

Opening Statement of Deanna Slamans

Regarding the Hospitalization and Death of Murrell Dean Bradley

Chairman Johnson and Members of the Committee:

My name is Deanna Slamans. Murrell Dean Bradley was my biological father, and I served as his medical power of attorney during his hospitalization at Penn State Health Milton S. Hershey Medical Center from December 22, 2021, until his death on January 6, 2022.

My father was 76 years old and fully independent. He lived in an in-law suite attached to my home and managed his own daily activities. His medical history included mild hypertension and schizophrenia, which had been stable for approximately 40 years on haloperidol.

On December 22, he became extremely weak, short of breath, and unable to stand. Upon admission to the hospital, his oxygen saturation was in the 80s and his heart rate reached the 170s. He was diagnosed with atrial flutter, rhabdomyolysis, acute kidney injury, and COVID-19. His CPK exceeded 40,000, indicating severe muscle injury.

The medical records provided to me contain an order labeled “COVID-19 Coronavirus Same Day,” and physician summaries repeatedly describe my father as COVID-positive. However, the records I received do not include the underlying SARS-CoV-2 laboratory report documenting the specimen, test method, result, collection time, accession number, or whether the test was PCR, NAAT, or antigen. I am not claiming that a test was never performed. I am saying that the records provided to me do not contain the test evidence supporting the diagnosis that guided his treatment.

During his first several days, my father showed improvement in his rhabdomyolysis and kidney function, although his rapid heart rhythm and oxygen needs continued. After he was transferred to the ICU, I was no longer permitted to visit. I asked his attending physician whether he could receive hydroxychloroquine, ivermectin, or Regeneron. I was told no. When I said that he was unvaccinated, I distinctly recall the physician responding, “Well, then there’s nothing else we can do for him.”

As his breathing worsened, the treatment team proposed intubation. I explained that my father had said he did not want to be kept alive on a machine. During an in-person December 31 meeting, I understood that if I did not agree to ventilation, CPR and other emergency interventions would not be provided. I felt pressured into consenting.

Only after that meeting was I permitted to see him. He recognized me and his 20 yr old granddaughter, asked about our dog, River, said he wanted Chinese food, laughed his

familiar laugh, and affectionately called his granddaughter “The Sweetie, his nickname for her.” He could recognize us, remember familiar details, converse, and joke.

The chart describes agitation and episodes in which he removed his oxygen equipment. My father had taken a stable haloperidol regimen for decades. Yet the hospital altered that regimen and administered additional haloperidol, including intravenous doses and as-needed doses for agitation. The records list scheduled 5-milligram doses and additional 2.5-milligram IV pushes. His agitation may have reflected severe hypoxia, fear, discomfort from BiPAP, ICU delirium, isolation, or medication effects—not worsening schizophrenia.

He was also placed on continuous dexmedetomidine, reaching 1.5 micrograms per kilogram per hour. His chart later documents bradycardia and a reduction in the infusion because of his slow heart rate. After intubation early on January 1, he received propofol, fentanyl, additional opioids, and vasopressors. He remained mechanically ventilated until his death five days later.

I am requesting an independent review of the evidence supporting his COVID diagnosis, restrictions on family access, consent surrounding ventilation, the escalation and intravenous use of haloperidol, the combined sedative burden, and whether his stated wishes were respected.

Thank you for allowing me to place his experience into the record.