

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION**

REIYN KEOHANE, <i>et al.</i>,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	Case No. 4:24-cv-434-AW-MAF
	)	
RICHARD COMERFORD, <i>et al.</i>,	)	
	)	
Defendants.	)	

THE FDC OFFICIALS' CLOSING BRIEF

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THE FDC OFFICIALS’ CLOSING BRIEF

Pursuant to this Court’s Order (doc. 211), Richard Comerford (“Secretary Comerford”), in his official capacity as Secretary of the Florida Department of Corrections (“FDC”); Clayton Weiss, in his official capacity as Health Services Director of the Florida Department of Corrections (“Weiss”); Gary Hewett, in his official capacity as Warden of Wakulla Correctional Institution (“Hewett”); Alonzo Horner, in his official capacity as Warden of Homestead Correctional Institution (“Horner”); and Nan Jeffcoat, in her official capacity as Warden of Florida Women’s Reception Center (“Jeffcoat,” and together with Secretary Comerford, Weiss, Hewett, and Horner, the “FDC Officials”), hereby respectfully submit this closing brief.

INTRODUCTION

Plaintiffs brought this lawsuit seeking a proclamation that FDC Officials’ denial of social accommodations, such as preferred clothing and grooming practices, to inmates with gender dysphoria constituted cruel and unusual punishment by showing deliberate indifference to those inmates’ serious medical needs. The evidence at trial confirmed an obvious fact: FDC’s decision to treat gender dysphoria with means other than social accommodations was rooted in its determination of medical necessity rather than deliberate indifference. Because there is a lack of consensus in the medical community that social accommodations are appropriate and necessary, permitting Plaintiffs, rather than FDC, to choose their means of treatment would radically diverge from Eighth Amendment jurisprudence.

FDC has no legal burden to prove that social accommodations lack value for inmates with gender dysphoria, and Plaintiffs may not prevail merely by showing that accommodations may provide some level of benefit for some inmates. The fundamental question remains whether these accommodations are medically necessary, not generally beneficial. Hoffer v. Sec’y, Fla. Dep’t of Corr., 973 F.3d 1263, 1271-72 (11th Cir. 2020); Harris v. Thigpen, 941 F.2d 1495, 1504, 1510 (11th Cir. 1991) (quoting Brown v. Beck, 481 F. Supp. 723, 726 (S.D. Cal. 1980)); Keohane v. Sec’y, Fla. Dep’t of Corr., 952 F.3d 1257, 1277 (11th Cir. 2020) (“Keohane I”). The evidentiary record reflects that that social accommodations fall

far short of medically necessary care. Although some inmates testified about episodes of distress reduction with accommodations, the full mental health histories of these same patients paint a much different picture. Even with social accommodations, the mental health records confirm that these patients continued to experience substantial psychiatric symptoms, mental health crises, and continuing distress with a variety of causative factors. The withdrawal of social accommodations did not result in the widespread negative mental health outcomes that Plaintiffs predicted. And the evidentiary record confirmed that clinical, professional, and scholarly debates continue today about the efficacy of social accommodations.

In sum, Plaintiffs failed to establish cruel and unusual punishment under the Eighth Amendment. FDC's medical officials reviewed the available literature, concluded that the evidence failed to establish social accommodations as medically necessary, and set forth a treatment protocol based on medical necessity. In accordance with that protocol, FDC continues to recognize and treat gender dysphoria through psychotherapy, individualized mental health care, treatment of co-occurring conditions, crisis services, and hormone therapy when approved by the Gender Dysphoria Variance Team ("GDVT"). Plaintiffs may disagree with FDC's judgment, but such disagreement does not equate to a demonstration of

constitutionally inadequate care, a substantial risk of serious harm from the HSB, or criminal-law recklessness by the FDC Officials.

This Court should enter judgment in favor of the FDC Officials for at least the following six reasons:

- (1) Plaintiffs failed to prove that the Eighth Amendment requires FDC to provide social accommodations;
- (2) Plaintiffs failed to establish that FDC's overall course of care is constitutionally inadequate;
- (3) Plaintiffs failed to prove that the HSB poses substantial risk of serious harm to Plaintiffs or class members;
- (4) The FDC Officials did not act with subjective recklessness;
- (5) Plaintiffs' experts lack credibility on the opinions necessary to establish Plaintiffs' claims; and
- (6) Plaintiffs are not entitled to the statewide injunction they seek.

Both the prevailing legal standard and evidentiary record support these conclusions.

LEGAL STANDARD

A plaintiff asserting an Eighth Amendment deliberate-indifference claim must “demonstrate, as a threshold matter, that he suffered a deprivation that was, ‘objectively, sufficiently serious.’” Wade v. McDade, 106 F.4th 1251, 1262 (11th Cir. 2024) (*en banc*) (quoting Farmer v. Brennan, 511 U.S. 825, 834 (1994)). After making that preliminary showing, the plaintiff must establish that the “defendant acted with ‘subjective recklessness as used in the criminal law,’” which requires showing that the defendant “was actually, subjectively aware that his own conduct

caused a substantial risk of serious harm to the plaintiff.” Id. (quoting Farmer, 511 U.S. at 839). This “subjective approach isolates those who inflict punishment.” Farmer, 511 U.S. at 839; see also Wade, 106 F.4th at 1257 (observing that “[t]he Eighth Amendment does not outlaw cruel and unusual conditions; it outlaws cruel and unusual punishments”) (quoting Farmer, 511 U.S. at 837) (some internal quotation marks omitted); Wilson v. Seiter, 501 U.S. 294, 300 (1991) (“If the pain inflicted is not formally meted out *as punishment* by the statute or the sentencing judge, some mental element must be attributed to the inflicting officer before it can qualify.”). Thus, as this Court concluded, “[a] defendant who subjectively believes he is acting appropriately and that his course of action will not cause harm is not violating the Eighth Amendment.” (Doc. 200 at 18-19 (citing Kosilek v. Spencer, 774 F.3d 63, 91 (1st Cir. 2014) (*en banc*)).

The deliberate-indifference standard also contains an objective prong: prison officials who “‘responded reasonably to the risk’” face no Eighth Amendment liability. Id. (quoting Farmer, 511 U.S. at 844); Swain v. Junior, 961 F.3d 1276, 1286 (11th Cir. 2020) (“Indeed, even where ‘prison officials . . . actually knew of a substantial risk to inmate health or safety,’ they may nonetheless ‘be found free from liability if they responded reasonably to the risk’—and, importantly for present purposes, ‘even if the harm ultimately was not averted.’”) (quoting Farmer, 511 U.S. at 844). “So ‘a plaintiff must show both that the defendant actually (subjectively)

knew that an inmate faced a substantial risk of serious harm and that the defendant disregarded that known risk by failing to respond to it in an (objectively) reasonable manner.”” Dunn v. Comm’r, Ala. Dep’t of Corr., 179 F.4th 1277, 1292 (11th Cir. 2026) (quoting Mosley v. Zachery, 966 F.3d 1265, 1270 (11th Cir. 2020)).

As to medical care specifically, not “every claim by a prisoner that he has not received adequate medical treatment states a violation of the Eighth Amendment.” Estelle v. Gamble, 429 U.S. 97, 105 (1976). Instead, “to state a cognizable claim, a prisoner must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs.” Id. at 106. While the Eighth Amendment requires prison officials to provide inmates with “minimally adequate” mental-health care, “as with all medical care provided to prisoners, it is not constitutionally required that mental health care be ‘perfect, the best obtainable, or even very good.’” Harris, 941 F.2d at 1504, 1510 (11th Cir. 1991) (quoting Brown, 481 F. Supp. at 726). Accordingly, “[m]edical treatment violates the [E]ighth [A]mendment only when it is ‘so grossly incompetent, inadequate, or excessive as to shock the conscience or to be intolerable to fundamental fairness.’” Id. at 1505 (quoting Rogers v. Evans, 792 F.2d 1052, 1058 (11th Cir. 1986)); Hoffer 973 F.3d at 1271-72 (“The question here . . . isn’t whether, in the best of all possible worlds,” plaintiffs would receive the treatment they seek, or “even whether, if we were sitting as a common-law court, we might conclude that ordinary prudence requires” the

treatment; instead, under “the Eighth Amendment, the sole question before us is whether [the treatment the inmates received] is so reckless—so conscience-shocking—that it violates the Constitution.”).

Moreover, “prisoners aren’t constitutionally entitled to their preferred treatment plan.” Keohane I, 952 F.3d at 1277. Thus, “‘a simple difference in medical opinion between the prison’s medical staff and the inmate as to the latter’s diagnosis or course of treatment [fails to] support a claim of cruel and unusual punishment.’” Id. at 1266. “Put simply, when the medical community can’t agree on the appropriate course of care, there is simply no legal basis for concluded that the treatment provided is ‘so grossly incompetent, inadequate, or excessive as to shock the conscience or to be intolerable to fundamental fairness.’” Id. at 1275 (quoting Harris, 941 F.2d at 1505); Hoffer, 973 F.3d at 1273 (“Because the plaintiffs here are receiving medical care—and because the adequacy of that care is the subject of genuine, good-faith disagreement between healthcare professionals—we are hard-pressed to find that the Secretary has acted in so reckless and conscience-shocking a manner as to have violated the Constitution”); Gibson v. Collier, 920 F.3d 212, 220 (5th Cir. 2019) (“There is no intentional or wanton deprivation of care if a genuine debate exists within the medical community about the necessity or efficacy of that care.”); Kosilek, 774 F.3d at 90 (“The 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 or to require that the DOC adopt the more compassionate of two adequate options.”) (citations omitted). This Court previously found that “there can be no conclusion based on this record that the Department offers medical care for gender dysphoria that ‘is so cursory as to amount to no treatment at all.’” (Doc. 200 at 16 (quoting Mandel v. Doe, 888 F.2d 783, 789 (11th Cir. 1989))).

In accordance with the controlling legal standards set forth above, this Court’s summary-judgment order established Plaintiffs’ trial burden:

At trial, Plaintiffs will have to prove that the care they do (or can) receive is constitutionally inadequate. It will not be enough to show that social accommodations are helpful or more efficacious than other treatments alone. . . . Instead, Plaintiffs will have to show that care that excludes social accommodations “is so grossly incompetent, inadequate, or excessive as to shock the conscience or to be intolerable to fundamental fairness.”

(Doc. 200 at 17-18 (quoting Hoffer, 973 F.3d at 1271)). This Court further stated that “Plaintiffs will have to prove at trial that this is something beyond a difference of opinion as to appropriate treatment for gender dysphoria. They will have to show a consensus in the medical community that the requested accommodations are appropriate and necessary.” (Doc. 200 at 14). This Court recognized that “[t]his will likely be a difficult burden.” (Doc. 200 at 15). (See also id. at 18 (acknowledging that Plaintiffs faced “a difficult task” in making this showing)). As set forth below, Plaintiffs failed to satisfy this “difficult burden” at trial.

ARGUMENT

I. PLAINTIFFS FAILED TO PROVE SOCIAL ACCOMMODATIONS ARE CONSTITUTIONALLY REQUIRED.

A. Plaintiffs Failed to Establish a Medical Consensus That Social Accommodations Are Appropriate and Necessary.

This Court notified Plaintiffs of their burden to prove more than a benefit or a difference of medical opinion. Plaintiffs needed to establish a medical consensus “that the requested accommodations are appropriate and necessary,” and that care excluding accommodations is constitutionally inadequate. (Doc. 200 at 17-18). The trial record shows mere disagreement, not consensus.

Plaintiffs’ purported expert, Dr. Dan Karasic, expressly limited his ultimate opinion. He stated his opinion that social accommodations “*can* be medically necessary,” not that accommodations *are* medically necessary for any named Plaintiff or class member. (Tr. (Vol. 2) 180:11-14) (emphasis added). When asked whether an “individual determination would need to be made by a clinician after an individual examination” of Plaintiffs to provide social accommodations, Dr. Karasic responded “[t]hat’s correct.” (Tr. (Vol. 2) 180:18-20). Dr. Karasic also acknowledged that “why an individual determination needs to be made is there probably some accommodations that are not impactful.” (Tr. (Vol. 2) 178:24-179:2). The FDC Officials’ expert Dr. Kristopher Kaliebe confirmed the absence of medical consensus. When asked “[i]s it your opinion that a consensus exists within

the medical community that social accommodations are appropriate and necessary,” Dr. Kaliebe responded “[n]o, I do not think there’s a consensus.” (Tr. (Vol. 4) 789:19-22). Thus, Plaintiffs failed to establish that any particular accommodation is medically necessary for any Plaintiff, much less that medical necessity requires the full universe of potential accommodations.

FDC’s former procedure applied a lower threshold for inmates to receive social accommodations than for hormones. When asked whether a mental health provider could recommend accommodations under FDC’s former procedure if the provider believed such accommodations “could alleviate the gender dysphoria” an inmate experienced, Dr. Suzonne Kline answered, “Correct.” (Tr. (Vol. 4) 739:3-6). Dr. Kline also agreed that a psychologist’s recommendation that accommodations were “likely to alleviate” gender dysphoria went to the Gender Dysphoria Review Team (“GDRT”) for review and approval. (Tr. (Vol. 4) 739:13-17). By contrast, hormone approval required a medical necessity determination. (Tr. (Vol. 4) 740:11-13 (Dr. Kline)) (“For a patient to be approved for hormone therapy it had to be determined they were medically necessary.” “Correct.”). Dr. Aloka Joshi, one of Centurion’s psychologists, similarly testified that whether social accommodations are necessary “depends on the person” and ultimately said only that accommodations “can be” necessary. (Tr. (Vol. 3) 459:6-19).

At most, Plaintiffs proved that FDC previously allowed social accommodations, clinicians previously recommended accommodations for some inmates, and clinicians reported that accommodations conferred partial or circumstantial benefits for a limited number of inmates. These facts fall well short of satisfying the additional requirements recognized by this Court: a consensus that the requested accommodations are appropriate and necessary and that care excluding accommodations is grossly inadequate or conscience-shocking. (Doc. 200 at 14-18); Keohane I, 952 F.3d at 1274-75. This evidentiary gap remains dispositive because the Eighth Amendment contains no requirement for FDC to provide accommodations merely because some clinicians or inmates believe accommodations to be beneficial, when the evidence established that no medical consensus exists.

B. Plaintiffs' Evidence Relied on Observational Studies, Self-Reported Surveys, Low-Certainty Evidence, and Nonmandatory Clinical Guidelines, While Their Experts Acknowledged That No Randomized Controlled Trial Examined Withdrawal of Social Accommodations and That the Available Literature Is Limited or Mixed.

The nature of Plaintiffs' evidence reinforces their failure to establish any clinical consensus regarding social accommodations. Dr. Karasic acknowledged on direct examination that the studies, which he identified, are not randomized

controlled trials and that, under the GRADE methodology¹, “observational studies are unlikely to have a high grade score. Really a randomized controlled trial is necessary for that.” (Tr. (Vol. 1) 30:12-20). On cross-examination, Dr. Karasic further agreed that “low quality of evidence” is a “well-known term in clinical studies” and “not something that the State of Florida made up.” (Tr. (Vol. 2) 144:11-15). He further agreed that “numerous contributors” characterized studies relied on by both Dr. Karasic and the World Professional Association for Transgender Health (“WPATH”) as relying on “a low quality of evidence.” (Tr. (Vol. 2) 144:11-145:18). Dr. Karasic agreed that, when predicting patient outcomes, “we can have more certainty” when relying on a study with “a high quality of evidence” than one with “a low quality of evidence.” (Tr. (Vol. 2) 146:4-13). Plaintiffs presented no evidence at trial of any high-certainty clinical studies related to social accommodations in a correctional setting. Although low and very low-quality evidence may be used to inform treatment decisions in some cases, Dr. Kaliebe testified that “we cannot depend on them because the certainty isn’t there. So it might be true, but it may not be true. And, so when you see very low or low quality evidence, it speaks to a phenomenon that we really do not understand well.” (Tr.

¹ “When individuals undergo a systematic review of evidence, they use the grade system to come up with a rating for what is the evidence, and it goes from . . . strong all the way down to low and very low. . . So it’s a systematic review of all studies that meet the inclusion criteria, and then grading them on where they’re at.” (Tr. (Vol. 4) 809:16-24 (Dr. Kaliebe)).

(Vol. 4) 810:2-6). Dr. Karasic agreed that no randomized controlled study examined a gender-dysphoric population after “withdrawal of social accommodations.” (Tr. (Vol. 2) 147:1-8). The absence of such a study fails to resolve the constitutional issue itself, but it bears directly on whether Plaintiffs proved a consensus concerning the effects of the challenged withdrawal of social accommodations.

The evidentiary question here asks not whether the studies relied upon by Plaintiffs or FDC Officials hold some probative value. (Doc. 200 at 14-18); Keohane I, 952 F.3d at 1275. The evidentiary question instead asks whether Plaintiffs carried the burden to prove a medical consensus of necessity despite acknowledged uncertainty, mixed results, and the absence of correctional research.

The U.S. Trans Survey illustrates the limitation of Plaintiffs’ evidence. The U.S. Trans Survey surveyed “over 90,000 trans people,” but Dr. Karasic did not know how many respondents carry a diagnosis of gender dysphoria. (Tr. (Vol. 2) 147:11-148:1). When asked whether the survey showed “evidence related to improved clinical outcomes,” he answered: “It wasn’t, because there weren’t clinicians rating the outcome. It was self-report of improved mental health and quality of life.” (Tr. (Vol. 2) 148:19-23). Dr. Karasic also agreed that the survey included no “clinical review” of respondents’ mental-health condition “before social transition and after,” and that it “did not look at the implications of withdrawing social accommodations.” (Tr. (Vol. 2) 149:15-23 (Dr. Karasic)). The U.S. Trans

survey therefore may establish that respondents perceived psychological or quality-of-life improvement, but it cannot establish clinically measured consequences of withdrawing the particular items challenged here from adults in a correctional setting.

Plaintiffs also relied heavily on WPATH's self-serving, biased documents, but their own expert explained why those documents fail to establish mandatory standards. Dr. Karasic testified that the WPATH Standards of Care constitute "guidelines" and that "clinicians ultimately have flexibility." (Tr. (Vol. 2) 153:1-7). He then explained: "They're recommendations. . . . [U]ltimately the clinician is taking care of the patient and looking at the advice that they're getting . . . and then the clinician is making the determination." (Tr. (Vol. 2) 153:11-23). Dr. Karasic likewise testified that WPATH, Endocrine Society, and University of California – San Francisco guidance contain "recommendations" that "the clinical judgment is up to the individual clinicians weighing the risks and benefits of a given intervention." (Tr. (Vol. 1) 35:13-18). Moreover, the terms "Standards of Care" and "WPATH standards of care" do not establish a physician's legal duties. (Tr. (Vol. 1) at 35:19-25 (Dr. Karasic)). Dr. Karasic further acknowledged that WPATH is "not a government agency," it holds no licensing authority, and no studies "demonstrate that WPATH physicians, who are certified, provide better care or have better outcomes than noncertified WPATH physicians." (Tr. (Vol. 2) 157:18-

158:10). Dr. Karasic's concessions negate Plaintiffs' attempt to characterize WPATH guidance as proof of a binding medical consensus that social accommodations are necessary to constitutionally adequate care.

The correctional literature regarding social accommodations remains thinner still. Dr. Kline testified that research involving incarcerated populations is "very minimal" and that she was "not aware of any studies that exist in the incarcerated population." (Tr. (Vol. 4) 718:17-25). Dr. Kaliebe was "not aware of any study" involving a gender-dysphoric population unable to access social accommodations, and that the overall evidence is "sparse" and "especially" so "within corrections." (Tr. (Vol. 4) 809:5-15). The lack of concrete evidence related to the benefits of social accommodations to the incarcerated population cannot support Plaintiffs' contention that the Constitution entitles them to social accommodations.

C. FDC's Witnesses and Expert Offered a Contrary Professional View Concerning the Necessity and Efficacy of Social Accommodations in the Correctional Setting.

The FDC Officials presented competing clinical evidence foreclosing a finding of medical consensus. Dr. Martinez acknowledged that social accommodations may provide some benefit, but after reviewing the literature, he testified: "we found no strong evidence indicating that social accommodations are medically necessary." (Tr. (Vol. 4) 648:22-649:3).

In regard to mental health, Dr. Kline found no correctional study regarding social accommodations and insufficient evidence of long-term benefits of providing social accommodations; in her words, the evidence “didn’t reach . . . medical necessity.” (Tr. (Vol. 4) 722:15-20). Dr. Kaliebe likewise testified that social accommodations “do not reach the standard of evidence in order to be medically necessary.” (Tr. (Vol. 4) 787:12-14). Taking a generous view of Plaintiffs’ case, they minimally presented contrary clinical views and evidence of reported anecdotal benefits, but not the medical consensus the Court required Plaintiffs to establish. Hoffer, 973 F.3d at 1273; Keohane I, 952 F.3d at 1274-75. The evidence presented at trial established a genuine professional dispute over the medical necessity and appropriateness of providing social accommodations in a correctional setting. Thus, Plaintiffs failed to prove any medical consensus regarding the purported medical necessity of social accommodations.

D. Keohane I Makes the Resulting Medical Disagreement Constitutionally Dispositive.

Keohane I addressed the same general categories of social accommodations and rejected an Eighth Amendment claim because the testifying professionals remained divided over medical necessity. 952 F.3d at 1274-75. The court held that when the medical community cannot agree on the appropriate course of care, “there is simply no legal basis for concluding that the treatment provided is ‘so grossly incompetent, inadequate, or excessive as to shock the conscience or to be intolerable

to fundamental fairness.” Id. at 1275 (quoting Harris, 941 F.2d at 1505). The resulting trial record here followed closely in line within Keohane I.

Plaintiffs invoke Keohane I’s separate “shoulder-shrugging refusal” and blanket ban language. (Doc. 217 at 53-54). But that discussion concerned the former hormone “freeze-frame” policy. Keohane I, 952 F.3d at 166-67. The same opinion rejected Keohane’s social accommodations claim because qualified professionals disagreed about the medical necessity of social transition. Id. at 1274-75. This Court should consider Keohane I’s holding with respect to social accommodations, not the holding with respect to hormone treatment.

The same distinction between social accommodations and other treatment for gender dysphoria distinguishes this case from De’lonta v. Johnson, 708 F.3d 520, 522-23, 526 (4th Cir. 2013), and Hicklin v. Precynthe, No. 4:16-cv-1357, 2018 WL 806764, at *11-12 (E.D. Mo. Feb. 9, 2018) (cited by Plaintiffs, doc. 217 at 35). These decisions respectively involved an alleged refusal to evaluate gender reassignment surgery despite repeated self-castration behavior and a policy-based denial of hormone therapy despite treating-provider recommendations. De’lonta, 708 F.3d at 522-23, 526; Hicklin, 2018 WL 806764, at *11-12. Here, FDC provides a variety of treatments for gender dysphoria, including hormone therapy, psychotherapy, individualized service planning, treatment of co-occurring conditions, and crisis care.

The professional disagreement surrounding social accommodations defeats Plaintiffs’ constitutional necessity theory under Keohane I. The Eighth Amendment does not authorize a court to choose the treatment it considers more compassionate or more beneficial when competent professionals genuinely disagree and the prison continues to provide care. Keohane I, 952 F.3d at 1274-77; Hoffer, 973 F.3d at 1272-73; Kosilek, 774 F.3d at 90. Plaintiffs argued disagreement and evidence of possible benefit. They failed to prove a medical consensus of necessity, and their claim fails under Keohane I.

II. PLAINTIFFS FAILED TO ESTABLISH THAT FDC’S OVERALL COURSE OF CARE IS CONSTITUTIONALLY INADEQUATE.

A. FDC Recognizes and Treats Gender Dysphoria.

This Court should evaluate the constitutionality of FDC’s overall course of care, not the single disputed intervention of social accommodations in isolation. See Harris, 941 F.2d at 1504-05, 1510; Hoffer, 973 F.3d at 1271-73. The trial record shows that FDC recognizes gender dysphoria as a diagnosable mental health condition, monitors inmates meeting the diagnostic criteria, and continues to provide treatment through multiple clinical pathways.

As Dr. Kline explained, FDC’s HSB moved inmates with gender dysphoria from an S-2 to an S-3 designation because she “wanted to make sure they had more contact with mental health if they needed it,” and that the designation provides both more frequent interaction and “a higher cadre” of available mental health staff. (Tr.

(Vol. 4) 709:7-20). She further testified that mental health staff continue to recognize gender dysphoria as a mental health condition. (Tr. (Vol. 4) 711:8-16). Thus, the HSB increased the overall level of mental health services and treatment available to inmates with gender dysphoria.

FDC's HSB further provides inmates with gender dysphoria a range of treatment, including individualized assessments, treatment of comorbid conditions, psychotherapy, psychological support, and access to hormone therapy through a medical-necessity variance process. The HSB requires assessment of the individual and comorbid conditions, incorporates "psychological objective testing," provides psychotherapy and other psychological support, and preserves "an avenue where we could continue providing the hormones" through a medical-necessity variance process. (Tr. (Vol. 4) 714:15-717:19, 722:1-20, 791:8-792:1 (Dr. Kline)). The hormone-variance process outlined in the HSB is individualized as well. As Dr. Martinez testified, FDC approved variances for "at least 67 people with gender dysphoria;" that the GDVT approves variances when hormone therapy is "deemed medically necessary for that individual;" and that approval requires "unanimous agreement among the [GDVT]." (Tr. (Vol. 4) 654:25-655:12). Additionally, when asked if he could identify a single "gender-dysphoric patient in the custody of FDC who went without medical or mental healthcare after the implementation of the HSB," Dr. Karasic answered, "No." (Tr. (Vol. 2) 174:15-18). And Dr. John Lay,

Centurion of Florida's statewide Medical Director, testified that Centurion's contract with FDC requires it to "provide comprehensive care for both medical, mental and dental care." (Tr. (Vol. 3) 395:24-396:2). When asked if, "[w]ith respect to social accommodations, the HSB impacted the ability of Centurion to fulfill its mission under that contract," Dr. Lay responded, "I don't think it has" and affirmed that "[w]e're still providing hormones" and "still provid[ing] psychotherapy." (Tr. (Vol. 3) 396:3-7). The dispute therefore concerns whether the Constitution requires FDC to add one contested category of intervention to an existing course of care. For all of the obvious reasons, it does not.

B. FDC Provides Individualized Treatment Plans, Psychotherapy, Psychiatric Care, and Crisis Intervention, Treatment for Co-Occurring Conditions to Named Plaintiffs.

As referenced above, FDC's mental health system offers a continuum of care rather than a single, cursory intervention. Dr. Kline described a tiered "S-1 to S-6" mental-health system in which inmates "can access mental health at any time, 24-hours a day," with progressively higher levels of care ranging from outpatient treatment and psychotropic medication to the Transitional Care Unit ("TCU"), Crisis Stabilization Unit ("CSU"), and involuntary commitment at the Court Mental Health Treatment Facility. (Tr. (Vol. 4) 708:1-709:5). FDC provides care via a multidisciplinary staff, including "psychologists," "psychiatrists," "mental health professionals," "behavioral health technicians," nursing staff available "24-7," and

medical doctors. (Tr. (Vol. 4) 709:21-710:14 (Dr. Kline)). Jillian Martell, a Centurion mental-health practitioner, testified that treatment “var[ies] on patient to patient” and includes “individualized service plans,” therapy, case management, and group treatment. (Tr. (Vol. 3) 441:16-20). She also confirmed that Centurion treats patients for “everything,” including gender dysphoria. (Tr. (Vol. 3) 441:21-25). Plaintiffs’ own expert likewise confirmed the individualized care reflected in the records. Dr. Evans testified that, for all five named Plaintiffs, the records showed psychotherapy and “individualized service plans” that listed “co-occurring disorders as well as gender dysphoria.” (Tr. (Vol. 4) 582:10-18). No evidence exists to suggest that FDC failed to provide necessary constitutional care to any named Plaintiffs.

Keohane’s testimony confirmed that Plaintiffs receive access to ongoing care. Keohane testified that psychotherapy “has been offered to me” throughout Keohane’s incarceration, that Keohane attended at times and refused at times, and that “the entire time that I’ve been in the Department of Corrections it’s always been offered.” (Tr. (Vol. 3) 317:3-9). Keohane also described receiving progressively higher levels of mental-health care when needed. Keohane testified that CSU placement involved “care and attention and medication related to [Keohane’s] mental health,” that TCU provided a transition from crisis stabilization, and that the Diversionary Treatment Unit (“DTU”) offered “a similar level of higher psychological treatment” with “groups and classes” and “much more intensive and

widespread mental healthcare” than general population. (Tr. (Vol. 3) 332:23-334:1). FDC Officials presented ample evidence at trial to support its position that it provided ongoing care for Keohane’s gender dysphoria.

Mendoza described an “Individualized Service Plan” developed by a “psych counselor and the multidisciplinary service team” based on the diagnosis and “how to best treat [the] symptoms and [the] conditions.” (Tr. (Vol. 2) 245:23-246:9). FDC provided Mendoza mental health care long before Mendoza received a gender dysphoria diagnosis. Mendoza testified to diagnoses of “depression, PTSD and anxiety” and to “receiving mental healthcare for those” conditions before the gender-dysphoria diagnosis. (Tr. (Vol. 2) 261:1-7). When Mendoza later reported suicidality after the death of Mendoza’s mother, FDC Officials placed Mendoza under “crisis observation” for an extended period while continuing hormone therapy. (Tr. (Vol. 2) 262:21-263:6, 266:23-267:7). FDC Officials presented ample evidence at trial to support its position that it provided ongoing care for Mendoza’s gender dysphoria.

Coleman began receiving hormone therapy around August 2025 and continued to receive it at the time of trial. (Tr. (Vol. 3) 491:25-492:7, 496:16-23). Coleman’s records reflect individual psychotherapy and continued treatment for depression, anxiety, and gender dysphoria. (Tr. (Vol. 3) 491:11-16, 495:3-7; Tr. (Vol. 4) 582:10-18). Jackson’s FDC evaluation included consultation with an

individual therapist and consideration of gender dysphoria, depressive symptoms, and intellectual-functioning concerns. (Tr. (Vol. 3) 507:15-25). The FDC Officials presented ample evidence at trial to demonstrate that they provided ongoing gender-dysphoria care for Coleman and Jackson.

Boothe likewise receives ongoing, individualized mental health care. Boothe testified that the individualized service plan listed gender dysphoria, anxiety, and PTSD; that Boothe received psychotherapy “at least once a week”; and that Boothe attended group therapy. (Tr. (Vol. 2) 216:9-217:1). Boothe also confirmed that Boothe could obtain additional mental health care outside scheduled therapy sessions by submitting a sick call. (Tr. (Vol. 2) 217:6-9). When asked whether FDC ever denied mental health care, Boothe answered, “no, I haven’t been denied mental healthcare.” (Tr. (Vol. 2) 218:23-24). Boothe also agreed that Boothe has “always been able to access the care” when needed and upon request. (Tr. (Vol. 2) 218:23-219:5). The record therefore reflects ongoing treatment for Boothe’s gender dysphoria and co-occurring conditions through weekly psychotherapy, group therapy, crisis intervention, and additional care upon request.

Taken together, the named Plaintiffs receive the very categories of care that defeat a claim of wholesale or cursory non-treatment: individualized planning, psychotherapy, treatment for co-occurring conditions, psychiatric services, and escalating crisis intervention. The Constitution does not require FDC to replace that

comprehensive system with accommodations that Plaintiffs prefer. Harris, 941 F.2d at 1504-05, 1510; Keohane I, 952 F.3d at 1277; Kosilek, 774 F.3d at 90. FDC's substantial and continuing course of care forecloses any finding that FDC's treatment is so inadequate as to violate the Eighth Amendment.

C. Plaintiffs Failed to Prove That the Care FDC Provides is Cursory, Ineffective, or So Grossly Inadequate That It Shocks the Conscience.

Because named Plaintiffs receive substantial ongoing care, Plaintiffs could not prevail merely by proving that symptoms remain or that another intervention might help. This Court has already held that, because FDC provides psychotherapy and hormones, the record could not support a conclusion that FDC's gender dysphoria care is "so cursory as to amount to no treatment at all." (Doc. 200 at 16 (quoting Mandel v. Doe, 888 F.2d 783, 789 (11th Cir. 1989))). The evidence at trial showed that Plaintiffs receive substantial continuing care from FDC. Section III below addresses why individual anecdotal patient reports fail to establish that the HSB itself created a substantial risk of harm.

Plaintiffs referenced the suicide of a former inmate within their Closing Brief as apparent evidence of deliberate indifference. (Doc. 217 at 17). On cross examination, Dr. Kline agreed that the psychological autopsy identified distress from the loss of social accommodations as "one of the factors that contributed" to the former inmate's suicide. (Tr. (Vol. 4) 750:17-24). Plaintiffs, however, omit the

multiple other factors that contributed to the incident. (Ex. 225). Most pertinently, the deceased engaged in a verbal altercation with a “partner” just “moments before [the former inmate] engaged in the behaviors that led to [the former inmate’s] death.” (*Id.* at 33). The testimony from Dr. Kline identified one contributing factor in a multifactorial event; it failed to establish that FDC’s overall course of treatment amounted to no treatment or shocked the conscience.

Anecdotal adverse episodes experienced by individual patients with extensive trauma, multiple diagnoses, and histories of crisis before and during access to social accommodations do not transform FDC’s multilayered response into mental healthcare that shocks the conscience. At most, Plaintiffs show that serious mental health conditions remain difficult to treat and that reasonable clinicians continue to disagree about whether social accommodations constitute a necessary component of the regimen. That showing remains insufficient for Plaintiffs to prevail under controlling precedents. *Harris*, 941 F.2d at 1505, 1510; *Hoffer*, 973 F.3d at 1271-73; *Keohane I*, 952 F.3d at 1274-77. Accordingly, the existence of adverse episodes fails to establish that FDC’s overall course of care falls below the constitutional minimum.

D. FDC Continues to Consider Individualized Medical Needs Outside the Withdrawn Social Accommodations.

The evidence presented at trial established that FDC withdrew social accommodations. (Tr. (Vol. 3) 372:3-1). Indisputably, the HSB permits no

individualized requests for social accommodations. But withdrawing social accommodations does not prohibit or foreclose individualized assessment and treatment of gender dysphoria or other medically supported needs.

FDC provides comprehensive and individualized psychotherapy as treatment for gender dysphoria because “psychotherapy can be helpful in so many different ways . . . [a]nd a lot of the gender dysphoria research literature talks about comorbid or co-occurring conditions like depression and anxiety or PTSD.” (Tr. (Vol. 4) 731:25-732:3 (Dr. Kline)). Additionally, “one of the most well-established treatment[s] . . . for depression or anxiety . . . is cognitive behavioral therapy.” (Tr. (Vol. 4) 732:3-7 (Dr. Kline)). In fact, the development and implementation of the HSB elevated mental health care for gender dysphoric inmates by providing “more frequent contact” with mental health providers and “a higher prevalence of mental health staff on-site” to provide care. (Tr. (Vol. 4) 732:22-733:2 (Dr. Kline)). This elevated mental health care allows inmates to access care “at any time, 24-hours a day” from psychologists, psychiatrists, mental health professionals, and behavioral health technicians. (Tr. (Vol. 4) 708:8, 710:5-8 (Dr. Kline)). Such mental health treatment also includes the development of individualized service plans for each gender dysphoric inmate, individual psychotherapy, and group therapy. (Tr. (Vol. 3) 441:19-20 (Martell)). Thus, FDC continues to treat gender dysphoria through an

individualized, multilayered mental health system rather than through cursory or nominal care.

Dr. Kline gave another example of FDC's individualized clinical process. Dr. Kline described an inmate with autism who experienced hypersensitivity to noise and whose mental health team requested "noise-cancellation headphones." (Tr. (Vol. 4) 737:2-12). Dr. Kline explained that hypersensitivity "varies by individual" and concluded that, "if the mental health [team] thinks it's clinically justified," FDC could make an exception and allow the headphones. FDC then "made an exception" and permitted the inmate to possess the otherwise-prohibited headphones. (*Id.*). On cross examination, Dr. Kline confirmed that clinicians can evaluate needs "that [are not] provided for in policy" and that she previously did "it with other things." (Tr. (Vol. 4) 769:5-9). Dr. Kline's testimony thus reinforces that FDC's treatment system remains responsive to individualized clinical needs rather than rigidly limiting care.

III. PLAINTIFFS FAIL TO PROVE THAT THE HSB POSES SUBSTANTIAL RISK OF SERIOUS HARM.

Plaintiffs' purported proof of harm suffers from the same fundamental problem as their proof concerning adequacy of treatment: it substitutes evidence that some individuals experienced episodes of distress after losing social accommodations for proof that FDC's policy itself creates a substantial risk of serious harm. These are not equivalent. The Eighth Amendment requires an

objectively serious deprivation, Farmer v. Brennan, 511U.S. 825, 834 (1994), and deliberate indifference liability requires proof that the challenged conduct placed the plaintiff at a “substantial risk of serious harm.” Wade v. McDade, 106 F.4th 1251, 1262 (11th Cir. 2024) (*en banc*). This Court accordingly held that Plaintiffs would need to prove at trial that FDC “was actually, subjectively aware that [its] own conduct caused a substantial risk of serious harm to the plaintiff[s].” (Doc. 200 at 18 (quoting Wade, 106 F.4th at 1261)). The evidence fails to support that conclusion.

A. Evidence That Some Inmates’ Symptoms Worsened Following Withdrawal of Social Accommodations Fails to Establish That the HSB Created a Substantial Risk of Serious Harm.

At most, Plaintiffs established that the withdrawal of social accommodations caused distress for some inmates. But the constitutional inquiry does not turn on whether the HSB caused distress. The trial record confirmed that the named Plaintiffs experienced distress resulting from numerous different causative factors before, during, and after their receipt of social accommodations. (See *infra*, pp. 30-33). Plaintiffs failed to establish that the distress attributable to the withdrawal of social accommodations rose to such a level as to render the withdrawal “conscience-shocking.”

In Keohane I, the Eleventh Circuit considered FDC’s refusal to permit the same general categories of social accommodations and observed that Keohane’s

treatment team concluded that requiring compliance with FDC’s hair and grooming policies did not place Keohane “at a substantial risk of self-harm or severe psychological pain.” Keohane I, 952 F.3d at 1274. The court rejected Keohane’s Eighth Amendment claim because the evidence reflected a professional disagreement about whether social accommodations were medically necessary. Id. at 1274-75 (“[T]he testifying medical professionals were - and remain - divided over whether social transitioning is medically necessary to Keohane’s gender-dysphoria treatment.”). Nothing in the present record establishes that withdrawal of social accommodations necessarily produces the substantial risk that the evidence failed to establish in Keohane I.

Plaintiffs’ own expert testimony illustrates the distinction. Dr. Evans repeatedly framed her prognoses in probabilistic terms: Plaintiffs’ symptoms “are likely to decrease” if accommodations return; self-harm ideation “is likely to continue” without a binder; and other symptoms “would likely continue or worsen” without accommodations. (Tr. (Vol. 3) 496:12-15 (testifying that Plaintiffs’ symptoms are “likely” to decrease); 517:20-23 (testifying that a Plaintiff’s symptoms would be “expected” to decrease)). For Plaintiff Coleman, Dr. Evans simultaneously acknowledged that even if Coleman received social accommodations, “co-occurring symptoms may not remit entirely, due to extraneous variables such as pre-existing mental health condition, symptom overlap, with

potential co-occurring PTSD, environmental factors and genetics.” (Tr. (Vol. 3) 496:9-497:2). Indeed, Dr. Evans expressed difficulty in determining causation for Coleman’s “symptoms for PTSD, depression, anxiety and gender dysphoria” due to the symptom overlap among Coleman’s mental health conditions. (Tr. (Vol. 4) 587:9-20). Dr. Evans’s testimony supports possible benefits of social accommodations, not proof that the absence of accommodations creates a substantial risk of serious harm.

The same distinction applies across the named Plaintiffs. Dr. Evans candidly agreed that multiple ordinary and extraordinary life circumstances caused the Plaintiffs significant psychological distress. (Tr. (Vol. 4) 579:8-15). Dr. Evans identified family rejection, refusal by family members or staff to use preferred pronouns, changes in living circumstances, incarceration itself, and transfers between institutions as sources of distress. (Tr. (Vol. 4) 579:8-580:14). She further agreed that a mental health provider “can’t control every distressful situation in [a] patient with any mental health condition.” (Tr. (Vol. 4) 580:18-22). However, Plaintiffs’ theory frequently reasons backward from the existence of post-HSB distress: a Plaintiff became depressed, anxious, suicidal, or engaged in self-harm; therefore, denial of accommodations created the serious risk. The individual histories of named Plaintiffs do not permit that inference.

1. Mendoza’s history demonstrates the difficulty of attributing psychiatric crises to the HSB.

Plaintiff Mendoza provides the clearest example of how an individual’s mental health history and psychiatric crises cannot be readily attributed to the HSB and withdrawal of social accommodations. In July 2024, after the death of Mendoza’s mother yet *before* the HSB’s implementation and *while* Mendoza received both social accommodations and hormone therapy, Mendoza became suicidal. (Tr. (Vol. 2) 262:21-24 (Mendoza)). Mendoza testified that the suicide attempts stopped after beginning treatment for gender dysphoria “up to the point that I lost my mother,” after which Mendoza again became suicidal. (Tr. (Vol.2) 262:16-24). As such, the case of Mendoza undermines Plaintiffs proposed causal connection between mental health crises and the absence of social accommodations.

Dr. Evans agreed that Mendoza continued to struggle with depression even while receiving social accommodations and that, because Mendoza experienced persistent depressive disorder, “that would mean [Mendoza] didn’t have any remission in [Mendoza’s] symptoms of depression.” (Tr. (Vol. 3) 552:8-13). On cross examination, Dr. Evans further acknowledged that the July 2024 crisis reflected what she called a “perfect storm” involving both the death of a loved one and an adverse legal development. (Tr. (Vol. 4) 571:18-572:1). The chronology after FDC implemented the HSB demonstrates that the HSB itself did not materially impact the trajectory of Mendoza’s struggles with mental health. Dr. Evans’s report

identified Mendoza's last panic attack as occurring in July 2024, prior to the release of the HSB. (Tr. (Vol. 3) 552:21-553:3). Further, Dr. Evans identified that Mendoza experienced no further panic attacks between implementation of the HSB and Evans's evaluation of Mendoza in April 2025. (Tr. (Vol. 3) 553:5-17) ("Had there been a panic attack since the change in HSB?" "No."). And, although records reflected that Mendoza "reported suicidal ideations to [Mendoza's] individual therapist directly related to the announcement of the HSB," Mendoza "denied any suicidal ideations" to Dr. Evans during the April 2025 evaluation. (Tr. (Vol. 3) 553:19-554:10 (Dr. Evans)). Taken together, Mendoza's history reflects multiple competing causes of distress and a post-HSB course that resists any simple attribution to the policy.

2. Boothe's principal post-HSB crisis stemmed from an independent, traumatic precipitating event.

Boothe's history presents the same challenge to Plaintiffs' causal theory. Dr. Evans acknowledged that Boothe's placement on Self-Harm Observation Status ("SHOS") in October 2024 followed the unexpected deaths of two family members - a "really tragic double loss" that contributed to the crisis. (Tr. (Vol. 4) 599:1-8). To Dr. Evans's knowledge, Boothe experienced no subsequent "episode of suicidal ideations," suicide attempts, or "self-injury since 2024," and Boothe further did not report "recent [suicidal or self-harm] attempts" or "experienc[e] ideation" at the time

of Dr. Evans’s evaluation. (Tr. (Vol. 4) 599:9-599:24). Dr. Evans also agreed that even if social accommodations reduced Boothe’s “symptoms associated with gender dysphoria, to some degree Plaintiff Boothe’s symptoms of depression and anxiety would continue.” (Tr. (Vol. 4) 600:2-10). Plaintiff Booth firmly demonstrates the absence of any connection between the deterioration of one’s mental health. Again, Plaintiffs cannot attribute serious psychiatric outcomes to the absence of social accommodations merely because an inmate with gender dysphoria experienced them.

3. Keohane experienced self-harm and suicidality even while receiving both hormones and accommodations.

Like the other named Plaintiffs, Keohane’s experience belies the concerns raised by Plaintiffs’ experts. Dr. Evans reported that Keohane’s symptoms worsened following the loss of social accommodations and that the confiscation of bras in particular preceded an episode of suicidality and cutting. (Tr. (Vol. 3) 502:12-503:13). As Dr. Evans acknowledged, Keohane continued to engage in self-harm while receiving hormone therapy and continued to experience suicidality while receiving social accommodations. (Tr. (Vol. 3) 546:14-547:13). Keohane also “continued to experience dysphoria . . . related to [Keohane’s] genitalia which was not going to be resolved by hormones . . . [and] unlikely to be alleviated unless [Keohane] has surgery.” (Tr. (Vol. 3) 546:14-23 (Dr. Evans)). Dr. Evans admitted

on direct examination that “Keohane made suicide attempts while being provided [hormones and accommodations].” (Tr. (Vol. 3) 501:11-13). Hence, the experiences of Keohane confirm that social accommodations do not constitute the panacea of treatment presented by Plaintiffs.

B. Plaintiffs Offered No Representative Classwide Evidence That the HSB Caused Widespread Serious Harm; The Statewide Evidence Showed Substantially Less Deterioration Than Anticipated.

Plaintiffs seek relief for a statewide class but failed to present evidence to substantiate such relief. (Doc. 217 at 60-61). Approximately 310 gender dysphoric inmates remain in FDC custody, yet Plaintiffs offered no before-and-after population data showing that withdrawal of social accommodations increased rates of suicide attempts, self-harm, SHOS placement, psychiatric hospitalization, or other serious outcomes throughout the population. (Tr. (Vol. 4) 711:19-23 (Dr. Kline)). The record therefore supplies no evidence from which the Court could infer a widespread institutional risk.

Implementation of the HSB was far more successful than FDC and Centurion anticipated based on the predictions of Plaintiffs and their experts. Dr. Lay stated that a prospective wave of decompensation “never happened,” that the number and severity of negative responses were “much less than expected,” and that he could not quantify whether the group experiencing negative effects outnumbered inmates who did well after implementation of the HSB. (Tr. (Vol. 3) 383:6-386:20 (Dr. Lay)).

Dr. Watkins-Ferrell, Centurion of Florida’s statewide Medical Director, similarly reported that implementation “went better than expected,” and, according to Dr. Martinez, implementation of the HSB “went better than we thought.” (Tr. (Vol. 3) 430:11-15 (Dr. Watkins-Ferrell); (Tr. (Vol. 4) 648:2-8 (Dr. Martinez)). Although FDC experienced a short-term, three-month “uptick in grievances,” many of the grievances surrounded the mistaken belief that hormone therapy would be discontinued. (Tr. (Vol. 4) 648:13-21 (Dr. Martinez)). However, the results of the implementation of the HSB show that there is a lack of meaningful evidence of widespread serious deterioration attributable to the HSB.

Plaintiffs emphasize Dr. Lay’s acknowledgement that some patients experienced negative reactions. (Doc. 217 at 19, 42). But proof that *some* patients experienced worsening symptoms fails to establish that the HSB places the class at substantial risk of serious harm. The evidence supplies neither a rate, a representative sample, nor a reliable comparison from which this Court could infer a substantial class-wide risk.

IV. THE FDC OFFICIALS ESTABLISHED THEY DID NOT ACT WITH SUBJECTIVE RECKLESSNESS.

Even if Plaintiffs proved that denying social accommodations created a substantial risk of serious harm, their claim would still fail because they failed to establish the criminal-law recklessness Wade requires. Plaintiffs must prove that FDC “was actually, subjectively aware that [its] own conduct caused a substantial

risk of serious harm” and nevertheless acted with subjective recklessness. Wade, 106 F.4th at 1262. Plaintiffs failed to do so.

A. Awareness That Some Patients Might Become Distressed Fails to Establish That the HSB Creates a Substantial Risk of Serious Harm.

Plaintiffs place substantial weight on evidence that FDC and Centurion anticipated patients might react negatively when FDC announced the HSB. (Doc. 217 at 18-19). However, this evidence proves foresight and caution, not actual belief that the policy itself would create a substantial risk of serious harm. Dr. Watkins-Ferrell agreed that Centurion staff felt “apprehensive about how the [inmates] might react” and prepared for the possibility that inmates might report suicidality or require SHOS placement. (Tr. (Vol. 3) 420:7-422:17). Dr. Lay described the same approach as “be-prepared-for-the-worst, hope-for-the-best.” (Tr. (Vol. 3) 394:16-24 (Dr. Lay)). But preparing for a possible adverse subjective reaction differs from actually believing that the policy itself will create a substantial objective risk of serious harm. The testimony repeatedly described the planning in conditional terms - what *might* occur and what Centurion wanted to be prepared to address. (See e.g., Tr. (Vol. 3) 394:16-24; 420:7-422:17).

At summary judgment, this Court clarified that the controlling inquiry is not “whether social accommodations are appropriate treatment,” but whether FDC knew that denying them created the constitutionally significant danger alleged by

Plaintiffs. (Doc. 200 at 18). Thus, evidence that FDC anticipated inmates experiencing possible distress or prepared for potential adverse reactions among the patient population which did not come to fruition does not establish criminal-law recklessness. FDC's preparations instead reflect a reasonable effort to manage uncertainty and protect inmates rather than an admission that officials believed the policy would create a substantial risk of serious harm. Farmer, 511 U.S. at 844 (officials who respond reasonably to a risk cannot face liability for deliberate indifference); Swain, 961 F.3d at 1286 (same); Dunn, 179 F.4th at 1292 (same).

B. Evidence Shows a Considered Clinical Judgment, Not Conscious Disregard of a Known Risk.

The HSB-development evidence likewise precludes a finding of subjective recklessness. Plaintiffs dispute the quality of FDC's literature review of gender dysphoria treatment. (Doc. 217 at 43-48). But the Eighth Amendment inquiry asks neither whether this Court would conduct the literature review differently nor whether it would reach a different medical judgment. Hoffer makes the distinction clear: the relevant question asks not whether, "if we were sitting as a common-law court," ordinary prudence might favor different treatment, but whether FDC's course of care "is so reckless – so conscience-shocking – that it violates the Constitution." 973 F.3d at 1272. As evidenced below, Plaintiffs failed to make this showing.

Dr. Martinez spent hundreds of hours researching gender-dysphoria care, reviewed relevant literature and systematic reviews, and assessed the reliability of the studies he encountered. (Tr. (Vol. 4) 636:7-637:4). Dr. Martinez’s “systematic review of the literature” led him to conclude that the literature supplied “no strong evidence indicating that social accommodations are medically necessary.” (Tr. (Vol. 4) 648:22-650:19). Dr. Kline independently searched for evidence applicable to incarcerated populations, concluding that the evidence of long-term benefit “didn’t reach . . . medical necessity.” (Tr. (Vol. 4) 718:3-719:16; 721:8-722:20). The record reflects a detailed, considered medical judgment grounded in FDC’s own review rather than a conscious disregard of prevailing standards, and, as such, it demonstrates an open consideration of potential risks, not an intentional ignorance of those.

Plaintiffs criticize the limited written record of Dr. Martinez’s and Dr. Kline’s literature review and research, (doc. 217 at 43-45), but the evidence presented at trial confirmed that Dr. Martinez and Dr. Kline actually held the medical view they described. Dr. Kline explained that her “running notes” were “by no means, the entirety” of what Dr. Kline reviewed. (Tr. (Vol. 4) 759:5-760:25; 762:3-5; 766:24-767:3). Dr. Martinez likewise acknowledged that he retained no notes regarding all of the documentation and literature reviewed, though he provided details about the sources and systematic reviews considered as part of his review. (Tr. (Vol. 4) 625:1-

638:6). At most, Plaintiffs’ criticism challenges the thoroughness of the review; it fails to establish the subjective recklessness required by Wade.

Moreover, development of the HSB did not occur in isolation without Centurion. FDC provided Centurion representatives with a draft of the HSB; Centurion supplied edits; and the leadership of FDC’s Office of Health Services, including Dr. Martinez and Dr. Kline, met and communicated with Centurion personnel concerning the HSB. (Tr. (Vol. 3) 429:5-430:6 (Dr. Watkins-Ferrell)). FDC adopted some, but not most of Centurion’s proposed changes to the HSB because Centurion’s proposed version of the HSB reflected a materially different approach from FDC’s approach. (Tr. (Vol. 4) 725:6-726:11 (Dr. Kline)). However, the fact that FDC declined to accept Centurion’s preferred approach establishes disagreement, not conscious disregard. See Keohane I, 952, F.3d at 1274-75; Hoffer, 973 F.3d at 1273. The subjective-recklessness requirement would contain little meaning if hearing contrary clinical advice and declining to adopt it automatically established conscious disregard.

C. FDC’s Objectively Reasonable Response to Anticipated Inmate Distress Independently Defeats Deliberate Indifference Liability.

Even assuming FDC knew of a substantial risk, Farmer supplies an independent reason Plaintiffs cannot prevail: an official who “responded reasonably to the risk” avoids deliberate indifference liability. 511 U.S. at 844; Wade, 106 F.4th

at 1262; Swain, 961 F.3d at 1286. FDC and Centurion did not simply announce the HSB and walk away from the resulting inmate population. Before implementation, Centurion intentionally strengthened mental health coverage at affected facilities. (Tr. (Vol. 3) 383:6-384:2; 389:22-390:5 (Dr. Lay)). After implementation of the HSB, multidisciplinary teams planned to reassess inmates within thirty days, prioritizing inmates “who [were] probably more . . . fragile or [who would] potential[ly] . . . decompensate.” (Tr. (Vol. 3) 391:1-11 (Dr. Lay)). Mental health professionals increased follow-up frequency for inmates who struggled, and Dr. Watkins-Ferrell testified that Centurion maintained staffing, scheduled MDST meetings, and supplemented support at facilities where necessary. (Tr. (Vol. 3) 430:11-431:22). FDC also continued hormones, psychotherapy, and other mental health care. (Tr. (Vol. 3) 395:24-396:7 (Dr. Lay); Tr. (Vol. 4) 732:22-733:2 (Dr. Kline)). Far from disregarding a known risk, FDC and Centurion took concrete steps before and after implementing the HSB to monitor inmates, expand support, and continue treatment.

Swain instructs courts to assess a defendant’s “entire course of conduct” rather than infer deliberate indifference from adverse outcomes or isolated shortcomings. 961 F.3d at 1287-88. The same principle drove Rasho v. Jeffreys, where a multifaceted response demonstrated a commitment to addressing a mental health problem – “the antithesis of callous disregard” required for an Eighth Amendment

claim. 22 F.4th 703, 710 (7th Cir. 2022) (finding no deliberate indifference because the defendant “made reasonable efforts to cure the deficiencies in the five areas identified in the plaintiffs’ claim”). FDC and Centurion anticipated possible distress, positioned staff, reassessed inmates, increased follow-up when needed, continued other gender dysphoria treatment, and maintained crisis services. This responsive and multifaceted course of conduct independently defeats deliberate indifference even if the Court finds that some patients suffered harm. See Farmer, 511 U.S. at 844; Wade, 106 F.4th at 1262; Swain, 961 F.3d at 1286-87; Rasho, 22 F.4th at 710. Plaintiffs may believe FDC chose the wrong response and treatment. But to violate the Eighth Amendment, FDC must have chosen no reasonable response despite actual knowledge of a substantial risk. Farmer, 511 U.S. at 844. The evidence forecloses any finding that FDC failed to respond reasonably to a known risk.

D. Plaintiffs’ Attack on FDC’s Motives Fails to Establish the Mental State Required by Wade.

Plaintiffs contend that political events surrounding the HSB’s development provide a more plausible explanation than medical literature. (See Doc. 217 at 48-52). Even if the Court credits that political context, Wade does not focus on the event that prompted an agency to revisit a policy. Instead, Wade examines whether a defendant actually knew that the defendant’s own conduct created a substantial risk of serious harm and nevertheless acted with criminal-law recklessness. 106 F.4th at 1262. The mere fact that a political or legislative event may prompt a policy review

does not establish that the medical officials who ultimately made the treatment decision believed the resulting policy would seriously harm inmates.

The trial evidence demonstrated that legal and political developments, standing alone, did not motivate the withdrawal of social accommodations. For example, Senate Bill 254 required changes to portions of the prior procedure but imposed no legal prohibition on providing social accommodations. (Tr. (Vol. 4) 641:2-22 (Dr. Martinez)). When asked whether the legislation “create[d] any legal restrictions on the provision of social accommodations,” Dr. Martinez answered, “No.” (Tr. (Vol. 4) 641:15-22). Thus, even accepting that legal and political developments affected the timing or scope of FDC’s review as to hormone treatment, the decision to exclude social accommodations in the HSB still required separate judgment.

The review also continued after implementation of the HSB: Dr. Martinez testified that FDC reviews HSBs annually and “didn’t stop looking at the literature.” (Tr. (Vol. 4) 683:16-684:10). Dr. Kline agreed that she felt no reservations about the “decision not to include social accommodations in the HSB.” (Tr. (Vol. 4) 736:4-8). Dr. Kline further testified that if Centurion identified significant problems attributable to the absence of social accommodations, she expected Centurion’s leadership to “move it up through their chain, through their leadership” to FDC so that FDC and Centurion could discuss it. (Tr. (Vol. 4) 736:9-23). This evidence

suggests that the FDC Officials believe the present policy to be medically appropriate while remaining open to new clinical information.

Dr. Kaliebe's contrary professional view further confirms that FDC's judgment falls within a professionally supportable range, even though his testimony cannot itself establish the FDC Officials' contemporaneous state of mind. (See supra Section I.D.). The record therefore supports mere disagreement with FDC's judgment, and not the criminal-law recklessness Wade requires.

V. PLAINTIFFS' EXPERTS LACK CREDIBILITY ON THE OPINIONS NECESSARY TO ESTABLISH PLAINTIFFS' CLAIMS.

A. Dr. Karasic's Opinions Fail to Answer Questions Before the Court and Should Be Afforded Little to No Weight.

Plaintiffs' reliance on Dr. Karasic highlights the disconnect between the testimony that social accommodations may benefit some individuals and the claim that those accommodations are constitutionally required medical treatment – the dispositive issue in this case. Dr. Karasic's trial testimony failed to cure the problems which the FDC Officials identified with Dr. Karasic's opinions prior to trial. (Doc. 186). Instead, Dr. Karasic's testimony confirmed that his opinions address a materially different question from the one the Court must decide, lack a sufficient connection to the particular accommodations and correctional setting at issue, and rest on evidence that fails to establish the medical consensus this Court directed Plaintiffs to prove.

First, Dr. Karasic’s opinions largely address whether social transition may be clinically beneficial or consistent with professional guidelines, rather than whether FDC’s course of treatment without social accommodations falls below the constitutional minimum. As stated above, this Court already held that “[i]t will not be enough to show that social accommodations are helpful or more efficacious than other treatments alone.” (Doc. 200 at 17). This Court instructed Plaintiffs to prove that care excluding social accommodations “is so grossly incompetent, inadequate, or excessive as to shock the conscience or to be intolerable to fundamental fairness,” and that a medical consensus exists “that the requested accommodations are appropriate and necessary.” (Id. at 14, 17-18); see Hoffer, 973 F.3d at 1271-73; Keohane I, 952 F.3d at 1274-75. Professional guidelines, community practice, and evidence of possible benefit therefore cannot themselves answer the constitutional question.

Dr. Karasic’s opinion remains not that social accommodations are medically necessary for the named Plaintiffs or class members, but only that they “can be medically necessary.” (Tr. (Vol. 2) 180:11-14). He agreed that an “individual determination would need to be made by a clinician after an individual examination” to determine whether accommodations should be provided. (Id. at 180:18-20). This testimony fails to establish that the Constitution requires social accommodations for any particular Plaintiff or class member.

Second, Dr. Karasic’s generalized opinions fail to fit the facts this Court must decide. This case concerns whether social accommodations constitute medically necessary treatment for the Plaintiffs, not whether accommodations can improve an inmate’s wellbeing in the abstract. When asked whether he could identify even one gender-dysphoric patient in FDC custody who went without medical or mental-health care after implementation of the HSB, Dr. Karasic answered, “No.” (Tr. (Vol. 2) 174:15-18). Evidence that a different treatment approach might provide additional benefit therefore fails to establish that the treatment FDC actually provides is conscience-shocking.

Third, the materials, particularly the WPATH Standards of Care, upon which Dr. Karasic relied, fails to support Plaintiffs’ overall conclusions. Dr. Karasic acknowledged that WPATH is not a government agency, possesses no licensing authority, and that he knew of no study demonstrating better outcomes from WPATH-certified physicians than from physicians who lack that certification. (Tr. (Vol. 2) 157:18-158:10). The United States Supreme Court recently opined on WPATH. Justice Thomas wrote that “[r]ecent revelations suggest that WPATH . . . bases its guidance on insufficient evidence and allows politics to influence its medical conclusions.” U.S. v. Skrmetti, 605 U.S. 495, 543 (2025) (Thomas, J., concurring); see also id. at 545 (noting that “newly released documents suggest that WPATH tailored its Standards of Care in part to achieve legal and political

objectives”) (Thomas, J., concurring); *Id.* at 546 (“[R]ecent reporting has exposed that WPATH changed its medical guidance to accommodate external political pressure.”). The Eleventh Circuit explained that WPATH’s Standards, “by their own terms,” are “[f]lexible [c]linical [g]uidelines” and identify “[c]hanges in gender expression” only as an “option[]” for treatment. *Bayse v. Ward*, 147 F.4th 1304, 1313 (11th Cir. 2025). The Eleventh Circuit concluded that the Standards were “far too equivocal” to establish that social-transition accommodations were constitutionally required. *Id.* WPATH guidance cannot transform Dr. Karasic’s generalized view that social accommodations can benefit some patients into evidence that the Constitution requires the particular accommodations at issue here.

Dr. Karasic failed to establish that any particular accommodation qualifies as medically necessary for any named Plaintiff or class member, failed to establish a medical consensus that the requested accommodations qualify as appropriate and necessary, and failed to establish that FDC’s continuing course of care without those accommodations falls so far below accepted standards as to violate the Eighth Amendment. The Court therefore should afford his opinions little to no weight in deciding Plaintiffs’ claims.

B. Dr. Evans’ s Opinions Rest on Methodology That Fails to Support the Conclusions Plaintiffs Ask the Court to Draw and Should Be Afforded Little to No Weight.

Plaintiffs rely on Dr. Evans to connect the withdrawal of social accommodations to the named Plaintiffs' psychiatric symptoms and to characterize social accommodations as medically necessary. However, several aspects of Dr. Evans's testimony undermine the reliability of her opinions.

First, Dr. Evans's testimony raises a threshold concern about the independence of her medical-necessity opinions. She opined that social accommodations qualified as medically necessary care for each named Plaintiff, yet she could not identify any example from her clinical experience in which social accommodations would not be medically necessary to treat gender dysphoria and acknowledged that, even after further consideration, she still could not identify one. (Tr. (Vol. 3) 518:7-21 ("I believe you testified that the accommodations to allow social transition are medically necessary for each of them, correct?" "Yes."); Tr. (Vol. 4) 606:1-607:5 (Can you think of any examples or scenarios where social accommodations for the treatment of gender dysphoria would not be medically necessary? "I can't think of any examples off the top of my head."))). This testimony weakens the inference that her opinions resulted from an individualized medical-necessity analysis capable of producing either outcome.

Second, Dr. Evans's evaluations depended substantially on subjective reporting. On cross examination, Dr. Evans testified that no clinical scale or written test exists to measure distress because "everything in mental health is subjective."

(Tr. (Vol. 4) 570:20-25). Her evaluations of the named Plaintiffs relied almost exclusively on Plaintiffs' self-reporting, together with "medical records and the reports of the medical and mental health providers." (Tr. (Vol. 4) 571:3-11). Dr. Evans did not tour the higher-level mental health units, did not independently know what services FDC provides in particular housing units, and drew conclusions from medical records and what Plaintiffs told her. (Tr. (Vol. 4) 591:11-592:8). Taken together, the limitations in Dr. Evans's evaluations and her lack of knowledge regarding FDC's mental health units and services weaken the reliability of her conclusions about both the severity of Plaintiffs' distress and the extent to which the HSB caused such distress.

Third, cross-examination exposed at least one concrete factual mistake affecting an opinion: Dr. Evans's report for Boothe stated that FDC rescinded Boothe's shower pass, and Dr. Evans recommended restoration of that pass. (Tr. (Vol. 4) 597:20-598:25). However, Boothe testified that the pass remained in place, with Dr. Evans acknowledging "perhaps there was a misunderstanding." (Tr. (Vol. 4) 597:17-25). The factual error illustrates the risk of drawing causal conclusions from evaluations that relied substantially on inmate's self-reporting and lack of an objective investigation into the inmate's conditions and the actual facts.

Finally, Dr. Evans conducted no representative before-and-after population analysis or even attempted to conduct any type of reliable, randomized review. Dr.

Evans evaluated only the five named Plaintiffs. When asked whether Plaintiffs engaged in more self-harm in the roughly comparable periods before and after the HSB, Dr. Evans acknowledged failing to conduct any such comparative analysis. (Tr. (Vol. 3) 554:12-555:13). Dr. Evans's opinions therefore depend primarily on five retrospective and subjective clinical evaluations rather than evidence capable of isolating the HSB's effect from the numerous competing causes of psychiatric distress reflected in the record. Accordingly, Dr. Evans's opinions on medical necessity and causation provide an unreliable basis for Plaintiffs' claims and warrant little to no weight.

VI. PLAINTIFFS FAILED TO ESTABLISH ENTITLEMENT TO THE REQUESTED INJUNCTION.

Even apart from Plaintiffs' failure to establish deliberate indifference, Plaintiffs failed to show entitlement to the prospective relief they seek. Under the Prison Litigation Reform Act ("PLRA"), any injunction must extend no further than necessary to correct a proven violation, be narrowly drawn, and constitute the least intrusive means of doing so. 18 U.S.C. § 3626(a)(1)(A); Hoffer, 973 F.3d at 1278-79. Plaintiffs' requested class-wide relief fails to meet these requirements.

Plaintiffs' own evidence defeats a uniform class-wide entitlement to social accommodations. As discussed above, Dr. Karasic would not say accommodations are medically necessary for any particular Plaintiff or class member and testified that necessity requires an individual clinical evaluation. (See supra Section I.A.). Jillian

Martell likewise testified that whether accommodations alleviate distress “very much depends on the patient.” (Tr. (Vol. 3) 452:3-8). Nor did Plaintiffs establish that each item grouped under the label “social accommodations” is medically necessary. Dr. Evans, for example, declined to opine that particular alternate canteen items such as deodorant or shampoo are medically necessary, explaining instead that her opinion concerned “the overall ability to socially transition.” (Tr. (Vol. 3) 518:25-519:1).

The PLRA permits relief only to the extent necessary to remedy the violation actually proven; a showing that broader relief might prove beneficial cannot justify a broader injunction. See Hoffer, 973 F.3d at 1278-79; See also Dunn, 179 F.4th 1315-16. Because Plaintiffs failed to establish either an Eighth Amendment violation or the necessity for the statewide prospective relief they seek, this Court should deny Plaintiffs’ request for a permanent injunction.

CONCLUSION

The FDC Officials respectfully request that the Court enter judgment for the FDC Officials and deny injunctive relief.

Dated: August 28, 2026

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CERTIFICATE OF COMPLIANCE

I hereby certify that this closing brief contains 10,856 words and does not exceed 14,000 words as required by this Court.

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CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing has been served upon all parties in this matter, including without limitation the following, by the Court's CM/ECF system on this 28th day of August, 2026:

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