Governor Jerry Brown
State Capitol, Suite 1173
Sacramento, CA 95814

Secretary Diane Dooley
California Health and Human Services
1600 Ninth Street, Room 460
Sacramento, CA 95814

Dr. Ron Chapman
Department of Public Health
PO Box 997377, MS 0500
Sacramento, CA 95899-7377

November 20, 2014

Dear Governor Brown, Secretary Dooley, and Dr. Chapman,

A groundbreaking NBC Bay Area investigation has uncovered that the Department of Public Health (DPH) collected reports of just 6,282 adverse events, like surgery on the wrong body part or unexpected death, in the past four fiscal years.[1] Given that an estimated 44,000 Californians die every year because of preventable medical error, this tiny number of reported adverse events is literally unbelievable. Some hospitals only reported a single adverse event in a year. DPH should recognize that it's a statistical impossibility for any hospital to have such a pristine patient safety record.

The Department of Public Health also fails to provide meaningful disclosure of adverse events to the public, only publishing the total numbers in an annual report that does not even contain the names of hospitals where adverse events occur. It is impossible for Californians to gauge the safety of the hospital they choose with the negligible information DPH provides.

You must take immediate action to correct the reporting and disclosure of adverse events so Californians can decide whether the hospital they choose is safe.

(1) Order a statewide audit of all California hospitals to identify unreported adverse events. Any hospitals found with unreported adverse events should be fined the maximum allowed under law and submit to ongoing monitoring to ensure future reports are properly filed.

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[1] http://www.nbcbayarea.com/investigations/CA-Hospitals-Make-Hundreds-of-Errors-Every-Year-Public-is-Unaware-283261121.html

(2) Ensure full disclosure of adverse events is made online, under the law, including the name of the hospital where the adverse event occurred, the type of event, the date of occurrence, whether an investigation was conducted, and any corrective action taken, including fines and discipline of staff.

This is only the latest example of inadequate patient safety regulation in California, but it is one area where the administration has complete authority to quickly reverse those failures. We look forward to your response to these concerns within the next two weeks.

Sincerely,

Carmen Balber

Michael Kapp