

IN THE
Supreme Court of the United States

DONALD J. TRUMP, PRESIDENT OF THE UNITED STATES, ET AL.,

Applicants,

— v. —

ALISHEA SOPHIA KINGDOM, ET AL.,

Respondents.

TO THE HONORABLE JOHN G. ROBERTS, CHIEF JUSTICE OF THE SUPREME COURT
OF THE UNITED STATES AND CIRCUIT JUSTICE FOR THE DISTRICT OF COLUMBIA CIRCUIT

**OPPOSITION TO APPLICATION TO STAY THE ORDER ISSUED BY THE
UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA**

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INTRODUCTION

The government asks this Court to overturn a three decades-long status quo. That request should be denied. Since at least 1992, the Federal Bureau of Prisons (“BOP”) has treated people diagnosed with gender dysphoria with hormone therapy. For over thirty years—from 1992 to 2025—BOP policy has been to continue providing hormone treatment for people who entered custody already receiving such care. During that period, BOP has also expanded access to care, including by initiating hormone therapy for people when clinically indicated and by providing accommodations to enable social transition (dressing and otherwise living consistently with one’s gender identity).

But in 2025, BOP abruptly reversed course and banned such care altogether, after President Trump signed an executive order barring the use of federal funds for “any medical procedure, treatment, or drug for the purpose of conforming an inmate’s appearance to that of the opposite sex.” Exec. Order No. 14168, *Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government* § 4(c), 90 Fed. Reg. 8615, 8617 (Jan. 20, 2025) (“EO”). To implement the EO, BOP overrode its own medical providers’ clinical judgment and mandated the cessation of treatment for almost 1,000 people in its custody.

The district court preliminarily enjoined BOP from enforcing its written policy implementing the EO, Program Statement 5260.01, App.8a (the “Program Statement”), concluding that the policy is likely arbitrary and capricious. Applying settled Administrative Procedure Act (“APA”) precedents, the district court held that

the Program Statement violates the APA in three independent but related ways.

First, the Program Statement is arbitrary and capricious because BOP changed its position without examining the highly “relevant data” of its own decades-long experience providing the very healthcare that the Program Statement now prohibits. *Motor Vehicle Mfrs. Ass’n of the U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). BOP asserts that it decided to stop providing hormone therapy and social transition accommodations because it concluded that this care is not medically necessary and poses security and administrative issues. But the administrative record is silent about BOP’s extensive experience providing this care and whether it supports these stated rationales. It is devoid of *any* evidence indicating whether BOP healthcare providers found this care effective, ineffective, or harmful to patients. Nor does the record indicate whether any security issues resulted from the provision of this care. Wholly ignoring its many years of experience providing this care is the opposite of a “reasoned explanation” that is “needed for disregarding facts and circumstances that underlay or were engendered by the prior policy.” *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 221–22 (2016) (quoting *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 516 (2009)).

Second, the Program Statement is arbitrary and capricious because it is unreasonable. By “fail[ing] to offer [a] rational connection between facts and judgment,” *Motor Vehicle Mfrs.*, 463 U.S. at 56, the Program Statement is not the product of “reasoned decisionmaking,” *id.* at 52. BOP cut off treatment that its healthcare providers had recommended for decades and replaced it with

psychotherapy—which its own expert acknowledges is backed by no evidence demonstrating its efficacy as a treatment for gender dysphoria—and psychotropic medications—which BOP’s Medical Director does not even claim treat gender dysphoria, only co-existing conditions. Nor does the assertion of security and administration concerns constitute a reasonable basis for rescinding this care given that BOP has not pointed to a single security incident relating to its provision of this treatment over the past 30 years, and it does not ban other types of medical care that actually do present security issues.

Lastly, the Program Statement is arbitrary and capricious because the government’s stated rationales are pretextual. *Dep’t of Com. v. New York*, 588 U.S. 752, 780 (2019). The BOP’s decision to reverse decades-long policy based on an administrative record that lacks key evidence relevant to its stated rationales gives rise to the inference that the agency’s purported reasons were not its actual reasons for the policy change. Had BOP’s doctors found this treatment unhelpful or harmful to patients or had the agency found that the treatment compromised security, surely BOP would have mentioned it in the administrative record. That glaring omission, as well as the unreasonableness of its decision, make it clear that the rationales were contrived to support the demand President Trump made in the EO. Where “evidence tells a story that does not match the explanation” given for a decision, the government violates the APA. *Id.* at 784.

The government offers no compelling defense of the agency’s errors. For the most part, the government repackages arguments that failed to persuade the district court

and which received no support at the D.C. Circuit—not from the majority that denied the stay request, nor from Judge Walker, who did not endorse the government’s defense of the Program Statement’s reasonableness in his dissent.

Perhaps for this reason, the government’s application advances a new contention—one not raised in its stay motion to the district court—asserting that the preliminary injunction does not comply with the Prison Litigation Reform Act (“PLRA”). The government forfeited this argument by failing to raise it below. In any event, this argument is meritless. As the district court correctly noted, the relief complies with the PLRA and extends no further than necessary.

The government fares no better on the remaining stay factors. It has failed to demonstrate irreparable harm absent a stay. The government did not appeal an earlier injunction preventing it from implementing the EO over a year ago, never claimed irreparable harm in its stay motion to the district court, and has failed to show how it would be harmed by continuing to provide the treatment that its own doctors recommend for patients.

In stark contrast, Respondents, who are named plaintiffs representing all those in BOP custody with gender dysphoria (the “Class”), face a significant risk of serious harm if their treatment is cut off. This care, which BOP’s healthcare providers have determined is clinically appropriate for them, has been provided to Class members for years, sometimes even decades. Withdrawing care will cause significant changes to their bodies and put Respondents and Class members at serious risk of worsening gender dysphoria as well as other mental health symptoms including depression,

anxiety, self-harm, and suicidality. Respondents have already experienced some of these harms when BOP temporarily discontinued their treatment and they justifiably fear such harm will recur if this care is again taken away. The equities and public interest thus decisively weigh against a stay.

Finally, the government comes to this Court seeking relief not because there is an important legal question that warrants this Court's review but because it is dissatisfied with the district court's application of longstanding legal standards to the facts of this case. That is not a basis to intervene in this interlocutory posture.

The Court should maintain the status quo and deny the government's request for a stay that would permit BOP to withdraw Respondents' and Class members' treatment while the case proceeds.

STATEMENT

I. BOP'S HISTORY OF TREATMENT OF GENDER DYSPHORIA

For over three decades, BOP has treated people diagnosed with gender dysphoria with hormone therapy.¹ *See, e.g. Cuoco v. Quinlan*, No. 91-7279, 1992 WL 350755, at *4 (S.D.N.Y. Nov. 16, 1992) (noting that historical Bureau of Prisons' Health Services Manual, § 6803, provided for continuation of hormone therapy to individuals with gender dysphoria). Initial BOP policy, dating back to at least 1992,

¹ Gender dysphoria is a serious medical condition characterized by the incongruence between one's gender identity and sex assigned at birth causing clinically significant distress. Supp.App.106a–07a. The diagnosis of gender dysphoria is described in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders ("DSM"). Supp.App.106a. Without treatment, gender dysphoria can cause depression, anxiety, self-harm, and suicidality, and can impair a person's ability to function in all aspects of life. Supp.App.107a.

was to maintain the treatment people were receiving prior to incarceration, while permitting BOP medical staff to make “progressive or regressive treatment changes” if such changes were “approved by the [Bureau of Prisons] Medical Director prior to implementation.” *Id.* A 2005 policy continued that approach, ensuring individuals prescribed hormone therapy continued receiving such treatment while in custody.²

In 2010, BOP issued a memorandum establishing that hormone therapy could be initiated in custody if BOP healthcare providers determined it was “medically indicated” based on an individualized evaluation. *See supra* n.2. Six years later, BOP issued clinical guidance, which continued to provide for hormone therapy when clinically indicated and gave healthcare providers more guidance on the treatment protocols for gender dysphoria.³ In 2017, BOP released its Transgender Offender Manual, which further formalized the policy and provided for social transition accommodations in addition to hormone therapy. *See* Supp.App.10a–11a.

The Transgender Offender Manual also established a decision-making body called the Transgender Executive Council, which included the senior psychologist, psychiatrist, security expert, and medical administrator in BOP. Supp.App.11a–12a. At the same time, BOP’s Health Services Division created a Transgender Clinical Care

² *See* Memorandum from RADM Newton E. Kendig, Assistant Dir./Med. Dir. & D. Scott Dodrill, Assistant Dir. Corr. Programs Div., to Chief Exec. Officers, *Adams v. Fed. Bureau of Prisons*, No. 09-cv-10272 (D. Mass. Sep. 3, 2010), Dkt. No. 36-3, <https://perma.cc/YSA8-TNNE> (discussing Program Statement 6031.01 (Jan. 15, 2005), which provided that “Inmates who have undergone treatment for gender identity disorder will be maintained only at the level of change which existed when they were incarcerated in the bureau.”).

³ Fed. Bureau of Prisons, *Medical Management of Transgender Inmates* 6 (Dec. 2016), <https://perma.cc/K7RQ-8NTU>; *see* Refiled Compl. ¶ 48 n.10, *Kingdom v. Trump*, No. 25-cv-691 (D.D.C. Mar. 10, 2025), Dkt. No. 4-1.

Team, composed of experienced medical professionals who provided guidance to medical providers. Supp.App.12a. BOP has updated the Transgender Offender Manual and clinical guidance, most recently in 2022 and 2023, respectively. *See* Supp.App.26a, 41a.

BOP developed its gender dysphoria clinical guidance based on a wide variety of sources including the Endocrine Society, the University of California San Francisco School of Medicine, the World Health Organization, and the World Professional Association for Transgender Health (“WPATH”). App.160a, App.165a (Declaration of BOP Medical Director, Dr. Elizabete Stahl). The clinical guidance was also based on scientific research on gender dysphoria and its treatment. Supp.App.73a–74a.⁴ When providing care to its patients, BOP has relied on the experience of its own healthcare officials and providers in the treatment of this patient population. *See, e.g.,* Supp.App.2a, 4a–5a, 258a–59a, 267a–68a (former senior BOP psychologist describing her experience overseeing care of transgender people in custody and noting her involvement in the development of policy regarding their care); Supp.App.33a (Transgender Offender Manual relying on “individualized assessment” of the patient

⁴ Half a century of research and clinical experience from health providers across the United States and around the world have demonstrated that the treatment BOP has provided for over 30 years is highly effective treatment for gender dysphoria. *See* Supp.App.103a, 107a, 112a–13a, 163a. It is therefore widely accepted in the medical community and supported by every major American medical professional association. Supp.App.167a. Moreover, hormone therapy for the treatment of gender dysphoria is safe and its risks are comparable to the risks of other well-accepted medical treatments, including the same medications when they are used to treat other conditions in non-transgender people, such as estrogen treatment for menopause and low testosterone due to genetic disorders or medical treatments that damage the testes. *See* Supp.App.193a–96a, 198a–99a, 200a–01a, 203a–04a.

“by institution medical staff” to provide “[h]ormone therapy or other medical treatment”).

II. EXECUTIVE ORDER 14168 AND BOP’S IMPLEMENTING MEMORANDA

On January 20, 2025, President Trump signed an EO declaring that “[f]ederal funds shall not be used to promote gender ideology,” defined as “the false claim that males can identify as and thus become women and vice versa.” App.1a–2a. The EO also directed the Attorney General to ensure that BOP “revises its policies concerning medical care to be consistent with this order” and to “ensure that no Federal funds are expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate’s appearance to that of the opposite sex.” App.3a.

One month after the EO, BOP issued memoranda implementing the EO. BOP’s first memorandum prohibited the use of appropriated funds to purchase “any items that align with transgender ideology” and prohibited any requests for clothing that did not “align with an inmate’s biological sex.” App.5a–6a. A second memorandum provided that no BOP funds “are to be expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate’s appearance to that of the opposite sex.” App.7a. The EO was the government’s sole provided rationale for the implementing memoranda. App.5a, 7a.

III. THE LAWSUIT AND THE INITIAL PRELIMINARY INJUNCTION

Following the EO (and without any stated clinical basis), BOP began moving forward with the termination of treatment that Respondents Alishea Kingdom, Jas Kapule, and Solo Nichols had been receiving for years. Despite the disagreement of

Ms. Kingdom’s BOP doctor, BOP stopped providing hormone therapy to Ms. Kingdom, who had been receiving this treatment from BOP doctors since 2016. The deprivation of her medication caused Ms. Kingdom “incapacitating” distress, panic attacks, and suicidal thoughts. Supp.App.271a, 272a–73a. Respondents Jas Kapule and Solo Nichols—who had also been treated with hormone therapy for several years—were told that their treatment would be discontinued, and a BOP doctor began tapering Mr. Nichols off his medication. Supp.App.281a, 282a–83a; Supp.App.291a–92a. Mr. Nichols’s BOP psychologist apologized to him and said this is not the decision she would have made. Supp.App.282a. BOP also withheld social transition accommodations from all Respondents. Supp.App.272a, 283a, 292a.

In March 2025, Respondents challenged BOP’s implementation of the EO under the Eighth and Fifth Amendments to the Constitution, the APA, and the Rehabilitation Act of 1973. Refiled Compl. ¶¶ 96–137, *Kingdom v. Trump*, No. 25-cv-691 (D.D.C. Mar. 10, 2025), Dkt. No. 4-1. Respondents moved for class certification and a preliminary injunction based on their Eighth Amendment and APA claims.

On June 3, 2025, the district court granted both motions. The court certified a class of all persons who are or will be in the custody of BOP facilities and who have or will have a diagnosis of gender dysphoria. It then preliminarily enjoined BOP from enforcing its memoranda implementing the EO, concluding that Respondents were likely to succeed on their APA claim. Order 1–2, *Kingdom v. Trump*, No. 25-cv-691 (D.D.C. June 3, 2025), Dkt. No. 68. The court subsequently granted Respondents’ motions to renew the preliminary injunction pursuant to the PLRA. 18 U.S.C.

§ 3626(a)(2); Orders, *Kingdom v. Trump*, No. 25-cv-691 (D.D.C. Aug. 20, 2025, Nov. 17, 2025, Feb. 12, 2026, May 26, 2026), Dkt. Nos. 79, 96, 114, 202.

The government did not appeal the initial preliminary injunction. Nor did the government appeal the August 20, 2025, November 17, 2025, or February 12, 2026, renewals of the preliminary injunction.⁵

IV. BOP'S PROGRAM STATEMENT AND ADMINISTRATIVE RECORD

On February 19, 2026, BOP issued the Program Statement. It mirrors the language used in the EO and implementing memoranda, stating that its intent “is for federal funds to not be expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate’s appearance to that of the opposite sex to the maximum extent permitted by law.” App.16a. BOP stated it was adopting this policy “independently of” the EO. The Program Statement also states that BOP will comply with the EO absent a court order prohibiting compliance. App.13a.

Like the implementing memoranda, the Program Statement categorically prohibits hormone therapy and social transition accommodations as treatments for gender dysphoria, regardless of an individual patient’s medical need or the recommendations of BOP’s medical providers. App.14a. For people already receiving such treatment, the policy requires that they be tapered off. App.14a–15a. Under the Program Statement, if someone currently has social transition accommodations, BOP

⁵ The government appealed the May 26, 2026 injunction and sought to stay the injunction pending its appeal. The Court of Appeals granted the stay, on the grounds that the order “appears to have been an administrative injunction,” which has no legal basis. Order 2–3, *Kingdom v. Trump*, No. 26-5181 (D.C. Cir. June 17, 2026), Dkt. No. 2179261. That injunction is not at issue here.

will, “when practicable, remove or confiscate” them. App.15a.

The Program Statement provides for psychotherapy as a treatment for gender dysphoria and directs that psychotropic medication be considered “to determine if its use may alleviate the symptoms of [gender dysphoria].” App.13a–14a.

The administrative record for the Program Statement includes a memorandum (“the AR memo”) which puts forward BOP’s stated reasoning for its policy change. According to the AR memo, BOP concluded categorically that the banned treatments were not medically necessary and that providing this care raises security and prison administration concerns. App.42a, 50a. The AR memo states that “[i]n evaluating its policies on gender dysphoria, BOP considered the relevant issues, factors, information, and sources, including conducting extensive reviews of existing research, medical expert opinions, medical journals, national media reports, recent medical studies, state correctional policies, BOP’s prior policies, and pertinent case law.” App.31a. It cites extensively to the opinions of Dr. Kristopher Kaliebe, a psychiatrist with virtually no experience treating patients with gender dysphoria and whom BOP retained as an expert specifically for this litigation. App.175a.

Nothing in the administrative record contains any discussion of BOP’s own experience providing hormone therapy for over three decades and social transition accommodations for the past ten years. The administrative record does not include any statements by BOP healthcare officials who oversee the provision of this treatment or by BOP doctors who continue to deem this care clinically indicated for the patients for whom they prescribe it. The administrative record is also silent about the impact of

this treatment on the health of patients who have been receiving this care and does not include or refer to any BOP medical records or other BOP clinical data about the Respondents or other Class members.

Similarly, at no point does the administrative record address whether any of the security or administrative concerns mentioned in the AR memo materialized during the more than 30 years the care at issue has been provided. The administrative record also does not include any discussion of whether there are measures available to provide this care safely, as BOP does with other medical treatments that pose security issues such as methadone treatment for opioid use disorder. *See* Supp.App.260a–62a. The administrative record contains no incident reports showing there were any security issues that arose from providing this care; nor is there discussion or mention of any such incidents.

V. THE UPDATED PRELIMINARY INJUNCTION AND PROCEEDINGS BELOW

Respondents filed a supplemental complaint challenging the Program Statement and moved for an updated preliminary injunction to enjoin the Program Statement. *See* Mot. for Prelim. Inj., *Kingdom v. Trump*, No. 25-cv-691 (D.D.C. Apr. 29, 2026), Dkt. No. 179; Suppl. Compl., *Kingdom v. Trump*, No. 25-cv-691 (D.D.C. Apr. 30, 2026), Dkt. No. 182. In support of their motion, Respondents submitted their own declarations and three expert declarations. In opposition, the government filed excerpts of the administrative record and a declaration from BOP Medical Director Dr. Elizabete Stahl that was not part of the administrative record. App.149a. Respondents submitted rebuttal expert declarations with their reply.

The district court issued a preliminary injunction barring BOP from enforcing the Program Statement and requiring BOP to continue providing treatment for gender dysphoria in accordance with its pre-EO policy. App.169a. Applying settled APA precedents, the court determined that Respondents are likely to succeed on their APA arbitrary-and-capricious claim on three interrelated but independent bases: (1) BOP did not consider its own prior experience providing the care banned by the Program Statement; (2) the Program Statement is objectively unreasonable in light of the evidence before BOP; and (3) the reasons given for the Program Statement were pretextual and the Program Statement was reverse engineered to implement the EO. App.187a–95a.

On June 22, 2026, the government appealed the updated preliminary injunction and moved for a stay pending appeal in the district court. Mot. to Stay the Prelim. Inj., *Kingdom v. Trump*, No. 25-cv-691 (D.D.C. June 22, 2026), Dkt. No. 222. The district court denied the government’s motion. Order, *Kingdom v. Trump*, No. 25-cv-691 (D.D.C. June 25, 2026), Dkt. No. 228. A divided panel of the D.C. Circuit also denied the government’s request for a stay. App.208a. Judge Walker did not adopt the government’s merits arguments, but dissented solely based on his view that the district court lacked authority to renew the preliminary injunction under the PLRA. The government did not make that argument below and does not make it here. App.211a–12a.

The updated preliminary injunction was renewed by the district court on August 26, 2026. Order, *Kingdom v. Trump*, No. 25-cv-691 (D.D.C. Aug. 26, 2026), Dkt. No. 242.

ARGUMENT

A stay pending appeal is reserved for “extraordinary circumstances.” *Williams v. Zbaraz*, 442 U.S. 1309, 1311 (1979) (Stevens, J., in chambers). To succeed on its application, the government must make a “strong showing” that it is “likely to succeed on the merits,” that it will be “irreparably injured” without a stay, that a stay will not “substantially injure the other parties,” and that a stay furthers “the public interest.” *Nken v. Holder*, 556 U.S. 418, 434 (2009). The government must also show “a reasonable probability” that the Court will grant certiorari on the question presented in its stay application. *Hollingsworth v. Perry*, 558 U.S. 183, 190 (2010) (per curiam). The government fails at each step.

I. THE GOVERNMENT IS UNLIKELY TO SUCCEED ON THE MERITS.

A. The District Court Correctly Held That Respondents Are Likely to Succeed on Their APA Claim.

To obtain a stay, the government must show it is likely to succeed in debunking all three of the district court’s independent, mutually reinforcing bases for concluding that the Program Statement is arbitrary and capricious. It cannot do so. As the district court correctly determined: (1) the government failed to consider the highly relevant evidence of BOP’s own experience providing the prohibited treatment for years; (2) the Program Statement is unreasonable given the evidence before BOP; and (3) the proffered justifications for the Program Statement are pretextual. App.187a–95a.

1. BOP ignored its own experience providing the prohibited care in promulgating the Program Statement.

This Court’s “well-worn arbitrary-and-capricious standard ensures that an administrative agency *examined the relevant data* and articulated a satisfactory explanation for its action.” *FDA v. Wages & White Lion Invs.*, 604 U.S. 542, 567 (2025) (citation modified) (emphasis added); *see also Ohio v. EPA*, 603 U.S. 279, 292 (2024). When changing an existing policy, “an agency must also be cognizant that longstanding policies may have engendered serious reliance interests” and therefore “a reasoned explanation is needed for disregarding facts and circumstances that underlay or were engendered by the prior policy.” *Encino Motorcars*, 579 U.S. at 221–22 (citation modified). In promulgating the Program Statement, BOP ignored highly relevant data: its own experience providing hormone therapy and social transition accommodations (often referred to as “gender-affirming care”) over the course of three decades. Though BOP asserted that its about-face was due to its determination that the newly prohibited treatments are not medically necessary and pose security risks, it did not consider its own decades of clinical data from providing those treatments to patients in its care.

The district court found that “[d]espite providing gender-affirming care to inmates in its custody for years, the government cites in the Program Statement *zero evidence* from its own medical or mental health professionals to support its conclusions,” and no “evidence that gender-affirming care was ineffective or harmful to its own inmates diagnosed with gender dysphoria, or that providing this care previously led to security concerns at BOP facilities.” App.190a (emphasis added).

Indeed, the court noted, “the government has not cited a single instance of gender-affirming care giving rise to safety concerns despite having provided such care for many years.” App.200a. The court of appeals similarly concluded that BOP “did not adequately consider its own experience providing gender-affirming care under its prior policy,” citing as an example that BOP did not address whether the security issues it raised have actually occurred. App.209a.

The government contends that both lower courts got it wrong, and that BOP did consider its experience providing this care. But this is belied by the administrative record, which is devoid of any discussion or evidence of BOP’s experience providing gender-affirming care as it relates to either of its asserted rationales.

1. With respect to the asserted lack of medical necessity, BOP says it considered its experience because it reviewed its “prior policies” regarding the treatment of gender dysphoria. Appl.17. But written policies are not clinical experience and BOP does not contend it considered its own clinical experience providing such care for decades. Neither the AR memo nor anything else in the administrative record mentions whether the now-banned treatments have been effective, ineffective, or harmful to patients in BOP custody.

Indeed, the government admits as much, but argues that BOP has no evidence that would be useful and dismisses any information BOP has about the clinical care of patients as “anecdotal” evidence. Appl.21–22. Regardless of the label the government wants to apply, BOP’s own medical professionals’ experience with respect to this care—and their clinical notes, impressions, and medical charts—is highly relevant to the

medical necessity of this treatment for the very patients whose care will be withdrawn under the Program Statement. And evidence that there are BOP patients who are experiencing improvements in their health because of the treatment is relevant to whether it is reasonable to categorically ban this care for everyone.

While the administrative record is devoid of any clinical data from BOP's own medical providers, the government points to a declaration from Dr. Stahl, submitted in response to Respondents' motion for an updated preliminary injunction. Dr. Stahl claimed that she and other unnamed BOP officials used their "experience with the prior policy to help formulate the 2026 Policy." App.154a. She further claimed that it is not possible for BOP to know the benefits of hormone therapy and social transition accommodations on its patients without a "validated clinical instrument that measures the success or failure" of the treatment. App.154a.

The Stahl declaration does little to help BOP. It asserts that BOP providers did rely on their experience in creating the Program Statement, but there is zero indication of that in the administrative record. Dr. Stahl's declaration therefore is either an unpersuasive effort to recharacterize the administrative record or a "*post hoc* rationalization" that is absent from the administrative record. *DHS v. Regents of the Univ. of Cal.*, 591 U.S. 1, 21 (2020). And even if the administrative record did contain Dr. Stahl's conclusory statement that her and other unnamed BOP officials' clinical experiences helped inform the Program Statement, it would still shed no light on *how* such experience did so. Dr. Stahl's vague reference to BOP officials'

“experience” does not explain what that “experience” was or how that experience counseled for or against the Program Statement.

Dr. Stahl’s other assertion about the impossibility of assessing treatment efficacy without a “validated clinical instrument” flies in the face of clinical practice, where clinicians routinely assess the effectiveness of treatment through clinical examinations of patients. *See* Supp.App.184a–86a. Dr. Stahl’s claim is, in fact, contradicted by her own admission that she did see “sustained mental health improvement” in some patients in her own experience treating a small number of patients with gender dysphoria, even if it was “rare[],” App.152a. And it is further contradicted by testimony from a former national-level BOP psychologist who has served on the Transgender Executive Council and who described observing the positive impact that hormone therapy and social transition accommodations had on patients. Supp.App.259a (treatment led to “improvement in mental health and functioning including a reduction in symptoms of depression and anxiety, a reduction in self-harm, and greater engagement in programs like education and reentry preparation.”). Yet the administrative record says nothing about the experiences or observations of members of the BOP Transgender Executive Council, the BOP Transgender Clinical Care Team, or *any* BOP healthcare provider about the impact of treatment on patient health while BOP has provided this care. In short, Dr. Stahl’s conclusory and self-serving declaration does not make up for BOP’s failure to consider clinical outcomes under its own longstanding past policy.

Instead of relying on its own healthcare professionals’ experience, BOP retained

an outside expert, Dr. Kaliebe, to write a declaration about his views on treating gender dysphoria with hormone therapy and social transition and included that in the administrative record. App.75a. But inclusion of that one declaration—from an expert retained for litigation purposes, who has virtually no experience treating patients with gender dysphoria, *see* App.175a; Supp.App.304a–13a—does not excuse the agency’s omission of its own data and clinical experience in providing gender-affirming care to patients.

2. The administrative record is also devoid of any consideration of BOP’s experience providing gender-affirming care as it relates to the government’s other asserted justification for the Program Statement: prison security and administration. Although the government claims that BOP looked to its own “experience and expertise” regarding security and administration concerns, Appl.18 (quoting the AR memo), there is no discussion in the administrative record of BOP’s thirty-plus years of experience providing this care in its facilities across the country and whether it substantiates the purported concerns. BOP provides no evidence, of any sort, that the provision of the now-banned treatments over many years has led to security problems. For example, BOP speculates that other incarcerated individuals “may” resent those who receive “special treatment” and retaliate, *see e.g.* App.46a, 55a, but fails to say whether that has happened in the decades that BOP has been providing this care. Indeed, the administrative record does not mention a single incident in which providing hormone therapy or social transition accommodations resulted in a security problem.

The most concrete assertion that the government’s Application can muster from the administrative record is the statement that BOP staff have to spend time to protect incarcerated people “who appear more feminine, *including* due to hormones or social transition accommodations” from sexual predators. Appl.19 (quoting the AR memo) (emphasis added). But, as BOP’s statement implicitly acknowledges, transgender women in BOP custody face a risk of being targeted regardless of whether they are receiving hormone therapy or social transition accommodations. The reality is that “transgender people are vulnerable to being targeted whether or not they are receiving gender-affirming care”; even before such care was consistently available, transgender people in BOP custody were subject to assault. Supp.App.261a–62a. Providing this care does not exacerbate targeting but, rather, can make people less vulnerable by improving their mental health and social functioning. Supp.App.262a. Moreover, BOP provides other medical treatments that pose security concerns—including making patients vulnerable to being targeted—and BOP does not deny needed care on that basis; rather, it establishes procedures to ensure individuals’ safety. Supp.App.260a–62a.

BOP’s failure to consider its own experience providing the care at issue is not excused by its purported consideration of “the experience and expertise of others.” Appl.23 (discussing two cases involving challenges to the denial of gender-affirming surgery and social transition accommodations, respectively—*Kosilek v. Spencer*, 774 F.3d 63, 94 (2014), *cert. denied*, 575 U.S. 998 (2015), and *Keohane v. Fla. Dep’t of Corr. Sec’y*, 952 F.3d 1257, 1275 (2020), *reh’g en banc denied*, 981 F.3d 994 (2020), *cert.*

denied, 142 S. Ct. 81 (2021)). In any case, no actual experience providing the care at issue was discussed in those cases, and in both cases, the prisons were providing hormone therapy. *See Kosilek*, 774 F.3d at 91; *Keohane*, 952 F.3d at 1263–64.

To cover up the holes in the record, the government falls back on *Bell v. Wolfish*, 441 U.S. 520 (1979), in which the Court acknowledged that prison administrators are owed deference when making judgments about institutional security. Appl.16–17, 23. But no such deference is due here. To start, BOP ignored its own experience in formulating the Program Statement—so the policy does not and cannot reflect administrators’ expertise. Moreover, this is not a case where BOP has considered all relevant evidence such that its ultimate conclusion concerning institutional security, if challenged, would be due such deference. Instead, this case is about BOP’s failure to consider relevant evidence altogether. Deference is not a substitute for reasoned decision making.

2. The Program Statement is unreasonable and cannot be explained as an exercise of agency expertise.

The Program Statement is also arbitrary and capricious because it is objectively unreasonable and not, as the “arbitrary-and-capricious standard requires[,] . . . reasonable and reasonably explained.” *FCC v. Prometheus Radio Project*, 592 U.S. 414, 423 (2021). The district court correctly determined that the Program Statement is “objectively unreasonable” because it “ban[s] evidence-backed care for an alternative that has no evidentiary support,” making it an “implausible strategy to treat gender dysphoria.” App.191a–92a (citation modified).

- i. BOP's policy of banning hormone therapy and social transition accommodations is an unreasonable approach to treating gender dysphoria.*

1. The Program Statement prohibits gender-affirming care and permits psychotherapy and psychotropic medications as the sole treatment options for gender dysphoria. App.12a-15a. The government's claim that psychotherapy is a "widely recognized" approach to treating gender dysphoria, Appl.26, is baseless. The government relies on its own expert, Dr. Kaliebe, for this claim, App.59a-60a, but Dr. Kaliebe has acknowledged that there is no evidence that psychotherapy can alleviate gender dysphoria. App.192a. *See also* Supp.App.171a-72a (explaining that psychotherapy can be important for people with gender dysphoria to address comorbidities and provide support, but it does not address gender dysphoria); *id.* (for decades, psychotherapy was attempted as a treatment for gender dysphoria without success and there are no psychotherapeutic protocols for the treatment of gender dysphoria).⁶

BOP does not even suggest there is evidence that psychotropic medications can treat gender dysphoria, and BOP's Medical Director recognizes that psychotherapy and psychotropic medications treat co-existing conditions such as depression and anxiety, not gender dysphoria itself. App.150a, 197a. Respondent Solo Nichols has experienced

⁶ The government also points to *K.C. v. Individual Members of the Med. Licensing Bd. of Ind.*, 121 F.4th 604 (7th Cir. 2024), Appl.26, which cites a paper that says that psychotherapy may be recommended for patients with gender dysphoria in order to provide support to patients as they transition, and recognizes hormone therapy as an established treatment for gender dysphoria. Danyon Anderson et al., *Gender Dysphoria and Its Non-Surgical and Surgical Treatments*, 10 Health Psych. Rsch. 3, 4 (2022). The paper does not suggest that psychotherapy can be a substitute for gender-affirming care.

this firsthand: he was treated unsuccessfully with 13 different psychotropic medications before starting testosterone, which finally treated his gender dysphoria. Supp.App.287a. Given the lack of evidence that either psychotherapy or psychotropic medications can effectively treat gender dysphoria, BOP's decision to rely solely on these treatments is, simply put, an "implausible strategy" to treat gender dysphoria. App.192a.

2. The government does not dispute that there *is* research demonstrating the efficacy of hormone therapy and social transition accommodations for the treatment of gender dysphoria. Instead, it says that the treatments are "insufficiently proven" because the studies backing the treatments are not "high quality" evidence such as randomized controlled clinical trials, which are generally considered the strongest type of evidence. Appl.20–21; *see also* App.32a (the AR memo citing Dr. Kaliebe stating that the treatments rest on "low-quality supporting evidence"). But as an expert declaration in the administrative record explained, the evidence supporting gender-affirming care is of the same type and quality that the medical community routinely relies on to support other medical treatments. Supp.App.112a; *see also* Supp.App.163a–64a (explaining that "low quality" evidence is a term of art in scientific research, typically referring to methods other than randomized controlled trials, which are widely relied on because randomized controlled trials are not always feasible or ethical).⁷ Dr. Kaliebe himself testified in another case that many

⁷ The AR memo cites to literature reviews by Haupt et al, and Baker et al., suggesting that those reviews support the assertion that there is little reliable evidence that hormone therapy addresses gender dysphoria. App.51a. They do not. They simply note that this body of

treatments for mental health conditions are based on “low quality” evidence and that he himself provides medications to patients that are not supported by “high quality” evidence. Supp.App.359a–60a. BOP is therefore holding the now-banned treatments to a standard that does not exist for other treatments and that its own expert does not require before prescribing treatment for other conditions. See *Westar Energy, Inc. v. FERC*, 473 F.3d 1239, 1241 (D.C. Cir. 2007) (“A fundamental norm of administrative procedure requires an agency to treat like cases alike.”).

Nor does BOP’s purported opinion that hormone therapy and social transition can be harmful supply a reasoned basis for the categorical ban on that care. Appl.26. The government points to no evidence that this care has caused harm to BOP’s patients in the decades it has been providing it, or that the risks are beyond those that BOP accepts for other treatments provided to patients in its custody. In fact, the only record evidence in the case about BOP’s experience providing hormone therapy and social transition accommodations is a former national-level BOP psychologist’s declaration stating that such care was effective in alleviating patients’ gender dysphoria. Supp.App.258a–59a. And as discussed, the risks of hormone therapy to treat gender dysphoria are comparable to the risks that exist for the same medications when given to non-transgender patients for other conditions and for many other medical treatments. See *supra* at 7, n.4.

research does not consist of “high quality” randomized controlled trials but do not suggest in any way that this research is not reliable. Supp.App.164a–65a.

3. In the government’s telling, there is a “serious debate” about the necessity of hormone therapy and social transition accommodations for the treatment of gender dysphoria, Appl.27, and BOP’s policy change reflected in the Program Statement is “more aligned with the latest scientific information,” Appl.18. This is not supported by the administrative record or otherwise. While the provision of this treatment for *youth* has been publicly debated, the government identifies no debate or controversy within the medical or mental health fields about the necessity and efficacy of hormone therapy and social transition for the treatment of *adults* with gender dysphoria. That is because there is no such debate. *See* Supp.App.167a–68a.⁸

In trying to paint a picture of a debate, the government claims that BOP’s prior policies were created in reliance on the WPATH Standards of Care, which it says have been called into question by medical professionals and are unreliable. Appl.9, 20. The government’s premise is incorrect; BOP’s Medical Director, Dr. Stahl, stated that multiple sources were used by BOP in developing their clinical guidelines and “[n]o single source was universally applied.” App.160a, 165a; *supra* at 7. So, even if the government’s assertion that WPATH’s standards have been called into question were accurate (and it is not, *see* Supp.App.177a–80a), that would not support a reversal in BOP’s treatment policy because the prior policy was not based on the WPATH

⁸ The AR memo misleadingly suggests that “the University of California at San Francisco, known for its clinical guidance in this area,” is revising its guidelines to discontinue recommending gender-affirming care. App.32a. As Respondents’ expert explained, it is the norm to periodically update clinical guidelines as UCSF indicated it was doing, but he is “not aware of any clinical practice guidelines for gender dysphoria that are shifting away from or questioning the effectiveness of hormone therapy for adults with gender dysphoria.” Supp.App.168a.

standards alone. Moreover, within the medical field, the widespread acceptance of hormone therapy and social transition to treat gender dysphoria does not turn on the WPATH standards; it is supported by every major U.S. medical association because it is based on decades of research and clinical experience. *See supra* at 7, n.4.

Because BOP replaced evidence-backed care with treatment that has absolutely no support in medical evidence, the decision of the agency is arbitrary and capricious.

ii. *BOP's policy of banning hormone therapy and social transition accommodations for security and administrative reasons is unreasonable.*

As discussed above, the administrative record is entirely devoid of any evidence that security issues have arisen due to BOP treating gender dysphoria with hormone therapy and social transition accommodations at its facilities nationwide. *Supra* at 19–20. The district court found it “conspicuous” that “the government ha[d] not cited a single instance of gender-affirming care giving rise to safety concerns despite having provided such care for many years,” and could identify no security incidents that occurred while BOP continued to provide hormone therapy and social transition accommodations pursuant to the court’s initial preliminary injunction. App.200a.

What is more, the only record evidence in this case shows not only a lack of security problems attributable to this care, but that providing hormone therapy and social transition accommodations to treat gender dysphoria *improves* prison security. A former national-level BOP psychologist with more than twenty years’ experience whose responsibilities have included addressing concerns at the intersection of mental health and security was not made aware of any security problems caused by the provision of gender-affirming care, including the types of incidents suggested by BOP.

Supp.App.259a–60a. Rather than creating security concerns, she said, providing this care improved institutional safety by reducing psychological distress and preventing mental health crises, which enhanced safety for those receiving care as well as for staff and others in custody. Supp.App.260a. Indeed, providing gender-affirming care to treat gender dysphoria *benefited* prison administration as there were fewer acute mental health crises and suicide watches, which require clinical and correctional management. *Id.*

In any event, given that other treatments that actually do present security issues are not denied for that reason, Supp.App.260a–61a, that same concern cannot now be credited as a basis to deny people this care.

iii. *The district court properly considered Respondents’ extra-record evidence, including expert declarations.*

In opposing the district court’s finding that the Program Statement is objectively unreasonable, the government argues that the district court “relied almost entirely on evidence outside the administrative record,” and “made no attempt to reconcile its consideration of extra-record evidence” with the rule that review in APA cases is generally confined to the administrative record. Appl.25. It is unsurprising that the district court did not discuss this rule given that the government did not raise it below, despite Respondents’ motion for an updating preliminary injunction relying on declarations that were not part of the administrative record. *See generally* Defs.’ Opp’n to Mot. for Preliminary Injunction, *Kingdom v. Trump*, No. 25-cv-691 (D.D.C. May 13, 2026), Dkt. No. 186. Because the record rule is not a jurisdictional limit, the government forfeited this argument by failing to raise it in the district court and this

Court should “not consider arguments not raised before trial courts.” *Sims v. Apfel*, 530 U.S. 103, 108–09 (2000).

Regardless, the district court properly considered Respondents’ evidence in deciding the preliminary injunction because it was necessary for effective judicial review. Courts may consider extra-record evidence when, *inter alia*, “the agency failed to consider factors which are relevant to its final decision” or “when a case is so complex that a court needs more evidence to enable it to understand the issues clearly.” *Esch v. Yeutter*, 876 F.2d 976, 991 (D.C. Cir. 1989) (citation modified). Here, both reasons apply. As both the district court and court of appeals observed, BOP omitted from the administrative record any evidence regarding its own experience providing hormone therapy and social transition accommodations under its prior policies. In light of that omission, it is no surprise that *both* sides relied on extra-record evidence and that the district court considered it. Moreover, given that the case involves scientific and medical issues that are not within the general knowledge, extra-record evidence was “necessary to explain . . . complex subject matter.” *Lands Council v. Powell*, 395 F.3d 1019, 1030 (9th Cir. 2005).

3. BOP’s Stated Justifications Are Pretextual.

It is a “settled proposition[]” that “an agency must ‘disclose the basis’ of its action.” *Dep’t of Com.*, 588 U.S. at 780 (citation modified). Where the “evidence tells a story that does not match the explanation” given for the agency’s action, such action must be aside. *Id.* at 784–85. “The reasoned explanation requirement of administrative law . . . is meant to ensure that agencies offer genuine justifications for important

decisions, reasons that can be scrutinized by courts and the interested public. Accepting contrived reasons would defeat the purpose of the enterprise.” *Id.* at 785.

Here, the district court correctly concluded that BOP’s rationales for the Program Statement were pretextual. App.194a–95a. The government claims BOP adopted the Program Statement based on its determination that hormone therapy and social transition accommodations are not medically necessary to treat gender dysphoria and pose security and administration concerns. Appl.8–9. But the evidence tells a different story. As discussed above, BOP included no information in the administrative record about the efficacy of hormone therapy for BOP’s patients or about any security problems caused by the provision of this care for more than 30 years. *See supra* Argument § I.A.1. If BOP’s experience treating gender dysphoria with hormone therapy and social transition accommodations did, in fact, indicate a lack of efficacy or the speculative security problems stated in the AR memo, BOP surely would have mentioned that. Instead, BOP relied on purported rationales that are unreasonable and do not follow from the evidence before it. *See supra* Argument § I.A.2.

This evidence makes clear that BOP’s rationales for the Program Statement were “contrived.” *Dep’t of Com.*, 588 U.S. at 784. The actual reason for the Program Statement is clear: banning this care for people in BOP custody was mandated by the EO, which left no discretion to the agency on this matter. BOP implemented the same policy prior to the Program Statement based solely on the EO, App.5a, 7a, and the government admits that it created the Program Statement in order to address deficiencies in the prior implementation of the EO. Appl.12. The Program Statement

itself states that BOP will comply with the EO absent a court order prohibiting compliance. App.13a.

The government argues that the APA permits agency policymaking to be influenced by political officials’ “policy preferences” or “prompted by an Administration’s priorities.” Appl.28 (quoting *Dep’t of Com.*, 588 U.S. at 781, 783). True enough, but asserting “policy preferences” is not a talismanic incantation that permits courts to “ignore the disconnect between the decision made and the explanation given.” *Dep’t of Com.*, 588 U.S. at 783, 785. Whatever the current Administration’s priorities on gender-affirming care, the APA does not permit pretextual justifications for agency policies.

The Program Statement is not arbitrary and capricious because it reflects “policy preferences” or was “prompted by an Administration’s priorities,” Appl.28, or even because BOP reached the same outcome as the previously enjoined implementing memoranda. Instead, as the district court correctly determined, BOP’s proffered reasons are pretextual because BOP failed to “demonstrate[] that it considered the relevant evidence and drew a reasonable conclusion from that evidence,” App.194a–95a, and because it “disregarded significant evidence in its possession to reach the EO’s mandated result.” App.194a. The evidence more than amply supports that conclusion.

B. The Preliminary Injunction Complies With the PLRA.

The government is also unlikely to succeed on its arguments that the district court’s injunction violates the PLRA. It forfeited such arguments by failing to raise them properly below. And, in any event, they are meritless.

1. The D.C. Circuit correctly concluded that the government likely forfeited these arguments by failing to make them in the district court. App.209a. The government itself admits that it made these arguments for the first time in its motion for a stay in the D.C. Circuit. Appl.32. Neither that court nor this Court are courts of “first view.” *Chatrue v. United States*, 146 S. Ct. 2193, 2216 (2026) (citation modified). This Court should not be the first to decide these arguments, and particularly not on a rushed stay application.

2. Even if the government had presented these arguments to the district court, they fail on the merits. The government’s argument that the district court did not make specific findings under the PLRA is wrong several times over. First, the government relies solely on *Hoffer v. Secretary, Fla. Dep’t of Corr.*, 973 F.3d 1263 (11th Cir. 2020). Appl. 30. But *Hoffer* concerned 18 U.S.C. § 3626(a)(1), which applies to permanent injunctions—not § 3626(a)(2), which applies to preliminary injunctions like the one here. The PLRA clearly applies different requirements for temporary and permanent relief and Congress’s choice must be respected. *See, e.g., Sebelius v. Auburn Reg’l Med. Ctr.*, 568 U.S. 145, 156 (2013) (“Congress’s use of certain language in one part of the statute and different language in another can indicate that different meanings were intended.”) (citation modified).

Second, neither section of the PLRA requires the district court to make “particularized findings.” Appl.30–31. Section 3626(a)(2)—the provision applicable here—does not speak to the sort of findings a court must make. Instead, the provision requires that preliminary injunctive relief be “narrowly drawn, extend no further than

necessary to correct the harm the court finds requires preliminary relief, and be the least intrusive means necessary to correct that harm.” 18 U.S.C. § 3626(a)(2). While Section 3626(a)(1)—the provision on which the government erroneously relies—requires the district court to “find[]” that the relief is “narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right,” the statute’s text does not impose a further requirement that a court make “particularized findings,” as the government now contends. This Court “has rejected every attempt to deviate from the PLRA’s textual mandate,” *Ross v. Blake*, 578 U.S. 632, 633 (2016), because “crafting and imposing” “rules [that] are not required by the PLRA . . . exceeds the proper limits on the judicial role,” *Jones v. Bock*, 549 U.S. 199, 203 (2007). *See also Brown v. Plata*, 563 U.S. 493, 531 (2011) (imposing no “particularized findings” requirement).

Third, and most importantly, the district court here *did* make particularized findings. App.170a, 206a–07a. Other than empty accusations that the district court relied on conclusory statements, the government does not identify any findings the district court failed to make before issuing interim relief that is narrowly tailored to address the irreparable harm that would result from BOP’s new policy. Appl.30. That the findings were “nearly identical” to the court’s findings in previous orders enjoining BOP’s implementation of the EO, Appl.30, is to be expected—the harms and scope of relief required to prevent those harms are “nearly identical.” Notably, the government did not take issue with the court’s “nearly identical” prior findings and did not appeal

those injunctions. *See supra* at 10.

3. The district court also comported with all of the PLRA's other requirements, including the least-restrictive rule, by ordering relief that is "narrowly drawn, extends no further than necessary to correct the harm that the Court finds requires preliminary relief, and is the least intrusive means necessary to correct that harm." App.206a (citing 18 U.S.C. § 3626(a)(2)). It determined that the injunction "extends no further than necessary to correct the harm that requires this preliminary relief" because it only "prevents the application of the Program Statement." *Id.* The preliminary injunction does not require BOP to provide treatment to all class members, but rather maintains the pre-EO status quo, which permitted BOP medical personnel to administer such care to those individuals for whom it is clinically indicated. App.205a–06a. The district court also carefully considered "any adverse impact on public safety or on the operation of the criminal justice system caused by this relief" and found that no such adverse impacts "will result from maintaining the status quo of the class members' medical care while this litigation proceeds." App.206–07a.

The government's argument to the contrary misunderstands the nature of the preliminary injunction. The government argues first that the district court should have enjoined only those portions of the Program Statement concerning hormone therapy and social transition accommodations. Appl.30–32. But the scope of the preliminary injunction is properly tailored to the evidence in the record demonstrating that the *entire* Program Statement likely is arbitrary and capricious. *Supra* Argument § I.A. The district court appropriately stayed the Program Statement under 5 U.S.C. § 705,

App.205a, which permits courts to “issue all necessary and appropriate process to postpone the effective date of an agency action” “[o]n such conditions as may be required and to the extent necessary to prevent irreparable injury.” 5 U.S.C. § 705. And where a court finds a prison policy unlawful, the PLRA permits enjoining the policy in its entirety. *E.g.*, *Fields v. Smith*, 653 F.3d 550, 558–59 (7th Cir. 2011) (affirming injunction of policy banning gender-affirming care); *Crawford v. Clarke*, 578 F.3d 39, 43–44 (1st Cir. 2009) (affirming injunction of policy restricting religious practice).

The government next tries a different attack on the scope of the relief granted, arguing that the preliminary injunction is not the least restrictive measure because not all class members may require hormone therapy or social transition accommodations to treat gender dysphoria. Appl.32–33. But that attack fails for two reasons. First, it is an untimely challenge to the district court’s class certification decision; the government never appealed that decision, and their time to do so has long passed. Fed. R. Civ. P. 23(f); *Nutraceutical Corp. v. Lambert*, 586 U.S. 188, 193–94 (2019) (Rule 23(f)’s deadline may not be equitably tolled).

Second, the government’s contention misses the point: Class members have gender dysphoria diagnoses and are injured because the Program Statement “precludes medical professionals from prescribing a gender-affirming treatment plan based on an inmate’s unique needs” and therefore “puts all class members at risk of being denied medically necessary care.” App.199a. The preliminary injunction thus “provide[s] relief to each member of the class,” *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 360 (2011), because it allows everyone in BOP custody with gender dysphoria to

be afforded an individualized assessment in which hormone therapy and social transition accommodations are *considered* as potential treatments if clinically indicated. Because the Program Statement imposed a categorical ban, permitting no one to be treated with hormone therapy or social transition accommodations, the remedy here is “proportional to the scope of the violation.” *Brown*, 563 U.S. at 531. It “extend[s] no further than necessary” because it does not require BOP to provide care to people who do not need it. *Id.* at 531–33 (rejecting claim that injunctive relief was overbroad in violation of the PLRA).

II. THE REMAINING STAY FACTORS FAVOR RESPONDENTS.

Given that government has failed to show it is likely to prevail on the merits, the Court can “start and stop with the first [stay] factor.” *Trump v. Cook*, 609 U.S. 528, 535 (2026). But the remaining factors also weigh strongly against a stay.

A. The Government Will Not Suffer Irreparable Harm Absent A Stay.

To obtain a stay, applicants must demonstrate that they “will be irreparably injured” in its absence. *Nken v. Holder*, 556 U.S. 418, 426 (2009); *Ruckelshaus v. Monsanto Co.*, 463 U.S. 1315, 1317 (1983) (Blackmun, J., in chambers) (“An applicant’s likelihood of success on the merits need not be considered, however, if the applicant fails to show irreparable injury from the denial of the stay” (citing *Whalen v. Roe*, 423 U.S. 1313, 1317–18 (1975) (Marshall, J., in chambers))). The government has failed to demonstrate any such irreparable harm.

The government’s claim of irreparable harm absent emergency relief is difficult to take seriously given that it did not appeal or seek a stay of the court’s preliminary

injunction issued over a year ago—which, just like the injunction at issue here, maintained the longstanding status quo permitting BOP medical staff to treat people with hormone therapy and social transition accommodations for gender dysphoria. The government has no explanation for why it is suddenly so urgent for it to rescind this health care and upend a three-decade status quo. *See Ruckelshaus*, 463 U.S. at 1317 (denying stay where the applicant “ha[d] not been particularly expeditious in seeking a stay”). In fact, the government failed to even raise any claim of irreparable injury before the district court, thus forfeiting the argument now.

But separate from the government’s forfeiture and inexcusable delay, its claim of irreparable harm is meritless. Its contention that it “is irreparably harmed by an improper intrusion by a federal court into the workings of a coordinate branch of the [g]overnment,” Appl.35 (citation modified)—rests on the false premise that the court’s decision was “improper.” As explained above, *supra* Argument § I.A, it was not.

Moreover, the government suffers no injury by being required to continue to provide care that they have been providing for decades—and which BOP’s own healthcare providers continue to recommend for patients while this case proceeds. The preliminary injunction does not impose any “administrative burden” on BOP, let alone a “considerable” one. *INS v. Legalization Assistance Project of L.A. Cnty. Fed’n of Labor*, 510 U.S. 1301, 1305 (1993) (O’Connor, J., in chambers).

Besides its arguments that it suffers irreparable harm by continuing to offer the health care that hundreds of individuals rely on, the government makes vague references to “security and administration concerns” and “scientific uncertainty” of

gender-affirming care. Appl.35–36. But the government does not explain how such indefinite and speculative interests would cause any sort of “ongoing and concrete harm” to the government, *Maryland v. King*, 567 U.S. 1301, 1303 (2012). “Simply showing some possibility of irreparable injury fails to satisfy” the standard for a stay. *Nken*, 556 U.S. at 434–35 (citation modified).

Thus, the government’s own actions belie any claim of irreparable harm that would warrant this Court’s extraordinary intervention pending the resolution of the appeal. Order 1, *Kingdom v. Trump*, No. 26-5236 (D.C. Cir. Sep. 22, 2026), Dkt. No. 2194449 (appeal to be fully briefed by December 23, 2026).

B. Respondents Will Be Irreparably Harmed If the Status Quo Is Upended By a Stay.

“[T]he traditional stay inquiry calls for assessing the harm to the opposing party and weighing the public interest. These factors merge when the Government is the opposing party.” *Nken*, 556 U.S. at 435. The harm to Respondents in the event of the stay would be immediate and catastrophic—they will have ongoing medical treatment withdrawn. The record clearly demonstrates that this will lead to serious adverse health consequences.

Respondents have already experienced negative physical and mental health consequences when BOP previously withdrew their hormone therapy temporarily in response to the EO. As discussed above, *supra* Statement § III, Respondents experienced worsening gender dysphoria and endured symptoms including depression, panic attacks, hot flashes, thoughts of self-harm, and suicidal ideation. Respondents have grave fears they will experience more of the same—and worse—if the government

permanently removes the gender-affirming treatment they rely on for their health. Supp.App.277a, 287a, 297a.

Respondents' sworn declarations are supported by those of medical experts, who explain that withdrawal of hormone therapy will lead to physical changes that exacerbate gender dysphoria, causing substantial distress and associated mental health consequences. *See* Supp.App.193a; Supp.App.205a ("In my experience with patients who had to discontinue hormone therapy because of loss of insurance, they experienced significant distress as their bodies began to misalign with their gender identity; in some cases, this caused severe functional impairment where patients were no longer able to function at work."). Those consequences can be extremely severe, as patients who are denied hormone therapy can suffer from increased depression, anxiety, suicidal ideation and self-harm, including attempts to remove their own genitals or breasts. Supp.App.114a–16a (discussing the impacts of delayed or denied gender affirming care).⁹ Though the government repeatedly tries to dismiss the risk of self-harm by characterizing it as an attempt to obtain "rewards" or "concessions" from prison officials, Appl.10, 24, such assertions grossly mischaracterize the nature of the medical condition and the depth of harm. Untreated gender dysphoria carries a high-risk of suicidality and self-harm for people both in and outside of custody. Supp.App.107a, 114a, 115a–16a.

The government's only response is its conclusory assertion that "BOP found that

⁹ These harms have been documented among incarcerated people with gender dysphoria who have not been able to receive necessary treatment. Supp.App.115a–16a.

hormone interventions in general . . . are not ‘medically necessary,’” Appl.36, which is undermined by the fact that its own medical staff have prescribed and continue to prescribe these treatments to Respondents and other Class members only after determining they were clinically indicated. Supp.App.41a.

The government asserts that BOP will offer psychotherapy and psychotropic medications as “appropriate, individualized treatment.” Appl.36. But such “treatment” categorically overrides the individualized determinations that previously have been made by BOP’s medical providers and offers only treatments that have not been shown to alleviate gender dysphoria. *See supra* Statement § I. Ultimately, the public interest is served by maintaining the status quo and preventing these predictable and irreparable harms to Respondents and the Class.

The government contends that Respondents have not demonstrated irreparable harm on a class-wide basis, but as already noted, *supra* at 34–35, this mischaracterizes the preliminary relief ordered by the district court. The Program Statement would cause irreparable harm to all members of the Class because it imposes a categorical ban on hormone therapy and social transition accommodations without regard to individualized need for those interventions, putting all class members at risk of being denied the care they need. The preliminary injunction does not require BOP to provide any intervention to people who do not need it; it merely prevents BOP from categorically withholding care that its own doctors deem appropriate for certain patients.

III. THE CASE IS NOT WORTHY OF CERTIORARI IN THIS POSTURE.

The stay application should also be denied because certiorari is not warranted in this posture. *Hollingsworth v. Perry*, 558 U.S. 183, 190 (2010).

The district court issued a fact-bound, preliminary order based on its determination that BOP's sudden reversal of its own longstanding policy of providing hormone therapy and social transition accommodations based on individual assessments of clinical need was arbitrary and capricious. *See* 5 U.S.C. § 705 (providing that district court may “postpone” agency action “to preserve status or rights pending conclusion of the review proceedings”). The standard for arbitrary-and-capricious review under the APA is “well-worn,” *Wages & White Lion*, 604 U.S. at 567, and does not merit this Court’s review, particularly in this “interlocutory posture,” which “is a factor counseling against this Court’s review at this time.” *Nat’l Football League v. Ninth Inning, Inc.*, 592 U.S. 1081, 1082 (2020) (Kavanaugh, J., statement respecting denial of certiorari). The government’s application concerns only Respondents’ APA arbitrary-and-capricious challenge and does not address Respondents’ other claims yet to be fully litigated in the district court. The resolution of the issue presented in the government’s application would not be dispositive of this case, which further counsels against this Court’s review. *Halbert v. Michigan*, 545 U.S. 605, 632 (2005) (Thomas, J., dissenting) (“[T]his Court would be unlikely to grant certiorari in a case to announce a rule that could not alter the case’s disposition”).

CONCLUSION

The Court should deny the government’s application for a stay.

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