Parker Stewart

As told by Parker's mom, Yvonne Gardner

My son Parker was very aware of others and how to help them. He often got teased himself because of his height, large 16 size feet and his big smile. He would walk with the kids that he had noticed being bullied down the halls of his high school to help them feel safe. Parker had grown up with 3 older brothers and 4 younger siblings and was not afraid of anyone or anything. He loved life and everyone in it. Parker had a tradition of buying a few dozen roses on Valentine's day and handing them out to the girls at school that didn't have someone to give them a valentine. At his funeral, many people told me of how he had helped them, from changing a tire in a snowstorm to sitting up with someone all night after they had told him about their desire to end their own life.

Parker's hugs were legendary. He would always greet you with a big hug by wrapping his long arms around you and pick you up off the ground. Those hugs would melt away the day's troubles because you knew someone loved and cared about you. (Especially for a mom with a lot of teenagers, hugs from your kids are the best!)

On that fateful day, I was sitting in church and my daughter leaned over and said, "Mom, look at your phone." I got it out of my bag and saw a message from my daughter-in-law to call her. I texted her and asked her if I could call her in a few minutes, but as I was sending the text, she called me. I got up and left the meeting and answered the call. The first thing she said over her sobs was, "Parker is not breathing." She said the ambulance was already there. I rushed back in and got my family and we drove the mile to their home. As we approached the house an EMT came up and told me it was too late. "What???" Too late for what? What happened to my son??? The police tried to tell me it was an overdose. "Really? That is what you are going to tell a grieving mother, this was an overdose??? Not my Parker, I told them". He hated taking Tylenol or any medication to treat pain. He would often tell me when he had a headache that he was going to go lay down for a bit, or drink some water,

instead of taking a pain killer. He was only taking this prescription because the doctor told him that a tonsillectomy surgery as an adult would be more painful and that he needed to stay on top of the pain so that he didn't have any complications." Parker would not have taken too many pills!

It was a bitter cold December morning as we stood in front of Parker and Madi's home trying to make sense of what happened. We were being told that his death was a "rare occurrence, a firestorm of events that came together and caused his death."

I asked myself over and over how could a healthy 21-year-old male could just go to sleep and not wake up? How does that happen? No one had any answers for me. I was devastated, I was not prepared, nor did I want, to bury my child.

Parker and Madi had come to our house the night before around 6 pm and delivered a Christmas gift for us. I was thinking how on top of things this new couple was, they had been married only three short months. We were able to visit for a few minutes and then they were off making the rest of their deliveries. This was the last great big bear hug that I received from my son.

Madi, Parker's wife described to me later what happened on their last night together. They had spent the day putting up their first Christmas tree. It looked beautiful. When they arrived home that evening, Parker wrapped his gifts to Madi and put them under the tree and told her that he was feeling tired, so he was going to lay down in the bedroom. This was around 8 pm. She finished taking care of the decorations and then went to bed. Parker woke up around 1 am and she went into the kitchen to get him a pain pill. Madi was very meticulous about recording what time Parker took his medication and how much. This helped us later as the Coroner proved that Parker had only taken half of the prescribed dose of his medication. They laid in bed that night talking for an hour before they both drifted back to sleep. They spent the time talking about their future, what they wanted to name their children and the exciting events they had planned for the holidays. No one knew that we would spend that Christmas with broken hearts burying her beloved husband, son, brother, grandson, nephew and friend.

Madi was up early the next morning and let Parker sleep to help him recover more quickly. She went in to wake him up for church at noon and could not get him to respond. She tried doing CPR but was told when the EMT's arrived that he had been gone too long and that they could not revive him.

Only a few days later, a good friend of mine told me that this same thing had happened to a 3-year-old neighbor that she knew. I called and spoke to the mother.

She told me her heart wrenching story. This got me thinking that this was not a "Firestorm of events" after all… How does a 3-year-old female and a 21-year-old male, both tonsillectomy patients, die the same way, a few days after the surgery, both found dead in bed? Within a year of each other? I started researching online and found many other stories about this happening to at least 5 in our valley within the last two years and many across the United States.

Three weeks after my son's death, my daughter-in-law told me of a 15-year-old girl that lived less than a mile from my home that was saved because Dr. Catten (Parker's doctor) had given her a pulse-oximeter to take home with her to monitor her oxygen levels. We went and visited with Amanda and cried right along with her as she told us her story. Her parents had been watching the monitor closely, but it was a model that did not alarm when her blood oxygen levels dropped below a safe level. After two long days of recovery and everyone was exhausted, her parents decided to have her sleep between them. At 3:45am her mother last talked to her and she seemed to be doing fine, at 4:00 am her mother suddenly awoke to find her daughter not breathing and not responding to any stimulation. They immediately began CPR and called for an ambulance, she started breathing and regained a pulse 2 times and then she would be gone again. Finally, the EMT's revived her with 4 doses of Narcan on the way to the hospital and more upon arrival. She spent several days in the hospital recovering from the effects caused from going without oxygen. We learned from her experience that this kind of death can happen so quickly, but your body gives you signs plenty of time in advance if you use a pulse-oximeter or proper monitoring.

I learned of another near-death story of a woman in her 30's that had had a tonsillectomy and was living in Idaho at the time. This had occurred 3 months before my son's death. A couple days after the surgery, she laid down on the couch to rest and later was found unresponsive by her daughter who called the EMT's and they were able to save her mother. She was treated at the hospital for pneumonia, she was told that she must have had it before she had her tonsils out, she said that she did not.

A young mother with 4 small children here in Vernal, Utah is lucky to be alive after taking pain medication for her tonsillectomy. Her husband had set a timer for every 4 hours to give her the dose prescribed by her doctor. At 5 am when he went to give her the medication, he was unable to wake her up and an ambulance was called, and thanks to the swift action of the ambulance crew, she is still with us.

Another tragic story was told to me by the father that lived it. He was at home on a Sunday night watching Sunday night football with his son. He was a football coach who had coach his son in football through all his growing up years and now loved watching his 21-year-old son excel at playing football for Portland State. His son AJ

had had his tonsils removed a couple of days prior and was still recovering. His son had taken his pain medication and sat down in the chair next to him to enjoy the game and then dosed off, so he just let him sleep. He noticed his son's breathing becoming labored and then his son stopped breathing. He shook his son trying to get a response and then put him on the floor, began CPR and called an ambulance. His son died and the EMT's were unable to resuscitate him. His mother and sister arrived home too late that evening to tell their brother and son goodbye. Another family devastated because we had no idea of the serious side-effects from these drugs that we are given to reduce pain.

In my research of the pain killer – Percocet (that is what Parker had been prescribed), the very first 2 side-effects listed were Respiratory Depression and Death. The drug label warning went on for another 15 pages listing out all the other side-effects in small print that have occurred and could occur if you take this product, so why was this not stressed when this was given to my son and daughter?

Yes, Parker and his sister Sadie had their tonsils removed the same day. She was at home on that fate-filled Sunday recovering and texting my other daughter telling me to call Madi, Parker's wife. Sadie had been prescribed the same dose of Percocet as Parker. Sadie is 5'9" 130 pounds, Parker was 6'5" weighing in at 230 pounds. They both had been prescribed a small dose. This had not affected her in the same way, but she had been unable to sleep much at all because of the pain. The medication took the edge off, but that was all.

It took 6 months from the day we buried Parker to get the final autopsy report. That is when I found out that Parker's cause of death was listed as Pneumonia. Again, I was so confused. Parker had been at my home the night before, looking good, he had no difficulty breathing, no problems at all. You would not have guessed that he just had his tonsils and adenoids removed and his sinuses stretched. He was laughing and teasing his sister Sadie that was still lying on the couch complaining of all the pain that she was still in.

In the beginning, I was relieved to hear of the stories of those that had been saved by Parker's doctor taking measures into his own hands and making changes at the local hospitals, but as time went on, I was hearing more and more tragic stories about others that were still dying unnecessarily.

Dr. Catten was given so much grief because he wanted to change the protocols at our local hospitals immediately before someone else died. For the others that had died this way, their deaths had been rationalized as some other cause, for example: poor health, possible other drug problems, sleep apnea, overdoses, surgical complications,

but many of the autopsy's had the same cause of death listed as Pneumonia.

The medical examiner was baffled by Parker's autopsy and we discussed her findings a few times before she submitted her final report. Everything showed Parker as an extremely healthy young man. An elevated white blood cell count along with fluid in the lungs are what she based her conclusion of Pneumonia on. I later learned that this is very typical symptom of respiratory depression caused by taking an opioid based drug for pain. There are many studies out there, but for some reason this is continuing to happen.

The day I received this report, I came across a medical article written by a Dr. Andrea Rubinstein. It was titled, 'Opioids linked to hospital pneumonia'. This tied in some of the puzzle pieces that I was missing to help me find out what happened to my son. Maybe the opioids had caused the pneumonia symptom???

During the time that this was all going on, Madi and I and my husband had met with Dr. Catten a few times to try and figure this problem out. Dr. Catten suggested trying to get the word out by taking this to the Utah Legislature. We set up an appointment with Senator Van Tassell and he got the ball rolling from there. The attorney that was drafting the bill sent us a few rough drafts to read over. After it was all said and done and ready to go before the legislative committees, we went before the committees and told our story. They seemed shocked! They had never heard of people dying this way. They had only heard of people overdosing from opioids, but people dying taking their prescribed amounts was unheard of. This was a side to the opioid problem that had never been looked at. Were people dying unnecessarily? Could this be prevented by monitoring that was already available? Could lives be saved as quickly as we could get the word out? Was it low cost? Yes, to all these questions.

Senator Van Tassell and his team were very wise to ask for the medical professionals help in solving this problem. Medical professionals are on the front lines every day and they have encountered these cases numerous times, but they had not been informed with the knowledge that the opioids could be causing the problem. Kim Bennion with Intermountain Health Care Hospitals has been working on finding a solution to this problem since 2008. She realized the connection when her 30-year-old brother-in-law was found dead in bed after taking opioids for pain after a bunion surgery, leaving her sister to raise 4 children under the age of 10 all by herself.

I have said many times, that I wish someone would have done something sooner so my son would still be alive, enjoying being married and possibly a father by now, but here I am. I learned from a wise grandmother growing up that when the question is asked, "Why didn't somebody do something? She told me that I needed to remember that I was somebody. I am hoping that we can get the word out along with all the

other things that the medical community is learning, to prevent these unnecessary deaths, so we can enjoy more time with our loved ones.