Honorable John H. Chun

UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF WASHINGTON AT SEATTLE

ALENA KRILEY, Plaintiff, vs. CHARLIE BROWNE, JAMIE PHIFER, STAFF MEMBER UNKNOWN NAME, ALL WOMEN'S CARE, Defendant	Case No.: 2:21-cv-01176-JHC FIRST AMENDED COMPLAINT PLEADING TITLE

FIRST AMENDED COMPLAINT

INTRODUCTION

On July 16, 2022 Defendant Jamie Phifer was served Summons and Complaint. She did not answer Complaint. On July 28, 2022 she joined Rule 12(b)(6) Motion to Dismiss filed on June 24, 2022. Joining the Rule 12(b)(6) Motion on July 28, 2022 is equal to her filing Rule 12(b)(6) Motion.

Rule 15 of FRCP Amended and Supplemental Pleadings states:
"(a) Amendments Before Trial.
(1) Amending as a Matter of Course. A party may amend its pleading once as a matter of course within:
(A) 21 days after serving it, or
(B) if the pleading is one to which a responsive pleading is required, 21 days after service of a responsive pleading or 21 days after service of a motion under Rule 12(b), (e), or (f), whichever is earlier."

Here Plaintiff Alena Kriley amends her Complaint *as a matter of course* based on Rule 15(a)(1)(B).

Plaintiff filed her Complaint within statute of limitations and within law. Arguments regarding statute of limitations were fully briefed in previous filings by parties.

PARTIES

Plaintiff: Alena Kriley is a citizen of Belarus and a resident of Illinois.

Address: 1124 Lake St, #509, Chicago IL 60301, Cook County

Defendant No. I: Charlie Browne, MD at All Women's Care, is a citizen of Washington

Address: 9730 3rd Ave NE, #200, Seattle, WA 98115, King County

Defendant No.2: Jamie Phifer, MD at All Women's Care, is a citizen of Washington

Address: 9730 3rd Ave NE, #200, Seattle, WA 98115, King County

Defendant No.3: Unknown name, Staff members at All Women's Care, is citizen of Washington

Address: 9730 3rd Ave NE, #200, Seattle, WA 98115, King County

Defendant No.4: All Women's Care is a clinic in Seattle,WA

Address: 9730 3rd Ave NE, #200, Seattle, WA 98115, King County

JURISDICTION AND VENUE

The United States District Court for the Western District of Washington is the appropriate venue based on diversity of citizenship 28 U.S. Code paragraph 1332 because:

1) the Plaintiff is a citizen of a foreign state and a resident of Illinois and all defendants are citizens of Washington state.

2) Plaintiff prays for judgement in excess of $75,000.

Additional basis for federal jurisdiction in this case is federal question jurisdiction.

STATEMENT OF CLAIM

I, Plaintiff Alena Kriley, complain of the Defendants Charlie Browne MD, Jamie Phifer MD, Unknown name Staff members at All Women's Care, individually and duly authorized agents and/or apparent agents of All Women's Care and state as follow.

This action is against Defendants for:

Count 1. Wrongful death claim

Count 2. Negligence

Count 3. Gross negligence

Count 4. Fraudulent Misrepresentation

Count 5. Fraudulent Concealment

Count 6. Undue influence

Count 7. Medical Battery

Count 8. Lack of Informed Consent

Count 9. Loss of chance

Count 10. Negligent Misrepresentation

Count 11. Negligent Concealement

Count 12. Lack of Consent

1. The cause of this action arises from August 30 and August 31, 2018. Defendants owed to Plaintiff a duty of care. They violated their duty of care. Their failure to follow the duty of care was a proximate cause of injuries complained of. Defendants performed abortion on Plaintiff Alena Kriley without her free and informed consent. Plaintiff did not consent to the

abortion performed on her because she lacked mental capacity to

do so due to altered mental state she was in at that time and cognitive impairment caused by extreme stress, exhaustion, lack of sleep and language barrier.

Defendants stated in the records:

"3. Complex psychiatric hx – suspect Axis 2" (Exhibit C).

Axis 2 is a part of the five part, multi-axial classification system designed for mental/psychiatric disorders by the American Psychiatrists Association (APA). Axis 2 provides information about personality disorders and mental retardation. Disorders which would have fallen under this axis include: Paranoid Personality Disorder, Schizoid Personality Disorder, Antisocial Personality Disorder, Borderline Personality Disorder, Histronic Personality Disorder, Narcissistic Personality Disorder, Avoidant Personality Disorder, Dependent Personality Disorder, Obsessive-Compalsive Personality Disorder, Personality Disorder not Otherwise Specified, Mental Retardation. Despite of the facts that Plaintiff reported taking multiple psychiatric medications (Zolpidem, Busporin, Alprozolam, Bupropion, Benadryl, Escitalopram) (Exhibit C) and that

Defendants suspected serious psychiatric disorder or mental retardation of Plaintiff, Defendants negligently or intentionally did not do assessment to determine if Plaintiff was competent or has capacity to consent to abortion. They did not refer her to a specialist qualified to assess her competency to consent. Instead, they took advantage of the vulnerability of Plaintiff, unduly influenced her and rushed her into abortion. Within 2 weeks after the abortion Plaintiff was diagnosed with resolved psychosis by a psychiatrist (medical record will be provided upon request). That confirms that Plaintiff had no capacity to consent to abortion performed on her by Defendants.

2. On August 30, 2018 was a day of the two days abortion, on which delators were inserted. Plaintiff was in severe distress, she asked at least 2-3 times for more time to talk to her husband. Despite of seeing and noting in records that "Patient appeared to be undecided herself", "Partner abruptly left room, pacing hallways and waiting room with aggressive body language", also "his behavior in the office was inappropriate and made stuff feel unsafe" (Exhibit D) Defendants did not care if Plaintiff felt safe with the partner, they did not talk to Plaintiff about her safety, they did not ask questions, they did not utilize available to healthcare providers tools to assess if undergoing abortion was Plaintiff's free will or a result of domestic violence, as they should have. It is recognized in publications of Department of Health that Healthcare employees are in a good position to do domestic violence assessments. On 08/30/2022 Defendants witnessed "aggressive body language" of Plaintiff's husband and his behavior that "made stuff feel unsafe" (Exhibit D). That observation warranted use by the healthcare providers Intimate Partner Violence screening tools or/and referring an immigrant Plaintiff to domestic violence program. Because of their negligence or willfull conduct Defendants did not use Intimate Partner Violence screening tools available to them. Defendants chosen to not ask any questions Plaintiff, to not let Plaintiff's husband back into the room where Plaintiff was. Defendants did not tell Plaintiff that her husband attempted to get back into the room where she was. Instead Defendants rushed her into late abortion which Plaintiff attempted to stop but was not able to. Plaintiff is asking this Court to take Judicial Notice of Fact Sheet of educational materials of Planned Parenthood Federation of America "Intimate Partner Violence and Reproductive Coercion." (Exhibit E) that clearly indicates that abortion clinics employees knew or should have known about issue of intimate partner violence and reproductive coercion, including "attempting to

force/coerce a partner to have an abortion against her will." The Fact Sheet of educational materials of Planned Parenthood Federation of America "Intimate Partner Violence and Reproductive Coercion." explains in details to abortion care industry employees the issue of intimate partner violence and what groups of women are the most vulnurable to reproductive coercion. The educational materials are not specific to particular state or states they are universal and apply to any state. Defendant Jamie Phifer and other employees of All Women's Care did not act in the best interest of Plaintiff and failed to exercise the degree of care, skill, and learning expected of a reasonably prudent health

care provider at that time in the profession or class to which she belongs, in the state of Washington, acting in the same or similar circumstances. The educational materials on page 3 indicate that abortion clinic's employees

new or should have known that "fear of deportation may cause immigrant women to be particularly hesitant to report IPV (ACOG, 2012)" On same page it states: "Women living in households with lower income experience much higher rates of domestic violence than women in households with higher annual incomes." Defendants knew that Plaintiff is an immigrant and her first language is not English but did not provide an enterpreter. They knew that Plaintiff was a woman from low income household based on the fact that the abortion was mainly paid by abortion funds, All Women's Care employee also gave Plaintiff's husband a big discount for which he thanked her. Defendants clearly noticed Plaintiff's husband was aggressive but instead of

utilizing screening tools for assessment of intimate partner violence they rushed Plaintiff into late abortion. Plaintiff's soon to be ex-husband stated to her that he regretted that he pressured her into abortion and that he wanted to stop abortion and tried to get back into the room where Plaintiff was but that Defendants closed the door in front of him and did not let him

get back. Defendants did not tell Plaintiff that her husband tried to get back and that they did not let him in, they asked no questions, instead they insisted to Plaintiff : "we need to start it right now."

3. Defendants saw and noted that "Patient appeared to be undecided herself" (Exhibit C), that was on August

30, 2018, the next day after signature on consent form was obtained from the Plaintiff and the day when delators were suppose to be inserted. Defendants did not give to Plaintiff copies of the documents she signed on August 29, 2018. Plaintiff had neither

capacity to consent nor time to fully understand what was written in the documents in the language that is foreign for her. Enterpreter was not provided to her. Copies of the documents she signed on August 29, 20218 were not given to her so she had no chance to even try to fully understand all medical terms in foreign language in the documents she signed.

Defendants performed late abortion on Plaintiff without disclosing to her material facts of the abortion and the serious risks and consequences of it.

Defendants did not disclose to the Plaintiff the material fact that the baby was at the stage of development when he could have survived outside of the uterus after birth, natural or induced, when supported by medicine.

On the first day of the 2 days abortion Defendants with use of undue influence rushed Plaintiff into abortion. Same day in the evening, despite of her husband precluding her from making the call, Plaintiff called medical director Defendant Charlie Browne and stated that she does not want abortion and requested to stop abortion. Defendant Charlie Brown stated that abortion cannot be stopped because an injection was administered. Defendants committed feticide by

administering Digoxin without Plaintiff's consent. Plaintiff did not consent to Digoxin injection and would have not consented to it. Consent form she signed without having mental capacity to sign it had no mentioning of an injection that causes prolonged painful cardiac arrest to the child and that leaves no choice to a patient other than to undergo the abortion surgery against her will. Plaintiff was hoping to somehow to escape abortion. The consent form states in the second paragraph: "If laminaria are inserted, I understand that the pregnancy may have been interrupted and I must return for completion of the abortion procedure." The consent form itself indicates a possibility of pregnancy interruption, it does not state that if laminaria is inserted the child is killed by it or the pregnancy is terminated. Progesterone injections can be used and are used in circumstances of pregnancy interruption or in abortion reversal protocols. Defendants did not disclose to Plaintiff that she was so far along in her pregnancy that her child could have been born alive after abortion medication to induce is given and before the abortion surgery on the second day.

They did not tell her that On November 5, 2003 was enacted a United States federal law Partial-Birth Abortion Ban Act prohibiting partial-birth abortion. They of course did not disclose to immigrant Plaintiff that there are abortionists who kill the partially delivered living children or fetuses and that there are lawsuits about this. There was no medical necessity to cause prolonged painful cardiac arrest to the Plaintiff's child. Plaintiff understood much later that Defendants willfully or grossly negligently or negligently violated their duty of care and acted not in the Plaintiff's best interests (who undergo IVF treatments in order to get pregnant) but in their own interests to make sure that the child is not born alive before Defendants rip him apart in pieces during barbaric late abortion surgery. Or was it to just to make it easier for themselves to grab a piece of living in the womb child and rip him apart?

Abortion industry employees electing to perform late abortions though probably are used to doing this. But is it ever possible though to get used to ripping apart living in the womb children? Defendants cared about their safety and their interests (profit and escape from legal liability). Defendants performed Digoxin injection to which Plaintiff did not consent. As a result of that Plaintiff suffered injury – she lost her chance to not undergo abortion and had no choice but to undergo surgical abortion against her will (during which she was severely injured and because of that she lost her health and ability to safely carry more children, her ability to hold employment) she lost her child, she lost a chance to have her child to be born, to be alive, her right to choose was taken away from her, her reproductive health was severely damaged).

Defendants greed is so high that they perform late abortions on the most vulnerable women – immigrant women with no capacity to consent and are in domestic violence situations – one of the easiest prey for predators. The risk of legal liability for them is the lowest in such cases – it takes a lot of time and effort for immigrants to even write a statement in court that can be properly understood. Their families are far away and cannot stand up for them. People with serious psychiatric disorders most likely will not recover. And if they ever do the trauma of loosing of their child will never leave them. That trauma does not leave them indeed but it may lead them to Court to stand up for their wrongfully deceased child and for themselves because earlier they couldn't.

Defendants did not disclose to Plaintiff material fact that they are going to inject Digoxin injection that causes prolonged painful cardiac arrest to the baby and takes a possibility to escape or refuse to undergo abortion surgery before it is performed. Plaintiff did not consent to Digoxin injection. Defendants performing Digoxin injection without Plaintiff's consent is a battery. Much later Plaintiff learned what Digoxin is and that it causes prolonged

cardiac arrest to the baby.

From the start of abortion Plaintiff was in excruciating pain. Had Plaintiff knew that she would have to undergo that extreme pain she would have not sign the papers and would have run away from the abortion clinic.

In the early morning of August 31, 2018 Plaintiff's waters broke. She was not informed about this material fact of abortion by Defendants. It was as she was going to give a birth but instead she had to go to abortion surgery against her will because Defendants caused cardiac arrest to her baby without her consent. Had she knew about the extreme emotional trauma and the longing for her baby and extreme grief and feeling trapped that she would be experiencing she would have not sign any papers.

When Plaintiff came back to her state a piece of tissue of her child that came out from her uterus. Plaintiff was not informed about this material fact of abortion by defendants. Had Plaintiff knew that pieces of her child can come out from her after the abortion and she would have not sign the fraudulently obtained from her consent to abortion.

Fetocide was performed without Plaintiff's consent and constitutes battery. I would have not agreed to an injection causing prolonged painfull cardiac arrest to the child. By injecting Digoxin injection without Plaintiff's consent and causing cardiac arrest to Plaintiff's child Defendants caused to Plaintiff loss of chance to have her child alive. Despite of her husband stopping her from calling Defendant Charlie Brown Plaintiff called Charlie Brown evening on August 30st and stated that she wanted to stop abortion. Defendants also caused loss of chance for better outcome by taking away from the Plaintiff her chance to escape abortion and having no injury(Exhibit B)

and 2 metal stents implanted (Exhibit A) and all the risks associated with the stents and exposure to radiation

of Plaintiff who grew up in Chernobyl area and has a history of cancer in her family and whose risk of cancer was further increased by 3 rounds of IVF (in vitro fertilization hormonal treatment) treatment in attempt to have a child. The child deceased by Defendanrs

After Defendants injected Digoxin without her consent Plaintiff had no other choice than to undergo abortion against her will, during which she was injured by Defendant Charlie Brown, sustained severe bleeding but was discharged without being examined by Defendant Charlie Brown or calling ambulance by him or his employees.

Loss of chance: to have her child, loss of chance to not undergo abortion and to not being injured by defendants. I was holding on to a hope that somehow I will escape abortion or my husband will let me have the child.

The cause of this action arises from August 30 and August 31, 2018. At All Women's Care Defendants performed abortion on me without disclosing material facts of the abortion and the risks and consequences of it. They did not disclose that the baby was at the stage of development when he could have survived outside of the uterus after birth, natural or induced, when supported by medicine. Had I knew this fact I would have not undergo the abortion. I am suffering continues devastating emotional pain. Employees did not explain to me the forms that I was given to sign and the risks and consequences of the procedure. If I was explained posibility of the devastating physical and emotional consequences I have suffered I would have not sign the consent form to undergo abortion.

Defendants owed a duty of care to Plaintiff, they willfully or negligentely violated that duty of care and that caused to Plaintiff injuries, Plaintiff suffered devastating damages.

Defendants intentionally or negligently did not take appropriate patient's history. They disregarded medical history that was taken and took advantage of Plaintiff's emotional and mental state, lack of knowledge in medical field, lack of understanding of medical terms and language barrier. Defendants rushed Plaintiff into abortion. When
Plaintiff tried to stop abortion she was told it was too late to stop it. During the abortion she was injured and suffered severe bleeding.

1. Material facts of the late abortion were not disclosed to me by Defendants. Defendants rushed me into abortion without disclosing material facts of the procedure and the risks and consequences of the procedure. They did not disclose that the baby was at the stage of development when he could have survived outside of the uterus after birth, natural or induced, when supported by medicine. Had I known that I would have not sign the papers and would have not undergo abortion.

5. Much later I learned what Digoxin is and that there is antidote to Digoxin. I learned that Digoxin causes prolonged painful cardiac arrest to the baby. Had Defendants disclosed that to me before they fraudulently obtained my signiture I would have not agreed to sign the papers and to undergo abortion.

6. Defendants knew that at the time of abortion the baby was at the stage of development when he could have survived on his own if he was born but had chosen to not disclose that material fact to me when unlawfully obtaining my signature. Charlie Brown had chosen to make

no attempts to safe life of my child when I called him and requested to stop abortion. At the time I requested to stop abortion Charlie Brown had a duty to do everything in order to safe the child's life. Instead, he had chosen to not check for the child's heartbeat or to refer me to emergency room. He had chosen to not disclose to me that that there is antidote to Digoxin.

7. Next day, on the day of the surgery, after I complained to Charlie Browne that I was rushed into the abortion by his employees I was severely injured and sustained severe bleeding. I was in extreme pain. Defendants did not examine me, did not call ambulance, they discharged me. They fraudulently wrote in medical records "Bleeding light", "Cramping none". (Exhibit F)

8. Within less than 2 weeks after abortion I was hospitalized at Northwestern Memorial Hospital in Chicago. Employees of that hospital concealed from me true diagnosis in order cover up misconducts of the abortion clinic employees they intentionally misdiagnosed me and implanted in me 2 metal stents 16 cm long (Exhibit A). Only in April 2021, after medical records from a clinic under Rush University umbrella were released to me I learned that the true diagnosis whenI was hospitalized after abortion was "Injury to iliac vein" (Exhibit B). If a possibility of metal implants to be implanted in my body as a result of abortion was disclosed to me prior to abortion, I would have not signed the papers and undergo abortion.

9. After the surgery I sustained severe bleeding, my clothes were soaked in blood, I was given new pants and pads by abortion clinic employees and I bled through them. While helping me to empty my shoes full of blood into the sink in the bathroom, "All Women's Care" employee asked me several times "Where are you staying?" All these was happening in the presence of Charlie Browne. I could not understand at that time why that question was asked in that shocking situation of severe bleeding. Later I understood how injuries and deaths of women at hands of abortionists are covered up by other medical providers. To this day there is

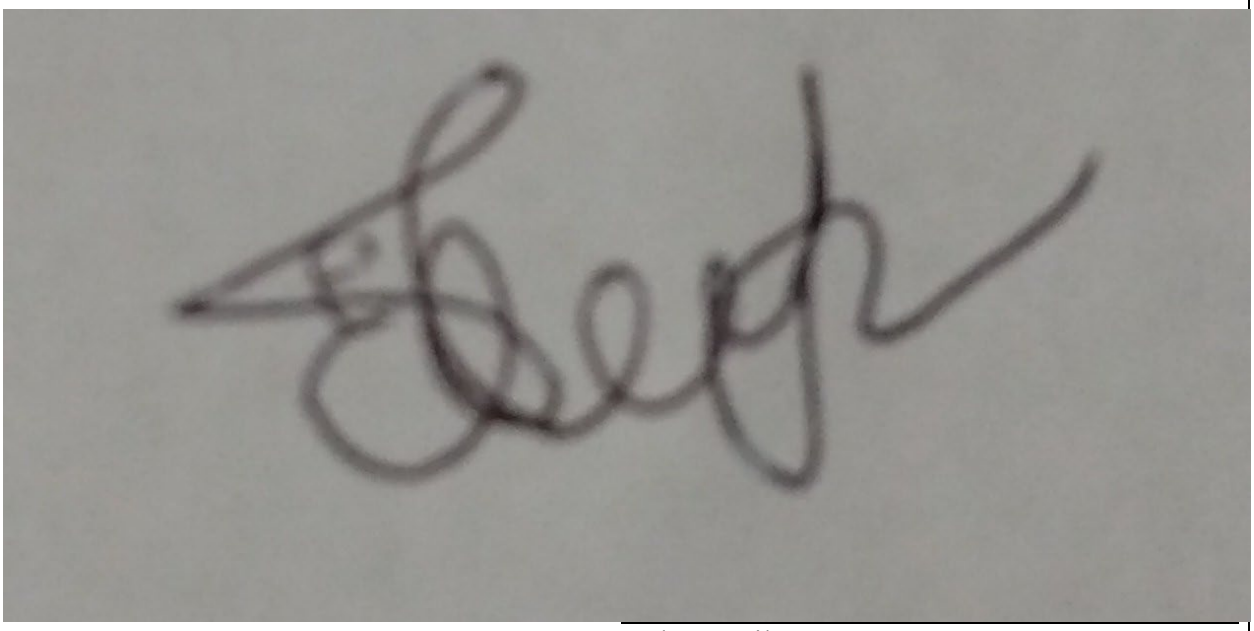
no law requiring to report injuries caused by abortions and as I learned through my experience the injuries are not just not reported but actively covered up by other medical providers. Defendants not performing exam on Plaintiff and by not calling ambulance constitute affirmative conduct that misleads Plaintiff about a possibility being injured. Furthermore, Plaintiff called Defendant Charlie Brown at least twice after the abortion with complaints of pain and bleeding and symptomsg with her leg but Defendant Charlie Brown assured her that her symptoms are normal and symptoms with her leg cannot be related to abortion, instead of warning her that to go to emergency room.

10. Defendants severely violated my reproductive rights, performed abortion on me without my free will and destroyed my reproductive health. As a result I suffered catastrophic damages for which I wish to be compensated: pain and suffering, physical and emotional; pain and suffering caused by loss of my child; pain and suffering caused by Defendants stealing my health; inability to safely carry more children. I wish to be compensated for past, present and future economic damages caused by Defendants. Including but not limited to costs of surrogate in order for me do become a mother again. Before the abortion I have undergone IVF (in vitro fertilization treatment) during which I took hundreds of hormonal injections and was 3 times hyperstimulated, 2 emergency hospital admissions. I have frozen embryos stored and I always wanted at least 3 children. I wish to be compensated for past, present and future damages to my health, including but not limited to foreseen shortening of my life due to implanted metal stents not approved by FDA for use in iliac veins. The stents require multiple invasive interventions with use of radiation and CT scan dye, to which I am allergic. I grew up in Chernobyl area, I have history of cancer in my family. Therefore, repeated exposure to radiation increases already high for me risk of cancer. I found out (and can provide proves) that implanted after the abortion

injury experimental stents are MRI conditional and that precludes use of MRI in situations where MRI could be safely used if I had no metal implants in me. Therefore, CT scans with radiation will have to be use instead of MRI and that again further increases risks of cancer for me and causes permanent stress additionally to the severe emotional trauma caused by abortion.

In support of likelihood of success on merits I am attaching a statement of a physician (Exhibit G). Name and address of the physician are not disclosed due to fear of retaliation by Defendants. Information of the doctor will be disclosed to Court when requested or the doctor will be called as a witness for the trial.

Executed on 08/18/2022. Signature:



Alena Kriley
1124 Lake St, #509
Oak Park, IL 60301
Phone: 773-414-3562
e-mail: fransevna@yahoo.com

Exhibit A

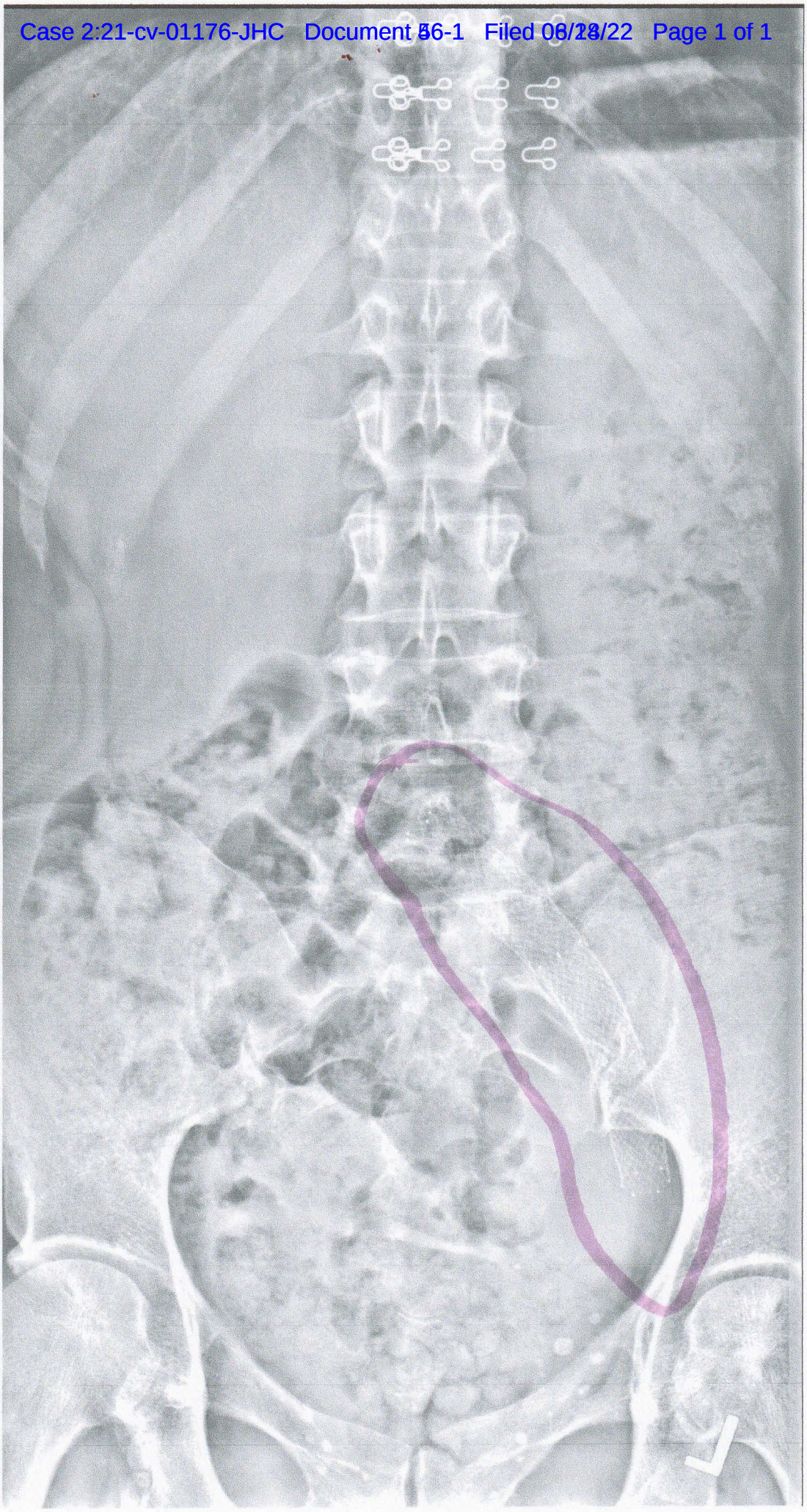


Exhibit B

RUSH

Rush University Medical Center Kriley, Alena
MRN: 8210762, DOB: 5/24/1980, Sex: F
Visit date: 10/9/2019

10/09/2019 - Ancillary Orders in T03 - IR OP CLINIC

Visit Information

Provider Information

Encounter Provider

Arslan, Bulent, MD

Department

Name	Address	Phone
T03 - IR OP CLINIC	1620 W HARRISON ST Chicago IL 60612	312-942-5000

Reason for Visit

Visit Diagnoses

- Pelvic varices [I86.2]
- Injury of left iliac vein, subsequent encounter [S35.515D]
- May-Thurner syndrome [I87.1]
- Varicose veins of bilateral lower extremities with pain [I83.813]
- Fatigue of lower extremity [R29.898]

Medication List

Medication List

This report is for documentation purposes only. The patient should not follow medication instructions within.
For accurate instructions regarding medications, the patient should instead consult their physician or after visit summary.

Active at the End of Visit

FLUoxetine (PROZAC) 10 mg PO capsule

Instructions: 20 mg.
Entered by: Henry, Maylissa, MA — Entered on: 10/7/2019
Start date: 8/6/2019

LOVENOX 40 mg/0.4 mL SC injection

Instructions: ADM 0.4 ML SC QD
Entered by: Henry, Maylissa, MA — Entered on: 10/7/2019
Start date: 9/19/2019

zolpidem (AMBIEN) 5 mg PO tablet

Entered by: Henry, Maylissa, MA — Entered on: 10/7/2019
Start date: 10/2/2019

methylPREDNISolone (MEDROL DOSPACK) 4 mg PO dose pack

Instructions: take by mouth as directed. Take as directed.
Authorized by: Carizey, Rene P, DO — Ordered on: 5/20/2020
Start date: 5/20/2020 — Refill: No refills remaining

Exhibit C

AWC
9730 3rd Ave NE, Suite 200, Seattle, WA 98115
p: (206) 985-9553 f: (206) 985-9806

DATE: 8-30-18

Alena Kriley is a(n) 38 year old G 3 P Ø requesting termination of pregnancy. The procedure has been fully discussed with the patient, all her questions have been answered to her satisfaction, and she has signed the consent forms.

LMP 3-17-18 EGA: by LMP 23 4/7 EGA by U/S 24 5/7 (done at AWC)

uHcg: Pos___ Neg___ ND X Hgb/Hct 10.5 Rh: Pos X Neg___

ALLERGIES: none

Meds: zolpidem, busporin, alprazolam, bupropion, benadryl, escitalopram

MHx: anx / dep

Surgeries: tumor removed from neck age 7

SocHx: none

Other: SABX 2

BP 98/57 P 89 T 97.9 Ht 5'5" Wt 124 BMI 20

	NL	ABNL	Comments
General	✓		
HEENT	✓		
Heart	✓		
Lungs	✓		
Back	✓		
Abdomen	✓		
Extremities	✓		
Pelvic			
- External	✓		
- Vagina	✓		
- Cervix	✓		
- Adnexa	✓		

- Uterus Size: 24 ☒ AV ☐ MID ☐ RV

Imp: (1) 38 yo G3PØ (4) Anemia
(2) Anxiety / depression
(3) Complex psychiatric hx - suspect Axis 2

Plan:
___ Abortion Today
✓ Dilators Today*/Procedure Day2
___ Beyond EGA Limit:___
___ Patient Undecided
___ Reschedule___
___ No IUP seen
☐ Too Early ☐ SAB ☐ Suspect Ectopic
Detail:___
___ Other:___

___, M.D.

Exhibit D

PROGRESS NOTES

11:30 am 8/30/18

Partner, Paul, initially unwilling to leave procedure room prior to starting sedation. Partner tearful & undecided. Team gave pt and partner an extra 5 min alone and returned to room. Patient appeared to be undecided herself. Partner abruptly left room, pacing hallways and waiting room with aggressive body language. With partner out of room, patient agreed to begin procedure.

12:00 pm

Patient in recovery refused to take mifepristone recommended by staff. Only agreed to mifepristone after advised and supervision by physician.

12:25 pm

Patient walked to car by myself and clinic manager. Reviewed with partner that his behavior in the office was inappropriate and made staff feel unsafe. He was explicitly told he would not be invited back to patient room tomorrow, may only stay in waiting room. He agreed.

Wiley, Alena 5.21.80

Exhibit E

Planned Parenthood® Federation of America, Inc.

Fact Sheet

Published by the Katharine Dexter McCormick Library
and the Education Division of
Planned Parenthood Federation of America
434 West 33rd Street, New York, NY 10001
212-261-4716
www.plannedparenthood.org

Current as of August 2012

Intimate Partner Violence and Reproductive Coercion

Intimate partner violence and reproductive coercion are major social problems in the U.S.

A growing body of research has recognized the connection between intimate partner violence and poor reproductive health outcomes for women. Intimate partner violence may come in many forms — emotional, verbal, physical, or sexual — and it often has serious long-term consequences for the individuals involved, their families, communities, and society as a whole (Chamberlain & Levenson, 2012; (Moore et al., 2010).

The term intimate partner violence (IPV) is often used interchangeably with relationship violence or domestic violence. It is used to describe violence in relationships as distinguished from other types of violent experiences. Recent studies have affirmed the connection between IPV and poor sexual and reproductive health outcomes in abused women compared to non-abused women (Moore et al, 2010). This fact sheet explores the problem of IPV, illustrates the magnitude of the problem, presents the reproductive health effects associated with it, and describes what can be done to prevent IPV.

Defining Intimate Partner Violence (IPV) and Reproductive Coercion

Intimate Partner Violence is a pattern of abusive and coercive behaviors that may include physical injury, psychological abuse, sexual assault, isolation, stalking, intimidation, and threats. These behaviors are carried out by someone who is, was, or wishes to be involved in a relationship with an adult or adolescent, and are aimed at establishing control by one partner over the other (Black et al., 2011).

Examples of physical and psychological IPV include

- pushing, shoving, slapping, and choking
- isolating partners from family and friends
- controlling what a partner can and can't do
- constantly threatening to leave a partner if they don't do what you want (Chamberlain & Levenson, 2012)

Many women who experience IPV also experience reproductive and sexual coercion.

Reproductive coercion involves behaviors that a partner uses to maintain power and control in a relationship that are related to reproductive health, such as explicit attempts to impregnate a partner against her wishes, controlling outcomes of a pregnancy, coercing a partner to have unprotected sex, and interfering with birth control methods. Control over one's partner is at the core of intimate partner violence and reproductive coercion; women experiencing both acts are less likely to have autonomy to make decisions about contraception and family planning (ACOG, 2012; Chamberlain & Levenson, 2012; Gee et al., 2009).

Examples of reproductive coercion include

- hiding, withholding, or destroying a partner's birth control pills
- intentionally breaking condoms or removing a condom during sex

- not withdrawing during intercourse when that was the agreed upon method of contraception
- removing contraceptive patches, rings, or IUDs
- attempting to force/ coerce a partner to have an abortion against their will
- controlling abortion-related decisions (Chamberlain & Levenson, 2012; Silverman et al., 2010)

Sexual control is when someone uses pressure or forces someone to do sexual things that they don't want to do.

Examples of sexual coercion include

- refusing to wear a condom when a partner wants to use one
- pressuring someone to do sexual things when they don't want to
- threatening to end a relationship if a partner doesn't have sex (Chamberlain & Levenson, 2012)

Magnitude of the problem: IPV and Reproductive Coercion

Recent studies show that one in four women in the U.S. experience intimate partner violence in her lifetime (Breiding et al., 2008). It is estimated that more than two million people are victims of IPV each year (Tjaden & Thoennes, 2000). Intimate partner violence caused 2,340 deaths in 2007 (Bureau of Justice Statistics, 2012).

In a nationally representative sample, approximately one in four women reported coerced sex at some point in her life, and more than a third were 15 years old or younger at the time of their first coerced sexual experience (Stockman et al., 2010).

In a college survey, 23 percent of female college students and seven percent of male college students reported at least one experience of unwanted sexual intercourse (Flack et al., 2007).

Among family planning clinic clients, 15 percent of female clients with a history of physical and/or sexual IPV reported birth control sabotage from a partner (Chamberlain & Levenson, 2012).

Reproductive Effects of IPV and Reproductive Coercion

Reproductive coercion may be one mechanism that helps to explain the known association between IPV and unintended pregnancy (Miller et al., 2010c).

IPV is associated with poor sexual and reproductive health outcomes compared to non-abused women (Moore et al., 2010). This includes being at a greater risk of unintended pregnancy, repeat abortions, second-trimester abortions, and sexually transmitted infections (Miller et al., 2010c; Jones & Finer, 2011)

Violence and reproductive health are strongly linked. Unplanned pregnancies increase women's risk for violence and violence increases women's risk for unplanned pregnancies. Women who are IPV victims are more likely to be in relationships with a partner who controls their contraceptive methods.

Practicing contraception is more difficult for women who have experienced IPV because of partner unwillingness to use contraception (Gee et al., 2009). Additionally, women who are exposed to IPV by the man who got them pregnant are more likely than non-abused women to have a second-trimester abortion (Jones & Finer, 2011).

Abusive men are more likely than their non-abusive peers to report being involved in pregnancies ending in abortion. There is a strong association between IPV and involvement in three or more abortions (Silverman et al., 2010).

IPV and reproductive coercion are associated with inconsistent condom use and sexually transmitted infections.

Women in abusive relationships are more likely to take part in risky behaviors like inconsistent condom use, which puts them at greater risk for sexually transmitted infections (STIs) (Coker, 2007). Additionally, women exposed to IPV are less likely to disclose an STI to a partner due to fear. Studies show that young women who are exposed to IPV are more likely to have partners say that the STI was not from them or accuse them of cheating (Decker et al., 2011).

Who is at Risk

Women and men of all sexual orientations, races, ages, and marital and socioeconomic statuses are at risk for relationship violence — however, some groups report higher rates of victimization.

- IPV disproportionately affects women. Women are at significantly higher risk than men of experiencing IPV and of sustaining serious injuries (Black et al., 2010). Approximately 85 percent of abuse victims are female with adolescents (Durose et al., 2005). ;

- Young women aged 20–24 have the highest rates of victimization (Rennison & Welchans, 2000).

- African-American women reported higher rates of victimization than women of other races (Rennison & Welchans, 2000).

- One in three indigenous women living in the U.S. will be sexually assaulted in her lifetime (Tjaden & Thoennes, 2000).

- Fear of deportation may cause immigrant women to be particularly hesitant to report IPV (ACOG, 2012).

- Women living in households with lower income experience much higher rates of domestic violence than women in households with higher annual incomes (Rennison & Welchans, 2000).

- Divorced and separated people experience relationship violence at three times the rate of never married people. Married and widowed people report the lowest rates of victimization (Rennison & Welchans, 2000).

- Few studies have focused on physical and sexual abuse in same-sex male relationships, despite its high prevalence (Brown, 2008). Intimate partner abuse occurs at similar and perhaps higher rates in same-sex male relationships as compared to heterosexual relationships. In a survey of gay and bisexual men, 32 percent reported any form of relationship abuse in a past or current relationship; 19 percent reported physical violence, and 19 percent reported unwanted sexual activity (Houston & McKirnan, 2007).

- While 30.4 percent of women in heterosexual relationships have reported abuse, only 11 percent of women in same-sex relationships have reported similar abuse (National Center for Injury Prevention and Control, 2003).

- Approximately four to eight percent of pregnant women overall are abused by their partners. (Gazmararian et al., 2000). Women with unwanted or mistimed pregnancies are at greater risk of being victims of violence.

- Women with physical disabilities are at a great risk of being victims of violence. Women with disabilities experienced almost twice the rate of all forms of abuse compared to women without disabilities (Smith, 2008).

Profile of Abusers

Most studies that have sought to identify characteristics of abusers have looked at men in heterosexual relationships. There is strong evidence that males who witness IPV during childhood are more likely to become perpetrators themselves as adults (Roberts et al., 2010). Additionally, men and boys without a positive role model are at greater risk for being in an abusive relationship (Kerpelman et al., 2009). Men who abuse alcohol are also more likely to physically assault their partners (Murphy et al., 2005).

IPV Among Adolescents/Teens

Adolescents' romantic relationships have a developmental purpose in their lives. Experiences in romantic relationships facilitate critical areas of personal and interpersonal development (Kerpelman et al., 2009).

For adolescents, examples of IPV include

- monitoring cell phone use including text messages
- telling a partner what he/she can wear
- controlling whether or not a partner goes to school
- manipulating contraceptive use (Chamberlain & Levenson, 2012)

Several studies examining the prevalence of IPV and sexual violence against youth have found that adolescents experience high rates of physical IPV.

One in five U.S. female high school students report experiencing physical and/or sexual intimate partner violence or dating violence (Silverman et al., 2001).

The Center for Disease Control and Prevention's 2011 national Youth Risk Survey reported that nearly one in 10 high school students has been hit,

slapped, or physically hurt on purpose by a boyfriend or girlfriend within the last 12 months. The prevalence of dating violence was higher among black (12 percent) and Hispanic (11 percent) than among white students (8 percent) (CDC, 2012).

Boys and girls who experience sexual dating violence are more likely to

- initiate sex before age 13
- have sexual intercourse with four or more people
- use alcohol or drugs before sex (Kim-Godwin et al., 2009)

Involvement in a verbally abusive adolescent relationship is associated with decreased condom use amongst females who are sexually experienced. Additionally, physical abuse by a partner is associated with pregnancy (Roberts et al., 2005).

One-quarter of female adolescents reported that their abusive male partners were trying to get them pregnant (Miller et al., 2007).

Among sexually active adolescent physically abusive relationships were more likely to become pregnant than non-abused girls (Roberts et al., 2005).

Adolescent mothers who experienced intimate partner violence within three months after delivery have a higher risk of experiencing a repeat pregnancy within two years (Raneri & Wiemann, 2007).

Teen girls who experienced both physical and sexual IPV were more likely than non-abused girls to report an STI diagnosis (Decker et al., 2005).

Adolescent girls who experienced IPV are significantly more likely to have foregone health care in the past 12 months compared to non-abused girls (Miller et al., 2010a).

Studies on the high prevalence of IPV and sexual victimization among female patients seen in health care settings highlight the need for routine screenings.

In an adolescent health clinic-based study, 45 percent of the sample had experienced intimate partner violence (Silverman et al., 2011).

Among a random sample of 1,278 women aged 16-29 in five family planning clinics, more than half reported physical or sexual IPV (Miller et al., 2010b).

What should be done?

Clearly, IPV and reproductive coercion is a serious, widespread problem that must be addressed. Schools, community groups, and health care providers are in an ideal position to identify IPV. Health care providers particularly have an essential role in the prevention of IPV and reproductive coercion by discussing healthy, consensual, and safe relationships with all patients (Miller et al., 2010c).

- Clinic-based interventions show promising evidence that they can increase IPV disclosure by patients. Providers in the interventions can recommend longer-acting, more discreet forms of birth control (Miller et al., 2010c; Gee, 2009).
- In 2011, the Institute of Medicine (IOM) issued guidelines that recommend routine IPV screening and counseling for all women and adolescent girls (IOM, 2011).
- Incorporating healthy relationship curricula into schools can increase the likelihood of healthy relationships into adulthood (Kerpelman et al., 2009).

Intimate partner violence and reproductive health are closely connected issues and one cannot be properly addressed without addressing the other. With IPV affecting rates of unplanned pregnancies, repeat abortions, second-trimester abortions, STIs, and inconsistent condom use, IPV itself is a reproductive health problem. Planned Parenthood is committed to reducing rates of intimate partner violence and reproductive coercion through education, training, screening, and advocacy.

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PPFA Media Contact — 212-261-4433

Exhibit F

ALL WOMENS CARE
Recovery Report

Name: Alena Kriley

DATE: 8-31-18

Time In: 1050 Temp: 98.1

Anesthesia Used: ☒ IV Sedation ☐ None ☐ Other: _____

Time	BP	Pulse	Bleeding	Cramping	O2 Sats	Initials
1050	97/50	69	—	none	96%	JR
1105	91/44	67	light	none	97%	JR
1120	96/49	70	—	none	97%	JR
1135	100/49	69	light	none	78%	JR

Comments: _____

MEDICATIONS ADMINISTERED POSTOPERATIVELY

- ☐ Rhogam: ☐ Mini ☐ Full ☐ Deltoid R / L ☐ Gluteus R / L ☐ _____
  Lot# _____ Exp: _____ Initials: _____
- ☐ Methergine: ☐ 0.2 mg p.o ☐ 0.2 mg im Initials: _____
- ☐ _____ Initials: _____
- ☐ _____ Initials: _____

DISCHARGE

Temp: 98.1

Patient appears: ☒ stable ☐ unstable: _____

IV Lock D/C'd: ☒ Yes ☐ No

This patient has been given written and verbal instructions concerning her aftercare and has had the opportunity to have all questions concerning her aftercare answered.

Date/Time of Next Appt: 8/n PRN

Patient Discharged in the Company of: Paul - Husband

Discharge Time: 11:42

MA: _____ MD: _____

Exhibit G

[redacted] MD
[redacted]
Chicago IL [redacted]
[redacted]

Information of the doctor is redacted due to fear of retaliation by Defendants. Information of the doctor will be disclosed to court if requested or the doctor will be called as witness for the trial.

February 28, 2022

To Whom This May Concern;

I am writing in regards to Ms Alena Kriley. I am a board certified Internist with training in numerous therapy modalities. Ms Kriley has been a patient of mine since June 8, 2020. She suffers from profound physical and emotional trauma. She presented seeking help for severe, chronic pain which was the direct result of complications from a surgical procedure. The pain impairs her ability to function on many levels and prevents her ability to maintain gainful employment.

Ms Kriley also suffers from real and complex emotional trauma. The interventions for this were organized around giving her support, helping her achieve self regulation, and with coping skills. Suffice it to say that her trauma is real and significant, and that her reactions are not unreasonable based on the severity and nature of her trauma. However, at no point were there any concerns on my part for her ability to be a loving mother to her son. Indeed, the majority of her significant efforts to heal herself arose from her will to present as his caregiver.

I can share more details of the complex nature of her history as deemed necessary by the court.

Sincerely,

[redacted] MD