

Submitted by: Debbie King

Regarding: Frank W. King III

Dates of Events: August 11, 2021 – September 14, 2021

Location: Hilton Head Hospital, South Carolina

On August 11, 2021, my 57-year-old husband, Frank W. King III, was admitted to Hilton Head Hospital after developing a fever and cough and having blood oxygen levels in the 70s at home. When he arrived at the emergency department, hospital staff enforced an isolation policy that prevented me from entering the hospital with him. I was not permitted to visit him during his hospitalization.

Hospital records document treatment that included a five-day course of Remdesivir, high-flow oxygen, approximately 10 days on BiPAP, and later mechanical ventilation. While Frank was receiving BiPAP treatment, he fell from his hospital bed. I was later informed of the fall, and I observed cuts and bruising on his face.

On August 19, 2021, at approximately 10:30 p.m., a physician called me and told me that Frank required immediate intubation to survive. Because I was not permitted to enter the hospital under the visitation restrictions, Frank and I were unable to communicate in person before he was intubated. We were also unable to communicate by FaceTime. A chest tube was subsequently inserted after he experienced a collapsed lung.

Medical records document that Frank underwent a tracheotomy on September 1, 2021, and placement of a PEG feeding tube on September 9, 2021. The records document a 32-pound weight loss during his 35-day hospitalization. His medication records list more than 31 medications during his treatment, including Remdesivir, Fentanyl, Propofol, Vecuronium, Ziprasidone, Precedex, Risperidone, and Metoprolol.

On the morning of September 14, 2021, nursing documentation states that Frank was initially responsive and communicating with staff. At 7:30 a.m., the night nurse documented elevated heart rate and respiratory rate and decreased oxygen levels. At 7:32 a.m., Metoprolol was administered.

Between approximately 7:45 and 8:10 a.m., the day nurse documented a blood pressure of 70/49. The nurse contacted the ICU physician and documented that no new orders were received. The nurse then left Frank's room and monitored him remotely. At 8:53 a.m., the nurse returned to the room and found Frank unresponsive and without a pulse.

Frank's medical record listed his code status as **Full Code**. Neither Frank nor I had signed a Do Not Resuscitate (DNR) order. Hospital staff-initiated resuscitation efforts, but Frank died on September 14, 2021.

After his death, hospital staff permitted me, our two adult children, my sister, and our pastor to enter Frank's room to view his body. We were permitted to remain with him for more than three hours.

Following Frank's death, I requested a medical autopsy to determine the cause of his sudden cardiac arrest. Hospital administration denied my request and stated that autopsies were not being performed on COVID-19 patients.

These events are based on my observations, statements made to me by hospital staff, and documentation contained in Frank's medical records. I respectfully request that Congress review the hospital's visitation, communication, emergency-response, and autopsy policies in effect during Frank's hospitalization and determine whether those policies affected his care and the ability of his family to participate in his treatment.

For my dear beloved Frank, our children, myself, and the millions of families who have suffered during these days of hospitalization and through the past five years of grieving under these hospital protocols, I respectfully ask the Senate to investigate what occurred and determine whether these policies and actions constituted crimes against humanity.