The Provincial Organization for Educational Pro-Life Groups Across Ontario

26 Norfolk Street, Guelph, Ontario, N1H 4H8 · Ph. 519-824-7797 · Fax. 519-836-2716 · Email: aflo@mgl.ca · www.allianceforlife.org

Murder in Plain Sight

The Case of the Women's Medical Society Philadelphia

A view on what should be learnt
from the case of the Women's Medical Society,
based on the Grand Jury Report

In the Court of the Common Pleas
First Judicial District of Pennsylvania Criminal Trial Division
In Re: Misc No 0009901-2008
County Investigating
Grand Jury XXIII

Report of the Grand Jury R. Seth Williams District Attorney

Respectfully submitted:
Mrs Jakki Jeffs, Executive Director
Mr Callum MacDonald BA., Researcher
May 31st 2011

Table of Contents

1. Executive Summary

The following report is an examination of issues which we believe must be discussed in the wake of the case of the Women's Medical Society (WMS) It is based solely on evidence taken from the Grand Jury Report, and highlights the three following key points;

1) This was not an isolated case, it was not carried out by one man, it was not performed in the shadows and it did not go unreported.

- A total of 10 inspections occurred during the 30 years the WMS was operating. These were carried out on behalf of 4 different organisations; the Department of Health (DoH), the Department of State (DoS), the Philadelphia Department of Public Health (PDPH) and the National Abortion Federation (NAF). The Grand Jury is certain that each of these inspections would have uncovered much, if not all, of the abuse and neglect occurring at the WMS. Despite this, not one of these inspections resulted in an attempt to shut the WMS down.

- At least six cases of malpractice committed by Kermit Gosnell and his staff were reported to the authorities, and many more passed through local hospitals. Two of the cases resulted in the death of a patient. Incredibly, not one of these reports triggered an investigation into Gosnell or the WMS.

- Several detailed complaints were lodged against Kermit Gosnell and the WMS. One was by a senior Doctor at the Children's Hospital of Philadelphia (CHP) and made to the DoH. Another was by a former employee of the WMS and filed with the DoS. A further complaint was made by the MCARE Fund, and concerned Gosnell's lack of liability insurance. All three complaints were ignored without any meaningful investigation being conducted.

- Multiple people were involved in the abuses which occurred at the WMS. Ten employees are charged with various offences by the Grand Jury. Three other doctors are recorded as working at or being associated with the WMS at various times.

2) A systemic and institutionalised desire to ignore blatant danger to women in order to protect access to abortion was responsible for the inaction against the WMS. This is shown in the following;

- Two government decisions regarding abortion are reported by the Grand Jury. The first was to abolish inspections of abortion facilities. The second was to not reinstate inspections. Both of these decisions were made out of a desire to protect abortion access at all costs

- The DoH twisted or ignored Pennsylvania law in order to treat abortion facilities differently from all other medical facilities. This included both the lack of inspections and the refusal to respond to any complaints.

- Oversight of abortion facilities was given to the DHH, a decision which confounded the Grand Jury. The DHH website makes no mention of its responsibility for abortion facilities, making it extremely difficult for any complaints to be made.

- The DoS and the PDPH also repeatedly ignored their duty to act against the WMS. This indicates that they were both under the same political instructions as the DoH.

- The NAF and other pro-abortion groups refused to act against the WMS despite being fully aware of the offences occurring. This can only be attributed to a desire not to tarnish abortion in a wider sense.

3) This case is relevant to any country, province or state sanctioning abortion. If transparent scrutiny of abortion facilities is not enforced, if abortion facilities are not openly treated the same as any other medical facility, then there is no safeguard against this happening elsewhere.

These atrocities were neither isolated nor hidden. It is clear that a systemic bias towards abortion ensured these offences were ignored and the perpetrators protected. It is the responsibility of all governments which sanction abortion as a medical procedure to protect the women in their care. Protect them from greed, gross misuses of the law and any political agenda. The Grand Jury Report is adamant that transparent scrutiny of abortion facilities is vital in providing this protection. **Any government that does not ensure this level of protection creates the same environment which allowed Kermit Gosnell and his accomplices at the WMS to operate for 30 years.** This happened in the Commonwealth of Pennsylvania under some of the strictest abortion laws in North America. If it happened there, it can happen anywhere.

2. Introduction

On the 18th of February 2010 an FBI raid brought to an end the three decade reign of Kermit Gosnell and his facility, the Women's Medical Society (WMS). Over the preceding 30 years Gosnell and the WMS had become infamous for both their willingness to carry out any abortion, regardless of legality, the horrific standard of the facility and the treatment provided there. The raid discovered the following and many more hideous crimes, including but not limited to;

- foetal remains stored in a variety of haphazard ways
- severed limbs of aborted children
- extensive evidence of infanticide
- evidence of numerous late term abortions
- proof of a reckless culture of unqualified persons providing treatment, including carrying out abortions.

The Grand Jury investigation into the WMS discovered even greater crimes, including at least two documented deaths and many cases of permanent injury being caused to women. The offences carried out at the WMS were vast, and the Grand Jury Report details them sufficiently. No one other than those involved will defend the horrific actions at the WMS, and it is certain that all those charged in the Grand Jury Report will pay heavily for their crimes.

2.1 Misconceptions

This report will focus on three areas, three misconceptions that could potentially be used in an attempt to limit the scope of discussion caused by this hideous case. These are;

1) That this was a case of one man abusing his position, a case which inexplicably escaped an otherwise effective body of abortion regulation in Pennsylvania.
2) That this case had nothing to do with the political debate on abortion.
3) That any concerns raised by this case should be limited to the Commonwealth of Pennsylvania.

This report will show that these three statements are false. Evidence presented by the impartial Grand Jury Report supports this claim.

3. Not an isolated case that “slipped” through the cracks.....

It would be very easy, and for some very convenient, to see the events that took place at the WMS as existing in a vacuum, brutal acts committed by one man, Kermit Gosnell, in an aberration of a facility that somehow went unnoticed due to a series of unfortunate mistakes or oversights. This simply was not the case.

3.1 The Inspections

In the three decades the WMS was open it was “inspected” no less than nine separate times, by four separate organisations. The Pennsylvania Department of Health (DoH) first inspected the WMS when it was established in 1979 (p139), then again in 1989 (p140), 1992 (p140-141) and finally in 1993 (p141-142). Throughout these inspections numerous serious problems were discovered but then overlooked. Among the inspectors that visited the WMS on behalf of the DoH was Janice Staloski, who would later make major decisions regarding complaints against the WMS, decisions which would allow it to remain open.

The Philadelphia Department of Public Health (PDPH) was the next body to inspect the WMS following a complaint made to its Environmental Engineering Section (EES). The first of these took place in 2003, although there are no official records of what the visit uncovered (p204). The second inspection of the WMS by the EES took place in 2004, as a result of the failure of the WMS to file a completed “infectious waste plan”. This inspection is on record; however it only details the issues pertinent to the previously mentioned “infectious waste”. No further observations of the facility were made in the report (p205-206).

In 2008 registered nurse Lori Matijkiw entered the WMS on behalf of the PDPH Division of Disease Control (DDC). Her report resulted in the expulsion of the facility from a city vaccination program (p199-202).

Her second inspection in 2009 prevented the facility from being re-admitted into the same program (p202-203). However, despite the strength and scope of Matijkiw's condemnation for the WMS in her reports, no further action was taken by her supervisors (p 199, 200, 203). It is also of note that other employees of the DDC had entered the WMS collecting blood for its Sexually Transmitted Disease Control Program. However, there is no evidence of any report being made regarding the conditions at the WMS to the DDC (p208). It appears that within the DDC, only Nurse Matijkiw encountered the WMS and felt it was her responsibility to act.

An inspector on behalf of the National Abortion Federation (NAF) was the last to assess the WMS. Her view of the facility was such that it was rejected membership to the NAF and her report detailed what the Grand Jury identifies as "life threatening practices (p 94). In front of the Grand Jury she admitted this was the first time in her experience that the rejection of a facility had happened. Despite this no further action was taken by the NAF (p91-96).

The above shows that countless people, from four organisations and on ten separate occasions, entered the WMS and inspected the facility. In all cases faults were discovered only to be ignored or acted upon within the narrowest of scopes. Each of these organisations will make excuses for the limitations of their actions, but what cannot be denied is that they were each made very aware of the highly dangerous medical neglect occurring at the WMS.

3.2 Reported Cases

The Grand Jury Report refers to six cases of serious malpractice occurring at the WMS of which officials were made aware of between 1996 and 2009. It is certain that many more such cases occurred, and possibly were also reported. However, these particular cases are detailed in full, as is the official reaction to them.

The first of these documented cases was reported to the DoH in 1996. It concerned an unnamed 19 year old who suffered a perforated uterus during an abortion at the WMS.

Following a delay in the staff calling for the emergency services, the woman was found not breathing by the paramedics. She was taken to the Hospital at the University of Pennsylvania (HUP), where a life saving hysterectomy was performed. The attorney of the unnamed women filed a complaint with the DoH. Other than making excuses for not releasing any records and redirecting the attorney to contact the DoS, no action was taken by the DoH (p195).

The death of Semika Shaw in 2000 was a result of sepsis caused by yet another perforated uterus (p174). This was reported to both the DoH and the DoS. An attorney representing her family first contacted the DoH requesting inspection reports for the WMS. Janice Staloski, who had inspected the WMS personally in 1992 and was at the time the director of the DoH's Division of Home Health (DHH), responded that there had been no inspections since 1993 due to a lack of complaints. This answer was not true (p143). The case was then reported to the DoS following a combined settlement totalling $900,000 by the Professional Underwriters Liability Insurance Company and the Pennsylvania Medical Professional Liability Catastrophe Loss Fund (p174). Despite this sizable settlement, the DoS dropped the case with no significant investigation in 2004 (p174-176).

In 2005 a woman named as "Alice" in the Grand Jury Report suffered a seizure after being given anaesthesia during an abortion at the WMS. "Alice" had informed the staff at the WMS that she was undergoing methadone treatment. However, the staff ignored this, and used a form of anaesthesia which reacts with methadone, causing the seizure. When her attorney informed DoS of the malpractice complaint lodged against Gosnell as a result, they also raised questions over his insurance coverage. No investigation was made into either of these issues, and no further action was taken by the DoS (p181-182).

In 2006 Dana Haynes suffered tears to her cervix, uterus and bowl during an abortion at the WMS, and was left with parts of the child still within her (p184). Following a lengthy delay caused by Gosnell and his staff, she was taken to the Hospital of the University of Pennsylvania (HUP), where she underwent

surgery and spent five days recovering (p213). In 2008 the DoS was made aware of a civil malpractice lawsuit lodged by Dana Haynes against Kermit Gosnell; however, no action was taken as they saw no “pattern of conduct” (p184-185).

In 2007 a 14 year old girl named as “Nancy” in the Grand Jury Report delivered a stillborn baby at Crozer-Chester Hospital (CCH) as a result of undergoing an abortion treatment at the WMS (p84). As this was obviously a result of an illegal late term abortion, the staff at CCH reported the case to the Delaware County Medical Examiner, who in turn reported it to the DoH. The DoH took no action (p86, 146).

In 2009 Karnamaya Mongar died following repeated overdosing during an abortion at the WMS (p117-125). After hours of delaying by Gosnell and his staff, she was taken to the HUP where she never recovered consciousness (p129-130). The DoH were informed of the death of Mrs. Mongar less than a week later, when it was decided by Janice Staloski that there would be no investigation (P149-152).

It is worth noting that four of the above cases passed through hospitals, three at the HUP, one more at CCH. Three more documented cases which appear to have not been reported to the DoS or the DoH also passed through hospitals. In 1999 Marie Smith was taken to the Presbyterian Hospital (PH) with parts of her child still inside her following an abortion at the WMS (p72). In 2004 Gosnell lied to a woman about the gestational age of her unborn child. He had said the baby was 21 weeks gestation rather than the actual 29 weeks. During the three day abortion procedure the woman changed her mind. Despite her objections Gosnell refused to halt the process. She was taken to the HUP where she gave birth to a premature baby. The baby was treated at the Children’s Hospital of Philadelphia (CHP) and is alive and well today. However, the hospital’s staff were aware that the premature birth was a result of the illegal actions of Gosnell (p86-87). In 2008 a woman named as “Sue” in the Grand Jury Report was taken to CCH following complications after Gosnell had “aborted” her 29 week old child. The child had in fact been murdered following birth, and is the child referred to as “Baby Boy A” in the Grand Jury Report (p100-103).

Latosha Lewis, employee of the WMS, testified in front of the Grand Jury that a HUP member of staff had told her they treat “a lot” of patients who come from the WMS with issues (p214). The knowledge that the medical community appears to have had of the WMS is important to highlight, as the Abortion Control Act of Pennsylvania clearly requires that any complications believed to be the result of an abortion must be reported to the DoH (p212).

The above clearly shows that the DoH, the DoS and the surrounding medical community were aware of individual cases proving the dangers of both Gosnell and the WMS, and had been for some time. The DoS had been aware of the danger Gosnell presented to women as far back as 1972, following his involvement in the “Mothers Day Massacre” (p96-98), when Gosnell, along with Harvey Karman butchered 15 women during the “testing” of Karman’s “super coil”. In spite of all of this evidence, no action was taken by either the DoS or the DoH for over 30 years.

3.3 Direct Complaints

There has been several recorded broader complaints lodged against Gosnell and the WMS which went ignored.

The first was made at some point between 1996 and 1997, by the then Head of Adolescent Services at the CHP, Dr Donald Schwarz. Dr Schwarz became suspicious of the WMS after a number of his patients referred to the facility returned to him or his colleagues with the same sexually transmitted parasite. Because of this a social worker was sent to the WMS, and in light of the findings of their report, Dr Schwarz hand delivered a letter of complaint to the DoH. No action was taken by the DoH (p144). The Grand Jury Report condemns this inaction, stating that if the complaint of Dr Schwarz did not result in action against the WMS, then nothing would (p145). It is also worth noting that some time later Dr Schwarz would become the Health Commissioner of Philadelphia (p204), where despite claims that he is taking steps to improve the department (p207), he has failed to act on what he was already aware was happening at the WMS.

In 2001 Marcella Stanley Choung, a former employee of Gosnell's, filed a highly detailed complaint against the WMS with the DoS, giving information on all the delinquent practices taking place there, information she expanded on when she later met with a DoS investigator. The DoS did launch an investigation of sorts; however this was limited to speaking with a doctor who had briefly worked at the WMS, a local pharmacy and Gosnell himself. No inspection of the facility was made. In 2004 the case was closed by the DoS (p176-179).

In 2005 a complaint was made by Medical Care Availability and Reduction of Error (MCARE) Fund to the DoS that Gosnell did not have full liability insurance. Despite this overlapping with the period during which the DoS was dealing with the case of "Alice", which also accused Gosnell of not holding insurance, only a minimal investigation was launched, and quietly dropped a year later (p183).

Any complaint against a medical facility should be investigated, to protect the public. It is remarkable that complaints so complete in detail and from sources as relevant as an ex-employee or a nearby physician could be ignored so easily, or information from a fellow government body be discounted without action. It should also be noted that Dr Schwarz made his complaint to the DoH prior to Janice Staloski claiming there had been no complaints against the WMS in 2000. What is clear is that this is further evidence that the DoS and the DoH was aware of repeated acts of malpractice performed by Kermit Gosnell, the highly dangerous conditions of the WMS and the brutal culture of mistreatment of patients adopted by those who worked there.

3.4 Number of People Involved

Kermit Gosnell has the most to answer for regarding the WMS; he was clearly the organising force and primary benefactor of all that happened there. However, he by no means acted alone.

Ten people are recommended for criminal charges in the Grand Jury Report. Lynda Williams and Sherry West are charged along with Gosnell on various counts regarding the death of Mrs. Mongar,

including third degree murder (p221-222). Williams is further charged, along with Gosnell, with the murder of a baby born alive (p225), as is Adrienne Moton for a separate murder (p226), and Steven Massof for another two murders (p227-228). All five are also charged with conspiracy to commit murder (p228). Williams, West, Kermit and Pearl Gosnell are also charged with performing illegal abortions (p234). They are joined on the charge sheet by Liz Hampton, Eileen O'Neil, Tina Baldwin and Maddline Joe, for various counts of perjury, corruption, hindering police investigations and corrupting a minor (p219-245). All but a few of these charges are also placed against Gosnell, but it must be stated clearly that he was not the only person who performed these crimes.

Various other doctors are documented as being involved with the WMS. Dr Joni Magee was listed on the WMS staff during the first DoH inspection in 1979 (p139). In 1992 and 1993 Dr Martin Weisberg is listed on the staff (p140). When investigating the complaints of Marcella Stanley Choung the DoH investigator contacted a Dr. Warren Taylor, who is documented to have performed abortions at the WMS (p178).

Gosnell also worked at a second abortion facility, the Atlantic Women's Medical Society (AWMS) in Delaware (p259). There is evidence that patients were being referred to the WMS from AWMS for late term abortions. This site was approved for membership by the NAF, a decision the Grand Jury Report questions strongly*. Surely questions should be asked of whether Gosnell operated in the same manor in this second facility, and if so, how did the facility pass a NAF inspection. In light of the findings at the WMS it is expected that a detailed investigation of any associated facility, and anyone working there, would be carried out.

3.5 It was an ongoing, widely known issue, carried out by numerous people

The above clearly shows that any attempt to view the WMS as an isolated case, carried out by one man, is folly. It also exposes the extent to which those responsible for preventing such things were aware of them taking place. This fact alone should lead to the question, "how it can be certain this did not occur elsewhere?" Kermit Gosnell has much to answer for, and should be punished by the full weight of the law. However, to paint the events that took place at the WMS as the fault and responsibility of one man, in effect making Gosnell the "bogey man" of the entire case, would be ignoring blatant facts. **These were not isolated cases, they were not carried out by one man, they were not performed in the shadows and they did not go unreported.** And the list of those responsible contains far more than the name Kermit Gosnell.

* On January 31st 2011 it was reported that the National Abortion Federation (NAF) has finally acted to retract the AWMS's membership.

NAF Suspends Delaware Clinics that Employed Abortionist Kermit Gosnell, National Right to Life News, Dave Andrusko*, 01/31/2011– http://www.nrlc.org/News_and_Views/Jan2011/nv013111.html*

4. This case was “about abortion”

The inaction previously noted is evident. More than once several organisations were made aware of the dire situation at the WMS and failed to act. Questions must now be asked. How was this ever allowed to happen? What drove these organisations to adopt a policy that facilitated 30 years of blatant disregard of the laws, health care regulations, medical principles and guidelines? This abandonment resulted in a complete lack of protection for women seeking induced abortions and a callous disregard for their safety. The Grand Jury Report acknowledges that a strong pro-abortion agenda led to what it called “*the official neglect that allowed these crimes and conditions to persist for years in a Philadelphia medical facility”* (p137). Whilst the Grand Jury Report details a disgraceful amount of incompetence within these organisations, there is also undeniable evidence that a political agenda was the driving force behind these actions, one which supported access to abortion at all costs.

4.1 The DoH

The DoH stands out above all other organisations in the lengths it went in order to ensure it did not take action against abortion facilities. As the body legally responsible to regulate such facilities, the DoH used a deliberately twisted interpretation of the law to justify a politically motivated decision not to regulate abortion facilities in any meaningful way.

Prior to 1993 the DoH was far from performing its task of regulating abortion facilities well. This is evident in the time allowed to lapse between the annual inspections and the willingness to ignore flaws when an inspection was eventually carried out, indicating an existing policy to treat abortion facilities differently. However, some time after the final inspection of the WMS the decision was made to cease annual inspections completely, stating that inspections represented “putting up barriers to women” seeking abortion. This move is attributed by the Grand Jury Report to the change of Pennsylvania Governor in this period (p9, 147). This is clear evidence of a politically driven policy to treat abortion facilities with less care than any other medical facility.

This decision was reinforced in what DoH Senior Counsel Kenneth Brody describes as a “meeting of high-level government officials”, where it was decided not to reinstate annual inspections as many facilities would fail, therefore reducing access to abortion (p147).

What has to be understood is that when the decision to no longer inspect abortion facilities was made, no laws were changed. DoH employees proceeded to twist what laws and regulations they could, and ignore those they could not. The Grand Jury Report is clear on this; throughout this period the DoH had both the authority and obligation to regulate abortion facilities (p137, 157-160). This certainly included regular inspections and an appropriate response to any complaints. This point was punctuated in 2010, when, following the media attention the WMS received, the DoH reinstated annual inspections, managing to suddenly find the authority in the (still unchanged) laws which they claimed had previously prevented them from doing so (p147).

Whilst the policy decision was made to no longer annually inspect abortion facilities, the official line was that an investigation would still be launched in the event of a complaint. Despite this, the DoH, like every other state or city department, refused to react on any complaints. Central to more than one decision to act against the WMS is one person, Janice Staloski. Staloski inspected the WMS in 1992, when despite a large number of serious issues it was reported that the facility had “no deficiencies” (p140-141). By 2002 Staloski had risen to the position of Director of the DHH, when she is shown to have responded to a lawyer’s request for information about the WMS by saying there had been no recent inspections of the facility due to a lack of complaints. While there had been no inspections since 1993, the claim that there had been no complaints was simply not true (p143). Seven years later Staloski, now the head of the Bureau of Community Licensure and Certification (BCLC) was informed of the death of Karnamaya Mongar by Darlene Augustine and Cynthia Boyne, and did not act. Augustine and Boyne both had the authority to launch an investigation into the death, but did not, as it was an abortion facility which was involved. In the words of Augustine, Staloski was “the ultimate decision maker” regarding abortion facilities (p149-150).

The existence of one person within the DoH who was viewed as an unchallengeable authority on the treatment of complaints against abortion facilities is in itself a disgrace. When pushed in front of the Grand Jury, Staloski blamed lawyers who changed their view of the law to support the prevailing political policy (p147), however Staloski did not explain why she never challenged such flimsy legal advice. This does show how deep the desire to follow political policy on abortion went in the DoH, and when viewed in light of the length of time this behaviour was taking place, and the number of people involved, Staloski is just one part of the machine of neglect towards abortion facilities which existed within the DoH, albeit by 2009 a clearly vital part.

Even prior to a case being dismissed by the DoH, barriers were in place which prevented complaints being heard. The Grand Jury Report voices its confusion at the DHH being placed in charge of abortion facilities, when it's more natural home would be the Division of Acute and Ambulatory Care (p169). As well as not being under the department one might expect, the DHH did not list abortion facilities on its website, meaning it was nearly impossible for anyone to discover this was where complaints were to be made.

In the Grand Jury Report it is clearly stated that the DoH was neglecting its responsibilities by treating abortion facilities this way. However, the DoH provided several bemusing reasons for acting in this manner. Two of the excuses given are unsurprisingly dismissed out of hand by the Grand Jury Report. These are;

- that abortion is controversial
- that there was a fear of "backlash" from abortion providers if they acted more strongly (p162-163)

Both of these "reasons" are discounted for what they are, irrelevant to the fact that the DoH had a duty to regulate abortion facilities. Another reason given was that Health Care Facilities Act prevented them from applying other laws regarding Ambulatory Surgical Facilities (ASF) to abortion facilities (p163-166). The Grand Jury Report correctly points out that this interpretation of the code was flawed.

The DoH would not have the authority to regulate **any** part of **any** facility which carried out abortions, including hospitals, if one were to use its interpretation of the Health Care Facilities Act (p164).

What is clear is that in addition to ignoring the duty it had to regulate abortion facilities, both by failing to inspect or respond to complaints, the DoH did so without any sound legal reasoning. This behaviour was driven by political policy, which in essence instructed the DoH to ignore the law in order to support a pro-abortion agenda. The DoH happily obliged.

4.2 The DoS and the PDPH

Whilst the Grand Jury Report is as scathing in its assessment of the DoS and the PDPH as it is of the DoH, there is no record presented of an event showing the deliberate nature of these actions. However, one would be naive to believe that these organisations did not come under the same political influences which directed the DoH to change their policy.

The responsibility for regulating medical practitioners, including responding to complaints, should be exercised by the DoS's Board of Medicine (BoM) .Yet in the face of complaints against Gosnell, the DoS refused to act on numerous occasions. The Grand Jury Report ascertains that this was not simple incompetence, stating that these choices were known to the superiors of those making them, and therefore the issue was more far reaching than just the attorneys involved (p190). Unless it can be believed that Kermit Gosnell alone was treated this way by the DoS, this is a clear indication of the refusal of all at the DoS to act against someone providing abortions.

A similar argument can be made against the PDPH. On several occasions employees of the PDPH entered the WMS, from two separate departments. Those of the EES appeared to ignore all but the narrow remit of their investigation, and even then took no action against the WMS for its failures (p205-206). When the nurse inspecting the WMS on behalf of the DDC reported all the issues she discovered within the WMS, her supervisors only acted to remove the facility from its vaccination program.

Not only was no further action taken, the facility was also considered for readmission less than a year later (p199-203). Again, in the absence of any reason why the WMS alone was treated this way, this is a clear indication of the refusal of the PDPH to act against an abortion facility.

The actions of the DoS and the PDPH, and the outcomes they produced (the continuation of abortion facilities regardless of their safety) are so similar to those of the DoH, that to assume they were not a result of the same instructions from the same political source would be ignoring blatant evidence to the contrary.

4.3 The NAF and other Pro-Abortion Groups

These are groups which claim to protect the safety of women by inspecting facilities and only referring women to those which are “safe”. The NAF did refuse the WMS admission following an inspection of the facility (p 95). The Grand Jury Report also refers to other sources of abortion referrals which stopped sending women to the WMS (p26-27). Being non government organisations, these groups may claim that these actions were the limit of their authority. However, they each were aware of the grievous issues of the WMS, particularly the NAF. The refusal of the NAF to act was an abandonment of the women they claim to protect in their mission statement. Whilst the NAF claims to “ensure safe, legal, and accessible abortion care, which promotes health and Justice for women”, it appears its only true concern was to protect access to abortion.

Lacking any legal authority themselves, any of these organisations still had the ability to lodge complaints. If such complaints then fell on deaf ears, they could have brought the issue to the attention of the media. However, they did not. Not one of these groups took action to bring wider attention to the WMS.

The only reason imaginable for this lack of action is that these groups did not want to “tarnish” abortion in a wider sense. That this political decision could be made in the face of the knowledge of such horrors, shows clearly that a pro-abortion agenda took priority over the safety of women.

Because of their desire to protect abortion at all costs, these groups are as much to blame as the DoH, the DoS and the PDPH, for allowing the WMS to continue to operate.

4.4 This was the result of a pro-abortion agenda

Having already established just how widespread knowledge of the danger to women the WMS presented, the motives for the flagrant and continuous inaction of those who were aware must be clearly stated. **The Grand Jury carried out a detailed investigation into this question, and the resulting evidence shows that a desire to ensure abortion facilities remained open regardless of their safety played a key role in the continuation of the WMS.** This policy prevailed in defiance of the law, which required action be taken. This policy prevented action by organisations whose very mission statement claims they seek to protect women. That a political agenda can grip several state and city departments to the point of ignoring their legal obligations for more than 30 years, resulting in untold death and harm, is as terrifying an abuse of power as any imaginable. It was just such an abuse which occurred in the Commonwealth of Pennsylvania. The political agenda behind it was one of protecting access to abortion at all costs.

5. Wider Relevance

Having dispelled the myth that this was an isolated, hidden case and the misconception that the government organisations involved (as well as others) could not have prevented this from occurring, the next and possibly last argument is that this case only applies to the Commonwealth of Pennsylvania.

Whilst it is true that the evidence in the Grand Jury Report refers to Pennsylvania alone, the question must be asked, what would stop this happening elsewhere? Is it conceivable that Pennsylvania is the only body of government to have a strongly pro-abortion political influence, or to have departments as malleable as those in Pennsylvania? Only a similar investigation to the one in Pennsylvania could truly say. However, the Grand Jury Report into the WMS clearly details the concealed neglect of duty by those who allowed the WMS to continue operating. In any province, state, or country that sanctions abortion, the regulatory actions should be transparent and open to public inquiry. If the answer to the following questions is either “no” or impossible to find, it would be illogical to believe a case like the WMS is not possible within that jurisdiction.

Does the state/country in question;

- **Annually inspect abortion facilities, and provide publically accessible results**
- **Record and respond to all complaints, and provide publically accessible reports on the outcome**
- **Record and investigate any medical complications occurring during an abortion procedure, with a publically accessible report on the outcome**
- **Have a clearly outlined and easy to use procedure for complaining against abortion facilities**
- **Keep detailed records of all abortions, with any non personal information accessible to the public**

Opponents of any of the above suggest that such transparency would present a barrier to women seeking abortion. However, the Grand Jury Report makes it clear that it was precisely this justification of secrecy which played a key part in the continuation of the WMS. In Pennsylvania the DoH used such arguments to treat abortion differently to any other medical procedure. A facility providing liposuction was (rightly) investigated and acted against following the report of a death (p161). The Grand Jury Report also noted that nail salons receive greater regulation than abortion facilities (p137). Abortion regulations are covered in one subsection of the DoH code; all other Ambulatory Surgical Facilities (ASF) are covered in 30 pages (p166). If governments, medical bodies and abortion advocates insist abortion is a valid medical procedure, why did the Grand Jury Report discover such resistance to submitting abortion to the same regulations and transparency required for other medical procedures? The number of recorded heart attacks in a country is not kept secret to protect those who suffered one. Inspecting hospitals is not seen as erecting “barriers” for those who wish to be treated there.

The aforementioned requests for transparency in abortion regulation are reasonable. If governments refuse to meet them, then we must ask why. There is not a single logical reason to believe that, in the absence of these assurances for honest oversight, the situation elsewhere will be different to the one exposed in the Commonwealth of Pennsylvania.

6. Conclusion

This report aimed to dispel three misconceptions that could be used to downplay the horrific truth regarding the case of the Women's Medical Society. We believe these misconceptions have been dispelled by the evidence presented in this report. Kermit Gosnell was not the only offender. It cannot be disputed that government and non-government organisations, as well as a large number of medical professionals, were aware of these offences for up to three decades. The influence of a systemic bias in support of abortion is evident in facts revealed throughout the Grand Jury Report. This is proven in the exposition of what the Grand Jury Report calls a "see no evil" policy displayed by those charged with safeguarding women's health (p8). This stance is directly referred to in the testimony of state employees. The ease with which the political agenda of those in power was imposed on the various state and city departments is as undeniable as it is terrifying. **Unless and until abortion facilities are treated with the same transparency and scrutiny applied to all other medical facilities, the potential for further abuse on this horrific scale exists in any other jurisdiction.**

These atrocities were neither isolated nor hidden. It is clear that an overwhelming desire to protect abortion access at all costs resulted in these offences being ignored and the perpetrators protected. It is the responsibility of all governments which sanction abortion as a medical procedure to protect the women in their care. Protect them from greed, gross misuses of the law and any political agenda. The Grand Jury Report is adamant that transparent scrutiny of abortion facilities, as with all other medical facilities, is vital in providing this security. Any government that does not ensure this creates the same environment which allowed Kermit Gosnell and those in the WMS to operate for 30 years. This happened in the Commonwealth of Pennsylvania under some of the strictest abortion laws in North America. If it happened there, it can happen anywhere.

7. List of Events

The following is a chronological list of all events detailed in the Grand Jury Report. Dates are given as they appear in the Grand Jury Report, missing information is denoted by two dashes (--).

(05/14/1972)

Kermit Gosnell experimented on 15 women with a "super coil", resulting in serious complications for 9 of the women, one of which needed a hysterectomy. The device was invented by **Harvey Karman**, who had previously "tested" his creation on Bangladeshi rape victims. Although the **DoS** and various other government bodies were made aware of what would become known as "the Mothers Day Massacre, the only action taken was a recommendation of "strict controls on future testing". **Karman** escaped punishment on a technicality, whilst **Gosnell** was not held accountable at all (p96-98).

(12/20/1979)

The WMS is granted approval by the DoH to operate as an abortion facility following a "site review". **Joni Magee**, a certified obstetrician/gynaecologist, was listed as the medical director, whilst **Kermit Gosnell** was noted as staff physician. A registered nurse was said to be working two days a week, lab work was being completed by an external contractor and all other considerations appear satisfied in the report. However, the Grand Jury Report questions the source of these findings, as much of the site review appeared to consist of staff interviews (p139).

(12/20/1980)

DoH approval for the WMS to operate as an abortion facility, granted 12/20/1979, expired (p140).

(02/--/1986)

Review supposedly carried out by the DoH on the WMS; however, no documentation could be produced to prove this (p140).

(08/--/1989)

The WMS is evaluated by the DoH and granted approval again for one year, despite numerous violations of regulations. This was the first documented review in nearly ten years, despite the **DoH** approval having expired close to nine years previously. The review was carried out by **Elizabeth Stein** and **Susan Mitchell**, who re-approved the site regardless of the many faults including; having no board certified doctor on staff or as a consultant, no registered nurse on site and incomplete records on patients. Approval is granted on the "mere promise to improve filing, and to hire nurses" (p140).

(08/--/1990)

The DoH approval for the WMS to operate as an abortion facility, granted in August 1989, expired (p140).

(03/--/1992)

The WMS was evaluated by the DoH and granted approval yet again for one year, despite still evident violations of regulations. Again this review appears to be late, given that the previous approval had expired close to one and a half years prior to the review. This time the reviewers were **Janice Staloski** and **Sara Telencio**. A **Dr. Martin Weisberg** was now listed as a consultant. The facility was still without nurses and no attempt was made to investigate the patient files, despite the "warning" noted in the previous evaluation. Parts of the **DoH** report on anaesthesia and "Post-Operative Care" were left blank. The report stated there was adequate access for stretchers and wheelchairs, despite the facility being multi-level and without an elevator. Even in view of the above, the report found there were "no deficiencies" and renewed approval (p140-141).

(04/08/1993)

The WMS was evaluated by the DoH. Carried out by **Susan Mitchell** and **Georgette Freed-Wolf**, this was the last **DoH** inspection prior to the February 2010 raid. **Dr. Martin Weisberg** was again listed as a consultant. There was still no registered nurse present at the facility and major faults were found in the record keeping, including pathology reports on second trimester abortions, required to prove the legality of the act under Pennsylvania law. Drugs on the premises were inspected and some found to be past there expiration date. However, no direct observation of the cleanliness of the facility or the condition of the emergency equipment was made (p141-142).

(07/23/1993)

DoH reapproved the WMS for a further year, retroactive from 1st of April that year. **Susan Mitchell** had recorded that "deficiencies had been corrected", despite there being no follow up inspection to that of 04/08/1993 (p142).

(Unknown date, after 1993)

Decision is made by DoH officials to no longer annually inspect abortion facilities unless in receipt of a complaint, deeming the inspections to be "putting barriers up to women" who seek an abortion. The Grand Jury Report sees this as a political move fuelled by the election of **Governor Tom Ridge** (p9, 147).

(04/16/1996)

An unnamed 19 year old had her uterus perforated during an abortion performed by Kermit Gosnell at the WMS. No call for emergency services was made for four and a half hours, as a result the patient was not breathing when paramedics arrived. She was then taken to the **HUP**, where in order to save her life doctors removed her uterus (p72).

Her attorney later filed a complaint with the **DoH**, which was ignored by director of home health **Robert Bastian**, who, after consultation with **DoH** Senior Counsel **Kenneth Brody**, simply redirected the attorney to the **DoS**. No further investigation was carried out by **Bastian** or anyone else at **DoH** (p195).

(Unknown date between 1996 and 1997)

Then head of adolescent Services at the CHP Dr Donald Schwarz, also a paediatrician, lodged a complaint against the WMS with the DoH. He first became suspicious after a number of patients he had referred to the **WMS** returned to him with a sexually transmitted parasite. As a result, he sent a social worker to visit the **WMS**. Based on the social workers findings, **Dr Donald Schwarz** ceased referring patients to the **WMS**, and hand delivered a letter of complaint to the **DoH**. When interviewed by the Grand Jury, **Schwarz** stated he never heard back from the **DoH**, and the **DoH** did not include the letter in the subpoenaed complaints regarding **Kermit Gosnell** and the **WMS** (p144).

(11/--/1999)

Marie Smith underwent an attempted abortion by Kermit Gosnell at the WMS which ended with parts of the child still inside the patient. **Gosnell** kept **Marie Smith** at the **WMS,** sedated and bleeding heavily. Once **Smiths** mother had found her, **Gosnell** allowed her to be taken home. When the mother called several days later after **Smiths** condition had declined, she was assured the patient would be fine. At no point was **Smith** or her mother informed of the remaining body parts inside her. Only because her mother did not believe **Gosnell**, **Smith** was taken to the **PH,** where the body parts and the infection caused by them were discovered (p72).

(--/--/1999)

What was described by Kenneth Brody as a “meeting of high-level government officials” took place, where the decision was taken to not reinstate regular inspections to abortion facilities, due to the fear that many of them would fail, and this would lead to less access to abortion for women (p147).

(03/--/2000)

Semika Shaw died of infection and sepsis caused by a perforated uterus and cervix, inflicted by Kermit Gosnell during an abortion (p174-176).

(12/--/2001)

Marcella Stanley Choung, a former employee at the WMS, filed a detailed complaint against the WMS with the DoS (p176-177).

(01/--/2002)

The Director of the DoH's DHH received a request from an attorney representing Semika Shaw, requesting inspection reports for the WMS. **Janice Staloski**, the then Director of the **DHH**, responded stating that there had been no inspection since 1993 due to a lack of complaints against the **WMS** in that time (p143).

(02/06/2002)

Janice Staloski at the DoH received a further call from an attorney requesting information about the WMS (p145).

(03/04/2002)

Marcella Stanley Choung met with a DoS investigator for an interview following her complaint. In the interview she described everything she had experienced, including the lack of cleanliness in the facility, the administration of drugs by untrained staff, abortions being performed on minors and the death of a patient caused by an abortion performed by **Kermit Gosnell** (p177).

(08/26/2002)

The DoS investigator completed his investigation into the complaint of Marcella Stanley Choung. The investigation comprised of three interviews; one with **Kermit Gosnel**l, one with a **Dr Warren Taylor** and one with a local Pharmacy. Despite the detail of **Marcella Stanley Choung's** complaint, no visit to the **WMS** or attempt to view the files held there was made. The interview **with Dr Warren Taylor**, who had performed abortions at the **WMS** during 2001, supported some of the accusations, but still, no further investigation was made. The only action suggested in the investigators report was that the information be passed to the **DoH**. There is no evidence this happened (p176-179).

(10/09/2002)

The Professional Underwriters Liability Insurance Company informed the DoS Board of Medicine that they have paid $400,000 to the estate of Semika Shaw as settlement for her death (p174).

(12/06/2002)

The DoS complaints department logged the report regarding the Semika Shaw settlement as "received" (p174).

(01/--/2003)

The Pennsylvania Medical Professional Liability Catastrophe Loss Fund informed the DoS that it had paid a further $500,000 to the family of Semika Shaw regarding her death (p174).

(08/--/2003)

Complaint received by the Philadelphia Health Department's (PHD) Environmental Engineering Section (EES) detailing the storage of aborted remains in an employee refrigerator. EES records indicate that sanitation specialist **Mandi Davis** wrote a memo to colleague **Ken Gruen**, requesting an inspection of the **WMS**.

The Assistant Health Commissioner at the time **Izzat Melhem** was copied into the memo. Current Philadelphia Health Commissioner **Donald Schwarz** testified that based information available, an inspection appears to of taken place. However, no records of an inspection could be found (p204).

(01/02/2004)

A printout of Kermit Gosnell's license was added to the DoS complaint file regarding the Semika Shaw settlement, stamped "received" (p174).

(03/28/2004)

Mandi Davis of the ESS wrote to Kermit Gosnell due to the lack of a complete "infectious waste plan" for the WMS being filed with the department. Kermit Gosnell had returned the paperwork; however, he had entered minimal information on it (p204).

(04/29/2004)

DoS prosecuting attorney Mark Greenwald closed the case of Semika Shaw's death, deeming "prosecution not warranted", apparently ruling that death is a risk of any surgical procedure. This decision was made with no further investigation into the **WMS** and the entry concerning the case being closed consisted of only selective use of the insurance company's original report to the **DoS**. The move to close the case was approved by **Greenwald's** supervisor, the Senior Prosecutor –in-Charge for the **DoS**'s **Bureau of Professional and Occupational Affair's (BPOA)**, **Charles J. Hartwell**, who gave his approval knowing only the limited information provided by Mark Greenwald (p174-176).

(04/29/2004)

DoS prosecuting attorney Mark Greenwald closed the file based on the Marcella Stanley Choung complaint.

This was done on the same day the case on Semika Shaw's death was closed, and by the same two people, **Greenwald** and **Charles J. Hartwell** (who again approved the decision). The reason given for closing the file was that "the allegations had not been confirmed". (p179)

(05/03/2004)

Mandi Davis of the Philadelphia EES again wrote to Kermit Gosnell regarding the lack of a complete "infectious waste plan" (p204-205).

(05/07/2004)

The WMS is inspected in light of the concerns of the EES regarding the lack of an "infectious waste plan". The report detailed the failings of the **WMS** in terms of dealing with "infectious waste". However, the inspector appeared oblivious to the other issues openly apparent within the **WMS**. Despite the problems that were noted by the inspector, no action was ever taken against either the facility or **Kermit Gosnell** (p205-206).

(--/--/2004)

Kermit Gosnell lied to a patient about the stage of her pregnancy, and then refused to stop the abortion process when the patient changed her mind. The patient was told the baby was 21 weeks of gestation; in fact it was 29 weeks. Once the patient had changed her mind, **Gosnell** stated it could not be stopped, and refused to return the fee the patient had paid. The Patient then went to the **HUP** where the laminaria, inserted as part of the abortion procedure, was removed.

Shortly after the patient gave birth to a premature baby, which following treatment at the **CHP** is alive and well today. Whilst at the **HUP**, someone informed the patient that what **Gosnell** had attempted was illegal (p86-87).

(03/--/2005)

A woman, named as "Alice" in the Grand Jury Report, suffered a seizure after being given anaesthesia during an abortion at the WMS. The seizure was attributed to **Gosnell** and his staff ignoring the fact that the patient was undergoing methadone treatment, a fact the patient was upfront about. Regardless, **Gosnell** proceeded to use an anaesthesia which was not safe for methadone patients. Once "**Alice**" started to have a reaction, **Gosnell** refused to remove the IV and stop the process. The staff also refused to call the emergency services or allow a friend of the patient to leave to find help. Eventually the individual with "**Alice**" was allowed to find some methadone, which stopped the seizure (p181-182).

(08/02/2005)

The DoS is informed by the MCARE Fund that Kermit Gosnell did not have correct liability insurance. The case is taken on by prosecuting attorney **William Newport** (p183).

(09/28/2005)

The DoS's William Newport wrote to Kermit Gosnell requesting a response to complaint of the MCARE Fund regarding his lack of correct liability insurance. No response is reported (p183).

(09/--/2005)

A plaintiff's attorney representing "Alice" informed the DoS of a malpractice complaint lodged against Kermit Gosnell regarding the seizure suffered by "Alice" at the WMS. The complaint also highlighted a strong suspicion that **Gosnell** was operating without insurance (p181-182).

(05/04/2006)

David Grubb, a prosecuting attorney for the BoM at the DoS recommended closing the file pertaining to "Alice" with no further action. This decision is made with no further investigation into the events of the case or the accusation that **Kermit Gosnell** was not properly insured (p182).

(05/16/2006)

David Grubb's supervisor, Senior Prosecutor-in-Charge at the BoM Andrew Kramer, approved the decision to close the file on "Alice" with no further action (p182).

(06/09/2006)

David Grubb informed Kermit Gosnell by letter that the DoS will be taking no further action against him (p182).

(07/05/2006)

The DoS's William Newport wrote to Kermit Gosnell requesting a response to complaint of the MCARE Fund regarding his lack of correct liability insurance again (p183).

(07/20/2006)

An insurance agent representing Kermit Gosnell contacted the DoS informing them that Gosnell was correctly covered from 1998 to 2003. Despite the obvious inadequacy of this information in answering an accusation that **Gosnell** did not have correct cover in August 2005, the only action taken by **William Newport**, or anyone at the **DoS**, was to instruct a paralegal to continually check with MCARE that **Gosnell** was correctly covered (p183).

(11/11/2006)

Dana Haynes suffers tears to her cervix, uterus and bowl during an abortion attempt performed by Kermit Gosnell at the WMS. She was then kept in the clinic for hours whilst in great pain and bleeding heavily, with parts of the child still within her (p184-189). Her cousins where kept outside until they threatened to call the police (p71). **Haynes** was finally taken to the **HUP** where she received surgery and spent five nights receiving care (p213).

(09/--/2007)

A 14 year old girl, named as "Nancy" in the Grand Jury Report, delivered a stillborn baby that is at least 30 weeks of gestation following Kermit Gosnell's deliberate actions to enable a late term abortion. The night before the final day of a three day "process", the girl entered advanced labour and, after being unable to contact anyone at the clinic, was taken to **the CCH**, where the child was delivered stillborn (p84). The hospital reported what was obviously a late term abortion to **Dr Fredrick Hellman**, the Delaware County Medical Examiner (p84-85). Following his examination and some contact with **Gosnell**, **Dr Hellman** reported the case to the **DoH** (p85, 146). Despite the abortion having taken place in Philadelphia, **DoH** Senior Counsel **Kenneth Brody** advised **Dr Hellman** to notify the District Attorney's Office in Delaware County. No further action was taken by **Brody** or anyone at the **DoH** (p146).

(07/16/2008)

A registered nurse inspected the WMS on behalf of the PDPH. Although the inspection, carried out by **Lori Matijkiw**, was aimed at the side of the facility providing vaccines to children, the inspector did not let this limit her observations. In her report she condemned the facility for using out of date vaccines, storing them next to the bloodied remains of aborted children and failing to keep proper records. She also included detailed descriptions of the dangerous lack of proper cleanliness and hygiene at the facility, and the serious lack of organisation.

Matijkiw also investigated the history of **Kermit Gosnell** with the vaccination program, and discovered that the facility had been repeatedly investigated since as far back as 2001. In these past reports the facility had also been condemned for improper storage, record keeping and out of date vaccines. As a result of **Matijkiw's** report the facility was suspended from the vaccination program, as it had been many times before. However, none of **Matijkiw's** supervisors at the **PDPH** who were aware of the report, including Program Manager **Lisa Morgan**, pursued the case any further, or passed the information onto another government body to do so (p199-201).

(07/--/2008)

Kermit Gosnell killed a baby over 29 weeks of gestation. The baby, named in the Grand Jury Report as "**Baby Boy A**", was born to a 17 year old girl named as "**Sue**". The baby was killed following birth, despite showing clear signs of life. The child was then placed in a shoebox for storage. "**Sue**" later developed serious complications caused by **Gosnell's** "procedure". She was then taken to the **CCH** where she then spent a week and a half receiving care (p100-103).

(09/05/2008)

The DoS paralegal dealing with the MCARE complaint of Kermit Gosnell's inadequate liability insurance closed the file, under the instruction of **William Newport**. The paralegal had been checking the compliance of **Gosnell** with MCARE insurance regulations for the previous two years, and not once was he found to be meeting them. Despite this, the file was closed with no further action taken (p183).

(11/--/2008)

Dana Haynes filed a civil malpractice lawsuit against Kermit Gosnell for the injuries inflicted during her uncompleted abortion at the WMS (p184).

(12/--/2008)

The DoS are made aware of the lawsuit brought against Kermit Gosnell by Dana Haynes (p184).

(04/20/2009)

DoS Prosecutor Juan Ruiz closed the case raised by the Dana Haynes lawsuit, stating he did not see a “pattern of conduct” (184-185).

(08/--/2009)

The PDPH indicated it would consider the Kermit Gosnell’s facility for re-admittance into the vaccine program it was suspended from as a result of Lori Matijkiw’s inspection, providing the site did “purchase a new unit to store their vaccines completely separate from all other medical products”, which presumably means separate from the bloodied remains of aborted children. No other requirements were set (p201-202).

(10/07/2009)

Registered Nurse Lori Matijkiw once again inspected the WMS. Her report observed the same worrying issues as the previous inspection, along with further concerns of the facilities ability to provided vaccines and the honesty of their claims about doing so. She also witnessed patients being escorted to the procedure area of the facility in the absence of **Kermit Gosnell**. All of this was again passed to her supervisor **Lisa Morgan**, who failed to take any further action (p202-203)

(11/19/2009)

Karnamaya Mongar died following a fatal drug overdose during an abortion at the WMS. This is the most recent and detailed case in the Grand Jury Report. Over the course of an afternoon and evening, **Karnamaya Mongar** was given a reckless cocktail of drugs which ultimately caused her death (p121-125).

The report further condemns **Kermit Gosnell** and his staff for failing to properly attempt to resuscitate the patient (p125-126), spending time before and after the paramedics arrived trying to cover up the events of that day (p127-128 & 130-135), trying to disguise the failings of the facilities equipment (127-128), delaying in calling for the emergency services (p126 & 128) and, through neglectful actions such as the emergency exit being chained shut, delaying the emergency personal from performing their tasks and removing the patient from the **WMS** (p128-129). Karnamaya Mongar was eventually taken to the **HUP**, where she never regained consciousness (p129-130).

(11/20/2009)

Kermit Gosnell applied for membership with the NAF the day after **Karnamaya Mongar's** death (p91).

(11/24/2009)

Kermit Gosnell sent a fax to the DoH informing them of the death of Karnamaya Mongar. The fax is received by **Darlene Augustine**, a registered nurse working as health quality administrator in the **DoH's DHH** (p149).

(11/25/2009)

Based on the fax regarding the death of Karnamaya Mongar, Darlene Augustine recommended to Cynthia Boyne, the then director of the DHH, that an immediate investigation be launched into the WMS. In front of the Grand Jury **Augustine** admitted that she had the power to launch an investigation herself, however felt she needed to get approval as this case involved an abortion facility. **Boyne** also declined to launch an investigation, and instead took the case to **Janice Staloski**, who by that time had been promoted to head of the **BCLC**. In the words of **Augustine**, **Staloski** was "the ultimate decision maker" on inspecting abortion facilities. **Staloski** declined to launch an investigation (p149-152).

(11/26/2009)

Kermit Gosnell wrote to the DoH confirming to them the death of Karnamaya Mongar. In the letter **Gosnell** lied about the dosages involved in the death and omitted information on who administered the drugs (p132-133).

(12/14/2009)

The NAF inspector began a two day inspection of the WMS. Kermit Gosnell and his staff had made some attempt to cover the extreme failings of the facility, including the replacement of some furniture and the hiring, for a few days only, of registered nurse **Della Mann**. However, the **NAF** inspector saw through these superficial acts, and rejected the membership application, citing faults which had been apparent for some time at the **WMS**, and would be discovered during the FBI led raid. During her Grand Jury appearance, the **NAF** inspector stated that this was the first time in her experience the **NAF** had outright rejected a facility, and, when asked if she had ever experienced anything like these conditions elsewhere, answered “no” (p91-96).

(12/--/2009)

The PDPH made the decision to not re-admit Kermit Gosnell’s facility into its vaccination program (p203).

(**01/04/2010)**

The NAF inspector wrote to Kermit Gosnell informing him of the decision to reject the WMS from NAF membership and outlined the areas in which he had failed to meet NAF standards. No further action was taken by the inspector or anyone else at the **NAF** (p95).

(02/18/2010)

FBI and agents from the Philadelphia District Attorney's Office carried out a raid on WMS, accompanied by agents for the **DoH** and the **DoS**. The raid uncovers all of the horrors believed to of been taking place at **WMS** for some time (p19-22, 157), and the **DoH**, finally entering the premises after nearly 20 years, found fourteen counts on which to close the facility down (p154-156).

(02/22/2010)

The DoS BoM suspended Kermit Gosnell's medical license, seeing him as "an immediate and clear danger to public health and safety" (p22).

(02/--/2010)

As the story of the WMS broke in the media, regular inspections of abortion facilities in Pennsylvania were reinstated by the DoH, despite there being no change to the laws and regulations the **DoH** previously claimed prevented such inspections (p147-152).

(03/12/2010)

The DoH began the process of shutting down the WMS (p22).

(05/04/2010)

The Philadelphia District Attorney submitted the case pertaining to all crimes committed at the WMS to the Grand Jury (p22).

8. List of Acronyms

DoH	**Department of Health**
DHH	**Division of Home Health**
BCLC	**Bureau of Community Licensure and Certification**
DoS	**Department of State**
PDPH	**Philadelphia Department of Public Health**
EES	**Environmental Engineering Section**
DDC	**Division of Disease Control**
WMS	**Women's Medical Society**
AWMS	**Atlantic Women's Medical Society**
NAF	**National Abortion Federation**
HUP	**Hospital of the University of Pennsylvania**
CCH	**Chester-Crozer Hospital**
PH	**Presbyterian Hospital**
CHP	**Children's Hospital of Philadelphia**
MCARE	**Fund Medical Care Availability and Reduction Error Fund**
ASF	**Ambulatory Surgical Facilities**