Scott Schara: Pfizer Drugs & Medical Malpractice Killed His Daughter Grace

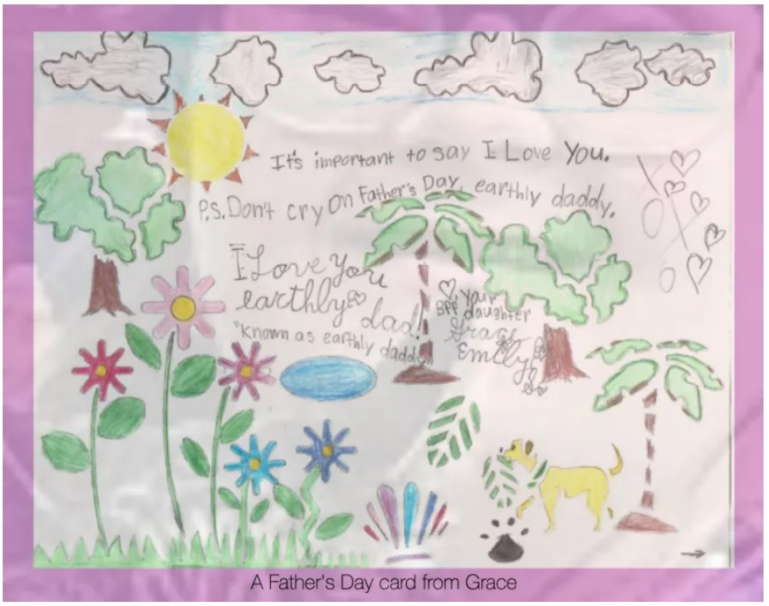
By **Michelle Edwards** - February 15, 2022

On Oct. 13, 2021, at 7:27 pm, beautiful Grace Schara—an inquisitive young woman with Down-Syndrome—died a tragic and preventable death at a Wisconsin hospital. Rather than using treatments proven to combat COVID-19, Ascension's St. Elizabeth's Hospital followed the U.S. government's ineffective COVID-19 treatment protocols, for which they reap significant financial rewards. On the final day of Grace's life, as her doctor assured her parents she was doing well, Dr. Gavin Shokar also *"unilaterally labeled Grace a DNR and ordered a lethal combination of IV sedatives and narcotics"*—a fatal combination of the drugs Precedex, Lorazepam, and Morphine—which were administered over an incredibly short period of time. Notably, all three drugs are manufactured by mRNA "vaccine" maker and pharmaceutical giant Pfizer.

Who Was Grace Schara?

Grace Schara was full of love. Properly describing the magical impact Grace had on every life she touched—especially her mom, dad, and sister—would require more space than this article. Her family and all those who knew and loved Grace were clearly blessed to have her in their lives for 19 years. Besides bringing an incredible amount of joy everywhere she went, Grace could read and write, drive a car, ride a horse, play the violin, and drive her riding lawnmower, and so much more. Truly, Grace loved absolutely everything about the life she was living. UncoverDC spoke at length with Scott Schara, Grace's father, about the tragic and immoral circumstances leading up to his daughter's death. Describing Grace, Scott recently wrote:

> *"Grace was our bright, beautiful, fun-loving 19-year-old daughter with Down Syndrome. Her precious life was taken from us at St. Elizabeth's Hospital in Appleton, Wisconsin, on Oct. 13, 2021. She was an angel who loved her Lord and Savior, Jesus. Everyone knew Grace. I was known only as 'Grace's dad.' She had a sense of her Heavenly Father that very few people ever have. She called me her 'Earthly dad.' Who does that?"*



A Father's Day card from Grace

Screenshot / Our Amazing Grace / Grace's Dad Remembers


Grace and her Mom


Grace and her Sister


Grace and her Dad

What Happened? Hospital Neglect Leading to Grace's Last Day

On Sept. 28, Grace began receiving appropriate doses of Ivermectin when facing COVID-19 symptoms. On Oct. 1, with symptoms persisting, Grace's parents gave her a home COVID test. She tested positive, but they were prepared. Already following recommendations from America's Frontline Doctors and FLCCC, the Schara's had on hand the necessary essentials to work through COVID. Still, according to Scott, a few days later, *"[Grace] couldn't maintain her oxygen above 90, so we ended up taking her to urgent care, which led to the emergency room. And the emergency room physician recommended that we admit her to the hospital."*

The Emergency Department at Ascension's St. Elizabeth Hospital wanted to admit Grace. However, the hospital informed Scott that due to "hospital protocol not allowing anyone in the room," he could not come with her. Scott told the hospital that he would take Grace home if he could not go to the room with her. After "a meeting of the minds," he was told he could stay with his daughter as long as he didn't leave the room. Scott was fine with that, as he was not planning to leave the room anyway. So, Grace was admitted to the hospital. Further explaining how important it was he stay with Grace, Scott added:

> *"One of the things Grace was unable to do in this situation is to speak up or stand up for herself in terms of treatment and things like that. That's a natural part of what she was dealing with. And so, I did what any dad should do. I stood by my daughter and tried to protect her."*

Grace's first full day in St. Elizabeth's was Oct. 7. Scott described the day as "very normal"—they watched movies and "horsed around." Scott explained that later in the day, Grace was frustrated and fighting back a little with the *"high-flow cannula [that was] shooting air up her nostrils at 40 miles an hour or so."* Clearly, Grace did not like the uncomfortable aspect of that treatment. On the morning of the second day, Oct. 8, Scott had the first real sense of *"there's something going on here"* when a doctor came into the room and told him:

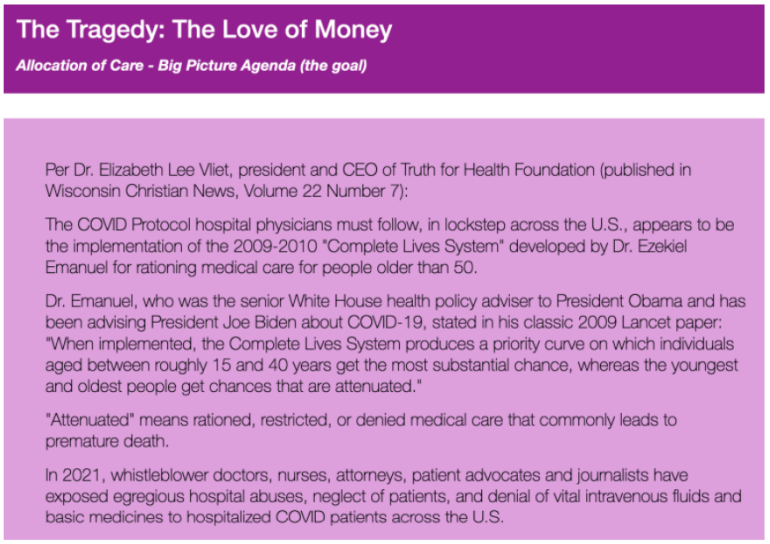
> *"In the next two hours, we're going to have to put your daughter on a ventilator."*

Immediately, Scott wanted to know the reasoning behind such a drastic decision. The directive turned out to be based on blood gas numbers from the previous night when Grace was aggravated with the cannula and "wrestling with a BiPAP mask." The situation had caused a blood pressure reading of 235/135 and a heart rate of 150 beats per minute. Knowing her elevated numbers were provoked by the situation the night before, Scott asked the hospital to retake them. They did, and just as he predicted, Grace was fine. Scott added:

> *"So we dodged the first ventilator bullet at that point."*

The next day, Saturday, Oct. 9, Scott said Grace felt back to normal. She was hungry after not eating much the day before, and they ordered food off the menu. Once it arrived, Scott began feeding Grace. Swiftly, a nurse entered the room and told him that he could not feed Grace due to her 85% oxygen saturation. Not buying the 85% number, Scott (who had much of his COVID protocol with him after being told by the hospital that *"he would get COVID-19 while there"*) retested Grace with his own oxygen saturation meter -it read 95%. He asked the nurse if his meter reading was correct, and she said it was. Thoroughly discouraged, Scott explained:

> *"The hospital's meter read 85%, so I put mine on, and it read 95%. I called the nurse back in, and I said, "is my oxygen meter accurate?" She said, "yes." I said, "well, why does yours only read 85% and mine reads 95%?"*
>
> *[The nurse] admitted my meter was accurate and said hers was inaccurate. I asked why, and she said, "well, the leads get sweaty." I said, "if you know that, why don't you proactively change them out every four hours or whatever it needs to be?" She [sarcastically] said to me, "you should be thankful you caught this."*
>
> *So process this reality. The primary statistic they're using to manage my daughter's care, including recommendations for all kinds of crazy things, including a ventilator, is the oxygen sat[uration]. Their oxygen saturation numbers are wrong, and they're recommending a ventilator based on that.*

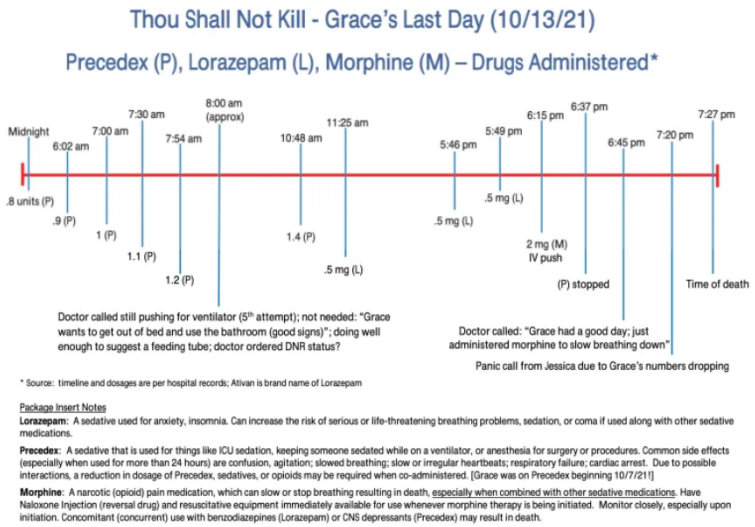


Screenshot / Our Amazing Grace / Allocation of Care – Big Picture Agenda

Following the oxygen saturation fiasco, at 7 am on Sunday, Oct. 10, Scott explained that the head nurse came into Grace's room with an armed guard and told him he needed to leave. It is crucial to note that previously, Scott had been trained by the nurses on how to turn off the alarms in Grace's room so they didn't keep her up all night. Confused about the directive to leave the room, Scott asked what prompted this out-of-the-blue action. The nurse replied, *"you've been shutting off the alarms at night."* Scott explained to the head nurse that he was given the OK to turn off the alarms by other nurses at the hospital. She replied, *"the main thing is the last three shifts of nurses don't want you in the room."* With that, the armed guard escorted Scott to his truck. He shared:

> *"These alarms are going off twenty, thirty times a night, and oftentimes it's 30 minutes before the nurses come in. Of course, they don't want me in the room challenging these things. And so I got walked out by an armed guard. He walked me all the way out to my truck. We got to my truck, he said he listened to this back and forth for an hour. He said, "you've got to take this to a higher level." He knew what the deal was. Fortunately, our special needs attorney was available on Sunday, and I got a hold of her. She coached me on how to get my daughter Jessica in the room as a replacement advocate [Cindy could not be the advocate due to having COVID]."*

Ready to go with her bags packed, on Monday, Oct. 11, Jessica was in Grace's room fifteen minutes after she was approved to go there. However, due to a lack of communication with the floor staff, Jessica could not stay overnight the first night and had to leave at 7 pm when visiting hours ended. She was with her sister all day on Tuesday, Oct. 12, watching movies and enjoying each other's company. Before Grace went to sleep, she had a FaceTime call with Jessica's boys—her two nephews—hollering, "hi boys!" The following morning, Wednesday, Oct. 13, the doctors called Scott and his wife and told them *"how good of a day Grace had the day before."*



Our Amazing Grace / Thou Shall Not Kill

Grace's Last Day: The Alarmingly Cruel Facts

In the four days leading up to her death, Grace was given the Pfizer drug Precedex, a short-term sedative (to be used for 24 hours or less, according to the package insert). On Oct. 13, the day of Grace's death, nurse Hollee McInnis—under orders from Dr. Gavin Shokar—started "ratcheting up" the administration of Precedex. By 10:48 am, Grace (who was placed in restraints around 9 am that day for wanting to go to the bathroom) was receiving 14 times the initial dose.

Then, at 11:25 am on the day of her death, the hospital gave Grace a dose of the Pfizer drug Lorazepam. Next, at 5:46 and 5:49 pm—three minutes apart—they gave her two more doses of Lorazepam. Following that, at 6:15 pm, they gave Grace a two-milligram dose of Morphine—also manufactured by Pfizer—as an IV push, not a drip.

As shown below, in a bold warning, Pfizer's prescribing information for Morphine highlights the severe and life-threatening risk of "profound sedation, respiratory distress, coma, and death" when combined with benzodiazepines (in this case, Lorazepam) and CNS (central nervous system) depressants (in this case, Precedex). Additionally, the insert clearly states, "Have Naloxone Injection and resuscitative equipment immediately available." As emphasized by a heartbroken Scott, the hospital did not have the reversal drug Naloxone at Grace's bedside ready to go if needed.

HIGHLIGHTS OF PRESCRIBING INFORMATION
These highlights do not include all the information needed to use MORPHINE SULFATE INJECTION safely and effectively. See full prescribing information for MORPHINE SULFATE INJECTION.

Morphine Sulfate injection, for intravenous or intramuscular use, CII
Initial U.S. Approval: 1941

Lorazepam

WARNING: ADDICTION, ABUSE, AND MISUSE; LIFE-THREATENING RESPIRATORY DEPRESSION; NEONATAL OPIOID WITHDRAWAL SYNDROME; and RISKS FROM CONCOMITANT USE WITH BENZODIAZEPINES OR OTHER CNS DEPRESSANTS — Precedex

See full prescribing information for complete boxed warning.

- **Morphine Sulfate Injection exposes users to risks of addiction, abuse, and misuse, which can lead to overdose and death. Assess patient's risk before prescribing and monitor regularly for these behaviors and conditions. (5.1)**
- **Serious, life-threatening, or fatal respiratory depression may occur. Monitor closely, especially upon initiation or following a dose increase. (5.2)**
- **Prolonged use of Morphine Sulfate Injection during pregnancy can result in neonatal opioid withdrawal syndrome, which may be life-threatening if not recognized and treated. If prolonged opioid use is required in a pregnant woman, advise the patient of the risk of neonatal opioid withdrawal syndrome and ensure that appropriate treatment will be available. (5.3)**
- **Concomitant use of opioids with benzodiazepines or other central nervous system (CNS) depressants, including alcohol, may result in profound sedation, respiratory depression, coma, and death. Reserve concomitant prescribing for use in patients for whom alternative treatment options are inadequate; limit dosages and durations to the minimum required; and follow patients for signs and symptoms of respiratory depression and sedation. (5.4, 7)**

RECENT MAJOR CHANGES

Boxed Warning	12/2016
Indications and Usage	12/2016
Dosage and Administration	12/2016
Contraindications	12/2016
Warnings and Precautions	12/2016

INDICATIONS AND USAGE
Morphine Sulfate Injection is an opioid agonist indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate. (1)

Limitations of Use (1)
Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve Morphine Sulfate Injection, for use in patients for whom alternative treatment options [e.g., non-opioid analgesics or opioid combination products]:
- Have not been tolerated, or are not expected to be tolerated,
- Have not provided adequate analgesia, or are not expected to provide adequate analgesia

DOSAGE AND ADMINISTRATION
- Use the lowest effective dosage for the shortest duration consistent with individual patient treatment goals. (2.1)
- Individualize dosing based on the severity of pain, patient response, prior analgesic experience, and risk factors for addiction, abuse, and misuse. (2.1)
- Direct Intravenous Injection: Initiate treatment with 0.1 mg to 0.2 mg per kg every 4 hours as needed to manage pain. (2.2)
- Intramuscular Injection: Initiate treatment with 10 mg, every 4 hours as needed to manage pain (based on a 70 kg adult). (2.2)
- Do not stop Morphine Sulfate Injection abruptly in a physically dependent patient. (2.4)

DOSAGE FORMS AND STRENGTHS
Injection, 2 mg/mL, 4 mg/mL, 5 mg/mL, 8 mg/mL, and 10 mg/mL in a pre-filled disposable syringe for intravenous or intramuscular use. (3)

CONTRAINDICATIONS
- Significant respiratory depression. (4)
- Acute or severe bronchial asthma in an unmonitored setting or in absence of resuscitative equipment. (4)
- Concurrent use of monoamine oxidase inhibitors (MAOIs) or use of MAOIs within the last 14 days (4)
- Known or suspected gastrointestinal obstruction, including paralytic ileus. (4)
- Hypersensitivity to morphine. (4)

WARNINGS AND PRECAUTIONS
- Cardiovascular Instability: High doses are excitory. Have Naloxone Injection and resuscitative equipment immediately available. (5.5)
- Life-Threatening Respiratory Depression in Patients with Chronic Pulmonary Disease or in Elderly, Cachectic, or Debilitated Patients: Monitor closely, particularly during initiation and titration. (5.2)
- Adrenal Insufficiency: If diagnosed, treat with physiologic replacement of corticosteroids, and wean patient off of the opioid. (5.8)
- Severe Hypotension: Monitor during dosage initiation and titration. Avoid use of Morphine Sulfate Injection in patients with circulatory shock. (5.9)
- Risks of Use in Patients with Increased Intracranial Pressure, Brain Tumors, Head Injury, or Impaired Consciousness: Monitor for sedation and respiratory depression. Avoid use of Morphine Sulfate Injection in patients with impaired consciousness or coma. (5.10)

ADVERSE REACTIONS
The most serious adverse reactions encountered are respiratory depression, apnea, circulatory depression, respiratory arrest, shock and cardiac arrest. Other common frequently observed adverse reactions include: sedation, lightheadedness, dizziness, nausea, vomiting, constipation and diaphoresis. (6)

To report SUSPECTED ADVERSE REACTIONS, contact Fresenius Kabi USA, LLC at 1-800-551-7176 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch

DRUG INTERACTIONS
- Serotonergic Drugs: Concomitant use may result in serotonin syndrome. Discontinue Morphine Sulfate Injection if serotonin syndrome is suspected. (7)
- Mixed Agonist/Antagonist and Partial Agonist Opioid Analgesics: Avoid use with Morphine Sulfate Injection because they may reduce analgesic effect of Morphine Sulfate Injection or precipitate withdrawal symptoms. (7)

USE IN SPECIFIC POPULATIONS
Pregnancy: May cause fetal harm. (8.1)

See 17 for PATIENT COUNSELING INFORMATION

12/2016

Our Amazing Grace / Morphine Package Insert

Precedex

Note from a doctor who reviewed the records:

Precedex is a med used for anesthesia to put people to sleep for surgery and procedures. Depending on the dose, it can induce a coma-level sleep.

Each of these meds (Precedex, Lorazepam, and Morphine), on their own, have an increased risk of serious or life-threatening breathing problems and cardiac arrest, and there's an additive effect when used in combination. To use them like they did in a person with a diagnosis of ***acute respiratory distress*** is beyond believable as to intention.

A nurses perspective:

I am a RN but left the bedside almost 3 years ago. I currently review clinical for acute inpatient admissions and have been seeing a ton of Covid cases lately. What never made sense, until now, was all of the people being put on Precedex while on HFNC or BiPAP. I never understood why they would need a sedative like that if they weren't actually intubated. Especially if sedatives decrease your respirations which in turn decrease your oxygen levels. They're doing this so they can throw an ET tube down their throats at a moment's notice without consent! You give up 100% control once they are in the hospital care and it is so very scary.

Precedex is an IV sedative

Very important:

1. Once on Precedex, the patient is considered ICU even though room does not change and level of care does not change. What does change? The amount of money the hospital receives!
2. Once sedated, the hospital can and will deny your right to leave the hospital against medical advice (AMA) if you feel you are not getting the care you choose or need.

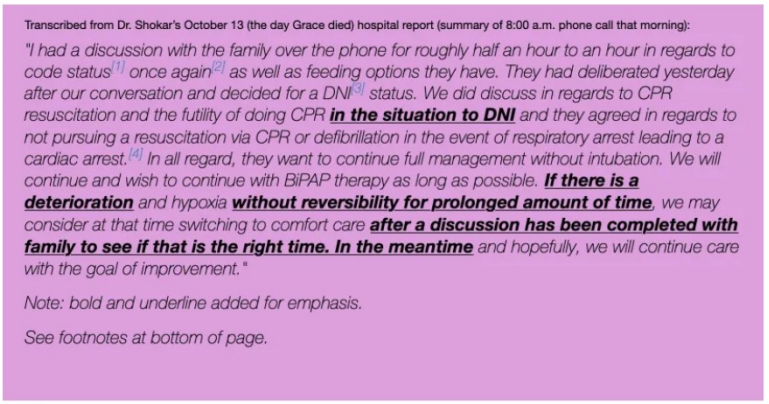
Screenshot / Our Amazing Grace / Precedex notes from doctor and nurse

At 6:45 pm, thirty minutes after the doctor administered the two-milligram dose of Morphine, he called Scott and his wife to tell them, *"Grace had a good day."* He also informed them he had just given Grace Morphine. Stunned, Scott asked the doctor why Grace was given Morphine and was told, *"because she was breathing at 51 breaths a minute."* In disbelief, a devastated Scott detailed to attorney Tom Renz the final 42 minutes of Grace's life, explaining:

> *"Think it through—they caused the breathing to go like this. Of course, I didn't know anything about this combination of drugs at that time. Jessica then called us at 7:20 pm while she was in the room with Grace. She has us on FaceTime. My wife and I are watching and can see Grace, and [we can also see] Jessica panicking because Grace's numbers are tanking. And we're hollering, "get the nurses in the room."*

Jessica said, "I've already done that, they won't come in." So we're all hollering at these nurses. She estimated there were about 30 nurses outside the door at that time because of the shift change, and they would not come into the room. We were hollering, "Save our daughter, help her." And they hollered back, "She's DNR [do not resuscitate]." We screamed, "She's not DNR." My wife questioned, "Are you not helping our little girl because she has Down Syndrome?"

This was the first we knew that Grace was DNR. The doctor had put the order in the computer, but we did not sign the DNR. We never asked for a DNR. At approximately 7:22 pm, one of the nurses read the DNR note to Jessica from the computer screen, [implying we couldn't] do anything about it. But the DNR law, which I've looked up, requires them to override a DNR if the patient or a power of attorney requests it. Well, of course we requested it—this is our daughter. They stood outside the room, and it got even worse. They had an armed guard outside the room. So we watched her die on FaceTime."

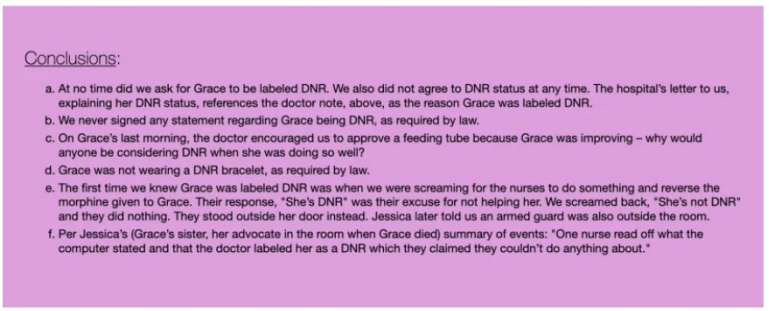


Transcribed from Dr. Shokar's October 13 (the day Grace died) hospital report (summary of 8:00 a.m. phone call that morning):

"I had a discussion with the family over the phone for roughly half an hour to an hour in regards to code status[1] once again[2] as well as feeding options they have. They had deliberated yesterday after our conversation and decided for a DNI[3] status. We did discuss in regards to CPR resuscitation and the futility of doing CPR ***in the situation to DNI*** *and they agreed in regards to not pursuing a resuscitation via CPR or defibrillation in the event of respiratory arrest leading to a cardiac arrest.[4] In all regard, they want to continue full management without intubation. We will continue and wish to continue with BiPAP therapy as long as possible.* ***If there is a deterioration*** *and hypoxia* ***without reversibility for prolonged amount of time****, we may consider at that time switching to comfort care* ***after a discussion has been completed with family to see if that is the right time. In the meantime*** *and hopefully, we will continue care with the goal of improvement."*

Note: bold and underline added for emphasis.

See footnotes at bottom of page.



Conclusions:

a. At no time did we ask for Grace to be labeled DNR. We also did not agree to DNR status at any time. The hospital's letter to us, explaining her DNR status, references the doctor note, above, as the reason Grace was labeled DNR.
b. We never signed any statement regarding Grace being DNR, as required by law.
c. On Grace's last morning, the doctor encouraged us to approve a feeding tube because Grace was improving – why would anyone be considering DNR when she was doing so well?
d. Grace was not wearing a DNR bracelet, as required by law.
e. The first time we knew Grace was labeled DNR was when we were screaming for the nurses to do something and reverse the morphine given to Grace. Their response, "She's DNR" was their excuse for not helping her. We screamed back, "She's not DNR" and they did nothing. They stood outside her door instead. Jessica later told us an armed guard was also outside the room.
f. Per Jessica's (Grace's sister, her advocate in the room when Grace died) summary of events: "One nurse read off what the computer stated and that the doctor labeled her as a DNR which they claimed they couldn't do anything about."

Footnotes

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

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

[3] Do Not Intubate – i.e. ventilator

[4] This was all hypothetical, in that Grace had good days on October 12 and 13, according to our calls with Dr. X and our bedside experience.

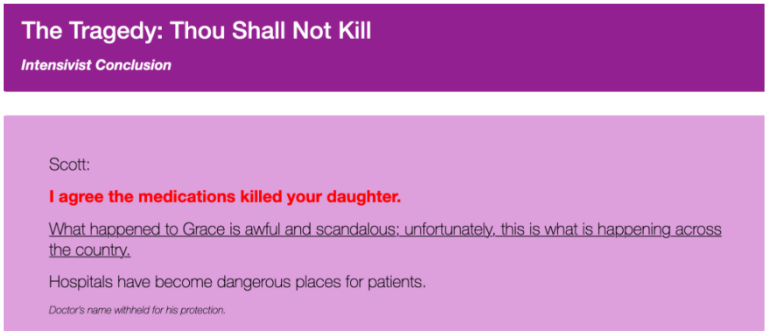
Screenshot /Our Amazing Grace / DNR Notes Transcribed from Dr. Shokar's Oct. 13 Hospital Report

To this day, Scott is uncertain of the motivation behind Grace's death. Still, he is convinced the combination of medications set up and caused her death. After all, why did the doctor label Grace DNR, administer Morphine, and then ignore the drug's warnings despite her family's desperate pleading to keep her alive? Why didn't the hospital have the reversal drug Naloxone on hand per Pfizer's instructions? Why was an armed guard posted outside Grace's hospital room door in an apparent effort to prevent staff from helping?

As Scott speculates whether Grace died because of her disability, hospital greed, or rationed care, his investigations have led him to *"put together some interesting information that may explain what took place."* He explained, *"If money was the primary motivator, and there's not a legal method to hold the individuals accountable, the evidence we've put together fits the crime."* A page on Grace's website explains Scott's findings further:

"As the U.S. population gets wise to Remdesivir, combined with staffing concerns related to doctors and nurses leaving because of refusing to take the jab and ethical concerns, the medical system will turn to drugs normally used for palliative (end of life) care as the primary tool to accomplish the agenda. This pattern, along with DNR

authority taken away from patients/advocates (through government-issued blanket DNR orders on certain population groups), is already happening in the U.K. (see U.K. Attorney, Clare Wills-Harrison explain "end of life drugs and protocols.") Surprisingly, in a Stateline Article dated Mar. 31, 2020, this abuse in the U.S. was already exposed. The article states, "Over the weekend, the U.S. Department of Health and Human Services issued a reminder that people with disabilities have the same worth as everybody else." Why the reminder? "...some U.S. Hospitals already are considering do-not-resuscitate orders for infected patients." Is COVID the convenient excuse to accomplish a portion of the agenda?"

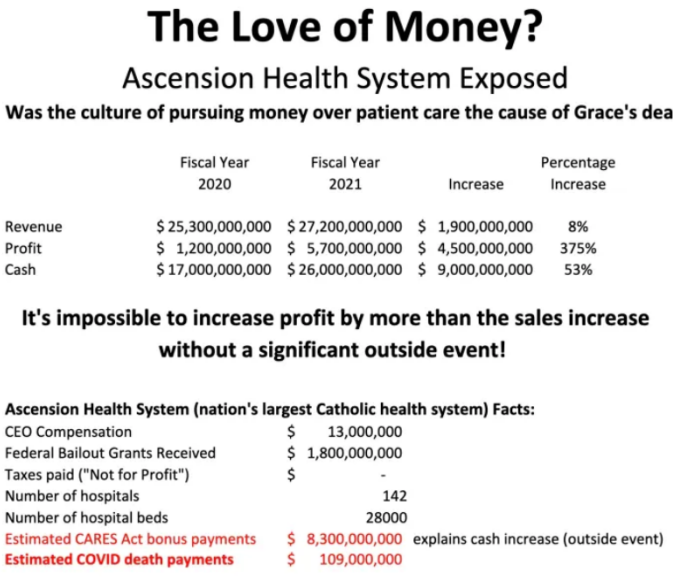


Screenshot / Our Amazing Grace / Intensivist Conclusion

No Liability & Massive Financial Incentives to COVID Hospitals

Since losing Grace, Scott has done extensive research into the "many abuses, dangers, and financial temptations" occurring in hospitals across the country following the government-funded protocols. As described in Scott's research, according to whistleblowers from the Centers for Medicare and Medicaid Services (CMS), the average CARES Act bonus payment is at least $100,000 per patient. With a combined total of 28,000 beds, St. Elizabeth's hospital is one of 142 hospitals in the Ascension Health System. The national average of hospital beds related to COVID-19 is 18%, and the average COVID-19 hospital stay is 22 days. Remarkably, Ascension health system revenue went up by $1.9 billion from 2020 to 2021, and profit by $4.5 billion. And with money from the U.S. government, its cash flow increased by nearly $9 billion. Scott explained his research into hospital corruption during COVID-19 further, adding:

"Doing the math, Ascension received approximately $8,300,000,000 in each of the two years of COVID! This money is in addition to patient and insurance payments received. This is 'free money' just for following the government's COVID protocol. On a national level, there has been 4,000,000 COVID hospital stays so far (per Dr. Paul Marik—testimony during Ron Johnson's 'Second Opinion' hearing on Jan. 24). Those hospital stays translate to $4,000,000,000,000 [that's 4 Trillion] of our money transferred by the government to their partners facilitating the crime. Where's the motivation to research cures when hospitals and their staff are incentivized to follow an agenda?"



Per Centers for Medicare and Medicaid Services (CMS) whistleblowers, the average CARES Act bonus is at least $100,000 per COVID patient. Hospitals receive:

* Fee for each "free" *required* PCR test in the Emergency Room or upon admission for every patient
* Added bonus payment for each positive COVID-19 diagnosis
* Another bonus for a COVID-19 admission to the hospital
* A 20% "boost" bonus payment from Medicare on the *entire hospital bill* for use of Remdesivir
* ICU bonus for patients on Precedex
* Large bonus payment to the hospital if a COVID-19 patient is mechanically ventilated
* More money if cause of death is listed as COVID-19, even if patient did not die directly of COVID-19

If COVID is cured, the "free" money stops flowing!

Ascension Facts Related to Grace's Death (St. Elizabeth Campus, Appleton, Wisconsin):

Percent ICU bed capacity when she died		100%	
Percent bed capacity when she died		99.8%	
Daily amount received from Medicaid	$	1,680	
COVID death bonus received	$	13,000	
Medicine administration grade		F (45%)	avg hospital = 86%
Avg cost oxygen satuation lead for Grace	$	78	only 3 charges in 7 days!

Screenshot / Our Amazing Grace / The Love of Money? Ascension Health System Exposed

Medical Malpractice

Doctors Are Immune From Liability!

Federal COVID Immunity:

Per the Congressional Research Service, "To encourage the expeditious development and deployment of medical countermeasures during a public health emergency, the Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the Secretary of Health and Human Services (HHS) to limit legal liability for losses relating to the administration of medical countermeasures such as diagnostics, treatments, and vaccines." This action was taken on February 4, 2020. "Under the HHS Declaration and its amendments, covered persons are generally immune from legal liability (i.e., they cannot be sued for money damages in court) for losses relating to the administration or use of covered countermeasures against COVID-19. The sole exception to PREP Act immunity is for death or serious physical injury caused by 'willful misconduct.'" This authority precludes state statutes!

State Immunity:

Wis. Stat. §§ 893.55:

- Limits liability claims to $750,000 to ensure affordable health care.
- This statutory limit has been in place for 16 years.

Wis. Stat. §§ 655.006:

- No loss of companionship for adult siblings.
- This statutory limit has been in place for 47 years.

Wis. Stat. §§ 895.04:

- No wrongful death claim for adult children.
- No exception made for disabled adult children under a parent's care.

Most states have similar provisions under the guise of "providing affordable health care."

Questions:
Why do doctors need immunity if they care about the health of the patient?
Does immunity impact quality of care?

Lack of patient advocacy and government bonuses, combined with immunity from liability, provide a deadly temptation.

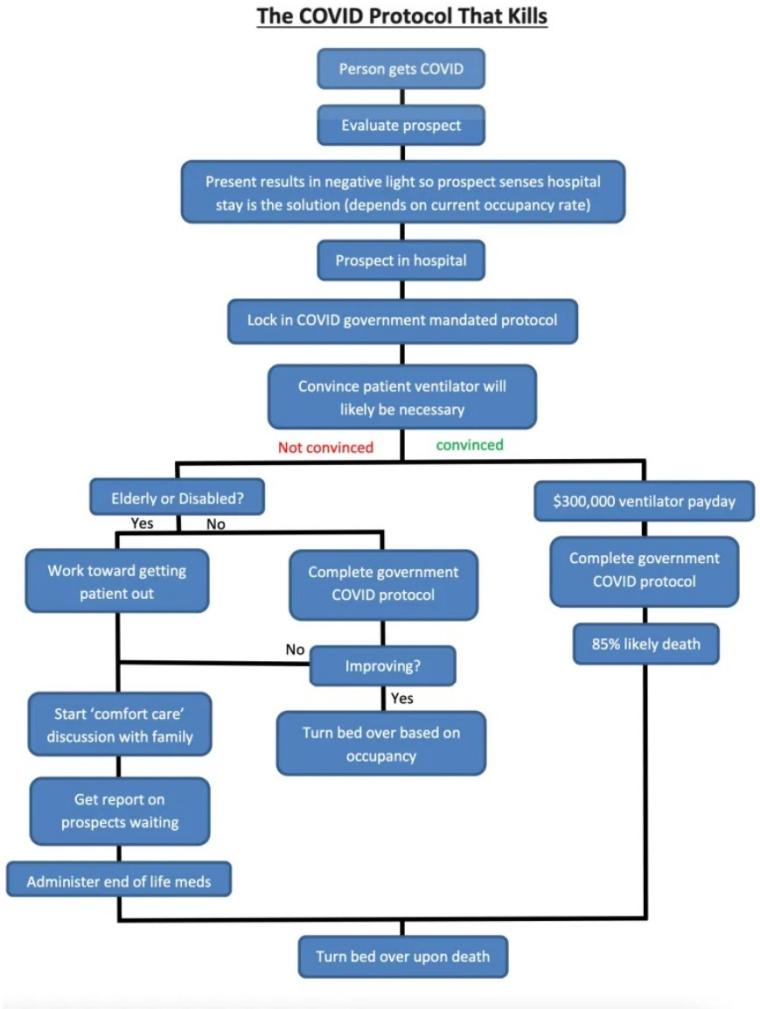
Screenshot / Our Amazing Grace / Medical Liability – summary of immunity from liability

With no accountability, government protocols are based on the WHO's 2005 International Health Regulations, as reported by UncoverDC. In the U.S., WHO statutes direct the Centers for Disease Control (CDC) and the National Institute of Health (NIH) on treatment protocols. From there, hospitals that are federally funded through CMS use coding tied to NIH and CDC-written COVID-19 protocols. If those hospitals take that funding, they must follow those protocols, starting with ICD-10 codes (International Classification of Diseases).

As explained further by attorney Todd Callender in the Epoch Times, these protocols *"are passed down hierarchically from the WHO to the CDC and the NIH arising from the Public Readiness and Emergency Preparedness Act (PREP Act) and Health and Human Services authorization to release funding for the declared pandemic that sets the protocols in motion."* Callender added:

> *"The WHO then directs the various state health bodies—in this case, the CDC and NIH —on treatment. This is why every country is responding in the same way at the same time globally; it's a back door to a one-world dictatorial government."*

Under the emergency declaration, once these protocols are passed down to the hospitals that accept funding, "patients' rights are waived under the CMS COVID waiver program in conjunction with the PREP and CARES Act, giving participating hospitals legal immunity.



Our Amazing Grace / Tragedy Money Covid Flowchart

The Miracles After Grace's Death

In this tragedy, it is natural to question, "Where was God?" According to Grace's family, *"The same place He's always been. He never changes. Grace is with Him today. How do we know? By the fruit she produced. Grace loved Jesus, and that love produced some amazing fruit. Grace's favorite Scripture was 1 John 4:8, which she abbreviated "God is Love."*

Steadfast in his faith, Scott is convinced that God has his back and he and his family are "walking accordingly." He said that doors keep opening for him to share what happened to Grace, and so far, he's *"documented over 30 miracles that have already taken place."* For example, after listening to Sen. Ron Johnson's hearing on Jan. 24, he began looking for a particular intensivist to discuss the deadly combination of medications the hospital gave to Grace. He explained:

> *"As soon as I was done watching the hearing, I wrote a letter to [the intensivist] and took it out to the mailbox. We live out in the country, and the mail had already been delivered. So I called the post office, and they were already closed. I decided to look the doctor up on a Google search. You can't make this up. I saw a phone number, and I called it. It happened to be his home landline, and his daughter picked up. I asked to speak to her dad, and she said, "who is this?" I replied, "I'm a dad in Wisconsin that lost his daughter in the hospital to a COVID situation." She hollered and asked her dad if he wanted to talk to someone who had lost their daughter. He came to the phone, and we talked. He gave me his email address, and we've had several conversations back and forth since."*

Without a doubt, Scott is certain Grace is working through God to shine a light on what happened to her and so many others. Another miracle helping to illuminate the truth occurred after Scott had recently been in the hospital himself for COVID-19. Extremely sick, his experience was entirely different from Grace's because, after what happened to her, he went to a different hospital (St. Vincent's in Green Bay) where his voice mattered. He was given a pill protocol including vitamin E, probiotics, fish oil, and the medicine Baricitinib (for reference, Grace was offered Tocilizumad but Scott rejected it after reviewing studies on the drug. She was never offered Baricitinib). Once recovered, Scott realized he had not received a bill from the hospital—he was expecting it to be approximately $30,000. He called the hospital, and they told him, *"they wrote it off to HRSA because we don't have insurance. We used the money for the billboards."*

After being informed by a medical malpractice attorney of the slim chances of winning a case on Grace's behalf, the attorney remarked that any money "would be better off spent on billboards" to spread the message about what happened to Grace. With the miracle from St. Vincent's, Scott bought space on the 12 billboards available on Highway 41. The cost is $29,000 for four weeks.

According to their website, the Schara family is in the process of establishing a charitable foundation to honor Grace and share her story, so more people don't die in hospitals during the pandemic. A true light for the Lord while on this earth, Grace's favorite Scripture verse was 1 John 4:8. She would include "God is Love" with many of her works of art. The family's website, called Our Amazing Grace, summarizes their mission, stating:

> *This is a tragic story. However, we know that God is sovereign and will use this tragedy for good. We envision the foundation we establish in Grace's memory to provide many people with disabilities the opportunity to share their talents and spread the light that Christ has placed in them with the world.*

TAGS Appleton | Ascension Healthcare | CARES Act | CDC | Coronavirus | Covid | COVID Hospital Protocol | Covid-19 | DNR | Down Syndrome | Dr. Elizabeth Lee Vliet | Dr. Gavin Shokar | Dr. Paul Marik | Grace Schara | Hollee McInnis | Lorazepam | Medical Malpractice | Morphine | mRNA Vaccines | Naloxone | NIH | pandemic | Pfizer | Precedex | PREP Act | Scott Schara | St. Elizabeth Hospital | St. Vincent's Hospital | UncoverDC | Ventilator | WHO | WI

Michelle Edwards