Covid Related? No

Complaint #: **23 NUR 537**

Screening Date(s): **8/21/2023** Type: **Prescreening** Atty Screener: **Dalla Santa**

Screening panel members (if applicable): *Click to enter text*

Screening Date(s): **9/7/2023** Type: **Screening** Atty Screener: Dalla Santa

Screening panel members (if applicable): **Weinman**

Closed w/o Investigation on: **9/7/2023** Reason for closure: **SD**

or

Opened for Investigation on: *Enter/select date* Reason for bypass (if applicable): *Choose one*

Priority: *Choose one* Direct to Paralegal? ☐ Y ☐ N

Team: *Choose one* Case Advisor: *Click to enter text*

Category:

☐ Advertising	☐ Fraud/Deceptive Practice	☐ Substance Abuse/Impairment
☐ Caregiver	☐ Inappropriate Contact	☐ Unlicensed Activity
☐ Discrimination	☐ Miscellaneous	☐ Unprofessional Conduct
☐ Diversion of Contr. Sub.	☐ Negligence/Incompetence	☐ Unsafe Prescribing of Contr. Subst.
☐ Earnest Money/Trust Acct	☐ Prescriptive Practice	☐ Violation of Related Law

Citation(s): *Click to enter text*

Notes: **20230821 Send to SP**

Case Summary

Case Number	Status	Track	Priority	Team
23 NUR 537	Complaint Received			

Screening Code	Screening Description	Bypass Code	Bypass Description

Complainant(s)	Source	Attorney(s)
Speid, Lorna	UNKNOWN	

Respondent(s)	Credential Number	Attorney(s)	XRef Cases ?
McInnis, Hollee J	138357-30 (Active) (Registered Nurse)	Franckowiak, Jason	No

Patient
[redacted]

Case Associate(s)	Role

Legacy Case Violation	Citation	Alleged	Prosecuted	Final Hearing	Violation Type	Auth	Comment

Case Event	Description
07/26/2023	DOE Received Complaint on
07/27/2023	Scrng Resp Req
07/27/2023	Case Number Assigned on
07/27/2023	CaseStatus Email Sent to Complainant.
08/21/2023	Sent to Attorney Screener on

Case Note(s)	Text
Intake Description 07/27/2023	Complainant alleges respondent administered a cocktail of drugs to patient in respiratory distress. Family wanted patient life save but R refused. Resulting in death.
General Note 07/28/2023	Granted 2-WK Extension to R's Atty.
General Note 08/16/2023	Granted end of the week extension to R's Atty.
General Note 08/21/2023	Timely Response Received, Ready for PS.

WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

CREDENTIAL HISTORY REPORT

LICENSE NO.	PROFESSION	STATUS	GRANT DATE	RENEWAL BY DATE
138357-030	REGISTERED NURSE	ACTIVE	08/03/2001	02/29/2024

NAME: HOLLEE J. MCINNIS

ADDRESS: [redacted]
NEENAH, WI 54956

DOB: [redacted]

OPT OUT Y

HISTORY EVENTS BY DATE

DATE	EVENT TYPE	COMMENTS	FJ
01/20/2022	RENEWEDAUTO	Cred Holder Renewed - Auto Event	N
01/15/2022	RESDECLARATIONLOG	Residency/Practicing States Declared Online. Primary:(WI) Practicing:(WI) Mil/Gov:(False) Not Working:(False) Prior Values: Primary:(WI), Practicing:(WI) Mil/Gov:(False)	N
01/30/2020	RENEWEDAUTO	Cred Holder Renewed - Auto Event	N
01/28/2020	RESDECLARATIONLOG	Residency/Practicing States Declared Online. Primary:(WI) Practicing:(WI) Mil/Gov:(False) Not Working:(False) Prior Values: Primary:(WI), Practicing:(WI) Mil/Gov:(False)	N
01/30/2018	RENEWEDAUTO	Cred Holder Renewed - Auto Event	N
01/26/2018	RESDECLARATIONLOG	Residency/Practicing States Declared Online. Primary:(WI) Practicing:(WI) Mil/Gov:(False) Not Working:(False) Prior Values: Primary:(WI), Practicing:(WI) Mil/Gov:(False)	N
01/25/2016	RENEWEDAUTO	Cred Holder Renewed - Auto Event	N
01/21/2016	RESDECLARATIONLOG	Residency/Practicing States Declared Online. Primary:(WI) Practicing:(WI) Mil/Gov:(False) Not Working:(False) Prior Values: Primary:(WI), Practicing:(WI) Mil/Gov:(False)	N
01/15/2014	RENEWEDAUTO	Cred Holder Renewed - Auto Event	N
01/13/2014	RESDECLARATIONLOG	Residency/Practicing States Declared Online. Primary:(WI) Practicing:(WI) Mil/Gov:(False) Not Working:(False) Prior Values: Primary:(WI), Practicing:(WI) Mil/Gov:(False)	N
02/07/2012	RENEWEDAUTO	Cred Holder Renewed - Auto Event	N
02/03/2012	RESDECLARATIONLOG	Residency/Practicing States Declared Online. Primary:(WI) Practicing:(WI) Mil/Gov:(False) Not Working:(False) Prior Values: Primary:(WI), Practicing:(WI) Mil/Gov:(False)	N
02/01/2010	RENEWEDAUTO	From fee rec. year=2010 date printed=02/01/2010	N
01/04/2010	STANDARDREQUIREMENTADDED	Standard Requirement Added: RES	
01/04/2010	STANDARDREQUIREMENTADDED	Standard Requirement Added: CLS	
01/04/2010	STANDARDREQUIREMENTADDED	Standard Requirement Added: FEE	
01/04/2010	STANDARDREQUIREMENTADDED	Standard Requirement Added: SVY	
02/06/2008	BLUELICENSEPRINTED		

WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

CREDENTIAL HISTORY REPORT

HISTORY EVENTS BY DATE

DATE	EVENT TYPE	COMMENTS	FJ
01/31/2008	RENEWEDAUTO	From fee rec. year=2008 date printed=01/31/2008	N
01/02/2008	STANDARDREQUIREMENTADDED	Standard Requirement Added: RES	
01/02/2008	STANDARDREQUIREMENTADDED	Standard Requirement Added: FEE	
12/14/2005	RENEWEDAUTO	From fee rec. year=2006 date printed=12/14/2005	N
01/07/2004	RENEWEDAUTO	From fee rec. year=2004 date printed=01/07/2004	N
01/08/2002	RENEWEDAUTO	From fee rec. year=2002 date printed=01/08/2002	N
08/03/2001	TEMPORARYGRANTEDPERMANENTLICENSE	Temporary license was valid from 06/01/2001 to 08/03/2001	N
08/03/2001	CREDHOLDERSTATUSCHANGE	STATUS CODE CHANGED FROM T TO A BY DZ	N
07/16/2001	EXAM	1X	N
06/01/2001	GRADUATEDFROM	graduated from UNIV WI-OSHKOSH WI	N

EXAM HISTORY FOR - REGISTERED NURSE

DATE	EXAM NAME	COMMENTS
07/16/2001	Member Board Office System for 30	MBOS (NCLEX) 30 PASSED

Wisconsin Department of Safety and Professional Services

DIVISION OF LEGAL SERVICES AND COMPLIANCE

Mail To: P.O. Box 7190
Madison, WI 53707-7190

Ship To: 4822 Madison Yards Way
Madison, WI 53705

FAX #: (608) 266-2264
Phone #: (608) 266-2112

Email: dsps@wisconsin.gov
Website: http://dsps.wi.gov

COMPLAINT FORM

Due to Wisconsin Open Records Laws, confidentiality cannot be guaranteed, and in most cases your name will be disclosed to the person or business complained of so that they can respond to the matter.

Complaint ID : 2023018536

Created Date : 7/26/2023 11:35:00 AM

Complaint Category : Health

Profession : Nurse,

Complaint filed by: DR LORNA [Middle Name] SPEID		
Address: [redacted]		
County: [redacted]	City: [redacted]	State: [redacted]
Zip Code: [redacted]	Email Address: [redacted]	
Primary Phone # : [redacted]	Secondary Phone # : [redacted]	

Complainant information:		
[Complainant First Name] [Complainant Middle Name] [Complainant Last Name]		
Address: [Complainant Address]		
County: [Complainant County]	City: [Complainant City]	State: Wisconsin
Zip Code: [Complainant Zipcode]	Email Address: [Complainant Email Address]	

Patient Information:		
[redacted]		
Address: [redacted]		
Is Patient Deceased? Yes	Patient Date of Birth [redacted]	Patient Date of Death [redacted]

Attorney Information:		
[Attorney First Name]	[Attorney Middle Name]	[Attorney Last Name]
Address: [Attorney Address]		
County: [Attorney County]	City: [Attorney City]	State: Wisconsin
Zip Code: [Attorney Zip Code]	Email Address: [Attorney Email Address]	
Primary Phone # : [Attorney Primary Phone Number]	Secondary Phone # : [Attorney Secondary Phone Number]	

Licensee1 Information:		
HOLLEE	J.	MCINNIS
Address: UNKNOWN		
County: UNKNOWN	City: UNKNOWN	State: Wisconsin
Zip Code: [Licensee Zipcode]	Email Address: [Licensee Email Address]	
Primary Phone#: [Licensee Primary Phone Number]	Secondary Phone#: [Licensee Secondary Phone Number]	

Licensee2 Information: [Licensee Two First Name] [Licensee Two Middle Name] [Licensee Two Last Name]		
Address: [Licensee Two Address]		
County: [Licensee Two County]	City: [Licensee Two City]	State: Wisconsin
Zip Code: [Licensee Two Zip Code]	Email Address: [Licensee Two Email Address]	
Primary Phone#: [Licensee Two Primary Phone Number]	Secondary Phone#: [Licensee Two Secondary Phone Number]	

Licensee3 Information: [Licensee Three First Name] [Licensee Three Middle Name] [Licensee Three Last Name]		
Address: [Licensee Three Address]		
County: [Licensee Three County]	City: [Licensee Three City]	State: Wisconsin
Zip Code: [Licensee Three Zip Code]	Email Address: [Licensee Three Email Address]	
Primary Phone#: [Licensee Three Primary Phone Number]	Secondary Phone#: [Licensee Three Secondary Phone Number]	

Licensee4 Information: [Licensee Four First Name] [Licensee Four Middle Name] [Licensee Four Last Name]		
Address: [Licensee Four Address]		
County: [Licensee Four County]	City: [Licensee Four City]	State: Wisconsin
Zip Code: [Licensee Four Zip Code]	Email Address: [Licensee Four Email Address]	
Primary Phone#: [Licensee Four Primary Phone Number]	Secondary Phone#: [Licensee Four Secondary Phone Number]	

Licensee5 Information: [Licensee Five First Name] [Licensee Five Middle Name] [Licensee Five Last Name]		
Address: [Licensee Five Address]		
County: [Licensee Five County]	City: [Licensee Five City]	State: Wisconsin
Zip Code: [Licensee Five Zip Code]	Email Address: [Licensee Five Email Address]	
Primary Phone#: [Licensee Five Primary Phone Number]	Secondary Phone #: [Licensee Five Secondary Phone Number]	

Business1 Information: [Business Name]		License Number [Business Licence Number]
Address: [Business Address]		
County: [Business County]	City: [Business City]	State: Wisconsin
Zip Code: [Business Zip Code]		Email Address: [Business Email Address]
Primary Phone#: [Business Primary Phone Number]		Secondary Phone#: [Business Secondary Phone Number]

Business2 Information: [Business Two Name]		License Number [Business Two Licence Number]
Address: [Business Two Address]		
County: [Business Two County]	City: [Business Two City]	State: Wisconsin
Zip Code: [Business Two Zip Code]		Email Address: Wisconsin
Primary Phone#: [Business Two Primary Phone Number]		Secondary Phone#: [Business Two Secondary Phone Number]

Business3 Information: [Business Three Name]		License Number [Business Three Licence Number]
Address: [Business Three Address]		
County: [Business Three County]	City: [Business Three City]	State: Wisconsin
Zip Code: [Business Three Zip Code]		Email Address: [Business Three Email Address]
Primary Phone#: [Business Three Primary Phone Number]		Secondary Phone#: [Business Three Secondary Phone Number]

Business4 Information: [Business Four Name]		License Number [Business Four Licence Number]
Address: [Business Four Address]		
County: [Business Four County]	City: [Business Four City]	State: Wisconsin
Zip Code: [Business Four Zip Code]		Email Address: [Business Four Email Address]
Primary Phone#: [Business Four Primary Phone Number]		Secondary Phone#: [Business Four Secondary Phone Number]

Business5 Information: [Business Five Name]		License Number [Business Five Licence Number]
Address: [Business Five Address]		
County: [Business Five County]	City: [Business Five City]	State: Wisconsin
Zip Code: [Business Five Zip Code]		Email Address: [Business Five Email Address]
Primary Phone#: [Business Five Primary Phone Number]		Secondary Phone#: [Business Five Secondary Phone Number]

Site/Project Information: [Project Name]		
Address: [Project Address]		
County: [Project County]	City: [Project City]	State: Wisconsin
Zip Code: [Project Zip Code]		

1. When did the incident occur (If you do not know the exact date, make as close an estimate as possible)?

12 October 2021 to 13 October 2021

---

2. Where did the incident occur (include town/city/village/county)?

St Elizabeth Hospital 1506 S Oneida St.

---

3. Have you tried to resolve this matter? If so, please provide details.

Family has tried to resolve the matter. This complaint relates to public safety, and that is why I am personally bringing it, as a healthcare professional, and an expert in the safe use of medicines.

---

4. If your complaint is, or has been, under consideration by another agency or court please provide that information.

N/A

---

5. Who else has information related to this incident? Provide names, addresses, email addresses and phone numbers for those persons.

[redacted]

---

6. Describe the incident. Include as much specific information as possible. Attach additional pages if needed. Attach copies of any relevant documents or evidence such as contracts, photographs, medical records, billing statements, personal notes, pill bottles, etc. It is very important that you do not dispose of any information or evidence even after you have filed a complaint.

Ms. McInnis administered a cocktail of drugs to Ms [redacted], a patient in respiratory distress. These drugs were Dexmedetomidine (Precedex), Lorazepam, and Morphine. All are well known to cause respiratory depression. These drugs should NOT have been administered to this patient or any patient in respiratory distress. Morphine was administered twice with the design to bring about the death of this patient. There is no other explanation for a nurse with 20 years of experience, administering this cocktail of drugs. When the family begged her over FaceTime (sister in hospital room begged her and the other nurses) to save [redacted] life, they refused, stating that the patient was Do Not Resuscitate. The family had not given authorization for the patient to be DNR and the patient was not able to give informed consent herself, because she is a Down Syndrome patient. A detailed and substantive complaint report is to be delivered to your offices. We cannot submit those confidential documents to this system.

Dr. Lorna Speid
Speid & Associates, Inc.
[redacted]

PLACE STICKER AT TOP OF ENVELOPE TO THE RIGHT OF THE RETURN ADDRESS. FOLD AT DOTTED LINE.

CERTIFIED MAIL

7022 2410 0002 9205 0767

Retail

53707

RDC 01

U.S. POSTAGE PAID
PM
BONDUEL, WI 54107
JUL 28, 2023

$18.45

R2305K138507-05

RECEIVED
AUG 3 – 2023

STRICTLY CONFIDENTIAL – TO ONLY BE OPENED BY SECRETARY HERETH

Dan Hereth, Secretary
Wisconsin Department of Safety and Professional Services
Division of Legal Services and Compliance
P.O. Box 7190
Madison, WI 53707-7190

Enclosed: McInnis Complaint

Received by
AUG – 2 2023
DMS Mailroom

Dr. Lorna Speid
Speid & Associates, Inc.
[redacted]

STRICTLY CONFIDENTIAL

26 July 2023

Dan Hereth, Secretary
Wisconsin Department of Safety and Professional Services
Division of Legal Services and Compliance
P.O. Box 7190
Madison, WI 53707-7190

FORMAL COMPLAINT AGAINST MS. HOLLEE J. MCINNIS, RN, A REGISTERED NURSE LICENSED BY WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

Dear Mr. Hereth

RE: HOLLEE J. MCINNIS, RN

Formal Complaint Regarding Gross Incompetence, Gross Negligence, Medical Malpractice, Dishonesty and Actions Taken that Caused the Death of the late Ms. [redacted] on 13 October 2021

It is seldom that I have felt compelled to take an interest in a medical case, but on this occasion, I consider it my duty to bring this case to your attention. Why? Because it demands action.

Ms. Hollee J. McInnis, RN, is licensed by the Wisconsin Department of Safety and Professional Services to practice nursing.

Her credential and license details are as follows:

Name: HOLLEE J. MCINNIS

Profession: REGISTERED NURSE (30)

Credential/License Number: 138357-30

Location: NEENAH, WI

Credential License Type: Regular

Status: License is current (Active)

Eligible to practice: credential license is current

Credential/License current through: 2/29/2024

Granted date: 8/3/2001

Multi-state: Y

ORDERS: NONE

Other Names: Hollee J. Stone

Hollee J. McInnis

I have consulted Chapter N6 of the *"STANDARDS OF PRACTICE FOR REGISTERED NURSES AND LICENSED PRACTICAL NURSES"* **[REF 1]**, and Chapter N7 *RULES of ETHICS* **[REF 2]**, and believe strongly that Ms. Hollee McInnis fails to meet the standards set for the practice of nursing. Her failure to meet these standards caused the death of Ms. Schara on 13 October 2021. This death verges on the criminal because it was so predictable, and avoidable. In my professional opinion, and this is not said lightly, deliberate actions were taken by Ms. McInnis, RN, to bring about Ms. [redacted] death.

The *"STANDARDS OF PRACTICE FOR REGISTERED NURSES AND LICENSED PRACTICAL NURSES"* clearly state that *"the Registered Nurse should "Consult with a provider where the RN knows or should know a delegated act may harm a patient."* Dr. Gavin Shokar prescribed Morphine on 13 October 2021, in addition to other drugs, including Lorazepam, and Dexmedetomidine (Precedex). Morphine on its own would have killed Ms. [redacted] but together with the other drugs, the blood levels of the three drugs would have been augmented, increasing the speed of death, and also making the death more excruciating; this was evidenced by the need to strap Ms. [redacted] down to her bed on 13 October 2021, as a result of the increased agitation caused by Dexmedetomidine (Precedex), which was being administered very frequently from the 12 October 2021 when Ms. McInnis took over the care of the patient. Up to that point, Ms. [redacted] had been improving, as evidenced by Dr. Baum's report to the patient's mother before he left for his vacation on 11 October 2021. I can attest to this improvement from my detailed review of the laboratory data.

On 13 October 2021, Ms. McInnis engaged in reckless and dangerous conduct that involved administering a cocktail of drugs that she should have known would kill Ms. [redacted] She not only administered Morphine, a drug that was contraindicated because the patient was recovering from respiratory distress, but she administered it twice, in quick succession. She also administered Lorazepam, a drug contraindicated for patients in respiratory distress. This drug was also administered twice in quick succession. The patient had also been administered Dexmedetomidine (Precedex), a drug that should not have been administered to this patient. Morphine on its own would have killed the patient, but all three drugs together ensured she would die a horrible death.

As a Nurse licensed since 3 August 2001, it is difficult to believe that Ms. McInnis did not realize that she was going to kill Ms [redacted] when she administered this cocktail of drugs. If she did not know, that emphasizes her gross incompetence. She does not have the luxury of saying that she

was following the physician's orders. As a nurse of so many years of experience, she had a duty of care to the patient and failed in her duty of care to protect this patient from a Physician who was reckless in his prescribing. She simply gave the drugs without questioning their safety. She should therefore forfeit her right to be licensed at the Registered level, which implies competence to practice unsupervised.

I have also consulted Chapter N7 RULES OF CONDUCT set by the Board of Nursing. It provides grounds for license removal and disciplinary action [**REF 2**]. Ms. McInnis has satisfied many grounds for the removal of her license including those shown in Table 1 below.

Table 1: Review of Chapter N7 in relation to Ms. McInnis RN competence

Chapter N7 Section	**Statement from the section**	**How satisfied by Ms. McInnis**
3	Confidentiality, patient privacy, consent, or disclosure violations, including any of the following:	Ms. McInnis acted without the patient's informed consent when she administered all the drugs that were administered without the consent of Ms. [redacted] guardians. Ms. [redacted] was unable to give her informed consent because she had Down's Syndrome, and Ms. McInnis was fully aware of that fact.
5 (b)	b) Intentionally making incorrect entries in a patient's medical record or other related documents.	Ms. McInnis did not require the correction of the death certificate, which did not state that it was the administration of Morphine that killed Ms. [redacted] Instead, she allowed the death certificate to be incorrectly completed to state unrelated causes of death.
6	(6) Unsafe practice or substandard care, including any of the following:	Ms. McInnis practiced nursing in an unsafe and substandard manner in many respects as detailed in this complaint.
6 (a)	(a) Failing to perform nursing with reasonable skill and safety	She demonstrated no skill and as a result her practice was and remains unsafe. She did not understand the drugs that she was administering to Ms. [redacted] She had no understanding of the half life of each drug and how they interacted with each other to potentiate respective blood levels.
6 (b)	(b) Lack of knowledge, skill, or ability to discharge professional obligations within the scope of nursing practice.	Ms. McInnis demonstrated a clear lack of knowledge, skill and ability in many respects during the time she oversaw the nursing care of Ms. [redacted]
6 (c)	(c) Departing from or failing to conform to the minimal standards	Nurse McInnis not only created risk for Ms. [redacted] she caused her death.

Chapter N7 Section	Statement from the section	How satisfied by Ms. McInnis
	of acceptable nursing practice that may create unnecessary risk or danger to a patient's life, health, or safety. Actual injury to a patient need not be established.	
6 (d)	(d) Failing to report to or leaving a nursing assignment without properly notifying appropriate supervisory personnel and ensuring the safety and welfare of the patient or client.	She could have reported Dr. Shokar for inappropriate prescribing and refused to administer the drugs he prescribed. Instead, she chose to fulfill the prescriptions, thereby killing Ms. [redacted]
6 (g)	(g) Unable to practice safely by reason of psychological impairment or mental disorder.	Ms. McInnis should be evaluated for serious psychological challenges, including some that are seen in nurses from time to time.
6 (i)	(i) Failure to consult or delay in consultation for clinical care beyond scope of practice	Ms. McInnis failed to recognize the limitations of her abilities.
6 (j)	(j) Failure to treat.	After administering two doses of Morphine to Ms. [redacted] after loading her up with Lorazepam, she failed to administer Narcan to reverse the effect of the Morphine, despite the family begging her to do so.
L	(L) Failure to provide medically necessary items or services	See entire complaint. She refused to administer emergency procedures or Narcan.
m	(m) Discriminating on the basis of age, marital status, gender, sexual preference, race, religion, diagnosis, socioeconomic status, or disability while providing nursing services.	Ms. [redacted] was discriminated against because she had Down Syndrome. At no time did Ms. McInnis speak to Ms. [redacted] or try to address her discomfort or concerns.
(n)	(n) Executing an order which the licensee knew or should have known would harm or present the likelihood of harm to a patient.	She should have known that administration of two doses of Morphine in quick succession would kill Ms. [redacted] but she administered the PRN doses anyway. At least the fact that they were PRN means they were administered at her discretion.
(p)	(p) Failing to observe the conditions, signs and symptoms of a patient, record them, or report significant changes to the appropriate person.	She failed to take action to save the patient, despite being begged to do so by the family. By this we know that her actions were deliberate.
8	(8) Improper prescribing, dispensing, or administrating medication	She administered drugs that should not have been administered to a patient in respiratory distress.

Chapter N7 Section	Statement from the section	How satisfied by Ms. McInnis
	or drug related offenses, including any of the following:	
8 (c)	(c) Administering any drug other than in the course of legitimate practice or as otherwise prohibited by law.	
8 (d)	(d) Error in prescribing, dispensing, or administering medication.	She made numerous errors in the two days that she worked with Dr. Shokar.

It is my understanding that litigation is currently ongoing, brought by Ms. [redacted] family. My concern is that this litigation could be protracted for at least another 18 months. In the meantime, Ms. McInnis could cause the death of other patients, unless action is taken. At the very least, future employers and patients and their families, should be informed when reviewing her license to practice, that she has caused the death of Ms. [redacted]

This serious and formal complaint consists of background materials, and Appendices, which provide detailed information about the case, and the methodology for arriving at my conclusions. I hope they will be helpful to you, and the experts you will call on, to assist you in your deliberations.

Prima Facie Collusion with Dr. Shokar to cause the death of Ms. [redacted]

Ms. [redacted] was making a recovery by the time that Dr. Shokar and Ms. McInnis took over her care on 12 October 2023. It is very likely that she would be alive today if Dr. Baum had not left her in Dr. Shokar's care, when he left on a 3 week vacation, on that date.

Given the circumstances of Dr. Shokar inserting *Do Not Resuscitate* in the medical notes on 13 October 2021 after an 8 am [local time] call to the family, and his prescribing of Morphine, Lorazepam, Insulin shortly thereafter, the administration of this series of medications that would cause Ms. [redacted] death could not reasonably have been accidental. She had already been dosed-up with high amounts of Dexmedetomidine (Precedex), which caused her respiratory system to be depressed. The respiratory depression was worsened by the addition of Lorazepam, and then Morphine was administered at 1830 hours to cause her death. To ensure she died, Ms. McInnis administered a second Morphine dose at 1845 hours, although the first would have killed her anyway. She seemed to want to speed up her already assured death.

Ms. [redacted] had been admitted with mild respiratory distress syndrome secondary to Sars-Cov-2 infection. The drugs that she was administered immediately upon admittance to the hospital made it difficult for her to breath and oxygenate her blood. Yet, she had excellent laboratory data, and the D-Dimer result showed that her system was in the process of recovery. The nursing notes and the physician notes clearly show that they either did not know the impact of the drugs they were administering, or knew and were deliberately administering the drugs to put the patient into crisis.

I respectfully allege that Ms. McInnis was a collaborator in bringing about the deliberate death of Ms. [redacted] because no reasonable nurse would have expected a patient recovering from a mild to

case of respiratory distress syndrome, secondary to infection with Sars-Cov-2, to be able to survive the combination of drugs that Dr. Shokar had prescribed recklessly, and deliberately. Ms. McInnis administered Morphine twice, and Lorazepam twice, while Dexmedetomidine was prescribed and administered by Ms. McInnis several times that day. It was still in Ms. [redacted] system. By so doing, at the very least, there is a case to answer for gross negligence, recklessness, and gross incompetence. I understand the family is pursuing criminal charges against both Dr. Shokar and Ms. McInnis and I applaud their actions because that is the level of seriousness that their actions warrant.

Troubling Case

When animals are put down, it causes tremendous distress to the families that they have been a part of. Normally, the family is given warning. In this case, Ms. McInnis used her position not to question or correct Dr. Shokar's egregiously poor prescribing, but to take the life of the patient who should have been able to depend upon her for protection. Ms. [redacted] was not even afforded the dignity that would be afforded a family pet.

Review of Other Deaths Urgently Required

I strongly urge that all the medical records for any patient(s) who died while under the care of Ms. McInnis are examined carefully to determine their cause(s) of death. It is high time that this situation is rectified, and Ms. McInnis' license is revoked. These events occurred in October 2021, and I find it deeply troubling that Ms. McInnis is still licensed to practice nursing. Are the written Board of Nursing standards just that, *written*, or are they actually *enforced*? At the very least, patients entrusted into Ms. McInnis' care should be made aware of this case, and that she is the subject of a civil, and hopefully, a criminal case. In my view she **should** be charged criminally. I cannot stress this enough, and this is based on my detailed review of the evidence.

Overview of this Complaint

In relation to this formal complaint, for which this is the cover letter, I am pleased to enclose the following documents for you to review.

1. **Cover Letter** –
2. **Background Document** - Formal Complaint Against Ms. H. McInnis, RN
3. Appendix 1: Complaint Form from the website
4. Appendix 2: Dr. Lorna Speid's Curriculum vitae
5. Appendix 3: Chronology of Events
6. Appendix 4: Medicines Administered by Ms. McInnis, RN
7. Appendix 5: Contraindications and Drug-Drug Interactions
8. Appendix 6: Morphine Administration and the Death of Ms. [redacted]
9. Appendix 7: Fraudulent Completion of the Death Certificate

I believe this provides you with a substantive complaint that requires not just a review and defensive response, **but action**, to protect patients, from Ms. McInnis, a woman who is not meeting the standards that your body has set for registered nurses.

In Summary, the points for this formal complaint can be summarized as follows:

1. In the best-case scenario, Ms. McInnis lacks the understanding of the proper use of medicines to safely administer them to patients
2. In the worst (and very credible) case scenario, Ms. McInnis acted deliberately to bring about the death of Ms. [redacted] It seems plausible, on the balance of the evidence, that she colluded with Dr. Shokar to bring about the death of Ms. [redacted]
3. Ms. McInnis shows a blatant disregard for the regulations and ethics of informed consent, particularly as these relate to vulnerable patients.
4. Ms. McInnis administered Dexmedetomidine (Precedex), Lorazepam and Morphine in a manner that could only have caused the death of any patient, but especially a patient in respiratory distress, secondary to Sars-Cov-2 infection.
5. Ms. McInnis' refusal to administer Narcan after realizing the impact of her actions, again raises the question on whether this was a deliberate and therefore criminal act.
6. The care of patients should not be entrusted to Ms. McInnis
7. The Wisconsin Board of Nursing should remove Ms. McInnis from the Nursing Register as a matter of extreme urgency.

Conclusions

I must say in closing that I have been deeply impacted by how Ms. [redacted] was ***mal***treated. I can only imagine the trauma experienced by her parents and family as they have lived through the events, and the aftermath of the death of their most beloved daughter.

In closing, Ms. McInnis is not a Nurse who should continue to be licensed to provide medical care to patients, supervised or unsupervised. She is a danger to every patient whose care she is involved with. Action must be taken to remove her from the Register to practice nursing.

I look forward to hearing from you at the earliest possible time.

Yours sincerely

Lorna Speid, Ph.D., MRPharm.S., B.Pharm.(Hons.)., RAC.

References

1. Chapter N6 *"STANDARDS OF PRACTICE FOR REGISTERED NURSES AND LICENSED PRACTICAL NURSES"* Wisconsin Board of Nursing.
2. Chapter N7 *"RULES OF CONDUCT"* Wisconsin Board of Nursing

Background to this Formal Complaint

Subject: Hollee J. McInnis, RN

Submission: Wisconsin Department of Safety and Professional Services
Division of Legal Services and Compliance

By Dr. Lorna Speid

Date: 27 July 2023

Table of Contents

This complaint is being filed because of the death of a young vulnerable patient, whose death was directly caused by the actions of Ms. McInnis. Because of the nature of the final substance administered, and how it was administered, I contend that the substance was administered with full knowledge that it would bring about the death of Ms. [redacted] Ms. McInnis is a danger to patients entrusted into her care. Urgent action is required to protect patients. The online complaint form is enclosed in Appendix 1. Ms [redacted] medical records are available upon request.

My Connection to this Case

Late last year, I heard the testimony of Mr. [redacted] Ms. [redacted] father. He spoke movingly about the events that led to his daughter's death, after admittance to the Ascension Saint Elizabeth Medical Center in Wisconsin, with a mild to moderate case of Sars-Cov-2 infection. He and his wife had taken their daughter to the ER when her oxygen saturation level was slightly lower than normal, as measured by a reliable home device.

I did not take an immediate interest in the case, until I read a journalist's write-up in a newspaper, some weeks later. By then, it was late December 2022. I knew that I had a duty to involve myself because of the specialized skills at my disposal. These skills would enable me to review the medical notes in a forensic, thorough and objective way. My goal was to determine Ms. [redacted] cause of death and any contributory factors. Why would a healthy young woman who walked unaided into the hospital with a mild case of Sars-Cov-2 infection (baseline laboratory data were normal), leave in the care of a funeral home, in less than 8 days?

My Background and Expertise

From my *Curriculum vitae* which is enclosed (**Appendix 2**), you will see that I am a Clinical Pharmacist, registered with the Royal Pharmaceutical Society of Great Britain. Whilst I work in the pharmaceutical industry as an expert consultant in new medicine development, I have expertise in the safe use of medicines, informed consent, drug safety/pharmacovigilance, and Global and Strategic Regulatory Affairs. In addition, and importantly for this case, I have extensive experience in the detailed/forensic review of medical records, honed during my Ph.D. into *The Safety Assessment of Medicines: Pre and Post-marketing* [REF 1].

These skills and experience qualify me to review Ms [redacted] medical records to determine the factors that contributed to, or directly caused her death. Whilst her parents were intrinsically involved in the events leading up to her death, I knew that my skills would allow me to give an independent and objective expert opinion on whether or not medical malfeasance was a contributing factor in Ms. [redacted] demise.

Ms. [redacted]

At the center of this tragedy is the late Ms. [redacted] Ms [redacted] was vulnerable because she was born with Down Syndrome. Her parents and family had poured their love into [redacted], and she had developed beyond levels achieved by many Down Syndrome children. She was a horse-rider, a violin player, a dancer, a student, and a lover of all things Elvis. She had intelligence, a sharp wit, personality and charisma. Everyone loved her, and all who hear this tragic story have been left devastated by her sudden, and unnecessary death. She was truly the life and soul of the party.

NIAID Treatment Guidelines and Their Influence on this Case

The drugs that were administered to Ms. [redacted] were clearly inappropriate. Their correct use is clearly written and documented in their product labels [REF 2, REF 3, REF 4].

At the start of the COVID19 crisis, the NIAID, the department of the National Institutes of Health that takes the lead in research for respiratory illnesses, issued treatment guidelines [REF 5]. These guidelines were issued to give just that, guidelines, on how patients should be treated. The guidelines unfortunately, removed the freedom of Physicians to treat their patients as was most appropriate on the basis of risk benefit. Instead, a one size fits all, was assumed. Physicians were also being threatened with loss of their licenses to practice if they stepped outside of the approach that was being pushed by the media, as well as official government agencies, including the CDC and the NIAID. I have taken that into account in the review of this case. What I have seen is far above Physicians and Nurses being afraid to step outside of what is considered appropriate for fear of losing their licenses. These were nurses and physicians who were deliberately setting out to cause harm.

Although Ms. McInnis was not the only nurse involved in inappropriate administration of medicines [REF 2, REF 3, REF 4], her role in Ms. [redacted] death cannot be under-estimated, dismissed or overlooked. She administered two lethal doses of Morphine that killed Ms. [redacted] Next to the Physician who prescribed the Morphine, her role was pivotal, because she elected to administer the lethal dose, instead of challenging Dr. Shokar's prescription, so that Ms. [redacted] life could be saved.

Financial Incentives to Cause Death

Because what happened in this case is so egregiously different to what would be expected of physicians and nurses, one has to ask about motive. The US government sought to provide compensation for losses incurred during COVID19. These payments were made to hospitals, and had the impact of incentivizing the hospital institutions without proper systems in place, to bring about the death of the patients under their care, to maximize the payment per patient. Whilst this does not absolve individuals like Ms. McInnis for what she did, it goes some way to explaining how the culture at the hospital, would make it acceptable to cause the death of a patient because there would be a benefit to the institution by so doing. Causing harm paid [REF 6, REF 7].

Methodology

Review of the Medical Notes

Late in December 2022 I contacted Mr. [redacted] and arranged to see the medical notes, in confidence. Mr [redacted] sent me the medical notes in PDF format (Table 1) early in January 2023. Since that time, I have spent many hours reviewing the medical notes and consulting with other experts in specialized fields, including Pharmacokinetic/Pharmacodynamic analysis of therapeutic blood levels.

Table 1: Documents Received, Reviewed and Forensically Analyzed

Document	Content	Number of Pages
Case Review No. 1 *Date 1/13/2023*	Medications by Prescriber with instructions to nursing staff	30
Case Review No. 2 *Date 11/04/2021*	Medications by Prescriber with instructions to nursing staff, and nursing administration records.	35
Case Review No. 3 *Date 11/08/2021*	Laboratory data	13
Case Review No. 4 *Date 11/03/2021*	Medical records	72
Case Review No. 5 *3/08/2022*	Medical records: includes duplicates of other records, audit files, healthcare status, and miscellaneous.	948
Case Review No. 6 *11/18/2021*	Nurse's notes.	26

After receiving the emailed medical notes in PDF format, I reviewed them forensically:

1. I carefully extracted and collated the medicines administered and their doses.
2. I reviewed the notes made by each Physician and each nurse.

A spreadsheet-like database was created to allow the data to be more effectively collated and sorted.

Results of the Review

My Findings

It is clear from a detailed review of the medical notes that Ms. [redacted] was effectively ignored by the Physicians and Nurses, including by Ms. McInnis, RN. The nurses and physicians held conversations in her room about her, but very seldom spoke to her. Because of Ms. [redacted] intelligence, she would have been aware of every slight, including the overt dismissal of her needs. Given the number of references to her having Down Syndrome in the medical notes, it is not too far-fetched to imagine that she heard herself described in this way, as they spoke about her, while ignoring her presence. This type of treatment that ultimately led to her deliberate and completely avoidable death, was borne of ignorance of a type that should not be evident in nurses and physicians in the 21st Century. It says a lot about the institution for which these *medical staff* work. I deliberately avoid the use of the word *professionals*.

Medicines Review

Ms. [redacted] was administered many medicines during the 7 days that she was in the hospital. The prescribing was atrocious, and downright dangerous. At no time did Ms. McInnis question the prescription of Dexmedetomidine (Precedex), Lorazepam, or Morphine prescribed. She also administered Insulin (**Appendix 4**) in the mix of drugs that killed her. There was no indication of a need for Insulin in a patient whose glucose level was effectively unchanged from her baseline level (151 mg/dL – {*normal range is 70-99 mg/dL*}).

I will focus my attention on three drugs that were administered in the 7 days, and that were absolutely contraindicated in a patient recovering (*and she was recovering*) from respiratory distress syndrome secondary to Sars-Cov-2 infection. These drugs are Dexmedetomidine (Precedex), Lorazepam, and Morphine.

Dexmedetomidine (Precedex)

The first drug that I want to bring to your attention as a professional review board is Dexmedetomidine (Precedex).

---------- INDICATIONS AND USAGE----------

PRECEDEX is a alpha$_2$-adrenergic receptor agonist indicated for:

- Sedation of initially intubated and mechanically ventilated patients during treatment in an intensive care setting. Administer PRECEDEX by continuous infusion not to exceed 24 hours. (1.1)
- Sedation of non-intubated patients prior to and/or during surgical and other procedures. (1.2)

Source: Dexmedetomidine (Precedex) product label

Dexmedetomidine (Precedex) should not have been administered to Ms [redacted] because she was not intubated and mechanically ventilated. See the extract of Indications above. She was not undergoing *a surgical procedure*. The drug should not have been administered at all, and even in patients in which it is indicated, it is not to be administered for longer than 24 hours. Ms. [redacted]

was administered this drug consistently, and repeatedly, for the duration of her stay in hospital (**Appendix 3, Appendix 4**).

---------- **WARNINGS AND PRECAUTIONS** ----------

- Monitoring: Continuously monitor patients while receiving PRECEDEX. (5.1)
- Bradycardia and Sinus Arrest: Have occurred in young healthy volunteers with high vagal tone or with different routes of administration, e.g., rapid intravenous or bolus administration. (5.2)
- Hypotension and Bradycardia: May necessitate medical intervention. May be more pronounced in patients with hypovolemia, diabetes mellitus, or chronic hypertension, and in the elderly. Use with caution in patients with advanced heart block or severe ventricular dysfunction. (5.2)
- Co-administration with Other Vasodilators or Negative Chronotropic Agents: Use with caution due to additive pharmacodynamic effects. (5.2)
- Transient Hypertension: Observed primarily during the loading dose. Consider reduction in loading infusion rate. (5.3)
- Arousability: Patients can become aroused/alert with stimulation; this alone should not be considered as lack of efficacy. (5.4)
- Tolerance and Tachyphylaxis: Prolonged exposure to dexmedetomidine beyond 24 hours may be associated with tolerance and tachyphylaxis and a dose-related increase in adverse events. (5.6)

Source: Dexmedetomidine (Precedex) product label

As indicated in the ADVERSE REACTIONS section of the product label (below), on more than one occasion when the Dexmedetomidine (Precedex) medicine was administered it caused her to become agitated and anxious, Ms. [redacted] was forcefully strapped to the bed on 13 October 2021 after the drug was administered repeatedly. Dexmedetomidine (Precedex) was what was causing the agitation and anxiety, yet the physicians and nurses evidently failed to realize this. Instead, they put Ms. [redacted] through the traumatic experience of being strapped to the bed, and this was done when her sister was forced to leave the room to take a shower. There is no reason that she could not have taken a shower in the room as Mr. [redacted] had done in the past. Not only this, but when Mrs. [redacted] (sister) left the room, [redacted] was not at all agitated. The veracity of the agitation at this point requiring her be strapped to the bed is something that should be investigated during the discovery (ongoing litigation). The fact is that she was strapped to the bed like in a mental asylum in the 1940s.

ADVERSE REACTIONS

- The most common adverse reactions (incidence ≥2%) are hypotension, bradycardia, and dry mouth. (6.1)
- Adverse reactions associated with infusions >24 hours in duration include ARDS, respiratory failure, and agitation. (6.1)

Source: Dexmedetomidine (Precedex) product label

Another area of concern with the use of Dexmedetomidine (Precedex), is the development of tolerance. The drug is subject to tachyphylaxis or tolerance, which means more of the drug is required to produce the same effect. This is the reason it should only be used for up to 24 hours. They were causing Ms. [redacted] body to develop tolerance to a drug dangerous to her, and were increasing the number of times that it was being administered to compensate for the tolerance that was developing.

Dexmedetomidine (Precedex) Drug-Drug Interactions

The drug was administered in the same timeframe as Lorazepam, and on the 13th October, Morphine. There is a dangerous interaction between all three of these drugs, causing potentiation of the respiratory depression (**Appendix 5**). This was why death occurred rapidly after the administration of Morphine, although Morphine alone would have killed the patient. See also **Appendix 5** for information on the use of these drugs and the interactions that must be guarded against.

---

7 DRUG INTERACTIONS

7.1 Anesthetics, Sedatives, Hypnotics, Opioids

Co-administration of PRECEDEX with anesthetics, sedatives, hypnotics, and opioids is likely to lead to an enhancement of effects. Specific studies have confirmed these effects with sevoflurane, isoflurane, propofol, alfentanil, and midazolam. No pharmacokinetic interactions between PRECEDEX and isoflurane, propofol, alfentanil and midazolam have been demonstrated. However, due to possible pharmacodynamic interactions, when co-administered with PRECEDEX, a reduction in dosage of PRECEDEX or the concomitant anesthetic, sedative, hypnotic or opioid may be required.

Source: Dexmedetomidine (Precedex) product label

Lorazepam

Lorazepam was prescribed and administered on many occasions during Ms. [redacted] stay (**Appendix 4, Appendix 5**). It should not be administered to patients in respiratory distress. It also interacts with Dexmedetomidine (Precedex), potentiating the depressor effect on respiration (**Appendix 5**).

Morphine

Dr. Shokar told the family that he administered Morphine to slow her heart rate. This is absolutely extraordinary. Morphine is not indicated for this purpose. The therapeutic index for this type of use is so narrow that no rational physician would use Morphine for this purpose.

The strong case against Ms. McInnis

Ms. McInnis had a pivotal role in the care of Ms. [redacted] She interacted with Mr. [redacted] and discussed his daughter's care with him. Ms. McInnis took over the nursing care around the 12 of October 2021, and overlapped with Dr. Shokar, whose role in the patient's death is indisputable, and is the subject of a separate formal complaint to your body.

Morphine was prescribed by Dr. Shokar and administered by Ms. McInnis. Whilst the prescribing was atrocious in general, it was the prescription and administration of Morphine that killed Ms. [redacted] Ms. McInnis was the person who administered the two doses of Morphine that killed Ms. [redacted] One of the doses would have been sufficient to kill Ms. [redacted] By administering two doses, Ms. [redacted] death was assured. Ms. McInnis refused to save her life when begged to save her by Mrs. [redacted] and the family on FaceTime. She allowed the patient to die when she knew that it was the Morphine that she administered that had caused her demise. As a nurse of over 20 years of experience, she had to have known. For this reason, there is a high probability that Nurse McInnis deliberately caused the death of Ms. [redacted] No reasonable nurse would have administered the cocktail of drugs that she administered.

To build the picture of what happened, we will follow the medicines administered by Ms. [redacted] from the 12 October 2021, i.e. from the time she took over Ms. [redacted] care, overlapping with Dr. Shokar. Dates and times are given below.

Date: 12 October 2021; **Time**: 0830 hours

	Administration of Dexmedetomidine (Precedex)					
Prescriber	**Nurse that administered the drug**	**Dose/ Rate**	**Date Administered**	**Time Administered**	**Nurse comments**	**Other comments in notes**
	MCINNIS	DOSE RATE CH. CURRENT RATE .5. RATE CHANGED TO 0.6.	10/12/2021	0830hours	GTT increased for comfort in breathing.	

Date: 12 October 2021; **Time**: 0941

	Administration of Dexmedetomidine (Precedex)					
Prescriber	**Nurse that administered the drug**	**Dose/ Rate**	**Date Administered**	**Time Administered**	**Nurse comments**	**Other comments in notes**
	MCINNIS		10/13/2021	0941 hours	DR SHOKAR PAGED FOR [redacted] TO RETURN CALL.	

Date: 12 October 2021; **Time**: 1014

	Date	Time By	Nurse Type	
Occurred:	10/12/21	1014 HJM MCINNIS,HOLLEE	RN	**Category**
Recorded:	10/12/21	1014 HJM MCINNIS,HOLLEE	RN	NURSING NOTES

Abnormal? N **Confidential?** N

PT'S MOTHER UPDATED BY DR SHOKAR ON PLAN, QUESTIONS ANSWERED.

Note Type	**Description**
No Type	NONE

Date: 12 October 2021; **Time**: 1356

	Date	Time By	Nurse Type	
Occurred:	10/12/21	1356 HJM MCINNIS,HOLLEE	RN	**Category**
Recorded:	10/12/21	1402 HJM MCINNIS,HOLLEE	RN	NURSING NOTES

Abnormal? N **Confidential?** N

PT TURNED FROM PRONE POSITION TO SUPINE WITH HOB 45 DEGREES. FIO2 INCREASED FROM 95% TO 100%, O2 SAT 78-85% AND NOT RECOVERING. DR SHOKAR INFORMED. STAT ABG, RT TO ADJUST BIPAP SETTINGS IF POSSIBLE AND MD WILL COME ASSESS PT AND TALK WITH FAMILY.

Note Type	**Description**
No Type	NONE

The Dexmedetomidine (Precedex) that was administered by Nurse McInnis was causing respiratory depression. Nurse McInnis demonstrated her incompetence because although she notes that the O2 SAT was at 78-85%, at no time did it dawn on her that it was the Dexmedetomidine (Precedex) that was depressing Ms. [redacted] ability to breath.

Date: 12 October 2021; **Time**: 1440

	Date	Time By	Nurse Type	
Occurred:	10/12/21	1440 HJM MCINNIS,HOLLEE	RN	**Category**
Recorded:	10/12/21	1442 HJM MCINNIS,HOLLEE	RN	NURSING NOTES

Abnormal? N **Confidential?** N

PT'S MOTHER TO CONFIR WITH PT'S FATHER AND GIVE DECISION ON CODE STATUS AS PT IS CURRENTLY DO NOT INTUBATE, BUT A FULL CODE. CLARIFICATION DECIDED PER DR SHOKAR'S CONVERSATION WITH MOTHER.

Note Type	**Description**
No Type	NONE

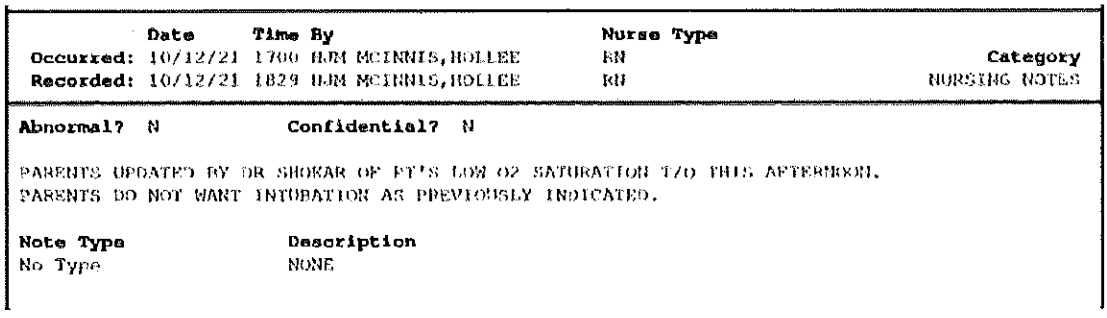
Date: 12 October 2021; **Time**: 1501

	Administration of Dexmedetomidine (Precedex)					
Prescriber	**Nurse that administered the drug**	**Dose/ Rate**	**Date Administered**	**Time Administered**	**Nurse comments**	**Other comments in notes**
	MCINNIS	104 MLS CURRENT RATE .7	10/12/2021	1501 hours		

Date: 12 October 2021; **Time**: 1700

	Administration of Dexmedetomidine (Precedex)					
Prescriber	**Nurse that administered the drug**	**Dose/ Rate**	**Date Administered**	**Time Administered**	**Nurse comments**	**Other comments in notes**
	MCINNIS			1700 hours	PARENTS UPDATED BY DR SHOKAR OF PT'S LOW O2 SATURATION T/O THIS AFTERNOON. PARENTS DO NOT WANT INTUBATION AS PREVIOUSLY INDICATED.	

The patient had been administered Dexmedetomidine (Precedex) many times, throughout the day and it should not have been any surprise that the oxygen saturation was low, because respiration would have been depressed. Ms. McInnis evidently failed to make this connection, demonstrating her incompetence and recklessness in the use of a drug dangerous to patients in respiratory distress.



	Date	Time	By	Nurse Type	
Occurred:	10/12/21	1700	BJM MCINNIS,HOLLEE	RN	**Category**
Recorded:	10/12/21	1829	BJM MCINNIS,HOLLEE	RN	NURSING NOTES

Abnormal? N **Confidential?** N

PARENTS UPDATED BY DR SHOKAR OF PT'S LOW O2 SATURATION T/O THIS AFTERNOON.
PARENTS DO NOT WANT INTUBATION AS PREVIOUSLY INDICATED.

Note Type	**Description**
No Type	NONE

Date: 13 October 2021; **Time**:0000

	Administration of Dexmedetomidine (Precedex)					
Prescriber	**Nurse that administered the drug**	**Dose/ Rate**	**Date Administered**	**Time Administered**	**Nurse comments**	**Other comments in notes**
	SHAIN002	104 MLS DOSE RATE CH. CURRENT RATE .7. RATE CHANGED TO 0.8.	10/13/2021	0000 hours		

Date: 13 October 2021; **Time** 0602

	Administration of Dexmedetomidine (Precedex)					
Prescriber	**Nurse that administered the drug**	**Dose/ Rate**	**Date Administered**	**Time Administered**	**Nurse comments**	**Other comments in notes**
	SHAIN002	104 MLS DOSE RATE CH. CURRENT RATE .8. RATE CHANGED TO 0.9.	10/13/2021	0602 hours		

At 0602, Nurse SHAIN002 administered Dexmedetomidine (Precedex). Less than an hour later, Ms. McInnis administered it again. The reason given by her in the notes was that the patient was not tolerating the prone position. The patient was being overdosed with Dexmedetomidine (Precedex).

Date: 13 October 2021; **Time** 0700

	Administration of Dexmedetomidine (Precedex)					
Prescriber	**Nurse that administered the drug**	**Dose/ Rate**	**Date Administered**	**Time Administered**	**Nurse comments**	**Other comments in notes**
	MCINNIS	DOSE RATE CH. CURRENT RATE .9. RATE CHANGED TO 1.0.	10/13/2021	0700 hours	pt not tolerating prone position.	

Ms. McInnis administered Dexmedetomidine (Precedex) again in 30 minute's time.

Date: 13 October 2021; **Time** 0730

	Administration of Dexmedetomidine (Precedex)					
Prescriber	**Nurse that administered the drug**	**Dose/ Rate**	**Date Administered**	**Time Administered**	**Nurse comments**	**Other comments in notes**
	MCINNIS	DOSE RATE CH. CURRENT RATE 1.0. RATE CHANGED TO 1.1.	10/13/2021	0730 hours	Pt rolling on side, increase to help tolerate prone position.	

Approximately 20 minutes later, Nurse McInnis administered the drug again.

Date: 13 October 2021; **Time** 0754

	Administration of Dexmedetomidine (Precedex)					
Prescriber	**Nurse that administered the drug**	**Dose/ Rate**	**Date Administered**	**Time Administered**	**Nurse comments**	**Other comments in notes**
	MCINNIS	DOSE RATE CH. CURRENT RATE 1.1. RATE CHANGED TO 1.2	10/13/2021	0754 hours	increased to help pt prone, rolling onto back and desats.	

She continued to administer the drug at a frequency not in the product label and not appropriate for this patient due to respiratory depression.

Date: 13 October 2021; **Time** 0815

	Administration of Dexmedetomidine (Precedex)					
Prescriber	**Nurse that administered the drug**	**Dose/ Rate**	**Date Administered**	**Time Administered**	**Nurse comments**	**Other comments in notes**
DR DANIEL P. LEONARD		TOTAL VOLUME 260 MLS. DURATION: TITRATE. TOTAL DISPENSED BAGS 3	10/13/2021	0815 hours		

Date: 13 October 2021; **Time**: 0941

	Date	Time	By	Nurse Type	
Occurred:	10/13/21	0941	HJM MCINNIS,HOLLEE	RN	**Category**
Recorded:	10/13/21	0942	HJM MCINNIS,HOLLEE	RN	NURSING NOTES

Abnormal? N **Confidential?** N

DR SHOKAR PAGED FOR SCOTT, TO RETURN CALL.

Note Type	**Description**
No Type	NONE

Time: 13 October 2021; **Time:** 1048

	Administration of Dexmedetomidine (Precedex)					
Prescriber	**Nurse that administered the drug**	**Dose/ Rate**	**Date Administered**	**Time Administered**	**Nurse comments**	**Other comments in notes**
	MCINNIS	VOLUME GIVEN 260 MLS DOSE RATE CH. CURRENT RATE 1.4.	10/13/2021	1048 hours		

Time: 13 October 2021; **Time:** 1837

	Administration of Dexmedetomidine (Precedex)					
Prescriber	**Nurse that administered the drug**	**Dose/ Rate**	**Date Administered**	**Time Administered**	**Nurse comments**	**Other comments in notes**
	MCINNIS	DOSE RATE CH. CURRENT RATE 1.4. RATE CHANGE TO OFF	10/13/2021	1837 hours	STOP GTT FOR NOW PER DR SHOKAR, RESTART AS NEEDED.	

Nurse McInnis then administered Lorazepam to reduce the anxiety and agitation that was resulting from the Dexemedetomidine (Precedex) that she had administered into Ms. [redacted] Now she was giving another drug to counteract the side effect that she had created and augmented. Lorazepam also causes respiratory depression, so the adverse effect was augmented.

Time: 13 October 2021; **Time:** 1930

	Administration of LORAZEPAM 2 MG/ML VIAL 0.5 MG (0.25 ML PER DOSE) I/V PRNQ6H 10/7/2021 1930 hours ANXIETY/AGITATION					
Prescriber DR DAVID BECK	**Nurse that administered the drug**	**Dose/ Rate**	**Date Administered**	**Time Administered**	**Nurse comments**	**Other comments in notes**
DR DANIEL P. LEONARD	MCINNIS	0.5 MG PRN	10/13/2021	1125 hours		

Date: 13 October 2021; **Time:** 1746

Ms. McInnis gave a 0.5 mg dose of Lorazepam, a contraindicated medication, at 1746 hours. She then gave another 0.5 mg dose of Lorazepam at 1749, approximately 3 minutes later. It was administered for anxiety and agitation as can be seen from the medication records (**Appendix 4**). He did not take into account the pharmacokinetic / pharmacodynamic profile of the drug. The interaction with Dexmedetomidine (Precedex) augmented the degree of respiratory depression experienced by Ms [redacted]

	Administration of LORAZEPAM 2 MG/ML VIAL 0.5 MG (0.25 ML PER DOSE) I/V PRNQ6H 10/7/2021 1930 hours ANXIETY/AGITATION					
Prescriber DR DAVID BECK	**Nurse that administered the drug**	**Dose/ Rate**	**Date Administered**	**Time Administered**	**Nurse comments**	**Other comments in notes**
	MCINNIS	0.5 MG PRN	10/13/2021	1746 hours		
	MCINNIS	0.5 MG PRN	10/13/2021	1746 hours		

Date: 13 October 2021; **Time:** 1750

In the following section of the nursing notes, Ms. McInnis writes in the notes that the patient's oxygen saturation was not improving. Ms. [redacted] oxygen saturation was measured at 54. Ms. McInnis had just administered two contraindicated doses of Lorazepam. Lorazepam is contraindicated in patients in respiratory distress. She failed to join up the dots that the drug she had administered caused the respiratory distress.

	Date	Time	By	Nurse Type	
Occurred:	10/13/21	1750	H.M MCINNIS,HOLLEE	RN	Category
Recorded:	10/13/21	1751	H.M MCINNIS,HOLLEE	RN	NURSING NOTES

Abnormal? N **Confidential?** N

PT O2 SAT 54 WITH PRONING. REVERSED WITH NO RECOVERY IN O2 SAT. PT'S SISTER AT BEDSIDE WHO FACETIMED PT'S FATHER TO UPDATE ON SITUATION. FAMILY PROVIDING COMFORT.

Note Type	Description
No Type	NONE

CONTRAINDICATIONS

ATIVAN Injection is contraindicated in patients with a known sensitivity to benzodiazepines or its vehicle (polyethylene glycol, propylene glycol, and benzyl alcohol), in patients with acute narrow-angle glaucoma, or in patients with sleep apnea syndrome. It is also contraindicated in patients with severe respiratory insufficiency, except in those patients requiring relief of anxiety and/or diminished recall of events while being mechanically ventilated. The use of ATIVAN Injection intra-arterially is

ence ID: 4742518

contraindicated because, as with other injectable benzodiazepines, inadvertent intra-arterial injection may produce arteriospasm resulting in gangrene which may require amputation (see **WARNINGS**).

ATIVAN Injection is contraindicated for use in premature infants because the formulation contains benzyl alcohol. (see **WARNINGS** and **PRECAUTIONS, Pediatric Use**).

WARNINGS

Risks from Concomitant Use with Opioids

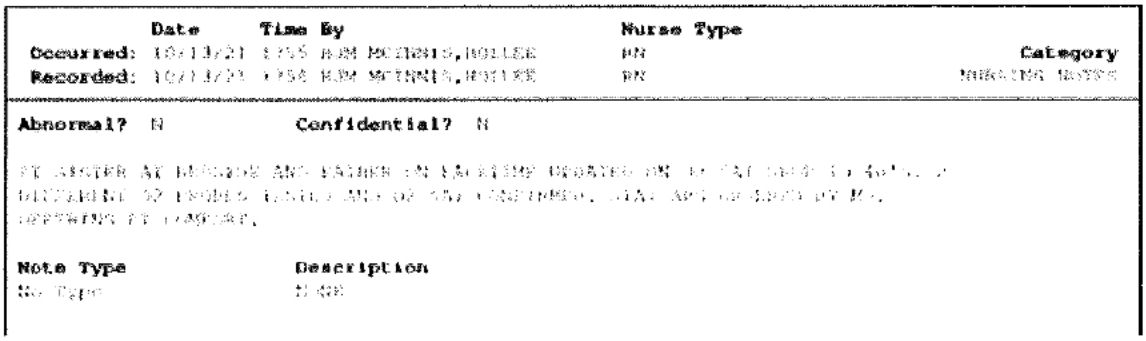
Concomitant use of benzodiazepines, including ATIVAN Injection, and opioids may result in profound sedation, respiratory depression, coma, and death. If a decision is made to use ATIVAN Injection concomitantly with opioids, monitor patients closely for respiratory depression and sedation (see **PRECAUTIONS, Drug Interactions**).

Source: Ativan product label

Ms [redacted] was not being mechanically ventilated. She was suffering in Ms. McInnis' own words from severe respiratory insufficiency.

By 1755 the patient was in severe respiratory distress, precipitated by the drugs administered by Ms. McInnis.

Date: 13 October 2021; **Time**: 1755



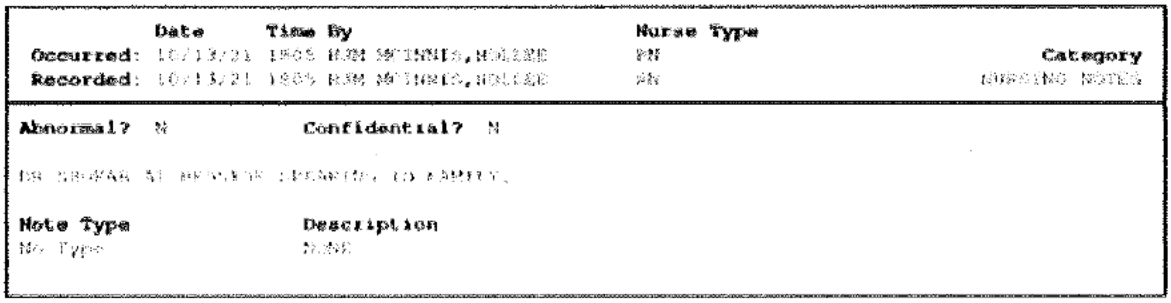
	Date	Time By	Nurse Type	
Occurred:	10/13/21	1755 RAM MCINNIS,HOLLEE	RN	**Category**
Recorded:	10/13/21	1758 RAM MCINNIS,HOLLEE	RN	NURSING NOTES

Abnormal? N **Confidential?** N

Note Type	**Description**
No Type	NOTE

Date: 13 October 2021; **Time**: 1805

Dr. Shokar called the family at 1805. He was at the patient's bedside while he was speaking to the family.



	Date	Time By	Nurse Type	
Occurred:	10/13/21	1805 RAM MCINNIS,HOLLEE	RN	**Category**
Recorded:	10/13/21	1805 RAM MCINNIS,HOLLEE	RN	NURSING NOTES

Abnormal? N **Confidential?** N

Note Type	**Description**
No Type	NOTE

Date: 13 October 2021; **Time**: 1830

Immediately after speaking to the family, Dr. Shokar then wrote a prescription for Morphine Sulfate. Ms. [redacted] was not a drug user. She had not been treated for cancer. She had no tolerance to Morphine. A dose of Morphine STAT / NOW would kill her, and any reasonable Physician and Nurse would know that. Yet the prescription was written as shown below, and it was administered by Ms. McInnis immediately, as written. This drug was administered at 1831. From Ms. McInnis' notes it is clear that Morphine was administered more than once, just as she administered Lorazepam more than once. She administered Morphine at 1831 hours, pushing it in over a minute (i.e. fast), and then she administered a second dose at 1845. This time she shows the reason as for pain. There is no other reference to the patient being in pain. Whenever Acetaminophen was previously administered, it as administered to bring Ms. [redacted] temperature down. She was not in pain, and certainly not the type of pain that would require a lethal dose of Morphine to be administered.

	Administration of Morphine					
Prescriber	**Nurse that administered the drug**	**Dose/ Rate**	**Date Administered**	**Time Administered**	**Nurse comments**	**Other comments in notes**
DR G SHOKAR	MCINNIS			1830 hours START. 1831 hours - STOP	MORPHINE SULFATE 2 MG IV SIG NOW (ONE). DOSE GIVEN 2 EACH -	SIG: NOW
	MCINNIS			1845 hours	DOSE GIVEN 2 EACH	PRN REASON GIVEN - PAIN

The morphine product label clearly contraindicates Morphine in patients with respiratory depression. This in addition to the fact that Ms. [redacted] had no tolerance to Morphine. By Ms. McInnis and Dr. Shokar's own admission in their notes, she had severe respiratory depression.

CONTRAINDICATIONS

Morphine Sulfate Injection is contraindicated in patients with:

- Significant respiratory depression (see **WARNINGS**)
- Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment (see **WARNINGS**)
- Concurrent use of monoamine oxidase inhibitors (MAOIs) or use of MAOIs within the last 14 days (see **WARNINGS**)
- Known or suspected gastrointestinal obstruction, including paralytic ileus (see **WARNINGS**)
- Hypersensitivity to morphine (e.g., anaphylaxis) (see **ADVERSE REACTIONS**)

Source: Morphine product label

Drug Drug Interactions

The patient had been administered Dexmedetomidine (Precedex) (**Appendix 5**). Dexmedetomidine (Precedex) is not supposed to be administered to patients in respiratory distress (**Appendix 5**). The oxygen saturation was falling because of the administration of a drug that was suppressing breathing (**Appendix 5**), but Ms. McInnis thought it was related to COVID19. In fact, Ms. [redacted] laboratory data had improved as reported by Dr. Baum just before Dr. Shokar took over her care. The Dexmedetomidine (Precedex) and Lorazepam had been reducing her ability to breath, and yet her lab data still showed she was improving. Had she not been administered these drugs she would have recovered.

The oxygen readings were unreliable. The machine used to measure oxygen saturation was poorly calibrated, and the reason that Mr. [redacted] was removed from his daughter's bedside was that he

had pointed this out to the nurses. Although the oxygen saturation data may not be reliable, the fact is that Ms. McInnis was using those data to draw the conclusion that the patient's condition was deteriorating. In fact, her general laboratory data continued to paint a different picture. She was actually doing well in spite of the fact that the drugs she was being administered were depressing her ability to breath and saturate her blood with oxygen. However, Ms. McInnis was not operating at this level of competence and understanding of the medicines that she was administering.

It is worrying that Ms. McInnis a licensed nurse did not realize that the Dexmedetomidine (Precedex)that had been administered together with Lorazepam, was depressing the patient's breathing, and therefore causing the challenge in Oxygen saturation. Not only did she not understand this, but she deliberately went on to administer Morphine at a lethal dose, a drug that would cause the death of the patient in a very short period of time. She then administered another lethal dose of Morphine. Ms. McInnis then tried to cover her tracks, by not taking responsibility, and by refusing to administer Narcan which would have saved Ms. [redacted] life. From this, we can draw a reasonable conclusion that Morphine was administered deliberately to bring about the death of Ms. McInnis. In my view, no other explanation is possible. The irresponsible administration of doses of Dexmedetomidine (Precedex) and Lorazepam, supports this conclusion.

Administration of Lethal Dose of Morphine

A nurse with the number of years of experience that Ms. McInnis has should have known that Morphine would kill anyone that it was administered to in the way that she administered it.

The Patient was malnourished

Date: 13 October 2021; **Time**: 1134

The notes indicate clearly that the patient as malnourished. She had a central port and could easily have been administered Total Parental Nutrition. She was not able to eat because the nurses and physicians feared that her oxygen saturation would fall. The oxygen saturation was falling because of the inappropriate prescribing the patient had to endure, not because her oxygen mask was left off for sufficient time for her to eat. Her father fed her when he was in the room with her. After he was forced to leave the room she was effectively and constructively left to starve. Placing a naso gastric tube was painful for Ms. [redacted] and by this time futile, because she was so sedated that the body would find it difficult to absorb nutrients.

	Date	Time	By	Nurse Type	
Occurred:	10/13/21	1134	HJM MCINNIS,HOLLEE	RN	**Category**
Recorded:	10/13/21	1137	HJM MCINNIS,HOLLEE	RN	NURSING NOTES

Abnormal? N **Confidential?** N

SMALL BORE NG TUBE PLACED LEFT NARE WITH PT ON 15L OXIMASK FOR PROCEEDURE, PLACED WITH EASE AND PIPAP REPLACED. O2 DESAT TO 61%, SLOW RECOVERY. CXR CALLED TO CONFIRM PLACEMENT. PT'S SISTER PRESENT FOR COMFORT. PT TOLERATED WELL. RR REMAINS IN THE 40'S.

Note Type	**Description**
No Type	NONE

	Date	Time By	Nurse Type	
Occurred:	[illegible]	[illegible]	RN	Category
Recorded:	[illegible]	[illegible]	RN	NURSING NOTES

Abnormal? N Confidential? N

[illegible]

Note Type	Description
[illegible]	[illegible]

Ms. McInnis Neglected Ms. [redacted] Right to Informed Consent

Although Ms. [redacted] cannot give consent to any medicines, the only person who could give this consent, i.e. her Father, was removed forcefully from her room. On 10 October 2021, Ms. [redacted] was made to watch as her Father was forced to leave her bedside by an armed guard, simply because he was actively advocating for her. At no time did Ms. McInnis take steps to ensure the family were fully aware of the toxic and lethal drugs she was administering to their daughter.

Medicines Administered During the Last 24 Hours of Ms. [redacted] Life

In this Background document we can see the medicines administered to Ms. McInnis administered during the last 24 hours of the patient's life (**Appendix 3, Appendix 4**). From Ms. McInnis' own notes the impression is given that she was at the end of her tether with this patient, and her family. She seemed frustrated that the patient was not responding to the Lorazepam administered, but the patient had been administered Dexmedetomidine (Precedex), which was making her agitated, and anxious, and this is when she administered another dose of Lorazepam. She then administered the dose of Morphine.

She administered the two lethal doses of Morphine that killed Ms. [redacted] at 1830 and 1845 hours on 13 October. I stress that one dose would have been enough to kill Ms. [redacted] but she administered two doses. Ms. [redacted] was pronounced dead at 1927 hours, less than 45 minutes later. In that time, Ms. McInnis refused to attend to the patient, or to save her life by administering Narcan even when Ms. [redacted] sister (in the room), and family (present by FaceTime) implored her to do so. She knew very well that the Morphine she had administered had caused her death, yet she lied in the medical notes and stated. She also lied to [redacted] sister, pretending not to know why she was becoming cold and *slipping away*.

	Date	Time By	Nurse Type	
Occurred:	10/13/21 1927	JC CASTRO,JORIZZA	RN	Category
Recorded:	10/13/21 2325	JC CASTRO,JORIZZA	RN	NURSING NOTES

Abnormal? N Confidential? N

No apical pulse, respirations, or blood pressure. Breath sounds absent. No pupil reaction in either eye. Dr. Watton notified and pronouncement of death order and permission to release the body to the funeral home received.

Note Type	Description
No Type	NONE

	Date	Time	By		Nurse Type	
Occurred:	10/13/21	1927	SP	PAGELS, SARAH	RN	Category
Recorded:	10/13/21	2330	SP	PAGELS, SARAH	RN	NURSING NOTES

Abnormal? N **Confidential?** N

DEATH NOTE:

No apical pulse, respirations, or blood pressure. Breath sounds absent. No pupil reaction in either eye.
Dr. WATTON notified and pronouncement of death order and permission to release the body to the funeral home received.

Note Type	Description
No Type	NONE

	Date	Time	By		Nurse Type	
Occurred:	10/13/21	1927	JC	CASTRO, JORIZZA	RN	Category
Recorded:	10/13/21	2331	JC	CASTRO, JORIZZA	RN	NURSING NOTES

Abnormal? N **Confidential?** N

Pt went asystole, No Code order in the computer. Day nurse with me at the bedside, team lead in the unit as well. No Pulse or respiration observed. Sister was on the phone with the family. No CPR done due to No Code status, MD informed by the changes.

Note Type	Description
No Type	NONE

	Date	Time	By		Nurse Type	
Occurred:	10/13/21	2320	JC	CASTRO, JORIZZA	RN	Category
Recorded:	10/14/21	0116	JC	CASTRO, JORIZZA	RN	NURSING NOTES

Abnormal? N **Confidential?** N

Pt picked up by the funeral home from room 2029. All of pt's belongings given

Nurse McInnis' Behavior After Killing Ms. [redacted] after Administering Morphine

When Ms. [redacted] died after she had administered Morphine, Ms. McInnis was cold and uncaring to the family. She took no responsibility for the fact that it was her action that had ultimately taken the life of their daughter. As a licensed nurse, she does not have the luxury of saying she was just following orders given by Dr. Shokar. She was a trained and licensed nurse, and should have known that Dexmedetomidine (Precedex), Lorazepam and then Morphine should not have been administered to a patient in a state of respiratory distress. Even if we presume that she did not know this, surely this is evidence that she is not qualified to be a licensed nurse, and that that license should be revoked? Her conduct and performance fell far below the standards expected of a licensed and registered nurse. I must stress that Morphine administered on its own was enough to kill Ms. [redacted] She administered Morphine twice (1830 hours and 1845 hours).

The [redacted] family whilst not educated in medicine and use of medicines, are highly educated. Mr. [redacted] is a highly trained financial executive, Chartered Accountant (CPA), and business owner. They were perfectly capable of researching the medical literature, and in fact did so to a greater extent than the medical staff overseeing their daughter's care. Their refusal to allow their daughter to be ventilated was an educated one, borne out by the medical literature. This was perceived negatively by Nurse McInnis and her colleagues. They despised the independence of Mr. [redacted] and his family. From this it is my impression that Ms. McInnis and her colleagues are not very sophisticated, and that they were determined to teach this family a lesson.

Whilst it was Dr. Shokar who inserted *DO NOT RESUSCITATE* into Ms [redacted] medical notes on 13 October 2021, Ms. McInnis is a Registered Nurse, and should have taken the authorization of the family to save their daughter given she was the one who had administered the Morphine that killed her. Her refusal to do so was malicious and unprofessional. In particular, the following are important to make note of in relation to *DO NOT RESUSCITATE* administration, particularly in relation to patients who cannot give informed consent.

Mr. [redacted] has provided the following summary of the DO NOT RESUSCITATE provisions provision in Wisconsin statutes.

Details Regarding Use of *DO NOT RESUSCITATE* (DNR)

For a DNR to be valid, the following criteria and procedures must be met:

- ☐ The qualified patient, guardian, or health care agent must request the DNR order. Wis. Stat. § 154.19(1)(b).

- ☐ An attending physician provides written information about resuscitation procedures and the methods by which the patient may revoke the DNR order. Wis. Stat. § 154.19(2)(a).

- ☐ The patient, guardian, or health care agent consents to the order after being provided the information mentioned above. Wis. Stat. § 154.19(1)(bm).

- ☐ The do-not-resuscitate order must be in writing and signed by the patient, guardian, or health care agent. Wis. Stat. §§ 154.19(1)(c) and (d).

After providing the required information:

- ☐ The attending physician must issue and document the DNR order in the patient's medical record and either affix a DNR bracelet to their wrist or provide a form so the patient may order a bracelet from a commercial vendor. Wis. Stat. §§ 154.19(1) and (2)(b).
- ☐ The desire of a patient to be resuscitated always supersedes a DNR. A patient may revoke their DNR at any time. Wis. Stat. §154.21, 154.25(6m).
- ☐ A guardian or health care agent may revoke a do-not-resuscitate order by giving direction to resuscitate the patient. Wis. Stat. §154.225(2).

The parents are adamant that in [redacted] case:

a. *At no time did we ask for [redacted] to be labeled DNR. We also did not agree to DNR status at any time. The hospital's letter to us, explaining her DNR status, references the doctor note as the reason [redacted] was labeled DNR.*

b. *We never signed any statement regarding [redacted] being DNR.*

c. *[redacted] was not wearing a DNR bracelet, as required by law.*

d. *The first time we knew [redacted] was labeled DNR was when we were screaming for the nurses to do something and reverse the morphine given to [redacted] Their response, "She's DNR" was their excuse for not helping her. We screamed back, "She's not DNR" and they did nothing. They stood outside her door instead. There was also an armed guard posted outside the room.*

e. *Per [redacted] ([redacted] sister, her advocate in the room when [redacted] died) summary of events: "One nurse read off what the computer stated and that the doctor labeled her as a DNR which they claimed they couldn't do anything about."*

One aspect of the tragedy that is truly distressing, is that [redacted] sister, watched what I would consider the murder of her sister, and could do nothing to help her. This is something that the family obviously finds very traumatic, as they relive the events of that day, wondering if there was anything that they could have done differently to save [redacted] The only people who had the power to save [redacted] were the nurses and physicians, and they chose to not save her after they had initiated the process of killing her. She would not have needed CPR or resuscitative procedures if they had not deliberately administered drugs they knew, or should have known would kill her.

The Appendices present data and information that will be helpful in the review of this case. I urge the reviewer to take the time to review the documentation that accompanies this complaint.

References

1. *"The Safety Assessment of Medicines: Pre and Post-marketing".* LH Speid. PhD Thesis, University of Wales, Department of Clinical Pharmacy, May 1991. The British Library.

2. Precedex Product Label
   a. https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/021038s031s033lbl.pdf
3. Ativan Product Label
   a. https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/18140s046lbl.pdf

4. Morphine Sulfate Product Label
   a. https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020631s001lbl.

5. COVID-19 Treatment Guidelines Panel. Coronavirus Disease 2019 (COVID-19) Treatment Guidelines. National Institutes of Health. Available at https://www.covid19treatmentguidelines.nih.gov/. Accessed [22 July 2023].

6. Ochieng N, Biniek JF, Musumeci M, Neuman T, Funding for Health Care Providers During the Pandemic: An Update, Published Jan 26, 2022. https://www.kff.org/coronavirus-covid-19/issue-brief/funding-for-health-care-providers-during-the-pandemic-an-update/

7. Amounts paid by US government to States during the COVID19 crisis. https://www.beckershospitalreview.com/finance/state-by-state-breakdown-of-federal-aid-per-covid-19-case.html?utm_campaign=bhr&utm_source=website&utm_content=related&fbclid=IwAR3D7taVX0-KyuISg8dDahscKE2sTwjMe7WXZwPjkoXxu7Z2UsWN4a0TRYQ

Overview of the Appendices

Appendix 1: Complaint Form from the website

Appendix 2: Dr. Lorna Speid's Curriculum vitae

Appendix 3: Chronology of Events

Appendix 4: Medicines Administered by Ms. McInnis, RN

Appendix 5: Contraindications and Drug-Drug Interactions

Appendix 6: Morphine Administration and the Death of Ms. [redacted]

Appendix 7: Fraudulent Completion of the Death Certificate

Appendix 1

Complaint Form (online)

(http://dsps.wi.gov/)

State of Wisconsin

Department of Safety and Professional Services

COMPLAINT FORM

Complaint ID:2023018536
Created Date:7/26/2023 11:35:12 AM
Complaint Category: Health
Profession: Nurse,

PERSON SUBMITTING THE COMPLAINT

First Name	Middle Name	Last Name
DR LORNA		SPEID

Address	City	State
[redacted]	[redacted]	[redacted]

Zip Code	County	E-Mail
[redacted]	[redacted]	[redacted]

Primary Phone	Secondary Phone	Date Of Birth
[redacted]	[redacted]	[redacted]

PATIENT INFORMATION

First Name	Middle Name	Last Name
[redacted]	[redacted]	[redacted]

Date of Birth	Patient Contact Information	Is patient deceased ?
[redacted]		Yes

Date of Death: [redacted]

LICENSEE THE COMPLAINT IS AGAINST

LICENSEE -1

First Name	Middle Name	Last Name
HOLLEE	J.	MCINNIS

Address	City	State
UNKNOWN	UNKNOWN	Wisconsin

Zip Code	County	E-Mail
	UNKNOWN	

Primary Phone	Secondary Phone

Please enter the names of any other people involved in this incident

DR GAVIN SHOKAR - a separate complaint will be filed.

INCIDENT INFORMATION

1. When did the incident occur (If you do not know the exact date, make as close an estimate as possible)?

12 October 2021 to 13 October 2021

2. Where did the incident occur?
St Elizabeth Hospital 1506 S Oneida St.

3. Have you tried to resolve this matter? If so, please provide details.
Family has tried to resolve the matter. This complaint relates to public safety, and that is why I am personally bringing it, as a healthcare professional, and an expert in the safe use of medicines.

4. If your complaint is, or has been, under consideration by another agency or court please provide the agency name, court name, case number and case status.
N/A

5. Who else has information related to this incident? Provide names, addresses, email addresses and phone numbers for those persons.
Mr. [redacted] and Mrs [redacted]

6. Describe the incident. Include as much specific information as possible.
Ms. McInnis administered a cocktail of drugs to Ms. [redacted], a patient in respiratory distress. These drugs were Dexmedetomidine (Precedex), Lorazepam, and Morphine. All are well known to cause respiratory depression. These drugs should NOT have been administered to this patient or any patient in respiratory distress. Morphine was administered twice with the design to bring about the death of this patient. There is no other explanation for a nurse with 20 years of experience, administering this cocktail of drugs. When the family begged her over FaceTime (sister in hospital room begged her and the other nurses) to save [redacted] life, they refused, stating that the patient was Do Not Resuscitate. The family had not given authorization for the patient to be DNR and the patient was not able to give informed consent herself, because she is a Down Syndrome patient. A detailed and substantive complaint report is to be delivered to your offices. We cannot submit those confidential documents to this system.

Authorization forms give your permission for our agency to obtain copies of treatment records, discuss that treatment with the persons who provided the treatment, and use the records as part of our inquiry and/or investigation of the complaint and, if necessary, during any hearing that may follow. **If you do not the complete the Authorization Form, we may not be able to investigate your complaint.**

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's First and Last Name: Patient's DOB:

I hereby authorize and all staff or employees of that facility or office to provide the Wisconsin Department of Safety and Professional Services (Department) and its attached Boards, or any attorney, investigator, employee, or agent thereof, with copies of all health care records relating to the above named patient in your possession or under your control, regardless of origin, including, but not limited to, the following: admission records, physical examinations and histories, nurses notes, progress notes, diagnostic test records, physician notes and orders, medication orders and records, operative reports, laboratory work, prescription and dispensing records, x-ray films, radiology reports, anesthesia records, physical therapy records, occupational therapy records, fetal monitoring strips, respiratory therapy records, consultation reports, pathology reports, emergency room records, discharge summaries, drug and alcohol treatment records, and mental health/psychiatric treatment records. This is to include records relating to HIV treatment, if such treatment has been given. I further authorize you to allow these persons to examine and copy any records or information relating to the above named patient. A reproduced copy of this Authorization Form shall be as valid as the original.

This disclosure is being made for the purposes of a legal inquiry and any subsequent proceedings by the Department and its attached Boards. Unless revoked earlier, this consent regarding records is effective until two (2) years from the date of signature. I understand that: (a) I may revoke this authorization at any time by sending a written notice of revocation to the Department at the above address; or by sending a written notice of revocation to the above health care provider; (b) information obtained as a result of this consent may be used after the above expiration date or revocation; (c) the information that the Department receives under this request will not be re-disclosed except in the case of a Department or board proceeding, or a valid open records request and then only under the circumstances permitted by law and re-disclosed information is no longer protected by privacy laws; and (d) the completion or non-completion of this consent has no effect on any treatment, payment, enrollment or eligibility for benefits by any health care provider.

I have been informed, pursuant to Wis. Admin. Code § DHS 92.03(3)(d), that I have the right to inspect and receive a copy of any mental health treatment record materials which are disclosed as a result of this authorization, as required under Wis. Admin. Code §§ DHS 92.05 and 92.06.

I further authorize you to discuss with these persons, any matters relating to the treatment of the above named patient.

Your Name: Date: **07/26/2023**

Authority for Signing if the patient is a minor, is deceased, or is not competent to sign (e.g.,"John Doe, parent of minor child Jane Doe"; "Mary Jones, surviving spouse of Henry Jones"):

State Equivalent of standard #102DLSC(Rev. 8/15) paper complaint form

Print Create New Complaint

Appendix 2

Curriculum vitae and Background for

Dr. Lorna Speid, Expert on the Safe Use of Medicines

LORNA SPEID, B.PHARM.(HONS.), M.R.PHARM.S., PH.D., RAC, DTM

Email: [redacted] Cell: [redacted]

SUMMARY OF QUALIFICATIONS

Dr. Speid is a consummate expert (views of peers), in global and strategic regulatory affairs. She is a quick thinker and a strategist that is able to assess challenges and very quickly find the solutions. Dr. Speid has a demonstrable track record of success in various aspects of the global regulatory process, including premarketing and postmarketing. Success (100%) has been demonstrated in securing regulatory approvals, leading to commercialization of medicines, by conducting appeals, even in cases where others have filed applications, and received rejections of the same marketing applications. Expertise translates to substantial profits and investments for all firms that Dr. Speid has worked for. Dr. Speid has a track record of success in terms both of the number of the programs she has worked on, and their subsequent successful progress to commercialization, and patient access, especially in unmet medical need areas.

DR. SPEID's BIOGRAPHIC SKETCH

Dr. Speid has achieved a high level of mastery and expertise in the field of global and strategic regulatory affairs. She has achieved a track record of success, securing approvals for new medicines from all the major regulatory authorities, including after conducting appeals to overturn rejections. Her skills with appeals were honed from submitting appeals to the Medicines Control Agency (now MHRA), as well as in US, UK, Belgium, Germany, Sweden, Netherlands, and Australia. She has a 100% success rate for appeals.

Lorna has experience with many therapeutic areas, including oncology (hematological and solid tumors), diabetes, obesity, anti-infectives (anti-bacterial and anti-viral), pulmonary (asthma, COPD), influenza, women's health (hormone replacement therapy), bone (Paget's disease and osteoporosis), lupus, Rheumatoid arthritis, transplantation, autoimmune diseases, Malaria, Sickle Cell Disease, and CNS (psychiatry, Alzheimer's Disease). She has a special practice in rare diseases, and another in neglected diseases. In all of these areas, she develops regulatory strategies, as well as operational approaches that can be used to secure regulatory approvals around the world. Lorna has worked with all treatment modalities, including small molecules, large molecules, gene therapy, combination products (drug and device), companion diagnostic approaches, cellular products, and Biosimilars. She has experience working with oral, injectable and topical medications.

Lorna has worked for large pharma as well as small biotech companies, including Sanofi Winthrop in the UK (now Sanofi-Aventis), Ciba Geigy and Novartis in Switzerland *(at Headquarters)*. Small companies that she has worked for include GeneMedicine/Valentis, Inc. (Director of Regulatory Affairs), NewBiotics (Vice President Regulatory Affairs and Project Management including QA oversight), and Avera, Inc. (Vice President of Regulatory Affairs). Dr. Speid was an officer at the last two companies. She founded and incorporated Speid & Associates in 2004. Since that time, she has been able to use her expertise to make a difference for many other companies and organizations.

Lorna's writing, negotiation skills, team leadership, and leadership skills enable her to produce the results needed in the regulatory and drug development arenas. She is hands-on as well as strategic. However, her

understanding of the need to delegate and how to develop the Team have been demonstrated throughout the years. She is able to operate at a senior level, providing input at the Board level, as well as at the executive management level.

Lorna is the Founder and President of Putting Rare Diseases Patients First!®, a 501 c 3 Charity set up to enable patients with rare diseases to effectively engage with the new medicine development process. The organization provides expert information on new medicine development to patients and parents. The organization takes steps that are challenging for other rare disease patient organizations to take because of the expert knowledge of the new medicine process, and expertise in regulatory affairs.

SUMMARY OF KEY ACHIEVEMENTS

- Worked on a COVID-19 program. Developed tactics to accelerate movement of the Phase 1 molecule into a registrational Phase 2 study in patients with Acute Respiratory Distress Syndrome secondary to COVID-19 infection. Wrote the Pre-IND package, presented to the senior management Team, provided input on regulatory strategy, TPP, CMC, clinical trial supplies, clinical protocol development, toxicology program, and many other areas.
- Under the auspices of PRDPF!, Submitted a Citizen's Petition to the FDA to add Sickle Cell Disease to the FDA's Tropical Disease Priority Review Voucher List. If effective, this will encourage additional investment in new medicine development for Sickle Cell Disease. Coordinated support including from major pharma, small biotech, patient groups, and Access to Medicines Index.
- Filed INDs and CTAs to US and many other major regulatory jurisdictions. These achievements have translated to many new treatments now marketed, included Foradil Dry Powder, Foradil Solution Formats, Skelid – UK and European Strategy, an anti-obesity treatment (FDA), and many other treatments, and line extensions.
- Secured approvals for all major health authorities for many drugs, as well as new indications, including the following.
    - Skelid – European approvals after an appeal process through the United Kingdom Health Authority
    - Anti-depressant drug – generic, and other generics through the UK Health Authority
    - Foradil – several different formats – global approvals after appeals in many countries
    - CellCept – line extension development for Lupus Nephritis
    - Obesity drug – played a major role in the development of the appeal after FDA rejection. The drug was approved.
    - Numerous other programs that have ultimately progressed through clinical development, and to approval
- Successfully filed appeals – 100% success rate for all appeals submitted
- Secured regulatory approvals for Foradil Dry Powder in all the major markets, after launching appeals [Ciba Geigy – Switzerland], Skelid for equivalent of the Centralized European Procedure.
- Founder and Chair of Drug Development Boot Camp®, an internationally recognized intensive training program in new medicine development for decision makers.
- Published author of a book on clinical trials written for patients and healthy volunteers.

- Set up Phase 1 / 2 oncology clinical trials at Dana Farber Cancer Center, University of Pennsylvania, UCLA, and USC. Indications were head and neck cancer, and advanced colorectal cancer.
- Created strategies for companion diagnostic and therapeutic treatment programs for cancer and transplantation.
- Founded the Drug Development Boot Camp® in 2009 and ran the first intensive training program in 2010 with Cornell University. The next eight years were run with Harvard University OTD. The following three years were run with Brown University. Hundreds of participants have been trained from pharma, biotech, academia and NIH/NCI. Participants have come from many countries.

PROFESSIONAL EXPERIENCE

December 2014 to Present
Founder and Board of Director Chair
PUTTING RARE DISEASES PATIENTS FIRST!®

- Founded a 501 (c) (3) non profit corporation with charitable status to provide actionable information about the clinical trial and drug development process to patients with rare diseases, and the parents of children with rare diseases.
- Chair of the Board of Directors
- Motivate and lead a Team of experienced professionals who want to give back to society
- Hosted FDA, Roche and several other major institutions to present pertinent information to patients with rare diseases using the Webinar format.
- Recruited a volunteer staff including Board of Director members.
- Submitted a Citizen's Petition to the FDA to add Sickle Cell Disease to the FDA's Tropical Disease Priority Review Voucher List. If effective, this will encourage additional investment in new medicine development for Sickle Cell Disease
- Ran a special Webinar on Sickle Cell Disease to discuss cures (May 2020, May 2021). Patients and physicians from many countries participated. Speakers were from major institutions involved in the curative treatment and transplantation. Many of them are at the cutting edge of curative approaches.

September 2010 to Present
Founder and Chair
DRUG DEVELOPMENT BOOT CAMP®

- Founded Drug Development Boot Camp®, now in its 13th year.
- Developed the concept for intensive accelerated learning and training in drug development.
- Developed the content with expert Faculty recruited from large pharma
- Trained participants in drug development from large pharma, small biotech, NIH, and academia, alongside high-profile Faculty from large pharma.

September 2010
Published Author

- Clinical Trials: What Patients and Healthy Volunteers Need to Know, published by Oxford University Press.
- Won several awards, including from the Library Journal.

February 2004 to Present

Founder and President

SPEID & ASSOCIATES, Inc.

Some Achievements are listed, but these are not comprehensive. Please apply to Dr. Speid for additional details

- Provided expert hands-on input to a potential new treatment for COVID19. This involved assisting with the set up of the clinical trial, development of strategic, tactical advice, and managing communications with many major regulatory authorities, including MHRA, FDA, South Korea, France, Germany, and others.
- Provided global and strategic regulatory advice to numerous management teams
- Past Invited Reviewer on the TRND (NCATS) (rare and neglected diseases) NIH Committee for three review cycles.
- Worked with senior management teams to develop strategies to appeal rejections from major regulatory authorities. Thus far, a 100% career success rate for these appeals.
- Developed strategies for a major US government division (USAID, USP) to assist with drug shortages for a neglected disease.
- Created many NDA/eCTD regulatory strategies.
- Developed European regulatory strategies.
- Acted as Interim VP of Regulatory Affairs for several companies.
- Negotiated with health authorities to secure corporate goals, avoid the need to conduct unnecessary studies, reduce study costs, etc.
- Negotiated competitive scopes of work and contracts with CROs and contract manufacturers, on behalf of clients.
- Developed and advised on corporate drug safety strategy and policies, on behalf of clients.

March 2003 to-Jan 2004

AVERA PHARMACEUTICALS, SAN DIEGO, CALIFORNIA

VICE PRESIDENT, REGULATORY AFFAIRS

OFFICER OF THE COMPANY

THERAPEUTIC AREAS: ANESTHESIA/CENTRAL NERVOUS SYSTEM

- Set up a global regulatory function, and drug safety function including the creation and implementation of SOPs.
- Set up Electronic Document Management Systems Team and evaluation process. An electronic document management system was selected for implementation.
- Created a standardized electronic filing structure and other regulatory systems.
- Conducted regulatory due diligence for compounds licensed-in from a large pharmaceutical company.
- Provided regulatory support and developed detailed regulatory strategy for the Company's three compounds.

October/November 2000 to February 2003

NEWBIOTICS, INC. SAN DIEGO, CALIFORNIA

VICE PRESIDENT, REGULATORY AFFAIRS & CLINICAL PROJECT MANAGEMENT

OFFICER OF THE COMPANY

THERAPEUTIC AREAS: ONCOLOGY (ADVANCED COLORECTAL)/ANTI-INFECTIVES (RESISTANT STRAINS)

- Recruited by the CEO to head up the floundering development program.
- Set up a global regulatory function, as well as clinical research and project management functions.
- Successfully filed the first IND for NB1011, the Company's first and lead compound. The IND was cleared.
- Secured IRB and Scientific Committee approvals at two prominent clinical sites (UCLA, USC); setting up clinical trial at these sites; setting up quality assurance function; project leader for the project for one year.
- Development of global regulatory strategy for the compound including setting up a Regulatory Strategy Advisory Board consisting of prominent advisors.
- Presented with an award for achievements in securing the company's first IND, and starting the company's first clinical trial at UCLA and USC, for advanced colorectal cancer.
- Secured 1 million USD milestone payment for the company when the IND was cleared by FDA.

1st Jun 1998 to 15 July 2000

GENEMEDICINE, INC./VALENTIS, INC. The Woodlands, Texas

DIRECTOR, WORLDWIDE REGULATORY AFFAIRS

TEAM LEADER INTERLEUKIN 12 PROJECT TEAM

THERAPEUTIC AREAS: HEMOPHILIA A & B, CANCER (HEAD AND NECK), CARDIOVASCULAR, CHRONIC ANEMIA

- Promoted to Director of Regulatory Affairs within about 18 months of joining
- Set up the global regulatory function.
- Devised and implemented regulatory strategies for gene medicines and biologicals.
- Led the IL-12 project team.
- Submitted IND for IL-12. The IND was cleared with no issues.
- Set up the IL-12 clinical trial at University of Pennsylvania and Dana Farber
- Submitted IND amendments for several gene medicines.
- Developed regulatory strategies for gene medicines.
- Trained senior management team members in regulatory affairs.
- Responsible for development of regulatory strategy, clinical development and drug safety.
- Responsible for Biologics/gene therapy - IL-12, IFN-α, IFN-γ, IL-2, growth factors, Factor IX, Factor VIII, pegylation technology. Set up clinical trial at two major investigative sites.
- In charge of drug safety for all gene medicines
- Represented the Company at Recombinant Advisory Committee Meetings.
- Created a format for the research and development report for the scientists to use.

Feb 1995 to End August 1997

CIBA GEIGY PLC/NOVARTIS PLC, Basel, Switzerland (Headquarters)

REGULATORY AFFAIRS PROJECT MANAGER – Global Head of Regulatory Affairs for Respiratory Affairs, then Global Head of Regulatory Affairs for Transplantation including Cyclosporin and Related Molecules

DEVELOPMENT REGULATORY AFFAIRS,

THERAPEUTIC AREAS: ASTHMA/IMMUNOLOGY/ TRANSPLANTATION/ GENE THERAPY

Secured approvals for Foradil Dry Powder in all the major markets, after launching appeals. These major markets included United Kingdom, Ireland, Italy, Australia, Germany, France, Portugal, South Africa, Spain, Switzerland, South Africa and New Zealand. Led the Regulatory Sub Team to secure approvals in all the developing markets such as Brazil, Africa /Middle East, and Asia.

The Situation

- Joined Ciba Geigy shortly after Foradil Dry Powder New Drug applications had been filed to all the major regulatory authorities, and developing market regulatory authorities, except the Unites States. Successive rejections were received week of joining the company.
- The regulatory authorities were refusing to approve the applications due to previous failures in formulation/ dose dumping with other formats.
- Leadership skills were used to lead a demotivated team consisting of senior scientists, pharmaceutical scientists, clinicians, to focus on filing well-constructed appeals to every regulatory authority that had rejected the applications, and refused to approve the drug.

Tasks

- Developing the appeals required expert level analytical skills. The key was to review the detailed rejection letters, often running into 30-40 pages and to determine the underlying reasons for each and every rejection.
- I motivated and led the Team to address the underlying causes for the rejections.

Results

- Turned around all rejections. Secured approvals in all major and minor jurisdictions. Not one single application had to be withdrawn, and there were no rejections.
- Foradil was one of the fastest growing drugs in the Ciba Geigy and Novartis portfolio.
- Advice sought from Reference Member States in preparation for mutual recognition procedures. Responsible for organising appeals for major marketed product for new indications.
- I was the regulatory Asthma specialist for inhaled formats of Foradil, a long acting ß2 agonist, and an early development compound (Substance P antagonist). Core member of International Project Teams for these drugs.
- Responsible for development of regulatory strategy for US, Europe and Japan and other major territories. Responsible for provision of regulatory input to business area responsible for licensing-in a range of asthma products from a third party.
- Organised and actively participated in meetings(/appeals) with Health Authorities (Australia, Holland, Sweden, UK) to secure regulatory approvals and/or to discuss proposed regulatory strategy.
- Authored and presented strategy document for a proposed mutual recognition procedure. Wrote regulatory section of internal document 'European Launch Sequence, May 1996'. Presented at meeting with Dutch Health Authority. Organised appeals (written and/or oral) for Australia, Canada, Finland, Germany, Ireland, Sweden and UK.

- Worked on Foradil NDA. Developed regulatory strategy for NDA submission. Worked on documents that went into compilation of the NDA.
- Awarded several commendations for achievements for Foradil from the senior management team of Ciba Geigy.
- Commended by senior management team at Ciba Geigy for support provided to major Ciba Geigy Group companies to achieve approvals of Foradil.
- Led the Registration Team (between 5 and 20 scientists as required). Chaired meetings with scientists to facilitate the evolution of regulatory and scientific strategy for development of NCEs and CFC replacement product.
- Regulatory transplantation lead at Novartis
- Lead for psoriasis, atopic dermatitis.

Award – Dr. Speid received an award of distinction in the form of a letter of praise from Dr. Brown, who was then in charge of the Ciba Geigy Medical and clinical research function, in recognition of her leadership and skills in turning around the many years of failure for the Foradil program. She also received salary increases in recognition of the results she was instrumental in helping the organization to achieve.

February 1992 to January 1995

SANOFI WINTHROP LIMITED, Guildford,

Surrey (Main Group Company)

SENIOR REGULATORY AFFAIRS OFFICER

- Participated in Project Steering Teams (other members of which were senior company executives) for projects highlighted as being of major financial significance to the Company.
- Specialist in areas of hormone replacement therapy (HRT) and bone (Paget's disease, osteoporosis). Together with the Medical Director, instrumental in setting up panel of external experts and opinion leaders to provide input into HRT programs.
- Responsible for regulatory affairs and strategy for the generics business (Sterwin), which was run as a separate business. Attended meetings with the senior executives of this business on a monthly basis.
- Responsible for organizing two appeals, one of which was for a key NCE, which was ultimately approved for Paget's Disease.
- Project managed major projects and ensured successful regulatory submissions and speedy approvals for ethical, and OTC products.
- Proactively helped to improve regulatory strategic planning within the Company for the projects involved in. Responsible for regulatory strategy for generics business.
- Identified and suggested solutions for problems within the regulatory department which improved the efficiency of the department, and the quality of dossiers produced.
- Seconded to act as Manager of Drug Safety Unit for 3 months

October 1987 to 1991

CENTRE FOR MEDICINES RESEARCH, Carshalton, Surrey.

RESEARCH ASSISTANT – *Awarded Ph.D. for research conducted into Safety Assessment of Medicines*

- Awarded PhD for research conducted into the safety assessment of medicines.

- Collated and analysed toxicological data supplied by major multinational pharmaceutical companies.
- Designed and set up databases which highlighted variations across major world markets for pre-clinical toxicity tests. Paper (see publications) used as source document for ICH process.
- Produced reports, published papers, attended and presented at major national and international meetings.
- Set up an adverse drug reaction monitoring scheme at the Radcliffe Infirmary, Oxford. Methodology and results of this study were used as a basis for introducing the adverse reaction monitoring scheme in other hospitals in the Oxford region.

August to October 1987 – during full time Ph.D. vacations

WHIPPS CROSS HOSPITAL, Walthamstow, London

STAFF PHARMACIST

- Initiated a number of feasibility studies for the Director of the Pharmacy Department. Managed and supervised a team of one pre-registration pharmacist and two pharmacy technicians in the dispensary and manufacturing departments.

1986 to 1987

KING ABDUL AZIZ MILITARY HOSPITAL, Tabuk, Saudi Arabia

DIRECTOR OF DRUG INFORMATION SERVICES

PHARMACY DEPARTMENT

- In charge of a major drug information referral centre in the Kingdom of Saudi Arabia.
- Responsible for answering drug information queries from all levels of medical, nursing and pharmacy staff at the hospital.
- Responsible for supervision and formal programme of training for pharmacists, technicians and assistants.
- Participated actively on Drug and Therapeutics Committee, Medical Library Advisory Committee, Infection Control Committee (co-opted to give advice on antibiotic usage policy).
- Author of a monthly newsletter on medical and pharmaceutical topics of interest. The newsletter was distributed throughout the Kingdom of Saudi Arabia and received many accolades.
- Initiated several research projects with the support of the medical staff, including examination of the feasibility of setting up an adverse drug reaction monitoring scheme, a total parenteral nutrition team and an Arabic patient medication history taking service.
- Gave monthly lectures to the nurses, and tutorials to the doctors.
- Gave lecture to Grand Round audience of 200 on the need for an antibiotic usage policy within the hospital.
- Studied Arabic, and dispensed to female patients during Ramadan in fluent Arabic

1985 to 1986

LONDON TEACHING HOSPITALS (The Middlesex, St Marks and St Phillips)

STAFF PHARMACIST, IN CHARGE

- Rotated around three major teaching hospitals, spending 3 to 4 months in each pharmacy, as the Pharmacist in Charge.
- Management experience gained. Responsible for supervising a technician and training a pre-registration pharmacist while at the Middlesex Hospital.

1984 to 1985

THE HAMMERSMITH HOSPITAL, Hammersmith, London

BASIC GRADE PHARMACIST

- Specialised in geriatric medicine - was responsible for provision of a clinical pharmacy service to geriatric unit at the Hammersmith Hospital. Participated in a weekly multidisciplinary case conference.
- Supervisory experience of technicians
- Given one-to-one basis management tutorials by District Pharmaceutical Officer to prepare me for special management training that I was selected for.

1983 to 1984

NORTHWICK PARK HOSPITAL, Harrow, Middlesex

PRE-REGISTRATION PHARMACIST

- Received training in all aspects of hospital pharmacy practice, including clinical trials, ward and clinical pharmacy, drug information, residency, psychiatric medicine, radiopharmacy, quality control, sterile and aseptic dispensing.
- Gave talks and presentations to other pre-registration pharmacists and pharmacists.
- Registered with the Royal Pharmaceutical Society of Great Britain (August 1984)

Educational and Professional Training

Chelsea College (now Kings College), Department of Pharmacy, University of London (1980 to 1983)

Bachelor of Pharmacy Degree with Honours - Class Upper Second

University of Wales - Research leading to PhD in conjunction with the Centre for Medicines Research, Carshalton Surrey (October 1987 to May 1991).

PhD Thesis "The Safety Assessment of Medicines: Pre and Post-marketing" (Speid, 1991)

Foreign Language Training

Italian (fluent) B2/C1 level of fluency
German (fluent while living in Basel Switzerland) – good working knowledge now. B1 fluency.
French (was fluent - very good working knowledge now)
Spanish ('O' Level) – working knowledge – currently developing in fluency. B1 fluency.
Ancient Greek (Koine and Attic) – Beginner – total immersion training by Polis Institute of Ancient Languages, Jerusalem, Israel
Language training received in Arabic (12 months), Hebrew (5 weeks in Israel).

Total immersion courses taken in France (University de Caen -1982) to study French, Germany (Munich - 1997) to study German, and Italy to study Italian (Firenze – 2006; Perugia – 2007; Trieste – 2011; Pisa – 2014). Ongoing language training weekly, in Italian B2/C1- upper intermediate, and Spanish B2- intermediate. Koine Greek (VIRTUAL- Polis Institute of Ancient Languages).

Publications

"Discrepancies in international regulations for animal toxicity tests of new medicines"

LH Speid, CE Lumley, SR Walker & DK Luscombe. Human Toxicology, (1989) 8, 408.

"Is there a need for a second species in long term toxicity testing?"

LH Speid, CE Lumley, SR Walker & DK Luscombe. Human Toxicology, (1989) 8, 409.

"How useful are 12 month toxicity tests in dogs?"

LH Speid, CE Lumley, SR Walker & DK Luscombe. The Toxicologist, (1990), 10(1), 143.

"Harmonisation of guidelines for toxicity testing of pharmaceuticals by 1992."

LH Speid, CE Lumley & SR Walker. Regulatory Toxicology and Pharmacology (1990) 12(2): 179-211.

"The Safety Assessment of Medicines: Pre and Post-marketing".

LH Speid. PhD Thesis, University of Wales, Department of Clinical Pharmacy, May 1991. The British Library.

"Enzyme-Catalyzed Therapeutic Activation (ECTA) NB1011 (Thymectacin ™) selectively targets thymidylate synthase (TS)-overexpressing tumor cells: preclinical and phase 1 clinical results."

M Pegram, N Ku, M Shepard, L Speid, HJ Lenz. Conference Paper November 2002.

"Research Subject Safety Series Part 1: A First-in-Man Phase 1 Clinical Trial—A Tragic Ending Leads to a New Guideline."

Speid L. Regulatory Focus, April 2008.

"Lessons Learned From the TeGenero First-in-Man Phase 1 Clinical Trial Part 2: Implications for Future First-in-Man Phase 1 Studies," Speid L. *Regulatory Focus*, May 2008 .

"Characterization of Risks, Research Subjects and the Regulatory Professional,"

Speid L. Regulatory Focus, June 2008.

Pointed View: Diabetes Drug Development: Post-Avandia. Dr. Lorna Speid, The RPM Report, Vol 4, No. 4, May 2009, Elsevier Business Intelligence.

Clinical Trials: What Patients and Healthy Volunteers Need to Know. Author: Lorna Speid, Ph.D.

Oxford University Press, Summer 2010. ISBN978-0-19-973416-0

Lorna Speid, Ph.D., Invited Author Biosimilar News: *Biosimilars: The Woy Forward in the United States.* Date 25 February 2012.

Speid, L. (2016), Don't Do Different Things – Do Things Differently! Drug Development in Rare Diseases: The Patient's Perspective. Clin. Pharmacol. Ther., 100: 336–338. doi:10.1002/cpt.403.

Invited Speaker / Panel Member or Chair

The Rare Disease Patient's Perspective - American Society of Clinical Pharmacology – represented the rare patient perspective – 12 March 2016. This publication became a publication in the peer reviewed journal published by ASCPT.

Biosimilars: Regulatory Strategies - The Way Forward for EU, US and Rest of the World. Orange County Regulatory Affairs Network, June 2012.

Biosimilars – the Way Forward Globally. IBC, San Diego, March 2012.

Regulating Biosimilars – Where to from Here. Allicense Meeting / Deloitte & Touche. Panel member and presenter, San Francisco, 2 May 2012.

The Ten Mistakes that Companies Make with INDs at Bioflorida, Session Chair and speaker. 2011.

The Ten Mistakes that Companies Make with INDs at the San Jose Biocenter – Lunchtime Keynote Presentation — in collaboration with Liquent. 2 March 2010

The Ten Mistakes that Companies Make with INDs at Bioflorida, Session Chair and speaker. 2010.

The Ten Mistakes of Combination Products. CHI Meeting. 2010, San Diego.

Clinical Trial Application: How it Differs from the IND Application – San Diego Regulatory Affairs Network, October 2005.

Invited Speaker – Annual Meeting – American Society of Clinical Pharmacology and Therapeutics (ASCPT) 2015 - Don't Do Different Things – Do Things Differently! Drug Development in Rare Diseases: The Patient's Perspective. Led to an invited peer reviewed publication.

Training Programs Founded and Chaired

The Diabetes Webinar Series – 2007

The Diabetes Series was an international webinar series that had two internationally known ex-FDA speakers and other speakers. The participants were from as far away as India, and small and large companies. The

number of participants on the webinar was approximately 150. The content covered diabetes as a disease and current research and treatment approaches.

Drug Development Boot Camp®

Dr. Lorna Speid is the Founder and Chair of the Drug Development Boot Camp®.

The Drug Development provides intensive training in drug development to experienced drug developers and researchers.

Founder and Co-chair of the Drug Development Boot Camp®. The first Boot Camp was held at Cornell University on September 9-10, 2010.

The second Drug Development Boot Camp® was held with Harvard University on November 9-10, 2011.

The third Drug Development Boot Camp® was held with Harvard University on November 14-15, 2012.

The fourth Drug Development Boot Camp® was held with Harvard University OTD on November 20-21, 2013

The fifth Drug Development Boot Camp® was held with Harvard University OTD on November 19-20, 2014.

The sixth Drug Development Boot Camp® was be held with Harvard University OTD on November 17-18, 2015.

The seventh Drug Development Boot Camp® was be held with Harvard University OTD on November 16-17, 2016.

The eighth Drug Development Boot Camp® was held with Harvard University OTD on November 15-16, 2017.

The ninth Drug Development Boot Camp® was held on November 14-15, 2018 with Harvard University OTD.

The tenth Drug Development Boot Camp® was held on November 20-21, 2019 with Brown University.

The Drug Development Boot Camp® 2020 VIRTUAL – was held on 18 and 19 November 2020. Chairing the VIRTUAL meeting required exceptional creativity, attention to detail, vision and determination. The Drug Development Boot Camp® VIRTUAL was a great success, as evidenced by the feedback from participants.

The Drug Development Boot Camp® 2021 VIRTUAL – was held on 17 and 18 November 2021. Chairing the second VIRTUAL meeting allowed us to build on the experience from the first VIRTUAL training. The second Drug Development Boot Camp® VIRTUAL was a great success, as evidenced by the feedback from participants.

The Drug Development Boot Camp® 2022 VIRTUAL – was held on 16 and 17 November 2022. The third Drug Development Boot Camp® VIRTUAL was a great success, as evidenced by the feedback from participants.

Memberships, Certifications and Miscellaneous Achievements

Member of Royal Pharmaceutical Society of Great Britain (M.R.Pharm.S.)

Board certified in Regulatory Affairs - Regulatory Affairs Certification (RAC)

Former Secretary of the San Diego Regulatory Affairs Network (SDRAN) Board of Directors

Distinguished Toastmaster Award [demonstrated leadership and communication capability to advanced level of mastery].

Appendix 3

Chronology of Events

Date	Event	Comment
Late September 2021	[redacted] developed relatively mild symptoms of COVID19.	
6 October 2021	ER Visit – [redacted] was taken by her parents. Her Father accompanied her to see the ER Physician.	Her Mother remained in the car because she was unwell due to COVID19.
7 October 2021	Admission into St. Elizabeth Ascension Hospital at 0012 hours. All Ms. [redacted] baseline labs were normal, except for Glucose which was slightly higher than normal at 138 (Ref range 70-99 mg/dL). Ms. [redacted] tested positive for Sars-Cov-2 virus using hospital pharmacy test.	Extremely poor prescribing occurred during Ms. [redacted] stay in the hospital. Respiration was depressed as a result of the drugs administered inappropriately and without regard to their contraindications and warnings. These drugs include LORAZEPAM, DEXMEDETOMIDINE and MORPHINE. MORPHINE was prescribed by Dr. Shokar, and was ultimately the drug that caused Ms. [redacted] death.
7 October 2021 1930 hours	Dr. David Beck prescribed of Lorazepam 2 mg/mL Injection. The dose was 0.5 MG IV as needed every 6 hours. 0.5 MG (0.25 ML PER DOSE) I/V PRNQ6H	Lorazepam was administered to Ms. [redacted] many times throughout the time Ms. [redacted] was in hospital. This was a highly inappropriate drug to administer because it depresses respiration. It is contraindicated in respiratory distress.
7 October 2021 2145 hours	Dr. Marada prescribed Dexmedetomidine (Precedex) DEXMED2ML - DEXMEDETOMIDINE INJ 100 MCG/ML VIAL 400 MCG (4 ML) IN NS100 - 0.9% SODIUM CHLORIDE 100 ML BAG - 100 ML.	Dexmedetomidine (Precedex) was an inappropriate drug to prescribe for Ms. [redacted] It was administered to her many times from its prescription, until it contributed to her death. It depressed her breathing, and interacted with Lorazepam and finally with Morphine to kill Ms. [redacted]
10 October 2021 0700 hours	Mr. [redacted] was removed from his daughter's bedside using an armed guard at the instigation of Nurse Alison because she was questioned about the mistakes she was making in the management of Ms. [redacted] in relation to the oxygen monitor that was not correctly calibrated.	Ms. [redacted] a vulnerable patient was left without an advocate.
11 October 2021	Dr. Baum called Mrs. [redacted] at 0955 hours and informed her that Ms. [redacted] blood work had *"improved across the board"*.	
11 October 2021 1400 hours	Ms. [redacted] sister, Mrs. [redacted] is permitted to stay in the room from 1400 hours.	

Date	Event	Comment
12 October 2021	Dr. Baum left on a 3 week vacation.	Dr. Shokar took over the management and care of Ms. [redacted]
12 October 2021 1402 hours	Dr. Shokar is informed that Ms. [redacted] oxygen saturation was at " 78-85% and not recovering.	It had already been established that the machine for measuring Oxygen saturation was unreliable. There is no evidence that the calibration of the system had been rectified. Despite this, Ms [redacted] was being administered frequent doses of Dexmedetomidine (Precedex) that depresses respiration, together with Lorazepam.
13 October 2021 0000 hours	Dexmedetomidine was administered by Nurse SHAIN002.	
13 October 2021 0602 hours	Dexmedetomidine was administered by Nurse SHAIN002	
13 October 2021 0700 hours	Dexmedetomidine was administered by Nurse McInnis	
13 October 2021 0730 hours	Dexmedetomidine was administered by Nurse SHAIN002	
13 October 2021 0754 hours	Dexmedetomidine (Precedex) was administered by Nurse McInnis.	Dr. Shokar claims that Ms. [redacted] was agitated and needed to be strapped to the bed in the time that Mrs. [redacted] had gone to take a shower. If this is true, this administration of Dexmedetomidine (Precedex) was what caused the agitation.
13 October 2021 0800 hours	Ms. McInnis RN refused to allow Mrs. [redacted] sister, to take a shower in the hospital room where her sister was, despite being told by Mrs [redacted] that her father was allowed to take a shower in the bathroom adjoining the room. Ms. McInnis RN insisted that she leave the hospital to go home to take the shower.	Mrs. [redacted] left to go home at 0800 hours. [redacted] was not at all agitated or anxious when Mrs. [redacted] left the room, or she would not have left her.
13 October 2021 0800 hours	Dr. Shokar called and spoke to Scott Schara. Transcribed from Dr. Shokar October 13 (the day [redacted] died) hospital report (summary of 8:00 a.m. phone call that morning): "I had a discussion with the family over the phone for roughly half an hour to an hour in regards to code	

Date	Event	Comment
	status[1] once again[2] as well as feeding options they have. They had deliberated yesterday after our conversation and decided for a DNI[3] status. We did discuss in regards to CPR resuscitation and the futility of doing CPR in the situation to DNI **and they agreed in regards to not pursuing a resuscitation via CPR or defibrillation in the event of respiratory arrest leading to a cardiac arrest.**[4] in all regard, they want to continue full management without intubation. We will continue and wish to continue with BiPAP therapy as long as possible. If there is a deterioration and hypoxia without reversibility for prolonged amount of time, we may consider at that time switching to comfort care after a discussion has been completed with family to see if that is the right time. In the meantime and hopefully, we will continue care with the goal of improvement."	
13 October 2021 Around 0800 hours	Dr. Shokar inserted *Do Not Resuscitate* into the medical notes after having a telephone call with the family. At no time did the family authorize for their daughter to be *Do Not Resuscitate*.	
13 October 2021 0815 hours	Dr. Daniel Leonard prescribed Dexmedetomidine (Precedex)	
13 October 2021 0930 hours	Mrs. [redacted] returned to the hospital room where her sister was. She overheard the hospital staff speaking about the fact that they had strapped Ms. [redacted] to the bed in her absence.	
13 October 2021 0945 hours	The strapping was removed from Ms [redacted] bed.	
13 October 2021 1048 hours	Ms. McInnis RN administered Dexmedetomidine (Precedex)	

[1] *This term was not discussed, and we now know it meant labeling Grace DNR – Do Not Resuscitate*

[2] *Discussion was in regard to the fifth incident of asking us for ventilator permission*

[3] *Do Not Intubate – i.e. ventilator*

[4] *This was all hypothetical; Grace had good days on October 12 and 13, according to our calls with the doctor and our bedside experience.*

<table>
<tr><th>Date</th><th>Event</th><th>Comment</th></tr>
<tr><td></td><td>DOSE RATE CH. CURRENT RATE 1.4. 260 mL.</td><td></td></tr>
<tr><td>13 October 2021
1125 hours</td><td>Lorazepam was administered by Nurse McInnis.</td><td></td></tr>
<tr><td>13 October 2021
1700 hours</td><td>Dr. Shokar prescribed INSULIN ASPART (NOVOLOG)</td><td>Ms. McInnis states that the reason for the Insulin was Glucose level was 151 mg/dL. ({normal range is 70-99 mg/dL}).

HMCINNIS WROTE "GLUCOSE: 151 mg/dL DATE 10/13/2021 TIME 1656 hours."

[redacted] baseline Glucose level was 151. On the 6 October when it was measured in the ER, her level was 152. Insulin was not administered at any other time.

Glucose levels on other days were:

<table>
<tr><th>Date</th><th>Glucose level mg/dL</th></tr>
<tr><td>6 October 2021</td><td>152</td></tr>
<tr><td>7 October 2021</td><td>138</td></tr>
<tr><td>8 October 2021</td><td>151</td></tr>
<tr><td>9 October 2021</td><td>123</td></tr>
<tr><td>10 October 2021</td><td>123</td></tr>
<tr><td>11 October 2021</td><td>116</td></tr>
<tr><td>12 October 2021</td><td>119</td></tr>
<tr><td>13 October 2021</td><td>174,101,151</td></tr>
</table>
</td></tr>
<tr><td>13 October 2021
1746 hours</td><td>Lorazepam 0.5 mg injected by Nurse McInnis.</td><td></td></tr>
<tr><td>13 October 2021
1749 hours</td><td>Lorazepam 0.5 mg injected by Nurse McInnis.</td><td></td></tr>
<tr><td>13 October 2021
1830 hours
1845 hours</td><td>MORPHINE was prescribed by Dr. Shokar for pain. Morphine was administered by Nurse McInnis at</td><td>There is no evidence in the medical notes that Ms [redacted] was experiencing pain, and certainly not pain requiring Morphine. When</td></tr>
</table>

Date	Event	Comment
	1830 hours, and again at 1845 hours.	ACETAMINOPHEN was administered on 8 October, it was administered for an elevated temperature. When Dr. Shokar called to tell the family he had administered MORPHINE, **he told them that he had administered MORPHINE to reduce her heart rate.**
13 October 2021 1927 hours	**Death occurred at 1927 hours.**	Death occurred quickly after Morphine was administered.
Post-13 October 2021	Medical notes were written after the death in a retrospective manner evidently in collusion with other Physicians involved with the care of the patient to give the impression that the patient died from natural causes and not from inappropriate prescribing, obvious morphine overdose, and the drug drug interactions.	From a forensic review of the medical notes it is evident that at least two Physicians colluded with Dr. Shokar to cover up the true cause of Ms [redacted] death. Medical records were fraudulently produced after the patient's death.

Appendix 4

Administration of Medicines by Ms. McInnis, RN

Table 1: Medicines Administered by Nurse McInnis

	DR DAVID BECK		LORAZEPAM 2 MG/ML VIAL	0.5 MG (0.25 ML PER DOSE) I/V PRNQ6H	IV	10/7/2021	1930 hours	ANXIETY/AGITATION
						DC: 10/13/2021 1927 hours		
		BBURGHAR		0.5 MG		10/7/2021	1954 hours	
						10/7/2021	1937 hours	discontinued 2025 hours
	DR. DAVID BECK	MMACHURI		0.5 MG	ONCE	10/7/2021	2113 hours	
						10/7/2021	2100 HOURS	
		MPAFF001		0.5 MG		10/8/2021	2338 hours	
	DR DANIEL P. LEONARD	MCINNIS		0.5 MG	PRN	10/13/2021	1125 hours	
						DC 1927 HOURS		
	***	MCINNIS		0.5 MG		10/13/2021	1746 hours	
	***	MCINNIS		0.5 MG		10/13/2021	1749 hours	
		"RR 55, GIVEN FOR WORK OF BREATHING RULE; PRNQ6HRULE"						

	DR DAVID BECK	METOPROLOL TARTRATE INJ 5 MG/5 ML VIAL	2.5 MG (2.5 ML PER DOSE)	IV SIG: ONCE			
	MMACHURI				10/7/2021	2113 hours	BP 131/60; APICAL PULSE 141
					DC: 10/07/2021 - 2101 hours		
		ACETAMINOPHEN 650 MG SUPPOSITORIES	1 SUPPOSITORY PER DOSE	PR	10/8/2021	0150 hours	TEMP >= 38.3 C (101 F)
	MCINNIS		650 MG	PR	10/13/2021	1448 hours	
[redacted]							
	DR RAMAN A R MARADA	ATROPINE SULFATE 1 MG/10 ML SYR	0.5 MG (5 ML PER DOSE)	IV ONCE	8/10/2021		REASON NOT GIVEN FOR PRESCRIPTION
	DR RAMAN A R MARADA				DC 10/08/21 - 1601 hours	DC 10/09/2021 - 1639 hours	
	AMIDD011		0.5 MG		10/8/2021	START 1610 hours	

					DC 10/08/21 - 1601 hours		
[redacted]							
DR DANIEL P. LEONARD		FAMOTIDINE INJ 20 MG/2 ML VIAL	20 MG (2 ML DOSE)	IV BID (SCH)	START 10/9/2021		NO REASON GIVEN FOR THE PRESCRIPTION
DR DANIEL P. LEONARD	CANCELLED		TOTAL VOLUME 50 MLS DURATION 20 MINUTES	IV Q12H (SCH)	10/9/2021	1009 hours	CANCELLED
DR DANIEL P. LEONARD	VWILLS		20 MG		10/9/2021	1033 hours	
	MPAFF001		20 MG		10/9/2021	2054 hours	
	KHALE		20 MG		10/10/2021	0901 hours	
	MPAFF001		20 MG		10/10/2021	2001 hours	
	ESTAR006		20 MG		10/11/2021	0811 hours	
	CORISKA		20 MG		10/11/2021	2032 hours	
	MCINNIS		20 MG		10/12/2021	0835 hours	

	SHAIN002		20 MG		10/12/2021	1014 hours
	DR. DANIEL P. LEONARD	FUROSEMIDE INJ 40 MG/4 ML VIAL	40 MG (4 ML PER DOSE)	IV 4 ML PER DOSE	START 10/10/2021	
					STOP 10/10/2021 1 10 31 hours	
	KHALE		40 MG		10/10/2021	1122 hours
	DR. GAVIN SHOKAR	STANDARD TF W FIBER 1,500 ML BOT		AS DIRECTED (SCH)	START 10/13/2021	1315 hours
					DC 10/13/2021	1927 hours
	MCINNIS			1,500 ML	10/13/2021	1338 hours
	DR GAVIN SHOKAR	CREON 12 (PANCREALIPASE) 1 CAP	PRN	1 CAP (1 CAPSULE PER DOSE) ROUTE TF	START 10/13/2021	1315 hours start UNCLOG TUBE

DR. GAVIN SHOKAR	SODIUM BICARBONATE 325 MG TAB	PRN	325 MG (1 TABLET PER DOSE) - TF	START 10/13/2021	1315 hours start	UNCLOG TUBE
DR. GAVIN SHOKAR	INSULIN ASPART (NOVOLOG		SS SUBCUTANEOUS CCBED TIME (SCH)	START 10/13/2021	1700 hours	MCINNIS WROTE *"GLUCOSE: 151mg/dL DATE 10/13/2021 TIME 1656 hours."*
MCINNIS				10/13/2021	1657 hours	
DR. GAVIN SHOKAR	MSI - 10 - MORPHINE SULFATE 1 EACH SYRINGE 2 MG IV	2 MG IV	IV NOW (ONE)	START 10/13/2021	1830 hours	
				STOP 10/10/2021 1831 hours	DC 10/13/2021 - 1831 hours	
MCINNIS			**DOSE GIVEN "2 EACH "**	ADMIN DATE: 10/13/2021	1815 hours	
DR GAVIN SHOKAR	MORPHINE SULFATE 4 MGML VIAL			10/13/2021	1820 hours	

					DC 10/13/2021 1927 hours		states total dispensed 1 RX E10031074
****	**DR. GAVIN SHOKAR**	MSI - 10 - MORPHINE SULFATE 1 EACH SYRINGE 2 MG IV	2 MG IV	PRNQ4H (PRN)	START: 10/13/2021	1845 hours	PRN REASON : PAIN
					DC: 10/13/2021 - 1927 hours		
	DR RAMANA R MARADA	DEXMED2ML - DEXMEDETOMIDINE INJ 100 MCG/ML VIAL 400 MCG (4 ML) IN NS100 - 0.9% SODIUM CHLORIDE 100 ML BAG - 100 ML.	SIG: TITRATE (SCH)	RATE: TITRATE TOTAL VOLUME 104 MLS	START: 10/07/2021	2145 hours	
				TOTAL DISP: 11	DC: 10/13/2021	0813 hours	
	SHAIN002			VOLUME GIVEN 104 MLS	10/7/2021	2200 hours	
	SHAIN002		104 MLS	DOSE RATE CH. CURRENT RATE	10/7/2021	2220 hours	

			1. RATE CHAN GED TO .7.		
			NEEDED TC QUICKLY REDUCE DOSE R/T OVERSEDA TION. PATIENT'S BP DROPPED TO A MAP<65 AND O2 SATURATI(N WAS DECREASI G.		
	LKEMP025	104 MLS	Current rate: 0.7. Rate changed to: 0.8. 104 MLS	10/8/2021	0400 hours
	AMIDD011	104 MLS	Current rate: 0.8. Rate changed to: 0.9. 104 MLS	10/8/2021	1008 hours
DR RAMAN A R MARAD A	AMIDD011	RATE 500 ML/HR	TOTAL VOLU ME 500 MLS	10/8/2021	1200 hours

	SIG ONCE.		
		STOP 10/08/202 1 1259 hours	
AMIDD011	VOLU ME GIVEN 500 MLS	10/8/2021	1210 hours
AMIDD011	DOSE RATE CH. CURRE NT RATE .6. RATE CHAN GED TO .5.	10/8/2021	1320 hours
AMIDD011	DOSE RATE CH. CURRE NT RATE .3. RATE CHAN GED TO OFF.	10/8/2021	1611 hours

EMFISHER1	104 MLS	DOSE RATE CH. CURRENT RATE .0. RATE CHANGED TO 0.1.	10/9/2021	0208 hours
MPAFF001		DOSE RATE CH. CURRENT RATE .2. RATE CHANGED TO 0.1.	10/10/2021	0005 hours
MPAFF001	104 MLS	DOSE RATE CH. CURRENT RATE .0. RATE CHANGED TO 0.2.	10/10/2021	2000 hours
MPAFF001	104 MLS	DOSE RATE CH.	10/10/2021	2341 hours

			CURRENT RATE .2.			
***	CORISKA	104 MLS	DOSE RATE CH. CURRENT RATE .2. RATE CHANGED TO 0.3.	10/11/2021	1932 hours	freq coughing, increased RR, increased anxiety/fidgeting.
	CORISKA		DOSE RATE CH. CURRENT RATE .3. RATE CHANGED TO 0.4.	10/11/2021	2042 hours	
***	CORISKA		DOSE RATE CH. CURRENT RATE .4. RATE CHAN	10/11/2021	2131 hours	RESTLESS, DESAT

		GED TO 0.5.			
CORISKA		DOSE RATE CH. CURRENT RATE .5. RATE CHANGED TO 0.6.	10/11/2021	2203 hours	ASSISTING WITH TOLERATING PRONE POSITION.
CORISKA		DOSE RATE CH. CURRENT RATE .6. RATE CHANGED TO 0.5.	10/12/2021	0440 hours	
CORISKA	104 MLS	CURRENT RATE .5.	10/12/2021	0620 hours	
MCINNIS		DOSE RATE CH. CURRENT	10/12/2021	0830hours	RR 40's, GTT INCREASED FOR COMFORT IN BREATHING

		RATE .5. RATE CHAN GED TO 0.6.		
MCINNIS	104 MLS	CURRE NT RATE .7.	10/12/202 1	1501 hours
SHAIN002	104 MLS	DOSE RATE CH. CURRE NT RATE .7. RATE CHAN GED TO 0.8.	10/13/202 1	0000 hours
SHAIN002	104 MLS	DOSE RATE CH. CURRE NT RATE .8. RATE CHAN GED TO 0.9.	10/13/202 1	0602 hours

MCINNIS	DOSE RATE CH. CURRENT RATE .9. RATE CHANGED TO 1.0.	10/13/2021	0700 hours	pt not tolerating prone position.

	MCINNIS		DOSE RATE CH. CURRENT RATE 1.0. RATE CHANGED TO 1.1.	10/13/2021	0730 hours	Pt rolling on side, increase to help tolerate prone position.
	MCINNIS		DOSE RATE CH. CURRENT RATE 1.1. RATE CHANGED TO 1.2.	10/13/2021	0754 hours	increased to help pt prone, rolling onto back and desats.
DR. DANIEL P. LEONA RD		TOTAL VOLUME 260 MLS. DURATION: TITRATE. TOTAL DISPENSED BAGS 3		10/13/2021	0815 hours	
				DC 10/13/2021 - 1927 hours		
	MCINNIS	VOLUME GIVEN 260 MLS	DOSE RATE CH. CURRENT RATE 1.4.	10/13/2021	1048 hours	
	MCINNIS		DOSE RATE CH. CURRENT RATE 1.4. RATE CHANGE TO OFF	10/13/2021	1837 hours	STOP GTT FOR NOW PER DR SHOKAR, RESTART AS NEEDED.

	DR. DAVID BECK	0.9% SODIUM CHLORIDE 1000 ML LVP - 1000 ML	ROUTE IV SITE IV - TOTAL VOLUME 1000 MLS.	RATE 30 MLS /HR. DURATION 33 HR 20 MIN.	10/07//2021	0100 hours
	BCHR1039			VOLUME GIVEN 1000 MLS	10/07//2021	0218 hours
	BBURGHAR			IV STOP TIME	10/07//2021	0900 hours
						STOP TIME
				RATE 100 MLS/HR	10/07//2021	2115 hours
						DC 1927 hours on 10/13202 7
	DR DAVID BECK					
	AMIDD011			1000 MLS	10/8/2021	0846 hours

	EMFISHER1		1000 MLS	10/9/2021	2226 hours
	KHALE		1000 MLS	10/10/2021	0845 hours
	CORISKA		1000 MLS	10/12/2021	0046 hours
	MCINNIS		1000 MLS	10/13/2021	1656 hours
DR. RAMANA MARADA	NOREPINEPHRINE INJ 4 MG/4 ML AMP - 4 MG (4 ML) IN NS250 - 0.9% SODIUM CHLORIDE 250 ML BAG - 250 ML	TOTAL VOLUME 254 MLS		10/08/2021 START DC 10/13/2021 - 1927 hours	1015 hours

AMIDD011	Site Central Line Infusing. Current rate .01, Rate changed to Start. MAP 50 if applicable. RASS if applicable.	VOLUME GIVEN 254 MLS	10/8/2021	1549 hours
AMIDD011	Site Central Line Infusing. DOSE RATE CH Central Line. Current rate .05. Rate changed to .02. MAP if applicable. RASS if applicable.		10/8/2021	1718 hours
EMFISHER1	Site Central Line Infusing. DOSE RATE CH Central Line. Current rate .02. Rate changed to .0. MAP if applicable. RASS if applicable.		10/8/2021	2226 hours

DR. RAMA NA MARA DA					
DR. RAMA NA MARA DA	**DOPAMINE 400 MG/250 D5W 400 MG250 ML BAG - 250 ML**		IV - DURATION TITRATE	10/8/2021 DC 10/13/2021 1927 hours	1700 hours start
	AMIDD011	VOLUME GIVEN 250 MLS	Site infusing: Central Line. Current rate: 2. Rate changed to START.	10/8/2021	1708 hours
	AMIDD011		Site infusing: Central Line. Current rate: 2. Rate changed to 4.	10/8/2021	1820 hours
	AMIDD011		Site infusing: Central Line. Current rate: 4. Rate changed to 6.	10/8/2021	1834 hours
	EMFISHER1		Site infusing: Central Line. Current rate: 6. Rate changed to 5.	10/8/2021	2000 hours

	EMFISHER1			Site infusing: Central Line. Current rate: 5. Rate changed to 4.	10/8/2021	2226 hours	
	EMFISHER1			Site infusing: Central Line. Current rate: 4. Rate changed to 0.	10/9/2021	0100 hours	
DR. RAMANA MARADA	CANCELLED/INCOMPLETE	FENTANYL CITRATE /PF 1,500 MCG/30 ML SYRINGE - 30 ML	TOTAL VOLUME 30 ML	IV	10/8/2021	1145 hours	
DR. DAVID BECK		ALBUTEROL HFA INHALER 8 GM INH	2 PUFFS INH PRN Q4H	INHALED	10/7/2021	0100 hours	PRN REASON SHORTNESS OF BREATH
	EMFISHER1			2 PUFFS	10/9/2021	1958 hours	
	MPAFF001			REFUSED	10/11/2021	0300 hours	

				"ATTEMPTED TO GIVE PT DOSE OF ALBUTEROL WITH SPACER. PT REFUSED TO PARTICIPATE."		
DR. ALLY E. ESCH	IBUPROFEN 200 MG TAB	DISP PRN			10/6/2021	1458 hours
					DC 10/07/2021 1508 hours	
DR. RAMA NA MARA DA	LIDOCAINE 1% INJ. 20 ML VIAL	DISP PRN			10/8/2021	1238 hours
					DC 10/9/2021 1639 hours	
DR. RAMA NA MARA DA						
DR. DANIEL P. LEONA RD	0.9% SODIUM CHLORIDE 10 ML VIAL	TOTAL VOLUME 10 MLS RATE: AS DIRECTED DURATION: AS DIRECTED	IV		10/10/2021	0824 hours

DC:
10/11/2021-
0855 hours

Do Not Resuscitate Insertion in the Medical Notes

When *Do Not Resuscitate* was inserted in the medical notes, Ms. McInnis did not query this. When the family begged her to *"save our daughter"*, she refused. She knew that Ms. [redacted] was dying because of the Morphine that she had administered (see Table 1), yet she saw nothing wrong with her actions.

Appendix 5

Contraindications and Drug-Drug Interactions

Reference: British National Formulary
https://doi.org/10.18578/BNF.944666613

Dexmedetomidine (Precedex)

Indications and dose

Maintenance of sedation during intensive care

By intravenous infusion

Adult

0.7 microgram/kg/hour, adjusted according to response; usual dose 0.2–1.4 micrograms/kg/hour.

Important safety information

Dexmedetomidine should only be administered by, or under the direct supervision of, personnel experienced in its use, with adequate training in anaesthesia and airway management.

MHRA/CHM advice: Dexmedetomidine: clinical trial finds increased risk of mortality in intensive care unit (ICU) patients aged 65 years or younger (June 2022)

A randomised controlled trial (SPICE III) in ventilated adult ICU patients found an increased risk of mortality in those aged 65 years or younger (median: 63.7 years) given dexmedetomidine when compared with usual standard of care. This effect was most prominent in patients admitted for reasons other than postoperative care, and increased with increasing APACHE II scores and with decreasing age; the mechanism is unknown. Healthcare professionals are advised to weigh these findings against the potential benefit of using dexmedetomidine compared with alternative sedatives in younger patients.

Contra-indications

Acute cerebrovascular disorders; second- or third-degree AV block (unless pacemaker fitted); uncontrolled hypotension –

Expert Observation: Dr. Shokar and the other Physicians did not have control of [redacted] BP. It tended to be on the low side. Dexmedetomidine was contraindicated, and should not have been used.

Interactions

List of individual interactants: **dexmedetomidine**

Side-effects

Common or very common

Agitation; arrhythmias; dry mouth; hyperglycaemia; hypertension; hyperthermia; hypoglycaemia; hypotension; myocardial infarction; myocardial ischaemia; nausea; respiratory depression; vomiting –

Expert Observation: Ms. [redacted] was placed on an anti emetic immediately she was admitted. It is clear then that there was a plan to place her Dexmedetomidine and that it was known that it could cause nausea and emesis. There was no consideration given to the fact that the drug should not be used in a patient susceptible to respiratory distress.

Uncommon

Abdominal distension; apnoea; atrioventricular block; dyspnoea; hallucination; hypoalbuminaemia; metabolic acidosis; thirst

Hepatic impairment

Manufacturer advises caution (increased risk of toxicity due to decreased clearance).

Dose adjustments

Manufacturer advises consider dose reduction.

Monitoring requirements

Monitor cardiac function.

Monitor respiratory function in non-intubated patients.

Expert Observation: Although respiratory function was being monitored the machines were malfunctioning, and the results were not always reliable.

Directions for administration

For *intravenous infusion*, give continuously in Glucose 5% or Sodium Chloride 0.9%; dilute concentrate for solution for infusion to 4 micrograms/mL or 8 micrograms/mL.

Medicinal forms

There can be variation in the licensing of different medicines containing the same drug.

Infusion

Solution for infusion

Dexmedetomidine

Dexmedetomidine has the following interactions:

Interactions relevant to Ms. Schara's care have been extracted and highlighted below.

Diamorphine

Both Dexmedetomidine and Diamorphine can have CNS depressant effects, which might affect the ability to perform skilled tasks (see 'Drugs and Driving' in **Guidance on Prescribing**).

Diazepam

Both Dexmedetomidine and Diazepam can have CNS depressant effects, which might affect the ability to perform skilled tasks (see 'Drugs and Driving' in **Guidance on Prescribing**).

Lorazepam

Both Dexmedetomidine and Lorazepam can have CNS depressant effects, which might affect the ability to perform skilled tasks (see 'Drugs and Driving' in **Guidance on Prescribing**).

Morphine

Both Dexmedetomidine and Morphine can have CNS depressant effects, which might affect the ability to perform skilled tasks (see 'Drugs and Driving' in **Guidance on Prescribing**).

	morphine	lorazepam	Explanation:	Action:
	systemic	systemic	Concurrent use of opioids and benzodiazepines can cause enhanced sedation and respiratory depression, and can result in death.	The degree of impairment will depend on the individual patient; monitor for increased adverse effects such as sedation and respiratory depression and warn all patients of the potential effects and counsel against driving or undertaking other skilled tasks. If concurrent use is unavoidable, use the minimum possible dose and duration required to achieve the desired clinical effect.

- **Severity:** Severe **Action:** Monitor **Evidence:** Theoretical
- For full information, see Stockley's Drug Interactions

	insulin	lorazepam	Explanation:	Action:

	systemic	systemic	The effects of lorazepam were found to be increased when patients were given beef or pork insulin compared with human insulin.	No special precautions would appear to be necessary. However, bear this interaction in mind should an increase in lorazepam adverse effects (drowsiness, sedation, ataxia) occur.

- **Severity**: Moderate **Action**: Information **Evidence**: Study
-  For full information, see Stockley's Drug Interactions

	morphine	diazepam	Explanation:	Action:
	systemic	systemic	Concurrent use of opioids and benzodiazepines can cause enhanced sedation and respiratory depression, and can result in death.	The degree of impairment will depend on the individual patient; monitor for increased adverse effects such as sedation and respiratory depression and warn all patients of the potential effects and counsel against driving or undertaking other skilled tasks. If concurrent use is unavoidable, use the minimum possible dose and duration required to achieve the desired clinical effect.

- **Severity:** Severe **Action:** Monitor **Evidence:** Theoretical
- For full information, see Stockley's Drug Interactions

	morphine	lorazepam	Explanation:	Action:
	systemic	systemic	Concurrent use of opioids and benzodiazepines can cause enhanced sedation and respiratory depression, and can result in death.	The degree of impairment will depend on the individual patient; monitor for increased adverse effects such as sedation and respiratory depression and warn all patients of the potential effects and counsel against driving or undertaking other skilled tasks. If concurrent use is unavoidable, use the minimum possible dose and duration required to achieve the desired clinical effect.

- **Severity:** Severe **Action:** Monitor **Evidence:** Theoretical
-  For full information, see Stockley's Drug Interactions

	salbutamol	dexamethasone	Explanation:	Action:
	systemic	systemic	Beta-agonists can cause hypokalaemia. This can be increased by other potassium-depleting drugs such as corticosteroids. In severe cases the risk of serious cardiac arrhythmias could be increased.	The CSM in the UK advises monitoring in severe asthma, because of the probability of multiple potassium-depleting drugs being used, and because of predisposing conditions. Consider monitoring based on the severity of the patients' condition, and the number of potassium-depleting drugs used.

Severity: Severe **Action**: Information **Evidence**: Theoretical

Appendix 6

Morphine Administration and the Death of Ms. [redacted]

Table 1: Morphine Administration to Ms. [redacted] by Nurse McInnis

No.	PHYSICIAN who prescribed drug	NURSE who administered it	DATE	TIME	EVENT	STATEMENT IN THE NOTES	O2 SATURATION
						IMPORTANT:IMPORTANT: "PT's MOTHER TO CONFIR [sic] WITH PT'S FATHER AND GIVE DECISION ON CODE STATUS AS PT IS CURRENTLY DO NOT INUBATE [sic], BUT A FULL CODE. CLARIFICATION NEEDED FOR DR SHOKAR'S CONVERSATION WITH	
		MCINNIS	10/12/2021	1440		MOTHER."	
		MCINNIS		1700		PARENTS UPDATED BY DR SHOKAR OF PT'S LOW O2 SATURATION T/O THIS AFTERNOON. PARENTS DO NOT WANT INTUBATION AS PREVIOUSLY INDICATED.	
[redacted]							
		MCINNIS	10/13/2021	0941 hours	DR SHOKAR PAGED FOR [redacted] TO RETURN CALL.		

	MCINNIS	1134 hours		SMALL BORE NG TUBE PLACED LEFT NARE WITH PT ON 15L OXIMASK FOR PROCEDURE, PLACED WITH EASE AND BIPAP REPLACD. O2 DESAT TO 61%, SLOW RECOVERY. CXR CALLED TO CONFIRM PLACEMENT. PT'S SISTER PRESENT FOR COMFORT. PT TOLERATED WELL. RR REMAINS IN THE 40s.
	MCINNIS	1358 hours		FEEDING TUBE CONFIRMED IN PLACE, TUBE FEEDING STARTED. ATTEMPTED BRIDLE x2, 2 RNS UNSUCCESSFUL D/T PT 5HAKING HEAD. TAPED IN PLACE.
		1457	Blood Culture Report Collected 10/13/21 at 1505. SPECIMEN NO. 21. **REPORT B0031396S. Collected 10/13/21 at 1457.**	
		1505	Blood Culture Report Collected 10/13/21 at 1505. SPECIMEN NO. 21.	

			REPORT B0031397S		
	MCINNIS	1750 hours		PT O2 SAT 54 WITH PRONING. REVERSED WITH NO RECOVERY IN O2 SAT. PT'S SISTER AT BEDSIDE WHO FACETIMED PT'S FATHER TO UPDATE ON SITUATION. FAMILY PROVIDING COMFORT.	MICCINNIS Reported - 54;
	MCINNIS	1755 hours		PT SISTER AT BEDSIDE AND FATHER ON FACETIME UPDATED ON O2 SAT DROP TO 40's. 2 DIFFERENT O2 PROBES TESTED AND O2 SAT CONFIRMED. STAT ABG ORDERED BY MD. OFFERING PT COMFORT.	MICCINNIS Reported - 40s;
	MCINNIS	1805 hours		DR SHOKAR AT BEDSIDE SPEAKING TO FAMILY.	
DR G SHOKAR	MCINNIS	1830 hours START	MORPHINE SULFATE 2 MG IV SIG NOW (ONE)		
		1831 hours - STOP	DOSE GIVEN 2 EACH - What does this mean? 2 MG IV	SIG: NOW	
	MCINNIS	1845 hours	DOSE GIVEN 2 EACH	PRN REASON GIVEN - PAIN	

	CASTRO	1927 hours	DC 1927 - DC must mean deceased.	No apical pulse, respirations, or blood pressure. Breath sounds absent. No pupil reaction in either eye. DR WATTON notified and pronouncement of death order and permission to release the body to the funeral home received.	
	PAGELS	1927 hours		DEATH NOTE:	N/A
				No apical pulse, respirations, or blood pressure. Breath sounds absent. No pupil reaction in either eye. DR WATTON notified and pronouncement of death order and permission to release the body to the funeral home received.	N/A

CASTRO	1927		Pt went asystole, No code order in the computer. Day nurse with me at the bedside, team lead in the unit as well. No pulse or respiration observed. Sister was on the phone with the family. No CPR done due to the Code status, MD informed by the changes.	N/A
	2320	Blood Culture Report Collected 10/13/21 at 2320. SPECIMEN NO. 21. **REPORT B0031397S**		
CASTRO	2320		Pt picked up by the funeral home from room 2029. All of pt's belongings given to the pt's mom and sister.	N/A

Appendix 7

Fraudulent Completion of the Death Certificate

The death certificate does not clearly state that the patient died from a combination of drugs that should not have been administered, and from an overdoes of Morphine, in particular. By not contradicting how the death certificate was completed, Ms. McInnis sought to cover her actions that led to the patient's death.

Averill, Philip - DSPS

From: Averill, Philip - DSPS
Sent: Thursday, July 27, 2023 1:15 PM
To: [redacted]
Subject: DSPS Complaint No. 23 NUR 537 McInnis RN - RESPONSE REQUIRED
Attachments: McInnis RN Complaint_Redacted.pdf

Importance: High

Dear Ms. McInnis,

The Division of Legal Services and Compliance provides enforcement services to the credentialing boards attached to the Department of Safety and Professional Services (Department) and to the Department for the credentials that it directly issues. The regulatory authority that issued your credential has requested that you provide a response to the enclosed complaint filed against you.

Patient: [redacted], DOB: [redacted]

You are required to provide a detailed written response to the allegations brought against you to include a description of the treatment provided to the patient if that is applicable in this instance.

You must submit your response by August 3, 2023. We encourage you to submit all materials electronically via email to Philip.Averill@wisconsin.gov or fax (608) 266-2264. Again, cooperation and a timely response to requests from the department, or attached board, is required pursuant to Wisconsin statute and/or administrative code. Failure to timely respond may have adverse consequences, which includes discipline of your credential, as identified per statute and/or administrative code provisions.

If we do not receive your response by the deadline established above, a decision may be made based on the information currently in our possession (and additional action may be taken against your credential as a result of your failure to respond in a timely manner to our requests). Information to include the complaint files against you (and, assuming you send a response, your response to the complaint), will be reviewed by a screening panel comprised of members of the board and a Department attorney. The screening panel will determine whether the complaint will be formally opened for investigation.

Sincerely,

Philip Averill
Consumer Complaint Program Associate
Dept. of Safety and Professional Services
Division of Legal Services & Compliance
PO Box 7190 / Madison, WI 53707

OTJEN LAW FIRM, S.C.
Attorneys at Law • Founded 1881

20935 Swenson Drive, Suite 310
Waukesha, WI 53186
Ph 262-777-2200
Fax 262-777-2201
www.otjen.com

Writer's Direct Dial # (262) 777-2222
Writer's e-mail address jfranckowiak@otjen.com

August 18, 2023

Philip Averill
Dept. of Safety and Professional Services
Division of Legal Services & Compliance
PO Box 7190
Madison, Wisconsin 53707
Philip.Averill@wisconsin.gov

RE: DSPS Complaint #23-NUR-537, McInnis, RN
Our File #: 230137

Dear Mr. Averill,

Hollee McInnis, RN is in receipt of your electronic communication dated July 27, 2023, in which it was requested of Nurse McInnis that she provide a written response to the allegations brought against her, to include a description of the treatment provided to the patient, if applicable. Please accept the following as Hollee McInnis' response to the allegations of the complaint, along with a description of the background of the patient underlying the Complaint, and a description of the role that Nurse McInnis played in the care provided to [redacted].

Should any additional information be requested by the Department, or should the Department require any elaboration upon anything included herein, please direct any request to undersigned counsel, who has been assigned to aid Nurse McInnis in her response to the Department's request.

Hollee McInnis, RN – Background

Hollee McInnis, RN graduated from the University of Wisconsin-Oshkosh with her Bachelor's degree in Nursing in 2001. Following graduation, she practiced for a year at UW Hospital on several different units, including the Rehabilitation Unit and the Medical Unit, before spending a year at Marshfield Clinic as a traveling nurse. At the Marshfield Clinic, she filled nursing roles on a number of units, including but not limited to, medical, surgical, and oncology.

Commencing in approximately 2003, and at all times subsequent, Nurse McInnis' practice has been dedicated exclusively to ICU care. She spent approximately three years in the ICU at St. Michael Hospital in Stevens Point, Wisconsin, before moving on to Oconomowoc Memorial Hospital, where she practiced in that hospital's ICU for a year. Starting in 2007, and continuing to the present date, Nurse McInnis has been working full time in the ICU, primarily at St. Elizabeth Hospital in Appleton, Wisconsin.

In the course of her employment in the ICU at St. Elizabeth Hospital, Nurse McInnis has been nominated for, and received, multiple awards and community recognition for her patient care. She was nominated by her Director of Nursing in 2022 for Ascension "Employee of the Year." Also in 2022, she received an award called the "Hero of Neenah" as recognition for her work with the hospital's COVID patients. This award is conferred upon only two people in the community each year.

As an ICU nurse, Hollee McInnis has been on the front lines of patient care throughout the COVID-19 pandemic, starting in the spring of 2020 and continuing through 2021 and 2022. Nurse McInnis has cared for hundreds of desperately ill COVID patients. It was in her role as an ICU nurse at St. Elizabeth Hospital in Appleton in October of 2021 that Nurse McInnis came to participate briefly in the care of [redacted], the patient who is at the center of the instant complaint to the Board.

Complainant Lorna Speid, PhD – Background

The instant complaint has been brought by an individual named Lorna Speid, rather than by [redacted] parents, or anyone else who is actually related to [redacted]. Research on Lorna Speid reveals that she appears to be a pharmacist who was educated in the United Kingdom – rather than a medical doctor practicing medicine in the United States. Ms. Speid was in no way involved in any of [redacted] medical care at any time. In fact, it does not appear that Lorna Speid is licensed by any professional board in the state of Wisconsin, nor is there any evidence that Ms. Speid has ever professionally practiced in the state of Wisconsin in the areas of medicine, nursing, or pharmacy. There is further no evidence that she has ever been privy to [redacted] medical records.

Lorna Speid is also, apparently, a prolific blogger. A copy of some of Ms. Speid's recent writings are provided along with this response, in order to provide a fuller portrayal of Ms. Speid's beliefs and apparent agenda. As can be gleaned from even a cursory review of Ms. Speid's writings, she is an ardent opponent of COVID vaccines. She appears to believe, based upon her writings, that healthcare leaders, such as those heading the CDC, the NIH, and the FDA, have been deliberately providing misleading information to the public for the express purpose of facilitating the injury and/or death of others, including children. Ms. Speid cites favorably in her writings to COVID "treatments" advocated by Dr. Pierre Kory and his followers with the Frontline COVID-19 Critical Care Alliance (FLCCC) – an organization that has advocated for the administration of certain vitamin cocktails and medications like ivermectin, as a supposedly effective treatment for COVID.

Ms. Speid further suggests in her writings that patients should exercise "caution" before presenting to a hospital for treatment with COVID symptoms, and she advocates for the filing of lawsuits, both criminal and civil, against hospitals and health care providers who "kill" their COVID patients.

Lorna Speid, in her complaint to the Board, purports to advance her allegations against Nurse McInnis ostensibly because they "relate to public safety." She further purports to bring the instant complaint as "a health care professional, and an expert in the safe use of medicine." Ms. Speid's lack of qualification as a physician or nurse, and her publicly professed beliefs and apparent fealty to the misinformation campaign promulgated by Dr. Kory and his colleagues with the FLCCC, are certainly pertinent considerations when assessing the credibility of the current complaint and the current "complainant."

St. Elizabeth Hospital's COVID Care Dedicated ICU

Beginning with the inception of the COVID-19 pandemic in the spring of 2020, and continuing throughout calendar year 2021, St. Elizabeth Hospital in Appleton, Wisconsin operated a pair of distinct ICU units. One was a 10-bed medical ICU unit, dedicated to providing critical care to medical patients at the hospital. The second ICU unit was a specialized "COVID unit," consisting of 10 beds located entirely in negative pressure rooms, and dedicated exclusively to the care of critically ill COVID patients. The nurses and other health care providers who staffed the COVID-dedicated ICU were always fully gowned and gloved, with N95 masks and helmets with full face shields.

It was on this COVID-dedicated ICU where [redacted] resided for approximately one week, in October 2021, before her COVID-ravaged lungs reached a point where they were no longer able to sustain her life. Nurse McInnis was involved in [redacted] care for only the final two days of her stay on the COVID ICU at St. Elizabeth Hospital (October 12th and October 13, 2021), but [redacted] progressive medical deterioration in the days leading up to October 12th and October 13, 2021 is pertinent and provides needed context when assessing the care provided to [redacted] during the days immediately preceding [redacted] passing.

[redacted] Deterioration in the ICU Between October 6th and October 11, 2021

[redacted] presented to the Emergency Department on October 6, 2021 at St. Elizabeth Hospital, after having been referred to the ER by urgent care in another facility. A history and physical was taken by Dr. David Beck in the ER. [redacted] was a 19-year-old with complete trisomy-21 syndrome, conductive hearing loss and obstructive sleep apnea who was brought into the ER by her family secondary to complaints of shortness of breath. She had been residing at home with her family.

[redacted] was described as a high-functioning Down Syndrome patient with obstructive sleep apnea and obesity. Her healthcare power of attorney was activated on October 8, 2021. Her mother was the first designated agent, and her father the second. The following is a chronology of relevant events leading up to the morning of October 12, 2021, when Nurse McInnis first became involved in [redacted] care.

- October 6, 2021. Dr. Beck's history and physical in the ER reflects that [redacted] father, [redacted] reported the whole family is not vaccinated and went to a Christian concert in Oshkosh on September 25. There were about 3,000 people indoors and the majority were not masked. Dr. Beck noted that "The dad thinks

she probably caught the virus from there." A couple days after that, September 28, [redacted] started experiencing a runny nose and then developed a fever and decreased appetite and was sleeping more. The assessment was acute hypoxic respiratory failure apparently secondary to viral COVID-19 pneumonia. [redacted] father was told and understood, that the clinicians at St. Elizabeth Hospital were not going to offer treatments advanced by the Frontline COVID-19 Critical Care Alliance (FLCCC) physicians.

- October 7, 2021. Dr. Zeimet, an infectious disease physician, evaluated [redacted] and determined that she was likely on day 10 or 11 of symptom onset. Dr. Zeimet noted that the family was following the "misinformation of the frontline physicians with their vitamin cocktails and Ivermectin, but clearly that did not really help her. She continued to decompensate and subsequently was brought in." He discussed with [redacted] father different modalities for treatment, including Remdesivir. Although she did not really qualify for it, the father indicated that he did not approve of its use with his daughter. [redacted] did not qualify for use of convalescent plasma, the Monoclonal antibody or Regeneron. Her treatment of choice was Dexamethasone. Dr. Zeimet discussed with [redacted] father the possible use of Tocilizumab, although at that time she did not meet the criteria. The father was going to do his own research on the drug in case it was recommended for his daughter if things worsened.

- October 8, 2021. A nurse noted that the patient's father wanted to prove that the patient was getting better and did not need BiPAP. The RN removed BiPAP per his request and placed the patient on Vapotherm. Ms. [redacted] quickly desaturated to 85% and the BiPAP was replaced.

- October 8, 2021. The hospitalist, Dr. Baum, noted that the patient had clinically worsened overnight as her oxygen requirement had gone up. She had to be started on a Precedex drip due to anxiety and was struggling against the BiPAP. Her father had questions about getting BiPAP at home so that he could take his daughter home. He had not decided if he would agree to intubation. Dr. Baum told [redacted] father that he needed to make a decision in case things would worsen suddenly. The father said he could not make a decision yet.

- October 8, 2021. Dr. Zeimet wrote a progress note on this date which included the following:

> "The patient's dad is quite antagonistic with me. He believes in the frontline doctor stuff and does not really believe or trust us here in the healthcare setting, which I think is going to be the detriment to his daughter to be honest."

Dr. Zeimet pointed out that he thought that [redacted] might benefit from the Tocilizumab drug, but the patient was in the middle of the 24-hour window for its use and the father had not completed his research about it.

- October 8, 2021. Dr. Marada, a pulmonologist, documented that the patient had been started on Precedex the night before for agitation.

  Dr. Marada further indicated that he discussed [redacted] prognosis and oxygenation with her parents. He indicated: "Unfortunately their understanding about CPAP ventilation we are using and the oxygen supplementation are different. They think that her home CPAP machine is good enough and they think that nasal cannula oxygen is better than what we are giving now. We tried to explain to the best of my ability, but they have their own concepts." He told [redacted] father about the need to intubate if oxygen saturation cannot be maintained above 90% with 100% FIO2 and adjusting the BiPAP. "At this point, he did not make a decision."

- October 9, 2021. The infectious disease physician, Dr. Zeimet noted the following:

  > "Yesterday when I saw this patient and spoke with her dad, I explained to him that we had a very limited window to consider use of Tocilizumab and he was going to do additional research on this though he had almost 24 hours, prior as well as I talked to him about it. At this time, this patient is now outside the window for clinical utility of this drug and this drug will not be utilized."

  Dr. Zeimet noted overall, "…prognosis is quite guarded at this junction."

- October 9, 2021. The pulmonologist noted that the patient remained on BiPAP with settings of 15/10 100% FiO2. "She will desaturate fairly rapidly if the mask is removed…" He expressed concern about the staff's ability to prone the patient due to behavioral issues.

- October 9, 2021. A nursing note reflected that [redacted] father was in the room with the patient since admission and had repeatedly yelled at the nurses on all shifts, and tonight had accused the nurses of lying about the severity of his daughter's status. When attempting to educate him on medications and patient care, [redacted] father stated to the nurse on duty, "I am not going to take any of your guff. You are here to follow my commands." The nurse noted that Mr. [redacted] had been regularly exhibiting ongoing, blatant disrespect to the nursing staff.

- October 10, 2021. A nursing note documented that Mr. [redacted] continued to be difficult with staff, including rude statements about care. He was also interfering with [redacted] pump alarms. Repeated attempts to provide education were not accepted. He wanted all alarms turned off at bedside, but was informed this was not safe. Mr. [redacted] was subsequently asked to leave the ICU, both because he had been engaging in conduct that endangered [redacted], such as turning off her pump alarms, but also because Mr. [redacted] had, by October 10, 2021, developed clinical symptoms of COVID infection, himself.

- October 10, 2021. Dr. Leonard, [redacted] consulting pulmonologist, noted the patient remained on BiPAP. He also noted the patient did have her father in the room previously and, given her Down Syndrome and young age, he was initially allowed to stay in the patient's room for the first several days, "but sounds like there was some chronic concern by nursing staff about abusive behavior and he was asked to leave this morning." Dr. Leonard documented that the patient was quite calm when he saw her, and more conversant than she had been when seen the day before. He also documented "my hope is to avoid intubation, but I am losing hope on this."

- October 11, 2021. Dr. Baum, the hospitalist prior to Dr. Shokar, noted that the patient was on low dose Precedex and they were trying to titrate her off of that. She was on high-flow oxygen through BiPAP.

- October 11, 2021. Dr. Zeimet noted that Dr. Leonard was not "overly encouraged that we are going to be able to provide this patient [sic] from getting intubated." Blood cultures had been negative over 72 hours. She remained in respiratory failure. She was outside the window for Tocilizumab. "Her father did not ever get back with me on Friday to consider use of this drug and now we are more than 72 hours from when she was overtly decompensated." She remained on Dexamethasone. She was also outside the clinical utility for Remdesivir, convalescent plasma or the Monoclonal antibody.

- October 11, 2021. A chest x-ray demonstrated worsening pulmonary opacities bilaterally. They were described as "extensive."

Hollee McInnis' Care of [redacted] on October 12th and October 13, 2021

In October of 2021, Hollee McInnis routinely worked three daytime shifts of 12 hours each per week (7:00 a.m. through 7:00 p.m.). The days of the week upon which she would be assigned to work typically varied from week to week. Nurse McInnis worked those shifts that were assigned to her by her charge nurse in the ICU.

Hollee McInnis had not been assigned to the COVID ICU between October 7th and October 11, 2021, and thus [redacted] was a new patient to her when she was assigned to care for [redacted] at the beginning of her shift on the morning of October 12, 2021. Taking report from the outgoing nurse at approximately 6:45 a.m. on the morning of October 12, 2021, Nurse McInnis was informed that the medical staff had been requesting authorization from [redacted] father for several days to permit intubation [redacted] was already at the highest BiPAP setting, and had been for several days). Nurse McInnis was also informed in the October 12th morning report that [redacted] parents had, up to that point, refused to confer authorization to permit [redacted] to be intubated. Nurse McInnis was additionally informed during report that morning that [redacted] had been BiPAP-dependent for several days, and that any attempt to wean her from BiPAP had resulted in immediate decompensation and a decrease in oxygenation. As a result, as of the morning of

October 12, 2021, [redacted] had been unable, for several days, to remove her BiPAP mask even to permit her to eat, without experiencing significant decompensation and a drop in her oxygen level.

At 10:14 a.m. on October 12, 2021, Nurse McInnis' note indicates that [redacted] mother was updated by the hospitalist on duty, Dr. Gavin Shokar, on the plan of care, and her questions were answered. At 1356 hours on October 12th, Nurse McInnis noted that the patient had turned from prone position to supine. Her FiO2 had increased from 95 to 100%. [redacted] oxygen saturations were fluctuating between 78 through 85, and were not recovering. Nurse McInnis informed Dr. Shokar of these findings. Respiratory therapy was contacted to adjust the BiPAP settings. Dr. Shokar agreed to come to the bedside to assess the patient, and to talk with [redacted] family.

A further nursing note at 1402 indicated that the patient continued to be on BiPAP, and was frequently drowsy but arousable. A subsequent note at 1440 hours, recorded that [redacted] mother was to confer with her husband, and was to provide a decision on code status, as [redacted] was then on a "Do Not Intubate" status, but was still a full code. Nurse McInnis related in her note of 1440 hours that clarification was needed on this point, per Dr. Shokar's conversation with [redacted] mother.

An infectious disease consult was performed once again by Dr. Zeimet on October 12, 2021. Dr. Zeimet noted that [redacted] main treatment now would be supportive measures and dexamethasone. He once again recommended trying to prone the patient, though acknowledged that it was difficult to do so while she was on the BiPAP machine.

October 12, 2021, Dr. Shokar's afternoon note about [redacted] indicated that the patient's oxygenation saturations had deteriorated. Despite maximum support on BiPAP, [redacted] oxygenation consistently remained in the low 80s. Dr. Shokar spoke to [redacted] and [redacted] and had a family conference with [redacted] and his children regarding intubation versus leaving her on BiPAP versus comfort care. This conference lasted over 60 minutes to answer all questions that were posed "and counseled as best as possible in regard to the unfortunate situation." Dr. Shokar implored [redacted] parents to make a decision as soon as possible in regard to consent for intubation. He discussed the futility of CPR if they were not going to approve intubation in the setting of a patient with lung disease and ongoing hypoxia. Dr. Shokar noted: "It seems that all parties understood what was discussed. Again, they will reconvene with an answer shortly."

Later on October 12, Dr. Shokar noted that the patient was hyperventilating, possibly from anxiety which would impair her oxygenation. For that reason, the Precedex was continued. Proning was once again encouraged.

A note authored by Nurse McInnis at 1700 hours on October 12, 2021 indicated that [redacted] parents had been updated by Dr. Shokar relative to [redacted] low oxygenation saturations. The note further indicated that the parents had confirmed to Dr. Shokar that they do not want intubation for [redacted]

On the morning of October 13, 2021, after his extensive earlier conversations with [redacted] parents, hospitalist Dr. Shokar entered a "no code" order at 1056 a.m.

In a progress note dated October 13, 2021 authored by pulmonologist Dr. Gandev, the doctor noted that [redacted] condition continued to deteriorate, and that she was completely BiPAP dependent on 100% FiO2. Dr. Gandev further noted that [redacted] had become more agitated and confused over the previous 24 hours, and was now unable to maintain her oxygen saturation above 90%. Dr. Gandev recorded that overall, "pulmonary does not have much to offer." [redacted] was agitated and very tachypneic. Dr. Gandev recommended continuing BiPAP for comfort mainly. Dr. Gandev further indicated in his note of October 13th that "we will accept that we will not be able to keep that oxygen saturation above the goal of 88%." Dr. Gandev noted that, "considering the poor prognosis, it looks like the course of action the family has chosen will be the most appropriate for the patient." He noted that the caregivers would thus focus on comfort.

Dr. Shokar also entered a progress note on October 13, 2021. He recorded that [redacted] continued to be unable to maintain 90% oxygen saturation. He also recorded that [redacted] had experienced an episode that morning where she became agitated after stooling, and her Precedex had been increased in order to help control that agitation when she began starting to pull out the PICC line and remove her BiPAP mask. Dr. Shokar continued to advocate attempts at proning.

An infectious disease progress note authored by Dr. Zeimet on October 13th indicated that [redacted] was now on day 16 with COVID symptomatology. He further noted that [redacted] remained BiPAP dependent, and that she was slowly "losing the battle" with BiPAP. Dr. Zeimet opined that [redacted] would likely need to be intubated, given the course of her deterioration, but acknowledged that [redacted] parents had decided against intubation. Dr. Zeimet further noted that [redacted] was now entering the final phase.

Unfortunately, over the afternoon of October 13th, [redacted] condition continued to deteriorate. Her labs were revealing an increasing inflammatory response with an elevated CRP and D-dimer as well as a fever of 101° The family agreed to a feeding tube due to concerns about the potential for malnutrition. At 12:15 on October 13th, a verbal order was given by Dr. Shokar to initiate tube feeding through an NG feeding tube.

The nursing notes indicate that Ms. [redacted] respiratory rate was 54 at 1500, 52 at 1600 and 47 at 1730 on maximum oxygenation.

A standing order for Ativan 0.5 mg p.r.n. had earlier been entered in order to help the providers control [redacted] anxiety as her work of breathing continued to increase. Pursuant to this order, at 1746 hours, Nurse McInnis administered 0.5 mg of IV Ativan. At this point, Dr. Shokar was at the patient's bedside.

When the 0.5 mg of IV Ativan administered at 1746 hours had no effect in relieving [redacted] agitation, Nurse McInnis relayed that information to Dr. Shokar at the patient's bedside. Dr. Shokar instructed McInnis to administer another 0.5 mg dose of IV Ativan. Pursuant to that instruction, Nurse McInnis administered a second dose of 0.5 mg Ativan IV at 1749 hours.

Nurse McInnis subsequently authored a nursing note at 1750 hours. She recorded that [redacted] O2 saturation was 54 with proning. [redacted] sister was at her bedside and was facetiming with [redacted] father, [redacted], in order to update him on the ongoing situation.

Nurse McInnis authored a nursing note at 1755, recording that she had updated Dr. Shokar on [redacted] oxygenation saturation dropping to the 40s. Dr. Shokar ordered stat ABGs.

A note at 1805 hours by Nurse McInnis indicated that Dr. Shokar was at the bedside and was speaking to the family about [redacted] critical condition. At 1815 hours, [redacted] was noted to be breathing 55 times per minute. Her work of breathing had increased to unsustainable levels given the COVID-ravaged status of her lungs. In an effort to address this unsustainable work of breathing, Dr. Shokar instructed Nurse McInnis to administer 2 mg of IV Morphine. Concurrently, Dr. Shokar discontinued the Precedex drip. Pursuant to Dr. Shokar's verbal instruction, Nurse McInnis administered the ordered Morphine. The order was then formally recorded in the MAR at 1830 hours.

After the Morphine was administered, Dr. Shokar remained in the patient's room for 10-15 minutes. [redacted] oxygenation improved following the administration of the Morphine. Her pulse oximetry reflected oxygenation in the 90s.

Shortly thereafter, Nurse McInnis gave report to the oncoming nurse, and left the unit. According to the records, [redacted] became pulseless at approximately 1927 hours on the evening of October 13, 2021. Dr. Shokar's death summary indicated a time of death of 1927 hours on October 13, 2021, with primary diagnoses of: 1) Acute respiratory failure with hypoxia and 2) Acute COVID-19 infection with pneumonia.

Hollee McInnis' Response to the Allegations of the Complaint to the Board

The allegations advanced by complainant Lorna Speid as to Nurse McInnis have no substance. The three medications identified by Ms. Speid – Precedex, Lorazepam (Ativan) and Morphine, had each been ordered by a treating physician for [redacted], and each of those medications are clearly indicated in [redacted] medication administration record. Precedex is an anti-anxiety medication ordered for [redacted] in order to help keep her increasing anxiety to a manageable level. Due to her increasingly difficult work of breathing as her stay in the ICU proceeded, [redacted] anxiety was increasing commensurately, and the Precedex was administered in an effort to reduce [redacted] anxiety level to a point where it was less likely to interfere with efforts at proning her, and efforts to keep the BiPAP mask on and her IV tubes intact. [redacted] treating physicians were aware of the fact that [redacted] was receiving Precedex until the afternoon of the 13th, as numerous notes in the hospital chart attest.

Ativan was also clearly noted in [redacted] MAR, and doses of this medication had been administered on several occasions prior to October 13th. Once again, [redacted] physicians were aware of the fact that Ativan was on her MAR, and Nurse McInnis administered the 1746 dose of that medication pursuant to the order in [redacted] MAR. Nurse McInnis administered the second dose of Ativan at 1749 hours upon the direct verbal order of Dr. Shokar, who was with her that afternoon at [redacted] bedside. The second dose of Ativan administered that afternoon was given because the first dose had not had any effect upon [redacted] clinical presentation.

Finally, the Morphine dose administered at 1815 hours was given by Nurse McInnis upon the verbal order of Dr. Shokar, who was at the patient's bedside at the time. [redacted] was attempting a breath 55 times per minute at that point – a rate that was both concerning and unstainable. The Morphine was indicated under the circumstances because of [redacted] hyperventilation. 2 mg of Morphine was a low dose under the circumstances, and was well within the recommended dosage parameters.

The second discrete allegation found in the complaint to the Board relates to a DNR order that was entered into [redacted] record by Dr. Shokar on October 13, 2021, after he had engaged in multiple lengthy discussions on the issue with [redacted] parents. Nurse McInnis was not involved in any way with the decision to enter a DNR order in [redacted] chart – this was done by Dr. Shokar. [redacted] maintained his refusal to permit [redacted] care providers to intubate her up to and including the time of her passing, despite being told by several physicians that CPR or other attempts at resuscitation would not be viable or sustainable in the absence of intubation, should [redacted] vital signs crash or oxygenation decrease further. Despite this, [redacted] refused to authorize [redacted] treating physicians to intubate her if her clinical situation so dictated. Because the treating doctors were not permitted by Mr. [redacted] to intubate [redacted] resuscitation would have done nothing to prolong [redacted] life, given the advanced stage of the COVID disease that had ravaged her lungs by the afternoon of October 13, 2021.

While Dr. Shokar's entry of a DNR order was fully consistent with his prior lengthy discussions with [redacted] and his wife prior to [redacted] passing, Nurse McInnis played no role whatsoever in either determining that a DNR order should be entered, or in the actual entry of the DNR order. Therefore, to the extent that the complaint to the Board somehow suggests that Nurse McInnis was involved in some way in the determination or entry of a DNR order for [redacted] such allegation is completely unsupported.

Finally, the complaint to the Board suggests that [redacted] family "begged" Nurse McInnis to "save" [redacted] after [redacted] became pulseless and that Nurse McInnis had somehow "refused" to "save" [redacted] This allegation has no basis in reality, or in the contemporary medical records. Nurse McInnis' shift had ended at 1900 hours. She was thus no longer assigned to [redacted] care at the time that [redacted] was pronounced at approximately 1927 hours on October 13th. At no time did the [redacted] "beg" Nurse McInnis to "save" their daughter, and at no time did Nurse McInnis ever "refuse" to do so. Not only would the DNR order in [redacted] chart have prevented Nurse McInnis from engaging in resuscitation efforts, but her shift had ended by the time of [redacted] passing, and she was never in a position to respond one way or another at that time.

Conclusion

The instant complaint to the Board has been brought by an anti-vaccine crusader (Lorna Speid) who has now joined Mr. [redacted] quixotic quest for vengeance against Hollee McInnis, a highly qualified, experienced and dedicated ICU nurse. Nurse McInnis did nothing but scrupulously follow the entirely reasonable orders issued by members of [redacted] experienced team of specialty care providers on October 13, 2021.

[redacted] presentation in the hospital, and the progression of her medical deterioration, unfortunately, followed a pattern that was all too familiar to an experienced ICU nurse like Hollee McInnis in October of 2021. Hundreds of similarly situated COVID patients had passed through the St. Elizabeth Hospital ICU in the two years preceding October of 2021, and Nurse McInnis had witnessed this type of medical decline many times. Despite this, Hollee McInnis soldiered on through the depths of a pandemic – the likes of which had not been seen in generations – at the "front lines" of pandemic-related medical care – in the ICU. For years, Nurse McInnis has provided impeccable and compassionate nursing care to desperately ill individuals just like [redacted]. She provided no less to [redacted] herself. Lorna Speid's unfounded and defamatory allegation that Hollee McInnis administered medications to [redacted] on the afternoon of October 13, 2021 with the intent to bring about [redacted] death, is as despicable as it is unsupported.

The Department is now faced with a choice between supporting the careful, evidence-based medical care provided by Nurse McInnis and [redacted] treating physicians at St. Elizabeth, or the misinformation campaign championed by complainant Lorna Speid. For all of the reasons set forth herein, Hollee McInnis requests that the Department close this matter at the present time, as there is no substance to this complaint, and no reason justifying any further investigation of Hollee McInnis by the Department or discipline by the Board.

Sincerely,

OTJEN LAW FIRM, S.C.

Jason J. Franckowiak

Hollee McInnis, RN

JJF/jlt

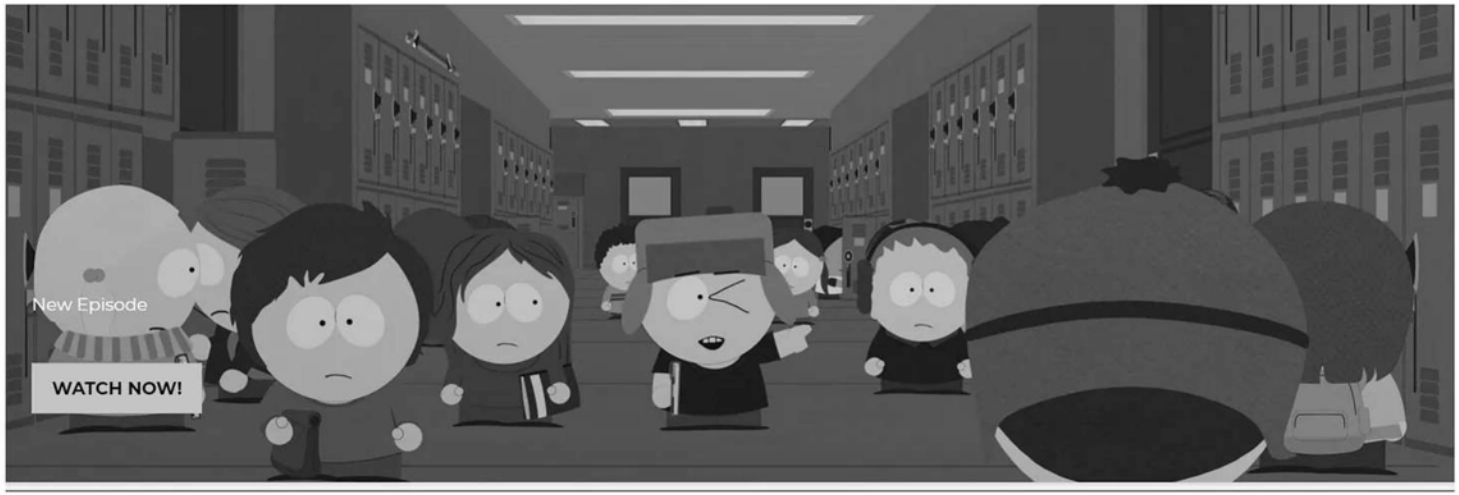
It's time for a South Park Skit about what happened over the last 3 years

What is it going to take for people to wake up?

LORNA SPEID, PH.D.

FEB 18, 2023

9 2 Share



It never ceases to amaze me that there are still people who are completely unaware of all that has happened in the last 3 years. They are unaware that excess mortality rates are off the charts in all the countries that pushed, and even mandated poorly tested experimental injections for their citizens. They remain completely unaware that the most dangerous place for anyone suffering from COVID19 is the hospital bed, especially where governments are paying by the death. They are completely unaware that children that have been injected with experimental injections that instruct their cells to produce Spike Protein, the most toxic part of the Sars-Cov-2 virus, are now experiencing cardiac toxicities at unprecedented levels. They fail to put two and two together when young healthy athletes drop dead suddenly, for no apparent reason. They are completely ignorant of the meaning of the trade secret inadvertently shared by the Pfizer Director about Pfizer's manipulation of the Sars-Cov-2 virus to make it more lethal. **And the list of issues they remain ignorant of goes on and on….**

Those of us in the medical field who are aware of what has happened appear to the wilfully ignorant to be misinformation spreaders. We appear to be against the regulators who have allowed themselves to be corrupted. Even when the European Commission is investigating the lies told in marketing campaigns by Pfizer and other pharmaceutical companies, we are the ones who appear to be at fault. I would rather be in the company of men and women who have stood up for the truth, and who did not turn away as evil flourished amongst the ignorant and the vulnerable. I know that when people who live in the future look back at what was allowed to happen, I and people like me will be judged to have been on the side of right.

Perhaps it is time for South Park to make a skit about what has happened over the last 3 years, and what continues to happen. Perhaps the satirical sketch will open up more eyes than all the obvious signs that keep happening around us.

Escape from 1984 to informed consent, privacy and autonomy is a reader-supported publication. To receive new posts and support my work, consider becoming a free or paid subscriber.

Type your email... Subscribe

9 Likes

2 Comments

Write a comment...

Jim Marlowe Feb 19 · *edited Feb 19* ❤ Liked by LORNA SPEID, PH.D.

Trey Parker and Matt Stone are brilliant, irreverent and willing to mock everyone. That includes "anti-vaxers," but in a way that didn't offend me. I get the sense that one or both of the creators are fully mRNA'd. Makes sense. The propaganda appealed best to people who have something to lose. So age demographic (over 50), wealthy, and a little sense of guilt for a previously unhealthy lifestyle combine to create a powerful incentive to get the mRNA elixir. Trey is infamous for hitting the high end strip clubs after finishing a season. In fact that is where he met his current spouse. That can tap into a sense of guilt. Of course this is all idle speculation on my part.

LIKE (1) REPLY ···

1 reply by LORNA SPEID, PH.D.

1 more comment...

Speid & Associates, Inc.

Bringing new drugs to market is like a relay race. Every person on the team must be ready to fulfill their role. Speid & Associates, Inc. is a regulatory and drug development consultancy, that will work with you to expedite your compounds' access to the clinic, and ultimately to commercialization.

Dr. Speid is the founder and President of the firm. She is supported by drug development experts, on a program by program basis. Dr. Speid is herself a recognized expert in global regulatory affairs and the development of novel molecules. Besides her track record in addressing unmet medical needs, she has a strong interest in bringing novel medicines to market for rare and neglected diseases.

Dr. Lorna Speid's Bio

Lorna Speid, B.Pharm.(Hons). M.R.Pharm.S., Ph.D., RAC is President of Speid & Associates, Inc. a regulatory and drug development consultancy based in San Diego, California. She works with small and large pharmaceutical companies, assisting them at the various stages of the drug development process, including US, European, international and global strategic regulatory affairs. Dr. Speid has an excellent track record of success in regulatory affairs, and is considered an expert in her field. She has registered therapeutics internationally, and has experience with all the major regulatory authorities. She has experience with many therapeutic areas including oncology, diabetes/obesity/metabolic Assessment of Medicines, Pre and Post Marketing. She has worked for large as well as small pharma companies, including Sanofi Winthrop in the UK (now Sanofi-Aventis), Ciba Geigy and Novartis in Switzerland (at Headquarters). Small companies that she has worked for include Valentis, Inc. (Director of Regulatory Affairs), NewBiotics (Vice President Regulatory Affairs and Project Management), and Avera, Inc. (Vice President of Regulatory Affairs). Dr. Speid was an officer at the last two companies. She has a Bachelor of Pharmacy degree from the University of London, UK (Kings College), and a Ph.D. from the University of Wales, College Cardiff, UK.

Lorna's Blog

- Do the Horrors of the Guatemala Syphilis Study Indicate A Disregard for International Standards of Human Clinical Research In the USA?

disease, anti-infectives, pulmonary, women's health, anti-inflammatory, lupus, transplantation, dermatology, and bone. She has worked on all types of products, including small and large molecules, gene therapy, combination products, devices and diagnostics.

Dr. Speid began her career as a pharmacist in the UK, after which she completed a Ph.D. at the Centre for Medicines Research International, into the Safety

Dr. Speid is the author of Clinical Trials: What Patients and Healthy Volunteers Need to Know, which was published by Oxford University Press in August 2010. This books is available from all major book stores in the US and abroad, and has garnered many awards for the service that it provides to research subjects and the families of those that are eligible for participation in clinical trials.

read more...

Services

- **Global and strategic regulatory affairs**
- **FDA regulatory affairs**
- **International regulatory affairs**
- **Chemistry Manufacturing Controls expert advice**
- **Clinical research and operations**
- **Due Diligence services for Venture Capitalists and Analysts**

In addition:

- **Strategic regulatory affairs support for Biosimilars**
- **Strategic regulatory affairs support for rare and orphan diseases**
- **NCEs, NBEs, Gene Therapy, Combination Products, diagnostics and devices**
- **Novel medicines for rare and neglected diseases - New Initiative involves a funding mechanism**

read more...

There's risk, and then there's Russian Roulette! [Part 1]

When is taking a medicine not worth the risk?

LORNA SPEID, PH.D.
MAR 15, 2022

This is a lengthy article, with two important videos. It is worth your while to read and assimilate the information I am sharing here. Please share with others you care about.

Last week I had the pleasure of speaking to a pharma executive who has recently retired. We had both worked for two top 10 pharmas. Naturally, we spent some time swapping stories, and seeing who we knew in common. Towards the end of a very pleasant, hour-long conversation, in making an argument for the pharmaceutical industry to improve its image, I mentioned the experimental genetic injections. The point I wanted to make was that the pharmaceutical industry has failed to provide appropriate leadership during the Sars-Cov-2 crisis, in relation to the experimental genetic injections. Immediately, I sensed defensiveness and push-back. I almost wished, I had not raised the subject. However, that feeling did not last long.

I have seen too much suffering to care about the feelings of a pharma executive, who lives in a bubble. Afterall, we are almost a year and a half into the roll out of, what are **easily**, the most disastrous medical products, since the Thalidomide crisis. Yet, he knew nothing, and cared even less about the injuries caused by these injections. When I began to tell him about the catastrophic injuries experienced by many, he immediately began to justify their safety profile in relation to the hundreds of millions who had received the injections.

There is a huge difference between a medicine that has some challenges, and a medicine that involves playing Russian Roulette. What is Russian Roulette? Russian Roulette involves placing one bullet in the chamber of a gun and then spinning the chamber. You then put the gun to your head and pull the trigger, hoping you **dodged the bullet**. If you are playing this dangerous game with someone else (an enemy perhaps?), you would then pass the gun to them and they would do the same. If their luck was out, they would drop down dead. **Please do not try this at home.**

When looking at any medicine, it is important to consider the balance between benefits and risks. Think of it like a scale with two arms - on one arm hangs a weighing bowl for risks, and on the other hangs a weighing bowl for benefits.

Photo by Elena Mozhvilo on Unsplash

If the risks weigh more than the benefits, then the medicine should not be administered or taken, especially if people are in good health. It is a sacrosanct rule in drug

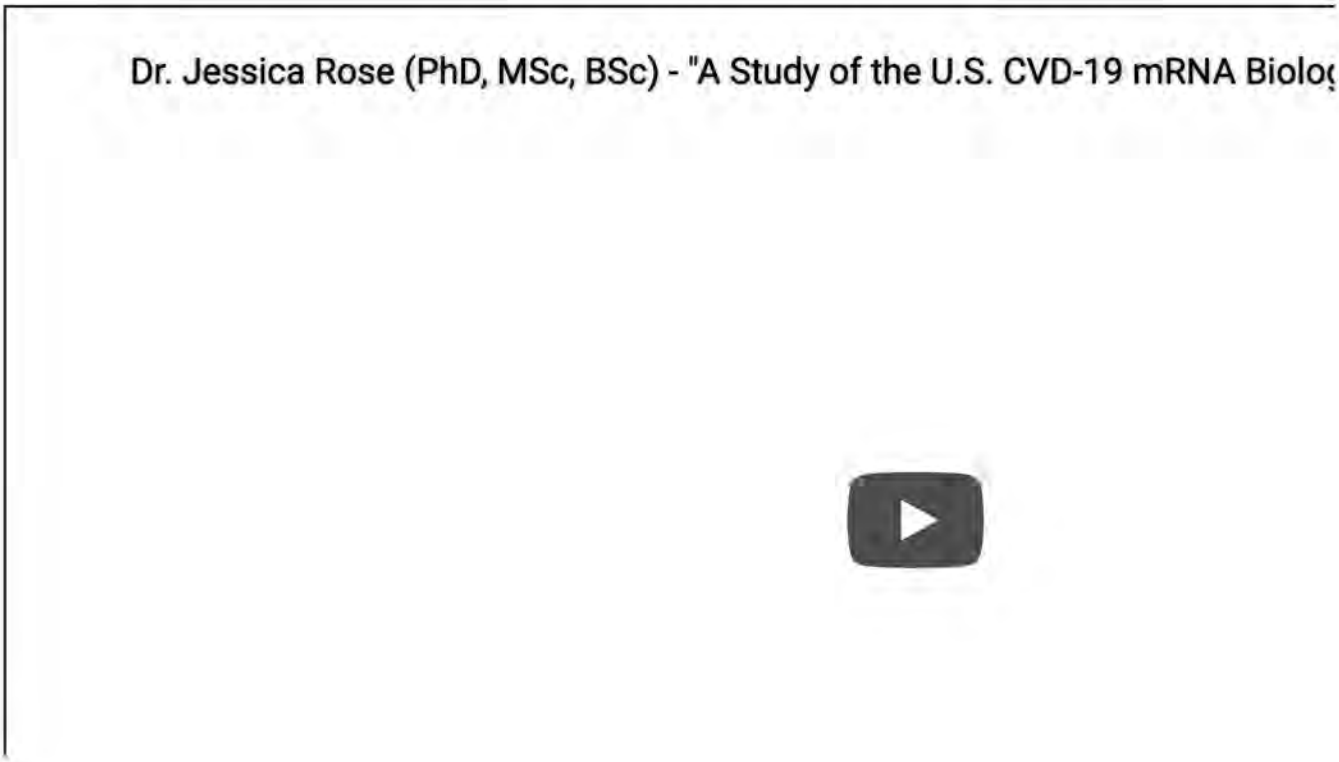
development that the healthy should not be harmed by any medicine administered to prevent disease.

We have known from the very beginning of the COVID19 pandemic that young healthy people, are not at risk from COVID19. Conversely, we have known that the elderly (above 80 years of age), especially with co-morbidities, are at the greatest risk of death. Yet, the elderly were not protected during the crisis. In nursing homes (at least in the US and UK), the elderly were exposed to other elderly who were known to be infected, or likely to be infected with the Sars-Cov-2 virus. Many died as a result.

One of my issues with the public health agencies, including the EMA (European Union), MHRA (UK), CDC (US), the FDA (US) and the NIH (US) is that they persist in telling the public that the experimental injections have an acceptable safety profile. Yet these agencies provide no data regarding the total number of deaths and serious adverse reactions. By neglecting to collect this information in a rigorious way, they are deliberately keeping people in the dark, about the true safety profile of these experimental injections.

For example, VAERS is the system that is supposed to gather this data in the US, but it suffers from under-reporting because it is a voluntary reporting system. To make matters worse, leaders from the CDC *"rubbish"* and talk down the VAERS system. By doing so, they actively, and in my opinion, deliberately, discourage the reporting of serious adverse reactions and deaths associated with the experimental genetic injections. The reports received for these injections, even with the under-reporting factor are numerically higher than all the vaccines in the system, when considered together.

Dr. Jessica Rose has analyzed the VAERS database. She presents her findings in the video below. Please take the time to watch this presentation, and come back and read the rest of this article. You will then understand why taking one of these injections is like playing Russian Roulette.



The leaders in at the CDC have *erroneously claimed* that the deaths in VAERS were not necessarily related to the experimental genetic injections. The pattern of spikes in deaths in days 0-5 after administration of the genetic injections are extremely revealing. Every one of those deaths is at least POSSIBLY RELATED to the experimental genetic injections, due to the relationship to the time of administration. They are most definitely not coincidences.

The process of assigning causality follows a process of investigation, but also medical probability. Until there is good reason to assign another cause, deaths that occur between 0 - 5 days of administration of the experimental genetic injections can reasonably be considered POSSIBLY RELATED to the administration of the experimental genetic injections.

Given this, the safety signals are clear, yet Dr. Walensky (CDC) and Dr. Marks (FDA) continue to ignore them. There are three possible reasons why they are ignoring these troubling safety signals.

The reasons are:

1. They are grossly incompetent
2. They are criminal in their negligence
3. They are corrupt. Corruption can include the existence of financial conflicts of interest. In other words, they benefit financially by taking **no action.**

What makes this even more like a Shakesparean tragedy than it already is, is that the general public tends to believe that they are competent. They hang on their every word. Recently, the CDC said there was no further need to wear masks. Last weekend, while I was at the local post office, I couldn't help noticing that most people had dispensed with their masks. The same applies to what the CDC, and FDA say about the safety of the experimental gene-based injections; the FDA and CDC say they are safe, so most of the general US public believes they are safe.

I have studied the various pharmaceutical disasters, including Thalidomide [1] and Diethylstilboestrol [2-6]. I believe that the roll out of these experimental genetic injections, is up there with the Thalidomide disaster.

Dr. Walensky has recently admitted that all data on safety are not being shared for fear of the safety data being misinterpreted. She is concerned that *misinterpretation* would lead to a reduction in confidence in the gene-based injections. We have all seen and heard about the high numbers of young sportsmen dropping dead all over the world. To take part in these sports all have had to be injected with the experimental genetic injections.

I would like to ask Dr. Walenksy - Can those deaths be *misinterpreted*? To selectively provide information, so that people will not be detered from taking the injections, is dangerous and criminal. Every time Dr. Walensky speaks, it is clear to anyone who knows a modicum about drug safety and drug development, that she is completely out of her depth.

It is precisely because the general public hangs on their every word, that leaders at the CDC, NIH and FDA who give out misleading information to facilitate the injury or death of others, including children, should be held criminally liable. Likewise, politicians and others who mandate that anyone, including working people, like the

truckers, take these experimental genetic injections, or lose their ability to earn a living, should face prison terms when injuries and deaths result from their abuse of power and incompetence.

Remember that this has been ongoing since early 2021. In the US, for example, the FDA, CDC and NIH have known about the deaths. They have known about the injuries. Yet, they persist in stating publicly that the benefits justify the risks. **They almost got away with this, except there are mechanisms for tracking deaths that are outside the control of the CDC, NIH and FDA.** When lots of working age people die, life insurance companies pay death benefits. When that happens at an alarming rate, they begin to be concerned about their losses. Life insurance companies are now raising the alarm. Note, these aren't payouts for the 80 -100 year olds that are most susceptible to the Sars-Cov-2 infection and COVID19 disease. These increased payouts coincide and overlap with the roll-out of the experimental injections.

Please turn to page A8

◆ Greg Ip: Ukraine clash puts dagger in globalization..... A2

lies this week rolled out a range of sanctions against Russia, which they have promised to ratchet up should Mr. Putin

Please turn to page A8

◆ U.S. stocks extend slide over Ukraine concerns..... B1

Rise in Non-Covid-19 Deaths Pares Life Insurers' Earnings

By Leslie Scism

U.S. life insurers, as expected, made a large number of Covid-19 death-benefit payouts last year. More surprisingly, many saw a jump in other death claims, too.

Industry executives and actuaries believe many of these other fatalities are tied to delays in medical care as a result of lockdowns in 2020, and then, later, people's fears of seeking out treatment and trouble lining up appointments.

Some insurers see continued high levels of these deaths for some time, even if Covid-19 deaths decline this year.

In earnings calls for the past two quarters, Globe Life Inc., Hartford Financial Services Group Inc., Primerica Inc. and Reinsurance Group of America Inc. were among insurers noting higher non-Covid-19 deaths, compared with pre-pandemic baselines.

"The losses we are seeing continue to be elevated over 2019 levels due at least in part, we believe, to the pandemic and the existence of either delayed or unavailable healthcare," Globe Life finance chief Frank Svoboda told analysts and investors earlier this month.

Among the non-coronavirus-specific claims are deaths from heart and circulatory issues and neurological disorders, he said.

"We anticipate that they'll start to be less impactful over the course of 2022 but we do anticipate that we'll still at least see some elevated levels throughout the year," he said.

Primerica executives simi-

Please turn to page A6

◆ New omicron strain presents a speed bump..... A6

◆ Maternal deaths rose in pandemic's first year..... A6

INSIDE

JANE HAHN/WSJ

BUSINESS & FINANCE

Online used-car seller Carvana is tested as the tailwinds that boosted growth fade. **B1**

Watch Edward Dowd, a former executive of Blackrock, speak about the deaths among the people of working age. Click on this link, or copy and paste into your browser.

https://rumble.com/vx0yfb-edward-dowd-on-future-recession-shocking-findings-in-the-cdc-covid-data-and.html

Edward Dowd's presentation - Life science data

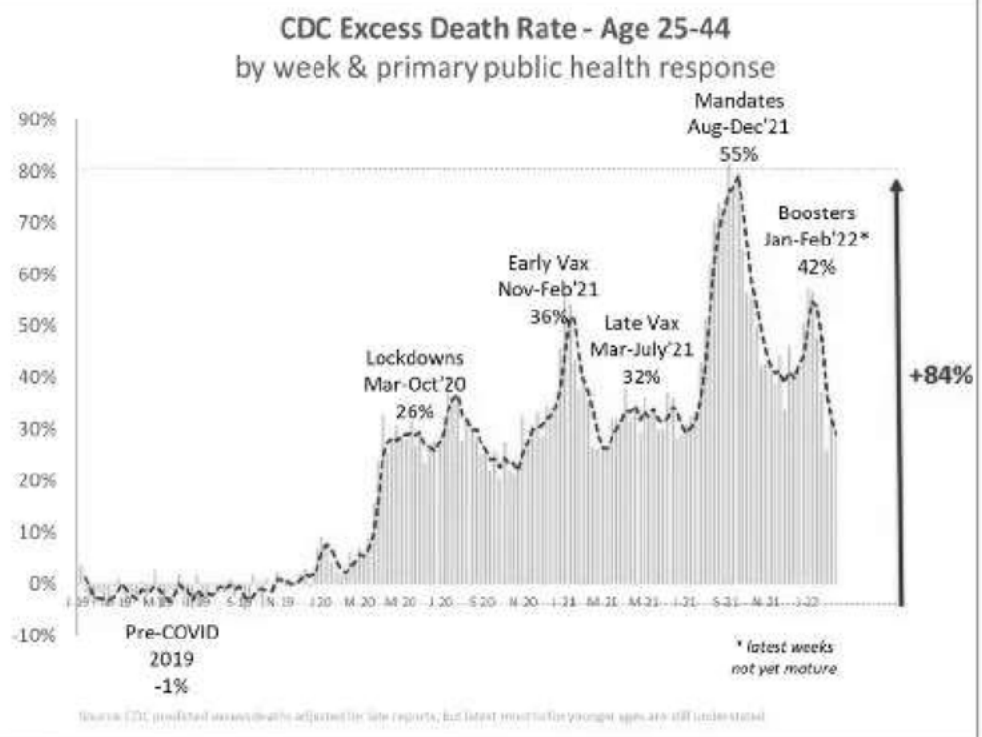
The excess death rate data for millenials can be summarized below:

The Millennial generation suffered its worst-ever excess mortality last fall, and these deaths occurred the same time as vaccine mandates were announced, and boosters approved.

This younger population is not particularly at risk to COVID, and the size and timing of this spike in fall of 2021, raises clear questions about potential contribution from the vaccines and boosters.

As you know, mortality reporting for younger age people is also typically much slower (due to slower reporting of non-hospital deaths), so the recently elevated levels for this age group persisting into early 2022 will most likely develop further, and may signal for continuing elevated mortality among working age in 2022.

Exhibit 4 | Millenials Suffered Rapid and Record Rate of Excess Deaths in Fall '21



Source:https://www.cdc.gov/nchs/nvss/vsrr/covid19/excess_deaths.htm#dashboard

You will be hearing a lot about the crimes against humanity that are being committed in Ukraine, and yes, let's be outraged about those crimes against humanity. At the same

time, let's not forget the crimes against humanity that were committed over the last 2 years, and that are still being committed. As we demand people are held to account for atrocities committed in Eastern Europe, let's not provide a free pass for those who are guilty and complicitly committing crimes against humanity *here* (wherever *here* is for you).

To my new pharma executive colleague, I would say, being injected with one of these experimental injections is akin to playing Russian Roulette. No one in their right mind plays Russian Roulette. Furthermore, Pharma companies like Pfizer, Moderna and Astra Zeneca (and others involved) should be shamed into creating a fund to take care of the injured around the world. The minimum that they should pay into this fund is $5 Billion **each**, **per year**. Yes, we know that they have indemnification. If they deliberately put lives at risk by cutting corners that they know should not be cut, that would amount to gross negligence, if not criminal activity for the sake of profits.

In **Part 2** of this series (later this week), I will explain why the batch that was injected into you determined if you experienced serious adverse reactions. Additionally, the batch injected into you determined if you lived or died. **How does it feel to have played Russian Roulette?**

Watch out for Part 2. In the meantime, share this article with those you care about.

References

1. Kim JH, Scialli AR. Thalidomide: the tragedy of birth defects and the effective treatment of disease. Toxicol Sci. 2011 Jul;122(1):1-6. doi: 10.1093/toxsci/kfr088. Epub 2011 Apr 19. Erratum in: Toxicol Sci. 2012 Feb;125(2):613. PMID: 21507989.
2. Professional and Public Relations Committee of the DESAD (Diethylstilbestrol and Adenosis) Project of the Division of Cancer Control and Rehabilitation. Exposure in utero to diethylstilbestrol and related synthetic hormones. Association with vaginal and cervical cancers and other abnormalities. *JAMA* 1976; 236(10):1107–1109.
   [PubMed Abstract].
3. Herbst AL, Ulfelder H, Poskanzer DC. Adenocarcinoma of the vagina. Association of maternal stilbestrol therapy with tumor appearance in young women. *The New*

England Journal of Medicine 1971; 284(15):878–881.
[PubMed Abstract]

4. FDA Drug Bulletin: Diethylstilbestrol contraindicated in pregnancy. *California Medicine* 1972; 116(2):85–86.
[PubMed Abstract]
5. Giusti RM, Iwamoto K, Hatch EE. Diethylstilbestrol revisited: A review of the long-term health effects. *Annals of Internal Medicine* 1995; 122(10):778–788.
[PubMed Abstract]
6. Palmer JR, Wise LA, Hatch EE, et al. Prenatal diethylstilbestrol exposure and risk of breast cancer. *Cancer Epidemiology, Biomarkers & Prevention* 2006; 15(8):1509–1514.
[PubMed Abstract]

As always, you are encouraged to seek medical advice for your own personal situation. Whatever you read here, should not take the place of your own personal consultation with your qualified and competent medical advisors.

16 Comments

Write a comment...

David Bolen Writes Drunk Tank Fiction Mar 15, 2022 ♥ Liked by LORNA SPEID, PH.D.

Thank You! These gutless cowards just keep defending this failed experiment by saying, 'minor,' adverse events, and how wonderful the gene therapy while ignoring Ivermectin's success around the world AND that the fully 'vaxxed,' seem to be dying at a much higher rate now. Nuremberg trials are demanded. Although, hopefully, most will hang, at least they will be FORCED to listen to EVIDENCE and DATA at trial.

LIKE (3) REPLY •••

Noname Mar 16, 2022 ♥ Liked by LORNA SPEID, PH.D.

Rather than the criminal drug makers paying annual fines, they must be destroyed, stripped of all current value, everyone in those companies involved in these crimes must have all blood money clawed back, then all of that can go to the injured and families of those murdered and we can finally remove the permanent home put around the American people to be force fed dangerous symptom-treating meds that don't address underlying disease. This is the same thing cigarette companies did. America needs the same outcome here to restore balance and hand down true justice.

LIKE (2) REPLY •••

1 reply by LORNA SPEID, PH.D.

14 more comments...

Senator Ron Johnson's Panel - Very important

COVID19 Vaccines - call for them to be withdrawn

LORNA SPEID, PH.D.
DEC 9, 2022

I, like many others, am delighted that Senator Ron Johnson was re-elected. He has wasted no time in holding a panel of experts to discuss the COVID19 gene-based injections.

What are the qualifications to be on the Panel?

Experts must:

1. Be experts
2. Be able to articulate their message so that non experts can understand them
3. Have a high degree of integrity
4. Not be bought.

This is the link to the video, from Rumble.

https://rumble.com/v1ze4d0-covid-19-vaccines-what-they-are-how-they-work-and-possible-causes-of-injuri.html?utm_source=substack&utm_medium=email

copy to a browser.

Some discussion points from the Panel

1. The Openvaers.com database clearly shows safety signals. These safety signals are being ignored by the CDC and the FDA
2. The VSAFE database has over 10 million proactively registered recipients of the gene-based injections. The CDC was forced to share the safety data. These data show that the safety signals give much cause for concern. Well over 50% of those who received these injections experience serious safety outcomes.
3. Something is causing excess mortality data for the US population in the working age. These are individuals who are in excellent health. The only societal change is the introduction of the gene based injections.
4. The COVID19 gene-based injections were not tested sufficiently for a global roll- out.
5. The informed consent document placed in the gene-based injections, is left completely blank. Yes - blank. There is no writing on it at all. The document even states, “Left intentionally blank”.
6. The pandemic was mis-managed by refusing to treat patients early. Effort was made by the CDC and FDA to sabotage any early stage treatments that could have changed the trajectory of the pandemic.
7. The FDA was co-opted by the pharmaceutical industry early in the pandemic, or at least the major companies that were seeking to market gene-based injections. Statements made by Dr. Marks (head of FDA for vaccines) were indications that the regulator was little more

than a promoter of the products made by the pharmaceutical industry. The independence of the regulator was and continues to be compromised.

For those of you who still have family members who are unaware of the true state of affairs, you can consider forwarding this video to them to watch. Please also consider forwarding my earlier Substacks to them to help them to get up to date on topics such as the safety of these products, or blatant lack thereof.

Comments

Write a comment...

Hospitals ..... or Killing Fields?

It's time to analyze the data on COVID19 deaths in hospitals

LORNA SPEID, PH.D.
JUL 25, 2022

My beloved cousin David, died from COVID19 in a New York hospital, early in 2021. I am seldom on WhatsApp and Facebook and missed the family news that he was ill in hospital, and even that he had passed away. I am still tormented by the fact that I might have been able to intervene to save his life, had I been aware that he was in hospital. Yet, how much did we know at that time about what was really happening in hospitals? Very little.

David had not taken the gene-based injections, and was healthy. He was actually working on a diagnostic test for Sars-Cov-2, so he was in the know about Sars-Cov-2. Why did he die? What drugs were administered to him in hospital? Why did a healthy man develop renal failure in hospital, and why was his advocating cousin (a highly qualified nurse) told that there was nothing that could be done to save his life? She remembers that she was told nonchalantly, "He's not going to make it". The fact that it took two weeks for him to die in hospital only confirms my concerns. As is typical, no one from the family was given access to him until the funeral home could collect his corpse.

With the passage of time, I have learnt a lot about what is taking place in the hospitals in the United States. For instance, I have discovered that the US hospitals are all following the NIH protocol [**1, 2**], and put pressure on patients and their families to allow the use of ventilators [**2**].

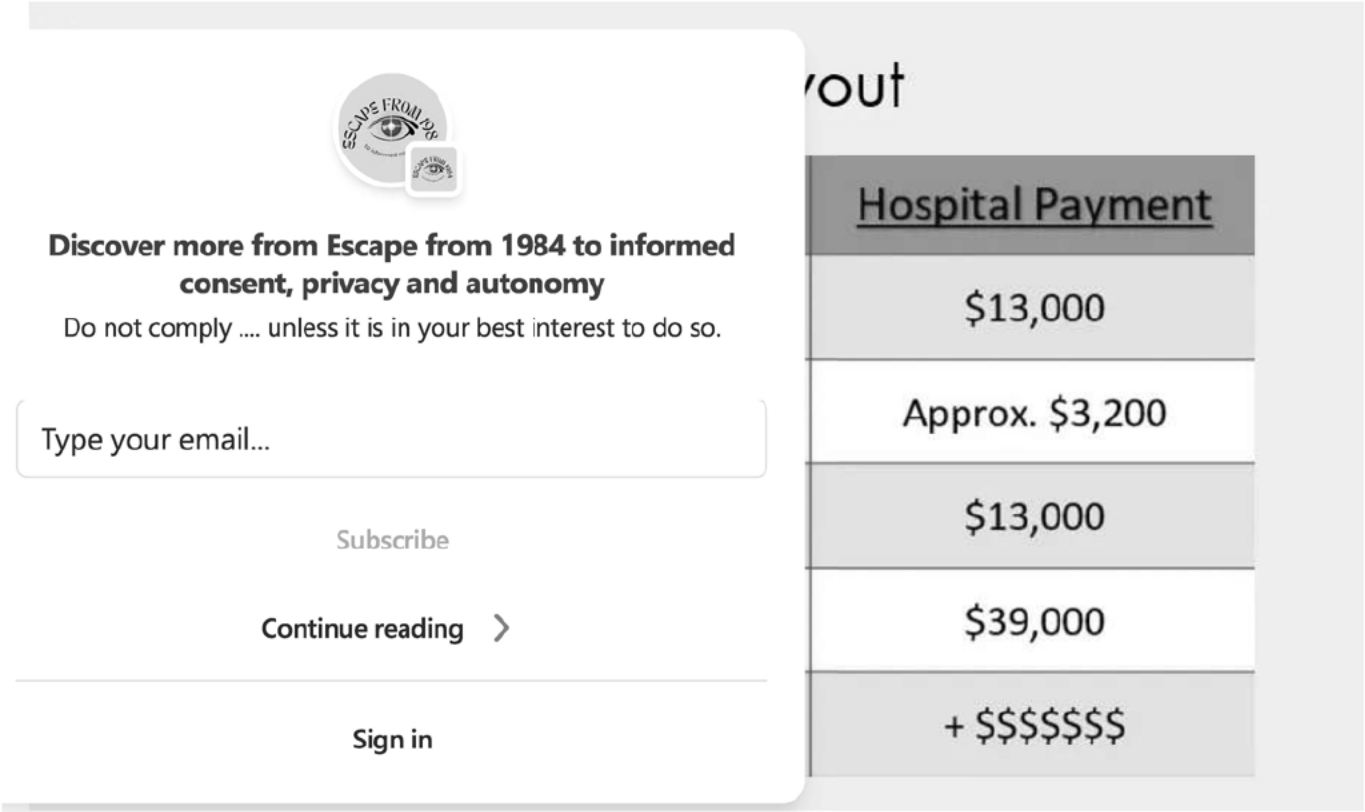
What I have learnt is extremely troubling, and confirms that people are dying, who should not be dying. I also found out that my cousin's wife probably received a payout of about 9000 USD [**3**], that to this day, she has never disclosed to the family. I call this *"shut up money"* or *"look the other way money"*.

Another uncomfortable truth is that hospitals receive money per death, thereby not incentivising them to ensure patients do not die while in their care. They also have full

indemnification from whatever happens to patients in their care, related to COVID19. Does this seem far-fetched? Keep reading.

Incentives and Payouts

A dead COVID19 patients is worth more than a recovered COVID19 patient. Death pays, at least where COVID19 is concerned. The following data are taken from **protocolkills.com**. The data are referenced below. The amounts that are earned by hospitals, at every step of the process, are astounding. These payments create conflicts of interest for patient care. Just look at how much is paid per patient placed on ventilators! **Is it any wonder so many people are placed on ventilators?**



The amounts paid per COVID19 patient in each State are shown in the following table taken from protocolkills.com.

What hospitals make in each state per Covid patient.

State	Money Received for EACH Covid Case	State	Money Received for EACH Covid Case
Alabama	$158,000	Montana	$315,000
Alaska	$306,000	Nebraska	$379,000
Arizona	$23,000	Nevada	$98,000
Arkansas	$285,000	New Hampshire	$201,000
California	$145,000	New Jersey	$18,000
Colorado	$58,000	New Mexico	$171,000
Connecticut	$38,000	New York	$12,000
Delaware	$127,000	North Carolina	$252,000
District of Columbia	$56,000	North Dakota	$339,000
Florida	$132,000	Ohio	$180,000
Georgia	$73,000	Oklahoma	$291,000
Hawaii	$301,000	Oregon	$220,000
Idaho	$100,000	Pennsylvania	$68,000
Illinois	$73,000	Rhode Island	$52,000
Indiana	$105,000	South Carolina	$186,000
Iowa	$235,000	South Dakota	$241,000
Kansas	$291,000	Tennessee	$166,000
Kentucky	$297,000	Texas	$184,000
Louisiana	$26,000	Utah	$94,000
Maine	$260,000	Vermont	$87,000
Maryland	$120,000	Virginia	$201,000
Massachusetts	$44,000	Washington	$58,000
Michigan	$44,000	West Virginia	$471,000
Minnesota	$380,000	Wisconsin	$163,000
Mississippi	$166,000	Wyoming	$278,000
Missouri	$175,000		

Sources:

- State-by-state breakdown of federal aid per COVID-19 case
- How much federal COVID-19 aid are hospitals getting? A state-by-state analysis
- Fact check: Hospitals get paid more if patients listed as COVID-19, on ventilators
- Financial Resources for Hospitals During the COVID-19 Emergency
- Hospitals Are Paid Federal Cash For Every COVID-19 Patient They Admit & Even More If You Die Of It

Now let's hear from nurse whistle blowers about what is really taking place in the hospitals.

What Happens in the Hospitals Usually Stays in the Hospitals

Nurse Whistle Blowers

Following is a video from two nurse whistle blowers. It is a must-watch. Warning: Expect to be shocked and distressed.

Copy this URL to a browser and watch the video.

https://rumble.com/v15fry1-full-episode-30-fighting-covid-corruption.html

The hospitals in the US do not prioritize early treatment. The media, FDA, NIH and CDC have spent the last two years denying that Ivermectin, Hydroxychloroquine, and other low cost generic treatments work. Yet, the new EUA authorized drugs that are very expensive, also rely on starting treatment as early as possible. Earlier versions of these types of treatments, were developed for the common cold and influenza. Relenza (GSK/Biota) and Tamiflu (Roche) have been around for approximately 30 years. The new drugs have simply been removed from the shelf in the large pharmas, dusted off, and moved through to Emergency Use Authorizations. If you decide to take one of these new drugs, be sure you examine the product label, particularly in relation to the safety profile and the warnings. See the Substack *The Uncensored Citizen* for more information about one of these new treatments [**4**].

The hospitals are typically not competent to follow effective treatment approaches, because they are incentivized to only use the NIH protocols. The latter, when combined with lack of competent care, and negligence, typically and evidently lead to renal failure and death, even in patients that should not experience renal failure or death. The NIH protocol incentivises the hospitals to allow patients to die, in the best case scenario, and to deliberately bring about their deaths, in the worse case scenario. A mixture of these two scenarios is undoubtedly taking place.

The Use of Ventilators

Hospitals are incentivized to place people on ventilators, and this means that you will be placed on a ventilator, whether it is in your best interest or not. Use of ventilators in intensive

care settings is labor intensive, and requires highly trained nurses and respiratory specialists. These staff are expensive. The use of bank staff and nurses to take care of patients on ventilators, is undoubtedly contributing to the high death rates.

The death rate for ventilators, must be examined and analyzed hospital by hospital, to determine why people are dying after they are placed on ventilators. At the start of the crisis, the ventilators were supposed to be life savers. The payment for ventilator use, certainly appears to have created an incentive for these devices to be used, whether they are needed or not. When bank nurses turn up to cover for trained nurses and other staff who refuse the gene-based injections, you can see how tragic outcomes arise as unqualified staff are placed in ICU setting, that they are not qualified to work within.

In the following video Mr. **Kurtis Bay** shares the tragic story of the death of his dearly loved wife, who died in hospital. This is a must watch.

Copy this URL to a browser and watch the video.

https://rumble.com/v1cmd17-kurtis-bay-shares-his-horrific-experience-with-covid-hospital-protocols.html

Find many other stories on **www.protocolkills.com.** This is a very important website, with a lot of data and information. There are commonalities in the stories. I recommend you spend some time on this site and then come back to finish this Substack.

Should you go to the hospital if you have tested positive for Sars-Cov-2 virus?

Sadly, if your loved one goes into hospital when they are feeling very unwell, the probability of your loved one leaving the hospital alive is nowhere near 100%. Monoclonal antibodies are not being administered to those who need them. If you or your loved one is treated according to the NIH protocol, they are unlikely to have a good outcome. Your family will be unable to advocate for you, because they will not be given access to you. Isolation appears to be an important part of the NIH treatment protocol.

The concern that you should have is loss of control over what happens to you if you become so unwell that you are incapacitated. If you are a relative, think very carefully before taking your

loved one to the hospital after they test positive for Sars-Cov-2 virus. Instead, procure early treatment for them, especially if they are in a high risk medical group. If you do need to be admitted to hospital, go to the hospital that has a record of allowing patients to exercise informed consent. Check the statistics on COVID19 deaths.

Start Early Treatment as Soon as Possible

Remember, for the majority of people who are in good health, the Sars-Cov-2 infection is experienced as mild, especially with the Omicron variant of the virus. So for the people who have a precarious health status, why are some of them dying?

People are usually told to go home and isolate, and then come back if they are getting worse. For the elderly, and people in poor health, or who have a number of co-morbidities, this is not good advice. If you are in poor health, and test positive for the virus, you should begin to take treatment that will supplement your normal immune response, kill the virus, and remove it from your system, as soon as possible. Doing this in the early stages of the viral replication process is crucial. If it is left too later, the virus will over-run your immune system, and more heroic treatment approaches will be needed. Unfortunately, the will to intervene and save lives is missing due to the corruption of the healthcare system. Just as an example of the corruption, when was the last time that you heard of anyone being diagnosed with influenza (flu)? **I rest my case.**

NIH Corruption

The NIH budget is huge - for 2021 it was 43 Billion USD. Most if not all hospitals in the United States are dependent on NIH funding in some form or another. The following link will take you to a report where you can see the huge amounts paid out by NIH to hospitals, academia and pharmaceutical and biotechnology companies.

https://report.nih.gov/award/index.cfm

The huge disposable budget gives individuals like Dr. Antony Fauci tremendous power. This power has had a corrupting influence on the COVID19 public health crisis. This influence guarantees that hospitals will do as the NIH demands.

Dr. Fauci has mandated that the NIH protocol must be used in US hospitals.

See the guidelines by visiting the following link.

https://www.covid19treatmentguidelines.nih.gov/management/clinical-management/hospitalized-adults--therapeutic-management/

The stipulation of treatment protocols for those admitted to hospitals creates major problems, due to the relationship of the institutions to the NIH. Because of the financial incentives hospitals dare not refuse to comply, even if it is in the best interest of patients. There is simply too much to lose. Remdesivir is stipulated but has a history of being an unsafe drug for Ebola [1], and now, also for COVID19.

Every approved drug has a product label. This product label clearly identifies the **Contraindications** and **Warnings -** in other words, the situations where the drug must not be administered. The NIH protocol effectively mandates that there are no exceptions to the use of the protocol. Product labels must be ignored.

The hospital administrators and financial overseers are focused on the bottomline for the hospital, not on saving lives. They are paid by the death, and so patients are dying. They cannot prioritize lives over the grants that the hospital can gain from the NIH, so they do as they are told. Dr. Fauci has a reputation for retaliating against those who go against his directives [5]. Additionally, physicians have been threatened with loss of their medical licenses if they do not do as they are told. Few take risks with their careers. The patients suffer as a result of this corruption.

Common Threads Running through all the Stories

There is a similar pattern to all of the stories you have read about and watched, starting with my cousin, David. They are as follows:

1. Patients and family members present to the hospital, a little unwell, and they are told that they will be out in a few days.
2. They are isolated from their loved ones. They have no one to advocate for them.
3. At some point after admittance they are typically sked to sign a document that essentially waives all their rights to be informed consented.

4. They suddenly "*take a turn for the worse" (or at least that is* what family is told), and their relatives and loved ones are told that they are not going to make it.
5. They die in hospital and their loved ones are left bereft, with extreme feelings of guilt, because their death makes no sense.

How do Hospitals Compare?

How do the different hospitals compare in terms of deaths? If the data were made available, patients and their families could choose between the hospitals. Are they all as bad as each other, or are some less like killing fields than others? We need this data. Freedom of Information requests need to be filed. When we examine the payouts to hospitals and States, we can draw the conclusion that the hospitals that have received large payouts would have higher numbers of deaths, resulting in the larger payouts. There is an urgent need for research on this.

What Should You Do if you become sick with COVID19?

Given what is happening, you should think carefully before presenting to the hospital. Remember, no one is going to be held accountable for their negligence or incompetence. I hope this will change, but for now that is the reality we are living with. Blanket immunity and indemnification has been granted. Many are trying to expose and pierce this veil, due to the fraud, but that process is moving rather slowly.

Here are some suggested steps to help to ensure you and your loved ones do not become victims of the corruption.

STEP 1: Create a plan now - don't wait to become ill

Purchase the medications that are effective for early treatment. Ensure these medicines are in your home. Buy sufficient for the whole family. The treatment protocols are available from **www.myfreedoctor.com**, and **https://covid19criticalcare.com/**

I do not want to advocate for any specific early treatments. Do your research. The NIH protocol has been called into question. Ensure you have strong advocates who will speak for you if you cannot speak for yourself.

STEP 2: Take early Treatment if you become ill - Stay out of the hospital

..... that is, unless you have a death-wish.

STEP 3: Do not leave your relative's side.

If you cannot stay with them, ask for an independent professional advocate. The hospital is supposed to provide advocates when they are requested. However, who pays their salaries? Are they going to take the hospital line?

Identify this person well in advance. Legal processes including injunctions may be needed. Be aware of how to start and use those, especially if your relative is in a high risk group.

STEP 4: Know your right to informed consent.

You have the right to refuse treatment if it is not in your best interest to receive it. You cannot be penalized for that refusal. Alternative treatment approaches must be made available to you. In the United States, you have the **right to try** any medication that you believe is appropriate for your care, within reason. The early treatments advocated by Dr. Pierre Kory, and many others, have been around for many years. They are fully approved, and physicians are able to prescribe them off-label. This is normal medical practice. If physicians could only prescribe according to the product label, most childhood diseases would never be treated.

STEP 5: If your loved one dies in hospital, obtain the Medical Records as soon As possible

If your loved one dies in hospital, it is vital that you secure the full medical records as a matter of urgency. Legal counsel should be retained to write to the hospital to obtain the medical records, to prevent them from being destroyed. These records should include all medicines administered while your loved one was in hospital. If you visit the hospital while your relative is there, take scans or photographs of all medical records with your phone or iPad.

STEP 6: Spread the word - warn others

1. It is extremely difficult to get these stories out to the wider public. Most people have not even heard the stories that you have watched.
2. Tell your story on **Rumble.com**, **YouTube.com**, and **www.realnotrare.com**.

STEP 7: Bring criminal and civil law suits against individuals and hospitals, when able to do so.

At some point, we can hope that lawsuits will be brought to hold individuals and hospital administrations to account. The medical records will be an important aspect of the evidence.

That day is coming, and the sooner the better.

Let's not forget .....

1. Turn off the propaganda ..... this will dramatically reduce your anxiety level.
2. There is a level of unreliability in relation to the COVID19 tests. If you test positive, don't panic. Test again with a different test.
3. Omicron is the prominent form of Sars-Cov-2 virus that is presenting now, and it causes mild symptoms in most people, especially the healthy. Most people in good or reasonable health, are not at elevated risk from Omicron.
4. Maintain your body weight in a normal range for your height and age. This will help you to remain at low risk from COVID19.
5. Eat well and exercise as much as you can ..... this will do a lot more to save your life than anything they can do for you in a hospital.
6. If you are already injected with the gene-based injections, think carefully before taking additional "Boosters". If it is working, why take more doses? If it has not worked so far, do you really need more of the same?
7. During the coming Fall and Winter the powers that be will try to turn up the heat by making as many people afraid as possible. I can hear it now — *"Get vaccinated, Get boosted....."* Do what is best for you after you have done your research.

Knowledge is Power

Knowledge is power. I wrote my first book, ***Clinical Trials: What Patients and Healthy Volunteers Need to Know [6]***, after the deaths and injuries of research subjects taking part in clinical trials. The book, was published in 2010, by Oxford University Press, a major publisher. It won awards, and has helped many families who needed to navigate clinical trials while they or their relatives were very ill. Although published 12 years ago, the book provides the information

needed to decipher the challenges around the experimental gene-based injections, and other aspects of care, including hospitalization, during the COVID19 crisis.

One of the tragedies of all of these stories is that so much of what has occurred over the last two years, was avoidable. The individuals who were most at risk of dying from COVID19, were the elderly in the 80+ age group, mostly living in nursing homes. Many nursing homes were not protecting their residents; patients with COVID19 were deliberately and negligently, moved into the nursing homes, thereby augmenting the rate of deaths from COVID19.

What is really unacceptable is the death of the healthy, either because they were denied early treatment, and / or because they were given inappropriate or bad treatment in the hospitals, after admittance. Coercion of healthy people to take the gene-based injections, only to result in their injury and/or deaths is a tragedy that should not have happened.

Whilst I am working on a second book that will address the challenges of informed consent in the age of COVID19, the first book puts the information that **you need right now, into your hands**. Lots of books are coming out, but my first book addresses the science of new medicine development in a lay-friendly way. The book has been used by hundreds of academics, scientists and pharma/biotech executives to gain insights into the new medicine development process.

You can purchase this book directly from the publisher, Oxford University Press, by clicking on the blue button below. Order your copy today and find out what you need to know. In particular, this book will help you to understand how new drug development is supposed to work.

I will provide the author discount code to all who sign up for a paid subscription to this Substack.

CLINICAL TRIALS

WHAT PATIENTS AND HEALTHY VOLUNTEERS NEED TO KNOW

LORNA SPEID, PhD

References

1. Mulangu, S., Dodd, L.E., & Davey, R.T., et. al. *A Randomized, Controlled Trial of Ebola Virus Disease Therapeutics,* N Engl J Med 2019;381:2293-303. DOI: 10.1056/NEJMoa1910993.
2. https://www.covid19treatmentguidelines.nih.gov/management/clinical-management/hospitalized-adults--therapeutic-management/
3. https://www.fema.gov/disaster/coronavirus/economic/funeral-assistance
4. Substack.com — The Uncensored Citizen. *To Paxlovid, or not to Paxlovid, that is the questi*on....
5. *The Real Anthony Fauci.* Robert F. Kennedy, Jr. New York Times Best Seller. Skyhorse Publishing. ISBN: 978-1-5107-6680-8.
6. *Clinical Trials: What Patients and Healthy Volunteers Need to Know.* Lorna Speid, Ph.D. Publisher: Oxford University Press. ISBN: 978-0-19-973416-0.

As always, you are encouraged to seek medical advice for your own personal situation. Whatever you read here, should not take the place of your own personal consultation with your qualified and competent medical advisors.

27 Likes

19 Comments

Write a comment...

Malach Jul 25, 2022 ♥ Liked by LORNA SPEID, PH.D.

It was not just those who "tested positive" either that were subjected to this hideous evil scheme. If a patient came in to the hospital who may have some semblance of one of the symptoms, they were immediately placed in the isolation units, some may have tested negative but were on 'rule out" status, sort of like guilty until proven innocent. These patients were never treated for what other medical conditions may have truly brought them to the hospital for such as heart disease or asthma. These patients were treated with the "protocol", not for their heart disease or diabetes. Many languished in isolation not just from their loved ones but from the staff on the units as well as the staff were told not to enter the rooms unless absolutely necessary. In all of my decades as a healthcare provider, I have never seen such malfeasance in my entire career. I quit practice in early 2021 rather than to be a silent participant in this evil.

LIKE (7) REPLY •••

2 replies by LORNA SPEID, PH.D. and others

jlakosman Jul 25, 2022 ♥ Liked by LORNA SPEID, PH.D.

My mother was a victim of these protocols. Luckily, because she's old world rig, she survived. However, she's not the same. Her voice has suffered due to intubation and she needed home care and extensive physical therapy for months after leaving hospital due to atrophy. She's also not the same mentally. She is afraid to be alone, easily agitated and has gaps in her long term memory that were not there before. She's not the same person and I want her back. These monsters must pay. As more of these details come out, I will certainly be searching out for legal advice to hold them to task.

LIKE (6) REPLY •••

2 replies by LORNA SPEID, PH.D. and others

17 more comments...

The Noble Lie is ....."Their Truth"

LORNA SPEID, PH.D.
FEB 18, 2022

We've all heard, *"How do you know a politician is lying?"* The answer is, *"Their lips are moving"*. That's right. Politicians lie. We have heard a lot of lies in the last two years, and they weren't only told by politicians.

In fact, it came as a shock to me, and perhaps to some of you, that those who oversee major institutions of public health and public policy, around the world lie. Then I began to hear about the concept of the *Noble Lie*.

It appears that in some quarters, it is acceptable to lie, as long as the lie that is told is *Noble*. What qualifies as a Noble Lie? A Noble Lie is a lie that keeps the Republic stable. This concept apparently started with Pluto. I will expand on this at some point in the future, but I want to cut to the chase and tell you what Noble Lies have been told over the last two years.

One of the best examples of a Noble Lie was told by Dr. Fauci when he stated that masks made at home were as good as surgical masks. Eventually he admitted that he had only stated this to prevent a run on the surgical masks, because they were needed for the hospitals. He felt a lie was justified, and so he lied.

What other lies have those in positions of authority told in the last two years? There are too many to count, but I am going to mention a few, as they relate to the experimental genetic injections. Feel free to add others that I have missed under comments.

Lie No. 1

The biggest lie is that the experimental genetic injections are like normal vaccines. This is a dangerous lie because most lay people really believe that this injection is similar to a flu vaccine or a vaccine given for Yellow Fever.

Truth

The technology used to develop this experimental injection is that of gene transfer. The injections are gene therapy.

Lie No. 2

The development program for these injections, that was shortened to 7 months, from 10-12 years, did not miss out any studies that are normally required for a therapeutic of this nature (vaccine or gene therapy).

Truth

Although we have not seen a detailed program of study for these injections, from what we have seen, it is clear that the these products were first of all, extremely poorly concieved. Then the development program was conducted to an extremely poor standard. Documented clinical trial fraud was overlooked by the FDA and other major regulatory authorities. It is factually correct to

state that the development programs for these gene therapy products missed out many of the steps and studies needed for a gene therapy. I will delve in this in detail in a future Substack post.

Lie No. 3

The experimental genetic injections are **safe and effective**.

Truth

The experimental genetic injections are **not safe** and they are **not effective**.

The **safety** of these injections is demonstrably **much** worse than any other vaccine in any of the databases that have been collecting data on a voluntary reporting basis (Yellow Card, VAERS, EUDRA). There is a characteristic increase in deaths and serious morbidities between days 0 to 5 in all of the voluntary reporting systems. Dr. Jessica Rose has demonstrated this in her analyses of the VAERS database. See her presentation here:

You will note that the CDC has never put out any similar analyzes, instead choosing to argue that the serious adverse reactions cannot be proven to be causally related. This is quite possibly another lie, but may be related more to incompetence than lying. I really believe the CDC have limited, and quite possibly, **no understanding of drug safety**.

The experimental genetic injections are not fit for purpose, and **are not effective** because:

1. They do not prevent infection with Sars-Cov-2 virus.

2. They do not stop the spread of the virus from one person to another.
3. The duration of the "effectiveness" is extremely short at 4-6 months. The manufacturers themselves argue for Boosters. They even state that an annual injection will be needed. How can this represent efficacy? It doesn't.
4. There is no properly conducted studies proving the truth of the propaganda statement that *the injections are preventing people from experiencing a serious form of COVID19*. A properly conducted randomized double blind study has never been carried out to demonstrate that this statement is true. Additionally, the efficacy claims from the original studies is suspect for a number of reasons, including the fact that the comparison to placebo in the original studies was not conducted for long enough. The placebo group might have been demonstrated to be better than or at least equal to the experimental group, in terms of efficacy, if the groups were studied for a longer duration. Additionally, the period of observation for safety (of 6 months after the second dose), was not long enough for a gene therapy that will produce the Spike Protein after administration for an indefinite period of time.
5. There is good reason to believe that the injections may induce the development of variants within the body.
6. There is good reason to believe that the injections themselves may cause the development of the COVID19 disease (antibody dependent disease).

Lie No. 4

The Boosters are safe.

Truth

The repeated administration of Booster doses would ultimately create a dependency in the immune system. They would then be susceptible to infections, and the development of auto immune diseases. They would also be at risk of iatrogenic disease caused by the experimental genetic injections. These illnesses are not insignificant, manifesting in many as traumatic life altering injuries. If the governments should ever refuse to pay for these injections, those without the funds to pay for them would eventually be without the means to maintain their immune system. The UK government has refused to continue to pay for tests, except for the elderly and the most vulnerable. The young and healthy will likely discover that their immune systems will have been wrecked for no apparent reason.

Lie No. 5

Sars-Cov-2 causes COVID19 is dangerous, and therefore we need to accept the collateral damage of these experimental genetic injections in some people, even the healthy.

Truth

The level of injury from the experimental genetic injections is not acceptable under any circumstances. A vaccine is supposed to undergo extensive testing and surpass a very high regulatory bar before approval. The reason is that vaccines are administered to healthy people. There can be no possible justification for the continued approval of an injection that is destroying the lives of so many around the world. This would be unacceptable for a vaccine, and it would even be unacceptable in a population with cancer, for which this gene transfer technology was developed. Medications have been withdrawn from the market for much less.

Lie No. 6

The experimental genetic injections are our best path out of the pandemic.

Truth

This is a lie. There are established, and much safer treatments available to treat patients early, to keep them out of hospital. Hospitals should be incentivised to make sure patients leave hospital alive. Currently, they are incentivised to amplify the deaths as credible whistleblowers have reported.

Lie No. 7

All deaths that we have seen over the last two years were due to COVID19.

Truth

If hospitals were incentivized to treat people effectively to ensure they live (instead of allowing them to die), the death statistics would go down dramatically.

The system of documenting how people die has been corrupted. When people are incentivized to lie, that is what they do. Death **with COVID19** and Death **from COVID19** are not the same. Without a detailed and thorough audit, we cannot know the true death statistics from **COVID19 alone**. Corrupting the system of collecting data by paying per death with an association with COVID19 will only further corrupt the data. Additionally, the lack of validated testing further means *rubbish in*, *rubbish out*.

Lie No. 8

The injuries that have occurred after the genetic injections are **rare**.

Truth

This is another blatant lie. There is nothing rare about the number of injuries. Those that are reported are traumatic and life altering, and that is for those who are fortunate enough not to die. Hospitals and their physician medical boards have placed pressure on physicians not to report what they are seeing on a daily basis. Most will not report or even acknowledge what they see, for fear of losing their medical licenses. These rates of deaths and injury are disturbingly common.

Lie No. 9

If you have a bad reaction from your "vaccination" that means it is working. You should go ahead and take the second dose as well.

Truth

This is a very dangerous lie. It has resulted in many deaths and serious and life altering injuries. When you have a bad reaction, this is your body's way of telling you that something dangerous to your life has been injected. Your body, including your immune system, is reacting to neutralize the harmful poison (at least to you) that was injected. When this occurs there is a clear reason to believe that the adverse or serious adverse event was related to the injection. It is not possible to remove the contents of the injection once they have entered your body after you were CHALLENGED. There is no way to DECHALLENGE, as such. If you then go ahead and take a second dose, this is now called a RECHALLENGE. Your body now goes into fight / flight mode.

You could find yourself fighting for your life as all sorts of cytokines and other inflammatory substances are released, to fight the poison. This reaction can lead to death or serious injuries.

This is the truthful advce that you should have been given. If you had a bad reaction with the first injection, **DO NOT TAKE THE SECOND INJECTION**. If you had a bad reaction with the second injection, **DO NOT TAKE A BOOSTER**, even if you are offered dinner with your favorite celebrity, and seats at the Oscars. This advice could save your life and certainly, your health.

Why do people believe the lies?

Over the last two years, people have been deliberately isolated and made to feel fear, like they have never felt it before. This loss of control causes PTSD in the general population. Mental illness and suicides are at an all time high. Self destructive behavior including drug taking are also at an all time high. People need to believe that those in authority mean well, and that they really are concerned about their best interests. If they are forced to face the fact that those in authority are not honest and do not care what happens to them as individuals, this could push many people over the edge. To protect themselves from being confronted with this truth, they shut out any arguments that would force them to confront the facts.

There is one lie they have not told

They have never said that they give a fig about what happens to any of us.

Crimes against humanity

The Noble Lie is **their truth**, but it is still a lie. Every time those in authority issue statements about the safety of these experimental genetic injections, they do so **knowing** that they are

unsafe. **They know** about the high number of formerly healthy people who have been seriously injured. **They know** about those who have died. **They know** about the children who have developed myocarditis, and seizures, and whose lives will never be the same. **They know.**

In the light of this, lies like *"The vaccines are safe and effective"*, *"The vaccines have been administered to x million people and we still believe that the benefits outweight the risks"*, *"Get your vaccination"*, *"Get Boosted"*, *"Take your child/baby for their COVID19 vaccination"*, are **a crime against humanity.**

1 Comment

Write a comment...

RiskTaker Feb 25, 2022 ♥ Liked by LORNA SPEID, PH.D.

Well said. Thank you for speaking TRUTH!

♡ LIKE (1) REPLY •••

This is what coercion looks like!

Babies should not be injected with an untested substance, and certainly not at the local Vons

LORNA SPEID, PH.D.
JUN 27, 2022

I received this Vons advert in my email inbox today. As many of you know, the FDA and the CDC have approved the EUA for babies as young as 6 months to be injected with the experimental gene-based injections. No other sophisticated health authority or public health authority around the world has done that.

This is what coercion looks like. Unfortunately, the same tactics will be used to promote the injections for babies, now that the CDC and FDA have approved the injections for 6 month old babies and upwards.

The clinical trials that were conducted in this age group (still can't believe anyone would sign their babies up for these clinical trials), were abysmal in design. I will provide a detailed analysis in a future Substack. Suffice it to say that they did not demonstrate efficacy in this age group. They did not demonstrate safety in this age group, because the children were not followed for any length of time.

The anticipate safety of the injections gives much cause for concern. We know what to expect, based on the safety profile in adults and the young. We know that the injections cause cardiac toxicity, neurological problems including seizures, Parkinsonism-like syndromes, cognition issues, fertility problems, and immune problems. We know that the injections are causally linked to sudden death syndromes, and that they are linked to an increase in all-cause-mortality.

Coercion

Coercion is any type of quid pro quo. In this case, coercive approaches are used to entice parents to bring their children to get them injected, and in return they will receive 10% discount off their grocery bill.

What's wrong with this? Plenty.

1. To start with, the local Vons is ill-equipped to deal with emergency situations that might arise if a child stops breathing, or starts fitting, yet, parents are being coerced into bringing their children to get 10% off their grocery bill. This is marketing at its worse. I plan to write to the CEO of Vons, and hope you will also write to him. These ads must be pulled.
2. The marketing department at Vons have created an advert to get the injections into as many children's arms as possible. They presume that all right thinking parents will say yes to their healthy children being injected, especially when they are offered 10% discount off their grocery bill.

What good is 10% discount off the grocery bill if the health of the child or children is forever destroyed, or if your child dies in their sleep after the injection?

Are you that parent?

Here is the question that we should all be asking ourselves. What type of parent would take their children to get this injection at all, and especially at the local Vons, while doing their shopping?

Vons, CDC, NIH, FDA, Pfizer and Moderna are hoping that there will be enough of this type of parent around, for the profits to start rolling in. Also, when the injections are added to the pediatric schedule, the manufacturers will be free of all liability. Then and only then, will the Emergency Use Authorization be cancelled and full approvals granted.

As always, you are encouraged to seek medical advice for your own personal situation. Whatever you read here, should not take the place of your own personal consultation with your qualified and competent medical advisors.

8 Likes

2 Comments

Write a comment...

Santini Fan Jun 27, 2022

Absolutely disgusting. WTF is wrong with people?

LIKE (1) REPLY •••

Dorothy Burton Jul 31, 2022

Dr Speid this is an excellent article. What right thinking person would want to have their baby injected with this vaccine?

LIKE REPLY •••

What will you be doing when you are 99 years old?

Children and the young are being taken advantage of

LORNA SPEID, PH.D.

APR 10, 2023

It is a privilege to live to the ripe old age of 99 years. Living to that age and also being relatively healthy is icing on the cake. If being healthy is icing on the cake, what is being a multi Billionnaire? Perhaps it is gold icing on the cake.

Well, let's say you live to 99, you are a multi-Billionnaire, you are in relatively good health, and many people hang on your every word, because you know how to make money..... what will you do?

I can tell you one thing I won't be doing, and that is using my money and considerable influence to design dormitories to house thousands of students, newly away from home. Not only won't I be designing dormitories for students who are a fraction of my ripe old age, but I wouldn't dream of designing dormitory bedrooms that have no windows whatsoever.

Why would anyone even conceive of such a thing? What sort of mind must one have to sit down and draw out architectural plans, and then decide students, newly away from home, must go to

bed in rooms that will not allow them to look out and see the moon, or the stars, or wake up with the sun streaming onto their faces?

Not only would these students have to spend at least a year in these poorly designed dormitories, but they would need to use the name of the person who foisted the design on them, every time they spoke about their dormitories.

What is so sickening is that the universities are falling over themselves to receive this money and the designs. Young people away from home for the first time, are extremely vulnerable. They are vulnerable to feelings of isolation, depression, and suicide. To compound that by forcing them into windowless spaces is immoral. It is unjust. Yet, it is yet another reminder of how unjust our society has become, particularly to its young.

Young children go to school because they want to learn to read and write, and do their sums. They go to school to socialize with friends, and learn social skills. School should not be a place of indoctrination, but education. Teachers should not look for ways to take advantage of vulnerable children, who may have had an unfortunate start in life, due to parents who are addicted to drugs, narcissistic, or just too busy keeping their social media profiles updated. All young children and young people, are extremely vulnerable to suggestion, sophisticated propaganda and indoctrination. Instead of helping children grow and thrive, an industry is growing up, fueled by the greed of a segment of pharma, to mutilate, sterilize, and destroy their lives. Once again, I have to ask when is someone from pharma, who has influence, going to stand up and say, **enough? This is wrong!**

The pharma industry has gone to great lengths to stop its drugs being used to put people to death. Yet, it is manufacturing and promoting drugs that have not been properly studied long-

term for young children and young people, who cannot vote, or legally drink alcohol.

So much of what we see around us is just plain immoral, including the following:

1. Ignorance of science that is inconvenient.
2. Indoctrination (instead of education) of children, teenagers and young adults.
3. Government agencies lying about the consequences of policies that they have been making and enforcing for 3 years.
4. Paying hospitals by the COVID death, instead of recoveries.

To the 99 year old, ***get over yourself***. If you want to design a dormitory for young people, ask them what they want. At 99 years old, you are way past the time to be designing any type of space for young people.

1 Like

4 Comments

Write a comment...

Dorothy Burton Apr 10 ♥ Liked by LORNA SPEID, PH.D.

Excellent points Dr Speid

♡ LIKE (1) REPLY ···

Christine Writes Christine's Newsletter Apr 10 ♥ Liked by LORNA SPEID, PH.D.

I am 76 now, my father died before he reached 76, my mother made 93 - I doubt I will live that long, but at least, when I do die, it won't be from these dreadful mRNA vaccines if I remain able to have any say in the matter.

Billionaire - money. Let me tell you something - I have been retired, more or less, these past 26 years and financially secure really, after late 2012 and money in the bank is just a number of zeroes with no meaning or purpose that I can see, so while I am comfortably secure and receive a small pension which covers most of my weekly outlay, the ideal situation is to be comfortably secure in your own home and want for nothing there and then everything external to your home and your life in it, is out of your sight or control and you don't need to partake in any of it - except perhaps here - which is what I do. No family, no one cares if I exist, live or die and i like it that way. I am. It is sufficient for me.

Zeroes in my bank, well yes, fortunately I do have a few, enough for me, but not too many - what is the point, when we eventually die, everything material is left behind, including those zeroes in a bank account - a pointless exercise in futility.

LIKE (1) REPLY •••

1 reply by LORNA SPEID, PH.D.

2 more comments...

Senator Ron Johnson's Panel - Very important

COVID19 Vaccines - call for them to be withdrawn

LORNA SPEID, PH.D.
DEC 9, 2022

I, like many others, am delighted that Senator Ron Johnson was re-elected. He has wasted no time in holding a panel of experts to discuss the COVID19 gene-based injections.

What are the qualifications to be on the Panel?

Experts must:

1. Be experts
2. Be able to articulate their message so that non experts can understand them
3. Have a high degree of integrity
4. Not be bought.

This is the link to the video, from Rumble.

https://rumble.com/v1ze4d0-covid-19-vaccines-what-they-are-how-they-work-and-possible-causes-of-injuri.html?utm_source=substack&utm_medium=email

copy to a browser.

Some discussion points from the Panel

1. The Openvaers.com database clearly shows safety signals. These safety signals are being ignored by the CDC and the FDA
2. The VSAFE database has over 10 million proactively registered recipients of the gene-based injections. The CDC was forced to share the safety data. These data show that the safety signals give much cause for concern. Well over 50% of those who received these injections experience serious safety outcomes.
3. Something is causing excess mortality data for the US population in the working age. These are individuals who are in excellent health. The only societal change is the introduction of the gene based injections.
4. The COVID19 gene-based injections were not tested sufficiently for a global roll- out.
5. The informed consent document placed in the gene-based injections, is left completely blank. Yes - blank. There is no writing on it at all. The document even states, "Left intentionally blank".
6. The pandemic was mis-managed by refusing to treat patients early. Effort was made by the CDC and FDA to sabotage any early stage treatments that could have changed the trajectory of the pandemic.
7. The FDA was co-opted by the pharmaceutical industry early in the pandemic, or at least the major companies that were seeking to market gene-based injections. Statements made by Dr. Marks (head of FDA for vaccines) were indications that the regulator was little more

than a promoter of the products made by the pharmaceutical industry. The independence of the regulator was and continues to be compromised.

For those of you who still have family members who are unaware of the true state of affairs, you can consider forwarding this video to them to watch. Please also consider forwarding my earlier Substacks to them to help them to get up to date on topics such as the safety of these products, or blatant lack thereof.

Comments

Write a comment...

The Noble Lie is ....."Their Truth"

LORNA SPEID, PH.D.
FEB 18, 2022

We've all heard, *"How do you know a politician is lying?"* The answer is, *"Their lips are moving"*. That's right. Politicians lie. We have heard a lot of lies in the last two years, and they weren't only told by politicians.

In fact, it came as a shock to me, and perhaps to some of you, that those who oversee major institutions of public health and public policy, around the world lie. Then I began to hear about the concept of the *Noble Lie*.

It appears that in some quarters, it is acceptable to lie, as long as the lie that is told is *Noble*. What qualifies as a Noble Lie? A Noble Lie is a lie that keeps the Republic stable. This concept apparently started with Pluto. I will expand on this at some point in the future, but I want to cut to the chase and tell you what Noble Lies have been told over the last two years.

One of the best examples of a Noble Lie was told by Dr. Fauci when he stated that masks made at home were as good as surgical masks. Eventually he admitted that he had only stated this to prevent a run on the surgical masks, because they were needed for the hospitals. He felt a lie was justified, and so he lied.

What other lies have those in positions of authority told in the last two years? There are too many to count, but I am going to mention a few, as they relate to the experimental genetic injections. Feel free to add others that I have missed under comments.

Lie No. 1

The biggest lie is that the experimental genetic injections are like normal vaccines. This is a dangerous lie because most lay people really believe that this injection is similar to a flu vaccine or a vaccine given for Yellow Fever.

Truth

The technology used to develop this experimental injection is that of gene transfer. The injections are gene therapy.

Lie No. 2

The development program for these injections, that was shortened to 7 months, from 10-12 years, did not miss out any studies that are normally required for a therapeutic of this nature (vaccine or gene therapy).

Truth

Although we have not seen a detailed program of study for these injections, from what we have seen, it is clear that the these products were first of all, extremely poorly concieved. Then the development program was conducted to an extremely poor standard. Documented clinical trial fraud was overlooked by the FDA and other major regulatory authorities. It is factually correct to

state that the development programs for these gene therapy products missed out many of the steps and studies needed for a gene therapy. I will delve in this in detail in a future Substack post.

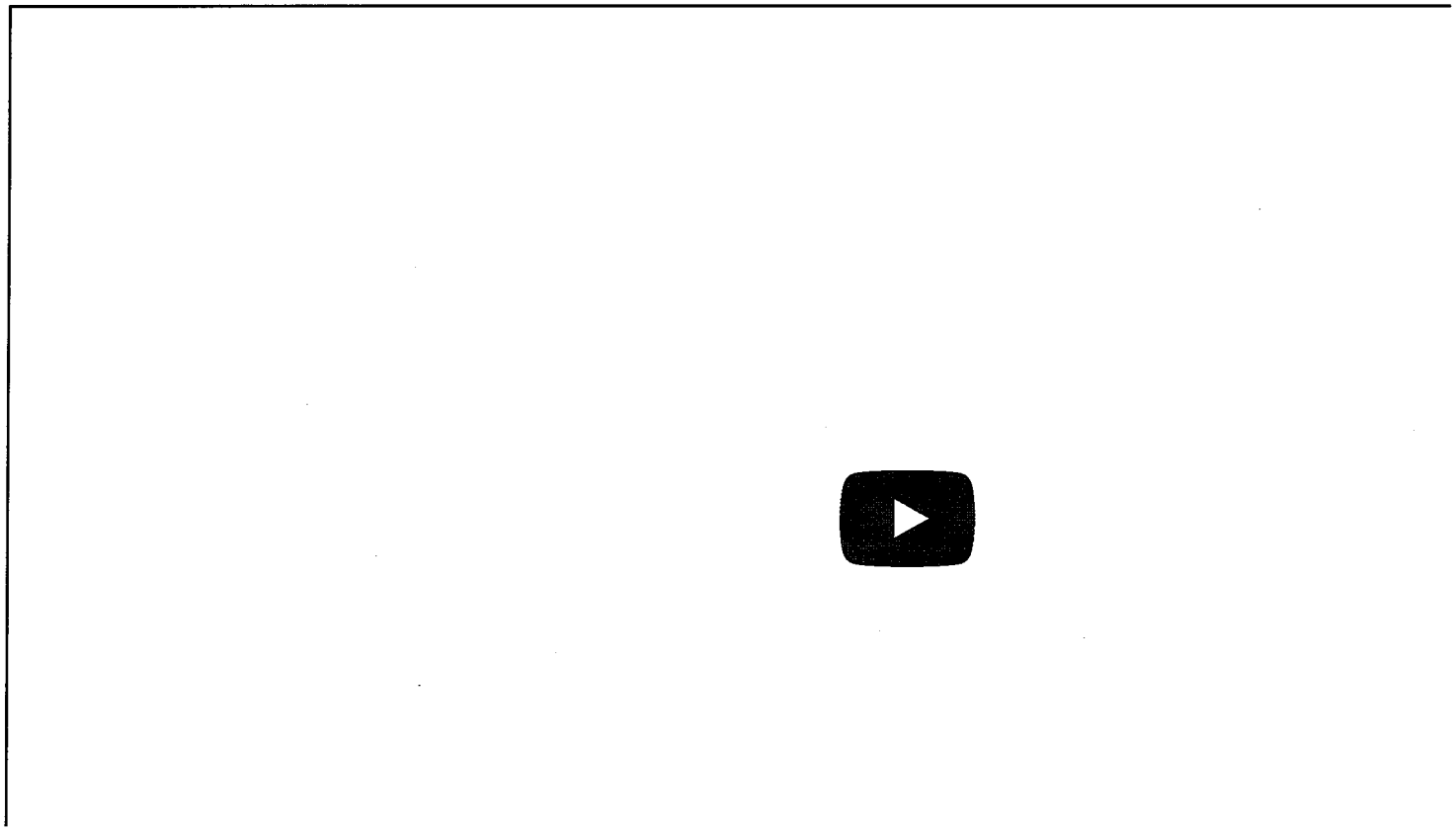
Lie No. 3

The experimental genetic injections are **safe and effective.**

Truth

The experimental genetic injections are **not safe** and they are **not effective.**

The **safety** of these injections is demonstrably **much** worse than any other vaccine in any of the databases that have been collecting data on a voluntary reporting basis (Yellow Card, VAERS, EUDRA). There is a characteristic increase in deaths and serious morbidities between days 0 to 5 in all of the voluntary reporting systems. Dr. Jessica Rose has demonstrated this in her analyses of the VAERS database. See her presentation here:



You will note that the CDC has never put out any similar analyzes, instead choosing to argue that the serious adverse reactions cannot be proven to be causally related. This is quite possibly another lie, but may be related more to incompetence than lying. I really believe the CDC have limited, and quite possibly, **no understanding of drug safety**.

The experimental genetic injections are not fit for purpose, and **are not effective** because:

1. They do not prevent infection with Sars-Cov-2 virus.

2. They do not stop the spread of the virus from one person to another.
3. The duration of the "effectiveness" is extremely short at 4-6 months. The manufacturers themselves argue for Boosters. They even state that an annual injection will be needed. How can this represent efficacy? It doesn't.
4. There is no properly conducted studies proving the truth of the propaganda statement that *the injections are preventing people from experiencing a serious form of COVID19*. A properly conducted randomized double blind study has never been carried out to demonstrate that this statement is true. Additionally, the efficacy claims from the original studies is suspect for a number of reasons, including the fact that the comparison to placebo in the original studies was not conducted for long enough. The placebo group might have been demonstrated to be better than or at least equal to the experimental group, in terms of efficacy, if the groups were studied for a longer duration. Additionally, the period of observation for safety (of 6 months after the second dose), was not long enough for a gene therapy that will produce the Spike Protein after administration for an indefinite period of time.
5. There is good reason to believe that the injections may induce the development of variants within the body.
6. There is good reason to believe that the injections themselves may cause the development of the COVID19 disease (antibody dependent disease).

Lie No. 4

The Boosters are safe.

Truth

The repeated administration of Booster doses would ultimately create a dependency in the immune system. They would then be susceptible to infections, and the development of auto immune diseases. They would also be at risk of iatrogenic disease caused by the experimental genetic injections. These illnesses are not insignificant, manifesting in many as traumatic life altering injuries. If the governments should ever refuse to pay for these injections, those without the funds to pay for them would eventually be without the means to maintain their immune system. The UK government has refused to continue to pay for tests, except for the elderly and the most vulnerable. The young and healthy will likely discover that their immune systems will have been wrecked for no apparent reason.

Lie No. 5

Sars-Cov-2 causes COVID19 is dangerous, and therefore we need to accept the collateral damage of these experimental genetic injections in some people, even the healthy.

Truth

The level of injury from the experimental genetic injections is not acceptable under any circumstances. A vaccine is supposed to undergo extensive testing and surpass a very high regulatory bar before approval. The reason is that vaccines are administered to healthy people. There can be no possible justification for the continued approval of an injection that is destroying the lives of so many around the world. This would be unacceptable for a vaccine, and it would even be unacceptable in a population with cancer, for which this gene transfer technology was developed. Medications have been withdrawn from the market for much less.

Lie No. 6

The experimental genetic injections are our best path out of the pandemic.

Truth

This is a lie. There are established, and much safer treatments available to treat patients early, to keep them out of hospital. Hospitals should be incentivised to make sure patients leave hospital alive. Currently, they are incentivised to amplify the deaths as credible whistleblowers have reported.

Lie No. 7

All deaths that we have seen over the last two years were due to COVID19.

Truth

If hospitals were incentivized to treat people effectively to ensure they live (instead of allowing them to die), the death statistics would go down dramatically.

The system of documenting how people die has been corrupted. When people are incentivized to lie, that is what they do. Death **with COVID19** and Death **from COVID19** are not the same. Without a detailed and thorough audit, we cannot know the true death statistics from **COVID19 alone**. Corrupting the system of collecting data by paying per death with an association with COVID19 will only further corrupt the data. Additionally, the lack of validated testing further means *rubbish in, rubbish out.*

Lie No. 8

The injuries that have occurred after the genetic injections are **rare.**

Truth

This is another blatant lie. There is nothing rare about the number of injuries. Those that are reported are traumatic and life altering, and that is for those who are fortunate enough not to die. Hospitals and their physician medical boards have placed pressure on physicians not to report what they are seeing on a daily basis. Most will not report or even acknowledge what they see, for fear of losing their medical licenses. These rates of deaths and injury are disturbingly common.

Lie No. 9

If you have a bad reaction from your "vaccination" that means it is working. You should go ahead and take the second dose as well.

Truth

This is a very dangerous lie. It has resulted in many deaths and serious and life altering injuries. When you have a bad reaction, this is your body's way of telling you that something dangerous to your life has been injected. Your body, including your immune system, is reacting to neutralize the harmful poison (at least to you) that was injected. When this occurs there is a clear reason to believe that the adverse or serious adverse event was related to the injection. It is not possible to remove the contents of the injection once they have entered your body after you were CHALLENGED. There is no way to DECHALLENGE, as such. If you then go ahead and take a second dose, this is now called a RECHALLENGE. Your body now goes into fight / flight mode.

You could find yourself fighting for your life as all sorts of cytokines and other inflammatory substances are released, to fight the poison. This reaction can lead to death or serious injuries.

This is the truthful advce that you should have been given. If you had a bad reaction with the first injection, **DO NOT TAKE THE SECOND INJECTION**. If you had a bad reaction with the second injection, **DO NOT TAKE A BOOSTER**, even if you are offered dinner with your favorite celebrity, and seats at the Oscars. This advice could save your life and certainly, your health.

Why do people believe the lies?

Over the last two years, people have been deliberately isolated and made to feel fear, like they have never felt it before. This loss of control causes PTSD in the general population. Mental illness and suicides are at an all time high. Self destructive behavior including drug taking are also at an all time high. People need to believe that those in authority mean well, and that they really are concerned about their best interests. If they are forced to face the fact that those in authority are not honest and do not care what happens to them as individuals, this could push many people over the edge. To protect themselves from being confronted with this truth, they shut out any arguments that would force them to confront the facts.

There is one lie they have not told

They have never said that they give a fig about what happens to any of us.

Crimes against humanity

The Noble Lie is **their truth**, but it is still a lie. Every time those in authority issue statements about the safety of these experimental genetic injections, they do so **knowing** that they are

unsafe. **They know** about the high number of formerly healthy people who have been seriously injured. **They know** about those who have died. **They know** about the children who have developed myocarditis, and seizures, and whose lives will never be the same. **They know.**

In the light of this, lies like *"The vaccines are safe and effective"*, *"The vaccines have been administered to x million people and we still believe that the benefits outweight the risks"*, *"Get your vaccination"*, *"Get Boosted"*, *"Take your child/baby for their COVID19 vaccination"*, are **a crime against humanity.**

1 Comment

Write a comment...

RiskTaker Feb 25, 2022 ♥ Liked by LORNA SPEID, PH.D.

Well said. Thank you for speaking TRUTH!

♡ LIKE (1) 💬 REPLY •••

Wisconsin Department of Safety and Professional Services
Division of Legal Services & Compliance
4822 Madison Yards Way
PO Box 7190
Madison WI 53707-7190
RETURN SERVICE REQUESTED

Email: dsps@wi.gov
Phone: 608-266-2112
Fax: 608-266-2264

Tony Evers, Governor
Dan Hereth, Secretary

September 21, 2023

LORNA SPEID
[redacted]

RE: Complaints # 23 MED 366, 23 MED 367, 23 MED 368 & 23 NUR 537

Dear Lorna Speid:

This letter is to inform you of the results of the complaints filed by you against David Beck, Ramana Marada, Gavin Shokar and Hollee McInnis.

The details of the complaint were reviewed and evaluated by a screening panel made up of members of the regulatory authority for the profession and/or a department attorney. Based on the review and evaluation of the complaint and other materials, a decision has been made that the information presented does not warrant further investigation.

The process of evaluating complaints is often difficult and complex, involving legal issues and professional or technical evaluation. While it may be disappointing to learn a decision has been made that your complaint will not be pursued further, we want to assure you that the decision was made only after serious consideration of the issues you raised. Your complaint will be retained on file for future reference.

Thank you for calling this matter to our attention. Information from the public is critical to the Department if we are to be made aware of potential violations of the law and the possible need for enforcement action.

We appreciate your patience as we considered this matter.

Sincerely,

Complaint Intake Unit
Dept. of Safety and Professional Services
Division of Legal Services and Compliance

Cramton, Beth - DSPS

From: Tessman, Lisa M - DSPS
Sent: Thursday, September 21, 2023 8:37 AM
To: jfranckowiak@otjen.com
Subject: Complaint Closed 23 NUR 537 - McInnis
Attachments: McInnis Closeout Letter - 23 NUR 537.pdf

Please see attached.

Lisa Tessman
Consumer Complaint Program Associate
Dept. of Safety and Professional Services
Division of Legal Services & Compliance
PO Box 7190 / Madison, WI 53707

Wisconsin Department of Safety and Professional Services
Division of Legal Services & Compliance
4822 Madison Yards Way
PO Box 7190
Madison WI 53707-7190
RETURN SERVICE REQUESTED

Email: dsps@wi.gov
Phone: 608-266-2112
Fax: 608-266-2264

Tony Evers, Governor
Dan Hereth, Secretary

September 21, 2023

JASON FRANCKOWIAK
OTJEN LAW FIRM, S.C.
20935 SWENSON DRIVE, SUITE 310
WAUKESHA WI 53186

RE: Complaint # 23 NUR 537

Dear Attorney Franckowiak:

This letter is to inform you of the results of the complaint filed against the professional license of your client, Hollee McInnis, by Lorna Speid.

The details of the complaint and other materials were reviewed and evaluated by a screening panel. Screening panels include members of the relevant profession and/or a department attorney. Based on their review and evaluation of the complaint, a decision has been made by the screening panel not to take any action based on this complaint.

Thank you for your patience as we considered this matter.

Sincerely,

Complaint Intake Unit
Dept. of Safety and Professional Services
Division of Legal Services and Compliance