Clerk of the Superior Court
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SUPERIOR COURT OF ARIZONA
MARICOPA COUNTY

CR2019-005397-001 DT 04/22/2021

HONORABLE GEOFFREY FISH

CLERK OF THE COURT
A. Dvornsky
Deputy

STATE OF ARIZONA

v.

ARLENA M WILLES (001)

FRANKIE LYNN GRIMSMAN

RICK G TOSTO

JUDGE FISH

ROBERT SWINFORD

RULING

This matter was taken under advisement following the evidentiary hearing held on April 12, 2021. The Court has reviewed and considered the State's *Notice of Intent to Use Defendant's Other Crimes, Wrong or Acts Pursuant to Rule 404(b), Arizona Rules of Evidence,* filed April 2, 2021, and the Defendant's Response *to State's Notice of Intent to Use Defendant's Other Crimes, Wrong or Acts Pursuant to Rule 404(b), Arizona Rules of Evidence,* filed on April 12, 2021, together with the testimony, evidence and argument presented at the evidentiary hearing held.

The State is seeking to introduce the following acts:

1. Defendant's isolation of the victim, including that he was receiving no services at the time of hospitalization, had not seen a primary care provider for a few years, was homeschooled and victim isolated from all providers, school personnel and others. The State seeks to introduce this evidence to prove motive, intent to isolate the victim, and absence of mistake or accident.

The State called Detective Christine Britt of the Glendale Police Department. Det. Britt testified regarding DCS records that were received. According to admitted Exhibit 1, Dr. Ingebo of Phoenix Children's Hospital made an assessment on 1/16/18 that the victim's ability to grow and thrive was impacted. Further, DCS records indicate that Defendant told PCH that victim had not had vaccines since age of 4 and had allergic reactions caused by a genetic mutation despite no genetic testing taking place and no medical documents indicating any anaphylaxis reaction at any time. DCS notes indicate Defendant reported victim is allergic to Neocate despite the fact that

earlier in the year when the victim was hospitalized and was given the drug, no medical documentation of any reaction existed. DCS notes indicate they had requested services be initiated as of 9/27/07 but it does not appear Defendant followed through with any of the recommendations at that time.

In November 2010, Defendant had attended four appointments after initial intake evaluation with Word House but had never followed up with any services or recommendation and services therefore ended. In 2015, Defendant was recommended to take the victim for an autism evaluation through PCH (Phoenix Children's Hospital) and Defendant never followed up. In 2018, it was noted that weight loss had occurred but Defendant had not sought services for any alleged food aversion. In 2018, Defendant was recommended health occupational therapy to address fine motor coordination and Defendant did not follow up. In 2018, PCH noted concerns about Defendant not providing prescribed medication to the victim. In 2018, Defendant declined a referral for JFCS case management services and despite finally allowing the social worker to initiate the referral, Defendant did not follow throw in obtaining any services through JFCS or any other provider.

On January 21, 2018, victim was diagnosed with allergic colitis and needed to adhere to a 6 food elimination diet. Defendant was provided instructions on discharge from the hospital regarding this diagnosis. Defendant was instructed to follow up with primary doctor and did not. On August 31, 2018, victim was back in the hospital at Banner Hospital. Defendant reported that victim had no allergies and was on a regular diet when in fact PCH doctors had diagnosed him with allergic colitis earlier that year. It further appears that Defendant took the victim to a GI only one time in February 2018 and had not been back since. Defendant discharged the victim on September 5, 2018 against medical advice from Banner Hospital. She was given directions to follow up with DDD for services which she failed to do.

On September 8, 2018, Dr. Kafle indicated that Defendant has a pattern of medical recommendations being made and an initial agreement, but shortly thereafter Defendant discontinues.

In 2018, PCH noted a lack of follow through beginning in 2016. Since 2016, victim had dropped below the first percentile for weight. A discharge order requisition from December 15, 2016 instructed Defendant to call Pediatric Surgeons for appointment in 2-3 weeks. This was never followed up on. As of September 11, 2018, victim weighed 68 pounds. Malnutrition had reached a point that his height velocity had flattened. Defendant was actually trespassed from the property on September 9, 2018 due to her behavior and becoming a security concern.

In February 2017, victim was seen at PCP's Emergency room for continuing stomach issues. The "Aftercare Instructions" indicate a diagnosis of gastroenteritis with a referral to the

pediatrician within 3-5 days. There was no record of any follow up to a primary care physician. Detective Britt testified she was never able to locate a Primary Care Physician for the victim.

In October 2017, victim was once again at PCP's Emergency room for acute chest pain and continuing GI issues including blood in stool. Defendant was given instructions regarding victim's diet that should include increased water and fiber. Defendant was also to follow up with a GI doctor. Detective Britt is not aware of any follow up.

During the February 2017 hospital visit, the victim had abdominal and back pain. Defendant was concerned that symptoms were due to an appendectomy done the prior December. Defendant had received a call from the surgeon's office to schedule a follow up appointment. According to Detective Britt, no follow up ever occurred.

PCH Progress notes from 1/10/18 indicate no follow up despites many issues. Victim presented with recurring blood in feces, severe food refusal behaviors, no past help or treatment for autism, no medications and no behavioral therapy. Victim was severely malnourished with a weight of 60 lbs. Notes further indicate the victim reads at a 3rd grade level. There was much discussion that Defendant believed vaccines caused autism taken from the study of Dr. Wakefield in the 90's. Doctors explained Dr. Wakefield faked the data and was discredited. Defendant continued to believe Dr. Wakefield was correct.

According to a Social Work Assessment conducted on January 10, 2018 at PCH, Defendant stated family was connected with DDD and SSI and not interested in other services. Dr. Britt could find no proof this information was true.

On September 7, 2018, DCS went to Defendant's home following a complaint. DCS employee met with Defendant outside her home and Defendant informed DCS employee she had made an appointment with primary care doctor and would give that information. Defendant reported no need for medical appointments two years ago. She was not happy with Banner Thunderbird and did not explain a plan or risks vs. benefits. She reported she left the hospital because she thought they were going to hold victim down and force the medication. She is afraid they will force steroids at PCH and Banner. She reported she home schools the victim because of his autism. The victim was present during this encounter and requested to see a doctor because he could not make it another day. Victim was requesting Defendant take him to the hospital which she did. DCS followed along. At PCH, Defendant told the hospital victim's only diagnosis are autism and ADHD. She reported that he was removed from the prior hospital the previous Friday because the "doctor was not working with her". She also reported victim has had bloody diarrhea for over two years.

A copy of Defendant's medical insurance card was entered as an exhibit. The insurance card does list a primary care physician. Dr. Britt followed up with the doctor listed. The office has no records of Defendant or any records of any visits.

Detective Britt tried to follow up on any medical records from directed follow ups. With the exception of one record in February 2018, Detective Britt was unable to find any follow up records. Detective Britt estimated speaking to at least 10 doctors during the investigation. Det. Britt talked to doctors about recommended treatment and lack of follow up. Det. Britt testified that Defendant was on ACHHSS and therefore assistance with medical costs was available. Further, there are no records of Defendant obtaining DDD or SSI services for any help.

THE COURT FINDS the State has proved by clear and convincing evidence the medical history, lack of follow-up and actions or inactions of Defendant as evidenced by the medical records and DCS records presented along with the testimony of Detective Britt.

THE COURT FURTHER FINDS the evidence presented regarding the medical care, lack of follow-up and overall actions of Defendant is intrinsic evidence because it directly proves the charged acts of Child Abuse and is therefore admissible.

THE COURT FURTHER FINDS that even if the evidence presented is not intrinsic evidence, the evidence is admissible for another purpose, such as showing intent, knowledge, absence of mistake or accident.

THE COURT FURTHER FINDS that evidence is relevant under Evidence Rule 401, and that the probative value is not substantially outweighed by unfair prejudice under Evidence Rule 403.

Good cause appearing,

IT IS ORDERED granting the State's *Notice* as follows:

With respect to the evidence regarding prior medical treatment or lack thereof, lack of follow up, lack of services, and other admitted evidence, the State shall be permitted to introduce this evidence at trial, including in its case-in-chief.

IT IS FURTHER ORDERED a limiting instruction will be given.