Covid Related? *Choose one.* Complaint #: **23 MED 368**

Screening Date(s): **9/19/2023** Type: **Screening** Atty Screener: **Peich Kiesling**

Screening panel members (if applicable): **Chou, Gerlach**

Screening Date(s): *Enter/select date* Type: *Choose one* Atty Screener: *Click to enter text*

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

Closed w/o Investigation on: **9/19/2023** 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: *Click to enter text*

Case Summary

Case Number	Status	Track	Priority	Team
23 MED 368	Complaint Received		Death of patient	

Screening Code	Screening Description	Bypass Code	Bypass Description

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

Respondent(s)	Credential Number	Attorney(s)	XRef Cases ?
Shokar, Gavin S	73805-20 (Active) (Medicine and Surgery, MD)	Guse, Randall	Yes

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
07/28/2023	Case Number Assigned on
07/28/2023	Scrng Records & Resp Req
07/28/2023	CaseStatus Email Sent to Complainant.
08/24/2023	Ready to Screen

Case Note(s)	Text
Intake Description 07/28/2023	Respondent allegedly labeled the patient as DNR and overdosed her on morphine.
General Note 08/08/2023	Granted 2-wk extension to R's Atty.
General Note 08/24/2023	timely response rec'd, ready for screening.

WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

CREDENTIAL HISTORY REPORT

LICENSE NO.	PROFESSION	STATUS	GRANT DATE	RENEWAL BY DATE
73805-020	MEDICINE AND SURGERY	ACTIVE	07/29/2020	10/31/2023

NAME: GAVIN S. SHOKAR

ADDRESS: [redacted]

DOB: [redacted]

OPT OUT Y

HISTORY EVENTS BY DATE

DATE	EVENT TYPE	COMMENTS	FJ
01/23/2022	ENDORSEMENT SENT	Illinois Dept of Financial & Professional Regulation	N
07/29/2020	LICENSEGRANTED	License granted.	N
07/29/2020	FROMAPPLICATIONMETHODINFORMATION	Application 722781 by method OLAS-MED-ENDORSEMENT	N
05/26/2020	ENDORSEDFROM	Endorsed from USMLE	N
03/31/2012	GRADUATEDFROM	Graduated from Ross University School of Medicine	N

RESPONDENT CROSS-REFERENCE REPORT
Gavin S. Shokar

Complaint Number: 23 MED 368 **License # & Reg Type:** 73805-20 Medicine and Surgery, MD

Respondent Status: Complaint Received

Case Categories:

Intake Description: Respondent allegedly labeled the patient as DNR and overdosed her on morphine.

Code/Statute Cite:

Case Status: Complaint Received 7/26/2023

Closing Reason/Description:

Case Associates:

Complaint Number: 23 MED 166 **License # & Reg Type:** 73805-20 Medicine and Surgery, MD

Respondent Status: Opened for Investigation

Case Categories: Negligence/Incompetence,Unprofessional conduct

Intake Description: OIG Referral: Patient was admitted for Anemia/blood loss, did not meet the inpatient criteria and lab work was not monitored appropriately. R allegedly engaged in practices that do not meet the standards of practice, federal regulations or both.

Code/Statute Cite: MED 10.03(2)(b)

Case Status: Open for Investigation 5/18/2023

Closing Reason/Description:

Case Associates:

Brandee Godfrey	Investigator
Colleen Meloy	Attorney
Angela Slaney	Paralegal
Emily S. Yu	Case Advisor

Complaint Number: 21 MED 509 **License # & Reg Type:** 73805-20 Medicine and Surgery, MD

Respondent Status: Closed at Screening

Case Categories:

Intake Description: Respondent allegedly labeled the patient as DNR and overdosed her on morphine.

Code/Statute Cite:

Case Status: Closed 1/18/2022

Closing Reason/Description: Case closed w/o Investigation

Case Associates:

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 : 2023018537

Created Date : 7/26/2023 12:58:00 PM

Complaint Category : Health

Profession : Medicine & Surgery, Doctor of Medicine (MD),

Complaint filed by: DR LORNA [Middle Name] SPEID		
Address: [redacted]		
County: [redacted]	City: [redacted]	State: [redacted]
Zip Code: 92130	Email Address: [redacted]	
Primary Phone # : [redacted]	Secondary Phone # : [Secondary Phone Number]	

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: [Patient First Name] [Patient Middle Name] [Patient Last Name]		
Address: [Patient Contact Information]		
Is Patient Deceased? [IsPatientDeased]	Patient Date of Birth [Patient Date Of Birth]	Patient Date of Death [Patient Date of Death]

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:		
GAVIN	S.	SHOKAR
Address: St Elizabeth Hospital		
County: UNKNOWN	City: UNKNOWN	State: Wisconsin
Zip Code: 54915	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 when the patient succumbed to the errors, negligence and incompetence of DR SHOKAR.

---

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.

The [redacted] family has made many concerted efforts to resolve this matter, with a view to protecting other patients in the care of this physician.

---

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]
[redacted] cellphone for [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. [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 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 further amplified by the addition of Lorazepam, and then Morphine was administered to cause her death, which occurred quickly after the second Morphine dose, although I must stress that the first dose was enough to kill Ms. [redacted]. The second dose was administered to assure her death.

In closing, Dr. Shokar is not a competent or trustworthy physician and should not be treating patients. His deliberate falsification of the death certificate to state that the patient died from natural causes, and secondary to COVID19 infection, instead of as a result of the deliberate administration of Morphine at a lethal dose, and in a way that could only bring about the patient's death, denotes a dishonesty and lack of integrity that disqualifies him from being licensed to practice medicine.

Furthermore, Dr. Gavin Shokar is not a physician who should continue to be licensed to provide medical care to patients, supervised or unsupervised. He is a danger to every patient whose care he is placed in charge of. In fact, it is appalling that he has still continued to practice after causing the death of Ms. [redacted] on 13 October 2021. It is high time that this situation is rectified, and Dr. Shokar's license is revoked.

Water and Tear Resistant

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

CERTIFIED MAIL

7022 2410 0002 9205 0781

Retail

53707

RDC 01

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

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: Shokar Complaint

PRIORITY MAIL

TRACKED INSURED

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 DR. GAVIN SHOKAR, A PHYSICIAN LICENSED BY WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

Dear Mr. Hereth

RE: GAVIN SHOKAR, MD

Formal Complaint against Dr. Gavin Shokar Regarding Gross Incompetence, Gross Negligence, Medical Malpractice, Dishonesty and Deliberate Cause of 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. Consequently, I am filing this formal complaint against Dr. Gavin Shokar, a Physician who is licensed to practice medicine by the Wisconsin Department of Safety and Professional Services.

His credential and license details are as follows:

Name: SHOKAR, GAVIN S

Profession: MEDICINE AND SURGERY (20)

Credential/License Number: 73805-20

Location: MENASHA WI

Credential License Type: Regular

Status: License is current (Active)

Eligible to practice: credential license is current

Credential/License current through: 10/31/2023

Granted date: 7/29/20

Multi-state: N

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. Whilst I reviewed the medical notes for all the Physicians and the Nurses involved in the care of [redacted] Dr. Shokar's role was indisputable in that he was instrumental in causing the death of Ms. [redacted] on the 13 October 2021. In fact, there were aspects of his role that caused great concern.

Dr. Shokar's actions lay him open to the charge that he deliberately caused the death of Ms. [redacted] In the process of doing that, the degree and level of cruelty that Ms. [redacted] was subjected to was extraordinary, and repugnant. I do not make this claim lightly, and will explain the evidence for the charge. It is my understanding that criminal charges are being considered, and in my very carefully considered view, they are warranted.

Dr. Shokar is a danger to every patient whose care he oversees or is a party to. It is worrying that he is still directly involved in the care of other patients. This situation needs to be addressed as a matter of extreme urgency, hence this complaint. In bringing this complaint, I have consulted the standards referenced by the licensing body. Unfortunately, the written standards for physicians are not very detailed, unlike the standards for Registered Nurses. Nevertheless, I am assured, based on the standards normally set for professionals involved in the care of patients, that Dr. Shokar falls far short of normal standards for physicians as well as those set by your body (Table 1).

Table 1: Standards Set by the Licensing Board for Physicians

Section	Statement from the section	How satisfied by Dr. Shokar
Chapter Med 10 Professional Conduct 2	Physicians act with a high level of independence and responsibility, often in emergencies. Every physician represents the medical profession in the community and must do so in a manner worthy of the trust bestowed upon the physician and the profession. The minimally competent practice of medicine and surgery require that care of the patient is paramount. Physicians must therefore act with honesty, respect for the law, reasonable judgment, competence, and respect for patient boundaries.	Dr. Shokar did not act in a manner worthy of the trust placed in him by the [redacted] family. He sought to deceive the family in his discussions. They were many, and sought to instill panic and fear. In the meantime, he twisted their directions not to intubate the patient, and added *DO NOT RESUSCITATE* into the notes as well. He knew that they would not have agreed to this. Then he prescribed lethal doses of Morphine. He then called the family in a panic as the patient was dying, but did not administer NARCAN to reverse the Morphine overdose. After the patient's death, he lied on the death certificate to indicate the patient died from COVID19/natural causes. She did not. She died from the

Section	Statement from the section	How satisfied by Dr. Shokar
		Morphine overdose he had prescribed, together with the other drugs he prescribed, and oversaw the administration of from 12 October 2021 (when he took over her care) to 13 October 2021, when he took over her care. The patient was recovering when he took over her care on 12 October 2021. Within hours of his being in charge of her care, she was dead. Her death was avoidable, and on the balance of probabilities, deliberate. Dr. Shokar did not act with honesty, respect for the law, reasonable judgment, competence, or respect for patient boundaries.
Med 10.03 Unprofessional Conduct	(e) Knowingly, negligently, or recklessly making any false statement, written or oral, in the practice of medicine and surgery which creates an unacceptable risk of harm to a patient, the public, or both.	Dr. Shokar knowingly, negligently and recklessly made false statements to the [redacted] family. He knowingly, negligently and recklessly falsified the medical notes after the patient death to try to obscure the true cause of death. He knowingly, negligently and recklessly falsified the medical records to insert DO NOT RESUSCITATE for a vulnerable patient, without the written and unequivocable consent of her parents / guardians.
2	(b) Departing from or failing to conform to the standard of minimally competent medical practice which creates an unacceptable risk of harm to a patient or the public whether or not the act or omission resulted in actual harm to any person.	Dr. Shokar departed from and failed to meet the normal standards of a competent physician. His medical practice falls far short of that of a competent physician. This created an unacceptable risk for the patient who was unfortunately left in his care on 12 October 2021. The patient died the day after he took over her care. There is good reason to believe his actions were deliberate because the probability that one physician could make all these mistakes and errors, accidently, is low. All reasonable physicians would know that the

Section	Statement from the section	How satisfied by Dr. Shokar
		actions Dr. Shokar took would lead to the death of the patient.
	(c) Prescribing, ordering, dispensing, administering, supplying, selling, giving, or obtaining any prescription medication in any manner that is inconsistent with the standard of minimal competence.	Dr. Shokar's prescribing was extremely poor. He told the [redacted] family that he administered/prescribed Morphine to slow her heart rate. Nurse McInnis claims in the notes she administered it for pain. Morphine is not administered to slow the heart rate EVER, and should NOT be administered to a patient who has never been administered it before, unless there is an intention to kill that patient. Nurse McInnis administered Morphine twice in a short period of time, and then refused to administer NARCAN because Dr. Shokar had written *DO NOT RESUSCITATE* into the medical notes.
	(j) Performing an act constituting the practice of medicine and surgery without required informed consent under s. 448.30, Stats.	Ms. [redacted] was not able to give informed consent. She had Down Syndrome. Dr. Shokar did not obtain informed consent for the medicines he administered to Ms. [redacted] He knew they were not going to agree to him administering a substance to kill her. They were careful not to allow him to place her on a ventilator, which Dr. Shokar was pressuring them to do, **<u>because of the high risk of death</u>**. The evidence points to Dr. Shokar's intention to take actions to kill this patient, from the start of taking over her care.
Chapter Med 18 Informed Consent		
	Med 18.03 Informed consent. Any physician who treats a patient shall inform the patient about the availability of reasonable alternate medical modes of treatment and about the benefits and risks of these treatments. The reasonable physician standard is the standard for informing a patient. The reasonable physician standard requires disclosure only of information that a reasonable	Ms. [redacted] was unable to give informed consent. Dr. Shokar did not obtain informed consent to insert *DO NOT RESUSCITATE* into the medical notes. Within hours of inserting *DO NOT RESUSCITATE* he prescribed Morphine PRN, for a patient who had never had more than Acetaminophen for pain. There is little to no indication of pain in the medical notes. She was not being treated for cancer pain. She was not at the end of life. She was

Section	Statement from the section	How satisfied by Dr. Shokar
	physician in the same or a similar medical specialty would know and disclose under the circumstances.	not on palliative care. The family had never agreed to this. He prescribed Morphine, knowing that it would bring about her death.

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, Dr. Shokar 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 his medical license that Dr. Shokar caused the death of Ms. [redacted] a vulnerable patient.

Prima Facie Evidence of Collusion to Cause the Death of Ms. [redacted]

I respectfully allege that Dr. Shokar and Nurse McInnis collaborated to bring about the deliberate death of Ms. [redacted] a young woman with Down Syndrome, who was entrusted to their care on 12 October 2021, when Dr. Baum left for his vacation. When a physician is so incompetent that he prescribes inappropriately so that his mistakes could kill patients, Pharmacists and Nurses are supposed to act as a buffer to protect patients. In this case, clearly the function of Pharmacy in the hospital was not working as it should have. Nurse McInnis is the subject of a separate formal complaint regarding this case. Clearly the nursing staff in this hospital were not acting to protect the patient in their care.

It is reasonable to presume that on the 13 October 2021, circumstances conspired to allow an incompetent physician and an incompetent nurse to both be on duty at the same time. However, because all nurses, and physicians know that the administration of Morphine to a patient in respiratory distress, will kill the patient, it is reasonable to presume they colluded to bring about the patient's death.

In the same way, there were a number of physicians who colluded with Dr. Shokar after the death of the patient to augment the patient records to paint a different picture to what actually happened. The fact is that Ms. [redacted] was doing well, despite all the prescribing mistakes, and then Dr. Shokar took over her care on the 12 October 2021, and she died within 48 hours after that, as a result of a catalogue of deliberate actions evidently designed to bring about her death.

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 respiratory distress syndrome secondary to infection with Sars-Cov-2, to be able to survive the combination of drugs that Dr. Shokar prescribed recklessly, and deliberately. Ms. McInnis administered Morphine twice, and Lorazepam twice, while Dexmedetomidine was still in Ms. [redacted] system. By so doing, at the very least, there is a case 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.

Review of Other Deaths is Urgently Required

I strongly urge that all the medical records for any patient(s) who died while under the care of Dr. Shokar should be examined. During the COVID19 crisis, he would have had much opportunity to bring about the death of many patients, with impunity.

The Format of this Complaint

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

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.

Cover Letter
Background Document - Formal Complaint Against Dr. Shokar
- Appendix 1: Complaint Form from the website
- Appendix 2: Dr. Lorna Speid's Curriculum vitae
- Appendix 3: Chronology of Events
- Appendix 4: Medicines Prescribed by Dr. Shokar
- Appendix 5: Contraindications and Drug-Drug Interactions
- Appendix 6: Morphine Prescription and the Death of Ms. [redacted]
- 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 Dr. Shokar, a physician your body has licensed, who is not meeting the standards that your body has set for licensed physicians.

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

1. Dr. Shokar took over the care of Ms. [redacted] on the 12 of October 2021, when Dr. Baum left for his vacation.
2. Up to that time, Ms. [redacted] had been making a recovery from a relatively mild case of Sars-Cov-2 infection, as evidenced by the call by Dr. Baum to the family to inform them of this.
3. I can verify that Ms. [redacted] laboratory and other data show that she was making a recovery from a mild case of Sars-Cov-2 infection, despite the very poor prescribing of drugs like Dexmedetomidine (Precedex) and Lorazepam, drugs that should not be administered to patients in respiratory distress. These drugs were depressing her respiration and ability to oxygenate her blood. This poor prescribing involved a number of physicians. However, none of those other physicians prescribed Morphine.
4. It was Dr. Shokar's prescribing of Morphine that ultimately killed the patient. This was such an egregious act, in a patient with respiratory distress, and no prior exposure to Morphine, that it could not have been done by accident. It was done deliberately to bring about her death, and as such was a criminal act of homicide.

5. The prescription of Morphine, in addition to many doses of Dexmedetomidine (Precedex) and Lorazepam, in the same timeframe, would serve to severely depress the patient's respiration and effectively suffocate her.
6. Upon taking over Ms. [redacted] care, Dr. Shokar sought to manipulate the parents, who were Ms. [redacted] guardians. She had Down Syndrome, and could not give informed consent. He deliberately sought to conflate terminology regarding intubation and resuscitation.
7. After finishing the telephone call with the patients at about 8 am on 13 October 2021, Dr. Shokar inserted *Do Not Resuscitate* into the medical notes without their knowledge and consent. On the same day he prescribed a lethal dose of Morphine, and told Ms. McInnis, RN, to give it "NOW". She then gave the dose of Morphine at 1830 hours and gave another dose of Morphine at 1845 hours. By so doing, they colluded together to cause Ms. [redacted] death. After the two doses of Morphine were administered, the patient died very quickly. The last dose of Morphine was administered at 1845 hours, and the patient was dead at 1927 hours (i.e. within 45 minutes).
8. Dr. Shokar called the family in a panic, but did not remove *Do Not Resuscitate* from the medical notes, and did not advise the nurses to administer Narcan, which would have reversed the opiate overdose.
9. In the best-case scenario, Dr. Shokar lacks the understanding of the proper use of medicines. However, given the egregious nature of the errors he made, on the balance of probabilities, it is more likely that he acted deliberately to cause the death of this patient.
10. A careful review of the medical notes provides evidence that after the patient's death, Dr. Shokar colluded with nurses and physicians involved in the prior care of the patient to adjust the medical records. They sought to give the impression that the patient's death was caused by COVID19, and was inevitable, which it was not. A discovery process will hopefully uncover the extent of this conspiracy.
11. Dr. Shokar falsified the death certificate, claiming that Ms. [redacted] died from natural causes/COVID19, instead of from a Morphine overdose. (**Appendix 6**).
12. Dr. Shokar shows a blatant disregard for the regulations and ethics of informed consent, particularly as these relate to vulnerable patients.
13. Dr. Shokar oversaw the administration of Dexmedetomidine (Precedex), prescription of 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.
14. Dr. Shokar's refusal to administer Narcan after realizing the impact of his actions, raises the question on whether this was a deliberate and therefore criminal act.
15. The care of patients should not be entrusted to Dr. Shokar
16. The Wisconsin Board of Licensing for Physicians should remove Dr. Shokar from the Physician's Register as a matter of extreme urgency.

Conclusion

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 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 further amplified by the addition of Lorazepam, and then Morphine was administered to cause her death, which occurred quickly after the second Morphine dose, although I must stress that the first dose was enough to kill Ms. [redacted] The second dose was administered to assure her death.

In closing, Dr. Shokar is not a **competent** or **trustworthy** physician and should not be treating patients. His **deliberate falsification** of the death certificate to state that the patient died from natural causes, and secondary to COVID19 infection, instead of as a result of the deliberate administration of Morphine at a lethal dose, and in a way that could only bring about the patient's death, denotes a **dishonesty** and **lack of integrity** that disqualifies him from being licensed to practice medicine.

Furthermore, Dr. Gavin Shokar is not a physician who should continue to be licensed to provide medical care to patients, supervised or unsupervised. He is a **danger** to every patient whose care he is placed in charge of. In fact, it is appalling that he has still continued to practice after causing the death of Ms. [redacted] on 13 October 2021. It is high time that this situation is rectified, and Dr. Shokar's license is revoked.

The form has been completed and is appended in Appendix 1.

Yours sincerely

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

References

1. Chapter Med 10 Professional Conduct
2. Med 10.03 Unprofessional Conduct
3. Chapter Med 18 Informed Consent

Formal Complaint against Gavin Shokar, MD

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

Background to this Formal Complaint

Subject: Gavin Shokar MD

This formal complaint is being filed against Dr. Shokar because he caused the death of a young vulnerable patient. Ms. [redacted] death was directly caused by the prescription of Morphine, and failure to correct the overdose that resulted. As evidenced by his gross incompetence, recklessness, and dishonesty, as I shall outline in this Background section, with Appendices, Dr. Shokar is a danger to patients entrusted into his care. The online complaint form is enclosed in **Appendix 1**. Ms. [redacted] medical records are available upon request.

Urgent action is required to protect patients; his license to practice medicine should immediately be revoked. The level to which his action arises is greater than incompetence, recklessness, and malpractice. I feel it appropriate and necessary to allege that Ms. [redacted] death on 13 October 2021 was deliberate, and that it was, indeed, a premeditated homicide.

The series of actions that Dr. Shokar took after taking over the care of Ms. [redacted] up to some-time after her death in the falsification of the death certificate, and the augmentation of the medical records to give the impression that the patient died from COVID19, and not from the Morphine he prescribed, are reprehensible actions in a Physician. On the balance of probability, and on the basis of what a reasonable physician would have known and done, I feel it reasonable to contend that Dr. Shokar prescribed Morphine, and colluded with a senior Nurse Ms. McInnis, in its administration with full knowledge that it would bring about the death of Ms. [redacted]

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 what sounded like a relatively 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 was 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 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.

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. 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 Dr. Shokar, throughout her hospital stay. 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 term *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 Dr. Shokar question the prescription of Dexmedetomidine (Precedex), or Lorazepam that she had been placed on immediately she was admitted. Instead, he amplified this poor prescribing, overseeing the increasing frequency of administration of these drugs that were making her agitated, and depressing her ability to breath and oxygenate her blood. He oversaw the administration of 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 the same as her baseline level (151 mg/dL).

I will focus my attention on three drugs that were administered in the 7 days, and that were absolutely contraindicated or inappropriate 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. Morphine was prescribed by Dr. Shokar, not by any other physician, and it was this drug that killed her, as any reasonable physician would expect it to.

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)**

Reference: Dexmedetomidine (Precedex) product label

Dexmedetomidine should not have been administered to Ms. [redacted] because she was not intubated and mechanically ventilated, or undergoing a surgical procedure. See the extract of Indications above. The product 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. As a sedative, it would reduce her capacity to breath and therefore oxygenate her blood. Dr. Shokar failed to stop the administration of this drug when he took over her care.

---------- **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)**

Reference: Dexmedetomidine (Precedex) product label

As indicated in the ADVERSE REACTIONS section of the product label, on more than one occasion when the Dexmedetomidine (Precedex) medicine was administered it caused Ms. [redacted] to become agitated and anxious, Ms. [redacted] was forcefully strapped to the bed on Dr. Shokar's watch, although the reason for this should be investigated. He claimed she was agitated. The sister had been made to leave the room to go home to take a shower. Ms. [redacted] was once again left without an advocate and it was at this time that she was strapped to the bed, like in a 1940s mental asylum. Presuming she was agitated, and her sister said she was not when she left the room, Dexmedetomidine (Precedex) was what was causing the agitation and anxiety. The physicians and nurses either did not understand the drug they were administering, or did not care.

---------- 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)

Reference: Dexmedetomidine (Precedex) product label

Another area of concern with Dexmedetoomidine is the development of tolerance. The product develops 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. Dr. Shokar was causing Ms. [redacted] body to develop tolerance to a drug dangerous to her, and was 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 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.

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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.

Reference: Dexmedetomidine (Precedex) product label

Lorazepam

Lorazepam was prescribed and administered on many occasions during Ms. [redacted] stay. It should not be administered to patients in respiratory distress (REF 2). It also interacts with Dexmedetomidine (Precedex), potentiating the depressor effect on respiration (**Appendix 5**). Dr. Shokar failed to realize and address this interaction.

Morphine

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] Nurses are supposed to address errors of prescribing with physicians. On this occasion, it appears that Ms. McInnis and Dr. Shokar may have colluded to bring about this patient's death.

Why should collusion be seriously considered? It is so unusual for two healthcare professionals to not realize that a Morphine injection push, administered twice, would cause death. Because this aspect of use of medicines is so well known, this makes the likelihood of two professions being ignorant of this, highly unlikely. It is more reasonable to believe that they colluded to bring about the death of this patient, than that they were unaware that giving Morphine, at all, and twice in a short space of time, would kill a patient already in respiratory distress.

The strong case against Dr. Gavin Shokar

Dr. Shokar played a pivotal role in the care of Ms. [redacted] after Dr. Baum left for his vacation on 11 October. Within hours of taking over the patient's care on 12 October 2021, Ms. [redacted] was dead; her death was a direct consequence of the actions and decisions Dr. Shokar took in those intervening hours.

Nurse McInnis took over the nursing care around the 12 of October 2021, and overlapped with Dr. Shokar. It was the overlap of these two individuals that probably ensured that the outcome would be adverse for Ms. [redacted] Unfortunately, the other nurses who took care of Ms. [redacted] were also suboptimal in their performance and competence. Nevertheless, it was Ms. McInnis who, instead of questioning Dr. Shokar's prescription of Morphine, administered it – not once, but twice, at 1830 hours, and again at 1845 hours.

Dr. Shokar has a lot to answer for. Besides lacking the knowledge about the safe and appropriate use of medicines, Dr. Shokar evidently also lacks honesty and integrity. His refusal to take responsibility for his actions makes him a danger to all patients unfortunate enough to be placed in his care. He conducts himself in a cavalier and reckless manner.

Furthermore, a careful and forensic review of Ms. [redacted] medical notes has led me to the unfortunate conclusion that Dr. Shokar set out to deliberately harm Ms. [redacted] This may seem far-fetched because Physicians are human, and they make mistakes. If we assume that the catalogue of errors was due to mistakes and misjudgments on his part, we still have to be concerned about the number of errors occurring in a short space of time.

Dr. Baum had called Mrs. [redacted] Mother, on 11 October and told her that her daughter's blood work had *"improved across the board"*. Immediately Dr. Shokar took over care, the reports to the family were negative and, in my personal view, deliberately traumatizing, and coercive. Remember, Dr. Baum's report to the family just a few hours before. She was expected to go home, and indeed they had been making preparations to take her home. I can confirm after reviewing all the laboratory data, that throughout the hospital stay, Ms. [redacted] laboratory results were normal and were good despite the dangerous prescribing she had endured, even up to the point of administration of Morphine.

Again, even if we give Dr. Shokar the benefit of the doubt, and presume he made a mistake in prescribing a push of Morphine, that could only bring about death of a patient, but especially one in a hospital for respiratory distress syndrome secondary to Sars-Cov-2 infection, his conduct and the events leading up to Ms. [redacted] death, and his behavior after Ms. [redacted] death tell a very different story.

Dexmedetomidine (Precedex) is completely contraindicated in a patient in respiratory distress, yet he continued its use. Furthermore, the patient was being administered Lorazepam, and that was also contraindicated in this patient (**Appendix 5**). Together, Dexmedetomidine (Precedex), and Lorazepam were depressing the patient's ability to breath, and would together kill the patient.

Coercive Behavior

Dr, Shokar consistently and persistently tried to coerce Ms. [redacted] parents into allowing him to put their daughter on a ventilator, allowing him to make the call when he felt it was appropriate. His argument was *"these things tend to happen late at night, when there is no one around"*. The family resisted his argument and coercion. Their preliminary research had revealed that Ms. [redacted] would likely not survive the ventilator, especially in the hands of nursing and physician staff, who were evidently not very skilled in normal patient care, much less care usually reserved for intensive care units.

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

Medication Review from time Dr. Shokar took over the patient's care

Please also see **Appendix 4.**

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.	

Dr. Shokar started pressuring and coercing the family immediately he took over the care of the patient.

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 POC, 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

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 NEEDED PER DR SHOKAR'S CONVERSATION WITH MOTHER.

Note Type	**Description**
No Type	NONE

You will note that Nurse McInnis wrote in the notes that the parents were asked by Dr. Shokar to provide clarification. The "clarification" required is not clear, but likely related to ventilation of [redacted] This clarification was not given. He did not have the informed consent to make those types of decisions on his own. There are regulations for assuring informed consent especially for patients who cannot give informed consent themselves. There is no record that the authorization was given to insert *Do Not Resuscitate* into the medical notes. As we will see later, Dr. Shokar inserted *Do Not Resuscitate* into the medical notes, and then prescribed Morphine shortly thereafter. This is proof of pre-medication.

In Dr. Shokar's own notes, he states the following:

> "I had a discussion with the family over the phone for roughly half an hour to an hour in regards to code 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."

The timing of this notation being added into the computer system by dictation should be verified by a forensic computer specialist. It is possible that this was added after the patient died.

Regardless of when these notes were dictated, I want those assessing his professional competence to note that he should have known that Dexmedetomidine (Precedex) and Lorazepam were impeding the patient's ability to breath and to oxygenate her blood. His *"In the meantime and hopefully, we will continue care with the goal of improvement."* Is extraordinary, given his prescribing was **impeding** her improvement.

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		

Note the patient's respiration was being depressed with Dexmedetomidine (Precedex). The patient had already been on this drug since admission, and it is supposed to be administered for a maximum of 24 hours (**Appendix 5**). This drug is subject to tachyphylaxis – the dose loses its effect, and we see that the drug was being administered frequently. The drug also causes agitation, and the patient was showing this side effect. Dr. Shokar failed to realize why the patient was showing agitation.

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[1] *This term was not discussed, and we now know it meant labeling* [redacted] *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;* [redacted] *had good days on October 12 and 13, according to our calls with the doctor and our bedside experience.*

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. Dr. Shokar failed to make this connection.

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

The poor prescribing caused the oxygen saturation to drop. Dr. Shokar failed to understand the ramifications of the prescribing he was overseeing.

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, another nurse (SHAIN002) administered Dexmedetomidine (Precedex). Less than an hour later, Ms. McInnis administered it again. The reason she gave was that the patient was not tolerating the prone position! Dexmedetomidine (Precedex) is not indicated for patient proning. Dr. Shokar failed to understand the impact of the frequency of administration of Dexmedetomidine (Precedex) on the patient's respiration. The patient's condition was worsening as a direct result of his medical practice.

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.	

Again, the patient is administered Dexmedetomidine (Precedex). Remember, the drug should not be administered to patients in respiratory distress, which this patient clearly was, as a result of the administration of this drug. Dr. Shokar did not stop this drug, to allow the patient to recover. Even if the drug were stopped, it could remain in the body system for approximately 2-6 hours.

Ms. McInnis administered Dexmedetomidine (Precedex) again in 30 minute's time, at 0730 hours.

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, she administered the drug again, at 0754 hours.

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.	

According to Dr. Shokar's directions, Ms. McInnis continued to administer the drug at a frequency not in the product label and not authorized in 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 [redacted], TO RETURN CALL.

Note Type	**Description**
No Type	NONE

The patient was clearly becoming worse as a result of the appalling prescribing and drug administration. Dr. Shokar called Ms. [redacted] father, [redacted] Shokar, but failed to stop the administration of the drugs that were making the patient worse.

Ms. McInnis again administered Dexmedetomidine (Precedex) at 1048 hours.

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		

Again, Nurse McInnis administered Dexmedetomidine (Precedex) at 1837. She is clearly under the supervision of Dr. Shokar, because she makes a note to that fact.

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.	

Date: 13 October 2021; **Time:** 1700

Dr. Shokar prescribed Insulin. Ms. [redacted] Glucose level was 151, but it was within the range of what had been observed for her over the last few days

A Glucose level was taken for her on 16 April 2021 and it was 84. The more recent baseline on 6 October 2021 was 152. Other levels are shown in the Table below.

Date	**Glucose level**
6 October 2021	152
7 October 2021	138
8 October 2021	151
9 October 2021	123
10 October	123
11 October 2021	116

Date	Glucose level
12 October 2021	119
13 October 2021	174,101,151

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 (Appendix 4). Dr. Shokar did not take into account the pharmacokinetic / pharmacodynamic profile of the drug. The interaction of Lorazepam with Dexmedetomidine (Precedex) augmented the degree of respiratory depression experienced by Ms. [redacted] **(Appendix 5).**

	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 (see below). The drug she had administered caused the respiratory distress.

	Date	Time	By	Nurse Type	
Occurred:	10/13/21	1750	BJM MCINNIS,HOLLEE	RN	**Category**
Recorded:	10/13/21	1751	BJM 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**).

Reference: 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, and overseen by Dr. Shokar.

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

	Date	Time	By	Nurse Type	Category
Occurred:	10/13/21	1755	RJM MCINNIS,HOLLEE	RN	
Recorded:	10/13/21	1756	RJM MCINNIS,HOLLEE	RN	NURSING NOTES

Abnormal? N **Confidential?** N

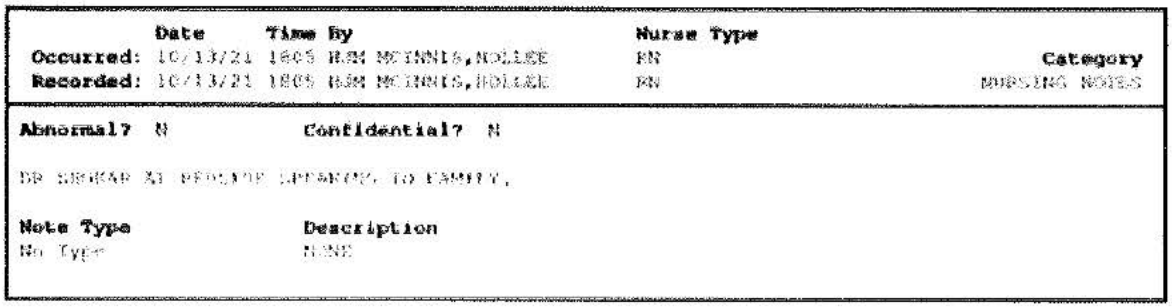
PT SISTER AT BEDSIDE AND FATHER ON FACETIME UPDATED ON O2 SAT DROP TO 40'S. 2 DIFFERENT O2 PROBES TESTED AND O2 SAT CONFIRMED. STAT ABG ORDERED BY [illegible]. OFFERING PT COMFORT.

Note Type No Type

Description NONE

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 BJM MCINNIS,NOLLEE	RN	Category
Recorded:	10/13/21	1805 BJM MCINNIS,NOLLEE	RN	NURSING NOTES

Abnormal? N Confidential? N

DR SHOKAR AT PATIENT BEDSIDE SPEAKING TO FAMILY.

Note Type	Description
No Type	NONE

Lethal Dose of Morphine Administered

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, and it was administered by Ms. McInnis immediately, as written.

Morphine was administered at 1831. From Ms. McInnis' notes it is clear that Morphine was administered more than once, just as Ms. McInnis 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 hours. 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 was 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

Statement from the family:

> *"I (Mr [redacted]) asked him about the screen reporting [redacted] at 80 oxygen saturation the entire time [redacted] had been in the room (many hours), that afternoon. He responded that there had been another machine malfunction. I asked about a staff who would let this happen without any alarm bells going off. If [redacted] O2 sat had truly remained at 80 for several hours, her organs would have started shutting down. Did that actually happen? If so, it would explain a lot."*

> *Statement from family: He said [redacted] had a good day but that had just ordered 2 mg of morphine because she was breathing at 51 breaths per minute. Thirty minutes after the call with Dr. Shokar [redacted] called me on Facetime panicking. [redacted] heart rate and blood pressure were plummeting. I told her to call the nurses in. [redacted] was gone a minute or two later. We screamed at the nurses (through the phone) to use a reversal drug. They said [redacted] was labeled 'DNR.' I pleaded that this status wasn't true. It was all over. We watched our precious daughter die on Facetime, without being able to hug her and say goodbye.*

The morphine product label [see below] clearly contraindicates Morphine in patients with respiratory depression. By Ms. McInnis and Dr. Shokar's own admission in their notes, she had severe respiratory depression, yet they still gave her Morphine, knowing was inappropriate.

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**)

Reference Label: Morphine Product Label

The patient was pronounced dead shortly after the administration of Morphine. Ms. McInnis refused to help to resuscitate Ms. [redacted] despite being begged to do so by the family, who were on Facetime.

	Date	Time	By		Nurse Type		
Occurred:	10/13/21	1927	JC	CASTRO,JORIZZA	RN		Category
Recorded:	10/13/21	2323	JC	CASTRO,JORIZZA	RN		NURSING NOTES

Abnormal? N **Confidential?** N

No apical pulse, respirations, or blood preasure. 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	Category
Occurred:	10/13/21	1927	CP	PAGELS,SARAH	RN	
Recorded:	10/13/21	2338	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	Category
Occurred:	10/13/21	1927	JC	CASTRO,JORIZZA	RN	
Recorded:	10/13/21	2131	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	Category
Occurred:	10/13/21	2320	JC	CASTRO,JORIZZA	RN	
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

Drug Drug Interactions

The patient had been administered Dexmedetomidine (Precedex). Dexmedetomidine (Precedex) is not supposed to be administered to patients in respiratory distress. The oxygen saturation was falling because of the administration of a drug that was suppressing breathing (**Appendix 5**). 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 made a full recovered.

Prescription of a Lethal Dose of Morphine

Any physician, even the most junior, should have known that Morphine would kill anyone that it was administered to in the way that he prescribed it to be administered, and especially in a patient in respiratory distress, recovering from Sars-Cov-2 infection. Addition of Morphine to Dexemedetomidine (Precedex) and Lorazepam, further depressed the patient's ability to breath, effectively suffocating her. He should have known that Morphine would kill the patient, and especially on top of the other two drugs he oversaw the administration of.

The Patient was malnourished

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

When Ms. [redacted] was seen in ER she was noted to be well-nourished (**Appendix 4**). The medical notes made by Dr. Shokar, likely after the death, indicates clearly that the patient was malnourished. Yet, Ms. [redacted] had a central port and could easily have been administered Total Parental Nutrition. She was not able to eat because the nurses and physicians would not allow her father or sister to feed her. Her father was feeding her when he was in the room with her, and she was eating. After he was forcefully removed from 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. Had Total Parenteral Nutrition been administered, with proper drug treatment, Ms. [redacted] would have recovered.

	Date	Time By	Nurse Type	
Occurred:	10/13/21	1134 RJM MCINNIS,HOLLEE	RN	**Category**
Recorded:	10/13/21	1137 RJM 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 BIPAP 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:	10/13/21	1358 RJM MCINNIS,HOLLEE	RN	**Category**
Recorded:	10/13/21	1359 RJM MCINNIS,HOLLEE	RN	NURSING NOTES

Abnormal? N **Confidential?** N

FEEDING TUBE CONFIRMED IN PLACE, TUBE FEEDING STARTED. ATTENDED BEDSIDE BY, 2 RN'S, UNSUCCESSFUL X/1 PT CHASING NEAR. CXR'S IN PLACE.

Note Type	**Description**
No Type	NONE

Dr. Shokar does not appear to have realized that it was his responsibility to ensure Ms. [redacted] was adequately nourishment.

Dr. Shokar Neglected Ms. [redacted] Right to Informed Consent

Although Ms. [redacted] cannot give consent to any medicines, the only person who could was removed from her room by an armed guard on 10 October 2021. Ms. [redacted] was made to watch as her beloved father was forced to leave her bedside. At no time did Dr. Shokar take steps to ensure the family were fully aware of the effect of the toxic and lethal drugs he was prescribing for their daughter. Deceptive discussions do not count.

Treatment of the [redacted] Family

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 Dr. Shokar and the nurses. They despised the independence of Mr. [redacted] and his family.

When Dr. Shokar inserted *Do Not Resuscitate* into Ms. [redacted] medical notes on 13 October 2021, he failed to take into account the rules regarding insertion of Do Not Resuscitate into the medical notes.

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] [redacted] sister, watched 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 over and over, 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, separately, and especially in combination.

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)

State of Wisconsin

Department of Safety and Professional Services

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

COMPLAINT FORM

Complaint ID:2023018537
Created Date:7/26/2023 12:58:57 PM
Complaint Category: Health
Profession: Medicine & Surgery, Doctor of Medicine (MD),

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]

LICENSEE THE COMPLAINT IS AGAINST

LICENSEE -1

First Name	Middle Name	Last Name
GAVIN	S.	SHOKAR

Address	City	State
St Elizabeth Hospital	UNKNOWN	Wisconsin

Zip Code	County	E-Mail
54915	UNKNOWN	

Primary Phone	Secondary Phone

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

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 when the patient succumbed to the errors, negligence and incompetence of DR SHOKAR.

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.

The [redacted] family has made many concerted efforts to resolve this matter, with a view to protecting other patients in the care of this physician.

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]. [redacted] - cellphone for Mr. [redacted]

6. Describe the incident. Include as much specific information as possible.
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 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 further amplified by the addition of Lorazepam, and then Morphine was administered to cause her death, which occurred quickly after the second Morphine dose, although I must stress that the first dose was enough to kill Ms. [redacted] The second dose was administered to assure her death. In closing, Dr. Shokar is not a competent or trustworthy physician and should not be treating patients. His deliberate falsification of the death certificate to state that the patient died from natural causes, and secondary to COVID19 infection, instead of as a result of the deliberate administration of Morphine at a lethal dose, and in a way that could only bring about the patient's death, denotes a dishonesty and lack of integrity that disqualifies him from being licensed to practice medicine. Furthermore, Dr. Gavin Shokar is not a physician who should continue to be licensed to provide medical care to patients, supervised or unsupervised. He is a danger to every patient whose care he is placed in charge of. In fact, it is appalling that he has still continued to practice after causing the death of Ms. [redacted] on 13 October 2021. It is high time that this situation is rectified, and Dr. Shokar's license is revoked.

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 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]

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.

Same 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 Way 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 [redacted]
13 October 2021 0800 hours	Dr. Shokar called and spoke to [redacted] 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[5] once again[6] as well as feeding options they have. They had deliberated yesterday after our conversation and decided for a DNI[7] 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.**[8] 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)	

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

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

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

[8] *This was all hypothetical; [redacted] 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.

HMCINNIS WROTE "GLUCOSE: 151 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</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 1830 hours, and again at 1845 hours.</td><td>There is no evidence in the medical notes that Ms. [redacted] was experiencing pain, and certainly not pain requiring Morphine. When ACETAMINOPHEN was administered on 8 October, it was administered</td></tr>
</table>

Date	Event	Comment
		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

Medicines Prescribed by Dr. Gavin Shokar

Dr. Shokar's prescribing can be seen in the following tables

There are three sets of Tables:

Table 1: Presents prescribing by several physicians, including Dr. Shokar.
Table 2: Presents prescribing by Dr. Shokar.
Table 3: Extracts Dr. Shokar's statements from the medical notes with commentary.

Table 1: Prescribing by Dr. Shokar and other Physicians (7 October 2021 to 13 October 2021)

Prescriber	Nurse	Drug	Dose	How given?	Date	Time	Reason	Comments
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	

Prescriber	Nurse	Drug	Dose	How given?	Date	Time	Reason	Comments
					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 RAMANA 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 RAMANA 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		

Prescriber	Nurse	Drug	Dose	How given?	Date	Time	Reason	Comments
	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 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		

Prescriber	Nurse	Drug	Dose	How given?	Date	Time	Reason	Comments
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 CCBEDTIME (SCH)	START 10/13/2021	1700 hours	MCINNIS WROTE *"GLUCOSE: 151 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		

	Prescriber	Nurse	Drug	Dose	How given?	Date	Time	Reason	Comments
						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 1. RATE CHANGED TO .7.	10/7/2021	2220 hours		

Prescriber	Nurse	Drug	Dose	How given?	Date	Time	Reason	Comments
				NEEDED TO QUICKLY REDUCE DOSE R/T OVERSEDATION. PATIENT'S BP DROPPED TO A MAP<65 AND O2 SATURATION WAS DECREASING.				
	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 RAMANA R MARADA	AMIDD011		RATE 500 ML/HR	TOTAL VOLUME 500 MLS SIG ONCE.	10/8/2021	1200 hours		
					STOP 10/08/2021 1259 hours			
	AMIDD011			VOLUME GIVEN 500 MLS	10/8/2021	1210 hours		

Prescriber	Nurse	Drug	Dose	How given?	Date	Time	Reason	Comments
	AMIDD011			DOSE RATE CH. CURRENT RATE .6. RATE CHANGED TO .5.	10/8/2021	1320 hours		
	AMIDD011			DOSE RATE CH. CURRENT RATE .3. RATE CHANGED 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	10/10/2021	2000 hours		

Prescriber	Nurse	Drug	Dose	How given?	Date	Time	Reason	Comments
				CHANGED TO 0.2.				
	MPAFF001		104 MLS	DOSE RATE CH. CURRENT RATE .2.	10/10/2021	2341 hours		
***	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 CHANGED TO 0.5.	10/11/2021	2131 hours	RESTLESS, DESAT	

Prescriber	Nurse	Drug	Dose	How given?	Date	Time	Reason	Comments
	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 RATE .5. RATE CHANGED TO 0.6.	10/12/2021	0830hours	RR 40's, GTT INCREASED FOR COMFORT IN BREATHING	
	MCINNIS		104 MLS	CURRENT RATE .7.	10/12/2021	1501 hours		
	SHAIN002		104 MLS	DOSE RATE CH. CURRENT RATE .7. RATE CHANGED TO 0.8.	10/13/2021	0000 hours		

Prescriber	Nurse	Drug	Dose	How given?	Date	Time	Reason	Comments
	SHAIN002		104 MLS	DOSE RATE CH. CURRENT RATE .8. RATE CHANGED TO 0.9.	10/13/2021	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. LEONARD			TOTAL VOLUME 260 MLS. DURATION: TITRATE. TOTAL DISPENSED BAGS 3		10/13/2021	0815 hours		
						DC 10/13/2021 - 1927 hours		

Prescriber	Nurse	Drug	Dose	How given?	Date	Time	Reason	Comments
	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 10/132 027	
DR DAVID BECK								
	AMIDD011			1000 MLS		10/8/2021	0846 hours	
	EMFISHER1			1000 MLS		10/9/2021	2226 hours	

Prescriber	Nurse	Drug	Dose	How given?	Date	Time	Reason	Comments
	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	1015 hours	
						DC 10/13/2021 - 1927 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	

Prescriber	Nurse	Drug	Dose	How given?	Date	Time	Reason	Comments
	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. RAMANA MARADA								
DR. RAMANA MARADA		**DOPAMINE 400 MG/250 D5W 400 MG250 ML BAG - 250 ML**		IV - DURATION TITRATE		10/8/2021	1700 hours start	
						DC 10/13/2021 1927 hours		
	AMIDD011		VOLUME GIVEN 250 MLS	Site infusing: Central Line. Current rate: 2. Rate changed to START.		10/8/2021	1708 hours	

Prescriber	Nurse	Drug	Dose	How given?	Date	Time	Reason	Comments
	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	

Prescriber	Nurse	Drug	Dose	How given?	Date	Time	Reason	Comments
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. RAMANA MARADA		LIDOCAINE 1% INJ. 20 ML VIAL	DISP PRN			10/8/2021	1238 hours	
						DC 10/9/2021 1639 hours		
DR. RAMANA MARADA								
DR. DANIEL P. LEONARD		0.9% SODIUM CHLORIDE 10 ML VIAL	TOTAL VOLUME 10 MLS RATE: AS DIRECTED DURATION: AS DIRECTED	IV		10/10/2021	0824 hours	

Prescriber	Nurse	Drug	Dose	How given?	Date	Time	Reason	Comments
						DC: 10/11/2021-0855 hours		

Table 2: Dr. Shokar's Prescribing only

	PHYSICIAN who prescribed drug	NURSE who administered it	DRUG	DOSE	DOSING INSTRUCTIONS	DATE	TIME	REASON FOR THE PRESCRIPTION
	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	
		HMCINNIS			1,500 ML	10/13/2021	1338 hours	
	DR GAVIN SHOKAR		CREON 12 (PANCREALI PASE) 1 CAP	PRN	1 CAP (1 CAPSULE PER DOSE) ROUTE TF	START 10/13/2021	1315 hours start	UNCLOG TUBE
	DR. GAVIN SHOKAR		SODIUM BICARBONA TE 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 CCBEDTIME (SCH)	START 10/13/2021	1700 hours	HMCINNIS WROTE *"GLUCOSE: 151 DATE 10/13/2021 TIME 1656 hours."*
		HMCINNIS				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	
		HMCINNIS			**DOSE GIVEN "2 EACH"**	ADMIN DATE: 10/13/2021	1815 hours	

Table 3: Dr. Shokar's Care of Ms. [redacted] from 12 October 2021 to 13 October 2021

Date in Medical Notes	Document Reference consulted	Summary Statement for the Complaint	Statements from medical notes	Comments in notes	Dr. Speid's Expert Commentary
10/13/2021		Dr. Shokar lists time of death as 7:27 pm on 10/13/2021.			
			Primary Diagnoses:		At no time does he indicate that the reason for the death was the inappropriate administration of Morphine.
			1. Acute respiratory failure with hypoxia		
			2. Acute COVID-19 infection with pneumonia.		
			SECONDARY DIAGNOSES		
			1. Malnutrition		
			2. Obstructive sleep apnea		
			3. High functioning Down syndrome		

Date in Medical Notes	Document Reference consulted	Summary Statement for the Complaint	Statements from medical notes	Comments in notes	Dr. Speid's Expert Commentary
			Dexamethasone	*"She received dexamethasone unfortunately deteriorated requiring BiPAP level support."*	Again, there is no mention of the administration of Morphine.
					Dr. Shokar claims [redacted] was receiving dexamethasone managing for several days but "unfortunately deteriorated requiring BiPAP level support." This is not true, [redacted] was improving. Virtually all of her chemistry, blood and other statistics showed that she was improving.

Date in Medical Notes	Document Reference consulted	Summary Statement for the Complaint	Statements from medical notes	Comments in notes	Dr. Speid's Expert Commentary
			She "had a significant amount of agitation" and that he prescribed Precedex to treat that agitation.	"Agitation requiring a Precedex drip"	Dr. Speid's observation. Precedex causes agitation. Dr. Shokar was giving a drug to stop what it was causing. No competent physician would prescribe Precedex to reduce a patient's agitation, when it is known to cause agitation!

Date in Medical Notes	Document Reference consulted	Summary Statement for the Complaint	Statements from medical notes	Comments in notes	Dr. Speid's Expert Commentary
					Dr. Speid's observation. Instead of ordering Total Parenteral Nutrition, Dr. Shokar put [redacted] through tremendous pain and distress and he installed a gastric tube. The Total Parenteral Nutrition would have been much more appropriate in this situation. [redacted] would not have been malnourished, and she would have received all the necessary nutrients at the appropriate levels, presuming the hospital has proper TPN support from the Pharmacy.

Date in Medical Notes	Document Reference consulted	Summary Statement for the Complaint	Statements from medical notes	Comments in notes	Dr. Speid's Expert Commentary
			"Unfortunately, on 10/13/2021, she developed sudden and significant hypotension and bradycardia after being on high levels of BiPAP pressures for few days. She deteriorated and passed away at 7:27 pm."		This statement is a blatant lie. [redacted] was killed by the administration of Morphine, and died quickly afterwards. Dr. Shokar tried to cover his mistake. He had also inserted DNR into her medical records without her patients consent, and so the nurses refused to administer NARCAN, which would have saved her life.

Date in Medical Notes	Document Reference consulted	Summary Statement for the Complaint	Statements from medical notes	Comments in notes	Dr. Speid's Expert Commentary
			"Throughout hospitalization, infectious Disease and pulmonary/critical care were involved with her care."		Dr. Shokar tries to give the impression that he was not the only Physician involved with the oversight of [redacted] care. However, he was the only Physician who prescribed Morphine, which killed her, and he is the only Physician who thought it was appropriate to prescribe Precedex that causes agitation, to treat what he thought was agitation. [redacted] was in an unfamiliar environment and what he perceived as agitation, even strapping her to the bed before her death, was simply normal fear in a young woman, who had never been away from her family who loved her dearly. On the day she died, her sister was not permitted to take a shower in the bathroom, and in the hour that her sister went home to take a shower and return, her sister had been strapped down, and shortly afterwards, she would be administered Morphine according

Date in Medical Notes	Document Reference consulted	Summary Statement for the Complaint	Statements from medical notes	Comments in notes	Dr. Speid's Expert Commentary
					to Dr. Shokar's prescription, and this is what killed [redacted] not COVID19. [redacted] was improving despite the atrocious care that she received in the hospital from Dr. Shokar and his team. In spite of the suboptimal care she was making improvement.

Date in Medical Notes	Document Reference consulted	Summary Statement for the Complaint	Statements from medical notes	Comments in notes	Dr. Speid's Expert Commentary
			"Unfortunately since she started developing malnutrition as she had not eaten well and given the high BiPAP requirements, a nasogastric small-bore tube was placed to assist with that."		Why was TPN not administered? Instead Dr. Shokar put [redacted] through the worst distress imaginable to input a nasogastric tube. The nasogastric feed was poorly constituted as evidenced by the high Glucose levels.
			"There were multiple discussions with family in regards to her plan of care and considerations for goals of care and worst case scenario. She was transitioned to a DNR/DNI. "		In the treatment of COVID19, as in the treatment of any disease, it is important to have discussions with family. In [redacted] case, she had to have appropriate documentation in place because she was unable to give informed consent herself. To imply that these multiple discussions were onerous, or that he went above and beyond, is highly inappropriate.

Date in Medical Notes	Document Reference consulted	Summary Statement for the Complaint	Statements from medical notes	Comments in notes	Dr. Speid's Expert Commentary
10/12/2021		After this morning's assessment, the patient's oxygenation saturations have deteriorated requiring increasing BiPAP settings 100% FiO2, yet still her oxygenation was in the low 80s.			The drugs that were being administered caused this deterioration.
		Respiratory adjusted the settings of 20/15, which did improve her oxygenation to the high 80s to low 90s.			
		Initially discussed with [redacted] the patient's mother in regard to goals of care in regard to worst case scenario if she was requiring intubation and she deferred me to her husband, [redacted]			
		I had called [redacted] and had a family conference with him and his children in regard to worst case scenario if the BiPAP at max settings was ineffective for. Initially we discussed positional changes such as proning and affect as well as multiple other questions were answered to the best of my ability.			

Date in Medical Notes	Document Reference consulted	Summary Statement for the Complaint	Statements from medical notes	Comments in notes	Dr. Speid's Expert Commentary
		We went over scenarios in regard to intubation versus leaving her on BiPAPP in the situation of hypoxia versus comfort care.			
		We spent over 60 minutes during this conference to answer all questions that were posed and counseled as best as possible to the unfortunate situation.			What unfortunate situation?
		Family will convene to decide by tomorrow morning;			Decide what?
		However, I did implore the importance of deciding as early as possible given her deterioration throughout the day.			What deterioration?
		We are hoping that she does improve gradually on BiPAPP and is able to wean down some from the use of max settings that were placed this am; however, we do need a direct answer in regards if she needs intubation, if we should intibate as well as on resuscitation.			The family did not authorize a Do not resuscitate. They authorized do not intubate - i.e. no ventilator to be used.

Date in Medical Notes	Document Reference consulted	Summary Statement for the Complaint	Statements from medical notes	Comments in notes	Dr. Speid's Expert Commentary
		I did discuss with them in regard to cardiac arrest in the context of respiratory arrest or respiratory distress and the futility of CPR compressions, defibrillation if we are not going to intubate and in someone who has underlying lung disease and ongoing hypoxia. It seems that all parties understood what was discussed. Again, they will reconvene ith an answer shortly.			
		ELECTRONICALLY SIGNED INSERT DATE and Time			
		Addendum to job #1013-0156			
		CRITICAL CARE TIME SPENT			
		40 minutes in direct care with the patient minimum as well as 30-45 minutes in discussion with family and another 15 minutes in chart review.			
		JOB ID 1064368			
		Trans R1			
		Dict 10/19/21 1728			
		Tran 10/19/21 1745			
		ELECTRONICALLY SIGNED INSERT GAVIN SHOKAR MD 10/21/21 1857			
		INSERT from 10/13 re SHORTNESS OF BREATH			
10/13/2021	Report No. 1013-0156	CHIEF COMPLAINT			

Date In Medical Notes	Document Reference consulted	Summary Statement for the Complaint	Statements from medical notes	Comments in notes	Dr. Speid's Expert Commentary
		Shortness of breath.			It is my belief that many of the comments were written retrospectively after the death of the patient. A forensic computer expert should review the hospital computer dictation and medical record system.
		SUBJECTIVE			
		The patient was doing well on same settings of BiPAP this am of 20/15 at 100% FiO2.			
		She was unable to wean to 90% as she does desaturate to about 80s.			
		She had an episode where she got agitated after being assisted to stool and her Precedex was increased to help control agitation as she is starting to try to pull out a PICC and remove the mask.			PRECEDEX causes Agitation. He increased the dose of the drug that was making [redacted] agitated. Dr. SHOKAR increased the dose of PRECEDEX because he said she was agitated.

Date in Medical Notes	Document Reference consulted	Summary Statement for the Complaint	Statements from medical notes	Comments in notes	Dr. Speid's Expert Commentary
		She required restraints by the time of interview ith the goal to remove the restraints as soon as possible.			The agony of this to [redacted] is difficult to imagine. She had only been surrounded with love from her family, and friends, and to suddenly find herself in this situation, not knowing why she felt the way she did and to suddenly be restrained. The agony is dificult to imagine. Her sister had not been permitted to shower in the room.
		I had a discussion with the family over the phone for roughly half an hour to an hour in regards to code status once again as well as feeding options they have.			
		They had deliberated yesterday after our conversation and decided for a DNI status. We did discuss in regards to CPR resuscitation and the futility of doing CPR in the situation in regards to DNI and they agreed in regards to not pursuing a resuscitation via CPR or defibrillation.			

Date in Medical Notes	Document Reference consulted	Summary Statement for the Complaint	Statements from medical notes	Comments in notes	Dr. Speid's Expert Commentary
		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 and with the goal of improvement.			[redacted] was not a psychiatric patient on a psychiatric ward. Restraining her for no good reason was outrageous. Research use of restraints in psychiatric wards. I am confident that this would not have occurred had she not had Down Syndrome.
		The patient was seen and examined at bedside today. She again was in restraints as above, relatively nonverbal as she was a bit more sedated with PRECEDEX as she was yesterday.			
		Her sister was bedside. All questions were answered.			
		OBJECTIVE:			
		VITAL SIGNS:			
		Temperature: 101.4			
		Pulse 93			
		Respiratory rate 41			
		Blood pressure 127/82			

Date in Medical Notes	Document Reference consulted	Summary Statement for the Complaint	Statements from medical notes	Comments in notes	Dr. Speid's Expert Commentary
		Oxygen saturation 82% on 100% FiO2 per charting; however she was 88% to 92% in room on assessment.			
		LABORATORY DATA			
		WBC 14			
		Neutrophil percentage 95%			
		Lymphocyte percentage 5%			
		Sodium 140			
		Potassium 4.2			
		Chloride 108			
		BUN 16			
	TO CARL	Creatinine 0.67			
		AST 34			
		ALT 22			
		LDH 909			
		CRP 10.4			
		Albumin 2.7			

Date in Medical Notes	Document Reference consulted	Summary Statement for the Complaint	Statements from medical notes	Comments in notes	Dr. Speid's Expert Commentary
		D-Dimer significant elevation to 23,657			D – Dimer result indicates she was recovering.
		INS AND OUTS			
		Positive fluid balance of 1565			
		ASSESSMENT			
		1. Acute respiratory failure with hypoxia requiring BiPAP level support.			
		2. Acute COVID-19 infection with pneumonia.			
		3. Malnutrition due to BiPAP requirement.			
		4. Obstructive sleep apnea			
		5. Down syndrome , high functioning			

Date in Medical Notes	Document Reference consulted	Summary Statement for the Complaint	Statements from medical notes	Comments in notes	Dr. Speid's Expert Commentary
		6. Agitation			He caused her to be agitated by administering PRECEDEX when it was not indicated.
		PLAN			
		1. Continue BiPAP at 20 over 15, FiO2 of 100% with goals to wean as she tolerates. Infectious diseases on board. On dexamethasone.			
		2. Tested positive on 10/1/2021. Currently on day 16.			The virus could have cleared from her system by day 16.
	Pass to Carl	3. Requiring PRECEDEX increased rate to 1.4 due to significant agitation this a.m. with goals to wean back down.			
		4. Labs revealing increased inflammatory response with an elevated CRP, D-dimer as well as she is having a fever this morning of 101.			
		5. Discussed with family in regards to malnutrition and agreed to a small-bore feeding tube. I discussed with dietary as well in regards to nutrition and recommended Jevity 1.2 at goal rate of 65 mL an hour.			DR SHOKAR made numerous mistakes.

Date in Medical Notes	Document Reference consulted	Summary Statement for the Complaint	Statements from medical notes	Comments in notes	Dr. Speid's Expert Commentary
		6. Goal of activity is to have her in a chair watching television. If she is lightly sedates as related by family. At this time, she is more agitated and on a higher dose of PRECEDEX and relatively bedbound, although we are working towards this goal if and when she recovers.			Why is there a doubt that she would recover?
		7. We will continue encouraging proning.			
		8. Code status was reviewed with family and she is a DNR/DNI.			
		DISPOSITION			
		Remain inpatient.			
		Dict 10/13/21 1257			
		Tran: 10/13/21 1330			
		Electronically signed GAVIN SHOKAR MD 10/17/21 2307			This document was created retrospectively. The patient died on the 13th and four days later, Dr. Shokar has adjusted the medical records.
10/12/2021 Date of service	Report No. 1012-0152	CHIEF COMPLAINT			
		Shortness of breath.			
		SUBJECTIVE			

Date in Medical Notes	Document Reference consulted	Summary Statement for the Complaint	Statements from medical notes	Comments in notes	Dr. Speid's Expert Commentary
		The patient seen and examined while she was lying in bed. She had a BiPAP mask on. She was comfortable and calm, somewhat cooperative, although not really verbal at this time.			
		She is currently on PRECEDEX at 0.6 as well as variable FiO2 use of BiPAP, currenlty at 85%, 15/12.			
		No concerns overnight.			
		She was able to prone.			
		OBJECTIVE:			
		VITAL SIGNS:			
		Temperature: 99.9			
		Pulse rate 64			
		Respiratory rate varying between 31 and 48 on BiPAP			
		Oxygen saturation 92% on 85% FIO2 per charting			
		GENERAL			
		No acute distress, alert			
		HEENT			
		BiPAP in place. PERRLA			
		CARDIOVASCULAR			

Date in Medical Notes	Document Reference consulted	Summary Statement for the Complaint	Statements from medical notes	Comments in notes	Dr. Speid's Expert Commentary
		RRR			
		PULMONARY Clear to auscultation bilaterally with some crackles in the right lower lobe.			
		ABDOMEN Soft, nontender, nondistended. Positive bowel sounds.			
		EXTREMITIES No edema			
		LABORATORY DATA			
		WBC 10.2			
		Hemoglobin 12.8			
		Platelets 252			
		BMP relatively unremarkable apart from a Chloride of 109			
		CK of 282			
		Albumin 2.7			
		Procalcitonin from 10/10/2021 of 0.24			
		D-Dimer from 10/8/2021 of 2243			
		Blood gas from 10/11/2021 revealing a normal pH, pCO_2 and HCO_3 with a pO_2 of 64.			
		IMAGING			

Date in Medical Notes	Document Reference consulted	Summary Statement for the Complaint	Statements from medical notes	Comments in notes	Dr. Speid's Expert Commentary
		Chest x-ray from 10/11/2021 revealing worsening pulmonary opacities, bilateral, concerning for pneumonia or edema, PICC in place.			
		Is and Os			
		Weight 178			
		Positive 1.6 liters			
		ASSESSMENT			
		1. Acute respiratory failure with hypoxia requiring BiPAP level support.			
		2. Acute COVID-19 infection with pneumonia.			
		3. Malnutrition due to BiPAP requirement.			
		4. Obstructive sleep apnea			
		5. Down syndrome , high functioning			
		PLAN			
		1. Currently requiring BiPAP, roughly the same as yesterday. Tested positive on 10/01/2021, currently on day #15. Infectious disease is on board.			
		2. On dexamethasone			

Date in Medical Notes	Document Reference consulted	Summary Statement for the Complaint	Statements from medical notes	Comments in notes	Dr. Speid's Expert Commentary
		3. Requiring PRECEDEX at 0.6.			
		She is hyperventilating, possibly from anxiety, which is going to impair her oxygenation;			[redacted] was trying to breath – the drugs were depressing her ability to do this. Her physiology was trying to compensate.
		however, her last ABG revealed a normal pCO2 and do nornt expect that the elevated RR/hyperventilation is impairing her oxygenation at this time unless it significantly increases; **however we should continue the PRECEDEX.**			
		4. Encourage proning			

Date in Medical Notes	Document Reference consulted	Summary Statement for the Complaint	Statements from medical notes	Comments in notes	Dr. Speid's Expert Commentary
		5. We will discuss with dietary in regards to nutritional status and recommendations.			
		6. PT, OT			
		DISPOSITION			
		Remain inpatient.			
		Dict 10/12/21 1018			
		Tran 10/12/21 1202			
		Electronically signed GAVIN SHOKAR MD 10/17/21 2304			

Dexmedetomidine (Precedex)

Dr. Shokar failed to realize that administering Precedex would make Ms. [redacted] agitated. Her distress upon being admitted to hospital was characterized as agitation, when it was most likely precipitated by the unfamiliar environment and the hostility being shown towards her family. Had care been taken to calm her down, as is done for children when they are admitted to hospital wards, there is every reason to believe that the administration of an inappropriate drug like Dexmedetomidine (Precedex) could have been avoided. It should have been abundantly clear that the administration of Precedex was inappropriate in a patient that Dr. Shokar characterizes as suffering from obstructive sleep apnea, acute respiratory failure with hypoxia, and Acute COVID19 infection with pneumonia.

No competent Physician would have administered Dexmedetomidine (Precede)x to this patient because it would adversely impact her ability to breath.

Morphine

Furthermore, the administration of Morphine, given these characterizations by Dr. Shokar was extremely inappropriate. This can only be characterized as reckless prescribing. He should have known that doing this would kill the patient. If he knew, then he premeditated her death. The timing of inserting DO NOT RESUSCITATE into the medical notes is suspect, and should be investigated by law enforcement.

Do Not Resuscitate

Dr. Shokar had no right to insert *DO NOT RESUSCITATE* into Ms. [redacted] medical notes. He was advised by the family not to intubate, because he wanted to place [redacted] on a ventilator, which she clearly did not need. He had prescribed a drug when she was first admitted to place [redacted] on a ventilator, and that was never stopped. He thought it was to be used to treat agitation, but it was causing agitation.

On the 13 October 2021, Dr. Shokar wrote in the notes, "*"There were multiple discussions with family in regards to her plan of care and considerations for goals of care and worst case scenario. She was transitioned to a DNR/DNI. " This the date that he "transitioned" Ms.* [redacted] *to Do Not Resuscitate, although he had only been authorized to not intubate her for ventilation. He took it upon himself, without their knowledge and permission to also insert Do Not Resuscitate or DNR into the medical notes. He then prescribed Morphine to be administered. The timeline is suspicious and deliberate.*

Dr. Shokar had no right to insert DNR into the medical notes. He was advised not to intubate, because he wanted to place [redacted] on a ventilator, which she clearly did not need. He had prescribed a drug when she was first admitted to place [redacted] on a ventilator. When her family refused to allow him to place a just in case in the medical notes for her to be ventilated, he still kept [redacted] on Dexmedetomidine (Precedex), although she did not need it. In hindsight, he tried to justify the prescription of Dexmedetomidine (Precedex) by indicating that she as agitated and needed it to calm her down. The drug was contraindicated and should not have been prescribed. It causes agitation, and so the agitation that [redacted] was exhibiting was caused by his inappropriate prescribing of Precedex. Any competent physician would know that it cannot be used stop agitation. The level of incompetence is horrifying.

Dr. Shokar took it upon himself to add DNR into her medical notes, without her family's consent and without their knowledge. [redacted] herself would not have given him authorization to write DNR into her medical notes. She had a lot to live for. She had a life that involved horse riding, activities with family and many friends. To call her high functioning is insulting, and shows the level of bias that contributed to the poor decisions that ultimately resulted in [redacted] unnecesary death.

Cause of Death

Dr. Shokar tries to give the impression that he was not the only Physician involved with the oversight of [redacted] care. However, he was the only Physician who prescribed Morphine, which killed her, and he is the only Physician who thought it was appropriate to prescribe Dexmedetomidine (Precedex) that causes agitation, to treat what he thought was agitation. On the day she died, her sister was not permitted to take a shower in the bathroom, and in the hour that her sister went home to take a shower and return, her sister had been strapped down, and shortly afterwards, she would be administered Morphine according to Dr. Shokar's prescription, and this is what killed [redacted], not COVID19. [redacted] was improving despite the atrocious care that she received in the hospital from Dr. Shokar and his team. In spite of the suboptimal care she was making improvement.

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

Expert Observation: Thirst is one of the side effects of this drug. [redacted] asked for water on xxx – FIND date.

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. [redacted] 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**).

From Stockley's Book of Interactions (online)

Lorazepam

	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

Dexamethasone

	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

Dr. Shokar's Prescription of Morphine, its Administration and the Death of Ms. [redacted]

Ms. [redacted] died within 45 minutes of the last dose of Morphine. Morphine was prescribed by Dr. Shokar and administered by Ms. McInnis. Any reasonable physician and nurse would know that the patient would die after being injected with Morphine, especially after being loaded with Dexmedetomidine (Precedex) and Lorazepam throughout the time that Dr. Shokar took over the care of the patient. The failure of Ms. McInnis to question the prescribing, and to instead, follow his orders, leads to the question of collaboration in bringing about the death of Ms. [redacted], a vulnerable patient. The overtones of failure to secure informed consent, and the timing of the insertion of *Do Not Resuscitate*, make an allegation of homicide plausible, and reasonable.

Morphine Administration

No	PHYSICIAN who prescribed drug	NURSE who administered it	DATE	TIME	EVENT	STATEMENT IN THE NOTES	O2 SATURATION
		MCINNIS	10/12/2021	1440		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 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.		

			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	1134 hours		
			FEEDING TUBE CONFIRMED IN PLACE, TUBE FEEDING STARTED. ATTEMPTED BRIDLE x2, 2 RNS UNSUCCESSFUL D/T PT SHAKING HEAD. TAPED IN PLACE.
MCINNIS	1358 hours		
		Blood Culture Report Collected 10/13/21 at 1505. SPECIMEN NO. 21. **REPORT B0031396S. Collected**	
	1457	**10/13/21 at 1457.**	
		Blood Culture Report Collected 10/13/21 at 1505.	
	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. Furthermore, it does not state that Ms. [redacted] died from the Morphine overdose that Dr. Shokar prescribed, and Nurse McInnis administered. Dr. Shokar lied on the death certificate indicating instead that Ms. [redacted] died of natural causes, and secondary to COVID19 pneumonia. This was a falsification of the death certificate. The notes he made, likely after the death about malnutrition are an inditement against him, because he should have ensured Ms. [redacted] was receiving Total Parental Nutrition. When Ms. [redacted] was seen in the ER just before being admitted to the hospital, she was considered *"well nourished"*.

Whilst the prescribing by the physicians who took care of Ms. [redacted] was amongst the worst I have ever seen, it was Dr. Shokar who prescribed, and oversaw the administration of the drug that killed her.

Andrzejczak, Jaclyn - DSPS

From: Andrzejczak, Jaclyn - DSPS
Sent: Friday, July 28, 2023 10:10 AM
To: [redacted]
Subject: DSPS Complaint No. 23 MED 368, Shokar MD - RESPONSE REQUIRED
Attachments: Shokar MD Complaint_Redacted.pdf; Certification of Records.pdf

Importance: High

Dear Dr. Shokar,

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 attached complaint filed against you.

Patient: [redacted]

You are required to provide the following:

1. A detailed written response to the allegations brought against you to include a description of the treatment provided to the patient.

2. Certified electronic copies of all relevant treatment records from 10/1/21 – 10/13/21. A standard certification form is attached or you may use one of your own. **If the total cost for certified copies exceeds $200.00, please contact me via email before processing this request.**

Wis. Stat. § 146.82(2)(a)5 grants the Department access to medical records for the purpose of performing this review unless those patients are private pay patients who have submitted the proper denial of access form prior to your receipt of this letter. Therefore, you do not need a signed consent form in order to release medical records to the Department.

You must submit your response by August 11, 2023. We encourage you to submit all materials electronically via email to **Jaclyn.andrzejczak@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,

Jaclyn Andrzejczak
Consumer Complaint Program Associate – Senior
Dept. of Safety and Professional Services

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) 777-2215
Writer's e-mail address rguse@otjen.com

August 23, 2023

Via Email: Jaclyn.Andrzejczak@wisconsin.gov
Jaclyn Andrzejczak
Consumer Complaint Program Associate – Senior
Dept. of Safety and Professional Services
Division of Legal Services & Compliance
PO Box 7190
Madison, WI 53707

RE: DSPS Complaint No. 23 MED 368, Gavin Shokar MD
Our File No. 230145

Dear Ms. Andrzejczak:

Please be advised that we have been retained to represent Dr. Gavin Shokar regarding the above-referenced matter.

This matter represents the second complaint filed against Dr. Shokar arising out of the care and treatment Dr. Shokar provided to [redacted]. The previous matter, 21 MED 509, was dismissed without a formal investigation. I have attached the closeout letter for your review.

As you may recall, [redacted] was admitted to St. Elizabeth's Hospital on October 6, 2021 suffering from acute respiratory failure. Although she was stabilized upon admission, she died on October 13, 2021 related to complications of Covid-19. Dr. Shokar has tremendous sympathy for the family due to this loss. The complaint includes numerous allegations, but only one issue related to Dr. Shokar. That issue seems to be the use of Morphine to control an agitated tachypnea. Context concerning Ms. [redacted] care and treatment at St. Elizabeth Hospital will be important. The use of Morphine was indicated and really the only available treatment at the time in question.

Dr. Shokar is a board-certified family practice physician specializing in hospital-based medicine. He was on the pulmonary unit from January to September 2020 at Christus Trinity Mother Francis Hospital in Tyler, Texas, when Covid was at its peak in Texas. He became truly knowledgeable and experienced regarding the care and treatment of Covid-19 patients during that time.

Dr. Shokar's first contact with Ms. [redacted] was on October 12, 2021. She had been admitted to the hospital on October 7, 2021.

Dr. Shokar reviewed the physician progress notes prior to his involvement in order to be up to speed on this patient. [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 based on Dr. Shokar's review of the chart.

- October 6, 2021. Dr. Beck's history and physical reflects that the father reported the whole family is not vaccinated and went to a Christian concert in Oshkosh. There were about 3,000 people indoors and the majority were not masked. "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. The father was told and understood that they were not going to offer treatments utilized by the frontline physicians.

- October 7, 2021. Dr. Zeimet, an infectious disease physician, evaluated Ms. [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 the father different modalities for treatment, including Remdesivir. Although she was not really qualified for it, the father indicated that he did not approve of its use with his daughter. She did not qualify for use of convalescent plasma, the Monoclonal antibody or Regeneron. Her treatment of choice was Dexamethasone. They discussed 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 the 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 she 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. The Precedex had to be discontinued though due to an episode of bradycardia.

Dr. Marada indicated that he discussed with the parents, prognosis and oxygenation. 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 the 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."

He 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 ability to prone the patient due to behavioral issues.

- October 9, 2021. A nursing note reflected that the 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, he stated "I am not going to take any of your guff. You are here to follow my commands. Parent shows ongoing, blatant disrespect of nurses."

- October 10, 2021. An RN documented that the father continues to be difficult with staff, including rude statements about care. He was interfering with 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.

- October 10, 2021. Dr. Leonard, the 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".

- October 12, 2021. An RN notified Dr. Shokar at 1356 that the patient was turned from a prone position to supine and that the O2 sats were 78-85% and not recovering. A stat ABG was ordered and respiratory therapy was to adjust BiPAP settings.

- October 12, 2021. At 1440, a nurse noted that the patient's mother would confer with the patient's father and give a decision regarding the code status as patient was currently a do not intubate, but a full code. Clarification was needed.

- October 12, 2021. At 1700, a nurse noted that the parents were updated by Dr. Shokar of the patient's low oxygen saturation. "Parents do not want intubation as previously indicated."

- October 12, 2021. Dr. Shokar's afternoon note about Ms. [redacted] indicated that the patient's oxygenation saturations had deteriorated, requiring increasing BiPAP yet still her oxygenation was 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 was over 60 minutes to answer all questions that were posed "and counseled as best as possible in regard to the unfortunate situation." He implored them 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. "It seems that all parties understood what was discussed. Again, they will reconvene with an answer shortly."

- October 12, 2021. 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 encouraged.

- October 13, 2021. Dr. Shokar's morning note indicated that she was unable to wean to 90% FIO2 as she would desaturate to the 80s. She was agitated, so her Precedex was increased and she was starting to pull out her PICC line and remove the mask. She had been able to be prone for an hour here and there overnight, but they were having less success proning her for more than 20-30 minutes as she returned to her side per nursing report.

- October 13, 2021. Dr. Shokar had a discussion with the family for roughly half an hour to an hour in regard to code status and feeding options. Restraints had been necessary due to her agitation with the understanding that they would be removed as soon as possible. After the discussion the day before, they decided on a do not intubate status. They discussed once again the futility of doing CPR with a DNI and the family agreed to not pursue resuscitation via

CPR in the event of respiratory arrest leading to a cardiac arrest. If there was a deterioration in hypoxia without reversibility for a prolonged period of time, they would discuss comfort care.

- October 13, 2021. At 1750, an RN documented that the patient's saturation was 54 with proning. Position was changed with no recovery in the saturation. The father was updated on Facetime that the O2 saturation had dropped to the 40s.

- October 13, 2021. Dr. Zeimet saw the patient on October 13, 2021, and noted that she was on maximum BiPap measures and she was desaturating down to 81%. He noted "it appears that she is slowly losing the battle with the BiPAP. She was at that point not a candidate for any approved or experimental treatments. As her cultures were negative, there was no indication for treatment with antibiotics.

The pulmonologist, Dr. Gandev, indicated "pulmonary does not have much to offer." She was BiPAP dependent and unable to increase oxygen saturation above 86%. The family opted for DNR and DNI status. "Considering the poor prognosis, it looks like the course of action that family has chosen will be most appropriate for the patient. We will focus on the comfort."

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.

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

The Precedex was discontinued the afternoon of the 13th due to her reducing heart rate. Her respiratory rate was in the mid-50s. The only option was to administer 2 mg of Morphine IV push as Ms. [redacted] could not tolerate a respiratory rate in the 50s for any period of time.

After the Morphine was administered, Dr. Shokar was in the patient's room 10-15 minutes. Her oxygenation had improved and she appeared to be stable. Her pulse oximetry reflected oxygenation in the 90s. He was not on the unit when the patient apparently lost her pulse. Pursuant to the family's decision, no CPR was performed. Dr. Shokar spoke to the father for approximately one hour the next day to answer any further questions.

The Morphine was indicated under the circumstances because of the hyperventilation. There was no other medical alternative to improve her oxygenation by reducing her tachypnea. 2 mg of Morphine was a low dose under the circumstances.

The complaint also suggests that [redacted] was on a maximum dose of Precedex. In fact, the Precedex was being weaned at the time and had been discontinued prior to the administration of Morphine. She had received Lorazepam previously in the day, which had not been effective in resolving her agitation.

It should be noted that of the three medications referenced in the complaint, the only medication ordered by Dr. Shokar was the morphine. Dr. Shokar did not place any orders for Lorazepam or Precedex.

It is also important for the Medical Examining Board to take into consideration the credibility of the individual filing this particular complaint and similar complaints against David Beck, M.D. and St. Elizabeth's Hospital.

Lorna Speid is not a medical doctor and she clearly comes to the table with an agenda. I have provided you a small sampling of Ms. Speid's social media postings. Ms. Speid is an individual who uses her position as a social media influencer to spread disinformation regarding several aspects of the Covid-19 pandemic. She subscribes to the theory that protocols were developed and treatment decisions were financially motivated and not developed for the purposes of providing the best health care to patients that was possible at the time and under the circumstances encountered by health care professionals. As an example, Ms. Speid espouses a theory that hospitals had financial incentives to place patients on ventilators and that hospitals made more money off the deaths of patients than keeping them alive. (Please see attached Exhibit A, Hospitals . . . Killing Fields.) Lorna Speid is also a vocal advocate against vaccinations for Covid-19. (Exhibit B, The Noble Lie is . . . "Their Truth".)

Dr. Shokar and all the other doctors and nurses who provided care for [redacted] did everything within the standard of care to preserve [redacted] life. They should not be subjected to further investigations and have their professional reputations impugned by individuals such as Lorna Speid who thrive off of the disinformation and outright lies they perpetuate through social media and other news outlets. Should the Medical Examining Board choose to proceed with a further investigation in this matter, such an investigation lends credibility to individuals such as Lorna Speid and others who profit off the disinformation they spread.

Certainly, it is tragic for this family to have lost their daughter. However, the death was not due to any fault on the part of Dr. Shokar or any other healthcare provider. Dr. Shokar's options were limited when faced with a patient who was in such extreme respiratory distress due to tachypnea. He utilized the appropriate treatment for a hospitalist in treating that condition.

On behalf of Dr. Gavin Shokar, I respectfully request that this matter be closed without further investigation.

Very truly yours,

OTJEN LAW FIRM, S.C.

Randall R. Guse

RRG/mjt
Enclosures

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].

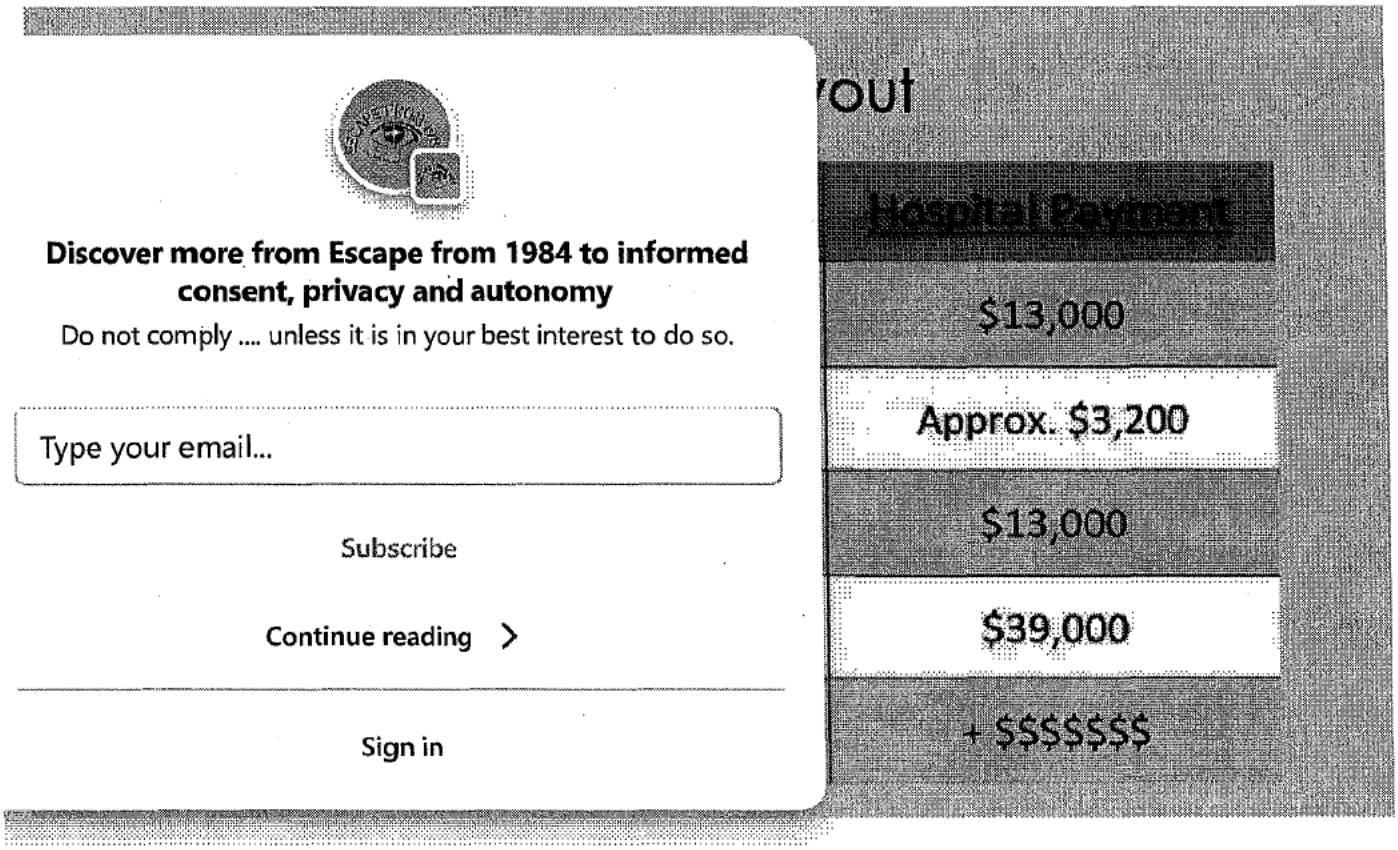
What I have learnt is extremely troubling, and confirms that people are dying, who should not be dying. I also found out that my cousin's wife probably received a payout of about 9000 USD [3], that to this day, she has never disclosed to the family. I call this *"shut up money"* or *"look the other way 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	$58,000
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	$14,000	Washington	$58,000
Michigan	$14,000	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.

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.

EXHIBIT B

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
Dawn B. Crim, Secretary

January 20, 2022

LORI GENDELMAN
OTJEN GENDELMAN ZITZER JOHNSON & WEIR SC
20935 SWENSON DR STE 310
WAUKESHA, WI 53186

RE: Complaint # 21 MED 509

Dear Attorney Gendelman:

This letter is to inform you of the results of the complaint filed against the professional license of your client, Gavin Shokar, by [redacted].

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

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

From: Tessman, Lisa M - DSPS
To: rguse@otjen.com
Subject: Complaint Closed 23 MED 368 - Shokar
Date: Thursday, September 21, 2023 8:38:00 AM
Attachments: Shokar Closeout Letter - 23 MED 368.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

RANDALL GUSE
OTJEN LAW FIRM, S.C.
20935 SWENSON DR STE 310
WAUKESHA WI 53186-2057

RE: Complaint # 23 MED 368

Dear Attorney Guse:

This letter is to inform you of the results of the complaint filed against the professional license of your client, Gavin Shokar, 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