

My name is Connie Coleman, and I am submitting this statement regarding the circumstances surrounding the hospitalization and death of my husband, David C. Coleman, at Sharp Memorial Hospital in San Diego. David passed away on August 8, 2021, after seventeen days in the hospital. I am asking for your help in bringing attention to the failures in his care and the broader issues affecting patients and families during this period. David was a former Marine who served in Vietnam. He was a devoted Husband, Father, and Grandfather to twelve grandchildren. He worked hard his entire life and was known for helping anyone in need. He loved his country deeply and lived with honor and integrity. On July 23, 2021, I took David to the emergency room at the direction of his Primary Doctor due to a high fever and extreme weakness. After examining him and confirming a COVID diagnosis, the ER Doctor told us privately that he believed David could recover at home using medications such as Ivermectin and Hydroxychloroquine. He explained that he could not write the prescriptions himself because doing so would put his medical license at risk, as these treatments were not part of hospital protocol. He left to prepare discharge papers. However, everything changed when a nurse entered the room and stated that David needed to be admitted for “Observation” for one or two nights. No medical explanation was provided for this sudden change in plan. I was told I would be allowed to stay with my husband, and this was confirmed by the Charge Nurse on the receiving floor. But once we arrived at his room, I was ordered to leave immediately or security would be called. Even the Floor Director told me I would be removed if I did not comply. This was the beginning of a pattern of restricted access, lack of communication, and decisions made without transparency. During his stay, David was given Remdesivir immediately—before receiving food or water. When I asked about side effects, I was told it was “proven and safe.” Throughout the following days, I struggled to reach anyone for updates. I was told that staff were “mitigating exposure” and conserving PPE, which meant he was not checked regularly by doctors or nurses. He was not fed consistently, nor did he receive adequate hydration. Staff repeatedly pressured him about his vaccination status and talk of him eventually being put on a ventilator, which caused him distress. There were also discrepancies in the information I received about his vitals and condition. I contacted Patient Relations and attempted to arrange a transfer, but I was told he “Would not Survive Transport,” even though he was only on a nasal cannula at the time. Without warning, David was moved to the ICU. He was heavily medicated, placed on a BiPAP mask, and his cell phone was taken from him after staff told him it “didn’t work.” I lost all communication with him. Within three days of his move to ICU, he was gone. Before entering the ICU, David was not sick enough to die. I believe the medications and protocols used contributed to his rapid decline, and I am asking for a “Formal Investigation” into the treatment he received and the policies that prevented me from advocating for him. My family lost our leader and provider. I am grateful for the opportunity to share David’s story, and I hope it will help protect other families from experiencing what we did. Sincerely, Connie Coleman