

My name is Laura Chapman. I am writing to share with you what had happened to my husband, SSgt Robert F. “Chappy” Chapman IV at Nebraska Medicine in Bellevue, NE and UNMC in Omaha, NE in the fall of 2021. Robert was only 45 years old, a loving husband and father of 3, and a proud USAF veteran working as a federal employee at Offutt AFB in Bellevue, NE. Prior to getting sick with COVID, my husband was healthy with no medical conditions, stayed active, and didn’t drink, smoke, or take any medications.

At the end of August 2021, my husband, our 2 children, and I came down with COVID. On 09/02/21, Robert began feeling very weak, confused, and having shortness of breath. Since we didn’t have a pulse oximeter at home, we proceeded to Bellevue Urgent Care Center to have his blood oxygen checked. Once there, I was asked 2 questions: if we were COVID positive and unvaccinated. After answering “yes” to both questions, we were immediately turned away and they suggested that we go to Nebraska Medicine in Bellevue, NE.

Upon entering the hospital, they immediately wanted to admit Robert to get him oxygen and observe him throughout the night. My 2 children and I were then asked to leave due to COVID restrictions. Later that evening, my husband had called and stated that they were transferring him by ambulance to UNMC in Omaha. This call would be the last time that I would hear my husband’s voice. The remainder of our conversations took place via text and we were strictly forbidden to visit him.

Robert was isolated from us for a total of 27 days (hospitalized for a total of 34 days), and was not provided adequate nutrition/fluids. Beginning on 09/02/21, he was given Remdesivir daily for 5 days (among other medications), and began retaining excessive amounts of fluid, along with having increased difficulty with breathing (even with the use of a CPAP). On the morning of 09/07/21, his doctor called me to tell me that they were planning on placing him on the ventilator later that day. I immediately texted my husband, but he did not respond or call me. The following day, 09/08/21, his doctor called to state that he was in dire need of being placed on the ECMO machine and he remained on it for 12 days.

My husband fought through the protocol, bacterial pneumonia, sepsis, UTI, and at various times, they were discussing moving him out of isolation to allow visitors, weaning him off of the ventilator, and putting in a trach.

On 09/29/21, his doctor called and was adamant about performing a “routine” CT-guided procedure that evening to retrieve a concerning abscess on the outside of his right lung. Yet, during this “routine” procedure, Robert sustained an iatrogenic injury that resulted in a tension pneumothorax, leading to cardiac arrest, and he suffered an anoxic brain injury. The next day, 09/30/21, we were allowed to visit and the doctor had stated on 2 occasions that “the needle went too deep”, but didn’t elaborate. Robert’s mother and I were advised by the panel of doctors on 10/04/21 that he would remain in a vegetative state or we could elect to move him to comfort care. Following extubation, we remained at his bedside for 2 hours until he took his final breath on 10/06/21.

I had requested all of his medical records, but the hospital only furnished 696 pages.