IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION
No. 3:22-cv-191

KANAUTICA ZAYRE-BROWN, Plaintiff, v. NORTH CAROLINA DEPARTMENT OF ADULT CORRECTION, et al., Defendant.	**MEMORANDUM OF LAW IN SUPPORT OF DEFENDANTS' MOTION FOR SUMMARY JUDGMENT** **(Hearing Requested)**

STATEMENT OF THE FACTS

A. Background Information

Plaintiff is a transgender woman who was first diagnosed with gender dysphoria ("GD") in 2010. (DE-1 ¶¶ 1-2) The term "transgender" means a person whose gender identity is different from their assigned sex at birth. (Ex. 1 at 1; DE-1 ¶ 33) GD is a mental health diagnosis which is defined in the Diagnostic and Statistical Manual of Mental Disorders as the "marked incongruence between one's experienced/expressed gender and assigned gender[.]" (DE-1 ¶¶ 34-35; Ex. 2 ¶ 23) GD is associated with "clinically significant distress or impairment in social, occupational, or other important areas of functioning." (Ex. 1 at 2; Ex. 2 ¶ 23) Growing up, Plaintiff experienced significant displacement and trauma. (Ex. 3 at 12, 139-40; Ex. 31 at 8) In 2010, Plaintiff began living socially as a woman and started receiving psychotherapy for GD. (DE 1 ¶¶ 46-47) Plaintiff also began transitioning to female. (Ex. 3 at 39-41) Transitioning is the "[p]rocess of changing one's gender presentation and/or sex characteristics to . . . align[] with one's internal sense of gender identity[.]" (Ex. 1 at 2)

In 2012, Plaintiff began hormone therapy to decrease her testosterone and "to get a more

female look" including breast tissue, softer skin, and decreased hair growth. (Ex. 3 at 34-37) Plaintiff was told that "achiev[ing] the look that [she] was [going] for" would be a "very long process . . . ." (Ex. 3 at 38) Plaintiff sought to change the way "people looked at [her]" because she felt that "[s]ocially, [she] just was not accepted." (Ex. 3 at 43-44)

Between 2012 and 2017, Plaintiff had multiple surgeries as part of her transition, including breast augmentation, facial feminization surgery (permanent fillers in her chin, cheek and forehead), earlobe replacement surgery, and a Brazilian butt lift (injection of fat into the buttocks). (Ex. 4 at 1; Ex. 3 at 41-42) Then in 2017, just before her incarceration, Plaintiff had an orchiectomy—surgical removal of the testes. (Ex. 3 at 60-61) Plaintiff reports that these many procedures caused only a slight improvement of her GD. (Ex. 3 at 52-65) Plaintiff was convicted of insurance fraud and was incarcerated on October 10, 2017. (DE-1 ¶¶ 64-65; Ex. 3 at 133) Plaintiff wanted, but did not complete, liposuction of her chin and mid-section prior to incarceration. (Ex. 3 at 68-69)

Beyond the requested vulvoplasty[1] at the center of this litigation, Plaintiff intends to pursue additional procedures upon her release, such as teeth veneers, liposuction and waistline contouring, laser hair removal, and possibly removal of a rib for a smaller waistline. (Ex. 3 at 113-22) Plaintiff reports that a smaller waistline is important to her because it would result in a more "enhanced, feminine look," which she believes would help ease her GD. (Ex. 3 at 118) Plaintiff has a projected release date of November 2, 2024. (Offender Public Information)

B. The Department's Policy for Evaluating Requests by Transgender Persons

Beyond routine labs and office procedures, all other medical services, including all

[1] A vulvoplasty is a genital reconstruction surgery that creates a neo-vulva but does not create a vaginal cavity. (Ex. 22 at 5).

surgeries, require review and approval by the North Carolina Department of Adult Correction ("the Department") through the utilization review process, which determines whether the treatment is medically necessary. (Ex. 5 at 61-62, 119-21; Ex. 6 at 1-2) In 2019, the Department adopted its current policy for the Evaluation and Management of Transgender Offenders ("EMTO Policy"), which was amended in 2021. (Ex. 1) The EMTO Policy provides for Facility Transgender Accommodation Review Committees ("FTARC") and a Division Transgender Accommodation Review Committee ("DTARC"), which review requests for medical and non-medical interventions requested by transgender persons. (Ex. 1 at 2-7) For the treatment of GD, the FTARC and/or DTARC serve in the role of the utilization review authority to approve or deny requested treatments. (Ex. 5 at 61-62, 101-07; Ex. 7 at 41)

The FTARC operates at the facility level and addresses requests for interventions that are considered routine, such as the provision of canteen items and the continuation of hormone therapy. (Ex. 1 at 2-6) The DTARC operates at the division level (for all 50+ facilities) and evaluates accommodations that are considered non-routine, such as requests for transfer from a male to female facility or vice versa, initiation of hormone therapy, and surgery. (Ex. 1 at 6-7) The Department is aware of the World Professional Association of Transgender Health ("WPATH") guidance and considers it a useful resource. (Ex. 7 at 28, 152; Ex. 8 at 124; Ex. 5 at 90-91)

The DTARC includes high level medical and mental health staff, including the Chief Medical Officer/Medical Director, Arthur L. Campbell, III, M.D.; the Chief of Psychiatry, Brian Sheitman, M.D.; and the Director of Behavioral Health, Lewis Jonathan Peiper, Ph.D. (Ex. 9 at 49; Ex. 1 at 2) The Director of Nursing is also on the DTARC, which also includes non-clinical staff, including custody experts such as the Prison Rape Elimination Act Director, the Director of Operations, and the Director of Rehabilitative Services (who supervises programs such as jobs and

education). (Ex. 9 at 49-50, 78; Ex. 1 at 2) The DTARC is intentionally multidisciplinary, with each person providing relevant input based on their area of expertise. (Ex. 9 at 49, 70-79; Ex. 5 at 108-09) Because some of the requested interventions implicate custody and security related concerns, the DTARC and FTARC include non-clinical personnel. (Ex. 9 at 60-61, 69-71)

At a DTARC meeting, the Director of Behavioral Health would generally give a behavioral health history, the Director of Psychiatry would give a mental health history, the Medical Director would provide a medical analysis, and the non-clinical personnel would provide any relevant input. (Ex. 9 at 75-78; Ex. 5 at 146-47) DTARC members generally do individualized reviews prior to the meeting to prepare their input. (Ex. 5 at 146-48) The non-clinical members of DTARC generally defer to the clinical members with respect to clinical requests. (Ex. 5 at 156-57) Once the DTARC makes its recommendation, the request undergoes final review by the Director of Health and Wellness Services and the Assistant Commissioner of Prisons. (Ex. 1 at 7) This review generally operates to ensure that the DTARC followed the appropriate process as they reached their recommendation. (Ex. 7 at 42-43)

C. The Process for Evaluating a Request for Surgery

A request for gender affirming surgery starts at the facility level to ensure that any needed assessments are done, and that relevant information is compiled. (Ex. 9 at 53-56, 67-68) FTARC does not make a determination regarding surgery. (Ex. 9 at 65, 67) Rather, the request is referred to the DTARC. (Ex. 9 at 62-63) The DTARC may authorize a surgical consultation to determine whether the requester is an appropriate candidate for surgery. (Ex. 9 at 74, 79-80) The determination of whether to approve the surgery as medically necessary remains with the DTARC. (Ex. 5 at 174-78)

For each case, the DTARC discusses the request and makes a recommendation. (Ex. 9 at

72-74, 98, 144-46; Ex. 1 at 5-8) Requests for surgery are reviewed on an individualized, case-by-case basis. (Ex. 5 at 107; Ex. 1 at 5-7) In conducting this review, DTARC members review medical and mental health assessments and make an overall determination of the patient's stability. (Ex. 5 at 138-40, 175-76; Ex. 8 at 64-66) The DTARC also considers whether the patient's symptoms of GD have been adequately addressed by other treatments. (Ex. 5 at 138-40) If the DTARC determines that additional information is needed, it can defer the request pending receipt of that additional information. (Ex. 9 at 102-03) If a request is denied, the individual has an opportunity to go through the process again if their condition changes. (Ex. 5 at 112) To date, the DTARC has not recommended approval of a request for gender affirming surgery. (Ex. 5 at 135) However, because the DTARC considers cases individually, it would approve such a procedure if it concluded that it was medically necessary. (Ex. 1 at 5-7; Ex. 10 at 12; Ex. 11 at 71-72, 84-86, Ex. 12 at 35, 43-44) The DTARC's determination in each case is documented. (Ex. 1 at 7-8; Ex. 9 at 176; Ex. 13)

Dr. Campbell, the Chief Medical Officer/Medical Director, wrote a document that he entitled, "DTARC medical necessity position statement on gender reassignment surgery." (Ex. 14) This document summarized his review of the research related to gender affirming surgery and set forth his formulation of the phrase "medical necessity." (Ex. 14 at 3-11) Dr. Campbell's position paper was never adopted by DTARC or the Department. (Ex. 5 at 199-200, 204-05; Ex. 11 at 60-61; Ex. 12 at 142-43) Rather, in evaluating requests for gender affirming surgery, the Department follows the EMTO policy. (Ex. 1)

D. The Department's Accommodation of and Treatment of Plaintiff's GD

Upon Plaintiff's incarceration, medical staff confirmed her GD diagnosis. (Ex. 15, Ex. 16 at 3) The Department does not dispute Plaintiff's GD diagnosis or her desire to transition. (Ex. 8

at 46, 51; Ex. 27 at 2-3) Throughout her incarceration, the Department has provided Plaintiff with gender affirming hormone therapy and mental health counseling. (Ex. 3 at 95-96, 105; Ex. 17; Ex. 33 at 30-31) The Department also transferred Plaintiff to a facility where she could be housed with other females and provided her with access to gender affirming canteen items. (Ex. 40 ¶ 40; Ex. 18 at 2)

Shortly before incarceration, Plaintiff's hormones were discontinued, presumably as part of her orchiectomy. (Ex. 18 at 1) Thus, upon incarceration she was not actively on hormones, so the Department began the process of evaluating her for the initiation of hormones. (Ex. 18 at 1) This process was completed in June 2018 and the Department approved hormones for Plaintiff, which she has received ever since. (Ex. 3 at 92-96) Plaintiff contends that she has at times received inaccurate doses, had inadequate hormone monitoring, and had some temporary gaps in hormone therapy of two weeks or less. (Ex. 3 at 94-98)

Plaintiff was placed on the mental health rotation in November 2017. (Ex. 17) The Department has provided Plaintiff with regular access to licensed mental health counselors, and she has participated in regular counseling sessions. (Ex. 33 at 30-31; Ex. 13 at 1-2; Ex. 27 at 2-3) Plaintiff initiated her own removal from mental health services in November 2022. (Ex. 33 at 30-31) Additionally, Plaintiff voluntarily discontinued medication for anxiety and depression on April 25, 2022. (Ex. 19)

Between October 10, 2017, and August 15, 2019, Plaintiff was housed in male facilities. (DE-26 ¶ 67) On August 15, 2019, Plaintiff was moved to the women's facility at Anson Correctional Institution. (DE-26 ¶ 68) Since that transfer, Plaintiff has been housed at female facilities. (Ex. 40 ¶ 40) Plaintiff was the first person to be housed based on their gender identity—as opposed to their gender assigned at birth—within the state prison system. (Ex. 40 ¶ 41)

E. Plaintiff's Request for Surgery

Plaintiff formally requested gender affirming genital surgery in December 2018. (Ex. 20) On January 7, 2019, a DAC provider saw Plaintiff and noted that prior to incarceration, she had a number of gender affirming procedures; that the "next stage for patient prior to incarceration was full genital gender-affirming surgery"; and that Plaintiff was "therefore requesting this surgery." (Ex. 4 at 1) That provider entered a Utilization Review request for the surgery. (Ex. 4 at 4; Ex. 9 at 120-22) On August 21, 2019, the DTARC deferred action on Plaintiff's request and wrote that "Vaginoplasty is an elective procedure which is not medically necessary for reassignment. Current staffing and resources does not allow for the proper postoperative care of this procedure." (Ex. 21)

In February 2020, the DTARC revisited Plaintiff's request and sought information from the UNC Transgender Health Program ("UNC THP"), regarding the nature of the procedure, number of visits required, and cost. (Ex. 10 at 12) In May 2020, after receiving this information, the DTARC recommended a referral to the UNC THP to determine whether Plaintiff was an appropriate candidate for surgery. (Ex. 10 at 12) Additionally, in May 2020, the DTARC acknowledged that gender affirming genital surgery could be considered medically necessary in a specific case "if there has been documented history that without this type of surgery, there would be severe psychiatric or psychological injuries to the person." (Ex. 10 at 12)

Dr. Peiper coordinated with Katherine Croft, the UNC THP Manager, to determine UNC's process and requirements. (Ex. 9 at 85, 134) Before the in-person consultation with the surgeon, Dr. Bradley Figler, UNC required a telephone interview. (Ex. 22 at 1) This interview occurred in August 2020. (Ex. 22 at 2-3) In March 2021, Department personnel had a phone consultation with Ms. Croft to discuss various logistical considerations. (Ex. 22 at 4) Then in May 2021, Plaintiff participated in an initial pre-operative evaluation with Ms. Croft. (Ex. 22 at 5-6)

On July 12, 2021, Dr. Figler completed his surgical consultation. (Ex. 23) Dr. Figler reported that based on meeting WPATH's criteria, some of which were noted as pending, Plaintiff was an appropriate candidate for surgery. (Ex. 23 at 2) Dr. Figler indicated that Plaintiff would need to meet a weight goal before surgery. (Ex. 23 at 2) One other pending WPATH criterion was the requirement of two referral letters, including at least one from a qualified mental health professional. (Ex. 23 at 1-2) After consulting with the UNC THP, Plaintiff decided to pursue a vulvoplasty rather than a vaginoplasty.[2] (Ex. 22 at 5-6; Ex. 3 at 73-74)

To satisfy UNC's requirements, Dr. Peiper approached Jennifer Dula, a Licensed Clinical Social Worker who had been Plaintiff's treating therapist, to request a letter. (Ex. 9 at 128-34; Ex. 24) Ms. Dula subsequently drafted and entered the letter as a clinical note. (Ex. 9 at 128-34; Ex. 24; Ex. 25) Ms. Dula wrote that Plaintiff met the WPATH criteria for surgery and that vulvoplasty was the next appropriate step for her. (Ex. 25) Ms. Dula wrote that the "surgery will help her make significant progress in further treatment of her [GD]." (Ex. 25)

The next day, on October 21, 2021, Dr. Donald Caraccio, an endocrinologist with UNC who had been providing Plaintiff's hormone treatment, wrote in his clinical encounter note: "regarding her desire for vulvoplasty, this is medically necessary part of treatment for this patient. . . . Will communicate my plans with Dr. Figler." (Ex. 26 at 2) Dr. Caraccio reported that Plaintiff's "mood [was] excellent" and that she appeared well with no apparent distress. (Ex. 26 at 1-2) In November 2021, Plaintiff met the weight loss goal set by Dr. Figler. (Ex. 13 at 1)

F. The DTARC's February 2022 Evaluation and Denial of Plaintiff's Request

On February 17, 2022, the DTARC again considered Plaintiff's request for vulvoplasty.

[2] A vaginoplasty is a more complex genital reconstruction surgery that creates a vagina (including a vaginal canal) and vulva. (Ex. 22 at 5).

(Ex. 13) Prior to the meeting, Drs. Peiper, Sheitman, and Campbell, reviewed Plaintiff's medical records, including her mental health records. (Ex. 5 at 149-50; Ex. 9 at 193; Ex. 12 at 27-29, 49) During the meeting, Drs. Peiper, Sheitman, and Campbell each provided input based on their own review and consideration. (Ex. 5 at 153-55; Ex. 8 at 58-60; Ex. 9 at 190-95; Ex. 12 at 109-117) The DTARC discussed and reached a consensus to not to approve the requested surgery, which it concluded was not medically necessary. (Ex. 5 at 153-58; Ex. 9 at 147; Ex. 12 at 131-32)

The DTARC's conclusion rested on two primary bases. First, the DTARC determined that Plaintiff was relatively well adjusted and was doing well with current treatments. (Ex. 8 at 58-60; Ex. 5 at 182; Ex12. 114-15; Ex. 13 at 1-2) Second, the DTARC concluded that the medical literature regarding the efficacy of gender affirming surgery as a treatment for GD was mixed in terms of outcomes. (Ex. 9 at 203-05; Ex. 13 at 2-5) The DTARC documented its process and their conclusions in a record and entered the same into Plaintiff's medical chart. (Ex. 13 at Ex. 27)

1. Consideration of Plaintiff's Overall Medical and Mental Health Presentation

The DTARC conducted a risk/needs assessment, which included a determination of the severity of Plaintiff's presentation and a review of her health records. (Ex. 9 at 88-89, 142-43; Ex. 5 at 170-72, 187-89) In reaching its conclusion, the DTARC was guided by Dr. Sheitman and Dr. Peiper's input regarding Plaintiff's mental state over time. (Ex. 5 at 179; Ex. 12 at 114-16; Ex. 13 at 1-2) Additionally, the DTARC's discussion of Plaintiff's request included a review and discussion about the history of and potential for self-injury (both suicidal and non-suicidal). (Ex. 9 at 193-95; Ex. 5 at 50)

Dr. Peiper, the Director of Behavioral Health, reviewed Plaintiff's records and determined that Plaintiff was "remarkably well adjusted," that "[s]ucidality wasn't a concern," and that "she was [not] at significant risk" without the procedure. (Ex. 9 at 193) Dr. Sheitman, Chief of

Psychiatry, separately reviewed Plaintiff's records and determined that Plaintiff's condition was "reasonably controlled," such that she "didn't really stand out … as excessively dysphoric, depressed, anxious." (Ex. 12 at 27-29, 49, 113-16) Dr. Sheitman's conclusions were based on objective information in the records and information about how Plaintiff was doing in general. (Ex. 12 at 116) After receiving input from Drs. Peiper and Sheitman, the DTARC concluded that Plaintiff was relatively well adjusted and doing well. (Ex. 9 at 193-95; Ex. 5 at 182-84; Ex. 13 at 1-2) Moreover, the DTARC's consensus was that Plaintiff was not presenting as a self-injury risk. (Ex. 9 at 195, 208-209)

a. Assessment of Specific Instances Reflected in the Medical Records

There are no medical records indicating that Plaintiff has any history of suicide attempts. Plaintiff's medical records reflect an incident in March 2019 in which she was sent to the local emergency room because she was "crying hysterically" and moving so much that nursing staff could not take her vitals. (Ex. 28 at 1, 3) The records reflect that during this episode, Plaintiff reportedly admitted using K2 and being high, and subsequently denied the same. (Ex. 28 at 33, 35) While at the hospital, the records indicate that Plaintiff refused a medical work up and expressed a desire to return to the facility. (Ex. 28 at 6, 11, 14-16, 24, 29) Upon returning to the facility Plaintiff stated she was "not crazy, [and] not suicidal." (Ex. 28 at 31) The records also show that Plaintiff reported that she "just lost it" after she learned that her request to be transferred to a female facility would not be acted on until May. (Ex. 28 at 31) Two and a half years later, Plaintiff would characterize this episode as a "suicide attempt . . . to get away from men prison", despite a lack of any contemporaneous records confirming it as such. (Ex. 29 at 1; Ex. 3 at 150-51)

On August 6, 2019, Plaintiff was again sent to the local emergency room after she was found breathing but unresponsive. (Ex. 30 at 1, 6, 9, 15) The emergency room records indicate that

Plaintiff fainted; that she stated that "her current facility causes her a lot of emotional distress"; and that she was more stressed than normal, crying, and vomiting. (Ex. 30 at 3, 6) The hospital records reflect no suicidal ideation. (Ex. 30 at 6) At the hospital, Plaintiff reported "emotional distress due to [her pending] transfer to a female facility." (Ex. 30 at 15) The records reflect that, upon returning from the hospital, Plaintiff "threatened to kill herself … due to not wanting to return" to restrictive housing. (Ex. 30 at 36-39) The records further indicate that the next day, on August 7, 2019, during a self-injury risk assessment, Plaintiff reported no self-injurious behavior or suicidal ideation. (Ex. 30 at 40-41) Plaintiff reported having a "breakdown yesterday" and being anxious about her upcoming transfer. (Ex. 30 at 41)

The DTARC was aware of both of the 2019 events and considered them as part of its review of Plaintiff's history. (Ex. 9 at 220) The DTARC did not consider the events to be suicide attempts or reflective of suicidal intent. (Ex. 9 at 220)

In December 2020, Plaintiff was transferred to the mental health unit at North Carolina Correctional Institution for Women ("NCCIW") after she reported to her therapist having thoughts of self-harm. (Ex. 31 at 1-4) Plaintiff reported that she was thinking of ripping the skin of her phallus and wished she could go to sleep and not wake up. (Ex. 31 at 2) This episode was preceded by an altercation that caused her to be disciplined and assigned to restrictive housing. (Ex. 9 at 221-24) Starting the day after her transfer to NCCIW, Plaintiff consistently denied thoughts of self-harm or suicidal ideation. (Ex. 31 at 5-18) However, after learning that she would be sent back to Anson (the women's facility) because she did not qualify for admission to the inpatient unit at NCCIW, Plaintiff started threatening self-harm again and expressed a preference for going to a male facility rather than returning to Anson. (Ex. 31 at 16-19) She was ultimately transferred back to Anson without incident. (Ex. 31 at 20-24) This December 2020 transfer to NCCIW and the

events preceding it were also known to and considered by the DTARC. (Ex. 9 at 221-24)

In April 2021, Plaintiff reported to her therapist that she placed a band on her phallus "as a protest" because she had not yet had her consultation with Dr. Figler. (Ex. 32 at 1) The record indicates that Plaintiff reported that she removed the band after receiving some information about the progress of the scheduling of the surgical consultation. (Ex. 32 at 1) There is no indication in the record that Plaintiff had to receive any medical care as a result of this protest. Dr. Peiper was aware of this incident but did not consider it to be a serious indication of risk of self-harm. (Ex. 8 at 37-38, 61, 75-78) Similarly, Dr. Sheitman was aware of this reported episode. (Ex. 12 at 84)

b. Consideration of Statements and Recommendations of Providers Outside of the DTARC

At the time of the February 2022 DTARC meeting, the DTARC was aware of and considered input from other health care providers. (Ex. 5 at 168-77; Ex. 9 at 146-51; Ex. 13; Ex. 12 at 70-81, 118-19) In reaching its determination on Plaintiff's request for surgery, the DTARC accepted Dr. Figler's assessment that Plaintiff was an appropriate candidate for surgery and was aware of the statements indicated in these other records. (Ex. 13 at 1) Nevertheless, the DTARC was still required to make its own determination as to whether the requested surgery was medically necessary, as that is the role of the DTARC. (Ex. 9 at 149)

c. DTARC's Conclusion on the State of Plaintiff's Mental Health

In general, Plaintiff's records demonstrate that she did not present a risk of self-harm or suicide. Throughout her incarceration, Plaintiff has continuously and consistently denied thoughts of self-harm or suicidal ideation. (Ex. 33; Ex. 34; Ex. 35) Plaintiff's medical records do not indicate a history of anxiety, depression, loss of interest, hopelessness, or other indications of significant or worsening symptoms often associated with GD. Indeed, there are indications of the opposite –

that Plaintiff was doing well. (Ex. 9 at 193; Ex. 8 at 129-130) Additionally, at the time of the DTARC's determination, Plaintiff continued to participate in programs, pursue career and academic goals, and plan for the future. (Ex. 5 at 198)

Plaintiff's frustration is reflected in her records. (Ex. 36) For example, in November 2021, Plaintiff reported making threats to self-mutilate "in order to force the need for surgical intervention." (Ex. 37) She "admitted that she said this out of frustration, and denied any thoughts, plan or intent to act on those statements." (Ex. 37) She reported she was not suicidal. (Ex. 37) DTARC thus attributed some of her behavior and comments to an attempt to force the Department to provide the desired surgery. (Ex. 12 at 116-17; Ex. 37) Ultimately, the DTARC's case summary reflects its conclusion that "the patient's mood and anxiety symptoms appear well controlled by psychiatric interventions." (Ex. 13 at 2; Ex. 27 at 2)

2. DTARC's Consideration of the Medical Literature

The second reason that the DTARC recommended against the requested procedure was its determination that the medical literature regarding the efficacy of gender affirming surgery as a treatment for GD was mixed in terms of outcomes. (Ex. 9 at 203-05; Ex. 13 at 2-5) This assessment was based on input from Dr. Campbell, the Chief Medical Officer. Dr. Campbell reviewed various studies and concluded that the literature was lacking high quality studies indicating the efficacy of gender affirming surgery in treating the symptoms associated with GD. (Ex. 13 at 2-5; Ex. 9 at 203-05) Additionally, Dr. Sheitman also did an independent review of medical literature that suggested that the procedure was not adequately evidence based. (Ex. 12 at 50-51, 57-58, 119-21)

In reaching its determination, the DTARC was also guided by Dr. Campbell's formulation of medical necessity. (Ex. 5 at 214-15) In general, Dr. Campbell considers a procedure to be medically necessary when the procedure is reasonable and appropriate for a particular individual

to protect their life, to prevent significant disability or illness, or to prevent significant pain and suffering. (Ex. 5 at 22-23) The relevant factors for the determination under this definition are (1) an individualized risk benefit analysis; (2) any standard of care; and (3) evidence-based medicine. (Ex. 5 at 22-24; Ex. 12 at 143-44)

The DTARC's judgment that the procedure was not medically necessary for Plaintiff at the time it evaluated the request was the only basis for the denial. (Ex. 13) The denial was not based on cost, security concerns, post operative needs, or Plaintiff's upcoming release date. (Ex. 9 at 195-96, 209-10; Ex. 5 at 25-26)

G. Plaintiff's Own Testimony Regarding Her Adjustment and Mental Health

Plaintiff's testimony about her mental health and adjustment in prison is consistent with the DTARC's assessment. Plaintiff has not experienced trouble sleeping. (Ex. 3 at 129-33, 140-41) In prison, Plaintiff has earned diplomas or certificates for completing educational programs between 2020 and 2022 (Ex. 3 at 27-28) Between January 2021 and January 2023, at the time of her deposition, Plaintiff described her stress and anxiety level as only 5 out of 100 (so, quite low). (Ex. 3 at 142-43) Plaintiff indicated that people at Anson started to accept her because the warden "put her foot down" and staff went through training – which all helped. (Ex. 3 at 142-43, 149) Plaintiff indicated that she does not allow her distress to affect her day to day and that she uses coping mechanisms such as journaling, meditation, and telephone communications. (Ex. 3 at 146)

Plaintiff has stated that there were no attempts at self-harm since the reported rubber band incident in April 2021. (Ex. 3 at 174-75) Plaintiff is making plans for the future and hopes to seek employment as a paralegal, go to law school, and spend time with family when she is released. (Ex. 3 at 178) Plaintiff is close with family members, including an aunt, cousins, grandmother, and other extended family. (Ex. 3 at 15) Plaintiff is currently married. (Ex. 3 at 44) Plaintiff's husband

and other family members accept her for who she is, and she does not report any issues with those relationships. (Ex. 3 at 44) Plaintiff describes herself as "always a happy person," with "loads of energy," "never a sad person," and "a very happy spirit person." (Ex. 3 at 137) Additionally, Plaintiff describes distress that is multifaceted and separate from her GD. (Ex. 3 at 136, 141)

H. Other Record Evidence From Plaintiff's Treating Providers

Patricia Hahn, Ph.D., was Plaintiff's mental health therapist between September 2018 and July 2021. (Ex. 38 at 90-97, 166-168, 180-186, 210-221) While Dr. Hahn did not doubt Plaintiff's desire to transition or her distress from GD, Dr. Hahn did not testify that she had ever determined that Plaintiff was at any serious risk of self-harm absent surgery. Dr. Hahn has not communicated with Plaintiff since Dr. Hahn stopped treating her in July 2021. (Ex. 38 at 210-221)

Dr. Marvella Bowman, Ph.D., provided mental health counseling to Plaintiff more recently. (Ex. 39 at 30-40) Dr. Bowman's assessment was that much of Plaintiff's distress appeared related to frustration with the progression of her requests for care. (Ex. 39 at 64-92) Dr. Bowman did not determine Plaintiff to be at any significant risk of self-harm or to be experiencing severe anxiety, depression, or other mental health distress, and testified that Plaintiff appeared to be functioning normally. (Ex. 39 at 53-57, 68-74, 78-82, 90-97)

ARGUMENT

I. Summary Judgment Standard

"The court shall grant summary judgment if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). On a motion for summary judgment, the moving party has the burden of "demonstrat[ing] the absence of a genuine issue of material fact." *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986). The nonmoving party "may not rest upon mere allegation or denials of his

pleading, but must set forth specific facts showing that there is a genuine issue for trial." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 256 (1986).

II. Defendants Are Entitled to Summary Judgment on Plaintiff's Deliberate Indifference Claims.

The record establishes that Defendants thoroughly assessed Plaintiff's request for gender affirming surgery and based on the collective clinical judgment of the DTARC, determined that the surgery was not medically necessary. This determination was informed by Defendants' assessment that Plaintiff was doing relatively well, and that her GD symptoms were well managed. On this record, Plaintiff cannot point to a genuine issue of material fact concerning whether the denial of her requested surgery created an "objectively, sufficiently serious" risk of harm. Nor can this evidence support an inference that any Defendant actually recognized an excessive risk of harm to Plaintiff and nonetheless consciously disregarded it. The evidence demonstrates the opposite—Defendants determined that Plaintiff did not face an excessive risk of harm related to her request for surgery. Plaintiff's disagreement with that determination cannot support a deliberate indifference claim. Therefore, Defendants are entitled to summary judgment on Plaintiff's deliberate indifference claims, Counts I and II[3] of her complaint.

A. An Eighth Amendment Deliberate Indifference Claim Requires a Two-Step Inquiry.

The deliberate indifference "inquiry proceeds in two parts[.]" *Thorpe v. Clarke*, 37 F.4th

[3] Article I, Section 27 of the North Carolina Constitution prohibits "cruel **or** unusual punishments" and the Eighth Amendment prohibits "cruel **and** unusual punishments." Notwithstanding this slight textual difference, historically "cruel and/or unusual punishment claims by criminal defendants" have been interpreted in the same manner under both constitutions. *See State v. Green*, 348 N.C. 588, 603 (1998). While the North Carolina Supreme Court recently recognized that in the context of juvenile sentencing, the two phrases can mean different things (*see State v. Kelliher*, 381 N.C. 558, 873 S.E.2d 366 (2022), it has not extended that holding to any other contexts. Thus, the federal deliberate indifference standard remains the appropriate standard for analyzing conditions-of-confinement claims under the North Carolina Constitution.

926, 933 (4th Cir. 2022). The first part, the objective component, asks "whether confinement conditions inflict harm that is 'objectively, sufficiently serious' to deprive prisoners of 'the minimal civilized measure of life's necessities[.]'" *Id*. (citing *Farmer v. Brennan*, 511 U.S. 825, 834 (1994)). The second part, the subjective component, asks, "whether officers subjectively acted with 'deliberate indifference to inmate health or safety' because they knew of but disregarded the inhumane treatment." *Id*. (citing *Farmer*, 511 U.S. 834).

The objective component requires the deprivation of rights that is "objectively, sufficiently serious." *Farmer*, 511 U.S. at 834 (cleaned up). "Only extreme deprivations are adequate to satisfy the objective component . . . ." *Rish v. Johnson*, 131 F.3d 1092, 1096 (4th Cir. 1997) (citing *Hudson v. McMillan*, 503 U.S. 1, 9 (1992). "In order to demonstrate such an extreme deprivation, a prisoner must produce evidence of a serious or significant physical or emotional injury resulting from the challenged conditions or demonstrate a substantial risk of such serious harm resulting from the challenged conditions." *Id*. (cleaned up) (citing *Helling*, 509 U.S. at 9).

The subjective component requires a showing of a "sufficiently culpable state of mind[,]" which "[i]n prison-conditions cases [] is one of 'deliberate indifference' to inmate health or safety. *Farmer*, 511 U.S. at 834. The Supreme Court "adopt[ed] [the subjective recklessness standard as used in the criminal law] as the test for 'deliberate indifference' under the Eighth Amendment." *Id*. 511 U.S. at 840. An official cannot be liable "unless the official knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference." *Id.* 511 U.S. at 837. Thus, under the subjective component, "it is not enough that an official **should** have known of a risk[,] [rather] he or she must have had actual subjective knowledge of both the inmate's serious medical condition and the excessive risk posed by the

official's action or inaction." *Jackson v. Lightsey*, 775 F.3d 170, 178 (4th Cir. 2014) (emphasis in original).

Accordingly, the deliberate indifference standard "is a higher standard for culpability than mere negligence or even civil recklessness, and as a consequence, many acts or omissions that would constitute medical malpractice will not rise to the level of deliberate indifference." *Jackson*, 775 F.3d at 178. Moreover, the Fourth Circuit has "consistently . . . found" that "disagreement[s] between an inmate and a physician over the inmate's proper medical care" . . . "fall short of showing deliberate indifference." *Id*. Also, the Fourth Circuit has held that deliberate indifference requires treatment that is "so grossly incompetent, inadequate or excessive as to shock the conscience or to be intolerable to fundamental fairness." *Stevens v. Holler*, 68 F.4th 921, 933 (4th Cir. 2023) (cleaned up).

B. The Record Evidence Cannot Support Plaintiff's Deliberate Indifference Claim Regarding the Requested Surgery.

Plaintiff's claim that the denial of her requested surgery constitutes deliberate indifference fails. First, the evidence does not support an inference that without the requested surgery, Plaintiff has experienced or is at risk of experiencing an "objectively, sufficiently serious" harm. Thus, there is no genuine issue of material fact concerning the objective component of the claim. Second, the record demonstrates that, in evaluating Plaintiff's request for surgery, Defendants reviewed and considered her medical and mental health history and concluded that her mood and anxiety symptoms were well-controlled by existing interventions. Thus, there is no evidence upon which a reasonable jury could conclude that any Defendant was actually aware of an excessive risk of harm to Plaintiff and nonetheless consciously disregarded the same. Accordingly, there is no genuine issue of material fact concerning the subjective component of her claim. Lastly, Plaintiff's

deliberate indifference claim amounts to a disagreement regarding the proper course of treatment, and, as such, it cannot support a deliberate indifference claim.

1. The Objective Prong Requires Evidence that the Challenged Condition Caused an Objectively, Sufficiently Serious Harm or Risk of Harm.

The law is well settled—the objective component requires a showing that the challenged condition has caused some "objectively, sufficiently serious" harm or risk thereof. "If a prisoner has not suffered serious or significant physical or mental injury as a result of the challenged condition, he simply has not been subjected to cruel and unusual punishment within the meaning of the Amendment." *Strickler v. Waters*, 989 F.2d 1375, 1381 (4th Cir. 1993). Indeed, in describing the objective component, the Supreme Court has stated that "[t]he deprivation alleged must be objectively, sufficiently serious, [and that] a prison official's act or omission must result in the denial of the minimal civilized measure of life's necessities . . . ." *Farmer*, 511 U.S. at 834 (cleaned up). This requirement has been applied in the context of medical deliberate indifference claims. *See e.g.*, *Moss v. Harwood*, 19 F.4th 614, 624 (4th Cir. 2021); *Scinto v. Stansberry*, 841 F.3d 219, 228 (2016); *Harden v. Green*, 27 F. App'x 173, 177 (4th Cir. 2001) (unpublished). Thus, in the instant case, Plaintiff must present evidence that the denial of her requested surgery has caused "objectively, sufficiently serious" harm or risks of the same.

2. The Record Does Not Support an Inference that the Denial of the Surgery Has Caused an Objectively, Sufficiently Serious Risk of Harm.

Plaintiff's medical records indicate that after her surgery request was not approved, she repeatedly denied having any concerns with sleep, appetite, energy level, or thoughts of self-harm or suicidal ideation. (Ex. 33 at 27-31) Additionally, Plaintiff contemporaneously reported that "she [was] doing well . . ." and her therapist noted that her "[m]ood was euthymic . . . ." (Ex. 33 at 28-31) Plaintiff's lack of issues with sleep, appetite, energy level, or thoughts of self-harm or suicidal

ideation, after learning of the surgery denial, is consistent with her past records. (Ex. 8 at 57-67; Ex. 5 at 182; Ex12. 94-97, 114-15; Ex. 13 at 1-2) Likewise, Plaintiff's presentation is consistent with her own self-description as "always a happy person," with "loads of energy." (Ex. 3 at 137) Moreover, Plaintiff's records indicate her resilience and ability to focus on the future in a hopeful manner. For example, Plaintiff turned her attention and focus toward trying to enroll in specific programming and preparing for her release. (Ex. 33 at 28-31; Ex. 3 at 178) In short, the record evidence does not show that Defendants' decision to deny Plaintiff's request for surgery caused an "objectively, sufficiently serious" harm, or a risk thereof. *See Thorpe*, 37 F.4th at 937. Therefore, there is no genuine issue of material fact as to the objective component of this claim.

3. The Record Evidence Does Not Establish the Subjective Component of the Deliberate Indifference Claim.

The subjective component has two crucial factors. The first is that prison officials must possess actual knowledge of an excessive risk of harm. The record in this case demonstrates the opposite—that Defendants concluded that Plaintiff would *not* face an excessive risk of harm without surgery. The second factor is that prison officials must consciously disregard a known excessive risk of harm. The evidence shows that Defendants have attended to Plaintiff's medical needs with full knowledge and awareness of her mental and physical health and did not disregard any risk. Thus, this record cannot support an inference by a reasonable jury that any Defendant was actually aware of an excessive risk of harm and nonetheless consciously disregarded the same. Instead, Plaintiff's claim concerning the surgery amounts to a disagreement over the appropriate way to treat her GD, which is insufficient to support a deliberate indifference claim.

a. Evidence of *Knowledge* of a Serious Risk of Harm is Required to Survive Summary Judgment.

"True subjective recklessness requires knowledge both of the general risk, and also that

the conduct is inappropriate in light of that risk." *Rich v. Bruce*, 129 F.3d 336, 340 n.2 (4th Cir. 1997). Thus, liability here would require showing that Defendants possessed knowledge of an excessive risk of harm and consciously disregarded that risk through their actions. *See Farmer,* 511 U.S. at 837. Importantly, courts focus solely on the risks actually perceived by the defendants and not with risks that should have been perceived. Accordingly, "[h]olding officials accountable for risk factors that they did not actually recognize . . . is not permissible when deliberate indifference is the standard." *Parrish v. Cleveland*, 372 F.3d 294, 303-04 (4th Cir. 2004).

b. There is No Evidence that Any Defendant Possessed Knowledge of an Excessive Risk of Serious Harm to Plaintiff.

In the instant case, the evidence shows that, in evaluating Plaintiff's request for surgery, Defendants reviewed her medical and mental health history as part of the risk-benefit calculus and assessed the state of her overall medical and mental health. (*See* Ex. 5 at 138-40, 149-55, 170-79, 187-89; Ex. 8 at 58-60, 64-66; Ex. 9 at 88-89, 142-43, 190-95; Ex. 12 at 27-29, 49, 109-117; Ex. 13 at 1-2) The evidence further shows that none of the Defendants actually perceived Plaintiff's physical or mental health to be at a significant risk of harm. (*See* Ex. 5 at 50, 170-72, 187-89; Ex. 9 at 88-89, 142-43; 193-95, 208-09; Ex. 12 at 27-29, 49, 113-16) In fact, the DTARC considered Plaintiff's mental health to be stable and well controlled. (*See* Ex. 9 at 193-95; Ex. 5 at 182-84; Ex. 12 at 113-16; Ex. 13 at 1-2)

This record evidence makes clear that Defendants purposely assessed the state of Plaintiff's physical and mental health and determined that she did not present with any significant risk. On this record, Plaintiff cannot present evidence sufficient for a reasonable jury to conclude that any of the Defendants were subjectively aware of any excessive risk of harm to Plaintiff that they consciously ignored.

c. Evidence That Defendants Consciously *Disregarded* a Known Serious Risk of Harm is Required to Survive Summary Judgment.

Even assuming there was evidence to support an inference that Defendants were subjectively aware of an excessive risk of harm, they would nonetheless be entitled to summary judgment because it is well settled that where prison officials take reasonable steps in response to a risk of harm, they cannot be liable for violating the Eighth Amendment. "[A]n official who responds reasonably to a known risk has not 'disregarded an excessive risk to inmate health or safety,' and has therefore not acted with deliberate indifference." *Brown v. Harris*, 240 F.3d 383, 389 (4th Cir. 2001) (cleaned up) (quoting *Farmer*, 511 U.S. at 837).

d. There is No Record Evidence that Any Defendant Consciously Disregarded an Excessive Risk of Harm to Plaintiff.

The evidence in the instant case establishes that Defendants' actions with respect to Plaintiff's requested surgery, and her treatment more generally, were reasonable in light of the risks that Defendants actually perceived. As discussed above, the record evidence demonstrates that Defendants specifically evaluated Plaintiff's overall medical and mental health in making their determination and determined that Plaintiff's mental health was stable and well controlled. (*See* Ex. 5 at 50, 138-40, 149-55, 170-79, 182-89; Ex. 8 at 58-60, 64-66; Ex. 9 at 88-89, 142-43, 190-95, 208-09; Ex. 12 at 27-29, 49, 109-117; Ex. 13 at 1-2)

Additionally, the record establishes that Defendants have accommodated and treated Plaintiff's GD by transferring her to female facilities, providing hormones, and providing access to mental health treatment. (Ex. 3 at 95-96; Ex. 17; Ex. 40 ¶ 40) Moreover, the evidence shows that the DTARC found these interventions to be sufficient to manage Plaintiff's mental health adequately. (Ex. 9 at 193-95; Ex. 5 at 182-84; Ex. 12 at 113-16; Ex. 13 at 1-2)

On this evidence and in this context, no reasonable jury could conclude that Defendants' decision to deny the requested surgery was deliberate indifference. Because the record shows that Defendants responded reasonably to the level of risk that they perceived, Plaintiff cannot demonstrate that Defendants consciously disregarded an excessive risk of harm, of which they were aware. *See Brown,* 240 F.3d at 390; *Parrish*, 372 F.3d at 308.

4. A Disagreement Regarding the Best Course of Medical Treatment Cannot Support a Deliberate Indifference Claim.

Plaintiff's claim of deliberate indifference boils down to her contention that Defendants have not *properly* treated her GD. The case law is quite clear—a disagreement over what constitutes a proper course of medical treatment cannot support a deliberate indifference claim, absent exceptional circumstances. *See Hixson v. Moran*, 1 F.4th 297 (4th Cir. 2021).

a. Absent Exceptional Circumstances, Disagreements Over Clinical Judgment Cannot Support a Medical Deliberate Indifference Claim.

It has long been established that "[t]he right to treatment is, of course, limited . . . and the essential test is one of medical necessity and not simply that which may be considered merely desirable." *Bowring v. Godwin*, 551 F.2d 44, 47-48 (4th Cir. 1977). Accordingly, as "with all other aspects of health care, [the propriety or adequacy of a particular course of treatment] remains a question of sound professional judgment[,] [and] . . . courts will not intervene upon allegations of mere negligence, mistake *or difference of opinion*." *Id*. (emphasis added). Thus, "[d]isagreements between an inmate and a physician over [an incarcerated person's] proper medical care are not actionable absent exceptional circumstances." *Wright v. Collins*, 766 F.2d 841, 849 (4th Cir. 1985). *See also, Scinto v. Stansberry*, 841 F.3d 219, 225 (4th Cir. 2016) (same)*; Hixson v. Moran*, 1 F.4th 297, 302-03 (4th Cir. 2021) (same); *United States v. Clawson*, 650 F.3d 530, 538 (4th Cir. 2011) (same); *Jackson v. Lightsey*, 775 F.3d 170, 178 (4th Cir. 2014) (cleaned up) (noting this

Circuit has "consistently" found that "disagreements between an inmate and a physician over the inmate's proper medical care . . . fall short of showing deliberate indifference.").

Hixson is instructive. In that case, the plaintiff claimed that the doctor was deliberately indifferent to the risks posed by his diabetes in failing to provide insulin. 1 F.4th at 303. However, the record showed that the doctor was regularly reviewing the plaintiff's blood sugar levels and had placed him on a diabetic diet. *Id*. Moreover, the doctor explained that he could have placed the plaintiff on insulin, but, given the plaintiff's variable readings, the doctor was concerned about a possible insulin overdose. *Id*. On this evidence, the Fourth Circuit affirmed summary judgment in favor of the doctor. *Id*. Importantly, the Court noted that despite the plaintiff's expert testifying that the doctor's actions violated the standard of care, summary judgment was still appropriate because "a disagreement among reasonable medical professionals is not sufficient to sustain a deliberate indifference claim." *Id*.

b. Plaintiff's Disagreement with Defendants' Determination of Medical Necessity of Her Requested Surgery is Not Deliberate Indifference.

Plaintiff requested gender affirming vulvoplasty. (Ex. 27) The Department evaluated and denied the request because it determined the procedure was not medically necessary. (Ex. 5 at 153-58; Ex. 9 at 147; Ex. 12 at 131-32; Ex. 13 at 1-2; Ex. 27) First, based on the collective clinical judgment of the Department's Chief Medical Officer, Chief Psychiatrist, and Director of Behavioral Health, the DTARC concluded that Plaintiff was doing well and was relatively well adjusted, and that her physical and mental health were not at significant risk. (*See* Ex. 5 at 50, 138-40, 149-55, 170-79, 182-89; Ex. 8 at 58-60, 64-66; Ex. 9 at 88-89, 142-43, 190-95, 208-09; Ex. 12 at 27-29, 49, 109-117; Ex. 13 at 2; Ex. 27 at 1-2) The DTARC summed up this conclusion by noting that Plaintiff's "mood and anxiety symptoms appear well controlled by psychiatric

interventions." (Ex. 13 at 2; Ex. 27 at 2) This conclusion followed a thorough review and evaluation of Plaintiff's overall physical and mental health. (Ex. 5 at 138-40, 149-55, 170-79, 187-89; Ex. 8 at 58-60, 64-66; Ex. 9 at 88-89, 142-43, 190-95; Ex. 12 at 27-29, 49, 109-117). Second, the DTARC concluded that the medical literature was mixed regarding the efficacy of gender affirming surgery as a treatment for GD. (Ex. 9 at 203-05) Plaintiff disputes these determinations. As such, Plaintiff's case turns on disagreements with the clinical and professional judgments of the Department's key medical and mental health professionals. Plaintiff cannot maintain a deliberate indifference claim on that basis.

Plaintiff and her expert contend that the Department's medical-necessity determination was incorrect and, therefore, unconstitutional. This, however, is the fundamental flaw in Plaintiff's legal theory—her contention that the Department's medical-necessity determination was incorrect, even if true, does not make it unconstitutional. The case law is well-established that an incarcerated patient's disagreement about what constitutes proper medical care cannot support a deliberate indifference claim. *See Wright*, 766 F.2d at 849. Therefore, Plaintiff's deliberate indifference claim fails as a matter of law.

5. Case Law Concerning Deliberate Indifference and Denial of Gender Affirming Surgery.

While the Fourth Circuit has not yet considered whether the denial of a request for gender affirming surgery can support an Eighth Amendment claim, the issue has been addressed in several other circuits. The majority of circuit courts to address the issue have found that the denial of a requested gender affirming surgery does not violate the Eighth Amendment.

The First Circuit held that the care provided to the plaintiff, which stopped short of surgery, did not violate the Eighth Amendment. *Kosilek v. Spencer*, 774 F.3d 63 (1st Cir. 2014) (*en banc*).

The evidence developed there mirrors this case. Namely, the plaintiff in *Kosilek* had received other ameliorative measures, including hormone therapy, psychotherapy, medication, and more. *Id*. at 89-90. The First Circuit held that the state's decision to continue treating the plaintiff's GD through these other treatments, rather than authorizing gender affirming surgery, was a reasonable choice between two alternatives that could not support a deliberate indifference claim. *Id*. at 90.

The Tenth Circuit reached the same conclusion four years later. In *Lamb v. Norwood*, 899 F.3d 1159 (10th Cir. 2018), the court held that there was no error in granting summary judgment to prison officials for not approving surgery because the combination of existing treatment and the sparseness of the summary judgment record precluded an inference of deliberate indifference. *Lamb*, 899 F.3d at 1162. The Tenth Circuit stated that the provision of some effective care, even if subpar or different from what the plaintiff wants, precludes a finding of deliberate indifference. *Id*. at 1163. Additionally, as in *Kosilek*, the court noted that a difference in opinion over a particular course of treatment cannot support a claim of deliberate indifference as a matter of law. *Id*.

A year later, the Fifth Circuit reached the same conclusion in *Gibson v. Collier*, 920 F.3d 212 (5th Cir. 2019). In *Gibson*, the plaintiff was receiving hormone replacement therapy and mental health counseling. *Id*. at 217. The Fifth Circuit affirmed summary judgment because it was indisputable that the necessity and efficacy of surgery was a matter of significant disagreement within the medical community, and it could not be cruel and/or unusual to deny treatment that no other prison had ever provided. *Id*. at 223, 228.

And the Seventh Circuit in *Campbell v. Kallas*, 936 F.3d 536, 537 (7th Cir. 2019), reversed the district court's denial of qualified immunity because, at the time of the inmate's request for surgery, no case clearly established a right to GD treatment beyond hormone therapy.

These cases support the principle that if a correctional system is providing other recognized

accommodations and treatment for GD, the decision not to approve a requested surgery cannot support a claim of deliberate indifference.[4] Just as in *Kosilek*, *Lamb*, *Gibson*, and *Campbell*, Plaintiff's GD has been and is being treated in other ways. And just as in *Kosilek*, *Lamb*, *Gibson*, and *Campbell*, Plaintiff's claim should fail because it is based on a disagreement over care. Review of the only circuit case to find that surgery was constitutionally required makes this point clear.

In *Edmo v. Corizon, Inc.*, 935 F.3d 757 (9th Cir. 2019), the Ninth Circuit affirmed injunctive relief directing the state of Idaho to provide the plaintiff with surgery because she had established that such treatment was medically necessary and that, in failing to provide the surgery, the correctional authorities had been deliberately indifferent to her serious medical needs. *Id.* at 767. *Edmo* is distinguishable from the instant case.

As with any deliberate indifference case, *Edmo* was decided on the "unique facts" in the record. *Id.* at 783. Those unique facts included evidence that the plaintiff had, on multiple occasions, actually harmed herself, including three efforts to self-castrate and the alleviation of thoughts of self-castration by cutting her arms. *Edmo,* 935 F.3d at 772-74. The district court specifically relied on this evidence in finding that Idaho officials had been deliberately indifferent. *See Edmo*, 358 F. Supp. 3d at 1126-27. Accordingly, the Ninth Circuit "emphasize[d] that the analysis [in *Edmo*] is individual to Edmo and rests on the record in th[at] case." *Edmo*, 935 F.3d at 767. This point is underscored by the Ninth Circuit's explanation that it did not believe that

[4] In at least four other instances, district courts have granted summary judgment in favor of prison officials on a medical deliberate indifference claim based on a denial of gender affirming surgery. *See Sabbats v. Clarke*, No. 7:21CV00198, 2022 U.S. Dist. LEXIS 164430, at *29 (W.D. Va. Sep. 12, 2022); *Fisher v. Fed. Bureau of Prisons*, No. 4:19-cv-1169, 2022 U.S. Dist. LEXIS 121233, at *31 (N.D. Ohio July 8, 2022); *Wright v. Parker*, No. 4:21-cv-00069-KGB-JJV, 2022 U.S. Dist. LEXIS 237751, at *10-11 (E.D. Ark. Apr. 11, 2022)*Armstrong v. Mid-Level Practitioner John B. Connally Unit*, No. SA-18-CV-00677-XR, 2020 U.S. Dist. LEXIS 6593, at *14-15 (W.D. Tex. Jan. 15, 2020).

Kosilek was wrongly decided, but instead that the same approach used in *Kosilek* warranted a different result. *See Edmo*, 935 F.3d at 794.

In the instant case, the record more closely matches that of *Kosilek*, *Lamb*, *Gibson*, and *Campbell*, as there is no evidence that Plaintiff engaged in any actual self-harm. As in those cases, Plaintiff's disagreement with medical professionals about whether gender affirming surgery was medically necessary to treat her GD cannot support a deliberate indifference claim.

6. The Record Cannot Support a Deliberate Indifference Claims Based on Housing or the Provision of Hormones.

Plaintiff has not developed any evidence tending to suggest that being housed at male facilities exposed her to an "objectively, sufficiently serious" risk of harm. Indeed, at one point Plaintiff expressed a desire to return to a male facility. (Ex. 31 at 16-19) Nor has Plaintiff developed any evidence that the timing of the initiation of hormone therapy created an excessive risk of harm. She also cannot point to evidence that the interruptions or other issues with her hormones have caused any excessive risk of harm. On this record Plaintiff cannot satisfy the objective prong of a deliberate indifference claim related to housing or hormone therapy.

In addition, Plaintiff cannot point to evidence that any Defendant was subjectively aware of any such risk but nonetheless consciously disregarded the risk. Plaintiff's claim here effectively amounts to a claim that her transfer to a female facility should have occurred sooner. (*See* DE-1 ¶¶ 67-68) However, because there is no evidence that any Defendant appreciated any risk associated with the timing of Plaintiff's housing assignment, she cannot maintain an Eighth Amendment claim. *See Moss*, 19 F.4th at 624-25 (noting that even assuming the evidence supporting the objective prong, summary judgment was still appropriate for prison officials because the evidence could not support an inference that the officials were subjective aware of any

risk caused by their delay in the provision of medication).

Similarly, the record shows that the Department began administering hormones to Plaintiff in June of 2018 (more than three years before the filing of this case), and that she continues to receive this treatment. (Ex. 3 at 95-96) Any contentions concerning incorrect doses or brief and inadvertent interruptions to the treatment (*see* Ex. 3 at 94-98), at most sound in negligence, but cannot support a deliberate indifference claim. *See Jackson*, 775 F.3d at 178.

C. Plaintiff Is Not Entitled to Damages Based on Her Deliberate Indifference Claim.

In Count I, the Eighth Amendment claim, Plaintiff does not seek damages from Defendants. (DE-1 at 38) Nor could she recover damages against any of the Defendants on this count. This is because Plaintiff asserts her federal constitutional claim only against the Department and the individual Defendants in their *official* capacities. An official capacity claim is not a suit against the official but rather is a suit against the official's office, and thus is no different from a suit against the State itself. *See Will v. Mich. Dep't of State Police*, 491 U.S. 58, 67 (1989). Claims for damages are not available against the State of its officers. *See Lynn v. Wes*t, 134 F.3d 582, 587 (4th Cir. 1998). Moreover, in enacting Section 1983, Congress did not abrogate North Carolina's Eleventh Amendment immunity. Specifically, Congress allowed only "persons" to be sued under Section 1983. *See Will*, 491 U.S. at 67. Thus, Plaintiff does not have a viable claim for damages against Defendants under the Eighth Amendment.

Nor could Plaintiff recover damages against the individual Defendants on Count II, her claim under the North Carolina Constitution. "Under North Carolina law, 'a public official, engaged in the performance of governmental duties involving the exercise of judgment and discretion, may not be held personally liable[.]'" *R.A. v. Johnson*, 36 F.4th 537, 542 (4th Cir. 2022)

(quoting *Smith v. State*, 289 N.C. 303, 331, 222 S.E.2d 412 (1976)). Thus, Plaintiff does not have a viable claim for damages against the individual Defendants under Article I, Section 27 of the North Carolina Constitution.

D. Plaintiff's State Constitutional Claim (Count II) Fails for Multiple Reasons.

Plaintiff's state constitutional claim fails for the same reasons discussed above. Additionally, Plaintiff's state constitutional claim is barred by sovereign immunity. In *Corum v. University of North Carolina*, the North Carolina Supreme Court held that, in very limited circumstances, a plaintiff may file a claim against the state or its agents directly under the North Carolina constitution. 330 N.C. 761, 782-84 (1992). To state a *Corum* claim, however, the plaintiff must have no other "adequate state remedy." *See Davis v. Town of S. Pines*, 116 N.C. App. 663, 675, 449 S.E.2d 240, 247 (1994)

Here, Plaintiff has other means to pursue relief. For instance, among other potential remedies, she could have filed an action against the Department in the North Carolina Industrial Commission related to her allegations of inadequate medical treatment or other acts of alleged negligence. *See* N.C.G.S. § 143-291. Because filing that kind of action is a potential means of securing relief, Plaintiff has no direct claim under the North Carolina Constitution.[5]

III. Defendants Are Entitled to Summary Judgement on Plaintiff's Disability Claims.

On this record, Plaintiff cannot establish any viable disability claim. The surgery was denied not because of Plaintiff's diagnosis of GD, but because the Department determined that it was not medically necessary. Thus, Plaintiff's effort to maintain an intentional disability

[5] In addition, Drs. Agarwal and Amos should be granted summary judgment because Plaintiff has developed no evidence that either: (1) was involved in any way in the events that are the subject of this litigation; or (2) is otherwise necessary for injunctive relief.

discrimination claim fails. There is no evidence of any adverse impact on Plaintiff beyond her not receiving the surgery she requested, which is insufficient to support a disparate impact disability claim. Additionally, there is no evidence that Plaintiff ever informed Defendants that she sought surgery as a reasonable accommodation for her GD. In any event, Plaintiff cannot show that the requested surgery was necessary to allow her "equal access to prison life." *See* DE-1 ¶¶ 164-65, 174-75. In short, the record simply does not support any viable disability claim.

A. To Succeed on a Disability Claim, Plaintiff Would Have to Establish a Viable Legal Theory.

Title II of the Americans with Disabilities Act of 1990, ("the ADA"), and Section 504 of the Rehabilitation Act, afford qualified individuals with a disability certain protection against public entities by prohibiting such entities from "discriminating against [them], or excluding [them] from participation in the benefits of services, programs, and activities." *Williams v. Kincaid*, 45 F.4th 759 (4th Cir. 2022), *cert denied*, 143 S. Ct. 2414 (2023). Title II ADA claims and Section 504 RA claims "can be combined for analytical purposes because the analysis is substantially the same." *Seremeth v. Bd. of Cnty. Comm'rs Frederick Cnty.*, 673 F.3d 333, 336 n.1 (4th Cir. 2012) (cleaned up). Under the ADA, three specific grounds for relief are available: "(1) intentional discrimination or disparate treatment; (2) disparate impact and (3) failure to make reasonable accommodations." *Richardson v. Clarke*, 52 F.4th 614, 619 (4th Cir. 2022).

For an intentional discrimination claim, a plaintiff must prove three elements: "(1) they have a disability; (2) they are otherwise qualified to receive the benefits of a public service, program, or activity; and (3) they were denied the benefits of such service, program, or activity, or otherwise discriminated against, on the basis of their disability." *Nat'l Fed'n of the Blind v. Lamone*, 813 F.3d 494, 503 (4th Cir. 2016).

"[D]isparate-impact claims involve . . . practices that are facially neutral in their treatment of different groups but that in fact fall more harshly on one group than another and cannot be justified by business necessity." *Raytheon Co. v. Hernandez*, 540 U.S. 44, 52 (2003) (cleaned up). In such a claim, a plaintiff must: (i) "identify the challenged [] practice or policy, (ii) demonstrate that the practice or policy had an adverse impact on the plaintiff with a disability, and (iii) demonstrate a causal relationship between the identified practice and the disparate impact." *Williams v. ABM Parking Servs.*, 296 F. Supp. 3d 779, 789 (E.D. Va. 2017).

"To prevail on [a failure to accommodate] ADA claim, plaintiffs must propose a reasonable modification to the challenged public program that will allow them the meaningful access they seek." *Lamone*, 813 F.3d at 507. "A modification is reasonable if it is 'reasonable on its face' or used 'ordinarily or in the run of cases' and will not cause 'undue hardship.' *Id*. (citing *Halpern v. Wake Forest Univ. Health Scis.*, 669 F.3d 454, 464 (4th Cir. 2012). Additionally, in the context of an ADA claim against a prison, courts "view the reasonableness of accommodations through the lens of operating a prison." *Richardson v. Clarke*, 52 F.4th 614, 621 (4th Cir. 2022) (citing *Torcasio v. Murray*, 57 F.3d 1340, 1355 (4th Cir. 1995).

B. The Record Evidence Cannot Support any Basis for Relief Under the ADA.

In her complaint, Plaintiff made conclusory allegations to support her ADA claim. She alleged that the Department failed to provide her with "equal access to prison life, on the basis of her disability[,] [fails] to accommodate [her gender dysphoria][,] [and] has discriminated against and continues to discriminate against [her] . . . by maintaining policies, practices, and procedures that deny her access to treatment and support needed to treat and manage her disability, causing her ongoing harm solely because of her disability." DE-1 ¶¶ 164-65, 174-75. While it is unclear which type of an ADA claim Plaintiff is pursuing, the end result is the same—the claim cannot

survive summary judgment. This is because Plaintiff cannot point to any record evidence to support any of these theories.

1. Plaintiff Cannot Establish a Discrimination Claim Under the ADA.

The Fourth Circuit has recently held that individuals with a diagnosis of GD have a qualified disability under the ADA and the RA. *Williams v. Kincaid*, 45 F.4th 759, 772-74 (4th Cir. 2022). Because Defendants do not challenge Plaintiff's GD diagnosis, they concede that she can satisfy the first element of a discrimination-based ADA claim. However, on this record, Plaintiff cannot present evidence to support the other elements of such a claim.

The record clearly establishes that the Department denied the request for surgery because it determined that the surgery was not medically necessary (*see* Ex. 5 at 153-58; Ex. 9 at 147; Ex. 12 at 131-32; Ex. 13 at 1-2; Ex. 27), and not on the basis of Plaintiff's GD. On this record, Plaintiff cannot point to any evidence sufficient for a jury to conclude that she was entitled to the requested surgery, but that the Department denied the surgery because of her GD. Notably, Plaintiff also cannot show exclusion from medical care more broadly due to her GD, as the record firmly establishes that she has received care and other accommodations for her GD. (DE-26: ¶¶ 67-68; Ex. 3 at 95-96, 105; Ex. 17). Similar efforts to assert a discrimination claim based on a denial of gender affirming surgery have not been successful. *See Shorter v. Garland*, No. 4:19-CV-108-WS-MAF, 2022 U.S. Dist. LEXIS 67143, at *21-25 (N.D. Fla. Mar. 4, 2022) (granting summary judgment in favor of the defendants on a disability discrimination claim where there was no evidence suggesting that "BOP denied her request for an orchiectomy or breast augmentation because she is transgender[,]" but rather after thorough consideration of the request).

2. Plaintiff Cannot Establish a Disparate Impact Claim Under the ADA.

Any disparate impact claim under the ADA likewise fails, because there is no record

evidence of a particular practice or policy that caused the denial or otherwise creates an adverse impact for those with GD. Instead, the record establishes that the surgery was denied not because of a policy or practice of denying that kind of treatment, but because of the DTARC's determination that the surgery was not medically necessary under Plaintiff's individualized circumstances. (*See* Ex. 5 at 153-58; Ex. 9 at 147; Ex. 12 at 131-32; Ex. 13 at 1-2; Ex. 27). And the evidence shows that the Department could approve gender affirming surgery as medical necessary under other appropriate circumstances. (Ex. 1 at 5-7; Ex. 10 at 12; Ex. 11 at 55-56, 71-72, 86, Ex. 12 at 35, 44, 50). Additionally, beyond not receiving a surgery that she has requested, Plaintiff cannot point to any record evidence of an adverse impact, let alone a causal connection between some identified policy or practice and an adverse impact.

3. Plaintiff Cannot Establish an Accommodation Claim Under the ADA.

Similarly, any accommodation claim fails. To the extent Plaintiff contends that surgery is necessary to reasonably accommodate her disability, such a contention is not supported by the record evidence or the law. As an initial matter, Plaintiff has no evidence that she ever informed Defendants that she sought surgery as a reasonable accommodation for a disability. Regardless, Plaintiff cannot establish that the surgery—as opposed to the other treatments provided—was necessary to allow her to fully participate in prison life or services. *See Shorter*, 2022 U.S. Dist. LEXIS 67143, at *25-32 (N.D. Fla. Mar. 4, 2022) (granting summary judgment in favor of the defendants on a failure-to-accommodate because the "surgery is a preferred accommodation[.]"). The evidence shows Plaintiff fully participated in prison life, including work and educational programs. (Ex. 3 at 27-28) Moreover, Plaintiff is not entitled to whatever accommodation she prefers, only to a reasonable accommodation. *See, e.g., Richardson*, 52 F. 4th at 620 (granting summary judgment for prison defendants because inmate failed to create issue of material fact on

reasonableness of the accommodations provided based on a "desire for more accommodations" than the ones already provided).

4. Plaintiff's Novel Claim Should Be Rejected.

Notably, Defendants have not located any cases holding that a prison has violated the ADA or RA where it has offered treatment for GD but denied one specific treatment—in this case, gender affirming surgery. Such a novel holding would have far-reaching consequences and lacks any legal support. In short, Plaintiff has not developed sufficient evidence to support the second or third elements of an ADA discrimination claim. *See Lamone*, 813 F.3d at 503. Nor does the record support a disparate impact or accommodation claim under the ADA. Therefore, Defendants are entitled to summary judgment on Plaintiff's disability claim.

CONCLUSION

For the reasons set forth herein, Defendants respectfully request that their Motion for Summary Judgment be granted and that all claims asserted against them be dismissed with prejudice. Pursuant to Section II(c) of the Pretrial Order and Case Management Plan entered in this case, DE-28, Defendants respectfully request a hearing on their Motion for Summary Judgment.

This the 5th day of October 2023.

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