KermitGosnellCrimes

Pennsylvania Departme

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I am using the Grand Jury Report on the crimes of Philadelphia abortionist Kermit Gosnell as the basis of this Wiki. I will add material to support my contention that though Gosnell is beyond the pale, this is mainly in the way he combined and refined aspects of the ghoulish and callous disregard for humanity often seen in abortionists. He was hardly a pioneer.

In order to distinguish between my own writings, and those of the Grand Jury, I will use a different font that makes the Grand Jury Report appear to be typed.

Summary:

This section details the multiple failures on the part of the Pennsylvania Department of Health to close down Gosnell's filthy clinic.

THE STATE DEPARTMENT OF HEALTH NEGLECTED ITS DUTY TO ENSURE THE HEALTH AND SAFETY OF PATIENTS IN PENNSYLVANIA'S ABORTION CLINICS.

We discovered that Pennsylvania's Department of Health has deliberately chosen not to enforce laws that should afford patients at abortion clinics the same safeguards and assurances of quality health care as patients of other medical service providers. Even nail salons in Pennsylvania are monitored more closely for client safety.

The State Legislature has charged the Department of Health (DOH) with responsibility for writing and enforcing regulations to protect health and safety in abortion clinics as well as in hospitals and other health care facilities. Yet a significant difference exists between how DOH monitors abortion clinics and how it monitors facilities where other medical procedures are performed.

Indeed, the department has shown an utter disregard both for the safety of women who seek treatment at abortion clinics and for the health of fetuses after they have become viable. State health officials have also shown a disregard for the laws the department is supposed to enforce. Most appalling of all, the Department of Health's neglect of abortion patients' safety and of Pennsylvania laws is clearly not inadvertent: *It is by design*.

Many organizations that perform safe abortion procedures do their own monitoring and adhere to strict, self-imposed standards of

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Women's Medical Society

Staff:

Ashley Baldwin
Tina Baldwin
Kareema Cross
Kermit Gosnell
Pearl Gosnell
Elizabeth (Liz) Hampton
Randy Hutchins
Maddline Joe
Jennifer Leach
Latosha Lewis
Steven Massof
Adrienne Moton
Eileen O'Neill
Sherry West
Lynda Williams

Known Victims:

Baby Boy A
Baby Boy B
Baby C
Baby D
Baby E
Baby F
Baby G
Baby Girl A

that these independently monitored clinics deliver to patients are no thanks to the Pennsylvania Department of Health. And not all women seeking abortion find their way to these high-quality facilities; some end up in a filthy, dangerous clinic such as Gosnell's. There the patients have to depend on DOH oversight to protect them – as do babies born alive, and helpless but viable fetuses after 24 weeks of gestation. Yet no protection is forthcoming.

State health officials knew that Gosnell and his clinic were offering unacceptable medical care to women and girls, yet DOH failed to take any action to stop the atrocities documented by this Grand Jury. These officials were far more protective of themselves when they testified before the Grand Jury. Even DOH lawyers, including the chief counsel, brought private attorneys with them – presumably at government expense.

Gosnell's clinic – with its untrained staff, its unsanitary conditions and practices, its perilously lax anesthesia protocols, its willingness to perform late-term abortions for exorbitant amounts of cash, and its routine procedure of killing babies after they were delivered by their unconscious mothers – offers a telling example of how horrendous a Pennsylvania facility can be and still operate with DOH "approval."

The Department of Health conducted sporadic, inadequate inspections for 13 years, and then none at all between 1993 and 2010.

Witnesses from DOH acknowledged before the Grand Jury that it is their department's responsibility to oversee clinics such as Gosnell's. Pennsylvania's Abortion Control Act charges DOH with regulating and overseeing the performance of abortions and the facilities where abortions are performed "so as to protect the health and safety of women having abortions and of premature babies aborted alive." 18 Pa.C.S. §3207(a).

Abortion facilities require the department's approval to begin operating. The Department of Health first granted approval for the Women's Medical Center to provide abortions at 3801 Lancaster Avenue on December 20, 1979. The approval followed an on-site review and was good for 12 months. The DOH "site review" at the time identified a certified obstetrician/gynecologist, Joni Magee, as the medical director, with Gosnell listed as a staff physician. The report noted that a registered nurse worked two days a week, four hours a day, and that lab work was sent out to an outside laboratory.

Other topics covered in the 1979 site review included: counseling for women to be sure they had considered alternatives to abortion and were sure about their decision; the physical facility (whether there was adequate space, and whether wheelchairs and stretchers could maneuver through doorways and to the outside); cleaning procedures; emergency preparedness (including the availability of resuscitation equipment and arrangements with an ambulance service and hospital for emergency treatment); and procedures for before, during, and after the operation. It is unclear from the site review who provided most of the information, but much of it appears to come from staff interviews. One significant finding in the 1979 evaluation was that there was adequate access for a stretcher,

Dana Haynes
Karnamaya Mongar
Marie Smith
Nancy
Semika Shaw
Mother's Day Massacre

Other Names of Note:
~DOH Employees~
Susan Mitchell
Janice Staloski
Kenneth Brody
Darlene Augustine
Cynthia Boyne
Christine Dutton
~Dept of State Employees~
Mark Greenwald
Charles Hartwell
David Grubb
Andrew Kramer
William Newport
Juan Ruiz
Kerry Maloney
~Philly Dept of Public Health~
Lisa Morgan
Lori Matijkiw
"Jim"
Mandi Davis
Health Commissioner Dr. Donald Schwarz
~Others~
Dr. Frederick Hellman, M.E.
Marcella Choung
National Abortion Federation

Supplemental:
1. Anesthesia Deaths
2. Delivering babies into toilets
3. Dirty Abortion Mills
4. Infanticide
5. Legal abortion deaths
6. Live births from abortions
7. Murder of abortion survivors
8. Phony doctors
9. Political Barriers to Oversight
10. Stockpiling fetal remains
11. Third trimester abortions
12. Unqualified Employees
13. Viability

transport Kathamaya Mongal from the facility in November 2009.

Even though the first DOH Certificate of Approval for Gosnell's clinic expired on December 20, 1980, the next documented site review was not conducted until August 1989. (There is a notation on the 1989 report that a review was conducted in February 1986, but DOH could not provide any documentation of it in response to the Grand Jury's subpoena.) The 1989 evaluation was conducted by Elizabeth Stein and Susan Mitchell.

Over 20 years later, Mitchell was part of the team that inspected Gosnell's clinic in February 2010 when law enforcement officials invited DOH to participate in their search. By 1989, Gosnell, who is not board-certified as either an obstetrician or a gynecologist, was the only doctor at the facility. The DOH site reviewers also noted that there were no nurses working at the clinic. Blood work was no longer sent out to an independent lab, but was done, supposedly, by "medical assistants." And in 7 of the 30 patient files reviewed, there was no lab work recorded. The evaluators noted several violations of Pennsylvania abortion regulations, including: no board-certified doctor on staff or contracted as a consultant; no nurses overseeing the recovery of patients; no transfer agreement with a hospital for emergency care; and no lab work recorded in several files. Even so, based on mere promises to improve documentation and filing, and to hire nurses, the DOH site reviewers recommended approval of Gosnell's clinic for another 12 months.

Two and a half years later, in March 1992, when DOH representatives next inspected the clinic, there were still no nurses to monitor patient recovery. Evaluators Janice Staloski and Sara Telencio noted that Gosnell was still the only doctor (a Dr. Martin Weisberg was listed as a consultant); that the facility employed no nurses; and that medical assistants were doing lab work. They did indicate there was adequate access for stretchers and wheelchairs, though it is not clear how they reached this conclusion: The facility is multi-leveled and has no elevator.

There is nothing to suggest that these evaluators reviewed any patient files. Gosnell reported performing 62 second-trimester abortions in the previous year, yet the DOH inspectors left blank the section in their report on anesthesia, including who is permitted to give it, what their qualifications are, and the type of anesthesia they are permitted to administer. Also left blank was a section titled "Post-Operative Care," which addresses the legal requirement that the recovery room be monitored at all times by a registered nurse or a licensed practical nurse under the supervision of a physician – the same regulation that the clinic was cited for violating three years earlier. Nevertheless, the evaluators inexplicably concluded on March 12, 1992, that there were "no deficiencies," and DOH approved Gosnell's clinic to continue to perform abortions.

The next inspection was conducted on April 8, 1993, by DOH evaluators Susan Mitchell and Georgette Freed-Wolf. This was also the *last* site review – until February 2010, when an inspection occurred because law enforcement executed search warrants for illegal drug activity. In the 1993 review, Gosnell was the only doctor listed on staff, but "Dr. Weisberg" was still described as a consultant. Four years after Gosnell had promised to hire nurses to oversee the recovery room, there was still none. Lab work was still

qualifications the evaluators apparently did not question, since that section of the review was left blank. For the third time, inspectors found the access for stretchers and wheelchairs adequate, even though the facility's layout had become even more convoluted and the building still did not have an elevator.

The 1993 site review did not include any first-hand observations about the cleanliness of the facility or the condition of the emergency equipment required for resuscitation. Instead of making their own inspection, the evaluators appeared to have relied on representations by staff about procedures for cleaning and checking equipment. They did, however, find drugs past their expiration dates. In reviewing 12 patient files, the surveyors found that 4 involved second-trimester abortions. In three of these four files, there were no pathology reports on the tissue, as required by the Abortion Control Act. In one file, there was no evidence that the tissue was sent to a pathologist at all. In 3 of the 12 files, the evaluators found that required lab work was missing.

On July 23, 1993, without a follow-up inspection, Susan Mitchell recorded that the deficiencies had been corrected. DOH sent Gosnell another Certificate of Approval. The certificate stated that it was "Effective From The 1st Day Of April 1993 Until March 31, 1994 In Accordance With Law."

Gosnell's clinic had, on May 1, 1993, submitted an "Abortion Facility Registration Form" to DOH. Whoever filled it out (it is not signed), filled in the name of the facility – Women's Medical Society – and its mailing address, and checked off boxes indicating that the Women's Medical Society had no parent, subsidiaries, or affiliated organizations and whether or not it had received state funds in the preceding 12 months.

During the next *16 plus years* – as Gosnell collected fetuses' feet in jars in his office and allowed medical waste to pile up in the basement; as he replaced his few licensed medical assistants with untrained workers and a high school student; as his outdated equipment rusted and broke and he routinely reused instruments designed for single-use; as he allowed unqualified staff to administer anesthesia and to deal with babies born before he arrived at work for the day; and as he caused the deaths of at least two patients while continuing to perform illegal third-trimester abortions and to kill babies outside their mothers' wombs – DOH never conducted another on-site inspection at the Lancaster Avenue facility.

The state Department of Health failed to investigate Gosnell's clinic even in response to complaints.

According to DOH witnesses, sometime after 1993, DOH instituted a policy of inspecting abortion clinics only when there was a complaint. In fact, as this Grand Jury's investigation makes clear, the department did not even do that.

Janice Staloski, one of the evaluators of Gosnell's clinic in 1992, 10 years later was the Director of DOH's Division of Home Health – the unit that is inexplicably responsible for overseeing the quality of care in abortion clinics. In January 2002, an attorney representing Semika Shaw, a 22-year-old woman who had died following

of inspection reports for any on-site inspections of the clinic conducted by DOH. Staloski wrote to the attorney that no inspections had been conducted since 1993 because DOH had received no complaints about the clinic in that time.

Except that it had. In 1996, another attorney, representing a different patient of Gosnell's, informed Staloski's predecessor as director of the Home Health Division that his client had suffered a perforated uterus, requiring a radical hysterectomy, as a result of Gosnell's negligence. The Home Health director discussed this patient with DOH Senior Counsel Kenneth Brody, and the complaint report was documented in records turned over to the Grand Jury. It was surely available to Staloski when she inaccurately told the attorney in January 2002 that DOH had received no complaints regarding Gosnell's clinic.

Not documented in the records turned over to the Grand Jury was a second complaint registered between 1996 and 1997. This one was hand-delivered to the secretary of health's administrative assistant by Dr. Donald Schwarz, now Philadelphia's health commissioner. Dr. Schwarz, a pediatrician, is the former head of adolescent services at Children's Hospital of Philadelphia and was the directing physician of a private practice in West Philadelphia. For 17 years, he treated teenage girls from the West Philadelphia community. Occasionally, he referred patients who wanted to terminate their pregnancies to abortion providers. Gosnell's clinic was originally included as a provider in the referral information that Dr. Schwarz gave to his patients. He and his physician partners noticed, however, that patients who had abortions at Woman's Medical Society were returning to their private practice, soon after, infected with trichomoniasis, a sexually transmitted parasite, that they did not have before the abortions.

When this happened repeatedly, Dr. Schwarz sent a social worker to talk to people at Gosnell's facility. Based on the social worker's visit to Women's Medical Society, Dr. Schwarz stopped referring patients to the clinic. He also hand-delivered a formal letter of complaint to the office of the Pennsylvania Secretary of Health. Dr. Schwarz told the Grand Jury that he does not know what happened to his complaint. He never heard back from DOH. And the department did not include it in response to the Grand Jury's subpoena requesting all complaints relating to Gosnell's' clinic. We know that no inspection resulted.

We are very troubled that state health officials ignored this respected physician's report that girls were becoming infected with sexually transmitted diseases *at Gosnell's clinic* when they had abortions there. If Dr. Schwarz's complaint did not trigger an inspection, we are convinced that none would.

We also do not understand how a report of this magnitude was not at least added to Gosnell's file at the state department of health. It suggests to us that there may have been many more complaints that were never turned over to the Grand Jury.

We heard testimony from DOH officials who should have been aware of Dr. Schwarz's complaint – Kenneth Brody and Janice Staloski, at the least. Yet they made no mention of it to the Grand Jury. Did they remember the complaint and choose to exclude it from their testimony? Is ignoring complaints of this seriousness so routine at

health never even forward it on for action? Of these possible explanations, we are not sure which is the most troubling.

In addition to these two complaints filed in 1996 and 1997, Staloski herself received two inquiries from attorneys' offices about Gosnell's clinic in the first two months of 2002. One was from the Shaw family's attorney. The other was from a paralegal for yet a third attorney who phoned her on February 6, 2002, asking for information concerning the clinic. Surely these two inquiries in 2002 should have alerted Staloski that there were complaints from at least two people about the clinic, complaints serious enough to warrant civil attorneys' involvement. Yet she ordered no investigation of the clinic, even though it had not been site-reviewed *in nine years*.

In 2007, Dr. Frederick Hellman, the Medical Examiner for Delaware County, reported to DOH the stillbirth of a 30-week-old baby girl. A medical examiner investigator, Irene LaFlore, made the phone calls. She spoke to several DOH employees, including Brody, the senior counsel. The investigator reported to the DOH officials that the medical examiner had conducted an autopsy on the stillborn baby delivered by a 14-year-old girl at Crozier-Chester Medical Center. She explained that the baby's delivery had been induced in the course of an abortion performed by Gosnell, and that the medical examiner was concerned because performing an abortion at 30 weeks was a clear violation of the Abortion Control Act.

According to the investigator's notes, Brody suggested that the medical examiner inform the District Attorney's Office in Delaware County – for possible referral to Philadelphia, where the procedure occurred – because it was a crime to perform an abortion beyond 24 weeks. Brody said that neither DOH nor the state medical board had any authority over the matter. The senior counsel did ask the investigator to keep him informed. The investigator's notes suggest Brody told her that, once the district attorney acted, then the medical board could get involved.

Brody was correct to refer Dr. Hellman to the district attorney to prosecute the abortion of the 30-week pregnancy as a crime. That, however, did not absolve DOH of its responsibility. The information provided by Dr. Hellman's investigator should have been received as a complaint to DOH. The department should have initiated an investigation. DOH could have revoked the clinic's license without waiting for a criminal prosecution that might never (and did not) happen. Yet no one from the department went to investigate Gosnell's clinic.

Since February 2010, Department of Health officials have reinstituted regular inspections of abortion clinics – finding authority in the same statute they used earlier to justify not inspecting.

Staloski blamed the decision to abandon supposedly annual inspections of abortion clinics on DOH lawyers, who, she said, changed their legal opinions and advice to suit the policy preferences of different governors. Under Governor Robert Casey, she said, the department inspected abortion facilities annually. Yet, when Governor Tom Ridge came in, the attorneys interpreted the same

longer authorize those inspections. Then, only complaint-driven inspections supposedly were authorized. Staloski said that DOH's policy during Governor Ridge's administration was motivated by a desire not to be "putting a barrier up to women" seeking abortions.

Brody confirmed some of what Staloski told the Grand Jury. He described a meeting of high-level government officials in 1999 at which a decision was made not to accept a recommendation to reinstitute regular inspections of abortion clinics. The reasoning, as Brody recalled, was: "there was a concern that if they did routine inspections, that they may find a lot of these facilities didn't meet [the standards for getting patients out by stretcher or wheelchair in an emergency], and then there would be less abortion facilities, less access to women to have an abortion."

Brody testified that he did not consider the "access issue" a legal one. The Abortion Control Act, he told the Grand Jurors, charges DOH with protecting the health and safety of women having abortions and premature infants aborted alive. To carry out this responsibility, he said, DOH should regularly inspect the facilities.

Nevertheless, the position of DOH remained the same after Edward Rendell became governor. Using the legally faulty excuse that the department lacked the authority to inspect abortion clinics, Staloski left them unmonitored, presumably with the knowledge and blessing of her bosses, Deputy Secretary Stacy Mitchell and a succession of Secretaries of Health. The department continued its do-nothing policy until 2010, when media attention surrounding the raid of the Gosnell clinic exposed the results of years of hands-off "oversight." Now, once again, the regulations, which have never been modified, apparently allow for regular inspections. This is, and always was, the correct position. The state legislature gave DOH the duty to enforce its regulations; the authority and power to do so are implicit in that duty. The department abandoned this responsibility without explanation, and without notice to the public or the legislature.

Whatever its motivation, DOH's deliberate policy decision not to conduct regular inspections of abortion clinics did not serve the women of this Commonwealth. Nor did it protect late-term fetuses or viable babies born alive. The Grand Jury heard testimony from legitimate abortion providers and from abortion-rights advocates, and not one indicated that annual inspections would be unduly burdensome. The doctors we heard from, and the organizations that refer women to abortion providers, told us that the reputable providers comply with all of the state regulations and more. Annual inspections are not an issue with them. Many clinics in Pennsylvania are already inspected by NAF, whose standards are, in many ways, more protective of women's safety than are the state's regulations.

Without regular inspections, providers like Gosnell continue to operate; unlawful and dangerous third-trimester abortions go undetected; and many women, especially poor women, suffer. These are all consequences of DOH's abdication of its responsibility. Moreover, even if Staloski was instructed not to conduct regular, annual inspections, that does not explain why she failed to order inspections when complaints *were received*. It is clear to us that she was made aware, numerous times, that serious incidents had occurred at Gosnell's clinic. These incidents, which evidenced alarming as well as illegal long-standing patterns of behavior,

department, Staloski never ordered even one inspection.

Not even Karnamaya Mongar's death triggered an inspection or investigation.

On November 24, 2009, Gosnell sent a fax to the department, followed by a letter addressed to Staloski, notifying DOH that Karnamaya Mongar had died following an abortion at his clinic. (Gosnell's letter inaccurately stated that the second day of her procedure was November 18.) Darlene Augustine, a registered nurse and health quality administrator in the department's Division of Home Health, received the fax. Augustine, who supervises surveyors who respond to and investigate complaints at health care facilities, testified that she immediately notified her boss, Cynthia Boyne. (Boyne had become director of DOH's Division of Home Health in 2007, when Staloski was promoted to head the Bureau of Community Licensure and Certification.) Augustine said that she told Boyne on November 25 that DOH should immediately go out to the clinic and initiate an investigation. Augustine acknowledged that she generally had the authority to send surveyors out to investigate – and she often did so within an hour of receiving a notice of a serious event such as a death. She testified, however, that she felt she needed Director Boyne's approval because Gosnell's notice involved an abortion clinic.

Boyne did not give her approval. Instead, she went to the bureau director, Staloski, to discuss the matter. Augustine explained that abortion clinics were treated differently from other medical facilities because Staloski had for years overseen the department's handling of complaints and inspections – or lack of inspections – relating to abortion clinics. Staloski, according to Augustine, was "the ultimate decision-maker" with respect to whether DOH would conduct an inspection or investigation. Augustine testified that neither Boyne nor Staloski ever gave her approval to conduct the investigation that she thought was appropriate.

Boyne blamed Staloski. She said that her boss told her that DOH did not have the authority to investigate Mrs. Mongar's death. Staloski apparently reached this decision on her own, without ever consulting Brody, the legal counsel. Staloski, according to Boyne, was only interested in making sure that Gosnell filed an on-line report in accordance with a 2002 law, the Medical Care Availability and Reduction of Error (MCARE) Act. That law requires health care facilities to report serious events, including deaths to DOH. 40 P.S. §313.

Staloski's plan, Boyne said, was to then charge Gosnell with failing to file the report in a timely and proper manner. This is absurd, and Boyne should not have accepted such a ridiculous idea. Gosnell had reported Mrs. Mongar's death to DOH on November 24, 2009. While this was three or fours days late, and the notification came by fax and letter rather than computer, it is preposterous to think that Staloski, who had ignored two deaths and other serious injuries at the clinic, would take action against a doctor for filing a report three days late. Staloski was absolutely wrong about DOH's lack of authority to investigate Mrs. Mongar's death.

Appallingly, the chief counsel for the department of health, Christine Dutton, defended Staloski's inaction following Mrs.

and documents showing that Staloski and her staff were communicating with Gosnell's office to get him to file the MCARE form. Based on these very minimal efforts, Dutton insisted: "we were responsive." Pushed as to whether the death of a woman following an abortion should have prompted more action – perhaps an investigation or a report to law enforcement – Dutton argued there was no reason to think the death was suspicious. "People die," she said.

Not only was a probe into Mrs. Mongar's death authorized and appropriate under the Abortion Control Act, it was required under the MCARE law. 40 P.S. §306. Yet DOH did not investigate. Staloski told the Grand Jury that she remembered reviewing with Boyne the letter in which Gosnell notified DOH of Mrs. Mongar's death. Staloski said that it was really Boyne's responsibility to order an investigation, but acknowledged that she, as the bureau director, also failed to do so. Instead of conducting an investigation, Staloski and Boyne concerned themselves with badgering Gosnell to re-notify them of Mrs. Mongar's death.

Bureau Director Staloski, in fact, readily acknowledged many deficiencies in DOH's, and her own, oversight of abortion facilities. But her dismissive demeanor indicated to us that she did not really understand – or care about – the devastating impact that the department's neglect had had on the women whom Gosnell treated in his filthy, dangerous clinic.

Staloski excused the DOH practices that enabled Gosnell to operate in the manner that killed Ms. Shaw, Mrs. Mongar, and untold numbers of babies. She simply said the abortion regulations – *written by DOH* – do not require DOH to inspect abortion clinics.

When DOH inspectors finally entered Gosnell's clinic in February 2010, not at Staloski's direction but at the urging of law enforcement, Staloski seemed more annoyed than appalled or embarrassed. On the morning after the raid, she received a copy of an email that Boyne wrote to Brody the night of the raid. Boyne reported to the department's senior counsel that, at 12:45 a.m., she had told the Department of Health staff members at the clinic to "wrap it up and secure lodging in the interest of their safety." Boyne told Brody that the "staff walked into a very difficult setup." She complained that a representative of the District Attorney's Office was "badgering" DOH staff to shut down the facility immediately. Boyne was seeking Brody's legal guidance. Staloski's response to Boyne's email was: "I'd say we were used." Boyne's reply: "Bingo."

Staloksi, the woman most directly responsible for the department's oversight of abortion facilities, told the Grand Jury: "I haven't been in any facilities in probably – in an abortion facility in many, many years." The citizens of Pennsylvania deserve far better from those charged with protecting public health and safety.

Department of Health evaluators found multiple grounds to shut down the Women's Medical Society once they finally entered the facility.

It was not until February 18, 2010, when DOH representatives were escorted in by law enforcement agents, that they finally inspected the clinic that they had not bothered to visit in 13 years. This

an option. Over the next few days, the DOH evaluators identified a multitude of violations of the Abortion Control Act and abortion regulations, many of which were apparent with even a cursory glance around the facility.

The abortion regulations promulgated by DOH (28 Pa. Code §29.33(1)) require that abortion providers have the following ready for use to resuscitate patients whenever anesthesia is used:

> (i) Suction source.
> (ii) Oxygen source.
> (iii) Assorted size oral airways and endotracheal tubes.
> (iv) Laryngoscope.
> (v) Bag and mask and bag and endotracheal tube attachments for assisted ventilation.
> (vi) Intravenous fluids including blood volume expanders.
> (vii) Intravenous catheters and cut-down instrument tray.
> (viii) Emergency drugs for shock and metabolic imbalance.
> (ix) An individual to monitor respiratory rate, blood pressure, and heart rate.

When patients are sedated to the point of being deeply asleep, as they were when Gosnell performed second-trimester abortions, additional equipment is required. Even when the sedation is less deep – a level referred to as conscious sedation, in which the patient can still respond to verbal instructions – Pennsylvania regulations require that additional equipment be readily available, including a "monitor defibrillator with electrocardiogram visual display of heart rate and rhythm" (ECG) and a pulse oximeter. Women's Medical Society effectively had none of this. A document filed by DOH on March 12, 2010, referred to as an "Order to Show Cause," laid out several grounds for shutting the clinic. It stated that the only items on the list that were in the facility in any form were suction and oxygen sources and an unusable monitor defibrillator and ECG. Yet there was only one suction source for each procedure room, meaning that the same suction source used to perform the abortion would have to be used to resuscitate patients. The DOH document noted, moreover, that neither suction machine had an inspection sticker to indicate that it was functioning properly. The suction tubing on both machines was corroded, according to the report.

As for the supposed oxygen sources, DOH noted:

> One oxygen source was an E cylinder oxygen tank that lacked a label to indicate whether the tank was full or empty. The oxygen mask and tubing hanging from the tank were covered in a thick gray layer of a substance that appeared to be dust. … The other oxygen source at the … facility was an oxygen concentrator covered with a thin layer of dust. The oxygen concentrator bore no inspection sticker and no evidence of inspection to assure proper functioning. There was no oxygen mask or tubing with the oxygen concentrator.

The DOH document stated that the monitor defibrillator and ECG not only had no inspection sticker, but was unusable because there were no electrodes to attach to the machine. Latosha Lewis testified that

to Show Cause noted in Count I, each time Gosnell performed a procedure without the required equipment and drugs for resuscitation, he violated the abortion regulations §29.33(1). He also violated §29.33(4) by failing to have a doctor certified by the American Board (or Osteopathic Board) of Obstetrics and Gynecology either on staff or available as a consultant. (Count II.) The Department of Health also cited the clinic for failing to conduct or to record required lab tests in violation of §29.33(6). (Counts III and IV.)

After entering Gosnell's facility with law enforcement agents, DOH representatives reviewed the files of some of its patients (some of whom were present and had procedures on February 18, 2010, when the search was conducted; and some of whom had had procedures in the previous few months). Nine of the patients had had second-trimester abortions. Under Pennsylvania's abortion regulations, abortion providers are required to send any tissue from second-trimester procedures to a pathologist to determine whether there is evidence of viability. Gosnell had failed to do this for any of the nine patients, thus violating §29.33(8) nine times. (Count V.)

The Department of Health also charged Gosnell's clinic with failing to have written procedures and policies for the administration of anesthesia and for failing to maintain a list of employees permitted to administer it. These failures constituted violations of §29.33(12). (Count VI.) Other violations detailed by DOH in March 2010 were the failure to have patients in recovery monitored by a registered nurse or a licensed practical nurse, or to have such nurses enter the doctor's orders in the patients' medical records as required by §29.33(13). (Counts VII and VIII.)

The DOH document stated (in Count IX) that the clinic violated §29.33(14) of the abortion regulations by failing to have corridor doors and passages adequate in size and arrangement to allow a stretcher-borne patient to be moved from each procedure room and recovery room to a street-level exit. DOH noted that ambulance crews on February 18, 2010, had wanted to evacuate two patients from Gosnell's clinic on stretchers, but instead had to help them walk through the corridors. The situation was made even worse because the closest exit door to the street was padlocked shut, and the staff could not find the key.

Count X alleged that Gosnell failed to ensure that one of the patients having an abortion on February 18, 2010, had a private consultation regarding the necessity of her abortion, as required by §29.32. Count XI stated that the clinic failed to report the death of Karnamaya Mongar within 24 hours as required under 40 Pa.C.S. §1303.313(a) (the Medical Care Availability and Reduction of Error, or MCARE, Act).

Count XII spelled out a violation of §29.38(a)(5) of the abortion regulations, which requires doctors to file a "Report of Complication" with DOH any time they treat a patient as a result of a complication from an abortion. The complication that Gosnell treated, but allegedly did not report, was the cardiac arrest suffered by Karnamaya Mongar.

Count XIII accused the clinic of violating §29.38(5), which requires abortion providers to file quarterly reports with DOH, stating the number of abortions performed by the facility in each trimester of

that it had performed 116 first-trimester and 2 second-trimester abortions in the fourth quarter of 2009. But even in the few files that DOH evaluators reviewed in February 2010, there were six second-trimester procedures performed in the last two months of 2009.

The last count in the DOH document – Count XIV – cited the failure to file reports on every abortion performed, as required by §29.38(3). Specifically, DOH stated that Gosnell did not file reports on six of the women whose files DOH reviewed in February 2010. This failure violated the abortion regulations and constituted grounds for revoking DOH approval to perform abortions.

Indeed, each of the violations enumerated by the DOH Order to Show Cause constitutes grounds for revoking the clinic's approval to perform abortions under §29.43(d) – many times over, in fact. Once the DOH inspectors entered the facility in February 2010, they did a thorough job of inspecting Gosnell's clinic and moved quickly to revoke its "approval," based on the clinic's many flagrant violations of law.

The travesty, from this Grand Jury's perspective, is that DOH could and should have closed down Gosnell's clinic years before. Many, if not all, of the violations cited in the March 12, 2010, document had been present for nearly two decades. The violations had been apparent when DOH site-reviewers, including Susan Mitchell and Janice Staloski, inspected the facility in 1989, 1992, and 1993. Yet it was not until law enforcement discovered the horrendous conditions inside 3801 Lancaster Avenue that DOH took action to close the clinic.

The state Department of Health monitors other comparable health care facilities to assure quality care.

The Department of Health's decades-long neglect of its duty to ensure the health and safety of women undergoing medical procedures in abortion clinics is in stark contrast to its policies and practices with respect to procedures performed in other types of health care facilities.

DOH's authority and duty to regulate, license, and oversee the operation of various health care facilities arises from the Health Care Facilities Act, 35 Pa.C.S. §448.102 et seq. The purpose of the Act is spelled out in §448.801a:

> It is the purpose of this chapter to protect and promote the public health and welfare through the establishment and enforcement of regulations setting minimum standards in the construction, maintenance and operation of health care facilities. Such standards are intended by the legislature to assure safe, adequate and efficient facilities and services, and to promote the health, safety and adequate care of the patients or residents of such facilities. It is also the purpose of this chapter to assure quality health care through appropriate and nonduplicative review and inspection with due regard to the protection of the health and rights of privacy of

> operation of the health care facility or home health agency.

The Health Care Facilities Act charges DOH with the oversight of health care facilities including hospitals, home health care agencies, nursing facilities, cancer treatment centers, birth centers, and ambulatory surgical centers. The health department regulates, licenses, and monitors each of these types of facilities differently. The type of facility that is relevant to this Grand Jury's investigation is the "ambulatory surgical facility" (ASF). The Health Care Facilities Act defines an Ambulatory Surgical Facility as:

> A facility or portion thereof not located upon the premises of a hospital which provides specialty or multispecialty outpatient surgical treatment. Ambulatory surgical facility does not include individual or group practice offices of private physicians or dentists, unless such offices have a distinct part used solely for outpatient surgical treatment on a regular and organized basis. For the purposes of this provision, outpatient surgical treatment means surgical treatment to patients who do not require hospitalization, but who require constant medical supervision following the surgical procedure performed.

This is precisely what Gosnell's clinic was – a facility that provided specialty outpatient surgical treatment. And, by definition, so are all freestanding abortion clinics (those not associated with hospitals). The regulations that DOH wrote pursuant to the Abortion Control Act (18 Pa. C.S. §3201 et seq.) are entitled "Regulations for Ambulatory Gynecological Surgery" (28 Pa. Code 29.1, et seq.). Section 29.33(13) expressly requires:

> Each patient shall be supervised constantly while recovering from surgery or anesthesia, until she is released from recovery by a registered nurse or a licensed practical nurse under the direction of a registered nurse or a physician. The nurse shall evaluate the condition of the patient and enter a report of the evaluation and orders in the medical record of the patient.

The plain language of the Health Care Facilities Act mandates that abortion clinics should be regulated, licensed, and monitored as Ambulatory Surgical Facilities. DOH licenses many types of facilities as ASFs, including endoscopy centers, where colonoscopies are performed; offices where plastic surgery procedures such as liposuction, facelifts, and breast augmentation are performed; and eye surgery centers. Under the regulations written by DOH, such facilities must be inspected and licensed *yearly*. In addition, DOH inspectors are expressly authorized to inspect ASFs, at any time, announced or unannounced, to investigate any complaints (28 Pa. Code §§ 551.31 through 551.51).

The regulations for Pennsylvania ASFs – which run over 50 pages – provide a comprehensive set of rules and procedures to assure overall quality of care at such facilities. They include, for example, measures for infection control (28 Pa. Code. §567.3 lists

requirement that items be sterile (§567.21-24), and a requirement that the premises and equipment be kept clean and free of vermin, insects, rodents, and litter (§567.31).

The ASF regulations devote three pages to anesthesia protocols alone. They not only spell out the equipment a facility must have, but also require that the equipment actually be used to monitor patients under anesthesia. "At a minimum," 28 Pa. Code §555.33(6) requires:

> (i) The use of oxygen saturation by pulse oximetry.
> (ii) The use of End Tidal CO [2] monitoring during endotracheal anesthesia.
> (iii) The use of EKG monitoring.
> (iv) The use of blood pressure monitoring.

And §555.33(5) requires:

> (5) A patient receiving anesthesia shall have an anesthetic record maintained. This shall include a record of vital signs and all events taking place during the induction of, maintenance of and emergence from anesthesia, including the dosage and duration of anesthetic agents, other drugs and intravenous fluids.

These and other ASF regulations set out basic, minimum standards of care that any patient having a surgical procedure should expect to receive when anesthesia is involved. They are the standards that DOH came up with when charged by the legislature to assure safe, adequate, and efficient facilities and services and to promote the health, safety, and adequate care of patients.

The law exists. The regulations are clear. Why does DOH not apply or enforce these standards for abortion facilities? The state Department of Health inexplicably allows abortion clinics, alone, to go unmonitored.

The Grand Jury asked several DOH employees, attorneys as well as those charged with overseeing abortion facilities, why the department does not treat abortion clinics as ASFs when the language of the Health Care Facilities Acts is so clear. Their unsatisfactory answers left us bewildered.

The two attorneys closest to the issue – Senior Counsel Kenneth Brody, who advises the Division of Home Health, which currently oversees abortion clinics; and Senior Counsel James Steele, who advises the division that oversees ambulatory surgical facilities – both testified that they believe that abortion clinics such as Gosnell's fit within the law's definition of an ambulatory surgical facility. Their boss, Chief Counsel Christine Dutton, refused to acknowledge that the ASF definition would cover abortion clinics, but could not explain why it did not. She said she "would have to research that to determine if that were the case."

Dutton, however, before becoming chief counsel, was assigned to advise the DOH division that licenses ambulatory surgical facilities. As such, she had to be very familiar with what constitutes an ambulatory surgical facility. In fact, she was senior counsel to the division when DOH was dealing with the aftermath of

performed in a plastic surgeon's office. When the girl's parents complained to DOH, an immediate investigation revealed that the office of the surgeon, Dr. Richard Glunk, should have been licensed as an ASF, but was not.

As a result of the Glunk case, DOH initiated a campaign to encourage compliance with ASF licensure requirements. Chief Counsel Dutton would have been in the middle of that effort in 2002 when she was senior counsel. Yet she testified that she never considered treating abortion clinics – facilities where, according to the abortion regulations, "ambulatory gynecological surgery" is performed – as ambulatory surgical facilities.

It was clear to us after hearing these witnesses testify that the decisions not to inspect abortion clinics or to license them as ASFs were not based on any serious interpretation of statutes or legal research. These lawyers were simply twisting and reinterpreting the law to explain policy decisions that changed with administrations, even though the laws did not. Dutton admitted in her testimony that the decision not to inspect was a policy decision, not one grounded in the law:

> Q: Does it surprise you to know that some of the reasons cited for the failure to go out and do these inspections is that they believed that they didn't have the legal authority to do so?
> A: That would surprise me, yes. . . . To me, I would believe that they didn't go out to do them because some policy had been set in the department at some point in time in the past that we were not going to do regular inspections of abortion facilities.

Dutton's failure to recognize and treat abortion clinics as ASFs, and her silence as DOH shirked its duty to protect women and infants at abortion clinics, reflect a blatant refusal to enforce the law.

The DOH attorneys offered multiple explanations to attempt to justify why the department does not license abortion clinics in the same manner as any other ASF. None of their explanations comports with the law or with common sense.

Two of their "justifications" are barely worth comment. One lawyer told us that there is always "push-back" from doctors who do not want to be licensed as ASFs. Not only is this argument irrelevant to any legal analysis, it is unpersuasive. We learned that there are fewer than 30 abortion providers in the entire state. These doctors should not be able to exert that much push-back. Moreover, the legitimate abortion providers who testified before the Grand Jury told us that they already comply with standards as demanding as those for ASFs. Abortion rights advocates told us the same thing – that licensing abortion clinics as ASFs would not be burdensome because clinics that are members of NAF, or associated with Planned Parenthood, already comply with the highest standards of care.

A second reason proffered by DOH attorneys for not licensing abortion clinics – that abortion is "controversial" – is just insulting. Abortion is a legal medical procedure. Any controversy surrounding the issue should not affect how the law is enforced or whether the Department of Health protects the safety of women

Finally, Dutton, Brody, and Steele asserted that a provision of the abortion regulations – one that gives DOH the authority to approve facilities as abortion providers – somehow precludes any other health care law from applying to abortion clinics. The provision of the abortion regulations that DOH relies on to exempt abortion clinics from the requirements of the Health Care Facilities Act reads:

Facility approval

> (a) **Every medical facility which performs abortions within this Commonwealth shall be approved by the Department.**
> (b) All medical facilities except hospitals may become approved facilities upon submission of an application to the Department from a person authorized to represent such facility and, at the discretion of the Department, satisfactory completion of an onsite survey.
> (c) **Every hospital** licensed or approved by the Department, which has filed with the Department the Abortion Facility Registration form, and which meets the standards set forth in this title, will be deemed to be an approved facility by virtue of its hospital license or approval . . .
> (d) Notwithstanding this section, facility approval for performance of abortions may be revoked if this subchapter is not adhered to.

28 Pa. Code § 29.43 (emphasis added).

On its face, this explanation is nonsensical. The cited provision requires not only clinics, but also hospitals, to obtain DOH approval before abortions can be performed. This added approval requirement certainly does not exempt hospitals from all other applicable licensing requirements. Indeed section (c) assumes and refers to the licensing of the hospitals. This provision can no more remove abortion facilities from the regulations covering ASFs than it can remove DOH oversight responsibilities for hospitals.

If one were to accept DOH's interpretation of its duties with respect to overseeing the quality of care in abortion facilities, those duties would be limited to granting or denying approval based on a single piece of paper – the "Abortion Facility Registration Form," which contains the name and mailing address of a facility and a couple of check marks. Brody said that it is DOH practice to conduct an on-site survey of facilities before granting approval, but acknowledged that even that feeble effort at oversight is discretionary under the regulations. Then, once the initial approval is given, DOH – according to the rules that it wrote and interprets – never has to do anything else to monitor what happens in the abortion clinic.

Dutton, the chief counsel, testified that DOH's only role with respect to abortion clinics is to collect certain reports from them:

> Q: So which department of the Commonwealth of Pennsylvania is responsible for enforcing the Abortion Control Act?
> A: Primarily the Department of State and the District Attorney's Office and other law enforcement.
> Q: What about the Department of Health?

not filed and we become aware of the fact that that they're not filed.

Q: And that's it?

A: Uh-huh.

Q: So it's just a paper thing?

* * *

A: Yes. . . .When you read the act, that is what it unfortunately says.

The DOH attorneys all complained similarly about how little authority the Abortion Control Act, and the accompanying regulations that DOH wrote, gives to the department to inspect, license, or monitor abortion clinics. But it is these lawyers who are responsible for allowing their department to ignore the plain language of the Health Care Facilities Act.

That act gives DOH all the power it needs to assure safe abortion clinics. Yet, instead of applying the law as it is written, and counseling DOH to license abortion clinics as ASFs, these lawyers have used illogical arguments to evade the Health Care Facilities Act. They have insisted that a criminal statute, the Abortion Control Act, provides DOH's only authority to protect the health and safety of women and premature infants aborted alive within abortion clinics. Essentially, they have tied their own hands and now complain that they are powerless.

The Secretary of Health has, since the February 2010 raid, ordered the department to start inspecting abortion clinics regularly. Nevertheless, the larger point remains:

Women who go to abortion clinics and premature babies born alive at them deserve the same DOH protection as patients at other health care facilities. Abortion is legal, and political agendas should not influence how DOH carries out its responsibility to ensure the health and safety of medical patients at all facilities.

Pennsylvania's abortion regulations, written by the Department of Health, are totally inadequate to protect the health and safety of women at abortion clinics.

The abhorrent conditions and practices inside Gosnell's clinic are directly attributable to the Pennsylvania Health Department's refusal to treat abortion clinics as ambulatory surgical facilities. But even if DOH's position with respect to whether abortion clinics are ASFs were reasonable – which it is not – that interpretation would not excuse the department's abdication of its duty to afford women who go to these clinics the same types of safeguards that plastic surgery patients receive. This is because – whether a facility is called an ambulatory surgical facility, a hospital, or a freestanding abortion clinic – the legislature with the Abortion Control Act has charged DOH with the duty to write and enforce regulations that protect the health and safety of women undergoing abortion procedures.

DOH's position is that one subsection of the abortion regulations – 28 Pa. Code §29.33 – contains all of the rules necessary to ensure that women will be protected. But patients at any other ASF are

et seq. Gosnell's clinic, which operated for decades with impunity, constitutes more than sufficient proof that one subsection of regulations, without monitoring, licensing, or inspections, offers inadequate protection. Given that DOH is capable of writing and enforcing regulations that are comprehensive and enforceable, such as those governing ASFs, we question whether DOH officials have even tried over the decades to protect women who go to clinics for abortion procedures. The ASF regulations, for example, require that patients undergoing every other kind of ambulatory surgery be monitored with high-tech equipment while under anesthesia. The abortion regulations, on the other hand, require that the facility have the high-tech equipment, but do not require that it be used (28 Pa. Code § 29.33(1) and (2)). There is not a single provision in the abortion regulations relating to infection control (nothing to prohibit Gosnell from eating cereal while doing procedures, for example, or from reusing single-use instruments, or from allowing sick, flea-infested cats in the procedure rooms), whereas several pages of rules cover infection control at ASFs.

Most importantly, the abortion regulations include no requirement for DOH ever to inspect or monitor abortion providers. The Grand Jury was astonished to discover that abortion clinics in Pennsylvania, unlike any other health care facility, are apparently supposed to operate on the honor system.

Many abortion clinics deliver quality care because that is their mission. But what if a particular doctor's mission is to maximize profits by cutting corners? He may hire unqualified staff, reuse instruments, administer expired drugs, tolerate unsanitary facilities, and use obsolete and broken equipment – until one or more of his patients dies. Then, *after law enforcement gets involved*, DOH might take action. This is what happened in Gosnell's case. It is not a workable system for regulating health care facilities that perform one of the most common surgical procedures, or for assuring safe medical care for the women of Pennsylvania.

The laws and regulations designed to protect viable late-term fetuses and infants aborted alive can only be effective with Department of Health oversight.

In contrast to the provisions of the abortion regulations that are supposed to protect women's health at abortion facilities, those designed to protect late-term fetuses and infants born alive should have been sufficient to accomplish that purpose. Late-term fetuses, because of their advanced gestation and likely viability, are accorded certain legal rights. Pennsylvania's Abortion Control Act strictly prohibits abortions "when the gestational age of the unborn child is 24 or more weeks." The only significant exception is to prevent the pregnant woman's death or the "substantial and irreversible impairment of a major bodily function of the woman." 18 Pa.C.S. §3211(b)(1).

Pennsylvania law also requires medical practitioners to resuscitate babies that are born alive. The Abortion Control Act states: "All physicians and licensed medical personnel attending a child who is born alive during the course of an abortion or premature delivery, or after being carried to term, shall provide such child that type and degree of care and treatment which, in the good faith judgment of the physician, is commonly and customarily provided to any other

§3212(b).

Gosnell routinely performed abortions beyond the 24-week limit. He was ruthless in severing the spinal cords of viable babies outside their mothers' wombs. This conduct clearly constitutes prosecutable criminal behavior. In order for district attorneys to be able to prosecute, however, the crimes must first be detected. This is DOH's job – to ensure that violations of Pennsylvania health care laws are detected. Its inspectors must review files as part of their inspections. They must look at ultrasound tests and pathology reports on second-trimester fetuses. They must make sure that informed and parental consent forms have been signed and that abortions have been reported to DOH. Instead, Pennsylvania officials have created what amounts to an honor system, a system conspicuously lacking in regulatory oversight or enforcement. If DOH abdicates its responsibility to monitor and inspect abortion clinics, the protections that the Abortion Control Act provides to prematurely born infants and unborn post-24-week fetuses become meaningless to those willing to break the law. The wrongful death of a viable fetus is deemed a homicide. DOH must ensure that the law is applied to protect those least able to protect themselves.

Assuring safety at abortion clinics has been a low priority for Pennsylvania's Department of Health for decades.

No one from DOH was able to tell us who decided to exclude abortion clinics from meaningful oversight that would protect patient safety, or why such a decision was made. Nor did the jurors get a satisfactory answer as to why abortion clinics are under DOH's Division of Home Health (which oversees agencies that provide care in people's houses), rather than the more appropriate Division of Acute and Ambulatory Care. Or why, on DOH's website, even on the page that lists the types of facilities overseen by the Division of Home Health, abortion clinics are not even mentioned.

The website states:

> The Division of Home Health establishes and enforces quality care and safety standards for Health Care Facilities in Pennsylvania. We conduct state licensure, Medicare certification, and complaint investigations for the following health care providers:
>
> Birth Centers
>
> Comprehensive Outpatient Rehabilitation Facilities (CORFs)
>
> Home Health Agencies
>
> Home Care Agencies/Home Care Registries
>
> Hospice Agencies

(ESRD)

Outpatient Physical/Speech/Occupational Therapy Clinics

Rural Health Clinics

In addition to demonstrating the low priority that DOH has assigned to patient care in abortion clinics, the invisibility of abortion facilities on the website makes it next to impossible for clients or others who want to make complaints to do so. The website publishes phone numbers to call for various types of complaints: the Division of Acute and Ambulatory Care for ambulatory surgical facilities, the Division of Home Health's "hotline" for home health agencies, hospices, and End State Renal Disease facilities. There is no mention, however, that DOH even oversees abortion facilities, or that it accepts complaints about them.

In light of this, the policy that DOH would inspect facilities only in response to complaints (leaving aside that even this policy was not followed) goes beyond bad management. It appears to reflect purposeful neglect. It raises the question – as does the failure to act on the serious complaints against Gosnell – whether DOH ever intended to
exercise its responsibility to protect the health and safety of women seeking abortions in Pennsylvania.

No matter why or when or by whom the decision not to license or monitor abortion facilities was made, the practice has continued for roughly two decades and through several administrations. We have no idea how many facilities like Gosnell's have remained out of sight, out of mind of DOH for decades – since they were first "approved." The only thing DOH seems to have consistently concerned itself with during this time is collecting reports that the Abortion Control Act requires abortion providers to file with the department and the department, in turn, to report to the Legislature – forms for every abortion performed and quarterly reports stating how many first, second, and third trimester abortions the facility performed. This responsibility is clearly meaningless, since providers' information is not verified. Gosnell simply made up the information, and DOH never audited or checked the reports. As long as the department received some paperwork, that apparently was sufficient. The forms that Gosnell filed between 2000 and 2010 – the ones DOH then relied on to compile its reports to the Legislature – recorded only one second-trimester abortion and no complications. His false entries, alone, make DOH's reports to the Legislature worthless. Instead of using its manpower to inspect facilities and protect women's health, DOH has devoted its resources to collecting and publishing inaccurate and meaningless data – data that mislead the legislature and the public.

State Department of Health inspectors refused to share information with law enforcement.

Darlene Augustine testified that she was instructed by senior attorneys for DOH, Kenneth Brody and James Steele, that she should not reveal anything about Karnamaya Mongar's death to law enforcement when she accompanied them on the raid in February 2010. The lawyers told her that if she were asked about it, she should

their instruction was that information received by the department pursuant to the MCARE law is strictly confidential.

The MCARE law does provide some degree of confidentiality for materials obtained by DOH solely for the purpose of complying with MCARE's reporting requirement:

> § 1303.311. Confidentiality and compliance
>
> (a) PREPARED MATERIALS.-- Any documents, materials or information solely prepared or created for the purpose of compliance with section 310(b) or of reporting under section 304(a)(5) or (b), 306(a)(2) or (3), 307(b)(3), 308(a), 309(4), 310(b)(5) or 313 which arise out of matters reviewed by the patient safety committee pursuant to section 310(b) or the governing board of a medical facility pursuant to section 310(b) are confidential and shall not be discoverable or admissible as evidence in any civil or administrative action or proceeding. Any documents, materials, records or information that would otherwise be available from original sources shall not be construed as immune from discovery or use in any civil or administrative action or proceeding merely because they were presented to the patient safety committee or governing board of a medical facility.

The act does not, however, preclude disclosures of information necessary for criminal prosecutions. There are several reasons that this provision should not have prevented Darlene Augustine from sharing information about Karnamaya Mongar's death with law enforcement. First, two laws required that Gosnell inform DOH of Mongar's death – not only the MCARE Act, but also the Abortion Control Act. Second, according to DOH witnesses, Gosnell had not complied properly with the MCARE reporting requirement when the raid took place. Third, the clear purpose of this provision is to preclude the use of self-reported materials against the reporter in malpractice cases. Nothing in the language prohibits sharing information on a death with law enforcement, even if it had come in solely as a report under MCARE.

Had DOH investigated Mrs. Mongar's death, as it should have – and had it discovered, as it would have, that an unlicensed employee had administered the fatal anesthesia – it would have been incumbent on the department to report these criminal circumstances. Someone should have shared what DOH had learned about Mrs. Mongar's death with law enforcement agents conducting a search of the facility. There could be many similar situations in which DOH would learn information that could be crucial to law enforcement – where crimes might go undetected without DOH's cooperation. To the extent DOH believes that the MCARE Act precludes sharing information in criminal investigations, that situation needs to be addressed.