Justice in the Wrongful Death of our Father
Mr. Wilford Lee Johnson

As the daughter and caregiver for my father, I spent about 10-12 hours a day at the hospital from October 10-31, 2013 with my father. These are the facts I witnessed that led to his tragic death at the hands of a local hospital and it's medical staff.
My father was admitted to a local hospital on Thursday, October 10, 2013 for pneumonia. A few days later, after having a swallow test done, it was determined that he was not swallowing his food properly which caused some of his food to go down into his lungs. The diagnosis was changed to aspiration pneumonia and he was put on a pureed diet to help with his swallowing and daily respiratory treatments to help with the pneumonia.
Thursday, October 10, 2013: He was admitted for pneumonia. My father was in good spirits.

Friday, October 11, 2013: Had swallow test that morning. I spoke with the Speech-Language Pathologist, the lady that performed the procedure. She informed me that he would be treated for aspiration pneumonia and would be put on a pureed diet while in the hospital along with the respiratory treatments and he would need to continue the pureed eating at home until his swallowing had improved.

Saturday, October 12, 2013: Treatment continued with no problems with eating.
Sunday, October 13 thru Sunday 20, 2013: Treatment continued. He was adjusting well with the pureed eating, however, I was informed by his CNA what he was brought a regular food meal twice during the week. The CNA said that she had reported it to the nurse on duty. That Saturday, he had several visitors and was up laughing and talking well. Sunday, dad's CNA called to advise me that the doctor was thinking of discharging my dad that day.
Sunday, October 20, 2013: I met with the doctor, (the attending physician) concerning my father's progress he and I agreed that due to my father still being congested, he would keep him another day and increase his respiratory treatments. My father was a little disoriented, so I decided to stay over that night along with his evening CNA. His overnight nurse and the respiratory therapist (a man) really worked with my father to get a lot of the secretions up and out using a tube down his nose first, then his mouth. This did give him some relief.

Monday, October 21, 2013: Daddy was due to be discharged on this day by the doctor. That morning dad's aid, the CNA from the private healthcare facility had been there overnight and ordered his breakfast. I heard her order from the menu (pancakes, sausage and eggs with lemonade and milk). Approximately 7:40am, the food came, the dietary staff member set it up, then the CNA proceeded to feed him the pancake, that's when I looked at her and asked if that's the way it was suppose to look and she replied, "Well, that's what they sent him."I was lying on the couch trying to sleep since I had been up most of the night. Shortly after that, I heard my Dad tell her he was full and did not want anymore. She kept trying to feed him and he kept turning his head. Finally I told her to stop trying to force him to eat. She replied, "Well, he really didn't eat a lot." Shortly after that, the overnight CNA was off work and her relief person came. Shortly after she arrived the respiratory therapist came in to give him his breathing treatment (she administered the smart vest and albuterol treatment), next the nurse came and gave him his medication. By this time, my father was very despondent and was not wanting to swallow the pills (some of which were crushed in applesauce and some not). She kept trying to get him to swallow them and she thought he did. I asked if his bed could be repositioned in chair position to help him cough after his treatment; the PCT came in made the adjustments and left the room. The CNA then asked me about the food because she noticed it was regular food and not

puréed. She then told the nurse about it and how it had happened twice before and was assured it wouldn't happen again. The nurse said she was going to call and speak with them again. Right after she left, I noticed my Dad's breathing was more rapid and his eyes were getting bigger. I asked him if he was ok and he didn't respond but started drooling from the mouth and having shortness of breath. I immediately pressed the call button for the nurse. She came from next door immediately and called for someone to check his heart rate on the monitor; it was from 38 to 34 to 30, she then called the code team. After about 15 mins of CPR they were able to get a pulse. He was immediately taken to ICU and put on a ventilator. One thing that shocked me was the fact that my daddy was on a heart monitor and nobody noticed his heart rate quickly declining and no one could explain it either. One of the doctors that was in the room during the code advised me that Daddy had aspirated on the food that was given to him that morning. The doctor asked the nurse why he was given regular food to eat. (I don't remember her response). My father was in ICU for a week on a ventilator making great improvements, with stable vital signs. His lung doctor said to me that because of the trauma done to his lungs during the full code, it caused respiratory failure. After a week on the ventilator, the doctor said my dad would need a tracheotomy, which was to be the next step to helping his lungs heal. After the aforementioned incident, I received a visit in ICU from someone from the Hospital Administration Office. He asked me how my father was doing then apologized for him having to go through this. He stated that the doctor had reported the incident to them. (The lung doctor, I assumed) which prompted their office investigate the incident. He said they were on top of the situation and and that someone from his office would be in touch with me soon. I told him that it had happen two times before and my father's CNA had complained to the nurse about it. The CNA said she
also spoke directly to the speech pathologist about it. The hospital representative said that he was not aware of that, but he would be talking with the dietary and nurses and get back to me. To this day, I have not heard from him or anyone else.
Monday, October 21, 2013: After my father was rushed to ICU and placed on a ventilator, I was told by the ICU nurse that his body would be cooled for 24 hours to prevent brain damage per both doctors on the case.

Tuesday, October 22, 2013: Around 2:00 pm, the staff began warming his body and he was alert by 9:00 pm and I was in the room when he came to. The staff kept him sedated for a few days to allow his body to heal. While sedated, his vital signs were strong but he had a slight fever of 99.3 and was given meds and the fever subsided.

Wednesday, October 23, 2013: He stayed sedated and at my request he had no visitors other than immediate family.

Thursday, October 24, 2013: He stayed sedated and at my request he had no visitors. He did try to communicate with his eyes and mouth. He wanted to know what happened and that he was thirsty. My father conveyed to me that he wanted to fight, so we set goals for his recovery and I put them up all over his room so he would know daily what to focus on.

Friday, October 25, 2013: Over the weekend, he became more alert and vitals signs were still improving. The nurse and the respiratory therapist worked well with removing the secretions and his oxygen level went to 100 and 45 on the vent machine. He was in good spirits, focused on his goal for that day. He also had several visitors.

Saturday and Sunday, October 26 - 27, 2013: Slowly improving, vitals still good, the staff continued working to remove secretions and my father was able to consistently follow commands. He was very alert on Sunday and was watching TV with us. Was seen by doctor on duty. Still focused on his daily goal.

Monday, October 28, 2013: I met with a general surgeon regarding the tracheotomy surgery. He advised me that he would perform the surgery on Wednesday at 1pm. Also, he was looking at putting in a feeding tube. I shared with him how Daddy was doing well with the puréed diet until someone gave him the wrong food and that's why he is in ICU- not because he can't eat. The doctor said he would talk to the GI doctor about it. He met with a young lady from the GI's office first and gave her Daddy's surgical history. I then asked the GI doctor if he could perform an X-Ray to see if Daddy was able to get a feeding tube. His response was positive about doing the X-RAY.

Tuesday, October 29, 2013: An X-Ray was done and the results showed that he was not a candidate for feeding tube. So, the surgeon decided he would insert feeding tube through his nose (called a Dobhoff).
Wednesday, October 30, 2013: Before surgery, my father and I discussed what his focus needed to be on, a successful surgery and quick recovery. He went into the OR with his goals taped to his bed. Surgery was to be done by a General Surgeon, who had operated on my father before. We were ok with using him. The doctor advised the family that the surgery went well. He said Daddy did great, his vitals were stable and that it only took him 20 minutes to do the surgery. The OR Team took my father back to ICU. The surgeon ordered another X-Ray to see if the feeding tube placed down his nose was positioned correctly. The X-Ray showed it was in his lungs as it should have been in his stomach. They removed it until further review by the GI doctor. Later that day, my father was complaining about the respiratory therapist and how rough she was with handling the trach. His CNA was there and confronted her about the incident. The aid immediately informed me and I immediately reported it to his nurse. He apologized and said he would discuss it with her. My father was very nervous about how the handling of the trach was painful to him, so I asked for him to be given something to calm him down. The nurse called the doctor to order something for him. The respiratory therapist came back into the room several times to suction and do his breathing treatments. Not once did she apologize or even discuss her care plan with us. She just made small talk. It was decided that since he was doing so well after surgery, that he would be transferred to a rehab facility for continued care. Shortly after that conversation, we received a visit from a young man from a rehabilitation facility confirming his transfer and explained his plan of care to us.

Thursday, October 31, 2013: Everything was good. Daddy's vitals were great; oxygen was at 100 and the ventilator machine on 45. His attending physician said that Dad's x-ray had shown a great improvement over the previous ones and she was confident in releasing him to the Rehab Facility for rehabilitation. She said it would be a step up towards his recovery. His lung doctor and attending doctor agreed that he would do better in a rehab facility and the quicker he got there, the better. Still focused on his daily goal. (Cough up the secretion, normal vitals, normal fever, off the ventilator)
Also, that day my father had a lot of bowel movements. One time in particular I witness was his nurse assisted by an older caucasian gentlemen changing him. I saw how rough daddy was being handled with turning him from side to side to clean him up with little to no regard to the position of the tube and trach. Daddy looked at me funny and I asked him if he was ok. He nodded yes.

At about 3:30pm, as he was in the process of being transferred to the rehab facility, his nurse and the respiratory therapist we're preparing him for the transfer. In the room with them were 2 of the paramedics and Daddy's CNA. I was in the hall giving information for the transfer to the 3rd paramedic when the aid told me that I needed to come in there quickly. I ran in and saw my Daddy covered in blood. I asked what happened. No one said anything. Then the nurse said to call the doctor (surgeon). He was bleeding so fast, the nurses kept bringing large towels and several packages of gauge. The paramedics team cancelled the transfer and left. The nurse and therapist continued to apply pressure on the area using towels and the nurse used something else to help it clot. By this time, the lung doctor came in, saw the situation and walked out. I asked him to do something about it and his response was "the surgeon is on the way" and he left without checking anything. After 25 to 30 minutes later, the surgeon still had not made it, I then asked the nurses if they could get someone else and they told me “NO” and that the surgeon was the only one who could fix it. So, I said “can you call him again”, and their response was “If he is not here in 15 minutes we will call again”. In the meantime, Daddy was still losing a lot of blood and no one seemed to care. I asked for his lung doctor again and was told he was gone. Finally about 40 minutes later, the surgeon finally showed up, walked in the room saw all the blood and said to me, “I think I can fix it in the room”. He immediately started to suture the area with the assistance of a nurse holding the trach back, with the aid and myself holding flashlights as there was not enough light for him to see. My father was awake and alert during this whole process initially was given nothing to even numb the area.. He would stick the needle to suture in and when Daddy flinched, the doctor would apologize. He kept apologizing to my father. This doctor didn't give him a shot until he was almost finished and he would occasionally grab the suction from the female nurse and do it himself. Also, the surgeon snapped at ICU nurse for not holding the Trach right. He was sweating and still trying to see what he was doing. Because we were holding the flashlights, the aid and I saw him suctioning and suturing through the hole of the trach. I witnessed the doctor use 3 needles and scissors that he kept putting into one of the pink wash buckets until he was ready to reuse them. This created a very unsterile area. I was very surprised as a doctor, of his bedside manner. After he saw he was still bleeding, it was then that he decided to go to the OR to repair it with surgery. The surgeon stated that he would just let him bleed out then correct it in the OR. By this time, my Dad was shaking and his vitals started going up, specifically his heart rate and his eyes started rolling back. I tried to keep Daddy calm, but to no avail, he looked at me shook his head and said in a whisper that he was tired of it and he wanted to give up. My father has always been a fighter and he has beat a lot of odds, but he was aware of how they were handling things and I believe he knew his fate. He lost so much blood that it was all in the bed, behind his head, covering his chest and neck and dipping onto the floor. With that much loss, my father was never given blood to replenish the blood lost. No other Doctor showed up until almost 6:00pm when my father was in distress...(almost 2 hours later). I believe In spite of all my efforts, my father was allowed to die prematurely. Earlier the CNA stated she witnessed the respiratory therapist suctioning and pulling on the trach and believed that caused him to start bleeding. After 2 hours of negligence of the doctors and staff, my dad died in a pool of his own blood still in his ICU room. I believe he drowned in his own blood. It took the doctor almost an hour to get there. His lung doctor was there and said he couldn't do anything and when I asked for another doctor, I was told only the surgeon could fix it. Which I discovered later that was an untrue statement. When he finally came, he had not informed the OR or called anyone else, but tried to fix it in the room using unskilled persons as myself and the CNA. In the room assisting him were 2 nurses, my sister who is an RN and 2 inexperienced individuals (the CNA and Myself) assisting him in an unsterile room and he was sweating over my father. All the

maneuvering caused his vitals to shoot up, he formed blood in lungs(the surgeon had the nurse check his lungs for blood) and he went into cardiac arrest and was pronounced dead at 6:24pm.

This was a tragedy that shouldn't have never happened and certainly one we including my father should not have witnessed. The doctors and the staff did not treat my father as an emergency situation until it was too late. After all was said and done, the nurse and a training nurse were the only two to offer their condolences. (The Therapist said nothing). I asked for an explanation of what had just happened and no one could or would explain it. I then requested that an autopsy be done. Soon after my request, the nurse came back and said one of the nurses had already called the Medical Examiner's office and they had refused to take the case. I asked to speak with the surgeon personally to discuss it. He came and I explained to him my concerns and he said he would see what he could do. Five minutes later, he came back with the nursing supervisor. The surgeon told me that it was out of his hands, and that they rarely listen to the doctor. I asked him did he even call and he said no. He went on to explain about other cases where he couldn't get them to change their mind. The nursing supervisor who I had not seen until It was all over, jumped in and spoke for the doctor and firmly said to me that there would not be an autopsy and that was their final decision and I that I needed to decide on a funeral home. After that conversation, I knew they were not going to assist me, So I called the medical examiner's office myself and spoke with an Investigator who told me that someone from the hospital did call and he said he asked specific questions and was given different answers. I explained to him all the things that had taken place leading up to my Dad's death. He sounded very shocked on how things were handled and he assured me he would get to the bottom of it. After several calls, He called me back and said he was putting a Medical Examiners hold on my Dad and nothing would happen until they investigated the situation and that he would call and advise the nursing supervisor of their decision. I was then advised by the medical examiner's office that because the hospital didn't have a morgue that my father's remains would be held over at the county morgue until a decision was made the next day. Approximately 11:20pm the Medical Examiner's office came and picked up my Father's remains pending further Investigation. November 1st - An autopsy was performed and results stated my father died from excessive blood loss as a result of a cut artery. This is why the hospital refused the autopsy because they knew what happened and was hoping we would never find out.

My conclusion: Numerous mistakes were made by the Hospital Staff and Doctors and the biggest one was they violated the Hippocratic Oath..FIRST DO NO HARM... This was inhuman for myself, my sister and his CNA, to witness. AS A RESULT OF, My father died not once but twice and the second time a slow and painful death at the hands of the people who we trusted to take care of him.

My father was a man who in his lifetime beat all odds set against him. He outlived all of his original doctors from his injury in 1976 and has overcome every challenge put before him. This was because of his unwavering faith in GOD, his attitude and willingness to get back up and fight. On October 10th, he went in the hospital determined to beat the pneumonia and he kept this attitude to the end. His age played no part in his death, people did.
To this day, no one from the hospital has called or written a letter of condolence or apology.

Rheanonda Johnson Gray, His Daughter and MPOA