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MARICOPA COUNTY SUPERIOR COURT

STATE OF ARIZONA

In Re Matter of: [redacted] **Petitioner,** **And** **CLAYTON ECHARD,** **Respondent.**	Case No: FC2023-052114 **PETITIONER'S RESPONSE TO RESPONDENT'S *AMENDED* MOTION FOR RELIEF BASED ON FRAUD** **(Assigned to Hon. Julie Mata)**

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Petitioner [redacted] ("Ms. [redacted] or "Petitioner") respectfully submits the following Response to Respondent Clayton Echard's ("Mr. Echard" or "Respondent") *Amended* Motion for Relief From Judgment Based on Fraud.

As explained below, there has been no fraud of any kind in this proceeding. YES, Ms. [redacted] made some misstatements along the way, including misstatements to third parties, and at least one minor misstatement to the Court (in the order of protection proceeding). As explained below, none of those misstatements affected the outcome of the order of protection proceeding, nor do they have any effect on the paternity proceeding (except, of course, to the extent they bear on Ms. [redacted] overall credibility).

As will eventually become clear once all the facts are known, even accepting the problems with Ms. [redacted] credibility, there is objective medical proof Ms. [redacted] was, in fact, pregnant, and she believed (with good reason) that Mr. Echard was the father.

Thus, even accepting *other unfortunate but unrelated* problems with credibility, Ms. [redacted] had a valid good faith basis to commence the paternity proceeding against Mr. Echard, and she also had a valid good faith basis to seek a protective order based on Mr. Echard's abusive and harassing conduct.

For these reasons, the protective order previously entered on October 26, 2023 in FC2023-052771 had a valid factual and legal basis, and there are no grounds to change that decision. Accordingly, Mr. Echard's motion should be denied, and Ms. [redacted] should be awarded her reasonable attorney's fees incurred in preparing this response pursuant to A.R.S. § 25-324.

I. PROCEDRUAL PREFACE

The posture of the current pleading is somewhat confusing, so in an abundance of caution, this Response begins with a short comment to remove any potential misunderstanding. First, on March 26, 2024, Mr. Echard filed a Motion for Relief From Judgment Based on Fraud in FC2023-052771 (the OOP matter). That initial motion was never served (the certificate of service indicates it was *emailed* to Ms. [redacted] who was self-represented at that point and had not agreed to accept electronic service).

Undersigned counsel was retained to represent Ms. [redacted] first in the paternity matter (FC2023-052114), and later in the OOP case. Upon appearing in the OOP matter on April 9, 2024, undersigned counsel filed a notice explaining the previous pending motion (for relief based on fraud) had not been served on Ms. [redacted] and that no response was currently due for that reason. The issue of service was later resolved between counsel, and the undersigned had intended to file a timely response to the motion seeking relief based on fraud.

In the interim, Mr. Echard filed a motion seeking a "joint hearing" in FC2023-052114 and FC2023-052771, which this Court granted via minute entry order issued April 26, 2024 (technically, the motion for joint hearing was never properly served either, but Ms. [redacted] had no objection to that request). Finally, on April 26, 2024, Mr. Echard filed pleading purporting to *amended* his prior motion for relief based on fraud, although

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it appears the amendment was filed only in FC2023-052114 (the paternity case) and not FC2023-052771 (the OOP case).

With that slightly complicated posture in mind, this pleading is intended to represent Ms. [redacted] response to both the original motion seeking relief based on fraud filed in the OOP case, and the *amended* version of that motion just filed in the paternity case. Hope that makes sense.

II. INTRODUCTION

Because the order of protection case has been functionally consolidated with the paternity proceeding, a brief recap is in order. On October 6, 2023, Ms. [redacted] filed a short *pro se* petition asking for an order of protection against Mr. Echard.

For her factual basis, the petition generally alleged Mr. Echard sent harassing and threatening messages to Ms. [redacted] expressing his "anger and hatred" towards her. Ms. [redacted] further claimed Mr. Echard published harassing and annoying messages about her online, and that he encouraged others to do so. Ms. [redacted] also argued Mr. Echard posted messages online sharing "private and confidential" information about her (and, again, he encouraged others to do so). Ms. [redacted] claimed these actions had caused her "extreme anxiety" and fear for her safety to such a degree that she was afraid to leave her own home.

After an *ex parte* order was issued, a contested hearing was held on the petition on October 25, 2023 at which Ms. [redacted] and Mr. Echard both testified. Following the hearing, the Court found "by a preponderance of the evidence that there is reasonable cause to believe that Defendant has committed an act of domestic violence within the last year." Minute Entry Order 10/25/2023 (filed 10/26/2023).

Mr. Echard now seeks relief from this order….but only sort of. As a starting point, and as a recurring theme, Mr. Echard argues "Plaintiff was never pregnant by Defendant" (a point which was arguably litigated and resolved against him at the hearing). Mr. Echard then proceeds to cite a handful of various "fraudulent" things done by Ms. [redacted] including modifying a sonogram image, and lying about which doctors saw her.

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Taken as a whole, Mr. Echard's motion seems to contain two main issues. First, he claims Ms. [redacted] was "never pregnant". If true, that would *potentially* affect her statutory rights to seek relief under the Order of Protection statutes, A.R.S. §§ 13–3601 and 13–3602.

Second, Mr. Echard claims Ms. [redacted] lied about things such as the authenticity of a sonogram image and other aspects of her pregnancy. In the narrow context of an OOP proceeding, it appears Mr. Echard is attempting to raise those issues to show that *if* he published a medical record online which did *not* belong to Ms. [redacted] that means he did not engage in the type of conduct that would support the order of protection entered here.

As explained below, none of these arguments are well-taken. The order of protection was properly and lawfully issued, and no grounds exist to vacate or modify it. As such, Mr. Echard's motion should be denied, and Ms. [redacted] should be awarded her reasonable attorney's fees incurred in preparing this response.

III. DISCUSSION

Arizona has many different laws permitting orders against harassment, threats, and other types of offensive conduct. The two main laws are A.R.S. § 12–1809 (permitting injunctions against harassment) and A.R.S. § 13–3602 (allowing orders of protection "for the purpose of restraining a person from committing an act included in domestic violence.")

These orders/injunctions are typically focused on preventing unlawful *conduct*, but they also have the potential to impact certain constitutionally-protected activities including free speech. To ensure the right to engage in vibrant discourse is not unduly chilled, protective orders/injunctions are subject to strict procedural and technical requirements, including very specific statutory standards which are necessary to protect the First Amendment rights of litigants, while still providing relief for victims of harassing conduct. *See*, *e.g.*, *Streeter v. Visor*, 2015 Ariz. App. Unpub. LEXIS 1451, *5 (App. Div. 1 2015) (vacating injunction against harassment on First Amendment grounds, and noting "A restriction like this based on the content of speech is permissible only if

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narrowly tailored to achieve a compelling state interest.") (citing *Perry Educ. Ass'n v. Perry Local Educators' Ass'n*, 460 U.S. 37, 45 (1983)). Of course, Mr. Echard has not raised any sort of constitutional challenge to the order Ms. [redacted] obtained in this matter, so this Response will not explain why the order *is* constitutionally proper.

With this backdrop in mind, to the extent Mr. Echard claims he is entitled to relief because Ms. [redacted] was "never pregnant", this appears to be an attack on the Court's statutory authority to grant any relief at all under the OOP statute. That attack is baseless, both legally and factually.

a. Ms. [redacted] Was Legally Eligible For OOP Protection

To begin, any party seeking an order of protection must show they are entitled to relief under the law. Unlike a harassment injunction under A.R.S. § 12–1809 (which may obtained by *anyone*, regardless of the relationship between the parties), orders of protection under A.R.S. § 13–3602 are limited in terms of eligibility. By definition, a party seeking an order of protection must show they fit within one or more of the categories described in A.R.S. § 13–3601(A) which include things like married couples (§ 3601(A)(1)), parents who share a child (§ 3601(A)(2)), and cases in which "The victim or the defendant is pregnant by the other party." § 3601(A)(3).

But the OOP law is not limited to only martial or filial/paternal relationships. A.R.S. § 13-3601(A)(6) allows relief in any case where "The relationship between the victim and the defendant is currently or was previously a romantic or sexual relationship." (emphasis added).

Here, fleeting as it was, there is no dispute Mr. Echard and Ms. [redacted] had a romantic relationship which involved some level of sexual conduct. Mr. Echard denies sexual *intercourse*, but Ms. [redacted] claims sex occurred, in addition to oral sex and other activities.

Thus, even if Mr. Echard was correct and even if Ms. [redacted] was "never pregnant", that point is entirely irrelevant to her right to seek relief under the OOP statute. A romantic or sexual relationship is sufficient, and here we have both.

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For that reason, Ms. [redacted] did not obtain the order of protection by fraudulently claiming she was pregnant. Relief was still available under the law, even if Ms. [redacted] was never pregnant at all, simply based on the brief romantic rendezvous.

b. The Court Properly Found The Facts Supported Relief

Aside from Ms. [redacted] statutory entitlement to relief based on her relationship with Mr. Echard, Mr. Echard argues the order of protection was obtained by fraud because Ms. [redacted] was not *factually* entitled to the relief she sought. Again, Mr. Echard's arguments are not well-taken.

As explained above, following a contested hearing, the court made a factual finding that Ms. [redacted] established "by a preponderance of the evidence that there is reasonable cause to believe that Defendant has committed an act of domestic violence within the last year." Minute Entry Order 10/25/2023 (filed 10/26/2023). In evaluating that finding, it is critical to understand in the context of an order of protection hearing, the term "domestic violence" has a *very* specific legal definition:

> "Domestic violence" means any act that is a dangerous crime against children as defined in section 13-705 or an offense prescribed in section 13-1102, 13-1103, 13-1104, 13-1105, 13-1201, 13-1202, 13-1203, 13-1204, 13-1302, 13-1303, 13-1304, 13-1406, 13-1425, 13-1502, 13-1503, 13-1504, 13-1602 or 13-2810, section 13-2904, subsection A, paragraph 1, 2, 3 or 6, section 13-2910, subsection A, paragraph 8 or 9, section 13-2915, subsection A, paragraph 3 or section 13-2916, 13-2921, 13-2921.01, 13-2923, 13-3019, 13-3601.02 or 13-3623[.]

A.R.S. § 13–3601(A).

This long list of numbers means little to non-lawyers, and probably nothing more to anyone else. The key to understand is this — the list includes an extremely broad range of conduct including completely unrelated acts like *negligent homicide* (A.R.S. § 13–1102) and *revenge porn* (A.R.S. § 13–1425). The statutory definition of "domestic violence" also covers things like: "Recklessly parking any vehicle in such a manner as to deprive livestock of access to the only reasonably available water." A.R.S. § 13–1602(A)(4). Seriously, that meets the definition of "domestic violence".

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Here, after the hearing, the court did not explain *precisely which aspect* of "domestic violence" was proved. But we can rule a few things out; it is undisputed Mr. Echard did not park his car in such a manner as to deprive livestock of access to water. Whew. Nothing worse than thirsty cows.

Instead, given the allegations in Ms. [redacted] petition, it is fairly clear the court's finding was based on A.R.S. § 13–2904(A) (prohibiting disorderly conduct) and/or A.R.S. § 13–2916 (using electronic communications to terrify, intimidate, threaten or harass). Both in her petition and in her testimony at the hearing, Ms. [redacted] established Mr. Echard sent her threatening, harassing, and insulting messages, and in the *ex parte* order entered on October 6, 2023, the court clearly was focused on Mr. Echard's online attacks and harassment (which were *extensive* and <u>not</u> limited to posting a single sonogram image):

OTHER ORDERS:
The Court finds reasonable cause to believe that the Defendant may commit an act of domestic violence or has committed an act of domestic violence within the past year (or good cause exists to consider a longer period). Defendant shall have no contact with Plaintiff other than as outlined herein and shall not cause others to contact Plaintiff other than as outlined herein. Defendant shall not communicate or post untrue or harassing comments regarding Plaintiff online, including but not limited to on social media, and shall not cause others to communicate or post untrue or harassing comments regarding Plaintiff online or otherwise.

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Notably, in Mr. Echard's motion for relief, he never even attempts to refute the allegations in Ms. [redacted] petition which address his harassing conduct toward Ms. [redacted] including messages he sent describing his rage, hatred, and fury towards her, as shown below here.

Approx. Date	(Do not write on back or in the margin. Attach additional paper if necessary.)
6/1/2023	Clayton has sent threatening messages since discovering I was pregnant, such as: I legitimately hate you right now. my hatred will only grow if you decide to put me through all of this. My animosity would last for a lifetime and that's not something either of us want to subject ourselves to. One thing about me is when I make up my mind for good, especially when it's rooted in anger, I don't sway. Ever My hate is toward you and you only. if you decide to not take plan B and in the wild event that you are pregnant, I would hate you even more.
9/21/2023	Clayton Echard was The Bachelor and has many diehard loyal fans. He and I are involved in a very public paternity case that is being covered by every major media outlet. Clayton posted to a story to his 270k followers to look me up, which they have, and I have been sent threatening and harassing messages by his followers. I explained this to him and asked him to take down the post, which he did not. By posting personal and sensitive information about me publicly (and without my consent), he has made me feel humiliated and embarrassed.

This conduct, which has *nothing* to do with an "altered" sonogram, was sufficient, standing alone, to support a finding of actual or potential domestic violence within the unique statutory definition of the term. Mr. Echard does not challenge that point. As such, even assuming Ms. [redacted] was not truthful about *other* issues, the undisputed evidence supported the order entered here on that basis alone.

i. Ms. [redacted] Was Pregnant

In his obsessive, never-ending quest to smear and defame Ms. [redacted] (just like Donald Trump did with writer E. Jean Carroll, to his later financial detriment), Mr. Echard claims Ms. [redacted] was "never pregnant", that she "has provided no verifiable medical evidence to support her alleged twin pregnancy" and that "every obstetrician and gynecologist [Plaintiff claimed to have seen] has indicated they have "no records as she was never seen as a patient." To be clear—each of these is a knowingly false statement which will result in a forthcoming motion for sanctions against Mr. Echard and his counsel. At some point, these constant lies must stop.

In the meantime, rather than pre-litigating the entire case in this pleading, Ms. [redacted] simply directs the Court's attention to the expert report of Dr. Michael T. Medchill, submitted herewith. Dr. Medchill is a recently-retired Arizona OB/GYN with more than 30 years of experience in the field. His *curriculum vitae* reflects that in addition to his medical degree, Dr. Medchill also separately holds a Ph.D. in immunology/biology, a masters degree in microbiology, and a BA (*magna cum laude*) in biology. His work experience is even more impressive.

During his lengthy career as an OB/GYN in Arizona, Dr. Medchill served as the Chairman of the OB/GYN department at St. Joseph's Hospital in Phoenix. Although not reflected in his CV or report, during his long career, Dr. Medchill personally delivered more than 22,000 children, likely more than any other physician in the State of Arizona. Prior to his recent retirement, Dr. Medchill was board certified by the National Board of Medical Examiners and the American Board of Obstetrics and Gynecology. His education, training, experience in the field are truly exceptional.

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In his report, Dr. Medchill explained he has reviewed Ms. [redacted] medical records (which are *extensive*, contrary to Mr. Echard's claims), and other evidence including an affidavit from Ms. [redacted] describing her contact with Mr. Echard and her activities relating to the pregnancy. Based on his review, Dr. Medchill's expert opinion is: "**She was clearly pregnant with 99+% certainty** based on five HCGs (from both urine and blood)." Report at Medchill0009, ¶ 6 (emphasis added).

Importantly, Dr. Medchill also directly refutes an extremely frustrating, inaccurate, and tired trope included in nearly every pleading filed by Mr. Echard, *to wit*: "**Plaintiff [Ms. [redacted] was never pregnant by Defendant [Echard]** as they did not have penetrative sexual intercourse." Mot. at 2:10–11 (emphasis in original). On that point, Dr. Medchill explains human beings can and do become pregnant even without penetrative sexual intercourse, noting "I have heard that story many times".

Dr. Medchill provides a fascinating discussion about a patient he treated named "Maria" who was confirmed to be pregnant despite claiming she never had intercourse. Dr. Medchill explained his physical exam verified she was pregnant, and her hymen was still intact (thus confirming she was, at least in the literal sense, a pregnant virgin):

> Would it be reasonable for Ms. [redacted] to assume she was pregnant based on the type of sexual contact she had and the lab test results she received? Yes. There was not a description of the foreplay and there was disputed testimony about the after play. It is well known that men are "like basketball players-they dribble before they shoot" which is why the withdrawal method has a much higher failure rate than most other methods of birth control. They also dribble after they shoot, so if he did put his penis in or near her vagina after orgasm, she could still get pregnant. The odds of getting pregnant obviously go down if semen is released just outside of the vagina but it is still possible. In fact, I had one patient who was clearly pregnant (ultrasound confirmed), **she absolutely denied intercourse, denied even ever using tampons and stated that she was a virgin**. I have heard that story many times. In this case, however, I was shocked at the time of her exam to see that her hymen was intact! That alone would be remarkable enough to remember her but her name was Maria and her due date was within a day or two of Christmas.

Report at Medchill0009, ¶ 5 (emphasis added).

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Thus, contrary to the wholly unsupported and self-serving allegations of Mr. Echard and his counsel, an OB/GYN with impeccable credentials has reviewed the facts in this case and will opine at trial, that Ms. [redacted] was not only pregnant, she "was clearly pregnant with 99+% certainty."

As if that evidence was not sufficient, equally notable is the expert report recently disclosed by Mr. Echard, a copy of which is also submitted herewith. For his part, Mr. Echard has disclosed two OB/GYN experts. The first, Dr. Faye Elizabeth Justicia-Linde, is a medical doctor and professor who appears to have experience *teaching* in the field of Obstetrics and Gynecology, although the extent of her practical and clinical experience as an OB/GYN is unknown (her CV reflects limited work experience in the field other than as a professor).

The second is Dr. Samantha Deans. Her work experience as an OB/GYN (like Dr. Justicia-Linde) appears to be primarily teaching, as an assistant professor. In terms of practical work experience in the field, Dr. Deans' CV indicates she has spent approximately nineteen (non-consecutive) months working as an Associate Medical Director for Planned Parenthood in Pennsylvania and Florida.

Given their relatively limited experience in the field, neither Dr. Justicia-Linde nor Dr. Deans express any opinion about whether Ms. [redacted] was, or was not, pregnant. Indeed, tellingly, nothing in their expert report ever comes close to refuting Dr. Medchill's opinion that Ms. [redacted] was, in fact, pregnant with 99+% certainty.

Instead, Drs. Justicia-Linde and Deans offer a lukewarm and strictly-qualified opinion stating they cannot "confirm" Ms. Owen had an "ongoing, viable clinical pregnancy" which meets their technical definition of that term:

> We cannot confirm by any objective data that Ms Owens had an ongoing, viable clinical pregnancy at any time in the last year. Clinical pregnancy is defined as "a pregnancy diagnosed by ultrasonographic visualization of one or more gestational sacs or definitive clinical signs of pregnancy. In addition to intra-uterine pregnancy, it includes a clinically documented ectopic pregnancy."[2] We have received no verifiable documentation of a clinical pregnancy as defined.

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With all due respect to the doctors, according to this bizarrely contrived definition, if a woman became pregnant and gave birth to a healthy child *without ever having an ultrasound*, Drs. Justicia-Linde and Deans would express the same opinion as they did with Ms. [redacted] – no "verifiable *clinical* pregnancy" according to their definition. In fact, by their definition, it is probably accurate to say undersigned counsel is not currently alive and writing this brief.

That level of gamesmanship speaks volumes about what is really going on here. But there is no need to speculate. The simple truth is this – **Mr. Echard's own experts do not support his contention that Ms. [redacted] was "never pregnant"**. **They don't even try to claim this**.

Instead, they simply created a bizarrely-specific definition of "*clinical* pregnancy" and then suggest they can't conclusively determine whether Ms. [redacted] ever met that specific definition. Of course, the question of whether Ms. [redacted] had a "*clinical* pregnancy" or just a plain old regular one is not relevant.

As a matter of law, A.R.S. § 25–804 *does not* limit paternity proceedings to only "verifiable *clinical* pregnancy" under the definition created by Mr. Echard's experts. And for the record—this issue is also irrelevant because Ms. [redacted] never claimed to have had a "*clinical* pregnancy" using the special definition created by Drs. Justicia-Linde and Deans. She just claimed she was pregnant, as Dr. Medchill confirms she was. Maybe someday Mr. Echard will stop falsely claiming Ms. [redacted] was "never pregnant", but sadly not today.

ii. The "Sonogram" Was Not Fraudulent

Another tired point raised by Mr. Echard is that Ms. [redacted] committed "fraud" because the order of protection was based on sonogram image that Ms. [redacted] has since admitted to altering. But this point does not in any way support the relief Mr. Echard asks for here. This is so for two reasons.

First and most importantly, the order of protection was issued in this matter based on evidence *unrelated* to the sonogram. Once again, throwing candor to the wind, Mr.

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Echard argues "the Court explicitly stated the sole reason it was upholding the Order of Protection was because of the image containing the sonogram." Mot. at 8:23–24 (emphasis in original).

Ms. [redacted] response is that NO, that is NOT what the Court said, and since Mr. Echard seems to have missed the Court's ruling on this issue, it will be repeated here:

> **OTHER ORDERS:**
> The Court finds reasonable cause to believe that the Defendant may commit an act of domestic violence or has committed an act of domestic violence within the past year (or good cause exists to consider a longer period). Defendant shall have no contact with Plaintiff other than as outlined herein and shall not cause others to contact Plaintiff other than as outlined herein. Defendant shall not communicate or post untrue or harassing comments regarding Plaintiff online, including but not limited to on social media, and shall not cause others to communicate or post untrue or harassing comments regarding Plaintiff online or otherwise.

The fact that the Court ordered Mr. Echard to refrain from posting "untrue or harassing comments regarding Plaintiff online" shows the order was *not* based solely on the sonogram image. It was based on Mr. Echard's relentless attacks against Mr. [redacted] trying to falsely portray her as a "pregnancy faker" (a campaign which has been extremely successful). Included in those attacks was this offensive photo showing Ms. [redacted] body Photoshopped onto a fake Halloween costume package (this image is attached to Mr. Echard's motion as Exhibit 3).

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Although this image is "fake" in the sense that Ms. [redacted] has never appeared on a Halloween costume package, Mr. Echard offered no evidence to show that Ms. [redacted] created this image or that she was responsible for posting it online (given the embarrassing and insulting nature of the image, it stands to reason Ms. [redacted] had no reason to create this image or to share it online). Indeed, the whole point of Ms. [redacted] seeking the order of protection was to provide *relief* from these types of attacks.

In short, Ms. [redacted] has admitted to modifying one sonogram image in a non-material way — she testified in her deposition that she changed the name of the facility on the image to prevent Mr. Echard from knowing where it was done. Beyond that, Ms. [redacted] has always maintained that the ultrasound image itself was not fake, it depicted her body, and it was taken at Planned Parenthood during the pregnancy which gives rise to this case. Simply changing the name of the location where the sonogram was taken does not mean the remainder of the image is "fraudulent".

It simply means Ms. [redacted] made a very dumb decision to alter the document in a way that, ultimately, only harms Ms. [redacted] case. But lying about the location where the image was created changes nothing about the fact that Ms. [redacted] was, indeed, pregnant.

Furthermore, Mr. Echard has also admitted to lying in this case (he lied to Ms. [redacted] about real estate agreements she asked him to prepare on her behalf). The fact that Mr. Echard has admitted lying to Ms. [redacted] does not mean he should automatically lose this case, anymore than the sonogram issue shows Ms. [redacted] should lose. Both parties in this case have acted stupidly at times. That is an unfortunate fact of life, and he who is without sin shall cast the first stone.

The bottom line is that Ms. [redacted] concedes she made a mistake here. As a result of that mistake, she cannot provide *verification* that her story about the sonogram is true, and she understands this is an issue that may affect her credibility. At the same time, it is important to note that even if the sonogram is completely ignored, there is still substantial other objective, verified proof to support her pregnancy claim. Because so much other proof exists, the sonogram becomes largely irrelevant (notably because the sonogram is

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disputed, Dr. Medchill completely disregarded it in his report, yet he still concluded sufficient other evidence exists to support Ms. [redacted] pregnancy, with a high degree of medical certainty).

IV. CONCLUSION

For all the reasons stated above, there is no basis for this Court to vacate the order of protection entered in this matter. Reasonable factual grounds existed to support the Court's finding of actual or potential domestic violence, as that term is defined in A.R.S. 13–3601, and Mr. Echard's motion fails to show any basis for a different conclusion now..

As such, Mr. Echard's *Amended* Motion for Relief Based on Fraud should be denied in its entirety, and Ms. [redacted] should be awarded her reasonable attorney's fees incurred in preparing this response pursuant to A.R.S. § 25–324.

DATED April 26, 2024.

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MARICOPA COUNTY SUPERIOR COURT

STATE OF ARIZONA

In Re Matter of: [redacted] **Petitioner,** **And** **CLAYTON ECHARD,** **Respondent.**	Case No: FC2023-052114 **PETITIONER'S EXPERT DISCLOSURE STATEMENT** **(Assigned to Hon. Julie Mata)**

Pursuant to Ariz. R. Fam. L.P. 49(j) Petitioner [redacted] discloses the following information regarding expert witnesses.

1. **Dr. Michael T. Medchill, M.D.**; [redacted], Cape Coral, FL, 33914; [redacted]

    a. Dr. Medchill is a recently-retired OB/GYN who has provided an expert report on the subjects of obstetrics and gynecology as applied to his review of certain medical records in this matter. Dr. Medchill is being compensated at the rate of $500/hr. for his services including records review and trial testimony (if needed). To date, Dr. Medchill has been paid a total of $2,500.00.

b. Dr. Medchill's *curriculum vitae* reflecting his qualifications and publications is attached hereto as Exhibit A.

c. The substance and facts of Dr. Medchill's opinions are contained in a written report attached hereto as Exhibit B.

d. The materials reviewed by Dr. Medchill in forming the grounds for his opinion are attached hereto as Exhibit C.

e. The reference materials cited in Dr. Medchill's report are attached hereto as Exhibit D.

DATED April 22, 2024.

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Original emailed April 22, 2024 to:

Gregg R. Woodnick, Esq.
Isabel Ranney, Esq.
Woodnick Law, PLLC
1747 E. Morten Avenue, Suite 505
Phoenix, AZ 85020
Attorneys for Respondent

[redacted]

[redacted]

[redacted] LAW OFFICE, PLLC
4802 E RAY ROAD, #23-271
PHOENIX, ARIZONA 85044

Exhibit A

Michael Tom Medchill M.D.

[redacted]

Cape Coral, FL 33914

EDUCATION

Undergraduate:

1969-- Associate Arts (A.A) Chemistry

Mesa Community College

1972-- Bachelor Arts (B.A.) Biology

Mankato State University

Magna Cum Laude

Graduate:

1974-- Master Arts (M.A.) Microbiology

Mankato State University

1974-76--PhD Candidate Immunology/Microbiology

University of Arizona

Medical School:

1985-- Doctor of Medicine (M.D.)

Medical College of Wisconsin

Internship:

1986--Maricopa Medical Center

Residency:

1989--Phoenix Integrated Residency in OB/GYN

PROFESSIONAL EXPERIENCE

1989-1992 Group Practice Marshfield Clinic

Helped develop the Laproscopic Cholecystectomy program – Chippewa Falls

Started Gynecologic Laser program at Marshfield Clinic—Chippewa Falls

1992-2001 Faculty -- Medical Director Department of Reproductive Medicine

Phoenix Integrated Residency in OB/GYN

1995-2001 Medical Director MOMobile

One of the Founders of the MOMobile

2001-2018 Private Practice – Phoenix, AZ

Helped develop the Cord Blood Banking Program at St Joseph Hospital

HOSPITAL MEMBERSHIP

St. Joseph Hospital – Chippewa Falls, WI

Chairman Dept. of OB/GYN 90-92

Active Staff 1989-1992

St. Joseph Hospital—Marshfield, WI

Active Staff 1989-1992

Luther Hospital—Eau Claire, WI

Active Staff 1989-1992

Victory Memorial Hospital – Stanley, WI

Active Staff 1989-1992

St. Joseph Hospital – Phoenix, AZ

Chairman Dept of OB/GYN 2000-2003

Vice Chairman Dept of OB/GYN 1998-2000, 2004-2005

Active Staff 1992-2018

Maricopa Medical Center—Phoenix, AZ

Active Staff 192-1994

Banner Good Samaritan Hospital--Phoenix, AZ

Active Staff 2004-2018

LICENSURES and BOARD CERTIFICATIONS

1989-2015 State of Wisconsin Medical License

1992-2022 State of Arizona Medical License

1985 National Board of Medical Examiners

1991-2019 American Board of Obstetrics and Gynecology

HONORS AND AWARDS

2000-- TOP DOCS –Phoenix Magazine

1998--Philosophy in Action Award --St Joseph Hospital

1997--TOP DOCS –Phoenix Magazine

1997-- Philosophy in Action Award --St Joseph Hospital

1996--St. Joseph Hospital OB/GYN Teacher of the Year

1994--St. Joseph Hospital OB/GYN Teacher of the Year

1993--University of Arizona Deans Teaching Scholar

1974--Mankato State University Biology Student of the Year

PROFESSIONAL SOCIETIES

1991-2010--American College of Obstetrics and Gynecology

1994-2008-- Phoenix Obstetrical and Gynecological Society

Vice President 1998-1999

President 2000-2001

1999-2011-- Pacific Coast Obstetrical and Gynecological Society

Caucus Chairman and Board of Directors 2005

PUBLICATIONS

Identification and Partial Characterization of Hemaglutinins in the Wax Moth Galleria mellonella. **Michael T. Medchill**, Master's Thesis on File at Mankato State University Library 1974

Diagnosis and Management of Tuberculosis during Pregnancy **M.T. Medchill** and M. Gillum. Obstetrical and Gynecological Survey 44: 81-84, 1989

inv(12) (p11.2q13) in an Endometrial Polyp. T. Walter, S.X.Fan, **M.T. Medchill**, C.S. Berger, H.H. Decker and A.A. Sandberg. Cancer, Genetics Cytogen 41: 99-103, 1989

Cesarean Section Prophylaxis: A Comparison of Cefamandole and Cefazolin by both the IV and Lavage Routes, and the risk factors Associated with Endometritis. C.M. Peterson, **M.T. Medchill**, D.S. Gordon, H.L. Chard. Obstetrics and Gynecology 75: 179-182, 1990

Cytogenetic Findings in Nine Leiomyomas of the Uterus. S.X. Fan, C. Sreekantaiah, C.S.Berger, **M.T. Medchill**, S. Pedron, A. A. Sandberg. Cancer, Genetics, Cytogenetics 47: 179-189, 1990

Prediction of Estimated Fetal Weight in Extremely Low Birthweight Neonates (500-1000 grams). **M.T. Medchill**, C.M. Peterson, C. Krenic, J. Garbaciak. Obstetrics and Gynecology 78: 286-90, 1991

Cluster of Trisomy 12 tumors of the female genitourinary tract. M. Kiechle-Schwartz, A. Pfleidereer, C. Sreekantaiah, C.S. Berger, **M.T. Medchill**, A.A. Sandberg. Cancer Genetics Cytogenetics 54(2): 273-5, 1991

Nonrandom Cytogenetic Changes in Leiomyomas of the Female Genitourinary Tract. A Report of 35 Cases. M. Kiechle-Schwartz, C. Sreekantaiah, C.S. Berger, S. Pedron, **M.T. Medchill**, U. Surti, A.A. Sandberg. Cancer, Genetics Cytogenetics 53(1): 125-136, 1991

Diagnosis and Treatment of Giardiasis in Pregnancy**. Michael Medchill**. Clinical Advances in the treatment of Infection. 5(6): 6-7, 1991

B-Lactamase Mediated Antibiotic Resistance. **Michael T. Medchill**. Clinical Advances in the Treatment of Infection. 6(6): 4-5, 1992

Aspects and Treatment of Episiotomy Infections. **Michael T. Medchill**. Clinical Advances in the Treatment of Infection. 6(5): 13-16, 1992

Cytogenetic Studies in Endometriosis Tissue. A. Dangel, **M.T. Medchill**, G. Davis, A. Meloni, A.A. Sandberg. Cancer, Genetics Cytogenetics 78(2): 172-4, 1994

Changes in mRNA and Protein Levels of the Cyclin Dependent Kinase Inhibitor p27KIP, During the Growth and Development of Adult and Cord Blood Human Hematopoietic Progenitor Cells. X. Ruiline, E. Firpo, **M. Medchill**, Jo-Anna Reems. Experimental Hematology 1998

Prenatal. Purified Protein Derivative Skin Testing in a Teaching Clinic with a Large Hispanic Population. **M.T. Medchill**. Am J Obstet Gynecol. 1999 Jun; 180(6): 1579-1983

Cord blood cells that retain a CD34+phenotype after ex vivo expansion have reduced engraftment potential relative to unmanipulated CD34+cells. R. Xu, **M Medchill**, Y. Chang, Jo-Anna Reems. Experimental Hematology 27.

Serum Supplement, Inoculum Cell Density and Accessory Cell Effects are Dependent upon the Cytokine Combination Selected to Expand Human Hematopoietic Cells ex vivo. R. Xu**, M. Medchill**, J.A. Reams. Transfusion 2000 Nov; 40(11):1299-307

Exhibit B

1. Did Ms. [redacted] good reason to believe she was pregnant on August 1, 2023?

   Intimacy of some type occurred on 5/20/23

   A faint positive urine HCG was noted on 5/31/23. Home pregnancy tests are usually positive by 14 days after conception. Depending on the quality of the test, a little sooner. The fact that the test was faintly positive at 11 days shows good correlation. With a twin pregnancy, HCG levels may rise a little faster and be detectable by a urine pregnancy test (UPT) a little sooner. These tests are approximately 99% accurate. (How Early Can You Detect Pregnancy? (clevelandclinic.org)

   She had a positive urine HCG at Banner Clinic on 6/1/2023. Therefore, she had a medically performed test which collaborated her home pregnancy test.

   On 7/23/23, she passed "two small fleshy objects" vaginally. This may have been just some blood and cervical mucus. It may have been one fetus passing. It may have been two fetuses passing.Pathology testing was not done on the material, so a precise answer is not possible.

   Having passed some material Ms. [redacted] logically would want to know if she was still pregnant. She did two more pregnancy tests on 7/25/23 and 8/1/2023. Both were positive. A reasonable person without more sophisticated testing (ultrasound)would reasonably think that not only was she proven to be pregnant on 5/31 and 6/1 but that she was still pregnant on 8/1/2023.

   The fact that her quantitative HCG was still 102 (positive) on 10/16/2023, documents that a pregnancy did exist on 5 different occasions. A quantitative HCG indicates not only if one is pregnant but how pregnant. A level of 102, this far into pregnancy would indicate that there was a pregnancy at some point in time but it was no longer viable or living. In fact, it would indicate that it had been nonviable for some time.

   Early pregnancy loss is defined as a nonviable, intrauterine pregnancy with either an empty gestational sac or a gestational sac containing an embryo or fetus without fetal cardiac activity within the first 13 weeks of gestation. With expectant management, 80% of early pregnancy losses will achieve complete expulsion within 8 weeks. Early Pregnancy Loss | ACOG(Number 200, November 2018). So, with early pregnancy losses, HCG levels do not return to "negative" for weeks and weeks.In fact, 20% don't resolve within 8 weeks. Dependingon how early the pregnancy loss occurred will determine if there is significant bleeding or not. In some early losses, the fetus/es and placenta/s get resorbed by the body with little or no bleeding at all. Small pieces of retained placenta attached to

the uterine wall will continue to produce small amounts of HCG until the tissue is expelled (bleeding) or resorbed.

The continued HCG levels would result in the patient “feeling pregnant”. Additionally, Ms. [redacted] is known to have Polycystic Ovarian syndrome (PCOS) which may result in ovarian cysts, weight gain, breast tenderness and commonly bloating.However, PCOS does not cause false positive pregnancy tests. PCOS and Bloating — PCOS Awareness Association (pcosaa.org)

On 11/14/2023 Ms. [redacted] HCG was negative. Clearly, Ms. [redacted] was pregnant, consistent with a conception date of 5/20/2023. She no longer had a viable pregnancy at some point. When the pregnancy became nonviable is impossible to determine but we know it happened before 10/16/2023.On that date, she had an HCG of only 102 when she would have been 21 weeks from conception.She was informed that this meant she probably had a nonviable pregnancy.

2. Ms. [redacted] quantitative HCG of 102 on 10/16/2023, along with her multiple nonquantitative urine tests would indicate to any reasonable person, that she was pregnant. Coupled with the negative HCG test on 11/14, indicatesthat she was initially pregnant, followed by a typical pattern for an early spontaneous abortion (miscarriage) and once all the HCG producing tissue had been resorbed, the HCG returned to “negative”.

3. Is the HCG verifiable medical evidence of pregnancy? In general, yes. With a certainty of greater than 99%.

    a. In rare situations, HCG may be elevated in patients with germ cell tumors. Clearly, we are not dealing with that.
    b. In other rare cases, HCG can be elevated following a pregnancy and a subsequent trophoblastic tumor. Again, we are not dealing with that in this situation.
    c. Approximately 1% false positive rate. The causes of these include user error (incorrect use of the test -evaporation lines) and use of an expired test. The likelihood of a false positive test on 5 separate occasionsmakes this possibility incredibly unlikely. Some medications have been implicated in giving false positive HCG tests.She was on the same types of medicationswhen her five HCG tests were positive and when the HCG was negative. Additionally, her HCG pattern followed a typical HCG pattern in which there was an early fetal loss followed by weeks and weeks of time passing before complete expulsion or resorption which was documented on 11/14/2023 with a negative test.

4. How reliable and accurate are home urine pregnancy tests. Approximately 99%. (How Early Can You Detect Pregnancy? (clevelandclinic.org)

5. Would it be reasonable for Ms. [redacted] to assume she was pregnant based on the type of sexual contact she had and the lab test results she received? Yes. There was not a description of the foreplay and there was disputed testimony about the after play.It is well known that men are "like basketball players-they dribble before they shoot" which is why the withdrawal method has a muchhigher failure rate than most other methods of birth control. They also dribble after they shoot, so if he did put his penis in or near her vagina after orgasm, she could still get pregnant. The odds of getting pregnant obviously go down if semen is released just outside of the vagina but it is still possible. In fact, I had one patient who was clearly pregnant (ultrasound confirmed), she absolutely denied intercourse, denied even ever using tamponsand stated that she was a virgin. I have heard that story many times. In this case, however, I was shocked at the time of her exam to see that her hymen was intact! That alone would be remarkable enough to remember her but her name was Maria and her due date was within a day or two of Christmas.

6. Is there any information in the records which are inconsistent with Ms. [redacted] being pregnant?
   No. She was clearly pregnant with 99+% certainty based on five HCGs (from both urine and blood). What we are not able to determine from the data is the exact time at which her pregnancy became nonviable.

7. The timing of the SAB/miscarriage. Data are consistent that Ms. [redacted] did indeed get pregnanton 5/20/2023. Sometimes, the SAB is completed with heavy bleeding and passage of tissue. In these cases, the timing of the SAB is relatively precise. In other cases, the SAB is incomplete. The fetus dies or stops developing but there may or may not be bleeding for weeks. A completed SAB is when everything is expelled or reabsorbed. When this happens, the HCG will return to negative.

   In Ms. [redacted] case,the miscarriage or completed SAB was not technically completed until 11/14/2023 when everything was resorbed and her HCG was negative.

   So, even though Ms. [redacted] felt pregnant and the HCGs were positive, unbeknownst to her, the process had started many weeks earlier. The exact timing is unable to be determined by the data available. Abnormal pregnancies frequently have a slower growth rate than normal fetuses and frequently are small for gestational age (SGA) before they expire. So, for example a 9-week fetus may only measure about the size of a 7-8 week size fetus which is about the size of a kidney bean.A 7-week size fetus is just a little bigger than ½ inch. Fetuses this size may simply get resorbed by the body or expelled with little blood loss.

It is possible that she passed one or both fetuses on 7/23/2023. Even if she did pass both, she still felt pregnant because of the positive HCG (pregnancy hormone) and possible PCOS symptoms which can cause weight gain, breast tenderness and bloating. This was confirmed in her mind by her continuing positive pregnancy tests, weight gain and protruding abdomen shown on pictures she took on 9/19/23 and 10/9/23.

Finally, it is illogical to think she would request the Ravgen test in August and have it performed in late September if she didn't think she was pregnant.Ravgen is a noninvasive prenatal test (NIPT) on maternal blood that detects fetal DNA.Based on the fact that this was likely an early pregnancy loss (before 12 weeks), the fetus/es expired before the Ravgen test. Therefore, it's not a surprise that the test was inconclusive and showed "little to no fetal DNA in late September".

8. Ms. [redacted] is not required to file a death certificate. In Arizona, a death certificate is required if the gestational age, at the time of fetal death, occurs after 20 weeks estimated gestational age or weighs more than 350 grams (about ¾ pound). Clearly, the fetal death was before 20 weeks. As I have pointed out the fetal death occurred before 12 weeksand likely several weeks earlier.

Exhibit C

[redacted] LAW OFFICE, PLLC

4802 E. Ray Road #23-271, Phoenix, AZ 85044 • Tel: (480) 264-1400

April 16, 2024

Dr. Michael T. Medchill
[redacted]
Cape Coral, FL 33914

Re: *Record Review & Expert Report*
[redacted] *& Clayton Echard;*
Maricopa County Superior Court Case No. FC2023-052114

Dr. Medchill,

Thank you for agreeing to review the enclosed information regarding my client, [redacted] As discussed, [redacted] has agreed to pay $500/hr. for your professional services in reviewing the enclosed records and answering some questions which will require you to offer an expert opinion in the area of obstetrics/gynecology.

As we discussed, [redacted] is aware you have retired from active practice and that your Arizona medical license is no longer current. Per the Arizona Medical Board website, it appears your most recent license expired on March 7, 2022, just over two years ago.

Your retirement does <u>not</u> preclude you from serving as an expert witness in this matter. If anything, your long career as an OB/GYN means you have even more experience and expertise in the areas we need help understanding. This makes your input that much more valuable. As such, both Laura and I greatly appreciate you taking the time to help.

To make this process as easy as possible, this letter will summarize the facts of the case and will ask you to express opinions about a few things. While the underlying story of this case is complicated, the basic issue we need your help with is very simple — Ms. [redacted] claims she became pregnant on May 20, 2023, and that her pregnancy later ended in miscarriage. The would-be father disputes this. He claims she "faked" the whole thing and that she was never pregnant at all.

The goal here is to try and help the Court determine the truth – did Ms. [redacted] knowingly lie about her pregnancy, or did she file this action in good faith believing that she was pregnant? Due to the unusual posture of the case (i.e., Ms. [redacted] admits she is no longer pregnant), it probably <u>does not matter</u> whether Ms. [redacted] was ever *actually* pregnant. Instead, the Court is being asking to impose monetary sanctions on Ms. [redacted] for filing a <u>frivolous case</u>. In that situation, the key issue is *whether she had any good faith basis to think she was pregnant*, even if that belief later turned out to be wrong.

I. BACKGROUND

To recap the situation, [redacted] is currently involved in a pending paternity case in Maricopa County (which she filed, as the petitioner). Attached is an affidavit from [redacted] that explains the basic facts and details of her story. Included with the affidavit are various medical records to support her story.

For purposes of clarity — [redacted] affidavit does *not* cover every single aspect of the dispute between her and the father. As a matter of necessity and brevity, we have tried to only provide you with the key facts and details that bear on the questions we need your help understanding.

[redacted] claims that on May 20, 2023 she had a brief (one night) sexual relationship with the putative father, Clayton Echard. [redacted] claims she and Mr. Echard had sex (briefly) and that she tested positive for pregnancy 11 days later.

Ms. [redacted] claims she tried to speak with Mr. Echard about the matter, but he was extremely hostile and dismissive. He encouraged her to terminate the pregnancy, and he denied that he could be the father because he claims he did not actually have intercourse with Ms. [redacted]

Ms. [redacted] explored the option of abortion, but ultimately decided not to terminate the pregnancy. After making that decision, she filed the paternity action against Mr. Echard on August 1, 2023. That date is important because one of the key questions here is whether [redacted] had a good faith basis to *think* she was pregnant at the time the action was first filed. As long as [redacted] had a good faith basis to think she was pregnant, she should not face sanctions even if that belief was later proven to be incorrect.

Under the law, people are generally allowed to bring cases without being 100% certain about the facts. A good faith mistake would typically not be sufficient grounds for a court to impose sanctions against a person in Ms. [redacted] position. So, while it would be helpful to know whether Ms. [redacted] was *actually* pregnant on August 1, 2023, the Court will also be looking at what she *believed* on that date, even if later events proved her belief was incorrect.

II. SUMMARY OF FATHER'S POSITION

As indicated in [redacted] affidavit, the putative father, Clayton Echard, claims it is impossible for him to be the father of [redacted] child, assuming she was ever pregnant. Mr. Echard claims this is impossible because he says he and [redacted] never had sexual intercourse. He also suggested [redacted] may have tried to "trap" him by transferring his semen from her mouth (following oral sex) to her vagina. [redacted] denies doing this.

Whether sexual intercourse did or did not occur is a disputed fact which you do not need to resolve. For the purposes of this review, you may simply assume the question of sexual intercourse is disputed and will be resolved by the Court at a later time.

Also, it is probably worth noting Clayton's attorney has made various arguments in support of his request for sanctions. These arguments are *probably* not directly relevant to your task, but they may be helpful for context.

If you are interested in seeing those arguments, I have included a copy of a pleading entitled "Motion for Sanctions Pursuant to Rule 26" filed by Mr. Echard in the case on January 3, 2024.

In this motion, Mr. Echard's lawyer explains why he thinks [redacted] lied about being pregnant. The primary arguments seem to be:

- HCG tests are not "verifiable medical evidence of pregnancy"
- The Ravgen tests suggested "little to no fetal DNA was found", implying that no fetal DNA was ever present
- Clayton claims [redacted] wore a "fake moon bump" prosthetic during a video court appearance ([redacted] flatly denies this and she has provided photos showing her body during the dates in question which are included here)

Incidentally, the Motion for Sanctions is no longer pending; it was withdraw for reasons that are not relevant to your task.

III. QUESTIONS FOR EXPERT EVALUTION

As you may recall from other matters, the rules of procedure generally require expert testimony to include certain specific things showing the expert is qualified to express an opinion on a given subject. In particular, Rule 49(j) of the Arizona Rules of Family Law Procedure requires the following:

> **(j) Disclosure of Expert Witnesses**. Each party must disclose the name, address and telephone number of any person the party expects to call as an expert witness at trial. The party also must disclose the subject matter on which the expert will testify, **the substance of the facts and opinions on which the expert will testify**, **a summary of the grounds for each opinion, the expert's qualifications**, and the name and address of any custodian of reports the expert prepared

With that rule in mind, here are the specific questions we would like you to address in a short written report for the Court (the report should also include a summary of your qualifications, as outlined in the paragraph above):

1.) Based on your review of Ms. [redacted] medical records and her affidavit explaining the facts and details of her interaction with Mr. Echard in May 2023, is there a reasonable probability Ms. [redacted] was, in fact, pregnant at or around the time she filed the paternity action on August 1, 2023?

2.) Keeping in mind that on August 1, 2023, Ms. [redacted] did not know what her HCG levels would be 10 weeks later in mid-October 2023, does the fact that Ms. [redacted] had a lab test on October 16, 2023 which showed HCG levels of 104 demonstrate that Ms. [redacted] was *never* pregnant?

3.) Mr. Echard has taken the position that an HCG test is not "verifiable medical evidence of pregnancy". Do you agree or disagree with this statement?

4.) How reliable and/or accurate are at home pregnancy tests? If a woman takes a test and receives a positive result, does that provide a reasonable basis for the woman to believe that she might be pregnant?

5.) In your opinion, if a woman engaged in sexual activity of the sort described in Ms. [redacted] affidavit, and she had a positive home pregnancy test 11 days later, followed by a positive pregnancy test administered by a reputable health care facility such as Banner Health 12 days later, followed by another positive home pregnancy test a month after the sexual contact, followed by another positive home pregnancy test five weeks after the sexual contact, would it be reasonable for that woman to conclude she was <u>probably pregnant</u>?

6.) Do the medical records attached to Ms. [redacted] affidavit contain any indication that she was *not* pregnant in or around August 2023? In other words, is there any information or evidence in the records which is clearly *inconsistent* with Ms. [redacted] being pregnant during this time period?

7.) **IMPORTANT NOTE**—[redacted] belief has always been that she became pregnant on May 20, 2023 during the encounter with Mr. Echard, and that she miscarried some time <u>after mid-October 2023</u>. That belief was based on the numerous positive pregnancy tests she took between May 31 and October 16. If the miscarriage occurred <u>after or around mid-October</u>, this would be around 21 weeks' gestation. At that stage, it is my understanding the fetus would be approximately 10 inches in length, and a stillbirth or miscarriage would be obvious to the mother — she would clearly see an identifiable

fetus. But [redacted] has always maintained that she did not experience any obvious miscarriage signs after mid-October, nor did she ever see a discharged fetus. This odd situation has caused Clayton's lawyer to question whether [redacted] was ever pregnant at all…simply because parts of the story do not make sense (such as the lack of an obvious, well-developed fetus, the low HCG levels on the October 16 test, and the finding from Ravgen in last September/early October that "little to no fetal DNA was present).

This leads to a very important final question — is it possible that [redacted] may have unknowingly miscarried on July 23, 2023, but continued to test positive for pregnancy several weeks afterwards? Again, her last positive pregnancy test was on October 16, 2023 which showed an HCG level of 104. Based on that, [redacted] previously believed her pregnancy may have continued all the way into October, but after viewing all the facts together, it appears her belief might have been mistaken. It seems entirely plausible that a miscarriage occurred on July 23, but [redacted] was unaware of this until months later.

One of the other reasons Mr. Echard's lawyer asserts the entire pregnancy was fake is because [redacted] claims she continued to show physical signs of pregnancy including a heavily swollen abdomen in September and October 2023. Mr. Echard's lawyer contends if [redacted] was still pregnant in that time period and had a miscarriage around 21-22 weeks, there MUST have been an obvious dead fetus and [redacted] should have been required to file a death certificate.

Thus, the question is **whether it is possible [redacted] miscarried on July 23, 2023, did not realize it, and that her swollen abdomen was simply a result of post-miscarriage inflammation or something similar**? This would explain why she did not pass a large ~10 inch stillborn fetus after mid-October, because the fetus was passed on July 23 when she was less than 8 weeks pregnant.

Any insight you can offer into this would be greatly appreciated.

When addressing these questions, please keep in mind expert testimony may be excluded if it fails to meet the "reliability" requirements of Rule 702 of the Rules of Evidence and case law interpreting those rules such as *Daubert v. Merrell Dow Pharmaceuticals, Inc*., 509 U.S. 579 (1993). In general, the Court will be interested in evaluating your opinions based on the following five factors:

(1) whether the expert's theory or technique can be or has been tested;

(2) whether the theory or technique has been subjected to peer review and publication;
(3) whether the technique or theory is generally accepted within the relevant scientific community;
(4) the known or potential rate of error of the technique or theory when applied; and
(5) the existence and maintenance of standards controlling application of the technique.

State ex rel. Montgomery v. Miller, 234 Ariz. 289, 299 (App. 2014)

Of course, this does not mean you need to provide any lengthy peer-reviewed analysis to support your answers. But if you are aware of any studies or publications which support your opinions, it would be helpful if you could cite them where applicable.

As I mentioned before, our trial in this matter is set for June 10, 2024, and the court has ordered both sides to complete their disclosures (including expert disclosures) no later than 30 days prior to trial; i.e., by May 10, 2024.

Of course, if you have any questions or would like any other information about Ms. [redacted] Mr. Echard, or the case, please do not hesitate to ask and I will be happy to provide you with anything I can. My cell number is (480) 570-6157 and I am available to speak with you at any time.

Very Truly Yours,

[redacted]

[redacted] S. [redacted] Esq.

cc: Client

P.S. After this package of information was finalized, [redacted] realized that we failed to mention one additional detail—[redacted] states around 2014, she was diagnosed with PCOS—polycystic ovary syndrome. [redacted] indicates that she has received care related to that condition, and attached on the follow pages are reports from a pelvic CT scan done by Southwest Medical Imaging in June 2022 – about one year prior to the events which give rise to this case. [redacted] indicates she has had problems with ovarian cysts from time to time, as this report appears confirm.

[redacted] is not sure what impact the PCOS had, if any, on her pregnancy in this case, but she wanted to mention this just in case you found it relevant.

SMIL
SOUTHWEST MEDICAL IMAGING

← **CT** PELVIS WITHOUT CONTRAST

Report

Patient	Acc#	Exam done on	Referred by
[redacted]	[redacted]	June 7, 2022	REILLY, REBECCA

CT PELVIS WITHOUT CONTRAST

HISTORY: Abdominal distention and concern for inguinal hernia

COMPARISON: Ultrasound dated 05/09/2022

TECHNIQUE: No contrast. Coronal and sagittal reformations.

FINDINGS:

No body wall hernias are identified. No inguinal lymphadenopathy is seen.

Moderate to large amounts of stool are seen throughout visualized colon. The rectum is mostly decompressed. No free fluid is identified.

Uterus is present. Bilateral ovarian cysts and follicles are seen with some complex heterogeneous components in the left ovary measuring up to 5.1 cm.

No acute osseous findings.

IMPRESSION:

No inguinal abnormalities or hernia is identified.

Increased colonic stool burden of the pelvis.

Bilateral ovarian follicles with some complexity within the left ovary, likely partially hemorrhagic. No routine follow-up is recommended.

SMIL
SOUTHWEST MEDICAL IMAGING

Southwest Medical Imaging LTD
9700 N. 91st Street
Suite B104
Scottsdale, AZ 85258
www.esmil.com

Patient Name:	[redacted]	**Accession Number:**	[redacted]
Patient ID:	100248536	**Requested Date:**	June 7, 2022 14:15
Gender:	Female	**Report Status:**	Final
Date of Birth:	[redacted]	**Requested Procedure:**	1
Home Phone:	[redacted]	**Procedure Description:**	CT PELVIS WITHOUT CONTRAST
	[redacted]	**Modality:**	CT
Referring Physician:	REILLY, REBECCA		
Organization:	MTV		

Findings

Reporting MD:	ALLEN, JARED
Dictation Time:	June 7, 2022 15:20
Transcriptionist:	Not available
Transcription Date:	

CT PELVIS WITHOUT CONTRAST

HISTORY: Abdominal distention and concern for inguinal hernia

COMPARISON: Ultrasound dated 05/09/2022

TECHNIQUE: No contrast. Coronal and sagittal reformations.

FINDINGS:

No body wall hernias are identified. No inguinal lymphadenopathy is seen.

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Uterus is present. Bilateral ovarian cysts and follicles are seen with some complex heterogeneous components in the left ovary measuring up to 5.1 cm.

No acute osseous findings.

IMPRESSION:

No inguinal abnormalities or hernia is identified.

Increased colonic stool burden of the pelvis.

Bilateral ovarian follicles with some complexity within the left ovary, likely partially hemorrhagic. No routine follow-up is recommended.

Relevant Clinical Information

Patient given discharge information

AFFIDAVIT OF [redacted]

1. My name is [redacted] If called to testify in court, I could and would testify to the following under penalty of perjury based on my own personal knowledge.

2. I am 33 years old. My date of birth is [redacted]. I am not married and I do not have any children. I am 5'5" tall and currently weigh around 91 pounds.

3. I currently reside in Scottsdale, Arizona with my parents.

4. I am the Petitioner in the matter of [redacted] *and Clayton Echard*, Maricopa County Superior Court Case No. FC2023-052114.

5. I first met Clayton Echard in May 2023 when I contacted him about purchasing some real estate investment properties. It is my understanding Clayton is a real estate agent, and I contacted him in that capacity via LinkedIn.com to inquire about some properties.

6. In addition to discussing real estate, Clayton and I flirted with each other and I believed that he was interested in me either romantically or physically. The feeling was mutual.

7. On May 20, 2023, after exchanging some flirty text messages, Clayton invited me to come over to his home in Scottsdale, which I did. Shortly after arriving that evening, Clayton offered me a THC (marijuana) edible "gummy", which I accepted. Clayton also took at least one edible, and he appeared fairly "high" at the time.

8. Clayton and I began kissing while seated on his couch. This eventually led to both of us removing all our clothing. I performed oral sex on Clayton, and he finished in my mouth which I later swallowed. During this time, I clearly told Clayton I did not want to have sexual intercourse with him. Despite this, at one point while on the couch, Clayton inserted his penis inside my vagina for a moment. It was clear to me this was not accidental on his part. In response, I pushed him away and removed his penis from my body.

9. Although Clayton's conduct might fit the technical definition of rape or sexual assault, I did not and do not want to accuse him of any crime, nor do I want him to be criminally prosecuted.

10. After the session on the couch ended, Clayton and I went to his bedroom and slept for several hours. During the night, we woke up and became physical again, and I performed oral sex on him again until he climaxed in my mouth. After we were done, I swallowed the semen and then went to the bathroom.

11. I understand Clayton claims I may have tried to "trap" him by "inseminating myself" – spitting his sperm from my mouth into my hand and then inserting the sperm into my vagina. That is not true. I swallowed both times, and I did not do anything to intentionally inseminate myself.

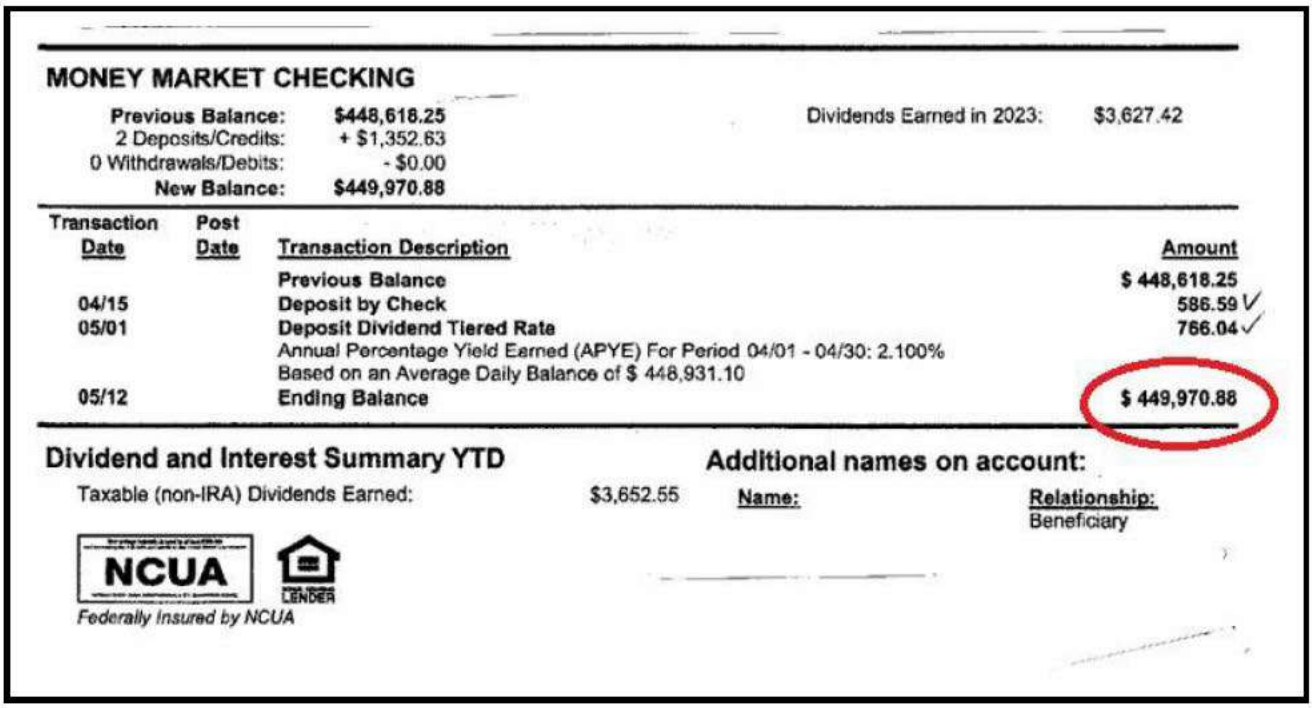
12. If I had wanted to "trap" Clayton, I would have told him I was willing to have sexual intercourse, and it was clear to me he would have accepted that offer. Instead, I told Clayton I did *not* want to have sex because I had no intention of getting pregnant.

13. After the physical activity that took place on the evening of May 20th, Clayton and I viewed some properties in Scottsdale a few days later.

14. After viewing several properties with Clayton, I asked him to prepare written purchase offers for two properties; one was located at 19777 North 67th Street in Scottsdale (offer amount was $425,000) and the other was located at 7609 N. Lynn Oaks Drive in Scottsdale (offer amount was $699,000).

15. As requested, Clayton prepared both offers which I signed on May 24, 2023 and asked him to transmit to the sellers.

16. To demonstrate my offers were serious, I attached proof of funds to the offers which included a current bank statement showing I had almost $450,000 in cash in my checking account, as shown below.



MONEY MARKET CHECKING

Previous Balance:	**$448,618.25**	Dividends Earned in 2023:	$3,627.42
2 Deposits/Credits:	+ $1,352.63		
0 Withdrawals/Debits:	- $0.00		
New Balance:	**$449,970.88**		

Transaction Date	Post Date	Transaction Description	Amount
		Previous Balance	**$ 448,618.25**
04/15		**Deposit by Check**	**586.59** ✓
05/01		**Deposit Dividend Tiered Rate**	**766.04** ✓
		Annual Percentage Yield Earned (APYE) For Period 04/01 - 04/30: 2.100%	
		Based on an Average Daily Balance of $ 448,931.10	
05/12		**Ending Balance**	**$ 449,970.88**

Dividend and Interest Summary YTD

Taxable (non-IRA) Dividends Earned: $3,652.55

Additional names on account:

Name:	Relationship:
	Beneficiary

NCUA LENDER

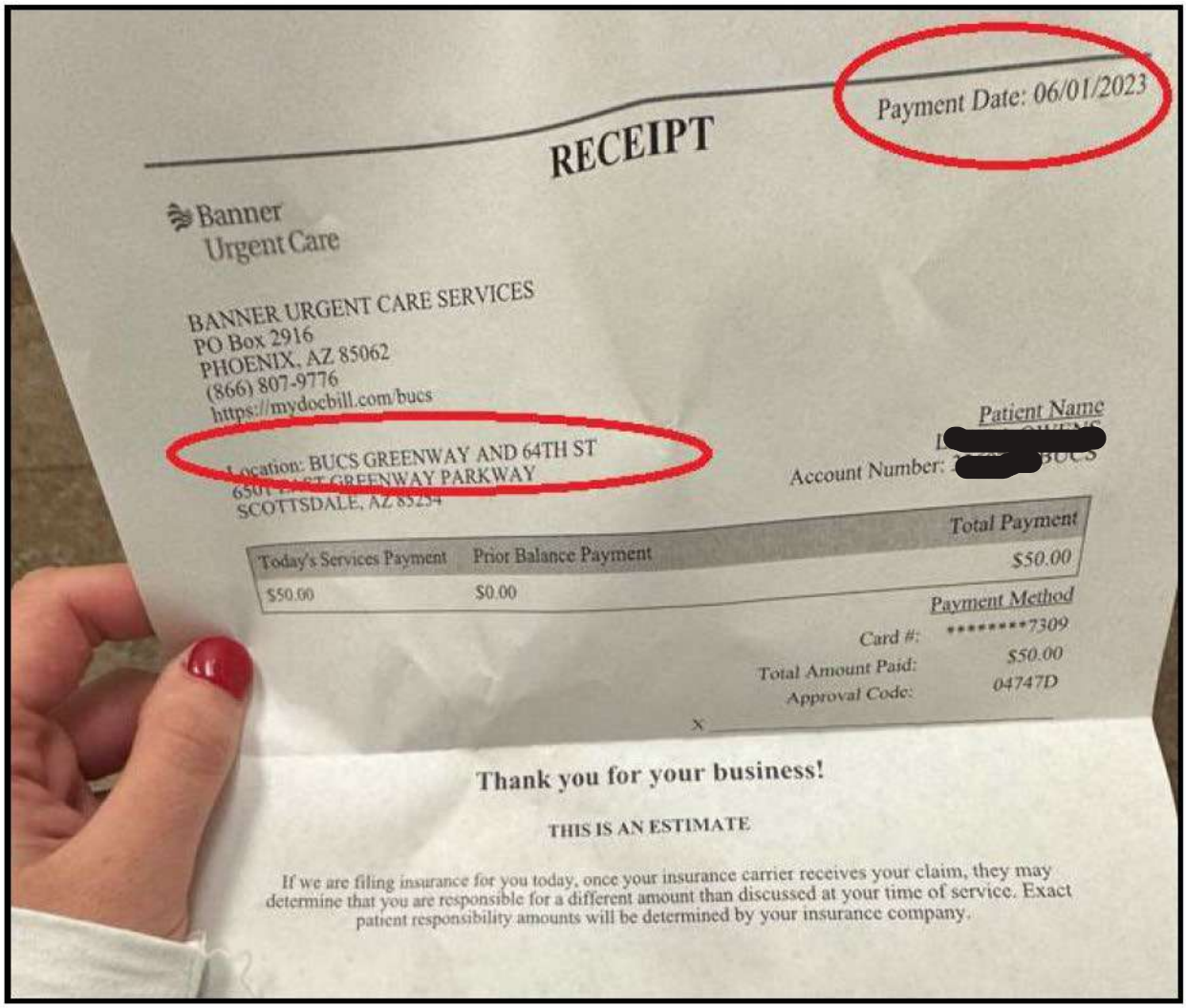
Federally Insured by NCUA

17. Shortly after the offers were signed, Clayton told me he sent them to the sellers or their agents. Several days later, after I did not receive any updates, I asked Clayton whether he had sent the offers and whether he had heard anything back. Clayton's response was that yes, he had sent the offers, and no he had not heard anything back.

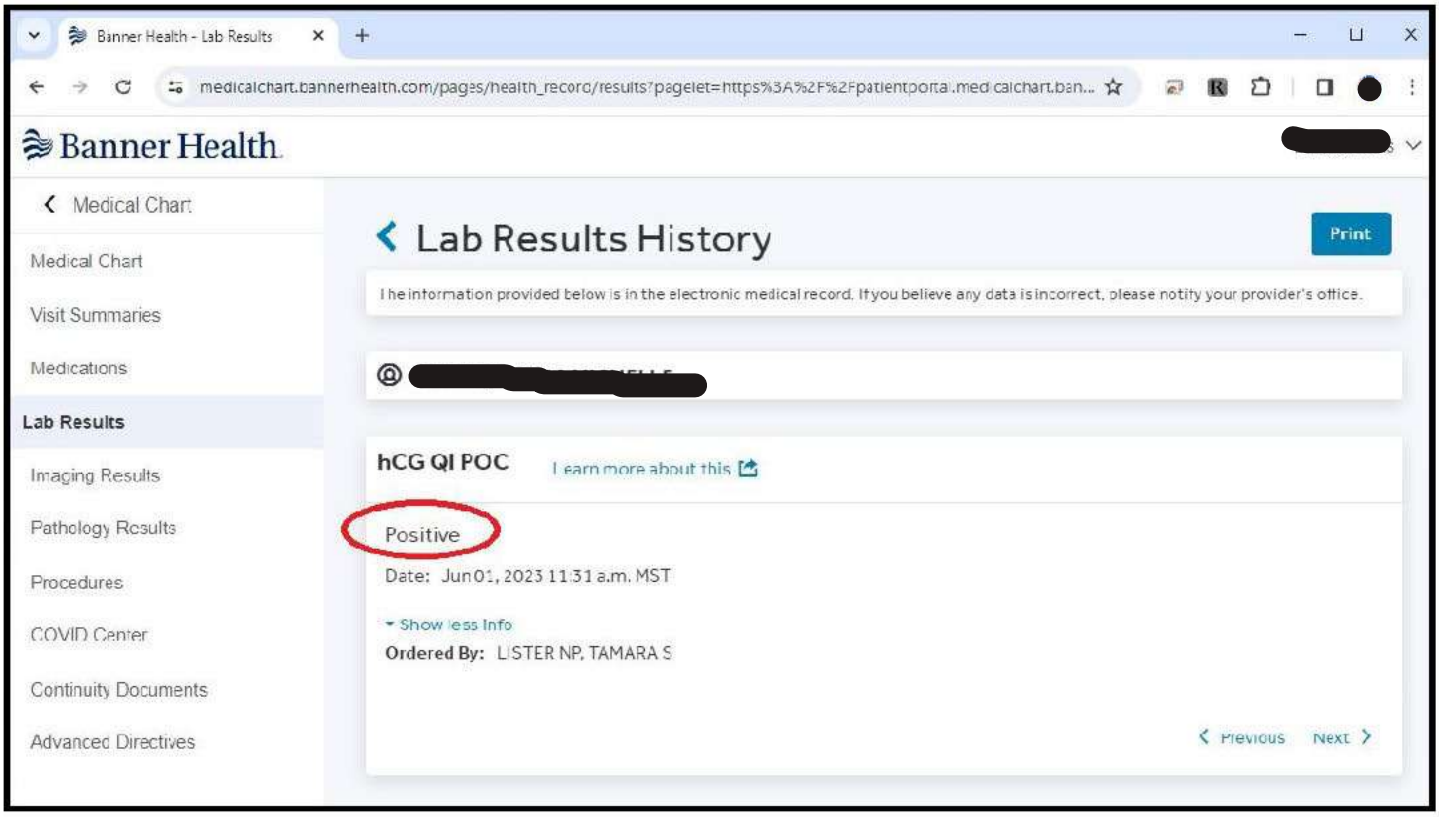
18. I did not know at the time, but later learned, that Clayton lied to me about submitting these offers. He never sent them to the sellers or their agents. As a result, my offers were never considered or accepted by the sellers.

19. On May 31, 2023, I took a home pregnancy test which showed a faint positive result. This caused me to believe I might be pregnant.

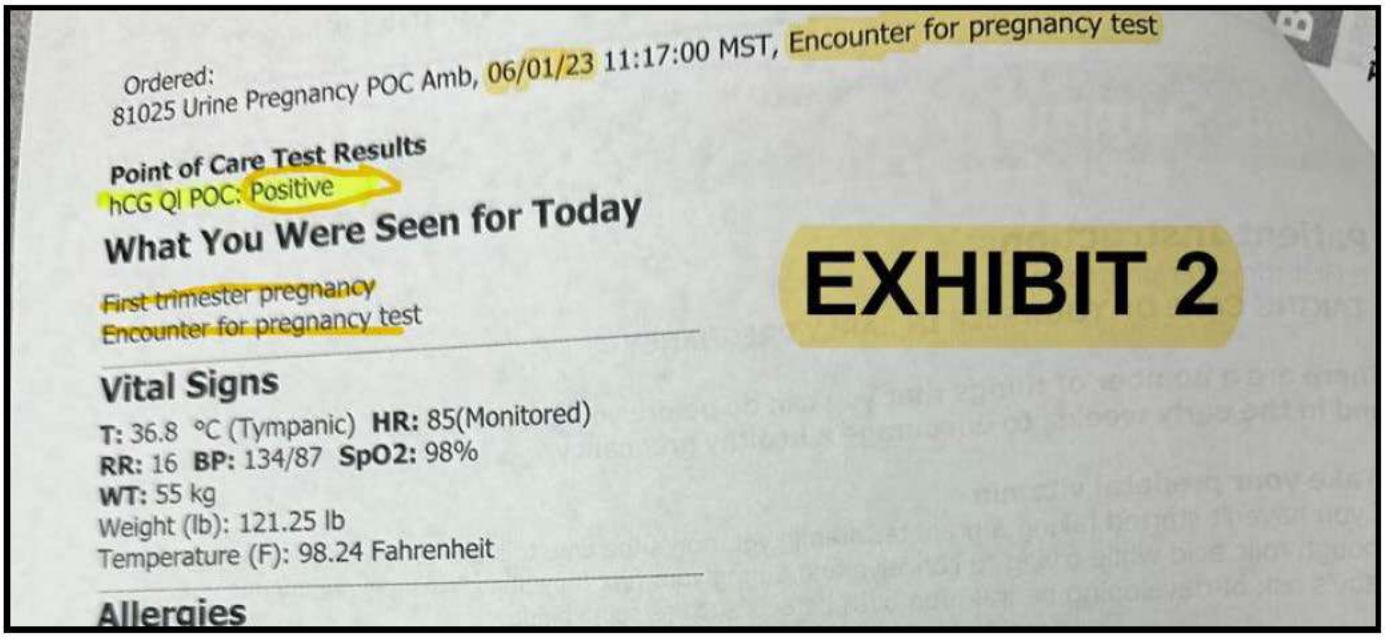
20. To confirm the home test results, on June 1, 2023 I went to my local Banner Urgent Care located at Greenway and 64th Street in Scottsdale. Upon arriving at the location, I informed the nurse I thought I might be pregnant based on the faint line on the home pregnancy test I took the day before. I did not ask the nurse for any specific type of test. I simply told her I wanted to know if I was pregnant.



21. The test results I received from Banner were positive for pregnancy. Those results were (and still are) available in my Banner Health patient portal, as shown below.



22. I also received a printout from Banner with the test results, as shown below.



23. After confirming I was pregnant, I contacted Clayton and tried to discuss the situation with him. I was not sexually active with any other men aside from Clayton around the time of conception, so I firmly believed he must be the father.

24. Clayton was very dismissive and angry. He claimed it was "impossible" for me to be pregnant because he claimed we "never had sex" (even though we did, albeit only briefly).

25. Clayton eventually agreed to meet with me on June 19, 2023 at his home. When I arrived around 7:45 PM, I brought the positive pregnancy tests to show Clayton. He still did not believe I was pregnant.

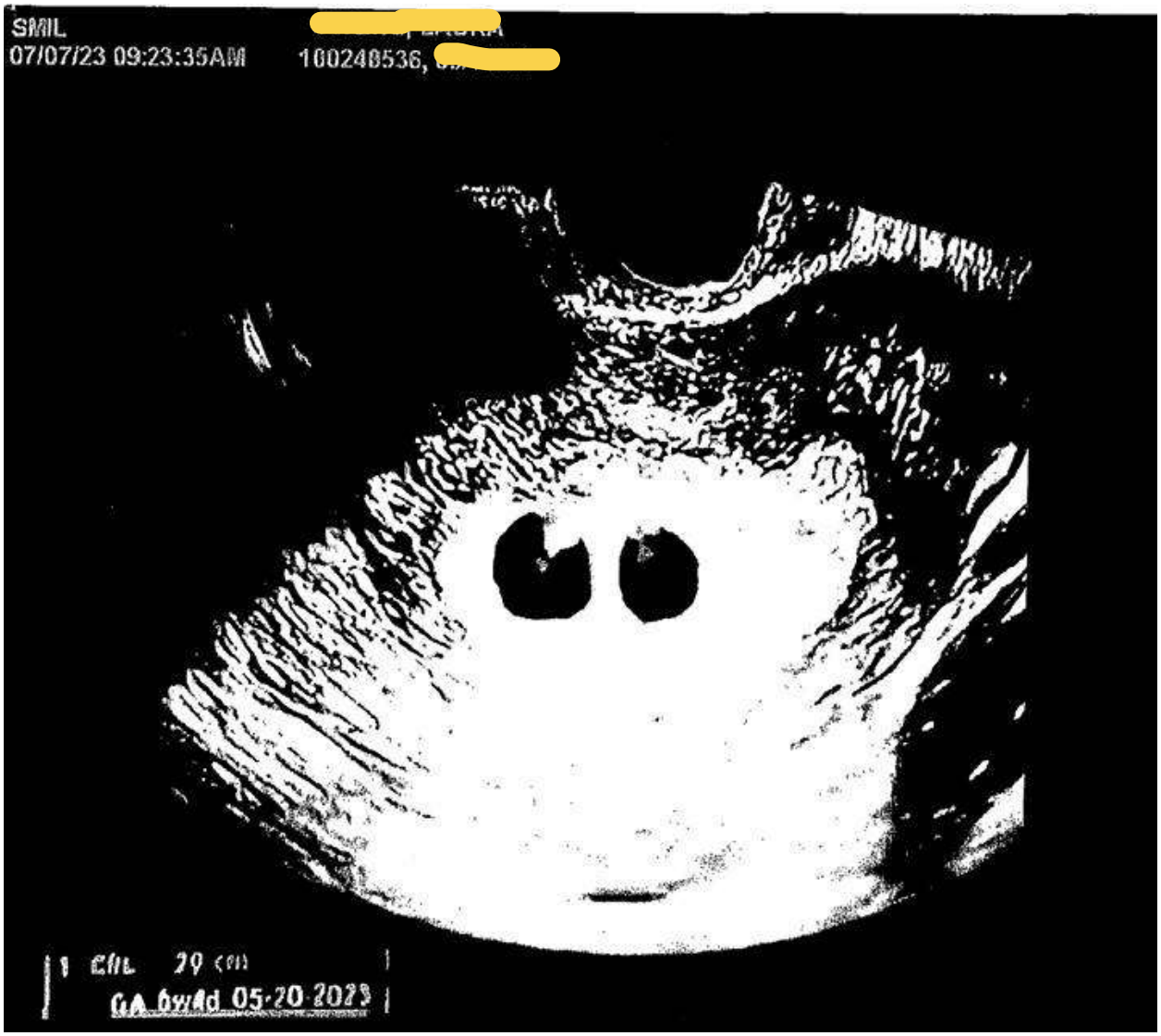
26. Clayton then produced a home pregnancy test he had purchased, and he demanded I take the test in front of him (which meant peeing on a stick). I complied with his request and I took the test directly in front of him, with him watching. I understand Clayton has claimed that I would not allow him to watch me take the test, but that is false – he watched me directly the entire time.

27. The test I took in front of Clayton also showed positive for pregnancy. Despite this Clayton continued to insist that I was not pregnant and that if I was, he was not the father. He later asked me to stop contacting him.

28. On July 2, 2023, while traveling in southern California, I made an appointment with Planned Parenthood for the purpose of obtaining pills to medically terminate the pregnancy. At that time, Clayton had told me that he had no intention of being a father, and that if I decided to carry through with the pregnancy, he would have nothing to do with the child/children. Clayton's attitude and horrible treatment caused me a great deal of stress and anxiety, and I was very close to making a decision to terminate the pregnancy.

29. My mother drove me to the Planned Parenthood location on July 2, 2023, but she did not come into the facility with me. I went into the appointment alone, and I explained my situation to the care provider. As part of my evaluation, the care provider at Planned Parenthood performed a sonogram on me and verified that I was, in fact, pregnant.

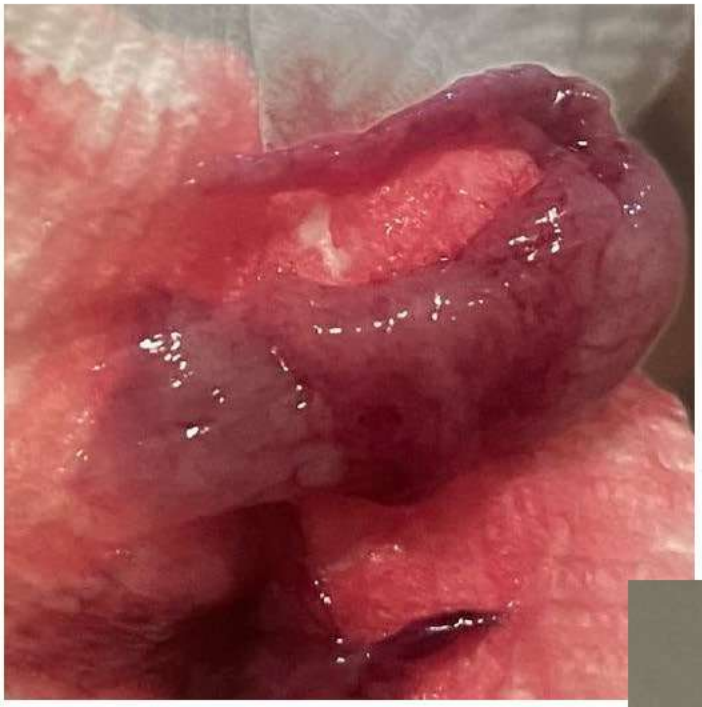
30. I took a photo of the sonogram screen with my phone, but I did not want Clayton to know where I had gone for the appointment. To conceal that information, I modified the image to change the facility name from Planned Parenthood to SMIL (Scottsdale Medical Imaging), and I also changed the date from July 2, 2023 to July 7, 2023. A copy of the modified sonogram image is shown below.

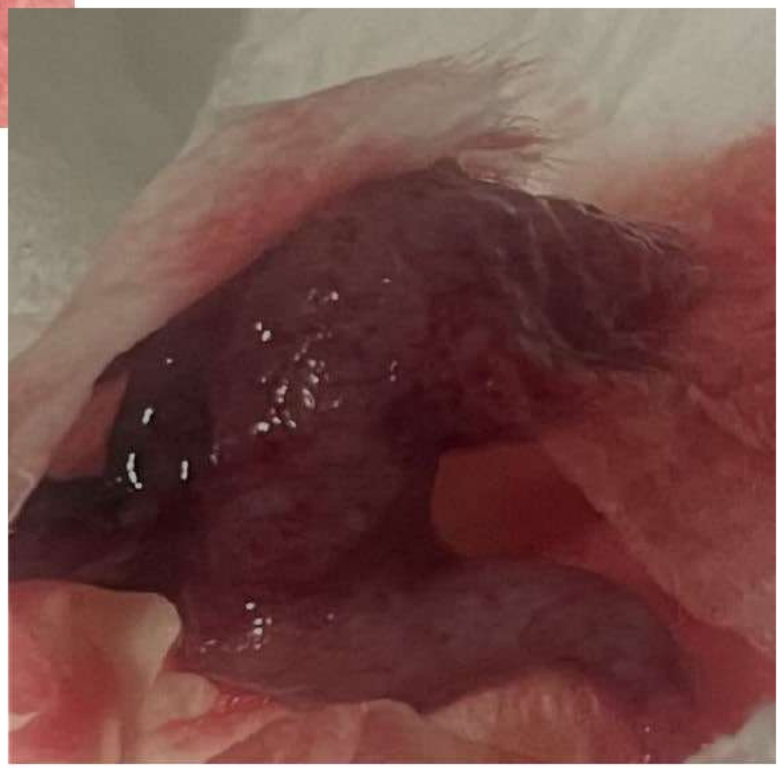


31. Other than changing the top part of the image to alter the facility name and date, I did not change any other part of the image. This image was taken at Planned Parenthood in California on July 2, 2023. I did not find this image online, and I did not take someone else's image and pretend it was mine. I obviously regret doing this, but I made a mistake due to the amount of stress, anxiety and depression I was experiencing.

32. Although I had not made a final decision about terminating the pregnancy, I wanted Planned Parenthood to give me the medication so I could take it home with me and have it available in case I made the decision to terminate. However, Planned Parenthood told me patients were not allowed to leave with abortion pills, so if I wanted to abort the pregnancy, I would have to take the pills while present in their office. Because of this, I left Planned Parenthood without any abortion medication.

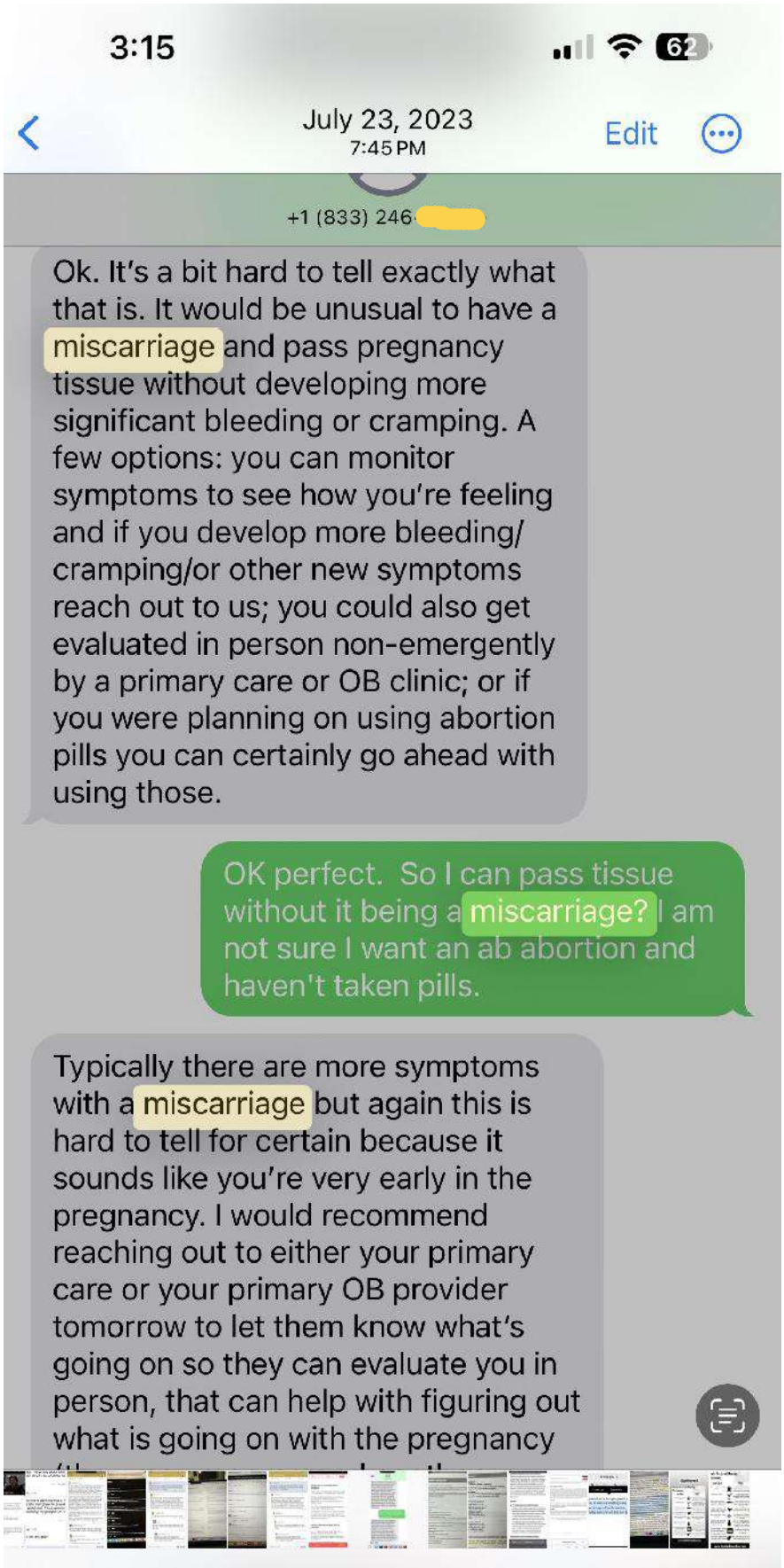
33. Several weeks later, on July 23, 2023, I experienced some bleeding and I passed what appeared to be two small fleshy objects, as shown in the photos below. These objects were very small, no more than an inch or two. Clayton's lawyer repeatedly asked me (later) whether these objects were the "size of your hand". My response was always: "smaller than my hand"





34. Larger versions of these photos, which I took on July 23, 2023, are attached hereto as Exhibit 2.

35. At this time, I did not know if I had miscarried, so I immediately contacted a telehealth provider for guidance, as shown below.

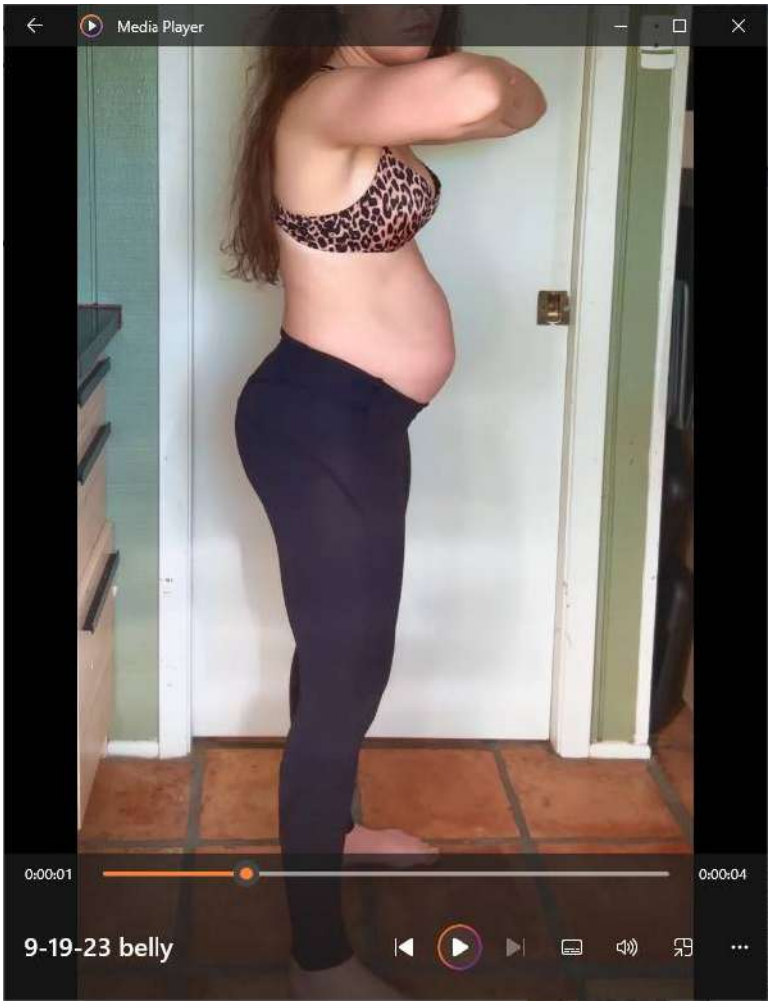


36. Based on my discussions with the telehealth provider, it was unclear whether I had just miscarried, so I decided to wait several days and see if I had any further symptoms. A few days later (around July 25), I took another at home test which continued to show positive for pregnancy.

37. Over the next week, I felt fine and did not experience any further bleeding or other symptoms. On August 1, 2023, I took another home pregnancy test, and that also showed a positive result.

38. Based on my inability to communicate with Clayton about the pregnancy, I filed a paternity petition in court on August 1, 2023. At the time I filed the petition, I believed I was still pregnant and that Clayton was the father.

39. Between August 1 and early October, 2023, I experienced weight gain, especially in my abdomen as shown in the photos below taken on Sept. 19, 2023 and October 9, 2023.



40. On August 15, 2023, I paid $725 to a company called Ravgen Diagnostics for a fetal DNA test. Unfortunately, Clayton refused to submit a sample for testing, so I had to cancel the first test with Ravgen.

41. Later, in late September/early October, both Clayton and I submitted samples to Ravgen for testing. I later received a call from Ravgen stating the initial tests were "inconclusive" because there was "little to no fetal DNA found".

42. As part of my further treatment and evaluation, I had a blood test done on October 16, 2023 which showed an HCG level of 102. It is my understanding that an HCG level this low at this stage of a pregnancy indicates the pregnancy is non-viable.

Report Status FINAL
Route 1006 Ordered by:
Any Lab Test Now Scottsdale
8989 E Via Linda
Suite 111
Scottsdale, AZ 85258

Judy Hunter, MD

Sonora Quest Laboratories
A Subsidiary of Laboratory Sciences of Arizona

Patient Information: [redacted]

Account: 13288
ID/MR#: [redacted]05141990
Patient Lab ID:
64af465705918060c771d791

Collected: 10/16/2023
Received: 10/16/2023 09:02 PM
Reported: 10/17/2023 12:27 AM

Order #: [redacted] / NL93226479
DOB: [redacted] Age: 33Y-5M-2D
Sex: F
Patient Phone:

TEST	RESULTS	REFERENCE RANGES	UNITS	PL
CHEMISTRY				
hCG Quantitative	102 H	≤4	mIU/mL	

hCG Reference Ranges:
Non-pregnant ovulating female: <= 4 mIU/mL
Non-pregnant post menopausal female: <=10 mIU/mL
Male: <= 2 mIU/mL

This hCG Electrochemiluminescent immunoassay was performed using Roche Elecsys reagents. This assay is a total beta subunit assay. It measures intact, nicked, free beta, and nicked free beta hCG. Rebaselining may be necessary when using another assay.

Tests Ordered: hCG Quantitative

43. A month later, on November 14, 2023, I had a gynecological visit with a provider at MomDoc. At that time, I was given two separate pregnancy tests, with both showing a negative result. Records from this visit are attached as Exhibit 6.

44. To be clear — Clayton claims I "faked" this pregnancy and I was never pregnant. That is absolutely false. I believe that I was pregnant, and that the pregnancy ended with a miscarriage. I know that I was not sexually active with any men other than Clayton during the period in which conception occurred, so I believe Clayton was the father.

45. I am aware Clayton has claimed I may have taken some sort of drugs or hormones in an attempt to create a false positive on the pregnancy tests I took. Again, that is completely false. I did not take any drugs, hormones, nor did I do anything to manipulate my HCG levels (I do not even know what HCG levels are, other than that they are something medical professionals use to determine if a woman is pregnant).

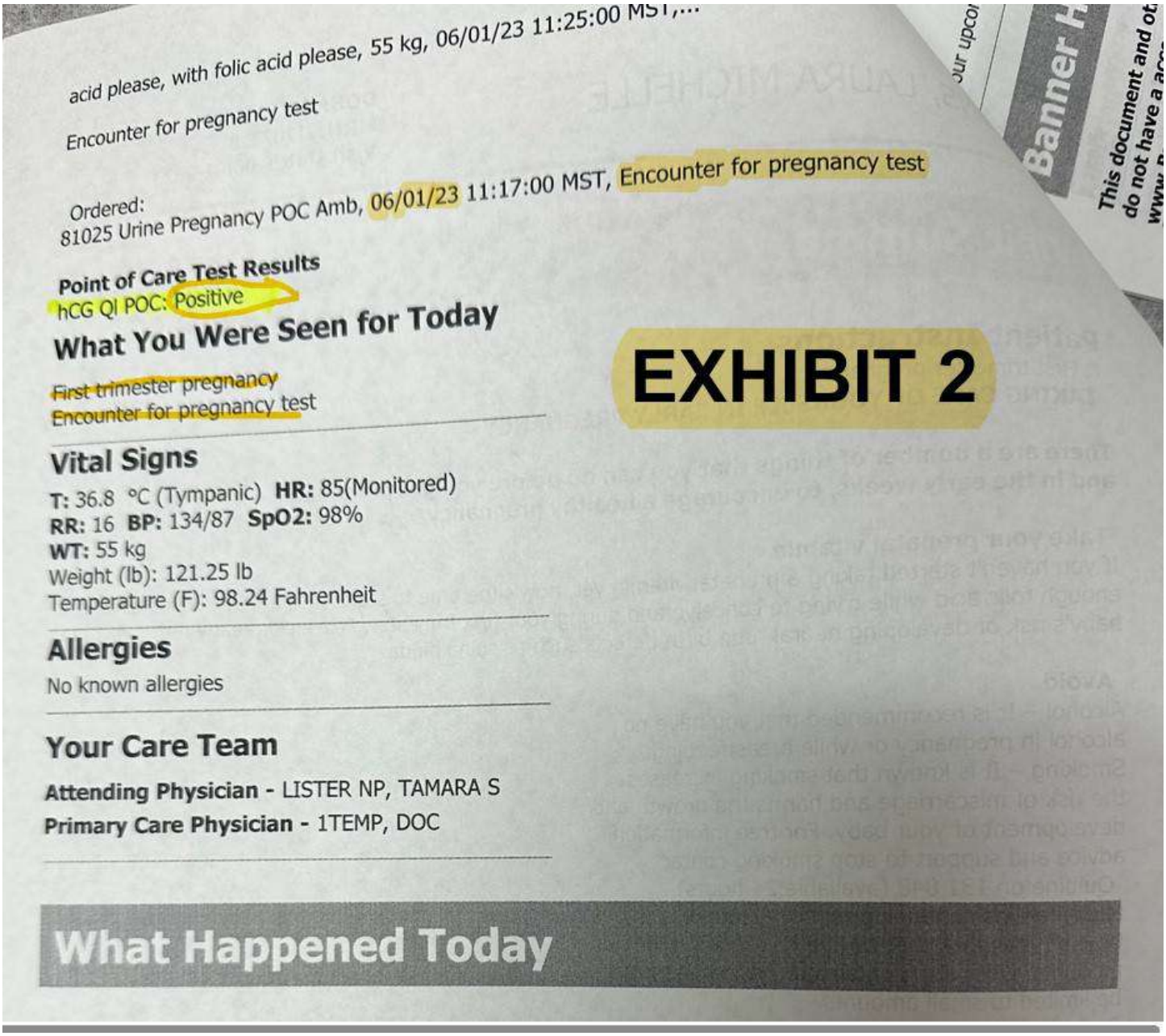
I, [redacted] do hereby swear or affirm under penalty of perjury that I am the Petitioner in the above-styled matter; that I have read the foregoing document and know the contents thereof, and the contents are true of my own knowledge and belief.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United State of America that the foregoing is true and correct.

Executed on April 16, 2024

INDEX OF EXHIBITS		
Exhibit	**Description**	**Date**
1	Pregnancy Test at Banner Health	June 1, 2023
2	Images of Tissue Discharged	July 23, 2023
3	Barrow (Zieman) Visit Summary	October 11, 2023
4	Barrow Epilepsy Pregnancy Specialist Appt.	October 17, 2023
5	HCG test – Sonora Quest	October 17, 2023
6	MomDoc Records	November 14, 2023

EXHIBIT 1



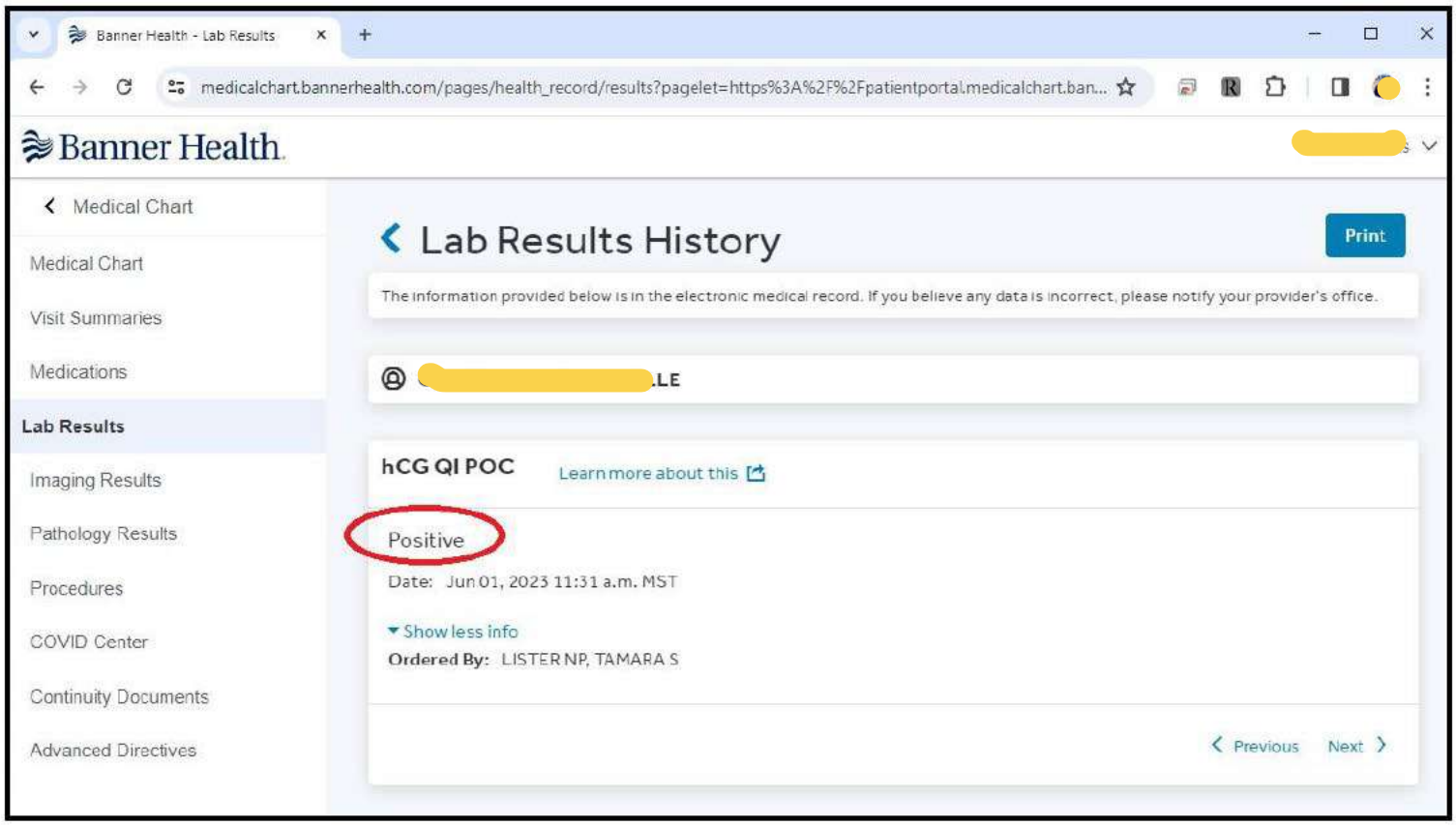
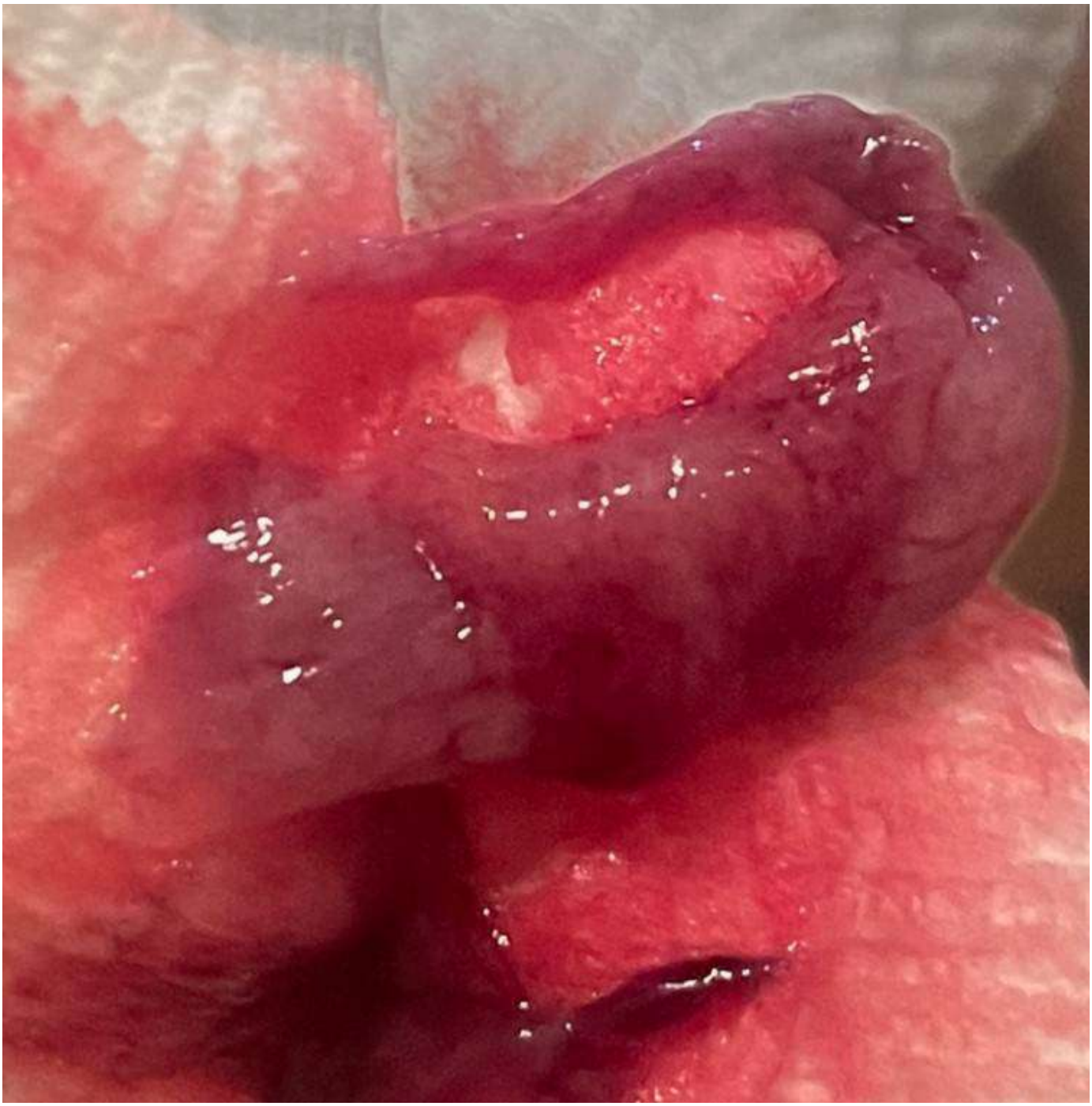


EXHIBIT 2



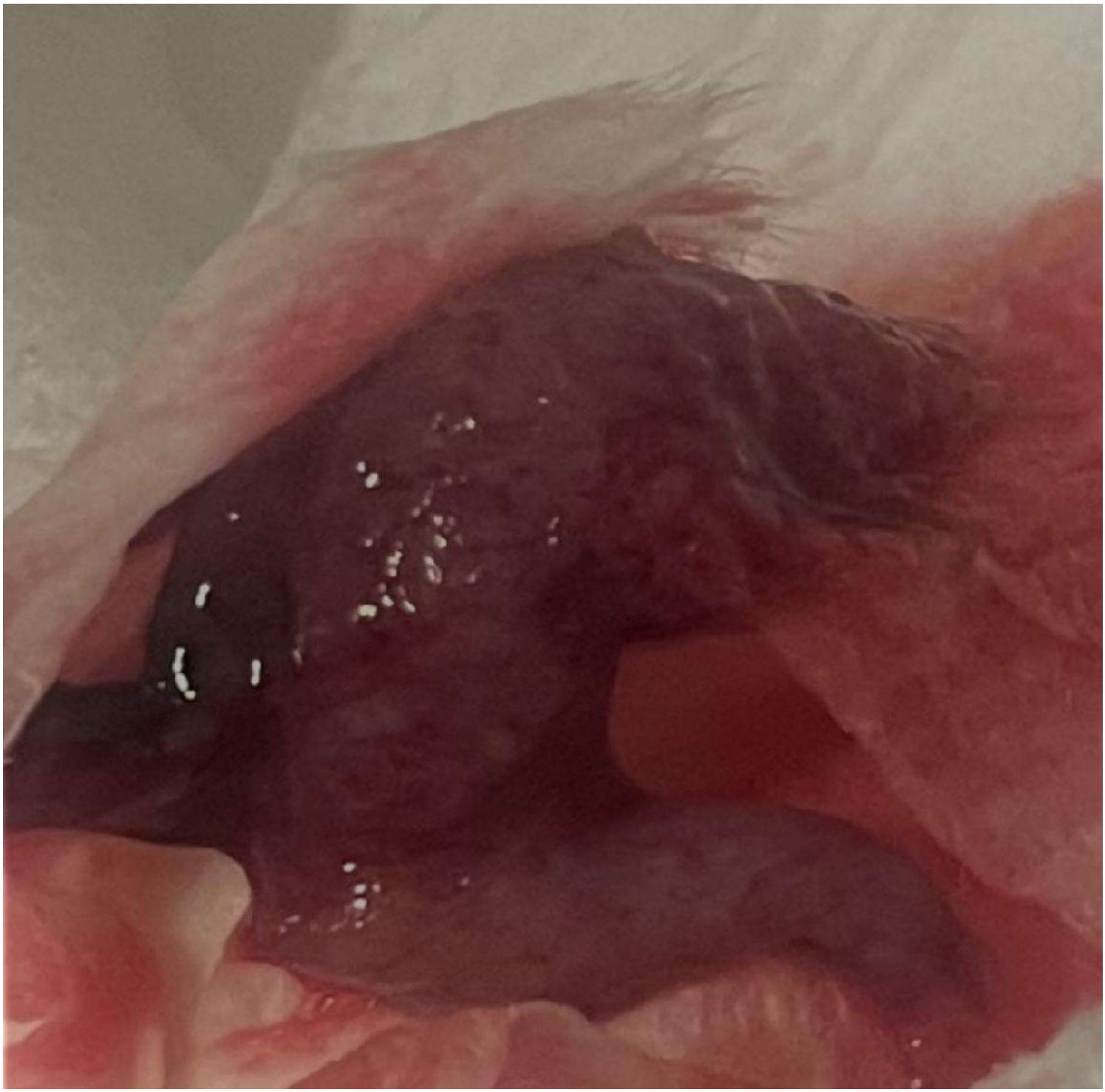


EXHIBIT 3

[redacted] [redacted] [redacted] Admin Sex: **Female** DOB: [redacted]

Continuity of Care Document

Summarization of Episode Note | 10/17/2023 to 10/17/2023

Source: Barrow Epilepsy

Created: 12/30/2023

Demographics

Contact Information:

[redacted]

Tel: [redacted]ork)

Tel: ([redacted]mary Home)

Email: [redacted]

Previous Address(es):

--

Marital Status: Unknown

Religion: Not Specified

Race: Multi Racial/Other

Previous Name(s):

[redacted]

Ethnic Group: Not Hispanic or Latino

Language: English

ID: URN:CERNER:IDENTITY-FEDERATION:REALM:99FAC598-D72A-4299-90B8-DD712E6433B2:PRINCIPAL:71A1ED68-7DFA-4721-95D4-BFE523C12738, 9489886, 9489886, 417D83E1-5BF0-4C7D-BE7A-0F5EB36B3FAB

Care Team

Type	Name	Represented Organization	Address	Phone
primary care physician	PCP, None per patient	--	--	--

Relationships

No Data to Display

Document Details

Source Contact Info

240 W Thomas RdSuite 403(602) 406-6686, Phoenix, AZ 85013- , US

Tel: (602)4[redacted]

Author Contact Info

12/30/2023 3:24 PM

Barrow Epilepsy

Recipient Contact Info

--

Healthcare Professionals

No Data to Display

IDs & Code Type Data

Document Type ID: 2.16.840.1.113883.1.3 : POCD_HD000040

Document Template ID: 2.16.840.1.113883.10.20.22.1.1 : --, 2.16.840.1.113883.10.20.22.1.1 : 2015-08-01, 2.16.840.1.113883.10.20.22.1.2 : 2015-08-01

Document ID: 2.16.840.1.113883.3.2828.7.43.999362 : 1277906541

Document Type Code: 2.16.840.1.113883.6.1, 34133-9

Document Language Code: en-US

Document Set ID: --

Document Version Number: --

Primary Encounter

Encounter Information

Registration Date: 10/17/2023

Discharge Date: 10/17/2023

Visit ID: --

Location Information

Barrow Epilepsy

(Work): 240 W Thomas RdSuite 403, Phoenix, AZ 85013- , US

Providers

Type	Name	Address	Phone
Attending	Chen, Stephanie C FNP	(Work): 240 W Thomas RdSuite 403, Phoenix, AZ 85013- , US	Tel: (602)406- (Work)

Encounter

AZSACLIN_FIN 51655557 Date(s): 10/17/23 - 10/17/23

Barrow Epilepsy 240 W Thomas Rd Suite 403 Phoenix, AZ 85013- US (602) 406-6262

Encounter Diagnosis

Epilepsy (Discharge Diagnosis) - 10/17/23
Pregnant (Discharge Diagnosis) - 10/17/23
Generalized epilepsy (Discharge Diagnosis) - 10/17/23
Traumatic brain injury (Discharge Diagnosis) - 10/17/23
Myoclonic jerking (Discharge Diagnosis) - 10/17/23
Discharge Disposition: Cerner Auto Discharge
Attending Physician: Chen, Stephanie C FNP

Author: Barrow Epilepsy
Last Modified: 10/25/2023 5:45 AM

Reason for Visit

FU PREGNANCY;FU PREGNANCY

Allergies, Adverse Reactions, Alerts

No Known Medication Allergies
Author: Perez, Evelyn, Barrow Concussion & Brain Injury Center
Last Modified: 02/8/2023 9:58 PM

Assessment and Plan

Extracted from:

Title: Office Visit Note: Neurology BNI	**Author:** Chen, Stephanie C FNP	**Date:** 10/17/23		

Ms. [redacted] is a 33 year old female with a history of TBI, epilepsy, depression and ADHD (not currently on ADHD meds during pregnancy) who is here to establish care with Epilepsy Clinic today. She is currently 22 weeks pregnant with twins (boy/girl). We will check a lamotrigine level, no baseline level available for comparison. Based off LTG level, we will adjust her LTG (if needed). Her first seizure was in May 2017. She had 3 seizures in May 2017 which have not recurred since she started lamotrigine. She was told she had generalized epilepsy in 2020 via a routine EEG with a neurologist in San Francisco. We discussed how generalized epilepsies are usually not associated with TBI and that focal epilepsies are usually more associated with TBI. We will repeat a EEG at BNI. Brain MRI in May 2023 was normal. She does have daily body jerks which she calls "myoclonic jerks" and symptoms she calls "vocal tics." These have increased recently. Today we discussed the following regarding pregnancy and epilepsy: - Continue prenatal vitamin and folic acid 4 mg - We recommended breastfeeding - She will get monthly AED levels and we will follow-up by phone.	Chen, Stephanie C FNP Barrow Epilepsy	10/17/2023 9:02 PM

- Call us when she enters hospital to deliver so we can follow AED levels after delivery

Plan:
1. Continue lamotrigine ER 300 mg for now.
2. Check LTG level tomorrow and monthly after then. I will f/u via the portal with any LTG dose adjustments.
3. Routine EEG ordered.
4. Continue PNV and folic acid.

5. AZ driving laws discussed- she is currently driving.
6. RTC in 2-3 mos, before she delivers.

A total time of 62 minutes was spent for this patient's visit. 12 minutes were on the day of the patient's visit reviewing past notes, interval notes, imaging, and labs. 35 minutes were spent with the patient collecting history, consulting, and formulating a care plan. 15 min was spent documenting and coordinating care after the visit.

Informed Consent: The risks, benefits, and alternatives to the virtual/video visit were explained to the patient and the patient consented to this modality of care. The telemedicine visit was performed via real time synchronous video and audio, using Zoom Video Communications, with the originating site at the patient's home and the distant site at Stephanie Chen's office. Verbal consent to participate in video visit was obtained. No technical issues occurred during the call.

I discussed with the patient the nature of our telemedicine visits, that:
* I would evaluate the patient and recommend diagnostics and treatments based on my assessment.
* Our sessions are not being recorded and that personal health information is protected.
* Our team would provide follow up care in person if/when the patient needs it.
Members of care team present at visit include: Stephanie Chen, NP

PATIENT LOCATION: Patient's residence
PROVIDER LOCATION: Provider's office
PATIENT INFORMED OF TREATING MEDICAL GROUP: Yes
VISIT TYPE: SECURED INTERACTIVE REAL TIME VIDEO
DATE OF SERVICE: 10/17/2023

Future Appointments

Appointment Date: 02/19/2024 09:00:00 AM

Scheduled Provider: Zieman, Glynnis MD

Location: CL BR CB IC

Appointment Type: OPC Telehealth Visit PCA

Diagnostic Tests Pending

Lamotrigine Level-AMB 10/17/23

Lamotrigine Level-AMB 10/18/23

Lamotrigine Level-AMB 11/17/23

Lamotrigine Level-AMB 12/17/23

Lamotrigine Level-AMB 1/17/24

Future Scheduled Tests

Laboratory:

Lamotrigine Level-AMB 2/17/24
Author: Chen, Stephanie C FNP, CommonSpirit
Last Modified: 10/17/2023 8:42 PM

Lamotrigine Level-AMB 3/17/24
Author: Chen, Stephanie C FNP, CommonSpirit
Last Modified: 10/17/2023 8:42 PM

Lamotrigine Level-AMB 4/17/24
Author: Chen, Stephanie C FNP, CommonSpirit
Last Modified: 10/17/2023 8:42 PM

Lamotrigine Level-AMB 5/17/24
Author: Chen, Stephanie C FNP, CommonSpirit
Last Modified: 10/17/2023 8:42 PM

Lamotrigine Level-AMB 6/17/24
Author: Chen, Stephanie C FNP, CommonSpirit
Last Modified: 10/17/2023 8:42 PM

Lamotrigine Level-AMB 7/17/24
Author: Chen, Stephanie C FNP, CommonSpirit
Last Modified: 10/17/2023 8:42 PM

Radiology:

MR TMJ Uni or Bil 5/30/23
Author: Zieman, Glynnis MD, CommonSpirit

Last Modified: 05/31/2023 5:45 AM

Referral:

Referral to Physical Therapy 2/9/23
Author: Zieman, Glynnis MD, CommonSpirit
Last Modified: 02/9/2023 5:41 PM

Referral to Psychiatric 2/9/23
Author: Zieman, Glynnis MD, CommonSpirit
Last Modified: 02/9/2023 5:41 PM

Referral to Speech Therapy 2/9/23
Author: Zieman, Glynnis MD, CommonSpirit
Last Modified: 02/9/2023 5:41 PM

Immunizations

No data available for this section

Medications

busPIRone (busPIRone 10 mg oral tablet) Status: Ordered Start Date: 11/29/23 1 tab(s) By mouth twice daily.		
dextroamphetamine (dextroamphetamine 10 mg oral tablet) Status: Ordered Start Date: 2/8/23 TAKE 3 TABLETS BY MOUTH TWICE DAILY.		
DULoxetine (DULoxetine 20 mg oral delayed release capsule) Status: Ordered Start Date: 11/29/23 2 pills daily for 1 week, then 1 pill daily for 1 week, then stop. Refills: 0. Ordering provider: Zieman, Glynnis MD	**CVS/pharmacy #9210** 10653 N Scottsdale Rd Scottsdale, AZ 852545263	
folic acid (folic acid 1 mg oral tablet) Status: Ordered Start Date: 11/29/23 1 tab(s) By mouth once daily. Refills: 5. Ordering provider: Zieman, Glynnis MD	**CVS/pharmacy #9210** 10653 N Scottsdale Rd Scottsdale, AZ 852545263	
lamoTRIgine (lamoTRIgine 100 mg oral tablet, extended release) Status: Ordered Start Date: 10/11/23 1 tab(s) By mouth once daily. take with 300mg ER tablet (total 400mg/day). Refills: 5. Ordering provider: Zieman, Glynnis MD	**CVS/pharmacy #9210** 10653 N Scottsdale Rd Scottsdale, AZ 852545263	
lamoTRIgine (lamoTRIgine 300 mg oral tablet, extended release) Status: Ordered Start Date: 10/11/23 1 tab(s) By mouth once daily. TAKE 1 TABLET BY MOUTH DAILY. Refills: 5. Ordering provider: Zieman, Glynnis MD	**CVS/pharmacy #9210** 10653 N Scottsdale Rd Scottsdale, AZ 852545263	

sertraline (sertraline 25 mg oral tablet) Status: Ordered Start Date: 11/30/23 1 tab(s) By mouth once daily. Refills: 5. Ordering provider: Zieman, Glynnis MD	**CVS/pharmacy #9210** 10653 N Scottsdale Rd Scottsdale, AZ 852545263	
sertraline (sertraline 25 mg oral tablet) Status: Ordered Start Date: 11/29/23 1 tab(s) By mouth once daily. Refills: 3. Ordering provider: Zieman, Glynnis MD	**CVS/pharmacy #9210** 10653 N Scottsdale Rd Scottsdale, AZ 852545263	

Problem List

Condition	Confirmation	Course	Effective Dates	Status	Health Status	Informant	Author	Last Modified
ADHD - Attention deficit disorder with hyperactivity	Confirmed			Resolved			Zieman, Glynnis MD Barrow Concussion & Brain Injury Center	02/9/2023 5:30 PM
Depression	Confirmed			Resolved			Zieman, Glynnis MD Barrow Concussion & Brain Injury Center	02/9/2023 5:30 PM
Depression	Confirmed			Active			Zieman, Glynnis MD Barrow Concussion & Brain Injury Center	02/9/2023 5:30 PM
Domestic violence	Confirmed			Resolved			Zieman, Glynnis MD Barrow Concussion & Brain Injury Center	02/9/2023 5:30 PM
Epilepsy	Confirmed			Resolved			Zieman, Glynnis MD Barrow Concussion & Brain Injury Center	02/9/2023 5:30 PM

Condition	Confirmation	Course	Effective Dates	Status	Health Status	Informant	Author	Last Modified
History of domestic violence	Confirmed			Active			Zieman, Glynnis MD Barrow Concussion & Brain Injury Center	02/9/2023 5:30 PM

Procedures

Procedure	Date	Related Diagnosis	Body Site	Status	Author	Last Modified
Endoscopy [1]				Completed	Zieman, Glynnis MD Barrow Concussion & Brain Injury Center	02/9/2023 5:30 PM
Foot [2]				Completed	Zieman, Glynnis MD Barrow Concussion & Brain Injury Center	02/9/2023 5:30 PM
Umbilical hernia				Completed	Zieman, Glynnis MD Barrow Concussion & Brain Injury Center	02/9/2023 5:30 PM

[1] 2016

Author: Zieman, Glynnis MD, Barrow Concussion & Brain Injury Center

Last Modified: 02/9/2023 5:30 PM

[2] x2

Author: Zieman, Glynnis MD, Barrow Concussion & Brain Injury Center

Last Modified: 02/9/2023 5:30 PM

Results

No data available for this section

Vital Signs

10/17/23

Sensory Deficits	None		Dominguez, Alina MA Barrow Epilepsy	10/17/2023 8:07 PM

Social History

Social History Type	Response	Author	Last Modified
Smoking Status	Never (less than 100 in lifetime) entered on: 10/17/23	Dominguez, Alina MA Barrow Epilepsy	10/17/2023 8:05 PM
Birth Sex		CommonSpirit	12/28/2023 4:45 PM

Goals

No data available for this section

Hospital Discharge Instructions

No data available for this section

Reason for Referral

No data available for this section

Health Concerns

No data available for this section

Implantable Device List

No data available for this section

Clinical Note

No data available for this section

Patient Care team information

Care Team Personnel
Author: CommonSpirit
Last Modified: 05/30/2023 3:58 PM
Name: PCP, None per patient
Member Role: Lifetime Physician(PCP)
Author: CommonSpirit
Last Modified: 05/30/2023 3:58 PM

Care Team Related Persons
Author: CommonSpirit
Last Modified: 05/30/2023 3:58 PM
Name: [redacted] JAN
Author: CommonSpirit
Last Modified: 05/30/2023 5:28 PM

Family History

No data available for this section

EXHIBIT 4

[redacted] [redacted] **MICHELLE** Admin Sex: **Female** DOB: [redacted]

Continuity of Care Document

Summarization of Episode Note | 10/11/2023 to 10/11/2023

Source: Barrow Concussion & Brain Injury Center

Created: 12/30/2023

Demographics

Contact Information:

[redacted]

Tel[redacted]

Tel[redacted] (Primary Home)

Email: [redacted]

Previous Address(es):

--

Marital Status: Unknown

Religion: Not Specified

Race: Multi Racial/Other

Previous Name(s):

[redacted]

Ethnic Group: Not Hispanic or Latino

Language: English

ID: URN:CERNER:IDENTITY-FEDERATION:REALM:99FAC598-D72A-4299-90B8-DD712E6433B2:PRINCIPAL:71A1ED68-7DFA-4721-95D4-BFE523C12738, 9489886, 9489886, 417D83E1-5BF0-4C7D-BE7A-0F5EB36B3FAB

Care Team

Type	Name	Represented Organization	Address	Phone
primary care physician	PCP, None per patient	--	--	--

Relationships

No Data to Display

Document Details

Source Contact Info

222 W Thomas RdSuite 304(602) 406-3810, Phoenix, AZ 85013- , US

Tel: (602)406[redacted]

Author Contact Info

12/30/2023 3:24 PM

Barrow Concussion & Brain Injury Center

Recipient Contact Info

--

Healthcare Professionals

No Data to Display

IDs & Code Type Data

Document Type ID: 2.16.840.1.113883.1.3 : POCD_HD000040

Document Template ID: 2.16.840.1.113883.10.20.22.1.1 : --, 2.16.840.1.113883.10.20.22.1.1 : 2015-08-01, 2.16.840.1.113883.10.20.22.1.2 : 2015-08-01

Document ID: 2.16.840.1.113883.3.2828.7.40.999362 : 1277986955

Document Type Code: 2.16.840.1.113883.6.1, 34133-9

Document Language Code: en-US

Document Set ID: --

Document Version Number: --

Primary Encounter

Encounter Information

Registration Date: 10/11/2023

Discharge Date: 10/11/2023

Visit ID: --

Location Information

Barrow Concussion & Brain Injury Center

(Work): 222 W Thomas RdSuite 304, Phoenix, AZ 85013- , US

Providers

Type	Name	Address	Phone
Attending	Zieman, Glynnis MD	(Work): 222 W Thomas RdSuite 304, Phoenix, AZ 85013- , US	Tel: (602)406-4323 (Work)

Encounter

AZSACLIN_FIN 49818786 Date(s): 10/11/23 - 10/11/23

Barrow Concussion & Brain Injury Center 222 W Thomas Rd Suite 304 Phoenix, AZ 85013- US (602) 406-4323

Encounter Diagnosis

Migraine (Discharge Diagnosis) - 10/11/23

Jaw pain (Discharge Diagnosis) - 10/11/23

Mood disorder as late effect of traumatic brain injury (Discharge Diagnosis) - 10/11/23

Epilepsy during pregnancy (Discharge Diagnosis) - 6/14/23

Late effect of traumatic injury to brain (Discharge Diagnosis) - 10/11/23

Discharge Disposition: Cerner Auto Discharge

Attending Physician: Zieman, Glynnis MD

Author: Barrow Concussion & Brain Injury Center

Last Modified: 10/19/2023 5:41 AM

Reason for Visit

DV FU;DV FU

Allergies, Adverse Reactions, Alerts

No Known Medication Allergies

Author: Perez, Evelyn, Barrow Concussion & Brain Injury Center

Last Modified: 02/8/2023 9:58 PM

Assessment and Plan

Extracted from:

Title: Brain Injury & Sports Neurology Center - FU	**Author:** Zieman, Glynnis MD	**Date:** 10/11/23		

Radiologic Interpretation Outpatient EEG performed March 9, 2020 (St. Mary's Medical Center, San Francisco, CA) was abnormal due to intermittent generalized sharp and slow wave discharges occurring in runs from 1-3 seconds. MRI brain without contrast performed May 30, 2023 (SJHMC) was normal. CT maxillofacial performed May 30, 2023 (SJHMC) revealed n o acute facial bone fracture. Asymmetric anterior orientation of the left mandibular condyle relative to the glenoid fossa as well as mild leftward positioning of the maxilla relative to the mandible. Findings are nonspecific may be positional versus related to soft tissue injury. MRI of the TMJ may be of benefit to better assess for any discal or ligamentous injury.	Zieman, Glynnis MD Barrow Concussion & Brain Injury Center	10/11/2023 5:54 PM

Assessment/Plan Epilepsy during pregnancy O99.350 Epilepsy, unspecified, not intractable, without status epilepticus G40.909 This is a 33 year old female with cognitive concerns, jaw pain, neck pain, as well a current worsened mood symptoms after sustaining multiple mild traumatic brain injuries, as well as strangulation injuries, due to domestic violence. She was also a victim of likely date rape and assault in 2022. Her symptoms are explained by these injuries and are persistent, which is expected, given her psychiatric history, as well as the repeat and traumatic nature of her injuries. Fortunately, brain MRI is normal. CT maxillofacial indicates some malpositioning/dislocation, which is somewhat expected, given her history. She is currently 21 weeks pregnant with twins. She has not yet established with the epilepsy clinic or with ENT. She continues to have jerks, and she has not yet done the EEG I previously ordered. I will check her serum lamotrigine level and increase her lamotrigine to 400mg daily. I will have her follow up with the epilepsy clinic. She remains on folic acid. She continues to have jaw pain, and she is going to call ENT to follow up. I previously ordered an MRI of the TMJ, which has not yet been completed. She is following with a trauma therapist. She has not started the propranolol I previously ordered for her tremor and anxiety, but we will hold off on having her start it now. All questions answered, [redacted] will return to clinic in 4 months.	Zieman, Glynnis MD Barrow Concussion & Brain Injury Center	10/11/2023 5:54 PM

Addendum by Zieman, Glynnis MD on October 11, 2023 10:53:20 MST	Case was discussed in detail with Dr. Kingsford and I interviewed the patient and confirmed appropriate aspects of the physical examination today. I agree with the above documentation and plan of care. All patient's questions answered. She will return to clinic in 4-6 weeks and I have contacted the BNI Epilepsy Clinic to get her scheduled for consultation there ASAP.		

Future Appointments

Appointment Date: 02/19/2024 09:00:00 AM

Scheduled Provider: Zieman, Glynnis MD

Location: CL BR CB IC

Appointment Type: OPC Telehealth Visit PCA

Diagnostic Tests Pending

[redacted]evel-AMB 10/11/23

Future Scheduled Tests

Laboratory:

La[redacted]Level-AMB 2/17/24
Author: Chen, Stephanie C FNP, CommonSpirit
Last Modified: 10/17/2023 8:42 PM

Lam[redacted]ine Level-AMB 3/17/24
Author: Chen, Stephanie C FNP, CommonSpirit
Last Modified: 10/17/2023 8:42 PM

La[redacted]ine Level-AMB 4/17/24
Author: Chen, Stephanie C FNP, CommonSpirit
Last Modified: 10/17/2023 8:42 PM

La[redacted] Level-AMB 5/17/24

EXHIBIT 5

Report Status FINAL
Route 1006 Ordered by:

Any Lab Test Now Scottsdale
8989 E Via Linda
Suite 111
Scottsdale, AZ 85258

Judy Hunter, MD

Sonora Quest Laboratories™
A Subsidiary of Laboratory Sciences of Arizona

Patient Information: [redacted]

Order #: 132885018873 / NL93226479

Account: 13288
ID/MR#: [redacted]
Patient Lab ID:
64af465705918060c771d791

Collected: 10/16/2023
Received: 10/16/2023 09:02 PM
Reported: 10/17/2023 12:27 AM

DOB: 05[redacted] Age: 33Y[redacted]D
Sex: F
Patient Phone:

TEST	RESULTS	REFERENCE RANGES	UNITS	PL
CHEMISTRY				
hCG Quantitative	**102 H**	≤4	mIU/mL	

hCG Reference Ranges:
Non-pregnant ovulating female: <= 4 mIU/mL
Non-pregnant post menopausal female: <=10 mIU/mL
Male: <= 2 mIU/mL

This hCG Electrochemiluminescent immunoassay was performed using Roche Elecsys reagents. This assay is a total beta subunit assay. It measures intact, nicked, free beta, and nicked free beta hCG. Rebaselining may be necessary when using another assay.

Tests Ordered: hCG Quantitative

Values Outside of Reference Range

TEST	RESULTS	REFERENCE RANGES	UNITS
hCG Quantitative	**102 H**	≤4	mIU/mL

Values listed above may not include all results considered abnormal for this patient (e.g., text-only results, such as those for some pathology/cytology specimens, and results for analytes without established reference ranges will not appear). Always review the entire patient report and correlate all results with the patient's clinical condition.

Unless otherwise noted, testing performed by: Sonora Quest Laboratories, 424 S 56th St, Phoenix, AZ 85034 800.766.6721

End of Report

Medchill0055

EXHIBIT 6

DATE: Jan-04-2024 TIME: 18:45:34 UTC

Fax

TO: 480[redacted]

FROM: MomDoc (4808[redacted])

SUBJECT [redacted]

MomDoc

MomDoc Medical Records
PO BOX 6730
Chandler, AZ 85246
Phone: 480-821-3600 Fax: 480-821-3628

Please fill out ALL information completely. **Any items left blank will prevent the timely release of records. Information cannot be changed, edited or added by MomDoc employees.** If you prefer to pick up your records **in one of our medical office** please specify when and which office. Records are normally available within seven to ten business days.

Send Records

☐ **TO** MomDoc **FROM**

☑ **FROM** MomDoc **TO**

Recipient's or Sender's Name:[redacted]S _____ *Phone:*[redacted] _____

Address:[redacted] _____ *Fax:*_____

Records to Release

☑ All Records ☐ OB Records ☐ GYN Records ☐ Labs ☐ Imaging

☐ Specific Date(s) -From _____to _____

☐ Other (please specify) _____

**Also include records about ☐ communicable disease ☐ HIV ☐ neither*

Reason for release

☑ Personal copy ☐ Referral / Continuity of Care ☐ Disability ☐ Moving ☐ Transferring Care

☐ Insurance ☐ Legal Reason ☐ Other (please specify):_____

I understand that I may revoke this authorization at anytime with the exception of records that have already been released and that any records received from another provider will not be released. I also understand there **may be a fee for records released to the patient or another non-medical provider/facility, and that any such fee must be paid before the records will be released. Upon fulfillment of the above stated purpose this authorization will expire in one year following the date of signature.*

Patient Name:[redacted]S _____ D.O.B:[redacted] _____

Signature [redacted] Digitally signed by [redacted]ns Date: 2023.12.26 15:31:34 -07'00' _____ Date[redacted] _____

Relation to patient: ☑Self ☐Other (please specify): _____

This message is intended for the use of the person or entity to which it is addressed and may contain information that is confidential, the disclosure of which is governed by applicable law. ***Please note we do not accept CD or Emailed records.***

Phone: (480) 821-3600
MomDoc.com

MomDoc Women for Women

Gynecological Visit Note

Date of Encounter: 11/14/2023 5:10 PM

Allergies

NKDA

Patient Information

Name: [redacted]ns DOB: [redacted]
PCP: . LMP: 11/09/2023
Referred by: .. Reason for Referral: .
Patient sent by: ..
The patient has been made aware of MomDoc's Advance Directive Policy

History & Physical

Last PAP smear: 11/14/2023 Results - pap smearLast WWE: 11/14/2023
Last mammography: N/A Last DEXA: N/A

Pregnancy History

Date	Weeks	Dur. of Labor	Sex	Wt.	Deliv. Mode	Neonatal Problems	OB Problems
08/12/0023	8				SAB		
01/01/2019	8				EAB		

Pap History

Year	Month	Procedure	Findings	Plan
2019	June	Pap	abnormal	

Medical History

Year	Diagnosis	Procedure	Outcome	Comments
	PCOS			
	epilepsy	lamotrigine		

Reason for Visit

had a +upt on June 1,2023 at urgent care and at home

Do you Smoke? No

Chief Complaint

Possible pregnancy, Annual exam

History of Presenting Illness

[redacted]is 33 y/o. G: 2 P: 0-0-2-0 SAB x 1, .
Possible pregnancy: Pt states she had positive hpt in June and then had pregnancy confirmed by planned parenthood. She had an initial US there which showed a twin pregnancy. She did not have subsequent care

and started bleeding a few weeks after the US. Pt reports she passed two sacs which appeared to have a membrane but denies having much bleeding outside of that. She was worried about what that could mean and continued to take hpt to assess if she was still pregnant. She ordered her own hcg through a "labs now" type place which showed a very low HCG level. She was told this was not consistent with a viable pregnancy. She reports she had bleeding last week that was like a period and lasted 2 days. She comes to MomDoc to find out if she is still pregnant. Pregnancy was unplanned.
Annual exam: Pap smear performed today. Mammogram not indicated today. Blood work not indicated today. Colonoscopy not indicated today. Dexa scan not indicated today. . Pertinent negatives include anxiety/irritability, back pain, bloating, blood in stool, hematuria, chills, depression, frequency, pyrosis, loss of appetite, vag discharge, urgency, coital pain, flank pain, abn discharge, fever, bowel changes, dizziness, hesitancy, incontinence, mood changes, abd/pelvic pain, constipation, n/v, vag bleeding, weight gain, weight loss, hot flashes/sweats, dysuria.

Device/Injection supplied by MomDoc? Not Applicable

Gynecological History Last Updated: 11/14/2023

Usual Periods: Menarche at age 13. Cycles are irregular. Duration of flow: >6 days. Heavy flow. Mid-cycle bleeding: none. Clots: occasionally Severe cramps. When: days 1-2
Periods Now: Cycles are irregular. Duration of flow: 1 days. Light flow. Mid-cycle bleeding: none Clots: none No cramps.
Premenstrual: Bloating. Irritability. Depression. Denies Other problems.
Menopausal: N/A
Sexual: She is sexually active. Age of coitarche: 21. Denies problems with orgasmia. Denies pain. Denies bleeding. Denies Other problems.
Contraceptives: Current contraceptive: nothing. Denies problems with current contraceptive. Denies problems with past contraceptives.
Skin/Breast: BSE done regularly. Denies lumps. Denies nipple problems. Denies mastalgia. Denies tenderness. Denies rash. Denies Other problems.
Infertility: N/A
Infection: HPV: 2017 , 2019 colp. Yeast: February 2023 was treated. Denies GC. Denies chlamydia. Denies syphilis. Denies herpes. Denies trichomonas. Denies bacterial vaginosis. Denies Other infections.
Pap:

Year	Month	Procedure	Findings	Plan
2019	June	Pap	abnormal	

Gastrointestinal: Denies nausea. Denies vomiting. Denies diarrhea. Denies constipation. Denies abnormal stools. Denies bloating. Denies cramps/pain. Denies heartburn. Denies epigastric pain. Denies other problems.
Genitourinary: Denies Hematuria. Denies Dysuria. Denies Frequency. Denies hesitation. Denies incomplete emptying. Denies urgency. Denies incontinence. Denies pads. Denies pain. Denies bloating. Denies rectal fulness. Denies defecation. Denies Other problems.
Vulvovaginal: Denies itching. Denies odor. Denies discharge. Denies lesions. Denies pain. Denies other problems.

Remaining Review of Systems Last Updated: 11/14/2023

EENT: Denies vision changes. Does not wear corrective lenses. Denies sinusitis. Denies tinnitus. Denies headache. Denies Other problems.
Cardiovascular: Denies orthopnea. Denies nocturia. Denies chest pain. Denies dyspnea on exertion. Denies edema. Denies palpitations. Denies other problems.
Respiratory: Denies wheezing. Denies coughing. Denies sputum. Denies hemoptysis. Denies shortness of breath. Denies snoring. Denies other problems.
Musculoskeletal: Denies muscle weakness. Denies joint problems. Denies pain. Denies fractures. Denies Other problems.

Neurological: Denies syncope. Denies seizures. Denies numbness. Denies stroke. Denies trouble walking. Denies Other problems.
Psychiatric: Denies Depression. Denies Crying. Denies anxiety. Denies mental illness. Denies trouble sleeping. Denies Other complaints.
Endocrine: Denies Diabetes. Denies Hypothyroid. Denies Hyperthyroid. Denies hot flashes. Denies other problems.
Hemat/Lymph: Denies bruising. Denies bleeding Denies adenopathy. Denies other problems.

Medications

Medication	Dose	Start Date	Sig Desc
Lamotrigine Er	300 Mg		take 1 tablet by oral route every day swallowing whole. Do not crush, chew and/or divide.

Family History Last Updated: 11/14/2023

Mother: living,Health - Unknown,
Father: living,Health - Poor,
History of diabetes - no,. History of heart disease - dad,. History of cancer - father. - mom, dad.

Social & Personal History Last Updated: 11/14/2023

Smoking - no, Alcohol - no, Drugs - none,Safe at home? - feels safe at home, Diet discussed - healthy,

Gardasil:

Today's Physical Exam

Vitals: BP: 118/80 **PR:** 92 **RR:**16 **T:** 97.0F **WT:** 133 lbs **HT:** 65"**BMI:**22

Appearance: Well developed. Well nourished. Well groomed. In good apparent health.
Skin: Good Hydration. Normal tone/turgor. Normal to inspection. No Lesions. Normal hair distribution. No actinic changes.
HEENT: Symmetrical pupils. Sclera WNL. No Strabismus. Teeth & gingiva WNL.
Neck: Normal ROM. No Adenopathy. Thyroid WNL. Normal to inspection. No kyphosis. No scars.
Breasts: No thickening. No scars. No tenderness. Nipples WNL. No mass(es). No nodularity. No adenopathy. No skin changes.
Lungs: Normal to auscultation. Good respiratory effort.
Cardiovascular: Normal rate & rhythm. Normal to auscultation. No peripheral vascular changes.
GI/Abdomen: Normal to Inspection. Normal to Palpation.
Lymphatic: No palpable nodes in neck. No palpable nodes in axilla.
Back: No CVA Tenderness. No kyphosis or scoliosis noted. No spasm.
Vulva: Normal crinis pubis and hair distribution. No localized or pigmented lesions. No mass(es). Normal clitoris. Normal BUS. Normal labia. Normal perineum and fourchette. Normal introitus.
Vagina: No localized lesions. No congestion. No abnormal discharge. No forniceal changes. Good estrogen effect. No mass(es). No cystourethrocele. No enterocele. No rectocele.
Cervix: Well supported. Without fixation. Not tender to motion.
Uterus: Normal position. Normal contour. Normal consistency. Freely movable. No tenderness / thickening. No masses.
Adnexa: Without tenderness, mass, thickening, fixation, or other abnormality.
Rectovaginal: Not indicated
Extremities: No edema. No Varicosities. No tenderness.
Neuro/Psych: Alert. Cooperative. Oriented to place, time, and person. Normal speech and behavior. No Tremors. Normal mood and affect. No outward signs of depression. No apparent anxiety. Not agitated. Cranial nerves II-XII grossly intact.
Procedure: UPT negative x 2

pap smear
gc/ct/trich

Assessment

Encounter for well women exam
Negative pregnancy test
Screening for STD
Encounter for other general counseling on contraception

Injections

Todays Assessment/Ongoing Problem List

Code	Description	Status	Diagnosed	Resolved	Note
Z01.419	Encntr for gyn exam (general) (routine) w/o abn findings				
Z11.3	Encntr screen for infections w sexl mode of transmiss				
Z30.09	Encounter for oth general cnsl and advice on contraception				
Z32.02	Encounter for pregnancy test, result negative				

Plan & Alternatives

1.UPT negative x 2 and discussed SAB complete. No additional work up needed at this time. DIscussed causes for early pregnancy loss and when evaluation for recurrent pregnancy loss would start.
2. Discussed forms of birth control and challenges of birth control while on lamotrigine. Encouraged either depo or IUDs. Pt undecided at this time and pamphlets gives on Mirena and paraguard. Pt will consider options.
3. Pap done today per ASCCP guidelines. Gc/ct/trich collected. We have discussed the natural hx of common GYN and general health problems that occur at her stage of life. Reviewed healthy diet, exercise, calcium supplements and multivit etc.
Patient to RTO: birth control options
Very careful and lengthy instructions given regarding possible complications and/or interactions. We have discussed the conditions under which the patient should call.

Labs

11/14/2023 05:10 PM: Sent/Pending: ORDER:CT, NG, TRICH VAG BY NAA
11/14/2023 05:10 PM: Sent/Pending: ORDER:Pap IG, APT HPV, Age Gdln CCS Only

Document Generated by: Gabrielle Richards
Document Generated at: 11/14/2023 7:59 PM
Documenting Provider: Gabrielle Richards FNP-C
MA who documented: Nancy Flores
Time MA finished: 5:26 PM
Chaperone: Flores, Nancy

MomDoc
2545 W Frye Rd
Chandler, AZ, 852246277
Phone #: (480) 821-3600

[redacted]
Sex: F
D[redacted]

Ordering: Faro, Constance MD **Performing #:** LabCorp **Location:** WFW-Scottsdale Office
Tests Ordered : CT, NG, TRICH VAG BY NAA (183160)

Ct, Ng, Trich vag by NAA (Collection Date: 11/15/2023 13:25, Status: Final)
SRC:VA
Performed At: CETWE, Labcorp Phoenix
5005 S 40th Street Ste 1200, Phoenix, AZ, 850402969
Earle, Collum, MD, Phone: 8007889743

Component	Result	Units	Flag	Range	Comment
Chlamydia by NAA	Negative			Negative	
Gonococcus by NAA	Negative			Negative	
Trich vag by NAA	Negative			Negative	

MomDoc
2545 W Frye Rd
Chandler, AZ, 852246277
Phone #: (480) 821-3600

[redacted]

Ordering: Faro, Constance MD **Performing #:** LabCorp **Location:** WFW-Scottsdale Office
Tests Ordered : Pap IG, APT HPV, Age Gdln CCS Only (193065)

IGP, Aptima HPV, rfx 16/18,45 (Collection Date: 11/15/2023 13:26, Status: Final)

Performed At: UZLCA, Labcorp Phoenix
5005 S 40th Street Ste 1200, Phoenix, AZ, 850402969
Earle, Collum, MD, Phone: 8007889743
Performed At: CETWE, Labcorp Phoenix
5005 S 40th Street Ste 1200, Phoenix, AZ, 850402969
Earle, Collum, MD, Phone: 8007889743

Component	Result	Units	Flag	Range	Comment
019018	.				
Clinician provided ICD10:	Comment				Z12.4
DIAGNOSIS:	Comment				NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY.
HPV Aptima	Negative		Negative		This nucleic acid amplification test detects fourteen high-risk HPV types (16,18,31,33,35,39,45,51,52,56,58,59,66,68) without differentiation.
HPV Genotype Reflex	Comment				Criteria not met, HPV Genotype not performed.
Note:	Comment				The Pap smear is a screening test designed to aid in the detection of premalignant and malignant conditions of the uterine cervix. It is not a diagnostic procedure and should not be used as the sole means of detecting cervical cancer. Both false-positive and false-negative reports do occur. .
Performed by:	Comment				Kai-Lin Wong, Cytotechnologist (ASCP)
Specimen adequacy:	Comment				Satisfactory for evaluation. Endocervical and/or squamous metaplastic cells (endocervical component) are present.
Test Methodology:	Comment				This liquid based ThinPrep(R) pap test was screened with the use of an image guided system.

IGP,Aptima HPV,Age Gdln (Collection Date: 11/15/2023 13:26, Status: Final)

CO-APD2023-31905370
Performed At: PDLCA, Labcorp Phoenix
5005 S 40th Street Ste 1200, Phoenix, AZ, 850402969
Earle, Collum, MD, Phone: 8007889743

Component	Result	Units	Flag	Range	Comment
Age Gdln ACOG Testing	30-65				

[redacted]

Clerk of the Superior Court
*** Electronically Filed ***
C. Brown, Deputy
1/3/2024 4:43:32 PM
Filing ID 17128207

WOODNICK LAW, PLLC
1747 E. Morten Avenue, Suite 205
Phoenix, Arizona 85020
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Office@WoodnickLaw.com

Gregg R. Woodnick, #020736
Isabel Ranney, #038564
Attorney for Respondent

IN THE SUPERIOR COURT OF THE STATE OF ARIZONA

IN AND FOR THE COUNTY OF MARICOPA

In Re the Matter of:

[redacted]

Petitioner,

and

CLAYTON ECHARD,

Respondent,

Case No.: **FC2023-052114**

MOTION FOR SANCTIONS PURSUANT TO RULE 26

(Assigned to The Honorable Julie Mata)

Respondent, **CLAYTON ECHARD**, by and through undersigned counsel and pursuant to Rule 26(b) and 26(c), *Arizona Rules of Family Law Procedure* (ARFLP), hereby filed his Motion for Sanctions against Petitioner, [redacted] for filing her Petition to Establish Paternity, Legal Decision-Making, Parenting Time, and Child Support, as well as all other subsequent filings by Petitioner.

Petitioner filed the underlying action for an improper purpose without medical evidence to support her claim that she was pregnant and/or that she was pregnant by Respondent. Petitioner could not have become pregnant from the limited encounter the parties had and

therefore premised this entire action on a fiction. Petitioner violated Rule 26(b)(1)-(3) in her Petition and subsequent filings.

ARGUMENT

1. This matter arises from the establishment petition filed August 1, 2023. Also pending before the Court are: Respondent's Motion for Leave to Amend Respondent's Response to Petition to Establish Paternity, Respondent's Expedited Motion to Extend Dismissal Date on Inactive Calendar and Schedule an Evidentiary Hearing, Respondent's Notice of Filing Affidavit of Non-Paternity, Petitioner's Motion to Dismiss Petition to Establish Paternity, Legal Decision-Making, Parenting Time and Child Support with Prejudice, Petitioner's Response to Expedited Motion and Respondent's Response/Objection to Petitioner's Motion to Dismiss Petition to Establish Paternity, Legal Decision-Making, Parenting Time and Child Support with Prejudice (filed consecutively).

2. Rule 26(b) ARFLP provides, as relevant here, that "*by signing a pleading, motion or other document, the attorney or party certifies to the best of the person's knowledge, information, and belief formed after reasonable inquiry: (1) it is not being presented for any improper purposes, such as to harass [...] (2) the claims, defenses, and other legal contentions are warranted by existing law [...] (3) the factual contentions have evidentiary support or, if specifically so identified, will likely have evidentiary support after a reasonable opportunity for further investigation or discovery [...]*".

3. Rule 26(c) provides: "*if a pleading, motion, or other document is signed in violation of this rule, the court—on motion or on its own—may impose on the person who signed it, a represented party, or both, an appropriate sanction, which may include an order*

to pay to the other party or parties the amount of the reasonable expenses incurred because of the filing of the document, including a reasonable attorney fee."

4. The requirements of Rule 9(c) have been met and a good faith consultation certificate is attached hereto. *See also* Respondent's Motion for Leave to Amend Respondent's Response to Petition to Establish Paternity; Respondent's Response/Objection to Petitioner's Motion to Dismiss Petition to Establish Paternity, Legal Decision-Making, Parenting Time and Child Support with Prejudice.

A. Rule 26 sanctions are appropriate and warranted

Petitioner's behavior is the exact type of conduct that Rule 26 is intended to sanction. Petitioner was never pregnant by Respondent and filed this underlying action in bad faith and with the sole intent of coercing Respondent into having a relationship with her.

1. Petitioner's commencement of this action and original filing was made for an improper purpose under Rule 26(b)(1).

Petitioner instigated this action when she filed her Petition to Establish Paternity, Legal Decision-Making, Parenting Time and Child Support on August 1, 2023, which alleges she had sexual intercourse with Respondent, became pregnant by him, and requested this Court enter Orders for Joint Legal Decision-Making, a parenting plan, and order Respondent to pay her Child Support. Petitioner's Petition to Establish was filed for an improper purpose because Petitioner was never pregnant by Respondent and could not have become pregnant based on their one (1) encounter of oral sex on May 20, 2023.

Despite no underlying Orders, Petitioner filed a Motion to Communicate on August 8, 2023, and Motion to Compel on August 23, 2023. This Court denied both Motions. Respondent

filed a Response on August 21, 2023, denying that Petitioner could be pregnant by Respondent after one incident of oral sex on May 20, 2023. When Petitioner did not get what she wanted (including attempting to get Respondent to enter into a dating "*contract*") she went to the media (Reddit, *The Sun, People Magazine, Page Six,* Medium.com, etc), the police, Respondent's father, and even threatened self-harm. *See* Respondent's Response/Objection to Petitioner's Motion to Dismiss (filed 1/3/24). When the media turned on Petitioner and had doubts about the veracity of her pregnancy (as no verifiable medical evidence exists), Petitioner obtained an Order of Protection against Respondent based on "cyberbullying." (**Exhibit 1).**

Respondent obtained an Injunction of Harassment against Petitioner based on the receipt of 500+ harassing messages in (CV2023-05392). During the proceedings, on November 2, 2023, Petitioner wore a fake stomach ("moon bump") to appear pregnant and claimed, with no scientific support, that she was 24 weeks pregnant with Respondent's twins and due on February 14, 2024 *See* Respondent's Response/Objection to Petitioner's Motion to Dismiss (filed 1/3/24); *see also* FTR for hearing on 11/2/23. Petitioner then sought to have this Court enter Orders against Respondent despite no verifiable proof Petitioner was pregnant and no child subject to this Court's jurisdiction (with respect to entering parenting-related Orders) by filing an *Application and Affidavit for Entry of Default* on August 23, 2023.

Despite providing no verifiable medical evidence that she was pregnant or that she was pregnant by him (only positive HCG tests and fabricated sonograms), Petitioner sought to force Respondent to communicate with her and threatened to go to the media if he did not comply. Notably, in her Motion to Communicate, Petitioner requested "*that Respondent […] is ordered to communicate with Petitioner […] The Respondent was* The Bachelor *on* ABC *and the*

Petitioner knows it would be in his best interests to keep the details of this case out of the public eye." *See* Petitioner's Motion to Communicate filed August 8, 2023.

Also, in her Motion to Compel (filed August 23, 2023), Petitioner admitted she "*had requested* [Respondent agree to] *a one to two week trial relationship"* prior to filing her underlying Petition and asked this Court to hold Respondent in **contempt of Court** for not talking to her. Petitioner's own words prove that she instigated this entire action (including fabricating a pregnancy) to coerce Respondent into talking to and dating her.

2. Petitioner's Motion to Dismiss is unsupported by existing law under Rule 26(b)(2).

Jurisdiction was established at the time of Petitioner's initial filing, which Petitioner continued to avail herself of through each additional filing made in the course of this matter. Ostensibly fearing that she would be held accountable for her disturbing and unsettling behavior, Petitioner recently filed a (contested) *Motion to Dismiss* on December 28, 2023 the entire action alleging lack of subject matter jurisdiction.

As discussed more fully in the Response to that Motion, Arizona law is crystal clear that jurisdiction attaches at the time the action is filed. Subsequent events or acts by the parties cannot deprive the court of jurisdiction once attached, even if those events would have defeated jurisdiction if occurring before the action was filed (i.e., Petitioner claimed at the time of filing that she was pregnant with Respondent's children at the time of filing, so the fact that she is not currently pregnant does not deprive the court of jurisdiction). Statutory jurisdiction does not automatically divest unless the statutes expressly state whether and to what extent divestiture occurs. Title 25 contains no such provision, and the *Fry* case cited in Respondent's

January 3, 2024 *Response to the Motion to Dismiss* is highly analogous to the current circumstances.

For purposes of Rule 26(b)(2), Petitioner's claim is not warranted by existing law and does not attempt to make a non-frivolous argument for modifying the law or establishing new law. Simply put, Petitioner misstates the law of subject matter jurisdiction despite clearly contrary precedent in an opaque attempt to avoid the consequences of her improper filings. This is sanctionable.

3. Petitioner's factual contentions are not supported by evidence and did not become supported by evidence after investigation and discovery under Rule 26(b)(3).

The Petition lacks evidentiary support beyond Petitioner's assertions that she was pregnant with Respondent's children. Admittedly, any establishment petition made prior to the birth of the child is necessarily lacking evidentiary support, but Title 25 and Rule 26 permit such filings because those claims, if true, will have evidentiary support after a reasonable opportunity for further investigation or discovery. In this case, however, Petitioner's claims were never true and could not be true because the parties did not have sexual intercourse requisite to conception. In matters where pregnancy and paternity are contested, Title 25 contemplates subsequent testing—either before or after the birth of the child—to establish the necessary factual support.

Since filing, Petitioner has provided no Rule 49 disclosure (and seeks to avoid a deposition) that would support her claim that she was pregnant by Respondent (no sonogram reports, fetal anatomy scans, reports of weekly ultrasounds, etc). She has participated in fetal DNA tests, none of which have conclusively established the existence of a pregnancy or

Respondent's paternity. At least two (2) fetal DNA tests have come back with "*little to no fetal DNA*," indicating that not only was Petitioner not pregnant by Respondent, but she was not pregnant at all. Petitioner carefully alleges in her Motion to Dismiss that she is "no longer pregnant" but refuses to provide evidence of the termination or miscarriage of the pregnancy (e.g., fetal death certificates). It is critical for this Court to take evidence and investigate whether Petitioner was ever pregnant in the first instance, both for purposes of declaring non-paternity and for determining the appropriateness of Rule 26(b)(3) sanctions.

4. Rule 26(c)(1) contemplates sanctions by motion or on the court's own impetus.

Even if Respondent did not request sanctions—which he previously did and now reiterates by separate Motion to address any proffered procedural irregularity—this Court may investigate and impose sanctions on its own motion. Rule 26 requires signatures on pleadings and filings and attaches substantial meaning to those signatures: a person filing a document certifies to the Court that it is being presented for a proper purpose and is supported by law and evidence. The Rule requires parties and attorneys to conduct at least a reasonable inquiry before signing filings, and sanctions exist to ensure compliance, vindicate misuse of the Court's resources and authority, and to make responding parties whole for frivolous lawsuits. Respondent asserts that the circumstances of this case are so egregious that this Court ought to impose sanctions on its own, even if for no other reason than to deter specific and general abuse of process.

///

///

CONCLUSION

Pursuant to the above and consistent with Rule 26(b) and (c), ARFLP, this Court should impose appropriate sanctions against Petitioner, including but not limited to awarding Respondent his reasonable attorney's fees and costs incurred.

RESPECTFULLY SUBMITTED this 3rd day of January, 2024.

WOODNICK LAW, PLLC

Gregg R. Woodnick
Isabel Ranney
Attorneys for Respondent

ORIGINAL of the foregoing e-filed this 3rd day of January, 2024 with:

Clerk of Court
Maricopa County Superior Court

COPY of the foregoing document delivered/emailed this 3rd day of January, 2024, to:

The Honorable Julie Mata
Maricopa County Superior Court

Alexis Lindvall
MODERN LAW
1744 S. Val Vista Drive, Suite 205
Mesa, Arizona 85204
Alexis.lindvall@mymodernlaw.com
Attorney for Petitioner

By: */s/ MB*

VERIFICATION

I, **CLAYTON ECHARD**, declare under penalty of perjury that I am the Respondent in the above-captioned matter; that I have read the foregoing *Motion for Sanctions Pursuant to Rule 26* and I know of the contents thereof; that the foregoing is true and correct according to the best of my own knowledge, information and belief; and as to those things stated upon information and belief, I believe them to be true.

Clayton Echard (Jan 3, 2024 16:05 MST)

CLAYTON ECHARD

01/03/2024

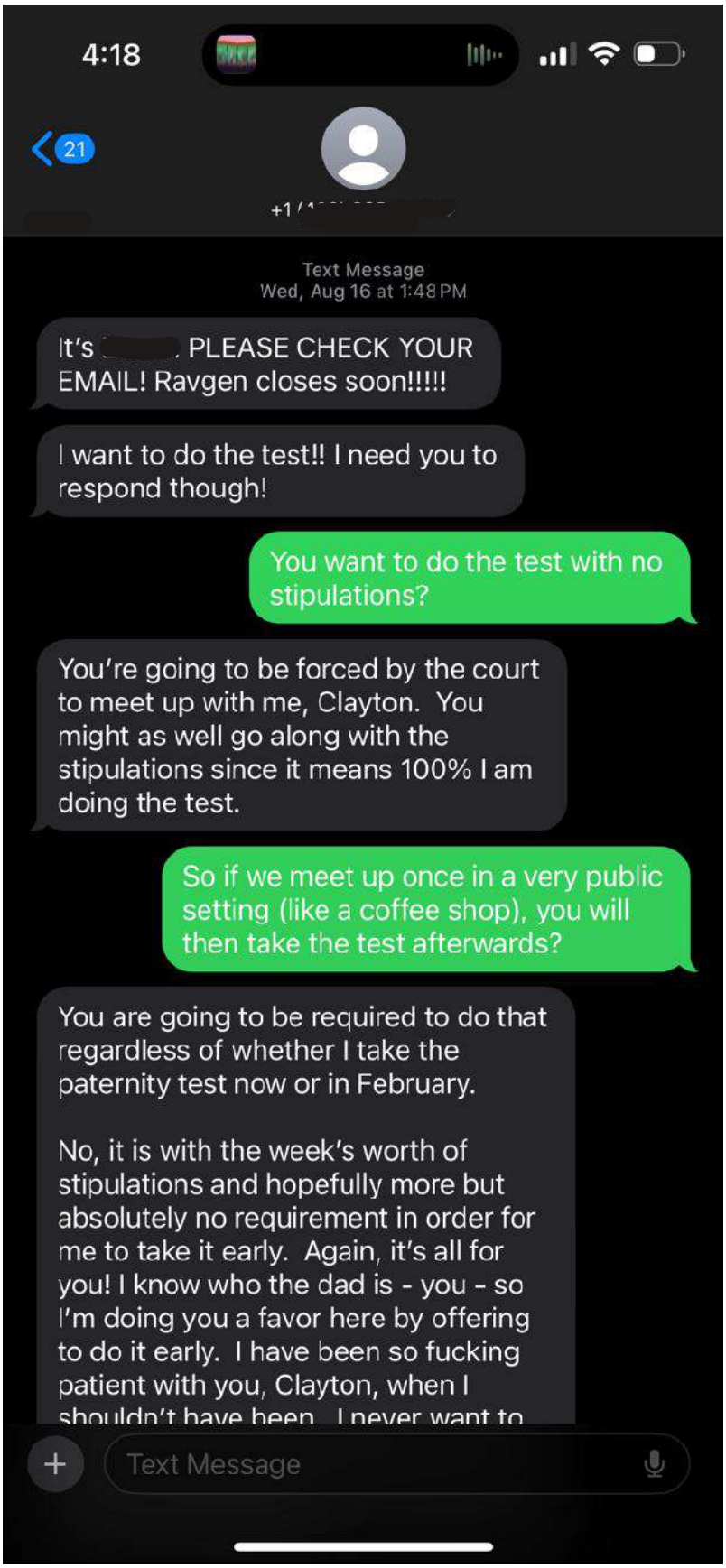
Date

GOOD FAITH CONSULTATION CERTIFICATE

In conformance with Rule 9(C), *Arizona Rules of Family Law Procedure*, counsel undersigned hereby certifies that Respondent, Clayton Echard, satisfied his Rule 9(c) obligation when he attempted to meet and confer with Petitioner, [redacted] on August 16, 2023 at 1:48 p.m. and 2:50 p.m. (text messages below) as well as in all of his subsequent filings and communications to Petitioner that indicated he could not be the father of her alleged twin fetuses (including but not limited to in Respondent's Injunction Against Harassment proceedings (CV2023-052952) against Petitioner on October 24, 2023 and November 2, 2023). *See also* Respondent's Motion for Leave to Amend Respondent's Response to Petition to Establish Paternity; Respondent's Response/Objection to Petitioner's Motion to Dismiss Petition to Establish Paternity, Legal Decision-Making, Parenting Time and Child Support with Prejudice. Additionally, undersigned met and conferred with Petitioner's counsel, Alexis Lindvall (who already has filed to withdraw from representing the Petitioner), over the phone on December 27, 2023.

WOODNICK LAW, PLLC

Gregg R. Woodnick
Attorneys for Respondent


4:18
21
+1 (
Text Message
Wed, Aug 16 at 1:48 PM
It's . PLEASE CHECK YOUR EMAIL! Ravgen closes soon!!!!!
I want to do the test!! I need you to respond though!
You want to do the test with no stipulations?
You're going to be forced by the court to meet up with me, Clayton. You might as well go along with the stipulations since it means 100% I am doing the test.
So if we meet up once in a very public setting (like a coffee shop), you will then take the test afterwards?
You are going to be required to do that regardless of whether I take the paternity test now or in February.
No, it is with the week's worth of stipulations and hopefully more but absolutely no requirement in order for me to take it early. Again, it's all for you! I know who the dad is - you - so I'm doing you a favor here by offering to do it early. I have been so fucking patient with you, Clayton, when I shouldn't have been. I never want to
Text Message

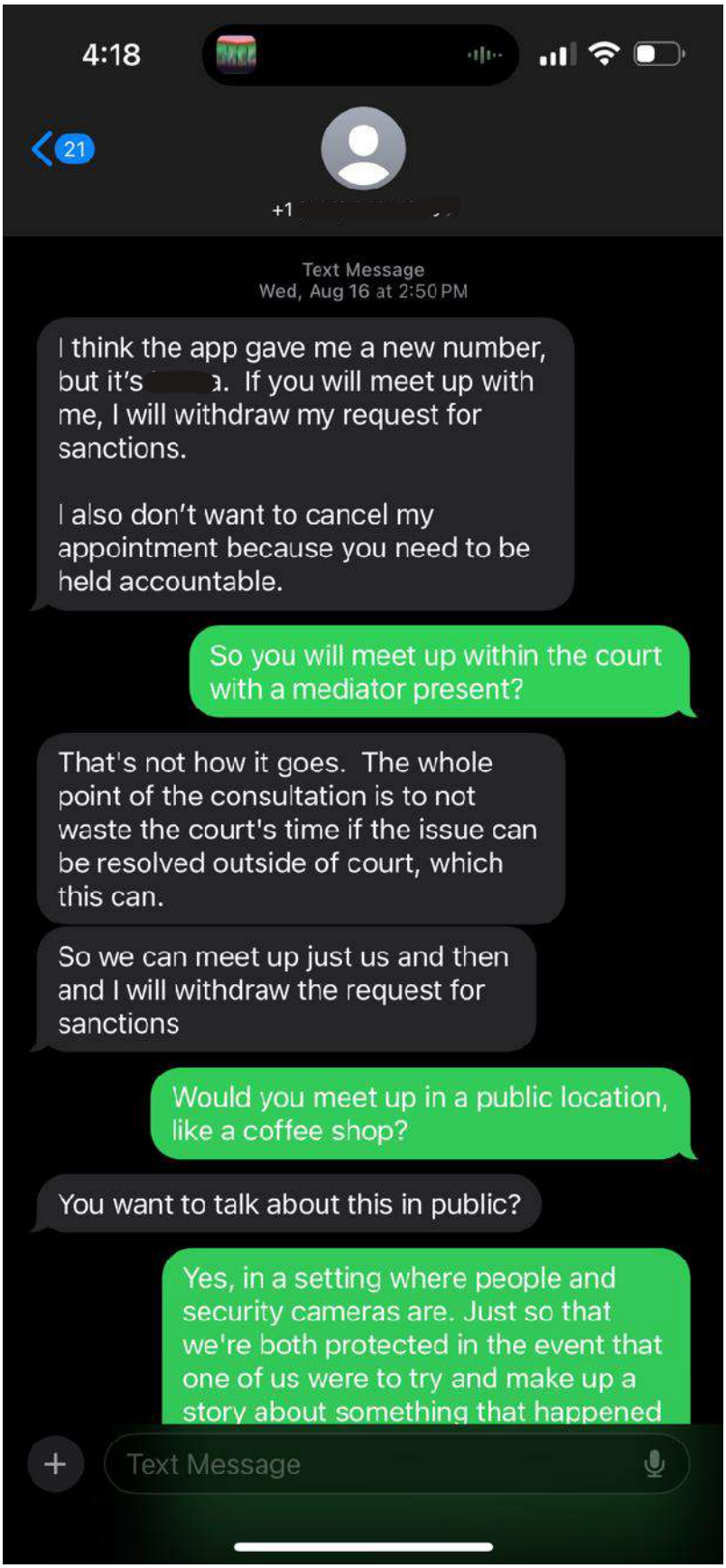

4:18
21
+1
Text Message
Wed, Aug 16 at 2:50 PM
I think the app gave me a new number, but it's a. If you will meet up with me, I will withdraw my request for sanctions.
I also don't want to cancel my appointment because you need to be held accountable.
So you will meet up within the court with a mediator present?
That's not how it goes. The whole point of the consultation is to not waste the court's time if the issue can be resolved outside of court, which this can.
So we can meet up just us and then and I will withdraw the request for sanctions
Would you meet up in a public location, like a coffee shop?
You want to talk about this in public?
Yes, in a setting where people and security cameras are. Just so that we're both protected in the event that one of us were to try and make up a story about something that happened
Text Message

EXHIBIT “1”

CLERK OF THE SUPERIOR COURT
FILED
10/6/2023 @ 10:43AM
Deputy

Superior Court of Arizona/AZ007035J/0700 18380 N. 40th St Phoenix, AZ 85032
602-506-7353 Monday - Friday 8am - 5pm

Plaintiff ☐ Employer-Plaintiff if Workplace Injunction	**Defendant**	**Case No.**
[redacted]	Clayton [redacted]ard	FC2023-052771
☐ **On behalf of minor/person in need of protection named:**	**Defendant's address** [redacted] Scottsdale, AZ 85254	**PETITION for:** ☒ **Order of Protection** ☐ **Injunction Against Harassment** ☐ **Workplace Injunction**
Agent's name (If Workplace Injunction)	**Defendant's birth date** [redacted]	
	Defendant's phone [redacted]	

[redacted]

DIRECTIONS: Please read the Plaintiff's Guide Sheet before filling out this form.

1. **Defendant/Plaintiff Relationship** *(Choose the options that best describe your relationship to the defendant. *If you are applying on behalf of another person, choose the relationship between the other person and the defendant)*

   ☐ Married (past or present)
   ☐ Live/lived together as intimate partners
   ☐ Parent of a child in common
   ☒ One party is pregnant by the other
   ☒ Romantic or sexual relationship (past or present)
   ☐ Related as parent, grandparent, child, grandchild, brother, sister (or in-law/step)
   ☐ Live/lived together but not as intimate partners
   ☐ Other (describe):

2. ☒ If checked, Defendant and I have a pending action involving maternity, paternity, annulment, legal separation, dissolution, custody, parenting time, or support in Maricopa County Superior Court, Case # FC2023-052114.

3. Name of court, if any, in which any other protective order related to this conduct has been filed.
   Court name_____ Case #_____

4. Tell the judge what happened and why you need this order. PRINT both the dates and a brief description of what happened. If there is a contested hearing, a judge can consider only what you write here.
   NOTE: Defendant will receive a copy of this petition when the order is served.

Approx. Date	(Do not write on back or in the margin. Attach additional paper if necessary.)
6/1/2023	Clayton has sent threatening messages since discovering I was pregnant, such as: I legitimately hate you right now. my hatred will only grow if you decide to put me through all of this. My animosity would last for a lifetime and that's not something either of us want to subject ourselves to. One thing about me is when I make up my mind for good, especially when it's rooted in anger, I don't sway. Ever My hate is toward you and you only. If you decide to not take plan B and in the wild event that you are pregnant, I would hate you even more.
9/21/2023	Clayton Echard was The Bachelor and has many diehard loyal fans. He and I are involved in a very public paternity case that is being covered by every major media outlet. Clayton posted to a story to his 270k followers to look me up, which they have, and I have been sent threatening and harassing messages by his followers. I explained this to him and asked him to take down the post, which he did not. By posting personal and sensitive information about me publicly (and without my consent), he has made me feel humiliated and embarrassed.

9/21/2023	Scottsdale PD Officer Vince Johnson called Clayton to explain that what he was doing was harassment in and of itself, coupled with the fact that he was inciting his followers to harass me as well. Despite this call, Clayton still did not take down the post.
10/5/2023	Between 9/22 and 10/5, Clayton has posed as several users on Reddit, including "sillygoosetits", "GossipGooseTits", "Sandbetweenhertoes", and others. He has posted private and confidential information, including facts about my medical history, that is known only to him because of our paternity case. This is why it is 100% traceable back to him. He has also been writing defamatory and very hurtful things about me, including comments about how I have gained weight (I am pregnant), how I am not attractive, how my photos are so poorly edited that it is laughable, how I am bad at my job (a self-help podcaster), and how my prior abusive relationship, which inspired a TEDx talk, never happened, despite mountains of evidence. He is doing everything in his power to ruin and hurt my reputation. As a result of what he has posted, I have gotten harassing messages that have told me to harm myself as a result of becoming pregnant with his twins. I am getting other threatening messages as well, and all of this attention from the general public that he has incited is very much unwanted. As a result of this public shaming, he has caused me extreme psychological harm and disrupted my peace. I have asked Clayton to stop the harassment on Reddit and social media so many times, but he won't. I have reported his accounts and posts to Reddit, but he continues to write unacceptable, cruel things about me. He has multiple accounts now and so even if one is blocked, he can create another one. As a result of him spreading false and damaging information under pseudonyms, I feel demeaned, humiliated, and like my deepest sense of privacy has been invaded. In addition, he has been in communication with my ex, who I have an order of protection against, and who he knows is dangerous. I have asked him to stop talking to him because it will put me in danger, but he continues to communicate with him.
10/6/2023	When combined, all of this has led me to feel extreme anxiety and fear for my safety. I have not left my house since September 28th because of this.

5. The following persons should also be on this order. They should be protected because Defendant is a danger to them:

6. Defendant should be ordered to stay away from these locations at all times, even when I am not present. **NOTE:** Do not list confidential addresses here.

   ☒ Residence (confidential)
   ☒ Work/Business
   ☒ School/other

7. ☐ Defendant owns or carries a firearm or other weapons.
   ☐ Defendant should be ordered NOT to possess firearms while this order is in effect because of the risk of harm to me or other protected persons.

8. ☐ Defendant should be ordered to stay away from any animal that is owned, possessed, leased, kept or held by me, Defendant, or a minor child living in either my household or Defendant's household.

9. Other requests: No cyberharassment or cyberbullying under real name or pseudonyms.;

Under penalty of perjury, I swear or affirm the above statements are true to the best of my knowledge, and I request an Order / Injunction granting relief as allowed by law.

/s/ [redacted]
Plaintiff

Attest:
Judicial Officer/Clerk/Notary

10/6/2023.
Date

Clerk of the Superior Court
*** Electronically Filed ***
10/26/2023 8:00 AM

SUPERIOR COURT OF ARIZONA
MARICOPA COUNTY

FC 2023-052771

10/25/2023

HONORABLE JOHN R. DOODY

CLERK OF THE COURT
T. Sachse
Deputy

IN RE THE MATTER OF
[redacted]

JOSHUA A LOPEZ

AND

CLAYTON RAY ECHARD

CLAYTON RAY ECHARD
[redacted]

COMM. DOODY

MINUTE ENTRY

There is a *LATER* at the end of this minute entry.

Prior to the commencement of today's proceedings, Plaintiff's Exhibits 1 through 18 and Defendant's Exhibits 19 through 51 are marked for identification.

Courtroom 101-NER

8:32 a.m. This is the time set for Hearing on Order of Protection issued on October 6, 2023. Plaintiff, [redacted] is present with the above-named counsel. Defendant, Clayton Ray Echard, is present on his own behalf.

A record of the proceedings is made digitally in lieu of a court reporter.

[redacted]nd Clayton Ray Echard are sworn.

The Court addresses previous motions filed by Plaintiff.

SUPERIOR COURT OF ARIZONA
MARICOPA COUNTY

FC 2023-052771 10/25/2023

IT IS ORDERED denying Plaintiff's Motion Requesting That the Hearing be Closed From the Public or That This Hearing Be Closed From Watching Online, filed October 25, 2023 and denying Plaintiff's Motion Requesting [redacted]s Attend Virtually or Telephonically for Hearing Scheduled October 25, 2023, filed on October 25, 2023.

Counsel for Plaintiff presents opening statements.

[redacted]s testifies.

Plaintiff's Exhibits 1 and 11 are received into evidence and Exhibit 52 is marked for identification and received into evidence.

Clayton Ray Echard testifies.

Defendant's Exhibits 34, 35, and 51 are received into evidence and Exhibit 53 is marked for identification and received into evidence.

Discussion is held.

Based on the testimony and matters presented,

THE COURT FINDS by a preponderance of the evidence that there is reasonable cause to believe that Defendant has committed an act of domestic violence within the last year.

THE COURT FURTHER FINDS that good cause exists to continue the Order of Protection in this case.

IT IS ORDERED that the Order of Protection issued at Superior Court on October 6, 2023 shall remain in full force and effect.

LET THE RECORD FURTHER REFLECT that the parties receive a copy of the aforementioned document in open court.

LET THE RECORD FURTHER REFLECT that Plaintiff's Exhibits 2 through 10, 12 through 18 and Defendant's Exhibits 19 through 33, and 36 through 50 are disposed.

Counsel for Plaintiff makes an Oral Motion to withdraw from these proceedings.

IT IS ORDERED granting Counsel's Motion to withdraw.

10:13 a.m. Hearing concludes.

FILED: Hearing Order

LATER:

LET THE RECORD REFLECT that the Court did not invoke the Brady Order due to the fact that it is still undetermined if Plaintiff is pregnant with Defendant's child.

All parties representing themselves must keep the Court updated with address changes. A form may be downloaded at:
http://www.superiorcourt.maricopa.gov/SuperiorCourt/LawLibraryResourceCenter/

Exhibit D

PCOS AND BLOATING

The PCOS Belly

Many women with PCOS have problems with bloating. Often this is aggravated by certain foods. The list of possible food culprits is varied, but it includes foods that contain a carbohydrate called raffinose. This carb doesn't digest well for some people, leading to increased gas production. Foods in this group include asparagus, beans, broccoli, Brussels sprouts, cabbage, and cauliflower.

Knowing what foods trigger your PCOS bloating can help reduce your abdominal pain and discomfort.

Other foods that can cause bloating, include dairy products if you are lactose intolerant, certain whole grains, fruits, carbonated drinks, and products containing artificial sweeteners. The PCOS tracker can help you keep tabs on these troublesome foods. Simply writing down trigger foods can help reduce PCOS bloating.

PCOS

About Us

Web Design by ASC

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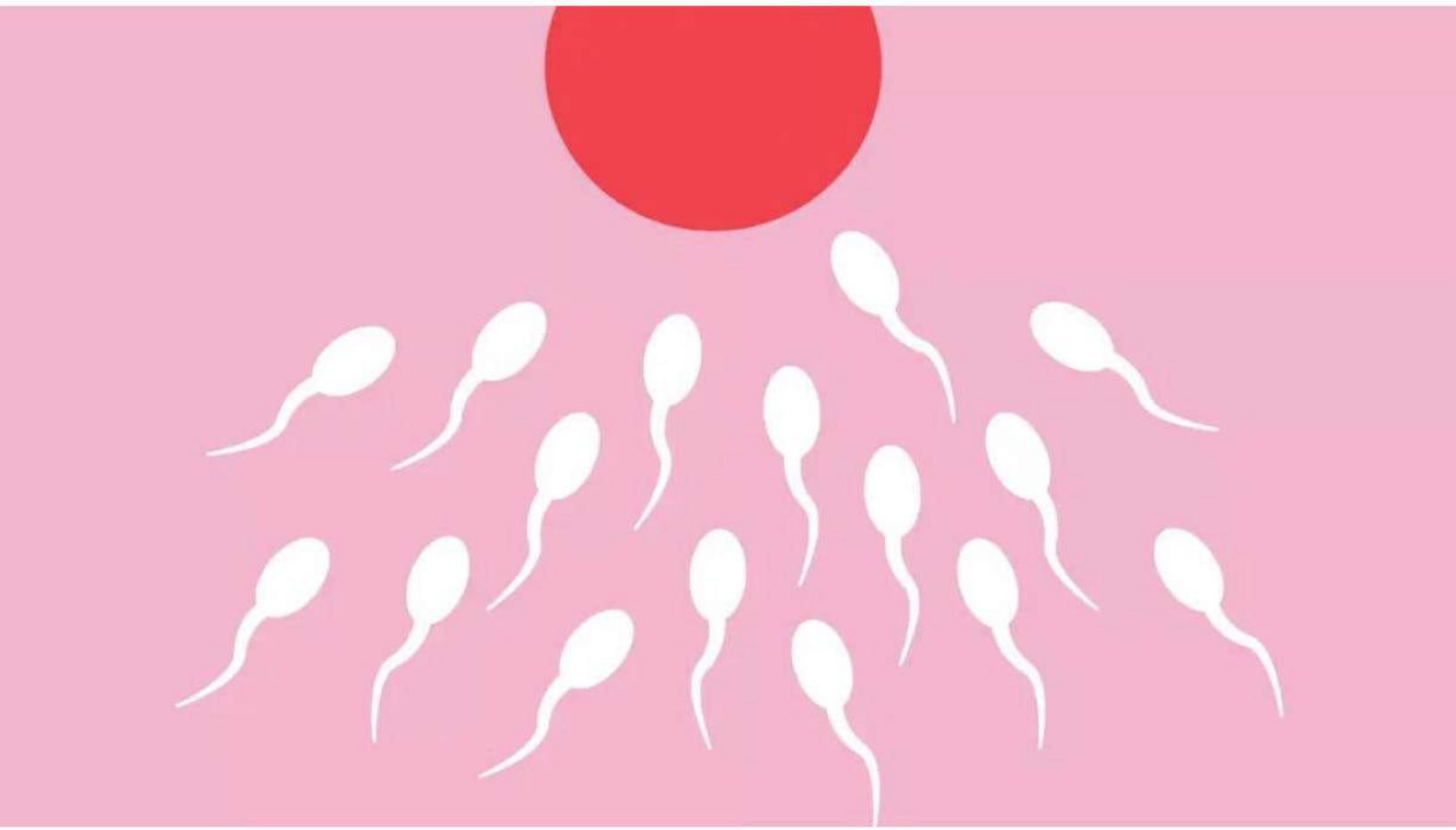
Medchill0086

September 27, 2022 / Pregnancy & Childbirth

How Soon Can You Tell You're Pregnant?

Home pregnancy tests can detect pregnancy just two weeks after ovulation



For some people, getting pregnant can take time and planning. For others … it just happens.

If you've had unprotected sex recently, you may be wondering how long it may be before you know whether you're pregnant.

Those over-the-counter tests say they're 99% accurate, but with something as important as whether you're going to have a baby, can you really rely on a piece of plastic you picked up in the supermarket health and beauty department?

Yes.

Home pregnancy tests are how most people find out they're pregnant, and for good reason, says OB/GYN Joi Robinson Tidmore, MD. They're safe, accurate and almost as quick to detect early pregnancy as a doctor's blood test.

Dr. Robinson Tidmore breaks down the journey to pregnancy and how early you can

Conception and implantation: A timeline

Without getting all “birds and the bees” about it, there are several steps that go on in your body to create new life. A quick look at these different phases will help to better understand when pregnancy actually happens and when it can be detected.

Ovulation: About 2 weeks before your period

This is your window to become pregnant. About two weeks after your last period (smack in the middle of a “typical” 28-day cycle) is when you ovulate. That means your ovary has released an egg and it’s hanging around in your fallopian tube waiting for sperm. You’ll ovulate for about 12 to 24 hours. If the egg isn’t fertilized, it’ll be reabsorbed by your body.

Conception: About 24 hours after unprotected sex

If you have unprotected intercourse during your ovulation window, sperm start swimming all fast and furious to reach the egg. Conception happens if a sperm wriggles its way in to fertilize the egg.

Implantation: About 6 days after unprotected sex

After an egg is fertilized, it attaches itself to the lining of your uterus. That triggers a placenta to begin to form.

Pregnancy hormones release: About 11 days

As the placenta forms, it releases human chorionic gonadotropin (hCG), also called the pregnancy hormone.

Detecting early pregnancy

Pregnancy tests, including home tests and blood tests taken at a doctor's office, measure hCG levels to detect pregnancy. Those levels will rise quickly and continue to rise throughout the first two to three months of your pregnancy. Your hCG levels will then begin to fall again, but will remain present throughout your pregnancy.

Home pregnancy tests

Home pregnancy tests — the sticks you find at the drug store that measure hCG in your urine — are most people's first step to determining whether they're pregnant. One study says they're the go-to for 76% of people seeking to detect pregnancy.

For people with regular menstrual cycles, a home pregnancy test can generally detect pregnancy about four weeks from the first day of your last period. That's

If your period is less-than-punctual, Dr. Robinson Tidmore suggests taking a home pregnancy test two weeks after having unprotected sex is a good rule of thumb.

And, yes, you can trust that the results on the stick are for real.

“In general, home pregnancy tests are sensitive and accurate,” Dr. Robinson Tidmore says. “Some of the tests on the market can detect pregnancy even before a missed period, but that effectiveness can vary. You can be confident, though, that if your period is usually regular and you’re a day or two late for your period, the results from a home-based test will be accurate.”

Blood tests

In some cases, a healthcare provider may order a blood test to determine if you’re pregnant. This is most often done for people who are undergoing fertility treatments or if, say, you’re about to have surgery or have medical tests performed where knowing whether you’re pregnant is important.

A doctor’s blood test can detect pregnancy just a few days earlier than a home test — usually around 10 days after you ovulate.

Early pregnancy symptoms

If your cycle doesn’t always match up to the calendar and you haven’t been actively testing yourself for pregnancy, you may notice some changes that can be your first clue that you may be pregnant.

Pro tip: No two pregnancies will look and feel the same. If you’re relying on symptoms alone to determine whether you may be pregnant, you’ll want to be extra vigilant about checking in on yourself and assessing any changes, Dr. Robinson Tidmore advises.

some people, some symptoms may appear right around the time you miss your period.

Light spotting, called implantation spotting, can be a sign of early pregnancy for some people. This happens as the embryo attaches to your uterus. Dr. Robinson Tidmore says it can be easy to dismiss implantation spotting because it may happen around the time you expect your period anyway. But implantation spotting will likely be lighter than your period and probably won't last as long.

Some other common early pregnancy symptoms include:

- Breast tenderness.
- Dizziness or lightheadedness.
- Fatigue.
- Mild cramping.
- Sensitivity to tastes and smells.

One symptom to be especially cautious of is pain that you feel in just one side of

ectopic (tubal) pregnancy. That happens when a fertilized egg implants in a fallopian tube instead of your uterus. This can be very dangerous.

Talking to a doctor

So, you just found out you're pregnant … now what?

One of your first calls should be to a doctor's office, but don't expect that they'll need to see you right away.

"Some people think that if they've had a positive home pregnancy test, we'll need them to come to the office and confirm they're pregnant," Dr. Robinson Tidmore says. "Because home tests are so accurate, most healthcare providers will accept that positive test as confirmation of your pregnancy and will look to schedule you several weeks later."

At that first prenatal appointment, expect that your healthcare provider will perform tests, like an ultrasound, to confirm your pregnancy is progressing normally.

Before that first appointment, however, there are a few things you can do to get your pregnancy starting off healthy:

- Discuss any medications you're taking with your healthcare provider to confirm whether they're safe during pregnancy.
- Start taking prenatal vitamins.
- Don't smoke or drink alcohol.
- Get plenty of sleep.
- Drink plenty of water and follow a healthy diet.
- Keep your body moving through regular exercise.

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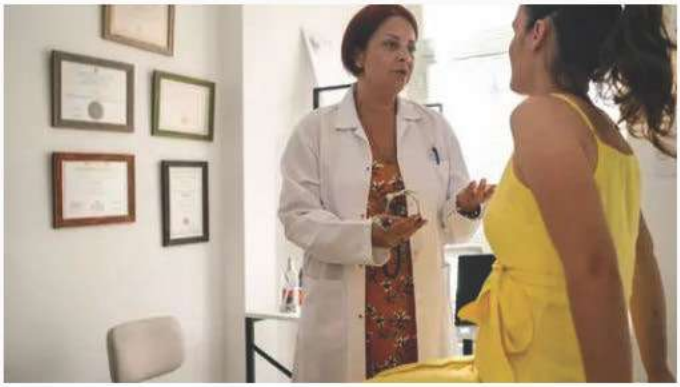

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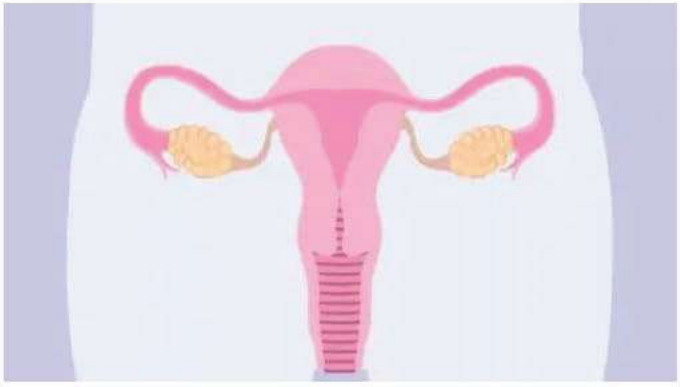

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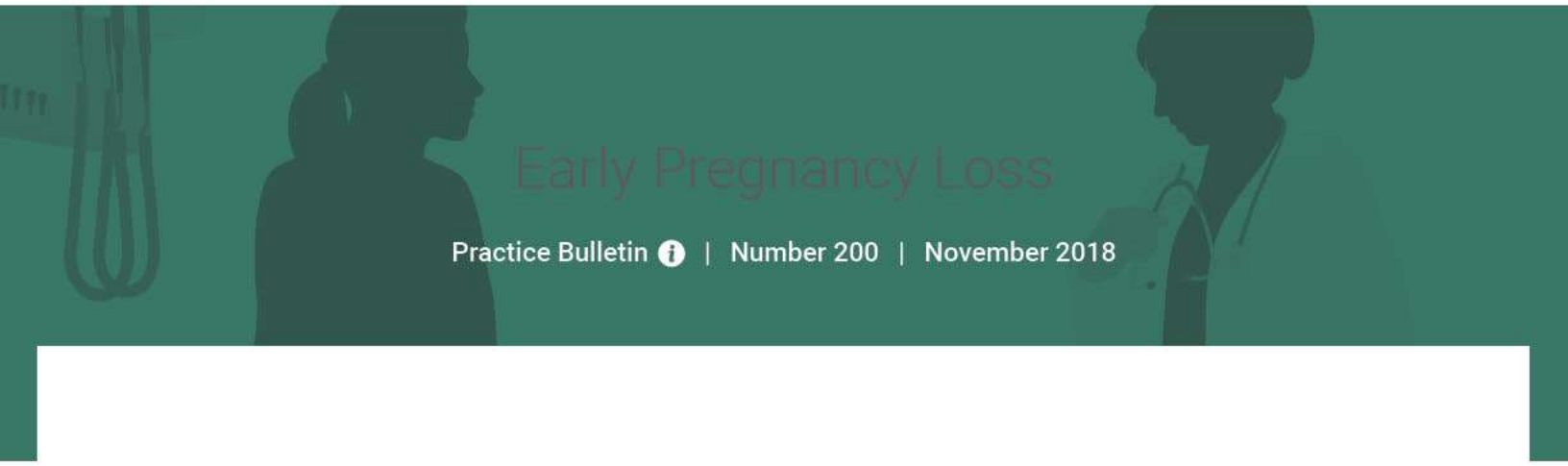

Early Pregnancy Loss

Practice Bulletin | Number 200 | November 2018

The following supplemental information has been issued for this document:

View the March 2024 Practice Advisory

View the January 2023 Practice Advisory

View the Physician FAQs

Number 200 *(Replaces Practice Bulletin Number 150, May 2015. Reaffirmed 2021)*

Committee on Practice Bulletins—Gynecology . This Practice Bulletin was developed by the ACOG Committee on Practice Bulletins—Gynecology in collaboration with Sarah Prager, MD; Vanessa K. Dalton, MD, MPH; and Rebecca H. Allen, MD, MPH.

INTERIM UPDATE: This Practice Bulletin is updated as highlighted to reflect recent evidence regarding the use of mifepristone combined with misoprostol for medical management of early pregnancy loss. This Practice Bulletin also includes limited, focused updates to align with Practice Bulletin No. 181, *Prevention of Rh D Alloimmunization* .

ABSTRACT: Early pregnancy loss, or loss of an intrauterine pregnancy within the first trimester, is encountered commonly in clinical practice. Obstetricians and gynecologists should understand the use of various diagnostic tools to differentiate between viable and nonviable pregnancies and offer the full range of therapeutic options to patients, including expectant, medical, and surgical management. The purpose of this Practice Bulletin is to review diagnostic approaches and describe options for the management of early pregnancy loss.

Background

Definition

Early pregnancy loss is defined as a nonviable, intrauterine pregnancy with either an empty gestational sac or a gestational sac containing an embryo or fetus without fetal heart activity within the first 12 6/7 weeks of gestation [1]. In the first trimester, the terms miscarriage, spontaneous abortion, and early pregnancy loss are used interchangeably, and there is no consensus on terminology in the literature. However, early pregnancy loss is the term that will be used in this Practice Bulletin.

Incidence

Early pregnancy loss is common, occurring in 10% of all clinically recognized pregnancies [2] [3] [4]. Approximately 80% of all cases of pregnancy loss occur within the first trimester [2] [3].

Etiology and Risk Factors

Approximately 50% of all cases of early pregnancy loss are due to fetal chromosomal abnormalities [5] [6]. The most common risk factors identified among women who have experienced early pregnancy loss are advanced maternal age and a prior early pregnancy loss [7] [8]. The frequency of clinically recognized early pregnancy loss for women aged 20–30 years is 9–17%, and this rate increases sharply from 20% at age 35 years to 40% at age 40 years and 80% at age 45 years [7]. Discussion of the many risk factors thought to be associated with early pregnancy loss is beyond the scope of this document and is covered in more detail in other publications [6] [7].

Clinical Considerations and Recommendations

What findings can be used to confirm a diagnosis of early pregnancy loss?

Common symptoms of early pregnancy loss, such as vaginal bleeding and uterine cramping, also are common in normal gestation, ectopic pregnancy, and molar pregnancy. Before initiating treatment, it is important to distinguish early pregnancy loss from other early pregnancy complications. Treatment of an early pregnancy loss before confirmed diagnosis can have detrimental consequences, including interruption of a normal pregnancy, pregnancy complications, or birth defects [9]. Therefore, a thorough evaluation is needed to make a definitive diagnosis. In combination with a thorough medical history and physical examination, ultrasonography and serum β-hCG testing can be helpful in making a highly certain diagnosis.

Ultrasonography, if available, is the preferred modality to verify the presence of a viable intrauterine gestation. In some instances, making a diagnosis of early pregnancy loss is fairly straightforward and requires limited testing or imaging. For example, early pregnancy loss can be diagnosed with certainty in a woman with an ultrasound-documented intrauterine pregnancy who subsequently presents with reported significant vaginal bleeding and an empty uterus on ultrasound examination. In other instances, the diagnosis of early pregnancy loss is not as clear. Depending on the specific clinical circumstances and how much diagnostic certainty the patient desires, a single serum β-hCG test or ultrasound examination may not be sufficient to confirm the diagnosis of early pregnancy loss.

The use of ultrasound criteria to confirm the diagnosis of early pregnancy loss was initially reported in the early 1990s, shortly after vaginal ultrasonography became widely available. Based on these early studies, a crown–rump length (CRL) of 5 mm without cardiac activity or an empty gestational sac measuring 16 mm in mean gestational sac diameter have been used as diagnostic criteria to confirm early pregnancy loss [10] [11]. Recently, two large prospective studies have been used to challenge these cutoffs. In the first study, 1,060 women with intrauterine pregnancies of uncertain viability were followed up to weeks 11–14 of gestation [12]. In this group of women, 55.4% received a diagnosis of nonviable gestation during the observation period. A CRL cutoff of 5 mm was associated with an 8.3% false-positive rate for early pregnancy loss. A CRL cutoff of 5.3 mm was required to achieve a false-positive rate of 0% in this study [12]. Similarly, the authors reported a 4.4% false-positive rate for early pregnancy loss when using a mean gestational sac diameter cutoff of 16 mm. A mean gestational sac diameter cutoff of 21 mm (without an embryo and with or without a yolk sac) on the first ultrasound examination was required to achieve 100% specificity for early pregnancy loss. In a second study of 359 women from the first study group, the authors concluded that growth rates for the gestational sac (mean gestational sac diameter) and the embryo (CRL) could not predict viability accurately [13]. However, the authors concluded that if a gestational sac was empty on initial scan, the absence of a visible yolk sac or embryo on a second scan performed 7 days or more after the first scan was always associated with pregnancy loss [13].

Based on these studies, the Society of Radiologists in Ultrasound Multispecialty Panel on Early First Trimester Diagnosis of Miscarriage and Exclusion of a Viable Intrauterine Pregnancy created guidelines that are considerably more conservative than past recommendations and also have stricter cutoffs than the studies on which they are based [14] **Table 1** . The authors of the guidelines report that the stricter cutoffs are needed to account for interobserver variability; however, this already was accounted for in the original study through its use of multiple ultrasonographers [12] [15] . Other important limitations in the development of these guidelines should be recognized. For example, there were few cases at or near the measurements ultimately identified as decision boundaries. Similarly, the time between observing a gestational sac and expecting to see a yolk sac or embryo was increased from 7 days or more in the clinical study [13] to 14 days in the guidelines [14] . The basis of this recommendation is unclear.

Table 1. Guidelines for Transvaginal Ultrasonographic Diagnosis of Pregnancy Failure in a Woman With an Intrauterine Pregnancy of Uncertain Viability*

Findings Diagnostic of Pregnancy Failure	Findings Suspicious for, but Not Diagnostic of, Pregnancy Failure†
Crown–rump length of 7 mm or greater and no heartbeat	Crown–rump length of less than 7 mm and no heartbeat
Mean sac diameter of 25 mm or greater and no embryo	Mean sac diameter of 16–24 mm and no embryo
Absence of embryo with heartbeat 2 weeks or more after a scan that showed a gestational sac without a yolk sac	Absence of embryo with heartbeat 7–13 days after a scan that showed a gestational sac without a yolk sac
Absence of embryo with heartbeat 11 days or more after a scan that showed a gestational sac with a yolk sac	Absence of embryo with heartbeat 7–10 days after a scan that showed a gestational sac with a yolk sac
	Absence of embryo for 6 weeks or longer after last menstrual period
	Empty amnion (amnion seen adjacent to yolk sac, with no visible embryo)
	Enlarged yolk sac (greater than 7 mm)
	Small gestational sac in relation to the size of the embryo (less than 5 mm difference between mean sac diameter and crown–rump length)

*Criteria are from the Society of Radiologists in Ultrasound Multispecialty Consensus Conference on Early First Trimester Diagnosis of Miscarriage and Exclusion of a Viable Intrauterine Pregnancy, October 2012.

†When there are findings suspicious for pregnancy failure, follow-up ultrasonography at 7–10 days to assess the pregnancy for viability is generally appropriate.

Reprinted from Doubilet PM, Benson CB, Bourne T, Blaivas M, Barnhart KT, Benacerraf BR, et al. Diagnostic criteria for nonviable pregnancy early in the first trimester. Society of Radiologists in Ultrasound Multispecialty Panel on Early First Trimester Diagnosis of Miscarriage and Exclusion of a Viable Intrauterine Pregnancy. N Engl J Med 2013;369:1443–51.

Obstetrician–gynecologists caring for women experiencing possible early pregnancy loss should consider other clinical factors when interpreting the Society of Radiologists in Ultrasound guidelines, including the woman's desire to continue the pregnancy; her willingness to postpone intervention to achieve 100% certainty of pregnancy loss; and the potential consequences of waiting for intervention, including unwanted spontaneous passage of pregnancy tissue, the need for an unscheduled visit or procedure, and patient anxiety. It is important to include the patient in the diagnostic process and to individualize these guidelines to patient circumstances.

Criteria that are considered suggestive, but not diagnostic, of early pregnancy loss are listed in **Table 1** [14]. Slow fetal heart rate (less than 100 beats per minute at 5–7 weeks of gestation) [16] and subchorionic hemorrhage also have been shown to be associated with early pregnancy loss but should not be used to make a definitive diagnosis [17]. These findings warrant further evaluation in 7–10 days [14].

In cases in which an intrauterine gestation cannot be identified with reasonable certainty, serial serum β-hCG measurements and ultrasound examinations may be required before treatment to rule out the possibility of an ectopic pregnancy. A detailed description of the recommended approach to ectopic pregnancy diagnosis and management is available in Practice Bulletin Number 193, *Tubal Ectopic Pregnancy* [18].

What are the management options for early pregnancy loss?

Accepted treatment options for early pregnancy loss include expectant management, medical treatment, or surgical evacuation. Although these options differ significantly in process, all have been shown to be reasonably effective and accepted by patients. In women without medical complications or symptoms requiring urgent surgical evacuation, treatment plans can safely accommodate patient treatment preferences. There is no evidence that any approach results in different long-term outcomes. Patients should be counseled about the risks and benefits of each option. The following discussion applies to symptomatic and asymptomatic patients.

Expectant Management

Because of a lack of safety studies of expectant management in the second trimester and concerns about hemorrhage, expectant management generally should be limited to gestations within the first trimester. With adequate time (up to 8 weeks), expectant management is successful in achieving complete expulsion in approximately 80% of women [19]. Limited data suggest that expectant management may be more effective in symptomatic women (those who report tissue passage or have ultrasound findings consistent with incomplete expulsion) than in asymptomatic women [20] [21]. Furthermore, studies that included women with incomplete early pregnancy loss tend to report higher success rates than those that included only women with missed or anembryonic pregnancy loss [22].

Patients undergoing expectant management may experience moderate-to-heavy bleeding and cramping. Educational materials instructing the patient on when and who to call for excessive bleeding and prescriptions for pain medications should be provided. It also is important to counsel patients that surgery may be needed if complete expulsion is not achieved. Studies among women with early pregnancy loss typically have used ultrasound criteria, patient-reported symptoms, or both, to confirm complete passage of gestational tissue. Although there is no consensus in the literature, a commonly used criterion for complete expulsion of pregnancy tissue is the absence of a gestational sac and an endometrial thickness of less than 30 mm [23]. However, there is no evidence that morbidity is increased in asymptomatic women with a thicker endometrial measurement [24]. Surgical intervention is not required in asymptomatic women with a thickened endometrial stripe after treatment for early pregnancy loss. Thus, the use of ultrasound examination for any diagnostic purpose other than documenting the absence of the gestational sac is not recommended. Other follow-up approaches, such as standardized follow-up phone calls, urine pregnancy tests, or serial quantitative serum β-hCG measurements, may be useful, especially for women with limited access to follow-up ultrasound examination [25]. However, these approaches have not been studied sufficiently among women with early pregnancy loss to provide meaningful guidance.

Medical Management

Medical management for early pregnancy loss can be considered in women without infection, hemorrhage, severe anemia, or bleeding disorders who want to shorten the time to complete expulsion but prefer to avoid surgical evacuation. Compared with expectant management, medical management of early pregnancy loss decreases the time to expulsion and increases the rate of complete expulsion without the need for surgical intervention [26].

Misoprostol-based regimens have been extensively studied for the medical management of early pregnancy loss [26]. Most studies suggest that a larger dose of misoprostol is more effective than a smaller dose, and vaginal or sublingual administration is more effective than oral administration, although the sublingual route is associated with more cases of diarrhea [26]. The largest randomized controlled trial conducted in the United States demonstrated complete expulsion by day 3 in 71% of women with first-trimester pregnancy loss after one dose of 800 micrograms of vaginal misoprostol [23]. The success rate was increased to 84% after a second dose of 800 micrograms of vaginal misoprostol was administered if needed. Therefore, in patients for whom medical management of early pregnancy loss is indicated, initial treatment using 800 micrograms of vaginal misoprostol is recommended, with a repeat dose as needed [Box 1].

Box 1.

Protocol for the Medical Management of Early Pregnancy Loss

- Misoprostol 800 micrograms vaginally, with one repeat dose as needed, no earlier than 3 hours after the first dose and typically within 7 days if there is no response to the first dose*
- A dose of mifepristone (200 mg orally) 24 hours before misoprostol administration should be considered when mifepristone is available.[†]
- Prescriptions for pain medications should be provided to the patient.
- Women who are Rh(D) negative and unsensitized should receive Rh(D)-immune globulin within 72 hours of the first misoprostol administration.
- Follow-up to document the complete passage of tissue can be accomplished by ultrasound examination, typically within 7–14 days. Serial serum β-hCG measurements may be used instead in settings where ultrasonography is unavailable. Patient-reported symptoms also should be considered when determining whether complete expulsion has occurred.
- If medical management fails, the patient may opt for expectant management, for a time determined by the woman and her obstetrician–gynecologist or other gynecologic provider, or suction curettage.

*Zhang J, Gilles JM, Barnhart K, Creinin MD, Westhoff C, Frederick MM. A comparison of medical management with misoprostol and surgical management for early pregnancy failure. National Institute of Child Health Human Development (NICHD) Management of Early Pregnancy Failure Trial. N Engl J Med 2005;353:761–9.

[†]Schreiber CA, Creinin MD, Atrio J, Sonalkar S, Ratcliffe SJ, Barnhart KT. Mifepristone pretreatment for the medical management of early pregnancy loss. N Engl J Med 2018;378:2161–70.

The addition of a dose of mifepristone (200 mg orally) 24 hours before misoprostol administration may significantly improve treatment efficacy and should be considered when mifepristone is available (Box 1). Although initial studies were unclear about the benefit of mifepristone for the management of early pregnancy loss [27], a 2018 randomized controlled trial showed that a combined mifepristone–misoprostol regimen was superior to misoprostol alone for the management of early pregnancy loss [28]. Among 300 women undergoing medical management for early pregnancy loss, those who received mifepristone (200 mg orally) followed by misoprostol (800 micrograms vaginally) 24 hours later had significantly increased rates of complete expulsion (relative risk [RR], 1.25; 95% CI, 1.09–1.43) compared with women who received misoprostol alone (800 micrograms vaginally) [28]. The mifepristone–misoprostol regimen also was associated with a decreased risk of surgical intervention with uterine aspiration to complete treatment (RR, 0.37; 95% CI, 0.21–0.68). Reports of bleeding intensity and pain as well as other adverse effects were generally similar for the two treatment groups, and the occurrence of serious adverse events was rare among all participants. These results are consistent with the demonstrated efficacy and safety of the mifepristone–misoprostol combined regimen for medication-induced abortion [29] [30]. Currently, the availability of mifepristone is limited by U.S. Food and Drug Administration Risk Evaluation and Mitigation Strategy restrictions [31]. The American College of Obstetricians and Gynecologists supports improving access to mifepristone for reproductive health indications [32].

A 2013 Cochrane review of limited evidence concluded that among women with incomplete pregnancy loss (ie, incomplete tissue passage), the addition of misoprostol does not clearly result in higher rates of complete evacuation when compared with expectant management (at 7–10 days, success rates were 80–81% versus 52–85%, respectively) [33]. Therefore, at this time, there is insufficient evidence to support or refute the use of misoprostol among women with incomplete pregnancy loss.

As with expectant management of early pregnancy loss, women opting for medical treatment should be counseled on what to expect while they pass pregnancy tissue, provided information on when to call regarding bleeding, and given prescriptions for pain medications. Counseling should emphasize that the woman is likely to have bleeding that is heavier than menses (and potentially accompanied by severe cramping). The woman should understand how much bleeding is considered too much. An easy reference for the patient to use is the soaking of two maxi pads per hour for 2 consecutive hours [34]. The patient should be advised to call her obstetrician–gynecologist or other gynecologic provider if she experiences this level of bleeding. As with expectant management, it also is important to counsel patients that surgery may be needed if medical management does not achieve complete expulsion.

Follow-up typically includes confirmation of complete expulsion by ultrasound examination, but serial serum β-hCG measurement may be used instead in settings where ultrasonography is unavailable. Patient-reported symptoms also should be considered when determining whether complete expulsion has occurred.

Surgical Management

Surgical uterine evacuation has long been the traditional approach for women presenting with early pregnancy loss and retained tissue. Women who present with hemorrhage, hemodynamic instability, or signs of infection should be treated urgently with surgical uterine evacuation. Surgical evacuation also might be preferable in other situations, including the presence of medical comorbidities such as severe anemia, bleeding disorders, or cardiovascular disease. Many women prefer surgical evacuation to expectant or medical treatment because it provides more immediate completion of the process with less follow-up.

In the past, uterine evacuation often was performed with sharp curettage alone. However, studies show that the use of suction curettage is superior to the use of sharp curettage alone [35] [36]. Furthermore, the routine use of sharp curettage along with suction curettage in the first trimester does not provide any additional benefit as long as the obstetrician–gynecologist or other gynecologic provider is confident that the uterus is empty. Suction curettage also can be performed in an office setting with an electric vacuum source or manual vacuum aspirator, under local anesthesia with or without the addition of sedation [37] [38]. Surgical management in the office setting offers significant cost savings compared with the same procedure performed in the operating room [38] [39] [40]. Patients often choose management in the office setting for its convenience and scheduling availability [38].

How do the different management options for early pregnancy loss compare in effectiveness and risk of complications?

Studies have demonstrated that expectant, medical, and surgical management of early pregnancy loss all result in complete evacuation of pregnancy tissue in most patients, and serious complications are rare. As a primary approach, surgical evacuation results in faster and more predictable complete evacuation [22]. The success of surgical uterine evacuation of early pregnancy loss approaches 99% [23]. The largest U.S. trial reported that success rates after medical management of anembryonic gestations (81%) was lower than with embryonic or fetal death (88%) or incomplete or inevitable early pregnancy loss (93%) [23]. However, a subsequent multivariable analysis of the same data revealed that only active bleeding and nulliparity were strong predictors of success [41]. Therefore, medical management is a reasonable option for any pregnancy failure type.

Overall, serious complications after early pregnancy loss treatment are rare and are comparable across treatment types. Clinically important intrauterine adhesion formation is a rare complication after surgical evacuation. Hemorrhage and infection can occur with all of the treatment approaches. In the Management of Early Pregnancy Failure Trial, women randomized to the misoprostol group were significantly more likely to have a decrease in their hemoglobin levels greater than or equal to 3 g/dL than women in the vacuum aspiration group [23] [42]. However, rates of hemorrhage-related hospitalization with or without transfusion are similar between treatment approaches (0.5–1%) [23] [43]. Pelvic infection also can occur after any type of early pregnancy loss treatment. One systematic review concluded that although infection rates appeared lower among those undergoing expectant management than among those undergoing surgical evacuation (RR, 0.29; 95% CI, 0.09–0.97), the overall rates of infection were low (1–2%) [43]. Because neither approach was clearly superior, the reviewers concluded that patient preference should guide choice of intervention [43].

The risk of infection after suction curettage for missed early pregnancy loss should be similar to that after suction curettage for induced abortion. Therefore, despite the lack of data, antibiotic prophylaxis also should be considered for patients with early pregnancy loss [44] [45]. The use of a single preoperative dose of doxycycline is recommended to prevent infection after surgical management of early pregnancy loss. Some experts have recommended administration of a single 200-mg dose of doxycycline 1 hour before surgical management of early pregnancy loss to prevent postoperative infection. The use of antibiotics based only on the diagnosis of incomplete early pregnancy loss has not been found to reduce infectious complications as long as unsafe induced abortion is not suspected [46]. The benefit of antibiotic prophylaxis for the medical management of early pregnancy loss is unknown.

How do the different treatment approaches to early pregnancy loss differ with respect to cost?

Studies have consistently shown that surgical management in an operating room is more costly than expectant or medical management [47] [48]. However, surgical management in an office setting can be more effective and less costly than medical management when performed without general anesthesia and in circumstances in which numerous office visits are likely or there is a low chance of success with medical management or expectant management [49]. Findings from studies comparing the cost-effectiveness of medical and expectant management schemes are inconsistent. However, a U.S. analysis of all three management approaches concluded that medical management with misoprostol was the most cost-effective intervention [48]. One limitation of the available studies on cost of early pregnancy loss care is that none of these studies can adequately consider clinical nuances or patient treatment preferences, which can affect patient adherence to the primary treatment regimen and, subsequently, the effectiveness of that treatment. For instance, in one observational study, the effectiveness of medical management of early pregnancy loss was far lower than rates reported in randomized clinical trials, which was due in large part to patients' unwillingness to complete the treatment regimen [50].

How should patients be counseled regarding interpregnancy interval after early pregnancy loss?

There are no quality data to support delaying conception after early pregnancy loss to prevent subsequent early pregnancy loss or other pregnancy complications. Small observational studies show no benefit to delayed conception after early pregnancy loss [51] [52]. Abstaining from vaginal intercourse for 1–2 weeks after complete passage of pregnancy tissue generally is recommended to reduce the risk of infection, but this is not an evidence-based recommendation.

How should patients be counseled regarding the use of contraception after early pregnancy loss?

Women who desire contraception may initiate hormonal contraception use immediately after completion of early pregnancy loss [53]. There are no contraindications to the placement of an intrauterine device immediately after surgical treatment of early pregnancy loss as long as septic abortion is not suspected [53]. The expulsion rate with immediate intrauterine device insertion after suction curettage in the first trimester is not clinically significantly different than placement 2–6 weeks postoperatively (5% versus 2.7% at 6 months) [54].

How should patients be counseled regarding prevention of alloimmunization after early pregnancy loss?

Although the risk of alloimmunization is low, the consequences can be significant, and administration of Rh D immune globulin should be considered in cases of early pregnancy loss, especially those that are later in the first trimester. If given, a dose of at least 50 micrograms should be administered. Because of the higher risk of alloimmunization, Rh D-negative women who have surgical management of early pregnancy loss should receive Rh D immune globulin prophylaxis [55].

What type of workup is needed after early pregnancy loss?

No workup generally is recommended until after the second consecutive clinical early pregnancy loss [7]. Maternal or fetal chromosomal analyses or testing for inherited thrombophilias are not recommended routinely after one early pregnancy loss. Although thrombophilias commonly are thought of as causes of early pregnancy loss, only antiphospholipid syndrome consistently has been shown to be significantly associated with early pregnancy loss [56] [57]. In addition, the use of anticoagulants, aspirin, or both, has not been shown to reduce the risk of early pregnancy loss in women with thrombophilias except in women with antiphospholipid syndrome [58] [59].

Are there any effective interventions to prevent early pregnancy loss?

There are no effective interventions to prevent early pregnancy loss. Therapies that have historically been recommended, such as pelvic rest, vitamins, uterine relaxants, and administration of β-hCG, have not been proved to prevent early pregnancy loss [60] [61] [62]. Likewise, bed rest should not be recommended for the prevention of early pregnancy loss [63]. A 2008 Cochrane review found no effect of prophylactic progesterone administration (oral, intramuscular, or vaginal) in the prevention of early pregnancy loss [64]. For threatened early pregnancy loss, the use of progestins is controversial, and conclusive evidence supporting their use is lacking [65]. Women who have experienced at least three prior pregnancy losses, however, may benefit from progesterone therapy in the first trimester [7].

Summary of Recommendations and Conclusions

The following recommendation and conclusion are based on good and consistent scientific evidence (Level A):

- In patients for whom medical management of early pregnancy loss is indicated, initial treatment using 800 micrograms of vaginal misoprostol is recommended, with a repeat dose as needed. The addition of a dose of mifepristone (200 mg orally) 24 hours before misoprostol administration may significantly improve treatment efficacy and should be considered when mifepristone is available.

- The use of anticoagulants, aspirin, or both, has not been shown to reduce the risk of early pregnancy loss in women with thrombophilias except in women with antiphospholipid syndrome.

The following recommendations are based on limited or inconsistent scientific evidence (Level B):

- Ultrasonography, if available, is the preferred modality to verify the presence of a viable intrauterine gestation.

- Surgical intervention is not required in asymptomatic women with a thickened endometrial stripe after treatment for early pregnancy loss.

- The routine use of sharp curettage along with suction curettage in the first trimester does not provide any additional benefit as long as the obstetrician–gynecologist or other gynecologic provider is confident that the uterus is empty.

The following recommendations are based primarily on consensus and expert opinion (Level C):

- Accepted treatment options for early pregnancy loss include expectant management, medical treatment, or surgical evacuation. In women without medical complications or symptoms requiring urgent surgical evacuation, treatment plans can safely accommodate patient treatment preferences.

- The use of a single preoperative dose of doxycycline is recommended to prevent infection after surgical management of early pregnancy loss.

- Although the risk of alloimmunization is low, the consequences can be significant, and administration of Rh D immune globulin should be considered in cases of early pregnancy loss, especially those that are later in the first trimester.

- Because of the higher risk of alloimmunization, Rh D-negative women who have surgical management of early pregnancy loss should receive Rh D immune globulin prophylaxis.

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The MEDLINE database, the Cochrane Library, and the American College of Obstetricians and Gynecologists' own internal resources and documents were used to conduct a literature search to locate relevant articles published between January 2000–July 2014. The search was restricted to articles published in the English language. Priority was given to articles reporting results of original research, although review articles and commentaries also were consulted. Abstracts of research presented at symposia and scientific conferences were not considered adequate for inclusion in this document. Guidelines published by organizations or institutions such as the National Institutes of Health and the American College of Obstetricians and Gynecologists were reviewed, and additional studies were located by reviewing bibliographies of identified articles. When reliable research was not available, expert opinions from obstetrician–gynecologists were used.

Studies were reviewed and evaluated for quality according to the method outlined by the U.S. Preventive Services Task Force:

- I Evidence obtained from at least one properly designed randomized controlled trial.
- II-1 Evidence obtained from well-designed controlled trials without randomization.
- II-2 Evidence obtained from well-designed cohort or case–control analytic studies, preferably from more than one center or research group.
- II-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments also could be regarded as this type of evidence.
- III Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Based on the highest level of evidence found in the data, recommendations are provided and graded according to the following categories:

Level A—Recommendations are based on good and consistent scientific evidence.

Level B—Recommendations are based on limited or inconsistent scientific evidence.

Level C—Recommendations are based primarily on consensus and expert opinion.

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Early pregnancy loss. ACOG Practice Bulletin No. 200. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;132:e197–207.

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Topics

Blood proteins | Combined oral contraceptives | Diagnostic imaging | Hormonal methods | Immunoglobulins | Immunoproteins | Induced abortion | Intrauterine devices | Intrauterine systems | LARC | Medicated intrauterine devices | Misoprostol | Obstetrical and gynecological diagnostic techniques | Obstetric surgical procedures | Oral contraceptives | Pregnancy complications | Prenatal diagnosis | Prenatal ultrasonography | Prostaglandins | Spontaneous abortion | Ultrasonography

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EDUCATION AND TRAINING

POSTGRADUATE:

7/2019 – 6/2021	UPMC Magee-Womens Hospital, University of Pittsburgh, Pittsburgh, PA	Fellowship in Complex Family Planning *Program Director:* Beatrice Chen, MD, MPH
6/2015 – 6/2019	University of Vermont Medical Center Burlington, VT	Residency in Obstetrics and Gynecology *Program Director:* Stephanie Mann, MD

GRADUATE:

8/2019 – 5/2021	University of Pittsburgh Graduate School of Public Health Pittsburgh, PA	Master of Public Health
8/2010 – 5/2015	Indiana University School of Medicine Indianapolis, IN	Doctor of Medicine

UNDERGRADUATE:

9/2006 – 5/2010	Indiana University Bloomington, IN	Bachelor of Science in Biology with Honors Minor in Anthropology Certificate in History and Philosophy of Science

APPOINTMENTS AND POSITIONS

2/2023 – Present	Obstetrics & Gynecology Jacobs School of Medicine and Biomedical Sciences University at Buffalo Buffalo, NY	Clinical Assistant Professor
8/2021 – 12/2022	Planned Parenthood of South, East, and North Florida Miami, FL	Associate Medical Director

12/2019 – 6/2021	Planned Parenthood of Western Pennsylvania Pittsburgh, PA	Staff Physician
10/2019 – Present	Organon Pharmaceuticals Co.	Certified Nexplanon Trainer
7/2019 – 6/2021	Obstetrics, Gynecology, and Reproductive Sciences UPMC Magee-Womens Hospital Pittsburgh, PA	Clinical Instructor
6/2015 – 6/2019	Obstetrics and Gynecology Larner College of Medicine at the University of Vermont Burlington, VT	Clinical Instructor

CERTIFICATION AND LICENSURE

SPECIALTY CERTIFICATION:

2022 – Present American Board of Obstetrics and Gynecology – Diplomate

SUBSPECIALTY CERTIFICATION:

2023 – Present American Board of Obstetrics and Gynecology, Complex Family Planning – Diplomate

MEDICAL LICENSURE:

2022 – Present New York Medical License
2021 – 2023 Florida Medical License
2019 – Present Pennsylvania Medical License
2015 – 2019 Vermont Medical License

MEMBERSHIPS IN PROFESSIONAL AND SCIENTIFIC SOCIETIES

2022 – Present Fellow, American College of Obstetricians and Gynecologists
2019 – Present Junior Fellow, Society of Family Planning
2018 – Present Member, National Abortion Federation
2015 – 2022 Junior Fellow, American College of Obstetricians and Gynecologists
2011 – 2015 Member, Medical Students for Choice
2010 – Present Member, American Medical Association

HONORS

2021	Gynecology Fellow Excellence in Teaching Award, UPMC Magee-Womens Hospital
2019	Ryan Program Resident Award for Excellence in Family Planning
2019	Recognition of Excellence in Minimally Invasive Gynecology
2019	Best Resident Research Project, University of Vermont Medical Center
2017	Resident Reporter, ACOG Ob-Gyn Resident Reporter Program for the Annual Clinical and Scientific Meeting

2017	Ryan Resident Scholarship
2015	Medical Student Golden Apple Teaching Award, Rotation 6, University of Vermont Medical Center
2014	Gold Humanism Honor Society
2014	Medical Students for Choice Reproductive Health Externship Grant
2012	Edward L. Hutton International Experiences Grant

PUBLICATIONS

REFEREED ARTICLES

1. Dougherty A, Kayongo A, **Deans SJ**, Mundaka J, Heil SH, et al. Knowledge and use of family planning among men in rural Uganda. BMC Public Health. 2018;18:1294.
2. Haas DM, Morgan AM, **Deans SJ**, Schubert FP. Ethanol for preventing preterm birth in threatened preterm labor. Cochrane Database Syst Rev. 2015 Nov 5;(11).
3. Clay JM, Daggy JK, Fluellen S, **Deans SJ**, Tucker Edmonds BM. Patient Knowledge and Attitudes Toward Cervical Cancer Screening After the 2012 Screening Guidelines. Obstetrics & Gynecology 2015;125:55S.
4. World Health Organization, Department of Reproductive Health and Research. Policy Brief 12.21: Expanding access to contraceptive services for adolescents. 2012. Retrieved from http://www.who.int/iris/handle/10665/75160

ABSTRACTS AND POSTER PRESENTATIONS

1. **Deans SJ**. Reproductive Decision Support Tool for Women with Substance Use Disorders: A Pilot Study. Presented at the Society of Family Planning Annual Meeting, Los Angeles, CA, October 2019.
2. **Deans SJ**, Modification of an evidence-based family planning intervention for a new target population: Postpartum women in Nakaseke district, Uganda. Poster presented at the Consortium of Universities for Global Health, Chicago, IL, March 2019.
3. **Deans SJ**, Dougherty A, Kayongo A, Mundaka J, Heil SH, et al. Knowledge, attitudes, and use of family planning in rural Uganda: Comparing the female and male perspectives. Poster presented at the Consortium of Universities for Global Health, New York, NY, March 2018; and the American College of Obstetricians & Gynecologists Annual Clinical & Scientific Meeting, Austin, TX, April 2018.
4. **Deans SJ**, Dougherty A, Kayongo A, Mundaka J, Heil SH, et al. Knowledge, attitudes, and use of family planning among rural women in Nakaseke District, Uganda. Poster presented at University of Vermont Global Health Day, Burlington, VT, April 2017.

MEDIA PUBLICATIONS

1. **Deans SJ**. “Florida’s proposed 15-week abortion ban is a direct assault on women” [Editorial]. Sun Sentinel, 2022 Feb 14; https://www.sun-sentinel.com/opinion/commentary/fl-op-com-15-week-abortion-ban-doctor-20220214-xknwtnsoi5gcfiay6ahy33xhry-story.html.

PROFESSIONAL ACTIVITIES

INVITED LECTURES, SEMINARS, PODIUM AND PANEL PRESENTATIONS

1. Grand Rounds, “In the Words of a Family Planner: Verbicaine and Trauma-Informed Care.” Presented at University at Buffalo OB/GYN Grand Rounds, Buffalo, NY (virtual), June 2022.
2. Invited Lecture, “The Past, Present, and Future of Abortion Policy & Politics in the United States.” Presented at Florida International University School of Medicine, Miami, FL, April 2022.
3. Seminar, “How Trauma Shows Up In Our Work.” Presented at Planned Parenthood of South, East, and North Florida’s Annual Meeting, West Palm Beach, FL (virtual), February 2022.
4. Grand Rounds, “In the Words of a Family Planner: Verbicaine and Trauma-Informed Care.” Presented at UPMC Magee-Womens Hospital OB/GYN Grand Rounds, Pittsburgh, PA, December 2020.
5. Seminar, “Reproductive Health Needs of Women with Substance Use Disorders.” Presented at the Mid-Atlantic AIDS Education & Training Center Program Regional Conference, Pittsburgh, PA (virtual) September 2020.
6. Invited Lecture, “Institutionalizing Resident Advocacy at the University of Vermont.” Presented at the Society of Family Planning Annual Meeting, Los Angeles, CA, October 2019.
7. Grand Rounds, “An evidence-based approach to surgical sterilization.” Presented at the University of Vermont Medical Center OB/GYN Grand Rounds, Burlington, VT, April 2019.

ADVOCACY AND MEDIA ENGAGEMENT

1. TV Interview, Featured on *CBS Evening News*. Interviewed by Manuel Bojorquez, July 2022; https://www.cbsnews.com/video/thousands-forced-to-travel-to-florida-for-abortion-access/
2. Keynote Speaker, “Bans off our Bodies” Rally, West Palm Beach, FL, May 2022.
3. Print Interview, “Florida no longer a haven for abortion access: ‘We cannot rest on any amount of protection that exists today’.” Sun Sentinel, May 2022; www.sun-sentinel.com/news/fl-ne-abortion-florida-reaction-20220505-4njho2h5bjbk7l7mcswzdg5j6u-story.
4. TV Interview, Featured on *Yasmin Vossoughian Reports*. Interviewed by Yasmin Vossoughian, February 2022; www.msnbc.com/yasmin-vossoughian-reports/watch/-an-absolute-infringement-on-our-rights-planned-parenthood-doctor-speaks-out-on-florida-s-proposed-15-week-abortion-ban-133630021986.
5. Radio Interview, “Florida's House passes a bill banning abortions after 15 weeks of pregnancy.” Featured on *Morning Edition*, National Public Radio, February 2022; www.npr.org/2022/02/17/1081387034/florida-s-house-has-passed-a-bill-banning-abortions-after-15-weeks-of-pregnancy.
6. TV Interview, Featured on *Zerlina*. Interviewed by Zerlina Maxwell, February 2022; https://twitter.com/ZerlinaShow/status/1494102571547516942?s=20&t=zVguxtj3vmH60Oo8TSiYRA
7. Print Interview, “Florida House approves Republican measure to ban abortion after 15 weeks.” Washington Post, February 2022; www.washingtonpost.com/politics/2022/02/17/abortion-florida-supreme-court.
8. Expert Testimony, “In opposition of SB146: Reducing fetal and infant mortality (15-week abortion ban).” Presented to the Senate Health Policy Committee, Florida State Capitol, Tallahassee, FL, February 2022.
9. Press Conference, “Advocating against HB5/SB146: The 15-week abortion ban in Florida.” Florida State Capitol, Tallahassee, FL, February 2022.
10. Press Conference, “Advocating against Texas-style abortion bans in Florida.” Miami, FL, September 2021.
11. Expert Testimony, “In support of Bill H57: an act relating to preserving the right to an abortion.” Presented to the Senate Health and Welfare Committee, Vermont State House, Montpelier, VT, April 2019.

We are two obstetrician gynecologists who have offered our services for expert review in the Matter of [redacted], Petitioner, and Clayton Echard, Respondent.

We have reviewed the medical records provided by Mr. Woodnick, including those from Banner Health Urgent Care, Barrow Neurological Institute, Scottsdale Perinatal Associates, an ultrasound image labeled as from SMIL (which was later disclosed to be images purportedly obtained from Planned Parenthood at Mission Viejo, CA, per Ms Owens' deposition testimony), MomDoc, and the transcript of Ms [redacted]' deposition from March 1, 2024.

Based on this information, we cannot confirm by any objective data that Ms. [redacted] had an ongoing, viable intrauterine pregnancy at the time of initiating this legal matter in August 2023 or since. There is no confirmation from any medical provider that a pregnancy was identified by ultrasound at any point in time. The patient showed no effort in maintaining a healthy pregnancy given her avoidance of standard in-person medical care, despite her reported episodes of vaginal bleeding and alleged pregnancy loss. It is our expert opinion that the evidence as presented is not conclusive that the petitioner was pregnant with a viable intrauterine pregnancy at any time in the last year.

Positive Pregnancy Tests:

There is evidence that on June 1, 2023, human chorionic gonadotropin (HCG) was present in the petitioner's urine. The only objective evidence of pregnancy *after* the initial urine pregnancy test at Banner Urgent care was a serum quantitative HCG value drawn on October 16, 2023 of 102 mIU/mL, which does not correlate with the gestational age that she would have been on that date had she had a normal ongoing pregnancy—it would have been much higher.[1]

Single HCG values are of minimal clinical significance and are more standardly used within the context of ultrasound evaluations and HCG trends. The presence of HCG can be due to a pregnancy, but pregnancy is not the sole cause of a positive urine HCG and furthermore, a single urine HCG test is not diagnostic of an intrauterine pregnancy. HCG can be present in serum, urine or both under non-pregnancy related conditions: exogenous injection, heterophilic antibodies, certain cancers, familial HCG syndrome, and pituitary secretion of sulfated HCG. There are clinical investigations that can be performed to distinguish one of

[1] A 2014 study by Korevaar et al. determined the median hCG level at 22 weeks of gestation to be 16,174 mIU/mL, with a minimum of 2599 mIU/mL and maximum of 86,541 mIU/mL. It should be noted that this data is for singleton pregnancies; twin gestations would expect even higher values.

these conditions from another. Additionally, there is a phenomenon of "quiescent" pregnancy in which a failed pregnancy leaves residual tissue that persistently (for up to about a year) produces HCG and causes false-positive pregnancy tests. Ongoing clinical care would soon confirm that a viable pregnancy is not present in such a case. In general, the quantity of HCG in these conditions remains at a low level and ultrasound evaluation does not reveal the development of a fetus over time. Additionally, this low level of HCG would not cause significant weight gain, bloating, nausea, or other systemic symptoms.

Ultrasound Image:

The single ultrasound image that, as Ms [redacted] has stated in her deposition, occurred on July 7, 2023 has not been authenticated from any healthcare provider. No medical records are known to exist regarding this pregnancy from SMIL or Planned Parenthood in California, despite multiple attempts to obtain these records. The image in question reports a gestational age of 6 weeks and 4 days, which is not consistent with the stated date of conception of May 20, 2023. If this image is, in fact, an image of Ms [redacted] alleged pregnancy, that would correlate to an estimated date of conception of June 5, 2023.

Planned Parenthood Visit:

Ms [redacted] stated that the reason that we, to this date, have not been able to corroborate the existence of a first trimester pregnancy ultrasound completed at any Planned Parenthood in California is because she completed this visit anonymously. As a former medical director of Planned Parenthood, Dr. Deans can confirm that there is no scenario where we would treat a patient without identifying the patient. Like all outpatient medical facilities, Planned Parenthood requires a name, date of birth, and a piece identification that confirms both (government ID, school ID, passport, birth certificate, etc), regardless of the reason for the visit or method of payment. Unless Ms. [redacted] gave false information at the time of her appointment, Planned Parenthood in California would have records of this ultrasound if it was performed at their facility. We have not been able to review these records.

The petitioner subsequently sent screenshots of a scheduled appointment and visit summary on July 2, 2023 at a Planned Parenthood in Westminster, CA. However, on review of these documents there are no vital signs documented, no orders or medication dispensing documentation, and no patient instructions. Given these findings, we cannot conclude from these documents alone that the petitioner was ever seen or evaluated at this location on this date.

Pregnancy dating and timeline:

In a message to her neurologist at Barrow Neurological Institute on June 28, 2023, the petitioner indicated that her Planned Parenthood visit, presumably including the aforementioned ultrasound, occurred when she was visiting California the weekend prior to the message, presumably the weekend of June 24, 2023. This would correlate to 7w0d by conception date of 5/20/2023. At 7 weeks gestation, a licensed ultrasound provider would be able to identify twins on ultrasound. In a later message to Scottsdale Perinatal Associates on July 3, 2023, she inquired how soon one could determine a twin gestation. From the positive urine pregnancy test at Banner Urgent Care in June 2023 until her visit to MomDoc on November 14, 2023, all healthcare encounters Ms Owens had were through telehealth. In the Barrow Neurological Institute's records of her telehealth appointments, it was noted that they were conducted with Ms[redacted] seated.

Per Ms[redacted]ns' deposition, she passed "two sacs" sometime in September or October. In that timeframe, the pregnancy would have been somewhere between 16 and 22 weeks of pregnancy. At that size, with twins, a loss would have produced significant bleeding and pain, such that it is implausible that she would have not received medical care beyond a telehealth visit. Additionally, the sacs would have contained formed and recognizable fetuses at that point in a pregnancy. Ms [redacted] testified that she showed what she passed to the provider on a telehealth visit. Gestational sacs with 16-week size fetuses would have been unmistakable to the provider and they would have unquestionably advised that she seek urgent in-person medical care.

Images and telehealth visit from July 23, 2023:

We have reviewed images submitted by the petitioner that are allegedly showing the tissue from the event noted in Ms[redacted] deposition of passing "two sacs". Ms [redacted] clarified at the time of submitting these pictures that the events actually took place on July 23, 2023, rather than in September or October. These pictures show toilet paper stained with blood and containing tissue, reportedly from the petitioner's vagina. From visual inspection, we cannot confirm the source of this tissue, nor can we confirm that this is pregnancy tissue. The only way any physician could confirm that this was in fact pregnancy tissue, would be to send the specimen to a pathologist. As the tissue in question was never brought in for pathologic evaluation, there is no way to confirm if it was trophoblast (pregnancy tissue) or a decidual cast (non-pregnant endometrium). There is no obvious embryonic or fetal tissue

in this image, further complicating the picture in a pregnancy that would have been approximately 11 weeks by a date of conception of May 20, 2023.

Furthermore, we have reviewed the discharge instructions of a telehealth visit addressing this incident on July 23, 2023. In that document, the telehealth provider instructed Ms [redacted] to proceed to an emergency room for additional evaluation and care. Ms [redacted] did not follow this medical advice. Instead, she contacted the Abortion & Miscarriage Hotline, the communications of which we have reviewed. Again, the hotline respondent encouraged the petitioner to seek in-person medical care, and she again did not follow these recommendations.

Conclusion:

We cannot confirm by any objective data that Ms [redacted] had an ongoing, viable clinical pregnancy at any time in the last year. Clinical pregnancy is defined as "a pregnancy diagnosed by ultrasonographic visualization of one or more gestational sacs or definitive clinical signs of pregnancy. In addition to intra-uterine pregnancy, it includes a clinically documented ectopic pregnancy."[2] We have received no verifiable documentation of a clinical pregnancy as defined.

Signed,

Faye Justicia-Linde, MD, FACOG

Samantha J Deans, MD, MPH, FACOG

[2] The International Committee for Monitoring Assisted Reproductive Technologies (ICMART) in partnership with ten global health societies developed a consensus-based and evidence-driven set of 283 terminologies used in infertility and fertility care to harmonize communication among health professionals and scientists as well as the lay public, patients and policy makers.

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