

# Part 1

## Medical Problems



# Chapter 1



These are primarily health department inspection reports, supplemented with some media coverage and other documents.

No state inspections for these types of facility are held in: Alaska, Colorado, Hawaii, Idaho, Iowa, Maine, Minnesota, Mississippi, Montana, New Hampshire, New Mexico, Rhode Island, Vermont, and West Virginia.

There are no Planned Parenthood centers in Louisiana, Mississippi, North Dakota or Wyoming

Inspections are held in New York, but what violations were found and at which location are heavily redacted and therefore not available to the public.

California investigates individual complaints but does not do full health inspections. Therefore, many of the health department documents contain nothing other than privacy complaints, and those are covered in Chapter 8 on Privacy.



Incidents in health inspection reports that involved an ambulance to the hospital have the highlight explaining it marked with this graphic.

## United States



Botched Care and Tired Staff: Planned Parenthood in Crisis  
by Katie Benner, *The New York Times*, February 15, 2025

### **Excerpt:**

A New York Times review of clinic documents and legal filings, as well as interviews with more than 50 current and former Planned Parenthood executives, consultants and medical staff members, found that some clinics are so short of cash that care has suffered. Many operate with aging equipment and poorly trained staff, as turnover has increased because of rock-bottom salaries . . .

Employees at various affiliates said it was common to run out of over-the-counter pain medication and I.V. flushes . . .

Clinic employees said repeatedly in interviews that patients routinely encountered long waits, undertrained staff members and trouble even booking an appointment.

“I saw clients get turned away for services because they couldn’t afford it and the process of getting aid through Planned Parenthood took too long,” said Damien Hamblin, a medical assistant who worked at health care clinics before joining Planned Parenthood Arizona in 2022; he later left. “We’re supposed to be the organization for people that don’t have resources.”

## Multi-State



Botched Care and Tired Staff: Planned Parenthood in Crisis  
by Katie Benner, *The New York Times*, February 15, 2025

### **Excerpt:**

in many clinics, they also draw blood and take vital signs. Medical assistants in Ohio, Minnesota, Arizona, California, New York, Texas, Indiana and Illinois said they practiced blood draws and I.V. placements for an hour or so on a fake arm and then on a colleague before performing the procedures in clinics. But they said they sometimes ran into problems, and some said they did not know what to do when they arose. Mr. Hamblin, the medical assistant in Arizona, said that he was often asked to draw blood after other assistants had failed.

# Affiliate: North Central States

Covers Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Botched Care and Tired Staff: Planned Parenthood in Crisis  
by Katie Benner, *The New York Times*, February 15, 2025

## Excerpt:

For months last year at the North Central States affiliate, which oversees the Nebraska clinic, an understaffed nursing department did not upload sexually transmitted infection test results into charts, and patients wrongly believed that their results were negative when they did not hear back.

## Alabama

### Birmingham

*The health department documents from 2009, 2013, 2014, 2016, and 2021 can be found at:*

[www.problemsatplannedparenthood.org/alabama](http://www.problemsatplannedparenthood.org/alabama)

## Highlights:

### Clinic Conditions

- The clinic failed to ensure staff cleaned equipment used in surgery, nor clean chairs in the recovery room, nor wash their hands.
- An examination table was in disrepair, increasing the chance of infection.

### Staff

- There was no policy to ensure that doctors were competent and qualified, such as observation of surgical procedures and interactions with patients.
- The medical director failed to document an annual review of competency for two doctors on staff.
- There was no job description on record for the Health Center Manager.
- Four medical employees had no record of a Hepatitis B vaccine or a TB test. There was also no record of a nurse practitioner being screened for hepatitis.

## Medical Records and Labels

- Paperwork given to women before surgery failed to include the names of medications given, what medications were to be taken home, and omitted the name of the doctor operating on them.

## Incidents

- In 2014, two employees sold drugs to patients in the parking lot. The director fired all staff. To hire and train new staff, the facility was closed, but the director never informed the Health Department of the closure. None of the former employees cooperated with health inspectors.

## Other

- The telephone number of the Alabama Department of Public Health complaint hotline was neither posted where patients could see it, nor given in the patient instructions.

## Mobile

*This clinic is permanently closed, so the health department documents from 2011, 2014, 2016, and 2021 can be found at:*

[www.problemsatplannedparenthood.org/closed-centers-health-violations](http://www.problemsatplannedparenthood.org/closed-centers-health-violations)

## Arizona



Botched Care and Tired Staff: Planned Parenthood in Crisis  
by Katie Benner, *The New York Times*, February 15, 2025

In one incident, a young woman who received an IUD was told “it would be rough, and just ride it out,” according to a written complaint emailed to the office of the Planned Parenthood affiliate’s president. She said she suffered months of sharp pain and bleeding, but the phone system routed her mother’s calls for help to automated phone tree messages, according to the complaint. A new doctor found that Planned Parenthood had botched the procedure. The affiliate continued to bill the family, even though they had paid their balance, according to the complaint, which cited conversations with one of the affiliate’s billing employees.

# Arkansas

## Little Rock

*The health Department documents from 2016 and 2018 can be found under Little Rock at:*

[www.problemsatplannedparenthood.org/arkansas](http://www.problemsatplannedparenthood.org/arkansas)

### Highlights:

#### Clinic Conditions

- Items required for patient care weren't stored in a clean environment. For example, white drapes used in exams were left on the floor of the storage room. The clinic was cited for allowing the contamination of patient care equipment.
- The facility "failed to ensure that equipment was kept in good repair."
- A stool in the ultrasound room had a cloth covering which "has an absorbent nature and cannot be disinfected." A hole in the covering extended down into the cushion.

#### Other

- The clinic failed to "develop, implement, or rehearse" plans for what to do in case of a disaster.
- The facility was required to make available a list of emergency phone numbers and contact information for police, the fire department, ambulance services, and other emergency responders. The list hadn't been updated in two years. This could cause a delay in contacting emergency.

# Arizona

## Flagstaff

*The health department document from 2016 can be found under Flagstaff at:*

[www.problemsatplannedparenthood.org/arizona](http://www.problemsatplannedparenthood.org/arizona)

### Highlights:

- The facility failed to properly sterilize instruments and textiles that "may come in contact with a patients' blood and internal tissue." Using unsterilized, dirty instruments on multiple women has the potential to spread infection.

## Glendale

The health department documents from 2015 and 2020 can be found under Glendale at:

[www.problemsatplannedparenthood.org/arizona](http://www.problemsatplannedparenthood.org/arizona)

### Highlights:

#### Clinic Conditions

- They used expired medications on patients. Some were two years past their expiration dates.
- Staff failed to perform required spore tests on the autoclaves (machines used to sterilize instruments). This could lead to “a potential risk of cross contamination and infection to their patients” according to the report.
- Staff failed to properly maintain, clean, and sterilize the autoclaves as per the manufacturer’s instructions. There was no documentation that the autoclaves were cleaned on a weekly or even monthly basis.
- When blood dripped from a used speculum onto the floor, staff was observed wiping it up with paper towels and cleaning spray rather than using bleach and properly disinfecting the floor.
- Hazardous chemicals weren’t properly labeled.
- Staff didn’t properly clean and disinfect post-procedure specimen bottles.
- Staff failed to clean and sanitize examination tables between patients.
- According to the report, these omissions, “have the potential for non-sterile instruments or non-disinfected supplies to be utilized on patients.”
- There was no designated infection control person assigned to the infection control position, no one whose job is specifically to ensure that cleanliness and proper sterilization practices were followed.
- There were multiple tears and punctures in the upholstered material of an examination table, exposing stuffing. This presents an infection risk as it makes the surface difficult or impossible to properly disinfect.

#### Staff

- Three staff members had not received yearly TB tests, and the test of another was improperly conducted, rendering it invalid.
- Two doctors weren’t certified in CPR. There was no documentation of present or past certification.

#### Privacy

- A HIPAA (privacy) violation that occurred at the clinic wasn’t documented.

## Incidents

- A patient had an adverse reaction to sedation administered before a procedure. She suffered severely low blood pressure. This wasn't reported to the medical director or recorded in the procedure notes. The RN who administered the sedation wasn't licensed to do so. When asked to show what protocols were in place for treating patients suffering severe hypotension (dangerously low blood pressure) the clinic was unable to provide any. The facility also had no guidelines for what blood pressure measurements indicated severe hypotension. According to the report, the center manager "verified, during an interview conducted on 2/13/15, that there are no established blood pressure parameters for severe hypotension, standing orders, and/or facility policy that identifies the care and treatment of a patient experiencing severe hypotension after adversely reacting to a medication provided for conscious sedation."

## Tempe

*The health department documents from 2014 can be found under Tempe at:*

[www.problemsatplannedparenthood.org/arizona](http://www.problemsatplannedparenthood.org/arizona)

### **Highlights:**

#### Clinic Conditions

- Didn't have a policy for the use, cleaning, and preventive maintenance of certain equipment used on patients, such as heating pads.
- The facility appeared to be using irrigation solution (Braun 0.9% Sodium Chloride) that, by manufacturer's standards, should've been discarded.
- The autoclave, used to sterilize the instruments, was required to be cleaned weekly. However, the last documented cleaning was nearly three months prior to the inspection. Staff couldn't verify the autoclave had been cleaned more recently than that.
- The clinic staff failed to monitor how many cycles the autoclave was running. This was supposed to be done automatically by a printout attached to the machine. However, the paper in the printer had run out and hadn't been replaced.

# California

*California investigates individual complaints but does not do full health inspections.*

## Antioch

*The health department document from 2016 can be found under Antioch at:*

[www.problemsatplannedparenthood.org/california-a-to-f](http://www.problemsatplannedparenthood.org/california-a-to-f)

### **Highlights:**

#### Staff

- Unlicensed and untrained staff were seeing patients and giving medical care.
- Employees were counseling patients, giving medical advice, examining patients, and obtaining informed consent even though they weren't qualified to do so.
- The staff member who performed vaginal ultrasounds was untrained and unqualified, with only a high school diploma with one medical assistant class. A transvaginal ultrasound is an invasive procedure.
- The medical director stated the only requirement in hiring an ultrasound technician was a high school diploma.
- The head of ultrasound training wasn't a certified ultrasound technician.
- According to the medical director, all 20 clinics she supervised employed untrained ultrasound technicians who were merely certified as medical assistants. The director stated she felt medical assistants were qualified to do ultrasounds but was unable to give an example of a health care facility, other than her clinics, where they were doing so.

#### Incident



A woman suffered a severe complication, and the clinic failed to cooperate with investigators as to the incident. Surveyors were turned away twice and not permitted to inspect the facility. Clinic staff refused to allow inspectors access to the patient records, refused to allow inspectors entry into the facility, and when they did allow investigators access to electronic records, refused to let them make copies or take notes.

The patient later began bleeding heavily and passed large clots, one of which was the size of a baseball. She passed out and went to the hospital. The patient later said, "I could have died." She needed surgery and a blood transfusion.

The nurse who gave the patient medications wasn't licensed to do so and failed to follow clinic protocol. She gave the patient three extra medications.

## Burbank

*The 2019 Court Complaint can be found under Burbank at:*

[www.problemsatplannedparenthood.org/california-a-to-f](http://www.problemsatplannedparenthood.org/california-a-to-f)

7. . . . on October 9, 2018, Plaintiff's insured witnessed water flowing onto the premises from a toilet that had overflowed that was owned and controlled by Defendants, Planned Parenthood . . .

13. As a result of the negligence of Defendants and each of them, Plaintiff's insured sustained at least \$296,158.54 in damages.

## Orange

*The health department document from 2014 can be found under Orange at:*

[www.problemsatplannedparenthood.org/california-g-to-r](http://www.problemsatplannedparenthood.org/california-g-to-r)

### Highlights:



One patient suffered copious bleeding after surgery and was sent to the hospital to be treated for complications and blood loss. Staff failed to properly document the incident in their records.

- A second patient also bled heavily after surgery. She was sent home with active bleeding after passing a large blood clot. It was estimated from her hemoglobin level that she lost 720 ml of blood. The clinic failed to document the amount of blood loss in their records.

## San Jose

### Doctor's License Revoked – Joplin

*Dr. Joplin served at Planned Parenthood, primarily at the San Jose Center, for many years and was working there at the time of his license revocation in 2011. The full license orders from 2011 and a previous one from 1997 can be found at:*

[www.problemsatplannedparenthood.org/california-san-jose](http://www.problemsatplannedparenthood.org/california-san-jose)

#### **Excerpt from the 2011 license document:**

8. . . . it was alleged that Respondent engaged in unprofessional conduct in that he consumed alcohol to excess and to an extent he endangered himself and others, and that he had been criminally convicted on two separate occasions of offenses related to the use and consumption of alcohol . . . Respondent's license was revoked, stayed, with seven years probation. The terms and conditions of probation . . . required him to abstain completely from the use of products or beverages containing alcohol, submit to biological fluid testing, undergo a psychiatric evaluation, participate in psychotherapy, have a practice monitor, and not engage in the sole practice of medicine . . .

9.A. . . . Respondent failed to comply with this term of his probation in that multiple bodily fluid tests resulted in a positive test result for the presence of alcohol.

#### **Excerpt from the 1997 license document:**

##### First Cause for Disciplinary Action

E. Y.G. had a normal prenatal course until on or about March 28, 1990 . . .

11.G. Despite elevated blood pressure, proteinuria and other findings on examination, respondent did not consider and/or did not chart the possibility of preeclampsia, did not consider and/or did not chart the potential for early induction of labor in Y.G. and did not conduct appropriate patient surveillance. . .

11.I. Four days later, on April 9, 1990, Y.G. presented to the Emergency Room at South Valley Hospital with complaints of severe acute low back pain. . . . Y.G. was diagnosed with toxemia. Emergent medical measures were taken. After delivering a viable male infant, Y.G. died on April 10, 1990.

12 . . . he is guilty of gross negligence and/or incompetence in the practice of his profession . . .

##### Second Cause for Disciplinary Action

13.B. On July 17, 1993, patient M.M. presented to respondent for examination at the Planned Parenthood Clinic in Seaside, California . . . Respondent recorded in the chart that the patient was 9 and ½ weeks pregnant. Respondent performed a pelvic examination at that time and recorded that the uterus was soft and felt approximately 11-12 weeks size . . .

13.C. On July 17, 1993, respondent undertook to perform an abortion . . .

13.D. Respondent ordered M.M. transferred to Natividad Medical Center, Where ultrasound demonstrated the fetus to be 27 weeks. Labor was induced and the female stillborn was taken for evaluation by the County Coroner.

13.E. At all relevant times, respondent knew, or in the exercise of reasonable care should have known, that M.M.'s fetus was 27 weeks and viable.

14. . . . he is guilty of gross negligence and/or incompetence .

## **Thousand Oaks**

*The health department documents from 2014 and 2018 can be found under Thousand Oaks at:*

[www.problemsatplannedparenthood.org/california-s-to-z](http://www.problemsatplannedparenthood.org/california-s-to-z)



An employee who was unfamiliar with the ultrasound machine mistakenly dated a patient's pregnancy. It was measured at 13 weeks when it was actually over 21 weeks. Prior to the procedure, the employee asked a nurse practitioner and the doctor to review the picture. Neither recognized it was incompatible with a pregnancy of 13 weeks. The doctor began surgery, but couldn't complete it, due to the advanced pregnancy. The woman was transferred to a hospital.

## **Ventura**

*The health department document from 2013 can be found under Ventura at:*

[www.problemsatplannedparenthood.org/california-s-to-z](http://www.problemsatplannedparenthood.org/california-s-to-z)



A 23-year-old woman, after surgery, began to bleed heavily. The staff unsuccessfully administered medicine to stop the bleeding, then called 911. According to paramedics, the woman was "confused with slurred speech." Her blood pressure was dangerously low.

At the hospital, the woman was said to be in "severe distress" and "hemorrhagic shock." The woman was given a "massive transfusion" and taken into surgery. Surgeons found that the doctor had perforated her uterus. A hysterectomy was done, and the patient permanently lost her ability to have children at 23.

Though legally required to, the clinic failed to report the complication to the California Department of Health; it only came to light with an anonymous tip. Clinic staff claimed they were "unaware" complications needed to be reported, implying they never reported complications to the Department of Health.

# Connecticut

## Bridgeport

*The below is taken from a video of testimony before the Connecticut House of Representatives by Connecticut state representative Treené McGee (D), April 19, 2022. The video can be found under Bridgeport at:*

[www.problemsatplannedparenthood.org/connecticut](http://www.problemsatplannedparenthood.org/connecticut)

### **Excerpt:**



The matter of Black life began for me when I talked to a young woman . . . She got a pill [from Planned Parenthood in Bridgeport] . . . And three days later she could not walk. She landed in the hospital . . . And she then had an infection behind her uterus. She needed a blood transfusion. And she relearned how to walk which it took her a month to do . . . She didn't have the resources to pursue a case.

## Hartford

*The health department document from 2016 can be found under Hartford at:*

[www.problemsatplannedparenthood.org/connecticut](http://www.problemsatplannedparenthood.org/connecticut)

### **Highlight:**

The clinic failed to have needed emergency supplies.

## **New Haven**

*The health department documents from 2015 and 2018 can be found at:*

[www.problemsatplannedparenthood.org/connecticut](http://www.problemsatplannedparenthood.org/connecticut)

### **Highlights:**

#### **Clinic Conditions**

- The autoclave, used to sterilize instruments, had not been cleaned for three months. The clinic manager was “not sure” why it hadn’t been cleaned.
- According to the inspection, “the facility failed to ensure that infection control practices were maintained.” The sterilization logs didn’t document the results of the steam indicator placed in each load of sterilized instruments.
- Medications were stored in a refrigerator with cans of ginger ale for the staff.
- Chairs in the recovery room were cloth-covered, meaning that they couldn’t be properly sterilized or cleaned.
- Prefilled syringes weren’t labeled with the dates and times filled, the initials of the staff member who filled them, and the doses.

#### **Staff**

- The staff didn’t properly clean instruments. Staff failed to mix the solution for cleaning instruments properly. Staff didn’t measure the amount of detergent to mix with water but estimated instead. They didn’t follow the manufacturer’s instructions to ensure a strong enough solution to properly clean the instruments.

#### **Medical Records and Labels**

- The times medications were given and the staff giving them weren’t recorded.
- In a subsequent inspection, records were also incorrect.

#### **Incidents**

- Before one woman’s procedure, a nurse noted no drug allergies. However, her later records showed that she was allergic to a Keflex. Fortunately, the woman didn’t suffer complications or a drug reaction, but the inconsistency in charts could’ve presented a risk.

#### **Treatment of Patients**

- Single-use intravenous fluids were used on multiple patients.
- Opened medications weren’t properly labeled and didn’t have expiration dates, leading to the use of expired medications on patients.

## **Norwich**

*The health department document from 2015 can be found under Norwich at:*

[www.problemsatplannedparenthood.org/connecticut](http://www.problemsatplannedparenthood.org/connecticut)

### **Highlights:**

#### **Clinic Conditions**

- Bags of soiled laundry, likely stained with bodily fluids, were stored in a post-anesthesia care area. Clinic staff admitted that the bags had been there for five days.
- Instruments required to be sterile were stored in the dirty decontamination area, along with multiple boxes, supplies, and equipment.
- The emergency light fixture in the staff bathroom wasn't working, nor the emergency light fixture in the waiting area. This was a violation of the fire code.
- Fire alarms and smoke detectors weren't regularly tested.

#### **Staff**

- Staff members didn't have the proper medical credentials.

#### **Medical Records and Labels**

- Sterilization logs were missing patient information. Instruments used on different women, therefore, weren't tracked to maintain proper infection control.
- Records for one patient failed to indicate that a comprehensive medical assessment was performed before surgery. Clinic staff claimed that one was performed but was not recorded due to a new computer system.

## **Torrington**

*The health department document from 2014 can be found at:*

[www.problemsatplannedparenthood.org/connecticut](http://www.problemsatplannedparenthood.org/connecticut)

### **Highlights:**

#### **Clinic Conditions**

- According to the inspection report, "the facility staff failed to follow acceptable infection control practices."

#### **Medical Records and Labels**

- An open multi-use vial of medication wasn't marked with the date it was opened or with the discard date. Another vial was missing the discard date. This meant that clinic staff didn't know when to discard these vials and risked giving expired medicine to women.

## Waterbury

*The health department document from 2015 can be found under Waterbury at:*

[www.problemsatplannedparenthood.org/connecticut](http://www.problemsatplannedparenthood.org/connecticut)

### **Highlights:**

- Medications and hepatitis vaccines were stored in the dirty utility room along with used, soiled instruments. This included an open, half-empty, multi-use vial of an injectable drug stored in a refrigerator. There was no documentation on the vial of when it was opened or when it should be discarded.
- The medication refrigerator was located under the sink in the dirty utility room where dirty instruments were washed.
- Blood samples were stored with medication in the refrigerator in the dirty utility room. According to the report, these blood samples “failed to be stored in a tightly sealed container in the refrigerator.”

## West Hartford

*The health department document from 2015, 2018, and 2020 can be found under West Hartford at:*

[www.problemsatplannedparenthood.org/connecticut](http://www.problemsatplannedparenthood.org/connecticut)

### **Highlights:**

#### **Clinic Conditions**

- Test strips are included with each load of instruments sterilized in the autoclaves. One test strip indicated a load wasn't properly sterilized. However, there was no indication in the records these instruments were subsequently sterilized again, as per proper procedure.
- The facility had cloth-covered chairs in the recovery room. These chairs couldn't be properly sterilized or cleaned.
- A cloth pillow in the procedure room wasn't cleaned between patients. The clinic failed to use disposable covers for the pillow and reused the same pillow.
- The clinic failed to test and maintain fire alarms and sprinklers.

#### **Staff**

- A staff member failed to wash her hands before preparing the procedure room for a patient.

## **Medical Records and Labels**

- Staff repeatedly failed to document whether test strips indicated instruments were properly sterilized. (See above)
- Medical records were incomplete. The times medications were given weren't documented, nor the names of the staff members giving medications.
- There was a discrepancy in the records about the type of sedation one patient received. One set of records indicated she received intravenous moderate sedation but failed to mention the medication given. The other record indicated fentanyl and Versed were given.
- In a later inspection, one patient's records mistakenly identified the procedure she had – the procedure checked off in her informed consent paperwork wasn't the one she received. This mistake could have jeopardized the integrity of the informed consent process.
- This same patient had a complication that staff failed to document. The patient was taken to the hospital via ambulance, but documentation stated the procedure had no complications and the patient "tolerated the procedure well."
- Staff confirmed the paperwork was automatically filled out before the procedure took place and wasn't changed to reflect what happened.

## **Incidents**



A woman at the facility suffered a complication during a medical procedure and was sent to the hospital via ambulance. She was admitted for treatment. (See under documentation above.)

## **Treatment of Patients**

- IV fluids meant to be single-use were reused for multiple patients.

## **Other**

- The staff failed to conduct fire drills and emergency preparedness training.
- The cabinet containing narcotics was left unlocked and unattended.
- There was a discrepancy in the records about the type of sedation one patient received. One set of records indicated she received intravenous moderate sedation but failed to mention the medication given. The other record indicated fentanyl and Versed were given.

## **Treatment of Patients**

- IV fluids meant to be single-use were reused for multiple patients.

# Delaware

See several documents at:

[www.problemsatplannedparenthood.org/delaware](http://www.problemsatplannedparenthood.org/delaware)

## **Excerpt from Testimony to the Delaware State Legislature by Nurse Mitchell-Werbrich:**

On April 20, 2012, I was hired as a recovery room nurse at Planned Parenthood of Delaware. I worked a total of 27 days (approximately) at Planned Parenthood. I worked 16 days at Planned Parenthood of Delaware's Wilmington site and 11 days at Planned Parenthood of Delaware's Dover site. I was forced to resign on August 8, 2012 as the conditions at Planned Parenthood continued to be unsafe and potentially life-threatening for the . . . I feared that a patient was going to end up being harmed and that I would lose my nursing license. I also endured a hostile environment at Planned Parenthood after reporting the horrendous conditions that were occurring there . . .

I witnessed meat market style assembly line abortions. This type of care was something I had never seen before in my entire nursing career. On an average day at the Wilmington Planned Parenthood site one abortion would be completed every 8-10 minutes. The doctor would be in such a hurry to get the patients in and out that he himself would bring the patients back into the unclean procedure room where the examination table would still have bloody drainage and body fluids on it from the previous patient . . .

Another very serious concern I had at Planned Parenthood was the mishandlings of RhoGAM. RhoGAM is a product that must be given within 72 hours to every . . . patient whose Rh factor is negative after having an abortion. . . I cannot help but think of all the Rh negative women that may be suffering from not having the RhoGAM they needed. It is likely that many women in Delaware may have to deal with future babies who have severe anemia, jaundice, brain damage, heart failure or even death. The sad thing is that these women may not even realized the fact that Planned Parenthood could be at fault for these medical tragedies even years after they had their abortions at Planned Parenthood . . .

I witnessed that the emergency box and equipment contained expired emergency medications as well as faulty emergency equipment such as an oxygen mask that was no longer functional. This could potentially cause death to a patient in need of emergency care . . .

I had reported to both of these state agencies the many unsafe conditions which included that there were no guidelines, no standards of care, no procedure, or protocol manuals to be found anywhere, intravenous (IV's) were being started using an unsterile technique and patients endured multiple needle sticks. I reported that Planned Parenthood's Dr. Timothy Liveright had struck a patient by inappropriately slapping her at the dilation phase during an abortion. I reported that most of the Planned Parenthood Staff members did not wear protective gear or utilize universal blood and body fluid

precautions; consents for sedation and procedures were sometimes obtained late as staff was rushed and hurried; registered nurses had to hide the patient's chart from Planned Parenthood's Dr. Timothy Liveright so the pre-procedure medications could have time to take effect because he was in such a rush to get to the next patient; lab work not being performed correctly thus the lab value results were incorrect; patients given sedation were found outside walking down Market Street dazed and confused; staff medical credentials were not verified; the emergency medications and equipment had expired; the narcotics were not being regulated; HIPPA privacy not being practiced; an intern who had been instructed by her instructor to only observe was pressured into providing abortion care; Planned Parenthood's Dr. Timothy Liveright once left sedated patients in the middle of an abortion procedure waiting for hours in order to handle a mechanical issue with his private airplane; and more . . .

Ms. Peterson also informed me that she could only take complaints from patients. I told her that this patient population was not at all likely to report to her. I explained to Ms. Peterson that abortion is a stigmatizing event that causes patients to feel too uncomfortable to advocate for themselves. I also shared with Ms. Peterson that many of the patients that receive care at Planned Parenthood are young, poor, often minorities that lack knowledge of the reporting process to Delaware Health and Social Services and that these patients generally do not have the financial means to hire legal assistance necessary to even defend themselves. I told her that I was reporting on behalf of the patients and to consider me to be the "voice of the patients." But Ms. Peterson refused again stating that she could only take complaints from a patient.



Planned Parenthood Doctor Gave Up Delaware License  
by Kara Nuzback, *Cape Gazette*, June 3, 2013

**Excerpt:**

A former physician at Planned Parenthood is facing charges of unethical practices and sexual misconduct . . .

According to the complaint, Liveright was reprimanded March 13, 2012 for screaming and cursing in front of Planned Parenthood patients and employees; he was also rebuked for sexually harassing female employees.

Between Feb. 12 and March 13, Fortune states, Liveright over-sedated patients; performed unnecessary suction procedures; failed to assess a patient's airway, lungs and heart prior to sedation; and did not properly document procedures.

The complaint also says Liveright caused at least one perforation during surgery, and some of his patients required emergency hospital treatment.



Nurses Claim Wilmington Planned Parenthood Never Notified Women of STDs  
by Tim Furlong and David Chang, Channel 10, Philadelphia,  
July 30, 2013

### Excerpt:

A Planned Parenthood facility in Wilmington is under fire following new accusations from three former employees.

Former manager Melody Meanor and former nurses Joyce Vasikonis and Jayne Mitchell-Werbrich spoke at a legislative hearing on Monday, claiming the Planned Parenthood clinic located on Shipley Street in Wilmington is unprofessional, under-trained and unsafe.

“Women are exposed to potential infection of any kind you can imagine that can be passed from one patient to another,” Vasikonis said. During their testimony, the women claimed the privacy of patients was jeopardized, that they were asked to falsify employee records, that medical assistants were poorly trained and that certain women in need of certain medications after abortions often didn’t receive them. They also claimed that the facility failed to inform up to 200 women that they tested positive for gonorrhea and chlamydia.

## Florida

*Some of the health department documents only list that the facility failed to provide a phone number to report complaints or that the license wasn’t posted, and those aren’t included here, but are on the Florida page on the website.*

### Fort Myers

*The health department documents from 2014, 2015, and 2022 can be found under Fort Myers at:*

[www.problemsatplannedparenthood.org/florida](http://www.problemsatplannedparenthood.org/florida)

### Highlight:

- The facility had no records documenting whether probes were sterilized between patients.

## **Miami – Golden Glades**

*The health department document from 2015 can be found under Miami-Golden Gates at:*

[www.problemsatplannedparenthood.org/florida](http://www.problemsatplannedparenthood.org/florida)

### **Highlights:**

#### **Clinic Conditions**

- An employee showed the inspector a room where medical procedures and patient counseling took place. The room contained empty shelves and supplies, including two paint cans. Staff later claimed the employee was in error, and that the room the employee showed the inspector was only used for storage.
- Desks were stored in the hallway. This could make the hallway difficult to navigate for emergency personnel with a stretcher and hinder evacuation during an emergency.

#### **Privacy**

- There was no curtain in the patients' changing area.
- The facility didn't provide gowns for patients to change into; they were expected to be naked from the waist down. After state inspectors complained, clinic staff said they would provide gowns to patients who requested them.

## **Pembroke**

*The health department document from 2015 can be found under Pembroke at:*

[www.problemsatplannedparenthood.org/florida](http://www.problemsatplannedparenthood.org/florida)

### **Highlights:**

- Staff performed surgery for which the clinic wasn't licensed.
- There were no logs or records for tracking the disposal of biological waste.

## **St. Petersburg**

*The health department documents from 2013, 2015, and 2017 can be found under St. Petersburg at:*

[www.problemsatplannedparenthood.org/florida](http://www.problemsatplannedparenthood.org/florida)

### **Excerpt:**

“The laboratory must define criteria for those conditions that are essential for proper storage of reagents and specimens, accurate and reliable test system operation, and test result reporting. The criteria must be consistent with the manufacturer’s instructions, if provided. These conditions must be monitored and documented and, if applicable, include the following: (1) Water quality. (2) Temperature. (3) Humidity. (4) Protection of equipment and instruments from fluctuations and interruptions in electrical current that adversely affect patient test results and test reports. This standard is not met.”

## **Sarasota**

*The health department documents from 2010 and 2014 can be found under Sarasota at:*

[www.problemsatplannedparenthood.org/florida](http://www.problemsatplannedparenthood.org/florida)

### **Highlights:**

#### **Clinic Conditions**

- The facility failed to regularly clean and test the autoclaves as per manufacturer’s instructions. Autoclaves are used to sterilize instruments used on multiple women. There were no logs or other records documenting times and dates when the autoclaves were to be cleaned. Autoclaves were required to be cleaned weekly; instead, they were not cleaned for months.
- The facility failed to ensure that emergency equipment was available. There was no defibrillator on the premises.

#### **Staff**

- The facility failed to conduct annual in-service training for staff.
- The facility did not provide proper training and orientation for new staff members and volunteers.
- There were no written policies or procedures for training staff on infection control, medical complications, or safety measure

#### **Treatment of Patients**

- Written policies and procedures for patient care were inadequate and did not contain the required information.

## Tampa

The health department document from 2015 and 2019 can be found at:

[www.problemsatplannedparenthood.org/florida](http://www.problemsatplannedparenthood.org/florida)

### Highlights:

- Laboratory proficiency testing was found to be deficient; it was later corrected.

### Incidents



A patient was sent to the hospital with complications after a procedure. Nevertheless, her records indicated her vital signs were stable at discharge, there were no complications, she was ambulatory, and she was discharged in good condition. Vital signs documented during the procedure did not show that the patient was stable and contradicted the medical record. These notes were signed by the attending physician. When questioned, the physician confirmed the statements were inaccurate. The patient had a pre-existing condition, but this was not documented in her records, which gave her medical history as normal. She was not properly evaluated for risk factors or pre-existing conditions. The attending physician classified her as low risk (level II out of a possible VI), which was incorrect based on her pre-existing condition. There was also no documentation that the attending physician had used a stethoscope or other means to listen to and evaluate the patient's heart and lungs before the procedure.

# Indiana

## Bloomington

*The health department documents from 2017, 2018, and 2019 can be found under Bloomington at:*

[www.problemsatplannedparenthood.org/indiana](http://www.problemsatplannedparenthood.org/indiana)

### Highlights:

#### Clinic Conditions

- According to inspectors, the facility “failed to provide a safe and healthful environment that minimizes infection exposure and risk to patients.”
- Human blood from blood tests wasn’t handled in a safe and sanitary manner, risking the spread of blood-borne infections such as HIV and hepatitis. Blood was stored with medications in the refrigerator. Blood tests for Rh factors were conducted on the same countertop used to prepare medications and blood drops from these tests were in close proximity to pregnancy tests. This was noted in multiple inspections.
- Medication was stored on the same countertop where tests were done on urine and blood. This was an ongoing problem cited in two inspections.
- The clinic’s backup generator wasn’t given regular maintenance.
- Other equipment, such as the two autoclaves used to sterilize instruments, weren’t adequately inspected and maintained. The autoclaves, exam lights, and exam tables weren’t examined for electrical current leakage.
- The clinic had (and appeared to be using) expired medication.
- An oxygen tank was stored improperly and, according to the report, “could create a source of a potential hazard to patients, visitors, or employees.”
- The facility failed to document (and possibly conduct) proper maintenance of equipment such as a defibrillator, emergency call system, recovery chairs, vacuum units, and procedure tables.
- Documents indicated that the telephone intercom system wasn’t working, and there was no indication it was fixed.
- Staff failed to document (and possibly perform) the cleaning and disinfection of exam rooms, labs, and equipment and weren’t properly trained to do so.

#### Staff

- The facility failed to have a policy to evaluate, test, and improve the skills of nurses, lab technicians, and other staff members. The clinic failed to review and evaluate nursing services, laundry services, medical record review services, maintenance services, or laboratory services. This was cited in multiple inspections.

- Staff failed to wash their hands after handling linens that were soiled with bodily fluids. No sink or handwashing facilities were present in the room where laundry was washed and handled.
- Staff wasn't trained to use the backup generator and no training manuals were available.
- The clinic didn't have someone "qualified by training or experience" responsible for supervising infection control and making sure proper procedures were implemented and followed.
- Staff didn't have proper training in cleaning and disinfecting instruments, equipment, and exam rooms.

### **Medical Records and Labels**

- The clinic failed to maintain accurate medical records, neglecting to record patient condition at discharge, transfers to hospitals of injured patients, procedures performed, and other data. All three inspections found that proper medical records weren't kept, indicating an ongoing problem.
- One inspection found that laboratory results weren't documented. For example, Rh testing results were neglected to be recorded. If these tests weren't performed (and we have no way of knowing whether they were, without documentation) and the clinic, therefore, neglected to administer RhoGAM, future pregnancies of women were put at risk. Rh sensitization can cause miscarriages and damage babies in subsequent pregnancies. Also not recorded were pre-abortion pelvic exams.
- Staff repeatedly failed to sign paperwork. This was an ongoing problem, cited in two different inspections.

### **Treatment of Patients**

- The facility failed to monitor patients' vital signs while they were in the recovery room after surgery. The clinic didn't monitor or record blood pressure, respiratory rate, and/or pulse of women post-surgery. This was true of all 22 patients whose records were examined. This was an ongoing problem; the clinic was cited for it in all three inspections.
- The clinic lacked the policy to ensure that medical histories were taken promptly and proper physical examinations were performed.

### **Other**

- The facility didn't have a quality assurance program to oversee and evaluate emergencies, infection control, patient complaints, safety, and competence.
- There were no training manuals to teach clinic staff how to operate equipment. This was not corrected and was found to be the case in more than one inspection. There were no user manuals for the emergency call system.
- The clinic failed to regularly evaluate the care given to patients.
- Controlled substances were unsecured and could be accessed by unauthorized persons, such as patients and staff.

## Indianapolis

The health department documents from 2012, 2014, 2017, 2018, and 2019 can be found under Indianapolis at:

[www.problemsatplannedparenthood.org/indiana](http://www.problemsatplannedparenthood.org/indiana)

### Highlights:

#### Clinic Conditions

- An oxygen tank was left unsecured standing upright in a room. According to the report “if the tank was knocked over and broke the head off the compressed cylinder, it could cause harm to people and/or property.”
- Regular preventative maintenance wasn’t conducted on the emergency call system, presenting a potential risk in the case of an emergency. Regular maintenance was also not conducted on a wheelchair.
- Emergency defibrillators weren’t tested or properly maintained.
- Although the facility gave IV sedation, it had no cardiac monitors available.
- The facility failed to change the disinfection solution used to sanitize the procedure room as per the manufacturer’s guidelines.
- The facility used expired test strips to test whether Cidex, a sterilization fluid, was of good enough quality to be effective.
- There was trash in the clinic parking lot, presenting a habitat and breeding ground for pests such as rodents and insects.
- There were expired emergency supplies, including IV bags.
- The facility failed to maintain 5 out of 7 pieces of equipment, including smoke detectors and an emergency generator. In a subsequent inspection, 11 of 12 pieces of equipment weren’t properly maintained.
- The facility failed to perform regular maintenance on emergency and other equipment. This included the cardiac monitor, defibrillator, suction machine, emergency call system, sterilizer, exam light, and wheelchair. This was cited in more than one inspection.
- The facility failed to test the defibrillator to ensure it was in working order.
- Electric current leakage checks weren’t performed on equipment.
- The facility failed to properly clean and sterilize the vaginal ultrasound probe.
- There were no monthly checks of medications, equipment, and supplies.
- Clinic staff failed to verify that blood specimens for Rh testing were stored at appropriate temperatures, which may compromise the integrity of the tests. Records indicated these specimens were stored at inappropriate temperatures, and this wasn’t addressed or fixed promptly, rendering the tests unreliable. Failure to detect and treat Rh compatibility problems can lead to miscarriage or infant death and negative outcomes in future pregnancies.

## **Staff**

- The clinic didn't conduct or document a proper orientation for new employees.
- Two out of four doctors (one half) and one health care assistant weren't trained in CPR and would not have been able to perform CPR in an emergency. In a subsequent inspection, a medical assistant and the medical director were found not to have CPR certification. This was an ongoing problem.
- The clinic had no designated person with prescriptive authority and no one in control of drug stocks.
- The clinic didn't verify staff immunizations and failed to provide hepatitis B vaccines to two employees who requested them. The clinic also knowingly employed several staff members who weren't vaccinated, despite having a written policy not to do so.

## **Medical Records and Labels**

- Medical records were incomplete with missing information. Some of the things the clinic staff failed to document were whether ultrasound was used when needed for surgery, whether the patient had used drugs or alcohol before the procedure, whether the airway was maintained for patients receiving sedation, and whether there were complications. Medical histories were incomplete, with no documentation of women's health conditions that could affect the safety of procedures. In some cases, the type of anesthesia given to patients and whether they received sedation wasn't documented. Start and stop times of procedures weren't documented. Doctors failed to sign paperwork.

## **Incidents**

- One patient who received versed and fentanyl had her oxygen saturation level drop to 76% during her surgery. Despite this dangerously low oxygen saturation level, no supplemental oxygen was given. There was no documentation in her chart of any intervention or medical treatment given for this medical crisis. The director and staff who were interviewed said they "didn't know" if any treatment was given to this patient.

## **Treatment of Patients**

- Clinic staff gave all women the same dosage of fentanyl without regard to body weight, so the clinic overdosed 17 of 18 patients on fentanyl for sedation.
- The staff failed to check vital signs for 18 out of 30 patients while they were in the recovery room. These patients had received fentanyl and/or valium but were left unmonitored.
- The facility failed to monitor the oxygen saturation of one patient under sedation.
- The clinic failed to monitor or record vital signs for women who were under sedation.

- Physical examinations weren't conducted before sedation and medical procedures and proper medical histories weren't taken. The clinic also failed to ask patients what other medications they were taking and what medications they were allergic to before giving sedation and didn't document this.
- The staff didn't document (or possibly conduct) Rh counseling for 5 out of 5 patients who were Rh-negative. Rh sensitization presents a risk to infants born in future pregnancies and can cause miscarriages of subsequent pregnancies.
- Clinic staff didn't document (or possibly give) patients proper counseling about aftercare after their procedures.
- There was no documentation or indication that the facility was giving patients proper informed consent before medical procedures.
- The facility failed to have a policy in place to inform doctors of adverse reactions and medication errors.
- Staff failed to verify whether patients who had experienced sedation had someone to drive them home.

### Other

- The facility didn't ensure that contracted services were provided safely and effectively. This was also an ongoing problem, cited in multiple inspections, with 71 different contracted services involved. The clinic also failed to keep a list of contracted services, including their scope and nature. This included pharmacy services, lab services, trash disposal, fire alarm, and sprinkler maintenance, and phone services.
- Although there was a committee tasked with implementing proper infection control procedures, that committee failed to meet regularly. When they did meet, the person designated to oversee infection control wasn't present. The medical director also failed to attend some of the meetings.
- No fire or safety inspections were conducted at the clinic.
- The clinic failed to have a plan to conduct fire drills.
- The facility failed to keep a proper log of controlled medications, presenting the possibility that some could be stolen or misplaced. Controlled substances were also left unsecured, where unauthorized persons had access to them.
- The clinic administrator failed to attend 5 of 5 meetings of the clinic governing board.
- The state license wasn't posted where patients could see it.
- The clinic had medications that were not listed in the formulary.
- There were concerns reported with a contracted waste disposal company, but no record of corrections or resolution.

## Indianapolis



### Book Excerpt:

When [Ann] began the new job, she was taken aback by the bare-bones training given to her and the dim dustiness of the clinic. She had a hazy memory of shadowing another counselor before she officially started her job, along with informal conversations with the clinic administrator that covered some of the do's and don'ts of the work . . .

An administrative office in the back smelled of cigarettes; the staff would sometimes come in on Saturdays when the clinic was closed to clean it themselves, to save money on janitorial staff . . .

Ann: "It did not have the kind of feel you expect when you walk into a doctor's office. I felt a sense of kind of shame because you want to help these women during what, for some of them, was a really difficult moment. You just realize that the standard is really not high, and there's this defeatist attitude of *there's only so much you can do.*"

Once, in a procedure room, she accidentally stepped on a blood clot, and no amount of sanitizing spray could make her feel like her shoe wasn't somehow forever tainted.

The carpets were stained; the clinic doctor liked to joke that it looked like a bloody body had been dragged down the hallway. He didn't seem to notice – or care – that his quip never got a laugh . . .

[A]nother clinic worker accidentally stuck herself with a used needle. The lab room she worked in was small, and the space limitation combined with the frenetic pace of the work meant that it was only a matter of time before there was an accident... [T]he worker wound up on medication meant to ward off the [AIDS] virus.

## Lafayette

*The health department document from 2019 can be found at:*

[www.problemsatplannedparenthood.org/indiana](http://www.problemsatplannedparenthood.org/indiana)

### Highlights:

#### Medical Records and Labels

- Doctors failed to sign medical records, and records were incomplete.

## **Merrillville**

*The health department documents from 2014, 2017, and 2019 can be found at:*

[www.problemsatplannedparenthood.org/indiana](http://www.problemsatplannedparenthood.org/indiana)

### **Highlights:**

#### **Clinic Conditions**

- Potentially infectious material was stored in a cabinet, and the cabinet wasn't labeled as containing biohazardous material.
- The facility failed to document (and possibly perform) electrical leakage checks of equipment. This was for 5 of 5 pieces of equipment, including the autoclave, centrifuge, and exam lights.

#### **Staff**

- The medical director hired a doctor without verifying his credentials.
- The facility failed to ensure that staff was vaccinated and failed to provide Hepatitis B immunization to staff who requested it. Some of the staff were unvaccinated for diseases such as rubella, measles, and others.

#### **Medical Records and Labels**

- Doctors failed to sign paperwork. This was noted in two inspections. Physicians didn't sign to indicate that they took a proper medical history.
- The clinic failed to ensure that records were complete and accurate. This was cited in two inspections. One patient's records stated the patient was discharged at 8:55 AM, but had vital signs taken at 9:38 AM. Another chart indicated a patient was discharged at 2:05 PM but had vital signs taken at 3:06 PM. A third patient was said to have gone to the recovery room at 12:59 PM but recorded as discharged at 12:11 PM. A fourth record documented a discharge time of 11:20 AM but claimed vital signs were taken at 12:56 PM and 1:02 PM. There were multiple other examples.
- Type of sedation patients received was not documented.
- Records failed to verify that patients understood discharge instructions.
- The facility had no policy to protect patient records from fire, water, or other damage.

## Treatment of Patients

- According to the report, the facility “failed to ensure the implementation of policy and standards of care related to the checking of vital signs in the procedure and recovery rooms.” There were no vital signs taken for 28 patients.
- The facility failed to conduct Rh counseling for Rh negative patients. Failure to treat Rh incompatibility can lead to miscarriage or health problems for the baby in future pregnancies.
- Patients weren’t given proper instructions as to hygiene and self-care after their surgery. Paperwork given to patients omitted this information.

## Other

- The governing body of the clinic failed to review and evaluate laundry and pharmacy services.
- There was no policy in place to report adverse reactions to medication or medication errors to the doctor.
- The facility didn’t have a policy to deal with health care workers’ practice problems. They had no policy for dealing with providers coming in under the influence, having criminal histories, needing disciplinary actions, or other potential problems.
- The clinic had no policy for infection control. The staff member in charge of infection control wasn’t qualified for that position, and had not been trained.
- The facility didn’t have a plan in place for working with state and federal agencies in the event of an emergency.

# Kansas

## Overland Park

*The health department document from 2015 and the pharmacy regulation document can be found under Overland Park at:*

[www.problemsatplannedparenthood.org/kansas](http://www.problemsatplannedparenthood.org/kansas)

### **Health Department Document Highlights:**

- None of the staff members had received a medical exam to clear them medically for working with patients.
- There was no record of immunizations for any of the workers. Nonvaccinated people can spread diseases to patients.

### **Excerpt from the Summary Order on Pharmacy Regulations:**

1. The Board has previously issued Responded Registration No . . . which entitles Respondent to function as a pharmacy in the State of Kansas . . .
2. On or about July 2, 2015, the Board office received notification from Respondent of Pharmacist in Charge (“PIC”) . . . Shafer’s resignation effective August 20, 2015 . . .
12. Respondent failed to submit the complete Change of PIC application and new PIC exam to the Board until April 27, 2016, which was 179 days beyond the 30-day window for designating a new PIC.

### **ORDER**

. . . Respondent is ordered to pay a fine . . . Because Respondent was 179 days late, the fine accrued . . . Respondent has 30 days from the date of this order to pay the full \$4,580.00 . . .

## **Louisiana**

### **New Orleans**

*The health department documents from can be found under New Orleans at:*

[www.problemsatplannedparenthood.org/louisiana](http://www.problemsatplannedparenthood.org/louisiana)

### **Excerpt from the 2018 document:**

Description of Violations: Dust control methods are not being employed. RESTROOM AIR VENTS

### **Excerpt from the 2021 document:**

Description of Violations: Dust control methods are not being employed. dusty tiles noted

# Maryland

## Annapolis

*The health department document from 2013 can be found under Annapolis at:*

[www.problemsatplannedparenthood.org/maryland-annapolis-baltimore](http://www.problemsatplannedparenthood.org/maryland-annapolis-baltimore)

### Highlights:

#### Clinic Conditions

- The autoclave, used to sterilize dirty instruments, wasn't properly sanitized or maintained. There was no documentation that basic maintenance was performed, and it was leaking onto shelves below.
- Routine spore testing (for mold) wasn't conducted on the autoclave.

## Baltimore

*The health department documents from 2013, 2015, 2016, and 2018 can be found under Baltimore at:*

[www.problemsatplannedparenthood.org/maryland-annapolis-baltimore](http://www.problemsatplannedparenthood.org/maryland-annapolis-baltimore)

### Highlights:

#### Staff

- A member of the nursing staff didn't appear to have experience or documentation of training to be competent in administering and monitoring intravenous sedation yet was administering sedation.
- Staff wasn't trained in the process for emergency transfer of a patient to the hospital in case of a complication. The manager acknowledged the staff member in question hadn't been trained.
- A member of the staff had no certification or training in CPR and basic life support.

#### Medical Records and Labels

- All five patient medical records examined were missing information. In all cases, the patients' discharge diagnosis had been omitted.

#### Other

- The staff failed to conduct fire drills. This remained the case in an inspection a year later.

# Michigan

## Ann Arbor

*The health department documents from 2014 and 2017 can be found under Ann Arbor at:*

[www.problemsatplannedparenthood.org/michigan](http://www.problemsatplannedparenthood.org/michigan)

### **Highlights:**

- The facility mixed clean and dirty instruments, potentially causing contamination. Clean instruments were being wrapped in the same place dirty instruments were being processed.
- There was no emergency call system in the bathroom. A patient having a medical crisis couldn't press a button to inform a nurse or other staff.
- The facility failed to post its license where it could be seen by patients.
- Patients were allowed to bring personal items into the operating room, without proper containment.

## Flint

*The health department documents from 2015 and 2016 can be found under Flint at:*

[www.problemsatplannedparenthood.org/michigan](http://www.problemsatplannedparenthood.org/michigan)

### **Highlights:**

- Privacy curtains prevented nurses from seeing patients in the recovery room. The curtains obstructed their view and they couldn't see if patients were in distress.
- Patients were allowed to bring personal items into the operating room, without proper containment.
- Single dose medications were used on multiple patients.

# Minnesota

*Minnesota doesn't do health inspections on this kind of facility.*



Botched Care and Tired Staff: Planned Parenthood in Crisis  
by Katie Benner, *The New York Times*, February 15, 2025

Grace Larson, a former Planned Parenthood nurse in Minnesota who was fired while trying to unionize the staff, said that clinics were operating like “a conveyor belt” for patients. She said that employees sometimes administered expired pain medication or the wrong medications as they scrambled to move people in and out. She said it was not uncommon for patients to be taken to the wrong room and prepped for the wrong procedure.

“We would catch it when a patient would say, ‘Why am I in a room with an ultrasound machine and a sedation nurse for a Pap smear?’ or when a nurse would come in and be like, ‘Wrong room, wrong patient,’” Ms. Larson said.

# Missouri

## Colombia

*The health department document from 2018 can be found at:*

[www.problemsatplannedparenthood.org/missouri](http://www.problemsatplannedparenthood.org/missouri)

### Highlights:

#### Clinic Conditions

- Suction machine cabinets were rusted and covered with adhesive tape, creating an uncleanable surface that could harbor infection-causing germs. One suction machine cabinet also had a six-inch-long dried brown stain on it. This was likely bodily fluids or blood that hadn't been cleaned.
- Tubing attached to the suction machine, intended to be used only once, wasn't disposed of between patients. The tubing was contaminated with red “bodily fluids.” The bloody tubing was still there six days after the last surgery.
- Re-usable tubing was contaminated with “a blackish-gray substance,” determined to be mold. Staff admitted mold had been present in the tube for four months, though using it on women.

- The re-usable glass bottle attached to the suction machine had a layer of “dried black substance” congealed on the bottom, likely dried blood and fluids.
- Exam tables were wooden with chipped paint, presenting an surface that couldn’t be disinfected.
- A cabinet under the sink hadn’t been cleaned and had a “large area of dried white residue and an area of dried yellowish-brown residue.”
- Equipment used on patients wasn’t approved for use in healthcare facilities. Heating pads were labeled “for household use only.” One of the heating pad covers was stained.
- The facility improperly used heating pads on patients who were sedated or had been given pain medication, which could lead to burns.

## **St. Louis**

*The health department documents from 2009, 2013, 2015, 2016, and 2019 can be found at:*

[www.problemsatplannedparenthood.org/missouri](http://www.problemsatplannedparenthood.org/missouri)

### **Highlights:**

#### **Clinic Conditions**

- The facility used worn, rusted, and deteriorating equipment with uncleanable surfaces, including a rusted surgical table. A stool for patients was covered with rust and clear tape, creating an uncleanable surface.
- An air vent was clogged with dust and debris.
- Plastic bins containing emergency supplies, IV solution, and IV supplies were covered in dust.
- An IV pole was rusted and in poor condition.
- An oxygen tank was dirty and covered with adhesive surfaces.
- The facility failed to keep the procedure rooms, supply rooms, and storage rooms free of dust and debris. The floor had visible dust and dirt. This was noted in multiple inspections.
- An exam tabletop pad was torn, with exposed foam, creating an uncleanable surface. The clinic hadn’t ordered a replacement.
- There was a dirty cloth pillow on the ultrasound table. The pillow was white but part of it was discolored gray.
- Pillows on tables in the procedure rooms had unzipped or missing plastic covers and were therefore uncleanable.
- The refrigerator was dirty and had tape and adhesive residue on the front, creating an uncleanable surface. There was hair and dust inside the refrigerator. A staff member was questioned and said he hadn’t cleaned the refrigerator or seen it cleaned in the 1 ½ years he worked at the clinic.

- The cabinet where IV catheters were stored had a thick layer of dust on the shelves.
- There was tape, adhesive residue, and peeling labels on cabinets and clipboards, creating uncleanable surfaces.
- Drawers contained dust, debris, and adhesive residue.
- Instruments were stored in a drawer that was dirty with dust and debris.
- There was a brownish residue on the floor and inside a cabinet. This may have been dried blood and/or bodily fluids.
- An ultrasound had tape on it and was extremely dusty, as was the case with a plastic tray holding protective bed pads. A wheelchair regularly used for patients also had a thick layer of dust.
- In a subsequent inspection, oxygen masks, nasal cannulas, and sterile IV tubing were found stored in bins that had “dust and loose particles” in them.
- There was expired medication, including IV fluid and ammonia (used to treat fainting), which had expired three years before. Nine vials of valium, being used on patients, had been expired for nearly a year. Other expired medications included naloxone (which is needed to give life-saving treatment to patients suffering from a narcotics overdose) and dextrose injectables. In another inspection, an expired epi-pen was found.
- Having and using expired medication was a repeat offense, cited in multiple inspections.
- The facility had expired postpartum balloons (used to stop bleeding) including one that had expired three years before. There were surgical gloves that expired six years before. In another inspection, inspectors found hand sanitizer expired by a year and expired thermometers.
- Glucose testing strips were supposed to be disposed of six months after opening. After that, they could give inaccurate results. Staff failed to note the date when the testing strips were opened, and one staff member in the lab said he had “no idea” when they were opened.
- The facility failed to inspect and maintain fire extinguishers.
- The facility failed to monitor the humidity in instrument processing areas.
- The facility failed to protect sterile items from dust and moisture by placing a solid barrier beneath them when they were on shelves.
- Staff didn’t have the manufacturer’s operating instructions for the autoclave, used to sterilize instruments. Instructions were eventually printed out from the internet. These instructions gave detailed information on how to clean and replace parts in the autoclaves. There were no records to show that the autoclave was properly cleaned and maintained. The insides of the autoclaves were discolored and had brown spots. These autoclaves were being used to sterilize instruments.
- In the sterilization room, around one of the autoclaves, there were dust and white flecks which left a mark when a finger was pulled through it.
- Staff failed to follow the manufacturer’s instructions to test the autoclaves, which are to be done after each instrument load. The tests were performed only once a week.

- The clinic failed to have a procedure in place to prevent cross-contamination of clean instruments by dirty ones.
- Instruments weren't properly sterilized.
- Peel packs were covered in off-white flakes that fell off when they were lifted. When clinic staff was asked about this a staff member admitted she didn't know where the white flakes came from.
- Staff failed to store refrigerated medication at appropriate temperatures. RhoGAM, used to treat RH sensitization, had a required temperature range to remain usable. Frequently, ranges of temperature weren't tested, but tests showed temperatures out of range for over a week. This wasn't addressed. RhoGAM was allowed to remain at inappropriate temperatures for an extended period.
- Open medications were left in the procedure room and not kept in a centralized location.
- Unsterile corrugated boxes were in the sterile supply room.

### **Staff**

- Two surgical assistants (out of four) weren't trained to assist in surgery, nor did they have certified surgical technologist credentials.
- The facility failed to perform Employee Disqualification List (EDL) checks on any of its employees before hiring them. Medical facilities are forbidden to hire staff whose names appear on the EDL.
- The facility failed to run criminal background checks before hiring. They also failed to perform background checks on volunteers, including one volunteer who had been there for over 30 years. This was an ongoing problem, cited in more than one inspection report.
- The staff didn't wear appropriate personal protective equipment. Inspectors observed one staff member cleaning instruments without wearing a mask or face shield.
- The facility failed to provide ongoing training for staff in infection control. One staff member had been working at the clinic for nearly 10 years and had no infection control training.
- The facility didn't conduct proper orientation for staff.

### **Medical Records and Labels**

- The clinic failed to document medication given to patients. Names of medications, times they were given, and dosages were omitted from records. Some records were inaccurate – one patient's chart said that she received medication at 4:46 PM but was discharged at 12:55 PM.
- The facility failed to ensure medication orders were timed, dated, and signed by a physician.
- The staff didn't document ongoing issues with quality control.

## Incidents

- The Missouri Department of Health investigated the clinic for complications in five cases, and all five doctors involved refused to cooperate. A letter from the Department states “RHS’s non-cooperation on this point is unprecedented and untenable.”

## Treatment of Patients

- Single-use medications weren’t discarded after one use, but were used on multiple patients. Clinic staff admitted that fentanyl vials were used on multiple patients because of a “shortage.” Using single-use medication on multiple patients was cited in multiple inspections.
- The facility didn’t give accurate information to patients concerning who to contact to file a complaint against the clinic or the process for doing so.
- The facility failed to monitor patients’ vital signs, including those of patients under sedation. The facility failed to monitor level of consciousness, blood pressure, pulse, oxygen saturation level, and respiratory rate frequently enough throughout the time patients were under sedation. This put patients at risk.
- Residents performing surgery weren’t properly supervised.

## Other

- Staff wasn’t knowledgeable about evacuation plans in the event of a fire, and fire drills weren’t conducted.
- The facility didn’t submit pathology specimen reports to the Missouri Department of Health and Senior Services, as they were required to do.

# Nebraska



Botched Care and Tired Staff: Planned Parenthood in Crisis  
by Katie Benner, *The New York Times*, February 15, 2025

Many clinics are in dire need of upgrades and repairs. In Omaha last year, sewage from a backed-up toilet seeped into the abortion recovery room for two days, according to interviews with staff members and photographs and text messages shared with *The Times*. Employees shoved exam table pads under the bathroom door to block the leak. Patients vomited from the stench.

# New York

*The health department in New York won't specify in reports which facility the report applies to, which precludes us from knowing which reports apply to Planned Parenthood centers. The two cases below aren't quite health violations, but that's the category they best fit. It's from an affidavit in a lawsuit.*

## Simmons

*The full 2024 Affidavit can be found at:*

[www.problemsatplannedparenthood.org/new-york](http://www.problemsatplannedparenthood.org/new-york)

### Excerpt:

5. I decided that I couldn't wait several weeks for an ultrasound, so I called Planned Parenthood and said I was pregnant and wanted to have an ultrasound. I was asked if I was considering an abortion. I figured that's what I had to say to get an ultrasound quickly, so I told them yes and I got a scheduled appointment much faster than I could get one with my regular doctor.
6. On December 21, 2023, I went to the Planned Parenthood at University Avenue in Rochester. . . I filled out my information on the tablet, including the fact that I have a history of seizures and high blood pressure, as well as the fact that I had pre-eclampsia with one of my babies. No one at the facility offered me any testing for HIV or other STDs. They didn't even take my blood pressure, after I had put down that I have a history of high blood pressure . . .
7. During the ultrasound, the woman wouldn't let me see the ultrasound screen. She kept tilting the screen so that I couldn't see what was going on, even when I asked her if she could turn it so that I could see it . . .
8. After asking me when I thought I had my last period and I said that I wasn't sure, she told me that she thought I was "4 months and some change" along in the pregnancy. I asked her if it was a boy or a girl and she said she couldn't tell me. . . I asked her if she saw any defects with the baby because my other child has a club foot, and she told me that she wouldn't be able to tell that from "this kind of ultrasound" . . .
9. I then went to leave and asked her for the ultrasound picture. She got all weird and kept saying it's not really going to show anything . . . I couldn't figure out what was going on, but I had come to get an ultrasound and I wanted the picture so I pushed for it . . .
10. When I looked at it, it was so blurry I couldn't even see anything on it . . .
11. As I left the Planned Parenthood office, I saw some people standing on the sidewalk outside . . . I told them about the appointment, and how I had gone into Planned Parenthood and had an ultrasound, and showed them my ultrasound picture. I asked them what they thought of it. They told me that I could have a free ultrasound right then in the mobile van . . .

12. The woman sonographer in the mobile van was very nice and she had it set up so that I could see the screen at the same time that she was looking at it, which made me feel better right from the start. As soon as I saw the screen come up, I saw a very clear picture of my baby and heard the heartbeat. I also learned that I was about 17 weeks along, and that the baby was a girl! . . .
13. I just couldn't, and still can't, believe the difference in two ultrasounds, done so close in time on the same day.

### **Thompson**

*The 2024 Pre-Action Petition can be found at*

[www.problemsatplannedparenthood.org/new-york-city](http://www.problemsatplannedparenthood.org/new-york-city)

On September 27, 2024, our paralegal . . . faxed a copy of our letter and executed authorization for release of the records to the medical records department at PLANNEDPARENTHOOD . . .

On November 5, 2024, [the paralegal] followed up with the medical records department by leaving voicemail messages and a second request was faxed . . . [the paralegal] followed up with the respondent via telephone on numerous occasions, faxed and mailed a third and final request via express mail (FedEx) on November 19, 2024 . . . To date, the respondent has not responded to [the paralegal's] messages or provided the medical records.

## **North Carolina**

### **Chapel Hill**

*The health department documents from 2014, 2015, 2016, and 2017 can be found under Chapel Hill at:*

[www.problemsatplannedparenthood.org/north-carolina](http://www.problemsatplannedparenthood.org/north-carolina)

#### **Highlights:**

##### **Clinic Conditions**

- Staff failed to clean and disinfect the floor in the procedure room. Inspectors found dirt and rust on the floor. There were dirt stains on the floor at the foot and head of the exam table. The floor wasn't cleaned between patients or even daily, but only several times a week, by janitorial staff

### Staff

- Medications were administered by unlicensed, unqualified staff members. This included intramuscular injections of RhoGAM and birth control injections.

### Medical Records and Labels

- The facility failed to document medication administration properly in its records. They didn't record at what times medications were given. Multiple inspections documenting this.

### Treatment of Patients

- The facility failed to conduct proper informed consent, as cited in multiple inspections.
- In seven out of seven cases, the facility failed to give women instructions about what to do and who to contact in the event of medical emergencies.
- Staff failed to sterilize a vaginal ultrasound probe between uses. They used the ultrasound probe on multiple women without properly cleaning and disinfecting it. This has the potential to spread infections.

## Fayetteville

*The health department documents from 2015 and 2016, can be found under Fayetteville at:*

[www.problemsatplannedparenthood.org/north-carolina](http://www.problemsatplannedparenthood.org/north-carolina)

### Highlights:

#### Clinic Conditions

- The facility had expired medications and supplies. An oxygen mask required for emergencies had expired eight years before. Needles and curettes were expired by over two years, and other supplies were also expired.

#### Treatment of Patients

- The facility was required to keep women in the recovery room for at least an hour after surgery to make sure there were no complications. Staff failed to do this. Women were discharged 35 – 37 minutes after surgery and were not observed long enough to rule out complications.

## Wilmington

*The health department document from 2015 can be found under Wilmington at:*

[www.problemsatplannedparenthood.org/north-carolina](http://www.problemsatplannedparenthood.org/north-carolina)

### Highlights:

#### Clinic Conditions

- Blood samples and human tissue were stored in the same refrigerator as medications. This brings a risk of cross-contamination.

#### Medical Records and Label

- Doctors failed to sign consent forms.

## Winston-Salem

*The health department documents from 2015, 2016, and 2020 can be found under Winston-Salem at:*

[www.problemsatplannedparenthood.org/north-carolina](http://www.problemsatplannedparenthood.org/north-carolina)

### Highlights:

#### Clinic Conditions

- Biohazardous waste, including used needles, was stored close to employees' personal belongings and extra supplies.
- A syringe filled with lidocaine was left unattended and unsecured, leaving open the possibility of contamination or tampering.
- A disposable lab coat and masks were used repeatedly, and there was not enough personal protective equipment for the staff.

#### Staff

- There was no evaluation of competency for staff preparing and administering medication. One of the doctors administering medication was not registered with the North Carolina Board of Pharmacy. The clinic failed to ensure that a healthcare assistant preparing medication was competent to do so.
- The staff didn't properly disinfect instruments. The staff failed to "follow safe practices to prevent the spread of infection," according to the report. There was possible cross-contamination between dirty and clean instruments as dirty instruments were lifted and passed over clean ones. Staff kept dirty and clean instruments in the same sink.

- Staff failed to wear sufficient personal protective equipment when handling dirty instruments.
- According to the clinic’s regional director, “a lot of our docs don’t use masks during procedures.”
- Staff did not practice good hand hygiene while handling potentially infectious material. Because of this, they were required to go through more training.

### **Medical Records and Labels**

- Documents verifying informed consent weren’t signed by doctors. This was the case for every patient whose paperwork was examined. This was an ongoing problem, also cited in a second inspection two years later.
- In this second inspection, it was also found that the time of the procedure wasn’t given for any of the patients whose records were examined. By way of excuse, the clinic’s regional director said that the clinic’s health service manager “did not receive the proper training and it was just poor training on my part.”

### **Other**

- The facility failed to conduct periodic checks of emergency equipment including the emergency defibrillator. The clinic’s regional director and vice president said, “I know we aren’t checking it, and to be honest, we haven’t looked at the manufacturer recommendations or developed a protocol. We are going to have to determine how often checks should be done . . . Maybe every six months or maybe we need to do it every month.” This lack of testing of equipment needed in an emergency could put patients’ lives at risk.

## **Ohio**

### **Bedford Heights**

*The health department documents from 2011, 2013, 2014, 2015, 2016, and 2019, along with a letter assessing a fine, can be found at:*

[www.problemsatplannedparenthood.org/ohio](http://www.problemsatplannedparenthood.org/ohio)

#### **Highlights:**

### **Clinic Conditions**

- According to an inspection report, the facility “failed to ensure a safe and sanitary environment” for patients, visitors, and staff.

- Walls in the waiting room were darkened, dirty, and discolored. A review of the contracted cleaning staff's duties revealed that the walls weren't cleaned.
- The clinic failed to ensure appropriate ventilation and humidity levels in the operating rooms and recover rooms, increasing the risk of infection to patients.
- The facility had expired supplies, including test strips to determine whether the proper concentration of disinfectant was used to sterilize instruments. This was a repeat offense. In a later inspection, the facility had and was using expired products for skin dressings, hand hygiene, and disinfectant.
- The waiting room door's automatic release wasn't working, possibly preventing patients and staff from exiting the building in the event of a fire or other emergency.
- Fire extinguishers, which were supposed to be inspected monthly, had not been inspected for several years.
- Several tests had labels indicating they should only be used within three months after opening, but products were opened and undated.
- Saline, only good for 60 days after opening, had been opened two years ago and was being used.
- Cardboard boxes were stored in an unsafe manner, creating a fire hazard.
- Band-Aids had been removed from the manufacturer's protective packaging. Staff claimed that the Band-Aids were open and exposed to save time.
- Condoms were used to cover the ultrasound probe which was placed inside women. These condoms were stored unwrapped before use, an unsanitary situation.
- A full urine specimen cup was left sitting in the bathroom for four days, untested and not disposed of.
- The facility wasn't monitoring temperature in the refrigerator where fetal remains were kept. Too low temperatures could allow decomposition and create a health risk. The refrigerator also wasn't given proper maintenance and testing.
- The facility failed to post the complaint hotline where patients could see it.
- There were unlabeled filled syringes with no indication of what medication was in them. A staff member admitted, "we don't know what's in them."

### **Staff**

- None of the nurses on staff had surgical experience and none was qualified to be the director of nursing.
- Doctors didn't have proper privileges to perform surgery, and there was no documentation of competence from the governing body of the clinic. The facility did not conduct evaluations based on medical records and references on their doctors. According to the inspection report, "this could affect all patients receiving surgical services in the facility."
- The facility failed to conduct tuberculosis testing on newly hired staff.
- The facility failed to perform a yearly evaluation of staff.

## Medical Records and Labels

- Medical records for patients were incomplete and missing information in all the records inspectors looked at. Vital signs were not recorded and may not have been taken. This was a repeat offense, with another inspection also finding omissions in patient records.
- Records weren't signed, and the times medications were given weren't recorded.
- There were also mistakes. One claimed the patient was given pain medication 1.5 hours after she was said to have left the facility.

## Incidents



A surgery patient suffered hemorrhaging and was taken by ambulance to the hospital. The clinic didn't send her medical records to the hospital or notify the hospital's emergency department.



A second patient was also transferred to the ER having suffered a uterine perforation, which is potentially life-threatening. She needed laparoscopic surgery.

- The facility didn't have "legible and complete" records on either of these women, omitting various pieces of information including medical outcomes. The writing in the records was illegible and couldn't be deciphered by staff or inspectors.

## Other

- The facility allowed unauthorized persons to have access to controlled substances. The facility also failed to properly repackage narcotic painkillers.

## Cincinnati

*The health department documents from 2012, 2013, 2014, 2015, 2016, 2018, and 2019 can be found under Cincinnati at:*

[www.problemsatplannedparenthood.org/ohio](http://www.problemsatplannedparenthood.org/ohio)

## Highlights:

### Clinic Conditions

- Two operating tables had tears in their vinyl covers.
- There was no emergency call system in the recovery room.
- Intravenous catheters in the operating room were found to be expired.

### **Incidents**

- A minor patient having surgery suffered an allergic reaction and an asthma attack and had to be taken to the hospital.
- Fifteen patients suffered incomplete procedures. Another three women hemorrhaged, and one needed a blood transfusion.

### **Treatment of Patients**

- facility failed to have a transfer agreement with the local hospital, putting patients at risk in the event of complications from surgery.
- Surgical devices being used on patients were improperly sterilized.
- The manufacturer's instructions say aspiration devices need to be disassembled in a steam sterilizer for 30 minutes. Staff were only sterilizing them for three minutes. These devices were used on 15-20 patients a week.
- The manufacturer's instructions say aspiration devices used in surgery could be reused "up to 25 times." Staff didn't keep track of how many times each device was used and didn't dispose of them unless they malfunctioned. A staff member stated one aspiration device had been used "for many years."

## **Columbus (East)**

*The health department documents from 2011, 2012, 2013, 2014, 2015, and 2018 can be found under Columbus – East at:*

[www.problemsatplannedparenthood.org/ohio](http://www.problemsatplannedparenthood.org/ohio)

### **Highlights:**

#### **Clinic Conditions**

- A suction machine and its table, still in use, were coated with a heavy layer of dust and dirt.
- Patient care supplies were stored in an unsanitary manner, cardboard boxes directly on the concrete floor.
- One exam table had a large tear in its vinyl cover, exposing foam and making it impossible be sterilized. A staff member said the tear was brought to the attention of clinic administration a month before, but had not been repaired.

#### **Medical Records and Labels**

- The facility didn't properly label filled syringes and open vials of medication. Filled syringes didn't have the dosages on them, which led one staff member to say he would be afraid to administer the medication to patients. Open vials of medication weren't all labeled with the date they were opened.
- The facility failed to document the times medications were given to patients.

### Treatment of Patients

- The facility was only supposed to discharge patients who were accompanied by someone. The facility sent patients away alone, and without documentation they were well enough.
- The facility failed to post the complaint hotline where patients could see it.

### Other

- Controlled substances weren't in a double-locked storage area, so they could be accessed by unauthorized persons.

## Pennsylvania

### Allentown

*The health department documents from 2011-2024 can be found under Allentown at:*

[www.problemsatplannedparenthood.org/pennsylvania](http://www.problemsatplannedparenthood.org/pennsylvania)

### Highlights:

#### Clinic Conditions

- Over thirty medical instruments were covered with a reddish-brown substance, even though they were supposed to be sterile. This was an ongoing problem. In a subsequent inspection, multiple instruments still had reddish-brown stains.
- The facility had no provisions for disposing of liquid waste. They washed it down the drain.
- There were expired medications in the emergency kit. This was an ongoing problem, cited in multiple inspections. Intravenous fluid, used in emergencies, was also expired.
- Lollipops and crackers, meant to be given to patients, were stored in close proximity to biohazardous material and medical waste in a dirty area. In a later inspection, lollipops and crackers were stored in a dirty area where blood was drawn and urine tests analyzed.
- In the examination room, there was a container of cotton swabs with blood in it. This presented the risk of infection when used on patients.
- There were open, partially used, undated bottles of medication. With no record of when they were opened, staff couldn't confirm whether they were expired. This was an ongoing problem, cited in more than one inspection. Staff confirmed the

facility had no policy of monitoring expiration dates for partially used medications or disposing of them.

- An open container labeled “saline” was found to have white and black debris floating in it.
- There was expired surgical equipment.
- The facility didn’t have needed emergency supplies. Items such as sterile hemostats (an instrument used to compress or treat bleeding vessels) were missing. This was an ongoing problem, cited repeatedly in multiple inspections between 2011 and 2019.
- The facility had no policies or procedures for monitoring supplies needed in emergencies.
- The garbage can in the procedure room had no bag and had bloody gauze and a used catheter in it.
- The refrigerator where medical waste was stored didn't have a biohazard sticker warning of its contents as required.
- Medication and cleaning solutions were stored together, in violation of regulations. This was an ongoing problem, cited in more than one inspection.
- Unsterilized, unwrapped metal speculums were stored in drawers on the examination table.
- Signage required by the Department of Health, including a complaint number, wasn’t posted in the waiting room.
- Pads, sheets, curettes, sponges, and other medical equipment that were supposed to be clean were stored on the floor.
- Biohazard buckets that held medical waste had no lids or covers.
- Needles and other sharps weren’t secured. This was an ongoing problem, cited in more than one inspection, and included used needles.
- Staff confirmed that heating pads and chair coverings in the recovery room weren’t cleaned between patients. This was an ongoing problem and wasn't corrected.
- An oxygen tank was found difficult to open. The facility didn't have proper tools to open it.
- Medications were kept in an unlocked cabinet.
- The facility failed to monitor the temperature of medications that required refrigeration and had no policy for doing so.
- Syringes full of medication were not labeled as to dosage, medication strength, expiration date, or date opened. The facility had no policy on labeling syringes.
- Scrubs that were considered clean were stored on top of the dryer where dirty linens were washed. The dryer lid wasn’t cleaned, raising the possibility of cross-contamination.
- The vent of the facility’s dryer had an amount of lint comparable to the size of a golf ball.
- Ceiling tiles were stained and damaged. Paint was scraped off the wall.
- Drapes used to cover the procedure table, and pillows were kept in the procedure room during surgeries, making them vulnerable to blood splatters.

- The facility had no generator to provide power in the case of a power outage during a procedure.
- There were no call buttons either in the operating rooms or in the patient bathrooms, making it difficult for patients to summon staff in an emergency.
- A colposcopy machine (used to illuminate and magnify the view of the cervix) was stored in an unclean area, and four ultrasound machines were stored in an examination room. Staff admitted that the facility didn't have adequate clean storage spaces for these machines.
- The facility didn't have oxygen available for an emergency.

### **Staff**

- The facility failed to perform criminal background checks on some of its employees. This was an ongoing problem, cited in more than one inspection.
- Staff were untrained and uncertified in advanced cardiac support and CPR.
- The facility failed to have guidelines for the proper dosing and administration of emergency medicine to pediatric patients requiring emergency care, and staff were untrained in this area.
- The facility did not have a Director of Nursing on staff.
- Staff didn't regularly check medication storage and had no policy for doing so.
- Staff didn't properly clean the examination room, "wiping down" only horizontal surfaces.
- The facility did not maintain health status files for staff.
- Staff failed to conduct preventative maintenance on an ultrasonic cleaner used to sterilize instruments.
- Staff failed to conduct preventative maintenance on an ultrasound machine.
- Staff didn't log the presence and amounts of medications.
- The facility failed to have a policy requiring staff to wear proper attire during surgical procedures.

### **Medical Records and Labels**

- Boxes of patient records were stored under water-stained ceiling tiles. The boxes weren't stored in a manner that prevented water damage. This was an ongoing problem, cited in more than one inspection.
- Physicians failed to write or dictate post-operative surgical reports immediately after procedures.

## Privacy

- The facility failed to keep medical records with patient information private. Medical records were stored in a manner where patients' names were visible.
- There were no curtains between the recliners in the recovery room, limiting patient privacy. This was an ongoing problem that wasn't fixed after first being cited.
- The medical records of seventeen patients that were supposed to be confidential were left open and in full view of other patients at an unattended desk in the waiting room. The computer was also left on and unattended, meaning patients could access private medical records.
- The computer's password was written on a piece of paper taped to the wall next to the computer in full view of those in the waiting room. An unauthorized person could therefore access records on the computer while the desk was unattended.

## Incidents



A woman's uterus was perforated during surgery, and she was transferred to a hospital. The facility failed to notify the woman of her complication in writing, as required.



A second woman hemorrhaged after surgery, suffering from "excessive bleeding with noticeable large clots." Staff called 911 and she was taken to the hospital by ambulance. The facility didn't conduct an internal investigation into the incident and failed to report the complication to the Department of Patient Safety Authority as required. It also failed to evaluate and discuss the case at its Patient Safety Committee Meeting and made no recommendations to prevent such events in the future.

## Treatment of Patients

- The facility failed to ensure that there was a licensed nurse on duty in the recovery room. Patients were therefore not properly monitored for complications after surgery.
- The facility failed to ensure only nonflammable agents were used for pre-surgical preparations. The facility was using an improper surgical prep (chlorhexidine gluconate solution 4.0%) to prepare patients' cervixes for surgery.
- In one inspection, the facility was found to have failed to test patients for Rh sensitization.
- In other inspections, patients who were known to be Rh-negative were found not to have received RhoGAM shots. Without a RhoGAM shot, a Rh-negative patient can develop Rh sensitization after surgery. Rh sensitization can lead to stillbirth, infant death, or medical complications for the infant and mother in a subsequent pregnancy.

- Physicians at the facility did not evaluate patients before administering anesthesia.
- Medical practitioners did not obtain informed consent before initiating procedures.
- Staff were cleaning instruments with unlabeled, possibly expired, cleaning solutions and were unaware the solution had an expiration date.

### Other

- Prescription pads were left in an unlocked cabinet, where they could be accessed by unauthorized personnel.
- According to inspectors, the facility's Child Abuse Policy failed to include required information and did not meet the standards of the Child Protective Services Law as mandated by the Department of Public Welfare.
- The facility failed to arrange an annual fire inspection with the fire department, as required by regulations.

## Harrisburg

*The health department documents from 2012, 2017, and 2018 can be found under Harrisburg at:*

[www.problemsatplannedparenthood.org/pennsylvania](http://www.problemsatplannedparenthood.org/pennsylvania)

### Highlights:

#### Clinic Conditions

- One of the patient restrooms was found to be dirty.
- One of the exam tables was ripped. The tear was held together with duct tape.
- They had expired supplies; namely, packages of surgical gloves and a Nanosonics Trophon Chemical Indicator, which verifies the proper concentrations of solutions to sterilize instruments.

#### Staff

- An employee had long fingernails with acrylic nail polish, which inspectors felt was unsanitary.
- The facility failed to conduct performance reviews for four out of five employees.

#### Medical Records and Labels

- The facility didn't keep copies of reports that were submitted to the Health Department

## Lancaster

The health department document from 2023 can be found under Lancaster at:

[www.problemsatplannedparenthood.org/pennsylvania](http://www.problemsatplannedparenthood.org/pennsylvania)

### Highlights:

#### Staff

- The facility had no Certification of Clinical Privileges form on file for one of its doctors. He may not have been properly credentialed.
- physician didn't have an up-to-date Drug Enforcement Administration (DEA) registration certificate.

## Norristown

The health department document from 2012 and 2023 can be found under Norristown at:

[www.problemsatplannedparenthood.org/pennsylvania](http://www.problemsatplannedparenthood.org/pennsylvania)

### Highlights:

#### 2012

#### Clinic Conditions

- The facility “failed to provide a functional and sanitary environment for the provision of surgical services” and didn’t “adhere to professionally acceptable standards of practice for the sterilization and disinfection of equipment.”
- Machines for sterilizing equipment only got spore tests (mold tests) monthly. The manufacturer’s instructions required weekly tests.
- Surgical instruments were covered with rust. This included suture scissors and speculums. These instruments were being used on patients.
- There was no emergency call system in the operating room or recovery room. There was no intercom in the exam room.
- They had no cardiac monitors or defibrillators. They also didn’t have any tracheostomy supplies, which might be needed in an emergency.
- They failed to ensure there was a “properly conditioned air supply in critical areas of the facility.”
- They failed to monitor the temperature and humidity in operating rooms or the recovery room.
- There was no nurse’s station in direct view of the recovery room.
- There was no scrub station located near the operating room.

- The facility's Soiled Storage Room, where biohazardous waste was stored, was a small closet. They had no provision for disposing of fluid waste.
- There was no area where staff could change their clothes or put on scrubs.
- Dirty instruments, linens, and other items are supposed to be kept separate from clean ones and kept in different areas. Instead, sinks and counters were used for both dirty and clean items. Wrapped sterile supplies were stored in the same area as dirty items. Syringes and needles were also stored close to dirty items.
- There were no temperature, humidity, or ventilation monitors where sterile supplies were stored.
- Medical waste wasn't kept in a designated area but scattered throughout the facility.
- A plastic gallon container used to collect used urine strips and other items that may have come in contact with bodily fluids was kept next to the sink where staff washed their hands.
- Bathrooms were not equipped with hardware that allowed staff to enter them if a patient was having a medical emergency.
- There were no grab bars in the bathrooms, so they weren't handicapped accessible.
- Doorways, including entrances and exits from the facility, were too narrow to accommodate a gurney in case of an emergency.
- The facility had no oxygen or vacuum available for emergencies.
- Clean and sterile items were kept in the same area as blood and urine samples.
- They had no room dedicated to laboratory tests.
- Staff used dirty, unsterilized brushes to clean instruments.
- Bottles of Tylenol with codeine, which is a controlled substance, weren't stored in a double-locked cabinet and were therefore accessible to unauthorized persons.
- A thermometer in the laboratory had expired.

### **Staff**

- There were no employees trained in Pediatric Advanced Life Support (PALS) for surgical procedures performed on children under 18. None of the doctors, nurses, or other employees were trained to conduct CPR on minors. Yet the facility had performed surgery on 77 minors in the past 11 months.
- They didn't have processes in place to perform criminal background checks on employees before hiring.
- The facility failed to conduct annual performance evaluations on half of its employees.
- None of the facility's doctors were licensed to administer anesthesia, but they were administering anesthesia anyway.

### **Privacy**

There were no cubicle curtains for patient privacy in the recovery room.

## Incidents

- One patient's medical record revealed medication failed to work, but there was no evidence the incident was reported or documented for tracking.

## Treatment of Patients

- They didn't have a contract or agreement with an ambulance service, putting patients in danger in case of emergencies.
- Staff failed to monitor patients' oxygen saturation while they were under anesthesia. The facility had no equipment capable of monitoring oxygen saturation. This created a risk for patients.
- They were giving expired medications to patients.

2023

## Staff

The facility failed to review the credentials of its physicians every two years as required.

## Philadelphia (Locust Street)

*The health department documents from 2011-2019 can be found under Philadelphia 0 Locust Street at:*

[www.problemsatplannedparenthood.org/pennsylvania](http://www.problemsatplannedparenthood.org/pennsylvania)

## Highlights:

### Clinic Conditions

- To quote: "the facility failed to provide a safe and sanitary environment."
- The cushion of a bench patients were expected to sit on was covered with multiple dark stains – likely blood or bodily fluids.
- There were multiple dark stains on the carpeted floor in the recovery room.
- Used needles had spilled out of containers and were scattered on the floor in the biohazard room. The containers were stored directly on the floor.
- A container of used needles was also on the floor in the recovery room.
- In the storage room, toilet paper, paper cups, latex gloves, and exam table rolls, all of which should have been kept clean, were sitting on the floor. Bottles of solution were also on the floor.
- There were no hands-free scrub sinks outside the operating rooms.
- The facility failed to properly store human tissue, creating unsanitary conditions. Biohazardous waste was stored in an unlocked refrigerator in an unlocked closet.

Biohazard bags were undated. In another inspection, cardboard boxes of biohazardous waste were found on the floor.

- The area where drugs, including narcotics, were stored wasn't periodically checked by a pharmacist or practitioner, and no log was kept.
- The facility failed to maintain temperatures per established guidelines in the Recovery Area. It was too cold. In another inspection, staff were found not to be monitoring temperature or humidity in the operating rooms or recovery room.
- Twenty Gauze Sponge packets used in surgery were stored under a sink in the procedure room.
- The facility's lab refrigerator/freezer, for storing control tests, had a buildup of ice.
- All of the wraps and pouches of sterilized instruments had wet stains on them.
- A metal container in the sterile processing room wasn't properly sterilized.
- They had no policy on how long to soak instruments in sterilizing solution as per the manufacturer's instructions. This could lead to instruments being used on patients that weren't properly sterilized.
- The facility was cited for numerous health code violations, and the facility's administration submitted a plan of correction. When the inspectors came back the next year, this plan hadn't been implemented. According to the report: "the facility failed to correct deficient practice and failed to follow the Plan of Correction submitted to, and accepted by, the Department of a full State Licensure survey... for one of six deficiencies cited."
- Two bags of Sodium Chloride solution, meant for intravenous use, and located in a heating cabinet, were undated. There was no way to determine if they had expired or were safe to use.
- The facility failed to ensure that stored drugs were periodically checked by a doctor or pharmacist.
- There was no record of the facility conducting maintenance on the ventilation system.
- Fusible link components of fire dampers were never tested. Fire alarms and fire extinguishers weren't inspected regularly.
- Electrical receptacles at patient bed locations and in locations where deep sedation or general anesthesia were administered weren't tested regularly.

### **Staff**

- The facility failed to request and consider reports from the National Practitioner Data Bank for employees, which is a tool to prevent medical professionals from moving from state to state without disclosing previous medical malpractice.
- The facility failed to conduct background checks on employees working with minors.

### **Medical Records and Labels**

- The facility had no written policy concerning the retention of medical records or specifying who had access to them. They also had no written policy dictating under what circumstances medical records could be removed or released.

- The facility's fire safety plan had no provisions for evacuating or securing patients' medical records.
- Staff failed to correctly complete paperwork on patients being discharged, neglecting to classify them according to physical status.

### **Privacy**

- There were no curtains between reclining chairs in the recovery room, compromising patient privacy.

### **Treatment of Patients**

- The facility wasn't reporting statutory rape or sexual assault of minors. They had no policy in place to do so.
- In 6 of 6 cases of pregnant minors under 16, the facility failed to ascertain whether the girls were victims of abuse by an adult and failed to report the incidents. These were four 13-year-olds and two 14-year-olds who were pregnant. No questions were asked, and no reports were made. Two of the minors reported that their first sexual intercourse occurred when they were twelve or younger. This wasn't reported.
- The facility failed to do physical examinations and assess patients' physical status before administering anesthesia and doing surgery.
- The facility failed to have a doctor supervise the nurse who gave anesthesia, nor were any doctors certified to give this supervision. The nurse giving anesthesia was not registered with the National Practitioner Data Bank.
- The facility didn't not have a policy that addressed the discharge of an incompetent patient.
- Patients having surgery weren't properly assessed before being discharged. Staff failed to check and document patients' respirations, activity level, pain, or nausea and vomiting.

### **Incidents**

- A patient suffered a "serious event," i.e., a complication, and the facility failed to notify her in writing of the complication within seven days, as required.

### **Other**

- When the entity that owns the facility (Planned Parenthood Southeastern Pennsylvania) held a Risk and Quality Management meeting for all its affiliates, no one from the facility attended.
- The facility did not request an annual inspection by the local fire department. Fire inspections weren't being done.

## **Philadelphia (Far Northeast)**

*The 18 health department inspections documents from 2012 to 2019 can be found under Philadelphia – Far Northeast at:*

[www.problemsatplannedparenthood.org/pennsylvania](http://www.problemsatplannedparenthood.org/pennsylvania)

### **Highlights:**

#### **Clinic Conditions**

- Potentially infectious pathological waste was improperly stored. The facility had no freezer or refrigerator for storing human tissue, so they stored it at room temperature. Staff didn't use preservatives but simply boxed the tissue to be picked up by a waste disposal company. This presented a health hazard due to potentially decomposing human tissue.
- The treatment bed in one of the operating rooms was stained brown, allegedly by a cleaning solution. The armrest of the bed had tape on it, creating a surface impossible to properly sterilize.
- An IV pole in the operating room was rusty, and an air vent in the operating room was dirty and covered in rust.
- Medication in pre-filled syringes was kept in the procedure room, raising the risk of contamination by surgical products, dirty instruments, and biohazardous waste. The staff were drawing up medication into syringes in potentially contaminated areas.
- Packets of purportedly sterile instruments had wet stains on them, meaning they weren't sterile. The facility was planning to use the instruments during surgery.
- They had no official policies in place to determine that surgical instruments were properly sterilized.
- Staff didn't monitor or document the total time, pressure, or temperature for each load of instruments being sterilized in the autoclave to ensure sterilization was done correctly.
- Staff failed to use test strips on an open bottle of medication as required to ensure the effectiveness and safety of the medication.
- They had no emergency call system in the operating rooms or recovery room. This could lead to delays in summoning help in emergencies.
- They failed to establish policies for the timely cleaning of equipment and were unable to provide cleaning schedules. Staff had no records to show inspectors when and how often equipment was cleaned.
- Soiled and clean work areas were located in the same room and close to one another, raising the risk of cross-contamination.
- There were no hands-free scrub sinks outside the operating rooms.
- They had no devices for monitoring temperature and humidity anywhere in the building. This included the operating room, post-anesthesia area, and elsewhere.

- The ventilation system wasn't regularly checked and maintained. There was no policy to do so.
- They failed to ensure drugs were checked periodically by a pharmacist or practitioner. This was an ongoing problem, mentioned in more than one inspection.
- They failed to conduct routine maintenance of electrical receptacles, plugs, wires, and connectors, or ensure that they were safe.
- Formalin containers, which are required to be in a secure area, were stored in a place accessible to unauthorized staff.
- The facility was out of compliance with regulations for ambulatory surgical centers. The operating rooms were too small, the ceiling was not monolithic, and the floor didn't have sealed seams.
- They didn't have proper emergency illumination at the exits, a violation of the fire code. In two subsequent inspections, the exits were still not illuminated.
- They were also out of compliance with the fire code because fire barriers didn't meet requirements. In a subsequent inspection, they were still found to be out of compliance with the fire code.
- They failed to ensure that automatic fire extinguishing systems and fire alarms were inspected by qualified personnel every three months, as required. There was no documentation for when they were last inspected.

### **Staff**

- The facility failed to conduct background checks on its employees who were working with minors, as required by law.
- Staff weren't trained in the operation of the fire warning system, the proper use of firefighting equipment, and the procedure to follow if electric power was impaired. None had ever attended a fire safety workshop.
- They were unable to provide inspectors with any records on the education of nurses nor to substantiate they had proper training.
- They failed to designate a physician to serve as the director of anesthesia services. Therefore, no doctor was overseeing the nurses who delivered anesthesia or ensuring it was safely administered.
- The facility had no established policies and procedures for the supervision of the nurses administering anesthesia. There were no policies and procedures in place to ensure the education, training, and responsibilities of non-physician anesthetists.

### **Medical Records and Labels**

- They had no official policy for specifying which employees had access to medical records and under what conditions medical records could be released or removed.
- In another inspection, inspectors found that unauthorized staff had access to confidential medical records.

- Records were stored in cardboard boxes alongside paint, ladders, light bulbs, and cleaning chemicals in a room that contained no fire extinguishers or fire-extinguishing system.
- The facility failed to have a proper plan for preserving medical records in the event of closure, as per state requirements.

### **Privacy**

- There were no curtains for privacy between recliners in the recovery room.

### **Incidents**

- Records showed that staff failed to report the possible sexual abuse of two minors under 16 who came to the facility pregnant. In such cases, staff are required by law to determine if the minor's sexual partner is four or more years older than she is. If so, a report must be filed. Staff failed to ask the minors the ages of their partners and filed no reports. Further questioning revealed that the facility had no policy for dealing with the sexual abuse of minors.
- Records showed five patients who had surgical procedures at the facility were not physically assessed before discharge.
- In a subsequent inspection, records show eight patients had been released without being assessed for nausea and vomiting, which could be symptoms of a complication.

### **Treatment of Patients**

- They failed to have a written policy concerning the discharge of minors and incompetent patients.
- They had no policy for assessing patients for nausea and vomiting before discharge.
- They had no quality assurance and improvement program. They weren't trying to monitor and evaluate the quality of patient care.
- In a later inspection, it was noted that the facility did have a Risk and Quality Management Committee. But there was no documentation that they were performing their duties. The committee didn't appear to be evaluating medical staff functions, anesthesia services, nursing services, pharmaceutical services, pathology services, infection control procedures, and reports of accidents, injuries, and safety hazards. The facility's governing body failed to review reports from the Quality Assurance and Improvement, Infection Control, and Patient Safety Committees, and problems mentioned in these reports were not addressed or corrected. This was an ongoing problem, cited in more than one inspection.
- In a later inspection, it was found that the facility no longer had a facility-specific Infection Control Committee at all.

## Other

- They failed to review contracted services to ensure they were provided safely and effectively. These services included housekeeping, linen, heating and ventilation systems services, electrical system services, anesthesia services, infectious waste removal, ambulance services, pest control, hospital transfer agreement, laboratory services, equipment preventative maintenance, water service, environmental systems, and fire alarm services.
- They failed to establish a workable plan with the nearest fire department.
- They failed to conduct fire drills. This was an ongoing problem, cited in multiple inspections. They also failed to arrange annual fire inspections, which was also an ongoing, uncorrected problem.
- They failed to maintain proper paperwork regarding staffing schedules and had no list of approved operative procedures performed at the facility.

## Pittsburgh

*The health department documents from 2011-2024 can be found under Pittsburgh at:*

[www.problemsatplannedparenthood.org/pennsylvania](http://www.problemsatplannedparenthood.org/pennsylvania)

### Highlights:

#### Clinic Conditions

- To quote: “the facility failed to keep the premises and equipment clean.”
- There were multiple large stains on the carpet in the patient waiting room.
- In the ultrasound room, there was heavy dust on the sharps container, paper towel dispenser, and picture frames.
- In the operating rooms, there was excessive dust on picture frames, paper towel dispensers, cabinet tops, and door frames. This was an ongoing problem, cited in more than one inspection.
- In the utility room, there was a buildup of dried sanitizing material adhering to the bottom and sides of the wash station. This was where instruments were cleaned.
- A washer and dryer were covered with “a heavy coat” of dust, and the dryer had a broken lint filter and was full of lint.
- A trashcan with a biohazard bag, used for medical waste, was stored in the back hall by the staff entrance.
- One of the recovery chairs had a cracked, split seat cover, making it difficult to sanitize.
- The clean and soiled work areas were shared. The clean and soiled work counters were connected, raising the risk of cross-contamination.
- There were multiple cracked tiles on the floors of three operating rooms.
- Doors to the operating rooms were too narrow to admit stretchers, possibly causing delays and difficulties in emergencies.

- They failed to maintain medications within the recommended temperature ranges on the manufacturer's packaging for four out of four medications.
- They had multiple medications and surgical products that had expired years ago.
- Sterile strips had expired nineteen years before the inspection. The facility also had expired Chlamydia culture tubes and one container of cytology fixative spray that had expired six years before. Other fixative sprays had expired seven years before.
- The facility had medication that was expired by seven years and surgical masks expired by three years. Birth control injections had expired three years before.
- More than fifty curettes, used in surgery, had expired three years before. Another had expired two years before. Dilators used in surgery were also expired. A bottle of solution was three years past its expiration date.
- A box contained over forty medical instruments, such as forceps, that were also expired. This box did have a label marking the instruments as expired. This was not so with other expired items in the facility.
- Supposedly clean surgical tools were left in a drawer under the exam table.
- The facility failed to have a cardiac monitor and defibrillator available in each operating room and the recovery area. They were also missing other emergency supplies and devices, which would compromise the staff's ability to assist patients experiencing complications.
- According to inspectors, "the facility failed to provide adequate space to perform the volume of work with optimal accuracy, precision, efficiency, and safety." This concerned the exam room, which inspectors felt was too small.
- Staff didn't monitor temperature and humidity in the surgical and recovery areas.
- There were no humidity or ventilation monitors in the area where sterile instruments were stored.
- Ceiling tiles in three operating rooms weren't "monolithic, scrubbable, and capable of withstanding chemicals," as was required.

### **Staff**

- None of the staff was certified in Advanced Life Support. They would be unprepared in an emergency. This was an ongoing problem, cited in more than one inspection.
- An unqualified nurse wrote prescriptions using prescription pads that were pre-signed by a doctor.
- They hired untrained staff to perform medical tasks, including assisting in medical procedures and surgeries. They required only a high school diploma and two years' educational/work experience after high school.
- When hiring staff, they didn't verify prospective employees' certifications and work experience, nor did they ask for references.
- Nursing staff had no experience in the postoperative care of pediatric patients.
- The facility had no anesthesiologist or certified registered nurse anesthetist on staff and yet was providing sedation to patients. This was an ongoing problem, cited in more than one inspection.

- When hiring doctors, the facility failed to examine and document evidence of their education, training, and assignment or curtailment of clinical privileges. They had no policies to do so.
- Nine out of ten doctors didn't have the paperwork regarding their DEA licenses in order, but all were dispensing a controlled substance.
- They granted privileges to doctors without doing proper background checks, in that they failed to request and consider reports from the National Practitioner Data Bank for each practitioner who requested privileges.
- They failed to specify which members of staff were allowed to dispense medications. Administration failed to ensure that only qualified staff dispensed them.
- They had no registered nurse, and no registered nurse was on the Quality Assurance and Improvement Committee.

### **Medical Records and Labels**

- Medical records didn't have the names of staff members who dispensed medication and administered anesthesia, raising the concern that unqualified staff were performing these medical tasks.
- Preoperative tests and their results weren't properly documented in the medical records. There was no documentation for evaluation, annotation, or signature of the person evaluating the test.
- Medical records did not contain pertinent information regarding the choice of anesthesia.
- The facility had no policy for the removal of medical records.
- Some entries in the medical records weren't dated or signed.

### **Privacy**

- There were no curtains between chairs in the recovery room, compromising patient privacy.

### **Treatment of Patients**

- They failed to properly monitor the vital signs of patients who had received anesthesia before surgery. EKG monitoring wasn't done during procedures.
- They failed to conduct proper informed consent before surgery. Consent forms were incomplete as to the comparative risks, benefits, and alternatives associated with performing a procedure.
- The staff failed to properly evaluate patients who had surgery before discharging them. Staff didn't monitor, document, or check if patients had nausea or vomiting before clearing them to leave.
- They failed to notify patients receiving sedation that they needed to have a responsible person escort them home. The preoperative instructions didn't include this requirement, nor did they state that a patient might need to go to the hospital in the event of complications.

- They failed to verify the identities of patients before administering anesthesia and had no policy for doing so.
- They failed to send tissue removed during surgical abortions to a laboratory for examination by a pathologist. This could lead to a missed diagnosis of retained tissue, endangering the patient.
- They didn't have a written transfer agreement with an ambulance service. This could cause a delay in transporting a patient to the hospital in the event of a surgical complication or other emergency.
- They failed to have medically qualified staff observe patients who received sedation or anesthesia for a period of time to ensure they didn't experience complications.
- Written post-operative instructions given to patients lacked important medical information, such as instructions to avoid certain physical activities.
- Staff didn't take patients' temperatures before discharging them.

### Other

- Prescription pads that had been pre-signed by a doctor were left in an unlocked cabinet in an unlocked room. They could be accessed by unauthorized personnel.
- Controlled substances were left unlocked and unattended in the crash cart. In a later inspection, controlled substances were not properly secured.
- The governing body of the facility failed to approve proper medical standards and techniques for administering anesthesia.
- They failed to track infections among patients and had no policy to do so.
- They failed to arrange regular fire inspections.

## Reading

*The health department documents from 2011, 2012, 2017, 2018, 2019, 2022, and 2023 can be found under Reading at:*

[www.problemsatplannedparenthood.org/pennsylvania](http://www.problemsatplannedparenthood.org/pennsylvania)

### Highlights:

#### Clinic Conditions

- The facility failed to separate the "clean" work area from the "soiled" one. They stored sterile instruments in the same area where dirty instruments were processed.
- The facility had an unsecured oxygen tank on the floor of one of the restrooms.
- The facility had two expired fire extinguishers, also on the floor of one of the restrooms.

- Both procedure rooms had surgical equipment without preventative maintenance labels so there was no way to determine when the equipment expired.
- The freezer didn't have a temperature gauge to ensure items inside were kept at the right temperature. This could lead to medications and tests being improperly maintained.
- The facility failed to monitor the temperature and humidity in the operating rooms and the recovery room.
- There were no temperature, humidity, or ventilation monitors in the area where the sterile instruments were stored. The temperature and humidity weren't being monitored.
- Sinks in the procedure rooms weren't hands-free. There were no scrub sinks located outside the rooms.
- The facility was unable to provide documentation that the autoclave, which sterilizes medical instruments, was properly tested for biologics that could contaminate instruments during the sterilization process.

### **Staff**

- No staff members were trained in advanced cardiac life support.
- The facility failed to reappraise and reappoint physicians and certified registered nurse practitioners every two years as required.
- The governing body failed to request and review reports from the National Practitioner Data Bank before granting doctors privileges. They didn't properly screen their physicians.
- The facility had no registered nurse on staff.
- The facility had no staff member(s) responsible for developing and monitoring the infection control program and maintaining records of infections among patients.
- The facility failed to train staff on infection control.
- The facility failed to conduct annual performance evaluations for its doctors. This was an ongoing problem, cited in more than one inspection.

### **Medical Records and Labels**

- The facility had no written policy regarding the preservation of medical records.
- The facility had no specific policy regarding which staff members had access to confidential medical records, under what conditions medical records could be removed, and under what circumstances medical information could be released.
- Physicians failed to sign pre-operative admission order sets and inter-operative notes.

### **Privacy**

- There were no curtains separating patients in the recovery room.

## Treatment of Patients

- Doctors at the facility failed to obtain informed consent and failed to notify patients of the risks of anesthesia and medical procedures.
- Staff failed to obtain proper informed consent for six out of six patients whose records were examined. The patients weren't given information on the comparative risks, benefits, and alternatives associated with performing a procedure in the ambulatory surgery facility instead of in a hospital.
- According to medical records, staff failed to assess patients for nausea and vomiting before discharge.
- Patients weren't provided with written pre-operative instructions before medical procedures, nor were they provided with post-operative instructions afterward.
- Staff failed to conduct necessary blood tests for patients prior to performing medical procedures. These tests, including hemoglobin or hematocrit measures, were meant to indicate whether a patient had risk factors that could complicate surgery.

## Other

- The facility failed to conduct fire drills.
- Staff didn't conduct periodic checks of the area where medication was stored, and didn't maintain logs of medications.
- The facility had no written policies for prevention, control, and investigation of infection.

## Warminster

*This clinic is permanently closed, so the health department documents from 2012, 2016, 2017, and 2018 can be found at:*

[www.problemsatplannedparenthood.org/closed-centers-health-violations](http://www.problemsatplannedparenthood.org/closed-centers-health-violations)

## West Chester

The health department documents from 2011, 2012, 2014, and 2017 can be found under West Chester at:

[www.problemsatplannedparenthood.org/pennsylvania](http://www.problemsatplannedparenthood.org/pennsylvania)

### Highlights:

#### Clinic Conditions

- A foul odor was noted and was present throughout the facility.
- The suction machines used in surgery didn't have a preventive maintenance label to indicate the inspection date. There was no indication they'd been inspected.
- Medical supplies were expired, including a box of masks that had been expired for five years and two packages of gowns that had been expired for four.
- Human tissue from surgery was stored in a paper bag that was leaking blood in the refrigerator.
- The facility failed to ensure that linen was handled in a manner to minimize contamination. Linens weren't washed long enough, and the clinic staff didn't monitor the temperature of water to determine if it was hot enough to properly sterilize the linens.
- The facility failed to inspect and properly maintain the ventilation system.
- The facility failed to monitor the temperature and humidity levels in the operating rooms and post-anesthesia care area.
- Automatic fire extinguishing systems and fire alarms weren't inspected and tested.
- Grab bars were missing in the patient bathroom, meaning it was not handicapped accessible.
- There were no cubicle curtains for privacy in the recovery room.
- The soiled work area and clean work area were located together in the same room, raising the risk of cross-contamination.
- The facility didn't meet structural requirements – the floor didn't have sealed seams and the operating rooms were too small.
- There were no hands-free scrub sinks located outside the operating rooms.
- The facility failed to ensure controlled substances were properly secured. For example, 26 containers of Tylenol with Codeine were left in an open cardboard container on the countertop in the recovery room.
- According to an inspection report, "the facility failed to adhere to professionally acceptable standards of practice to assure a functional and sanitary environment."

### **Staff**

- One of the doctors who maintained a supply of controlled substances, dispensed, and prescribed controlled substances didn't have the proper certification from the DEA.
- The facility failed to conduct background checks on its employees and didn't have a policy for doing so.
- There was no documentation that a doctor had privileges to administer anesthesia. There was no delineation of privileges regarding doctors administering anesthesia.

### **Medical Records and Labels**

- The facility failed to have a written policy regarding the retention of medical records. It also failed to have a policy specifying which employees had access to medical records and under what conditions they could be released.
- There was no plan to evacuate medical records in case of an emergency.

### **Treatment of Patients**

- The facility had a policy in place to monitor patients' blood pressure after surgery by taking vital signs every 15 minutes. However, this wasn't done for 11 out of 25 patients.
- The facility failed to provide a written policy for the discharge of an incompetent patient, i.e., a patient who couldn't consent to medical care because of age or mental condition.

### **Other**

- Managers had erroneously instructed employees that they could turn away health inspectors if the inspectors arrived on a day that surgeries were being done.

## **Wilkes-Barre**

*The health department document from 2023 can be found under Wilkes-Barre at:*

[www.problemsatplannedparenthood.org/pennsylvania](http://www.problemsatplannedparenthood.org/pennsylvania)

### **Highlights:**

#### **Treatment of Patients**

- According to medical records and staff interview, staff failed to offer required documents from the Department of Health to a minor patient and her parent to review before the minor's medical procedure. The facility failed to document that the educational materials were offered and failed to document whether the patient and/or parent chose to view them.

## York

The health department documents from 2011-2025 can be found under York at:

[www.problemsatplannedparenthood.org/pennsylvania](http://www.problemsatplannedparenthood.org/pennsylvania)

### Highlights:

#### Clinic Conditions

- The facility had no emergency call system in the bathrooms, operating rooms, and recovery area.
- They failed to ensure the ventilation system was inspected and maintained. They therefore failed to ensure air quality was kept at proper filtration, humidity, and temperature requirements in operating rooms and the recovery room.
- They had no fire extinguishing systems or fire alarms.
- Ceilings consisted of textured tiles that were not scrubbable or gasketed.
- There were no scrub sinks located outside of the procedure rooms.
- Doors were too narrow to admit a gurney in case a patient needed to be transferred to the hospital in an emergency.
- The facility failed to have emergency equipment readily available for resuscitation for procedures using local anesthesia.
- They failed to conduct regular testing of their automated external defibrillator to ensure it was in working order. This equipment could be critical in an emergency.
- The only oxygen tanks in the facility were empty.

#### Staff

- They failed to request and consider reports from the National Practitioner Data Bank for both of its doctors. The National Practitioner Data Bank is a tool that prevents medical professionals from moving from state to state without disclosing previous medical malpractice.
- They failed to ensure a Registered Nurse was on the Quality Assurance and Improvement Committee.
- Staff didn't have training or education in infection control.
- They failed to provide a committee for the prevention, control, and investigation of infection.
- They failed to complete annual performance evaluations for three of their four physicians.

#### Medical Records and Labels

- None of the medical records contained documentation the patients were assessed for nausea and vomiting before discharge.
- No post-operative surgical reports were written for six of six patients.

- Entries in medical records weren't dated and authenticated by the person making the entries. Paperwork wasn't signed or dated in 100% of cases.
- The facility didn't have a policy regarding the preservation of medical records.

### **Incidents**

- The facility failed to administer a RhoGAM shot to a woman who was Rh-Negative. This could lead to Rh sensitization, which can cause serious complications and infant death or disability in future pregnancies.
- A patient suffered a medical complication, and they failed to notify the patient in writing of the event within seven days because, at the time, they had no patient safety officer.
- In 2023, the facility was cited for "failing to report a serious event." This was likely a complication, but no more information is available.

### **Treatment of Patients**

- They failed to ensure practitioners documented informed consent.
- They failed to conduct a physical exam and evaluation before performing surgery or giving anesthesia for six of six patients whose records were examined.
- The facility failed to ensure patients were properly identified by the operating surgeon before the start of surgery for six of six medical records reviewed. In every case, the surgeon didn't identify the patient prior to the start of the procedure.
- The facility failed to document whether a Rh-negative patient was given or refused a RhoGAM shot.

### **Other**

- They didn't have written policies and procedures that only authorized people in the proper attire could be in the surgical area.
- They failed to establish a workable plan with the nearest fire department.
- They failed to conduct fire drills.

# South Carolina

## Charleston

### Highlights:

#### Clinic Conditions

- Eighteen disposable syringes, used on patients, were found to be expired.

#### Incidents

- The facility failed to conduct proper informed consent before a surgical procedure on one patient. There was no documentation of informed consent, and the patient hadn't signed the required form attesting to receiving it.

#### Treatment of Patients

- There were no emergency call buttons in any of the bathrooms, meaning patients couldn't summon staff in the event of an emergency.

#### Other

- A doctor on staff failed to report procedures to Vital Records and Public Health Statistics at the Department of Health, as was required.

## Columbia

*The 2015 health department document can be found under Columbia at:*

[www.problemsatplannedparenthood.org/south-carolina](http://www.problemsatplannedparenthood.org/south-carolina)

Modern Healthcare  
Associated Press, September 12, 2015

### Excerpt:

The Department of Health and Environmental Control issued suspension orders for Planned Parenthood's Columbia clinic and the Greenville Women's Clinic, citing violations found during recent inspections . . . The Columbia clinic was cited for 21 violations . . . Planned Parenthood's additional citations include having expired medicine and storing sterile and nonsterile gloves together.

# South Dakota

## Sioux Falls

The health department document from 2014 can be found at:

[www.problemsatplannedparenthood.org/south-dakota](http://www.problemsatplannedparenthood.org/south-dakota)

### Highlights:

#### Clinic Conditions

- According to the inspection reports, the facility failed to maintain an environment “in such a manner that the safety and well-being of the patients are assured.”
- There were holes in three of the four walls in the elevator equipment room. There were four holes in the ceiling of the generator room. There were eight holes in the ceiling of the second floor mechanical room. There were holes in the walls in the boiler room. These problems were cited in multiple inspections, and were not fixed.
- The exhaust fan in the soiled storage room wasn’t functioning.

The facility had the following fire hazards:

- A hand sanitizer dispenser was installed above a light switch.
- Electrical receptacles in a corridor had a damaged cover.
- Light fixtures in many of the rooms did not have bulb protection.
- The facility had not had its fire dampers inspected in four years.
- Access to a fire extinguisher was obstructed by an advertisement sign.
- Another fire extinguisher was taped to the wall and wasn’t available to be used in an emergency.
- None of the fire extinguishers were being inspected or tested.
- Doors were blocked with rubber wedges, possibly preventing patients and staff from escaping in the event of a fire.
- Signs were stored in the hallways, interfering with evacuation in case of an emergency.
- In a different inspection, cases of water were blocking hallways and bottles of beer were blocking stairs leading out.
- There were unsecured oxygen cylinders in the surgery room.
- There were no hazard signs located in areas where oxygen and other flammable gases were stored.

This problem was not corrected and was cited in two different inspections.

# Tennessee

## Nashville

*The health department/board of medical examiners document can be found under Nashville at:*

[www.problemsatplannedparenthood.org/tennessee](http://www.problemsatplannedparenthood.org/tennessee)

### **Highlights:**

At the Planned Parenthood facility, the doctor gave a prescription to an employee without proper examination, and later gave the employee a signed blank prescription. The doctor was required to complete a course on proper medical oversight of prescriptions.

# Texas

## Austin (South)

*The health department document from 2015 can be found at:*

[www.problemsatplannedparenthood.org/texas-austin](http://www.problemsatplannedparenthood.org/texas-austin)

### **Highlights:**

#### Clinic Conditions

- The facility “failed to ensure a safe and sanitary environment for all surgical patients.”
- There were pieces of debris around patient beds in the operating rooms. There were used alcohol pads on the floor of one OR and on the table in another. Staff said that the rooms had been cleaned and were ready for patients. They said they believed that the rooms had been cleaned the day before.
- The bed rests on tables in both OR’s were covered with socks, and the socks weren’t changed between patients.
- There was tape on multiple surfaces in both operating rooms. Tape creates a sticky surface that can’t be properly disinfected.
- There was a “thick, visible layer of dust” on surfaces in both operating rooms. Inspectors said this indicated “ineffective cleaning.”
- The facility was improperly sterilizing instruments. Sterile instruments were left open or sealed in a way that inspectors felt would prevent them from being fully sterilized.
- Packages of patient tubing and curettes were stored improperly, in potentially unsanitary conditions.

- Multi-dose vials of Lidocaine were stored improperly.
- Patient care items weren't taken out of shipping containers, and were stored within them, leading to possible unsanitary conditions. The publication "Preventing Infection in Ambulatory Care" states that shipping containers can be contaminated with dirt or other debris and shouldn't be stored with patient supplies to prevent contamination.
- \* Two autoclaves (used to sterilize instruments) were also stored in the supply room with the shipping containers, leading to the risk of cross-contamination.
- 

### **Treatment of Patients**

- The facility was only supposed to discharge patients if they were accompanied by a responsible adult. The facility didn't follow this policy and sent patients away alone. There was no documentation that these patients were well enough to leave the facility and travel home alone.

## **Dallas (South)**

*The health department document from 2015 can be found at:*

[www.problemsatplannedparenthood.org/texas-dallas-ft-worth](http://www.problemsatplannedparenthood.org/texas-dallas-ft-worth)

### **Highlights:**

#### **Clinic Conditions**

- The facility "failed to ensure a safe and sanitary environment for surgical patients."
- A cabinet beneath the sink in the waiting room had a large circle of dark brown dried substance on it.
- The emergency call button in one of the patient bathrooms was too high off the floor for a patient to reach if they had fallen. A patient who had fallen to the floor would be unable to summon help in an emergency.
- Patient bags were stored on the sitting bench in the bathroom across from the toilet.
- Other patient bags and belongings were stored in a cardboard shipping box on the floor of the pre-op storage area.
- In another one of the patient bathrooms, three of the ceiling tiles had large brown water stains.
- There was no gauge on the oxygen tank that was available for patient emergencies. This meant the oxygen couldn't be turned on. It was the only oxygen tank available.
- The vital sign machine was three months past the date when it should have received preventative maintenance and an electrical safety check.

- The cabinet covering where sterile instruments were wrapped was peeling and cracked. Under the cabinet, empty cardboard boxes were stored on the floor in the same area where sterile instruments were wrapped. According to the report, “this had the likelihood to contaminate supplies which could cause an infection.”
- Cardboard shipping boxes were stored with open patient supplies on the shelves. Cardboard boxes were on the shelf above the open sterile supplies.
- Open sterile supplies were stored near the floor where dust particles could contaminate them. In addition, cardboard shipping boxes containing patient belongings were stored on the floor in the same area where open sterile supplies were kept.
- Two suction machines had no preventative maintenance safety check stickers on them, meaning they were not being inspected or properly maintained. Staff told inspectors these machines weren’t being used, but they did not have a “do not use” label and inspectors believed they “were available for patient’s use.”
- Cardboard shipping boxes with biohazard needles were stored on the floor in the same area where sterile supplies were kept.
- There were trash and dust particles in the area where open sterile supplies were stored.
- There was a mop bucket with dirty brown water sitting in the janitor’s closet. A staff member didn’t know when the bucket of water had last been used.
- Clean linen was observed on the floor of the laundry room.
- The biohazard waste storage room, where human tissue was kept, had an unsealed cement floor. This created a situation for blood to leak from the biohazard bags onto the unsealed cement floor, creating a surface that was impossible to clean and increasing the risk of transmitting infection.
- Temperature and humidity weren’t monitored in areas where sterile instruments were stored. According to the inspection report, this could cause a fire hazard, the buildup of dust, and/or the growth of microbes.
- Sterile instrument packages were incorrectly sealed. According to the report, this had the potential to cause contamination and microbial growth. According to one staff member, “the girls assisting me did not have the knowledge to recognize that the peel pouches were not sealed or labeled correctly and that they would need further training.”

### **Staff**

- A staff member reached into a washing machine and handled dirty linen, potentially stained with blood and bodily fluids, without personal protective equipment.
- Staff failed to wear proper operating room attire during surgeries.
- The facility didn’t know the hepatitis B status of half of its employees.

### **Medical Records and Labels**

- Sealed packages of instruments weren’t labeled correctly and were also improperly sealed.

## Treatment of Patients

- Doctors didn't perform physical exams on patients prior to surgery. There was no documentation of exams for half of the patients whose charts were examined and inspectors were "unable to find evidence" that exams were done.
- Patients weren't evaluated by a physician or advanced practice registered nurse prior to being dismissed from the facility after surgery. An employee stated, "the physician completes their procedure and does not see them in recovery unless there is a complication." However, without an exam, it could be hard to determine if there was in fact a complication. Other employees confirmed patients weren't seen in recovery prior to going home.

## Other

- The facility failed to store medication in a safe and secure area. Lidocaine vials were located in an unlocked storage area, where they could be accessed by unauthorized persons.

## Fort Worth (Southwest)

*The health department document from 2016 can be found at:*

[www.problemsatplannedparenthood.org/texas-dallas-ft-worth](http://www.problemsatplannedparenthood.org/texas-dallas-ft-worth)

### Highlights:

#### Clinic Conditions

- The facility "failed to ensure a safe and sanitary environment for surgical patients."
- The facility wasn't conducting proper maintenance on three suction machines. The facility was nevertheless performing surgery with these machines.
- Supplies in the emergency crash cart were expired.
- There were no oxygen tanks available in case of emergencies.
- Cardboard shipping boxes were stored with sterile patient supplies, creating a risk of contamination. A dirty feather duster was lying beside sterile supplies.
- A cardboard box containing biohazardous waste was also stored right next to the sterile supplies. According to the report, "this had the likelihood to contaminate the clean and sterile supplies from the waste products brought into the room and placed in the biohazard box."
- Trash and dust particles were on the floor of the room where sterile supplies were stored.
- There were exposed wires from an uncovered electrical outlet in the laundry room, creating a fire hazard. These wires were close to where water ran into the washing machine.

- The wall in the laundry room had areas where plaster was missing. This made it so employees couldn't clean the wall and created the risk of contamination of clean linens.
- Snacks for patients were kept in a cardboard box placed on a dusty and dirty cart.
- There was equipment that wasn't labeled or sorted to determine if it was clean or dirty.
- In the pharmacy, there were several carts covered with dust.
- Packages of instruments weren't sealed correctly, leaving the possibility of contamination.
- Staff didn't maintain the autoclave, which was used to sterilize dirty instruments. They failed to monitor pressure and temperatures. According to the report, this "had the likelihood to cause contamination and microbial growth in the sterile instrument packages." The printer on the autoclave hadn't been working for six months, so there was no way for staff to know if the autoclave had reached the proper pressure and temperature to sterilize the instruments.
- The facility failed to conduct a monthly examination of one of its two fire extinguishers.

### **Staff**

- None of the nurses who were administering conscious sedation to patients had proper training.
- Staff didn't wear proper operating room attire in surgery.
- The facility didn't know the Hepatitis B status for half of its employees.

### **Treatment of Patients**

- Doctors at the facility didn't conduct physical exams on patients before their surgery in every patient case reviewed. Staff could find no documentation or evidence that physical exams had been performed and couldn't provide evidence that they were.
- The facility had expired laminaria (sticks put inside women's bodies before abortions to open the cervix) and seemed to be using them on women.

### **Other**

The facility had no policy of surveillance techniques to minimize sources of infections. They didn't track infections of patients.

## **Houston**

The health department documents from 2015, 2017 and 2020 can be found at:

[www.problemsatplannedparenthood.org/texas-houston-stafford](http://www.problemsatplannedparenthood.org/texas-houston-stafford)

### **Highlights:**

#### **Clinic Conditions**

- The biological indicator used on the autoclave wasn't properly tested. The autoclave was used to sterilize instruments. Inspectors determined that the biological indicator tests being conducted weren't valid.
- Medical equipment in the operating room was covered with rust and couldn't be disinfected.
- Packages of dilators marked as sterile had dime-sized brown spots on them. When questioned about the stains, a staff member admitted that the instruments weren't sterile and shouldn't have been labeled as such or stored with the sterile instruments.
- Instruments were improperly sterilized. Instruments were improperly packaged, preventing them from being properly sterilized.

#### **Staff**

- The doctor was operating on women without washing his hands. Staff members failed to wash their hands after handling dirty instruments.
- When a doctor was observed not washing her hands after surgery, she told inspectors, "Yes, I should do that, but because maybe sometimes if people are watching you, it's kind of overwhelming."
- Staff didn't have training on how to properly sterilize instruments. Three of the staff working in sterile processing had no documentation of training or competency.
- Staff didn't properly measure the amount of detergent per water used to clean instruments.
- None of the nurses administering sedation were officially trained to do so or had documentation of competency to do so. The Director of Nurses claimed that nurses administering sedation learned on the job, by observing others in a mentorship-type situation, but none of the employees administering sedation were formally trained.

#### **Treatment of Patients**

- Contaminated, unsterile instruments were used in surgery.
- Staff didn't clean the IV port prior to injecting medications into women

## **San Antonio – San Pedro**

*The health department documents from 2020 and 2021 can be found at:*

[www.problemsatplannedparenthood.org/texas-san-antonio](http://www.problemsatplannedparenthood.org/texas-san-antonio)

### **Highlights:**

#### **Clinic Conditions**

- Instruments were washed and sterilized in the same area where dirty, biologically contaminated surgical instruments and medical waste were processed.
- The facility failed to keep medical waste and dirty instruments separated from clean ones, creating cross-contamination.
- There was only one sink and eyewash station. It was located in the same area as the dirty instruments and medical waste.
- sterile instruments intended for surgery were stored in a manner that they were no longer sterile. This created a risk of infection when those instruments were used on patients.
- There were no protective barriers on heating pads. The pads weren't properly cleaned between patients.
- The solution used to decontaminate vaginal ultrasound probes had dust and “unidentifiable debris” in it. The facility was using this solution to sterilize the vaginal probes between uses. This was not corrected and was found to be the case in another inspection a year later.
- In this later inspection, the ultrasound and ultrasound probes were found to be dusty and had pinkish-red stains on them.
- There were red stains (presumably blood) on the walls and floors of all the operating rooms.

#### **Staff**

- Staff had no set schedule to clean the operating rooms between patients, and did not appear to be doing so.

## **San Antonio – South Texas**

*The health department documents from 2012, 2015 and 2019 can be found at:*

[www.problemsatplannedparenthood.org/texas-san-antonio](http://www.problemsatplannedparenthood.org/texas-san-antonio)

### **Highlights:**

#### **Clinic Conditions**

- to the report, “the facility failed to follow its own procedures to maintain separation of contaminated and sterile supplies.”
- Biological indicators used for monitoring the effectiveness of steam sterilizers were in the same refrigerator as medications. Biological indicators contain bacteria spores and, according to the inspection report, should be regarded as contaminated and should be stored apart from medication and sterile supplies.
- The medication refrigerator was kept in the dirty utility room.
- The facility failed to have signs posted which offered sex trafficking victims a hotline they could call for help. It was a legal requirement for them to be posted in patient bathrooms and consulting areas.

#### **Other**

- The facility allowed unlicensed staff to have access to the cabinet where controlled substances were kept. An unlicensed staff member had the keys to the cabinet and unlimited access to the narcotics.

## **Stafford**

*The health department documents from 2019 can be found at:*

[www.problemsatplannedparenthood.org/texas-houston-stafford](http://www.problemsatplannedparenthood.org/texas-houston-stafford)

### **Highlights:**

#### **Clinic Conditions**

- Hazardous chemicals and cleaning products were not stored in a secure manner.
- The facility had expired supplies including needles and surgical equipment.

#### **Staff**

- Two of the five staff providing direct patient care didn't have training or certification in CPR or basic life support.

## Treatment of Patients

- The facility failed to develop and implement written discharge instructions. None of the patients had been given a list of potential complications to be aware of. They weren't instructed on what symptoms indicated an emergency and necessitated calling the facility or going to an emergency room. They weren't given an emergency number to call to reach a doctor in the event of a complication or if they had questions. The clinic staff didn't inform women of the number and location of the nearest hospital.
- The facility wasn't having women return for a follow-up appointment after taking a medication that might put them in danger of suffering infection or hemorrhaging.

## Waco

*The health department documents from 2019 and 2020 can be found under Waco at:*

[www.problemsatplannedparenthood.org/texas](http://www.problemsatplannedparenthood.org/texas)

The 2019 inspection report is entirely redacted, so the violations are unknown. For 2020: A patient didn't return for a scheduled follow-up appointment and examination after receiving the abortion pill. The facility did not try to contact her, as was then required by Texas.

## Utah

### Salt Lake City - Metro

*The health department documents from 2012, 2015 and 2017 can be found under Salt Lake City at:*

[www.problemsatplannedparenthood.org/utah](http://www.problemsatplannedparenthood.org/utah)

#### **Highlights:**

- Hot water in patient areas was measured at temperatures that were too high, risking burns.
- There were no grab bars in the bathrooms for patients.
- The facility's communication room ceiling had two loose or missing tiles, creating a fire hazard.
- The facility didn't have emergency exit lighting. There was no back-up emergency light over the stairs, creating a hazard if the building needed to be evacuated.
- In another inspection, exit signs weren't lit, presenting a risk in case of an emergency.
- The facility failed to have smoke detectors in the required locations.
- Fire drills weren't conducted and documented properly.

# Virginia

## Charlottesville

The health department document from 2012, 2014, 2016, and 2018 can be found under Charlottesville at:

[www.problemsatplannedparenthood.org/virginia](http://www.problemsatplannedparenthood.org/virginia)

### Highlights:

#### Clinic Conditions

- The exam table was torn at the corners. Half the reclining chairs also had tears. This created porous surfaces impossible to sterilize, risking infection.
- There were open packages of medication that staff were administering to patients. However, staff failed to document the dates they were opened. Since open medications must be discarded a certain number of days after being opened, this oversight created the risk of using expired medication on patients.
- Medication that had been removed from its original packaging and stored elsewhere was improperly labeled.
- Used needles and sharp instruments weren't stored safely. Sharp containers were on the floor and unsecured.
- Two sinks in the procedure room didn't meet the requirements of hand-washing stations.
- The facility didn't have medications on hand to treat cardiac emergencies that may arise during surgery.
- The building failed to comply with state and local codes regulating surgical facilities.

#### Staff

- Unqualified staff were dispensing medication (including controlled substances), administering vaccines, and doing birth control injections without sufficient training.
- Inspectors observed a staff member perform a pelvic exam without washing their hands. They then went on to complete surgery, conduct an ultrasound, and handle medical waste without washing their hands between tasks or afterwards.
- The governing body of the facility failed to document the appointment of a clinic administrator and staff couldn't provide the name of one.
- All but one employee were providing direct care to patients without proof of licensure on file.
- The facility failed to conduct criminal background checks on staff who had access to controlled substances in violation of Virginia law.

- The staff member in charge of infection control was not a licensed medical professional and had not received adequate training.
- indicated two staff members tested positive for tuberculosis, but there wasn't any follow-up from a physician.

### Privacy

- The facility staff failed to ensure that medical records were stored in a secure area. Records containing personal information were observed lying on top of a shelf just inside a door, accessible to anyone who opened the unlocked door.

### Other

- Unsigned prescriptions for controlled substances were stored behind an unlocked door, where they could be accessed by unauthorized persons.
- Narcotics weren't kept locked up but were unsecured.

## Richmond

*The health department document from 2014 can be found under Richmond at:*

[www.problemsatplannedparenthood.org/virginia](http://www.problemsatplannedparenthood.org/virginia)

### **Highlights:**

- Surfaces weren't disinfected between patients.
- Staff failed to maintain procedures which prevented cross-contamination and transmission of infections.
- There was a sticky residue from tape on one of the exam tables that prevented the table from being properly disinfected between patients.
- Four of the seven recliners in the recovery room were dirty, with particles of food in crevices between the seat cushions and the sides. Staff admitted the recliners hadn't been disinfected between patients.
- Disposable absorbent padding wasn't changed between cases. Instruments and surgical supplies were placed on this padding, raising the risk of infection.
- Staff failed to wash their hands after changing out of contaminated gloves before putting on new gloves. They also failed to use hand sanitizer and didn't clean their hands after touching blood, bodily fluids, and dirty instruments.
- Inspectors witnessed a staff member place a dirty container that had been sitting on top of a biohazard box onto an exam table a woman was about to lie on.

## Roanoke

The health department document from 2012, 2014 and three from 2016 can be found at:

[www.problemsatplannedparenthood.org/virginia](http://www.problemsatplannedparenthood.org/virginia)

### Highlights:

#### Clinic Conditions

- A brownish-red stain one inch long was found on an operating table. Staff claimed the stain was “possibly [the medication] betadine.” Staff attempted unsuccessfully to clean the table, then lifted the cushion, revealing extensive bloodstains beneath the cushion.
- The report says: “The undercarriage of the support cushion had multiple areas where blood had dripped and ran down the undercarriage. The accumulation of dried blood varied in coloration and thickness. Staff #10 acknowledged the substance was dried blood and not betadine.”
- One of the procedure tables was torn with exposed foam, creating a surface that couldn’t be properly sterilized.
- Five of five chairs in the recovery room were torn and couldn’t be properly sterilized. Three chairs were also dirty, with food particles and “unidentifiable” substances between the seat cushions and arms. Staff admitted they weren’t being cleaned.
- The facility had outdated supplies available for patient use. Tracheal tubes, used to maintain a patient’s airway in the event of an emergency, had expired eight years earlier. Sutures in the facility were 2-4 years past their expiration dates.
- Indicator strips being used to test sterilization equipment were past their expiration dates.
- Expired supplies were an ongoing problem. In a subsequent inspection, defibrillator pads, needed in an emergency, were found to be expired. There were no pads in the facility that hadn’t expired.
- Emergency medication, available to be administered to patients, was also expired.
- The surgery facility was out of compliance with requirements regarding airflow and air filtration.
- There was no inspection report on one of the vacuum suction machines used for surgery. The same problem was found in a subsequent inspection.
- There was no record that a pulse oximeter used for emergencies had been inspected.
- In a subsequent inspection several years later, the facility’s pulse oximeter hadn’t been inspected by staff as required or given proper maintenance.
- Inspectors found “dried yellow debris circled in brown” on a heating pad stored in a drawer labeled “gloves.”
- Controlled substances weren’t stored securely. Although they were kept in a lockbox in a locked cabinet, the keys were kept in an unsecured location - an

unlocked drawer in an unlocked office. Staff admitted every employee therefore had access to the medication.

- Controlled substances in the crash cart weren't monitored, regularly counted, or kept secure.
- A bottle of Ativan in the facility's lockbox was open, and staff didn't know whether the medicine had been accessed, or if any was unaccounted for.
- The crash cart was missing vital emergency supplies. There were no foley catheters or Vasopressin, needed in emergencies.
- There was no paperwork to indicate a completed inventory check of the emergency supplies for two months.
- Regular inspections weren't conducted of the emergency defibrillator.
- There were open bottles of medication in the refrigerator with no labels as to when they'd been opened. One of those medications was supposed to be discarded 28-30 days after opening. Without a date on the bottle, staff were unable to determine how long it had been open, or when it should be discarded.
- Emergency medications were listed as being in the crash cart, but weren't there, and staff were unable to find them anywhere in the facility.

### **Staff**

- The facility failed to conduct criminal background checks on staff who were handling controlled substances, as required by Virginia law. This was an ongoing problem, also found in two other inspections, years later.
- Staff failed to conduct pill counts and properly monitor controlled substances.
- Staff failed to properly put on and take off personal protective equipment.
- After handling materials in the medical waste lab, one staff member neglected to change gloves.
- When mixing the solution used to sterilize instruments, a staff member failed to measure the components of the mixture or follow guidelines on how to prepare it. This created the risk that instruments weren't properly sterilized.
- A staff member was observed placing instruments that had just been cleaned on a surface covered in blood and tissue. These re-contaminated, dirty instruments were intended to be used on patients.
- The facility failed to screen staff for vaccination status or communicable diseases to prevent staff from spreading diseases to patients, in violation of requirements from the US Occupational & Health Administration.
- The facility had no policy for reporting "inappropriate behaviors" or violations among staff to the Board of Medicine or the Board of Nursing.
- There were three doctors listed as employees of the facility. Inspectors asked a staff member if they were the only doctors performing surgery, and the staff member said that they were. However, inspectors found that multiple residents, who weren't listed on the paperwork as employees, were also performing surgery. The facility had no written records as to the competency, privileges or credentials of these doctors, nor any records of their training.

- The facility’s quality control committee failed to review the residents’ training program or “recognize the need to establish a system to verify resident physician’s qualification.”
- Required drills on active shooter situations and patient complications were held, but attendance sheets showed some staff didn't attend them.
- Paperwork on drills for complications such as hemorrhage and anaphylaxis stated all nurses were present and demonstrated correct knowledge. However, when investigators looked at the sign-in sheets for these drills, they saw the nurses weren't present. When questioned, staff admitted the nurses hadn't attended the drills, and the paperwork was false.
- Paperwork admitted that one nurse, who worked four hours a week in the recovery room, “has not been fully trained on medical standards and guidelines.”
- An unlicensed staff member was administering Depo-Provera injections. There was no documentation indicating that this staff member had proficiency in the administration of intramuscular injections.
- Two staff members didn’t have documentation on file that they underwent CPR training or were certified in CPR.
- Internal paperwork reported that administrators had concerns about staffing (lack of nurses) in 2015 and 2016 that weren’t resolved at the time of the inspection. Staff said they intended to attract and hire more nurses, but there was no documented plan on how to do so. There was also no documentation on steps taken to resolve the issue.
- observed a staff member conducting a urine pregnancy test without wearing gloves.
- Staff handled medication and dispensed it to patients without wearing gloves.
- Staff left medication in an unlabeled, open container unattended in a room frequented by patients and staff.
- Staff failed to document, log, or maintain any records of infections, as required.
- Staff claimed that patient records were evaluated for completeness and accuracy but could provide no documentation that this was done.

### **Medical Records and Labels**

- Paperwork on individual surgeries didn’t list the names of the doctors who performed them. When asked how many surgeries were performed by each resident, staff couldn’t answer because no records were kept.
- Records on employees were incomplete and lacked job descriptions as well as information about performance evaluations.
- The facility had conducted audits of staff on personal protective equipment and hand hygiene but failed to record the results.
- When staff took inventories of medication, they were required to document the expiration date (listed on the paperwork as “exp”) and the location of the medication in the facility (“loc”). When inspectors examined the records, they saw these boxes had been left blank. When questioned, the staff member tasked with doing the inventories stated that they had left them blank because they didn’t know what “exp” and “loc” meant.

- One set of paperwork had checkmarks beside names of medications. Inspectors asked what the checkmarks meant, and staff didn't know.

### **Incidents**

- Inspectors discovered that a patient had called the regional call center and reported that she was experiencing a complication and couldn't get through to staff at the Roanoke facility. According to the notes, "Patient was very upset, stating that she thinks that she has a possible infection and can't get in touch with anyone, and nobody will help her." The patient said she'd been trying to contact the Roanoke clinic and the doctor "refuses to see her." Even though the call was logged in the patient's medical records, it was never documented as an official complaint or addressed as such by Planned Parenthood. When questioned, staff members at the Roanoke facility weren't aware of the call or the situation. They didn't recognize the name of the call center employee listed in the records. It is unknown whether and where the patient received medical assistance.

### **Treatment of Patients**

- Paperwork given to patients about the process for filing complaints didn't include a statement that all complaints would be responded to within 30 days.
- Staff were performing surgery with vacuum curettes that had expired two years before. Surgical supplies used for IVs were 12 years past their expiration date.
- When preparing to give a patient an injection from a multi-dose bottle of lidocaine, a staff member failed to clean the top of the bottle with an alcohol swab before inserting the needle into the bottle. This created a risk of infection for the patient.
- Staff admitted that the operating tables (one of which had bloodstains) had not been sterilized between patients.
- Staff had no system to report or respond to patient complaints, and complaints that had been made weren't investigated or resolved.
- The facility didn't offer testing for sexually transmitted diseases to patients coming in for surgery, nor did they ask patients about symptoms or STD history. Patients who have surgery while infected with an untreated STD [have a higher risk](#) of developing pelvic inflammatory disease.

### **Other**

- The facility had no policy for reporting disease outbreaks or infection rates to the health department in accordance with requirements and weren't doing so.
- The facility had no policies or procedures for reporting potential patient deaths to the Office of Licensure and Certification.
- The facility had no policies or procedures for infection control and performed no annual review related to infection prevention policy.

# Wisconsin

## Milwaukee (Water Street)

*The health department document from 2011 and 2017 can be found under Milwaukee – Water Street at:*

[www.problemsatplannedparenthood.org/wisconsin](http://www.problemsatplannedparenthood.org/wisconsin)

### Highlights:

#### Staff

- The laboratory staff failed to monitor temperatures in the laboratory. Specimens and reagents need to be kept at a certain temperature to prevent them from being compromised. Fluctuating or too warm temperatures can prevent proper results.
- The laboratory staff didn't follow the proper procedures for testing samples. Lab technicians didn't follow manufacturer's instructions while conducting tests with laboratory equipment.
- The laboratory director failed to sign off on documentation of test results.
- In another inspection, the facility was found not to have procedures for evaluating the competence of laboratory staff who were conducting tests.

#### Patients

- Four patients who were tested for Rh incompatibility were listed as Rh negative in one set of paperwork and Rh positive in another. Rh negative patients need a RhoGAM shot to protect future pregnancies. Confusion over Rh status can lead to patients who need the shot not receiving it.
- The laboratory director failed to review or evaluate the documentation about corrective action for this incident.

# Chapter 2



This chapter does not include deaths, which are listed separately in Chapter 4. We include only cases since 2000, and only those where details of the allegations are known.

We use the plaintiff's last name to distinguish the cases, but the plaintiff's full name and the name of individual defendants are redacted in the excerpts on our pages. They are of course available in the official court documents on the Problems at Planned Parenthood website ([problemsatplantedparenthood.org](http://problemsatplantedparenthood.org)).

We have focused on the Complaints (or in some states Petitions) and not on the disposition of the case. Most malpractice cases are settled out of court, and this is true with these as well. Being settled doesn't mean that the defendant admits liability; they may just be willing to pay some money to make the case go away. But at the very least, these complaints are more substantive than reviews. People have to go to considerable trouble and think through the evidence carefully in order to file them, and in most cases an attorney has to ascertain that the case has merit.

# Categories of Complaints

## Not Diagnosed

**Ectopic Pregnancy:** California: El Cerrito, Fresno, San Diego / Delaware: Wilmington / New York: Hempstead / New York City: Bronx, Manhattan (2 cases), Queens

**Cervical Cancer:** California: San Diego / Pennsylvania: Norristown

**Fibroids/Polyps:** California: Pasadena / Arizona: Maricopa County / Michigan: Ann Arbor

**Actual Age of Pregnancy:** Connecticut: Danbury / New York: White Plains

## Complications

**IUD:** California: Sacramento, Los Angeles (2 cases), Pasadena, Orange / Connecticut: New Hartford / Illinois – Chicago: Near North Center / New York: Massapequa / Pennsylvania: Reading / Texas: Houston

**Implant:** California: Costa Mesa, Glendora, San Bernardino, Los Angeles

**Depo-Provera:** New York: Newburgh / Pennsylvania: Philadelphia – Castor Avenue

**Tubal Ligation:** New Mexico: Albuquerque / From a Diagnostic Test / California: Fresno, Orange

**Uterine and/or Bowel Perforation:** California: Los Angeles (2 cases) / New York City: Manhattan (3 cases) / New York: Smithtown, West Seneca / Washington, D.C.

**Other Surgery Problems:** Arizona: Glendale, Phoenix / California: San Diego (5 cases), San Ramon, Los Angeles (2 cases), Orange / Connecticut: Hartford / Massachusetts: Boston (2 cases), Worcester / New York: Albany, Hempstead, Hudson Peconic Affiliate, Smithtown / Pennsylvania: Philadelphia – Locust

## Non-Consent

**Needed Information not Given for Truly Informed Consent:** New York City: Bronx / New York: Albany, Hempstead, Spring Valley / Texas: Austin

**Outright Coercion:** California: Anaheim, San Bernardino / Colorado: Colorado Springs / Nebraska: Lincoln

## Unspecified

California: San Diego, Orange / New York: Albany, Hempstead, Kingston, New Rochelle, Patchogue / New York City: Brooklyn

## Other

**Toxins in Vicinity of Toddler:** Colorado: Colorado Springs

**Caused a Miscarriage:** California: Oakland

# Alabama

## Birmingham

### Clark

*The 2012 Malpractice Complaint can be found under Birmingham at:*

[www.problemsatplannedparenthood.org/alabama](http://www.problemsatplannedparenthood.org/alabama)

### Excerpt:

12. On August 20, 2010, defendants performed an ultrasound showing estimated fetal gestational age of 8 weeks 4 days. . .

17. On September 14, 2010, plaintiff presented to emergency department of BMC Princeton Medical Center in Birmingham Alabama with complaints of nausea, vomiting and left lower quadrant pain.

18. On September 14, 2010 following physical examination and ultrasound exam at the emergency department of BMC Princeton Medical Center, the ultrasound showed evidence of a 13-week gestation that was extrauterine involving left adnexa (fallopian tube), this finding prompted emergency admission of plaintiff for surgical intervention, pain management and treatments.

19. On September 15, 2010, at MBC-Princeton Medical Center, plaintiff underwent a laparoscopy with conversion to laparotomy in which plaintiff's left tube was removed with the 13-week fetus and placenta.

# Arizona

## Glendale

### **Waters**

*The 2017 Malpractice Complaint can be found under Glendale at:*

[www.problemsatplannedparenthood.org/arizona](http://www.problemsatplannedparenthood.org/arizona)

#### **Excerpt:**

11. During the procedure, Defendant's employee was unable to control Ms. Waters' vaginal bleeding, causing significant blood loss, dizziness and lightheadedness.

12. Defendant's employee then . . . called an ambulance to transport Ms. Waters to the emergency room with instructions that she needed a blood transfusion due to the massive vaginal bleed . . .

15. As a result of the procedure . . . Ms. Waters suffered from, among other things, a bowel obstruction, fever, anemia due to blood loss, uterine bleeding and hemorrhagic shock.

16. Since the procedure, Ms. Waters has experienced serious pain and suffering throughout her body but especially in her abdomen area . . .

18. Ms. Waters has exhausted most of her income paying for medical care to treat the numerous health issues caused by Defendant's actions . . .

## Maricopa County

### **Sanderson**

*The Complaint doesn't specify which Planned Parenthood center is involved.*

*The 2013 Malpractice Complaint can be found under Maricopa County at:*

[www.problemsatplannedparenthood.org/arizona](http://www.problemsatplannedparenthood.org/arizona)

#### **Excerpt:**

12. The annual examination Defendant . . . performed on February 6, 2008 included a physical examination that should have identified the presence of any uterine masses or fibroids then present and presenting a risk to the health and/or reproductive capability of Plaintiff . . .

13. Defendant . . . did not report to Plaintiff . . . that she had detected the presence of any uterine masses or fibroids . . .

15. The annual examination Defendant . . . performed on March 5, 2009 included a physical examination that should have identified the presence of any uterine masses or fibroids . . .

16. Defendant . . . did not report to Plaintiff . . . that she had detected the presence of any uterine masses or fibroids . . .

20. The annual examination Defendant . . . performed on May 25, 2010 included a physical examination that should have identified the presence of any uterine masses or fibroids . . .

21. The person or persons who performed the annual examination . . . did not report to Plaintiff . . . that she had detected the presence of any uterine masses or fibroids . . .”

22. On August 2, 2011 Plaintiff . . . was scheduled . . . to undergo an ultrasound examination to assess for the presence of fibroids, ovarian cysts or multi-gestation.

23. On August 3, 2011, Plaintiff Sanderson was informed about the results of the ultrasound and learned for the first time about the presence of multiple large fibroids throughout the uterus.

4. On October 5, 2011 Plaintiff underwent hysteroscopic myomectomy for surgical removal of a submucosal fibroid and an endometrial mass , . .

26. . . . Plaintiff . . . was told to avoid future labor and plan cesarean section for future birth delivery to minimize the risk of uterine rupture . . .

34. As a direct and proximate result of the negligent acts and omissions of Defendant . . . Plaintiff . . . experienced a miscarriage she may not have experienced with earlier notice of the presence of fibroids and growths and medical care appropriate to address the presence of the fibroids and growths that then existed.

## Phoenix

### Dixon

*The 2012 Malpractice Complaint can be found under Phoenix at:*

[www.problemsatplannedparenthood.org/arizona](http://www.problemsatplannedparenthood.org/arizona)

### Excerpt:

11. Planned Parenthood recommended a medical abortion . . . [but] did not determine that an abortion was medical necessary . . .

14. Defendant . . . performed a medical abortion on Plaintiff on or about November 6, 2020 . . .

17. On or about November 17, 2010, Plaintiff returned . . . Planned Parenthood had an ultrasound performed and prepared a closing report . . . Planned Parenthood claimed that her uterus was empty. Planned Parenthood failed to properly assess Plaintiff's condition . . .

18. . . . no physician ever saw Plaintiff when she arrived at Planned Parenthood in Phoenix, Arizona for the follow-up appointment . . .

22. Any information that the abortion was necessary was false, untrue and designed to coerce Plaintiff into having the medical abortion . . .

27. [Plaintiff] suffered an incomplete abortion, resulting in serious complications due to the actions of Defendant Planned Parenthood. These complications resulted in her going to the hospital and suffering physical psychological, and other injuries.

# California

## Anaheim

### **Bible**

*The 2020 Malpractice Complaint be found under Anaheim at:*

[www.problemsatplannedparenthood.org/california-a-to-f](http://www.problemsatplannedparenthood.org/california-a-to-f)

#### **Excerpt:**

14. On or about July 24, 2019, Plaintiff went to get a test done at Defendant Planned Parenthood for a possible sexually transmitted disease believing it was going to only be a blood or urine test.

15. However, the provider employed by Defendant . . . insisted that Plaintiff had to be given a manual pelvic exam.

16. Plaintiff's sister was prevented from going into the examination room with Plaintiff, though Plaintiff desired her presence.

17. Plaintiff told the provider that she did not want to have a manual pelvic exam, but Defendant . . . performed the exam anyway.

18. Plaintiff became very anxious and screamed telling Defendant . . ., "No!"

19. As a result of the forced manual pelvic exam, Plaintiff suffered emotional distress, anxiety and depression.

## Concord

### **Horde**

*The 2005 Malpractice Complaint be found under Anaheim at:*

[www.problemsatplannedparenthood.org/california-a-to-f](http://www.problemsatplannedparenthood.org/california-a-to-f)

#### **Excerpt:**

9. In April 2004, [Plaintiff] . . . began a regimen of Depo Provera hormone injections at Planned Parenthood . . .

10. [The] first injections was April 8, 2004. At that time, she gave a urine sample and was told she was not pregnant. She later found out she became pregnant sometime between June 1 and June 15, 2004, despite the Depo Provera injection.

11. On June 30, 2004 . . . She returned to Planned Parenthood and had a second Depo Provera injection. [She] gave a urine sample. Apparently, the urine sample was misread or disregarded because she was told she was not pregnant and was injected . . .

13. On August 21, 2004, [she] went to Planned Parenthood for her annual exam, and to find out if the vomiting and acid reflux were side effects of Depo Provera . . . She

was told she was healthy and not pregnant. There was no explanation for the vomiting and acid reflux as these are not side effects of Depo Provera.

14. On September 21, 2004, when Horde was four months pregnant, she returned to Planned Parenthood for the scheduled Depo Provera injections. She gave a urine sample, which she believed was for pregnancy testing. She was injected and left . . . She thought she had a tumor because her abdomen was getting larger. Again, she was assured she was not pregnant because she was taking Depo Provera.

16. . . . She waited out the remainder of her pregnancy with great anxiety that the baby would be born with birth defects given she had two Depo Provera injections and prescribed medications for a peptic ulcer and acid reflux while she was pregnant.

17. Ms. Horde gave birth on March 28, 20015, to a healthy baby boy . . .

## Costa Mesa

### Fagan

*The 2018 Malpractice can be found under Costa Mesa at:*

[www.problemsatplannedparenthood.org/california-a-to-f](http://www.problemsatplannedparenthood.org/california-a-to-f)

#### **Excerpt:**

5. On March 30, 2015, Plaintiff presented for family planning services with Planned Parenthood at their office in Costa Mesa.

6. Planned Parenthood's doctor . . . implanted a Nexplanon birth control device in Plaintiff's left arm.

7. On February 15, 2017, Plaintiff presented for removal of the birth control device . . . Planned Parenthood's employee . . . was unable to remove the implant. Plaintiff decided to leave the implant in for the time being because it was effective at controlling her ability to get pregnant despite confronting her with numerous unpleasant side effects . . .

9. On August 14, 2017, Plaintiff against presented . . . for removal of the Nexplanon implant. [Defendant] was unable to remove it, however, because the implant rod palpated deep near Plaintiff's bicep muscle. Dr. [Defendant] indicated Plaintiff would need to present again for surgical removal.

10. On October 3, 2017, Plaintiff again presented with [Defendant] for removal of the implant.

11. While [Defendant] was able to successfully remove the device, it was clear that the implant was improperly inserted by Planned Parenthood in 2015. It was too close to her bicep muscle and not placed in an area of benign skin tissue; instead, it was placed in an area that caused severe nerve and muscle damage . . .

12. Because of the improper implantation of the Nexplanon device, Plaintiff suffers from permanent nerve damage and pain. Plaintiff is a yoga instructor and is unable to practice or teach yoga anymore because of the damage caused by the implant.

13. Plaintiff has lost mobility and will suffer the effects of the improper implantation for the rest of her life

## **El Cerrito**

### **Trujillo**

*The 2018 Malpractice Complaint can be found under El Cerrito at:*

[www.problemsatplannedparenthood.org/california-a-to-f](http://www.problemsatplannedparenthood.org/california-a-to-f)

#### **Excerpt:**

Plaintiff's complaint is based upon medical treatment that she received from defendants on January 26, 2017 . . . During that visit, plaintiff underwent an ultrasound and was told that she had an intrauterine pregnancy . . . As it turned out, however, plaintiff had an ectopic pregnancy, which required emergency surgery and hospitalization from January 30 to February 3, 2017 . . . She was then hospitalized again from February 4 to either the 8th or 11th.

## **Fresno**

### **Crowder**

*The 2017 Malpractice Complaint can be found under Fresno – First Avenue at:*

[www.problemsatplannedparenthood.org/california-a-to-f](http://www.problemsatplannedparenthood.org/california-a-to-f)

#### **Excerpt:**

6. On or about January 29, 2016, Plaintiff underwent a skin biopsy of her right ankle at Defendant Family First Health Center, a subsidiary of Defendant Planned Parenthood Mar Monte . . .
9. Shortly thereafter, Defendants provided Plaintiff with follow up treatment and antibiotics. Defendants told her any discomfort would resolve within a month or two.
10. By May 16, 2016, Plaintiff had developed a severe infection in the area of the biopsy and went to the emergency room at St. Agnes hospital.
11. At that time Plaintiff discovered she had developed a severe infection due to the negligent skin biopsy . . .
14. As a direct and proximate result of the professional negligence of Defendants, and each of them, Plaintiff has suffered severe pain and suffering, severe emotional distress, loss of physical and mental stamina and acuity, and employability.

### **Lupercio**

*The 2015 Malpractice Complaint can be found under Fresno at:*

[www.problemsatplannedparenthood.org/california-a-to-f](http://www.problemsatplannedparenthood.org/california-a-to-f)

### **Excerpt - Description of Reason for Liability:**

An intravaginal ultrasound was performed by defendant on plaintiff on 3/5/15. She was then informed that a viable pregnancy could be terminated by means of a chemical abortion on 3/6/15. However, the defendant failed to detect plaintiff's ectopic or tubal pregnancy which was or should have been apparent on the ultrasound and for which a chemical abortion was unsafe and contraindicated. This conduct fell below the standard of care for the community and constitutes negligence and medical malpractice directly causing plaintiff's serious personal injuries, including permanent removal of her left fallopian tube.

## **Glendora**

### **Lewis**

*The 2018 Malpractice Complaint can be found under Glendora at:*

[www.problemsatplannedparenthood.org/california-g-to-r](http://www.problemsatplannedparenthood.org/california-g-to-r)

### **Excerpt:**

12. On . . . April 10, 2017, Plaintiff presented to Defendants . . . for consultation regarding a birth control device. During this consultation, Defendants recommended-implantation of the Nexplanon Birth Control Device but failed to fully disclose to Plaintiff all risks that were known, or should have been known, and which were associated with said device and procedure . . .

15. As a result of the implantation . . . Plaintiff 'suffered and will continue to suffer serious bodily injuries, including pain, discomfort, humiliation, scarring and disfigurement.

## **Long Beach**

### **Castillo**

*The 2025 Malpractice Complaint can be found under Long Beach at:*

[www.problemsatplannedparenthood.org/california-g-to-r](http://www.problemsatplannedparenthood.org/california-g-to-r)

### **Excerpt:**

7. From at least May 2023, Plaintiff . . . sought a consultation for vasectomy from Planned Parenthood Los Angeles and its agents and employees.

8. On May 20, 2023, Plaintiff . . . underwent a vasectomy . . .

9. On March 25, 2024, Plaintiff . . . was diagnosed with epididymo-orchitis.

10. On July 22, 2024, Plaintiff . . . was required to undergo a Left Epididymectomy & Right Orchiectomy as a result of his diagnosis of epididymo-orchitis.

11. Defendant . . . so negligently failed to exercise the proper degree of knowledge and skill in examining, diagnosing, treating and caring for, Plaintiff . . . that he sustained severe and excruciating bilateral testicular pain, persistent and terrible physical pain, emotional pain and suffering, trauma, sickness, dread, fright, and shock. Additionally, he has incurred economic damages including, but not limited to medical expenses, loss of income, loss of future income, out of pocket expenses and non-economic damages, including excruciating physical and emotional pain, suffering, agony, stress, torment, fear, sleeplessness and devastation.

## **Los Angeles**

### **Bennett**

*The 2022 Malpractice Complaint can be found at:*

[www.problemsatplannedparenthood.org/california-los-angeles](http://www.problemsatplannedparenthood.org/california-los-angeles)

#### **Excerpt:**

6. Plaintiff had an intrauterine device (“IUD”) placed by Planned Parenthood Los Angeles as a form of temporary birth control in 2015 . . .

8. On January 26, 2021, Plaintiff went to Planned Parenthood Los Angeles to have the IUD removed so that she could become pregnant. Planned Parenthood Los Angeles was unable to remove the IUD from Plaintiff.

9. On January 28, 2021, Plaintiff again went to Planned Parenthood Los Angeles to have the IUD removed. Planned Parenthood Los Angeles was unable to remove the IUD from Plaintiff.

10. On February 15, 2021, Plaintiff underwent surgery under general anesthesia to remove the IUD at Cedars-Sinai Hospital. The surgery was unsuccessful. The IUD could not be removed. The IUD remains lodged inside Plaintiff against her will . . .

13. The irremovable, defective IUD has caused damage to Plaintiff in the form of bodily injury, infertility, and related emotional distress. Plaintiff has been forced to undergo costly and risky medical treatment as a result of the irremovable, defective IUD and will need to undergo further costly, risky medical treatment in the future.

## Contreras

*The 2005 Malpractice Complaint can be found at:*

[www.problemsatplannedparenthood.org/california-los-angeles](http://www.problemsatplannedparenthood.org/california-los-angeles)

### Excerpt:

9. On or about September 23, 2004 and thereafter, Plaintiff sought medical care for, including, but not limited to, terminating a pregnancy . . . and treatment for subsequent excessive bleeding, at Planned Parenthood.

10. Defendants punctured the Plaintiff's uterus and failed to remove the entire fetus; a blood clot the size of a baseball formed and Plaintiff experienced excessive bleeding . . .

11. As an actual and proximate result of the actions of Defendants . . . Plaintiff is informed and believes and thereon alleges that she can no longer have children, among other damages.

## Hernandez

*The 2020 Malpractice Complaint can be found at:*

[www.problemsatplannedparenthood.org/california-los-angeles](http://www.problemsatplannedparenthood.org/california-los-angeles)

### Excerpt:

6. On March 19, 2019, Defendants, and each of them, negligently failed to exercise the degree of knowledge and skill proper in their service and/or profession, and so negligently and unskillfully performed and/or assisted during the care and treatment of Plaintiff while applying a subdermal implant inserted in Plaintiff's right arm for birth control . . .

8. As a direct and legal result of said Defendants' wrongful conduct, Plaintiff was hurt and injured in her health, strength and activities thereby sustaining injury to her body and shock and injury to her nervous system and person, thereby causing and continuing to cause her mental and physical pain and suffering and economic damage.

9. Plaintiff . . . alleges that her injuries have and will result in permanent injury and disability including, but not limited to, loss of function . . .

10. As a further legal result of Defendants' aforementioned wrongful acts, Plaintiff did and will continue to employ health care professionals to examine, treat, and care for her injuries as a result of this incident, thereby incurring medical and incidental expenses according to proof at the time of trial.

## **Landeros**

*The 2012 Malpractice Complaint can be found under the Bixby Center at*

[www.problemsatplannedparenthood.org/california-los-angeles](http://www.problemsatplannedparenthood.org/california-los-angeles)

### **Excerpt:**

7. On February 9, 2011, Defendants administered anesthetics to Plaintiff during and abortion procedure, which was the direct cause of Plaintiff suffering brain damage due to the extended period of time in which the Plaintiff was deprived of oxygen.

## **Montenegro**

*The 2020 Malpractice Complaint can be found under the Hollywood Center at:*

[www.problemsatplannedparenthood.org/california-los-angeles](http://www.problemsatplannedparenthood.org/california-los-angeles)

### **Excerpt:**

13. On or about August of 20, 18, [Plaintiff] went to PPC to receive medical care and treatment. Defendants and each of them through their employees and agents implanted in Plaintiff's body an intrauterine device ("IUD") device for purposes of birth control. The IUD device was improperly selected, chosen and/or placed in Plaintiff's body during said procedure. Defendants and each of them were negligent and careless in the selection, placement, management, control, and monitoring of said IUD in Plaintiff's body. Said IUD caused serious injuries and damages to Plaintiff's body and became difficult and dangerous to extract. Because of said Defendants negligent and wrongful actions, the Plaintiff unnecessarily suffered intense pain, discomfort, and other temporary and permanent damage to her body . . .

## **Thomas**

*The 2001 Malpractice Complaint can be found at:*

[www.problemsatplannedparenthood.org/california-los-angeles](http://www.problemsatplannedparenthood.org/california-los-angeles)

1. On or about August 18, 2000 . . . plaintiff . . . employed defendants . . . to perform a Dilation & Extraction procedure for Intrauterine Fetal Demise (IUFD) . . . At the time of the procedure, plaintiff sustained extensive blood loss as a result of a laceration of the cervix, a posterior tear of the uterus and a rectal-sigmoid tear. As a result of the injuries sustained, plaintiff required emergency transfer to Los Angeles County Hospital for removal of her uterus, blood transfusions and a colostomy. She will no longer be able to bear children.

## Zepeda

*The 2018 Malpractice Complaint can be found under the Taper Foundation Center at:*

[www.problemsatplannedparenthood.org/california-los-angeles](http://www.problemsatplannedparenthood.org/california-los-angeles)

### Excerpt:

15. . . . As a direct and proximate consequence of the operation, Plaintiff began developing a series of debilitating and near fatal injuries — about 48 hours following the operation.

16. She was taken to the ICU of Holy Cross Medical Center where a successful attempt was made to resuscitate her. Her injuries were severe. She developed complications to her heart, kidneys, as well being diagnosed with septic shock, secondary to Strep group A (pyogenes) bacteremia, likely secondary with improper sterilization of surgical instruments used by Planned Parenthood, during the performance of the late term abortion. Said negligence caused a bacterial infection, which lead to multiple organ failure. Plaintiff was diagnosed with, but not limited to, pulmonary edema, acute kidney failure, acute hypoxic respiratory failure.

17. Despite Defendant's aforementioned knowledge and understanding of the variable and foreseeable risks for proceeding with such operation, Defendant disregarded Plaintiff's safety and proceeded to perform the surgical procedure, therefore causing the aforementioned sustained damages.

## Oakland

### Moreno

*The 2005 Malpractice Complaint can be found under Oakland at:*

[www.problemsatplannedparenthood.org/california-g-to-r](http://www.problemsatplannedparenthood.org/california-g-to-r)

### Excerpt:

7. Prior to March 19, 2004, plaintiff employed defendants, and each of them, to give medical treatment and care to plaintiff and to decedent. Pursuant to this employment, defendants rendered professional services in the diagnosis, treatment and care of plaintiff, for her pregnancy, and decedent.

8. From and after the time of the employment, defendants, and each of them, so negligently failed to exercise the proper degree of knowledge and skill in examining, diagnosing, treating, and caring for plaintiff, that plaintiff was caused to suffer the unbearable pain of losing a child. The death of plaintiff's unborn child resulted in the injuries and damages to plaintiff herein alleged.

## Orange

### Johnson

*The 2012 Malpractice Complaint can be found under Orange at:*

[www.problemsatplannedparenthood.org/california-g-to-r](http://www.problemsatplannedparenthood.org/california-g-to-r)

#### **Excerpt:**

7. Plaintiff . . . engaged the services of defendants to . . . provide the removal of an old intrauterine device (“IUD”) and insertion of a new IUD to prevent pregnancy . . .

9. . . . Defendant . . . used . . . a device he represented he designed and caused to be built and used for removing the IUD . . . Plaintiffs are informed and believe that the device was defective and unsafe for its use and that it was not approved for use by any regulatory entity but employed without informed consent . . .

10. As a direct and proximate result . . . plaintiff . . . suffered a perforation and internal bleeding that was negligently not discovered by the defendants before authorizing her discharge . . .

23. At all times herein mentioned, defendants represented . . . that the instrument was safely designed, tested, approved for use by some regulatory authority including the Federal Food and Drug Administration . . .

24. Defendants knew . . . it did not meet US FDA requirements . . . Neither did the defendants inform plaintiff that a safer alternative was available to preserve her health and tissues.

### Kim

*The 2012 Malpractice Complaint can be found under Orange at:*

[www.problemsatplannedparenthood.org/california-g-to-r](http://www.problemsatplannedparenthood.org/california-g-to-r)

8. That in the aforesaid examination and diagnosis of Plaintiff, the prescription of medicines and drugs, the providing of information relative to the medical abortion ultimately performed, the handling and control of the care and treatment of the Plaintiff, and the performance of a medical abortion procedure on or about March 24, 2011, and thereafter, and each of them, negligently failed to possess and to exercise that degree of knowledge and skill ordinarily possessed . . .

9. As a direct and proximate result . . . Plaintiff sustained severe and serious injury to her person . . .

10. By reason of the foregoing, Plaintiff has been required to employ the services of hospitals, physicians, surgeons, nurses and other professional services, Plaintiff has been compelled to incur expenses for ambulance service, medicines, x-rays, and other medical supplies and services . . .

## Martinez

The 2019 Malpractice Complaint can be found under Orange at:

[www.problemsatplannedparenthood.org/california-g-to-r](http://www.problemsatplannedparenthood.org/california-g-to-r)

### Excerpt:

15. Plaintiff was suffering from long, terrible periods and was told it could be cancer. A cervical biopsy was recommended.
16. A nurse practitioner . . . performed the cervical biopsy.
17. Plaintiff was told she would suffer discomfort for a few days, but that this was normal and would abate in a few days.
18. Plaintiff was told to take ibuprofen for pain, if necessary and was discharged.
19. That night, Plaintiff began to suffer severe pain in the left side of her groin.
20. Plaintiff went to the Emergency Department of St. Joseph's Hospital in Orange, California, where she was diagnosed with a perforated intestine and diverticulitis, likely requiring surgery.

## Velasquez

### Excerpt: Trellis Case Complaint Summary

Filing Date June 23, 2023 / Case Number CIVSB2313079

The plaintiffs allege that [redacted] were physicians and surgeons licensed to practice medicine in Orange and Los Angeles counties . . . The plaintiffs claim that on March 31, 2022, they employed the defendants to provide an abortion of their impaired fetus and to treat and care for them in regard to the procedure. They allege that the defendants negligently performed the medical services, resulting in injuries to [Plaintiff-, including incisions and lacerations to her vagina and uterus, excessive bleeding, and dismemberment of the fetus.

## Pasadena

## Chidinma

The 2023 Malpractice Complaint can be found under Pasadena at:

[www.problemsatplannedparenthood.org/california-g-to-r](http://www.problemsatplannedparenthood.org/california-g-to-r)



Planned Parenthood Pasadena Sued Over Allegedly Wrong  
'Common Constipation' Diagnosis  
City News Service, *Pasadena Now*, August 22, 2023

## **Excerpt:**

A former Planned Parenthood patient Monday sued the organization for medical malpractice, alleging she was incorrectly diagnosed with “common constipation” when she actually had serious issues that put her reproductive capability at risk . . .

Chidinma went to Planned Parenthood in March 2022 for a wellness exam and told her provider that she was having abnormally heavy vaginal bleeding, headaches, hormonal imbalance and other related discomforts and abnormalities, according to her suit . . .

Chidinma additionally told informed the provider that she had bloating and a possible mass in her abdomen, but was denied an ultrasound and told she had “common constipation,” the suit states.

Chidinma argued that her condition was more serious and again requested the ultrasound and equivalent testing, but she was again turned down . . .

Chidinma’s symptoms persisted for several months and worsened, so she returned to Planned Parenthood in January and asked again for an ultrasound, finding out for the first time that the facility did not have ultrasound equipment, the suit alleges.

Chidinma was granted a request to be examined by someone else and it took less than a minute for the new provider to diagnose that the plaintiff’s uterus was sharply expanded and that masses were present that could have been found during the March 2022 Planned Parenthood office visit, the suit states.

Chidinma cried and contacted her insurance carrier from her car to obtain coverage from a different provider organization and she learned during her visit to the new facility that she had fibroids so large and advanced that her reproductive health was at risk and that non-surgical options she had in March 2022 were no longer available, the suit states.

## **Moulton**

*The 2017 Malpractice Complaint can be found under Pasadena at:*

[www.problemsatplannedparenthood.org/california-g-to-r](http://www.problemsatplannedparenthood.org/california-g-to-r)

9. . . . on or about January 19, 2015, Plaintiff . . . underwent a procedure for the insertion of a Paragard T 380 Intrauterine device for birth control. Said medical procedure was performed in such a manner that fell below the applicable standard of care.

10. Such negligence has caused Plaintiff . . . to sustain what appears to be a life-long injury, thereby requiring medical intervention and the expenditure of monies in an attempt to somehow remedy the pain and suffering . . .

## Sacramento

### Vega

*The 2018 Malpractice Complaint can be found at:*

[www.problemsatplannedparenthood.org/california-sacramento](http://www.problemsatplannedparenthood.org/california-sacramento)

#### **Excerpt:**

15. On or about November 23,2017, Plaintiff went to the Defendant Planned Parenthood's facility in North Highland for a pelvic exam . . .
17. Defendant Doe No. 1 told Plaintiff that she had moved her IUD string and that her husband would be happy about it.
18. Plaintiff did not consent . . . to move the IUD . . .
19. In mid-March 2018, Plaintiff was informed that she was pregnant.
20. Plaintiff was informed that due to her recent bariatric surgery she would need an abortion.
21. On or about April 18,2018, Plaintiff underwent an abortion procedure.
22. At that time, Plaintiff was informed that her IUD was no longer in her cervix.
23. Plaintiff contends that when Defendant Doe No. 1 moved her IUD without her consent in November 2017, it rendered the IUD ineffective, causing her pregnancy and eventual abortion.
24. As a result of the negligence of Defendants, Plaintiff suffered injury, damage and loss.

## San Bernardino

### Gonzalez

*The 2021 Malpractice Complaint can be found under San Bernardino at:*

[www.problemsatplannedparenthood.org/california-s-to-z](http://www.problemsatplannedparenthood.org/california-s-to-z)

#### **Excerpt:**

11. Prior to the procedure she was asked if she wanted a contraceptive implant placed in her arm during the scheduled procedure, she specifically refused the offer of the contraceptive implant. However, when the plaintiff awoke, following the procedure, she became aware that the implant was placed in her arm, and when she requested that it be removed she was told that they could not remove it.
12. Subsequently, on or about April 20<sup>th</sup>, 2020, the Plaintiff was taken to St. Mary's Hospital by ambulance; her initial complaints were fever, abdominal pain, vomiting. And severe cramping. The Plaintiff was admitted into the hospital and required surgery in order to address a lacerated cervix, an infection, and to remove large amounts of fetal material.
13. Following the surgery the plaintiff was informed that the damage caused to her reproductive organs would most likely prevent her from having another child and that a hysterectomy may be necessary in the future.

## Quinones

### Excerpt:

11. On or about March 6, 2020, Plaintiff . . . consulted With and employed Defendants . . . to examine, diagnose, treat, and perform medical care, namely the insertion of a Nexplanon birth control implant . . .

13. Defendants . . . breached their respective duties to [Plaintiff] in improperly performing the insertion of a Nexplanon birth control implant within her left arm . . . by improperly inserting the device so that it injured [Plaintiff's] arm including but not limited to the nerve . . .

15. Plaintiff . . . felt immediate numbness, pain and discomfort, and was informed by [Defendant's] hotline on multiple occasions that the discomfort was normal and would subside. She was informed and believes and herein alleges she was advised her discomfort was normal. On April 5, 2020, and it would subside. [Defendants] . . . negligently failed to inform her the symptoms and pain were not normal and that she should seek medical care . . .

19. Defendants . . . breached their respective duties to [Plaintiff] in improperly performing the removal of a Nexplanon birth control implant from her left arm . . . The Plaintiff . . . alleges an x-ray was not used to locate the device prior to removal nor was she referred to a surgeon for the removal despite the continued complaints of pain and numbness since the Nexplanon insertion . . .

20. Specifically, in conjunction with and/or immediately after the Nexplanon removal [Plaintiff] felt an immediate electric type shock through her left extremity. Defendant . . . advised [Plaintiff] this sensation would diminish and heal on its own, and no referrals were made to a neurologist on her behalf . . .

29. Despite the representations and assurances from Defendants that the condition was normal and would heal on its own, sometime on or after August 11, 2021, Plaintiff . . . realized the condition of her left arm is chronic, potentially permanent . . .

## San Diego

### Alirezapoor

*The 2023 Malpractice Complaint can be found at:*

[www.problemsatplannedparenthood.org/california-san-diego](http://www.problemsatplannedparenthood.org/california-san-diego)

### Excerpt:

15. In May 2022, the lives of Alirezapoor and Bakhshi, husband and wife, took an unexpected turn when they discovered they were expecting a child. Eager to ensure the well-being of the pregnancy, they scheduled with an obstetric nurse . . .

17. On June 21, 2022, concerns arose following a Non-Invasive Prenatal Testing ("NIPT"), which indicated an 83% possibility of Down Syndrome. This prompted a referral to a genetic center for further assessment . . .

18. On July 12, 2022, the couple received a call . . . recommending to the couple an abortion before the 15th week and referring them to Planned Parenthood ("PP") . . .

22. Post-abortion complications arose, leading to persistent bleeding and an emergency room visit on August 13, 2022. An ultrasound revealed remaining tissues . . .

23. The couple faced challenges, including long waits in the ER and communication gaps. Ebrahimi performed a subsequent surgery on August 18, 2022, placing a balloon to control bleeding and administering blood transfusions.

24. Despite these efforts, bleeding persisted, leading to ongoing concerns about Alirezapoor's health. Follow-up visits with Ebrahimi, including an ultrasound on August 26, 2022, revealed the severity of the situation . . .

37. Defendants committed medical battery by damaging Plaintiff's internal organs, reproductive parts, without her authorization or informed consent.

38. Plaintiff did not consent to Defendants damaging her reproductive organs that caused her to be unable to carry a baby to term, which was done by Defendants without Plaintiff's necessary and legal consent.

### **Andersson**

*The 2013 court document can be found at:*

[www.problemsatplannedparenthood.org/california-san-diego](http://www.problemsatplannedparenthood.org/california-san-diego)

#### **Description of Reason for Liability:**

Plaintiff was a patient of both defendant's on March 21, 2012 when she presented for an abortion. Defendants failed to properly treat Plaintiff for her abortion at defendant's facility and failed to provide proper follow up care. Plaintiff had an ectopic pregnancy which defendant failed to diagnose and treat. As a result, plaintiff's left fallopian tube ruptured 10 days after having been seen and treated by defendants at defendants facility. Plaintiff had to undergo an emergency surgery to remove her ruptured tube and had to have a blood transfusion due to the blood loss she suffered. Plaintiff alleges that defendant's actions fell below the standard of care and resulted in her injuries.

### **Fakhoury**

*The 2007 court document can be found at:*

[www.problemsatplannedparenthood.org/california-san-diego](http://www.problemsatplannedparenthood.org/california-san-diego)

#### **Excerpt:**

7. At the date and time aforesaid, Defendants . . . failed to adequately and properly perform a surgical procedure on plaintiff by among other things, leaving foreign objects inside plaintiff's body.

## Glover

The 2007 court document can be found at:

[www.problemsatplannedparenthood.org/california-san-diego](http://www.problemsatplannedparenthood.org/california-san-diego)

### Excerpt:

*PPSDRC = Planned Parenthood of San Diego and Riverside Counties*

10. Among other things, PPSDRC promises on its website, "We will tell you exactly what you need to do next about an abnormal Pap smear. "

11. Upon information and belief and thereupon alleged, PPSDRC has been cited by the State of California Department of Health for one or more deficiencies in its care and record-keeping within the last four years . . .

43. Defendants . . . informed Plaintiff that she had an abnormal Pap test and that additional medical procedures were needed to further diagnose . . . She was not told that she had cancer and/or that she ran the risk that her

condition could turn into cancer should she forgo or delay any recommended treatment. She also was not referred to any . . . medical professional for a second opinion and/or who was more qualified to diagnose and treat cervical cancer.

44. . . . Defendants . . . misdiagnosed Plaintiff as having "Mild Dysplasia" and/or HPV . . .

46. A notation in Plaintiff's medical records . . . state "cancer vs. HPV" and "growth on entire cervix extreme abnormal presentation." . . . [The doctor] herself noted, "sounds suspicious for higher grade lesion-entire (cervix) involved. " . . . it is noted in Plaintiff's medical chart., "CIN I in all 4 quads." . . .

50. Defendants have and continue to withhold all of Plaintiff's records from her and thereby there may be additional parties and/or dates of treatment or phone calls by which Plaintiff is unaware at this time due to Defendants' refusal to turn over all medical records to Plaintiff.

51. . . . Defendants assured Plaintiff again and again that she did not have cervical cancer.

65. . . . if Plaintiff died prior to realizing the negligence of Plaintiff, then she could not pursue any legal remedies against the Defendants and/or their negligence would never be discovered . . .

69. Among other things, by the time Plaintiff discovered the negligence and fraud of Defendants, it was determined that she had cervical cancer which, upon information and belief, could have been treated at its early stages, by less invasive procedures but, had progressed so far that certain medical treatment options were no longer available. Further, by the time Plaintiff discovered the negligence and/or fraud of the Defendants, and each of them, her cervical cancer had progressed all the way to Stage IIIB cervical cancer.

## Piomari

*The 2018 Malpractice Complaint can be found at:*

[www.problemsatplannedparenthood.org/california-san-diego](http://www.problemsatplannedparenthood.org/california-san-diego)

### Excerpt:

11. On or around February 17, 2017, Defendants . . . negligently treated Plaintiff in the course of terminating her pregnancy causing injury which led to severe complications including hospitalization and ongoing care.

12. As a result of Defendants' professional negligence Plaintiff was admitted to the Emergency Department at UCSD Hospital on or around February 17, 2017.

## Reyes

*The 2012 Malpractice Complaint can be found at:*

[www.problemsatplannedparenthood.org/california-san-diego](http://www.problemsatplannedparenthood.org/california-san-diego)

### Excerpt:

10. As a legal result of the conduct of the defendants . . . Plaintiff . . . has suffered ongoing and disabling injuries, requiring hospitalization, additional surgical procedures, and ongoing evaluation and treatment . . .

12. As a further legal result of the conduct of the defendants . . . Plaintiff . . . has incurred and will continue to incur medical, hospital, healthcare, and related expenses. . .

13. As a further legal result of the conduct of the defendants . . . Plaintiff . . . was injured in her health and physical ability permanently, thereby causing diminishment of her earning capacity . . .

## Richter

*The 2022 Malpractice Complaint can be found at:*

[www.problemsatplannedparenthood.org/california-san-diego](http://www.problemsatplannedparenthood.org/california-san-diego)

### Excerpt:

11. On or about May 14, 2021, Defendant . . . negligently treated [Plaintiff] in the course of terminating her pregnancy, causing injury which led to severe complications including hospitalization and subsequent (and ongoing) medical care.

12. As a result of Defendants' professional negligence, Plaintiff was required to undergo emergency surgery . . . on or about August 11, 2021.

## San Ramon

### Liang

*The 2012 Malpractice Complaint can be found under San Ramon at:*

[www.problemsatplannedparenthood.org/california-s-to-z](http://www.problemsatplannedparenthood.org/california-s-to-z)

#### **Excerpt:**

13. In or around late 2011, Plaintiff experienced bleeding during her early pregnancy. On or around December 9, 2011, Plaintiff was seen by doctors at Defendant Planned Parenthood, Shasta Diablo, in the City of San Ramon. Upon consent of the Plaintiff, Plaintiff was given abortion pill to terminate her pregnancy of around eight (8) weeks. Plaintiff made follow-up office visits at Defendant Planned Parenthood on December 12, 2011 and had ultrasound and other medical examinations taken to confirm termination of her pregnancy. She was then requested to make another office visit on the date of December

15, 2011 when she was again examined to confirm termination of her pregnancy. During the office visit of December 15, 2011, she was given additional abortion pills to take to terminate her pregnancy. Shortly after . . . Plaintiff started to experience excessive bleeding.

16. To stop the excessive bleeding, she was transferred by ambulance to another medical facility . . . emergency room for treatment . . .

21. . . . Plaintiff experienced more and more bleeding, pain and even stronger odor which was intense and noticeable by anyone around her. She was terrified and went to Asian Health Services Medical Clinic . . .

22. Upon examination, Dr. Yang removed around three to four gauges or cotton balls left unremoved in her vaginal area and already turned hard and inseparable . . .

# Colorado

## Colorado Springs

### Byer

*The 2013 Malpractice Complaint can be found under Colorado Springs at:*

[www.problemsatplannedparenthood.org/colorado](http://www.problemsatplannedparenthood.org/colorado)

#### **Excerpt:**

12. Upon Plaintiff's condition that she would receive anesthesia for pain through an I.V. for which Plaintiff would pay an additional fee, Plaintiff agreed to the surgical abortion . . .

14. However, before the I.V. was inserted and before the Plaintiff received any anesthesia, the Planned Parenthood Doctor [name unknown] began the procedure . . .

15. At this time, Plaintiff immediately told the Planned Parenthood Doctor to stop and that she did not want to go through with the abortion procedure because she had not received any anesthetic. Plaintiff also informed . . . that she believed this to be a sign she should not go through with the abortion. The Planned Parenthood Doctor did not stop, despite Plaintiff's request . . .

17. The Planned Parenthood Doctor then proceeded to use the vacuum machines while Plaintiff was fully awake and had not received any anesthetic despite their agreement. Plaintiff was forced to feel the full pain of the procedure against her will . . .

24. Upon Plaintiff's return home, it was evident the pain medication did not work . . . After approximately two (2) days Plaintiff just barely had enough strength to make it to the Emergency Room at Penrose Hospital . . .

25. The medical staff at Penrose informed Plaintiff she needed an emergency D&C . . .

27. Plaintiff remained in the hospital for approximately two (2) to four (4) days due to her weakness from fever and loss of blood. Most D&C patients leave the same day, which is evidence of Plaintiff's severe injury from Planned Parenthood's negligent procedure.

## Muzarek

*The 2016 Malpractice Complaint can be found under Colorado Springs at:*

[www.problemsatplannedparenthood.org/colorado](http://www.problemsatplannedparenthood.org/colorado)

9. On or about August 4<sup>th</sup>, 2016, [Plaintiff's mother] entered into a Planned Parenthood facility to seek out personal care.

10. Accompanying her on this visit was her 18-month-old daughter . . . While [Plaintiff's mother] was asked to answer intake questions by a staff member of Planned Parenthood, her daughter picked up and quickly started to ingest liquid material that was negligently left out near an exam table, easily accessible and within the reach of a small child.

11. The ingested substance, later identified as Potassium Hydroxide, is toxic, potentially lethal, and is an extremely basic substance that is used, amongst other purposes, to conduct abortions.

12. Prior to August 4<sup>th</sup>, 2016, Plaintiff was a healthy toddler with no physical, mental or social problems.

13. As a direct and proximate cause of Defendants negligence in handling and storing a lethal chemical . . . Plaintiff suffered severe burns to her mouth, esophagus and stomach lining amongst other burn related injuries, causing her to have surgical intervention and a prolonged stay in the intensive care unit. In addition, Plaintiff is now forced to participate in extensive ongoing medical care, which will continue into the future.

14. Because of her injuries, Plaintiff receives sustenance through a feeding tube and has significant psychological damage.

## Connecticut

### Danbury

#### Lafo

*The 2021 Malpractice Complaint can be found under Danbury at:*

[www.problemsatplannedparenthood.org/connecticut](http://www.problemsatplannedparenthood.org/connecticut)

#### **Excerpt:**

5. On February 10, 2020, the plaintiff . . . presented to the Danbury Planned Parenthood for an evaluation after she received a positive home pregnancy test.
6. During her visit . . . the defendant . . . performed a transvaginal ultrasound which she read to show there was no fetus and just an empty sac at 6 weeks and 3 days gestation.

7. As a result of her reading of the ultrasound the defendant . . . recommended a medical abortion for what she determined to be a non-viable pregnancy prescribing Mifeprex and Misoprostol which the plaintiff took as instructed.
8. On or about February 12, 2020, at approximately 3:00 AM, after experiencing severe cramping and discomfort, the plaintiff delivered a deceased but intact male fetus with a weight of 474.5 grams consistent with a 22 week gestation age into a toilet at her home.

## **Hartford**

### **Thompson**

*The 2021 Malpractice Complaint can be found under Hartford at:*

[www.problemsatplannedparenthood.org/connecticut](http://www.problemsatplannedparenthood.org/connecticut)

#### **Excerpt:**

10. As a direct and proximate result of the aforementioned departures from the standard of care, the plaintiff suffered the following serious and severe injuries:
- a. Perforated uterus;
  - b. Perforated bowel;
  - c. Need for emergency hysterectomy;
  - d. Need for emergency bowel resection; and
  - e. Need for emergency unilateral salpingo-oophorectomy.

## **New Haven**

### **Hackett**

*The 2018 Malpractice Complaint can be found under New Haven at:*

[www.problemsatplannedparenthood.org/connecticut](http://www.problemsatplannedparenthood.org/connecticut)

#### **Excerpt:**

3. At all times relevant herein, the defendant, Planned Parenthood of Southern New England . . . was located in New Haven, Connecticut . . .
4. On June 4, 2015, [Plaintiff] was seen at Planned Parenthood . . .
5. On June 18, 2015, [Plaintiff] returned to Planned Parenthood and Defendant . . . inserted an intrauterine contraceptive device (hereinafter referred to as “IUC” or “IUD”), known as Liletta, to prevent pregnancy. . .
7. On March 7, 2016, [Plaintiff] was seen at Planned Parenthood by Defendant . . . for an IUD check. Medical records from this visit document that the patient is “Happy with IUD, no menses, occasional spotting.” Defendant . . . charted that she performed

an examination of the female genitalia. Her notes of this examination include: “Cervix: no discharge per os or cervical motion tenderness and normal appearance and IUC string per os. Uterus: normal size and shape and mobile, non-tender, and no uterine prolapse” and “reassurance offered that IUD strings are correctly located and appropriate length.” . . .

8. On June 27, 2016, [Plaintiff] was seen at Planned Parenthood by Defendant . . . because she had been feeling sick and nauseous for a few months. [She] reported that she did a home pregnancy test which yielded a positive result. Defendant . . . documented that she performed an examination of the female genitalia. Her notes of this examination included: “Uterus: mobile, non-tender, normal shape, no uterine prolapse and enlarged (20 wk size).” An office pregnancy test rendered a positive result. And office ultrasound was performed and interpreted by Defendant . . . as “indeterminate for pregnancy location,” and questionable molar pregnancy. [Plaintiff] was sent to Hammers Imaging for a STAT ultrasound. The result was a “viable pregnancy of 31 weeks 3 days.” The estimated date of delivery was August 26, 2016 and no definite IUD was identified . . .

11. Defendant . . . deviated from applicable standards of care in one or more of the following ways:

a. She failed to perform a full, thorough, internal examination . . . at the March 7, 2016 appointment and had she done so she would have determined that [Plaintiff] was approximately 14 weeks pregnant at that time . . .

## Washington D.C.

Butler

*Filed February 12, 2008, settled February 24, 2009. Court documents can be found at:*

[www.problemsatplannedparenthood.org/washington-dc](http://www.problemsatplannedparenthood.org/washington-dc)

### **Excerpt from Complaint:**

#### II. STATEMENT OF FACTS

14. That within twenty-four (24) hours of her discharge from Defendant’s facility after the termination procedure, the minor Plaintiff . . . became very ill.
15. That on or about September 8, 2006, the minor Plaintiff . . . presented to the emergency room at Civista Medical Center with severe abdominal pain and peritonitis.
16. That a CT scan of the minor Plaintiff’s abdomen on September 8, 2006, showed a significant amount of bleeding in the abdomen with free air. Consequently, the minor Plaintiff underwent immediate emergency surgery to evacuate the large abdominal bleeding the day after the termination procedure performed by Defendant . . .

17. That during the surgery on September 8, 2006, it was discovered, intra-operatively, that the minor Plaintiff . . . had suffered the following injuries as a direct and proximate result of the termination procedure performed by Defendant . . . :
- a. severe abdominal bleeding;
  - b. severe vaginal injury;
  - c. severe injury to the cervix;
  - d. significant uterine perforation; and
  - e. a small bowel tear.
18. That a significant portion of the fetus that was allegedly removed from the minor Plaintiff . . . during the pregnancy termination performed by Defendant, was also found inside the minor Plaintiff's abdomen on September 8, 2006.
19. That the minor Plaintiff . . . is now infertile for the rest of her life due to the injuries sustained . . .

**Note:**

*The petition states that plaintiff was 13 years old and became pregnant due to a rape. There is no indication in the petition that the Planned Parenthood staff collected evidence to help identify the rapist with DNA, and no further information on whether he was ever charged.*

## Delaware

*The 2006 Malpractice Complaint can be found under Wilmington at:*

[www.problemsatplannedparenthood.org/delaware](http://www.problemsatplannedparenthood.org/delaware)

### **Moore**

**Excerpt:**

7. . . . an ultrasound was conducted and Plaintiff . . . was told she was under five (5) weeks pregnant and would not require a surgical abortion, which gave the impression that Defendant Planned Parenthood established an intrauterine pregnancy.

8. . . . Plaintiff . . . was given one (1) pill to be taken by mouth, instructed to go home and on the 17th of December, after having a prescription filled for additional pills, she was instructed to insert four (4) of the pills into her vagina and that she would cramp and bleed for the next seven (7) or eight (8) days producing loss of the baby.

9. On about January 5, 2005, Plaintiff . . . had a follow up visit with Defendant, Planned Parenthood, and at that time had her urine checked through use of a "dip test", and was subsequently informed . . . that she was no longer pregnant.

10. At the same time and place, Plaintiff . . . was given an ultrasound . . . and she was again assured that she was no longer pregnant and that the medical abortion had been successful.

11. By about January 7, 2005, Plaintiff . . . was having problems urinating, was bloated and began experiencing severe pain in her body, and especially in her back and stomach.

12. On about January 8, 2005, Plaintiff . . . was rushed to Kent General Hospital where she again underwent a urine test which showed positive for pregnancy and an ultrasound which confirmed that there was an acute ruptured ectopic pregnancy in her right fallopian tube diagnosed as ruptured right ampullary/corneal ectopic gestation with Hemoperitoneum (an effusion of blood into the peritoneal cavity) requiring an emergency laparoscopy and surgical removal of the right fallopian tube (salpingectomy).

## Illinois

### Chicago

#### Castro

*The 2019 Malpractice Complaint, and the recording of the 911 dispatch call for May 24, 2018, can be found at:*

[www.problemsatplannedparenthood.org/illinois-chicago](http://www.problemsatplannedparenthood.org/illinois-chicago)

#### Excerpt:

4. On May 24, 2018, [Plaintiff] was present at Planned Parenthood, 1200 North LaSalle, Chicago, Illinois, for the implantation of intrauterine contraception (“IUC”) . .

9. . . . before the IUC procedure, a Planned Parenthood healthcare professional told [Plaintiff] that she may experience side-effects from the procedure, including, but not limited to, dizziness and cramping.

10. . . . shortly after the insertion of the IUC, [Plaintiff] experienced dizziness and informed the Planned Parenthood healthcare professional present at the time of the dizziness.

11. . . . following her complaints of dizziness [Plaintiff] was left alone and unmonitored. . . . while unmonitored, [Plaintiff] lost consciousness and fell off the table to the ground, striking her head and neck area, and resulting in a broken neck.

# Massachusetts

## Boston

### **Cullen**

*The full Malpractice Complaint, handwritten by plaintiff on a Civil Case Cover Sheet In 2012, can be found at:*

[www.problemsatplannedparenthood.org/massachusetts](http://www.problemsatplannedparenthood.org/massachusetts)

#### **Excerpt:**

In August of 2012, I . . . received a suction abortion at Planned Parenthood. 3 hours after leaving the clinic I was taken ch ambulance to Mass General Hospital in Boston. I was told the abortion had been done wrong. I had suffered extreme blood loss which had caused me to black out when I left the clinic. Due to losing consciousness after the abortion I fainted hit my head 2 times once in the front breaking 2 of my teeth and splitting by chin open. I needed 4 stiches in my chin which left a life-long permanent scar. I suffered a concussion, sprained neck, which has caused me to miss many days of work. I suffered from PTSD which has prevented me from going to Boston where the incident happened. I am permanently physically + mentally damaged due to this malpractice.

### **Davis**

*The 2019 Malpractice Complaint, Affidavit, and Offer of Proof can be found at:*

[www.problemsatplannedparenthood.org/massachusetts](http://www.problemsatplannedparenthood.org/massachusetts)

#### **Excerpt from the Complaint:**

9. On or about February 4, 2016, the plaintiff, then twenty-one (21) years old and of limited financial means, presented to . . . Planned Parenthood in Boston, Massachusetts for a first-term surgical abortion.
10. On or about that date, [the doctor] confirmed the ten (10) week gestational age of the pregnancy, performed the surgical abortion procedure with the assistance of ultrasound guidance (due to difficulty with dilation), then purportedly conducted a gross tissue exam of the removed products, declared the pregnancy “terminated” and discharged the plaintiff . . .
16. Neither [the doctor] or anyone else at Planned Parenthood ever advised the plaintiff that prolonged bleeding and severe abdominal pain/cramping could be a sign that she had RPOC [Retained Products of Conception].
17. During the days following the . . . procedure, the plaintiff suffered significant and continuous bleeding, abdominal pain and cramping.

18. Notwithstanding that Planned Parenthood had correctly recorded the plaintiff's phone number . . . neither [the doctor] or anyone else from Planned Parenthood ever called her to obtain her post-abortion status, or to schedule a follow-up appointment.
19. Moreover, the plaintiff's repeated phone call messages to [the doctor] and/or Planned Parenthood during the two (2) week period following her procedure were never returned.
20. Her debilitating symptoms having not resolved, and having received no reply . . . the plaintiff presented at the CHA Cambridge Hospital Emergency Department on/or about March 15, 2016 . . .
25. Her symptoms having not abated, the plaintiff ultimately presented at the MGH Emergency Department on April 4, 2016, where a gynecological consultation summarily advised the need for an US, which I turn revealed to the plaintiff, for the first time, that the abortion procedure at Planned Parenthood had resulted in substantial RPOC; the plaintiff received appropriate medical treatment at MGH and was discharged . . .
37. As a direct and proximate result of said acts and omissions of Planned Parenthood . . . the plaintiff suffered significant pain, mental anguish and disability, was deprived of a more favorable medical outcome, and suffered unnecessary hospitalization and medical expense.

## Worcester

### Casas

*The 2018 Malpractice Complaint, Amended Complaint, and 2<sup>nd</sup> Amended Complaint can be found under Worcester at:*

[www.problemsatplannedparenthood.org/massachusetts](http://www.problemsatplannedparenthood.org/massachusetts)

### **Excerpt from Second Amended Complaint:**

5. On or about March 12, 2015, [the doctor] performed the first step in a two-sept abortion at the Planned Parenthood clinic in Worcester by softening the cervix.
6. This first-step placed Ms. Casas at risk for vaginal delivery of the fetus.
7. Neither the doctor] nor [the nurse], who discharged [Plaintiff] ever informed her that she was at risk for vaginal delivery of the fetus . . .
9. Later in the afternoon on the same day she was discharged, [Plaintiff] began experiences severe labor type pains and called Planned Parenthood looking for advice and instructions. [Plaintiff] was told by a nurse . . . to take the pain medication that she had been prescribed; she was not advised that she was at risk for a vaginal delivery and she was not instructed to seek medical attention.
10. [Plaintiff] called Planned Parenthood later that evening, after hours, and was connected to an unknown person acting as an agent, servant and/or employee of Planned Parenthood. [Plaintiff] again explained that she was having severe

stomach pains and again was advised to take the medications that had been prescribed to her. She was not advised that she was at risk for a vaginal delivery and she was not instructed to seek medical attention.

11. The following morning [Plaintiff] delivered the fetus in the bathroom of her home, causing her physical pain and severe emotional and mental trauma.

## Michigan

### Ann Arbor

#### Rygwelski

*The 2017 Malpractice Petition can be found under Ann Arbor at:*

[www.problemsatplannedparenthood.org/michigan](http://www.problemsatplannedparenthood.org/michigan)

#### **Excerpt:**

27. On September 25, 2014, Plaintiff . . . was admitted to PLANNED PARENTHOOD seeking confirmation of pregnancy and also because she was experiencing vaginal discharge and odor. Her pregnancy was confirmed but an ultrasound was not performed in order to assess viability and gestational age.

28. On October 1, 2014, Plaintiff . . . returned to PLANNED PARENTHOOD. A biopsy of her cervical tissue was performed and her specimen was sent to Quest Diagnostics for testing.

29. On October 3, 2014, the lab results indicated that the cervical tissue was a product of conception. The tissue was actually an endocervical polyp. Defendant . . . misdiagnosed Plaintiff's signs and symptoms as inevitable abortion. Defendant . . . wrongfully prescribed misoprostol and failed to perform an ultrasound to assess viability and gestational age of the fetus.

30. Plaintiff . . . did not pass any tissue after the first course of misoprostol.

31. On October 3, 2014, Plaintiff . . . was given a second course of misoprostol. No tissue was passed after the second course of misoprostol.

32. On October 7, 2014, Plaintiff . . . saw her primary doctor . . . After performing a physical examination, Dr. . . . discovered polypoidal tissue in her cervix that was consistent with an endocervical polyp. An ultrasound examination was performed at Dr. . . . 's office and it revealed a viable intrauterine pregnancy at 7 weeks and 2 days with an expected date of conception on May 19, 2015.

33. On October 10, 2014, Defendant . . . advised Plaintiff . . . that she should have a therapeutic abortion due to teratogenetic effects of misoprostol.

34. On October 20, 2014, Plaintiff . . . had an abortion performed by a third party.

35. Agents of PLANNED PARENTHOOD misdiagnosed Plaintiff . . . with an inevitable abortion. Agents of PLANNED PARENTHOOD should have performed an ultrasound to determine the status of the pregnancy and should not have prescribed misoprostol to a patient who desired to continue her pregnancy. As a result, Plaintiff's pregnancy was wrongfully terminated.

# Nebraska

## Lincoln

### Roe

*The 2007 Malpractice Complaint can be found under Lincoln at:*

[www.problemsatplannedparenthood.org/nebraska](http://www.problemsatplannedparenthood.org/nebraska)

*Plaintiff uses Jane Roe as a pseudonym to protect her privacy.*

#### **Excerpt:**

10. . . . Plaintiff was laid back on an examination table and her feet were placed up in stirrups. She then felt an injection into her cervix. The shot was painful and she cried out and told the attendants and Defendant [doctor] of the painful nature of the injection. Shortly thereafter, Plaintiff heard a suctioning sound and felt pressure in her uterus. Plaintiff immediately complained of excruciating pain and told [the doctor] that something was terribly wrong and to stop the procedure. Defendant refused. Plaintiff continued to complain of pain and continued to plead for the procedure to be stopped. Defendant . . . refused and continued moving the suctioning device in the Plaintiff's uterus. Plaintiff told Defendant . . . that the pain was unbearable. Rather than stopping the procedure or providing Plaintiff with pain medication, Defendant . . . told the Plaintiff, "We can't stop," and instructed the attendants to hold her down . . .

12. After the procedure, Plaintiff was in acute pain, nauseous, and bleeding from the vagina. A pad was placed over Plaintiff's vaginal area . . . Plaintiff was then asked to walk over to the recovery room. Plaintiff advised employees that she was in too much pain. She was then assisted to the recovery area . . . When Plaintiff continued to complain of pain, she was provided a heating pad. Plaintiff was not otherwise provided with additional medical treatment at that time . . . Plaintiff was given a prescription for 800 mg. Ibuprofen to be filled after she left the center . . .

14. . . . In attempting to get to the bathroom, Plaintiff passed out, fell to the floor, and suffered a seizure type event. Plaintiff was on the floor for approximately 10 to 15 minutes during which time Planned Parenthood's medical treatment of the Plaintiff consisted of placing numerous blankets on her because she was complaining of being cold . . . While on the floor, Plaintiff suffered a second seizure type event. Then Plaintiff, with assistance, was returned to one of the recliner chairs where she suffered a third seizure, this one more acute than the others with Plaintiff's body stiffening and her eyes rolling up into her head. Plaintiff's condition continued to deteriorate, and at 4:38 PM Lincoln Fire and Rescue was called . . .

16. At Bryan LGH East, Plaintiff underwent life-saving emergency surgery. During surgery, the hospital physician discovered that Plaintiff had suffered a catastrophic perforation of her uterus . . . [The doctor] had cut into and through the

sidewall of Plaintiff's uterus and had suctioned tissue from the surrounding area thereby ripping through uterine vessels and ligament . . .

18. Due to the "extensive nature of the trauma" . . . they performed an emergency hysterectomy . . .

19. Neither of the operating physicians had ever seen such extensive wounds to the female uterus and surrounding tissues . . .

20. . . . Plaintiff required multiple blood transfusions at the hospital. Her final blood loss was approximately 4 liters which is equivalent to 80 percent of the average woman's total blood volume.

21. Had she not received the emergency care of the paramedics and the life-saving care of the Bryan LGH medical team when she did, Plaintiff would likely have hemorrhaged to death.

COUNT I: NEGLIGENCE . . .

COUNT II: BATTERY

23. Plaintiff withdrew her consent when she told the Defendants she was in severe pain and ordered them to stop the procedure. By failing to heed the requests of the Plaintiff to stop, and by physically restraining her against her will, Defendants committed a battery upon the Plaintiff.

## New Mexico

### Albuquerque

#### Griego

*The 2012 Malpractice Complaint and Amended Complaint can be found at:*

[www.problemsatplannedparenthood.org/new-mexico](http://www.problemsatplannedparenthood.org/new-mexico)

Suit: Tubal Ligation Causes Injury  
by Olivier Uyttebrouck, *Albuquerque Journal*, December 15, 2012  
(no longer on web)

#### **Excerpt from article:**

An Albuquerque woman alleges in a lawsuit that she required emergency surgery for a perforated bowel three days after she received a tubal ligation at a Planned Parenthood of New Mexico clinic.

Planned Parenthood and two physicians named in the lawsuit deny responsibility for the alleged injury.

Anathea Griego also contends she became pregnant seven months after receiving the tubal ligation, which is intended to make a woman sterile. She is expecting in January, the suit said . . .

Griego contends the physicians perforated her bowel when she received the tubal ligation on Aug. 29, 2011. She sought treatment for abdominal pain on Sept. 1, 2011, at the University of New Mexico Hospital, where she received emergency surgery.

## New York

### Albany

#### **Alston**

*The 2022 Complaint can be found under Albany at:*

[www.problemsatplannedparenthood.org/new-york](http://www.problemsatplannedparenthood.org/new-york)



Lawsuit: Capital Region hospitals failed to help woman after botched abortion  
by Rachel Silberstein, *The Times Union*, September 29, 2022

#### **Excerpt:**

An Albany woman is suing Upper Hudson Planned Parenthood and the Capital Region's largest hospital systems for allegedly neglecting to provide her medical care and guidance after a failed abortion – which she said resulted in weeks of pain, extreme blood loss and, eventually, a premature birth . . .

Alston encountered logistical challenges due to an unstable housing situation and likely racial bias, as studies show that women of color are far more likely (than white women) to experience life-threatening complications in pregnancy and have their medical concerns dismissed by physicians.



Albany woman sues three healthcare providers after botched abortion  
by Tessa Bentulan, *News Channel 13, WNYT*, October 5, 2022

**Excerpt:**

Alston immediately called Upper Hudson Planned Parenthood to schedule an abortion.

“I thought everything done and said,” Alston said. “Days go by. I’m still heavily bleeding, pain in my stomach, just nauseous and just a lot of heavy bleeding.”

Her pregnancy had not terminated.

“Planned Parenthood had no process for checking to make certain that the suction abortion was successful,” said Lewis Oliver, Alston’s attorney.

Oliver said the next few months were agonizing . . .

Her whole ordeal is detailed in a 55-page lawsuit. It claims that just three weeks after her botched abortion, she went to her regular OB-GYN at St. Peter’s because of the continued bleeding and debilitating pain. Another test confirmed she was still pregnant at about 15 weeks. Planned Parenthood told her the bleeding, pain, and a positive test were all normal.



Botched Care and Tired Staff: Planned Parenthood in Crisis  
by Katie Benner, *The New York Times*, February 15, 2025

**Excerpt:**

Alston was leaving her boyfriend when she learned she was eight weeks pregnant. In desperation, she got an abortion at a Planned Parenthood clinic in Albany, N.Y., and moved with her two daughters into a homeless shelter.

But something was clearly wrong. Several weeks after the procedure, she was still bleeding heavily and suffering from painful cramps. She took another home pregnancy test, and when it came back positive, the clinic staff assured her that they had seen the aborted fetus and there was nothing to worry about. It was only after she went to an emergency room that she discovered the problem: The baby was still in her womb.

Twelve weeks after the failed abortion, Ms. Alston went into labor and delivered a baby who quickly died.

Ms. Alston filed a malpractice suit against Upper Hudson Planned Parenthood, one of several complaints about patient care at the New York clinic that women have brought to her lawyer, Louis B. Oliver. “Planned Parenthood provides a very important area of medical care,” Mr. Oliver said. “But I speak out and have sued them because even disadvantaged people deserve good care.”

## Hineman

*The 2024 Complaint can be found under Albany at:*

[www.problemsatplannedparenthood.org/new-york](http://www.problemsatplannedparenthood.org/new-york)

### Excerpt:

2. [Plaintiff] had a relatively normal childhood, despite struggling with the effects of her then undiagnosed Asperger’s syndrome. Notably, she never felt any discomfort with her gender or expressed any desire to be a different gender. However, as she entered into her teen years, [she] began dealing with significant mental health issues. [She] began to suffer from anxiety and major depressive disorder, social exclusion disorder, self-harm, and passive suicidal ideation. Despite seeking professional help, her mental health spiraled into a point of crisis.

3. . . . When she told her mental health providers that she was adopting a transgender identity, they unquestioningly “affirmed” this suddenly onset new identity, without conducting appropriate mental health evaluations or offering [her] appropriate psychological counseling. They would eventually encourage her to pursue life-altering cross-sex hormones and even a double-mastectomy of her healthy breasts.

4. [Plaintiff]’s mental health struggles, however, continued to persist and worsen. But convinced that gender transition was the only thing that could fix her, a mere week after switching her identity from agender to transgender male, she went to Upper Hudson Planned Parenthood, where, after a single, roughly thirty-minute visit, she was prescribed life-altering cross-sex hormones . . .

5. As [Plaintiff] continued to pursue her gender transition, she ultimately sought “top surgery,” or an unnecessary removal of her healthy breasts, all the while cheered on by her supposed mental health providers. Settling on the cheapest option she could find, [Plaintiff] had a double mastectomy performed on her. It was almost immediately thereafter that she experienced profound regret and realized that transitioning was not resolving her mental health issues but was in fact worsening them . . .

## Parker

*The 2018 Complaint can be found under Albany at:*

[www.problemsatplannedparenthood.org/new-york](http://www.problemsatplannedparenthood.org/new-york)

### Excerpt:

21. At all times mentioned herein, Defendants represented to Plaintiff that the medical care . . . would be safe and did not at any time pertinent thereto disclose or discuss with her the risks, benefits, and/or alternatives to the care or treatment provided . . . including but not limited to the risks, benefits, and/or alternatives of conducting one or more diagnostic tests, evaluations, and/or surgeries, and of the use of a particular implant device . . .

23. Plaintiff would not have consented to the medical care . . . if she had been advised of the risks . . .

24. A reasonably prudent person would not have consented to the medical care . . . if he or she had been presented with the reasonably foreseeable risks . . .

26. The aforementioned failure to provide informed consent was a direct and proximate cause of the serious and personal injuries sustained by the Plaintiff.

27. As a direct and proximate result of the foregoing, Plaintiff required further medical care . . . and endured severe pain and suffering.

## **Bronx**

### **Hernandez**

*The 2022 Complaint can be found under Bronx at:*

[www.problemsatplannedparenthood.org/new-york-city](http://www.problemsatplannedparenthood.org/new-york-city)

### **Excerpt:**

3. During her first visit to Planned Parenthood, Plaintiff complained of abnormal bleeding and pain as a result of her pregnancy.

4. Upon administering care, and performing an ultrasound, Defendants recognized that Plaintiff did not currently have a normal intra-uterine pregnancy . . . As Defendants even noted in their medical records, and told Plaintiff, there was a possibility that she was having an ectopic pregnancy . . .

5. Yet . . . Defendants did not perform any further testing to confirm in order to provide the proper treatment. Instead, Defendants simply sent Plaintiff home . . .

6. After Defendants failure to provide adequate medical care, Plaintiff began experiencing even more severe pain and bleeding, causing her to re-visit Defendants' office within two days and multiple more times over the following two weeks. Each time, Plaintiff inquired with Lake about whether she should go to the hospital. And, each time, Lake told her "no, she did not need to at this time."

7. Finally, after over two weeks of severe pain and multiple visits to Defendants' office, another one of Defendant's employees called Plaintiff and told her that she should go to the hospital.

8. Accordingly, Plaintiff immediately went to the hospital, Stony Brook . . . After evaluating her, the doctors determined that one of Plaintiff's fallopian tubes had already ruptured and she was experiencing internal bleeding. Given the potential risks of fatality, Plaintiff was rushed into emergency surgery. Thankfully, the doctors at Stony Brook were able to save her life but she permanently lost one of her fallopian tubes. This places Plaintiff's plans of having more children in the future in jeopardy.

## Mitchell

*The 2014 Complaint can be found under Bronx at:*

[www.problemsatplannedparenthood.org/new-york-city](http://www.problemsatplannedparenthood.org/new-york-city)

### Excerpt:

26. That by reason of the foregoing, the plaintiff . . . was severely injured and damaged, rendered sick, sore, lame and disabled, sustained severe nervous shock and mental anguish, great physical pain and emotional upset, some of which injuries are permanent in nature and duration, and plaintiff will be permanently caused to suffer pain, inconvenience and other effects of such injuries; plaintiff incurred and in the future will necessarily incur further health care facility and/or medical expenses in an effort to be cured of said injuries; and plaintiff has suffered and in the future will necessarily suffer additional loss of time and earnings from employment . . .

32 . . . the defendant failed to inform the plaintiff as to the exact nature and extent of plaintiff's condition and failed to inform the plaintiff as to the risks, complications, consequences and danger of the care . . . and further failed to inform the plaintiff as to the possible alternative methods of treatment applicable to the plaintiff's condition.

33. That had the plaintiff known of the foregoing nature and extent of the conditions and risks . . . and had the plaintiff known of the possible alternate methods of treatment applicable to the plaintiff's condition, the plaintiff would have chosen other necessary, required, and alternative methods of treatment so as to have avoided serious injury . . .

## Brooklyn

## Meese

*The 2012 Complaint can be found at:*

[www.problemsatplannedparenthood.org/new-york-city](http://www.problemsatplannedparenthood.org/new-york-city)

### Excerpt:

10. That the defendants . . . undertook and agreed to render medical care to the Plaintiff . . . on or about January 7<sup>th</sup>, 2011 continuing through January 20<sup>th</sup>, 2012 and for other times prior and subsequent thereto.

11. The defendants . . . were negligent in the care rendered . . .

12. As a result of the foregoing, the plaintiff was rendered sick and disabled, suffered injuries, pain and mental anguish, was compelled to seek medical care, was forced to undergo additional medical procedures/treatment, incurred expenses and was permanently injured and disabled.

## Hempstead

### Breslin

*The 2014 Complaint can be found under Hempstead at:*

[www.problemsatplannedparenthood.org/new-york](http://www.problemsatplannedparenthood.org/new-york)

#### **Excerpt:**

47. . . . on or about October 3, 2011 through and including May 13, 2013, the defendant Planned Parenthood of Nassau County . . . undertook to and did perform, render and/or provide medical, diagnostic and/or technical examinations, evaluations, care . . . to the plaintiff . . .

49. As a proximate result of the foregoing, the plaintiff . . . was caused to and did suffer and sustain severe and serious personal injuries of a physical, emotional and mental nature; severe and serious conscious pain and suffering, had been rendered sick, sore and lame . . . incurred medical and other expenses, was unable to perusue her usual vocations, and will cause her eventual death.

66. A reasonably prudent person in [Plaintiff's] position would not have consented to the procedures and treatments as undertaken by the defendants . . . and would have instead elected other procedures and/or treatments.

67. As a result . . . were done without [Plaintiff's] informed consent.

### Calder

*The 2023 Complaint can be found under Hempstead at:*

[www.problemsatplannedparenthood.org/new-york](http://www.problemsatplannedparenthood.org/new-york)

#### **Excerpt:**

114. On or about April 9, 2022, Plaintiff . . . was admitted to Defendant Plann ed Parenthood Hempstead . . . [for] signs and symptoms that were consistent with ectopic pregnancy.

115. . . . Defendant Planned Parenthood . . . failed to properly and timely diagnose and treat [Plaintiff's] ectopic pregnancy . . .

121. On or about April 21, 2022 and/or April 22, 2022, [Plaintiff's] ectopic pregnancy resulted in the rupture of and/or loss of utility of her fallopian tube in which the ectopic pregnancy was located.

## D'Avanzo

*The 2017 Complaint can be found under Hempstead at:*

[www.problemsatplannedparenthood.org/new-york](http://www.problemsatplannedparenthood.org/new-york)

### **Excerpt:**

34. Contrary to accepted standards of medical treatment, the defendants . . . Planned Parenthood . . . performed a procedure for the termination of pregnancy, negligently and improperly a dilation and curettage, failed to properly remove the products of conception . . . failed to take steps to ensure that the products of conception had been removed . . . failed to send the biologic material removed . . . for analysis and pathological examination . . . failed to properly examine plaintiff, failed to properly perform repeat examinations; failed to properly perform sonograms on plaintiff; failed to determine that plaintiff had an ectopic pregnancy . . . failed to properly schedule follow-up visits for plaintiff; failed to order and perform appropriate diagnostic and laboratory tests for plaintiff, and were otherwise negligent . . .

## DeBrosse

*The 2020 Complaint can be found under Hempstead at:*

[www.problemsatplannedparenthood.org/new-york](http://www.problemsatplannedparenthood.org/new-york)

### **Excerpt:**

82. The above medical care, diagnosis, treatment and services rendered to Plaintiff . . . were rendered negligently . . . in failing to timely diagnose breast cancer; in failing to order ultrasounds . . . in causing plaintiff to be diagnosed with pathology suspicious for cancer on February 28, 2018; in causing plaintiff to be diagnosed with cancer via biopsy on March 7, 2018; in failing to properly communicate; in failing to properly evaluate and treat her medical condition . . . in failing to document all treatment provided to Plaintiff; in failing to give proper care in allowing adequate time to observe the Plaintiff; in failing to properly diagnose and treat the Plaintiff's true medical condition . . . in misdiagnosing the Plaintiff's condition; in failing to advise the Plaintiff of the risks, hazards and complications attendant to the medical and/or surgical procedures performed; in failing to use and employ the best medical and surgical judgment in the treatment of the Plaintiff herein; in failing to timely refer the Plaintiff for a specialist's opinion and second opinion . . .

83. By reason of the above, Plaintiff . . . has sustained severe injuries, pain, agony, suffering, disability, hospitalization, pain and suffering, surgery, as well as severe conscious pain and suffering.

## **Manhattan**

*Malpractice suits in which the patient died – Owens and Buchanan – are covered under patient deaths in Chapter 4.*

### **Burton**

*The 2006 Complaint can be found under Manhattan at:*

[www.problemsatplannedparenthood.org/new-york-city](http://www.problemsatplannedparenthood.org/new-york-city)

#### **Excerpt:**

78. That on or about the 21st day of September, 2004, the Defendant . . . improperly handled the post-operative care of Plaintiff at PLANNED PARENTHOOD, resulting in injuries, including but not limited to, a uterine perforation, need for surgical intervention, hematoma and a permanent left leg neuropathy.<sup>4</sup>

79. That during all of the procedures and treatment rendered to the Plaintiff, the Defendants departed from acceptable standards of medical care to the Plaintiff.

80. That the Defendants caused Plaintiff to sustain serious injuries, including but not limited to, a uterine perforation, exploratory laparotomy, repair of a uterine perforation, infection, and a lumbosacral plexus neuropathy

### **Cox**

*The 2014 Complaint can be found under Manhattan at:*

[www.problemsatplannedparenthood.org/new-york-city](http://www.problemsatplannedparenthood.org/new-york-city)

#### **Excerpt:**

14. The Defendants failed to properly and timely assess, diagnose, and treat an ectopic pregnancy.

15. The Defendants failed to perform, review and interpret proper and timely diagnostic testing, including, but not limited to sonography and laboratory tests.

16. The Defendants failed to properly and timely treat the ectopic pregnancy medically . . .

21. As a result of the Defendants' negligence and malpractice, [Plaintiff] suffered . . . serious, severe, and permanent personal injuries, had and will continue to have severe conscious pain and suffering, had to undergo surgery that in the absence of negligence would have and should have been unnecessary, lost a fallopian tube, damage to reproductive system, suffers a decreased chance of conceiving, carrying and delivering a baby, suffers scar tissues/adhesion formation, abdominal scarring and related injuries, the risk of further scar tissue formation and related injuries, emotional injuries and sustained general and special damages.

## Pusey

*The 2017 Complaint can be found under Manhattan at:*

[www.problemsatplannedparenthood.org/new-york-city](http://www.problemsatplannedparenthood.org/new-york-city)

### Excerpt:

15. That the defendants PLANNED PARENTHOOD . . . were negligent and committed malpractice in performing surgery in a negligent manner; in negligently perforating the uterus; in negligently lacerating, traumatizing and injuring the left uterine artery; in negligently causing massive hemorrhage and shock; in rendering negligent post-operative monitoring, care and treatment; in failing to exercise proper supervision

. . .

14. That by reason of the foregoing, the plaintiff was proximately caused to sustain severe and permanent personal injuries, pain, suffering loss of enjoyment of life, mental anguish, cosmetic disfigurement, economic and pecuniary damages.

## Richards

*The 2005 Complaint can be found under Manhattan at:*

[www.problemsatplannedparenthood.org/new-york-city](http://www.problemsatplannedparenthood.org/new-york-city)

### Excerpt:

13. That on or about April 8, 2004, plaintiff was admitted to SUNY Downstate Medical Center where she was diagnosed with a right ruptured ectopic pregnancy and was required to undergo a diagnostic laparoscopy, exploratory laparotomy, evacuation of hematoma, right partial salpingectomy, and lysis of adhesions.

14. That defendants departed and deviated from good and accepted gynecological and obstetrical practice in the care and treatment rendered to plaintiff and that as a result of the negligent and careless treatment rendered to the plaintiff, plaintiff sustained serious injury and was required to undergo hospitalization and procedure and, upon information and belief, further hospitalizations and procedures may be required . . .

16. That defendants were negligent and careless . . . in failing to adequately test and exam plaintiff and diagnose an ectopic or tubal pregnancy . . .

17. By reason of the foregoing, plaintiff sustained severe and serious personal injuries; was caused to suffer severe physical pain and mental anguish as a result thereof; and many of the injuries are of a permanent and lasting nature; that plaintiff was confined to bed and home and hospital as a result thereof; and was incapacitated from attending to her usual duties and activities.

## Thompson

*The 2021 Complaint can be found under Manhattan at:*

[www.problemsatplannedparenthood.org/new-york-city](http://www.problemsatplannedparenthood.org/new-york-city)

### **Excerpt from Complaint:**

11. That at all times mentioned herein defendants . . . were negligent in failing to follow good and accepted medical and surgical practices . . . in failing to properly consult the plaintiff's chart and/or medical records; in failing to properly diagnose plaintiff's condition; in failing to timely and properly perform surgeries . . . in negligently perforating plaintiff's uterine; in failing to use the proper surgical tools; in failing to properly examine plaintiff, especially plaintiff's uterus . . .
12. That as a result . . . plaintiff was caused to sustain severe and permanent personal injuries including uterine injuries, bowel injuries, nerve injuries, pain and suffering, medical expenses, loss of enjoyment of life, pain and suffering and other damages.

## **Massapequa**

*The 2025 Malpractice Complaint can be found under Massapequa at:*

[www.problemsatplannedparenthood.org/new-york](http://www.problemsatplannedparenthood.org/new-york)

### **Excerpt:**

17. That commencing on or about July 29, 2024, the plaintiff was a patient of, and under the care and treatment at a Planned Parenthood clinic . . . for treatment, an IUD removal and IUD insertion/placement.

18. That the defendants . . . were negligent and committed malpractice . . . in failing to timely and properly test, care for, observe, administer to, diagnose and otherwise treat the plaintiff; in failing to treat the plaintiff in accordance with the proper and accepted standards of medical care and treatment; in deviating and departing from the good and accepted standards of medical and surgical care and practice in the manner in which the insertion was performed and in the failure to timely diagnose and treat the conditions and complications that developed; in carelessly and negligently placing an IUD in the body of the plaintiff; in carelessly and negligently perforating the uterus during the IUD procedure; in failing to timely and properly diagnose that the plaintiff was suffering from a perforated uterus; in failing to notice, realize and/or recognize the fact that the uterus had been perforated after the IUD insertion; in failing to examine the plaintiff's uterus pre-insertion; in failing to perform a bimanual exam; in failing to utilize the proper methods and techniques of IUD insertion; in failing to timely and properly diagnose that the plaintiff was suffering from a perforated uterus; in failing to remove the IUD after it had perforated the uterus; in failing to remove the IUD after it had perforated the uterus; in failing to timely and properly request and/or refer the

plaintiff to a specialist in the appropriate fields of medicine; that as a e further consequence of the failure to properly insert the IUD, and the failure to properly measure the uterus and recognize an abnormal measurement, the IUD migrated to the pelvis and the plaintiff was required to undergo surgery to remove the malposition device; and in violating the applicable laws, rules, statutes and regulations in such cases made and provided; and the defendants were otherwise careless and negligent and failed to act in a reasonable and acceptable medical manner.

## **New Rochelle**

### **Baker**

*The 2019 Poor Person Order PSLR 1101(d) can be found at:*

[www.problemsatplannedparenthood.org/new-york](http://www.problemsatplannedparenthood.org/new-york)

### **Excerpt handwritten by plaintiff in the form:**

10. Briefly stated, the facts of my case are as follows:

Nerve damage, and permanent cervix damage. Painful intercourse, abdominal pain, and vaginal bleeding. Pain and suffering. Discomfort, and delay in work and daily activities.

## **Newburgh**

### **Sampson**

*The 2018 Complaint can be found under Newburgh at:*

[www.problemsatplannedparenthood.org/new-york](http://www.problemsatplannedparenthood.org/new-york)

### **Excerpt:**

30. That at all times hereinafter mentioned, including on or about January 14, 2016 and March 24, 2016, and prior and subsequent thereto, the defendant PLANNED PARENTHOOD OF THE MID-HUDSON VALLEY, INC. d/b/a NEWBURGH HEALTH CENTER . . . was/were negligent, careless, unskillful and committed acts and omissions which constituted medical negligence and medical malpractice in connection with the medical, gynecological and obstetrical care rendered to plaintiff, in the following manner: in deviating from good and accepted medical practices which were prevailing in the community; in failing to undertake and administer proper gynecological and obstetrical care; in failing to properly and adequately diagnose pregnancy; in failing to properly and adequately perform a pregnancy test and in failing to timely act upon same; in failing to timely recognize, heed, appreciate and act upon the plaintiff's

complaints, signs and symptoms; in failing to timely recognize, heed, appreciate and act upon signs of pregnancy; in failing to timely refer the plaintiff for prenatal care and diagnostic testing; in failing to undertake and administer proper prenatal care and diagnostic testing and practice; in negligently administering contraindicated medications and/or chemical agents; in administering medications and/or chemical agents in excessive and/or contraindicated dosages; in negligently administering Depo Provera birth control without testing the plaintiff for pregnancy and while plaintiff was pregnant; in failing to obtain and/or arrange for the necessary and indicated specialist consultations; in failing to timely undertake and administer proper examinations and testing; in failing to assign and provide competent medical staff or to supervise its medical staff; and by other negligent acts and/or omissions; and by all of the foregoing did thereby proximately cause the severe injuries and conditions and associated direct complications and pain and suffering sustained and suffered by the plaintiff.

## Patchogue

### Fitsimmons

*The 2021 Amended Complaint can be found under Patchogue at:*

[www.problemsatplannedparenthood.org/new-york](http://www.problemsatplannedparenthood.org/new-york)

#### **Excerpt:**

*Note: This is brought by the administrator of an estate, which is why “decedent” is referred to. However, because there are several defendants and Planned Parenthood is only listed as one of them, and because neither the nature of the medical condition nor how the alleged malpractice led to the death are stated in the Complaint, we are including this under Malpractice Suits and not putting it under Patient Deaths – unless further information shows it’s warranted to put it in the more severe category.*

47. On or about July 1, 2014, plaintiff’s decedent presented to defendant PLANNED PARENTHOOD with certain signs, symptoms, and complaints.

48. On and between July 1, 2014 and August 1, 2017, plaintiff’s decedent received regular and continuous medical care and treatment from defendant PLANNED PARENTHOOD for the aforesaid certain signs, symptoms, and complaints . . .

62. As a result of the negligence, malpractice, and wrongdoing of the defendants as aforesaid, and without any fault on the part of plaintiff’s decedent contributing thereto, plaintiff’s decedent was caused to sustain serious, severe, and permanent personal injuries, and has suffered physical pain and mental anguish, and an untimely death.

## Queens

### Taraskovic

*The 2020 Complaint can be found under Queens at:*

[www.problemsatplannedparenthood.org/new-york](http://www.problemsatplannedparenthood.org/new-york)

#### **Excerpt:**

18. The above medical care . . . were caused by the carelessness and negligence, negligent acts and/or omissions, medical malpractice and surgical malpractice of Defendants . . . in performing a dilatation and curettage despite no uterine pregnancy being seen on ultrasound; in failing to schedule and perform follow up testing . . . in failing to assure proper follow-up knowing that there was questionable indication of intrauterine pregnancy; in failing to schedule and perform HCH level testing within 24-72 hours of the procedure; in failing to properly communicate; in failing to establish a differential diagnosis; in failing to establish a proper differential diagnosis; in failing to diagnose ectopic pregnancy; in failing to treat ectopic pregnancy . . .

## Smithtown

### Thomas

*The 2007 Complaint can be found under Smithtown at:*

[www.problemsatplannedparenthood.org/new-york](http://www.problemsatplannedparenthood.org/new-york)

#### **Excerpt:**

This is a medical malpractice action wherein the plaintiff . . . alleges that during the performance of a second trimester abortion on April 18, 2009, the defendant, Planned Parenthood Hudson Peconic, Inc., by its staff, negligently perforated her uterus, resulting in her having to undergo a hysterectomy and suffer other permanent injury.

Ms. Thomas testified that she went to the West Islip Planned Parenthood on about April 15th or 16th 2009 for an abortion of her third pregnancy, had a blood test and applied for health insurance which covers the procedure and a three month period thereafter. She was referred to the Smithtown Planned Parenthood on April 18, 2009, as she was told she was too far along in her pregnancy to take the pill for the abortion at the West Islip Planned Parenthood office. She believed she was about 11 or 12 weeks pregnant. When she arrived at the Smithtown location, she showed the staff her 10 and filled out some paperwork for insurance . . .

She then had a sonogram and was advised that she was about thirteen and a half to fourteen weeks pregnant. Thereafter, she had some blood work performed . . . she went into a room where she was seen by [the doctor] and a nurse who gave her some pills to soften her uterus or cervix . . . She was placed on a table, and an intravenous was started. She then felt [the doctor] insert a "metal thing" into her vagina. When she started to feel a sharp pain, she told the doctor to stop, but he advised her that the procedure was already started and that he could not stop. She testified that shortly after that, the doctor advised her that there was "just a minor complication," and that he was calling Stony Brook Hospital. The next thing she knew, the paramedics were at her side. When they moved her she felt a gush of blood. Upon arrival to Stony Brook University Hospital, she was given a partial hysterectomy . . .

### **Dorival**

*From a 2011 court order dismissing another defendant from the case, which can be found under Smithtown at:*

[www.problemsatplannedparenthood.org/new-york](http://www.problemsatplannedparenthood.org/new-york)

The medical records of Planned Parenthood reveal that on January 17, 2001, plaintiff presented to the office for an abortion, which was performed. However, after the procedure, plaintiff developed uterine atony and persistent vaginal bleeding which required transfer to a hospital for further treatment.

### **Spring Valley**

### **Acocella**

*The 2011 Complaint can be found under Spring Valley at:*

[www.problemsatplannedparenthood.org/new-york](http://www.problemsatplannedparenthood.org/new-york)

### **Excerpt:**

23. Defendant . . . was negligent in the care rendered . . . in failing to heed or appreciate the significance of the signs and symptoms exhibited by Plaintiff; in improperly prescribing medication; in improperly administering medication . . . in failing to timely refer Plaintiff to specialists, in failing to take a proper medical history of the Plaintiff; in failing to properly test the Plaintiff prior to prescribing, administering, and/or providing medication the Plaintiff . . .

28. Defendant . . . failed to disclose and/or inform Plaintiff of the risks associated with the medication . . . and of the alternatives thereto and the reasonably foreseeable risks and benefits association therewith as a reasonable medical practitioner under similar circumstances would have disclosed, in a manner permitting said Plaintiff to make a knowledgeable evaluation.

29. A reasonably prudent person in Plaintiff's position who had been fully informed would not have undergone the treatment . . .

## West Seneca

### Ford

*The 2020 Complaint can be found under West Seneca at:*

[www.problemsatplannedparenthood.org/new-york](http://www.problemsatplannedparenthood.org/new-york)

18. That upon information and belief, Plaintiff . . . did seek and received medical care, treatment and/or services from Defendants . . . on or about January 11, 2019, at Planned Parenthood - West Seneca Medical Center . . . for care and/or treatment pertaining to her pregnancy . . .

26. That . . . they failed to properly observe, monitor and evaluate Plaintiff . . . despite their awareness that her uterine wall had been pierced during the aforementioned medical procedure and her complaints of extreme pain, discomfort, cramping, heavy bleeding and inability to and/or difficulty walking, dizziness, and nausea thereafter; failed and omitted to timely order or perform studies including but not limited to an ultrasound; failed and omitted to properly treat Plaintiff . . . despite their awareness that her uterine wall had been pierced during the aforementioned medical procedure and her complaints . . . failed and omitted to administer adequate pain control medication during and after the aforementioned medical procedure; failed and omitted to perform proper and timely tests, examinations, procedures, in giving medical care to the Plaintiff . . . ; failed and omitted to timely transfer Plaintiff . . . to another facility capable of rendering a higher level of care and/or diagnostic imaging; failed to observe and address Plaintiff's continuing complaints . . . and otherwise failed to properly monitor Plaintiff's symptoms and other vital signs . . .

29. As a result of the Defendants' failure to render reasonable care and to meet good and accepted standards of practice in their care, treatment and services . . . Plaintiff . . . sustained severe permanent, personal and emotional injuries, to which the full extent of each is not presently known, including but not limited to . . . damage to her urine wall . . . All injuries claimed and sustained are permanent.

## White Plains

### Austin

*The 2020 Complaint can be found under White Plains at:*

[www.problemsatplannedparenthood.org/new-york](http://www.problemsatplannedparenthood.org/new-york)

### Excerpt:

FIFTH: Plaintiff . . . was a patient of defendants at various times from on or about March 3, 2020 to on or about March 8, 2020 . . .

EIGHTH: Defendants . . . were negligent and careless in the medical and surgical care and treatment of plaintiff . . .

NINTH: As a result of the aforementioned, plaintiff . . . sustained severe and serious personal injury, conscious pain and suffering, mental anguish, emotional distress, psychological trauma and loss of enjoyment of life, all of a permanent nature . . .

TWELFTH: Defendants failed to inform plaintiff of the risks, hazards and alternatives connected with the treatment rendered, so that an informed consent could be given.

THIRTEENTH: Reasonably prudent persons in plaintiff's position would not have undergone the treatment utilized if fully informed of the risk, hazards and alternatives connected with the treatment.

FOURTEENTH: The failure to adequately and fully inform plaintiff of the risks, hazards and alternatives of the treatment utilized was a proximate cause of plaintiff's injuries.

FIFTEENTH: As a consequence of the foregoing, there was no informed consent to the treatment utilized.

### **Jane Doe**

*The 2021 Complaint can be found under White Plains at:*

[www.problemsatplannedparenthood.org/new-york](http://www.problemsatplannedparenthood.org/new-york)

#### **Excerpt:**

49. On May 4, 2020, Defendant . . . prescribed the two-medication regimen of Mifeprex and misoprostol to terminate Plaintiff's pregnancy.

50. Plaintiff did not sign the required Patient Agreement Form, or any other form.

51. Defendants failed to conduct a physical exam of any type on Plaintiff, let alone a bimanual pelvic exam or abdominal exam.

52. Defendant failed to conduct an ultrasound on Plaintiff.

53. Plaintiff began her regimen of Mifeprex and misoprostol on May 4, 2020.

54. That evening, Plaintiff began experiencing painful cramping and pressure.

55. Plaintiff went into full labor in the early morning hours of May 5, 2020.

56. Plaintiff experienced extreme and painful accelerated changes to her body, including a vaginal laceration or tear, as the delivery progressed.

57. At approximately 3:00 am, while sitting on the toilet, Plaintiff gave birth to a fully formed, stillborn baby boy named J.T.

58. Plaintiff was shocked and traumatized when she saw the lifeless, fully-formed baby in the toilet covered in mucous, blood, and the placenta.

59. The next morning, Plaintiff advised Defendants about the ordeal. Plaintiff described the size of J.T.'s body to the Defendants. She described his size as the length of her forearm, not including his legs. Defendant . . . repeatedly asked whether the body was the size of a fist, but Plaintiff and her mother corrected her.

60. Instead of directing Plaintiff to the nearest emergency room, and despite knowing that J.T. was a fully-formed baby, Defendants directed Plaintiff to bring J.T. across county lines to Dr. [the doctor] at the White Plains Center for examination of both J.T. and herself.

61. At the White Plains Center, [the doctor] performed an ultrasound and physical exam on Plaintiff and also examined J.T.

62. Defendants determined that J.T.'s length and femur size were consistent with that of a thirty-three to thirty-six week old baby.

63. Defendants advised Plaintiff that they would dispose of J.T., further upsetting Plaintiff and her family.

64. Plaintiff, just hours post-partum and in shock, was made to wait for many hours at the White Plains Center.

65. Defendants told Plaintiff not to call law enforcement.

66. Plaintiff refused to allow Defendants to dispose of J.T. and a family member contacted law enforcement authorities for assistance.

67. Defendants made misleading statements to law enforcement, including the indisputably untrue statement that Plaintiff was "examined" and that Plaintiff decided on her own to bring J.T. across county lines.

68. J.T. was taken to the Westchester County Morgue.

69. J.T. was a fully formed and otherwise healthy baby.

70. Plaintiff had no intention of aborting a near-term baby, did not consent to the termination of a near-term baby, and would not have aborted a near-term baby or any baby after her first trimester.

71. An autopsy was performed on J.T. on May 7, 2020.

72. The cause of J.T.'s death was determined to be a "medically induced termination of pregnancy of a 30-week fetus."

73. As a result of Plaintiff's ordeal, she has endured significant stress, trauma, emotional anguish, physical pain, including laceration and an accelerated labor and delivery unaided by medication, lactation, soreness, and bleeding.

## Pennsylvania

### Norristown

#### McNamee

*The Complaint can be found under Norristown at:*

[www.problemsatplannedparenthood.org/pennsylvania](http://www.problemsatplannedparenthood.org/pennsylvania)

#### Excerpt:

8. On or about August 1, 1999, plaintiff . . . underwent a pap smear . . . performed at Planned Parenthood of Southeastern Pennsylvania . . .

10. The aforementioned pap smear was misread and misreported . . .

15. Between the calendar year 1999 and the ultimate diagnosis of cervical cancer, plaintiff presented to Planned Parenthood . . . on numerous occasions for gynecologic examinations . . .

16. On or about August 1, 2000 . . . Plaintiff complained to the health providers from Planned Parenthood . . . of bleeding, particularly post coital bleeding and bleeding

[not] in conjunction with her normal menstrual cycle. Despite these complaints, the healthcare providers from Planned Parenthood did not perform diagnostic tests and studies designed to rule out cervical cancer . . .

21. On or about October 5, 2002, plaintiff underwent biopsy of her cervix. The biopsy revealed invasive squamous carcinoma . . .

23. Following her diagnosis, plaintiff underwent debilitating surgery as well as debilitating chemoradiation. As a result of her cancer and the delayed diagnosis, plaintiff required debilitating, painful and disfiguring surgical procedures and adjuvant therapies . . .

31. Plaintiff's cancer was misdiagnosed by all of the defendants.

## **Philadelphia – Castor Street**

### **Matalski**

*The 2016 Complaint can be found under Philadelphia – Castor Street at:*

[www.problemsatplannedparenthood.org/pennsylvania](http://www.problemsatplannedparenthood.org/pennsylvania)

#### **Excerpt:**

1. In November of 2004, Pfizer the manufacturer of Depo-Provera Contraceptive Injection (hereinafter “Depo-Provera”) released a 22 page report containing detailed information related to Depo-Provera . . .

3. The report contains a detailed “black boxed warning,” about loss of bone density on the first page, which should be relayed to the patient . . .

43. According to the chart, Ms. Mastalski, then 29 years old, had already been taking Depo-Provera (a/k/a “depo shot”) as a form of birth control for more than 2 years . . .

46. On August 16, 2010, Defendants knew or should have known that Ms. Mastalski had been receiving the Depo-Provera injection beyond the time recommended by the manufacturer.

161. She received her sixteenth injection of Depo-Provera on March 22, 2014 . . .

167. On June 19 2014, Ms. Mastalski underwent a DEXA scan . . .

170. The interpretation states: “Abnormal DEXA study. The lowest T-score in the central DEXA is -2.8. There is severe osteoporosis with highly increased risk of fracture.” . . .

179. On December 9, 2014, Ms. Mastalski had an x-ray of her right foot which revealed a fracture of the right fourth proximal phalynx . . .

184. Defendants' failure to timely consider, diagnose and treat Ms. Mastalski caused her to develop severe osteoporosis and fractures.

## Philadelphia – Locust Street

### Allen

*The 2009 Complaint can be found under Philadelphia – Locust Street at:*

[www.problemsatplannedparenthood.org/pennsylvania](http://www.problemsatplannedparenthood.org/pennsylvania)

#### Excerpt:

7. On or about May 26, 2007, Defendant Planned Parenthood by and through its agents . . . evaluated the Plaintiff and partially performed the abortion.

8. Thereafter . . . Defendants discharged Plaintiff, despite the fact that the abortion was not complete . . .

10. At all times relevant hereto, Plaintiff was improperly and inappropriately treated by the Defendants despite the availability of Plaintiff's test results and screening . . .

16. As a direct and/or proximate result of Defendant's negligence, Plaintiff has experienced excruciated pain . . . a necessity for extended care and/or treatment, embarrassment, mental anguish and/or humiliation as well as out of pocket expenses.

## Reading

### Matos

*The 2021 Complaint can be found under Reading at:*

[www.problemsatplannedparenthood.org/pennsylvania](http://www.problemsatplannedparenthood.org/pennsylvania)

#### Excerpt:

7. On or about September 10, 2018, plaintiff was treated at defendant Planned Parenthood for the insertion of an IUD . . .

11. Planned Parenthood, as a national purveyor of birth control advice and treatment, knew, or should have known of the defects in the MIRENA® device . . .

14. Plaintiff was not provided with the risks of the procedure prior to the insertion of the IUD.

15. Subsequently plaintiff developed intense headaches and severe abdominal pain and accordingly sought treatment at Reading Hospital.

16. On January 10, 2019, a pelvic ultrasound was preformed which revealed the IUD was mal-positioned. It lay in the posterior uterine myometrium and extended close to but not definitely through the posterior serosa in the body of the uterus . . .

18. On March 4, 2019, plaintiff underwent IUD removal.

19. Plaintiff continued to suffer from severe abdominal pain.

20. However, following the procedure, plaintiff continued to suffer from pain including chest pain . . .

22. On April 23, 2019, plaintiff presented to Reading Hospital complaining of shortness of breath and nausea and vomiting. Initial evaluation was suggestive of congestive heart failure and possible community acquired pneumonia.,

23. While at Reading Hospital plaintiff's condition worsened with a concern for myocarditis. As a result on April 25, 2019, plaintiff was transferred to Jefferson Hospital in Philadelphia.

24. Plaintiff was an inpatient at Jefferson from April 25, 2019 until May 4, 2019 having been discharged with congestive heart failure.

## Texas

### Austin

#### Foster

*The 2012 Complaint can be found at:*

[www.problemsatplannedparenthood.org/texas-austin](http://www.problemsatplannedparenthood.org/texas-austin)

#### **Excerpt:**

4.1 On November 20, 2009, Defendants administered Plaintiff a drug known as Cytotec/Misoprostol ("Cytotec") for cervical dilation. Not only has the FDA not approved this drug's use for cervical dilation, but in fact the manufacturer expressly prohibits its use for that purpose. This is not an example of "off-label" use, but rather is in direct contravention to the labels set forth by the manufacturer.

4.2 The true risks of this drug were not adequately explained. Instead, the consent form merely stated that possible side effects include nausea, vomiting, fever, hot flashes, chills, diarrhea, headache, dizziness, tiredness and back pain.

4.3 In fact, the true risks as stated by its own manufacturer include uterine rupture, uterine bleeding, uterine perforation, severe vaginal bleeding, retained placenta and pelvic pain . . . If those risks were in fact disclosed, no reasonable woman would then choose to use it. Furthermore, it was not necessary to administer this drug to Plaintiff due to previous pregnancies and deliveries and it was therefore negligent to administer it to her.

4.4 As a result of being improperly administered this drug and without Plaintiff's informed consent, on November 23, 2009 Plaintiff thereafter presented to Seton Hospital with severe uterine cramping and severe vaginal bleeding. Retained placenta was ultimately found, a known risk of Cytotec. The administration of the drug caused subsequent surgeries and additional damages . . .

## Houston

*The 2011 Complaint can be found at:*

[www.problemsatplannedparenthood.org/texas-houston-stafford](http://www.problemsatplannedparenthood.org/texas-houston-stafford)

### **Excerpt:**

9. Plaintiff . . . was treated by Defendant Planned Parenthood on May 19, 2009. During this visit, staff . . . prescribed the intrauterine contraceptive device manufactured by Defendant Bayer, Mirena. Staff of Planned Parenthood implanted this device . . . Over the next several months, Ms. Gonzalez developed symptoms such as rashes, hair loss, rapid weight loss, weakness, muscle deterioration, and chronic pain. She returned to Planned Parenthood, but the staff failed to diagnose the cause of such symptoms and failed to remove the Merena device. On December 3, the Merena device was removed. In late December, Ms. Gonzalez was again hospitalized, and later diagnosed with systemic lupus, caused by the product and/or the implantation process.

## Washington DC

### **Butler**

*The 2008 Complaint and 2009 Settlement can be found at:*

[www.problemsatplannedparenthood.org/washington-d-c](http://www.problemsatplannedparenthood.org/washington-d-c)

### **Excerpt from Complaint:**

#### **II. STATEMENT OF FACTS**

14. That within twenty-four (24) hours of her discharge from Defendant's facility after the termination procedure, the minor Plaintiff . . . became very ill.

15. That on or about September 8, 2006, the minor Plaintiff . . . presented to the emergency room at Civista Medical Center with severe abdominal pain and peritonitis.

16. That a CT scan of the minor Plaintiff's abdomen on September 8, 2006, showed a significant amount of bleeding in the abdomen with free air. Consequently, the minor Plaintiff underwent immediate emergency surgery to evacuate the large abdominal bleeding the day after the termination procedure performed by Defendant . . .

17. That during the surgery on September 8, 2006, it was discovered, intra-operatively, that the minor Plaintiff . . . had suffered the following injuries as a direct and proximate result of the termination procedure performed by Defendant . . . :

- a. severe abdominal bleeding;
- b. severe vaginal injury;
- c. severe injury to the cervix;
- d. significant uterine perforation; and
- e. a small bowel tear.

18. That a significant portion of the fetus that was allegedly removed from the minor Plaintiff . . . during the pregnancy termination performed by Defendant, was also found inside the minor Plaintiff's abdomen on September 8, 2006.

19. That the minor Plaintiff . . . is now infertile for the rest of her life due to the injuries sustained . . .

**Note:**

*The petition states that plaintiff was 13 years old and became pregnant due to a rape. There is no indication in the petition that the Planned Parenthood staff collected evidence to help identify the rapist with DNA, and no further information on whether he was ever charged.*

# Chapter 3



We only report what can be documented by sources who are not Planned Parenthood opponents. Pictures taken from a sidewalk are not used.

First we list calls for an ambulance on known dates, along with mentions of incidents from the health inspection reports already covered in Chapter 1. Dispatch audio recordings and paper documents were received through official agencies and are available on the Problems at Planned Parenthood website.

Then we select Google and Yelp reviews from patients who discuss their own experiences of going to the hospital. These cases are usually well after the visit to Planned Parenthood and so would not involve an ambulance being called to the center. Reviews and links to the reviewing sites are also included on the website under the location listed in the label for each review.

[www.problemsatplannedparenthood.org](http://www.problemsatplannedparenthood.org)

# Alabama

Audio of calls to dispatch an ambulance and/or written documents can be found at:

[problemsatplannedparenthood.org/closed-centers-911-calls](https://problemsatplannedparenthood.org/closed-centers-911-calls)

## Mobile

February 23, 2017

# California

**Antioch:** An incident involving an ambulance call is listed in a health inspection document under California – Antioch above in Chapter 1.

## Orange

Audio of calls to dispatch an ambulance and/or written documents can be found under Orange at:

[problemsatplannedparenthood.org/california-g-to-r](https://problemsatplannedparenthood.org/california-g-to-r)

February 22, 2013

May 9, 2013

January 16, 2021

February 13, 2021

April 5, 2024

May 31, 2024

An incident involving an ambulance call is listed in a health inspection document under California – Orange above in Chapter 1.

A transcript part of the May 31, 2024 call is at the end of this chapter. It indicates deliberate failure to answer normal medical questions of dispatch staff.

**Thousand Oaks:** An incident involving an ambulance call is listed in a health inspection document under California – Thousand Oaks above in Chapter 1.

**Ventura:** An incident involving an ambulance call is listed in a health inspection document under California – Ventura above in Chapter 1.

## **Walnut Creek**

Audio of calls to dispatch an ambulance and/or written documents can be found at:

[problemsatplannedparenthood.org/california-s-to-z](https://problemsatplannedparenthood.org/california-s-to-z)

May 14, 2019  
September 25, 2020  
May 14, 2021  
May 21, 2021  
July 23, 2021

## **Colorado**

Audio of calls to dispatch an ambulance and/or written documents can be found at:

[problemsatplannedparenthood.org/colorado](https://problemsatplannedparenthood.org/colorado)

## **Aurora**

September 24, 2022

## **Denver (Park Hill Center)**

October 26, 2012  
March 5, 2013  
January 8, 2016  
April 15, 2016  
August 13, 2016  
August 31, 2016  
November 3, 2016  
July 28, 2022  
December 8, 2022  
December 9, 2023

## **Fort Collins**

January 7, 2023

# Connecticut

**Connecticut – Bridgeport:** Legislator testimony about an incident involving an ambulance call is listed in a health inspection document under Connecticut - Bridgeport above in Chapter 1.

**Connecticut – West Hartford:** An incident involving an ambulance call is listed in a health inspection document under California – Thousand Oaks above in Chapter 1.

# Delaware

## Wilmington

Audio of calls to dispatch an ambulance can be found at:

[problemsatplannedparenthood.org/delaware](https://problemsatplannedparenthood.org/delaware)

February 8, 2013  
February 16, 2013

**Florida - Tampa:** An incident involving an ambulance call is listed in a health inspection document under Florida - Tampa above in Chapter 1.

# Illinois

Audio of calls to dispatch an ambulance and/or written documents can be found at:

[problemsatplannedparenthood.org/illinois](https://problemsatplannedparenthood.org/illinois)

## Aurora

December 24, 2018  
January 12, 2019  
March 12, 2019  
November 16, 2019  
April 22, 2020  
May 27, 2020  
December 12, 2021  
September 24, 2022  
March 16, 2024  
January 19, 2025  
February 9, 2025

## **Carbondale**

May 10, 2024

## **Chicago, Near North Center**

Audio of calls to dispatch an ambulance and/or written documents can be found at:

[problemsatplannedparenthood.org/illinois-chicago](https://problemsatplannedparenthood.org/illinois-chicago)

February 10, 2016  
March 23, 2016  
April 7, 2016  
April 25, 2016  
May 21, 2016  
June 16, 2016  
August 29, 2016  
November 1, 2016  
October 4, 2017  
November 16, 2017  
May 24, 2018  
July 5, 2018  
July 27, 2018  
September 5, 2018  
September 11, 2018  
October 6, 2018  
March 21, 2019  
October 30, 2019  
November 19, 2019  
July 10, 2020  
July 15, 2021  
January 20, 2023  
January 25, 2023

## **Fairview Heights**

December 19, 2019

## **Flossmoor**

December 14, 2018  
November 12, 2019  
May 8, 2020  
October 9, 2020  
May 23, 2023  
July 13, 2023  
July 25, 2023  
December 22, 2023  
August 20, 2024  
October 15, 2024

## **Springfield**

January 8, 2020  
May 27, 2020  
June 3, 2020  
August 6, 2020  
November 19, 2020  
February 4, 2021

## **Indiana**

Audio of calls to dispatch an ambulance can be found at:

[problemsatplannedparenthood.org/indiana](https://problemsatplannedparenthood.org/indiana)

## **Indianapolis, Georgetown**

November 2, 2012

# Massachusetts

Written documents can be found at:

[problemsatplannedparenthood.org/massachusetts](http://problemsatplannedparenthood.org/massachusetts)

## Boston

May 19, 2018  
May 30, 2018  
July 5, 2018  
September 7, 2018  
September 11, 2018  
October 19, 2018  
November 28, 2018  
February 4, 2019  
April 20, 2019  
April 23, 2019

# Maryland

## Annapolis

Audio of calls to dispatch an ambulance can be found at:

[problemsatplannedparenthood.org/maryland-annapolis-baltimore](http://problemsatplannedparenthood.org/maryland-annapolis-baltimore)

October 24, 2016

## Baltimore

Audio of calls to dispatch an ambulance can be found at:

[problemsatplannedparenthood.org/maryland-annapolis-baltimore](http://problemsatplannedparenthood.org/maryland-annapolis-baltimore)

December 7, 2018  
October 2, 2019

# Michigan

Audio of calls to dispatch an ambulance and/or written documents can be found at:

[problemsatplannedparenthood.org/michigan](http://problemsatplannedparenthood.org/michigan)

## Flint

August 30, 2023

## Kalamazoo

July 4, 2016  
September 10, 2015  
October 29, 2022

## Lansing

March 15, 2018

## Traverse City

October 27, 2023

# Missouri

Written documents can be found at:

[problemsatplannedparenthood.org/missouri](http://problemsatplannedparenthood.org/missouri)

## St. Louis

MO St Louis List of EMS Calls January 2009-April 6, 2016

P1 Urgent Response: 50  
P2 Urgent on the Quiet Response: 2  
P3 On the Quiet Response: 6

MO St Louis List of EMS Calls November 15, 2016-November 15, 2018

P1 Urgent Response: 7  
P3 On the Quiet Response: 2

## Nebraska



Botched Care and Tired Staff: Planned Parenthood in Crisis  
by Katie Benner, *The New York Times*, February 15, 2025

A Nebraska clinician in 2022 did not realize that a woman was four months pregnant when she inserted an IUD. Several hours later, the patient was rushed to an emergency room and gave birth to a stillborn fetus.

## New York

### Hempstead

March 2, 2023  
August 3, 2023  
April 25, 2024  
November 9, 2024

## North Carolina

Audio of calls to dispatch an ambulance and/or written documents can be found at:

[problemsatplannedparenthood.org/north-carolina](https://problemsatplannedparenthood.org/north-carolina)

### Chapel Hill

February 26, 2022  
October 7, 2022  
January 28, 2023  
April 1, 2023  
October 19, 2023

## Ohio

Audio of calls to dispatch an ambulance can be found at:

[problemsatplannedparenthood.org/ohio](http://problemsatplannedparenthood.org/ohio)

**Bedford Heights:** Two incidents involving ambulances calls are listed in a health inspection document under Ohio-Bedford Heights above in Chapter 1.

## Cincinnati

February 20, 2015  
July 27, 2017

## Columbus

October 9, 2015

## Oregon

Audio of calls to dispatch an ambulance can be found at:

[problemsatplannedparenthood.org/oregon](http://problemsatplannedparenthood.org/oregon)

## Salem

November 14, 2014

## Pennsylvania

Audio of calls to dispatch an ambulance can be found at:

[problemsatplannedparenthood.org/Pennsylvania](http://problemsatplannedparenthood.org/Pennsylvania)

**Allentown:** Two incidents involving ambulance calls are listed in health inspection documents under Pennsylvania - Allentown above in Chapter 1.

## West Chester

October 21, 2022

# Rhode Island

Audio of calls to dispatch an ambulance can be found at:

[problemsatplannedparenthood.org/rhode-island](https://problemsatplannedparenthood.org/rhode-island)

## Providence

June 11, 2014

# South Carolina

Audio of calls to dispatch an ambulance can be found at:

[problemsatplannedparenthood.org/south-carolina](https://problemsatplannedparenthood.org/south-carolina)

## Charleston

March 12, 2021

## Columbia

April 22, 2022

# Texas

## Austin

Audio of calls to dispatch an ambulance can be found at:

[problemsatplannedparenthood.org/texas-austin/](https://problemsatplannedparenthood.org/texas-austin/)

January 25, 2019

July 14, 2020

## Houston

These are all for Prevention Park, which closed on October 1, 2025.  
Audio of calls to dispatch an ambulance can be found at:

[problemsatplannedparenthood.org/closed-centers-911-calls](https://problemsatplannedparenthood.org/closed-centers-911-calls)

August 23, 2012  
December 14, 2013  
January 31, 2015  
February 6, 2015  
February 25, 2015  
February 26, 2015  
February 28, 2015  
March 10, 2015  
April 30, 2015  
June 2, 2015  
August 4, 2015  
October 19, 2015  
April 17, 2017  
October 3, 2017  
October 4, 2017  
January 31, 2018  
March 15, 2018  
March 31, 2018  
June 29, 2019  
June 30, 2018  
July 26, 2018  
August 1, 2019  
October 2, 2019  
February 18, 2020  
June 12, 2020  
November 24, 2020  
April 16, 2021  
June 9, 2021  
July 17, 2021  
August 3, 2021

## Virginia

Audio of calls to dispatch an ambulance can be found at:

[problemsatplannedparenthood.org/virginia](https://problemsatplannedparenthood.org/virginia)

## Richmond

April 12, 2024

## Virginia Beach

October 14, 2011

April 7, 2017

## Washington

Audio of calls to dispatch an ambulance can be found at:

[problemsatplannedparenthood.org/washington](https://problemsatplannedparenthood.org/washington)

## Everett

February 15, 2023

July 24, 2024

## Lynnwood

March 12, 2023

## Spokane

September 15, 2015

## Wisconsin

Audio of calls to dispatch an ambulance can be found at:

[problemsatplannedparenthood.org/wisconsin](https://problemsatplannedparenthood.org/wisconsin)

## Madison

August 9, 2016

# Google or Yelp Reviews

## Indicating Hospitalization Was Needed

*This includes emergency room visits or subsequent surgery due to complications. These are reports from any individual who wishes to post their perceptions and aren't vetted for accuracy. There are thousands of reviews, most less dire, on the website. Reviews for each center are listed under that center.*

### AZ Phoenix Desert Sky Google. Accessed 04.24.21.



Amy Colburn

4 reviews

★ ★ ★ ★ ★ a year ago

Called my doctor 4 days ago & she never called me back. I also called again yesterday & the lady apologized & said she'd definitely call me back. NEVER did! I ended up going to the ER. What a joke!

### CA Concord Yelp 2



Melly L.

📍 9 🌟 123 📷 23

★ ★ ☆ ☆ ☆ 1/3/2018

Two stars because I've gone to this location several times for basic things and always got good service. Last trip however really disappointed me. I had an appointment because I KNEW I had a urinary tract infection, told them I had it for a few weeks. They've diagnosed me for that in the past and gave me medicine. Except this time the nurse says test showed negative for UTI. I told her that's incorrect, I know how it feels. I was sent away with nothing. A week and a half later I just spent 5.5 hours in John Muir emergency for a UTI that traveled up my kidneys and caused me a kidney infection. Pretty pricey bill that could have been avoided and very painful.

### CA North Highlands Google. Accessed 06.07.21.



**Tazia Allen**  
1 review



★★★★★ 5 years ago

I took a pregnancy test and they told me it was negative so I went ahead and started depo the same day a week later im in the hospital sick as hell and come to find out im ten weeks pregnant

### CA Los Angeles Bixby Google. Accessed 06.07.21.



**Mia Rose**  
1 review



★★★★★ 5 years ago

Was given no info on what exactly was going to happen before during and after. I was awake the whole time, and the pain, there are no words. They tied my legs open with gauze. I was given no antibiotics after the procedure. And ended up in the ER ten days later with an infection on my uterus walls. Go somewhere else.

### CA San Diego First Avenue Google. Accessed 06.07.21.



**April Showers**  
1 review



★★★★★ 5 years ago

I went here to get an abortion jun 4th 2015 they killed the baby but never took the fetus out..I wasn't bleeding For the first month, I called a week after my abortion telling them I wasn't bleeding and if I should come in and get seen because I didn't think the baby was gone, they told me that they were sure the baby was gone and that it could take a few months for my bleeding to start. i called again 2 weeks later still concerned the baby was still there the nurse I spoke with told me its fine and its was normal to not bleed for the first few weeks, the nurses never suggested I go to the Dr and get seen .. Well a month later july 5th I started bleeding out of control going through a pad with in 5 min no plan parenthood was open I called a nurse and asked what I should do she told me I should go to the er and I did well the hospital had to remove the fetus.. My insurance didn't cover the hospital visit and parent planhood doesn't want to cover the cost of my hospital visit. Telling me I should have never went to the er and I should have went to a parent planhood which isn't open on Sundays ... They are more or less telling me it's my fault that they left the dead fetus in me and I should be responsible for paying my medical bill because i went to the er and not a parent planhood...

## CO Fort Collins Google. Accessed 07.30.22.



**Danni Lawrence-Cohen**

4 reviews



★★★★★ 2 months ago

If I could give them lower than a one I would! DO NOT GO HERE, they landed me in a hospital for three weeks following care with them. Be weary, stay safe.

## FL Kissimmee Google. Accessed 09.25.22.



**Samantha Hart**

1 review



★★★★★ 7 months ago

Came to this location to get my iud replaced. Firstly, most painful iud placement I've ever had, couldn't even manage to drive home so I had to sit in the parking lot for 45 mins after. Nurse was nice but obviously had no idea what she was doing. She couldn't get it placed and had to repeatedly start over. I had nothing but problems with the iud for a month before deciding to get it taken out. The doctor I saw for that was amazing and took it out quickly and with little discomfort. However, a few days after I woke up massively bleeding. After calling planned parenthood and talking to an awful nurse who had no interest in listening to my concern, I ended up going to the Winnie Palmer ER. The iud caused multiple cysts on my ovaries that had ruptured. It also gave me a massive infection that I'm still trying to get rid of to this day. Nice staff but I advise against getting any sort of iud placement here.

## FL Miami Golden Glades. Accessed 05.06.25.



**Krista**

8 reviews



★★★★★ 5 months ago

I went to have a biopsy done. It was the worst experience of my life. I usually see a practitioner at another location and she told me that I had to go to this one to do the biopsy. I was hesitant as I already suffered medical trauma and only trusted her. She assured me that I wouldn't have the same bad experience as I did with another doctor. When I arrived, it took more than 30 minutes to be taken back. I was there nearly 3 hours and was told the procedure should only be 10 minutes. It was very much like an assembly line. They were running women down a queue. It wasn't very personable at all. The sedation I was promised wasn't real. I remembered everything, was fully alert, and even felt some pain. After leaving I suffered a huge complication and was unable to get in contact with anyone at that location. I tried for hours before they closed to no avail. I ended up in the ER that night. Not a single promise or assurance that was made to me was kept. This place was supposed to give me peace of mind but instead inflicted more medical trauma on me.

**FL Orlando Google. Accessed 09.25.22.**



**Deidra James**

3 reviews



★★★★★ a year ago

Planned parenthood almost killed me. They didn't preform a procedure correctly which lead to significant blood loss coming from uterus. I was hospitalized and it was impossible to reach anyone at clinic to consult with my surgeon about the procedure performed. Which lead to an emergency procedure in the ER to correct planned parenthood procedure. Terrible office staff, Terrible doctors. If you value your life don't go here.

**FL Orlando Google. Accessed 07.23.21.**



**Megan O**

2 reviews



★★★★★ 11 months ago

I've been here multiple times However my last experience was horrible. As soon as I got home I had a clots coming out of me that were huge went to the hospital they told me I had 17 cm worth of product inside my uterus four days later I'm bleeding constantly with huge clots coming out the size of my hand long story short I ended up having a whole miscarriage at my house due to my procedure being in complete! I was in so much pain I literally felt like I was having a baby and I was 1 cm dilated at a Winnie Palmer

**IL Aurora Google. Accessed 04.29.21.**



**Morgan Kunert**

8 reviews



★★★★★ 3 months ago

Had a D&c done due to having an empty sac not developing a baby or anything inside it for a while. I will NEVER be back to you guys. I ended up in the ER last night almost septic from an infection. I called all during the week to try to be seen and they just pushed it off. This place is horrible, dirty and very rude staff.

**IL Aurora Google. Accessed 04.29.21.**



**Ant Buggs**

15 reviews



★★★★★ 9 months ago

((Cw))

IUD was put in incorrectly. Called probably 8 times screaming and begging for someone to tell me if it was normal. No one would give me even an answer and told me to come in near 20 hours later. I had to go to the emergency room. The fact that an organization I've fought for my whole life does not even care that I had to be taken to the ER, six hours after getting it in? Hurts. Still support but will not return to this location. I'm still in pain the next day after it was removed. I'd also like to say they didn't tell me what kind I was getting or any risks (I asked twice) until I was ready to go. So. Oh, and my appointment started an hour and a half late.

**IL Aurora Google 8. Accessed April 29, 2021.**



**San Davis**  
2 reviews



★★★★★ 3 months ago

The staff were respectful and helpful. The wait time was absolutely horrible. I had an operation done. I was told 8 weeks of bleeding was normal. I go to a quick care clinic to be told to see the er because I have bled for 3 months straight . I get to the er, the operation performed at this planned parenthood was not complete. I had a horrific infection due to an incomplete surgery and needed immediate surgery at the er! Would not reccomend!!!

**IL Chicago Rogers Park Google. Accessed 03.10.22.**



**Grace Arnold**  
5 reviews



★★★★★ a year ago

I got an IUD placed here. A little over a year later I started experiencing immense pain in the area and very heavy bleeding. I went back and she did an exam and said everything was fine and sent me away, saying I had a bad period. I am now in the ER over a week later with a perforated uterus, and it's infected. They diagnosed me with an ultrasound which could of been done at planned parenthood. They completely dismissed my pain and as a result missed something very serious. Seriously so upset. I tried calling and they are closed already and I can't leave a message so I will be calling as soon as they open tomorrow.

**MA Springfield Yelp**



**Elizabeth S.**  
👤 101 📌 2

★★★☆☆ 3/13/2017

The staff where really nice, but when I was there I told them that I couldn't go through with the procedure and they told me I signed the paperwork so they were going to do it anyway. Now I'm getting admitted to a hospital for having pregnancy tissue still in my uterus and an infection because of dirty tools.

## MI Livonia Google. Accessed 05.06.25



**Val Basinger**

3 reviews · 1 photo



★★★★☆ 7 months ago

Beyond terrible experience. My health was clearly not important to none of them since I ended up in the ER. Not only that, I even got an ultrasound at this PP and they couldn't even tell me that I had two ovarian cysts that are the size of a tangerine, but when I was in the ER, that was the first thing they told me about... and they weren't even looking for cysts.

Its Beyond disappointing that a medical facility cant even be straightforward with their patients.

Also, I find it crazy that I spoke to planned parenthood about my insurance days in advance before my appointment, and when I get there, the receptionist straight up asks me to pay \$600 instead of even inquiring about my insurance.

## MO St Louis Reproductive Health Google. Accessed 05.03.21.



**Jen Pagano**

2 reviews



★★★★☆ 11 years ago

There were complications that required an ambulance. Really terrible. Found out later that the doctors are careless and women have even died here. I'm not going back.

## MT Helena Google 1. Accessed 05.01.21.



**Cheyenne B**

2 reviews



★★★★☆ a year ago

My sister got an abortion there and the dr didnt take out all of the debris 2 days later my sister went in for an emergency Dnc at st Pete's because she was going into toxic shock from the left over fetus pieces

## NE Lincoln Google 1. Accessed 04.22.21.



**Miranda Niemeier**

5 reviews



★★★★★ 8 months ago

I had an IUD put in place in January of 2020 and upon insertion I felt the most extreme pain I had ever felt. A few days later I started breaking out around my legs but was treated by my physician for a "skin infection" This July I was admitted to the hospital for over a week for a violent infection in my Fallopian tubes that almost killed me. When I was taken to surgery they saw my uterus had a huge hole that almost made my surgeon give me a hysterectomy at age 21. Once we told the surgeons about the IUD insertion and the pain I had the surgeons knew (but could not physically prove) that the person that put my IUD in punctured my uterus, the break out afterwards was toxic shock, and believe whole heartily that the person that inserted my IUD KNEW that they had punctured it, because the amount of pain was NOT normal. I love and support planned parenthood but this particular one almost killed me. I support affordable healthcare for women, but not at the sacrifice of clean and thorough care. DO NOT RUN THIS RISK. DO NOT GO TO THIS PLANNED PARENTHOOD.

## NJ Shrewsbury Google . Accessed 05.04.21.



**Jae**

Local Guide · 18 reviews · 2 photos



★★★★★ 2 months ago

Brushed off by the white female doctor and later was rushed to the hospital because she didn't do her due diligence nor listen to me when I tried to tell her I felt something was off and we both seen something on the sonogram screen.

Tried to file a complaint and they never returned my call.

She seemed so bothered by having to see patients it seems. Pick another profession or leave the negative energy at the door when you get to work.

Front desk and nurse were friendly and helpful but that does not negate the poor service by the doctor.

Would not recommend this location

## NY Bronx Google added. Accessed 05.06.25



**Sally Zhang**

1 review

★★★★★ a month ago

Nurse perforated my cervix with IUD insertion. Needed emergency surgery for this

## NY Smithtown Google. Accessed 06.20.21.



**Jay Yams**

1 review



★★★★★ 8 months ago

Incompetent and rude doctors went in for a removal of ectopic pregnancy and according to my other doctor they pushed the embryo up gave up and gave me an iud I didn't ask for that is now infected and told me they didn't do the procedure . The whole building and staff is a joke and can cause serious problems in the future river head is a much better facility with doctors that can read

## OH Bedford Heights Google. Accessed 10.07.22.



**Brittany Dieffenbaugher**

1 review



★★★★★ 6 months ago

I wouldn't even give one star. I hope this review finds other women before they decide to come here for a surgical procedure. I ended up in the ER because they didn't finish the job and almost died from blood loss. Absolutely awful facility. Thankful I'm still alive to pass this message along.

## OH Kent Google. Accessed 10.08.22.

*This one is quite lengthy, so we give an excerpt. The full review is on the website's Ohio page.*



**Amber**

2 reviews



★★★★★ 5 months ago

If I could give zero stars for my experience based on the amount of emotional anguish that I've experienced over about the last week, I would. I made an appointment at this particular center to get my Nexplanon implant removed and decided to get another put in, since the gal on the phone had informed

During my approximately five hour visit to the ER, my SECOND red flag about PP and this location, should've been when the attending doctor scoffed a bit (a scoff that seemed indicative of some negative impressions of PP, to say the least) when I stated that I had gotten this implant placed there, and that was the reason for my visit to the ER. I thankfully got the implant removed by a much more competent OB-GYN several days after it was placed by PP, and I would NOT recommend this PP (or any, based on what I've learned) to ANYONE that cares about not only their physical health, but also their mental/emotional health.

**PA Pittsburgh Google. Accessed 05.15.21.**



**maria moreno**

2 reviews



★★★★★ 4 years ago

This place put me in the hospital now have to be on blood thinners for 3 months don't care what anyone says smh

**TX Arlington Google. Accessed 05.23.21.**



**Jessica Martinez**

Local Guide · 25 reviews



★★★★★ a month ago

Do not get an IUD inserted here. The recommendation for the string length is 2-3 cm. I have now gone to two doctors who cannot find the strings. I underwent painful fishing inside my cervix only to be told I have to undergo emergency surgery to get it removed as my IUD is literally just swimming inside my uterus. I remember The Dr who inserted it had finished then said she would cut it a bit more so my husband didn't feel them. I have always supported PP but it's unfortunate to know the Dr was more concerned about my husbands pleasure versus my own safety.

**UT Salt Lake City Metro Google. Accessed 05.06.25**



**Jazmyn Quenton**

6 reviews



★★★★★ 2 years ago

My friend went here to get some things done and now is in the hospital after waking up in a pool of blood and passing out because they didn't fully do there job or thoroughly check on her after the procedure I DO NOT RECOMMEND THIS PLACE!!!

**WI Madison East. Accessed 05.06.25.**



**Whiisp Disch**

1 review



★★★★★ 7 months ago

Left RPOC, however told me everything had passed through with an ultrasound for "confirmation" ...After I was told all the tissue has passed they inserted the Copper IUD (painful but staff was nice). 3 weeks later I got the Copper IUD removed from excruciating painful cramps, even after I called Planned Parenthood twice about the pain. All they said was the IUD will come out if it's rejecting and to leave it be. Not even a day later i was taken to the hospital through ambulance and admitted because I was hemorrhaging internally seems not all of the conception tissue was removed before iud insertion at planned parenthood...staff was nice but missed a huge error that almost led to me bleeding out...

# Transcript of Calls, Orange California

## May 31, 2024, Call 1:

*After questions from the dispatcher weren't answered by the worker who called, the manager came on the line:*

**Planned Parenthood Manager:** Can I help you?

**Fire Department Operator:** Hi, this is the Orange Fire Department. We just have to confirm about how far along she was so in our response we know what to send from the paramedics' end.

**Planned Parenthood Manager:** You just need to send the paramedics. They've come here many times before.

**Fire Department Operator:** They're on their way. First trimester? Second trimester?

**Planned Parenthood Manager:** First trimester. She's lost some blood. We would like to transfer her, please.

**Fire Department Operator:** I understand. Help is already on the way, but I explained to

**Planned Parenthood Manager:** Thank you!

**Fire Department Operator:** – the first person I need some more information. So we are on our way to –

**Planned Parenthood Manager:** This is not typical for you guys to ask so many questions. That's why we're kind of concerned.

**Fire Department Operator:** It's absolutely typical. This is our –

**Planned Parenthood Manager:** No, it's not. I've had, I've done this before.

**Fire Department Operator:** Allow me to do my job, okay? We're on our way. Just have her medication information available, and if anything changes –

**Planned Parenthood Manager:** We have everything ready.

**Fire Department Operator:** – just call me back,

**Planned Parenthood Manager:** we know what to do.

...

## May 31, 2024, Call 2:

**9-1-1 Operator:** 9 1 1. Emergency. Do you need police fire or –

**Planned Parenthood Worker:** If she did, she said it really softly –

**9-1-1 Operator:** Hello? 9 1 1.

**Planned Parenthood Manager:** All you have to say, "Are you refusing to send an ambulance?"

**9-1-1 Operator:** Hello? Can you hear me?

**Planned Parenthood Manager:** and she said, "Yes," and that's a documented –

**Planned Parenthood Manager:** I'm sorry, can you hear me? This is 9 1 1.

**2nd Planned Parenthood Manager:** You just need to send –

**2nd 9-1-1 Operator:** Hello. Hello.

**Planned Parenthood Worker:** Like, if we called and they hung up –

**2nd 9-1-1 Operator:** Hello?

[Hung up]

# Chapter 4



# California

## Contra Costa

### Tran



Suit Links Death to ‘Abortion Pill’  
By Jennifer Muir, *Orange County Register*, October 7th, 2005.

#### Excerpt:

The husband of a Fountain Valley woman who died after taking the so-called abortion pill RU-486 has sued the drug’s manufacturers and a local Planned Parenthood, accusing them of not warning her of the drug’s risks . . .

Tran died Dec. 29, 2003 – six days after beginning the drugs’ cycle. She was 22. An autopsy revealed evidence of sepsis, an illness caused by infection in the bloodstream, according to the complaint.

The Federal Drug Administration in July issued a public health advisory warning after four women in California, including Tran, died from sepsis after taking the drugs. The first U.S. death was reported in September 2003; a death in Canada was reported in 2001 . . .

Also named is Planned Parenthood of Orange and San Bernardino Counties . . . Tran, a former education student at Santa Ana College, received the drugs Dec. 23, 2003, at the Planned Parenthood in Costa Mesa . . . Had she known of the risks, she would not have taken the drug or would have gotten the medical attention necessary to save her life, the lawsuit said.

## Riverside

### Goode

Court Document:

[CA Riverside Meloncon 2007 Complaint for Wrongful Death and Medical Malpractice filed by her mother](#)

#### Excerpt:

5. Despite the clearly demonstrated bacterial vaginosis infection, [the nurse] proceeded to place five seaweed stick cervical dilators through . . . Goode's already infected vagina and into her cervix. Thus, the seaweed stick cervical dilators became like wicks that would take the existing local infection through the vagina into the cervix and turn the local vaginal infection into a raging systemic infection rapidly leading to sepsis and toxic shock syndrome of the entire body . . . the Riverside County Coroner determined that the cause of death was "toxic shock syndrome secondary to retained laminaria cervical dilators."



Abortion procedure caused death of Riverside woman, lawsuit alleges  
by Jonathan Abrams, *The Los Angeles Times*, June 21, 2017

#### Excerpt:

The mother of a Riverside woman who died of toxic shock syndrome after allegedly undergoing an abortion procedure at Planned Parenthood filed a malpractice suit against the organization and a Riverside County hospital this week. The lawsuit alleges that . . . a nurse inserted cervical dilators, used to gradually expand the cervix in preparation for second-trimester abortions, despite the fact that Goode had a vaginal infection.

The dilators, which are shaped like small sticks and consist primarily of seaweed, became a conduit that spread the infection to the rest of her body, the lawsuit alleges.



Mother blames Riverside abortion procedure for daughter's death  
*Orange Register*, June 25, 2007

**Excerpt:**

“My daughter made a choice, but she didn’t choose to die,” Meloncon [her mother] said. “A lost dog gets more attention than my daughter did. This has really torn at my family.”

Planned Parenthood mailed two letters to Goode stating the dilators needed to be taken out, but Meloncon said the family never received the letters. The woman said Planned Parenthood should have been more aggressive in contacting her daughter . . .

With her condition deteriorating, Goode was taken to Riverside County Regional Medical Center in Moreno Valley on Feb. 4. A blood test confirmed Goode was pregnant, and Meloncon said she asked that a pelvic examination be performed. But the hospital said it couldn’t perform one because Goode would not consent, the suit said.

“She was confused and disorientated,” Meloncon said. “It was totally out of character for what her behavior normally is.”

The hospital performed a pelvic examination Feb. 13 and found the dilators. Goode had a miscarriage that day and died the next, the lawsuit said.

## Hayward

### Patterson



“Monty Patterson Learns about RU-486 the Hard Way”  
By Julian Guthrie, *The San Francisco Chronicle*, December 5th, 2011.

#### Excerpt:

It was just after 9 a.m. on Sept. 17, 2003, when Monty Patterson got the call from the hospital. His daughter was in intensive care, and Patterson, a construction supervisor working on a home in the Oakland hills, was told to hurry. At ValleyCare Medical Center in Pleasanton, Patterson, a divorced dad, was informed that Holly, who had turned 18 three weeks earlier, had an infection from an “incomplete abortion.” The doctor said Holly had taken the abortion pill Sept. 10, and was in septic shock . . .

Efforts to save the vivacious teenager with the blond hair and bright blue eyes failed. She died shortly before 2 p.m.



“Monty Patterson Critical of Planned Parenthood After Daughter’s Death”  
By Carly Schwartz, *Huffpost*, December 6th, 2011.

#### Excerpt:

On September 17, 2003, Monty Patterson rushed to ValleyCare Medical Center in Pleasanton, Calif., where his 18-year-old daughter, Holly, was suffering from septic shock brought on by a medical abortion. Five hours later, Holly was dead . . .

Holly had visited a Planned Parenthood center a week earlier seeking RU-486 — a medical abortion pill — but the center did not follow FDA guidelines when administering the medication. As a result, Holly died from a severe infection brought on by an incomplete abortion . . .

After extensive research, Patterson claimed that it was not only the medication that killed her, but also what he believes to be its improper application, as directed by the Planned Parenthood center that Holly visited. And according to Patterson, this practice is dangerously common. In his research, he claims to have uncovered other previously unreported deaths linked to the pill.

## Los Angeles (Bixby)

### Lopez



“Clinic Doctor Faulted in Abortion Death”

By Steve Hymon, Staff Writer, *Los Angeles Times*, June 25th, 2003.

A 25-year-old woman bled to death last year after a Planned Parenthood clinic in East Los Angeles neglected to follow established medical procedures during an abortion, according to a report by the state Department of Health Services. The report also found that the clinic failed to report Diana Lopez’s death within 24 hours, as required, and that a doctor working there did not follow clinic policies that would have excluded the woman as a candidate for the procedure. . .

Among the most serious allegations in the state report is that Maltzer violated clinic procedure because he went forward with the abortion even though Lopez’s hemoglobin levels were below the clinic’s standards. Low hemoglobin levels often lead to increased bleeding. The report also states that Maltzer did not follow the clinic’s standards in waiting until Lopez was sufficiently dilated before the procedure.

The clinic did not report Lopez’s death to the state until a week later, even though such notification is supposed to be done within 24 hours, the report said.

The report also found that Planned Parenthood’s patient records lacked basic information on Lopez’s care and condition . . .

# Illinois

## Chicago

### Reaves

The autopsy report and court settlement document for \$2 million can be found at:

[www.problemsatplannedparenthood.org/illinois-chicago](http://www.problemsatplannedparenthood.org/illinois-chicago)

#### Excerpt from Autopsy:

OPINION: The cause of death of this 24-year-old, Black female . . . is due to hemorrhage resulting from cervical dilation and evacuation due to an intrauterine pregnancy.



“Family Seeks Answers After Woman’s Death Following Abortion”  
Published *Channel 2 CBS Chicago*, July 21st, 2012

#### Excerpt:

Tonya Reaves, 24, died late Friday night from a hemorrhage, with a cervical dilation and evacuation, as well as an intrauterine pregnancy as contributing causes, according to the medical examiner's office.

She died after she'd had an abortion at Planned Parenthood at 18 S. Michigan Av, according to the medical examiner's office.

Her death was ruled an accident, but the Reaves family wants to know more, especially Tonya's twin sister Toni.

"We were born the same day. She was my other half," Toni said.

Toni Reaves said the family is trying to get through this.

"It happened so fast. She was just fine one day and then the next day she was gone. We're just trying to figure out what happened. what happened," she said.

Toni Reaves said her sister was engaged to be married and had one son - Alvin - who just had his first birthday.

# Massachusetts

## Worcester

### Name Unknown

#### Incident Report “Anonymous Woman Death Incident Report”

Report available at:

[www.problemsatplannedparenthood.org/massachusetts](http://www.problemsatplannedparenthood.org/massachusetts)

#### Excerpt/Screenshot:

4

|                 |            |                   |           |
|-----------------|------------|-------------------|-----------|
| Date Reported:  | 12/31/2008 | Date of Incident: | 12/ /2008 |
| Date Submitted: | 06/22/2011 | Time of Incident: | :         |

---

#### FACILITY INFORMATION

|           |  |                    |             |
|-----------|--|--------------------|-------------|
| Facility: | Planned Parenthood Leag Ma Cnt Ma C (4163)<br>470 Pleasant Street<br>Worcester, MA 01609 | ID:                | 4163        |
|           |  | Type:              | Clinic Form |
|           |  | Facility Reported: | No          |

---

#### INCIDENT NARRATIVE

Complainant's Letter: The Complainant is reporting that allegedly a Client/Patient of this Clinic died because of medical practice by an identified Doctor. The Complainant also alleges that this Clinic has not complied with the Law and is asking DPH to investigate this Clinic's actions and death of the Client/Patient of this Clinic, who allegedly died by an The Complainant has enclosed and attached a copy of the Death Certificate of the Client/Patient.

---

# Michigan

## Kalamazoo

### Erwin-Sheppard



“Dead Woman’s Ultrasound Showed Clot, Problems after Abortion, Records Show”  
by Rosemary Parker, *Mlive Michigan*, April 13th, 2017

#### Excerpt:

Cree Erwin-Sheppard went to the emergency department at Bronson Battle Creek Hospital the evening of July 2, 2016 vomiting and in extreme pain . . . By July 4, she was dead . . .

According to the medical record of that emergency visit, shared by her brother Thursday, April 13 at a protest of her death, “the patient’s symptoms and work-up results were consistent with an incomplete miscarriage and pelvic pain.”

An ultrasound showed “the presence of a clot and/or retained products of conception,” the record shows.

She was given morphine for pain, another prescription to calm her vomiting, and prescriptions for more pain pills and anti-nausea medication to be filled after discharge.

Erwin-Sheppard was sent home with her mother with instructions to follow up with a doctor or Planned Parenthood after the holiday weekend. She died before that was possible.

A copy of an unfilled prescription for pain medication obtained from Erwin-Sheppard’s mother bears the signature of a doctor at Planned Parenthood in Kalamazoo, but the clinic, citing privacy laws, would not confirm the woman had ever been a patient there . . .

[T]he redacted death certificate received shows Erwin-Sheppard was pronounced dead shortly before 1 a.m. July 4 of “complications of intrauterine pregnancy, including (with lay translations in parentheses) pulmonary emboli (blood clots in the lungs) related to uterine vein thrombosis (blood clot in the uterus) and uterine perforation status post early vacuum aspiration (abortion) and intrauterine contraceptive device placement (placement of an IUD).”

# Nevada



Las Vegas Hospital Sued After Woman Dies from “Septic Abortion” in 2022.  
by Gregg Haas, *KLAS Channel 8 News*, September 22, 2023

## **Excerpt:**

Alyona Dixon of Pahrump died Sept. 28, 2022, six days after she sought help at a Planned Parenthood clinic for a medically induced abortion. Four days later, she went to St. Rose Dominican’s Blue Diamond campus with “sharp” lower abdominal pain that started the previous day, according to details provided in the lawsuit.

After a few tests — notably without a pelvic exam or a consultation with a gynecologist — Dixon was discharged on the afternoon of Sept. 26, the lawsuit says. She was told to follow up with a gynecologist, and go to the emergency room right away if her symptoms worsened or changed.

Dixon went to the emergency room at Desert View Hospital in Pahrump after 11 p.m. on Sept. 27, and also reported vaginal bleeding. A doctor there described her condition: “abdominal pain, vomiting and diarrhea, severe dehydration, acute renal failure, leukocytosis, sepsis, lactic acidosis, hypokalemia, sinus tachycardia, metabolic acidoses, pulseless electrical activity, respiratory failure.” After treating Dixon and seeing her symptoms improve, the doctor got approval to transfer her to a Clark County hospital.

But her condition quickly deteriorated an hour later and she remained at Desert View, according to an attorney.

As her heart rate elevated to 150 and she had trouble breathing, doctors worked to intubate and sedate her. She vomited during the process and her heart stopped. Attempts to resuscitate her failed, and she was declared dead at 5:32 a.m. on Sept. 28. The Clark County Coroner’s Office gave her cause of death as “complications from septic abortion.” . . .

When she went to Planned Parenthood, Dixon was “determined to be an appropriate candidate for elective termination of pregnancy with mifepristone followed 24-48 hours later by misoprostol intravaginally,” according to Atallah’s letter. But it does not say she was given the treatment. “She was appropriately counseled about the risks of the medical abortion and was discharged home,” the letter says.

# New York

## Manhattan

### Owens

*The full Complaint and settlement document can be found at:*

[www.problemsatplannedparenthood.org/new-york-city](http://www.problemsatplannedparenthood.org/new-york-city)

#### **Excerpt:**

16. In April, 2009, 17-year-old . . . was a senior in high school in excellent health, looking forward to graduating and attending college in the fall.

17. On the morning of April 11, 2009 [she] went to Defendant Planned Parenthood for a scheduled termination of pregnancy . . .

18. . . . Defendant [doctor] . . . noted in his operative report that the procedure was “uneventful” and that there were no complications.

19. According to Defendant Planned Parenthood’s own records, however, [she] was observed experiencing labored breathing immediately after the procedure ended at 9:20 A.M. Her oxygen saturation levels were also reported to have dropped.

20. Despite [her] apparent deteriorating condition, the Doctor and Nurse Anesthetist and Planned Parenthood failed to properly monitor her or to administer the proper treatment and failed to make timely contact with EMS until 9:43 A.M. In fact, due to the delay in recognizing and treating [her] condition, [she] was not transported to St. Vincent’s Medical Center . . . until 10:05 A.M.

21. Although St. Vincent’s was able to stabilize [her], Defendants’ delay and the resultant hypoxia caused [her] to suffer severe irreversible injury. She required a new respirator thereafter and was unable to leave the hospital. [She] died at St. Vincent’s five months later on September 8, 2009.

# New York

## Manhattan

### Buchanan

*The 2017 Complaint, letter informing of death, and new Complaint can be found at:*

[www.problemsatplannedparenthood.org/new-york-city](http://www.problemsatplannedparenthood.org/new-york-city)

:

#### **Excerpt from original Complaint**

29. That the foregoing treatment [on May 12, 2015] and management of the plaintiff . . . by the defendant . . . was performed in a careless, negligent, and improper manner . . . including the failure to properly evaluate or diagnose cervical bleeding and cancer thereby causing the plaintiff . . . to sustain severe injuries and dangers . . .
30. That by reason of the foregoing, the plaintiff . . . was severely injured and damaged, rendered sick, sore, lame and disabled, sustained severe nervous shock and mental anguish, great physical pain and emotional upset, some of which injuries are permanent in nature and duration, and plaintiff will be permanently caused to suffer pain, inconvenience, and other effects of just injuries; plaintiff incurred and in the future will necessarily incur further health care facility and/or medical expenses in an effort to be cured of said injuries; and plaintiff has suffered and in the future will necessarily suffer additional loss of time and earnings from employment . . .

#### Content of Letter, March 19, 2018

Please be advised that plaintiff . . . died on February 24, 2018. We request that action be marked Stayed. Our Office will commence proceedings to appoint an administrator of the estate.

#### Excerpt from subsequent Complaint

29. That the foregoing treatment and management of the decedent . . . was performed in a careless, negligent, and improper manner . . . including the failure to properly evaluate or to diagnose cervical bleeding and cancer thereby causing the decedent . . . to sustain severe injuries and damages and death . . .
35. That by reason of the foregoing, the decedent . . . was severely injured and damaged, rendered sick, sore, lame and disabled, sustained severe nervous shock and mental anguish, great physical pain and emotional upset, up to the moment of her death.

# Part 2: Non-Medical Problems



# Chapter 5



Cases cited here are in three categories:

- Non-reporting of cases of abuse of minors (which allowed the abuse to continue)
- Sexual harassment (of patients or of staff)
- Lack of policy to report abuse as required by law

# United States



“The Health Consequences of Sex Trafficking and Their Implications for Identifying Victims in Healthcare Facilities”  
by Laura J. Lederer and Christopher A. Wetzel  
*Annals of Health Law* - Vol 23 Issue 1, 2014, Page 77

## BEAZLEY INSTITUTE FOR HEALTH LAW AND POLICY

Despite their abusive situations, most survivors did receive medical treatment at some point during their trafficking. Of those who answered the questions about their contact with healthcare (N=98), 87.8% had contact with a healthcare provider while they were being trafficked. By far the most frequently reported treatment site was a hospital/emergency room, with 63.3% being treated at such a facility. Survivors also had significant contact with clinical treatment facilities, most commonly **Planned Parenthood** clinics, which more than a quarter of survivors (29.6%) visited. More than half (57.1%) of respondents had received treatment at some type of clinic (urgent care, women’s health, neighborhood, or **Planned Parenthood**).

Table 6. Victim Contact with Health Care Provider

| Treatment Source                   | % Reporting (N=98) |
|------------------------------------|--------------------|
| <i>Any contact with healthcare</i> | 87.8%              |
| <i>Any type of clinic</i>          | 57.1%              |
| Hospital/ER                        | 63.3%              |
| <b>Planned Parenthood</b>          | 29.6%              |
| Regular doctor                     | 22.5%              |
| Urgent care clinic                 | 21.4%              |
| Women’s health clinic              | 19.4%              |
| Neighborhood clinic                | 19.4%              |
| On-site doctor                     | 5.1%               |
| Other <sup>39</sup>                | 13.3%              |

**Excerpt:**

Case study, pp. 76-77:

During the time I was on the street, I went to hospitals, urgent care clinics, women's health clinics, and private doctors. No one ever asked me anything anytime I ever went to a clinic . . . I was on birth control during the 10 years I was on the streets – mostly Depo-Provera shots which I got at Planned Parenthood and other neighborhood clinics. I also got the morning-after pill from them. I was young and so I had to have a waiver signed in order to get these – one of the doctors (A private doctor I think) signed this waiver when my uncle took me to see him.

-- Lauren, survivor

## Alabama

### Birmingham

*The 2010 court document, Consent Agreement for Downgrade of License to Probation, can be found at*

[www.problemsatplannedparenthood.org/alabama](http://www.problemsatplannedparenthood.org/alabama)

**Excerpt:**

1. In order to settle this dispute, Planned Parenthood voluntarily accepts a downgrade of its license to operate the Center to probational status . . .

5. . . . Planned Parenthood agrees that it shall:

a) . . . the Center's policies shall also require reasonable measures to verify that any individual signing the consent for an abortion involving a minor patient is actually a parent or legal guardian capable of giving such consent . . .

b) Develop and implement written policies and procedures to ensure full compliance with the mandatory reporting requirements of the Alabama Child Abuse Reporting Act

. . .

f) . . . maintain an infection surveillance logbook in the manner required [by Alabama law] . . .

## **Mobile**

*Because this center is closed, The Alabama Department of Public Health Statement of Deficiencies can be found at:*

[www.problemsatplannedparenthood.org/closed-centers-sexual-abuse](http://www.problemsatplannedparenthood.org/closed-centers-sexual-abuse)

### **Excerpt:**

Pages 1-2:

Based on the review of the Alabama Code 1975, Title 26, Chapter 14, Reporting of Child Abuse or Neglect, facility's policies and procedures, medical record (MR), and interview, it was determined the facility failed to report reasonable suspected abuse or neglect for a minor. This affected MR # 16 and had the potential to affect all patients served by this facility.



Planned Parenthood in Mobile Failed to Report Possible Abuse of 14-Year-Old  
by Keith Lane, NBC News 15, August 26th 2015

### **Excerpt:**

The Alabama Department of Public Health confirmed that the report is from their annual inspection in Mobile back in November 2014. The deficiency report details several incidents including a case involved a 14-year-old minor identified in the report as MR#16. According to the findings, the 14-year-old had recently received her second abortion from the clinic in four months and she already had two other children. It said there was evidence that she was “abused,” but the incident wasn’t reported to police at the time.

Under Alabama’s state law, all hospital, clinic, doctors, physicians and professional health employees are “mandatory reporters” and must report when a child is “known or suspected of being a victim or child abuse or neglect”

# Alaska

## Anchorage

### **Rogers**

*The Court of Appeals document that can be found under Anchorage at*

[www.problemsatplannedparenthood.org/alaska](http://www.problemsatplannedparenthood.org/alaska)

#### **Excerpt:**

Footnote 5: Count IV was based on E.C.'s testimony that Rogers took her to Planned Parenthood on her twelfth birthday to get birth control, and that Rogers then began to have vaginal sex with her.

*Note: Police were finally notified when E.C. was 16.*

### **Thompson**

*The Court of Appeals document that can be found under Anchorage at*

[www.problemsatplannedparenthood.org/alaska](http://www.problemsatplannedparenthood.org/alaska)

#### **Excerpt:**

Dana Ray Thompson was convicted of multiple counts of first- and second-degree sexual abuse of a minor, plus multiple counts of exploitation of a minor and possession of child pornography . . .

On J.C.'s fifteenth birthday, she and Thompson went to Planned Parenthood so that J.C. could obtain birth control. After leaving Planned Parenthood, J.C. and Thompson had multiple types of sexual intercourse . . .

The prosecutor noted that J.C. lived continuously in the trailer during those months, working for Rainbow Earth. The prosecutor told the jurors that, according to the testimony, J.C. referred to Anchorage as her "home" during this time, and J.C. listed Thompson's address (i.e., the trailer's address) as her home address in her Planned Parenthood records.

# Arizona

## Phoenix

**Doe / Stevens**

*The Complaint can be found under Phoenix at:*

[www.problemsatplannedparenthood.org/arizona](http://www.problemsatplannedparenthood.org/arizona)



Planned Parenthood found negligent in reporting girl's abortion by Beth DeFalco, *Arizona Daily Sun*, Dec 26, 2002

### **Excerpt:**

A judge found Planned Parenthood negligent for failing to report to Child Protective Services an abortion performed on a 13-year-old girl in foster care . . . The girl's case dates back to 1998, when the teen went for an abortion at a Planned Parenthood clinic accompanied by her 23-year-old foster brother, with whom she was having a sexual relationship.

Planned Parenthood didn't notify authorities until the girl returned six months later for a second abortion, court records show.

Lawsuits filed on behalf of the teen contend the Glendale girl was subjected to continued molestation and sexual exploitation because the abortion provider and others didn't notify police or CPS of her first abortion on Nov. 10, 1998. The girl's attorney also argues that Planned Parenthood's gross negligence led to her second abortion six months later.

Maricopa County Superior Court Judge Cathy Holt ruled last month that the abortion provider was negligent in failing to notify authorities when the girl first came in.

## Tovar

An appeals court document can be found under Phoenix at:

[www.problemsatplannedparenthood.org/arizona](http://www.problemsatplannedparenthood.org/arizona)

### Excerpt:

Incident #1: In 2003-04, M.G. and Tovar were having sexual intercourse and . . . M.G. discovered she was pregnant. She was fifteen years old. M.G.'s mother arranged for an abortion. Tovar knew about M.G.'s pregnancy and abortion . . .

Incident #7: Shortly before her nineteenth birthday, M.G. moved into her own apartment, but Tovar "would still come over . . . and sexually abuse her."

Incident #8: Around Thanksgiving 2009, M.G. "had another abortion." She reported "she was pretty sure the child was [Tovar's] and that she went to the same place, Planned Parenthood, as she had for the previous abortion . . .

## Tempe

### Kost

The sheriff's report can be found under Tempe at:

[www.problemsatplannedparenthood.org/arizona](http://www.problemsatplannedparenthood.org/arizona)



Pinal sheriff seeks reviews of Planned Parenthood claim by Sean Holstege, *The Arizona Republic*, May 21, 2014

### Excerpt:

The Pinal County Sheriff's Office has asked two state agencies to investigate a claim that a Planned Parenthood clinic in Tempe refused to report evidence of a suspected teen rape.

That allegation, brought by a parent of an accuser, surfaced in a sheriff's report as part of an investigation involving an 18-year-old high-school student who officials suspect is connected to a series of reported sexual assaults on teenage girls . . .

On May 5, the Sheriff's Office asked the Arizona Department of Health Services to look into Planned Parenthood's handling of a 15-year-old girl who claimed Kost had raped and impregnated her. On April 17, the girl's mother told detectives that clinicians said they "did not want the hassle" of reporting the assault, according to a police report filed in court.

# California

## Affiliate: Mar Monte



A former employee sues Planned Parenthood, alleging retaliation for speaking up about harassment  
by Mary Duan, *Monterey County Weekly*, October 31, 2019

### **Excerpt:**

The woman once responsible for cultivating donors and bringing in major cash contributions to the largest Planned Parenthood affiliate in the country has sued her former employer, alleging the organization mishandled a sexual harassment and assault claim brought by another employee, then fired her when she repeatedly expressed her concerns about it.

Elizabeth Winchester says she was fired in late 2018 from the job she held at Planned Parenthood Mar Monte after she twice complained to her supervisor and CEO Stacy Cross about how they were handling the harassment and assault complaint. In her suit, filed Oct. 10 in Monterey County Superior Court, Winchester says Planned Parenthood issued her a “final written warning for alleged professional misconduct” after her second complaint, which she made on Oct. 24, 2018, and that her subsequent firing was in retaliation.

## Fresno



‘Nowhere is safe.’ Women accuse ex-Planned Parenthood official of sexual harassment.  
by Mackenzie Mays, *Fresno Bee*, October 12, 2018

### **Excerpt:**

For years, Pedro Elias was the face of Fresno’s branch of Planned Parenthood. At news conferences and events, as the director of public affairs, he stood out in a sea of women advocating for reproductive rights: A muscular man often wearing a bright pink Planned Parenthood T-shirt.

But when his employment ended in September after working for the organization since 2000, his colleagues came forward to surmise why.

“He flaunted his advocacy for women while sexually harassing and assaulting multiple women for years,” said Sarah Hutchinson, policy director for ACT for Women and Girls in Visalia.

## Los Angeles

### Lenihan



Diocese Pays \$1.2 Million In Sex Lawsuit  
by Greg Winter, *The New York Times*, April 2, 2002

#### Excerpt:

A California woman who accused a priest of sexually abusing her and then paying for an abortion when she was a teenager will receive \$1.2 million to settle her suit against the Roman Catholic Church, the two sides said yesterday.

The woman . . . said that in 1978, when she was 14, the priest . . . began a pattern of abuse that lasted throughout much of her adolescence. The contact began with fondling and kissing, she said, culminating in her pregnancy at 16.

"When I told him about the pregnancy, he told me that I had to get an abortion . . . Father John drove me to his bank, withdrew the money and gave it to me to pay for the abortion. Father John did not go with me to Planned Parenthood. I remember how alone and scared I felt."

*Note: Though the successful lawsuit was against the church, Planned Parenthood also allowed the abuse to continue since they apparently never reported; if they had, the abuse would have stopped earlier.*

### Ramirez

*The Appeals Court Document. Response of prosecutors when defendant appealed aspects of the verdict, can be found at:*

[www.problemsatplannedparenthood.org/california-los-angeles](http://www.problemsatplannedparenthood.org/california-los-angeles)

#### Excerpt:

. . . The undisputed evidence in this case established beyond a reasonable doubt that defendant continued to have sexual intercourse with his 13-year-old Daughter . . .  
BACKGROUND

. . . In July of 2010, K.R. [the daughter] had an abortion at a Planned Parenthood clinic. She did not tell the clinic staff that defendant had impregnated her, but instead made up a story about having a boyfriend her own age. The doctor told her not to have sex for three weeks after her abortion. Although she relayed this information to defendant, he resumed having sex with her a "couple of days later."

By December of 2010, defendant had again impregnated K.R. and she returned to Planned Parenthood for another abortion. The physician who performed the

second abortion testified that K.R. was approximately six weeks pregnant. After the abortion, he implanted an intrauterine device to prevent additional pregnancies.

K.R. testified that she did not have sex with anyone other than defendant during the time she lived with him.

Defendant was arrested on or before March 16, 2011, after J.R.[K.R.'s older sister] reported his conduct toward her to the police.

### **Ramos**

*The 2020 Complaint can be found at:*

[www.problemsatplannedparenthood.org/california-los-angeles](http://www.problemsatplannedparenthood.org/california-los-angeles)

## **SECOND CAUSE OF ACTION**

### **(Sexual Harassment (Government Code § 12955(a), (d)))**

43. The hostility and harassment that Plaintiff suffered included the following:

a. On many instances, Defendant . . . would pass by Plaintiff's workspace and ask her unwanted and inappropriate questions.

b. On several instances, Defendant . . . attempted to and/or did take photographs of Plaintiff as Plaintiff was sitting/working at her desk, without her knowledge and/or consent . . .

46. As a proximate result of Defendants' willful, knowing, and intentional sexual harassment of Plaintiff, Plaintiff has suffered and continues to suffer humiliation, emotional distress, and mental and physical pain and anguish, all to her damage in a sum according to proof.

47. Defendants' sexual harassment was done intentionally, in a malicious, oppressive, fraudulent manner, entitling Plaintiff to punitive damages.

## Sacramento

### Martin-Santana

|   |   |
|---|---|
|  | Medical assistant at Planned Parenthood faces sex charge<br>by Michelle Schultz, NBC KCRA Channel 3, December 4, 2013 |
|---|---|

|   |  |
|---|--|
|  | Parenthood Employee Accused Of Sexual Battery Against Patient<br>December 4, CBS Sacramento Channel 13, 2013 |
|---|--|

## San Francisco

### Cross

*The court document, People of California v. Cross, Appeal Opinion, can be found at:*

[www.problemsatplannedparenthood.org/california-s-to-z](http://www.problemsatplannedparenthood.org/california-s-to-z)

#### Excerpt:

#### Evidence at Trial

. . . K. testified that when she was 13 years old . . . appellant had her lie on his bed, took off her clothes, and had sexual intercourse with her. Appellant told K. not to tell her mother what had happened or K. would be sent to a foster home.

Over the next several weeks, appellant had sexual intercourse with K. once or twice a week when her mother was away at work. K. testified that occasionally she would pretend she was asleep, but that sometimes appellant would then get angry and punish her by taking away her cell phone or telling her that she could not see her friends. Appellant put his penis in her mouth three or four times. K. said that she did not tell her mother about any of this because she believed she would be taken away from her mother if she did.

K. told appellant that she had missed her menstrual period and he took her to Planned Parenthood where a pregnancy test confirmed that she was pregnant. K. testified that appellant told her that she "had to get an abortion."

On December 17, 2002, appellant drove K. to San Francisco General Hospital for an abortion . . . K. testified that she did not tell her mother about the abortion because she "didn't want her to have the police take me away or want her to hate me." . . .

One night, appellant's wife (Wife) caught appellant naked in bed with K. K.'s mother picked up the phone to call the police but appellant and K. convinced her that they were not having sex. About two weeks later, Wife found some old papers related to the abortion. When she confronted K., K. admitted that she had been pregnant and had had an abortion. Wife testified that K. said that appellant had told her not to tell because she would be taken away from her mother.

## Colorado

### Denver

#### Smith

*The Complaints can be found under Denver at:*

[www.problemsatplannedparenthood.org/colorado](http://www.problemsatplannedparenthood.org/colorado)

#### **Excerpt from Amended Complaint:**

#### **SUMMARY OF THE CASE**

This case seeks economic and non-economic damages arising from the Defendants' multiple failures to inquire about how a thirteen-year-old girl became pregnant, or what her relationship was to the adult man who brought her to Defendants for an abortion, despite numerous opportunities to speak to the girl alone; their failures to report known or suspected sexual abuse despite numerous indications that the man had sexually abused the girl; and administration of a long-term and undetectable form of birth control to the girl despite her fear of needles, all of which enabled the man to continue his years of sexual abuse of the girl without discovery or consequence.

#### *Note:*

*In July of 2012, the adult man was charged with two counts of felony sexual abuse and, in January of 2013, he was sentenced to 28 years in prison.*

# Connecticut

## Enfield

### Lanza

|                                      |  |
|--------------------------------------|--|
| This article is no longer on the web | Man imprisoned for sex with underage Enfield girls<br>by Zachary F. Vasile, Journal Inquirer, January 10, 2018 |
|--------------------------------------|--|

#### Excerpt:

A man convicted of having a three-way sexual encounter with two underage Enfield girls, one 14 and the other 12, when he was 18 was sentenced Tuesday in Hartford Superior Court on Tuesday to spend two years in prison . . .

Affidavits supporting Lanza's arrest claim that the older girl told Enfield police that she had a relationship with Lanza starting in February 2014 and continuing on until April 2015. She also said that he got her pregnant in November 2014, while she was still 14, and claimed that Lanza forced her to have an abortion.

The affidavits do not explain how the girl alleged that Lanza forced her to have the abortion, but did include her statement that Lanza made an appointment for her at Planned Parenthood in Enfield and that Lanza's father had driven her to the clinic.

## Norwich

### Walker

*An Affidavit can be found at:*

[www.problemsatplannedparenthood.org/connecticut](http://www.problemsatplannedparenthood.org/connecticut)

#### Excerpt:

10. That witness #1 said that the victim told her sometime in April of 2006 she (victim) was pregnant and the accused, Kevon Walker, was the father of her child. Witness #1 told the affiant that after she found out the victim was pregnant she went to Kevon Walker and told him that the victim was only fourteen years old. Witness #1 stated that she took the victim to Planned Parenthood in Norwich for an abortion . . .
11. That . . . sometime in June of 2006 the victim told her that she (victim) was pregnant a second time . . . On July 22, 2006 witness #1 said she took the victim to Planned Parenthood Clinic in Norwich for a second abortion.
12. That . . . Claudia stated the victim was pregnant for a third time and an abortion was scheduled for September 23, 2006 at the Planned Parenthood Clinic in Norwich.

## West Hartford

|                                       |   |
|---------------------------------------|---|
| This article is no longer on the web. | 3 sentenced for holding teenage girl prisoner by Jenna N. Carlesso, <i>Journal Inquirer</i> , July 12, 2008 (updated March 6, 2013) |
|---------------------------------------|---|

In the year she was held captive by a West Hartford dog trainer . . . Cramer endured the same treatment as the animals in his business: She was groomed and abused by someone she trusted, a prosecutor said Friday.

But when police found the girl locked away deep inside Adam Gault's home last summer, they did more than rescue an abducted teenager.

They broke Gault's cycle of preying on impressionable young females . . .

During the months Gault held Cramer captive, police say, he repeatedly abused and raped her, resulting in her pregnancy. He later ordered Cray to bring the girl to a Planned Parenthood clinic where, under a false identity, Cramer had an abortion.

## Delaware

### **Nurse's Testimony**

*See the full letter from Nurse Mitchell at:*

[www.problemsatplannedparenthood.org/delaware](http://www.problemsatplannedparenthood.org/delaware)

### **Excerpt:**

Sexual Harassment: I have noted Dr. Liveright inappropriately look up and down patients as well as staff members in a sexual kind of way. He actually stands back with a grin and slowly directs his eyes up and down a patient's body.

# Illinois

## Chicago

### Mitchell



Man charged in sexual assault of family member of friend by Genevieve Bookwalter, *The Chicago Tribune*, May 23, 2019

The girl was 8 years old when the attacks started . . .

The man allegedly assaulted the friend's family member about twice a week for more than three years, ending when the victim reached puberty, prosecutors said . . .

The victim told a Planned Parenthood counselor of the assaults at some point in 2006 or 2007, Gonzales said. Prosecutors and court record information did not indicate whether the counselor reported the incidents to authorities.

# Indiana

See the Court of Appeals Opinion at:

[www.problemsatplannedparenthood.org/indiana](http://www.problemsatplannedparenthood.org/indiana)

### Excerpt:

The Defendant made a conscious choice to continue his sexual assaults on the victim even after promising her that he wouldn't do it again . . . the Defendant told the victim not to tell anyone because it would ruin his life . . . He also took her to Planned Parenthood to get her birth control pills without her mother's knowledge.

## Iowa

### Lathrop

See the Iowa Court of Appeals Decision at:

[www.problemsatplannedparenthood.org/iowa](http://www.problemsatplannedparenthood.org/iowa)

#### Excerpt:

Ritchie Lee Lathrop appeals from his conviction and sentence for third-degree sexual abuse. [Conviction] AFFIRMED . . .  
Lathrop was . . . twenty-seven years old when he met fifteen-year-old C.W. in March 2005 . . .

On March 25, 2005, C.W. visited Planned Parenthood. After she obtained birth control pills, she and Lathrop began having sex “at least every other weekend, if not more.”

## Massachusetts

*All the media coverage of Dr. Roger Ian Hardy indicates he is a fertility doctor and worked at various fertility clinics, primarily in Boston, but there is also documentation that he also worked at Planned Parenthood centers. The Boston Globe has quite a bit of coverage of this case; this article offers the best summary:*



Why didn't anyone stop Doctor Hardy? In college and in his medical practice, Roger Hardy left a long trail of women who said he abused them.  
by Liz Kowalczyk and Patricia Wen, *The Boston Globe*, December 6, 2015

# Michigan

## Ann Arbor

### **Borokwa**

*The 2019 Court Complaint and the Settlement Order can be found at:*

[www.problemsatplannedparenthood.org/michigan](http://www.problemsatplannedparenthood.org/michigan)

#### **Excerpt:**

28. Plaintiff was continually harassed by Defendant . . . during her employment with Defendant PPM.

29. Plaintiff reported this harassment . . .

30. Plaintiff made continuous complaints and no action was taken . . .

35. The following day, at the conclusion of the training, Defendant . . . hugged Plaintiff goodbye, when doing so he rubbed his hand down her back to her butt, and kissed her on the forehead.

36. On November 22, 2017, after discussing Defendant's . . . inappropriate behavior with her female coworkers, Plaintiff's female coworker sent an email on behalf of a group of female employees, including Plaintiff, as a complaint. . .

46. Plaintiff was advised that an investigation was open regarding the harassment matter.

47. Plaintiff was never approached by any team member regarding the investigation. Defendant PPM allowed Defendant's . . . harassment and discrimination to continue after being made aware of the ongoing harassment and discrimination . . .

69. Plaintiff was terminated on May 23, 2018, and was told the reason for her termination was because she was "not fit for the company." . . .

71. Plaintiff was retaliated against for her sexual harassment complaint against Defendant Lockett by being placed on a Professional Development Plan and by being terminated.

# Minnesota

## Frederick

*The Michigan Court of Appeals Decision Affirming Conviction can be found at:*

[www.problemsatplannedparenthood.org/minnesota](http://www.problemsatplannedparenthood.org/minnesota)

### Excerpt:

[Page 2] Based on the stipulated evidence, the district court found Frederick guilty of first-degree criminal sexual conduct . . . Frederick was 42 years old and the complainant, S.H., was 14 years old when the conduct occurred . . . review 1A used condom in a dated, sealed bag with S.H.'s name on it was found in Frederick's bedroom and DNA testing matched S.H. and Frederick.

[Page 5] Frederick took her to Planned Parenthood to get birth control.

*Note: Because Planned Parenthood didn't report this to authorities as required by law, the abuse continued.*

# New York

## Rochester

*Commissioner's Order Number 7906 can be found at:*

[www.problemsatplannedparenthood.org/new-york](http://www.problemsatplannedparenthood.org/new-york)

## Lizardi

### Excerpt:

(a) On or about February 2, 1983, while the Respondent was employed at Planned Parenthood of Rochester . . . the Respondent preformed a gynecological examination on Patient A . . . During this examination, the Respondent without medical purpose:

- (i) Stimulated Patient A's clitoris;
- (ii) Questioned Patient A about her sexual ac tivities; and
- (iii) Told Patient A that she had a pretty face and beautiful eyes, while touching Patient A's breasts.

(b) In or about July 1983, while the Respondent was employed at Planned Parenthood, the Respondent performed a gynecological examination on Patient B. During this examination, the Respondent without medical purpose:

- (i) Suggested to Patient B that she call him anytime she wanted;
- (ii) The Respondent subsequently telephoned Patient B at her home in or about August, 1983 and had sexual relations with her; and
- (iii) Patient B returned to Planned Parenthood in or about September 1983, because of a vaginal infection. During Patient B's examination, the Respondent spoke to Patient B in an obscene, threatening and disparaging manner.

## Ohio

### Roe / Haller

*The 2007 appeals court document can be found at:*

[www.problemsatplannedparenthood.org/ohio](http://www.problemsatplannedparenthood.org/ohio)

### **Excerpt from the Facts and Procedural History**

Pages 3-4:

6} In the fall of 2003, when Jane was 13 and in the eighth grade, she began a sexual relationship with her 21-year-old soccer coach, John Haller. In March 2004, Jane discovered that she was pregnant and told Haller. Haller convinced Jane to have an abortion. He called Planned Parenthood and attempted to schedule an abortion for her. Planned Parenthood told Haller that he could not schedule the procedure and that Jane would have to make the appointment. After this conversation, Haller told Jane to schedule it, and he also instructed her that if asked to provide a parent's telephone number, she should give Planned Parenthood his cell phone number in lieu of her father's phone number.

7} Jane called Planned Parenthood and told an employee that she was 14 years old and that her parents could not accompany her. She asked whether her "stepbrother" could come with her. The employee asked whether Jane's parents knew about her pregnancy. Jane lied and told the employee that one or both of her parents knew. In fact, neither knew. Jane gave the employee her father's correct name and address, but she lied twice more, telling the employee that her father did not have a home phone number and then giving Haller's cell phone number as her father's phone number.

8} Planned Parenthood scheduled the abortion for March 30, 2004. The employee told Jane that someone would have to stop at Planned Parenthood to pick up an information packet but that Jane did not have to personally retrieve the packet. Sometime before the procedure, Haller picked up the information packet for Jane . . .

13} Haller ended the relationship soon afterward. After the breakup, a teacher overheard an argument between Jane and Haller's sister, a classmate of Jane's, about Haller and his relationship with Jane, including references to Jane's sexual relationship with Haller. The teacher reported the suspected sexual abuse to the police. After a criminal investigation, Haller was convicted of seven counts of sexual battery. A criminal investigation was also conducted into Planned Parenthood's culpability, but the Hamilton County prosecutor did not prosecute Planned Parenthood for any statutory violation.

## Fairbanks

*Fairbanks v. Planned Parenthood Southwest Ohio Region et al.*  
Filed May 7, 2007. Settled September, 2012.

In her own words, a letter from Plaintiff Fairbanks, January 2, 2012:

She's out there. Somewhere. A girl just like me. Somewhere there's a young innocent girl—barely a teenager. And right now, she's suffering from the horrors of sexual abuse at the hands of an adult as I did. Somewhere “that girl” is getting raped. Like I was. Impregnated. Like I was.

And she may be taken to a Planned Parenthood abortion center. Like I was. “That girl” may actually be *telling* Planned Parenthood that she's being abused. Probably by her boyfriend. In my case, I was abused by my own father . . .

I was thirteen years old when my father started to abuse me, and my father continued to abuse me for almost two years after he took me to Planned Parenthood to have an abortion.

## Pennsylvania

### Philadelphia (Locust Street)

*The inspection document can be found at:*

[www.problemsatplannedparenthood.org/pennsylvania](http://www.problemsatplannedparenthood.org/pennsylvania)

#### **No policy for sex abuse reporting**

#### **Excerpt:**

Based on feedback from surveyor during the August 29, 2013 survey, the surgical center manager reviewed Pennsylvania State law and PPSP protocols specific to mandatory reporting at center staff meeting on September 17, 2013. PPSP Chief Operating Officer and Manager of Center Quality with legal consultation will revise current protocol to include language on when to ascertain if the child had sexual intercourse with an individual who was four or more years older than the child. The revised protocol will be in place by January 15, 2014 . . .

Lack of documentation when reporting child sexual abuse as revealed in survey 8/29/13 was reviewed at the 9/17/13 center staff meeting. Detailed instructions on required documentation was reviewed.

# Texas

## Austin

### Lenox



Accused child sex trafficker became victim's guardian  
by Andy Jechow, KXAN, Austin NBC news affiliate  
February 6, 2017

#### Excerpt:

A Del Valle man accused of sex trafficking a 16 year old is alleged to have gained guardianship over the girl, removed her from school, vowed to marry her and at one point threatened to kill her family.

James Aaron Lenox, 51, was arrested Monday afternoon by the Lone Star Fugitive Task Force in the 10200 block of FM 812 in Austin. He has been charged with trafficking a child — causing the child to engage in sexual conduct, a first degree felony

...

Lenox told police he took the victim to Planned Parenthood in Austin because she had never been to a doctor. He told investigators the victim was worried about having some kind of disease. In an interview, the victim told police she had sexual encounters with Lenox . . .



Warrant: Central Texas man forced teen into sex, threatened to 'kill her family'  
by Tyler White, *San Antonio Express News*, February 7, 2017

#### Excerpt:

Lenox also allegedly took the girl to Planned Parenthood to get an IUD implanted, the documents said.

## Houston

*The full Consent Decree of the Equal Employment Opportunity Commission can be found at:*

[www.problemsatplannedparenthood.org/texas-houston-stafford](http://www.problemsatplannedparenthood.org/texas-houston-stafford)

### **Castro**

*No incidents are detailed, and Planned Parenthood denies culpability, but settled the case for a \$40,000 payment plus agreeing to training and policy changes to prevent sexual harassment of employees.*

## Washington State

### **Savanah**

*The full Savannah Appeals Decision can be found at:*

[www.problemsatplannedparenthood.org/washington](http://www.problemsatplannedparenthood.org/washington)

### **Excerpt:**

*(Savanah is the defendant; his daughter is only identified as R)*

After Savannah's daughter, R, disclosed that she had been sexually abused, the State charged Savannah with four domestic violence sex offenses. At trial, R testified at length to the abuse. R stated that Savannah raped her for the first time when she was 14 years old. She recounted sexual abuse that continued for the next seven years.

R testified that she became pregnant three times, when she was 14, 16, and 17 years old. In each case, Savannah took her to Planned Parenthood for an abortion. Records from Planned Parenthood confirmed that Savannah took R to the clinics for the procedures.

## Bellingham

**Gonzalez-Jose**

|                                   |   |
|-----------------------------------|---|
| This article is no longer on web. | <i>The Bellingham Herald</i> , May 16, 2014 |
|-----------------------------------|---|

An Everson man who impregnated a preteen girl and forced her to have an abortion must serve a six-year prison sentence, then leave the country.

Luis Gonzalez-Jose, 31, raped the girl at a home in rural Whatcom County while her mother was in the shower, according to charging documents filed in Whatcom County Superior Court.

He brought the girl to a Planned Parenthood clinic in August 2012. She told staff members that her 14-year-old boyfriend impregnated her, but she couldn't give the boy's name or address.

Six weeks after the abortion, the girl told a detective how she had really become pregnant.

## West Virginia

**Puskas**

*This center has been closed for some time. The full West Virginia Court Memorandum Opinion and Order can be found at:*

[www.problemsatplannedparenthood.org/closed-centers-sexual-abuse](http://www.problemsatplannedparenthood.org/closed-centers-sexual-abuse)

### **Excerpt:**

“the victim advised that during the period that she and Puskas were sexually active, he would drive her to a Planned Parenthood Clinic in Parkersburg, West Virginia, so that she could receive birth control injections.”

# Chapter 6



# United States



Planned Parenthood Has a History of Trying to Beat Back Labor Unions.  
Erin Heger, *ReWire News Group*, July 19, 2018

## Excerpt:

Out of 56 Planned Parenthood affiliates across the United States, only five are unionized, according to the Planned Parenthood Federation of America (PPFA): Planned Parenthood of New York City, Planned Parenthood Metro D.C., Planned Parenthood of Central and Western New York, Planned Parenthood of the Great Northwest and Hawaiian Islands, and Planned Parenthood Columbia Willamette.



Planned Parenthood Is Accused of Mistreating Pregnant Employees  
by Natalie Kitroeff and Jessica Silver-Greenberg, *The New York Times*, December 20, 2018



Botched Care and Tired Staff: Planned Parenthood in Crisis  
by Katie Benner, *The New York Times*, February 15, 2025

## Excerpt:

Salaries are so low that it is not unusual for staff members to qualify for Medicaid and federal food assistance.

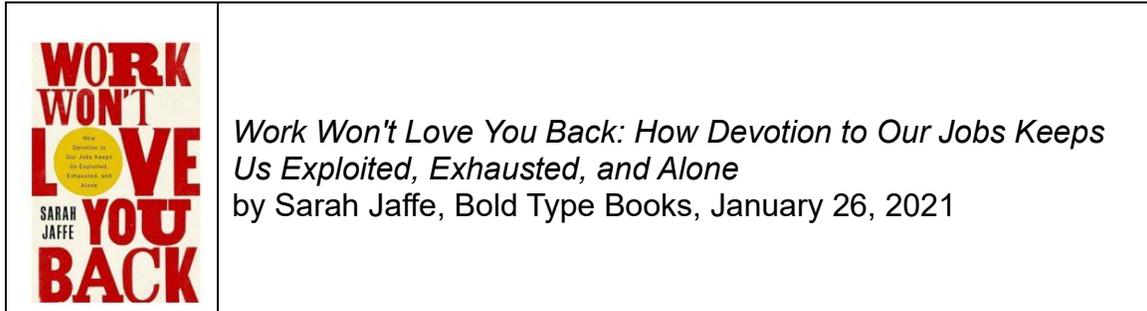
Turnover is hovering at around 50 percent a year in many parts of the country, and clinic workers complained that they were learning from inexperienced peers. More than a dozen said they did not receive adequate training for patient intake, blood draws and other tasks.

“We’re begging for supplies, and we get denied constantly because they just can’t afford it,” said Ashley Schmidt, a training and development specialist in Nebraska who resigned in December.

[*Picture caption*]: The broken air conditioning at an administrative center in Iowa kept temperatures in the 90s for several weeks, according to photos and text messages about the problem . . .

Scores of former employees have sued Planned Parenthood, raising complaints that include refusing to pay overtime or provide breaks, pushing out employees who needed time off to deal with injuries or newborn babies, and firing people who complained about discrimination or clinic practices.

Planned Parenthood said that it does not retaliate against employees. The organization has settled most of these claims.



### Book Excerpt, Page 167

Brink was in a unique position during the union drive. As a traveling employee, she was able to talk to many more of her colleagues than the average health-center staffer. But that additional work made her life even more exhausting, she said: “I can honestly say that there was a solid six to eight months that I cried every day on my way home in my car. Trying to unionize is also a job in and of itself. It was all of the emotional pieces of my job, and then another job, plus travel time.” Because, of course, during the union drive, she was still doing the rest of her job, as were all her coworkers (aside from the time they spent in those anti-union meetings, which took away from their work time). It frustrated her that hourly staff, like her, were being “nickel and dimed”: they were sent home early if the clinic was slow; if budgeting was tight, their hours might be cut back. “That was always hurtful, this idea that we were disposable . . .”

## Affiliate: Arkansas, Kansas, Missouri, Oklahoma



Planned Parenthood Great Plains Cuts Staff Amid Complaints Of 'Chaos and Toxicity'  
by Dan Margolies, KCUR (Kansas City Public Radio),  
July 9, 2020

## Affiliate: California – Mar Monte

**Mendoza**

*The 2018 Class Action Complaint can be found at:*

[www.problemsatplannedparenthood.org/california-san-jose](http://www.problemsatplannedparenthood.org/california-san-jose)

2. This Complaint challenges systemic illegal employment practices resulting in violations of the California Labor Code against employees of Defendants.

3. . . . Defendants . . . have acted intentionally and with deliberate indifference and conscious disregard to the rights of all employees by failing to pay proper minimum, regular and overtime wages, failing to provide rest breaks, failing to provide accurate itemized age statements, and failing to timely pay wages to terminated employees.

**Noye**

*The 2019 Complaint can be found at:*

[www.problemsatplannedparenthood.org/california-san-jose](http://www.problemsatplannedparenthood.org/california-san-jose)

### **CA Mar Monte Noye 2019 Labor**

7. Plaintiff, . . . an African-American female, over age 45, was hired by Defendant . . . in 2008. Plaintiff was a dedicated, hardworking employee that provided over 10 years of service . .

8. In or about June 2018, Plaintiff began to raise complaints about unethical hiring practices, ageism and discrimination that was taking place . . . Once the complaints were lodged, Plaintiff's work environment became hostile.

9. The hostile work environment included but was not limited to the forgoing: Plaintiff's supervisors began to disproportionately micro-manage her work; Plaintiff was singled out for criticism by her supervisors; Plaintiff was disparately monitored by her supervisors; and Plaintiff's ability to perform her day to day work functions was substantially hindered.

10. On or about September 25, 2018, Plaintiff again reported her concerns about unethical hiring practices, ageism and discrimination, as well as her concerns that she believed that she was being retaliated against at Planned Parenthood Mar Monte, Inc. for Whistleblowing.

11. The very next day after Plaintiff raised her legitimate complaints, she was terminated.

## Affiliate: Colorado, New Mexico, Nevada



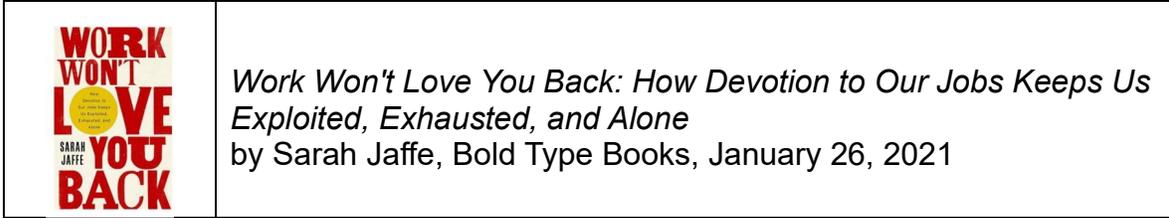
Planned Parenthood's Union Busting Could Have a Chilling Effect for Workers Everywhere,  
by Rebecca Burns, *In These Times*, June 25, 2018



'Frustrating,' 'Confusing': Planned Parenthood Workers Grapple With Organization's Union Fight: A fight in Colorado over Planned Parenthood unionization has some wondering why the reproductive health-care champion would stand in the way,  
by Erin Heger, *ReWire News Group*, June 14, 2018



Planned Parenthood is Asking Donald Trump's Labor Board for Help Busting its Colorado Union: If Planned Parenthood is to prevail, it could be a setback for similar workers across the country  
by Aida Chávez, *The Intercept*, May 23, 2018

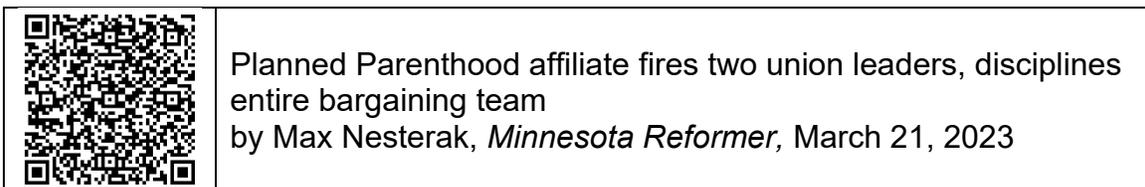


**Book Excerpt, Page 166**

But it wasn't [Cecile] Richards the burgeoning union had to negotiate with – it was the leadership at the regional affiliate. And that leadership hired a law firm, Fisher Phillips, that on its website trumpets its services in “union avoidance.”

[Ashley] Brink was surprised at the intensity of the anti-union campaign from her bosses. They held captive audience meetings – a common anti-union tactic, where part of the workday is carved out for all staff to attend a lecture on the potential downsides of a union. At PPRM [Planned Parenthood of the Rocky Mountains], Brink noted, that meant holding time where patients wouldn't be scheduled in order to have the meetings. “They were claiming that there would be pay freezes because it takes so long to bargain to get pay changes, that it was going to negatively impact our relationships with our managers, that it was going to negatively affect patient care,” she said. But Brink felt the union would improve patient care, because the workers would no longer be burned out, exhausted and worried about how to pay the bills.

**Affiliate:**  
**Iowa, Massachusetts, Minnesota,**  
**Nebraska, South Dakota**



**Excerpt:**

Planned Parenthood North Central States has fired two members of the elected bargaining team in charge of negotiating wages, benefits and working conditions for hundreds of newly unionized employees across five states.

The other 11 bargaining team members have received “final written warnings,” which says they can be terminated immediately if they violate any other policy. It's a uniquely severe form of discipline that longtime employees say they hadn't heard of before . . .

Yet union leaders say Planned Parenthood’s hardball approach is reminiscent of giant corporations like Amazon, Starbucks and Tesla, which have waged expensive campaigns to prevent the proliferation of unions among their rank-and-file workers.

“I’ve never seen anything like this,” said Phillip Cryan, executive vice president for SEIU Healthcare Minnesota & Iowa.

“It has been really concerning to see the way that the organization’s leadership has decided to treat the elected members of their bargaining team in ways we’ve literally not seen any other employer ever do,” he said.



After ‘unprecedented’ disrespect from Planned Parenthood, union plans to escalate contract campaign in the *Union Advocate*, September 8, 2023

### Excerpt

:

“For my mental health, I am leaving – like so many other leaders of this bargaining team have done since receiving their final notices,” Clark said, choking back tears. “Unfortunately, so are many of our other coworkers. I don’t know anyone who isn’t actively looking for employment elsewhere, and that isn’t hyperbole.”

For Clark and others, the final straw came during negotiations last week. Previous sessions had yielded “slow but steady progress,” health educator and LGBTQ care coordinator Elizabeth Wolfe said, and at a meeting in July, management pledged to bring a new health insurance proposal to the next session.

But instead of new health care language, Wolfe said, PPNCS executives offered the union a choice between a three-year contract with “minimal wage increases,” or one with bigger raises that clawed back several agreements reached earlier in negotiations, including longevity pay, increases to paid time off and floating holidays, expanded bereavement leave and new professional development opportunities.

“What the negotiators and leaders of our union have told us is that they’ve never seen an employer make a proposal to undo so many substantial pieces of progress already won through the bargaining process,” Wolfe said.



Unionizing Planned Parenthood  
by Becca Andrews, *Capital & Main: Investigating Money, Power and Society*, March 25, 2024

**Excerpt:**

Tensions escalated after workers voted to unionize in July 2022. Contract negotiations were slow, say workers, and coupled with management hostility. “The union-busting started as soon as we unionized,” Larson said. In spring 2023, Planned Parenthood North Central States management informed Larson and 11 other members of the union’s bargaining team that “final warnings” [had been placed](#) in their personnel files after management apparently obtained a copy of an encrypted chat indicating that workers were organizing. The next infraction at work, even a paperwork error, could be grounds for firing someone. When Larson sent a personal email last March to a partner organization accusing a co-worker of assault, there was no warning left. Larson said the manager of human resources fired her “on a five minute Zoom call.” SEIU filed an unfair labor practice complaint against Planned Parenthood North Central States, charging that the affiliate had fired Larson in retaliation for union organizing; the case remains open with the National Labor Relations Board.

Management’s resistance to the union’s demands was so profound that in fall 2023, SEIU Healthcare Minnesota [rescinded](#) its endorsement of the state representative who’d recently taken on the job of CEO, Ruth Richardson.

## **Affiliate:** **Maine, New Hampshire, Vermont**



New Planned Parenthood Union Takes to the Street  
by Arnie Alpert, *The New Hampshire Center for Public Interest Journalism*, August 29, 2021

**Excerpt:**

The issue in contention is wages, which union members say are too low at the low end of the agency’s pay scale and rising too slowly for long-term employees.

New When Katelin Smith, a Holderness resident, arrived, she quickly grabbed a blank placard and marker to make a sign that said, “I cannot afford the care I provide.” Others made signs reading, “Better Pay, Help Us Stay,” and “A Livable Wage is All the Rage.”

# Arizona

The 2017 Complaint can be found under Glendale at:

[www.problemsatplannedparenthood.org/arizona](http://www.problemsatplannedparenthood.org/arizona)



Planned Parenthood Whistleblower Awarded \$3M, Ending Wrongful Termination Case  
by Brianna Smith, Legal Reader, August 23, 2019

## Excerpt:

According to the suit, a former Planned Parenthood director, Mayra Rodriguez, sued the organization for wrongful termination in 2017 after 17 years of service. Towards the end of her career, she began reporting that the “organization was endangering the health and safety of the women visiting their facility.” Soon after, she was fired.

Though Rodriguez’s suit did not list specific damages she hoped to win, a two-week trial and a three-hour deliberation resulted in an Arizona jury siding with her. In the end, the jury unanimously awarded her \$3 million for acting as a whistleblower . . .

What were the accusations included in the suit, though? What were the issues Rodriguez reported that led to her wrongful termination? For starters, the lawsuit included several “accusations against Planned Parenthood that demonstrated its lack of medical care, concern for patients, and unethical practices.” Her suit added that “Planned Parenthood fired her after she observed its many violations of state law and ethics guidelines, and after it fabricated a bunk claim that she had narcotics in her desk.”

Additionally, “a couple of months before her termination, Rodriguez made several complaints against doctors and questioned business practices,” according to the suit. On top of that, she began to notice a pattern of a “Planned Parenthood official performing abortions on patients who then experienced significant complications, including bleeding and cramps.” The suit further stated, “Ms. Rodriguez was concerned about the substantial health, welfare, and safety risks to these patients, as well as the substantial risk to the health, safety, and welfare of the inevitable future of PPA patients.”

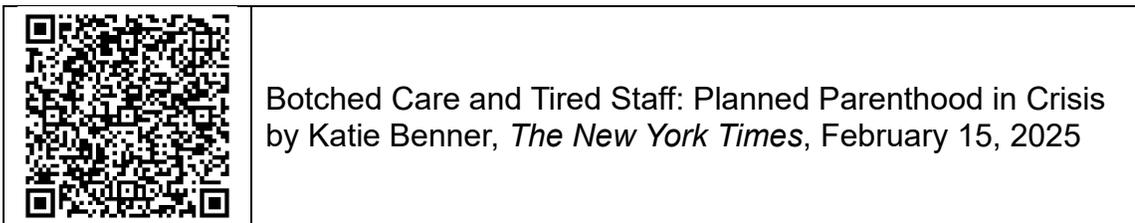
As if those claims weren’t enough, the suit also alleged that a handful of medical assistants often “complained about working with the same doctor during abortions and that the doctor had been requiring the assistants to sign an affidavit stating the abortion procedure was performed properly before they even did the procedure.” The suit stated:

*“The medical assistants believed the attestations were premature, wrong, and illegal because the abortion surgery had not yet been performed and they were concerned about the quality and thoroughness of the procedures.”*

On one occasion, a medical assistant even had to track down the doctor “after an ultrasound revealed the doctor had placed an IUD in a patient before an abortion was fully completed.” On another occasion, one of the facility’s managers allegedly “did not report that a minor with an adult partner was seeking an abortion, a blatant violation of state law meant to protect potential victims of statutory rape.”

Eventually, Rodriguez voiced her concerns to her supervisor, even though she did not feel comfortable doing so because her supervisor and doctor in question were friends.

Soon after the jury’s decision, Tim Casey, Rodriguez’s attorney, met with reporters and said “the jury found Rodriguez was doing her job by reporting her concerns . . . It vindicated what she found and it ought to help our community be safer.”



**Excerpt:**

As for the staff, morale problems have persisted. In Arizona, a planning report in 2023 found that the affiliate was suffering from “prior operational mismanagement, a fragile financial state, and staff recruitment retention and morale issues.” The report cited “chronic underinvestment and negligence” among problems that had led to a “poor patient experience.” . . .

Several clinic employees there quit, citing a work culture they called “chaotic” and “toxic” and low wages, according to a separate 2023 report by an outside consulting firm. The report said that clinic staff members made about 20 percent less than other health care workers in the region.

“Staff have been explicitly told to get part-time work in order to cover their basic needs,” the report said. It said that staff members worked after hours without clocking in “because the work must get done.”

# California

## Chula Vista

### Murray

*The 2014 Complaint can be found under Chula Vista at:*

[www.problemsatplannedparenthood.org/california-a-f](http://www.problemsatplannedparenthood.org/california-a-f)

#### Excerpt:

14. In or about the late summer or early fall of 2012, [Plaintiff complained to [Defendant] that the Chula Vista clinic was in violation of the law because Mendoza was directing non-licensed Clinicians to access the locked medication cabinet and dispense medication to patients . . .

15. [Defendant] began to retaliate against Plaintiff . . .

25. Despite Planned Parenthood's mission as alleged, the Chula Vista clinic manager (a non-licensed staff member), authorized the injection of birth control to a minor patient, against the will of the minor and absent an order by a licensed medical provider. This unauthorized administration of medication without a license was, and is, a violation of California law . . .

35. On or about March 30, 2013, [Plaintiff] was terminated. In its termination letter, Planned Parenthood indicated that [Plaintiff] was terminated because her performance was "below expectations."

36. A short time later, Planned Parenthood reported to the California Employment Development Department that Plaintiff was terminated because after she reported the March 8<sup>th</sup> incident, Plaintiff "refused to move on."

37. Plaintiff is informed and believes, and thereon alleges that she was terminated because she reported her supervisor's unlawful administration of medication without a license.

## Coachella

### **Barron**

*The 2012 Complaint can be found under Chula Vista at:*

[www.problemsatplannedparenthood.org/california-a-f](http://www.problemsatplannedparenthood.org/california-a-f)

#### **Excerpt:**

7. Plaintiff began working for defendants in or about 1987 . . .

11. In or about February 2012, plaintiff notified defendants' human resources department that plaintiff's physician, who had been treating plaintiff for a shoulder condition, restricted the distance plaintiff could drive . . . Despite the fact plaintiff had in the past successfully performed her job duties on a remote/telecommuting basis while working in Riverside County, defendant's human resources department informed plaintiff defendant would not be able to accommodate plaintiff's driving restrictions and would not permit her to work remotely or on a telecommuting basis. Defendant told plaintiff the only accommodation it would provide plaintiff was a leave of absence . . . Plaintiff provided the required medical certification from her physician with defendants approving the leave of absence on or about March 19, 2012, and designating the leave of absence as a leave taken under the California Family Rights Act (CFRA) set forth in Government Code § 12945.2 . . .

18. On or about March 20, 2012, while plaintiff was still on her CFRA leave which was set to expire on May 15, 2012, defendants terminated plaintiff thus refusing to reinstate her to her previous or comparable position upon expiration of her leave of absence under CFRA . . .

35. Plaintiff is informed and believes, and based thereon alleges, her physical disability was a motivating factor in defendants' decision to terminate her employment . . .

## Fresno

### **Aoki**

*The 2015 Complaint can be found under Fresno at:*

[www.problemsatplannedparenthood.org/california-fresno](http://www.problemsatplannedparenthood.org/california-fresno)

*Note: The complaint details several incidents in detail.*

8. In or around August 2012, Ms. Aoki was hired by Planned Parenthood as a Response Center Agent in Clovis, California . . .

9. Throughout Ms. Aoki's employment with Planned Parenthood, [E.R.] was head of the Planned Parenthood Response Center . . . From the beginning of Ms. Aoki's employment with Planned Parenthood, Ms. Aoki regularly hear Planned Parenthood

employees complain about [E.R.] because he yelled at employees, retaliated against employees who complained about him, and made disparaging remarks toward female employees . . .

18. Ms. Aoki understood [E.R.]’s regular reference to female employees as his “bitches” as sexual harassment . . .

21. . . When Ms. Aoki encouraged the female coworkers to report [E.R.]’s sexist comments, the female coworkers told Ms. Aoki that [E.R.] had a close relationship with Human Resources and that nothing could be done to stop [E.R.]’s behavior . . .

32. After [E.R.] closed the door to his office, Ms. Aoki saw that he was visibly furious. [E.R.]’s hands were shaking and he was red in the face. Ms. Aoki was scared that [E.R.] was going to react violently to any complaints . . .

41. Ms. Aoki was terrified and on the verge of tears. Her supervisor had gotten in her face, nearly hit her, and screamed at her and all the other template specialists in an enraged and demeaning tone. After thinking about all of [E.R.]’s sexist comments as detailed above, Ms. Aoki feared [E.R.]’s repeated harassment and that he might physically assault her . . .

56. Between January 31, 2017 and February 2, 2017, Ms. Aoki heard from at least two co-workers that [E.R.] was showing Ms. Aoki’s resignation letter to other employees. [E.R.] also told employees that [two supervisors] told him that he “did not have anything to worry about.” [E.R.] was bragging about the fact that Planned Parenthood managers had ratified his harassing and retaliatory behavior.

61. To this day, Ms. Aoki has never received any information from Planned Parenthood about the results of this investigation or any investigation that Planned Parenthood made as a result of her Ms. Aoki’s complaints about [E.R.]’s sexual harassment and retaliation.

## **Los Angeles**

### **Abutaleb**

*The 2022 Complaint can be found at:*

[www.problemsatplannedparenthood.org/california-los-angeles](http://www.problemsatplannedparenthood.org/california-los-angeles)

26. Plaintiff and the Aggrieved Employees were required to clock in at the beginning of their shifts and out at the end of their shifts by calling Defendants on their personal cell phones. Plaintiff and the Aggrieved Employees were not paid for all hours worked because employees were required to work off the clock and because Defendants unlawfully rounded the hours worked . . .

27. . . . Plaintiff and the Aggrieved Employees were required to work off the clock without proper compensation including . . . attending pre-shift and post-shift activities, COVID-19 related screenings, and cellular phone use outside of scheduled shifts. Plaintiff and the Aggrieved Employees were also required to attend a firearms training, but were not compensated for the hours spent at said training.

28. Plaintiff and the Aggrieved Employees were regularly required to call Defendants on a day they were scheduled to work or a day before in order to be informed of their exact hours. However, due to the uncertainty of which schedule they would be assigned for the following day,

they were forced to remain available the entirety of the following day. Plaintiff and . . . the Aggrieved Employees, were not compensated for on-call or standby time.

29. In addition, Plaintiff and the Aggrieved Employees worked in excess of eight (8) hours in day and/or over forty (40) hours in a workweek. However, they were not properly paid for such time . . .

36. . . . Plaintiff and the Non-Exempt Employees were systematically not authorized and permitted to take one net ten-minute paid, rest period for every four hours worked or major fraction thereof, which is a violation of the Labor Code and IWC wage order . . .

42. Defendants also failed to provide accurate, lawful itemized wage statements to Plaintiff and the Aggrieved Employees in part because of the above specified violations . . .

## **Barton**

### **Excerpt, Trellis Case Complaint Summary**

Filing Date June 24, 2024 / Case #24STCV15716 / Matter Type Wrongful Termination

This complaint filed by [Plaintiff] against Planned Parenthood Los Angeles and others alleges retaliation in violation of California Labor Code sections 1102.5 and 98.6, as well as wrongful termination in violation of public policy. The complaint outlines that [Plaintiff], a Behavioral Health Therapist, reported violations of laws to Planned Parenthood, including issues with patient privacy, lack of tele-health compliance, and unpaid work hours. In response to her complaints, she was accused of fraudulent timekeeping and subsequently terminated, despite being required to work off the clock to fulfill job responsibilities. The complaint seeks damages for lost earnings, emotional distress, and statutory damages not exceeding \$10,000 per violation of Labor Code § 1102.5.

Additionally, the complaint asserts that the termination and adverse actions taken against [Plaintiff] were in violation of California public policy as outlined in the Labor Code. It details the adverse employment actions, lack of accommodation, and failure to engage in good faith interactions with the plaintiff.

## **Ceniceros**

*The 2015 Class Action Complaint can be found at:*

[www.problemsatplannedparenthood.org/california-los-angeles](http://www.problemsatplannedparenthood.org/california-los-angeles)

### **Excerpt:**

As set forth below, Plaintiff alleges that Defendants have failed to pay her and all other similarly situated individuals for all vested vacation pay, failed to provide them with meal periods, failed to provide them with rest periods, failed to pay premium wages for unprovided meal and/or rest periods. . . failed to pay overtime wages, failed to provide them with accurate written wage statements, and failed to timely pay them all of their final wages following separation of employment. Based on these alleged Labor Code violations, Plaintiff now brings this class and representative action to recover unpaid wages, restitution, and related relief on behalf of herself, all others similarly situation, and the general public.

## **Cristobal**

*The 2015 Class Action Complaint can be found at:*

[www.problemsatplannedparenthood.org/california-los-angeles](http://www.problemsatplannedparenthood.org/california-los-angeles)

### **Excerpt:**

12. During Plaintiff's employment with Defendants . . . rather than paying Plaintiff "one additional hour of pay" as required by Section 226.7, Defendants only paid these meal period premium payments in increments of one half of one hour.

13. During Plaintiff's employment with Defendants, Defendants regularly, systematically, and impermissibly rounded the hours worked by their non-exempt employees in Defendants' favor, over a period of time, in the failure to properly compensate them, including Plaintiff, for all hours worked, therefore depriving them of all required minimum and additional overtime wages earned.

14. As a result . . . Defendants maintained inaccurate payroll records and issued inaccurate wage statements to Plaintiff Defendants also issues inaccurate wage statements because they failed to list the name of the legal entity that was the actual employee of Plaintiff and putative class in violation of Labor Code section 226(a)(8)

## **Dawson**

*The 2017 Complaint can be found at:*

[www.problemsatplannedparenthood.org/california-los-angeles](http://www.problemsatplannedparenthood.org/california-los-angeles)

### **Excerpt:**

16. Plaintiff Dawson . . . came to PPLA in July 2013 with some 30 years of sophisticated fundraising experience . . . By all legitimate measures he had a good record of success with his work at PPLA . . .

17. Plaintiff was targeted for retaliation in early 2016 by his supervisor, [B.B.], specifically because he had expressed dissatisfaction with the work being performed by a direct-mail vendor to PPLA . . . owned and operated by [B.B.]'s husband . . .

20. At the beginning of 2016, the problems became more serious . . . With his manager also on the phone, Plaintiff attempted to discern what the problems were, but could not seem to get straight answers . . .

21. Retribution began the very next day . . .

26. Plaintiff's employment was terminated on June 20, 2016 . . . after which he packed his personal belongings, overseen by security, then was escorted from the building by security . . .

## Gonzalez

*The 2023 Complaint can be found at:*

[www.problemsatplannedparenthood.org/california-los-angeles](http://www.problemsatplannedparenthood.org/california-los-angeles)

### Excerpt:

1. This is a wage and hour class action lawsuit on behalf of Plaintiff and other current and former non-exempt employees . . .
  - (a) failure to pay wages for all hours worked at minimum wage;
  - (b) failure to pay overtime wages for all overtime hours worked;
  - (c) failure to pay overtime at the proper overtime rate by failing to include all remuneration in calculating the regular rate of pay for purposes of paying overtime;
  - (d) failure to authorize or permit all legally required and compliant meal periods and/or pay meal period premium wages;
  - (e) failure to authorize or permit all legally required and compliant rest periods and/or pay rest period premium wages;
  - (f) failure to pay accrued and vested vacation/PTO wages;
  - (g) failure to pay sick pay at the proper regular rate;
  - (h) failure to indemnify all necessary expenditures or losses incurred by employees in direct consequence of discharging their duties;
  - (i) statutory penalties for failure to timely pay earned wages during employment;
  - (j) statutory waiting time penalties in the form of continuation wages for failure to timely pay employees all wages due upon separation of employment; and
  - (k) statutory penalties for failure to provide accurate wage statements.

## Pereira

*The 2020 Complaint for disability discrimination can be found at:*

[www.problemsatplannedparenthood.org/california-los-angeles](http://www.problemsatplannedparenthood.org/california-los-angeles)

16. . . .

a) On or about June 29, 2018, while at work, Plaintiff suffered severe injuries to her right knee, including multiple lacerations and a torn meniscus, after a faulty metal file cabinet fell onto her. As witnessed by many of Plaintiff's coworkers . . . Plaintiff bled profusely and was immediately rushed to the hospital where she received stitches and related care.

b) As a result of her condition, Plaintiff notified Human Resources Director . . . of her need to take several days of protected medical leave.

c) Upon Plaintiff's return to work . . . Plaintiff duly communicated her restrictions and/or need for accommodations to Defendant Planned Parenthood, including the need to elevate her leg, among the other accommodations . . .

d) Moreover, Plaintiff contacted Human Resources Manager . . . and requested a parking space closer to her work area due to the severe pain and swelling she was experiencing.

e) Additionally . . . Plaintiff underwent surgery as a result of said injuries, after which time she was placed on a medical leave of absence through approximately July 8, 2019. At all times relevant herein, Defendant Planned Parenthood had notice of Plaintiff's need for protected medical leave.

f) At the completion of her aforesaid medical leave of absence, in hopes of returning to work, Plaintiff submitted medical documentation to Defendant Planned Parenthood identifying her restrictions, including no kneeling, squatting, or lifting over ten pounds . . .

18. However, on a severe and/or pervasive basis continuing at least through the time of Plaintiff's wrongful termination on or about September 19, 2019, and continuing, Defendant . . . harassed Plaintiff and created and maintained a hostile work environment . . .

c) In further harassment, rather than accommodate Plaintiff's request for a closer parking space due to the severe pain and swelling she was experiencing, Defendant Planned Parenthood instead offered the parking spaces to non-disabled employees in upper Management . . .

## **Ramos**

*The 2020 Complaint can be found at:*

[www.problemsatplannedparenthood.org/california-los-angeles](http://www.problemsatplannedparenthood.org/california-los-angeles)

17. In or about March of 2019, Plaintiff began experiencing back pain from sitting down over long periods of time. Plaintiff spoke to Defendant [D] about her back pain and requested a standing desk to help alleviate her pain. Defendant [D] informed Plaintiff that Plaintiff cannot receive the standing desk accommodation because Defendant PPLA was "on a budget." Following this interaction, Plaintiff reported her worsening back pain to Defendant [D] on multiple occasions.

18. On or around April 2, 2019, Plaintiff exchanged emails with Defendant PPLA's employee . . . regarding Plaintiff's request for a standing desk. [She] told Plaintiff that she was placed on a "queue" for a workstation evaluation. However, Plaintiff's workstation was never evaluated and Plaintiff never received her standing workstation accommodation from Defendants.

19. On or about, April 10, 2019, Plaintiff informed Defendants that she was pregnant. After learning about Plaintiff's pregnancy, both Defendant[s] . . . began treating Plaintiff differently in the workplace . . .

25. On or about January 23, 2020, Plaintiff visited Defendants' office with her newborn baby to show her newborn baby to her friends and co-workers. As soon as she arrived, Defendants escorted Plaintiff and her baby off the premises and instructed her not to return.

26. Based on Defendants' conduct, Plaintiff believes and alleges that she her employment was constructively terminated, if not actually terminated . . .

31. During the course of Plaintiff's employment, Defendants failed to prevent their employees from engaging in intentional actions that resulted in Plaintiff's being treated less favorably because of Plaintiff's protected status (*i.e.*, her disability and sex). During the course of Plaintiff's employment, Defendants failed to prevent their employees from engaging in unjustified employment practices against employees in such protected classes. During the course of Plaintiff's employment, Defendants failed to prevent a pattern and practice by their employees of intentional discrimination, retaliation, and harassment on the basis of disability, sex, and/or protected status or protected activities.

### **Rivera**

*The 2020 Complaint can be found at:*

[www.problemsatplannedparenthood.org/california-los-angeles](http://www.problemsatplannedparenthood.org/california-los-angeles)

10. Plaintiff was hired by Defendant on or about December 2016 as a Surgical Registered Nurse . . .

12. On or about 10/2018, and continuing, Plaintiff sustained and/or aggravated and/or developed perceived physical disabilities, including but not limited to a wrist injury and associated condition . . .

14. Plaintiff was placed on work restriction from 10/2018 through 04/2019;

15. Plaintiff requested and/or was granted a leave of absence on or about 04/2019 to have a wrist surgery.

16. In and around 07/2019, Plaintiff was released back to work and was placed on work restrictions and/or modified duties.

17. Plaintiff notified Defendant, and each of them, of Plaintiff's work restrictions.

18. On or about 06/2019, Defendant, and each of them, now discriminated and retaliated against Plaintiff by refusing to engage in a good faith interactive process, refusing to provide a reasonable accommodation and refusing to allow her to return to work.

19. On or about 07/2019, Plaintiff spoke with Defendant's Human Resources Department and was informed her employment was terminated.

### **Sherf**

*The 2015 Complaint can be found at:*

[www.problemsatplannedparenthood.org/california-los-angeles](http://www.problemsatplannedparenthood.org/california-los-angeles)

7. Plaintiff was hired by Defendants in or about April 2013 as a Physician's Assistant. At all times herein mentioned, Sherf was qualified for and was able to perform her essential duties as Physician Assistant.

8. In or about September 2013, Plaintiff was taken off work by her doctor to undergo surgery on her kidney. Plaintiff's doctor took her off work for six to eight weeks. Plaintiff was released to go back to work in November 2013. In response to Plaintiff's request for time off to undergo kidney surgery, Defendants terminated her employment effective September 12, 2013.

## Wallace

*The 2013 Complaint can be found at:*

[www.problemsatplannedparenthood.org/california-los-angeles](http://www.problemsatplannedparenthood.org/california-los-angeles)

6. Defendant PPLA hired Plaintiff in approximately March 2012 . . . as a Senior Accountant . . .

8. In approximately 2013, Defendant PPLA underwent a change in management whereby it sought to employ employees much younger than Plaintiff in its accounting department . . .

9. On or about March 26, 2013, PPLA falsely accused Plaintiff of defacing the outside of a window of its office building with sexually graphic graffiti the previous day . . . and thereby sexually harassing the employee who used the affected office . . . PPLA produced a security camera video showing Plaintiff walking on the sidewalk outside the building in the general vicinity of said wall, during her daily morning break . . . However, that is all the video showed. Plaintiff was not carrying a spray can nor did her arm gestures at any time suggest that she was engaged in graffiti . . .

10. The security camera footage showed numerous other Planned Parenthood employees, as well as other unknown individuals, walking by the subject window . . .

12. Despite the complete lack of evidence implicating Ms. Wallace, nor any reason at all to suspect her of such conduct, PPLA terminated Plaintiff immediately without any further investigation. This was also despite . . . the utter absurdity of the idea that a 53-year-old female accountant, working for a non-profit organization devoted to women's health care, who had no conflicts whatsoever with PPLA nor any other members of the staff, and who barely even knew the woman who used the affected office . . . would deface the building where she worked with a drawing of a penis, in broad daylight no less . . .

13. Notably, PPLA's abrupt notice of termination was given on Plaintiff's one-year anniversary of employment with PPLA, when she was due to become vested in the organization's 403(b) retirement plan . . .

## Wang

*The 2016 Complaint can be found at:*

[www.problemsatplannedparenthood.org/california-a-to-f](http://www.problemsatplannedparenthood.org/california-a-to-f)

1. In or around January 2015, Planned Parenthood hired Plaintiff as a Clinician. From the beginning . . . [R.M], a Medical Assistant . . . together with [E.H.], manager of the same office, engaged in a discriminatory campaign against Plaintiff solely on the basis of her color, race, ethnicity, and national origin (Asian/Chinese) as well as a known disability. Not only was Plaintiff forced to endure substantially unfavorable working conditions in comparison to the super-majority of Hispanic, Spanish-speaking employees, Plaintiff was terminated from her employment for complaining of such Labor Code violations . . .

25. . . . Plaintiff . . . complained . . . regarding Planned Parenthood's failure and refusal to offer her the statutorily required meal periods and rest breaks . . . In so complaining, Plaintiff advised Planned Parenthood of her pre-diabetic condition/disability and her frustration with not being able to monitor and regulate her blood sugar levels . . . that the simple and reasonable accommodations or providing her with timely meal periods and rest periods would permit her to perform the essential functions of her job without materially and/or adversely affecting her health.

## **Pasadena and San Gabriel Valley Affiliate**

**Garcia**

### **Excerpt: Trellis Case Complaint Summary**

Filing Date May 12, 2025 / Case #25STCV13839 / Matter Type General Employment

This complaint is a PAGA representative action filed by Plaintiff Ana Garcia against Planned Parenthood Pasadena and San Gabriel Valley, Inc., and unnamed defendants. The complaint alleges various violations of the California Labor Code, including failure to pay for all hours worked, failure to provide meal periods, failure to authorize rest breaks, failure to pay earned wages twice per month, failure to maintain accurate records, and failure to indemnify for necessary expenditures. The complaint seeks civil penalties under PAGA for these violations. Plaintiff seeks penalties on behalf of herself, other aggrieved employees, and the State of California.

## **Redding**

**Smith**

### **Excerpt, Trellis Case Complaint Summary**

Filing Date March 25, 2024 / Case Number 24CV00944

The complaint alleges three causes of action: discrimination, retaliation under the Fair Employment and Housing Act (FEHA), and whistleblower retaliation.

According to the complaint, Mariah Smith was an employee of Planned Parenthood and experienced discrimination and hostility due to her heterosexual, white, married, female status with children. She alleges that she faced exclusion and reprimand for not conforming to the company's cultural beliefs and business model. Smith also claims that she was retaliated against after announcing her pregnancy and requesting maternity leave. She alleges that she was subjected to unwarranted discipline, placed on a performance improvement plan, and denied a pay increase.

Smith further asserts that she made lawful complaints about an employee stealing company time and the company's money handling decisions, but her concerns were not addressed and she faced further retaliation. She alleges that her whistleblower activities were a substantial motivating reason for the defendant's conduct.

## Payne

### Trellis Case Complaint Summary

Filing Date June 29, 2023 / Case #CGC23607359

This complaint alleges various violations of the California Labor Code and unfair business practices by Defendant Planned Parenthood: Shasta-Diablo, Inc. The plaintiff, Jasmine Payne, brings this class action complaint on behalf of herself and other similarly situated individuals. The complaint alleges the following violations:

1. Failure to Pay Minimum and Straight Time Wages (Cal. Lab. Code §§ 204, 1194, 1194.2, and 1197)
2. Failure to Pay Overtime Wages (Cal. Lab. Code §§ 1194 and 1198)
3. Failure to Provide Meal Periods (Cal. Lab. Code §§ 226.7, 512)
4. Failure to Authorize and Permit Rest Periods (Cal. Lab. Code §§ 226.7)
5. Failure to Timely Pay Final Wages at Termination (Cal. Lab. Code §§ 201-203)
6. Failure to Provide Accurate Itemized Wage Statements (Cal. Lab. Code § 226)
7. Failure to Indemnify Employees for Expenditures (Cal. Lab. Code § 2802)
8. Unfair Business Practices (Cal. Bus. & Prof. Code §§ 17200, et seq.)

The complaint alleges that Defendant failed to comply with these requirements throughout the statutory period. It further alleges that Defendant was aware of these improprieties but intentionally refused to rectify its unlawful policies. The complaint seeks damages and other relief for the plaintiff and the class members.

## San Diego

## Macias

### Trellis Case Complaint Summary

Filing Date May 19, 2025 / Case #TCN-363413 / Matter Type Wage and Hour

Plaintiff Daisy Lizete Macias filed a complaint against Planned Parenthood of the Pacific Southwest and unnamed Doe defendants on behalf of herself, similarly situated non-exempt employees, and the State of California under the Private Attorneys General Act (PAGA). The complaint alleges widespread violations of California labor laws, including failure to pay all wages owed such as unpaid minimum wages, unpaid overtime and double time calculated at correct regular rates that include shift differentials and other remuneration, and failure to pay accrued vacation wages upon separation. Plaintiff asserts that Defendants engaged in unlawful company-wide practices, such as editing time records to underreport hours worked, denying or undercompensating meal and rest breaks, and failing to reimburse employees for necessary business expenses like personal cell phone use.

Further allegations include inaccurate and incomplete wage statements, failure to maintain accurate payroll and employment records, untimely payment of wages during employment and upon termination, and violations of paid sick leave laws through improper accrual, notice, and payment calculations. Plaintiff provides specific wage statement examples from 2024 illustrating these deficiencies and claims that Defendants' policies and payroll systems caused these systemic violations.

## Lonconte-Crowe

The 2023 Complaint can be found at:

[www.problemsatplannedparenthood.org/california-san-diego](http://www.problemsatplannedparenthood.org/california-san-diego)

### Excerpt:

*PPPS = Planned Parenthood Pacific Southwest affiliate  
The individual Defendant is redacted to Ms. S.*

9. On or about May 22, 2023, PPPS hosted the 60th anniversary dinner for the non-profit organization at the Hilton Hotel . . . Ms. S yelled out to [Plaintiff] from across two tables. Ms. S quickly rushed to [Plaintiff], hugging [Plaintiff] from the side and rubbing [Plaintiff's] arm up and down.

10. [Plaintiff] could smell the alcohol in Ms. S's breath, causing [Plaintiff] to feel very uncomfortable. Ms. S's demeanor was very touchy, touching [Plaintiff's] shoulders, arms, and hands . . . It became clear that Ms. S was intoxicated when she persisted in touching [Plaintiff] excessively as they spoke.

11. At some point during the interaction Ms. S stopped mid-sentence, looked down at [Plaintiff's] cleavage, smiled and said, "oh yeah, you look very good" . . . the entire situation made [Plaintiff] extremely nervous. [Plaintiff] managed to get away from Ms. S and actively tried to avoid Ms. Sedillo for the rest of the event.

12. At the end of the night [Plaintiff] headed to the elevator to leave. At the elevator [Plaintiff]bumped into Ms. S and PPPS supervisors . . . Ms. S once again started hugging [Plaintiff] and slowly caressing up and down [Plaintiff's] arm. Ms. S swayed back and forth, her speech slurred from how intoxicated she was . . .

13. . . . None of the PPPS supervisors that accompanied Ms. S corrected her behavior. Instead, they giggled, and proceeded to guide Ms. S into the elevator to leave . . . [Plaintiff] was confused as to why someone in a leadership role like Ms. S would be so negligent of their alcohol consumption in a professional setting . . .

15. Later that same day, [supervisors] spoke with [Plaintiff] and expressed their sentiments about what [Plaintiff] experienced. Both . . . stated that they believed [Plaintiff's] statement about the incident and admired [Plaintiff] for having the courage to speak up. [One] informed [Plaintiff] that several other people had mentioned that Ms. S was also very touchy with them .

17. . . . Although Ms. S did not work directly at the clinic, Ms. S would often visit the clinic without giving any prior notice. Having Ms. S show up to the clinic unannounced caused Shiloh a great deal of anxiety . . .

18. . . . Had Ms. S been a male . . . PPPS might have addressed the situation in an entirely different way. Frustrated with the way PPPS handled the situation, [Plaintiff] began to dread going into work. [Plaintiff] would experience crippling anxiety on the drive to work before every shift . . . [Plaintiff] . . . ultimately decided that leaving PPPS was the best option.

## Mendoza

The 2019 Complaint can be found at:

[www.problemsatplannedparenthood.org/california-san-diego](http://www.problemsatplannedparenthood.org/california-san-diego)

5. In late 2017, Plaintiff was told she should retire or Defendants would be forced to issue written discipline Plaintiff. Sure enough, Plaintiff was given unjustified written discipline as a pretext for age discrimination . . .

7. As a result of Defendants attempts to defame Plaintiff's work performance and refusal to remedy the situation, Plaintiff was forced to quit her employment due her age on January 19, 2018. Plaintiff was over 40 years old at the time of her constructive termination.

8. On information and belief, Plaintiff was replaced by someone significantly younger with much less experience . . .

42. Defendants willfully refused and continue to refuse to pay Plaintiff overtime in a timely manner, as required by the aforementioned statutes. Plaintiff therefore requests restitution and penalties as provided by California Labor Code §203 . . .

53. During the course of Plaintiff's employment, Defendants failed to provide Plaintiff with mandated meal or rest periods and required Plaintiff to work during mandated meal and rest periods, in violation of the Industrial Welfare Commission Orders, Labor Code Section 226.7, subdivision (a), and Labor Code section 512 . . .

## Warren

### Excerpt: Trellis Case Complaint Summary

Filing Date May 16, 2025 / Case #TCN-362079 / Matter Type Wage and Hour

The complaint . . . alleges multiple violations of California labor laws by the Defendants. The claims assert that Defendants engaged in unlawful wage and hour practices, including failing to pay minimum wages and overtime for all hours worked—such as off-the-clock pre-shift activities and communications—and not incorporating non-discretionary bonuses, commissions, or shift differentials into the regular rate of pay for calculating overtime, double time, sick pay, PTO, and meal/rest break premiums.

The complaint further alleges that Defendants violated Labor Code provisions by failing to provide timely, uninterrupted 30-minute meal breaks and 10-minute rest breaks as required, and by not paying premium wages for missed or inadequate breaks. Defendants are also accused of issuing inaccurate wage statements that omitted required compensation components and underreported hours worked, failing to pay all wages timely upon termination or resignation, neglecting to maintain accurate payroll records, and failing to reimburse necessary business expenses such as cell phone costs.

These unlawful labor practices are asserted to constitute unfair business practices under California's Business & Professions Code § 17200 et seq. The complaint includes class action allegations with multiple subclasses addressing minimum wage, overtime, meal and rest breaks, wage statements, termination pay, payroll records, expense reimbursements, and unfair business practices.

## Santa Barbara

### Withers

*The 2021 Complaint can be found under Santa Barbara at:*

[www.problemsatplannedparenthood.org/california-s-to-z](http://www.problemsatplannedparenthood.org/california-s-to-z)

6. Plaintiff began his employment with Defendant on or about October 19, 2015. At the time of Plaintiff's wrongful termination on or about April 30, 2020, Plaintiff was employed by Defendant as a Lead System Analyst . . .

8. Unfortunately, on or about January 24, 2020, Plaintiff suffered a Transient Ischemic Attack ("TIA") and/or mini stroke while at work. Following the TIA and/or mini stroke, Plaintiff only took approximately two days off of work to heal and recover and thereafter returned to work.

9. After Plaintiff returned to work, he worked for approximately two weeks. However, after consulting with his healthcare providers, Plaintiff's healthcare providers recommended a medical leave of absence. Therefore, Plaintiff requested and Defendant granted Plaintiff a medical leave of absence.

10. On or about February 25, 2020, while Plaintiff was on his medical leave of absence, Plaintiff suffered a second TIA and/or mini stroke and thereafter, requested an extension of his medical leave of absence through March 2020.

11. Plaintiff returned to work on or about April 6, 2020 . . . Plaintiff's supervisor Systems Administrator . . . began to discriminate and/or retaliate against Plaintiff by, among other things, avoiding Plaintiff, taking away his job duties, over scrutinizing his work performance and ultimately giving Plaintiff a false and/or pretextual write up on or about April 24, 2020 . . .

13. Shockingly . . . within a few days after Plaintiff's complaint to Defendant's Human Resources department, Defendant wrongfully terminated Plaintiff for the false and/or pretextual reason of violation of company values.

14. Plaintiff is informed and believes, and thereon alleges, that Defendant wrongfully terminated Plaintiff on account of his perceived and/or disabilities and/or medical conditions and/or in retaliation for his requests for leaves of absence and/or taking leaves of absence and/or requesting accommodations and/or protesting discrimination and/or retaliation.

## Colorado

### Aurora

Post from June 18, 2018, next page:

Pro-Choice. Pro-Patient.  
Pro-Union.

# PPRM Bargaining Team

## PPRM Bargaining Team

PPRMBargaining

Home

Posts

Photos

About

Community

Info and Ads

Create a Page

Liked

Following

Share

...



PPRM Bargaining Team

June 18 · 🌐

...

### REGARDING THE EVENTS LAST WEDNESDAY.

This past Wednesday evening a colleague and I, in our role as members of the SEIU, Local 105 collective bargaining team and proud representatives of the clinical staff from 14 PPRM centers who voted and won the right to unionize in December, 2017; planned to attend the annual fund-raising event held by Planned Parenthood of the Rocky Mountains to raise support for their advocacy & political arm, Planned Parenthood Votes Colorado. Our purpose was to ask donors to specify their money be used only for patient care activities and legislation that supports those activities, not for paying the high-price law firm hired by PPRM last summer to stop the formation of our collective bargaining unit. The event was being held at a public venue with certain areas reserved exclusively for ticketed attendees.

The tickets we purchased for the event were revoked with our money refunded immediately before start time of the event. I had arrived at the venue before learning I no longer had a ticket. My colleague was called off and never arrived; three SEIU staff members had also arrived to learn of ticket cancellations.

Suspecting our tickets had been revoked to prevent us from attending and speaking to donors, I decided to go up to the event to see if there was a public space outside the private event where I could talk to donors as they went in. I was accompanied in this by one union staff member. Upstairs, we were able to determine there was no public space, and while figuring this out, I was seen and recognized by event organizers and attendees. Becoming nervous, I suggested we return to the main floor.

Stepping back into the first floor public space, I saw uniformed and armed Aurora police officers beginning to approach us. Not wanting a confrontation, I walked away from them. Although I had seen three Aurora police cars when I first met up with union staff, I honestly did not believe they were there to keep us out of the event. However, it quickly became obvious that was exactly their purpose, because they began to follow us as we walked away into the mall.

Recognizing we were not going to be able to accomplish anything useful, the four of us decided to split up and make our way casually, visiting some shops along the way, back to the main entrance. The police officers also split up to follow each of us, thus leaving the event itself indicating they were not there for event security.

My car was parked on the opposite side of the building from the union staff so I had to walk back through the mall to reach it. As I walked past the event, the police officers saw me and watched me all the way to the exit. Getting into my car, I became very afraid that I was going to be followed and pulled over by one of the police units. I called my husband and recounted the entire story and he was also concerned and told me to stay on the phone with him and not to leave the parking lot for a while. I think I sat there in my car about 15 minutes, then finally got up the courage to leave through a small exit in the back of the parking lot, feeling very shaken. My impression was the police were there to ensure I and my SEIU companions left the event and did not return. That impression was fully supported later when I learned from one of our union organizers, that he had doubled back to the event and watched all of the police cars leave as soon as we were not on the premises.

# Delaware

## Wilmington

*Two documents for the same case from the Occupational Safety and Health Administration (OSHA) from 2013 can be found at:*

[www.problemsatplannedparenthood.org/delaware](http://www.problemsatplannedparenthood.org/delaware)

*Documents from the Occupational Safety and Health Administration (OSHA) from 2012 and 2013 can be found at:*

[www.problemsatplannedparenthood.org/delaware](http://www.problemsatplannedparenthood.org/delaware)

### **Occupational Safety & Health**

#### **Highlights:**

An employee filed a complaint alleging:

- Employees were exposed to skin punctures from contaminated needles.
- Contaminated medical equipment wasn't properly sterilized.
- Employees weren't provided with or required to wear personal protective equipment when handling infectious materials.
- Contaminated personal protective equipment wasn't properly handled or cleaned.
- Equipment and services weren't properly cleaned or sterilized after coming in contact with infectious materials.
- Employees hadn't received sufficient training in infection control.

Planned Parenthood of Delaware was required to pay \$3,060 in fines.

Later, Planned Parenthood of Delaware was found to not have trained staff properly in the handling of infectious medical waste. Planned Parenthood was fined \$4,250.

Additionally, 12 employees were stuck with contaminated, "non-engineered" needles during testing for tuberculosis. Planned Parenthood of Delaware was required to pay \$850 for this violation.

# Florida

## Miami



Planned Parenthood Is Accused of Mistreating Pregnant Employees  
by Natalie Kitroeff and Jessica Silver-Greenberg, *The New York Times*, Dec. 20, 2018

In Miami, one current and two former employees said that women at a Planned Parenthood office were scared to tell managers they were pregnant. One of them said that, in conversations with supervisors, colleagues would often volunteer that they were not planning on having children or were gay or single.

“It was looked down upon for you to get pregnant,” said Carolina Delgado, who worked in the Miami office until 2012. “I don’t think that any supervisor had to literally say it for us to feel it.”

### Dupont

*The 2018 Complaint can be found under Sarasota at:*

[www.problemsatplannedparenthood.org/florida](http://www.problemsatplannedparenthood.org/florida)

### Excerpt:

#### FACTUAL ALLEGATIONS

7. Defendant hired Ms. Dupont to serve as its Controller on or about August 1, 2016, at an annual salary of \$87,500 per year; Defendant increased her salary to \$97,500 . . .
8. On June 14, 2017, Ms. Dupont suffered serious physical injuries in an automobile accident.
9. The severity of Ms. Dupont’s injuries required her to seek continuing treatment, and to take time away from work to heal and continue her recovery for same.
10. Specifically, Ms. Dupont suffered from bulging and herniated disks, one of which pressed against Ms. Dupont’s sciatic nerve, causing her immense pain, and inability, to walk, sit, sleep, or stand, for any prolonged period.
11. Based on the severity of these impairments and her continuing treatment for same, Ms. Dupont’s medical condition was a serious health condition as defined by the FMLA.
12. Ms. Dupont, accordingly, notified Defendant, that she intended to take FMLA time away from work to treat her injuries and heal, as advised by her doctors and medical team . . .
17. Defendant, without valid cause, reason, or explanation, denied same.

18. Instead, Defendant notified Plaintiff that it was, instead, terminating her employment, and then ultimately replaced her with a temporary employee that Defendant had intended for Plaintiff to train.
19. This too not only constitutes FMLA interference, but also actionable FMLA retaliation.
20. Had Defendant complied with the FMLA, which it didn't, it would have known that an employee cannot be penalized for absences that are FMLA protected.

## Sarasota

### Nazario

*The 2017 Complaint can be found under Sarasota at:*

[www.problemsatplannedparenthood.org/florida](http://www.problemsatplannedparenthood.org/florida)

#### Excerpt:

11. On or about April 15, 2016, Plaintiff was injured at work. Specifically, Plaintiff tripped and nearly fell. Although Plaintiff was able to catch herself before falling to the floor she sustained an injury to her knee . . .

16. She required a short time off for surgery. She notified Defendant of the need for a short leave.

17. Defendant responded by attempting to impede Plaintiff's Worker's Compensation claim. Just weeks after advising the Defendant of her need for medical attention and surgery, she was terminated.

**18. On or about July 13, 2016, Defendant retaliated against plaintiff for lawfully claiming benefits under the FWCA by termination Plaintiff's employment for pretextual reasons.**

## Tallahasee

*The 2018 document from the Occupational Health and Safety Administration (OSHA) can be found at:*

[www.problemsatplannedparenthood.org/florida](http://www.problemsatplannedparenthood.org/florida)

#### Excerpt:

**Hazard Description:** The employer does not have a needle stick program, exposing employees to health hazards.

## Treasure Coast

### Novoa

*The 2020 Complaint can be found under Treasure Coast at:*

[www.problemsatplannedparenthood.org/florida](http://www.problemsatplannedparenthood.org/florida)

#### **Excerpt:**

11. Plaintiff began working for the Defendant on or about April 1, 2018 as a medical assistant. Plaintiff is a 48 year old individual with a daughter suffering from gastritis. On or about August 2018, Plaintiff advised her manager Lucia Cabrera that she was going back to school. Immediately, Ms. Cabrera began to make unwarranted and discriminatory comments regarding Plaintiff's age. Such as Plaintiff was "too old to be returning back to school." Meanwhile, Plaintiff's younger coworkers, who are all below the age of 30 years old were attending school and they weren't subjected to the same discriminatory comments and harassment in the workplace. On or about December 12, 2018, Plaintiff requested to have Mondays off from work due to her school schedule, although the younger co-workers were given revised work schedules to attend school, Plaintiff's request was denied. On or about November 4, 2019, Plaintiff requested time off due to her daughter having a medical procedure and to care for her daughter during the period of convalescence. Doctor's notes were provided by Plaintiff. Upon return to work, false accusations were made against client. Thereby, causing Plaintiff to have an adverse employment experience . . .

19. Plaintiff believed defendant was committed to ensuring a respectful workplace for all employees, reported the illegal employer transgressions to various leadership members of Defendant executives with the expectation that human resources for Defendant would investigate Plaintiff's complaints and take appropriate remedial action. Instead of taking appropriate actions and investigating these serious issues Defendant's proclaimed stance on discrimination does not reflect the actual culture of the employer. Time after time Defendant has chosen corporate profits over doing the right thing and taking meaningful action to eradicate discrimination on its own.

# Illinois

## Chicago

### Harkless

*The Complaint can be found at:*

[www.problemsatplannedparenthood.org/illinois-chicago](http://www.problemsatplannedparenthood.org/illinois-chicago)

#### Headings for Allegations of Complaint:

B. [Planned Parenthood of Illinois] PPIL's Failure to Notify Plaintiff of Her Rights Under the [Family and Medical Leave Act] After Notification of Her Serious Health Conditions

C. Violations of the Confidentiality of Plaintiff's Medical Records by Defendants PPIL and Tao

D. Defendant Tao's Inappropriate and Discriminatory Comments and Behavior Toward Plaintiff and Other PPIL Employees

E. PPIL Had Notice of Defendant Tao's Discriminatory Behavior and Comments

F. Plaintiff's Termination and PPIL's Changing Reasons Given to Support It

G. Defendant PPIL's Intimidation of a Witness Who Did Not Support Its Defense for Terminating Plaintiff

### Kolosso

*The 2025 Complaint can be found at:*

[www.problemsatplannedparenthood.org/illinois-chicago](http://www.problemsatplannedparenthood.org/illinois-chicago)

#### Excerpt:

10. On or about May 17, 2023, Kolosso experienced a serious workplace injury that caused significant damage to her back and other areas, including, but not limited to, strains, tears, hip dysplasia, and other serious medical issues . . .

14. Kolosso's disability is not transient and will require continued medical attention, surgeries, and treatment in order to ameliorate her ongoing conditions . . .

16. Planned Parenthood failed to grant Kolosso her requested accommodations or effective, alternative accommodations in order to permit Kolosso to return to the workplace full time . . .

25. Following the discussion, and Defendant's unreasonable offer to return to work with a demotion and significant pay cut, Defendant changed Kolosso's status from "Workman's Comp" to "Unpaid Leave" in their human resources system.

26. Defendant subjected Kolosso to harassment throughout Kolosso's efforts to return to work, and subjected her to retaliation in response to Kolosso engaging in protected activity.

# Indiana

## Indianapolis

### **Brown**

*The Complaint can be found at:*

[www.problemsatplannedparenthood.org/indiana](http://www.problemsatplannedparenthood.org/indiana)

#### **Excerpt:**

10. The Defendant hired Ms. Brown on or about September 30, 2013.
11. Throughout her employment with Defendant, Ms. Brown met or exceeded Defendant's legitimate expectations of performance.
12. On or about June 13, 2016, Ms. Brown provided the Defendant with notice of her disability, which was a diagnosis of cervical cancer.
13. Due to her disability Ms. Brown had to undergo frequent doctor visits.
14. Ms. Brown had to have a biopsy performed every three (3) months.
15. The Defendant made it difficult for Ms. Brown to take a day off every three (3) months in order to have her biopsy performed.
16. The Defendant told Ms. Brown to schedule her biopsies for Monday's as that would make it easier for her to have the day off.
17. The Defendant continued to make it difficult for Ms. Brown to get the day off for her biopsy, even when scheduled on Mondays.
18. Ms. Brown informed the Defendant that she was going to have surgery due to her disability.
19. The day before her surgery, Ms. Brown called off of work due to pain and bleeding associated with her disability.
20. The Defendant texted Ms. Brown stating "you will not take off without a valid reason."
21. Ms. Brown had never called into work prior to this date.
22. When Ms. Brown returned to work after surgery she had restrictions.
23. It was difficult for Ms. Brown to sit due to her disability.
24. If and when Ms. Brown did sit she needed a comfortable chair.
25. On or about March 20, 2017, approximately two (2) weeks after Ms. Brown's surgery there was a staff meeting.
26. When Ms. Brown arrived for the staff meeting there were no open chairs.
27. Ms. Brown felt that standing was better for her anyway due to her disability.
28. Ms. Brown would have had to violate her restrictions in order to carry a chair into the room.
29. Ms. Brown opted to stand due to these complications caused by her disability.
30. Ms. Brown was terminated on or about March 20, 2017 for standing during the staff meeting.
31. Ms. Brown was told that her standing during the staff meeting was "intimidating" and "disrespectful" towards the Vice President . . .

34. The Defendant intentionally and willfully discriminated against Ms. Brown due to her disability.

COUNT I: DISCRIMINATION ON THE BASIS OF A DISABILITY

COUNT II: FAMILY MEDICAL LEAVE ACT

## Kansas

### Overland Park

*The Complaint can be found under Overland Park at:*

[www.problemsatplannedparenthood.org/kansas](http://www.problemsatplannedparenthood.org/kansas)

#### **Blunt**

#### **Excerpt:**

1. This action arises under Title I of the Americans with Disabilities Act . . .
2. Plaintiff Blunt, an African American female, who also has a disability as defined under the ADA . . .
7. Plaintiff Blunt has exhausted all her administrative remedies, having received a Notice of Right to Sue from the Equal Employment Opportunity Commission . . .
11. When Plaintiff began her job with PPKM, she was instructed to catch up on approximately three years of backlogged accounts receivable. She was told to fix serious accounting problems and reconcile numbers which could not be substantiated.
12. Plaintiff was not provided substantial, meaningful, or sufficient training to do her job. . .
17. The stress caused by the workload and pressure to provide an immediate solution to the backlog began to affect Plaintiff's Bipolar Disorder, resulting in her promptly visiting her doctor to adjust her medication.
18. Plaintiff's doctor and therapist advised her to speak with her supervisor(s) to request help with her workload . . .
22. The following day, on October 1, 2015, PPKM terminated Plaintiff and refused to provide her with a reason.
23. At all times, Plaintiff was meeting the legitimate job expectations of Defendant, and, upon information and belief, had not been disciplined, written up, or warned about her performance.

Count I: Failure to Provide a Reasonable Accommodation in Violation of the ADA . . .

Count II: Disability Discrimination/Disparate Treatment in Violation of the ADA

Count III: Retaliation in Violation of the ADA

Count IV: Discrimination in Violation of 42 U.S.C. § 1981

# Nebraska



Dysfunction, turnover at Omaha Planned Parenthood clinic further limiting abortion access in Nebraska  
by Sara Gentzler, *Flatwater Free Press* May 1, 2025

## Excerpt:

The Flatwater Free Press spoke with seven current and former Planned Parenthood employees. Most said that out-of-state executives are largely responsible for the staffing woes and other issues. Several said that recent news coverage of the national organization's broader struggles in clinics across the country resonated with their own experiences.

Insufficient training has led to problems beyond burnout, they said, including a recent pause on rapid testing for two sexually transmitted infections due to inconsistencies in how the tests were being administered . . .

Regional executives at the headquarters in Minnesota are disconnected from the reality in Nebraska and clinics generally, Schmidt and others said, resulting in a lack of transparency and communication around big decisions.

Training suffered within the churn of turnover and expectations that they do more with fewer people, current and former employees said.

Employees recently discovered that training was inconsistent for staff performing rapid tests for HIV and syphilis, prompting the clinic to pause those tests while management sorted through whether past tests were accurate.

Employees were not sure what follow-up ultimately happened with patients, and said management attempted to pin the problem on one particular trainer . . .

When she arrived last year, she said morale was already poor and she took on the task of activities meant to boost it, including goodbye parties. Earlier this year, she started planning more and more of them before, ultimately, she planned her own.

"In the end, construction's a factor, turnover is a factor, but I think when it all comes down to it . . . I don't think they felt heard. I don't think they felt respected in their work," Forsyth said.

"And you do that for so long that you eventually just decide to move on."



Unionizing Planned Parenthood  
by Becca Andrews, *Capital & Main: Investigating Money, Power and Society*, March 25, 2024

### Excerpt:

In Nebraska, Ashley Schmidt, who helps train new workers and oversees professional development within Planned Parenthood North Central States, told *Capital & Main* that her starting salary in 2019 was \$15 an hour. Schedulers routinely overbooked appointments, creating massive wait times, frustrated patients and rushed medical care. Turnover at the office was striking, and it continued to worsen — during contract negotiations last year, it climbed to 44%.

Schmidt earned so little, she recalls, that her utilities got shut off. To continue working that winter, she began taking calls for work in her car, which was heated, instead of her home, which was not. Both Schmidt and Larson say they have colleagues who've worked second jobs to make ends meet. And they point out, too, that overburdened workers will struggle to provide good care.

"We're human beings that don't even get a lunch break, so we're running on empty tummies and we're rushing to get through it," Schmidt said. "We're always trying to be the best caregivers that we possibly can, but we're also human beings and human errors are going to be inevitable when we're overbooked and underfed."

## New Jersey

### Absecon

#### Murphy

*The 2025 Complaint can be found at:*

[www.problemsatplannedparenthood.org/new-jersey](http://www.problemsatplannedparenthood.org/new-jersey)

1. This Complaint alleges that Defendant, Planned Parenthood, a well-known healthcare facility and clinic, wrongfully terminated Plaintiff . . . for following COVID-19 protocols by requesting reasonable accommodations for virtual work after an exposure to COVID-19 and experiencing symptoms. Defendant's actions not only violated Plaintiff's rights but also potentially endangered public health by discouraging adherence to critical pandemic safety measures . . .

48. Plaintiff suffered significant financial losses, having resigned from a stable full-time job in reliance on Defendant's promises of long-term employment.

49. She has experienced severe emotional distress, including anxiety, depression, insomnia and exacerbation of pre-existing medical conditions.

# New York

See also the *Open Letter from Employees in Chapter 7, Racism*.

|   |   |
|---|---|
|  | <p>A Worker Uprising at Planned Parenthood<br/>Melissa Gira Grant, <i>The New Republic</i>, June 18, 2020</p> |
|---|---|

**Excerpt:**

As Covid-19 hit New York, staff at a number of Planned Parenthood health centers found themselves facing two crises at once: keeping health services going and keeping their jobs. As some health centers closed temporarily and shifted to telehealth services, staff also saw their hours cut or positions furloughed. To hear workers describe it, this was not entirely unforeseen. For more than a year, they had pressed management to improve conditions for staff, particularly for Black workers, and for the patients they care for. Some on staff have now decided to take their demands public, “inspired and emboldened by national movements led by Black people holding organizations and institutions accountable and working to dismantle systems of oppression and white supremacy.”

|   |  |
|---|--|
|  | <p>How an Ousted CEO Built a Culture of 'Covert Racism' and Fear at Planned Parenthood's Largest Affiliate<br/>by Esther Wang, <i>Jezebel</i>, June 24, 2020</p> |
|---|--|

**Excerpt:**

[W]hen Laura McQuade, the former head of Planned Parenthood Great Plains, became the new CEO of Planned Parenthood of New York City, Adams quickly felt a shift in the organization’s culture. Part of it stemmed from a promotion that required Adams to move from the Brooklyn clinic, which was largely staffed by people of color, to the organization’s administrative office—a “largely white space,” as she put it. “People of color are at the frontlines, but as you go through the ranks, it becomes whitewashed,” Adams said . . .

But Adams pinned most of the blame on McQuade, who instituted what she described as a toxic “mean girl” culture and an environment suffused with “covert racism.”

On Tuesday, the board of Planned Parenthood Greater New York announced that they had “parted ways” with McQuade . . . Staff concerns against McQuade included accusations of racism and bullying, as well as charges that she had instituted a revenue-driven, assembly-line approach to PPGNY clinics—one that put patients, and in particular Black and other patients of color, at potential risk.



As Contract Fight Drags On, Planned Parenthood Workers Say Enough is Enough  
 1199 Magazine (SEIU union), February 22, 2021

**Excerpt:**

Frustrated 1199ers at four New York City clinics run by Planned Parenthood of Greater New York (PPGNY) held informational pickets Jan. 7 to demand that management stop dragging their feet and settle a fair contract now.

Workers voted unanimously in August 2019 to join 1199SEIU. And PPGNY's stalling around a contract settlement commenced almost immediately. More recently, PPGNY telegraphed its intransigence by hiring an HR director straight from a union-busting law firm. And as New York City's second wave of COVID-19 hit its peak, PPGNY proposed givebacks on workers' healthcare coverage.

|                   |   |
|-------------------|---|
| No longer on web. | Planned Parenthood In Crisis: Workers Demand Union!<br>by Joe Maniscalco, LaborPress.org, July 23, 2014 |
|-------------------|---|

**Excerpt:**

No less than eight elected officials from both the New York State Legislature and United States Congress are calling upon Karen Nelson, CEO, Planned Parenthood of Western and Central New York, to honor workers' overwhelming decision to have CWA Local 1168 represent them in future contract negotiations.

So, far, however, Planned Parenthood's leadership is refusing – insisting that an official election must be held.

Roughly 70 percent of the Planned Parenthood workers in Central New York already signed union authorization cards in June. The 60-plus employees working in five Planned Parenthood centers around Central New York, say that management has busted down workers to part-time status, while also stripping them of their job titles, and telling them they must reapply for their positions . . .

Fed up, as many as 10 Planned Parent workers have reportedly left the organization in the last three weeks. Those remaining, say that patients are often double booked, requiring staffers to stay on the job long past regular business hours. At the same time, workers say that post-merger management has callously altered worker schedules with no regard for employees' familial obligations.

## DeSouza

The 2021 Complaint and the Appeals Court Decision in favor of plaintiff can be found at:

[www.problemsatplannedparenthood.org/new-york](http://www.problemsatplannedparenthood.org/new-york)

### Excerpt:

The Complaint plausibly alleges facts showing “but-for” causation. There is a close temporal connection of approximately one month between Plaintiff’s protected activity and the adverse employment action. Plaintiff sent emails complaining of microaggressions against Jewish people to Walker on October 20 and 28, 2020. Her employment was terminated on November 30, 2020.



Fired Jewish Planned Parenthood Worker Can Sue for Retaliation  
by Patrick Dorrian, *Bloomberg Law*, June 8, 2022

## White Plains



Planned Parenthood Is Accused of Mistreating Pregnant Employees  
by Natalie Kitroeff and Jessica Silver-Greenberg, *The New York Times*, December 20, 2018

Tracy Webber, the former director of clinical services in White Plains, sued the organization for pregnancy discrimination in 2009, saying she had been fired four weeks after giving birth. Planned Parenthood settled for undisclosed terms. . .

As a medical assistant at Planned Parenthood, Ta’Lisa Hairston urged pregnant women to take rest breaks at work, stay hydrated and, please, eat regular meals.

Then she got pregnant and couldn’t follow her own advice.

Last winter, Ms. Hairston told the human-resources department for Planned Parenthood’s clinic in White Plains, N.Y., that her high blood pressure was threatening her pregnancy. She sent the department multiple notes from her nurse recommending that she take frequent breaks.

Managers ignored the notes. They rarely gave her time to rest or to take a lunch break, Ms. Hairston said.

“I had to hold back tears talking to pregnant women, telling them to take care of their pregnancies when I couldn’t take care of mine,” she said . . .

When Ms. Hairston asked for regular breaks, including 30 minutes for lunch, her supervisors brushed her off. Ms. Hairston said she sent multiple notes from her nurse at Full Circle Women’s Health to the regional office’s human resources department, stating

that the extra breaks were medically necessary. No one responded, and nothing changed, according to Ms. Hairston and the former human resources manager.

Ms. Hairston's hands and feet swelled; the clinic's plastic gloves no longer fit. Her blood pressure got so high that her doctor put her on bed rest when she was seven months pregnant.

She returned to work on strict orders to not work more than six hours a day and to take regular breaks. One day in March, she worked a much longer shift. She soon became so sick that her doctor told her to go back on bed rest. A few days later, on March 23, she went to the hospital. Doctors performed an emergency C-section. She was 34 weeks pregnant.

When she had been on maternity leave for eight of the 12 weeks guaranteed by the Family and Medical Leave Act, Planned Parenthood's human resources department called her multiple times and urged her to return to work early, Ms. Hairston said. She emailed the department and said she felt "discriminated against." She resigned in June.

"I didn't get into the medical field to be treated like this," she said.

## North Carolina



Planned Parenthood Has a History of Trying to Beat Back Labor Unions  
Erin Heger, ReWire News Group, July 19, 2018

### Excerpt:

Jessica Rubio, a nurse practitioner in North Carolina, said she experienced pushback 14 years ago when she and her colleagues tried to unionize at Planned Parenthood of Central North Carolina (PPCNC).

"Management became very nasty," Rubio told *Rewire.News*. "There was a lot of blatant intimidation."

After seeing discrepancies in promotions and wanting to address concerns over pay and benefits, Rubio and several of her colleagues at PPCNC began organizing a union in 2004. They received immediate pushback, Rubio said, with management scheduling mandatory anti-union meetings as well as pulling workers aside in the hallway and telling them a union would hurt Planned Parenthood . . .

Rubio and her colleagues eventually won their union election, but management dragged out contract negotiations for so long that many workers ended up leaving and the bargaining unit dissolved . . .

Rubio's experience trying to unionize at PPCNC ended with her vowing to never again work for a Planned Parenthood affiliate. "I'm passionate about reproductive health, but I'm sad to say that's no longer funneled toward Planned Parenthood," Rubio said. "I am so disillusioned by the exploitation of those working and sacrificing for the cause."

## Ohio



The Worker's View: Inside the Planned Parenthood of Greater Ohio vote to unionize  
by Mandy Shunnarah, January 30, 2025

“When I got hired, I was paid \$45,000. Then I compared notes with my other regional field managers, and we all had different pay, which was strange because some of us were hired at the same time. Of the two of us who were hired at the same time, I had more experience, but he got paid significantly more than me,” Oney said. “Like, oh, we’re doing the gender pay gap at Planned Parenthood? We did push management to give us a raise, which got it up to \$55,000, but that required a lot of pushing and a lot of risk because we didn’t have a union at the time.” . . .

“I talked to an RN (registered nurse) in Cleveland, and she said they were asking RNs to travel from Cleveland to Columbus to work at the [Planned Parenthood] East health center because they didn’t have enough consistent staff. But that’s like a five-hour round trip, and they weren’t going to give them a raise. They’d pay for the mileage, but not a raise,” Oney says. “How can you expect people to do five hours of commuting round trip without raises?” . . .

For PPGOH Workers United, management would only voluntarily recognize the union if it was split in two units: one for clinicians and one for administration, which workers argue doesn’t make sense.

“It’s just bold to try to consistently preach to us that we’re all working toward the same mission,” Oney said. “It was irritating because it felt like they were just doing it to limit our bargaining power. Like if the admin side felt like they were being screwed over, we wouldn’t have clinical to strike with us unless it was a solidarity strike, which takes more work, and they know that. . . . We hope that despite their efforts we’re able to work with two units. They’re assuming there’s a lot less solidarity than there is.”

# Tennessee

## Nashville



Former Planned Parenthood Employees Allege Mismanagement.  
by Steven Hale, *The Nashville Scene*, December 18, 2018

The *Scene* spoke to four staffers from the facility, some of whom have lost their jobs as a result of the closure, and all describe a turbulent six months leading up to the announcement. Some learned of the news by email, while others found out when they checked a work schedule and noticed their name no longer appeared on it.

The staffers also say a number of patients with upcoming appointments received a terse text message informing them that the appointment had been canceled . . . The blunt, cold delivery of the news is in line with what they describe as a number of recent policy changes at the clinic that they perceived as being designed to prioritize money over patients . . .

As for “quality improvement,” some former staff members say they believe that’s a euphemism for replacing employees who pushed back on troublesome policy changes with new ones who will be more compliant.

# Texas

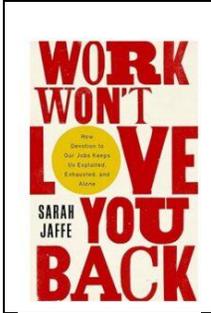
## Austin



Planned Parenthood employees laid off, claim it’s retaliation for voicing concerns  
by Alex Caprariello, KXAN, Austin NBC news affiliate, April 10, 2020

More than a dozen workers at Planned Parenthood clinics across Austin are now without a job. They say they believe it’s direct retaliation for both voicing complaints to the CEO and their ongoing efforts to unionize within the past year.

Planned Parenthood management confirmed it made staff cuts, but it says it’s a business decision it had to make because of COVID-19.



*Work Won't Love You Back: How Devotion to Our Jobs Keeps Us Exploited, Exhausted, and Alone*  
by Sarah Jaffe, Bold Type Books, January 26, 2021

**Book Excerpt, Page 170:**

In Texas, around twenty staffers were laid off in April 2020, and they suspected it was retaliation for their union drive. The workers had raised issues around the lack of personal protective equipment and paid sick leave. “There’s this big disconnect between the people managing us and the work that is being done on the ground,” Ella Nonni, one of those workers, told reporters.

**Austin**

**Dalton**

*The 2017 Complaint can be found at:*

[www.problemsatplannedparenthood.org/texas-austin](http://www.problemsatplannedparenthood.org/texas-austin)

**Excerpt:**

**IV. FACTUAL BACKGROUND**

5. Mrs. Dalton is a licensed registered nurse with a statutory duty to her patients in accordance with the Texas Occupations Code.

6. Mrs. Dalton worked for Planned Parenthood . . . from June 6, 2016 until February 28, 2017 when she was suddenly discharged from her employment in retaliation for tirelessly advocating for patients by making repeated protected reports about safety concerns that exposed the patients and the public to risk of injury and even death . . .

7. Mrs. Dalton made the first report about safety concerns when she was sent for training at the Fort Worth Planned Parenthood ASC location [Southwest Center] in June of 2016. Specifically, Mrs. Dalton recognized that a patient who was . . . in the recovery room was increasingly pale, shaky, sweating and made the nursing diagnosis of potential for shock with decreasing blood pressure and oxygen saturation. The nurse in the recovery room was simply recording vital signs without critically thinking at all about the data assimilated with the patient condition. Mrs. Dalton had to rescue the patient by providing emergency fluid resuscitation and was “written up” for doing so. At that point she was told that she could only “observe” and not do patient care. She asked to terminate her “observation period” and returned to Austin where she immediately reported the situation in Fort Worth as well as the absence of fluids and orders to administer them in the recovery area. Her concern fell on deaf ears . . .

9. The Ben White Clinic [South Austin Center] was chronically understaffed with nurses who kept quitting yet overflowing with patients. As a result, the “flow” of patients was increased to dangerous levels and corners were cut to save time. When Mrs. Dalton reported the dangerous conditions, the Charge Nurse . . . stated “I was hired to improve patient flow. I am not a nurse manager.”

10. For example, patient operative records were “pre-populated” . . . with information even before they went to the operating room in violation of minimum nursing standards . . .

11. Patients were allowed to wear long sleeved garments that would not accommodate being “rolled up” to expose the deltoid as an injection site . . . Mrs. Dalton . . . complained about this practice to her Charge Nurse . . . after such an event caused . . . the tight garment to slip and encounter the needles . . .

12. . . . Mrs. Dalton raised valid concerns about liter bags being used and single dose medications NOT MULTI DOSE and posing yet another safety hazard and consulted with the clinic pharmacist . . .

20. Mrs. Dalton alleges and will prove that Defendants engaged in needless dangerous practices that exposed patients to risk of injury an death and she tried to prevent such risk from recurring and Defendants response to her protected reports was to cause termination of Mrs. Dalton’s employment.

## **Fort Worth**

*The 2019 Complaint can be found at:*

### **Belmonte**

[www.problemsatplannedparenthood.org/texas-dallas-fort-worth](http://www.problemsatplannedparenthood.org/texas-dallas-fort-worth)

### **Excerpt:**

#### **III. FACTS**

12. On August 8, 2017, Decedent, . . . Belmonte, was at her place of employment at a location of Defendant Planned Parenthood, where she experienced intermittent chest pain. When paramedics and employees of MedStar first arrived at Planned Parenthood, Decedent stated that her chest pain was not severe. However, her condition quickly deteriorated, and she went into cardiac arrest immediately after being loaded onto a stretcher.

13. Plaintiff . . . arrived on the scene at Planned Parenthood and attempted to enter the room where his wife, the Decedent, was being treated by Defendant MedStar first responders. Even though the employees of Defendant Planned Parenthood knew Plaintiff . . . was the spouse of Decedent, the employees prohibited him from entering the room where Decedent was being treated . . .

14. After treating Decedent for an unreasonably extended period of time at Planned Parenthood, Defendant MedStar’s first responders transported Decedent to

Harris Methodist Hospital Southwest in Fort Worth, Texas where she subsequently passed away within an hour of arrival.

15. Several weeks following the passing of Decedent, Plaintiff . . . received a letter from UT Southwester informing him the Decedent was involuntarily placed in a federal study that consisted of conducting alternative cardiac arrest treatments on qualified patients. However, Decedent never gave consent to be placed into this study as she was unconscious . . . nor did the first responders receive consent from her husband . . . because he was never consulted . . .

18. Defendants . . . negligently caused and negligently permitted nonconsensual and inadequate treatment to be administered . . . and negligently failed to warn Decedent or Plaintiff . . . of the risks associated with the treatment; prevented Plaintiff] . . from refusing the treatment being studied; and prevented [Plaintiff] . . . from taking [the Decedent, his wife, to the nearby hospital emergency room, despite the fact that Defendants . . . should have known of the risks involved with the treatment and that there was a likelihood Decedent could be injured or pass away, which is exactly what happened to Decedent.

## Washington State

### Yakima

#### Sharp



Former Planned Parenthood employee wins lawsuit in Benton County  
*The News Tribune*, Tacoma News, July 11, 2012

#### Excerpt:

After an eight-year battle, a former Planned Parenthood employee won a lawsuit in Benton County alleging that the organization fired her because of a disability . . .

Her neck and back pain sometimes made Sharp unable to perform all of her job functions, and her lawsuit alleged that Planned Parenthood fired Sharp rather than provide reasonable accommodations. . .

[Her attorney] said Sharp had never received a negative performance evaluation or reprimand, and that the organization's human resources department performed no independent investigation . . .

The case finally came to trial in June, and a jury on June 27 awarded more than \$136,000 to Sharp after finding that she was fired because of her disability.

# Chapter 7



# United States

Planned Parenthood itself offers detailed information on its own racist history:

|   |  |
|---|--|
|  | The History & Impact of Planned Parenthood |
|---|--|

Further examples from recent years:

|   |   |
|---|---|
|    | Employees Are Calling Out Major Reproductive Rights Organizations for Racism and Hypocrisy<br>by Ema O'Connor, <i>Buzzfeed</i> , August 21, 2020                |
|  | Dozens of Black Employees Said They Faced Racism at Planned Parenthood, An Internal Audit Found<br>by Ema O'Connor, <i>Buzzfeed</i> , October 9, 2020           |
|  | Ex-Planned Parenthood Employee Says Racist, Toxic Culture Sent Her to the ER<br>by Emily Shugerman and Brianna Sacks, <i>The Daily Beast</i> , October 19, 2022 |

## Excerpt:

(NEW YORK) — A former Planned Parenthood employee is suing the organization, alleging the reproductive healthcare nonprofit retaliated against her and ultimately fired her for speaking out against its treatment of Black women.

Plaintiff Nicole Moore, the former director for multicultural engagement at Planned Parenthood based at the national headquarters in Manhattan, New York, claims in the complaint filed on Wednesday that Planned Parenthood has perpetuated a culture of racism where Black women within the organization are discriminated against through unequal work distribution and opportunities for promotions.

“[Planned Parenthood] has blatantly ignored reports by dozens of its Black employees of systemic unequal hiring and promotion, more work for lower pay, overt hostility, and trafficking in stereotypes by leadership,” according to a copy of the complaint obtained by ABC News.

Moore, who says she served in the role from Jan. 13, 2020, through Nov. 2, 2021, also claims that “Black-centered campaigns were deprioritized and under-resourced.”



A South Jersey nurse practitioner is suing Planned Parenthood alleging race discrimination. Her case is one of many against the reproductive health giant.

by Sarah Gantz, *The Philadelphia Inquirer*, April 18, 2023

**Excerpt:**

Over the last five years, discrimination lawsuits have been filed by at least two dozen former and current employees of Planned Parenthood’s 49 affiliates, which employ thousands across the country and are a leading source of reproductive health care in almost every state, according to an *Inquirer* analysis of publicly available national case databases.

In court records and interviews, employees said they faced racist comments from coworkers and were held to a different standard than white colleagues. Many said supervisors were more critical of their work, while valuing their contributions less, compared with white coworkers . . .

For every former employee who has sued, many more likely have experienced discrimination but stayed quiet for fear that it will affect their ability to find new employment, lawyers representing workers told *The Inquirer*. The number and geographic spread of the cases suggest a systemic problem, according to a University of Pennsylvania expert in diversity in health-care workplaces.

## Moore

The 2022 Complaint can be found at:

[www.problemsatplannedparenthood.org/united-states](http://www.problemsatplannedparenthood.org/united-states)

### Excerpt:

When [Plaintiff] politely spoke up about the inequitable distribution of work, she was falsely accused of being negative, angry, difficult to work with, and chastised for her "tone" - complaints that had no basis in reality but comported with well-trafficked stereotypes about Black women. Planned Parenthood executives then proceeded to thwart Moore's ideas, sabotage her projects, and subject her to unfounded disciplinary measures that were clearly intended to silence her complaints. The barrage of mistreatment caused Moore to suffer a panic attack so severe that she spent a day in the hospital. After complaining to HR that the disciplinary measures appeared to be retaliation for her complaints of racial inequality at the organization, she was summarily fired.

## Joyner

|  |  |
|--|--|
|  | <p>Joyner v. Planned Parenthood Federation, 2007 NY Slip Op 31798(U) (N.Y. Sup. Ct. 6/8/2007)</p> <p>Court Decision on Discovery, June 8, 2007</p> |
|--|--|

### Excerpt:

Plaintiff was the Vice President for Diversity of defendant Planned Parenthood Federation of America, Inc. ("defendant" or "PPFA") from August 2004 until she was terminated, purportedly for cause, in or about February 2006. Her complaint alleges that she was terminated in retaliation for her efforts to document and to remedy pay disparities between white employees and others, and for her repeated complaints to defendant about a pattern and practice of discrimination on the basis of race and national origin.

← Post



**Amber J. Phillips**  
@AmberAbundance



I'm so glad this people shared their stories. I worked at @PPact on the @PPGenAction team and it was the most racist and toxic work environment I have ever experienced in my life.

[buzzfeednews.com/article/emaoco...](https://buzzfeednews.com/article/emaoco...)

7:09 PM · Aug 25, 2020

## California



A South Jersey nurse practitioner is suing Planned Parenthood alleging race discrimination. Her case is one of many against the reproductive health giant.

by Sarah Gantz, *The Philadelphia Inquirer*, April 18, 2023

### Excerpt:

The cases detail how inappropriate behavior, racist tropes, microaggressions, and unequal expectations went unchecked, even after employees complained. A few examples . . . A Black nurse practitioner in California said she was called a “homie” by a supervisor who also made comments about her hair and used racial slurs when referring to other Black people. The Planned Parenthood affiliate settled the case privately in 2019.

## Los Angeles

### **Bryant**

*The 2017 Complaint can be found at:*

[www.problemsatplannedparenthood.org/california-los-angeles](http://www.problemsatplannedparenthood.org/california-los-angeles)

#### **Excerpt:**

1. Plaintiff . . . was employed by defendant Planned Parenthood Los Angeles . . . she began her employment on or about July 11, 2016. Plaintiff's race is African - American. Her title was Family Nurse Practitioner.

2. During her employment, defendant PPLA's managerial and supervisory Employees . . . harassed and discriminated against plaintiff and other co -employees because of their African - American race.

3. This harassment and discrimination occurred on a daily basis and included, but was not limited to, the following:

- a) Calling African -Americans "homies;"
- b) Criticizing the performance of African -American employees;
- c) Making comments about the hair and braids of African -American employees; and
- d) Making derogatory racial slurs about African -Americans.

4. Non-African-American employees were not treated in such a manner . . .

9. On or about August 2, 2017, plaintiff was terminated. Plaintiff was terminated because she was a witness in support of another employee's complaints of discrimination and harassment and because she complained of harassment and discrimination.

### **Jones**

*The 2004 Complaint can be found at:*

[www.problemsatplannedparenthood.org/california-los-angeles](http://www.problemsatplannedparenthood.org/california-los-angeles)

#### **Excerpt:**

8 . . . Plaintiff was the first African American male employee to ever be hired in his particular department by PPLA, and was the first such minority to hold his specific position . . .

12. Among other things, as alleged below, Plaintiff refused to engage in PPLA promotional practices that were intended to deceive the African American community in South Los Angeles . . . Plaintiff, an African American, was not comfortable being forced to misrepresent facts to other similarly situated persons.

13. During this same time period, PPLA was also engaged in other activities having a deleterious effect on African American persons, including Plaintiff's fellow employee, one Nick Nkwuda, an African immigrant. Specifically, in or around January of 2004, Mr. Nkwuda was referred to as a "nigger." PPLA's management did nothing to punish the management employee who used such degrading language toward an employee similarly situated to Plaintiff in terms of minority status . . .

14. In fact, throughout 2003 and most of 2004, PPLA had created and allowed the continuation of an environment that was hostile toward African American and other minority employees, especially male employees. A female accounting supervisor referred to male employees in position of authority and officers of the company as "dickheads," and other derogatory terms, constantly defaming and engaging in confrontational behavior which was known throughout and brought to the attention of Human Resources and the interim and permanent CEO and President of PPLA. These terms were most often uttered by the female executive management of PPLA.

15. At the time of Plaintiff's employment, PPLA's white, female management staff also caused openly discriminatory comments and representations to be made that would have made a reasonable person feel uncomfortable . . .

16. The various circumstances described above created an environment that was racist and sexist in tone, policy and practice. These practices have not been abated by PPLA and continue to cause harm to individuals employed by PPLA. PPLA is the subject of multiple verified complaints having been filed with the California Department of Fair Employment and Housing within the last six months.

## **Nwuda**

*The 2006 Complaint can be found at:*

[www.problemsatplannedparenthood.org/california-los-angeles](http://www.problemsatplannedparenthood.org/california-los-angeles)

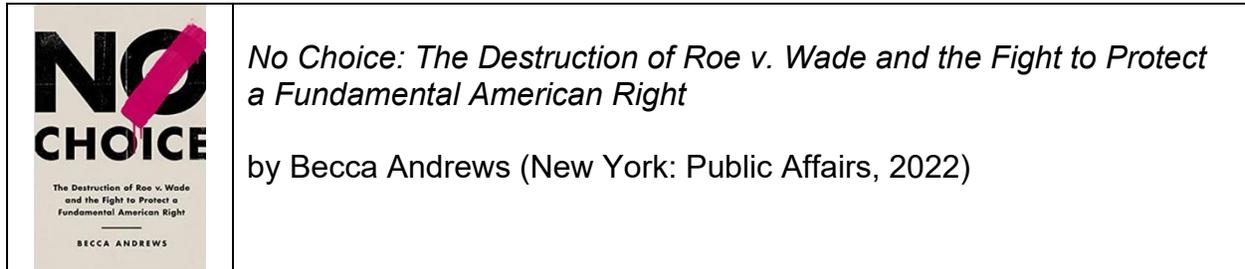
*PPLA = Planned Parenthood Los Angeles*

12. Around January 2004, PPLA hired one [person] . . . Upon her hiring by PPLA, [she] immediately began to get into verbal altercations with plaintiff and others. She constantly used profanity and created a very hostile work environment. This culminated in an incident where she used the word "nigger" directed at plaintiff. Plaintiff immediately placed his concerns in writing and requested disciplinary action with the human resources department at PPLA. Nothing ever happened to correct this wrong. In fact, plaintiff was later put on probation by a female supervisor and then was forced to quit on March 6, 2004 due to a hostile environment.

13. On or about January 2004, plaintiff complained about the derogatory racial terms and slurs and profanity used by [a different staff member], Operations Account. All the accounting staff was in close quarters and these terms were heard by everyone. On February 5, 2004, plaintiff complained in an electronic mail . . . He informed here of the insults and verbal confrontations . . . Nothing was done to prevent further racial harassment and an increasing hostility in the work place environment by management.

# Indiana

## Indianapolis



### **Book Excerpt:**

Nowhere was the survival mode mentality more evident than in the unchecked behavior of the [doctor] at the clinic, a graying white man in his 50s . . .

She suspected that he was harder on patients who did not speak English, and she fought for privileges as the only Spanish speaker on staff to accompany Latinx patients into the procedure room so she could answer their questions and advocate for them if necessary.

# Michigan

## Grand Rapids

*The 2015 Complaint can be found under Grand Rapids at:*

[www.problemsatplannedparenthood.org/michigan](http://www.problemsatplannedparenthood.org/michigan)

### **Excerpt:**

In conclusion, I don't feel that Planned Parenthood is providing me with a safe work and non-hostile environment because of my race, ethnicity, and not taking the complaint seriously . . . I love my job here at Planned Parenthood, but if this workplace harassment continues and I don't feel safe at work, then I will be forced to take further action.

# Missouri

## St. Louis



Former St. Louis Planned Parenthood employee sues for racial discrimination

by Deion Broxton, First Alert Channel 4, June. 6, 2024

# New Jersey

## Bryn Mawr



A South Jersey nurse practitioner is suing Planned Parenthood alleging race discrimination. Her case is one of many against the reproductive health giant.

by Sarah Gantz, *The Philadelphia Inquirer*, April 18, 2023

### Excerpt:

A patient's urine test landed on Michelle Fisher's desk with a warm, wet splash. Fisher, a Black nurse practitioner, remembers looking up from her lunch to see the white manager of Planned Parenthood's Bellmawr clinic in Camden County.

The clinic manager often berated Fisher for asking questions the nurse practitioner thought were necessary to do her job — including this time, when she'd asked to see a urine test before authorizing birth control, she says in a federal discrimination lawsuit. Fisher claims that the supervisor frequently ended their terse exchanges by flicking a fist at her, making a whip-cracking sound and ordering, "Now get back to work."

Such interactions were emotionally draining, Fisher said in an interview, but she continued to show up, day after day, for almost three years because she wanted to provide for Black women and girls what she'd rarely had: a medical provider who looked like her.

When she was laid off in spring 2021 in what she believes was retaliation for filing multiple discrimination complaints to human resources, Fisher decided to do more.

In May 2022, Fisher sued Planned Parenthood of Northern, Central and Southern New Jersey for race discrimination and wrongful termination and was deposed in March of this year. The case is ongoing.

"What if this is someone else's dream job and they look like me?" she said in an interview. "I want other people to be able to go in there and not be treated like that." . . .

“If we can’t count on Planned Parenthood to respect Black employees, how can we count on them to care for people of color as patients?” said Valerie Shore, Fisher’s Cherry Hill-based lawyer.

## New York

### General Open Letter: Save PPGNY

|   |  |
|---|--|
|  | Current and former staffers of Planned Parenthood of Greater New York<br>June 18, 2020 |
|---|--|

#### Excerpt:

#### Racism and Weaponizing of the Work of Diversity, Equity and Inclusion Against Staff

Planned Parenthood was founded by a racist, white woman. That is a part of history that cannot be changed . . . After years of complaints from staff about issues of systemic racism, pay inequity, and lack of upward mobility for Black staff, highly-paid consultants were brought in three separate times to assess the situation. Each time, employees of color were brutally honest about their experiences, but nothing changed . . .

When diversity and equity are weaponized to make changes that are harmful to staff it diminishes the value of these very important areas of change. We know that Planned Parenthood has a history and a present steeped in white supremacy and we, the staff, are motivated to do the difficult work needed to improve.

#### Decimation of Institutional Knowledge Due to Unprecedented Rates of Staff Turnover

McQuade’s time at PPGNY has been defined by constant staff departures. Under her leadership, 23 members of senior staff have quit or been forced out. Many of these colleagues had 10-20+ years of experience with our affiliate. Others were people hired by McQuade directly to newly created positions who left mere months into their roles. This high amount of turnover has had a destabilizing effect on the organization. The loss of institutional knowledge is so profound as to be detrimental to every aspect of the organization.



## Supplemental Open Letter: On Equity

**June 18, 2020**

We write this — as a group of both current and former BIPOC (Black, Indigenous, People of Color) employees of Planned Parenthood of Greater New York — to expand on the issues of racism and anti-Blackness in our workplace mentioned in our general open letter to the PPGNY Board . . .

PPGNY, under the leadership of CEO Laura McQuade, has effectively gaslit and silenced their marginalized staff thus creating a toxic work environment. While we stand together as people of color, we also stand firm in our commitment to acknowledge that anti-Blackness is a critical and specific fulcrum of white supremacy.

The PPGNY Senior Leadership team, despite the visual appearance of diversity, has repeatedly weaponized the language of diversity, equity, and inclusion. Rather than using their true definitions, senior leaders and upper management have used these terms to manipulate and silence those with differing opinions and perspectives. They have leveraged identity politics by putting Black and other people of color in positions of leadership who actively participate in harming Black staff and other staff members of color below them.

At this point, PPGNY's attempts to present itself as a diverse workplace have been carefully orchestrated and superficial at best. PPGNY repeatedly tokenizes their Chief Equity and Learning Officer, a Woman of Color who is not of African descent, as the "voice" for BIPOC staff. The decision to hire a non-Black person in this role exemplifies the ways in which white-led organizations use non-Black people as a buffer to actually confront and uproot anti-Blackness within organizations . . .

The class tensions are made clearer when the BIPOC leadership were also complicit in the decisions to furlough/terminate 28% of staff. This included the closing of health centers in the Bronx and Queens, as those areas were being devastated by COVID-19. Additionally furloughed staff, many of which are BIPOC women, remain unclear when they will be called back to work and left with no official information regarding when their health insurance will be terminated.

With multiple attempts by the BIPOC staff to bring these concerns to our supervisors, we continue to be invalidated and marginalized. White and non-Black employees are still given more pay and more advancement opportunities than their Black colleagues. Blanket statements are used to overshadow our grievances, while only exacerbating the problem. Black staff are further disheartened when our white and non-Black colleagues use their privilege to amplify our concerns, and find they, too, are challenged and manipulated into silence.

## Mitchell

*The 2023 Complaint can be found at*

[www.problemsatplannedparenthood.org/new-york-city](http://www.problemsatplannedparenthood.org/new-york-city)

### Excerpt:

. . . the reality is that Planned Parenthood continues to be run by people who are openly hostile to racial minorities, the disabled, older workers and those who complain about discriminatory practices.

Proof of this reality lies in the lawsuit filed by . . . Moore\*, who on October 19, 2022 . . . alleged that Planned Parenthood continued to discriminate against African American employees . . .

Now , [defendant], the Chief Operational Officer and highest ranking African American male in Planned Parenthood of Greater New York's history, is filing this lawsuit alleging that he too has been victimized by race, gender, age and disability in violation of Federal State, and New York City laws. This lawsuit is meant to shine a light on the discriminatory and retaliatory employment practices that permeate the organization and bring justice to Mr. Mitchell for the unrelenting discriminatory practices he had and continues to endure.

\* Moore's case is listed above in this chapter under United States.

## Duckett-Holmes

*The 2024 Complaint can be found at*

[www.problemsatplannedparenthood.org/new-york-city](http://www.problemsatplannedparenthood.org/new-york-city)

### Excerpt:

21. On or about September 27, 2021, PPGNY hired Plaintiff as Regional Director of Operations . . . based at the Manhattan location . . .

26. Throughout Plaintiff's employment, she was subjected to a continuing pattern and practice of discrimination and hostile work environment based upon her race, color, and gender and in retaliation for complaining about PPGNY's discriminatory actions and other wrongdoing, and for being absent from work due to valid protected leave under the FMLA . . .

28. By way of example, PPGNY required Plaintiff to endure brutal and unsafe working conditions due to her race, color, and gender. Specifically, Plaintiff was forced by her supervisor, . . . to work every single day of the months of October and November 2022 without a day off as a charge nurse.

29. PPGNY's requirements in this regard were clearly discriminatory on these bases, because PPGNY did not require similarly situated white, Caucasian, or male employees to work slave-like hours doing work that was effectively a demotion

30. In or around the end of October 2022, Plaintiff engaged in protected conduct by complaining . . .

32. In fact, in response to Claimant's complaint, PPGNY began a targeted campaign against Claimant in retaliation for this protected conduct, including subjecting her to an increased and disproportionately burdensome workload.

33. Plaintiff suffered a stress-induced medical event as a result of this retaliatory misconduct that necessitated her taking FMLA leave from work on or about March 27, 2023, to about May 22, 2023, when she returned to work.

34. Following her return, and in violation of the FMLA, Plaintiff was placed in a substantively different role than the one she had prior to her job-protected medical leave, a role that would require significantly more stress and responsibility than the role she worked prior to her leave of absence . . .

36. The new responsibilities being hazardous to her health, on June 6, 2023, Plaintiff was constructively terminated effective July 7, 2023 . . .

43. While Plaintiff's employment with PPGNY was a harrowing, traumatic experience, the events complained of herein do not reflect a unique incident, as rudimentary internet research paints a similarly distressing picture of discriminatory abuse and misconduct<sup>5</sup> by PPGNY<sup>6</sup> and those occupying the most powerful positions within PPGNY . . .

48. As a result of PPGNY's unlawful and discriminatory actions, Plaintiff has endured unlawful humiliation resulting in extreme emotional distress, severe depression, extreme anxiety, and physical ailments.

### **Screenshot:**

Complaint filed November 12, 2014

#### Department of Health and Human Services – Office for Civil Rights Health Information Privacy Complaint

On three separate visits this year, I've been made to feel unwanted in by Planned Parenthood of NY 26 Bleeker Street practice. It seems a negative change in attitudes with the predominantly Black front end staff occurs once my insurance info is looked up. There has been repeated incidences dehumanizing behaviors while having morning appointments bumped to late afternoons/evening. Staff will put more effort into pressuring me to leave the office than to process my paperwork. Opting to stay in the waiting area, I've witnessed Caucasian patients be accommodated immediately with similar circumstances as me. Directors, Supervisors, Doctors and Nurses do NOT respond to complaints on obvious unequal treatment of patients. I have been a patient of this location from 2010-2014. There has not been a problem until this year. Attached are detailed incidences experienced this year with the November 8th appointment change email.

# Pennsylvania

## Open Letter: Save PPPA



On November 24, 2020, employees of Planned Parenthood released an open letter alleging racism and poor management of severe budget cuts. It was signed by the entire staff. The letter demanded the resignation of Executive Director. She resigned on December 1, 2020.



Planned Parenthood's Pennsylvania Chapter Director Resigns After Racism Claims  
by Emily Shugerman, *The Daily Beast*, December 2, 2020.

### Huffmeyer

*The full Race Discrimination Complaint can be found at*

[www.problemsatplannedparenthood.org/texas-houston-stafford](http://www.problemsatplannedparenthood.org/texas-houston-stafford)

#### Excerpt:

18. At the end of August 2017, PPGC assigned a new supervisor to oversee Ms. Huffmeyer's performance . . . Following that appointment, Ms. Huffmeyer's workplace quickly turned into a living nightmare. Not only did [the new supervisor] persistently belittle Ms. Huffmeyer; she also resorted to treating her so badly that her work environment quickly became sufficiently hostile to start causing her health to deteriorate, all because of Ms. Huffmeyer's race and national origin. Among other health issues, Ms. Huffmeyer developed daily headaches and fever blisters . . .

22. Not only did [the supervisor] abuse Ms. Huffmeyer without cause as to her work; she also made inappropriate comments about her national origin. [She] once asked Ms. Huffmeyer how "close" she was to Ms. . . . Nguyen (the Director of the PPGC Center for Choice), just because both Ms. Huffmeyer and Ms. Nguyen were Vietnamese. Essentially, [she] assumed that two unrelated people would immediately form a clique in their workplace, just because they both happen to be of Vietnamese origin. Ms. Huffmeyer told Ms. [her] that she did not know Ms. Nguyen well at all. Ms. Farrell responded by stating that she did not trust Ms. Nguyen and that Ms. Huffmeyer should not trust her either. When Ms. Huffmeyer tried to reassure [her] that her only goal was to make sure she looked good, [she] dismissed her, saying, "I'm not sure about that! Birds of a feather . . .

29. Instead of seeing her working conditions improve, Ms. Huffmeyer was unceremoniously terminated, just over three months after the complaint was filed, without any respect for the ten years of impeccable service she delivered to the Company.

## Tennessee



A South Jersey nurse practitioner is suing Planned Parenthood alleging race discrimination. Her case is one of many against the reproductive health giant.

by Sarah Gantz, *The Philadelphia Inquirer*, April 18, 2023

### **Excerpt:**

The cases detail how inappropriate behavior, racist tropes, microaggressions, and unequal expectations went unchecked, even after employees complained. A few examples . . . A Latina community organizer in Tennessee who complained about racism in the workplace said she was written off as “mean” and “hostile.” A supervisor scolded her for having a “snarky look” during a meeting to discuss her concerns, according to a 2023 complaint in an ongoing case.

## Texas



A South Jersey nurse practitioner is suing Planned Parenthood alleging race discrimination.

by Sarah Gantz, *The Philadelphia Inquirer*, April 18, 2023

### **Excerpt:**

The cases detail how inappropriate behavior, racist tropes, microaggressions, and unequal expectations went unchecked, even after employees complained. A few examples . . . A lab manager in Texas was repeatedly berated by her supervisor, whose criticism often centered on her Vietnamese heritage. “It’s so annoying that you can’t speak English,” the manager once screamed at her, she said in a complaint filed in 2019. The Planned Parenthood affiliate settled the case with undisclosed terms.

# Chapter 8



The website includes many individual complaints listed under the specific locations at which they occurred. They're not re-iterated here.

## United States



You scheduled an abortion. Planned Parenthood's website could tell Facebook. The organization left marketing trackers running on its scheduling pages  
by Tatum Hunter, *The Washington Post*, June 29, 2022

## California

### Los Angeles



400,000 Patients Potentially Affected by Planned Parenthood Ransomware Attack  
by Steve Alder. *The HIPPA Journal*, December 3, 2021



Planned Parenthood Los Angeles Settles Class Action Data Breach Lawsuit for \$6 Million  
by Steve Alder. *The HIPPA Journal*, April 8, 2024

*Court Complaints for a class action lawsuit were originally filed separately from:*

- A.K.,
- Danchick,
- Garza,
- Jane Doe,
- Orellana
- T.S.

*The full documents can be found at:*

[www.problemsatplannedparenthood.org/california-los-angeles](http://www.problemsatplannedparenthood.org/california-los-angeles)

## San Jose

### Balli

*The 2022 Complaint can be found at:*

[www.problemsatplannedparenthood.org/california-san-jose](http://www.problemsatplannedparenthood.org/california-san-jose)

22. Defendants hired Plaintiff as VoIP Architect on October 7, 2019. Plaintiff was hired with more than 20 years of relevant work experience. Plaintiff's work responsibilities included . . . general information technology responsibilities, ensuring data security . . .

32. On or about November 15, 2019, Plaintiff learned that Defendants had experienced a serious data breach which had exposed confidential and private Personal Health Information ("PHI") protected by . . . (HIPAA). Plaintiff immediately reported the breach to [J.L.] Plaintiff reported that the PHI of hundreds of individuals had been unlawfully disclosed . . . [and] that the breach needed to be addressed as soon as possible . . . [and] that Defendants were required to inform the Company's Ethics and Compliance Department and the State of California about the PHI data breach.

33. [J.L.] stated that she could not take any steps to address or remedy the PHI data breach because doing so would risk PPM's accreditation status with parent entity Planned Parenthood Federation of American. Plaintiff nonetheless continued to insisted that the PHI data breach be reported to the proper authorities and remedied according to applicable regulations.

34. [J.L.] became agitated and ordered Plaintiff not to discuss the PHI data breach with any other individual. She threatened Plaintiff and told him that if he disobeyed her instruction his employment with Defendants would be terminated.

35. Plaintiff believed that Defendants PHI data breach needed to be further reported and remedied. Initially, however, he complied with [J.L.]'s orders because he relied upon the income from his employment with Defendants to support himself and his family.

36. On or about January 28, 2020, Plaintiff reported the November 2019 PHI data breach to the Company's Interim General Counsel and Chief Compliance Officer . . .

38. Plaintiff further reported to [her] that Defendants were poised to expose additional HIPAA-protected PHI due to the compromised nature of Defendant's network infrastructure.

39. [She] told Plaintiff that the Company had made multiple mistakes . . . [and] thanked Plaintiff for reporting the data breach and assured him that there would be no retaliation for his actions.

40. The very next day, January 29, 2020, Defendants revoked Plaintiff's information technology (IT) account rights so that he could not perform his job duties. Defendants' Human Resources department informed Plaintiff that he was being suspended from work effective immediately. Plaintiff surrendered his work laptop, keys, and security badge.

# Delaware

## Wilmington

Testimony at a Delaware legislative hearing, July 20, 2013  
Melody Meanor, the former Health Center Manager of Family Planning at Planned Parenthood of Delaware in Wilmington

One area I attempted to correct was inadequate protection of patient confidentiality and privacy. At the beginning of my employment, I struggled to correct negative patient care violations that involved HIPAA violations. Untrained health center assistants simply did not understand the importance of protecting patient privacy. My attempts to train and discipline health center assistants were significantly undermined... The Medical Director . . . should have put a stop to these sorts of behaviors. However, at the same time as she was serving as the Medical Director of Planned Parenthood of Delaware, [she] was simultaneously employed by the Planned Parenthood Federation of America as an auditor inspecting other Planned Parenthood affiliates.

# Iowa

## Dubuque



Planned Parenthood leaves records in Dubuque; info of 2,500 potentially exposed  
by Jeff Montgomery, July 6, 2016

### **Excerpt:**

About 2,500 patients of Planned Parenthood of the Heartland's now-closed Dubuque center recently were notified that their health records might have been among those left behind when the facility closed in April.

Public Relations Manager Rachel Lopez said hard copies of patient information were inadvertently left at the building at 3365 Hillcrest Road and that they might have been accessed by unauthorized parties following the center's closure and ensuing building sale. . .

The documents were found by the building's new owner May 6. Lopez said Planned Parenthood sent letters to all affected patients Friday, July 1 — nearly two months after the discovery . . .

Executive Director Kris Nauman said the documents were discovered during a May 6 final walk-through at the facility. Clarity Clinic closed on the building purchase later that day.

The medical information was located in a closet in "copy paper boxes" that were not sealed, she said.

# Montana

Documents for both class action lawsuits can be found at:

[www.problemsatplannedparenthood.org/montana](http://www.problemsatplannedparenthood.org/montana)

## Downey

6. The impact to its systems strongly implies that Defendant lacked sufficient cybersecurity incident response and disaster recovery plans . . . as is the industry norm.

7. Notwithstanding that the attack occurred at least by August 24, 2024, Defendant waited until November 5, 2024, to begin notifying its current and former patients of the Data Breach.

8. Defendant's unreasonable and unexplained delays prevented Plaintiff from being able to timely protect herself from the significantly increased risk of harm . . .

78. Because of the Data Breach, Plaintiff Downey anticipates spending considerable time and money on an ongoing basis to try to mitigate and address harms caused by the Data Breach . . . Plaintiff is at present risk and will continue to be at increased risk of identity theft and fraud for years to come.

## Sullivan

2. The Private Information compromised in the Data Breach included certain personal or protected health information . . . including Plaintiff's minor child . . .

3. The Private Information was exposed to cybercriminals who perpetrated the attack and remains in the hands of those cybercriminals. According to Defendant's report to the U.S. Department of Health and Human Services, 18,003 individuals' sensitive data was compromised . . .

32. The U.S. Department of Health and Human Services requires, "[i]f a breach of unsecured protected health information affects *500 or more individuals*, a covered entity must notify the Secretary of the breach without unreasonable delay in *no case later than 60 calendar days* from the discovery of the breach." . . .

34. Defendant's notice to HHS was dated November 5, 2024 – around ten weeks after the incident was discovered.

35. Defendant had obligations created by HIPPA, contract, industry standards, state statutes, common law, and representations made to Class Members, to keep Class Members' Private Information confidential and to protect it from unauthorized access and disclosure.

# Ohio

## Cincinnati

Documents can be found under Cincinnati

[www.problemsatplannedparenthood.org/ohio](http://www.problemsatplannedparenthood.org/ohio)

### Excerpt from the letter of the Office of Civil Rights:

On October 1, 2014, the Covered Entity (CE) mistakenly disposed of binders containing protected health information (PHI). The CE's archived prescription dispensing logs and waived lab test logs were left in an unlocked closet after business hours and a custodian mistakenly put them in a trash dumpster. The following morning, the dumpster was emptied by the trash collector who took it to be buried with other garbage at a landfill that same day. The PHI involved in the incident included the names, dates of birth, lab results, and medications of approximately 5,000 individuals. After the CE filed the breach report, it determined that the incident was a nonreportable breach based on a four part breach assessment and a low probability that the PHI in the binders had been compromised.

## Washington, D.C.



D.C.'s Planned Parenthood reports data was breached last fall. Months later, the organization has started reaching out to affected patients and donors  
by Brittany Renee Mayes, *The Washington Post*, April 16, 2021

### Excerpt:

On Oct. 21, the investigation determined that "unauthorized actors gained access to [the] network." It also revealed that the data breach, which occurred from Aug. 27 to Oct. 8, impacted only the D.C. branch . . . Leaked information included names, addresses, dates of birth, diagnoses, treatments and prescription information. Social Security and financial information was also included in the breach . . .

On April 9, PPMW began mailing letters to affected patients about whom they could reach for guidance on further protecting their information. The findings of the investigation found "no reason to suspect that there has been any fraudulent use of patient information associated with this incident." However, the organization is providing patients whose Social Security and driver's license numbers were compromised with complimentary credit monitoring and identity-theft protection services. Donors with compromised bank information did not receive the same service offer.

# Chapter 9



We include large cases of overbilling the government. Smaller cases are on the website but not re-iterated here. There is also one lawsuit.

# California

## Los Angeles

### Dawson

*The 2017 Complaint can be found at:*

[www.problemsatplannedparenthood.org/california-los-angeles](http://www.problemsatplannedparenthood.org/california-los-angeles)

17. Plaintiff . . . had expressed dissatisfaction with the work being performed by a direct-mail vendor to PPLA . . . owned and operated by [his supervisor B.B.]’s husband . . . This was a blatant conflict of interest from which [B.B.] received direct financial benefit . . . It did not matter to [B.B.] that her husband’s company was performing substandard work, often delayed . . .

18. The challenge faced by Plaintiff in being forced to work with [B.B.]’s husband and his untouchable (though incompetent) company became increasingly difficult . . . There are many vendors to choose from in this very competitive field. Instead, [B.B.] compounded the challenge by informing Plaintiff in 2014 that her husband’s company would now be retained not only as a direct mail vendor, but as a “consultant” at \$2,500 per month . . .

19. At a certain point, Plaintiff had had to hire a new [person] . . . because the first one had successfully sought a new job because of, among other reasons, the frustration from being forced to work with this vendor. This second person . . . eventually left PPLA as well . . . in large measure due to the same issues . . . Plaintiff was forced to hire a third employee . . . she encountered the very same problems . . . during the time Plaintiff supervised her, not one Direct Mail mailing went out without significant negative impact caused by the vendor’s failures.

# Texas

## El Paso

### **Attestation –**

**Agreed-Upon Procedures Report on Planned Parenthood Center of El Paso,**  
09-56-00001-SP-19 Aug. 31, 2009. Audit conducted July 20-24, 2009.

There were numerous instances of subcontractors remaining unpaid for services rendered, despite the amounts needed having been included in PPCEP’s requests for DSHS reimbursement. The total amount of the outstanding billings was likely between \$409,675.10 and \$529,707.97.

# Overbilling the Government

**Affiliate: Gulf Coast**

(has now merged into Greater Texas)

The Press Release of the U.S. Attorney's Office for the Eastern District of Texas can be found out:

[www.problemsatplannedparenthood.org/texas-houston-stafford](http://www.problemsatplannedparenthood.org/texas-houston-stafford)

**Excerpt:**

Houston-based Planned Parenthood Gulf Coast has paid \$4.3 million to resolve civil allegations under the False Claims Act in the Eastern District of Texas, announced U.S. Attorney John M. Bales.

The government alleges that between 2003 and 2009, Planned Parenthood Gulf Coast billed and was paid by government programs, Texas Medicaid, Title XX, and the Women's Health Program, for certain items and services related to birth control counseling, STD testing and contraceptives when such items and services were either not medically necessary, not medically indicated or not actually provided.

*Note: at time of publishing, there is ongoing litigation as to whether this affiliate violated the False Claims Act by charging Medicaid at a time when it was illegal to do so under Texas and Louisiana law.*

**Affiliate: South Atlantic**



Office of Inspector General, U.S. Department of Health and Human Services (hhs.gov)

June 24, 2016

# Chapter 10



The website has hundreds of employee and thousands of patient reviews, organized under each center. We've collected the reviews that deal with the themes below and made each into a single pdf. Links to click can be found on the website at the bottoms of the "Explanations and Lists" page and the "United States" page.



# Phone Problems

*On the website, this marker is put on every center it applies to:*



When we had an intern call Planned Parenthood centers to check on who their local mammogram referrals were, we found that about a quarter of the phone numbers never answered or left her on hold until she gave up. To document this and to specify which centers have this problem, we've listed the centers where reviews indicate patients having phone trouble. That also comes to about a quarter of the centers.

We don't include those where one person had trouble once, which can be a fluke, but only where people tried several times to reach them without success. In some cases, this included having specific medical problems due to the inability to reach them.

[Arizona](#) - Glendale, Phoenix

[California](#) - Anaheim, El Centro, Fresno

[California](#) - Palmdale, Pasadena, Rancho Mirage

[California - Los Angeles](#) - Hecht

[California - Sacramento](#) - B Street Google 2

[California](#) - Santa Barbara, Santa Monica, Watsonville, Westminster

[Colorado](#) - Aurora, Boulder, Colorado Springs, Denver Central, Fort Collins, Glenwood, Greeley, Littleton

[Connecticut](#) - Danbury, West Hartford

[Washington D.C.](#)

[Delaware](#) - Dover, Newark

[Florida](#) - Boca Raton, Fort Meyers, Jacksonville, Kissimmee, Lakeland, Naples, Miami-Golden Glades, Miami-Kendall, Orlando, Pembroke Pines, Port St. Lucie, Saint Petersburg, Sarasota, Tampa, Tampa North, West Palm Beach.

[Georgia](#) - Atlanta, Lawrenceville

[Iowa](#) - Iowa City

[Illinois - Chicago](#) - Chicago Loop, Wicker Park

[Indiana](#) - Fort Wayne, Indianapolis - Midtown, Indianapolis - South Side, Lafayette, Mishawaka, New Albany

[Kansas](#) - Overland Park

[Kentucky](#) - [Lexington](#), Louisville

[Louisiana](#) - New Orleans

[Maine](#) - Portland

[Massachusetts](#) – Marlborough  
[Maryland – Annapolis and Baltimore](#)  
[Maryland](#) – Owings Mills, Towson, Waldorf  
[Michigan](#) – Detroit, Grand Rapids, Kalamazoo, Livonia, Warren  
[Minnesota](#) – Brooklyn Park, Mankato, Moorhead, St. Cloud, St. Paul, Woodbury  
[Missouri](#) - Columbia, Gladstone, Independence, Kansas City, Springfield, St. Peters  
[Nebraska](#) - Lincoln  
[New Jersey](#) – Camden, Delran, East Orange, Flemington, Hackensack, Hamilton Square, Montclair, Morristown, Paterson, Trenton  
[Nevada](#) – Las Vegas East Flamingo, Las Vegas West Charleston, Reno  
[North Carolina](#) - Chapel Hill, Charlotte, Fayetteville, Raleigh, Wilmington, Winston-Salem  
[Ohio](#) – Cincinnati Mount Auburn, Cleveland, Columbus Franklinton, Mansfield, Toledo  
[Oklahoma](#) - Edmond, Oklahoma City, Tulsa  
[South Carolina](#) - Charleston, Columbia  
[Tennessee](#) - Nashville  
[Texas](#) – Addison, Paris, Spring  
[Texas - Houston and Stafford](#) – Northwest, Prevention Park, Southwest, Stafford  
[Texas - San Antonio](#) – Richland Hills, Northeast, San Pedro, South Texas  
[Utah](#) - Logan, Ogden, Orem, Salt Lake City – Metro, Salt Lake City, West Valley City  
[Virginia](#) - Charlottesville, Hampton, Richmond – Hamilton Center, Roanoke, Virginia Beach  
[Washington](#) – Bellevue, Centralia, Kennewick, Lynnwood, Pullman, Seattle-Central, Spokane  
[Wisconsin](#) - Waukesha

# QR Codes to Website Pages

Home Page



United States Page



Explanations & Lists



Alabama



Alaska



Arizona



Arkansas



California Overview Page



CA cities & towns: A-F



CA: G-R



CA: S-Z



CA - Los Angeles



CA - Sacramento



CA - San Diego



CA - San Jose



Colorado



Connecticut



Delaware



Florida



Georgia



Hawaii



Idaho



Illinois



Illinois - Chicago



Indiana



Iowa



Kansas



Kentucky



Louisiana



Maine



Maryland:

Annapolis & Baltimore



Maryland



Massachusetts



Michigan



Minnesota



Missouri



Montana



Nebraska



Nevada



New Hampshire



New Jersey



New Mexico



New York



New York: NYC



North Carolina



Ohio



Oklahoma



Oregon



Pennsylvania



Rhode Island



South Carolina



South Dakota



Tennessee



Texas



Texas:  
Austin



Texas:  
Dallas & Fort Worth



Texas:  
Houston & Stafford



Texas:  
San Antonio



Utah



Vermont



Virginia



Washington DC



Washington



West Virginia



Wisconsin

