

My husband, James Roger Guile, Jr., was 49 years old when he became ill with COVID-19 in August 2021. He was generally healthy but had high blood pressure that he managed with a low dose of lisinopril. He had proudly served 24½ years in the USAF and retired as a Chief Master Sergeant. He was working full-time as a civilian on Robins AFB when he became sick.

He went to urgent care on August 8th and was diagnosed with COVID-19. He was prescribed the antibiotic doxycycline.

On August 12, 2021, he went to the E.R. due to reduced oxygen levels and stayed overnight to receive fluids and oxygen. He was released after less than 24 hours due to his condition improving.

On August 14th, we received monoclonal antibody infusions. That afternoon, his condition became worse, and he was taken by ambulance to the ER. He was admitted with oxygen levels below 80%, but he remained in the ER because there were no hospital rooms available.

He was placed on high-flow oxygen and BiPAP. He experienced extreme anxiety and was given Ambien to help him sleep, but it made his mental state worse. Because of isolation protocols, I could not be with him to comfort or advocate for him. Updates were few and far between, sometimes coming only every 2-3 days, and when I called for information, I was told to stop calling. I was repeatedly told his X-rays were improving and they were trying to wean him off oxygen, yet he was placed on higher oxygen levels.

On August 21st, he was transferred to the ICU on BiPAP. At 12:27 a.m. on August 22, I called and was told he had been placed on a ventilator. No one had called me beforehand for consent. A regular ventilator was unavailable and a makeshift ventilator made from a BiPAP was being used. He developed a pneumothorax and two tubes were placed in his lungs in an emergency procedure. In the hospital he received steroids, blood thinners, and the experimental drug Olumiant along with other medications. On August 23rd, he was placed on a paralytic drip because he was breathing over the ventilator.

On August 22nd, the hospital called for permission to place a central venous line. On August 24th, they called for consent to place a VasCath for dialysis. He had developed acute renal failure, and the doctor explained that it was from the drug Remdesivir. His kidneys stopped functioning, and he eventually had no urine output.

On August 25th, he received dialysis, and his ventilator was changed. On August 26th, tube feedings were stopped because he was no longer digesting them. TPN was started August 28th. His kidneys were still not functioning. On August 29th, I was told he needed a blood transfusion, and he received two units of blood on August 30th. His paralytic drip was stopped to see if he could tolerate it, but when he began breathing over the ventilator again, it was restarted.

On August 28th and August 30th, I was told his X-rays showed improvement and he was tolerating 70% oxygen. On September 2nd, there was no change. On September 3rd, I was told he was doing well and being weaned from the paralytic drip again.

On September 4th, the hospital called to say his oxygen had dropped severely low. A few hours later, I was told to come say goodbye. I was asked to sign a DNR and was given only about 15 minutes with my husband before being made to leave. About an hour and a half later, the hospital called to say he had died.

His death certificate listed severe sepsis, acute respiratory failure with hypoxia, bilateral pneumonia from COVID-19, and obstructive sleep apnea.

I will always believe the isolation, hospital protocols, inability of his family to advocate for him, inadequate treatments, and complications are what killed him.