

My father, Joseph R. Di Bella, entered Katherine Shaw Bethea Hospital (KSB) in Dixon, Illinois, on July 17, 2021, for severe shortness of breath and low oxygen, and no other symptoms. KSB's COVID screening documentation contains "Symptomatic as defined by CDC? No" and "Hospitalized due to COVID-19? No." He had COPD, sleep apnea, and a past smoking history. Diagnosed with Pneumonia.

Before he lost the ability to speak for himself, he objected to being ventilated and placed into an induced coma. On July 18, he texted me that a doctor wanted to put him on a ventilator and induce a coma; his message included "hell no" and "No. Thank you." Our family recalls his wife being told he had to be placed into an induced coma and intubated or he would die, that there was no other treatment, and that this would likely last two weeks or less.

KSB intubated and induced a coma on July 20 and arranged helicopter transfer to OSF Saint Anthony Medical Center in Rockford. Our family was told KSB did not have the beds, equipment, or capability to manage the level of care he would need after intubation. OSF records document that during transfer he became bradycardic, received about one minute of chest compressions and 1 mg of epinephrine, and arrived requiring blood-pressure support.

When he arrived at OSF, I recall being told we could not see him because he was under COVID isolation. I objected because, based on the timeline we had been following, he was already well beyond the isolation period. The nurse spoke with a doctor and returned saying visiting hours had ended but we could begin seeing him the next day. I also recall that earlier only his wife had been allowed to be present, leaving her alone during major treatment decisions. An OSF physician later documented on July 28 that COVID isolation could be discontinued.

Later at OSF, after doctors and nurses repeatedly told us his numbers were improving, I repeatedly asked why he still had to remain unconscious and whether his remaining pneumonia could be treated while he was awake. I specifically asked OSF doctors and nurses about ivermectin and hydroxychloroquine. I recall being told those treatments were not allowed, that remdesivir was the only COVID treatment protocol they would use, and that a different course would require court action.

OSF later documented a lower-respiratory infection and a healthcare-associated urinary tract infection. Our family recalls that infection and fever postponed a planned awakening. He improved again. We were told sedation would be reduced, he was going to wake and see his family, and rehabilitation arrangements were being established. Kindred Sycamore accepted him, and on August 14 reported an ICU bed available.

A PEG feeding tube had been placed on August 6 while our family understood he was being prepared for recovery and rehabilitation. Instead of waking and transferring, another fever escalated. On August 14, CT imaging showed the gastrostomy tube outside the stomach with contrast spilling into the peritoneal cavity. Emergency surgery documented a displaced PEG and leaking stomach opening; approximately six liters of intraperitoneal fluid were evacuated. The

chart then states septic shock was due to peritonitis from the leaking PEG. He developed acute renal failure, shock liver, multi-organ failure, and died on August 16.

I ask Congress to investigate whether his expressed wishes were honored; whether isolation and visitation restrictions impaired family advocacy; why an only-protocol treatment approach was imposed; when the PEG became displaced; whether warning signs were missed; and whether these policies contributed to a preventable death. All due to covid protocols.