THE PROTOCOL THAT KILLS

A TRUE CRIME STORY

By Sheila Skiba
with Roberta and Allen Stalvey

The Protocol That Kills

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Dedication

I dedicate this book to my amazing husband, Robert A. Skiba II. It is my desire to be a continuation of his voice in honor of his life and motivate people to stand together in unity saying, "*Never Again!*"

Rob lived every day of his life to the fullest. He was a cheerful soul who had a song in each step. His presence was a joy and a gift, and I miss him terribly.

I wrote this book to honor his life and help save others by exposing the depth of the darkness behind an intentional, modern-day, genocidal medical tyranny.

Robert A. Skiba II, you are the love of my life, and I cannot wait to see you again. We were stronger together and I miss having you in my arms.

In memory of the innocent victims of the protocol
that kills and in honor of their families.
May their voices not be silenced.

The Masquerade
Vultures in hospitals masquerade,
As doctors with murder
for money their trade,
Sedatives and paralytics their tools,
Comatose patients
their unfortunate fools.
Isolation, prison, stripped and bare,
Humiliation, alone, lost,
frightened and scared,
No one to hear their silent cries,
Their bodies violated, their spirits die.
These vultures, a scourge of the land,
Stealing the sick, and taking a stand,
Against the weak,
the vulnerable, the poor.
Their greed and cruelty,
forever a scourge.
But justice will come, in the end,
For the vultures,
their time is near at hand,
And the families, they will find peace,
When much needed
justice, is finally released.

Foreward

I met Sheila Skiba after the passing of her husband, Rob, and I later learned more about who Rob was and what he stood for through his books and videos.

After serving as a medical/surgical nurse for 26 years, I became overcome with frustration, disgust, and horror at how Covid patients were being treated. So, in September of 2021, the same month Rob Skiba was hospitalized, I decided to leave a profession I truly loved.

I had to leave because I could no longer stand by and watch patients' and their families' rights being violated by colleagues who blindly followed and were willing to force their patients to succumb to a protocol that does not heal but harms; a protocol that was leading to the death of a large number of patients.

The Protocol That Kills is the most exhaustive exposé ever written on a government-incentivized protocol that must be **stopped** *to save future lives*. I hope hundreds of thousands read this book and send copies to colleagues, friends, and family members—especially to those who believe that everyone in the medical profession always has their best interests in mind.

Despite her pain, Sheila somehow crafted a work of art that could be called a true crime story, a legal brief, or an exhaustive exposé. Her insightful treatise is the most comprehensive and detailed book on the subject.

Be prepared, as in this book you will encounter the gripping details of Rob and Sheila Skiba's 40-day journey through hell; a journey that is sadly not unique as thousands of innocent victims have also traveled down this road of destruction.

After reading Sheila's story, you will have a clearer understanding of the risks involved in placing your life or the life of someone you love into the hands of modern-day “medical professionals” who have become protocol and profit-driven and who place both “the protocol” and their “bottom line” far above the health, welfare, and lives of their patients.

If this insanity is allowed to continue, thousands more will die needlessly. I hope that Sheila's insightful book will result in an outcry so strong and so loud that “the protocol that kills” will be stopped for good and that patients and their families will once again be treated with respect, dignity, and therapies that prolong their lives rather than end them.

Peggy Lawler

Medical/Surgical Nurse

Preface

I never imagined that I would be writing the tragic and true account of my husband's suffering and death at the hands of a group of "medical professionals"—a wholly callous and insensitive group that blindly adhered to a government-incentivized COVID-19 hospital "protocol that kills."

During my ordeal, it was as if I were a chess piece on a larger-than-life chessboard, and my husband, Rob, was the king the opposing side wanted to take down. My mother, sister, and close friends were the pawns on my side of the board. The opposing team comprised doctors, nurses, respiratory therapists, social workers, and hospital administrators.

Unfortunately, our opposition had the upper hand, as they had far more pieces on the board and were seasoned masters of the game, which they admitted they had played numerous times. They even broke the rules when it served their interests to do so.

Regrettably, this same game of cunning strategy is being played out in hospitals across the United States, where treacherous and devious masters of the game are defeating inexperienced patients and their unwary families.

Day and night I fought for his life during the forty days my husband was held captive by a team hell-bent on enforcing "the protocol." I insisted that he not be given dangerous drugs and therapies. However, they forced their will on him—until he died.

After the unnecessary and tragic death of my husband on October 13, 2021, my suffering and outrage grew stronger as I spent months working with a team of close friends, family, and medical experts who aided me in conducting a detailed analysis of the over 5,000 pages of his hospital records.

In addition, my team and I analyzed hours of conversations I had recorded with doctors, nurses, and staff during my husband's 40-day hospitalization—as allowed by Texas Penal Code, Section 16.02, Paragraph (c)(3)(A). https://statutes.capitol.texas.gov/Docs/PE/htm/PE.16.htm#16.02

Sadly, conducting a thorough investigation and authoring this book required reliving the trauma. Numerous disturbing facts uncovered during our investigation verified that my husband did not die of natural causes but due to the doctors' insistence that he follow their mandated and inhumane "protocol that kills."

Speaking of the protocol from a nurse's point of view, Nicole Sirotek, a registered critical care flight nurse who founded American Frontline Nurses to advocate for patients mistreated by hospitals' Covid protocols, said during a Senate hearing on January 24, 2022: "*Following orders has led to the sheer number of deaths that have occurred in these hospitals. I didn't see a single patient die of Covid. I've seen a substantial number of patients die of negligence and medical malfeasance*."

My story is a raw, firsthand account of how "protocol-focused" doctors and nurses are violating the rights of patients and their families and how incentivized drugs and therapies are leading to needless deaths.

I decided to share my story for two reasons. First, I wish to inform the public that the U.S. medical establishment has devised and has been following a strict, unwavering, and lethal protocol that prioritizes hospital profits over patients' rights, health, and well-being.

Second, since being forewarned is to be forearmed, I hope to provide valuable insights that will protect you and your loved ones from falling victim to "the protocol that kills." That way, if you are confronted with tough decisions and a formidable opponent, as my husband and I were, you can declare "*Checkmate!*" and emerge victorious.

Sheila Skiba

Sheila Skiba

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Chapter 1 – Introduction

I hope that this true and tragic story will deeply touch you and, more importantly, that it will lead to the saving of many lives as the outright tyranny, corruption, and maliciousness of the Medical Industrial Complex is laid plain.

As I stated in the preface, my goal in sharing this story is to raise public awareness of the fact that the U.S. medical establishment has devised and recklessly follows a strict, unwavering, and lethal protocol that places hospitals' profits ahead of the rights, health, and well-being of patients and their families.

I also want to equip you with invaluable insights regarding what to do if you or someone you love chooses to attempt to recover at home or if hospitalization becomes the only option. In the latter case, my hope is that what you learn from reading my story can help you or a loved one avoid becoming another victim and statistic of "the protocol that kills."

Philippians 4:6 says, "*Do not be anxious about anything, but in every situation, by prayer and petition, with thanksgiving present your requests to God.*" I believe God hears our requests. I trust He is great, good, just, and true. He is ever active in human affairs and is sovereign.

Despite the immense trauma I experienced and the pain I still suffer today, I can assure you that God has never left my side as I walked through the valley of the shadow of death. It has been, and continues to be, exceedingly difficult; however, God is faithful and continues to sustain me. I pray that He will also sustain you through your life's journey.

I now invite you to serve as **an informal juror in the court of public opinion** in the case of Robert A. Skiba II versus the Medical Industrial Complex. As a jury member, you will be asked to base your verdict solely upon the evidence without prejudice.

In this book, you will be presented with an abundance of compelling facts and exhibits that will allow you to decide whether my husband's death was caused by "the protocol that kills" or if he died an unavoidable death of natural causes.

You should base your decisions on the evidence presented here. However, you are not expected to set aside your life's experiences and common sense. Even then, I must warn you that my story

is factually driven and emotionally charged because our lives were torn into millions of pieces during the forty tortuous and terrifying days I desperately struggled to keep Rob alive.

It is totally unacceptable that I was locked out of the hospital for 21 days while being forced to struggle tirelessly to defend my husband's rights and fight for his life. The experience was unbearably frustrating and emotionally draining, as I had to argue with doctors, nurses, and hospital staff daily until my husband died. What I experienced and many others have experienced at the hands of so-called "medical professionals" is a clear sign of a serious problem with our "health care" system in America.

I realize many kind and compassionate doctors and nurses have refused to support "the protocol that kills," even when doing so cost them their jobs. *Those who bravely stood up to this atrocity deserve to be recognized as modern-day heroes.*

Even then, it is undeniable that there have been and continue to be instances where patients have needlessly suffered and died at the hands of licensed physicians who, out of willful ignorance, uncaring negligence, or nefarious intent, forced their patients to succumb to "the protocol." Many of these professionals believe they are immune from prosecution because they have been sheltered by federal and state "pandemic" laws.

This senseless slaughter of innocent people at the hands of callous "professionals" must end. **Enough is enough!**

However, this evil abomination will not come to an end until enough of us who are awake and aware band together and, with one voice, say, "*We will no longer tolerate the systematic annihilation of innocent people in the name of a murderous protocol, and those who have committed these crimes against humanity **must** be held to account! This atrocity must stop now!*"

> **LEGAL COUNSEL STATEMENT**
> Members of the jury, this is the first of many "**legal counsel statements**" you will find throughout this book. Their purpose is made clear in Chapter 2.
>
> At this point, we want to take a moment to salute and thank the doctors, nurses, respiratory therapists, and other medical staff who have *stood against this evil* and risked their careers and their lives to save the patients who entrusted them with their care. *These brave souls are true, modern-day heroes!*
>
> Please join us in a moment of silence to thank our heavenly Father for their bravery, courage, and willingness to stand against medical tyranny. We pray for their safety and prosperity as they stand for truth and life.
>
> In this book, we sound an alarm against a lethal protocol that must be stopped—and it is our sincere desire that Sheila and Rob Skiba's story touches hearts, opens eyes, saves lives, and helps to once and for all put an end to this modern-day genocide.

Sadly, Rob had no voice because his rights were stripped away. His medical treatment options were exclusively decided by his "medical caregivers," as they ignored his and my inputs and demands.

After Rob's death, a review of the over 5,000 pages of his hospital records clearly showed that it was (a) the lack of adequate food and water, (b) the large quantities and dosages of dangerous and deadly drugs such as remdesivir (which was refused but was administered anyway), (c) the continual stress of the constant badgering by doctors and nurses to be intubated and

placed on a ventilator, (d) the use of a contraindicated therapy, and (e) his being intubated and administered toxic levels of oxygen for extended periods both before and after he was placed on a ventilator (see Page C-54 in Appendix C)—that led to Rob's death.

Rob had often said, "**Evil happens when good men do nothing.**" Is it possible that "the protocol that kills" is a covert aspect of a broad and sinister plan to vastly decrease the world's population? Regardless, it is high time we stand against this insanity and take back our God-given rights to life, liberty, and the pursuit of happiness.

Rob is just one of the countless innocent victims of an inflexible "protocol" that is being forced on patients by an oppressive and tyrannical medical system. This fatal protocol must be stopped! It is clear that the Hippocratic oath of "*above all else, do no harm*" that doctors were once said to ascribe to is NO LONGER being honored.

It may be time that we herald a "Nuremberg Trial II" to call the barbarous assassins who promote and execute this "protocol" to account—because if we do not stand together, we may all end up dying alone—just like my husband, Rob.


IN GOD WE TRUST

Juror Notes

Chapter 2 – Legal Counsel Argument

As you are being asked to serve as a member of the jury in the court of public opinion, it is essential that you have ready access to all of the evidence.

Therefore, we will be presenting the evidence in seven distinct voices:

1. **Sheila Skiba's voice**—as she candidly shares her personal story of the forty days of terror that she and Rob experienced at the hands of a medical system that is dead set on ensuring patients follow *the protocol that kills*.
2. **Rob Skiba's voice**—via his text messages to Sheila, friends, and family as he shares his fear that the doctors would kill him if Sheila could not be by his side as his on-site advocate.
3. **The voices of Sheila's family and friends**—who were trying to assist Sheila with keeping Rob alive and helped prevent Sheila from falling into severe depression.
4. **The comments of a quasi-legal counsel**— who provides a wealth of insightful and invaluable details and evidence—including over 100 citations from clinical studies, medical journals, federal regulations, and relevant books and articles—that prove Rob did not die of natural causes but due to the perpetrators' insistence that he follow the mandated and inhumane "*protocol that kills*."
5. **The voices of the doctors, therapists, nurses, and staff entrusted with Rob's care**—based on conversations Sheila recorded and transcribed, as allowed by Texas law. They reveal how Sheila and Rob were deceived and manipulated. *Their voices are displayed in gray text to make it easy for you to distinguish them.*
6. **The voice of Sammy Wong, MD**— an American Board of Internal Medicine Certified Internist and Assistant Professor of Medicine (ret) at Loma Linda University School of Medicine who has provided expert opinions and testimonies on well over a hundred cases over the past 30 years and has given multiple presentations on Medical Malpractice, Patient Safety, Cognitive Bias, and Diagnostic Errors. *His Letter of Introduction, Interim Analysis, and Causes of Action against the culpable parties appear in Appendix B.*
7. **Extracts from Rob's hospital records**—which expose the harmful drugs and therapies provided to Rob, the doctors' and nurses' frustration at Rob's and Sheila's continued insistence that he not be given remdesivir and not be intubated and placed on a ventilator, and their total disregard for the fact that Rob (who had not been able to eat for over a week prior to his admission and was already malnourished) was not consuming an adequate amount of food and water. *Each hospital record includes detailed notations that show how flagrant biases, willful negligence, malicious intent, and harmful therapies led to Rob's needless death.*

The evidence we will present strongly supports the claim that Rob and Sheila's constitutional, civil, patient, and Medical Power of Attorney rights were violated and that Rob Skiba did not die a natural death from his unquestionably curable illness.

Instead, due to gross negligence and possibly malicious intent, his needless death was caused by iatrogenic injury (injury caused by doctor-prescribed drugs and medical treatments).

LEGAL COUNSEL STATEMENT
Members of the jury, Sheila's being locked out of the hospital—which she was told was one of the hospital's "*unwritten policies*"—violates **Title 42 of the Code of Federal Regulations, Section 482.13** (as noted in **Appendix E**), which states that, "*A hospital must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reasons for the clinical restriction or limitation*."

Sheila repeatedly requested a written copy of the hospital's "21-day isolation policy," but she was repeatedly refused and never received one. Due to this hospital's "unwritten rule," Sheila was unaware of critical details of Rob's medical care until it was too late for her even to attempt to intercede for him.

Sheila was intimidated and shouted at over the phone the day after Rob's arrival at the hospital by a physician who was standing by Rob's bedside at the time of the call as he insisted Rob would die if he was not placed on a ventilator. Sheila's sister and mother were with her when the call came through and heard every word.

Due to this harsh and inappropriate treatment, Sheila began recording all future conversations with doctors, nurses, and hospital staff. The dialog that appears in this book was taken directly from her recordings. Anyone who "*is a party to the communication*" is legally permitted to record and disclose the contents of their communications under Texas Penal Code, Section 16.02, Paragraph (c)(3)(A). https://statutes.capitol.texas.gov/Docs/PE/htm/PE.16.htm#16.02

We contend that the hospital purposely locked Sheila out for 21 days so she could not watch over and question his care, advocate for him in person, ensure he was provided with adequate food and water, and aid him in eating and drinking—something he found impossible to do on his own with the high-flow oxygen therapy he was on. In addition, locking Sheila out allowed them to flood Rob with unwanted, unnecessary, and harmful drugs while starving him into submission.

As you will read and see in a text message screenshot later in this book, Rob texted Sheila, "*No food,*" at 7:30 PM on September 5, 2021, over 48 hours after his arrival at the hospital. He then texted, "*No strength, no hope left.*" On Page 104 of the hospital records (see Page C-27 in Appendix C), a dietitian openly admitted Rob had "poor intake" and had "not been ordering 3 meals daily."

A hospital staff member told Sheila she could not be provided with access to her husband's records until after he was discharged to keep her from learning the details of how he was being treated. However, four days after he was admitted, she was able to retrieve a code the hospital emailed to her husband and gain access to his online MyChart records.

Even with access to the records, Sheila was at a significant disadvantage because she could only confirm what treatments Rob had received after the previous day's records had been posted. As a result, while being locked out of the hospital, she was dependent on the limited information she could obtain during her daily phone calls with nurses and doctors—which you will observe as you read her story. Disturbingly, their daily updates often conflicted with what was later recorded in the hospital records.

After being assaulted by a barrage of dangerous drugs since his arrival, on the morning of September 8, 2021, Rob was then subjected to 4.5 hours on a BiPAP—a contraindicated therapy for someone suffering from pneumomediastinum, a condition Rob was diagnosed with upon his

admission five days earlier. Pneumomediastinum is a condition where a patient has air abnormally trapped in the space in the chest between the lungs, and BiPAP therapy can (and did) significantly worsen that condition.

To make matters worse, as noted on Page 127 of Rob's hospital records (see Page C-35 in Appendix C), a doctor informed Sheila that BiPAP therapy might cause barotrauma, a potentially life-threatening condition where the alveoli, the air sacs of the lungs, rupture and collapse. The "*Repeat CXR [Chest X-ray] this afternoon to monitor barotrauma*" note on page 141 of the hospital records (see Page C-44) confirms their placing Rob on a BiPAP for 4.5 hours **did** cause this life-threatening condition—making it nearly impossible for him to adequately breathe on his own.

Sammy Wong, MD, our expert medical witness, listed Rob's being placed on a BiPAP with known pneumomediastinum as one of his "**Causes of Action**" [grounds for litigation] against the doctors, as noted on Page B-7 in **Appendix B**. We believe this therapy further damaged Rob's lungs to the point of no return, giving the doctors the excuse they were looking for to force Rob to be intubated and placed on a ventilator.

How and why Rob died—which we unravel in detail in this book—***is an absolute crime***. Moreover, it is a crime that racked up a hospital bill of $794,587.10 (before adjustments) for Rob's 40-day stay at what Sheila later referred to as a "kill shelter." In addition, the hospital received government (and perhaps pharmaceutical companies') incentives (see **Appendix D**). With the doctors' private bills added, the unadjusted total came to over $1 million.

Sadly, incentivized medications and protocols
have become a dangerous weapon against humanity.

The actions taken by the hospital administrators, doctors, nurses, and staff—such as isolating Rob, heavily medicating him, intimidating and humiliating him, depriving him of nourishment, causing him total desperation, and ultimately intubating and ventilating him—were motivated by their self-interests.

We argue that their single-minded focus on what would most benefit them rather than what would most benefit the patient ultimately resulted in his unnecessary and tragic death. They literally "forced their will down Rob's throat" by weakening him through a lack of adequate nutrition and the use of harmful medications and therapies. This allowed them to achieve their objective of intubating and ventilating him, which ultimately ended his life.

As you will discover by reading this emotional and disturbing true crime story, the protocol that kills' pattern of treatment—a pattern that is being followed in hospitals throughout the United States and possibly in other countries—consists of **isolation, heavy medication, intimidation, humiliation, starvation, desperation, intubation, ventilation, devastation, and termination**.

From the day of Rob's admission, the doctors and nurses never let up on their daily, and sometimes hourly, badgering of Rob to agree to be sedated, intubated, and placed on a ventilator. They continually referred to it as Rob's need to agree to "*elective intubation*."

As a result of this harassment, Rob texted Sheila on his 4th day in the hospital, "*Doing all they can to try to get me to agree to intubate. I'm dead if they do.*" Sadly, their daily abuse continued until Rob was finally sedated, intubated, paralyzed, and ventilated.

We believe that Robert A. Skiba II died as a direct result of the hospital's and doctors' unwavering, ruthless, and deadly protocol that they consistently followed whenever a patient had "**COVID-19**" stamped on their chart, especially if the record stated "**UNVACCINATED**" in **BOLD CAPITALS**, as can be seen on page 53 of Rob's medical records (see Page C-8 in Appendix C). *In addition, we contend that many doctors and nurses are prejudiced against the "unvaccinated" and especially target them for ventilation.*

> **LEGAL COUNSEL STATEMENT**
> Members of the jury, to protect the identity of the doctors, nurses, and hospital staff—and to universalize the story, which is regrettably repeating itself in hospitals across the U.S. and potentially abroad—**their names have been redacted and replaced with pseudonyms**.
>
> We admit that the aliases selected are not complimentary. They were chosen to help portray the terror Sheila, and her family experienced as the doctors, nurses, and staff indifferently and rigidly followed "the protocol that kills." In addition, we have chosen to refer to the hospital as the **Covid Coven Hospital of Plano, Texas**.

Clear evidence that "*the protocol that kills*" was the plan of care for Rob from the moment he arrived can be found in the "**Impression and Plan**" written by Nurse Practitioner Horrendous, who, at 9:07 PM, minutes after his admission to the ICU, wrote in Rob's records on Page 27 (see Page C-3 in Appendix C), "***Patient is at high risk for intubation.***" *She wrote this note even though Rob, as noted on Page 3005 of his records (see Page C-4), was improving on supplemental oxygen and his blood oxygen level had risen up to the range of 95% to 98%.*

Once he was on the ventilator, Rob's doctors continued to poison him with thousands of dollars' worth of unnecessary and harmful medications that helped hasten his death, which occurred after 40 days in the hospital and 35 days on a ventilator. Below is a list of just three:

- Tocilizumab (a rheumatoid arthritis drug given for a condition Rob did not have) = $12,175
- Nimbex (a paralytic used while Rob was on the ventilator) $1,070/dose x 50 doses = $53,500
- VELETRI (instead of the budesonide they requested) $148.36 per dose x 104 doses = $15,429

As you read this story, you will find yourself asking, "*Why?*"—just as Sheila did regarding the actions of the doctors, nurses, and staff during Rob's 40-day hospital stay while a man's life was being weighed in the balance. *We believe the choices they made cost Rob Skiba his life.*

If you have had any doubt about whether patients have been dying needlessly in hospitals across America, consider this quote from Undercover Epicenter Nurse: How Fraud, Negligence, & Greed Led to Unnecessary Deaths at Elmhurst Hospital, where Erin Marie Olszewski, BSN, RN, stated:

"*I can't tell you how many people I've seen in hospitals across the country who would rather live in denial than admit to themselves that their loved one is dying unnecessarily. Especially in America, many people would rather live in the comfortable bubble of ignorance than look evil in the eye.*"

Olszewski, Erin. "Introduction." Undercover Epicenter Nurse: How Fraud, Negligence, & Greed Led to Unnecessary Deaths at Elmhurst Hospital, Skyhorse, 2020.

Rob once proudly served as an Army helicopter pilot who swore to—and throughout his life stood by—the following oath:

*I, Robert A. Skiba II, do solemnly swear (or affirm) that I will support and defend the Constitution of the United States against all enemies, foreign **and domestic**; that I will bear true faith and allegiance to the same; and that I will obey the orders of the President of the United States and the orders of the officers appointed over me, according to regulations and the Uniform Code of Military Justice. So help me God.*

Rob was willing to risk his life to defend his country. He was brave and he was courageous. He was a man who was constantly in search of and who stood for truth and justice. *A valiant soldier has fallen at the hands of a domestic enemy. After you have read his harrowing story, we ask that you stand with us against this unspeakable tyranny.*

Join us now in looking evil square in the eye as we reveal the disturbing, true story of what was done to Rob Skiba by so-called "medical professionals."

We now present to you, members of the jury of the court of public opinion, a wealth of compelling evidence we believe will incontrovertibly prove that Robert A. Skiba II, a healthy 52-year-old male with no comorbidities, would be alive today if the hospital had taken a conservative, personalized approach to his care and limited the scope of their treatment to supplemental oxygen, steroids (such as budesonide), antibiotics (for infection), and nutrition.

Unfortunately, a conservative and life-saving plan of care would not have been financially beneficial to the hospital or the doctors. Thus, they forced Rob to succumb to the horrifying "protocol that kills."

After Rob's death, Sheila and a small, dedicated team thoroughly reviewed Rob's hospital records. During their review, they unearthed many nefarious and incomprehensible acts that unraveled the mystery of why her otherwise strong and healthy 52-year-old husband of 14 years—and who faced an exceptionally negligible risk (a less than 1% chance) of dying from COVID-19—lost his life in a hospital after suffering 40 days of "the protocol that kills."

The gavel has fallen.
Jurors, you may now be seated.

Chapter 3 – Hospitalization & Isolation

THIS CHAPTER COVERS SEPTEMBER 3, 2021 (Admission Day)

Friday, September 3, 2021

The entire world had mysteriously turned violently upside down. Everyone seemed to be in a trance as I rolled Rob into the Emergency Department at around 4:50 PM. A nurse and a security guard cowered behind their obligatory blue masks. The nurse at the desk gave me a stern stare that broadcast a sense of annoyance instead of radiating a sense of welcome.

Another nurse tossed a blue mask at my husband and yelled, "He needs to put this on!" She did not seem to notice or care that he was already wearing a transparent plastic shield that made it far easier for him to breathe while still protecting others from his consistent coughing.

After looking down at the mask in his lap, Rob gave me a pitiful and apprehensive look as he struggled to breathe between his uncontrollable bouts of coughing. I cried out, "No, he can't breathe!" The hateful and heartless nurse pointed at the mask with a demanding look.

Her chief concern was getting a mask on Rob's face—as if that was the most pressing issue, not Rob's difficulty breathing. When did it make sense to ask someone struggling to breathe to cover their face with a paper mask? Whatever happened to the age of reason?

She glared at me and waited for my compliance; I removed his clear face shield and begrudgingly put the mask on his face. Even then, I knew full well that my doing so would further reduce his blood oxygen level—which had already dropped to 71% according to the pulse oximeter we had used at home. A wave of panic overcame me as I could sense Rob's anxiety increasing because of how he was being treated.

When I finished placing the mask on Rob's face, the unsympathetic nurse shouted, "You need to leave!" She then quickly and forcefully wheeled my anxious husband away, indicating that I could not follow her and stay by his side. As she sped off, I yelled to her, "Don't you want my husband's medical history?" Her abrupt response was, "Is he vaccinated?"

I immediately thought, "What difference does it make whether or not Rob is vaccinated?" But, knowing how paranoid some people can be, I nervously squeaked out, "No!" as Rob began to vanish into the distance. Then, before they turned the corner, I heard him blurt out in an apprehensive tone between coughs, the last words I would hear him speak to me in person: "*If they don't let you be my advocate, I'm going to die in here!*"

> **LEGAL COUNSEL STATEMENT**
> Members of the jury, as noted above, Sheila thought, "*What difference does it make whether or not Rob is vaccinated*." Sadly, she would soon find out, as Page 28 of Rob's hospital records (see Page C-6 in Appendix C) states in bold italics, "***He has not been vaccinated.***" On Page 53 of his records (see Page C-8) you will find, "**COVID 19 VACCINATION STATUS: UNVACCINATED**."
>
> *They were not at all concerned with Rob's medical history. They only wanted to know if he had been vaccinated. Patients and their families across America have reported that unvaccinated patients have been targeted and received harsh treatment by cold-hearted pro-vax doctors and nurses who appear to have a substantial prejudice against the "unvaxxed" and wish to make examples of them.*

Covid Coven Hospital Waiting Room

As the nurse sped away, I pleaded, "**His father lost a kidney. So, NO remdesivir and NO ventilator!**" The Emergency Department waiting room had such an eerie feeling about it, and as the angry nurse sped away with my husband, I thought, "*Oh Lord, what are they going to do to Rob in this place?*"

In compliance with the nurse's demands, the security guard assigned to the Emergency Department rapidly and brutishly ushered me out the sliding glass doors, not unlike a bar bouncer ushers an unruly patron out of a bar.

As the automatic doors abruptly slid closed behind me, I found myself standing outside in a daze with my sister, who had followed us to the hospital, standing by my side with a blank stare on her face. I was shocked and unable to speak. My heart sank, and I felt a deep fear choking me and making it hard for me to breathe. I thought, "What in the world just happened!" I had fully expected to be able to stay by his side, assist the nurses with his care, and even sleep overnight in a chair at his bedside as I had before at this hospital when other relatives of mine had been

hospitalized in the past. Now I was standing outside while Rob was trapped inside with no loving family member by his side.

While reflecting on what had just happened, I wondered whether I should run back in past the guard, chase down the nurse, snatch the wheelchair from her hands, and dart back out to my car with Rob. The temptation to do that was unbearable. Yet I realized if I ran out with him, I would have no way of saving him on my own as I had no other means of quickly getting him the supplemental oxygen he desperately needed.

I looked at my phone and saw it was a little after 5:00 PM. Although the sun had not yet set, I felt like everything had become black and dreary. No light could penetrate the unnatural darkness that now surrounded me.

When I arrived home, I called Rob to ensure he was okay. He said they had placed him on oxygen, his blood oxygen level had risen to a normal 95%, and he was feeling much better. I told him he would be okay and encouraged him to get some much-needed rest.

I tried to calm my mind by telling myself that his hospital stay should be brief and that he would likely return home fully recovered in just a day or two. I began to think, "Okay. Be calm. The hospital staff will stabilize Rob with oxygen, help him regain his strength, and he will come home soon."

Rob and I fully expected that if we both took a hardline stance against remdesivir, intubation, and ventilation, he would be okay—and would not become another grim statistic.

Hoping for assurance that I had made the right decision, I called my son, Jeremiah, who lived nearby. When I shared with him what had just happened, he was horrified to hear I had been abruptly ushered out of the hospital. He knew we had both been sick, yet he did not realize that while I had gotten better, Rob had only worsened and needed supplemental oxygen.

I tearfully told him, "They took him away from me and told me to leave, Jeremiah! What am I to do? I'm so afraid!" He tried to assure me, "Don't worry, mom. Everything is going to be okay. That's the same hospital you took Papi to, and they took good care of him. Remember how they saved his life when he got a pacemaker? So, there's nothing to worry about. They will give Rob the same kind of care they gave Papi. Besides, Rob is a man of God, and there is no way God would allow him to be taken out this way. You did the right thing."

I shared, "His oxygen was so low, Jeremiah. The telemedicine doctors told me to take him to the Emergency Department." He assured me that Rob's getting oxygen and antibiotics would fix everything. Even then, Jeremiah's encouraging words did nothing to quell my fear. I wanted to believe my family was right. They all agreed that God had a plan for Rob's life, that he had much more to do, and that it was not his time to go.

I continued, "Jeremiah! Rob said he would die in there if I couldn't be his advocate." He said, "Mom, don't worry. He will be okay. I know he will. I'm on my way over. Just give me a few minutes. I'll gather my things and stay the night with you." I pitifully cried, "Okay," and hung up the phone.

Despite my son's attempts to reassure me, I still felt desperate and overwhelmed. It was as if I was on a fast-moving rollercoaster that was constantly flipping and turning, causing me to feel physically ill and drained. My body's fight-or-flight response had been kicked into high gear, and I could not turn it off.

My family fully believed Rob would be okay and would survive this ordeal. Yet I kept hearing Rob saying, "***If they don't let you be my advocate, I'm going to die in here!***" I cried out, "Oh God, HELP ME! If Rob dies, I will die! I cannot and will not live without him. He's my everything!"

I yelled, "Nothing matters anymore!" I beat my fists against the wall and slid down to the cold, hard, tiled floor as I cried uncontrollably with angry tears that transitioned to fearful and grief-stricken wailing tears. I had never known this level of grief before.

My mother's heart broke as she watched her broken daughter lie limp on the floor. Her tears joined with mine as she suffered from the angst of not knowing how to save me from my self-implosion.

Jeremiah finally arrived, swung open the front door, and could hear me crying at the back of the house. He sat beside me and placed his hand on my back to comfort me. Seeing my face drenched with tears, he gently lifted me as I clung to him and cried on his shoulder.

He lovingly said, "Mom, everything is going to be okay. I'm here now and will help you in any way I can. You did the right thing. In a few days, Rob will be home. I'm praying for Rob. God will not allow him to die in the hospital. He's such a good man. Don't worry, Mom. Everything is going to be okay. All he needs is a little oxygen."

He listened with great compassion as I poured out my heart. Finally, my anxiety had lessened enough that I could call the Emergency Department to check on how Rob was doing. They told me his blood oxygen was still at 95%, and he was doing okay. My sister said, "See, I told you they would help him and get him on the road to recovery."

At 10:33 PM, I called the Emergency Department again and was advised that at 9:05 PM, Rob had been admitted and moved to the Intensive Care Unit (ICU). So, I called the main hospital number and asked to be connected with the ICU.

LEGAL COUNSEL STATEMENT
Members of the jury, upon being administered oxygen, Rob's blood oxygen level rose **from 71%** into the **upper 90s**. Yet at 9:05 PM, they decided to admit Rob to the ICU instead of a room on a regular floor so they could give him a high-risk, nebulized, off-label drug called **VELETRI**, a drug that is so high-risk that it may only be administered in the ICU because it can cause patients *severe shortness of breath, gasping for breath, and possible death*— risks that were not disclosed to Rob or Sheila.

Drugs.com notes, "*VELETRI may cause **serious side effects***," which include "***symptoms of pulmonary edema*** (an X-Ray on September 5, 2021, noted Rob had multifocal pneumonia and pulmonary edema)—*anxiety, sweating, pale skin, **severe shortness of breath**, wheezing, **gasping for breath**, cough with foamy mucus, chest pain, fast or uneven heart rate*."
VELETRI uses, Side Effects & Warnings. Drugs.com. (n.d.). From https://www.drugs.com/mtm/veletri.html

Why would the doctors prescribe someone suffering from Covid pneumonia, who had been diagnosed with pulmonary edema (which VELETRI can cause or exacerbate), and is already having difficulty breathing, a drug that can cause increased fluid in the lungs, increased difficulty breathing, and severe anxiety?

Our independent medical expert, Sammy Wong, MD (as noted in Appendix B), stated that **VELETRI** "*is indicated for people with known 'severe pulmonary arterial hypertension [PAH].' There was no objective evidence [that is, a diagnosis of pulmonary arterial hypertension does not appear anywhere in Rob's records indicating] that he had severe PAH.*"

In his **Causes of Action,** Dr. Wong stated that VELETRI "*can incite a profound inflammatory response in the pulmonary interstitium [the tissue in and around the wall of the alveoli (air sacs) of the lung where oxygen moves from the alveoli into the capillary network (the bloodstream)]. Due to a lack of indication for its use, the patient was subjected to unnecessary risks*."

Covid creates a significant inflammatory response in the lungs, and the last thing a Covid patient needs is increased inflammation of the tissue between the alveoli (air sacs) and the capillary network where oxygen is delivered into the bloodstream.

We firmly believe Rob would have continued to improve and be alive today if he had only been given supplemental oxygen, antibiotics, steroids (such as budesonide, an inhaled corticosteroid that had been proven **90% effective for Covid** with two randomized control trials as noted in **Appendix F**), and adequate nutrition. Instead, as you learn, he was administered an abundance of dangerous drugs and contraindicated therapies—drugs and therapies that only worsened his condition and caused his death.

Just after midnight the evening of Rob's arrival in the Emergency Department, Dr. Useless, the hospitalist, wrote on Page 23 of Rob's hospital records (see Page C-2), "*It is anticipated that he will require at least a two-midnight inpatient stay*." Unfortunately, a plan for a short-term stay where every effort would be made to stabilize Rob with the least number of medications and the least invasive therapies possible so he could be promptly discharged and sent home would not be profitable for the hospital or the doctors. As we stated earlier, the actual plan for Rob was laid out when Nurse Practitioner Horrendous wrote in Rob's record at 9:07 PM, minutes after his admission to the ICU (see Page C-3 in Appendix C), "*Patient is at high risk for intubation.*"

In an editorial published on April 22, 2022, in the peer-reviewed journal Surgical Neurology International, Russell L. Blaylock, MD, a retired neurosurgeon, said: "*For the first time in American history, a president, governors, mayors, hospital administrators, and federal bureaucrats are determining medical treatments based not on accurate scientifically based or even experience-based information, but rather to force the acceptance of special forms of care and 'prevention'—including remdesivir, use of respirators and ultimately a series of essentially untested messenger RNA vaccines. For the first time in history medical treatment, protocols are not being formulated based on the experience of the physicians treating the largest number of patients successfully, but rather individuals and bureaucracies that have never treated a single patient—including Anthony Fauci, Bill Gates, EcoHealth Alliance, the CDC, WHO, state public health officers and hospital administrators. . . even worse is the virtually universal control hospital administrators have exercised over the details of medical care in hospitals.* ***These hirelings are now instructing doctors which treatment protocols they will adhere to and which treatments they will not use, no matter how harmful the 'approved' treatments are or how beneficial the 'unapproved' treatments are****.*

"*Never in the history of American medicine have hospital administrators dictated to its physicians how they will practice medicine and what medications they can use. The CDC has no authority to dictate to hospitals or doctors concerning medical treatments.* ***Yet, most physicians complied without the slightest resistance.***

> "*The federal Care Act encouraged this human disaster by offering all US hospitals up to 39,000 dollars for each ICU patient they put on respirators, despite the fact that early on it was obvious that the respirators were a major cause of death among these unsuspecting, trusting patients. In addition, the hospitals received 12,000 dollars for each patient that was admitted to the ICU—explaining, in my opinion and others, why all federal medical bureaucracies (CDC, FDA, NIAID, NIH, etc.) did all in their power to prevent life-saving early treatments.*"
> Covid update: What is the truth? Surgical Neurology International. (2022, May 10). From https://surgicalneurologyint.com/surgicalint-articles/covid-update-what-is-the-truth

With a nervous and shaky voice, I advised nurse Imposter, who answered the phone, that I was Sheila Skiba, Rob's wife, and asked her how he was doing. She said, "His blood oxygen level is currently at 99% while on high-flow oxygen. His blood pressure is 116/67, which looks great, and his heart rate is 72." Wow, he is doing great! I thought.

> **LEGAL COUNSEL STATEMENT**
> Members of the jury, Sheila and Rob initially had no idea that long durations of unnecessarily high concentrations of oxygen would further injure his lungs. We will cover this in greater detail later in the book.

I told the nurse that Rob and I did not want him to have remdesivir, nor did we want him to be intubated and placed on a ventilator. To my horror, she informed me that he had already been given an initial double dose of remdesivir! I insisted that she write in his record that they needed to stop giving it to him because it could damage his kidneys.

She promised to note my request in his records and mention it to the day shift nursing staff when they arrived in the morning. She then said Rob had "refused insulin." What? Rob had refused insulin but accepted remdesivir. That made no sense, as he would have refused BOTH drugs if he knew they were being administered—especially remdesivir because he had called it, "Run Death Is Near!"

END OF MAIN BODY PREVIEW

Chapter 3 continues for several more pages and is followed by Chapters 4 through 9 for a total of over 300 more pages in the main body.

Appendix A – Key Facts

- **Initial condition:** Rob Skiba, an otherwise healthy 52-year-old man with no comorbidities, was admitted to a hospital in Plano, Texas, on September 3, 2021, with the hope of receiving beneficial treatments for persistent coughing and a low blood oxygen level.
- **Expected treatments:** Even if Mr. Skiba were accurately diagnosed with COVID-19, being under age 65 with no comorbidities, he faced an exceptionally minimal risk (a less than 1% chance) of dying from COVID-19 *if given the proper and conservative treatments he expected.*
    - *Conservative treatments would have included:*
        - *supplemental oxygen at as low a percentage as necessary to maintain an adequate blood oxygen level while avoiding oxygen toxicity,*
        - *aiding Rob in self-proning to reduce the pressure of the heart and mediastinum on his lungs, thereby reducing the percentage of inspired oxygen required to keep his blood oxygen level at 90% or higher,*
        - *nebulized budesonide (a corticosteroid) at a dose of 1 mg every 4 hours to reduce the inflammation in his lungs,*
        - *adequate nutrition to ensure he could regain the strength he needed to heal, and*
        - *antibiotics, as necessary, for bacterial pneumonia or other infections.*
    - Once adequately stabilized by conservative treatments, Rob could have been sent home within a few days with orders for at-home supplemental oxygen therapy and prescriptions for the few remaining medications necessary to continue his recovery.
- **PCR testing:** Soon after his arrival, Rob was given a PCR test. According to the hospital records, he tested positive for COVID-19. At that time, in the U.S., the PCR test was generally cycled up to 40 times to detect "*viral fragments*" from nasal or throat samples.
    - *PCR test cycles of greater than 35 can be relatively meaningless because they may detect fragments of dead viruses or a nucleotide (a fundamental building block of DNR and RNA) that are mistaken for a live virus fragment. Thus, most of the "positive" results are false positives.*
- **Apparently targeted:** Rob appears to have been targeted because he had not received an admittedly *experimental mRNA COVID-19 vaccine*.
    - This is evidenced by the fact that the first and only question Sheila was asked when she delivered Rob to the hospital Emergency Department was, "Is he vaccinated?" On Page 28 of Rob's hospital records (see Page C-6 in **Appendix C**), you can see they wrote in bold italics, "***He has not been vaccinated***." On Page 53 of his records (see Page C-8), you will find, "**COVID 19 VACCINATION STATUS: UNVACCINATED**."
    - *Patients and their families across America have reported that unvaccinated patients have been targeted and received harsh treatment by cold-hearted pro-vax doctors and nurses who appear to have a substantial prejudice against the "unvaxxed" and wish to make examples of them.*

- **Protocol initiated:** "The Protocol That Kills" plan of action was **in play from the moment Rob arrived at the hospital,** as evidenced by the fact that although Rob's blood oxygen level rose from 71% into the upper 90s upon the administration of supplemental oxygen, Nurse Practitioner Horrendous wrote in Rob's record at 9:07 PM, minutes after his admission to the ICU (see Page C-3), "*Patient is at high risk for intubation.*"
    - *Her note clearly indicates that the plan was to force on Rob "the protocol" from the moment he arrived—a protocol that consisted of isolation, heavy medication, intimidation, humiliation, starvation, desperation, intubation, ventilation, devastation, and eventual termination.*
- **Unnecessary lockout:** Although Sheila Skiba, Rob's wife of 14 years, had a signed Medical Power of Attorney, had been exposed to Rob during his illness for seven days at home, had overcome the illness, and had antibodies to the disease, the moment she delivered Rob to the Emergency Department, **they forced her to leave and needlessly forbid her visiting her husband** (other than two brief 20-minute and one-hour exceptions) **for 21 days**.
    - *The conduct of all defendants to this cause of action where they prevented Rob and Sheila from having physical contact for 21 days, thereby preventing Sheila from serving as Rob's on-site medical advocate and properly overseeing his care (or mistreatment), constituted criminal neglect.*
    - Sheila repeatedly demanded a copy of the hospital's "21-day" visitation restriction in writing, yet one was never provided. *The defendants' refusal to provide her with a written copy of their visitation policy and restrictions violated Title 42 of the Code of Federal Regulations, Section 482.13 (as noted in **Appendix E**), which states, "A hospital must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reasons for the clinical restriction or limitation.*"
- **ICU Admission:** Despite his immediate improvement on supplemental oxygen alone, at 9:05 PM on September 3, 2021, they decided to **admit Rob to the ICU** instead of a room on a regular floor so they could give him a high-risk, nebulized, **off-label use drug called VELETRI**. Veletri is *so high-risk* that it may only be administered in the ICU because it can cause patients severe shortness of breath, gasping for breath, and possible death— risks that were not disclosed to Rob or Sheila. Rob was given 12 doses of this drug.
    - In his "Causes of Action" (see **Appendix B**), Sammy Wong, MD, stated that VELETRI "*can incite a profound inflammatory response in the pulmonary interstitium [the tissue in and around the wall of the alveoli (air sacs) of the lung where oxygen moves from the alveoli into the capillary network (the bloodstream)]. Due to a lack of indication for its use, the patient was subjected to unnecessary risks*."
- **Forced remdesivir:** Mr. Skiba's risk of death dramatically changed for the worse after being assaulted with nebulized **VELETRI** and then being given a high-risk drug named **remdesivir** without his "informed consent" and against the express wishes of his wife, Sheila Skiba, who had Medical Power of Attorney. Instead of honoring their directives that he NOT be given remdesivir, they administered six doses from September 3rd to September 9th, with two being double, 200 mg "loading" doses.
    - This was done to Rob despite the WHO's 2020 "Solidarity Trial" indicating that remdesivir had little or no effect on hospitalized patients with Covid-19. On

November 19, 2020, the British Medical Journal published an article titled "**WHO Guideline Development Group advises against use of remdesivir for covid-19**" where they stated, "*The antiviral drug remdesivir is not suggested for patients admitted to hospital with covid-19, regardless of how severely ill they are, because there is currently no evidence that it improves survival or the need for ventilation.*"
Who guideline development group advises against use of remdesivir for covid-19. BMJ. (n.d.). From https://www.bmj.com/company/newsroom/who-guideline-development-group-advises-against-use-of-remdesivir-for-covid-19

- In addition, on February 26, 2021, the National Library of Medicine published an article titled "**Kidney disorders as serious adverse drug reactions of remdesivir in coronavirus disease 2019,**" where they pointed out that "*the use of remdesivir was associated with an increased reporting of kidney disorders*" and stated, "*real-life data from > 5000 COVID-19 patients support that kidney disorders, almost exclusively AKI [Acute Kidney Injury], represent a serious, early, and potentially fatal adverse drug reaction of remdesivir.*" It is, therefore, no surprise that on Rob's death certificate, the underlying cause of death was listed as "**ACUTE KIDNEY INJURY**."
Chouchana, L., Preta, L.-H., Tisseyre, M., Terrier, B., Treluyer, J.-M., & Montastruc, F. (2021, May). Kidney disorders as serious adverse drug reactions of Remdesivir in coronavirus disease 2019: A retrospective case-noncase study. Kidney international. From https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7907730

- **Refused budesonide.** Instead of giving Rob life-saving drugs such as **nebulized budesonide**, which Sheila repeatedly requested, they flooded him with **SOLU-MEDROL**, a potent steroid that can cause trouble breathing and shortness of breath and increase the risk of systemic infections. Although he was eventually administered one small dose of nebulized budesonide per day starting on September 9, 2021, the day after he was placed on a ventilator, it was far too little too late.
  - Speaking of SOLU-MEDROL, an article in WebMD noted, "*This medication may lower your ability to fight infections. This may make you more likely to get a serious (rarely fatal) infection or make any infection you have worse.*"
    WebMD. (n.d.). Solu-Medrol intravenous: Uses, side effects, interactions, pictures, warnings & dosing. WebMD. From https://www.webmd.com/drugs/2/drug-152303/solu-medrol-intravenous
  - *Rob already had symptoms (trouble breathing and shortness of breath) that this high-powered systemic steroid was known to likely cause or exacerbate, and he already had a severe infection (pneumonia). If this drug could "make any infection you have worse," and cause or worsen symptoms Rob already had, why would his physicians administer SOLU-MEDROL instead of safe and effective budesonide, which was known to reduce patients' recovery time as noted in the article abstract in* ***Appendix F****.*

- **Negligent starvation:** While isolated and on his own, Rob did not have the strength to even think about ordering meals. In addition, he was too weak to feed himself even if a meal were delivered. On September 5, 2021, the third day of his stay, Rob texted Sheila, "*Doing all they can to try to get me to agree to intubate. I'm dead if they do.*" Later that same day, he texted, "***No food***." Whether due to willful ignorance, uncaring negligence, or nefarious intent—Robert A. Skiba II was slowly and systematically **starved into submission** so he would eventually succumb to "the protocol that kills."
  - *As noted on Pages 104, 105, 117, and 149 of Rob's hospital records (see Pages C-27, C-28, C-30, and C-31 in* ***Appendix C****), Rob was being slowly starved into submission while being further weakened by the* ***remdesivir*** *(which is known to cause trouble breathing and acute kidney injury) and* ***VELETRI*** *(which should NEVER be used on a patient who*

is already short of breath because it may cause SERIOUS side effects that include "severe shortness of breath, gasping for breath, and anxiety").

- *The "pt has not been ordering 3 meals a day" and "Unsure about pt's weight history" notes on Page 149 (see Page C-31) are especially troubling as they clearly indicate the doctors, nurses, and dietitian were all well aware that Rob—who had no one assisting him in eating and drinking—was becoming critically weakened by severe malnourishment.*
- *On September 13, 2021, five days after Rob was placed on the ventilator, Dr. Wicked admitted to Sheila, "So, by the time he got on the ventilator, of course, **we were nutritionally down,** **and he hadn't been fed for several days before**. So, he may not, you know, he may not have enough reserve in two weeks."*

- *Medical malpractice occurs when a physician fails to follow accepted standards of care, thereby causing harm to a patient. The ongoing and unaddressed malnutrition clearly harmed Rob. The doctors' negligence of Rob's nutritional state further depleted any "reserves" (physical strength) he may have had when he arrived at Covid Coven Hospital in Plano, Texas.*

- **Constant badgering:** From the moment of his arrival, Rob was **continually badgered** to agree to be intubated and placed on a **ventilator** and agree to receive **remdesivir** (which they had already begun to give him without his consent).
  - One example can be found in the 5:43 PM note on September 5, 2021, located at the bottom of Page 78 (and continues at the top of Page 79) of the hospital records (see Pages C-17 and C-18), where Nurse Malign noted she had a "*Lengthy discussion with patient regarding intubation and use of Remdesivir.*"
  - Less than 5 hours later, at 10:40 PM, Nurse Felonious disrupted Rob's insufficient rest and "checked with pt [patient] about limited DNR [Do Not Resuscitate] status," as you can see in the note on the bottom of Page 79 of the hospital records (see Page C-18). Rob reiterated, "**I want to avoid intubation,**" as you can see in the highlighted notes on Page 79 of the records (see Page C-18).
    - At the same time, she noted on Page 79 that Rob's blood oxygen level was at 94% (see the top of Page 79 on Page C-18), which is substantiated by the vital signs shown on Pages 2411-2412 (see Page C-19). Thus, there was no reason to be pressing Rob to agree to be intubated and placed on a ventilator.
  - During a call with Sheila on September 7, 2021, Rob said, "*The doctors are doing all they can to make me take remdesivir and be intubated. They harass me every time they come into my room. They send in the nurses to badger me. I told them to put it in my record NO remdesivir and in bold DO NOT INTUBATE. I don't know how I'm going to survive this if they have their way! But I'm trying to be strong and need the oxygen*."
  - *These so-called "medical professionals" would not let up—and their continual harassment of Rob violated Paragraph (c)(3) of Title 42 of the Code of Federal Regulations, Section 482.13 (see **Appendix E**), which clearly states: "The patient has the right to be free from all forms of abuse or harassment."*

END OF APPENDIX A PREVIEW

Appendix A continues for 8 more pages.

Appendix B – Medical Expert Testimony

Sammy Wong, MD FACP — Letter of Introduction

July 21, 2022

To whom it may concern:

Re: Robert Skiba

Having provided formal and informal opinions, often without compensation, on well over a hundred cases over the past 30 years along with expert opinions and testimonies for the Medical Board of California, I recently came across a case that has multiple areas of medicolegal vulnerabilities.

While most cases that are presented to me are from attorneys, physician-clients and the Medical Board, I was introduced to Mrs. Sheila Skiba through a physician friend. Her 52-year-old previously healthy, robust and highly influential husband, Robert, was speaking at a conference in Ohio in August 2021 and came down with COVID symptoms. He was treated but continued to have a cough as he returned home to Plano, Texas.

He was seen at a local hospital and his oxygen saturation was noted to be low at 71%. A chest X-ray showed pneumomediastinum (abnormal air collection in the space between the lungs).

As he was hospitalized, he and Sheila requested that he not be given **remdesivir** and not be mechanically ventilated. Instead, a nurse practitioner prescribed **remdesivir** which was given. **VELETRI**, used for pulmonary hypertension, was also given even though he had no evidence for this condition. (*VELETRI is associated with development of profound inflammatory response in the lungs*.)

He was also given **Tocilizumab** even though an article in New England Journal of Medicine published 5 months earlier clearly indicated lack of benefit in people with COVID. He was also given **baricitinib** which resulted in hepatitis yet was ineffective against COVID. The baricitinib-associated hepatitis was overlooked. He developed liver failure 9 days after the baricitinib was stopped. He died 3 days later.

Aside from giving Robert *ineffective and harmful medications*, he was subjected to bi-level positive airway pressure (BiPAP) even though he had the known pneumomediastinum. He was oxygenating adequately with supplemental high flow oxygen. BiPAP is contraindicated in pneumomediastinum. He was reportedly "claustrophobic" with BiPAP and was intubated shortly thereafter in spite of prior refusals.

There were no arterial blood gases (ABGs) prior to the intubation to verify impending respiratory failure. Available notes indicated that he was not in acute distress prior to the intubation. After he was sedated, paralyzed, intubated, and mechanically ventilated, a chest X-ray showed new extensive pneumomediastinum.

Since he was sedated and paralyzed, he was dependent on the ventilator. All of the ABGs showed profound respiratory acidosis indicating that the staff chose not to adjust the ventilator settings to improve his alveolar ventilation. *They just maintained his ventilator settings essentially unchanged . . . until he died.*

While there were multiple treatment-related issues, the standard diagnostic process was clearly abandoned. As soon as he informed the ER staff that he was treated for COVID, they perseverated (repeat or prolong an action, thought, or utterance after the stimulus that prompted it has ceased) in keeping that diagnosis. They did not expand the differential diagnosis in this patient who had caught something while in Ohio. They also did not consider doing a bronchoscopy or lung biopsy in this otherwise, young healthy man.

After his death, a private autopsy showed severe and extensive fibrosis with diffuse alveolar damage consistent with (cryptogenic) organizing pneumonia. (This is not "pneumonia" per se that is treated with antibacterial antibiotics.) The standard treatment for organizing pneumonia is high dose corticosteroids which results in complete recovery in up to 80% of patients within a few weeks.

Many of the cases that I have reviewed have a single extreme departure from the standard of care or a few simple departures. In this case, there are ***multiple extreme departures****. There were multiple temporal and proximate relationships that would suggest causation.*

The lack of expediting an aggressive diagnostic work up for his cough yet attributing everything to COVID reflects disregard to basic diagnostic medicine. *If you do not make the diagnosis, you can't treat the patient properly and often subject the patient to* ***unnecessary harms****. It took 40 days and an autopsy to make the diagnosis.*

Although I have not completely reviewed and analyzed all of the over 5,000 pages of the medical record, I have already identified key medicolegal vulnerabilities (**Interim Analysis Report**), indexed the huge document, and entered data into Excel format for ease of trending and associating conditions with interventions.

I believe this is a case that bears altruistic impact, accountability, and societal benefit.

Sincerely,

Sammy S. Wong, MD FACP
Assistant Professor of Medicine (ret)
Medical Consultant and Expert, Department of Consumer Affairs, Medical Board of California

The views expressed by Dr. Wong are solely his own and
do not necessarily reflect the views of his affiliated institutions or organizations.

Interim Analysis

Sammy S. Wong, MD FACP Bio
American Board of Internal Medicine Certified Internist.
Assistant Professor of Medicine (ret), Loma Linda University School of Medicine.
Annual lecturer in ACP-sponsored ABIM preparation conferences since 1999, giving multiple presentations on Medical Malpractice, Patient Safety, Cognitive Bias, and Diagnostic Errors.
Provided expert opinions and testimonies on over a hundred cases over the past 30 years.

Mr. Skiba was a robust and healthy 52-year-old married, former Army helicopter pilot who was a keynote speaker at a major conference in Ohio late August 2021.

About 2 weeks later, on Friday, September 3, prior to the Labor Day weekend, he was seen at a hospital in Plano, Texas with a cough, congestion, shortness of breath and an oxygen saturation of 71% (normal is > 92%).

He was placed on supplemental oxygen which improved the oxygen saturation to 95%. He was without a fever and had a respiratory rate of 22 per minute. He was not ill-appearing and was not in respiratory distress. A chest X-ray showed pneumomediastinum [air abnormally trapped in the space in the chest between the lungs] and air in the soft tissue of the neck. A CT scan showed no (large) pulmonary embolus but had multiple pulmonary opacities. His white cell count was normal, but the inflammatory markers (CRP, ferritin, D-dimer) were abnormally elevated. An arterial blood gas (ABG) showed respiratory alkalosis with an arterial oxygen of 62 mmHg (saturation 94%) while on 80% supplemental oxygen.

He was admitted to the hospitalist service though a nurse practitioner from the Critical Care service was consulted. She noted that the patient had "increased work of breathing," yet he was "without use of accessory muscles or paradoxical movements" (of the diaphragm). The hospitalist noted that the patient "appears comfortable" and "in no acute distress." Even the ER physician noted "*He is not ill-appearing*" and "*No respiratory distress*." Nevertheless, the Critical Care nurse practitioner indicated that the "*Patient is at high risk for needing* intubation [as if it was a foregone conclusion—see Page 27 of the hospital records on Page C-3 in Appendix C]." Her plans included Optiflow, **VELETRI**, **remdesivir**, empiric antibiotics and enoxaparin.

At 9:05 PM on 9/3/21 he was transferred from the ED to the ICU, and at about midnight that evening he was given remdesivir in spite of the patient's and spouse's objections. He was given another five doses over the next several days. VELETRI was also started at 3:25 AM (on 9/4/21). He was temporarily moved out of the ICU on 9/5/21 because he refused intubation but was transferred back to the ICU on 9/6/21 to resume VELETRI administration. Reportedly, his oxygenation worsened though no repeat ABGs [Arterial Blood Gasses] were done. VELETRI was given without any evidence of pulmonary hypertension.

On September 8, he was placed on bi-level positive airway pressure (BiPAP) for 4 1/2 hours even though he had a known pneumomediastinum [see the bottom of Page 135 of the hospital records on Page C-37 in Appendix C]. The patient felt claustrophobic with the BiPAP [see the bottom of Page 136 of the hospital records on Page C-41 in Appendix C]. At 5:48 PM, the nurse noted that the patient was "alert, awake, cooperative, oriented (x4) and tranquil" [see the bottom of Page 3729 of the hospital records on Page C-40 in Appendix C] and that his "speech was clear." His lungs were clear though he was tachypneic and had a productive cough. Although his respiratory rate was in the 30s at 4 PM and 5 PM, it had been fluctuating in the 20s and 30s for at least the prior two days. His oxygen saturation at 5 PM was 88% though he had been fluctuating between 89 and 97% in the prior two days [see pages 3012 and 3013 of the hospital records on Pages C-38 and C-39 in Appendix C].

At 6:28 PM, the physician documented that the patient was in "mild respiratory distress," [see the top of Page 136 of the hospital records on Page C-41 in Appendix C] but the note also indicated that "Called back to bedside at 6:00 p.m. increased work of breathing respiratory muscle fatigue and requesting intubation." It is unknown whether the physician actually witnessed increased reliance of accessory muscles of ventilation, paradoxical ventilatory motion of the diaphragm, sweating, or nasal flaring. There are no available ABGs to document acidosis or increased PCO2 (to reflect lactic acidosis due to muscle fatigue with hypoventilation) prior to intubation. End-tidal CO2 was checked only during intubation and not prior.

With intubation, he was sedated and paralyzed for the rest of his hospitalization with continuous infusions of cisatracurium, fentanyl, midazolam, propofol and ketamine. Prior to this hospitalization he had never been on any of these medicines.

His course was complicated with Klebsiella bacteremia and fungemia as well as profound anemia with blood noted in the stool. No endoscopy was done. The spouse requested Procrit instead of blood transfusion.

On September 20, baricitinib was prescribed for 12 days. Notably, he developed hepatitis on October 2, but the cause was attributed to hepatic steatosis or COVID. The liver enzymes returned near normal but on October 10, the liver enzymes shot up into the thousands. This was attributed to "ischemic" liver. The next day, he developed acute renal failure (Cr 1.5).

By the morning of October 13, his kidney function worsened (Cr 2.11) and for some reason at this level of kidney dysfunction, Continuous Renal Replacement Therapy (CRRT) was to be implemented. He had a dialysis catheter placed via the right internal jugular vein that morning. However, later that afternoon, he developed pulseless asystole and died after 4 rounds of epinephrine were given between chest compressions. No attempts at defibrillation were documented in the event the asystole was fine ventricular fibrillation. Mr. Skiba was pronounced dead at 5:11 PM.

An autopsy was performed by a privately paid pathologist 2 days later showed the following:
I. Organizing pneumonia:
   a. Diffuse, bilateral, dense, tan-red, fibrotic lung parenchyma
   b. Focal firm brown lung parenchyma in the left upper lobe
   c. Cysts and honeycombing with necrotic debris/hemorrhage
   d. Small pleural effusions
   e. Microscopic findings consistent with end-stage organizing pneumonia:
   i. Diffuse alveolar damage
   ii. Areas of ischemic/necrotic lung parenchyma
   iii. Diffuse fibrosis
   iv. Microcystic remodeling
   v. Arteriolar clots and re-cannulization.
II. Cardiac hypertrophy (552g).
III. Anasarca of the soft tissues.
IV. Red-purple contusions of the chest and abdomen.

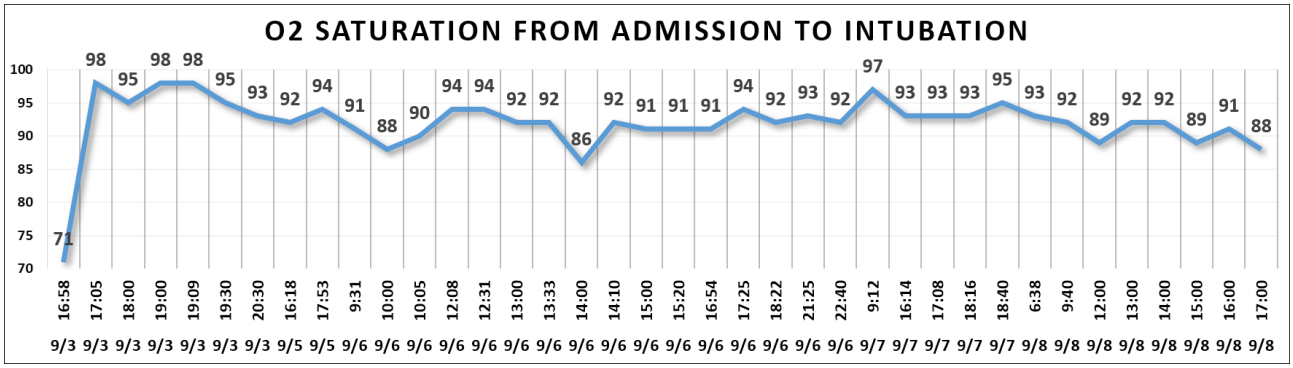
The final cause of death was "Organizing pneumonia."

The pathologist noted the following microscopic description of the lungs: End-stage organizing pneumonia with diffuse alveolar damage. There are numerous alveolar macrophages and reactive pneumocytes, squamous metaplasia, and increased mixed inflammation with fibrin in the alveoli. Extensive interstitial fibrosis is present. In some areas there is frank ischemic necrosis of the parenchyma. Small clots are present in the small arterioles and there are focal areas demonstrating long term architectural changes such as recannulization of vessels and microcystic honeycombing.

In summary, this was a healthy 52-year young married man who was seen at the ER about two weeks after exhibiting COVID-like symptoms. He and his wife specifically requested that he not be on remdesivir, but it was given. He was given **VELETRI** (epoprostenol) which is indicated for people with known "severe pulmonary arterial hypertension." There was no objective evidence [that is, a diagnosis of pulmonary arterial hypertension does not appear anywhere in Rob's records indicating] that he had severe PAH. It is unknown whether the VELETRI caused or contributed to this patient's eventual "extensive interstitial fibrosis." (Epoprostenol-associated pneumonitis. J Heart Lung Transplant. 2010 Sep;29(9):1071-5. doi: 10.1016/j.healun.2010.04.023. Epub 2010 Jun 8.)

He had known pneumomediastinum on admission, yet he was subjected to 4 1/2 hours of BiPAP which substantially increases the risk for barotrauma. After the BiPAP and then intubation, a chest X-ray showed "Extensive pneumomediastinum and chest wall and soft tissue gas in the neck." *It is conceivable that the "claustrophobia" was more likely feeling shortness of breath from the iatrogenic [caused or worsened by medical treatment] pneumomediastinum.*

There is no clear documentation readily available that provides clear indications for intubation. The vital signs recorded did not reflect significant deviation from the vital signs taken in the days leading up to the intubation though there were variations in the oxygen saturations and respiratory rate. There was no pre-intubation ABGs. Even the ID specialist documented (within the hour or so of intubation) that the patient was in no acute distress ("NAD"). The oxygen saturations noted in the chart below indicate adequate oxygenation:



Although the autopsy did not reveal endocarditis, it should be concerning on a prospective basis that a TEE was not performed as soon as symptomatic fungemia was known in face of known thickened aortic valve (on September 4 echocardiogram). The treatment and management differ substantially with fungal endocarditis as opposed to bacterial endocarditis.

It is beyond this reviewer's practice to opine on the type and extent of the sedatives and paralytics that were administered to this patient during this hospitalization. It is unknown whether there was a reasonable and compassionate level of sedation administered versus excessive though all of the ABGs after he was intubated and mechanically ventilated showed profound respiratory acidosis. He was completely dependent on the ventilator, yet he was not being ventilated adequately. An opinion regarding the sedatives and paralytics would not have been necessary if the patient was not intubated and be completely dependent on the ventilator.

It is also troublesome that the physicians were focused on the patient having only COVID to explain all the symptoms. It appears that there were cognitive errors in the diagnostic work up. These errors included premature closure [a type of cognitive error in which the physician fails to consider reasonable alternatives after an initial diagnosis is made. It is a common cause of delayed diagnosis and misdiagnosis borne out of a faulty clinical decision-making process], framing effect [an effect that occurs when decision makers choose inconsistent solutions for identical problems based on the way the

problems are presented to them], and diagnostic momentum [a type of confirmation bias that can occur in medical settings where the tendency is for a diagnosis to be blindly accepted and passed on with little examination of the underlying evidence for its validity]. There was no evidence that a bronchoscopy or even lung biopsy was even considered in this previously healthy young man. Limited expansion of the differential diagnosis was made for the rapidly and markedly elevated transaminases but that merely included blood work.

The diagnostic work up for the profound anemia was inadequately addressed. It appears that the presence of blood on the fecal occult blood test (FOBT positive on October 4) was not addressed. He likely had intraluminal gastrointestinal bleeding. Lack of blood in spite of adequate arterial oxygenation and cardiac function still results in poor tissue oxygenation.

There was lack of clear documentation of the risks, benefits and reasonable alternatives on procedures and medications given. **VELETRI** and **baricitinib** were given in spite of substantial harms which did not benefit and were without clear indications for them. Tocilizumab, known not to benefit in those with COVID, was given without benefit and he was exposed to risk of harm.

The above highlights the concerns that reflect suboptimal partnered collaboration with the patient and spouse by specific physicians involved.

At times, it appears that there was absolute disregard of the patient's and spouse's wishes. With continued review of the over 5,000 pages of the hospital documents, additional medicolegal vulnerabilities may arise.

Sammy S. Wong, MD FACP
Assistant Professor of Medicine (ret)
Medical Consultant and Expert, Department of Consumer Affairs, Medical Board of California

September 12, 2022

The views expressed by Dr. Wong are solely his own and
do not necessarily reflect the views of his affiliated institutions or organizations.

Causes of Action

September 12, 2022

#	Issue	Comments
1	Physician acknowledged that he refused remdesivir but was given six doses a total of 800 mg.	Does this rise to the level of criminal assault and/or battery? The renal failure toward the end of his hospitalization could be argued as due to acute tubular necrosis (ATN) due to hypoperfusion due to hypotension.
2	No indication for the use of epoprostenol (**VELETRI**).	He had no evidence of pulmonary arterial hypertension. His ECGs did not demonstrate right ventricular hypertrophy. Both echocardiograms did not demonstrate right ventricular hypertrophy or right ventricular enlargement. **VELETRI** is a prostanoid vasodilator indicated for the treatment of pulmonary arterial hypertension (PAH) (WHO Group 1) to improve exercise capacity. Studies establishing effectiveness included predominantly patients with NYHA Functional Class III-IV symptoms and etiologies of idiopathic or heritable PAH or PAH associated with connective tissue diseases. (www.accessdata.fda.gov/drugsatfda_docs/label/2012/022260s005lbl.pdf) The initiation of iEPO and iNO in patients with refractory hypoxemia secondary to COVID-19, on average, did not produce significant increases in oxygenation metrics such as Pao2/Fio2, Pao2, or Spo2 despite minimal other confounding interventions. (www.ncbi.nlm.nih.gov/pmc/articles/PMC7581066/#__sec11title)
3	Side effect of epoprostenol (**VELETRI**) includes profound interstitial lung disease.	**Epoprostenol** can incite a profound inflammatory response in the pulmonary interstitium. Due to a lack of indication for its use, the patient was subjected to unnecessary risks. (www.ncbi.nlm.nih.gov/pmc/articles/PMC2926193) Epoprostenol-associated pneumonitis. J Heart Lung Transplant. 2010 Sep;29(9):1071-5. doi: 10.1016/j.healun.2010.04.023. Epub 2010 Jun 8.
4	**Tocilizumab** given in spite of lack of literature to support its use in COVID	**Tocilizumab**, known not to benefit in those with COVID, was given without benefit and he was exposed to risk of harm. In a randomized trial involving hospitalized patients with severe COVID-19 pneumonia, the use of tocilizumab did not result in significantly better clinical status or lower mortality than placebo at 28 days. (N Engl J Med 2021; 384:1503-1516 (April 2021))
5	BiPAP instituted in spite of having pneumomediastinum - contraindication	He had known pneumomediastinum on admission, yet he was subjected to 4 ½ hours of BiPAP which substantially increases the risk for barotrauma. After the BiPAP and then intubation, a chest X-ray showed "Extensive pneumomediastinum and chest wall and soft tissue gas in the neck." It is conceivable that the "claustrophobia" was more likely feeling shortness of breath from the iatrogenic [caused or worsened by medical treatment] pneumomediastinum.
6	Physician acknowledged his refusal of intubation and mechanical ventilation but eventually sedated, paralyzed him, intubated, and mechanically ventilated him until he died.	Does this rise to the level of criminal assault and/or battery?

7	Indications for intubation and mechanical ventilation not met	There is no clear documentation readily available that provides clear indication for intubation. There were no pre-intubation ABGs [Arterial Blood Gasses]. Even the ID [Infectious Disease] specialist documented (within the hour or so of intubation) that the patient was in no acute distress ("NAD"). It is clear that the facility had an end-tidal CO2 monitor since they used it during intubation.
8	Remained profoundly in primary respiratory acidosis while mechanically ventilated, sedated and paralyzed without appropriate adjustment of the ventilator settings.	Refer to ABGs [Arterial Blood Gasses] post intubation and during rest of his course.
9	**Baricitinib** causing hepatitis unrecognized	He was given **baricitinib** daily starting on September 20 for 12 days. His liver enzymes rose to greater than 3 times upper limit of normal by early October. The PA covering for Infectious Disease did not address this on October 2 even after s/he acknowledged elevated liver enzymes in the progress note. The Hospitalist attributed the elevated liver enzymes to COVID or hepatic steatosis. Although the liver enzymes eventually returned toward normal, it again increased dramatically into the thousands prompting the liver specialist (gastroenterologist) to order a wide spectrum of labs ("shot-gunning" a diagnosis) but later attributed the hepatitis to ischemic liver.
10	Profound anemia in face of blood in stool not addressed	When he was admitted, his hemoglobin was 15.7 (normal). On October 4, he was noted to have blood in the stool sample which was not addressed. His hemoglobin was 7.7 on that day. A reticulocyte count was not done until October 8 (which was slightly elevated suggesting the anemia was not a marrow-suppressive cause). His hemoglobin dropped even further October 11 to 5.9. He died two days later. Oxygen delivery to the tissues include three factors: • Cardiac output • Oxygen saturation • Hemoglobin His cardiac output based on ejection fractions on the echocardiogram was normal. His oxygen saturation has been consistently above 90%. His hemoglobin dropped dramatically and was not addressed appropriately. Oxygen in the blood was adequate and blood was being circulated with a normal cardiac output but delivery to the tissues was profoundly lacking.

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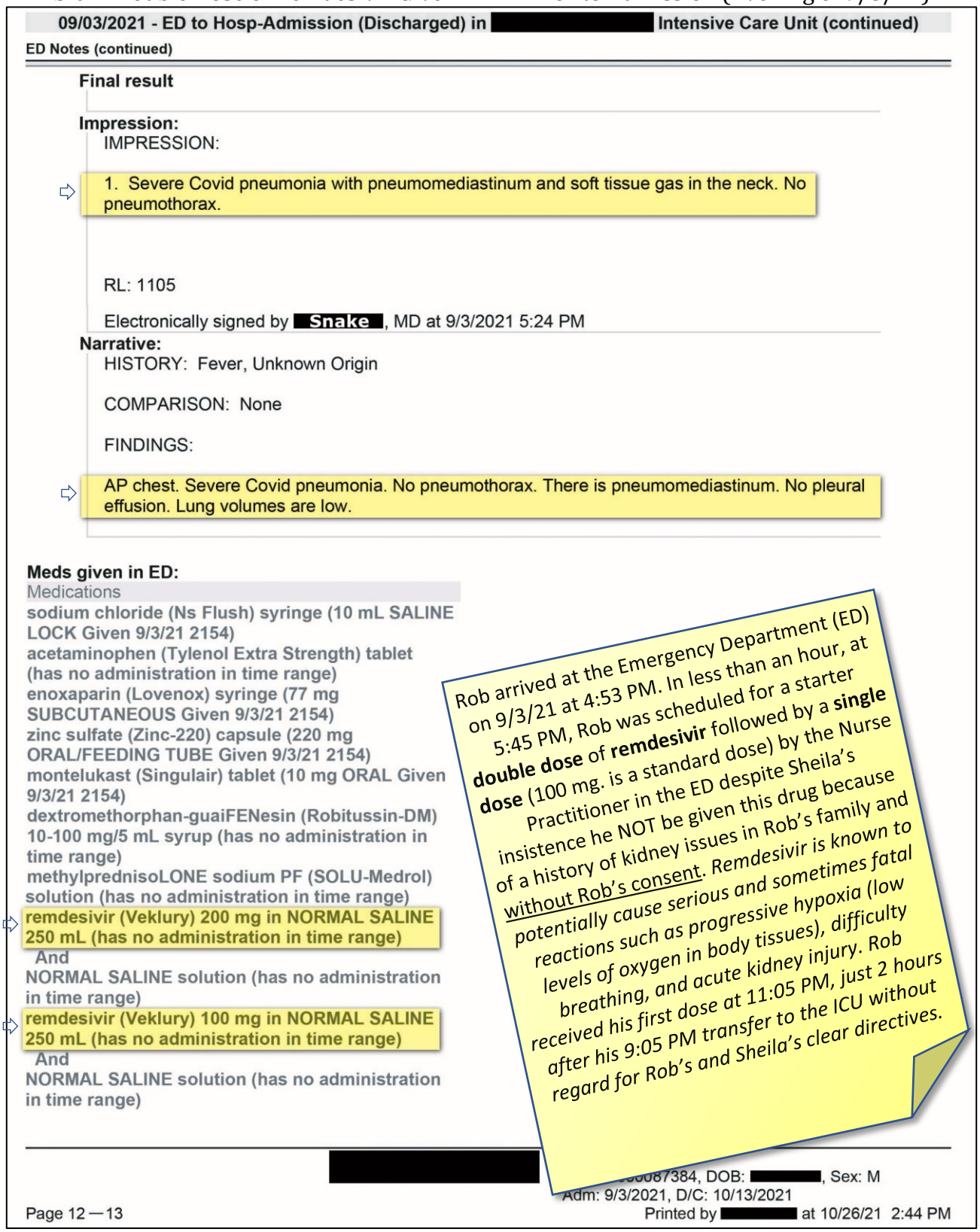
BELOW ARE 9 SELECTED PAGES
from the 56 pages contained in Appendix C.

Appendix C – Excerpts from Hospital Records

Exhibit 1–Double Dose of Remdesivir Given in ED Prior to Admission (Evening of 9/3/21)



09/03/2021 - ED to Hosp-Admission (Discharged) in [redacted] Intensive Care Unit (continued)

ED Notes (continued)

Final result

Impression:

IMPRESSION:

1. Severe Covid pneumonia with pneumomediastinum and soft tissue gas in the neck. No pneumothorax.

RL: 1105

Electronically signed by [redacted], MD at 9/3/2021 5:24 PM

Narrative:

HISTORY: Fever, Unknown Origin

COMPARISON: None

FINDINGS:

AP chest. Severe Covid pneumonia. No pneumothorax. There is pneumomediastinum. No pleural effusion. Lung volumes are low.

Meds given in ED:

Medications

sodium chloride (Ns Flush) syringe (10 mL SALINE LOCK Given 9/3/21 2154)
acetaminophen (Tylenol Extra Strength) tablet (has no administration in time range)
enoxaparin (Lovenox) syringe (77 mg SUBCUTANEOUS Given 9/3/21 2154)
zinc sulfate (Zinc-220) capsule (220 mg ORAL/FEEDING TUBE Given 9/3/21 2154)
montelukast (Singulair) tablet (10 mg ORAL Given 9/3/21 2154)
dextromethorphan-guaiFENesin (Robitussin-DM) 10-100 mg/5 mL syrup (has no administration in time range)
methylprednisoLONE sodium PF (SOLU-Medrol) solution (has no administration in time range)
remdesivir (Veklury) 200 mg in NORMAL SALINE 250 mL (has no administration in time range)
And
NORMAL SALINE solution (has no administration in time range)
remdesivir (Veklury) 100 mg in NORMAL SALINE 250 mL (has no administration in time range)
And
NORMAL SALINE solution (has no administration in time range)

Rob arrived at the Emergency Department (ED) on 9/3/21 at 4:53 PM. In less than an hour, at 5:45 PM, Rob was scheduled for a starter **double dose** of **remdesivir** followed by a **single dose** (100 mg. is a standard dose) by the Nurse Practitioner in the ED despite Sheila's insistence he NOT be given this drug because of a history of kidney issues in Rob's family and without Rob's consent. Remdesivir is known to potentially cause serious and sometimes fatal reactions such as progressive hypoxia (low levels of oxygen in body tissues), difficulty breathing, and acute kidney injury. Rob received his first dose at 11:05 PM, just 2 hours after his 9:05 PM transfer to the ICU without regard for Rob's and Sheila's clear directives.

[redacted]

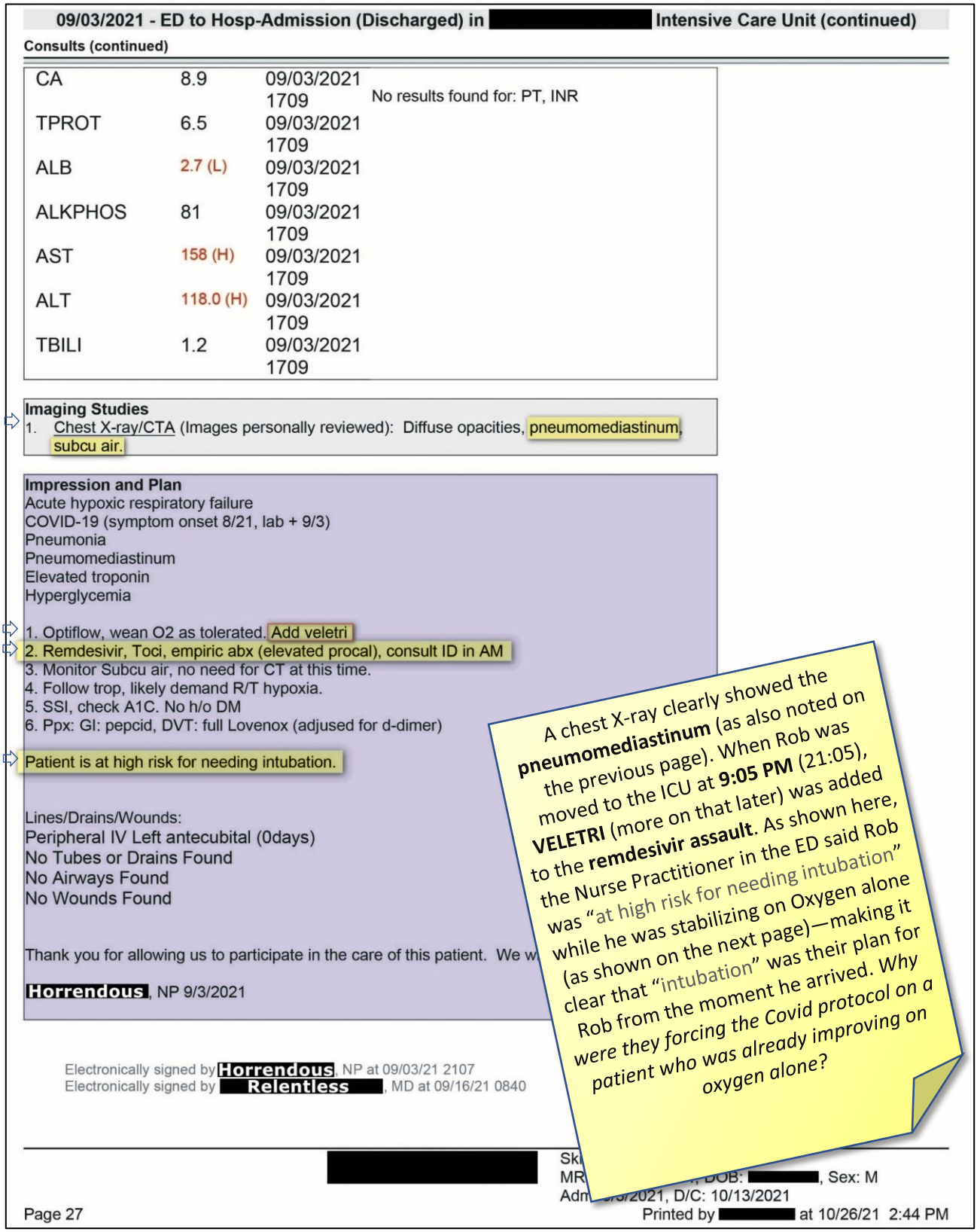
[redacted]384, DOB: [redacted], Sex: M

Adm: 9/3/2021, D/C: 10/13/2021

Page 12 — 13

Printed by [redacted] at 10/26/21 2:44 PM

Exhibit 3–Pneumomediastinum, VELETRI, High Risk for Needing Intubation (9/3/21)



09/03/2021 - ED to Hosp-Admission (Discharged) in [redacted] Intensive Care Unit (continued)

Consults (continued)

CA	8.9	09/03/2021 1709	No results found for: PT, INR
TPROT	6.5	09/03/2021 1709	
ALB	2.7 (L)	09/03/2021 1709	
ALKPHOS	81	09/03/2021 1709	
AST	158 (H)	09/03/2021 1709	
ALT	118.0 (H)	09/03/2021 1709	
TBILI	1.2	09/03/2021 1709	

Imaging Studies
1. Chest X-ray/CTA (Images personally reviewed): Diffuse opacities, pneumomediastinum, subcu air.

Impression and Plan
Acute hypoxic respiratory failure
COVID-19 (symptom onset 8/21, lab + 9/3)
Pneumonia
Pneumomediastinum
Elevated troponin
Hyperglycemia

1. Optiflow, wean O2 as tolerated. Add veletri
2. Remdesivir, Toci, empiric abx (elevated procal), consult ID in AM
3. Monitor Subcu air, no need for CT at this time.
4. Follow trop, likely demand R/T hypoxia.
5. SSI, check A1C. No h/o DM
6. Ppx: GI: pepcid, DVT: full Lovenox (adjused for d-dimer)

Patient is at high risk for needing intubation.

Lines/Drains/Wounds:
Peripheral IV Left antecubital (0days)
No Tubes or Drains Found
No Airways Found
No Wounds Found

Thank you for allowing us to participate in the care of this patient. We w

Horrendous, NP 9/3/2021

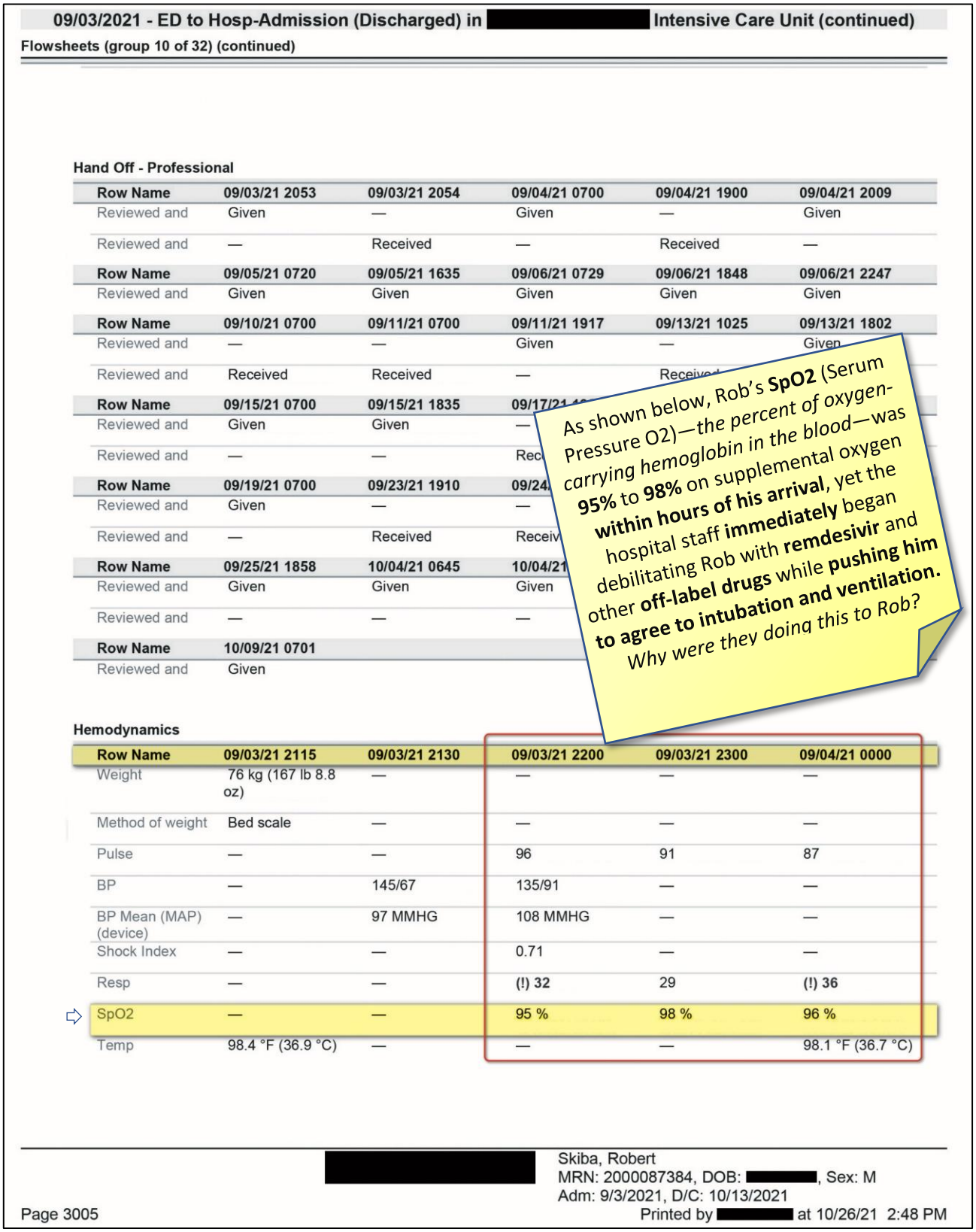
Electronically signed by Horrendous, NP at 09/03/21 2107
Electronically signed by Relentless, MD at 09/16/21 0840

A chest X-ray clearly showed the **pneumomediastinum** (as also noted on the previous page). When Rob was moved to the ICU at **9:05 PM** (21:05), **VELETRI** (more on that later) was added to the **remdesivir assault**. As shown here, the Nurse Practitioner in the ED said Rob was "at high risk for needing intubation" while he was stabilizing on Oxygen alone (as shown on the next page)—making it clear that "intubation" was their plan for Rob from the moment he arrived. Why were they forcing the Covid protocol on a patient who was already improving on oxygen alone?

[redacted] Sk
MR [redacted], DOB: [redacted], Sex: M
Adm [redacted]2021, D/C: 10/13/2021

Page 27 Printed by [redacted] at 10/26/21 2:44 PM

Exhibit 4–Rob's Vital Signs the Evening of His Arrival (Evening of 9/3/21)



09/03/2021 - ED to Hosp-Admission (Discharged) in [redacted] Intensive Care Unit (continued)

Flowsheets (group 10 of 32) (continued)

Hand Off - Professional

Row Name	09/03/21 2053	09/03/21 2054	09/04/21 0700	09/04/21 1900	09/04/21 2009
Reviewed and	Given	—	Given	—	Given
Reviewed and	—	Received	—	Received	—
Row Name	**09/05/21 0720**	**09/05/21 1635**	**09/06/21 0729**	**09/06/21 1848**	**09/06/21 2247**
Reviewed and	Given	Given	Given	Given	Given
Row Name	**09/10/21 0700**	**09/11/21 0700**	**09/11/21 1917**	**09/13/21 1025**	**09/13/21 1802**
Reviewed and	—	—	Given	—	Given
Reviewed and	Received	Received	—	Receiv	
Row Name	**09/15/21 0700**	**09/15/21 1835**	**09/17/21**		
Reviewed and	Given	Given	—		
Reviewed and	—	—	Rec		
Row Name	**09/19/21 0700**	**09/23/21 1910**	**09/24**		
Reviewed and	Given	—	—		
Reviewed and	—	Received	Receiv		
Row Name	**09/25/21 1858**	**10/04/21 0645**	**10/04/21**		
Reviewed and	Given	Given	Given		
Reviewed and	—	—	—		
Row Name	**10/09/21 0701**				
Reviewed and	Given				

As shown below, Rob's **SpO2** (Serum Pressure O2)—*the percent of oxygen-carrying hemoglobin in the blood*—was **95%** to **98%** on supplemental oxygen **within hours of his arrival**, yet the hospital staff **immediately** began debilitating Rob with **remdesivir** and other **off-label drugs** while **pushing him to agree to intubation and ventilation.** *Why were they doing this to Rob?*

Hemodynamics

Row Name	09/03/21 2115	09/03/21 2130	09/03/21 2200	09/03/21 2300	09/04/21 0000
Weight	76 kg (167 lb 8.8 oz)	—	—	—	—
Method of weight	Bed scale	—	—	—	—
Pulse	—	—	96	91	87
BP	—	145/67	135/91	—	—
BP Mean (MAP) (device)	—	97 MMHG	108 MMHG	—	—
Shock Index	—	—	0.71	—	—
Resp	—	—	**(!) 32**	29	**(!) 36**
SpO2	—	—	95 %	98 %	96 %
Temp	98.4 °F (36.9 °C)	—	—	—	98.1 °F (36.7 °C)

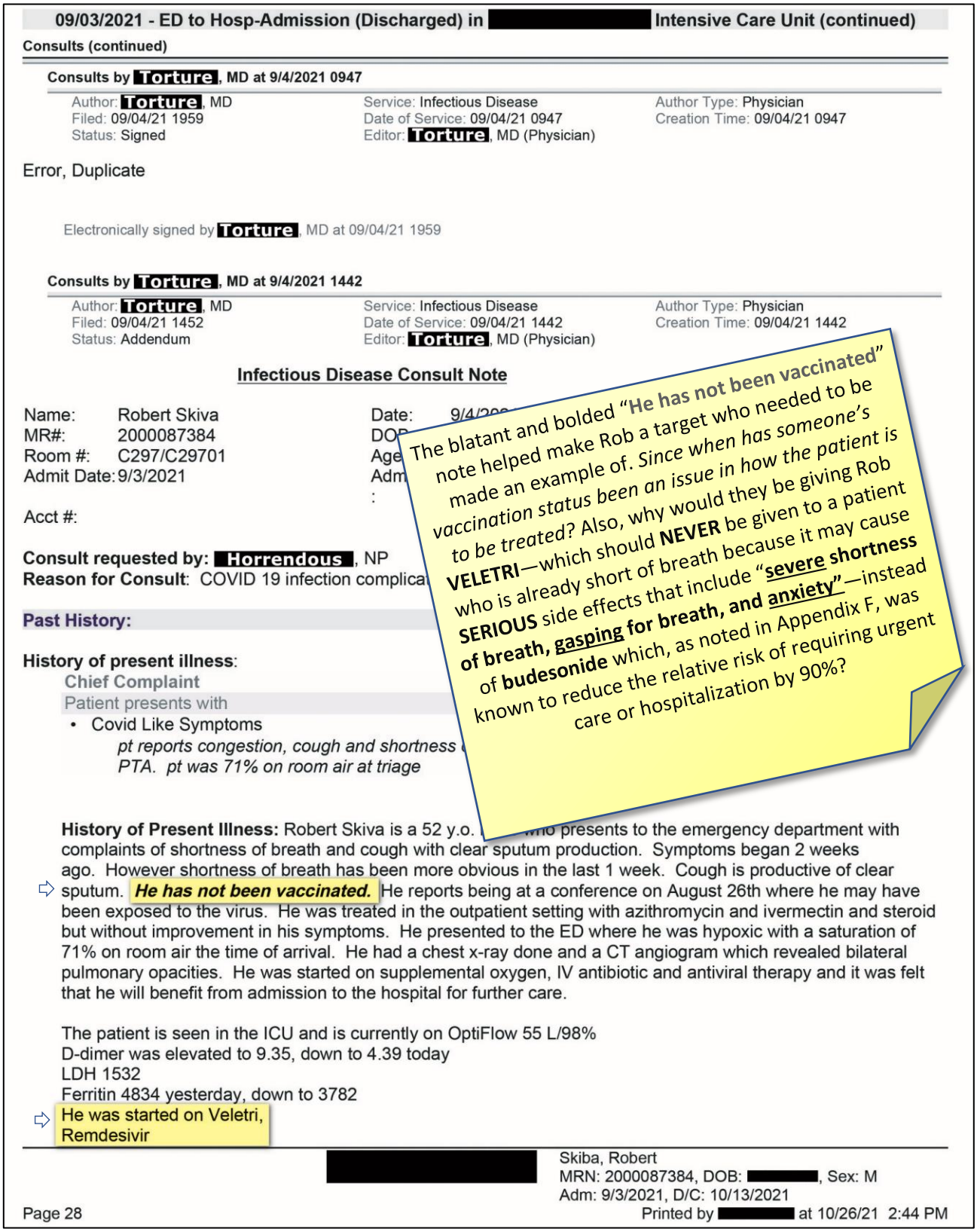
[redacted]

Skiba, Robert
MRN: 2000087384, DOB: [redacted], Sex: M
Adm: 9/3/2021, D/C: 10/13/2021

Page 3005

Printed by [redacted] at 10/26/21 2:48 PM

Exhibit 6–Not Vaccinated (Bolded), Started on VELETRI & Remdesivir (Morning of 9/4/21)



09/03/2021 - ED to Hosp-Admission (Discharged) in [redacted] Intensive Care Unit (continued)

Consults (continued)

Consults by Torture, MD at 9/4/2021 0947

Author: Torture, MD | Service: Infectious Disease | Author Type: Physician
Filed: 09/04/21 1959 | Date of Service: 09/04/21 0947 | Creation Time: 09/04/21 0947
Status: Signed | Editor: Torture, MD (Physician)

Error, Duplicate

Electronically signed by Torture, MD at 09/04/21 1959

Consults by Torture, MD at 9/4/2021 1442

Author: Torture, MD | Service: Infectious Disease | Author Type: Physician
Filed: 09/04/21 1452 | Date of Service: 09/04/21 1442 | Creation Time: 09/04/21 1442
Status: Addendum | Editor: Torture, MD (Physician)

Infectious Disease Consult Note

Name: Robert Skiva
MR#: 2000087384
Room #: C297/C29701
Admit Date: 9/3/2021
Acct #:

Date: 9/4/20
DOB
Age
Adm
:

Consult requested by: Horrendous, NP
Reason for Consult: COVID 19 infection complica

Past History:

History of present illness:

Chief Complaint

Patient presents with

- Covid Like Symptoms

pt reports congestion, cough and shortness
PTA. pt was 71% on room air at triage

The blatant and bolded "**He has not been vaccinated**" note helped make Rob a target who needed to be made an example of. *Since when has someone's vaccination status been an issue in how the patient is to be treated?* Also, why would they be giving Rob **VELETRI**—which should **NEVER** be given to a patient who is already short of breath because it may cause **SERIOUS** side effects that include "**severe shortness of breath, gasping for breath, and anxiety**"—instead of **budesonide** which, as noted in Appendix F, was known to reduce the relative risk of requiring urgent care or hospitalization by 90%?

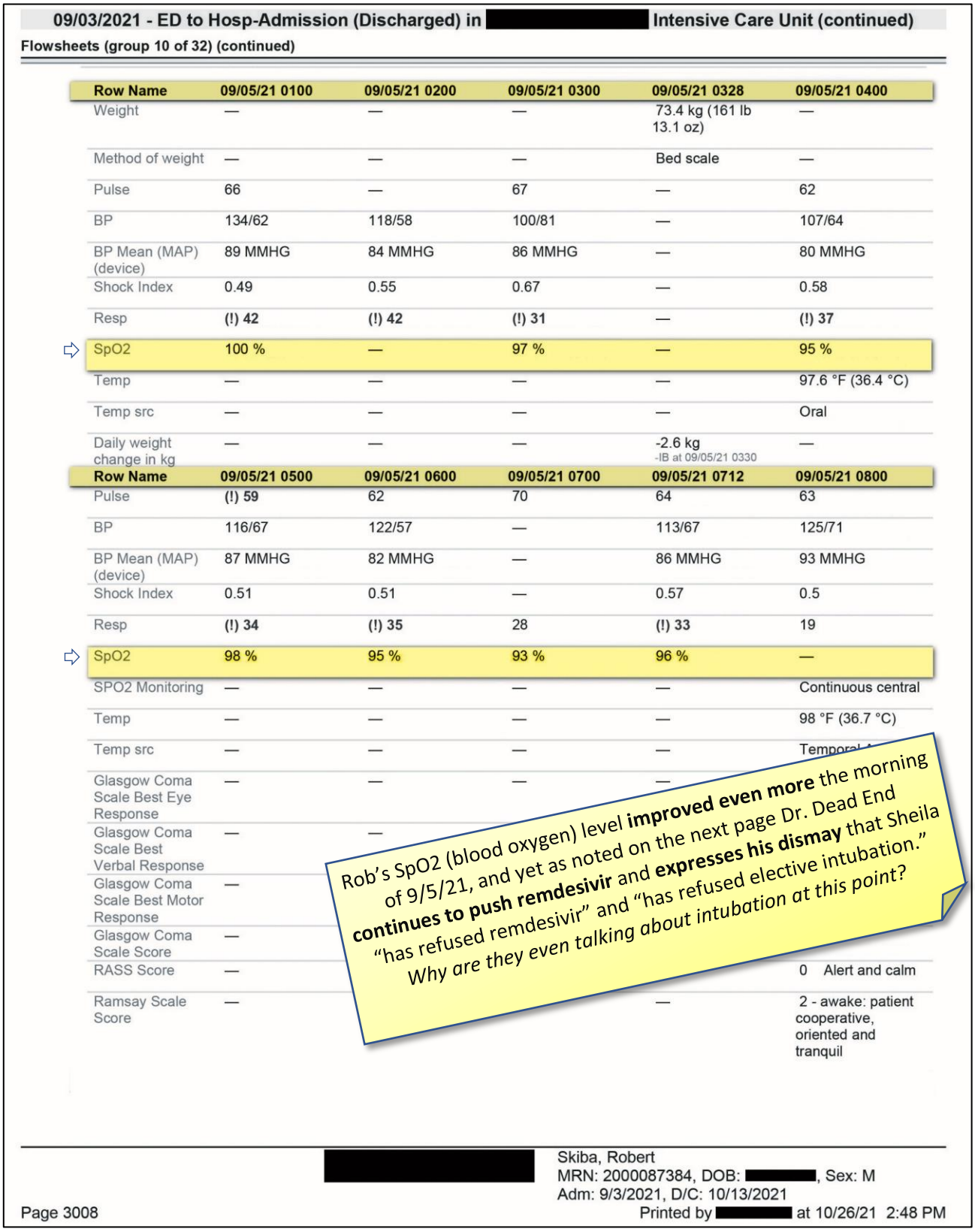
History of Present Illness: Robert Skiva is a 52 y.o. [redacted] who presents to the emergency department with complaints of shortness of breath and cough with clear sputum production. Symptoms began 2 weeks ago. However shortness of breath has been more obvious in the last 1 week. Cough is productive of clear sputum. ***He has not been vaccinated.*** He reports being at a conference on August 26th where he may have been exposed to the virus. He was treated in the outpatient setting with azithromycin and ivermectin and steroid but without improvement in his symptoms. He presented to the ED where he was hypoxic with a saturation of 71% on room air the time of arrival. He had a chest x-ray done and a CT angiogram which revealed bilateral pulmonary opacities. He was started on supplemental oxygen, IV antibiotic and antiviral therapy and it was felt that he will benefit from admission to the hospital for further care.

The patient is seen in the ICU and is currently on OptiFlow 55 L/98%
D-dimer was elevated to 9.35, down to 4.39 today
LDH 1532
Ferritin 4834 yesterday, down to 3782
He was started on Veletri, Remdesivir

[redacted]
Skiba, Robert
MRN: 2000087384, DOB: [redacted], Sex: M
Adm: 9/3/2021, D/C: 10/13/2021

Page 28
Printed by [redacted] at 10/26/21 2:44 PM

Exhibit 14–Rob's Vital Signs the Early Morning of 9/5/21 (1:00-8:00 AM)



09/03/2021 - ED to Hosp-Admission (Discharged) in [redacted] Intensive Care Unit (continued)

Flowsheets (group 10 of 32) (continued)

Row Name	09/05/21 0100	09/05/21 0200	09/05/21 0300	09/05/21 0328	09/05/21 0400
Weight	—	—	—	73.4 kg (161 lb 13.1 oz)	—
Method of weight	—	—	—	Bed scale	—
Pulse	66	—	67	—	62
BP	134/62	118/58	100/81	—	107/64
BP Mean (MAP) (device)	89 MMHG	84 MMHG	86 MMHG	—	80 MMHG
Shock Index	0.49	0.55	0.67	—	0.58
Resp	**(!) 42**	**(!) 42**	**(!) 31**	—	**(!) 37**
SpO2	100 %	—	97 %	—	95 %
Temp	—	—	—	—	97.6 °F (36.4 °C)
Temp src	—	—	—	—	Oral
Daily weight change in kg	—	—	—	-2.6 kg -IB at 09/05/21 0330	—

Row Name	09/05/21 0500	09/05/21 0600	09/05/21 0700	09/05/21 0712	09/05/21 0800
Pulse	**(!) 59**	62	70	64	63
BP	116/67	122/57	—	113/67	125/71
BP Mean (MAP) (device)	87 MMHG	82 MMHG	—	86 MMHG	93 MMHG
Shock Index	0.51	0.51	—	0.57	0.5
Resp	**(!) 34**	**(!) 35**	28	**(!) 33**	19
SpO2	98 %	95 %	93 %	96 %	—
SPO2 Monitoring	—	—	—	—	Continuous central
Temp	—	—	—	—	98 °F (36.7 °C)
Temp src	—	—	—	—	Temporal
Glasgow Coma Scale Best Eye Response	—	—	—	—	
Glasgow Coma Scale Best Verbal Response	—	—			
Glasgow Coma Scale Best Motor Response	—				
Glasgow Coma Scale Score	—				
RASS Score	—				0 Alert and calm
Ramsay Scale Score	—			—	2 - awake: patient cooperative, oriented and tranquil

Rob's SpO2 (blood oxygen) level **improved even more** the morning of 9/5/21, and yet as noted on the next page Dr. Dead End **continues to push remdesivir** and **expresses his dismay** that Sheila "has refused remdesivir" and "has refused elective intubation." *Why are they even talking about intubation at this point?*

[redacted]

Skiba, Robert
MRN: 2000087384, DOB: [redacted], Sex: M
Adm: 9/3/2021, D/C: 10/13/2021

Page 3008

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Exhibit 15–Staff Frustrated by Sheila's Refusal of Remdesivir and Intubation (9/5/21)

09/03/2021 - ED to Hosp-Admission (Discharged) in [redacted] Intensive Care Unit (continued)

Progress Notes (group 1 of 15) (continued)

2130 Spoke with pt's wife. Pt's wife states, " We don't want him to have Remdesivir. He was railroaded today and was given it. Please do not give this to him anymore." Pt's wife informed that I would let the day shift RN aware that pt is not to get Remdesivir. Wife also requested to know all medications that the patient was receiving. Pt's wife also requested to have an increase in Vit D dosage as well as wanting to have pt to be given Vit C. Pt's wife informed that she would need to speak with the doctor who is providing care to the patient. Pt's wife verbalized understanding. Pt's wife also stated, "We do not want him to be intubated but if he stops breathing it is ok but just to intubate him because his oxygen levels are low and someone thinks its a good idea we do not want him intubated." Pt's wife informed that I would communicate this information to the night on call provider.

2140 spoke with night on call provider regarding conversation that I had with pt's wife.

M.O.R.E guidelines implemented appropriately.

REMINDER: Address the patient/family progress this shift (including the ab
Plan and demonstrate the compassionate care given.

You can clearly see how frustrated the staff are at Sheila's continued insistence that Rob **NOT be given remdesivir,** and the **NOT be intubated and placed on a ventilator**. Sadly, she had to continue to conduct her fight for Rob by phone because she was **shut out** by an unwritten policy **for 21 days**.

Electronically signed by **Impostor**, RN at 09/0

Progress Notes by Malicious, RN at 9/5/2021 090

Author: **Malicious**, RN | Service: Nursing | Author Type: Registered Nurse
Filed: 09/05/21 0912 | Date of Service: 09/05/21 0909 | Creation Time: 09/05/21 0909
Status: Signed | Editor: **Malicious**, RN (Registered Nurse)

Pt's wife spoke with him and **Dr Dead End** on phone speaker and refused remdesivir. She stated that she will speak with hospital administrator regarding the medications she would like him to be treated with.

Electronically signed by **Malicious**, RN at 09/05/21 0912

Progress Notes by [redacted] Dead End [redacted], MD at 9/5/2021 0931

Author: **[redacted] Dead End [redacted]**, MD | Service: Medicine | Author T
Filed: 09/05/21 0936 | Date of Service: 09/05/21 0931
Status: Signed | Editor: **[redacted] Dead End [redacted]**

Unfortunately, **by his 5th day** (on 9/8/21) they had their way after **starving** Rob into submission (*no family was allowed in to help feed him*) and **bombarding** him with harmful drugs and therapies that brought him to a point of desperation **where he could no longer breathe for himself** as noted in the pages that follow.

Critical Care Pro

Patient Name: Robert Skiva
Medical Record No.: 2000087384
Date of Birth: [redacted]
Age/Sex: 52 y.o. male

Chief complaint: COVID-19

Subjective:

Overnight events reviewed. Patient's wife was upset with us. Thinks we are trying to harm patient. She has refused remdesivir. She has refused elective intubation, she has advised her husband to not proceed with intubation if necessary. She would want resuscitative measures done

[redacted]

Skiba, Robert
MRN: 2000087384, DOB: [redacted], Sex: M
Adm: 9/3/2021, D/C: 10/13/2021

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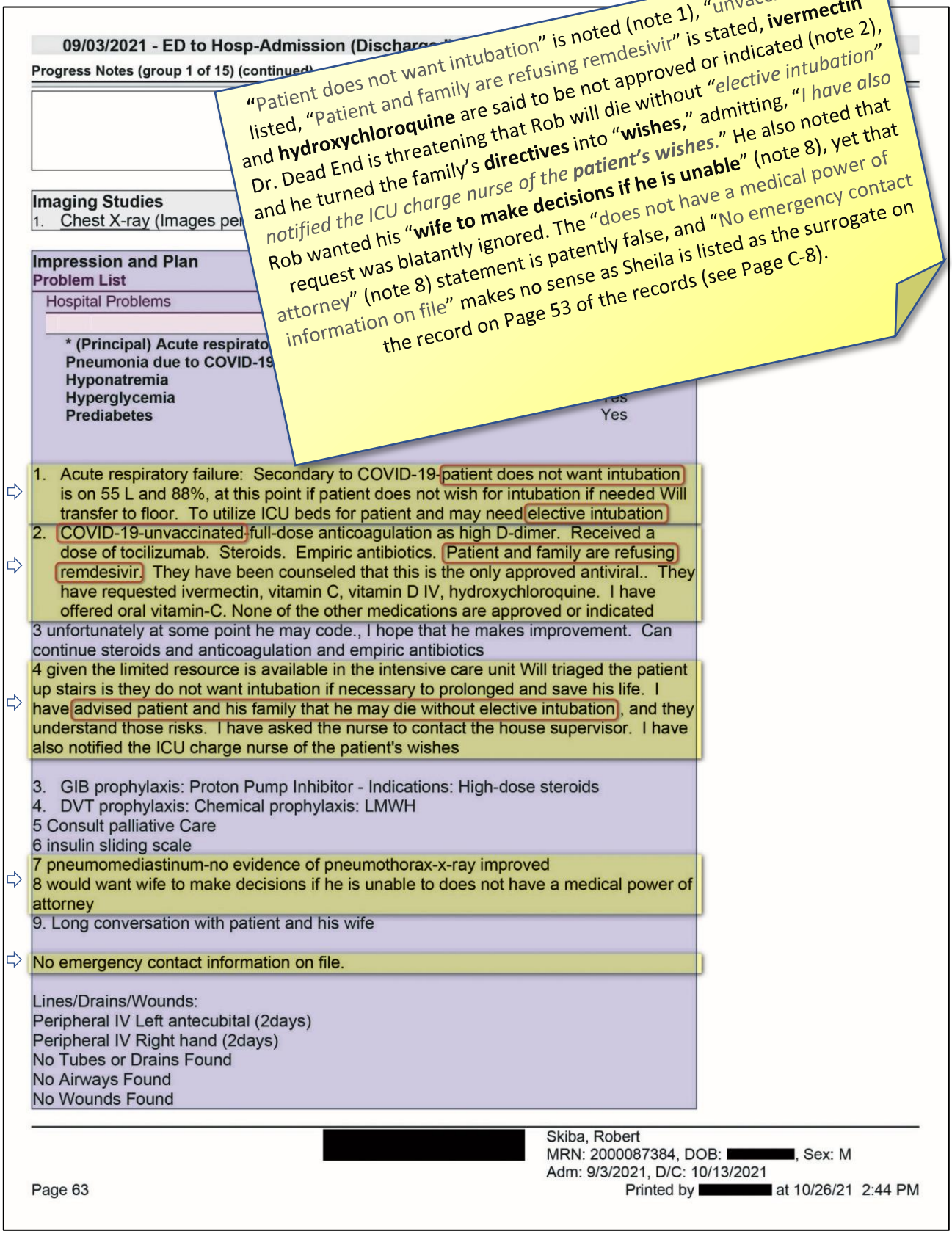
Printed by [redacted] at 10/26/21 2:44 PM

Exhibit 16–Patient Does NOT Want Intubation, Refusing Remdesivir (9/5/21)



09/03/2021 - ED to Hosp-Admission (Discharge)

Progress Notes (group 1 of 15) (continued)

Imaging Studies

1. Chest X-ray (Images per

Impression and Plan

Problem List

Hospital Problems

* (Principal) Acute respirato	
Pneumonia due to COVID-19	
Hyponatremia	
Hyperglycemia	
Prediabetes	Yes

1. Acute respiratory failure: Secondary to COVID-19-patient does not want intubation is on 55 L and 88%, at this point if patient does not wish for intubation if needed Will transfer to floor. To utilize ICU beds for patient and may need elective intubation
2. COVID-19-unvaccinated-full-dose anticoagulation as high D-dimer. Received a dose of tocilizumab. Steroids. Empiric antibiotics. Patient and family are refusing remdesivir. They have been counseled that this is the only approved antiviral.. They have requested ivermectin, vitamin C, vitamin D IV, hydroxychloroquine. I have offered oral vitamin-C. None of the other medications are approved or indicated

3 unfortunately at some point he may code., I hope that he makes improvement. Can continue steroids and anticoagulation and empiric antibiotics

4 given the limited resource is available in the intensive care unit Will triaged the patient up stairs is they do not want intubation if necessary to prolonged and save his life. I have advised patient and his family that he may die without elective intubation, and they understand those risks. I have asked the nurse to contact the house supervisor. I have also notified the ICU charge nurse of the patient's wishes

3. GIB prophylaxis: Proton Pump Inhibitor - Indications: High-dose steroids
4. DVT prophylaxis: Chemical prophylaxis: LMWH

5 Consult palliative Care

6 insulin sliding scale

7 pneumomediastinum-no evidence of pneumothorax-x-ray improved

8 would want wife to make decisions if he is unable to does not have a medical power of attorney

9. Long conversation with patient and his wife

No emergency contact information on file.

Lines/Drains/Wounds:
Peripheral IV Left antecubital (2days)
Peripheral IV Right hand (2days)
No Tubes or Drains Found
No Airways Found
No Wounds Found

[redacted]

Skiba, Robert
MRN: 2000087384, DOB: [redacted], Sex: M
Adm: 9/3/2021, D/C: 10/13/2021

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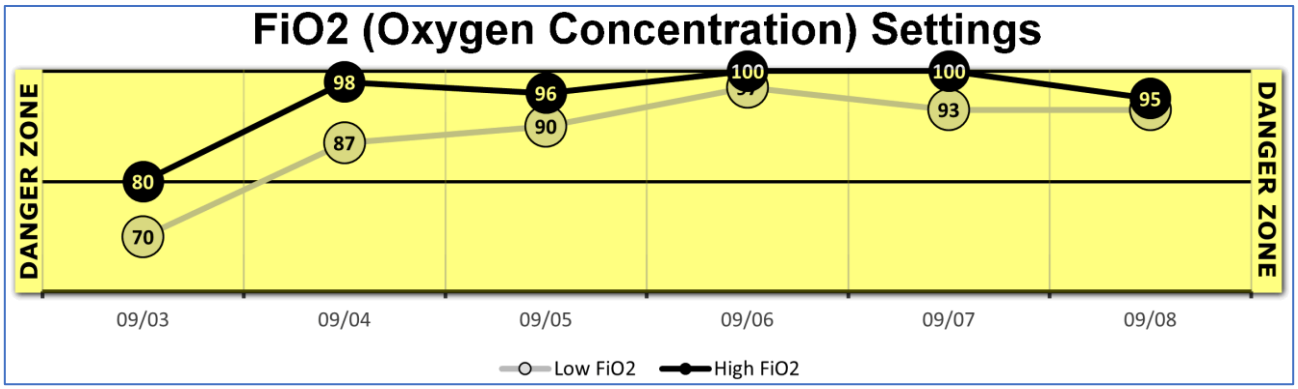
Printed by [redacted] at 10/26/21 2:44 PM

"Patient does not want intubation" is noted (note 1), "unvaccinated" is listed, "Patient and family are refusing remdesivir" is stated, **ivermectin** and **hydroxychloroquine** are said to be not approved or indicated (note 2), Dr. Dead End is threatening that Rob will die without *"elective intubation"* and he turned the family's **directives** into "**wishes**," admitting, "*I have also notified the ICU charge nurse of the* ***patient's wishes***." He also noted that Rob wanted his "**wife to make decisions if he is unable**" (note 8), yet that request was blatantly ignored. The "does not have a medical power of attorney" (note 8) statement is patently false, and "No emergency contact information on file" makes no sense as Sheila is listed as the surrogate on the record on Page 53 of the records (see Page C-8).

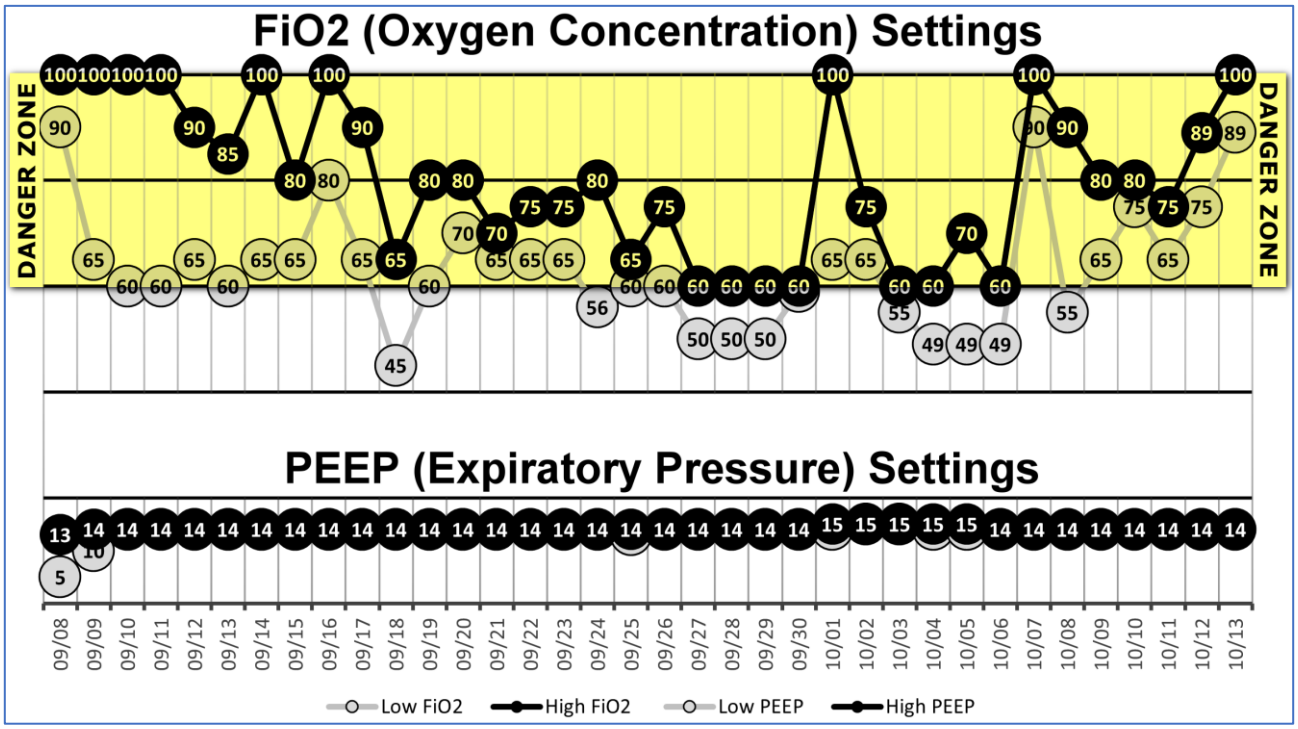
Exhibit 54–Excessively High O2 Levels on Optiflow (High-Flow Nasal Cannula) and Ventilator

These charts show the **excessively high levels of oxygen** Rob was subjected to before and after being placed on a ventilator. *Levels **above 60% for over 24 hours** can create pulmonary toxicity, extensive damage to the alveoli, and **atelectasis** (where alveoli in a lung or a part of a lung deflate, causing a partially or completely collapsed lung), resulting in shortness of breath and painful breathing.* As noted on **Page 127** of the hospital records (see Page C-35 in this Appendix), Rob was diagnosed with **atelectasis** on September 8, 2021, the day he was placed on a ventilator. The **atelectasis** followed by **barotrauma** caused by 4.5 hours of BiPAP therapy (see Pages C-37 and C-38) resulted in Rob's ending up on a ventilator against his will.

Optiflow High-Flow Nasal Cannula Oxygen Concentration Settings (High & Low)



Ventilator Oxygen Concentration and PEEP Settings (High & Low)

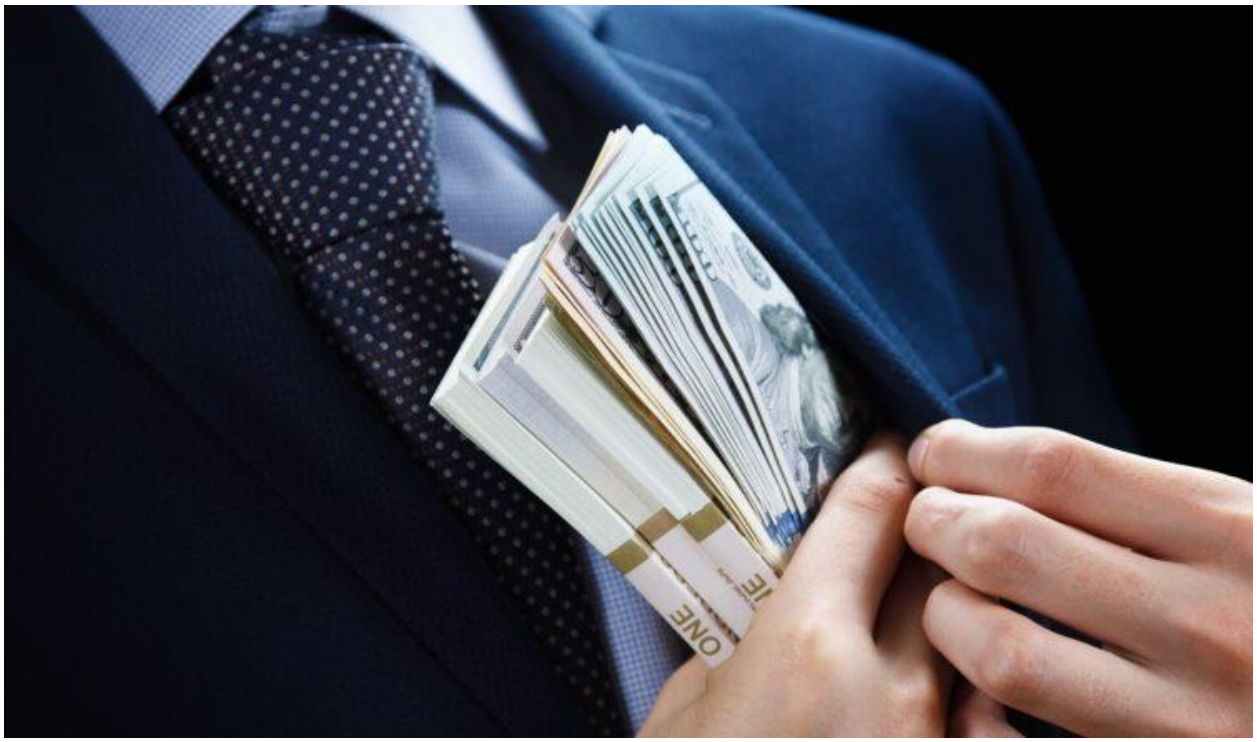


The assault of high concentrations of oxygen (above 60%) continued on the ventilator. This further damaged Rob's lungs to the extent that the medical examiner who conducted Rob's private autopsy said his lungs looked "shredded," were "unsurvivable," and did not look human. The continuously high PEEP (Positive End-Expiratory Pressure), pressure applied by the ventilator at the end of each breath (high = above 5 cm H_2O) placed added stress on Rob's fragile lungs. *Removing Rob from the ventilator required a PEEP setting of 8 cm H_2O or lower, yet they kept it at 14 to 15 cm H_2O for the entire 35 days Rob was on the ventilator.*

Appendix D – Hospitals' Incentive Payments for COVID-19

NOVEMBER 17, 2021

Hospitals' Incentive Payments for COVID-19



By Elizabeth Lee Vliet, M.D. and Ali Shultz, J.D.

Source: https://aapsonline.org/bidens-bounty-on-your-life-hospitals-incentive-payments-for-covid-19

Upon admission to a once-trusted hospital, American patients with COVID-19 become virtual prisoners, subjected to a rigid treatment protocol with roots in Ezekiel Emanuel's "Complete Lives System" for rationing medical care in those over age 50. They have a shockingly high mortality rate. How and why is this happening, and what can be done about it?

As exposed in audio recordings, hospital executives in Arizona admitted meeting several times a week to *lower* standards of care, with coordinated restrictions on visitation rights. Most COVID-19 patients' families are deliberately kept in the dark about what is really being done to their loved ones.

The combination that enables this tragic and avoidable loss of hundreds of thousands of lives includes (1) The CARES Act, which provides hospitals with bonus incentive payments for all things related to COVID-19 (testing, diagnosing, admitting to hospital, use of remdesivir and ventilators, reporting COVID-19 deaths, and vaccinations) and (2) waivers of customary and long-standing patient rights by the Centers for Medicare and Medicaid Services (CMS).

In 2020, the Texas Hospital Association submitted requests for waivers to CMS. According to Texas attorney Jerri Ward, *"CMS has granted 'waivers' of federal law regarding patient rights.*

Specifically, CMS purports to allow hospitals to violate the rights of patients or their surrogates about medical record access, to have patient visitation, and to be free from seclusion." She notes that *"rights do not come from the hospital or CMS and cannot be waived, as that is the antithesis of a 'right.' The purported waivers are meant to isolate and gain total control over the patient and to deny patient and patient's decision-maker the ability to exercise informed consent."*

Creating a "National Pandemic Emergency" provided justification for such sweeping actions that override individual physician medical decision-making and patients' rights. The CARES Act provides incentives for hospitals to use treatments dictated solely by the federal government under the auspices of the NIH. These "bounties" must be paid back if not "earned" by making the COVID-19 diagnosis and following the COVID-19 protocol.

The hospital payments include:

- A "free" *required* PCR test in the Emergency Room or upon admission for every patient, with government-paid fee to hospital.
- Added bonus payment for each positive COVID-19 diagnosis.
- Another bonus for a COVID-19 admission to the hospital.
- A 20 percent "boost" bonus payment from Medicare on the *entire hospital bill* for use of remdesivir instead of medicines such as Ivermectin.
- Another and larger bonus payment to the hospital if a COVID-19 patient is mechanically ventilated.
- More money to the hospital if cause of death is listed as COVID-19, even if patient did not die directly of COVID-19.
- A COVID-19 diagnosis also provides extra payments to coroners.

CMS implemented "value-based" payment programs that track data such as how many workers at a healthcare facility receive a COVID-19 vaccine. Now we see why many hospitals implemented COVID-19 vaccine mandates. They are paid more.

Outside hospitals, physician MIPS quality metrics link doctors' income to performance-based pay for treating patients with COVID-19 EUA drugs. Failure to report information to CMS can cost the physician 4% of reimbursement.

Because of obfuscation with medical coding and legal jargon, we cannot be certain of the actual amount each hospital receives per COVID-19 patient. But Attorney Thomas Renz and CMS whistleblowers have calculated a total payment of at least $100,000 per patient.

What does this mean for your health and safety as a patient in the hospital?

There are deaths from the government directed COVID treatments. For remdesivir, studies show that 71–75 percent of patients suffer an adverse effect, and the drug often had to be stopped after five to ten days because of these effects, such as kidney and liver damage, and death. Remdesivir trials during the 2018 West African Ebola outbreak had to be discontinued because *death rate exceeded 50%.* Yet, in 2020, Anthony Fauci directed that remdesivir was to be the drug hospitals use to treat COVID-19, even when the COVID clinical trials of remdesivir showed similar adverse effects.

In ventilated patients, the death toll is staggering. A National Library of Medicine January 2021 report of 69 studies involving more than 57,000 patients concluded that fatality rates were 45 percent in COVID-19 patients receiving invasive mechanical ventilation, increasing to 84 percent in older patients. Renz announced at a Truth for Health Foundation Press Conference that CMS data showed that in Texas hospitals, 84.9% percent of all patients died after more than 96 hours on a ventilator.

Then there are deaths from restrictions on effective treatments for hospitalized patients. Renz and a team of data analysts have estimated that more than 800,000 deaths in America's hospitals, in COVID-19 and other patients, have been caused by approaches restricting fluids, nutrition, antibiotics, effective antivirals, anti-inflammatories, and therapeutic doses of anti-coagulants.

We now see government-dictated medical care at its worst in our history since the federal government *mandated* these ineffective and dangerous treatments for COVID-19, and then *created financial incentives* for hospitals and doctors to use only those "approved" (and paid for) approaches.

Our formerly trusted medical community of hospitals and hospital-employed medical staff have effectively become "bounty hunters" for *your* life. Patients need to now take unprecedented steps to *avoid* going into the hospital for COVID-19.

Patients need to take active steps to plan before getting sick to use early home-based treatment of COVID-19 that can help you *save* your life.

END OF PREVIEW EDITION

The book continues with:

Appendix E - Title 42 of the Code of Federal Regulations

Appendix F - University of Oxford Study (Budesonide)

Appendix G - Quesionable Drugs & Dosages Given

Appendix H - Darkness Exposed by a Respiratory Therapist

Appendix I - Falsification of Hospital Consent Forms

Rob Skiba—the Man Behind the Story

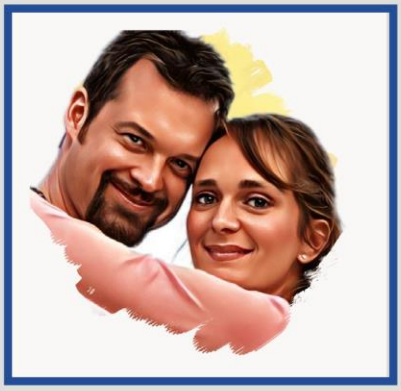
CHECKMATE FIGHT FOR RIGHT AND RIGHT THE WRONG!

You might not agree with me, but whatever you think I want to be known as a man who was on a quest for truth because we are living in a sea of lies. To be forewarned is to be forearmed!
— **Rob A. Skiba II**

The Protocol that Kills tragically and accurately portrays the accounts given to me by families of patients in hospitals for the last two and a half years. If the Covid Protocol is the supposed "standard of care," then we are listening to the wrong "experts." — **Jerri Lynn Ward, J.D.**

American citizens have far too long been the victims of medical tyranny in the name of Covid. For that very reason, July 2022, I provided expert witness testimony to the Texas Senate's HHS committee regarding hard lessons learned from the response to the COVID-19 pandemic. In her well-documented book, Sheila Skiba clearly details the appalling circumstances surrounding her husband's untimely and unnecessary death. While honoring the memory of a great man, Rob Skiba, she shares a wealth of critical insights that will greatly aid in preventing future needless losses of life. — **Richard P. Bartlett, MD**

Be prepared, as in this book, you will encounter the gripping details of a government-incentivized protocol that must be stopped if we wish to save future lives. Sheila Skiba's insightful true crime story, legal brief, and exposé is the most comprehensive and detailed book on the subject. I hope hundreds of thousands read this book and send copies to colleagues, friends, and family members—especially to those who believe that everyone in the medical profession always has their best interests in mind. — **Peggy Lawler, Medical/Surgical Nurse**



Rob and Sheila Skiba

About the author — Sheila Skiba

Rob and I dedicated our lives to searching for truth. My husband was a filmmaker, international speaker, and author. I aided him in conducting the research for the numerous books we published and had the privilege of traveling the world with him. My purpose in writing this book was to help you and your loved ones avoid becoming victims of a corrupt and lethal medical system. Rob is deeply missed, and my life will never be the same without him. I will never be quiet, I will not back down, and I will always stand strong with you against medical tyranny.

theprotocolthatkills.com

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