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 25, 2014

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

Within a week, two television stations have done more to inform consumers of the dangers at local hospitals than the Department of Public Health has done in years.

Days after an NBC Bay Area investigation uncovered that the Department of Public Health collected reports of just 6,282 adverse events over four years in California hospitals, ABC News 10 in Sacramento reported on 1,500 of those documented incidents at 42 hospitals in the northern Central Valley.[1] The report recounted several serious stories of patient abuse or neglect, including one hospital where a former CEO is facing criminal charges for failing to report the alleged abuse of a patient – exactly the type of widespread failure to disclose we warned about in our letter last week.

ABC News 10 reported that it took two months and a Public Records Act request to receive fewer than 30 reports from the Department of Public Health. The Department of Public Health refused to answer the news station's questions. We draw your attention to this recent investigation to reiterate that it should not be this difficult for a news station, let alone the public, to obtain information about safety incidents at California hospitals.

As we wrote last week, immediate action must be taken to:

(1) Order a statewide audit of all California hospitals to identify unreported adverse events. Any hospitals found with unreported adverse events should be

[1] http://www.news10.net/longform/news/investigations/watchdog/2014/11/25/hospital-safety-and-tyrone-lees-story/19471561/

fined the maximum allowed under law and submit to ongoing monitoring to ensure future reports are properly filed.

(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.

We look forward to your response by the end of next week to our call for a statewide audit and full online disclosure of adverse events at hospitals.

Sincerely,

Carmen Balber

Michael Kapp