

To Testify

Dear Senator Johnson,

My husband, Steve Gregory, died on September 13, 2021, at the Malcom Randall VA Medical Center in Gainesville, Florida. He was a Vietnam veteran who served two tours of duty. We were married 47 years and had three children, twelve grandchildren and three great grandchildren.

Steve was admitted on August 21, 2021, for COVID-19 and shortness of breath. His admission records state: not vaccinated, "verbal consent DNR" and his wishes of "No remdesivir and no ventilation." Yet remdesivir was started his first night. There was no informed consent regarding remdesivir or tocilizumab. Steve received five doses of remdesivir, ten doses of dexamethasone, and one dose of tocilizumab.

Two physicians instructed Steve to mobilize, ambulate, and shower. One warned that if he did not get up walk and shower he would die in the hospital. Against physicians orders a RN forbid him to follow those instructions.

Five days after admission, Steve developed coffee-ground emesis followed by 300 cc of bright red blood documented with NG-tube insertion. He was transferred to Gainesville VA where imaging showed a gastric perforation requiring emergency surgery. His records state: "GI Tract Perforation after Tocilizumab-Treatment Halted"

Radiology reports 8/26 day of surgery noted "No Abdominal Aortic Aneurysm Present" An 8/30 radiology report noted " Abdominal Aortic Aneurysm Present" I was never informed of this nor was there any treatment in records found.

A NG-tube left in too long for 17 days-tore his nostril.

Steve asked for water. He went without water for 5 days and because of me urging did hospital staff give him moistened sponge sticks that he would feverishly suck on. I have a video of Steve saying "They think they ain't got no water"

A Catheter bag not being emptied overnight caused him pain.

One RN, himself a veteran, told me he was trying to "change the culture" because "they don't care enough."

A couple days after extubation on the 3rd his WBC count climbed and remained elevated and rose to 18.85 on September 8 and 19.26 on September 9.

Imaging not taken until the ninth raised concern for inflammatory seroma's or abscesses.

Which was communicated to the doctor on that day. Yet antibiotics Vancomycin and Cefepime were not started until September 11, when clinicians documented HAP-bacterial pneumonia.

On September 13, I received a call from the physician in Steve's room informing me of having to intubate again. She stated Steve could likely go into cardiac arrest and we should "let him go peacefully". Steve was full code I said no resuscitate but she kept on urging a DNR finally I asked Steve directly what he wanted. He answered:

"I WANT TO LIVE."

Those were the last words I ever heard my husband speak.

That afternoon he was intubated. By 4:42 PM his blood pressure had fallen to 60/43, and propofol and fentanyl drips were held. At 4:45 PM, while mechanically ventilated on 100% oxygen, his ABG showed severe acidosis and CO2 retention: pH 7.121, pCO2 86.5, pO2 63.1, and oxygen saturation 79.1%.

Medical Records state:

results called to Dr. ____

provider read back and verified. ""

Despite the profound hypotension, the medication timeline records another 2 mg of Versed and

50 mcg of fentanyl given at approximately 5:00 PM. Within minutes, Steve suffered a Cardiac arrest. My son and I had arrived and after repeated resuscitations with a tear running down his cheek Steve died.

After all but one attending nurse left the room this nurse urged me to get an autopsy.

The final ABG showed catastrophic CO₂ retention while he was documented to be on substantial mechanical-ventilation.

Causing me to question the functioning of ventilator.

I respectfully ask for this committee to investigate what happened during Covid-19 to our loved ones in the hospitals.

Do no harm was suppose to be the standard of care.

Thank you.

Debbie Gregory