No. 15-15712

IN THE

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

MICHELLE-LAEL B. NORSWORTHY,

Plaintiff-Appellee,

v.

JEFFREY BEARD, et al.,

Defendants-Appellants.

Appeal from the United States District Court
for the Northern District of California
in Case Number C 14-00695 JST (PR)

ANSWERING BRIEF OF PLAINTIFF-APPELLEE NORSWORTHY

Ilona M. Turner (SBN 256219)
Jennifer Orthwein (SBN 255196)
Shawn T. Meerkamper (SBN 296964)
TRANSGENDER LAW CENTER
1629 Telegraph Avenue, Suite 400
Oakland, California 94612
Telephone: (415) 865-0176
Facsimile: (877) 847-1278

Christopher J. Banks (SBN 218779)
Herman J. Hoying (SBN 257495)
MORGAN, LEWIS & BOCKIUS LLP
One Market Street, Spear Tower
San Francisco, California 94105
Telephone: (415) 442-1000
Facsimile: (415) 442-1001

Attorneys for Plaintiff-Appellee,
MICHELLE-LAEL B. NORSWORTHY

TABLE OF CONTENTS

TABLE OF CONTENTS
(continued)

Page

TABLE OF AUTHORITIES

Page(s)

CASES

TABLE OF AUTHORITIES
(continued)

Page(s)

TABLE OF AUTHORITIES
(continued)

Page(s)

STATUTES

OTHER AUTHORITIES

I. STATEMENT OF JURISDICTION[1]

Plaintiff-Appellee Michelle-Lael Norsworthy ("Plaintiff") agrees with Defendants-Appellees' ("Defendants") jurisdictional statement. (AOB 3-4.)

II. STATEMENT OF THE ISSUE

1. Did the district court correctly grant a preliminary injunction, where the district court found, based on substantial record evidence, that Defendants deliberately ignored Plaintiff's continuing symptoms of gender dysphoria and the recognized standards of care for gender dysphoria; that they were deliberately indifferent to the recommendations of Plaintiff's treating health care provider; that their reasons for denying sex reassignment surgery ("SRS") are pretextual; and that the California Department of Corrections and Rehabilitation ("CDCR") has a blanket policy against providing SRS for transgender inmates?

III. STATEMENT OF THE CASE

A. Plaintiff's Gender Dysphoria

Plaintiff is a transsexual woman—an individual whose female gender identity is different from the male gender assigned to her at birth—seeking SRS to treat her serious gender dysphoria. Since adolescence, she has experienced

[1] We abbreviate Appellants/Defendants' Opening Brief "AOB," the court docket "CD," the Excerpts of Record "ER" and the Supplemental Excerpts of Record "SER."

significant distress and anxiety because of the discrepancy between her male body and her female gender identity. (ER 167; SER 018, 020.)

In the 1990s, while in custody of CDCR, Plaintiff began to understand and accept that she was a transsexual woman. (ER 167-68, SER 018.) As early as 1996, Plaintiff informed prison personnel that she was a transsexual woman and needed hormone therapy and SRS to treat her dysphoria. (ER 167, SER 018.) In 1999, Plaintiff self-referred to CDCR's Gender Clinic—a clinic founded by Dr. Lori Kohler that specialized in the treatment of transgender inmates. (SER 026-27.)

B. CDCR Policies Regarding the Treatment of Gender Dysphoria

Dr. Kohler ran the Gender Clinic from 1998 through 2010 and also ran a telemedicine clinic for transgender inmates in other CDCR facilities from approximately 2007 through 2010. (*Id.*) At any given time, Dr. Kohler had a population of approximately 80-100 transgender patients at the Gender Clinic and approximately 400 transgender patients that she saw through the telemedicine clinic. (*Id.*) In total, she saw approximately 500-600 different transgender patients through the Gender Clinic and telemedicine program. (*Id.*) Almost all of the 500-600 transgender patients seen by Dr. Kohler through her contract with CDCR were given hormone therapy to treat their gender dysphoria. (*Id.*) Approximately 60-70 percent of those patients made some inquiry regarding the availability of SRS as a treatment. (*Id.*) Although Dr. Kohler believed that SRS was a medically

necessary treatment for some of her transgender patients, ***zero*** patients were provided SRS by the CDCR because SRS was not a treatment that CDCR was willing to provide. (SER 027-28.)

Based on her conversations with supervisors, Dr. Kohler testified that there was an "understanding" that SRS was not to be provided—"[i]t was more like don't even think about it." (SER 028.) Dr. Kohler's "understanding" is confirmed by CDCR's written policies in place at the time Plaintiff's administrative appeal within the CDCR system was denied. The CDCR Department Operations Manual ("DOM") Section 91020.26, entitled "Gender Dysphoria Treatment," states "implementation of surgical castration, vaginoplasty, or other such procedures shall be deferred beyond the period of incarceration. Surgical procedure shall not be the responsibility of the Department." (SER 073.) CDCR's health care services' policy regarding the "Treatment of Transgender Persons" expressly discusses the requirements for diagnosing and treating gender dysphoria, but makes no mention of SRS. (SER 075-081.)

C. Treatment of Plaintiff's Gender Dysphoria

Upon arriving at the Gender Clinic, Plaintiff underwent a series of tests based upon which she was diagnosed with gender identity disorder ("GID").[2] (ER

[2] Subsequent to Plaintiff's initial diagnosis, the American Psychiatric Association published a revised version of its Diagnostic and Statistical Manual of Mental Disorders ("DSM-V") in 2013, which replaced the "gender identity

168-69.) Upon receiving this diagnosis in early 2000, Dr. Kohler prescribed hormone therapy as a medically necessary treatment that would help to bring Plaintiff's body into greater conformity with her gender identity. (ER 169.) As a result of the estrogen and progesterone (used for chemical castration) treatments that Plaintiff has received over the past fifteen years, Plaintiff's physical features and voice have feminized. Plaintiff's medical records repeatedly describe her as a "biological female" based upon her presentation, her estrogen and testosterone levels, and the chemical castration. (*See, e.g.*, ER 158-184; SER 042-059.) Her prison records describe her as "a pleasant-looking woman, slender and coiffed in a pony tail" who "is able to walk the yard . . . as a woman." (SER 053.)

Despite counseling and hormone therapy, Plaintiff's symptoms of anxiety, dysphoria and distress have persisted. That Plaintiff is forced to live with male genitalia while the rest of her body has feminized and while living openly as a woman is the source of severe emotional distress. (ER 117-120, SER 017.) Plaintiff feels that she is "not allowed to be a person" because she is "caught in this

---

disorder" diagnosis with "gender dysphoria." The DSM-V characterizes gender dysphoria as follows: "[i]ndividuals with gender dysphoria have a marked incongruence between the gender they have been assigned to (usually at birth, referred to as natal gender) and their experienced/expressed gender." Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders 453 (5th ed. 2013) ("DSM-V") In addition to this marked incongruence, "[t]here must also be evidence of distress about this incongruence." *Id.* Plaintiff's Answering Brief generally refers to the condition as gender dysphoria even when referring to diagnoses prior to 2013.

between state" of neither being a woman nor a man. (SER 020.) Plaintiff experiences "excruciating pain and frustration" that manifest in physical symptoms, including sleeplessness, cold sweats, hypervigilance, panic attacks and mood swings. (SER 017, 019.) As a result of the persistent dysphoria, anxiety and distress that Plaintiff continues to experience even after receiving hormone therapy, Plaintiff needs SRS, and her medical records starting in the mid-1990s repeatedly reflect her efforts to obtain this necessary treatment. (*See, e.g.*, SER 024, 042, 059.)

D. WPATH Standards of Care

The prevailing standards of care for transgender patients acknowledge that SRS is a medically necessary treatment for certain individuals, like Plaintiff, who continue to suffer severe gender dysphoria even after being treated with counseling and hormone therapy. The World Professional Association for Transgender Health ("WPATH") is the leading international body of experts on transgender care. (SER 126.) WPATH's published Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People ("Standards of Care") are recognized as authoritative standards of care by numerous leading health organizations, including the American Medical Association, the American Psychiatric Association and the American Psychological Association.[3] (ER 205-

[3] Defendants attempt to diminish the importance of the Standards of Care by characterizing WPATH as "a small medical organization comprising over 300 members" compared to the American Medical Association with over 200,000

206, ¶ 21.) The current version of the Standards of Care—Version 7—was released in September 2011 following a five-year process in which eighteen gender dysphoria specialists submitted peer-reviewed papers to help identify the most effective treatments for gender dysphoria. (CD 10-1; SER 125-169.)

As the Standards of Care explain:

> While many transsexual, transgender, and gender-nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria. [ ] For the latter group, relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity.

(SER 159.) WPATH, the American Medical Association, the Endocrine Society, and the American Psychological Association all endorse the Standards of Care's conclusion that SRS is a medically necessary treatment for individuals with severe gender dysphoria. (ER 210, ¶ 41.) The United States Department of Health and Human Services has concluded that "transsexual surgery is an effective treatment option for transsexualism in appropriate cases." (ER 212, ¶ 54.) And Medi-Cal

---

members and the American Psychiatric Association with over 33,000 members. (AOB 26.) As an initial matter, the purported sizes of the memberships of these organizations are not facts in evidence and thus not properly considered by this Court. *See U.S. v. Carroll*, 750 F.3d 700, 707 (7th Cir. 2014) (finding that court may not consider internet articles because they were not presented to the district court and are not part of the record on appeal). Moreover, the argument is completely undermined by the fact that both the American Medical Association and the American Psychiatric Association have explicitly endorsed the Standards of Care. (ER 205-206, ¶ 21.)

provides coverage for SRS when medically necessary under the Standards of Care. (ER 212, ¶ 53.)

The Standards of Care apply equally to incarcerated individuals, stating:

> Health care for transsexual, transgender, and gender-nonconforming people living in an institutional environment should mirror that which would be available to them if they were living in a non-institutional setting within the same community. . . . All elements of assessment and treatment as described in the SOC can be provided to people living in institutions. Access to these medically necessary treatments should not be denied on the basis of institutionalization or housing arrangements.

(SER 166-167.)

E. Plaintiff's CDCR Appeal Seeking SRS

Plaintiff spoke to nearly all of her therapists about SRS—relaying that she wanted and needed SRS. (SER 021-022.) In response, Plaintiff was told that CDCR did not provide SRS. For example, in a progress note dated April 28, 2009, Plaintiff's mental health provider noted that Plaintiff struggles emotionally as a result of her gender dysphoria on an "ongoing basis" and her suffering is "possibly more pronounced by not being able to complete the *required* surgeries." (SER 059 (emphasis added).) Plaintiff's primary mental health provider, Dr. Reese, with whom she met almost weekly from 2011-2013, repeatedly noted Plaintiff's need for SRS. (*See, e.g.*, SER 053-056.) In November 2012, Dr. Reese expressly stated: "It is clear that clinical medical necessity suggest and mandate a sex change medical operation before normal mental health can be achieved for this female

patient." (ER 157.) Dr. Reese repeatedly renewed this opinion for the following five months (ER 138-57), at which time CDCR Headquarters issued a directive to remove Plaintiff from his care (SER 083). Around this same time, Plaintiff learned that a judge in Massachusetts had ruled in favor of an inmate seeking SRS and decided to file a formal appeal seeking SRS. (SER 022.)

On September 16, 2012, Plaintiff submitted an administrative appeal—her CDCR 602 Health Care Appeal—seeking "adequate and sufficient medical care" for her gender dysphoria, including SRS. (ER 104-107.) As part of that submission, Plaintiff highlighted that she received "the highest possible dose of estrogen." (ER 106.) There are significant risks associated with long term use of high dosage hormone replacement therapy, including heart attack, stroke, blood clots, and liver toxicity. (ER 193.) Plaintiff's hepatitis C—contracted during a 2009 gang rape in CDCR custody—makes her hormone replacement therapy more difficult and dangerous as hepatitis C is associated with ongoing liver damage, which can be exacerbated by the hormone replacement therapy. (ER 193-94.) Indeed, Plaintiff experiences complications with hormone replacement therapy, which resulted in her endocrinologist completely removing her from hormone therapy for several months in late 2014. (ER 194-96.) Although Plaintiff was put back on a very low dosage of estrogen, she was provided the estrogen through an oral application—described by her endocrinologist as a "last resort"—that puts her

at very high risk for further liver damage. (ER 195-196, ¶¶ 26-27.) Thus, in addition to treating the persistent symptoms of her gender dysphoria, SRS would also have positive health effects by significantly reducing the required dosage of hormones required and thereby minimizing the risks associated with the hormone therapy. (ER 199, ¶ 37.)

Plaintiff's appeal was denied at the first and second levels of review by administrators at the facility at which she was housed who had no experience treating transgender patients or assessing their needs for care. (SER 086, 090, 112.) None of these individuals consulted with Plaintiff's treating health care providers or with a transgender specialist. (SER 085-088, 090, 112-113.) This failure was particularly telling given that Dr. Kohler—CDCR's transgender specialist who had been involved with Plaintiff's care for several years—was working at the same facility where the appeal was considered. (SER 029-030.) At the first level of appeal, Plaintiff's request for SRS was denied "per state policy." (ER 110.) The second level denial stated that "neither your mental health nor your PCP [Primary Care Physician] has recommended SRS as a treatment for any of your medical conditions." (ER 109.) In fact, however, Plaintiff's primary mental health provider, Dr. Reese, repeatedly had recommended SRS. (*See, e.g.*, SER 049, 053-056.)

Plaintiff then appealed to the Office of Third Level Appeals. By this time, Dr. Reese had expressly recommended that SRS be provided as a "medical necessity." (ER 157.) The appeal was referred to the mental health consultant utilized by the Office of Third Level Appeals, who found that Plaintiff's records "indicate that [she] is psychologically ready for the SRS." (SER 091.) The consultant noted, however, "I do not know if CDCR is performing SRS." (*Id.*) Contrary to its usual practice, the Office of Third Level Appeals did not follow these opinions and instead requested that an evaluation be conducted by Defendant Coffin ("Coffin"), a psychologist who had no experience evaluating a patient for SRS and who had not been involved in the treatment of transgender patients in more than ten years. (SER 094-098.) Coffin's only qualification for evaluating Plaintiff was his attendance at a one-day training session related to transgender care led by Dr. Stephen Levine ("Levine"), who was retained as Defendants' expert after this lawsuit was filed. (SER 098.) Coffin's training, however, provided no instruction on evaluating a patient for SRS, and instead made clear that SRS was not a treatment available to incarcerated patients. (SER 104 (stating that patients must understand that hormone treatment "will not lead to SRS in prison"), 106 ("Surgical candidates may use experience to decide to have surgery when they are released").) After conducting an evaluation and consulting with the legal department, Coffin concluded that "[w]hile it appears likely that [Plaintiff's]

medical consultants would approve [her] as a candidate for SRS as an *elective* procedure, in the opinion of this evaluator the available documentation does not establish SRS as medically necessary at this time." (ER 182.)

Plaintiff's appeal was subsequently denied at the third level based on the false assertion that Plaintiff's "current providers have documented the determination that the subject surgery is not medically necessary for you." (SER 032.) In fact, CDCR's Dr. Reese is the only *provider* that has ever documented a determination with regard to Plaintiff's need for SRS, and he expressly found SRS to be a medical necessity.[4] (ER 157.)

F. Procedural History

1. Preliminary Injunction Schedule and Discovery

Having exhausted her appeals, Plaintiff filed this lawsuit seeking, *inter alia*, access to adequate medical care, including SRS, based upon violations of the Eighth and Fourteenth Amendments. (CD 1.) At the initial case management

[4] In their Opening Brief, Defendants repeatedly suggest that SRS is not appropriate for Plaintiff because "[n]o treating physician has ever determined that [SRS] is medically necessary." (AOB 11; *see also* AOB 1, 3.) Defendants' contention is a red herring. As Defendants' own expert has acknowledged, mental health care professionals—not physicians—are qualified to determine whether or not SRS is a medically necessary treatment for an individual's gender dysphoria. (ER 296-297.) Indeed, Defendants' expert concluded that Plaintiff's treating mental health provider, Dr. Reese, was a "qualified mental health professional" to make the recommendation for SRS. (*Id.*) Defendants' baseless contention that the recommendation must be made by a physician also is inconsistent with the Standards of Care. (SER 159.)

conference, counsel for Plaintiff notified Defendants and the Court of her intention to seek a preliminary injunction to relieve the severe mental distress she experiences as a result of her gender dysphoria and the physical health issues caused by the high dosages of hormone therapy required in the absence of surgery.

The parties stipulated to a schedule for the preliminary injunction motion, which included significant time for fact and expert discovery. (SER 009-10.) Subsequently, the parties stipulated to an extension of the discovery period. (ER 45-48.) Defendants did not seek any further extension of the discovery period and opposed any effort by Plaintiff to obtain further discovery. (*Id.*) The parties conducted substantial discovery, consisting of the production of thousands of pages of documents, substantial written discovery, seven depositions, and four expert reports. (SER 116.) Defendants refused Plaintiff's proposal that the parties depose the experts. (*Id.*)

2. Expert Reports

In support of her motion for summary judgment, Plaintiff submitted the expert testimony of three experts in transgender care: Dr. Randi Ettner ("Ettner"), Dr. Nick Gorton ("Gorton") and Dr. Marci Bowers ("Bowers"). Defendants offered the expert testimony of Dr. Stephen Levine.

a. *Dr. Ettner*

Ettner has a doctorate in psychology from Northwestern University and has been involved in the treatment of patients with gender dysphoria since 1977. (ER 202, ¶ 2.) In that time, she has evaluated and/or treated between 2,500 and 3,000 individuals suffering from gender dysphoria and other mental health issues related to gender variance. (*Id.*, ¶ 4.) Ettner reviewed Plaintiff's medical records and deposition testimony and Coffin's evaluation and deposition testimony, and conducted an in-person interview with Plaintiff, applying a battery of psychological tests designed to provide an objective measure of an individual's distress. (ER 203-204.)

Ettner testified that for certain individuals with severe gender dysphoria, "[r]elief from their dysphoria cannot be achieved without surgical intervention to modify primary sex characteristics." (ER 209, ¶ 38.) Based upon psychological testing, Ettner found that Plaintiff experiences "severe" symptoms of anxiety, including discomfort in the abdomen, feeling hot, pounding heart, feeling faint, and fear of 'the worst happening.'" (ER 216, ¶ 69.) Ettner further found that "[d]espite fourteen years of feminizing hormone therapy and counseling, Ms. Norsworthy continues to suffer from gender dysphoria and attendant anxiety. The long-term hormone treatment she has undergone has served to intensify Ms. Norsworthy's anatomical dysphoria." (ER 217, ¶ 75.) Ettner concluded that

Plaintiff "meets, and exceeds, the criteria for surgery" and that "[o]wing to the severity of gender dysphoria and resultant clinically significant distress, and its persistence despite years of hormone therapy and counseling, reassignment surgery is the necessary intervention for Ms. Norsworthy and should be immediately implemented." (ER 218, ¶¶ 78-79.) Ettner pointed out that gender dysphoria intensifies with age and that, although Plaintiff currently denies suicidal ideation, if she is denied access to surgery, she "is at risk for emotional destabilization, which may result in renewed suicide attempts given Ms. Norsworthy's past suicide attempts and familial history." (ER 219, ¶ 83.)

Ettner also examined Coffin's evaluation and deposition testimony and found it to "reveal[] a profound misunderstanding of, and lack of scientific information regarding, the nature, assessment and treatment of gender dysphoria." (ER 220, ¶ 86.) In particular, Ettner challenged Coffin's assertion that self-mutilation, suicidality and/or severe mental illness are required indicators for a conclusion that SRS is medically necessary. (ER 221, ¶ 92.) According to Ettner, mental illness of the severity described by Coffin could preclude an individual from qualifying for SRS. Ettner also pointed out that Coffin's proposed requirement that patients have attempted auto-castration or suicide is contrary to the Standards of Care and professional best practices. (*Id.*) Ettner also disputed Coffin's suggestion that Plaintiff is not capable of making an informed decision

about SRS until she has had an opportunity to live as a woman outside of prison, noting that this viewpoint is not supported by the Standards of Care nor the scientific literature. (ER 221-222, ¶ 93.) Per Ettner, "[g]ender dysphoria is not contextually-based. Patients do not 'decide' they have a male gender identity in one 'community' and a female gender in another." (*Id.*)

b. *Dr. Gorton*

Gorton is a physician with extensive experience treating transgender patients, having provided primary care and transition-related care to more than 200 transgender patients. (ER 191, ¶¶ 2-4.) Gorton is involved in determining "whether and when patients meet the criteria for sex reassignment surgeries, provid[ing] pre-operative preparation and clearance, and providing post-operative care in consultation with the appropriate surgeon." (*Id.*, ¶ 4.) Gorton reviewed Plaintiff's medical records and deposition testimony and Coffin's evaluation. (ER 192, ¶¶ 12-14.)

Gorton testified that Plaintiff's hepatitis C and allergy to spironolactone "make her hormone replacement therapy more difficult and more dangerous"; he noted that she "has experienced significant complications with her hormone replacement therapy," including significant elevation of toxin levels in her liver function tests. (ER 193-194, ¶¶ 19-21.) This elevation resulted in Plaintiff being removed entirely from hormone therapy for several months in 2014, which "is an

extremely dangerous course of action for a patient's overall well-being." (ER 194, ¶¶ 22, 24.) Gorton noted that there is a "very real risk that Ms. Norsworthy will have to be completely removed from hormone therapy again, thereby exposing her to increased dysphoria, which may result in serious depression, suicidal ideation, or self harm." (ER 196, ¶ 28.)

"Given these circumstances, sex reassignment surgery would not only significantly diminish (and potentially even permanently eliminate) Ms. Norsworthy's gender dysphoria, but would also have the significant health benefit of decreasing the need for hormone therapy." (ER 199, ¶ 37.) Gorton criticized Coffin's asserted criteria for evaluating medical necessity, noting that "Coffin's purported use of psychological functioning as a determinant of medical necessity is neither appropriate nor reflective of current standards by which patients are treated." (ER 197, ¶ 32.) In particular, Gorton noted that the standard applied by Coffin was inconsistent with the Standards of Care, AMA policies and the policies of both Medi-Cal and other insurers with which Gorton has worked. (*Id.*)

c. *Dr. Bowers*

Bowers is a pelvic and gynecologic surgeon with more than 25 years experience who has completed more than 3,000 sex reassignment surgeries. (ER 186, ¶¶ 2, 5.) Bowers described the development of sex reassignment surgery and its current status as a recognized, effective and medically necessary treatment for

gender dysphoria. (ER 188.) Bowers testified that "[i]t is vital that patients with severe gender dysphoria have access to sex-reassignment surgery in a timely manner" because if left untreated, it "can result in clinically significant psychological distress, dysfunction, debilitating expression and . . . suicidality and death." (*Id.*, ¶ 34.)

d. *Dr. Levine*

Defendants offered the expert testimony of Levine, a psychiatrist whose work and research has focused on sexuality. (ER 288.) Levine's report was based upon his review of the complaint, Coffin's evaluation, certain of Plaintiff's mental health and medical records, and an interview with Plaintiff. (ER 289, 299.) Notably, although Levine's testimony was submitted as a "rebuttal report," he did not review any of Plaintiff's experts' testimony. Nor did Levine review Plaintiff's or Coffin's deposition testimony.

Levine acknowledges that SRS "has been repeatedly positively evaluated for over twenty years" as an effective treatment to diminish gender dysphoria. (ER 294, 308.) Levine conceded that "SRS will diminish [Plaintiff's] dysphoria from the presence of her genitalia." (ER 308.) Levine noted that Plaintiff's treating mental health provider during the relevant period, Dr. Reese, "has long thought that the patient was ready for and would benefit from SRS"; from Levine's perspective, Reese's "can be read as meaning that a qualified mental health

professional has made a judgment." (ER 296-297.) Levine further concedes that Plaintiff has "met" most of the criteria for surgery under the Standards of Care. (ER 310-11.) Although Levine felt Plaintiff had not "strictly met" a purported criterion requiring "12 months[] of continuous living in the female gender role *in society*" (ER 311 (emphasis added)), the Standards of Care includes no such requirement; they speak only of "12 continuous months of living in a gender role that is congruent with the patient's identity." (SER 162.) As to that, Levine concluded that Plaintiff has "met" the criteria. (ER 310-311.)

Surprisingly, given the analysis just outlined, Levine concluded that SRS is not medically necessary for Plaintiff. As a general matter, Levine took the position that incarcerated individuals should never have access to SRS because inmates "have no comparable opportunity to live in free society" and thus are unable to obtain the real life experience necessary to qualify for SRS. (ER 293.) But Levine offered no scientific studies or experiences from his practice to support his view. Instead, Levine offered a single anecdote relating to a California inmate whose health allegedly "dramatically deteriorated" after receiving SRS while incarcerated. (ER 293.) Defendants subsequently acknowledged, however, that Levine's inclusion of this anecdote was "in error because . . . no SRS has been performed on any inmate in CDCR custody." (SER 116.) Levine's conclusions are also undermined by the fact that he misrepresented the Standards of Care to

support his position, contending that the Standards of Care "do[] not even mention prisoners specifically" and "make[] no mention of inmate's [sic] psychiatric co-morbidity." (ER 293.) In fact, however, the Standards of Care expressly state their applicability to individuals in "prisons" and expressly caution that institutionalized individuals "may also have coexisting mental health conditions." (SER 166-167.)

Levine also thought SRS was not medically necessary because "SRS is always an elective procedure. There is no immediacy to it." (ER 312.) In that regard, Levine thought SRS was not medically necessary for Plaintiff because she is not likely to commit suicide or mutilate her genitals if she is denied surgery and because "[g]ender dysphoria is not comparable to physical pain. A full vocational life is possible for those with gender dysphoria. Trans individuals learn to ignore their genitalia, just as all others do, when they concentrate on other things." (ER 309.) Levine concluded that "SRS will not significantly improve [Plaintiff's] ability to function in prison," because she allegedly "is doing better today than ever before." (ER 310.) Without explanation and despite his acknowledgement that Plaintiff has suffered numerous sexual assaults in prison, Levine concluded that "[n]ot having SRS would prevent a possible psychological decompensation, another rape or a sexually transmitted disease." (ER 297.) Finally, Levine thought Plaintiff's "priorities will change" if she is released from prison and "she may life

[sic] her life differently," suggesting without factual support or citation to scientific studies that Plaintiff's gender transition may merely be "an adaptive response to long term incarceration." (ER 312.)

3. Preliminary Injunction Hearing and Order

In accord with the schedule agreed to by the Parties, the district court heard oral argument on the motion for preliminary injunction on April 1, 2015. Defendants did not request an evidentiary hearing even though the trial court expressly invited the parties to do so. (SER 10 n.1, ER 47 n.1.) In fact, Defendants vigorously opposed the introduction of live testimony at the hearing. (SER 013.)

On April 2, the district court granted the motion for preliminary injunction and ordered Defendants to take all necessary steps to provide SRS "as promptly as possible." (ER 38.) The district court found that Plaintiff was likely to succeed on the merits of her Eighth Amendment claim because Plaintiff established that Defendants were deliberately indifferent to her serious medical need. Plaintiff presented "extensive and consistent evidence that, notwithstanding years of treatment in the form of hormone therapy and counseling, she continues to experience severe symptoms of gender dysphoria" and thus has a serious medical need. (ER 25.) The district court found compelling evidence that "prison officials deliberately ignored her continuing symptoms of gender dysphoria and the

recognized standards of care; that they were deliberately indifferent to the recommendations of her treating health care provider; that CDCR's reasons for denying SRS are pretextual; and that CDCR has a blanket policy against providing SRS for transgender inmates." (ER 30.)

The district court gave "very little weight" to Levine's opinions because his testimony "misrepresents the Standards of Care; overwhelmingly relies on generalizations about gender dysphoric prisoners rather than individualized assessment of Norsworthy; contains illogical inferences; and admittedly includes references to a fabricated anecdote." (ER 28.) The district court found Defendants' reliance on the opinions of Coffin and Levine unpersuasive because they "are inconsistent with the Standards of Care, based on the unsupported assumption that SRS should never be available to incarcerated patients, and convincingly refuted by Plaintiff's experts." (ER 34.) The district court thus concluded that "for Norsworthy, the only adequate medical treatment for her gender dysphoria is SRS, that the decision not to address her persistent symptoms was medically unacceptable under the circumstances, and that CDCR denied her the necessary treatment for reasons unrelated to her medical need." (ER 34.) Given the strength of the evidence, the district court concluded "[t]his is not a 'doubtful case'" and thus mandatory injunctive relief was appropriate. (ER 34.)

The district court further found that Plaintiff "established that she is currently suffering irreparable harm and that it will likely continue in the absence of preliminary injunction." (*Id.*) In addition to the excruciating psychological and emotional pain Plaintiff is suffering, the district court found that the deprivation of Plaintiff's constitutional rights under the Eighth Amendment also constitutes irreparable harm. (ER 34-35.) The district court was unpersuaded by Defendants' contention that Plaintiff must demonstrate a change in circumstances or "sudden urgency," finding that "[t]he continuation of suffering constitutes irreparable injury, whether this is the first month she has suffered it or the hundredth." (ER 35-36.)

The district court concluded that the balance of the hardships "tips heavily in [Plaintiff's] favor." (ER 37.) The district court "is not persuaded that CDCR's safety and security concerns override Norsworthy's interest in receiving constitutionally adequate care." (ER 36.) The district court noted that CDCR already has experience "housing one post-operative male-to-female transsexual individual" and "[a]ny suggestion that housing a female inmate with a history of violence against women would be a novel security challenge is hard to square with the fact that CDCR already houses many women with a history of violence, including violence against their female partners." (ER 36-37.)

Finally, the district court concluded that the preliminary injunction was in the public interest, noting that "it is always in the public interest to prevent the violation of a party's constitutional rights." (ER 37 (quotation omitted).) The district court found that there was no credible evidence that the requested relief would have any adverse impact on public safety or the operation of the criminal justice system. (ER 38.)

IV. SUMMARY OF THE ARGUMENT

Although Defendants attempt to frame their appeal as a challenge to the legal standard applied by the district court, the district court applied the same legal precedents advocated by Defendants. In reality, all of Defendants' arguments on appeal are based upon their disagreement with the district court's factual findings and application of those facts to the correct legal standard. The district court's factual determinations are entitled to substantial deference, and all find more than sufficient support in the record.

Defendants contend that the district court erred by finding them deliberately indifferent, because CDCR has provided Plaintiff with other treatment—primarily counseling and hormone therapy—for the past fifteen years. The evidence is undisputed, however, that despite these treatments, Plaintiff continues to suffer from severe gender dysphoria manifesting in anxiety, emotional distress and physical impairments. The district court's determination that SRS is the *only*

effective treatment for these continuing symptoms is supported by Plaintiff's treating mental health provider, a CDCR consulting psychologist, and Plaintiff's expert witnesses. Even the medical professionals relied upon by Defendants concede that SRS would be an effective treatment for Plaintiff's gender dysphoria, though they contend it is not medically necessary. The district court articulated numerous, well-founded reasons for disregarding these opinions.

Defendants' contention that the district court substituted the Standards of Care for Eighth Amendment jurisprudence is entirely unsupported. In fact, the district court applied the same authorities relied upon by Defendants. The district court's finding of deliberate indifference was not premised solely upon Defendants' failure to comply with the Standards of Care, but rather was based upon Defendants' complete indifference to Plaintiff's continuing dysphoria, disregard for the recommendation of Plaintiff's mental health provider, and application of a blanket policy barring SRS as an available treatment. Defendants' challenge to the merits of the Standards of Care on appeal is improper both because Defendants failed to raise this issue before the district court and also because Defendants' own experts purported to rely upon the Standards of Care. It was in this context that the district court applied the Standards of Care to challenge Defendants' witnesses' credibility, not because the witnesses disagreed with the Standards of Care but because they misstated them while purporting to apply them.

The district court's finding that Plaintiff is suffering irreparable harm as a result of her dysphoria, anxiety and distress is fully supported by the factual record and consistent with the applicable law. There is no support in law or common sense for Defendants' contention that, when a plaintiff has been suffering irreparable harm for an extended period of time, she must demonstrate a worsening of her suffering to justify injunctive relief.

Defendants' contention that the district court erred in failing to conduct an evidentiary hearing and that Defendants will suffer irreparable harm if the order is permitted to stand without a full trial is baseless. Defendants have waived any argument that the record is incomplete because the purported deficiencies are the direct result of Defendants' own litigation tactics. Defendants voluntarily stipulated to the discovery and briefing schedule for Plaintiff's motion for preliminary injunction and opposed any further extension of those dates. Defendants declined Plaintiff's proposal to take depositions of the expert witnesses in advance of the preliminary injunction hearing and made no attempt to take the deposition of any of Plaintiff's experts. Most importantly, Defendants failed to request an evidentiary hearing, even though the district court expressly invited them to have one if they believed an evidentiary hearing would be beneficial to deciding the motion. Defendants also opposed the introduction of any evidence at the hearing.

Finally, Defendants lamely contend that the district court failed to "adequately consider" the evidence offered in support of their purported security concerns. In reality, the district court provided a sound and detailed explanation for why it did not find the single, four-page declaration offered by Defendants in relation to that issue persuasive. Most notably, although Defendants contend that the ordered surgery would present novel, challenging security concerns, Defendants conceded that CDCR already is successfully housing a transgender female inmate who obtained SRS prior to her incarceration.

The Court should affirm the district court's order of injunctive relief because the district court applied the correct legal standard; its findings of fact and application of facts to the legal standards are plausible, sound, and well-supported by the record.

V. STANDARD OF REVIEW

Defendants acknowledge, this Court "reviews the district court's decision granting preliminary injunctive relief for abuse of discretion." (AOB 21 (citing *Fyock v. Sunnyvale*, 779 F.3d 991, 995 (9th Cir. 2015)).) Under this standard, review "is limited and deferential." *See Shell Offshore, Inc. v. Greenpeace, Inc.*, 709 F.3d 1281, 1286 (9th Cir. 2013) (quoting *Sw. Voter Registration Educ. Project v. Shelley*, 344 F.3d 914, 918 (9th Cir. 2003) (*en banc*)). "As long as the district court got the law right, it will not be reversed simply because the appellate court

would have arrived at a different result if it had applied the law to the facts of the case." *Thalheimer v. City of San Diego*, 645 F.3d 1109, 1115 (9th Cir. 2011) (internal quotation omitted). Rather, the Court asks whether "the district court's findings of fact, and its application of those findings of fact to the correct legal standard, were illogical, implausible, or without support in inferences that may be drawn from the record." *United States v. Hinkson*, 585 F.3d 1247, 1251 (9th Cir. 2009). If the district court's conclusions are "plausible in light of the record viewed in its entirety," however, this Court "may not reverse [them] even though convinced that had it been sitting as the trier of fact, it would have weighed the evidence differently." *Anderson v. City of Bessemer City, N.C.*, 470 U.S. 564, 573-74 (1985).

That the parties did not request—and therefore the district court did not conduct—an evidentiary hearing has no effect on the governing standards of review. *See* Fed. R. Civ. P. 52(a)(6) ("Findings of fact, whether based on oral or other evidence, must not be set aside unless clearly erroneous, and the reviewing court must give due regard to the trial court's opportunity to judge the witnesses' credibility."); *Hale v. Dept. of Energy*, 806 F.2d 910, 914 (9th Cir. 1986) (affirming the abuse of discretion standard in the face of a similar argument and explaining that "[t]he advisory committee's note makes it clear that the [1985] amendment was intended to reject the line of authority holding that, when a trial

court's finding are based solely on documentary evidence, appellate review may be de novo"). "Regardless of whether there is an evidentiary hearing or just papers of the case, the parties must realize that their appearance before the district court is the 'main event.'" *Hale*, 806 F.2d at 914 (citing *Lawson Prods., Inc. v. Avnet, Inc.*, 782 F.2d 1429, 1440 (7th Cir. 1986)).

VI. ARGUMENT

A. The District Court Correctly Found That Plaintiff Is Not Receiving Constitutionally Adequate Medical Care

The district court correctly concluded that Defendants were deliberately indifferent to Plaintiff's condition because they "deliberately ignored" the continuing severe dysphoria, anxiety and distress that Plaintiff experiences despite the counseling and hormone therapy she has received over the past fifteen years. (ER 30.) In fact, the evidence shows that Plaintiff's dysphoria has intensified over this period. (ER 217 ("The long-term hormonal treatment . . . has served to intensify Ms. Norsworthy's anatomical dysphoria. Having a female body and male genitalia generates significant distress.").) Despite the persistence and intensification of her symptoms, Defendants refused to provide Plaintiff access to the only treatment available to address those symptoms, SRS.

Defendants argue that they could not have been deliberately indifferent to Plaintiff's gender dysphoria because they "have provided Ms. Norsworthy with appropriate and continuous treatment for her gender dysphoria for the past 15

years, including referral to a psychologist for transsexual assessment, consultation with various endocrinologists, mental health treatment and counseling, hormone therapy, and clothing accommodations." (AOB 24.) Defendants essentially ask this Court to adopt a rule that SRS is never constitutionally required when the prison is providing the inmate with some treatment to address gender dysphoria.

That proposition is indefensible. Defendants contend that "other courts have found similar care to be constitutional," but cite only to the First Circuit's decision in *Kosilek v. Spencer*, 774 F.3d 63, 90 (1st Cir. 2014) (*en banc*). (AOB 24-25.) In *Kosilek*, however, the First Circuit expressly cautioned that its decision did not create a *de facto* rule against finding SRS a medically necessary treatment under the Eighth Amendment and noted that a "blanket policy" barring SRS would run afoul of the requirement that medical care be individualized based on a particular prisoner's serious medical needs. *Id.* at 90 n.12, 91.

Here, the district court expressly applied *Kosilek*, finding the evidence established that "CDCR has a blanket policy barring SRS as a treatment for transgender inmates."[5] (ER 32.) There is significant evidence to support this

[5] The district court "expresse[d] no view as to whether *Kosilek* was otherwise correctly decided on its facts." (ER 33 n.6.) Plaintiff respectfully submits that *Kosilek* was wrongly decided and should not be followed by this Court. As one of the dissenters in *Kosilek* eloquently stated:

> I am confident that I would not need to pen this dissent, over twenty years after Kosilek's quest for constitutionally adequate medical care began, were she not seeking a treatment that many see as strange or

finding, including an express policy in the CDCR Operations Manual (SER 073), testimony from Dr. Kohler that there was an "understanding" that SRS was not a treatment option (SER 028), training materials making clear SRS was not available (SER 104, 106), and transgender health care policies that included specific guidelines for counseling and hormone therapy but no mention of SRS (SER 075-081).[6] Notably, Defendants do not challenge the district court's finding that CDCR has a blanket policy barring SRS as a treatment for gender dysphoria.

Defendants entirely ignore other appellate decisions holding that a plaintiff states a valid Eighth Amendment claim when a prison system refuses to offer SRS as a treatment option even though the prison provides other types of treatment for gender dysphoria, like counseling and hormone therapy. *Fields v. Smith*, 653 F.3d

---

> immoral. Prejudice and fear of the unfamiliar have undoubtedly played a role in this matter's protraction. Whether today's decision brings this case to a close, I cannot say. But I am confident that this decision will not stand the test of time, ultimately being shelved with the likes of *Plessy v. Ferguson*, 163 U.S. 537 [ ] (1896), deeming constitutional state laws requiring racial segregation, and *Korematsu v. United States*, 323 U.S. 214[ ] (1944), finding constitutional the internment of Japanese–Americans in camps during World War II. I only hope that day is not far in the future, for the precedent the majority creates is damaging.

Kosilek, 774 F.3d at 113 (Thompson, J., dissenting).

[6] CDCR's blanket policy against SRS is further evidenced by arguments Defendants have made in this litigation. For example, Defendants' expert contends that SRS "is always an elective procedure." (ER 312.) Defendants also rely upon testimony from their medical experts suggesting that incarcerated persons are incapable of obtaining the "real life experience" necessary to qualify for SRS. (AOB 29-30; *see also* ER 182; ER 293.)

550, 556 (7th Cir. 2011) (finding policy barring access to hormone therapy or SRS unconstitutional, even though patients were receiving counseling and other forms of treatment); *De'lonta v. Johnson*, 708 F.3d 520, 526 (4th Cir. 2013) (reversing dismissal where prison refused to refer plaintiff for assessment for SRS because plaintiff was receiving counseling and hormone therapy). As the Court in *De'Lonta* held, "[j]ust because [defendants] have provided [a prisoner] with *some* treatment consistent with the [ ] Standards of Care, it does not follow that they have necessarily provided her with *constitutionally adequate* treatment." 708 F.3d at 526 (emphasis in original).

Citing *Kosilek*, 774 F.3d at 90, Defendants contend: "[t]he law is clear that where two alternative courses of medical treatment exist, and both alleviate negative effects within the boundaries of modern medicine, it is not the place of our court to 'second guess medical judgments' . . ." (AOB 26.) The district court agreed, applying this statement of the law, but finding that "the evidence does not suggest that, in this case, Defendants made a professional judgment in choosing between two possibilities or that there was a difference of opinion between a prisoner and her provider or between providers." (ER 33.) Indeed, there is no evidence in this case of "two alternative courses of medical treatment," both effective at "alleviating the negative effects" of Plaintiff's gender dysphoria. SRS was not ordered as an *alternative* treatment, but rather as a necessary, *additional*

form of treatment. For some patients, like Plaintiff, counseling and hormone therapy alone are not effective in alleviating the negative effects of gender dysphoria. (ER 209-210; SER 159.) As the district court found, "[t]he weight of the evidence demonstrates that for Norsworthy, the ***only*** adequate medical treatment for her gender dysphoria is SRS . . . ." (ER 34 (emphasis added).)

As this Court has acknowledged, "to prevail on a claim involving choices between alternative courses of treatment, a prisoner must show that the chosen course of treatment was medically unacceptable under the circumstances, and was chosen in conscious disregard of an excessive risk to [the prisoner's] health." *Toguchi v. Chung*, 391 F.3d 1051, 1058 (9th Cir. 2004) (internal quotation marks omitted). There is ample evidence in the record to support the district court's conclusion that counseling and hormone therapy alone were medically unacceptable under the circumstances and were chosen in conscious disregard of an excessive risk to Plaintiff's health, including Plaintiff's own testimony (SER 017-020), the recommendation of Plaintiff's treating mental health provider (ER 157), the recommendation of CDCR's consulting psychologist for health care appeals (SER 091), and the recommendations of Plaintiff's expert witnesses (ER 196, 199; ER 218-219). The district court offered compelling reasons for crediting this evidence over the contrary opinions offered by Coffin and Levine, who

nonetheless concurred that SRS would be effective in reducing the continuing dysphoria Plaintiff experiences.[7]

Moreover, as is clear from the record, Coffin and Levine were selected to render opinions with regard to the medical necessity of SRS for Plaintiff precisely because they could be relied upon to apply CDCR's blanket policy against providing SRS. Indeed, Coffin's only qualification was that he had attended a training session conducted by Levine where Levine made clear that SRS was not a treatment option in prisons. (SER 98, 104, 106.) As the First Circuit emphasized in *Kosilek*, manufacturing medical opinions in this way does not shield Defendants from Eighth Amendment liability. *Kosilek*, 774 F.3d at 90 n.12 (noting that its decision "in no way suggests that correctional administrators wishing to avoid the treatment need simply to find a single practitioner willing to attest that some well-accepted treatment is not necessary. We do not establish here a per se rule allowing a dissenting medical opinion to carry the day.") This is particularly pertinent where, as here, the pretextual medical opinion is contrary to the recommendations

[7] *See, e.g.*, ER 31 (noting that "it is clear from Coffin's deposition that he has a profound misunderstanding of and lack of scientific information . . ."") (internal quotation omitted); ER 37 (noting that each only "met [with] Norsworthy on one occasion" and thus "can hardly be described as the health care professionals 'most familiar with [Norsworthy's] care'"); ER 28 (giving "very little weight" to the opinions of Levine, "whose report misrepresents the Standards of Care, overwhelmingly relies on generalizations about gender dysphoric prisoners, rather than an individualized assessment of Norsworthy; contains illogical inferences; and admittedly includes references to a fabricated anecdote").

of the plaintiff's treating health care provider. *Wakefield v. Thompson*, 177 F.3d 1160, 1165 (9th Cir. 1999) ("a prison official acts with deliberate indifference when he ignores the instructions of the prisoner's treating physician or surgeon"); *Hamilton v. Endell*, 981 F.2d 1062, 1067 (9th Cir. 1992) ("By choosing to rely upon a medical opinion which a reasonable person would likely determine to be inferior, the prison officials took actions which may have amounted to the denial of medical treatment, and the 'unnecessary and wanton infliction of pain.'"), *overruled in part on other grounds as recognized in Colwell v. Bannister*, 763 F.3d 1060, 1069 (9th Cir. 2014); *see also Estelle v. Gamble*, 429 U.S. 97, 104-105 (1976) (prison officials act with deliberate indifference when they intentionally interfere with treatment once prescribed).

B. The Court Did Not Substitute the WPATH Standards of Care for the Eighth Amendment Standard

Defendants argue that "[t]he district court did not apply Eighth Amendment jurisprudence and instead relied on the WPATH Standards of Care." (AOB 26.) Defendants base this argument, however, on two statements in the district court's order related to the credibility of the opinions offered by Levine and Coffin, *not* the standards associated with an Eighth Amendment claim. (AOB 29-30.) Specifically, the district court found Levine and Coffin unreliable, in part, because their opinions "are inconsistent with the Standards of Care" (ER 34) and gave

"very little weight" to the opinions of Levine, in part, because his "report misrepresents the Standards of Care" (ER 28).

Fairly read, nothing in the record suggests the district court failed to apply Eighth Amendment precedent. The district court explicitly cited and applied the correct legal standards. Defendants contend that, under the Eighth Amendment, "the key question is whether Ms. Norsworthy's prison doctors were deliberately indifferent to a serious risk of harm that would result from her not receiving the surgery." (AOB 30.) Indeed, this is exactly the standard advocated by both parties in their briefing and applied by the district court. (ER 227-229, CD 73 at 12; ER 24-25.) As the district court articulated:

> [D]eliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain' proscribed by the Eighth Amendment." *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (internal citation omitted). Such indifference may be "manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed." *Id.* In the Ninth Circuit, a plaintiff alleging deliberate indifference must first "show a serious medical need by demonstrating that failure to treat a prisoner's condition could result in further significant injury or the unnecessary and wanton infliction of pain." *Jett v. Penner*, 439 F.3d 1091, 1096 (9th Cir. 2006) (citing *Estelle*, 429 U.S. at 104) (internal quotation marks omitted). Second, she "must show the defendant's response to the need was deliberately indifferent." *Id.* This second prong "is satisfied by showing (a) a purposeful act or failure to respond to a prisoner's pain or possible medical need and (b) harm caused by the indifference." *Id.*

(ER 24-25.)

Applying this legal standard, the district court found that Defendants were deliberately indifferent to Plaintiff's continuing severe symptoms of gender dysphoria. The district court's decision was not premised solely or even primarily on their failure to apply the Standards of Care. Instead, the district court found compelling evidence that Defendants "deliberately ignored her continuing symptoms of gender dysphoria and the recognized standards of care; that they were deliberately indifferent to the recommendations of her treating health care provider; that CDCR's reasons for denying SRS are pretextual; and that CDCR has a blanket policy against providing SRS." (ER 30.)

Moreover, Defendants have waived any argument that the Standards of Care "do not necessarily reflect the consensus of the entire medical community" (AOB 28) and should not have been considered by the district court. As the district court noted, "Defendants [did] not . . . dispute that the WPATH Standards [of Care] are the accepted standards of care for the treatment of transgender patients like Norsworthy" in opposing Plaintiff's motion for preliminary injunction. (ER 26; *See George v. Morris*, 736 F.3d 829, 837 (9th Cir. 2013), *cert. denied*, 134 S. Ct. 2695 (2014) (finding defendants waived arguments that had been made in passing but not developed in the briefing before the trial court).) Indeed, Levine and Coffin—upon whom Defendants extensively rely—both purported to rely upon the Standards of Care. (*See, e.g.*, CD 70 at 154:19-22, 172:13-173:7; ER 293, 310-

311.) The district court thus was not applying the Standards of Care as a "constitutional litmus test" as Defendants contend (AOB 30). Rather, the court was assessing Levine's and Coffin's credibility against the very standards they purported to be applying. The district court thus discounted Levine's testimony that Plaintiff "does not have any time, let alone 12 months, of continuous living in the female gender role in society" (ER 311) not merely because such an opinion deviated from the Standards of Care but because Levine contended that this was a requirement under the Standards of Care when, in fact, it is not. As the district court explained, "the Standards of Care require '12 continuous months of living in a gender role that is congruent with a patient's identity,' which Levine concedes that Norsworthy has experienced, not a year living *in society* as a woman." (ER 28 (emphasis in original).)[8] The district court was not "substituting its own opinion for that of Defendants' medical professionals," as Defendants contend. (AOB 31.) Instead, the district court determined that the opinions offered by Plaintiff's treating mental health provider and medical experts were more trustworthy than those of the medical professionals relied upon by Defendants, in part because

[8] Defendants' contention that "the record actually establishes that while some of the criteria for sex-reassignment surgery under the WPATH guidelines were met, others were not" is based entirely upon Levine's inaccurate representation of the WPATH criteria. (AOB 29 n.6.) There is significant evidence in the record to support the district court's finding that Plaintiff has met all of the WPATH eligibility criteria for SRS. (ER 36; *see, e.g.*, ER 218 (Ettner opining that Plaintiff "meets, and exceeds, the criteria for surgery"); ER 196 (Gorton testifying that Plaintiff "meets the criteria established by the WPATH Standards of Care").

Defendants' experts misapplied the Standards of Care. The district court provided numerous other reasons for discounting the opinions of Levine and Coffin. *See supra* note 7.

Having failed to offer any evidence to the district court to refute the Standards of Care, Defendants improperly attempt to rely on facts introduced in a wholly unrelated case to support their argument. (*See* AOB 27-28 (relying on "psychiatric textbooks" and articles referenced in Judge Holmes's concurring opinion in *O'Donnabhain v. C.I.R.*, 134 T.C. 34 (U.S. Tax Ct. 2010)).) On appeal, this Court generally will not consider any evidence that is not part of the district court record. *Kirshner v. Uniden Corp. of Am.*, 842 F.2d 1074, 1077 (9th Cir. 1988) ("[p]apers not filed with the district court or admitted into evidence by that court are not part of the clerk's record and cannot be part of the record on appeal").

Regardless, contrary to Defendants' suggestion in their Opening Brief, the majority in *O'Donnabhain* concluded that the Standards of Care are "widely accepted in the psychiatric profession" and that the "widespread recognition of the [WPATH] standards in the medical literature in evidence strongly supports the conclusion that the standards enjoy substantial acceptance." 134 T.C. at 65, 67; *see also De'Lonta*, 708 F.3d at 522-523 (describing the Standards of Care as "the generally accepted protocols" for the treatment of gender dysphoria").

C. Plaintiff Is Suffering Irreparable Harm

Defendants argue that Plaintiff has failed to demonstrate that "she faces immediate threatened injury warranting urgent preliminary relief." (AOB 32.) Defendants' contention is unsupported by the district court's findings of fact and the record evidence, and it is premised on a misstatement of the applicable legal standard.

Based upon its consideration of all the evidence, the district court determined that Plaintiff suffers continuing "[e]motional distress, anxiety, depression, and other psychological problems" and "is at risk of significant worsening of her gender dysphoria in the event that her hormone therapy must again be modified or discontinued because of liver complications." (ER 35.) These factual determinations are supported by Plaintiff's deposition testimony (SER 017-022), contemporaneous medical records (SER 042-059; ER 138-57), and the testimony of Plaintiff's expert witnesses (ER 196, 199; ER 218-219).[9]

---

[9] Defendants attempt to downplay the severity of Plaintiff's suffering by contending that Ettner testified only that Plaintiff experiences "'mild symptoms of depression' and 'generalized anxiety.'" (AOB 34.) But, as Ettner explained, "[t]he intensity of Plaintiff's symptoms is severe, and represents subjective and panic-related aspects of anxiety" manifesting in physical symptoms, "not subject to voluntary control or cognitive reappraisal." (ER 216, ¶ 69.) Ettner further emphasizes that gender dysphoria intensifies with age and that although Plaintiff currently is optimistic about her prospects for surgery, if she is denied surgery, she is "at risk for emotional destabilization, which may result in renewed suicide attempts given Ms. Norsworthy [sic] past suicide attempts and familial history." (ER 219, ¶ 83.)

Defendants' contention that Plaintiff failed to prove "that her condition has worsened or will worsen in any appreciable way" if the surgery is not provided is based upon a misunderstanding of the law and misstates the record. (AOB 33.) As the district court correctly explained:

> [Plaintiff] is not required to demonstrate that she is at risk of death or imminent self-harm, or that her risk of injury or pain is new. [Plaintiff] is likely to succeed in demonstrating that she has experienced decades of severe psychological pain because SRS is the only way to treat her persistent symptoms of gender dysphoria. The fact that she has not yet received SRS does not lessen her need for it now.

(ER 28.)[10] Regardless, Plaintiff introduced evidence that there is a substantial risk that Plaintiff's condition will worsen if she is not provided access to surgery, including an increased risk for renewed suicide attempts. (*See, e.g.*, ER 199, 217.)

D. No Evidentiary Hearing Was Required

Defendants' contention that the district court erred by not conducting an evidentiary hearing—and that Defendants face irreparable harm as a result—is entirely without merit. Contrary to Defendants' representation that "the district court set an expedited briefing and discovery schedule," Defendants voluntarily stipulated to the briefing and discovery schedule, which was then extended by

[10] *See, e.g.*, *McNearney v. Washington Dep't of Corr.*, No. C11-5930 RBL/KLS, 2012 WL 3545267, at *14 (W.D. Wash. June 15, 2012) *adopted*, No. 11-CV-5930-RBL/KLS, 2012 WL 3545218 (W.D. Wash. Aug. 16, 2012) *and modified*, No. C11-5930 RBL/KLS, 2013 WL 392489 (W.D. Wash. Jan. 31, 2013) (finding irreparable injury where plaintiff "continues to suffer unnecessary pain despite [current treatment]" even though condition was not new, went untreated for years prior to incarceration, and had not worsened).

further stipulation of the parties. (CD 33, 48.) Defendants "object[ed] to any further continuances to the preliminary injunction hearing." (SER 116)

Similarly, Defendants falsely contend that the district court granted the motion for preliminary injunction "without allowing Defendants a chance to file separate evidentiary objections to Ms. Norsworthy's experts, depose them, or otherwise to test their testimony and expertise in an evidentiary hearing." (AOB 36.) Defendants never sought permission to do any of these things. To the contrary, Defendants made the tactical decisions ***not to pursue*** any of these avenues for factual development.

To the extent Defendants wanted to file evidentiary objections to Plaintiff's expert declarations, the local rules for the district court provided them a mechanism to do so. N.D. Cal. Civil L.R. 7-3, 16-10(b). Defendants failed to avail themselves of this opportunity, even after the district court denied Defendants' motion to strike Plaintiff's evidentiary objections to Defendants' expert testimony. (CD 81, 83, 88.)

Plaintiff expressly proposed that the parties conduct depositions of the experts prior to the hearing on Plaintiff's motion for preliminary injunction, but Defendants refused. (SER 116.) Contrary to counsel for Plaintiff's understanding, counsel for Defendants took the position that "the parties have only agreed to exchange expert reports; the parties have not agreed to expert discovery." (*Id.*) On

this basis, Defendants refused to agree to allow Plaintiff to depose Defendants' expert and never sought to take the deposition of any of Plaintiff's experts.

In both of the scheduling orders, the district court expressly invited the parties to seek an evidentiary hearing "if they believe one would be beneficial in deciding Plaintiff's Motion for Preliminary Injunction." (ER 47 n.1; SER 010 n.1.) Despite this invitation, Defendants never sought an evidentiary hearing. To the contrary, Defendants vigorously opposed the introduction of any evidence at the hearing not submitted to the district court with the parties' briefing. (SER 013.)

Defendant's failure to request an evidentiary hearing—particularly here, where the district court expressly invited such a hearing—constitutes a waiver of any argument that the district court erred by failing to conduct an evidentiary hearing. *See, e.g., Jacobson & Co., Inc. v. Armstrong Cork Co.*, 548 F.2d 438, 442 (2d Cir. 1977) (cited with approval by *Int'l Molders' & Allied Workers' Local Union No. 164 v. Nelson*, 799 F.2d 547, 555 (9th Cir. 1986)); *Semmes Motors, Inc., v. Ford Motor Co.*, 429 F.2d 1197, 1204–05 (2d Cir. 1970) (holding that party waived argument that district court should have conducted evidentiary hearing where party did not formally request evidentiary hearing but merely made an offer during oral argument to submit live testimony). Regardless, an evidentiary hearing need not occur as a matter of course before a district court rules on a preliminary injunction. *See Kenneally v. Lungren*, 967 F.2d 329, 334-35 (9th Cir.

1992) (holding that there is no "presumption in favor of evidentiary hearings" for preliminary injunction motions). This Court repeatedly has upheld preliminary injunctions granted without evidentiary hearings. *See, e.g.*, *Int'l Molders' & Allied Workers' Local Union No. 164*, 799 F.2d at 555 ("The district court did not abuse its discretion in granting the preliminary injunction without an evidentiary hearing."); *San Francisco-Oakland Newspaper Guild v. Kennedy for & on Behalf of N.L.R.B.*, 412 F.2d 541, 546 (9th Cir. 1969) (holding that the presentation of oral argument and affidavits "afforded" parties "sufficient opportunity to present their case without using oral testimony").[11]

E. The District Court Correctly Rejected Defendants' Purported Safety Considerations

Defendants baselessly contend that the district court abused its discretion because it "did not adequately consider" the evidence regarding Defendants purported security concerns with regard to housing Plaintiff following sex

[11] Tellingly, none of the cases cited by Defendants arose in the context of a preliminary injunction and none supports reversal of the district court's decision here. *United Commercial Ins., Inc. v. Paymaster Corp*., 962 F.2d 853, 858 (9th Cir. 1992) (oral testimony not required on a motion for partial relief from judgment under Rule 60(b)(5) because appellants conceded the oral testimony was redundant to a declaration already submitted); *Sanders v. Monsanto Co*., 574 F.2d 198, 199 (5th Cir. 1978) (appellant's request for full hearing should have been granted prior to court ruling on civil contempt motion); *United States v. Ridgeway*, 300 F.3d 1153 (9th Cir. 2002) (if district court refers motion to suppress to a magistrate judge, district court must conduct its own evidentiary hearing before rejecting magistrate judge's credibility findings).

reassignment surgery. (AOB 41.) Although this is not the appropriate standard for abuse of discretion review, the district court, in fact, fully considered the evidence.

Notably, Defendants' denial of Plaintiff's request for SRS never mentioned any concerns with regard to security. The only evidence supporting Defendants' contention is a four page declaration from CDCR's Director of Adult Institutions, Kelly Harrington ("Harrington"), prepared specifically for this litigation. (ER 133-36.) The declaration consists solely of generalized statements without citation to any data or research. (*Id.*) Notably, Harrington neither interviewed Plaintiff nor reviewed her deposition testimony.

Moreover, Harrington's testimony is internally inconsistent and contradicted by other evidence in the record. For example, Harrington contends that "Mule Creek has successfully accommodated Norsworthy's correctional programming and her medical and mental health needs, without serious incident." (ER 135, ¶ 6.) Harrington previously conceded in his testimony, however, that Plaintiff was sexually assaulted at Mule Creek in 2009. (ER 134, ¶ 5.) In fact, it is undisputed that Plaintiff was gang raped at Mule Creek over the course of several hours. (ER 168; ER 307.) Nor are Plaintiff's mental health needs being met at Mule Creek, where Plaintiff sees her mental health provider, "who knows nothing about transgenders," only once every 90 days. (CD 66-4 at 136:1-14.) Without citation to any specific records, Harrington claims that "Norsworthy's central file shows

that Mule Creek staff, similar to staff at institutions where she was previously housed, have generally respected her female sexual identification." (ER 135, ¶ 5.) Plaintiff testified, however, that the officers refer to her as a man and "[t]he only chance that [she] get[s] to actually be a woman or be referred to in the feminine pronouns is when [she] call[s] [her] attorney." (CD 66-4 at 136:1-19.)

In addition to these credibility concerns, Harrington's declaration expressly concedes that CDCR already houses a transgender female inmate who obtained SRS prior to incarceration. (ER 135, ¶ 6.) Without providing specifics, Harrington contends that "[a]s a result of threats there have been frequent internal transfers, including to administrative segregation, and transfers between the female institutions" with regard to this transgender female inmate. (*Id.*) The same is true for Plaintiff in an all-male facility, except that instead of contending with mere threats of assault, Plaintiff repeatedly has suffered sexual assaults. (ER 307 (Levine report noting that Plaintiff has endured "five one-person rapes" and a gang rape involving nine persons over a six-hour period).) As the district court explained:

> CDCR may not have experience housing an inmate undergoing SRS, but it does have experience housing inmates who require surgery and housing one post-operative male-to-female transsexual individual. Any suggestion that housing a female inmate with a history of violence against women would be a novel security challenge is hard to square with the fact that CDCR already houses many women with a history of violence, including violence against their female partners.

(ER 36-37.)

The district court's conclusion that CDCR's safety and security concerns do not "override Plaintiff's interest in receiving constitutionally adequate care" thus is fully supported by the record. (ER 36.) It was more than plausible for the court to conclude that Defendants failed to provide credible evidence that the provision of SRS would have "any adverse impact on public safety or the operation of the criminal justice system." (ER 38 (quoting 18 U.S.C. § 3626(a)(2)).)

Quoting *Kosilek*, Defendants contend "the appropriate inquiry was not whether the court believed that [Ms. Norsworthy] could be housed safely, but whether the [CDCR] has a reasoned basis for its stated concerns." (AOB 41 (quoting *Kosilek*, 774 F.3d at 92).) Here, the district court concluded that CDCR did not have a reasoned basis for its alleged concerns—raised for the first time during the litigation after Plaintiff already had been denied SRS without mention of any purported safety concerns—because Harrington's testimony was unreliable and CDCR already is housing a transgender female inmate who received surgery prior to her incarceration by CDCR.[12]

[12] By contrast, in *Kosilek*, medical providers and the prison system both expressed safety concerns at the time SRS was denied and the Massachussetts prison system did not have any experience housing a transgender inmate who had received SRS. *Kosilek*, 774 F.3d at 93 n.15, 95 n.18.

VII. CONCLUSION

For the foregoing reasons, the Court should affirm the district court's order granting a preliminary injunction.

Dated: June 5, 2015

MORGAN, LEWIS & BOCKIUS LLP

By: */s/ Herman J. Hoying*
HERMAN J. HOYING

Attorney for Plaintiff-Appellee,
MICHELLE-LAEL B. NORSWORTHY
(a/k/a JEFFREY B. NORSWORTHY)

STATEMENT OF RELATED CASES

Pursuant to Ninth Circuit Rule 28-2.6, Plaintiff states that she is not aware of any related cases pending in this Circuit other than that identified by Defendants.

Dated: June 5, 2015

MORGAN, LEWIS & BOCKIUS LLP

By: */s/ Herman J. Hoying*
HERMAN J. HOYING
Attorneys for Plaintiff-Appellee,
MICHELLE-LAEL B. NORSWORTHY
(a/k/a JEFFREY B. NORSWORTHY)

CERTIFICATE OF COMPLIANCE

Pursuant to Fed.R.App.P. 32 (a)(7)(C) and Ninth Circuit Rule 32-1, I certify that this brief is proportionately spaced, is set in Times New Roman Font, has a typeface of 14 points or more, and contains 10,958 words.

Dated: June 5, 2015

MORGAN, LEWIS & BOCKIUS LLP

By: */s/ Herman J. Hoying*
HERMAN J. HOYING
Attorneys for Plaintiff-Appellee,
MICHELLE-LAEL B. NORSWORTHY
(a/k/a JEFFREY B. NORSWORTHY)

CERTIFICATE OF SERVICE

Case Name: Michelle-Lael B. Norsworthy v. J. Beard, et al.
Case No. 15-15712

I hereby certify that on June 5, 2015, I caused the following documents to be filed with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the CM/ECF system:

ANSWERING BRIEF OF PLAINTIFF-APPELLEE NORSWORTHY

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the United States Court of Appeals CM/ECF system.

I declare under penalty of perjury under the laws of the State of California the foregoing is true and correct and that this declaration was executed on June 5, 2015, at San Francisco, California.

MORGAN, LEWIS & BOCKIUS LLP

By: */s/ Herman J. Hoying*
HERMAN J. HOYING
Attorneys for Plaintiff-Appellee,
MICHELLE-LAEL B. NORSWORTHY
(a/k/a JEFFREY B. NORSWORTHY)