Pinson.¹ I am over the age of 18 and fully competent to make this declaration. Under penalty of perjury, pursuant to 28 U.S.C. § 1746, I declare:

1. On or around February 10, 2025, my hormone medication was cut off. I was housed in FCI Atlanta at the time and had been taking hormone therapy consistently since 2015. At the pill line that morning, BOP staff only gave me my mental health medications. I asked the nurse where the rest of my medications were. The nurse said that if they were medications for transgender people, I would not receive them as the Bureau of Prisons was working to get everyone off of hormones. I asked if I would be titrated off of my hormones, and she told me no, it would be stopped “cold turkey,” and to make a sick call if I experienced symptoms of a heart attack or stroke.

¹ My legal name is Jeremy Pinson. My Federal Bureau of Prisons Register Number is 16267-064.

2. I spoke to a health services administrator a few days after my access to gender dysphoria medications was ended, and she told me that the decision to discontinue hormone therapy was above her head and she couldn't countermand the order she had been given.
3. On or around February 19, 2025, I was transferred to FCI Butner, where I am currently incarcerated.
4. When I first came to FCI Butner, I received my medication for the first few days, from February 21 to 24; then, Butner also then discontinued medications to treat my gender dysphoria.
5. I spoke with the FCI Butner warden on February 21, and he told me that hormone medications were being stopped at Butner and that this was a regional order.
6. When I met with Dr. Lawrence Sichel at FCI Butner near the end of February, he told me that he was not authorized to provide any transgender care to me besides allowing me to go to a mammogram that was already scheduled.
7. I did not speak with any medical provider about my hormone therapy being stopped before it was discontinued at either facility.
8. I have not received hormone therapy since it was discontinued on February 24, 2025.
9. As far as I know, another transgender woman also had her hormone therapy discontinued on January 26, 2025, while she was incarcerated at Federal Correctional Institution, Fairton, and has not received any medication since. She is currently housed at the FCI Butner Annex.

I, Grace Pinson, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and recollection.

Dated: 05/07/2025

/s/ Grace Pinson
Grace Pinson

I, Milo Inglehaty, certify that I have read the foregoing to Grace Pinson, and that she affirmed that the foregoing is true and correct on 05/07/2025.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: 05/07/2025

/s/ Milo Inglehart
Milo Inglehart

**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

ALISHEA KINGDOM, et al.,

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v.

DONALD J. TRUMP, et al.,

Defendants.

Case No. 1:25-cv-691-RCL

MEMORANDUM OPINION

The plaintiffs in this dispute are inmates in the custody of the Bureau of Prisons (“BOP”) who have been medically diagnosed with gender dysphoria. During their periods of incarceration, the BOP has provided the plaintiffs with “social accommodations,” such as clothing and hair removal devices, as well as hormone therapy (collectively “gender-affirming care”), to mitigate the negative psychological effects of their conditions. On January 20, President Trump issued an Executive Order which provides that federal funds shall not be spent on any medical treatment for the purpose of conforming an inmate’s appearance to that of the opposite sex. The BOP subsequently promulgated two implementing memoranda to guide the agency’s execution of the Executive Order’s commands. The plaintiffs’ access to hormone medications and social accommodations was subsequently cut off or reduced. Access to hormone medications has since been restored, but the plaintiffs remain unable to procure social accommodations.

The plaintiffs, on behalf of a putative class of BOP inmates diagnosed with gender dysphoria, have moved to certify their proposed class and to preliminarily enjoin the implementation of the Executive Order and the implementing memoranda while this litigation is

pending. For the reasons that follow, both the plaintiffs’ Motion to Certify a Class and their Motion for a Preliminary Injunction will be **GRANTED**.

I. BACKGROUND

On January 20, 2025, President Donald Trump signed an Executive Order which provides, in pertinent part:

Sec. 4(c): “The Attorney General shall ensure that the Bureau of Prisons revises its policies concerning medical care to be consistent with this order, and shall ensure that no Federal funds are expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate’s appearance to that of the opposite sex.”

. . .

Sec. 8(b): “This order shall be implemented consistent with applicable law and subject to the availability of appropriations.”

Exec. Order 14168, *Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government*, 90 Fed. Reg. 8615 (Jan. 20, 2025) (the “Executive Order”). Pursuant to the directions contained in Section 4(c), the Bureau of Prisons began the process of formulating a policy consistent with the Executive Order. On February 21, 2025, the Bureau of Prisons issued an implementing memorandum (the “First Implementing Memorandum”) which, in relevant part, provides that “[n]o appropriated funds should be utilized to purchase any items that align with transgender ideology (e.g., binders, stand-to-pee devices, hair removal devices, etc.)” and that “[r]equests for clothing accommodations (e.g., issuance of smocks for male inmates and undergarments that do not align with an inmate’s biological sex) will not be issued. Additionally, . . . previously purchased commissary items by inmates may remain in their possession.” First Implementing Memorandum, Compl. Ex. A, ECF No. 1-1. On February 28, 2025, the BOP issued another implementing memorandum (the “Second Implementing Memorandum”) providing that “Consistent with Executive Order (EO) 14168, . . . no Bureau of Prisons funds are to be expended for any medical procedure, treatment, or drug for the purpose of

conforming an inmate's appearance to that of the opposite sex. This policy is to be implemented in a manner consistent with applicable law including the Eighth Amendment.” Second Implementing Memorandum, Compl. Ex. 2, ECF No. 1-2.

The three named plaintiffs in this case—transgender inmates who were diagnosed with gender dysphoria by BOP medical staff, were in BOP custody at the time that the Executive Order and implementing memoranda were issued, and who remain in BOP custody today—initiated this action on March 7, 2025. Compl. ¶¶ 1, 4, 24–26, ECF No. 1.

To be “transgender” is to feel that one is a member of a particular gender that is different from one's sex assigned at birth. *See* Declaration of Dr. Dan H. Karasic (“Karasic Decl.”) ¶¶ 32, 36, 42, ECF No. 7-2. Both gender identity and sex assigned at birth have biological causes; for example, sex assigned at birth depends on factors such as a person's genital appearance, assortment of chromosomes, and endogenous hormones. *Id.* ¶¶ 33, 38. Gender identity may also be influenced in part by external factors. *Cf. id.* at ¶ 38 (“Gender identity, which has biological bases . . . is not merely a product of external influence . . .”). “Gender dysphoria” is a medical condition wherein a person's incongruence between their sex and their gender identity causes “clinically significant distress and social/occupational impairment.” *Id.* ¶¶ 45, 47. “When untreated, gender dysphoria can cause significant distress including increased risk of depression, anxiety, self-harm and suicidality. It can also impair individuals' ability to function in all aspects of life . . .” *Id.* ¶ 51. The parties agree that gender dysphoria exists and that it can have serious manifestations. The parties also agree that hormone therapy is an important method for the treatment of gender dysphoria, although not every gender dysphoric person requires hormone therapy. *See id.* ¶ 66 (“While social transition alone can adequately address gender dysphoria for some people, many individuals with gender dysphoria cannot obtain relief without also receiving medical interventions

to align the body with their gender identity.”); Declaration of Chris A. Bina (“Bina Decl.”) ¶ 24, Defs.’ Opp’n Ex. 1, ECF No. 36-1 (describing the plaintiffs’ hormone therapy treatment regimens as “medically necessary care”).

Plaintiff Alishea Kingdom is a transgender woman who was diagnosed with gender dysphoria in 2016, prescribed hormone therapy injections, and approved to receive social accommodations including women’s undergarments and cosmetics. Kingdom Decl. ¶¶ 8–9, Mot. for Preliminary Injunction Attach. 4, ECF No. 7-4. She was denied her usual hormone shot on three occasions: on January 26, 2025, on February 6, 2025, and on February 12, 2025. *Id.* ¶¶ 13, 16, 19. The commissary at Ms. Kingdom’s facility also removed social accommodation items on January 26, 2025. *Id.* ¶ 13. On February 4, 2025, Ms. Kingdom submitted a BP-08 grievance form seeking a restoration of her hormone treatments, and two days later received a response that essentially contained only a recitation the text of Section 4(c) of the Executive Order. *Id.* ¶¶ 17–18. On February 27, 2025—after the issuance of the First Implementing Memorandum, and just one day before the issuance of the Second Implementing Memorandum—Ms. Kingdom was informed by a local BOP Clinical Director that her access to hormone therapy would not be restored, and that BOP “was receiving new policies confirming the denial of hormone therapy.” *Id.* ¶ 20. Ms. Kingdom states that the discontinuation of her hormone therapy caused her to experience anxiety, hopelessness, panic attacks, and suicidal ideation. *Id.* ¶ 21. On March 13 or 14, 2025—about a week after the initiation of this lawsuit, and two weeks after the issuance of the Second Implementing Memorandum—Ms. Kingdom had her access to hormone therapy restored. Suppl. Kingdom Decl. ¶ 2, Mot. for Leave to File Suppl. Decls. Attach. 1, ECF No. 47-1. The BOP avers that Ms. Kingdom received an individualized assessment of her medical needs prior to the restoration of her hormone therapy. *See* Bina Decl. ¶ 17. Ms. Kingdom, however, claims that

the BOP doctor with whom she met had informed her that the decision to restore her treatment had been taken in response to this litigation, and that the original discontinuation decision had been “out of [his] hands.” Suppl. Kingdom Decl. ¶ 2. Her access to feminine undergarments and commissary items has not been restored. Suppl. Kingdom Decl. ¶ 6.

Plaintiff Solo Nichols is a transgender man who was diagnosed with gender dysphoria in 2021, prescribed hormone therapy in the form of 100mg testosterone injections, and given access to men’s undergarments, men’s hygiene products, and chest binders. Nichols Decl. ¶¶ 6, 7, 13, Mot. for Preliminary Injunction Attach. 5, ECF No. 7-5.¹ On February 12, 2025, Mr. Nichols was instead given a 50mg dose, and was informed that his next dose would be only 25mg, after which his treatment would be discontinued entirely. *Id.* ¶ 14. On February 21, 2025, Mr. Nichols was informed that his original testosterone treatment regimen would be re-implemented. *Id.* ¶ 17. The BOP claims that this decision was made “after an individualized assessment” of Mr. Nichols’s medical needs, *see* Bina Decl. ¶ 23, but according to Mr. Nichols, BOP staff informed him that the restoration of his therapy would last only as long as “the restraining order is up,” presumably in reference to the preliminary injunctive relief that this Court granted in the related case *Doe v. McHenry*, No. 25-cv-286-RCL. Nichols Decl. ¶ 17. Mr. Nichols further avers that, although he met with a BOP physician prior to the restoration of his full-dosage treatment, the doctor did not examine him or discuss his mental health, and that the decisions to reduce and then increase the testosterone dosage was made uniformly and at the same time for all transgender men at his facility. Suppl. Nichols Decl. ¶¶ 1, 3–4, Suppl. Decls. Attach. 1, ECF No. 56-1. Mr. Nichols was informed during the last week of February that he would no longer have access to boxers or chest binders, and his access to those products has not been restored. Nichols Decl. ¶ 19; Suppl. Nichols

¹ A chest binder is tight-fitting garment worn around the chest to reduce the visibility of breasts.

Decl. ¶ 5. Mr. Nichols states that he is “very scared to live without testosterone therapy,” fearing that he will lose muscle mass and start menstruating again, Nichols Decl. ¶ 18, and likewise maintains that the thought of wearing feminine undergarments makes him feel “deeply uncomfortable, like I can’t breathe. I would feel inadequate and embarrassed.” Suppl. Nichols Decl. ¶ 6.

Lastly, plaintiff Jas Kapule is a transgender man who began receiving hormone therapy and gained access to social accommodation commissary items in 2023. Suppl. Kapule Decl. ¶ 1, Suppl. Decls. Attach. 2, ECF No. 56-2; Kapule Decl. ¶¶ 5, 7, Mot. for Preliminary Injunction Attach. 6, ECF No. 7-6. Sometime between January 23, 2025 and March 12, 2025, BOP staff informed Mr. Kapule that his hormone therapy would be discontinued when his current prescription ran out. Kapule Decl. ¶ 9. As of April 3, 2025—well after the Complaint was filed—Mr. Kapule continued to believe, based on the BOP’s representation, that his therapy would be discontinued with the expiration of his prescription. Suppl. Kapule Decl. ¶ 3. His hormone therapy was never discontinued, but on February 24, 2025, Mr. Kapule was told that he would no longer have access to chest binders, and the next day was made to turn in his boxers in exchange for feminine undergarments. *Id.* ¶ 12. Mr. Kapule fears that the discontinuation of his therapy would result in the return of his menstrual cycle and will lead to depression. *Id.* ¶ 13.

On March 17, the plaintiffs filed a Motion for a Preliminary Injunction and for Provisional Class Certification. *See generally* Mot. for Preliminary Injunction, ECF No. 7. The plaintiffs seek relief in the form of a stay, pursuant to 5 U.S.C. § 705, of the two implementing memoranda, as well as an injunction forbidding the defendants from enforcing the Executive Order and implementing memoranda’s provisions on medical care and social accommodations and ordering them to continue providing gender-affirming hormones and social accommodations in accordance

with BOP policy prior to the issuance of the Executive Order. *Id.* at 5. On the same day, the plaintiffs filed a Motion for Class Certification, seeking to certify a class consisting of:

All persons who are or will be incarcerated in the custody of the BOP who are or will be diagnosed with gender dysphoria or meet the criteria for a gender dysphoria diagnosis and who are receiving, or would receive, gender-affirming health care absent such care being proscribed by EO 14168 and the Implementing Memoranda.

Mot. for Class Certification 1, ECF No. 8. The defendants submitted their opposition to both motions on March 28, 2025. *See generally* Defs.’ Opp’n, ECF No. 46. The plaintiffs then submitted separate replies in support of their original motions on April 4, 2025. *See generally* Preliminary Injunction Reply, ECF No. 48; Class Certification Reply, ECF No. 49. Finally, in response to a handful of supplemental declarations filed by the plaintiffs, the defendants moved to file a sur-reply on April 9, 2025, *see* Mot. for Leave to File Sur-Reply, ECF No. 52, which the Court granted on April 28, 2025. *See* Order of April 28, 2025, ECF No. 55. Accordingly, both motions are now ripe for the Court’s review.

For the reasons contained herein, the Court concludes first that the plaintiffs’ action is not barred by the administrative exhaustion requirements of the Prison Litigation Reform Act (“PLRA”); second, that the plaintiffs have demonstrated a substantial likelihood of success on their APA claims, and that the Court accordingly need not assess the plaintiffs’ constitutional claims based on the limited record now available; third, that the plaintiffs have demonstrated a likelihood of irreparable harm absent a grant of preliminary injunctive relief, and that the balance of the equities favors granting such relief; fourth, that the plaintiffs’ proposed class meets the requirements for certification under Rule 23(a) and Rule 23(b)(2); and fifth, that the President shall not be dismissed from the case as a defendant at this juncture given the potential availability of declaratory relief. In accord with these legal conclusions, the Court will **ORDER** that the plaintiffs’ proposed class, with slight modification from the Court explained below, be certified

and that class counsel be appointed. The Court will further **ORDER** the BOP to make social accommodations available to all class members to the same extent they were available prior to the issuance of the Executive Order, and to provide hormone therapy to all class members who have been prescribed hormone medications by BOP or other medical personnel to the same extent as before the issuance of the Executive Order.

II. LEGAL STANDARDS

A. Preliminary Injunction

Preliminary injunctive relief is warranted if the movant meets its burden to show that 1) the movant is likely to succeed on the merits; 2) the movant is likely to suffer irreparable harm unless preliminary relief is granted; 3) the balance of the equities favors a TRO or preliminary injunction; and 4) that a TRO or preliminary injunction is in the public interest. *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). Courts in this Circuit have adopted a sliding scale approach to the TRO analysis, whereby a relatively strong showing on one of these factors may partially offset weakness in another, although some non-speculative showing of irreparable harm is essential. *CityFed Fin. Corp. v. Office of Thrift Supervision*, 58 F.3d 738, 747 (D.C. Cir. 1995). Where, as here, the Government is a party, the latter two factors of the preliminary analysis merge into one, because the interest of the government is taken to be identical to the interest of the public. *Nken v. Holder*, 556 U.S. 418, 435 (2009). In evaluating these factors, a Court must bear in mind that preliminary injunctive relief is an extraordinary form of relief that “should be sparingly exercised.” *Dorfmann v. Boozer*, 414 F.2d 1168, 1173 (D.C. Cir. 1969) (internal citation omitted). A motion to stay agency action pending review under 5 U.S.C. § 705 is governed by the same standard. *Green Oceans v. U.S. Dep’t of the Interior*, No. 24-cv-141-RCL, 2024 WL 3104945, at *2 n.3 (D.D.C. June 24, 2024) (Lamberth, J.).

B. Class Certification

Rule 23 of the Federal Rules of Civil Procedure provides the conditions that must be met for a district court to certify a class. First, pursuant to Rule 23(a), the party moving for class certification must show that:

(1) the class is so numerous that joinder of all members is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, and (4) the representative parties will fairly and adequately protect the interests of the class.

Fed. R. Civ. P. 23(a). If all these requirements are met, the putative class must still fit into one of the Rule 23(b) categories, discussed in greater detail below.

“Rule 23 does not set forth a mere pleading standard.” *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 350 (2011). “A party seeking class certification must affirmatively demonstrate his compliance with the Rule,” which requires the court to conduct a “‘rigorous analysis’” of the facts of the case and their applicability to Rule 23’s requirements. *Id.* at 351 (quoting *Gen. Tel. Co. of Sw. v. Falcon*, 457 U.S. 147, 161 (1982)). “Although the D.C. Circuit has not yet articulated a precise standard of proof, the emerging consensus in this district and among the courts of appeals is that the movant must prove each element of Rule 23 by a preponderance of the evidence.” *Lewis v. U.S. Parole Comm’n*, 743 F. Supp. 3d 181, 194 & n.2 (D.D.C. 2024) (collecting cases).

III. THE PLAINTIFFS’ CLAIMS ARE NOT MOOT

Though the defendants do not argue that the case is moot due to the restoration of Ms. Kingdom’s or Mr. Nichols’s hormone therapy, the Court has an “independent obligation to assure [itself] of jurisdiction,” *City of N.Y. v. Nat’l R.R. Passenger Corp.*, 776 F.3d 11, 14 (D.C. Cir. 2015), so the Court will briefly address this possibility. “[A]t least one named plaintiff must keep her individual dispute live until [class] certification, or else the class action based on that claim

generally becomes moot.” *J.D. v. Azar*, 925 F.3d 1291, 1307 (D.C. Cir. 2019) (citing *United States v. Sanchez-Gomez*, 584 U.S. 381, 386 (2018)).

Clearly, the named plaintiffs’ requests for access to social accommodations is not moot because, as recounted above, all three remain unable to access garments and other items intended to help the plaintiffs conform their appearance to that of the opposite sex. Mr. Kapule’s request for the continuation of his hormone therapy is not moot because, as far as the Court is aware, Mr. Kapule remains under the impression that his hormone therapy will be discontinued when his prescription runs out, and thus has a live claim for relief that persists to this day. That alone would be sufficient to keep this action alive. But furthermore, Ms. Kingdom’s and Mr. Nichols’s claims for hormone therapy access are not moot either because of a mootness exception known as the “voluntary cessation” doctrine, which dictates that “[a] party’s voluntary cessation of challenged conduct does not moot the challenge unless it is “absolutely clear” that the challenged conduct will not recur after the litigation.” *Valancourt Books, LLC v. Garland*, 82 F.4th 1222, 1230 (D.C. Cir. 2023) (citing *Trinity Lutheran Church of Columbia, Inc. v. Comer*, 582 U.S. 449, 457 n.1 (2017)). In Ms. Kingdom’s case, there is no indication at all that the BOP means to leave her hormone therapy in place long-term; indeed, as noted above, she was informed by BOP personnel that the decision to resume her treatment was a consequence of this litigation itself, raising the specter that her treatments might be discontinued as soon as the litigation has concluded. Suppl. Kingdom Decl. ¶ 2. Likewise in Mr. Nichols’s case: The BOP official with whom he spoke told him explicitly that the hormone therapy ban would resume once the injunctive relief granted in *McHenry* had run its course. Nichols Decl. ¶ 17. Accordingly, Ms. Kingdom’s and Mr. Nichols’s claims related to the cessation of hormone therapy are not moot under the voluntary cessation doctrine.

The defendants argue separately that the plaintiffs’ request for a stay of the BOP’s actions while the case remains under review, pursuant to 5 U.S.C. § 705, is moot because the BOP has already taken the actions that, according to the plaintiffs, are violative of the APA. That argument is unpersuasive, as various courts have interpreted § 705 to permit a “stay”—which may be more aptly described as a temporary rollback—even of already-consummated agency action. *See, e.g., Texas v. Biden*, 646 F. Supp. 3d 753, 769–771 (N.D. Tex. 2022) (collecting cases from the Supreme Court and Fifth Circuit); *Boyle v. Bessent*, No. 2:24-cv-81-SDN, 2025 WL 509519, at *4 n.5 (D. Me. Feb. 14, 2025).

Having assured itself that all of the plaintiffs’ claims are alive and well, the Court may proceed to the next jurisdictional issue in the case: whether the plaintiffs were required to exhaust administrative remedies before initiating their action in federal court.

IV. THE PLAINTIFFS WERE NOT REQUIRED TO EXHAUST ADMINISTRATIVE REMEDIES UNDER THE PLRA

The defendants’ first argument, which the Court must take up before reaching the merits because it speaks to the Court’s jurisdiction to entertain this dispute, is that the plaintiffs have failed to complete the grievance procedure prescribed by the PLRA. *See Porter v. Nussle*, 534 U.S. 516, 532 (2002) (“[T]he PLRA’s exhaustion requirement applies to all inmate suits about prison life”); *Jones v. Bock*, 549 U.S. 199, 211 (2007) (holding that inmates’ unexhausted claims “cannot be brought in court”). Under that remedial scheme, to challenge any aspect of an inmate’s confinement, that inmate must proceed through four steps. First, an inmate must attempt to resolve the problem informally with prison officials; second, if unsuccessful, the inmate may initiate a request to the warden of their penitentiary facility; third, if unsatisfied by the warden’s response, the inmate may appeal to the regional BOP director within twenty calendar days; and finally, if the regional director does not provide the relief sought, the inmate may escalate the

complaint to the BOP's general counsel office within thirty days. 28 C.F.R. §§ 542.13–15. *DeBrew v. Atwood*, 847 F. Supp. 2d 95, 107 (D.D.C. 2012).

As this Court wrote in *McHenry*, courts are obliged to hew strictly to the PLRA's mandatory exhaustion requirement: "not even facially meritorious constitutional claims are exempt, nor are claims that the inmate believes—rightly or wrongly—to be futile." *McHenry*, 763 F. Supp. 3d at 86 (first citing *Woodford v. Ngo*, 548 U.S. 81, 91 n.2 (2006), and then citing *Kaemmerling v. Lappin*, 553 F.3d 669, 675 (D.C. Cir. 2008) (Sentelle, C.J.)). However, while courts have no power to carve out new exceptions from the PLRA's statutory text, they must apply the narrow implicit exception that Congress wrote into the statute itself: that exhaustion is not required if administrative remedies are not "available." *Ross v. Blake*, 578 U.S. 632, 639 (2016). Administrative remedies are considered "unavailable" if the administrative scheme is "so opaque that it becomes, practically speaking, incapable of use," or if "prison administrators thwart inmates from taking advantage of a grievance process through machination, misrepresentation, or intimidation" or, as relevant here, if the grievance process "operates as a simple dead end—with officers unable or consistently unwilling to provide any relief to aggrieved inmates." *Id.* at 643–44. The D.C. Circuit has underscored the difference between the dead-end exception and the concept of futility: If the agency has "authority to take *some action*" in response to a complaint, but not the action which the plaintiff seeks, exhaustion remains mandatory notwithstanding the claim's futility. *Kaemmerling*, 553 F.3d at 675. However, if the agency "lacks authority to provide any relief or to take any action whatsoever in response to a complaint," the plaintiff has reached a genuine dead end and administrative exhaustion is excused. *Id.* at 675 (quoting *Booth v. Churner*, 532 U.S. 731, 736 (2001)).

The defendants contend that the plaintiffs are not confronted with a dead-end situation because, as discussed above, each plaintiffs' access to hormone therapy has been restored. And moreover, the BOP is currently providing hormone therapy to roughly 628 of the 1,028 BOP inmates diagnosed with gender dysphoria. Bina Decl. ¶¶ 7, 14. At a preliminary injunction hearing held on May 22, 2025, the defendants attempted to explain, for the first time, how this reality can be reconciled with the text of the Executive Order. They argued that the BOP's policy is to provide hormone therapy to inmates as necessary to address medical needs *other than* "conforming an inmate's appearance to that of the opposite sex," such as to ameliorate anxiety, depression, or suicidality associated with gender dysphoria. Therefore, they argue, the BOP has the authority to provide not just *some* relief, but the very relief that the plaintiffs sought in their Complaint—to wit, restoration of their hormone therapy.²

In response, the plaintiffs reiterated at the hearing one plaintiff, Alishea Kingdom, filed an initial BP-08 grievance form with the staff at her penitentiary requesting access to her gender

² The Court pauses to underscore the apparent inconsistency of this position with the text of the Executive Order. The defendants are representing that, even though the text plainly says that BOP may not use federal funds "for the purpose of conforming an inmate's appearance to that of the opposite sex," BOP is still using federal funds for treatments (such as hormone therapy) that have that exact effect. But, the defendants state that for inmates who have *additional* reasons for those treatments, *separate from* appearance conformity (e.g. to combat symptoms such as anxiety, depression, and suicidality), the Executive Order does not prohibit the use of federal funds for treatments that will inevitably conform a person's appearance to that of the opposite sex.

The plaintiffs argue that the defendants' distinction between treatment for the purpose of appearance-conformity and symptom-mitigation is imaginary, and that hormone therapy is only effective to treat these symptoms *because* it alters the user's physical appearance. In other words, the symptom alleviation flows from the change in appearance. That is a question of medical fact that the Court lacks requisite information to resolve at this time. Yet even in the current posture, the Court observes that the defendants' position does indeed seem hard to square with the text of the Executive Order. The defendants appear to be relying on a fabricated distinction that appears nowhere on the face of the Order—representing that some prisoners seek medical treatment *solely* for appearance conformity, with no other symptoms of gender dysphoria requiring medical attention, and it is merely *those* prisoners whom the Executive Order bars from receiving hormone treatment.

In any event, if the BOP's current practice is indeed inconsistent with the Executive Order as the plaintiffs suggest, that is not immediately relevant to the Motions presently under consideration. The Court merely emphasizes this position given that it is not explained in the defendants' papers and it is not the most natural reading of the Executive Order, to say the least.

dysphoria treatment, which was met with a response merely reciting the terms of the Executive Order. Kingdom Decl. ¶ 17. This negative response, they contended, shows that administrative remedies were not “available” to the plaintiffs. This argument is unavailing. Although the BOP’s response was undoubtedly not the response that Ms. Kingdom wanted, she completed only the first step of the four-step administrative exhaustion process. If a negative response at step one—no matter how firm or uncompromising—could by itself constitute an administrative “dead-end”, the exception would soon swallow the rule, and there would be nothing left of the PLRA’s exhaustion scheme.

Nevertheless, under the unusual circumstances of this dispute, administrative exhaustion was not required. That is because administrative exhaustion under the PLRA is assessed as of the date that a complaint is filed, not as of the date that a motion is filed or the date at which the court is rendering its decision. *United States v. Dunlap*, 485 F. Supp. 3d 129, 131 n.2 (D.D.C. 2020) (Brown Jackson, J.) (“[I]n considering motions to dismiss for failure to exhaust under [the Prison Litigation Reform Act], the district court must look to the time of filing, not the time the district court is rendering its decision, to determine if exhaustion has occurred.”) (quoting *Johnson v. Jones*, 340 F.3d 624, 627 (8th Cir. 2003)); cf. *Grupo Dataflux v. Atlas Glob. Grp., L.P.*, 541 U.S. 567, 570 (2004) (“[T]he jurisdiction of the court depends upon the state of things at the time of the action brought.”) (quoting *Mollan v. Torrance*, 22 U.S. (9 Wheat.) 537, 539 (1824)); *Norton v. United States*, 530 F. Supp. 3d 1, 7 (D.D.C. 2021) (holding, in the FTCA context, that “the appropriate analysis is whether the claimant exhausted her administrative remedies *at the time she filed her complaint*”) (emphasis in original). This rule normally works to shield the BOP from plaintiffs’ efforts to skirt the PLRA’s remedial scheme, but here it serves a complementary purpose: The BOP may not erect a dead-end administrative exhaustion process, then invoke the

protections of the PLRA by strategically replacing the dead-end remedial process with a viable one as soon as a plaintiff sues in federal court. It cannot have its cake and eat it too.³

Therefore, the operative question is not whether the plaintiffs *would* be required to exhaust their administrative remedies under the circumstances now prevailing for gender dysphoric BOP inmates—a question as to which the Court expresses no opinion. Rather, the question is whether the plaintiffs *were* required to do so under the circumstances prevailing on March 7, 2025, when their Complaint was filed.

Recall that, as of March 7, two of the three named plaintiffs—Ms. Kingdom and Mr. Nichols—had already had their hormone therapies discontinued or reduced, whereas the third—Mr. Kapule—had been promised that his hormone therapy would be discontinued as soon as his prescription ran out. Ms. Kingdom and Mr. Nichols were told explicitly that the discontinuation of their hormone therapy was attributable to the Executive Order. *See* Kingdom Decl. ¶ 12; Nichols Decl. ¶ 14. As already discussed, the BOP’s response to Ms. Kingdom’s BP-08 largely recited the terms of the Executive Order. And similarly, Mr. Kapule submitted a BP-08 form on March 3, 2025, to which the BOP responded on March 12, also citing the Executive Order and stating that “[u]ntil further notice, the Bureau of Prisons will follow any updated policies published by the Department of Justice.” Kapule Decl. ¶ 15. These facts suggest that, as of the time that the Complaint was filed, the BOP’s policy and the Executive Order were essentially one and the same, and that the BOP was then interpreting the Executive Order to forbid the provision of hormone therapies.

³ This should not be taken to suggest, at this early stage in the proceedings, that the BOP has engaged in such bad-faith gamesmanship. Indeed, as the defendants point out in their sur-reply, agencies such as the BOP have historically received a “presumption of good faith and regularity in agency action” *Sierra Club v. Costle*, 657 F.2d 298, 334 (D.C. Cir. 1981). The Court is merely stating, in the abstract, a justification for this rule of general applicability.

Furthermore, consider the circumstances under which the plaintiffs’ treatments were restored. Ms. Kingdom noted that her hormone therapy was not restored until March 14, 2025—a week *after* the Complaint was filed—at the same time as nine other transgender women at her facility, after a conversation in which the BOP physician explicitly referred to this litigation. Suppl. Kingdom Decl. ¶¶ 1–2. Although Mr. Nichols’s treatments were restored before the Complaint was filed, that evidently happened in response to the events unfolding in the parallel *McHenry* litigation, rather than pursuant to a change in BOP policy. Nichols Decl. ¶17. And even as of April, Mr. Kapule’s situation remained largely unchanged since February: he was still under the impression that his hormone therapy would be discontinued as soon as his prescription expires. Suppl. Kapule Decl. ¶ 3.

Taking these largely uncontroverted facts into consideration, even if the BOP has recently instituted policies allowing for the provision of hormone therapy to certain inmates with demonstrable medical needs, it seems clear that this was not the policy in place at the time that the Complaint was filed. As of March 7, 2025, all evidence suggests that the BOP’s policy at the time was to withhold hormone therapy except where a court order mandated it do otherwise. To the extent that the BOP now claims that the text of the Executive Order and the implementing memoranda afford it some discretion to provide hormone therapy to those inmates who most desperately need it—in other words, “to take some action” in response to the plaintiffs’ grievances—the agency’s conduct during the days and weeks surrounding the filing of the Complaint strongly implies that this was not the agency’s understanding at the time.

In sum: the plaintiffs challenge the BOP’s actions as unconstitutional and contrary to the Administrative Procedure Act. The BOP’s conduct contemporaneous with the filing of that challenge all but declares that the agency believed itself to have no authority, under the Executive

Order and its own implementing memoranda, to act on the plaintiffs' grievances. Under those circumstances, the plaintiffs had reached an administrative dead end, so their suit could move forward notwithstanding their failure to exhaust administrative remedies, and notwithstanding the BOP's reconceptualization of its own authority in the months that followed the initiation of the action.

V. THE PLAINTIFFS ARE ENTITLED TO PRELIMINARY INJUNCTIVE RELIEF

A. The Plaintiffs Are Likely to Succeed on the Merits of their APA Claims.

The plaintiffs argue that the BOP's enforcement of the Executive Order and the two implementing memoranda violate the APA's prohibition of arbitrary and capricious agency action. Specifically, the plaintiffs argue that the memoranda are arbitrary and capricious because they provide no reasoned explanation for the denial of gender-affirming care, treat gender dysphoria different than other medical conditions with no justification, and fail to adequately take stock of the sudden reversal in agency policy from before the Executive Order was issued. The Court agrees, and accordingly holds that the plaintiffs are likely to succeed on the merits of their APA claims.⁴

1. The Plaintiffs Are Challenging Final Agency Action

As a threshold matter, the Court must determine whether the BOP's decisions constitute "final agency action" susceptible to APA review. 5 U.S.C. § 704. Executive orders themselves are not susceptible to APA review for the simple reason that "the President is not an 'agency' under [the APA]" *Chamber of Comm. of U.S. v. Reich*, 74 F.3d 1322, 1326 (D.C. Cir. 1996); *see also League of United Latin Am. Citizens v. Exec. Off. of President*, No. 24-cv-0946, 2025 WL

⁴ The plaintiffs also contend that the BOP's actions should be set aside as contrary to law because they violate the Eighth Amendment to the United States Constitution. As discussed below, the Court declines to reach the plaintiffs' constitutional arguments at this time, and accordingly will not take up this aspect of the plaintiffs' APA claims.

1187730, at *16 (D.D.C. Apr. 24, 2025) (holding that, because the President is not an agency, “the APA does not supply a cause of action to challenge an executive order”). However, where the President delegates the implementation of an executive order to an agency, that agency’s actions are not derivatively shielded from APA review. *See Tate v. Pompeo*, 513 F. Supp. 3d 132, 142–43 (D.D.C. 2021) (holding that an “attempt to bootstrap the nonreviewability of presidential actions to discretionary authority delegated to” an agency did “not have support in precedent”); *Gomez v. Trump*, 485 F. Supp. 3d 145, 176–77 (D.D.C. 2020) (“To the extent Defendants contend that the court is foreclosed from reviewing agency actions taken to implement [Presidential] Proclamations, they are wrong.”) (emphasis omitted); *O.A. v. Trump*, 504 F. Supp. 3d 109, 147 (D.D.C. 2019). Here, such a delegation plainly appears on the face of the Executive Order. *See* Executive Order 14168 § 4(c) (instructing the Attorney General and BOP to “revise[] [the BOP’s] policies concerning medical care to be consistent with this order”). Therefore, the BOP’s actions taken pursuant to this directive, including the implementing memoranda, do not partake of the President’s exemption from APA review.

Having determined that the actions challenged here are those of an “agency,” the next question is whether they are “final.” An agency’s action is final if it “mark[s] the ‘consummation’ of the agency’s decisionmaking process” and is “one by which ‘rights or obligations have been determined,’ or from which ‘legal consequences will flow’” *Bennett v. Spear*, 520 U.S. 154, 177–78 (1997) (first quoting *Chi. & S. Air Lines, Inc. v. Waterman S.S. Corp.*, 333 U.S. 103, 113 (1948), and then quoting *Port of Bos. Marine Terminal Ass’n v. Rederiaktiebolaget Transatlantic*, 400 U.S. 62, 71 (1970)). Both aspects of the *Bennett* test are met here. It appears clear that the agency had made up its mind with respect to the plaintiffs’ gender-affirming care as of the date that the Complaint was filed. The implementing memoranda, quoted earlier in this Opinion, do

not utilize equivocal language or otherwise suggest that the agency was still in the midst of its decisionmaking process at the time of their issuance. And the plaintiffs' experiences confirm that, by March 7, the agency was no longer mulling whether the plaintiffs' hormone therapy should cease. As recounted above, in the case of Ms. Kingdom, her hormone medication had already been discontinued for forty days, during which time she missed three scheduled treatment sessions. In the case of Mr. Nichols, his hormone therapy had been restored, but the BOP represented that this restoration was only a temporary measure occasioned by the *McHenry* litigation, and that the decision had evidently been made to terminate his medications as soon as the litigation was resolved. And with respect to Mr. Kapule, the plaintiff remained under the impression, even *after* the Complaint was filed, that the decision to terminate his medications after the expiration of his current prescription was still in effect. And all this is to say nothing of the BOP's withholding of social accommodations, which was in effect by the time the Complaint was filed and remains so today.

Certainly, then, the BOP's actions with respect to Ms. Kingdom were "consummated" and represented the agency's final disposition of her right to access hormone therapy, and of the BOP's supposed obligation to provide it. And with respect to Mr. Nichols and Mr. Kapule: though the challenged deprivation had not yet taken place when the Complaint was filed, the BOP's *decisionmaking process* undergirding the future termination of their treatments was complete, which is all that *Bennett* requires.⁵ The fact that, after the Complaint was filed, the agency later restored Ms. Kingdom's access to hormone therapy and seemingly altered its hormone therapy policies makes no difference to the finality determination: "[T]he possibility that a decision may

⁵ Because the decision to terminate Mr. Nichols and Mr. Kapule's treatments had been made in full, this is not the sort of situation where the adverse effects of the action depend "on the contingency of future administrative action." *Rhea Lana, Inc. v. U.S. Dep't of Lab.*, 824 F.3d 1023, 1032 (D.C. Cir. 2016) (internal quotation omitted) (quoting *DRG Funding Corp. v. Sec'y of Hous. & Urb. Dev.*, 76 F.3d 1212, 1214 (D.C. Cir. 1996)).

later be revised based on new information does not render ‘an otherwise definitive decision nonfinal.’” *Seeger v. Dep’t of Def.*, 306 F. Supp. 3d 265, 285 (D.D.C. 2018) (quoting *Safari Club Int’l v. Jewell*, 842 F.3d 1280, 1289 (D.C. Cir. 2016)); *POET Biorefining, LLC v. EPA*, 970 F.3d 392, 400 (D.C. Cir. 2020) (“The possibility of revision ‘is a common characteristic of agency action, and does not make an otherwise definitive decision nonfinal.’”) (quoting *U.S. Army Corps of Eng’rs v. Hawkes Co.*, 578 U.S. 590, 598 (2016)).⁶

2. The Plaintiffs have Demonstrated a Likelihood that the BOP’s Actions Were Arbitrary and Capricious.

The APA provides certain standards by which an agency must abide in the course of formulating and executing policy, and empowers courts to “set aside” agency action that does not conform to these standards. 5 U.S.C. § 706(2). Relevant here, agency action may be set aside if it is “arbitrary” or “capricious.” *Id.* § 706(2)(a). Among other possible reasons, agency action may be deemed arbitrary and capricious if it is taken without an “explanation,” *see Dep’t of Comm. v. New York*, 588 U.S. 752, 785 (2019), or if that explanation evinces a lack of “reasoned decisionmaking,” *Michigan v. EPA*, 576 U.S. 743, 750 (2015), i.e. a failure to “consider[] . . . the relevant factors.” *Motor Vehicle Mfrs. Ass’n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). Alternatively, an agency action may earn the moniker of “arbitrary and capricious” if it violates the “fundamental principle of administrative law that agencies must treat like cases alike,” *Grayscale Invs., LLC v. SEC*, 82 F.4th 1239, 1242 (D.C. Cir. 2023), and fails to “point to a relevant distinction” between two facially similar cases that it decides to treat differently. *Westar Energy, Inc. v. Fed. Energy Regul. Com’n*, 473 F.3d 1239, 1241 (D.C. Cir.

⁶ Even if the agency *did in fact* revise its policies after the submission of the plaintiffs’ Complaint, which appears to be the case here, that fact—knowable only with the benefit of hindsight—does not implicate the APA’s finality requirement. Rather, it goes to whether the plaintiffs’ claims are moot, a possibility with which the Court has already dispensed above.

2007). And finally, when an agency adopts a new policy that reverses course from its prior policy, the new policy is not subject to a “heightened standard,” but the agency must “display awareness that it *is* changing position” and provide a “more detailed justification than what would suffice for a new policy created on a blank slate” if the new policy “rests upon factual findings that contradict those which underlay its prior policy” or where the “prior policy has engendered serious reliance interests” *F.C.C. v. Fox Television Stations, Inc.*, 556 U.S. 502, 514–15 (2009).

The BOP’s implementing memoranda fall short on each of these criteria. The BOP’s *only* explanation for its new policies is that the Executive Order required the adoption of those policies, and that the Executive Order itself provided adequate explanations for BOP’s new policies. *See* Defs.’ Opp’n at 20–21. But as numerous courts have held, the fact that an agency’s actions were undertaken to fulfill a presidential directive does not exempt them from arbitrary-and-capricious review. *See, e.g., Gomez*, 485 F. Supp. 3d at 177 (“APA review of an Executive Branch official’s actions is . . . not precluded merely because the official is carrying out an executive order.”); *Louisiana v. Biden*, 622 F. Supp. 3d 267, 294–95 (E.D. La. 2022) (“A command in an Executive Order does not exempt an agency from the APA’s reasoned decision-making requirement. A decision supported by no reasoning whatsoever in the record cannot be saved merely because it involves an Executive Order.”); *Texas v. United States*, 524 F. Supp. 3d 598, 653–54 (S.D. Tex. 2021) (determining that a Department of Homeland Security memorandum issued to confront the COVID pandemic was arbitrary and capricious, despite the fact that it “stem[med] from” an Executive Order signed contemporaneously by the President, because it failed to independently demonstrate reasoned decisionmaking). The reason for this rule is self-evident: if an agency could avoid the need to justify its decisions simply by gesturing to an Executive Order and claiming that it was just following the President’s directions, the President could unilaterally eviscerate the

judicial oversight that Congress contemplated in passing the APA simply by issuing a carbon-copy executive order mandating that an agency act in a particular way before it does so. *See Arizona v. Su*, 1221 F.4th 1, 15 (9th Cir. 2024).

Moreover, even if the BOP may incorporate the Executive Order’s reasoning into its own implementing memoranda, the reasoning contained therein is plainly deficient. Section 1 of the Executive Order sets out its manifold purposes: to promote the “dignity, safety, and well-being” of women, as well as “scientific inquiry, public safety, morale, and trust in government,” by combatting the spread of “gender ideology” which denies “the immutable biological reality of sex” in favor of “an identity-based, inchoate social concept.” The Court takes no position on the desirability of this goal; a Court conducting judicial review under the APA may not “substitute [its own] judgment for that of the agency” *Steel Mfr’s Ass’n v. EPA*, 27 F.3d 642, 646 (D.C. Cir. 1994). But even taking the Executive Order’s rationale at face value, it has little, if anything, to do with the agency’s decision to discontinue inmates’ gender-affirming care. By taking hormone medications and accessing social accommodations, the plaintiffs do not seem interested in propagating any particular “ideology”; to the contrary, their sworn declarations make clear that they are taking these measures to lessen the personal anguish caused by their gender dysphoria, a benefit on which they have relied for years under the BOP’s longstanding policy of providing this type of care. In light of the plaintiffs’ largely personal motives for undergoing gender-affirming care, neither the BOP nor the Executive Order provides any serious explanation as to why the treatment modalities covered by the Executive Order or implementing memoranda should be handled differently than any other mental health intervention. Nor does the Executive Order make any effort whatsoever to explain how providing hormone medications or social accommodations to prisoners hampers “scientific inquiry, public safety, morale, trust in government,” or any other

virtue animating the Executive Order. And nothing in the thin record before the Court suggests that either the BOP or the President consciously took stock of—much less studied—the potentially debilitating effects that the new policies could have on transgender inmates before the implementing memoranda came into force.

To be sure, agency action is not arbitrary and capricious merely because it is bad for some identifiable population. New policies nearly always have uneven effects on different groups; that is part and parcel of living within a democratic system. But the APA *does* require an agency to take actions that are rationally and demonstrably related to its stated goals, explain why it treats similarly situated people differently, and give consideration to the reliance interests of those who may be harmed by a new policy. Based on the limited information now before the Court, it appears that the implementing memoranda do none of these things, nor does the Executive Order on which they rely for their own justification. Accordingly, the Court concludes that the plaintiffs have established a sufficient likelihood of success on the merits of their APA claims.

“[A]s a matter of judicial restraint and ‘governance,’ courts generally should endeavor to resolve cases on non-constitutional grounds and should entertain constitutional questions only when necessary.” *Uthman v. Trump*, 486 F. Supp. 3d 350, 356 (D.D.C. 2020) (Lamberth, J.) (quoting *Ashwander v. Tenn. Valley Auth.*, 297 U.S. 288, 346 (1936)). It stands to reason that the need for such “judicial restraint” is heightened in cases, such as the one at hand, where the factual record is necessarily thin due to the procedural posture of the litigation. Therefore, because the Court assesses that the plaintiffs are likely to prevail on their APA claims, the Court need not delve into the merits of their Eighth Amendment claims at this time.⁷

⁷ The Court notes that, in *McHenry*, the Court instead took up the plaintiffs’ constitutional claims while leaving their APA claims for another day. See 763 F. Supp. 3d at 85. There is a good reason for this difference in approaches: in *McHenry*, the defendants pointed to two statutory provisions that potentially foreclosed any consideration of the

B. The Plaintiffs Have Shown Sufficient Likelihood of Irreparable Harm

Turning to the second aspect of the preliminary injunction analysis, the Court concludes that the plaintiffs have demonstrated a sufficient likelihood of irreparable harm in the absence of preliminary injunctive relief. The defendants argue that the plaintiffs have not alleged irreparable harm because they are all currently receiving hormone medications. But it suffices to say that all three plaintiffs' access to hormone therapy is, as best the Court can tell, tenuous. As already discussed, one named plaintiff, Ms. Kapule, remains under the impression that her hormone therapy will be terminated as soon as her prescription runs out, unless the Court orders otherwise. The other two have both been advised by BOP officials that their continued access to hormone therapy depends on the vagaries and vicissitudes of this very litigation and its related cases; based on these statements, it seems probable that without an order to the contrary, these plaintiffs will lose access to their medicine. Though the BOP represents that more than 600 other inmates with gender dysphoria are receiving hormone treatments, it has given no affirmation that these treatments would be likely to continue in the absence of judicial intervention. Circumstantial evidence suggests otherwise: When Mr. Nichols's and Ms. Kingdom's access to hormone therapy was restored, they noted that other inmates at their facility were given access to medicine all at the same time, suggesting that their fates have risen and—without an injunction—will likely fall together. And all of this is to say nothing of the *ongoing* deprivation of the plaintiffs' social accommodations, which is uncontested.

Just as the plaintiffs' harms are either manifest already or imminent and likely, so too are they severe. As recounted above, Dr. Karasic's declaration explains that gender dysphoria can

McHenry plaintiffs' APA claims, meriting a departure from the usual practice of avoiding constitutional claims except where necessary. *Id.* (citing 18 U.S.C. §§ 3621, 3625). By contrast, in the case at hand, the defendants have identified no statute or regulation that would seem to immunize the challenged policies from judicial review under the APA.

produce severe side effects ranging from depression and anxiety to suicidal ideation and self-harm if inadequately treated. The BOP does not dispute this medical reality, and indeed the declaration of Chris Bina, Assistant Director of the BOP’s Health Services Division, seems to confirm as much when it states that the three named plaintiffs are currently “receiving medically necessary care,” referring to their restored hormone therapy regimens. Nor are these abstract dangers confined to the pages of medical textbooks and prison care manuals: Ms. Kingdom herself attests that during the interruption of her hormone therapy she lost sleep, began having suicidal thoughts, and regularly contemplated autocastration. Kingdom Decl. ¶¶ 21–22. These are not the sorts of harms capable of recompense through normal judicial processes.

The defendants’ only other argument is that some gender dysphoric people do not need hormone therapy, so the possibility that they may not be able to receive it does not constitute irreparable harm. Defs.’ Opp’n at 22–23. Though true, this argument misses the point. All parties seem to agree that the named plaintiffs do, in fact, need hormone therapy. That being the case, it is virtually certain that at least some other current and future gender dysphoric inmates need or will need it as well, and even that some gender dysphoric inmates who do not presently need it will need it in the future. The Court can reasonably infer that at least some gender dysphoric inmates would be immediately and irreparably harmed by a return to the BOP’s policies in effect as of the initiation of this action, an outcome that seems likely without preliminary judicial intervention.

C. The Balance of the Equities and the Public Interest Favor an Injunction

The final piece of the preliminary injunction analysis is the most easily resolved. In *McHenry*, this Court held that the balance of the equities and the public interest favored preliminarily enjoining the enforcement of the Executive Order’s provision requiring the rehousing

of certain transgender inmates in facilities consistent with their birth sex and the denial of hormone therapy. 763 F. Supp. 3d at 89–90. As the Court then explained, “it is hard to cognize of *any* public interest in the immediate cessation of [the *McHenry* plaintiffs’] hormone therapy—aside, perhaps, from whatever small sum of money the BOP may save by ceasing administration of these drugs, or the abstract interest in the enforcement of Executive Branch policy decisions.” *Id.*

In the case at hand, the equities tilt even more strongly in the plaintiffs’ favor, because the BOP now represents that it *is, in fact, providing hormone therapy to over 600 gender dysphoric inmates*. Therefore, the defendants cannot even credibly claim that an injunction will impose a financial burden, since according to their own representations they would incur that burden anyway. The only deleterious public effect of the Court’s injunction will be to require that, during the pendency of litigation, the BOP will continue to shoulder a certain administrative cost that it has already willingly assumed since the commencement of this action, and that it had voluntarily borne for many years prior.

The defendants argue that there is a strong countervailing public interest in letting democratic processes play out and allowing elected leaders to effectuate their political agendas. Defs.’ Opp’n at 31. The court readily endorses this principle, and agrees that it weighs in the defendants’ favor, but it does so only modestly. That is because democracy is not as simple as the defendants make it sound: Just as the Executive Order was issued by a democratically elected President with a platform to implement, so too is the Administrative Procedure Act the output of democratic processes, namely the constitutional schema of bicameralism and presentment. If democratic self-governance means anything, it means giving effect to *all* duly enacted laws, including those—like the APA—that were enacted decades ago; it does not mean blind submission to the whims of the most recent election-victor.

Finally, the defendants contend that the effect of a preliminary injunction at this stage would stifle the ongoing debate about the medical necessity and efficacy of gender-affirming care. At this stage of litigation, the Court lacks the factual record necessary to know whether such a debate exists. But even assuming it does, granting a preliminary injunction would do no such thing. To conclude that the defendants have failed to meet the procedural strictures of the APA is not to take any position on the underlying merits of the BOP's substantive policy decisions or the goals motivating the Executive Order.⁸

VI. THE COURT WILL CERTIFY A CLASS AND APPOINT CLASS COUNSEL

The plaintiffs' proposed class definition, with slight adjustments made by the Court, satisfies each of the requirements of Rule 23(a) and falls under the rubric of Rule 23(b)(2). *See Wagner v. Taylor*, 836 F.2d 578, 590 (D.C. Cir. 1987) (noting a court's "broad discretion to redefine and reshape the proposed class to the point that it qualifies for certification under Rule 23"); Charles A. Wright & Arthur R. Miller, 7A Fed. Prac. & Proc. § 1759 (4th Ed. 2025) ("[I]f plaintiff's definition of the class is found to be unacceptable, the court may . . . redefine the class to bring it within the scope of Rule 23 . . ."). Therefore, the Court will certify a class consisting of all persons who are currently or will be incarcerated in BOP facilities with a current diagnosis of gender dysphoria or who receive such a diagnosis in the future.⁹ The Court will also appoint counsel to represent that class.

⁸ It is conceivable that the Court will be required to make a factual determination about the medical necessity of gender-affirming care at some later stage of litigation to address the plaintiffs' constitutional claims, though even this is not a foregone conclusion. It is certain, however, that the Court need not and will not make any such determination now.

⁹ The plaintiffs' proposed class definition would include all BOP inmates who "meet the criteria for a gender dysphoria diagnosis . . ." Mot. for Class Certification at 1. The Court has excised this group from the class definition because it introduces uncertainty and unascertainability into the class, and risks freezing medical standards in time. The Court lacks the requisite information to know what it means to "meet the criteria for a gender dysphoria diagnosis," and even it did, the Court must be sensitive to the possibility that those criteria may change over time. Admitting new class members on the basis of an actual diagnosis is an easily administrable task that supports the ascertainability of

A. The Proposed Class Satisfies Rule 23(a).

Any proposed class must meet the familiar requirements of Rule 23(a), often referred to in brief as numerosity, commonality, typicality, and adequacy of representation.

1. Numerosity

Numerosity is not in dispute. The proposed class would include all current and future BOP inmates diagnosed with gender dysphoria. Mot. for Class Certification at 1. The BOP represents that, at present, there are 1,028 inmates with gender dysphoria in its custody. Bina Decl. ¶ 7. That is more than enough to satisfy Rule 23(a)’s numerosity requirement, even if not for the fact that the class definition includes an unknown number of future class members as well. *J.D. v. Azar*, 925 F.3d 1291, 1322 (D.C. Cir. 2019) (“[C]lasses including future claimants generally meet the numerosity requirement due to the ‘impracticality of counting such class members, much less joining them.’”) (quoting 1 William B. Rubenstein, *Newberg on Class Actions* § 3:15 (5th Ed. 2018)).

2. Commonality and Typicality

The defendants contend that the proposed class does not meet the requirements of commonality and typicality because whether any individual class member is in need of gender-affirming care is an individual inquiry that is not susceptible to class-wide resolution. Defs.’ Opp’n at 24–27. This is particularly problematic, argue the defendants, because the plaintiffs allege a

the class; speculating about whether a given individual *may* be a new class member by comparing his or her constellation of symptoms to the most recent medical understanding of gender dysphoria is not.

The Court has also deleted the plaintiffs’ qualifier that class members either be “receiv[ing], or would receive, gender-affirming health care absent such care being proscribed by EO 14168 and the Implementing Memoranda.” First, this qualifier is unnecessary: It appears more logical to extend relief to all BOP inmates with gender dysphoria, and who may therefore be eligible for gender-affirming care, rather than to limit it to those who are in fact receiving such care or would be. Second, it is hopeless to speculate about whether any given individual “would receive” gender-affirming care in the absence of the Executive Order or implementing memoranda because, as all seem to agree, not all people with gender dysphoria need hormone therapy.

violation of their Eighth Amendment protections, which requires both that “the plaintiff must be confronted with an ‘objectively intolerable risk of harm,’ and [that] prison officials must knowingly or recklessly subject the plaintiff to such a known risk.” *McHenry*, 763 F. Supp. 3d at 88 (quoting *Farmer v. Brennan*, 511 U.S. 825, 839–40 (1994)). This dual objective and subjective analysis is necessarily fact specific as to each prospective class member, rendering it a poor fit for resolution en masse.

If the contemplated relief were for each class member to be provided with gender-affirming care, the defendants might be right; whether such care is appropriate for any given inmate is indeed a person-specific judgment. But that is not the nature of the plaintiffs’ claims, nor does it accurately describe the relief sought. Though the members of the putative class have their own distinctive medical needs, they are united insofar as they each share a diagnosis of a condition that is sometimes treated by the provision of gender-affirming care. The plaintiffs do not claim that all class members are actually injured by the denial of gender-affirming care, but rather by a blanket policy that may prevent them from accessing such care, should they be deemed to need it due to their shared medical condition. While the Court may not be able to answer whether all individual class members should receive gender-affirming care on a class basis, the questions that the plaintiffs *do* present—i.e. whether a uniform policy prohibiting people with a given medical condition from receiving a certain treatment for that condition violates the Eighth Amendment or the Administrative Procedure Act—are amenable to judicial consideration without the Court wading into a thousand personalized medical assessments.¹⁰

¹⁰ As before, the defendants argue that no such blanket policy exists, as demonstrated by their ongoing provision of hormone therapy to hundreds of inmates. But this argument is, at this stage, unavailing for at least two reasons. First, it begs the question as to what the BOP’s policy is today, which remains a matter of dispute. Second, although the defendants represented at the hearing that the BOP will continue to provide hormone therapy to inmates for whom it is medically necessary, that policy is not in the record before the Court.

3. Adequacy

Finally, the defendants' one-paragraph argument that the plaintiffs' claims do not meet the adequacy requirement of Rule 23(a) also fails. Defs.' Opp'n at 27. The defendants argue that because the plaintiffs' individual medical conditions may not be identical to those of the putative class members, they are not likely to be able to adequately represent the interests of the putative class members. *Id.* at 27. But this is clearly wrong. In order to adequately represent the other members of the class, the named plaintiffs "(i) must not have antagonistic or conflicting interests with the unnamed members of the class and (ii) must appear able to vigorously prosecute the interests of the class through qualified counsel." *J.D.*, 925 F.3d at 1312.

As the plaintiffs point out, the named plaintiffs and putative class members all face the same *legal* injury: namely, the harm that will flow from a uniform policy prohibiting prescribed medical treatment. The named plaintiffs have each been diagnosed with gender dysphoria and seek gender-affirming care just like every other member of the putative class. And they have demonstrated, through sworn declarations submitted to the Court, that they are committed to vigorously prosecuting the interests of the putative class members. *See generally* Kingdom Decl.; Nichols Decl.; Kapule Decl. Even if the defendants were right that the named plaintiffs suffer medical conditions different from the rest of the putative class, their harm flows from the same acts of the defendants as the rest of the putative class: the Executive Order and BOP implementing memoranda. Indeed, it would not be possible for the named plaintiffs to obtain full relief without enjoining the actions of the Executive branch.

The Court thus finds that the four requirements of Rule 23(a) are met. Additionally, the Court is satisfied that the plaintiffs' attorneys of record satisfy the requirements of Rule 23(g) and

can adequately represent the putative class as class counsel. The defendants do not oppose this appointment.

B. The Proposed Class is Certifiable Under Rule 23(b)(2)

Once a plaintiff has cleared the hurdles of Rule 23(a), they must show that the class can be certified under Rule 23(b). The plaintiffs argue that their claims satisfy the requirements of Rules 23(b)(1)(A), 23(b)(1)(B), and 23(b)(2), and the Court evaluates each argument in turn. For the reasons that follow, the plaintiffs' arguments under Rules 23(b)(1)(A) and (B) fail, but their claims are certifiable Rule 23(b)(2).

1. Rule 23(b)(1)(A)

If the Court determines that “inconsistent or varying adjudications with respect to individual class members . . . would establish incompatible standards of conduct for the party opposing the class,” then it may certify a class to avoid such inconsistency under Fed. R. Civ. P. 23(b)(1)(A). The plaintiffs claim that because there are over 2,000 potential members of the putative class, the risk of imposing a different standard on the defendants from individual adjudication is high. Mot. for Class Certification at 11. The defendants argue that there is no such risk because the PLRA requires injunctive relief to be limited to the plaintiffs only. Defs.' Opp'n at 28. Neither side's position fully captures the spirit of the Rule.

The plaintiffs are right that there is a risk that if all 2,000+ putative class members were to file individual lawsuits, different courts adjudicating those claims would reach different conclusions of law and findings of fact. And the BOP would be forced to adhere to different standards of conduct for each individual plaintiff based on the order of the court overseeing that plaintiff's litigation. However, this would not create “incompatible standards of conduct” for the

BOP because the courts' orders would only be binding on the BOP as to the specific plaintiff in the litigation.

But contrary to the BOP's assertions, the PLRA does not dictate this outcome. Indeed, although § 3626(a)(1)(A) of the PLRA says that relief "shall extend no further than necessary to correct the violation of the Federal right of a *particular plaintiff or plaintiffs*," it goes on to say in § 3626(a)(2)—which governs preliminary injunctive relief—only that relief shall "extend no further than necessary" to correct the recognized harm. 18 U.S.C. § 3626(a)(1)(A), (2). Section 3626(a)(2) conspicuously omits the "particular plaintiff or plaintiffs" language. In any event, the Supreme Court has found that even when the language does apply, it does not operate to bar classwide relief if such relief is appropriate to satisfy the "particular plaintiff or plaintiffs" limitation. *Brown v. Plata*, 563 U.S. 493, 531–32 (2011).

Nevertheless, it is axiomatic that even outside the prison litigation context, a district court's orders are only binding on the parties to the lawsuit. Therefore, the plaintiffs' arguments to the contrary are unavailing.

2. Rule 23(b)(1)(B)

Rule 23(b)(1)(B) counsels class certification where "adjudications with respect to individual class members . . . would be dispositive of the interests of the other members not parties to the individual adjudications or would substantially impair or impede their ability to protect their interests." Fed. R. Civ. P. 23(b)(1)(B). The plaintiffs cite three district court cases where Rule 23(b)(1)(B) has been successfully invoked in actions by inmates challenging the conditions of their confinement. Mot. for Class Certification at 11–12. And they further argue that in the absence of class certification, "the ability of future plaintiffs to challenge" the BOP's policy will be inhibited "under *stare decisis*." *Id.* at 12. But the force exerted by any decision of a district court on its

sister district courts is at best persuasive. The plaintiffs cite *Riley v. Nev. Sup. Court* for the proposition that a decision made by a district court creates binding precedent on future district courts. *Id.* (citing 763 F. Supp 446, 453 (D. Nev. 1991)). But the plaintiffs’ reading of that case is overbroad. The court there only said that if a subsequent plaintiff were to raise the same claims as those the court had already found foreclosed *in front of that* “particular court,” then *stare decisis* would bind the subsequent plaintiff. While the Court does not endorse this reasoning, even taken at face value it cannot support the heavy weight the plaintiffs try to place on it.

3. Rule 23(b)(2)

The plaintiffs’ quest for class certification finally arrives at Rule 23(b)(2), which requires that the party opposing certification has “acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive or corresponding declaratory relief with respect to the class as a whole.” Fed. R. Civ. P. 23(b)(2). Injunctive relief must be “indivisible” in these cases, meaning that the relief for any individual plaintiff can only be obtained if the court enjoins the actions of the opposing party “as to all of the class members.” *Wal-Mart*, 564 U.S. at 360. Because they challenge the Executive Order and BOP implementing memoranda, and because they seek only to enjoin those actions, the plaintiffs argue that the relief they seek would resolve their claims “in one stroke.” Mot. for Class Certification at 13 (citing *Wal-Mart*, 564 U.S. at 350). The Court agrees. Enjoining the BOP implementing memoranda will provide swift, indivisible relief to all plaintiffs during the pendency of this litigation.

To avoid this conclusion, the defendants devote most of their Rule 23(b)(1)(B) discussion to the plaintiffs’ failure to satisfy a “presumption of cohesiveness” with respect to their Eighth Amendment claims. Defs.’ Opp’n 30–31 (citing *Borum v. Brentwood Vill., LLC*, 324 F.R.D. 1, 19 (D.D.C. 2018) (citations omitted)). They further argue that the BOP has not acted on grounds that

generally apply to the entire class, but instead has conducted “individualized assessments to address the medical needs of inmates in its custody.” *Id.* at 31. But this argument fails for at least two reasons. First, the plaintiffs have provided declarations showing that BOP officials terminated hormone therapy treatments for them and other inmates in direct response to the Executive Order. Rather than reflecting an “individualized assessment,” this comprehensive, blanket policy to end hormone therapy is the exact type of “generally applicable” policy that a Rule 23(b)(2) class action can properly seek to enjoin. *R.I.L.-R v. Johnson*, 80 F. Supp. 3d 164, 182 (D.D.C. 2015) (citing Fed. R. Civ. P. 23(b)(2)).

Second, even if the BOP officials’ actions over the last several months did amount to making medical assessments as to each plaintiff, it is clear to this Court that all of those assessments are being made with the full information of the Executive Order, implementing memoranda, and the Court’s rulings in this case and *McHenry* in mind. As Ms. Kingdom says, she and nine other plaintiffs had access to their hormone therapy restored by a BOP medical official who explicitly referred to this litigation when meeting with them. Suppl. Kingdom Decl. ¶¶ 1–2. And Mr. Kapule indicates that his hormone therapy will end as soon as his prescription expires, which hardly seems like the type of medical decision that was made after an “individualized assessment.” Suppl. Kapule Decl. ¶ 3. Therefore, to the extent the BOP officials have been meeting with the plaintiffs about their medical needs, none of the assessments made by those officials can be said to have been “individualized.”

For the foregoing reasons, the Court finds that the plaintiffs’ claims can properly be certified under Rule 23(b)(2).

VII. THE PRESIDENT WILL NOT BE DISMISSED AS A DEFENDANT FROM THIS LITIGATION

The defendants argue that the President should be dismissed as a defendant because he is immune from injunctive relief. *See* Defs.’ Opp’n 34. The plaintiffs respond that, even though they do not seek to enjoin the President, declaratory relief against the President is still available. Preliminary Injunction Reply 25. At least in this early stage of the litigation, and with thin minimal briefing from the parties on this matter, the Court agrees with the plaintiffs.

“In contrast to the case law concerning injunctive relief against the president, the Court notes the lack of clear authority on the availability of declaratory relief against a sitting president.” *Missouri v. Biden*, 662 F. Supp. 3d 626, 682 (W.D. La. 2023). Courts in this District, and the D.C. Circuit, have previously affirmed the issuance of declaratory relief involving the President. *See Harris v. Bessent*, No. 25-cv-412 (RC), 2025 WL 679303, at *9 (D.D.C. Mar. 4, 2025) (entering declaratory judgment against the President given the plaintiff’s “strong claim for relief under established standards”) (internal citations omitted); *see also Nat’l Treasury Emps. Union v. Nixon*, 492 F.2d 587, 616 (D.C. Cir. 1974) (considering declaratory judgment to be a less drastic remedy than a writ of mandamus); *Clinton v. City of New York*, 524 U.S. 417, 421 (1998) (affirming declaratory judgment that the President’s actions under Line Item Veto Act were invalid). But the Court also observes that on other occasions, courts have dismissed the President as a defendant when doing so would have “no substantive effect on the outcome” of the case, *see Make the Rd. New York v. Pompeo*, 475 F. Supp. 3d 232, 253 (S.D.N.Y. 2020), and have construed the availability of declaratory relief against the President narrowly, *see New Mexico v. Musk*, No. 25-cv-429 (TSC), 2025 WL 1502747, at *19 (D.D.C. May 27, 2025). Facing this ambiguous landscape, the Court declines to dismiss President Trump as a defendant at this early juncture, without prejudice to later dismissal.

VIII. CONCLUSION

During the pendency of this litigation, the BOP is required to restore and maintain access to those treatment modalities for those who previously received them pursuant to a prescription rendered by BOP staff. And moreover, if BOP medical personnel subsequently determine that an existing or future class member is in need of either or both of these treatment modalities, the BOP may not take those treatment options off the table while this dispute is pending.

The import of the Opinion is essentially this: Under the APA, the BOP may not arbitrarily deprive inmates of medications or other lifestyle accommodations that its own medical staff have deemed to be medically appropriate without considering the implications of that decision. Even if the BOP *did* support such a decision with the consideration, study, and reasoning that the APA requires of it, its freedom of action may nevertheless be constrained by the Eighth Amendment of the Constitution, but that is a matter better left for another day—whether that be a later stage of litigation, or another case entirely.

For the foregoing reasons, the plaintiffs' Motion for a Preliminary Injunction will be **GRANTED**, and their Motion for Class Certification will likewise be **GRANTED**. A separate Order consistent with this Opinion shall issue.

Date: June 3, 2025



Royce C. Lamberth
United States District Judge

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, *et al.*,

Plaintiffs,

v.

DONALD J. TRUMP, *et al.*,

Defendants.

Case No. 1:25-cv-691-RCL

ORDER

Upon consideration of Plaintiffs' Motions for a Preliminary Injunction, to Stay Agency Action, and for Rule 23 Class Certification, any oppositions and replies thereto, and the entire record herein,

It appearing to the Court that Plaintiffs are likely to succeed on the merits of their action, that they will suffer irreparable injury if the requested relief is not issued, and that the balance of the equities and public interest favor the entry of such an order,

And it further appearing to the Court that the proposed class satisfies the requirements of Fed. R. Civ. P. 23 in that the class is sufficiently numerous, satisfies the commonality, typicality, and adequacy requirements, and that Plaintiffs' counsel are qualified to serve as class counsel for the certified class, and that the proposed class should therefore be certified, it therefore is

ORDERED that Plaintiffs' motions are **GRANTED**. It is further

ORDERED that this case is certified as a class action on behalf of all persons who are or will be incarcerated in the custody of BOP facilities, with a current medical diagnosis of gender dysphoria or who receive such a diagnosis in the future. It is further

ORDERED that Plaintiffs' counsel, from the American Civil Liberties Union, Transgender Law Center, and the attorneys at the American Civil Liberties Union Foundation of the District of Columbia, are hereby appointed as counsel for the Plaintiff Class. It is further

ORDERED that both the February 21, 2025 memorandum from BOP Reentry Services Division Acting Assistant Director Dana R. DiGiacomo and Correctional Programs Division Assistant Director Shane Salem and the February 28, 2025 memorandum from BOP Health Services Division Assistant Director Chris A. Bina implementing Executive Order 14168 (the "Implementing Memoranda") are stayed pursuant to 5 U.S.C. § 705. It is further

ORDERED that Defendants Pamela J. Bondi, William W. Lothrop, Christopher A. Bina, Dana R. DiGiacomo, and Shane Salem, in their official capacities, and their contractors, employees, and agents (i) are enjoined from enforcing Executive Order 14168 as applied to medical hormone therapy and social accommodations for people in the custody of the BOP and from enforcing the BOP's memoranda implementing Executive Order 14168, and (ii) shall provide and continue providing Plaintiffs and members of the class gender-affirming hormone therapy and social accommodations in accordance with BOP policy and practice in effect immediately prior to Defendant Trump's issuance of Executive Order 14168 on January 20, 2025. It is further

ORDERED that this injunction shall be effective upon service on the Defendants, and no bond shall be required.

In accordance with the Prison Litigation Reform Act, the Court finds that this preliminary injunction is narrowly drawn, extends no further than necessary to correct the harm that the Court finds requires preliminary relief, and is the least intrusive means necessary to correct that harm. 18 U.S.C. § 3626(a)(2). The plaintiffs have shown a substantial likelihood of success on their claims that implementation of Section 4(c) and the Implementing Memoranda to the class members

is or would be unlawful and is causing or would cause them immediate, irreparable harm. Because applying Section 4(c) or the Implementing Memoranda to the class members would cause such serious and irreparable harm, a preliminary injunction preventing such implementation as to the class members is necessary to correct the harm and is the least intrusive means necessary to do so. Furthermore, because this preliminary injunction prevents the implementation of only Section 4(c) of the Executive Order and the accompanying Implementing Memoranda, and the plaintiffs have demonstrated a likelihood of success on the merits and immediate, irreparable harm if a preliminary injunction is not entered to enjoin that implementation, this Order extends no further than necessary to correct the harm that requires this preliminary relief.

Finally, this Court has considered any adverse impact on public safety or on the operation of the criminal justice system caused by this relief and has given substantial weight to such impacts. After this consideration, the Court has concluded and so finds that no adverse impacts on public safety or the operation of the criminal justice system will result from maintaining the status quo of the plaintiff class members' medical care while this litigation proceeds.

IT IS SO ORDERED.

Date: June 3, 2025



Royce C. Lamberth
United States District Judge

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA S. KINGDOM, et al. .
 .
 Plaintiffs, . CA No. 25-0691 (RCL)
 .
 v. .
 .
 DONALD J. TRUMP, et al., . Washington, D.C.
 . Thursday, May 22, 2025
 Defendants. . 10:19 a.m.

PRELIMINARY INJUNCTION HEARING
BEFORE THE HONORABLE ROYCE C. LAMBERTH
UNITED STATES DISTRICT JUDGE

APPEARANCES:

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Proceedings reported by stenotype shorthand.
Transcript produced by computer-aided transcription.

P R O C E E D I N G S

THE DEPUTY CLERK: Your Honor, this is civil action 25-691, Alishea Sophia Kingdom, et al., versus Donald J. Trump, et al. Will counsel please approach the lectern and state your appearance for the record. And we'll start with plaintiff's counsel first.

MS. SHAH: Good morning, Your Honor. Aditi Shah for plaintiffs.

MS. NOWLIN-SOHL: Good morning, Your Honor. Li Nowlin-Sohl for plaintiffs, and with me at counsel's table are Michael Perloff, Milo Inglehart, James Esseks, Maria Morris, Shana Knizhnik, and Leslie Cooper.

MS. LIN: Good morning, Your Honor. Jean Lin on behalf of Department of Justice. With me at counsel table are Elizabeth Layendecker and Alex Yun.

THE COURT: All right. The plaintiffs may proceed first.

MS. SHAH: Thank you, Your Honor. If it's okay with Your Honor, I'd like to start with the class certification motion and then hand it to my colleague, Ms. Nowlin-Sohl, for the preliminary injunction motion.

THE COURT: All right.

MS. SHAH: With respect to class certification, this is a quintessential Rule 23(b)(2) civil rights class action. The class that we proposed is defined as all persons who are

1 or will be incarcerated in BOP custody who are or will be
2 diagnosed with gender dysphoria or meet the criteria for a
3 gender dysphoria diagnosis and who are receiving or would
4 receive gender-affirming healthcare absent such care being
5 proscribed by Executive Order 14168 and the implementing
6 memoranda.

7 All of the putative class members are subject to the
8 same injury, which is a blanket denial of gender-affirming
9 healthcare, caused by the same action, the executive order
10 and BOP's implementing memoranda, and remediable by the same
11 injunctive relief, namely, enjoining defendants from
12 implementing the executive order and memoranda that impose a
13 blanket ban on gender-affirming healthcare, and restoring the
14 status quo ante, where class members would receive an
15 individualized medical determination as to whether they
16 qualify for such gender-affirming healthcare. And I'm happy
17 to start with the requirements of Rule 23(a). Numerosity is
18 not contested in this case, as Your Honor is aware.

19 THE COURT: Well, let me see if we can get some
20 definitions first, and then I'll start with that. Who decides
21 whether someone has gender dysphoria?

22 MS. SHAH: The diagnosis of gender dysphoria would be
23 made by a medical professional.

24 THE COURT: A medical professional. Okay. Now, I
25 guess in the cases I've had, we don't know how that's decided

1 within the government, but I'll come back to that. But in
2 your experience within BOP, how's that decided?

3 MS. SHAH: My understanding, Your Honor, at least prior
4 to the executive order and this categorical ban on
5 gender-affirming healthcare, is that there was a system in
6 place within BOP to have medical professionals diagnose
7 individuals who would seek medical treatment --

8 THE COURT: So a medical professional within BOP
9 decided if you had gender dysphoria, or they accepted some
10 medical professional had made that decision?

11 MS. SHAH: I believe that's correct. I think it's
12 possible that as with other types of medical conditions, if a
13 person has a pre-existing diagnosis, that diagnosis would be
14 reflected in the medical records that are made available to
15 BOP once BOP assumes custody.

16 THE COURT: So if there's a medical record that showed
17 that they had been diagnosed with that, BOP accepted that.

18 MS. SHAH: I believe that's correct. I'm not sure if
19 that's a hundred percent true in every case --

20 THE COURT: I'm going to ask the government the same
21 question.

22 Then if they had gender dysphoria in the medical records,
23 then BOP accepted that, and that's -- and that was changed as
24 a result of the executive order, then?

25 MS. SHAH: I'm not sure that the actual diagnosis has

1 been changed, and we know from, for example, the Bondi
2 declaration that defendants submitted where the BOP official
3 said that there are over 1,000 individuals with a gender
4 dysphoria diagnosis in BOP custody as of March 27. So I don't
5 think that the executive order has erased those diagnoses.

6 But what it has done -- and the reason we've brought this
7 case -- is that it prohibits on a categorical basis
8 gender-affirming healthcare to those individuals who have been
9 diagnosed with gender dysphoria or who otherwise meet the
10 criteria for a gender dysphoria diagnosis.

11 THE COURT: So if they're being given medication for
12 it, it can't be given under the executive order.

13 MS. SHAH: That's correct.

14 THE COURT: And yet I take it from something I read,
15 that 600 people are still being given the medication. Is that
16 right?

17 MS. SHAH: That is their claim, Your Honor.

18 THE COURT: That's their claim, okay.

19 MS. SHAH: Yes.

20 THE COURT: Now, how can that be?

21 MS. SHAH: Well, I think they are trying to draw a sort
22 of false distinction between what the executive order plainly
23 prescribes -- it's very clear from the text of the executive
24 order that federal funds cannot be used to provide any sort of
25 medical treatment or gender-affirming healthcare. But I think

1 that BOP has been drawing some sort of distinction, or at
2 least that's what I could tell from their papers, between what
3 the executive order proscribes and being able to provide the
4 same treatments or similar treatments for purposes other than
5 conforming one's gender to a sex that's different from their
6 biological sex.

7 And we dispute that there is any such principal distinction
8 that can be drawn from the executive order and what BOP is
9 required to do under its plain text. But that's my
10 understanding of why they're making this claim with regard to
11 the 600 individuals.

12 And the record is very clear, including for our named
13 plaintiffs and the supplemental declarations that we've
14 submitted, that all of the individuals that at least we've
15 been in touch with and have provided their specific examples,
16 either had their hormone therapy and medications cut off at
17 some point, or were told that they will be cut off.

18 And I think that notwithstanding BOP's representation
19 regarding this subset of individuals who they claim are still
20 receiving medication, nowhere have they said that moving
21 forward all individuals who are diagnosed with gender
22 dysphoria or who meet the criteria will continue to receive
23 their medication.

24 And that comes down to why we think that a certified class
25 is crucial here. There clearly is a common contention for

1 which class-wide relief is available. And my friends on the
2 other side have made arguments about commonality, typicality,
3 adequacy, but they all come down to an essentially red herring
4 argument that, well, whether or not someone gets a specific
5 medical treatment is an individualized medical determination.
6 Of course it is. We don't dispute that. What we are arguing
7 is that the categorical ban on gender-affirming healthcare,
8 indeed the type of ban that prevents --

9 THE COURT: That's what the executive order says.

10 MS. SHAH: Exactly. That's exactly what it says, and
11 it prevents the kind of individualized medical determinations
12 that are required under the Eighth Amendment. And so that's
13 why we think that this case is particularly apt for class-wide
14 treatment. There is a single categorical ban that stems from
15 the executive order and from the BOP's implementing memoranda
16 that apply to all class members.

17 And so for those reasons, we don't think any of their
18 arguments with respect to Rule 23(a) have any merit. And
19 unless Your Honor has any specific questions about that,
20 I'm happy to briefly discuss the Rule 23(b) --

21 THE COURT: Let me ask just a couple -- because I'm
22 not educated in the subject matter at all. What's the typical
23 medical treatment for gender dysphoria?

24 MS. SHAH: My understanding is that the most common and
25 typical treatment is hormone therapy. And hormone therapy, as

1 our expert declaration discusses, is absolutely fundamental
2 for individuals with gender dysphoria. It is the key way that
3 people with gender dysphoria are able to receive treatment for
4 the significant and undisputed distress that they face as a
5 result of the incongruence between their gender identity and
6 the sex that they were born with.

7 And that's why there really, we think, is no principled
8 way to make a distinction between what the executive order
9 proscribes, which is using federal funds for medications and
10 healthcare that would allow an individual to conform their sex
11 to their gender identity, and using such hormone therapy for
12 other medical reasons.

13 And I also want to just point out to Your Honor that within
14 this umbrella of gender-affirming healthcare, we also have
15 include social transition accommodations, binders, bras, other
16 things that have traditionally been available to transgender
17 individuals in BOP custody. And the executive order also
18 imposes a categorical ban on all of those social transition
19 accommodations. And those are also crucial for people who are
20 living with gender dysphoria in BOP custody.

21 THE COURT: Tell me a little bit about those.

22 MS. SHAH: Sure. So those items include things, as I
23 said, like binders, bras, undergarments that, you know, if an
24 individual is transgender, has gender dysphoria and identifies
25 as a woman but was born with male sex genitalia, part of the

1 transition and part of what is necessary to treat that
2 person's gender dysphoria is providing them access to social
3 transition accommodations, including for that person to be
4 able to access and wear a bra or have the appropriate
5 undergarments that match that of the gender identity that they
6 identify with.

7 And there is no dispute from defendants that that aspect of
8 the gender-affirming healthcare, the social transition
9 accommodations, are categorically banned. They haven't made
10 any claim that any individuals in their custody who have
11 gender dysphoria are receiving those items. And we know from
12 the individual examples we provided that they are unable to
13 access any new briefs or binders or bras or whatever they may
14 be, they're unable to access those either on their own
15 purchase through the commissary or get one through BOP.

16 THE COURT: Before the executive order, were all the
17 thousand people then able to have those services?

18 MS. SHAH: My understanding is that those services were
19 available and being provided by BOP.

20 THE COURT: By BOP.

21 MS. SHAH: Yes. Yes.

22 THE COURT: Until the executive order.

23 MS. SHAH: Until the executive order. And similar
24 to the last question, I can't say with certainty that every
25 single BOP facility in the country provided equal access or

1 perfect access, but there was certainly no categorical ban
2 on such items as there is through the executive order here.

3 THE COURT: Now, the other part of what you were
4 talking about is the executive order says "at government
5 expense." "At federal government expense," I guess.

6 What happens if you don't have -- in the case of other
7 drugs, if you're in a federal prison, what happens if you
8 can't get the drugs yourself? And I know there's situations
9 I've had in other cases where Bureau of Prisons decided it
10 wasn't medically urgent to have an operation, for example, and
11 the person had to go pay for it themselves or they wouldn't
12 get the operation, or maybe some kinds of medication weren't
13 deemed medically necessary by BOP. I remember, I've heard of
14 cases like that.

15 You can pay for it yourself or the state -- if you're
16 impecunious, the state has to pay for it? I don't really know
17 what happens in those circumstances. Can you deal with that?
18 I don't really know any of the law on that.

19 MS. SHAH: So my understanding just sort of as a
20 practical matter based on experience with BOP facilities is
21 that it really depends on the individual person's capacity and
22 resources to be able to obtain --

23 THE COURT: Most people in federal prisons aren't going
24 to have any money.

25 MS. SHAH: Absolutely.

1 THE COURT: So then if -- they have to wait till
2 they get out to have the procedure done, or do the states
3 sometimes pick it up? I don't know.

4 MS. SHAH: I think there are instances where if there
5 is a dispute between BOP and an individual person as to
6 whether BOP's determination that this specific type of medical
7 treatment or drug or operation is or is not medically
8 necessary for that person, I think that would become --
9 sometimes it escalates to an individual lawsuit after the
10 person has tried to do what they can administratively to
11 grieve that complaint.

12 And the examples Your Honor is raising I think are again
13 important and reflective of why class certification is crucial
14 in this case. Because what our case is about is actually
15 making sure that individuals even get to that point where they
16 can even have that kind of fight with BOP.

17 Right now, with the categorical ban, there's not even a
18 question as to whether an individual can raise with BOP this
19 specific type of treatment or this social transition
20 accommodation or this -- the hormone therapy is medically
21 necessary because there is this categorical ban. And just to
22 be clear, certifying the class here --

23 THE COURT: Well, it's been characterized that way, but
24 he said in the executive order, at government expense. Right?

25 MS. SHAH: At government expense. So federal funds.

1 And the social transition accommodations are a great example
2 of this. So the executive order says no federal funds shall
3 be expended towards gender-affirming healthcare including the
4 medication, treatments, and the social transition
5 accommodations. But people in BOP custody right now are not
6 able to get the accommodations that they need through BOP, and
7 they're not able to use their own money to buy those items at
8 the commissary because the commissary is what BOP --

9 THE COURT: Oh, I see.

10 MS. SHAH: -- makes available.

11 THE COURT: So that provision wouldn't allow the
12 private purchase of the things.

13 MS. SHAH: That's correct. That's my understanding,
14 Your Honor. And of course there may be rare situations where
15 someone perhaps has a family member who can bring them things,
16 although I'm not aware if those items might actually get
17 screened out in the BOP visitation process. That might be a
18 question for defendants.

19 THE COURT: This is a question I'll direct to the
20 government, then. If they wouldn't let the family member
21 bring it in, then that doesn't -- okay.

22 MS. SHAH: Exactly. Exactly. And the whole idea
23 around the reason why we have to challenge this, even though
24 the ban is with respect to federal funds, is because these
25 are treatments and healthcare that is mandated by the Eighth

1 Amendment, which my colleague will discuss in much greater
2 detail. But just to put a pin on it, it really is about the
3 fact that this care is medically necessary, at least with
4 respect to ensuring that people in BOP custody get the care
5 that is the standard, community standard of care. And the
6 major problem with this executive order and the reason why
7 we're challenging it is because of the categorical blanket ban
8 that it imposes.

9 And for those reasons, that key reason, this class also
10 satisfies the requirements of Rule 23(b), and specifically
11 Rule 23(b)(1) as well as (b)(2). And with respect to (b)(1),
12 we've argued it under both (b)(1)(A) as well as (b)(1)(B),
13 with (b)(1)(A) focusing essentially on the incompatible
14 standard of conduct that would be imposed on BOP if there were
15 to be a number of different individual lawsuits all
16 challenging the same categorical ban.

17 It's not difficult to imagine that if there isn't a class
18 here and there are different people running to different
19 courthouses, that BOP would be in a position where it might
20 have to -- it can't obey one court order without violating
21 another should the courts come out in different ways.

22 And similarly with (b)(1)(B), which is about ensuring that
23 the interests of the absent class members are protected. The
24 fact that this is a categorical ban means that by nature it is
25 a collective nature -- the nature of the conduct we're

1 challenging is collective. And therefore it applies to the
2 entire class. A decision by a court where, let's say there's
3 an expedited appeal and there's a ruling from a circuit, that
4 would then become a binding decision that would potentially
5 create different rights for different people just depending on
6 which circuit they're in or which jurisdiction the BOP
7 facility that they reside in happens to be in.

8 And with (b) (2) it is very clear here that the conduct that
9 we're challenging is generally applicable to the entire class.
10 As I said earlier, we have a common contention that's capable
11 of class-wide resolution here, and that is capable of
12 resolution by a single injunction, that injunction being as we
13 requested in our preliminary injunction, to enjoin the
14 defendants from implementing the categorical ban that's
15 imposed by the executive order and the implementing memoranda.

16 And if Your Honor does not have further questions on class
17 certification, I'm happy to hand it over to my colleague,
18 Ms. Nowlin-Sohl, who will address the preliminary injunction
19 motion.

20 THE COURT: I think that's all for now.

21 MS. SHAH: Thank you.

22 THE COURT: I'm sure I'll dream up something else.

23 MS. NOWLIN-SOHL: Good morning, Your Honor. Li
24 Nowlin-Sohl for the plaintiffs.

25 So there's a lot in this case that is not in dispute. It

1 is not disputed that gender dysphoria is a serious medical
2 need. You were talking earlier with my colleague a little bit
3 about that diagnosis. Defendants do not dispute how gender
4 dysphoria is diagnosed, that it is a real disorder, or that it
5 is a serious medical need.

6 It is also undisputed that the executive order states,
7 "No federal funds are expended for any medical procedure,
8 treatment, or drug for the purpose of" --

9 THE COURT: Treatment or drugs, yeah.

10 MS. NOWLIN-SOHL: -- "of conforming an inmate's
11 appearance to that of the opposite sex." And earlier you were
12 talking about the federal funds piece part, and I think that's
13 important. A couple points on that. First, the federal
14 government has a responsibility to provide medical care to
15 those who are incarcerated in its custody.

16 It is our understanding that people who are incarcerated
17 do not have the option to pay for their own medical care. So
18 if the government is not providing hormones, people are not
19 able to access it on their own, nor should they, because that
20 is the government's responsibility.

21 The no federal funds piece is also important because it
22 doesn't say that the government cannot provide it. And I
23 think that's made clear in Mr. Kapule's declaration where he
24 was told that he would be provided his hormones until his
25 prescription ran out. So BOP already has some of the

1 treatment on hand, and he is allowed to receive it until it
2 runs out. Defendants have not disputed his statement or said
3 that that is incorrect.

4 It is also undisputed that the executive order and the
5 February 21st implementing memorandum, under that, that
6 individuals with gender dysphoria can no longer receive
7 gender-affirming accommodations for social transition, such as
8 the chest binders, the undergarments and the commissary items.
9 There are several declarations indicating that those items
10 have been confiscated. Right? So it's not just that the
11 federal government is not providing them or that people can't
12 purchase them, but they've also been confiscated. And that is
13 undisputed.

14 And defendants do not refute plaintiffs' expert testimony
15 that social transition is medically necessary for many people
16 with gender dysphoria, and that denying accommodations that
17 allow for social transition can cause serious harm to mental
18 health.

19 It is undisputed that categorical bans on medically
20 necessary treatment violate the Eighth Amendment, and
21 defendants do not dispute that hormone therapy can be
22 medically necessary for the treatment of gender dysphoria and
23 that indeed BOP has determined that it is medically necessary
24 for hundreds of people in its care.

25 And it is undisputed that the February 28 implementing

1 memorandum implements the rest of the portions of the
2 executive order not covered by the February 21st memorandum.

3 So given all of that that's undisputed, what's left in the
4 Eighth Amendment claim comes down to two areas of dispute.

5 So first with regard to the social accommodations for
6 social transition, the only point in disagreement is a
7 question of law. Defendants contend that medically necessary
8 accommodations for social transition can somehow be carved out
9 of the protections of the Eighth Amendment. And as I'll
10 explain, there's no basis in the law for that.

11 The second point of dispute is with respect to hormone
12 therapy, and the only real dispute is whether the executive
13 order and the February 28th implementing memorandum mean what
14 they say, and thus that the putative class members' continued
15 access to hormone therapy is at risk. Defendants say that it
16 is not, but I think the record is very clear that it is.

17 So I'd like to start with the social accommodations --
18 or the accommodations for social transition piece, because
19 I think it's a little bit more tight. But as I mentioned,
20 defendants do not dispute that these are not being provided,
21 that they have been confiscated, and that people are no longer
22 able to purchase them. They do not rebut Dr. Karasic's expert
23 testimony that social transition can be medically necessary
24 for people with gender dysphoria and that it is part of the
25 accepted community standard of care.

1 And indeed, when we were talking about how gender dysphoria
2 is treated, the only accepted community standards of care for
3 the treatment of gender dysphoria are social transition and
4 medical treatment such as hormones. There are no other
5 treatments that are accepted within the medical community.

6 THE COURT: What's the basis for that? Whose
7 affidavit?

8 MS. NOWLIN-SOHL: That's Dr. Karasic's expert
9 declaration. He talks about that. He talks about the
10 standards of care and the fact that every major medical
11 association in the United States support these treatments for
12 gender dysphoria. I'm sorry, did you have a question, Your
13 Honor?

14 THE COURT: What does the government rely on to refute
15 that?

16 MS. NOWLIN-SOHL: So they don't refute that those are
17 the community standards of care. I think they try to point to
18 the fact that -- they argue that there is some kind of ongoing
19 debate within the medical community about this, but there is
20 no debate about adult treatment for gender dysphoria and with
21 regard to hormones. They provide no evidence, they cite to
22 dissenting opinions --

23 THE COURT: I mean, I remember at our first TRO
24 hearing, I said did the president have any medical evidence
25 as a basis and they couldn't answer. And then I said did he

1 cite any medical evidence and they couldn't answer. I guess
2 I'm still waiting on those answers, right?

3 MS. NOWLIN-SOHL: Correct. Yes. There is none in the
4 executive order, there is none in either of the implementing
5 memoranda. Again, it is Dr. Karasic's unrefuted testimony
6 that these are the only treatments. There is no evidence of
7 other treatments. There is no debate about adult -- hormone
8 therapy for adults.

9 And defendants also do not rebut Dr. Karasic's testimony
10 that being deprived of the ability to socially transition
11 predictably leads to deterioration in people with gender
12 dysphoria's mental health. The plaintiffs have also -- and
13 the putative class members have submitted declarations talking
14 about the harms they have been experiencing since the
15 accommodations have been confiscated.

16 Defendants' only argument is that somehow these
17 accommodations are carved out of the Eighth Amendment's
18 protections. But they support -- they cite no case law
19 for such a rule, because there is none. There is no case
20 suggesting that a blanket ban on gender dysphoria
21 accommodations would be constitutional.

22 And plaintiffs cite a number of cases showing that
23 treatment of medical needs is not limited to medications and
24 surgeries. Treatment can include accommodations and supplies
25 that people need, such as orthopedic shoes or hospital

1 mattresses. And other courts have recognized that gender
2 congruent undergarments and other gender-affirming
3 accommodations can be medically necessary.

4 Your Honor, turning to hormone therapy. Defendants do not
5 dispute that a ban on hormone therapy would violate the Eighth
6 Amendment. Rather, they're trying to assert that there is no
7 ban and thus no risk of medically necessary hormone therapy
8 being denied to the plaintiffs or the putative class members.
9 But the overwhelming evidence shows otherwise and we've
10 touched on some of this but I just want to run through it
11 again.

12 The undisputed facts are the language of the executive
13 order and the implementing memoranda are very clear. The
14 Bureau of Prisons has stopped providing hormone therapy to
15 some of the plaintiffs and the putative class members pursuant
16 to the executive order. And, for example, when Ms. Kingdom
17 filed a grievance after her hormones had been cut off, almost
18 immediately after the executive order was implemented, BOP
19 responded to her saying that the hormones have been denied
20 pursuant to the executive order in denying her grievance.

21 Mr. Kapule received a similar response to his grievance.
22 Mr. Kapule was also told that his hormones would be stopped
23 once his prescription ran out. Two other people have been
24 told the same thing.

25 Defendants do not actually say that those statements are

1 wrong or that these hormones won't be stopped. They're very
2 careful in their language to avoid saying that.

3 The fact that the hormone therapy was restored doesn't mean
4 that there's not a risk that it's going to be cut off here in
5 the immediate future. Defendants rely heavily on the fact
6 that it's been restored for people whose hormones were
7 terminated immediately after the executive order, and they try
8 to say that this suggests there's no risk of loss for hormone
9 therapy.

10 But there's substantial evidence that the resumption of
11 hormone therapy was in response to this litigation, and as the
12 Supreme Court has said, "It is the duty of the courts to be
13 aware of efforts to defeat injunctive relief by protestations
14 of repentance and reform, especially when abandonment seems
15 timed to anticipate suit and there's a probability of
16 resumption."

17 So this happened with Ms. Kingdom. Her hormones were
18 restored after almost two months, after this case was filed.
19 Mr. Nichols' hormones were restored in response to the TRO in
20 the McHenry case. And we just spoke to our declarant
21 Ms. Pinson, that after we submitted her declaration saying
22 that her hormones had been cut off, we spoke to her on Monday
23 and she said that her hormones had been restored that day.
24 So there are repeated instances of hormones being restored in
25 response to litigation.

1 The declaration of Mr. Bina is very carefully worded to say
2 that each plaintiff is currently receiving hormones. He does
3 not say that they will continue to receive hormones, and he
4 also does not say that hormones have not been cut off for
5 other class members. So we don't know that there aren't other
6 class members who have been denied their hormones under the
7 executive order and the implementing memoranda.

8 And defendants, as I mentioned, have not contradicted the
9 testimony of three declarants that people were told that their
10 hormone therapy will stop soon, including Mr. Kapule, who was
11 told his hormone therapy would stop once his prescription ran
12 out.

13 I want to address the defendants' argument that they're
14 suggesting that hormone therapy can still be provided under
15 the executive order because it only prohibits treatment for
16 the purposes of "conforming an inmate's appearance to that of
17 the opposite sex," suggesting that they might be providing
18 hormone therapy to plaintiffs for some different medical
19 reason. It is important, as Dr. Karasic in his declaration
20 stated, hormone therapy treats gender dysphoria by conforming
21 an individual's appearance to their gender identity. That is
22 the purpose of the treatment.

23 So to the extent that defendants might be arguing that they
24 are providing hormone therapy for the purpose of treating
25 gender dysphoria rather than for the purpose of conforming

1 somebody's body to that of the opposite sex, such a reading
2 would swallow the policy entirely, rendering it meaningless.
3 It's impossible to credit defendant's position in that
4 instance, which would make the executive order a nullity.

5 So lastly, I want to turn to their argument around the
6 saving clause. They point to the saving clause in the
7 executive order and in the February 28th implementing
8 memoranda, implying that because those say they must be
9 implemented in accordance with the Constitution, they must be
10 read to permit the provision of hormone therapy when medically
11 necessary. But these clauses do not rescue the policy from
12 its constitutional infirmities. The Supreme Court has long
13 rejected interpretations of sweeping saving clauses that prove
14 absolutely inconsistent with the provisions of the act in
15 which they are found.

16 As your colleague Judge Kollar-Kotelly recently explained
17 in the LULAC decision, if an executive order unambiguously
18 commands action that a saving clause purports to negate, a
19 reviewing court must ignore the saving clause and read the
20 order's operative provision to mean what it says.

21 And as Judge Kollar-Kotelly further explains, a saving
22 clause comes into play in a situation where an executive order
23 directs a subordinate to achieve a goal, and that goal can be
24 achieved in both legal and illegal ways. The court will then
25 interpret the executive order to direct only the legal action.

1 That is not the case here. There is only one way, and it
2 is an illegal way. So complying with the Constitution here is
3 directly at odds with the executive order.

4 Unless Your Honor has any follow-up questions on the Eighth
5 Amendment piece, I would like to turn to the plaintiffs' APA
6 claim.

7 So very briefly, to the extent that defendants imply that
8 this policy is not reviewable by the court because it is
9 implementing an executive order, the courts have been very
10 clear that the APA contains no carve-out for agency actions
11 implementing executive orders, and the Supreme Court has never
12 found one. And I think that is apparent by the number of
13 cases that this district is currently evaluating, you know,
14 agency action implementing executive orders. So this action
15 is reviewable.

16 The APA's arbitrary and capricious standard requires that
17 the agency action be reasonable and reasonably explained.
18 Here there is no reasoned explanation. There is no
19 administrative record. There is no explanation of this policy
20 reversal, and simply saying that you're implementing the
21 executive order does not satisfy the APA.

22 To hold otherwise would allow the president to simply issue
23 agency regulations that evade APA review by simply issuing an
24 executive order first. This has been rejected by courts
25 evaluating similar executive orders such as in the AIDS

1 Vaccine Coalition case.

2 There are also no explanations given in the executive
3 order itself, and defendants don't even try to point to one.
4 They only point to the sweeping executive order in its
5 entirety. The executive order offers no medical or mental
6 health analysis or discussion. It is focused only on gender
7 ideology. So because the implementing memoranda contain none
8 of the hallmarks of reasoned decisionmaking, they are
9 arbitrary and capricious.

10 So turning now to the rest of the PI factors. With
11 regard to irreparable injury, in addition to the harm of the
12 Constitutional violation, plaintiffs and members of the
13 putative class face severe irreparable harms to their health
14 absent an injunction. Again, defendants do not dispute that
15 accommodations for social transition have been confiscated and
16 that they are no longer allowed. And they do not refute the
17 evidence presented in plaintiffs' declarations, in the
18 putative class member declarations, or in Dr. Karasic's
19 declaration, demonstrating the harm of losing access to
20 accommodations that enable social transition. Thus, absent
21 an injunction, plaintiffs and the putative class members would
22 be significantly harmed.

23 With regard to hormones, injunctive relief is also
24 necessary to protect against the loss of hormones. Defendants
25 do not dispute the harms of denying medically necessary

1 hormone therapy for gender dysphoria that Dr. Karasic has laid
2 out. They also do not dispute the harms that plaintiffs and
3 the declarants discuss as a result of having their hormone
4 therapy cut off, weaned or threatened. They only argue that
5 there's no harm because the plaintiffs are currently receiving
6 hormone therapy. But as we've discussed, their hormone
7 therapy is at substantial risk of loss as a result of this
8 policy.

9 Turning to the last two factors, the balance of the
10 hardships and the public interest, which merge in this case
11 because the government is the defendant. Plaintiffs are
12 simply asking for a return and maintenance of the status quo
13 that has been in place for years. BOP has provided hormone
14 therapy and accommodations for years, and it is the undisputed
15 declaration testimony of Dr. Thompson that this is beneficial
16 to the inmates and also to the operation of the prisons.

17 Defendants have identified no hardships that they would
18 suffer under a preliminary injunction, and they do not dispute
19 the very severe hardships that plaintiffs and the putative
20 class members would suffer. It is always in the public
21 interest to prevent the violation of a party's constitutional
22 rights, and for these reasons the last two factors also weigh
23 in plaintiffs' favor.

24 Your Honor, I'd like to briefly touch on the exhaustion
25 piece.

1 THE COURT: Before you do that, is it your --
2 plaintiffs' position that -- that there's very little
3 difference in how the various prison entities are acting, so
4 there could be a nationwide class of all the prisons or --
5 I'm a little nervous about saying all the federal prisons are
6 acting the same way and there can be a nationwide class,
7 versus doing it institution by institution. Tell me a little
8 more about that.

9 MS. NOWLIN-SOHL: Yes, Your Honor. So the executive
10 order and the policies apply nationwide, and that is undisputed.

11 THE COURT: Right.

12 MS. NOWLIN-SOHL: And it is very clear what those
13 policies say and the harms they are imposing. So we do think
14 that a nationwide class would be very appropriate here, or
15 certification of the class to include everybody who is subject
16 to these policies.

17 THE COURT: The nationwide policies.

18 MS. NOWLIN-SOHL: They're nationwide policies. Yes,
19 Your Honor. So we think that the class including everybody
20 in BOP custody subject to our class definition and subject to
21 these policies would be appropriate.

22 THE COURT: At least those institutions that are
23 currently housing transgender people that are being housed
24 by what criteria? How do you get certified to be housed in
25 transgender wing or whatever?

1 MS. NOWLIN-SOHL: Yeah. So, Your Honor, I think our
2 class members are housed in facilities all across the country.
3 So not always consistent with their gender identity, and in
4 fact most of the time not consistent with their gender
5 identity. I don't know the details on this, but my
6 understanding is that there are people who are transgender in
7 many BOP facilities and that they're not necessarily in
8 specific facilities. There might be some that tend to house
9 more. But again, this is a BOP policy that applies to
10 everybody, and they're in BOP custody, and therefore a class
11 that applies to everyone subject to those policies is
12 appropriate.

13 THE COURT: So they could be in every BOP facility?

14 MS. NOWLIN-SOHL: Correct.

15 THE COURT: And this program could apply in every BOP
16 facility.

17 MS. NOWLIN-SOHL: I mean, I think the policies, they do
18 apply to every -- the executive order and the Bina February 28
19 implementing memoranda say no federal funds. Right? That is
20 anywhere. That is in any facility. And we are only
21 challenging the Bureau of Prisons at this point. But I will
22 point out that this applies to other federal facilities where
23 people are incarcerated as well.

24 THE COURT: And does -- all right. I'll ask the
25 government more about that. Go ahead.

1 MS. NOWLIN-SOHL: Okay, Your Honor.

2 So quickly on defendants' arguments regarding exhaustion.
3 The Supreme Court has said that an inmate need exhaust only
4 those administrative remedies that are available. And as this
5 court has held, administrative remedies were not available
6 here because the text of the executive order plainly requires
7 BOP to withhold the proscribed hormone therapy treatments and
8 also prevents them from providing accommodations.

9 For a remedy to provide some relief, the prison officials
10 must have the authority to grant it. Under the executive
11 order and the BOP memos, they don't have that authority. And
12 I think it's clear in the responses that plaintiffs Kingdom
13 and Kapule received to their grievances that there is no
14 discretion. They received responses that simply cited the
15 executive order as the reason why their hormones were denied.

16 You also evaluate exhaustion at the time the complaint was
17 filed. At that time plaintiff Kingdom's hormones had been cut
18 off, she had filed a grievance, she had received this response
19 telling her that it was a result of the executive order. So
20 at the time of her filing, when her hormones were cut off and
21 she'd received these responses, there was no administrative
22 remedy available to her.

23 Unless Your Honor has any further questions?

24 THE COURT: Thank you. Ms. Lin?

25 MS. LIN: Good morning, Your Honor.

1 THE COURT: I think this is our first time. Where
2 are you at Justice? Where are you assigned at Justice?

3 MS. LIN: Well, I've been at Justice for decades.

4 THE COURT: I know. Where are you, though?

5 MS. LIN: Oh, I'm sorry. Federal Programs Branch.

6 THE COURT: Oh, Federal Programs. Okay. Nice to have
7 you here.

8 MS. LIN: Thank you, Your Honor.

9 THE COURT: I love Federal Programs Branch. I always
10 have. They put the best lawyers there.

11 MS. LIN: Thank you, Your Honor.

12 So there are a lot of statements made about what the
13 government's policy is, what the BOP is or isn't doing, and
14 most importantly, whether the government disputed or didn't
15 dispute something. And I think there's just a lot of
16 misstatements. And so I hope I can decipher and explain
17 things that hopefully would resolve some of that confusion.

18 So I think most fundamentally both of the plaintiffs'
19 motions rest on a misinterpretation, a misunderstanding of
20 what the BOP's policy is. There is no blanket ban --

21 THE COURT: You can pull that mic down a little.

22 MS. LIN: There is no blanket ban on hormone
23 medication. And I think -- this is a very weird posture where
24 plaintiffs are trying to interpret an executive order and
25 agency policy in a way that injure the plaintiffs, when the

1 way that the agency is interpreting its own policy does not
2 injure the plaintiffs, which is that the plaintiffs are
3 getting the hormones.

4 And so there are two components to the BOP policy on this.
5 And just before I begin, there are a lot of terms used about
6 gender-affirming care in the discussion from my friends on the
7 other side. What is before the court, though, does not
8 include the surgery piece because the plaintiffs have carved
9 that out from this PI and from the motions. So I just want to
10 be clear that when they refer to gender-affirming care,
11 quote-unquote, that's the language that they have from their
12 experts, even their expert acknowledged that the surgery piece
13 is not part of this.

14 So on the BOP policy itself, there are two components, one
15 is the one that Your Honor previously had opined on, which is
16 section 4(c) of the executive order, which does say that no
17 federal funds shall be expended for any medical procedure,
18 medical treatment, or drug for the purpose of conforming an
19 inmate's appearance to that of the opposite sex.

20 So that again came from 4(c), which requires BOP to revise
21 its policies concerning medical care to be consistent with the
22 executive order.

23 The second piece of this policy is section 8(b) of the
24 executive order, which says that the executive order shall be
25 implemented consistent with applicable law. BOP has issued

1 policy statements saying that they interpret it to mean that
2 consistent with applicable law means consistent with the
3 Eighth Amendment as well.

4 So construing these two pieces together, the Health
5 Services Division at BOP, which is the authority for BOP's
6 health programs, and the medical director, who is the final
7 health authority for all clinical issues, who oversees all
8 clinical activities related to physical and psychiatric care
9 of the inmates, collectively they construe these provisions to
10 say that BOP will continue to provide hormones to inmates
11 diagnosed with gender dysphoria, based on those inmates'
12 individual medical conditions and the special -- the specific
13 needs, the clinical needs of that inmate.

14 So of course there's a limitation, and that limitation
15 is if the provision of the hormone is only for the purpose
16 of conforming the inmate's appearance to that of the opposite
17 sex. So plaintiffs argue that that's a false distinction, but
18 the BOP doctors have analyzed this question, they've construed
19 the provisions as they're required to do by the executive
20 order, they construe it in a way that does not injure the
21 plaintiffs, so it's very strange to us to hear that well, you
22 should construe it the other way so that we could be injured,
23 so that we would be deprived of hormones. So that's just kind
24 of an interesting situation here.

25 And the BOP declaration from the Health Services Division

1 assistant director says that BOP will continue to assess each
2 inmate's medical needs on an individualized basis going
3 forward.

4 So I guess the question then is it's a medical issue which
5 the BOP providers make this determination. Does the provision
6 of hormones provide benefits other than what might be
7 incidental effects of transforming or conforming the inmate's
8 appearance to that of the opposite sex. And the answer is
9 yes.

10 The BOP medical providers have determined that the
11 provision of hormones to inmates with gender dysphoria serve
12 many beneficial medical benefits, and that could include
13 improving the psychological and social well-being, quality
14 of life, it could ease symptoms of depression, anxiety, and
15 psychological and emotional distress, and decrease symptoms
16 of suicidality and self-mutilation.

17 And these are important medical benefits. And they exist
18 to address what has been determined to be a gender dysphoria.
19 As Your Honor may be aware, gender dysphoria doesn't occur in
20 every trans identifying people. Under the DSM 5 -- that's the
21 diagnostic code for gender dysphoria -- it requires
22 significant clinical distress. So what the BOP medical
23 providers have determined is that hormones have benefits
24 towards addressing the things that I've identified and the
25 significant clinical distress is alleviated to some extent by

1 hormones, at least based on the current medical science.

2 So it is incorrect to say that the only way to interpret
3 the executive order is to stop hormones. That is not what the
4 decisionmaker who is charged with interpreting the executive
5 order has decided and so we think that -- and which is why the
6 plaintiffs are getting the hormones.

7 And so I guess just to clarify things a little bit too
8 because there is -- there was some confusion and there was
9 some I guess representation by plaintiffs that somehow some
10 people lost their hormone medication.

11 So the number of inmates getting hormones both right before
12 the executive order and today remain roughly the same. So,
13 yes, there are over a thousand inmates with gender dysphoria,
14 but not all inmates with gender dysphoria require hormone
15 medication. And I think that is recognized by the plaintiffs'
16 own expert, Dr. Karasic. He said not everyone with gender
17 dysphoria needs hormone therapy. Which is consistent with
18 what BOP is seeing and is doing.

19 So immediately before the executive order, there were
20 roughly about 600-some inmates getting hormone medication,
21 and as of yesterday, we still have over 600 inmates getting
22 hormone medication. So that has not changed.

23 And clearly there's some inmates who might have been
24 released, the medical conditions might have changed, so the
25 numbers obviously cannot be exact. And in fact, one of the

1 putative class members who submitted a declaration saying that
2 his hormone was stopped, we submitted a sealed declaration
3 explaining why that occurred, which by the way has nothing to
4 do with the implementation of the executive order. That is
5 the sealed declaration which we filed on May 13 in response to
6 the plaintiffs' additional declarations.

7 So -- and an even broader number which the plaintiffs have
8 used is the total number of trans identifying people, which is
9 about 2,200 inmates. And again, Dr. Karasic's testimony
10 saying simply being transgender or gender nonconforming is not
11 a medical condition to be treated and is not considered a
12 mental illness. And that's plaintiffs' own expert,
13 Dr. Karasic.

14 So there are lots of numbers being thrown around. So I
15 think the relevant number is the roughly 600 or so inmates who
16 were receiving hormone medication and who continue to receive
17 hormone medication today.

18 And I do want to clarify why there was some
19 inconsistencies. And as the plaintiffs correctly noted, that
20 for two of the named plaintiffs, their hormone medications was
21 stopped for some period. And so this was the period -- you
22 know, following the executive order, as Your Honor's aware,
23 the new administration came in, there were many different
24 executive orders. This one is one of the ones where the
25 agency was acting quickly trying to interpret what it means.

1 So the BOP medical director, together with the Health
2 Services Division, were working to determine how to comply
3 with the executive order. That means both provisions of the
4 executive order. And so -- which ultimately led to the
5 February 8th policy.

6 But while that was ongoing, a couple of clinical directors
7 at various institutions -- so there's the Health Services
8 Division that governs the healthcare programs, then there's
9 the medical director that's responsible for all delivery of
10 healthcare within the BOP system. But at each institution
11 there was a -- there is a clinical director who is responsible
12 for the delivery of healthcare at that institution.

13 So at least a couple, inclusive of the ones where plaintiff
14 Kingdom is housed, a couple of them got ahead of the policy
15 that was to be implemented. And Your Honor's aware that when
16 we initially had the cases about the transfers of the
17 placements, we continued to represent at that point too that
18 hormone was going to be continued. So that had not changed.
19 It wasn't as if everything stopped. We continued to do that
20 and we represented that to this court in those cases.

21 So same thing here, BOP was trying to determine how to
22 comply with the executive order. And so a couple of clinical
23 directors got ahead of that. And even after the guidance was
24 issued, there remained some confusion by the clinical
25 directors as to how to implement that. But here's the bottom

1 line, though. As soon as BOP learned of problems, it took
2 steps to address them. So, yes, there was some initial
3 confusion in the early days of the administration, but now if
4 BOP learns of a problem, it takes steps to address them, which
5 also leads to our separate argument that -- which is why
6 exhaustion is very important.

7 It's not that BOP never makes mistakes. Like any large
8 agency -- and here we're talking about 122 institutions, at
9 least, and then 155,000 inmates, mistakes are going to happen,
10 which is why the exhaustion mechanism is there.

11 So now there's also reference to the idea that the inmates
12 or the -- sorry, the named plaintiffs or putative class
13 members were told that their hormones would be stopped. So
14 that is misinformation. And at institutions like those, those
15 are not the people -- to the extent we even know who they are,
16 the unnamed unknown BOP staff member saying oh, your hormone's
17 going to be stopped, oh, your hormone is going to be stopped
18 when we run out of drugs. That does not represent what the
19 BOP policy is. And so those should not be credited,
20 particularly given that they're also double hearsay, which is
21 inherently unreliable.

22 And there's also argument about, well, BOP doesn't say that
23 it would never stop hormones. So I think as with any
24 government agency, you talk about what the policy is, what it
25 currently is. Nobody can say never, right? Because you know,

1 there are a couple of things that could happen. On a broad
2 scope, it's possible medical science could evolve. It's also
3 possible as to individual inmates, their medical conditions
4 could change. So if someone's diagnosed with cancer, the
5 common response is do you stop any hormone treatment or not.
6 So that's just an example of how things can change.

7 So there is no reasonable belief that the plaintiffs are
8 going to suffer serious harm from the stoppage of hormone as
9 of now. And for the court to issue a preliminary injunction,
10 it has to determine that the injunction is necessary. So it's
11 not what happened when the complaint was filed. That's to
12 determine standing, perhaps. But it's what happens today,
13 whether the preliminary injunction is necessary and
14 appropriate, particularly in light of the constraints imposed
15 by the PLRA, which Your Honor's familiar with.

16 So I just want to also address very briefly the proposition
17 that somehow BOP is misconstruing the executive order as to
18 the savings clause. Again, this is a very weird posture where
19 a plaintiff is saying please construe it in a way that injures
20 me, so you would stop hormones. So putting that scenario
21 context aside, whether the savings clause does anything, and
22 my reading of the plaintiffs' position is that it doesn't; it
23 should not be given any effect. And we strongly disagree.

24 So the provision says you have to implement the executive
25 order in a manner consistent with applicable law here,

1 includes the Eighth Amendment. That is precisely the kind of
2 language that the D.C. Circuit has construed before, and to
3 say that you have to give effect to language like that, and
4 it's a case that we cited in our brief, it's the D.C.
5 Circuit's decision in *Building and Construction Trades*
6 *Department v. Allbaugh*, 295 F.3d 28. And it's cited in our
7 briefs, D.C. Circuit.

8 There it was a facial challenge to an executive order, and
9 the president had directed to the -- directed the agencies in
10 this executive order how to proceed in administering federally
11 funded projects. But the executive order also said the
12 agencies must comply with the executive order only to the
13 extent permitted by law.

14 So the D.C. Circuit explained it this way: If an executive
15 agency may lawfully implement the executive order, then it
16 must do so. If the agency's prohibited by statute or other
17 law from implementing the executive order, then the executive
18 order itself instructs the agency to follow the law. That's
19 kind of the situation here.

20 And the court specifically rejected the plaintiffs'
21 argument in that case, that, well, the phrase "to the extent
22 permitted by law" should be ignored because it doesn't prevent
23 an agency from violating the law. And so the D.C. Circuit
24 explained that, no, in the event an agency does contravene the
25 law in a particular instance, an aggrieved party may seek

1 redress through any of the procedures ordinarily available to
2 it. Which is the situation here.

3 So the idea that we should read the provision out of the
4 executive order makes no sense. And I know that the
5 plaintiffs have -- and there's one other case that we also
6 cited from this court, but it was a three-judge panel case
7 that included Judge Katsas, which also involved the language
8 where the presidential memorandum says this memorandum shall
9 be implemented consistent with applicable law.

10 And the court said -- this was written by Judge Katsas --
11 says "we cannot ignore such unambiguous qualifier imposing
12 lawfulness and feasibility constraints on implementing the
13 memorandum." So again, that's the situation here; and we're
14 giving it effect, and we read it consistently with other
15 provisions of the executive order.

16 So -- and I know that the plaintiffs have relied on a Ninth
17 Circuit decision that says if the saving clause contradicts
18 provisions in the executive order, the savings clause has no
19 effect. Well, that's not the situation here. In that case
20 the court said well, you have to construe the narrow as
21 overriding the broader provision in the executive order. But
22 there is no specific language barring the provision of hormone
23 medication in the executive order. It doesn't say that.
24 Because if that were the case, that would be a direct conflict
25 between that provision and our interpretation of the Eighth

1 Amendment. But the specific language doesn't say that. It
2 says "drug for purposes of conforming an inmate's appearance."
3 And as I have explained, there are many other medical benefits
4 for providing hormones. And to the extent there's incidental
5 benefit, BOP is still providing the hormone.

6 So there's also an accusation, which is a significant one,
7 that the government is engaged in litigation gamesmanship.
8 There was accusation that BOP is providing hormones purely to
9 avoid liability or, as counsel just said, in response to
10 ongoing litigation. We categorically reject this accusation
11 of government misconduct.

12 I think the court -- I think it defies logic to say BOP
13 is providing hormones to some 600 inmates today with gender
14 dysphoria purely to -- for this litigation, despite, despite
15 purportedly thinking and knowing that BOP is violating the
16 executive order. That makes no sense. And plus, to lodge
17 this kind of significant misconduct allegation against the
18 government, they have to have more. There is a presumption
19 of good faith and regularity for government agency. BOP's
20 entitled to that, and there's nothing suggesting that BOP is
21 trying to engage in litigation gamesmanship.

22 THE COURT: I have a couple of questions. Do you know
23 the -- I don't know. I haven't checked the dockets. Do you
24 know the status of the pending appeals of the PIs I've entered
25 in these hormone cases? Has the government sought to expedite

1 the appeals or what is happening there? Do you know?

2 MS. LIN: Yes. The D.C. Circuit has granted expedition
3 and the government has filed its opening brief.

4 THE COURT: Okay.

5 MS. LIN: I think the other briefs are forthcoming.

6 THE COURT: Okay. Blue I guess they don't hear
7 argument even on expedited cases till the fall?

8 MS. LIN: No. Actually, I believe the argument's
9 scheduled --

10 THE COURT: They set it?

11 MS. LIN: They've set argument as well. I believe --
12 I'm sorry, Your Honor. I just know that expedition was
13 granted and briefing have already started.

14 THE COURT: Okay.

15 MS. LIN: And before I move on, I just also want to
16 address a couple of I think misstatements about what BOP is
17 doing. So Your Honor had a few questions earlier about who
18 decides whether someone has gender dysphoria. Plaintiffs are
19 correct that the BOP medical professionals would make those
20 determinations. And to the extent --

21 THE COURT: But if someone has a prescription for
22 hormone therapy, can BOP then decide they won't honor it?

23 MS. LIN: So this is a situation where someone is
24 transferred from, let's say, a state prison facility.

25 THE COURT: Or in private practice. I mean, maybe

1 they're just convicted off the street but they've been taking
2 hormone drugs and they have prescription for hormone drugs.
3 Does BOP not honor that?

4 MS. LIN: So, Your Honor, I think it's not a question
5 of honoring or not honoring, because the general patient care
6 policy is that when an inmate comes into the BOP facility,
7 they look at if they have existing prescriptions and other
8 things. BOP medical providers make an assessment whether
9 continuation is consistent with the inmate's current medical
10 needs. So certainly there are inmates that come in already
11 have hormones and then they, depending on what their current
12 medical conditions are, they would get that medication.

13 And the two -- I believe at least two or if not all
14 three -- actually, all three plaintiffs here, they were
15 actually diagnosed by BOP medical professionals and their
16 hormone medications started while they had been incarcerated
17 for quite some time.

18 THE COURT: Right.

19 MS. LIN: But the BOP I do not believe blanketly
20 accepts just any diagnosis. It does its own independent
21 assessment and analysis of the inmates' medical conditions.

22 There was also discussion about what is the typical
23 treatment that Your Honor --

24 THE COURT: So at best the president's executive
25 order -- when I read it at that first hearing -- has not been

1 interpreted by BOP the way I read it at that first hearing.

2 MS. LIN: That's correct. Your Honor was construing
3 or assessing whether BOP has discretion --

4 THE COURT: Right.

5 MS. LIN: -- to construe it one way or the other. And
6 Your Honor is not the only one, of course. Right? A couple
7 of clinical directors also reviewed it and kind of came to
8 their own conclusion.

9 THE COURT: They thought it meant what I thought it
10 meant.

11 MS. LIN: And we submit that is not how BOP medical
12 providers have determined to be -- because it also has to be
13 read together with the requirement that BOP complies with the
14 Eighth Amendment. So that's kind of the current status.

15 I think Your Honor had a question earlier --

16 THE COURT: Someone sitting in the... (Inaudible.)

17 MS. LIN: I'm sorry. I missed that, Your Honor?

18 THE COURT: Oh, you don't need to.

19 MS. LIN: And you had a question earlier about what
20 is typical treatment for gender dysphoria. And I think it's
21 helpful to just explain that quickly before I move on. So,
22 certainly hormone therapy is one key way which, as the
23 plaintiff said, key way for people with gender dysphoria to
24 address that. There are also psychotherapy, mental health
25 counseling. And then there's the separate and distinct area

1 that is social transition, which the plaintiffs' expert submit
2 that social transition is also an important aspect of
3 treatment of gender dysphoria. I mean, I think -- you know,
4 BOP does not agree with that.

5 We certainly dispute social transition as being medically
6 necessary in the institutional context, because if that were
7 correct, if the Eighth Amendment requires that, then the 1,000
8 or so inmates would all have to be transferred to the
9 institutions of their preferred sex. And that clearly is not
10 what the Eighth Amendment requires.

11 So what then falls under that is the smaller aspects or
12 aspects of the social transition and the accommodations. So
13 I just want to be very clear about what accommodations we're
14 talking about. And I think even Dr. Karasic, plaintiffs'
15 expert, does not use the word "accommodations."

16 He says social transition, and separate from that, and
17 I quote, "gender-affirming care." Right? So he's treating
18 social transition as distinct from gender-affirming care, and
19 that I think we can say that includes for sure surgery and
20 hormones and drugs and maybe psychotherapy and those other
21 things. But social transition, even he treated it as
22 separate.

23 So on the accommodations -- so I'm assuming the plaintiffs
24 are saying, underneath the social transition umbrella, the
25 accommodations that BOP was giving were basically to help with

1 the social transition, and as I mentioned, the broader picture
2 is that if that were true, if that's what the Eighth Amendment
3 requires, then all 1,000 or so inmates would have to be
4 transferred. But be that as it may, the accommodations, there
5 are distinct types. I think at one point plaintiffs mentioned
6 medical accommodations. So just to be -- and they cited the
7 example of orthopedic shoes.

8 So just to be very clear, BOP policy does not affect
9 medical accommodations. Orthopedic shoes require
10 prescription. For people who had vaginal plasty, there are
11 certain devices they need to have that are medical. You know,
12 prosthetics need prescription. So what we're really talking
13 about are the kind of social aspect of accommodation, and so
14 that would be like cosmetic items. So that would be
15 lipsticks, makeup, hair rollers, lip gloss, shoes, lotion, and
16 that's the commissary items. That's the one category.

17 The other -- and that's covered by the February 28th policy
18 which is when BOP decided that it's no longer going to allow
19 people to purchase these commissary items. And just to be
20 very clear, this is not from an implementation of 4(c) of the
21 executive order. This is to implement a separate provision of
22 the executive order saying that federal funds shall not be
23 used to promote gender ideology.

24 So in order to stop these commissary items, you have to be
25 purchasing them using government funds, and so BOP decided,

1 not as a medical care policy revision, but separately to
2 improve -- to comply with the executive order about not
3 promoting gender ideology, it stopped providing these
4 commissary items.

5 The other categories are very similar, is the clothing
6 accommodations, undergarments and things. And then the third
7 is things that you can't buy in the commissary items and
8 previously you needed to get approval to get them. That would
9 be binders, stand to pee cups and hair removal things, but not
10 surgical, but hair removal devices, the cosmetic kind of
11 items. So these are the things that are no longer allowed for
12 purposes of implementing the EO.

13 The medical accommodations, things that doctors say you
14 need orthopedic shoes, here's a prescription, here's a
15 prosthetic prescription for you to get prosthetic. Those
16 continued. Those are not affected. So because the items
17 affected, which I think at points plaintiffs say social
18 accommodations. So these social accommodations are not
19 medical. And so when we're thinking in terms of the Eighth
20 Amendment standard, it's talking about a serious medical need.
21 That's a well-established Supreme Court standard.

22 So the serious medical need in our view does not include
23 the social accommodation items. And we cited a compilation of
24 cases specifically disputing that deprivation of let's say
25 makeup or hair rollers or cosmetic items would rise to the

1 level of an Eighth Amendment violation.

2 So courts have denied that transgender inmates' makeup and
3 other nonmedical accommodations for social transition would
4 rise to the Eighth Amendment, so that there is a developed
5 body of law out there that address these issues. So we
6 definitely dispute that these items could constitute an Eighth
7 Amendment violation.

8 So I think just one last point about the social transition
9 is that although we do have plaintiffs' expert, Dr. Karasic,
10 talking about social transition is medically necessary, and we
11 don't currently have an expert saying, no, it's not, but the
12 BOP policy itself reflects the BOP medical director and
13 medical health services position that they do not rise to an
14 Eighth Amendment issue.

15 And I think one other way to look at this is in addition to
16 what Dr. Karasic said, which is he said that he's the leading
17 author of the guidelines issued by WPATH, which we included
18 some information about the current debate concerning WPATH.
19 But putting aside WPATH, Dr. Karasic said and the other
20 medical guidelines that people typically use is the Endocrine
21 Society guidelines. So I took a quick look at the Endocrine
22 Society guidelines to see what they say about social
23 transition.

24 And the Endocrine Society recognizes, at least my
25 interpretation, is that this is just social issues. So it

1 says social transition may test a person's resolve, the
2 capacity to function in the affirmed gender, and the adequacy
3 of social, economic, and psychological supports. So social
4 transition helps with both the individual and the connection
5 in their judgment about how to proceed. During social
6 transition the person's feelings about the social transition
7 is a major focus of the counseling.

8 So I think that that confirms BOP's view that social
9 transitions is not something that rises to an Eighth Amendment
10 violation, or within the realm of that, and even if BOP were
11 to be wrong, they have a good faith determination that Eighth
12 Amendment only requires deliberate indifference to a serious
13 medical need. And I think that it defies logic at this point
14 to say that the serious medical need is to have makeup, hair
15 rollers, and other things that help with the social transition
16 aspect of an inmate in order to address the gender dysphoria.

17 The important thing is that BOP is providing not just
18 hormone medication for those whose medical conditions require
19 it, but inmates have access to psychotherapy, mental health
20 counseling, and other medications that may be needed to
21 address their symptoms. So it provides a full range of things
22 currently.

23 So even assuming, even assuming social accommodations is
24 one aspect of possible treatment, missing that one piece, we
25 submit, is simply not enough to rise to a level of deliberate

1 indifference to a serious medical need.

2 So I think that this kind of underscores what my next point
3 is, which is about what is necessary to get a preliminary
4 injunction in this context and whether there is irreparable
5 harm. So we talked about the idea that they are being
6 provided hormones. There is no current plans by BOP to stop
7 that, and BOP has construed the executive order to permit the
8 continuing provision of hormone medication. So any harm that
9 the plaintiffs are arguing is purely hypothetical.

10 Again, there's no reason to believe that BOP's providing
11 hormones just for litigation advantage or that it will be
12 imminently stopping the hormones as soon as the litigation
13 stops. And it certainly would not be knowingly violating the
14 executive order.

15 So the D.C. Circuit standard for irreparable harm, as Your
16 Honor is aware, is a very high standard. And so they must
17 face an injury that is both certain and great, and it must be
18 actual, not hypothetical, and the injury must be of such
19 imminence that there is a clear and present need for equitable
20 relief to prevent irreparable harm, and not just merely feared
21 as liable to occur at some indefinite time. That's D.C.
22 Circuit long-standing proposition.

23 So one case that plaintiffs cited in support is a Supreme
24 Court case, and so I want to address that very quickly. They
25 cited *Helling v. McKinney* -- this is 509 U.S. 25 -- for the

1 proposition that an inmate's Eighth Amendment claim can be
2 based on possible future harm to health.

3 But in -- that case is entirely different, right? Yes,
4 it's a Supreme Court case about future harm to health is
5 appropriate. But in that case it was about current exposure
6 to environmental tobacco smoke. And the argument was that
7 exposure posed an unreasonable risk of serious damage to the
8 inmate's future health. But there was current exposure to the
9 tobacco smoke. And the Supreme Court said, well, the inmates
10 had plainly proved an unsafe, life-threatening condition in
11 their prisons.

12 So this conditions of confinement has been proven in that
13 case. So the fact that nothing yet had happened doesn't
14 preclude preliminary relief. But here, unlike the condition
15 of confinement claim in *Helling*, there is no current BOP
16 policy that affect plaintiffs' ability to receive hormone
17 treatment. And as we explained before, the accommodations
18 question just does not rise to a serious medical need to
19 constitute an Eighth Amendment violation.

20 So then I guess the key question back to what we started
21 our brief earlier, and I know we presented this argument to
22 the court before, is that what is the PLRA's requirement that
23 the plaintiffs go through exhaustion requirement is applicable
24 here. And we submit that it is. It is a mandatory
25 requirement that Congress decided to reduce prison litigation

1 that inmates should exhaust. And the Supreme Court said very
2 clearly that is mandatory.

3 And I know Your Honor previously had held differently with
4 respect to transfer. But putting that situation aside, here,
5 if a mistake occurred, instead of running directly to Your
6 Honor in this court, to say my hormone might be stopped
7 because BOP staff told me it could be stopped and it might be
8 stopped as soon as the prescription runs out, that should not
9 even happen. They should go to the proper BOP personnel and
10 the layers of exhaustion, and BOP, if it recognizes to be a
11 mistake, it will correct that mistake, as it has done in
12 recent times.

13 So this is not a situation where there is no hope of BOP
14 providing hormone. BOP's providing that to 600 or so inmates.
15 So if there's an inmate out there whose hormones all of a
16 sudden got stopped, and the inmate doesn't know the reason,
17 they should go through the BOP process. At a very minimum,
18 there will be a record for the court to review. So the court
19 would know why did BOP stop and is BOP providing other kinds
20 of treatments. Maybe BOP determined that the risk of hormones
21 for that particular inmate outweigh the benefit of providing
22 hormone. All that should be in the record for a federal
23 Article III judge to say, okay, BOP's violating the Eighth
24 Amendment.

25 So we think the exhaustion requirement plays a significant

1 and important role here, even putting aside the idea that it's
2 mandatory by the statute, and Supreme Court has clearly
3 confirmed that.

4 THE COURT: I just had a couple other things I wanted
5 to ask you. Prior to January 20, was BOP providing hormone
6 therapy meds to anybody solely for the purpose of conforming
7 appearance to the opposite sex? Do you know?

8 MS. LIN: BOP had done an assessment. It did not
9 believe so. But was it possible that in the 155,000 inmate
10 population and the 122 clinical directors who might have done
11 it, because a lot of times an inmate might come -- I wouldn't
12 say a lot of times -- sometimes an inmate might say I think
13 hormone's going to help me.

14 And it may or may not be a gender dysphoria diagnosis,
15 or even with gender dysphoria diagnosis. So there could be
16 inconsistencies, so I can't say for sure. But BOP's review
17 is that there wasn't, but it's not easy to make this kind of
18 assessment given the number of inmates there are. But it was
19 not the policy of BOP to provide hormones to treat a cosmetic
20 preference, right, because you really need the clinical --
21 significant clinical distress of gender dysphoria.

22 So if an inmate has the gender dysphoria diagnosis, that is
23 a significant clinical distress for six months or more, plus
24 the inability to function in a range of things, that's two
25 components of the diagnosis -- if an inmate has that, an

1 inmate say I think hormone is going to help me, BOP is going
2 to properly give it. And if the inmate secretly thinks, and I
3 also would like to change my appearance, I mean, maybe that's
4 part of it, but even in that situation, BOP would provide it.
5 I think the unlikely situation would be I'm totally fine in
6 terms of my trans identifying identity and I don't have gender
7 dysphoria but give me hormones anyway because I like to look a
8 little bit more conforming to the opposite sex.

9 And that's not to say the provision in the 4(c) is doing
10 nothing, because it is making sure that BOP is complying with
11 the president's directive, and also it covers most
12 significantly about surgeries, and so that is something that
13 is not before this court for these motions, but we will, in
14 the regular course of this litigation, we will be talking
15 about that going forward.

16 THE COURT: Okay. Now, if the -- as I understand,
17 if the president issued an executive order stating that no
18 federal funds would be used for chemotherapy to rid inmates
19 of cancer, would that be deliberately indifferent?

20 MS. LIN: Not knowing enough about the science, you
21 know, this is just layman's guess, I think that may be
22 deliberately indifferent if that's the treatment determined to
23 be medically necessary. So this is a difficult area, right,
24 because it requires BOP medical provider's assessment. So
25 if the question is if there's a categorical ban on cancer

1 treatment, I would think that would be a problem. But we need
2 more facts to know --

3 THE COURT: And here there's a medical determination
4 that they need -- by a doctor who's prescribed the drugs, and
5 the president -- but you say the president's order does not
6 say that BOP can't give them the drugs.

7 MS. LIN: Right. It doesn't say no provision of
8 gender-affirming care. I mean, I'm quoting plaintiffs'
9 statement. But it doesn't say that. But I think more
10 importantly is how you treat gender dysphoria is really the
11 question, because gender-affirming care is such a broad term,
12 and whether gender could be affirmed is obviously a question
13 of debate.

14 So limiting ourselves to the question of if someone has
15 gender dysphoria diagnosis that is determined by medical
16 doctor, that person will get the hormone medication if the
17 medical provider determines the hormone medication would help
18 to relieve this diagnosis, to relieve gender dysphoria.

19 THE COURT: So it's because it's gender dysphoria that
20 your doctor will decide, but if it's cancer, your doctor will
21 just accept the other medical diagnosis.

22 MS. LIN: The BOP doctors are the ones making the
23 determination. So they would decide, subject to the guidance
24 and supervision of the medical director for BOP, as well as
25 consistent with the Health Services Division. And BOP does

1 treat cancer and BOP does treat a whole range of medical
2 conditions, and gender dysphoria is one of them.

3 So to think of it this way, because gender dysphoria is
4 classified by significant clinical distress, so BOP has to
5 address that, and in addressing that, it so far is doing a
6 hormone medication, it's doing psychotherapy, it's doing
7 counseling, and other medications that could additionally help
8 with alleviating the distress.

9 So I think for purposes of this preliminary injunction, we
10 established that preliminary injunction is not appropriate in
11 this circumstance as to the hormones. And as to the social
12 accommodations, again, if I could just remind the court that
13 the Eighth Amendment standard is so high that they don't meet
14 it here because the Eighth Amendment really proscribes medical
15 care so unconscionable to fall below society's minimum
16 standard of decency.

17 So the question is -- the Eighth Amendment question is
18 whether treatment provided is so grossly incompetent,
19 inadequate, or excessive as to shock the conscience. As Your
20 Honor knows, that's kind of the Eighth Amendment framework.
21 And our submission is that social accommodations such as
22 makeup, cosmetics and undergarments just do not rise to that
23 level. So for that, even if it is, there is no serious
24 medical need or irreparable harm in a way that it requires
25 preliminary relief now.

1 In the regular course of this litigation, the parties can
2 present their position and then the court can decide on the
3 merits as to that as well. So the preliminary injunction
4 aspect, we submit that it should be denied.

5 And, you know, there is serious harm too to the defendants
6 if the court were to issue the injunction. And just to cite
7 the court's example, court's PI order last time, it kind of
8 froze medical care at one moment in time, which is the day
9 before the executive order. But the very nature of medical
10 care is that it's a constantly evolving situation. Inmates'
11 medical conditions change, and so BOP must have the
12 flexibility to address the inmates' medical conditions at the
13 time that the BOP is assessing them.

14 So we just -- we think that the harm to defendant could be
15 significant if somehow medical care is frozen in time --

16 THE COURT: Oh, I wasn't the one that tampered with it.
17 I thought it was the president who said they couldn't have it.
18 That's all.

19 MS. LIN: Okay. So we just submit that, you know, in
20 terms of the balancing of the equities, given the record of
21 this case and the current situation, we don't think
22 preliminary injunction is appropriate. And so if the court
23 has no other questions, I want to move on very briefly to the
24 classification questions.

25 (Court conferring with staff.)

1 THE COURT: Go ahead.

2 MS. LIN: Okay. So I think that the discussion so far
3 shows that class certification is inappropriate. If we start
4 with the idea of the hormone medication, given the fundamental
5 disconnect between what the plaintiffs' claims are for class
6 certification and what the actual BOP policy is, there is no
7 common question capable of wide -- class-wide resolution,
8 because BOP's hormone policy is not a categorical ban. It is
9 an individualized assessment to see whether hormone is
10 appropriate. It is -- BOP is not stopping hormones. So the
11 class certification is based on this illusory BOP policy that
12 does not exist.

13 And because the BOP policy is one that depends on each
14 inmate's medical situation, in this instance class
15 certification isn't appropriate because for each inmate
16 whether there's any future stoppage of hormones is going to
17 rise to a level of Eighth Amendment violation is not something
18 that the court can decide today as to the whole class or even
19 as to the inmate, because we're talking about people are still
20 getting their hormones.

21 So we're talking about people who hypothetically hormone
22 might be stopped, but in that instance the court needs the
23 information about why is the BOP stopping hormones for this
24 particular inmate, what is this inmate's medical condition,
25 and more importantly, what BOP medical providers determine to

1 be appropriate for this inmate's medical condition.

2 So that kind of illustrates that why class certification is
3 inappropriate in this instance, precisely because the policy
4 is not what the plaintiffs argue or believe it to be.

5 Again, BOP's the one that's charged with implementing the
6 executive order. BOP is the one with discretion as to how to
7 do it, and BOP doctors are the medical providers who are
8 trying to assess how can I comply with the Eighth Amendment
9 and comply with the executive order and are doing so that meet
10 both requirements.

11 But in terms of whether this is amenable for class
12 certification, we submit that it is not because, again, the
13 plaintiffs' arguments is based on a policy that does not
14 exist. So I think we can look at a very --

15 THE COURT: What if I said that the injunction says BOP
16 cannot withhold medication from anybody whose gender dysphoria
17 is causing severe mental distress, suicidal ideation or
18 anything like that? That's consistent with what you're doing
19 now. And that would be consistent with letting BOP treat, but
20 saying you can't deny it if -- on those conditions you
21 couldn't deny it. And that would be consistent with having a
22 class.

23 MS. LIN: Your Honor, but I think, in order to
24 establish preliminary injunction, the court is bound by what
25 the Supreme Court says a plaintiff has to establish. The

1 question is not what's the harm. And the harm we kind of
2 explained, but --

3 THE COURT: The harm is what the president did. He had
4 no basis for what he did, the way it was first interpreted by
5 this court and by some medical professionals in BOP.

6 MS. LIN: But the president is not providing medical
7 care to BOP inmates. BOP is.

8 THE COURT: He ordered they couldn't give the drugs
9 even with prescription. That's what happened.

10 MS. LIN: So again, we submit that that is an incorrect
11 reading of what the executive order is.

12 THE COURT: The Justice Department lawyer standing
13 there before me couldn't tell me that was wrong at that
14 hearing when I issued the TRO and it became a PI. I got no
15 assurance that that wasn't what was going on.

16 MS. LIN: Your Honor, and I was at that hearing, and
17 I think what we represented at that time, that BOP is trying
18 to determine its medical policy because the president say BOP,
19 go and revise your medical care policies.

20 THE COURT: He didn't say that.

21 MS. LIN: Yeah, he did that in section --

22 THE COURT: He said you cannot give them the drugs.

23 MS. LIN: For purposes of conforming the inmate's
24 appearance. And it did require BOP to look at the medical
25 policy. So to avoid this debate with Your Honor, at that

1 hearing we said --

2 THE COURT: What's wrong with the injunction I just
3 told you about, if I did that?

4 MS. LIN: Because they failed to establish the
5 requirements for getting an injunction. Again, an injunction,
6 the question is not what's the harm -- and the harm here is
7 also -- just as Your Honor described, the court does not sit
8 as the super medical director who oversees BOP's medical
9 provision.

10 So freezing any kind of condition is something that BOP
11 strongly objects, because if let's say someone has cancer,
12 they would have to stop hormones even though they have the
13 clinical distress stemming from gender dysphoria. Or that
14 somebody might be allergic to the medication, or there's a
15 whole range of people. And I'm not a doctor so this is just
16 a couple that comes to mind.

17 But that is the very nature of delivering medical care
18 by BOP medical providers, and the court needs to give them
19 that discretion. To the extent that plaintiffs are not being
20 harmed, plaintiffs are getting the hormones, there is no
21 injury or irreparable injury, there is no deliberate
22 indifference to a serious medical need. So the question is
23 not what's the harm, why not just issue an injunction and bind
24 the government. The harm is significant in terms of the
25 delivery of medical care.

1 And it's not like the inmates have no recourse. They would
2 be able to go through the exhaustion process as required by
3 PLRA and as recognized by the Supreme Court as being mandatory
4 to alleviate or to address why that is. And often, though,
5 what happens that they have consultation with their medical
6 provider. So they usually wouldn't be in the dark as to, hey,
7 your hormones could be causing you problems because you need
8 to take these cancer drugs. So it's not as if they're
9 completely in the dark. And to the extent that they are,
10 there's a process for them to figure out is my hormone
11 properly stopped.

12 And this court is not a medical review board. This court
13 also does not set medical standards. And the preliminary
14 injunction that you just proposed, almost as if here's the
15 medical standard that I want the BOP to follow, and we think
16 that is entirely inappropriate, particularly given that the
17 elements of the preliminary injunction are not met in this
18 case, because plaintiffs have simply not been injured by the
19 deprivation of hormones. And so, again, speculation alone
20 does not justify it.

21 THE COURT: Thank you, Ms. Lin.

22 MS. LIN: So on the class certification point, I just
23 want to highlight the difference between our situation from
24 the ones that the plaintiffs might have posited before. I
25 think they cited -- just take one example, a Supreme Court

1 case, *Brown v. Plata*.

2 So that was a case that involved, although the Supreme
3 Court didn't decide the class certification, but the case
4 involved a class that was certified. And that shows why the
5 situation here doesn't justify class certification, because
6 in that case it was about prison crowding. And so the prison
7 crowding caused people who have serious medical conditions to
8 not be able to get the care that they needed.

9 So again, that is a very different situation, a kind of
10 across-the-board situation that affects everybody, even if
11 slightly different in terms of how much it affects them, but
12 it still is -- you know, I think the classic conditions of
13 confinement cases tend to be much easier for across-the-board
14 resolution, which is not the case here. Again, no blanket ban
15 on hormones.

16 And they also relied on a case which I think highlights
17 the difference here. They cited a case that actually involved
18 fairly similar language in terms of what is being banned by
19 the prison facility, and that is a district in Idaho. It's
20 *Robinson v. Labrador*. In that case the prison officials had a
21 blanket ban on hormones. So the court said, well, the key
22 question is then whether hormone therapy is medically
23 necessary for individuals with gender dysphoria. So class
24 certification was appropriate in that case. But that's
25 exactly not what our situation here.

1 BOP is providing hormones for people with gender dysphoria
2 if their medical conditions suggest that they would benefit
3 from it. And I laid out the benefits before. So -- and even
4 in that case the court said the court is not convinced that
5 WPATH or the Idaho legislature have answered the question
6 conclusively, and this is not the type of questions that can
7 be answered without deliberate investigation. But they raise
8 a serious question.

9 So we don't have such -- they raise a serious question
10 about the Eighth Amendment. We don't have such serious
11 question here. BOP is providing hormones. So we think that's
12 why this is a case that is not amenable for class
13 certification.

14 And I think there's a couple of references to other 23(b)
15 certifications, that's (b)(1)(A) and (b)(1)(B), and we stand
16 on our brief on that. There is going to be no inconsistent
17 adjudication because again PLRA requires this court to limit
18 its ruling to the plaintiffs before the court. And that's the
19 very foundation of PLRA is to try to limit these litigations.
20 So to suggest that somehow if the court were to decide that
21 lipstick is not appropriate for an inmate, somehow that's
22 going to cause inconsistent adjudication as to cause BOP
23 problems, we submit that it won't. Or whether someone needs,
24 like, binders or things of that nature.

25 And same thing about (b)(1)(B), which is really just kind

1 of a common funds type of case. So deciding favorably for
2 one inmate is not going to affect the other one. There's no
3 common fund, there's no, like, a group of -- adjudication
4 that's going to be affecting other people.

5 So I don't know if Your Honor has other questions. I hope
6 I have answered your questions, but if possible, if I could be
7 allowed two or three minutes just to address any confusions
8 that might arise in my colleague's rebuttal, I would greatly
9 appreciate it.

10 THE COURT: I'll let you.

11 MS. LIN: Thank you, Your Honor.

12 THE COURT: Nice job, Ms. Lin.

13 MS. LIN: Thanks.

14 THE COURT: That's what I call a nice day of arguing
15 for both sides.

16 MS. NOWLIN-SOHL: And we're not even done yet.

17 THE COURT: Normally I give you the last word, but
18 if she wants to say more, I will give the plaintiffs the last
19 word. You do have the burden.

20 MS. NOWLIN-SOHL: Okay. Thank you, Your Honor. So
21 plaintiffs would love to trust that the government is going
22 to continue providing hormone therapy to people when it's
23 medically indicated despite the executive order and the policy
24 that prohibit it. But the record doesn't allow for such
25 confidence. A lot has been said today that is not in the

1 record, and the government can't stand here today and make
2 up a new policy, right? All of that about the supposed
3 government policy, it's not in the record, it's not under
4 oath, and it was not provided by any witnesses.

5 What is in the record is the executive order, the
6 implementing memoranda, and the Bina declaration. So to the
7 extent that counsel was saying that the BOP has created this
8 other policy that allows them to do these things, we have not
9 seen that policy. They've had multiple opportunities to
10 provide that policy, right? There were the briefs, there were
11 supplemental declarations, there were surreplies. That policy
12 has not been put into the record.

13 The only thing that the BOP policy says on the subject of
14 hormone therapy is what's in the February 28th implementing
15 memoranda by Chris Bina. And I can read it to you briefly,
16 because it is very brief.

17 It says, "Consistent with the Executive Order 14168,
18 Defending Women from Gender Ideology Extremism and Restoring
19 Biological Truth to the Federal Government, no Bureau of
20 Prisons funds are to be expended for any medical procedure,
21 treatment, or drug for the purpose of conforming an inmate's
22 appearance to that of the opposite sex." And then there's the
23 savings clause.

24 That's all that this policy says that's in the record.
25 It doesn't say that hormones can be continued, it doesn't say

1 that they will be continued. That's also not in the Bina
2 declaration. And I think it's worth looking at the Bina
3 declaration as well as to what that does say.

4 And so the key kind of paragraphs that defendants cite,
5 particularly in their surreply, are 13 through 15. And I'm
6 going to read that out as well.

7 So paragraph 13 says -- and this is after kind of citing
8 BOP's general policy about the provision of medical care and
9 mental health care to inmates, right, not specific to gender
10 dysphoria but BOP's general obligations to provide health
11 care.

12 So paragraph 13 says, "Each inmate is individually
13 evaluated and given a treatment plan consistent with their
14 medical needs. Patients with the same diagnosis may be
15 offered different medical treatment based on the individual
16 clinical need." Okay. That's a general statement.

17 Paragraph 14 says, "BOP provides prescription medications
18 to inmates. This has included, for some individuals, hormone
19 medication. As of March 27, 2025, BOP is providing hormone
20 medication to approximately 628 inmates with a diagnosis of
21 gender dysphoria or gender incongruence."

22 I'd like to note that that number of people receiving
23 hormone therapy is two months after the executive order was
24 issued. We don't know how many people were cut off prior to
25 that. So that 628 number, I just want to flag that.

1 Paragraph 15 then says, "If inmates are taken off estrogen
2 or testosterone treatments, they receive treatment for any
3 symptoms they may experience as clinically indicated. The
4 Bureau would monitor, as clinically indicated, their" -- and
5 I'm not going to pronounce all of these correctly, but their
6 "hematopoietic, endocrine, renal, hepatic, and cardiovascular
7 systems to assess the need for other medical intervention."
8 That is all that the Bina declaration says about hormones.

9 It talks about hormones being withdrawn. The record does
10 not say that hormones are going to continue to be provided.
11 And so to the extent that defendants are talking about there
12 will be individual medical assessments of folks, that doesn't
13 negate the Constitutional violation if you've taken the core
14 treatment out of the running.

15 So a hypothetical here can be helpful. If there were an
16 executive order denying insulin treatment to people with
17 diabetes, or just generally, it couldn't be that BOP can say
18 well, we're going to individually evaluate people and their
19 treatment, and we're going to give them information about
20 their diet and about exercise to help manage their diabetes.
21 The fact that insulin has been taken off the table would
22 qualify as a deliberate indifference to a serious medical
23 need.

24 And that's what's happening here. Dr. Karasic's testimony
25 is very clear about what the treatment is for gender

1 dysphoria. The science and the medical community understands
2 that the treatment for gender dysphoria includes social
3 transition and medical treatment, including hormones. There
4 are no other proven treatments. Dr. Karasic says that
5 psychotherapy has not been shown to be an effective treatment
6 for gender dysphoria. Defendants have put nothing in the
7 record to show that it is. And so these treatments have been
8 taken off the table.

9 We're not asking Your Honor to make any medical decisions
10 for people today. We're asking that the BOP medical providers
11 be allowed to have the treatments in front of them as options
12 when making medical decisions for individuals. That is not
13 what the policy says.

14 To the extent that Ms. Lin talked about the other benefits
15 of hormone therapy as about reducing suicidality and
16 psychological well-being, those, as Dr. Karasic testifies, are
17 a result of somebody's presentation being consistent with
18 their gender identity. That is how social transition works.
19 That is how hormones work. And so there is of no purpose that
20 hormone therapy is provided other than to bring somebody's
21 body into alignment with their gender identity. And the
22 government has put nothing in the record to suggest that there
23 are other purposes.

24 And I think the confusion around the policy and what it
25 says is very clear by the testimony today that BOP's own

1 clinical directors have interpreted this policy as banning
2 this healthcare, and have been banning it at several of their
3 institutions. You know, they're saying they're interpreting
4 it differently than what the actual policy says, but they've
5 given no guidance that we're aware of to these clinical
6 directors, and these clinical directors are banning the care
7 as a result of this executive order and these implementing
8 memoranda.

9 And in kind of going a little bit back to the social
10 accommodations, it is incorrect that Dr. Karasic said that
11 those were separate from the medical care. They are part of
12 the treatment for gender dysphoria that is replete throughout
13 his declaration. And it makes sense. If you think about it,
14 if somebody is transgender, that means they have a gender
15 identity that is different than the sex that has been assigned
16 to them at birth.

17 The treatment is to bring their body and their expression
18 into alignment with their gender identity. And that can be
19 through hormones, which can cause secondary sex characteristics
20 to align with their gender identity. For example, if a trans
21 man takes testosterone, he may grow a beard, his voice will
22 deepen. But it is also important for that trans man to have a
23 presentation that is consistent with that, right?

24 So to wear a chest binder, to wear in this instance boxers,
25 or for a trans woman to be able to wear a bra and feminine

1 underwear and potentially makeup and these commissary items.

2 One quick clarification. Counsel was trying to say that
3 none of the accommodations are medical. That's not a
4 distinction that's found in the Eighth Amendment. But even
5 if it were, that's not true. The chest binders were actually
6 issued by medical. I just wanted to clarify that. But again,
7 the accommodations are not just, you know, prosthetic legs.
8 In the examples we gave, it was also like a special mattress
9 and things like that.

10 And to the extent that opposing counsel mentioned there's
11 a developed body of law suggesting that accommodations can be
12 banned, they cite two cases in the brief. These cases are
13 easily distinguishable. One of them was a pro se plaintiff
14 that relied on a misreading of the *Keohane* case in the
15 Eleventh Circuit. And in that case there was an individual
16 determination by that individual's doctor that social
17 accommodations were not medically necessary for her. There
18 was not anything that said a blanket ban could be justified.

19 And that's what we're asking the court to do today, is to
20 remove this blanket ban and allow for individual
21 determinations by medical providers about what is appropriate
22 treatment for each person.

23 And then the second case that they cite is the *Fisher* case,
24 and in that case the plaintiff was provided undergarments and
25 commissary items, and that case had to do with whether she was

1 entitled to specific brands of that. So there are actually no
2 cases suggesting that these accommodations can be carved out
3 from the Eighth Amendment, and plaintiffs cite a robust body
4 of law suggesting that accommodations and supplies can be
5 medically necessary.

6 So just to touch on a couple of other points that came up.
7 Opposing counsel was talking a lot about the saving clause.
8 And again, their interpretation of the saving clause would
9 render the executive order a nullity. It's not clear what
10 purpose the executive order would serve if they're now saying
11 that hormones can be provided in any situation where it's
12 medically necessary. And again, as we've talked about, there
13 are no people who are getting hormones for a reason other than
14 to conform their body with the opposite sex or their gender
15 identity.

16 And I think their own clinical directors' confusion again
17 suggests that the savings clause isn't clear that there's a
18 legal path or an illegal path. They are interpreting this
19 policy to mean what you and I have understood it to mean, that
20 this doesn't allow for hormone treatment.

21 Sorry to be jumping around a lot, but there was a lot
22 that was said. But going back to the social transition,
23 there's no evidence that social transition is not necessary.
24 Again, defendants have provided none. It is not in the
25 record. What was said today is not evidence, it's not in the

1 record, and it's not sworn testimony.

2 So going a little bit I think to the irreparable harm.
3 Again, there is nothing in the record that is rebutting the
4 testimony of the plaintiffs, the putative class members, and
5 Dr. Karasic about the harms that are resulting from the denial
6 of accommodations for social transition, or will result from
7 the denial of hormones.

8 The D.C. Circuit has been clear that Your Honor has the
9 authority to prevent harm and enjoin harm -- sorry. I'm
10 getting a little bit confused -- but with regard to the PLRA
11 as well, pending exhaustion. So this is not a situation where
12 the harm is theoretical. The harm has been very clear. It is
13 already happening with regard to social accommodations.

14 And just because the BOP hasn't given the plaintiffs and
15 the putative class members a set date as to when their
16 hormones are going to be cut off, doesn't mean that it is not
17 certain that it's going to happen or that it is not imminent
18 or that they are not at risk of irreparable harm. And that is
19 the status under the Eighth Amendment, is a substantial risk
20 of irreparable harm.

21 And just to clarify about what BOP's policies are and
22 what's in the record. Absent an injunction, how is a BOP
23 clinical director supposed to know that they're still allowed
24 to provide hormone therapy to people in their custody? The
25 executive order and the BOP policy do not make that clear;

1 there has been no follow-up clarification issued; and the memo
2 and the executive order prohibit treatment. Treatment has
3 been cut off, treatment has been -- or plaintiffs have been
4 told that their treatment will be cut off, and clinical
5 directors have interpreted it to cut off treatment.

6 So absent an injunction, I don't think we can rely on the
7 fact that hormone therapy will not be cut off in the future.

8 Thank you, Your Honor. I'm going to pass it to my
9 colleague, Aditi, Ms. Shah, to address some of the things
10 about class cert, and I appreciate the offer to have a couple
11 of minutes at the end if necessary.

12 MS. SHAH: Thank you, Your Honor. And I will try to
13 keep this quite brief. Just a few points in response to
14 counsel's arguments regarding class certification. First, all
15 of the arguments that counsel made, even when counsel said
16 they were about class certification, in fact are only about
17 the merits of the underlying claims.

18 And as the Supreme Court held in *Amgen* very clearly, courts
19 may only delve into the merits of underlying claims on a class
20 certification motion to the extent that those merits actually
21 are relevant to the requirements for class certification. And
22 none of the disputes regarding the merits of the underlying
23 claims here preclude class certification in this case.

24 Commonality, typicality and adequacy, the Rule 23(a)
25 requirements, are all still met because the claims are still

1 common to the entire class. And all of the Eighth Amendment
2 prisoner class actions that we have cited in our briefing
3 demonstrate this, including in the cases that counsel
4 discussed, like *Brown v. Plata*. We also cite *Parsons v. Ryan*
5 from the Ninth Circuit and several other cases as well where
6 courts determined that class certification was appropriate
7 because of the alleged system-wide common policy. And here we
8 have clearly alleged that for all class members there is a
9 common contention, a common claim that there is a blanket ban
10 imposed by the executive order and the implementing memoranda
11 on a type of medical care -- on a type of healthcare that
12 affects all members of the class.

13 Briefly I also want to just respond to the argument
14 regarding the PLRA language that my friend on the other side
15 suggests in any way restricts the court's ability to grant
16 class certification. That is not the case for three reasons.
17 First, the plain text of the PLRA says nothing about class
18 certification. The provision that they cite, 3626(a), does
19 not say class certification at all. Instead, it deals with
20 the type of remedy that courts can grant.

21 And the language that they quote, "plaintiffs or particular
22 plaintiffs," that language belongs in a subsection of that
23 provision of 3626 that does not deal with preliminary
24 injunctive relief. The PLRA discusses injunctive relief in a
25 separate subsection that does not contain that language and

1 instead only says that the injunctive relief should correspond
2 to the violation and be no further than necessary to correct
3 the harm to the -- the harm that was demonstrated, which is of
4 course just another sort of axiomatic principle of what a
5 preliminary injunction would achieve anyways.

6 And several cases have held that this specific language
7 in the PLRA that defendants rely on does not preclude class
8 certification, including a Tenth Circuit decision written by
9 then-Judge Gorsuch that held that this provision of the PLRA
10 does not preclude class certification.

11 And lastly with respect to the (b) (1) (A) and (b) (1) (B)
12 arguments, there too defendants rely on the same PLRA argument
13 that does not apply. And certainly the (b) (1) (B) standard is
14 not limited to, quote, limited fund class actions. Those may
15 be a common type of (b) (1) (B) class actions, but there are
16 several examples, including some that we've cited in our
17 briefs, where (b) (1) (B) was employed to certify prisoner class
18 actions.

19 And I won't even really get into (b) (2) again because there
20 was no specific argument made about (b) (2) by counsel, but for
21 the reasons that I mentioned earlier, a single injunction that
22 enjoins defendants from implementing the unlawful executive
23 order and implementing memoranda certainly would provide
24 class-wide relief to the entire class that we've proposed
25 here. So for all of those reasons, I urge the court to

1 certify the class in this case.

2 THE COURT: Thank you, Ms. Shah.

3 MS. LIN: I promise to be extremely brief. So first of
4 all, I think just for the last points first, I think it's a
5 misreading of our brief to say that PLRA precludes any and all
6 class certifications. Our position is that in this case class
7 certification is inappropriate particularly considering the
8 requirement in the PLRA that the relief to be narrowly drawn,
9 extend no further than necessary, and be the least intrusive
10 means to correct the violations by the prison officials.

11 As you know, the congress really wanted to curtail rampant
12 prisoner lawsuits, and not to say that they wouldn't have
13 merits, but that the underlying concept of PLRA should help
14 the -- should inform the court as to whether class
15 certification is appropriate.

16 The case that counsel on the other side just noted by Judge
17 Gorsuch when he was on the Tenth Circuit, that case did say
18 explicitly that Rule 23(b)(2) does not apply where -- and I'm
19 quoting -- "redressing class members' injuries requires
20 time-consuming inquiry into individual circumstances or
21 characteristics of class members or groups of class members."

22 And that I think -- granted that the case there might be
23 broader than here, but that applies equally here because given
24 the lack of a blanket ban, which we continue to say that it
25 does not exist, that there's a blanket ban -- you have to look

1 at each inmate's individual circumstances.

2 And I think my representations to the court today reflect
3 what the policy is, but that's not to say that BOP somehow
4 is -- so let me just rephrase it this way. I think what BOP
5 is doing speaks volumes as to what the policy is, and more
6 importantly, whether they are depriving inmates of hormones.

7 So the only reason that the court will find it not
8 credible, if you think that BOP is doing this in order to
9 either mislead the court, purely for litigation advantages, or
10 I'm not even sure why else we would be doing this, if BOP
11 thinks that it's violating the executive order. Clearly, it's
12 done an analysis and a study of how to implement the executive
13 order and this is what it's doing.

14 And just to go back to the prior, very early days of the
15 hearings in front of this court, I want to confirm that at the
16 time, even at the time, we said BOP was trying to determine
17 what the medical policy would be. So -- and at that time it
18 didn't terminate anyone's hormone, and even today it's not.
19 So to the extent there were some, they were mistakes, and I
20 think that, as I argued before, mistakes do happen, and the
21 important thing is that once BOP recognizes there's a mistake,
22 it takes steps to address that.

23 So given that, given the record before the court, there's
24 no basis to say, well, any day they could still change their
25 mind. That is not what a preliminary injunction is supposed

1 to do.

2 And I think there's a lot of references about defendants
3 didn't dispute this, defendants didn't submit anything to
4 rebut that. This is not a summary judgment motion where we
5 have material facts, that if it's not disputed, then it's
6 admitted. This is a preliminary injunction. The court is
7 acting and sitting in equity.

8 The weight of the record should inform the court whether
9 preliminary relief, this extraordinary relief is appropriate
10 in this prisoner context, and I think we also submit it's
11 sufficient, or in my view overwhelming information suggesting
12 that the plaintiffs are not suffering irreparable harm, that
13 there is significant concern for other claims, whether there's
14 an Eighth Amendment violation, whether there's APA violation,
15 all of which based unfortunately on a misreading of BOP's
16 policy.

17 And just, finally, there's accusation about how there's no
18 follow-up, and so people might still be confused. I mean, I
19 don't think -- plaintiffs are not in the position to speak to
20 BOP's internal deliberations what the medical provider
21 guidance might be giving to the clinical directors. There are
22 122 institutions, at least, and so the medical provider has
23 been providing guidance.

24 And so it's weird that we would have to somehow submit
25 records showing that and don't worry, mistakes won't happen,

1 we're doing it, and the BOP should be presumed to act in good
2 faith, and it is providing guidance to the clinical directors,
3 and that is in conjunction with the health services.

4 Again, just to repeat myself, BOP's actions speaks volumes.
5 And so only if the court thinks that there's misconduct, then
6 would the court -- should the court be inquiring into those
7 further.

8 And then just one very final point here is that I just took
9 a quick look at Dr. Karasic's expert declaration, and he does
10 say consistently throughout his declaration -- he separates
11 social transition from, and I quote, gender-affirming care.
12 And just one quick look, paragraph 27 does that.

13 So we're not saying that he somehow says social transition
14 is not necessary. He definitely says that. We're saying that
15 even in the plaintiffs' expert's mind, he's separating the two
16 things. Social transition as distinct from the
17 gender-affirming care or medical care. That's our view.

18 So we're simply saying that the social transition aspect
19 doesn't rise to the level of the Eighth Amendment violation.
20 So thank you, Your Honor, unless you have other questions.

21 THE COURT: Thank you, Ms. Lin.

22 Can you resist?

23 MS. NOWLIN-SOHL: I'm sorry, Your Honor, but I will be
24 quick as well.

25 Just a couple of points, Your Honor. Going again back to

1 the exhaustion thing. The PLRA remedies were not available
2 here. And as we talked about, plaintiff Kingdom, her hormones
3 were cut off. She filed a grievance. She asked, hey, like,
4 my hormones have been cut off. I need these hormones. The
5 response to her was, this is a result of the executive order.
6 Plaintiff Kapule received the same response. It is clear that
7 this is flowing from the executive order, and then through the
8 implementing memoranda.

9 With regard to the social accommodations, it is undisputed
10 that these have been banned. There is no Eighth Amendment
11 carve-out for this. And to clarify Dr. Karasic's testimony,
12 he is saying that social accommodations are distinct from
13 medical care, and whereas medical care refers to hormone
14 therapy, he is not saying it is distinct from gender-affirming
15 care. And throughout his declaration he talks about the
16 necessity of social transition and the accommodations for it
17 to treat gender dysphoria.

18 With regard to hormones, the record, the record is clear
19 that there is a substantial risk of harm. And that is the
20 question under the Eighth Amendment, is whether there's a risk
21 of denial of medically necessary hormones.

22 You know, the entirety of the directive to BOP's provider
23 is contained in the executive order and in this memo based on
24 February 28th. To the extent that there is a saving clause,
25 the doctors are not lawyers. They don't know what that means.

1 The only directive that we've been given that's in the record
2 is that this care is prohibited.

3 And then I want to turn to the APA. The court can grant on
4 the APA alone. There's been no reasoned explanation for this
5 policy change. There is no administrative record. And to the
6 extent that counsel on the other side is talking about
7 guidance that has been given to BOP's providers, that is not
8 in the record. We have not seen that. That's not sufficient
9 for the Eighth Amendment claim, it's also not sufficient for
10 the APA claim, especially because it would be after the fact.
11 They've had multiple opportunities to put that into the
12 record. They have not.

13 And so in sum, Your Honor, we're not asking this court
14 today to make any medical decision for plaintiffs or the
15 putative class members. We're asking the court to allow
16 doctors to make those medical decisions, rather than the
17 president through executive order or the BOP through this
18 policy, and to give doctors the option to treat people who are
19 incarcerated and have gender dysphoria with the only medical
20 care that is supported by every major medical association in
21 this country, and leave that decisionmaking to the doctors.
22 Thank you, Your Honor.

23 THE COURT: Thank you very much, counsel. The case is
24 submitted -- the motion is submitted. Court will be in
25 recess. (Proceedings adjourned at 12:31 p.m.)

* * *

CERTIFICATE

I, BRYAN A. WAYNE, Official Court Reporter, certify
that the foregoing pages are a correct transcript from the
record of proceedings in the above-entitled matter.

/s/ Bryan A. Wayne
Bryan A. Wayne

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, et al.,

Defendants.

Case No. 1:25-cv-00691-RCL

**[PROPOSED] ORDER GRANTING
PLAINTIFFS' MOTION FOR RENEWED
PRELIMINARY INJUNCTION**

This Court entered a preliminary injunction in this case on June 3, 2025. ECF No. 67 [*Kingdom v. Trump*, 2025 WL 1568238 (D.D.C. June 3, 2025)]. On August 20, 2025, the Court extended the injunction for 90 days, to run from September 1 to November 30, 2025, as required by the Prison Litigation Reform Act's ("PLRA") plain language. 18 U.S.C. § 3626(a)(2) (preliminary relief "shall automatically expire on the date that is 90 days after its entry unless the court . . . makes the order final before the expiration of the 90-day period."). *See* ECF No. 79 (extending the PI). On November 17, 2025, the Court extended the injunction for another 90 days, to run from December 1, 2025, to March 1, 2026. *See* ECF No. 96.

On February 5, 2026, Plaintiffs moved the Court to renew this preliminary injunction for another 90 days, to run from March 2, 2026 to May 31, 2026. ECF No. 111. Counsel for Defendants stated on February 1, 2026, that they "oppose the relief sought in this motion, pursuant to Local Rule 7(m), because under the PLRA, preliminary injunctions 'automatically expire on the date that is 90 days after its entry.' Additionally, Defendants oppose the relief sought in this motion because the Federal Bureau of Prison's implementation of Executive Order No. 14168 is consistent with law. *See* ECF No. 35 (Defendants' response to Plaintiffs' preliminary injunction motion); ECF No.

52-1 (Defendants' sur-reply). Defendants do not plan on filing any further opposition." ECF No. 111-2, Ex. 1.

There are no newly discovered factual circumstances that necessitate a reassessment of this Court's prior holding that the Plaintiffs have met their burden for preliminary injunctive relief or that require a reevaluation of that relief. Furthermore, district courts—including this one—regularly renew or extend preliminary relief for additional 90-day periods under the Prison Litigation Reform Act while litigation on the merits of a case continue. *See* ECF Nos. 79, 96; *Doe v. Bondi*, Case No. 1:25-cv-286-RCL, 2025 WL 1607094 at *1 (D.D.C. May 15, 2025); *Smith v. Edwards*, 88 F.4th 1119, 1125 (5th Cir. 2023) ("Though a preliminary injunction entered under the PLRA otherwise automatically expires ninety days after entry, the injunction may be extended by the district court if it makes the requisite findings."); *Mayweathers v. Newland*, 258 F.3d 930, 935 (9th Cir. 2001) ("Nothing in the statute limits the number of times a court may enter preliminary relief. ... the provision simply imposes a burden on plaintiffs to continue to prove that preliminary relief is warranted."); *see also Alloway v. Hodge*, 72 F.App'x 812, 817 (10th Cir. 2003) (unpublished) (renewal of preliminary injunction that expired under the PLRA is not an abuse of discretion).

Therefore, upon consideration of Plaintiffs' Motion for Renewed Preliminary Injunction, ECF No. 111, it is **ORDERED** that Plaintiffs' Motion is **GRANTED**; and it is further

ORDERED that the Defendants are enjoined from implementing Section 4(c) of Executive Order 14168 against any class member in this action, as defined at ECF No. 67 at 27, for the period from March 2, 2026 through May 31, 2026; and it is further

ORDERED that BOP is required to restore and maintain access to those treatment modalities for those who previously received them pursuant to a prescription rendered by BOP

staff. If BOP medical personnel subsequently determine that an existing or future class member is in need of either or both of these treatment modalities, the BOP may not take those treatment options off the table while this dispute is pending.

In accordance with the Prison Litigation Reform Act, the Court finds that this preliminary injunction is narrowly drawn, extends no further than necessary to correct the harm that the Court finds requires preliminary relief, and is the least intrusive means necessary to correct that harm. 18 U.S.C. § 3626(a)(2). The Plaintiffs and the certified class have shown a substantial likelihood of success on their claims that Defendants' implementation of Section 4(c) of the Executive Order as to them would be unlawful and is causing or will cause them immediate, irreparable harm. Because applying Section 4(c) to the Plaintiffs and the certified class would cause this serious and irreparable harm, a preliminary injunction is necessary to correct the harm and is the least intrusive means to do so. Furthermore, because this preliminary injunction only prevents the implementation of those sections of the Executive Order for which Plaintiffs have demonstrated a likelihood of success on the merits and irreparable harm, this injunction extends no further than necessary to correct the harm. Finally, this Court has considered any adverse impact on public safety or on the operation of the criminal justice system caused by this relief and has given substantial weight to such impacts. After this consideration, the Court concludes and finds that no adverse impact on public safety or the operation of the criminal justice system will result from maintaining the status quo while this litigation proceeds.

IT IS SO ORDERED.

Dated: February 12, 2026



Hon. Royce C. Lamberth
United States District Judge

[Oral Argument Not Yet Scheduled]

Nos. 25-5099, 25-5101, 25-5108 (consol.)

**IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT**

JANE DOE, et al.; JANE JONES, et al.; MARIA MOE,

Plaintiffs-Appellees,

v.

PAMELA BONDI, in her official capacity as Attorney General of the United States, et al.;

DONALD J. TRUMP, in his official capacity as President of the United States, et al.,

Defendants-Appellants.

On Appeal from the United States District Court for the District of Columbia

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CERTIFICATE OF PARTIES, RULINGS, AND RELATED CASES

Pursuant to D.C. Circuit Rule 28(a)(1), undersigned counsel certifies as follows:

A. Parties and Amici

Plaintiffs in district court, and appellees here, are nineteen people in the custody of the Federal Bureau of Prisons. With the permission of the district court, Plaintiffs-Appellees are proceeding pseudonymously in this litigation. *Jones v. Bondi*, Dkt Nos. 14, 47; *Doe v. Bondi*, Dkt. 7; *Moe v. Trump*, Dkts. 7, 67. Their pseudonyms are Jane Doe, Mary Doe, Sara Doe, Emily Doe, Zoe Doe, Tori Doe, Olivia Doe, Susan Doe, Lois Doe, Sally Doe, Wendy Doe, Rachel Doe, Ellen Doe, Jane Jones, Amy Jones, Barbara Jones, Carla Jones, Donna Jones, and Maria Moe.¹

Defendants in district court, and appellants here, are Donald J. Trump, in his official capacity as President of the United States; Pamela Bondi, in her official capacity as Attorney General of the United States; and William K. Marshall III, in his official capacity as Director of the Federal Bureau of Prisons.² Defendant Donald J. Trump is only a party in *Moe v. Trump*. There were no additional parties

¹ Plaintiff Sophia Doe voluntarily dismissed her claims on May 12, 2025. *Doe v. Bondi*, ECF No. 80.

² This action was originally brought against Defendant James R. McHenry, III, in his official capacity as Acting Attorney General of the United States, and William Lothrop, in his official capacity as Acting Director of the Federal Bureau of Prisons. Attorney General Bondi and Director Marshall were automatically substituted as parties under Federal Rule of Civil Procedure 25(d) and Federal Rule of Appellate Procedure 43(c)(2).

and no *amici curiae* in the district court. One *amicus curiae* brief was filed on May 16, 2025, by Idaho, Indiana, 23 other states, and the Arizona Legislature in support of Appellants. Dkt. No. 2116284.

B. Rulings Under Review

The Honorable Royce C. Lamberth issued initial orders granting Plaintiffs' motions for preliminary injunctions on February 18, February 24, and March 19, 2025, in *Doe v. Bondi* (Dkt Nos. 44, 55, 68); March 10, 2025, in *Moe v. Trump* (Dkt. No. 62); and February 24 and March 3, 2025, in *Jones v. Bondi* (Dkt Nos. 28, 46). Some of the orders are available at *Doe v. Bondi*, No. 1:25-cv-286, 2025 WL 596653 (D.D.C. Feb. 24, 2025); *Doe v. McHenry*, No. 1:25-cv-286, 2025 WL 596651 (D.D.C. Feb. 18, 2025); *Jones v. Bondi*, No. 1:25-cv-401, 2025 WL 923117 (D.D.C. Feb. 24, 2025); and *Jones v. Bondi*, No. 1:25-cv-401, 2025 WL 923755 (D.D.C. Mar. 3, 2025). *See also* JA168–69 (*Doe* Feb. 18 Order), JA185–88 (*Doe* Feb. 24 Order), JA240–43 (*Doe* Mar. 19 Order), JA333–34 (*Jones* Feb. 24 Order), JA445–49 (*Jones* Mar. 3 Order), and JA569–71 (*Moe* Mar. 10 Order). The district court issued renewed preliminary injunctions in all three cases on May 15, and May 22, 2025. *See* JA954–62.

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C. Related Cases

This case has not previously been before this Court. There is one related case for purposes of D.C. Circuit Rule 28(a)(1)(C): *Kingdom v. Trump*, No. 1:25-cv-00691-RCL (D.D.C.).

/s/ Kara Janssen

Kara Janssen

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GLOSSARY

APA	Administrative Procedure Act
BJS	Bureau of Justice Statistics
BOP	Federal Bureau of Prisons
EO	Executive Order
JA	Joint Appendix
PI	Preliminary Injunction
PLRA	Prison Litigation Reform Act
PREA	Prison Rape Elimination Act
SHU	Segregated Housing Unit
TEC	Transgender Executive Council
TRO	Temporary Restraining Order

INTRODUCTION

This case concerns nineteen transgender women whom the Federal Bureau of Prisons (“BOP”) previously determined, after individualized assessments, should be housed in women's facilities for their safety and security. The district court did not abuse its discretion by ordering the Government to maintain Plaintiffs’ housing status while their claims proceed.

These women are a very small subset—less than one percent—of all transgender individuals in BOP custody, and they were placed in women’s facilities due to their unique vulnerabilities. All have undergone extensive medical treatment to transition and live as women. Some have only ever been housed in women’s facilities due to their obvious vulnerability to sexual violence. Others were sexually assaulted when previously held in men’s prisons. All were placed in women's facilities based on BOP's careful evaluation of regulatory factors designed to protect vulnerable prisoners from violence.

That changed when President Trump issued Executive Order 14168 (“EO 14168” or “the Executive Order”) on January 20, 2025. The Executive Order requires BOP to transfer these women to men's prisons regardless of their individual circumstances. BOP concedes it has no discretion to consider the Plaintiffs’ safety or its own prior determinations when following this mandate. The Executive Order strips away individualized protections that took nearly a

decade to develop under the Prison Rape Elimination Act (“PREA”), replacing them with a categorical mandate that ignores the serious risks these particular women face.

The court’s preliminary injunctions were amply supported by Plaintiffs’ evidence of the violence and self-harm they are likely to suffer if transferred from women’s prisons. Plaintiffs are likely to succeed in showing that the categorical transfer policy mandated by the Executive Order violates their Eighth Amendment rights, and violates the Administrative Procedure Act by discarding duly promulgated PREA regulations without notice and comment, and by failing to provide any reasoned justification for the policy.

The preliminary injunctions should be affirmed. They preserve the housing arrangements that BOP itself determined were necessary to ensure these women's safety, pending resolution of Plaintiffs' constitutional and statutory claims.

JURISDICTIONAL STATEMENT

Plaintiffs invoked the district court’s jurisdiction under 28 U.S.C. §§ 1331, 2201, and 2202. JA201–02; JA340; JA461. The district court issued initial orders granting Plaintiffs’ motions for preliminary injunctions in February 2025, and the district court issued renewed preliminary injunctions on May 15, and May 22, 2025. JA954–62. The Government filed timely notices of appeal of those preliminary injunction orders, and this Court consolidated its appeals on June 12,

2025. This Court has jurisdiction under 28 U.S.C. § 1292(a)(1).

STATEMENT OF THE ISSUES

Did the district court abuse its discretion in finding that, based on their individual histories and circumstances, the evidence showed that these individual Plaintiffs would likely face a substantial risk of serious harm if they are transferred from women's facilities and that prison officials likely knew of and disregarded that risk?

Are Plaintiffs likely to succeed in showing that Defendants' adoption and implementation of the challenged EO violates the Administrative Procedure Act ("APA") because it directly conflicts with binding PREA regulations, was adopted and issued without notice and comment, lacks a reasoned explanation, and/or is arbitrary and capricious?

Did the district court abuse its discretion in finding that Plaintiffs are at immediate risk of irreparable harm and that the balance of equities and public interest weigh in favor of preliminary relief?

PERTINENT STATUTES AND REGULATIONS

Pertinent statutes and regulations are reproduced in the addendum to this brief.

STATEMENT OF THE CASE

I. Plaintiffs Are a Uniquely Situated Small Group of Transgender Women in BOP Custody Who Have Spent Extended Time (for Some, Their Entire Incarceration) Living in Women’s Facilities.

Plaintiffs³ are a uniquely situated group of transgender women⁴ incarcerated in BOP women’s facilities who have undergone extensive medical treatment to transition and live as women and are regarded as women by the facilities in which they reside. Every Plaintiff has been designated and placed in women’s housing by BOP. All Plaintiffs receive ongoing female hormone treatments from BOP. *See, e.g.*, JA645 ¶ 3; JA739–40 ¶¶ 4, 8; JA814 ¶ 3; JA903–05 ¶¶ 4–10. Some have been on hormones for decades, and many began hormone treatment long before their incarceration. *See, e.g.*, JA920, 969 ¶ 2. Many have also undergone surgical procedures as part of their transitions, including [REDACTED] [REDACTED]. *See, e.g.*, JA286, 740 ¶ 5; JA232, 703 ¶ 6; JA916, 965 ¶ 8; JA947, 996 ¶ 5; JA951, 1000 ¶ 3. They are referred to as women; most have legally changed their names or gender markers on official records and

³ Plaintiffs—assuming pseudonyms to protect their identities—are Jane, Mary, Sara, Emily, Zoe, Tori, Olivia, Susan, Lois, Sally, Wendy, Rachel, and Ellen Doe, *see* JA189; Jane, Amy, Barbara, Carla, and Donna Jones, *see* JA335; and Maria Moe, *see* JA490. Plaintiff Sophia Doe voluntarily dismissed her claims on May 12, 2025. *Doe v. Bondi*, ECF No. 80.

⁴ Plaintiffs use the term “transgender women” to describe themselves, which is consistent with the approach of the United States Supreme Court. *See United States v. Skrametti*, 145 S. Ct. 1816, 1830 n.2 (2025).

documents. *See, e.g.*, JA286, 740 ¶ 6; JA375, 809 ¶ 18; JA947, 996 ¶ 6; JA951, 1000 ¶ 3.

After individualized assessments of their health and safety risks, BOP assigned Plaintiffs to women's facilities, where they have consistently resided for long periods of time. *See, e.g.*, JA916, 965 ¶ 6 (Zoe Doe has been housed in women's prisons since [REDACTED]); JA385, 819 ¶ 10; JA943, 992 ¶ 6; JA947–48, 996–97 ¶ 6; JA951, 1000 ¶ 3 (Donna Jones, Wendy, Sara, and Mary Doe have been housed in women's prisons since [REDACTED]). Prior to EO 14168, Maria Moe, Jane Jones, Rachel Doe, Wendy Doe, and Sara Doe had only ever been housed with women. *See* JA233, 704 ¶ 7; JA286, 740 ¶¶ 8–10; JA492–93, 904–05 ¶¶ 7–9; JA947–48, 996–97 ¶ 6; JA951, 1000 ¶ 3.

BOP is aware that each Plaintiff has been diagnosed with gender dysphoria, which the agency has recognized as “a mental health diagnosis currently defined by DSM-5” that is “manifested by a stated desire to be the opposite sex and persistent discomfort with [one's] biologically assigned sex.” JA121. Gender dysphoria is a “serious medical condition” that is highly treatable through “transition, which enables a transgender person to live in a sex other than their birth sex, and hormone therapy to feminize or masculinize the body.” JA181–82 ¶¶ 3–4; *see also* JA17, 578 ¶ 6; JA92 ¶ 5. Treatment may also include “various surgeries.” JA182 ¶ 4. “[T]here are no alternative treatments for effectively

managing gender dysphoria.” *Id.* ¶ 6. Failure to treat gender dysphoria, or cessation of treatment, “constitutes a serious medical risk that can severely impact both physical and mental health,” including “[i]ncreased risk of suicidal ideation due to intensified gender dysphoria.” JA93 ¶ 10; *see also* JA95 ¶ 19 (“The medical community is well aware that the consequences of denying this care are predictable and dire.”). Based on their individual treatment histories, the district court found that transferring Plaintiffs from women’s prisons would exacerbate their gender dysphoria. JA186–87.⁵

II. Pursuant to BOP Policies and PREA Regulations, BOP Placed Plaintiffs in Women’s Facilities for Safety and Security Reasons.

PREA’s implementing regulations require BOP to conduct individualized assessments when housing transgender people, including whether to place them in women’s facilities. *See* 28 C.F.R. § 115.42. Under PREA, BOP must consider a variety of factors, including whether the individual has previously experienced sexual victimization and the individual’s perception of their own vulnerability, *id.* § 115.41(d)(8)–(9), and must use this information to make housing assignments based on “individualized determinations about how to ensure the safety of each

⁵ The district court explained that transferring these individuals from women’s prisons would exacerbate their gender dysphoria “because they will be subject to searches by male correctional officers, made to shower in the company of men, referred to as men, forced to dress as men, or simply because the mere homogenous presence of men will cause uncomfortable dissonance.” JA187 n.2.

inmate.” *Id.* § 115.42(a)–(b). The PREA regulations explicitly authorize housing transgender women in women’s facilities when doing so promotes safety and security. *Id.* § 115.42(c).

Until January 20, 2025, BOP used the “Transgender Executive Council” (“TEC”) to implement these PREA regulations and oversee facility designations. JA123–25. The TEC considered “an inmate’s security level, criminal and behavioral/disciplinary history, current gender expression, programming, medical, and mental health needs/information, vulnerability to sexual victimization, and likelihood of perpetrating abuse.” JA125. Since the Executive Order, BOP has disbanded the TEC and rescinded its policies implementing PREA’s individualized assessment requirements for housing transgender persons. *See* Appellants’ Opening Br. (“AOB”) at 9.

The district court made specific factual findings that “BOP determined that considering all statutorily and constitutionally required factors, a women’s facility was the appropriate facility” for these Plaintiffs. JA186. As the district court explained, BOP “is subjectively aware that transferring the plaintiffs to a male penitentiary would substantially increase the likelihood of them experiencing [a] parade of harms,” including “significantly elevated risk of physical and sexual violence,” and the exacerbation of “symptoms of their gender dysphoria.” JA164–65. BOP’s assessment under its prior policy that these Plaintiffs should be housed

in women's facilities reflects its awareness not only of the high risk of sexual violence for incarcerated transgender people in general,⁶ but that Plaintiffs' individual circumstances make this risk particularly acute. *Id.*

These safety concerns are not hypothetical. As detailed in their declarations, nearly all of the Plaintiffs who were previously housed in men's facilities were sexually assaulted when they were there, which ultimately resulted in their transfers to women's prisons to ensure their safety. *See, e.g.*, JA85, 646 ¶¶ 7–8; JA374–75, 808–09 ¶¶ 12, 17; JA382, 816 ¶ 8; JA385, 819 ¶¶ 6, 10; JA921, 970 ¶¶ 4, 6–7. Zoe Doe was stalked by a man in the showers of a medium-security men's facility. JA916, 965 ¶ 5. Donna Jones was raped in a shower at a men's facility, before she was transferred to a women's facility. JA385, 819 ¶ 6. Jane Doe was subjected to [REDACTED] while in a men's facility and continues to suffer from [REDACTED] as a result. JA85, 646 ¶¶ 7–8. Amy Jones was violently sexually attacked by three men while in a men's facility. JA374, 808 ¶ 12. Carla Jones was sexually assaulted in three separate men's facilities. JA382, 816 ¶ 8. Olivia Doe was “brutally raped” in a

⁶ For example, a 2014 study by the Department of Justice estimated that nearly 35% of transgender people incarcerated in state and federal prisons were sexually victimized between 2007 and 2012. Bureau of Just. Stats., U.S. Dep't of Just., *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12: Supplemental Tables*, 2 tbl. 1 (2014), https://bjs.ojp.gov/content/pub/pdf/svpjri1112_st.pdf.

men's facility, resulting in "medical complications." JA921, 970 ¶ 4. Emily Doe was raped while in a men's facility, JA934, 983 ¶ 4, as was Mary Doe "multiple times." JA943, 992 ¶ 6. And outside of BOP custody, Lois Doe was "raped twice" in a men's state facility. JA939, 988 ¶ 6.

Two of these assaults occurred in minimum-security men's facilities. JA374, 808 ¶¶ 10, 12; JA382, 816 ¶ 13. BOP knew of the assaults. *E.g.*, JA85, 646 ¶ 7; JA385, 819 ¶ 10; JA921, 970 ¶ 4; JA943, 992 ¶ 6. Such pervasive sexual assault is precisely the type of harm that PREA and its regulations seek to prevent. *See* 34 U.S.C. § 30302 (describing the first purpose of PREA as establishing "a zero-tolerance standard for the incidence of prison rape"). In addition, multiple Plaintiffs previously experienced suicidal ideation or engaged in suicide attempts or self-harm while housed in men's prisons. *See* JA381, 815 ¶ 5; JA915, 964 ¶ 4; JA921, 970 ¶ 5; JA934–35, 983–84 ¶¶ 3, 12. The district court was "unconvinced by the Government's proffered statistics attempting to show that a low-security men's facility" would be safe for these Plaintiffs. JA187 n.2.⁷

In sum, BOP determined that Plaintiffs' unique health and safety risks necessitated their placement in women's facilities. As part of that determination, BOP was also required to consider whether the placements would raise any

⁷ In addition, if any Plaintiffs are transferred by BOP, nothing restrains Defendants from transferring them to a men's prison with a higher security designation.

“management and security problems” for BOP staff or the other women housed with Plaintiffs. 28 C.F.R. § 115.42(c). The Plaintiffs’ housing assignments were repeatedly reaffirmed during the reassessments BOP was required to conduct at least twice a year. *Id.* § 115.42(d). BOP only sought to transfer Plaintiffs from women’s facilities after the issuance of the Executive Order.

III. EO 14168 Contravenes the PREA Regulations’ Mandatory Individualized Assessments and Strips BOP of its Discretion over Safe Housing Placements and Medical Care.

On January 20, 2025, President Trump issued Executive Order 14168, *Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government*, 90 Fed. Reg. 8615 (Jan. 20, 2025). The Order stripped BOP of discretion over housing assignments for transgender people, consistent with this Administration’s open disapproval of transgender people and its stated intention to deny them any legal recognition or protection. In relevant part, the Order: (1) categorically bars transgender women from women’s prisons, regardless of individual safety considerations; and (2) prohibits BOP from providing “any medical procedure, treatment, or drug for the purpose of conforming an inmate’s appearance to that of the opposite sex.” 90 Fed. Reg. at 8616–17 ¶¶ 4(a), (c).

EO 14168 is part of a broader pattern of targeted discrimination against transgender people by this Administration, including reversing protections for

transgender people in schools, healthcare, military service, federal funding, shelters, and more.⁸ In addition, federal agencies have systematically removed information about transgender individuals from government websites,⁹ including deleting the word “transgender” every time it appeared in agency documents. Most recently, the administration removed a dedicated suicide hotline available to transgender youth callers.¹⁰ BOP, for its part, issued a policy formalizing implementation of the Executive Order. Fed. Bureau of Prisons, Memorandum for All Chief Executive Officers (Feb. 21, 2025), <https://storage.courtlistener.com/recap/gov.uscourts.dcd.278186/gov.uscourts.dcd.278186.1.1.pdf>. And it

⁸ See, e.g., Exec. Order No. 14190, 90 Fed. Reg. 8853 (Jan. 29, 2025) (schools); Exec. Order No. 14187, 90 Fed. Reg. 8771 (Jan. 28, 2025) (healthcare); Exec. Order No. 14183, 90 Fed. Reg. 8757 (Jan. 27, 2025) (military service); Exec. Order No. 14168, 90 Fed. Reg. 8615 (Jan. 20, 2025) (federal funding and shelters).

⁹ See Mem. in Opp. to Pls.’ Mot. for Preliminary Injunction, *Doctors for America v. OPM*, No. 1:25-cv-00322-JDB, 2025 WL 1357700 (D.D.C. Mar. 24, 2025) (stating that “under Executive Order 14168, webpages could no longer use the word ‘gender’ or contain language promoting gender ideology” and that “every” federal agency “promptly began to implement” the Order); see also, e.g., Nico Lang, *Trump Is Purging Federal Websites of LGBTQ+ Content. Here’s What’s Been Affected So Far*, Them, (Feb. 7, 2025), <https://www.them.us/story/trump-administration-federal-websites-lgbtq-content-deleted-cdc-doe-usaid>; Judd Legum & Rebecca Crosby, *The NSA’s ‘Big Delete’*, Popular Information (Feb. 10, 2025), https://popular.info/p/the-nsas-big-delete?utm_campaign=post&utm_medium=web.

¹⁰ Devi Shastri, *Trump Administration Removing 988 Hotline Service Tailored to LGBTQ+ Youth in July*, Associated Press (June 18, 2025), <https://apnews.com/article/988-lgbtq-suicide-prevention-hotline-trump-382342828b381b6a32964f09fe9aa59c>.

announced the “[c]ancellation” of the Transgender Offender Manual that specified the risks transgender people face and the actions agency staff should take to mitigate those risks. *See* Fed. Bureau of Prisons, Program Statement Cancellation of Statement No. 5200.08, Cancellation No. PSC04-2025 (Feb. 25, 2025); *see also* JA120 (stating objective of Transgender Offender Manual is “[t]o enhance staff’s understanding of the increased risk of suicide, mental health issues and victimization”).

IV. Pursuant to EO 14168 and in Direct Violation of PREA Regulations, BOP Decided to Transfer Plaintiffs from Women’s Prisons.

In response to EO 14168, BOP officials moved rapidly to transfer transgender women housed in women’s prisons to men’s prisons. While BOP claims it undertook an individualized review of “the inmates’ assigned security level, disciplinary record, medical record, and psychology record” in making transfer decisions, *see* JA174, BOP’s review was triggered solely by the challenged Executive Order and was done for the sole purpose of removing transgender women from women’s facilities regardless of whether doing so would put them at increased risk of sexual violence. *See* JA186 (district court finding that “the *only* change in circumstances from when the initial housing determination was made to now is Executive Order 14168”). The timing and speed of the transfers further undercuts BOP’s claim that these decisions were based on a considered, individualized review.

BOP transferred Plaintiffs Ellen Doe, Rachel Doe, and Jane Jones from women's to men's facilities.¹¹ JA230, 701 ¶ 7; JA233, 704 ¶ 11; JA287, 741 ¶ 14. Once there, all three experienced continuous sexual harassment from male prisoners; invasive strip searches from male BOP officers; lack of access to women's clothing, including undergarments; and reasonably feared that they would be targeted for sexual violence.¹²

Male BOP officers conducted strip searches of Ellen Doe and Rachel Doe after they were moved from women's to men's prisons, requiring them to bend over, squat, and lift their breasts. JA230, 701 ¶ 7; JA233, 704 ¶ 10. Rachel Doe [REDACTED], and before EO 14168 she had only ever been housed in women's facilities, [REDACTED]. JA232-33, 703–04 ¶¶ 6–7. At the men's facility to which BOP transferred her after the Order, Rachel Doe experienced daily sexual harassment. JA233–34, 704–05 ¶ 11. She was not allowed to wear a bra, which made her even more vulnerable. JA234, 705

¹¹ BOP informed other Plaintiffs of their pending transfer to men's facilities due to the EO, and, through counsel, Plaintiffs quickly filed their complaints and applications for emergency relief before BOP had an opportunity to make the transfers. *See, e.g.*, JA930, 979 ¶ 8. BOP staff told certain Plaintiffs that they could not challenge the transfers because the transfers were required under the Executive Order. *See* JA494, 906 ¶ 12; JA88, 649 ¶ 14.

¹² Ellen, Rachel, and Jane were eventually transferred back to their assigned women's facilities and were protected from future transfers under the district court's preliminary injunctions. JA240–43, 333–34.

¶ 15. Ellen Doe's [REDACTED]

[REDACTED]; she experienced constant sexual harassment at the facility. JA230, 701 ¶ 8.

Plaintiff Jane Jones was transferred from a minimum-security women's facility to a medium-security men's facility. JA286–87, 740–41 ¶¶ 9, 14. Jane Jones has a vagina, and before her transfer she had never been housed in a men's prison. JA740 ¶¶ 5, 8. Officials held her in the Segregated Housing Unit (“SHU”) at the men's facility for four days in solitary confinement. JA288, 742 ¶ 16. She was made to wear male undergarments, held in a small cell with no outside or recreational time, permitted extremely limited communication with family members, told by BOP that her supply of female hormone medication would not be renewed, and subjected to 24-hour surveillance by male guards, including while using the restroom. JA287–88, 741–42 ¶¶ 15–17.

V. Plaintiffs Obtained Preliminary Injunctions Protecting Them from Transfers from Women's Prisons and Loss of Medication.

Plaintiffs brought three separate actions against the Government alleging that BOP, following the commands of EO 14168, had transferred or was preparing to transfer Plaintiffs from women's facilities and end Plaintiffs' access to necessary medical care, in violation of the Eighth Amendment, the Fifth Amendment, the Rehabilitation Act of 1973, the Administrative Procedure Act, and separation of powers principles. *See* JA213–23, 356–67, 472–81.

Plaintiffs sought a declaratory judgment that Sections 4(a) and 4(c) of EO 14168 violate their constitutional and statutory rights, as well as a permanent injunction prohibiting the Government from enforcing those provisions of EO 14168 and requiring BOP to maintain Plaintiffs' preexisting housing and medical treatment. JA223, 367, 481. In all cases, Plaintiffs obtained temporary restraining orders (TROs) and preliminary injunctions (PIs) to enjoin enforcement of Sections 4(a) and 4(c) as to the named Plaintiffs. *E.g.*, JA157–67.

The TROs and PIs were all supported by factual findings about the serious harms Plaintiffs would face in men's facilities. The Government mischaracterizes the basis for the PIs. For example, it suggests that the district court granted the second PI in *Doe* and the second PI in *Jones* solely because BOP had found women's facilities "appropriate" for them and "only reassessed their housing due to EO 14168." *See* AOB at 18, 20. In fact, in its second *Doe* PI order, the district court also relied on findings that the *Doe* Plaintiffs would be subjected to a significantly elevated risk of sexual assault as well as a predictable worsening of gender dysphoria if transferred. JA186 (incorporating reasoning from first *Doe* order); JA187 n.2 (referring to risk of sexual assault and exacerbated gender dysphoria). The second *Jones* PI order also relied on those factual findings, as well as the fact that "the named Plaintiffs here were housed in men's facilities early in their incarceration, during which period they experienced numerous

unspeakable harms including multiple rapes, suicide attempts, and severe psychological distress.” JA446–47.

The Government filed notices of appeal in all cases, challenging only the portion of the preliminary injunctions related to the Plaintiffs’ housing. AOB at 5. This Court consolidated the cases for appeal. Order at 2, No. 25-5099 (Apr. 30, 2025). The district court then granted Plaintiffs’ requests to issue renewed preliminary injunctions in all cases with the Government’s non-opposition. JA954–62. The renewed injunctions will expire on August 23, 2025. JA955, 958, 961. The Government filed notices of appeal from the renewed injunctions, and this Court consolidated those appeals with the Government’s appeals from the initial injunctions.

STANDARD OF REVIEW

“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. NRDC*, 555 U.S. 7, 20 (2008). On appeal from a preliminary injunction, this Court reviews the district court’s “findings of fact under the ‘clearly erroneous’ standard,” *Serono Lab’ys, Inc. v. Shalala*, 158 F.3d 1313, 1318 (D.C. Cir. 1998), its “legal conclusions *de novo*,” and “its weighing of the four relevant factors for abuse of discretion.” *In re Fed.*

Bureau of Prisons' Execution Protocol Cases, 955 F.3d 106, 111–12 (D.C. Cir. 2020).

SUMMARY OF THE ARGUMENT

The district court properly granted preliminary injunctions to maintain the *status quo* and protect these uniquely situated Plaintiffs from sexual violence and other irreparable harm while this case proceeds.

Plaintiffs have demonstrated a strong likelihood of success on the merits of their Eighth Amendment claim. BOP previously conducted individualized assessments required by PREA and determined that these specific transgender women required placement in women's facilities for their safety and security. As the district court found, substantial evidence shows that these individuals are at risk of serious harm if transferred from women's to men's facilities. Defendants' disregard of these known risks is deliberate indifference.

Defendants' adoption of a new policy, replacing individualized determinations with a categorical rule that bars the placement of transgender women in a women's facility under any circumstances, also violates the APA. This new policy directly conflicts with existing PREA regulations, was adopted without the required notice and comment, and is arbitrary and capricious, as it reflects animus against transgender people and lacks any reasoned explanation.

The district court found that Plaintiffs face an imminent risk of irreparable

harm if transferred from women's facilities. The balance of equities and public interest favor Plaintiffs, as enforcement of an unconstitutional policy is never in the public interest, whereas Plaintiffs face serious irreparable harms including sexual violence and self-injury or suicide.

The Government's jurisdictional challenge fails. 18 U.S.C. § 3621(b) does not bar judicial review because Plaintiffs challenge a categorical policy mandated by Executive Order, not individual placement decisions under that statute.

Similarly, the Prison Litigation Reform Act ("PLRA") does not bar these claims because no administrative remedy was available. BOP lacked authority to provide relief from the Executive Order, and Plaintiffs faced immediate transfer without any opportunity to exhaust remedies.

The district court's preliminary injunctions are narrowly tailored, necessary to prevent irreparable harm, and contain adequate findings under the PLRA. The injunctions merely preserve the *status quo* by maintaining housing placements that BOP itself previously determined were appropriate for these specific individuals' safety and security.

ARGUMENT

I. PLAINTIFFS HAVE DEMONSTRATED A LIKELIHOOD OF SUCCESS ON THEIR CLAIMS.

A. The District Court Did Not Abuse its Discretion in Finding that Plaintiffs Are Likely to Succeed on the Merits of their Eighth Amendment Claim.

The U.S. Supreme Court made clear more than three decades ago that “prison officials have a duty ... to protect prisoners from violence at the hands of other prisoners.” *Farmer v. Brennan*, 511 U.S. 825, 833 (1994). “[D]eliberate indifference to serious medical needs of prisoners” violates the Eighth Amendment. *Estelle v. Gamble*, 429 U.S. 97, 104 (1976). To prove an Eighth Amendment claim, Plaintiffs must establish that the conditions of their incarceration “pos[ed] a substantial risk of serious harm” and that prison officials “kn[ew] of and disregard[ed] an excessive risk” to their “health or safety.” *Farmer*, 511 U.S. at 834, 837. The district court correctly found that Defendants’ decision to transfer Plaintiffs from women’s to men’s facilities—where Defendants know that Plaintiffs will face extremely high risks of physical and sexual violence, as well as excessive risks of self-harm and suicidality as a result of aggravated gender dysphoria—would likely violate the Eighth Amendment.

1. Plaintiffs Face Substantial Risks of Violence and Other Serious Harm If Transferred from Women’s Facilities.

To be clear, Plaintiffs do not argue that the Eighth Amendment requires every transgender woman to be housed in a women’s prison, nor did the district

court so find. Rather, as the district court found, the particular vulnerabilities of these women—the same vulnerabilities that led BOP to house them in women’s prisons in the first place—will result in predictable violence against them and a serious risk of self-harm if they are forced to live in men’s prisons. *See* JA164–65.

Every Plaintiff has been placed in women’s housing by BOP based on consideration of the relevant PREA factors. This distinguishes them both from other incarcerated transgender women and from men who may be vulnerable to sexual assault. If these Plaintiffs are transferred from women’s to men’s facilities, men in those facilities will know that BOP has transferred a woman to a men’s facility. As the district court found, this puts them at extremely high risk of sexual victimization.

BOP’s assessment that these Plaintiffs’ individual situations require placement in women’s facilities was well founded. Each has received extensive medical treatment in order to live as a woman. For all, this includes long-term hormone therapy. Some have had genital and other surgeries. Some have only ever been housed in women’s prisons. Many were previously sexually victimized in men’s facilities. This is an especially at-risk group, and all of these facts are known to BOP. That is why Plaintiffs are part of the small, unique group of transgender women whom BOP placed in women’s facilities.

Plaintiffs presented extensive evidence to the district court that they would

be at substantial risk of serious harm if BOP is permitted to move them from women's prisons. All Plaintiffs would be at an excessive and obvious increased risk of sexual assault in men's prisons because they have been classified and housed as women and have undergone significant medical treatment; many are outwardly indistinguishable from non-transgender women.¹³ *See supra* at 4–5. As set forth above, several Plaintiffs have had genital surgeries, and all receive female hormone therapy, which causes breasts to develop. *See supra* at 4.

Nearly all of the Plaintiffs who were previously housed in men's prisons were assaulted there (some multiple times), and they only escaped sexual violence when they were placed in women's prisons by the BOP. Olivia Doe was “brutally raped” in a men's facility; Amy Jones was violently attacked by two male prisoners; Donna Jones was raped in the shower; Jane Doe suffered [REDACTED]; [REDACTED]; Carla Jones was sexually assaulted in three separate men's facilities; Emily Doe was raped; Mary Doe was “raped multiple times.” *See supra* at 8–9. Others have a history of serious self-harm and suicidality when housed in men's facilities, as that placement caused their gender dysphoria symptoms to worsen. *See, e.g.*, JA815 ¶ 5; JA934 ¶ 3.

¹³ *Cf. Pichardo De Veloz v. Miami-Dade Cty.*, 756 F. App'x 869, 877 (11th Cir. 2018) (finding that housing a woman among men “poses an outrageous risk that she will be harassed, assaulted, raped, or even murdered”).

Plaintiffs' visible female characteristics, histories of sexual assault, and prior self-harm in men's facilities mark them as especially vulnerable members of a population that is already uniquely vulnerable to physical and sexual violence in men's facilities. *See, e.g.*, JA703 ¶ 6; JA808 ¶ 15; JA819 ¶ 6; *see also* Bureau of Just. Stats., U.S. Dep't of Just., *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12: Supplemental Tables*, 2 tbl. 1 (2014) (showing that from 2011 to 2012, 39.9% of transgender prisoners had experienced sexual violence in the past 12 months alone).¹⁴ When BOP undertook its individualized assessment of Plaintiffs pursuant to PREA, it determined that these nineteen highly vulnerable transgender women should each be assigned to a women's facility. BOP was required to reassess Plaintiffs' housing placements at least every six months thereafter, 28 C.F.R. § 115.42(d), and it opted to keep each Plaintiff in women's

¹⁴ The Supreme Court, federal courts of appeals, and federal district courts throughout the country have also recognized that transgender women face a high risk of sexual assault and abuse in men's prisons. *See, e.g.*, *Farmer*, 511 U.S. at 848-49; *Williams v. Kincaid*, 45 F.4th 759, 778–79 & n.11 (4th Cir. 2022); *Powell v. Schriver*, 175 F.3d 107, 115 (2d Cir. 1999); *Tay v. Dennison*, 457 F. Supp. 3d 657, 684 (S.D. Ill. 2020); *Doe v. District of Columbia*, 215 F. Supp. 3d 62, 77 (D.D.C. 2016); *Zollicoffer v. Livingston*, 169 F. Supp. 3d 687, 691, 696 (S.D. Tex. 2016); *Gilliam v. Dep't of Pub. Safety & Corr. Servs.*, No. MJM-23-1047, 2024 WL 5186706, at *12–13 (D. Md. Dec. 20, 2024); *Finnegan v. Kink*, No. 3:20-cv-00218-GCS, 2024 WL 1345632, at *11 (S.D. Ill. Mar. 29, 2024); *Doe v. Wash. State Dep't of Corr.*, No. 4:21-CV-5059-TOR, 2021 WL 2453099, at *5 (E.D. Wash. May 17, 2021); *Lojan v. Crumbsie*, No. 12-CV-0320 (LAP), 2013 WL 411356, at *4 (S.D.N.Y. Feb. 1, 2013).

facilities until the issuance of EO 14168.

The harms Plaintiffs face if removed from women's prisons are "sufficiently serious" to meet the objective element of the Eighth Amendment. *Farmer*, 511 U.S. at 834. As the Supreme Court has explained, "[b]eing violently assaulted in prison is simply not 'part of the penalty that criminal offenders pay for their offenses against society.'" *Id.* (quoting *Rhodes v. Chapman*, 452 U.S. 337, 347 (1981)). Federal courts of appeals have held that suicide and self-harm are also sufficiently serious to satisfy the Eighth Amendment's objective element. *See, e.g., Cope v. Cogdill*, 3 F.4th 198, 206 (5th Cir. 2021); *Comstock v. McCrary*, 273 F.3d 693, 703-04 (6th Cir. 2001); *Est. of Miller ex rel. Bertram v. Tobiasz*, 680 F.3d 984, 989 (7th Cir. 2012); *Disability Rts. Mont., Inc. v. Batista*, 930 F.3d 1090, 1098 (9th Cir. 2019); *Est. of Burgaz ex rel. Zommer v. Bd. of Cnty. Comm'rs*, 30 F.4th 1181, 1186 (10th Cir. 2022).

The district court did not clearly err in finding, based on the record in this case, that Plaintiffs, transgender women previously individually assessed and placed in women's facilities, were likely to succeed in showing that they would be exposed to a substantial risk of serious harm if transferred to men's prisons. This is especially true given the paucity of the evidence submitted by the Government. Instead of addressing Plaintiffs' individual circumstances, the Government's evidence consisted mainly of generalized statistics about overall rates of assault in

women's BOP facilities compared to rates of assault in men's BOP facilities. *See, e.g.,* JA658–59 ¶¶ 19–23; *see also* AOB at 36–39 (reiterating this evidence). But as the district court rightly found, the Government's "statistics do not disaggregate assaults against transgender inmates from overall rates of assault" and "are still consistent with the 'numerous government reports and regulations recognizing that transgender persons are at significantly elevated risk of physical and sexual violence,'" JA187, as well as the record evidence that Plaintiffs' individual circumstances make them even more vulnerable. The district court did not clearly err by concluding that it was "unconvinced by the Government's proffered statistics." *Id.*

Nor can the Government "minimize any risk to plaintiffs by, among other things, transferring them to low-security institutions with non-violent offenders." AOB at 49–50. The Government again ignores the specific risks these transgender women would face in men's facilities given their prior classification as women and their housing in women's facilities, medical histories, and past experiences of sexual assault in men's facilities. As described above, multiple Plaintiffs have been assaulted by men in minimum-security men's facilities, and others faced pervasive sexual harassment in low-security men's prisons. *See supra* at 9, 13. In addition, if reclassified and transferred, nothing restricts BOP from moving any Plaintiff to a men's facility with a different security designation.

The Government also did not contest Plaintiffs’ evidence that “forcing a transgender woman to reside in a men’s facility ... will predictably worsen gender dysphoria and cause severe psychological distress,” and that this harm will be especially acute for individuals who have “lived in a sex different than their birth sex for a significant amount of time, including through use of medications and surgeries.” JA313, 753 ¶ 5; *accord*, e.g., JA86 ¶ 12; JA382 ¶ 14; JA922 ¶¶ 8, 10; JA935 ¶ 12 (Plaintiffs’ declarations attesting to their fears that their gender dysphoria will worsen). The district court therefore did not clearly err when it found that “placement in a male penitentiary *by itself* will exacerbate the symptoms of [Plaintiffs’] gender dysphoria.” JA187. Plaintiffs’ histories of self-injury, self-surgery, and suicidal ideation in men’s prisons show that this worsening gender dysphoria would put them at significant risk of harm. *See*, e.g., JA815 ¶ 5.¹⁵

2. Defendants Knew of and Disregarded These Substantial Risks.

The district court also did not clearly err in finding that the Government knew of and disregarded these substantial risks when it decided to transfer Plaintiffs to men’s prisons regardless of their individual vulnerabilities. As the

¹⁵ Defendants suggest Plaintiffs did not assert these harms below. AOB at 40. But Plaintiffs set forth and relied on these harms in their initial and amended complaint, e.g., JA191 ¶ 5; JA259 ¶ 7, in declarations by Plaintiffs and experts, e.g., JA86 ¶ 12; JA753 ¶ 5, and in multiple rounds of briefing, e.g., *Doe v. Bondi*, ECF No. 50-1 at 6; *Jones v. Trump*, ECF No. 21-1 at 6; *Moe v. Bondi*, ECF No. 31-1 at 4.

district court found, the Government did not “dispute the plaintiffs’ allegations that BOP is subjectively aware that transferring the plaintiffs to a male penitentiary would substantially increase the likelihood of them experiencing [a] parade of harms” including sexual assault and worsening gender dysphoria. JA165. The Government has never claimed that BOP is unaware of any of the salient facts about Plaintiffs’ histories of assault and abuse in men’s prisons, their surgical and medical treatment, or the other evidence that shows Plaintiffs’ likelihood of serious harm if transferred to men’s facilities.

Indeed, in previously deciding that Plaintiffs needed to be housed in women’s facilities, BOP determined that placement in a women’s facility “would ensure [their] health and safety.” 28 C.F.R. § 115.42(c). BOP is also obligated by PREA regulations to consider Plaintiffs’ specific vulnerabilities and previous experiences of sexual victimization. *Id.* § 115.41(d)(1)–(9). BOP’s determinations that Plaintiffs were among the 1% of transgender women who should be housed in women’s facilities shows that BOP was aware of the risks Plaintiffs would face in men’s prisons.

Moreover, BOP’s own statistics show that Plaintiffs are uniquely at risk within an already high-risk population. The most recently available government-collected data shows that transgender incarcerated people experience about 10 times the rate of sexual victimization compared to the general population. Bureau

of Just. Stats., U.S. Dep't of Just., *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12: Supplemental Tables*, at 2 tbl. 1 (2014), https://bjs.ojp.gov/content/pub/pdf/svpjri1112_st.pdf (showing sexual victimization rates for transgender incarcerated people at 39.9% from 2011 to 2012); Bureau of Just. Stats., U.S. Dep't of Just., *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12*, at 6 (2014) (estimating sexual victimization rates for the general prison population at 4.0% during the same period). “The vulnerability of transgender prisoners to sexual abuse is no secret.” *Zollicoffer*, 169 F. Supp. 3d at 691. The heightened risk transgender women face in men’s prisons is widely acknowledged by federal courts. *See supra* n.14.

The Government argues it did not act with deliberate indifference because BOP considered the risks to Plaintiffs when it decided *which* men’s prison it would transfer them to. AOB at 42–43. But the Government’s choice not to place Plaintiffs in the most dangerous men’s prisons does not cure its deliberate indifference. *Cf. Hudson v. McMillian*, 503 U.S. 1, 9 (1992) (holding that the Eighth Amendment does not require further proof of “some arbitrary quantity of injury” once elements of violation are established).

The Government also argues that its prior placement of Plaintiffs in women’s facilities was “not based solely on safety considerations.” AOB at 46. But the Government does not dispute that it assessed Plaintiffs’ “vulnerability to

sexual victimization” and their medical and mental health needs when it decided that *these* individuals needed to be housed in women’s prisons. *See id.* Those assessments put BOP on notice of Plaintiffs’ specific histories and vulnerabilities to serious harm in men’s facilities, including the fact that many Plaintiffs have been physically and sexually assaulted in men’s facilities before. *See* 28 C.F.R. §§ 115.41(d), 115.42(c) (requiring BOP to consider past experiences of “sexual victimization” in determining housing placements and to “ensure” a transgender person’s “health and safety” in determining whether to place them in a men’s or women’s facility); *see also id.* § 115.42(e) (requiring BOP to give “serious consideration” to a transgender person’s “own views with respect to his or her safety” in determining housing placements). The Government’s *post hoc* claim that it also considered other information does not erase BOP’s knowledge that Plaintiffs would be at excessive risk of harm in men’s prisons.

Finally, the Government claims that the deliberate indifference cases Plaintiffs cited below are inapposite because “[i]n each case, the court found that additional, case-specific factors heightened the risk of assault.” AOB at 45. The Government misunderstands Plaintiffs’ claim, as demonstrated by its attempt to distinguish Plaintiffs’ cases.

Plaintiffs have never argued, and the district court has not concluded, that all transgender women must be housed in women’s prisons to comply with the Eighth

Amendment. Instead, there are “additional, case-specific factors” showing that Plaintiffs—the tiny group of transgender women whom BOP previously determined needed to be housed in women’s facilities—would be at heightened risk of assault and self-harm if placed in men’s prisons. *Id.* These factors include Plaintiffs’ history of victimization—as in *Zollicoffer*, 169 F. Supp. 3d at 689–90 and *Stover v. Corrs. Corp. of Am.*, No. 12-cv-393, 2015 WL 874288, at *7 (D. Idaho Feb. 27, 2015)—and their medical treatment that has caused them to develop female sex characteristics—as in *Doe*, 215 F. Supp. 3d at 65 and *Lojan*, 2013 WL 411356, at *1, 4. The Government knows of the specific, serious risks Plaintiffs would face in men’s prisons and has chosen to disregard those risks to comply with the Executive Order. Nothing more is required to prove Plaintiffs’ Eighth Amendment claim. *Farmer*, 511 U.S. at 837.¹⁶

B. Plaintiffs Are Also Likely to Prevail on Their Claims Under the Administrative Procedure Act.

This Court “review[s] the district court’s judgment, not its reasoning,” and “may affirm on any ground properly raised.” *Jones v. Bernanke*, 557 F.3d 670, 674 (D.C. Cir. 2009). Plaintiffs argued below that BOP’s implementation of EO

¹⁶ To the extent the Government suggests that BOP has unfettered discretion to reweigh policy priorities affecting housing assignments, *see* AOB at 47–48, that cannot justify its disregard of the known and substantial risks of serious harm to Plaintiffs. Although BOP has significant discretion to set prison housing policy, it still must comply with the Constitution.

14168 violates the APA, 5 U.S.C. § 706(2), because it is arbitrary and capricious, not in accordance with law, and revokes PREA regulations without following the procedures necessary to amend or rescind those regulations. *See, e.g., Doe v. Bondi*, ECF No. 81-1 at 8; ECF No. 50-1 at 19–23. Agency actions implementing an executive order are subject to APA review. *See, e.g., Nebraska v. Su*, 121 F.4th 1, 15–16 (9th Cir. 2024); *see also Chamber of Com. of U.S. v. Reich*, 74 F.3d 1322, 1327 (D.C. Cir. 1996).

BOP’s decision to transfer Plaintiffs to men’s prisons in compliance with EO 14168 is a final agency action. *See Bennett v. Spear*, 520 U.S. 154, 177–78 (1997); *see also* AOB at 12–13 (acknowledging that BOP decided to transfer Plaintiffs and told Plaintiffs they would be transferred).

1. Defendants’ Implementation of the Executive Order Violates Notice and Comment Requirements

PREA regulations have long required BOP to make individualized determinations, considering both men’s and women’s facilities, about where to house transgender individuals. *See* 28 C.F.R. § 115.42(c). These regulations were promulgated through notice and comment rulemaking. *See* National Standards to Prevent, Detect, and Respond to Prison Rape, 77 Fed. Reg. 37106, 37204 (June 20, 2012); *see also* 5 U.S.C. § 553.

The APA requires agencies to “use the same procedures when they amend or repeal a rule as they used to issue the rule in the first instance.” *Perez v. Mortg.*

Bankers Ass’n, 575 U.S. 92, 101 (2015). As this Court has explained, “‘an agency issuing a legislative rule is itself bound by the rule until that rule is amended or revoked’ and ‘may not alter [such a rule] without notice and comment.’” *Clean Air Council v. Pruitt*, 862 F.3d 1, 9 (D.C. Cir. 2017) (per curiam) (alteration in original) (quoting *Nat’l Fam. Plan. & Reprod. Health Ass’n, Inc. v. Sullivan*, 979 F.2d 227, 234 (D.C. Cir. 1992)).

BOP’s implementation of the Executive Order would repeal PREA regulations without following the necessary notice and comment procedures. The order instructs BOP to ensure that all transgender women in federal custody “are not detained in women’s prisons or housed in women’s detention centers,” regardless of their individual circumstances. EO 14168 § 4(a). This is directly contrary to PREA regulations that require BOP to make “case-by-case” determinations about “whether to assign a transgender or intersex inmate to a facility for male or female inmates” based on “the inmate’s health and safety, and whether the placement would present management or security problems.” 28 C.F.R. § 115.42(c).

Requiring “notice and comment before repeal of a final rule ‘ensures that an agency will not undo all that it accomplished through its rulemaking without giving all parties an opportunity to comment on the wisdom of repeal.’” *Humane Soc’y of the U.S. v. U.S. Dep’t of Agric.*, 41 F.4th 564, 568 (D.C. Cir. 2022)

(quoting *Consumer Energy Council of Am. v. FERC*, 673 F.2d 425, 446 (D.C. Cir. 1982)). For that reason, this Court has carefully scrutinized agency efforts to “effectively amend or withdraw the legal force of a rule without undergoing a new notice-and-comment rulemaking.” *Guedes v. Bureau of Alcohol, Tobacco, Firearms & Explosives*, 920 F.3d 1, 23 (D.C. Cir. 2019). An agency may not take action that “effectively repeal[s] a final rule while sidestepping the statutorily mandated process for revising or repealing that rule on the merits.” *Air All. Houston v. EPA*, 906 F.3d 1049, 1065 (D.C. Cir. 2018). Nor may it “substantively alter[.]” the requirements of the rule without following appropriate procedures for the rule’s amendment or repeal. *Liquid Energy Pipeline Ass’n v. FERC*, 109 F.4th 543, 548 (D.C. Cir. 2024); *see also NRDC v. EPA*, 643 F.3d 311, 320–21 (D.C. Cir. 2011).

These concerns are especially acute here. It took more than eight years after the enactment of PREA in 2003 to finalize the regulations that the Executive Order unravels. The housing requirements of the regulations reflect a deliberate balancing of the interests of prison administrators and the needs of incarcerated transgender people. BOP may not “simply disregard rules that are still on the books.” *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009). BOP’s choice to “depart from a prior policy *sub silentio*” violates its procedural obligations under the APA. *Id.*

2. BOP's Action is Arbitrary and Capricious and Not in Accordance with Law.

BOP's implementation of the Executive Order is also arbitrary and capricious and not in accordance with law. *See* 5 U.S.C. § 706(2)(A). BOP has provided no reasoned explanation for its new policy that categorically forbids Plaintiffs from ever being housed in their current facilities or other women's facilities—facilities to which BOP assigned Plaintiffs based on individualized determinations, *see* 28 C.F.R. § 115.42, and in which Plaintiffs have been housed for months or years.

The APA requires agencies “to engage in reasoned decisionmaking” through a “logical and rational” process. *Nw. Immigrant Rts. Project v. U.S. Citizenship & Immigr. Servs.*, 496 F. Supp. 3d 31, 70 (D.D.C. 2020) (quoting *DHS v. Regents of the Univ. of California*, 591 U.S. 1, 16 (2020) and *Allentown Mack Sales & Servs., Inc. v. NLRB*, 522 U.S. 359, 374 (1998)). When an agency departs from prior policy, it must show “that there are good reasons for [the new policy], and that the agency believes it to be better.” *Fox Television Stations*, 556 U.S. at 515. The agency cannot disregard the facts and circumstances that formed the basis of the prior policy without providing “a reasoned explanation.” *Id.* And an agency's decision is arbitrary or capricious if it “entirely failed to consider an important aspect of the problem.” *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

BOP failed to meet the requirements for reasoned decisionmaking, as it admits its decision started and ended with the Executive Order. Responding to Plaintiffs' APA claim before the district court, the Government failed to offer any justification independent of the Executive Order. Instead, the Government stated only that "[t]he Executive Order has articulated why the Executive has changed its policy." Defs' Resp. to Pls.' Mot. for TRO, *Doe v. Bondi*, ECF 53-1 at 36; Defs' Resp. to Pls.' Mot. for TRO, *Jones v. Trump*, ECF 24 at 34.

But an "executive order does not exempt [an agency] from basic APA requirements of reasoned decisionmaking." *Su*, 121 F.4th at 15; *see also AIDS Vaccine Advoc. Coal. v. U.S. Dep't of State*, 766 F. Supp. 3d 74, 83 (D.D.C. 2025). Indeed, courts considering agency action taken pursuant to *this* Executive Order (No. 14168) have already held it arbitrary and capricious when the agency's justification was the Executive Order. *See Orr v. Trump*, — F. Supp. 3d —, 2025 WL 1145271, at *19 (D. Mass. Apr. 18, 2025); *Kingdom v. Trump*, No. 1:25-cv-00691-RCL, 2025 WL 1568238, at *9–10 (D.D.C. June 3, 2025). *Orr* considered a new State Department passport policy, the record of which revealed "that the State Department considered virtually nothing aside from the Executive Order's directive when it developed the [new] [p]olicy." *Orr*, 2025 WL 1145271 at *18–19 (observing that the Department made no factual findings and did not explain why facts supporting prior policy "no longer carry weight"). Just so here: the

Executive Order constitutes BOP's only justification for its new policy.¹⁷

BOP has thus failed to provide “a satisfactory explanation for its action.” *State Farm*, 463 U.S. at 43. Plaintiffs’ current housing designations are the result of individualized determinations pursuant to 28 C.F.R. § 115.42 to “ensure the inmate’s health and safety.” Mandating that BOP *disregard* those safety determinations is not rational, and the Order provides no explanation to reconcile the apparent conflict. The Executive Order “entirely fail[s] to consider an important aspect of the problem”: the extreme risks of rape, sexual and physical violence, and self-harm that Plaintiffs will face if transferred to men’s facilities. *State Farm*, 463 U.S. at 43. Put differently, the Executive Order entirely ignores the people who will be transferred and the known dangers those transfers pose. “To be sure, agency action is not arbitrary and capricious merely because it is bad for some identifiable population,” but “the APA *does* require an agency to take

¹⁷ The administrative record for APA claims consists exclusively of the record the agency made *before* it acted. *AT&T Info. Sys., Inc. v. Gen. Servs. Admin.*, 810 F.2d 1233, 1236 (D.C. Cir. 1987) (per curiam) (citing *Camp v. Pitts*, 411 U.S. 138, 142 (1973)). Courts “bar introduction of litigation affidavits” that “offer post-hoc rationalizations” when the contemporaneous record revealed “no rationalization at the agency level.” *Id.* The government endorsed this position when defending a different agency action taken to comply with Executive Order 14168. *See* Defs.’ Opp. to Pls.’ Mot. to Stay Agency Action and for PI, *Orr v. Trump*, No. 1:25-CV-10313-JEK, ECF No. 53 at 15 (D. Mass. March 12, 2025). The declarations of Rick Stover submitted to the District Court are thus not proper subjects of consideration for Plaintiffs’ APA claim.

actions that are rationally and demonstrably related to its stated goals, ... and give consideration to the reliance interests of those who may be harmed by a new policy.” *Kingdom*, 2025 WL 1568238, at *10. Because the Executive Order falls short of *Fox Television Stations’* and *State Farm’s* requirements, it cannot save BOP’s otherwise unsupported arbitrary and capricious action.

BOP’s implementation of the Executive Order is also arbitrary and capricious or “otherwise not in accordance with law,” 5 U.S.C. § 706(A)(2), because it directly violates the PREA regulations’ requirement that BOP conduct individualized assessments when determining whether to house transgender people in men’s or women’s facilities. *See* 28 C.F.R. § 115.42(c); *Williams v. Kincaid*, 45 F.4th 759, 778 (4th Cir. 2022) (holding that a categorical approach to housing decisions “flouts the case-by-case analysis federal law requires”); *see generally United States ex rel. Accardi v. Shaughnessy*, 347 U.S. 260 (1954) (establishing that agencies must follow their own regulations).¹⁸

The Government also acts in an arbitrary and capricious manner when it acts based on animus. *Robbins v. Reagan*, 780 F.2d 37, 50 n.20 (D.C. Cir. 1985). Animus may take the form of a “desire to harm a politically unpopular group,”

¹⁸ *Accardi* claims can be brought through an APA cause of action. *See Damus v. Nielsen*, 313 F. Supp. 3d 317, 335–36 (D.D.C. 2018); *Fed. Defs. of N.Y., Inc. v. Fed. Bureau of Prisons*, 954 F.3d 118, 130 (2d Cir. 2020).

U.S. Dep’t of Agric. v. Moreno, 413 U.S. 528, 534 (1973), or it may reflect “negative attitudes,” “fear,” or “irrational prejudice,” *City of Cleburne, Tex. v. Cleburne Living Ctr.*, 473 U.S. 432, 448, 450 (1985).

The text and sweeping scope of the Executive Order demonstrate animosity against transgender people. It makes it the official “policy of the United States” to purposefully exclude transgender people from any legal recognition or protection. EO 14168 §§ 2, 2(a). It defines “gender ideology” as “permitting the false claim that males can identify as and thus become women and vice versa”; orders all agencies to “remove all statements, policies, regulations, forms, communications, or other internal and external messages that promote or otherwise inculcate gender ideology”; and orders agencies to “end the Federal funding of gender ideology.” EO 14168 §§ 2(g), 3(e); *see also id.* § 3(g).

In short, the Executive Order declares a federal policy of denying the existence of transgender people. *See Orr*, 2025 WL 1145271, at *19 (“[T]he language of the Executive Order is candid in its rejection of the identity of an entire group—transgender Americans.”); *S.F. A.I.D.S. Found. v. Trump*, No. 25-cv-01824-JST, 2025 WL 1621636, at *14–15 (N.D. Cal. June 9, 2025) (similar). The “principal purpose and the necessary effect” of the Order is to “demean those persons who are” transgender. *United States v. Windsor*, 570 U.S. 744, 774 (2013). Although the Executive Order sets out other alleged purposes—promoting

women’s “dignity, safety, and well-being”; advancing “scientific inquiry, public safety, morale, and trust in government”; and “protect[ing] freedom of conscience”—the “sheer breadth” of the Order “is so discontinuous” with these purposes that it can only be explained by animus. *Romer v. Evans*, 517 U.S. 620, 632 (1996).

The Government’s broader attack on transgender people removes any doubt that animus is the principal driver of the Government’s challenged housing policy. The President has issued Executive Orders designed to strip protections from transgender people across multiple domains. *See supra* n.8 (listing Executive Orders). “Although aimed at different policy goals,” each of the above-mentioned Executive Orders, “in tone and language, conveys a fundamental moral disapproval of transgender Americans.” *Orr*, 2025 WL 1145271, at *14. The Executive Orders, including EO 14168, attack transgender people “not to further a proper [governmental] end but to make them unequal to everyone else.” *Romer*, 517 U.S. at 635. The Government’s policy is borne of animus and thus is necessarily arbitrary and capricious.

C. Plaintiffs’ Claims are Not Barred by the PLRA Or Any Other Statute.

1. 18 U.S.C. § 3621(b) Does Not Bar Judicial Review.

Section 3621(b) does not bar Plaintiffs’ challenges to BOP’s categorical policy implementing the Executive Order. The statute prohibits judicial review of

“a *designation* of a place of imprisonment *under this subsection*.” 18 U.S.C.

§ 3621(b) (emphasis added). BOP’s transfer of Plaintiffs from women’s facilities was not an individualized placement decision under § 3621(b). BOP transferred Plaintiffs pursuant to a categorical policy mandated by the Executive Order, not based on the factors in § 3621(b). *See* EO 14168, § 4(a); AOB at 1, 12.

Accordingly, because BOP’s actions fall outside § 3621(b)’s scope, the statute’s bar of judicial review does not apply.

In addition, as the district court correctly held, § 3621(b) does not preclude judicial review of Plaintiffs’ constitutional claims. JA160. “[W]here Congress intends to preclude judicial review of constitutional claims its intent to do so must be clear ... to avoid the ‘serious constitutional question’ that would arise if a federal statute were construed to deny any judicial forum for a colorable constitutional claim.” *Webster v. Doe*, 486 U.S. 592, 603 (1988) (quoting *Bowen v. Mich. Acad. of Fam. Physicians*, 476 U.S. 667, 681 n.12 (1986)). Congress did not do so in § 3621.¹⁹

¹⁹ *McBryde v. Comm. to Review Cir. Council Conduct*, 264 F.3d 52, 58, 60 (D.C. Cir. 2001) does not support the Government’s argument. In *McBryde*, this Court found clear and convincing evidence that Congress intended to deny judicial review of judicial disciplinary proceedings. *Id.* at 62–63. None of the unusual factors the Court relied on to reach its conclusion apply here. *See Ralls Corp. v. Comm. on Foreign Inv. in U.S.*, 758 F. 3d 296, 309–10 (D.C. Cir. 2014) (describing the unique statutory language and legislative history relied on by this Court in *McBryde*).

The cases cited by the Government are inapposite because they all involved individualized placement decisions. *See Wills v. Barnhardt*, No. 21-1383, 2022 WL 4481492, at *1 (10th Cir. Sept. 27, 2022) (declining to review BOP’s decision on plaintiff’s transfer request); *Touizer v. U.S. Att’y Gen.*, No. 21-10761, 2021 WL 3829618, at *1–2 (11th Cir. Aug. 27, 2021) (per curiam) (rejecting plaintiff’s request for home confinement); *Jiau v. Tews*, 812 F. App’x 638, 639 (9th Cir. 2020) (rejecting plaintiff’s claims to the extent they challenged her placement in a prison rather than a residential re-entry center).

Moreover, the Supreme Court has held that a provision limiting judicial review of individual agency decisions does not preclude judicial review of statutory or constitutional challenges to blanket policies. *McNary v. Haitian Refugee Ctr., Inc.*, 498 U.S. 479, 492 (1991) (holding that a provision like § 3621(b), which limited judicial review of individual amnesty applications by immigrants, did not bar pattern and practice challenges to the INS’s processing of such applications); *see also, e.g., Ahmad v. Jacquez*, 860 F. App’x 459, 462 (9th Cir. July 1, 2021) (stating that § 3621(b) strips jurisdiction over individual transfer decisions but “does not preclude review of all challenges that might implicate individual designation decisions,” including challenges to generally applicable BOP policies (citing *McNary*, 498 U.S. at 492)). Like the analogous provision in *McNary*, the language of § 3621(b) refers to judicial review of individual decisions

rather than to general “challenges to unconstitutional practices and policies used by the agency” in making such decisions. 498 U.S. at 492. Plaintiffs here are not seeking review of individual placement decisions under § 3621(b) but rather of BOP’s adoption of a blanket policy requiring their transfer to men’s facilities regardless of their individual circumstances. As such, § 3621(b) does not bar judicial review of their claims.

2. Section 3625 Similarly Does Not Bar Plaintiffs’ APA Claims.

Any argument that 18 U.S.C. § 3625 bars Plaintiffs’ APA claims fails for the same reasons. That provision makes the APA inapplicable “to the making of any determination, decision, or order” under Title 18, Part II, Chapter 229, Subchapter C, of which the only relevant section is § 3621(b). 18 U.S.C. § 3625. “§ 3625 bars review of individualized housing determinations, not ... a challenge to a broad policy that informs the designation decision.” *Love v. Bureau of Prisons*, No. 24-CV-2571 (APM), 2025 WL 105845, at *11–12 (D.D.C. Jan. 15, 2025) (holding § 3625 “no bar to review” because “[p]laintiffs are not challenging their individual housing placements. They contest the BOP’s alleged discriminatory treatment of [a subset of prisoners] in the decision-making process”); *see also Jasperson v. Fed. Bureau of Prisons*, 460 F. Supp. 2d 76, 84 (D.D.C. 2006) (holding § 3625 no bar where plaintiff “challenges the rulemaking leading to the BOP policy that informed his confinement determination, rather than challenging the determination itself”).

Multiple circuit courts have reached the same conclusion. *See Richmond v. Scibana*, 387 F.3d 602, 605 (7th Cir. 2004) (distinguishing between contesting a housing assignment and contesting “the rules that will be used to decide” that placement); *see also Martin v. Gerlinski*, 133 F.3d 1076, 1079 (8th Cir. 1998) (explaining that “§ 3625 does not divest this court of jurisdiction to review whether the BOP exceeded its statutory authority by categorically considering sentencing enhancement factors”); *Fristoe v. Thompson*, 144 F.3d 627, 630–31 (10th Cir. 1998) (holding that section 3625 did not prevent judicial review of a BOP rule affecting sentencing reduction).

It is also well settled that § 3625 does not bar judicial consideration of Plaintiffs’ challenge to BOP’s failure to comply with the rulemaking provisions of the APA. *E.g.*, 5 U.S.C. § 553. As both the statute’s text and judicial decisions make clear, § 3625 does not apply to agency rulemaking. *See* 18 U.S.C. § 3625; *Martin*, 133 F.3d at 1079 (“[I]t is apparent” that § 3625 does not bar review of “rulemaking decisions.”).

3. The District Court Correctly Found that No Administrative Remedy Was Available.

Failure to exhaust administrative remedies is an affirmative defense under the PLRA, *Jones v. Bock*, 549 U.S. 199, 215–16 (2007), which “the defendants have the burden of pleading and proving,” *Chandler v. Fed. Bureau of Prisons*, 226 F. Supp. 3d 1, 6 (D.D.C. 2016). The Government cannot show that this

affirmative defense makes Plaintiffs unlikely to succeed on the merits because it concedes that BOP must implement the categorical policy mandated by the Executive Order without discretion to do otherwise. AOB at 32 (stating that “BOP lacks discretion to continue housing plaintiffs in female facilities under EO 14168”).

An aggrieved incarcerated person “must exhaust available remedies, but need not exhaust unavailable ones.” *Ross v. Blake*, 578 U.S. 632, 642 (2016) (citing 42 U.S.C. § 1997e(a)). A remedy is unavailable “where the relevant administrative procedure lacks authority to provide any relief.” *Id.* at 643 (citing *Booth v. Churner*, 532 U.S. 731, 736 & n.4 (2001)). Such is the case when BOP acts pursuant to a mandatory directive that divests it of any authority to provide relief. *Kaemmerling v. Lappin*, 553 F.3d 669, 675 (D.C. Cir. 2008).

In *Kaemmerling*, petitioner sought injunctive relief against BOP’s enforcement of a federal statute under which “BOP ha[d] no discretion not to collect [his] DNA, as the statute’s mandatory language indicates and as the BOP conceded.” *Id.* at 675. There was thus “no administrative process to exhaust.” *Id.* Similarly, here, Plaintiffs seek injunctive relief against BOP’s implementation of an executive order with mandatory language that requires BOP to transfer Plaintiffs from women’s prisons, as BOP concedes. *See* AOB at 32; *see also* EO 14168, § 4(a).

Moreover, BOP staff told Plaintiffs it lacked authority to provide relief.

JA494 ¶ 12 (Maria Moe “was told that [she] did not have an ability to challenge the transfer because it was required by Executive Order”); JA649 ¶¶ 13–14 ([REDACTED]

[REDACTED]”). The text of the Executive Order, BOP’s interpretation of it, and BOP staff statements to Plaintiffs all point to the same conclusion: BOP’s administrative process “operate[d] as a simple dead end—with officers unable ... to provide any relief.” *Ross*, 578 U.S. at 643.

The Government suggests that Plaintiffs should have exhausted administrative remedies anyway because BOP could have taken actions unrelated to the Executive Order to “protect [Plaintiffs’] safety,” such as “changes to housing and programming assignments, and protective custody.” AOB at 32. This contention ignores that Plaintiffs’ complaint arises out of an Executive Order that BOP is required to implement. BOP’s administrative process is not capable of changing the terms of the Order or overruling its mandates—just as the grievance process in *Kaemmerling* could not alter or invalidate the text of a binding federal statute, *see* 553 F.3d at 676 (emphasizing that the plaintiff was challenging “the enforceability of a statute rather than the prison’s method of enforcement”). The Government also cites *Savage v. United States Department of Justice*, 91 F.4th 480

(D.C. Cir. 2024). But in that case, this Court held that administrative remedies were available to a plaintiff challenging the terms of an order issued by the Department of Justice, reasoning that the administrative process “ends with review by the Department of Justice, which has the authority to modify or rescind” the order. *Id.* at 484. Because BOP lacked that authority here, Plaintiffs faced “a dead end” in challenging the application of the Executive Order to them. *Ross*, 578 U.S. at 643.

Administrative remedies were unavailable in this case for another reason as well: Plaintiffs faced immediate danger and could not have received relief before being exposed to the substantial risk of serious harm posed by transfer. Some Plaintiffs were in fact transferred to men’s facilities without time or opportunity to file a grievance. JA230, 233–34. Others were moved to segregated housing and told they would be transferred imminently. *See, e.g.*, JA86, 88, 493–94.

Exhaustion is not required when the administrative process cannot possibly remedy the threatened harm in time. *Fletcher v. Menard Corr. Ctr.*, 623 F.3d 1171, 1173 (7th Cir. 2010) (“If a prisoner has been placed in imminent danger of serious physical injury by an act that violates his constitutional rights, administrative remedies that offer no possible relief in time to prevent the imminent danger from becoming an actual harm can’t be thought available.”).

II. PLAINTIFFS HAVE MET ALL OTHER REQUIREMENTS FOR PRELIMINARY INJUNCTIVE RELIEF

The district court did not abuse its discretion in weighing the *Winter* factors, *see Winter*, 555 U.S. at 20, and concluding that Plaintiffs met their burden on the remaining prongs for a preliminary injunction.

A. Plaintiffs Have Shown They Will Suffer Irreparable Harm if the Government Implements EO 14168 and Transfers them from Women's Prisons.

Plaintiffs must show that they “will likely suffer irreparable harm before the district court can resolve the merits of the case.” *Singh v. Berger*, 56 F.4th 88, 95 (D.C. Cir. 2022) (citing *Archdiocese of Wash. v. Wash. Metro. Area Transit Auth.*, 897 F.3d 314, 321 (D.C. Cir. 2018)). Here, Plaintiffs face irreparable harm arising out of the Government’s implementation of Section 4(a) of EO 14168, including the violation of their Eighth Amendment rights and substantial risks of sexual violence and physical harm.

1. BOP’s Prospective Violation of Plaintiffs’ Eighth Amendment Rights Causes Irreparable Harm.

Plaintiffs satisfy the irreparable harm standard where, as here, they face imminent violation of their Eighth Amendment right to be free from cruel and unusual punishment. As the district court properly recognized, “a prospective violation of a constitutional right constitutes irreparable injury.” JA166 (quoting *Davis v. District of Columbia*, 158 F.3d 1342, 1346 (D.C. Cir. 1998)). “Where a plaintiff requests injunctive relief ... that, if completed could ... alleviate harsh

conditions of confinement, the harm from detention surely cannot be remediated after the fact.” *Ramirez v. U.S. Immigr. and Customs Enf’t*, 310 F. Supp. 3d 7, 31 (D.D.C. 2018).

2. BOP’s Implementation of EO 14168 Exposes Plaintiffs to a High Risk of Sexual Violence and Other Serious Harms.

Plaintiffs face a substantial risk of irreparable bodily harm in the absence of injunctive relief. *See supra* Argument § I(A)(1). If Plaintiffs are transferred to men’s prisons, they will likely face physical violence and sexual harassment. Multiple Plaintiffs were physically attacked and sexually harassed in men’s prisons before they were placed in women’s facilities. *See, e.g.*, JA374–75, 382, 385. And two of the Plaintiffs who were transferred from women’s to men’s facilities under EO 14168 both suffered immediate and pervasive sexual harassment in those men’s facilities. JA230, 233–34.

In addition, Plaintiffs Maria Moe, Jane Jones, and Zoe, Rachel, Wendy and Sara Doe are at extremely high risk of assault in men’s prisons because they have undergone surgical treatment and/or appear indistinguishable from other women. *See* JA286, 703–04, 903, 965, 996, 1000. All Plaintiffs have been on female hormones for years and live as women.

Finally, the likelihood of irreparable harm is supported by the Government’s own data demonstrating an elevated risk for the transgender prisoner population, as well as the un rebutted declarations submitted by Plaintiffs and Plaintiffs’ experts

showing that Plaintiffs are at particularly high risk. *See supra* Argument § I(A).

The district court also did not clearly err in finding that, given the individual histories and vulnerabilities identified by these plaintiffs, “placement in a male penitentiary *by itself* will exacerbate the symptoms of [Plaintiffs’] gender dysphoria, *even if* they are not subject to physical or sexual violence in their new facility ... because the mere homogenous presence of men will cause uncomfortable dissonance.” JA187 n.2. As the district court found, this worsening of gender dysphoria will expose Plaintiffs to a serious risk of harm if they are moved to men’s prisons. *Id.*

Defendants’ reliance on *Citizens for Responsibility and Ethics in Washington (CREW) v. Federal Election Commission*, 904 F.3d 1014 (D.C. Cir. 2018) is misplaced. In *CREW*, this Court found no irreparable harm existed where the plaintiff campaign donors failed to provide “actual evidence” that the FEC’s new disclosure requirements had a “chilling effect” on their behavior or evidence of “any actual independent expenditures [they had] made this quarter” or were deterred from making. *Id.* at 1019. In contrast, here, Plaintiffs submitted more than 20 declarations from themselves and experts describing the harms they have already experienced in men’s prisons in addition to the imminent and certain harm they will face if forced to live in men’s prisons. *See* JA84, 91, 229, 232, 285, 292, 373, 377, 380, 384, 490, 915, 920, 925, 929, 934, 938, 942, 947, 951.

B. The Balance of Equities and Public Interest Weigh in Favor of Preliminary Injunctive Relief.

When the party opposing a preliminary injunction is the Government, the final two prongs merge. *Nken v. Holder*, 556 U.S. 418, 435 (2009). The district court did not abuse its discretion in concluding “the public interest in seeing the plaintiffs relocated *immediately* to male facilities is slight at best,” whereas “[t]he plaintiffs’ interests ... are not abstract at all,” as Plaintiffs face substantiated harms to their physical and psychological wellbeing if transferred under the challenged Executive Order. JA167. In addition, “enforcement of an unconstitutional law is always contrary to the public interest.” *Karem v. Trump*, 960 F.3d 656, 668 (D.C. Cir. 2020).

The Government now makes blanket, unsupported assertions on appeal that the Plaintiffs endanger the safety of others at the women’s prisons where they reside. AOB at 4. The Government did not submit any evidence to support this assertion in any of the six oppositions filed in response to the motions for TROs and PIs in the underlying cases. Nor is there any support for the suggestion that simply being transgender makes Plaintiffs a threat to women’s safety, privacy, or dignity.

Likewise, the Government cannot show that the injunctions undermine the public interest by forcing BOP to keep in place a housing policy “that no longer reflects its current ... thinking.” AOB at 53. In arguing to the contrary, the

Government relies on *MediNatura, Inc. v. FDA*, 998 F.3d 931, 945 (D.C. Cir. 2021). But *MediNatura* is inapposite. In that case, this Court denied a preliminary injunction seeking to retain a thirty-year-old agency guidance document, where the change in policy followed a multi-year review process that reflected the agency’s “current enforcement thinking” and involved scientific analysis and public input. *See id.* at 935–37, 945. In contrast, here, the Government has not provided any explanation or evidence to support the policy change other than the text of the Executive Order at issue. Nor could there be evidence-based decision making to support the abrupt policy change, which was issued on day one of the current presidential administration before any serious review of BOP policies and practices had been taken, and which explicitly contravenes PREA and its implementing regulations.

The Government’s analogy to *Hatim v. Obama*, 760 F.3d 54 (D.C. Cir. 2014) to argue that that the injunctions “impermissibly interfere with the government’s administration of its federal prisons and the execution of Executive Branch policy” also fails. AOB at 53. In *Hatim*, the plaintiffs did not challenge an Executive Order, but rather an on-the-ground policy change at a specific detention facility the Court found was “needed to preserve internal order and discipline and to maintain institutional security.” *Hatim*, 760 F.3d at 59 (internal citations omitted). There are no such findings here. In fact, the injunctions restore, rather

than interfere with, BOP's discretion to determine housing placements as needed to "ensure health and safety" for people in custody and maintain "security" in federal prisons. 28 C.F.R. § 115.42(c).

Defendants' position that this Court should defer to unfettered executive power also fundamentally misunderstands constitutional separation of powers. The Constitution represents the outer limits of deference to the Executive Branch; where a likely constitutional violation has been shown, deference is neither warranted nor in the public interest. *See Int'l Refugee Assistance Proj. v. Trump*, 857 F.3d 554, 603 (4th Cir. 2017) (en banc), *vacated on mootness grounds*, 583 U.S. 912 (2017) (explaining that "the issuance of a preliminary injunction which prevents [the government] from enforcing restrictions likely to be found unconstitutional" does not harm the government and likely "improve[s]" our system of government).

III. THE DISTRICT COURT'S ORDERS COMPLY WITH THE PRISON LITIGATION REFORM ACT

The operative preliminary injunctions contain ample PLRA findings and meet the requirements of the statute. *See* 18 U.S.C. § 3626(a)(2). Specifically, the court found that Plaintiffs are likely to succeed on the merits of their Eighth Amendment claim and that they will experience "serious and irreparable harm" if Defendants' implementation of the Executive Order proceeds; enjoining the application of the Order to Plaintiffs was therefore "necessary to correct the harm";

there was no less intrusive means of correcting the harm; and the injunction was narrowly drawn because it addressed only the specific harms to the individual Plaintiffs and did not extend to protect non-parties or enjoin other aspects of the EO 14168. JA955, 958, 961. The district court also found that the injunctions would not cause any “adverse impacts on public safety or the operation of the criminal justice system” because they simply maintained the status quo during the pendency of the litigation. JA955–56, 959, 961–62.

The district court’s articulation of its findings was nothing like the “one-sentence, boilerplate paragraph” the Government points to from *Hoffer v. Sec’y, Fla. Dep’t of Corr.*, 973 F.3d 1263, 1278 (11th Cir. 2020). Nothing in the PLRA “suggest[s] that Congress intended a provision-by-provision explanation of a district court’s findings,” and there is no reason to “read such an obligation into the statute.” *Armstrong v. Schwarzenegger*, 622 F.3d 1058, 1070 (9th Cir. 2010); *see also Fields v. Smith*, 653 F.3d 550, 558 (7th Cir. 2011) (reaching same conclusion and collecting cases).

The Government spends one paragraph arguing that the PIs were not in fact necessary to avert the harm threatened by the Executive Order. AOB at 56–57. This Court reviews for clear error the district court’s factual findings that the injunctions were necessary, narrowly tailored, and the least intrusive means of correcting the harm. *Brown v. Plata*, 563 U.S. 493, 541 (2011); *see also United*

States v. Hinds Cnty. Bd. of Supervisors, 128 F.4th 616, 626 (5th Cir. 2025); *Armstrong v. Newsom*, 58 F.4th 1283, 1293 (9th Cir. 2023). As the district court explained, its findings were amply supported by the evidence that (1) transferring Plaintiffs to men’s prisons would put them at a “significantly elevated risk of physical and sexual violence relative to other inmates,” JA164; (2) moving Plaintiffs to men’s prisons would “exacerbate the symptoms of their gender dysphoria,” potentially causing “numerous and severe symptoms,” JA165; (3) BOP had previously determined that “a women’s facility was the appropriate placement for each named plaintiff” based on the constitutional and statutory factors that required it to consider Plaintiffs’ risk of harm in men’s prisons, JA186; and (4) the fact that Rachel and Ellen Doe were “abused at their new facilities” after their brief transfer to men’s prisons could “only strengthen their claims of irreparable harm,” JA241–42. The Government’s cursory and unsupported argument that it is “self-evident” that less intrusive relief could avert the harm shows no clear error in these findings. AOB at 56–57.

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CONCLUSION

For the foregoing reasons, the preliminary injunctions should be affirmed.

DATED: June 30, 2025

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit of Federal Rule of Appellate Procedure 32 (a)(7)(B) because it contains 12,525 words. This brief also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because it was prepared using Word for Microsoft 365 in Times New Roman 14-point font, a proportionally spaced typeface.

/s/ Kara Janssen

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CERTIFICATE OF SERVICE

I hereby certify that on June 30, 2025, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the District of Columbia Circuit by using the appellate CM/ECF system.

/s/ Kara Janssen

Kara Janssen

ADDENDUM

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18 U.S.C. § 3621(b)**§ 3621. Imprisonment of a convicted person**

* * *

(b) Place of imprisonment.--The Bureau of Prisons shall designate the place of the prisoner's imprisonment, and shall, subject to bed availability, the prisoner's security designation, the prisoner's programmatic needs, the prisoner's mental and medical health needs, any request made by the prisoner related to faith-based needs, recommendations of the sentencing court, and other security concerns of the Bureau of Prisons, place the prisoner in a facility as close as practicable to the prisoner's primary residence, and to the extent practicable, in a facility within 500 driving miles of that residence. The Bureau shall, subject to consideration of the factors described in the preceding sentence and the prisoner's preference for staying at his or her current facility or being transferred, transfer prisoners to facilities that are closer to the prisoner's primary residence even if the prisoner is already in a facility within 500 driving miles of that residence. The Bureau may designate any available penal or correctional facility that meets minimum standards of health and habitability established by the Bureau, whether maintained by the Federal Government or otherwise and whether within or without the judicial district in which the person was convicted, that the Bureau determines to be appropriate and suitable, considering--

- (1) the resources of the facility contemplated;
- (2) the nature and circumstances of the offense;
- (3) the history and characteristics of the prisoner;
- (4) any statement by the court that imposed the sentence--
 - (A) concerning the purposes for which the sentence to imprisonment was determined to be warranted; or
 - (B) recommending a type of penal or correctional facility as appropriate; and
- (5) any pertinent policy statement issued by the Sentencing Commission pursuant to section 994(a)(2) of title 28.

In designating the place of imprisonment or making transfers under this subsection, there shall be no favoritism given to prisoners of high social or economic status. The Bureau may at any time, having regard for the same matters, direct the transfer of a prisoner from one penal or correctional facility to another. The Bureau shall make available appropriate substance abuse treatment for each prisoner the Bureau

determines has a treatable condition of substance addiction or abuse. Any order, recommendation, or request by a sentencing court that a convicted person serve a term of imprisonment in a community corrections facility shall have no binding effect on the authority of the Bureau under this section to determine or change the place of imprisonment of that person. Notwithstanding any other provision of law, a designation of a place of imprisonment under this subsection is not reviewable by any court.

* * *

18 U.S.C. § 3625**§ 3625. Inapplicability of the Administrative Procedure Act**

The provisions of sections 554 and 555 and 701 through 706 of title 5, United States Code, do not apply to the making of any determination, decision, or order under this subchapter.

18 U.S.C. § 3626(a)(1)-(2)**§ 3626. Appropriate remedies with respect to prison conditions****(a) Requirements for relief.--****(1) Prospective relief.—**

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

(B) The court shall not order any prospective relief that requires or permits a government official to exceed his or her authority under State or local law or otherwise violates State or local law, unless--

(i) Federal law requires such relief to be ordered in violation of State or local law;

(ii) the relief is necessary to correct the violation of a Federal right; and

(iii) no other relief will correct the violation of the Federal right.

(C) Nothing in this section shall be construed to authorize the courts, in exercising their remedial powers, to order the construction of prisons or the raising of taxes, or to repeal or detract from otherwise applicable limitations on the remedial powers of the courts.

(2) Preliminary injunctive relief.--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 caused by the preliminary relief and shall respect the principles of comity set out in paragraph (1)(B) in tailoring any preliminary relief. Preliminary injunctive relief shall automatically expire on the date that is 90 days

after its entry, unless the court makes the findings required under subsection (a)(1) for the entry of prospective relief and makes the order final before the expiration of the 90-day period.

* * *

5 U.S.C. § 553**§ 553. Rule making**

- (a) This section applies, according to the provisions thereof, except to the extent that there is involved--
- (1) a military or foreign affairs function of the United States; or
 - (2) a matter relating to agency management or personnel or to public property, loans, grants, benefits, or contracts.
- (b) General notice of proposed rule making shall be published in the Federal Register, unless persons subject thereto are named and either personally served or otherwise have actual notice thereof in accordance with law. The notice shall include--
- (1) a statement of the time, place, and nature of public rule making proceedings;
 - (2) reference to the legal authority under which the rule is proposed;
 - (3) either the terms or substance of the proposed rule or a description of the subjects and issues involved; and
 - (4) the Internet address of a summary of not more than 100 words in length of the proposed rule, in plain language, that shall be posted on the Internet website under section 206(d) of the E-Government Act of 2002 (44 U.S.C. 3501 note) (commonly known as regulations.gov).

Except when notice or hearing is required by statute, this subsection does not apply--

- (A) to interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice; or
 - (B) when the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rules issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest.
- (c) After notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments with or without opportunity for oral presentation. After consideration of the relevant matter presented, the agency shall incorporate in the rules adopted a

concise general statement of their basis and purpose. When rules are required by statute to be made on the record after opportunity for an agency hearing, sections 556 and 557 of this title apply instead of this subsection.

- (d)** The required publication or service of a substantive rule shall be made not less than 30 days before its effective date, except--

 - (1)** a substantive rule which grants or recognizes an exemption or relieves a restriction;
 - (2)** interpretative rules and statements of policy; or
 - (3)** as otherwise provided by the agency for good cause found and published with the rule.
- (e)** Each agency shall give an interested person the right to petition for the issuance, amendment, or repeal of a rule.

5 U.S.C. § 706**§ 706. Scope of review**

To the extent necessary to decision and when presented, the reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action. The reviewing court shall--

- (1)** compel agency action unlawfully withheld or unreasonably delayed; and
- (2)** hold unlawful and set aside agency action, findings, and conclusions found to be--
 - (A)** arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;
 - (B)** contrary to constitutional right, power, privilege, or immunity;
 - (C)** in excess of statutory jurisdiction, authority, or limitations, or short of statutory right;
 - (D)** without observance of procedure required by law;
 - (E)** unsupported by substantial evidence in a case subject to sections 556 and 557 of this title or otherwise reviewed on the record of an agency hearing provided by statute; or
 - (F)** unwarranted by the facts to the extent that the facts are subject to trial de novo by the reviewing court.

In making the foregoing determinations, the court shall review the whole record or those parts of it cited by a party, and due account shall be taken of the rule of prejudicial error

42 U.S.C. § 1997e(a)**§ 1997e. Suits by prisoners****(a) Applicability of administrative remedies**

No action shall be brought with respect to prison conditions under section 1983 of this title, or any other Federal law, by a prisoner confined in any jail, prison, or other correctional facility until such administrative remedies as are available are exhausted.

* * *

28 C.F.R. § 115.41**§ 115.41 Screening for risk of victimization and abusiveness.**

- (a) All inmates shall be assessed during an intake screening and upon transfer to another facility for their risk of being sexually abused by other inmates or sexually abusive toward other inmates.
- (b) Intake screening shall ordinarily take place within 72 hours of arrival at the facility.
- (c) Such assessments shall be conducted using an objective screening instrument.
- (d) The intake screening shall consider, at a minimum, the following criteria to assess inmates for risk of sexual victimization:
 - (1) Whether the inmate has a mental, physical, or developmental disability;
 - (2) The age of the inmate;
 - (3) The physical build of the inmate;
 - (4) Whether the inmate has previously been incarcerated;
 - (5) Whether the inmate's criminal history is exclusively nonviolent;
 - (6) Whether the inmate has prior convictions for sex offenses against an adult or child;
 - (7) Whether the inmate is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming;
 - (8) Whether the inmate has previously experienced sexual victimization;
 - (9) The inmate's own perception of vulnerability; and
 - (10) Whether the inmate is detained solely for civil immigration purposes.
- (e) The initial screening shall consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the agency, in assessing inmates for risk of being sexually abusive.
- (f) Within a set time period, not to exceed 30 days from the inmate's arrival at the facility, the facility will reassess the inmate's risk of victimization

- or abusiveness based upon any additional, relevant information received by the facility since the intake screening.
- (g) An inmate's risk level shall be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the inmate's risk of sexual victimization or abusiveness.
 - (h) Inmates may not be disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section.
 - (i) The agency shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the inmate's detriment by staff or other inmates.

28 C.F.R. § 115.42**§ 115.42 Use of screening information.**

- (a) The agency shall use information from the risk screening required by § 115.41 to inform housing, bed, work, education, and program assignments with the goal of keeping separate those inmates at high risk of being sexually victimized from those at high risk of being sexually abusive.
- (b) The agency shall make individualized determinations about how to ensure the safety of each inmate.
- (c) In deciding whether to assign a transgender or intersex inmate to a facility for male or female inmates, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the inmate's health and safety, and whether the placement would present management or security problems.
- (d) Placement and programming assignments for each transgender or intersex inmate shall be reassessed at least twice each year to review any threats to safety experienced by the inmate.
- (e) A transgender or intersex inmate's own views with respect to his or her own safety shall be given serious consideration.
- (f) Transgender and intersex inmates shall be given the opportunity to shower separately from other inmates.
- (g) The agency shall not place lesbian, gay, bisexual, transgender, or intersex inmates in dedicated facilities, units, or wings solely on the basis of such identification or status, unless such placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such inmates.

[Oral Argument Not Yet Scheduled]

Nos. 25-5099, 25-5101, 25-5108 (consol.)

**IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT**

JANE DOE, et al.; JANE JONES, et al.; MARIA MOE,

Plaintiffs-Appellees,

v.

PAMELA BONDI, in her official capacity as Attorney General of the United States, et al.;

DONALD J. TRUMP, in his official capacity as President of the United States, et al.,

Defendants-Appellants.

On Appeal from the United States District Court for the District of Columbia

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CERTIFICATE OF PARTIES, RULINGS, AND RELATED CASES

Pursuant to D.C. Circuit Rule 28(a)(1), undersigned counsel certifies as follows:

A. Parties and Amici

Plaintiffs in district court, and appellees here, are nineteen people in the custody of the Federal Bureau of Prisons. With the permission of the district court, Plaintiffs-Appellees are proceeding pseudonymously in this litigation. *Jones v. Bondi*, Dkt Nos. 14, 47; *Doe v. Bondi*, Dkt. 7; *Moe v. Trump*, Dkts. 7, 67. Their pseudonyms are Jane Doe, Mary Doe, Sara Doe, Emily Doe, Zoe Doe, Tori Doe, Olivia Doe, Susan Doe, Lois Doe, Sally Doe, Wendy Doe, Rachel Doe, Ellen Doe, Jane Jones, Amy Jones, Barbara Jones, Carla Jones, Donna Jones, and Maria Moe.¹

Defendants in district court, and appellants here, are Donald J. Trump, in his official capacity as President of the United States; Pamela Bondi, in her official capacity as Attorney General of the United States; and William K. Marshall III, in his official capacity as Director of the Federal Bureau of Prisons.² Defendant Donald J. Trump is only a party in *Moe v. Trump*. There were no additional parties

¹ Plaintiff Sophia Doe voluntarily dismissed her claims on May 12, 2025. *Doe v. Bondi*, ECF No. 80.

² This action was originally brought against Defendant James R. McHenry, III, in his official capacity as Acting Attorney General of the United States, and William Lothrop, in his official capacity as Acting Director of the Federal Bureau of Prisons. Attorney General Bondi and Director Marshall were automatically substituted as parties under Federal Rule of Civil Procedure 25(d) and Federal Rule of Appellate Procedure 43(c)(2).

and no *amici curiae* in the district court. One *amicus curiae* brief was filed on May 16, 2025, by Idaho, Indiana, 23 other states, and the Arizona Legislature in support of Appellants. Dkt. No. 2116284.

B. Rulings Under Review

The Honorable Royce C. Lamberth issued initial orders granting Plaintiffs' motions for preliminary injunctions on February 18, February 24, and March 19, 2025, in *Doe v. Bondi* (Dkt Nos. 44, 55, 68); March 10, 2025, in *Moe v. Trump* (Dkt. No. 62); and February 24 and March 3, 2025, in *Jones v. Bondi* (Dkt Nos. 28, 46). Some of the orders are available at *Doe v. Bondi*, No. 1:25-cv-286, 2025 WL 596653 (D.D.C. Feb. 24, 2025); *Doe v. McHenry*, No. 1:25-cv-286, 2025 WL 596651 (D.D.C. Feb. 18, 2025); *Jones v. Bondi*, No. 1:25-cv-401, 2025 WL 923117 (D.D.C. Feb. 24, 2025); and *Jones v. Bondi*, No. 1:25-cv-401, 2025 WL 923755 (D.D.C. Mar. 3, 2025). *See also* JA168–69 (*Doe* Feb. 18 Order), JA185–88 (*Doe* Feb. 24 Order), JA240–43 (*Doe* Mar. 19 Order), JA333–34 (*Jones* Feb. 24 Order), JA445–49 (*Jones* Mar. 3 Order), and JA569–71 (*Moe* Mar. 10 Order). The district court issued renewed preliminary injunctions in all three cases on May 15, and May 22, 2025. *See* JA954–62.

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C. Related Cases

This case has not previously been before this Court. There is one related case for purposes of D.C. Circuit Rule 28(a)(1)(C): *Kingdom v. Trump*, No. 1:25-cv-00691-RCL (D.D.C.).

/s/ Kara Janssen

Kara Janssen

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GLOSSARY

APA	Administrative Procedure Act
BJS	Bureau of Justice Statistics
BOP	Federal Bureau of Prisons
EO	Executive Order
JA	Joint Appendix
PI	Preliminary Injunction
PLRA	Prison Litigation Reform Act
PREA	Prison Rape Elimination Act
SHU	Segregated Housing Unit
TEC	Transgender Executive Council
TRO	Temporary Restraining Order

INTRODUCTION

This case concerns nineteen transgender women whom the Federal Bureau of Prisons (“BOP”) previously determined, after individualized assessments, should be housed in women's facilities for their safety and security. The district court did not abuse its discretion by ordering the Government to maintain Plaintiffs’ housing status while their claims proceed.

These women are a very small subset—less than one percent—of all transgender individuals in BOP custody, and they were placed in women’s facilities due to their unique vulnerabilities. All have undergone extensive medical treatment to transition and live as women. Some have only ever been housed in women’s facilities due to their obvious vulnerability to sexual violence. Others were sexually assaulted when previously held in men’s prisons. All were placed in women's facilities based on BOP's careful evaluation of regulatory factors designed to protect vulnerable prisoners from violence.

That changed when President Trump issued Executive Order 14168 (“EO 14168” or “the Executive Order”) on January 20, 2025. The Executive Order requires BOP to transfer these women to men's prisons regardless of their individual circumstances. BOP concedes it has no discretion to consider the Plaintiffs’ safety or its own prior determinations when following this mandate. The Executive Order strips away individualized protections that took nearly a

decade to develop under the Prison Rape Elimination Act (“PREA”), replacing them with a categorical mandate that ignores the serious risks these particular women face.

The court’s preliminary injunctions were amply supported by Plaintiffs’ evidence of the violence and self-harm they are likely to suffer if transferred from women’s prisons. Plaintiffs are likely to succeed in showing that the categorical transfer policy mandated by the Executive Order violates their Eighth Amendment rights, and violates the Administrative Procedure Act by discarding duly promulgated PREA regulations without notice and comment, and by failing to provide any reasoned justification for the policy.

The preliminary injunctions should be affirmed. They preserve the housing arrangements that BOP itself determined were necessary to ensure these women's safety, pending resolution of Plaintiffs' constitutional and statutory claims.

JURISDICTIONAL STATEMENT

Plaintiffs invoked the district court’s jurisdiction under 28 U.S.C. §§ 1331, 2201, and 2202. JA201–02; JA340; JA461. The district court issued initial orders granting Plaintiffs’ motions for preliminary injunctions in February 2025, and the district court issued renewed preliminary injunctions on May 15, and May 22, 2025. JA954–62. The Government filed timely notices of appeal of those preliminary injunction orders, and this Court consolidated its appeals on June 12,

2025. This Court has jurisdiction under 28 U.S.C. § 1292(a)(1).

STATEMENT OF THE ISSUES

Did the district court abuse its discretion in finding that, based on their individual histories and circumstances, the evidence showed that these individual Plaintiffs would likely face a substantial risk of serious harm if they are transferred from women's facilities and that prison officials likely knew of and disregarded that risk?

Are Plaintiffs likely to succeed in showing that Defendants' adoption and implementation of the challenged EO violates the Administrative Procedure Act ("APA") because it directly conflicts with binding PREA regulations, was adopted and issued without notice and comment, lacks a reasoned explanation, and/or is arbitrary and capricious?

Did the district court abuse its discretion in finding that Plaintiffs are at immediate risk of irreparable harm and that the balance of equities and public interest weigh in favor of preliminary relief?

PERTINENT STATUTES AND REGULATIONS

Pertinent statutes and regulations are reproduced in the addendum to this brief.

STATEMENT OF THE CASE

I. Plaintiffs Are a Uniquely Situated Small Group of Transgender Women in BOP Custody Who Have Spent Extended Time (for Some, Their Entire Incarceration) Living in Women’s Facilities.

Plaintiffs³ are a uniquely situated group of transgender women⁴ incarcerated in BOP women’s facilities who have undergone extensive medical treatment to transition and live as women and are regarded as women by the facilities in which they reside. Every Plaintiff has been designated and placed in women’s housing by BOP. All Plaintiffs receive ongoing female hormone treatments from BOP. *See, e.g.*, JA645 ¶ 3; JA739–40 ¶¶ 4, 8; JA814 ¶ 3; JA903–05 ¶¶ 4–10. Some have been on hormones for decades, and many began hormone treatment long before their incarceration. *See, e.g.*, JA920, 969 ¶ 2. Many have also undergone surgical procedures as part of their transitions, including [REDACTED] [REDACTED]. *See, e.g.*, JA286, 740 ¶ 5; JA232, 703 ¶ 6; JA916, 965 ¶ 8; JA947, 996 ¶ 5; JA951, 1000 ¶ 3. They are referred to as women; most have legally changed their names or gender markers on official records and

³ Plaintiffs—assuming pseudonyms to protect their identities—are Jane, Mary, Sara, Emily, Zoe, Tori, Olivia, Susan, Lois, Sally, Wendy, Rachel, and Ellen Doe, *see* JA189; Jane, Amy, Barbara, Carla, and Donna Jones, *see* JA335; and Maria Moe, *see* JA490. Plaintiff Sophia Doe voluntarily dismissed her claims on May 12, 2025. *Doe v. Bondi*, ECF No. 80.

⁴ Plaintiffs use the term “transgender women” to describe themselves, which is consistent with the approach of the United States Supreme Court. *See United States v. Skrametti*, 145 S. Ct. 1816, 1830 n.2 (2025).

documents. *See, e.g.*, JA286, 740 ¶ 6; JA375, 809 ¶ 18; JA947, 996 ¶ 6; JA951, 1000 ¶ 3.

After individualized assessments of their health and safety risks, BOP assigned Plaintiffs to women's facilities, where they have consistently resided for long periods of time. *See, e.g.*, JA916, 965 ¶ 6 (Zoe Doe has been housed in women's prisons since [REDACTED]); JA385, 819 ¶ 10; JA943, 992 ¶ 6; JA947–48, 996–97 ¶ 6; JA951, 1000 ¶ 3 (Donna Jones, Wendy, Sara, and Mary Doe have been housed in women's prisons since [REDACTED]). Prior to EO 14168, Maria Moe, Jane Jones, Rachel Doe, Wendy Doe, and Sara Doe had only ever been housed with women. *See* JA233, 704 ¶ 7; JA286, 740 ¶¶ 8–10; JA492–93, 904–05 ¶¶ 7–9; JA947–48, 996–97 ¶ 6; JA951, 1000 ¶ 3.

BOP is aware that each Plaintiff has been diagnosed with gender dysphoria, which the agency has recognized as “a mental health diagnosis currently defined by DSM-5” that is “manifested by a stated desire to be the opposite sex and persistent discomfort with [one's] biologically assigned sex.” JA121. Gender dysphoria is a “serious medical condition” that is highly treatable through “transition, which enables a transgender person to live in a sex other than their birth sex, and hormone therapy to feminize or masculinize the body.” JA181–82 ¶¶ 3–4; *see also* JA17, 578 ¶ 6; JA92 ¶ 5. Treatment may also include “various surgeries.” JA182 ¶ 4. “[T]here are no alternative treatments for effectively

managing gender dysphoria.” *Id.* ¶ 6. Failure to treat gender dysphoria, or cessation of treatment, “constitutes a serious medical risk that can severely impact both physical and mental health,” including “[i]ncreased risk of suicidal ideation due to intensified gender dysphoria.” JA93 ¶ 10; *see also* JA95 ¶ 19 (“The medical community is well aware that the consequences of denying this care are predictable and dire.”). Based on their individual treatment histories, the district court found that transferring Plaintiffs from women’s prisons would exacerbate their gender dysphoria. JA186–87.⁵

II. Pursuant to BOP Policies and PREA Regulations, BOP Placed Plaintiffs in Women’s Facilities for Safety and Security Reasons.

PREA’s implementing regulations require BOP to conduct individualized assessments when housing transgender people, including whether to place them in women’s facilities. *See* 28 C.F.R. § 115.42. Under PREA, BOP must consider a variety of factors, including whether the individual has previously experienced sexual victimization and the individual’s perception of their own vulnerability, *id.* § 115.41(d)(8)–(9), and must use this information to make housing assignments based on “individualized determinations about how to ensure the safety of each

⁵ The district court explained that transferring these individuals from women’s prisons would exacerbate their gender dysphoria “because they will be subject to searches by male correctional officers, made to shower in the company of men, referred to as men, forced to dress as men, or simply because the mere homogenous presence of men will cause uncomfortable dissonance.” JA187 n.2.

inmate.” *Id.* § 115.42(a)–(b). The PREA regulations explicitly authorize housing transgender women in women’s facilities when doing so promotes safety and security. *Id.* § 115.42(c).

Until January 20, 2025, BOP used the “Transgender Executive Council” (“TEC”) to implement these PREA regulations and oversee facility designations. JA123–25. The TEC considered “an inmate’s security level, criminal and behavioral/disciplinary history, current gender expression, programming, medical, and mental health needs/information, vulnerability to sexual victimization, and likelihood of perpetrating abuse.” JA125. Since the Executive Order, BOP has disbanded the TEC and rescinded its policies implementing PREA’s individualized assessment requirements for housing transgender persons. *See* Appellants’ Opening Br. (“AOB”) at 9.

The district court made specific factual findings that “BOP determined that considering all statutorily and constitutionally required factors, a women’s facility was the appropriate facility” for these Plaintiffs. JA186. As the district court explained, BOP “is subjectively aware that transferring the plaintiffs to a male penitentiary would substantially increase the likelihood of them experiencing [a] parade of harms,” including “significantly elevated risk of physical and sexual violence,” and the exacerbation of “symptoms of their gender dysphoria.” JA164–65. BOP’s assessment under its prior policy that these Plaintiffs should be housed

in women's facilities reflects its awareness not only of the high risk of sexual violence for incarcerated transgender people in general,⁶ but that Plaintiffs' individual circumstances make this risk particularly acute. *Id.*

These safety concerns are not hypothetical. As detailed in their declarations, nearly all of the Plaintiffs who were previously housed in men's facilities were sexually assaulted when they were there, which ultimately resulted in their transfers to women's prisons to ensure their safety. *See, e.g.*, JA85, 646 ¶¶ 7–8; JA374–75, 808–09 ¶¶ 12, 17; JA382, 816 ¶ 8; JA385, 819 ¶¶ 6, 10; JA921, 970 ¶¶ 4, 6–7. Zoe Doe was stalked by a man in the showers of a medium-security men's facility. JA916, 965 ¶ 5. Donna Jones was raped in a shower at a men's facility, before she was transferred to a women's facility. JA385, 819 ¶ 6. Jane Doe was subjected to [REDACTED] while in a men's facility and continues to suffer from [REDACTED] as a result. JA85, 646 ¶¶ 7–8. Amy Jones was violently sexually attacked by three men while in a men's facility. JA374, 808 ¶ 12. Carla Jones was sexually assaulted in three separate men's facilities. JA382, 816 ¶ 8. Olivia Doe was “brutally raped” in a

⁶ For example, a 2014 study by the Department of Justice estimated that nearly 35% of transgender people incarcerated in state and federal prisons were sexually victimized between 2007 and 2012. Bureau of Just. Stats., U.S. Dep't of Just., *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12: Supplemental Tables*, 2 tbl. 1 (2014), https://bjs.ojp.gov/content/pub/pdf/svpjri1112_st.pdf.

men's facility, resulting in "medical complications." JA921, 970 ¶ 4. Emily Doe was raped while in a men's facility, JA934, 983 ¶ 4, as was Mary Doe "multiple times." JA943, 992 ¶ 6. And outside of BOP custody, Lois Doe was "raped twice" in a men's state facility. JA939, 988 ¶ 6.

Two of these assaults occurred in minimum-security men's facilities. JA374, 808 ¶¶ 10, 12; JA382, 816 ¶ 13. BOP knew of the assaults. *E.g.*, JA85, 646 ¶ 7; JA385, 819 ¶ 10; JA921, 970 ¶ 4; JA943, 992 ¶ 6. Such pervasive sexual assault is precisely the type of harm that PREA and its regulations seek to prevent. *See* 34 U.S.C. § 30302 (describing the first purpose of PREA as establishing "a zero-tolerance standard for the incidence of prison rape"). In addition, multiple Plaintiffs previously experienced suicidal ideation or engaged in suicide attempts or self-harm while housed in men's prisons. *See* JA381, 815 ¶ 5; JA915, 964 ¶ 4; JA921, 970 ¶ 5; JA934–35, 983–84 ¶¶ 3, 12. The district court was "unconvinced by the Government's proffered statistics attempting to show that a low-security men's facility" would be safe for these Plaintiffs. JA187 n.2.⁷

In sum, BOP determined that Plaintiffs' unique health and safety risks necessitated their placement in women's facilities. As part of that determination, BOP was also required to consider whether the placements would raise any

⁷ In addition, if any Plaintiffs are transferred by BOP, nothing restrains Defendants from transferring them to a men's prison with a higher security designation.

“management and security problems” for BOP staff or the other women housed with Plaintiffs. 28 C.F.R. § 115.42(c). The Plaintiffs’ housing assignments were repeatedly reaffirmed during the reassessments BOP was required to conduct at least twice a year. *Id.* § 115.42(d). BOP only sought to transfer Plaintiffs from women’s facilities after the issuance of the Executive Order.

III. EO 14168 Contravenes the PREA Regulations’ Mandatory Individualized Assessments and Strips BOP of its Discretion over Safe Housing Placements and Medical Care.

On January 20, 2025, President Trump issued Executive Order 14168, *Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government*, 90 Fed. Reg. 8615 (Jan. 20, 2025). The Order stripped BOP of discretion over housing assignments for transgender people, consistent with this Administration’s open disapproval of transgender people and its stated intention to deny them any legal recognition or protection. In relevant part, the Order: (1) categorically bars transgender women from women’s prisons, regardless of individual safety considerations; and (2) prohibits BOP from providing “any medical procedure, treatment, or drug for the purpose of conforming an inmate’s appearance to that of the opposite sex.” 90 Fed. Reg. at 8616–17 ¶¶ 4(a), (c).

EO 14168 is part of a broader pattern of targeted discrimination against transgender people by this Administration, including reversing protections for

transgender people in schools, healthcare, military service, federal funding, shelters, and more.⁸ In addition, federal agencies have systematically removed information about transgender individuals from government websites,⁹ including deleting the word “transgender” every time it appeared in agency documents. Most recently, the administration removed a dedicated suicide hotline available to transgender youth callers.¹⁰ BOP, for its part, issued a policy formalizing implementation of the Executive Order. Fed. Bureau of Prisons, Memorandum for All Chief Executive Officers (Feb. 21, 2025), <https://storage.courtlistener.com/recap/gov.uscourts.dcd.278186/gov.uscourts.dcd.278186.1.1.pdf>. And it

⁸ See, e.g., Exec. Order No. 14190, 90 Fed. Reg. 8853 (Jan. 29, 2025) (schools); Exec. Order No. 14187, 90 Fed. Reg. 8771 (Jan. 28, 2025) (healthcare); Exec. Order No. 14183, 90 Fed. Reg. 8757 (Jan. 27, 2025) (military service); Exec. Order No. 14168, 90 Fed. Reg. 8615 (Jan. 20, 2025) (federal funding and shelters).

⁹ See Mem. in Opp. to Pls.’ Mot. for Preliminary Injunction, *Doctors for America v. OPM*, No. 1:25-cv-00322-JDB, 2025 WL 1357700 (D.D.C. Mar. 24, 2025) (stating that “under Executive Order 14168, webpages could no longer use the word ‘gender’ or contain language promoting gender ideology” and that “every” federal agency “promptly began to implement” the Order); see also, e.g., Nico Lang, *Trump Is Purging Federal Websites of LGBTQ+ Content. Here’s What’s Been Affected So Far*, Them, (Feb. 7, 2025), <https://www.them.us/story/trump-administration-federal-websites-lgbtq-content-deleted-cdc-doe-usaid>; Judd Legum & Rebecca Crosby, *The NSA’s ‘Big Delete’*, Popular Information (Feb. 10, 2025), https://popular.info/p/the-nsas-big-delete?utm_campaign=post&utm_medium=web.

¹⁰ Devi Shastri, *Trump Administration Removing 988 Hotline Service Tailored to LGBTQ+ Youth in July*, Associated Press (June 18, 2025), <https://apnews.com/article/988-lgbtq-suicide-prevention-hotline-trump-382342828b381b6a32964f09fe9aa59c>.

announced the “[c]ancellation” of the Transgender Offender Manual that specified the risks transgender people face and the actions agency staff should take to mitigate those risks. *See* Fed. Bureau of Prisons, Program Statement Cancellation of Statement No. 5200.08, Cancellation No. PSC04-2025 (Feb. 25, 2025); *see also* JA120 (stating objective of Transgender Offender Manual is “[t]o enhance staff’s understanding of the increased risk of suicide, mental health issues and victimization”).

IV. Pursuant to EO 14168 and in Direct Violation of PREA Regulations, BOP Decided to Transfer Plaintiffs from Women’s Prisons.

In response to EO 14168, BOP officials moved rapidly to transfer transgender women housed in women’s prisons to men’s prisons. While BOP claims it undertook an individualized review of “the inmates’ assigned security level, disciplinary record, medical record, and psychology record” in making transfer decisions, *see* JA174, BOP’s review was triggered solely by the challenged Executive Order and was done for the sole purpose of removing transgender women from women’s facilities regardless of whether doing so would put them at increased risk of sexual violence. *See* JA186 (district court finding that “the *only* change in circumstances from when the initial housing determination was made to now is Executive Order 14168”). The timing and speed of the transfers further undercuts BOP’s claim that these decisions were based on a considered, individualized review.

BOP transferred Plaintiffs Ellen Doe, Rachel Doe, and Jane Jones from women's to men's facilities.¹¹ JA230, 701 ¶ 7; JA233, 704 ¶ 11; JA287, 741 ¶ 14. Once there, all three experienced continuous sexual harassment from male prisoners; invasive strip searches from male BOP officers; lack of access to women's clothing, including undergarments; and reasonably feared that they would be targeted for sexual violence.¹²

Male BOP officers conducted strip searches of Ellen Doe and Rachel Doe after they were moved from women's to men's prisons, requiring them to bend over, squat, and lift their breasts. JA230, 701 ¶ 7; JA233, 704 ¶ 10. Rachel Doe [REDACTED], and before EO 14168 she had only ever been housed in women's facilities, [REDACTED]. JA232-33, 703–04 ¶¶ 6–7. At the men's facility to which BOP transferred her after the Order, Rachel Doe experienced daily sexual harassment. JA233–34, 704–05 ¶ 11. She was not allowed to wear a bra, which made her even more vulnerable. JA234, 705

¹¹ BOP informed other Plaintiffs of their pending transfer to men's facilities due to the EO, and, through counsel, Plaintiffs quickly filed their complaints and applications for emergency relief before BOP had an opportunity to make the transfers. *See, e.g.*, JA930, 979 ¶ 8. BOP staff told certain Plaintiffs that they could not challenge the transfers because the transfers were required under the Executive Order. *See* JA494, 906 ¶ 12; JA88, 649 ¶ 14.

¹² Ellen, Rachel, and Jane were eventually transferred back to their assigned women's facilities and were protected from future transfers under the district court's preliminary injunctions. JA240–43, 333–34.

¶ 15. Ellen Doe's [REDACTED]

[REDACTED]; she experienced constant sexual harassment at the facility. JA230, 701 ¶ 8.

Plaintiff Jane Jones was transferred from a minimum-security women's facility to a medium-security men's facility. JA286–87, 740–41 ¶¶ 9, 14. Jane Jones has a vagina, and before her transfer she had never been housed in a men's prison. JA740 ¶¶ 5, 8. Officials held her in the Segregated Housing Unit (“SHU”) at the men's facility for four days in solitary confinement. JA288, 742 ¶ 16. She was made to wear male undergarments, held in a small cell with no outside or recreational time, permitted extremely limited communication with family members, told by BOP that her supply of female hormone medication would not be renewed, and subjected to 24-hour surveillance by male guards, including while using the restroom. JA287–88, 741–42 ¶¶ 15–17.

V. Plaintiffs Obtained Preliminary Injunctions Protecting Them from Transfers from Women's Prisons and Loss of Medication.

Plaintiffs brought three separate actions against the Government alleging that BOP, following the commands of EO 14168, had transferred or was preparing to transfer Plaintiffs from women's facilities and end Plaintiffs' access to necessary medical care, in violation of the Eighth Amendment, the Fifth Amendment, the Rehabilitation Act of 1973, the Administrative Procedure Act, and separation of powers principles. *See* JA213–23, 356–67, 472–81.

Plaintiffs sought a declaratory judgment that Sections 4(a) and 4(c) of EO 14168 violate their constitutional and statutory rights, as well as a permanent injunction prohibiting the Government from enforcing those provisions of EO 14168 and requiring BOP to maintain Plaintiffs' preexisting housing and medical treatment. JA223, 367, 481. In all cases, Plaintiffs obtained temporary restraining orders (TROs) and preliminary injunctions (PIs) to enjoin enforcement of Sections 4(a) and 4(c) as to the named Plaintiffs. *E.g.*, JA157–67.

The TROs and PIs were all supported by factual findings about the serious harms Plaintiffs would face in men's facilities. The Government mischaracterizes the basis for the PIs. For example, it suggests that the district court granted the second PI in *Doe* and the second PI in *Jones* solely because BOP had found women's facilities "appropriate" for them and "only reassessed their housing due to EO 14168." *See* AOB at 18, 20. In fact, in its second *Doe* PI order, the district court also relied on findings that the *Doe* Plaintiffs would be subjected to a significantly elevated risk of sexual assault as well as a predictable worsening of gender dysphoria if transferred. JA186 (incorporating reasoning from first *Doe* order); JA187 n.2 (referring to risk of sexual assault and exacerbated gender dysphoria). The second *Jones* PI order also relied on those factual findings, as well as the fact that "the named Plaintiffs here were housed in men's facilities early in their incarceration, during which period they experienced numerous

unspeakable harms including multiple rapes, suicide attempts, and severe psychological distress.” JA446–47.

The Government filed notices of appeal in all cases, challenging only the portion of the preliminary injunctions related to the Plaintiffs’ housing. AOB at 5. This Court consolidated the cases for appeal. Order at 2, No. 25-5099 (Apr. 30, 2025). The district court then granted Plaintiffs’ requests to issue renewed preliminary injunctions in all cases with the Government’s non-opposition. JA954–62. The renewed injunctions will expire on August 23, 2025. JA955, 958, 961. The Government filed notices of appeal from the renewed injunctions, and this Court consolidated those appeals with the Government’s appeals from the initial injunctions.

STANDARD OF REVIEW

“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. NRDC*, 555 U.S. 7, 20 (2008). On appeal from a preliminary injunction, this Court reviews the district court’s “findings of fact under the ‘clearly erroneous’ standard,” *Serono Lab’ys, Inc. v. Shalala*, 158 F.3d 1313, 1318 (D.C. Cir. 1998), its “legal conclusions *de novo*,” and “its weighing of the four relevant factors for abuse of discretion.” *In re Fed.*

Bureau of Prisons' Execution Protocol Cases, 955 F.3d 106, 111–12 (D.C. Cir. 2020).

SUMMARY OF THE ARGUMENT

The district court properly granted preliminary injunctions to maintain the *status quo* and protect these uniquely situated Plaintiffs from sexual violence and other irreparable harm while this case proceeds.

Plaintiffs have demonstrated a strong likelihood of success on the merits of their Eighth Amendment claim. BOP previously conducted individualized assessments required by PREA and determined that these specific transgender women required placement in women's facilities for their safety and security. As the district court found, substantial evidence shows that these individuals are at risk of serious harm if transferred from women's to men's facilities. Defendants' disregard of these known risks is deliberate indifference.

Defendants' adoption of a new policy, replacing individualized determinations with a categorical rule that bars the placement of transgender women in a women's facility under any circumstances, also violates the APA. This new policy directly conflicts with existing PREA regulations, was adopted without the required notice and comment, and is arbitrary and capricious, as it reflects animus against transgender people and lacks any reasoned explanation.

The district court found that Plaintiffs face an imminent risk of irreparable

harm if transferred from women's facilities. The balance of equities and public interest favor Plaintiffs, as enforcement of an unconstitutional policy is never in the public interest, whereas Plaintiffs face serious irreparable harms including sexual violence and self-injury or suicide.

The Government's jurisdictional challenge fails. 18 U.S.C. § 3621(b) does not bar judicial review because Plaintiffs challenge a categorical policy mandated by Executive Order, not individual placement decisions under that statute.

Similarly, the Prison Litigation Reform Act ("PLRA") does not bar these claims because no administrative remedy was available. BOP lacked authority to provide relief from the Executive Order, and Plaintiffs faced immediate transfer without any opportunity to exhaust remedies.

The district court's preliminary injunctions are narrowly tailored, necessary to prevent irreparable harm, and contain adequate findings under the PLRA. The injunctions merely preserve the *status quo* by maintaining housing placements that BOP itself previously determined were appropriate for these specific individuals' safety and security.

ARGUMENT

I. PLAINTIFFS HAVE DEMONSTRATED A LIKELIHOOD OF SUCCESS ON THEIR CLAIMS.

A. The District Court Did Not Abuse its Discretion in Finding that Plaintiffs Are Likely to Succeed on the Merits of their Eighth Amendment Claim.

The U.S. Supreme Court made clear more than three decades ago that “prison officials have a duty ... to protect prisoners from violence at the hands of other prisoners.” *Farmer v. Brennan*, 511 U.S. 825, 833 (1994). “[D]eliberate indifference to serious medical needs of prisoners” violates the Eighth Amendment. *Estelle v. Gamble*, 429 U.S. 97, 104 (1976). To prove an Eighth Amendment claim, Plaintiffs must establish that the conditions of their incarceration “pos[ed] a substantial risk of serious harm” and that prison officials “kn[ew] of and disregard[ed] an excessive risk” to their “health or safety.” *Farmer*, 511 U.S. at 834, 837. The district court correctly found that Defendants’ decision to transfer Plaintiffs from women’s to men’s facilities—where Defendants know that Plaintiffs will face extremely high risks of physical and sexual violence, as well as excessive risks of self-harm and suicidality as a result of aggravated gender dysphoria—would likely violate the Eighth Amendment.

1. Plaintiffs Face Substantial Risks of Violence and Other Serious Harm If Transferred from Women’s Facilities.

To be clear, Plaintiffs do not argue that the Eighth Amendment requires every transgender woman to be housed in a women’s prison, nor did the district

court so find. Rather, as the district court found, the particular vulnerabilities of these women—the same vulnerabilities that led BOP to house them in women’s prisons in the first place—will result in predictable violence against them and a serious risk of self-harm if they are forced to live in men’s prisons. *See* JA164–65.

Every Plaintiff has been placed in women’s housing by BOP based on consideration of the relevant PREA factors. This distinguishes them both from other incarcerated transgender women and from men who may be vulnerable to sexual assault. If these Plaintiffs are transferred from women’s to men’s facilities, men in those facilities will know that BOP has transferred a woman to a men’s facility. As the district court found, this puts them at extremely high risk of sexual victimization.

BOP’s assessment that these Plaintiffs’ individual situations require placement in women’s facilities was well founded. Each has received extensive medical treatment in order to live as a woman. For all, this includes long-term hormone therapy. Some have had genital and other surgeries. Some have only ever been housed in women’s prisons. Many were previously sexually victimized in men’s facilities. This is an especially at-risk group, and all of these facts are known to BOP. That is why Plaintiffs are part of the small, unique group of transgender women whom BOP placed in women’s facilities.

Plaintiffs presented extensive evidence to the district court that they would

be at substantial risk of serious harm if BOP is permitted to move them from women's prisons. All Plaintiffs would be at an excessive and obvious increased risk of sexual assault in men's prisons because they have been classified and housed as women and have undergone significant medical treatment; many are outwardly indistinguishable from non-transgender women.¹³ *See supra* at 4–5. As set forth above, several Plaintiffs have had genital surgeries, and all receive female hormone therapy, which causes breasts to develop. *See supra* at 4.

Nearly all of the Plaintiffs who were previously housed in men's prisons were assaulted there (some multiple times), and they only escaped sexual violence when they were placed in women's prisons by the BOP. Olivia Doe was “brutally raped” in a men's facility; Amy Jones was violently attacked by two male prisoners; Donna Jones was raped in the shower; Jane Doe suffered [REDACTED]; [REDACTED]; Carla Jones was sexually assaulted in three separate men's facilities; Emily Doe was raped; Mary Doe was “raped multiple times.” *See supra* at 8–9. Others have a history of serious self-harm and suicidality when housed in men's facilities, as that placement caused their gender dysphoria symptoms to worsen. *See, e.g.*, JA815 ¶ 5; JA934 ¶ 3.

¹³ *Cf. Pichardo De Veloz v. Miami-Dade Cty.*, 756 F. App'x 869, 877 (11th Cir. 2018) (finding that housing a woman among men “poses an outrageous risk that she will be harassed, assaulted, raped, or even murdered”).

Plaintiffs' visible female characteristics, histories of sexual assault, and prior self-harm in men's facilities mark them as especially vulnerable members of a population that is already uniquely vulnerable to physical and sexual violence in men's facilities. *See, e.g.*, JA703 ¶ 6; JA808 ¶ 15; JA819 ¶ 6; *see also* Bureau of Just. Stats., U.S. Dep't of Just., *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12: Supplemental Tables*, 2 tbl. 1 (2014) (showing that from 2011 to 2012, 39.9% of transgender prisoners had experienced sexual violence in the past 12 months alone).¹⁴ When BOP undertook its individualized assessment of Plaintiffs pursuant to PREA, it determined that these nineteen highly vulnerable transgender women should each be assigned to a women's facility. BOP was required to reassess Plaintiffs' housing placements at least every six months thereafter, 28 C.F.R. § 115.42(d), and it opted to keep each Plaintiff in women's

¹⁴ The Supreme Court, federal courts of appeals, and federal district courts throughout the country have also recognized that transgender women face a high risk of sexual assault and abuse in men's prisons. *See, e.g.*, *Farmer*, 511 U.S. at 848-49; *Williams v. Kincaid*, 45 F.4th 759, 778–79 & n.11 (4th Cir. 2022); *Powell v. Schriver*, 175 F.3d 107, 115 (2d Cir. 1999); *Tay v. Dennison*, 457 F. Supp. 3d 657, 684 (S.D. Ill. 2020); *Doe v. District of Columbia*, 215 F. Supp. 3d 62, 77 (D.D.C. 2016); *Zollicoffer v. Livingston*, 169 F. Supp. 3d 687, 691, 696 (S.D. Tex. 2016); *Gilliam v. Dep't of Pub. Safety & Corr. Servs.*, No. MJM-23-1047, 2024 WL 5186706, at *12–13 (D. Md. Dec. 20, 2024); *Finnegan v. Kink*, No. 3:20-cv-00218-GCS, 2024 WL 1345632, at *11 (S.D. Ill. Mar. 29, 2024); *Doe v. Wash. State Dep't of Corr.*, No. 4:21-CV-5059-TOR, 2021 WL 2453099, at *5 (E.D. Wash. May 17, 2021); *Lojan v. Crumbsie*, No. 12-CV-0320 (LAP), 2013 WL 411356, at *4 (S.D.N.Y. Feb. 1, 2013).

facilities until the issuance of EO 14168.

The harms Plaintiffs face if removed from women's prisons are "sufficiently serious" to meet the objective element of the Eighth Amendment. *Farmer*, 511 U.S. at 834. As the Supreme Court has explained, "[b]eing violently assaulted in prison is simply not 'part of the penalty that criminal offenders pay for their offenses against society.'" *Id.* (quoting *Rhodes v. Chapman*, 452 U.S. 337, 347 (1981)). Federal courts of appeals have held that suicide and self-harm are also sufficiently serious to satisfy the Eighth Amendment's objective element. *See, e.g., Cope v. Cogdill*, 3 F.4th 198, 206 (5th Cir. 2021); *Comstock v. McCrary*, 273 F.3d 693, 703-04 (6th Cir. 2001); *Est. of Miller ex rel. Bertram v. Tobiasz*, 680 F.3d 984, 989 (7th Cir. 2012); *Disability Rts. Mont., Inc. v. Batista*, 930 F.3d 1090, 1098 (9th Cir. 2019); *Est. of Burgaz ex rel. Zommer v. Bd. of Cnty. Comm'rs*, 30 F.4th 1181, 1186 (10th Cir. 2022).

The district court did not clearly err in finding, based on the record in this case, that Plaintiffs, transgender women previously individually assessed and placed in women's facilities, were likely to succeed in showing that they would be exposed to a substantial risk of serious harm if transferred to men's prisons. This is especially true given the paucity of the evidence submitted by the Government. Instead of addressing Plaintiffs' individual circumstances, the Government's evidence consisted mainly of generalized statistics about overall rates of assault in

women's BOP facilities compared to rates of assault in men's BOP facilities. *See, e.g.,* JA658–59 ¶¶ 19–23; *see also* AOB at 36–39 (reiterating this evidence). But as the district court rightly found, the Government's "statistics do not disaggregate assaults against transgender inmates from overall rates of assault" and "are still consistent with the 'numerous government reports and regulations recognizing that transgender persons are at significantly elevated risk of physical and sexual violence,'" JA187, as well as the record evidence that Plaintiffs' individual circumstances make them even more vulnerable. The district court did not clearly err by concluding that it was "unconvinced by the Government's proffered statistics." *Id.*

Nor can the Government "minimize any risk to plaintiffs by, among other things, transferring them to low-security institutions with non-violent offenders." AOB at 49–50. The Government again ignores the specific risks these transgender women would face in men's facilities given their prior classification as women and their housing in women's facilities, medical histories, and past experiences of sexual assault in men's facilities. As described above, multiple Plaintiffs have been assaulted by men in minimum-security men's facilities, and others faced pervasive sexual harassment in low-security men's prisons. *See supra* at 9, 13. In addition, if reclassified and transferred, nothing restricts BOP from moving any Plaintiff to a men's facility with a different security designation.

The Government also did not contest Plaintiffs’ evidence that “forcing a transgender woman to reside in a men’s facility ... will predictably worsen gender dysphoria and cause severe psychological distress,” and that this harm will be especially acute for individuals who have “lived in a sex different than their birth sex for a significant amount of time, including through use of medications and surgeries.” JA313, 753 ¶ 5; *accord*, e.g., JA86 ¶ 12; JA382 ¶ 14; JA922 ¶¶ 8, 10; JA935 ¶ 12 (Plaintiffs’ declarations attesting to their fears that their gender dysphoria will worsen). The district court therefore did not clearly err when it found that “placement in a male penitentiary *by itself* will exacerbate the symptoms of [Plaintiffs’] gender dysphoria.” JA187. Plaintiffs’ histories of self-injury, self-surgery, and suicidal ideation in men’s prisons show that this worsening gender dysphoria would put them at significant risk of harm. *See*, e.g., JA815 ¶ 5.¹⁵

2. Defendants Knew of and Disregarded These Substantial Risks.

The district court also did not clearly err in finding that the Government knew of and disregarded these substantial risks when it decided to transfer Plaintiffs to men’s prisons regardless of their individual vulnerabilities. As the

¹⁵ Defendants suggest Plaintiffs did not assert these harms below. AOB at 40. But Plaintiffs set forth and relied on these harms in their initial and amended complaint, e.g., JA191 ¶ 5; JA259 ¶ 7, in declarations by Plaintiffs and experts, e.g., JA86 ¶ 12; JA753 ¶ 5, and in multiple rounds of briefing, e.g., *Doe v. Bondi*, ECF No. 50-1 at 6; *Jones v. Trump*, ECF No. 21-1 at 6; *Moe v. Bondi*, ECF No. 31-1 at 4.

district court found, the Government did not “dispute the plaintiffs’ allegations that BOP is subjectively aware that transferring the plaintiffs to a male penitentiary would substantially increase the likelihood of them experiencing [a] parade of harms” including sexual assault and worsening gender dysphoria. JA165. The Government has never claimed that BOP is unaware of any of the salient facts about Plaintiffs’ histories of assault and abuse in men’s prisons, their surgical and medical treatment, or the other evidence that shows Plaintiffs’ likelihood of serious harm if transferred to men’s facilities.

Indeed, in previously deciding that Plaintiffs needed to be housed in women’s facilities, BOP determined that placement in a women’s facility “would ensure [their] health and safety.” 28 C.F.R. § 115.42(c). BOP is also obligated by PREA regulations to consider Plaintiffs’ specific vulnerabilities and previous experiences of sexual victimization. *Id.* § 115.41(d)(1)–(9). BOP’s determinations that Plaintiffs were among the 1% of transgender women who should be housed in women’s facilities shows that BOP was aware of the risks Plaintiffs would face in men’s prisons.

Moreover, BOP’s own statistics show that Plaintiffs are uniquely at risk within an already high-risk population. The most recently available government-collected data shows that transgender incarcerated people experience about 10 times the rate of sexual victimization compared to the general population. Bureau

of Just. Stats., U.S. Dep't of Just., *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12: Supplemental Tables*, at 2 tbl. 1 (2014), https://bjs.ojp.gov/content/pub/pdf/svpjri1112_st.pdf (showing sexual victimization rates for transgender incarcerated people at 39.9% from 2011 to 2012); Bureau of Just. Stats., U.S. Dep't of Just., *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12*, at 6 (2014) (estimating sexual victimization rates for the general prison population at 4.0% during the same period). “The vulnerability of transgender prisoners to sexual abuse is no secret.” *Zollicoffer*, 169 F. Supp. 3d at 691. The heightened risk transgender women face in men’s prisons is widely acknowledged by federal courts. *See supra* n.14.

The Government argues it did not act with deliberate indifference because BOP considered the risks to Plaintiffs when it decided *which* men’s prison it would transfer them to. AOB at 42–43. But the Government’s choice not to place Plaintiffs in the most dangerous men’s prisons does not cure its deliberate indifference. *Cf. Hudson v. McMillian*, 503 U.S. 1, 9 (1992) (holding that the Eighth Amendment does not require further proof of “some arbitrary quantity of injury” once elements of violation are established).

The Government also argues that its prior placement of Plaintiffs in women’s facilities was “not based solely on safety considerations.” AOB at 46. But the Government does not dispute that it assessed Plaintiffs’ “vulnerability to

sexual victimization” and their medical and mental health needs when it decided that *these* individuals needed to be housed in women’s prisons. *See id.* Those assessments put BOP on notice of Plaintiffs’ specific histories and vulnerabilities to serious harm in men’s facilities, including the fact that many Plaintiffs have been physically and sexually assaulted in men’s facilities before. *See* 28 C.F.R. §§ 115.41(d), 115.42(c) (requiring BOP to consider past experiences of “sexual victimization” in determining housing placements and to “ensure” a transgender person’s “health and safety” in determining whether to place them in a men’s or women’s facility); *see also id.* § 115.42(e) (requiring BOP to give “serious consideration” to a transgender person’s “own views with respect to his or her safety” in determining housing placements). The Government’s *post hoc* claim that it also considered other information does not erase BOP’s knowledge that Plaintiffs would be at excessive risk of harm in men’s prisons.

Finally, the Government claims that the deliberate indifference cases Plaintiffs cited below are inapposite because “[i]n each case, the court found that additional, case-specific factors heightened the risk of assault.” AOB at 45. The Government misunderstands Plaintiffs’ claim, as demonstrated by its attempt to distinguish Plaintiffs’ cases.

Plaintiffs have never argued, and the district court has not concluded, that all transgender women must be housed in women’s prisons to comply with the Eighth

Amendment. Instead, there are “additional, case-specific factors” showing that Plaintiffs—the tiny group of transgender women whom BOP previously determined needed to be housed in women’s facilities—would be at heightened risk of assault and self-harm if placed in men’s prisons. *Id.* These factors include Plaintiffs’ history of victimization—as in *Zollicoffer*, 169 F. Supp. 3d at 689–90 and *Stover v. Corrs. Corp. of Am.*, No. 12-cv-393, 2015 WL 874288, at *7 (D. Idaho Feb. 27, 2015)—and their medical treatment that has caused them to develop female sex characteristics—as in *Doe*, 215 F. Supp. 3d at 65 and *Lojan*, 2013 WL 411356, at *1, 4. The Government knows of the specific, serious risks Plaintiffs would face in men’s prisons and has chosen to disregard those risks to comply with the Executive Order. Nothing more is required to prove Plaintiffs’ Eighth Amendment claim. *Farmer*, 511 U.S. at 837.¹⁶

B. Plaintiffs Are Also Likely to Prevail on Their Claims Under the Administrative Procedure Act.

This Court “review[s] the district court’s judgment, not its reasoning,” and “may affirm on any ground properly raised.” *Jones v. Bernanke*, 557 F.3d 670, 674 (D.C. Cir. 2009). Plaintiffs argued below that BOP’s implementation of EO

¹⁶ To the extent the Government suggests that BOP has unfettered discretion to reweigh policy priorities affecting housing assignments, *see* AOB at 47–48, that cannot justify its disregard of the known and substantial risks of serious harm to Plaintiffs. Although BOP has significant discretion to set prison housing policy, it still must comply with the Constitution.

14168 violates the APA, 5 U.S.C. § 706(2), because it is arbitrary and capricious, not in accordance with law, and revokes PREA regulations without following the procedures necessary to amend or rescind those regulations. *See, e.g., Doe v. Bondi*, ECF No. 81-1 at 8; ECF No. 50-1 at 19–23. Agency actions implementing an executive order are subject to APA review. *See, e.g., Nebraska v. Su*, 121 F.4th 1, 15–16 (9th Cir. 2024); *see also Chamber of Com. of U.S. v. Reich*, 74 F.3d 1322, 1327 (D.C. Cir. 1996).

BOP’s decision to transfer Plaintiffs to men’s prisons in compliance with EO 14168 is a final agency action. *See Bennett v. Spear*, 520 U.S. 154, 177–78 (1997); *see also* AOB at 12–13 (acknowledging that BOP decided to transfer Plaintiffs and told Plaintiffs they would be transferred).

1. Defendants’ Implementation of the Executive Order Violates Notice and Comment Requirements

PREA regulations have long required BOP to make individualized determinations, considering both men’s and women’s facilities, about where to house transgender individuals. *See* 28 C.F.R. § 115.42(c). These regulations were promulgated through notice and comment rulemaking. *See* National Standards to Prevent, Detect, and Respond to Prison Rape, 77 Fed. Reg. 37106, 37204 (June 20, 2012); *see also* 5 U.S.C. § 553.

The APA requires agencies to “use the same procedures when they amend or repeal a rule as they used to issue the rule in the first instance.” *Perez v. Mortg.*

Bankers Ass’n, 575 U.S. 92, 101 (2015). As this Court has explained, “‘an agency issuing a legislative rule is itself bound by the rule until that rule is amended or revoked’ and ‘may not alter [such a rule] without notice and comment.’” *Clean Air Council v. Pruitt*, 862 F.3d 1, 9 (D.C. Cir. 2017) (per curiam) (alteration in original) (quoting *Nat’l Fam. Plan. & Reprod. Health Ass’n, Inc. v. Sullivan*, 979 F.2d 227, 234 (D.C. Cir. 1992)).

BOP’s implementation of the Executive Order would repeal PREA regulations without following the necessary notice and comment procedures. The order instructs BOP to ensure that all transgender women in federal custody “are not detained in women’s prisons or housed in women’s detention centers,” regardless of their individual circumstances. EO 14168 § 4(a). This is directly contrary to PREA regulations that require BOP to make “case-by-case” determinations about “whether to assign a transgender or intersex inmate to a facility for male or female inmates” based on “the inmate’s health and safety, and whether the placement would present management or security problems.” 28 C.F.R. § 115.42(c).

Requiring “notice and comment before repeal of a final rule ‘ensures that an agency will not undo all that it accomplished through its rulemaking without giving all parties an opportunity to comment on the wisdom of repeal.’” *Humane Soc’y of the U.S. v. U.S. Dep’t of Agric.*, 41 F.4th 564, 568 (D.C. Cir. 2022)

(quoting *Consumer Energy Council of Am. v. FERC*, 673 F.2d 425, 446 (D.C. Cir. 1982)). For that reason, this Court has carefully scrutinized agency efforts to “effectively amend or withdraw the legal force of a rule without undergoing a new notice-and-comment rulemaking.” *Guedes v. Bureau of Alcohol, Tobacco, Firearms & Explosives*, 920 F.3d 1, 23 (D.C. Cir. 2019). An agency may not take action that “effectively repeal[s] a final rule while sidestepping the statutorily mandated process for revising or repealing that rule on the merits.” *Air All. Houston v. EPA*, 906 F.3d 1049, 1065 (D.C. Cir. 2018). Nor may it “substantively alter[.]” the requirements of the rule without following appropriate procedures for the rule’s amendment or repeal. *Liquid Energy Pipeline Ass’n v. FERC*, 109 F.4th 543, 548 (D.C. Cir. 2024); *see also NRDC v. EPA*, 643 F.3d 311, 320–21 (D.C. Cir. 2011).

These concerns are especially acute here. It took more than eight years after the enactment of PREA in 2003 to finalize the regulations that the Executive Order unravels. The housing requirements of the regulations reflect a deliberate balancing of the interests of prison administrators and the needs of incarcerated transgender people. BOP may not “simply disregard rules that are still on the books.” *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009). BOP’s choice to “depart from a prior policy *sub silentio*” violates its procedural obligations under the APA. *Id.*

2. BOP's Action is Arbitrary and Capricious and Not in Accordance with Law.

BOP's implementation of the Executive Order is also arbitrary and capricious and not in accordance with law. *See* 5 U.S.C. § 706(2)(A). BOP has provided no reasoned explanation for its new policy that categorically forbids Plaintiffs from ever being housed in their current facilities or other women's facilities—facilities to which BOP assigned Plaintiffs based on individualized determinations, *see* 28 C.F.R. § 115.42, and in which Plaintiffs have been housed for months or years.

The APA requires agencies “to engage in reasoned decisionmaking” through a “logical and rational” process. *Nw. Immigrant Rts. Project v. U.S. Citizenship & Immigr. Servs.*, 496 F. Supp. 3d 31, 70 (D.D.C. 2020) (quoting *DHS v. Regents of the Univ. of California*, 591 U.S. 1, 16 (2020) and *Allentown Mack Sales & Servs., Inc. v. NLRB*, 522 U.S. 359, 374 (1998)). When an agency departs from prior policy, it must show “that there are good reasons for [the new policy], and that the agency believes it to be better.” *Fox Television Stations*, 556 U.S. at 515. The agency cannot disregard the facts and circumstances that formed the basis of the prior policy without providing “a reasoned explanation.” *Id.* And an agency's decision is arbitrary or capricious if it “entirely failed to consider an important aspect of the problem.” *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

BOP failed to meet the requirements for reasoned decisionmaking, as it admits its decision started and ended with the Executive Order. Responding to Plaintiffs' APA claim before the district court, the Government failed to offer any justification independent of the Executive Order. Instead, the Government stated only that "[t]he Executive Order has articulated why the Executive has changed its policy." Defs' Resp. to Pls.' Mot. for TRO, *Doe v. Bondi*, ECF 53-1 at 36; Defs' Resp. to Pls.' Mot. for TRO, *Jones v. Trump*, ECF 24 at 34.

But an "executive order does not exempt [an agency] from basic APA requirements of reasoned decisionmaking." *Su*, 121 F.4th at 15; *see also AIDS Vaccine Advoc. Coal. v. U.S. Dep't of State*, 766 F. Supp. 3d 74, 83 (D.D.C. 2025). Indeed, courts considering agency action taken pursuant to *this* Executive Order (No. 14168) have already held it arbitrary and capricious when the agency's justification was the Executive Order. *See Orr v. Trump*, — F. Supp. 3d —, 2025 WL 1145271, at *19 (D. Mass. Apr. 18, 2025); *Kingdom v. Trump*, No. 1:25-cv-00691-RCL, 2025 WL 1568238, at *9–10 (D.D.C. June 3, 2025). *Orr* considered a new State Department passport policy, the record of which revealed "that the State Department considered virtually nothing aside from the Executive Order's directive when it developed the [new] [p]olicy." *Orr*, 2025 WL 1145271 at *18–19 (observing that the Department made no factual findings and did not explain why facts supporting prior policy "no longer carry weight"). Just so here: the

Executive Order constitutes BOP's only justification for its new policy.¹⁷

BOP has thus failed to provide “a satisfactory explanation for its action.” *State Farm*, 463 U.S. at 43. Plaintiffs’ current housing designations are the result of individualized determinations pursuant to 28 C.F.R. § 115.42 to “ensure the inmate’s health and safety.” Mandating that BOP *disregard* those safety determinations is not rational, and the Order provides no explanation to reconcile the apparent conflict. The Executive Order “entirely fail[s] to consider an important aspect of the problem”: the extreme risks of rape, sexual and physical violence, and self-harm that Plaintiffs will face if transferred to men’s facilities. *State Farm*, 463 U.S. at 43. Put differently, the Executive Order entirely ignores the people who will be transferred and the known dangers those transfers pose. “To be sure, agency action is not arbitrary and capricious merely because it is bad for some identifiable population,” but “the APA *does* require an agency to take

¹⁷ The administrative record for APA claims consists exclusively of the record the agency made *before* it acted. *AT&T Info. Sys., Inc. v. Gen. Servs. Admin.*, 810 F.2d 1233, 1236 (D.C. Cir. 1987) (per curiam) (citing *Camp v. Pitts*, 411 U.S. 138, 142 (1973)). Courts “bar introduction of litigation affidavits” that “offer post-hoc rationalizations” when the contemporaneous record revealed “no rationalization at the agency level.” *Id.* The government endorsed this position when defending a different agency action taken to comply with Executive Order 14168. *See* Defs.’ Opp. to Pls.’ Mot. to Stay Agency Action and for PI, *Orr v. Trump*, No. 1:25-CV-10313-JEK, ECF No. 53 at 15 (D. Mass. March 12, 2025). The declarations of Rick Stover submitted to the District Court are thus not proper subjects of consideration for Plaintiffs’ APA claim.

actions that are rationally and demonstrably related to its stated goals, ... and give consideration to the reliance interests of those who may be harmed by a new policy.” *Kingdom*, 2025 WL 1568238, at *10. Because the Executive Order falls short of *Fox Television Stations’* and *State Farm’s* requirements, it cannot save BOP’s otherwise unsupported arbitrary and capricious action.

BOP’s implementation of the Executive Order is also arbitrary and capricious or “otherwise not in accordance with law,” 5 U.S.C. § 706(A)(2), because it directly violates the PREA regulations’ requirement that BOP conduct individualized assessments when determining whether to house transgender people in men’s or women’s facilities. *See* 28 C.F.R. § 115.42(c); *Williams v. Kincaid*, 45 F.4th 759, 778 (4th Cir. 2022) (holding that a categorical approach to housing decisions “flouts the case-by-case analysis federal law requires”); *see generally United States ex rel. Accardi v. Shaughnessy*, 347 U.S. 260 (1954) (establishing that agencies must follow their own regulations).¹⁸

The Government also acts in an arbitrary and capricious manner when it acts based on animus. *Robbins v. Reagan*, 780 F.2d 37, 50 n.20 (D.C. Cir. 1985). Animus may take the form of a “desire to harm a politically unpopular group,”

¹⁸ *Accardi* claims can be brought through an APA cause of action. *See Damus v. Nielsen*, 313 F. Supp. 3d 317, 335–36 (D.D.C. 2018); *Fed. Defs. of N.Y., Inc. v. Fed. Bureau of Prisons*, 954 F.3d 118, 130 (2d Cir. 2020).

U.S. Dep’t of Agric. v. Moreno, 413 U.S. 528, 534 (1973), or it may reflect “negative attitudes,” “fear,” or “irrational prejudice,” *City of Cleburne, Tex. v. Cleburne Living Ctr.*, 473 U.S. 432, 448, 450 (1985).

The text and sweeping scope of the Executive Order demonstrate animosity against transgender people. It makes it the official “policy of the United States” to purposefully exclude transgender people from any legal recognition or protection. EO 14168 §§ 2, 2(a). It defines “gender ideology” as “permitting the false claim that males can identify as and thus become women and vice versa”; orders all agencies to “remove all statements, policies, regulations, forms, communications, or other internal and external messages that promote or otherwise inculcate gender ideology”; and orders agencies to “end the Federal funding of gender ideology.” EO 14168 §§ 2(g), 3(e); *see also id.* § 3(g).

In short, the Executive Order declares a federal policy of denying the existence of transgender people. *See Orr*, 2025 WL 1145271, at *19 (“[T]he language of the Executive Order is candid in its rejection of the identity of an entire group—transgender Americans.”); *S.F. A.I.D.S. Found. v. Trump*, No. 25-cv-01824-JST, 2025 WL 1621636, at *14–15 (N.D. Cal. June 9, 2025) (similar). The “principal purpose and the necessary effect” of the Order is to “demean those persons who are” transgender. *United States v. Windsor*, 570 U.S. 744, 774 (2013). Although the Executive Order sets out other alleged purposes—promoting

women’s “dignity, safety, and well-being”; advancing “scientific inquiry, public safety, morale, and trust in government”; and “protect[ing] freedom of conscience”—the “sheer breadth” of the Order “is so discontinuous” with these purposes that it can only be explained by animus. *Romer v. Evans*, 517 U.S. 620, 632 (1996).

The Government’s broader attack on transgender people removes any doubt that animus is the principal driver of the Government’s challenged housing policy. The President has issued Executive Orders designed to strip protections from transgender people across multiple domains. *See supra* n.8 (listing Executive Orders). “Although aimed at different policy goals,” each of the above-mentioned Executive Orders, “in tone and language, conveys a fundamental moral disapproval of transgender Americans.” *Orr*, 2025 WL 1145271, at *14. The Executive Orders, including EO 14168, attack transgender people “not to further a proper [governmental] end but to make them unequal to everyone else.” *Romer*, 517 U.S. at 635. The Government’s policy is borne of animus and thus is necessarily arbitrary and capricious.

C. Plaintiffs’ Claims are Not Barred by the PLRA Or Any Other Statute.

1. 18 U.S.C. § 3621(b) Does Not Bar Judicial Review.

Section 3621(b) does not bar Plaintiffs’ challenges to BOP’s categorical policy implementing the Executive Order. The statute prohibits judicial review of

“a *designation* of a place of imprisonment *under this subsection*.” 18 U.S.C.

§ 3621(b) (emphasis added). BOP’s transfer of Plaintiffs from women’s facilities was not an individualized placement decision under § 3621(b). BOP transferred Plaintiffs pursuant to a categorical policy mandated by the Executive Order, not based on the factors in § 3621(b). *See* EO 14168, § 4(a); AOB at 1, 12.

Accordingly, because BOP’s actions fall outside § 3621(b)’s scope, the statute’s bar of judicial review does not apply.

In addition, as the district court correctly held, § 3621(b) does not preclude judicial review of Plaintiffs’ constitutional claims. JA160. “[W]here Congress intends to preclude judicial review of constitutional claims its intent to do so must be clear ... to avoid the ‘serious constitutional question’ that would arise if a federal statute were construed to deny any judicial forum for a colorable constitutional claim.” *Webster v. Doe*, 486 U.S. 592, 603 (1988) (quoting *Bowen v. Mich. Acad. of Fam. Physicians*, 476 U.S. 667, 681 n.12 (1986)). Congress did not do so in § 3621.¹⁹

¹⁹ *McBryde v. Comm. to Review Cir. Council Conduct*, 264 F.3d 52, 58, 60 (D.C. Cir. 2001) does not support the Government’s argument. In *McBryde*, this Court found clear and convincing evidence that Congress intended to deny judicial review of judicial disciplinary proceedings. *Id.* at 62–63. None of the unusual factors the Court relied on to reach its conclusion apply here. *See Ralls Corp. v. Comm. on Foreign Inv. in U.S.*, 758 F.3d 296, 309–10 (D.C. Cir. 2014) (describing the unique statutory language and legislative history relied on by this Court in *McBryde*).

The cases cited by the Government are inapposite because they all involved individualized placement decisions. *See Wills v. Barnhardt*, No. 21-1383, 2022 WL 4481492, at *1 (10th Cir. Sept. 27, 2022) (declining to review BOP’s decision on plaintiff’s transfer request); *Touizer v. U.S. Att’y Gen.*, No. 21-10761, 2021 WL 3829618, at *1–2 (11th Cir. Aug. 27, 2021) (per curiam) (rejecting plaintiff’s request for home confinement); *Jiau v. Tews*, 812 F. App’x 638, 639 (9th Cir. 2020) (rejecting plaintiff’s claims to the extent they challenged her placement in a prison rather than a residential re-entry center).

Moreover, the Supreme Court has held that a provision limiting judicial review of individual agency decisions does not preclude judicial review of statutory or constitutional challenges to blanket policies. *McNary v. Haitian Refugee Ctr., Inc.*, 498 U.S. 479, 492 (1991) (holding that a provision like § 3621(b), which limited judicial review of individual amnesty applications by immigrants, did not bar pattern and practice challenges to the INS’s processing of such applications); *see also, e.g., Ahmad v. Jacquez*, 860 F. App’x 459, 462 (9th Cir. July 1, 2021) (stating that § 3621(b) strips jurisdiction over individual transfer decisions but “does not preclude review of all challenges that might implicate individual designation decisions,” including challenges to generally applicable BOP policies (citing *McNary*, 498 U.S. at 492)). Like the analogous provision in *McNary*, the language of § 3621(b) refers to judicial review of individual decisions

rather than to general “challenges to unconstitutional practices and policies used by the agency” in making such decisions. 498 U.S. at 492. Plaintiffs here are not seeking review of individual placement decisions under § 3621(b) but rather of BOP’s adoption of a blanket policy requiring their transfer to men’s facilities regardless of their individual circumstances. As such, § 3621(b) does not bar judicial review of their claims.

2. Section 3625 Similarly Does Not Bar Plaintiffs’ APA Claims.

Any argument that 18 U.S.C. § 3625 bars Plaintiffs’ APA claims fails for the same reasons. That provision makes the APA inapplicable “to the making of any determination, decision, or order” under Title 18, Part II, Chapter 229, Subchapter C, of which the only relevant section is § 3621(b). 18 U.S.C. § 3625. “§ 3625 bars review of individualized housing determinations, not ... a challenge to a broad policy that informs the designation decision.” *Love v. Bureau of Prisons*, No. 24-CV-2571 (APM), 2025 WL 105845, at *11–12 (D.D.C. Jan. 15, 2025) (holding § 3625 “no bar to review” because “[p]laintiffs are not challenging their individual housing placements. They contest the BOP’s alleged discriminatory treatment of [a subset of prisoners] in the decision-making process”); *see also Jasperson v. Fed. Bureau of Prisons*, 460 F. Supp. 2d 76, 84 (D.D.C. 2006) (holding § 3625 no bar where plaintiff “challenges the rulemaking leading to the BOP policy that informed his confinement determination, rather than challenging the determination itself”).

Multiple circuit courts have reached the same conclusion. *See Richmond v. Scibana*, 387 F.3d 602, 605 (7th Cir. 2004) (distinguishing between contesting a housing assignment and contesting “the rules that will be used to decide” that placement); *see also Martin v. Gerlinski*, 133 F.3d 1076, 1079 (8th Cir. 1998) (explaining that “§ 3625 does not divest this court of jurisdiction to review whether the BOP exceeded its statutory authority by categorically considering sentencing enhancement factors”); *Fristoe v. Thompson*, 144 F.3d 627, 630–31 (10th Cir. 1998) (holding that section 3625 did not prevent judicial review of a BOP rule affecting sentencing reduction).

It is also well settled that § 3625 does not bar judicial consideration of Plaintiffs’ challenge to BOP’s failure to comply with the rulemaking provisions of the APA. *E.g.*, 5 U.S.C. § 553. As both the statute’s text and judicial decisions make clear, § 3625 does not apply to agency rulemaking. *See* 18 U.S.C. § 3625; *Martin*, 133 F.3d at 1079 (“[I]t is apparent” that § 3625 does not bar review of “rulemaking decisions.”).

3. The District Court Correctly Found that No Administrative Remedy Was Available.

Failure to exhaust administrative remedies is an affirmative defense under the PLRA, *Jones v. Bock*, 549 U.S. 199, 215–16 (2007), which “the defendants have the burden of pleading and proving,” *Chandler v. Fed. Bureau of Prisons*, 226 F. Supp. 3d 1, 6 (D.D.C. 2016). The Government cannot show that this

affirmative defense makes Plaintiffs unlikely to succeed on the merits because it concedes that BOP must implement the categorical policy mandated by the Executive Order without discretion to do otherwise. AOB at 32 (stating that “BOP lacks discretion to continue housing plaintiffs in female facilities under EO 14168”).

An aggrieved incarcerated person “must exhaust available remedies, but need not exhaust unavailable ones.” *Ross v. Blake*, 578 U.S. 632, 642 (2016) (citing 42 U.S.C. § 1997e(a)). A remedy is unavailable “where the relevant administrative procedure lacks authority to provide any relief.” *Id.* at 643 (citing *Booth v. Churner*, 532 U.S. 731, 736 & n.4 (2001)). Such is the case when BOP acts pursuant to a mandatory directive that divests it of any authority to provide relief. *Kaemmerling v. Lappin*, 553 F.3d 669, 675 (D.C. Cir. 2008).

In *Kaemmerling*, petitioner sought injunctive relief against BOP’s enforcement of a federal statute under which “BOP ha[d] no discretion not to collect [his] DNA, as the statute’s mandatory language indicates and as the BOP conceded.” *Id.* at 675. There was thus “no administrative process to exhaust.” *Id.* Similarly, here, Plaintiffs seek injunctive relief against BOP’s implementation of an executive order with mandatory language that requires BOP to transfer Plaintiffs from women’s prisons, as BOP concedes. *See* AOB at 32; *see also* EO 14168, § 4(a).

Moreover, BOP staff told Plaintiffs it lacked authority to provide relief.

JA494 ¶ 12 (Maria Moe “was told that [she] did not have an ability to challenge the transfer because it was required by Executive Order”); JA649 ¶¶ 13–14 ([REDACTED]

[REDACTED]”). The text of the Executive Order, BOP’s interpretation of it, and BOP staff statements to Plaintiffs all point to the same conclusion: BOP’s administrative process “operate[d] as a simple dead end—with officers unable ... to provide any relief.” *Ross*, 578 U.S. at 643.

The Government suggests that Plaintiffs should have exhausted administrative remedies anyway because BOP could have taken actions unrelated to the Executive Order to “protect [Plaintiffs’] safety,” such as “changes to housing and programming assignments, and protective custody.” AOB at 32. This contention ignores that Plaintiffs’ complaint arises out of an Executive Order that BOP is required to implement. BOP’s administrative process is not capable of changing the terms of the Order or overruling its mandates—just as the grievance process in *Kaemmerling* could not alter or invalidate the text of a binding federal statute, *see* 553 F.3d at 676 (emphasizing that the plaintiff was challenging “the enforceability of a statute rather than the prison’s method of enforcement”). The Government also cites *Savage v. United States Department of Justice*, 91 F.4th 480

(D.C. Cir. 2024). But in that case, this Court held that administrative remedies were available to a plaintiff challenging the terms of an order issued by the Department of Justice, reasoning that the administrative process “ends with review by the Department of Justice, which has the authority to modify or rescind” the order. *Id.* at 484. Because BOP lacked that authority here, Plaintiffs faced “a dead end” in challenging the application of the Executive Order to them. *Ross*, 578 U.S. at 643.

Administrative remedies were unavailable in this case for another reason as well: Plaintiffs faced immediate danger and could not have received relief before being exposed to the substantial risk of serious harm posed by transfer. Some Plaintiffs were in fact transferred to men’s facilities without time or opportunity to file a grievance. JA230, 233–34. Others were moved to segregated housing and told they would be transferred imminently. *See, e.g.*, JA86, 88, 493–94.

Exhaustion is not required when the administrative process cannot possibly remedy the threatened harm in time. *Fletcher v. Menard Corr. Ctr.*, 623 F.3d 1171, 1173 (7th Cir. 2010) (“If a prisoner has been placed in imminent danger of serious physical injury by an act that violates his constitutional rights, administrative remedies that offer no possible relief in time to prevent the imminent danger from becoming an actual harm can’t be thought available.”).

II. PLAINTIFFS HAVE MET ALL OTHER REQUIREMENTS FOR PRELIMINARY INJUNCTIVE RELIEF

The district court did not abuse its discretion in weighing the *Winter* factors, *see Winter*, 555 U.S. at 20, and concluding that Plaintiffs met their burden on the remaining prongs for a preliminary injunction.

A. Plaintiffs Have Shown They Will Suffer Irreparable Harm if the Government Implements EO 14168 and Transfers them from Women's Prisons.

Plaintiffs must show that they “will likely suffer irreparable harm before the district court can resolve the merits of the case.” *Singh v. Berger*, 56 F.4th 88, 95 (D.C. Cir. 2022) (citing *Archdiocese of Wash. v. Wash. Metro. Area Transit Auth.*, 897 F.3d 314, 321 (D.C. Cir. 2018)). Here, Plaintiffs face irreparable harm arising out of the Government’s implementation of Section 4(a) of EO 14168, including the violation of their Eighth Amendment rights and substantial risks of sexual violence and physical harm.

1. BOP’s Prospective Violation of Plaintiffs’ Eighth Amendment Rights Causes Irreparable Harm.

Plaintiffs satisfy the irreparable harm standard where, as here, they face imminent violation of their Eighth Amendment right to be free from cruel and unusual punishment. As the district court properly recognized, “a prospective violation of a constitutional right constitutes irreparable injury.” JA166 (quoting *Davis v. District of Columbia*, 158 F.3d 1342, 1346 (D.C. Cir. 1998)). “Where a plaintiff requests injunctive relief ... that, if completed could ... alleviate harsh

conditions of confinement, the harm from detention surely cannot be remediated after the fact.” *Ramirez v. U.S. Immigr. and Customs Enf’t*, 310 F. Supp. 3d 7, 31 (D.D.C. 2018).

2. BOP’s Implementation of EO 14168 Exposes Plaintiffs to a High Risk of Sexual Violence and Other Serious Harms.

Plaintiffs face a substantial risk of irreparable bodily harm in the absence of injunctive relief. *See supra* Argument § I(A)(1). If Plaintiffs are transferred to men’s prisons, they will likely face physical violence and sexual harassment. Multiple Plaintiffs were physically attacked and sexually harassed in men’s prisons before they were placed in women’s facilities. *See, e.g.*, JA374–75, 382, 385. And two of the Plaintiffs who were transferred from women’s to men’s facilities under EO 14168 both suffered immediate and pervasive sexual harassment in those men’s facilities. JA230, 233–34.

In addition, Plaintiffs Maria Moe, Jane Jones, and Zoe, Rachel, Wendy and Sara Doe are at extremely high risk of assault in men’s prisons because they have undergone surgical treatment and/or appear indistinguishable from other women. *See* JA286, 703–04, 903, 965, 996, 1000. All Plaintiffs have been on female hormones for years and live as women.

Finally, the likelihood of irreparable harm is supported by the Government’s own data demonstrating an elevated risk for the transgender prisoner population, as well as the un rebutted declarations submitted by Plaintiffs and Plaintiffs’ experts

showing that Plaintiffs are at particularly high risk. *See supra* Argument § I(A).

The district court also did not clearly err in finding that, given the individual histories and vulnerabilities identified by these plaintiffs, “placement in a male penitentiary *by itself* will exacerbate the symptoms of [Plaintiffs’] gender dysphoria, *even if* they are not subject to physical or sexual violence in their new facility ... because the mere homogenous presence of men will cause uncomfortable dissonance.” JA187 n.2. As the district court found, this worsening of gender dysphoria will expose Plaintiffs to a serious risk of harm if they are moved to men’s prisons. *Id.*

Defendants’ reliance on *Citizens for Responsibility and Ethics in Washington (CREW) v. Federal Election Commission*, 904 F.3d 1014 (D.C. Cir. 2018) is misplaced. In *CREW*, this Court found no irreparable harm existed where the plaintiff campaign donors failed to provide “actual evidence” that the FEC’s new disclosure requirements had a “chilling effect” on their behavior or evidence of “any actual independent expenditures [they had] made this quarter” or were deterred from making. *Id.* at 1019. In contrast, here, Plaintiffs submitted more than 20 declarations from themselves and experts describing the harms they have already experienced in men’s prisons in addition to the imminent and certain harm they will face if forced to live in men’s prisons. *See* JA84, 91, 229, 232, 285, 292, 373, 377, 380, 384, 490, 915, 920, 925, 929, 934, 938, 942, 947, 951.

B. The Balance of Equities and Public Interest Weigh in Favor of Preliminary Injunctive Relief.

When the party opposing a preliminary injunction is the Government, the final two prongs merge. *Nken v. Holder*, 556 U.S. 418, 435 (2009). The district court did not abuse its discretion in concluding “the public interest in seeing the plaintiffs relocated *immediately* to male facilities is slight at best,” whereas “[t]he plaintiffs’ interests ... are not abstract at all,” as Plaintiffs face substantiated harms to their physical and psychological wellbeing if transferred under the challenged Executive Order. JA167. In addition, “enforcement of an unconstitutional law is always contrary to the public interest.” *Karem v. Trump*, 960 F.3d 656, 668 (D.C. Cir. 2020).

The Government now makes blanket, unsupported assertions on appeal that the Plaintiffs endanger the safety of others at the women’s prisons where they reside. AOB at 4. The Government did not submit any evidence to support this assertion in any of the six oppositions filed in response to the motions for TROs and PIs in the underlying cases. Nor is there any support for the suggestion that simply being transgender makes Plaintiffs a threat to women’s safety, privacy, or dignity.

Likewise, the Government cannot show that the injunctions undermine the public interest by forcing BOP to keep in place a housing policy “that no longer reflects its current ... thinking.” AOB at 53. In arguing to the contrary, the

Government relies on *MediNatura, Inc. v. FDA*, 998 F.3d 931, 945 (D.C. Cir. 2021). But *MediNatura* is inapposite. In that case, this Court denied a preliminary injunction seeking to retain a thirty-year-old agency guidance document, where the change in policy followed a multi-year review process that reflected the agency’s “current enforcement thinking” and involved scientific analysis and public input. *See id.* at 935–37, 945. In contrast, here, the Government has not provided any explanation or evidence to support the policy change other than the text of the Executive Order at issue. Nor could there be evidence-based decision making to support the abrupt policy change, which was issued on day one of the current presidential administration before any serious review of BOP policies and practices had been taken, and which explicitly contravenes PREA and its implementing regulations.

The Government’s analogy to *Hatim v. Obama*, 760 F.3d 54 (D.C. Cir. 2014) to argue that that the injunctions “impermissibly interfere with the government’s administration of its federal prisons and the execution of Executive Branch policy” also fails. AOB at 53. In *Hatim*, the plaintiffs did not challenge an Executive Order, but rather an on-the-ground policy change at a specific detention facility the Court found was “needed to preserve internal order and discipline and to maintain institutional security.” *Hatim*, 760 F.3d at 59 (internal citations omitted). There are no such findings here. In fact, the injunctions restore, rather

than interfere with, BOP's discretion to determine housing placements as needed to "ensure health and safety" for people in custody and maintain "security" in federal prisons. 28 C.F.R. § 115.42(c).

Defendants' position that this Court should defer to unfettered executive power also fundamentally misunderstands constitutional separation of powers. The Constitution represents the outer limits of deference to the Executive Branch; where a likely constitutional violation has been shown, deference is neither warranted nor in the public interest. *See Int'l Refugee Assistance Proj. v. Trump*, 857 F.3d 554, 603 (4th Cir. 2017) (en banc), *vacated on mootness grounds*, 583 U.S. 912 (2017) (explaining that "the issuance of a preliminary injunction which prevents [the government] from enforcing restrictions likely to be found unconstitutional" does not harm the government and likely "improve[s]" our system of government).

III. THE DISTRICT COURT'S ORDERS COMPLY WITH THE PRISON LITIGATION REFORM ACT

The operative preliminary injunctions contain ample PLRA findings and meet the requirements of the statute. *See* 18 U.S.C. § 3626(a)(2). Specifically, the court found that Plaintiffs are likely to succeed on the merits of their Eighth Amendment claim and that they will experience "serious and irreparable harm" if Defendants' implementation of the Executive Order proceeds; enjoining the application of the Order to Plaintiffs was therefore "necessary to correct the harm";

there was no less intrusive means of correcting the harm; and the injunction was narrowly drawn because it addressed only the specific harms to the individual Plaintiffs and did not extend to protect non-parties or enjoin other aspects of the EO 14168. JA955, 958, 961. The district court also found that the injunctions would not cause any “adverse impacts on public safety or the operation of the criminal justice system” because they simply maintained the status quo during the pendency of the litigation. JA955–56, 959, 961–62.

The district court’s articulation of its findings was nothing like the “one-sentence, boilerplate paragraph” the Government points to from *Hoffer v. Sec’y, Fla. Dep’t of Corr.*, 973 F.3d 1263, 1278 (11th Cir. 2020). Nothing in the PLRA “suggest[s] that Congress intended a provision-by-provision explanation of a district court’s findings,” and there is no reason to “read such an obligation into the statute.” *Armstrong v. Schwarzenegger*, 622 F.3d 1058, 1070 (9th Cir. 2010); *see also Fields v. Smith*, 653 F.3d 550, 558 (7th Cir. 2011) (reaching same conclusion and collecting cases).

The Government spends one paragraph arguing that the PIs were not in fact necessary to avert the harm threatened by the Executive Order. AOB at 56–57. This Court reviews for clear error the district court’s factual findings that the injunctions were necessary, narrowly tailored, and the least intrusive means of correcting the harm. *Brown v. Plata*, 563 U.S. 493, 541 (2011); *see also United*

States v. Hinds Cnty. Bd. of Supervisors, 128 F.4th 616, 626 (5th Cir. 2025); *Armstrong v. Newsom*, 58 F.4th 1283, 1293 (9th Cir. 2023). As the district court explained, its findings were amply supported by the evidence that (1) transferring Plaintiffs to men’s prisons would put them at a “significantly elevated risk of physical and sexual violence relative to other inmates,” JA164; (2) moving Plaintiffs to men’s prisons would “exacerbate the symptoms of their gender dysphoria,” potentially causing “numerous and severe symptoms,” JA165; (3) BOP had previously determined that “a women’s facility was the appropriate placement for each named plaintiff” based on the constitutional and statutory factors that required it to consider Plaintiffs’ risk of harm in men’s prisons, JA186; and (4) the fact that Rachel and Ellen Doe were “abused at their new facilities” after their brief transfer to men’s prisons could “only strengthen their claims of irreparable harm,” JA241–42. The Government’s cursory and unsupported argument that it is “self-evident” that less intrusive relief could avert the harm shows no clear error in these findings. AOB at 56–57.

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CONCLUSION

For the foregoing reasons, the preliminary injunctions should be affirmed.

DATED: June 30, 2025

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit of Federal Rule of Appellate Procedure 32 (a)(7)(B) because it contains 12,525 words. This brief also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because it was prepared using Word for Microsoft 365 in Times New Roman 14-point font, a proportionally spaced typeface.

/s/ Kara Janssen

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CERTIFICATE OF SERVICE

I hereby certify that on June 30, 2025, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the District of Columbia Circuit by using the appellate CM/ECF system.

/s/ Kara Janssen

Kara Janssen

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18 U.S.C. § 3621(b)**§ 3621. Imprisonment of a convicted person**

* * *

(b) Place of imprisonment.--The Bureau of Prisons shall designate the place of the prisoner's imprisonment, and shall, subject to bed availability, the prisoner's security designation, the prisoner's programmatic needs, the prisoner's mental and medical health needs, any request made by the prisoner related to faith-based needs, recommendations of the sentencing court, and other security concerns of the Bureau of Prisons, place the prisoner in a facility as close as practicable to the prisoner's primary residence, and to the extent practicable, in a facility within 500 driving miles of that residence. The Bureau shall, subject to consideration of the factors described in the preceding sentence and the prisoner's preference for staying at his or her current facility or being transferred, transfer prisoners to facilities that are closer to the prisoner's primary residence even if the prisoner is already in a facility within 500 driving miles of that residence. The Bureau may designate any available penal or correctional facility that meets minimum standards of health and habitability established by the Bureau, whether maintained by the Federal Government or otherwise and whether within or without the judicial district in which the person was convicted, that the Bureau determines to be appropriate and suitable, considering--

- (1) the resources of the facility contemplated;
- (2) the nature and circumstances of the offense;
- (3) the history and characteristics of the prisoner;
- (4) any statement by the court that imposed the sentence--
 - (A) concerning the purposes for which the sentence to imprisonment was determined to be warranted; or
 - (B) recommending a type of penal or correctional facility as appropriate; and
- (5) any pertinent policy statement issued by the Sentencing Commission pursuant to section 994(a)(2) of title 28.

In designating the place of imprisonment or making transfers under this subsection, there shall be no favoritism given to prisoners of high social or economic status. The Bureau may at any time, having regard for the same matters, direct the transfer of a prisoner from one penal or correctional facility to another. The Bureau shall make available appropriate substance abuse treatment for each prisoner the Bureau

determines has a treatable condition of substance addiction or abuse. Any order, recommendation, or request by a sentencing court that a convicted person serve a term of imprisonment in a community corrections facility shall have no binding effect on the authority of the Bureau under this section to determine or change the place of imprisonment of that person. Notwithstanding any other provision of law, a designation of a place of imprisonment under this subsection is not reviewable by any court.

* * *

18 U.S.C. § 3625**§ 3625. Inapplicability of the Administrative Procedure Act**

The provisions of sections 554 and 555 and 701 through 706 of title 5, United States Code, do not apply to the making of any determination, decision, or order under this subchapter.

18 U.S.C. § 3626(a)(1)-(2)**§ 3626. Appropriate remedies with respect to prison conditions****(a) Requirements for relief.--****(1) Prospective relief.—**

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

(B) The court shall not order any prospective relief that requires or permits a government official to exceed his or her authority under State or local law or otherwise violates State or local law, unless--

(i) Federal law requires such relief to be ordered in violation of State or local law;

(ii) the relief is necessary to correct the violation of a Federal right; and

(iii) no other relief will correct the violation of the Federal right.

(C) Nothing in this section shall be construed to authorize the courts, in exercising their remedial powers, to order the construction of prisons or the raising of taxes, or to repeal or detract from otherwise applicable limitations on the remedial powers of the courts.

(2) Preliminary injunctive relief.--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 caused by the preliminary relief and shall respect the principles of comity set out in paragraph (1)(B) in tailoring any preliminary relief. Preliminary injunctive relief shall automatically expire on the date that is 90 days

after its entry, unless the court makes the findings required under subsection (a)(1) for the entry of prospective relief and makes the order final before the expiration of the 90-day period.

* * *

5 U.S.C. § 553**§ 553. Rule making**

- (a) This section applies, according to the provisions thereof, except to the extent that there is involved--
- (1) a military or foreign affairs function of the United States; or
 - (2) a matter relating to agency management or personnel or to public property, loans, grants, benefits, or contracts.
- (b) General notice of proposed rule making shall be published in the Federal Register, unless persons subject thereto are named and either personally served or otherwise have actual notice thereof in accordance with law. The notice shall include--
- (1) a statement of the time, place, and nature of public rule making proceedings;
 - (2) reference to the legal authority under which the rule is proposed;
 - (3) either the terms or substance of the proposed rule or a description of the subjects and issues involved; and
 - (4) the Internet address of a summary of not more than 100 words in length of the proposed rule, in plain language, that shall be posted on the Internet website under section 206(d) of the E-Government Act of 2002 (44 U.S.C. 3501 note) (commonly known as regulations.gov).

Except when notice or hearing is required by statute, this subsection does not apply--

- (A) to interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice; or
 - (B) when the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rules issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest.
- (c) After notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments with or without opportunity for oral presentation. After consideration of the relevant matter presented, the agency shall incorporate in the rules adopted a

concise general statement of their basis and purpose. When rules are required by statute to be made on the record after opportunity for an agency hearing, sections 556 and 557 of this title apply instead of this subsection.

- (d)** The required publication or service of a substantive rule shall be made not less than 30 days before its effective date, except--
- (1)** a substantive rule which grants or recognizes an exemption or relieves a restriction;
 - (2)** interpretative rules and statements of policy; or
 - (3)** as otherwise provided by the agency for good cause found and published with the rule.
- (e)** Each agency shall give an interested person the right to petition for the issuance, amendment, or repeal of a rule.

5 U.S.C. § 706**§ 706. Scope of review**

To the extent necessary to decision and when presented, the reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action. The reviewing court shall--

- (1) compel agency action unlawfully withheld or unreasonably delayed; and
- (2) hold unlawful and set aside agency action, findings, and conclusions found to be--
 - (A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;
 - (B) contrary to constitutional right, power, privilege, or immunity;
 - (C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right;
 - (D) without observance of procedure required by law;
 - (E) unsupported by substantial evidence in a case subject to sections 556 and 557 of this title or otherwise reviewed on the record of an agency hearing provided by statute; or
 - (F) unwarranted by the facts to the extent that the facts are subject to trial de novo by the reviewing court.

In making the foregoing determinations, the court shall review the whole record or those parts of it cited by a party, and due account shall be taken of the rule of prejudicial error

42 U.S.C. § 1997e(a)**§ 1997e. Suits by prisoners****(a) Applicability of administrative remedies**

No action shall be brought with respect to prison conditions under section 1983 of this title, or any other Federal law, by a prisoner confined in any jail, prison, or other correctional facility until such administrative remedies as are available are exhausted.

* * *

28 C.F.R. § 115.41**§ 115.41 Screening for risk of victimization and abusiveness.**

- (a) All inmates shall be assessed during an intake screening and upon transfer to another facility for their risk of being sexually abused by other inmates or sexually abusive toward other inmates.
- (b) Intake screening shall ordinarily take place within 72 hours of arrival at the facility.
- (c) Such assessments shall be conducted using an objective screening instrument.
- (d) The intake screening shall consider, at a minimum, the following criteria to assess inmates for risk of sexual victimization:
 - (1) Whether the inmate has a mental, physical, or developmental disability;
 - (2) The age of the inmate;
 - (3) The physical build of the inmate;
 - (4) Whether the inmate has previously been incarcerated;
 - (5) Whether the inmate's criminal history is exclusively nonviolent;
 - (6) Whether the inmate has prior convictions for sex offenses against an adult or child;
 - (7) Whether the inmate is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming;
 - (8) Whether the inmate has previously experienced sexual victimization;
 - (9) The inmate's own perception of vulnerability; and
 - (10) Whether the inmate is detained solely for civil immigration purposes.
- (e) The initial screening shall consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the agency, in assessing inmates for risk of being sexually abusive.
- (f) Within a set time period, not to exceed 30 days from the inmate's arrival at the facility, the facility will reassess the inmate's risk of victimization

- or abusiveness based upon any additional, relevant information received by the facility since the intake screening.
- (g) An inmate's risk level shall be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the inmate's risk of sexual victimization or abusiveness.
 - (h) Inmates may not be disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section.
 - (i) The agency shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the inmate's detriment by staff or other inmates.

28 C.F.R. § 115.42**§ 115.42 Use of screening information.**

- (a) The agency shall use information from the risk screening required by § 115.41 to inform housing, bed, work, education, and program assignments with the goal of keeping separate those inmates at high risk of being sexually victimized from those at high risk of being sexually abusive.
- (b) The agency shall make individualized determinations about how to ensure the safety of each inmate.
- (c) In deciding whether to assign a transgender or intersex inmate to a facility for male or female inmates, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the inmate's health and safety, and whether the placement would present management or security problems.
- (d) Placement and programming assignments for each transgender or intersex inmate shall be reassessed at least twice each year to review any threats to safety experienced by the inmate.
- (e) A transgender or intersex inmate's own views with respect to his or her own safety shall be given serious consideration.
- (f) Transgender and intersex inmates shall be given the opportunity to shower separately from other inmates.
- (g) The agency shall not place lesbian, gay, bisexual, transgender, or intersex inmates in dedicated facilities, units, or wings solely on the basis of such identification or status, unless such placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such inmates.

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[ORAL ARGUMENT NOT SCHEDULED]
Nos. 25-5099, 25-5101, 25-5108 (consol.)

**IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT**

JANE DOE, et al.,
Plaintiffs-Appellees,

v.

PAMELA BONDI, in her official capacity as Attorney General
of the United States, et al.,
Defendants-Appellants.

JANE JONES, et al.,
Plaintiffs-Appellees,

v.

PAMELA BONDI, in her official capacity as Attorney General
of the United States, et al.,
Defendants-Appellants.

MARIA MOE,
Plaintiff-Appellee,

v.

DONALD J. TRUMP, in his official capacity as President
of the United States, et al.,
Defendants-Appellants.

On Appeal from the United States District Court
for the District of Columbia

JOINT APPENDIX – VOLUME I
PUBLIC APPENDIX – SEALED MATERIAL IN
SEPARATE SUPPLEMENT

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Order Granting Preliminary Injunction, Dkt. 62 (Mar. 10, 2025) [REDACTED]	JA569
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Declaration of [REDACTED], Dkt. 5-5.....	JA649
Exhibit to Opposition to Motion for TRO or PI (Feb. 5, 2025) Declaration of Rick Stover, Dkt. 24-1.....	JA652
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(Feb. 21, 2025),

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Jane Jones (Feb. 22, 2025),

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Exhibits to Reply in Support of Motions for TRO and PI for

Plaintiff Jane Jones (Feb. 25, 2025)

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Declaration of Donna Jones, Dkt. 38-4.....JA818

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***Moe v. Trump*, No. 1:25-cv-653 (D.D.C.)**

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(Feb. 5, 2025),

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Dkt. 62 (Mar. 10, 2025) JA911

**U.S. District Court
District of Columbia (Washington, DC)
CIVIL DOCKET FOR CASE #: 1:25-cv-00286-RCL**

DOE et al v. MCHENRY et al
Assigned to: Judge Royce C. Lamberth
Related Cases: [1:25-cv-00401-RCL](#)
[1:25-cv-00691-RCL](#)
[1:25-cv-00653-RCL](#)

Case in other court: USCA, 25-05099
Cause: 28:1331 Fed. Question: Violation 5th & 8th Amendme

Plaintiff

JANE DOE

represented by **Jennifer Levi**
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Plaintiff

SARA DOE

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ATTORNEY TO BE NOTICED

V.

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Defendant

WILLIAM LOTHROP
in his official capacity as Acting Director
of the Federal Bureau of Prisons

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ATTORNEY TO BE NOTICED

Jean Lin

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LEAD ATTORNEY

ATTORNEY TO BE NOTICED

Elizabeth Brooke Layendecker

(See above for address)

ATTORNEY TO BE NOTICED

John Robinson

(See above for address)

TERMINATED: 04/04/2025

ATTORNEY TO BE NOTICED

Date Filed	#	Docket Text
01/30/2025	<u>1</u>	COMPLAINT against WILLIAM LOTHROP, JAMES R. MCHENRY III (Filing fee \$ 405 receipt number ADCDC-11444829) filed by JANE DOE, SARA DOE, MARY DOE. (Attachments: # <u>1</u> Civil Cover Sheet, # <u>2</u> Summons – James R. McHenry III, Acting AG, # <u>3</u> Summons – William Lothrop, Acting Director, Federal BOP, # <u>4</u> Summons – Edward R. Martin Jr., U.S. Attorney for DC, # <u>5</u> Motion to File Under Seal and for Protective Order, # <u>6</u> Memorandum in Support of Motion to Seal, # <u>7</u> Text of Proposed Order)(Hill, Eve) (Entered: 01/30/2025)
01/30/2025	<u>2</u>	MOTION to File Under Seal <i>Motion for Temporary Restraining Order and Preliminary Injunction</i> by JANE DOE, MARY DOE, SARA DOE. (Attachments: # <u>1</u> Memorandum in Support, # <u>2</u> Text of Proposed Order)(Hill, Eve) Modified event on 1/30/2025 (znmw). (Entered: 01/30/2025)
01/30/2025	<u>3</u>	MOTION for Leave to Proceed Under Pseudonyms by JANE DOE, MARY DOE, SARA DOE. (Attachments: # <u>1</u> Memorandum in Support, # <u>2</u> Text of Proposed Order)(Hill, Eve) Modified event on 1/30/2025 (znmw). (Entered: 01/30/2025)
01/30/2025	<u>4</u>	NOTICE <i>Corrected Summonses – Summons – James R. McHenry III</i> by JANE DOE, MARY DOE, SARA DOE re <u>1</u> Complaint,, (Attachments: # <u>1</u> Summons – William Lothrop, # <u>2</u> Summons – Edward R. Martin Jr.)(Hill, Eve) (Entered: 01/30/2025)
01/30/2025	<u>5</u>	SEALED MOTION for Temporary Restraining Order and Preliminary Injunction filed by JANE DOE, MARY DOE, SARA DOE (Attachments: # <u>1</u> Memorandum in Support, # <u>2</u> Declaration of Eve Hill, # <u>3</u> Declaration of Loren Schechter, MD, # <u>4</u> Declaration of Jane Doe, # <u>5</u> Declaration of Ivana Kuc, # <u>6</u> Declaration of Frederic M. Ettner, MD, # <u>7</u> Text of Proposed Order)(Hill, Eve) Modified docket text on 1/31/2025 (znmw). (Entered: 01/30/2025)
01/30/2025	<u>6</u>	MOTION for Leave to Appear Pro Hac Vice :Attorney Name– Jennifer L. Levi, Filing fee \$ 100, receipt number ADCDC-11446078. Fee Status: Fee Paid. by JANE DOE, MARY DOE, SARA DOE. (Attachments: # <u>1</u> Declaration for Pro Hac Vice Admission, # <u>2</u> Supplemental Statement ISO Motion to Appear Pro Hac Vice, # <u>3</u> Certificate of Good Standing, # <u>4</u> Text of Proposed Order)(Hill, Eve) (Entered: 01/30/2025)
01/31/2025	<u>7</u>	ORDER: The Court ORDERS that: 1) Plaintiffs' <u>2</u> Motion to Seal and <u>3</u> Motion to Proceed Under Pseudonyms are GRANTED IN PART and DENIED IN PART; 2) All parties shall use the pseudonyms listed in the Complaint in all documents filed in this action; 3) Plaintiffs' <u>1</u> redacted Complaint shall remain on the public docket; 4) Their <u>5</u> unredacted TRO Motion shall remain under seal for now; and 5) Within five days of this Order, Plaintiffs shall file on the public docket a redacted version of their <u>5</u> Motion for a Temporary Restraining Order and Preliminary Injunction and associated documents; an unredacted version of their Complaint, filed under seal; and a declaration containing their real names and residential addresses, filed under seal. Signed by Chief Judge James E. Boasberg on January 31, 2025. (lcjeb3) (Entered: 01/31/2025)
02/03/2025		Case Assigned to Judge Royce C. Lamberth. (zmtm) (Entered: 02/03/2025)
02/03/2025	<u>8</u>	SUMMONS (3) Issued Electronically as to All Defendants, U.S. Attorney and U.S. Attorney General (Attachments: # <u>1</u> Notice and Consent)(zmtm) (Entered: 02/03/2025)

02/03/2025	<u>9</u>	ORDER: Upon consideration of the Motion <u>6</u> for Leave to Appear Pro Hac Vice, and the entire record herein, it is hereby ORDERED that the Motion is GRANTED. Counsel should register for e-filing via PACER and file a notice of appearance pursuant to LCvR 83.6(a) Click for instructions . Signed by Judge Royce C. Lamberth on 02/03/2025. (lcrcl2) (Main Document 9 replaced on 2/3/2025) (zsmc). (Entered: 02/03/2025)
02/03/2025	<u>10</u>	NOTICE of Appearance by Jennifer Levi on behalf of JANE DOE, MARY DOE, SARA DOE (Levi, Jennifer) (Entered: 02/03/2025)
02/03/2025		NOTICE OF HEARING: Motion Hearing set for 2/4/2025 at 10:00 AM in Courtroom 15 (In Person) before Judge Royce C. Lamberth. (smc) (Entered: 02/03/2025)
02/03/2025	<u>11</u>	Memorandum in opposition to re <u>5</u> Sealed Motion, <i>for Temporary Restraining Order or Preliminary Injunction</i> filed by JAMES R. MCHENRY, III, WILLIAM LOTHROP. (Attachments: # <u>1</u> Exhibit 1–Declaration of Rick Stover, # <u>2</u> Exhibit 2–2018 Transgender Offender Manual, # <u>3</u> Exhibit 3–2022 Transgender Offender Manual, # <u>4</u> Exhibit 4–Keohane v. Dixon Order, # <u>5</u> Text of Proposed Order)(Lin, Jean) (Entered: 02/03/2025)
02/03/2025	<u>12</u>	ENTERED IN ERROR.....SEALED MOTION FOR LEAVE TO FILE DOCUMENT UNDER SEAL filed by JAMES R. MCHENRY, III, WILLIAM LOTHROP (This document is SEALED and only available to authorized persons.) (Attachments: # <u>1</u> Exhibit Sealed declaration of Rick Stover, # <u>2</u> Text of Proposed Order)(Lin, Jean) Modified on 2/4/2025 (zdp). (Entered: 02/03/2025)
02/03/2025	<u>13</u>	MOTION for Temporary Restraining Order , MOTION for Preliminary Injunction by JANE DOE, MARY DOE, SARA DOE. (Attachments: # <u>1</u> Memorandum in Support, # <u>2</u> Exhibit Declaration of Eve Hill (Redacted), # <u>3</u> Exhibit Declaration of Loren Schechter (Redacted), # <u>4</u> Exhibit Declaration of Jane Doe (Redacted), # <u>5</u> Exhibit Declaration (Redacted), # <u>6</u> Exhibit Declaration of Frederic M. Ettner, MD, # <u>7</u> Text of Proposed Order)(Hill, Eve) (Entered: 02/03/2025)
02/03/2025	<u>14</u>	NOTICE of Appearance by John Robinson on behalf of JAMES R. MCHENRY, III, WILLIAM LOTHROP (Robinson, John) (Entered: 02/03/2025)
02/03/2025	<u>15</u>	MOTION for Leave to Appear Pro Hac Vice :Attorney Name– Sarah K. Austin, Filing fee \$ 100, receipt number ADCDC–11453369. Fee Status: Fee Paid. by JANE DOE, MARY DOE, SARA DOE. (Attachments: # <u>1</u> Certification of Sarah K. Austin, # <u>2</u> Certificate of Good Standing, # <u>3</u> Text of Proposed Order)(Hill, Eve) (Entered: 02/03/2025)
02/04/2025		NOTICE of AMENDED HEARING: Motion Hearing reset for 2/4/2025 at 11:00 AM (same day, different time) in Courtroom 15 (In Person) before Judge Royce C. Lamberth. (smc) (Entered: 02/04/2025)
02/04/2025	<u>16</u>	SEALED DOCUMENT filed by JANE DOE, MARY DOE, SARA DOE re <u>1</u> Complaint,, (This document is SEALED and only available to authorized persons.)(Hill, Eve) (Entered: 02/04/2025)
02/04/2025		Minute Entry for Motion Hearing held on 2/4/2025 before Judge Royce C. Lamberth: re <u>13</u> MOTION for Temporary Restraining Order and Preliminary Injunction. Oral arguments heard and TAKEN UNDER ADVISEMENT. Court Reporter: Lisa Edwards. (smc) (Entered: 02/04/2025)
02/04/2025		NOTICE OF ERROR regarding <u>12</u> SEALED MOTION FOR LEAVE TO FILE DOCUMENT UNDER SEAL filed by JAMES R. MCHENRY, III, WILLIAM LOTHROP (This document is SEALED and only available to authorized persons.). The following error(s) need correction: Invalid attorney signature– signature on document must match PACER login. Please refile. (zdp) (Entered: 02/04/2025)
02/04/2025	<u>17</u>	MOTION for Leave to Appear Pro Hac Vice :Attorney Name– Kara J. Janssen, Filing fee \$ 100, receipt number ADCDC–11456399. Fee Status: Fee Paid. by JANE DOE, MARY DOE, SARA DOE. (Attachments: # <u>1</u> Declaration for PHV Admission – Kara J. Janssen, # <u>2</u> Certificate of Good Standing, # <u>3</u> Text of Proposed Order)(Hill, Eve) (Entered: 02/04/2025)

02/04/2025	<u>18</u>	MOTION for Leave to Appear Pro Hac Vice :Attorney Name– Adrienne Spiegel, Filing fee \$ 100, receipt number ADCDC–11456420. Fee Status: Fee Paid. by JANE DOE, MARY DOE, SARA DOE. (Attachments: # <u>1</u> Declaration for PHV Admission – Adrienne Spiegel, # <u>2</u> Certificate of Good Standing, # <u>3</u> Text of Proposed Order)(Hill, Eve) (Entered: 02/04/2025)
02/04/2025	<u>19</u>	SEALED DOCUMENT filed by JANE DOE, MARY DOE, SARA DOE re <u>1</u> Complaint,, (This document is SEALED and only available to authorized persons.)(Hill, Eve) (Entered: 02/04/2025)
02/04/2025	<u>20</u>	ERRATA by JANE DOE, MARY DOE, SARA DOE re <u>1</u> Complaint,, (Attachments: # <u>1</u> Errata – Complaint)(Hill, Eve) (Entered: 02/04/2025)
02/04/2025	<u>21</u>	ERRATA by JANE DOE, MARY DOE, SARA DOE re <u>13</u> Motion for TRO,, Motion for Preliminary Injunction,. (Attachments: # <u>1</u> Memorandum in Support (Errata))(Hill, Eve) (Entered: 02/04/2025)
02/04/2025	<u>22</u>	MOTION for Leave to Appear Pro Hac Vice :Attorney Name– Benjamin Hattem, Filing fee \$ 100, receipt number ADCDC–11456563. Fee Status: Fee Paid. by JANE DOE, MARY DOE, SARA DOE. (Attachments: # <u>1</u> Declaration Benjamin Hattem, # <u>2</u> Certificate of Good Standing, # <u>3</u> Text of Proposed Order)(Hill, Eve) (Entered: 02/04/2025)
02/04/2025	<u>23</u>	MEMORANDUM & ORDER: Upon consideration of the plaintiffs' Motion <u>13</u> for a Temporary Restraining Order, the defendants' Opposition <u>11</u> thereto, and the entire record herein, and for the reasons contained in this Memorandum and Order, it is hereby ORDERED that the Motion is GRANTED; and it is further ORDERED that the defendants are temporarily enjoined and restrained from implementing Sections 4(a) and 4(c) of Executive Order 14168 as to the plaintiffs, pending further Order of this Court; and it is further ORDERED that, pending further Order of this Court, defendants shall maintain and continue the plaintiffs' housing status and medical care as they existed immediately prior to January 20, 2025. Signed by Judge Royce C. Lamberth on 02/04/2025. (lcrcl2) (Entered: 02/04/2025)
02/05/2025	<u>24</u>	SEALED MOTION FOR LEAVE TO FILE DOCUMENT UNDER SEAL filed by JAMES R. MCHENRY, III, WILLIAM LOTHROP (This document is SEALED and only available to authorized persons.) (Attachments: # <u>1</u> Exhibit Declaration of Rick Stover (sealed), # <u>2</u> Text of Proposed Order)(Robinson, John) (Entered: 02/05/2025)
02/05/2025	<u>25</u>	MOTION for Leave to Appear Pro Hac Vice :Attorney Name– Amy Whelan, Filing fee \$ 100, receipt number ADCDC–11458891. Fee Status: Fee Paid. by JANE DOE, MARY DOE, SARA DOE. (Attachments: # <u>1</u> Declaration for PHV Admission – Amy Whelan, # <u>2</u> Certificate of Good Standing, # <u>3</u> Text of Proposed Order)(Hill, Eve) (Entered: 02/05/2025)
02/05/2025		RESOLVED.....NOTICE of Provisional/Government Not Certified Status re <u>24</u> SEALED MOTION FOR LEAVE TO FILE DOCUMENT UNDER SEAL filed by JAMES R. MCHENRY, III, WILLIAM LOTHROP (This document is SEALED and only available to authorized persons.) (Attachments: # <u>1</u> Exhibit Declaration of Rick Stover (sealed), # <u>2</u> Text of Proposed Order)(Robinson, John). Your attorney renewal/government certification has not been received. As a result, your membership with the U.S. District & Bankruptcy Courts for the District of Columbia is not in good standing, and you are not permitted to file. Pursuant to Local Civil Rule 83.9, you must immediately correct your membership status by following the appropriate instructions on this page of our website: https://www.dcd.uscourts.gov/attorney-renewal . Please be advised that the presiding judge in this case has been notified that you are currently not in good standing to file in this court. Renewal Due by 2/12/2025. (zhcn) Modified on 2/6/2025 (zhcn). (Entered: 02/06/2025)
02/06/2025	<u>26</u>	MOTION for Leave to Appear Pro Hac Vice :Attorney Name– Ernest J. Galvan, Filing fee \$ 100, receipt number ADCDC–11462000. Fee Status: Fee Paid. by JANE DOE, MARY DOE, SARA DOE. (Attachments: # <u>1</u> Declaration for PHV Admission – Ernest J. Galvan, # <u>2</u> Certificate of Good Standing, # <u>3</u> Text of Proposed Order)(Hill, Eve) (Entered: 02/06/2025)

02/06/2025	<u>27</u>	ORDER: Upon consideration of the Motion <u>15</u> for Leave to Appear Pro Hac Vice, it is hereby ORDERED that the Motion is GRANTED. Counsel should register for e-filing via PACER and file a notice of appearance pursuant to LCvR 83.6(a) Click for instructions. Signed by Judge Royce C. Lamberth on 02/06/2025. (lcrcl2) (Entered: 02/06/2025)
02/06/2025	<u>28</u>	ORDER: Upon consideration of the Motion <u>17</u> for Leave to Appear Pro Hac Vice, it is hereby ORDERED that the Motion is GRANTED. Counsel should register for e-filing via PACER and file a notice of appearance pursuant to LCvR 83.6(a) Click for instructions. Signed by Judge Royce C. Lamberth on 02/06/2025. (lcrcl2) (Entered: 02/06/2025)
02/06/2025	<u>29</u>	ORDER: Upon consideration of the Motion <u>18</u> for Leave to Appear Pro Hac Vice, it is hereby ORDERED that the Motion is GRANTED. Counsel should register for e-filing via PACER and file a notice of appearance pursuant to LCvR 83.6(a) Click for instructions. Signed by Judge Royce C. Lamberth on 02/06/2025. (lcrcl2) (Entered: 02/06/2025)
02/06/2025	<u>30</u>	ORDER: Upon consideration of the Motion <u>22</u> for Leave to Appear Pro Hac Vice, it is hereby ORDERED that the Motion is GRANTED. Counsel should register for e-filing via PACER and file a notice of appearance pursuant to LCvR 83.6(a) Click for instructions. Signed by Judge Royce C. Lamberth on 02/06/2025. (lcrcl2) (Entered: 02/06/2025)
02/06/2025	<u>31</u>	ORDER: Upon consideration of the Motion <u>25</u> for Leave to Appear Pro Hac Vice, it is hereby ORDERED that the Motion is GRANTED. Counsel should register for e-filing via PACER and file a notice of appearance pursuant to LCvR 83.6(a) Click for instructions. Signed by Judge Royce C. Lamberth on 02/06/2025. (lcrcl2) (Entered: 02/06/2025)
02/06/2025	<u>32</u>	ORDER: Upon consideration of the Motion <u>26</u> for Leave to Appear Pro Hac Vice, it is hereby ORDERED that the Motion is GRANTED. Counsel should register for e-filing via PACER and file a notice of appearance pursuant to LCvR 83.6(a) Click for instructions. Signed by Judge Royce C. Lamberth on 02/06/2025. (lcrcl2) (Entered: 02/06/2025)
02/06/2025	<u>33</u>	TRANSCRIPT OF MOTION HEARING before Judge Royce C. Lamberth held on February 4, 2025; Page Numbers: 1–41. Date of Issuance: February 6, 2025. Court Reporter/Transcriber Lisa Edwards. Telephone number (202) 354–3269. Transcripts may be ordered by submitting the <u>Transcript Order Form</u> For the first 90 days after this filing date, the transcript may be viewed at the courthouse at a public terminal or purchased from the court reporter referenced above. After 90 days, the transcript may be accessed via PACER. Other transcript formats, (multi–page, condensed, CD or ASCII) may be purchased from the court reporter. NOTICE RE REDACTION OF TRANSCRIPTS: The parties have twenty–one days to file with the court and the court reporter any request to redact personal identifiers from this transcript. If no such requests are filed, the transcript will be made available to the public via PACER without redaction after 90 days. The policy, which includes the five personal identifiers specifically covered, is located on our website at www.dcd.uscourts.gov. Redaction Request due 2/27/2025. Redacted Transcript Deadline set for 3/9/2025. Release of Transcript Restriction set for 5/7/2025.(Edwards, Lisa) (Entered: 02/06/2025)
02/07/2025	<u>34</u>	RETURN OF SERVICE/AFFIDAVIT of Summons and Complaint Executed as to the District of Columbia Attorney General. Date of Service Upon District of Columbia Attorney General 2/3/2025. Answer due for ALL D.C. DEFENDANTS by 2/24/2025. (Hill, Eve) (Entered: 02/07/2025)
02/07/2025	<u>35</u>	RETURN OF SERVICE/AFFIDAVIT of Summons and Complaint Executed. WILLIAM LOTHROP served on 2/3/2025 (Hill, Eve) (Entered: 02/07/2025)
02/07/2025	<u>36</u>	NOTICE of Appearance by Sarah K. Austin on behalf of JANE DOE, MARY DOE, SARA DOE (Austin, Sarah) (Entered: 02/07/2025)

02/07/2025	<u>38</u>	NOTICE of Appearance by Amy Whelan on behalf of All Plaintiffs (Whelan, Amy) (Entered: 02/07/2025)
02/07/2025	<u>39</u>	NOTICE of Appearance by Kara Jane Janssen on behalf of All Plaintiffs (Janssen, Kara) (Entered: 02/07/2025)
02/07/2025	<u>40</u>	NOTICE of Appearance by Ernest Galvan on behalf of All Plaintiffs (Galvan, Ernest) (Entered: 02/07/2025)
02/07/2025	<u>41</u>	NOTICE of Appearance by Adrienne Spiegel on behalf of All Plaintiffs (Spiegel, Adrienne) (Entered: 02/07/2025)
02/10/2025	<u>42</u>	MOTION for Leave to Appear Pro Hac Vice :Attorney Name- Christopher F. Stoll, Filing fee \$ 100, receipt number ADCDC-11467664. Fee Status: Fee Paid. by JANE DOE, MARY DOE, SARA DOE. (Attachments: # <u>1</u> Declaration for PHV Admission - Christopher F. Stoll, # <u>2</u> Certificate of Good Standing, # <u>3</u> Text of Proposed Order)(Hill, Eve) (Entered: 02/10/2025)
02/14/2025	<u>43</u>	ORDER: Upon consideration of the Motion <u>42</u> for Leave to Appear Pro Hac Vice, it is hereby ORDERED that the Motion is GRANTED. Counsel should register for e-filing via PACER and file a notice of appearance pursuant to LCvR 83.6(a) Click for instructions. Signed by Judge Royce C. Lamberth on 02/14/2025. (lcrcl2) (Entered: 02/14/2025)
02/18/2025	<u>44</u>	ORDER: Upon consideration of the plaintiffs' Motion <u>13</u> for a Preliminary Injunction, the Opposition <u>11</u> thereto, and the entire record herein which is essentially unchanged since the issuance of the Temporary Restraining Order <u>23</u> , and for the reasons contained in the Temporary Restraining Order, it is hereby ORDERED that the plaintiffs' Motion for a Preliminary Injunction is GRANTED; and it is further ORDERED that the defendants are hereby enjoined from implementing Sections 4(a) and 4(c) of Executive Order 14168 against plaintiffs Jane, Mary, and Sara Doe, pending further Order of this Court; and it is further ORDERED that, pending further Order of this Court, the defendants shall maintain and continue the plaintiffs' housing status and medical care as they existed immediately prior to January 20, 2025. See Order for details. Signed by Judge Royce C. Lamberth on 02/18/2025. (lcrcl2) (Entered: 02/18/2025)
02/19/2025	<u>45</u>	NOTICE of Appearance by Christopher F. Stoll on behalf of All Plaintiffs (Stoll, Christopher) (Entered: 02/19/2025)
02/21/2025	<u>46</u>	RETURN OF SERVICE/AFFIDAVIT of Summons and Complaint Executed on United States Attorney General. Date of Service Upon United States Attorney General 02/07/2025. (Hill, Eve) (Entered: 02/21/2025)
02/21/2025	<u>47</u>	AMENDED COMPLAINT against All Defendants filed by JANE DOE, SARA DOE, MARY DOE.(Hill, Eve) (Entered: 02/21/2025)
02/21/2025	<u>48</u>	SEALED MOTION FOR LEAVE TO FILE COMPLAINT UNDER SEAL filed by JANE DOE, MARY DOE, SARA DOE. (Attachments: # <u>1</u> Memorandum in Support, # <u>2</u> Text of Proposed Order, # <u>3</u> AMENDED COMPLAINT)(Hill, Eve) (Entered: 02/21/2025)
02/21/2025	<u>49</u>	MOTION to Proceed Under Pseudonyms by JANE DOE, MARY DOE, SARA DOE. (Attachments: # <u>1</u> Memorandum in Support, # <u>2</u> Text of Proposed Order)(Hill, Eve) (Entered: 02/21/2025)
02/21/2025	<u>50</u>	MOTION for Temporary Restraining Order , MOTION for Preliminary Injunction (<i>Expanded</i>) by JANE DOE, MARY DOE, SARA DOE. (Attachments: # <u>1</u> Memorandum of Points and Authorities ISO Motion for TRO and Expanded PI, # <u>2</u> Declaration of Eve Hill ISO Motions for TRO and PI and to Proceed Under Pseudonym and Partially Seal the Record, # <u>3</u> Text of Proposed Order)(Hill, Eve) (Entered: 02/21/2025)
02/21/2025	<u>51</u>	SEALED DOCUMENT filed by JANE DOE, MARY DOE, SARA DOE re <u>50</u> MOTION for Temporary Restraining Order MOTION for Preliminary Injunction (<i>Expanded</i>) (This document is SEALED and only available to authorized persons.)(Hill, Eve) (Entered: 02/21/2025)

02/23/2025	<u>52</u>	Memorandum in opposition to re <u>50</u> Motion for TRO,, Motion for Preliminary Injunction, (<i>Redacted</i>) filed by JAMES R. MCHENRY, III, WILLIAM LOTHROP. (Attachments: # <u>1</u> Declaration of Rick Stover (redacted), # <u>2</u> Text of Proposed Order)(Robinson, John) (Entered: 02/23/2025)
02/23/2025	<u>53</u>	SEALED MOTION FOR LEAVE TO FILE DOCUMENT UNDER SEAL filed by JAMES R. MCHENRY, III, WILLIAM LOTHROP (This document is SEALED and only available to authorized persons.) (Attachments: # <u>1</u> Response to Plaintiffs' Motion for TRO, # <u>2</u> Declaration of Rick Stover, # <u>3</u> Text of Proposed Order)(Robinson, John) (Entered: 02/23/2025)
02/24/2025	<u>54</u>	REPLY in Support of Motion for Temporary Restraining Order and Preliminary Injunction filed by JANE DOE, MARY DOE, SARA DOE. (Attachments: # <u>1</u> Declaration of Lauren Meade, M.D. ISO Plaintiffs' Motion for TRO and Expanded PI)(Hill, Eve) (Entered: 02/24/2025)
02/24/2025	<u>55</u>	ORDER granting <u>50</u> Motion for TRO and Preliminary Injunction; It is hereby ORDERED that the plaintiffs' Motion is GRANTED; and it is further ORDERED that the defendants are hereby enjoined from implementing Sections 4(a) and 4(c) of Executive Order 14168 against plaintiffs Jane, Mary, Sara, Emily, Zoe, Tori, Olivia, Susan, Lois, Sophia, Sally, and Wendy Doe, pending further Order of this Court; and it is further ORDERED that, pending further Order of this Court, the defendants shall maintain and continue the plaintiffs' housing status and medical care as they existed immediately prior to January 20, 2025. Signed by Judge Royce C. Lamberth on 2/24/2025. (lcrcl3) (Entered: 02/24/2025)
02/24/2025	<u>56</u>	NOTICE of Appearance by Benjamin Hattem on behalf of All Plaintiffs (Hattem, Benjamin) (Entered: 02/24/2025)
02/27/2025	<u>57</u>	ORDER granting Plaintiffs' Motion for Protective Order, ECF No. 1–5. See Order for details. Signed by Judge Royce C. Lamberth on 2/27/2025. (lcrcl3) (Entered: 02/27/2025)
03/14/2025	<u>58</u>	Consent MOTION for Leave to File <u>47</u> Amended Complaint by JANE DOE, MARY DOE, SARA DOE. (Attachments: # <u>1</u> Exhibit Redlined Second Amended Complaint, # <u>2</u> Exhibit Second Amended Complaint – Redacted)(Janssen, Kara) Modified event on 3/17/2025 (znmw). (Entered: 03/14/2025)
03/14/2025	<u>59</u>	SEALED DOCUMENT re <u>58</u> Motion for Leave to File filed by JANE DOE, MARY DOE, SARA DOE(This document is SEALED and only available to authorized persons.)(Janssen, Kara) Modified to add link on 3/17/2025 (znmw). (Entered: 03/14/2025)
03/14/2025	<u>60</u>	SEALED MOTION to Proceed Under Pseudonym filed by JANE DOE, MARY DOE, SARA DOE (Attachments: # <u>1</u> Memorandum in Support, # <u>2</u> Text of Proposed Order)(Janssen, Kara) (Entered: 03/14/2025)
03/14/2025	<u>61</u>	MOTION for Temporary Restraining Order by JANE DOE, MARY DOE, SARA DOE. (Attachments: # <u>1</u> Memorandum in Support, # <u>2</u> Declaration of Kara Janssen ISO Motions for Temporary Restaining Order & to Proceed Under Pseudonym, # <u>3</u> Declaration of Ellen Doe, # <u>4</u> Declaration of Rachel Doe, # <u>5</u> Text of Proposed Order)(Janssen, Kara) (Entered: 03/14/2025)
03/14/2025	<u>62</u>	SEALED DOCUMENT filed by JANE DOE, MARY DOE, SARA DOE re <u>61</u> MOTION for Temporary Restraining Order (This document is SEALED and only available to authorized persons.) (Attachments: # <u>1</u> Declaration of Ellen Doe (Unredacted), # <u>2</u> Declaration of Rachel Doe (Unredacted))(Janssen, Kara) (Entered: 03/14/2025)
03/17/2025	<u>63</u>	RESPONSE re <u>61</u> MOTION for Temporary Restraining Order (<i>redacted</i>) filed by JAMES R. MCHENRY, III, WILLIAM LOTHROP. (Attachments: # <u>1</u> Declaration of Health Services Administrator, # <u>2</u> Declaration of Associate Warden, # <u>3</u> Text of Proposed Order)(Robinson, John) (Entered: 03/17/2025)
03/17/2025	<u>64</u>	SEALED OPPOSITION filed by JAMES R. MCHENRY, III, WILLIAM LOTHROP. re <u>61</u> Motion for TRO, (Attachments: # <u>1</u> Declaration of Health Services Administrator, # <u>2</u> Declaration of Associate Warden)(Robinson, John) (Entered: 03/17/2025)

03/18/2025	<u>65</u>	REPLY to opposition to motion re <u>61</u> MOTION for Temporary Restraining Order filed by JANE DOE, MARY DOE, SARA DOE. (Janssen, Kara) Modified docket text on 3/25/2025 (zdp). (Entered: 03/18/2025)
03/18/2025	<u>66</u>	MOTION to Convert Pending Motion for Further Temporary Restraining Order to Motion for Further Preliminary Injunction or Temporary Restraining Order by JANE DOE, MARY DOE, SARA DOE. (Attachments: # <u>1</u> Memorandum in Support, # <u>2</u> Text of Proposed Order)(Janssen, Kara) (Entered: 03/18/2025)
03/18/2025	<u>67</u>	SEALED DOCUMENT filed by JANE DOE, MARY DOE, SARA DOE(This document is SEALED and only available to authorized persons.)(Janssen, Kara) (Entered: 03/18/2025)
03/19/2025	<u>68</u>	ORDER granting <u>58</u> Motion for Leave to File; granting <u>66</u> Motion to Convert/Motion for Preliminary Injunction; it is hereby ORDERED that the plaintiffs' Motion for a Preliminary Injunction is GRANTED; and it is further ORDERED that the defendants are hereby enjoined from implementing sections 4(a) and 4(c) of Executive Order 14168 with regard to Rachel Doe and Ellen Doe, pending further Order of this Court; and it is further ORDERED that the defendants shall immediately transfer plaintiffs Rachel Doe and Ellen Doe back to women's penitentiaries and reinstate or continue their gender dysphoria treatment, pending further Order of this Court. See Order for details. Signed by Judge Royce C. Lamberth on 3/19/2025. (lcrcl3) (Entered: 03/19/2025)
03/31/2025	<u>69</u>	NOTICE of Appearance by Elizabeth Brooke Layendecker on behalf of All Defendants (Layendecker, Elizabeth) (Main Document 69 replaced on 4/1/2025) (zdp). (Entered: 03/31/2025)
04/01/2025	<u>70</u>	NOTICE of Appearance by Alexander James Yun on behalf of All Defendants (Yun, Alexander) (Main Document 70 replaced on 4/1/2025) (zdp). (Entered: 04/01/2025)
04/01/2025	<u>71</u>	Consent MOTION for Extension of Time to File Answer by JAMES R. MCHENRY, III, WILLIAM LOTHROP. (Attachments: # <u>1</u> Text of Proposed Order)(Yun, Alexander) (Entered: 04/01/2025)
04/02/2025	<u>72</u>	NOTICE OF APPEAL TO DC CIRCUIT COURT as to <u>44</u> Order on Motion for Preliminary Injunction,,, <u>55</u> Order on Motion for TRO,,, Order on Motion for Preliminary Injunction,,, <u>68</u> Order on Motion for Leave to File,,, Order on Motion for TRO,,, Order on Motion for Miscellaneous Relief,, by JAMES R. MCHENRY, III, WILLIAM LOTHROP. Fee Status: No Fee Paid. Parties have been notified. (Layendecker, Elizabeth) (Entered: 04/02/2025)
04/02/2025	<u>73</u>	Transmission of the Notice of Appeal, Order Appealed (Memorandum Opinion), and Docket Sheet to US Court of Appeals. The Court of Appeals docketing fee was not paid because the appeal was filed by the government re <u>72</u> Notice of Appeal to DC Circuit Court,. (zdp) Modified docket text on 4/2/2025 (zdp). (Entered: 04/02/2025)
04/02/2025		USCA Case Number 25-5099 for <u>72</u> Notice of Appeal to DC Circuit Court, filed by WILLIAM LOTHROP, JAMES R. MCHENRY, III. (zdp) (Entered: 04/03/2025)
04/04/2025	<u>74</u>	NOTICE OF WITHDRAWAL OF APPEARANCE as to WILLIAM LOTHROP, JAMES R. MCHENRY, III. Attorney John Robinson terminated. (Robinson, John) (Entered: 04/04/2025)
04/11/2025	<u>75</u>	ORDER: Upon consideration of the consent Motion <u>71</u> for an Extension of Time to Answer or Otherwise Respond to the Complaint, and the entire record herein, it is hereby ORDERED that the Motion is GRANTED; and it is further ORDERED that the defendants' deadline to respond to the Complaint shall be extended to April 25, 2025. Signed by Judge Royce C. Lamberth on 04/10/2025. (lcrcl2) (Entered: 04/11/2025)
04/24/2025	<u>76</u>	Consent MOTION to Stay <i>Proceedings</i> by WILLIAM LOTHROP, JAMES R. MCHENRY, III. (Attachments: # <u>1</u> Text of Proposed Order)(Yun, Alexander) (Entered: 04/24/2025)
04/25/2025	<u>77</u>	ORDER granting <u>76</u> Motion to Stay. Signed by Judge Royce C. Lamberth on 4/25/2025. (lcrcl3) (Entered: 04/25/2025)

04/28/2025		Case Stayed. (smc) (Entered: 04/28/2025)
04/29/2025	<u>78</u>	Joint MOTION for Protective Order by WILLIAM LOTHROP, JAMES R. MCHENRY, III. (Attachments: # <u>1</u> Text of Proposed Order)(Layendecker, Elizabeth) (Entered: 04/29/2025)
05/06/2025	<u>79</u>	ORDER: Upon consideration of the parties' joint Motion <u>78</u> for a Protective Order, and the entire record herein, it is hereby ORDERED that the Motion is GRANTED. See Order for details as to the Protective Order. Signed by Judge Royce C. Lamberth on 05/06/2025. (lcrcl2) (Entered: 05/06/2025)

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**UNITED STATES DISTRICT COURT
DISTRICT OF COLUMBIA**

JANE DOE, et al.,

Plaintiffs,

v.

JAMES R. MCHENRY III, in his official
capacity as Acting Attorney General of the
United States; WILLIAM LOTHROP, in his
official capacity as Acting Director of the
Federal Bureau of Prisons,

Defendants.

Case No.: 1:25-cv-00286

**DECLARATION OF EVE HILL IN SUPPORT OF
PLAINTIFFS' MOTIONS FOR A TEMPORARY RESTRAINING
ORDER/PRELIMINARY INJUNCTION AND TO
PROCEED UNDER PSEUDONYM, PARTIALLY SEAL THE RECORD,
AND FOR A PROTECTIVE ORDER**

I, Eve Hill, of full age, do hereby declare as follows:

1. I am an attorney in good standing with the District of Columbia Bar and licensed to practice law in the District of Washington, D.C.

2. I make the following declaration based on personal knowledge and pursuant to F.R.C.P. 65(b).

3. Plaintiff Jane Doe is a transgender woman who has taken hormones [REDACTED], has been housed in a women's facility [REDACTED]. She faces imminent transfer to a men's prison and immediate cessation of medically-necessary treatment for gender dysphoria.

4. Plaintiff May Doe is a transgender woman who has taken hormones [REDACTED], [REDACTED], and has been housed in a women's facility for [REDACTED]

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[REDACTED]. She faces imminent transfer to a men's prison and immediate cessation of medically-necessary treatment for gender dysphoria.

5. Plaintiff Sara Doe is a transgender woman who has lived as a woman and taken hormones [REDACTED]. She has been housed in a women's facility [REDACTED]. She faces imminent transfer to a men's prison and immediate cessation of medically-necessary treatment for gender dysphoria.

6. Plaintiffs file this Emergency Motion for a Temporary Restraining Order, which seeks to preserve the status quo prior to January 20, 2025, when Executive Order 14166 was issued, while the parties litigate the lawfulness of certain provisions of the Executive Order. Because of the serious risk of irreparable harm, the imminence of the transfer, and the time sensitivity involved in getting immediate relief from this Court, Plaintiffs' counsel filed the Emergency Motion ex parte and without notice to Defendants. However, Plaintiffs' counsel will send the Complaint and Emergency Motion for Temporary Restraining Order and Preliminary Injunction to the United States Attorney for the District of Columbia and the Attorney General by email.

7. In conjunction with the Complaint and Emergency Motion, Plaintiffs' counsel also filed a Motion To Proceed Under a Pseudonym, To Partially Seal Documents, and for a Protective Order. This motion is based on the specific potential harms that would follow from revealing Plaintiffs' identities, including the potential risk to them of violence in the corrections system and the violation of their interests in maintaining privacy of their medical status, history, and records.

8. All redactions proposed for the partially sealed documents stem from the necessity to protect their identities, as set forth below.

9. The locations and dates of the Plaintiffs' current and former correctional facilities are redacted because of the limited number of incarcerated transgender women at those facilities. If the facilities and time periods when Plaintiffs were there were identified, Plaintiffs' identities could be easily surmised from among a small number of transgender women at those facilities.

10. Specific biographical details concerning Plaintiffs are redacted, including their current and former names and dates of birth. Any one of these details would also provide an easy means of identification with minimal internet or public records research.

11. Details of Plaintiffs' medical records, medical treatment, and mental health issues outside of their gender dysphoria treatment are redacted because the confluence of these records would serve to easily identify Plaintiffs to those that are aware of their other medical diagnosis/diagnoses.

12. Certain details about Plaintiffs' time in federal correctional facilities are redacted, including the period of their incarceration, any disciplinary record, harms they experienced, rehabilitation activities, and medical care they have received. Individuals within the correctional facility or those with whom they might communicate are likely aware of these details of Plaintiffs' time in federal custody and would be able to guess their identities if they were left unredacted.

Pursuant to 28 U.S.C. § 1746, I affirm under penalty of perjury that the above statements are true and correct.

Dated: January 30, 2025



Eve L. Hill

**UNITED STATES DISTRICT COURT
DISTRICT OF COLUMBIA**

JANE DOE, ET AL.,

Plaintiffs,

v.

JAMES R. MCHENRY III, in his
official capacity as Acting Attorney
General of the United States;
WILLIAM LOTHROP, in his official
capacity as Acting Director of the
Federal Bureau of Prisons,

Defendants.

Case No.:

**DECLARATION OF LOREN SCHECHTER, MD, IN SUPPORT OF
PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER
AND PRELIMINARY INJUNCTION**

I, Loren Schechter, MD, hereby declare and state:

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

2. I am a board certified plastic surgeon. I specialize in performing surgeries to treat gender dysphoria (including chest reconstruction surgeries, genital reconstruction surgeries, and other procedures to feminize or masculinize the body).

3. The information provided regarding my professional background, experiences, publications, and presentations are detailed in my curriculum vitae. A true and correct copy of my CV is attached to this declaration as Exhibit A.

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4. I have provided surgical care to patients diagnosed with gender dysphoria for more than 25 years. For the past 8-10 years, I have been performing over 150 gender confirming procedures every year. I have performed over 2000 gender confirming surgeries during my medical career. Currently, approximately 85-90 percent of the patients in my clinical practice are transgender individuals seeking surgeries to treat their gender dysphoria.

5. My opinions contained in this declaration are based on: (1) my clinical experience as a doctor and surgeon treating gender dysphoria and performing surgeries for patients; (2) my knowledge of the peer reviewed research, including my own, regarding medical care for gender dysphoria; (3) my work as a contributing author of the WPATH Standards of Care (SOC); and (4) my work as an author and teacher of surgical techniques used in surgeries to treat gender dysphoria.

6. Gender dysphoria is a highly treatable condition. Without access to medical treatment, many such individuals are unable to function effectively in daily life.

7. [REDACTED]

The medical purpose of vaginoplasty for transgender women is to create genitalia for the patient to allow her to live as a woman and not in her birth sex. The goal of these surgeries is to reduce or alleviate a person's gender dysphoria.

8. Surgeries to treat gender dysphoria have been performed for many decades and are a part of the established medical standard of care which has been endorsed by major medical associations.

9. Vaginoplasty surgery, like many other surgeries, requires post-surgical care. This is an essential part of the healing process and of maintaining post-surgical health.

10. If this necessary aftercare does not take place, serious complications become more

likely. These include vaginal stenosis and a heightened risk of infection. In the most serious cases, those infections could lead to sepsis, which can be life-threatening. For a transgender woman who has this surgery, post-surgical care is also essential to ensure that doctors can perform effective monitoring for prostate health.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct. Executed January 29, 2025, in Chicago, Illinois.

Loren S. Schechter, MD

Loren Schechter, MD

EXHIBIT A

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Curriculum Vitae

NAME : LOREN SLONE SCHECHTER, MD, FACS

OFFICE :

[REDACTED]

E-MAIL :

[REDACTED]

MARITAL STATUS : Married ([REDACTED])

CERTIFICATION : The American Board of Plastic Surgery 2001
Certificate Number 6271
Date Issued: September 2001
Maintenance of Certification: 2011
Maintenance of Certification: 2021

EDUCATION :
1986-1990 The University of Michigan BS, 1990
1990-1994 The University of Chicago MD, 1994
Pritzker School of Medicine

POSTGRADUATE TRAINING :

Residency: The University of Chicago Hospitals 1994-1999
Coordinated Training Program in
Plastic and Reconstructive Surgery
Chief Resident: The University of Chicago Hospitals 1998-1999
Section of Plastic and Reconstructive
Surgery
Fellowship: Reconstructive Microsurgery 1999-2000
The University of Chicago Hospitals
Section of Plastic and Reconstructive
Surgery

TEACHING APPOINTMENT and CURRENT PRACTICE LOCATION :

Professor of Surgery (Department of Surgery, Division
of Plastic Surgery with joint appointment in the
Department of Urology), Chief Section of Gender-
Affirmation Surgery, Rush University Medical Center
Director, Gender Affirmation Surgery-Rush University
Medical Center

Adjunct Professor, Department of Surgery, Icahn School
of Medicine at Mt. Sinai, NY

LICENSURE : Illinois

Illinois Controlled Substance
DEA
Georgia

STAFF APPOINTMENTS:

Rush University Medical Center
Advocate Lutheran General Hospital

HONORS AND AWARDS:

2022	WPATH award for Courage and Bravery
2022	Chicago Magazine Top Doctor
2021	Chicago Magazine Top Doctor-Surgery
2020	The University of Minnesota Program in Human Sexuality, recipient of 50 Distinguished Sexual and Gender Health Revolutionaries
2017-2020	Castle Connolly Top Doctor (Chicago)
2017	Chicago Consumer Checkbook Top Doctor
2015	University of Minnesota Program in Human Sexuality Leadership Council
2014-2015	Rosalind Franklin University of Medicine and Science Chicago Medical School Honors and recognizes for dedication and commitment to teaching
2014	National Center for Lesbian Rights honored guest
2013	Illinois State Bar Association Award for Community Leadership
2010	Advocate Lutheran General 2009 Physicians Philanthropy Leadership Committee-Outstanding Leadership
2009	Advocate Lutheran General Hospital Value Leader (received for compassion)
1994	Doctor of Medicine with Honors
1994	University of Chicago Department of Surgery Award for Outstanding Performance in the Field of Surgery
1994	Catherine Dobson Prize for the Best Oral Presentation Given at the 48 th Annual Senior Scientific Session in The Area of Clinical Investigation
1993	Alpha Omega Alpha
1991	University of Chicago National Institutes Of Health Summer Research Award
1990	Bachelor of Science with High Distinction And Honors in Economics
1990	James B. Angell Award for Academic Distinction
1989	Omicron Delta Epsilon-National Economic Honor Society
1988	College Honors Program Sophomore Honors Award For Academic Distinction
1988	Class Honors (Dean's List)

MEMBERSHIPS:

2024-	International Society of Vascularized Composite Allotransplantation

2023-	Society of Gender Surgeons, President (previously The American Society for Gender Surgeons, founding member 2016)
2018-	The American Association of Plastic Surgeons
2010-	World Society for Reconstructive Microsurgery
2005-	The University of Chicago Plastic Surgery Alumni Association
2005-	The Chicago Surgical Society
2004-	The American Society for Reconstructive Microsurgery
2003-	The American College of Surgeons
2002-	The American Society of Plastic Surgeons
2001-	Illinois Society of Plastic Surgeons (formerly Chicago Society of Plastic Surgeons)
2001-	The American Society of Maxillofacial Surgeons
2001-	American Burn Association
2001-	Midwest Association of Plastic Surgeons
2001-	WPATH
1994-	The University of Chicago Surgical Society
1994-	The University of Chicago Alumni Association
1992-	American Medical Association
1992-	Illinois State Medical Society
1992-	Chicago Medical Society
1990-	The University of Michigan Alumni Association

CURRENT HOSPITAL COMMITTEES:

Patient Safety and Quality Officer, Division of Plastic Surgery, Rush University Medical Center

PROFESSIONAL SOCIETY COMMITTEES:

WPATH, President-Elect

Nominating Committee-American Society of Plastic Surgeons

Committee on Sex and Gender Identification and Implications for Disability Evaluation, The National Academies for Science, Engineering, and Medicine

WPATH Executive Committee

Treasurer, The World Professional Association for Transgender Health

Chair, Development Committee, Global Education Institute, WPATH

Chair, Finance and Investment Committee, The American Society of Plastic Surgeons

American Board of Plastic Surgery, Guest Oral Board Examiner

WPATH Ethics Committee

Contractor Advisory Committee, National Government
Services Inc

OTHER:

American Board of Plastic Surgery-Oral Board Guest
Examiner (2020, 2021, 2022)

Guest Reviewer, Pain Management

Guest Reviewer, Plastic and Aesthetic Research

Guest Reviewer, European Medical Journal

Guest Reviewer, Open Forum Infectious Diseases

Guest Reviewer, The Journal of The American
College of Surgeons

Guest Book Reviewer, Plastic and Reconstructive
Surgery

Editorial Board, Transgender Health

Editorial Board (Associate Editor), International
Journal of Transgenderism

Fellow of the Maliniac Circle

Guest Reviewer, Journal of Reconstructive Microsurgery

Guest Reviewer, Journal of Plastic and Reconstructive
Surgery

Guest Reviewer, Journal of Sexual Medicine

Guest Editor, Clinics in Plastic Surgery, Transgender
Surgery (Elsevier Publishing)

Guest Reviewer, The Journal of Plastic and
Reconstructive Surgery

PREVIOUS EDITORIAL ROLE:

Guest Reviewer, EPlasty, online Journal

Module Editor for Patient Safety, Plastic Surgery
Hyperguide

Editorial Advisory Board, Plastic Surgery Practice

Guest Reviewer, International Journal of
Transgenderism

Guest Reviewer, Pediatrics

PREVIOUS ACADEMIC APPOINTMENT:

Clinical Professor of Surgery, The University of Illinois at Chicago

Visiting Clinical Professor in Surgery, The University of Illinois at Chicago

Chief, Division of Plastic and Reconstructive Surgery, Chicago Medical School, Rosalind Franklin University of Medicine and Science

Associate Professor, Physician Assistant Program, College of Health Professionals, Rosalind Franklin University

Associate Professor of Surgery, The College of Health Professionals, Rosalind Franklin University

Clinical Associate in Surgery, The University of Chicago

PREVIOUS HOSPITAL COMMITTEES:

Director, Center for Gender Confirmation Surgery, Louis A. Weiss Memorial Hospital

Division Director, Plastic Surgery, Lutheran General Hospital

Division Director, Plastic Surgery, St. Francis Hospital

Medical Staff Executive Committee, Secretary, Advocate Lutheran General Hospital

Credentials Committee, Lutheran General Hospital

Pharmacy and Therapeutics Committee Lutheran General Hospital

Operating Room Committee, St. Francis Hospital

Cancer Committee, Lutheran General Hospital
-Director of Quality Control

Risk and Safety Assessment Committee, Lutheran General Hospital

Nominating Committee, Rush North Shore Medical Center

Surgical Advisory Committee, Rush North Shore Medical Center

Section Director, Plastic Surgery, Rush North Shore
Medical Center

PREVIOUS SOCIETY COMMITTEES:

WPATH 2020 Biennial Meeting Steering Committee

American Society of Breast Surgeons Research
Committee, ASPS representative

American College of Radiology Committee on
Appropriateness Criteria Transgender Breast Imaging
Topic, Expert Panel on Breast Imaging: Transgender
Breast Cancer Screening Expert Panel on Breast Imaging

American Society of Plastic Surgeons, Finance and
Investment Committee

Board of Directors, at-large, The World Professional
Association for Transgender Health

PlastyPac, Chair, Board of Governors

Chair of the Metro Chicago District #2 Committee on
Applicants, American College of Surgeons

American Society of Plastic Surgery, Health Policy
Committee

American Society of Plastic Surgery, Patient Safety
Committee

American Society of Plastic Surgeons, Coding and
Payment Policy Committee

American Society of Plastic Surgeons, Practice
Management Education Committee

Board of Governors, Governor-at-large, The American
College of Surgeons

American College of Surgeons, International Relations
Committee

Chair, Government Affairs Committee, American Society
of Plastic Surgeons

President, The Metropolitan Chicago Chapter of The
American College of Surgeons

2012 Nominating Committee, American Society of Plastic
Surgeons

Program Committee, The World Society for
Reconstructive Microsurgery, 2013 Bi-Annual
Meeting

President, Illinois Society of Plastic Surgeons

Vice-President, The Illinois Society of Plastic
Surgeons (formerly the Chicago Society of Plastic
Surgery)

Vice-President, The Metropolitan Chapter of the
American College of Surgeons

American Society of Plastic Surgery, Chairman, Patient
Safety Committee

2006-2007 Pathways to Leadership, The American Society
of Plastic Surgery

2005 & 2006 President, The University of Chicago
Plastic Surgery Alumni Association

2003 Leadership Tomorrow Program, The American Society
of Plastic Surgery

Senior Residents Mentoring Program, The American
Society of Plastic Surgery

American Society of Maxillofacial Surgery, Education
Committee

Alternate Councilor, Chicago Medical Society

American Society of Aesthetic Plastic Surgery,
Electronic Communications Committee

American Society of Aesthetic Plastic Surgery,
Intranet Steering Committee

American Society of Aesthetic Plastic Surgery,
International Committee

Membership Coordinator, The Chicago Society of Plastic
Surgeons

The Illinois State Medical Society, Governmental
Affairs Council

The Illinois State Medical Society, Council on
Economics

Chicago Medical Society, Physician Review Committee
-Subcommittee on Fee Mediation

Chairman, Chicago Medical Society, Healthcare Economics Committee

Secretary/Treasurer, The Metropolitan Chicago Chapter of the American College of Surgeons

Scientific Committee, 2007 XX Biennial Symposium WPATH

Local Organizing Committee 2007 WPATH

Secretary, The Chicago Society of Plastic Surgeons

Treasurer, The Chicago Society of Plastic Surgeons

Council Member, The Metropolitan Chicago Chapter of the American College of Surgeons

INTERNATIONAL MEDICAL SERVICE:

Galilee Medical Center, Nahariya, Israel

Northwest Medical Teams
Manos de Ayuda (Oaxaca, Mexico)

Hospital de Los Ninos (San Juan, Puerto Rico)

COMMUNITY SERVICE:

Alumni Council, The University of Chicago Medical and Biological Sciences Alumni Association

The University of Minnesota Presidents Club
Chancellors Society

Board of Directors, Chicago Plastic Surgery Research Foundation

National Center for Gender Spectrum Health Advisory Council

PREVIOUS COMMUNITY SERVICE:

Solomon Schechter Day School of Metropolitan Chicago, Co-Chair, 60th Anniversary Celebration

Board of Directors, Committee on Jewish Genetic Diseases, Jewish United Fund, Chicago, Illinois

Governing Council, Lutheran General Hospital, Park Ridge, IL

Lutheran General Hospital Development Council, Park Ridge, IL

Lutheran General Hospital Men's Association, Park Ridge, IL

Advisory Board, Committee on Jewish Genetic Diseases,
Cancer Genetics Subcommittee, Jewish United Fund,
Chicago, Illinois

Health Care Advisory Board, Congressman Mark Kirk, 10th
Congressional District, Illinois

Major Gifts Committee, Saint Francis Hospital
Development Council, Evanston, IL

Visiting Professor:

1. University of Utah, Division of Plastic Surgery, November 6-8, 2014.
2. Northwestern University, Division of Plastic Surgery, April 21-22, 2016.
3. The University of North Carolina, Division of Plastic Surgery, March 28-29, 2017
4. Georgetown University, Department of Plastic Surgery, May 17-18, 2017
5. The University of Basel, Basel, Switzerland, August 31-September 1, 2018
6. The Ochsner Health System, New Orleans, LA January 28-January 30, 2019
7. The University of Toronto, Toronto, Ontario, Canada, February 21-22, 2019
8. The University of Michigan, October 3-4, 2019, Ann Arbor, MI
9. Georgetown University, Department of Plastic Surgery, July 21, 2022
10. Galilee Medical Center, Nahariya, Israel, Department of Obstetrics and Gynecology, July 1-11, 2023
11. Icahn School of Medicine at Mount Sinai, Department of Surgery, Barsky Memorial Grand Rounds, December 6, 2023, NY, NY
12. Plastic Surgery Foundation, Visiting Professor, 2024-2025
 - a. University of New Mexico, August 18-20, 2024, Albuquerque, NM
 - b. University of Mississippi, August 22-23, 2024, Jackson, MI
 - c. Albany Med Health System, November 21, 2024, Albany, NY
 - d. SUMMA Health, December 12-13, 2024, Akron, OH (James Lewis Visiting Professor in Plastic Surgery)
 - e. Corewell Health - Grand Rapids/Michigan State University

Invited Discussant:

1. Department of Defense, Military service by people who are transgender, Invitation from Terry Adirim, M.D., M.P.H. Deputy Assistant Secretary of Defense for Health Services Policy & Oversight, The Pentagon, November 9, 2017

2. Aesthetic Surgery Journal, Invited Discussant May 7, 2019, Journal Club. "What is "Nonbinary" and What Do I need to Know? A Primer for Surgeons Providing Chest Surgery for Transgender Patients."

Honorary Lecture:

1. 2023 Arthur D. Bevan Lectureship, The Chicago Surgical Society, February 2, 2023, Chicago, IL
2. 1° Congreso Argentino de Salud Transgénero (CAST), Relato Oficial: Memorias de un cirujano consagrado: "Secretos para llevar a cabo una genitoplastia exitosa" resultado de más de 20 años de experiencia ("Memoirs of an hardened surgeon: "Benchmarks for successful genitoplasty after more than 20 years of experience" November 9, 2023, Buenos Aires, Argentina
3. OneIowa LGBTQ Health and Wellness Conference, Virtual Keynote Speaker, Gender Affirmation Surgery: Where we are and where we're going, September 23, 2024 (presented virtually)

Research Interests:

1. Role of Omental Stem Cells in Wound Healing (Grant: Tawani Foundation)
2. Robotic-Assisted Bilateral Prophylactic Nipple Sparing Mastectomy with Immediate Tissue Expander/Implant Reconstruction
3. Uterine Transplantation
4. Support for Transgender and Nonbinary Individuals Seeking Vaginoplasty (STRIVE) Study, PCORI funding support (project funding \$7,038,257, organization: Oregon Health Sciences University, principal investigator, Geolani Dy, MD)
5. National Network for Gender Affirming Surgeries: Canadian Institute of Health Research, Training Grant - LGBTQ 2S Stigma Reduction & Life Course Mental Wellness (application in process)
6. Active IRBs (Rush University Medical Center)
 - Advocacy work of American Medical Boards 22091601-IRB01
 - Gender Affirmation Surgery Prospective Surveys 21032905-IRB01
 - Peri-Operative Venous Thromboembolism Protocol in Gender Affirming Vaginoplasty 23060601-IRB01
 - Gender-Q Field Test Protocol Version 1 22101802-IRB01

Grant:

1. 2024 Tawani Foundation Grant to The Chicago Plastic Surgery Research Foundation: \$80,000 3rd edition of *Principles of Transgender Medicine and Surgery*
2. 2024 Kerecis \$13,000 educational grant

BIBLIOGRAPHY:

PEER REVIEWED ARTICLES:

1. Wall E, D. Schoeller DA, **Schechter LS**, Gottlieb LJ. Measured Total Energy Requirements of Adult Patients with Burns. *The Journal of Burn Care and Rehabilitation* 20:329, 1999.
2. Cronin DC, **Schechter LS**, Lohman RF, Limsrichamrern S, Winans CG, Gerzenshtein J, Millis JM. Advances in pediatric liver transplantation: continuous monitoring of portal venous and hepatic artery flow with an implantable Doppler probe. *Transplantation*. 2002 Sep 27;74(6):887-90. doi: 10.1097/00007890-200209270-00027. PMID: 12364874.
3. Lohman RF, **Schechter LS**, Zachary LS, Aronson S. Evaluation of changes in skeletal muscle blood flow in the dog with contrast ultrasonography revisited: has the technique been useful, and where are we headed now? *Plast Reconstr Surg*. 2003 Apr 1;111(4):1477-80. doi: 10.1097/01.PRS.0000049466.95273.C8. PMID: 12618609.
4. Odessey EA, Cohn AB, Casper F, **Schechter LS**. Hereditary gingival fibromatosis: aggressive 2-stage surgical resection in lieu of traditional therapy. *Ann Plast Surg*. 2006 Nov;57(5):557-60. doi: 10.1097/01.sap.0000229059.20539.0e. PMID: 17060739
5. Odessey E, Cohn A, Beaman K, **Schechter LS**. Invasive mucormycosis of the maxillary sinus: extensive destruction with an indolent presentation. *Surg Infect (Larchmt)*. 2008 Feb;9(1):91-8. doi: 10.1089/sur.2006.039. PMID: 18363473.
6. Seitz IA, Tojo D, **Schechter LS**. Anatomy of a medication error: inadvertent subcutaneous injection of neosynephrine during nasal surgery. *Plast Reconstr Surg*. 2010 Mar;125(3):113e-4e. doi: 10.1097/PRS.0b013e3181cb68f9. PMID: 20195091.
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9. Haeck PC, Swanson JA, Iverson RE, **Schechter LS**, Singer R, Basu CB, Damitz LA, Glasberg SB, Glassman LS, McGuire MF; ASPS Patient Safety Committee. Evidence-based patient safety advisory: patient selection and procedures in ambulatory surgery. *Plast Reconstr Surg*. 2009 Oct;124(4 Suppl):6S-27S. doi: 10.1097/PRS.0b013e3181b8e880. PMID: 20827237.
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11. **Schechter LS.** The Surgeon's Relationship with The Physician Prescribing Hormones and the Mental Health Professional: Review for Version 7 of the World Professional Association of Transgender Health's Standards of Care *International Journal of Transgenderism* 11 (4), p.222-225 Oct-Dec 2009
12. Seitz IA, Williams C, **Schechter LS.** Facilitating harvest of the serratus fascial flap with ultrasonic dissection. *Eplasty*. 2010 Feb 23;10:e18. PMID: 20204058; PMCID: PMC2829196.
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15. Kalliainen LK; ASPS Health Policy Committee Evidence-Based Clinical Practice Guidelines: Reduction Mammoplasty, The American Society of Plastic Surgeons *Plast Reconstr Surg*. 2012 Oct;130(4):785-9 **Schechter LS**(member and contributor, ASPS Health Policy Committee)
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31. **Schechter LS** and Safa B. Preface: Gender Surgery: A Truly Multidisciplinary Field, *Gender Confirmation Surgery, Clin Plast Surg.*, Vol. 45 (3), p. xiii July 2018 (editors Loren S. Schechter, Bauback Safa)
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23. The 7th Annual Chicago Trauma Symposium, August 11-14, 2005, Chicago, IL "Management of Complex Injuries"

24. Current Concepts in Advanced Wound Healing: *A Practical Overview*, Rush North Shore Medical Center, Skokie, Il September 18, 2005 "From Flaps to Grafts"
25. Taizoon Baxamusa, M and Loren S. Schechter, MD, Abdominoplasty: Use in Reconstruction of the Mangled Upper Extremity, The American Association For Hand Surgery Annual Scientific Meeting, January 11-14, 2006, Tucson, Arizona.
26. The American Academy of Orthopedic Surgeons 2006 Annual Meeting, March 22-26, 2006, Chicago, Il "Methods of Patella-Femoral and Extensor Mechanism Reconstruction for Fracture and Disruption After Total Knee Arthroplasty"
27. Midwestern Association of Plastic Surgeons 44th Annual Meeting, April 29-30, 2006, Oak Brook, Illinois "Elective Abdominal Plastic Surgery Procedures Combined with Concomitant Intra-abdominal Operations: A Single Surgeon's Four Year Experience"
28. Midwestern Association of Plastic Surgeons 44th Annual Meeting, April 29-30, 2006, Oak Brook, Illinois "Hereditary Gingival Fibromatosis: Aggressive Two-Stage Surgical Resection Versus Traditional Therapy"
29. Midwestern Association of Plastic Surgeons 44th Annual Meeting, April 29-30, 2006, Oak Brook, Illinois "Abdominoplasty Graft & VAC Therapy: Two Useful Adjuncts in Full-Thickness Grafting of the Mangled Upper Extremity"
30. The American Association of Plastic Surgeons 85th Annual Meeting, May 6-9, 2006 Hilton Head, South Carolina "Excision of Giant Neurofibromas"
31. The 8th Annual Chicago Trauma Symposium, July 27-30, 2006, Chicago, Il "Management of Complex Injuries"
32. The American Society of Plastic Surgeons Annual Meeting, October 6-12, 2006, San Francisco, California "Excision of Giant Neurofibromas"
33. The American College of Surgeons Poster Presentation, October, 2006, Chicago, Il "Abdominoplasty: Use in Reconstruction of the Mangled Upper Extremity"
34. American Medical Association-RFS 3rd Annual Poster Symposium, November 10, Las Vegas, NV, 2006 "Abdominal Wall Reconstruction With Alloderm"
35. Advocate Injury Institute: "Trauma 2006: The Spectrum of Care", November 30-December 2, 2006, Lisle, Il, "Pit Bull Mauling: A Case Study"
36. The 9th Annual Chicago Trauma Symposium, August 10-12, 2007, Chicago, Il "Management of Complex Injuries"
37. The World Professional Association for Transgender Health (WPATH) 2007 XX Biennial Symposium, September 5-8, 2007, Chicago, Il Revision Vaginoplasty With Sigmoid Interposition: "A Reliable Solution for a Difficult Problem"

38. Metropolitan Chicago Chapter of the American College of Surgeons, 2008 Annual Meeting, March 15, 2008 "ER Call: Who's Job is it Anyway"
39. The 10th Annual Chicago Trauma Symposium, August 7-10, 2008, Chicago, IL "Management of Complex Injuries"
40. 23rd Annual Clinical Symposium on Advances in Skin & Wound Care: The Conference for Prevention and Healing October 26-30, 2008, Las Vegas, Nevada, poster presentation "Use of Dual Therapies Consisting of Negative Pressure Wound Therapy (NPWT) and Small Intestine Mucosa (SIS) on a Complex Degloving Injury With an Exposed Achilles Tendon: A Case Report."
41. The American Society of Plastic Surgeons Annual Meeting, October 31-November 3, 2008, Chicago, IL "Panel: Fresh Faces, Real Cases"
42. The American Association for Hand Surgery Annual Meeting, January 7-13, 2009, Maui, Hawaii, poster session: "Omental Free Tissue Transfer for Coverage of Complex Upper Extremity and Hand Defects-The Forgotten Flap."
43. Plastic Surgery At The Red Sea Symposium, March 24-28, 2009 Eilat, Israel, "Omental Free Tissue Transfer for Coverage of Complex Upper Extremity and Hand Defects-The Forgotten Flap."
44. ASPS/IQUAM Transatlantic Innovations Meeting, April 4-7, 2009 Mison de la Chimie, Paris, France, "Advertising in Plastic Surgery?"
45. ASPS/IQUAM Transatlantic Innovations Meeting, April 4-7, 2009 Mison de la Chimie, Paris, France, "Cost-Effectiveness of Physician Extenders in Plastic Surgery"
46. Midwestern Association of Plastic Surgeons, 47th Annual Meeting, April 18-19, 2009, Chicago, IL, "Microvascular Reconstruction of Iatrogenic Femoral Artery Injury in a Neonate"
47. Midwestern Association of Plastic Surgeons, 47th Annual Meeting, April 18-19, 2009, Chicago, IL, "Two Birds, One Stone: Combining Abdominoplasty with Intra-Abdominal Procedures"
48. The 11th Annual Chicago Trauma Symposium, August 1, 2009, Chicago, IL "Management of Complex Injuries"
49. Societa Italiana Di Microchirurgia, XXIII Congresso Nazionale della Societa Italiana di Microchirurgia, First Atlanto-Pacific Microsurgery Conference, Modena, Italy, October 1-3, 2009, "Omental Free Tissue Transfer for Coverage of Complex Extremity Defects: The Forgotten Flap."
50. Societa Italiana Di Microchirurgia, XXIII Congresso Nazionale della Societa Italiana di Microchirurgia, First Atlanto-Pacific Microsurgery Conference, Modena, Italy, October 1-3, 2009, "Challenging Cases."
51. American Society of Plastic Surgeons Annual Meeting, October 23-27, 2009, Seattle, WA, "President's Panel: The Future of the Solo Practice-Can We, Should We Survive?"

52. The 12th Annual Chicago Trauma Symposium, August 5-8, 2010, Chicago, IL "Management of Complex Injuries"
53. Breast MRI to Define The Blood Supply to the Nipple-Areolar Complex. German Society of Plastic, Reconstructive and Aesthetic Surgery (DGPREAC), Dresden, Germany, September 2010
54. Roundtable Discussion: Electronic Health Records-Implications for Plastic Surgeons, The American Society of Plastic Surgeons Annual Meeting, October 3, 2010, Toronto, CA
55. Breast MRI Helps Define the Blood Supply to the Nipple-Areolar Complex, The American Society of Plastic Surgeons Annual Meeting, October 3, 2010, Toronto, CA.
56. ASPS/ASPSN Joint Patient Safety Panel: Patient Selection and Managing Patient Expectations, The American Society of Plastic Surgeons Annual Meeting, October 4, 2010, Toronto, CA
57. Lunch and Learn: Prevention of VTE in Plastic Surgery Patients, The American Society of Plastic Surgeons Annual Meeting, October 5, 2010, Toronto, CA
58. Breast MRI Helps Define the Blood Supply to the Nipple-Areolar Complex, 16th Congress of The International Confederation for Plastic Reconstructive and Aesthetic Surgery, May 22-27, 2011, Vancouver, Canada
59. Breast MRI Helps Define the Blood Supply to the Nipple-Areolar Complex, The 6th Congress of The World Society for Reconstructive Microsurgery, WSRM 2011, 29 June-2 July, 2011, Helsinki, Finland
60. Applications of the Omentum for Limb Salvage: The Largest Reported Series, The 6th Congress of The World Society for Reconstructive Microsurgery, WSRM 2011, 29 June-2 July, 2011, Helsinki, Finland
61. Successful Tongue Replantation Following Auto-Amputation Using Supermicrosurgical Technique, Poster Session, The 6th Congress of The World Society for Reconstructive Microsurgery, WSRM 2011, 29 June-2 July, 2011, Helsinki, Finland
62. The 13th Annual Chicago Trauma Symposium, August 25-28, 2011, Chicago, IL "Soft Tissue Defects-Getting Coverage"
63. WPATH: Pre-conference Symposium, September 24, 2011, Atlanta, GA "Surgical Options and Decision-Making"
64. American Society of Plastic Surgeons Annual Meeting, September 27, 2011, Denver, CO Closing Session Lunch and Learn: Pathways to Prevention-Avoiding Adverse Events, Part I: Patient Selection and Preventing Adverse Events in the Ambulatory Surgical Setting
65. American Society of Plastic Surgeons Annual Meeting, September 27, 2011, Denver, CO Closing Session Lunch and Learn: Pathways to Prevention-Avoiding Adverse Events, Part III: Preventing VTE

66. XXIV Congresso Nazionale della Societa Italiana di Microchirurgia congiunto con la American Society for Reconstructive Microsurgery, October 20-22, 2011, Palermo, Sicily: 3 Step Approach to Lower Extremity Trauma
67. XXIV Congresso Nazionale della Societa Italiana Microchirurgia congiunto con la American Society for Reconstructive Microsurgery, October 20-22, 2011, Palermo, Sicily: Applications of the Omentum for Limb Salvage: The Largest Reported Series
68. American Society for Reconstructive Microsurgery, Poster Presentation, January 14-17, 2012, Las Vegas, NV: Neonatal Limb Salvage: When Conservative Management is Surgical Intervention
69. The 14th Annual Chicago Trauma Symposium, August 2-5, 2012, Chicago, IL "Soft Tissue Defects-Getting Coverage"
70. The Annual Meeting of The American Society of Plastic Surgeons, October 25th-30, 2012, New Orleans, LA "Reimbursement in Breast Reconstruction"
71. The Annual Meeting of The American Society of Plastic Surgeons, October 25th-30, 2012, New Orleans, LA "Thriving in a New Economic Reality: Business Relationships and Integration in the Marketplace"
72. The 15th Annual Chicago Trauma Symposium, August 2-5, 2013, Chicago, IL "Soft Tissue Defects-Getting Coverage"
73. 2014 WPATH Symposium, Transgender Health from Global Perspectives, February 14-18, 2014, "Short Scar Chest Surgery."
74. 2014 WPATH Symposium, Transgender Health from Global Perspectives, February 14-18, 2014, "Intestinal Vaginoplasty with Right and Left Colon."
75. 24th Annual Southern Comfort Conference, September 3-7, 2014, Atlanta, Georgia, "Gender Confirmation Surgery: State of the Art."
76. The 15th Annual Chicago Trauma Symposium, September 4-7, 2014, Chicago, IL "Soft Tissue Defects-Getting Coverage"
77. The Midwest Association of Plastic Surgeons, May 30, 2015, Chicago, IL "Gender Confirmation Surgery: A Single-Surgeon's Experience"
78. The Midwest Association of Plastic Surgeons, May 30, 2015, Chicago, IL, Moderator, Gender Reassignment.
79. the American Society of Plastic Surgeons 2015 Professional Liability Insurance and Patient Safety Committee Meeting, July 17, 2015, "Gender Confirmation Surgery."
80. The American Society of Plastic Surgeons, October 16-20, 2015, Boston, MA. From Fee-for-Service to Bundled Payments
81. The American Society of Plastic Surgeons, October 16-20, 2015, Boston, MA. Moderator, Transgender Surgery

82. The American Society of Plastic Surgeons, October 16-20, 2015, Boston, MA. Efficient Use of Physician Assistants in Plastic Surgery.
83. The American Society of Plastic Surgeons, October 16-20, 2015, Boston, MA. Patient Safety: Prevention of VTE
84. The World Professional Association for Transgender Health, Objective Quality Parameters for Gender Confirmation Surgery, June 18-22, 2016, Amsterdam, Netherlands
85. The World Professional Association for Transgender Health, Resident Education Curriculum for Gender Confirmation Surgery, June 18-22, 2016, Amsterdam, Netherlands
86. The World Professional Association for Transgender Health, Urologic Management of a Reconstructed Urethra(Poster session #195), June 18-22, 2016, Amsterdam, Netherlands
87. The World Professional Association for Transgender Health, Construction of a neovagina for male-to-female gender reassignment surgery using a modified intestinal vaginoplasty technique, poster session (Poster session #198), June 18-22, 2016, Amsterdam, Netherlands
88. Aesthetica Super Symposium, The American Society of Plastic Surgeons, Genital Aesthetics: What are we trying to achieve?, Washington, DC June 23-25, 2016
89. Aesthetica Super Symposium, The American Society of Plastic Surgeons, Female to Male Gender Reassignment, Washington, DC June 23-25, 2016
90. Aesthetica Super Symposium, The American Society of Plastic Surgeons, The journal of retractions, what I no longer do, Washington, DC June 23-25, 2016
91. Aesthetica Super Symposium, The American Society of Plastic Surgeons, The three minute drill, tips and tricks, Washington, DC June 23-25, 2016
92. Aesthetica Super Symposium, The American Society of Plastic Surgeons, Moderator, Mini master class: Male genital plastic surgery, Washington, DC June 23-25, 2016
93. The 16th Annual Chicago Trauma Symposium, August 18-21, 2016, Chicago, IL "Soft Tissue Defects-Getting Coverage"
94. USPATH Poster Session, Feb 2-5, 2017, Los Angeles, CA, Partial Flap Failure Five Weeks Following Radial Forearm Phalloplasty: Case Report and Review of the Literature
95. USPATH Poster Session, Feb 2-5, 2017, Los Angeles, CA, Urethroplasty for Stricture after Phalloplasty in Transmen Surgery for Urethral Stricture Disease after Radial Forearm Flap Phalloplasty-Management Options in Gender Confirmation Surgery

96. USPATH, Feb 2-5, 2017, Los Angeles, CA, Patient Evaluation and Chest Surgery in Transmen: A Pre-operative Classification
97. USPATH, Feb 2-5, 2017, Los Angeles, CA Single Stage Urethral Reconstruction in Flap Phalloplasty: Modification of Technique for Construction of Proximal Urethra
98. USPATH, Feb 2-5, 2017, Los Angeles, CA, Use of Bilayer Wound Matrix on Forearm Donor Site Following Phalloplasty
99. USPATH, Feb 2-5, 2017, Los Angeles, CA, Vaginoplasty: Surgical Techniques
100. USPATH, Feb 2-5, 2017, Los Angeles, CA, Positioning of a Penile Prosthesis with an Acellular Dermal Matrix Wrap following Radial Forearm Phalloplasty
101. USPATH, Feb 2-5, 2017, Los Angeles, CA, Principles for a Gender Surgery Program
102. USPATH, Feb 2-5, 2017, Los Angeles, CA, Construction of a Neovagina Using a Modified Intestinal Vaginoplasty Technique
103. The 18th Annual Chicago Orthopedic Symposium, July 6-9, 2017, Chicago, IL "Soft Tissue Defects-Getting Coverage"
104. The American Society of Plastic Surgeons Annual meeting, October 6-10, 2017, Orlando, FL, Moderator: Genital Surgery Trends for Women
105. The American Society of Plastic Surgeons Annual meeting, October 6-10, 2017, Orlando, FL, Adding Transgender Surgery to Your Practice, Moderator and Speaker
106. The American Society of Plastic Surgeons Annual meeting, October 6-10, 2017, Orlando, FL, Transbottom Surgery
107. 14th Congress of The European Federation of Societies for Microsurgery, Belgrade, May 5-8, 2018 A Novel Approach to IPP Implantation Post Phalloplasty: The Chicago Experience
108. 14th Congress of The European Federation of Societies for Microsurgery, Belgrade, May 5-8, 2018, A Novel Approach for Neovagina Configuration During Vaginoplasty for Gender Confirmation Surgery
109. 14th Congress of The European Federation of Societies for Microsurgery, Belgrade, May 5-8, 2018 Development of a Pelvic Floor Physical Therapy Protocol for Patients Undergoing Vaginoplasty for Gender Confirmation
110. 14th Congress of The European Federation of Societies for Microsurgery, Belgrade, May 5-8, 2018 Establishing Guidelines for Gender Confirmation Surgery: The Perioperative Risk of Asymptomatic Deep Venous Thrombosis for Vaginoplasty

111. The 19th Annual Chicago Trauma Symposium, August 16-19, 2018, Chicago, IL "Soft Tissue Defects-Getting Coverage"
112. Midwest LGBTQ Health Symposium, September 14-15, 2018, Chicago, IL "Quality Parameters in Gender Confirmation Surgery"
113. 25th WPATH Symposium, November 2-6, 2018, Buenos Aires, Argentina, Poster Session, Proposed Guidelines for Medical Tattoo Following Phalloplasty; An Interdisciplinary Approach
114. 25th WPATH Symposium, November 2-6, 2018, Buenos Aires, Argentina, Establishment of the First Gender Confirmation Surgery Fellowship
115. 25th WPATH Symposium, November 2-6, 2018, Buenos Aires, Argentina, ISSM Lecture, The Importance of Surgical Training
116. 25th WPATH Symposium, November 2-6, 2018, Buenos Aires, Argentina, Tracking Patient-Reported Outcomes in Gender Confirmation Surgery
117. "Theorizing the Phantom Penis," The Psychotherapy Center for Gender and Sexuality's 6th Biannual Conference, Transformations, March 29-March 30, 2019, NY, NY
118. "Uterine Transplantation and Donation in Transgender Individuals; Proof of Concept," World Professional Association for Transgender Health 27th Scientific Symposium, September 16-20, 2022, Montreal, Canada
119. Differences and Similarities of Vaginoplasty Techniques Throughout the World: Is There a Consensus?, World Professional Association for Transgender Health 27th Scientific Symposium, September 16-20, 2022, Montreal, Canada
120. Sigmoid Vaginoplasty for Primary Gender Affirming Vaginoplasty, Brielle Weinstein, Brendan O'Donnell, Henry Govekar, Loren Schechter, Chicago Surgical Society Colorectal Symposium Poster Session, March 18, 2023, Chicago, IL
121. Metoidioplasty: Preventing and Managing Complications and Improving Outcomes, USPATH Scientific Symposium, Surgeon's Program, November 9-10, Westminster, CO

INSTRUCTIONAL COURSES:

1. Emory University and WPATH: Contemporary Management of Transgender Patients: Surgical Options and Decision-Making, September 5, 2007 Chicago, IL
2. Craniomaxillofacial Trauma Surgery: An Interdisciplinary Approach, February 16-17, 2008, Burr Ridge, IL
3. Societa Italiana Di Microchirurgia, XXIII Congresso Nazionale della Societa Italiana di Microchirurgia, First Atlanto-Pacific Microsurgery Conference, Modena, Italy, October 1-3, 2009, Moderator: Free Papers, Lower Extremity

4. American Society of Plastic Surgeons Annual Meeting, October 23-27, 2009, Seattle, WA, Moderator: ASPS/ASPSN Patient Panel: Effective Communication-A Key to Patient Safety and Prevention of Malpractice Claims
5. American Society of Plastic Surgeons Annual Meeting, October 23-27, 2009, Seattle, WA, Instructional Course: Strategies to Identify and Prevent Errors and Near Misses in Your Practice
6. American Society of Plastic Surgeons Annual Meeting, October 23-27, 2009, Seattle, WA, Roundtable Discussion: Electronic Health Records-Implications for Plastic Surgeons
7. 10th Congress of The European Federation of Societies for Microsurgery, May 2-22, 2010, Genoa, Italy, "The Mangled Lower Extremities: An Algorithm for Soft Tissue Reconstruction."
8. Multispecialty Course for Operating Room Personnel-Craniomaxillofacial, Orthopaedics, and Spine, A Team Approach, AO North American, June 26-27, 2010, The Westin Lombard Yorktown Center.
9. Management of Emergency Cases in the Operating Room, The American Society of Plastic Surgeons Annual Meeting, October 4, 2010, Toronto, CA.
10. Surgical Approaches and Techniques in Craniomaxillofacial Trauma, November 6, 2010, Burr Ridge, IL.
11. The Business of Reconstructive Microsurgery: Maximizing Economic value (Chair)The American Society for Reconstructive Microsurgery, January 14-17, 2012, Las Vegas, Nevada.
12. Strategies to Identify and Prevent Errors and Near Misses in Your Practice, The Annual Meeting of The American Society of Plastic Surgeons, October 25th-30th, 2012, New Orleans, LA
13. Strategies to Identify and Prevent Errors and Near Misses in Your Practice, The Annual Meeting of The American Society of Plastic Surgeons, October 11th-15th, 2013, San Diego, CA
14. Mythbusters: Microsurgical Breast Reconstruction in Private Practice, The Annual Meeting of The American Society of Plastic Surgeons, October 11th-15th, 2013, San Diego, CA
15. Minimizing Complications in Perioperative Care, The American Society for Reconstructive Microsurgery, January 11-14, 2014, Kauai, Hawaii
16. Genitourinary and Perineal Reconstruction, The American Society for Reconstructive Microsurgery, January 11-14, 2014, Kauai, Hawaii
17. Transgender Breast Surgery, The American Society of Plastic Surgeons, October 16-20, 2015, Boston, MA
18. Gender Confirmation Surgery, The School of the Art Institute (recipient of American College Health Fund's Gallagher Koster Innovative Practices in College Health Award), October 27, 2015, Chicago, IL

19. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, November 5-7, 2015, Chicago, IL Overview of Surgical Treatment Options
20. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, November 5-7, 2015 Chicago, IL Surgical Procedures
21. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, November 5-7, 2015, Chicago, IL Surgical Complications
22. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, November 5-7, 2015, Chicago, IL Post-operative Care
23. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, November 5-7, 2015, Chicago, IL Case Discussions: The Multidisciplinary Team
24. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, January 20-23, 2016, Atlanta, GA Overview of Surgical Treatment Options
25. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, January 20-23, 2016, Atlanta, GA Surgical Treatment Options
26. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, March 30-April 1, 2016, Springfield, MO, Surgical Treatment Options.
27. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, March 30-April 1, 2016, Springfield, MO, Multi-disciplinary Case Discussion.
28. Introduction to Transgender Surgery, ASPS Breast Surgery and Body Contouring Symposium, Santa Fe, NM, August 25-27, 2016
29. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Global Education Initiative Advanced Training Course, September 28, 2016, Ft. Lauderdale, FL.
30. Cirugias de Confirmacion de Sexo Paso a Paso, XXXV Congreso Confederacion Americana de Urologia (CAU), Panama City, Panama, October 4-8, 2016.
31. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Global Education Initiative Advanced Training Course, December 3, 2016, Arlington, VA.
32. PSEN (sponsored by ASPS and endorsed by WPATH), Transgender 101 for Surgeons, January 2017-March 2017

33. Surgical Anatomy and Surgical Approaches to M-to-F Genital Gender Affirming Surgery and the Management of the Patient Before, During and After Surgery: A Human Cadaver Based Course, Orange County, CA, Feb. 1, 2017
34. Gender Confirmation Surgery, ALAPP, 2 Congreso Internacional de la Asociacion Latinoamericana de Piso Pelvico, Sao Paulo, Brasil, 9-11 de marzo de 2017
35. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Global Education Initiative Foundations Training Course, Overview of Surgical Treatment, March 31-April 2, 2017, Minneapolis Minnesota.
36. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Global Education Initiative Foundations Training Course, The Multi-Disciplinary Team Case Discussions, March 31-April 2, 2017, Minneapolis Minnesota.
37. Transfeminine Cadaver Course, WPATH, May 19-20, 2017, Chicago, IL
38. Transgender/Penile Reconstruction-Penile Reconstruction: Radial Forearm Flap Vs. Anterolateral Thigh Flap, Moderator and Presenter, The World Society for Reconstructive Microsurgery, June 14-17, 2017, Seoul, Korea
39. Primer of Transgender Breast Surgery, ASPS Breast Surgery and Body Contouring Symposium, San Diego, CA, August 10-12, 2017
40. Confirmation Surgery in Gender Dysphoria: current state and future developments, International Continence Society, Florence, Italy, September 12-15, 2017
41. The American Society of Plastic Surgeons Annual meeting, October 6-10, 2017, Orlando, FL, ASPS/WPATH Joint Session, Session Planner and Moderator
42. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Global Education Initiative Foundations Training Course: Overview of Surgical Treatment, Columbus, OH, October 20-21, 2017
43. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Global Education Initiative Advanced Training Course: Medical Care in the Perioperative Period, Aftercare: Identifying Potential Complications, Columbus, OH, October 20-21, 2017
44. Webinar: Gender Affirming Surgeries 101: Explore The Latest Topics in Gender Affirmation Surgery, PSEN, April 18, 2018
45. Course Director: MT. Sinai/WPATH Live Surgery Training Course for Gender Affirmation Procedures, April 26-28, 2018, New York, NY
46. Philadelphia Trans Wellness Conference, Perioperative Care of the Transgender Woman Undergoing Vaginoplasty (Workshop), Philadelphia, PA, August 3, 2018

47. Philadelphia Trans Wellness Conference, Gender Confirmation Surgery (Workshop), Philadelphia, PA, August 3, 2018
48. Gender Confirmation Surgery, 2018 Oral and Written Board Preparation Course, The American Society of Plastic Surgeons, August 16-18, 2018, Rosemont, IL
49. Confirmation Surgery in Gender Dysphoria: Current State and Future Developments, The International Continence Society, Philadelphia, PA August 28, 2018
50. WPATH Global Education Initiative, Foundations Training Course, "Overview of Surgical Treatment," Cincinnati, OH, September 14-15, 2018
51. WPATH Global Education Initiative, Foundations Training Course, "The Multi-Disciplinary Team: Case Discussions," Cincinnati, OH, September 14-15, 2018
52. WPATH Global Education Initiative, Advanced Training Course, "Medical Care in the Perioperative Period After Care: Identifying Potential Complications," Cincinnati, OH, September 14-15, 2018
53. 25th WPATH Symposium, Surgeons Conference, November 1, 2018, Buenos Aires, Argentina, Moderator
54. 25th WPATH Symposium, November 2-6, 2018, Buenos Aires, Argentina, Global Education Initiative (GEI): Surgery and Ethics
55. WPATH GEI: Best Practices in Medical and Mental Health Care, Foundations in Surgery, New Orleans, March 22, 2019
56. WPATH GEI: Best Practices in Medical and Mental Health Care, Advanced Surgery, New Orleans, March 22, 2019
57. Program Chair: ASPS/WPATH GEI Inaugural Gender-Affirming Breast, Chest, and Body Master Class, Miami, FL, July 20, 2019
58. Overview of Surgical Management and The Standards of Care (WPATH, v. 7) ASPS/WPATH GEI Inaugural Gender-Affirming Breast, Chest, and Body Master Class, Miami, FL, July 20, 2019
59. Program Director, Gender Affirming Breast, Chest, and Body Master Class, The American Society of Plastic Surgeons, Miami, FL, July 20, 2019
60. Gender Confirmation Surgery, The American Society of Plastic Surgeons Oral and Written Board Preparation Course, August 15, 2019, Rosemont, IL
61. Upper Surgeries (chest surgery & breast augmentation), WPATH, Global Education Initiative, September 4-5, 2019, Washington, DC
62. Preparing for Upper Surgeries-Case Based (chest surgery & breast augmentation), WPATH, Global Education Initiative, September 4-5, 2019, Washington, DC

63. Preparing for Feminizing Lower Surgeries-Case Based (vaginoplasty), WPATH, Global Education Initiative, September 4-5, 2019, Washington, DC
64. Lower Surgeries-Masculinizing (phalloplasty & metoidioplasty), WPATH, Global Education Initiative, September 4-5, 2019, Washington, DC
65. Preparing for Masculinizing Lower Surgeries-Case Based (phalloplasty & metoidioplasty), WPATH, Global Education Initiative, September 4-5, 2019, Washington, DC
66. Panel Discussion about Ethics in Surgery and Interdisciplinary Care, WPATH, Global Education Initiative, September 4-5, 2019, Washington, DC
67. Discussion about Ethics and Tensions in Child and Adolescent Care, WPATH, Global Education Initiative, September 4-5, 2019, Washington, DC
68. Transgender Health: Best Practices in Medical and Mental Health Care Foundation Training Courses, Hanoi, Viet Nam, Jan 14-17, 2020 (Foundations in Surgery, Advanced Medical-surgery and complicated case studies), Planning & Documentation (upper surgeries-chest surgery and breast augmentation, preparing for upper surgeries-case based (chest surgery and breast augmentation), lower surgeries (feminizing-vaginoplasty), preparing for feminizing lower surgeries-case based, lower surgeries-masculinizing (phalloplasty and metoidioplasty), preparing for masculinizing lower surgeries-case-based (phalloplasty and metoidioplasty), Ethics-panel discussion about ethics in surgery and interdisciplinary care)
69. WPATH GEI Panel Cases Discussion, via Webinar, May 29, 30, 31, 2020
70. WPATH GEI: Illinois Dept. of Corrections, Foundations in Surgery, November 20, 2020
71. WPATH GEI: Illinois Dept. of Corrections, Ethical Considerations in Transgender Healthcare, November 20, 2020
72. WPATH GEI: Illinois Dept. of Corrections, Foundations in Surgery, February 26, 2021
73. WPATH GEI: Illinois Dept. of Corrections, Ethical Considerations in Transgender Healthcare, February 26, 2021.
74. Current Concepts in Gender Affirming Surgery for Women in Transition, March 11-12, 2021 (online event), Moderator, Transgender Health.
75. GEI Foundations Course, Live Q&A, March 21, 2021
76. GEI Foundations Course, Live Case Panel Discussion, March 23, 2021
77. GEI Advanced Ethics Workshop; Surgical and Interdisciplinary care ethics panel, May 1, 2021 (virtual)
78. Wpath GEI Foundations course for the Illinois Dept of Corrections, Foundations in Surgery, May 21, 2021

79. Wpath GEI, Foundations course for the Illinois Dept of Corrections, Ethical considerations in Transgender Healthcare, May 21, 2021
80. WPATH GEI, Online GEI Foundations Course, Moderator, August 31, 2021.
81. WPATH Health Plan Provider (HPP) Training, Q&A Panel, September 13, 14, 21 2021, via Zoom
82. WPATH, GEI Advanced Medical Course, Upper and Lower Surgery (via zoom), December 9, 2021
83. I want to be a gender surgeon: where do I even start, American Society for Reconstructive Microsurgery, Annual Meeting, January 17, 2022, Carlsbad, CA
84. Faculty Instructor, Upper Extremity Flaps and Lower Extremity Trauma, 1st Annual Rush University – University of Chicago Cadaver Lab, June 11, 2022
85. WPATH Health Plan Provider (HPP) Training, Q&A Panel, July 12, 2022, via Zoom
86. Nonbinary Workshop, WPATH GEI, July 23, 2022, via Zoom
87. WPATH GEI Advanced Ethics workshop (2022-2023), September 17-18, 2022, Montreal, Canada
88. Course Director: 3rd Live Surgery Conference for Gender Affirmation Procedures presented by MT. Sinai and WPATH May 11-13, 2023, New York, New York
90. Advanced Medical Course, Advanced Surgical Course, Global Education Institute (GEI), USPATH, November 9-10, 2023, Westminster, CO
91. Secondary Surgeries in Gender Affirming Phalloplasty: Implants, Revisions and Redos, Loren Schechter (moderator), Mang Chen, Lee Zhao, Walter Lin, Ulrich Reiger, January 16, 2024, ASRM 2024 Annual Meeting, Nassau, Bahamas
92. GEI, Ethics Workshop-Surgeons' Panel, WPATH, 28th Scientific Symposium, September 26, Lisbon, Portugal

SYMPOSIA:

1. Program Director, 2011 Chicago Breast Symposium, October 15, 2011, The Chicago Plastic Surgery Research Foundation and The Chicago Medical School at Rosalind Franklin University, North Chicago, IL,
2. Fundamentals of Evidence-Based Medicine & How to Incorporate it Into Your Practice, Challenging Complications in Plastic Surgery: Successful Management Strategies, The American Society of Plastic Surgeons, July 13-14, 2012 Washington, DC

3. Understanding Outcome Measures in Breast & Body Contouring Surgery, Challenging Complications in Plastic Surgery: Successful Management Strategies, The American Society of Plastic Surgeons, July 13-14, 2012 Washington, DC
4. Benchmarking Complications: What We Know About Body Contouring Complication Rates from Established Databases, Challenging Complications in Plastic Surgery: Successful Management Strategies, The American Society of Plastic Surgeons, July 13-14, 2012 Washington, DC
5. Special Lecture: VTE Prophylaxis for Plastic Surgery in 2011, Challenging Complications in Plastic Surgery: Successful Management Strategies, The American Society of Plastic Surgeons, July 13-14, 2012 Washington, DC
6. Nipple Sparing Mastectomy: Unexpected Outcomes, Challenging Complications in Plastic Surgery: Successful Management Strategies, The American Society of Plastic Surgeons, July 13-14, 2012 Washington, DC
7. Program Director, 2011 Chicago Breast Symposium, October 13-14, 2012, The Chicago Plastic Surgery Research Foundation and The Chicago Medical School at Rosalind Franklin University, North Chicago, IL
8. Practice Strategies in a Changing Healthcare Environment, Moderator, Midwestern Association of Plastic Surgeons, April 27-28, 2013, Chicago, IL
9. Moderator: Breast Scientific Paper Session, The Annual Meeting of The American Society of Plastic Surgery, October 12, 2014, Chicago, IL.
10. Transgender Health and Medicine Research Conference, National Institutes of Health, Bethesda, MD May 7-8, 2015
11. Moderator: The World Professional Association for Transgender Health, Tuesday, June 21, Surgical Session (0945-1045), June 18-22, 2016, Amsterdam, Netherlands
12. Course Director: Transmale Genital Surgery: WPATH Gender Education Initiative, October 21-22, 2016 Chicago, IL
13. Co-Chair and Moderator: Surgeon's Only Session, USPATH, Los Angeles, CA, Feb. 2, 2017
14. Vascular Anastomosis: Options for Lengthening Vascular Pedicle, Surgeon's Only Session, USPATH, Los Angeles, CA, Feb. 2, 2017
15. Transgender Healthcare Mini-Symposium, Chicago Medical School of Rosalind Franklin University, North Chicago, IL March 10, 2017.
16. Moderator: Penile Transplant: Genito-urinary trauma/penile cancer, The European Association of Urologists, Meeting of the EAU Section of Genito-Urinary Reconstructive Surgeons (ESGURS), London, United Kingdom, March 23-26, 2017

17. 25th WPATH Symposium, November 2-6, 2018, Buenos Aires, Argentina, Mini-Symposium: A Comprehensive Approach to Gender Confirming Surgery
18. Program Director, 2nd Annual Live Surgery Conference for Gender Affirmation Procedures, Ichan School of Medicine at Mt. Sinai, NY, NY February 28, 2019-March 2, 2019.
19. Moderator, "Genital Reassignment for Adolescents: Considerations and Conundrums," Discussions on gender affirmation: surgery and beyond, Dignity Health Saint Francis Memorial Hospital and WPATH GEI, San Francisco, CA, May 30-June 1, 2019
20. Moderator, "Reconstructive Urology and Genitourinary Options in Gender Affirming Surgery," Discussions on gender affirmation: surgery and beyond, Dignity Health Saint Francis Memorial Hospital and WPATH GEI, San Francisco, CA, May 30-June 1, 2019
21. Moderator, "Complications in Masculinizing Genital Reconstruction Surgery," Dignity Health Saint Francis Memorial Hospital and WPATH GEI, San Francisco, CA, May 30-June 1, 2019
22. Moderator, "Preparing for Surgery and Recovery," Dignity Health Saint Francis Memorial Hospital and WPATH GEI, San Francisco, CA, May 30-June 1, 2019
23. Discussant, "WPATH Standards of Care Version 8 Preview," Dignity Health Saint Francis Memorial Hospital and WPATH GEI, San Francisco, CA, May 30-June 1, 2019
24. Program Coordinator, Surgeon's Only Course, USPATH, September 5, 2019, Washington, DC
25. Master Series in Transgender Surgery 2020: Vaginoplasty and Top Surgery, course co-director, Mayo Clinic, Rochester, MN, August 7-8, 2020
26. WPATH 2020 Surgeons' Program, Co-Chair, November 6-7, 2020, Virtual Symposium (due to covid-19 cancellation of Hong Kong meeting)
27. WPATH Journal Club #3, Uterine Transplantation and Donation in Transgender Individuals; Proof of Concept, December 13, 2021 (Zoom)
28. Program Coordinator and Moderator, Surgeon's Only Course, WPATH 27th Scientific Symposium, September 16-17, 2022, Montreal, Canada
29. 'Metoidioplasty: Preventing and Managing Complications and Improving Outcomes,' Submission Reference Number: 0794_1189_000333, Presentation Number: WED-S3-M, USPATH, Westminster, CO, Nov 1-2, 2023
30. Clinical Consideration in the Assessment and Management of Sex Hormone-Responsive Cancers in Transgender and Gender Diverse People, WPATH 28th Scientific Symposium, September 25th-30th, Lisbon, Portugal.

FACULTY SPONSORED RESEARCH:

1. Societa Italiana Di Microchirurgia, XXIII Congresso Nazionale della Societa Italiana di Microchirurgia, First Atlanto-Pacific Microsurgery Conference, Modena, Italy, October 1-3, 2009, "Free Tissue Transfer in the Treatment of Zygomycosis." Presented by Michelle Roughton, MD
2. Hines/North Chicago VA Research Day, Edward Hines, Jr., VA Hospital, Maywood, IL, April 29, 2010, "Breast MRI Helps to Define the Blood Supply to the Nipple-Areolar Complex." Presented by Iris A. Seitz, MD, PhD.
3. Advocate Research Forum, Advocate Lutheran General Hospital, May 5, 2010, "Breast MRI Helps to Define the Blood Supply to the Nipple-Areolar Complex." Presented by Iris A. Seitz, MD, PhD.
4. Advocate Research Forum, Advocate Lutheran General Hospital, May 5, 2010, "Achieving Soft Tissue Coverage of Complex Upper and Lower Extremity Defects with Omental Free Tissue Transfer." Presented by Iris A. Seitz, MD, PhD.
5. Advocate Research Forum, Advocate Lutheran General Hospital, May 5, 2010, "Facilitating Harvest of the Serratus Fascial Flap with Ultrasonic Dissection." Presented by Iris A. Seitz, MD, PhD.
6. Advocate Research Forum, Advocate Lutheran General Hospital, May 5, 2010, "Patient Safety: Abdominoplasty and Intra-Abdominal Procedures." Presented by Michelle Roughton, MD
7. The Midwestern Association of Plastic Surgeons, 49th Annual Scientific Meeting, May 15th, 2010, "Breast MRI Helps Define The Blood Supply to the Nipple-Areolar Complex." Presented by Iris A. Seitz, MD, PhD.
8. Jonathan M. Hagedorn, BA, **Loren S. Schechter**, MD, FACS, Dr. Manoj R. Shah, MD, FACS, Matthew L. Jimenez, MD, Justine Lee, MD, PhD, Varun Shah. Re-examining the Indications for Limb Salvage, 2011 All School Research Consortium at Rosalind Franklin University. Chicago Medical School of Rosalind Franklin University, 3/16/11.
9. Jonathan Bank, MD, Lucio A. Pavone, MD, Iris A. Seitz, Michelle C. Roughton, MD, Loren S. Schechter, MD Deep Inferior Epigastric Perforator Flap for Breast Reconstruction after Abdominoplasty The Midwestern Association of Plastic Surgeons, 51st Annual Educational Meeting, April 21-22, 2012, Northwestern Memorial Hospital, Chicago, Illinois
10. Samuel Lake, Iris A. Seitz, MD, PhD, Loren S. Schechter, MD, Daniel Peterson, PhD Omentum and Subcutaneous Fat Derived Cell Populations Contain hMSCs Comparable to Bone Marrow-Derived hMSCs First Place, Rosalind Franklin University Summer Research Poster Session
11. J. Siwinski, MS II, Iris A. Seitz, MD PhD, Dana Rioux Forker, MD, Lucio A. Pavone, MD, Loren S. Schechter, MD FACS. Upper and Lower Limb Salvage With Omental Free Flaps: A Long-Term Functional Outcome Analysis. Annual Dr. Kenneth A. Suarez Research Day, Midwestern University, Downers Grove, IL, May 2014

12. Whitehead DM, Kocjancic E, Iacovelli V, Morgantini LA, **Schechter LS**. A Case Report: Penile Prosthesis With an Alloderm Wrap Positioned After Radial Forearm Phalloplasty. Poster session presented at: American Society for Reconstructive Microsurgery Annual Meeting, 2018 Jan 13-16; Phoenix, AZ.
13. Whitehead DM, Kocjancic E, Iacovelli V, Morgantini LA, **Schechter LS**. An Innovative Technique: Single Stage Urethral Reconstruction in Female-to-Male Patients. Poster session presented at: American Society for Reconstructive Microsurgery Annual Meeting, 2018 Jan 13-16; Phoenix, AZ.
14. Whitehead, DM Inflatable Penile Prosthesis Implantation Post Phalloplasty: Surgical Technique, Challenges, and Outcomes, MAPS 2018 Annual Scientific Meeting, April 14, 2018, Chicago, IL
15. Whitehead, DM, Inverted Penile Skin With Scrotal Graft And Omission of Sacrospinal Fixation: Our Novel Vaginoplasty Technique MAPS 2018 Annual Scientific Meeting, April 14, 2018, Chicago, IL
16. S. Marecik, J. Singh. **L. Schechter**, M. Abdulhai, K. Kochar, J. Park, Robotic Repair of a Recto-Neovaginal Fistula in a Transgender Patient Utilizing Intestinal Vaginoplasty, The American College of Surgeons Clinical Congress 2020, October 7, 2020
17. Natalia Whitney, Randi Ettner, **Loren Schechter**, Sexual Function Expectations, Outcomes, and Discussions for Patients Undergoing Gender-Affirming Surgery, 2022 Trainee Research Day, Rush University Medical Center, The Irwin Press Patient Experience Research Poster Award
18. Natalia Whitney, Randi Ettner, **Loren Schechter**, Sexual Function Expectations, Outcomes, and Discussions for Patients Undergoing Gender-Affirming Surgery, 2022 Trainee Research Day, Rush University Medical Center, Peoples Choice-Third Place Poster Presentation
19. Adam Steur, Christy Ciesla, Clarion Mendes, Loren Schechter, The Need for a Comprehensive Interprofessional Postsurgical Rehabilitation Pathway: Initial Recommendations and Future Visions, The World Professional Association for Transgender Health, 27th Scientific Symposium, Surgeon's Only Program September 16-17, 2022, Montreal, Canada
20. Brielle Weinstein, MD, Kristin Jacobs, MD, Edward Cherullo, MD and Loren Schechter, MD, Illinois Surgical Society, Interesting Case Competition: Revision Vaginoplasty, April 22, 2023, Chicago, IL
21. Najafali D, Hinson C, Camacho JM, Galbraith LG, Tople TL, Eble D, Weinstein B, Schechter LS, Dorafshar AH, Morrison SD. Artificial Intelligence Knowledge of Evidence-Based Recommendations in Gender Affirmation Surgery and Gender Identity: Is ChatGPT Aware of WPATH Recommendations? USPATH 2023 Scientific Symposium. Westminster, CO, November 4, 2023. (Podium Presentation)
22. The Use of Acellular Tissue Matrices in Gender-Affirming Surgery, September 26, 2024, WPATH 28th Scientific Symposium, Surgeons' Day, Lisbon Portugal

23. A 5-Year Analysis of Level of Evidence Ratings in Gender Affirming Surgery, September 25th-30th, WPATH 28th Scientific Symposium, Poster Session, Lisbon Portugal

24. Targeted Nipple-Areolar Complex Reinnervation after Gender-Affirming Mastectomy: Systematic Review and Institutional Experience, September 25th-30th, WPATH 28th Scientific Symposium, Surgeons' Day, Lisbon Portugal

25. Advocacy in American Medical Organizations: A Cross Sectional Review and Implications for Healthcare Advocacy in American Medical Organizations, September 25th-30th, WPATH 28th Scientific Symposium, Surgeons' Day, Lisbon Portugal

26. Gender-Affirming DIEP Flap Breast Augmentation, September 25th-30th, WPATH 28th Scientific Symposium, Poster Session, Lisbon Portugal

Keynote Address:

1. University of Utah, Gender Confirmation Surgery, Transgender Provider Summit, November 8, 2014

INVITED LECTURES:

1. Management of Soft Tissue Injuries of the Face, Grand Rounds, Emergency Medicine, The University of Chicago, August, 1999

2. Case Report: Excision of a Giant Neurofibroma, Operating Room Staff Lecture Series, Continuing Education Series, St. Francis Hospital, Evanston, Il March 2000

3. Wounds, Lincolnwood Family Practice, Lincolnwood, Il April 2000

4. The Junior Attending, Grand Rounds, Plastic and Reconstructive Surgery, The University of Chicago, June 2000

5. Case Report: Excision of a Giant Neurofibroma, Department of Medicine Grand Rounds, St. Francis Hospital, Evanston, Il June 2000

6. Facial Trauma, Resurrection Medical Center Emergency Medicine Residency, September 2000

7. Plastic Surgery of the Breast and Abdomen, Grand Rounds, Dept. of Obstetrics and Gynecology, Evanston Hospital, September, 2000

8. Change of Face; Is Cosmetic Surgery for You?, Adult Education Series, Rush North Shore Medical Center, October, 2000

9. Reconstructive Surgery of the Breast, Professional Lecture Series on Breast Cancer, St. Francis Hospital, October, 2000

10. Plastic Surgery of the Breast and Abdomen, Grand Rounds, Dept. of Obstetrics and Gynecology, Lutheran General Hospital, December, 2000

11. Change of Face; Is Cosmetic Surgery for You?, Adult Education Series, Lutheran General Hospital and The Arlington Heights Public Library, December, 2000
12. Updates in Breast Reconstruction, The Breast Center, Lutheran General Hospital, January 2001
13. Abdominal Wall Reconstruction, Trauma Conference, Lutheran General Hospital, February 2001
14. Wound Care, Rush North Shore Medical Center, March 2001
15. Breast Reconstruction, Diagnosis and Treatment Updates on Breast Cancer, Lutheran General Hospital, April 2001
16. Wound Care and V.A.C. Therapy, Double Tree Hotel, Skokie, Il October 2001
17. The Role of the V.A.C. in Reconstructive Surgery, LaCrosse, WI November 2001
18. Dressing for Success: The Role of the V.A.C. in Reconstructive Surgery, Grand Rounds, The University of Minnesota Section of Plastic and Reconstructive, Minneapolis, MN January, 2002
19. The Vacuum Assisted Closure Device in the Management of Complex Soft Tissue Defects, Eau Claire, WI February, 2002
20. The Vacuum Assisted Closure Device in Acute & Traumatic Soft Tissue Injuries, Orland Park, Il March, 2002
21. Body Contouring After Weight Loss, The Gurnee Weight Loss Support Group, Gurnee, Il April, 2002
22. An Algorithm to Complex Soft Tissue Reconstruction With Negative Pressure Therapy, Owensboro Mercy Medical Center, Owensboro, Ky, April, 2002
23. Breast and Body Contouring, St. Francis Hospital Weight Loss Support Group, Evanston, Il April, 2002
24. The Wound Closure Ladder vs. The Reconstructive Elevator, Surgical Grand Rounds, Lutheran General Hospital, Park Ridge, Il, May, 2002.
25. An Algorithm for Complex Soft Tissue Reconstruction with the Vacuum Assisted Closure Device, The Field Museum, Chicago, Il, May, 2002
26. The Role of Negative Pressure Wound Therapy in Reconstructive Surgery, Kinetic Concepts, Inc. San Antonio, Texas, July 31, 2002
27. Management of Complex Soft Tissue Injuries of the Lower Extremity, Chicago Trauma Symposium, August 2-5, 2002, Chicago, Illinois:
28. Wound Bed Preparation, Smith Nephew, Oak Brook, Il, August 6, 2002

29. Getting Under Your Skin...Is Cosmetic Surgery for You?, Rush North Shore Adult Continuing Education Series, Skokie, Il August 28, 2002.
30. The Role of Negative Pressure Therapy in Complex Soft Tissue Wounds, Columbia/St. Mary's Wound, Ostomy, and Continence Nurse Program, Milwaukee, Wi, September 17, 2002
31. A Systematic Approach to Functional Restoration, Grand Rounds, Dept. of Physical Therapy and Rehabilitation Medicine, Lutheran General Hospital, September 19, 2002
32. The Role of Negative Pressure Wound Therapy in Reconstructive Surgery, Ann Arbor, Mi September 26, 2002
33. Dressing for Success: The Role of the Vacuum Assisted Closure Device in Plastic Surgery, Indianapolis, In November 11, 2002
34. The Wound Closure Ladder Versus the Reconstructive Elevator, Crystal Lake, Il November 21, 2002
35. A Systematic Approach to Functional Restoration, Grand Rounds, Dept. of Physical Therapy, Evanston Northwestern Healthcare, Evanston, Il February 13, 2003
36. Case Studies in Traumatic Wound Reconstruction, American Association of Critical Care Nurses, Northwest Chicago Area Chapter, Park Ridge, Il February 19, 2003
37. Reconstruction of Complex Soft Tissue Injuries of the Lower Extremity, Podiatry Lecture Series, Rush North Shore Medical Center, Skokie, Il March 5, 2003
38. The Use of Negative Pressure Wound Therapy in Reconstructive Surgery, Kalamazoo, Mi March 19, 2003
39. Updates in Breast Reconstruction, The Midwest Clinical Conference, The Chicago Medical Society, Chicago, Il March 21, 2003
40. Updates of Vacuum Assisted Closure, Grand Rounds, The Medical College of Wisconsin, Department of Plastic Surgery, Milwaukee, Wi March 26, 2003
41. Breast Reconstruction, Surgical Grand Rounds, Lutheran General Hospital, Park Ridge, Il March 27, 2003
42. Decision-Making in Breast Reconstruction: Plastic Surgeons as Members of a Multi-Disciplinary Team, 1st Annual Advocate Lutheran General Hospital Breast Cancer Symposium, Rosemont, Il, April 11, 2003
43. The Wound Closure Ladder Versus The Reconstructive Elevator, Duluth, Mn, April 24, 2003
44. Dressing For Successs: The Role of The Wound VAC in Reconstructive Surgery, Detroit, Mi, May 9, 2003

45. Plastic Surgery Pearls, Grand Rounds Orthopedic Surgery Physician Assistants Lutheran General Hospital and Finch University of Health Sciences, Park Ridge, Il, June 5, 2003
46. A Systematic Approach to Complex Reconstruction, 12th Annual Vendor Fair "Surgical Innovations," October 18, 2003, Lutheran General Hospital, Park Ridge, Il 2003
47. Dressing For Success: The Role of the Wound VAC in Reconstructive Surgery, American Society of Plastic Surgery, October 26, 2003, San Diego, CA
48. Beautiful You: From Botox to Weekend Surgeries, 21st Century Cosmetic Considerations, March 21, 2004 Hadassah Women's Health Symposium, Skokie, Il
49. Updates in Breast Reconstruction, The 2nd Annual Breast Cancer Symposium, Advocate Lutheran General, Hyatt Rosemont, April 2, 2004
50. Head and Neck Reconstruction, Grand Rounds, The University of Illinois Metropolitan Group Hospitals Residency in General Surgery, Advocate Lutheran General Hospital, May 6, 2004
51. Abdominal Wall Reconstruction, Surgeons Forum, LifeCell Corporation, May 15, 2004, Chicago, Il
52. 4th Annual Chicagoland Day of Sharing for Breast Cancer Awareness, Saturday, October 2, 2004, Hoffman Estates, Il
53. Abdominal Wall Reconstruction, University of Illinois Metropolitan Group Hospitals Residency in General Surgery, November 19, 2004, Skokie, Il
54. Advances in Wound Care, Wound and Skin Care Survival Skills, Advocate Good Samaritan Hospital, Tuesday, February 8, 2005, Downer's Grove, Il
55. Plastic Surgery: A Five Year Perspective in Practice, Grand Rounds, The University of Chicago, May 18, 2005, Chicago, Il
56. New Techniques in Breast Reconstruction, The Cancer Wellness Center, October 11, 2005 Northbrook, Il
57. Principles of Plastic Surgery; Soft Tissue Reconstruction of the Hand, Rehab Connections, Inc., Hand, Wrist, and Elbow Forum, October 28, 2005, Homer Glen, Il
58. Principles of Plastic Surgery, Lutheran General Hospital Quarterly Trauma Conference, November 9, 2005, Park Ridge, Il
59. Principles of Plastic Surgery, Continuing Medical Education, St. Francis Hospital, November 15, 2005, Evanston, Il
60. Dressing for Success: A Seven Year Experience with Negative Pressure Wound Therapy, Kinetic Concepts Inc, November 30, 2005, Glenview, Il.

61. Breast Reconstruction: The Next Generation, Breast Tumor Conference, Lutheran General Hospital, May 9, 2006.
62. Complex Wound Care: Skin Grafts, Flaps, and Reconstruction, The Elizabeth D. Wick Symposium on Wound Care, *Current Concepts in Advanced Healing: An Update*, Rush North Shore Medical Center, November 4, 2006.
63. An Approach to Maxillofacial Trauma: Grand Rounds, Lutheran General Hospital/Univ. of Illinois Metropolitan Group Hospital Residency in General Surgery, November 9, 2006.
64. "From Paris to Park Ridge", Northern Trust and Advocate Lutheran General Hospital, Northern Trust Bank, June 7, 2007.
65. "Private Practice Plastic Surgery: A Seven Year Perspective," Grand Rounds, The University of Chicago, Section of Plastic Surgery.
66. "Meet the Experts on Breast Cancer," 7th Annual Chicagoland Day of Sharing, Sunday, April 13th, 2008
67. Gender Confirmation Surgery: Surgical Options and Decision-Making, The University of Minnesota, Division of Human Sexuality, May 10, 2008, Minneapolis, Minnesota.
68. "Private Practice Plastic Surgery: A Seven Year Perspective," Grand Rounds, Loyola University, 2008 Section of Plastic Surgery.
69. "Management of Lower Extremity Trauma," Grand Rounds, The University of Chicago, Section of Plastic Surgery, October, 8, 2008.
70. "Concepts in Plastic Surgery: A Multi-Disciplinary Approach," Frontline Surgical Advancements, Lutheran General Hospital, November 1, 2008
71. "Surgical Techniques-New Surgical Techniques/Plastic Surgery/Prosthetics," Caldwell Breast Center CME Series, Advocate Lutheran General Hospital, November 12, 2008
72. "Genetics: A Family Affair" Panel Discussion: Predictive Genetic Testing, 23rd Annual Illinois Department of Public Health Conference, Oak Brook Hills Marriott Resort, Oak Brook, Il, March 18, 2009
73. "Gender Confirmation Surgery" Minnesota TransHealth and Wellness Conference, May 15, 2009, Metropolitan State University, Saint Paul, MN.
74. "The Role of Plastic Surgery in Wound Care, " Practical Wound Care A Multidisciplinary Approach, Advocate Lutheran General Hospital, October 9-10, 2009, Park Ridge, Il.
75. "In The Family," Panel, General Session III, 2009 Illinois Women's Health Conference, Illinois Dept. of Health, Office of Women's Health October 28-29, 2009, Oak Brook, Il.
76. "Patient Safety in Plastic Surgery," The University of Chicago, Section of Plastic Surgery, Grand Rounds, November 18, 2009.

77. "Compartment Syndrome," 6th Annual Advocate Injury Institute Symposium, Trauma 2009: Yes We Can!, November 19-20, 2009.
78. "Maxillofacial Trauma," 6th Annual Advocate Injury Institute Symposium, Trauma 2009: Yes We Can!, November 19-20, 2009.
79. "Management of Complex Lower Extremity Injuries," Grand Rounds, The Section of Plastic Surgery, The University of Chicago, December 16, 2009, Chicago, IL.
80. "Gender-Confirming MTF Surgery: Indications and Techniques," Working Group on Gender, New York State Psychiatric Institute, March 12, 2010
81. "Gender-Confirmation Surgery," Minnesota Trans Health and Wellness Conference, Metropolitan State University, St. Paul Campus, May 14th, 2010
82. "Physical Injuries and Impairments," Heroes Welcome Home The Chicago Association of Realtors, Rosemont, Illinois, May 25th, 2010.
83. "Genetics and Your Health," Hadassah Heals: Healing Mind, Body, & Soul, Wellness Fair, 2010, August 29, 2010, Wilmette, Illinois.
84. "GCS," Southern Comfort Conference 2010, September 6-11, 2010, Atlanta, GA.
85. "Gender Confirming Surgery," The Center, The LGBT Community Center, October 22, 2010 New York, NY.
86. "Gender Confirming Surgery," the Center, The LGBT Community Center, May 20, 2011, New York, NY.
87. "Gender Confirming Surgery," Roosevelt-St. Lukes Hospital, May 20, 2011, New York, NY
88. "Principles of Plastic Surgery," Learn about Ortho, Lutheran General Hospital, May 25, 2011, Park Ridge, IL.
89. "Forging Multidisciplinary Relationships in Private Practice," Chicago Breast Reconstruction Symposium 2011, September 9, 2011, Chicago, IL
90. "Gender Confirming Surgery," Minnesota TransHealth and Wellness Conference, Diverse Families: Health Through Community, September 10, 2011, Minneapolis, Minnesota
91. "Gender Confirming Surgery," University of Chicago, Pritzker School of Medicine, Anatomy Class, September 16, 2011, Chicago, IL
92. "Facial Trauma," 8th Annual Advocate Injury Institute Symposium, Trauma 2011: 40 years in the Making, Wyndham Lisle-Chicago, November 9-10, 2011
93. "Establishing a Community-Based Microsurgical Practice," QMP Reconstructive Symposium, November 18-20, 2011, Chicago, IL

94. "Surgery for Gender Identity Disorder," Grand Rounds, Dept. of Obstetrics and Gynecology, Northshore University Health System, December 7, 2011
95. "Managing Facial Fractures," Trauma Grand Rounds, Lutheran General Hospital, Park Ridge, Il July 17, 2012
96. "Principles of Transgender Medicine," The University of Chicago Pritzker School of Medicine, Chicago, Il, September 7, 2012
97. "State of the art breast reconstruction," Advocate Health Care, 11th Breast Imaging Symposium, January 26, 2013, Park Ridge, Il.
98. "State of the art breast reconstruction," Grand Rounds, Dept. of Surgery, Mount Sinai Hospital, April 25, 2013, Chicago, Il.
99. "Getting under your skin: is cosmetic surgery right for you?" Lutheran General Hospital community lecture series, May 7, 2013, Park Ridge, Il.
100. "Gender Confirming Surgery," University of Chicago, Pritzker School of Medicine, Anatomy Class, September 27, 2013, Chicago, Il
101. "State of the Art Breast Reconstruction," Edward Cancer Center, Edward Hospital, October 22, 2013, Naperville, Il
102. "Transgender Medicine and Ministry," Pastoral Voice, Advocate Lutheran General Hospital, October 23, 2013, Park Ridge, Il
103. "Principles of Transgender Medicine and Surgery," The University of Illinois at Chicago College of Medicine, January 28, 2014, Chicago, Il
104. "Principles of Transgender Medicine and Surgery," Latest Surgical Innovations and Considerations, 22nd Annual Educational Workshop, Advocate Lutheran General Hospital, March 1, 2014, Park Ridge, Il.
105. "Principles of Transgender Medicine: Gender Confirming Surgery," Loyola University Medical Center, March 12, 2014.
106. "Principles of Plastic Surgery," Grand Rounds, Dept. of Obstetrics and Gynecology, Lutheran General Hospital, September 12, 2014.
107. "Gender Confirmation Surgery," The University of Chicago, Pritzker School of Medicine, October 3, 2014
108. "Private Practice: Is There a Future?" The Annual Meeting of The American Society of Plastic Surgical Administrators/The American Society of Plastic Surgery Assistants, Chicago, Il, October 11, 2014.
109. "Private Practice: Is There a Future?" The Annual Meeting of The American Society of Plastic Surgery Nurses, Chicago, Il, October 12, 2014.
110. "Gender Confirmation Surgery" Grand Rounds, The University of Minnesota, Dept. of Plastic Surgery, Minneapolis, MN, October 29, 2014.

111. "Body Contour After Massive Weight Loss," The Bariatric Support Group, Advocate Lutheran General Hospital, February 5, 2015, Lutheran General Hospital, Park Ridge, Il.
112. "Gender Confirmation Surgery," The School of the Art Institute of Chicago, February 1, 2015, Chicago, Il.
113. "Gender Confirmation Surgery," The Community Kinship Life/Bronx Lebanon Department of Family Medicine, Bronx, NY, March 6, 2015
114. "Gender Confirmation Surgery," Educational Inservice, Lutheran General Hospital, Park Ridge, Il, April 20, 2015
115. "Principles of Plastic Surgery, " Surgical Trends, Lutheran General Hospital, Park Ridge, Il, May 16, 2015
116. "Updates on Gender Confirmation Surgery, " Surgical Trends, Lutheran General Hospital, Park Ridge, Il, May 16, 2015
117. "Gender Confirmation Surgery," Lurie Childrens' Hospital, Chicago, Il, May 18, 2015, Chicago, Il 2015.
118. "Gender Confirmation Surgery," TransClinical Care and Management Track Philadelphia Trans-Health Conference, June 5, 2015, Philadelphia, Pa.
119. "Gender Confirmation Surgery: A Fifteen Year Experience," Grand Rounds, The University of Minnesota, Plastic and Reconstructive Surgery and the Program in Human Sexuality, July 30, 2015, Minneapolis, Mn
120. "Gender Confirmation Surgery," Grand Rounds, Tel Aviv Medical Center, Tel Aviv, Israel, August 13, 2015
121. "Gender Confirmation Surgery," Grand Rounds, University of Illinois, Dept of Family Medicine, September 2, 2015
122. "Principles of Plastic Surgery," Grand Rounds, St. Francis Hospital, Evanston, Il September 18, 2015
123. "Gender Confirmation Surgery," Midwest LGBTQ Health Symposium, Chicago, Il, October 2, 2015
124. "Gender Confirmation Surgery," Southern Comfort Conference, Weston, Fl, October 3, 2015
125. "Surgical Transitions for Transgender Patients," Transgender Health Training Institute, Rush University Medical Center, Chicago, Il, October 8, 2015
126. "Gender Confirmation Surgery," The Transgender Health Education Peach State Conference, Atlanta, GA, October 30, 2015
127. "Gender Confirmation Surgery," Weiss Memorial Medical Center, November 4, 2015, Chicago, Il

128. "Gender Confirmation Surgery," University of Illinois at Chicago, Operating Room Staff Inservice, November 18, 2015, Chicago, IL
129. "Gender Confirmation Surgery," University of Illinois at Chicago, Plastic Surgery and Urology Inservice, November 18, 2015, Chicago, IL
130. "Gender Confirmation Surgery," Weiss Memorial Medical Center, November 19, 2015, Chicago, IL
131. "Gender Confirmation Surgery," Section of Plastic Surgery, The University of Illinois at Chicago, January 13, 2016, Chicago, IL
132. "Gender Confirmation Surgery," Dept. of Medicine, Louis A. Weiss Memorial Hospital, February 18, 2016, Chicago, IL
133. "Gender Confirmation Surgery," BCBSIL Managed Care Roundtable March 2, 2016 Chicago, IL
134. "Gender Confirmation Surgery-MtF," Keystone Conference, March 10, 2016, Harrisburg, PA
135. "Gender Confirmation Surgery-FtM," Keystone Conference, March 10, 2016, Harrisburg, PA
136. "Gender Confirmation Surgery," Grand Rounds, Dept. of Ob-Gyn, March 25, 2016, Lutheran General Hospital, Park Ridge, IL 60068
137. "Surgical Management of the Transgender Patient," Spring Meeting, The New York Regional Society of Plastic Surgeons, April 16, 2016, New York, NY
138. "A Three Step Approach to Complex Lower Extremity Trauma," University of Illinois at Chicago, April 27, 2016, Chicago, IL.
139. "Gender Confirmation Surgery," Howard Brown Health Center, July 12, 2016, Chicago, IL
140. "Creating the Transgender Breast M-F; F-M", ASPS Breast surgery and Body Contouring Symposium, Santa Fe, NM, August 25-27, 2016
141. "Overview of Transgender Breast Surgery," ASPS Breast surgery and Body Contouring Symposium, Santa Fe, NM, August 25-27, 2016
142. "VTE Chemoprophylaxis in Cosmetic Breast and Body Surgery: Science or Myth", ASPS Breast surgery and Body Contouring Symposium, Santa Fe, NM, August 25-27, 2016
143. "Gender Confirmation Surgery," Gender Program, Lurie Childrens', Parent Group, September 20, 201, 467 W. Deming, Chicago, IL
144. "Gender Confirmation Surgery," The American Society of Plastic Surgeons Expo, September 24, 2016, Los Angeles, CA

145. Transgender Surgery, Management of the Transgender Patient, Female to Male Surgery, Overview and Phalloplasty, The American College of Surgeons, Clinical Congress 2016 October 16-20, 2016 Washington, DC
146. "Gender Confirmation Surgery," The Department of Anesthesia, The University of Illinois at Chicago, November 9, 2016
147. "Gender Confirmation Surgery," The Division of Plastic Surgery, The University of Illinois at Chicago, December 14, 2016
148. "Gender Confirmation Surgery," Nursing Education, The University of Illinois at Chicago, January 10, 2017
149. "F2M-Radial Forearm Total Phalloplasty: Plastic Surgeon's Point of View," The European Association of Urologists, Meeting of the EAU Section of Genito-Urinary Reconstructive Surgeons (ESGURS), London, United Kingdom, March 23-26, 2017
150. "Gender Confirmation Surgery," Grand Rounds, The Department of Surgery, The University of North Carolina, March 29, 2017.
151. "Transgender Facial Surgery," *The Aesthetic Meeting 2017 - 50 Years of Aesthetics* - in San Diego, California April 27- May 2, 2017.
152. "Gender Confirmation Surgery: A New Surgical Frontier," 15th Annual Morristown Surgical Symposium Gender and Surgery, Morristown, NJ, May 5, 2017.
153. "Gender Confirmation Surgery: A New Surgical Frontier," Dept. of Obstetrics and Gynecology, The Medical College of Wisconsin, May 24, 2017
154. "Gender Confirmation Surgery: A New Surgical Frontier," Dept. of Obstetrics and Gynecology, Howard Brown Health Center, August 8, 2017
155. "Current State of the Art: Gynecomastia," ASPS Breast Surgery and Body Contouring Symposium, San Diego, CA, August 10-12, 2017
156. "Gender Confirmation Surgery-An Overview," ASPS Breast Surgery and Body Contouring Symposium, San Diego, CA, August 10-12, 2017
157. "Gender Confirmation Surgery," Grand Rounds, Dept. of Obstetrics and Gynecology, The University of Chicago, August 25, 2017
158. "Gender Confirmation Surgery," Wake Forest School of Medicine, Transgender Health Conference, Winston-Salem, NC, September 28-29, 2017
159. "Phalloplasty," Brazilian Professional Association for Transgender Health, Teatro Marcos Lindenberg, Universidade Federal de São Paulo (Unifesp), November 1-4, 2017
160. "Gender Confirmation Surgery," Brazilian Professional Association for Transgender Health/WPATH Session, Teatro Marcos Lindenberg, Universidade Federal de São Paulo (Unifesp), November 1-4, 2017

161. "Gender Confirmation Surgery," The Division of Plastic Surgery, The University of Illinois at Chicago, December 13, 2017, Chicago, IL
162. "Gender Confirmation Surgery," Gender and Sex Development Program, Ann and Robert H. Lurie Children's Hospital of Chicago, December 18, 2017, Chicago, IL
163. "Transgender Breast Augmentation," 34th Annual Atlanta Breast Surgery Symposium, January 19-21, 2018, Atlanta, GA
164. "Top Surgery: Transmasculine Chest Contouring," 34th Annual Atlanta Breast Surgery Symposium, January 19-21, 2018, Atlanta, GA
165. "Gender Confirmation Surgery," The 17th International Congress of Plastic and Reconstructive Surgery in Shanghai, March 18-25, 2018, Shanghai, China
166. "Gender Confirmation Surgery: Facial Feminization and Metoidioplasty," 97th Meeting of the American Association of Plastic Surgeons, Reconstructive Symposium, April 7-10, 2018, Seattle, WA
167. Moderator: "Gender Confirmation Surgery: Top Surgery", The Annual Meeting of The American Society of Aesthetic Plastic Surgery, April 26-May 1, 2018, New York, NY
168. "Gender Confirmation Surgery," Econsult monthly meeting, Dept. of Veterans' Affairs, May 24, 2018
169. "Gender Confirmation Surgery," Transgender Care Conference: Improving Care Across the Lifespan, Moses Cone Hospital, Greensboro, NC, June 8, 2018
170. "WPATH State of the Art," 1st Swiss Consensus Meeting on the Standardization of Sex Reassignment Surgery, The University of Basel, August 31, 2018-September 1, 2018
171. "Facial Feminization Surgery: The New Frontier?" 1st Swiss Consensus Meeting on the Standardization of Sex Reassignment Surgery, The University of Basel, August 31, 2018-September 1, 2018
172. "Current Techniques and Results in Mastectomies," 1st Swiss Consensus Meeting on the Standardization of Sex Reassignment Surgery, The University of Basel, August 31, 2018-September 1, 2018
173. "Gender Confirmation Surgery," The University of Chicago, Pritzker School of Medicine, September 7, 2018, Chicago, IL.
174. The Business End: Incorporating Gender Confirmation Surgery, Plastic Surgery The Meeting, Annual Meeting of The American Society of Plastic Surgeons, September 29, 2018, Chicago, IL
175. Body Contouring in Men, Gynecomastia, Plastic Surgery The Meeting, Annual Meeting of The American Society of Plastic Surgeons, September 30, 2018, Chicago, IL

176. Moderator: Breast Augmentation and Chest Surgery in Gender Diverse Individuals, Plastic Surgery The Meeting, Annual Meeting of The American Society of Plastic Surgeons, October 1, 2018, Chicago, IL

177. Moderator: Aesthetic Surgery of The Male Genitalia, Plastic Surgery The Meeting, Annual Meeting of The American Society of Plastic Surgeons, October 1, 2018, Chicago, IL

178. Moderator: Gender Confirmation Surgeries: The Standards of Care and Development of Gender Identity, Plastic Surgery The Meeting, Annual Meeting of The American Society of Plastic Surgeons, October 1, 2018, Chicago, IL

179. The Center for Gender Confirmation Surgery Lecture Series, "Introduction to Gender Confirmation Surgery," Weiss Memorial Hospital, October 17, 2018, Chicago, IL

180. Institute 3: Gender Dysphoria Across Development: Multidisciplinary Perspectives on the Evidence, Ethics, and Efficacy of Gender Transition, Gender Confirming Care in Adolescence: Evidence, Timing, Options, and Outcomes, The American Academy of Child and Adolescent Psychiatry, 65th Annual Meeting, October 22-27, 2018, Seattle, WA

181. Gender Confirmation Surgery, Combined Endocrine Grand Rounds, The University of Illinois at Chicago, Rush University, Cook County Hospital, January 8, 2019

182. Gender Confirmation Surgery: An Update, Division of Plastic Surgery, The University of Illinois at Chicago, January 23, 2019

183. Gender Confirmation Surgery from Top to Bottom: A 20 Year Experience, Grand Rounds, The Department of Surgery, Ochsner Health System, January 30, 2019, New Orleans, LA

184. Master Series of Microsurgery: Battle of the Masters One Reconstructive Problem – Two Masters with Two Different Approaches, Gender Affirmation, Male-to-Female Vaginoplasty: Intestinal Vaginoplasty, The American Society for Reconstructive Microsurgery, Palm Desert, California, February 2, 2019

185. Gender Confirmation Surgery: From Top to Bottom, The University of Toronto, Toronto, Canada, February 21, 2019

186. Gender Confirmation Surgery: Where are We, The University of Toronto, Toronto, Canada, February 21, 2019

187. Professors' Rounds: Gender Confirmation Surgery: A Twenty Year Experience, Princess Margaret Hospital, Toronto, Canada, February 22, 2019

188. A 3 Step Approach to Lower Extremity Trauma, Plastic Surgery at The Red Sea, Eilat, Israel, March 6-9, 2019.

189. Gender Surgery: Where are We Now?, Plastic Surgery at The Red Sea, Eilat, Israel, March 6-9, 2019.

190. Gender Confirmation Surgery, A Single Surgeon's 20 Year Experience, Plastic Surgery at The Red Sea, Eilat, Israel, March 6-9, 2019.
191. Gender Confirmation Surgery: Where We Have Been and Where We Are Going, Grand Rounds, The University of Chicago, Section of Plastic Surgery, March 13, 2019
192. Gender Confirmation Surgery: From Top To Bottom, Resident Core Curriculum Conference, The University of Chicago, Section of Plastic Surgery, March 13, 2019.
193. "Gender Confirmation Surgery," WPATH/AMSA Medical School Trans Health Elective, Webinar, March 13, 2019
194. Robotic Vaginoplasty: An Alternative to Penile Inversion Vaginoplasty in Cases of Insufficient Skin, Vaginal Stenosis, and Rectovaginal Fistula. The European Professional Association for Transgender Health, April 9-13, Rome, Italy
195. Current State of Gender-Affirming Surgery in the US and Beyond, Gender-affirming genital surgery presented by the American Urologic Association in collaboration with the Society for Genitourinary Reconstructive Surgeons (GURS), May 2, 2019, Chicago, IL
196. Surgical Training-How Can I get it, The Aesthetic Meeting 2019, New Orleans, LA, May 20, 2019
197. What is the Standard of Care in This New Frontier, The Aesthetic Meeting 2019, New Orleans, LA, May 20, 2019
198. The 20th Annual Chicago Orthopedic Symposium, August 15-18, 2019, Chicago, IL "Soft Tissue Defects-Getting Coverage"
199. Gender Confirmation Surgery, The Potocsnak Family Division of Adolescent and Young Adult Medicine, Ann & Robert H. Lurie Children's Hospital of Chicago, August 19, 2019
200. Anatomy, Embryology, and Surgery, The University of Chicago, First Year Medical Student Anatomy Lecture, September 9, 2019, The University of Chicago, Chicago, IL.
201. Gender Confirmation Surgery, Howard Brown Health Center Gender Affirming Learning Series, September 13, 2019, Chicago, IL.
202. Moderator, Patient Selection in Gender Affirming Surgery, 88th Annual Meeting of The American Society of Plastic Surgeons, September 20-23, 2019, San Diego, CA
203. Breast Augmentation in Transwomen: Optimizing Aesthetics and Avoiding Revisions, 88th Annual Meeting of The American Society of Plastic Surgeons, September 20-23, 2019, San Diego, CA

204. Breast Reconstruction, State of the Art, NYU-Langone Health, NYU School of Medicine, Standards of Care and Insurance Coverage, Saturday, November 23, 2019, New York, NY.
205. ASRM Masters Series in Microsurgery: Think Big, Act Small: The Building Blocks for Success, "Building a Microsurgery Private Practice from the Ground Up", 2020 ASRM Annual Meeting, Ft. Lauderdale, Florida, January 10-14, 2020
206. ASPS/ASRM Combined Panel II: Gender Affirmation Surgery: Reconstruction Challenges of Function and Sensation, 2020 ASRM Annual Meeting, Ft. Lauderdale, Florida, January 10-14, 2020
207. Rush University Medical Center, Division of Urology, Grand Rounds, "Gender Confirmation Surgery: A Single Surgeon's Experience," January 22, 2020
208. Rush University Medical Center, Department of General Surgery, Grand Rounds, "Gender Confirmation Surgery: A Single Surgeon's Experience," February 5, 2020.
209. WPATH/AMSA (American Medical Association) Gender Scholar Course, Webinar, March 11, 2020
210. Rush University Medical Center, Division of Plastic Surgery, Weekly Presentation, Gender Confirmation Surgery: Can a Surgeon Provide Informed Consent?, April 29, 2020
211. Legal Issues Faced by the Transgender Community, ISBA Standing Committee on Women and The Law and the ISBA Standing Committee on Sexual Orientation and Gender Identity, Co-Sponsored by the National Association of Women Judges District 8, Live Webinar, May 28, 2020
212. Principles of Transgender Surgery, National Association of Women's Judges, District 8, Webinar, June 4, 2020
213. Gender-Affirming Surgery, National Association of Women's Judges, District 8, Webinar, July 8, 2020
214. Gender-Affirming Surgery, The University of Chicago, Pritzker School of Medicine, 1st year Anatomy, September 15, 2020
215. Gender-Affirming Surgery, Rush University Medical School, 2nd year Genitourinary Anatomy, September 16, 2020.
216. Surgical Management of the Transgender Patient, Rosalind Franklin University, The Chicago Medical School, Plastic Surgery Interest Group, October 7, 2020
217. Breast Augmentation in Transgender Individuals, The American Society of Plastic Surgeons Spring Meeting, March 20, 2021

218. International Continence Society Institute of Physiotherapy Podcast 5-Pelvic Floor Most Common Disorders and Transgender Patients (recorded April 30, 2021)
219. The American Association of Plastic Surgeons Annual Meeting, Reconstructive Symposium, Gender Affirmation Panel, Complications of GCS, Miami, FL, May 15, 2021 (presented virtually)
220. Gender Confirmation Surgery, Grand Rounds, Rush University, Section of Urology, June 8, 2021.
221. Genitourinary introduction lecture, M2, Rush University School of Medicine, September 2, 2021 (by Zoom)
222. Demystifying Gender: Fostering Gender Friendly Healthcare, Gender Affirmative Care in Adults, Querencia (Lady Hardinge Medical College, WHO Collaborating Center for Adolescent Health, Dept of Paediatrics, JSCH & LHMC, New Delhi, WPATH September 5, 2021 (by Zoom))
223. Gender Confirmation Surgery, The University of Chicago Pritzker School of Medicine, MS-1, Anatomy lecture, September 14, 2021, Chicago IL.
224. Gender Confirmation Surgery, A Single Surgeon's 22 Year Experience: Where are We Now?, Research Seminar, Section of Endocrinology, The University of Chicago, Chicago, IL, October 4, 2021 (by Zoom)
225. Chest Surgery, The Illinois Dept. of Corrections (by Zoom), October 13, 2021.
226. Vaginoplasty, The Illinois Dept. of Corrections (by Zoom), October 15, 2021.
227. International Continence Society, 20th Physioforum, Pelvic Floor Physical Therapy and Gender-Affirming Surgery, October 16, 2021, Melbourne, Australia (by Zoom)
228. Rush University Division of Plastic Surgery, Gender Affirmation Surgery: Where Are We Now?, educational conference, November 23, 2021, Chicago, IL
229. 51 Congreso Argentino de Cirugía Plástica, Microsurgery Symposium, SACPER-FILACP, 3 Step Approach to Lower Extremity Trauma, November 29, 2021, Mar del Plata, Argentina
230. 51 Congreso Argentino de Cirugía Plástica, Genital Aesthetics and Gender Confirmation Surgery I, "Gestión Quirúrgica de la Disforia de Género: Descripción general del manejo quirúrgico y los estándares de atención," December 1, 2021, Mar del Plata, Argentina
231. 51 Congreso Argentino de Cirugía Plástica, Genital Aesthetics and Gender Confirmation Surgery II, Cirugía Genital Masculinizante (Metoidioplastia y Faloplastia), December 2, 2021, Mar del Plata, Argentina

232. 51 Congreso Argentino de Cirugia Plastica, Genital Aesthetics and Gender Confirmation Surgery III, Faloplastia: optimización de resultados y reducción de complicaciones, December 2, 2021, Mar del Plata, Argentina
233. Government of India, Ministry of Health and Welfare, National AIDS Control Organization, Meeting with AIIMS on Gender Affirmation Care (GAC) Clinic Pilot Intervention, December 21, 2021, New Delhi (virtual)
234. Affirming Care for Gender Diverse Patients, Rosalind Franklin University, January 5, 2022, North Chicago, IL (Virtual by Zoom)
235. Sub-Unit Transplantation, Penile Transplant, WSRM/ASRT Mini-Symposium VCA Transplant, World Society for Reconstructive Microsurgery/American Society for Reconstructive Transplantation/American Society for Reconstructive Microsurgery Annual Meeting, January 14, 2022, Carlsbad, CA
236. Strategies for Penile Transplantation, American Society for Reconstructive Microsurgery, Annual Meeting, January 16, 2022, Carlsbad, CA
237. ASRM/WSRM/ASRT Battle of the Frontiers: To Transplant or Not? Conventional Reconstruction (Phalloplasty), American Society for Reconstructive Microsurgery, Annual Meeting, January 16, 2022, Carlsbad, CA
238. Strategies for Penile Innervation, American Society for Gender Surgeons, Annual Meeting, January 18, 2022, Carlsbad, CA
239. Pathway To Informed Consent: Vaginoplasty, Illinois Dept. of Corrections (virtual), February 10, 2022
240. Gender Confirmation Surgery From Top to Bottom: A Single Surgeon's 22 Year Experience, Where are We Now, Grand Rounds (virtual), Department of Plastic Surgery, University of South Florida, February 14, 2022
241. Vaginoplasty: Dissection of the vaginal canal and selection of technique, International Confederation of Plastic Surgery Societies (ICOPLAST), First World Congress, Lima Peru May 19-21, 2022 (President of the session: Genital/Transgender Session 1)
242. Phalloplasty: Strategies to reduce complications and optimize outcomes, International Confederation of Plastic Surgery Societies (ICOPLAST), First World Congress, Lima Peru May 19-21, 2022
243. Chest Surgery in Transgender Men, International Confederation of Plastic Surgery Societies (ICOPLAST), First World Congress, Lima Peru May 19-21, 2022
244. Gender-Affirming Surgery: A 23 Year Experience Where are we now, 65th Annual Scientific Meeting, Southeastern Society of Plastic and Reconstructive Surgeons (Finding The Solutions Now and The Future), Orlando, FL, June 11-15, 2022
245. Top Tips for Safety: The Culture of Safety, 65th Annual Scientific Meeting, Southeastern Society of Plastic and Reconstructive Surgeons (Finding The Solutions Now and The Future), Orlando, FL, June 11-15, 2022

246. Uterine Transplantation, GAPS (Ghent Academy of Plastic Surgery) 2022: Bridging the Gap Between Reconstructive and Aesthetic Surgery, June 17-18, 2022, Ghent, Belgium
247. In Honor of Professor Stan Monstrey, GAPS (Ghent Academy of Plastic Surgery) 2022: Bridging the Gap Between Reconstructive and Aesthetic Surgery, June 17-18, 2022 Ghent, Belgium
248. "TRANS" Grand Rounds Panel Discussion (panel discussants: Loren S. Schechter, MD, Michaela West, MD, PhD, Courtney Cripps, MD, Ervin Kocjancic, MD), University of Chicago, Department of Surgery, July 6, 2022, Chicago, IL
249. Gender Affirming Surgery, Grand Rounds, July 12, 2022, Department of Urology, Rush University Medical Center, Chicago, IL
250. Gender Affirming Surgery, Gender Affirmation Lecture Series, Rush University Medical Center, July 15, 2022, Chicago, IL
251. Anatomy of A Lawsuit, Rush PRS Weekly Didactic Conference, Rush University Medical Center, Plastic and Reconstructive Surgery, July 20, 2022, Chicago, IL
252. Gender Affirmation Surgery: Where are We Now? The University of Chicago, Section of Plastic Surgery, Grand Rounds, August 10, 2022, Chicago, IL
253. Thriving in Sexual & Gender Diversity, The Transgender Patient, August 10, Virtual CME Event (broadcast from Dr. Shino Bay Aguilera's office in Miami, FL)
254. Gender Affirming Medical and Surgical Therapies, Illinois College of Emergency Physicians Webinar, August 17, 2022
255. Gender Affirming Surgery Panel, Liebert Publishing, Webinar, August 26, 2022, Moderator: Jeffrey Spiegel, MD
256. Gender Confirmation Surgery, The University of Chicago Pritzker School of Medicine, MS-1, Anatomy lecture, September, 14, 2022, Chicago IL
257. Gender Affirmation Surgery: Where We Have Been and Where We are Going: GURS-WPATH Invited Lecture, Society of Genitourinary Reconstructive Surgeons, Academic Congress, Montreal, Canada, September 15, 2022
258. Phalloplasty: Optimizing Outcomes and Reducing Complications, North Carolina Society of Plastic Surgeons 2022 Annual Scientific Meeting, Pinehurst, North Carolina, October 7-9, 2022
259. Special Guest Lecture: Gender Affirmation Surgery: Where We've Been and Where We're Going, North Carolina Society of Plastic Surgeons 2022 Annual Scientific Meeting, Pinehurst, North Carolina, October 7-9, 2022
260. Diversity in Practice, North Carolina Society of Plastic Surgeons 2022 Annual Scientific Meeting, Pinehurst, North Carolina, October 7-9, 2022

261. Gender Affirming Surgery, Fenway/HMS Advances in Transgender Care, October 15, 2022
262. Genitourinary introduction lecture, M2, Rush University School of Medicine, October 26, 2022, Chicago, IL
263. Optimizing Aesthetics and Sensation in Vaginoplasty and Phalloplasty, The American Society of Plastic Surgeons 91st Annual Meeting (PSTM), Boston, MA, October 30, 2022
264. Gender-Affirming Surgery: From Top to Bottom, The Rush University Medical Center Departments of Emergency Medicine and Internal Medicine for the Emergency Medicine Grand Rounds Lecture, Chicago, IL, November 16, 2022
265. Dueling Perspectives in Transgender Surgery, New York Regional Society of Plastic Surgeons, New York, New York, November 19, 2022
266. Gender-Affirming Surgery: From Top to Bottom, Rush University Medical Center Department of Anesthesia Grand Rounds, November 30, 2022, Chicago, IL.
267. Gender-Affirming Surgery: Where We Have Been and Where We are Going, Mass General Brigham Center For Transgender Health, Grand Rounds, December 13, 2022 Boston, MA (lecture delivered virtually)
268. An Intro to Providing Gender Affirming Care to Gender Diverse Patients, Rosalind Franklin University, Chicago Medical School, December 21, 2022, North Chicago, IL (virtual by Zoom)
269. Surgical Techniques and Outcomes in Penile Reconstruction, WSRM/ ASRT Symposium on VCA in the Transgender Patient, Annual Meeting of The American Society for Reconstructive Microsurgery, January 20, 2023, Aventura, FL
270. Argument for Transgender Transplantation, WSRM/ ASRT Symposium on VCA in the Transgender Patient, Annual Meeting of The American Society for Reconstructive Microsurgery, January 20, 2023, Aventura, FL
271. Moderator: Gender Surgery Symposium, Society of Gender Surgeons, January 24, 2023, Aventura, FL
272. Trans female top surgery, 38th Annual Atlanta Breast Surgery Symposium, January 27-29-2023, Atlanta, GA
273. Trans male top surgery, 38th Annual Atlanta Breast Surgery Symposium, January 27-29-2023, Atlanta, GA
274. Top Surgery for Transgender Women, What Implant I use and Why, American Society of Plastic Surgeons Spring Meeting, March 4, 2023 (virtual)
275. Over The Top Surgery, The Aesthetic Meeting 2023, The American Society of Aesthetic Plastic Surgery, Miami Beach, FL, April 22, 2023

276. Panel: Gender Affirming Surgery: Beyond the Knife, The American Association of Plastic Surgeons 101st Annual Meeting, April 29-May 2, 2023, Chicago, IL
277. SOC 8 Panel-What's New and How We Use It: 3rd Live Surgery Conference for Gender Affirmation Procedures presented by MT. Sinai and WPATH May 11-13, 2023, New York, New York
278. Meet the Professor, Long Term Outcomes After Gender Affirming Surgeries, Endo 2023, The Annual Meeting of The Endocrine Society, June 15-18, 2023, Chicago, IL
279. Gender-Affirming Surgery, Forensic Friday, Populations with Unique Needs, The Illinois Association of Forensic Nurses, June 16, 2023, Chicago, IL
280. Gender Affirmation Surgery, Galilee Medical Center, Nahariya, Israel, July 5, 2023
281. Gender Affirmation Surgery, Grand Rounds, Department of Obstetrics and Gynecology, Rabin Medical Center, Tel Aviv, Israel, July 6, 2023
282. Gender Affirmation Surgery: Where We've Been and Where We're Going, Midwestern Association of Plastic Surgeons (MAPS), Safety in Gender Affirmation Surgery Session, Grand Geneva Resort, Lake Geneva, Wisconsin, July 15, 2023
283. Revision Vaginoplasty, Rush Gender Affirmation Surgery Didactic Conference, Friday, July 28, 2023
284. Gender Affirming Surgery, Carolina Society of Endocrinologists, August 18-20, 2023, Asheville, North Carolina
285. Gender Affirming Surgery, The University of Chicago, Pritzker School of Medicine, Dept. of Anatomy, September 6, 2023, Chicago, IL
286. 4th International Congress of The International Society of Uterine Transplantation, "Uterus Transplantation: The Next Generation," Uterus Transplantation in Transgender Women, September 11, 2023, Birmingham, Alabama
287. "Uterine Transplantation," Rush Gender Didactic Lecture Series, Rush University Medical Center, September 22, 2023, Chicago, IL
288. "Plastic Surgery: from biology to bedside," Rush University, Division of Plastic Surgery, Grand Rounds, October 18, 2023, Chicago, IL
289. "Gender Affirmation Surgery: where we've been and where we're going," The Houston Society of Plastic Surgeons, October 19, 2023, Houston, TX
290. "Introduction to Gender Affirmation Surgery," Rush University School of Medicine, MS-2, October 25, 2023, Chicago, IL

291. Falloplastia (Phalloplasty), 1° Congreso Argentino de Salud Transgénero (CAST), November 9, 2023, Buenos Aires, Argentina.
292. Gender Affirmation Surgery, IPATHCON 2023, November 29-30, 2023, New Delhi, India (presented virtually by recording)
293. Gender Affirmation-State of the Art, 16th Congress of the International Society of Vascularized Composite Allotransplantation, December 1-2, Los Angeles, CA
294. VCA for Gender Affirmation, 16th Congress of the International Society of Vascularized Composite Allotransplantation, December 1-2, Los Angeles, CA
295. Gender Affirming Surgery: Where We've Been and Where We're Going, Grand Rounds, The Division of Endocrinology, The University of Illinois at Chicago, December 19, 2023, Chicago, IL
296. Gender Affirmation Surgery, Rosalind Franklin University of Medicine and Science (by Zoom), December 20, 2023, North Chicago, IL
297. Gender Affirmation Surgery, Transgender Health Training, Callen Lorde, NY, NY February 12, 2024 (by zoom)
298. Avoiding and Treating Implant Malposition, The American Society of Plastic Surgeons, Spring Meeting, March 2, 2024 (virtual)
299. Chest and Breast Surgery, 62nd Annual MAPS Scientific Meeting, Chicago, IL, May 10-11, 2024
300. Vaginoplasty, Howard Brown Health Center, Grand Rounds, May 21, 2024, Chicago, IL (virtual, by Zoom)
301. Chest Surgery, Metoidioplasty, Phalloplasty, Howard Brown Health Center, Grand Rounds, May 28, 2024, Chicago, IL (virtual, by Zoom)
302. Understanding surgical options: Overview of gender-affirming surgeries, including top surgery, bottom surgery, and facial feminization surgeries, Tel Aviv, Israel, June 25, 2024 (virtual, by Zoom)
303. Variations in Sex Traits and Surgery: Consensus and Controversy International Conference Beyond Binaries: Intersex Body Politics in Premodern Islamic Legal, Medical, and Literary Discourses Utrecht University Department of Philosophy and Religious Studies Sweelinckzaal Drift 21, room 0.05 Wednesday 26 June 2024
304. ISPS / MAPS 1st Annual Intern Bootcamp Schedule
UIC Surgical Innovation Training Laboratory, Introduction to Flaps, August 3, 2024, Chicago, IL
305. Atlanta Comfort Conference, Transfeminine Surgery, August 16, 2024, Atlanta, GA
306. Atlanta Comfort Conference, Transmasculine Surgery, August 16, 2024, Atlanta, GA

307. University of New Mexico ASPS/PSF Visiting Professor, Vaginoplasty: Optimizing Outcomes, August 19, 2024, Albuquerque, NM
308. University of New Mexico ASPS/PSF Visiting Professor, Phalloplasty and Metoidioplasty: Optimizing Outcomes and Minimizing Complications, August 19, 2024, Albuquerque, NM,
309. University of New Mexico ASPS/PSF Visiting Professor, Uterine Transplantation, August 20, 2024, Albuquerque, NM
310. University of New Mexico ASPS/PSF Visiting Professor, Plastic Surgery: From Benchtop to Bedside, August 20, 2024, Albuquerque, NM
311. University of Mississippi Medical Center, Gender Affirmation Surgery: Where We've Been and Where We're Going, August 22, 2024, Jackson, MI
312. University of Mississippi Medical Center, Uterine Transplantation, August 23, 2024, Jackson, MI
313. Gender Affirming Surgery: Where We've Been and Where We're Going, 2nd Mediterranean Conference of Plastic Surgery Innovations, September 2, 2024 Grand Resort Lagonissi, Athens Riviera, Greece
314. Metoidioplasty and Phalloplasty, Lurie Children's Hospital, September 16, 2024, Chicago, IL
315. Gender Affirming Surgery, The University of Chicago, Pritzker School of Medicine, September 16, 2024, Chicago, IL
316. Contemporary Surgical Updates: What's New, WPATH 28th Scientific Symposium, September 25-30, 2024, Lisbon, Portugal
317. ACS Clinical Congress 2024, Medical and Surgical Management of Youth with Gender Dysphoria: Current Status and Controversies | CC2024-129, 'The WPATH Perspective,' October 20, 2024
318. Vaginoplasty: Optimizing Outcomes through a Multidisciplinary Approach, Grand Rounds, The University of Chicago, Division of Plastic Surgery, October 23, 2024.
319. Introduction to Gender Affirming Surgery, Rush University Medical School, M-2 lecture, October 23, 2024.
320. SKY Meeting - Surgical Knowledge for Youth congress, Research, Training, and Science Department of the Student's Association at the Faculty of Medicine, University of Porto, Portugal, November 8, 2024 (Virtual-by Zoom)
321. Albany Med Health System ASPS/PSF Visiting Professor, Gender Affirmation Surgery: Where We've Been and Where We're Going, November 21, 2024, Albany, NY

322. Albany Med Health System ASPS/PSF Visiting Professor, Vaginoplasty and Phalloplasty: Optimizing Outcomes, November 21, 2024, Albany, NY
323. Uterine Transplantation, The American Society for Reconstructive Transplantation Biennial Meeting, November 22, 2024, New Haven, CT
324. Summa Health ASPS/PSF Visiting Professor (2024-2025 James Lewis Visiting Professor in Plastic Surgery), From Biology to Bedside, December 12, 2024, Akron, OH
325. Summa Health ASPS/PSF Visiting Professor (2024-2025 James Lewis Visiting Professor in Plastic Surgery), Gender Affirming Surgery, Where We've Been and Where We're Going, December 13, 2024, Akron, OH
326. Summa Health ASPS/PSF Visiting Professor (2024-2025 James Lewis Visiting Professor in Plastic Surgery), Masculinizing Genital Surgery: Reducing Complications, December 13, 2024, Akron, OH
327. Summa Health ASPS/PSF Visiting Professor (2024-2025 James Lewis Visiting Professor in Plastic Surgery), Vaginoplasty: Satisfaction, Outcomes, and Complications, December 13, 2024, Akron, OH
328. Foundations for Interprofessional Practice-Gender Affirming Care, Rosalind Franklin University of Medicine and Science, December 18, 2024 (by Zoom)

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**UNITED STATES DISTRICT COURT
DISTRICT OF COLUMBIA**

JANE DOE, et al.,

Plaintiffs,

v.

JAMES R. MCHENRY III, *in his official capacity as* Acting Attorney General of the United States; WILLIAM LOTHROP, *in his official capacity as* Acting Director of the Federal Bureau of Prisons,

Defendants.

Case No.: 1:25-cv-00286

DECLARATION OF JANE DOE

I, Jane Doe, declare:

1. I am currently incarcerated in the Bureau of Prisons. I am submitting this declaration in support of my request for relief. I am using the pseudonym Jane Doe to protect myself.

2. I am a transgender woman. I was born male, but [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

3. [REDACTED], my distress, anxiety and depression became so bad that I reached out to mental health and medical staff. I was diagnosed with gender dysphoria and began taking hormone medications [REDACTED]. Those medications have saved my life. I would not be able to function without them.

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4. I also socially transitioned at that time and have been living as a woman in the
BOP [REDACTED]

[REDACTED]

5. BOP doctors [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

6. [REDACTED]

[REDACTED] I have been housed here ever since and would be very afraid to go back to
a men's facility. I feel much safer here and being here has helped the trauma that I experience

[REDACTED]

7. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

8. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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9. On January [REDACTED] 2025, guards removed all of the transgender women, including me, from our housing units and [REDACTED]. The Warden and many other staff were there. The Warden informed us that we were being moved to a separate housing unit. They told all of us that this was happening because of the President's Executive Order.

10. The Warden also told us that we would all be transferred to men's facilities and that the paperwork for those transfers was already being processed. They said the transfers would happen that week and no later than Thursday, January 30.

11. On January [REDACTED] staff moved all of us back to general population. We were not told why we were being moved back and tried to get information. As far as I know, the transfers are still happening [REDACTED]. I am very afraid that I could be moved at any moment.

12. I am terrified of going back to a men's prison, especially if I will not have any access to my long-term medical care. I know that this will cause [REDACTED] and all of my symptoms from gender dysphoria to return. I am also terrified of having pat searches by men which I have not experienced [REDACTED] and being forced to shower with men. [REDACTED]
[REDACTED] Some staff have already started calling me and the other women "men," which has been extremely upsetting.

13. I also know the Executive Order requires the BOP to cut off hormone therapy and other medical treatments for transgender people.

14. I have been taking hormones [REDACTED]. This will be incredibly dangerous for me. I am afraid that without medication, I will go back to feeling like there is no purpose for me to live. I know that my birth sex is male, but I have lived as a woman [REDACTED] and could never go back.

I declare pursuant to 28 U.S.C. § 1746 and under penalty of perjury that the foregoing is true and correct.

Dated: _____

Jane Doe¹

¹ Ms. Doe has reviewed and approved the contents of this Declaration. Because Ms. Doe is incarcerated, a copy of the Declaration has been sent to her via first-class mail. Ms. Doe's counsel will submit a copy of the signed Declaration when they receive it from her.

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DECLARATION OF [REDACTED]

I, [REDACTED], declare:

1. [REDACTED] is my daughter. She is incarcerated in the Bureau of Prisons. I am submitting this declaration in support of her request for relief.
2. [REDACTED] was born in [REDACTED].
3. [REDACTED] was feminine [REDACTED]
4. [REDACTED] It was difficult to accept at first as a mother as I knew how difficult her life would be, but I knew that she had to get acceptance from her family before the rest of the world would accept her.
5. [REDACTED] slowly began transitioning. She started wearing makeup, then earrings. She grew out her hair and then started [REDACTED]. When she told me she was transgender, I was not surprised.
6. [REDACTED]
7. [REDACTED] legal ID documents reflect that she is female.
8. [REDACTED] was incarcerated. [REDACTED] she was housed with other women. [REDACTED]
9. While she has been incarcerated, [REDACTED] received [REDACTED]
10. [REDACTED]
11. [REDACTED]
12. On [REDACTED] called me and said she was being put in isolation, her room was being cleaned out, and she was being transferred to a men's facility.
13. [REDACTED]
14. [REDACTED]
15. I am terrified that [REDACTED] will be raped, sexually assaulted, or even killed if she is placed in a men's prison. She is also terrified.
16. I am also aware that the executive order requires the BOP to cut off hormone therapy and other medical treatments for transgender people.

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17. I am worried for [REDACTED] physical and mental health if her hormone therapy is cut off. She has relied on this treatment [REDACTED]. Without it, I believe she will suffer, and I fear for her safety.

Executed on this 29th day of January 29, 2025.

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UNITED STATES DISTRICT COURT
DISTRICT OF COLUMBIA

JANE DOE, ET AL.,

Plaintiffs,

v.

JAMES R. MCHENRY III, *in his official capacity as* Acting Attorney General of the United States; WILLIAM LOTHROP, *in his official capacity as* Acting Director of the Federal Bureau of Prisons,

Defendants.

Case No.:

**DECLARATION OF FREDERIC M. ETTNER IN SUPPORT OF
PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER
AND PRELIMINARY INJUNCTION**

I, Frederic M. Ettner, MD, hereby declare and state:

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

2. I have been a board certified family practice physician for the past 47 years. Attached hereto as Exhibit A is a true and correct copy of my CV, which provides more detailed information about my professional background, experiences, publications, and presentations.

3. During the past 30 years, I have consulted and treated more than 2500 patients who have been diagnosed with gender dysphoria.

4. My opinions contained in this declaration are based on my clinical experience as a family medicine practitioner for nearly five decades and my knowledge of peer reviewed research regarding gender dysphoria, transgender patients, and family medicine.

5. Gender dysphoria, while a serious medical condition, is highly treatable.

6. Once a diagnosis of gender dysphoria is established, a treatment plan should be developed based on the individualized assessment of the medical needs of the patient. From a medical perspective, the medical management of gender dysphoria for incarcerated individuals should not differ from protocols for non-institutionalized persons. This is true for all medical conditions—the fact that a doctor or medical professional practices in an institutional setting does not change the treatment protocols for medical conditions those professionals treat, such as diabetes, heart disease, or any other conditions.

7. Gender dysphoria is a recognized physiological condition that can impact multiple organ systems, including: Neurology—gender dysphoria affects the brain and the autonomic nervous system (sympathetic and parasympathetic systems); Endocrinology—gender dysphoria impacts hormonal functions, including corticosteroids and insulin regulation; Immunology/Hematology—gender dysphoria leads to suppression of white and red blood cells; Gastrointestinal system—gender dysphoria can result in digestive disorders; and Cardiology—gender dysphoria may cause or exacerbate hypertension.

8. Proper hormonal balance is critical for all people, not just transgender people, with respect to the following body systems: Immunological function—the immune system's maintenance depends on hormonal equilibrium; Gastrointestinal health—normal digestive function requires balanced sex steroid levels; Cardiovascular health—dysregulation of sex hormones can significantly affect the cardiovascular system; Bone health and metabolism - is regulated by sex steroids.

9. Transgender women who have not had surgery are typically prescribed estradiol hormone in addition to medications that stop their endogenous production of testosterone. Estrogen

has a systemic impact on a person's physical health, influencing all cells in the human body. For transgender women, estrogen plays a critical role in stabilizing brain chemistry and neuro-receptor functions. Since sex steroids are essential for maintaining physiological homeostasis, transgender individuals require lifelong hormonal support.

10. Based on my professional experience, termination of hormone replacement therapy (HRT) constitutes a serious medical risk that can severely impact both physical and mental health. These medical risks, include:

- Rapid hormonal changes trigger severe mood swings, anxiety, and depression
- Increased risk of suicidal ideation due to intensified gender dysphoria
- Hot flashes, insomnia, and physical discomfort
- Loss of breast tissue and feminine fat distribution
- Return of masculine secondary sex characteristics causing psychological distress

11. These risks associated with the termination of hormone medication would be present for both transgender women who are prescribed estrogen medication and transgender men who are prescribed testosterone medication.

12. If patients have other co-occurring medical conditions, additional risks could also occur depending on what those conditions are and what treatment they require.

13. Transgender women who have had urogenital surgeries, including removal of their testes, no longer have circulating testosterone in their bodies. If their estrogen medication is also removed, these women would experience serious and cascading medical difficulties in the body systems described above.

14. Replacement estrogen for these women stabilizes their endocrine function. If estrogen is removed, the complex relationship of these hormones to muscle metabolism, glucose metabolism, gastric acidity, bone metabolism, neuro-excitability, fluid and electrolyte balance, anti-inflammatory action and blood pressure would be radically altered. Without estrogen or

testosterone, the following conditions will occur: muscular weakness, hypertension, obesity, bruisability (capillary fragility), poor wound healing, sleeplessness, psychoses (accelerate suicidal ideation), polyuria, polydipsia (diabetes), hyperacidity, gastric ulcer, and osteoporosis.

15. Removing estrogen medication from a post-surgical transgender woman would also cause her to rapidly experience menopause. Because estrogen treats a transgender woman's gender dysphoria, cessation of this medication will lead to the loss of secondary sex characteristics and thus increased risk of depression, anxiety, and suicidal ideation or even attempts. These are the symptoms caused by gender dysphoria and they will return if the medical treatment for that condition is removed.

16. Transgender women who have not had surgery will also experience the serious medical risks described above. Hormone medication for these women has shut down their nascent ability to secrete testosterone. Until their bodies are able to produce and regulate the regular secretion of hormones again, they will have the same serious medical risks described above. Moreover, once their bodies secrete sufficient testosterone, they will experience serious and potentially life-threatening symptoms from their gender dysphoria.

17. The pathophysiologic processes, diseases, and co-occurring conditions described above will be avoided or severely reduced by appropriate hormone treatment.

18. Some transgender patients, like non-transgender patients, are prescribed medications to treat depression or anxiety. While these treatments can be helpful to individual patients, they are not, on their own, an effective, evidence-based treatment protocol for gender dysphoria. Simply providing these medications to a patient with gender dysphoria is analogous to treating a cancer patient with anti-anxiety medication rather than chemotherapy.

19. Gender dysphoria, like any serious medical condition, requires treatment. Prohibiting this treatment would force medical professionals to violate their ethical and professional duties to patients. The medical community is well aware that the consequences of denying this care are predictable and dire.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct. Executed January 28, 2025, in Lincolnwood, Illinois.



Frederic M. Ettner, MD

Medical Staff Appointments

St. Francis Hospital, Evanston, Illinois: Active Staff, 1977- present
Evanston Hospital, Evanston, Illinois: Active Staff, 1999-present
Glenbrook Hospital, Glenview, Illinois: Active Staff, 1999-present
Highland Park Hospital, Highland Park, Illinois: Active Staff, 2000-present

Education

The University of Wisconsin, BS, 1971 (honors)
The Chicago Medical School, MD, 1975
Cook County Hospital, Chicago: Rotating Internship, 1975-1976
University of Illinois Family Practice Residency at Ravenswood Hospital,
1994-1996
Cook County Hospital, Family Practice Fellowship: Faculty Development,
1995-1996

Certifications, Awards and Honors

University of Wisconsin, BS with honors, 1971
Vocalis, Chicago Medical School Newspaper: Editor, 1972-1973
University of Illinois, Urban Preceptorship, Department of
Preventive Medicine and Community Health, 1974-1975
Dean's Award, Chicago Medical School, 1975
National Board of Medical Examiners, Diplomate, 1976
Resident of the Year Award, University of Illinois Family Medicine Program
Ravenswood Hospital, 1995
Certification, American Board of Family Medicine, 1996
Re-certification American Board of Family Medicine, 2002, 2009, 2016, 2023
The Randi and Fred Ettner Transgender Health Fellowship – Program in Human Sexuality,
University of Minnesota Department of Family Medicine, 2016 - present
Alpha Omega Alpha Honor Medical Society - Volunteer Clinical Faculty Award - The University of
Chicago 2017

Consultant Appointments

Advocate® - Ravenswood Alternative Health Partners, Chicago, Illinois: Medical Director, 1998-
1999
University of Health Sciences, College of Osteopathic Medicine, Kansas City,
Missouri, Clinical Instructor, 1998-present
University of Illinois Family Medicine Program at Ravenswood Hospital,
Family Medicine, Preceptor, 1996-2000
University of Chicago Pritzker School of Medicine, Associate Clinical Professor Family Medicine
2010 - present
Northwestern University Feinberg School of Medicine, Clinical Instructor Family
Medicine 1996 - present
University of Southern California Keck School of Medicine, Associate Clinical Professor
Family Medicine 2009 - present
Rosalind Franklin University of Medicine and Science College of Health Professions Physician
Assistant Program, Clinical Instructor 2013 - present
Loyola University Stritch School of Medicine Graduate School of Nursing, Clinical Instructor
University of Minnesota Medical School Family Medicine/Program in Human Sexuality Leadership
Advisory Council 2009 - present
Cook County Department of Corrections advisor for transgender health
World Professional Association for Transgender Health Global Education Initiative 2016-present

Consultant Appointments (continued)

Brush Ranch Camp, Terrero, New Mexico, Camp Physician, 1995-present
Camp Beber, B'nai Brith Foundation, Mukwonago, Wisconsin, Camp Physician, 1989-1991
Head Start Consultation Service Physician, Chicago, Illinois 1976-1978
Evanston Hospital, Protection of Human Subjects Committee, 1977-1978
Cook County Public Guardian Office Physician, 1980-1995
LaLeche League International, 1976-present

Board Memberships

New Health Foundation Worldwide, 1996 - 2023
Evanston Hospital Complementary/Alternative Medicine Advisory Board, 1999 - 2007
Doctor's People, Advisory Board Member, 1988-1990
Council of Jewish Elderly, Health Commission Board Member, 1977-1978

Hospital Appointments

St. Francis Hospital, Evanston: Quality Assurance Reviewer for
Department of Family Practice
Ravenswood Hospital: Breastfeeding Initiative – “Baby Friendly Hospital”
Evanston-Northwestern Hospital, Evanston: Advisory Board to Complementary/
Alternative Medicine Department

Publications

Clinics in Plastic Surgery: Gender Confirmation Surgery. Schechter, L., Bauback, S. (Eds) Primary Care for the Transgender and Gender Non-conforming Patient (contributor), 2017
Berli JU, Knudson G, Fraser L, Tangpricha V, Ettner R, Ettner FM, Safer JD, Graham J, Monstrey S, Schechter L. “What Surgeons Need to Know About Gender Confirmation Surgery When Providing Care for Transgender Individuals: A Review.” *JAMA Surg.* 2017 Apr 1;152(4):394-400.
Ettner, F., Primary Care of the Transgender Patient in Schechter (Ed.)
Feng, Z., Ettner, F. Primary Care for Transgender Persons e-poster American College of Physicians October, 2016.
Ettner, R., White, T., & Ettner, F., Choosing a surgeon: an exploratory study of factors influencing the selection of a gender affirmation surgeon. *Transgender Health*, 1(1), 2016.
“Medical Therapy Care,” Schechter, L., Transgender Health - Surgical Atlas
Surgical Management of the Transgender Patient, Elsevier 2016 (contributor)
Ettner, R., Monstrey, S., Coleman, E. (Eds) Foreword. Principles of Transgender Medicine and Surgery, 2nd edition; Taylor & Francis, 2016.
Ettner, R., White, T., Ettner, F., “Hypertension: Pathology of a Secret,” WPATH Emory University Atlanta, Georgia, 2011 International Journal of Family Medicine, 2012 vol. 2012.
Ettner, Monstrey, Eyler. Foreword. Principles of Transgender Medicine and Surgery. New York: Haworth P, 2007. xxi.
Schechter, L., Boffa, J., Ettner, R., and Ettner, F. Revision vaginoplasty with sigmoid interposition: A reliable solution for a difficult problem. The World Professional Association for Transgender Health (WPATH), 2007, *XX Biennial Symposium*, 31-32.
“The Obstetrical Care of Young Women,” Clinics in Family Practice, 2:4, December 2000.
Internationally syndicated columnist, “Pregnancy Q&A,” 1993-present
“Breast-Assured: Methodology Leading To Early Success In Breastfeeding,”
17th Annual Conference on Patient Education, San Antonio, Texas, 1995
A Healthy Opinion, Medical Newsletter, 1997-present
“Comparative Study of Obstetrics – With Data & Details of a Working Physician’s Home OB Service,” Safe Alternatives in Childbirth, winner of the 1976 Books of the Year Award.
“Hospital Obstetrics: Do the Benefits Outweigh the Risks?” 21st Century Obstetrics, NAPSAC, 1977.

Presentations

Managed Care Organization Training on Gender Affirming Services State of Illinois Governor J.

B. Pritzker – panel presenter and discussant 2020

World Professional Association for Transgender Health – Global Education Initiative (invited presentations)

Primary Care for the Transgender Patient – Viet Duc Hospital, Hanoi, Vietnam 2020

Role of Primary Care Physician in Gender Affirming Surgeries – Weiss Memorial Hospital, Chicago, Illinois 2018

Multi-disciplinary Health Care for the Transgender Patient – James A. Lovell Federal Health Care Center, North Chicago, Illinois 2017

Primary Health Care Evaluation for Transgender Affirming Surgeries – Weiss Memorial Hospital, Chicago, Illinois 2017

Foundations in Primary Care for Transgender Persons

Chicago, Illinois 2015

Atlanta, Georgia 2016

Fort Lauderdale, Florida 2016

Columbia, Missouri 2016

Minneapolis, Minnesota – 2017

Columbus, Ohio 2017

Evidence-based Care for the Transgender Patient – St. Vincent/Columbia Presbyterian Hospital 2011

Rosalind Franklyn University, The Chicago Medical School

Loyola University, School of Medicine

Northwestern University School of Medicine

University of Illinois, Department of Public Health

Purdue University, School of Nursing

Columbia University's College of Physicians and Surgeons

Gender Information for Families of Transsexuals (GIFT) Seminar 1994

LaLeche League International

Numerous television and radio programs

Memberships

World Professional Association for Transgender Health

Licensed as Physician and Surgeon

State of Illinois, 1976-present

**UNITED STATES DISTRICT COURT
DISTRICT OF COLUMBIA**

JANE DOE, et al.,

Plaintiffs,

Civil Action No. 1:25-00286

v.

JAMES R. MCHENRY III, in his official
capacity as Acting Attorney General of the
United States; WILLIAM LOTHROP, *in his*
Official capacity as Acting Director of the
Federal Bureau of Prisons,

Defendants.

**DECLARATION OF RICK STOVER,
SENIOR DEPUTY ASSISTANT DIRECTOR
DESIGNATION AND SENTENCE COMPUTATION CENTER**

I, Rick Stover, declare and state as follows:

1. I am currently employed by the Federal Bureau of Prisons (Bureau). Since June 2024, I have served as the Senior Deputy Assistant Director of the Designation and Sentence Computation Center, within the Bureau's Correctional Programs Division.

2. Prior to becoming Senior Deputy Assistant Director of the Designation and Sentence Computation Center, I worked in positions of increasing responsibility within the Bureau, most recently as the Warden at the Federal Correctional Institution in Danbury, Connecticut.

3. I am familiar with the Bureau's general policies and practices on housing for transgender inmates, including the rationales for those policies. As part of my official duties, I have access to records maintained in the ordinary course of business by the Bureau, including inmate medical and mental health records.

4. As the Senior Deputy Assistant Director within the Bureau's Correctional Programs Division, I am a member of the Transgender Executive Council (TEC). I am

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responsible for monitoring and providing guidance on transgender issues. I manage monthly or twice monthly Transgender Executive Counsel (TEC) multi-disciplinary team meetings and review all initial designations and re-designation requests of inmates self-identifying as transgender in the Bureau. I am involved in the development of accommodations, resource information, programs, and policy to ensure the needs of transgender inmates are met.

5. The information below is based upon personal knowledge and upon information and belief.

6. As of January 10, 2025, there are 2,230 transgender inmates housed in BOP facilities and halfway houses. There are 1,506 Male to Female Transgender inmates and 724 Female to Male Transgender inmates. The BOP currently has 16 Male to Female transgender inmates living in female institutions.

7. Plaintiff, Jane Doe, is currently housed at [REDACTED]

[REDACTED] Jane Doe is currently housed in general population.

8. Plaintiff, Mary Doe, is currently housed at [REDACTED]

[REDACTED] Mary Doe is currently housed in general population.

9. Plaintiff, Sara Doe, is currently housed at [REDACTED]

[REDACTED] Sara Doe is currently housed in general population.

10. The Transgender Executive Council reviewed the progress and current housing placement of several of the BOP's transgender inmates.

11. In determining the most appropriate placement for transgender inmates, the council takes into consideration the inmates' assigned security level, disciplinary record, medical record and psychology record.

12. The council has found that low security facilities are primary options because each houses a large number of non-violent offenders. Based on the council's experience and range of



expertise, placing Jane, Mary, and Sara Doe at a low security institution with non-violent offenders would minimize the likelihood that they would be victimized.

In accordance with 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Dated: February 3, 2025



RICK STOVER



U.S. Department of Justice
Federal Bureau of Prisons

CHANGE NOTICE

OPI: RSD/WSP
NUMBER: 5200.04 CN-1
DATE: May 11, 2018

Transgender Offender Manual

A handwritten signature in black ink, appearing to read "Mark S. Inch", is positioned above the approval text.

Approved: Mark S. Inch
Director, Federal Bureau of Prisons

This Change Notice (CN) implements the following change to Program Statement 5200.04, **Transgender Offender Manual**, dated January 18, 2017. The purpose of the Change Notice is to ensure that the Transgender Executive Council (TEC) considers issues related to prison management and security in determining appropriate housing of transgender inmates, including risks posed to staff, other inmates, and members of the public. The clarifications to policy will establish appropriate expectations for the inmate population concerning designations.

The changes are marked with a **highlight** and inserted into the policy. Deleted text is struck through. In addition, the branch name has been changed from Female Offender Branch to Women and Special Populations Branch.

1. PURPOSE AND SCOPE

To ensure the Bureau of Prisons (Bureau) properly identifies, tracks, and provides services to the transgender population, **consistent with maintaining security and good order in Federal prisons.**

4. STAFF TRAINING

The **Women and Special Populations Branch** will be responsible for developing training materials and current information on the management of transgender inmates. **Training will include information concerning best practices for maintaining the safety of transgender inmates, while also ensuring security and good order in Federal prisons and the safety of staff, inmates, and the public.** This information will be made available to staff on the **Women and Special Populations Branch** Sallyport page.

5. INITIAL DESIGNATIONS

The TEC will consider factors including, but not limited to, an inmate's security level, criminal and disciplinary history, current gender expression, medical and mental health needs/information, vulnerability to sexual victimization, and likelihood of perpetrating abuse. The TEC may also consider facility-specific factors, including inmate populations, staffing patterns, and physical layouts (e.g., types of showers available). ~~The TEC will recommend housing by gender identity when appropriate.~~

In deciding the facility assignment for a transgender or intersex inmate, the TEC should make the following assessments on a case-by-case basis:

- The TEC will use biological sex as the initial determination for designation;
- The TEC will consider the health and safety of the transgender inmate, exploring appropriate options available to assist with mitigating risk to the transgender offender, to include but not limited to cell and/or unit assignments, application of management variables, programming missions of the facility, etc.;
- The TEC will consider factors specific to the transgender inmate, such as behavioral history, overall demeanor, and likely interactions with other inmates; and
- The TEC will consider whether placement would threaten the management and security of the institution and/or pose a risk to other inmates in the institution (e.g., considering inmates with histories of trauma, privacy concerns, etc.).

The designation to a facility of the inmate's identified gender would be appropriate only in rare cases after consideration of all of the above factors and where there has been significant progress towards transition as demonstrated by medical and mental health history.

It will be noted in SENTRY designation notes that the TEC reviewed the inmate for appropriate institution designation.

7. HOUSING AND PROGRAMMING ASSIGNMENTS

In order for an inmate to be considered for transfer to another institution of the same sex as the inmate's current facility location, ~~including a facility housing individuals of the inmate's identified gender~~, the Warden should consult with the TEC prior to submitting a designation request to the DSCC, but this is not required.

In addition, the Warden may make a recommendation to the TEC to transfer a transgender or intersex inmate based on an inmate's identified gender.

In considering such recommendations, the TEC will apply all criteria of Section 5, above, and make the following assessments concerning the recommendation:

- The TEC will use biological sex as the initial determination for designation;
- The TEC will consider the health and safety of the transgender inmate, exploring appropriate options available to assist with mitigating risk to the transgender offender, to include but not limited to cell and/or unit assignments, application of management variables, programming missions of the facility, re-designation to another facility of the same sex, etc.;
- The TEC will also consider factors specific to the transgender inmate, such as behavioral history, overall demeanor, program participation, and likely interactions with other inmates; and
- The TEC will consider whether placement would threaten the management and security of the institution and/or pose a risk to other inmates in the institution (e.g., considering inmates with histories of trauma, privacy concerns, etc.).

The designation to a facility of the inmate's identified gender would be appropriate only in rare cases after consideration of all of the above factors and where there has been significant progress towards transition as demonstrated by medical and mental health history, as well as positive institution adjustments.

It will be noted in SENTRY designation notes that the TEC reviewed the inmate for appropriate institution designation.

9. HORMONE AND **NECESSARY** MEDICAL TREATMENT

Hormone or other **necessary** medical treatment may be provided after an individualized assessment of the requested inmate by institution medical staff. Medical staff should request consultation from Psychology Services regarding the mental health benefits of hormone or other **necessary** medical treatment. If appropriate for the inmate, hormone treatment will be provided in accordance with the Program Statement **Patient Care** and relevant clinical guidance. Questions concerning hormone treatment may be referred to the TCCT.



U.S. Department of Justice
Federal Bureau of Prisons

PROGRAM STATEMENT

OPI: RSD/FOB
NUMBER: 5200.04
DATE: January 18, 2017

Transgender Offender Manual

/s/

Approved: Thomas R. Kane
Acting Director, Federal Bureau of Prisons

1. PURPOSE AND SCOPE

To ensure the Bureau of Prisons (Bureau) properly identifies, tracks, and provides services to the transgender population, **consistent with maintaining security and good order in Federal prisons.**

a. Program Objectives. Expected results of this program are:

- This policy is meant to provide guidance to staff in dealing with the unique issues that arise when working with transgender inmates.
- Institutions ensure transgender inmates can access programs and services that meet their needs as appropriate, and prepare them to return to the community.
- Sufficient resources will be allocated to deliver appropriate services to transgender inmates.
- Staff will be offered training, enabling them to work effectively with transgender inmates.
- To support staff's understanding of the increased risk of suicide, mental health issues and victimization of transgender inmates.

b. Institution Supplement. None required. Should local facilities make any changes outside changes required in national policy or establish any additional local procedures to implement national policy, the local Union may invoke to negotiate procedures or appropriate arrangements.

2. DEFINITIONS

Gender – a construct used to classify a person as male, female, both, or neither. Gender encompasses aspects of social identity, psychological identity, and human behavior.

Gender identity – a person’s sense of their own gender, which is communicated to others by their gender expression.

Gender expression – includes mannerisms, clothing, hair style, and choice of activities.

Gender nonconforming – a person whose appearance or manner does not conform to traditional societal gender expectations.

Transgender – the state of one’s gender identity not matching one’s biological sex. For the purposes of this policy, a transgender inmate is one who has met with a Bureau of Prisons psychologist and signed the form indicating consent to be identified within the agency as transgender. This step allows for accommodations to be considered.

Cisgender – the state of one’s gender identity matching one’s biological sex.

Sexual orientation – the direction of one’s sexual interest towards members of the same, opposite, or both genders (e.g., heterosexual, homosexual, bisexual, asexual). Sexual orientation and gender identity are not related.

Gender Dysphoria (GD) – a mental health diagnosis currently defined by DSM-5 as, “A strong and persistent cross-gender identification. It is manifested by a stated desire to be the opposite sex and persistent discomfort with his or her biologically assigned sex.” Not all transgender inmates will have a diagnosis of GD, and a diagnosis of GD is not required for an individual to be provided services.

Intersex – a person whose sexual or reproductive anatomy or chromosomal pattern does not seem to fit typical biological definitions of male or female. Not all intersex people identify as transgender; unless otherwise specified, this policy does not apply to intersex people who do not identify as transgender.

Transition – measures that change one’s gender expression or body to better reflect a person’s gender identity.

3. STAFF RESPONSIBILITIES

The following Bureau components are responsible for ensuring consistent establishment of the programs, services, and resource allocations necessary for transgender offenders.

a. **Central Office**

(1) The **Women and Special Populations Branch** is the agency's primary source and point of contact on classification, management, and intervention programs and practices for transgender inmates in Bureau custody. The Branch is responsible for the following functions as they relate to transgender inmates:

- Engaging stakeholders, including serving as the primary point of contact on issues affecting transgender inmates with judges, political figures, and advocacy groups.
- Ensuring the Bureau offers appropriate services to transgender inmates.
- Preparing budgetary requests to deliver national and pilot programs or services affecting transgender inmates.
- Providing guidance and direction to Regional staff and institution leadership on transgender issues.
- Developing and implementing staff training on transgender issues.
- Building a research-based foundation for the Bureau's work with transgender inmates.
- Presenting at internal and external conferences/events regarding the agency's transgender inmates' practices.
- Developing and monitoring monthly reports on the transgender population and institutional programs.
- Issuing an annual report on the state of transgender offenders in the Bureau that will be made available to all staff and stakeholders.
- Advising agency leadership on transgender inmate needs.
- Conducting an annual survey of transgender inmates in the Bureau and sharing results with internal and external stakeholders.
- Providing national oversight of pilot programs and initiatives serving transgender offenders.

(2) The **Health Services Division** oversees all medical and psychiatric activity as it applies to transgender inmates. Guidance on the most current research-driven clinical medical and psychiatric care of transgender inmates will be provided by the Medical Director.

The Health Services Division also has oversight of a Transgender Clinical Care Team (TCCT). This team will be comprised of Physicians, Pharmacists, and Psychiatrists. Social Workers, Psychologists, and other clinical providers can also be included when appropriate. The TCCT will offer advice and guidance to health services staff on the medical treatment of transgender inmates and/or inmates with GD. Medical staff can raise issues to the TCCT through the Health Services Division.

(3) The **Psychology Services Branch** oversees all psychological mental health programs and services as they apply to transgender inmates, to include providing advice and guidance on

identification and evaluation of transgender inmates, and making recommendations for treatment needs of transgender inmates and/or inmates with GD.

(4) **Central Office Branches/Divisions** of Correctional Services, Psychology Services, Education, Correctional Programs, Reentry Affairs, Residential Reentry Management, Health Services, Health Programs, Social Work, Office of General Counsel, and Trust Fund meet annually with the **Women and Special Populations Branch** to discuss transgender population needs and evaluate current gender-responsive services. The National Union and the Central Office LGBT Special Emphasis Program Manager will be invited to attend these meetings.

(5) The **Transgender Executive Council (TEC)** will consist of staff members from the Health Services Division, the **Women and Special Populations Branch**, Psychology Services, the Correctional Programs Division, the Designation and Sentence Computation Center (DSCC), and the Office of General Counsel. The TEC will meet a minimum of quarterly to offer advice and guidance on unique measures related to treatment and management needs of transgender inmates and/or inmates with GD, including designation issues. Institution staff and DSCC staff may raise issues on specific inmates to the TEC through the **Women and Special Populations Branch**. The National PREA Coordinator is consulted as needed.

b. Regional Offices

- Provide oversight to institutions regarding services and other relevant trends managing transgender inmates.
- Assign transgender responsibilities to the Regional Female Offender/Transgender Coordinator Collateral Duty Assignment. This individual meets quarterly with the **Women and Special Populations Branch** to discuss staffing and programming needs.

c. Institutions

The institution CEO will establish a multi-disciplinary approach to the management of transgender inmates; specifically:

- Ensure transgender inmates have access to services.
- Enter tracking information for self-identified transgender inmates by updating SENTRY and other databases (e.g., PDS), as appropriate.
- Provide appropriate reentry resources that may be specific to the population.
- Advise the Local Union of transgender inmate management issues, as appropriate.

4. STAFF TRAINING

Staff will be provided specialized training in working with unique issues when managing transgender inmates, with refresher training at annual training. Institutions housing known transgender inmates should provide additional training, if needed.

The **Women and Special Populations Branch** will be responsible for developing training materials and current information on the management of transgender inmates. **Training will include information concerning best practices for maintaining the safety of transgender inmates, while also ensuring security and good order in Federal prisons and the safety of staff, inmates, and the public.** This information will be made available to staff on the **Women and Special Populations Branch** Sallyport page.

In addition, the Prison Rape Elimination Act (PREA) regulations incorporated into the BOP Program Statement **Sexually Abusive Behavior Prevention and Intervention Program** have training requirements concerning pat searches and communication skills for transgender inmates. See 28 C.F.R. § 115.15(f) and 115.31 (a) (9). Please refer to this Program Statement regarding implementation of those training requirements.

Staff will be provided adequate time to complete these trainings during duty hours.

5. INITIAL DESIGNATIONS

The PREA regulations, incorporated into the Program Statement **Sexually Abusive Behavior Prevention and Intervention Program**, state in section 28 C.F.R. § 115.42 (c):

“In deciding whether to assign a transgender or intersex inmate to a facility for male or female inmates...the agency shall consider on a case-by-case basis whether a placement would ensure the inmate’s health and safety, and whether the placement would present management or security problems.”

Upon receipt of information from a Pre-Sentence Report, court order, U.S. Attorney’s Office, defense counsel, the offender, or other source that an individual entering BOP custody is transgender, designations staff will refer the matter to the TEC for advice and guidance on designation.

Institution staff managing pretrial or holdover offenders may also refer cases to the TEC for review. Any TEC recommendations concerning pretrial inmates will be coordinated with the appropriate United States Marshal’s Office.

The TEC will consider factors including, but not limited to, an inmate's security level, criminal and disciplinary history, current gender expression, medical and mental health needs/information, vulnerability to sexual victimization, and likelihood of perpetrating abuse. The TEC may also consider facility-specific factors, including inmate populations, staffing patterns, and physical layouts (e.g., types of showers available). ~~The TEC will recommend housing by gender identity when appropriate.~~

In deciding the facility assignment for a transgender or intersex inmate, the TEC should make the following assessments on a case-by-case basis:

- The TEC will use biological sex as the initial determination for designation;
- The TEC will consider the health and safety of the transgender inmate, exploring appropriate options available to assist with mitigating risk to the transgender offender, to include but not limited to cell and/or unit assignments, application of management variables, programming missions of the facility, etc.;
- The TEC will consider factors specific to the transgender inmate, such as behavioral history, overall demeanor, and likely interactions with other inmates; and
- The TEC will consider whether placement would threaten the management and security of the institution and/or pose a risk to other inmates in the institution (e.g., considering inmates with histories of trauma, privacy concerns, etc.).

The designation to a facility of the inmate's identified gender would be appropriate only in rare cases after consideration of all of the above factors and where there has been significant progress towards transition as demonstrated by medical and mental health history.

It will be noted in SENTRY designation notes that the TEC reviewed the inmate for appropriate institution designation.

6. INTAKE SCREENING

The PREA regulations in 28 C.F.R. part 115, Subpart A, incorporated into the Program Statement **Sexually Abusive Behavior Prevention and Intervention Program** and the Program Statement **Intake Screening**, address intake screening. Screening of transgender inmates will be conducted in accordance with these policies and all other applicable policies and procedures.

7. HOUSING AND PROGRAMMING ASSIGNMENTS

During Initial classification and Program Reviews, Unit Management staff will twice-yearly review the inmate(s) current housing unit status and programming available for transgender inmates; this review will be documented by Unit Management.

The reviews will consider on a case-by-case basis that the inmate placement does not jeopardize the inmate's health and safety and does not present management or security concerns.

In making housing unit and programming assignments, a transgender or intersex inmate's own views with respect to his/her own safety must be given serious consideration.

Transgender inmates shall be given the opportunity to shower separate from other inmates.

The agency shall not place transgender or intersex inmates in dedicated facilities, units, or wings solely on the basis of such identification or status, unless such placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such inmates.

In order for an inmate to be considered for transfer to another institution of the same sex as the inmate's current facility location, including a facility housing individuals of the inmate's identified gender, the Warden should consult with the TEC prior to submitting a designation request to the DSCC, but this is not required.

In addition, the Warden may make a recommendation to the TEC to transfer a transgender or intersex inmate based on an inmate's identified gender.

In considering such recommendations, the TEC will apply all criteria of Section 5, above, and make the following assessments concerning the recommendation:

- The TEC will use biological sex as the initial determination for designation;
- The TEC will consider the health and safety of the transgender inmate, exploring appropriate options available to assist with mitigating risk to the transgender offender, to include but not limited to cell and/or unit assignments, application of management variables, programming missions of the facility, re-designation to another facility of the same sex, etc.;
- The TEC will also consider factors specific to the transgender inmate, such as behavioral history, overall demeanor, program participation, and likely interactions with other inmates; and
- The TEC will consider whether placement would threaten the management and security of the institution and/or pose a risk to other inmates in the institution (e.g., considering inmates with histories of trauma, privacy concerns, etc.).

The designation to a facility of the inmate's identified gender would be appropriate only in rare cases after consideration of all of the above factors and where there has been significant progress

towards transition as demonstrated by medical and mental health history, as well as positive institution adjustments.

It will be noted in SENTRY designation notes that the TEC reviewed the inmate for appropriate institution designation.

8. DOCUMENTATION AND SENTRY ASSIGNMENTS

a. **Medical and Mental Health Information.** Medical and mental health information for transgender inmates will be maintained in the current electronic recordkeeping system in accordance with the Program Statement **Health Information Management**. Medical and mental health information is considered confidential, and may only be released in accordance with appropriate laws, rules, and regulations.

b. **Initial Screening.** For initial designations, designations staff will assign Case Management Activity (CMA) SENTRY assignments if information in the PSR or other documentation indicates a likely transgender identity. The screening codes will be:

SCRN M2F – inmate should be screened for male to female.

SCRN F2M – inmate should be screened for female to male.

Any inmate arriving at the designated institution with a screening code is to be referred to the Chief Psychologist or designee for review within 14 days. If the code was assigned in error, the screening code will be removed by the psychologist. If the inmate identifies as transgender, the psychologist will replace the screening code with an identifying code, as indicated below. Holdover facilities will be exempt from this initial screening requirement, as limited available records and brevity of stay do not allow for a comprehensive screening.

Any inmate who arrives without a screening code but identifies as transgender during intake, or at any time during the incarceration period, is referred to the Chief Psychologist or designee and interviewed within 14 days of the inmate notification. Inmates in pretrial status at Bureau facilities may also receive a SENTRY code.

c. **Notification to Staff and Tracking.** After consultation with Psychology Services, and if the inmate affirms his/her transgender identity, the screening code will be updated to a permanent assignment by a psychologist:

TRN M2F – inmate is male to female transgender (transgender female).

TRN F2M – inmate is a female to male transgender (transgender male).

The inmate must request to Psychology Services staff that the CMA assignment be entered, and the inmate consents that all staff will therefore be notified that the individual is transgender. The inmate's request will be documented on BP-A1110, Case Management Activity (CMA) SENTRY Assignment Consent Form for Transgender Inmates (included as Attachment A to this policy). Psychology Services will maintain the form in the electronic mental health record and forward a copy of the form to the Unit Team. The Unit Team will maintain the form in the FOI Exempt section of the Central File.

Staff should consult the CMA assignment when interacting with the inmate; e.g., use of pronouns, searches, commissary items, etc., as indicated below.

If there are questions about the need to continue a CMA assignment, the Warden should contact the **Women and Special Populations Branch**. Should the CMA assignment change, staff members will not be disciplined for the continued provision of accommodations or use of pronouns.

9. HORMONE AND **NECESSARY** MEDICAL TREATMENT

Hormone or other **necessary** medical treatment may be provided after an individualized assessment of the requested inmate by institution medical staff. Medical staff should request consultation from Psychology Services regarding the mental health benefits of hormone or other **necessary** medical treatment. If appropriate for the inmate, hormone treatment will be provided in accordance with the Program Statement **Patient Care** and relevant clinical guidance. Questions concerning hormone treatment may be referred to the TCCT.

In the event this treatment changes the inmate's appearance to the extent a new identification card is needed, the inmate will not be charged for the identification card.

10. INSTITUTION PSYCHOLOGY SERVICES

Bureau psychologists are available to provide assessment and treatment services for transgender inmates, if appropriate. Guidance on assessment procedures will be provided by the Psychology Services Branch.

If an inmate identifies as transgender, the psychologist will provide the inmate with information regarding the range of treatment options available in the Bureau and their implications. In addition, based upon the psychologist's preliminary assessment and the inmate's expressed interest, a referral to the Clinical Director and/or Chief Psychiatrist may be generated. While the initial interview must be scheduled within 14 days, an assessment may take longer in some instances.

In addition to a referral to medical services, a transgender inmate may be offered individual psychotherapy. Individual psychotherapy goals might include: (1) helping the inmate to live more comfortably within a gender identity and deal effectively with non-gender issues; (2) emphasizing the need to set realistic life goals related to daily living, work, and relationships, including family of origin; (3) seeking to define and address issues that may have undermined a stable lifestyle, such as substance abuse and/or criminality; and (4) addressing any co-occurring mental health issues. Mood disorders, anxiety disorders, substance use disorders, and personality disorders, etc., may also be present; any effective treatment plan will fully address these symptoms.

If an institution has multiple transgender inmates, a support group facilitated by a mental health provider may also be a component of the treatment plan. Common concerns of transgender inmates, which may be addressed effectively in a group setting, include self-esteem issues and relationship issues.

Psychologists who provide mental health treatment for transgender inmates address all mental health needs, including suicide risk, if present.

Psychologists working with transgender inmates are encouraged to consult the Reentry Services Division in Central Office for additional resources.

11. PRONOUNS AND NAMES

Staff interacting with inmates who have a CMA assignment of transgender can use the authorized gender-neutral communication with inmates (e.g., by the legal last name or “Inmate” last name). Transgender inmates often prefer to be called by pronouns of their identified gender identity. Staff may choose to use these gender-specific pronouns or salutations per the inmate’s request, and will not be disciplined for doing so.

An official committed name change while in BOP custody must be done consistent with the Program Statement **Correctional Systems Manual**, Chapter 4. The name entered on the inmate’s Judgement and Commitment Order will remain the official committed name for all Bureau records (incident reports, progress reviews, sentence calculations, etc.). However, any additional names or aliases can be entered into SENTRY as appropriate.

12. PAT SEARCHES

Pat searches of transgender inmates will be conducted in accordance with the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas**. The policy language, included here as a reference, states:

“Transgender Inmates – For purposes of pat searching, inmates will be pat-searched in accordance with the gender of the institution, or housing assignment, in which they are assigned. Transgender inmates may request an exception. The exception must be pre-authorized by the Warden, after consultation with staff from Health Services, Psychology Services, Unit Management, and Correctional Services. Exceptions must be specifically described (e.g., “pat search only by female staff”), clearly communicated to relevant staff through a memorandum, and reflected in SENTRY (or other Bureau database; e.g., posted picture file). Inmates should be provided a personal identifier (e.g., notation on commissary card, etc.) that indicates their individual exception, to be carried at all times and presented to staff prior to pat searches.”

It is recommended the inmate request the exception by submitting an Inmate Request to Staff (BP-A0148) to the Warden. The Warden will consult with the departments listed above, and the memo approving or denying the request will be generated by the Warden’s Office.

Inmates who are granted this exception under policy may have it reversed by the Warden if found to have violated institution rules concerning contraband.

In exigent circumstances, any staff member may conduct a pat search of any inmate consistent with the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas**.

13. VISUAL SEARCHES

For purposes of a visual search, inmates will be searched in accordance with the gender of the institution, or housing assignment, to which they are assigned. The visual search shall be made in a manner designed to ensure as much privacy to the inmate as practicable. Staff should consider the physical layout of the institution, and the characteristics of an inmate with a transgender CMA assignment, to adjust conditions of the visual search as needed for the inmate’s privacy.

Transgender inmates may also request an exception to be visually searched by a staff member of the inmate’s identified gender. The exception must be pre-authorized by the Warden, after consultation with staff from Health Services, Psychology Services, Unit Management, and Correctional Services. Exceptions must be specifically described (e.g., “visual search only by female staff”), clearly communicated to relevant staff through a memorandum, and reflected in SENTRY (or other Bureau database; e.g., posted picture file). Inmates should be provided a

personal identifier (e.g., notation on commissary card, etc.) that indicates their individual exception, to be carried at all times and presented to staff prior to visual searches.

It is recommended the inmate request the exception by submitting an Inmate Request to Staff (BP-A0148) to the Warden. The Warden will consult with the departments listed above, and the memo approving or denying the request will be generated by the Warden's Office.

Inmates who are granted this exception under policy may have it reversed by the Warden if found to have violated institution rules concerning contraband.

Transgender inmates placed at an institution or in a housing unit that does not correspond with their identified gender, and who are granted an exemption as indicated above, will be searched by: bargaining unit staff of the inmate's identified gender who consent to participate in the search; management staff of the inmate's identified gender who consent to participate in the search; or available Health Services clinical staff.

Transgender inmates placed at an institution or in a housing unit of their identified gender will be searched by bargaining unit staff of the inmate's identified gender who consent to participate in the search; management staff of the inmate's identified gender; or available medical staff.

Institutions should consider using available body scanning technology in lieu of visual searches of transgender inmates.

In exigent circumstances, any staff member may conduct a visual search of any inmate consistent with the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas**.

14. CLOTHING AND COMMISSARY ITEMS

Consistent with safety and security concerns, inmates with the CMA assignment of transgender will have the opportunity to have undergarments of their identified gender even if they are not housed with inmates of the identified gender. Institutional laundry will have available institutional undergarments that fulfill the needs of transgender inmates. Undergarments will not have metal components.

Standardized lists of Commissary items for transgender inmates are available in accordance with the Program Statement **Trust Fund/Deposit Manual**.

Additional items based on an individualized assessment of the transgender inmate may be approved by the Warden. Additional items may be provided by the institution or purchased by the inmate, as appropriate.

Inmates who purchase and/or are provided items under this section will be subject to disciplinary sanctions, including the removal of these items, if they are found to have violated institution rules relating to the possession of these items.

15. REENTRY NEEDS

In accordance with the Program Statement **Release Preparation Program**, institution staff should assist transgender inmates in addressing these issues prior to release or placement in a Residential Reentry Center/Home Confinement.

During initial classifications and Program Reviews, Unit Management will formulate a pre-release plan that will assist transgender inmates in obtaining appropriate identification, finding housing and employment, and providing community resources to reintegrate into the community.

The Reentry Affairs Coordinator may assist staff with identifying these resources. Institution and/or Regional Social Workers should be contacted concerning the continuity of medical care.

The **Women and Special Populations Branch** and/or Social Workers can be contacted to provide guidance and resources for reentry needs of transgender inmates.

16. ADMINISTRATIVE REMEDIES

Inmates may use the procedures of the Program Statement **Administrative Remedy Program** concerning any issues relating to this policy.

REFERENCES

Program Statements

P1330.18	Administrative Remedy Program (1/6/14)
P4500.11	Trust Fund/Deposit Fund Manual (4/9/15)
P5100.08	Security Designation and Custody Classification Manual (9/12/06)
P5290.15	Intake Screening (3/30/09)
P5310.12	Psychology Services Manual (03/07/95)
P5310.16	Treatment and Care of Inmates with Mental Illness (5/1/14)
P5322.13	Inmate Classification and Program Review (5/16/14)
P5324.08	Suicide Prevention (4/5/07)
P5324.12	Sexually Abusive Behavior Prevention and Intervention Program (6/4/15)
P5325.07	Release Preparation Program (12/31/07)
P5521.06	Searches of Housing Units, Inmates, and Inmate Work Areas (6/4/15)
P5800.15	Correctional Systems Manual (9/23/16)

P6031.04 Patient Care (6/3/14)
P6090.04 Health Information Management (3/2/15)

Federal Regulations

28 CFR part 115

Additional Resources For Clinicians

Diagnostic and Statistical Manual of Mental Disorders (DSM), most current version.
World Professional Association for Transgender Health (WPATH) standards.

BOP Forms

BP-A0148 Inmate Request to Staff
BP-A1110 Case Management Activity (CMA) SENTRY Assignment Consent Form for Transgender Inmates

*ACA Standards (see Program Statement, **Directives Management Manual**, sections 2.5 and 10.3)*

- American Correctional Association Standards for Adult Correctional Institutions, 4th Edition: 4-4056M, 4-4084M, 4-4084.1M, 4-4133M, 4-4180M, 4-4194M, 4-4278M, 4-4281.1M, 4-4281.2M, 4-4281.3M, 4-4281.4M, 4-4281.5M, 4-4281.6M, 4-4281.7M, 4-4281.8M, 4-4362M, 4-4371M, 4-4406M.
- American Correctional Association Performance Based Standards for Adult Local Detention Facilities, 4th Edition: 4-ALDF-2A-29, 4-ALDF-2A-32, 4-ALDF-2A-34, 4-ALDF-6B-03, 4-ALDF-2C-03, 4-ALDF-4C-22M, 4-ALDF-4C-30M, 4-ALDF-4D-22, 4-ALDF-4D-22-1, 4-ALDF-4D-22-2, 4-ALDF-4D-22-3, 4-ALDF-4D-22-4, 4-ALDF-4D-22-5, 4-ALDF-4D-22-6M, 4-ALDF-4D-22-7, 4-ALDF-4D-22-8, 4-ALDF-7B-08, 4-ALDF-7B-10, 4-ALDF-7B-10-1.
- American Correctional Association Standards for Administration of Correctional Agencies, 2nd Edition: None.
- American Correctional Association Standards for Correctional Training Academies: None.

Records Retention

Requirements and retention guidance for records and information applicable to this program are available in the Records and Information Disposition Schedule (RIDS) on Sallyport.

**Attachment A. Case Management Activity (CMA) SENTRY Assignment
Consent Form for Transgender Inmates (BP-A1110)**

I agree that Bureau of Prisons staff may enter a CMA assignment on SENTRY concerning my gender identity.

I understand that this CMA assignment will identify me as transgender to all staff members.

I understand that the purpose of the CMA assignment is to assist staff members in providing programs and taking measures as described in the Program Statement **Transgender Offender Manual**.

I understand that specific medical and mental health information will not be disclosed to all staff using the CMA assignment; specific medical and mental health information is maintained separately.

Inmate Name:

Register Number:

Signature:

Date:



U.S. Department of Justice
Federal Bureau of Prisons

PROGRAM STATEMENT

OPI: RSD/WASPB
NUMBER: 5200.08
DATE: January 13, 2022

Transgender Offender Manual

/s/

Approved: M.D. Carvajal
Director, Federal Bureau of Prisons

1. PURPOSE AND SCOPE

To ensure the Bureau of Prisons (Bureau) properly identifies, tracks, and provides services to the transgender population.

a. Program Objectives. Expected results of this program are:

- This policy provides guidance to staff in dealing with the unique issues that arise when working with transgender inmates.
- Institutions ensure transgender inmates can access programs and services that meet their needs as appropriate, and prepare them to return to the community.
- Sufficient resources will be allocated to deliver appropriate services to transgender inmates.
- Staff will complete training, enabling them to work effectively with transgender inmates.
- To enhance staff's understanding of the increased risk of suicide, mental health issues and victimization of transgender inmates.

b. Summary of Changes

Rescinded P5200.04 CN-1 Transgender Offender Manual (5/11/2018)

This reissuance incorporates the following modifications:

- Clarified duties and responsibilities of various staff.
- Added an institution requirement for maintaining a copy of the Case Management Activity (CMA) Assignment form BP-A1110, Consent Form for Transgender Inmates. Inmates can no longer request to have a CMA assignment removed, and then re-added at a later date.
- Clarified transfer, consultation, and program requirements.

- Updated guidance regarding initial designation and redesignation procedures for transgender offenders.
- Added information about gender affirming surgery.

c. **Institution Supplement.** None required. Should local facilities make any changes outside changes required in national policy or establish any additional local procedures to implement national policy, the local Union may invoke to negotiate procedures or appropriate arrangements.

2. DEFINITIONS

Gender – a construct used to classify a person as male, female, both, or neither. Gender encompasses aspects of social identity, psychological identity, and human behavior.

Gender identity – a person’s sense of their own gender, which is communicated to others by their gender expression.

Gender expression – includes mannerisms, clothing, hairstyle, and choice of activities.

Gender nonconforming – a person whose appearance or manner does not conform to traditional societal gender expectations.

Transgender – the state of one’s gender identity not matching one’s sex assigned at birth. For the purposes of this policy, a transgender inmate is one who has met with a Bureau Psychologist and signed the form indicating consent to be identified within the agency as transgender. This step allows accommodations to be considered.

Cisgender – the state of one’s gender identity matching one’s sex assigned at birth.

Sexual orientation – the direction of one’s sexual interest towards members of the same, opposite, or both genders (e.g., heterosexual, homosexual, bisexual, asexual). Sexual orientation and gender identity are not related.

Gender Dysphoria (GD) – a mental health diagnosis currently defined by DSM-5 as, “A strong and persistent cross-gender identification. It is manifested by a stated desire to be the opposite sex and persistent discomfort with his or her biologically assigned sex.” Not all transgender inmates will have a diagnosis of GD, and a diagnosis of GD is not required for an individual to be provided services.

Intersex – a person whose sexual or reproductive anatomy or chromosomal pattern does not seem to fit typical physiological definitions of male or female. Not all intersex people identify as

transgender; unless otherwise specified, this policy does not apply to intersex people who do not identify as transgender.

Transition – measures that change one’s gender expression or body to better reflect a person’s gender identity.

Gender Affirming – describes behaviors or interventions that support the gender identity of a person.

3. STAFF RESPONSIBILITIES

The following Bureau components are responsible for ensuring consistent establishment of the programs, services, and resource allocations necessary for transgender offenders.

a. Central Office

(1) The **Women and Special Populations Branch (WASPB)** is the agency’s primary source and point of contact on accommodation/transition, classification, management, and intervention/treatment programs and practices for transgender inmates in Bureau custody. The Branch is responsible for the following functions as they relate to transgender inmates:

- Engaging stakeholders, including serving as the primary point of contact on issues affecting transgender inmates with external entities including judges, congress, and advocacy groups.
- Ensuring the Bureau offers appropriate services to transgender inmates.
- Preparing budget requests to deliver national and pilot programs or services affecting transgender inmates.
- Providing guidance and direction to staff and institution, region, and agency leadership on transgender issues.
- Developing and implementing staff training on transgender issues.
- Building a research-based foundation for the Bureau’s work with transgender inmates, including implementation support and intervention services.
- Presenting at internal and external conferences/events regarding the agency’s transgender inmates’ practices.
- Developing and monitoring monthly reports on the transgender population and institutional programs.
- Conducting an annual survey of transgender inmates in the Bureau and sharing results with internal and external stakeholders.
- Providing national oversight of pilot programs and initiatives serving transgender offenders.
- Overseeing the Transgender Executive Council (TEC).
- Ensure that a National Program and Policy Coordinator is assigned to each Region who will meet quarterly to discuss staffing and programming needs of transgender inmates.

(2) The **Health Services Division** oversees all medical and psychiatric guidance and treatment as it applies to transgender inmates. Clinical guidance on the most current research-driven clinical medical and psychiatric care of transgender inmates will be provided at the direction of the Medical Director. The Medical Director only receives referrals from the TEC and determines whether gender affirming surgery requests will be referred to a surgeon.

(3) The **Psychology Services Branch** oversees all mental health programs and services as they apply to transgender inmates, to include providing advice and guidance on identification and evaluation of transgender inmates, and making recommendations for treatment needs of transgender inmates and/or inmates with GD.

(4) **Central Office Branches** of Correctional Services, Psychology Services, Education, Correctional Programs, Reentry Affairs, Residential Reentry Management, Health Programs, Litigation, Chaplaincy Services, Intelligence and Counter Terrorism Branch, and Trust Fund meet annually with the Women and Special Populations Branch to discuss transgender population needs and evaluate current gender-responsive services. The National Union and the Central Office LGBT Special Emphasis Program Manager will be invited to attend these meetings.

(5) The **Transgender Executive Council (TEC)** will consist of senior level staff members (GS-14 and above) from the Women and Special Populations Branch, the Psychology Services Branch, Health Services Division, and the Designation and Sentence Computation Center (DSCC). The team is led by the Senior Deputy Assistant Director, Reentry Services and also includes the Senior Deputy Assistant Director, Correctional Programs Division (DSCC), and the Senior Deputy Assistant Director, Health Services. The TEC is the agency's official decision-making body on all issues affecting the transgender population. It will meet a minimum of monthly to offer advice and guidance on unique measures related to treatment and management needs of transgender inmates and/or inmates with GD, including training, designation issues, and reviewing all transfers for approval. Staff or inmates may raise issues on specific inmates to the TEC through the Women and Special Populations Branch. The Office of General Counsel is consulted as needed.

b. Regional Offices

- Provide oversight to institutions regarding services and other relevant trends managing transgender inmates.

c. Institutions

The Warden will establish a multi-disciplinary approach to the management of transgender inmates. The Associate Warden of Programs is the primary point of contact in the institution for transgender issues and will consult as needed with the Chief Psychologist, Captain, Clinical

Director, Unit Manager, or other individuals as appropriate; and specifically to:

- Ensure transgender inmates have access to services.
- Enter tracking information for self-identified transgender inmates by updating SENTRY CMA assignments and other databases (e.g., PDS).
- Maintain a copy of the Case Management Activity (CMA) SENTRY Assignment Consent Form for Transgender Inmates (BP-A1110) in the Central File and Psychology Data System (PDS).
- Provide appropriate reentry resources that may be specific to the population.
- Advise the Local Union of transgender inmate management issues.
- Consult and refer transgender inmates to the TEC.
- Provide programming developed by the Reentry Services Division for transgender inmates.

4. STAFF TRAINING

Staff are provided specialized training in working with unique issues when managing transgender inmates as part of annual training. Institutions housing transgender inmates should provide additional training.

The Women and Special Populations Branch is responsible for developing training materials and current information on the management of transgender inmates. This information will be made available to staff via the Bureau's intranet.

In addition, the Prison Rape Elimination Act (PREA) regulations incorporated into the BOP Program Statement, **Sexually Abusive Behavior Prevention and Intervention Program** have training requirements concerning pat searches and communication skills for transgender inmates. See 28 C.F.R. § 115.15(f) and 115.31 (a) (9). Please refer to this Program Statement regarding implementation of those training requirements.

Staff will be provided adequate time to complete these trainings during duty hours. Staff will be provided proper relief to complete the training.

5. INITIAL DESIGNATIONS

The PREA regulations (section 28 C.F.R. § 115.42 (c)), incorporated into the Program Statement **Sexually Abusive Behavior Prevention and Intervention Program**, state:

“In deciding whether to assign a transgender or intersex inmate to a facility for male or female inmates...the agency shall consider on a case-by-case basis whether a placement would ensure the inmate's health and safety, and whether the placement would present management or security problems.”

Upon receipt of information from a Pre-Sentence Report, court order, U.S. Attorney's Office, defense counsel, the offender, or other source that an individual entering BOP custody is

transgender or intersex, designations staff will refer the matter to the TEC.

Institution staff managing pretrial or holdover offenders must also refer cases to the TEC for review. Any TEC recommendations concerning pretrial inmates will be coordinated with the appropriate United States Marshals Service District Office.

The TEC will consider factors including, but not limited to, an inmate's security level, criminal and behavioral/disciplinary history, current gender expression, programming, medical, and mental health needs/information, vulnerability to sexual victimization, and likelihood of perpetrating abuse. The TEC may also consider facility-specific factors, including inmate populations, staffing patterns, and physical layouts (e.g., types of showers available). The TEC will consider the wellbeing of all inmates while exploring appropriate options available to assist with mitigating risk to the inmate, to include but not limited to cell and/or unit assignments, application of management variables, programming missions of the facility, and security of the institution.

It will be documented on all SENTRY designation notes for transgender inmates that the TEC reviewed the inmate for appropriate institution designation.

6. HOUSING AND PROGRAMMING ASSIGNMENTS

During Initial Classification and subsequent Program Reviews, unit management staff will review the inmate's current housing unit status and programming available for transgender inmates. This review will be documented by Unit Management staff in the inmate central file and for holdovers in the holdover file, with institution oversight by the Associate Warden.

The reviews will consider on a case-by-case basis that the inmate placement does not jeopardize the inmate's wellbeing and does not present management or security concerns.

In making housing unit and programming assignments, a transgender or intersex inmate's own views with respect to his/her own safety must be given serious consideration.

Transgender inmates shall be given the opportunity to shower separate from other inmates when individual shower stalls are unavailable.

The agency shall not place transgender or intersex inmates in dedicated facilities, units, or wings solely on the basis of such identification or status. The only exception is if such placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such inmates.

Wardens will consult with WASPB prior to submitting a designation request to the DSCC for the redesignation of transgender inmates when the designation is related to the individual's

transition. The DSCC and Office of Medical Designations will consult with WASPB prior to the designation or redesignation of all transgender inmates.

In situations where the transfer request is related to progressing the individual inmate's transition (i.e., transfer to a different sex facility) the TEC will consider the case. Prior to considering the case, the Warden will submit documentation to the TEC showing the inmate has met the minimum standards of compliance with programs, medications and mental health treatment, and meeting hormone goal levels. Ordinarily, inmates will not be submitted to the TEC for consideration until they have maintained one year clear conduct for 100 and 200 series incident report sanctions, though they may be considered for submission on a case-by-case basis by the Warden, as appropriate.

It will be noted in all SENTRY designation notes that the TEC reviewed the inmate for appropriate institution designation.

7. DOCUMENTATION AND SENTRY ASSIGNMENTS

The PREA regulations in 28 C.F.R. part 115, Subpart A, incorporated into the Program Statement **Sexually Abusive Behavior Prevention and Intervention Program** and the Program Statement **Intake Screening**, address intake screening. Screening of transgender inmates will be conducted in accordance with these policies and all other applicable policies and procedures.

a. Medical and Mental Health Information. Medical and mental health information for transgender inmates will be maintained in the current electronic recordkeeping system or health record system in accordance with the Program Statements **Health Information Management and Psychology Services Manual**. Medical and mental health information is considered confidential, and may only be released in accordance with appropriate laws, rules, and regulations.

b. Initial Screening. For initial designations, staff will assign Case Management Activity (CMA) SENTRY assignments if information in the PSR or other documentation indicates a likely transgender identity. The screening codes are:

SCRN M2F – inmate should be screened for male to female transgender identification.

SCRN F2M – inmate should be screened for female to male transgender identification.

Any inmate arriving at the designated institution with a screening code is to be referred to the Chief Psychologist or designee for review within 14 days. If the code was assigned in error, the screening code will be removed by the Psychologist. If the inmate identifies as transgender, the psychologist will replace the screening code with an identifying code, as indicated below. Holdover facilities are exempt from this initial screening requirement, as limited available

records and brevity of stay do not typically allow for a comprehensive screening.

Any inmate who arrives without a screening code but identifies as transgender during intake, or at any time during the incarceration period, is referred to the Chief Psychologist or designee and interviewed within 14 days of the inmate notification. Inmates in pretrial status at Bureau facilities may also receive a transgender screening CMA SENTRY assignment.

c. Notification to Staff and Tracking. After consultation with Psychology Services, and if the inmate affirms his/her transgender identity, the screening code will be updated to a permanent assignment by a Psychologist:

TRN M2F – inmate identifies as male to female transgender (transgender female).

TRN F2M – inmate identifies as female to male transgender (transgender male).

The inmate must request to Psychology Services staff that the Case Management Activity (CMA) assignment be entered, and the inmate consents that all staff will therefore be notified that the individual is transgender. The inmate's request will be documented on a Case Management Activity (CMA) SENTRY Assignment Consent Form for Transgender Inmates (BP-A1110). Psychology Services shall maintain the form in the electronic mental health record.

Staff should consult the transgender CMA assignment when interacting with the inmate; e.g., use of pronouns and access to accommodations. All inmates have access to transgender treatment, regardless of assignment.

If there are questions about the need to continue a CMA assignment, the Warden will contact the WASPB. Inmates may request in writing to have CMA assignments removed. If this occurs, ordinarily the assignment will not be re-added at a later date.

8. HORMONE THERAPY AND MEDICAL TREATMENT

Hormone therapy or other medical treatment may be provided after an individualized assessment of the requested inmate by institution medical staff. Medical staff will request consultation from Psychology Services regarding the mental health benefits of hormone or other medical treatment. If appropriate for the inmate, hormone treatment will be provided in accordance with the Program Statement **Patient Care** and relevant Clinical Guidance. Questions concerning hormone treatment may be referred to the WASPB or the Health Services Division.

In the event this treatment changes the inmate's appearance to the extent a new identification card is needed, the inmate will not be charged for the identification card as is standard practice.

9. SURGERY

While not all inmates who identify as transgender may be interested in seeking surgical intervention, such a decision does not preclude them from obtaining other accommodations as described in this Program Statement. For transgender inmates in Bureau custody, surgery may be the final stage in the transition process and is generally considered only after one year of clear conduct and compliance with mental health, medical, and programming services at the gender affirming facility. Once that period elapses, an inmate may submit a request to his or her Warden requesting surgical consideration. The Warden will forward the request to the TEC. The TEC is the sole body who may determine that all milestones and individual goals for surgical consideration have been met. When this occurs, the case is referred to the agency's Medical Director for medical consideration. He or she may review existing records and/or interview the inmate, institution staff, and members of the TEC. After this individualized assessment, the Medical Director will determine if the surgery is medically appropriate for referral to a gender affirming surgeon.

10. OTHER MENTAL HEALTH SERVICES

Bureau Psychologists provide assessment and treatment services for transgender inmates, as appropriate. Guidance on assessment procedures is available on the Psychology Services intranet page.

If an inmate identifies as transgender, the Psychologist will provide the inmate with information regarding the range of treatment options available in the Bureau and their implications. In addition, based upon the Psychologist's preliminary assessment and the inmate's expressed interest, a referral to the Clinical Director and/or Chief Psychiatrist may be generated. While the initial interview must be scheduled within 14 days, an assessment may take longer in some instances.

In addition to a referral for medical services, a transgender inmate may be offered individual psychotherapy. Individual psychotherapy goals might include: (1) helping the inmate to live more comfortably within a gender identity and deal effectively with non-gender issues; (2) emphasizing the need to set realistic life goals related to daily living, work, and relationships, including family of origin; (3) seeking to define and address issues that may have undermined a stable lifestyle, such as substance abuse and/or criminality; and (4) addressing any co-occurring mental health issues. Mood disorders, anxiety disorders, substance use disorders, and personality disorders, etc., may also be present; any effective treatment plan will fully address these symptoms. Group treatment may also be recommended.

Common concerns of transgender inmates, which can be addressed effectively in a group setting, include self-esteem issues and relationship issues.

Psychologists who provide mental health treatment for transgender inmates address all mental health needs, including suicide risk, if present. If an inmate who identifies as a transgender harms, attempts to remove, or removes his or her genitalia or other gender-specific anatomy, a suicide risk assessment is conducted consistent with the Program Statement, Suicide Prevention Program. In addition, the treating psychologist notifies the Chief Psychologist who in turn notifies the Regional Psychology Services Administrator and the Psychology Services Branch.

Psychologists working with transgender inmates are encouraged to consult the Reentry Services Division in Central Office for additional resources.

11. SPECIAL POPULATIONS SERVICES

Some facilities have Special Populations Coordinators on staff. These individuals are responsible for delivering First Step Act and other programs, which includes programs developed specifically for inmates who identify as transgender. In the absence of such staff, the Warden will seek consultation from WASPB regarding the delivery of group interventions and services.

12. PRONOUNS AND NAMES

Staff interacting with inmates who have a CMA assignment of transgender, shall either use the authorized gender-neutral communication with inmates (e.g., by the legal last name or “Inmate” last name) or the pronouns associated with the inmate’s identified gender. Deliberately and repeatedly mis-gendering an inmate is not permitted.

The name entered on the inmate’s Judgment and Commitment Order is the official committed name for all Bureau records (incident reports, progress reviews, sentence calculations, etc.). An official committed name change while in BOP custody must be done consistent with the Program Statement **Correctional Systems Manual**. Any additional names or aliases should be entered into SENTRY, as appropriate.

13. PAT SEARCH ACCOMMODATIONS

Pat searches of transgender inmates will be conducted in accordance with the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas**.

Pat search information refers only to individuals at male facilities who identify as female. The Bureau does not offer “male only” pat searches.

Unless there is a history of inappropriate sexual behavior suggesting approval poses risks to staff, requests are ordinarily approved by the Warden’s Office. Inmates may request denials be reviewed by the TEC through the Administrative Remedy Program. Inmates who are granted this exception under policy may have it reversed by the Warden if found to have violated

institution rules concerning contraband.

In exigent circumstances, any staff member may conduct a pat search of any inmate consistent with the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas**.

14. VISUAL SEARCHES

For purposes of a visual search, inmates will be searched in accordance with the gender of the institution, or housing assignment, to which they are assigned. The visual search shall be made in a manner designed to ensure as much privacy to the inmate as practicable. Staff should consider the physical layout of the institution, and the characteristics of an inmate with a transgender CMA assignment, to adjust conditions of the visual search as needed for the inmate's privacy.

Transgender inmates may also request an exception to be visually searched by a staff member of the inmate's identified gender. The exception must be pre-authorized by the Warden, after consultation with staff from Health Services, Psychology Services, Unit Management, and Correctional Services. Exceptions must be specifically described (e.g., "visual search only by female staff"), clearly communicated to relevant staff through a memorandum, and reflected in SENTRY (or other Bureau database). Inmates should be provided a personal identifier (e.g., notation on identification, etc.) that indicates their individual exception, to be carried at all times and presented to staff prior to visual searches.

Inmates request an exception by submitting an Inmate Request to Staff (BP-A0148) to the Warden. The Warden will consult with the departments listed above, and the memo approving or denying the request will be generated by the Warden's Office. Inmates may request denials be reviewed by the TEC through the Administrative Remedy Program. Inmates who are granted this exception may have it reversed by the Warden if found to have violated institution rules concerning contraband.

Transgender inmates placed at an institution or in a housing unit that does not correspond with their identified gender, and who are granted an exemption as indicated above, will be searched by staff of the inmate's identified gender who consent to participate in the search, or Health Services clinical staff.

Transgender inmates placed at an institution or in a housing unit of their identified gender will be searched by staff of the inmate's identified gender who consent to participate in the search or medical staff.

Institutions should consider using available body scanning technology in lieu of visual searches of transgender inmates.

In exigent circumstances, any staff member may conduct a visual search of any inmate consistent with the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas**.

15. CLOTHING, COMMISSARY ITEMS, AND OTHER ACCOMMODATIONS

Consistent with safety and security concerns, inmates with the CMA assignment of transgender will have the opportunity to have undergarments of their identified gender even if they are not housed with inmates of the identified gender. Institutional laundry will have available institutional undergarments that fulfill the needs of transgender inmates. Undergarments will not have metal components.

Standardized lists of Commissary items for transgender inmates are available in accordance with the Program Statement **Trust Fund/Deposit Manual** and the information on the RSD intranet page.

Additional items based on an individualized assessment of the transgender inmate population may be approved by the Warden. Additional items may be provided by the institution or purchased by the inmate, as appropriate. Any concerns regarding such items are directed to the WASPB.

Inmates who purchase and/or are provided items under this section will be subject to disciplinary sanctions, including the removal of these items, if they are found to have violated institution rules relating to the possession of these items.

Any other accommodation requests are discussed with the TEC through the WASPB.

16. REENTRY NEEDS

In accordance with the Program Statement **Release Preparation Program**, institution staff assist transgender inmates in addressing reentry issues prior to release or placement in a Residential Reentry Center/Home Confinement.

During Initial Classification and Program Reviews, unit management formulates a pre-release plan that assists transgender inmates in obtaining identification, finding housing and employment, and providing community resources to assist with reintegration into the community.

The Reentry Affairs Coordinator will assist staff with identifying these resources. Community Treatment Services staff or Institution and/or Regional Social Workers may be contacted concerning the continuity of medical care.

The WASPB can be contacted to provide guidance and resources for any additional reentry

needs of transgender inmates. All accommodation and treatment decisions for inmates in community custody are made by the Residential Reentry Management Branch in consultation with the TEC.

17. ADMINISTRATIVE REMEDIES

Inmates who wish to seek formal review of any issue relating to this policy may use the procedures in the Program Statement **Administrative Remedy Program**.

REFERENCES

Program Statements

P1330.18	Administrative Remedy Program (1/6/14)
P4500.12	Trust Fund/Deposit Fund Manual (3/15/18)
P5100.08	Security Designation and Custody Classification Manual (9/4/19)
P5290.15	Intake Screening (3/30/09)
P5310.17	Psychology Services Manual (08/25/16)
P5310.16	Treatment and Care of Inmates with Mental Illness (5/1/14)
P5322.13	Inmate Classification and Program Review (5/16/14)
P5324.08	Suicide Prevention (4/5/07)
P5324.12	Sexually Abusive Behavior Prevention and Intervention Program (6/4/15)
P5325.07	Release Preparation Program (8/15/19)
P5521.06	Searches of Housing Units, Inmates, and Inmate Work Areas (6/4/15)
P5800.15	Correctional Systems Manual (9/23/16)
P6031.04	Patient Care (6/3/14)
P6090.04	Health Information Management (3/2/15)

Federal Regulations

28 CFR part 115

Additional Resources For Clinicians

Diagnostic and Statistical Manual of Mental Disorders (DSM), most current version. World Professional Association for Transgender Health (WPATH) standards.

ACA Standards

- American Correctional Association Standards for Adult Correctional Institutions, 5th Edition: 5-ACI-1C-09, 5-ACI-1D-12, 5-ACI-1D-13, 5-ACI-2C-02, 5-ACI-1D-08, 5-ACI-3D-05, 5-ACI-3D-08(M), 5-ACI-3D-09, 5-ACI-3D-10, 5-ACI-3D-11, 5-ACI-3D-12, 5-ACI-3D-13, 5-ACI-3D-14, 5-ACI-3D-15, 5-ACI-3D-16, 5-ACI-6A-21(M), 5-ACI-6A-32(M), 5-ACI-6C-14(M)
- American Correctional Association Performance Based Standards for Adult Local Detention Facilities, 4th Edition: 4-ALDF-2A-29, 4-ALDF-2A-32, 4-ALDF-2A-34, 4-ALDF-6B-03, 4-ALDF-2C-03, 4-ALDF-4C-22M, 4-ALDF-4C-30M, 4-ALDF-4D-22, 4-ALDF-4D-22-1, 4-

ALDF-4D-22-2, 4-ALDF-4D-22-3, 4-ALDF-4D-22-4, 4-ALDF-4D-22-5, 4-ALDF-4D-22-6M, 4-ALDF-4D-22-7, 4-ALDF-4D-22-8, 4-ALDF-7B-08, 4-ALDF-7B-10, 4-ALDF-7B-10-1.

- American Correctional Association Standards for Administration of Correctional Agencies, 2nd Edition: None.
- American Correctional Association Standards for Correctional Training Academies: None.

Records Retention

Requirements and retention guidance for records and information applicable to this program are available in the Records and Information Disposition Schedule (RIDS) on Sallyport.

**IN THE UNITED STATES DISTRICT COURT FOR THE
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION**

REIYN KEOHANE,

Plaintiff,

v.

Case No. 4:24-cv-434-AW-MAF

**RICKY D. DIXON, in his official capacity
as Secretary of the Florida Department of
Corrections, et al.,**

Defendants.

ORDER DENYING MOTION FOR PRELIMINARY INJUNCTION

Plaintiff Reiyne Keohane, a transgender Florida inmate, brought this § 1983 action against three prison officials.¹ Keohane, a male who self-identifies as a woman, has gender dysphoria.² For several years, the Department of Corrections has provided Keohane (and other inmates) with hormone treatment. The Department has

¹ Defendants are Ricky Dixon, in his official capacity as Secretary of the Florida Department of Corrections; Clayton Weiss, in his official capacity as Health Services Director of the Florida Department of Corrections; and Gary Hewett, in his official capacity as Warden of the Wakulla Correctional Institution. ECF No. 1. A suit against any official-capacity defendant is, in essence, against the entity he represents. *See Kentucky v. Graham*, 473 U.S. 159, 166 (1985). Thus, and for simplicity, this order will refer to Defendants collectively as the “Department.”

² Gender dysphoria, “in general terms, ‘refers to the distress that may accompany the incongruence between one’s experienced or expressed gender and one’s assigned gender.’” *Keohane v. Fla. Dep’t of Corr. Sec’y*, 952 F.3d 1257, 1262 (11th Cir. 2020) (quoting Am. Psychiatric Ass’n, Diagnostic and Statistical Manual of Mental Disorders 451 (5th ed. 2013)).

also allowed certain policy deviations regarding hair length, makeup, and women's undergarments.

Now, a new policy prohibits all male inmates—including transgender inmates with gender dysphoria—from wearing long hair, makeup, or women's undergarments.³ In addition, the Department will reevaluate all inmates who have been receiving hormone treatment to determine whether the treatment should continue. That reevaluation process has begun, and as of now, the Department has not discontinued hormone treatment for any inmate based on the policy or any reevaluation.

Keohane sued to enjoin the new policy's implementation, contending it violates the Eighth Amendment. At issue now is Keohane's request for a preliminary injunction and temporary restraining order. After a hearing, and after careful consideration of the record and the parties' arguments, I deny the motion.

I.

At the litigation's outset, Keohane sought both a temporary restraining order and a preliminary injunction. ECF No. 4. I denied the motion to the extent it sought a temporary restraining order before the Department could have notice and an opportunity to respond. ECF No. 14. Then, after a telephonic hearing to address

³ Inmates needing breast support may still possess bras, *see* ECF No. 46-3 at 2, but this exception does not cover Keohane, ECF No. 53-5 at 2.

procedural matters, I set a briefing schedule and a hearing. ECF No. 22. The Department agreed in the meantime to postpone applying the new policy to Keohane, pending resolution of the preliminary-injunction motion.

Both sides submitted evidence. Keohane and two other transgender inmates provided declarations, ECF Nos. 4-7, 16-2, 46-10, 46-11, as did Keohane's counsel, ECF Nos. 4-1, 16-1, 46-1. The Department submitted declarations from Dr. Danny Martinez, Chief of Medical Services, ECF Nos. 38-1, 52-1; Dr. Suzonne Klein, Chief of Mental Health, ECF No. 38-2; and Clayton Weiss, Health Services Director, ECF No. 38-3. At the hearing, both sides agreed I could consider all the declarations. *Cf. Levi Strauss & Co. v. Sunrise Int'l Trading Inc.*, 51 F.3d 982, 985 (11th Cir. 1995) (noting that courts may consider hearsay evidence at the preliminary-injunction stage).⁴ Neither side elected to present live direct testimony. But over the Department's objection, I allowed Keohane to cross-examine Dr. Martinez as to his declarations. Keohane also submitted several exhibits at the hearing. *See* ECF No. 53. I have considered the entire evidentiary record.

⁴ The Department moved to strike two inmate declarations submitted with Keohane's reply. ECF No. 47. I denied the motion but indicated I would entertain argument at the hearing about whether I should consider the declarations. ECF No. 49. At the hearing, the Department withdrew its objection to my considering those declarations.

The Department previously asserted lack of exhaustion under the Prison Litigation Reform Act as one reason why Keohane is not entitled to a preliminary injunction. ECF No. 38 at 22-24. It was the Department's burden to demonstrate failure to exhaust administrative remedies, which is an affirmative defense. *Whatley v. Smith*, 898 F.3d 1072, 1082 (11th Cir. 2018). After the hearing, the Department withdrew its exhaustion defense, ECF No. 54, so I will not consider it here.

II.

A preliminary injunction is “an extraordinary and drastic remedy” that is unavailable unless the movant clearly establishes entitlement. *Siegel v. LePore*, 234 F.3d 1163, 1176 (11th Cir. 2000) (en banc) (quoting *McDonald's Corp. v. Robertson*, 147 F.3d 1301, 1306 (11th Cir. 1998)); see also *Texas v. Seatrain Int'l, S.A.*, 518 F.2d 175, 179 (5th Cir. 1975) (“[G]ranted a preliminary injunction is the exception rather than the rule.”). To obtain a preliminary injunction, a plaintiff must clearly establish: (1) “a substantial likelihood of success on the merits”; (2) that the plaintiff will suffer irreparable injury without an injunction; (3) that the threatened injury “outweighs whatever damage the proposed injunction may cause” the other side; and (4) that “the injunction would not be adverse to the public interest.” *Siegel*, 234 F.3d at 1176.

Because a plaintiff must clearly establish all four requirements, a failure on even one is fatal. *ACLU of Fla., Inc. v. Miami-Dade Cnty. Sch. Bd.*, 557 F.3d 1177,

1198 (11th Cir. 2009). “[T]he most common failure is not showing a substantial likelihood of success on the merits.” *Id.* As explained below, Keohane fails on that point. I therefore must deny the motion, and I need not address the remaining requirements.

III.

Keohane’s complaint presents a single count: one for “denial of medically necessary treatment in violation of the Eighth Amendment.” ECF No. 1 at 21. The Eighth Amendment “prohibits ‘deliberate indifference to serious medical needs of prisoners.’” *Hoffer v. Sec’y, Fla. Dep’t of Corr.*, 973 F.3d 1263, 1270 (11th Cir. 2020) (quoting *Estelle v. Gamble*, 429 U.S. 97, 104 (1976)). States “therefore have a constitutional obligation to provide minimally adequate medical care to those whom they are punishing by incarceration.” *Id.* (quoting *Harris v. Thigpen*, 941 F.2d 1495, 1504 (11th Cir. 1991)). A prison official acts with deliberate indifference only if he (1) has subjective knowledge of a risk of serious harm and (2) disregards that risk (3) in what amounts to recklessness as defined in the criminal law. *Wade v. McDade*, 106 F.4th 1251, 1255 (11th Cir. 2024) (en banc); *see also Farmer v. Brennan*, 511 U.S. 825, 839-40 (1994).

Keohane’s single count has two components. It challenges the policy’s separate restrictions on hormone treatment and on “clothing and grooming accommodations.” ECF No. 1 ¶¶ 71, 74. The “clothing and grooming

accommodations” include permission to wear long hair, makeup, and women’s undergarments. For simplicity and clarity, I will refer to the two components as “hormone treatment” and “social accommodations.”⁵

Although part of one claim, the two components differ in some ways. The Department defends them differently: it argues, for example, that Keohane lacks standing as to hormone treatment and that issue preclusion bars the social accommodations piece. And the facts differ: it is undisputed, for example, that no inmate has lost hormone treatment based on the new policy but that all inmates (other than Keohane) have lost their social accommodations.⁶ Accordingly, I will address the hormone-treatment and social-accommodations aspects of the claim separately.

A. Hormone Treatment

As to hormone treatment, the Department first argues standing. To succeed in any case, a plaintiff must have standing, “an essential and unchanging part of the case-or-controversy requirement.” *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560

⁵ Department records use the term “GD [gender dysphoria] accommodations” to refer to all accommodations other than hormone treatment. *See* ECF No. 46-5 at 1; *see also* Dr. Martinez hearing testimony. This terminology is imperfect because some would call hormone treatment a gender dysphoria accommodation and because there is disagreement about whether the social accommodations constitute medical treatment. Thus, this order will use the terms “hormone treatment” and “social accommodations.”

⁶ As already noted, the Department agreed to pause implementation as to Keohane—including the social accommodations—pending resolution of the preliminary injunction.

(1992). To establish standing, a plaintiff must show (1) an injury in fact (2) traceable to the defendant’s action (3) that is redressable by a favorable decision. *Id.*; *see also Lewis v. Gov. of Ala.*, 944 F.3d 1287, 1296 (11th Cir. 2019). “[E]ach element must be supported . . . with the manner and degree of evidence required at the successive stages of litigation.” *Lujan*, 504 U.S. at 561. Thus, at the preliminary injunction stage, “the plaintiff must make a ‘clear showing’ that she is ‘likely’ to establish each element of standing.” *Murthy v. Missouri*, 603 U.S. 43, 58 (2024) (cleaned up). That means that to succeed at this stage, Keohane had to clearly demonstrate, among other things, a likelihood of a prospective injury.

Keohane’s ultimate concern is that the new policy will lead to a discontinuation of hormone treatment. But importantly, as counsel confirmed at the hearing, Keohane does not currently advance any claim that eliminating hormone treatment would necessarily violate the Eighth Amendment. Instead, the claim is that the new policy is a “blanket ban” on hormone treatment and that any “blanket ban” against specific treatments violates the Eighth Amendment. The main problem with this argument is that the record shows the new policy is *not* a “blanket ban.”

The evidence, including hearing testimony, demonstrated that the Department will individually evaluate every inmate who was receiving hormone treatment. Based on that evaluation, the Department will determine if continued hormone treatment is medically necessary. If the Department concludes it *is* medically

necessary, the hormone treatment will continue. Dr. Martinez testified this was the case, and I credit his testimony. *See also* ECF No. 4-4 at 3 (“All inmates diagnosed with gender dysphoria will be individually evaluated.”). The evidence further demonstrated the Department has conducted an initial review and “preliminarily determined” that Keohane should continue with hormone treatment. ECF No. 38-1 ¶ 23. That preliminary determination remains subject to final approval, *id.* ¶ 24, so it remains to be determined whether Keohane will, in fact, continue receiving it. But the bottom line is that Keohane has not shown any blanket ban.

In arguing otherwise, Keohane points to the written policy (the “Health Bulletin,” ECF No. 4-4) and insists that several of its provisions suggest it will function as a complete bar to hormone treatment.

First, Keohane argues that the Health Bulletin assumes the default is that inmates will not receive hormone treatment and that exceptions will be available in “rare instances.” Health Bulletin § IX(C). That is consistent with Dr. Martinez’s testimony that the Department will provide hormone treatment only when medically necessary. It is true, as Keohane argues, that the Health Bulletin also provides that hormone treatment will be available only with a variance that itself is available only in specific circumstances. But that does not mean no inmate will receive a variance. Indeed, the Department’s multidisciplinary team has already recommended a variance for Keohane. At any rate, a policy of providing hormone treatment in “rare

instances deemed medically necessary,” *id.*, is a far cry from a blanket policy. As Dr. Martinez explained, the key inquiry under the policy is medical necessity.

It is also true that the Health Bulletin limits hormone treatment to instances when it is “necessary to comply with the U.S. Constitution or a court decision.” *Id.* But that is no obstacle to constitutionally required care. Keohane notes it is unclear how the Department determines what is constitutionally required, but, again, Dr. Martinez testified that inmates would receive any “medically necessary” care. And to the extent the Department provides what is medically necessary, it has provided what is constitutionally required. Keohane never argues that the Eighth Amendment requires care beyond what is medically necessary. Indeed, even medical care falling below what is medically necessary does not necessarily violate the Eighth Amendment. *See Harris*, 941 F.2d at 1505 (“[T]he Supreme Court has also emphasized that not ‘every claim by a prisoner that he has not received adequate medical treatment states a violation of the Eighth Amendment.’” (quoting *Estelle*, 429 U.S. at 105)).

Next, Keohane notes the Health Bulletin’s observation that state law forbids “expending any state funds to purchase cross-sex hormones for the treatment of Gender Dysphoria.” ECF No. 46 at 2 (quoting Health Bulletin); *see also* Fla. Stat. § 286.311(2) (“A governmental entity . . . may not expend state funds . . . for sex-reassignment prescriptions or procedures . . .”). This, though, does not support

finding a blanket ban. For one, that statutory provision became effective May 2023, and the Department has nonetheless continued providing hormone treatment to Keohane and others. For another thing, the hearing testimony showed that the Department provides the hormones through an outside vendor—apparently leaving the Department to maintain that state funds are not involved. *See* Trans. (Q: “Who pays for hormone therapy of inmates?” Dr. Martinez: “We contract with an outside vendor to provide the actual hands-on clinical care . . . and they are covering the cost of hormones . . . to be in compliance with the law that is mentioned in the [Health Bulletin].”). Moreover, even if the Department generally viewed the statute as an obstacle to providing hormone treatment, the Health Bulletin suggests it will disregard the statute if necessary to provide constitutionally adequate care. *See* Health Bulletin § IX(B) (“The Department shall comply with this statutory requirement unless compliance with the U.S. Constitution or a court decision requires otherwise.”).

Keohane also points to the fact that the Health Bulletin limits variances to instances in which “the treating physician can demonstrate with documented evidence that [hormone] treatment may improve clinical outcomes by treating the etiological basis of the pathology.” *Id.* § IX(C)(1). In Keohane’s view, that means transgender inmates can never have hormone treatment because hormone treatment

“is not intended to treat the etiological basis of gender dysphoria.” ECF No. 4 at 21

(emphasis omitted). Keohane explains it this way:

hormone therapy helps align a person’s secondary sex characteristics with their gender identity, thereby alleviating the distress that results from the incongruity between their gender identity and sex assigned at birth. It does not treat the root cause of their gender dysphoria—having a gender identity different from one’s sex assigned at birth—because that is not something that needs to be fixed.

Id. (citing Am. Psychiatric Ass’n, Diagnostic and Statistical Manual of Mental Disorders 451 (5th ed. 2013)) (“DSM-V”).

To the extent Keohane reads the Health Bulletin as allowing hormone treatment only when it would change an inmate’s “gender identity,” that is a serious misreading. Keohane asserts that distress flowing from the “incongruity between” sex and gender identity is at the core of gender dysphoria—and that the purpose of hormone treatment is to alleviate distress. *Id.*; *see also* DSM-V (explaining that gender dysphoria “refers to the distress that may accompany the incongruence between one’s experienced or expressed gender and one’s assigned gender”); *id.* at 453 (noting that gender dysphoria in adults “is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning”). Indeed, as Keohane acknowledges, not all transgender individuals have gender dysphoria. *See* ECF No. 4 at 4 (“For some but not all transgender people, the incongruence between gender identity and assigned gender results in gender dysphoria”); *see also* DSM-V at 451 (“[N]ot all individuals will

experience distress as a result of such incongruence.”). Thus, Keohane has not shown that the policy’s “etiological basis” provision would preclude hormone treatment.

Regardless, the fact remains that Dr. Martinez credibly testified that the Department will provide hormone treatment if medically necessary to treat gender dysphoria. So whatever one makes of the Health Bulletin’s phrase “treating the etiological basis of the pathology,” that language does not support a conclusion that there is a blanket ban.

Keohane next argues that the Health Bulletin operates as a blanket ban because it allows hormone treatment only when supported by “evidence that such treatment may improve clinical outcomes” and only when that evidence is “based on sound scientific methods and research that were subject to the formal peer review process.” Health Bulletin § IX(C)(1). The Health Bulletin notes that studies supporting the benefits of hormones “are either low or very low quality and rely on unreliable methods,” *id.* § IX(A), and Dr. Martinez testified that there have been no double-blind studies on the subject, which he considers the gold standard. From this, Keohane concludes no existing studies could meet the policy’s daunting standard, meaning the requirement for “sound scientific methods” operates to ban hormone treatment altogether.

There are at least two problems with this argument. First, Dr. Martinez also testified he would consider studies that fell short of the gold standard. He further clarified he could not testify whether particular studies would meet the policy without analyzing their application to specific cases. So Keohane has not shown that the standard is impossible to satisfy. Second, under the very policy Keohane challenges, the Department's preliminary conclusion is that Keohane *does* qualify for continued hormone treatment. This further undermines any argument that the "sound scientific methods" requirement is an insurmountable obstacle.

All of this is to say the Health Bulletin, as written, does not impose any blanket ban. But even assuming there is some tension between the written policy and what Dr. Martinez testified will happen in practice, that provides no basis for relief. Again, Dr. Martinez—who coauthored the Health Bulletin and was instrumental in its development—testified credibly that there is no blanket ban, that every inmate will receive an individual evaluation, and that inmates will receive hormone treatment when medically necessary. Thus, if Keohane were correct that the Health Bulletin's text imposes a blanket ban forever precluding hormone treatment, then I would agree with Keohane that the Department "ignore[s] what the policy actually says." ECF No. 46 at 2. Either way, I find, based on the evidence, that the Department intends to conduct individualized assessments and to provide hormone treatment when medically necessary.

That leads us back to where we started: Keohane has not shown there is a blanket ban on hormone treatment. Keohane thus has not shown an imminent injury relating to hormone treatment. That means Keohane has not shown a likelihood of establishing standing as to any claim about hormone treatment, which necessarily means there is no showing of a likelihood of success on the merits. *See Murthy*, 603 U.S. at 58. But even putting standing aside, it also means there is no likelihood of success on the merits for the simple reason that the claim depends on showing a blanket ban, and there has been no showing of a blanket ban as to hormone treatment.

B. Social Accommodations

Keohane has not shown a substantial likelihood of success on the merits as to social accommodations either. As to this component, there is no problem with standing: the parties agree the new policy will preclude Keohane from wearing long hair, makeup, and women's undergarments. That is a concrete and particularized harm. *See Spokeo, Inc. v. Robins*, 578 U.S. 330, 339-40 (2016) (noting that a particularized harm is one that "affect[s] the plaintiff in a personal and individual way" and that "intangible injuries can nevertheless be concrete"). That harm is also traceable to the Department's actions, and an injunction requiring the Department to permit social accommodations would redress the injury.

Showing standing is only part of the burden. Whether a plaintiff has standing and whether he can succeed on the merits are two separate inquiries. *See Corbett v.*

Transp. Sec. Admin., 930 F.3d 1225, 1228 (11th Cir. 2019) (explaining that standing is a “threshold jurisdictional question which must be addressed prior to and independent of the merits of a party’s claims” (quoting *Bochese v. Town of Ponce Inlet*, 405 F.3d 964, 974 (11th Cir. 2005))); *Culverhouse v. Paulson & Co. Inc.*, 813 F.3d 991, 994 (11th Cir. 2016) (“[I]n reviewing the standing question, the court must be careful not to decide the questions on the merits for or against the plaintiff, and must therefore assume that on the merits the plaintiffs would be successful in their claims.” (quoting *City of Waukesha v. EPA*, 320 F.3d 228, 235 (D.C. Cir. 2003))). I thus now turn to the merits.

The Department leads off with an issue-preclusion argument, noting that Keohane already litigated entitlement to social accommodations. In a 2016 lawsuit, Keohane sought both hormones and social accommodations. *See Keohane v. Fla. Dep’t of Corr. Sec’y*, 952 F.3d 1257, 1262 (11th Cir. 2020) (*Keohane I*). The district court granted an injunction and required the Department to provide both. *Id.* But after the Department adopted a new policy that allowed hormone treatment, the Eleventh Circuit concluded the claim as to hormones was moot. *Id.* at 1272. As to social accommodations, though, the Eleventh Circuit reversed the judgment on the merits. *Id.* at 1277-78. It found no basis to conclude prison officials showed deliberate indifference by denying the requested social accommodations. *Id.* at 1274.

The Eleventh Circuit rejected Keohane’s claim for two reasons. First, it concluded “the testifying medical professionals were—and remain—divided over whether social transitioning is medically necessary to Keohane’s gender-dysphoria treatment.” *Id.* The professional disagreement meant there was no Eighth Amendment violation because “a simple difference in medical opinion between the prison’s medical staff and the inmate as to the latter’s diagnosis or course of treatment cannot support a claim of cruel and unusual punishment.” *Id.* (quoting *Harris*, 941 F.2d at 1505) (cleaned up). Second, the Court explained that the Department “denied Keohane’s social-transitioning-related requests, at least in part, on the ground that they presented serious security concerns—including, most obviously, that an inmate dressed and groomed as a female would inevitably become a target for abuse in an all-male prison.” *Id.* at 1275. At bottom, the Court rejected the claim that the Department violated the Eighth Amendment by not providing Keohane’s requested social accommodations. *Id.* at 1277-78.

The Department argues the earlier case precludes relief here. ECF No. 38 at 18. Issue preclusion applies when (1) an issue is identical to one in a prior proceeding; (2) the issue was actually litigated; (3) the issue was a critical and necessary part of the judgment; and (4) the opposing party had a full and fair opportunity to litigate the issue. *Christo v. Padgett*, 223 F.3d 1324, 1339 (11th Cir. 2000). Because the issue must be identical, issue preclusion does not apply when

“controlling facts or legal principles have changed significantly.” *Montana v. United States*, 440 U.S. 147, 155 (1979). The burden is on the party asserting issue preclusion to show it applies. *In re McWhorter*, 887 F.2d 1564, 1566 (11th Cir. 1989).

The Department has not met its burden. While it correctly argues that Keohane sought the same accommodations under the same general legal theory, ECF No. 29 at 18, it does not show that Keohane’s medical needs or the science relating to those alleged needs have not changed. Keohane asserts that conditions and treatment are significantly different now. ECF No. 39 at 21-22. Common sense also cautions against giving preclusive effect to determinations about medical needs, which may sometimes change.

But even without issue preclusion, the Department prevails. Keohane presented no evidence showing that denying requested social accommodations is tantamount to providing care so deficient that it constitutes an Eighth Amendment violation.

As a starting point, it is worth remembering that “[a] prisoner bringing a deliberate-indifference claim has a steep hill to climb.” *Keohane I*, 952 F.3d at 1266; accord *Hoffer*, 973 F.3d at 1272. “[T]he Constitution doesn’t require that the medical care provided to prisoners be ‘perfect, the best obtainable, or even very good.’” *Keohane I*, 952 F.3d at 1266 (quoting *Harris*, 941 F.2d at 1510). Instead,

“medical treatment violates the Eighth Amendment only when it is so grossly incompetent, inadequate, or excessive as to shock the conscience or to be intolerable to fundamental fairness.” *Id.* (cleaned up). Thus, Keohane had to demonstrate that denying social accommodations could reach this level. Keohane fell short.

In the earlier litigation, Keohane presented expert medical testimony, but even that was insufficient. *Id.* at 1275. Here, Keohane presented no expert testimony at all. Keohane instead pointed to the World Professional Association for Transgender Health’s (WPATH) Standards of Care, ECF No. 4 at 4-6, explaining that “[d]ressing, grooming, and presenting oneself in a manner consistent with one’s gender identify is an important part of treatment for gender dysphoria.” *Id.* at 6 (citing the WPATH Standards of Care). Some courts have considered WPATH recommendations authoritative, *see, e.g., Edmo v. Corizon, Inc.*, 935 F.3d 757, 769 (9th Cir. 2019), but others have not, *see, e.g., Gibson v. Collier*, 920 F.3d 212, 223 (5th Cir. 2019) (noting that “the WPATH Standards of Care do not reflect medical consensus”); *Kosilek v. Spencer*, 774 F.3d 63, 90 (1st Cir. 2014) (discussing the WPATH standards as “one of two alternatives—both of which are reasonably commensurate with the medical standards of prudent professionals”). But either way, the cited WPATH recommendations do not show the social accommodations are medically necessary.

Next, even if WPATH recommendations suggested social accommodations were medically necessary, Keohane has not shown the absence of any debate about that. Where there is reasonable disagreement about appropriate medical treatment, preferring one reasonable course over another does not violate the Constitution. *See Keohane I*, 952 F.3d at 1275 (“Put simply, when the medical community can’t agree on the appropriate course of care, there is simply no legal basis for concluding that the treatment provided is ‘so grossly incompetent, inadequate, or excessive as to shock the conscience or to be intolerable to fundamental fairness.’” (quoting *Harris*, 941 F.2d at 1505)); *see also id.* at 1275 n.11 (noting that in decisions finding deliberate indifference to a transgender inmate’s serious medical needs “there appeared to be general (and consistent) consensus among the inmate’s medical providers that a particular treatment was medically necessary”).

Keohane relies extensively on three declarations in which inmates express a profound desire for social accommodations. Keohane’s own declaration reports immense distress flowing from being denied these accommodations and that the distress could lead to self-harm, including suicide. ECF No. 4-7 ¶¶ 11, 14. Two other inmate declarations report similar feelings. *See* ECF Nos. 46-10 ¶ 18, 46-11 ¶ 16. But while these are serious matters evidencing serious psychological concerns, Keohane has not shown that the only proper way to address risks of self-harm is to provide inmates with whatever items they contend would reduce those risks. *Cf.*

Keohane I, 952 F.3d at 1274 (“[N]othing in the Eighth Amendment requires that inmates be housed in a manner that is most pleasing to them.” (quoting *Harris*, 941 F.2d at 1511 n.24) (cleaned up)).

Moreover, putting aside the issue of whether the requested social accommodations constitute appropriate medical care, Keohane has not shown any complete absence of care. The record indicates Keohane receives extensive medical treatment relating to gender dysphoria. In addition to the hormone treatment currently provided, the Department makes psychotherapy available to those with gender dysphoria. This is not a case in which the Department simply provides no treatment at all.

The bottom line is that, as before, Keohane has not shown that denying social accommodations violates the Eighth Amendment. *See id.* at 1277-78. This is true even if the Department has a one-size-fits-all policy prohibiting social accommodations for all transgender inmates. As with the hormone treatment, Keohane does not assert entitlement to the social accommodations (at least not at this stage). Instead, the argument is that prison officials must consider on an individualized basis whether an inmate will receive them.⁷ But an across-the-board

⁷ Keohane’s counsel clarified this at the hearing: “I think at this point in the case we don’t need to prove that it is medically necessary for each person; I think that the fact that it is a ban, and there was no individualized determination of medical

prohibition on a particular treatment cannot constitute deliberate indifference when there is no showing that the treatment is ever medically necessary. *See Gibson*, 920 F.3d at 216 (rejecting argument that blanket ban against sex-reassignment surgery—without individual assessment—was unconstitutional: “To use an analogy: If the FDA prohibits a particular drug, surely the Eighth Amendment does not require an individualized assessment for any inmate who requests that drug.”).

And Keohane, having presented no expert evidence, has not shown that the requested social accommodations are ever medically necessary. In short, Keohane—who had the burden of proof—has not shown that the policy of precluding social accommodations violates the Eighth Amendment. *Cf. Hoffer*, 973 F.3d at 1274 (“[I]t wasn’t the Secretary’s burden to demonstrate that treatment [sought] isn’t medically necessary; it was the plaintiffs’ burden to prove that such treatment *is* necessary.”).

None of Keohane’s out-of-circuit authorities supports a conclusion that all “prison policies that automatically exclude certain forms of treatment for gender dysphoria violate the Eighth Amendment.” ECF No. 4 at 19. In *Rosati v. Igbinoso*, 791 F.3d 1037 (9th Cir. 2015), which dealt with the plausibility standard, the decision did not turn on any blanket ban but on allegations regarding plaintiff’s own care. *Id.* at 1040 (“Even absent such a blanket policy, Rosati plausibly alleges her

necessity is sufficient for Eighth Amendment purposes to show deliberate indifference.”

symptoms (including repeated efforts at self-castration) are so severe that prison officials recklessly disregarded an excessive risk to her health by denying [sexual reassignment surgery] solely on the recommendation of a physician’s assistant with no experience in transgender medicine.”). Similarly, in *Fields v. Smith*, 653 F.3d 550 (7th Cir. 2011), the trial evidence “indicated that plaintiffs could not be effectively treated without hormones,” so a blanket hormone ban was unconstitutional. *Id.* at 556, 559. And the decision in *De’Lonta v. Angelone*, 330 F.3d 630 (4th Cir. 2003), decided at the motion-to-dismiss stage, focused on the standard of care for the particular plaintiff. *Id.* at 635-36.

The only Eleventh Circuit authority Keohane cites regarding a blanket ban is *Keohane I*, which stated that “[i]t seems to us that responding to an inmate’s acknowledged medical need with what amounts to a shoulder-shrugging refusal even to consider whether a particular course of treatment is appropriate is the very definition of ‘deliberate indifference’—anti-medicine, if you will.” *Keohane I*, 952 F.3d at 1266-67. This was dicta. *See id.* at 1267 (“We conclude, though, that we are *not* free to reach the merits.”). Regardless, that line does not suggest plaintiffs need not show the “banned” treatment *could be* medically necessary. Furthermore, the evidence here does not show any “shoulder-shrugging refusal” to consider social accommodations. The evidence shows that the new policy was the product of hundreds of hours of reviewing medical literature, followed by a careful

determination that the requested social accommodations would not be provided. The Department, in short, was not “turning a blind eye.” *Hoffer*, 973 F.3d at 1272.

At the end of the day, Keohane has not shown a substantial likelihood of success on the claim about social accommodations.

* * *

Because Keohane has not shown a likelihood of success on the merits, I cannot grant preliminary injunctive relief. I need not address the remaining preliminary-injunction prerequisites. I also need not address Keohane’s request for preliminary classwide relief.

CONCLUSION

The preliminary-injunction motion (ECF No. 4) and the motion for reconsideration (ECF No. 16) are DENIED.

Through separate orders to issue shortly, the court will address the motion to dismiss and provide an initial litigation schedule.

SO ORDERED on December 27, 2024.

s/ Allen Winsor
United States District Judge

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JANE DOE, *et al.*,

Plaintiffs,

v.

Case No. 1:25-cv-286-RCL

JAMES R. MCHENRY, III, in his official
capacity as Acting Attorney General of the
United States, *et al.*,

Defendants.

ORDER

I. Background

The plaintiffs are three male-to-female transgender women in the custody of the Bureau of Prisons (“BOP”) and housed in female penitentiary facilities. Compl. ¶¶ 3, 7, 10, ECF No. 1. Plaintiffs allege that they each suffer from gender dysphoria, a condition marked by significant distress and a host of physiological and psychological symptoms when a person lives in a manner conforming to their biological sex. *Id.* at ¶ 35. For several years before and including their time in BOP custody, the plaintiffs have been prescribed and have generally received hormone therapy to treat their gender dysphoria. *Id.* ¶¶ 3, 7, 10.

On January 20, 2025, President Donald Trump signed an Executive Order which provides, in pertinent part:

Sec. 4(a) (the “Transfer Provision”): “The Attorney General and Secretary of Homeland Security shall ensure that males are not detained in women’s prisons or housed in women’s detention centers, including through amendment, as necessary, of Part 115.41 of title 28, Code of Federal Regulations and interpretation guidance regarding the Americans with Disabilities Act.

Sec. 4(c) (the “Medication Provision”): “The Attorney General shall ensure that the Bureau of Prisons revises its policies concerning medical care to be consistent with this order, and shall ensure that no Federal funds are expended for any medical

procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex.”

Exec. Order 14168, *Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government*, 90 Fed. Reg. 8615 (Jan. 20, 2025) (the “Executive Order”). Shortly after the Executive Order was signed, all three plaintiffs were alerted of BOP's intention to transfer them to a male penitentiary. Compl. ¶¶ 25, 27, 29–30. All three have since been returned to the general population at their respective facilities, but the BOP continues to represent that they will soon be transferred. *Id.* ¶¶ 28, 33. It is not alleged that the BOP has withheld the plaintiffs' hormone therapy medications.

Plaintiffs bring this suit, alleging that the Executive Order and its enforcement against the plaintiffs violate the Eighth Amendment, the equal protection principles embodied within the Due Process Clause of the Fifth Amendment, and the Administrative Procedure Act (“APA”). *Id.* ¶¶ 56–98. The plaintiffs have moved for a temporary restraining order (“TRO”) or preliminary injunction to prevent the defendants from enforcing the Executive Order against them during the pendency of their claim. *See* Unredacted Mot. for Temporary Restraining Order, ECF No. 13. The defendants have filed an opposition to that Motion. *See* Gov'ts Opp'n, ECF No. 11. On February 4, 2025, the Court held a hearing, during which both parties voiced their arguments for and against the issuance of a TRO. The Motion is now ripe for the Court's review. For the reasons that follow, the request for a temporary restraining order is **GRANTED** on the narrow grounds of the plaintiffs' Eighth Amendment claims. Because the plaintiffs' Eighth Amendment claims are sufficient unto themselves to sustain a TRO, the Court will take no position on the merits of the plaintiffs' equal protection or APA claims at this time.

II. Legal Standard

A TRO or preliminary injunction should be granted if the movant meets its burden to show that 1) the movant is likely to succeed on the merits; 2) the movant is likely to suffer irreparable harm unless preliminary relief is granted; 3) the balance of the equities favors a TRO or preliminary injunction; and 4) that a TRO or preliminary injunction is in the public interest. *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). Courts in this Circuit have adopted a sliding scale approach to the TRO analysis, whereby a relatively strong showing on one of these factors may partially offset weakness in another, although some non-speculative showing of irreparable harm is essential. *CityFed Fin. Corp. v. Office of Thrift Supervision*, 58 F.3d 738, 747 (D.C. Cir. 1995). Where, as here, the Government is a party, the latter two factors of the preliminary analysis merge into one, because the interest of the government is taken to be identical to the interest of the public. *Nken v. Holder*, 556 U.S. 418, 435 (2009).

III. The Court Has Jurisdiction to Entertain the TRO Request

The defendants raise two jurisdictional defenses. First, the defendants argue that any legal objection to the Transfer Provision and all APA claims are statutorily foreclosed. Specifically, the Prison Litigation Reform Act provides that “[t]he Bureau of Prisons shall designate the place of the prisoner’s imprisonment” and that “[n]otwithstanding any other provision of law, a designation of a place of imprisonment under this subsection is not reviewable by any court.” 18 U.S.C. § 3621. Moreover, 18 U.S.C. § 3625 dictates that the APA “do[es] not apply to the making of any determination, decision, or order under this subchapter”

The defendants may be correct that these statutory provisions foreclose any APA challenges to facility designations and transfer decisions. *See Brown v. Holder*, 770 F. Supp. 2d 363, 365–66 (D.D.C. 2011) (collecting cases from this and other districts for the proposition that federal courts lack jurisdiction to hear APA challenges to BOP facility designations). The Court

need not reach that issue conclusively, because the Court holds, in any event, that these provisions do not divest the Court of jurisdiction to entertain constitutional claims arising from BOP facility designations. “[W]here Congress intends to preclude judicial review of constitutional claims its intent to do so must be clear . . . to avoid the ‘serious constitutional question’ that would arise if a federal statute were construed to deny any judicial forum for a colorable constitutional claim.” *Webster v. Doe*, 486 U.S. 592, 603 (1988) (quoting *Weinberger v. Salfi*, 422 U.S. 749, 762 (1975)). Indeed, this Court has held before that 18 U.S.C. §§ 3621 and 3625 preclude judicial review of “BOP ‘determination[s], decision[s], or order[s]’ as to a prisoner’s place of imprisonment,” but do not “explicitly preclude[] review of *constitutional* claims based on these or similar decisions.” *Royer v. Federal Bureau of Prisons*, 933 F. Supp. 2d 170, 181–82 (D.D.C. 2013) (Lamberth, C.J.). *Webster* compels that this Court adopt a narrow reading of these statutory provisions. Without prejudice to the question of whether they strip the Court of jurisdiction to entertain statutory challenges arising from BOP facility designations, they are not sufficiently explicit to bar consideration of constitutional claims.¹

The defendants’ second jurisdictional argument is that the plaintiffs have not exhausted their administrative remedies with the BOP. To exhaust administrative remedies as to any given complaint, an inmate must follow a four-step process: First; an inmate must attempt to resolve the problem informally with prison officials; second, if unsuccessful, the inmate may initiate a request to the warden of their penitentiary facility; third, if unsatisfied by the warden’s response, the inmate may appeal to the regional BOP director within 20 calendar days; and finally, if the regional

¹ The defendants argued at the TRO hearing that the statute was amended to add the nonreviewability clause of 18 U.S.C. § 3621(b) after this Court’s decision in *Royer*. However, the addition of this language does not alter the Court’s conclusion with respect to its jurisdiction to entertain constitutional challenges arising from BOP facility designations. It would be extraordinary to impute to Congress the intent to completely bar courts from considering claims related to prison facility designations with a constitutional valence. The text of the statute is not sufficiently clear on this point to justify such an extreme conclusion.

director does not provide the relief sought, the inmate may escalate the complaint to the BOP's general counsel office. *DeBrew v. Atwood*, 847 F. Supp. 2d 95, 107 (D.D.C. 2012). Undoubtedly, a statutorily-prescribed exhaustion provision such as the PLRA's is "mandatory," and therefore not "amenable to judge-made exceptions." *Ross v. Blake*, 578 U.S. 632, 639 (2016). Indeed, courts refuse to entertain the argument that "special circumstances" may justify an inmate's failure to exhaust, *id.* at 640; not even facially meritorious constitutional claims are exempt, nor are claims that the inmate believes—rightly or wrongly—to be futile. *Woodford v. Ngo*, 548 U.S. 81, 91 n.2 (2006) (rejecting an exception for constitutional claims); *Kaemmerling v. Lappin*, 553 F.3d 669, 675 (D.C. Cir. 2008) (Sentelle, C.J.) ("Even if an inmate believes that seeking administrative relief from the prison would be futile and even if the grievance system cannot offer the particular form of relief sought, the prisoner nevertheless must exhaust the available administrative process.").

There is, however, a narrow exception to the administrative exhaustion requirement embedded within the text of the PLRA itself: exhaustion is required so long as administrative remedies are "available." *Ross*, 578 U.S. at 642. The Supreme Court has noted three archetypical circumstances where administrative remedies can be considered "unavailable" and may therefore be bypassed: 1) when the administrative scheme is "so opaque that it becomes, practically speaking, incapable of use"; 2) "when prison administrators thwart inmates from taking advantage of a grievance process through machination, misrepresentation, or intimidation"; and 3) when "it operates as a simple dead end—with officers unable or consistently unwilling to provide any relief to aggrieved inmates." *Id.* at 643–44. The "dead end" exception is narrowly construed. If the BOP is capable of providing *some* relief, even if it is not the relief that the plaintiff requests, administrative exhaustion is required. *See Booth v. Churner*, 532 U.S. 731, 735–36 (2001) (holding that an inmate seeking money damages for alleged Eighth Amendment violations must

exhaust administrative remedies, even though the Pennsylvania Department of Corrections could not award the monetary relief sought, because it could award other forms of relief).

The plaintiffs have set forth the rare sort of case that fits into the “dead end” exception to the PLRA’s administrative exhaustion requirement. As detailed below, the plaintiffs claim that their imminent transfer to a male penitentiary and deprivation of their hormone therapy would inherently work an Eighth Amendment injury. The text of the Executive Order plainly requires the BOP to perform the allegedly unlawful facility transfer and to withhold the prescribed hormone therapy drugs. Thus, there is no form of relief that is within the BOP’s discretion to provide and that would remedy the plaintiffs’ supposed constitutional violations. In that sense, their allegations are less like *Booth*, where exhaustion was required because the defendant could offer injunctive relief in lieu of damages, and more like *Kaemmerling*. In that case, the plaintiff sought an order restraining the BOP from collecting DNA samples from him on First, Fourth, and Fifth Amendment grounds. 553 F.3d at 673. The D.C. Circuit distinguished *Booth*, writing:

Even under questioning from this court, counsel for the BOP could not articulate a single possible way the prison’s administrative system could provide relief or take any action at all in response to Kaemmerling’s claim that collecting his DNA would violate his statutory and constitutional rights. . . . This is not a situation like that in *Booth*, where the prison grievance process cannot grant the exact type of relief the inmate seeks or where the inmate believes pursuing the process would be futile because it is unlikely to resolve his complaint. Although the administrative process in *Booth* could not offer money damages—the exclusive form of redress the inmate sought—it did authorize at least some responsive action on the inmate’s complaint of abuse, such as reassigning the abusive guard. Here, the prison grievance process cannot authorize any action on the subject of Kaemmerling’s complaint because he challenges the statute’s command that BOP collect his DNA sample. Kaemmerling does not complain about the method or timing of collecting the sample, which counsel for the BOP suggested the prison might have authority to change; he complains only about the fact that the BOP will collect his DNA at all, a complaint for which the BOP can offer no possible relief.

Id. at 675–676 (internal citations omitted). Just so in the case at hand: the alleged constitutional violation arises from the forthcoming transfer to a male penitentiary and withdrawal of hormone therapy, actions which the BOP has no discretion not to take. Under these rare circumstances, administrative exhaustion is excused; “‘where the relevant administrative procedure lacks authority to provide *any* relief,’ the inmate has ‘nothing to exhaust.’” *Ross*, 578 U.S. at 643 (quoting *Booth*, 532 U.S. at 736 & n.4).

Satisfied that the Court has jurisdiction to hear the plaintiffs’ TRO request, the Court now turns to the plaintiffs’ likelihood of success on the merits.

IV. The Plaintiffs Have Established a Likelihood of Success on the Merits of Their Eighth Amendment Claim

The parties dispute what level of scrutiny applies to the plaintiffs’ equal protection and Eighth Amendment claims. The defendants, relying on *Turner v. Safley*, argue that “when a prison regulation impinges on inmates’ constitutional rights, the regulation is valid if it is reasonably related to legitimate penological interests,” a standard of review that is deferential to the Government as compared to the elevated scrutiny that ordinarily attaches to complaints alleging discrimination based on a suspect classification or the burdening of a fundamental right. 482 U.S. 78, 89 (1987). The plaintiffs retort that later cases, such as *Johnson v. California*, have applied heightened scrutiny even to suspect classifications arising in the prison context. 543 U.S. 499, 510 (2005) (holding that *Turner* is inapplicable in a challenge to the California Department of Corrections’ “unwritten policy of racially segregating prisoners”).

There is good reason to doubt that *Johnson*’s cabining of *Turner* applies to laws that discriminate among inmates on the basis of sex: *Johnson* stressed that “[t]he right not to be discriminated against based on one’s race is not susceptible to the logic of *Turner*” because that right need not “be compromised for the sake of proper prison administration.” *Id.* By contrast,

“the segregation of inmates by sex is unquestionably constitutional” because it is reasonably related to legitimate prison management concerns. *Women Prisoners of Dist. of Columbia Dep’t of Corrections v. Dist. of Columbia*, 93 F.3d 910, 926 (D.C. Cir. 1996). Indeed, the sole case that the plaintiffs cite where heightened scrutiny was applied to a law discriminating among inmates by sex is *Pitts v. Thornburgh*, 866 F.2d 1450 (D.C. Cir. 1989). The *Pitts* Court was careful to distinguish *Turner*, noting that *Turner* “applies to cases involving regulations that govern the day-to-day operation of prisons and that restrict the exercise of prisoners’ individual rights within prisons,” whereas heightened scrutiny was appropriate in cases “challeng[ing] general budgetary and policy choices made over decades in the give and take of city politics.” *Id.* at 1453–54. The case at hand appears to more nearly resemble *Turner* than *Pitts*.

However, the Court need not reach any firm conclusion about *Turner*’s effects on the plaintiffs’ equal protection claims, because it is beyond peradventure that the Supreme Court “[has] not used *Turner* to evaluate Eighth Amendment claims,” which are adjudicated “under the ‘deliberate indifference’ standard, rather than *Turner*’s ‘reasonably related’ standard.” *Johnson*, 543 U.S. at 511. Under this standard, as the Court will now explain, the plaintiffs have demonstrated a sufficient likelihood of success to justify a TRO at this stage.

To prove an Eighth Amendment violation based on theories such as failure-to-protect or deliberate indifference, a plaintiff must show that both an objective and subjective element are met: the plaintiff must be confronted with an “objectively intolerable risk of harm,” and prison officials must knowingly or recklessly subject the plaintiff to such a known risk. *Farmer v. Brennan*, 511 U.S. 825, 839–40, 846 (1994). With respect to the transfer provision, the plaintiffs cited to various government reports and regulations recognizing that transgender persons are at a significantly elevated risk of physical and sexual violence relative to other inmates when housed

in a facility corresponding to their biological sex—which the defendants do not dispute. *See* Compl. ¶ 44. The plaintiffs further claim that placement in a male penitentiary *by itself* will exacerbate the symptoms of their gender dysphoria, *even if* they are not subject to physical or sexual violence in their new facility—whether because they will be subject to searches by male correctional officers, made to shower in the company of men, referred to as men, forced to dress as men, or simply because the mere homogenous presence of men will cause uncomfortable dissonance. *See* Compl. ¶¶ 5, 44. And with respect to the medication provision, the plaintiffs have also provided an affidavit from a physician explaining the numerous and severe symptoms that may arise from failure to treat gender dysmorphia, effects which the defendants likewise do not contest. *See generally* Aff. of Dr. Frederic Ettner, ¶¶ 7–8, 10, 14–15, Mot. for TRO Ex. 6, ECF No. 13-6. Nor do the defendants dispute the plaintiffs’ allegations that the BOP is subjectively aware that transferring the plaintiffs to a male penitentiary would substantially increase the likelihood of them experiencing this parade of harms; indeed, the government resources and regulations to which the plaintiffs gesture in their complaint strongly suggest the requisite awareness on the part of the BOP.

The defendants’ only substantial retort to these arguments is that the matter is not yet ripe for the Court’s review because the BOP has neither stated which type of facility the plaintiffs will be transferred to, nor formulated its new policy on hormone therapy pursuant to the Executive Order. Neither of these arguments is persuasive. The plain text of the Executive Order affords the BOP no discretion to keep the plaintiffs in a female penitentiary, nor to continue providing hormonal therapy to help them conform physically to their non-birth sex. To reiterate, the plaintiffs’ alleged constitutional harms would arise entirely and narrowly out of their placement in a male penitentiary and the denial of their hormone therapeutics. Though the BOP may have some

discretion in formulating new policies with respect to transgender inmates—e.g., whether they should be housed in high- or low-security facilities or in segregated housing—the Executive Order plainly leaves the agency with no discretion with respect to these actions. The Court is therefore satisfied that the plaintiffs’ Eighth Amendment claims are sufficiently “fit . . . for judicial decision” at this time, and that the plaintiffs have adequately demonstrated that “hardship” will flow from “withholding court consideration,” as to justify pre-enforcement review. *Abbott Lab’ys v. Gardner*, 387 U.S. 136, 149 (1967).

It is, of course, possible that further briefing of the constitutional issues at the center of this dispute, or factual discovery, will eventually yield a different outcome. But the plaintiffs, through their largely undisputed factual allegations and proffered affidavits, have met their burden to show a likelihood of success on the merits. Therefore, the first TRO factor is satisfied.

V. The Remaining TRO Factors Favor the Plaintiffs

Plaintiffs have straightforwardly demonstrated that irreparable harm will follow if their TRO request is denied. This is so because “a prospective violation of a constitutional right constitutes irreparable injury” *Davis v. Dist. of Columbia*, 158 F.3d 1342, 1346 (D.C. Cir. 1998). And this is to say nothing of the substantial harms that plaintiffs have plausibly stated, through affidavit, will follow if the plaintiffs are denied their hormone therapy. *See generally* Ettner Aff.

Moreover, the balance of the equities and the public interest favor the plaintiffs. Even if the Court credits the Executive Order’s representation that housing biological males in female penitentiaries has some deleterious effect on privacy and security, by the defendants’ own admission, there are only about sixteen male-to-female transgender women housed in female penitentiaries, including the plaintiffs. Stover Decl. ¶ 6, Gov’s Opp’n Ex. 1, ECF No. 11-1. And the defendants have not so much as alleged that the plaintiffs in this particular suit present any

threat to the female inmates housed with them, or that this threat cannot be managed locally by prison staff. Thus, the public interest in seeing the plaintiffs relocated *immediately* to male facilities is slight at best. And it is hard to cognize of *any* public interest in the immediate cessation of their hormone therapy—aside, perhaps, from whatever small sum of money the BOP may save by ceasing administration of these drugs, or the abstract interest in the enforcement of Executive Branch policy decisions. The plaintiffs’ interests, on the other hand, are not abstract at all, as discussed above. The balance of the equities therefore favors a TRO so that the litigation may run its course.

Therefore, upon consideration of the plaintiffs’ Motion [ECF No. 13] for a Temporary Restraining Order, the defendant’s Opposition [ECF No. 11] thereto, and the entire record herein, it is hereby

ORDERED that the plaintiffs’ Motion for a Temporary Restraining Order is **GRANTED**; and it is further

ORDERED that the defendants are temporarily enjoined and restrained from implementing Sections 4(a) and 4(c) of Executive Order 14168, pending further Order of this Court; and it is further

ORDERED that, pending further Order of this Court, defendants shall maintain and continue the plaintiffs’ housing status and medical care as they existed immediately prior to January 20, 2025.

Date: February 4, 2025
7:00 p.m.



Royce C. Lamberth
United States District Judge

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JANE DOE, *et al.*,

Plaintiffs,

v.

JAMES R. MCHENRY, III, in his official
capacity as Acting Attorney General of the
United States, *et al.*,

Defendants.

Case No. 1:25-cv-286-RCL

ORDER

On February 4, 2025, after a hearing, this Court entered a Temporary Restraining Order [ECF No. 23] enjoining the enforcement of Sections 4(a) and 4(c) of Executive Order 14168 on Eighth Amendment grounds. In their papers submitted to the Court and at the hearing, the plaintiffs adduced facts suggesting that they would be at a substantially elevated risk of physical and sexual violence if they were transferred to a male penitentiary pursuant to the Executive Order; that the transfer itself would be likely to exacerbate the plaintiffs' diagnosed mental health conditions; and that the withholding of their prescribed hormone therapy medication would be likely to cause severe harm. Importantly, the defendants did not substantially dispute those facts. Instead, the defendants pointed to speculative action that the Bureau of Prisons might take to mitigate those harms and thus assuage the Court's Eighth Amendment concerns. Those hypothetical measures were insufficient to defeat the plaintiffs' largely uncontroverted evidence of harm.

The Temporary Restraining Order noted that the revelation of additional facts then unknown to the Court could affect the plaintiffs' likelihood of success on the merits. However,

since the issuance of the Temporary Restraining Order, the Court has received no further information about what ameliorative steps, if any, the government intends to or would take if the plaintiffs were to be transferred and deprived of their prescribed medications per the terms of the Executive Order.

Therefore, in consideration of the plaintiffs' Motion [ECF No. 13] for a Preliminary Injunction, the Opposition [ECF No. 11] thereto, and the entire record herein, which is essentially unchanged since the issuance of the Temporary Restraining Order [ECF No. 23], and for the reasons contained in the Temporary Restraining Order, it is hereby

ORDERED that the plaintiffs' Motion for a Preliminary Injunction is **GRANTED**; and it is further

ORDERED that the Defendants are hereby enjoined from implementing Sections 4(a) and 4(c) of Executive Order 14168 against plaintiffs Jane, Mary and Sara Doe, pending further Order of this Court; and it is further

ORDERED that, pending further Order of this Court, defendants shall maintain and continue the plaintiffs' housing status and medical care as they existed immediately prior to January 20, 2025.

Date: February 18, 2025
2:10 p.m.



Royce C. Lamberth
United States District Judge

UNITED STATES DISTRICT COURT
DISTRICT OF COLUMBIA

JANE DOE, et al.,

Plaintiffs,

v.

Case No.: 1:25-cv-00286- RCL

PAMELA BONDI, in her official capacity as
Attorney General of the United States;
WILLIAM LOTHROP, in his official
capacity as Acting Director of the Federal
Bureau of Prisons,

Defendants.

**DECLARATION OF EVE HILL IN SUPPORT OF
PLAINTIFFS' MOTIONS FOR A TEMPORARY RESTRAINING
ORDER/PRELIMINARY INJUNCTION AND TO
PROCEED UNDER PSEUDONYM, AND TO PARTIALLY SEAL THE RECORD,**

I, Eve Hill, of full age, do hereby declare as follows:

1. I am an attorney in good standing with the District of Columbia Bar and licensed to practice law in the District of Washington, D.C.

2. I make the following declaration based on personal knowledge and pursuant to F.R.C.P. 65(b).

3. Plaintiffs Emily Doe, Zoe Doe, Tori Doe, Olivia Doe, Susan Doe, Lois Doe, Sophia Doe, Sally Doe, and Wendy Doe are all transgender women incarcerated in women's Bureau of Prison's facilities.

4. In the days after President Trump issued Executive Order 14168 on January 20, 2025, and again in February, 2025, Plaintiffs were removed from the general population of their

women's facilities and placed into separate housing with other transgender women, pending transfer to men's prisons.

5. Plaintiffs had all been housed in women's units for months or years before this abrupt removal from their housing. Even though BOP has recognized Plaintiffs as women during their incarceration, they face imminent transfer to men's prisons.

6. Plaintiffs are transgender women who have been diagnosed with gender dysphoria and have maintained medically necessary hormone treatment for their gender dysphoria for years.

7. Plaintiffs file this Emergency Motion for a Temporary Restraining Order, which seeks to preserve the status quo prior to January 20, 2025, when Executive Order 14168 was issued, while the parties litigate the lawfulness of certain provisions of the Executive Order. Plaintiffs, through counsel, notified Defendants' counsel of their intent to file an amended complaint and motion for temporary restraining order and preliminary injunction on February 20, 2025. Plaintiffs' counsel will send the Amended Complaint and Motion for Temporary Restraining Order and Preliminary Injunction to counsel for Defendants by email.

8. In conjunction with the Amended Complaint and Motion, Plaintiffs' counsel also filed a Motion To Proceed Under a Pseudonym, and a Motion To Partially Seal Documents. These motions are based on the specific potential harms that would follow from revealing Plaintiffs' identities, including the potential risk to them of violence in the corrections system and the violation of their interests in maintaining privacy of their medical status, history, and records.

9. All redactions proposed for the partially sealed documents stem from the necessity to protect their identities, as set forth below.

10. The locations and dates of the Plaintiffs' current and former correctional facilities are redacted because of the limited number of incarcerated transgender women at those facilities. If the facilities and time periods when Plaintiffs were there were identified, Plaintiffs' identities could be easily surmised from among a small number of transgender women at those facilities.

11. Specific biographical details concerning Plaintiffs are redacted, including their current and former names and dates of birth. Any one of these details would also provide an easy means of identification with minimal internet or public records research.

12. Details of Plaintiffs' medical records, medical treatment, and mental health issues outside of their gender dysphoria treatment are redacted because the confluence of these records would serve to easily identify Plaintiffs to those that are aware of their other medical diagnosis/diagnoses.

13. Certain details about Plaintiffs' time in federal correctional facilities are redacted, including the period of their incarceration, any disciplinary record, harms they experienced, rehabilitation activities, and medical care they have received. Individuals within the correctional facility or those with whom they might communicate are likely aware of these details of Plaintiffs' time in federal custody and would be able to guess their identities if they were left unredacted.

Pursuant to 28 U.S.C. § 1746, I affirm under penalty of perjury that the above statements are true and correct.

Dated: February 21, 2025



Eve L. Hill

**UNITED STATES DISTRICT COURT
DISTRICT OF COLUMBIA**

**JANE DOE; MARY DOE
SARA DOE; EMILY DOE;
ZOE DOE; TORI DOE;
OLIVIA DOE; SUSAN DOE;
LOIS DOE; SOPHIA DOE;
SALLY DOE; and WENDY
DOE,**

Plaintiffs,

Civil Action No. 1:25-cv-00286

v.

PAMELA BONDI, et al.,

Defendants.

**DECLARATION OF RICK STOVER,
SENIOR DEPUTY ASSISTANT DIRECTOR
DESIGNATION AND SENTENCE COMPUTATION CENTER**

I, Rick Stover, declare and state as follows:

1. I am currently employed by the Federal Bureau of Prisons (Bureau). Since June 2024, I have served as the Senior Deputy Assistant Director of the Designation and Sentence Computation Center, within the Bureau's Correctional Programs Division.

2. Prior to becoming Senior Deputy Assistant Director of the Designation and Sentence Computation Center, I worked in positions of increasing responsibility within the Bureau, most recently as the Warden at the Federal Correctional Institution in Danbury, Connecticut.

3. I am familiar with the Bureau's general policies and practices on housing for inmates who identify with the opposite biological sex, including the rationales for those policies. As part of my official duties, I have access to records maintained in the ordinary course of business by the Bureau, including inmate medical and mental health records.

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4. The information below is based upon personal knowledge and upon information and belief.

5. As of February 20, 2025, there are 2,198 inmates housed in FBOP facilities and halfway houses who identify as the opposite biological sex. There are 1,488 biological male inmates who identify as female and 710 biological female inmates who identify as male. The FBOP currently has 22 biological male inmates living in female institutions. BOP has 1 biological female inmate living in a male institution.

6. [REDACTED]

7. [REDACTED]

[REDACTED]

10. The FBOP has reevaluated plaintiffs' placement. In determining the most appropriate placement for the plaintiffs, the Bureau took into consideration the inmates' assigned security level, disciplinary record, medical record, and psychology record.

11. Based on these factors, the Bureau found that the following facilities would serve as prime locations for each of the plaintiffs. Each plaintiff was reviewed and assessed individually.

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12. The Bureau found that placement at [REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]. Nonviolent crimes are defined as crimes involving property, drug, and other offenses which do not involve a threat of harm or an actual attack upon a victim. The most frequently identified nonviolent crimes involve drug trafficking, drug possession, burglary, and larceny. Moreover, inmates housed in low security facilities tend to have minor infractions in their disciplinary history with the Bureau.

13. The Bureau found that placement at [REDACTED]

14. The Bureau found that placement [REDACTED]

15. The Bureau found that placement at [REDACTED]

MATERIAL UNDER SEAL DELETED

16. The Bureau found that [REDACTED]

17. In response to the preliminary injunction that was entered on February 18, 2025,

18. The Bureau found that placing the plaintiffs at low security institutions and Residential Management Centers greatly reduces the chances of plaintiffs being victimized by other inmates.

19. Plaintiffs, [REDACTED]

20. [REDACTED]

21. [REDACTED]

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22. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

23. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

24. The facilities chosen for each of the plaintiffs currently house other inmates who identify as female, thereby ensuring that the staff members at the facilities are experienced in managing and providing care to this special population. [REDACTED]

[REDACTED]

[REDACTED]

25. [REDACTED]

[REDACTED]

[REDACTED]

26. The Bureau follows the requirements of the Prison Rape Elimination Act of 2003's (PREA) implementing regulations to ensure the safety of all inmates, including those who identify as the opposite biological sex. In deciding whether to assign an inmate to a facility for male or female inmates, the Bureau's policy is consistent with PREA standards, in that the Bureau considers on a case-by-case basis whether a placement would ensure the inmate's health

and safety, and whether the placement would present management or security problems. FMC Rochester is thus particularly well situated to deliver medically necessary health care to inmates in accordance with proven standards without compromising public safety concerns.

27. The FBOP recognizes the importance of protecting all inmates from sexually abusive behavior and ensure their continued safety. In fact, pursuant to FBOP Program Statement 5324.12, Sexually Abusive Behavior Prevention and Intervention Program (effective June 4, 2015), the FBOP implements zero tolerance toward all form of sexual activity in the custodial environment, including sexual abuse and sexual harassment. Routine training is provided to all FBOP staff to help detect incidents, perpetrators, and inmate victims of sexually abusive behavior. FBOP staff are educated to intervene properly and in a timely manner. BOP staff are required to document, report, and investigate reported incidents. Moreover, BOP is responsible for disciplining and referring for prosecution perpetrators of sexually abusive behavior against other inmates.

28. All institutional staff are trained to monitor and to intervene when they observe problematic interactions between inmates. At each FBOP institutions, staff review a Posted Picture File (PPF) of inmates who are potentially disruptive, escape risks, or present a threat to staff or institutional security. The FBOP identifies inmates who, because of prior record, current offense, institutional adjustment, or other factors, pose a significant threat to inmate or staff safety, the institution's security, or the surrounding community's welfare. The PPF is updated at least quarterly. Institution staff review the PPF regularly for the purpose of determining inmates with a history of assaultive behavior or a history of sexual offenses, for the purpose of keeping the institution safe and secure.

29. The FBOP conducts a Prison Rape Elimination Act (PREA) Intake screening upon an inmate's arrival to an institution, to ensure any potential for victimization or abusiveness. Consistent with PREA's implementing regulations, this screening includes the inmate's own perception of their safety and history of sexual assault, FBOP staff's assessment of the inmate's general physical appearance and presentation, and a review of the inmate's criminal history. FBOP staff must notify Correctional Services of the inmate's history of predation to ensure that the appropriate steps (investigation, documentation, CIMS concerns, etc.) have been taken. Moreover, if an inmate presents as a risk of victimization, staff will consider a referral to Psychology Services.

30. Furthermore, if at any time, FBOP staff believe that an inmate's safety may be seriously jeopardized by placement in the general population, the inmate may be housed in more restrictive conditions as a protective custody case in the Special Housing Unit. When an inmate is placed in administrative detention for placement, the Warden or designee (ordinarily to Captain), must review the placement within two workdays of the placement to determine if continued protective custody is necessary. This review includes documents that led to the inmate being placed in protective custody and any other documents pertinent to the inmate's protection.

31. Inmates have numerous ways to report if they have been sexually assaulted or have been a victim of sexual harassment. An inmate can write directly to the Warden, Regional Director, or Director. An inmate can send the Warden an Inmate Request to Staff Member (Cop-out) or a letter reporting the sexually abusive behavior. Moreover, an inmate may also send a letter to the Regional Director or Director of the Bureau of Prisons, and to ensure confidentiality, can use special mail procedures. Finally, an inmate can file a Request for Administrative Remedy (BP-9). If the inmate determines that the complaint is too sensitive to file with the

Warden, the inmate has the opportunity to file the administrative remedy directly with the Regional Director (BP-10). The inmate can also email or write the Office of Inspector General (OIG) which investigates certain allegations of staff misconduct by employees of the U.S. Department of Justice. Moreover, anyone can report abuse on behalf of the inmate by using, https://www.bop.gov/inmates/custody_and_care/sexual_abuse_prevention.jsp. Finally, an inmate can send reports of sexual abuse to a dedicated email address managed by OIG, and the inmate can request the report remain confidential. OIG is completely independent of the FBOP. OIG protects the identity of victims and other individuals who report allegations to the greatest extent possible, while still thoroughly vetting and investigating the allegations.

In accordance with 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Dated: February 22, 2025

RICHARD STOVER Digitally signed by RICHARD
STOVER
Date: 2025.02.22 14:45:01 -06'00'

RICK STOVER

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JANE DOE et al,

Plaintiffs

v.

Civil Action No. 1:25-cv-00286-RCL

PAMELA BONDI, in her official capacity as
Attorney General of the United States; WILLIAM
LOTHROP, in his official capacity as Acting
Director of the Federal Bureau of Prisons,

Defendants.

**DECLARATION OF LAUREN
MEADE, M.D. IN SUPPORT OF
PLAINTIFFS' MOTION FOR
TEMPORARY RESTRAINING
ORDER AND EXPANDED
PRELIMINARY INJUNCTION**

I, Lauren Meade, of full age, do hereby declare as follows:

1. I respectfully submit this supplemental declaration in further support of Plaintiffs' Motion for a Temporary Restraining Order and Expanded Preliminary Injunction.

2. I am a board-certified internal medicine doctor 19 years of experience treating transgender patients. I am familiar with standard protocols for hormone therapy and its effects. A true and correct copy of my curriculum vitae is attached. I submit this declaration in order to respond to certain claims about the plaintiffs need for additional medical care and to elaborate on the potential harms to plaintiffs if they do not continue to receive treatment for her gender dysphoria. A copy of my curriculum vitae is attached as **Exhibit A**.

3. Gender dysphoria is a serious medical condition that, left untreated, can result in debilitating psychological harms, including anxiety, depression, suicidality, and other mental health issues. Gender dysphoria is a highly treatable condition. The standards of care for treating gender dysphoria are well-established and are endorsed by the major medical and mental health

associations in the United States, including but not limited to the American Medical Association, the American Psychiatric Association, the American Psychological Association, and the Endocrine Society.

4. Treatments include social transition, which enables a transgender person to live in a sex other than their birth sex, and hormone therapy to feminize or masculinize the body. It may also include various surgeries. For many transgender women, hormone therapy is an essential, medically indicated treatment to alleviate the distress of gender dysphoria.

5. Discontinuing hormone therapy for transgender women who have been on long term treatment poses serious medical risks, including both severe psychological distress and physical complications including: intensified gender dysphoria; increased risk of severe anxiety, depression, and suicidality due to intensified gender dysphoria; rapid hormonal changes that trigger severe mood swings, anxiety, and depression; loss of breast tissue and feminine fat distribution; loss of bone density and increased risk of osteoporosis. Over time, the negative mental and physical health impacts of being denied care are likely to worsen and to result in debilitating distress. Based on my professional experience, terminating hormone therapy for a transgender woman constitutes a serious medical risk that can severely impact physical and mental health.

6. Without treatment, many people with gender dysphoria are unable to adequately function in occupational, social or other areas of life. Other than socially transitioning, hormone therapy, and surgery, there are no alternative treatments for effectively managing gender dysphoria.

7. Allowing transgender people to transition and live in a different sex has also been proven effective in combatting the severe health consequences of gender dysphoria.

8. Forcing a transgender person to live in their birth sex, such as for example, forcing a transgender woman to reside in a men's facility and forcing her to present and live as a male will

predictably worsen gender dysphoria and cause severe psychological distress. This is especially true for a transgender individual who has lived in a sex different than their birth sex for a significant amount of time, including through use of medications and surgeries. The fact that it is harmful to make a transgender person live in their birth sex is true as well for someone who has not had medications or surgery.

9. In addition, it would be harmful for transgender women who have been diagnosed with gender dysphoria to cut off their access to female-designated commissary items such as undergarments, hair removal tools, and those items that allow a transgender woman to live as a woman.

10. Providing any kind of purported medical care or behavior health modalities to try to make a transgender person comfortable or even able to live in their birth sex and suppress who they are as a transgender person is a rejected as a harmful approach that is inconsistent with established medical care. Like conversion therapy targeting lesbian, gay, bisexual, and transgender individuals, these approaches have been widely discredited by medical professionals due to their documented harmful effects. Research shows they not only fail to achieve their intended outcomes but also inflict psychological trauma and substantially increase the risk of self-harm among those subjected to them.

11. For example, in a 2020 article titled “Statement on Conversion Therapy,” the Independent Forensic Expert Group explained that “[a]ll forms of conversion therapy, including talk or psychotherapy, can cause intense psychological pain and suffering,” and “[i]n many studies, the rates of suicidal ideation and suicide attempt are several times higher than in other lesbian, gay, bisexual, trans, and gender diverse populations who have not been exposed to conversion therapy.” The article further explains that “the likely harm of conversion therapy cannot be outweighed by

any clinical benefits, as there are none.” A true and correct copy of the article is attached as **Exhibit B**.

12. By way of further example, a 2022 study of study of lesbian, gay, bisexual, transgender, queer, or questioning (“LGBTQ”) youths in the United States found that when compared to LGBTQ individuals who experience conversion therapy, the conversion therapy recipients were more likely to experience serious psychological distress (47% vs 34%), depression (65% vs 27%), substance abuse (67% vs 50%), and attempted suicide (58% vs 39%). A true and correct copy of the study is attached as **Exhibit C**.

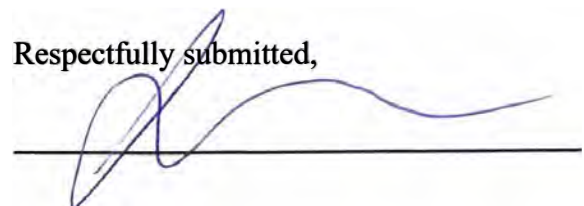
13. Cutting off a transgender woman’s access to female hormones is also harmful because it is the hormones that affect her body in ways that enable her to live as a woman.

14. It is critically important that transgender individuals receive access to hormone therapy and other medical care in accordance with well-established and proven standards of care. However, for most individuals who have been on hormone therapy for an extended period of time, which includes the plaintiffs here, such care does not necessarily require specialized medical facilities or proximity to advanced care centers and can be managed as part of their routine care.

Pursuant to 28 U.S.C. § 1746, I affirm under penalty of perjury that the above statements are true and correct.

Dated: February 23, 2025

Respectfully submitted,



UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JANE DOE, *et al.*,

Plaintiffs,

v.

Case No. 1:25-cv-286-RCL

PAMELA BONDI, in her official capacity as
Attorney General of the United States, *et al.*,¹

Defendants.

ORDER

On February 18, 2025, this Court entered a Preliminary Injunction [ECF No. 44] enjoining the enforcement of Sections 4(a) and 4(c) of Executive Order 14168 on Eighth Amendment grounds against plaintiffs Jane, Mary, and Sara Doe. On February 21, the plaintiffs filed an Amended Complaint adding nine new plaintiffs, all of whom are transgender women incarcerated in women's BOP facilities seeking the same relief as the original three plaintiffs. *See* Amended Complaint, ECF No. 47. That same day, the plaintiffs filed a Motion for a Temporary Restraining Order and Expanded Preliminary Injunction [ECF No. 50] ("TRO/PI Mot.") to prevent the Government from implementing Executive Order 14168 as to all plaintiffs. The plaintiffs emphasized the urgency in resolving this Motion because "the additional plaintiffs . . . were rounded up by BOP officials and informed that they would be immediately transferred to men's prisons and would have their healthcare terminated pursuant to the Executive Order." TRO/PI Mot. 2. On February 23, the Government filed an Opposition [ECF No. 50] ("Opp'n"), and the plaintiffs filed a Reply [ECF No. 54] on February 24.

¹ Under Fed. R. Civ. Pr. 25(d), Attorney General Pamela Bondi is "automatically substituted as a party" as the successor for Acting Attorney General James R. McHenry III.

The Court has reviewed the parties' filings and determines that the same reasoning from the Court's original TRO Order [ECF No. 23] still applies, with nothing in the record to compel a different outcome. At the outset, the Court sees no reason to change its legal conclusions from the original TRO Order regarding availability of judicial review or unavailability of administrative exhaustion. The Government's proffered reasons for doing so are unavailing. The Court also observes that the Government offers no new developments regarding the Medication Provision, Sec. 4(c), of the Executive Order, so the same outcome will hold.

The only new development on the record is that the Government has identified low-security men's facilities in which to house the plaintiffs, which, according to the Government, completely alleviates the plaintiffs' alleged Eighth Amendment harms regarding the Transfer Provision, Sec. 4(a), of the Executive Order. *See* Opp'n 20; *see generally* Decl. of Rick Stover, Senior Deputy Assistant Director, Designation and Sentence Computation Center, ECF No. 53-2 ("Stover Decl."). The plaintiffs urge the Court to strike the Stover Declaration or at least afford it "little weight." Reply 6.

But even considering the Stover Declaration, the Court finds that the plaintiffs are still likely to succeed on their Eighth Amendment claim regarding the Transfer Provision, as this Court concluded in granting the original TRO motion. The Stover Declaration indicates that housing reassessments were conducted to identify men's facilities in which to house each plaintiff—but the Government's filings also make clear that the *only* change in circumstances from when the initial housing determination was made to now is Executive Order 14168. Stover Decl. ¶¶ 10, 17; Opp'n 3. When the initial housing determination was made for each of the named plaintiffs, the BOP determined that considering all statutorily and constitutionally required factors, a women's facility was the appropriate facility for each named plaintiff. This was the conclusion even in a

landscape where ninety-nine percent of transgender women in BOP custody are housed in men's facilities. *See* Opp'n 3. Summarily removing the possibility of housing the plaintiffs in a women's facility, when that was determined to be the appropriate facility under the existing constitutional and statutory regime, demonstrates a likelihood of success on the merits of the plaintiffs' Eighth Amendment claim.² The Court still takes no position on the plaintiffs' equal protection, APA, or separation of powers claims. *See* TRO Order 1.

Therefore, in consideration of the plaintiffs' Motion [ECF No. 50] for a Temporary Restraining Order and Preliminary Injunction, the Opposition [ECF No. 52] thereto, the Reply [ECF No. 54], and the entire record herein, and for the reasons contained in the original Temporary Restraining Order [ECF No. 23], it is hereby

ORDERED that the plaintiffs' Motion for a Temporary Restraining Order and Expanded Preliminary Injunction is **GRANTED**; and it is further

ORDERED that the Defendants are hereby enjoined from implementing Sections 4(a) and 4(c) of Executive Order 14168 against plaintiffs Jane, Mary, Sara, Emily, Zoe, Tori, Olivia, Susan, Lois, Sophia, Sally, and Wendy Doe, pending further Order of this Court; and it is further

² The Court is also unconvinced by the Government's proffered statistics attempting to show that a low-security men's facility would be *safer* for the plaintiffs than their current housing assignment. *See* Opp'n 3, 10. The Government's statistics do not disaggregate assaults against transgender inmates from overall rates of assault. And in any event, the proffered statistics are still consistent with the "numerous government reports and regulations recognizing that transgender persons are at a significantly elevated risk of physical and sexual violence relative to other inmates when housed in a facility corresponding to their biological sex." TRO Order 5. And that is to say nothing of the other harms identified by plaintiffs, which the Government fails to address: "that placement in a male penitentiary *by itself* will exacerbate the symptoms of their gender dysphoria, *even if* they are not subject to physical or sexual violence in their new facility—whether because they will be subject to searches by male correctional officers, made to shower in the company of men, referred to as men, forced to dress as men, or simply because the mere homogenous presence of men will cause uncomfortable dissonance." *Id.*

ORDERED that, pending further Order of this Court, Defendants shall maintain and continue the plaintiffs' housing status and medical care as they existed immediately prior to January 20, 2025.

Date: February 24, 2025
1:58 p.m.



Royce C. Lamberth
United States District Judge

EXHIBIT 2

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**UNITED STATES DISTRICT COURT
DISTRICT OF COLUMBIA**

JANE DOE; MARY DOE; SARA DOE;
EMILY DOE; ZOE DOE; TORI DOE;
OLIVIA DOE; SUSAN DOE; LOIS DOE;
SOPHIA DOE; SALLY DOE; WENDY
DOE; RACHEL DOE; and ELLEN DOE

Plaintiffs,

v.

PAMELA BONDI, *in her official capacity* as
Attorney General of the United States; and
WILLIAM LOTHROP, *in his official
capacity* as Acting Director of the Federal
Bureau of Prisons,

Defendants.

Case No.: 1:25-cv-00286-RCL

SECOND AMENDED COMPLAINT

1. This Action is a federal statutory and constitutional challenge to Sections 4(a) and 4(c) of Executive Order 14168, titled “Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government,” (the “Order”) which President Donald Trump issued just hours after his inauguration on January 20, 2025. The Order directly targets transgender individuals and attempts to strip them of established legal protections. Under Sections 4(a) and 4(c) of the Order, all transgender women who are incarcerated in federal prisons will be transferred to men’s facilities, regardless of safety concerns, and all transgender people who are incarcerated in federal prisons will be denied medically necessary healthcare for gender dysphoria.

2. Plaintiff Jane Doe is a transgender woman incarcerated in a [REDACTED]

[REDACTED] for women located in [REDACTED]

[REDACTED] Jane is diagnosed with gender dysphoria, a rare but serious medical condition and

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disability. The medical standard of care for treatment of gender dysphoria is to allow a transgender person to live in a sex different than their birth sex through medications, surgical care, and social transition.

3. Consistent with this standard of care, Jane has lived as a woman and has taken hormones continuously for nearly a decade. She is currently housed in a women's facility

[REDACTED]

[REDACTED]

4. Pursuant to [REDACTED] and the recommendations of BOP staff members, Jane has been housed in a women's facility since [REDACTED]. She has been designated as a minimum recidivism risk, poses no threat to her female peers, and her presence in the women's facility has not caused any disruption or interference with prison operations.

5. If Jane is transferred to a men's facility, she will not be safe. She will be at an extremely high risk of harassment, abuse, violence, and sexual assault. She has previously been sexually assaulted in BOP men's facilities before she was moved to a women's facility. If transferred, she may also be subject to strip searches by male correctional officers. She may be forced to shower in full view of men who are incarcerated. And she will predictably experience worsening gender dysphoria exacerbated by a lack of medical care, which can lead to serious harm, including dramatically increased rates of suicidality and depression.

6. Plaintiff Mary Doe is a transgender woman who is also incarcerated at [REDACTED] and is diagnosed with gender dysphoria.

7. Consistent with the standard of care, Mary has lived as a woman and has taken hormones for [REDACTED]. She has been housed in a women's

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facility for [REDACTED]. Prior to that she was housed in women's facilities in [REDACTED].

8. If Mary is transferred to a men's facility, she will not be safe. She will be at an extremely high risk of harassment, abuse, violence, and sexual assault. When she was previously housed in BOP men's facilities, she was raped multiple times. She may be subject to strip searches by male correctional officers. She may be forced to shower in full view of men who are incarcerated. And she will predictably experience worsening gender dysphoria exacerbated by a lack of medical care, which can lead to serious harm, including dramatically increased rates of suicidality and depression.

9. Plaintiff Sara Doe is a transgender woman who is incarcerated at [REDACTED] [REDACTED] and is diagnosed with gender dysphoria. She also has [REDACTED] [REDACTED].

10. Consistent with the standard of care, Sara has lived as a woman and has taken hormones for several years, including [REDACTED]. Prior to her incarceration, she had several surgeries, including [REDACTED] [REDACTED]. Since her arrest [REDACTED].

11. If Sara is transferred to a men's facility, she will not be safe. She will be at an extremely high risk of harassment, abuse, violence, and sexual assault. She may be subject to strip searches by male correctional officers. She may be forced to shower in full view of men who are incarcerated, and her breasts and female genitalia will be exposed and vulnerable to sexual harassment, assault, and rape.

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12. In a men's facility, Sara will also predictably experience worsening gender dysphoria exacerbated by a lack of medical care, which can lead to serious harm, including worsening [REDACTED] and dramatically increased risks of suicidality and depression.

13. Plaintiff Emily Doe is a transgender woman who is incarcerated at [REDACTED] and is diagnosed with gender dysphoria.

14. Consistent with the standard of care, she has lived as a woman, been treated as a woman, and taken hormones for over [REDACTED] years, all while in BOP custody. When Emily was housed in male facilities, she was not able to participate in programming due to her fears about her safety, and she [REDACTED]. She was transferred to [REDACTED] by BOP's Transgender Executive Committee in [REDACTED]. Since being housed at a female facility, she has started [REDACTED] [REDACTED].

15. If Emily is transferred to a men's facility, she will not be safe. She will be at an extremely high risk of harassment, abuse, violence, and sexual assault. She may be subject to strip searches by male correctional officers. She may be forced to shower in full view of men who are incarcerated. And she will predictably experience worsening gender dysphoria exacerbated by a lack of medical care, which can lead to serious harm, including dramatically increased rates of suicidality and depression.

16. Plaintiff Zoe Doe is a transgender woman who is incarcerated in [REDACTED]. Zoe Doe is diagnosed with gender dysphoria.

17. Consistent with the standard of care, Zoe has lived as a woman and has taken hormones since [REDACTED]. She was first diagnosed with "gender identity disorder" in [REDACTED] by a psychiatrist. She has repeatedly been diagnosed with gender dysphoria by BOP medical

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personnel as well. She has been housed in a federal women's facility for [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

18. If Zoe were transferred to a men's facility, she would not be safe. She will be at an extremely high risk of harassment, abuse, violence, and sexual assault. She may be subject to strip searches by male correctional officers. She may be forced to shower in full view of men who are incarcerated. And she will predictably experience worsening gender dysphoria without medical care, which can lead to serious harm, including dramatically increased rates of suicidality and depression.

19. Plaintiff Tori Doe is a transgender woman who is also incarcerated in [REDACTED]

[REDACTED] Tori is diagnosed with gender dysphoria.

20. Consistent with the standard of care, Tori has lived as a woman and has taken hormones for more than [REDACTED]. In [REDACTED] prior to her incarceration, [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] Tori has been treated as a woman by federal correctional officials and has been housed in a women's facility for over [REDACTED].

21. If Tori is transferred to a men's facility, she will not be safe. She will be at an extremely high risk of harassment, abuse, violence, and sexual assault. She has previously experienced sexual assault and sexual harassment while housed in a men's facility. She may be subject to strip searches by male correctional officers. She may be forced to shower in full view

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of men who are incarcerated. And she will predictably experience worsening gender dysphoria without medical care, which can lead to serious harm, including dramatically increased rates of suicidality and depression.

22. Plaintiff Olivia Doe is a transgender woman who is incarcerated at [REDACTED] and is diagnosed with gender dysphoria.

23. Consistent with the standard of care, Olivia has lived as a woman and has taken hormones since [REDACTED]. When Olivia entered BOP custody, her hormone treatment abruptly ended. But her treatment was eventually restored, and she has been consistently receiving hormones again [REDACTED]. Olivia has been housed at a female facility since [REDACTED].

24. If Olivia is transferred to a men's facility, she will not be safe. When previously housed in BOP men's facilities, Olivia was brutally raped; [REDACTED]
[REDACTED] She will be at an extremely high risk of harassment, abuse, violence, and sexual assault. She may be subject to strip searches by male correctional officers. She may be forced to shower in full view of men who are incarcerated. And she will predictably experience worsening gender dysphoria exacerbated by a lack of medical care, which can lead to serious harm, including dramatically increased rates of suicidality and depression.

25. Plaintiff Susan Doe is a transgender woman who is incarcerated at [REDACTED]. She is diagnosed with gender dysphoria.

26. Consistent with the standard of care, Susan has lived as a woman for over [REDACTED] years. She has known she was a woman for a very long time, and she has been taking hormones since [REDACTED] Susan was transferred to [REDACTED] by BOP's Transgender Executive

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Committee in [REDACTED]. Since being placed in a women's facility, she finally feels like she can move around without worrying about being attacked and needing to defend herself.

27. If Susan is transferred to a men's facility, she will not be safe. When previously housed in BOP men's facilities, she was the victim of an attempted rape and was always on alert to guard against being attacked. [REDACTED]. If returned to a male facility, Susan may be subject to strip searches by male correctional officers. She may be forced to shower in full view of men who are incarcerated. And she will predictably experience worsening gender dysphoria exacerbated by a lack of medical care, which can lead to serious harm, including dramatically increased rates of suicidality and depression.

28. Plaintiff Lois Doe is a transgender woman who is incarcerated at [REDACTED]. She is diagnosed with gender dysphoria.

29. Consistent with the standard of care, Lois has lived as a woman and been taking hormones since [REDACTED]. She began dressing as a woman and feminizing her voice and her hair at that time. Lois was transferred to [REDACTED] by BOP's Transgender Executive Committee in [REDACTED].

30. If Lois is transferred to a men's facility, she will not be safe. She will be at an extremely high risk of harassment, abuse, violence, and sexual assault. When she was previously housed with men at a [REDACTED], Lois was raped [REDACTED]. At a male BOP facility, Lois may be subject to strip searches by male correctional officers. She may be forced to shower in full view of men who are incarcerated. In a men's facility, she will also predictably experience worsening gender dysphoria exacerbated by a lack of medical care, which can lead to serious harm, including worsening anxiety and dramatically increased risks of suicidality and depression.

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31. Plaintiff Sophia Doe is a transgender woman who is incarcerated at [REDACTED]

[REDACTED]. She is diagnosed with gender dysphoria.

32. Consistent with this standard of care, Sophia has been living as a woman and presenting as a woman for over [REDACTED] years. She has taken hormones for more than [REDACTED] years, [REDACTED]. Sophia has had persistent gender dysphoria since she was a child. Sophia has been housed in a women's facility for over [REDACTED].

33. If Sophia is transferred to a men's facility, she will not be safe. She will be at an extremely high risk of harassment, abuse, violence, and sexual assault. She may be subject to strip searches by male correctional officers. She may be forced to shower in full view of men who are incarcerated. And she will predictably experience worsening gender dysphoria exacerbated by a lack of medical care, which can lead to serious harm, including dramatically increased rates of suicidality and depression.

34. Plaintiff Sally Doe is a transgender woman who is incarcerated at [REDACTED] and is diagnosed with gender dysphoria.

35. Consistent with the standard of care, Sally has received hormone treatment for [REDACTED] and she receives [REDACTED]. She was transferred to [REDACTED] in [REDACTED]. Sally has had gender dysphoria since childhood. She has suffered with [REDACTED] for most of her life. Treatment for her gender dysphoria has been the only effective way of alleviating those symptoms.

36. If Sally is transferred to a men's facility, she will not be safe. She will be at an extremely high risk of harassment, abuse, violence, and sexual assault. She may be subject to strip searches by male correctional officers. She may be forced to shower in full view of men who are incarcerated. And she will predictably experience worsening gender dysphoria

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exacerbated by a lack of medical care, which can lead to serious harm, including dramatically increased rates of suicidality and depression.

37. Plaintiff Wendy Doe is a transgender woman who is incarcerated at [REDACTED] and is diagnosed with gender dysphoria.

38. Consistent with the standard of care, Wendy has been living as a woman and taking hormones since [REDACTED]. In [REDACTED], before entering BOP custody, Wendy received [REDACTED]. Since entering BOP custody in [REDACTED] Wendy [REDACTED].

39. Wendy has been living at [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

40. If Wendy is transferred to a men's facility, she will not be safe. She will be at an extremely high risk of harassment, abuse, violence, and sexual assault. She may be subject to strip searches by male correctional officers. She may be forced to shower in full view of men who are incarcerated. And she will predictably experience worsening gender dysphoria exacerbated by a lack of medical care, which can lead to serious harm, including dramatically increased rates of suicidality and depression.

41. In addition to facing immediate transfers to men's facilities, Plaintiffs are at imminent risk of losing access to the medical care they each need to treat their gender dysphoria. Executive Order 14168 singles out transgender people to deny them essential healthcare, including medications that BOP may continue to provide to non-transgender people. The Order

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categorically bans transgender healthcare regardless of medical necessity. It prohibits prison medical providers from treating transgender patients' gender dysphoria on an individual basis according to independent medical judgment. This blanket ban will deprive Plaintiffs of essential treatment, putting them at high risk of serious harm.

42. Plaintiff Rachel Doe is a transgender woman who is incarcerated in [REDACTED]

[REDACTED]. Rachel was diagnosed with gender dysphoria in [REDACTED] when she was [REDACTED].

43. Consistent with the standard of care, Rachel has lived as a woman since then and been on hormones [REDACTED]

[REDACTED]

[REDACTED]

44. Until [REDACTED], Rachel had been housed in women's facilities while in federal custody. [REDACTED]

[REDACTED]

[REDACTED] On [REDACTED], Rachel was sent to [REDACTED] where she was again housed with women.

45. On or about [REDACTED], BOP transferred Rachel from the women's side to the men's side of [REDACTED]. In early [REDACTED], BOP transferred her to [REDACTED] which houses only men. When she left [REDACTED] Rachel was subjected to a visual strip search by two male officers with no female officers present. In front of these two men, Rachel had to remove all of her clothes and while nude, lift her breasts, bend over, squat, spread her behind and genital area with her hands, and cough. Since being housed with men, Rachel has experienced daily sexual harassment by male inmates. When she walks to the facility to get her meals, men stare, whistle, clap, and knock on their windows. Several male inmates have told her

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verbally and in writing to meet them in various places in the prison for sex. She has reported these incidents [REDACTED]

[REDACTED]

46. Rachel also has not been issued a bra or women's underwear, and she is unable to access those items through commissary. These deprivations are exacerbating Rachel's gender dysphoria and placing her at a heightened risk of sexual assault.

47. BOP has denied Rachel her hormone treatment since she arrived at [REDACTED]. She is being denied this medication [REDACTED]. [REDACTED] As a direct result of these deprivations of medical care, Rachel currently faces a serious risk of medical injury and complications.

48. Plaintiff Ellen Doe is a transgender woman who is incarcerated in [REDACTED]. Ellen was diagnosed with gender dysphoria [REDACTED].

49. Consistent with the standard of care, Ellen has been living as a woman and receiving hormone treatment for [REDACTED], all while in BOP custody. Prior to February 2025, Ellen had been housed with women for two years at [REDACTED] pursuant to the recommendation of the Transgender Executive Council. Ellen was also in the process of being evaluated [REDACTED].

50. In [REDACTED], BOP transferred Ellen to [REDACTED] and then to [REDACTED], which houses only men. When she left [REDACTED] and again when she arrived at [REDACTED], Ellen was subjected to a visual strip search by male officers. Since arriving in [REDACTED] Ellen has been propositioned for sex and threatened by inmates. She is terrified of

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being assaulted in her room or in the shower, which have no locks. When Ellen was previously housed in a men's facility, she [REDACTED]

51. Ellen has not been issued a bra or women's underwear, and she is unable to access those items through commissary. These deprivations are exacerbating Ellen's gender dysphoria and placing her at a heightened risk of sexual assault.

52. Although Ellen is still receiving her hormone treatment, she is at imminent risk of losing access to this medical care she needs to treat her gender dysphoria. Executive Order 14168 singles out transgender people to deny them essential healthcare, including medications that BOP may continue to provide to non-transgender people. The Order categorically bans transgender healthcare regardless of medical necessity. It prohibits prison medical providers from treating transgender patients' gender dysphoria on an individual basis according to independent medical judgment. This blanket ban will deprive Ellen of essential treatment, putting her at high risk of serious harm.

53. Plaintiffs bring claims for violations of the Fifth Amendment to the United States Constitution; the Eighth Amendment to the United States Constitution; the Rehabilitation Act of 1973, 29 U.S.C. § 701, *et seq.*; the Separation of Powers; and the Administrative Procedure Act, 5 U.S.C. §§ 701–06. Plaintiffs seek declaratory and injunctive relief to enjoin enforcement of Sections 4(a) and 4(c) of Executive Order 14168. Without the injunctive relief sought, Plaintiffs will experience irreparable injury.

JURISDICTION AND VENUE

54. This action arises under the Constitution and statutes of the United States. This Court has subject matter jurisdiction pursuant to 28 U.S.C. § 1331.

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55. This Court has authority to enter a declaratory judgment and to provide preliminary and permanent injunctive relief pursuant to 28 U.S.C. §§ 2201 and 2202, Fed. R. Civ. P. 57 and 65, and this Court's inherent equitable powers.

56. Venue is proper in this district under 28 U.S.C. § 1391(e)(1) because the Defendants are domiciled in this district.

PARTIES

57. Plaintiff Jane Doe is a transgender woman. She is incarcerated in [REDACTED]
[REDACTED] Jane Doe is a pseudonym.

58. Plaintiff Mary Doe is a transgender woman. She is incarcerated in [REDACTED]
[REDACTED]. Mary Doe is a pseudonym.

59. Plaintiff Sara Doe is a transgender woman. She is incarcerated in [REDACTED]
[REDACTED] Sara Doe is a pseudonym.

60. Plaintiff Emily Doe is a transgender woman. She is incarcerated in [REDACTED]
[REDACTED]. Emily Doe is a pseudonym.

61. Plaintiff Olivia Doe is a transgender woman. She is incarcerated in [REDACTED]
[REDACTED] Olivia Doe is a
pseudonym.

62. Susan Doe is a transgender woman. She is incarcerated [REDACTED]
[REDACTED]. Susan Doe is a
pseudonym.

63. Lois Doe is a transgender woman. She is incarcerated at [REDACTED]
[REDACTED]. Lois Doe is a pseudonym

64. Plaintiff Sally Doe is a transgender woman. She is incarcerated in [REDACTED]
[REDACTED]. Sally Doe is a pseudonym.

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65. Plaintiff Sophia Doe is a transgender woman. She is incarcerated [REDACTED]
[REDACTED]. Sophia Doe is a
pseudonym.

66. Plaintiff Sally Doe is a transgender woman. She is incarcerated at [REDACTED]
[REDACTED]. Sally Doe is a pseudonym.

67. Wendy Doe is a transgender woman. She is incarcerated [REDACTED]
[REDACTED]. Wendy Doe is a pseudonym.

68. Zoe Doe is a transgender woman. She is incarcerated [REDACTED]
[REDACTED]. Zoe Doe is a pseudonym.

69. Tori Doe is a transgender woman. She is incarcerated [REDACTED]
[REDACTED]. Tori Doe is a pseudonym.

70. Rachel Doe is a transgender woman. She is incarcerated at [REDACTED]
[REDACTED]. Rachel Doe is a pseudonym.

71. Ellen Doe is a transgender woman. She is incarcerated at [REDACTED]
[REDACTED]. Ellen Doe is a pseudonym.

72. Defendant Pamela Bondi is sued in her official capacity as Attorney General of
the United States. The Attorney General oversees the Department of Justice, including the
Federal Bureau of Prisons (BOP), and has responsibility for overseeing the enforcement and
implementation of Sections 4(a) and 4(c) of Executive Order 14168 with respect to the Bureau of
Prisons.

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73. Defendant William Lothrop is sued in his official capacity as Acting Director of the Federal Bureau of Prisons. The Acting Director of BOP has responsibility for overseeing enforcement and implementation of Executive Order 14168 by all BOP staff.

FACTS

Plaintiffs' Sudden and Unjustified Removal from General Population and Risk of Transfer to a Men's Facility

74. BOP maintains separate housing facilities for men and women. Before January 20, 2025, BOP applied an individualized assessment process to determine appropriate housing for transgender women, consistent with the safety and security of all individuals and pursuant to the federal Prison Rape Elimination Act (PREA) and its implementing regulations. Based on this assessment, transgender women may be housed in women's facilities when doing so promotes safety and security.¹

75. On January 20, 2025, President Trump issued an Executive Order directing the BOP to disregard its established policy and any associated safety and security risks concerning the housing and care of transgender women.

76. On January 24, 2025, pursuant to this Executive Order, the BOP removed Plaintiffs Jane Doe, Mary Doe, and the other Plaintiffs incarcerated at [REDACTED] from the general population of [REDACTED].

77. BOP officials placed Plaintiffs in separate housing with other transgender women. All of these women, including Plaintiffs, were told they were removed from general population because of the Executive Order.

¹ U.S. Dep't of Just., Transgender Offender Manual §§ 5–6 (2022), *see* Dkt. 11-3.

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78. Plaintiffs were also informed that they would be imminently transferred to men's facilities because of the Executive Order. When they were placed into the segregated unit, BOP officials told them they would be transferred no later than Thursday, January 30, 2025. BOP officials told several of the Plaintiffs that the transfer paperwork had already been processed.

79. On January 28, 2025, after transgender individuals at [REDACTED] began contacting counsel, the Plaintiffs at [REDACTED] were returned to general population housing but continued to be told that they would be imminently transferred to men's facilities.

80. Similarly, on January 25, 2025, the BOP removed Sara Doe from the general population at [REDACTED]. BOP officials allowed Sara to make a phone call to her family and then placed her in the Special Housing Unit (SHU) with another transgender woman.

81. BOP officials told Sara Doe that she was being transferred to a men's facility, and that her cell was being cleaned out and she would not be permitted to return.

82. Sara Doe's mother and sister emailed [REDACTED] on January 25, 2025, to request that they reconsider the decision to transfer Sara to a men's prison. They wrote: "Sending her to an all-male prison will be the end of her. No one deserves this. There needs to be another way, we beg for your sympathy. She will get sexually assaulted and even possibly killed for being who she is. She is a citizen designated as a female and deserves protection like any other human. . . . This could mean life or death and she has not received a death penalty as her sentence."

83. In response to the email from Sara Doe's family, the BOP stated that they could not house Sara at [REDACTED] or any other women's facility because of the Executive Order.

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84. On about January 29, 2025, Sara Doe was returned to the women's general population at [REDACTED]. Upon information and belief, Sara still faces imminent transfer to a men's facility.

85. Similarly, on or about January 24, 2025, pursuant to the Executive Order, the BOP removed Olivia Doe, Susan Doe, and the other Plaintiffs at [REDACTED] from the general population of that facility.

86. BOP officials placed these women in separate housing. BOP officials told these women that because of the Executive Order, they had to place all transgender female inmates into special housing pending transfer to a male facility.

87. On or about February 5, 2025, the Plaintiffs at [REDACTED] were returned to general population housing. BOP officials continue to state that they will be imminently transferred to men's facilities.

88. On February 20, 2025, BOP officials at [REDACTED] called the transgender women incarcerated at [REDACTED], including many of the Plaintiffs at that facility, into the warden's office. They were told that the Department of Justice had called the warden that morning and directed the warden to transfer all of them to men's facilities. The women were told that the transfers could happen as early as Monday, February 24, 2025, and that their medical treatment would be cut off in the men's facilities. Each of the women met with psychology staff for suicide assessments before being sent back to their units.

89. On or about February 21, 2025, BOP officials at [REDACTED] told Susan Doe, Lois Doe, and Olivia Doe that they were all being transferred to male facilities imminently.

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90. Plaintiffs' removal from general population, placement in segregated housing, and anticipated transfer to men's facilities have caused them significant distress and raise serious and imminent concerns regarding their safety and well-being.

Plaintiffs Rachel and Ellen Doe's Transfer to a Men's Facility

91. In early March 2025, BOP transferred Rachel and Ellen Doe to [REDACTED], a men's facility.

92. During the transfer, both of them were subjected to visual strip searches by male officers. Rachel and Ellen thus had to strip completely nude in front of male officers and lift up their breasts, bend over, spread their genital area, and remain completely exposed in the nude in front of men.

93. Being housed in a men's facility places Rachel and Ellen at an immediate risk of physical and sexual assault. Both Rachel and Ellen are being subjected to daily verbal sexual harassment by men in the facility, who whistle, clap, ogle, and bang on the windows of their rooms when Rachel or Ellen walk by.

94. They are housed in a room that does not lock, and they use the bathroom and shower in a room that does not lock.

95. Rachel and Ellen have both been propositioned for sex multiple times. [REDACTED]
[REDACTED] about one sexual solicitation she received and reported. Both women are frightened of being sexually assaulted.

96. Rachel and Ellen are also at serious risk of worsening gender dysphoria in men's facilities. Treating transgender women with gender dysphoria as men is known to intensify dysphoria, undermine medical treatment, and increase emotional distress, and it can precipitate self-harm.

Gender Dysphoria

97. Gender dysphoria is a serious medical condition marked by the significant distress or impairment that occurs when a transgender individual is made to live in their birth sex. The condition is highly treatable. When left untreated, however, it causes serious physical and emotional harms.

98. Scientific and medical research also shows that gender dysphoria has a physiological and biological etiology.

99. The only current, medically accepted treatment for gender dysphoria is to enable a transgender person to live in the sex different than their birth sex.

100. The medical and scientific community recognize well-established protocols for supporting a person to go through gender transition, the treatment that allows a transgender person to live in their target sex. These protocols are endorsed by the major medical and mental health associations in the United States, including but not limited to the American Medical Association, the American Psychiatric Association, the American Psychological Association, and the Endocrine Society.

101. Under these accepted protocols, treatment for gender dysphoria can involve any combination of social transition, medications (including hormones), and a range of surgeries. The treatment prescribed for a particular patient depends on an individualized assessment of the patient's health and needs. Gender transition care, including hormone therapy, is a highly effective treatment for gender dysphoria.

Executive Order 14168 Will Cause Plaintiffs Irreparable Injury

102. Executive Order 14168 began causing harm to Plaintiffs almost immediately. As a result of the Order, they have already suffered significant distress. The Order also raises serious concerns for their safety and well-being going forward.

103. Section 2 of the Order includes a definition of “sex” that is intentionally designed to discriminate against transgender people. Specifically, Section 2 of the Order defines “sex” as “an individual’s immutable biological classification as either male or female.” In turn, it defines “male” as “a person belonging, at conception, to the sex that produces the small reproductive cell,” and “female” as “a person belonging, at conception, to the sex that produces the large reproductive cell.” It includes these definitions to preclude transgender people from being able to live in a sex different than their birth sex and to deny them equal treatment.

104. Section 4(a) of the Order then directs federal agencies to implement this discriminatory provision, including requiring the Attorney General to categorically bar all transgender women from ever being housed in women’s prisons with no individualized consideration of their safety and security. That section acknowledges that the requirement contradicts federal regulations found at 28 C.F.R. § 115.41.

105. Evidence, research, case law, and practical experience show that transgender women housed in men’s prisons face near constant sexual harassment and extremely high levels of violence and sexual assault. Federal regulations recognize transgender status as a risk factor for sexual assault. *See* 28 C.F.R. §§ 115.41(d)(7), 115.42(c)–(g). A 2013 study by the Department of Justice estimated that nearly 35% of transgender people in state and federal prisons were sexually assaulted between 2007 and 2012. U.S. Dep’t of Justice Off. of Justice Programs, *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12*, NCJ No. 241399, Supplemental Table 1 (2013).² From 2011 to 2012, transgender people were sexually assaulted at nearly ten times the rate for the general incarcerated population.³

² Available at https://bjs.ojp.gov/content/pub/pdf/svpjri1112_st.pdf.

³ *Compare id.* (noting a 39.9% sexual victimization rate for transgender people from 2011 to 2012), *with* the full report at 6 (reflecting a 4.0% rate of sexual victimization in the general

106. Further, Plaintiffs will predictably experience worsening gender dysphoria in men's facilities. They may be forced to wear men's clothing and undergarments, prevented from styling their hair as female, referred to as men, and addressed by their stereotypically male former names. Treating transgender women with gender dysphoria as men is known to intensify dysphoria, undermine medical treatment, and increase emotional distress, and it can precipitate self-harm.

107. Section 4(c) of the Order will also cause Plaintiffs serious, irreparable injury. That provision requires the Attorney General to "ensure that no Federal funds are expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex." Section 4(c) eliminates Plaintiffs' ability to continue taking hormone medications to treat their gender dysphoria, which their bodies have adjusted to receiving.

108. The BOP is aware that each of the Plaintiffs has a diagnosis of gender dysphoria, that gender dysphoria is a serious medical condition requiring treatment, and that Plaintiffs have a serious medical need for such treatment. BOP policy expressly allows hormone medication as a treatment for gender dysphoria based on an "individualized assessment" by medical staff.⁴ If providers determine that hormone medications are appropriate for an individual, that medication "will be provided."⁵ Consistent with this policy, upon information and belief, the BOP has consistently provided hormone medications to Plaintiffs for years pursuant to treatment plans determined by BOP medical and mental health staff.

prison population from 2011 to 2012), available at <https://bjs.ojp.gov/content/pub/pdf/svpjri1112.pdf>.

⁴ U.S. Dep't of Just., Transgender Offender Manual § 8 (2022), *see* Dkt. 11-3.

⁵ *Id.*

109. If Plaintiffs' medically necessary treatment for gender dysphoria is terminated or restricted under Section 4(c), they will be at a well-known and substantial risk of serious harm. Medical professionals experienced in the treatment of gender dysphoria and in the prolonged use of hormone medications recognize that the abrupt termination and ongoing denial of hormone therapy can have disastrous consequences, including serious risk of permanent physical and emotional harm, severe danger of self-mutilation, and suicidal ideation and attempts. Some of the Plaintiffs who have had surgery to treat their gender dysphoria can no longer produce hormones on their own. Without prescription hormone medication, these Plaintiffs will not have sufficient hormones of any kind in their systems, which will lead to serious medical difficulties.

Executive Order 14168 Facially Classifies Based on Sex and Transgender Status and Was Motivated By Discriminatory Animus

110. Executive Order 14168 classifies individuals on the basis of sex and transgender status. It was motivated by a sex-based discriminatory purpose and animus against transgender people.

111. President Trump has been transparent about his hostility toward transgender people and openly stated his intentions to eliminate legal protections for transgender people and to deter them from obtaining medical care or being able to live in a sex other than their birth sex. On November 15, 2022, when he announced his candidacy for President, he explicitly promised to target transgender Americans through executive action.⁶ He pledged a "day one" executive order to "cease all programs that promote the concept of sex and gender transition at any age."⁷

⁶ ABC Action News, *(Full Speech) Former President Trump Announces 2024 Presidential Bid* at 48:40-49:13, YouTube (Nov. 15, 2022), https://www.youtube.com/watch?v=8tSYwJ1_htE; *id.* at 50:39-53 (suggesting he would attempt to ban transgender people from military service).

⁷ *President Trump's Plan to Protect Children from Left-Wing Gender Insanity*, Trump Vance: Make America Great Again! 2025 (Feb. 1, 2023), <https://www.donaldjtrump.com/agenda47/president-trumps-plan-to-protect-children-from-left->

112. Throughout his campaign, President Trump repeatedly characterized transgender Americans in dehumanizing terms, referring to them as “deranged”⁸ and as victims of “madness”⁹ and “insanity.”¹⁰ He falsely claimed transgender identity was “never heard of in all of human history” and described transgender healthcare as “mutilation.”¹¹

113. President Trump’s campaign devoted substantial resources to promoting anti-transgender policies, spending approximately \$215 million on advertisements vilifying transgender Americans.¹² These advertisements comprised over 40 percent of all pro-Trump campaign messaging in the weeks before the 2024 election.¹³

wing-gender-insanity.

⁸ Gabriel Bertrand, *Trump’s Shocking Admission Exposes GOP’s Bigoted Agenda*, Medium (June 17, 2023), <https://medium.com/illumination/trumps-shocking-admission-exposes-gop-s-bigoted-agenda-e981becb2c5f>.

⁹ *President Trump’s Plan to Protect Children from Left-Wing Gender Insanity*, *supra* note 7.

¹⁰ Jackson Walker, *Trump vows to remove 'transgender insanity' and critical race theory from US schools*, IdahoNews (Dec. 23, 2024, 8:37AM), <https://idahonews.com/news/nation-world/trump-vows-to-remove-transgender-insanity-and-critical-race-theory-from-us-schools-phoeniz-arizona-woke-speech-usa-donald-president-white-house-education-department-crt-transgender-lgbt>; *Trump and Vance make anti-transgender attacks central to their campaign’s closing argument*, NBC News (Nov. 1, 2024, 10:23 AM), <https://www.nbcnews.com/nbc-out/out-politics-and-policy/donald-trump-jd-vance-transgender-2024-election-rcna178390>; Donald J. Trump, Truth Social (Dec. 18, 2023), <https://truthsocial.com/@realDonaldTrump/posts/111599880929254153>; Gabriel Bertrand, *supra* note 8; Joe Middleton, *Trump attacks transgender rights at Waco rally saying he will ban ‘disfigurement of our youth’*, The Independent (Mar. 26, 2023), <https://www.independent.co.uk/news/world/americas/donald-trump-transgender-waco-rally-b2308177.html>.

¹¹ *President Trump’s Plan to Protect Children from Left-Wing Gender Insanity*, *supra* note 7.

¹² Audrey Kemp, *What Trump’s win – and \$215m worth of anti-trans ads – mean for the future of campaigning*, The Drum (Nov. 6, 2024), <https://www.thedrum.com/news/2024/11/06/after-donald-trump-s-victory-marketers-weigh-their-role-countering-divisive>.

¹³ Lauren Barrón-López et al., *Why anti-transgender political ads are dominating the airwaves this election*, PBS News (Nov. 2, 2024 5:35 PM), <https://www.pbs.org/newshour/show/why-anti-transgender-political-ads-are-dominating-the-airwaves-this-election>.

114. President Trump’s official campaign platform included a “Plan to Protect Children from Left-Wing Gender Insanity,” which promised to deny legal recognition to transgender Americans and restrict access to medically necessary healthcare.¹⁴

115. On December 23, 2024, after winning the election, President Trump reaffirmed his intent to implement discriminatory policies through executive action, stating “with a stroke of [his] pen on day one,” he would “stop the transgender lunacy” and “get transgender out of the military and out of our elementary schools and middle schools and high schools.”¹⁵

116. Executive Order 14168, issued on President’s Trump’s first day in office, implements these campaign promises, demonstrating that the discriminatory animus expressed throughout his campaign was the driving force behind the Order's restrictions on medical care and housing for incarcerated transgender people.

117. The timing, content, and context of Executive Order 14168 demonstrate it was motivated by and implements the same discriminatory animus President Trump repeatedly expressed during his campaign, rather than any legitimate government purpose.

CLAIMS FOR RELIEF

COUNT I

Challenge to Sections 4(a) and 4(c) Fifth Amendment to the United States Constitution Due Process Clause - Deprivation of Equal Protection of the Laws Against All Defendants in Their Official Capacities

118. Plaintiffs incorporate all preceding paragraphs of the Complaint as though fully set forth herein.

¹⁴ *President Trump’s Plan to Protect Children from Left-Wing Gender Insanity*, *supra* note 7.

¹⁵ Azcentral.com and The Arizona Republic, *Turning Point USA Donald Trump full speech: The 'golden age of America' begins now, says Trump*, YouTube (Dec. 23, 2024), <https://www.youtube.com/watch?v=XuleXJw6BA8>, at 57:02-24.

119. Like the Equal Protection Clause of the Fourteenth Amendment, the Due Process Clause of the Fifth Amendment prohibits unwarranted discrimination by the federal government.

120. Sections 4(a) and 4(c) unjustifiably discriminate based on sex. They are facial sex classifications and use individuals' birth sex to determine their housing placements and available medical care. Section 4(a) compels the BOP to exclude "males" from "women's prisons." Section 4(c) prohibits the use of federal funds for any medical treatment prescribed "for the purpose of conforming an inmate's appearance *to that of the opposite sex*." Section 4(c)'s express purpose is to deter all medical treatment deemed inconsistent with birth sex.

121. Sections 4(a) and 4(c) require BOP to treat incarcerated people differently depending on their birth sex. Under section 4(a), transgender women must be transferred to a men's facility based on their birth sex, while other women may remain in women's facilities. Similarly, under Section 4(c), transgender women are prohibited from obtaining medical treatments that are permitted for other women.

122. Under the Fifth Amendment, sex classifications are subject to heightened scrutiny and are presumptively unconstitutional.

123. Sections 4(a) and 4(c) also discriminate based on transgender status. Section 4(a) requires dangerous transfers to men's facilities for all transgender women, solely because they are transgender. Section 4(c) denies medically necessary healthcare to transgender people, solely because they are transgender. Discrimination based on transgender status is sex discrimination subject to heightened scrutiny.

124. Classifications based on transgender status are also subject to heightened scrutiny because transgender people constitute a quasi-suspect class. Transgender people are a discrete and identifiable group of people with one shared distinguishing characteristic: they identify and

seek to live as a sex different than their birth sex. This defining characteristic bears no relation to a transgender person's ability to contribute to society. Nevertheless, transgender people have faced historical discrimination in law and in fact, and they have been unable to secure equality through the political process.

125. There is no legitimate penological purpose or other legitimate basis for Section 4(a)'s dangerous transfer requirement or Section 4(c)'s categorical healthcare ban.

126. Neither Section 4(a) nor Section 4(c) is narrowly tailored to further a compelling government interest or substantially related to an important government interest. Sections 4(a) and 4(c) are not even rationally related to a government interest. Accordingly, these aspects of Executive Order 14168 violate the Fifth Amendment.

127. Finally, Sections 4(a) and 4(c) are motivated by discriminatory animus and are unconstitutional under any level of scrutiny.

128. If Section 4(a) and 4(c) are implemented, Plaintiffs will suffer irreparable injury, including serious physical, psychological and emotional harm, mental anguish, distress, humiliation, and indignity.

COUNT II

Challenge to Section 4(a) Eighth Amendment to the United States Constitution Failure to Protect Against All Defendants in Their Official Capacities

129. Plaintiff incorporates all preceding paragraphs of the Complaint as though fully set forth herein.

130. Under the Eighth Amendment, Plaintiffs are entitled to be free from a known and substantial risk of serious harm while in BOP custody.

131. Transferring Plaintiffs to men’s prisons will pose a substantial risk of serious harm, including an extremely high risk of violence and sexual assault from other incarcerated people and BOP staff. In a men’s prison, Plaintiffs will also be at high risk of worsening gender dysphoria exacerbated by a lack of medical care, which can lead to serious physical and mental health conditions including severe depression and suicidality. These risks are obvious, well documented, and well known to BOP officials.

132. The risk of sexual violence to transgender people in prison is recognized in existing federal regulations. 28 C.F.R. § 115.41(d)(7) requires BOP officials to consider an individual’s transgender status as a factor increasing their “risk of sexual victimization.” An individual’s sexual victimization risk must be considered as part of all housing and transfer decisions. *Id.* §§ 115.41, 115.42(a). Decisions about whether to house a transgender person in a men’s or women’s facility must be made “on a case-by-case basis” to ensure the individual’s “health and safety” and the security of the facility. *Id.* § 115.42(c). Given the extremely high safety risks for transgender people in BOP custody, housing placements for transgender people “shall be reassessed at least twice each year to review any threats to [their] safety.” *Id.* § 115.42(d).

133. Section 4(a) of the Order contains a citation to 28 C.F.R. § 115.41, indicating that President Trump was aware of transgender women’s heightened risk of sexual victimization and the federal regulatory scheme that requires individualized housing placements to ensure their safety. Nevertheless, the Order intentionally directed the Attorney General to “amend[]” § 115.41 “as necessary” to ensure that all transgender women would be transferred to men’s facilities, no matter how dangerous, without regard for their individual safety and security. The

Order's intentional disregard of a known and substantial risk of serious harm to transgender women in BOP custody, including Plaintiffs, violates the Eighth Amendment.

134. Defendants are well aware of the grave risks Plaintiffs will face if they are transferred to men's prisons, but they are actively implementing Section 4(a) and have caused BOP officials to initiate Plaintiffs' transfers anyway. Their decision to disregard the known and substantial risks of serious harm violates Plaintiffs' rights under the Eighth Amendment.

135. If Section 4(a) is implemented, Plaintiffs will suffer irreparable injury, including serious physical, psychological and emotional harm, mental anguish, distress, humiliation, and indignity.

COUNT III

Challenge to Section 4(c) Eighth Amendment to the United States Constitution Medical Deliberate Indifference Against All Defendants in Their Official Capacities

136. Plaintiffs incorporates all preceding paragraphs of the Complaint as though fully set forth herein.

137. A prison official who has knowledge of an individual's serious need for medical care and intentionally refuses to provide that care acts with deliberate indifference and therefore violates the Eighth Amendment's prohibition on cruel and unusual punishment.

138. Plaintiffs have serious medical needs for hormone therapy as treatment for their gender dysphoria, which is a rare and serious health condition. Abrupt termination of this treatment would violate the applicable standard of care and subject Plaintiffs to a known and substantial risk of serious harm.

139. Terminating Plaintiffs' hormone therapy and other transition treatments would contravene their medical providers' consistent professional judgment that they need continuous

treatment for their gender dysphoria. Denying Plaintiffs this medically necessary healthcare would constitute deliberate indifference to their serious medical needs and would violate the Eighth Amendment's prohibition on cruel and unusual punishment.

140. Section 4(c) of the Order, which is being implemented by Defendants, establishes a blanket rule banning medically necessary treatments for all transgender people in BOP custody, without consideration of any individual's medical needs or their healthcare providers' independent medical judgment. As such, Section 4(c) constitutes deliberate indifference to the serious medical needs of all transgender people in BOP custody and violates the Eighth Amendment's prohibition on cruel and unusual punishment.

141. If Section 4(c) is implemented, Plaintiffs will suffer irreparable injury, including serious physical, psychological and emotional harm, mental anguish, distress, humiliation, and indignity.

COUNT IV

Challenge to Section 4(a) Rehabilitation Act of 1973, Section 504 Failure to Accommodate a Disability Against All Defendants in Their Official Capacities

142. Plaintiffs incorporate all preceding paragraphs of the Complaint as though fully set forth herein.

143. Plaintiffs have a current diagnosis of gender dysphoria as well as a record of gender dysphoria that is known to BOP officials.

144. Gender dysphoria is a serious medical condition that qualifies as a disability. It is a physical impairment that substantially limits the major life activities of interacting with others, reproduction, social and occupational functioning, and caring for oneself, among others.

145. Housing Plaintiffs in women’s facilities is a reasonable accommodation for their gender dysphoria and is part of the recommended treatment protocol set forth by the applicable standards of care and clinical practice guidelines.

146. Involuntarily transferring Plaintiffs to men’s facilities under Section 4(a) of the Order would be a cruel and unnecessary revocation of this reasonable accommodation and would deny them equal benefits of correctional and rehabilitative programs and services, including but not limited to safe housing, showers, and healthcare consistent with accepted medical standards. Accordingly, Section 4(a) violates Section 504 of the Rehabilitation Act of 1973.

147. If Section 4(a) is implemented, Plaintiffs will suffer irreparable injury, including serious physical, psychological and emotional harm, mental anguish, distress, humiliation, and indignity.

COUNT V

Challenge to Section 4(c) Rehabilitation Act of 1973, Section 504 Disability Discrimination Against All Defendants in Their Official Capacities

148. Plaintiffs incorporate all preceding paragraphs of the Complaint as though fully set forth herein.

149. Section 4(c) categorically bans medical treatments, regardless of medical need, if they are prescribed to “conform[] an inmate’s appearance to that of the opposite sex”—meaning treatments are banned only if they are prescribed to treat gender dysphoria.

150. Section 4(c) discriminates based on disability by excluding people with gender dysphoria, including Plaintiffs, from accessing medically necessary healthcare services that are provided to all other people in BOP custody based on medical need. Accordingly, Section 4(c) violates Section 504 of the Rehabilitation Act of 1973.

151. If Section 4(c) is implemented, Plaintiffs will suffer irreparable injury, including serious physical, psychological and emotional harm, mental anguish, distress, humiliation, and indignity.

COUNT VI

Challenge to Sections 4(a) and 4(c) Administrative Procedure Act Arbitrary and Capricious, Unlawful, and Unconstitutional Agency Action Taken Without Observance of Procedure Required By Law Against All Defendants in Their Official Capacities

152. Plaintiffs incorporate all preceding paragraphs of the Complaint as though fully set forth herein.

153. Defendants' actions to implement Sections 4(a) and 4(c) of the Executive Order constitute final agency action that has harmed Plaintiffs, affected their legal rights, and subjected them to an imminent risk of further harm.

154. Defendants' decision to transfer Plaintiffs to men's facilities and the imminent threat to deny their necessary medical care solely because of their birth sex and transgender status are unconstitutional and violate their federal statutory rights.

155. Defendants' decision to transfer Plaintiffs to men's facilities solely because of their birth sex and transgender status is arbitrary and capricious.

156. Defendants' decision to deny Plaintiffs medically necessary care to treat their gender dysphoria solely because of their birth sex and transgender status is arbitrary and capricious.

157. Defendants' decision to transfer Plaintiffs to men's facilities solely because of their birth sex and transgender status is contrary to law as set forth in 28 C.F.R. §§ 115.41–42 and in 29 U.S.C. § 794.

158. Defendants’ segregation of Plaintiffs in separate housing with only transgender women is contrary to law as set forth in 28 C.F.R. § 115.42(g) (“The agency shall not place lesbian, gay, bisexual, transgender, or intersex inmates in dedicated facilities, units, or wings solely on the basis of such identification or status, unless such placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such inmates.”).

159. For the transfer decision to comply with 28 C.F.R. §§ 115.41–42, amendments to 28 C.F.R. §§ 115.41–42 would have to be made through notice-and-comment rulemaking. Section 4(a) directs the Attorney General to make such an “amendment,” but no amendment has been made at this time. Defendants’ decision to transfer Plaintiffs prior to a valid amendment to 28 C.F.R. §§ 115.41–42 was made without observance of procedure required by law.

160. Defendants’ decision to transfer Plaintiffs without conducting an individualized assessment of all relevant circumstances, including their safety, was made without observance of procedure required by law.

161. If Sections 4(a) and 4(c) are implemented, Plaintiffs will suffer irreparable injury, including serious physical, psychological and emotional harm, mental anguish, distress, humiliation, and indignity.

COUNT VII

Challenge to Section 4(c) Violation of Separation of Powers Ultra Vires Presidential Action in Excess of Authority Usurping the Legislative Function Violation of Bicameralism and Presentment Clauses Against All Defendants in Their Official Capacities

162. Plaintiffs incorporate all preceding paragraphs of the Complaint as though fully set forth herein.

163. Defendants, as part of the Executive branch of the United States government, cannot directly and unilaterally amend or cancel appropriations Congress has duly enacted, nor can Defendants order federal agencies to do so.

164. BOP receives federal funds to provide necessary medical care to incarcerated people, including medically necessary treatment for gender dysphoria. Section 4(c) of the Executive Order directs the withholding of this funding: by its terms, the Attorney General “shall ensure that no Federal funds are expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate’s appearance to that of the opposite sex.” The Executive Order issues this directive without regard to any statute regarding funds appropriated to the Bureau of Prisons, or any applicable regulations.

165. By directing the Bureau of Prisons to terminate or withhold congressionally appropriated funds based on the President’s own policy preferences, Section 4(c) of the Executive Order attempts to amend, repeal, rescind, or circumvent duly enacted federal appropriations.

166. By directing the Bureau of Prisons to terminate or withhold congressionally appropriated funds, Section 4(c) of the Executive Order attempts to allocate public funds to advance the President’s policy preferences, rather than those of Congress. These actions exceed the President’s Article II powers, unconstitutionally infringe upon Congress’s powers, and attempt to amend federal legislation while bypassing Article I’s Bicameralism and Presentment Clauses.

167. Pursuant to 28 U.S.C. § 2201, Plaintiffs are entitled to a declaration that Section 4(c) of the Executive Order violates the separation of powers and impermissibly arrogates to the Executive power that is reserved to Congress.

168. Plaintiffs are further entitled to an injunction preventing Defendants from enforcing or implementing Section 4(c) of the Executive Order.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs request that this Court grant the following relief:

- (1) Issue a judgment under 28 U.S.C. §§ 2201–02 declaring that Sections 4(a) and 4(c) of Executive Order 14168 violate Plaintiffs’ rights under the Fifth and Eighth Amendments to the United States Constitution, the Rehabilitation Act of 1973, the Administrative Procedure Act, and the United States Constitution’s division of powers among the separate branches of government, for the reasons and on the Counts set forth above;
- (2) Enter a preliminary and permanent injunction prohibiting Defendants and their officers, employees, servants, agents, appointees, and successors from implementing Sections 4(a) and 4(c) of Executive Order 14168, and requiring Defendants to maintain Plaintiffs’ housing and medical treatment consistent with the status quo before January 20, 2025;
- (3) Award Plaintiffs damages, as well as their costs, expenses, and reasonable attorneys’ fees pursuant to 28 U.S.C. § 2412, 42 U.S.C. § 12205, and other applicable laws; and
- (4) Grant such other and further relief as the Court deems just and proper.

Dated: March 14, 2025

/s/ Kara Janssen

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Attorneys for Plaintiffs

**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

JANE DOE, et al.,

Plaintiffs,

v.

Case No.: 1:25-cv-00286-RCL

PAMELA BONDI, *in her official capacity as*
Attorney General of the United States;
WILLIAM LOTHROP, *in his official*
capacity as Acting Director of the Federal
Bureau of Prisons,

Defendants.

**DECLARATION OF KARA JANSSEN IN SUPPORT OF
PLAINTIFFS' MOTIONS FOR A TEMPORARY RESTRAINING ORDER AND TO
PROCEED UNDER PSEUDONYM**

I, Kara Janssen, of full age, do hereby declare as follows:

1. I am an senior counsel with Rosen Bien Galvan & Grunfeld LLP and admitted to practice law in the District of Washington, D.C on this matter *pro hac vice*.

2. I make the following declaration based on personal knowledge and pursuant to F.R.C.P. 65(b).

3. Plaintiffs Rachel Doe and Ellen Doe are transgender women incarcerated in Bureau of Prison's facilities.

4. Plaintiffs Rachel Doe and Ellen Doe had been housed in women's units before the issuance of Executive Order 14168. Even though BOP has recognized Plaintiffs as women during their incarceration, they have now been transferred to men's prisons.

5. Plaintiffs are transgender women who have been diagnosed with gender dysphoria and have maintained medically necessary hormone treatment for their gender dysphoria for years.

6. Plaintiffs file this Emergency Motion for a Temporary Restraining Order, which seeks to preserve the status quo prior to their transfer to men's facilities pursuant to the Executive Order, while the parties litigate the lawfulness of certain provisions of the Executive Order. Plaintiffs, through counsel, notified Defendants' counsel of their intent to file an amended complaint and motion for temporary restraining order and preliminary injunction on March 13, 2025.

7. In conjunction with the Second Amended Complaint and Motion, Plaintiffs' counsel also filed a Motion To Proceed Under a Pseudonym. This motion is based on the specific potential harms that would follow from revealing Plaintiffs' identities, including the potential risk to them of violence in the corrections system and the violation of their interests in maintaining privacy of their medical status, history, and records.

8. Pursuant to the protective order in this case, Plaintiffs have also filed redacted versions of documents. All redactions proposed for the partially sealed documents stem from the necessity to protect Plaintiffs' identities, as set forth below.

9. The locations and dates of the Plaintiffs' current and former correctional facilities are redacted because of the limited number of incarcerated transgender women at those facilities. If the facilities and time periods when Plaintiffs were there were identified, Plaintiffs' identities could be easily surmised from among a small number of transgender women at those facilities.

10. Specific biographical details concerning Plaintiffs are redacted, including their current and former names and dates of birth. Any one of these details would also provide an easy means of identification with minimal internet or public records research.

11. Details of Plaintiffs' medical records, medical treatment, and mental health issues outside of their gender dysphoria treatment are redacted because the confluence of these records

would serve to easily identify Plaintiffs to those that are aware of their other medical diagnosis/diagnoses.

12. Certain details about Plaintiffs' time in federal correctional facilities are redacted, including the period of their incarceration, any disciplinary record, harms they experienced, rehabilitation activities, and medical care they have received. Individuals within the correctional facility or those with whom they might communicate are likely aware of these details of Plaintiffs' time in federal custody and would be able to guess their identities if they were left unredacted.

Pursuant to 28 U.S.C. § 1746, I affirm under penalty of perjury that the above statements are true and correct.

Dated: March 14, 2025

/s/ Kara Janssen
Kara Janssen

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**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

JANE DOE, et al.,

Plaintiffs,

v.

Case No.: 1:25-cv-00286-RCL

PAMELA BONDI, *in her official capacity as*
Attorney General of the United States;
WILLIAM LOTHROP, *in his official*
capacity as Acting Director of the Federal
Bureau of Prisons,

Defendants.

DECLARATION OF ELLEN DOE

I, Ellen Doe, declare:

1. I am a party in the above-entitled action. I have personal knowledge of the facts set forth herein, and if called as a witness, I could and would competently so testify.

2. I am currently incarcerated in the Bureau of Prisons. I am submitting this declaration in support of my request for relief. I am using the pseudonym Ellen Doe to protect myself.

3. I am a transgender woman. I was born male, but I have felt female for a very long time.

4. I was diagnosed with gender dysphoria [REDACTED]

[REDACTED]
[REDACTED] I have taken prescribed hormone medication for years to treat my gender dysphoria. [REDACTED]

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5. I felt safe at [REDACTED]. After the President issued the Executive Order about transgender prisoners, staff told me that they were going to taper me off my hormone medication. So far, I am still receiving my hormone medication but I am very afraid that the BOP will stop providing it.

6. On or about [REDACTED], staff at [REDACTED] told me that I was being shipped to a men's prison as soon as possible. This was terrifying to me. I have been in men's prisons before and they were not safe for me. I was constantly propositioned by other inmates when I was in men's facilities and I was very afraid that I might be attacked.

7. Shortly after that I was put on a chartered plane and flown to the [REDACTED]. I was then flown to [REDACTED] to be housed with men. When I arrived at [REDACTED], two male officers, with no female officer present, did a visual strip search of me when I did not have any clothes on. While I was naked, they directed me to bend over, squat, cough, and lift my breasts in front of them. I have had a very hard time processing this transfer. I cry all the time and am having nightmares. I do not feel safe and am afraid I will be attacked.

8. Men keep coming up to me to ask for sexual favors and to proposition me. I am afraid that one of them will sexually assault me. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] I am on edge all the time and feel like I can never let down my guard.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge. I spoke with counsel on March 13 and due to time constraints that prevented me from signing by mail and my current inability to

receive documents to sign electronically I could not personally sign this declaration and have authorized counsel to sign on my behalf.

Executed in San Francisco, California this 14th day of March, 2025.

/s/ Kara Janssen

Ellen Doe c/o Kara Janssen

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**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

JANE DOE, et al.,

Plaintiffs,

v.

Case No.: 1:25-cv-00286-RCL

PAMELA BONDI, *in her official capacity as*
Attorney General of the United States;
WILLIAM LOTHROP, *in his official*
capacity as Acting Director of the Federal
Bureau of Prisons,

Defendants.

DECLARATION OF RACHEL DOE

I, Rachel Doe, declare:

1. I am a party in the above-entitled action. I have personal knowledge of the facts set forth herein, and if called as a witness, I could and would competently so testify.

2. I am currently incarcerated in the Bureau of Prisons. I am submitting this declaration in support of my request for relief. I am using the pseudonym Rachel Doe to protect myself.

3. I am a transgender woman. I was born male, but I have always felt female.

4. I was diagnosed with gender dysphoria in [REDACTED] and started receiving medical treatment around that same time.

5. [REDACTED]

6. [REDACTED]

[REDACTED]. I am prescribed hormone medication to treat my gender dysphoria. [REDACTED]

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[REDACTED]

7. I was housed with women in federal custody [REDACTED]

[REDACTED]. For most of that time, I was at [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

8. Then, about [REDACTED] after arriving in [REDACTED], BOP transferred me from the women's unit to the men's unit. [REDACTED]

[REDACTED]

9. Being housed with men in [REDACTED] was horrible. [REDACTED]

[REDACTED] I already faced a high propensity of violence as a transgender woman in a men's unit and knowing this information made me even more afraid. [REDACTED]

[REDACTED], it became a whole different ballgame when it comes to safety. I have been frightened of being assaulted this entire time.

10. Because of the Executive Order, BOP then decided to send me from [REDACTED] [REDACTED]. When I was leaving [REDACTED], I had to dress out. Two male officers, with no female officer present, did the strip search. I had to bend over, squat, cough, and lift my breasts in front of them. It was humiliating and degrading. I was sick to stomach and felt like I might vomit when it was happening. I had never been strip searched by male officers before.

11. I was then transferred to [REDACTED], which is a men's prison. Being housed with men is terrifying. When I walk to main line to go eat, the men stare, whistle, clap, and knock on

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their windows.

12. In addition to the constant sexual innuendos and harassment, I have been repeatedly propositioned for sex. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] These men are scaring me and I fear I will be attacked.

13. I reported these incidents to staff [REDACTED]

[REDACTED]. This still does not make me feel safe.

14. Since arriving at [REDACTED], I have not received any of my medical treatment. I have not received my hormone medication [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

15. I also have been denied a bra and women's underwear. [REDACTED]

[REDACTED] I feel like men stare at me even more because I do not have any support.

16. I am frightened that I will be sexually assaulted while being housed with men. I am also very concerned about what will happen to my body and my health without any hormone medication.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge. I spoke with counsel on March 13 and due to time constraints that prevented me from signing by mail and my current inability to receive documents to sign electronically I could not personally sign this declaration and have authorized counsel to sign on my behalf.

Executed in San Francisco, California this 14 day of March, 2025.

/s/ Kara Janssen

Rachel Doe c/o Kara Janssen

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**UNITED STATES DISTRICT COURT
DISTRICT OF COLUMBIA**

**JANE DOE; MARY DOE
SARA DOE; EMILY DOE;
ZOE DOE; TORI DOE;
OLIVIA DOE; SUSAN DOE;
LOIS DOE; SOPHIA DOE;
SALLY DOE; WENDY
DOE, RACHEL DOE; and
ELLEN DOE**

Plaintiffs,

Civil Action No. 1:25-cv-00286

v.

PAMELA BONDI, et al.,

Defendants.

**DECLARATION OF [REDACTED],
HEALTH SERVICES ADMINISTRATOR
[REDACTED]**

I, [REDACTED], declare and state as follows:

1. I am currently employed by the Federal Bureau of Prisons (Bureau) as the Health Services Administrator at [REDACTED]. I assumed this position in [REDACTED]

2. Prior to becoming the Health Services Administrator, I worked in positions of increasing responsibility at [REDACTED], including as [REDACTED] and [REDACTED].

3. As part of my official duties, I have access to records maintained in the ordinary course of business by the Bureau, including inmate medical and mental health records.

4. The information below is based upon my personal knowledge and upon information I received as part of my official duties.

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5. Plaintiffs Rachel Doe and Ellen Doe arrived at [REDACTED] on [REDACTED].

6. Ellen Doe is currently receiving hormone treatments at [REDACTED] and there are no plans to discontinue treatment.

7. Prior to arriving at [REDACTED], Rachel Doe had an active prescription for a daily dose of 2 mg of estradiol pills. Rachel Doe received a dose of 2 mg of estradiol when Rachel arrived at [REDACTED] on [REDACTED].

8. After receiving the dose of estradiol on [REDACTED], Rachel Doe refused to take the medication until Rachel Doe was able to speak with certain medical staff members. Rachel Doe did come to the pill line to receive other medications but refused to accept the estradiol pills.

9. Rachel Doe has since met with the medical staff at [REDACTED], and will continue to receive estradiol, but due to [REDACTED], Rachel Doe's prescription is being changed to an estradiol patch. Rachel Doe will no longer receive oral tablets of estradiol.

10. Rachel Doe was also given a physical exam by the medical staff at [REDACTED]

[REDACTED] A [REDACTED]
[REDACTED] The medical staff found that normal routine care is all that is necessary at this time pending receipt of outside medical records, and that Rachel Doe will be monitored accordingly.

In accordance with 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Dated: March 17, 2025 [REDACTED]

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**UNITED STATES DISTRICT COURT
DISTRICT OF COLUMBIA**

**JANE DOE; MARY DOE
SARA DOE; EMILY DOE;
ZOE DOE; TORI DOE;
OLIVIA DOE; SUSAN DOE;
LOIS DOE; SOPHIA DOE;
SALLY DOE; WENDY
DOE, RACHEL DOE; and
ELLEN DOE**

Plaintiffs,

Civil Action No. 1:25-cv-00286

v.

PAMELA BONDI, et al.,

Defendants.

**DECLARATION OF [REDACTED]
ASSOCIATE WARDEN
[REDACTED]**

I, [REDACTED] declare and state as follows:

1. I am currently employed by the Federal Bureau of Prisons (Bureau) as an Associate Warden at [REDACTED] I assumed this position in [REDACTED]

2. Prior to becoming an Associate Warden, I worked in positions of increasing responsibility within the Bureau, most recently as [REDACTED]
[REDACTED]

3. As part of my official duties, I have access to records maintained in the ordinary course of business by the Bureau, including inmate investigative files.

4. The information below is based upon my personal knowledge and upon information I received as part of my official duties.

MATERIAL UNDER SEAL DELETED

5. The Bureau carefully reviewed the files of Rachel Doe and Ellen Doe, prior to transferring the plaintiffs to a low security male facility.

6. In determining the most appropriate placement for the two plaintiffs, the Bureau took into consideration those two inmates' assigned security level, disciplinary record, medical record, and psychology record.

7. The Bureau found that [REDACTED]
[REDACTED] would be the most appropriate placement for both plaintiffs.

8. Plaintiffs Rachel Doe and Ellen Doe arrived at [REDACTED].

9. Since arriving at [REDACTED], Ellen Doe has not made any complaints of sexual harassment.

10. Rachel Doe reported receiving a note that was sexual in nature from an unknown inmate and was therefore interviewed by Special Investigative Services (SIS).

11. Rachel Doe indicated to SIS that Rachel did not feel threatened or concerned. Rachel also did not know who wrote or gave the note, as it was thrown on Rachel's lap while Rachel was watching TV.

12. Rachel Doe has been living in general population and attending recreation without issue.

In accordance with 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Dated: March 17, 2025

[REDACTED]

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JANE DOE, *et al.*,

Plaintiffs,

v.

PAMELA BONDI, in her official capacity as
Attorney General of the United States, *et al.*,

Defendants.

Case No. 1:25-cv-286-RCL

ORDER

On February 18, 2025, this Court entered a preliminary injunction enjoining the enforcement of Sections 4(a) and 4(c) of Executive Order 14168 against a group of transgender women on Eighth Amendment grounds. *See* Preliminary Injunction, ECF No. 44; *see also Doe v. McHenry*, No. 25-cv-286-RCL, 2025 WL 388218 (D.D.C. Feb. 4, 2025) (discussing the Eighth Amendment implications of the Executive Order and granting a temporary restraining order). On February 21, the plaintiffs filed a Motion to extend that preliminary injunction to a group of additional plaintiffs, *see* ECF No. 50, which the Court granted on February 24. *See Doe v. Bondi*, No. 25-cv-286-RCL, 2025 WL 596653 (D.D.C. Feb. 24, 2025).

On March 14, 2025, the plaintiffs moved with the consent of the defendants to file a Second Amended Complaint in this dispute. *See* Consent Mot. for Leave to File, ECF No. 58. The Second Amended Complaint is substantially identical to the First Amended Complaint, except that it adds two additional plaintiffs, Rachel Doe and Ellen Doe. The new plaintiffs are in most respects similarly situated to the other plaintiffs in this suit, with one exception: while the other plaintiffs were pending transfer to a male penitentiary when the Court ruled on their motions for a

preliminary injunction, these new plaintiffs have already been transferred to male facilities. *See* Second Amended Compl. ¶¶ 45, 50, ECF No. 58-2.

The plaintiffs have now moved for a preliminary injunction to enjoin enforcement of the Executive Order against them and to have them returned to female prison facilities. Mot. for PI, ECF No. 66.¹ The Motion repeats the plaintiffs' previous arguments against the Executive Order, but adds new factual grounds for their claims which arise from the new plaintiffs' different circumstances. First, the plaintiffs allege that BOP has already halted new plaintiff Rachel Doe's hormone therapy, unlike the earlier plaintiffs who were only threatened with discontinuation of their therapy. Mot. for PI at 2. Second, the new plaintiffs allege that they have actually been subjected to sexual harassment at their new facilities. *Id.*; *see also* Decl. of Ellen Doe ¶ 8, Mot. for TRO² Attach. 1, ECF No. 61-3; Decl. of Rachel Doe ¶ 11-12, Mot. for TRO Attach. 2, ECF No. 61-4. Third, the new plaintiffs allege that since their transfer to a male facility they have been unable to access bras and women's underwear. Mot. for PI at 2. Fourth and finally, the new plaintiffs allege that they have been subject to strip searches by male prison officials without female officials present. *Id.* at 2. In a sealed Response, the defendants contest each of these new claims on either factual or legal grounds. ECF No. 64.

The Court need not dwell on these arguments at this time because, even supposing that the defendant is correct that each of the plaintiffs' new arguments is either factually or legally defunct, the new plaintiffs are at least as strongly situated, in terms of the merits of their Eighth Amendment claims, as the existing plaintiffs. Moreover, the fact that they have already been transferred and,

¹ The plaintiffs originally styled this as a motion for a temporary restraining order. *See* Mot. for TRO, ECF No. 61. Then, per the Government's suggestion and after discussion with the Court, the plaintiffs filed a motion to convert the original TRO motion into a Motion for a Preliminary Injunction. *See* Mot. to Convert, ECF No. 66. The Court therefore addresses this motion in the posture of a preliminary injunction request, rather than a TRO.

² The declarations are attached to Plaintiffs original motion for a TRO, rather than the converted PI Motion.

allegedly, have been abused at their new facilities can only strengthen their claims of irreparable harm. The final two prongs of the preliminary injunction analysis—the balance of the equities and the public interest in the injunction—are at least unchanged from the Court’s previous temporary restraining order and preliminary injunction analyses, or at most have tilted further in the plaintiffs’ favor. Therefore, the Court is satisfied that preliminary injunctive relief is appropriate for the two new plaintiffs, for the same reasons that it was appropriate for the existing ones.

The Court determines that it is appropriate in this case to enter a preliminary injunction, rather than a temporary restraining order. The Government has communicated its view that, should the Court decide that some form of preliminary injunctive relief is necessary, the Court should enter a preliminary injunction rather than TRO. A preliminary injunction is the better form of relief here because the factual circumstances underlying this dispute are unlikely to significantly change before a TRO would expire, and because judicial economy counsels in favor of situating the new plaintiffs similarly to their existing counterparts, rather than revisiting their specific circumstances alone in two weeks’ time.

In accordance with the Prison Litigation Reform Act, the Court finds that this preliminary injunction is narrowly drawn, extends no further than necessary to correct the violation of plaintiffs’ federal rights, and is the least intrusive means necessary to correct the violation of the plaintiffs’ federal rights. 18 U.S.C. § 3626(a)(1). Plaintiffs have shown a substantial likelihood of success on their claims that implementation of sections 4(a) and 4(c) of the Executive Order is or will be unlawful as to them and has caused or will cause them immediate and irreparable harm. A preliminary injunction reversing and preventing the implementation of those sections as to these plaintiffs is necessary to correct the violation of their rights and is the least intrusive means to do so. Furthermore, because this preliminary injunction prevents the implementation of only those

sections of the Executive Order for which the plaintiffs have demonstrated a likelihood of success on the merits and immediate, irreparable harm, this order extends no further than necessary to correct the violation.

Finally, this Court has considered any adverse impact on public safety or on the operation of the criminal justice system caused by this relief, given substantial weight to such impacts, and has concluded and finds that no adverse impacts on public safety or the operation of the criminal justice system will result from reinstating and maintaining the previous status of the plaintiffs' medical care and housing while the litigation proceeds.

Therefore, upon consideration of the plaintiffs' Consent Motion for Leave to File, their Motion for a Preliminary Injunction, the opposition thereto, and the entire record herein, and for the reasons contained in this Order and in the Court's prior Orders granting TROs and preliminary injunctions in this dispute, it is hereby

ORDERED that the Motion for Leave to File is **GRANTED**; and it is further

ORDERED that the Plaintiffs' Motion for a Preliminary Injunction is **GRANTED**; and it is further

ORDERED that the defendants are enjoined and restrained from implementing sections 4(a) and 4(c) of Executive Order 14168 with regard to plaintiffs Rachel Doe and Ellen Doe, pending further Order of this Court; and it is further

ORDERED that the Defendants shall immediately transfer plaintiffs Rachel Doe and Ellen Doe back to women's penitentiaries and reinstate or continue their gender dysphoria treatment, pending further Order of this Court.

Date: March 19, 2025

12:30 p.m.



Royce C. Lamberth
United States District Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JANE DOE, *et al.*,

Plaintiffs,

v.

PAMELA BONDI, in her official
capacity as Attorney General of the
United States, *et al.*,

Defendants.

Civil Docket No. 1:25-cv-286

NOTICE OF APPEAL

Defendants hereby appeal to the United States Court of Appeals for the District of Columbia Circuit from the Court's Order granting Plaintiffs' February 3, 2025, (publicly filed) Motion for Emergency Temporary Restraining Order and Preliminary Injunction (ECF No. 44), the Court's Order granting Plaintiffs' February 21, 2025, Motion for a Temporary Restraining Order and Expanded Preliminary Injunction (ECF No. 55), and the Court's Order granting Plaintiffs' Motion to Convert Pending Motion for Further Temporary Restraining Order to Motion for Further Preliminary Injunction or Temporary Restraining Order (ECF No. 68).

Dated: April 2, 2025

Respectfully submitted,

YAAKOV M. ROTH
Acting Assistant Attorney General

ALEX HAAS
Director, Federal Programs Branch

JEAN LIN
Special Litigation Counsel

/s/ Elizabeth B. Layendecker
ELIZABETH B. LAYENDECKER

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Counsel for Defendants

**U.S. District Court
District of Columbia (Washington, DC)
CIVIL DOCKET FOR CASE #: 1:25-cv-00401-RCL**

JONES v. TRUMP et al
Assigned to: Judge Royce C. Lamberth
Related Case: 1:25-cv-00286-RCL
Case in other court: USCA, 25-05101
Cause: 28:1331 Fed. Question: Violation 5th & 8th Amendme
Plaintiff

JANE JONES

Date Filed: 02/10/2025
Jury Demand: None
Nature of Suit: 550 Prisoner Petition: Civil
Rights (Other)
Jurisdiction: U.S. Government Defendant

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V.

Defendant

DONALD J. TRUMP

*in his official capacity as President of the
United States*

TERMINATED: 02/28/2025

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Date Filed	#	Docket Text
02/10/2025	<u>1</u>	COMPLAINT (<i>REDACTED</i>) against All Defendants (Filing fee \$ 405 receipt number ADCDC-11470734) filed by JANE JONES. (Attachments: # <u>1</u> Civil Cover Sheet)(Delgado, Jennifer) (Entered: 02/10/2025)
02/10/2025	<u>2</u>	NOTICE OF RELATED CASE by JANE JONES. Case related to Case No. 1:25-cv-286 and Moe v Trump, 1:25-cv-10195 (D. Mass). (Delgado, Jennifer) (Main Document 2 replaced on 2/11/2025) (znmw). (Entered: 02/10/2025)
02/11/2025	<u>3</u>	SEALED MOTION for Leave to Proceed Under Pseudonym <i>Proceed Under Pseudonym, Seal Documents, and for a Protective Order</i> by JANE JONES. (Delgado, Jennifer) Modified event on 2/11/2025 (znmw). (Entered: 02/11/2025)
02/11/2025	<u>4</u>	MEMORANDUM re <u>3</u> MOTION for Leave to Proceed Under Pseudonym , <i>Proceed Under Pseudonym and for a Protective Order</i> filed by JANE JONES by JANE JONES. (Delgado, Jennifer) (Entered: 02/11/2025)
02/11/2025	<u>5</u>	DECLARATION of <i>Jennifer Fiorica Delgado (REDACTED)</i> by JANE JONES re <u>3</u> MOTION for Leave to Proceed Under Pseudonym , <i>Proceed Under Pseudonym and for a Protective Order</i> . (Delgado, Jennifer) (Entered: 02/11/2025)
02/11/2025	<u>6</u>	DECLARATION of <i>Jane Jones (REDACTED)</i> by JANE JONES re <u>3</u> MOTION for Leave to Proceed Under Pseudonym , <i>Proceed Under Pseudonym and for a Protective Order</i> . (Delgado, Jennifer) (Entered: 02/11/2025)
02/11/2025	<u>7</u>	DECLARATION of <i>Lauren B. Meade M.D. and Curriculum Vitae</i> by JANE JONES re <u>3</u> MOTION for Leave to Proceed Under Pseudonym , <i>Proceed Under Pseudonym and for a Protective Order</i> . (Delgado, Jennifer) (Entered: 02/11/2025)
02/11/2025	<u>8</u>	NOTICE of Proposed Order by JANE JONES re <u>3</u> MOTION for Leave to Proceed Under Pseudonym , <i>Proceed Under Pseudonym and for a Protective Order</i> (Delgado, Jennifer) (Entered: 02/11/2025)
02/11/2025		NOTICE OF NEW CASE ERROR regarding <u>1</u> Complaint. The following error(s) need correction: Incorrect civil cover sheet. Please file the Civil Cover Sheet (JS44) form at www.dcd.uscourts.gov/new-case-forms & file using the event Civil Cover Sheet. For future filings, all parts of a motion must be uploaded to one motion docket entry, not filed separately. COMPLIANCE DEADLINE is by close of business today. This case will not proceed any further until all errors are satisfied. (znmw) (Entered: 02/11/2025)
02/11/2025	<u>9</u>	CIVIL COVER SHEET by JANE JONES filed by JANE JONES.(Delgado, Jennifer) (Main Document 9 replaced on 2/11/2025) (znmw). (Entered: 02/11/2025)
02/11/2025	<u>10</u>	WITHDRAWN PURSUANT TO NOTICE FILED 2/14/2025..... MOTION for Leave to Appear Pro Hac Vice :Attorney Name- Jennifer L. Levi, Filing fee \$ 100, receipt number ADCDC-11473108. Fee Status: Fee Paid. by JANE JONES. (Attachments: # <u>1</u> Declaration, # <u>2</u> Exhibit Certificate of Good Standing, # <u>3</u> Text of Proposed Order)(Delgado, Jennifer) Modified on 2/14/2025 (znmw). (Entered: 02/11/2025)

02/11/2025	<u>11</u>	MOTION for Leave to Appear Pro Hac Vice :Attorney Name- Markiana J. Julceus, Filing fee \$ 100, receipt number ADCDC-11473201. Fee Status: Fee Paid. by JANE JONES. (Attachments: # <u>1</u> Declaration, # <u>2</u> Exhibit Certificate of Good Standing, # <u>3</u> Text of Proposed Order)(Delgado, Jennifer) (Entered: 02/11/2025)
02/11/2025	<u>12</u>	MOTION for Leave to Appear Pro Hac Vice :Attorney Name- Wayne Fang, Filing fee \$ 100, receipt number ADCDC-11473211. Fee Status: Fee Paid. by JANE JONES. (Attachments: # <u>1</u> Declaration, # <u>2</u> Exhibit Certificate of Good Standing, # <u>3</u> Text of Proposed Order)(Delgado, Jennifer) (Entered: 02/11/2025)
02/13/2025	<u>13</u>	MOTION for Leave to Appear Pro Hac Vice :Attorney Name- Sarah K. Austin, Filing fee \$ 100, receipt number ADCDC-11479751. Fee Status: Fee Paid. by JANE JONES. (Attachments: # <u>1</u> Declaration, # <u>2</u> Exhibit Certificate of Good Standing, # <u>3</u> Text of Proposed Order)(Delgado, Jennifer) (Entered: 02/13/2025)
02/13/2025	<u>14</u>	MEMORANDUM OPINION AND ORDER: The Court accordingly ORDERS that: 1) Plaintiff's <u>3</u> Motion to Proceed Under Pseudonym, Partially Seal Documents, and for a Protective Order is GRANTED; 2) All parties shall use the pseudonym listed in the Complaint and redact information that would identify Plaintiff in all documents filed in this action; 3) Defendants shall not disclose Plaintiff's identity to any third party unless such disclosure is necessary to defend against this action; 4) Plaintiff's <u>1</u> redacted Complaint shall remain on the public docket; and 5) Within five days of this Order, Plaintiff shall file on the public docket: a) An unredacted version of her Complaint, filed under seal; and b) A declaration containing her real name and residential address, filed under seal. Signed by Chief Judge James E. Boasberg on 2/13/2025. (lcjeb4) (Entered: 02/13/2025)
02/14/2025	<u>15</u>	ENTERED IN ERROR....NOTICE OF WITHDRAWAL OF MOTION by JANE JONES re <u>10</u> MOTION for Leave to Appear Pro Hac Vice :Attorney Name- Jennifer L. Levi, Filing fee \$ 100, receipt number ADCDC-11473108. Fee Status: Fee Paid. (Delgado, Jennifer) Modified on 2/18/2025 (zdp). (Entered: 02/14/2025)
02/14/2025		Case Assigned to Judge Royce C. Lamberth. (znmw) (Entered: 02/14/2025)
02/14/2025		NOTICE OF NEW CASE ERROR regarding <u>1</u> Complaint. The following error(s) need correction: Missing summonses- U.S. government. When naming a U.S. government agent or agency as a defendant, you must supply a summons for each defendant & two additional summonses for the U.S. Attorney & U.S. Attorney General. Please submit using the event Request for Summons to Issue. (znmw) (Entered: 02/14/2025)
02/18/2025		NOTICE OF ERROR regarding <u>15</u> Notice of Withdrawal of Motion. The following error(s) need correction: Incorrect format (Letter)- correspondence is not permitted (LCvR 5.1(a)). Please refile. (zdp) (Entered: 02/18/2025)
02/18/2025	<u>16</u>	REQUEST FOR SUMMONS TO ISSUE filed by JANE JONES. (Attachments: # <u>1</u> Summons, # <u>2</u> Summons, # <u>3</u> Summons)(Delgado, Jennifer) (Entered: 02/18/2025)
02/18/2025	<u>17</u>	NOTICE OF WITHDRAWAL OF MOTION by JANE JONES (Delgado, Jennifer) (Entered: 02/18/2025)
02/18/2025	<u>18</u>	SEALED DOCUMENT filed by JANE JONES re <u>14</u> Order,,, Memorandum & Opinion,,, (This document is SEALED and only available to authorized persons.)(Delgado, Jennifer) (Entered: 02/18/2025)
02/18/2025	<u>19</u>	SEALED DOCUMENT filed by JANE JONES re <u>14</u> Order,,, Memorandum & Opinion,,, (This document is SEALED and only available to authorized persons.)(Delgado, Jennifer) (Entered: 02/18/2025)
02/20/2025	<u>20</u>	SUMMONS (4) Issued Electronically as to WILLIAM LOTHROP, JAMES R. MCHENRY, III, DONALD J. TRUMP, AND U.S. Attorney (zdp) (Entered: 02/20/2025)
02/21/2025	<u>21</u>	MOTION for Temporary Restraining Order , MOTION for Preliminary Injunction by JANE JONES. (Attachments: # <u>1</u> Memorandum in Support (REDACTED), # <u>2</u> Declaration of Jennifer Fiorica Delgado (REDACTED), # <u>3</u> Declaration of Jane Jones (REDACTED), # <u>4</u> Declaration of Lauren B Meade M.D. and Curriculum Vitae, # <u>5</u> Text of Proposed Order)(Delgado, Jennifer) (Entered: 02/21/2025)

02/21/2025	<u>22</u>	SEALED DOCUMENT filed by JANE JONES(This document is SEALED and only available to authorized persons.) (Attachments: # <u>1</u> Declaration of Jennifer Fiorica Delgado, # <u>2</u> Declaration of Jane Jones)(Delgado, Jennifer) (Entered: 02/21/2025)
02/21/2025	<u>23</u>	DECLARATION of Jennifer Fiorica Delgado (Supplemental) by JANE JONES re <u>21</u> MOTION for Temporary Restraining Order MOTION for Preliminary Injunction . (Attachments: # <u>1</u> Exhibit A – Email exchange (REDACTED))(Delgado, Jennifer) (Entered: 02/21/2025)
02/22/2025	<u>24</u>	Memorandum in opposition to re <u>21</u> Motion for TRO,, Motion for Preliminary Injunction, (Redacted) filed by DONALD J. TRUMP, JAMES R. MCHENRY, III, WILLIAM LOTHROP. (Attachments: # <u>1</u> Declaration of Rick Stover, # <u>2</u> Text of Proposed Order)(Robinson, John) (Entered: 02/22/2025)
02/22/2025	<u>25</u>	SEALED MOTION FOR LEAVE TO FILE DOCUMENT UNDER SEAL filed by DONALD J. TRUMP, JAMES R. MCHENRY, III, WILLIAM LOTHROP (This document is SEALED and only available to authorized persons.) (Attachments: # <u>1</u> Defendants' Response to Plaintiff's Motion for TRO, # <u>2</u> Declaration of Rick Stover, # <u>3</u> Text of Proposed Order)(Robinson, John) (Entered: 02/22/2025)
02/24/2025	<u>26</u>	REPLY to opposition to motion re <u>21</u> Motion for TRO,, Motion for Preliminary Injunction, (REDACTED) filed by JANE JONES. (Attachments: # <u>1</u> Declaration of Lauren Meade, M.D. (Supplemental) (REDACTED), # <u>2</u> Exhibit A – 2020 Article, # <u>3</u> Exhibit B – 2022 Study)(Delgado, Jennifer) (Entered: 02/24/2025)
02/24/2025	<u>27</u>	ENTERED IN ERROR.....SEALED REPLY TO OPPOSITION filed by JANE JONES re <u>21</u> Motion for TRO,, Motion for Preliminary Injunction, (This document is SEALED and only available to authorized persons.) (Attachments: # <u>1</u> Declaration of Lauren Meade, M.D. (Supplemental), # <u>2</u> Exhibit A, # <u>3</u> Exhibit B)(Delgado, Jennifer) Modified on 2/25/2025 (zdp). (Entered: 02/24/2025)
02/24/2025	<u>28</u>	ORDER granting <u>21</u> Motion for TRO and Preliminary Injunction: It is hereby ORDERED that the plaintiff's Motion is GRANTED; and it is further ORDERED that the defendants are hereby enjoined from implementing Sections 4(a) and 4(c) of Executive Order 14168 against Plaintiff Jane Jones, pending further Order of this Court; and it is further ORDERED that, pending further Order of this Court, the defendants shall maintain and continue the plaintiff's housing status and medical care as they existed immediately prior to January 20, 2025. Signed by Judge Royce C. Lamberth on 2/24/2025. (lcrcl3) (Entered: 02/24/2025)
02/24/2025	<u>29</u>	ORDER granting <u>13</u> Motion for Leave to Appear Pro Hac Vice Counsel should register for e-filing via PACER and file a notice of appearance pursuant to LCvR 83.6(a) Click for instructions. Signed by Judge Royce C. Lamberth on 2/24/2025. (lcrcl3) (Entered: 02/24/2025)
02/24/2025	<u>30</u>	ORDER granting <u>11</u> Motion for Leave to Appear Pro Hac Vice Counsel should register for e-filing via PACER and file a notice of appearance pursuant to LCvR 83.6(a) Click for instructions. Signed by Judge Royce C. Lamberth on 2/24/2025. (lcrcl3) (Entered: 02/24/2025)
02/24/2025	<u>31</u>	ORDER granting <u>12</u> Motion for Leave to Appear Pro Hac Vice Counsel should register for e-filing via PACER and file a notice of appearance pursuant to LCvR 83.6(a) Click for instructions. Signed by Judge Royce C. Lamberth on 2/24/2025. (lcrcl3) (Entered: 02/24/2025)
02/25/2025		NOTICE OF ERROR regarding <u>27</u> Sealed Reply,. The following error(s) need correction: Incorrect court case number. Please refile. (zdp) (Entered: 02/25/2025)
02/25/2025	<u>32</u>	Amended MOTION for Leave to Appear Pro Hac Vice :Attorney Name– Jennifer L. Levi, Filing fee \$ 100, receipt number ADCDC-11502692. Fee Status: Fee Paid. by JANE JONES. (Attachments: # <u>1</u> Declaration, # <u>2</u> Supplement Statement, # <u>3</u> Exhibit Certificate of Good Standing, # <u>4</u> Text of Proposed Order)(Delgado, Jennifer) (Entered: 02/25/2025)
02/25/2025	<u>33</u>	SEALED REPLY TO OPPOSITION filed by JANE JONES re <u>21</u> Motion for TRO,, Motion for Preliminary Injunction, (This document is SEALED and only available to authorized persons.) (Attachments: # <u>1</u> Declaration of Lauren Meade, M.D. (Supplemental), # <u>2</u> Exhibit A, # <u>3</u> Exhibit B)(Delgado, Jennifer) (Entered: 02/25/2025)

		02/25/2025)
02/26/2025	<u>34</u>	ORDER granting <u>32</u> Motion for Leave to Appear Pro Hac Vice Counsel should register for e-filing via PACER and file a notice of appearance pursuant to LCvR 83.6(a) Click for instructions . Signed by Judge Royce C. Lamberth on 2/26/2025. (lcrcl3) (Entered: 02/26/2025)
02/28/2025	<u>35</u>	AMENDED COMPLAINT against All Defendants filed by JANE JONES, AMY JONES, DONNA JONES, CARLA JONES, BARBARA JONES.(Delgado, Jennifer) (Entered: 02/28/2025)
02/28/2025	<u>36</u>	SEALED DOCUMENT filed by AMY JONES, DONNA JONES, CARLA JONES, BARBARA JONES, JANE JONES(This document is SEALED and only available to authorized persons.)(Delgado, Jennifer) (Entered: 02/28/2025)
02/28/2025	<u>37</u>	MOTION for Temporary Restraining Order , MOTION for Preliminary Injunction by AMY JONES, DONNA JONES, CARLA JONES, BARBARA JONES, JANE JONES. (Attachments: # <u>1</u> Memorandum in Support (REDACTED), # <u>2</u> Declaration of Jennifer Fiorica Delgado, # <u>3</u> Declaration of Amy Jones (REDACTED), # <u>4</u> Declaration of of Barbara Jones (REDACTED), # <u>5</u> Declaration of Carla Jones (REDACTED), # <u>6</u> Declaration of Donna Jones (REDACTED), # <u>7</u> Text of Proposed Order)(Delgado, Jennifer) (Entered: 02/28/2025)
02/28/2025	<u>38</u>	ENTERED IN ERROR.....SEALED MOTION filed by AMY JONES, DONNA JONES, CARLA JONES, BARBARA JONES, JANE JONES (Attachments: # <u>1</u> Declaration of Amy Jones, # <u>2</u> Declaration of Barbara Jones, # <u>3</u> Declaration of Carla Jones, # <u>4</u> Declaration of Donna Jones)(Delgado, Jennifer) Modified on 3/6/2025 (zdp). (Entered: 02/28/2025)
02/28/2025	<u>39</u>	MOTION to Proceed Under Pseudonym, Seal Documents, and for a Protective Order by AMY JONES, DONNA JONES, CARLA JONES, BARBARA JONES, JANE JONES. (Attachments: # <u>1</u> Memorandum in Support, # <u>2</u> Declaration of Jennifer Fiorica Delgado, # <u>3</u> Declaration of Amy Jones (REDACTED), # <u>4</u> Declaration of Barbara Jones (REDACTED), # <u>5</u> Declaration of Carla Jones (REDACTED), # <u>6</u> Declaration of Donna Jones (REDACTED), # <u>7</u> Text of Proposed Order)(Delgado, Jennifer) (Entered: 02/28/2025)
02/28/2025	<u>40</u>	SEALED DOCUMENT filed by AMY JONES, DONNA JONES, CARLA JONES, BARBARA JONES, JANE JONES(This document is SEALED and only available to authorized persons.) (Attachments: # <u>1</u> Declaration of Barbara Jones, # <u>2</u> Declaration of Carla Jones, # <u>3</u> Declaration of Donna Jones)(Delgado, Jennifer) (Entered: 02/28/2025)
02/28/2025	<u>41</u>	NOTICE of Appearance by Sarah K. Austin on behalf of AMY JONES, DONNA JONES, CARLA JONES, BARBARA JONES, JANE JONES (Austin, Sarah) (Entered: 02/28/2025)
02/28/2025	<u>48</u>	SEALED DOCUMENT filed by JAMES R. MCHENRY, III, WILLIAM LOTHROP. re <u>25</u> Sealed Motion for Leave to File Document Under Seal,. (This document is SEALED and only available to authorized persons.) (Attachments: # <u>1</u> Declaration)(zdp) (Entered: 03/06/2025)
03/01/2025	<u>42</u>	RESPONSE re <u>37</u> MOTION for Temporary Restraining Order MOTION for Preliminary Injunction filed by PAMELA BONDI, WILLIAM LOTHROP. (Attachments: # <u>1</u> Exhibit 1 Declaration of Rick Stover (redacted), # <u>2</u> Exhibit 2 BOP Memorandum, # <u>3</u> Text of Proposed Order)(Robinson, John) (Entered: 03/01/2025)
03/01/2025	<u>43</u>	SEALED DOCUMENT filed by PAMELA BONDI, WILLIAM LOTHROP re <u>42</u> Response to motion, (This document is SEALED and only available to authorized persons.)(Robinson, John) (Entered: 03/01/2025)
03/01/2025	<u>44</u>	ENTERED IN ERROR.....REPLY to opposition to motion re <u>37</u> Motion for TRO,, Motion for Preliminary Injunction, filed by AMY JONES, DONNA JONES, CARLA JONES, BARBARA JONES, JANE JONES. (Delgado, Jennifer) Modified on 3/6/2025 (zdp). (Entered: 03/01/2025)
03/03/2025	<u>46</u>	ORDER granting <u>37</u> Motion for TRO and Preliminary Injunction: It is hereby ORDERED that the plaintiffs' Motion is GRANTED; and it is further ORDERED that

		the defendants are hereby enjoined from implementing Sections 4(a) and 4(c) of Executive Order 14168 against Plaintiffs Amy, Barbara, Carla, and Donna Jones, pending further Order of this Court; and it is further ORDERED that, pending further Order of this Court, the defendants shall maintain and continue the plaintiffs' housing status and medical care as they existed immediately prior to January 20, 2025. Signed by Judge Royce C. Lamberth on 3/3/2025. (lcrcl3) (Entered: 03/03/2025)
03/04/2025	<u>47</u>	ORDER granting <u>39</u> Motion to proceed under pseudonyms, to partially seal documents, and for a protective order. See Order for details. Signed by Judge Royce C. Lamberth on 3/3/3035. (lcrcl3) (Entered: 03/04/2025)
03/06/2025		NOTICE OF ERROR regarding <u>44</u> Reply to opposition to Motion, <u>38</u> SEALED MOTION filed by AMY JONES, DONNA JONES, CARLA JONES, BARBARA JONES, JANE JONES. The following error(s) need correction: Incorrect format (Letter)- correspondence is not permitted (LCvR 5.1(a)). Please refile. (zdp) (Entered: 03/06/2025)
03/06/2025	<u>49</u>	NOTICE of Appearance by Markiana Julceus on behalf of All Plaintiffs (Julceus, Markiana) (Entered: 03/06/2025)
03/06/2025	<u>50</u>	NOTICE of Appearance by Wayne Fang on behalf of All Plaintiffs (Fang, Wayne) (Entered: 03/06/2025)
03/12/2025	<u>52</u>	MOTION for Leave to Appear Pro Hac Vice :Attorney Name- Amy Whelan, Filing fee \$ 100, receipt number ADCDC-11538044. Fee Status: Fee Paid. by AMY JONES, DONNA JONES, CARLA JONES, BARBARA JONES, JANE JONES. (Attachments: # <u>1</u> Declaration, # <u>2</u> Exhibit Certificate of Good Standing, # <u>3</u> Text of Proposed Order)(Delgado, Jennifer) (Entered: 03/12/2025)
03/12/2025	<u>53</u>	MOTION for Leave to Appear Pro Hac Vice :Attorney Name- Christopher Stoll, Filing fee \$ 100, receipt number ADCDC-11538048. Fee Status: Fee Paid. by AMY JONES, DONNA JONES, CARLA JONES, BARBARA JONES, JANE JONES. (Attachments: # <u>1</u> Declaration, # <u>2</u> Exhibit Certificate of Good Standing, # <u>3</u> Text of Proposed Order)(Delgado, Jennifer) (Entered: 03/12/2025)
03/14/2025	<u>54</u>	ORDER granting <u>53</u> Motion for Leave to Appear Pro Hac Vice Counsel should register for e-filing via PACER and file a notice of appearance pursuant to LCvR 83.6(a) Click for instructions. Signed by Judge Royce C. Lamberth on 3/13/2025. (lcrcl3) Modified to correct date signed on 3/17/2025 (smc). (Entered: 03/14/2025)
03/14/2025	<u>55</u>	ORDER granting <u>52</u> Motion for Leave to Appear Pro Hac Vice Counsel should register for e-filing via PACER and file a notice of appearance pursuant to LCvR 83.6(a) Click for instructions. Signed by Judge Royce C. Lamberth on 3/13/2025. (lcrcl3) Modified to correct date signed on 3/17/2025 (smc). (Entered: 03/14/2025)
03/19/2025	<u>56</u>	NOTICE of Appearance by Jennifer Levi on behalf of AMY JONES, DONNA JONES, CARLA JONES, BARBARA JONES, JANE JONES (Levi, Jennifer) (Entered: 03/19/2025)
03/19/2025	<u>57</u>	NOTICE of Appearance by Amy Whelan on behalf of All Plaintiffs (Whelan, Amy) (Entered: 03/19/2025)
03/19/2025	<u>58</u>	NOTICE of Appearance by Christopher F. Stoll on behalf of All Plaintiffs (Stoll, Christopher) (Entered: 03/19/2025)
03/31/2025	<u>59</u>	NOTICE of Appearance by Elizabeth Brooke Layendecker on behalf of All Defendants (Layendecker, Elizabeth) (Main Document 59 replaced on 4/1/2025) (zdp). (Entered: 03/31/2025)
04/01/2025	<u>60</u>	NOTICE of Appearance by Alexander James Yun on behalf of All Defendants (Yun, Alexander) (Main Document 60 replaced on 4/1/2025) (zdp). (Entered: 04/01/2025)
04/02/2025	<u>61</u>	NOTICE OF APPEAL TO DC CIRCUIT COURT as to <u>28</u> Order on Motion for TRO,,, Order on Motion for Preliminary Injunction,, <u>46</u> Order on Motion for TRO,,, Order on Motion for Preliminary Injunction,, by PAMELA J. BONDI, WILLIAM LOTHROP. Fee Status: No Fee Paid. Parties have been notified. (Layendecker, Elizabeth) (Entered: 04/02/2025)

04/02/2025	<u>62</u>	Transmission of the Notice of Appeal, Order Appealed (Memorandum Opinion), and Docket Sheet to US Court of Appeals. The Court of Appeals docketing fee was not paid because the appeal was filed by the government re <u>61</u> Notice of Appeal to DC Circuit Court,. (zdp) (Entered: 04/02/2025)
04/03/2025		USCA Case Number 25-5101 for <u>61</u> Notice of Appeal to DC Circuit Court, filed by PAMELA J. BONDI, WILLIAM LOTHROP. (zdp) (Entered: 04/04/2025)
04/04/2025	<u>63</u>	NOTICE OF WITHDRAWAL OF APPEARANCE as to PAMELA J. BONDI, WILLIAM LOTHROP, JAMES R. MCHENRY, III. Attorney John Robinson terminated. (Robinson, John) (Entered: 04/04/2025)
04/14/2025	<u>64</u>	NOTICE of Appearance by Alexander Shalom on behalf of All Plaintiffs (Shalom, Alexander) (Entered: 04/14/2025)
04/30/2025	<u>65</u>	Consent MOTION to Stay by PAMELA J. BONDI, WILLIAM LOTHROP, JAMES R. MCHENRY, III, DONALD J. TRUMP. (Attachments: # <u>1</u> Text of Proposed Order)(Yun, Alexander) (Entered: 04/30/2025)

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**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

JANE JONES,

Plaintiff,

v.

DONALD TRUMP, in his official capacity as
President of the United States; JAMES R.
MCHENRY III, in his official capacity as Acting
Attorney General of the United States; WILLIAM
LOTHROP, in his official capacity as Acting
Director of the Federal Bureau of Prisons,

Defendants.

Civil Action No. 1:25-cv-401

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

1. This Action is a federal constitutional challenge to Sections 4(a) and 4(c) of Executive Order 14166, titled “Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government,” (“Executive Order 14166”) which President Donald Trump issued just hours after his inauguration on January 20, 2025. The Order directly targets transgender individuals by attempting to deny them legal recognition under federal law and to strip them of long-established legal protections with the stroke of a pen. Under Sections 4(a) and 4(c) of the Order, transgender women who are incarcerated in federal prisons will be unlawfully transferred to men’s facilities and denied medically necessary healthcare.

2. Plaintiff Jane Jones is an adult transgender woman who, until [REDACTED] was incarcerated in [REDACTED]

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[REDACTED]. Jane Jones is diagnosed with gender dysphoria, a rare but serious medical condition and disability. The medical standard of care for treatment of gender dysphoria is to allow a transgender person to live in a sex different than their birth sex through counseling, medications, surgical care, and social transition.

3. Consistent with this standard of care, Jane Jones has lived as a woman and has taken hormones continuously since [REDACTED]. Additionally, she has had sex- reassignment surgeries, including a vaginoplasty, and legally changed her name and sex markers on her identifications to reflect that she is a woman. During her term of incarceration, she has always been treated as a woman by federal correctional officials and her peers. Other than during a brief period of time after the issuance of Executive Order 14166, she has never been housed in a men's facility. As of the date of this filing, publicly available records from the Bureau of Prisons (BOP) identified her sex as "female."

4. On [REDACTED], BOP officials removed Jane Jones from the general population of the minimum-security [REDACTED] and transferred her to the men's unit of the medium security facility [REDACTED]. BOP officials provided her no prior notice of the transfer and did not allow her to bring the vast majority of her belongings. They placed her in the Special Housing Unit ("SHU") within the men's prison, which Plaintiff described as a "shoebox" where she felt like a "zoo animal" that everyone comes to stare at.

5. Jane Jones feared that she would be imminently transferred to a men's general population unit because a high-ranking prison official came to her cell on [REDACTED], and asked her what men's unit she would like to be sent to.

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6. On [REDACTED], Jane Jones was transferred back to the [REDACTED]. She now fears that at any moment she will again be transferred to a men's prison pursuant to Executive Order 14166.

7. Jane Jones is not safe in any men's prison. She will be at an extremely high risk of harassment, abuse, violence, and sexual assault. She may be subject to strip searches by male correctional officers. She may be forced to shower in full view of men who are incarcerated. And she will be at a high risk of worsening gender dysphoria, which can lead to serious harm, including dramatically increased rates of suicidality and depression.

8. Jane Jones is also at imminent risk of losing access to the medical care she needs to treat her gender dysphoria. Executive Order 14166 singles out transgender people in order to deny them essential healthcare while continuing to provide such healthcare to others. The Order categorically bans this care regardless of medical necessity. It prohibits prison medical providers from treating transgender patients' gender dysphoria on an individual basis according to their independent medical judgment. This blanket ban will deprive Jane Jones of essential medication she has taken continuously over a decade, putting her at high risk of serious harm.

9. Jane Jones brings claims for violations of the Fifth Amendment to the United States Constitution; the Eighth Amendment to the United States Constitution; the Rehabilitation Act of 1973, 29 U.S.C. § 701, *et seq.*; and the Administrative Procedure Act, 5 U.S.C. §§ 701–06. Jane Jones seeks declaratory and injunctive relief to enjoin enforcement of Sections 4(a) and 4(c) of Executive Order 14166. Without the injunctive relief sought, Jane Jones will experience irreparable injury.

JURISDICTION AND VENUE

10. This action arises under the Constitution of the United States. This Court has subject matter jurisdiction pursuant to 28 U.S.C. § 1331.

11. This Court has authority to enter a declaratory judgment and to provide preliminary and permanent injunctive relief pursuant to 28 U.S.C. §§ 2201 and 2202, Fed. R. Civ. P. 57 and 65, and this Court's inherent equitable powers.

12. Venue is proper in this district under 28 U.S.C. § 1391(e)(1)(A) and (B) because all defendants reside in the district and a substantial part of the events giving rise to the claim occurred in the district.

PARTIES

13. Plaintiff Jane Jones is a transgender adult woman. Jane Jones is a pseudonym.

14. Defendant Donald Trump is sued in his official capacity as the President of the United States. Defendant Trump issued and will oversee the implementation of Executive Order 14166.

15. Defendant James R. McHenry III is sued in his official capacity as Acting Attorney General of the United States. The Acting Attorney General oversees the Department of Justice, including the Bureau of Prisons, and has responsibility for overseeing the enforcement and implementation of Sections 4(a) and 4(c) of Executive Order 14166 with respect to the Bureau of Prisons.

16. Defendant William Lothrop is sued in his official capacity as Acting Director of the Federal Bureau of Prisons (BOP). The Acting Director of BOP has responsibility for overseeing enforcement and implementation of Executive Order 14166 by all BOP staff.

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FACTS

I. Jane Jones's Sudden and Unjustified Transfer to a Men's Facility

17. The BOP maintains separate housing facilities for men and women. With respect to transgender women, the BOP applies an individualized assessment process to determine appropriate housing, consistent with the safety and security of all individuals. Based on this assessment, transgender women may be housed in women's facilities when doing so promotes safety and security.¹

18. Jane Jones has been housed in women's facilities within the BOP since her sentencing.

19. On January 20, 2025, the President issued Executive Order 14166 directing the BOP to disregard its established policy and any associated safety and security risks concerning the housing and care of transgender women.

20. Pursuant to Executive Order 14166, the BOP removed Jane Jones from the general population of the low-security women's facility where she had been housed and transferred her to a medium-security men's facility where she was placed in the Special Housing Unit (SHU).

21. She was also informed that she would be transferred to another men's facility and would be imminently placed in a male general population unit.

22. On [REDACTED], Jane Jones was then transferred back to the women's facility.

¹ U.S. Dep't of Just., Transgender Offender Manual §§ 5–6, available at <https://www.bop.gov/policy/progstat/5200-08-cn-1.pdf>.

23. Jane Jones remains at risk of being transferred to a men's facility, as she was before, and has no ability to contest the Executive Order or her placement in a men's prison.

24. Jane Jones's removal from general population, placement in the SHU of a men's prison, and anticipated second transfer to a men's facility have caused her significant distress and raise serious concerns regarding her safety and well-being.

II. Gender Dysphoria

25. Gender dysphoria is a serious medical condition marked by the significant distress or impairment that occurs when a transgender individual is made to live in their birth sex. The condition is highly treatable. When left untreated, however, it causes serious physical and emotional harms.

26. Scientific and medical research also shows that gender dysphoria has a physiological and biological etiology.

27. The only current, medically accepted treatment for gender dysphoria is to enable a transgender person to live in the sex different than their birth sex.

28. The medical and scientific community recognize well-established protocols for supporting a person to go through gender transition, the treatment that allows a transgender person to live in their target sex. These protocols are endorsed by the major medical and mental health associations in the United States, including but not limited to the American Medical Association, the American Psychiatric Association, the American Psychological Association, and the Endocrine Society.

29. Under these accepted protocols, treatment for gender dysphoria can involve any combination of social transition, medications, including hormones, and a range of surgeries. The

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treatment prescribed for a particular patient depends on an individualized assessment of the patient's health and needs. Gender transition care, including hormone therapy, is a highly effective treatment for gender dysphoria.

III. Jane Jones's Gender Dysphoria Diagnosis and Gender Transition

30. Jane Jones was born on [REDACTED]. Her sex at birth was identified as male and her parents gave her a male-associated name. From a young age, Jane Jones gravitated toward traditionally feminine activities, including playing with dolls and liked to wear feminine clothing. Jane Jones recalls her earliest memories as being shaped by tendencies that she recognized as intrinsically female. As she grew older, her sense of being a woman intensified.

31. Jane Jones attended [REDACTED] and became an [REDACTED]. She eventually owned and operated an [REDACTED]. But Jane Jones still struggled with feelings that her birth sex did not match her female identity.

32. Jane Jones began seeing a therapist in approximately [REDACTED]. She was diagnosed with gender dysphoria. In [REDACTED], she began hormone therapy and began living as a woman.

33. In [REDACTED], Jane Jones received facial reconstructive and breast augmentation surgery. In January [REDACTED], she received a vaginoplasty.

34. Around [REDACTED], Jane Jones legally changed her name and her gender marker to female on her driver's license, her [REDACTED], with [REDACTED], and with the social security office.

35. On [REDACTED] Jane Jones was convicted of a non-violent crime [REDACTED] [REDACTED] and was sentenced to less than [REDACTED] in prison.

36. She was sent to a women's facility.

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IV. Executive Order 14166 Will Cause Jane Jones Irreparable Injury

37. Executive Order 14166 began causing harm to Jane Jones almost immediately. As a result of the Order, she has already suffered significant distress. The Order also raises serious concerns for her safety and well-being going forward.

38. Section 2 of the Order includes a definition of “sex” that is intentionally designed to discriminate against transgender people. Specifically, Section 2 defines “sex” as “an individual’s immutable biological classification as either male or female.” In turn, it defines “male” as “a person belonging, at conception, to the sex that produces the small reproductive cell,” and “female” as “a person belonging, at conception to the sex that produces the large reproductive cell.” It includes these definitions to preclude transgender people from being able to live in a sex different than their birth sex and to deny them equal treatment.

39. Section 4(a) of the Order then directs federal agencies to implement this discriminatory provision, including requiring the Attorney General to categorically bar all transgender women from ever being housed in women’s prisons with no individualized consideration of their safety and security. That section acknowledges that the requirement contradicts federal regulations found at 28 C.F.R. § 115.41 directing the Attorney General to amend those regulations as necessary to implement Section 4(a).

40. On the evening of [REDACTED], BOP officials informed Jane Jones that because of the Order, she would be transferred to a men’s facility. This was a shock to Jane Jones, who at the time, was being held in a minimum-security [REDACTED]. Jane Jones had always been housed with other women and given access to all items available to other women. She was able to live as a woman in all respects at the [REDACTED].

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41. BOP officials made Jane Jones change into an orange jumpsuit and shoes, which denotes high risk inmates, gave her men's boxer shorts, hand-cuffed her, and transferred her to a men's medium security facility at [REDACTED].

42. Jane Jones asked why she was being transferred, and the Corrections Officers said that they had been told to bring her to the men's [REDACTED]. Jane Jones asked if she could bring her possessions and she was denied that request, except that the corrections officers allowed her to bring what remained of her hormone therapy medication (a less than 30-day supply). They advised, however, that she would not be permitted to obtain another prescription from the prison once these medications run out.

43. In both female prisons in which she has was housed since receiving her sentence, Jane Jones has been subjected to searches by female Corrections Officers only. Jane Jones also has a flawless disciplinary record.

44. Jane Jones was placed in the Special Housing Unit ("SHU") upon transfer to the men's prison. She was housed alone in solitary confinement in a tiny cell with nothing to do all day. She had no one to talk to and did not go outside. She was only provided with men's toiletries.

45. Jane Jones has expressed that she felt like a zoo animal. The corrections officers went by the small window to her cell and looked at her. Male guards were also able to watch her use the restroom, as she was under 24/7 video surveillance. She no longer had access to email or to other inmates. She was only allowed very limited contact with her spouse.

46. Jane Jones greatly fears what will happen when BOP terminates her medical treatment. Jane Jones has been taking hormones for [REDACTED] years. If she stops taking hormones, the

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physical and psychological impact will be devastating. This will cause her extreme emotional distress and could cause physical harm given how long she has been taking the hormones. Moreover, because she no longer has the anatomy to produce male sex hormones, she needs replacement hormones in order to maintain bone density and blood pressure regulation.

47. On [REDACTED], a BOP official came to Jane Jones and informed her she would be placed in general population.

48. Though Jane Jones was transferred back to a women's facility on [REDACTED], she lives in constant fear of being transferred to a men's prison again.

49. Other than the three days in which she was housed in the SHU, Jane Jones has never been housed in a men's facility.

50. If she is transferred back to a men's facility, she will face an extremely high risk of sexual victimization and sexual and physical violence. She will not be safe. Evidence, research, case law, and practical experience show that transgender women housed in men's prisons face near constant sexual harassment and extremely high levels of violence and sexual assault. Federal regulations recognize transgender status as a risk factor for sexual assault. *See* 28 C.F.R. §§ 115.41(d)(7), 115.42. A 2013 study by the Department of Justice estimated that 35% of transgender inmates in state and federal prisons were sexually assaulted between 2007 and 2012, nearly ten times the rate for the general incarcerated population. U.S. Dep't of Just. Off. of Justice Programs, *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–*

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12 (2014).² The rate of sexual assault reported by transgender inmates in jails and detention centers was around the same as for those in prisons. *Id.*

51. In a men's facility, Jane Jones may also be subjected to humiliating, terrifying, and dangerous circumstances like being strip searched by male correctional officers and forced to shower among men, with her female body, including her breasts and female genitalia, exposed and vulnerable to sexual violence.

52. Further, Jane Jones will predictably experience worsening gender dysphoria in a men's facility. She may be forced to wear men's clothing and undergarments, prevented from styling her hair as female, and referred to as a man. Treating a transgender woman with gender dysphoria as a man is known to intensify dysphoria, undermine medical treatment, and increase emotional distress, and it can precipitate self-harm.

53. Section 4(c) of the Order will also cause Jane Jones serious, irreparable injury. Section 4(c) eliminates Jane Jones' ability to continue taking female hormones to treat her gender dysphoria and that her body has adjusted to receiving for the last [REDACTED] years. Specifically, the provision requires the Attorney General to "ensure that no Federal funds are expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex."

54. The BOP is aware that gender dysphoria creates a serious medical need for gender transition treatments, including hormone therapy, and that Jane Jones has a serious medical need for such treatment. BOP policy expressly allows hormone therapy as a treatment for gender

² Findings available at <https://www.ojp.gov/library/publications/sexual-victimization-prisons-and-jails-reported-inmates-2011-12>. Statistics specific to transgender adults are available through a supplemental table at https://bjs.ojp.gov/content/pub/pdf/svpjri1112_st.pdf.

dysphoria based on an “individualized assessment” by medical staff.³ If providers determine that hormone therapy is appropriate for an individual, hormone therapy “will be provided.”⁴ Consistent with this policy, the BOP has consistently provided hormone therapy to Jane Jones throughout her incarceration.

55. If Jane Jones’s medically necessary treatment for gender dysphoria is terminated or restricted under Section 4(c), she will be at a well-known and substantial risk of serious harm. Medical professionals experienced in the treatment of gender dysphoria and in the prolonged use of hormones for medical care recognize that the abrupt termination and ongoing denial of hormone therapy can have disastrous consequences, including serious risk of permanent physical and emotional harm, severe danger of self-mutilation, and suicidal ideation and attempts. This harm is amplified for transgender individuals like Jane Jones who have undergone surgeries that prevent them from producing endogenous hormones.

V. Executive Order 14166 Was Motivated By Discriminatory Animus

56. Executive Order 14166 was motivated by a sex-based discriminatory purpose and animus against transgender people. The text of the challenged Executive Order describes transgender people’s existence as a “false claim.” It also scapegoats transgender people, declaring that the existence of transgender people “has a corrosive impact . . . on the validity of the entire American system.”

³ U.S. Dep’t of Just., Transgender Offender Manual § 8, available at <https://www.bop.gov/policy/progstat/5200-08-cn-1.pdf>.

⁴ *Id.*

57. Defendant Trump has been transparent about his hostility toward transgender people and openly stated his intentions to create legal obstacles to eliminate legal protections for transgender people and to deter them from obtaining medical care or being able to live in a sex other than their birth sex. On November 15, 2022, when he announced his candidacy for President, he explicitly promised to target transgender Americans through executive action.⁵ He pledged a “day one” executive order to “cease all programs that promote the concept of sex and gender transition at any age.”⁶

58. Throughout his campaign, Defendant Trump repeatedly characterized transgender Americans in dehumanizing terms, referring to them as “deranged,”⁷ and victims of “madness”⁸

⁵ ABC Action News, *(Full Speech) Former President Trump Announces 2024 Presidential Bid* at 48:40-49:13, YouTube (Nov. 15, 2022), https://www.youtube.com/watch?v=8tSYwJ1_htE; *id.* at 50:39-53 (indicating he would attempt to ban transgender people from military service).

⁶ *President Trump’s Plan to Protect Children from Left-Wing Gender Insanity*, Trump Vance: Make America Great Again! 2025 (Feb. 1, 2023), <https://www.donaldjtrump.com/agenda47/president-trumps-plan-to-protect-children-from-left-wing-gender-insanity>.

⁷ Gabriel Bertrand, *Trump’s Shocking Admission Exposes GOP’s Bigoted Agenda*, Medium (June 17, 2023), <https://medium.com/illumination/trumps-shocking-admission-exposes-gop-s-bigoted-agenda-e981becb2c5f>.

⁸ *President Trump’s Plan to Protect Children from Left-Wing Gender Insanity*, *supra* n.6.

and “insanity.”⁹ He falsely claimed transgender identity was “never heard of in all of human history”¹⁰ and described transgender healthcare as “mutilation.”¹¹

59. Defendant Trump’s campaign devoted substantial resources to promoting anti-transgender policies, spending approximately \$215 million on advertisements vilifying transgender Americans.¹² These advertisements comprised over 40% of all pro-Trump campaign messaging in the weeks before the 2024 election.¹³

⁹ Joe Middleton, *Trump Attacks Transgender Rights at Waco Rally Saying He Will Ban ‘Difigurement of Our Youth’*, The Independent (Mar. 26, 2023), <https://www.independent.co.uk/news/world/americas/donald-trump-transgender-waco-rally-b2308177.html>; <https://medium.com/illumination/trumps-shocking-admission-exposes-gop-s-bigoted-agenda-e981becb2c5f>; Donald J. Trump, Truth Social (Dec. 18, 2023), <https://truthsocial.com/@realDonaldTrump/posts/111599880929254153>; *Trump and Vance Make Anti-Transgender Attacks Central to Their Campaign’s Closing Argument*, NBC News (Nov. 1, 2024, 10:23 AM), <https://www.nbcnews.com/nbc-out/out-politics-and-policy/donald-trump-jd-vance-transgender-2024-election-rcna178390>; <https://idahonews.com/news/nation-world/trump-vows-to-remove-transgender-insanity-and-critical-race-theory-from-us-schools-phoeniz-arizona-woke-speech-usa-donald-president-white-house-education-department-crt-transgender-lgbt>.

¹⁰ *President Trump’s Plan to Protect Children from Left-Wing Gender Insanity*, *supra* n.6.

¹¹ *Id.*

¹² Audrey Kemp, *What Trump’s Win – and \$215m Worth of Anti-Trans Ads – Mean for the Future of Campaigning*, The Drum (Nov. 6, 2024), <https://www.thedrum.com/news/2024/11/06/after-donald-trump-s-victory-marketers-weigh-their-role-counter-divisive>.

¹³ Lauren Barrón-López et al., *Why Anti-Transgender Political Ads Are Dominating the Airwaves this Election*, PBS News (Nov. 2, 2024 5:35 PM), <https://www.pbs.org/newshour/show/why-anti-transgender-political-ads-are-dominating-the-airwaves-this-election>.

60. Defendant Trump’s official campaign platform included a “Plan to Protect Children from Left-Wing Gender Insanity,” which promised to deny legal recognition to transgender Americans and restrict access to medically necessary healthcare.¹⁴

61. On December 23, 2024, after winning the election, Defendant Trump reaffirmed his intent to implement discriminatory policies through executive action, stating “with a stroke of [his] pen on day one,” he would “stop the transgender lunacy” and “get transgender out of the military and out of our elementary schools and middle schools and high schools.”¹⁵

62. Executive Order 14166, issued on Defendant Trump’s first day in office, implements these campaign promises virtually verbatim, demonstrating that the discriminatory animus expressed throughout his campaign was the driving force behind the Order’s restrictions on medical care and housing.

63. The timing, content, and context of Executive Order 14166 demonstrate it was motivated by and implements the same discriminatory animus Defendant Trump repeatedly expressed during his campaign, rather than any legitimate government purpose.

CLAIMS FOR RELIEF

COUNT I

Challenge to Sections 4(a) and 4(c) Fifth Amendment to the United States Constitution Due Process Clause - Deprivation of Equal Protection of the Laws Against All Defendants in Their Official Capacities

¹⁴ *President Trump’s Plan to Protect Children from Left-Wing Gender Insanity*, supra n.6.

¹⁵ Azcentral.com and The Arizona Republic, *Turning Point USA Donald Trump Full Speech: The ‘Golden age of America’ Begins Now, Says Trump*, YouTube (Dec. 23, 2024), <https://www.youtube.com/watch?v=XuIeXJw6BA8>, at 57:02-24.

64. Plaintiff incorporates all preceding paragraphs of the Complaint as though fully set forth herein.

65. Like the Equal Protection Clause of the Fourteenth Amendment, the Due Process Clause of the Fifth Amendment prohibits unwarranted discrimination by the federal government.

66. Sections 4(a) and 4(c) unjustifiably discriminate based on sex. They are facial sex classifications and use explicitly sex-based language to dictate government decision-making. Section 4(a) compels the BOP to exclude “males” from “women’s prisons.” Section 4(c) prohibits the use of federal funds for any medical treatment prescribed “for the purpose of conforming an inmate’s appearance *to that of the opposite sex*.” Section 4(c)’s express purpose is to prohibit all medical treatment deemed inconsistent with birth sex.

67. Sections 4(a) and 4(c) require the BOP to treat incarcerated people differently depending on their sex. Under section 4(a), women who are not transgender can go on living in a women’s facility, while otherwise similarly situated transgender women must be transferred to a men’s facility based on their male birth sex. Similarly, under Section 4(c), women who are not transgender are able to obtain the same medical treatments that are prohibited if they are prescribed for transgender women.

68. Under the Fifth Amendment, sex classifications are subject to heightened scrutiny and are presumptively unconstitutional.

69. Sections 4(a) and 4(c) also discriminate based on transgender status. Section 4(a) requires dangerous transfers to men’s facilities for all transgender women, solely because they are transgender. Section 4(c) denies medically necessary healthcare to transgender people, solely because they are transgender.

70. Under the Fifth Amendment, classifications based on transgender status are sex-based classifications that are subject to heightened scrutiny.

71. Classifications based on transgender status are also subject to heightened scrutiny because transgender people constitute a quasi-suspect class. Transgender people are a discrete and identifiable group of people with one shared distinguishing characteristic: they identify and seek to live as a sex different than their birth sex. This defining characteristic bears no relation to a transgender person's ability to contribute to society. Nevertheless, transgender people have faced historical discrimination in law and in fact, and they have been unable to secure equality through the political process.

72. There is no legitimate penological purpose or other legitimate basis for Section 4(a)'s dangerous transfer requirement or Section 4(c)'s categorical healthcare ban.

73. Neither Section 4(a) nor Section 4(c) is narrowly tailored to further a compelling government interest or substantially related to an important government interest. Moreover, Sections 4(a) and 4(c) are not even rationally related to a government interest. Accordingly, these aspects of Executive Order 14166 violate the Fifth Amendment.

74. If Section 4(a) and 4(c) are implemented, Jane Jones will suffer irreparable injury, including serious physical, psychological and emotional harm, mental anguish, distress, humiliation, and indignity.

COUNT II

Challenge to Section 4(a) Eighth Amendment to the United States Constitution Failure to Protect Against All Defendants in Their Official Capacities

75. Plaintiff incorporates all preceding paragraphs of the Complaint as though fully set forth herein.

76. Under the Eighth Amendment, Jane Jones is entitled to be free from a known and substantial risk of serious harm while in BOP custody.

77. Placing Jane Jones in a men's prison will pose a substantial risk of serious harm, including an extremely high risk of violence and sexual assault from other incarcerated people and BOP staff. In a men's prison, Jane Jones will also be at high risk of worsening gender dysphoria, which can lead to serious physical and mental health conditions including severe depression and suicidality. These risks are obvious, well-documented, and well known to BOP officials.

78. The risk of sexual violence to transgender people in prison is recognized in existing federal regulations. 28 C.F.R. § 115.41(d)(7) requires BOP officials to consider an individual's transgender status as a factor increasing their "risk of sexual victimization." An individual's sexual victimization risk must be considered as part of all housing and transfer decisions. *Id.* § 115.41. Decisions about whether to house a transgender person in a men's or women's facility must be made "on a case-by-case basis" to ensure the individual's "health and safety" and the security of the facility. *Id.* § 115.42(c). Given the extremely high safety risks for transgender people in BOP custody, housing placements for transgender people "shall be reassessed at least twice a year to review any threats to safety." *Id.* § 115.42(d).

79. Section 4(a) of the Order contains a citation to 28 C.F.R. § 115.41, indicating that Defendant Trump was aware of transgender women's heightened risk of sexual victimization and the federal regulatory scheme that requires individualized housing placements to ensure their

safety. Nevertheless, Defendant Trump intentionally directed the Attorney General to “amend[]” § 115.41 “as necessary” to ensure that all transgender women would be transferred to men’s facilities, no matter how dangerous, without regard for their safety and security. The President’s intentional disregard of a known and substantial risk of serious harm to transgender women in BOP custody, including Jane Jones, violates the Eighth Amendment.

80. Defendants McHenry and Lathrop are well aware of the grave risks Jane Jones will face if she is transferred to a men’s prison, but they are actively enforcing Section 4(a) and caused BOP officials to transfer Jane Jones to a men’s facility at least once already anyway. Their decision to disregard the known and substantial risks of serious harm violates Jane Jones’s rights under the Eighth Amendment.

81. If Section 4(a) is implemented, Jane Jones will suffer irreparable injury, including serious physical, psychological and emotional harm, mental anguish, distress, humiliation, and indignity.

COUNT III

Challenge to Section 4(c) Eighth Amendment to the United States Constitution Medical Deliberate Indifference Against All Defendants in Their Official Capacities

82. Plaintiff incorporates all preceding paragraphs of the Complaint as though fully set forth herein.

83. A prison official who has knowledge of an individual’s serious need for medical care and intentionally refuses to provide that care acts with deliberate indifference and therefore violates the Eighth Amendment’s prohibition on cruel and unusual punishment.

84. Jane Jones has a serious medical need for hormone therapy as treatment for her gender dysphoria, which is a rare and serious health condition. Abrupt termination of this treatment would violate the applicable standard of care and subject her to a known and substantial risk of serious harm.

85. Terminating Jane Jones's hormone therapy would contravene her medical providers' consistent professional judgment that she needs continuous treatment for her gender dysphoria, as the BOP has previously recognized by placing her on this medication. Denying Jane Jones this medically necessary healthcare would constitute deliberate indifference to her serious medical needs and would violate the Eighth Amendment's prohibition on cruel and unusual punishment.

86. Section 4(c) of the Order, which was issued by Defendant Trump and is being implemented by all other Defendants, establishes a blanket rule banning medically necessary treatments for all transgender people in BOP custody, without consideration of any individual's medical needs or their healthcare providers' independent medical judgment. As such, Section 4(c) constitutes deliberate indifference to the serious medical needs of all transgender people in BOP custody and violates the Eighth Amendment's prohibition on cruel and unusual punishment.

87. If Section 4(c) is implemented, Jane Jones will suffer irreparable injury, including serious physical, psychological and emotional harm, mental anguish, distress, humiliation, and indignity.

COUNT IV

Challenge to Section 4(a) Rehabilitation Act of 1973, Section 504

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**Failure to Accommodate a Disability
Against All Defendants in Their Official Capacities**

88. Plaintiff incorporates all preceding paragraphs of the Complaint as though fully set forth herein.

89. Jane Jones has a current diagnosis of gender dysphoria as well as a record of gender dysphoria that is known to BOP officials.

90. Gender dysphoria is a serious medical condition that qualifies as a disability. It is a physical impairment that substantially limits the major life activities of interacting with others, reproduction, social and occupational functioning, and caring for oneself.

91. Housing Jane Jones in a women's facility is a reasonable accommodation for her gender dysphoria and is part of the recommended treatment protocol set forth by the applicable standards of care and clinical practice guidelines.

92. Continuing to house Jane Jones at the [REDACTED] would not materially impair the safe and efficient operation of the facility or the BOP generally, present a safety hazard to any staff or other incarcerated person, threaten the security of the facility, or otherwise cause undue hardship.

93. Continuing to house Jane Jones at the [REDACTED] would not fundamentally alter the nature of any service, program, or activity.

94. Involuntarily transferring Jane Jones to a men's facility under Section 4(a) of the Order would be a cruel and unnecessary revocation of this reasonable accommodation and would deny her equal benefits of correctional and rehabilitative programs and services, including but not limited to safe housing, showers, and healthcare consistent with accepted medical standards. Accordingly, Section 4(a) violates Section 504 of the Rehabilitation Act of 1973.

95. If Section 4(a) is implemented, Jane Jones will suffer irreparable injury, including serious physical, psychological and emotional harm, mental anguish, distress, humiliation, and indignity.

COUNT V

**Challenge to Section 4(c)
Rehabilitation Act of 1973, Section 504
Disability Discrimination
Against All Defendants in Their Official Capacities**

96. Plaintiff incorporates all preceding paragraphs of the Complaint as though fully set forth herein.

97. Section 4(c) categorically bans medical treatments, regardless of medical need, if they are prescribed to “conform[] an inmate’s appearance to that of the opposite sex”—meaning treatments are banned only if they are prescribed to treat gender dysphoria.

98. Section 4(c) discriminates based on disability by excluding people with gender dysphoria, including Jane Jones, from accessing medically necessary healthcare services that are provided to all other people in BOP custody based on medical need. Accordingly, Section 4(c) violates Section 504 of the Rehabilitation Act of 1973.

99. If Section 4(c) is implemented, Jane Jones will suffer irreparable injury, including serious physical, psychological and emotional harm, mental anguish, distress, humiliation, and indignity.

COUNT VI

**Challenge to Sections 4(a) and 4(c)
Administrative Procedure Act
Arbitrary and Capricious, Unlawful, and Unconstitutional Agency Action
Taken Without Observance of Procedure Required By Law
Against Defendant Lothrop in His Official Capacity**

100. Plaintiff incorporates all preceding paragraphs of the Complaint as though fully set forth herein.

101. BOP's actions to implement Sections 2, 4(a), and 4(c) of the Executive Order constitute final agency action that has harmed Jane Jones, affected her legal rights, and subjected her to an imminent risk of further harm.

102. BOP's transfer of Jane Jones to a men's facility and the imminent threat to deny her necessary medical care solely because of her birth sex are unconstitutional.

103. BOP's transfer of Jane Jones to a men's facility solely because of her birth sex and transgender status is arbitrary and capricious.

104. BOP's decision to deny Jane Jones medically necessary care to treat her gender dysphoria solely because of her birth sex and transgender status is arbitrary and capricious.

105. BOP's transfer of Jane Jones to a men's facility solely because of her birth sex is contrary to law as set forth in 28 C.F.R. §§ 115.41–42.

106. For BOP's first transfer and any future transfer of Jane Jones to a men's prison to be lawful, amendments to 28 C.F.R. §§ 115.41–42 would have to be made through notice-and-comment rulemaking. Section 4(a) directs the Attorney General to make such an "amendment," but no amendment has been made at this time. BOP's transfer of Jane Jones prior to a valid amendment to 28 C.F.R. §§ 115.41–42 was made without observance of procedure required by law.

107. BOP's decision to transfer Jane Jones without conducting an individualized assessment of all relevant circumstances, including her safety, was made without observance of procedure required by law.

108. If Sections 4(a) and 4(c) are implemented, Jane Jones will suffer irreparable injury, including serious physical, psychological and emotional harm, mental anguish, distress, humiliation, and indignity.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff requests that this Court grant the following relief:

- (1) Issue a judgment under 28 U.S.C. §§ 2201–02 declaring that Sections 4(a) and 4(c) of Executive Order 14166 violate Plaintiff’s rights under the Fifth and Eighth Amendments to the United States Constitution, the Rehabilitation Act of 1973, and the Administrative Procedure Act for the reasons and on the Counts set forth above;
- (2) Enter a permanent injunction prohibiting Defendants and their officers, employees, servants, agents, appointees, and successors from enforcing Sections 4(a) and 4(c) of Executive Order 14166, and requiring Defendants to maintain Plaintiff’s housing and medical treatment consistent with the status quo before January 20, 2025;
- (3) Award Plaintiff nominal damages, as well as her costs, expenses, and reasonable attorneys’ fees pursuant to 28 U.S.C. § 2412, 42 U.S.C. § 12205, and other applicable laws; and
- (4) Grant such other and further relief as the Court deems just and proper.

Respectfully submitted,

/s/ Jennifer Fiorica Delgado

Jennifer Fiorica Delgado (Bar No. NY296)
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and admission forthcoming)
Natalie Kraner (*pro hac vice* pending and
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**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

JANE JONES,

Plaintiff,

v.

Civil Action No. 25-cv-0040-RCL

DONALD TRUMP, in his official capacity as
President of the United States; JAMES R.
MCHENRY III, in his official capacity as Acting
Attorney General of the United States; WILLIAM
LOTHROP, in his official capacity as Acting
Director of the Federal Bureau of Prisons,

Defendants.

**DECLARATION OF JENNIFER
FIORICA DELGADO IN
SUPPORT OF PLAINTIFF'S
MOTION TO PROCEED UNDER
PSEUDONYM, PARTIALLY SEAL
THE RECORD, AND FOR A
PROTECTIVE ORDER**

I, Jennifer Fiorica Delgado, Esq., of full age, do hereby declare as follows:

1. I am an attorney in good standing with the United States District Court for the District of Columbia Bar and licensed to practice law in said Court, as well as in New York and New Jersey.
2. I make the following declaration based on personal knowledge and pursuant to Fed. R. Civ. P. 65(b).
3. Ms. Jones, an incarcerated transgender woman who has been housed in women's prisons for nearly a year, was abruptly transferred to a men's prison on [REDACTED]. She was transferred back to a women's facility on [REDACTED], but remains at risk of again being placed in a men's prison and faces the cessation of medically necessary treatment for gender dysphoria.
4. Upon information and belief, at all times since being in the custody of the Federal Bureau of Prisons ("BOP"), BOP has listed Ms. Jones's sex as female.

5. Ms. Jones's abrupt transfer and the impending cessation of her medical care is due to Executive Order 14168 (the "Executive Order"), specifically, Sections 4(a) and 4(c).

6. On February 10, 2025, Plaintiff filed a Complaint challenging Sections 4(a) and 4(c) of the Executive Order.

7. Plaintiff did not file a motion seeking emergency relief at that time because, at the time, the temporary restraining order issued by this Court in *Doe v. McHenry* ("*Doe*"), No. 25-cv-286-RCL (the "*Doe* TRO") prevented Defendants from "implementing Sections 4(a) and 4(c) of Executive Order 14168." Thus, Plaintiff was protected from transfer and potential cessation of medical treatment by the *Doe* TRO.

8. On February 18, 2025, this Court entered an order granting plaintiffs' motion for a Preliminary Injunction in *Doe* (the "*Doe* PI"). The *Doe* PI is substantially similar to the *Doe* TRO, except that it does not contain a blanket prohibition against implementing Sections 4(a) and 4(c). Therefore, while the *Doe* plaintiffs remain protected from transfer or cessation of medical care, Ms. Jones is not.

9. On a call that took place on February 19, 2025, I asked John J. Robinson, counsel for Defendants, whether Defendants would consent to an identical preliminary injunction being entered in this case. On February 20, 2025, Mr. Robinson informed me that Defendants would not consent to the entry of a preliminary injunction. On the same call, I inquired whether Defendants would be willing to consent to the entry of a TRO while the motion for preliminary injunction was pending.

10. Later that day, I followed up via email inquiring whether Defendants would be willing to consent to the entry of a TRO, or otherwise enter a stipulation that would protect Ms.

Jones while the motion for a preliminary injunction is pending. In response, Mr. Robinson informed me that Defendants would not consent to the entry of a TRO or enter a stipulation.

11. On February 21, 2025, in an email to Mr. Robinson, I gave Defendants actual notice of Ms. Jones' Motion for Temporary Restraining Order and Preliminary Injunction (the "Motion") and attached a copy of the Motion to my email.

12. The Motion relies on the same legal arguments raised to the Court in *Doe*. The proposed order submitted herewith seeks the identical relief sought in the *Doe* PI, except to the extent it seeks relief on behalf of Plaintiff, and not the plaintiffs in *Doe*.

Pursuant to 28 U.S.C. § 1746, I affirm under penalty of perjury that the above statements are true and correct.

Dated: February 21, 2025

Respectfully submitted,

/s/ Jennifer Fiorica Delgado

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**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

JANE JONES,

Plaintiff,

v.

Civil Action No. _____

DONALD TRUMP, in his official capacity as
President of the United States; JAMES R.
MCHENRY III, in his official capacity as Acting
Attorney General of the United States; WILLIAM
LOTHROP, in his official capacity as Acting
Director of the Federal Bureau of Prisons,

Defendants.

DECLARATION OF [REDACTED]
[REDACTED]

I, [REDACTED] make the following declaration based on my personal
knowledge and declare under the penalty of perjury pursuant to 28 U.S.C § 1746 that the
following is true and correct:

1. My name is [REDACTED]. I am incarcerated in the Bureau of Prisons.
I am submitting this declaration in support of my request for relief.

2. I was born on [REDACTED]. My sex at birth was identified as male and my
parents gave me a male name. From a young age, I gravitated toward traditionally feminine
activities, including playing with dolls. I recall my earliest memories as being shaped by
tendencies that I recognized as intrinsically female. As I grew older, my sense of being a woman
intensified. When I closed my eyes and pictured myself, the vision was female.

3. I attended [REDACTED] and became an [REDACTED]. I eventually
owned and operated [REDACTED] in [REDACTED].

4. I began seeing a therapist in approximately [REDACTED]. I was diagnosed with gender
dysphoria. In [REDACTED], I began hormone therapy and began living as a woman.

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5. In [REDACTED], I received facial reconstructive surgery; in February of that year, I received breast augmentation surgery. In [REDACTED], I received a vaginoplasty.

6. Around [REDACTED], I legally changed my name and my sex marker to female on my driver's license, my [REDACTED], with [REDACTED], and with the social security office.

7. I met my wife and we began a relationship in 2020. On [REDACTED] I was convicted of a non-violent crime [REDACTED] and was sentenced to [REDACTED]. My wife and I had been planning to marry for a long time and decided to do so in [REDACTED] in [REDACTED] shortly before I began my sentence.

8. In [REDACTED], I was placed in a women's facility: [REDACTED]
[REDACTED]. I was placed in general population and had multiple cellmates (all female). I was provided with all necessary female toiletries through commissary. I began seeing a nurse practitioner, who prescribed me the same hormone therapy I had been taking before my incarceration, which was also provided by the prison. I was also permitted to [REDACTED]
[REDACTED]. Put simply, while in federal custody, I have been permitted to keep living as a woman in all respects.

9. In [REDACTED] I was transferred to a minimum-security [REDACTED]
[REDACTED] in [REDACTED]

10. Like in [REDACTED], the [REDACTED] commissary provides all necessary items that are needed by the women housed there. As with my initial facility, I have been able to live as a woman in all respects at [REDACTED]

11. The facility provides me with a lot of freedom of movement. It is a minimum-security facility, and I am permitted to move through the facility throughout the day. I spend a

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lot of time at the [REDACTED]. I also appreciate the ability to shower in a private stall. I am also able to speak with my wife on the phone daily and email her multiple times per day.

12. At [REDACTED], I also became involved with a program where incarcerated women [REDACTED] I was selected for this position based on my good behavior and performance during my interview. This program has helped me exponentially; I love [REDACTED] and knowing that I am helping others. As part of this program, [REDACTED]. Though it is difficult to be an incarcerated transgender woman, I believe my current housing at the [REDACTED] is the safest place, short of home confinement or in a halfway house, for me to be in federal custody.

13. In both female prisons in which I have been housed, I have been subjected to searches by female corrections officers only. I also have a flawless disciplinary record at both facilities.

14. In the evening, on [REDACTED], BOP officials informed me that I would be transferred to a men's facility. They handcuffed me, made me change into an orange jumpsuit and shoes, which denotes high risk inmates, gave me men's boxer shorts, and transferred me to the men's prison, which is a medium security facility at [REDACTED]. I was shocked to be handcuffed because no one at the [REDACTED] is handcuffed or shackled, even when we leave camp.

15. I asked why I was being transferred, and the corrections officers said that they had been told to bring me to the men's unit. I asked if I could bring my possessions and I was denied that request, except that the corrections officers allowed me to bring what remained of my hormone therapy medications (a less than 30-day supply). They advised, however, that I would not be permitted to obtain another prescription from the prison once these medications run out.

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16. While at the men's prison, I was housed in the Special Housing Unit ("SHU"). There, I was housed alone in solitary confinement in a tiny cell with nothing to do all day. I had no one to talk to and was not allowed to go outside or engage in any recreation whatsoever. While I was able to call my wife once a day, I had no access to email, and our calls were cut short. I was only provided with men's toiletries.

17. While in the SHU, I was under 24/7 video surveillance. There was both a toilet and shower in my cell. This meant that I was observed by male corrections officers when I used the restroom. I was provided with a towel no bigger than a letter-sized piece of paper. Because male corrections officers would have been able to observe me showering and drying off, I was not comfortable using the shower while I was in the SHU.

18. I asked various guards and prison officials why I had been transferred, and who had ordered the transfer. No one would answer this question; instead, the guards walked by the small window in my cell and looked at me as if I was a zoo animal.

19. On one occasion, a prison official told me that he was surprised that I had been transferred to the SHU in a male facility. He believed that I was going to be transferred to the SHU in a different women's facility because the [REDACTED] does not have a SHU. I asked why I would be housed in the SHU given my stellar disciplinary record. He told me that it was because of President Trump's executive order.

20. Though I am a resilient person, my mental health began to suffer while I was in the SHU. I felt completely hopeless, fearful, and extremely anxious. Isolation is very triggering for me given the isolation from family and friends I experienced when I transitioned. It felt as if I was being forcefully detransitioned. I also had no idea how long I would be there, which made me feel completely out of control and depressed.

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21. On [REDACTED], I wrote [REDACTED]
[REDACTED]. I handed it to a guard the next morning.

22. On [REDACTED], a high-ranking prison official informed me that I would be transferred to another men's prison and released to the general population. Later, a prison psychologist came to ask me which men's facility I would prefer to be transferred to. We spoke for about one hour, during which time I explained that there was no men's prison that was safe for me to be housed.

23. On [REDACTED], I was transferred back to the [REDACTED].

24. Despite my transfer back to the women's facility, I remain deeply concerned for my safety. I live in fear that I may, at any time, be transferred to a men's facility, as I was once before. Now, every time I hear the intercom, I have a physical reaction out of fear of being transferred. On one occasion, my name was called over the intercom and I began crying uncontrollably. And, any time the intercom is turned on, as I wait to see if my name will be called, I break out in sweats, my heart rate goes up, and I get nauseous. This is very unlike me; I have never had these symptoms before.

25. I learned on [REDACTED] that [REDACTED]
[REDACTED] had been denied.

26. I am female in all respects. This is how I have lived for [REDACTED] years. I will be an easy target for harassment, abuse, and violence, including sexual assault, if I am transferred to a men's prison. A woman with full female anatomy has no place in a men's facility.

27. I am also concerned that I may be denied access to hormone therapy medications. I have been taking hormones for [REDACTED] years. If I stop taking hormones, the physical and psychological impact will be devastating. This will cause extreme emotional distress and could

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cause physical harm. In fact, I no longer have the anatomy to produce male sex hormones, so it is a medical necessity for me to take replacement hormones. Without it, I would lose bone mass, blood pressure regulation, and would experience other serious medical issues.

28. I am a non-violent offender with an exemplary track-record while incarcerated. There is simply no reason to transfer me to a men's prison, and in fact, doing so will cause me significant physical and emotional harm.

29. This declaration was prepared by my attorney, Jennifer Fiorica Delgado, based on the facts I provided, and it was read to me by Ms. Delgado on [REDACTED] on a telephone call. I approve of the contents of this declaration, and authorize my wife, [REDACTED], to execute it on my behalf as my power of attorney. If given the opportunity, I will add my signature to this declaration.

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Executed on the 10th day of February in the year of 2025,

Signature: _____

[REDACTED]

Date: 2/10/2025

[REDACTED], as power of attorney for

[REDACTED]

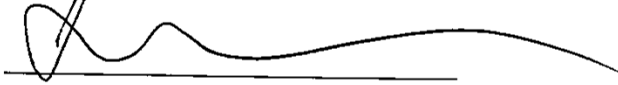
DECLARATION OF LAUREN MEADE, M.D.

I, Dr. Lauren Meade, declare:

1. I am a board-certified internal medicine doctor 19 years of experience treating transgender patients. I am familiar with standard protocols for hormone therapy and its effects. A true and correct copy of my curriculum vitae is attached.
2. Gender dysphoria is a serious medical condition that, left untreated, can result in debilitating psychological harms, including anxiety, depression, suicidality, and other mental health issues. Without treatment, many people with gender dysphoria are unable to adequately function in occupational, social or other areas of life.
3. Gender dysphoria is a highly treatable condition. The standards of care for treating gender dysphoria are well-established and are endorsed by the major medical and mental health associations in the United States, including but not limited to the American Medical Association, the American Psychiatric Association, the American Psychological Association, and the Endocrine Society.
4. Treatments include social transition, which enables a transgender person to live in a sex other than their birth sex, and hormone therapy to feminize or masculinize the body. It may also include various surgeries.
5. For many transgender women, hormone therapy is an essential, medically indicated treatment to alleviate the distress of gender dysphoria.
6. Discontinuing hormone therapy for transgender women who have been on long term treatment poses serious medical risks, including both severe psychological distress and physical complications.
7. These risks include:
 - Intensified gender dysphoria
 - Increased risk of severe anxiety, depression, and suicidality due to intensified gender dysphoria
 - Rapid hormonal changes that trigger severe mood swings, anxiety, and depression
 - Loss of breast tissue and feminine fat distribution
 - Loss of bone density and increased risk of osteoporosis.
8. Over time, the negative mental and physical health impacts of being denied care are likely to worsen and to result in debilitating distress.
9. Based on my professional experience, terminating hormone therapy for a transgender woman constitutes a serious medical risk that can severely impact physical and mental health.

I declare under the pains of perjury that the foregoing is true and correct.

Signed this 25th day of January, 2025.

A handwritten signature in black ink, appearing to be "Dr. Lauren Meade", written over a horizontal line.

Dr. Lauren Meade

Lauren B Meade, M.D.
Department of Medicine
Baystate Health – High Street Health Center
140 High Street
Springfield, MA 01199
(413) 794-1407
lauren.meade@baystatehealth.org

Education

M.D., University of California at San Francisco, San Francisco, California	1990-1994
B.A., Biology (<i>cum laude</i>), Highest departmental honors Sigma Xi Honor Society Smith College Northampton, Massachusetts	1983-1987

Postdoctoral Training

Internal Medicine, Residency, Baystate Medical Center, Springfield, Massachusetts	1995-1997
Internal Medicine, Internship, Yale-New Haven Hospital, New Haven, Connecticut	1994-1995

Academic Appointments

Associate Professor Department of Medicine, Tufts University School of Medicine, Boston MA	2014-present
Assistant Professor Department of Medicine, Tufts University School of Medicine, Boston MA	1997-2014

Other Positions and Employment

Primary Care, High Street Health Center, Springfield, MA	1997-2016
Hospitalist, Baystate Medical Center, Springfield, MA	1997-2016
Substance Abuse Primary Care, High Street Health Center, Springfield, MA	2000-2013
Women's Health Primary Care, High Street Health Center, Springfield, MA	1997-2013
HIV Primary Care, High Street Health Center, Springfield, MA	1997-2011
Correctional Health, Hamden County Correctional Facility, Springfield, MA	2000-2007

Honors and Awards

Macy Faculty Scholars Award, The Josiah Macy Jr. Foundation	2013-2015
Massachusetts Medical Society Lesbian Gay Bisexual Transgender Award, Waltham, MA	2014
Fellow, American College of Internal Medicine, Philadelphia, PA	2014
Third Year Clerkship Faculty Recognition for Excellence in Teaching, Tufts University School of Medicine, Boston, MA	2013
Third Year Clerkship Faculty Recognition for Excellence in Teaching, Tufts University School of Medicine, Boston, MA	2012
Physician Spotlight, Baystate Medical Practice Bulletin, Baystate Medical Center, Springfield, MA	2011
Paul Winske Access Award, Stavros, Advocates for Independent Living, Springfield, MA	2011
Third Year Clerkship Faculty Recognition for Excellence in Teaching, Tufts University School of Medicine, Boston, MA	2009

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Oliver Wendell Holmes Stethoscope Award, Hamden District Medical Society, Holyoke, MA	2005
Third Year Clerkship Faculty Recognition for Excellence in Teaching, Tufts University School of Medicine, Boston, MA	2005
House Staff Recognition Award for Teaching in Excellence, Baystate Medical Center, Springfield, MA	2003
Award for Excellence for outstanding Achievement in HIV/AIDS, Between Family and Friends, Springfield, MA	2001
Third Year Clerkship Faculty Recognition for Excellence in Teaching, Tufts University School of Medicine, Boston, MA	2001

Educational Activities

Educational Leadership, Administration and Service

Director of Clinical Learning and Development, Sound Physicians, Tacoma, WA	2016-2018
Director of Faculty Development and Engagement, Baystate Medical Center, Springfield MA	2013-2016
Director of Faculty Development and Engagement, The Wright Center Graduate Medical Education, Scranton, PA	2012-2016
Director of the Transitions of Care rotation, 20 residents per year	2006-2016
Associate Program Director, Internal Medicine Residency	2005-2016
Clinical Competence Committee, Internal Medicine (participant)	1997-2016
Residency Education Committee, Internal Medicine (participant)	1997-2016
Faculty Development Senior Hospitalist Educators, Baystate Medical Center, Springfield, MA	2011-2015
Program for Educators in Health Professions, Harvard Macy Institute, Faculty	2015
Co-Course Director, Academic Half Day, Internal Medicine Residency, Baystate Medical Center, Springfield, MA	2013-2014
Women's Health Track Director, Internal Medicine Residents	2000-2013
Women's Health Medical Student Clerkship Director	2000-2011
Tufts University School of Medicine Faculty Senate (participant)	2006-2009
Tufts University School of Medicine Clinical Faculty Subcommittee (participant)	2006-2009
HIV/AIDS lectures, 60 residents per year	1996-2006
Medical Clerkship Director, Springfield College Physician Assistant Students	1998-2000

Teaching Activities in Programs and Courses

Mortality and Morbidity Ambulatory Report, 60 residents per year; 3 hours/year; 3 1 hour small group teaching, Wright Center for Medical Education, Scranton PA	2012-2015
Tracer Rounds; 20 clerks/year; 20 residents per year; 80 hours/year; 2 hours per week, small group teaching	2005-2015
Palliative Care and Hospice, 60 residents per year	1999-2013
Mortality and Morbidity Ambulatory Report, 30 clerks/year; 60 residents per year; 48 hours/year; 1 hour per week small group teaching	2006 - 2011
Getting Energized, Baystate Academic Affairs, 300 residents	2010

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Women's Health Elective Clerkship; 1-3 clerks per year; 2-3 residents per year, 20 hours per clerk/resident; 2-4 week elective with exposure to office gynecology, breast cancer screening, gynecologic oncology, urogynecology, hospice, family planning and colonoscopy.	1998-2010
Diversity and Inclusion, Baystate Academic Affairs, 300 residents	2009
Transgender Health, Baystate Academic Affairs, 300 residents	2008
HIV/AIDS lectures, Springfield College Physician Assistant Program, 3rd year student	1996-2007
Sexual Harassment, Baystate Academic Affairs, 300 residents	2007
Women's Health Curriculum; 60 residents per year; 4 hours per year; 4 lectures per year, lecture topics including Sexually Transmitted Diseases, Contraception, Domestic Violence and Cervical Cancer Screening.	1996-2006
HIV/AIDS Curriculum; 60 residents per year; 4 hours per year; 4 lectures per year; lecture topics including acute HIV, HIV treatment, Opportunistic Infections, Sexually Transmitted Diseases and HIV medication adherence principles.	1996-2006
Substance Abuse Curriculum; 60 residents per year, 2 hours per year; 2 lectures per year on topics including alcoholism and narcotic addiction	1996-2004
Women's Health Journal Club; 1-5 residents per year; 6 hours per year; monthly journal club presentation.	1998-2002

Clinical Education

University of Massachusetts Medical School-Baystate, Springfield, MA

Population Health Clerkship Academic Faculty, 1 st year, 4 students, 8 hours over 2 week clerkship	2019 - 2020
Ambulatory Precepting; 6 - 12 residents/year; 12 hours per week, High Street Health Center	2018-present
PURCH Medical Student, 1 st year, longitudinal preceptor, High Street Health Center, 32 hours per year	2018-2019
PURCH Medical Student, longitudinal 1 st – 4 th year, Capstone advisor, High Street Health Center, 12 hours per year	2018-2021

Tufts University School of Medicine/Baystate, Springfield, MA

Ambulatory Attending Rounds; prepared and delivered curriculum at a teaching conference at the academic health center for residents and medical students, Baystate Medical Center, High Street Health Center, 4 hours per week	1996-2016
Ward Attending Rounds; 8 clerks/year; 12 -24 residents per year, 32 hours per year; 1 hours session per day; prepared and delivered curriculum at a teaching conference	1997-2015
Women's Health rotation, 20 residents per year, 1-3 medical students per year	1997-2014
HIV/AIDS rotation, 1-2 residents per year, 2 fellows per year	1997-2006
Ambulatory Attending Rounds; 8 clerks/year; 60 residents per year, 52 hours per year; 1 hours session per week; prepared and delivered curriculum at a teaching conference	1997-2006
Tufts Medical School Continuity Program; 1 clerk/year; 10 hours/year; precepted 1 medical student for a full year of continuous learning about one high utilizer patient, Baystate Medical Center	2008-2009
Tufts Medical School Mentor Program, 1 clerk/year, 3 years/year; mentored 1 medical student in a formal curriculum for supporting their career goals, Baystate Medical Center	2006-2007

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Educational Development: Curricula and Educational Materials

Mortality and Morbidity curricula, Residents; Wright Center for Graduate Medical Education; Scranton, PA; Case based interactive Mortality and Morbidity review based in safety principles.	2012 - 2015
Tracer curricula, Residents; Baystate Medical Center, Springfield, MA; Experiential learning across the transition from hospital to post-acute care with focus on route cause analysis.	2005 - 2015
Women's health curricula, Residents; Baystate Medical Center, Springfield, MA; Topic based didactic lectures in Women's Health.	1996 - 2013
Ambulatory Mortality and Morbidity curricula, Residents; Baystate Medical Center, Springfield, MA; Case based interactive Mortality and Morbidity review based in safety principles.	2006 - 2011
HIV/AIDS curricula, Medical students, PA students, Residents, Fellows; Baystate Medical Center, Springfield, MA; Topic based didactic lectures in HIV/AIDS.	1996 - 2006
Substance abuse curricula, Residents; Baystate Medical Center, Springfield, MA; Topic based didactic lectures in substance abuse.	1996 - 2004
General Medicine curricula, Residents; Baystate Medical Center, Springfield, MA; Topic based didactic lectures in General Medicine.	1999 - 2004

Advising and Mentoring

Students

Lindsay Rockwell, Internal Medicine Residency, Mentor/Advisor for a Women's Health Project, Medical Director of Hematology/Oncology, Cooley Dickenson Hospital, Northampton, MA	2000 - present
Kathleen McGraw, Internal Medicine Residency, Mentor/Advisor for a Women's Health Project, Chief Medical Officer, Brattleboro Hospitalist, Brattleboro, VT	1994-2004

Residents

Michael Rosenblum, Baystate Internal Medicine Resident, Career Mentor/Advisor Mercy Hospital, Program Director, Medicine	2001 - present
Anthony Poindexter, Baystate Internal Medicine Resident, Career Mentor/Advisor Tufts, Associate Program Director, Nephrology Fellowship	2001 - present
Patrick Mailloux, Baystate Internal Medicine Resident, Career Mentor/Advisor Tufts, Program Director, Critical Care Medicine	2001 - present
Raquel Belforti, Baystate Internal Medicine Resident, Career Mentor/Advisor Tufts, Associate Program Director, Medicine	2010 - 2013
Reham Shaaban, Baystate Internal Medicine Resident, Career Mentor/Advisor Tufts, Program Director, Medicine	2002 - 2005

Faculty

Wasique Mirza, Wright Center for Graduate Education Faculty, Career Mentor/Advisor Program Director, Wright Center for Graduate Education	2012 - present
Kathleen Suddarth, Alliance for Academic Internal Medicine, Career Mentor/Advisor Associate Program Director, University of Colorado	2008 - present
Aimee Kirsch Zaas, Alliance for Academic Internal Medicine, Career Mentor/Advisor Program Director, Medicine, Duke Medical School	2008 - present
Christine Bryson, Baystate Internal Medicine Faculty, Career Mentor/Advisor Associate Program Director, Baystate Medical Center	2000 - present

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Maria Maldonado, Alliance for Academic Internal Medicine, Career Mentor/Advisor Vice-Chair of Diversity, Assistant Professor Medicine, Mount Sinai Hospital	2000 - present
Rebecca Andrews, UCONN Faculty, Career Mentor/Advisor Ambulatory Clinic Director, UCONN Health Center	2013 - 2015

Investigation

Grants

Completed

Macy Faculty Scholars Grant: Lauren Meade, MD "Training Internal Medicine Residents in a Safe and Effective Discharge from the Hospital." Implemented an educational checklist for a safe discharge across 25 Internal Medicine programs. Total, direct & indirect costs: \$124,000 annually Role: PI (50%)	2013-2015
Robert Wood Johnson & Kelly Aiken "Care Transitions Educational Grant, Western Massachusetts Nursing Collaborative." Consultant for a grant to improve care transitions through interprofessional practice and structured nursing education. Total, direct & indirect costs: \$225,000 annually Role: Consultant (5%)	2011-2014
Tufts University School of Medicine Innovations in Education: Jasmine Paadam "Medical Students in Transitions of care." Implementing an experience learning curriculum for medical students to bridge the gap between the transition from hospital to home. Total, direct & indirect costs: \$7,500 Role: Co- Principle Investigator (10%)	2012-2013
Tufts University School of Medicine Innovations in Education: Aleah Nesteby "Increasing Competency in Transgender Care." Description (1 sentence) Total, direct & indirect costs: \$7,500 Role: Co- Principle Investigator (5%)	2012-2013
Baystate Health System Corporate Risk Management "A Prospective Study of a Pharmacy Provider Intervention to Identify Medical Errors in the Ambulatory Setting." Use of a pharmacy provider in an outpatient HIV multidisciplinary team to identify medical errors. Total, direct & indirect costs: \$72,000 Role: Co-PI 10% (Developed and implemented research)	2003-2004

In progress

UMASS Interprofessiona Education Grant
"Title"
goal
Total, direct & indirect costs: ?
Role: Co-PI (Developed and implemented research)

Health Care Delivery

Leadership Positions

Co-Director Transgender Health, High Street Medical Center, Baystate Medical Center, Springfield, MA	2006-present

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Medical Director HIV/AIDS, High Street Health Center, Baystate Medical Center, Springfield, MA 1997-2011

Certification and Licensure

Massachusetts State Medical License (*active*) 1994-present
American Board of Internal Medicine 1997-present

Clinical Discipline

General Internal Medicine, Hospital Medicine, Ambulatory Medicine, HIV/AIDS, Women's Health, Correctional Health, Substance Abuse 1997-present

Clinical Activities

Baystate Health, Primary Care, High Street Health Center, Springfield, MA, 44 weeks per year 2018-present
Baystate Medical Center, Springfield, MA, Hospitalist, 12 weeks per year 1997-2016
Baystate Medical Center, Springfield, MA, Primary Care, 36 weeks per year 1997-2016
Baystate Medical Center, Springfield, MA, Substance Abuse Primary Care, 4 hours per week; all year 2000-2013
Baystate Medical Center, Springfield, MA, Women's Health Primary Care, 4 hours per week; all year, 1997-2013
Baystate Medical Center, Springfield, MA, HIV Primary Care, 8 hours per week, all year 1997-2011
Hamden County Correctional Facility, Baystate Medical Center, Springfield, MA, Correctional Health, 4 hours per week; all year 2000-2007

Clinical Innovations, Safety, and Quality Improvement Projects

Scripts to go- discharge medications, Baystate Medical Center, Springfield, MA 2014-2016
Transfer summary report for skilled nursing facility, Baystate Medical Center, Springfield, MA 2008-2016
Medication Reconciliation, Baystate Medical Center, Springfield, MA 2000-2016
Reducing readmission from post-acute care, Baystate Medical Center, Springfield, MA 2008-2014
Assessment for visiting nursing care after discharge, Baystate Medical Center, Springfield, MA 2008-2010
Discharge summary electronic medical record template, Baystate Medical Center, Springfield, MA 2004-2006

Scholarship

Peer-reviewed publications

1. Fazio SB Cheda S, Hingle S, Lo MC, **Meade L**, Blanchard M, Hoellein A, Brandenburg S, Denton GD. The Challenges of Teaching Ambulatory Internal Medicine: Faculty Recruitment, Retention, and Development: An AAIM/SGIM Position Paper. Am J Med. 2017 Jan;130(1):105-110. 2017
2. **Meade L**, Suddarth KH, Jones RR, MD, Zaas AK, Albanese T, Yamazaki K, O'Malley CW. Patients, Nurses, and Physicians Developing a Discharge Direct Observation Tool. Acad Med. 2016 Oct;91(10):1388-1391. 2016
3. Ruddy MP, Thomas-Hemak L, **Meade L**. Practice Transformation: Professional Development Is Personal. Acad Med. 2016 May;91(5):624-7. 2016.

4. Denton GD, Lo MC, Brandenburg S, Hingle S, **Meade L**, Chheda S, Fazio SB, Blanchard M, Heollein A. Solutions to Common Problems in Training Learners in General Internal Medicine Ambulatory Settings. *Am J Med.* Oct;128(10):1152-7. 2015.
5. **Meade L**, Hall SL, Kleppel RW, Hinchey KT. TRACER: an 'eye-opener' to the patient experience across the transition of care in an internal medicine resident program. *J Community Hosp Intern Med Perspect.* 2015 Apr 1;5(2):26230. 2015.
6. **Meade L**, Todd CY, Walsh MM. Found in transition: applying milestones to three unique discharge curricula. *PeerJ.* 2015 Mar 5;3:e819. doi: 10.7717/peerj.819. 2015.
7. Thomas-Hemak L, Palamaner Subash Shantha G, Gollamudi LR, Sheth J, Ebersole B, Gardner KJ, Nardella J, Ruddy MP, **Meade L**. Nurturing 21st century physician knowledge, skills and attitudes with medical home innovations: the Wright Center for Graduate Medical Education teaching health center curriculum experience. *PeerJ* 2015 Feb 10;3:e766. 2015
8. Lobst W, Aagaard E, Bazari H, Brigham T, Bush RW, Caverzagie K, Chick D, Green M, Hinchey KT, Holmboe E, Hood S, Kane G, Kirk L, **Meade L**, Smith C, Swing S. Internal Medicine Milestones Journal of graduate medical education. 03/2013; 5(1 Suppl 1):14-23. 2013.
9. Caverzagie KJ, Lobst WF, Aagaard MD, Hood S, Chick DA, Kane GC, Brigham TP, Swing SR, **Meade L**, Bazari H, Bush RW, Kirk LM, Green ML, Hinchey KT, Smith CD. The Internal Medicine Reporting Milestones and the Next Accreditation System *Ann Int Med* 2013 Apr 2;158(7):557-9. 2013.
10. **Meade L**, Caverzagie KJ, Swing SR, Jones, RR; O'Malley CW, Yamazaki K, Zaas AK. Playing with milestones in the educational sandbox: Q-sort results from an educational collaborative. *Acad Med* 2013 Aug; 88(8):1142.8. 2013.
11. Heist K, Post J, Brandenburg S, **Meade L**. Milestones for Essential Ambulatory Care agreement of residents and attendings. *Am J Med.* 2013 Mar;126(3):270-4. 2013.
12. Leasure EL, Jones RR, **Meade L**, Sanger MI, Thomas KG, Tilden VP, Bowen JL, Warm EJ. There is no "I" in Teamwork in the Patient Centered Medical Home: Defining Teamwork Competencies for Academic Practice. *Acad Med.* 2013 May;88(5):585-92. 2013.
13. **Meade L**, Borden SH, McArdle P, Rosenblum MJ, Picchioni MS, Hinchey KT. From Theory to Actual Practice: Creation and application of milestones in an Internal Medicine Residency Program. *Med Teach* 2012; 34(9):717-23. 2012.
14. Heelon MW, Skiest D, Tereso G, **Meade L**, Weeks J, Pekow P, Rothberg MB. Effect of a clinical pharmacist's interventions on duration of antiretroviral-related errors in hospitalized patients. *American Journal of Health Systems Pharmacy* 2007; 64(19): 2064-2068. 2007.
15. Skiest DJ, Camelo-Piragua S, **Meade L**. Images in HIV/AIDS. "Painful oral ulcerations in a patient with AIDS." *The AIDS reader*; 16(10):531-2. 2006.
16. Heelon MW, **Meade L**. Methadone withdrawal when starting a Nevirapine containing antiretroviral regimen. *Pharmacotherapy* 1999; 19(4):471-472. 1999.
17. Topp, KS, **Meade L**, LaVail JH. Microtubule polarity in the peripheral processes of trigeminal ganglion cells: relevance for the retrograde transport of Herpes Simplex Virus. *The Journal of Neuroscience* 1994; 14(1): 318-325. 1994.
18. LaVail, JH, **Meade L**, Dawson CR. Ultrastructural immunocytochemical localization of Herpes Simplex Virus (type 1) in trigeminal ganglion neurons. *Current Eye Research* 1991; 10; 23-39. 1991

Non-peer-reviewed publications

1. **Meade L**, Grover J, Rudolph M. Speak out! Taking care of patients is what we do. Online comment. *Annals Internal Medicine* 2016 https://www.researchgate.net/publication/305082631_Non-peer_review_comment_in_Annals_of_Internal_Medicine_in_response_to_Mazor_KM_Smith_KM_Fisher_KA_Gallagher_TH_Speak_Up_Addressing_the_Paradox_Plaguing_Patient-Centered_Care_Ann_Intern_Med_2016164618. Accessed July 6 2016. Accessed July 9 2016.
2. Combs B, **Meade L**, Bollman K, Brandenburg S How to Incorporate High Value Care Curricula into Existing Educational Conferences *AAIM Insight.* 12(3)6-7 2014.
3. Ekpenyong A, Burday M, Delanoche N, Halvorson S, Raj J, **Meade L**. The AAIM Clinical Competency Committee Collaborative Learning Community. *AAIM Insight.* 13(3):18. 2015.
4. **Meade L**. Interview with Maria Maldonado, Leader in Diversity for Alliance of Academic Internal Medicine. <http://www.im.org/p/cm/ld/fid=805> Accessed on March 5, 2015.

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5. Rosenblum MJ, Borden SH, McArdle P, **Meade L**, Picchioni MS, Stefan M, Hinchey KT. Baystate Medical Center EIP Workgroup. The Baystate Manager Model. Academic Internal Medicine Insight 2007; 5(2):18. 2007.
6. **Meade L**. Regulation of hydrogen peroxide synthesis in rat thyroid gland: a cytochemical study. Thesis. Smith College. 1987.

Invited Presentations

National

Seminar: Engaging your program in the culture change of direct observation. APDIM Spring Meeting. Houston, TX	April 26, 2015
Workshop: "Applying milestones to a safe and effective discharge: lessons from the Education Research Outcomes Collaborative." AAIM Fall Meeting. Washington, DC	Sept 11, 2014
"National networking with Academic Alliance for Internal Medicine" Grand Rounds, Wright Center, Scranton, PA	Aug 19, 2014
"High Value Care" Professor Day, Wright Center, Scranton, PA	June 4, 2014
"Program evaluation" Grand Rounds, Wright Center, Scranton, PA	Mar 26, 2014
"The struggling learner" Grand Rounds, Wright Center, Scranton, PA	Feb 12, 2014
"Transition of Care: TRACER" Grand Rounds, Wright Center, Scranton, PA	Dec 18, 2013
"Next Accreditation System" Grand Rounds, Wright Center, Scranton, PA	Nov 13, 2013
"Engaging the learner in Milestones and Competency Based Advancement" Grand Rounds, Wright Center, Scranton, PA	Oct 7, 2013
Workshop "Building Faculty Development into the Daily Activities of Our Teachers." APDIM Fall Meeting. New Orleans, LA	Oct 2, 2013
Workshop: "How to incorporate High Value Care Curricula into Existing Educational Conferences." APDIM Spring Meeting. Orlando, FL	Oct 2, 2013
Plenary Co-Moderator "Operationalizing NAS, EPAs, NAS Milestones, and Curricular Milestones." APDIM Spring Meeting. Orlando, FL	April 30, 2013
Workshop "Engaging Residents in the Milestones: Results of the Educational Research Outcomes Collaborative (E-ROC)." APDIM Spring Meeting. Orlando, FL	April 30, 2013
"Leadership and mentoring" Grand Rounds, Wright Center, Scranton, PA	April 24, 2013
"A Dozen Teaching Techniques" Grand Rounds, Wright Center, Scranton, PA	Mar 3, 2013
Workshop "Like a Flip Book: Serial Precepting in Essential Ambulatory Care" APDIM Fall Meeting. Phoenix, AZ	Oct 11, 2012
Plenary: Bringing it all home: EPAs to Narratives to Reporting. APDIM Fall Meeting. Phoenix, AZ	Oct 11, 2012
Plenary: How Do They Do This. "TRACER: Early Transitions of Care." APDIM Spring Meeting. Atlanta, GA	April 24, 2012
Workshop "Applying Milestones in training: lessons from a multi-center educational study." APDIM Spring Meeting. Atlanta, GA	April 24, 2012
"Teamwork in a Patient Centered Medical Home" Professor Day, Wright Center, Scranton, PA	Mar 21, 2012
Workshop "Lessons from Geese: Teaching Teamwork in a Patient Centered Medical Home." APDIM Fall Meeting. Anaheim, CA	Oct 20, 2011

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CDIM pre-course "Solutions to 21st Challenges in Medical Education" Susan Hingle, chair. Session "Competency based Assessment in Medical Residencies and How it Might be Applied to Medical Student Education" APDIM Fall Meeting. Anaheim, CA	Oct 20, 2011
Workshop: "Lost or Found in Transition: Educational Innovation for Transitions of Care" APDIM Spring Meeting, Las Vegas, NV	April 11, 2011
Pre-course Presenter: "Incorporating Milestones into Internal Medicine Residency Training: Innovations and Opportunities" Presentation "Early Projects Investigating Landmarks". APDIM Spring Meeting, Las Vegas, NV	April 11, 2011
Plenary: "Milestones: Theory to Practice." ACGME Education Conference, Nashville, TN	March 6, 2011
Workshop: "Kicking it up a notch...fundamental residency redesign in the new millennium." APDIM Fall Meeting, San Antonio, TX	Oct 15, 2011
Workshop "Applying the Internal Medicine Milestones: Lessons of a Multi-Institutional Collaborative." APDIM Fall Meeting, San Antonio, TX	Oct 15, 2011
Workshop: "CBME and Milestones: The EIP Pilot" EIP APDIM Spring Meeting, Baltimore, MD	April 26, 2010
Workshop: "Fundamental Residency Redesign: Three Giant Steps". APDIM Spring Meeting, Baltimore, MD	April 28, 2010

Regional

<i>"Cookers, Cottons, and Compassion: An immersive medical student curriculum to explore the needs of persons who inject drugs"</i> 2020 NEGEA Annual Conference, Burlington, VT	April 30, 2020
"A Safe and Effective Discharge Curriculum Implemented in 11 Internal Medicine Programs" Society for General Internal Medicine, Massachusetts Chapter Annual Meeting, Waltham, MA	April 12, 2015
Workshop: Relationship-based Interprofessional Education and Practice: Turning Challenges into Opportunities. Harvard Macy Institute 20th Anniversary Symposium. Educating to Innovate in Healthcare: Celebrating 20 Years of Innovation at the Harvard Macy Institute. Boston, MA. Harvard Medical School, Boston, MA.	June 20, 2014
Workshop: "Sharing professional values for collaborative practice and IPE." Harvard Macy Institute, Program for Educators in Health Professions. Boston, MA	May 19, 2014

Local

"NAS from punitive to restorative" Program Administrators and Education Coordinators Annual Retreat, Baystate Medical Center, Springfield, MA	Oct 21, 2013
"State of the Art Development Series: Educational Innovation Project" Medicine Grand Rounds, Baystate Medical Center, Springfield, MA	Dec 1, 2010
"Transgender Health: My Right Self" Medicine Grand Rounds, Baystate Medical Center, Springfield, MA	Mar 10, 2010
"On Diversity to Inclusion" Medicine Grand Rounds, Baystate Medical Center, Springfield, MA	Mar 11, 2009

Other Presentations, Posters & Abstracts

International

Meade L , Benjamin E, Scavron J. Dying with AIDS: Issues Confronting a North American Community. 11th International Congress on Care of the Terminally Ill. Poster Montreal, Canada	Sept 7, 1996

National

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Workshop. "The Quadruple Aim: Strategic Initiatives to Foster Engagement and Build Resilience Across the Continuum of Hospital Medicine." SHM Annual Meeting Las Vegas, NV accepted	May 1, 2017
Meade L , Katie Heist Suddarth, Ron Jones, Cheryl O'Malley, Kenji Yamazaki, Aimee Zaas. Advancement by Competence: Comparison of a Discharge Curriculum versus usual practice in multiple programs. Poster AAIM Fall Meeting. Atlanta, GA	Oct 8, 2015
Meade L , Katie Heist Suddarth, Ron Jones, Cheryl O'Malley, Kenji Yamazaki, Aimee Zaas. A safe and effective discharge curriculum implemented in 11 internal medicine programs. Poster, SGIM Annual Meeting. Toronto, Ontario Canada, April 22-25, 2015; SHM Annual Meeting. National Harbor Maryland, March 29 – April 1, 2015; and APDIM Spring Meeting. Houston, TX	April 2015
Gregg Novak, Jumea Barooah, Jignesh Sheth, Tiffany Elks, Meade L . AAIM Fall Meeting. The "PDSA Tracker": Promoting Resident CQI Project Completion and Hand-Offs. Poster, AAIM Fall Meeting, Washington, DC	Sept 11, 2014
Meade L , Jones R, Zaas A, Heist MD, O'Malley C, Day L, Willgerodt, M, Implementing Resident Training in an Internal Medicine Collaborative for a Safe Discharge from the Hospital. Harvard Macy Institute, Program for Educators in Health Professions. Poster, Boston, MA	May 19, 2014
Yamazaki, K; Albanese, T; Swing, S; Jones, R; O'Malley, C; Zaas, A; Caverzagie, K; , Heist, K; Meade L . How and when do learners advance by milestones, Poster, ACGME Annual Education Conference, Nashville, TN	Feb 27, 2014
Samavedam S, Meade L , Shantha G, Gollamudi LR, Gardner K, Gopavaram D, Thomas-Hemak L. Developing self-reflection in the Teaching Health Center resident: a milestones based portfolio. National Association of Community Health Centers, Poster, Annual Meeting, Chicago, IL	Aug 25, 2013
Shantha G, Gollamudi LR, Irukulla PK, Samavedam S, Sheth J, Ebersole B, Gardner K, Barooah J, Meade L , Thomas-Hemak L. Data Driven Residency Program Improvement Affirmation in a Teaching Health Center Consortium (THC). Poster, National Association of Community Health Centers. Annual Meeting, Chicago, IL	Aug 25, 2013
Thomas-Hemak L, Shantha G, Ebersole B, Meade, L . The Wright Center's Diversification of Graduate Medical Education (GME) Finances in a Teaching Health Center Community-Based Consortium. National Association of Community Health Centers. Poster, Annual Meeting, Chicago, IL	Aug 25, 2013
Yadav, S; Kleppel, R; Shaaban, R; Paadam J; Meade, L . Embedding the concepts of waste and systems failure reduction in an innovative quality curriculum for resident education. Poster, Society of Hospital Medicine's Annual Meeting, San Diego, CA	2012
Post J, Heist K, Brandenburg S, Meade L ; Sorting the Milestones: Can residents and attendings agree? Poster, ACGME Annual Meeting Orlando, FL	2012

Academic Service

Internal Administration and Service

Department of Medicine, Baystate Medical Center, Springfield, MA

Advancing and Achieving in Diversity Task Force (Chair), Baystate Medical Center, Springfield, MA	2014-2016
Lesbian Gay Bisexual Transgender Health Leadership Committee (Co-chair), Baystate Medical Center, Springfield, MA	2013-2016
Baystate Medical Center Medical Staff Administrative Affairs (participant), Baystate Medical Center, Springfield, MA	2011-2016

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Women Advancing and Achieving in Medicine (Chair), Baystate Medical Center, Springfield, MA	2003-2016
Committee for Quality Peer Review for Medicine (participant), Baystate Medical Center, Springfield, MA	2001-2016
Committee for Quality Peer Review for Ambulatory Medicine (Chair), Baystate Medical Center, Springfield, MA	2012-2014
Post-Acute Care Performance Improvement Team (participant), Baystate Medical Center, Springfield, MA	2005-2011

Professional Memberships and Activities

Society of Hospital Medicine	2015-present
Wellness Executive Committee (2016-2017)	
American College of Physicians	1998-present
Massachusetts Medical Society	1997-present
American Medical Association	1997-present
Alliance of Academic Internal Medicine	2000-present
- Collaborative for Healing and Renewal for Medicine (participant) (2014-2018) - Collaborative Learning Community (chair) (2014-2016) - Innovations Committee (participant) (2014-2016) - Diversity and Inclusion Committee (participant) (2014-2016) - Alliance of Academic Internal Medicine, Council (2013-2016)	
Association for Program Directors in Internal Medicine	2005-present
- Community Program Leaders Council (chair) (2015-2016) - Educational Research Outcomes Collaborative (chair) (2008-2016) - Spotlight Committee (participant) (2013-2015) - Educational Innovations Program (EIP) (participant) (2005-2015)	
Society for General Internal Medicine, Patient Centered Medical Home Medical Education Summit (participant)	2011
American Academy of HIV Medicine	2000-2004
Gay and Lesbian Medical Association	1999-2002

Editorial Responsibilities

Academic Medicine, reviewer	2011-present
Journal of General Medical Education, reviewer	2011-present
Medical Teacher, reviewer	2011-present

External Professional Service

National

Internal Reviewer for the Medicine Residency (Consultant), Wright Center for Medical Education, Scranton, PA	2011

Regional

Contract Advisory Committee (Participant), Baycare Health Partners, Springfield, MA	2013-2017

Healthcare Interprofessional Education of Pioneer Valley (Participant), Springfield, MA 2014-2016

Professional Development

Leading Innovation in Health Care and Education, Harvard Macy Institute, Boston, MA 2015

Executive Leadership Program, Alliance for Academic Internal Medicine, Cambridge, MA 2014

Program for Educators in Health Professions, Harvard Macy Institute, Boston, MA 2014

**UNITED STATES DISTRICT COURT
DISTRICT OF COLUMBIA**

JANE JONES,

Plaintiffs,

Civil Action No. 1:25- 01

v.

DONALD J. TRUMP, et al.,

Defendants.

**DECLARATION OF RICK STOVER,
SENIOR DEPUTY ASSISTANT DIRECTOR
DESIGNATION AND SENTENCE COMPUTATION CENTER**

I, Rick Stover, declare and state as follows:

1. I am currently employed by the Federal Bureau of Prisons (Bureau). Since June 2024, I have served as the Senior Deputy Assistant Director of the Designation and Sentence Computation Center, within the Bureau's Correctional Programs Division.

2. Prior to becoming Senior Deputy Assistant Director of the Designation and Sentence Computation Center, I worked in positions of increasing responsibility within the Bureau, most recently as the Warden at the Federal Correctional Institution in Danbury, Connecticut.

3. I am familiar with the Bureau's general policies and practices on housing for inmates, including the rationales for those policies. As part of my official duties, I have access to records maintained in the ordinary course of business by the Bureau, including inmate medical and mental health records.

4. The information below is based upon personal knowledge and upon information and belief.

MATERIAL UNDER SEAL DELETED

5. As of February 20, 2025, there are 2,198 inmates housed in FBOP facilities and halfway houses that identify as the opposite biological sex. There are 1,488 biological male inmates who identify as female and 710 biological female inmates who identify as male. The FBOP currently has 22 biological male inmates living in female institutions. It has 1 biological female inmate living in a male institution.

6. Plaintiff, Jane Jones, is a biological male inmate currently housed in a female facility at [REDACTED] The FBOP has reevaluated this placement and determined that placement at the [REDACTED] [REDACTED] is appropriate.

7. In determining the most appropriate placement for Jane Jones, the FBOP took into consideration the inmates' assigned security level, disciplinary record, medical record, and psychology record. Additional medical consideration was given to plaintiff's placement because Jane Jones previously underwent surgery to conform Jones's appearance to that of the opposite sex and will have additional medical care needs beyond what most male inmates need.

8. Based on these factors, the Bureau found that placement at [REDACTED] [REDACTED] would safely house Jane Jones. [REDACTED] [REDACTED] is a low security facility that houses several biological male inmates who identify as the opposite sex and a large number of nonviolent offenders. Nonviolent crimes are defined as crimes involving property, drug, and other offenses which do not involve a threat of harm or an actual attack upon a victim. The most frequently identified nonviolent crimes involve drug trafficking, drug possession, burglary, and larceny. Moreover, inmates housed in low security facilities tend to have minor infractions in their disciplinary history with the Bureau.

MATERIAL UNDER SEAL DELETED

9. Being housed at [REDACTED] greatly reduces the chance of Jane Jones being victimized by other inmates. Jane Jones is currently housed at [REDACTED]. [REDACTED] The institution has a population size of approximately [REDACTED] inmates. In 2024, [REDACTED] had a total of [REDACTED] guilty findings of assaults on inmates. [REDACTED] has a population size of approximately [REDACTED] total inmates. In 2024, [REDACTED] had a total of [REDACTED] guilty findings of assaults on inmates. Moreover, [REDACTED] currently houses [REDACTED] biological male inmates who identify as the opposite sex, thereby having staff members that are experienced with providing care to this special population.

10. [REDACTED] was also selected because it has [REDACTED]. [REDACTED]. Jones would be medically assessed and given a treatment plan consistent with Jones' medical needs.

11. The Bureau follows the requirements of the Prison Rape Elimination Act of 2003's (PREA) implementing regulations to ensure the safety of inmates. In deciding whether to assign an inmate to a facility for male or female inmates, the Bureau's policy is consistent with PREA standards, in that the Bureau considers on a case-by-case basis whether a placement would ensure the inmate's health and safety, and whether the placement would present management or security problems. [REDACTED] is thus particularly well situated to deliver medically necessary health care to inmates in accordance with proven standards without compromising public safety concerns.

12. The FBOP recognizes the importance of protecting all inmates from sexually abusive behavior and ensure their continued safety. In fact, pursuant to FBOP Program Statement 5324.12, Sexually Abusive Behavior Prevention and Intervention Program (effective June 4, 2015), the FBOP implements zero tolerance toward all form of sexual activity in the custodial environment, including sexual abuse and sexual harassment. Routine training is provided to all FBOP staff to

help detect incidents, perpetrators, and inmate victims of sexually abusive behavior. FBOP staff are educated to intervene properly and in a timely manner. FBOP staff are required to document, report, and investigate reported incidents. Moreover, FBOP is responsible for disciplining and referring for prosecution perpetrators of sexually abusive behavior against other inmates.

13. All institutional staff are trained to monitor and to intervene when they observe problematic interactions between inmates. At each FBOP institution, staff review a Posted Picture File (PPF) of inmates who are potentially disruptive, escape risks, or present a threat to staff or institutional security. The FBOP identifies inmates who, because of prior record, current offense, institutional adjustment, or other factors, pose a significant threat to inmate or staff safety, the institution's security, or the surrounding community's welfare. The PPF is updated at least quarterly. Institution staff review the PPF regularly for the purpose of determining inmates with a history of assaultive behavior or a history of sexual offenses, for the purpose of keeping the institution safe and secure.

14. The FBOP conducts a Prison Rape Elimination Act (PREA) Intake screening upon an inmate's arrival to an institution, to ensure any potential for victimization or abusiveness. Consistent with PREA's implementing regulations, this screening includes the inmate's own perception of their safety and history of sexual assault, FBOP staff's assessment of the inmate's general physical appearance and presentation, and a review of the inmate's criminal history. FBOP staff must notify Correctional Services of the inmate's history of predation to ensure that the appropriate steps (investigation, documentation, CIMS concerns, etc.) have been taken. Moreover, if an inmate presents as a risk of victimization, staff will consider a referral to Psychology Services.

15. Furthermore, if at any time, FBOP staff believe that an inmate's safety may be seriously jeopardized by placement in the general population, the inmate may be housed in more

restrictive conditions as a protective custody case in the Special Housing Unit. When an inmate is placed in administrative detention for placement, the Warden or designee (ordinarily to Captain), must review the placement within two workdays of the placement to determine if continued protective custody is necessary. This review includes documents that led to the inmate being placed in protective custody and any other documents pertinent to the inmate's protection.

16. Inmates have numerous ways to report if they have been sexually assaulted or have been a victim of sexual harassment. An inmate can write directly to the Warden, Regional Director or Director. An inmate can send the Warden an Inmate Request to Staff Member (Cop-out) or a letter reporting the sexually abusive behavior. Moreover, an inmate may also send a letter to the Regional Director or Director of the Bureau of Prisons, and to ensure confidentiality, can use special mail procedures. Finally, an inmate can file a Request for Administrative Remedy (BP-9). If the inmate determines that the complaint is too sensitive to file with the Warden, the inmate has the opportunity to file the administrative remedy directly with the Regional Director (BP-10). The inmate can also email or write the Office of Inspector General (OIG) which investigates certain allegations of staff misconduct by employees of the U.S. Department of Justice. Moreover, anyone can report abuse on behalf of the inmate by using, https://www.bop.gov/inmates/custody_and_care/sexual_abuse_prevention.jsp. Finally, an inmate can send reports of sexual abuse to a dedicated email address managed by OIG, and the inmate can request the report remain confidential. OIG is completely independent of the FBOP. OIG protects the identity of victims and other individuals who report allegations to the greatest extent possible, while still thoroughly vetting and investigating the allegations.

In accordance with 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Dated: February 22, 2025

RICHARD
STOVER

Digitally signed by RICHARD
STOVER
Date: 2025.02.22 12:28:30
-06'00'

RICK STOVER

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JANE JONES,

Plaintiff,

v.

Civil Action No. 25-cv-00401-RCL

DONALD TRUMP, in his official capacity as
President of the United States; JAMES R.
MCHENRY III, in his official capacity as Acting
Attorney General of the United States; WILLIAM
LOTHROP, in his official capacity as Acting
Director of the Federal Bureau of Prisons,

Defendants.

**SUPPLEMENTAL
DECLARATION OF LAUREN
MEADE, M.D.**

I, Lauren Meade, of full age, do hereby declare as follows:

1. I respectfully submit this supplemental declaration in further support of Plaintiff's motion for a temporary restraining order and preliminary injunction.

2. My background and qualifications are set forth in my January 25, 2025 declaration. I submit this supplemental declaration in order to respond to certain claims about Ms. Jones's need for additional medical care and to elaborate on the potential harms to Ms. Jones if she does not continue to receive treatment for her gender dysphoria.

3. As I stated in my previous declaration, gender dysphoria is a serious medical condition if left untreated. Other than socially transitioning, hormone therapy, and surgery, there are no alternative treatments for effectively managing gender dysphoria.

4. Allowing transgender people to transition and live in a different sex has been proven effective in combatting the severe health consequences of gender dysphoria.

5. Forcing a transgender person to live in their birth sex, such as for example, forcing a transgender woman to reside in a men's facility and forcing her to present and live as a male will predictably worsen gender dysphoria and cause severe psychological distress. This is especially true for a transgender individual who has lived in a sex different than their birth sex for a significant amount of time, including through use of medications and surgeries. The fact that it is harmful to make a transgender person live in their birth sex is true as well for someone who has not had medications or surgery.

6. Providing any kind of purported medical care or behavior health modalities to try to make a transgender person comfortable or even able to live in their birth sex and suppress who they are as a transgender person is a rejected and harmful approach and inconsistent with established medical care. Like conversion therapy targeting lesbian, gay, bisexual, and transgender individuals, these approaches have been widely discredited by medical professionals due to their documented harmful effects. Research shows they not only fail to achieve their intended outcomes but also inflict psychological trauma and substantially increase the risk of self-harm among those subjected to them.

7. For example, in a 2020 article titled "Statement on Conversion Therapy," the Independent Forensic Expert Group explained that "[a]ll forms of conversion therapy, including talk or psychotherapy, can cause intense psychological pain and suffering," and "[i]n many studies, the rates of suicidal ideation and suicide attempt are several times higher than in other lesbian, gay, bisexual, trans, and gender diverse populations who have not been exposed to conversion therapy." The article further explains that "the likely harm of conversion therapy cannot be outweighed by any clinical benefits, as there are none." Expert Group A true and correct copy of the article is attached as **Exhibit A**.

MATERIAL UNDER SEAL DELETED

8. By way of further example, a 2022 study of study of lesbian, gay, bisexual, transgender, queer, or questioning (“LGBTQ”) youths in the United States found that when compared to LGBTQ individuals who experience conversion therapy, the conversion therapy recipients were more likely to experience serious psychological distress (47% vs 34%), depression (65% vs 27%), substance abuse (67% vs 50%), and attempted suicide (58% vs 39%). A true and correct copy of the study is attached as **Exhibit B**.

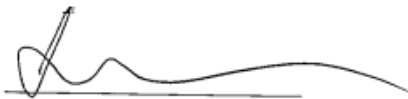
9. Cutting off a transgender woman’s access to female hormones is harmful because it is the hormones that affect her body in ways that enable her to live as a woman.

10. It is critically important that transgender individuals receive access to hormone therapy and other medical care in accordance with well-established and proven standards of care.

11. Based on my training and experience as a physician, an individual who has been stable on hormone therapy for [REDACTED] and is [REDACTED] post-gender-transition surgery requires only routine medical care. Indeed, this would typically be true even for someone who has been stable on hormones for a much shorter period and who underwent surgery more recently. Once stability on hormone therapy is established and post-surgical recovery is complete, ongoing medical needs consist simply of regular hormone medication, which can be administered orally like any other daily prescription. This established post-transition care does not require specialized medical facilities or proximity to advanced care centers. The medical protocol at this stage is straightforward and can be managed like any other routine prescription medication regimen. There is no justification for increased medical attention for someone whose transition is well-established.

Pursuant to 28 U.S.C. § 1746, I affirm under penalty of perjury that the above statements are true and correct.

Dated: February 23, 2025

A handwritten signature in black ink, appearing to be "Dr. Lauren Meade", written over a horizontal line.

Dr. Lauren Meade

Exhibit A



Contents lists available at ScienceDirect

Journal of Forensic and Legal Medicine

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Review

Statement on conversion therapy^{*}

Independent Forensic Expert Group¹



ARTICLE INFO

Keywords:

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Psychotherapy
Sexual orientation and gender identity
Torture and ill-treatment
Child abuse and neglect
Fraud
Medical ethics

ABSTRACT

Conversion therapy is a set of practices that aim to change or alter an individual's sexual orientation or gender identity. It is practiced in every region of the world by health professionals, religious practitioners, and community or family members often by or with the support of the state. Conversion therapy is performed despite evidence that it is ineffective and likely to cause individuals significant or severe physical and mental pain and suffering with long-term harmful effects. The purpose of this medico-legal statement is to provide legal experts, adjudicators, health care professionals, and policy makers, among others, with an understanding of: 1) the lack of medical and scientific validity of conversion therapy; 2) the likely physical and psychological consequences of undergoing conversion therapy; and 3) whether, based on these effects, conversion therapy constitutes cruel, inhuman, or degrading treatment or torture when individuals are subjected to it forcibly or without their consent. This medico-legal statement also addresses the responsibility of states in regulating the practice, the ethical implications of offering or performing it, and the role that health professionals and medical and mental health organisations should play with regards to it.

1. Introduction

Conversion therapy is a set of practices that aim to change or alter an individual's sexual orientation or gender identity. It is premised on a belief that an individual's sexual orientation or gender identity can be changed and that doing so is a desirable outcome for the individual, family, or community. Other terms used to describe this practice include sexual orientation change effort (SOCE), reparative therapy, reintegrative therapy, reorientation therapy, ex-gay therapy, and gay cure.

Conversion therapy is practiced in every region of the world. We have identified sources confirming or indicating that conversion therapy is performed in over 60 countries.²

In those countries where it is performed, a wide and variable range of practices are believed to create change in an individual's sexual orientation or gender identity. Some examples of these include: talk therapy or psychotherapy (e.g., exploring life events to identify the cause); group therapy; medication (including anti-psychotics, anti-depressants, anti-anxiety, and psychoactive drugs, and hormone injections); Eye

Movement Desensitization and Reprocessing (where an individual focuses on a traumatic memory while simultaneously experiencing bilateral stimulation); electroshock or electroconvulsive therapy (ECT) (where electrodes are attached to the head and electric current is passed between them to induce seizure); aversive treatments (including electric shock to the hands and/or genitals or nausea-inducing medication administered with presentation of homoerotic stimuli); exorcism or ritual cleansing (e.g., beating the individual with a broomstick while reading holy verses or burning the individual's head, back, and palms); force-feeding or food deprivation; forced nudity; behavioural conditioning (e.g., being forced to dress or walk in a particular way); isolation (sometimes for long periods of time, which may include solitary confinement or being kept from interacting with the outside world); verbal abuse; humiliation; hypnosis; hospital confinement; beatings; and "corrective" rape.

Conversion therapy appears to be performed widely by health professionals, including medical doctors, psychiatrists, psychologists, sexologists, and therapists. It is also conducted by spiritual leaders,

^{*} Please send correspondence to ifeg@irct.org. For full details about the Independent Forensic Expert Group, please visit <https://irct.org/campaigns/istanbul-protocol>.

¹ Djordje Alempijevic, Rusudan Beriashvili, Jonathan Beynon, Bettina Birmanns, Marie Brasholt, Juliet Cohen, Maximo Duque, Pierre Duterte, Adriaan van Es, Ravindra Fernando, Sebnem Korur Fincanci, Sana Hamzeh, Steen Holger Hansen, Lilla Hardi, Michele Heisler, Vincent Iacopino, Peter Mygind Leth, James Lin, Said Louahlia, Hege Luytkis, Jens Modvig, Maria-Dolores Morcillo Mendez, Alejandro Moreno, Valeria Moscoso, Resmiye Oral, Onder Ozkalipci, Jason Payne-James, Jose Quiroga, Hernan Reyes, Sidsel Rogde, Antti Sajantila, Matthis Schick, Agis Terzidis, Jorgen Lange Thomsen, Morris Tidball-Binz, Felicitas Treue, Peter Vanezis, Duarte Nuno Viera.

² IRCT research on conversion therapy available at https://irct.org/uploads/media/IRCT_research_on_conversion_therapy.pdf

<https://doi.org/10.1016/j.jflm.2020.101930>

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religious practitioners, traditional healers, and community or family members. Conversion therapy is undertaken both in contexts under state control, e.g., hospitals, schools, and juvenile detention facilities, as well as in private settings like homes, religious institutions, or youth camps and retreats. In some countries, conversion therapy is imposed by the order or instructions of public officials, judges, or the police.

The practice is undertaken with both adults and minors who may be lesbian, gay, bisexual, trans, or gender diverse. Parents are also known to send their children back to their country of origin to receive it. The practice supports the belief that non-heterosexual orientations are deviations from the norm, reflecting a disease, disorder, or sin. The practitioner conveys the message that heterosexuality is the normal and healthy sexual orientation and gender identity.

The purpose of this medico-legal statement is to provide legal experts, adjudicators, health care professionals, and policy makers, among others, with an understanding of: 1) the lack of medical and scientific validity of conversion therapy; 2) the likely physical and psychological consequences of undergoing conversion therapy; and 3) whether, based on these effects, conversion therapy constitutes cruel, inhuman, or degrading treatment or torture when individuals are subjected to it forcibly³ or without their consent.

This medico-legal statement also addresses the responsibility of states in regulating this practice, the ethical implications of offering or performing it, and the role that health professionals and medical and mental health organisations should play with regards to this practice.

Definitions of conversion therapy vary. Some include any attempt to change, suppress, or divert an individual's sexual orientation, gender identity, or gender expression. This medico-legal statement only addresses those practices that practitioners believe can effect a genuine change in an individual's sexual orientation or gender identity. Acts of physical and psychological violence or discrimination that aim solely to inflict pain and suffering or punish individuals due to their sexual orientation or gender identity, are not addressed, but are wholly condemned.

This medico-legal statement follows along the lines of our previous publications on Anal Examinations in Cases of Alleged Homosexuality¹ and on Forced Virginity Testing.² In those statements, we opposed attempts to minimise the severity of physical and psychological pain and suffering caused by these examinations by qualifying them as medical in nature. There is no medical justification for inflicting on individuals torture or other cruel, inhuman, or degrading treatment or punishment. In addition, these statements reaffirmed that health professionals should take no role in attempting to control sexuality and knowingly or unknowingly supporting state-sponsored policing and punishing of individuals based on their sexual orientation or gender identity.

2. About the authors

The opinions expressed in this statement are based on international standards and the experiences of members of the Independent Forensic Expert Group (IFEG) in documenting the physical and psychological

³ This statement considers an examination to be "forcibly conducted" when it is "committed by force, or by threat of force or coercion, such as that caused by fear of violence, duress, detention, psychological oppression or abuse of power, against such person incapable of giving genuine consent." International Criminal Court. Elements of Crimes. Art. 7(1) (g)-1. RC/11.2011:8.

effects of torture and other cruel, inhuman, or degrading treatment or punishment (also ill-treatment). Consisting of 39 preeminent independent medico-legal specialists from 23 countries, the IFEG represents a vast collective experience in the evaluation and documentation of the physical and psychological evidence of torture and ill-treatment.

The IFEG provides technical advice and expertise in cases where allegations of torture or ill-treatment are made.⁴ Its members are global experts on and authors of the Istanbul Protocol, the key international standard-setting instrument on the investigation and documentation of torture and ill-treatment.³

IFEG members also hold influential positions in and act as advisors to governments, international bodies, professional health associations, non-governmental organisations, and academic institutions worldwide on forensics in general and more specifically on the investigation and documentation of torture and ill-treatment.

3. Medical and scientific validity

There is no empirical evidence to support pathologising or medicalising variations in sexual orientation and gender identity. Studies have found that variation in sexual orientation is ubiquitous and that there is substantial variability in patterns of sexual and gender expression both between individuals and within individuals across time.⁴ The World Medical Association (WMA) has strongly emphasised "*that homosexuality does not represent a disease, but a normal variation within the realm of human sexuality.*"⁵ For almost half a century, the Diagnostic and Statistical Manual of Mental Disorders (DSM-III, 1973) has stopped recognising homosexuality as a disorder. Similarly, for three decades, the World Health Organisation (WHO), which issues the International Statistical Classification of Diseases and Related Health Problems, has not defined homosexuality as a disorder (ICD-10, endorsed in 1990). Moreover, in 2018, the WHO declassified all remaining disorders correlated with same-sex attraction, such as ego-dystonic sexual orientation,⁵ which had been (mis)used in the past to justify conversion therapy, thereby eliminating all medical bases correlated to sexual orientation that can be used to justify conversion therapy.

To our knowledge, there also are no credible scientific peer-reviewed studies that demonstrate that conversion therapy in any form is effective. On the contrary, in 2009, the American Psychological Association conducted a systematic review of peer-reviewed journal literature on conversion therapy and concluded that "*the results of scientifically valid research indicate that it is unlikely that individuals will be able to reduce same-sex attractions or increase other-sex sexual attractions through [sexual orientation change efforts].*"⁶ In 2016, the World Psychiatric Association issued a statement finding that "*[t]here is no sound scientific evidence that innate sexual orientation can be changed.*"⁷

Practices that purport to change an individual's sexual orientation or gender identity therefore lack any foundation in science or medicine and are unlikely to be effective. Instead, they are based on an antiquated misconception about the nature of sexual orientation and gender identity.

⁴ See, e.g., Independent Forensic Expert Group. Statement on Hooding. Torture. 2011; 21(3):186–189; Independent Forensic Expert Group. Statement on access to relevant medical and other health records and relevant legal records for forensic medical evaluations of alleged torture and other cruel, inhuman or degrading treatment or punishment. Torture. 2012; 22 (Supplementum 1):39–48. Independent Forensic Expert Group. Statement on Virginity Testing. Torture. 2015; 25(1):62–68; Independent Forensic Expert Group. Statement on Anal Examinations in Cases of Alleged Homosexuality. Torture. 2016; 26(2):85–91.

⁵ "The gender identity or sexual preference is not in doubt but the individual wishes it were different because of associated psychological and behavioural disorders and may seek treatment to change it." World Health Organisation. The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. 1992.

4. Physical and psychological effects

Conversion therapy represents a form of discrimination, stigmatisation, and social rejection. Many conversion therapy practices bear similarity to acts that are internationally acknowledged to constitute torture or other cruel, inhuman, or degrading treatment or punishment. Those include beatings, rape, forced nudity, force-feeding, isolation and confinement, deprivation of food, forced medication, verbal abuse, humiliation, and electrocution. These specific acts as well as the entire period during which the individual experiences them is recognised internationally to subject individuals to significant or severe physical and/or mental pain and suffering.

The fact that a treatment or practice has a valid medical use does not mean that it is not physically and psychologically harmful to individuals. In addition, a valid medical use for some conditions does not mean that the treatment is valid to treat other conditions under different circumstances. For instance, ECT or electroshock therapy applied with muscle relaxant and general anaesthesia is a recognised and valid form of treatment for psychiatric patients suffering from treatment-resistant, life-threatening depression. But in almost every instance, individuals will experience significant disorientation, cognitive deficits, and retrograde amnesia, which can be severely distressing. Concerningly, ECT is reportedly used for conversion therapy in some countries, although it is unproven and therefore medically invalid. In countries where ECT is still administered in its unmodified form (i.e., without anaesthetic and muscle relaxants), it not only causes significant psychological harm, but leads to violent convulsions commonly resulting in joint dislocations and bone fractures.

Medication is also used in conversion therapy and can cause significant physical and mental adverse effects. When such medication is medically inappropriate or used forcibly or without the individual's consent, it is likely to intensify the psychological terror or trauma related to the experience of conversion therapy and has been recognised as a method of torture or other cruel, inhuman, or degrading treatment.⁸ Neuroleptics, anxiolytics, and anti-depressants (including thioridazine, citalopram, fluoxetine, and risperidone) have been used on individuals to diminish their sexual desire. In addition, they are often prescribed due to the false belief that psychosis or other mental disorder is the underlying cause of an individual's particular sexual orientation or gender expression. These anti-depressants, mostly from the selective serotonin reuptake inhibitor group, may cause sexual dysfunction, while anti-psychotic medications may cause movement disorders, mental slowing, tiredness, memory problems, numbness of the body, weight gain, and sexual dysfunction, among other effects, which serve only to compound an individual's distress and suffering.

All forms of conversion therapy, including talk or psychotherapy, can cause intense psychological pain and suffering.⁹⁻¹² All practices attempting conversion are inherently humiliating, demeaning, and discriminatory. The combined effects of feeling powerless and extreme humiliation generate profound feelings of shame, guilt, self-disgust, and worthlessness, which can result in a damaged self-concept and enduring personality changes. The injury caused by conversion therapy begins with the notion that an individual is sick, diseased, and abnormal due to their sexual orientation or gender identity and must therefore be treated. This starts a process of victimisation through conversion therapy. Individuals who have undergone the practice often experience a decrease in self-esteem, episodes of significant anxiety, depressive tendencies, depressive syndromes, social isolation, intimacy difficulties, self-hatred, sexual dysfunction, and suicidal thoughts. In many studies, the rates of suicidal ideation and suicide attempt are several times higher than in other lesbian, gay, bisexual, trans, and gender diverse populations who have not been exposed to conversion therapy.¹³⁻¹⁵

Conversion therapy can often lead to posttraumatic stress disorder.^{11,16} Group therapy, camps and retreats may incorporate highly traumatic elements such as exposure to physical, verbal, and sexual abuse and humiliation. Talk or psychotherapy can also become a

repeatedly traumatic event. Session after session, the individual is confronted with their own "deviancy," while repetition and duration increase its intensity and importance. We have seen that conversion therapies can lead to avoidance behaviours, hypervigilance (e.g., difficulty falling or staying asleep), intrusive flashbacks, traumatic nightmares, and other symptoms of posttraumatic stress disorder.

Children and minors are particularly vulnerable.^{13,14,17} In children and minors exposed to conversion therapy, psychological symptoms are expressed in a significant loss of self-esteem and a sharp increase in suicidal or depressive tendencies. These can often lead to school dropout and the adoption of high-risk behaviours, self-destructive behaviours, and substance abuse. Conversion therapy causes a delay in sexual and personal development, which can lead to depression, increased feelings of guilt and stress, and can also bring about feelings of social rejection and social isolation. Minors are at especially high risk to develop serious psychological disorders afterwards, due to the loss of self-esteem, negative feelings toward oneself, self-loathing, feelings of debasement, and the forced rejection of one's own identity.

The long-term duration of many conversion therapies can be particularly harmful. Individuals often undergo therapy for several years to more than a decade.^{9,17} The long-term duration creates chronic stress, which has been known to result in many negative health consequences, including stomach ulcers, gastrointestinal disorders, skin diseases, sexual and eating disorders, and migraines. Psychosomatic symptoms can be especially pronounced in children who are unable to express their difficulties and may manifest their distress through eczema breakouts, insomnia, sleep disorders, vomiting, asthma, and impaired growth or development. Psychological symptoms can become chronic. Despair, disillusion, and shame can last for many years. Even into adulthood, studies have found that exposure to conversion efforts results in adverse mental health outcomes, including severe psychological distress, lifetime suicidal thoughts, and lifetime suicide attempts.^{13,14}

In both adults and minors, the failure of conversion therapy often exacerbates the individual's feelings of inadequacy, self-worthlessness, and shame.^{9,12} Individuals often feel intense guilt of failure, reinforced by the idea that they are ill, unacceptable, incurable, and a burden to their families.

When health professionals are involved in the performance of this harmful act, in our experience, their involvement is likely to exacerbate the pain and suffering experienced by individuals given the betrayal it represents of the social norm of trusting health professionals. Betrayal of the fragile trust between patient and clinician can have severe consequences, leading to feelings of guilt, rejection, and humiliation. The individual can lose self-esteem and may exhibit anger or withdrawal, which will impair their future interpersonal and romantic relationships and professional life.

Where conversion therapy is ordered, conducted, or supported by public authorities, the experience of being betrayed by the law likely adds to the individual's mental pain and suffering. These amplify any shame and stigma they may already experience, including social rejection, victimisation and punishment by their family or religious community, and conflict with their faith.

5. Cruel, inhuman, and degrading treatment and torture

Torture and other forms of cruel, inhuman, or degrading treatment or punishment are unequivocally prohibited, without exception, by the UN Convention against Torture¹⁸ as well as other international and regional human rights instruments. The UN Committee against Torture, the UN Special Rapporteur on Torture, the UN Subcommittee on Prevention of Torture, and the Office of the High Commissioner for Human Rights (OHCHR) have stated that conversion therapy contravenes the prohibition against torture and other cruel, inhuman, or degrading treatment or punishment. In its 2015 annual report, the OHCHR stressed that states "*have an obligation to protect all persons, including LGBT and intersex persons, from torture and other cruel, inhuman or degrading*

treatment or punishment” and found that conversion therapy breaches this duty.¹⁹

In May 2018, the UN Independent Expert on Sexual Orientation and Gender Identity observed that: “The violence reported against persons on the basis of their actual or perceived sexual orientation or gender identity also includes ... so-called ‘conversion therapy’. Considering the pain and suffering caused and the implicit discriminatory purpose and intent of these acts, they may constitute torture or other cruel, inhuman or degrading treatment or punishment in situation where a State official is involved, at least by acquiescence.”²⁰ Subsequently, the UN Special Rapporteur on Torture in July 2019 affirmed that: “given that ‘conversion therapy’ can inflict severe pain or suffering, given also the absence both of a medical justification and of free and informed consent, and that it is rooted in discrimination based on sexual orientation or gender identity or expression, such practices can amount to torture or, in the absence of one or more of those constitutive elements, to other cruel, inhuman or degrading treatment or punishment.”²¹

Based on these findings, the UN Committee against Torture, the UN Independent Expert on Sexual Orientation and Gender Identity, the UN Special Rapporteur on Torture, and the OHCHR have all called upon states to ban the practice. In 2016, the UN Committee against Torture recommended that a state take “the necessary legislative, administrative and other measures to guarantee respect for the autonomy and physical and personal integrity of lesbian, gay, bisexual, transgender and intersex persons and prohibit the practice of so-called ‘conversion therapy’.”²²

6. State involvement and responsibility

The UN Convention against Torture and other international and regional human rights instruments not only prohibit torture, but oblige states to prevent public authorities from “directly committing, instigating, inciting, encouraging, acquiescing in or otherwise participating or being complicit in any acts of torture” and other cruel, inhuman, or degrading treatment or punishment.²³ In several countries, we have found that public officials are directly involved in the provision of conversion therapy. In some cases, the therapy is offered and performed by medical personnel in state hospitals, public clinics, schools, and juvenile detention centres. Sometimes, the therapy is performed pursuant to an order by public officials, judges, or the police. All these acts would seem to contravene the international legal obligations of these states to prohibit and prevent torture and other cruel, inhuman, or degrading treatment or punishment.

Furthermore, states have a responsibility to “prohibit, prevent and redress torture and ill-treatment in all contexts of custody and control,” not just those operated by public entities.²³ We have found in almost 30 countries that conversion therapy is being committed, instigated or supported by private institutions and private individuals acting in an official capacity and executing a state function. This includes health professionals in private clinics performing conversion therapies or private schools providing it. The UN Convention against Torture and other human rights instruments require that states oversee the provision of services that are in the public interest, such as health and education. As stated by the UN Committee against Torture, states have the special duty to protect the life and personal integrity of persons by regulating and supervising these services, regardless of whether the entity providing them is public or private.²³ Accordingly, personnel in private hospitals and clinics as well as teachers are considered to act in an official capacity on behalf of the state, as they are executing a state function²³ and should similarly be prevented from directly committing, instigating, inciting, encouraging, acquiescing in, or otherwise participating or being complicit in any acts of torture and ill-treatment, including conversion therapy.

In over a dozen countries, we found that conversion therapy practices, e.g., beatings, isolation, exorcisms, and “corrective” rape, appear to take place primarily in the private sphere by religious practitioners, traditional healers, or sometimes by community and family members. These acts which are not originally directly attributable to the state (i.e.,

acts committed by private individuals) can nevertheless lead to state responsibility, due to the lack of due diligence to eliminate, prevent, investigate, and punish acts of torture and other cruel, inhuman, or degrading treatment or punishment. The failure of the state to act in due diligence leads to a form of encouragement or *de facto* permission of those harmful practices.²³

The UN Committee against Torture has applied this principle to states that have failed to prevent and protect victims from gender-based violence, such as rape, domestic violence, female genital mutilation, and trafficking.²³ A parallel can thus be drawn to the obligation to ban the practice of female genital mutilation which also takes place in a context of profound discrimination. As stated by the UN Special Rapporteur on Torture: “Domestic laws permitting the practice contravene States’ obligation to prohibit and prevent torture and ill-treatment, as does States’ failure to take measures to prevent and prosecute instances of female genital mutilation by private persons.”²³

Children enjoy special protection. An alarming number of minors are subjected to conversion therapy; indeed, minors may account for the majority of all cases.²⁴ The UN Convention on the Rights of the Child requires the best interests of the child to be a primary consideration in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities, or legislative bodies.²⁵ The Convention on the Rights of the Child requires states to take all measures to “protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.”²⁵ Conversion therapy, which is rooted in profound discrimination, lacks scientific and medical validity, is ineffective, and is likely to cause the minor significant or severe pain and suffering, clearly violates these standards. When a minor is subjected to conversion therapy, in addition to amounting to torture or other cruel, inhuman, or degrading treatment, it may constitute a form of child abuse and neglect.

7. Professional and ethical standards

Conversion therapy is inconsistent with the fundamental ethical principles and professional duties of health professionals for the following reasons:

- 1) It is clear that conversion therapy is a form of cruel, inhuman, or degrading treatment when it is conducted forcibly on individuals or without their consent and may amount to torture depending on the circumstances, namely the severity of physical and mental pain and suffering inflicted. International standards of professional ethics unequivocally prohibit health professionals from participating in or condoning any treatment or procedure that may constitute cruel, inhuman, or degrading treatment or torture.^{26,27}
- 2) Variation in sexual orientation and gender identity is not a disease or disorder. Health professionals, therefore, have no role in diagnosing it or treating it. The provision of any intervention purporting to treat something that is not a disease or disorder is wholly unethical.²⁸ If adults voluntarily seek out assistance in hope of changing their sexual orientation, ethical professionals are advised to explain why they don’t attempt this type of practice and not to refer clients to someone who does.²⁹
- 3) Conversion therapy is ineffective and harmful. Health professionals must abide by their core ethical principles to act in the best interests of patients (beneficence) and to “do no harm” (non-maleficence).³⁰ The likely harm of conversion therapy cannot be outweighed by any clinical benefits, as there are none. Moreover, health professionals are prohibited from offering treatments that are recognised as ineffective or purport to achieve unattainable results. Offering conversion therapy thereby constitutes a form of deception, false advertising, and fraud.³¹

4) Ensuring informed consent may be impossible in most circumstances. As noted in previous statements, examinations based on profound discrimination may create situations where a person is incapable of giving genuine consent.¹ This is likely the case when conversion therapy is being conducted based on the order of a public authority, when the individual's liberty is restricted, or when the individual is a minor coerced by family members or others in a position of authority or trust.

In the case of conversion therapy, informed consent would require that an individual is informed about the practices that will be applied, as well as their ineffectiveness, the likely physical and psychological harm that will result, and the inability to achieve the desired result. The individual's consent must be considered invalid if acquired without this knowledge or as a result of false information; and it should be considered suspect, particularly in the case of minors.

5) Conversion therapy creates an inherently discriminatory environment. Even when an individual wants the therapy, the individual may be motivated by self-hatred or a conflict between their actual sexual orientation or gender identity and the self-image that they feel it is safe or acceptable to present to themselves and others. It would be counter therapeutic for the practitioner to add to those internalised feelings. Their efforts would be ineffective in reducing the individual's desires even if the individual's behaviour changes, leaving the client with unexpressed feelings that have the potential to be very damaging.³² Instead, any psychiatric or psychotherapeutic approaches to treatment must not focus on the individual's sexual orientation or gender identity, but on the conflicts that may arise between their orientation, identity, and religious, social, or internalised norms and prejudices.³³

8. Role of health professionals in policing and punishing sexual orientation and gender identity

The practice of conversion therapy runs contrary to respect for the dignity, humanity, and rights of individuals, including to privacy, self-determination, non-discrimination, and to be free from torture and ill-treatment.

Most major medical and mental health organisations have repudiated the practice of conversion therapy. It continues, however, to be widespread and practiced by health professionals and others due to pervasive discrimination and societal bias against lesbian, gay, bisexual, trans, and gender diverse individuals. This represents a challenge to individual health professionals and medical and mental health professional organisations.

Health professionals who are conducting conversion therapies are contributing to a social, cultural, or state-sponsored system of profound repression and stigmatisation against their patients, targeted on the basis of their sexual orientation and gender identity. Health professionals should understand that by providing these treatments, they are serving to perpetuate social customs and norms that are in conflict with their ethical obligations and respect for the rights and dignity of individuals, and that, ultimately, they may be facilitating or participating in cruel, inhuman, or degrading treatment or torture.

The WMA has condemned conversion therapy as a violation of human rights and has called for its practitioners to be denounced and subject to sanctions and penalties.³³ It has also called on national medical associations to "*promote ethical conduct among physicians for the benefit of their patients. Ethical violations must be promptly corrected, and the physicians guilty of ethical violations must be disciplined and rehabilitated.*"³⁴

As more awareness is raised about the issue of conversion therapy both globally and nationally, national medical and mental health associations should create accessible mechanisms for the public to register complaints against health professionals who offer conversion therapy or who have harmed them by performing this practice. Health

professionals who conduct conversion therapies violate the basic standards and ethics of our profession and should be reported by their colleagues to the appropriate authorities.³⁵ National medical and mental health associations should encourage and support health professionals in denouncing this practice and reporting colleagues who practice it.

Recently, there has been a growing trend to call for a ban on conversion therapy in many parts of the world, although few countries have done so yet.³⁶ National medical and mental health associations should support these legislative initiatives and the development of programmes to support individuals who have been harmed by the practice.³⁷

9. Conclusion

Conversion therapy has no medical or scientific validity. The practice is ineffective, inherently repressive, and is likely to cause individuals significant or severe physical and mental pain and suffering with long-term harmful effects. It is our opinion that conversion therapy constitutes cruel, inhuman, or degrading treatment when it is conducted forcibly or without an individual's consent and may amount to torture depending on the circumstances, namely the severity of physical and mental pain and suffering inflicted.

As a form of cruel, inhuman, or degrading treatment or torture, states have an obligation to ensure that both public and private actors are not directly committing, instigating, inciting, encouraging, acquiescing in or otherwise participating or being complicit in conversion therapy. States also have a responsibility to regulate all health and education services, which may be promoting this harmful practice.

Health professionals that offer conversion therapy are violating the basic standards and ethics of our profession. Health professionals should understand that by offering these treatments, they are serving to perpetuate social customs and norms that are in conflict with respect for the rights and dignity of individuals; they are engaging in false advertising or fraud; and they may be facilitating and participating in cruel, inhuman, or degrading treatment or torture. Where minors are concerned, in addition to torture and other cruel, inhuman, or degrading treatment, they may be facilitating or perpetrating child abuse and neglect.

Health professionals should refuse to conduct conversion therapy and report their colleagues who advertise, offer, or perform them to the appropriate authorities. National medical and mental health associations should take steps to hold practitioners accountable and work with civil society and government officials to pass laws that ban conversion therapy.

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Exhibit B

JAMA Pediatrics | Original Investigation

Humanistic and Economic Burden of Conversion Therapy Among LGBTQ Youths in the United States

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IMPORTANCE Sexual orientation and gender identity change efforts (SOGICE), also called *conversion therapy*, is a discredited practice attempting to convert lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ) individuals to be heterosexual and/or cisgender.

OBJECTIVES To identify and synthesize evidence on the humanistic and economic consequences of SOGICE among LGBTQ youths in the US.

DESIGN, SETTING, AND PARTICIPANTS This study, conducted from December 1, 2020, to February 15, 2021, included a systematic literature review and economic evaluation. The literature review analyzed published evidence on SOGICE among LGBTQ individuals of any age. The economic model evaluated the use of SOGICE vs no intervention, affirmative therapy vs no intervention, and affirmative therapy vs SOGICE to estimate the costs and adverse outcomes for each scenario and to assess the overall US economic burden of SOGICE. Published literature and public sources were used to estimate the number of LGBTQ youths exposed to SOGICE, the types of therapy received, and the associated adverse events (anxiety, severe psychological distress, depression, alcohol or substance abuse, suicide attempts, and fatalities).

EXPOSURES SOGICE (licensed or religion-based practitioners) or affirmative therapy (licensed practitioners).

MAIN OUTCOMES AND MEASURES Total incremental costs and quality-adjusted life-years (QALYs) vs no intervention and total economic burden of SOGICE.

RESULTS Among 28 published studies, which included 190 695 LGBTQ individuals, 12% (range, 7%-23%) of youths experienced SOGICE, initiated at a mean age of 25 years (range, 5-58 years), with a mean (SD) duration of 26 (29) months. At least 2 types of SOGICE were administered to 43% of recipients. Relative to LGBTQ individuals who did not undergo SOGICE, recipients experienced serious psychological distress (47% vs 34%), depression (65% vs 27%), substance abuse (67% vs 50%), and attempted suicide (58% vs 39%). In the economic analysis, over a lifetime horizon with a 3% annual discount rate, the base-case model estimated additional \$97 985 lifetime costs per individual, with SOGICE associated with 1.61 QALYs lost vs no intervention; affirmative therapy yielded cost savings of \$40 329 with 0.93 QALYs gained vs no intervention. With an estimated 508 892 youths at risk for SOGICE in 2021, the total annual cost of SOGICE is estimated at \$650.16 million (2021 US dollars), with associated harms totaling an economic burden of \$9.23 billion.

CONCLUSIONS AND RELEVANCE This economic evaluation study suggests that there is a high economic burden and high societal costs associated with SOGICE and identifies additional research questions regarding the roles of private and public funding in supporting this harmful practice.

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+ Supplemental content

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Sexual orientation and gender identity change efforts (SOGICE) (also called *conversion therapy*) are dangerous, discredited practices rooted in false beliefs that being lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ) is pathologic.¹ Based on evidence that SOGICE is ineffective and detrimental,² the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and other medical, mental health, and human rights organizations formally oppose it.³⁻¹⁰

Minority stress theory contends that disproportionate rates of health issues among LGBTQ individuals stem from chronic stress and mental health detriments caused by increased exposure to social bigotry and rejection.¹¹ SOGICE reinforces societal prejudices and stigmas through promoting sexual and gender identity rejection.¹¹ For already vulnerable youths, it may exacerbate distress or incite guilt, shame, and self-hatred and is associated with devastating mental and physical health consequences, including new or increased depression, anxiety, self-harm, suicidal ideation, nightmares, gastrointestinal distress, sexual dysfunction, relationship problems, and isolation.^{3,11,12}

As of August 2021, 25 states, the District of Columbia, and Puerto Rico have instituted bans on or executive orders protecting minors from SOGICE¹; unlicensed individuals such as religious practitioners are not regulated. Per a 2019 study, 698 000 LGBTQ adults in the US have undergone SOGICE; approximately half underwent it as minors.¹³ Many of these individuals require therapy and support to address the harms of SOGICE.

Limited research has synthesized the overall clinical, humanistic (ie, quality-of-life), and economic burden of SOGICE. To inform legal and health care policy makers, we conducted a systematic literature review (SLR) and economic evaluation to quantify the consequences of SOGICE, focusing on adolescents and young adults, who are especially vulnerable and common targets.¹³

Methods

This economic evaluation study, conducted from December 1, 2020, to February 15, 2021, included an SLR, which comprised LGBTQ individuals of any age. The SLR was conducted to compile a broad evidence base regarding SOGICE and its effects and to support the economic model, focusing on key research questions:

- How many individuals, particularly adolescents and young adults, in the US have undergone SOGICE?
- What are the types and duration of therapy?
- What are the humanistic and economic harms of SOGICE?
- What are the health care resources and costs associated with SOGICE?

Detailed methods are outlined in the eMethods, eTable 1, and eFigure 1 in the [Supplement](#). This economic evaluation used data only from previously published literature; such data were deidentified, publicly available, and protected by prior consent. This study followed the Consolidated Health Economic Evaluation Reporting Standards (CHEERS) reporting

Key Points

Question What is the total economic cost of sexual orientation and gender identity change efforts (SOGICE), also called *conversion therapy*, including adverse consequences, among lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ) youths in the US?

Findings This systematic literature review and economic evaluation found that the total annual cost of SOGICE among 4 554 300 LGBTQ youths in the US is estimated at \$650.16 million, with associated harms, such as substance abuse and suicide attempts, totaling an estimated total economic burden of \$9.23 billion.

Meaning This study suggests that, in addition to being detrimental from a clinical and humanistic standpoint, SOGICE and their harmful effects among LGBTQ youths in the US are estimated to cost billions of dollars each year.

guideline, the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) reporting guideline, and the National Institute for Health and Care Excellence guideline.¹⁴⁻¹⁷

A decision-tree model was developed in Excel, version 2018 for Microsoft 365 (Microsoft Corp) to assess the costs and consequences of SOGICE vs no intervention, affirmative therapy vs no intervention, and affirmative therapy vs SOGICE, supplemented with an economic evaluation to assess the overall US economic burden of SOGICE. In this analysis, we defined *affirmative therapy* as psychotherapy validating the positive expression of sexual and gender identities and recognizing the association of macrolevel forces, such as heterosexism and homophobia, with well-being.¹⁸

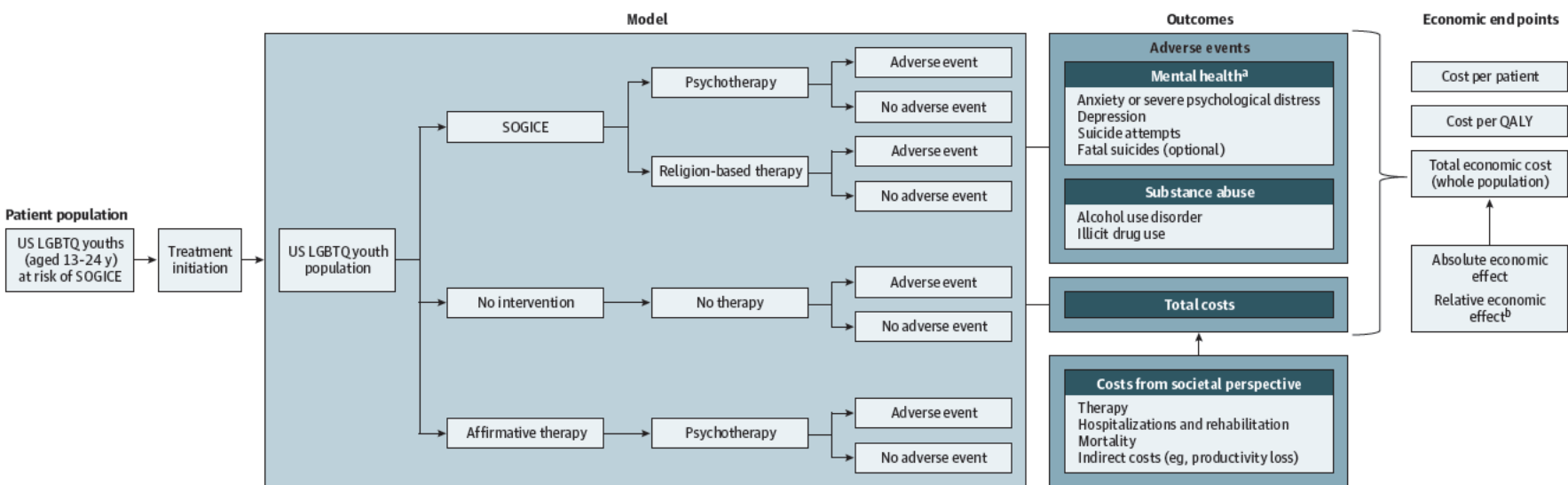
The decision-tree structure accounted for various SOGICE modalities (psychotherapy and religion-based therapy), which incur different costs owing to factors such as type of practitioner and duration of therapy. The model evaluated the probability of therapy outcomes (adverse events) in the at-risk population, such as anxiety, severe psychological distress, depression, alcohol or substance abuse, suicide attempts, and fatal suicide attempts (**Figure 1**). For simplicity, the decision tree considered the costs and consequences of adverse events separately (ie, if an individual experienced anxiety and alcohol use disorder, then these were considered as discrete events and not as a combined adverse event).

The analysis was conducted from the US societal perspective; both direct costs (costs of treatment, health outcomes, and mortality) and indirect costs (ie, costs such as productivity loss that are not directly incurred by therapy and its outcomes) were analyzed. The base-case analysis considered a lifetime horizon, with costs and effectiveness discounted at 3% annually.

Assumptions

The model made several assumptions because of the limited availability of data. First, it assumed the same likelihood of adverse outcomes regardless of SOGICE method. It also assumed that individuals of all sexual orientations, gender identities, and ages experience the same likelihood of outcomes,

Figure 1. Model Framework



LGBTQ indicates lesbian, gay, bisexual, transgender, queer, or questioning; QALY, quality-adjusted life-year; and SOGICE, sexual orientation and gender identity change efforts.

^a Because the adverse events are not mutually exclusive, the decision tree evaluates these outcomes separately. The adverse event can be anxiety or depression or suicide attempts with or without fatal suicide or alcohol use disorder or illicit drug use.

^b The absolute economic effect is the difference in total economic costs between the interventions. The relative economic effect is the percentage change in economic costs for an intervention when compared with another.

Table 1. Likelihood of Health Outcomes by Intervention

Health outcome	LGBTQ youths, %		
	No intervention	SOGICE	Affirmative therapy
Anxiety or severe psychological distress	34 ²⁴	47 ²⁴	20 ²⁵
Depression	27 ²⁶	65 ²⁶	14 ²⁵
Alcohol use disorder	42 ²⁶	41 ²⁶	30 ²⁵
Illicit drug use	50 ²⁶	67 ²⁶	26 ^{27,28}
Index suicidal attempt	22 ²⁶	63 ²⁶	3 ²⁹
Fatal suicide on index attempt	0.9 ²⁸⁻³⁰	2.5 ²⁸⁻³⁰	0.1 ²⁸⁻³⁰

Abbreviations: LGBTQ, lesbian, gay, bisexual, transgender, queer, or questioning; SOGICE, sexual orientation and gender identity change efforts.

costs, and quality-of-life utility values. The likelihood of outcomes for affirmative therapy was calculated using the relative risk reduction and relative risk estimates applied to the no-intervention likelihoods of each outcome. Furthermore, it was assumed that the suicidality score used in this estimation is indicative of the likelihood of a suicide attempt. The model also considered the costs associated with suicide attempts that require acute medical care. Equivalent costs were assumed for rehabilitation for alcohol use disorder and substance abuse. The model assumes that people receive 1 type of therapy, although, in principle, an individual could receive multiple therapy modalities. The assumed cost of psychotherapy (60-minute individual sessions with a licensed mental health professional; *Current Procedural Terminology* code 90837) was \$142. The model also assumed that individuals experience the health-state utility values and costs related to therapy and adverse events for up to 3 years. Last, given the dearth of LGBTQ-specific suicide mortality data, the likelihood of fatal suicide on index attempt was assumed to be equivalent across all interventions and no different than the likelihood observed in the general population.

Model Inputs

Model inputs were based on the most current and robust evidence sources identified in the SLR, to ensure that the inputs reflected the current experiences of LGBTQ adolescents and young adults in the US.

Population

The target population was LGBTQ adolescents and young adults aged 13 to 17 years in the states where SOGICE directed at minors is legal ($n = 1\,157\,000$),¹⁹ LGBTQ adolescents and young adults aged 13 to 17 years in states where SOGICE directed at minors is illegal but religious efforts are permitted ($n = 835\,000$),¹⁹ and LGBTQ adolescents and young adults aged 18 to 24 years nationally ($n = 3\,313\,800$).^{20,21} Approximately 10% of the target population is considered at risk for receiving SOGICE.²² For minors in states in which SOGICE is illegal, the at-risk population for SOGICE was assumed to be those who would undergo religious therapy. An estimated 43% of the target population aged 16 to 24 years is employed and will experience indirect costs from adverse events.²³

Type of Therapy

We analyzed the outcomes of 2 key methods: therapy provided by licensed health professionals (26%) and religion-

based SOGICE (74%).¹³ The base case considered these modalities to be mutually exclusive.

Adverse Outcomes

The probabilities of adverse events experienced by LGBTQ youths undergoing SOGICE as compared with no intervention and with affirmative therapy were estimated using data obtained from the SLR (Table 1).²⁴⁻³⁰ The relative effectiveness of affirmative therapy was indirectly calculated using estimates of relative risk reduction and relative risks (eTable 2 in the Supplement) for each adverse health outcome.

Utilities

Utility inputs for different health states in the model are summarized in eTable 3 in the Supplement. The SLR did not identify published evidence on quality of life or utility values in LGBTQ youths. Additional searches were conducted to obtain utility inputs associated with health outcomes, which were assumed to be the same regardless of the intervention.³¹⁻³³ The model assumed that the health-state utility values were experienced for 3 years and then returned to baseline. With the use of Centers for Disease Control and Prevention life tables, natural mortality was used to generate lifetime survival for all health states except fatal suicide or death.³⁴ Lifetime survival was used to estimate quality-adjusted life-years (QALYs) after 3 years over a lifetime using the baseline value of 0.865, which is lower than that of the general population, in accordance with the minority stress theory.

Costs

The model considered the costs associated with interventions and adverse events (eTable 4 in the Supplement).^{33,35-47} All costs were estimated for 3 years, after which the population was assumed to not experience further intervention or adverse events and hence incur no further costs. Inflation rates were calculated using the medical care index of the US Consumer Price Index.⁴⁸

The model considered the costs of 2 types of SOGICE (religion-based or licensed practitioners) and the costs of affirmative therapy (administered as psychotherapy and assumed to have the same costs as SOGICE administered by licensed practitioners). The cost per session and the duration of therapy varied by therapy type. The mean (SD) number of sessions was assumed to be 118 (135), with a mean (SD) duration of 26 (29) months.⁴⁹

The direct medical costs and the indirect costs (such as mortality and productivity loss) were obtained and estimated for each health outcome from public data sources and published literature; these costs were not specific to the LGBTQ population but were based on the general population (eTable 5 in the [Supplement](#)).³⁵

Model Outputs

Base-Case Analysis

Total costs were calculated separately for SOGICE, no therapy, and affirmative therapy as the sum of individual cost inputs. Quality-adjusted life-years lost were calculated as mean values per person over the modeled time horizon. The total economic burden of SOGICE in the US, based on 30 states where the practice is legal among minors (13-17 years of age) and states where SOGICE directed at minors is illegal but religious efforts are permitted, and nationwide for young adults (18-24 years of age), was estimated based on these quantitative analyses.

Scenario Analysis

The following scenarios were compared for overall association with the final results:

- Varied use of SOGICE by type of therapy was observed by Blois et al,¹¹ where SOGICE was provided by health care professionals (31%) and/or religious leaders (81%). Therapy with health care professionals was assumed to cost the same as psychotherapy.
- Indirect costs (productivity loss and mortality costs) were excluded owing to uncertainty associated with estimates.
- Utilities for adverse events were reweighted based on a baseline utility of 0.865 instead of 1.
- Lifetime likelihood of fatality due to suicide reattempt (2%) within 1 year of the episode period (3-year period during which individuals experience health-state utility and costs associated with therapy and adverse events in the model) was included.³⁰
- Fatal suicide attempts were excluded from the model.

Results

Systematic Literature Review

The SLR provided a broad view of the published evidence regarding SOGICE; selected recent and robust sources from the SLR were used as inputs in the economic model. The 28 publications^{11-13,22,24-27,49-72} identified comprised 190 695 LGBTQ individuals; among these publications, overall, 12% (range, 7%-23%) of youths experienced SOGICE, including individual or group psychotherapy (31%-100%), inpatient SOGICE (7%), and SOGICE administered by religious leaders (18%-81%). SOGICE was initiated at a mean age of 25 years (range, 5-58 years), with a mean (SD) of 118 (135) sessions per individual and a mean (SD) duration of treatment of 26 (29) months. The literature was not sufficient to determine the overall proportion of individuals starting SOGICE as minors vs adults. At least 2 types of SOGICE were administered to 43% of recipients, with 15% undergoing more than 3 modalities.

Relative to LGBTQ individuals who did not undergo SOGICE, those who did undergo SOGICE experienced severe consequences, including serious psychological distress (47% vs 34%), depression (65% vs 27%), problematic substance use (67% vs 50%), attempted suicide (58% vs 39%; odds ratio, 2.27 [95% CI, 1.60-3.24; $P < .001$]), and attempted suicide causing moderate or severe injury (67% higher odds; odds ratio, 1.67 [95% CI, 0.76-3.64]).

Economic Evaluation

Over a lifetime horizon, LGBTQ youths who received SOGICE were expected to incur a total discounted cost of \$206 159 vs \$108 174 for no therapy and \$67 844 for affirmative therapy per individual at risk ([Figure 2](#)). The direct medical discounted cost incurred for SOGICE was \$148 098 vs \$85 292 for no therapy and \$62 056 for affirmative therapy. The direct cost of affirmative therapy was higher (\$15 936) compared with SOGICE (\$14 619) because affirmative therapy was provided only by licensed medical professionals, whereas SOGICE was provided by licensed practitioners as well as unlicensed religion-based professionals. Although SOGICE administration costs were lower than for affirmative therapy, costs associated with adverse health outcomes were \$139 632 higher with SOGICE. The primary factors associated with the costs for SOGICE were outcomes including suicide attempts, fatal suicide attempts, depression, and substance abuse. Overall discounted QALYs were 23.30 for SOGICE, 24.91 for no therapy, and 25.84 for affirmative therapy ([Table 2](#)).

The economic model estimated that SOGICE was associated with 1.61 QALYs lost at an additional cost of \$97 985, whereas affirmative therapy was associated with an increase of 0.93 QALYs with a \$40 329 cost decrease vs no therapy ([Table 2](#)). The model estimated that affirmative therapy would be associated with \$138 315 in decreased costs for 2.53 QALYs gained vs SOGICE. Relative to no intervention, SOGICE leads to higher costs and worse outcomes, whereas affirmative therapy leads to lower costs and better outcomes compared with both SOGICE and no therapy. The results of the scenario analysis agreed with the results of the base-case analysis (eTable 6 in the [Supplement](#)).

With an estimated 508 892 LGBTQ youths at risk to receive SOGICE in 2021 based on reported rates of therapy (eFigure 2 in the [Supplement](#)), total SOGICE costs were estimated at \$650.16 million, with harms associated with an estimated economic burden of \$8.58 billion, for a total burden of \$9.23 billion ([Table 3](#)). Although affirmative therapy incurred costs of \$709 million vs no therapy, we estimated total savings of \$1.81 billion for affirmative therapy in the same population.

Discussion

Despite the increase in public support for LGBTQ individuals in the US,⁶⁹ current published literature reveals that SOGICE reinforces societal prejudices and stigmas through promoting sexual and gender identity rejection.¹¹ Approximately 10% of LGBTQ individuals undergo SOGICE in the form of individual or group psychotherapy, inpatient treatment, or ad-

Figure 2. Total Discounted Costs Per At-Risk Individual by Intervention Type

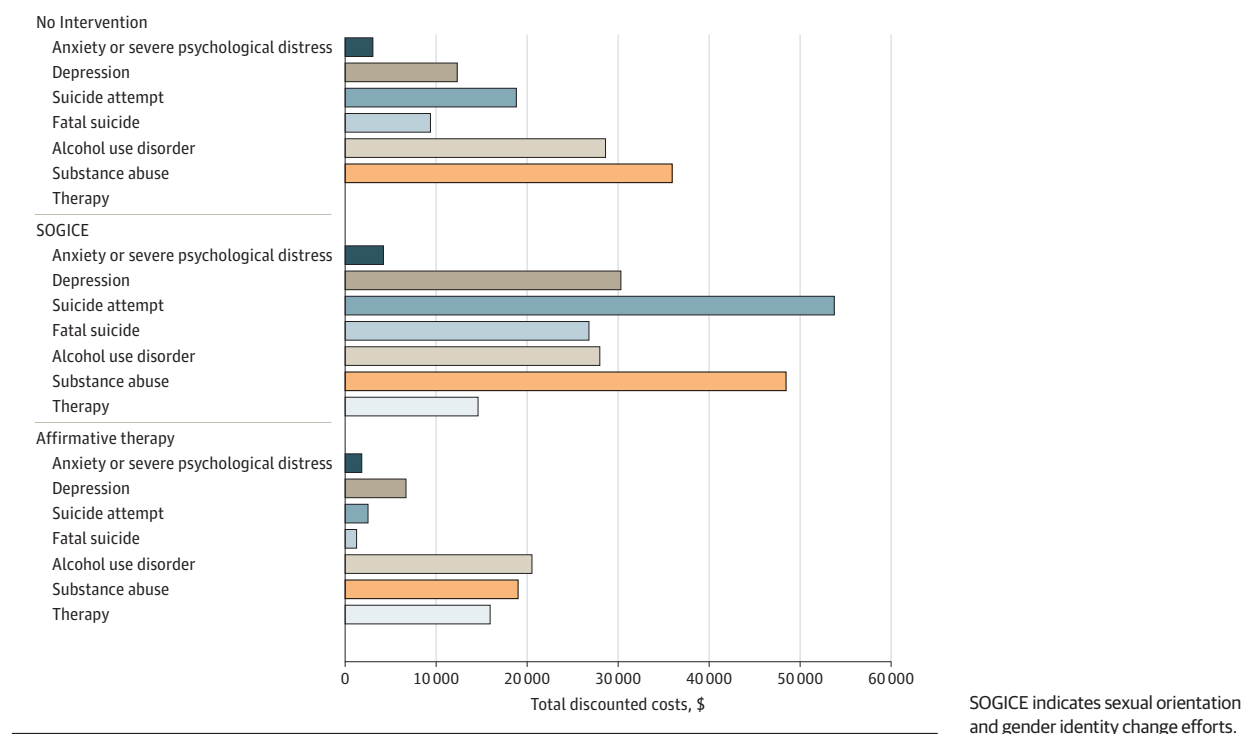


Table 2. Cost-Utility Analysis Comparing No Intervention With SOGICE and Affirmative Therapy

Intervention	Discounted		Incremental ^{a,b}		Interpretation of ICURs
	Costs, \$	QALYs	Costs, \$	QALYs	
No intervention	108 174	24.91	NA	NA	NA
SOGICE	206 159	23.30	97 985	(1.61)	SOGICE dominated
Affirmative therapy	67 844	25.84	(40 329)	0.93	Affirmative therapy dominated

Abbreviations: ICURs, incremental cost-utility ratios; NA, not applicable; QALYs, quality-adjusted life-years; SOGICE, sexual orientation and gender identity change efforts.

^b Incremental values are based on unrounded, exact values, not the rounded costs presented in the table.

^a Values in parentheses are negative.

ministration by religious leaders; many individuals undergo multiple modalities, typically as youths.²² SOGICE recipients experience increased rates of psychological distress, depression, substance abuse, and suicidality.^{11,12,24} Although these clinical and humanistic consequences are severe, no published studies have formally evaluated the economic costs of this unnecessary, harmful practice.

To our knowledge, our economic evaluation is the first to assess the association of SOGICE with socioeconomic outcomes. Its findings underscore the costs of inflicting harm on a vulnerable young population. In addition to the resources wasted on SOGICE, the downstream consequences are associated with lifetime excess costs of \$83 366 per individual at risk, primarily associated with suicidality, anxiety, severe psychological distress, depression, and substance abuse. From a population perspective, this translated to total costs of \$650 million for SOGICE in 2021, with harms associated with an estimated economic burden of \$9.23 billion.

The base-case analysis compared SOGICE with no intervention, but affirmative therapy is an economically feasible alternative that may benefit LGBTQ youths by reducing rates of adverse outcomes. The lifetime excess costs per individual decreased by \$138 315 for affirmative therapy vs SOGICE. Overall, the potential US savings with affirmative therapy are estimated at \$1.81 billion (vs no intervention) and nearly \$6.19 billion (vs SOGICE).

This study's design has several distinct features that allow us to provide robust estimates to inform policy. The key model inputs originated from an SLR, which identified multiple large-scale studies regarding the use and outcomes of SOGICE. The model structure incorporated various methods of SOGICE and a range of literature-reported outcomes. Last, overall estimates of the economic burden of conversion therapy reflect the real-world treatment landscape and are adjusted based on the legality of minor-directed SOGICE in different states at the time of analysis.

Table 3. Total Economic Burden by Intervention and Factors Associated With Cost^a

Intervention	No therapy	SOGICE	Affirmative therapy	SOGICE vs no therapy ^b	Affirmative therapy vs no therapy ^b	Affirmative therapy vs SOGICE ^b
Therapy costs, \$	0.00	0.65	0.71	0.65	0.71	0.06
Total costs by health outcomes, \$						
Anxiety or severe psychological distress	0.14	0.19	0.08	0.05	(0.06)	(0.11)
Depression	0.55	1.36	0.30	0.81	(0.25)	(1.06)
Suicide attempt	0.85	2.42	0.11	1.57	(0.73)	(2.30)
Fatal suicide	0.41	1.17	0.06	0.76	(0.35)	(1.12)
Alcohol use disorder	1.29	1.26	0.92	(0.03)	(0.36)	(0.34)
Substance abuse	1.62	2.18	0.86	0.56	(0.76)	(1.32)
Total costs, \$	4.85	9.23	3.04	4.38	(1.81)	(6.19)

Abbreviation: SOGICE, sexual orientation and gender identity change efforts.

^a All costs in billions of 2021 US dollars. Values in parentheses are negative (cost savings).

^b Incremental costs are calculated from unrounded, exact costs, not the rounded costs presented in the table.

Limitations

This study has some limitations. Given the evolving societal understanding of gender and sexual orientation, this study focused on recent evidence to ensure that the economic analysis reflected current practices and experiences of LGBTQ adolescents and young adults in the US. A key limitation is that, owing to limited data, the model makes several assumptions, including that the risk of adverse outcomes was the same across different sexual orientations and gender identities and for various SOGICE modalities. The likelihood of adverse outcomes was obtained from the published literature based on participant self-reporting, which is associated with bias in the estimates and increases the uncertainty for these values. The estimation of the likelihood of these events for affirmative therapy using a comparative approach introduces additional uncertainty. The literature used to estimate the likelihood of adverse outcomes was selected to reflect the target population of this model (adolescents and young adults aged 13-24 years), but individual publications may focus on teens, young adults, or broader age ranges, adding to the uncertainty. The inclusion of non-LGBTQ-specific health utilities may be associated with an underestimation of the association of these interventions with quality-of-life measures among LGBTQ individuals. There is uncertainty surrounding the costs associated with adverse events over a lifetime horizon because they were obtained from the current published and available evidence, which generally was not specific to the LGBTQ population. Because the estimation of indirect costs was not standardized among publications, using the human capital approach to estimate productivity loss (eg, suicide attempt and fatal suicide attempt) may be associated with further uncertainty and an overestimation of costs.

Although there are various uncertainties associated with this economic model, in general, it took a conservative approach and is likely to underestimate the true economic effect of SOGICE. The model accounts for costs and outcomes associated with adverse events for 3 years after SOGICE, even though harms and their costs may persist much longer, leading to higher costs. Moreover, there may be additional consequences of SOGICE not included in the analysis (eg, the de-

velopment of eating disorders or posttraumatic stress disorder) as well as medical consequences of some techniques (such as inappropriate use of medications or electroconvulsive therapy). Owing to the limitations and challenges in collecting suicide data, there is also uncertainty associated with the proportion of suicide attempts that may lead to fatalities among the LGBTQ population; the base-case model does not consider the rate and fatality of suicide reattempts.^{28,29} Last, as an economic analysis, this model necessarily examines SOGICE with a focus on direct and indirect monetary costs and cost offsets. Beyond the economic consequences, as noted by multiple international organizations, individuals subjected to this practice experience serious detrimental effects.³⁻¹⁰ Limitations in the evidence base represent opportunities for additional research to better understand this diverse, underserved community that is often actively harmed by clinicians, mental health professionals, and unlicensed practitioners.

Although it is possible that there may be selection bias, in that youths who undergo SOGICE are at elevated risk for adverse outcomes owing to a greater level of distress with their gender and/or sexual identity that may lead them to seek conversion therapy, such an argument assumes that they freely seek SOGICE. In a 2020 survey, 58% of LGBTQ youths reported that someone, typically parents, friends, relatives, or religious leaders, attempted to convince them to change their sexual orientation or gender identity.²² With such prevalent pressure to change orientation or identity, it is unlikely that LGBTQ individuals who undergo SOGICE differ from their peers except for the extent of the pressure or coercion they receive.

Conclusions

There are already multiple, unambiguous statements from professional societies and human rights groups on the imperative to stop SOGICE because of its discriminatory nature and profoundly harmful effects. This current analysis adds an economic dimension to the discussion, demonstrating a difference in economic consequences between SOGICE, no intervention, and affirmative therapy. It is incumbent on policy

makers to act to protect youths from—and stop all funding for—this unacceptable practice. Likewise, increasing access to affirmative therapy may promote health by empowering LGBTQ youths with skills and strategies to counteract minority stress.²⁵

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JANE JONES,

Plaintiff,

v.

Case No. 1:25-cv-401-RCL

PAMELA BONDI, in her official capacity as
Attorney General of the United States, *et al.*,¹

Defendants.

ORDER

On February 21, Plaintiff Jane Jones filed a Motion for a Temporary Restraining Order and Preliminary Injunction [ECF No. 21] (“TRO/PI Mot.”) to prevent the Government from implementing Executive Order 14168 as to the plaintiff. On February 22, the Government filed an Opposition [ECF No. 24] (“Opp’n”), and the plaintiff filed a Reply [ECF No. 26] on February 24. The Court has reviewed the parties’ filings and determines that the same reasoning from the Court’s TRO Order in *Doe v. McHenry* applies here. *See* Order of February 4, 2025, *Doe v. McHenry*, No. 25-cv-286 (RCL), ECF No. 23. The Court also applies the reasoning from the Court’s most recent Order in *Doe v. Bondi*, granting the plaintiffs’ renewed Motion for TRO and Preliminary Injunction in that case. *See* Order of February 24, 2025, *Doe v. Bondi*, No. 25-cv-286 (RCL), ECF No. 55. The facts are substantially similar, and the same result will hold.

Therefore, in consideration of the plaintiffs’ Motion [ECF No. 21] for a Temporary Restraining Order and Preliminary Injunction, the Opposition [ECF No. 24] thereto, the Reply

¹ Under Fed. R. Civ. Pr. 25(d), Attorney General Pamela Bondi is “automatically substituted as a party” as the successor for Acting Attorney General James R. McHenry III. Plaintiff also voluntarily dismissed her claims against President Donald Trump. Reply 1 n.1.

[ECF No. 26], and the entire record herein, and for the reasons contained in the original Temporary Restraining Order [ECF No. 23], it is hereby

ORDERED that the plaintiffs' Motion for a Temporary Restraining Order and Preliminary Injunction is **GRANTED**; and it is further

ORDERED that the Defendants are hereby enjoined from implementing Sections 4(a) and 4(c) of Executive Order 14168 against Plaintiff Jane Jones, pending further Order of this Court; and it is further

ORDERED that, pending further Order of this Court, Defendants shall maintain and continue the plaintiff's housing status and medical care as they existed immediately prior to January 20, 2025.

Date: February 24, 2025

2:00 p.m.



Royce C. Lamberth
United States District Judge

**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

JANE JONES; AMY JONES; BARBARA JONES;
CARLA JONES; DONNA JONES

Plaintiffs,

v.

PAMELA BONDI, in her official capacity as
Attorney General of the United States; WILLIAM
LOTHROP, in his official capacity as Acting
Director of the Federal Bureau of Prisons,

Defendants.

Civil Action No. 25-cv-00401-RCL

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

1. This Action is a federal constitutional challenge to Sections 4(a) and 4(c) of Executive Order 14168, titled “Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government,” (“Executive Order 14168” or “the Order”) which President Donald Trump issued just hours after his inauguration on January 20, 2025. The Order directly targets transgender individuals by attempting to deny them legal recognition under federal law and to strip them of long-established legal protections with the stroke of a pen. Under Sections 4(a) and 4(c) of the Order, transgender women who are incarcerated in federal prisons will be unlawfully transferred to men’s facilities and denied medically necessary healthcare.

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2. Plaintiff Jane Jones is an adult transgender woman who, until [REDACTED], was incarcerated in [REDACTED]. Jane Jones is diagnosed with gender dysphoria, a rare but serious medical condition and disability. The medical standard of care for treatment of gender dysphoria is to allow a transgender person to live in a sex different than their birth sex through counseling, medications, surgical care, and social transition.

3. Consistent with this standard of care, Jane Jones has lived as a woman and has taken hormones continuously since [REDACTED]. Additionally, she has had sex-reassignment surgeries, including a vaginoplasty, and legally changed her name and sex markers on her identifications to reflect that she is a woman. During her term of incarceration, she has always been treated as a woman by federal correctional officials and her peers. Other than during a brief period of time after the issuance of Executive Order 14168, she has never been housed in a men's facility. As of the date of this filing, publicly available records from the Bureau of Prisons (BOP) identified her sex as "female."

4. On [REDACTED], BOP officials removed Jane Jones from the general population of the [REDACTED] and transferred her to the men's unit of the [REDACTED]. BOP officials provided her no prior notice of the transfer and did not allow her to bring the vast majority of her belongings. They placed her in the Special Housing Unit ("SHU") within the men's prison, which Plaintiff described as a "shoebox" where she felt like a "zoo animal" that everyone comes to stare at.

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5. Jane Jones feared that she would be imminently transferred to a men's general population unit because a high-ranking prison official came to her cell on [REDACTED], and asked her what men's unit she would like to be sent to.

6. On [REDACTED], Jane Jones was transferred back to the [REDACTED]. She now fears that at any moment she will again be transferred to a men's prison pursuant to Executive Order 14168.

7. Jane Jones is not safe in any men's prison. She will be at an extremely high risk of harassment, abuse, violence, and sexual assault. She may be subject to strip searches by male correctional officers. She may be forced to shower in full view of men who are incarcerated. And she will be at a high risk of worsening gender dysphoria, which can lead to serious harm, including dramatically increased rates of suicidality and depression.

8. Plaintiff Amy Jones is an adult transgender woman incarcerated in [REDACTED]. She [REDACTED] in the custody of the Bureau of Prisons (BOP). Amy Jones is also diagnosed with gender dysphoria.

9. Consistent with the standard of care for gender dysphoria, Amy Jones has lived as a woman and has taken hormones since [REDACTED]. Since [REDACTED], she has been consistently held in all women's facilities. As of February 27, 2025, publicly available records from the BOP identified her sex as "female."

10. Amy Jones is not safe in any men's prison or [REDACTED]. She will be at an extremely high risk of harassment, abuse, violence, and sexual assault. She may be subject to strip searches by male correctional officers. She may be forced to shower in full view of men

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who are incarcerated. And she will be at a high risk of worsening gender dysphoria, which can lead to serious harm, including dramatically increased rates of suicidality and depression.

11. Plaintiff Barbara Jones is an adult transgender woman incarcerated in [REDACTED]. Barbara Jones is also diagnosed with gender dysphoria.

12. Consistent with the standard of care, Barabara Jones has lived as a woman and has taken hormones since [REDACTED]. Since [REDACTED], she has been consistently held in all women's facilities. As of February 27, 2025, publicly available records from the BOP identified her sex as "female."

13. Barbara Jones is not safe in any men's prison. She will be at an extremely high risk of harassment, abuse, violence, and sexual assault. She may be subject to strip searches by male correctional officers. She may be forced to shower in full view of men who are incarcerated. And she will be at a high risk of worsening gender dysphoria, which can lead to serious harm, including dramatically increased rates of suicidality and depression.

14. Plaintiff Carla Jones is an adult transgender woman incarcerated in [REDACTED]. Carla Jones is diagnosed with gender dysphoria.

15. Consistent with the standard of care, Carla Jones has lived as a woman and taken hormones since [REDACTED]. Since [REDACTED], she has been consistently held in all women's facilities, without incident. As of February 27, 2025, publicly available records from the BOP identified her as female.

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16. Carla Jones is not safe in any men's prison. She will be at an extremely high risk of harassment, abuse, violence, and sexual assault. She may be subject to strip searches by male correctional officers. She may be forced to shower in full view of men who are incarcerated. And she will be at a high risk of worsening gender dysphoria, which can lead to serious harm, including dramatically increased rates of suicidality and depression.

17. Plaintiff Donna Jones is an adult transgender woman incarcerated in [REDACTED]. Donna Jones is diagnosed with gender dysphoria.

18. Consistent with accepted standard of care, Donna Jones has lived as a woman and taken hormones since [REDACTED]. Since [REDACTED], she has been consistently held in all women's facilities, without incident. As of February 27, 2025, publicly available records from the BOP identified her as female.

19. Donna Jones is not safe in any men's prison. She will be at an extremely high risk of harassment, abuse, violence, and sexual assault. She may be subject to strip searches by male correctional officers. She may be forced to shower in full view of men who are incarcerated. And she will be at a high risk of worsening gender dysphoria, which can lead to serious harm, including dramatically increased rates of suicidality and depression.

20. In addition to facing immediate transfers to men's facilities, Plaintiffs are also at imminent risk of losing access to the medical care they each need to treat their gender dysphoria. Executive Order 14168 singles out transgender people to deny them essential healthcare while continuing to provide such healthcare to others. The Order categorically bans this care regardless of medical necessity. It prohibits prison medical providers from treating transgender patients'

gender dysphoria on an individual basis according to their independent medical judgment. This blanket ban will deprive Plaintiffs of essential medical care, including medication they have taken continuously for years, putting them at high risk of serious harm.

21. Plaintiffs bring claims for violations of the Fifth Amendment to the United States Constitution; the Eighth Amendment to the United States Constitution; the Rehabilitation Act of 1973, 29 U.S.C. § 701, *et seq.*; and the Administrative Procedure Act, 5 U.S.C. §§ 701–06. Plaintiffs seek declaratory and injunctive relief to enjoin enforcement of Sections 4(a) and 4(c) of Executive Order 14168. Without the injunctive relief sought, Plaintiffs will experience irreparable injury.

JURISDICTION AND VENUE

22. This action arises under the Constitution of the United States. This Court has subject matter jurisdiction pursuant to 28 U.S.C. § 1331.

23. This Court has authority to enter a declaratory judgment and to provide preliminary and permanent injunctive relief pursuant to 28 U.S.C. §§ 2201 and 2202, Fed. R. Civ. P. 57 and 65, and this Court’s inherent equitable powers.

24. Venue is proper in this district under 28 U.S.C. § 1391(e)(1)(A) and (B) because all defendants reside in the district and a substantial part of the events giving rise to the claim occurred in the district.

PARTIES

25. Plaintiff Jane Jones is a transgender adult woman. Jane Jones is a pseudonym.

26. Plaintiff Amy Jones is a transgender adult woman. Amy Jones is a pseudonym.

27. Plaintiff Barbara Jones is a transgender adult woman. Barbara Jones is a pseudonym.

28. Plaintiff Carla Jones is a transgender adult woman. Carla Jones is a pseudonym.

29. Plaintiff Donna Jones is a transgender adult woman. Donna Jones is a pseudonym.

30. Defendant Pamela Bondi is sued in her official capacity as Attorney General of the United States. The Attorney General oversees the Department of Justice, including the Bureau of Prisons, and has responsibility for overseeing the enforcement and implementation of Sections 4(a) and 4(c) of Executive Order 14168 with respect to the Bureau of Prisons.

31. Defendant William Lothrop is sued in his official capacity as Acting Director of the Federal Bureau of Prisons (BOP). The Acting Director of BOP has responsibility for overseeing enforcement and implementation of Executive Order 14168 by all BOP staff.

FACTS

I. Jane Jones’s Sudden and Unjustified Transfer to a Men’s Facility and Barbara Jones, Carla Jones, and Donna Jones’s Transfer to Segregated Housing.

32. The BOP maintains separate housing facilities for men and women. Before January 20, 2025, with respect to transgender women, the BOP applied an individualized assessment process to determine appropriate housing, consistent with the safety and security of all individuals. Based on this assessment, transgender women could be housed in women’s facilities when doing so promoted safety and security.¹

¹ U.S. Dep’t of Just., Transgender Offender Manual §§ 5–6. This policy was previously available on the BOP website at <https://www.bop.gov/policy/progstat/5200-08-cn-1.pdf>. It was still available as of the date of Plaintiff Jane Jones’s initial filing on February 10, 2025. However, as of February 27, 2025, the page is unavailable and states the following: “This content is temporarily unavailable as we implement the Executive Order on ‘Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government.’”

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33. Jane Jones has been housed in women's facilities within the BOP since [REDACTED].

34. On January 20, 2025, the President issued Executive Order 14168 directing the BOP to disregard its established policy and any associated safety and security risks concerning the housing and care of transgender women.

35. Pursuant to Executive Order 14168, the BOP removed Jane Jones from the general population of the [REDACTED] women's facility where she had been housed and transferred her to a [REDACTED] men's facility where she was placed in the Special Housing Unit (SHU).

36. She was also informed that she would be transferred to another men's facility and would be imminently placed in a male general population unit.

37. On [REDACTED], Jane Jones was then transferred back to the women's facility.

38. Jane Jones remains at risk of being transferred to a men's facility, as she was before, and has no ability to contest the Executive Order or her placement in a men's prison.

39. Jane Jones's removal from general population, placement in the SHU of a men's prison, and anticipated second transfer to a men's facility have caused her significant distress and raise serious concerns regarding her safety and well-being.

40. Pursuant to Executive Order 14168, the BOP removed Barbara Jones, Carla Jones, and Donna Jones from the general population of the low-security women's facility where they had been housed and moved them to the SHU. They were told by staff to prepare to be

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transferred to a men's prison. They were also told that their medical care would stop after they were transferred.

41. They remained in the SHU for [REDACTED], before they were returned to general population. They remain at risk of being transferred to men's facilities.

42. Barbara Jones, Carla Jones, and Donna Jones's removal from general population and transfer to the SHU and anticipated transfer to men's prisons have caused them significant distress and raise serious concerns regarding their safety and well-being.

II. Gender Dysphoria

43. Gender dysphoria is a serious medical condition marked by the significant distress or impairment that occurs when a transgender individual is made to live in their birth sex. The condition is highly treatable. When left untreated, however, it causes serious physical and emotional harms.

44. Scientific and medical research also shows that gender dysphoria has a physiological and biological etiology.

45. The only current, medically accepted treatment for gender dysphoria is to enable a transgender person to live in the sex different than their birth sex.

46. The medical and scientific community recognize well-established protocols for supporting a person to go through gender transition, the treatment that allows a transgender person to live in their target sex. These protocols are endorsed by the major medical and mental health associations in the United States, including but not limited to the American Medical

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Association, the American Psychiatric Association, the American Psychological Association, and the Endocrine Society.

47. Under these accepted protocols, treatment for gender dysphoria can involve any combination of social transition, medications, including hormones, and a range of surgeries. The treatment prescribed for a particular patient depends on an individualized assessment of the patient's health and needs. Gender transition care, including hormone therapy, is a highly effective treatment for gender dysphoria.

III. Plaintiffs' Gender Dysphoria Diagnoses and Gender Transitions

48. Jane Jones was born on [REDACTED]. Her sex at birth was identified as male and her parents gave her a male-associated name. From a young age, Jane Jones gravitated toward traditionally feminine activities, including playing with dolls and liked to wear feminine clothing. Jane Jones recalls her earliest memories as being shaped by tendencies that she recognized as intrinsically female. As she grew older, her sense of being a woman intensified.

49. Jane Jones attended [REDACTED] and became an [REDACTED]. She eventually owned and operated an [REDACTED]. But Jane Jones still struggled with feelings that her birth sex did not match her female identity.

50. Jane Jones began seeing a therapist in approximately [REDACTED]. She was diagnosed with gender dysphoria. In [REDACTED], she began hormone therapy and began living as a woman.

51. In [REDACTED], Jane Jones received facial reconstructive and breast augmentation surgery. In [REDACTED], she received a vaginoplasty.

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52. Around [REDACTED], Jane Jones legally changed her name and her gender marker to female on her driver's license, her [REDACTED], with [REDACTED], and with the social security office.

53. On [REDACTED], Jane Jones was convicted of a non-violent [REDACTED] [REDACTED] and was sentenced to less than [REDACTED] in prison.

54. She was sent to a women's facility.

55. Amy Jones was born on [REDACTED]. Her sex at birth was identified as male and her parents gave her a male-associated name. From a young age, Amy Jones knew she was a girl. As she grew older the disconnect between who she was and how she presented to the world caused her increasing distress.

56. In [REDACTED], Amy Jones was diagnosed with gender dysphoria. She began taking hormones and living as a woman. In [REDACTED], she legally changed her name and the gender markers on her birth certificate.

57. Since [REDACTED], Amy Jones has been housed in women's facilities. In [REDACTED], with less than two years remaining on her sentence, she was sent to [REDACTED].

58. Barbara Jones was born on [REDACTED]. Her sex at birth was identified as male and her parents gave her a male-associated name. From a young age, Barbara Jones knew she was a girl. As she grew older the disconnect between who she was and how she presented to the world caused her increasing distress. Before she was incarcerated, she took female hormones and began to use a female-associated name.

59. In [REDACTED], Barbara Jones was diagnosed with gender dysphoria. She began taking hormones and living as a woman.

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60. Since [REDACTED], she has been housed exclusively in women's facilities.

61. Carla Jones is [REDACTED] years old. Her sex at birth was identified as male and her parents gave her a male-associated name. For [REDACTED], Carla Jones knew she was a woman. The disconnect between who she was and how she presented to the world caused her significant distress. [REDACTED]

[REDACTED].

62. In [REDACTED], Carla Jones was diagnosed with gender dysphoria. She began taking hormones and living as a woman.

63. Since [REDACTED], she has been housed exclusively in women's facilities.

64. Donna Jones is [REDACTED] years old. Her sex at birth was identified as male and her parents gave her a male-associated name. Since childhood, Donna Jones knew she was a girl. Although she initially tried to suppress the fact that she was transgender, as she grew older, she told more and more people that she felt like a woman trapped in a man's body.

65. In [REDACTED], Donna Jones was diagnosed with gender dysphoria. She began taking hormones and living as a woman.

66. Since [REDACTED], she has been housed exclusively in women's facilities.

IV. Executive Order 14168 Will Cause Plaintiffs Irreparable Injury

67. Executive Order 14168 began causing harm to Plaintiffs almost immediately. As a result of the Order, they have already suffered significant distress. The Order also raises serious concerns for their safety and well-being going forward.

68. Section 2 of the Order includes a definition of "sex" that is intentionally designed to discriminate against transgender people. Specifically, Section 2 defines "sex" as "an

individual's immutable biological classification as either male or female." In turn, it defines "male" as "a person belonging, at conception, to the sex that produces the small reproductive cell," and "female" as "a person belonging, at conception to the sex that produces the large reproductive cell." It includes these definitions to preclude transgender people from being able to live in a sex different than their birth sex and to deny them equal treatment.

69. Section 4(a) of the Order then directs federal agencies to implement this discriminatory provision, including requiring the Attorney General to categorically bar all transgender women from ever being housed in women's prisons with no individualized consideration of their safety and security. That section acknowledges that the requirement contradicts federal regulations found at 28 C.F.R. § 115.41 by directing the Attorney General to amend those regulations as necessary to implement Section 4(a).

70. On the evening of [REDACTED], BOP officials informed Jane Jones that because of the Order, she would be transferred to a men's facility. This was a shock to Jane Jones, who at the time, was being held in a [REDACTED]. Jane Jones had always been housed with other women and given access to all items available to other women. She was able to live as a woman in all respects at the [REDACTED].

71. BOP officials made Jane Jones change into an orange jumpsuit and shoes, which denotes high risk inmates, gave her men's boxer shorts, hand-cuffed her, and transferred her to a men's medium security facility at [REDACTED].

72. Jane Jones asked why she was being transferred, and the Corrections Officers said that they had been told to bring her to the men's [REDACTED]. Jane Jones asked if she could bring her possessions and she was denied that request, except that the corrections officers allowed her to

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bring what remained of her hormone therapy medication (a less than 30-day supply). They advised, however, that she would not be permitted to obtain another prescription from the prison once these medications run out.

73. In both female prisons in which she has was housed since receiving her sentence, Jane Jones has been subjected to searches by female Corrections Officers only. Jane Jones also has a flawless disciplinary record.

74. Jane Jones was placed in the Special Housing Unit (“SHU”) upon transfer to the men’s prison. She was housed alone in solitary confinement in a tiny cell with nothing to do all day. She had no one to talk to and did not go outside. She was only provided with men’s toiletries.

75. Jane Jones has expressed that she felt like a zoo animal. The corrections officers went by the small window to her cell and looked at her. Male guards were also able to watch her use the restroom, as she was under 24/7 video surveillance. She no longer had access to email or to other inmates. She was only allowed very limited contact with her spouse.

76. Jane Jones greatly fears what will happen when BOP terminates her medical treatment. Jane Jones has been taking hormones for [REDACTED] years. If she stops taking hormones, the physical and psychological impact will be devastating. This will cause her extreme emotional distress and could cause physical harm given how long she has been taking the hormones. Moreover, because she no longer has the anatomy to produce male sex hormones, she needs replacement hormones in order to maintain bone density and blood pressure regulation.

77. On [REDACTED], a BOP official came to Jane Jones and informed her she would be placed in general population.

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78. Though Jane Jones was transferred back to a women's facility on [REDACTED], she lives in constant fear of being transferred to a men's prison again.

79. Other than the [REDACTED] days in which she was housed in the SHU, Jane Jones has never been housed in a men's facility.

80. Before [REDACTED], Amy Jones had been housed in men's prisons, where she was subjected to sexual and physical assaults.

81. Before [REDACTED], Barbara Jones was housed in men's prisons, where she experienced severe depression and attempted suicide. Since [REDACTED], Barbara Jones, has only been housed in women's prisons, where her mental and physical health have improved dramatically.

82. Before Carla Jones was housed in women's prisons, she was subjected to repeated sexual assaults, including at low-security men's prisons.

83. Donna Jones was subjected to sexual assault while incarcerated in a men's prison.

84. If Plaintiffs are transferred to men's facilities, they will face an extremely high risk of sexual victimization and sexual and physical violence. They will not be safe. Evidence, research, case law, and practical experience, including Plaintiffs' own experience, show that transgender women housed in men's prisons face near constant sexual harassment and extremely high levels of violence and sexual assault. Federal regulations recognize transgender status as a risk factor for sexual assault. *See* 28 C.F.R. §§ 115.41(d)(7), 115.42. A 2013 study by the Department of Justice estimated that nearly 35% of transgender inmates in state and federal prisons were sexually assaulted between 2007 and 2012. U.S. Dep't of Justice Off. of Justice Programs, *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12*, NCJ No.

241399, Supplemental Table 1 (2013).² From 2011 to 2012, transgender people were sexually assaulted at nearly ten times the rate for the general incarcerated population.³

85. In men's facilities, Plaintiffs may also be subjected to humiliating, terrifying, and dangerous circumstances like being strip searched by male correctional officers and forced to shower among men, with their female bodies exposed and vulnerable to sexual violence.

86. Further, Plaintiffs will predictably experience worsening gender dysphoria in men's facilities. They may be forced to wear men's clothing and undergarments, prevented from styling their hair as female, and referred to as men. Treating a transgender woman with gender dysphoria as a man is known to intensify dysphoria, undermine medical treatment, and increase emotional distress, and it can precipitate self-harm.

87. Section 4(c) of the Order will also cause Plaintiffs serious, irreparable injury. Section 4(c) eliminates Plaintiffs' ability to continue their medical care, including taking hormone medications to treat their gender dysphoria and that their bodies have adjusted to receiving for years. Specifically, the provision requires the Attorney General to "ensure that no Federal funds are expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex."

88. The BOP is aware that gender dysphoria creates a serious medical need for gender transition treatments, including hormone therapy, and that Plaintiffs each have a serious medical

² Available at https://bjs.ojp.gov/content/pub/pdf/svpjri1112_st.pdf.

³ *Compare id.* (noting a 39.9% sexual victimization rate for transgender people from 2011 to 2012), with the full report at 6 (reflecting a 4.0% rate of sexual victimization in the general prison population from 2011 to 2012), available at <https://bjs.ojp.gov/content/pub/pdf/svpjri1112.pdf>.

need for such treatment. Before January 20, 2025, BOP policy expressly allowed hormone therapy as a treatment for gender dysphoria based on an “individualized assessment” by medical staff.⁴ Under that policy, if providers determine that hormone therapy is appropriate for an individual, hormone therapy “will be provided.”⁵ Consistent with that policy, the BOP has consistently provided hormone therapy to Plaintiffs for years.

89. If Plaintiffs’ medically necessary treatment for gender dysphoria is terminated or restricted under Section 4(c), they will be at a well-known and substantial risk of serious harm. Medical professionals experienced in the treatment of gender dysphoria and in the prolonged use of hormones for medical care recognize that the abrupt termination and ongoing denial of hormone therapy can have disastrous consequences, including serious risk of permanent physical and emotional harm, severe danger of self-mutilation, and suicidal ideation and attempts. This harm is amplified for transgender individuals like Jane Jones who have undergone surgeries that prevent them from producing endogenous hormones.

V. Executive Order 14168 Was Motivated by Discriminatory Animus Toward Transgender People

90. Executive Order 14168 was motivated by a sex-based discriminatory purpose and animus against transgender people. Such animus is evident on the face of the Order.

91. The Order provides no evidence of problems with the prior policy of housing transgender women in female facilities, and entirely disregards extensive documentation of

⁴ U.S. Dep’t of Just., Transgender Offender Manual § 8.

⁵ *Id.*

disproportionate rates of sexual assault and violence against incarcerated transgender people. No urgent safety or security concerns precipitated this dramatic policy shift.

92. President Trump has been transparent about his hostility toward transgender people and has openly stated his intentions to eliminate legal protections for transgender people, to deter them from obtaining medical care, and to prevent them from being able to live in a sex other than their birth sex. On November 15, 2022, when he announced his candidacy for President, he explicitly promised to target transgender Americans through executive action.⁶ President Trump pledged a “day one” executive order to “cease all programs that promote the concept of sex and gender transition at any age.”⁷

93. Throughout his campaign, President Trump repeatedly characterized transgender Americans in dehumanizing terms, referring to them as “deranged,”⁸ and victims of “madness”⁹

⁶ ABC Action News, *(Full Speech) Former President Trump Announces 2024 Presidential Bid* at 48:40-49:13, YouTube (Nov. 15, 2022), <https://www.youtube.com/watch?v=8tSYwJ1 htE>; *id.* at 50:39-53 (indicating he would attempt to ban transgender people from military service).

⁷ *President Trump’s Plan to Protect Children from Left-Wing Gender Insanity*, Trump Vance: Make America Great Again! 2025 (Feb. 1, 2023), <https://www.donaldjtrump.com/agenda47/president-trumps-plan-to-protect-children-from-left-wing-gender-insanity>.

⁸ Gabriel Bertrand, *Trump’s Shocking Admission Exposes GOP’s Bigoted Agenda*, Medium (June 17, 2023), <https://medium.com/illumination/trumps-shocking-admission-exposes-gop-s-bigoted-agenda-e981becb2c5f>.

⁹ *President Trump’s Plan to Protect Children from Left-Wing Gender Insanity*, *supra* n.6.

and “insanity.”¹⁰ He falsely claimed transgender identity was “never heard of in all of human history”¹¹ and described transgender healthcare as “mutilation.”¹²

94. President Trump’s campaign devoted substantial resources to promoting anti-transgender policies, spending approximately \$215 million on advertisements vilifying transgender Americans.¹³ These advertisements comprised over 40% of all pro-Trump campaign messaging in the weeks before the 2024 election.¹⁴

¹⁰ Joe Middleton, *Trump Attacks Transgender Rights at Waco Rally Saying He Will Ban ‘Difigurement of Our Youth’*, The Independent (Mar. 26, 2023), <https://www.independent.co.uk/news/world/americas/donald-trump-transgender-waco-rally-b2308177.html>; <https://medium.com/illumination/trumps-shocking-admission-exposes-gop-s-bigoted-agenda-e981becb2c5f>; Donald J. Trump, Truth Social (Dec. 18, 2023), <https://truthsocial.com/@realDonaldTrump/posts/111599880929254153>; *Trump and Vance Make Anti-Transgender Attacks Central to Their Campaign’s Closing Argument*, NBC News (Nov. 1, 2024, 10:23 AM), <https://www.nbcnews.com/nbc-out/out-politics-and-policy/donald-trump-jd-vance-transgender-2024-election-rcna178390>; <https://idahonews.com/news/nation-world/trump-vows-to-remove-transgender-insanity-and-critical-race-theory-from-us-schools-phoenix-arizona-woke-speech-usa-donald-president-white-house-education-department-crt-trans-gender-lgbt>.

¹¹ *President Trump’s Plan to Protect Children from Left-Wing Gender Insanity*, *supra* n.6.

¹² *Id.*

¹³ Audrey Kemp, *What Trump’s Win – and \$215m Worth of Anti-Trans Ads – Mean for the Future of Campaigning*, The Drum (Nov. 6, 2024), <https://www.thedrum.com/news/2024/11/06/after-donald-trump-s-victory-marketers-weigh-their-role-counter-divisive>.

¹⁴ Lauren Barrón-López et al., *Why Anti-Transgender Political Ads Are Dominating the Airwaves this Election*, PBS News (Nov. 2, 2024 5:35 PM), <https://www.pbs.org/newshour/show/why-anti-transgender-political-ads-are-dominating-the-airwaves-this-election>.

95. President Trump’s official campaign platform included a “Plan to Protect Children from Left-Wing Gender Insanity,” which promised to deny legal recognition to transgender Americans and restrict access to medically necessary healthcare.¹⁵

96. On December 23, 2024, after winning the election, President Trump reaffirmed his intent to implement discriminatory policies through executive action, stating “with a stroke of [his] pen on day one,” he would “stop the transgender lunacy” and “get transgender out of the military and out of our elementary schools and middle schools and high schools.”¹⁶

97. Executive Order 14168, issued on President Trump’s first day in office, implements these campaign promises virtually verbatim, demonstrating that the discriminatory animus expressed throughout his campaign was the driving force behind the Order’s restrictions on medical care and housing.

98. Executive Order 14168 was part of a broader pattern of targeted discrimination against transgender people. Beginning on January 20, 2025, President Trump also issued a series of executive orders specifically reversing protections for transgender people in schools, healthcare, military service, federal funding, shelters, and more. *See, e.g.*, Exec. Order No. 14190, 90 Fed. Reg. 8853 (Jan. 29, 2025) (schools); Exec. Order No. 14187, 90 Fed. Reg. 8771 (Jan. 28, 2025) (healthcare); Exec. Order No. 14183, 90 Fed. Reg. 8757 (Jan. 27, 2025) (military service); Exec. Order No. 14168, 90 Fed. Reg. 8615 (Jan. 20, 2025) (federal funding and shelters).

¹⁵ *President Trump’s Plan to Protect Children from Left-Wing Gender Insanity*, supra n.6.

¹⁶ Azcentral.com and The Arizona Republic, *Turning Point USA Donald Trump Full Speech: The ‘Golden age of America’ Begins Now, Says Trump*, YouTube (Dec. 23, 2024), <https://www.youtube.com/watch?v=XuIeXJw6BA8>, at 57:02-24.

99. Since President Trump’s inauguration, federal agencies have systematically removed research, data, and information about transgender individuals from government websites. *See, e.g.,* Nico Lang, “*Trump Is Purging Federal Websites of LGBTQ+ Content. Here’s What’s Been Affected So Far,*” Them, (Feb. 7, 2025), <https://www.them.us/story/trump-administration-federal-websites-lgbtq-content-deleted-cdc-doe-usaid> (documenting systematic removal of LGBTQ+ content across federal websites); Judd Legum & Rebecca Crosby, *The NSA’s ‘Big Delete’* Popular Information (Feb 10, 2025), https://popular.info/p/the-nsas-big-delete?utm_campaign=post&utm_medium=web (revealing directive to eliminate references to “transgender” and “gender identity” from federal websites).

100. The timing, content, and context of Executive Order 14168 demonstrate it was motivated by and implements the same discriminatory animus President Trump repeatedly expressed during his campaign, rather than any legitimate government purpose.

CLAIMS FOR RELIEF

COUNT I

**Challenge to Sections 4(a) and 4(c)
Fifth Amendment to the United States Constitution
Due Process Clause - Deprivation of Equal Protection of the Laws
Against All Defendants in Their Official Capacities**

101. Plaintiffs incorporate all preceding paragraphs of the Complaint as though fully set forth herein.

102. Like the Equal Protection Clause of the Fourteenth Amendment, the Due Process Clause of the Fifth Amendment prohibits unwarranted discrimination by the federal government.

103. Sections 4(a) and 4(c) unjustifiably discriminate based on sex. They are facial sex classifications and use explicitly sex-based language to dictate government decision-making. Section 4(a) compels the BOP to exclude “males” from “women’s prisons.” Section 4(c) prohibits the use of federal funds for any medical treatment prescribed “for the purpose of conforming an inmate’s appearance *to that of the opposite sex*.” Section 4(c)’s express purpose is to prohibit all medical treatment deemed inconsistent with birth sex.

104. Sections 4(a) and 4(c) require the BOP to treat incarcerated people differently depending on their sex. Under section 4(a), women who are not transgender can go on living in a women’s facility, while otherwise similarly situated transgender women must be transferred to a men’s facility based on their male birth sex. Similarly, under Section 4(c), women who are not transgender are able to obtain the same medical treatments that are prohibited if they are prescribed for transgender women.

105. Under the Fifth Amendment, sex classifications are subject to heightened scrutiny and are presumptively unconstitutional.

106. Sections 4(a) and 4(c) also discriminate based on transgender status. Section 4(a) requires dangerous transfers to men's facilities for all transgender women, solely because they are transgender. Section 4(c) denies medically necessary healthcare to transgender people, solely because they are transgender.

107. Under the Fifth Amendment, classifications based on transgender status are sex-based classifications that are subject to heightened scrutiny.

108. Classifications based on transgender status are also subject to heightened scrutiny because transgender people constitute a quasi-suspect class. Transgender people are a discrete and identifiable group of people with one shared distinguishing characteristic: they identify and seek to live as a sex different than their birth sex. This defining characteristic bears no relation to a transgender person's ability to contribute to society. Nevertheless, transgender people have faced historical discrimination in law and in fact, and they have been unable to secure equality through the political process.

109. There is no legitimate penological purpose or other legitimate basis for Section 4(a)'s dangerous transfer requirement or Section 4(c)'s categorical healthcare ban.

110. Neither Section 4(a) nor Section 4(c) is narrowly tailored to further a compelling government interest or substantially related to an important government interest.

111. Moreover, Sections 4(a) and 4(c) are not even rationally related to a government interest.

112. The Order was motivated by discriminatory animus against transgender people and therefore fails Equal Protection analysis under any standard of review. Section 2 of the Order patently demonstrates this Administration's hostility toward transgender individuals.

113. The Order cites no urgent safety or security concerns necessitating its implementation. It instead reflects the President’s pattern and practice of expressing discriminatory animus towards transgender people, who he has characterized as “deranged,” victims of “madness,” and “insanity.” Even before his inauguration, President Trump was transparent about his goal to “stop the transgender lunacy,” with a “stroke of [the] pen, on day one.”

114. The Order was the first in a series of executive orders issued by President Trump in his first 10 days in office seeking to eliminate protections for transgender people across multiple domains, including schools, healthcare, military service, federal funding, shelters, and, as here, prisons.

115. The proximity and pattern of these official actions across unrelated domains evidence discriminatory intent without any rational basis for reversing pre-existing protections, signifying animus targeted toward transgender people.

116. Accordingly, these aspects of Executive Order 14168 violate the Fifth Amendment.

117. If Section 4(a) and 4(c) are implemented, Plaintiffs will suffer irreparable injury, including serious physical, psychological and emotional harm, mental anguish, distress, humiliation, and indignity.

COUNT II

**Challenge to Section 4(a)
Eighth Amendment to the United States Constitution
Failure to Protect
Against All Defendants in Their Official Capacities**

118. Plaintiffs incorporate all preceding paragraphs of the Complaint as though fully set forth herein.

119. Under the Eighth Amendment, Plaintiffs are entitled to be free from a known and substantial risk of serious harm while in BOP custody.

120. Placing Plaintiffs in men's prisons will pose a substantial risk of serious harm, including an extremely high risk of violence and sexual assault from other incarcerated people and BOP staff. In men's prisons, Plaintiffs will also be at high risk of worsening gender dysphoria, which can lead to serious physical and mental health conditions including severe depression and suicidality. These risks are obvious, well-documented, and well known to BOP officials.

121. The risk of sexual violence to transgender people in prison is recognized in existing federal regulations. 28 C.F.R. § 115.41(d)(7) requires BOP officials to consider an individual's transgender status as a factor increasing their "risk of sexual victimization." An individual's sexual victimization risk must be considered as part of all housing and transfer decisions. *Id.* § 115.41. Decisions about whether to house a transgender person in a men's or women's facility must be made "on a case-by-case basis" to ensure the individual's "health and safety" and the security of the facility. *Id.* § 115.42(c). Given the extremely high safety risks for transgender people in BOP custody, housing placements for transgender people "shall be reassessed at least twice a year to review any threats to safety." *Id.* § 115.42(d).

122. Section 4(a) of the Order contains a citation to 28 C.F.R. § 115.41, indicating that President Trump was aware of transgender women’s heightened risk of sexual victimization and the federal regulatory scheme that requires individualized housing placements to ensure their safety. Nevertheless, President Trump intentionally directed the Attorney General to “amend[]” § 115.41 “as necessary” to ensure that all transgender women would be transferred to men’s facilities, no matter how dangerous, without regard for their safety and security. The President’s intentional disregard of a known and substantial risk of serious harm to transgender women in BOP custody, including Plaintiffs, violates the Eighth Amendment.

123. Defendants are well aware of the grave risks Plaintiffs will face if they are transferred to men’s prisons, but they are actively enforcing Section 4(a) and caused BOP officials to transfer Jane Jones to a men’s facility at least once already. Their decision to disregard the known and substantial risks of serious harm violates Plaintiffs’ rights under the Eighth Amendment.

124. If Section 4(a) is implemented, Plaintiffs will suffer irreparable injury, including serious physical, psychological and emotional harm, mental anguish, distress, humiliation, and indignity.

COUNT III

**Challenge to Section 4(c)
Eighth Amendment to the United States Constitution
Medical Deliberate Indifference
Against All Defendants in Their Official Capacities**

125. Plaintiffs incorporate all preceding paragraphs of the Complaint as though fully set forth herein.

126. A prison official who has knowledge of an individual's serious need for medical care and intentionally refuses to provide that care acts with deliberate indifference and therefore violates the Eighth Amendment's prohibition on cruel and unusual punishment.

127. Plaintiffs all have a serious medical need for hormone therapy as treatment for their gender dysphoria, which is a rare and serious health condition. Abrupt termination of this treatment would violate the applicable standard of care and subject Plaintiffs to a known and substantial risk of serious harm.

128. Terminating Plaintiffs' hormone therapies would contravene their medical providers' consistent professional judgment that they need continuous treatment for their gender dysphoria, as the BOP has previously recognized by placing Plaintiffs on these medications. Denying Plaintiffs this medically necessary healthcare would constitute deliberate indifference to their serious medical needs and would violate the Eighth Amendment's prohibition on cruel and unusual punishment.

129. Section 4(c) of the Order, which was issued by President Trump and is being implemented by all other Defendants, establishes a blanket rule banning medically necessary treatments for all transgender people in BOP custody, without consideration of any individual's medical needs or their healthcare providers' independent medical judgment. As such, Section

MATERIAL UNDER SEAL DELETED

4(c) constitutes deliberate indifference to the serious medical needs of all transgender people in BOP custody and violates the Eighth Amendment's prohibition on cruel and unusual punishment.

130. If Section 4(c) is implemented, Plaintiffs will suffer irreparable injury, including serious physical, psychological and emotional harm, mental anguish, distress, humiliation, and indignity.

COUNT IV

**Challenge to Section 4(a)
Rehabilitation Act of 1973, Section 504
Failure to Accommodate a Disability
Against All Defendants in Their Official Capacities**

131. Plaintiffs incorporate all preceding paragraphs of the Complaint as though fully set forth herein.

132. Plaintiffs each have a current diagnosis of gender dysphoria as well as a record of gender dysphoria that is known to BOP officials.

133. Gender dysphoria is a serious medical condition that qualifies as a disability. It is a physical impairment that substantially limits the major life activities of interacting with others, reproduction, social and occupational functioning, and caring for oneself.

134. Housing Plaintiffs in women's facilities is a reasonable accommodation for their gender dysphoria and is part of the recommended treatment protocol set forth by the applicable standards of care and clinical practice guidelines.

135. Continuing to house Jane Jones at [REDACTED], Amy Jones in [REDACTED], [REDACTED], Barbara Jones at [REDACTED], Carla Jones at [REDACTED], and Donna Jones at [REDACTED] would not materially impair the safe and efficient operation of these facilities

MATERIAL UNDER SEAL DELETED

or the BOP generally, present a safety hazard to any staff or other incarcerated person, threaten the security of the facility, or otherwise cause undue hardship.

136. Continuing to house Jane Jones at [REDACTED], Amy Jones in [REDACTED], Barbara Jones at [REDACTED], Carla Jones at [REDACTED], and Donna Jones at [REDACTED] would not fundamentally alter the nature of any service, program, or activity.

137. Involuntarily transferring Plaintiffs to men's facilities under Section 4(a) of the Order would be a cruel and unnecessary revocation of this reasonable accommodation and would deny them equal benefits of correctional and rehabilitative programs and services, including but not limited to safe housing, showers, and healthcare consistent with accepted medical standards. Accordingly, Section 4(a) violates Section 504 of the Rehabilitation Act of 1973.

138. If Section 4(a) is implemented, Plaintiffs will suffer irreparable injury, including serious physical, psychological and emotional harm, mental anguish, distress, humiliation, and indignity.

COUNT V

**Challenge to Section 4(c)
Rehabilitation Act of 1973, Section 504
Disability Discrimination
Against All Defendants in Their Official Capacities**

139. Plaintiffs incorporate all preceding paragraphs of the Complaint as though fully set forth herein.

140. Section 4(c) categorically bans medical treatments, regardless of medical need, if they are prescribed to "conform[] an inmate's appearance to that of the opposite sex"—meaning treatments are banned only if they are prescribed to treat gender dysphoria.

141. Section 4(c) discriminates based on disability by excluding people with gender dysphoria, including Plaintiffs, from accessing medically necessary healthcare services that are provided to all other people in BOP custody based on medical need. Accordingly, Section 4(c) violates Section 504 of the Rehabilitation Act of 1973.

142. If Section 4(c) is implemented, Plaintiffs will suffer irreparable injury, including serious physical, psychological and emotional harm, mental anguish, distress, humiliation, and indignity.

COUNT VI

**Challenge to Sections 4(a) and 4(c)
Administrative Procedure Act
Arbitrary and Capricious, Unlawful, and Unconstitutional Agency Action
Taken Without Observance of Procedure Required By Law
Against Defendant Lothrop in His Official Capacity**

143. Plaintiffs incorporate all preceding paragraphs of the Complaint as though fully set forth herein.

144. BOP's actions to implement Sections 2, 4(a), and 4(c) of the Executive Order constitute final agency action that has harmed Plaintiffs, affected their legal rights, and subjected them to an imminent risk of further harm.

145. BOP's decision to transfer Plaintiffs to men's facilities and the imminent threat to deny their necessary medical care solely because of their birth sex are unconstitutional.

146. BOP's decision to transfer Plaintiffs to men's facilities solely because of their birth sex and transgender status is arbitrary and capricious.

147. BOP's decision to deny Plaintiffs medically necessary care to treat their gender dysphoria solely because of their birth sex and transgender status is arbitrary and capricious.

148. BOP's decision to transfer Plaintiffs to men's facilities solely because of their birth sex is contrary to law as set forth in 28 C.F.R. §§ 115.41–42.

149. For BOP's first transfer of Jane Jones and any future transfer of Plaintiffs to a men's prison to be lawful, amendments to 28 C.F.R. §§ 115.41–42 would have to be made through notice-and-comment rulemaking. Section 4(a) directs the Attorney General to make such an "amendment," but no amendment has been made at this time. BOP's transfer of Jane Jones and decision to transfer all Plaintiffs to men's facilities prior to a valid amendment to 28 C.F.R. §§ 115.41–42 was made without observance of procedure required by law.

150. BOP's decision to transfer Plaintiffs to men's facilities without conducting an individualized assessment of all relevant circumstances, including their safety, was made without observance of procedure required by law.

151. If Sections 4(a) and 4(c) are implemented, Plaintiffs will suffer irreparable injury, including serious physical, psychological and emotional harm, mental anguish, distress, humiliation, and indignity.

COUNT VII

**Challenge to Section 4(c)
Violation of Separation of Powers
Ultra Vires Presidential Action in Excess of Authority
Usurping the Legislative Function
Violation of Bicameralism and Presentment Clauses
Against All Defendants in Their Official Capacities**

152. Plaintiffs incorporate all preceding paragraphs of the Complaint as though fully set forth herein.

153. Defendants, as part of the Executive branch of the United States government, cannot directly and unilaterally amend or cancel appropriations Congress has duly enacted, nor can Defendants order federal agencies to do so.

154. BOP receives federal funds to provide necessary medical care to incarcerated people, including medically necessary treatment for gender dysphoria. Section 4(c) of the Executive Order directs the withholding of this funding: by its terms, the Attorney General “shall ensure that no Federal funds are expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate’s appearance to that of the opposite sex.” The Executive Order issues this directive without regard to any statute regarding funds appropriated to the Bureau of Prisons, or any applicable regulations.

155. By directing the Bureau of Prisons to terminate or withhold congressionally appropriated funds based on the President’s own policy preferences, Section 4(c) of the Executive Order attempts to amend, repeal, rescind, or circumvent duly enacted federal appropriations.

156. By directing the Bureau of Prisons to terminate or withhold congressionally appropriated funds, Section 4(c) of the Executive Order attempts to allocate public funds to advance the President’s policy preferences, rather than those of Congress. These actions exceed the President’s Article II powers, unconstitutionally infringe upon Congress’s powers, and attempt to amend federal legislation while bypassing Article I’s Bicameralism and Presentment Clauses.

157. Pursuant to 28 U.S.C. § 2201, Plaintiffs are entitled to a declaration that Section 4(c) of the Executive Order violates the separation of powers and impermissibly arrogates to the Executive power that is reserved to Congress.

158. Plaintiffs are further entitled to an injunction preventing Defendants from enforcing or implementing Section 4(c) of the Executive Order.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs request that this Court grant the following relief:

- (1) Issue a judgment under 28 U.S.C. §§ 2201–02 declaring that Sections 4(a) and 4(c) of Executive Order 14168 violate Plaintiffs’ rights under the Fifth and Eighth Amendments to the United States Constitution, the Rehabilitation Act of 1973, and the Administrative Procedure Act for the reasons and on the Counts set forth above;
- (2) Enter a permanent injunction prohibiting Defendants and their officers, employees, servants, agents, appointees, and successors from enforcing Sections 4(a) and 4(c) of Executive Order 14168, and requiring Defendants to maintain Plaintiffs’ housing and medical treatment consistent with the status quo;
- (3) Award Plaintiffs nominal damages, as well as their costs, expenses, and reasonable attorneys’ fees pursuant to 28 U.S.C. § 2412, 42 U.S.C. § 12205, and other applicable laws; and
- (4) Grant such other and further relief as the Court deems just and proper.

Respectfully submitted,

/s/ Jennifer Fiorica Delgado

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Natalie Kraner (admission forthcoming)
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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JANE JONES, AMY JONES, BARBARA JONES,
CARLA JONES, DONNA JONES,

Plaintiffs,

v.

PAMELA BONDI, in her official capacity as
Attorney General of the United States; WILLIAM
LOTHROP, in his official capacity as Acting
Director of the Federal Bureau of Prisons;

Defendants.

Civil Action No. 25-00401-RCL

**DECLARATION OF JENNIFER F.
DELGADO IN SUPPORT OF
PLAINTIFFS' MOTION TO
PROCEED UNDER
PSEUDONYM, PARTIALLY SEAL
THE RECORD, AND FOR A
PROTECTIVE ORDER AND FOR
A TEMPORARY RESTRAINING
ORDER AND PRELIMINARY
INJUNCTION**

I, Jennifer Fiorica Delgado, Esq., of full age, do hereby declare as follows:

1. I am an attorney in good standing with the United States District Court for the District of Columbia Bar and licensed to practice law in said Court, as well as in New York and New Jersey.
2. I make the following declaration based on personal knowledge and pursuant to Fed. R. Civ. P. 65(b).
3. As detailed in the declarations filed on behalf of Plaintiffs Amy Jones, Barbara Jones, Carla Jones, and Donna Jones ("Plaintiffs"), Plaintiffs are incarcerated transgender women

whom have been housed in women's prisons for several years, and face imminent transfer to men's facilities and the imminent cessation of medically necessary treatment for gender dysphoria.

4. Plaintiffs' imminent transfers and cessation of medical care is due to Executive Order 14166 (the "Executive Order"), specifically, Sections 4(a) and 4(c).

5. Plaintiffs are filing an Emergency Motion for a Temporary Restraining Order and Preliminary Injunction, which seeks to preserve the *status quo* prior to January 20, 2025, when the Executive Order was issued, while the parties litigate the constitutionality and lawfulness of certain provisions of the Executive Order (the "Emergency Motion").

6. On February 26, 2025, counsel for Plaintiffs provided notice to Defendants that they would be making the Emergency Motion. Copies of all pleadings and papers filed in the action to date or to be presented to the Court at the hearing, will be provided to Defendants simultaneous with the filing on February 28, 2025, via email transmitted to their counsel, John J. Robinson, Esq.

7. In conjunction with the Complaint and Emergency Motion, Plaintiffs' counsel also filed a Motion To Proceed Under a Pseudonym, To Partially Seal Documents, and for a Protective Order. This motion is based on the specific potential harms that would follow from revealing Plaintiffs' identities, including the potential risk to them of violence in the corrections system and the violation of their interest in maintaining privacy of their medical status, history and records.

8. Indeed, Plaintiff Amy Jones was violently and sexually attacked by three male inmates while at a low-security male facility. Plaintiff Donna Jones was also targeted and raped while in a men's facility because she is transgender. And, all Plaintiffs have experienced harassment within the BOP, compulsions of self-harm, and several have attempted suicide.

9. All redactions proposed for the partially sealed documents stem from the necessity to protect their identities, set forth as follows:

- a. The locations of Plaintiffs' current and former correctional facilities are redacted because of the limited number of incarcerated transgender women at those facilities. If the facilities are identified, Plaintiffs' identities could be easily surmised from among a small number of transgender women at those facilities.
- b. Specific biographical details concerning Plaintiffs are redacted, including their current and former names, dates of birth, professions, the crimes they were convicted of, and the identities of any family members. Any one of these details would also provide an easy means of identification with minimal internet or public records research.
- c. Certain details about Plaintiffs' time in federal correctional facilities are redacted, including the period of their incarceration and any disciplinary record, rehabilitation activities, and medical care they have received. Individuals within the correctional facility or those with whom they might communicate are likely aware of these details about Plaintiffs.

Pursuant to 28 U.S.C. § 1746, I affirm under penalty of perjury that the above statements are true and correct.

Dated: February 28, 2025

Respectfully submitted,

/s/ Jennifer Fiorica Delgado

Jennifer Fiorica Delgado (Bar No. NY296)

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MATERIAL UNDER SEAL DELETED

**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

JANE JONES, et al.,
Plaintiff,

v.

Civil Action No. 25-cv-00401-RCL

PAMELA BONDI, *in her official capacity as*
Attorney General of the United States; WILLIAM
LOTHROP, *in his official capacity as* Acting
Director of the Federal Bureau of Prisons,

Defendants.

DECLARATION OF

I, [REDACTED], make the following declaration based on my personal knowledge and declare under the penalty of perjury pursuant to 28 U.S.C § 1746 that the following is true and correct:

1. My name is [REDACTED], I am currently incarcerated at a

[REDACTED]. I am in the custody of the Federal Bureau of Prisons. I am using the pseudonym Amy Jones to protect myself.

2. My inmate number is [REDACTED]. I have been incarcerated since February 2006.

3. I was sentenced to [REDACTED] in the Bureau of Prisons in [REDACTED].

4. I am submitting this declaration in support of my request for relief.

5. I was born on [REDACTED]. My sex at birth was identified as male and my parents gave me a male name.

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6. Since I was about 5 or 6 years old, I have always known I was a girl. The disconnect between who I was and how I presented to the world caused me significant distress. I have attempted many times to cut myself.

7. Sometime in early [REDACTED], I remember reading an article about a person who had come out as transgender. After reading this article I came to the realization that I was a transgender woman. I always knew I was a woman, but I now understood there was something I could do to alleviate my pain.

8. At the time I was housed at a [REDACTED] male facility, [REDACTED].

9. During my time at [REDACTED] I was participating in therapy. After reading the article I began talking to my psychologist about being a woman. She diagnosed me with gender dysphoria.

10. I was then transferred to [REDACTED] a [REDACTED] male facility.

11. Once at [REDACTED], still in [REDACTED], I was prescribed and began taking hormone medication and began living as a woman.

12. While at [REDACTED], staff members outed me to other inmates. These were very dark times. Three male inmates violently and sexually attacked me.

13. I spent two months in the [REDACTED] after this incident.

14. I was then transferred to [REDACTED] a [REDACTED] male facility.

15. At [REDACTED], I saw psychologists and received therapy and medication. I began to more publicly socially transition at that time. But, despite the more supportive environment, I was still sexually harassed and assaulted. I attempted suicide.

16. I was then transferred to another men's [REDACTED] facility in [REDACTED]. During my time at [REDACTED] I was continuously harassed and threatened.

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17. I was then transferred to a [REDACTED]. This was a program to address trauma and depression related to the harassment and attacks.

18. In [REDACTED], I legally changed my name and shortly thereafter I changed my sex marker to female on my birth certificate.

19. I had various housing assignments after that, but since [REDACTED], when I was transferred to an all-women's facility, [REDACTED], in [REDACTED], I have been housed exclusively in women's facilities.

20. Since then, I have finally been able to blossom and to begin to find peace and happiness.

21. On [REDACTED], as had been contemplated for several weeks, I was transferred to the all-female section of the [REDACTED]. I am supposed to be housed here for the next two years.

22. Before I left [REDACTED] to come to the [REDACTED], I was told by staff that the administration was going to be placing transgender women in men's facilities.

23. I am concerned that I will be transferred to a [REDACTED]. I am concerned about losing access to medical treatments upon which I have come to rely for my health and safety. I am terrified at what could happen to me. I fear being the target of sexual violence again and feel hopeless.

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24. I declare pursuant to 28 U.S.C. § 1746 and under penalty of perjury that the foregoing is true and correct.

██████████ has provided the information contained in this Declaration and approves the content. Because ██████████ is incarcerated, a copy of the Declaration has been sent to her via first-class mail. ██████████ counsel will submit a copy of the signed Declaration when they receive it from her.

Executed on this 27th day of February, 2025

MATERIAL UNDER SEAL DELETED

**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

JANE JONES, et al.,

Plaintiff,

v.

Civil Action No. 25-cv-00401-RCL

PAMELA BONDI, *in her official capacity as*
Attorney General of the United States; WILLIAM
LOTHROP, *in his official capacity as* Acting
Director of the Federal Bureau of Prisons,

Defendants.

DECLARATION OF
[REDACTED]

I, [REDACTED], make the following declaration based on my personal knowledge and declare under the penalty of perjury pursuant to 28 U.S.C § 1746 that the following is true and correct:

1. My legal name is [REDACTED]. My chosen name is [REDACTED], and I began using this name when I was a teenager and have consistently used it since then. I tried to legally change my name in [REDACTED] but have not been able to do so on my own while I am incarcerated. I am using the pseudonym Barbara Jones to protect myself.

2. I am currently incarcerated at [REDACTED], which is a women's prison. I am in the custody of the Federal Bureau of Prisons. My BOP records list my sex as female, as can be seen in the BOP inmate locator search engine.

3. My inmate number is [REDACTED]. I have been incarcerated since [REDACTED].

4. I was sentenced to almost [REDACTED] in the Bureau of Prisons in [REDACTED].

5. I am submitting this declaration in support of my request for relief.

MATERIAL UNDER SEAL DELETED

6. I was born on [REDACTED]. My sex at birth was identified as male and my parents gave me a male name.

7. Since I was a child, I have always known I was a girl. The disconnect between who I was and how I presented to the world was confusing and made me feel like I was hiding my authentic self. It caused me significant pain. I have attempted to cut myself and attempted suicide on several occasions.

8. I took female hormones before I was incarcerated.

9. When I began my incarceration, I was housed in men's prisons. My depression and suicide attempts continued.

10. Although I did not have access to female commissary items, I presented as a female to the best that I could at that time.

11. In [REDACTED], I was formally diagnosed with gender dysphoria by a psychiatrist. A month later, I began receiving prescription hormone medication.

12. At the time, I was housed at [REDACTED] male facility, [REDACTED].

13. In [REDACTED], I was transferred to a [REDACTED] all-women's facility, [REDACTED].

14. In [REDACTED], I was transferred to another low-custody all-women's facility, [REDACTED].

15. Since [REDACTED], I have been housed exclusively in women's facilities.

16. Since then, my self-esteem and mental well-being have peaked. I have not had any incidents of self-harm while incarcerated with women.

17. In late [REDACTED], I was moved to the [REDACTED] and told by staff that I should prepare for a transfer to a men's prison. After about a week, I was returned to general population.

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18. I am very concerned that I will soon be transferred to a male prison. I am concerned about losing access to medical treatments upon which I have come to rely for my health and safety. I am terrified at what could happen to me.

Ms. [REDACTED] has provided the information contained in this Declaration and approves the content. Because Ms. [REDACTED] is incarcerated, a copy of the Declaration has been sent to her via first-class mail. Ms. [REDACTED] counsel will submit a copy of the signed Declaration when they receive it from her.

Executed on this 27th day of February, 2025

MATERIAL UNDER SEAL DELETED

**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

JANE JONES, et al.,
Plaintiff,

v.

Civil Action No. 25-cv-00401-RCL

PAMELA BONDI, *in her official capacity as*
Attorney General of the United States; WILLIAM
LOTHROP, *in his official capacity as* Acting
Director of the Federal Bureau of Prisons,

Defendants.

DECLARATION OF
[REDACTED]

I, [REDACTED], make the following declaration based on my personal knowledge and declare under the penalty of perjury pursuant to 28 U.S.C § 1746 that the following is true and correct:

1. I am currently incarcerated in the Bureau of Prisons. I am submitting this declaration in support of my request for relief. I am using the pseudonym Carla Jones to protect myself.
2. I am a transgender woman. I was born male, but have felt like a woman for [REDACTED]. My legal name is [REDACTED].
3. In about [REDACTED], my distress, anxiety, and depression became so intense that I sought medical help. It took the BOP a long time to provide that, but in about [REDACTED], BOP clinicians diagnosed me with gender dysphoria. I also began taking hormone medication then and have taken that medication continually since that time. That treatment has been a God send to me and I finally felt like I was starting to become myself.

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4. Although the hormone medications I take have saved my life and relieved a significant amount of my gender dysphoria, I continue to have symptoms. I have notified BOP staff of this many times and have also requested surgery. For many years, the BOP denied this care but never provided a medical reason for doing that.
5. After several years of trying to get more care and even filing a lawsuit about it, I became so desperate that [REDACTED]. That happened in [REDACTED]. I felt at the time that I had no other option. [REDACTED]
[REDACTED]
[REDACTED].
6. I have lived as a woman in the BOP for many years and have been housed in women's facilities since about [REDACTED]. The TEC approved my transfer to a women's facility at that time. I was housed in [REDACTED] first and then moved to [REDACTED]
[REDACTED].
7. I was told by the TEC that I would be at [REDACTED] for a year or so and then would be considered for surgery. The TEC eventually did approve me for surgery to treat my gender dysphoria and then I was also approved for that care by the BOP's utilization review committee. [REDACTED], the BOP performed some medical tests on me to make sure I am healthy enough for surgery. During my last appointment with a [REDACTED], however, I was informed by the clinician that there was a note in my file stating that my surgery has been canceled. I asked her who canceled it and whether it was the Medical Director of the BOP. She told me it was someone "higher up" but did not say anything else.

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8. I felt incredible relief when I was finally transferred to a women's facility. I suffered many physical assaults in men's prisons and experienced sexual assaults in three prisons. I felt like I was in constant danger in the men's facilities and that I would never be safe. My housing with women has alleviated the fears and terror I felt in men's prisons.
9. On [REDACTED], guards removed all of the transgender women from their housing units and housed us together. They told us we were being segregated because of the President's Executive Order.
10. I was told by staff that I would be transferred to a men's prison and the paperwork was already processed. They said the transfer would happen by Thursday, January 30.
11. On [REDACTED], I was allowed to go back to general population, but staff told me I was still being transferred to a men's prison.
12. Last week, BOP staff told me again that they are moving ahead with my transfer and that I would likely move this week and that my medical care would stop after transfer.
13. I am terrified of moving back to men's facilities. I am not safe in those facilities and I fear that I will be targeted again for sexual and physical violence. One of my sexual assaults happened at a low security facility.
14. I also know the Executive Order requires the BOP to cut off hormone medication and other medical treatments for transgender people. I have been taking hormones for almost [REDACTED]. This would be devastating and dangerous for me. I am afraid that without medication, I will go back to experiencing extremely serious symptoms of my gender dysphoria and that I will again become desperate for care. I know my birth sex is male, but I would not be able to survive without treatment for my gender dysphoria.

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15. I declare pursuant to 28 U.S.C. § 1746 and under penalty of perjury that the foregoing is true and correct.

Ms. [REDACTED] has reviewed and approved the contents of this Declaration. Because Ms. [REDACTED] is incarcerated, a copy of the Declaration has been sent to her via first-class mail. Ms. [REDACTED]'s counsel will submit a copy of the signed Declaration when they receive it from her.

Executed on this 27th day of February, 2025.

MATERIAL UNDER SEAL DELETED

**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

JANE JONES, et al.,
Plaintiff,

v.

Civil Action No. 25-cv-00401-RCL

PAMELA BONDI, *in her official capacity as*
Attorney General of the United States; WILLIAM
LOTHROP, *in his official capacity as* Acting
Director of the Federal Bureau of Prisons,

Defendants.

DECLARATION OF
[REDACTED]

I, [REDACTED], make the following declaration based on my personal knowledge and declare under the penalty of perjury pursuant to 28 U.S.C § 1746 that the following is true and correct:

1. I am currently incarcerated in the Bureau of Prisons. I am submitting this declaration in support of my request for relief. I am using the pseudonym Donna Jones to protect myself.

2. My legal name is [REDACTED], but I go by [REDACTED]. I am a transgender woman. I was born male but have felt like a girl since childhood. When I was about five or six years old, I told my parents this but they said, “No you’re a boy.”

3. I fought being transgender for a long time and tried to live as a boy and then a man.

4. When I was in college and away from home for the first time, I started to live as myself. I started wearing makeup. I told my friend that I felt like a woman trapped in a man’s body.

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5. But once I was home again, I kept fighting my identity. [REDACTED]
[REDACTED], I married a woman. [REDACTED]. Everything was good on the surface, but I was hiding my identity.

6. When I first entered BOP custody in [REDACTED], I was placed in a men's facility [REDACTED]. In [REDACTED], I started telling friends in custody the truth: that I felt like I was a woman. When I was in the shower, a male inmate came up behind me, pressed my face into the wall, and said, [REDACTED] He raped me from behind. I blacked out from the event. It felt like a part of me died.

7. In [REDACTED], I officially came out as transgender to my psychologist during a [REDACTED] psychology class. The class covered coping mechanisms as they relate to Post Traumatic Stress Disorder (PTSD).

8. In [REDACTED], I was diagnosed with gender dysphoria by a BOP psychologist. And in [REDACTED], I started taking hormone medications.

9. Those medications have been lifesaving. I finally felt like I had some emotional relief and freedom. I began using women's hygiene products and clothing and anything and everything that could help me express who I am.

10. In [REDACTED], I told a PREA coordinator who was visiting [REDACTED] that I had been raped by a male inmate because I was a transgender woman. BOP then transferred me to [REDACTED] in [REDACTED].

11. Since being housed in a women's facility, I feel validated in my identity. Most of my life, my brain has told me what my body should be like. Now that I am here and around my peers, and I have the opportunity to be who I am, I no longer have any judgment against myself for thinking that I am a woman. I feel validated as a woman.

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12. I also feel much more secure in my mental and physical safety in a women's facility. Gender dysphoria has been crippling, and made me want to self-harm. Now that I am in a women's facility and receiving hormone medication, I have no compulsion to self-harm.

13. On [REDACTED], guards took me out of my cell and put me in separate housing with other transgender women. They told me I was being segregated because of the President's Executive Order.

14. BOP staff told me I was being transferred to a men's prison, and the paperwork was being processed. The warden said they were ordered to do the transfers, and the transfers were complete, but they were waiting for a designation of which facility.

15. On [REDACTED], I was allowed to go back to the general population, but guards told me I was still being transferred to a men's prison and that my medical care would stop after transfer.

16. On [REDACTED], the warden told me that my transfer was still pending. I am very scared of being transferred to a men's facility.

17. I also know the Executive Order requires the BOP to cut off hormone medications and other medical treatments for transgender people.

18. I have been receiving hormone treatment for almost [REDACTED] years. If I am cut off from my medication, my body is going to attempt to correct course and it's going to do so negatively and painfully. I would go through menopause and I don't know if my body can survive that. Right now, every time I get my hormone injection, I feel relief that I have treatment for my gender dysphoria. If I lose my hormone medication, my gender dysphoria will come back and I will struggle. My body would start becoming masculine, and I am afraid I will want to self-harm again.

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Ms. [REDACTED] has reviewed and approved the contents of this Declaration. Because Ms. [REDACTED] is incarcerated, a copy of the Declaration has been sent to her via first-class mail. Ms. [REDACTED]'s counsel will submit a copy of the signed Declaration when they receive it from her.

Executed on this 27th day of February, 2025

**UNITED STATES DISTRICT COURT
DISTRICT OF COLUMBIA**

JANE JONES,

Plaintiffs,

Civil Action No. 1:25-401

v.

DONALD J. TRUMP, et al.,

Defendants.

**SECOND DECLARATION OF RICK STOVER,
SENIOR DEPUTY ASSISTANT DIRECTOR
DESIGNATION AND SENTENCE COMPUTATION CENTER**

I, Rick Stover, declare and state as follows:

1. I am currently employed by the Federal Bureau of Prisons (Bureau or FBOP).

Since June 2024, I have served as the Senior Deputy Assistant Director of the Designation and Sentence Computation Center, within the Bureau's Correctional Programs Division.

2. Prior to becoming Senior Deputy Assistant Director of the Designation and Sentence Computation Center, I worked in positions of increasing responsibility within the Bureau, most recently as the Warden at the Federal Correctional Institution in Danbury, Connecticut.

3. I am familiar with the Bureau's general policies and practices on housing for inmates, including the rationales for those policies. As part of my official duties, I have access to records maintained in the ordinary course of business by the Bureau, including inmate medical and mental health records.

4. As the Senior Deputy Assistant Director within the Bureau's Correctional Programs Division, I served as co-chair of what was formerly known as the Transgender Executive Council (TEC). I managed monthly or twice monthly TEC multi-disciplinary team

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meetings and reviewed all initial designations and re-designation requests of male and female inmates that identify as the opposite biological sex. I was involved in the development of accommodations, resource information, programs, and policy to ensure the needs of this population were met.

5. This is the second declaration that I have submitted in this matter. The information below is based upon personal knowledge and upon information and belief.

Plaintiffs' Housing Information

6. In my first declaration, I provided information on where Plaintiff Jane Jones is currently housed and where Jones would be transferred. Plaintiff has since amended the complaint to add four new Plaintiffs. I address below each of the new Plaintiffs' current housing and where each new Plaintiff would be transferred.

7. Plaintiff, Barbara Jones, is a biological male inmate currently housed in a female facility at [REDACTED]

[REDACTED]

[REDACTED]

8. Plaintiff, Carla Jones, is a biological male inmate currently housed in a female facility at [REDACTED]

[REDACTED]

[REDACTED]

9. Plaintiff, Donna Jones, is a biological male inmate currently housed in [REDACTED]

[REDACTED]

[REDACTED]

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10. Plaintiff, Amy Jones, is a biological male inmate currently housed in [REDACTED]

11. In determining the most appropriate placement for the four plaintiffs, the FBOP took into consideration the inmates' assigned security level, disciplinary record, medical record, and psychology record.

12. Based on these factors, the Bureau found that placement at the above-named institutions would safely house the plaintiffs. All three institutions are low security facilities that house several biological male inmates who identify as female and a large number of nonviolent offenders. Nonviolent crimes are defined as crimes involving property, drug, and other offenses which do not involve a threat of harm or an actual attack upon a victim. The most frequently identified nonviolent crimes involve drug trafficking, drug possession, burglary, and larceny. Moreover, inmates housed in low security facilities tend to have minor infractions in their disciplinary history with the Bureau.

13. Being housed at these low security institutions greatly reduces the chance of the plaintiffs being victimized by other inmates. Barbara Jones is currently housed at [REDACTED]

Moreover, [REDACTED] currently houses approximately [REDACTED] biological male inmates who identify as the opposite sex, thereby having staff members that are experienced with providing care to this special population.

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14. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] Moreover, [REDACTED]

[REDACTED] currently houses approximately [REDACTED] biological male inmates who identify as female, thereby having staff members that are experienced with providing care to this special population.

15. [REDACTED]

[REDACTED]

[REDACTED] Moreover, [REDACTED] currently houses approximately

[REDACTED] biological male inmates who identify as female, thereby having staff members that are experienced with providing care to this special population.

16. In the seven facilities that the *Jones* and *Doe* plaintiffs may be transferred, there was only one guilty finding (at [REDACTED] of sexual assault (Prohibited Act Codes 114 and 229) in 2024.

Assault Rate Data

17. The assault data provided above and in my prior declaration was generated by a Federal Bureau of Prisons Senior Research Analyst and Social Science Research Analyst from the Bureaus' Office of Research and Evaluation (ORE), which is part of the Information Technology and Data Division (ITDD). ITDD oversees the agency's IT program, including IT systems development and support, information security, management of the agency's public and intranet sites, and correctional security technology. Additionally, the Division has oversight of other

functions within the agency, including privacy compliance, records management, and research and evaluations.

18. ORE assists the FBOP by evaluating the efficacy of the Bureau's programs, services, and operations; preparing annual inmate population projections; projecting impact of various policy changes on inmate population; providing Bureau management with the tools and information needed to make informed policy and operational decisions; and producing general purpose statistics for use by BOP staff and outside agencies.

19. ORE compiled guilty findings by facility from the SENTRY Chronological Disciplinary Record (CDR) data for 2020 to 2024. The data was based on Guilty Findings for Assaults on Inmates based on the following Prohibited Act Code violations: 100 (killing), 101 (assault), 107 (taking hostages), 114 (sexual assault—greatest severity), 203 (threatening another with bodily harm), 205 (sexual acts), 206 (sexual proposals or threats), 224 (assault), 225 (stalking), and 229 (sexual assault—high severity). *See* 28 C.F.R. § 541.3 (defining codes).

The data that ORE used is also reflected in BOP's public statistics regarding prison safety, which are available at bop.gov/about/statistics. I am also attaching to this declaration the entire data set.

BOP's Practice of Housing Inmates According to Their Biological Sex

20. The FBOP believes that housing inmates according to their biological sex helps to ensure prisoner safety, security, and privacy. That is why the FBOP has always housed the vast majority of inmates with other individuals of their own biological sex.

21. Of the nearly 153,746 federal offenders, women consistently account for approximately 6.5 % of the federal inmate population. Men account for the remaining 93.5%. *See*

https://www.bop.gov/about/statistics/statistics_inmate_gender.jsp (last updated February 22, 2023).

22. Housing inmates with inmates of the opposite biological sex is a statistical anomaly, and quite rare. Presently, only 23 inmates in BOP custody are housed in a facility of the opposite biological sex, out of a total population of 153,746. Out of 10,009 biological female inmates in FBOP custody, only 1 biological female is housed in a male institution. Out of the 143,737 biological male inmates in FBOP custody, only 22 biological male inmates are housed in female institutions.

23. It is FBOP's correctional judgment that housing inmates with inmates of their own biological sex ensures bodily privacy and safety and limits the risk of sexual abuse, disciplinary problems, and illicit intimate relationships. No FBOP housing unit is co-ed. Rather, female inmates are housed separate and apart from male inmates in 29 facilities.

24. It is not the case that all 22 biological male inmates who have been housed in a women's facility were placed there because BOP determined that they were particularly at risk or could not be safely housed in a men's facility. Several of the inmates were placed in a women's facility because they were seeking sex reassignment surgery, such as Zoe Doe and Mary Doe. BOP's policy at that time required that biological male inmates seeking sex reassignment surgery have to live in a women's facility for at least a year with no substantial issues prior to receiving surgery. Furthermore, two of the biological males were placed in a women's facility due to court orders, while another was placed in a women's facility as part of the terms of a settlement agreement. Others were placed in a women's facility because they were already being housed with women prior to coming into the FBOP's custody. FBOP believes that all 22 biological male inmates can be safely housed in low security men's facilities.

Other Issues

25. In my prior declaration in this case, I noted that if FBOP staff believe that an inmate's safety may be jeopardized by placement in the general population, the inmate may be housed in more restrictive conditions as a protective custody case in the Special Housing Unit (SHU). I noted that the Warden or the designee would then need to review the placement within two workdays to determine if continued protective custody is necessary. I wish to emphasize that FBOP does not intend to house any plaintiff in the SHU as a matter of course or for an extended period of time. I noted the possibility of SHU placement only because it is one of many options available to FBOP to ensure inmate safety.

26. I am also aware that the plaintiffs have alleged that if they are transferred to men's facilities, they may be forced to shower in full view of the other men who are incarcerated. All of the men's facilities to which the plaintiffs could be transferred have individual shower stalls, so no inmate would be required to shower in full view of another inmate.

In accordance with 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Dated: February 28, 2025

**RICHARD
STOVER**

Digitally signed by RICHARD
STOVER
Date: 2025.02.28 13:19:29
-06'00'

RICK STOVER

EXHIBIT A

**Total Guilty Findings for Assaults on Inmates
BOP Typical Facilities**

Facility	2020	2021	2022	2023	2024	Total
ALDERSON FPC	3	1	3	2	2	11
ALICEVILLE FCI	15	19	30	30	24	118
ALLENWOOD LOW FCI	3	13	7	4	9	36
ALLENWOOD MED FCI	23	16	15	42	31	127
ALLENWOOD USP	25	26	28	15	10	104
ASHLAND FCI	1	2	.	7	7	17
ATLANTA FCI	19	11	6	17	4	57
ATWATER USP	44	63	99	130	110	446
BASTROP FCI	4	12	14	12	8	50
BEAUMONT LOW FCI	8	11	11	9	10	49
BEAUMONT MED FCI	9	50	51	109	91	310
BEAUMONT USP	55	64	121	185	171	596
BECKLEY FCI	37	59	39	48	51	234
BENNETTSVILLE FCI	12	8	31	26	36	113
BERLIN FCI	13	12	38	16	31	110
BIG SANDY USP	39	103	137	143	182	604
BIG SPRING FCI	3	10	4	7	4	28
BROOKLYN MDC	26	15	43	66	52	202
BRYAN FPC	4	4	2	2	3	15
BUTNER FMC	8	2	7	4	12	33
BUTNER LOW FCI	2	3	4	4	1	14
BUTNER MED I FCI	17	16	23	20	14	90
BUTNER MED II FCI	18	15	29	24	22	108
CANAAN USP	86	114	116	123	124	563
CARSWELL FMC	22	31	21	14	34	122
CHICAGO MCC	13	5	10	10	11	49
COLEMAN I USP	34	79	86	98	62	359
COLEMAN II USP	46	40	45	54	67	252
COLEMAN LOW FCI	17	14	11	12	15	69
COLEMAN MED FCI	17	19	21	23	31	111
CUMBERLAND FCI	18	6	16	15	11	66
DANBURY FCI	13	10	15	22	23	83
DEVENS FMC	18	14	27	24	18	101
DUBLIN FCI	5	6	11	9	.	31
DULUTH FPC	1	2	1	.	3	7
EDGEFIELD FCI	10	12	40	43	22	127
EL RENO FCI	21	17	23	21	40	122
ELKTON FCI	21	11	13	19	7	71
ENGLEWOOD FCI	5	8	9	9	31	62
ESTILL FCI	8	.	1	.	.	9
FAIRTON FCI	35	20	25	15	15	110
FLORENCE ADMAX USP	4	3	1	.	.	8
FLORENCE FCI	43	44	73	75	91	326
FLORENCE HIGH USP	62	86	84	119	96	447
FORREST CITY FCI	10	4	3	7	4	28
FORREST CITY MED FCI	24	48	52	72	27	223
FORT DIX FCI	9	8	10	10	25	62
FORT WORTH ADMINISTRATIVE FMC	24	7	16	18	7	72
GILMER FCI	10	17	.	25	18	70
GREENVILLE FCI	9	16	18	18	29	90

GUAYNABO MDC	13	12	17	18	45	105
HAZELTON FCI	36	47	53	55	69	260
HAZELTON USP	24	65	59	78	82	308
HERLONG FCI	26	19	51	88	77	261
HONOLULU FDC	1	1	9	6	9	26
HOUSTON FDC	16	6	12	24	35	93
JESUP FCI	10	18	15	24	28	95
LA TUNA FCI	15	7	4	9	14	49
LEAVENWORTH FCI	43	63	20	40	52	218
LEE USP	55	86	106	156	143	546
LEWISBURG FCI	12	5	22	20	16	75
LEXINGTON FMC	8	7	15	7	5	42
LOMPOC FCI	4	5	2	3	10	24
LOMPOC II FCI	23	33	78	23	28	185
LORETTO FCI	4	8	4	9	7	32
LOS ANGELES MDC	21	11	25	20	20	97
MANCHESTER FCI	15	11	12	18	19	75
MARIANNA FCI	.	12	29	16	37	94
MARION FCI	18	12	18	17	25	90
MCCREARY USP	52	75	148	109	118	502
MCDOWELL FCI	7	13	10	23	36	89
MCKEAN FCI	6	15	23	35	20	99
MEMPHIS FCI	19	22	23	14	5	83
MENDOTA FCI	8	13	15	16	34	86
MIAMI FCI	6	1	8	5	4	24
MIAMI FDC	20	32	28	17	12	109
MILAN FCI	11	9	13	9	17	59
MONTGOMERY FPC	.	2	.	.	2	4
MORGANTOWN FPC	1	1	1	2	2	7
NEW YORK MCC	31	17	.	.	.	48
OAKDALE I FCI	4	4	6	7	13	34
OAKDALE II FCI	2	4	10	6	4	26
OKLAHOMA CITY FTC	12	18	20	29	22	101
OTISVILLE FCI	25	14	11	22	27	99
OXFORD FCI	28	19	29	37	14	127
PEKIN FCI	8	21	14	32	21	96
PENSACOLA FPC	1	1	.	.	.	2
PETERSBURG FCI	5	2	1	.	1	9
PETERSBURG MED FCI	15	13	13	11	20	72
PHILADELPHIA FDC	32	19	15	30	13	109
PHOENIX FCI	12	20	9	31	47	119
POLLOCK MED FCI	33	23	50	56	50	212
POLLOCK USP	24	68	34	39	48	213
RAY BROOK FCI	9	13	27	39	39	127
ROCHESTER FMC	6	5	6	16	12	45
SAFFORD FCI	4	4	19	4	10	41
SAN DIEGO MCC	5	9	10	26	21	71
SANDSTONE FCI	6	6	10	31	19	72
SCHUYLKILL FCI	20	10	8	21	49	108
SEAGOVILLE FCI	15	20	30	11	20	96
SEATAC FDC	19	17	24	17	18	95
SHERIDAN FCI	27	15	11	20	49	122
SPRINGFIELD USMCFP	11	12	11	30	21	85
TALLADEGA FCI	10	6	8	21	27	72

TALLAHASSEE FCI	17	13	13	18	11	72
TERMINAL ISLAND FCI	1	6	9	3	7	26
TERRE HAUTE FCI	19	27	52	41	35	174
TERRE HAUTE USP	40	54	48	66	87	295
TEXARKANA FCI	3	2	5	5	2	17
THOMSON FCI	100	82	50	20	13	265
THREE RIVERS FCI	38	51	76	88	70	323
TUCSON FCI	3	5	3	9	3	23
TUCSON USP	37	41	69	58	34	239
VICTORVILLE MED I FCI	17	40	29	63	57	206
VICTORVILLE MED II FCI	37	21	20	43	80	201
VICTORVILLE USP	68	62	66	84	107	387
WASECA FCI	22	26	25	25	22	120
WILLIAMSBURG FCI	7	25	22	15	22	91
YANKTON FPC	6	.	1	5	.	12
YAZOO CITY LOW FCI	4	4	9	10	9	36
YAZOO CITY LOW II FCI	18	13	12	17	3	63
YAZOO CITY MED FCI	7	6	14	47	24	98

Prohibited act codes 100, 101, 107, 114, 203, 205, 206, 224, 225, 229

**Total Guilty Findings for Assaults on Inmates
BOP Typical Facilities**

Facility	2020	2021	2022	2023	2024	Total
ALDERSON FPC	3	1	3	2	2	11
ALICEVILLE FCI	15	19	30	30	24	118
ALLENWOOD LOW FCI	3	13	7	4	9	36
ALLENWOOD MED FCI	23	16	15	42	31	127
ALLENWOOD USP	25	26	28	15	10	104
ASHLAND FCI	1	2	.	7	7	17
ATLANTA FCI	19	11	6	17	4	57
ATWATER USP	44	63	99	130	110	446
BASTROP FCI	4	12	14	12	8	50
BEAUMONT LOW FCI	8	11	11	9	10	49
BEAUMONT MED FCI	9	50	51	109	91	310
BEAUMONT USP	55	64	121	185	171	596
BECKLEY FCI	37	59	39	48	51	234
BENNETTSVILLE FCI	12	8	31	26	36	113
BERLIN FCI	13	12	38	16	31	110
BIG SANDY USP	39	103	137	143	182	604
BIG SPRING FCI	3	10	4	7	4	28
BROOKLYN MDC	26	15	43	66	52	202
BRYAN FPC	4	4	2	2	3	15
BUTNER FMC	8	2	7	4	12	33
BUTNER LOW FCI	2	3	4	4	1	14
BUTNER MED I FCI	17	16	23	20	14	90
BUTNER MED II FCI	18	15	29	24	22	108
CANAAN USP	86	114	116	123	124	563
CARSWELL FMC	22	31	21	14	34	122
CHICAGO MCC	13	5	10	10	11	49
COLEMAN I USP	34	79	86	98	62	359
COLEMAN II USP	46	40	45	54	67	252
COLEMAN LOW FCI	17	14	11	12	15	69
COLEMAN MED FCI	17	19	21	23	31	111
CUMBERLAND FCI	18	6	16	15	11	66
DANBURY FCI	13	10	15	22	23	83
DEVENS FMC	18	14	27	24	18	101
DUBLIN FCI	5	6	11	9	.	31
DULUTH FPC	1	2	1	.	3	7
EDGEFIELD FCI	10	12	40	43	22	127
EL RENO FCI	21	17	23	21	40	122
ELKTON FCI	21	11	13	19	7	71
ENGLEWOOD FCI	5	8	9	9	31	62
ESTILL FCI	8	.	1	.	.	9
FAIRTON FCI	35	20	25	15	15	110
FLORENCE ADMAX USP	4	3	1	.	.	8
FLORENCE FCI	43	44	73	75	91	326
FLORENCE HIGH USP	62	86	84	119	96	447
FORREST CITY FCI	10	4	3	7	4	28
FORREST CITY MED FCI	24	48	52	72	27	223
FORT DIX FCI	9	8	10	10	25	62
FORT WORTH ADMINISTRATIVE FMC	24	7	16	18	7	72
GILMER FCI	10	17	.	25	18	70
GREENVILLE FCI	9	16	18	18	29	90

GUAYNABO MDC	13	12	17	18	45	105
HAZELTON FCI	36	47	53	55	69	260
HAZELTON USP	24	65	59	78	82	308
HERLONG FCI	26	19	51	88	77	261
HONOLULU FDC	1	1	9	6	9	26
HOUSTON FDC	16	6	12	24	35	93
JESUP FCI	10	18	15	24	28	95
LA TUNA FCI	15	7	4	9	14	49
LEAVENWORTH FCI	43	63	20	40	52	218
LEE USP	55	86	106	156	143	546
LEWISBURG FCI	12	5	22	20	16	75
LEXINGTON FMC	8	7	15	7	5	42
LOMPOC FCI	4	5	2	3	10	24
LOMPOC II FCI	23	33	78	23	28	185
LORETTO FCI	4	8	4	9	7	32
LOS ANGELES MDC	21	11	25	20	20	97
MANCHESTER FCI	15	11	12	18	19	75
MARIANNA FCI	.	12	29	16	37	94
MARION FCI	18	12	18	17	25	90
MCCREARY USP	52	75	148	109	118	502
MCDOWELL FCI	7	13	10	23	36	89
MCKEAN FCI	6	15	23	35	20	99
MEMPHIS FCI	19	22	23	14	5	83
MENDOTA FCI	8	13	15	16	34	86
MIAMI FCI	6	1	8	5	4	24
MIAMI FDC	20	32	28	17	12	109
MILAN FCI	11	9	13	9	17	59
MONTGOMERY FPC	.	2	.	.	2	4
MORGANTOWN FPC	1	1	1	2	2	7
NEW YORK MCC	31	17	.	.	.	48
OAKDALE I FCI	4	4	6	7	13	34
OAKDALE II FCI	2	4	10	6	4	26
OKLAHOMA CITY FTC	12	18	20	29	22	101
OTISVILLE FCI	25	14	11	22	27	99
OXFORD FCI	28	19	29	37	14	127
PEKIN FCI	8	21	14	32	21	96
PENSACOLA FPC	1	1	.	.	.	2
PETERSBURG FCI	5	2	1	.	1	9
PETERSBURG MED FCI	15	13	13	11	20	72
PHILADELPHIA FDC	32	19	15	30	13	109
PHOENIX FCI	12	20	9	31	47	119
POLLOCK MED FCI	33	23	50	56	50	212
POLLOCK USP	24	68	34	39	48	213
RAY BROOK FCI	9	13	27	39	39	127
ROCHESTER FMC	6	5	6	16	12	45
SAFFORD FCI	4	4	19	4	10	41
SAN DIEGO MCC	5	9	10	26	21	71
SANDSTONE FCI	6	6	10	31	19	72
SCHUYLKILL FCI	20	10	8	21	49	108
SEAGOVILLE FCI	15	20	30	11	20	96
SEATAC FDC	19	17	24	17	18	95
SHERIDAN FCI	27	15	11	20	49	122
SPRINGFIELD USMCFP	11	12	11	30	21	85
TALLADEGA FCI	10	6	8	21	27	72

TALLAHASSEE FCI	17	13	13	18	11	72
TERMINAL ISLAND FCI	1	6	9	3	7	26
TERRE HAUTE FCI	19	27	52	41	35	174
TERRE HAUTE USP	40	54	48	66	87	295
TEXARKANA FCI	3	2	5	5	2	17
THOMSON FCI	100	82	50	20	13	265
THREE RIVERS FCI	38	51	76	88	70	323
TUCSON FCI	3	5	3	9	3	23
TUCSON USP	37	41	69	58	34	239
VICTORVILLE MED I FCI	17	40	29	63	57	206
VICTORVILLE MED II FCI	37	21	20	43	80	201
VICTORVILLE USP	68	62	66	84	107	387
WASECA FCI	22	26	25	25	22	120
WILLIAMSBURG FCI	7	25	22	15	22	91
YANKTON FPC	6	.	1	5	.	12
YAZOO CITY LOW FCI	4	4	9	10	9	36
YAZOO CITY LOW II FCI	18	13	12	17	3	63
YAZOO CITY MED FCI	7	6	14	47	24	98

Prohibited act codes 100, 101, 107, 114, 203, 205, 206, 224, 225, 229

Total Guilty Findings for Assaults on Inmates by Prohibited Act Code
BOP Typical Facilities

Year=2020

Facility	100	101	107	114	203	205	206	224	225	229	Total
ALDERSON FPC	.	.	.	.	.	1	.	2	.	.	3
ALICEVILLE FCI	.	.	.	.	1	.	.	14	.	.	15
ALLENWOOD LOW FCI	.	.	.	.	.	.	.	3	.	.	3
ALLENWOOD MED FCI	.	.	.	.	.	2	.	21	.	.	23
ALLENWOOD USP	.	3	.	.	.	1	.	21	.	.	25
ASHLAND FCI	.	.	.	.	1	.	.	.	.	.	1
ATLANTA FCI	.	.	.	.	1	.	.	18	.	.	19
ATWATER USP	.	7	.	.	3	.	.	34	.	.	44
BASTROP FCI	.	.	.	.	.	.	1	3	.	.	4
BEAUMONT LOW FCI	.	.	.	.	.	.	.	8	.	.	8
BEAUMONT MED FCI	.	.	.	.	1	2	.	6	.	.	9
BEAUMONT USP	.	2	.	.	.	.	.	53	.	.	55
BECKLEY FCI	.	1	.	.	4	.	.	32	.	.	37
BENNETTSVILLE FCI	.	.	.	.	3	.	.	9	.	.	12
BERLIN FCI	.	.	.	.	1	.	.	12	.	.	13
BIG SANDY USP	.	2	.	.	2	.	.	35	.	.	39
BIG SPRING FCI	.	.	.	.	1	.	.	2	.	.	3
BROOKLYN MDC	.	.	.	.	2	.	.	24	.	.	26
BRYAN FPC	.	.	.	.	.	.	.	4	.	.	4
BUTNER FMC	.	.	.	.	1	3	.	4	.	.	8
BUTNER LOW FCI	.	.	.	.	.	1	.	1	.	.	2
BUTNER MED I FCI	.	1	.	.	.	6	.	10	.	.	17
BUTNER MED II FCI	.	.	.	.	1	8	.	9	.	.	18
CANAAN USP	.	2	.	.	.	.	.	84	.	.	86
CARSWELL FMC	.	.	.	.	2	.	.	20	.	.	22
CHICAGO MCC	.	3	.	.	1	.	.	9	.	.	13
COLEMAN I USP	.	1	.	.	7	.	.	26	.	.	34
COLEMAN II USP	.	1	.	.	13	5	.	27	.	.	46
COLEMAN LOW FCI	.	1	.	.	.	4	.	12	.	.	17
COLEMAN MED FCI	.	.	.	.	1	.	.	16	.	.	17
CUMBERLAND FCI	.	4	.	.	.	2	.	12	.	.	18
DANBURY FCI	.	.	.	.	.	.	.	13	.	.	13
DEVENS FMC	.	.	.	.	4	2	2	10	.	.	18
DUBLIN FCI	.	.	.	.	.	.	.	5	.	.	5
DULUTH FPC	.	.	.	.	.	.	.	1	.	.	1
EDGEFIELD FCI	.	1	.	.	.	.	.	9	.	.	10
EL RENO FCI	.	3	.	.	.	.	.	18	.	.	21
ELKTON FCI	.	.	.	.	1	.	.	20	.	.	21
ENGLEWOOD FCI	.	.	.	.	.	.	.	5	.	.	5
ESTILL FCI	.	.	.	.	1	2	.	5	.	.	8
FAIRTON FCI	.	.	.	.	8	.	.	27	.	.	35
FLORENCE ADMAX USP	1	2	.	.	.	.	.	1	.	.	4
FLORENCE FCI	.	.	.	.	1	.	.	42	.	.	43
FLORENCE HIGH USP	.	5	.	.	.	.	.	57	.	.	62
FORREST CITY FCI	.	1	.	.	.	.	1	8	.	.	10
FORREST CITY MED FCI	.	.	.	.	1	3	.	20	.	.	24
FORT DIX FCI	.	2	.	.	.	2	1	4	.	.	9
FORT WORTH ADMINISTRATIVE FMC	.	.	.	.	1	4	.	19	.	.	24

GILMER FCI	.	.	.	.	4	2	.	4	.	.	10
GREENVILLE FCI	.	.	.	.	2	.	.	7	.	.	9
GUAYNABO MDC	.	.	.	.	1	.	.	12	.	.	13
HAZELTON FCI	.	.	.	.	2	10	.	24	.	.	36
HAZELTON USP	.	6	.	.	.	.	.	18	.	.	24
HERLONG FCI	.	3	.	.	2	.	.	21	.	.	26
HONOLULU FDC	.	.	.	.	.	.	.	1	.	.	1
HOUSTON FDC	.	.	.	.	3	7	.	6	.	.	16
JESUP FCI	.	2	.	.	1	3	.	4	.	.	10
LA TUNA FCI	.	2	.	.	3	3	.	7	.	.	15
LEAVENWORTH FCI	.	1	.	.	.	.	.	42	.	.	43
LEE USP	.	13	.	.	1	.	.	41	.	.	55
LEWISBURG FCI	.	.	.	.	3	.	.	9	.	.	12
LEXINGTON FMC	.	.	.	.	2	.	.	6	.	.	8
LOMPOC FCI	.	.	.	.	.	.	.	4	.	.	4
LOMPOC II FCI	.	2	.	.	2	.	.	19	.	.	23
LORETTO FCI	.	.	.	.	1	.	.	3	.	.	4
LOS ANGELES MDC	.	2	.	.	1	.	.	18	.	.	21
MANCHESTER FCI	.	.	.	.	5	.	1	9	.	.	15
MARION FCI	.	.	.	.	1	1	.	16	.	.	18
MCCREARY USP	.	.	.	.	.	1	.	51	.	.	52
MCDOWELL FCI	.	.	.	.	1	.	.	6	.	.	7
MCKEAN FCI	.	.	.	.	1	.	.	5	.	.	6
MEMPHIS FCI	.	2	.	.	.	.	.	17	.	.	19
MENDOTA FCI	.	.	.	.	1	.	.	7	.	.	8
MIAMI FCI	.	5	.	.	.	.	.	1	.	.	6
MIAMI FDC	.	1	.	.	.	.	.	19	.	.	20
MILAN FCI	.	.	.	.	2	.	.	9	.	.	11
MORGANTOWN FPC	.	.	.	.	.	.	.	1	.	.	1
NEW YORK MCC	.	.	.	.	2	.	.	29	.	.	31
OAKDALE I FCI	.	.	.	.	.	.	.	4	.	.	4
OAKDALE II FCI	.	.	.	.	.	.	.	2	.	.	2
OKLAHOMA CITY FTC	.	1	.	.	.	1	.	10	.	.	12
OTISVILLE FCI	.	1	.	.	5	4	.	15	.	.	25
OXFORD FCI	.	3	.	.	1	2	.	22	.	.	28
PEKIN FCI	.	.	.	.	.	.	.	8	.	.	8
PENSACOLA FPC	.	.	.	.	.	.	.	1	.	.	1
PETERSBURG FCI	.	4	.	.	.	.	.	1	.	.	5
PETERSBURG MED FCI	.	.	.	.	2	1	.	12	.	.	15
PHILADELPHIA FDC	.	.	.	.	2	3	.	27	.	.	32
PHOENIX FCI	.	.	.	.	.	5	.	7	.	.	12
POLLOCK MED FCI	1	.	.	.	1	1	.	30	.	.	33
POLLOCK USP	2	1	.	.	1	.	.	20	.	.	24
RAY BROOK FCI	.	1	.	.	2	1	.	5	.	.	9
ROCHESTER FMC	.	.	.	.	3	.	.	3	.	.	6
SAFFORD FCI	.	.	.	.	1	.	.	3	.	.	4
SAN DIEGO MCC	.	1	.	.	.	.	.	4	.	.	5
SANDSTONE FCI	.	.	.	.	.	.	.	6	.	.	6
SCHUYLKILL FCI	.	.	.	.	4	.	.	16	.	.	20
SEAGOVILLE FCI	.	.	.	.	1	.	1	13	.	.	15
SEATAC FDC	.	1	.	.	.	4	.	14	.	.	19
SHERIDAN FCI	.	4	.	.	6	.	.	17	.	.	27
SPRINGFIELD USMCFP	.	.	.	.	2	.	.	9	.	.	11
TALLADEGA FCI	.	.	.	.	5	.	.	5	.	.	10

TALLAHASSEE FCI	.	1	.	.	2	2	.	12	.	.	17
TERMINAL ISLAND FCI	.	.	.	.	.	.	.	1	.	.	1
TERRE HAUTE FCI	1	2	.	.	4	.	.	12	.	.	19
TERRE HAUTE USP	1	3	.	.	4	2	.	30	.	.	40
TEXARKANA FCI	.	.	.	.	.	.	.	3	.	.	3
THOMSON FCI	2	3	.	.	3	20	.	72	.	.	100
THREE RIVERS FCI	.	20	.	.	.	.	.	18	.	.	38
TUCSON FCI	.	1	.	.	1	.	.	1	.	.	3
TUCSON USP	.	.	.	.	10	4	.	23	.	.	37
VICTORVILLE MED I FCI	.	3	.	.	.	.	.	14	.	.	17
VICTORVILLE MED II FCI	.	8	.	.	.	2	.	27	.	.	37
VICTORVILLE USP	.	11	.	.	4	.	.	53	.	.	68
WASECA FCI	.	.	.	.	1	6	.	15	.	.	22
WILLIAMSBURG FCI	.	1	.	.	1	.	.	5	.	.	7
YANKTON FPC	.	1	.	.	.	.	.	5	.	.	6
YAZOO CITY LOW FCI	.	.	.	.	.	.	.	4	.	.	4
YAZOO CITY LOW II FCI	.	1	.	.	.	.	.	17	.	.	18
YAZOO CITY MED FCI	.	.	.	.	1	.	.	6	.	.	7

Year=2021

Facility	100	101	107	114	203	205	206	224	225	229	Total
ALDERSON FPC	.	.	.	.	.	.	.	1	.	.	1
ALICEVILLE FCI	.	.	.	.	1	2	.	16	.	.	19
ALLENWOOD LOW FCI	.	.	.	.	.	2	.	11	.	.	13
ALLENWOOD MED FCI	1	1	.	.	1	.	.	13	.	.	16
ALLENWOOD USP	.	3	.	.	1	.	.	22	.	.	26
ASHLAND FCI	.	.	.	.	.	.	.	2	.	.	2
ATLANTA FCI	.	.	.	.	1	.	.	10	.	.	11
ATWATER USP	.	2	.	.	.	.	.	61	.	.	63
BASTROP FCI	.	.	.	.	4	.	.	8	.	.	12
BEAUMONT LOW FCI	.	.	.	.	2	1	.	8	.	.	11
BEAUMONT MED FCI	.	4	.	.	1	.	.	45	.	.	50
BEAUMONT USP	.	9	.	.	.	1	1	53	.	.	64
BECKLEY FCI	.	2	.	.	1	.	.	56	.	.	59
BENNETTSVILLE FCI	.	1	.	.	1	.	.	6	.	.	8
BERLIN FCI	.	.	.	.	1	.	.	11	.	.	12
BIG SANDY USP	.	3	.	.	.	.	.	100	.	.	103
BIG SPRING FCI	5	.	.	.	1	.	.	4	.	.	10
BROOKLYN MDC	.	.	.	.	2	.	.	13	.	.	15
BRYAN FPC	.	1	.	.	.	.	.	3	.	.	4
BUTNER FMC	.	.	.	.	1	.	.	1	.	.	2
BUTNER LOW FCI	.	.	.	.	.	.	.	3	.	.	3
BUTNER MED I FCI	.	.	.	.	2	3	.	11	.	.	16
BUTNER MED II FCI	.	.	.	.	.	3	.	12	.	.	15
CANAAN USP	1	4	.	.	.	.	.	109	.	.	114
CARSWELL FMC	.	.	.	.	1	7	.	23	.	.	31
CHICAGO MCC	.	.	.	.	3	1	.	1	.	.	5
COLEMAN I USP	1	11	.	.	5	.	.	62	.	.	79
COLEMAN II USP	1	2	.	.	4	2	.	31	.	.	40
COLEMAN LOW FCI	.	.	.	.	1	.	.	13	.	.	14
COLEMAN MED FCI	1	.	.	.	2	1	.	15	.	.	19
CUMBERLAND FCI	.	1	.	.	.	.	.	5	.	.	6
DANBURY FCI	.	.	.	.	.	.	1	9	.	.	10

DEVENS FMC	.	.	.	.	2	.	2	10	.	.	14
DUBLIN FCI	.	.	.	.	1	3	.	2	.	.	6
DULUTH FPC	.	.	.	.	.	.	.	2	.	.	2
EDGEFIELD FCI	.	.	.	.	1	2	.	9	.	.	12
EL RENO FCI	1	1	.	.	.	.	.	15	.	.	17
ELKTON FCI	.	.	.	.	.	.	.	11	.	.	11
ENGLEWOOD FCI	.	.	.	.	.	4	.	4	.	.	8
FAIRTON FCI	.	.	.	.	3	1	.	16	.	.	20
FLORENCE ADMAX USP	.	.	.	.	.	.	.	3	.	.	3
FLORENCE FCI	.	2	.	.	.	.	.	42	.	.	44
FLORENCE HIGH USP	3	13	.	.	.	2	.	68	.	.	86
FORREST CITY FCI	.	.	.	.	.	.	.	4	.	.	4
FORREST CITY MED FCI	1	3	.	.	2	.	.	42	.	.	48
FORT DIX FCI	.	2	.	.	1	.	.	5	.	.	8
FORT WORTH ADMINISTRATIVE FMC	.	.	.	.	2	.	1	4	.	.	7
GILMER FCI	.	.	.	.	5	2	.	10	.	.	17
GREENVILLE FCI	.	.	.	.	3	3	.	10	.	.	16
GUAYNABO MDC	.	.	.	.	2	.	.	10	.	.	12
HAZELTON FCI	.	3	.	.	2	4	.	38	.	.	47
HAZELTON USP	.	4	.	.	.	.	.	61	.	.	65
HERLONG FCI	.	3	.	.	2	.	.	14	.	.	19
HONOLULU FDC	.	.	.	.	.	.	.	1	.	.	1
HOUSTON FDC	.	.	.	.	3	.	.	3	.	.	6
JESUP FCI	.	2	.	.	2	2	.	12	.	.	18
LA TUNA FCI	.	1	.	.	.	.	.	6	.	.	7
LEAVENWORTH FCI	.	.	.	.	2	.	.	61	.	.	63
LEE USP	1	8	.	.	.	.	.	77	.	.	86
LEWISBURG FCI	.	1	.	.	3	.	.	1	.	.	5
LEXINGTON FMC	.	.	.	.	.	.	1	6	.	.	7
LOMPOC FCI	.	1	.	.	.	.	.	4	.	.	5
LOMPOC II FCI	.	2	.	.	2	2	.	27	.	.	33
LORETTO FCI	.	.	.	.	.	2	.	6	.	.	8
LOS ANGELES MDC	.	.	.	.	3	.	.	8	.	.	11
MANCHESTER FCI	.	1	.	.	.	.	.	10	.	.	11
MARIANNA FCI	.	2	.	.	4	2	.	4	.	.	12
MARION FCI	.	.	.	.	2	3	.	7	.	.	12
MCCREARY USP	2	1	.	.	2	.	.	70	.	.	75
MCDOWELL FCI	.	.	.	.	.	.	.	13	.	.	13
MCKEAN FCI	.	.	.	.	4	.	.	11	.	.	15
MEMPHIS FCI	.	1	.	.	2	1	.	18	.	.	22
MENDOTA FCI	.	1	.	.	1	.	1	10	.	.	13
MIAMI FCI	.	.	.	.	.	.	.	1	.	.	1
MIAMI FDC	.	.	.	.	3	.	.	29	.	.	32
MILAN FCI	.	1	.	.	.	.	1	7	.	.	9
MONTGOMERY FPC	.	.	.	.	2	.	.	.	.	.	2
MORGANTOWN FPC	.	.	.	.	.	.	.	1	.	.	1
NEW YORK MCC	.	.	.	.	.	.	.	17	.	.	17
OAKDALE I FCI	.	.	.	.	.	.	.	4	.	.	4
OAKDALE II FCI	.	.	.	.	1	.	.	3	.	.	4
OKLAHOMA CITY FTC	.	.	.	.	.	5	.	13	.	.	18
OTISVILLE FCI	.	.	.	.	1	2	.	11	.	.	14
OXFORD FCI	.	1	.	.	1	3	.	14	.	.	19
PEKIN FCI	.	.	.	.	1	2	1	17	.	.	21
PENSACOLA FPC	.	.	.	.	.	.	.	1	.	.	1

PETERSBURG FCI	.	.	.	.	.	.	.	2	.	.	2
PETERSBURG MED FCI	.	.	.	.	1	1	.	11	.	.	13
PHILADELPHIA FDC	.	5	.	.	3	.	.	11	.	.	19
PHOENIX FCI	.	4	.	.	1	.	.	15	.	.	20
POLLOCK MED FCI	.	.	.	.	.	.	.	23	.	.	23
POLLOCK USP	.	6	.	.	2	3	.	57	.	.	68
RAY BROOK FCI	.	4	.	.	1	.	.	8	.	.	13
ROCHESTER FMC	.	.	.	.	1	.	.	4	.	.	5
SAFFORD FCI	.	.	.	.	1	.	.	3	.	.	4
SAN DIEGO MCC	.	.	.	.	1	.	.	8	.	.	9
SANDSTONE FCI	.	.	.	.	.	3	.	2	.	1	6
SCHUYLKILL FCI	.	1	.	.	.	.	.	9	.	.	10
SEAGOVILLE FCI	.	1	.	.	1	1	.	17	.	.	20
SEATAC FDC	.	.	.	.	6	1	.	10	.	.	17
SHERIDAN FCI	.	.	.	.	1	.	1	13	.	.	15
SPRINGFIELD USMCFP	.	1	.	.	.	2	.	9	.	.	12
TALLADEGA FCI	.	.	.	.	1	1	.	4	.	.	6
TALLAHASSEE FCI	.	.	.	.	2	2	.	9	.	.	13
TERMINAL ISLAND FCI	.	.	.	.	.	.	1	5	.	.	6
TERRE HAUTE FCI	.	1	.	.	2	.	.	24	.	.	27
TERRE HAUTE USP	2	2	.	.	9	.	.	41	.	.	54
TEXARKANA FCI	.	1	.	.	.	.	.	1	.	.	2
THOMSON FCI	1	7	.	.	5	2	.	67	.	.	82
THREE RIVERS FCI	.	.	.	.	1	8	.	42	.	.	51
TUCSON FCI	.	.	.	.	.	.	.	5	.	.	5
TUCSON USP	.	2	.	.	8	4	1	26	.	.	41
VICTORVILLE MED I FCI	.	.	.	.	.	.	.	40	.	.	40
VICTORVILLE MED II FCI	1	3	.	.	.	.	.	17	.	.	21
VICTORVILLE USP	.	.	.	.	7	.	.	55	.	.	62
WASECA FCI	.	.	.	.	1	.	.	25	.	.	26
WILLIAMSBURG FCI	.	.	.	.	8	.	.	17	.	.	25
YAZOO CITY LOW FCI	.	.	.	.	1	.	.	3	.	.	4
YAZOO CITY LOW II FCI	.	.	.	.	.	.	.	13	.	.	13
YAZOO CITY MED FCI	.	.	.	.	1	2	.	3	.	.	6

Year=2022

Facility	100	101	107	114	203	205	206	224	225	229	Total
ALDERSON FPC	.	.	.	.	.	2	.	1	.	.	3
ALICEVILLE FCI	.	.	.	.	2	6	.	22	.	.	30
ALLENWOOD LOW FCI	.	.	.	.	1	.	.	6	.	.	7
ALLENWOOD MED FCI	.	1	.	.	4	.	.	10	.	.	15
ALLENWOOD USP	.	1	.	.	2	.	.	25	.	.	28
ATLANTA FCI	.	.	.	.	1	1	1	3	.	.	6
ATWATER USP	.	16	.	.	.	.	.	83	.	.	99
BASTROP FCI	.	1	.	.	.	1	.	12	.	.	14
BEAUMONT LOW FCI	.	.	.	.	1	2	.	8	.	.	11
BEAUMONT MED FCI	.	2	.	.	.	2	.	47	.	.	51
BEAUMONT USP	1	7	.	.	2	.	.	111	.	.	121
BECKLEY FCI	1	.	.	.	2	.	1	35	.	.	39
BENNETTSVILLE FCI	.	.	.	.	1	.	.	30	.	.	31
BERLIN FCI	.	18	.	.	1	.	.	19	.	.	38
BIG SANDY USP	2	13	.	.	1	.	.	121	.	.	137
BIG SPRING FCI	.	.	.	.	.	.	.	4	.	.	4

BROOKLYN MDC	.	11	.	.	1	.	.	31	.	.	43
BRYAN FPC	.	.	.	.	1	.	.	1	.	.	2
BUTNER FMC	.	.	.	.	1	.	.	6	.	.	7
BUTNER LOW FCI	.	.	.	.	.	.	.	4	.	.	4
BUTNER MED I FCI	.	.	.	.	8	4	.	11	.	.	23
BUTNER MED II FCI	.	.	.	.	.	.	.	29	.	.	29
CANAAN USP	.	5	.	.	1	.	.	110	.	.	116
CARSWELL FMC	.	.	.	1	2	4	.	14	.	.	21
CHICAGO MCC	.	.	.	.	2	.	.	8	.	.	10
COLEMAN I USP	.	9	.	.	3	.	.	74	.	.	86
COLEMAN II USP	.	2	.	.	4	.	.	38	.	1	45
COLEMAN LOW FCI	.	.	.	.	1	.	.	10	.	.	11
COLEMAN MED FCI	.	.	.	.	4	.	.	17	.	.	21
CUMBERLAND FCI	.	.	.	.	.	.	.	16	.	.	16
DANBURY FCI	.	.	.	.	3	1	2	9	.	.	15
DEVENS FMC	.	1	.	.	5	1	.	19	.	1	27
DUBLIN FCI	.	.	.	.	3	.	.	8	.	.	11
DULUTH FPC	.	.	.	.	.	.	.	1	.	.	1
EDGEFIELD FCI	.	1	.	.	1	.	.	38	.	.	40
EL RENO FCI	.	.	.	.	1	.	.	22	.	.	23
ELKTON FCI	.	.	.	.	2	.	.	10	.	1	13
ENGLEWOOD FCI	.	.	.	.	.	.	.	9	.	.	9
ESTILL FCI	.	.	.	.	.	.	.	1	.	.	1
FAIRTON FCI	.	1	.	.	6	.	.	18	.	.	25
FLORENCE ADMAX USP	.	.	.	.	.	.	.	1	.	.	1
FLORENCE FCI	.	2	.	.	.	.	.	71	.	.	73
FLORENCE HIGH USP	1	2	.	.	2	.	.	79	.	.	84
FORREST CITY FCI	.	.	.	.	.	.	.	3	.	.	3
FORREST CITY MED FCI	.	.	.	.	3	.	.	49	.	.	52
FORT DIX FCI	.	1	.	.	.	2	.	7	.	.	10
FORT WORTH ADMINISTRATIVE FMC	.	.	.	.	1	.	1	14	.	.	16
GREENVILLE FCI	.	.	.	.	1	.	2	14	.	1	18
GUAYNABO MDC	.	.	.	1	.	.	.	16	.	.	17
HAZELTON FCI	.	3	.	.	1	.	.	49	.	.	53
HAZELTON USP	.	6	.	.	.	.	.	53	.	.	59
HERLONG FCI	.	.	.	.	1	2	.	48	.	.	51
HONOLULU FDC	.	5	.	.	1	.	.	3	.	.	9
HOUSTON FDC	.	.	.	.	2	.	.	10	.	.	12
JESUP FCI	.	1	.	.	.	.	.	14	.	.	15
LA TUNA FCI	.	.	.	.	.	.	.	4	.	.	4
LEAVENWORTH FCI	.	2	.	.	.	3	.	15	.	.	20
LEE USP	.	9	.	.	1	.	.	96	.	.	106
LEWISBURG FCI	.	1	.	.	2	1	.	18	.	.	22
LEXINGTON FMC	.	.	.	.	1	2	.	12	.	.	15
LOMPOC FCI	.	.	.	.	1	.	.	1	.	.	2
LOMPOC II FCI	.	.	.	.	2	.	.	76	.	.	78
LORETTO FCI	.	.	.	.	1	.	.	3	.	.	4
LOS ANGELES MDC	.	6	.	.	4	.	.	15	.	.	25
MANCHESTER FCI	.	.	.	.	2	.	.	10	.	.	12
MARIANNA FCI	.	3	.	.	3	4	.	19	.	.	29
MARION FCI	.	.	.	.	1	4	.	12	.	1	18
MCCREARY USP	.	.	.	.	.	.	.	148	.	.	148
MCDOWELL FCI	.	.	.	.	.	.	.	10	.	.	10
MCKEAN FCI	.	.	.	.	7	.	.	16	.	.	23

MEMPHIS FCI	.	2	.	.	8	.	.	13	.	.	23
MENDOTA FCI	.	.	.	.	1	.	.	14	.	.	15
MIAMI FCI	.	.	.	.	2	.	.	6	.	.	8
MIAMI FDC	.	.	.	.	1	.	.	27	.	.	28
MILAN FCI	.	.	.	.	1	2	.	10	.	.	13
MORGANTOWN FPC	.	.	.	.	.	.	.	1	.	.	1
OAKDALE I FCI	.	.	.	.	1	.	.	5	.	.	6
OAKDALE II FCI	.	.	.	.	1	.	.	9	.	.	10
OKLAHOMA CITY FTC	.	.	.	.	2	1	.	17	.	.	20
OTISVILLE FCI	.	.	.	.	2	.	.	9	.	.	11
OXFORD FCI	.	4	.	.	2	.	.	23	.	.	29
PEKIN FCI	.	1	.	.	.	2	1	10	.	.	14
PETERSBURG FCI	.	.	.	.	.	.	.	1	.	.	1
PETERSBURG MED FCI	.	.	.	.	.	3	.	10	.	.	13
PHILADELPHIA FDC	.	.	.	.	.	.	.	15	.	.	15
PHOENIX FCI	.	.	.	.	1	1	.	7	.	.	9
POLLOCK MED FCI	.	.	.	.	.	.	.	50	.	.	50
POLLOCK USP	3	7	.	.	.	.	.	24	.	.	34
RAY BROOK FCI	.	2	.	.	1	3	.	21	.	.	27
ROCHESTER FMC	.	.	.	.	1	2	.	3	.	.	6
SAFFORD FCI	.	.	.	.	1	.	.	18	.	.	19
SAN DIEGO MCC	.	.	.	.	2	.	.	8	.	.	10
SANDSTONE FCI	.	.	.	.	1	.	.	9	.	.	10
SCHUYLKILL FCI	.	.	.	.	1	.	.	7	.	.	8
SEAGOVILLE FCI	.	.	.	.	.	.	.	30	.	.	30
SEATAC FDC	.	.	.	.	3	6	.	14	.	1	24
SHERIDAN FCI	.	1	.	.	1	.	.	9	.	.	11
SPRINGFIELD USMCFP	.	.	.	.	2	.	.	9	.	.	11
TALLADEGA FCI	.	.	.	.	3	.	.	5	.	.	8
TALLAHASSEE FCI	.	.	.	.	3	6	.	4	.	.	13
TERMINAL ISLAND FCI	.	.	.	.	2	.	.	7	.	.	9
TERRE HAUTE FCI	.	.	.	.	3	.	.	49	.	.	52
TERRE HAUTE USP	1	5	.	.	5	4	.	33	.	.	48
TEXARKANA FCI	.	.	.	.	.	.	.	5	.	.	5
THOMSON FCI	.	1	.	.	1	2	.	46	.	.	50
THREE RIVERS FCI	.	2	.	.	1	2	.	71	.	.	76
TUCSON FCI	.	.	.	.	2	.	.	1	.	.	3
TUCSON USP	3	1	.	.	13	4	1	47	.	.	69
VICTORVILLE MED I FCI	.	.	.	.	.	.	.	29	.	.	29
VICTORVILLE MED II FCI	.	2	.	.	.	.	.	17	.	1	20
VICTORVILLE USP	.	2	.	.	2	2	.	60	.	.	66
WASECA FCI	.	.	.	.	2	5	.	18	.	.	25
WILLIAMSBURG FCI	.	1	.	.	.	1	.	20	.	.	22
YANKTON FPC	.	.	.	.	.	.	.	1	.	.	1
YAZOO CITY LOW FCI	.	.	.	.	3	.	.	6	.	.	9
YAZOO CITY LOW II FCI	.	2	.	.	.	.	.	10	.	.	12
YAZOO CITY MED FCI	.	.	.	.	.	1	.	13	.	.	14

Year=2023

Facility	100	101	107	114	203	205	206	224	225	229	Total
ALDERSON FPC	.	.	.	.	.	.	.	2	.	.	2
ALICEVILLE FCI	.	.	.	.	2	4	.	24	.	.	30
ALLENWOOD LOW FCI	.	.	.	.	.	.	.	4	.	.	4

ALLENWOOD MED FCI	.	1	.	.	5	.	.	36	.	.	42
ALLENWOOD USP	.	2	.	.	3	.	.	10	.	.	15
ASHLAND FCI	.	.	.	.	2	.	.	5	.	.	7
ATLANTA FCI	.	.	.	.	1	2	.	14	.	.	17
ATWATER USP	.	21	.	.	.	.	.	109	.	.	130
BASTROP FCI	.	.	.	.	.	.	.	12	.	.	12
BEAUMONT LOW FCI	.	.	.	.	.	.	.	9	.	.	9
BEAUMONT MED FCI	.	.	.	.	.	2	.	107	.	.	109
BEAUMONT USP	.	8	.	.	1	.	.	176	.	.	185
BECKLEY FCI	2	3	.	.	.	.	.	43	.	.	48
BENNETTSVILLE FCI	.	.	.	.	.	.	.	26	.	.	26
BERLIN FCI	.	5	.	.	.	.	.	11	.	.	16
BIG SANDY USP	.	8	.	.	.	.	.	135	.	.	143
BIG SPRING FCI	.	1	.	.	2	2	.	2	.	.	7
BROOKLYN MDC	.	21	.	.	1	.	.	44	.	.	66
BRYAN FPC	.	.	.	.	2	.	.	.	.	.	2
BUTNER FMC	.	.	.	.	.	.	.	4	.	.	4
BUTNER LOW FCI	.	.	.	1	.	.	.	3	.	.	4
BUTNER MED I FCI	.	.	.	.	2	4	1	13	.	.	20
BUTNER MED II FCI	.	2	.	.	1	.	.	21	.	.	24
CANAAN USP	.	4	.	.	3	.	.	116	.	.	123
CARSWELL FMC	.	.	.	.	.	.	.	14	.	.	14
CHICAGO MCC	.	.	.	.	1	.	.	9	.	.	10
COLEMAN I USP	4	1	.	.	3	.	.	90	.	.	98
COLEMAN II USP	.	4	.	.	4	2	.	44	.	.	54
COLEMAN LOW FCI	.	1	.	.	.	.	.	11	.	.	12
COLEMAN MED FCI	.	.	.	.	2	.	.	21	.	.	23
CUMBERLAND FCI	.	.	.	.	.	2	.	13	.	.	15
DANBURY FCI	.	.	.	.	1	3	.	18	.	.	22
DEVENS FMC	.	1	.	.	8	3	.	12	.	.	24
DUBLIN FCI	.	.	.	.	.	5	.	4	.	.	9
EDGEFIELD FCI	.	3	.	.	.	4	.	36	.	.	43
EL RENO FCI	.	.	.	.	.	.	.	21	.	.	21
ELKTON FCI	.	1	.	.	.	3	.	15	.	.	19
ENGLEWOOD FCI	.	1	.	.	2	.	.	6	.	.	9
FAIRTON FCI	.	1	.	.	3	.	.	11	.	.	15
FLORENCE FCI	.	3	.	.	.	1	.	71	.	.	75
FLORENCE HIGH USP	.	4	.	.	.	.	.	115	.	.	119
FORREST CITY FCI	.	.	.	.	.	.	.	7	.	.	7
FORREST CITY MED FCI	.	.	.	.	2	.	.	70	.	.	72
FORT DIX FCI	.	2	.	.	.	.	.	7	1	.	10
FORT WORTH ADMINISTRATIVE FMC	.	.	.	.	2	6	.	10	.	.	18
GILMER FCI	.	.	.	.	3	.	.	22	.	.	25
GREENVILLE FCI	.	3	.	.	1	.	.	14	.	.	18
GUAYNABO MDC	.	2	.	.	.	.	.	16	.	.	18
HAZELTON FCI	.	6	.	.	1	.	.	47	.	1	55
HAZELTON USP	.	10	.	.	.	.	.	68	.	.	78
HERLONG FCI	.	3	.	.	2	1	.	82	.	.	88
HONOLULU FDC	.	.	.	.	.	.	.	6	.	.	6
HOUSTON FDC	.	.	.	.	.	5	.	19	.	.	24
JESUP FCI	.	.	.	.	.	.	.	24	.	.	24
LA TUNA FCI	.	.	.	.	.	2	.	7	.	.	9
LEAVENWORTH FCI	.	2	.	.	1	.	.	37	.	.	40
LEE USP	.	23	.	.	1	.	.	132	.	.	156

LEWISBURG FCI	.	5	.	.	.	.	1	14	.	.	20
LEXINGTON FMC	.	.	.	.	2	.	.	5	.	.	7
LOMPOC FCI	.	.	.	.	2	.	.	1	.	.	3
LOMPOC II FCI	.	.	.	.	3	.	.	20	.	.	23
LORETTO FCI	.	1	.	.	2	2	.	4	.	.	9
LOS ANGELES MDC	.	.	.	.	.	.	.	19	.	1	20
MANCHESTER FCI	.	.	.	.	.	.	.	18	.	.	18
MARIANNA FCI	.	.	1	.	4	.	.	11	.	.	16
MARION FCI	.	.	.	.	.	1	.	16	.	.	17
MCCREARY USP	1	.	.	.	.	.	.	108	.	.	109
MCDOWELL FCI	.	4	.	.	1	.	.	18	.	.	23
MCKEAN FCI	.	1	.	.	2	1	.	31	.	.	35
MEMPHIS FCI	.	.	.	.	2	.	.	12	.	.	14
MENDOTA FCI	.	1	.	.	.	.	.	15	.	.	16
MIAMI FCI	.	.	.	.	2	.	.	3	.	.	5
MIAMI FDC	.	.	.	.	3	.	.	14	.	.	17
MILAN FCI	.	.	.	.	1	1	.	7	.	.	9
MORGANTOWN FPC	.	.	.	.	1	.	.	1	.	.	2
OAKDALE I FCI	.	.	.	.	.	2	.	5	.	.	7
OAKDALE II FCI	.	.	.	.	.	2	.	4	.	.	6
OKLAHOMA CITY FTC	.	2	.	.	3	5	.	19	.	.	29
OTISVILLE FCI	.	.	.	.	.	2	.	20	.	.	22
OXFORD FCI	.	.	.	.	2	1	.	34	.	.	37
PEKIN FCI	.	.	.	.	1	3	.	28	.	.	32
PETERSBURG MED FCI	.	.	.	.	.	2	.	9	.	.	11
PHILADELPHIA FDC	.	.	.	.	4	.	.	26	.	.	30
PHOENIX FCI	.	1	.	.	1	1	.	28	.	.	31
POLLOCK MED FCI	.	.	.	.	1	.	.	55	.	.	56
POLLOCK USP	.	3	.	.	.	.	.	36	.	.	39
RAY BROOK FCI	.	.	.	.	3	2	.	34	.	.	39
ROCHESTER FMC	.	6	.	.	.	2	.	8	.	.	16
SAFFORD FCI	.	.	.	.	1	.	.	3	.	.	4
SAN DIEGO MCC	.	.	.	.	.	.	.	26	.	.	26
SANDSTONE FCI	.	22	.	.	2	.	.	7	.	.	31
SCHUYLKILL FCI	.	1	.	.	4	.	.	16	.	.	21
SEAGOVILLE FCI	.	1	.	.	1	.	.	9	.	.	11
SEATAC FDC	.	.	.	.	2	2	.	13	.	.	17
SHERIDAN FCI	.	.	.	.	.	1	.	19	.	.	20
SPRINGFIELD USMCFP	.	2	.	.	1	2	.	25	.	.	30
TALLADEGA FCI	.	.	.	.	.	4	.	17	.	.	21
TALLAHASSEE FCI	.	.	.	.	2	9	.	7	.	.	18
TERMINAL ISLAND FCI	.	.	.	.	1	.	.	2	.	.	3
TERRE HAUTE FCI	.	7	.	.	3	.	.	31	.	.	41
TERRE HAUTE USP	1	8	.	.	3	2	.	52	.	.	66
TEXARKANA FCI	.	.	.	.	.	2	.	3	.	.	5
THOMSON FCI	.	.	.	.	7	.	.	13	.	.	20
THREE RIVERS FCI	.	2	.	.	.	2	.	84	.	.	88
TUCSON FCI	.	.	.	.	2	.	.	7	.	.	9
TUCSON USP	1	2	.	.	18	3	.	34	.	.	58
VICTORVILLE MED I FCI	.	2	.	.	1	.	.	60	.	.	63
VICTORVILLE MED II FCI	.	.	.	.	2	.	.	41	.	.	43
VICTORVILLE USP	.	6	.	.	1	.	.	77	.	.	84
WASECA FCI	.	.	.	.	5	4	.	16	.	.	25
WILLIAMSBURG FCI	.	.	.	.	.	2	1	12	.	.	15

YANKTON FPC	.	.	.	.	.	.	.	5	.	.	5
YAZOO CITY LOW FCI	.	.	.	.	.	.	.	10	.	.	10
YAZOO CITY LOW II FCI	.	.	.	.	.	2	.	15	.	.	17
YAZOO CITY MED FCI	.	2	.	.	.	.	.	45	.	.	47

Year=2024

Facility	100	101	107	114	203	205	206	224	225	229	Total
ALDERSON FPC	.	.	.	.	.	.	.	2	.	.	2
ALICEVILLE FCI	.	.	.	.	2	.	.	21	.	1	24
ALLENWOOD LOW FCI	.	.	.	.	.	.	.	9	.	.	9
ALLENWOOD MED FCI	.	1	.	.	1	.	.	29	.	.	31
ALLENWOOD USP	.	.	.	.	.	1	.	9	.	.	10
ASHLAND FCI	.	.	.	.	1	2	.	4	.	.	7
ATLANTA FCI	.	.	.	.	1	.	.	3	.	.	4
ATWATER USP	.	12	.	.	2	.	.	96	.	.	110
BASTROP FCI	.	.	.	.	1	.	.	7	.	.	8
BEAUMONT LOW FCI	.	.	.	.	.	.	.	10	.	.	10
BEAUMONT MED FCI	.	3	.	1	9	4	.	74	.	.	91
BEAUMONT USP	1	15	.	.	1	.	.	154	.	.	171
BECKLEY FCI	.	2	.	.	4	.	.	45	.	.	51
BENNETTSVILLE FCI	.	1	.	.	.	1	.	34	.	.	36
BERLIN FCI	.	4	.	.	1	.	.	26	.	.	31
BIG SANDY USP	1	2	.	.	.	2	.	177	.	.	182
BIG SPRING FCI	.	.	.	.	.	.	.	4	.	.	4
BROOKLYN MDC	.	14	.	.	2	.	.	36	.	.	52
BRYAN FPC	.	.	.	.	2	.	.	1	.	.	3
BUTNER FMC	.	.	.	.	3	2	.	6	.	1	12
BUTNER LOW FCI	.	.	.	.	.	.	.	1	.	.	1
BUTNER MED I FCI	.	.	.	.	.	6	.	8	.	.	14
BUTNER MED II FCI	.	.	.	.	.	.	.	22	.	.	22
CANAAN USP	.	4	.	.	3	.	.	117	.	.	124
CARSWELL FMC	.	.	.	.	6	4	.	24	.	.	34
CHICAGO MCC	.	.	.	.	.	.	.	11	.	.	11
COLEMAN I USP	.	7	.	.	3	2	.	50	.	.	62
COLEMAN II USP	.	1	.	.	5	4	.	57	.	.	67
COLEMAN LOW FCI	.	2	.	.	.	.	.	13	.	.	15
COLEMAN MED FCI	.	.	.	.	2	.	.	29	.	.	31
CUMBERLAND FCI	.	.	.	.	1	.	.	10	.	.	11
DANBURY FCI	.	1	.	.	1	.	.	21	.	.	23
DEVENS FMC	.	.	.	.	7	.	1	10	.	.	18
DULUTH FPC	.	.	.	.	.	.	.	3	.	.	3
EDGEFIELD FCI	.	.	.	.	.	2	.	20	.	.	22
EL RENO FCI	.	2	.	.	.	.	.	38	.	.	40
ELKTON FCI	.	.	.	.	.	.	.	7	.	.	7
ENGLEWOOD FCI	.	.	.	.	4	1	.	26	.	.	31
FAIRTON FCI	.	.	.	.	.	.	1	14	.	.	15
FLORENCE FCI	.	.	.	.	1	.	.	90	.	.	91
FLORENCE HIGH USP	.	8	.	.	1	1	.	86	.	.	96
FORREST CITY FCI	.	.	.	.	.	.	.	4	.	.	4
FORREST CITY MED FCI	.	3	.	.	.	.	.	24	.	.	27
FORT DIX FCI	.	4	.	.	4	.	1	16	.	.	25
FORT WORTH ADMINISTRATIVE FMC	.	.	.	.	.	3	.	4	.	.	7
GILMER FCI	.	.	.	.	.	.	.	18	.	.	18

GREENVILLE FCI	.	4	.	.	2	.	.	23	.	.	29
GUAYNABO MDC	.	1	.	.	1	.	.	43	.	.	45
HAZELTON FCI	.	8	.	.	1	2	1	57	.	.	69
HAZELTON USP	.	6	.	.	1	.	.	75	.	.	82
HERLONG FCI	.	2	.	.	2	2	.	71	.	.	77
HONOLULU FDC	.	.	.	.	.	.	.	9	.	.	9
HOUSTON FDC	.	1	.	1	2	4	.	27	.	.	35
JESUP FCI	.	.	.	.	2	3	.	23	.	.	28
LA TUNA FCI	.	.	.	.	.	.	.	14	.	.	14
LEAVENWORTH FCI	.	.	.	.	2	.	.	50	.	.	52
LEE USP	.	4	.	.	5	2	.	132	.	.	143
LEWISBURG FCI	.	.	.	.	6	.	.	10	.	.	16
LEXINGTON FMC	.	.	.	.	.	.	.	5	.	.	5
LOMPOC FCI	.	2	.	.	.	.	.	8	.	.	10
LOMPOC II FCI	.	3	.	.	1	3	.	21	.	.	28
LORETTO FCI	.	.	.	.	2	.	.	5	.	.	7
LOS ANGELES MDC	.	.	.	.	1	.	.	19	.	.	20
MANCHESTER FCI	.	.	.	.	2	.	.	17	.	.	19
MARIANNA FCI	.	1	.	.	9	.	.	27	.	.	37
MARION FCI	.	.	.	.	1	4	.	20	.	.	25
MCCREARY USP	.	.	.	.	.	.	.	118	.	.	118
MCDOWELL FCI	.	4	.	.	2	.	.	30	.	.	36
MCKEAN FCI	.	1	.	.	1	.	.	18	.	.	20
MEMPHIS FCI	.	.	.	.	.	.	.	5	.	.	5
MENDOTA FCI	.	2	.	.	8	1	.	23	.	.	34
MIAMI FCI	.	.	.	.	.	.	.	4	.	.	4
MIAMI FDC	.	3	.	.	.	.	.	9	.	.	12
MILAN FCI	.	.	.	.	3	4	1	8	.	1	17
MONTGOMERY FPC	.	.	.	.	2	.	.	.	.	.	2
MORGANTOWN FPC	.	.	.	.	.	.	.	2	.	.	2
OAKDALE I FCI	.	.	.	.	.	.	.	13	.	.	13
OAKDALE II FCI	.	.	.	.	.	.	.	4	.	.	4
OKLAHOMA CITY FTC	.	.	.	.	2	.	.	20	.	.	22
OTISVILLE FCI	.	1	.	.	.	.	.	26	.	.	27
OXFORD FCI	.	1	.	.	.	.	1	12	.	.	14
PEKIN FCI	.	5	.	1	.	.	.	15	.	.	21
PETERSBURG FCI	.	.	.	.	.	.	.	1	.	.	1
PETERSBURG MED FCI	.	.	.	1	.	2	.	17	.	.	20
PHILADELPHIA FDC	.	.	1	.	1	.	.	11	.	.	13
PHOENIX FCI	.	.	.	.	.	.	.	47	.	.	47
POLLOCK MED FCI	.	.	.	.	.	.	.	50	.	.	50
POLLOCK USP	.	2	.	.	.	.	.	46	.	.	48
RAY BROOK FCI	.	7	.	.	1	.	.	31	.	.	39
ROCHESTER FMC	.	1	.	.	2	1	.	8	.	.	12
SAFFORD FCI	.	.	.	.	1	.	.	9	.	.	10
SAN DIEGO MCC	.	.	.	.	1	.	.	20	.	.	21
SANDSTONE FCI	.	3	.	.	3	.	.	13	.	.	19
SCHUYLKILL FCI	.	4	.	.	2	.	.	43	.	.	49
SEAGOVILLE FCI	.	.	.	.	1	10	.	9	.	.	20
SEATAC FDC	.	.	.	.	1	1	.	16	.	.	18
SHERIDAN FCI	.	2	.	.	3	.	.	44	.	.	49
SPRINGFIELD USMCFP	.	2	.	.	3	.	.	15	.	1	21
TALLADEGA FCI	.	2	.	.	2	1	.	22	.	.	27
TALLAHASSEE FCI	.	.	.	.	1	7	.	3	.	.	11

TERMINAL ISLAND FCI	.	4	.	.	.	.	.	3	.	.	7
TERRE HAUTE FCI	.	3	.	.	.	.	.	32	.	.	35
TERRE HAUTE USP	1	5	.	.	5	.	.	76	.	.	87
TEXARKANA FCI	.	.	.	.	.	.	.	2	.	.	2
THOMSON FCI	.	.	.	.	.	.	.	13	.	.	13
THREE RIVERS FCI	.	1	.	.	.	.	.	69	.	.	70
TUCSON FCI	.	.	.	.	1	.	.	2	.	.	3
TUCSON USP	.	3	.	.	9	1	.	21	.	.	34
VICTORVILLE MED I FCI	.	1	.	.	7	.	.	49	.	.	57
VICTORVILLE MED II FCI	.	.	.	.	2	.	.	78	.	.	80
VICTORVILLE USP	.	7	.	.	1	2	.	97	.	.	107
WASECA FCI	.	.	.	.	3	2	.	17	.	.	22
WILLIAMSBURG FCI	.	.	.	.	.	.	.	22	.	.	22
YAZOO CITY LOW FCI	.	1	.	.	.	.	.	8	.	.	9
YAZOO CITY LOW II FCI	.	.	.	.	.	.	.	3	.	.	3
YAZOO CITY MED FCI	.	3	.	.	1	.	.	20	.	.	24

Guilty Findings for Assaults on Inmates

Rate per 1,000

BOP Typical Facilities

Facility	2020	2021	2022	2023	2024	Total
ALDERSON FPC	4.39	1.63	4.82	2.91	2.75	16.50
ALICEVILLE FCI	11.06	14.87	19.58	18.08	15.07	78.66
ALLENWOOD LOW FCI	2.70	14.38	6.94	3.80	8.85	36.67
ALLENWOOD MED FCI	20.28	14.01	12.11	32.68	24.88	103.96
ALLENWOOD USP	39.43	44.37	43.08	40.76	39.68	207.32
ASHLAND FCI	.90	1.89	.	5.32	5.32	13.43
ATLANTA FCI	10.14	7.43	6.30	10.14	2.23	36.24
ATWATER USP	41.24	63.44	93.31	107.53	92.75	398.27
BASTROP FCI	3.12	10.74	12.93	10.50	7.29	44.58
BEAUMONT LOW FCI	4.11	5.89	5.43	4.37	4.83	24.63
BEAUMONT MED FCI	6.08	33.90	32.50	65.50	57.16	195.14
BEAUMONT USP	49.95	48.30	84.14	142.97	139.25	464.61
BECKLEY FCI	23.87	37.99	23.97	28.50	30.48	144.81
BENNETTSVILLE FCI	8.98	5.41	19.28	15.85	22.24	71.76
BERLIN FCI	19.43	16.09	48.28	21.95	35.31	141.06
BIG SANDY USP	30.14	81.36	101.26	98.15	140.32	451.23
BIG SPRING FCI	2.69	10.01	3.54	6.10	4.51	26.85
BROOKLYN MDC	17.02	10.55	26.25	43.59	39.69	137.10
BRYAN FPC	5.63	7.98	3.87	3.13	4.55	25.16
BUTNER FMC	9.08	2.74	8.47	4.79	14.32	39.40
BUTNER LOW FCI	1.80	4.50	4.67	4.26	1.05	16.28
BUTNER MED I FCI	20.41	22.22	31.12	24.63	17.31	115.69
BUTNER MED II FCI	12.39	11.01	20.54	16.16	14.70	74.80
CANAAN USP	70.55	92.68	91.55	94.91	96.12	445.81
CARSWELL FMC	15.16	22.51	17.83	13.20	30.71	99.41
CHICAGO MCC	21.74	8.85	17.39	18.66	20.83	87.47
COLEMAN I USP	30.85	61.96	64.04	69.11	46.23	272.19
COLEMAN II USP	44.70	43.81	40.25	44.44	60.04	233.24
COLEMAN LOW FCI	7.94	7.30	5.55	5.81	7.38	33.98
COLEMAN MED FCI	11.79	13.55	13.30	14.84	20.31	73.79
CUMBERLAND FCI	15.54	5.16	13.00	15.27	10.77	59.74
DANBURY FCI	13.99	10.95	14.65	22.40	20.03	82.02
DEVENS FMC	19.72	18.16	28.97	25.95	18.15	110.95
DUBLIN FCI	4.91	7.57	15.99	15.49	.	43.96
DULUTH FPC	2.67	6.73	3.47	.	4.95	17.82
EDGEFIELD FCI	6.47	7.26	21.25	21.91	11.20	68.09
EL RENO FCI	18.88	17.02	19.66	16.98	33.81	106.35
ELKTON FCI	9.93	7.62	7.37	9.51	3.66	38.09
ENGLEWOOD FCI	4.93	8.32	8.72	8.93	32.67	63.57
ESTILL FCI	17.54	.	14.08	.	.	31.62
FAIRTON FCI	34.58	22.70	29.52	18.27	18.82	123.89
FLORENCE ADMAX USP	10.87	8.70	2.95	.	.	22.52
FLORENCE FCI	33.86	34.84	54.89	58.64	66.86	249.09
FLORENCE HIGH USP	84.12	119.44	119.15	135.69	116.50	574.90
FORREST CITY FCI	5.25	2.67	1.78	3.94	2.21	15.85
FORREST CITY MED FCI	21.82	34.99	32.75	43.24	16.54	149.34
FORT DIX FCI	3.13	2.74	3.05	2.63	6.27	17.82
FORT WORTH ADMINISTRATIVE FMC	17.23	5.36	10.58	11.44	4.64	49.25
GILMER FCI	7.06	11.14	.	15.11	12.91	46.22

GREENVILLE FCI	7.02	13.38	14.46	14.53	22.27	71.66
GUAYNABO MDC	11.45	9.51	12.84	14.94	40.61	89.35
HAZELTON FCI	21.06	24.92	25.21	26.44	33.74	131.37
HAZELTON USP	17.99	46.36	38.76	47.10	58.36	208.57
HERLONG FCI	26.26	15.74	34.88	58.28	55.64	190.80
HONOLULU FDC	2.72	3.29	26.95	19.67	38.46	91.09
HOUSTON FDC	28.12	9.48	16.76	30.65	43.53	128.54
JESUP FCI	6.96	13.02	9.94	14.99	16.83	61.74
LA TUNA FCI	19.11	7.44	4.55	10.74	19.55	61.39
LEAVENWORTH FCI	26.20	40.36	12.64	22.35	30.21	131.76
LEE USP	40.71	67.40	75.55	101.63	104.15	389.44
LEWISBURG FCI	12.13	6.36	21.26	19.70	14.80	74.25
LEXINGTON FMC	6.04	6.08	11.88	5.43	3.90	33.33
LOMPOC FCI	3.67	6.17	2.04	3.18	11.79	26.85
LOMPOC II FCI	16.45	26.00	37.32	12.63	13.08	105.48
LORETTO FCI	4.44	9.96	4.52	10.59	8.51	38.02
LOS ANGELES MDC	37.30	19.30	35.46	31.20	30.53	153.79
MANCHESTER FCI	14.52	10.70	11.15	16.59	17.50	70.46
MARIANNA FCI	.	15.00	24.68	13.09	30.30	83.07
MARION FCI	14.16	9.30	13.19	13.12	19.73	69.50
MCCREARY USP	35.99	51.37	94.99	66.38	79.14	327.87
MCDOWELL FCI	6.16	9.08	6.57	15.05	22.89	59.75
MCKEAN FCI	7.27	15.45	21.58	31.82	17.87	93.99
MEMPHIS FCI	16.24	19.86	18.64	12.10	4.50	71.34
MENDOTA FCI	9.07	11.67	10.60	12.52	37.61	81.47
MIAMI FCI	5.70	1.10	8.29	5.11	3.93	24.13
MIAMI FDC	19.31	27.30	22.80	16.22	11.96	97.59
MILAN FCI	8.18	6.78	8.66	5.75	10.83	40.20
MONTGOMERY FPC	.	6.13	.	.	2.84	8.97
MORGANTOWN FPC	1.80	2.40	2.26	3.94	5.10	15.50
NEW YORK MCC	46.27	51.36	.	.	.	97.63
OAKDALE I FCI	4.21	4.58	6.73	8.10	14.08	37.70
OAKDALE II FCI	2.34	4.18	8.87	5.07	3.48	23.94
OKLAHOMA CITY FTC	9.57	14.26	17.33	22.85	16.12	80.13
OTISVILLE FCI	39.94	24.26	19.71	20.74	27.86	132.51
OXFORD FCI	29.63	19.69	26.34	32.66	12.64	120.96
PEKIN FCI	6.71	17.92	11.24	24.52	16.42	76.81
PENSACOLA FPC	2.41	3.03	.	.	.	5.44
PETERSBURG FCI	5.25	2.99	1.32	.	1.63	11.19
PETERSBURG MED FCI	9.95	8.67	8.00	6.53	12.35	45.50
PHILADELPHIA FDC	32.45	22.75	17.20	31.19	14.44	118.03
PHOENIX FCI	10.75	18.42	7.46	25.49	40.31	102.43
POLLOCK MED FCI	23.97	15.85	31.55	35.53	30.73	137.63
POLLOCK USP	19.54	54.23	26.92	30.07	46.11	176.87
RAY BROOK FCI	14.59	16.99	30.30	52.07	52.14	166.09
ROCHESTER FMC	9.13	7.99	10.45	26.85	16.64	71.06
SAFFORD FCI	5.06	5.04	25.07	5.49	15.13	55.79
SAN DIEGO MCC	6.94	11.24	12.17	35.81	29.70	95.86
SANDSTONE FCI	5.70	7.02	9.03	27.43	16.30	65.48
SCHUYLKILL FCI	18.37	9.26	7.25	18.55	43.44	96.87
SEAGOVILLE FCI	8.12	11.87	17.39	6.07	11.72	55.17
SEATAC FDC	29.46	25.00	28.85	21.38	25.28	129.97
SHERIDAN FCI	16.70	9.89	7.26	12.53	31.74	78.12
SPRINGFIELD USMCFP	12.14	13.94	10.93	30.21	20.04	87.26

TALLADEGA FCI	10.87	6.37	7.87	19.63	23.30	68.04
TALLAHASSEE FCI	20.00	15.72	16.03	20.32	10.05	82.12
TERMINAL ISLAND FCI	1.05	8.30	9.83	3.08	7.38	29.64
TERRE HAUTE FCI	15.91	22.59	38.07	28.31	25.74	130.62
TERRE HAUTE USP	30.65	45.84	39.57	54.41	69.43	239.90
TEXARKANA FCI	2.68	1.86	4.16	3.97	1.54	14.21
THOMSON FCI	87.95	69.02	54.53	20.41	6.62	238.53
THREE RIVERS FCI	33.72	45.37	59.84	65.57	56.41	260.91
TUCSON FCI	9.17	22.94	11.32	26.32	7.92	77.67
TUCSON USP	25.80	30.21	49.22	40.31	28.15	173.69
VICTORVILLE MED I FCI	14.85	30.89	17.43	36.80	35.29	135.26
VICTORVILLE MED II FCI	30.43	17.37	16.95	33.52	53.66	151.93
VICTORVILLE USP	55.42	57.73	66.53	74.01	88.80	342.49
WASECA FCI	34.54	36.88	33.20	32.98	26.51	164.11
WILLIAMSBURG FCI	5.39	16.77	14.26	10.42	16.99	63.83
YANKTON FPC	15.11	.	3.39	12.59	.	31.09
YAZOO CITY LOW FCI	2.27	2.82	6.08	7.06	6.39	24.62
YAZOO CITY LOW II FCI	13.41	9.21	8.98	11.24	2.22	45.06
YAZOO CITY MED FCI	8.76	6.81	12.67	30.44	16.68	75.36

Prohibited act codes 100, 101, 107, 114, 203, 205, 206, 224, 225, 229

Guilty Findings for Assaults on Inmates by Prohibited Act Code

**Rate per 1,000
BOP Typical Facilities**

Year=2020

Facility	100	101	107	114	203	205	206	224	225	229	Total
ALDERSON FPC	.	.	.	.	.	1.46	.	2.92	.	.	4.39
ALICEVILLE FCI	.	.	.	.	.74	.	.	10.32	.	.	11.06
ALLENWOOD LOW FCI	.	.	.	.	.	.	.	2.70	.	.	2.70
ALLENWOOD MED FCI	.	.	.	.	.	1.76	.	18.52	.	.	20.28
ALLENWOOD USP	.	4.73	.	.	.	1.58	.	33.12	.	.	39.43
ASHLAND FCI	.	.	.	.	.90	.	.	.	.	.	.90
ATLANTA FCI	.	.	.	.	.53	.	.	9.61	.	.	10.14
ATWATER USP	.	6.56	.	.	2.81	.	.	31.87	.	.	41.24
BASTROP FCI	.	.	.	.	.	.	.78	2.34	.	.	3.12
BEAUMONT LOW FCI	.	.	.	.	.	.	.	4.11	.	.	4.11
BEAUMONT MED FCI	.	.	.	.	.68	1.35	.	4.05	.	.	6.08
BEAUMONT USP	.	1.82	.	.	.	.	.	48.14	.	.	49.95
BECKLEY FCI	.	.65	.	.	2.58	.	.	20.65	.	.	23.87
BENNETTSVILLE FCI	.	.	.	.	2.25	.	.	6.74	.	.	8.98
BERLIN FCI	.	.	.	.	1.49	.	.	17.94	.	.	19.43
BIG SANDY USP	.	1.55	.	.	1.55	.	.	27.05	.	.	30.14
BIG SPRING FCI	.	.	.	.	.90	.	.	1.79	.	.	2.69
BROOKLYN MDC	.	.	.	.	1.31	.	.	15.71	.	.	17.02
BRYAN FPC	.	.	.	.	.	.	.	5.63	.	.	5.63
BUTNER FMC	.	.	.	.	1.14	3.41	.	4.54	.	.	9.08
BUTNER LOW FCI	.	.	.	.	.	.90	.	.90	.	.	1.80
BUTNER MED I FCI	.	1.20	.	.	.	7.20	.	12.00	.	.	20.41
BUTNER MED II FCI	.	.	.	.	.69	5.51	.	6.19	.	.	12.39
CANAAN USP	.	1.64	.	.	.	.	.	68.91	.	.	70.55
CARSWELL FMC	.	.	.	.	1.38	.	.	13.78	.	.	15.16
CHICAGO MCC	.	5.02	.	.	1.67	.	.	15.05	.	.	21.74
COLEMAN I USP	.	.91	.	.	6.35	.	.	23.59	.	.	30.85
COLEMAN II USP	.	.97	.	.	12.63	4.86	.	26.24	.	.	44.70
COLEMAN LOW FCI	.	.47	.	.	.	1.87	.	5.60	.	.	7.94
COLEMAN MED FCI	.	.	.	.	.69	.	.	11.10	.	.	11.79
CUMBERLAND FCI	.	3.45	.	.	.	1.73	.	10.36	.	.	15.54
DANBURY FCI	.	.	.	.	.	.	.	13.99	.	.	13.99
DEVENS FMC	.	.	.	.	4.38	2.19	2.19	10.95	.	.	19.72
DUBLIN FCI	.	.	.	.	.	.	.	4.91	.	.	4.91
DULUTH FPC	.	.	.	.	.	.	.	2.67	.	.	2.67
EDGEFIELD FCI	.	.65	.	.	.	.	.	5.83	.	.	6.47
EL RENO FCI	.	2.70	.	.	.	.	.	16.19	.	.	18.88
ELKTON FCI	.	.	.	.	.47	.	.	9.46	.	.	9.93
ENGLEWOOD FCI	.	.	.	.	.	.	.	4.93	.	.	4.93
ESTILL FCI	.	.	.	.	2.19	4.39	.	10.96	.	.	17.54
FAIRTON FCI	.	.	.	.	7.91	.	.	26.68	.	.	34.58
FLORENCE ADMAX USP	2.72	5.43	.	.	.	.	.	2.72	.	.	10.87
FLORENCE FCI	.	.	.	.	.79	.	.	33.07	.	.	33.86
FLORENCE HIGH USP	.	6.78	.	.	.	.	.	77.34	.	.	84.12
FORREST CITY FCI	.	.52	.	.	.	.	.52	4.20	.	.	5.25
FORREST CITY MED FCI	.	.	.	.	.91	2.73	.	18.18	.	.	21.82
FORT DIX FCI	.	.70	.	.	.	.70	.35	1.39	.	.	3.13

FORT WORTH ADMINISTRATIVE FMC	.	.	.	.	.72	2.87	.	13.64	.	.	17.23
GILMER FCI	.	.	.	.	2.82	1.41	.	2.82	.	.	7.06
GREENVILLE FCI	.	.	.	.	1.56	.	.	5.46	.	.	7.02
GUAYNABO MDC	.	.	.	.	.88	.	.	10.57	.	.	11.45
HAZELTON FCI	.	.	.	.	1.17	5.85	.	14.04	.	.	21.06
HAZELTON USP	.	4.50	.	.	.	.	.	13.49	.	.	17.99
HERLONG FCI	.	3.03	.	.	2.02	.	.	21.21	.	.	26.26
HONOLULU FDC	.	.	.	.	.	.	.	2.72	.	.	2.72
HOUSTON FDC	.	.	.	.	5.27	12.30	.	10.54	.	.	28.12
JESUP FCI	.	1.39	.	.	.70	2.09	.	2.78	.	.	6.96
LA TUNA FCI	.	2.55	.	.	3.82	3.82	.	8.92	.	.	19.11
LEAVENWORTH FCI	.	.61	.	.	.	.	.	25.59	.	.	26.20
LEE USP	.	9.62	.	.	.74	.	.	30.35	.	.	40.71
LEWISBURG FCI	.	.	.	.	3.03	.	.	9.10	.	.	12.13
LEXINGTON FMC	.	.	.	.	1.51	.	.	4.53	.	.	6.04
LOMPOC FCI	.	.	.	.	.	.	.	3.67	.	.	3.67
LOMPOC II FCI	.	1.43	.	.	1.43	.	.	13.59	.	.	16.45
LORETTO FCI	.	.	.	.	1.11	.	.	3.33	.	.	4.44
LOS ANGELES MDC	.	3.55	.	.	1.78	.	.	31.97	.	.	37.30
MANCHESTER FCI	.	.	.	.	4.84	.	.97	8.71	.	.	14.52
MARION FCI	.	.	.	.	.79	.79	.	12.59	.	.	14.16
MCCREARY USP	.	.	.	.	.	.69	.	35.29	.	.	35.99
MCDOWELL FCI	.	.	.	.	.88	.	.	5.28	.	.	6.16
MCKEAN FCI	.	.	.	.	1.21	.	.	6.06	.	.	7.27
MEMPHIS FCI	.	1.71	.	.	.	.	.	14.53	.	.	16.24
MENDOTA FCI	.	.	.	.	1.13	.	.	7.94	.	.	9.07
MIAMI FCI	.	4.75	.	.	.	.	.	.95	.	.	5.70
MIAMI FDC	.	.97	.	.	.	.	.	18.34	.	.	19.31
MILAN FCI	.	.	.	.	1.49	.	.	6.70	.	.	8.18
MORGANTOWN FPC	.	.	.	.	.	.	.	1.80	.	.	1.80
NEW YORK MCC	.	.	.	.	2.99	.	.	43.28	.	.	46.27
OAKDALE I FCI	.	.	.	.	.	.	.	4.21	.	.	4.21
OAKDALE II FCI	.	.	.	.	.	.	.	2.34	.	.	2.34
OKLAHOMA CITY FTC	.	.80	.	.	.	.80	.	7.97	.	.	9.57
OTISVILLE FCI	.	1.60	.	.	7.99	6.39	.	23.96	.	.	39.94
OXFORD FCI	.	3.17	.	.	1.06	2.12	.	23.28	.	.	29.63
PEKIN FCI	.	.	.	.	.	.	.	6.71	.	.	6.71
PENSACOLA FPC	.	.	.	.	.	.	.	2.41	.	.	2.41
PETERSBURG FCI	.	4.20	.	.	.	.	.	1.05	.	.	5.25
PETERSBURG MED FCI	.	.	.	.	1.33	.66	.	7.96	.	.	9.95
PHILADELPHIA FDC	.	.	.	.	2.03	3.04	.	27.38	.	.	32.45
PHOENIX FCI	.	.	.	.	.	4.48	.	6.27	.	.	10.75
POLLOCK MED FCI	.73	.	.	.	.73	.73	.	21.79	.	.	23.97
POLLOCK USP	1.63	.81	.	.	.81	.	.	16.29	.	.	19.54
RAY BROOK FCI	.	1.62	.	.	3.24	1.62	.	8.10	.	.	14.59
ROCHESTER FMC	.	.	.	.	4.57	.	.	4.57	.	.	9.13
SAFFORD FCI	.	.	.	.	1.26	.	.	3.79	.	.	5.06
SAN DIEGO MCC	.	1.39	.	.	.	.	.	5.56	.	.	6.94
SANDSTONE FCI	.	.	.	.	.	.	.	5.70	.	.	5.70
SCHUYLKILL FCI	.	.	.	.	3.67	.	.	14.69	.	.	18.37
SEAGOVILLE FCI	.	.	.	.	.54	.	.54	7.03	.	.	8.12
SEATAC FDC	.	1.55	.	.	.	6.20	.	21.71	.	.	29.46
SHERIDAN FCI	.	2.47	.	.	3.71	.	.	10.51	.	.	16.70
SPRINGFIELD USMCFP	.	.	.	.	2.21	.	.	9.93	.	.	12.14

TALLADEGA FCI	.	.	.	.	5.43	.	.	5.43	.	.	10.87
TALLAHASSEE FCI	.	1.18	.	.	2.35	2.35	.	14.12	.	.	20.00
TERMINAL ISLAND FCI	.	.	.	.	.	.	.	1.05	.	.	1.05
TERRE HAUTE FCI	.84	1.68	.	.	3.35	.	.	10.05	.	.	15.91
TERRE HAUTE USP	.77	2.30	.	.	3.07	1.53	.	22.99	.	.	30.65
TEXARKANA FCI	.	.	.	.	.	.	.	2.68	.	.	2.68
THOMSON FCI	1.76	2.64	.	.	2.64	17.59	.	63.32	.	.	87.95
THREE RIVERS FCI	.	17.75	.	.	.	.	.	15.97	.	.	33.72
TUCSON FCI	.	3.06	.	.	3.06	.	.	3.06	.	.	9.17
TUCSON USP	.	.	.	.	6.97	2.79	.	16.04	.	.	25.80
VICTORVILLE MED I FCI	.	2.62	.	.	.	.	.	12.23	.	.	14.85
VICTORVILLE MED II FCI	.	6.58	.	.	.	1.64	.	22.20	.	.	30.43
VICTORVILLE USP	.	8.96	.	.	3.26	.	.	43.19	.	.	55.42
WASECA FCI	.	.	.	.	1.57	9.42	.	23.55	.	.	34.54
WILLIAMSBURG FCI	.	.77	.	.	.77	.	.	3.85	.	.	5.39
YANKTON FPC	.	2.52	.	.	.	.	.	12.59	.	.	15.11
YAZOO CITY LOW FCI	.	.	.	.	.	.	.	2.27	.	.	2.27
YAZOO CITY LOW II FCI	.	.75	.	.	.	.	.	12.67	.	.	13.41
YAZOO CITY MED FCI	.	.	.	.	1.25	.	.	7.51	.	.	8.76

Year=2021

Facility	100	101	107	114	203	205	206	224	225	229	Total
ALDERSON FPC	.	.	.	.	.	.	.	1.63	.	.	1.63
ALICEVILLE FCI	.	.	.	.	.78	1.56	.	12.52	.	.	14.87
ALLENWOOD LOW FCI	.	.	.	.	.	2.21	.	12.17	.	.	14.38
ALLENWOOD MED FCI	.88	.88	.	.	.88	.	.	11.38	.	.	14.01
ALLENWOOD USP	.	5.12	.	.	1.71	.	.	37.54	.	.	44.37
ASHLAND FCI	.	.	.	.	.	.	.	1.89	.	.	1.89
ATLANTA FCI	.	.	.	.	.68	.	.	6.75	.	.	7.43
ATWATER USP	.	2.01	.	.	.	.	.	61.43	.	.	63.44
BASTROP FCI	.	.	.	.	3.58	.	.	7.16	.	.	10.74
BEAUMONT LOW FCI	.	.	.	.	1.07	.54	.	4.28	.	.	5.89
BEAUMONT MED FCI	.	2.71	.	.	.68	.	.	30.51	.	.	33.90
BEAUMONT USP	.	6.79	.	.	.	.75	.75	40.00	.	.	48.30
BECKLEY FCI	.	1.29	.	.	.64	.	.	36.06	.	.	37.99
BENNETTSVILLE FCI	.	.68	.	.	.68	.	.	4.05	.	.	5.41
BERLIN FCI	.	.	.	.	1.34	.	.	14.75	.	.	16.09
BIG SANDY USP	.	2.37	.	.	.	.	.	78.99	.	.	81.36
BIG SPRING FCI	5.01	.	.	.	1.00	.	.	4.00	.	.	10.01
BROOKLYN MDC	.	.	.	.	1.41	.	.	9.14	.	.	10.55
BRYAN FPC	.	2.00	.	.	.	.	.	5.99	.	.	7.98
BUTNER FMC	.	.	.	.	1.37	.	.	1.37	.	.	2.74
BUTNER LOW FCI	.	.	.	.	.	.	.	4.50	.	.	4.50
BUTNER MED I FCI	.	.	.	.	2.78	4.17	.	15.28	.	.	22.22
BUTNER MED II FCI	.	.	.	.	.	2.20	.	8.80	.	.	11.01
CANAAN USP	.81	3.25	.	.	.	.	.	88.62	.	.	92.68
CARSWELL FMC	.	.	.	.	.73	5.08	.	16.70	.	.	22.51
CHICAGO MCC	.	.	.	.	5.31	1.77	.	1.77	.	.	8.85
COLEMAN I USP	.78	8.63	.	.	3.92	.	.	48.63	.	.	61.96
COLEMAN II USP	1.10	2.19	.	.	4.38	2.19	.	33.95	.	.	43.81
COLEMAN LOW FCI	.	.	.	.	.52	.	.	6.77	.	.	7.30
COLEMAN MED FCI	.71	.	.	.	1.43	.71	.	10.70	.	.	13.55
CUMBERLAND FCI	.	.86	.	.	.	.	.	4.30	.	.	5.16
DANBURY FCI	.	.	.	.	.	.	1.10	9.86	.	.	10.95

DEVENS FMC	.	.	.	.	2.59	.	2.59	12.97	.	.	18.16
DUBLIN FCI	.	.	.	.	1.26	3.78	.	2.52	.	.	7.57
DULUTH FPC	.	.	.	.	.	.	.	6.73	.	.	6.73
EDGEFIELD FCI	.	.	.	.	.60	1.21	.	5.44	.	.	7.26
EL RENO FCI	1.00	1.00	.	.	.	.	.	15.02	.	.	17.02
ELKTON FCI	.	.	.	.	.	.	.	7.62	.	.	7.62
ENGLEWOOD FCI	.	.	.	.	.	4.16	.	4.16	.	.	8.32
FAIRTON FCI	.	.	.	.	3.41	1.14	.	18.16	.	.	22.70
FLORENCE ADMAX USP	.	.	.	.	.	.	.	8.70	.	.	8.70
FLORENCE FCI	.	1.58	.	.	.	.	.	33.25	.	.	34.84
FLORENCE HIGH USP	4.17	18.06	.	.	.	2.78	.	94.44	.	.	119.44
FORREST CITY FCI	.	.	.	.	.	.	.	2.67	.	.	2.67
FORREST CITY MED FCI	.73	2.19	.	.	1.46	.	.	30.61	.	.	34.99
FORT DIX FCI	.	.68	.	.	.34	.	.	1.71	.	.	2.74
FORT WORTH ADMINISTRATIVE FMC	.	.	.	.	1.53	.	.77	3.06	.	.	5.36
GILMER FCI	.	.	.	.	3.28	1.31	.	6.55	.	.	11.14
GREENVILLE FCI	.	.	.	.	2.51	2.51	.	8.36	.	.	13.38
GUAYNABO MDC	.	.	.	.	1.58	.	.	7.92	.	.	9.51
HAZELTON FCI	.	1.59	.	.	1.06	2.12	.	20.15	.	.	24.92
HAZELTON USP	.	2.85	.	.	.	.	.	43.51	.	.	46.36
HERLONG FCI	.	2.49	.	.	1.66	.	.	11.60	.	.	15.74
HONOLULU FDC	.	.	.	.	.	.	.	3.29	.	.	3.29
HOUSTON FDC	.	.	.	.	4.74	.	.	4.74	.	.	9.48
JESUP FCI	.	1.45	.	.	1.45	1.45	.	8.68	.	.	13.02
LA TUNA FCI	.	1.06	.	.	.	.	.	6.38	.	.	7.44
LEAVENWORTH FCI	.	.	.	.	1.28	.	.	39.08	.	.	40.36
LEE USP	.78	6.27	.	.	.	.	.	60.34	.	.	67.40
LEWISBURG FCI	.	1.27	.	.	3.82	.	.	1.27	.	.	6.36
LEXINGTON FMC	.	.	.	.	.	.	.87	5.21	.	.	6.08
LOMPOC FCI	.	1.23	.	.	.	.	.	4.94	.	.	6.17
LOMPOC II FCI	.	1.58	.	.	1.58	1.58	.	21.28	.	.	26.00
LORETTO FCI	.	.	.	.	.	2.49	.	7.47	.	.	9.96
LOS ANGELES MDC	.	.	.	.	5.26	.	.	14.04	.	.	19.30
MANCHESTER FCI	.	.97	.	.	.	.	.	9.73	.	.	10.70
MARIANNA FCI	.	2.50	.	.	5.00	2.50	.	5.00	.	.	15.00
MARION FCI	.	.	.	.	1.55	2.32	.	5.42	.	.	9.30
MCCREARY USP	1.37	.68	.	.	1.37	.	.	47.95	.	.	51.37
MCDOWELL FCI	.	.	.	.	.	.	.	9.08	.	.	9.08
MCKEAN FCI	.	.	.	.	4.12	.	.	11.33	.	.	15.45
MEMPHIS FCI	.	.90	.	.	1.81	.90	.	16.25	.	.	19.86
MENDOTA FCI	.	.90	.	.	.90	.	.90	8.98	.	.	11.67
MIAMI FCI	.	.	.	.	.	.	.	1.10	.	.	1.10
MIAMI FDC	.	.	.	.	2.56	.	.	24.74	.	.	27.30
MILAN FCI	.	.75	.	.	.	.	.75	5.28	.	.	6.78
MONTGOMERY FPC	.	.	.	.	6.13	.	.	.	.	.	6.13
MORGANTOWN FPC	.	.	.	.	.	.	.	2.40	.	.	2.40
NEW YORK MCC	.	.	.	.	.	.	.	51.36	.	.	51.36
OAKDALE I FCI	.	.	.	.	.	.	.	4.58	.	.	4.58
OAKDALE II FCI	.	.	.	.	1.05	.	.	3.14	.	.	4.18
OKLAHOMA CITY FTC	.	.	.	.	.	3.96	.	10.30	.	.	14.26
OTISVILLE FCI	.	.	.	.	1.73	3.47	.	19.06	.	.	24.26
OXFORD FCI	.	1.04	.	.	1.04	3.11	.	14.51	.	.	19.69
PEKIN FCI	.	.	.	.	.85	1.71	.85	14.51	.	.	17.92
PENSACOLA FPC	.	.	.	.	.	.	.	3.03	.	.	3.03

PETERSBURG FCI	.	.	.	.	.	.	.	2.99	.	.	2.99
PETERSBURG MED FCI	.	.	.	.	.67	.67	.	7.34	.	.	8.67
PHILADELPHIA FDC	.	5.99	.	.	3.59	.	.	13.17	.	.	22.75
PHOENIX FCI	.	3.68	.	.	.92	.	.	13.81	.	.	18.42
POLLOCK MED FCI	.	.	.	.	.	.	.	15.85	.	.	15.85
POLLOCK USP	.	4.78	.	.	1.59	2.39	.	45.45	.	.	54.23
RAY BROOK FCI	.	5.23	.	.	1.31	.	.	10.46	.	.	16.99
ROCHESTER FMC	.	.	.	.	1.60	.	.	6.39	.	.	7.99
SAFFORD FCI	.	.	.	.	1.26	.	.	3.78	.	.	5.04
SAN DIEGO MCC	.	.	.	.	1.25	.	.	9.99	.	.	11.24
SANDSTONE FCI	.	.	.	.	.	3.51	.	2.34	.	1.17	7.02
SCHUYLKILL FCI	.	.93	.	.	.	.	.	8.33	.	.	9.26
SEAGOVILLE FCI	.	.59	.	.	.59	.59	.	10.09	.	.	11.87
SEATAC FDC	.	.	.	.	8.82	1.47	.	14.71	.	.	25.00
SHERIDAN FCI	.	.	.	.	.66	.	.66	8.57	.	.	9.89
SPRINGFIELD USMCFP	.	1.16	.	.	.	2.32	.	10.45	.	.	13.94
TALLADEGA FCI	.	.	.	.	1.06	1.06	.	4.25	.	.	6.37
TALLAHASSEE FCI	.	.	.	.	2.42	2.42	.	10.88	.	.	15.72
TERMINAL ISLAND FCI	.	.	.	.	.	.	1.38	6.92	.	.	8.30
TERRE HAUTE FCI	.	.84	.	.	1.67	.	.	20.08	.	.	22.59
TERRE HAUTE USP	1.70	1.70	.	.	7.64	.	.	34.80	.	.	45.84
TEXARKANA FCI	.	.93	.	.	.	.	.	.93	.	.	1.86
THOMSON FCI	.84	5.89	.	.	4.21	1.68	.	56.40	.	.	69.02
THREE RIVERS FCI	.	.	.	.	.89	7.12	.	37.37	.	.	45.37
TUCSON FCI	.	.	.	.	.	.	.	22.94	.	.	22.94
TUCSON USP	.	1.47	.	.	5.90	2.95	.74	19.16	.	.	30.21
VICTORVILLE MED I FCI	.	.	.	.	.	.	.	30.89	.	.	30.89
VICTORVILLE MED II FCI	.83	2.48	.	.	.	.	.	14.06	.	.	17.37
VICTORVILLE USP	.	.	.	.	6.52	.	.	51.21	.	.	57.73
WASECA FCI	.	.	.	.	1.42	.	.	35.46	.	.	36.88
WILLIAMSBURG FCI	.	.	.	.	5.37	.	.	11.40	.	.	16.77
YAZOO CITY LOW FCI	.	.	.	.	.70	.	.	2.11	.	.	2.82
YAZOO CITY LOW II FCI	.	.	.	.	.	.	.	9.21	.	.	9.21
YAZOO CITY MED FCI	.	.	.	.	1.14	2.27	.	3.41	.	.	6.81

Year=2022

Facility	100	101	107	114	203	205	206	224	225	229	Total
ALDERSON FPC	.	.	.	.	.	3.22	.	1.61	.	.	4.82
ALICEVILLE FCI	.	.	.	.	1.31	3.92	.	14.36	.	.	19.58
ALLENWOOD LOW FCI	.	.	.	.	.99	.	.	5.95	.	.	6.94
ALLENWOOD MED FCI	.	.81	.	.	3.23	.	.	8.07	.	.	12.11
ALLENWOOD USP	.	1.54	.	.	3.08	.	.	38.46	.	.	43.08
ATLANTA FCI	.	.	.	.	1.05	1.05	1.05	3.15	.	.	6.30
ATWATER USP	.	15.08	.	.	.	.	.	78.23	.	.	93.31
BASTROP FCI	.	.92	.	.	.	.92	.	11.08	.	.	12.93
BEAUMONT LOW FCI	.	.	.	.	.49	.99	.	3.95	.	.	5.43
BEAUMONT MED FCI	.	1.27	.	.	.	1.27	.	29.96	.	.	32.50
BEAUMONT USP	.70	4.87	.	.	1.39	.	.	77.19	.	.	84.14
BECKLEY FCI	.61	.	.	.	1.23	.	.61	21.51	.	.	23.97
BENNETTSVILLE FCI	.	.	.	.	.62	.	.	18.66	.	.	19.28
BERLIN FCI	.	22.87	.	.	1.27	.	.	24.14	.	.	48.28
BIG SANDY USP	1.48	9.61	.	.	.74	.	.	89.43	.	.	101.26
BIG SPRING FCI	.	.	.	.	.	.	.	3.54	.	.	3.54
BROOKLYN MDC	.	6.72	.	.	.61	.	.	18.93	.	.	26.25

BRYAN FPC	.	.	.	.	1.93	.	.	1.93	.	.	3.87
BUTNER FMC	.	.	.	.	1.21	.	.	7.26	.	.	8.47
BUTNER LOW FCI	.	.	.	.	.	.	.	4.67	.	.	4.67
BUTNER MED I FCI	.	.	.	.	10.83	5.41	.	14.88	.	.	31.12
BUTNER MED II FCI	.	.	.	.	.	.	.	20.54	.	.	20.54
CANAAN USP	.	3.95	.	.	.79	.	.	86.82	.	.	91.55
CARSWELL FMC	.	.	.	.85	1.70	3.40	.	11.88	.	.	17.83
CHICAGO MCC	.	.	.	.	3.48	.	.	13.91	.	.	17.39
COLEMAN I USP	.	6.70	.	.	2.23	.	.	55.10	.	.	64.04
COLEMAN II USP	.	1.79	.	.	3.58	.	.	33.99	.	.89	40.25
COLEMAN LOW FCI	.	.	.	.	.50	.	.	5.04	.	.	5.55
COLEMAN MED FCI	.	.	.	.	2.53	.	.	10.77	.	.	13.30
CUMBERLAND FCI	.	.	.	.	.	.	.	13.00	.	.	13.00
DANBURY FCI	.	.	.	.	2.93	.98	1.95	8.79	.	.	14.65
DEVENS FMC	.	1.07	.	.	5.36	1.07	.	20.39	.	1.07	28.97
DUBLIN FCI	.	.	.	.	4.36	.	.	11.63	.	.	15.99
DULUTH FPC	.	.	.	.	.	.	.	3.47	.	.	3.47
EDGEFIELD FCI	.	.53	.	.	.53	.	.	20.19	.	.	21.25
EL RENO FCI	.	.	.	.	.85	.	.	18.80	.	.	19.66
ELKTON FCI	.	.	.	.	1.13	.	.	5.67	.	.57	7.37
ENGLEWOOD FCI	.	.	.	.	.	.	.	8.72	.	.	8.72
ESTILL FCI	.	.	.	.	.	.	.	14.08	.	.	14.08
FAIRTON FCI	.	1.18	.	.	7.08	.	.	21.25	.	.	29.52
FLORENCE ADMAX USP	.	.	.	.	.	.	.	2.95	.	.	2.95
FLORENCE FCI	.	1.50	.	.	.	.	.	53.38	.	.	54.89
FLORENCE HIGH USP	1.42	2.84	.	.	2.84	.	.	112.06	.	.	119.15
FORREST CITY FCI	.	.	.	.	.	.	.	1.78	.	.	1.78
FORREST CITY MED FCI	.	.	.	.	1.89	.	.	30.86	.	.	32.75
FORT DIX FCI	.	.31	.	.	.	.61	.	2.14	.	.	3.05
FORT WORTH ADMINISTRATIVE FMC	.	.	.	.	.66	.	.66	9.26	.	.	10.58
GREENVILLE FCI	.	.	.	.	.80	.	1.61	11.24	.	.80	14.46
GUAYNABO MDC	.	.	.	.76	.	.	.	12.08	.	.	12.84
HAZELTON FCI	.	1.43	.	.	.48	.	.	23.31	.	.	25.21
HAZELTON USP	.	3.94	.	.	.	.	.	34.82	.	.	38.76
HERLONG FCI	.	.	.	.	.68	1.37	.	32.83	.	.	34.88
HONOLULU FDC	.	14.97	.	.	2.99	.	.	8.98	.	.	26.95
HOUSTON FDC	.	.	.	.	2.79	.	.	13.97	.	.	16.76
JESUP FCI	.	.66	.	.	.	.	.	9.28	.	.	9.94
LA TUNA FCI	.	.	.	.	.	.	.	4.55	.	.	4.55
LEAVENWORTH FCI	.	1.26	.	.	.	1.90	.	9.48	.	.	12.64
LEE USP	.	6.41	.	.	.71	.	.	68.42	.	.	75.55
LEWISBURG FCI	.	.97	.	.	1.93	.97	.	17.39	.	.	21.26
LEXINGTON FMC	.	.	.	.	.79	1.58	.	9.50	.	.	11.88
LOMPOC FCI	.	.	.	.	1.02	.	.	1.02	.	.	2.04
LOMPOC II FCI	.	.	.	.	.96	.	.	36.36	.	.	37.32
LORETTO FCI	.	.	.	.	1.13	.	.	3.39	.	.	4.52
LOS ANGELES MDC	.	8.51	.	.	5.67	.	.	21.28	.	.	35.46
MANCHESTER FCI	.	.	.	.	1.86	.	.	9.29	.	.	11.15
MARIANNA FCI	.	2.55	.	.	2.55	3.40	.	16.17	.	.	24.68
MARION FCI	.	.	.	.	.73	2.93	.	8.79	.	.73	13.19
MCCREARY USP	.	.	.	.	.	.	.	94.99	.	.	94.99
MCDOWELL FCI	.	.	.	.	.	.	.	6.57	.	.	6.57
MCKEAN FCI	.	.	.	.	6.57	.	.	15.01	.	.	21.58
MEMPHIS FCI	.	1.62	.	.	6.48	.	.	10.53	.	.	18.64

MENDOTA FCI	.	.	.	.	.71	.	.	9.89	.	.	10.60
MIAMI FCI	.	.	.	.	2.07	.	.	6.22	.	.	8.29
MIAMI FDC	.	.	.	.	.81	.	.	21.99	.	.	22.80
MILAN FCI	.	.	.	.	.67	1.33	.	6.66	.	.	8.66
MORGANTOWN FPC	.	.	.	.	.	.	.	2.26	.	.	2.26
OAKDALE I FCI	.	.	.	.	1.12	.	.	5.61	.	.	6.73
OAKDALE II FCI	.	.	.	.	.89	.	.	7.98	.	.	8.87
OKLAHOMA CITY FTC	.	.	.	.	1.73	.87	.	14.73	.	.	17.33
OTISVILLE FCI	.	.	.	.	3.58	.	.	16.13	.	.	19.71
OXFORD FCI	.	3.63	.	.	1.82	.	.	20.89	.	.	26.34
PEKIN FCI	.	.80	.	.	.	1.61	.80	8.03	.	.	11.24
PETERSBURG FCI	.	.	.	.	.	.	.	1.32	.	.	1.32
PETERSBURG MED FCI	.	.	.	.	.	1.85	.	6.16	.	.	8.00
PHILADELPHIA FDC	.	.	.	.	.	.	.	17.20	.	.	17.20
PHOENIX FCI	.	.	.	.	.83	.83	.	5.80	.	.	7.46
POLLOCK MED FCI	.	.	.	.	.	.	.	31.55	.	.	31.55
POLLOCK USP	2.38	5.54	.	.	.	.	.	19.00	.	.	26.92
RAY BROOK FCI	.	2.24	.	.	1.12	3.37	.	23.57	.	.	30.30
ROCHESTER FMC	.	.	.	.	1.74	3.48	.	5.23	.	.	10.45
SAFFORD FCI	.	.	.	.	1.32	.	.	23.75	.	.	25.07
SAN DIEGO MCC	.	.	.	.	2.43	.	.	9.73	.	.	12.17
SANDSTONE FCI	.	.	.	.	.90	.	.	8.12	.	.	9.03
SCHUYLKILL FCI	.	.	.	.	.91	.	.	6.34	.	.	7.25
SEAGOVILLE FCI	.	.	.	.	.	.	.	17.39	.	.	17.39
SEATAC FDC	.	.	.	.	3.61	7.21	.	16.83	.	1.20	28.85
SHERIDAN FCI	.	.66	.	.	.66	.	.	5.94	.	.	7.26
SPRINGFIELD USMCFP	.	.	.	.	1.99	.	.	8.95	.	.	10.93
TALLADEGA FCI	.	.	.	.	2.95	.	.	4.92	.	.	7.87
TALLAHASSEE FCI	.	.	.	.	3.70	7.40	.	4.93	.	.	16.03
TERMINAL ISLAND FCI	.	.	.	.	2.18	.	.	7.64	.	.	9.83
TERRE HAUTE FCI	.	.	.	.	2.20	.	.	35.87	.	.	38.07
TERRE HAUTE USP	.82	4.12	.	.	4.12	3.30	.	27.21	.	.	39.57
TEXARKANA FCI	.	.	.	.	.	.	.	4.16	.	.	4.16
THOMSON FCI	.	1.09	.	.	1.09	2.18	.	50.16	.	.	54.53
THREE RIVERS FCI	.	1.57	.	.	.79	1.57	.	55.91	.	.	59.84
TUCSON FCI	.	.	.	.	7.55	.	.	3.77	.	.	11.32
TUCSON USP	2.14	.71	.	.	9.27	2.85	.71	33.52	.	.	49.22
VICTORVILLE MED I FCI	.	.	.	.	.	.	.	17.43	.	.	17.43
VICTORVILLE MED II FCI	.	1.69	.	.	.	.	.	14.41	.	.85	16.95
VICTORVILLE USP	.	2.02	.	.	2.02	2.02	.	60.48	.	.	66.53
WASECA FCI	.	.	.	.	2.66	6.64	.	23.90	.	.	33.20
WILLIAMSBURG FCI	.	.65	.	.	.	.65	.	12.96	.	.	14.26
YANKTON FPC	.	.	.	.	.	.	.	3.39	.	.	3.39
YAZOO CITY LOW FCI	.	.	.	.	2.03	.	.	4.05	.	.	6.08
YAZOO CITY LOW II FCI	.	1.50	.	.	.	.	.	7.49	.	.	8.98
YAZOO CITY MED FCI	.	.	.	.	.	.90	.	11.76	.	.	12.67

Year=2023

Facility	100	101	107	114	203	205	206	224	225	229	Total
ALDERSON FPC	.	.	.	.	.	.	.	2.91	.	.	2.91
ALICEVILLE FCI	.	.	.	.	1.21	2.41	.	14.47	.	.	18.08
ALLENWOOD LOW FCI	.	.	.	.	.	.	.	3.80	.	.	3.80
ALLENWOOD MED FCI	.	.78	.	.	3.89	.	.	28.02	.	.	32.68
ALLENWOOD USP	.	5.43	.	.	8.15	.	.	27.17	.	.	40.76

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ASHLAND FCI	.	.	.	.	1.52	.	.	3.80	.	.	5.32
ATLANTA FCI	.	.	.	.	.60	1.19	.	8.35	.	.	10.14
ATWATER USP	.	17.37	.	.	.	.	.	90.16	.	.	107.53
BASTROP FCI	.	.	.	.	.	.	.	10.50	.	.	10.50
BEAUMONT LOW FCI	.	.	.	.	.	.	.	4.37	.	.	4.37
BEAUMONT MED FCI	.	.	.	.	.	1.20	.	64.30	.	.	65.50
BEAUMONT USP	.	6.18	.	.	.77	.	.	136.01	.	.	142.97
BECKLEY FCI	1.19	1.78	.	.	.	.	.	25.53	.	.	28.50
BENNETTSVILLE FCI	.	.	.	.	.	.	.	15.85	.	.	15.85
BERLIN FCI	.	6.86	.	.	.	.	.	15.09	.	.	21.95
BIG SANDY USP	.	5.49	.	.	.	.	.	92.66	.	.	98.15
BIG SPRING FCI	.	.87	.	.	1.74	1.74	.	1.74	.	.	6.10
BROOKLYN MDC	.	13.87	.	.	.66	.	.	29.06	.	.	43.59
BRYAN FPC	.	.	.	.	3.13	.	.	.	.	.	3.13
BUTNER FMC	.	.	.	.	.	.	.	4.79	.	.	4.79
BUTNER LOW FCI	.	.	.	1.06	.	.	.	3.19	.	.	4.26
BUTNER MED I FCI	.	.	.	.	2.46	4.93	1.23	16.01	.	.	24.63
BUTNER MED II FCI	.	1.35	.	.	.67	.	.	14.14	.	.	16.16
CANAAN USP	.	3.09	.	.	2.31	.	.	89.51	.	.	94.91
CARSWELL FMC	.	.	.	.	.	.	.	13.20	.	.	13.20
CHICAGO MCC	.	.	.	.	1.87	.	.	16.79	.	.	18.66
COLEMAN I USP	2.82	.71	.	.	2.12	.	.	63.47	.	.	69.11
COLEMAN II USP	.	3.29	.	.	3.29	1.65	.	36.21	.	.	44.44
COLEMAN LOW FCI	.	.48	.	.	.	.	.	5.33	.	.	5.81
COLEMAN MED FCI	.	.	.	.	1.29	.	.	13.55	.	.	14.84
CUMBERLAND FCI	.	.	.	.	.	2.04	.	13.24	.	.	15.27
DANBURY FCI	.	.	.	.	1.02	3.05	.	18.33	.	.	22.40
DEVENS FMC	.	1.08	.	.	8.65	3.24	.	12.97	.	.	25.95
DUBLIN FCI	.	.	.	.	.	8.61	.	6.88	.	.	15.49
EDGEFIELD FCI	.	1.53	.	.	.	2.04	.	18.34	.	.	21.91
EL RENO FCI	.	.	.	.	.	.	.	16.98	.	.	16.98
ELKTON FCI	.	.50	.	.	.	1.50	.	7.51	.	.	9.51
ENGLEWOOD FCI	.	.99	.	.	1.98	.	.	5.95	.	.	8.93
FAIRTON FCI	.	1.22	.	.	3.65	.	.	13.40	.	.	18.27
FLORENCE FCI	.	2.35	.	.	.	.78	.	55.51	.	.	58.64
FLORENCE HIGH USP	.	4.56	.	.	.	.	.	131.13	.	.	135.69
FORREST CITY FCI	.	.	.	.	.	.	.	3.94	.	.	3.94
FORREST CITY MED FCI	.	.	.	.	1.20	.	.	42.04	.	.	43.24
FORT DIX FCI	.	.53	.	.	.	.	.	1.84	.26	.	2.63
FORT WORTH ADMINISTRATIVE FMC	.	.	.	.	1.27	3.81	.	6.36	.	.	11.44
GILMER FCI	.	.	.	.	1.81	.	.	13.29	.	.	15.11
GREENVILLE FCI	.	2.42	.	.	.81	.	.	11.30	.	.	14.53
GUAYNABO MDC	.	1.66	.	.	.	.	.	13.28	.	.	14.94
HAZELTON FCI	.	2.88	.	.	.48	.	.	22.60	.	.48	26.44
HAZELTON USP	.	6.04	.	.	.	.	.	41.06	.	.	47.10
HERLONG FCI	.	1.99	.	.	1.32	.66	.	54.30	.	.	58.28
HONOLULU FDC	.	.	.	.	.	.	.	19.67	.	.	19.67
HOUSTON FDC	.	.	.	.	.	6.39	.	24.27	.	.	30.65
JESUP FCI	.	.	.	.	.	.	.	14.99	.	.	14.99
LA TUNA FCI	.	.	.	.	.	2.39	.	8.35	.	.	10.74
LEAVENWORTH FCI	.	1.12	.	.	.56	.	.	20.67	.	.	22.35
LEE USP	.	14.98	.	.	.65	.	.	85.99	.	.	101.63
LEWISBURG FCI	.	4.93	.	.	.	.	.99	13.79	.	.	19.70
LEXINGTON FMC	.	.	.	.	1.55	.	.	3.88	.	.	5.43

LOMPOC FCI	.	.	.	2.12	.	1.06	.	3.18
LOMPOC II FCI	.	.	.	1.65	.	10.98	.	12.63
LORETTO FCI	.	1.18	.	2.35	2.35	4.71	.	10.59
LOS ANGELES MDC	.	.	.	.	.	29.64	1.56	31.20
MANCHESTER FCI	.	.	.	.	.	16.59	.	16.59
MARIANNA FCI	.	.	.82	3.27	.	9.00	.	13.09
MARION FCI	.	.	.	.	.77	12.35	.	13.12
MCCREARY USP	.61	.	.	.	.	65.77	.	66.38
MCDOWELL FCI	.	2.62	.	.65	.	11.78	.	15.05
MCKEAN FCI	.	.91	.	1.82	.91	28.18	.	31.82
MEMPHIS FCI	.	.	.	1.73	.	10.37	.	12.10
MENDOTA FCI	.	.78	.	.	.	11.74	.	12.52
MIAMI FCI	.	.	.	2.04	.	3.07	.	5.11
MIAMI FDC	.	.	.	2.86	.	13.36	.	16.22
MILAN FCI	.	.	.	.64	.64	4.48	.	5.75
MORGANTOWN FPC	.	.	.	1.97	.	1.97	.	3.94
OAKDALE I FCI	.	.	.	.	2.31	5.79	.	8.10
OAKDALE II FCI	.	.	.	.	1.69	3.38	.	5.07
OKLAHOMA CITY FTC	.	1.58	.	2.36	3.94	14.97	.	22.85
OTISVILLE FCI	.	.	.	.	1.89	18.85	.	20.74
OXFORD FCI	.	.	.	1.77	.88	30.01	.	32.66
PEKIN FCI	.	.	.	.77	2.30	21.46	.	24.52
PETERSBURG MED FCI	.	.	.	.	1.19	5.34	.	6.53
PHILADELPHIA FDC	.	.	.	4.16	.	27.03	.	31.19
PHOENIX FCI	.	.82	.	.82	.82	23.03	.	25.49
POLLOCK MED FCI	.	.	.	.63	.	34.90	.	35.53
POLLOCK USP	.	2.31	.	.	.	27.76	.	30.07
RAY BROOK FCI	.	.	.	4.01	2.67	45.39	.	52.07
ROCHESTER FMC	.	10.07	.	.	3.36	13.42	.	26.85
SAFFORD FCI	.	.	.	1.37	.	4.12	.	5.49
SAN DIEGO MCC	.	.	.	.	.	35.81	.	35.81
SANDSTONE FCI	.	19.47	.	1.77	.	6.19	.	27.43
SCHUYLKILL FCI	.	.88	.	3.53	.	14.13	.	18.55
SEAGOVILLE FCI	.	.55	.	.55	.	4.96	.	6.07
SEATAC FDC	.	.	.	2.52	2.52	16.35	.	21.38
SHERIDAN FCI	.	.	.	.	.63	11.90	.	12.53
SPRINGFIELD USMCFP	.	2.01	.	1.01	2.01	25.18	.	30.21
TALLADEGA FCI	.	.	.	.	3.74	15.89	.	19.63
TALLAHASSEE FCI	.	.	.	2.26	10.16	7.90	.	20.32
TERMINAL ISLAND FCI	.	.	.	1.03	.	2.05	.	3.08
TERRE HAUTE FCI	.	4.83	.	2.07	.	21.41	.	28.31
TERRE HAUTE USP	.82	6.60	.	2.47	1.65	42.87	.	54.41
TEXARKANA FCI	.	.	.	.	1.59	2.38	.	3.97
THOMSON FCI	.	.	.	7.14	.	13.27	.	20.41
THREE RIVERS FCI	.	1.49	.	.	1.49	62.59	.	65.57
TUCSON FCI	.	.	.	5.85	.	20.47	.	26.32
TUCSON USP	.69	1.39	.	12.51	2.08	23.63	.	40.31
VICTORVILLE MED I FCI	.	1.17	.	.58	.	35.05	.	36.80
VICTORVILLE MED II FCI	.	.	.	1.56	.	31.96	.	33.52
VICTORVILLE USP	.	5.29	.	.88	.	67.84	.	74.01
WASECA FCI	.	.	.	6.60	5.28	21.11	.	32.98
WILLIAMSBURG FCI	.	.	.	.	1.39	.69	8.33	10.42
YANKTON FPC	.	.	.	.	.	12.59	.	12.59
YAZOO CITY LOW FCI	.	.	.	.	.	7.06	.	7.06

YAZOO CITY LOW II FCI	.	.	.	.	.	1.32	.	9.92	.	.	11.24
YAZOO CITY MED FCI	.	1.30	.	.	.	.	.	29.15	.	.	30.44

Year=2024

Facility	100	101	107	114	203	205	206	224	225	229	Total
ALDERSON FPC	.	.	.	.	.	.	.	2.75	.	.	2.75
ALICEVILLE FCI	.	.	.	.	1.26	.	.	13.18	.	.63	15.07
ALLENWOOD LOW FCI	.	.	.	.	.	.	.	8.85	.	.	8.85
ALLENWOOD MED FCI	.	.80	.	.	.80	.	.	23.27	.	.	24.88
ALLENWOOD USP	.	.	.	.	.	3.97	.	35.71	.	.	39.68
ASHLAND FCI	.	.	.	.	.76	1.52	.	3.04	.	.	5.32
ATLANTA FCI	.	.	.	.	.56	.	.	1.67	.	.	2.23
ATWATER USP	.	10.12	.	.	1.69	.	.	80.94	.	.	92.75
BASTROP FCI	.	.	.	.	.91	.	.	6.38	.	.	7.29
BEAUMONT LOW FCI	.	.	.	.	.	.	.	4.83	.	.	4.83
BEAUMONT MED FCI	.	1.88	.	.63	5.65	2.51	.	46.48	.	.	57.16
BEAUMONT USP	.81	12.21	.	.	.81	.	.	125.41	.	.	139.25
BECKLEY FCI	.	1.20	.	.	2.39	.	.	26.90	.	.	30.48
BENNETTSVILLE FCI	.	.62	.	.	.	.62	.	21.00	.	.	22.24
BERLIN FCI	.	4.56	.	.	1.14	.	.	29.61	.	.	35.31
BIG SANDY USP	.77	1.54	.	.	.	1.54	.	136.47	.	.	140.32
BIG SPRING FCI	.	.	.	.	.	.	.	4.51	.	.	4.51
BROOKLYN MDC	.	10.69	.	.	1.53	.	.	27.48	.	.	39.69
BRYAN FPC	.	.	.	.	3.03	.	.	1.52	.	.	4.55
BUTNER FMC	.	.	.	.	3.58	2.39	.	7.16	.	1.19	14.32
BUTNER LOW FCI	.	.	.	.	.	.	.	1.05	.	.	1.05
BUTNER MED I FCI	.	.	.	.	.	7.42	.	9.89	.	.	17.31
BUTNER MED II FCI	.	.	.	.	.	.	.	14.70	.	.	14.70
CANAAN USP	.	3.10	.	.	2.33	.	.	90.70	.	.	96.12
CARSWELL FMC	.	.	.	.	5.42	3.61	.	21.68	.	.	30.71
CHICAGO MCC	.	.	.	.	.	.	.	20.83	.	.	20.83
COLEMAN I USP	.	5.22	.	.	2.24	1.49	.	37.29	.	.	46.23
COLEMAN II USP	.	.90	.	.	4.48	3.58	.	51.08	.	.	60.04
COLEMAN LOW FCI	.	.98	.	.	.	.	.	6.40	.	.	7.38
COLEMAN MED FCI	.	.	.	.	1.31	.	.	19.00	.	.	20.31
CUMBERLAND FCI	.	.	.	.	.98	.	.	9.79	.	.	10.77
DANBURY FCI	.	.87	.	.	.87	.	.	18.29	.	.	20.03
DEVENS FMC	.	.	.	.	7.06	.	1.01	10.08	.	.	18.15
DULUTH FPC	.	.	.	.	.	.	.	4.95	.	.	4.95
EDGEFIELD FCI	.	.	.	.	.	1.02	.	10.18	.	.	11.20
EL RENO FCI	.	1.69	.	.	.	.	.	32.12	.	.	33.81
ELKTON FCI	.	.	.	.	.	.	.	3.66	.	.	3.66
ENGLEWOOD FCI	.	.	.	.	4.21	1.05	.	27.40	.	.	32.67
FAIRTON FCI	.	.	.	.	.	.	1.25	17.57	.	.	18.82
FLORENCE FCI	.	.	.	.	.73	.	.	66.13	.	.	66.86
FLORENCE HIGH USP	.	9.71	.	.	1.21	1.21	.	104.37	.	.	116.50
FORREST CITY FCI	.	.	.	.	.	.	.	2.21	.	.	2.21
FORREST CITY MED FCI	.	1.84	.	.	.	.	.	14.71	.	.	16.54
FORT DIX FCI	.	1.00	.	.	1.00	.	.25	4.01	.	.	6.27
FORT WORTH ADMINISTRATIVE FMC	.	.	.	.	.	1.99	.	2.65	.	.	4.64
GILMER FCI	.	.	.	.	.	.	.	12.91	.	.	12.91
GREENVILLE FCI	.	3.07	.	.	1.54	.	.	17.67	.	.	22.27
GUAYNABO MDC	.	.90	.	.	.90	.	.	38.81	.	.	40.61
HAZELTON FCI	.	3.91	.	.	.49	.98	.49	27.87	.	.	33.74

HAZELTON USP	.	4.27	.	.	.71	.	.	53.38	.	.	58.36
HERLONG FCI	.	1.45	.	.	1.45	1.45	.	51.30	.	.	55.64
HONOLULU FDC	.	.	.	.	.	.	.	38.46	.	.	38.46
HOUSTON FDC	.	1.24	.	1.24	2.49	4.98	.	33.58	.	.	43.53
JESUP FCI	.	.	.	.	1.20	1.80	.	13.82	.	.	16.83
LA TUNA FCI	.	.	.	.	.	.	.	19.55	.	.	19.55
LEAVENWORTH FCI	.	.	.	.	1.16	.	.	29.05	.	.	30.21
LEE USP	.	2.91	.	.	3.64	1.46	.	96.14	.	.	104.15
LEWISBURG FCI	.	.	.	.	5.55	.	.	9.25	.	.	14.80
LEXINGTON FMC	.	.	.	.	.	.	.	3.90	.	.	3.90
LOMPOC FCI	.	2.36	.	.	.	.	.	9.43	.	.	11.79
LOMPOC II FCI	.	1.40	.	.	.47	1.40	.	9.81	.	.	13.08
LORETTO FCI	.	.	.	.	2.43	.	.	6.08	.	.	8.51
LOS ANGELES MDC	.	.	.	.	1.53	.	.	29.01	.	.	30.53
MANCHESTER FCI	.	.	.	.	1.84	.	.	15.65	.	.	17.50
MARIANNA FCI	.	.82	.	.	7.37	.	.	22.11	.	.	30.30
MARION FCI	.	.	.	.	.79	3.16	.	15.79	.	.	19.73
MCCREARY USP	.	.	.	.	.	.	.	79.14	.	.	79.14
MCDOWELL FCI	.	2.54	.	.	1.27	.	.	19.07	.	.	22.89
MCKEAN FCI	.	.89	.	.	.89	.	.	16.09	.	.	17.87
MEMPHIS FCI	.	.	.	.	.	.	.	4.50	.	.	4.50
MENDOTA FCI	.	2.21	.	.	8.85	1.11	.	25.44	.	.	37.61
MIAMI FCI	.	.	.	.	.	.	.	3.93	.	.	3.93
MIAMI FDC	.	2.99	.	.	.	.	.	8.97	.	.	11.96
MILAN FCI	.	.	.	.	1.91	2.55	.64	5.10	.	.64	10.83
MONTGOMERY FPC	.	.	.	.	2.84	.	.	.	.	.	2.84
MORGANTOWN FPC	.	.	.	.	.	.	.	5.10	.	.	5.10
OAKDALE I FCI	.	.	.	.	.	.	.	14.08	.	.	14.08
OAKDALE II FCI	.	.	.	.	.	.	.	3.48	.	.	3.48
OKLAHOMA CITY FTC	.	.	.	.	1.47	.	.	14.65	.	.	16.12
OTISVILLE FCI	.	1.03	.	.	.	.	.	26.83	.	.	27.86
OXFORD FCI	.	.90	.	.	.	.	.90	10.83	.	.	12.64
PEKIN FCI	.	3.91	.	.78	.	.	.	11.73	.	.	16.42
PETERSBURG FCI	.	.	.	.	.	.	.	1.63	.	.	1.63
PETERSBURG MED FCI	.	.	.	.62	.	1.23	.	10.49	.	.	12.35
PHILADELPHIA FDC	.	.	1.11	.	1.11	.	.	12.22	.	.	14.44
PHOENIX FCI	.	.	.	.	.	.	.	40.31	.	.	40.31
POLLOCK MED FCI	.	.	.	.	.	.	.	30.73	.	.	30.73
POLLOCK USP	.	1.92	.	.	.	.	.	44.19	.	.	46.11
RAY BROOK FCI	.	9.36	.	.	1.34	.	.	41.44	.	.	52.14
ROCHESTER FMC	.	1.39	.	.	2.77	1.39	.	11.10	.	.	16.64
SAFFORD FCI	.	.	.	.	1.51	.	.	13.62	.	.	15.13
SAN DIEGO MCC	.	.	.	.	1.41	.	.	28.29	.	.	29.70
SANDSTONE FCI	.	2.57	.	.	2.57	.	.	11.15	.	.	16.30
SCHUYLKILL FCI	.	3.55	.	.	1.77	.	.	38.12	.	.	43.44
SEAGOVILLE FCI	.	.	.	.	.59	5.86	.	5.28	.	.	11.72
SEATAC FDC	.	.	.	.	1.40	1.40	.	22.47	.	.	25.28
SHERIDAN FCI	.	1.30	.	.	1.94	.	.	28.50	.	.	31.74
SPRINGFIELD USMCFP	.	1.91	.	.	2.86	.	.	14.31	.	.95	20.04
TALLADEGA FCI	.	1.73	.	.	1.73	.86	.	18.98	.	.	23.30
TALLAHASSEE FCI	.	.	.	.	.91	6.40	.	2.74	.	.	10.05
TERMINAL ISLAND FCI	.	4.22	.	.	.	.	.	3.16	.	.	7.38
TERRE HAUTE FCI	.	2.21	.	.	.	.	.	23.53	.	.	25.74
TERRE HAUTE USP	.80	3.99	.	.	3.99	.	.	60.65	.	.	69.43

TEXARKANA FCI	.	.	.	.	.	.	.	1.54	.	.	1.54
THOMSON FCI	.	.	.	.	.	.	.	6.62	.	.	6.62
THREE RIVERS FCI	.	.81	.	.	.	.	.	55.60	.	.	56.41
TUCSON FCI	.	.	.	.	2.64	.	.	5.28	.	.	7.92
TUCSON USP	.	2.48	.	.	7.45	.83	.	17.38	.	.	28.15
VICTORVILLE MED I FCI	.	.62	.	.	4.33	.	.	30.34	.	.	35.29
VICTORVILLE MED II FCI	.	.	.	.	1.34	.	.	52.31	.	.	53.66
VICTORVILLE USP	.	5.81	.	.	.83	1.66	.	80.50	.	.	88.80
WASECA FCI	.	.	.	.	3.61	2.41	.	20.48	.	.	26.51
WILLIAMSBURG FCI	.	.	.	.	.	.	.	16.99	.	.	16.99
YAZOO CITY LOW FCI	.	.71	.	.	.	.	.	5.68	.	.	6.39
YAZOO CITY LOW II FCI	.	.	.	.	.	.	.	2.22	.	.	2.22
YAZOO CITY MED FCI	.	2.08	.	.	.69	.	.	13.90	.	.	16.68

Guilty Findings for Assaults on Inmates

Rate per 1,000

BOP Typical Facilities

Facility	2020	2021	2022	2023	2024	Total
ALDERSON FPC	4.39	1.63	4.82	2.91	2.75	16.50
ALICEVILLE FCI	11.06	14.87	19.58	18.08	15.07	78.66
ALLENWOOD LOW FCI	2.70	14.38	6.94	3.80	8.85	36.67
ALLENWOOD MED FCI	20.28	14.01	12.11	32.68	24.88	103.96
ALLENWOOD USP	39.43	44.37	43.08	40.76	39.68	207.32
ASHLAND FCI	.90	1.89	.	5.32	5.32	13.43
ATLANTA FCI	10.14	7.43	6.30	10.14	2.23	36.24
ATWATER USP	41.24	63.44	93.31	107.53	92.75	398.27
BASTROP FCI	3.12	10.74	12.93	10.50	7.29	44.58
BEAUMONT LOW FCI	4.11	5.89	5.43	4.37	4.83	24.63
BEAUMONT MED FCI	6.08	33.90	32.50	65.50	57.16	195.14
BEAUMONT USP	49.95	48.30	84.14	142.97	139.25	464.61
BECKLEY FCI	23.87	37.99	23.97	28.50	30.48	144.81
BENNETTSVILLE FCI	8.98	5.41	19.28	15.85	22.24	71.76
BERLIN FCI	19.43	16.09	48.28	21.95	35.31	141.06
BIG SANDY USP	30.14	81.36	101.26	98.15	140.32	451.23
BIG SPRING FCI	2.69	10.01	3.54	6.10	4.51	26.85
BROOKLYN MDC	17.02	10.55	26.25	43.59	39.69	137.10
BRYAN FPC	5.63	7.98	3.87	3.13	4.55	25.16
BUTNER FMC	9.08	2.74	8.47	4.79	14.32	39.40
BUTNER LOW FCI	1.80	4.50	4.67	4.26	1.05	16.28
BUTNER MED I FCI	20.41	22.22	31.12	24.63	17.31	115.69
BUTNER MED II FCI	12.39	11.01	20.54	16.16	14.70	74.80
CANAAN USP	70.55	92.68	91.55	94.91	96.12	445.81
CARSWELL FMC	15.16	22.51	17.83	13.20	30.71	99.41
CHICAGO MCC	21.74	8.85	17.39	18.66	20.83	87.47
COLEMAN I USP	30.85	61.96	64.04	69.11	46.23	272.19
COLEMAN II USP	44.70	43.81	40.25	44.44	60.04	233.24
COLEMAN LOW FCI	7.94	7.30	5.55	5.81	7.38	33.98
COLEMAN MED FCI	11.79	13.55	13.30	14.84	20.31	73.79
CUMBERLAND FCI	15.54	5.16	13.00	15.27	10.77	59.74
DANBURY FCI	13.99	10.95	14.65	22.40	20.03	82.02
DEVENS FMC	19.72	18.16	28.97	25.95	18.15	110.95
DUBLIN FCI	4.91	7.57	15.99	15.49	.	43.96
DULUTH FPC	2.67	6.73	3.47	.	4.95	17.82
EDGEFIELD FCI	6.47	7.26	21.25	21.91	11.20	68.09
EL RENO FCI	18.88	17.02	19.66	16.98	33.81	106.35
ELKTON FCI	9.93	7.62	7.37	9.51	3.66	38.09
ENGLEWOOD FCI	4.93	8.32	8.72	8.93	32.67	63.57
ESTILL FCI	17.54	.	14.08	.	.	31.62
FAIRTON FCI	34.58	22.70	29.52	18.27	18.82	123.89
FLORENCE ADMAX USP	10.87	8.70	2.95	.	.	22.52
FLORENCE FCI	33.86	34.84	54.89	58.64	66.86	249.09
FLORENCE HIGH USP	84.12	119.44	119.15	135.69	116.50	574.90
FORREST CITY FCI	5.25	2.67	1.78	3.94	2.21	15.85
FORREST CITY MED FCI	21.82	34.99	32.75	43.24	16.54	149.34
FORT DIX FCI	3.13	2.74	3.05	2.63	6.27	17.82
FORT WORTH ADMINISTRATIVE FMC	17.23	5.36	10.58	11.44	4.64	49.25
GILMER FCI	7.06	11.14	.	15.11	12.91	46.22

GREENVILLE FCI	7.02	13.38	14.46	14.53	22.27	71.66
GUAYNABO MDC	11.45	9.51	12.84	14.94	40.61	89.35
HAZELTON FCI	21.06	24.92	25.21	26.44	33.74	131.37
HAZELTON USP	17.99	46.36	38.76	47.10	58.36	208.57
HERLONG FCI	26.26	15.74	34.88	58.28	55.64	190.80
HONOLULU FDC	2.72	3.29	26.95	19.67	38.46	91.09
HOUSTON FDC	28.12	9.48	16.76	30.65	43.53	128.54
JESUP FCI	6.96	13.02	9.94	14.99	16.83	61.74
LA TUNA FCI	19.11	7.44	4.55	10.74	19.55	61.39
LEAVENWORTH FCI	26.20	40.36	12.64	22.35	30.21	131.76
LEE USP	40.71	67.40	75.55	101.63	104.15	389.44
LEWISBURG FCI	12.13	6.36	21.26	19.70	14.80	74.25
LEXINGTON FMC	6.04	6.08	11.88	5.43	3.90	33.33
LOMPOC FCI	3.67	6.17	2.04	3.18	11.79	26.85
LOMPOC II FCI	16.45	26.00	37.32	12.63	13.08	105.48
LORETTO FCI	4.44	9.96	4.52	10.59	8.51	38.02
LOS ANGELES MDC	37.30	19.30	35.46	31.20	30.53	153.79
MANCHESTER FCI	14.52	10.70	11.15	16.59	17.50	70.46
MARIANNA FCI	.	15.00	24.68	13.09	30.30	83.07
MARION FCI	14.16	9.30	13.19	13.12	19.73	69.50
MCCREARY USP	35.99	51.37	94.99	66.38	79.14	327.87
MCDOWELL FCI	6.16	9.08	6.57	15.05	22.89	59.75
MCKEAN FCI	7.27	15.45	21.58	31.82	17.87	93.99
MEMPHIS FCI	16.24	19.86	18.64	12.10	4.50	71.34
MENDOTA FCI	9.07	11.67	10.60	12.52	37.61	81.47
MIAMI FCI	5.70	1.10	8.29	5.11	3.93	24.13
MIAMI FDC	19.31	27.30	22.80	16.22	11.96	97.59
MILAN FCI	8.18	6.78	8.66	5.75	10.83	40.20
MONTGOMERY FPC	.	6.13	.	.	2.84	8.97
MORGANTOWN FPC	1.80	2.40	2.26	3.94	5.10	15.50
NEW YORK MCC	46.27	51.36	.	.	.	97.63
OAKDALE I FCI	4.21	4.58	6.73	8.10	14.08	37.70
OAKDALE II FCI	2.34	4.18	8.87	5.07	3.48	23.94
OKLAHOMA CITY FTC	9.57	14.26	17.33	22.85	16.12	80.13
OTISVILLE FCI	39.94	24.26	19.71	20.74	27.86	132.51
OXFORD FCI	29.63	19.69	26.34	32.66	12.64	120.96
PEKIN FCI	6.71	17.92	11.24	24.52	16.42	76.81
PENSACOLA FPC	2.41	3.03	.	.	.	5.44
PETERSBURG FCI	5.25	2.99	1.32	.	1.63	11.19
PETERSBURG MED FCI	9.95	8.67	8.00	6.53	12.35	45.50
PHILADELPHIA FDC	32.45	22.75	17.20	31.19	14.44	118.03
PHOENIX FCI	10.75	18.42	7.46	25.49	40.31	102.43
POLLOCK MED FCI	23.97	15.85	31.55	35.53	30.73	137.63
POLLOCK USP	19.54	54.23	26.92	30.07	46.11	176.87
RAY BROOK FCI	14.59	16.99	30.30	52.07	52.14	166.09
ROCHESTER FMC	9.13	7.99	10.45	26.85	16.64	71.06
SAFFORD FCI	5.06	5.04	25.07	5.49	15.13	55.79
SAN DIEGO MCC	6.94	11.24	12.17	35.81	29.70	95.86
SANDSTONE FCI	5.70	7.02	9.03	27.43	16.30	65.48
SCHUYLKILL FCI	18.37	9.26	7.25	18.55	43.44	96.87
SEAGOVILLE FCI	8.12	11.87	17.39	6.07	11.72	55.17
SEATAC FDC	29.46	25.00	28.85	21.38	25.28	129.97
SHERIDAN FCI	16.70	9.89	7.26	12.53	31.74	78.12
SPRINGFIELD USMCFP	12.14	13.94	10.93	30.21	20.04	87.26

TALLADEGA FCI	10.87	6.37	7.87	19.63	23.30	68.04
TALLAHASSEE FCI	20.00	15.72	16.03	20.32	10.05	82.12
TERMINAL ISLAND FCI	1.05	8.30	9.83	3.08	7.38	29.64
TERRE HAUTE FCI	15.91	22.59	38.07	28.31	25.74	130.62
TERRE HAUTE USP	30.65	45.84	39.57	54.41	69.43	239.90
TEXARKANA FCI	2.68	1.86	4.16	3.97	1.54	14.21
THOMSON FCI	87.95	69.02	54.53	20.41	6.62	238.53
THREE RIVERS FCI	33.72	45.37	59.84	65.57	56.41	260.91
TUCSON FCI	9.17	22.94	11.32	26.32	7.92	77.67
TUCSON USP	25.80	30.21	49.22	40.31	28.15	173.69
VICTORVILLE MED I FCI	14.85	30.89	17.43	36.80	35.29	135.26
VICTORVILLE MED II FCI	30.43	17.37	16.95	33.52	53.66	151.93
VICTORVILLE USP	55.42	57.73	66.53	74.01	88.80	342.49
WASECA FCI	34.54	36.88	33.20	32.98	26.51	164.11
WILLIAMSBURG FCI	5.39	16.77	14.26	10.42	16.99	63.83
YANKTON FPC	15.11	.	3.39	12.59	.	31.09
YAZOO CITY LOW FCI	2.27	2.82	6.08	7.06	6.39	24.62
YAZOO CITY LOW II FCI	13.41	9.21	8.98	11.24	2.22	45.06
YAZOO CITY MED FCI	8.76	6.81	12.67	30.44	16.68	75.36

Prohibited act codes 100, 101, 107, 114, 203, 205, 206, 224, 225, 229

Guilty Findings for Assaults on Inmates by Prohibited Act Code

**Rate per 1,000
BOP Typical Facilities**

Year=2020

Facility	100	101	107	114	203	205	206	224	225	229	Total
ALDERSON FPC	.	.	.	.	.	1.46	.	2.92	.	.	4.39
ALICEVILLE FCI	.	.	.	.	.74	.	.	10.32	.	.	11.06
ALLENWOOD LOW FCI	.	.	.	.	.	.	.	2.70	.	.	2.70
ALLENWOOD MED FCI	.	.	.	.	.	1.76	.	18.52	.	.	20.28
ALLENWOOD USP	.	4.73	.	.	.	1.58	.	33.12	.	.	39.43
ASHLAND FCI	.	.	.	.	.90	.	.	.	.	.	.90
ATLANTA FCI	.	.	.	.	.53	.	.	9.61	.	.	10.14
ATWATER USP	.	6.56	.	.	2.81	.	.	31.87	.	.	41.24
BASTROP FCI	.	.	.	.	.	.	.78	2.34	.	.	3.12
BEAUMONT LOW FCI	.	.	.	.	.	.	.	4.11	.	.	4.11
BEAUMONT MED FCI	.	.	.	.	.68	1.35	.	4.05	.	.	6.08
BEAUMONT USP	.	1.82	.	.	.	.	.	48.14	.	.	49.95
BECKLEY FCI	.	.65	.	.	2.58	.	.	20.65	.	.	23.87
BENNETTSVILLE FCI	.	.	.	.	2.25	.	.	6.74	.	.	8.98
BERLIN FCI	.	.	.	.	1.49	.	.	17.94	.	.	19.43
BIG SANDY USP	.	1.55	.	.	1.55	.	.	27.05	.	.	30.14
BIG SPRING FCI	.	.	.	.	.90	.	.	1.79	.	.	2.69
BROOKLYN MDC	.	.	.	.	1.31	.	.	15.71	.	.	17.02
BRYAN FPC	.	.	.	.	.	.	.	5.63	.	.	5.63
BUTNER FMC	.	.	.	.	1.14	3.41	.	4.54	.	.	9.08
BUTNER LOW FCI	.	.	.	.	.	.90	.	.90	.	.	1.80
BUTNER MED I FCI	.	1.20	.	.	.	7.20	.	12.00	.	.	20.41
BUTNER MED II FCI	.	.	.	.	.69	5.51	.	6.19	.	.	12.39
CANAAN USP	.	1.64	.	.	.	.	.	68.91	.	.	70.55
CARSWELL FMC	.	.	.	.	1.38	.	.	13.78	.	.	15.16
CHICAGO MCC	.	5.02	.	.	1.67	.	.	15.05	.	.	21.74
COLEMAN I USP	.	.91	.	.	6.35	.	.	23.59	.	.	30.85
COLEMAN II USP	.	.97	.	.	12.63	4.86	.	26.24	.	.	44.70
COLEMAN LOW FCI	.	.47	.	.	.	1.87	.	5.60	.	.	7.94
COLEMAN MED FCI	.	.	.	.	.69	.	.	11.10	.	.	11.79
CUMBERLAND FCI	.	3.45	.	.	.	1.73	.	10.36	.	.	15.54
DANBURY FCI	.	.	.	.	.	.	.	13.99	.	.	13.99
DEVENS FMC	.	.	.	.	4.38	2.19	2.19	10.95	.	.	19.72
DUBLIN FCI	.	.	.	.	.	.	.	4.91	.	.	4.91
DULUTH FPC	.	.	.	.	.	.	.	2.67	.	.	2.67
EDGEFIELD FCI	.	.65	.	.	.	.	.	5.83	.	.	6.47
EL RENO FCI	.	2.70	.	.	.	.	.	16.19	.	.	18.88
ELKTON FCI	.	.	.	.	.47	.	.	9.46	.	.	9.93
ENGLEWOOD FCI	.	.	.	.	.	.	.	4.93	.	.	4.93
ESTILL FCI	.	.	.	.	2.19	4.39	.	10.96	.	.	17.54
FAIRTON FCI	.	.	.	.	7.91	.	.	26.68	.	.	34.58
FLORENCE ADMAX USP	2.72	5.43	.	.	.	.	.	2.72	.	.	10.87
FLORENCE FCI	.	.	.	.	.79	.	.	33.07	.	.	33.86
FLORENCE HIGH USP	.	6.78	.	.	.	.	.	77.34	.	.	84.12
FORREST CITY FCI	.	.52	.	.	.	.	.52	4.20	.	.	5.25
FORREST CITY MED FCI	.	.	.	.	.91	2.73	.	18.18	.	.	21.82
FORT DIX FCI	.	.70	.	.	.	.70	.35	1.39	.	.	3.13

FORT WORTH ADMINISTRATIVE FMC	.	.	.	.	.72	2.87	.	13.64	.	.	17.23
GILMER FCI	.	.	.	.	2.82	1.41	.	2.82	.	.	7.06
GREENVILLE FCI	.	.	.	.	1.56	.	.	5.46	.	.	7.02
GUAYNABO MDC	.	.	.	.	.88	.	.	10.57	.	.	11.45
HAZELTON FCI	.	.	.	.	1.17	5.85	.	14.04	.	.	21.06
HAZELTON USP	.	4.50	.	.	.	.	.	13.49	.	.	17.99
HERLONG FCI	.	3.03	.	.	2.02	.	.	21.21	.	.	26.26
HONOLULU FDC	.	.	.	.	.	.	.	2.72	.	.	2.72
HOUSTON FDC	.	.	.	.	5.27	12.30	.	10.54	.	.	28.12
JESUP FCI	.	1.39	.	.	.70	2.09	.	2.78	.	.	6.96
LA TUNA FCI	.	2.55	.	.	3.82	3.82	.	8.92	.	.	19.11
LEAVENWORTH FCI	.	.61	.	.	.	.	.	25.59	.	.	26.20
LEE USP	.	9.62	.	.	.74	.	.	30.35	.	.	40.71
LEWISBURG FCI	.	.	.	.	3.03	.	.	9.10	.	.	12.13
LEXINGTON FMC	.	.	.	.	1.51	.	.	4.53	.	.	6.04
LOMPOC FCI	.	.	.	.	.	.	.	3.67	.	.	3.67
LOMPOC II FCI	.	1.43	.	.	1.43	.	.	13.59	.	.	16.45
LORETTO FCI	.	.	.	.	1.11	.	.	3.33	.	.	4.44
LOS ANGELES MDC	.	3.55	.	.	1.78	.	.	31.97	.	.	37.30
MANCHESTER FCI	.	.	.	.	4.84	.	.97	8.71	.	.	14.52
MARION FCI	.	.	.	.	.79	.79	.	12.59	.	.	14.16
MCCREARY USP	.	.	.	.	.	.69	.	35.29	.	.	35.99
MCDOWELL FCI	.	.	.	.	.88	.	.	5.28	.	.	6.16
MCKEAN FCI	.	.	.	.	1.21	.	.	6.06	.	.	7.27
MEMPHIS FCI	.	1.71	.	.	.	.	.	14.53	.	.	16.24
MENDOTA FCI	.	.	.	.	1.13	.	.	7.94	.	.	9.07
MIAMI FCI	.	4.75	.	.	.	.	.	.95	.	.	5.70
MIAMI FDC	.	.97	.	.	.	.	.	18.34	.	.	19.31
MILAN FCI	.	.	.	.	1.49	.	.	6.70	.	.	8.18
MORGANTOWN FPC	.	.	.	.	.	.	.	1.80	.	.	1.80
NEW YORK MCC	.	.	.	.	2.99	.	.	43.28	.	.	46.27
OAKDALE I FCI	.	.	.	.	.	.	.	4.21	.	.	4.21
OAKDALE II FCI	.	.	.	.	.	.	.	2.34	.	.	2.34
OKLAHOMA CITY FTC	.	.80	.	.	.	.80	.	7.97	.	.	9.57
OTISVILLE FCI	.	1.60	.	.	7.99	6.39	.	23.96	.	.	39.94
OXFORD FCI	.	3.17	.	.	1.06	2.12	.	23.28	.	.	29.63
PEKIN FCI	.	.	.	.	.	.	.	6.71	.	.	6.71
PENSACOLA FPC	.	.	.	.	.	.	.	2.41	.	.	2.41
PETERSBURG FCI	.	4.20	.	.	.	.	.	1.05	.	.	5.25
PETERSBURG MED FCI	.	.	.	.	1.33	.66	.	7.96	.	.	9.95
PHILADELPHIA FDC	.	.	.	.	2.03	3.04	.	27.38	.	.	32.45
PHOENIX FCI	.	.	.	.	.	4.48	.	6.27	.	.	10.75
POLLOCK MED FCI	.73	.	.	.	.73	.73	.	21.79	.	.	23.97
POLLOCK USP	1.63	.81	.	.	.81	.	.	16.29	.	.	19.54
RAY BROOK FCI	.	1.62	.	.	3.24	1.62	.	8.10	.	.	14.59
ROCHESTER FMC	.	.	.	.	4.57	.	.	4.57	.	.	9.13
SAFFORD FCI	.	.	.	.	1.26	.	.	3.79	.	.	5.06
SAN DIEGO MCC	.	1.39	.	.	.	.	.	5.56	.	.	6.94
SANDSTONE FCI	.	.	.	.	.	.	.	5.70	.	.	5.70
SCHUYLKILL FCI	.	.	.	.	3.67	.	.	14.69	.	.	18.37
SEAGOVILLE FCI	.	.	.	.	.54	.	.54	7.03	.	.	8.12
SEATAC FDC	.	1.55	.	.	.	6.20	.	21.71	.	.	29.46
SHERIDAN FCI	.	2.47	.	.	3.71	.	.	10.51	.	.	16.70
SPRINGFIELD USMCFP	.	.	.	.	2.21	.	.	9.93	.	.	12.14

TALLADEGA FCI	.	.	.	.	5.43	.	.	5.43	.	.	10.87
TALLAHASSEE FCI	.	1.18	.	.	2.35	2.35	.	14.12	.	.	20.00
TERMINAL ISLAND FCI	.	.	.	.	.	.	.	1.05	.	.	1.05
TERRE HAUTE FCI	.84	1.68	.	.	3.35	.	.	10.05	.	.	15.91
TERRE HAUTE USP	.77	2.30	.	.	3.07	1.53	.	22.99	.	.	30.65
TEXARKANA FCI	.	.	.	.	.	.	.	2.68	.	.	2.68
THOMSON FCI	1.76	2.64	.	.	2.64	17.59	.	63.32	.	.	87.95
THREE RIVERS FCI	.	17.75	.	.	.	.	.	15.97	.	.	33.72
TUCSON FCI	.	3.06	.	.	3.06	.	.	3.06	.	.	9.17
TUCSON USP	.	.	.	.	6.97	2.79	.	16.04	.	.	25.80
VICTORVILLE MED I FCI	.	2.62	.	.	.	.	.	12.23	.	.	14.85
VICTORVILLE MED II FCI	.	6.58	.	.	.	1.64	.	22.20	.	.	30.43
VICTORVILLE USP	.	8.96	.	.	3.26	.	.	43.19	.	.	55.42
WASECA FCI	.	.	.	.	1.57	9.42	.	23.55	.	.	34.54
WILLIAMSBURG FCI	.	.77	.	.	.77	.	.	3.85	.	.	5.39
YANKTON FPC	.	2.52	.	.	.	.	.	12.59	.	.	15.11
YAZOO CITY LOW FCI	.	.	.	.	.	.	.	2.27	.	.	2.27
YAZOO CITY LOW II FCI	.	.75	.	.	.	.	.	12.67	.	.	13.41
YAZOO CITY MED FCI	.	.	.	.	1.25	.	.	7.51	.	.	8.76

Year=2021

Facility	100	101	107	114	203	205	206	224	225	229	Total
ALDERSON FPC	.	.	.	.	.	.	.	1.63	.	.	1.63
ALICEVILLE FCI	.	.	.	.	.78	1.56	.	12.52	.	.	14.87
ALLENWOOD LOW FCI	.	.	.	.	.	2.21	.	12.17	.	.	14.38
ALLENWOOD MED FCI	.88	.88	.	.	.88	.	.	11.38	.	.	14.01
ALLENWOOD USP	.	5.12	.	.	1.71	.	.	37.54	.	.	44.37
ASHLAND FCI	.	.	.	.	.	.	.	1.89	.	.	1.89
ATLANTA FCI	.	.	.	.	.68	.	.	6.75	.	.	7.43
ATWATER USP	.	2.01	.	.	.	.	.	61.43	.	.	63.44
BASTROP FCI	.	.	.	.	3.58	.	.	7.16	.	.	10.74
BEAUMONT LOW FCI	.	.	.	.	1.07	.54	.	4.28	.	.	5.89
BEAUMONT MED FCI	.	2.71	.	.	.68	.	.	30.51	.	.	33.90
BEAUMONT USP	.	6.79	.	.	.	.75	.75	40.00	.	.	48.30
BECKLEY FCI	.	1.29	.	.	.64	.	.	36.06	.	.	37.99
BENNETTSVILLE FCI	.	.68	.	.	.68	.	.	4.05	.	.	5.41
BERLIN FCI	.	.	.	.	1.34	.	.	14.75	.	.	16.09
BIG SANDY USP	.	2.37	.	.	.	.	.	78.99	.	.	81.36
BIG SPRING FCI	5.01	.	.	.	1.00	.	.	4.00	.	.	10.01
BROOKLYN MDC	.	.	.	.	1.41	.	.	9.14	.	.	10.55
BRYAN FPC	.	2.00	.	.	.	.	.	5.99	.	.	7.98
BUTNER FMC	.	.	.	.	1.37	.	.	1.37	.	.	2.74
BUTNER LOW FCI	.	.	.	.	.	.	.	4.50	.	.	4.50
BUTNER MED I FCI	.	.	.	.	2.78	4.17	.	15.28	.	.	22.22
BUTNER MED II FCI	.	.	.	.	.	2.20	.	8.80	.	.	11.01
CANAAN USP	.81	3.25	.	.	.	.	.	88.62	.	.	92.68
CARSWELL FMC	.	.	.	.	.73	5.08	.	16.70	.	.	22.51
CHICAGO MCC	.	.	.	.	5.31	1.77	.	1.77	.	.	8.85
COLEMAN I USP	.78	8.63	.	.	3.92	.	.	48.63	.	.	61.96
COLEMAN II USP	1.10	2.19	.	.	4.38	2.19	.	33.95	.	.	43.81
COLEMAN LOW FCI	.	.	.	.	.52	.	.	6.77	.	.	7.30
COLEMAN MED FCI	.71	.	.	.	1.43	.71	.	10.70	.	.	13.55
CUMBERLAND FCI	.	.86	.	.	.	.	.	4.30	.	.	5.16
DANBURY FCI	.	.	.	.	.	.	1.10	9.86	.	.	10.95

DEVENS FMC	.	.	.	.	2.59	.	2.59	12.97	.	.	18.16
DUBLIN FCI	.	.	.	.	1.26	3.78	.	2.52	.	.	7.57
DULUTH FPC	.	.	.	.	.	.	.	6.73	.	.	6.73
EDGEFIELD FCI	.	.	.	.	.60	1.21	.	5.44	.	.	7.26
EL RENO FCI	1.00	1.00	.	.	.	.	.	15.02	.	.	17.02
ELKTON FCI	.	.	.	.	.	.	.	7.62	.	.	7.62
ENGLEWOOD FCI	.	.	.	.	.	4.16	.	4.16	.	.	8.32
FAIRTON FCI	.	.	.	.	3.41	1.14	.	18.16	.	.	22.70
FLORENCE ADMAX USP	.	.	.	.	.	.	.	8.70	.	.	8.70
FLORENCE FCI	.	1.58	.	.	.	.	.	33.25	.	.	34.84
FLORENCE HIGH USP	4.17	18.06	.	.	.	2.78	.	94.44	.	.	119.44
FORREST CITY FCI	.	.	.	.	.	.	.	2.67	.	.	2.67
FORREST CITY MED FCI	.73	2.19	.	.	1.46	.	.	30.61	.	.	34.99
FORT DIX FCI	.	.68	.	.	.34	.	.	1.71	.	.	2.74
FORT WORTH ADMINISTRATIVE FMC	.	.	.	.	1.53	.	.77	3.06	.	.	5.36
GILMER FCI	.	.	.	.	3.28	1.31	.	6.55	.	.	11.14
GREENVILLE FCI	.	.	.	.	2.51	2.51	.	8.36	.	.	13.38
GUAYNABO MDC	.	.	.	.	1.58	.	.	7.92	.	.	9.51
HAZELTON FCI	.	1.59	.	.	1.06	2.12	.	20.15	.	.	24.92
HAZELTON USP	.	2.85	.	.	.	.	.	43.51	.	.	46.36
HERLONG FCI	.	2.49	.	.	1.66	.	.	11.60	.	.	15.74
HONOLULU FDC	.	.	.	.	.	.	.	3.29	.	.	3.29
HOUSTON FDC	.	.	.	.	4.74	.	.	4.74	.	.	9.48
JESUP FCI	.	1.45	.	.	1.45	1.45	.	8.68	.	.	13.02
LA TUNA FCI	.	1.06	.	.	.	.	.	6.38	.	.	7.44
LEAVENWORTH FCI	.	.	.	.	1.28	.	.	39.08	.	.	40.36
LEE USP	.78	6.27	.	.	.	.	.	60.34	.	.	67.40
LEWISBURG FCI	.	1.27	.	.	3.82	.	.	1.27	.	.	6.36
LEXINGTON FMC	.	.	.	.	.	.	.87	5.21	.	.	6.08
LOMPOC FCI	.	1.23	.	.	.	.	.	4.94	.	.	6.17
LOMPOC II FCI	.	1.58	.	.	1.58	1.58	.	21.28	.	.	26.00
LORETTO FCI	.	.	.	.	.	2.49	.	7.47	.	.	9.96
LOS ANGELES MDC	.	.	.	.	5.26	.	.	14.04	.	.	19.30
MANCHESTER FCI	.	.97	.	.	.	.	.	9.73	.	.	10.70
MARIANNA FCI	.	2.50	.	.	5.00	2.50	.	5.00	.	.	15.00
MARION FCI	.	.	.	.	1.55	2.32	.	5.42	.	.	9.30
MCCREARY USP	1.37	.68	.	.	1.37	.	.	47.95	.	.	51.37
MCDOWELL FCI	.	.	.	.	.	.	.	9.08	.	.	9.08
MCKEAN FCI	.	.	.	.	4.12	.	.	11.33	.	.	15.45
MEMPHIS FCI	.	.90	.	.	1.81	.90	.	16.25	.	.	19.86
MENDOTA FCI	.	.90	.	.	.90	.	.90	8.98	.	.	11.67
MIAMI FCI	.	.	.	.	.	.	.	1.10	.	.	1.10
MIAMI FDC	.	.	.	.	2.56	.	.	24.74	.	.	27.30
MILAN FCI	.	.75	.	.	.	.	.75	5.28	.	.	6.78
MONTGOMERY FPC	.	.	.	.	6.13	.	.	.	.	.	6.13
MORGANTOWN FPC	.	.	.	.	.	.	.	2.40	.	.	2.40
NEW YORK MCC	.	.	.	.	.	.	.	51.36	.	.	51.36
OAKDALE I FCI	.	.	.	.	.	.	.	4.58	.	.	4.58
OAKDALE II FCI	.	.	.	.	1.05	.	.	3.14	.	.	4.18
OKLAHOMA CITY FTC	.	.	.	.	.	3.96	.	10.30	.	.	14.26
OTISVILLE FCI	.	.	.	.	1.73	3.47	.	19.06	.	.	24.26
OXFORD FCI	.	1.04	.	.	1.04	3.11	.	14.51	.	.	19.69
PEKIN FCI	.	.	.	.	.85	1.71	.85	14.51	.	.	17.92
PENSACOLA FPC	.	.	.	.	.	.	.	3.03	.	.	3.03

PETERSBURG FCI	.	.	.	.	.	.	.	2.99	.	.	2.99
PETERSBURG MED FCI	.	.	.	.	.67	.67	.	7.34	.	.	8.67
PHILADELPHIA FDC	.	5.99	.	.	3.59	.	.	13.17	.	.	22.75
PHOENIX FCI	.	3.68	.	.	.92	.	.	13.81	.	.	18.42
POLLOCK MED FCI	.	.	.	.	.	.	.	15.85	.	.	15.85
POLLOCK USP	.	4.78	.	.	1.59	2.39	.	45.45	.	.	54.23
RAY BROOK FCI	.	5.23	.	.	1.31	.	.	10.46	.	.	16.99
ROCHESTER FMC	.	.	.	.	1.60	.	.	6.39	.	.	7.99
SAFFORD FCI	.	.	.	.	1.26	.	.	3.78	.	.	5.04
SAN DIEGO MCC	.	.	.	.	1.25	.	.	9.99	.	.	11.24
SANDSTONE FCI	.	.	.	.	.	3.51	.	2.34	.	1.17	7.02
SCHUYLKILL FCI	.	.93	.	.	.	.	.	8.33	.	.	9.26
SEAGOVILLE FCI	.	.59	.	.	.59	.59	.	10.09	.	.	11.87
SEATAC FDC	.	.	.	.	8.82	1.47	.	14.71	.	.	25.00
SHERIDAN FCI	.	.	.	.	.66	.	.66	8.57	.	.	9.89
SPRINGFIELD USMCFP	.	1.16	.	.	.	2.32	.	10.45	.	.	13.94
TALLADEGA FCI	.	.	.	.	1.06	1.06	.	4.25	.	.	6.37
TALLAHASSEE FCI	.	.	.	.	2.42	2.42	.	10.88	.	.	15.72
TERMINAL ISLAND FCI	.	.	.	.	.	.	1.38	6.92	.	.	8.30
TERRE HAUTE FCI	.	.84	.	.	1.67	.	.	20.08	.	.	22.59
TERRE HAUTE USP	1.70	1.70	.	.	7.64	.	.	34.80	.	.	45.84
TEXARKANA FCI	.	.93	.	.	.	.	.	.93	.	.	1.86
THOMSON FCI	.84	5.89	.	.	4.21	1.68	.	56.40	.	.	69.02
THREE RIVERS FCI	.	.	.	.	.89	7.12	.	37.37	.	.	45.37
TUCSON FCI	.	.	.	.	.	.	.	22.94	.	.	22.94
TUCSON USP	.	1.47	.	.	5.90	2.95	.74	19.16	.	.	30.21
VICTORVILLE MED I FCI	.	.	.	.	.	.	.	30.89	.	.	30.89
VICTORVILLE MED II FCI	.83	2.48	.	.	.	.	.	14.06	.	.	17.37
VICTORVILLE USP	.	.	.	.	6.52	.	.	51.21	.	.	57.73
WASECA FCI	.	.	.	.	1.42	.	.	35.46	.	.	36.88
WILLIAMSBURG FCI	.	.	.	.	5.37	.	.	11.40	.	.	16.77
YAZOO CITY LOW FCI	.	.	.	.	.70	.	.	2.11	.	.	2.82
YAZOO CITY LOW II FCI	.	.	.	.	.	.	.	9.21	.	.	9.21
YAZOO CITY MED FCI	.	.	.	.	1.14	2.27	.	3.41	.	.	6.81

Year=2022

Facility	100	101	107	114	203	205	206	224	225	229	Total
ALDERSON FPC	.	.	.	.	.	3.22	.	1.61	.	.	4.82
ALICEVILLE FCI	.	.	.	.	1.31	3.92	.	14.36	.	.	19.58
ALLENWOOD LOW FCI	.	.	.	.	.99	.	.	5.95	.	.	6.94
ALLENWOOD MED FCI	.	.81	.	.	3.23	.	.	8.07	.	.	12.11
ALLENWOOD USP	.	1.54	.	.	3.08	.	.	38.46	.	.	43.08
ATLANTA FCI	.	.	.	.	1.05	1.05	1.05	3.15	.	.	6.30
ATWATER USP	.	15.08	.	.	.	.	.	78.23	.	.	93.31
BASTROP FCI	.	.92	.	.	.	.92	.	11.08	.	.	12.93
BEAUMONT LOW FCI	.	.	.	.	.49	.99	.	3.95	.	.	5.43
BEAUMONT MED FCI	.	1.27	.	.	.	1.27	.	29.96	.	.	32.50
BEAUMONT USP	.70	4.87	.	.	1.39	.	.	77.19	.	.	84.14
BECKLEY FCI	.61	.	.	.	1.23	.	.61	21.51	.	.	23.97
BENNETTSVILLE FCI	.	.	.	.	.62	.	.	18.66	.	.	19.28
BERLIN FCI	.	22.87	.	.	1.27	.	.	24.14	.	.	48.28
BIG SANDY USP	1.48	9.61	.	.	.74	.	.	89.43	.	.	101.26
BIG SPRING FCI	.	.	.	.	.	.	.	3.54	.	.	3.54
BROOKLYN MDC	.	6.72	.	.	.61	.	.	18.93	.	.	26.25

BRYAN FPC	.	.	.	.	1.93	.	.	1.93	.	.	3.87
BUTNER FMC	.	.	.	.	1.21	.	.	7.26	.	.	8.47
BUTNER LOW FCI	.	.	.	.	.	.	.	4.67	.	.	4.67
BUTNER MED I FCI	.	.	.	.	10.83	5.41	.	14.88	.	.	31.12
BUTNER MED II FCI	.	.	.	.	.	.	.	20.54	.	.	20.54
CANAAN USP	.	3.95	.	.	.79	.	.	86.82	.	.	91.55
CARSWELL FMC	.	.	.	.85	1.70	3.40	.	11.88	.	.	17.83
CHICAGO MCC	.	.	.	.	3.48	.	.	13.91	.	.	17.39
COLEMAN I USP	.	6.70	.	.	2.23	.	.	55.10	.	.	64.04
COLEMAN II USP	.	1.79	.	.	3.58	.	.	33.99	.	.89	40.25
COLEMAN LOW FCI	.	.	.	.	.50	.	.	5.04	.	.	5.55
COLEMAN MED FCI	.	.	.	.	2.53	.	.	10.77	.	.	13.30
CUMBERLAND FCI	.	.	.	.	.	.	.	13.00	.	.	13.00
DANBURY FCI	.	.	.	.	2.93	.98	1.95	8.79	.	.	14.65
DEVENS FMC	.	1.07	.	.	5.36	1.07	.	20.39	.	1.07	28.97
DUBLIN FCI	.	.	.	.	4.36	.	.	11.63	.	.	15.99
DULUTH FPC	.	.	.	.	.	.	.	3.47	.	.	3.47
EDGEFIELD FCI	.	.53	.	.	.53	.	.	20.19	.	.	21.25
EL RENO FCI	.	.	.	.	.85	.	.	18.80	.	.	19.66
ELKTON FCI	.	.	.	.	1.13	.	.	5.67	.	.57	7.37
ENGLEWOOD FCI	.	.	.	.	.	.	.	8.72	.	.	8.72
ESTILL FCI	.	.	.	.	.	.	.	14.08	.	.	14.08
FAIRTON FCI	.	1.18	.	.	7.08	.	.	21.25	.	.	29.52
FLORENCE ADMAX USP	.	.	.	.	.	.	.	2.95	.	.	2.95
FLORENCE FCI	.	1.50	.	.	.	.	.	53.38	.	.	54.89
FLORENCE HIGH USP	1.42	2.84	.	.	2.84	.	.	112.06	.	.	119.15
FORREST CITY FCI	.	.	.	.	.	.	.	1.78	.	.	1.78
FORREST CITY MED FCI	.	.	.	.	1.89	.	.	30.86	.	.	32.75
FORT DIX FCI	.	.31	.	.	.	.61	.	2.14	.	.	3.05
FORT WORTH ADMINISTRATIVE FMC	.	.	.	.	.66	.	.66	9.26	.	.	10.58
GREENVILLE FCI	.	.	.	.	.80	.	1.61	11.24	.	.80	14.46
GUAYNABO MDC	.	.	.	.76	.	.	.	12.08	.	.	12.84
HAZELTON FCI	.	1.43	.	.	.48	.	.	23.31	.	.	25.21
HAZELTON USP	.	3.94	.	.	.	.	.	34.82	.	.	38.76
HERLONG FCI	.	.	.	.	.68	1.37	.	32.83	.	.	34.88
HONOLULU FDC	.	14.97	.	.	2.99	.	.	8.98	.	.	26.95
HOUSTON FDC	.	.	.	.	2.79	.	.	13.97	.	.	16.76
JESUP FCI	.	.66	.	.	.	.	.	9.28	.	.	9.94
LA TUNA FCI	.	.	.	.	.	.	.	4.55	.	.	4.55
LEAVENWORTH FCI	.	1.26	.	.	.	1.90	.	9.48	.	.	12.64
LEE USP	.	6.41	.	.	.71	.	.	68.42	.	.	75.55
LEWISBURG FCI	.	.97	.	.	1.93	.97	.	17.39	.	.	21.26
LEXINGTON FMC	.	.	.	.	.79	1.58	.	9.50	.	.	11.88
LOMPOC FCI	.	.	.	.	1.02	.	.	1.02	.	.	2.04
LOMPOC II FCI	.	.	.	.	.96	.	.	36.36	.	.	37.32
LORETTO FCI	.	.	.	.	1.13	.	.	3.39	.	.	4.52
LOS ANGELES MDC	.	8.51	.	.	5.67	.	.	21.28	.	.	35.46
MANCHESTER FCI	.	.	.	.	1.86	.	.	9.29	.	.	11.15
MARIANNA FCI	.	2.55	.	.	2.55	3.40	.	16.17	.	.	24.68
MARION FCI	.	.	.	.	.73	2.93	.	8.79	.	.73	13.19
MCCREARY USP	.	.	.	.	.	.	.	94.99	.	.	94.99
MCDOWELL FCI	.	.	.	.	.	.	.	6.57	.	.	6.57
MCKEAN FCI	.	.	.	.	6.57	.	.	15.01	.	.	21.58
MEMPHIS FCI	.	1.62	.	.	6.48	.	.	10.53	.	.	18.64

MENDOTA FCI	.	.	.	.	.71	.	.	9.89	.	.	10.60
MIAMI FCI	.	.	.	.	2.07	.	.	6.22	.	.	8.29
MIAMI FDC	.	.	.	.	.81	.	.	21.99	.	.	22.80
MILAN FCI	.	.	.	.	.67	1.33	.	6.66	.	.	8.66
MORGANTOWN FPC	.	.	.	.	.	.	.	2.26	.	.	2.26
OAKDALE I FCI	.	.	.	.	1.12	.	.	5.61	.	.	6.73
OAKDALE II FCI	.	.	.	.	.89	.	.	7.98	.	.	8.87
OKLAHOMA CITY FTC	.	.	.	.	1.73	.87	.	14.73	.	.	17.33
OTISVILLE FCI	.	.	.	.	3.58	.	.	16.13	.	.	19.71
OXFORD FCI	.	3.63	.	.	1.82	.	.	20.89	.	.	26.34
PEKIN FCI	.	.80	.	.	.	1.61	.80	8.03	.	.	11.24
PETERSBURG FCI	.	.	.	.	.	.	.	1.32	.	.	1.32
PETERSBURG MED FCI	.	.	.	.	.	1.85	.	6.16	.	.	8.00
PHILADELPHIA FDC	.	.	.	.	.	.	.	17.20	.	.	17.20
PHOENIX FCI	.	.	.	.	.83	.83	.	5.80	.	.	7.46
POLLOCK MED FCI	.	.	.	.	.	.	.	31.55	.	.	31.55
POLLOCK USP	2.38	5.54	.	.	.	.	.	19.00	.	.	26.92
RAY BROOK FCI	.	2.24	.	.	1.12	3.37	.	23.57	.	.	30.30
ROCHESTER FMC	.	.	.	.	1.74	3.48	.	5.23	.	.	10.45
SAFFORD FCI	.	.	.	.	1.32	.	.	23.75	.	.	25.07
SAN DIEGO MCC	.	.	.	.	2.43	.	.	9.73	.	.	12.17
SANDSTONE FCI	.	.	.	.	.90	.	.	8.12	.	.	9.03
SCHUYLKILL FCI	.	.	.	.	.91	.	.	6.34	.	.	7.25
SEAGOVILLE FCI	.	.	.	.	.	.	.	17.39	.	.	17.39
SEATAC FDC	.	.	.	.	3.61	7.21	.	16.83	.	1.20	28.85
SHERIDAN FCI	.	.66	.	.	.66	.	.	5.94	.	.	7.26
SPRINGFIELD USMCFP	.	.	.	.	1.99	.	.	8.95	.	.	10.93
TALLADEGA FCI	.	.	.	.	2.95	.	.	4.92	.	.	7.87
TALLAHASSEE FCI	.	.	.	.	3.70	7.40	.	4.93	.	.	16.03
TERMINAL ISLAND FCI	.	.	.	.	2.18	.	.	7.64	.	.	9.83
TERRE HAUTE FCI	.	.	.	.	2.20	.	.	35.87	.	.	38.07
TERRE HAUTE USP	.82	4.12	.	.	4.12	3.30	.	27.21	.	.	39.57
TEXARKANA FCI	.	.	.	.	.	.	.	4.16	.	.	4.16
THOMSON FCI	.	1.09	.	.	1.09	2.18	.	50.16	.	.	54.53
THREE RIVERS FCI	.	1.57	.	.	.79	1.57	.	55.91	.	.	59.84
TUCSON FCI	.	.	.	.	7.55	.	.	3.77	.	.	11.32
TUCSON USP	2.14	.71	.	.	9.27	2.85	.71	33.52	.	.	49.22
VICTORVILLE MED I FCI	.	.	.	.	.	.	.	17.43	.	.	17.43
VICTORVILLE MED II FCI	.	1.69	.	.	.	.	.	14.41	.	.85	16.95
VICTORVILLE USP	.	2.02	.	.	2.02	2.02	.	60.48	.	.	66.53
WASECA FCI	.	.	.	.	2.66	6.64	.	23.90	.	.	33.20
WILLIAMSBURG FCI	.	.65	.	.	.	.65	.	12.96	.	.	14.26
YANKTON FPC	.	.	.	.	.	.	.	3.39	.	.	3.39
YAZOO CITY LOW FCI	.	.	.	.	2.03	.	.	4.05	.	.	6.08
YAZOO CITY LOW II FCI	.	1.50	.	.	.	.	.	7.49	.	.	8.98
YAZOO CITY MED FCI	.	.	.	.	.	.90	.	11.76	.	.	12.67

Year=2023

Facility	100	101	107	114	203	205	206	224	225	229	Total
ALDERSON FPC	.	.	.	.	.	.	.	2.91	.	.	2.91
ALICEVILLE FCI	.	.	.	.	1.21	2.41	.	14.47	.	.	18.08
ALLENWOOD LOW FCI	.	.	.	.	.	.	.	3.80	.	.	3.80
ALLENWOOD MED FCI	.	.78	.	.	3.89	.	.	28.02	.	.	32.68
ALLENWOOD USP	.	5.43	.	.	8.15	.	.	27.17	.	.	40.76

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ASHLAND FCI	.	.	.	.	1.52	.	.	3.80	.	.	5.32
ATLANTA FCI	.	.	.	.	.60	1.19	.	8.35	.	.	10.14
ATWATER USP	.	17.37	.	.	.	.	.	90.16	.	.	107.53
BASTROP FCI	.	.	.	.	.	.	.	10.50	.	.	10.50
BEAUMONT LOW FCI	.	.	.	.	.	.	.	4.37	.	.	4.37
BEAUMONT MED FCI	.	.	.	.	.	1.20	.	64.30	.	.	65.50
BEAUMONT USP	.	6.18	.	.	.77	.	.	136.01	.	.	142.97
BECKLEY FCI	1.19	1.78	.	.	.	.	.	25.53	.	.	28.50
BENNETTSVILLE FCI	.	.	.	.	.	.	.	15.85	.	.	15.85
BERLIN FCI	.	6.86	.	.	.	.	.	15.09	.	.	21.95
BIG SANDY USP	.	5.49	.	.	.	.	.	92.66	.	.	98.15
BIG SPRING FCI	.	.87	.	.	1.74	1.74	.	1.74	.	.	6.10
BROOKLYN MDC	.	13.87	.	.	.66	.	.	29.06	.	.	43.59
BRYAN FPC	.	.	.	.	3.13	.	.	.	.	.	3.13
BUTNER FMC	.	.	.	.	.	.	.	4.79	.	.	4.79
BUTNER LOW FCI	.	.	.	1.06	.	.	.	3.19	.	.	4.26
BUTNER MED I FCI	.	.	.	.	2.46	4.93	1.23	16.01	.	.	24.63
BUTNER MED II FCI	.	1.35	.	.	.67	.	.	14.14	.	.	16.16
CANAAN USP	.	3.09	.	.	2.31	.	.	89.51	.	.	94.91
CARSWELL FMC	.	.	.	.	.	.	.	13.20	.	.	13.20
CHICAGO MCC	.	.	.	.	1.87	.	.	16.79	.	.	18.66
COLEMAN I USP	2.82	.71	.	.	2.12	.	.	63.47	.	.	69.11
COLEMAN II USP	.	3.29	.	.	3.29	1.65	.	36.21	.	.	44.44
COLEMAN LOW FCI	.	.48	.	.	.	.	.	5.33	.	.	5.81
COLEMAN MED FCI	.	.	.	.	1.29	.	.	13.55	.	.	14.84
CUMBERLAND FCI	.	.	.	.	.	2.04	.	13.24	.	.	15.27
DANBURY FCI	.	.	.	.	1.02	3.05	.	18.33	.	.	22.40
DEVENS FMC	.	1.08	.	.	8.65	3.24	.	12.97	.	.	25.95
DUBLIN FCI	.	.	.	.	.	8.61	.	6.88	.	.	15.49
EDGEFIELD FCI	.	1.53	.	.	.	2.04	.	18.34	.	.	21.91
EL RENO FCI	.	.	.	.	.	.	.	16.98	.	.	16.98
ELKTON FCI	.	.50	.	.	.	1.50	.	7.51	.	.	9.51
ENGLEWOOD FCI	.	.99	.	.	1.98	.	.	5.95	.	.	8.93
FAIRTON FCI	.	1.22	.	.	3.65	.	.	13.40	.	.	18.27
FLORENCE FCI	.	2.35	.	.	.	.78	.	55.51	.	.	58.64
FLORENCE HIGH USP	.	4.56	.	.	.	.	.	131.13	.	.	135.69
FORREST CITY FCI	.	.	.	.	.	.	.	3.94	.	.	3.94
FORREST CITY MED FCI	.	.	.	.	1.20	.	.	42.04	.	.	43.24
FORT DIX FCI	.	.53	.	.	.	.	.	1.84	.26	.	2.63
FORT WORTH ADMINISTRATIVE FMC	.	.	.	.	1.27	3.81	.	6.36	.	.	11.44
GILMER FCI	.	.	.	.	1.81	.	.	13.29	.	.	15.11
GREENVILLE FCI	.	2.42	.	.	.81	.	.	11.30	.	.	14.53
GUAYNABO MDC	.	1.66	.	.	.	.	.	13.28	.	.	14.94
HAZELTON FCI	.	2.88	.	.	.48	.	.	22.60	.	.48	26.44
HAZELTON USP	.	6.04	.	.	.	.	.	41.06	.	.	47.10
HERLONG FCI	.	1.99	.	.	1.32	.66	.	54.30	.	.	58.28
HONOLULU FDC	.	.	.	.	.	.	.	19.67	.	.	19.67
HOUSTON FDC	.	.	.	.	.	6.39	.	24.27	.	.	30.65
JESUP FCI	.	.	.	.	.	.	.	14.99	.	.	14.99
LA TUNA FCI	.	.	.	.	.	2.39	.	8.35	.	.	10.74
LEAVENWORTH FCI	.	1.12	.	.	.56	.	.	20.67	.	.	22.35
LEE USP	.	14.98	.	.	.65	.	.	85.99	.	.	101.63
LEWISBURG FCI	.	4.93	.	.	.	.	.99	13.79	.	.	19.70
LEXINGTON FMC	.	.	.	.	1.55	.	.	3.88	.	.	5.43

LOMPOC FCI	.	.	.	.	2.12	.	.	1.06	.	.	3.18
LOMPOC II FCI	.	.	.	.	1.65	.	.	10.98	.	.	12.63
LORETTO FCI	.	1.18	.	.	2.35	2.35	.	4.71	.	.	10.59
LOS ANGELES MDC	.	.	.	.	.	.	.	29.64	.	1.56	31.20
MANCHESTER FCI	.	.	.	.	.	.	.	16.59	.	.	16.59
MARIANNA FCI	.	.	.82	.	3.27	.	.	9.00	.	.	13.09
MARION FCI	.	.	.	.	.	.77	.	12.35	.	.	13.12
MCCREARY USP	.61	.	.	.	.	.	.	65.77	.	.	66.38
MCDOWELL FCI	.	2.62	.	.	.65	.	.	11.78	.	.	15.05
MCKEAN FCI	.	.91	.	.	1.82	.91	.	28.18	.	.	31.82
MEMPHIS FCI	.	.	.	.	1.73	.	.	10.37	.	.	12.10
MENDOTA FCI	.	.78	.	.	.	.	.	11.74	.	.	12.52
MIAMI FCI	.	.	.	.	2.04	.	.	3.07	.	.	5.11
MIAMI FDC	.	.	.	.	2.86	.	.	13.36	.	.	16.22
MILAN FCI	.	.	.	.	.64	.64	.	4.48	.	.	5.75
MORGANTOWN FPC	.	.	.	.	1.97	.	.	1.97	.	.	3.94
OAKDALE I FCI	.	.	.	.	.	2.31	.	5.79	.	.	8.10
OAKDALE II FCI	.	.	.	.	.	1.69	.	3.38	.	.	5.07
OKLAHOMA CITY FTC	.	1.58	.	.	2.36	3.94	.	14.97	.	.	22.85
OTISVILLE FCI	.	.	.	.	.	1.89	.	18.85	.	.	20.74
OXFORD FCI	.	.	.	.	1.77	.88	.	30.01	.	.	32.66
PEKIN FCI	.	.	.	.	.77	2.30	.	21.46	.	.	24.52
PETERSBURG MED FCI	.	.	.	.	.	1.19	.	5.34	.	.	6.53
PHILADELPHIA FDC	.	.	.	.	4.16	.	.	27.03	.	.	31.19
PHOENIX FCI	.	.82	.	.	.82	.82	.	23.03	.	.	25.49
POLLOCK MED FCI	.	.	.	.	.63	.	.	34.90	.	.	35.53
POLLOCK USP	.	2.31	.	.	.	.	.	27.76	.	.	30.07
RAY BROOK FCI	.	.	.	.	4.01	2.67	.	45.39	.	.	52.07
ROCHESTER FMC	.	10.07	.	.	.	3.36	.	13.42	.	.	26.85
SAFFORD FCI	.	.	.	.	1.37	.	.	4.12	.	.	5.49
SAN DIEGO MCC	.	.	.	.	.	.	.	35.81	.	.	35.81
SANDSTONE FCI	.	19.47	.	.	1.77	.	.	6.19	.	.	27.43
SCHUYLKILL FCI	.	.88	.	.	3.53	.	.	14.13	.	.	18.55
SEAGOVILLE FCI	.	.55	.	.	.55	.	.	4.96	.	.	6.07
SEATAC FDC	.	.	.	.	2.52	2.52	.	16.35	.	.	21.38
SHERIDAN FCI	.	.	.	.	.	.63	.	11.90	.	.	12.53
SPRINGFIELD USMCFP	.	2.01	.	.	1.01	2.01	.	25.18	.	.	30.21
TALLADEGA FCI	.	.	.	.	.	3.74	.	15.89	.	.	19.63
TALLAHASSEE FCI	.	.	.	.	2.26	10.16	.	7.90	.	.	20.32
TERMINAL ISLAND FCI	.	.	.	.	1.03	.	.	2.05	.	.	3.08
TERRE HAUTE FCI	.	4.83	.	.	2.07	.	.	21.41	.	.	28.31
TERRE HAUTE USP	.82	6.60	.	.	2.47	1.65	.	42.87	.	.	54.41
TEXARKANA FCI	.	.	.	.	.	1.59	.	2.38	.	.	3.97
THOMSON FCI	.	.	.	.	7.14	.	.	13.27	.	.	20.41
THREE RIVERS FCI	.	1.49	.	.	.	1.49	.	62.59	.	.	65.57
TUCSON FCI	.	.	.	.	5.85	.	.	20.47	.	.	26.32
TUCSON USP	.69	1.39	.	.	12.51	2.08	.	23.63	.	.	40.31
VICTORVILLE MED I FCI	.	1.17	.	.	.58	.	.	35.05	.	.	36.80
VICTORVILLE MED II FCI	.	.	.	.	1.56	.	.	31.96	.	.	33.52
VICTORVILLE USP	.	5.29	.	.	.88	.	.	67.84	.	.	74.01
WASECA FCI	.	.	.	.	6.60	5.28	.	21.11	.	.	32.98
WILLIAMSBURG FCI	.	.	.	.	.	1.39	.69	8.33	.	.	10.42
YANKTON FPC	.	.	.	.	.	.	.	12.59	.	.	12.59
YAZOO CITY LOW FCI	.	.	.	.	.	.	.	7.06	.	.	7.06

YAZOO CITY LOW II FCI	.	.	.	.	.	1.32	.	9.92	.	.	11.24
YAZOO CITY MED FCI	.	1.30	.	.	.	.	.	29.15	.	.	30.44

Year=2024

Facility	100	101	107	114	203	205	206	224	225	229	Total
ALDERSON FPC	.	.	.	.	.	.	.	2.75	.	.	2.75
ALICEVILLE FCI	.	.	.	.	1.26	.	.	13.18	.	.63	15.07
ALLENWOOD LOW FCI	.	.	.	.	.	.	.	8.85	.	.	8.85
ALLENWOOD MED FCI	.	.80	.	.	.80	.	.	23.27	.	.	24.88
ALLENWOOD USP	.	.	.	.	.	3.97	.	35.71	.	.	39.68
ASHLAND FCI	.	.	.	.	.76	1.52	.	3.04	.	.	5.32
ATLANTA FCI	.	.	.	.	.56	.	.	1.67	.	.	2.23
ATWATER USP	.	10.12	.	.	1.69	.	.	80.94	.	.	92.75
BASTROP FCI	.	.	.	.	.91	.	.	6.38	.	.	7.29
BEAUMONT LOW FCI	.	.	.	.	.	.	.	4.83	.	.	4.83
BEAUMONT MED FCI	.	1.88	.	.63	5.65	2.51	.	46.48	.	.	57.16
BEAUMONT USP	.81	12.21	.	.	.81	.	.	125.41	.	.	139.25
BECKLEY FCI	.	1.20	.	.	2.39	.	.	26.90	.	.	30.48
BENNETTSVILLE FCI	.	.62	.	.	.	.62	.	21.00	.	.	22.24
BERLIN FCI	.	4.56	.	.	1.14	.	.	29.61	.	.	35.31
BIG SANDY USP	.77	1.54	.	.	.	1.54	.	136.47	.	.	140.32
BIG SPRING FCI	.	.	.	.	.	.	.	4.51	.	.	4.51
BROOKLYN MDC	.	10.69	.	.	1.53	.	.	27.48	.	.	39.69
BRYAN FPC	.	.	.	.	3.03	.	.	1.52	.	.	4.55
BUTNER FMC	.	.	.	.	3.58	2.39	.	7.16	.	1.19	14.32
BUTNER LOW FCI	.	.	.	.	.	.	.	1.05	.	.	1.05
BUTNER MED I FCI	.	.	.	.	.	7.42	.	9.89	.	.	17.31
BUTNER MED II FCI	.	.	.	.	.	.	.	14.70	.	.	14.70
CANAAN USP	.	3.10	.	.	2.33	.	.	90.70	.	.	96.12
CARSWELL FMC	.	.	.	.	5.42	3.61	.	21.68	.	.	30.71
CHICAGO MCC	.	.	.	.	.	.	.	20.83	.	.	20.83
COLEMAN I USP	.	5.22	.	.	2.24	1.49	.	37.29	.	.	46.23
COLEMAN II USP	.	.90	.	.	4.48	3.58	.	51.08	.	.	60.04
COLEMAN LOW FCI	.	.98	.	.	.	.	.	6.40	.	.	7.38
COLEMAN MED FCI	.	.	.	.	1.31	.	.	19.00	.	.	20.31
CUMBERLAND FCI	.	.	.	.	.98	.	.	9.79	.	.	10.77
DANBURY FCI	.	.87	.	.	.87	.	.	18.29	.	.	20.03
DEVENS FMC	.	.	.	.	7.06	.	1.01	10.08	.	.	18.15
DULUTH FPC	.	.	.	.	.	.	.	4.95	.	.	4.95
EDGEFIELD FCI	.	.	.	.	.	1.02	.	10.18	.	.	11.20
EL RENO FCI	.	1.69	.	.	.	.	.	32.12	.	.	33.81
ELKTON FCI	.	.	.	.	.	.	.	3.66	.	.	3.66
ENGLEWOOD FCI	.	.	.	.	4.21	1.05	.	27.40	.	.	32.67
FAIRTON FCI	.	.	.	.	.	.	1.25	17.57	.	.	18.82
FLORENCE FCI	.	.	.	.	.73	.	.	66.13	.	.	66.86
FLORENCE HIGH USP	.	9.71	.	.	1.21	1.21	.	104.37	.	.	116.50
FORREST CITY FCI	.	.	.	.	.	.	.	2.21	.	.	2.21
FORREST CITY MED FCI	.	1.84	.	.	.	.	.	14.71	.	.	16.54
FORT DIX FCI	.	1.00	.	.	1.00	.	.25	4.01	.	.	6.27
FORT WORTH ADMINISTRATIVE FMC	.	.	.	.	.	1.99	.	2.65	.	.	4.64
GILMER FCI	.	.	.	.	.	.	.	12.91	.	.	12.91
GREENVILLE FCI	.	3.07	.	.	1.54	.	.	17.67	.	.	22.27
GUAYNABO MDC	.	.90	.	.	.90	.	.	38.81	.	.	40.61
HAZELTON FCI	.	3.91	.	.	.49	.98	.49	27.87	.	.	33.74

HAZELTON USP	.	4.27	.	.	.71	.	.	53.38	.	.	58.36
HERLONG FCI	.	1.45	.	.	1.45	1.45	.	51.30	.	.	55.64
HONOLULU FDC	.	.	.	.	.	.	.	38.46	.	.	38.46
HOUSTON FDC	.	1.24	.	1.24	2.49	4.98	.	33.58	.	.	43.53
JESUP FCI	.	.	.	.	1.20	1.80	.	13.82	.	.	16.83
LA TUNA FCI	.	.	.	.	.	.	.	19.55	.	.	19.55
LEAVENWORTH FCI	.	.	.	.	1.16	.	.	29.05	.	.	30.21
LEE USP	.	2.91	.	.	3.64	1.46	.	96.14	.	.	104.15
LEWISBURG FCI	.	.	.	.	5.55	.	.	9.25	.	.	14.80
LEXINGTON FMC	.	.	.	.	.	.	.	3.90	.	.	3.90
LOMPOC FCI	.	2.36	.	.	.	.	.	9.43	.	.	11.79
LOMPOC II FCI	.	1.40	.	.	.47	1.40	.	9.81	.	.	13.08
LORETTO FCI	.	.	.	.	2.43	.	.	6.08	.	.	8.51
LOS ANGELES MDC	.	.	.	.	1.53	.	.	29.01	.	.	30.53
MANCHESTER FCI	.	.	.	.	1.84	.	.	15.65	.	.	17.50
MARIANNA FCI	.	.82	.	.	7.37	.	.	22.11	.	.	30.30
MARION FCI	.	.	.	.	.79	3.16	.	15.79	.	.	19.73
MCCREARY USP	.	.	.	.	.	.	.	79.14	.	.	79.14
MCDOWELL FCI	.	2.54	.	.	1.27	.	.	19.07	.	.	22.89
MCKEAN FCI	.	.89	.	.	.89	.	.	16.09	.	.	17.87
MEMPHIS FCI	.	.	.	.	.	.	.	4.50	.	.	4.50
MENDOTA FCI	.	2.21	.	.	8.85	1.11	.	25.44	.	.	37.61
MIAMI FCI	.	.	.	.	.	.	.	3.93	.	.	3.93
MIAMI FDC	.	2.99	.	.	.	.	.	8.97	.	.	11.96
MILAN FCI	.	.	.	.	1.91	2.55	.64	5.10	.	.64	10.83
MONTGOMERY FPC	.	.	.	.	2.84	.	.	.	.	.	2.84
MORGANTOWN FPC	.	.	.	.	.	.	.	5.10	.	.	5.10
OAKDALE I FCI	.	.	.	.	.	.	.	14.08	.	.	14.08
OAKDALE II FCI	.	.	.	.	.	.	.	3.48	.	.	3.48
OKLAHOMA CITY FTC	.	.	.	.	1.47	.	.	14.65	.	.	16.12
OTISVILLE FCI	.	1.03	.	.	.	.	.	26.83	.	.	27.86
OXFORD FCI	.	.90	.	.	.	.	.90	10.83	.	.	12.64
PEKIN FCI	.	3.91	.	.78	.	.	.	11.73	.	.	16.42
PETERSBURG FCI	.	.	.	.	.	.	.	1.63	.	.	1.63
PETERSBURG MED FCI	.	.	.	.62	.	1.23	.	10.49	.	.	12.35
PHILADELPHIA FDC	.	.	1.11	.	1.11	.	.	12.22	.	.	14.44
PHOENIX FCI	.	.	.	.	.	.	.	40.31	.	.	40.31
POLLOCK MED FCI	.	.	.	.	.	.	.	30.73	.	.	30.73
POLLOCK USP	.	1.92	.	.	.	.	.	44.19	.	.	46.11
RAY BROOK FCI	.	9.36	.	.	1.34	.	.	41.44	.	.	52.14
ROCHESTER FMC	.	1.39	.	.	2.77	1.39	.	11.10	.	.	16.64
SAFFORD FCI	.	.	.	.	1.51	.	.	13.62	.	.	15.13
SAN DIEGO MCC	.	.	.	.	1.41	.	.	28.29	.	.	29.70
SANDSTONE FCI	.	2.57	.	.	2.57	.	.	11.15	.	.	16.30
SCHUYLKILL FCI	.	3.55	.	.	1.77	.	.	38.12	.	.	43.44
SEAGOVILLE FCI	.	.	.	.	.59	5.86	.	5.28	.	.	11.72
SEATAC FDC	.	.	.	.	1.40	1.40	.	22.47	.	.	25.28
SHERIDAN FCI	.	1.30	.	.	1.94	.	.	28.50	.	.	31.74
SPRINGFIELD USMCFP	.	1.91	.	.	2.86	.	.	14.31	.	.95	20.04
TALLADEGA FCI	.	1.73	.	.	1.73	.86	.	18.98	.	.	23.30
TALLAHASSEE FCI	.	.	.	.	.91	6.40	.	2.74	.	.	10.05
TERMINAL ISLAND FCI	.	4.22	.	.	.	.	.	3.16	.	.	7.38
TERRE HAUTE FCI	.	2.21	.	.	.	.	.	23.53	.	.	25.74
TERRE HAUTE USP	.80	3.99	.	.	3.99	.	.	60.65	.	.	69.43

TEXARKANA FCI	.	.	.	.	.	.	.	1.54	.	.	1.54
THOMSON FCI	.	.	.	.	.	.	.	6.62	.	.	6.62
THREE RIVERS FCI	.	.81	.	.	.	.	.	55.60	.	.	56.41
TUCSON FCI	.	.	.	.	2.64	.	.	5.28	.	.	7.92
TUCSON USP	.	2.48	.	.	7.45	.83	.	17.38	.	.	28.15
VICTORVILLE MED I FCI	.	.62	.	.	4.33	.	.	30.34	.	.	35.29
VICTORVILLE MED II FCI	.	.	.	.	1.34	.	.	52.31	.	.	53.66
VICTORVILLE USP	.	5.81	.	.	.83	1.66	.	80.50	.	.	88.80
WASECA FCI	.	.	.	.	3.61	2.41	.	20.48	.	.	26.51
WILLIAMSBURG FCI	.	.	.	.	.	.	.	16.99	.	.	16.99
YAZOO CITY LOW FCI	.	.71	.	.	.	.	.	5.68	.	.	6.39
YAZOO CITY LOW II FCI	.	.	.	.	.	.	.	2.22	.	.	2.22
YAZOO CITY MED FCI	.	2.08	.	.	.69	.	.	13.90	.	.	16.68



**U.S. Department of Justice
Federal Bureau of Prisons**

Health Services Division

Washington, D.C. 20534

February 28, 2025

MEMORANDUM FOR CHIEF EXECUTIVE OFFICERS

Chris A. Bina
Digitally signed by CHRISTOPHER
BINA
Date: 2025.02.28 14:19:08 -05'00'

FROM: RADM Chris A. Bina, Assistant Director
Health Services Division

SUBJECT: Executive Order 14168 Compliance

Consistent with Executive Order (EO) 14168, Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government, no Bureau of Prisons funds are to be expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex.

This policy is to be implemented in a manner consistent with applicable law including the Eighth Amendment.

cc: BOP Executive Team
Health Services Division Employees
Clinical Directors
Health Services Administrators

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JANE JONES, *et al.*,

Plaintiffs,

v.

Case No. 1:25-cv-401-RCL

PAMELA BONDI, in her official capacity as
Attorney General of the United States, *et al.*,

Defendants.

ORDER

On February 28, 2025, Plaintiffs filed an Amended Complaint [ECF No. 35] adding four new plaintiffs to this action. Am. Compl. ¶¶ 8, 11, 14, 17. The new plaintiffs are all male-to-female transgender women in the custody of the Bureau of Prisons (“BOP”), housed in women’s facilities but “facing immediate transfers to men’s facilities” and “imminent risk of losing access to the medical care they each need to treat their gender dysphoria” as a result of the implementation of Executive Order 14168. *Id.* ¶ 20. On the same day Plaintiffs filed their Amended Complaint, Plaintiffs also filed a Motion for a Temporary Restraining Order and Preliminary Injunction [ECF No. 37] (“TRO/PI Mot.”) to prevent the Government from implementing Executive Order 14168 as to the newly added plaintiffs. On March 1, the Government filed an Opposition [ECF No. 42] (“Opp’n”), and Plaintiffs filed a Reply [ECF No. 44].

The Court has reviewed the parties’ filings and determines that the same reasoning from the Court’s TRO Order in the related case, *Doe v. McHenry*, applies here. *See Doe v. McHenry*, No. 25-cv-286-RCL, 2025 WL 388218 (D.D.C. Feb. 4, 2025). The Court will only address the new arguments raised by the parties as applied to these newly added plaintiffs.

In the Court’s most recent Order in *Doe*, in which the Court granted the plaintiffs’ renewed Motion for TRO and Preliminary Injunction, the Court observed that when making housing determinations for each of the named plaintiffs, “the BOP determined that considering all statutorily and constitutionally required factors, a women’s facility was the appropriate facility for each named plaintiff.” *See* Order of February 24, 2025, *Doe v. Bondi*,¹ No. 25-cv-286 (RCL), ECF No. 55. And “the *only* change in circumstances” to justify the imminent transfer of each Plaintiff to a men’s facility was Executive Order 14168—nothing about the plaintiffs’ individual situations. *Id.*

The Government, in trying to justify the immediate transfer of Plaintiffs to men’s facilities, states that any pre-Executive Order decision to place each Plaintiff in a women’s facility was made for a “variety of reasons,” and not simply because of a finding that the plaintiffs could not be safely housed in a men’s facility. Opp’n at 2; *see* Decl. of Rick Stover, Senior Deputy Assistant Director, Designation and Sentence Computation Center, ECF No. 53-2 (“Stover Decl.”) ¶ 24 (listing reasons why some transgender inmates were housed in women’s facilities beyond just safety concerns, including because some inmates were seeking sex reassignment surgery, or because of a court order, or because “they were already being housed with women prior to coming into the FBOP’s custody”). That may be true—but it actually underscores this Court’s original reasoning. Before the Executive Order, the BOP determined that women’s facilities are the *appropriate* facilities for Plaintiffs under the prevailing legal regime “considering all statutorily and constitutionally required factors.” Order of February 24, 2025 at 2, *Doe v. Bondi*, No. 25-cv-286 (RCL). The BOP took account of court orders, settlement agreements, medical and psychological

¹ Under Fed. R. Civ. P. 25(d), Attorney General Pamela Bondi was “automatically substituted as a party” as the successor for Acting Attorney General James R. McHenry III in the *Doe* case.

records, and other applicable circumstances to place Plaintiffs in women’s facilities, despite the fact that “housing inmates with inmates of the opposite biological sex is a statistical anomaly.”² Stover Decl. ¶¶ 22, 24. Indeed, the named Plaintiffs here were housed in men’s facilities early in their incarceration, during which period they experienced numerous unspeakable harms including multiple rapes, suicide attempts, and severe psychological distress. TRO/PI Mot. at 3–6. And now, the sole reason behind summarily removing Plaintiffs from their appropriate housing assignment is the implementation of the Transfer Provision, Section 4(a), of Executive Order 14168.

The standard that Plaintiffs must meet the preliminary injunction stage is a likelihood of success on the merits on an Eighth Amendment theory of “deliberate indifference” or “failure-to-protect.” *See Doe v. McHenry*, 2025 WL 388218, at *4 (citing *Johnson v. California*, 543 U.S. 499, 511 (2005)). The Court once again concludes—as it has for each of the named plaintiffs in this action and in *Doe*—that implementation of the Transfer Provision, resulting in blanket removal of the plaintiffs from their appropriate housing placement with no discretion to place them in any women’s facility, suggests such a likelihood of success on the merits.³

The Court also reiterates that at the preliminary relief stage of litigation, the Court must consider the balance of equities and the public interest. These factors favor Plaintiffs: the

² Taking it as true that some male-to-female transgender inmates were housed in women’s facilities “due to court orders” or “as part of the terms of a settlement agreement,” then it appears that the Transfer Provision is in direct conflict with these existing orders. The Government also does not tie these proposed reasons to the individual Plaintiffs in this case—in fact, the Government names two individuals, Zoe and Mary Doe, who are not plaintiffs in this case. Stover Decl. ¶ 24.

³ The Government states that it “has no current plans to transfer Plaintiff Amy Jones.” Opp’n at 1. The Court faced this posture before in the initial TRO Order in *Doe* and concluded that, even considering the fact that BOP had not yet determined where the plaintiffs would be transferred, “[t]he plain text of the Executive Order affords the BOP no discretion to keep the plaintiffs in a female penitentiary.” *See Doe*, 2025 WL 388218, at *5. The Court “is therefore satisfied that [Amy Jones’s] Eighth Amendment claims are sufficiently ‘fit . . . for judicial decision’ at this time.” *Id.* (quoting *Abbott Lab’ys v. Gardner*, 387 U.S. 136, 149 (1967)).

Government “ha[s] not so much as alleged that the plaintiffs in this particular suit present any threat to the female inmates housed with them, or that this threat cannot be managed locally by prison staff. Thus, the public interest in seeing the plaintiffs relocated *immediately* to male facilities is slight at best.” *Id.* at *5. Therefore, a preliminary injunction to stop the implementation of the Transfer Provision as to the Plaintiffs is the appropriate relief.

The Government also continues to argue that Plaintiffs’ challenges to the Medication Provision, Section 4(c), of Executive Order 14168 are “unripe and unlikely to succeed” because “Plaintiffs cannot show that they are likely to be denied any medically necessary care.” Opp’n at 3. The Government highlights a new BOP memorandum, released on February 28, 2025, which states that compliance with the Executive Order “is to be implemented in a manner consistent with applicable law including the Eighth Amendment.” *Id.* But as the Court observed in its original TRO Order in *Doe*, “the plain text of the Executive Order affords the BOP no discretion . . . to continue providing hormonal therapy to help [Plaintiffs] conform physically to their non-birth sex.” *See Doe*, 2025 WL 388218, at *5. If anything, the BOP memorandum seems to suggest that termination of hormonal therapy is imminent, stating that “no Bureau of Prisons funds are to be expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate’s appearance to that of the opposite sex.” Ex. 2 to Opp’n, ECF No. 42-2. The Court therefore concludes again here that Plaintiffs’ challenges to the Medication Provision are ripe and likely to succeed on Eighth Amendment grounds.

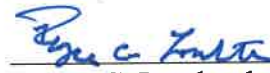
In sum, in consideration of Plaintiffs’ Motion [ECF No. 37] for a Temporary Restraining Order and Preliminary Injunction, the Opposition [ECF No. 42] thereto, the Reply [ECF No. 44], and the entire record herein, it is hereby

ORDERED that the plaintiffs' Motion for a Temporary Restraining Order and Preliminary Injunction is **GRANTED**; and it is further

ORDERED that the Defendants are hereby enjoined from implementing Sections 4(a) and 4(c) of Executive Order 14168 against Plaintiffs Amy, Barbara, Carla, and Donna Jones, pending further Order of this Court; and it is further

ORDERED that, pending further Order of this Court, Defendants shall maintain and continue the plaintiffs' housing status and medical care as they existed immediately prior to January 20, 2025.

Date: March 3, 2025
8:15 pm



Royce C. Lamberth
United States District Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JANE JONES, *et al.*,

Plaintiffs,

v.

PAMELA BONDI, in her official
capacity as Attorney General of the
United States, *et al.*,

Defendants.

Civil Docket No. 1:25-cv-401

NOTICE OF APPEAL

Defendants hereby appeal to the United States Court of Appeals for the District of Columbia Circuit from this Court's Order granting Plaintiffs' February 21, 2025, Emergency Application for a Temporary Restraining Order and Preliminary Injunction (ECF No. 28) and from the Court's Order granting Plaintiffs' February 28, 2025, Emergency Application for a Temporary Restraining Order and Preliminary Injunction (ECF No. 46).

Dated: April 2, 2025

Respectfully submitted,

YAAKOV M. ROTH
Acting Assistant Attorney General

ALEX HAAS
Director, Federal Programs Branch

JEAN LIN
Special Litigation Counsel

/s/ Elizabeth B. Layendecker
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Counsel for Defendants

**U.S. District Court
District of Columbia (Washington, DC)
CIVIL DOCKET FOR CASE #: 1:25-cv-00653-RCL**

SEALED v. SEALED

Assigned to: Judge Royce C. Lamberth

Related Case: [1:25-cv-00286-RCL](#)

Case in other court: USCA, 25-05108

Cause: 28:1331 Fed. Question: Violation 5th & 8th Amendme

Plaintiff**MARIA MOE**

Date Filed: 03/06/2025

Jury Demand: None

Nature of Suit: 550 Prisoner Petition: Civil Rights (Other)

Jurisdiction: U.S. Government Defendant

represented by **Alexander Shalom**
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V.

Defendant**DONALD J. TRUMP***in his official capacity as President of the
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Defendant**PAMELA J. BONDI***in her official capacity as Attorney
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(See above for address)

LEAD ATTORNEY

ATTORNEY TO BE NOTICED

Elizabeth Brooke Layendecker

(See above for address)

LEAD ATTORNEY

ATTORNEY TO BE NOTICED

Defendant**WILLIAM LOTHROP***in his official capacity as Acting Director
of the Federal Bureau of Prisons*represented by **Alexander James Yun**

(See above for address)

LEAD ATTORNEY

ATTORNEY TO BE NOTICED

Elizabeth Brooke Layendecker

(See above for address)

LEAD ATTORNEY

ATTORNEY TO BE NOTICED

Date Filed	#	Docket Text
01/26/2025	<u>1</u>	COMPLAINT (Redacted) against All Defendants, filed by Maria Moe. (Attachments: # <u>1</u> Civil Cover Sheet)(BAH) [Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] (Entered: 01/26/2025)
01/26/2025	2	ELECTRONIC NOTICE of Case Assignment. Judge George A. OToole, Jr assigned to case. (BAH) [Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 01/26/2025)
01/26/2025	<u>5</u>	MOTION to File under Seal, MOTION Proceed under Pseudonym, and MOTION for Protective Order by Maria Moe.(BAH) [Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 01/26/2025)
01/26/2025	<u>6</u>	MEMORANDUM in Support re <u>5</u> MOTION to Partially Seal, MOTION Proceed under Pseudonym, and MOTION for Protective Order filed by Maria Moe. (Attachments: # <u>1</u> Declaration of Jennifer L. Levi, # <u>2</u> Declaration of Lauren B. Meade, M.D., # <u>3</u> Proposed Order)(BAH) [Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 01/26/2025)
01/26/2025	7	Judge George A. OToole, Jr: ELECTRONIC ORDER entered granting <u>5</u> Motion to Seal, <u>5</u> Motion to Proceed using Pseudonym; <u>5</u> Motion for Protective Order. The motions are granted, and the case is ordered sealed, subject to further consideration by the court. (BAH) [Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 01/26/2025)
01/26/2025	<u>12</u>	Judge George A. OToole, Jr: TEMPORARY RESTRAINING ORDER, ENTERED. Motion Hearing set for 1/28/2025 at 4:00 PM in Courtroom 22 (In person only) before Judge George A. OToole Jr. (BAH) (Copy of Order provided to counsel of record by email.)[Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 01/26/2025)
01/27/2025	13	Judge George A. OToole, Jr: ELECTRONIC ORDER entered. Any response to the Plaintiff's 3 Emergency Motion for a Temporary Restraining Order and Preliminary Injunction is due by 1:00 PM on Tuesday, January 28, 2025. (FGD)[Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 01/27/2025)

01/28/2025	<u>14</u>	NOTICE of Appearance by John Robinson on behalf of Donald J. Trump, James R. McHenry, III, William Lothrop. (FGD) [Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 01/28/2025)
01/28/2025	<u>15</u>	NOTICE of Appearance by Jean Lin on behalf of Donald J. Trump, James R. McHenry, III, William Lothrop. (FGD) [Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 01/28/2025)
01/28/2025	<u>16</u>	NOTICE of Appearance by Rayford A. Farquhar on behalf of Donald J. Trump, James R. McHenry, III, William Lothrop. (FGD) [Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 01/28/2025)
01/28/2025	<u>18</u>	MOTION to Seal Document 17 Response to Motion, by Donald J. Trump, James R. McHenry, III, William Lothrop.(FGD) [Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 01/28/2025)
01/29/2025	19	Electronic Clerk's Notes for proceedings held before Judge George A. O'Toole, Jr: Case sealed. Motion Hearing held on 1/28/2025 re 3 Emergency Motion for a Temporary Restraining Order and Preliminary Injunction filed by Plaintiff. Current status of Plaintiff discussed. Parties to decide which documents will remain under seal. Merits argument continued to 2:00 PM on Thursday, January 30, 2025. (Court Reporter: Jamie Halpin at jkhhalpin@gmail.com.) (Attorneys present: J. Levi and S. Austin for the Plaintiff; R. Farquhar, J. Lin and J. Robinson for the Defendants.) (JMF) Modified on 2/6/2025 to correct date of hearing (JMF). [Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 01/29/2025)
01/29/2025	20	ELECTRONIC NOTICE Setting Hearing on Motion 3 MOTION for Temporary Restraining Order MOTION for Preliminary Injunction, <u>18</u> MOTION to Seal Document 17 Response to Motion, : Motion Hearing set for 1/30/2025 02:00 PM in Courtroom 22 (In person only) before Judge George A. O'Toole Jr.. (JMF) [Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 01/29/2025)
01/30/2025	<u>22</u>	MOTION for Leave to Appear Pro Hac Vice for admission of Amy Whelan by Maria Moe. (Attachments: # <u>1</u> Certification of Amy Whelan). (FGD) [Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 01/30/2025)
01/30/2025	<u>23</u>	MOTION for Leave to Appear Pro Hac Vice for admission of Natalie J. Kraner by Maria Moe. (Attachments: # <u>1</u> Certification of Natalie J. Kraner). (FGD) [Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 01/30/2025)
01/30/2025	<u>24</u>	MOTION for Leave to Appear Pro Hac Vice for admission of Alexander Shalom by Maria Moe. (Attachments: # <u>1</u> Certification of Alexander Shalom). (FGD) [Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 01/30/2025)
01/30/2025	<u>25</u>	MOTION for Leave to Appear Pro Hac Vice for admission of Christopher F. Stoll by Maria Moe. (Attachments: # <u>1</u> Certification of Christopher F. Stoll). (FGD) [Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 01/30/2025)
01/30/2025	<u>26</u>	MOTION for Leave to Appear Pro Hac Vice for admission of Sarah K. Austin by Maria Moe. (Attachments: # <u>1</u> Certification of Sarah K. Austin). (FGD) [Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 01/30/2025)
01/30/2025	27	Judge George A. O'Toole, Jr: ORDER entered. Order to Unseal Case. The case and docket entries <u>1</u> , <u>2</u> , and 20 shall be unsealed. All other presently sealed matters shall remain sealed until further order of the Court. (FGD)[Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 01/30/2025)

01/30/2025	28	Filing fee/payment: \$ 125, receipt number 100010474 for <u>26</u> MOTION for Leave to Appear Pro Hac Vice for admission of Sarah K. Austin. (FGD) [Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 01/30/2025)
01/30/2025	29	Judge George A. OToole, Jr: ELECTRONIC ORDER entered GRANTING <u>26</u> Motion for Leave to Appear Pro Hac Vice Added Sarah K. Austin. Attorneys admitted Pro Hac Vice must have an individual PACER account, not a shared firm account, to electronically file in the District of Massachusetts. To register for a PACER account, go the Pacer website at https://pacer.uscourts.gov/register-account. You must put the docket number under ADDITIONAL FILER INFORMATION on your form when registering or it will be rejected. Pro Hac Vice Admission Request Instructions https://www.mad.uscourts.gov/caseinfo/nextgen-pro-hac-vice.htm. A Notice of Appearance must be entered on the docket by the newly admitted attorney. (FGD) [Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 01/30/2025)
01/30/2025	30	Electronic Clerk's Notes for proceedings held before Judge George A. O'Toole, Jr: Motion Hearing held on 1/30/2025 re 3 MOTION for Temporary Restraining Order MOTION for Preliminary Injunction and <u>18</u> MOTION to Seal Document 17 Response to Motion. Counsel for Plaintiff and Defendants present. Current status of Plaintiff and Pro Hac Vice filings discussed. Arguments held re: 3 MOTION for Temporary Restraining Order MOTION for Preliminary Injunction. Matter taken under advisement. (Court Reporter: Kelly Mortellite at mortellite@gmail.com.) (Attorneys present: S. Austin and J. Levi for the Plaintiff; R. Farquhar and J. Lin for the Defendants.) (JMF) [Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 01/30/2025)
01/30/2025	<u>31</u>	Emergency MOTION for Temporary Restraining Order <i>and Preliminary Injunction</i> by Maria Moe. (Attachments: # <u>1</u> REDACTED Memorandum of Law in Support of Plaintiffs' Ex-Parte Emergency Motion for a Temporary Restraining Order and Preliminary Injunction, # <u>2</u> Declaration of Jennifer L. Levi in Support of Plaintiff's Motion for a Temporary Restraining Order/Preliminary Injunction and to Proceed Under Pseudonym, Partially Seal The Record, and for a Protective Order, # <u>3</u> REDACTED Declaration of Maria Moe's Mother, # <u>4</u> Declaration of Lauren B Meade, M.D. and Curriculum Vitae)(Klein, Bennett) [Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 01/30/2025)
01/30/2025	<u>32</u>	MOTION to Seal , <i>Proceed Under Pseudonym, and for Protective Order</i> by Maria Moe. (Attachments: # <u>1</u> Memorandum of Law in Support of Motion to Proceed Under Pseudonym, to Partially Seal Documents and for Protective Order, # <u>2</u> Declaration of Jennifer L. Levi in Support of Plaintiff's Motion for a Temporary Restraining Order/Preliminary Injunction and to Proceed Under Pseudonym, Partially Seal The Record, and for a Protective Order, # <u>3</u> REDACTED Declaration of Maria Moe's Mother, # <u>4</u> Declaration of Lauren B Meade, M.D. and Curriculum Vitae, # <u>5</u> Proposed Order Granting Plaintiff's Motion to Proceed Under Pseudonym, to File Under Seal, and for Protective Order)(Klein, Bennett)[Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 01/30/2025)
01/30/2025	<u>33</u>	REPLY to Response to <u>31</u> Emergency MOTION for Temporary Restraining Order <i>and Preliminary Injunction</i> filed by Maria Moe. (Klein, Bennett) [Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 01/30/2025)
01/31/2025	34	<u>ELECTRONIC NOTICE TO COUNSEL:</u> Pursuant to the CM/ECF Administrative Procedures Section (G) Number (4): Any memorandum of law or other attachment filed in support of a main document shall be filed as a separate document, using the proper event. For future filings, please make sure all memorandums in support and any

		exhibits are filed correctly in their own separate entry from the motion. (FGD) [Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 01/31/2025)
01/31/2025	<u>35</u>	Judge George A. OToole, Jr: ELECTRONIC ORDER entered. Docket entries 7 , <u>12</u> , 13 , <u>14</u> , <u>15</u> , <u>16</u> , and 19 shall be unsealed. All other presently sealed matters shall remain sealed until further order of the Court. The Court acknowledges <u>31</u> Emergency Motion for Temporary Restraining Order and Preliminary Injunction and <u>32</u> Motion to Seal, Proceed Under Pseudonym, and for Protective Order as redacted versions of previously-filed documents. The Court has ruled on these Motions at 7 and <u>12</u> . (FGD) [Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 01/31/2025)
02/03/2025	<u>36</u>	NOTICE of Appearance by Sarah K Austin on behalf of Maria Moe (Austin, Sarah) [Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 02/03/2025)
02/05/2025	<u>37</u>	RESPONSE to Motion re <u>31</u> Emergency MOTION for Temporary Restraining Order and Preliminary Injunction (redacted version of sealed response at ECF No. 17) filed by Donald J. Trump, James R. McHenry, III, William Lothrop. (Attachments: # <u>1</u> Declaration of Rick Stover (redacted), # <u>2</u> Transgender Offender Manual 2022, # <u>3</u> Transgender Offender Manual 2018, # <u>4</u> Keohane Order)(Robinson, John) [Transferred from Massachusetts on 2/10/2025.][Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 02/05/2025)
02/05/2025	<u>39</u>	NOTICE is hereby given that an official transcript of a proceeding has been filed by the court reporter in the above-captioned matter. Counsel are referred to the Court's Transcript Redaction Policy, available on the court website at https://www.mad.uscourts.gov/caseinfo/transcripts.htm (DRK) [Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 02/05/2025)
02/07/2025	<u>40</u>	Judge George A. OToole, Jr: ORDER entered. OPINION AND ORDER. (FGD) [Transferred from Massachusetts on 2/10/2025.] [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 02/07/2025)
02/07/2025	<u>41</u>	Case transferred to the District in which Plaintiff is currently confined; Original file certified copy of transfer order and docket sheet sent to Clerk in that district. (FGD) [Transferred from Massachusetts on 2/10/2025.][Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 02/07/2025)
02/10/2025	<u>45</u>	NOTICE of Appearance by Jessica Braverman on behalf of Maria Moe. (Braverman, Jessica) [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 02/10/2025)
02/10/2025	<u>46</u>	MOTION for Admission Pro Hac Vice for Attorney Alexander Shalom. Filing fee \$ 150, receipt number [Redacted] filed by Maria Moe. (Braverman, Jessica) [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 02/10/2025)
02/10/2025	<u>47</u>	MOTION for Admission Pro Hac Vice for Attorney Natalie J. Kraner. Filing fee \$ 150, receipt number [Redacted] filed by Maria Moe. (Braverman, Jessica) [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 02/10/2025)
02/11/2025	<u>51</u>	NOTICE of Appearance by Ann M Bildtsen on behalf of Donald J Trump, James R. McHenry, III, William Lothrop. (kt) Document QC'd on 2/27/2025 (JME). [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 02/11/2025)
02/14/2025	<u>52</u>	Motion Regarding Continued Sealing <u>45</u> Notice of Appearance, <u>50</u> Order on Motion for Pro Hac Vice, <u>49</u> Temporary Restraining Order, <u>51</u> Notice of Appearance, <u>43</u> Notice re: Non-Admitted Attorney,,,,, <u>48</u> Order on Motion for Pro Hac Vice, <u>42</u> Case Transferred In - District Transfer, <u>44</u> Notice re: Removed and Transferred Cases,, filed by Maria Moe. (Braverman, Jessica) [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 02/14/2025)
02/24/2025	<u>54</u>	SEALED LETTER to District Judge by Maria Moe. (Shalom, Alexander) [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 02/24/2025)

02/24/2025	<u>55</u>	SEALED PROPOSED ORDER TO JUDGE re Temporary Restraining Order by Maria Moe. (Shalom, Alexander) [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 02/24/2025)
02/26/2025	<u>57</u>	SEALED Plaintiff's Motion to Transfer and Supporting Memorandum of Law by Maria Moe. (Attachments: # <u>1</u> Meet and Confer Statement Pursuant to L.Civ.R.7.1(a)(1), # <u>2</u> Proposed Order)(Braverman, Jessica) Modified text/event on 2/27/2025 (CLK). Modified text on 2/27/2025 (CLK). [Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 02/26/2025)
02/27/2025	<u>58</u>	SEALED NOTICE by Donald J Trump, James R. McHenry, III, William Lothrop re <u>57</u> Sealed Document <i>Defendants' Notice of Consent to Plaintiff's Motion to Transfer Venue</i> (Bildtsen, Ann) Modified text on 2/27/2025 (MMP).[Transferred from [Redacted] on 3/6/2025.] Modified on 4/11/2025 (znmw). (Entered: 02/27/2025)
03/06/2025	<u>60</u>	Case transferred in from District of [Redacted]; Case Number [Redacted]. Original file ,transfer order and docket sheet received. Modified on 4/11/2025 (znmw). (Entered: 03/06/2025)
03/07/2025	<u>61</u>	Case directly reassigned to Judge Royce C. Lamberth as related. Judge Loren L. AliKhan is no longer assigned to the case. (ztnr) (Entered: 03/10/2025)
03/10/2025	<u>62</u>	SEALED ORDER (This document is SEALED and only available to authorized persons.) See ORDER for further details. Signed by Judge Royce C. Lamberth on 3/10/2025.(zcll) (Main Document 62 replaced on 4/3/2025) (zsmc). (Entered: 03/10/2025)
03/10/2025		Set/Reset Deadlines: Show Cause deadline as to why the case shall remain under seal due by 12:30PM EST on 3/12/2025. (zcll) (Entered: 03/10/2025)
03/17/2025	<u>63</u>	REQUEST FOR SUMMONS TO ISSUE filed by MARIA MOE. (Attachments: # <u>1</u> Summons, # <u>2</u> Summons)(zdp) (Entered: 03/21/2025)
03/21/2025		SUMMONS (3) Issued as to PAMELA BONDI, WILLIAM LOTHROP, and U.S. Attorney. (Emailed to Attorney of Record) (zdp) (Entered: 03/21/2025)
04/02/2025	<u>64</u>	ORDER: this case is hereby UNSEALED; All parties shall use the pseudonym listed in the Complaint and redact information that would identify Plaintiff in all documents filed in this action; and this case will proceed under protective order. See Order for details. Signed by Judge Royce C. Lamberth on 4/2/2025.(smc) (Entered: 04/03/2025)
04/02/2025		***Case Unsealed Pursuant to 4/2/2025 Order (zdp) (Entered: 04/04/2025)
04/02/2025	<u>65</u>	NOTICE OF APPEAL TO DC CIRCUIT COURT as to <u>62</u> Sealed Order by PAMELA J. BONDI, WILLIAM LOTHROP, DONALD J. TRUMP. Fee Status: NO Fee Paid. Parties have been notified. (zdp) (Entered: 04/07/2025)
04/07/2025	<u>66</u>	Transmission of the Notice of Appeal, Order Appealed (Memorandum Opinion), and Docket Sheet to US Court of Appeals. The Court of Appeals docketing fee was not paid because the appeal was filed by the government re <u>65</u> Notice of Appeal to DC Circuit Court. (zdp) (Entered: 04/07/2025)
04/09/2025		USCA Case Number 25-5108 for <u>65</u> Notice of Appeal to DC Circuit Court filed by DONALD J. TRUMP, PAMELA J. BONDI, WILLIAM LOTHROP. (zdp) (Entered: 04/09/2025)
04/10/2025	<u>67</u>	ORDER: this case is hereby UNSEALED; All parties shall use the pseudonym listed in the Complaint and redact information that would identify Plaintiff in all documents filed in this action; this case will proceed under protective order; and the Court's prior unsealing order <u>64</u> is amended as noted in this Order. See Order for details.(smc) (Entered: 04/10/2025)
04/11/2025		***Case Unsealed pursuant to <u>67</u> Order filed 4/10/2025. (znmw) (Entered: 04/11/2025)
04/14/2025	<u>68</u>	NOTICE of Appearance by Alexander Shalom on behalf of MARIA MOE (Shalom, Alexander) (Entered: 04/14/2025)

04/16/2025	<u>69</u>	NOTICE of Appearance by Alexander James Yun on behalf of All Defendants (Yun, Alexander) (Entered: 04/16/2025)
04/18/2025	<u>70</u>	NOTICE of Appearance by Jennifer Levi on behalf of All Plaintiffs (Levi, Jennifer) (Main Document 70 replaced on 4/18/2025) (zdp). (Entered: 04/18/2025)
04/18/2025	<u>71</u>	MOTION for Leave to Appear Pro Hac Vice :Attorney Name– Sarah K. Austin, Filing fee \$ 100, receipt number ADCDC–11627008. Fee Status: Fee Paid. by MARIA MOE. (Attachments: # <u>1</u> Declaration Declaration of Sarah K. Austin, # <u>2</u> Exhibit Certificate of Good Standing, # <u>3</u> Text of Proposed Order)(Levi, Jennifer) (Entered: 04/18/2025)
04/30/2025	<u>72</u>	Consent MOTION to Stay by PAMELA J. BONDI, WILLIAM LOTHROP, DONALD J. TRUMP. (Attachments: # <u>1</u> Text of Proposed Order)(Yun, Alexander) (Entered: 04/30/2025)

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

MARIA MOE,

Plaintiff,

v.

DONALD TRUMP, in his official capacity as
President of the United States; JAMES R.
MCHENRY III, in his official capacity as Acting
Attorney General of the United States; WILLIAM
LOTHROP, in his official capacity as Acting
Director of the Federal Bureau of Prisons,

Defendants.

Civil Action No. 1:25-cv-10195

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

1. This Action is a federal constitutional challenge to Sections 4(a) and 4(c) of Executive Order 14166, titled “Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government,” which President Donald Trump issued just hours after his inauguration on January 20, 2025. The Order directly targets transgender Americans by attempting to deny them legal recognition under federal law and to strip them of long-established legal protections. Under Sections 4(a) and 4(c) of the Order, transgender women who are incarcerated in federal prisons will be unlawfully transferred to men’s facilities and denied medically necessary healthcare.

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2. Plaintiff Maria Moe is an adult transgender woman incarcerated in a low-security federal prison for women [REDACTED]. Maria Moe is diagnosed with gender dysphoria, a rare but serious medical condition and disability. The medical standard of care for treatment of gender dysphoria is to allow a transgender person to live in a sex different than their birth sex through counseling, medications, surgical care, and social transition.

3. Consistent with this standard of care, Maria Moe has lived as a woman and has taken hormones continuously since she was a teenager. During her term of incarceration, she has always been treated as a woman by federal correctional officials and her peers. She has never been housed in a men's facility and has never stopped taking hormones. Until January 23, 2025, publicly available records from the Bureau of Prisons (BOP) identified her sex as "female." On January 25, the same records classified her as "male" because of the Executive Order.

4. On January 21, 2025, one day after Defendant Trump signed Executive Order 14166, BOP officials removed Maria Moe from the general population at [REDACTED] and placed her in the Special Housing Unit (SHU). BOP officials informed her that because of the Order, she was being transferred to a men's facility. Maria Moe remains in the SHU pending transfer. She has not been permitted to have contact with others for at least four days.

5. If Maria Moe is transferred to a men's facility, she will not be safe. She will be at an extremely high risk of harassment, abuse, violence, and sexual assault. She may be subject to strip searches by male correctional officers. She may be forced to shower in full view of men who are incarcerated. And she will predictably experience worsening gender dysphoria, which can lead to serious harm, including dramatically increased rates of suicidality and depression.

6. Maria Moe is also at imminent risk of losing access to the medical care she needs to treat her gender dysphoria. Executive Order 14166 singles out transgender people to deny them essential healthcare, including medications that BOP may continue to provide to non-transgender people. The Order categorically bans transgender healthcare regardless of medical necessity. It prohibits prison medical providers from treating transgender patients' gender dysphoria on an individual basis according to independent medical judgment. This blanket ban will deprive Maria Moe of essential medication she has taken continuously since she was a teenager, putting her at high risk of serious harm.

7. Maria Moe brings claims for violations of the Fifth Amendment to the United States Constitution; the Eighth Amendment to the United States Constitution; the Rehabilitation Act of 1973, 29 U.S.C. § 701, *et seq.*; and the Administrative Procedure Act, 5 U.S.C. §§ 701–06. Maria Moe seeks declaratory and injunctive relief to enjoin enforcement of Sections 4(a) and 4(c) of Executive Order 14166. Without the injunctive relief sought, Maria Moe will experience irreparable injury.

JURISDICTION AND VENUE

8. This action arises under the Constitution of the United States. This Court has subject matter jurisdiction pursuant to 28 U.S.C. § 1331.

9. This Court has authority to enter a declaratory judgment and to provide preliminary and permanent injunctive relief pursuant to 28 U.S.C. §§ 2201 and 2202, Fed. R. Civ. P. 57 and 65, and this Court's inherent equitable powers.

10. Venue is proper in this district under 28 U.S.C. § 1391(e)(1) because the Plaintiff is domiciled in this district.

PARTIES

11. Plaintiff Maria Moe is a transgender adult woman. She is domiciled in Massachusetts, where she resided prior to her incarceration and where she faced criminal prosecution and sentencing to BOP's custody. Maria Moe is a pseudonym.

12. Defendant Donald Trump is sued in his official capacity as the President of the United States. Defendant Trump issued and will oversee the implementation of Executive Order 14166.

13. Defendant James R. McHenry III is sued in his official capacity as Acting Attorney General of the United States. The Acting Attorney General oversees the Department of Justice, including the Bureau of Prisons, and has responsibility for overseeing the enforcement and implementation of Sections 4(a) and 4(c) of Executive Order 14166 with respect to the Bureau of Prisons.

14. Defendant William Lothrop is sued in his official capacity as Acting Director of the Federal Bureau of Prisons (BOP). The Acting Director of BOP has responsibility for overseeing enforcement and implementation of Executive Order 14166 by all BOP staff.

FACTS

I. Maria Moe's Sudden and Unjustified Removal From General Population and Risk of Transfer to a Men's Facility

15. BOP maintains separate housing facilities for men and women. With respect to transgender women, BOP applies an individualized assessment process to determine appropriate housing, consistent with the safety and security of all individuals. Based on this assessment,

transgender women may be housed in women's facilities when doing so promotes safety and security.¹

16. Maria Moe has been housed in a women's facility since her arrest. She remained in a women's facility through her arraignment, pre-sentence detention, and subsequent incarceration.

17. On January 20, 2025, the President issued an Executive Order directing the BOP to disregard its established policy and any associated safety and security risks concerning the housing and care of transgender women.

18. Pursuant to this Executive Order, the BOP removed Maria Moe from the general population of the women's facility where she had been housed.

19. Maria Moe was subsequently placed in the SHU. She was told that the reason she was removed from general population was because of the Executive Order.

20. She was also informed that she will be imminently transferred to a men's facility because of the Executive Order.

21. On January 23, 2025, Marie Moe's publicly accessible BOP classification of her sex was "female." On January 25, that classification indicated "male."

22. Maria Moe has no ability to contest her placement in the SHU, and BOP officials told her she could not challenge the transfer because it was required by the Executive Order.

¹ U.S. Dep't of Just., Transgender Offender Manual §§ 5–6 (2022), available at <https://www.bop.gov/policy/progstat/5200-08-cn-1.pdf>.

23. Maria Moe's removal from general population, placement in the SHU, and anticipated transfer to a men's facility have caused her significant distress and raise serious and imminent concerns regarding her safety and well-being.

II. Gender Dysphoria

24. Gender dysphoria a serious medical condition marked by the significant distress or impairment that occurs when a transgender individual is made to live in their birth sex. The condition is highly treatable. When left untreated, however, it causes serious physical and emotional harms.

25. Scientific and medical research also shows that gender dysphoria has a physiological and biological etiology.

26. The only current, medically accepted treatment for gender dysphoria is to enable a transgender person to live in the sex different than their birth sex.

27. The medical and scientific community recognize well-established protocols for supporting a person to go through gender transition, the treatment that allows a transgender person to live in their target sex. These protocols are endorsed by the major medical and mental health associations in the United States, including but not limited to the American Medical Association, the American Psychiatric Association, the American Psychological Association, and the Endocrine Society.

28. Under these accepted protocols, treatment for gender dysphoria can involve any combination of social transition, medications, including hormones, and a range of surgeries. The treatment prescribed for a particular patient depends on an individualized assessment of the

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patient's health and needs. Gender transition care, including hormone therapy, is a highly effective treatment for gender dysphoria.

III. Maria Moe's Gender Dysphoria Diagnosis and Gender Transition

29. Maria Moe is a [REDACTED] transgender woman from [REDACTED], Massachusetts.

30. Maria Moe identified as female at a young age. This mismatch between her birth sex and who she knew herself to be caused her significant distress, which manifested as depression, anxiety, and lack of self-esteem.

31. In middle school, Maria Moe disclosed to her mother that she felt like a girl and believed she was transgender. Her mother contacted medical and mental health providers, who diagnosed Maria with gender dysphoria.

32. Maria Moe began living as female, used a female name, and was socialized as a girl among family and friends. When she entered high school, she matriculated as a girl. Throughout her time in high school, she was integrated in the school community as other girls. She used the girls' bathroom at school, [REDACTED]
[REDACTED]

33. Based on the recommendations of her healthcare providers, Maria Moe began taking hormones to treat her gender dysphoria and to allow her to live as female at around age 15. Since then, she has continuously taken hormones to treat her gender dysphoria according to her medical providers' judgment and advice.

34. Maria Moe has lived as a woman for the last [REDACTED] years. She is acknowledged, accepted, and treated as a woman by her peers, her friends, her close family. [REDACTED]
[REDACTED]

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[REDACTED]

35. [REDACTED]

[REDACTED] she has always been housed in a women's facility while in federal custody. She has no violent disciplinary history, poses no threat to her female peers, and her presence in the women's facility has not caused any disruption or interference with prison operations.

36. [REDACTED]

[REDACTED] Prior to January 20, 2025, Maria Moe was consistently receiving this medically necessary treatment and had no reason to believe it would be terminated.

IV. Executive Order 14166 Will Cause Maria Moe Irreparable Injury

37. Executive Order 14166 began causing harm to Maria Moe almost immediately. As a result of the Order, she has already suffered significant distress. The Order also raises serious concerns for her safety and well-being going forward.

38. Section 2 of the Order includes a definition of "sex" that is intentionally designed to discriminate against transgender people. Specifically, Section 2 defines "sex" as "an individual's immutable biological classification as either male or female." In turn, it defines "male" as "a person belonging, at conception, to the sex that produces the small reproductive cell," and "female" as "a person belonging, at conception to the sex that produces the large

reproductive cell.” It includes these definitions to preclude transgender people from being able to live in a sex different than their birth sex and to deny them equal treatment.

39. Section 4(a) of the Order then directs federal agencies to implement this discriminatory provision, including requiring the Attorney General to categorically bar all transgender women from ever being housed in women’s prisons with no individualized consideration of their safety and security. That section acknowledges that the requirement contradicts federal regulations found at 28 C.F.R. § 115.41.

40. On January 21, 2025, BOP officials informed Maria Moe that because of the Order, she would be transferred to a men’s facility. They then placed her in the SHU, where she has no contact with others, pending transfer.

41. On January 25, 2025, BOP changed Maria Moe’s sex designation on publicly available records. Prior to January 25, the same records identified Maria Moe as “female.” Now, solely because of her birth sex, they designate her as “male.”

42. Maria Moe has never been housed in a men’s facility. If she is transferred to a men’s facility, she will face serious risk of victimization and sexual violence. She will not be safe. Evidence, research, case law, and practical experience show that transgender women housed in men’s prisons face near constant sexual harassment and extremely high levels of violence and sexual assault. Federal regulations recognize transgender status as a risk factor for sexual assault. *See* 28 C.F.R. §§ 115.41(d)(7), 115.42(c)–(f). A 2013 study by the Department of Justice estimated that nearly 35% of transgender inmates in state and federal prisons were sexually assaulted between 2007 and 2012. U.S. Dep’t of Justice Off. of Justice Programs, *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12*, NCJ No. 241399,

Supplemental Table 1 (2013).² From 2011 to 2012, transgender people were sexually assaulted at nearly ten times the rate for the general incarcerated population.³

43. In a men's facility, Maria Moe will be at extremely high risk of rape and sexual assault. She may also be subjected to humiliating, terrifying, and dangerous circumstances like being strip searched by male correctional officers and forced to shower among men, with her female body, including her breasts, exposed and vulnerable to sexual violence.

44. Further, Maria Moe will predictably experience a worsening gender dysphoria in a men's facility. She may be forced to wear men's clothing and undergarments, prevented from styling her hair as female, referred to as a man, and addressed by her stereotypically male former name rather than the female name she has had for over [REDACTED] years. Treating a transgender woman with gender dysphoria as a man is known to intensify dysphoria, undermine medical treatment, and increase emotional distress, and it can precipitate self-harm.

45. Section 4(c) of the Order will also cause Maria Moe serious, irreparable injury. Section 4(c) eliminates Maria Moe's ability to continue taking female hormones to treat her gender dysphoria and that her body has adjusted to receiving for the last [REDACTED] years. Specifically, the provision requires the Attorney General to "ensure that no Federal funds are expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex."

² Available at https://bjs.ojp.gov/content/pub/pdf/svpjri1112_st.pdf.

³ *Compare id.* (noting a 39.9% sexual victimization rate for transgender people from 2011 to 2012), with the full report at 6 (reflecting a 4.0% rate of sexual victimization in the general prison population from 2011 to 2012), available at <https://bjs.ojp.gov/content/pub/pdf/svpjri1112.pdf>.

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46. The BOP is aware that gender dysphoria creates a serious medical need for gender transition treatments, including hormone therapy, and that Maria Moe has a serious medical need for such treatment. BOP policy expressly allows hormone therapy as a treatment for gender dysphoria based on an “individualized assessment” by medical staff.⁴ If providers determine that hormone therapy is appropriate for an individual, hormone therapy “will be provided.”⁵ Consistent with this policy, the BOP has consistently provided hormone therapy to Maria Moe for years.

47. If Maria Moe’s medically necessary treatment for gender dysphoria is terminated or restricted under Section 4(c), she will be at a well-known and substantial risk of serious harm. Medical professionals experienced in the treatment of gender dysphoria and in the prolonged use of hormones for medical care recognize that the abrupt termination and ongoing denial of hormone therapy can have disastrous consequences, including serious risk of permanent physical and emotional harm, severe danger of self-mutilation, and suicidal ideation and attempts.

48. In addition, Ms. Doe [REDACTED]

[REDACTED]

[REDACTED]

⁴ U.S. Dep’t of Just., Transgender Offender Manual § 8 (2022), available at <https://www.bop.gov/policy/progstat/5200-08-cn-1.pdf>.

⁵ *Id.*

V. **Executive Order 14166 Facially Classifies on Behalf of Sex and Transgender Status and Was Motivated By Discriminatory Animus**

49. Executive Order 14166 classifies individuals on the basis of sex and transgender status. It was motivated by a sex-based discriminatory purpose and animus against transgender people.

50. Defendant Trump has been transparent about his hostility toward transgender people and openly stated his intentions to create legal obstacles to eliminate legal protections for transgender people and to deter them from obtaining medical care or being able to live in a sex other than their birth sex. On November 15, 2022, when he announced his candidacy for President, he explicitly promised to target transgender Americans through executive action.⁶ He pledged a “day one” executive order to “cease all programs that promote the concept of sex and gender transition at any age.”⁷

51. Throughout his campaign, Defendant Trump repeatedly characterized transgender Americans in dehumanizing terms, referring to them as “deranged,”⁸ and victims of “madness”⁹

⁶ ABC Action News, *(Full Speech) Former President Trump announces 2024 presidential bid* at 48:40-49:13, YouTube (Nov. 15, 2022), https://www.youtube.com/watch?v=8tSYwJ1_htE; *id.* at 50:39-53 (suggesting he would attempt to ban transgender people from military service).

⁷ *President Trump’s Plan to Protect Children from Left-Wing Gender Insanity*, Trump Vance: Make America Great Again! 2025 (Feb. 1, 2023), <https://www.donaldjtrump.com/agenda47/president-trumps-plan-to-protect-children-from-left-wing-gender-insanity>.

⁸ Gabriel Bertrand, *Trump’s Shocking Admission Exposes GOP’s Bigoted Agenda*, Medium (June 17, 2023), <https://medium.com/illumination/trumps-shocking-admission-exposes-gop-s-bigoted-agenda-e981becb2c5f>.

⁹ *President Trump’s Plan to Protect Children from Left-Wing Gender Insanity*, *supra* note 7.

and “insanity.”¹⁰ He falsely claimed transgender identity was “never heard of in all of human history” and described transgender healthcare as “mutilation.”¹¹

52. Defendant Trump’s campaign devoted substantial resources to promoting anti-transgender policies, spending approximately \$215 million on advertisements vilifying transgender Americans.¹² These advertisements comprised over 40 percent of all pro-Trump campaign messaging in the weeks before the 2024 election.¹³

53. Defendant Trump’s official campaign platform included a “Plan to Protect Children from Left-Wing Gender Insanity,” which promised to deny legal recognition to transgender Americans and restrict access to medically necessary healthcare.¹⁴

¹⁰ Jackson Walker, *Trump vows to remove 'transgender insanity' and critical race theory from US schools*, IdahoNews (Dec. 23, 2024, 8:37AM), <https://idahonews.com/news/nation-world/trump-vows-to-remove-transgender-insanity-and-critical-race-theory-from-us-schools-phoenix-arizona-woke-speech-usa-donald-president-white-house-education-department-crt-transgender-lgbt>; *Trump and Vance make anti-transgender attacks central to their campaign's closing argument*, NBC News (Nov. 1, 2024, 10:23 AM), <https://www.nbcnews.com/nbc-out/out-politics-and-policy/donald-trump-jd-vance-transgender-2024-election-rcna178390>; Donald J. Trump, Truth Social (Dec. 18, 2023), <https://truthsocial.com/@realDonaldTrump/posts/111599880929254153>; Gabriel Bertrand, *supra* note 8; Joe Middleton, *Trump attacks transgender rights at Waco rally saying he will ban 'disfigurement of our youth'*, The Independent (Mar. 26, 2023), <https://www.independent.co.uk/news/world/americas/donald-trump-transgender-waco-rally-b2308177.html>.

¹¹ *President Trump’s Plan to Protect Children from Left-Wing Gender Insanity*, *supra* note 7.

¹² Audrey Kemp, *What Trump’s win – and \$215m worth of anti-trans ads – mean for the future of campaigning*, The Drum (Nov. 6, 2024), <https://www.thedrum.com/news/2024/11/06/after-donald-trump-s-victory-marketers-weigh-their-role-countering-divisive>.

¹³ Lauren Barrón-López et al., *Why anti-transgender political ads are dominating the airwaves this election*, PBS News (Nov. 2, 2024 5:35 PM), <https://www.pbs.org/newshour/show/why-anti-transgender-political-ads-are-dominating-the-airwaves-this-election>.

¹⁴ *President Trump’s Plan to Protect Children from Left-Wing Gender Insanity*, *supra* note 7.

54. On December 23, 2024, after winning the election, Defendant Trump reaffirmed his intent to implement discriminatory policies through executive action, stating “with a stroke of [his] pen on day one,” he would “stop the transgender lunacy” and “get transgender out of the military and out of our elementary schools and middle schools and high schools.”¹⁵

55. Executive Order 14166, issued on Defendant Trump’s first day in office, implements these campaign promises, demonstrating that the discriminatory animus expressed throughout his campaign was the driving force behind the Order's restrictions on incarcerated transgender people for medical care and housing.

56. The timing, content, and context of Executive Order 14166 demonstrate it was motivated by and implements the same discriminatory animus Defendant Trump repeatedly expressed during his campaign, rather than any legitimate government purpose.

CLAIMS FOR RELIEF

COUNT I

Challenge to Sections 4(a) and 4(c) Fifth Amendment to the United States Constitution Due Process Clause - Deprivation of Equal Protection of the Laws Against All Defendants in Their Official Capacities

57. Plaintiff incorporates all preceding paragraphs of the Complaint as though fully set forth herein.

58. Like the Equal Protection Clause of the Fourteenth Amendment, the Due Process Clause of the Fifth Amendment prohibits unwarranted discrimination by the federal government.

¹⁵ Azcentral.com and The Arizona Republic, *Turning Point USA Donald Trump full speech: The 'golden age of America' begins now, says Trump*, Youtube (Dec. 23, 2024), <https://www.youtube.com/watch?v=XuIeXJw6BA8>, at 57:02-24.

59. Sections 4(a) and 4(c) unjustifiably discriminate based on sex. They are facial sex classifications and use explicitly sex-based language to dictate government decision-making. Section 4(a) compels the BOP to exclude “males” from “women’s prisons.” Section 4(c) prohibits the use of federal funds for any medical treatment prescribed “for the purpose of conforming an inmate’s appearance *to that of the opposite sex*.” Section 4(c)’s express purpose is to deter all medical treatment deemed inconsistent with birth sex.

60. Sections 4(a) and 4(c) require BOP to treat incarcerated people differently depending on their sex. Under section 4(a), women who are not transgender can go on living in a women’s facility, while otherwise similarly situated transgender women must be transferred to a men’s facility based on their birth sex. Similarly, under Section 4(c), women who are not transgender are able to obtain the same medical treatments that are prohibited if they are prescribed for transgender women.

61. Under the Fifth Amendment, sex classifications are subject to heightened scrutiny and are presumptively unconstitutional.

62. Sections 4(a) and 4(c) also discriminate based on transgender status. Section 4(a) requires dangerous transfers to men’s facilities for all transgender women, solely because they are transgender. Section 4(c) denies medically necessary healthcare to transgender people, solely because they are transgender.

63. Under the Fifth Amendment, classifications based on transgender status are sex-based classifications that are subject to heightened scrutiny.

64. Classifications based on transgender status are also subject to heightened scrutiny because transgender people constitute a quasi-suspect class. Transgender people are a discrete

and identifiable group of people with one shared distinguishing characteristic: they identify and seek to live as a sex different than their birth sex. This defining characteristic bears no relation to a transgender person's ability to contribute to society. Nevertheless, transgender people have faced historical discrimination in law and in fact, and they have been unable to secure equality through the political process.

65. There is no legitimate penological purpose or other legitimate basis for Section 4(a)'s dangerous transfer requirement or Section 4(c)'s categorical healthcare ban.

66. Neither Section 4(a) nor Section 4(c) is narrowly tailored to further a compelling government interest or substantially related to an important government interest. Moreover, Sections 4(a) and 4(c) are not even rationally related to a government interest. Accordingly, these aspects of Executive Order 14166 violate the Fifth Amendment.

67. If Section 4(a) and 4(c) are implemented, Maria Moe will suffer irreparable injury, including serious physical, psychological and emotional harm, mental anguish, distress, humiliation, and indignity.

COUNT II

Challenge to Section 4(a) Eighth Amendment to the United States Constitution Failure to Protect Against All Defendants in Their Official Capacities

68. Plaintiff incorporates all preceding paragraphs of the Complaint as though fully set forth herein.

69. Under the Eighth Amendment, Maria Moe is entitled to be free from a known and substantial risk of serious harm while in BOP custody.

70. Transferring Maria Moe to a men’s prison will pose a substantial risk of serious harm, including an extremely high risk of violence and sexual assault from other incarcerated people and BOP staff. In a men’s prison, Maria Moe will also be at high risk of worsening gender dysphoria, which can lead to serious physical and mental health conditions including severe depression and suicidality. These risks are obvious, well-documented, and well known to BOP officials.

71. The risk of sexual violence to transgender people in prison is recognized in existing federal regulations. 28 C.F.R. § 115.41(d)(7) requires BOP officials to consider an individual’s transgender status as a factor increasing their “risk of sexual victimization.” An individual’s sexual victimization risk must be considered as part of all housing and transfer decisions. *Id.* § 115.41. Decisions about whether to house a transgender person in a men’s or women’s facility must be made “on a case-by-case basis” to ensure the individual’s “health and safety” and the security of the facility. *Id.* § 115.42(c). Given the extremely high safety risks for transgender people in BOP custody, housing placements for transgender people “shall be reassessed at least twice a year to review any threats to safety.” *Id.* § 115.42(d).

72. Section 4(a) of the Order contains a citation to 28 C.F.R. § 115.41, indicating that Defendant Trump was aware of transgender women’s heightened risk of sexual victimization and the federal regulatory scheme that requires individualized housing placements to ensure their safety. Nevertheless, Defendant Trump intentionally directed the Attorney General to “amend[]” § 115.41 “as necessary” to ensure that all transgender women would be transferred to men’s facilities, no matter how dangerous, without regard for their safety and security. The President’s

intentional disregard of a known and substantial risk of serious harm to transgender women in BOP custody, including Maria Moe, violates the Eighth Amendment.

73. Defendants McHenry and Lathrop are well aware of the grave risks Maria Moe will face if she is transferred to a men's prison, but they are actively enforcing Section 4(a) and have caused BOP officials to initiate her transfer anyway. Their decision to disregard the known and substantial risks of serious harm violates Maria Moe's rights under the Eighth Amendment.

74. If Section 4(a) is implemented, Maria Moe will suffer irreparable injury, including serious physical, psychological and emotional harm, mental anguish, distress, humiliation, and indignity.

COUNT III

Challenge to Section 4(c) Eighth Amendment to the United States Constitution Medical Deliberate Indifference Against All Defendants in Their Official Capacities

75. Plaintiff incorporates all preceding paragraphs of the Complaint as though fully set forth herein.

76. A prison official who has knowledge of an individual's serious need for medical care and intentionally refuses to provide that care acts with deliberate indifference and therefore violates the Eighth Amendment's prohibition on cruel and unusual punishment.

77. Maria Moe has a serious medical need for hormone therapy as treatment for her gender dysphoria, which is a rare and serious health condition. Abrupt termination of this treatment would violate the applicable standard of care and subject her to a known and substantial risk of serious harm.

MATERIAL UNDER SEAL DELETED

78. Terminating Maria Moe's hormone therapy would contravene her medical providers' consistent professional judgment that she needs continuous treatment for her gender dysphoria, as both the BOP [REDACTED] have recognized. Denying Maria Moe this medically necessary healthcare would constitute deliberate indifference to her serious medical needs and would violate the Eighth Amendment's prohibition on cruel and unusual punishment.

79. Section 4(c) of the Order, which was issued by Defendant Trump and is being implemented by all other Defendants, establishes a blanket rule banning medically necessary treatments for all transgender people in BOP custody, without consideration of any individual's medical needs or their healthcare providers' independent medical judgment. As such, Section 4(c) constitutes deliberate indifference to the serious medical needs of all transgender people in BOP custody and violates the Eighth Amendment's prohibition on cruel and unusual punishment.

80. If Section 4(c) is implemented, Maria Moe will suffer irreparable injury, including serious physical, psychological and emotional harm, mental anguish, distress, humiliation, and indignity.

COUNT IV

**Challenge to Section 4(a)
Rehabilitation Act of 1973, Section 504
Failure to Accommodate a Disability
Against All Defendants in Their Official Capacities**

81. Plaintiff incorporates all preceding paragraphs of the Complaint as though fully set forth herein.

MATERIAL UNDER SEAL DELETED

82. Maria Moe has a current diagnosis of gender dysphoria as well as a record of gender dysphoria that is known to BOP officials.

83. Gender dysphoria is a serious medical condition that qualifies as a disability. It is a physical impairment that substantially limits the major life activities of interacting with others, reproduction, social and occupational functioning, and caring for oneself.

84. Housing Maria Moe in a women's facility is a reasonable accommodation for her gender dysphoria and is part of the recommended treatment protocol set forth by the applicable standards of care and clinical practice guidelines.

85. Continuing to house Maria Moe at [REDACTED] or another women's facility would not materially impair the safe and efficient operation of the facility or the BOP generally, present a safety hazard to any staff or other incarcerated person, threaten the security of the facility, or otherwise cause undue hardship.

86. Continuing to house Maria Moe at [REDACTED] or another women's facility would not fundamentally alter the nature of any service, program, or activity.

87. Involuntarily transferring Maria Moe to a men's facility under Section 4(a) of the Order would be a cruel and unnecessary revocation of this reasonable accommodation and would deny her equal benefits of correctional and rehabilitative programs and services, including but not limited to safe housing, showers, and healthcare consistent with accepted medical standards. Accordingly, Section 4(a) violates Section 504 of the Rehabilitation Act of 1973.

88. If Section 4(a) is implemented, Maria Moe will suffer irreparable injury, including serious physical, psychological and emotional harm, mental anguish, distress, humiliation, and indignity.

COUNT V

**Challenge to Section 4(c)
Rehabilitation Act of 1973, Section 504
Disability Discrimination
Against All Defendants in Their Official Capacities**

89. Plaintiff incorporates all preceding paragraphs of the Complaint as though fully set forth herein.

90. Section 4(c) categorically bans medical treatments, regardless of medical need, if they are prescribed to “conform[] an inmate’s appearance to that of the opposite sex”—meaning treatments are banned only if they are prescribed to treat gender dysphoria.

91. Section 4(c) discriminates based on disability by excluding people with gender dysphoria, including Maria Moe, from accessing medically necessary healthcare services that are provided to all other people in BOP custody based on medical need. Accordingly, Section 4(c) violates Section 504 of the Rehabilitation Act of 1973.

92. If Section 4(c) is implemented, Maria Moe will suffer irreparable injury, including serious physical, psychological and emotional harm, mental anguish, distress, humiliation, and indignity.

COUNT VI

**Challenge to Sections 4(a) and 4(c)
Administrative Procedures Act
Arbitrary and Capricious, Unlawful, and Unconstitutional Agency Action
Taken Without Observance of Procedure Required By Law
Against Defendant Lothrop in His Official Capacity**

93. Plaintiff incorporates all preceding paragraphs of the Complaint as though fully set forth herein.

94. BOP's actions to implement Sections 2, 4(a), and 4(c) of the Executive Order constitute final agency action that has harmed Maria Moe, affected her legal rights, and subjected her to an imminent risk of further harm.

95. BOP's decision to transfer Maria Moe to a men's facility and the imminent threat to deny her necessary medical care solely because of her birth sex and transgender status are unconstitutional.

96. BOP's decision to transfer Maria Moe to a men's facility solely because of her birth sex and transgender status is arbitrary and capricious.

97. BOP's decision to deny Maria Moe medically necessary care to treat her gender dysphoria solely because of her birth sex and transgender status is arbitrary and capricious.

98. BOP's decision to transfer Maria Moe to a men's facility solely because of her birth sex and transgender status is contrary to law as set forth in 28 C.F.R. §§ 115.41–42.

99. For BOP's transfer decision to be lawful, amendments to 28 C.F.R. §§ 115.41–42 would have to be made through notice-and-comment rulemaking. Section 4(a) directs the Attorney General to make such an "amendment," but no amendment has been made at this time. BOP's decision to transfer Maria Moe prior to a valid amendment to 28 C.F.R. §§ 115.41–42 was made without observance of procedure required by law.

100. BOP's decision to transfer Maria Moe without conducting an individualized assessment of all relevant circumstances, including her safety, was made without observance of procedure required by law.

101. If Sections 4(a) and 4(c) are implemented, Maria Moe will suffer irreparable injury, including serious physical, psychological and emotional harm, mental anguish, distress, humiliation, and indignity.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff requests that this Court grant the following relief:

- (1) Issue a judgment under 28 U.S.C. §§ 2201–02 declaring that Sections 4(a) and 4(c) of Executive Order 14166 violate Plaintiff’s rights under the Fifth and Eighth Amendments to the United States Constitution, the Rehabilitation Act of 1973, and the Administrative Procedure Act for the reasons and on the Counts set forth above;
- (2) Enter a preliminary and permanent injunction prohibiting Defendants and their officers, employees, servants, agents, appointees, and successors from enforcing Sections 4(a) and 4(c) of Executive Order 14166, and requiring Defendants to maintain Plaintiff’s housing and medical treatment consistent with the status quo before January 20, 2025;
- (3) Award Plaintiff nominal damages, as well as her costs, expenses, and reasonable attorneys’ fees pursuant to 28 U.S.C. § 2412, 42 U.S.C. § 12205, and other applicable laws; and
- (4) Grant such other and further relief as the Court deems just and proper.

Respectfully submitted,

/s/Jennifer Levi
Jennifer L. Levi (Bar No. 562298)
Bennett Klein (Bar No. 550702)
Sarah Austin (*pro hac vice* pending)
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The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. (SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)

I. (a) PLAINTIFFS

Maria Moe

(b) County of Residence of First Listed Plaintiff Essex
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys (Firm Name, Address, and Telephone Number)

GLBTQ Legal Advocates & Defenders; National Center
for Lesbian Rights; Lowenstein Sandler, LLP

DEFENDANTS

Donald Trump (official capacity), et al.

County of Residence of First Listed Defendant _____
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF
THE TRACT OF LAND INVOLVED.

Attorneys (If Known)

II. BASIS OF JURISDICTION (Place an "X" in One Box Only)

- ☐ 1 U.S. Government Plaintiff ☐ 3 Federal Question (U.S. Government Not a Party)
- ☒ 2 U.S. Government Defendant ☐ 4 Diversity (Indicate Citizenship of Parties in Item III)

III. CITIZENSHIP OF PRINCIPAL PARTIES (Place an "X" in One Box for Plaintiff and One Box for Defendant)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated or Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated and Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT (Place an "X" in One Box Only)

Click here for: [Nature of Suit Code Descriptions.](#)

CONTRACT	TORTS	FORFEITURE/PENALTY	BANKRUPTCY	OTHER STATUTES
☐ 110 Insurance ☐ 120 Marine ☐ 130 Miller Act ☐ 140 Negotiable Instrument ☐ 150 Recovery of Overpayment & Enforcement of Judgment ☐ 151 Medicare Act ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans) ☐ 153 Recovery of Overpayment of Veteran's Benefits ☐ 160 Stockholders' Suits ☐ 190 Other Contract ☐ 195 Contract Product Liability ☐ 196 Franchise	PERSONAL INJURY ☐ 310 Airplane ☐ 315 Airplane Product Liability ☐ 320 Assault, Libel & Slander ☐ 330 Federal Employers' Liability ☐ 340 Marine ☐ 345 Marine Product Liability ☐ 350 Motor Vehicle ☐ 355 Motor Vehicle Product Liability ☐ 360 Other Personal Injury ☐ 362 Personal Injury - Medical Malpractice PERSONAL INJURY ☐ 365 Personal Injury - Product Liability ☐ 367 Health Care/Pharmaceutical Personal Injury Product Liability ☐ 368 Asbestos Personal Injury Product Liability PERSONAL PROPERTY ☐ 370 Other Fraud ☐ 371 Truth in Lending ☐ 380 Other Personal Property Damage ☐ 385 Property Damage Product Liability	☐ 625 Drug Related Seizure of Property 21 USC 881 ☐ 690 Other LABOR ☐ 710 Fair Labor Standards Act ☐ 720 Labor/Management Relations ☐ 740 Railway Labor Act ☐ 751 Family and Medical Leave Act ☐ 790 Other Labor Litigation ☐ 791 Employee Retirement Income Security Act IMMIGRATION ☐ 462 Naturalization Application ☐ 465 Other Immigration Actions	☐ 422 Appeal 28 USC 158 ☐ 423 Withdrawal 28 USC 157 PROPERTY RIGHTS ☐ 820 Copyrights ☐ 830 Patent ☐ 835 Patent - Abbreviated New Drug Application ☐ 840 Trademark ☐ 880 Defend Trade Secrets Act of 2016 SOCIAL SECURITY ☐ 861 HIA (1395ff) ☐ 862 Black Lung (923) ☐ 863 DIWC/DIWW (405(g)) ☐ 864 SSID Title XVI ☐ 865 RSI (405(g)) FEDERAL TAX SUITS ☐ 870 Taxes (U.S. Plaintiff or Defendant) ☐ 871 IRS—Third Party 26 USC 7609	☐ 375 False Claims Act ☐ 376 Qui Tam (31 USC 3729(a)) ☐ 400 State Reapportionment ☐ 410 Antitrust ☐ 430 Banks and Banking ☐ 450 Commerce ☐ 460 Deportation ☐ 470 Racketeer Influenced and Corrupt Organizations ☐ 480 Consumer Credit (15 USC 1681 or 1692) ☐ 485 Telephone Consumer Protection Act ☐ 490 Cable/Sat TV ☐ 850 Securities/Commodities/Exchange ☐ 890 Other Statutory Actions ☐ 891 Agricultural Acts ☐ 893 Environmental Matters ☐ 895 Freedom of Information Act ☐ 896 Arbitration ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision ☐ 950 Constitutionality of State Statutes
REAL PROPERTY ☐ 210 Land Condemnation ☐ 220 Foreclosure ☐ 230 Rent Lease & Ejectment ☐ 240 Torts to Land ☐ 245 Tort Product Liability ☐ 290 All Other Real Property	CIVIL RIGHTS ☐ 440 Other Civil Rights ☐ 441 Voting ☐ 442 Employment ☐ 443 Housing/Accommodations ☐ 445 Amer. w/Disabilities - Employment ☐ 446 Amer. w/Disabilities - Other ☐ 448 Education PRISONER PETITIONS Habeas Corpus: ☐ 463 Alien Detainee ☐ 510 Motions to Vacate Sentence ☐ 530 General ☐ 535 Death Penalty Other: ☐ 540 Mandamus & Other ☒ 550 Civil Rights ☐ 555 Prison Condition ☐ 560 Civil Detainee - Conditions of Confinement			

V. ORIGIN (Place an "X" in One Box Only)

- ☐ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District (specify) ☐ 6 Multidistrict Litigation - Transfer ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing (Do not cite jurisdictional statutes unless diversity):
5 U.S.C. § 704 and the United States Constitution
Brief description of cause:
Federal constitutional challenge to Sections 4(a) and 4(c) of Executive Order 14166

VII. REQUESTED IN COMPLAINT:

☐ CHECK IF THIS IS A CLASS ACTION UNDER RULE 23, F.R.Cv.P. DEMAND \$ CHECK YES only if demanded in complaint:
JURY DEMAND: ☐ Yes ☒ No

VIII. RELATED CASE(S) IF ANY

(See instructions):

JUDGE _____ DOCKET NUMBER _____

DATE

SIGNATURE OF ATTORNEY OF RECORD

1/26/2025

/s/Jennifer Levi

FOR OFFICE USE ONLY

RECEIVED AMOUNT _____ APPLYING IFP **JA483** JUDGE _____ MAG. JUDGE _____

Additional Attorneys for Plaintiff:

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National Center for Lesbian Rights
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(415) 392-6257

Lowenstein Sandler LLP
1251 Avenue of the Americas
New York, NY 10020
(862) 926-2029

Additional Defendants:

DONALD TRUMP, in his official capacity as President of the United States;
JAMES R. MCHENRY III, in his official capacity as Acting Attorney General of the United States;
WILLIAM LOTHROP, in his official capacity as Acting Director of the Federal Bureau of Prisons

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

MARIA MOE,

Plaintiff,

v.

Civil Action No. 25-10195-GAO

DONALD TRUMP, in his official capacity as
President of the United States; JAMES R.
MCHENRY III, in his official capacity as Acting
Attorney General of the United States; WILLIAM
LOTHROP, in his official capacity as Acting
Director of the Federal Bureau of Prisons;

Defendants.

TEMPORARY RESTRAINING ORDER

Plaintiff's Motion for a Temporary Restraining Order is **GRANTED**. Defendants and their officers, employees, servants, agents, appointees, and successors are hereby enjoined from reassigning Plaintiff to another facility until this matter can be heard at a schedule hearing.

Counsel shall appear for hearing on January 28, 2025, at 4:00 p.m. in Courtroom 22, at which time the court will hear further arguments.

This Temporary Restraining Order shall become effective immediately upon entry by this Court. It shall remain in effect until further order of this Court.

DONE and Ordered this 26 day of January, 2025.

/s/ George A. O'Toole
United States District Judge

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

MARIA MOE,

Plaintiff,

v.

Civil Action No. 1:25-cv-10195

DONALD TRUMP, in his official capacity as
President of the United States; JAMES R.
MCHENRY III, in his official capacity as Acting
Attorney General of the United States; WILLIAM
LOTHROP, in his official capacity as Acting
Director of the Federal Bureau of Prisons,

Defendants.

**DECLARATION OF JENNIFER L.
LEVI IN SUPPORT OF
PLAINTIFF'S MOTIONS FOR A
TEMPORARY RESTRAINING
ORDER/PRELIMINARY
INJUNCTION AND TO
PROCEED UNDER
PSEUDONYM, PARTIALLY
SEAL THE RECORD, AND FOR A
PROTECTIVE ORDER**

I, Jennifer L. Levi, Esq., of full age, do hereby declare as follows:

1. I am an attorney in good standing with the Massachusetts Bar and licensed to practice law in the District of Massachusetts.
2. I make the following declaration based on personal knowledge and pursuant to Fed. R. Civ. P. 65(b).
3. Ms. Moe, a transgender woman who has been housed in women's prisons for several years, faces imminent transfer to a men's prison and cessation of medically necessary treatment for gender dysphoria.
4. As of Thursday, January 23, 2025, the Federal Bureau of Prisons website listed Ms. Moe as female. By Saturday, January 25, 2025, the website had changed her sex to male, as directed by Executive Order 14166, Sections 2 and 3(b).

5. Plaintiff is filing this Emergency Motion for a Temporary Restraining Order, which seeks to preserve the *status quo* prior to January 20, 2025, when the Executive Order was issued, while the parties litigate the constitutionality and lawfulness of certain provisions of the Executive Order. Because of the serious risk of irreparable harm, the imminence of the transfer, and the time sensitivity involved in getting immediate relief from this Court, Plaintiff's counsel filed the Emergency Motion *ex parte* and without notice to Defendants.

6. In conjunction with the Complaint and Emergency Motion, Plaintiff's counsel also filed a Motion To Proceed Under a Pseudonym, To Partially Seal Documents, and for a Protective Order. This motion is based on the specific potential harms that would follow from revealing Ms. Moe's identity, including the potential risk to her of violence in the corrections system and the violation of her interest in maintaining privacy of her medical status, history and records.

7. All redactions proposed for the partially sealed documents stem from the necessity to protect her identity, as set forth below.

8. The locations of Ms. Moe's current and former correctional facilities are redacted because of the limited number of incarcerated transgender women at those facilities. If the facilities are identified, Ms. Moe's identity could be easily surmised from among a small number of transgender women at those facilities.

9. Similarly, Ms. Moe's age, place of residence, and details of her school experiences are redacted because Ms. Moe is likely one of a very few transgender women from her hometown and of her age who are incarcerated at a federal correctional facility. If her age, place of residence, or school activities are identified, it would likely lead to her being publicly identified.

10. Specific biographical details concerning Ms. Moe are redacted, including her current and former names, date of birth, and the identity of her parent. Any one of these details would also provide an easy means of identification with minimal internet or public records research.

11. Details of Ms. Moe's medical records, medical treatment, and mental health issues outside of her gender dysphoria treatment are redacted because the confluence of these records could easily identify her to those that are aware of her other medical diagnosis/diagnoses.

12. Certain details from Ms. Moe's sentencing, such as quotes from the sentencing judge, are redacted because they can be directly tied to Ms. Moe's criminal case via public records. Performing a search for these details would easily yield results from her case and thus reveal her identity.

13. Certain details about Ms. Moe's time in federal correctional facilities are redacted, including the period of her incarceration and any disciplinary record, rehabilitation activities, and medical care she has received. Individuals within the correctional facility or those with whom they might communicate are likely aware of these details of Ms. Moe's time in federal custody and would be able to guess her identity if they were left unredacted.

14. Information about Ms. Moe's relationship and information related to her lawyer's representation of her are also confidential and entitled to privacy protections.

Pursuant to 28 U.S.C. § 1746, I affirm under penalty of perjury that the above statements are true and correct.

Dated: January 26, 2025

Respectfully submitted,

/s/ Jennifer Levi

Jennifer L. Levi (Bar No. 562298)
GLBTQ Legal Advocates & Defenders
18 Tremont Street, Suite 950
Boston, MA 02108
(617) 426-1350
jlevi@glad.org

MATERIAL UNDER SEAL DELETED

I, [REDACTED], make the following declaration based on my personal knowledge and declare under the penalty of perjury pursuant to 28 U.S.C § 1746 that the following is true and correct:

1. My name is [REDACTED]. I am the mother of [REDACTED], who is incarcerated in the Bureau of Prisons. I am submitting this declaration in support of my daughter's request for relief.
2. [REDACTED] was born on [REDACTED]. She is my only child. Her original name was [REDACTED]. From a young age, I remember noticing things about [REDACTED] that didn't quite match what I saw among her peers. It wasn't anything dramatic—just little things, like the way [REDACTED] seemed to gravitate toward dolls or how she carried herself or dressed in ways that felt unique compared to other kids. At the time, I didn't think too much of it—I just figured she was her own unique person, a bit outside the mold. In middle school, she initially shared with me that she thought she was gay but soon came back to tell me that she felt like a girl, thought she was a girl, and believed herself to be transgender. I told her I loved her, of course. I also wanted to be sure that she and our family had the medical and mental health support to be able to provide her the support she needed. That began a process of reaching out to medical and mental health providers.
3. Working with therapists and doctors, we learned that [REDACTED] had gender dysphoria. Based on professional recommendations and with the support of her providers, [REDACTED] stopped using her male birth name, began using female

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pronouns, and living as a girl. Students at her high school who had known her throughout her life knew that she was a transgender girl, so she encountered some initial hostility, but—especially with her core group of friends—she was eventually embraced and accepted as a young woman.

4. [REDACTED] was largely succeeding academically, but for a range of reasons relating to her experience and family history she was [REDACTED]
[REDACTED]
[REDACTED]. By her sophomore year in high school, [REDACTED], our family found a doctor for [REDACTED] who specialized in providing healthcare to transgender young adults. Under his care, she initiated hormone replacement therapy to bring her body into alignment with typical female ranges. I have seen over the years the impact of the hormone therapy on her. She has a female body, soft facial features, hips, and breasts.
5. The same doctor who provided her with transgender health care also treated [REDACTED] that she has had since she was [REDACTED]. The doctor ensured that the prescribed hormones worked in conjunction with the [REDACTED] medicine that she took.
6. In [REDACTED] grade, [REDACTED] joined the cheerleading squad and continued in school, ultimately graduating in June [REDACTED]. She finished her degree in the school's home

MATERIAL UNDER SEAL DELETED

instruction program. After graduation, she worked part time until her arrest in

[REDACTED].

7. After [REDACTED]'s arraignment, she was housed in a federal detention facility in

[REDACTED]. While she was

there, we spoke several times per week. [REDACTED] was initially housed in an

individual unit but soon thereafter was housed exclusively with women. While

[REDACTED] was at [REDACTED], she continued to receive hormone therapy. She also

continued to receive [REDACTED] medication.

8. After [REDACTED] was sentenced, she was sent to [REDACTED]. In her approximately

[REDACTED], a women's prison, [REDACTED] continued to receive the

hormones she was prescribed to treat her gender dysphoria as well as the [REDACTED]

[REDACTED] medication. She was housed exclusively with women. During this time,

we continued to speak several times per week. [REDACTED]'s period of incarceration

at [REDACTED] was generally unremarkable; with the exception of one infraction

for [REDACTED], I am not aware of any other disciplinary

charges against [REDACTED] while she was there.

9. In [REDACTED], [REDACTED] was transferred to [REDACTED]. That prison is also

a women's prison. Until this week, she has been housed in general population.

Other than [REDACTED]

[REDACTED], she has stayed out of trouble. At this facility, [REDACTED] has been involved

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with a program where [REDACTED]

[REDACTED]

[REDACTED] is a women's prison, the commissary provides things like makeup, female undergarments, and other items needed by the women housed there.

10. I have been able to speak to [REDACTED] during her time at [REDACTED]. She keeps me updated on her life and her medical care. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]. While at [REDACTED], [REDACTED] has continued to received hormones and [REDACTED] medication, as far as I know, both of which she has been taking for many, many years.

11. On Tuesday, January 21, 2025, I received a call from [REDACTED]. She was frantic. Through tears, she told me that she and [REDACTED] were being segregated from the rest of the prison. She was told that they were being housed in the Special Housing Unit ("SHU") and then would be sent to a transfer facility and, ultimately, to a men's prison. Later that day she called me back to say that she [REDACTED] had been told that because of an Executive Order signed by the President, they were being transferred to a men's prison.

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12. Until that transferred occurred, she was told, they would be held in the SHU.

Because people held in the SHU do not have access to the telephone, she would not be able to speak with me again until she had been transferred. She did not have any ability to contest her placement in the SHU before being sent there, or since. Similarly, she was told that did not have an ability to challenge the transfer because it was required by Executive Order. Although she was told that transfer to a new facility would happen soon, and that transfer to the SHU would be immediate, [REDACTED] was not told when, exactly, she would be transferred. I have not had any contact with [REDACTED] since Tuesday.

13. [REDACTED] is my daughter. For more than a decade, she has lived as a woman. For the [REDACTED] years during which she has been incarcerated, she has only been housed with women. [REDACTED]
[REDACTED] and being housed with women is the only way she can remain safe.

14. When your child is incarcerated, you worry about them. If [REDACTED] were transferred to a men's prison, my fears would multiply. As a mother, I am terrified for my daughter's safety and well-being if she is placed in a men's prison. My biggest fear is that she will be targeted for harassment, abuse, and violence, including rape, because she is transgender. I know how vulnerable she

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would be in that environment, surrounded by people who would see her as an easy target for violence.

15. I worry that she will get assaulted in a men's prison. Given her previous bouts with [REDACTED]

[REDACTED].

16. If [REDACTED] were forced to stop taking hormones, it would throw her body into shock. She has been taking the medications for so long that the changes they produce in her body have become a part of her. Without the medicine, [REDACTED]
[REDACTED], and I fear for her safety.

Executed on the 25th day of January in the year of 2025.

Signature:

Date: 1/25/2025

[REDACTED]

DECLARATION OF LAUREN MEADE, M.D.

I, Dr. Lauren Meade, declare:

1. I am a board-certified internal medicine doctor 19 years of experience treating transgender patients. I am familiar with standard protocols for hormone therapy and its effects. A true and correct copy of my curriculum vitae is attached.
2. Gender dysphoria is a serious medical condition that, left untreated, can result in debilitating psychological harms, including anxiety, depression, suicidality, and other mental health issues. Without treatment, many people with gender dysphoria are unable to adequately function in occupational, social or other areas of life.
3. Gender dysphoria is a highly treatable condition. The standards of care for treating gender dysphoria are well-established.
4. Treatments include social transition, which enables a transgender person to live in a sex other than their birth sex, and hormone therapy to feminize or masculinize the body. It may also include various surgeries.
5. For many transgender women, hormone therapy is an essential, medically indicated treatment to alleviate the distress of gender dysphoria.
6. For transgender women, beginning hormone therapy as a teenager will mitigate the development of some unwanted secondary sex characteristics, such as the development of facial masculinization, heavy growth of facial and body hair, and substantially increased muscle mass. If hormone therapy is stopped, the development of these characteristics will resume.
7. Discontinuing hormone therapy for transgender women who have been on long term treatment poses serious medical risks, including both severe psychological distress and physical complications.
8. These risks include:
 - Intensified gender dysphoria
 - Increased risk of severe anxiety, depression, and suicidality due to intensified gender dysphoria
 - Rapid hormonal changes that trigger severe mood swings, anxiety, and depression
 - Loss of breast tissue and feminine fat distribution
 - Development or return of unwanted and potentially irreversible masculine secondary sex characteristics, such as facial masculinization, facial and body hair growth, and increased muscle mass.

9. Over time, the negative mental and physical health impacts of being denied care are likely to worsen and to result in debilitating distress.

10. For patients with a seizure disorder, sudden estrogen withdrawal, leading to the emotional distress outlined above, may create additional serious medical risks of lowered seizure threshold.

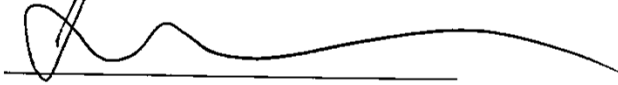
11. Based on my professional experience, terminating hormone therapy for a transgender woman constitutes a serious medical risk that can severely impact physical and mental health.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on January 25, 2025

I declare under the pains of perjury that the foregoing is true and correct.

Signed this 25th day of January, 2025.

A handwritten signature in black ink, appearing to be "Dr. Lauren Meade", written over a horizontal line.

Dr. Lauren Meade

Lauren B Meade, M.D.
Department of Medicine
Baystate Health – High Street Health Center
140 High Street
Springfield, MA 01199
(413) 794-1407
lauren.meade@baystatehealth.org

Education

M.D., University of California at San Francisco, San Francisco, California	1990-1994
B.A., Biology (<i>cum laude</i>), Highest departmental honors Sigma Xi Honor Society Smith College Northampton, Massachusetts	1983-1987

Postdoctoral Training

Internal Medicine, Residency, Baystate Medical Center, Springfield, Massachusetts	1995-1997
Internal Medicine, Internship, Yale-New Haven Hospital, New Haven, Connecticut	1994-1995

Academic Appointments

Associate Professor Department of Medicine, Tufts University School of Medicine, Boston MA	2014-present
Assistant Professor Department of Medicine, Tufts University School of Medicine, Boston MA	1997-2014

Other Positions and Employment

Primary Care, High Street Health Center, Springfield, MA	1997-2016
Hospitalist, Baystate Medical Center, Springfield, MA	1997-2016
Substance Abuse Primary Care, High Street Health Center, Springfield, MA	2000-2013
Women's Health Primary Care, High Street Health Center, Springfield, MA	1997-2013
HIV Primary Care, High Street Health Center, Springfield, MA	1997-2011
Correctional Health, Hamden County Correctional Facility, Springfield ,MA	2000-2007

Honors and Awards

Macy Faculty Scholars Award, The Josiah Macy Jr. Foundation	2013-2015
Massachusetts Medical Society Lesbian Gay Bisexual Transgender Award, Waltham, MA	2014
Fellow, American College of Internal Medicine, Philadelphia, PA	2014
Third Year Clerkship Faculty Recognition for Excellence in Teaching, Tufts University School of Medicine, Boston, MA	2013
Third Year Clerkship Faculty Recognition for Excellence in Teaching, Tufts University School of Medicine, Boston, MA	2012
Physician Spotlight, Baystate Medical Practice Bulletin, Baystate Medical Center, Springfield, MA	2011
Paul Winske Access Award, Stavros, Advocates for Independent Living, Springfield, MA	2011
Third Year Clerkship Faculty Recognition for Excellence in Teaching, Tufts University School of Medicine, Boston, MA	2009

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Oliver Wendell Holmes Stethoscope Award, Hamden District Medical Society, Holyoke, MA	2005
Third Year Clerkship Faculty Recognition for Excellence in Teaching, Tufts University School of Medicine, Boston, MA	2005
House Staff Recognition Award for Teaching in Excellence, Baystate Medical Center, Springfield, MA	2003
Award for Excellence for outstanding Achievement in HIV/AIDS, Between Family and Friends, Springfield, MA	2001
Third Year Clerkship Faculty Recognition for Excellence in Teaching, Tufts University School of Medicine, Boston, MA	2001

Educational Activities

Educational Leadership, Administration and Service

Director of Clinical Learning and Development, Sound Physicians, Tacoma, WA	2016-2018
Director of Faculty Development and Engagement, Baystate Medical Center, Springfield MA	2013-2016
Director of Faculty Development and Engagement, The Wright Center Graduate Medical Education, Scranton, PA	2012-2016
Director of the Transitions of Care rotation, 20 residents per year	2006-2016
Associate Program Director, Internal Medicine Residency	2005-2016
Clinical Competence Committee, Internal Medicine (participant)	1997-2016
Residency Education Committee, Internal Medicine (participant)	1997-2016
Faculty Development Senior Hospitalist Educators, Baystate Medical Center, Springfield, MA	2011-2015
Program for Educators in Health Professions, Harvard Macy Institute, Faculty	2015
Co-Course Director, Academic Half Day, Internal Medicine Residency, Baystate Medical Center, Springfield, MA	2013-2014
Women's Health Track Director, Internal Medicine Residents	2000-2013
Women's Health Medical Student Clerkship Director	2000-2011
Tufts University School of Medicine Faculty Senate (participant)	2006-2009
Tufts University School of Medicine Clinical Faculty Subcommittee (participant)	2006-2009
HIV/AIDS lectures, 60 residents per year	1996-2006
Medical Clerkship Director, Springfield College Physician Assistant Students	1998-2000

Teaching Activities in Programs and Courses

Mortality and Morbidity Ambulatory Report, 60 residents per year; 3 hours/year; 3 1 hour small group teaching, Wright Center for Medical Education, Scranton PA	2012-2015
Tracer Rounds; 20 clerks/year; 20 residents per year; 80 hours/year; 2 hours per week, small group teaching	2005-2015
Palliative Care and Hospice, 60 residents per year	1999-2013
Mortality and Morbidity Ambulatory Report, 30 clerks/year; 60 residents per year; 48 hours/year; 1 hour per week small group teaching	2006 - 2011
Getting Energized, Baystate Academic Affairs, 300 residents	2010

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Women's Health Elective Clerkship; 1-3 clerks per year; 2-3 residents per year, 20 hours per clerk/resident; 2-4 week elective with exposure to office gynecology, breast cancer screening, gynecologic oncology, urogynecology, hospice, family planning and colonoscopy.	1998-2010
Diversity and Inclusion, Baystate Academic Affairs, 300 residents	2009
Transgender Health, Baystate Academic Affairs, 300 residents	2008
HIV/AIDS lectures, Springfield College Physician Assistant Program, 3rd year student	1996-2007
Sexual Harassment, Baystate Academic Affairs, 300 residents	2007
Women's Health Curriculum; 60 residents per year; 4 hours per year; 4 lectures per year, lecture topics including Sexually Transmitted Diseases, Contraception, Domestic Violence and Cervical Cancer Screening.	1996-2006
HIV/AIDS Curriculum; 60 residents per year; 4 hours per year; 4 lectures per year; lecture topics including acute HIV, HIV treatment, Opportunistic Infections, Sexually Transmitted Diseases and HIV medication adherence principles.	1996-2006
Substance Abuse Curriculum; 60 residents per year, 2 hours per year; 2 lectures per year on topics including alcoholism and narcotic addiction	1996-2004
Women's Health Journal Club; 1-5 residents per year; 6 hours per year; monthly journal club presentation.	1998-2002

Clinical Education

University of Massachusetts Medical School-Baystate, Springfield, MA

Population Health Clerkship Academic Faculty, 1 st year, 4 students, 8 hours over 2 week clerkship	2019 - 2020
Ambulatory Precepting; 6 - 12 residents/year; 12 hours per week, High Street Health Center	2018-present
PURCH Medical Student, 1 st year, longitudinal preceptor, High Street Health Center, 32 hours per year	2018-2019
PURCH Medical Student, longitudinal 1 st – 4 th year, Capstone advisor, High Street Health Center, 12 hours per year	2018-2021

Tufts University School of Medicine/Baystate, Springfield, MA

Ambulatory Attending Rounds; prepared and delivered curriculum at a teaching conference at the academic health center for residents and medical students, Baystate Medical Center, High Street Health Center, 4 hours per week	1996-2016
Ward Attending Rounds; 8 clerks/year; 12 -24 residents per year, 32 hours per year; 1 hours session per day; prepared and delivered curriculum at a teaching conference	1997-2015
Women's Health rotation, 20 residents per year, 1-3 medical students per year	1997-2014
HIV/AIDS rotation, 1-2 residents per year, 2 fellows per year	1997-2006
Ambulatory Attending Rounds; 8 clerks/year; 60 residents per year, 52 hours per year; 1 hours session per week; prepared and delivered curriculum at a teaching conference	1997-2006
Tufts Medical School Continuity Program; 1 clerk/year; 10 hours/year; precepted 1 medical student for a full year of continuous learning about one high utilizer patient, Baystate Medical Center	2008-2009
Tufts Medical School Mentor Program, 1 clerk/year, 3 years/year; mentored 1 medical student in a formal curriculum for supporting their career goals, Baystate Medical Center	2006-2007

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Educational Development: Curricula and Educational Materials

Mortality and Morbidity curricula, Residents; Wright Center for Graduate Medical Education; Scranton, PA; Case based interactive Mortality and Morbidity review based in safety principles.	2012 - 2015
Tracer curricula, Residents; Baystate Medical Center, Springfield, MA; Experiential learning across the transition from hospital to post-acute care with focus on route cause analysis.	2005 - 2015
Women's health curricula, Residents; Baystate Medical Center, Springfield, MA; Topic based didactic lectures in Women's Health.	1996 - 2013
Ambulatory Mortality and Morbidity curricula, Residents; Baystate Medical Center, Springfield, MA; Case based interactive Mortality and Morbidity review based in safety principles.	2006 - 2011
HIV/AIDS curricula, Medical students, PA students, Residents, Fellows; Baystate Medical Center, Springfield, MA; Topic based didactic lectures in HIV/AIDS.	1996 - 2006
Substance abuse curricula, Residents; Baystate Medical Center, Springfield, MA; Topic based didactic lectures in substance abuse.	1996 - 2004
General Medicine curricula, Residents; Baystate Medical Center, Springfield, MA; Topic based didactic lectures in General Medicine.	1999 - 2004

Advising and Mentoring

Students

Lindsay Rockwell, Internal Medicine Residency, Mentor/Advisor for a Women's Health Project, Medical Director of Hematology/Oncology, Cooley Dickenson Hospital, Northampton, MA	2000 - present
Kathleen McGraw, Internal Medicine Residency, Mentor/Advisor for a Women's Health Project, Chief Medical Officer, Brattleboro Hospitalist, Brattleboro, VT	1994-2004

Residents

Michael Rosenblum, Baystate Internal Medicine Resident, Career Mentor/Advisor Mercy Hospital, Program Director, Medicine	2001 - present
Anthony Poindexter, Baystate Internal Medicine Resident, Career Mentor/Advisor Tufts, Associate Program Director, Nephrology Fellowship	2001 - present
Patrick Mailloux, Baystate Internal Medicine Resident, Career Mentor/Advisor Tufts, Program Director, Critical Care Medicine	2001 - present
Raquel Belforti, Baystate Internal Medicine Resident, Career Mentor/Advisor Tufts, Associate Program Director, Medicine	2010 - 2013
Reham Shaaban, Baystate Internal Medicine Resident, Career Mentor/Advisor Tufts, Program Director, Medicine	2002 - 2005

Faculty

Wasique Mirza, Wright Center for Graduate Education Faculty, Career Mentor/Advisor Program Director, Wright Center for Graduate Education	2012 - present
Kathleen Suddarth, Alliance for Academic Internal Medicine, Career Mentor/Advisor Associate Program Director, University of Colorado	2008 - present
Aimee Kirsch Zaas, Alliance for Academic Internal Medicine, Career Mentor/Advisor Program Director, Medicine, Duke Medical School	2008 - present
Christine Bryson, Baystate Internal Medicine Faculty, Career Mentor/Advisor Associate Program Director, Baystate Medical Center	2000 - present

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Maria Maldonado, Alliance for Academic Internal Medicine, Career Mentor/Advisor Vice-Chair of Diversity, Assistant Professor Medicine, Mount Sinai Hospital	2000 - present
Rebecca Andrews, UCONN Faculty, Career Mentor/Advisor Ambulatory Clinic Director, UCONN Health Center	2013 - 2015

Investigation

Grants

Completed

Macy Faculty Scholars Grant: Lauren Meade, MD "Training Internal Medicine Residents in a Safe and Effective Discharge from the Hospital." Implemented an educational checklist for a safe discharge across 25 Internal Medicine programs. Total, direct & indirect costs: \$124,000 annually Role: PI (50%)	2013-2015
Robert Wood Johnson & Kelly Aiken "Care Transitions Educational Grant, Western Massachusetts Nursing Collaborative." Consultant for a grant to improve care transitions through interprofessional practice and structured nursing education. Total, direct & indirect costs: \$225,000 annually Role: Consultant (5%)	2011-2014
Tufts University School of Medicine Innovations in Education: Jasmine Paadam "Medical Students in Transitions of care." Implementing an experience learning curriculum for medical students to bridge the gap between the transition from hospital to home. Total, direct & indirect costs: \$7,500 Role: Co- Principle Investigator (10%)	2012-2013
Tufts University School of Medicine Innovations in Education: Aleah Nesteby "Increasing Competency in Transgender Care." Description (1 sentence) Total, direct & indirect costs: \$7,500 Role: Co- Principle Investigator (5%)	2012-2013
Baystate Health System Corporate Risk Management "A Prospective Study of a Pharmacy Provider Intervention to Identify Medical Errors in the Ambulatory Setting." Use of a pharmacy provider in an outpatient HIV multidisciplinary team to identify medical errors. Total, direct & indirect costs: \$72,000 Role: Co-PI 10% (Developed and implemented research)	2003-2004

In progress

UMASS Interprofessiona Education Grant
"Title"
goal
Total, direct & indirect costs: ?
Role: Co-PI (Developed and implemented research)

Health Care Delivery

Leadership Positions

Co-Director Transgender Health, High Street Medical Center, Baystate Medical Center, Springfield, MA	2006-present

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Medical Director HIV/AIDS, High Street Health Center, Baystate Medical Center, 1997-2011
Springfield, MA

Certification and Licensure

Massachusetts State Medical License (*active*) 1994-present
American Board of Internal Medicine 1997-present

Clinical Discipline

General Internal Medicine, Hospital Medicine, Ambulatory Medicine, HIV/AIDS, Women's 1997-present
Health, Correctional Health, Substance Abuse

Clinical Activities

Baystate Health, Primary Care, High Street Health Center, Springfield, MA, 44 weeks per 2018-present
year
Baystate Medical Center, Springfield, MA, Hospitalist, 12 weeks per year 1997-2016
Baystate Medical Center, Springfield, MA, Primary Care, 36 weeks per year 1997-2016
Baystate Medical Center, Springfield, MA, Substance Abuse Primary Care, 4 hours per 2000-2013
week; all year
Baystate Medical Center, Springfield, MA, Women's Health Primary Care, 4 hours per 1997-2013
week; all year,
Baystate Medical Center, Springfield, MA, HIV Primary Care, 8 hours per week, all year 1997-2011
Hamden County Correctional Facility, Baystate Medical Center, Springfield, MA, 2000-2007
Correctional Health, 4 hours per week; all year

Clinical Innovations, Safety, and Quality Improvement Projects

Scripts to go- discharge medications, Baystate Medical Center, Springfield, MA 2014-2016
Transfer summary report for skilled nursing facility, Baystate Medical Center, Springfield, 2008-2016
MA
Medication Reconciliation, Baystate Medical Center, Springfield, MA 2000-2016
Reducing readmission from post-acute care, Baystate Medical Center, Springfield, MA 2008-2014
Assessment for visiting nursing care after discharge, Baystate Medical Center, Springfield, 2008-2010
MA
Discharge summary electronic medical record template, Baystate Medical Center, 2004-2006
Springfield, MA

Scholarship

Peer-reviewed publications

1. Fazio SB Cheda S, Hingle S, Lo MC, **Meade L**, Blanchard M, Hoellein A, Brandenburg S, Denton GD. The Challenges of Teaching Ambulatory Internal Medicine: Faculty Recruitment, Retention, and Development: An AAIM/SGIM Position Paper. Am J Med. 2017 Jan;130(1):105-110. 2017
2. **Meade L**, Suddarth KH, Jones RR, MD, Zaas AK, Albanese T, Yamazaki K, O'Malley CW. Patients, Nurses, and Physicians Developing a Discharge Direct Observation Tool. Acad Med. 2016 Oct;91(10):1388-1391. 2016
3. Ruddy MP, Thomas-Hemak L, **Meade L**. Practice Transformation: Professional Development Is Personal. Acad Med. 2016 May;91(5):624-7. 2016.

4. Denton GD, Lo MC, Brandenburg S, Hingle S, **Meade L**, Chheda S, Fazio SB, Blanchard M, Heollein A. Solutions to Common Problems in Training Learners in General Internal Medicine Ambulatory Settings. *Am J Med.* Oct;128(10):1152-7. 2015.
5. **Meade L**, Hall SL, Kleppel RW, Hinchey KT. TRACER: an 'eye-opener' to the patient experience across the transition of care in an internal medicine resident program. *J Community Hosp Intern Med Perspect.* 2015 Apr 1;5(2):26230. 2015.
6. **Meade L**, Todd CY, Walsh MM. Found in transition: applying milestones to three unique discharge curricula. *PeerJ.* 2015 Mar 5;3:e819. doi: 10.7717/peerj.819. 2015.
7. Thomas-Hemak L, Palamaner Subash Shantha G, Gollamudi LR, Sheth J, Ebersole B, Gardner KJ, Nardella J, Ruddy MP, **Meade L**. Nurturing 21st century physician knowledge, skills and attitudes with medical home innovations: the Wright Center for Graduate Medical Education teaching health center curriculum experience. *PeerJ* 2015 Feb 10;3:e766. 2015
8. Lobst W, Aagaard E, Bazari H, Brigham T, Bush RW, Caverzagie K, Chick D, Green M, Hinchey KT, Holmboe E, Hood S, Kane G, Kirk L, **Meade L**, Smith C, Swing S. Internal Medicine Milestones Journal of graduate medical education. 03/2013; 5(1 Suppl 1):14-23. 2013.
9. Caverzagie KJ, Lobst WF, Aagaard MD, Hood S, Chick DA, Kane GC, Brigham TP, Swing SR, **Meade L**, Bazari H, Bush RW, Kirk LM, Green ML, Hinchey KT, Smith CD. The Internal Medicine Reporting Milestones and the Next Accreditation System *Ann Int Med* 2013 Apr 2;158(7):557-9. 2013.
10. **Meade L**, Caverzagie KJ, Swing SR, Jones, RR; O'Malley CW, Yamazaki K, Zaas AK. Playing with milestones in the educational sandbox: Q-sort results from an educational collaborative. *Acad Med* 2013 Aug; 88(8):1142.8. 2013.
11. Heist K, Post J, Brandenburg S, **Meade L**. Milestones for Essential Ambulatory Care agreement of residents and attendings. *Am J Med.* 2013 Mar;126(3):270-4. 2013.
12. Leasure EL, Jones RR, **Meade L**, Sanger MI, Thomas KG, Tilden VP, Bowen JL, Warm EJ. There is no "I" in Teamwork in the Patient Centered Medical Home: Defining Teamwork Competencies for Academic Practice. *Acad Med.* 2013 May;88(5):585-92. 2013.
13. **Meade L**, Borden SH, McArdle P, Rosenblum MJ, Picchioni MS, Hinchey KT. From Theory to Actual Practice: Creation and application of milestones in an Internal Medicine Residency Program. *Med Teach* 2012; 34(9):717-23. 2012.
14. Heelon MW, Skiest D, Tereso G, **Meade L**, Weeks J, Pekow P, Rothberg MB. Effect of a clinical pharmacist's interventions on duration of antiretroviral-related errors in hospitalized patients. *American Journal of Health Systems Pharmacy* 2007; 64(19): 2064-2068. 2007.
15. Skiest DJ, Camelo-Piragua S, **Meade L**. Images in HIV/AIDS. "Painful oral ulcerations in a patient with AIDS." *The AIDS reader*; 16(10):531-2. 2006.
16. Heelon MW, **Meade L**. Methadone withdrawal when starting a Nevirapine containing antiretroviral regimen. *Pharmacotherapy* 1999; 19(4):471-472. 1999.
17. Topp, KS, **Meade L**, LaVail JH. Microtubule polarity in the peripheral processes of trigeminal ganglion cells: relevance for the retrograde transport of Herpes Simplex Virus. *The Journal of Neuroscience* 1994; 14(1): 318-325. 1994.
18. LaVail, JH, **Meade L**, Dawson CR. Ultrastructural immunocytochemical localization of Herpes Simplex Virus (type 1) in trigeminal ganglion neurons. *Current Eye Research* 1991; 10; 23-39. 1991

Non-peer-reviewed publications

1. **Meade L**, Grover J, Rudolph M. Speak out! Taking care of patients is what we do. Online comment. *Annals Internal Medicine* 2016 https://www.researchgate.net/publication/305082631_Non-peer_review_comment_in_Annals_of_Internal_Medicine_in_response_to_Mazor_KM_Smith_KM_Fisher_KA_Gallagher_TH_Speak_Up_Addressing_the_Paradox_Plaguing_Patient-Centered_Care_Ann_Intern_Med_2016164618. Accessed July 6 2016. Accessed July 9 2016.
2. Combs B, **Meade L**, Bollman K, Brandenburg S How to Incorporate High Value Care Curricula into Existing Educational Conferences *AAIM Insight.* 12(3)6-7 2014.
3. Ekpenyong A, Burday M, Delanoche N, Halvorson S, Raj J, **Meade L**. The AAIM Clinical Competency Committee Collaborative Learning Community. *AAIM Insight.* 13(3):18. 2015.
4. **Meade L**. Interview with Maria Maldonado, Leader in Diversity for Alliance of Academic Internal Medicine. <http://www.im.org/p/cm/ld/fid=805> Accessed on March 5, 2015.

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5. Rosenblum MJ, Borden SH, McArdle P, **Meade L**, Picchioni MS, Stefan M, Hinchey KT. Baystate Medical Center EIP Workgroup. The Baystate Manager Model. Academic Internal Medicine Insight 2007; 5(2):18. 2007.
6. **Meade L**. Regulation of hydrogen peroxide synthesis in rat thyroid gland: a cytochemical study. Thesis. Smith College. 1987.

Invited Presentations

National

Seminar: Engaging your program in the culture change of direct observation. APDIM Spring Meeting. Houston, TX	April 26, 2015
Workshop: "Applying milestones to a safe and effective discharge: lessons from the Education Research Outcomes Collaborative." AAIM Fall Meeting. Washington, DC	Sept 11, 2014
"National networking with Academic Alliance for Internal Medicine" Grand Rounds, Wright Center, Scranton, PA	Aug 19, 2014
"High Value Care" Professor Day, Wright Center, Scranton, PA	June 4, 2014
"Program evaluation" Grand Rounds, Wright Center, Scranton, PA	Mar 26, 2014
"The struggling learner" Grand Rounds, Wright Center, Scranton, PA	Feb 12, 2014
"Transition of Care: TRACER" Grand Rounds, Wright Center, Scranton, PA	Dec 18, 2013
"Next Accreditation System" Grand Rounds, Wright Center, Scranton, PA	Nov 13, 2013
"Engaging the learner in Milestones and Competency Based Advancement" Grand Rounds, Wright Center, Scranton, PA	Oct 7, 2013
Workshop "Building Faculty Development into the Daily Activities of Our Teachers." APDIM Fall Meeting. New Orleans, LA	Oct 2, 2013
Workshop: "How to incorporate High Value Care Curricula into Existing Educational Conferences." APDIM Spring Meeting. Orlando, FL	Oct 2, 2013
Plenary Co-Moderator "Operationalizing NAS, EPAs, NAS Milestones, and Curricular Milestones." APDIM Spring Meeting. Orlando, FL	April 30, 2013
Workshop "Engaging Residents in the Milestones: Results of the Educational Research Outcomes Collaborative (E-ROC)." APDIM Spring Meeting. Orlando, FL	April 30, 2013
"Leadership and mentoring" Grand Rounds, Wright Center, Scranton, PA	April 24, 2013
"A Dozen Teaching Techniques" Grand Rounds, Wright Center, Scranton, PA	Mar 3, 2013
Workshop "Like a Flip Book: Serial Precepting in Essential Ambulatory Care" APDIM Fall Meeting. Phoenix, AZ	Oct 11, 2012
Plenary: Bringing it all home: EPAs to Narratives to Reporting. APDIM Fall Meeting. Phoenix, AZ	Oct 11, 2012
Plenary: How Do They Do This. "TRACER: Early Transitions of Care." APDIM Spring Meeting. Atlanta, GA	April 24, 2012
Workshop "Applying Milestones in training: lessons from a multi-center educational study." APDIM Spring Meeting. Atlanta, GA	April 24, 2012
"Teamwork in a Patient Centered Medical Home" Professor Day, Wright Center, Scranton, PA	Mar 21, 2012
Workshop "Lessons from Geese: Teaching Teamwork in a Patient Centered Medical Home." APDIM Fall Meeting. Anaheim, CA	Oct 20, 2011

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CDIM pre-course "Solutions to 21st Challenges in Medical Education" Susan Hingle, chair. Session "Competency based Assessment in Medical Residencies and How it Might be Applied to Medical Student Education" APDIM Fall Meeting. Anaheim, CA	Oct 20, 2011
Workshop: "Lost or Found in Transition: Educational Innovation for Transitions of Care" APDIM Spring Meeting, Las Vegas, NV	April 11, 2011
Pre-course Presenter: "Incorporating Milestones into Internal Medicine Residency Training: Innovations and Opportunities" Presentation "Early Projects Investigating Landmarks". APDIM Spring Meeting, Las Vegas, NV	April 11, 2011
Plenary: "Milestones: Theory to Practice." ACGME Education Conference, Nashville, TN	March 6, 2011
Workshop: "Kicking it up a notch...fundamental residency redesign in the new millennium." APDIM Fall Meeting, San Antonio, TX	Oct 15, 2011
Workshop "Applying the Internal Medicine Milestones: Lessons of a Multi-Institutional Collaborative." APDIM Fall Meeting, San Antonio, TX	Oct 15, 2011
Workshop: "CBME and Milestones: The EIP Pilot" EIP APDIM Spring Meeting, Baltimore, MD	April 26, 2010
Workshop: "Fundamental Residency Redesign: Three Giant Steps". APDIM Spring Meeting, Baltimore, MD	April 28, 2010

Regional

"Cookers, Cottons, and Compassion: An immersive medical student curriculum to explore the needs of persons who inject drugs" 2020 NEGEA Annual Conference, Burlington, VT	April 30, 2020
"A Safe and Effective Discharge Curriculum Implemented in 11 Internal Medicine Programs" Society for General Internal Medicine, Massachusetts Chapter Annual Meeting, Waltham, MA	April 12, 2015
Workshop: Relationship-based Interprofessional Education and Practice: Turning Challenges into Opportunities. Harvard Macy Institute 20th Anniversary Symposium. Educating to Innovate in Healthcare: Celebrating 20 Years of Innovation at the Harvard Macy Institute. Boston, MA. Harvard Medical School, Boston, MA.	June 20, 2014
Workshop: "Sharing professional values for collaborative practice and IPE." Harvard Macy Institute, Program for Educators in Health Professions. Boston, MA	May 19, 2014

Local

"NAS from punitive to restorative" Program Administrators and Education Coordinators Annual Retreat, Baystate Medical Center, Springfield, MA	Oct 21, 2013
"State of the Art Development Series: Educational Innovation Project" Medicine Grand Rounds, Baystate Medical Center, Springfield, MA	Dec 1, 2010
"Transgender Health: My Right Self" Medicine Grand Rounds, Baystate Medical Center, Springfield, MA	Mar 10, 2010
"On Diversity to Inclusion" Medicine Grand Rounds, Baystate Medical Center, Springfield, MA	Mar 11, 2009

Other Presentations, Posters & Abstracts

International

Meade L, Benjamin E, Scavron J. Dying with AIDS: Issues Confronting a North American Community. 11th International Congress on Care of the Terminally Ill. Poster Montreal, Canada	Sept 7, 1996

National

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Workshop. "The Quadruple Aim: Strategic Initiatives to Foster Engagement and Build Resilience Across the Continuum of Hospital Medicine." SHM Annual Meeting Las Vegas, NV accepted	May 1, 2017
Meade L , Katie Heist Suddarth, Ron Jones, Cheryl O'Malley, Kenji Yamazaki, Aimee Zaas. Advancement by Competence: Comparison of a Discharge Curriculum versus usual practice in multiple programs. Poster AAIM Fall Meeting. Atlanta, GA	Oct 8, 2015
Meade L , Katie Heist Suddarth, Ron Jones, Cheryl O'Malley, Kenji Yamazaki, Aimee Zaas. A safe and effective discharge curriculum implemented in 11 internal medicine programs. Poster, SGIM Annual Meeting. Toronto, Ontario Canada, April 22-25, 2015; SHM Annual Meeting. National Harbor Maryland, March 29 – April 1, 2015; and APDIM Spring Meeting. Houston, TX	April 2015
Gregg Novak, Jumea Barooah, Jignesh Sheth, Tiffany Elks, Meade L . AAIM Fall Meeting. The "PDSA Tracker": Promoting Resident CQI Project Completion and Hand-Offs. Poster, AAIM Fall Meeting, Washington, DC	Sept 11, 2014
Meade L , Jones R, Zaas A, Heist MD, O'Malley C, Day L, Willgerodt, M, Implementing Resident Training in an Internal Medicine Collaborative for a Safe Discharge form the Hospital. Harvard Macy Institute, Program for Educators in Health Professions. Poster, Boston, MA	May 19, 2014
Yamazaki, K; Albanese, T; Swing, S; Jones, R; O'Malley, C; Zaas, A; Caverzagie, K; , Heist, K; Meade L . How and when do learners advance by milestones, Poster, ACGME Annual Education Conference, Nashville, TN	Feb 27, 2014
Samavedam S, Meade L , Shantha G, Gollamudi LR, Gardner K, Gopavaram D, Thomas-Hemak L. Developing self-reflection in the Teaching Health Center resident: a milestones based portfolio. National Association of Community Health Centers, Poster, Annual Meeting, Chicago, IL	Aug 25, 2013
Shantha G, Gollamudi LR, Irukulla PK, Samavedam S, Sheth J, Ebersole B, Gardner K, Barooah J, Meade L , Thomas-Hemak L. Data Driven Residency Program Improvement Affirmation in a Teaching Health Center Consortium (THC). Poster, National Association of Community Health Centers. Annual Meeting, Chicago, IL	Aug 25, 2013
Thomas-Hemak L, Shantha G, Ebersole B, Meade, L . The Wright Center's Diversification of Graduate Medical Education (GME) Finances in a Teaching Health Center Community-Based Consortium. National Association of Community Health Centers. Poster, Annual Meeting, Chicago, IL	Aug 25, 2013
Yadav, S; Kleppel, R; Shaaban, R; Paadam J; Meade, L . Embedding the concepts of waste and systems failure reduction in an innovative quality curriculum for resident education. Poster, Society of Hospital Medicine's Annual Meeting, San Diego, CA	2012
Post J, Heist K, Brandenburg S, Meade L ; Sorting the Milestones: Can residents and attendings agree? Poster, ACGME Annual Meeting Orlando, FL	2012

Academic Service

Internal Administration and Service

Department of Medicine, Baystate Medical Center, Springfield, MA

Advancing and Achieving in Diversity Task Force (Chair), Baystate Medical Center, Springfield, MA	2014-2016
Lesbian Gay Bisexual Transgender Health Leadership Committee (Co-chair), Baystate Medical Center, Springfield, MA	2013-2016
Baystate Medical Center Medical Staff Administrative Affairs (participant), Baystate Medical Center, Springfield, MA	2011-2016

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Women Advancing and Achieving in Medicine (Chair), Baystate Medical Center, Springfield, MA	2003-2016
Committee for Quality Peer Review for Medicine (participant), Baystate Medical Center, Springfield, MA	2001-2016
Committee for Quality Peer Review for Ambulatory Medicine (Chair), Baystate Medical Center, Springfield, MA	2012-2014
Post-Acute Care Performance Improvement Team (participant), Baystate Medical Center, Springfield, MA	2005-2011

Professional Memberships and Activities

Society of Hospital Medicine	2015-present
Wellness Executive Committee (2016-2017)	
American College of Physicians	1998-present
Massachusetts Medical Society	1997-present
American Medical Association	1997-present
Alliance of Academic Internal Medicine	2000-present
- Collaborative for Healing and Renewal for Medicine (participant) (2014-2018) - Collaborative Learning Community (chair) (2014-2016) - Innovations Committee (participant) (2014-2016) - Diversity and Inclusion Committee (participant) (2014-2016) - Alliance of Academic Internal Medicine, Council (2013-2016)	
Association for Program Directors in Internal Medicine	2005-present
- Community Program Leaders Council (chair) (2015-2016) - Educational Research Outcomes Collaborative (chair) (2008-2016) - Spotlight Committee (participant) (2013-2015) - Educational Innovations Program (EIP) (participant) (2005-2015)	
Society for General Internal Medicine, Patient Centered Medical Home Medical Education Summit (participant)	2011
American Academy of HIV Medicine	2000-2004
Gay and Lesbian Medical Association	1999-2002

Editorial Responsibilities

Academic Medicine, reviewer	2011-present
Journal of General Medical Education, reviewer	2011-present
Medical Teacher, reviewer	2011-present

External Professional Service

National

Internal Reviewer for the Medicine Residency (Consultant), Wright Center for Medical Education, Scranton, PA	2011

Regional

Contract Advisory Committee (Participant), Baycare Health Partners, Springfield, MA	2013-2017

Healthcare Interprofessional Education of Pioneer Valley (Participant), Springfield, MA 2014-2016

Professional Development

Leading Innovation in Health Care and Education, Harvard Macy Institute, Boston, MA 2015

Executive Leadership Program, Alliance for Academic Internal Medicine, Cambridge, MA 2014

Program for Educators in Health Professions, Harvard Macy Institute, Boston, MA 2014

**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS**

MARIA MOE,

Plaintiff,

Civil Action No. 25-10195-GAO

v.

DONALD TRUMP, in his official capacity as
President of the United States; JAMES R.
MCHENRY III, in his official capacity as Acting
Attorney General of the United States; WILLIAM
LOTHROP, in his official capacity as Acting
Director of the Federal Bureau of Prisons;

Defendants.

**DECLARATION OF RICK STOVER,
SENIOR DEPUTY ASSISTANT DIRECTOR
DESIGNATION AND SENTENCE COMPUTATION CENTER**

I, Rick Stover, declare and state as follows:

1. I am currently employed by the Federal Bureau of Prisons (Bureau). Since June 2024, I have served as the Senior Deputy Assistant Director of the Designation and Sentence Computation Center, within the Bureau's Correctional Programs Division.

2. Prior to becoming Senior Deputy Assistant Director of the Designation and Sentence Computation Center, I worked in positions of increasing responsibility within the Bureau, most recently as the Warden at the Federal Correctional Institution in Danbury, Connecticut.

3. I am familiar with the Bureau's general policies and practices on housing for transgender inmates, including the rationales for those policies. As part of my official duties, I have access to records maintained in the ordinary course of business by the Bureau, including inmate medical and mental health records.

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4. As the Senior Deputy Assistant Director within the Bureau's Correctional Programs Division, I am a member of the Transgender Executive Council (TEC). I am responsible for monitoring and providing guidance on transgender issues. I manage monthly or twice monthly Transgender Executive Council (TEC) multi-disciplinary team meetings and review all initial designations and re-designation requests of inmates self-identifying as transgender in the Bureau. I am involved in the development of accommodations, resource information, programs, and policy to ensure the needs of transgender inmates are met.

5. The information below is based upon personal knowledge and upon information and belief.

6. As of January 10, 2025, there are 2,230 transgender inmates housed in BOP facilities and halfway houses. There are 1,506 Male to Female Transgender inmates and 724 Female to Male Transgender inmates. The BOP currently has 16 Male to Female transgender inmates living in female institutions.

7. Plaintiff, Maria Moe, Register Number *****-***, is currently housed at the Federal Correctional Institution in [REDACTED]. Plaintiff is a transgender prisoner that has been receiving treatment for Gender Dysphoria since [REDACTED].

8. Maria Moe was removed from the Special Housing Unit and placed back into general population on January 27, 2025.

9. The Transgender Executive Council convened on January 24, 2025, and reviewed Moe's progress and current housing placement. The council found that the institutions that were most appropriate for Moe were the [REDACTED]

[REDACTED] and [REDACTED] The

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council reviewed [REDACTED]

10. In determining the most appropriate placement, the council took into account the

11. The council found that [REDACTED] were primary options

because each is [REDACTED]

Based on the council's experience and range of expertise, placing Moe at [REDACTED]

[REDACTED] would minimize the likelihood that Moe would be victimized.

In accordance with 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Dated: January 28, 2025


RICK STOVER



U.S. Department of Justice
Federal Bureau of Prisons

PROGRAM STATEMENT

OPI: RSD/WASPB
NUMBER: 5200.08
DATE: January 13, 2022

Transgender Offender Manual

/s/

Approved: M.D. Carvajal
Director, Federal Bureau of Prisons

1. PURPOSE AND SCOPE

To ensure the Bureau of Prisons (Bureau) properly identifies, tracks, and provides services to the transgender population.

a. Program Objectives. Expected results of this program are:

- This policy provides guidance to staff in dealing with the unique issues that arise when working with transgender inmates.
- Institutions ensure transgender inmates can access programs and services that meet their needs as appropriate, and prepare them to return to the community.
- Sufficient resources will be allocated to deliver appropriate services to transgender inmates.
- Staff will complete training, enabling them to work effectively with transgender inmates.
- To enhance staff's understanding of the increased risk of suicide, mental health issues and victimization of transgender inmates.

b. Summary of Changes

Rescinded P5200.04 CN-1 Transgender Offender Manual (5/11/2018)

This reissuance incorporates the following modifications:

- Clarified duties and responsibilities of various staff.
- Added an institution requirement for maintaining a copy of the Case Management Activity (CMA) Assignment form BP-A1110, Consent Form for Transgender Inmates. Inmates can no longer request to have a CMA assignment removed, and then re-added at a later date.
- Clarified transfer, consultation, and program requirements.

- Updated guidance regarding initial designation and redesignation procedures for transgender offenders.
- Added information about gender affirming surgery.

c. **Institution Supplement.** None required. Should local facilities make any changes outside changes required in national policy or establish any additional local procedures to implement national policy, the local Union may invoke to negotiate procedures or appropriate arrangements.

2. DEFINITIONS

Gender – a construct used to classify a person as male, female, both, or neither. Gender encompasses aspects of social identity, psychological identity, and human behavior.

Gender identity – a person’s sense of their own gender, which is communicated to others by their gender expression.

Gender expression – includes mannerisms, clothing, hairstyle, and choice of activities.

Gender nonconforming – a person whose appearance or manner does not conform to traditional societal gender expectations.

Transgender – the state of one’s gender identity not matching one’s sex assigned at birth. For the purposes of this policy, a transgender inmate is one who has met with a Bureau Psychologist and signed the form indicating consent to be identified within the agency as transgender. This step allows accommodations to be considered.

Cisgender – the state of one’s gender identity matching one’s sex assigned at birth.

Sexual orientation – the direction of one’s sexual interest towards members of the same, opposite, or both genders (e.g., heterosexual, homosexual, bisexual, asexual). Sexual orientation and gender identity are not related.

Gender Dysphoria (GD) – a mental health diagnosis currently defined by DSM-5 as, “A strong and persistent cross-gender identification. It is manifested by a stated desire to be the opposite sex and persistent discomfort with his or her biologically assigned sex.” Not all transgender inmates will have a diagnosis of GD, and a diagnosis of GD is not required for an individual to be provided services.

Intersex – a person whose sexual or reproductive anatomy or chromosomal pattern does not seem to fit typical physiological definitions of male or female. Not all intersex people identify as

transgender; unless otherwise specified, this policy does not apply to intersex people who do not identify as transgender.

Transition – measures that change one’s gender expression or body to better reflect a person’s gender identity.

Gender Affirming – describes behaviors or interventions that support the gender identity of a person.

3. STAFF RESPONSIBILITIES

The following Bureau components are responsible for ensuring consistent establishment of the programs, services, and resource allocations necessary for transgender offenders.

a. Central Office

(1) The **Women and Special Populations Branch (WASPB)** is the agency’s primary source and point of contact on accommodation/transition, classification, management, and intervention/treatment programs and practices for transgender inmates in Bureau custody. The Branch is responsible for the following functions as they relate to transgender inmates:

- Engaging stakeholders, including serving as the primary point of contact on issues affecting transgender inmates with external entities including judges, congress, and advocacy groups.
- Ensuring the Bureau offers appropriate services to transgender inmates.
- Preparing budget requests to deliver national and pilot programs or services affecting transgender inmates.
- Providing guidance and direction to staff and institution, region, and agency leadership on transgender issues.
- Developing and implementing staff training on transgender issues.
- Building a research-based foundation for the Bureau’s work with transgender inmates, including implementation support and intervention services.
- Presenting at internal and external conferences/events regarding the agency’s transgender inmates’ practices.
- Developing and monitoring monthly reports on the transgender population and institutional programs.
- Conducting an annual survey of transgender inmates in the Bureau and sharing results with internal and external stakeholders.
- Providing national oversight of pilot programs and initiatives serving transgender offenders.
- Overseeing the Transgender Executive Council (TEC).
- Ensure that a National Program and Policy Coordinator is assigned to each Region who will meet quarterly to discuss staffing and programming needs of transgender inmates.

(2) The **Health Services Division** oversees all medical and psychiatric guidance and treatment as it applies to transgender inmates. Clinical guidance on the most current research-driven clinical medical and psychiatric care of transgender inmates will be provided at the direction of the Medical Director. The Medical Director only receives referrals from the TEC and determines whether gender affirming surgery requests will be referred to a surgeon.

(3) The **Psychology Services Branch** oversees all mental health programs and services as they apply to transgender inmates, to include providing advice and guidance on identification and evaluation of transgender inmates, and making recommendations for treatment needs of transgender inmates and/or inmates with GD.

(4) **Central Office Branches** of Correctional Services, Psychology Services, Education, Correctional Programs, Reentry Affairs, Residential Reentry Management, Health Programs, Litigation, Chaplaincy Services, Intelligence and Counter Terrorism Branch, and Trust Fund meet annually with the Women and Special Populations Branch to discuss transgender population needs and evaluate current gender-responsive services. The National Union and the Central Office LGBT Special Emphasis Program Manager will be invited to attend these meetings.

(5) The **Transgender Executive Council (TEC)** will consist of senior level staff members (GS-14 and above) from the Women and Special Populations Branch, the Psychology Services Branch, Health Services Division, and the Designation and Sentence Computation Center (DSCC). The team is led by the Senior Deputy Assistant Director, Reentry Services and also includes the Senior Deputy Assistant Director, Correctional Programs Division (DSCC), and the Senior Deputy Assistant Director, Health Services. The TEC is the agency's official decision-making body on all issues affecting the transgender population. It will meet a minimum of monthly to offer advice and guidance on unique measures related to treatment and management needs of transgender inmates and/or inmates with GD, including training, designation issues, and reviewing all transfers for approval. Staff or inmates may raise issues on specific inmates to the TEC through the Women and Special Populations Branch. The Office of General Counsel is consulted as needed.

b. Regional Offices

- Provide oversight to institutions regarding services and other relevant trends managing transgender inmates.

c. Institutions

The Warden will establish a multi-disciplinary approach to the management of transgender inmates. The Associate Warden of Programs is the primary point of contact in the institution for transgender issues and will consult as needed with the Chief Psychologist, Captain, Clinical

Director, Unit Manager, or other individuals as appropriate; and specifically to:

- Ensure transgender inmates have access to services.
- Enter tracking information for self-identified transgender inmates by updating SENTRY CMA assignments and other databases (e.g., PDS).
- Maintain a copy of the Case Management Activity (CMA) SENTRY Assignment Consent Form for Transgender Inmates (BP-A1110) in the Central File and Psychology Data System (PDS).
- Provide appropriate reentry resources that may be specific to the population.
- Advise the Local Union of transgender inmate management issues.
- Consult and refer transgender inmates to the TEC.
- Provide programming developed by the Reentry Services Division for transgender inmates.

4. STAFF TRAINING

Staff are provided specialized training in working with unique issues when managing transgender inmates as part of annual training. Institutions housing transgender inmates should provide additional training.

The Women and Special Populations Branch is responsible for developing training materials and current information on the management of transgender inmates. This information will be made available to staff via the Bureau's intranet.

In addition, the Prison Rape Elimination Act (PREA) regulations incorporated into the BOP Program Statement, **Sexually Abusive Behavior Prevention and Intervention Program** have training requirements concerning pat searches and communication skills for transgender inmates. See 28 C.F.R. § 115.15(f) and 115.31 (a) (9). Please refer to this Program Statement regarding implementation of those training requirements.

Staff will be provided adequate time to complete these trainings during duty hours. Staff will be provided proper relief to complete the training.

5. INITIAL DESIGNATIONS

The PREA regulations (section 28 C.F.R. § 115.42 (c)), incorporated into the Program Statement **Sexually Abusive Behavior Prevention and Intervention Program**, state:

“In deciding whether to assign a transgender or intersex inmate to a facility for male or female inmates...the agency shall consider on a case-by-case basis whether a placement would ensure the inmate's health and safety, and whether the placement would present management or security problems.”

Upon receipt of information from a Pre-Sentence Report, court order, U.S. Attorney's Office, defense counsel, the offender, or other source that an individual entering BOP custody is

transgender or intersex, designations staff will refer the matter to the TEC.

Institution staff managing pretrial or holdover offenders must also refer cases to the TEC for review. Any TEC recommendations concerning pretrial inmates will be coordinated with the appropriate United States Marshals Service District Office.

The TEC will consider factors including, but not limited to, an inmate's security level, criminal and behavioral/disciplinary history, current gender expression, programming, medical, and mental health needs/information, vulnerability to sexual victimization, and likelihood of perpetrating abuse. The TEC may also consider facility-specific factors, including inmate populations, staffing patterns, and physical layouts (e.g., types of showers available). The TEC will consider the wellbeing of all inmates while exploring appropriate options available to assist with mitigating risk to the inmate, to include but not limited to cell and/or unit assignments, application of management variables, programming missions of the facility, and security of the institution.

It will be documented on all SENTRY designation notes for transgender inmates that the TEC reviewed the inmate for appropriate institution designation.

6. HOUSING AND PROGRAMMING ASSIGNMENTS

During Initial Classification and subsequent Program Reviews, unit management staff will review the inmate's current housing unit status and programming available for transgender inmates. This review will be documented by Unit Management staff in the inmate central file and for holdovers in the holdover file, with institution oversight by the Associate Warden.

The reviews will consider on a case-by-case basis that the inmate placement does not jeopardize the inmate's wellbeing and does not present management or security concerns.

In making housing unit and programming assignments, a transgender or intersex inmate's own views with respect to his/her own safety must be given serious consideration.

Transgender inmates shall be given the opportunity to shower separate from other inmates when individual shower stalls are unavailable.

The agency shall not place transgender or intersex inmates in dedicated facilities, units, or wings solely on the basis of such identification or status. The only exception is if such placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such inmates.

Wardens will consult with WASPB prior to submitting a designation request to the DSCC for the redesignation of transgender inmates when the designation is related to the individual's

transition. The DSCC and Office of Medical Designations will consult with WASPB prior to the designation or redesignation of all transgender inmates.

In situations where the transfer request is related to progressing the individual inmate's transition (i.e., transfer to a different sex facility) the TEC will consider the case. Prior to considering the case, the Warden will submit documentation to the TEC showing the inmate has met the minimum standards of compliance with programs, medications and mental health treatment, and meeting hormone goal levels. Ordinarily, inmates will not be submitted to the TEC for consideration until they have maintained one year clear conduct for 100 and 200 series incident report sanctions, though they may be considered for submission on a case-by-case basis by the Warden, as appropriate.

It will be noted in all SENTRY designation notes that the TEC reviewed the inmate for appropriate institution designation.

7. DOCUMENTATION AND SENTRY ASSIGNMENTS

The PREA regulations in 28 C.F.R. part 115, Subpart A, incorporated into the Program Statement **Sexually Abusive Behavior Prevention and Intervention Program** and the Program Statement **Intake Screening**, address intake screening. Screening of transgender inmates will be conducted in accordance with these policies and all other applicable policies and procedures.

a. Medical and Mental Health Information. Medical and mental health information for transgender inmates will be maintained in the current electronic recordkeeping system or health record system in accordance with the Program Statements **Health Information Management and Psychology Services Manual**. Medical and mental health information is considered confidential, and may only be released in accordance with appropriate laws, rules, and regulations.

b. Initial Screening. For initial designations, staff will assign Case Management Activity (CMA) SENTRY assignments if information in the PSR or other documentation indicates a likely transgender identity. The screening codes are:

SCRN M2F – inmate should be screened for male to female transgender identification.

SCRN F2M – inmate should be screened for female to male transgender identification.

Any inmate arriving at the designated institution with a screening code is to be referred to the Chief Psychologist or designee for review within 14 days. If the code was assigned in error, the screening code will be removed by the Psychologist. If the inmate identifies as transgender, the psychologist will replace the screening code with an identifying code, as indicated below. Holdover facilities are exempt from this initial screening requirement, as limited available

records and brevity of stay do not typically allow for a comprehensive screening.

Any inmate who arrives without a screening code but identifies as transgender during intake, or at any time during the incarceration period, is referred to the Chief Psychologist or designee and interviewed within 14 days of the inmate notification. Inmates in pretrial status at Bureau facilities may also receive a transgender screening CMA SENTRY assignment.

c. Notification to Staff and Tracking. After consultation with Psychology Services, and if the inmate affirms his/her transgender identity, the screening code will be updated to a permanent assignment by a Psychologist:

TRN M2F – inmate identifies as male to female transgender (transgender female).

TRN F2M – inmate identifies as female to male transgender (transgender male).

The inmate must request to Psychology Services staff that the Case Management Activity (CMA) assignment be entered, and the inmate consents that all staff will therefore be notified that the individual is transgender. The inmate's request will be documented on a Case Management Activity (CMA) SENTRY Assignment Consent Form for Transgender Inmates (BP-A1110). Psychology Services shall maintain the form in the electronic mental health record.

Staff should consult the transgender CMA assignment when interacting with the inmate; e.g., use of pronouns and access to accommodations. All inmates have access to transgender treatment, regardless of assignment.

If there are questions about the need to continue a CMA assignment, the Warden will contact the WASPB. Inmates may request in writing to have CMA assignments removed. If this occurs, ordinarily the assignment will not be re-added at a later date.

8. HORMONE THERAPY AND MEDICAL TREATMENT

Hormone therapy or other medical treatment may be provided after an individualized assessment of the requested inmate by institution medical staff. Medical staff will request consultation from Psychology Services regarding the mental health benefits of hormone or other medical treatment. If appropriate for the inmate, hormone treatment will be provided in accordance with the Program Statement **Patient Care** and relevant Clinical Guidance. Questions concerning hormone treatment may be referred to the WASPB or the Health Services Division.

In the event this treatment changes the inmate's appearance to the extent a new identification card is needed, the inmate will not be charged for the identification card as is standard practice.

9. SURGERY

While not all inmates who identify as transgender may be interested in seeking surgical intervention, such a decision does not preclude them from obtaining other accommodations as described in this Program Statement. For transgender inmates in Bureau custody, surgery may be the final stage in the transition process and is generally considered only after one year of clear conduct and compliance with mental health, medical, and programming services at the gender affirming facility. Once that period elapses, an inmate may submit a request to his or her Warden requesting surgical consideration. The Warden will forward the request to the TEC. The TEC is the sole body who may determine that all milestones and individual goals for surgical consideration have been met. When this occurs, the case is referred to the agency's Medical Director for medical consideration. He or she may review existing records and/or interview the inmate, institution staff, and members of the TEC. After this individualized assessment, the Medical Director will determine if the surgery is medically appropriate for referral to a gender affirming surgeon.

10. OTHER MENTAL HEALTH SERVICES

Bureau Psychologists provide assessment and treatment services for transgender inmates, as appropriate. Guidance on assessment procedures is available on the Psychology Services intranet page.

If an inmate identifies as transgender, the Psychologist will provide the inmate with information regarding the range of treatment options available in the Bureau and their implications. In addition, based upon the Psychologist's preliminary assessment and the inmate's expressed interest, a referral to the Clinical Director and/or Chief Psychiatrist may be generated. While the initial interview must be scheduled within 14 days, an assessment may take longer in some instances.

In addition to a referral for medical services, a transgender inmate may be offered individual psychotherapy. Individual psychotherapy goals might include: (1) helping the inmate to live more comfortably within a gender identity and deal effectively with non-gender issues; (2) emphasizing the need to set realistic life goals related to daily living, work, and relationships, including family of origin; (3) seeking to define and address issues that may have undermined a stable lifestyle, such as substance abuse and/or criminality; and (4) addressing any co-occurring mental health issues. Mood disorders, anxiety disorders, substance use disorders, and personality disorders, etc., may also be present; any effective treatment plan will fully address these symptoms. Group treatment may also be recommended.

Common concerns of transgender inmates, which can be addressed effectively in a group setting, include self-esteem issues and relationship issues.

Psychologists who provide mental health treatment for transgender inmates address all mental health needs, including suicide risk, if present. If an inmate who identifies as a transgender harms, attempts to remove, or removes his or her genitalia or other gender-specific anatomy, a suicide risk assessment is conducted consistent with the Program Statement, Suicide Prevention Program. In addition, the treating psychologist notifies the Chief Psychologist who in turn notifies the Regional Psychology Services Administrator and the Psychology Services Branch.

Psychologists working with transgender inmates are encouraged to consult the Reentry Services Division in Central Office for additional resources.

11. SPECIAL POPULATIONS SERVICES

Some facilities have Special Populations Coordinators on staff. These individuals are responsible for delivering First Step Act and other programs, which includes programs developed specifically for inmates who identify as transgender. In the absence of such staff, the Warden will seek consultation from WASPB regarding the delivery of group interventions and services.

12. PRONOUNS AND NAMES

Staff interacting with inmates who have a CMA assignment of transgender, shall either use the authorized gender-neutral communication with inmates (e.g., by the legal last name or “Inmate” last name) or the pronouns associated with the inmate’s identified gender. Deliberately and repeatedly mis-gendering an inmate is not permitted.

The name entered on the inmate’s Judgment and Commitment Order is the official committed name for all Bureau records (incident reports, progress reviews, sentence calculations, etc.). An official committed name change while in BOP custody must be done consistent with the Program Statement **Correctional Systems Manual**. Any additional names or aliases should be entered into SENTRY, as appropriate.

13. PAT SEARCH ACCOMMODATIONS

Pat searches of transgender inmates will be conducted in accordance with the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas**.

Pat search information refers only to individuals at male facilities who identify as female. The Bureau does not offer “male only” pat searches.

Unless there is a history of inappropriate sexual behavior suggesting approval poses risks to staff, requests are ordinarily approved by the Warden’s Office. Inmates may request denials be reviewed by the TEC through the Administrative Remedy Program. Inmates who are granted this exception under policy may have it reversed by the Warden if found to have violated

institution rules concerning contraband.

In exigent circumstances, any staff member may conduct a pat search of any inmate consistent with the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas**.

14. VISUAL SEARCHES

For purposes of a visual search, inmates will be searched in accordance with the gender of the institution, or housing assignment, to which they are assigned. The visual search shall be made in a manner designed to ensure as much privacy to the inmate as practicable. Staff should consider the physical layout of the institution, and the characteristics of an inmate with a transgender CMA assignment, to adjust conditions of the visual search as needed for the inmate's privacy.

Transgender inmates may also request an exception to be visually searched by a staff member of the inmate's identified gender. The exception must be pre-authorized by the Warden, after consultation with staff from Health Services, Psychology Services, Unit Management, and Correctional Services. Exceptions must be specifically described (e.g., "visual search only by female staff"), clearly communicated to relevant staff through a memorandum, and reflected in SENTRY (or other Bureau database). Inmates should be provided a personal identifier (e.g., notation on identification, etc.) that indicates their individual exception, to be carried at all times and presented to staff prior to visual searches.

Inmates request an exception by submitting an Inmate Request to Staff (BP-A0148) to the Warden. The Warden will consult with the departments listed above, and the memo approving or denying the request will be generated by the Warden's Office. Inmates may request denials be reviewed by the TEC through the Administrative Remedy Program. Inmates who are granted this exception may have it reversed by the Warden if found to have violated institution rules concerning contraband.

Transgender inmates placed at an institution or in a housing unit that does not correspond with their identified gender, and who are granted an exemption as indicated above, will be searched by staff of the inmate's identified gender who consent to participate in the search, or Health Services clinical staff.

Transgender inmates placed at an institution or in a housing unit of their identified gender will be searched by staff of the inmate's identified gender who consent to participate in the search or medical staff.

Institutions should consider using available body scanning technology in lieu of visual searches of transgender inmates.

In exigent circumstances, any staff member may conduct a visual search of any inmate consistent with the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas**.

15. CLOTHING, COMMISSARY ITEMS, AND OTHER ACCOMMODATIONS

Consistent with safety and security concerns, inmates with the CMA assignment of transgender will have the opportunity to have undergarments of their identified gender even if they are not housed with inmates of the identified gender. Institutional laundry will have available institutional undergarments that fulfill the needs of transgender inmates. Undergarments will not have metal components.

Standardized lists of Commissary items for transgender inmates are available in accordance with the Program Statement **Trust Fund/Deposit Manual** and the information on the RSD intranet page.

Additional items based on an individualized assessment of the transgender inmate population may be approved by the Warden. Additional items may be provided by the institution or purchased by the inmate, as appropriate. Any concerns regarding such items are directed to the WASPB.

Inmates who purchase and/or are provided items under this section will be subject to disciplinary sanctions, including the removal of these items, if they are found to have violated institution rules relating to the possession of these items.

Any other accommodation requests are discussed with the TEC through the WASPB.

16. REENTRY NEEDS

In accordance with the Program Statement **Release Preparation Program**, institution staff assist transgender inmates in addressing reentry issues prior to release or placement in a Residential Reentry Center/Home Confinement.

During Initial Classification and Program Reviews, unit management formulates a pre-release plan that assists transgender inmates in obtaining identification, finding housing and employment, and providing community resources to assist with reintegration into the community.

The Reentry Affairs Coordinator will assist staff with identifying these resources. Community Treatment Services staff or Institution and/or Regional Social Workers may be contacted concerning the continuity of medical care.

The WASPB can be contacted to provide guidance and resources for any additional reentry

needs of transgender inmates. All accommodation and treatment decisions for inmates in community custody are made by the Residential Reentry Management Branch in consultation with the TEC.

17. ADMINISTRATIVE REMEDIES

Inmates who wish to seek formal review of any issue relating to this policy may use the procedures in the Program Statement **Administrative Remedy Program**.

REFERENCES

Program Statements

P1330.18	Administrative Remedy Program (1/6/14)
P4500.12	Trust Fund/Deposit Fund Manual (3/15/18)
P5100.08	Security Designation and Custody Classification Manual (9/4/19)
P5290.15	Intake Screening (3/30/09)
P5310.17	Psychology Services Manual (08/25/16)
P5310.16	Treatment and Care of Inmates with Mental Illness (5/1/14)
P5322.13	Inmate Classification and Program Review (5/16/14)
P5324.08	Suicide Prevention (4/5/07)
P5324.12	Sexually Abusive Behavior Prevention and Intervention Program (6/4/15)
P5325.07	Release Preparation Program (8/15/19)
P5521.06	Searches of Housing Units, Inmates, and Inmate Work Areas (6/4/15)
P5800.15	Correctional Systems Manual (9/23/16)
P6031.04	Patient Care (6/3/14)
P6090.04	Health Information Management (3/2/15)

Federal Regulations

28 CFR part 115

Additional Resources For Clinicians

Diagnostic and Statistical Manual of Mental Disorders (DSM), most current version. World Professional Association for Transgender Health (WPATH) standards.

ACA Standards

- American Correctional Association Standards for Adult Correctional Institutions, 5th Edition: 5-ACI-1C-09, 5-ACI-1D-12, 5-ACI-1D-13, 5-ACI-2C-02, 5-ACI-1D-08, 5-ACI-3D-05, 5-ACI-3D-08(M), 5-ACI-3D-09, 5-ACI-3D-10, 5-ACI-3D-11, 5-ACI-3D-12, 5-ACI-3D-13, 5-ACI-3D-14, 5-ACI-3D-15, 5-ACI-3D-16, 5-ACI-6A-21(M), 5-ACI-6A-32(M), 5-ACI-6C-14(M)
- American Correctional Association Performance Based Standards for Adult Local Detention Facilities, 4th Edition: 4-ALDF-2A-29, 4-ALDF-2A-32, 4-ALDF-2A-34, 4-ALDF-6B-03, 4-ALDF-2C-03, 4-ALDF-4C-22M, 4-ALDF-4C-30M, 4-ALDF-4D-22, 4-ALDF-4D-22-1, 4-

ALDF-4D-22-2, 4-ALDF-4D-22-3, 4-ALDF-4D-22-4, 4-ALDF-4D-22-5, 4-ALDF-4D-22-6M, 4-ALDF-4D-22-7, 4-ALDF-4D-22-8, 4-ALDF-7B-08, 4-ALDF-7B-10, 4-ALDF-7B-10-1.

- American Correctional Association Standards for Administration of Correctional Agencies, 2nd Edition: None.
- American Correctional Association Standards for Correctional Training Academies: None.

Records Retention

Requirements and retention guidance for records and information applicable to this program are available in the Records and Information Disposition Schedule (RIDS) on Sallyport.



U.S. Department of Justice
Federal Bureau of Prisons

CHANGE NOTICE

OPI: RSD/WSP
NUMBER: 5200.04 CN-1
DATE: May 11, 2018

Transgender Offender Manual

A handwritten signature in black ink, appearing to read "Mark S. Inch", is positioned above the name and title of the Director.

Approved: Mark S. Inch
Director, Federal Bureau of Prisons

This Change Notice (CN) implements the following change to Program Statement 5200.04, **Transgender Offender Manual**, dated January 18, 2017. The purpose of the Change Notice is to ensure that the Transgender Executive Council (TEC) considers issues related to prison management and security in determining appropriate housing of transgender inmates, including risks posed to staff, other inmates, and members of the public. The clarifications to policy will establish appropriate expectations for the inmate population concerning designations.

The changes are marked with a **highlight** and inserted into the policy. Deleted text is struck through. In addition, the branch name has been changed from Female Offender Branch to Women and Special Populations Branch.

1. PURPOSE AND SCOPE

To ensure the Bureau of Prisons (Bureau) properly identifies, tracks, and provides services to the transgender population, **consistent with maintaining security and good order in Federal prisons.**

4. STAFF TRAINING

The **Women and Special Populations Branch** will be responsible for developing training materials and current information on the management of transgender inmates. **Training will include information concerning best practices for maintaining the safety of transgender inmates, while also ensuring security and good order in Federal prisons and the safety of staff, inmates, and the public.** This information will be made available to staff on the **Women and Special Populations Branch** Sallyport page.

5. INITIAL DESIGNATIONS

The TEC will consider factors including, but not limited to, an inmate's security level, criminal and disciplinary history, current gender expression, medical and mental health needs/information, vulnerability to sexual victimization, and likelihood of perpetrating abuse. The TEC may also consider facility-specific factors, including inmate populations, staffing patterns, and physical layouts (e.g., types of showers available). ~~The TEC will recommend housing by gender identity when appropriate.~~

In deciding the facility assignment for a transgender or intersex inmate, the TEC should make the following assessments on a case-by-case basis:

- The TEC will use biological sex as the initial determination for designation;
- The TEC will consider the health and safety of the transgender inmate, exploring appropriate options available to assist with mitigating risk to the transgender offender, to include but not limited to cell and/or unit assignments, application of management variables, programming missions of the facility, etc.;
- The TEC will consider factors specific to the transgender inmate, such as behavioral history, overall demeanor, and likely interactions with other inmates; and
- The TEC will consider whether placement would threaten the management and security of the institution and/or pose a risk to other inmates in the institution (e.g., considering inmates with histories of trauma, privacy concerns, etc.).

The designation to a facility of the inmate's identified gender would be appropriate only in rare cases after consideration of all of the above factors and where there has been significant progress towards transition as demonstrated by medical and mental health history.

It will be noted in SENTRY designation notes that the TEC reviewed the inmate for appropriate institution designation.

7. HOUSING AND PROGRAMMING ASSIGNMENTS

In order for an inmate to be considered for transfer to another institution of the same sex as the inmate's current facility location, ~~including a facility housing individuals of the inmate's identified gender~~, the Warden should consult with the TEC prior to submitting a designation request to the DSCC, but this is not required.

In addition, the Warden may make a recommendation to the TEC to transfer a transgender or intersex inmate based on an inmate's identified gender.

In considering such recommendations, the TEC will apply all criteria of Section 5, above, and make the following assessments concerning the recommendation:

- The TEC will use biological sex as the initial determination for designation;
- The TEC will consider the health and safety of the transgender inmate, exploring appropriate options available to assist with mitigating risk to the transgender offender, to include but not limited to cell and/or unit assignments, application of management variables, programming missions of the facility, re-designation to another facility of the same sex, etc.;
- The TEC will also consider factors specific to the transgender inmate, such as behavioral history, overall demeanor, program participation, and likely interactions with other inmates; and
- The TEC will consider whether placement would threaten the management and security of the institution and/or pose a risk to other inmates in the institution (e.g., considering inmates with histories of trauma, privacy concerns, etc.).

The designation to a facility of the inmate's identified gender would be appropriate only in rare cases after consideration of all of the above factors and where there has been significant progress towards transition as demonstrated by medical and mental health history, as well as positive institution adjustments.

It will be noted in SENTRY designation notes that the TEC reviewed the inmate for appropriate institution designation.

9. HORMONE AND NECESSARY MEDICAL TREATMENT

Hormone or other necessary medical treatment may be provided after an individualized assessment of the requested inmate by institution medical staff. Medical staff should request consultation from Psychology Services regarding the mental health benefits of hormone or other necessary medical treatment. If appropriate for the inmate, hormone treatment will be provided in accordance with the Program Statement **Patient Care** and relevant clinical guidance. Questions concerning hormone treatment may be referred to the TCCT.



U.S. Department of Justice
Federal Bureau of Prisons

PROGRAM STATEMENT

OPI: RSD/FOB
NUMBER: 5200.04
DATE: January 18, 2017

Transgender Offender Manual

/s/

Approved: Thomas R. Kane
Acting Director, Federal Bureau of Prisons

1. PURPOSE AND SCOPE

To ensure the Bureau of Prisons (Bureau) properly identifies, tracks, and provides services to the transgender population, **consistent with maintaining security and good order in Federal prisons.**

a. Program Objectives. Expected results of this program are:

- This policy is meant to provide guidance to staff in dealing with the unique issues that arise when working with transgender inmates.
- Institutions ensure transgender inmates can access programs and services that meet their needs as appropriate, and prepare them to return to the community.
- Sufficient resources will be allocated to deliver appropriate services to transgender inmates.
- Staff will be offered training, enabling them to work effectively with transgender inmates.
- To support staff's understanding of the increased risk of suicide, mental health issues and victimization of transgender inmates.

b. Institution Supplement. None required. Should local facilities make any changes outside changes required in national policy or establish any additional local procedures to implement national policy, the local Union may invoke to negotiate procedures or appropriate arrangements.

2. DEFINITIONS

Gender – a construct used to classify a person as male, female, both, or neither. Gender encompasses aspects of social identity, psychological identity, and human behavior.

Gender identity – a person’s sense of their own gender, which is communicated to others by their gender expression.

Gender expression – includes mannerisms, clothing, hair style, and choice of activities.

Gender nonconforming – a person whose appearance or manner does not conform to traditional societal gender expectations.

Transgender – the state of one’s gender identity not matching one’s biological sex. For the purposes of this policy, a transgender inmate is one who has met with a Bureau of Prisons psychologist and signed the form indicating consent to be identified within the agency as transgender. This step allows for accommodations to be considered.

Cisgender – the state of one’s gender identity matching one’s biological sex.

Sexual orientation – the direction of one’s sexual interest towards members of the same, opposite, or both genders (e.g., heterosexual, homosexual, bisexual, asexual). Sexual orientation and gender identity are not related.

Gender Dysphoria (GD) – a mental health diagnosis currently defined by DSM-5 as, “A strong and persistent cross-gender identification. It is manifested by a stated desire to be the opposite sex and persistent discomfort with his or her biologically assigned sex.” Not all transgender inmates will have a diagnosis of GD, and a diagnosis of GD is not required for an individual to be provided services.

Intersex – a person whose sexual or reproductive anatomy or chromosomal pattern does not seem to fit typical biological definitions of male or female. Not all intersex people identify as transgender; unless otherwise specified, this policy does not apply to intersex people who do not identify as transgender.

Transition – measures that change one’s gender expression or body to better reflect a person’s gender identity.

3. STAFF RESPONSIBILITIES

The following Bureau components are responsible for ensuring consistent establishment of the programs, services, and resource allocations necessary for transgender offenders.

a. **Central Office**

(1) The **Women and Special Populations Branch** is the agency's primary source and point of contact on classification, management, and intervention programs and practices for transgender inmates in Bureau custody. The Branch is responsible for the following functions as they relate to transgender inmates:

- Engaging stakeholders, including serving as the primary point of contact on issues affecting transgender inmates with judges, political figures, and advocacy groups.
- Ensuring the Bureau offers appropriate services to transgender inmates.
- Preparing budgetary requests to deliver national and pilot programs or services affecting transgender inmates.
- Providing guidance and direction to Regional staff and institution leadership on transgender issues.
- Developing and implementing staff training on transgender issues.
- Building a research-based foundation for the Bureau's work with transgender inmates.
- Presenting at internal and external conferences/events regarding the agency's transgender inmates' practices.
- Developing and monitoring monthly reports on the transgender population and institutional programs.
- Issuing an annual report on the state of transgender offenders in the Bureau that will be made available to all staff and stakeholders.
- Advising agency leadership on transgender inmate needs.
- Conducting an annual survey of transgender inmates in the Bureau and sharing results with internal and external stakeholders.
- Providing national oversight of pilot programs and initiatives serving transgender offenders.

(2) The **Health Services Division** oversees all medical and psychiatric activity as it applies to transgender inmates. Guidance on the most current research-driven clinical medical and psychiatric care of transgender inmates will be provided by the Medical Director.

The Health Services Division also has oversight of a Transgender Clinical Care Team (TCCT). This team will be comprised of Physicians, Pharmacists, and Psychiatrists. Social Workers, Psychologists, and other clinical providers can also be included when appropriate. The TCCT will offer advice and guidance to health services staff on the medical treatment of transgender inmates and/or inmates with GD. Medical staff can raise issues to the TCCT through the Health Services Division.

(3) The **Psychology Services Branch** oversees all psychological mental health programs and services as they apply to transgender inmates, to include providing advice and guidance on

identification and evaluation of transgender inmates, and making recommendations for treatment needs of transgender inmates and/or inmates with GD.

(4) **Central Office Branches/Divisions** of Correctional Services, Psychology Services, Education, Correctional Programs, Reentry Affairs, Residential Reentry Management, Health Services, Health Programs, Social Work, Office of General Counsel, and Trust Fund meet annually with the **Women and Special Populations Branch** to discuss transgender population needs and evaluate current gender-responsive services. The National Union and the Central Office LGBT Special Emphasis Program Manager will be invited to attend these meetings.

(5) The **Transgender Executive Council (TEC)** will consist of staff members from the Health Services Division, the **Women and Special Populations Branch**, Psychology Services, the Correctional Programs Division, the Designation and Sentence Computation Center (DSCC), and the Office of General Counsel. The TEC will meet a minimum of quarterly to offer advice and guidance on unique measures related to treatment and management needs of transgender inmates and/or inmates with GD, including designation issues. Institution staff and DSCC staff may raise issues on specific inmates to the TEC through the **Women and Special Populations Branch**. The National PREA Coordinator is consulted as needed.

b. Regional Offices

- Provide oversight to institutions regarding services and other relevant trends managing transgender inmates.
- Assign transgender responsibilities to the Regional Female Offender/Transgender Coordinator Collateral Duty Assignment. This individual meets quarterly with the **Women and Special Populations Branch** to discuss staffing and programming needs.

c. Institutions

The institution CEO will establish a multi-disciplinary approach to the management of transgender inmates; specifically:

- Ensure transgender inmates have access to services.
- Enter tracking information for self-identified transgender inmates by updating SENTRY and other databases (e.g., PDS), as appropriate.
- Provide appropriate reentry resources that may be specific to the population.
- Advise the Local Union of transgender inmate management issues, as appropriate.

4. STAFF TRAINING

Staff will be provided specialized training in working with unique issues when managing transgender inmates, with refresher training at annual training. Institutions housing known transgender inmates should provide additional training, if needed.

The **Women and Special Populations Branch** will be responsible for developing training materials and current information on the management of transgender inmates. **Training will include information concerning best practices for maintaining the safety of transgender inmates, while also ensuring security and good order in Federal prisons and the safety of staff, inmates, and the public.** This information will be made available to staff on the **Women and Special Populations Branch** Sallyport page.

In addition, the Prison Rape Elimination Act (PREA) regulations incorporated into the BOP Program Statement **Sexually Abusive Behavior Prevention and Intervention Program** have training requirements concerning pat searches and communication skills for transgender inmates. See 28 C.F.R. § 115.15(f) and 115.31 (a) (9). Please refer to this Program Statement regarding implementation of those training requirements.

Staff will be provided adequate time to complete these trainings during duty hours.

5. INITIAL DESIGNATIONS

The PREA regulations, incorporated into the Program Statement **Sexually Abusive Behavior Prevention and Intervention Program**, state in section 28 C.F.R. § 115.42 (c):

“In deciding whether to assign a transgender or intersex inmate to a facility for male or female inmates...the agency shall consider on a case-by-case basis whether a placement would ensure the inmate’s health and safety, and whether the placement would present management or security problems.”

Upon receipt of information from a Pre-Sentence Report, court order, U.S. Attorney’s Office, defense counsel, the offender, or other source that an individual entering BOP custody is transgender, designations staff will refer the matter to the TEC for advice and guidance on designation.

Institution staff managing pretrial or holdover offenders may also refer cases to the TEC for review. Any TEC recommendations concerning pretrial inmates will be coordinated with the appropriate United States Marshal’s Office.

The TEC will consider factors including, but not limited to, an inmate's security level, criminal and disciplinary history, current gender expression, medical and mental health needs/information, vulnerability to sexual victimization, and likelihood of perpetrating abuse. The TEC may also consider facility-specific factors, including inmate populations, staffing patterns, and physical layouts (e.g., types of showers available). ~~The TEC will recommend housing by gender identity when appropriate.~~

In deciding the facility assignment for a transgender or intersex inmate, the TEC should make the following assessments on a case-by-case basis:

- The TEC will use biological sex as the initial determination for designation;
- The TEC will consider the health and safety of the transgender inmate, exploring appropriate options available to assist with mitigating risk to the transgender offender, to include but not limited to cell and/or unit assignments, application of management variables, programming missions of the facility, etc.;
- The TEC will consider factors specific to the transgender inmate, such as behavioral history, overall demeanor, and likely interactions with other inmates; and
- The TEC will consider whether placement would threaten the management and security of the institution and/or pose a risk to other inmates in the institution (e.g., considering inmates with histories of trauma, privacy concerns, etc.).

The designation to a facility of the inmate's identified gender would be appropriate only in rare cases after consideration of all of the above factors and where there has been significant progress towards transition as demonstrated by medical and mental health history.

It will be noted in SENTRY designation notes that the TEC reviewed the inmate for appropriate institution designation.

6. INTAKE SCREENING

The PREA regulations in 28 C.F.R. part 115, Subpart A, incorporated into the Program Statement **Sexually Abusive Behavior Prevention and Intervention Program** and the Program Statement **Intake Screening**, address intake screening. Screening of transgender inmates will be conducted in accordance with these policies and all other applicable policies and procedures.

7. HOUSING AND PROGRAMMING ASSIGNMENTS

During Initial classification and Program Reviews, Unit Management staff will twice-yearly review the inmate(s) current housing unit status and programming available for transgender inmates; this review will be documented by Unit Management.

The reviews will consider on a case-by-case basis that the inmate placement does not jeopardize the inmate's health and safety and does not present management or security concerns.

In making housing unit and programming assignments, a transgender or intersex inmate's own views with respect to his/her own safety must be given serious consideration.

Transgender inmates shall be given the opportunity to shower separate from other inmates.

The agency shall not place transgender or intersex inmates in dedicated facilities, units, or wings solely on the basis of such identification or status, unless such placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such inmates.

In order for an inmate to be considered for transfer to another institution of the same sex as the inmate's current facility location, including a facility housing individuals of the inmate's identified gender, the Warden should consult with the TEC prior to submitting a designation request to the DSCC, but this is not required.

In addition, the Warden may make a recommendation to the TEC to transfer a transgender or intersex inmate based on an inmate's identified gender.

In considering such recommendations, the TEC will apply all criteria of Section 5, above, and make the following assessments concerning the recommendation:

- The TEC will use biological sex as the initial determination for designation;
- The TEC will consider the health and safety of the transgender inmate, exploring appropriate options available to assist with mitigating risk to the transgender offender, to include but not limited to cell and/or unit assignments, application of management variables, programming missions of the facility, re-designation to another facility of the same sex, etc.;
- The TEC will also consider factors specific to the transgender inmate, such as behavioral history, overall demeanor, program participation, and likely interactions with other inmates; and
- The TEC will consider whether placement would threaten the management and security of the institution and/or pose a risk to other inmates in the institution (e.g., considering inmates with histories of trauma, privacy concerns, etc.).

The designation to a facility of the inmate's identified gender would be appropriate only in rare cases after consideration of all of the above factors and where there has been significant progress

towards transition as demonstrated by medical and mental health history, as well as positive institution adjustments.

It will be noted in SENTRY designation notes that the TEC reviewed the inmate for appropriate institution designation.

8. DOCUMENTATION AND SENTRY ASSIGNMENTS

a. **Medical and Mental Health Information.** Medical and mental health information for transgender inmates will be maintained in the current electronic recordkeeping system in accordance with the Program Statement **Health Information Management**. Medical and mental health information is considered confidential, and may only be released in accordance with appropriate laws, rules, and regulations.

b. **Initial Screening.** For initial designations, designations staff will assign Case Management Activity (CMA) SENTRY assignments if information in the PSR or other documentation indicates a likely transgender identity. The screening codes will be:

SCRN M2F – inmate should be screened for male to female.

SCRN F2M – inmate should be screened for female to male.

Any inmate arriving at the designated institution with a screening code is to be referred to the Chief Psychologist or designee for review within 14 days. If the code was assigned in error, the screening code will be removed by the psychologist. If the inmate identifies as transgender, the psychologist will replace the screening code with an identifying code, as indicated below. Holdover facilities will be exempt from this initial screening requirement, as limited available records and brevity of stay do not allow for a comprehensive screening.

Any inmate who arrives without a screening code but identifies as transgender during intake, or at any time during the incarceration period, is referred to the Chief Psychologist or designee and interviewed within 14 days of the inmate notification. Inmates in pretrial status at Bureau facilities may also receive a SENTRY code.

c. **Notification to Staff and Tracking.** After consultation with Psychology Services, and if the inmate affirms his/her transgender identity, the screening code will be updated to a permanent assignment by a psychologist:

TRN M2F – inmate is male to female transgender (transgender female).

TRN F2M – inmate is a female to male transgender (transgender male).

The inmate must request to Psychology Services staff that the CMA assignment be entered, and the inmate consents that all staff will therefore be notified that the individual is transgender. The inmate's request will be documented on BP-A1110, Case Management Activity (CMA) SENTRY Assignment Consent Form for Transgender Inmates (included as Attachment A to this policy). Psychology Services will maintain the form in the electronic mental health record and forward a copy of the form to the Unit Team. The Unit Team will maintain the form in the FOI Exempt section of the Central File.

Staff should consult the CMA assignment when interacting with the inmate; e.g., use of pronouns, searches, commissary items, etc., as indicated below.

If there are questions about the need to continue a CMA assignment, the Warden should contact the **Women and Special Populations Branch**. Should the CMA assignment change, staff members will not be disciplined for the continued provision of accommodations or use of pronouns.

9. HORMONE AND **NECESSARY** MEDICAL TREATMENT

Hormone or other **necessary** medical treatment may be provided after an individualized assessment of the requested inmate by institution medical staff. Medical staff should request consultation from Psychology Services regarding the mental health benefits of hormone or other **necessary** medical treatment. If appropriate for the inmate, hormone treatment will be provided in accordance with the Program Statement **Patient Care** and relevant clinical guidance. Questions concerning hormone treatment may be referred to the TCCT.

In the event this treatment changes the inmate's appearance to the extent a new identification card is needed, the inmate will not be charged for the identification card.

10. INSTITUTION PSYCHOLOGY SERVICES

Bureau psychologists are available to provide assessment and treatment services for transgender inmates, if appropriate. Guidance on assessment procedures will be provided by the Psychology Services Branch.

If an inmate identifies as transgender, the psychologist will provide the inmate with information regarding the range of treatment options available in the Bureau and their implications. In addition, based upon the psychologist's preliminary assessment and the inmate's expressed interest, a referral to the Clinical Director and/or Chief Psychiatrist may be generated. While the initial interview must be scheduled within 14 days, an assessment may take longer in some instances.

In addition to a referral to medical services, a transgender inmate may be offered individual psychotherapy. Individual psychotherapy goals might include: (1) helping the inmate to live more comfortably within a gender identity and deal effectively with non-gender issues; (2) emphasizing the need to set realistic life goals related to daily living, work, and relationships, including family of origin; (3) seeking to define and address issues that may have undermined a stable lifestyle, such as substance abuse and/or criminality; and (4) addressing any co-occurring mental health issues. Mood disorders, anxiety disorders, substance use disorders, and personality disorders, etc., may also be present; any effective treatment plan will fully address these symptoms.

If an institution has multiple transgender inmates, a support group facilitated by a mental health provider may also be a component of the treatment plan. Common concerns of transgender inmates, which may be addressed effectively in a group setting, include self-esteem issues and relationship issues.

Psychologists who provide mental health treatment for transgender inmates address all mental health needs, including suicide risk, if present.

Psychologists working with transgender inmates are encouraged to consult the Reentry Services Division in Central Office for additional resources.

11. PRONOUNS AND NAMES

Staff interacting with inmates who have a CMA assignment of transgender can use the authorized gender-neutral communication with inmates (e.g., by the legal last name or “Inmate” last name). Transgender inmates often prefer to be called by pronouns of their identified gender identity. Staff may choose to use these gender-specific pronouns or salutations per the inmate’s request, and will not be disciplined for doing so.

An official committed name change while in BOP custody must be done consistent with the Program Statement **Correctional Systems Manual**, Chapter 4. The name entered on the inmate’s Judgement and Commitment Order will remain the official committed name for all Bureau records (incident reports, progress reviews, sentence calculations, etc.). However, any additional names or aliases can be entered into SENTRY as appropriate.

12. PAT SEARCHES

Pat searches of transgender inmates will be conducted in accordance with the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas**. The policy language, included here as a reference, states:

“Transgender Inmates – For purposes of pat searching, inmates will be pat-searched in accordance with the gender of the institution, or housing assignment, in which they are assigned. Transgender inmates may request an exception. The exception must be pre-authorized by the Warden, after consultation with staff from Health Services, Psychology Services, Unit Management, and Correctional Services. Exceptions must be specifically described (e.g., “pat search only by female staff”), clearly communicated to relevant staff through a memorandum, and reflected in SENTRY (or other Bureau database; e.g., posted picture file). Inmates should be provided a personal identifier (e.g., notation on commissary card, etc.) that indicates their individual exception, to be carried at all times and presented to staff prior to pat searches.”

It is recommended the inmate request the exception by submitting an Inmate Request to Staff (BP-A0148) to the Warden. The Warden will consult with the departments listed above, and the memo approving or denying the request will be generated by the Warden’s Office.

Inmates who are granted this exception under policy may have it reversed by the Warden if found to have violated institution rules concerning contraband.

In exigent circumstances, any staff member may conduct a pat search of any inmate consistent with the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas**.

13. VISUAL SEARCHES

For purposes of a visual search, inmates will be searched in accordance with the gender of the institution, or housing assignment, to which they are assigned. The visual search shall be made in a manner designed to ensure as much privacy to the inmate as practicable. Staff should consider the physical layout of the institution, and the characteristics of an inmate with a transgender CMA assignment, to adjust conditions of the visual search as needed for the inmate’s privacy.

Transgender inmates may also request an exception to be visually searched by a staff member of the inmate’s identified gender. The exception must be pre-authorized by the Warden, after consultation with staff from Health Services, Psychology Services, Unit Management, and Correctional Services. Exceptions must be specifically described (e.g., “visual search only by female staff”), clearly communicated to relevant staff through a memorandum, and reflected in SENTRY (or other Bureau database; e.g., posted picture file). Inmates should be provided a

personal identifier (e.g., notation on commissary card, etc.) that indicates their individual exception, to be carried at all times and presented to staff prior to visual searches.

It is recommended the inmate request the exception by submitting an Inmate Request to Staff (BP-A0148) to the Warden. The Warden will consult with the departments listed above, and the memo approving or denying the request will be generated by the Warden's Office.

Inmates who are granted this exception under policy may have it reversed by the Warden if found to have violated institution rules concerning contraband.

Transgender inmates placed at an institution or in a housing unit that does not correspond with their identified gender, and who are granted an exemption as indicated above, will be searched by: bargaining unit staff of the inmate's identified gender who consent to participate in the search; management staff of the inmate's identified gender who consent to participate in the search; or available Health Services clinical staff.

Transgender inmates placed at an institution or in a housing unit of their identified gender will be searched by bargaining unit staff of the inmate's identified gender who consent to participate in the search; management staff of the inmate's identified gender; or available medical staff.

Institutions should consider using available body scanning technology in lieu of visual searches of transgender inmates.

In exigent circumstances, any staff member may conduct a visual search of any inmate consistent with the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas**.

14. CLOTHING AND COMMISSARY ITEMS

Consistent with safety and security concerns, inmates with the CMA assignment of transgender will have the opportunity to have undergarments of their identified gender even if they are not housed with inmates of the identified gender. Institutional laundry will have available institutional undergarments that fulfill the needs of transgender inmates. Undergarments will not have metal components.

Standardized lists of Commissary items for transgender inmates are available in accordance with the Program Statement **Trust Fund/Deposit Manual**.

Additional items based on an individualized assessment of the transgender inmate may be approved by the Warden. Additional items may be provided by the institution or purchased by the inmate, as appropriate.

Inmates who purchase and/or are provided items under this section will be subject to disciplinary sanctions, including the removal of these items, if they are found to have violated institution rules relating to the possession of these items.

15. REENTRY NEEDS

In accordance with the Program Statement **Release Preparation Program**, institution staff should assist transgender inmates in addressing these issues prior to release or placement in a Residential Reentry Center/Home Confinement.

During initial classifications and Program Reviews, Unit Management will formulate a pre-release plan that will assist transgender inmates in obtaining appropriate identification, finding housing and employment, and providing community resources to reintegrate into the community.

The Reentry Affairs Coordinator may assist staff with identifying these resources. Institution and/or Regional Social Workers should be contacted concerning the continuity of medical care.

The **Women and Special Populations Branch** and/or Social Workers can be contacted to provide guidance and resources for reentry needs of transgender inmates.

16. ADMINISTRATIVE REMEDIES

Inmates may use the procedures of the Program Statement **Administrative Remedy Program** concerning any issues relating to this policy.

REFERENCES

Program Statements

P1330.18	Administrative Remedy Program (1/6/14)
P4500.11	Trust Fund/Deposit Fund Manual (4/9/15)
P5100.08	Security Designation and Custody Classification Manual (9/12/06)
P5290.15	Intake Screening (3/30/09)
P5310.12	Psychology Services Manual (03/07/95)
P5310.16	Treatment and Care of Inmates with Mental Illness (5/1/14)
P5322.13	Inmate Classification and Program Review (5/16/14)
P5324.08	Suicide Prevention (4/5/07)
P5324.12	Sexually Abusive Behavior Prevention and Intervention Program (6/4/15)
P5325.07	Release Preparation Program (12/31/07)
P5521.06	Searches of Housing Units, Inmates, and Inmate Work Areas (6/4/15)
P5800.15	Correctional Systems Manual (9/23/16)

P6031.04 Patient Care (6/3/14)
P6090.04 Health Information Management (3/2/15)

Federal Regulations

28 CFR part 115

Additional Resources For Clinicians

Diagnostic and Statistical Manual of Mental Disorders (DSM), most current version.
World Professional Association for Transgender Health (WPATH) standards.

BOP Forms

BP-A0148 Inmate Request to Staff
BP-A1110 Case Management Activity (CMA) SENTRY Assignment Consent Form for Transgender Inmates

*ACA Standards (see Program Statement, **Directives Management Manual**, sections 2.5 and 10.3)*

- American Correctional Association Standards for Adult Correctional Institutions, 4th Edition: 4-4056M, 4-4084M, 4-4084.1M, 4-4133M, 4-4180M, 4-4194M, 4-4278M, 4-4281.1M, 4-4281.2M, 4-4281.3M, 4-4281.4M, 4-4281.5M, 4-4281.6M, 4-4281.7M, 4-4281.8M, 4-4362M, 4-4371M, 4-4406M.
- American Correctional Association Performance Based Standards for Adult Local Detention Facilities, 4th Edition: 4-ALDF-2A-29, 4-ALDF-2A-32, 4-ALDF-2A-34, 4-ALDF-6B-03, 4-ALDF-2C-03, 4-ALDF-4C-22M, 4-ALDF-4C-30M, 4-ALDF-4D-22, 4-ALDF-4D-22-1, 4-ALDF-4D-22-2, 4-ALDF-4D-22-3, 4-ALDF-4D-22-4, 4-ALDF-4D-22-5, 4-ALDF-4D-22-6M, 4-ALDF-4D-22-7, 4-ALDF-4D-22-8, 4-ALDF-7B-08, 4-ALDF-7B-10, 4-ALDF-7B-10-1.
- American Correctional Association Standards for Administration of Correctional Agencies, 2nd Edition: None.
- American Correctional Association Standards for Correctional Training Academies: None.

Records Retention

Requirements and retention guidance for records and information applicable to this program are available in the Records and Information Disposition Schedule (RIDS) on Sallyport.

**Attachment A. Case Management Activity (CMA) SENTRY Assignment
Consent Form for Transgender Inmates (BP-A1110)**

I agree that Bureau of Prisons staff may enter a CMA assignment on SENTRY concerning my gender identity.

I understand that this CMA assignment will identify me as transgender to all staff members.

I understand that the purpose of the CMA assignment is to assist staff members in providing programs and taking measures as described in the Program Statement **Transgender Offender Manual**.

I understand that specific medical and mental health information will not be disclosed to all staff using the CMA assignment; specific medical and mental health information is maintained separately.

Inmate Name:

Register Number:

Signature:

Date:

**IN THE UNITED STATES DISTRICT COURT FOR THE
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION**

REIYN KEOHANE,

Plaintiff,

v.

Case No. 4:24-cv-434-AW-MAF

**RICKY D. DIXON, in his official capacity
as Secretary of the Florida Department of
Corrections, et al.,**

Defendants.

_____ /

ORDER DENYING MOTION FOR PRELIMINARY INJUNCTION

Plaintiff Reiyne Keohane, a transgender Florida inmate, brought this § 1983 action against three prison officials.¹ Keohane, a male who self-identifies as a woman, has gender dysphoria.² For several years, the Department of Corrections has provided Keohane (and other inmates) with hormone treatment. The Department has

¹ Defendants are Ricky Dixon, in his official capacity as Secretary of the Florida Department of Corrections; Clayton Weiss, in his official capacity as Health Services Director of the Florida Department of Corrections; and Gary Hewett, in his official capacity as Warden of the Wakulla Correctional Institution. ECF No. 1. A suit against any official-capacity defendant is, in essence, against the entity he represents. *See Kentucky v. Graham*, 473 U.S. 159, 166 (1985). Thus, and for simplicity, this order will refer to Defendants collectively as the “Department.”

² Gender dysphoria, “in general terms, ‘refers to the distress that may accompany the incongruence between one’s experienced or expressed gender and one’s assigned gender.’” *Keohane v. Fla. Dep’t of Corr. Sec’y*, 952 F.3d 1257, 1262 (11th Cir. 2020) (quoting Am. Psychiatric Ass’n, Diagnostic and Statistical Manual of Mental Disorders 451 (5th ed. 2013)).

also allowed certain policy deviations regarding hair length, makeup, and women's undergarments.

Now, a new policy prohibits all male inmates—including transgender inmates with gender dysphoria—from wearing long hair, makeup, or women's undergarments.³ In addition, the Department will reevaluate all inmates who have been receiving hormone treatment to determine whether the treatment should continue. That reevaluation process has begun, and as of now, the Department has not discontinued hormone treatment for any inmate based on the policy or any reevaluation.

Keohane sued to enjoin the new policy's implementation, contending it violates the Eighth Amendment. At issue now is Keohane's request for a preliminary injunction and temporary restraining order. After a hearing, and after careful consideration of the record and the parties' arguments, I deny the motion.

I.

At the litigation's outset, Keohane sought both a temporary restraining order and a preliminary injunction. ECF No. 4. I denied the motion to the extent it sought a temporary restraining order before the Department could have notice and an opportunity to respond. ECF No. 14. Then, after a telephonic hearing to address

³ Inmates needing breast support may still possess bras, *see* ECF No. 46-3 at 2, but this exception does not cover Keohane, ECF No. 53-5 at 2.

procedural matters, I set a briefing schedule and a hearing. ECF No. 22. The Department agreed in the meantime to postpone applying the new policy to Keohane, pending resolution of the preliminary-injunction motion.

Both sides submitted evidence. Keohane and two other transgender inmates provided declarations, ECF Nos. 4-7, 16-2, 46-10, 46-11, as did Keohane's counsel, ECF Nos. 4-1, 16-1, 46-1. The Department submitted declarations from Dr. Danny Martinez, Chief of Medical Services, ECF Nos. 38-1, 52-1; Dr. Suzonne Klein, Chief of Mental Health, ECF No. 38-2; and Clayton Weiss, Health Services Director, ECF No. 38-3. At the hearing, both sides agreed I could consider all the declarations. *Cf. Levi Strauss & Co. v. Sunrise Int'l Trading Inc.*, 51 F.3d 982, 985 (11th Cir. 1995) (noting that courts may consider hearsay evidence at the preliminary-injunction stage).⁴ Neither side elected to present live direct testimony. But over the Department's objection, I allowed Keohane to cross-examine Dr. Martinez as to his declarations. Keohane also submitted several exhibits at the hearing. *See* ECF No. 53. I have considered the entire evidentiary record.

⁴ The Department moved to strike two inmate declarations submitted with Keohane's reply. ECF No. 47. I denied the motion but indicated I would entertain argument at the hearing about whether I should consider the declarations. ECF No. 49. At the hearing, the Department withdrew its objection to my considering those declarations.

The Department previously asserted lack of exhaustion under the Prison Litigation Reform Act as one reason why Keohane is not entitled to a preliminary injunction. ECF No. 38 at 22-24. It was the Department's burden to demonstrate failure to exhaust administrative remedies, which is an affirmative defense. *Whatley v. Smith*, 898 F.3d 1072, 1082 (11th Cir. 2018). After the hearing, the Department withdrew its exhaustion defense, ECF No. 54, so I will not consider it here.

II.

A preliminary injunction is “an extraordinary and drastic remedy” that is unavailable unless the movant clearly establishes entitlement. *Siegel v. LePore*, 234 F.3d 1163, 1176 (11th Cir. 2000) (en banc) (quoting *McDonald's Corp. v. Robertson*, 147 F.3d 1301, 1306 (11th Cir. 1998)); see also *Texas v. Seatrain Int'l, S.A.*, 518 F.2d 175, 179 (5th Cir. 1975) (“[G]ranted a preliminary injunction is the exception rather than the rule.”). To obtain a preliminary injunction, a plaintiff must clearly establish: (1) “a substantial likelihood of success on the merits”; (2) that the plaintiff will suffer irreparable injury without an injunction; (3) that the threatened injury “outweighs whatever damage the proposed injunction may cause” the other side; and (4) that “the injunction would not be adverse to the public interest.” *Siegel*, 234 F.3d at 1176.

Because a plaintiff must clearly establish all four requirements, a failure on even one is fatal. *ACLU of Fla., Inc. v. Miami-Dade Cnty. Sch. Bd.*, 557 F.3d 1177,

1198 (11th Cir. 2009). “[T]he most common failure is not showing a substantial likelihood of success on the merits.” *Id.* As explained below, Keohane fails on that point. I therefore must deny the motion, and I need not address the remaining requirements.

III.

Keohane’s complaint presents a single count: one for “denial of medically necessary treatment in violation of the Eighth Amendment.” ECF No. 1 at 21. The Eighth Amendment “prohibits ‘deliberate indifference to serious medical needs of prisoners.’” *Hoffer v. Sec’y, Fla. Dep’t of Corr.*, 973 F.3d 1263, 1270 (11th Cir. 2020) (quoting *Estelle v. Gamble*, 429 U.S. 97, 104 (1976)). States “therefore have a constitutional obligation to provide minimally adequate medical care to those whom they are punishing by incarceration.” *Id.* (quoting *Harris v. Thigpen*, 941 F.2d 1495, 1504 (11th Cir. 1991)). A prison official acts with deliberate indifference only if he (1) has subjective knowledge of a risk of serious harm and (2) disregards that risk (3) in what amounts to recklessness as defined in the criminal law. *Wade v. McDade*, 106 F.4th 1251, 1255 (11th Cir. 2024) (en banc); *see also Farmer v. Brennan*, 511 U.S. 825, 839-40 (1994).

Keohane’s single count has two components. It challenges the policy’s separate restrictions on hormone treatment and on “clothing and grooming accommodations.” ECF No. 1 ¶¶ 71, 74. The “clothing and grooming

accommodations” include permission to wear long hair, makeup, and women’s undergarments. For simplicity and clarity, I will refer to the two components as “hormone treatment” and “social accommodations.”⁵

Although part of one claim, the two components differ in some ways. The Department defends them differently: it argues, for example, that Keohane lacks standing as to hormone treatment and that issue preclusion bars the social accommodations piece. And the facts differ: it is undisputed, for example, that no inmate has lost hormone treatment based on the new policy but that all inmates (other than Keohane) have lost their social accommodations.⁶ Accordingly, I will address the hormone-treatment and social-accommodations aspects of the claim separately.

A. Hormone Treatment

As to hormone treatment, the Department first argues standing. To succeed in any case, a plaintiff must have standing, “an essential and unchanging part of the case-or-controversy requirement.” *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560

⁵ Department records use the term “GD [gender dysphoria] accommodations” to refer to all accommodations other than hormone treatment. *See* ECF No. 46-5 at 1; *see also* Dr. Martinez hearing testimony. This terminology is imperfect because some would call hormone treatment a gender dysphoria accommodation and because there is disagreement about whether the social accommodations constitute medical treatment. Thus, this order will use the terms “hormone treatment” and “social accommodations.”

⁶ As already noted, the Department agreed to pause implementation as to Keohane—including the social accommodations—pending resolution of the preliminary injunction.

(1992). To establish standing, a plaintiff must show (1) an injury in fact (2) traceable to the defendant’s action (3) that is redressable by a favorable decision. *Id.*; *see also Lewis v. Gov. of Ala.*, 944 F.3d 1287, 1296 (11th Cir. 2019). “[E]ach element must be supported . . . with the manner and degree of evidence required at the successive stages of litigation.” *Lujan*, 504 U.S. at 561. Thus, at the preliminary injunction stage, “the plaintiff must make a ‘clear showing’ that she is ‘likely’ to establish each element of standing.” *Murthy v. Missouri*, 603 U.S. 43, 58 (2024) (cleaned up). That means that to succeed at this stage, Keohane had to clearly demonstrate, among other things, a likelihood of a prospective injury.

Keohane’s ultimate concern is that the new policy will lead to a discontinuation of hormone treatment. But importantly, as counsel confirmed at the hearing, Keohane does not currently advance any claim that eliminating hormone treatment would necessarily violate the Eighth Amendment. Instead, the claim is that the new policy is a “blanket ban” on hormone treatment and that any “blanket ban” against specific treatments violates the Eighth Amendment. The main problem with this argument is that the record shows the new policy is *not* a “blanket ban.”

The evidence, including hearing testimony, demonstrated that the Department will individually evaluate every inmate who was receiving hormone treatment. Based on that evaluation, the Department will determine if continued hormone treatment is medically necessary. If the Department concludes it *is* medically

necessary, the hormone treatment will continue. Dr. Martinez testified this was the case, and I credit his testimony. *See also* ECF No. 4-4 at 3 (“All inmates diagnosed with gender dysphoria will be individually evaluated.”). The evidence further demonstrated the Department has conducted an initial review and “preliminarily determined” that Keohane should continue with hormone treatment. ECF No. 38-1 ¶ 23. That preliminary determination remains subject to final approval, *id.* ¶ 24, so it remains to be determined whether Keohane will, in fact, continue receiving it. But the bottom line is that Keohane has not shown any blanket ban.

In arguing otherwise, Keohane points to the written policy (the “Health Bulletin,” ECF No. 4-4) and insists that several of its provisions suggest it will function as a complete bar to hormone treatment.

First, Keohane argues that the Health Bulletin assumes the default is that inmates will not receive hormone treatment and that exceptions will be available in “rare instances.” Health Bulletin § IX(C). That is consistent with Dr. Martinez’s testimony that the Department will provide hormone treatment only when medically necessary. It is true, as Keohane argues, that the Health Bulletin also provides that hormone treatment will be available only with a variance that itself is available only in specific circumstances. But that does not mean no inmate will receive a variance. Indeed, the Department’s multidisciplinary team has already recommended a variance for Keohane. At any rate, a policy of providing hormone treatment in “rare

instances deemed medically necessary,” *id.*, is a far cry from a blanket policy. As Dr. Martinez explained, the key inquiry under the policy is medical necessity.

It is also true that the Health Bulletin limits hormone treatment to instances when it is “necessary to comply with the U.S. Constitution or a court decision.” *Id.* But that is no obstacle to constitutionally required care. Keohane notes it is unclear how the Department determines what is constitutionally required, but, again, Dr. Martinez testified that inmates would receive any “medically necessary” care. And to the extent the Department provides what is medically necessary, it has provided what is constitutionally required. Keohane never argues that the Eighth Amendment requires care beyond what is medically necessary. Indeed, even medical care falling below what is medically necessary does not necessarily violate the Eighth Amendment. *See Harris*, 941 F.2d at 1505 (“[T]he Supreme Court has also emphasized that not ‘every claim by a prisoner that he has not received adequate medical treatment states a violation of the Eighth Amendment.’” (quoting *Estelle*, 429 U.S. at 105)).

Next, Keohane notes the Health Bulletin’s observation that state law forbids “expending any state funds to purchase cross-sex hormones for the treatment of Gender Dysphoria.” ECF No. 46 at 2 (quoting Health Bulletin); *see also* Fla. Stat. § 286.311(2) (“A governmental entity . . . may not expend state funds . . . for sex-reassignment prescriptions or procedures . . .”). This, though, does not support

finding a blanket ban. For one, that statutory provision became effective May 2023, and the Department has nonetheless continued providing hormone treatment to Keohane and others. For another thing, the hearing testimony showed that the Department provides the hormones through an outside vendor—apparently leaving the Department to maintain that state funds are not involved. *See* Trans. (Q: “Who pays for hormone therapy of inmates?” Dr. Martinez: “We contract with an outside vendor to provide the actual hands-on clinical care . . . and they are covering the cost of hormones . . . to be in compliance with the law that is mentioned in the [Health Bulletin].”). Moreover, even if the Department generally viewed the statute as an obstacle to providing hormone treatment, the Health Bulletin suggests it will disregard the statute if necessary to provide constitutionally adequate care. *See* Health Bulletin § IX(B) (“The Department shall comply with this statutory requirement unless compliance with the U.S. Constitution or a court decision requires otherwise.”).

Keohane also points to the fact that the Health Bulletin limits variances to instances in which “the treating physician can demonstrate with documented evidence that [hormone] treatment may improve clinical outcomes by treating the etiological basis of the pathology.” *Id.* § IX(C)(1). In Keohane’s view, that means transgender inmates can never have hormone treatment because hormone treatment

“is not intended to treat the etiological basis of gender dysphoria.” ECF No. 4 at 21

(emphasis omitted). Keohane explains it this way:

hormone therapy helps align a person’s secondary sex characteristics with their gender identity, thereby alleviating the distress that results from the incongruity between their gender identity and sex assigned at birth. It does not treat the root cause of their gender dysphoria—having a gender identity different from one’s sex assigned at birth—because that is not something that needs to be fixed.

Id. (citing Am. Psychiatric Ass’n, Diagnostic and Statistical Manual of Mental Disorders 451 (5th ed. 2013)) (“DSM-V”).

To the extent Keohane reads the Health Bulletin as allowing hormone treatment only when it would change an inmate’s “gender identity,” that is a serious misreading. Keohane asserts that distress flowing from the “incongruity between” sex and gender identity is at the core of gender dysphoria—and that the purpose of hormone treatment is to alleviate distress. *Id.*; *see also* DSM-V (explaining that gender dysphoria “refers to the distress that may accompany the incongruence between one’s experienced or expressed gender and one’s assigned gender”); *id.* at 453 (noting that gender dysphoria in adults “is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning”). Indeed, as Keohane acknowledges, not all transgender individuals have gender dysphoria. *See* ECF No. 4 at 4 (“For some but not all transgender people, the incongruence between gender identity and assigned gender results in gender dysphoria”); *see also* DSM-V at 451 (“[N]ot all individuals will

experience distress as a result of such incongruence.”). Thus, Keohane has not shown that the policy’s “etiological basis” provision would preclude hormone treatment.

Regardless, the fact remains that Dr. Martinez credibly testified that the Department will provide hormone treatment if medically necessary to treat gender dysphoria. So whatever one makes of the Health Bulletin’s phrase “treating the etiological basis of the pathology,” that language does not support a conclusion that there is a blanket ban.

Keohane next argues that the Health Bulletin operates as a blanket ban because it allows hormone treatment only when supported by “evidence that such treatment may improve clinical outcomes” and only when that evidence is “based on sound scientific methods and research that were subject to the formal peer review process.” Health Bulletin § IX(C)(1). The Health Bulletin notes that studies supporting the benefits of hormones “are either low or very low quality and rely on unreliable methods,” *id.* § IX(A), and Dr. Martinez testified that there have been no double-blind studies on the subject, which he considers the gold standard. From this, Keohane concludes no existing studies could meet the policy’s daunting standard, meaning the requirement for “sound scientific methods” operates to ban hormone treatment altogether.

There are at least two problems with this argument. First, Dr. Martinez also testified he would consider studies that fell short of the gold standard. He further clarified he could not testify whether particular studies would meet the policy without analyzing their application to specific cases. So Keohane has not shown that the standard is impossible to satisfy. Second, under the very policy Keohane challenges, the Department's preliminary conclusion is that Keohane *does* qualify for continued hormone treatment. This further undermines any argument that the "sound scientific methods" requirement is an insurmountable obstacle.

All of this is to say the Health Bulletin, as written, does not impose any blanket ban. But even assuming there is some tension between the written policy and what Dr. Martinez testified will happen in practice, that provides no basis for relief. Again, Dr. Martinez—who coauthored the Health Bulletin and was instrumental in its development—testified credibly that there is no blanket ban, that every inmate will receive an individual evaluation, and that inmates will receive hormone treatment when medically necessary. Thus, if Keohane were correct that the Health Bulletin's text imposes a blanket ban forever precluding hormone treatment, then I would agree with Keohane that the Department "ignore[s] what the policy actually says." ECF No. 46 at 2. Either way, I find, based on the evidence, that the Department intends to conduct individualized assessments and to provide hormone treatment when medically necessary.

That leads us back to where we started: Keohane has not shown there is a blanket ban on hormone treatment. Keohane thus has not shown an imminent injury relating to hormone treatment. That means Keohane has not shown a likelihood of establishing standing as to any claim about hormone treatment, which necessarily means there is no showing of a likelihood of success on the merits. *See Murthy*, 603 U.S. at 58. But even putting standing aside, it also means there is no likelihood of success on the merits for the simple reason that the claim depends on showing a blanket ban, and there has been no showing of a blanket ban as to hormone treatment.

B. Social Accommodations

Keohane has not shown a substantial likelihood of success on the merits as to social accommodations either. As to this component, there is no problem with standing: the parties agree the new policy will preclude Keohane from wearing long hair, makeup, and women's undergarments. That is a concrete and particularized harm. *See Spokeo, Inc. v. Robins*, 578 U.S. 330, 339-40 (2016) (noting that a particularized harm is one that "affect[s] the plaintiff in a personal and individual way" and that "intangible injuries can nevertheless be concrete"). That harm is also traceable to the Department's actions, and an injunction requiring the Department to permit social accommodations would redress the injury.

Showing standing is only part of the burden. Whether a plaintiff has standing and whether he can succeed on the merits are two separate inquiries. *See Corbett v.*

Transp. Sec. Admin., 930 F.3d 1225, 1228 (11th Cir. 2019) (explaining that standing is a “threshold jurisdictional question which must be addressed prior to and independent of the merits of a party’s claims” (quoting *Bochese v. Town of Ponce Inlet*, 405 F.3d 964, 974 (11th Cir. 2005))); *Culverhouse v. Paulson & Co. Inc.*, 813 F.3d 991, 994 (11th Cir. 2016) (“[I]n reviewing the standing question, the court must be careful not to decide the questions on the merits for or against the plaintiff, and must therefore assume that on the merits the plaintiffs would be successful in their claims.” (quoting *City of Waukesha v. EPA*, 320 F.3d 228, 235 (D.C. Cir. 2003))). I thus now turn to the merits.

The Department leads off with an issue-preclusion argument, noting that Keohane already litigated entitlement to social accommodations. In a 2016 lawsuit, Keohane sought both hormones and social accommodations. *See Keohane v. Fla. Dep’t of Corr. Sec’y*, 952 F.3d 1257, 1262 (11th Cir. 2020) (*Keohane I*). The district court granted an injunction and required the Department to provide both. *Id.* But after the Department adopted a new policy that allowed hormone treatment, the Eleventh Circuit concluded the claim as to hormones was moot. *Id.* at 1272. As to social accommodations, though, the Eleventh Circuit reversed the judgment on the merits. *Id.* at 1277-78. It found no basis to conclude prison officials showed deliberate indifference by denying the requested social accommodations. *Id.* at 1274.

The Eleventh Circuit rejected Keohane’s claim for two reasons. First, it concluded “the testifying medical professionals were—and remain—divided over whether social transitioning is medically necessary to Keohane’s gender-dysphoria treatment.” *Id.* The professional disagreement meant there was no Eighth Amendment violation because “a simple difference in medical opinion between the prison’s medical staff and the inmate as to the latter’s diagnosis or course of treatment cannot support a claim of cruel and unusual punishment.” *Id.* (quoting *Harris*, 941 F.2d at 1505) (cleaned up). Second, the Court explained that the Department “denied Keohane’s social-transitioning-related requests, at least in part, on the ground that they presented serious security concerns—including, most obviously, that an inmate dressed and groomed as a female would inevitably become a target for abuse in an all-male prison.” *Id.* at 1275. At bottom, the Court rejected the claim that the Department violated the Eighth Amendment by not providing Keohane’s requested social accommodations. *Id.* at 1277-78.

The Department argues the earlier case precludes relief here. ECF No. 38 at 18. Issue preclusion applies when (1) an issue is identical to one in a prior proceeding; (2) the issue was actually litigated; (3) the issue was a critical and necessary part of the judgment; and (4) the opposing party had a full and fair opportunity to litigate the issue. *Christo v. Padgett*, 223 F.3d 1324, 1339 (11th Cir. 2000). Because the issue must be identical, issue preclusion does not apply when

“controlling facts or legal principles have changed significantly.” *Montana v. United States*, 440 U.S. 147, 155 (1979). The burden is on the party asserting issue preclusion to show it applies. *In re McWhorter*, 887 F.2d 1564, 1566 (11th Cir. 1989).

The Department has not met its burden. While it correctly argues that Keohane sought the same accommodations under the same general legal theory, ECF No. 29 at 18, it does not show that Keohane’s medical needs or the science relating to those alleged needs have not changed. Keohane asserts that conditions and treatment are significantly different now. ECF No. 39 at 21-22. Common sense also cautions against giving preclusive effect to determinations about medical needs, which may sometimes change.

But even without issue preclusion, the Department prevails. Keohane presented no evidence showing that denying requested social accommodations is tantamount to providing care so deficient that it constitutes an Eighth Amendment violation.

As a starting point, it is worth remembering that “[a] prisoner bringing a deliberate-indifference claim has a steep hill to climb.” *Keohane I*, 952 F.3d at 1266; *accord Hoffer*, 973 F.3d at 1272. “[T]he Constitution doesn’t require that the medical care provided to prisoners be ‘perfect, the best obtainable, or even very good.’” *Keohane I*, 952 F.3d at 1266 (quoting *Harris*, 941 F.2d at 1510). Instead,

“medical treatment violates the Eighth Amendment only when it is so grossly incompetent, inadequate, or excessive as to shock the conscience or to be intolerable to fundamental fairness.” *Id.* (cleaned up). Thus, Keohane had to demonstrate that denying social accommodations could reach this level. Keohane fell short.

In the earlier litigation, Keohane presented expert medical testimony, but even that was insufficient. *Id.* at 1275. Here, Keohane presented no expert testimony at all. Keohane instead pointed to the World Professional Association for Transgender Health’s (WPATH) Standards of Care, ECF No. 4 at 4-6, explaining that “[d]ressing, grooming, and presenting oneself in a manner consistent with one’s gender identify is an important part of treatment for gender dysphoria.” *Id.* at 6 (citing the WPATH Standards of Care). Some courts have considered WPATH recommendations authoritative, *see, e.g., Edmo v. Corizon, Inc.*, 935 F.3d 757, 769 (9th Cir. 2019), but others have not, *see, e.g., Gibson v. Collier*, 920 F.3d 212, 223 (5th Cir. 2019) (noting that “the WPATH Standards of Care do not reflect medical consensus”); *Kosilek v. Spencer*, 774 F.3d 63, 90 (1st Cir. 2014) (discussing the WPATH standards as “one of two alternatives—both of which are reasonably commensurate with the medical standards of prudent professionals”). But either way, the cited WPATH recommendations do not show the social accommodations are medically necessary.

Next, even if WPATH recommendations suggested social accommodations were medically necessary, Keohane has not shown the absence of any debate about that. Where there is reasonable disagreement about appropriate medical treatment, preferring one reasonable course over another does not violate the Constitution. *See Keohane I*, 952 F.3d at 1275 (“Put simply, when the medical community can’t agree on the appropriate course of care, there is simply no legal basis for concluding that the treatment provided is ‘so grossly incompetent, inadequate, or excessive as to shock the conscience or to be intolerable to fundamental fairness.’” (quoting *Harris*, 941 F.2d at 1505)); *see also id.* at 1275 n.11 (noting that in decisions finding deliberate indifference to a transgender inmate’s serious medical needs “there appeared to be general (and consistent) consensus among the inmate’s medical providers that a particular treatment was medically necessary”).

Keohane relies extensively on three declarations in which inmates express a profound desire for social accommodations. Keohane’s own declaration reports immense distress flowing from being denied these accommodations and that the distress could lead to self-harm, including suicide. ECF No. 4-7 ¶¶ 11, 14. Two other inmate declarations report similar feelings. *See* ECF Nos. 46-10 ¶ 18, 46-11 ¶ 16. But while these are serious matters evidencing serious psychological concerns, Keohane has not shown that the only proper way to address risks of self-harm is to provide inmates with whatever items they contend would reduce those risks. *Cf.*

Keohane I, 952 F.3d at 1274 (“[N]othing in the Eighth Amendment requires that inmates be housed in a manner that is most pleasing to them.” (quoting *Harris*, 941 F.2d at 1511 n.24) (cleaned up)).

Moreover, putting aside the issue of whether the requested social accommodations constitute appropriate medical care, Keohane has not shown any complete absence of care. The record indicates Keohane receives extensive medical treatment relating to gender dysphoria. In addition to the hormone treatment currently provided, the Department makes psychotherapy available to those with gender dysphoria. This is not a case in which the Department simply provides no treatment at all.

The bottom line is that, as before, Keohane has not shown that denying social accommodations violates the Eighth Amendment. *See id.* at 1277-78. This is true even if the Department has a one-size-fits-all policy prohibiting social accommodations for all transgender inmates. As with the hormone treatment, Keohane does not assert entitlement to the social accommodations (at least not at this stage). Instead, the argument is that prison officials must consider on an individualized basis whether an inmate will receive them.⁷ But an across-the-board

⁷ Keohane’s counsel clarified this at the hearing: “I think at this point in the case we don’t need to prove that it is medically necessary for each person; I think that the fact that it is a ban, and there was no individualized determination of medical

prohibition on a particular treatment cannot constitute deliberate indifference when there is no showing that the treatment is ever medically necessary. *See Gibson*, 920 F.3d at 216 (rejecting argument that blanket ban against sex-reassignment surgery—without individual assessment—was unconstitutional: “To use an analogy: If the FDA prohibits a particular drug, surely the Eighth Amendment does not require an individualized assessment for any inmate who requests that drug.”).

And Keohane, having presented no expert evidence, has not shown that the requested social accommodations are ever medically necessary. In short, Keohane—who had the burden of proof—has not shown that the policy of precluding social accommodations violates the Eighth Amendment. *Cf. Hoffer*, 973 F.3d at 1274 (“[I]t wasn’t the Secretary’s burden to demonstrate that treatment [sought] isn’t medically necessary; it was the plaintiffs’ burden to prove that such treatment *is* necessary.”).

None of Keohane’s out-of-circuit authorities supports a conclusion that all “prison policies that automatically exclude certain forms of treatment for gender dysphoria violate the Eighth Amendment.” ECF No. 4 at 19. In *Rosati v. Igbinoso*, 791 F.3d 1037 (9th Cir. 2015), which dealt with the plausibility standard, the decision did not turn on any blanket ban but on allegations regarding plaintiff’s own care. *Id.* at 1040 (“Even absent such a blanket policy, Rosati plausibly alleges her

necessity is sufficient for Eighth Amendment purposes to show deliberate indifference.”

symptoms (including repeated efforts at self-castration) are so severe that prison officials recklessly disregarded an excessive risk to her health by denying [sexual reassignment surgery] solely on the recommendation of a physician’s assistant with no experience in transgender medicine.”). Similarly, in *Fields v. Smith*, 653 F.3d 550 (7th Cir. 2011), the trial evidence “indicated that plaintiffs could not be effectively treated without hormones,” so a blanket hormone ban was unconstitutional. *Id.* at 556, 559. And the decision in *De’Lonta v. Angelone*, 330 F.3d 630 (4th Cir. 2003), decided at the motion-to-dismiss stage, focused on the standard of care for the particular plaintiff. *Id.* at 635-36.

The only Eleventh Circuit authority Keohane cites regarding a blanket ban is *Keohane I*, which stated that “[i]t seems to us that responding to an inmate’s acknowledged medical need with what amounts to a shoulder-shrugging refusal even to consider whether a particular course of treatment is appropriate is the very definition of ‘deliberate indifference’—anti-medicine, if you will.” *Keohane I*, 952 F.3d at 1266-67. This was dicta. *See id.* at 1267 (“We conclude, though, that we are *not* free to reach the merits.”). Regardless, that line does not suggest plaintiffs need not show the “banned” treatment *could be* medically necessary. Furthermore, the evidence here does not show any “shoulder-shrugging refusal” to consider social accommodations. The evidence shows that the new policy was the product of hundreds of hours of reviewing medical literature, followed by a careful

determination that the requested social accommodations would not be provided. The Department, in short, was not “turning a blind eye.” *Hoffer*, 973 F.3d at 1272.

At the end of the day, Keohane has not shown a substantial likelihood of success on the claim about social accommodations.

* * *

Because Keohane has not shown a likelihood of success on the merits, I cannot grant preliminary injunctive relief. I need not address the remaining preliminary-injunction prerequisites. I also need not address Keohane’s request for preliminary classwide relief.

CONCLUSION

The preliminary-injunction motion (ECF No. 4) and the motion for reconsideration (ECF No. 16) are DENIED.

Through separate orders to issue shortly, the court will address the motion to dismiss and provide an initial litigation schedule.

SO ORDERED on December 27, 2024.

s/ Allen Winsor
United States District Judge

MATERIAL UNDER SEAL DELETED

**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

MARIA MOE,

Plaintiff,

v.

DONALD J. TRUMP, in his official
capacity as President of the United States, *et*
al.,

Defendants.

**Case No. 1:25-cv-653-RCL
*SEALED***

ORDER

This case was transferred from the District [REDACTED] on March 6, 2025, and was subsequently assigned to this Court on March 7, 2025. In reviewing the docket, the Court observes that Plaintiff still has an outstanding Motion for Preliminary Injunction [ECF No. 3]. This PI motion has been fully briefed. *See* Defs.' Resp. to Mot. for TRO and PI, ECF No. 17; Pls.' Reply, ECF No. 21.

Plaintiff Maria Moe is similarly situated to the plaintiffs in *Doe v. Bondi*, 25-cv-286-RCL and the plaintiffs in *Jones v. Trump*, 25-cv-401-RCL, two cases before this Court challenging the implementation of Sections 4(a) and 4(c) of Executive Order 14168, *Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government*, 90 Fed. Reg. 8615 (Jan. 20, 2025). In both of those cases, the Court has granted a PI in favor of the plaintiffs, enjoining the defendants from implementing Sections 4(a) and 4(c) of the Executive Order. Here, the Court has reviewed the parties' filings and determines that the same reasoning from the Court's TRO and PI Orders in those cases applies here. *See Doe v. McHenry*, No. 25-cv-

286-RCL, 2025 WL 388218 (D.D.C. Feb. 4, 2025);¹ *see Doe v. Bondi*, 25-cv-286-RCL, ECF Nos. 44, 55; *see Jones v. Trump*, 25-cv-286-RCL, ECF Nos. 28, 46. The Court therefore applies that reasoning here to grant Plaintiff's PI motion.

The Court also observes that the entire matter here is under seal. However, both of the related cases referenced *supra* are only *partially* sealed—the filings are submitted with proposed redactions to remove all details that could identify the plaintiffs to the public, and the plaintiffs are proceeding under the pseudonyms. Given the “strong presumption in favor of public access to judicial proceedings,” *Hardaway v. D.C. Hous. Auth.*, 843 F.3d 973, 980 (D.C. Cir. 2016), and juxtaposed to the related cases with similarly situated plaintiffs, the Court cannot identify a compelling reason to keep this entire case under seal.

In sum, in consideration of Plaintiffs' Motion [ECF No. 3] for a Temporary Restraining Order and Preliminary Injunction, the Opposition [ECF No. 17] thereto, the Reply [ECF No. 21], and the entire record herein, it is hereby

ORDERED that the plaintiff's Motion for a Preliminary Injunction is **GRANTED**; and it is further

ORDERED that the Defendants are hereby enjoined from implementing Sections 4(a) and 4(c) of Executive Order 14168 against Plaintiff Maria Moe, pending further Order of this Court; and it is further

ORDERED that, pending further Order of this Court, Defendants shall maintain and continue the plaintiff's housing status and medical care as they existed immediately prior to January 20, 2025; and it is further

¹ Under Fed. R. Civ. Pr. 25(d), Attorney General Pamela Bondi was “automatically substituted as a party” as the successor for Acting Attorney General James R. McHenry III.

ORDERED that within 48 hours, the parties must show cause as to why this *entire* case should remain under seal rather than simply proceeding pseudonymously, partially sealed, and subject to protective order.

Date: March 50, 2025
12:30 P.M.


Royce C. Lamberth
United States District Judge

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

MARIA MOE,

Plaintiff,

v.

DONALD J. TRUMP, in his official
capacity as President of the United
States, *et al.*,

Defendants.

No. 1:25-cv-653-RCL
SEALED

NOTICE OF APPEAL

Defendants hereby appeal to the United States Court of Appeals for the District of Columbia Circuit from this Court's Order granting Plaintiff's Emergency Motion for a Temporary Restraining Order and Preliminary Injunction (ECF No. 62).

Dated: April 2, 2025

Respectfully submitted,

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Acting Assistant Attorney General

ALEX HAAS
Director, Federal Programs Branch

JEAN LIN
Special Litigation Counsel

/s/ Elizabeth B. Layendecker
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CERTIFICATE OF SERVICE

I hereby certify that on May 9, 2025, I electronically filed the foregoing Volume of the Joint Appendix with the Clerk of the Court for the United States Court of Appeals for the District of Columbia Circuit by using the appellate CM/ECF system.

/s/ McKaye L. Neumeister

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